



Treatment Needs Assessment

Department of Drug and Alcohol Programs

York/Adams Drug & Alcohol Commission

12/30/2015

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OBJECTIVE OF TREATMENT NEEDS ASSESSMENT

It is well documented that the prevalence of substance use disorders and the demand for treatment do not commonly match available resources. An estimate of a community's substance use prevalence, incidence and treatment demand can be utilized to match available treatment resources with projected demand and to plan for the development of new resources based upon unmet needs. Drug use trends and vulnerable populations can change over time across communities. These changes will impact prevalence, incidence and treatment demand estimates and are utilized to develop new treatment approaches and systems, if warranted.

It is anticipated that the information contained in this treatment needs assessment, as provided by the York/Adams Drug & Alcohol Commission, will significantly contribute to the Commonwealth's ability to detect patterns of unmet need, and provide a strategic view to funding agencies regarding what must occur in order to improve treatment service systems.

YORK/ADAMS DRUG & ALCOHOL COMMISSION BACKGROUND

The York/Adams Drug & Alcohol Commission, hereafter known as the Commission, was established in 1973 to serve as the Single County Authority (SCA) for the joinder counties of York and Adams. As such, the Commission is responsible for oversight evaluation, planning, funding, and administration of the local drug & alcohol prevention, intervention and treatment and treatment related services within the joinder counties.

The direction of the Commission comes from an on-going assessment of community needs and corresponding Comprehensive Strategic Plan. The Commission Needs Assessment provides the foundation for the Commission Comprehensive Strategic Plans. These plans outline an analysis of the needs assessment results, the corresponding plan of action and assist the Commission in using available data as part of the county planning process, in addition to defining needs and developing the resources necessary to meet those needs.

PREVALENCE OF SUBSTANCE USE DISORDER OF TOTAL POPULATION

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

Definitions:

Estimate: A numerical 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 of individuals with a diagnosable condition at a given time.

Substance use disorder: A problematic pattern of substance use leading to clinically significant impairment or distress.

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

In order to evaluate the prevalence of substance abuse disorders of the total population of York/Adams Counties, one must first examine the population of both counties. Appendix A (Table 1: Estimates of the Prevalence of Substance Use Disorders: as reported by Pennsylvania, SCAs and State and based upon the 2006-2007 National Survey on Drug Use and Health) provides estimates of the prevalence of substance use disorders in the total population.

According to Appendix A, a total of 521,828 residents resided in York/Adams Counties in 2006-2007. Of this population, 85% were age 12 or above, with a total of 34,089 persons potentially experiencing a substance use disorder. The most represented age group is adults (Age 26+) with 19,734 persons, followed by young adults (Age 18-25) with an estimated 10,717 persons, and adolescents (Age 12-17) with an estimated 3,095 persons with potential substance use disorders.

While examining total population data allows for a broad overview of estimated substance use disorders of the total population, it is important to additionally focus attention to special populations, such as criminal justice, child abuse and neglect cases, and domestic violence as this data can further assist in determination of substance use prevalence. Appendix B, (Table 2: Prevalence of Substance Abuse Dependency Disorders in Special Populations) outlines estimates of substance abuse for these special populations. This data is further expanded upon by category, below:

Criminal Justice

The Pennsylvania Uniform Crime Reporting Program reports crime statistics for the Commonwealth of Pennsylvania. According to this report, in 2014 a total of 1,811 persons

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were estimated to have substance use problems based upon drug possession offense. York County represented 87% of the total offenses, with Adams only representing 13%. Adults (Age 18+) committed 1,625 of the offenses while adolescents (Age 18 and under) committed 186. Further, in 2014, there were a reported total of 976 DUI arrests, 972 Liquor Law violations, and 738 arrests for Drunkenness, resulting in a total of 2,686 alcohol related offenses. York County represented 76% of total offenses and Adams County represented 24%. Adults (Age 18+) committed 2,490 of the offenses while adolescents (Age 18 and under) committed 196.

Further, based upon data from the Pennsylvania Board of Probation and Parole, a total of 11,877 adult individuals were on County Probation or Parole during 2014. The following is breakdown of those individuals per County:

York County

ARD	0
PROBATION	2, 265
PAROLE	2, 112
ABSCONDERS	238
PWV	0
BAIL	475
IPP	1,320
INACTIVE	3,520

TOTAL: 9,930

Adams County

ARD	337
PROBATION	255
PAROLE	570
ABSCONDERS	103
PWV	Data Not Available
BAIL	3
IPP	576
INACTIVE	103

TOTAL: 1,947

Based upon Department of Correction estimates, 70% or 8,313 individuals in York/Adams County have substance use problems that are on County Probation/Parole.

York and Adams County house two correctional facilities. The York County Prison is located in York County and the Adams County Correctional Complex is located in Adams County. As of 2014, York County Prison houses 12,476 inmates, and Adams County Correctional Complex houses 1,585 inmates for a total of 14,061 inmate capacity for both facilities combined.

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The Department of Corrections estimates that 70% of incarcerated individuals have a substance use disorder. Based upon total combined jail population of 14,061, this would mean that 9,843 incarcerated individuals in York County Prison and Adams County Correctional Complex have substance abuse problems.

In York/Adams Counties, in 2014, a total of 2,300 individuals were on State probation or parole. Of those reported on State parole residing in York County, there were a total of 290 individuals of which 244 were male and 46 were female. Of those reported on State parole residing in Adams County, there were a total of 1,713 individuals, of which 1,557 were male and 156 were female. The Department of Corrections estimates that 70% of individuals on State probation/parole have a substance problem. Based upon total figures for both Counties, 1,402 individuals on State probation/parole in York/Adams are estimated to have a substance problem.

Child Abuse/Neglect

Data for substantiated child abuse and neglect cases reveal a total of 166 for York/Adams County in 2014. Totals specific to York County are 142 individuals and totals for Adams County are 24. It is estimated that 50% or 83 total individuals in York/Adams have substance problems according to the National Center on Substance Abuse and Child Welfare.

Domestic Violence

According to the Family Court Caseload Report of the Administrative Office of Pennsylvania Courts, there was a total of 771 Protection from Abuse cases filed in York/Adams County in 2014. Two hundred and seven of those cases were disposed by final order by stipulation or agreement. SAMHSA Substance Abuse Treatment and Domestic Violence TIP 25 indicate that 25% or 51 of those cases involve substance abuse.

IDENTIFICATION OF EMERGING SUBSTANCE USE PROBLEMS/TRENDS

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

Definitions:

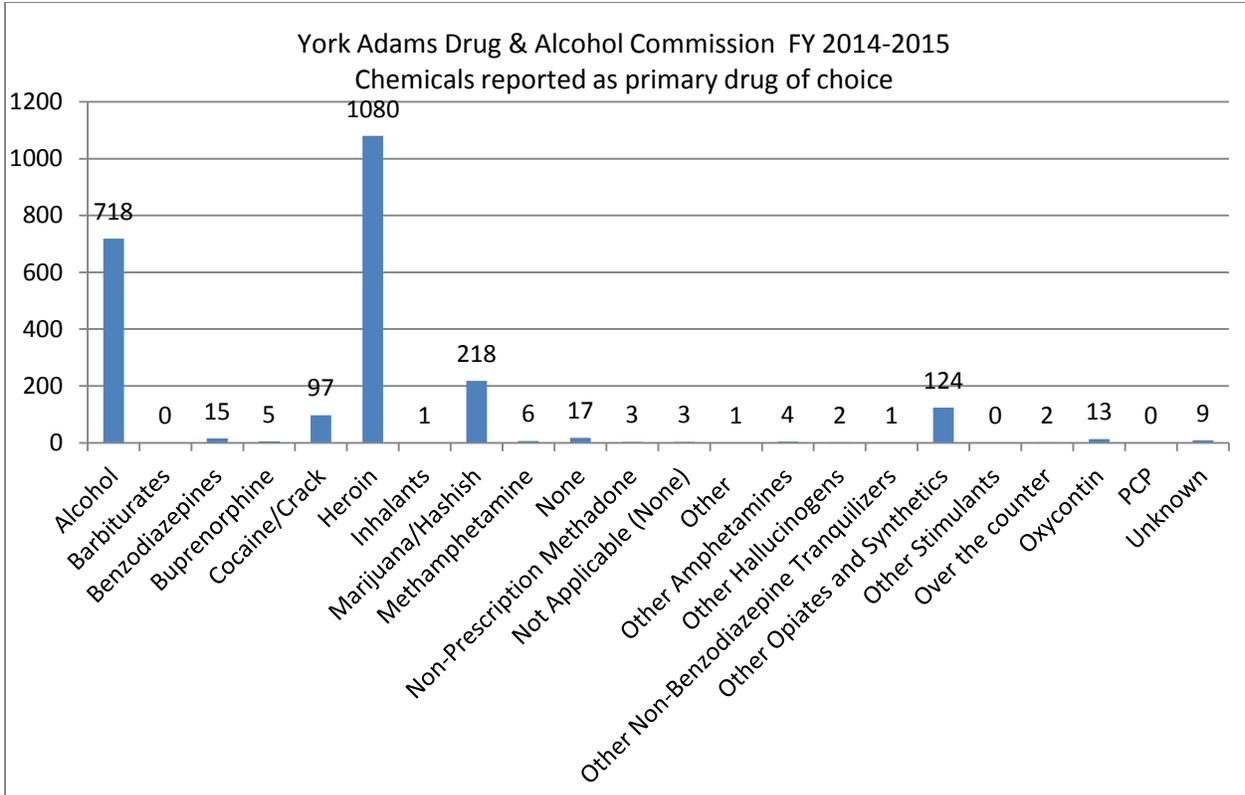
Emerging substance use problems: This implies that there is a situation which is qualitatively different from what came before, and which could not have been fully anticipated and planned for. The difference may be the population of users, the type of substance, the nature of the substance or the rate of increase. The implication is that a new problem confronts the community and it may need to be addressed. 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, tracked over time, and now requires a response impacting service delivery.

Opioid Epidemic:

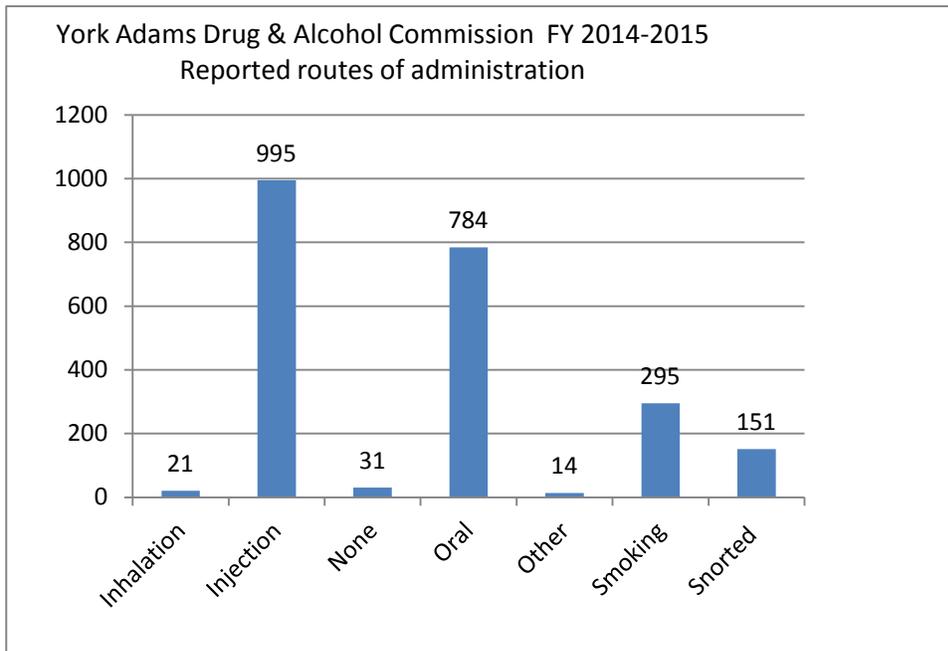
According to Appendix F, (Treatment Needs Assessment Table 7a and 7b: Demand for Substance by Primary Substance of Abuse,) during fiscal year 2012-2013, Heroin ranked as the primary drug of abuse for adult admissions and second among those 18 and under. Percentages of admissions for both exceed statewide percentages. Further, Other Opiates/Synthetics admissions rank fourth among adult admissions and tie for fourth place in the 18 and under population.

As evidenced by the table below, STAR data for total population for fiscal year 2014/2015 reports Heroin and Other Opiates/Synthetics as the number one and number four primary drug of choice, which is consistent with 2012/2013 data reported in Appendix F. Most telling is that Other Opiates/Synthetics and Oxycontin did not see increases in admissions compared to Appendix F 2012/2013 data. This decrease may be attributed to individuals who started their opiate addiction with prescription opiates, and later turned to Heroin.

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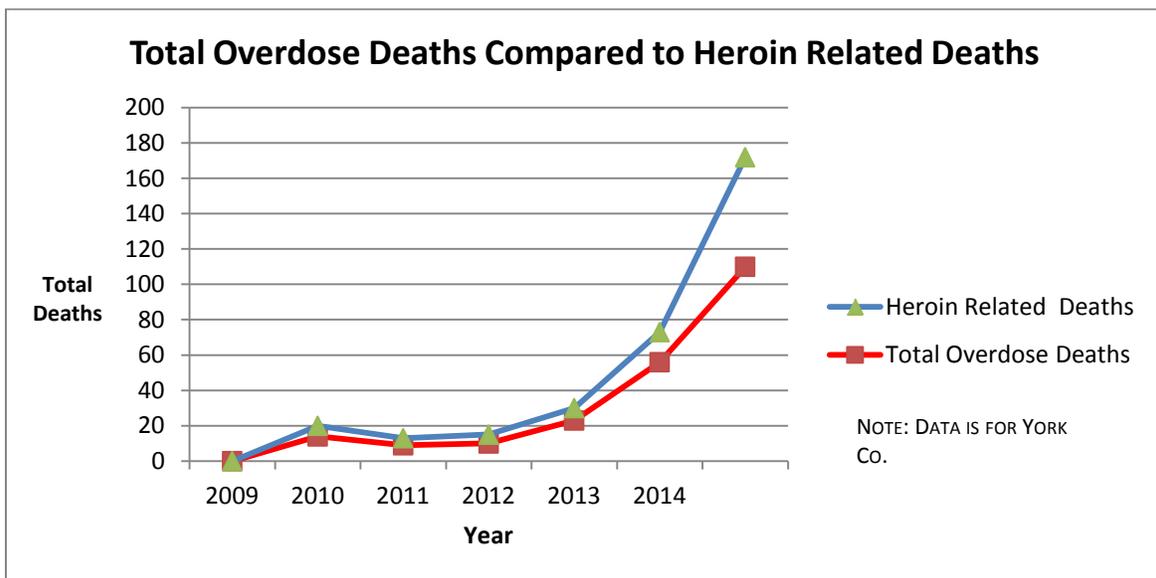


Further, STAR data for fiscal year 2014/2015 ranks Injection as the primary reported route of administration as evidenced on the chart below, which is the primary route of administration for Heroin according to STAR data.



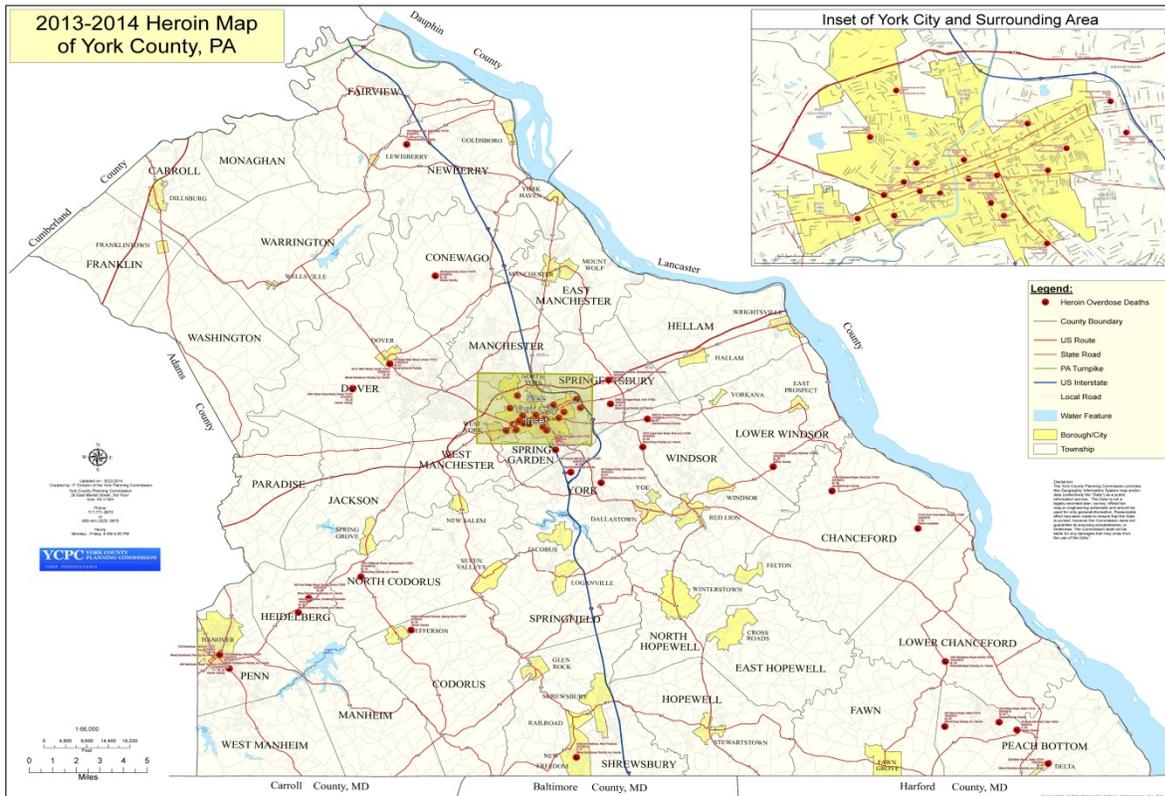
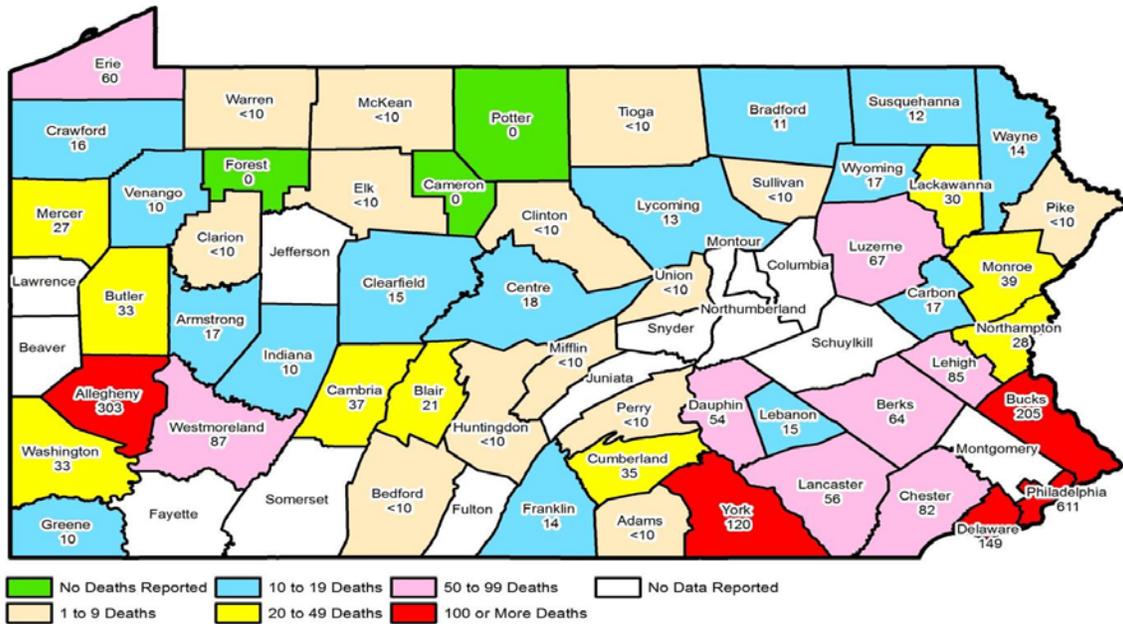
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Direct results of the increase in opiate usage are opioid overdose deaths. Reports of opioid overdose deaths in York/Adams County are staggering. According to the 2014 Pennsylvania State Coroners Association's report, the region is averaging 17.4 deaths per 100,000 persons. The report ranks York County as one of the top five counties in Pennsylvania experiencing an overdose crisis, with reports of over 100 overdose deaths in 2014. Of these deaths, a reported 62 were confirmed due to heroin according to the York County Coroner. Heroin overdose deaths in 2014 surpassed the total reported for all of the previous year, 2013, in which 56 drug related deaths occurred with 17 attributed to heroin according to the York County Coroner. Heroin related deaths only totaled 7 for all of 2012 and 10 in 2011. During the first 6 months of 2013, there were 9 heroin related deaths compared to June 30, 2014, where there were 26 deaths attributed to heroin, resulting in an astonishing 189% increase. These sharp increases compared to previous years only highlight the opioid epidemic that York County is facing.



The Adams County Coroner's office reports that there were a total of 43 overdose deaths in the past 5 years, with opioids contributing to the majority of the cases. The Adams County Coroner reports that 40 of the 43 deaths fell between an age range of 18-60, specifically with 9 between the ages of 18-30 and 31 between the ages of 31 and 60. A number of deaths are being reported in the Hanover area, which borders both York and Adams County. With close proximity to the Maryland line, easy access to heroin and other opioids makes Adams County extremely vulnerable to an increase in overdose deaths attributed to opioids.

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Due to the staggering volume of overdoses occurring in the York County area, the York County District Attorney’s Office established a Heroin Task Force in 2014 with the sole intention of

reducing the abuse of heroin and overdose deaths in the York community. Town hall events are held regularly by the task force to educate the public and offer resources to combat the epidemic. Further, York County was chosen as one of the 21 counties in Pennsylvania to receive funding from Capital BlueCross to purchase and equip municipal police departments with Naloxone.

Since equipping York County police departments, as of late Spring of 2015, officers have had cause to administer the medication seven times, with the first Naloxone administration occurring a mere day after being equipped with the medication. Heroin toxicity accounted for five of the seven overdoses for which Naloxone was administered. Of the five cases, three required two doses of Naloxone to reverse the overdose state. In all cases reported, all victims survived after receiving the life-saving medication.

It is evident that York/Adams County is facing a serious opioid problem.

Marijuana/Hashish:

According to Appendix F, during fiscal year 2012-2013, Marijuana/Hashish was the primary abused drug of individuals under age 18 and ranked third for adult admissions. State and National trends regarding medicinal and legalized Marijuana heavily influence attitudes towards these substances and as a result, many no longer view these substances as illegal, dangerous, or even a substance to be abused. While admissions for these substances are lower than the statewide percentage as of fiscal year 2012/2013, according to fiscal year 2014/2015 Star data, Marijuana/Hashish primary drug of choice data, use of these substances is on the rise, with an increase of 42% since fiscal year 2012/2013.

Further, synthetic marijuana is rapidly becoming an epidemic in Central Pennsylvania. A recent explosion of individuals reportedly using the drug occurred in April/May of 2015. Poison Centers received 1,277 calls regarding the drug during the first three weeks in April, which is more than 4 times the normal volume.

During a two week period in April of 2015, York County police reported that they have encountered nine individuals who appeared to be under the influence of synthetic marijuana. In multiple instances, the individuals required hospitalization and in one instance potentially led directly to the death of one person. Emergency personnel report individuals displaying extreme psychotic behavior in addition to aggression and violent behavior as a result of the drug. According to Fox 43 news, York County police officers have stated that individuals can turn in the drug with no criminal charges and have visited 58 convenience stores throughout

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York City, offering a one-time amnesty deal for stores who sell the substance to turn over their supply.

LOCAL, STATE AND NATIONAL TREND IMPACTS

Objective 3: Identify local, state, and national trends that may impact the SCA.

Definitions:

Local, state, and national trends: A prevailing tendency or information relating to the economy, government, legal issues, technological and medical advances, or socio-culture patterns that may influence business practices of the SCA.

Examples of local, state, or national trends may include a move to integrated health/behavioral health care, implementation of the Affordable Care Act, local unemployment rates, aging of “baby boomers”, electronic medical records, implementation of evidence-based/promising practices, focus on special initiatives (i.e., Underage Drinking, offender re-entry, co-occurring), medication management, political priorities, etc.

TABLE 3: TRENDS IMPACTING THE SCA					
Aging Population		Increase in Overdose Deaths	X	Other (please explain)	
Drug Court Implementation		Prescription Drug Abuse/Addiction	X		
DUIs		Synthetic Drug Use (bath salts, K2, etc.)			
Growth of Latino Population	X	Workforce Issues			
Heroin Use	X	Underage Alcohol Use			
High Unemployment Rate		Underage Drug Use			

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Growth of Latino Population:

According to the Pew Research Center, and as evidenced in the tables below, both York and Adams Counties have seen an increase of Hispanic population. Adams County saw a significant increase in this population from 1990 to 2000, but growth has appeared to taper from 2000 to 2011. While York County saw a smaller increase from 1990 – 2000 compared to Adams County, growth from 2000-2011 shows continual increase of this population, which exceeds growth reported from 1990-2000.

Adams County:

	1990	2000	2011
Hispanic Population ^{Rank}	1,216 ⁷⁶¹	3,323 ⁶⁴⁴	6,333 ⁶²⁵
Total County Population	78,274	91,292	101,434
Hispanics as Percent of County Population ^{Rank}	2 ^{1,085}	4% ⁹⁷⁹	6% ^{1,007}
		Change from 1990	Change from 2000
Hispanic Population Change ^{Rank}		2,107 ⁵²⁸	3,010 ⁵⁶⁸
Percent Change in Hispanic Population ^{Rank}		173% ⁸⁶⁸	91% ^{1,330}

York County:

	1990	2000	2011
Hispanic Population ^{Rank}	5,165 ³⁴⁴	11,296 ³⁰³	25,367 ²⁵¹
Total County Population	339,574	381,751	436,770
Hispanics as Percent of County Population ^{Rank}	2 ^{1,100}	3% ^{1,127}	6% ^{1,066}
		Change from 1990	Change from 2000
Hispanic Population Change ^{Rank}		6,131 ²⁶¹	14,071 ²¹¹

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	1990	2000	2011
Percent Change in Hispanic Population ^{Rank}		119% ^{1,341}	125% ⁷⁶⁵

As reported by the U.S. Census Bureau, as of 2014, Hispanics/Latinos account for 6.6% of the total population of Pennsylvania. In comparison, in 2014 Hispanics/Latinos accounted for 6.6% of Adams County residents and 6.5% of York County residents. This is of importance to note as no Spanish speaking substance abuse treatment services exist in Adams County although total Hispanic/Latino population is higher than in York County, where services do exist.

Heroin Use/Increase in Overdose Deaths/Prescription Drug Abuse/Addiction:

As York and Adams County residents, we have been bombarded by news that heroin use and heroin related deaths have skyrocketed. According to the 2013 National Survey on Drug Use and Health (NSDUH), an estimated 24.6 million Americans aged 12 and older were current (within the past month) illicit drug users. This amounts to a total of 9.4% of the population aged 12 and above who currently use illicit drugs. Additionally, according to the survey, the number of individuals aged 12 and older who had used heroin in the past year is trending upwards with an 82% increase since 2007. Further, there was a reported 79% increase in the number reporting as having used heroin in the last 12 months and a staggering 87% increase in new initiates to heroin since 2006.

On a local level, according to 2010, 2011 and 2012 NSDUH data, an estimated 5.92% of Pennsylvanians aged 12 and above used illicit drugs in the past month and according to Pennsylvania law enforcement officials, Pennsylvania has the third highest number of heroin users in the United States, with an estimated 40,000 individuals. In 2013, the Pennsylvania Office of Attorney General reported that, out of 1,376 arrests, 522 involved heroin.

Drastic increases in the number of opiate prescriptions being written, greater social acceptance of prescription medication, along with increased availability has contributed to a large number of individuals on prescription opiate medication. Many of these individuals are becoming addicted. Results from the 2013 National Survey on Drug Use and Health (NSDUH) indicate that about 15.3 million people aged 12 or older used prescription drugs non-medically in the past year, and 6.5 million did so in the past month. Additionally, according to the National Institute on Drug Abuse, 1 in 15 who take non-medical prescription pain relievers will try heroin in 10 years. Negative outcomes of individuals abusing prescription opiates include an increase in ER visits as well as potential overdose and death. Many individuals are unable to afford their medication or require more due to addiction. Prescription drug monitoring has increasingly

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made it difficult to “doctor shop” for prescription opiates. Heroin, on the other hand, is extremely easy to obtain in Pennsylvania due to an increase in production in Mexico. With a bag of heroin estimated to cost a mere \$10-\$15 in York County compared to one Oxycodone pill, which is estimated to cost \$20-\$25 a pill, it is easy to see why individuals are turning to heroin in record numbers.

According to a 2014 report, “Heroin: Combating this Growing Epidemic in Pennsylvania”, from the Center for Rural Pennsylvania, nationally more individuals age 25 to 64 are dying from drug overdoses than in vehicle crashes. The report states that the same holds true in Pennsylvania, as more adults age 20 to 44 are dying from drug overdoses than motor vehicle accidents. Further, the report states that the increased use of heroin has catapulted Pennsylvania to seventh in the nation for drug related overdose deaths.

DEMAND FOR SUBSTANCE USE DISORDER TREATMENT

Objective 4: 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.

Pattern of Referrals:

According to Appendix C, (STAR Pattern of Referrals for York/Adams; SCA Unique Clients), 43% or 570 first admissions for adults were referred by the Court/Criminal Justice System, making the Court/Criminal Justice system the highest referral source for SCA clients. Statewide, Courts/Criminal Justice account for only 37.7% of total referrals of SCA clients. It is not surprising that York/Adams Commission Court/Criminal Justice referrals exceed the State wide average considering that York and Adams Counties house multiple criminal justice programs. Specifically, York County houses County houses four adult treatment courts, two juvenile treatment courts, and one adult diversionary program specific to offenders with a substance abuse disorder. The York County Prison houses a large inmate population with substance use disorders and as such, has two programs designed specifically to address the needs of this population. In Adams County, screening, level of care assessment and treatment coordination services are provided in the Adams County Adult Correctional Complex in addition to Adult Probation Intermediate Punishment eligible individuals. Additionally, Outpatient services as provided through an SCA contracted, licensed provider are also being provided in the Adams County Adult Correctional Complex.

The second highest referral source is Self, at 21.1% or 278 first admissions for adults as referred by Self. Statewide self-referrals account for 20.9% of total referrals, thus the Commission percentage is right on target. The third highest referral is SCA, which accounts for 16.4% of referrals, or 216 first admissions for adults as referred by SCA. Statewide SCA referrals account for 15.1% of total referrals, thus again Commission percentage is comparable with the State. School/SAP referrals account for only .04% of total Commission referrals, while the statewide average is 1.1%. The Commission has recently discovered based upon interactions at community events, presentations and surveys that Student Assistance Program (SAP) knowledge is considerably lacking, and referrals to these services may suffer due to this lack of knowledge. Disturbingly, based upon a 2015 survey of York/Adams County schools districts, only 23.68% stated that they were very familiar with the SAP service in their school district/building and only 49.17% stated that they were aware that SAP services are required in all school districts including charter schools, cyber charter schools and schools K-12. A

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staggering 22.33% stated that they were unfamiliar with who the SAP team members are in their school district building.

According to Appendix D, (Table 5: Unique Clients Not Referred by a Provider, CJ/Non-Voluntary Proportion), the Commission had 586 unique STAR non-voluntary criminal justice referrals (not referred by a provider), which accounts for 44% of SCA total clients. Commission referral volume exceeds the statewide percentage of 38.9%. As previously stated, York and Adams County house a number of forensic programs, thus it is not surprising that Commission percentages are above state average.

Service Strategy:

A direct result of the pervasive pandemic of opioid use observed in the York/Adams area is encountering copious increases of individuals seeking intensive treatment. Coupled with continued budget cuts and budget constraints, York/Adams County is facing an acute intensive treatment crisis. Dramatic increases in detox referrals coupled with a lack of available beds across the State has resulted in delayed detox access.

According to Appendix E, (Table 6: Service Strategy for York/Adams) Medically Monitored Inpatient Detox is the primary level of care for admission with 670 adult admission and Medically Monitored Short-Term Residential following closely behind as the third most frequently accessed level of care with 287 adult admissions.

Further, according to Commission data of SCA referred clients, individuals seeking Commission funded detox services have risen a total of 17% over the past five years. The number of detox referrals received weekly surpasses that of the previous four years, with 13 on average, attributing to referral totals for the third quarter of fiscal year 2014-2015 nearly equaling the total number of referrals for all of fiscal year 2013-2014. With projected referrals for fiscal year 2014-2015 totaling 721, detox referrals for the current fiscal year will far exceed referral totals for each of the previous four fiscal years, elevating the percentage increase for the past five years to 33% with a staggering 28% percent increase over the previous fiscal year.

Detox:

Detox	<u>Yearly-Total</u>	<u>Avg #</u>	<u>Avg # Days Funded by</u>
	<u>Referrals</u>	<u>Referrals/Week</u>	<u>SCA</u>
*3 rd Quarter Data			
2014-2015*	487	13	4
2013-2014	639	12	4
2012-2013	649	12	4
2011-2012	609	11	4

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Outpatient and Intensive Outpatient services are additionally heavily accessed. According to Appendix E, Outpatient services rank the second most frequently accessed level of care with 389 adult admissions. Intensive Outpatient services follow closely behind, ranking fourth most frequently accessed level of care with 250 adult admissions.

Based upon the data presented in Appendix E, the majority of individuals are accessing Medically Monitored Inpatient Detox, followed by Outpatient treatment. One would anticipate that the number of Medically Monitored Short-Term Residential admissions would be comparable to the number of Medically Monitored Inpatient Detox admissions; however the conversion rate from detox to rehab is under 50% according to Appendix E. SCA data reports a much higher conversion rate based upon SCA referrals. With Outpatient level of care the second most accessed level of care, it would appear that individuals may be refusing recommended Medically Monitored Short-Term Residential following Medically Monitored Inpatient Detox and subsequently end up attending Outpatient treatment.

Additionally, according to Appendix E, adolescent service access numbers are considerably low, with only 8 admissions to Adolescent Inpatient Non-Hospital Detoxification (III.5D), 1 admission for Adolescent Inpatient Non-Hospital Drug Free (III.1) and 0 for Adolescent Inpatient Non-Hospital Drug Free (III.5). Adolescent Outpatient numbers reflect similarly. One can conclude that this number may not capture the full number of adolescents accessing services, as the majority of these individuals are covered by some sort of insurance, thus not reflected on Appendix E.

According to Appendix F, (Treatment Needs Assessment Table 7a and 7b: Demand for Service by Primary Substance of Abuse) during fiscal year 2012-2013, Heroin is the primary drug of abuse for adults, with 817 admissions, accounting for 43.5% of all admissions. Heroin ranks second among those 18 and under, with 4 admissions, accounting for 16.7% of total admissions. Both adult and age 18 and under Heroin admissions far exceed statewide averages of 31.3% for adults and 4.8% for 18 and under. Given that York County is now tied for fourth place for Counties experiencing overdose deaths, it is to be anticipated that corresponding Heroin use exceeds statewide averages.

Other Opiates/Synthetics admissions rank 4th among adults with 128 admissions, accounting for 6.8% of total admissions, below the statewide percentage of 11.7%. Other Opiates/Synthetics admissions tie for 4th most frequent admissions with 1, or 4.2%. This number is considerably higher than the statewide percentage of 0.0%. It is interesting that adult percentages of admission for this substance are lower than the State, while the under 18 population are

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incredibly higher. This may be due to adolescents starting their opioid addiction with prescription opiates/synthetics and turning to Heroin as adults.

Marijuana/Hashish was the primary abused drug of individuals under age 18, with 16 admissions, accounting for 66.7% of total admissions. Comparably, this is lower than statewide admissions, of which Marijuana/Hashish account for 69.2%. Marijuana/Hashish ranks third for adult admissions with 137 individuals, accounting for 7.3% of total admissions. Commission admissions for adult Marijuana/Hashish are also lower than the State percentage, which comes in at 12.5%. State and National trends regarding medicinal and legalized Marijuana heavily influence attitudes towards these substances and as a result, many no longer view these substances as illegal, dangerous, or even a substance to be abused.

Alcohol admissions rank second for adults with 640 admissions, accounting for 34.0% of admissions. Alcohol admissions rank third for those 18 and under with 2 admissions, accounting for 8.3% of admissions. Statewide percentages for admission for adults are 32.9% and 12.4% for those 18 and under.

Based upon the data contained under Objective 4, one can conclude that Heroin use/other Opiates/Synthetics use is on the rise. This rise in substance abuse directly correlates to increased demand for intensive treatment services, and subsequently a possible delayed admission to these services due to lack of bed availability. More Medically Monitored Inpatient Detox and Medically Monitored Residential beds are necessary to meet the demand. Increased MAT services may assist with the opiate abusing population. Further, increased motivation for individuals to attend recommended aftercare, in particular Medically Monitored Residential following detoxification is necessary.

While the criminal justice system represents a high volume of referrals to the substance abuse system, it is important that we also engage individuals in treatment early in their addiction and prior to addiction, through prevention/SAP services. Prevention services will be particularly useful in addressing the increase of Marijuana Hashish and Other Opiates/Synthetics in the 18 and under population.

IDENTIFICATION OF ISSUES/SYSTEM BARRIERS

Objective 5: 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 5.

Examples of system barriers include lack of access, quality and appropriateness of care, insurance denials, childcare, transportation, language, zoning restrictions, parental resistance to permitting SAP assessments, interface with county systems, length of time from application to acceptance for HealthChoices, restrictions of available funds, ineffectual tracking of individuals between payers, varied perceptions of medical necessity criteria, SCA protocols/policies & procedures, etc.

TABLE 8: SYSTEM BARRIERS				
Funding Issues	X	Lack of Safe/Affordable Housing	X	Other (please explain)
Health Insurance	X	MA Eligibility		Multiple Need Barrier Complications – people waiting for rehab beds – phone, other issues difficult to stay connected
Lack of Childcare	X	Poor Stakeholder Collaboration		
Lack of MAT availability	X	Stigma	X	
Lack of Recovery Supports		Transportation		

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Lack of Treatment Providers	X	Workforce Issues		
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Funding Issues:

Budget cuts and ever threatening anticipated budget cuts are one of the most daunting obstacles that the Commission faces. As evidenced by the table below, the Commission budget was significantly cut during fiscal year 2012-2013 due to State wide budget reductions of Act 152 and BHSI funds. These funds are specifically utilized to fund Inpatient services such as Medically Monitored Inpatient Detox, Medically Monitored Short and Long Term Residential and Half-Way House. The Commission has not yet seen restoration to these funding streams.

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Budget Comparison

Fiscal Year	Budget Amount	Criminal Justice	SAPT B.G. Prevention	SAPT B.G. PWDC	State SAP	SAPT B.G. Treatment	Comp./Prob. Gambling	Act 152 DPW	BHSI DPW	Gaming Funds	DUI Funds	Interest & Training	State Base	Rental Income (a.k.a. Match)	Difference from Previous Year
2010-2011	\$ 3,148,910	\$ 81,177	\$ 234,801	\$ 60,981	\$ 74,458	\$ 574,807	\$ -	\$ 428,625	\$ 268,038	\$ 77,408	\$ 406,805	\$ 10,519	\$ 831,292	\$ 100,000	
2011-2012	\$ 3,491,156	\$ 154,200	\$ 234,801	\$ 60,981	\$ 74,458	\$ 700,073	\$ -	\$ 493,625	\$ 244,450	\$ 219,677	\$ 391,360	\$ 8,000	\$ 809,531	\$ 100,000	\$ 342,246
2012-2013	\$ 3,209,304	\$ 65,000	\$ 234,801	\$ 60,981	\$ 74,458	\$ 700,073	\$ 109,406	\$ 444,249	\$ 222,650	\$ 77,408	\$ 300,000	\$ 8,000	\$ 812,278	\$ 100,000	\$ (281,852)
2013-2014	\$ 3,163,169	\$ 149,576	\$ 226,993	\$ 60,981	\$ 74,458	\$ 676,652	\$ -	\$ 444,249	\$ 232,574	\$ 77,408	\$ 300,000	\$ 8,000	\$ 812,278	\$ 100,000	\$ (46,135)
2014-2015	\$ 3,134,485	\$ 180,816	\$ 226,993	\$ 60,981	\$ 74,458	\$ 676,652	\$ -	\$ 444,249	\$ 222,650	\$ 77,408	\$ 250,000	\$ 8,000	\$ 812,278	\$ 100,000	\$ (28,684)

As a result of the continued and significant increase in demand for Commission funding for drug and alcohol inpatient treatment services coupled with significant budget cuts to inpatient treatment funding, it became necessary during fiscal year 2012-2013 for the Commission to place increased limitations on inpatient treatment funding for Medically Monitored Short and Long Term Residential and Half-Way House levels of care. These limitations restrict inpatient funding to the priority population of Pregnant Substance Users. The limitations were enacted to ensure that funding for the priority population of Pregnant Substance Users shall always be available. These limitations have continued to current fiscal year 15-16 and are expected to continue into the next fiscal year, if funding remains stagnant. As a result of these limitations, many individuals appropriate for Medically Monitored Short and Long Term Residential and Half-Way House services are unable to access these services. Individuals not falling into the priority population of Pregnant Substance Users typically seek community based treatment. Individuals are unable to receive the appropriate level of care recommended as a result of their Level of Care Assessment, thus placing these individuals at a higher risk for relapse and potential overdose.

Numbers of individuals during fiscal year 2013-2014 and fiscal year 2014-2015 (as of March 3, 2015) who were unable to receive recommended Medically Monitored Short and Long Term Residential and Half-Way House levels of care are listed below.

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	#	#
Rehab Totals (3B/3C)	Referred	Denied
2014-2015 (As of 3/3/15)	595	24
2013-2014	533	22

	#	#
Halfway House (2B)	Referred	Denied
2014-2015 (As of 3/3/15)	4	0
2013-2014	5	1

A further direct result of budget cuts is a historically low reimbursement rate to the Commission contracted Outpatient providers. Ironically, while the reimbursement rates remain unchanged, the amount of required tasks for the treatment providers has disproportionately increased. The contracted providers are being asked to do more without proportionate compensation. The contracted providers seem to have struggled with maintaining a consistently competent staff due to these factors, making it difficult to provide services within the required time frame. Staff shortages amongst the contracted providers have created delays in treatment for residents.

Health Insurance:

According to NIDA, it is critical to improving positive outcomes that individuals remain in substance use disorder treatment for the right amount of time. This amount of time is dependent upon the type and degree of the individuals' problems and needs, rather than a set prescribed amount. NIDA research has shown unequivocally that positive outcomes are dependent upon appropriate treatment length; with research indicating that most individuals with a substance use disorder require at least 3 months in treatment to show significant reduction or elimination of their substance use and that treatment stays less than 90 days is of limited effectiveness.

Unfortunately rather than basing length of treatment stay and continuum of care based upon clinical integrity, private insurance companies ascribe to a "set" amount of coverage of which they cannot deviate. Even when within the "set" amount of coverage, many insurance companies are driven to pay for minimal substance abuse treatment.

Pennsylvania's Act 106 of 1989 requires all commercial group health plans, HMOs (Health Maintenance Organizations) and the Children's Health Insurance Program (CHIP) to provide comprehensive treatment substance abuse. Only Pennsylvania insurance companies are mandated to adhere to this law and many individuals who have insurance coverage do not fall under this law. While the act is well intended, it does not prescribe to a clinical integrity model, but rather a continuation of minimal "set" guidelines for number of days and admissions per

lifetime. Further, it does not distinguish between 3B or 3C under non-hospital residential, which further compounds the concerns regarding clinical integrity. MAT is not even mentioned under the law.

The Affordable Care Act (ACA) extends health insurance coverage to individuals who lack access to an affordable coverage option. Through the ACA, a larger volume of individuals are eligible for Medicaid and private insurance. Even so, according to the Kaiser Family Foundation (KFF), approximately 994,000 Pennsylvania residents are still uninsured as of October 2015. Further, the KFF reports that the majority of those uninsured cite the high cost of insurance as the main reason they do not have coverage. Specifically in 2014, 48% of uninsured adults reported the high cost of insurance as the main reason they were uninsured.

The ACA mandates that most Americans obtain health insurance or pay a penalty. According to the Kaiser Family Foundation (KFF), the cost of the average individual mandate penalty is expected to rise from \$661.00 in 2015 to \$969.00 in 2016. While this cost continues to rise, comparably speaking, it may be more affordable for some to pay this penalty than to become insured. Similarly, many may choose a lower cost level plan which offers less coverage based upon affordability. Under the 2016 Marketplace Bronze plans, which offer services at the lowest yearly cost, a 35 year old non-smoker with a \$25,000 income may pay up to \$926.00 yearly for coverage, and be responsible for up to a \$6,000.00 or more deductible, which must be met before the plan covers any substance abuse under the cheapest yearly cost plan available. The same person would pay upwards of \$4,000 yearly for premium coverage and be responsible for zero deductible, with full Inpatient Substance Abuse coverage and \$25.00 Outpatient co-pay. While according to according to Healthcare.gov, all Marketplace plans cover substance abuse services as essential health benefits, premiums, copays and deductibles remain so high that it is difficult for individuals to afford substance abuse services even with healthcare coverage.

Not only is there an affordability barrier to private insurance coverage, it is often difficult for individuals to navigate their insurance benefits. One local substance abuse provider cited the following in regards to private insurance benefit access in addition to stating that they have 10 billing staff solely dedicated to accessing client coverage and processing insurance denials/appeals:

Private Insurance Access:

1. Client needs to call the behavioral health phone number on the back of their card to determine their mental health carrier. Client will have co-pay and/or deductible if the deductible has not been met for the year. Co-pay amount may be on their insurance card. If not, client can call their insurance company to find out their co-pay and/or deductible amount.

2. Sometimes, the behavioral health benefits are with plans we do not participate with or the insurance company is not credentialing any new therapists, even when they are licensed.
3. Co-Pays and deductibles are high and unrealistic for no or low income clients to pay.
4. We are not in network with certain insurances and there are no out of network benefits for that plan.

The provider further stated the following in regards to Medicare & Medicare Replacement plans:

Medicare & Medicare Replacement Plans

Client Responsibility:

1. There is always a deductible/co-pay with Medicare. The only exception that a client would not be responsible for a co-pay/deductible is if they have Straight MA, a managed care plan; i.e., PerformCare, CCBH or any other managed care, or a supplemental private insurance as a secondary insurance.

From discussions with local providers in regards to Medicare/Medicare Replacement Plans, of the individuals who have Medicare coverage, they must be seen by a licensed and Medicare credentialed Licensed clinical social worker (LCSW) or by a licensed social worker (LSW) or licensed professional counselor (LPC). If seen by an LSW or LPC, the individual must obtain a psychiatric evaluation in addition to seeing the clinician and a doctor must be present in the building for billing purposes. Often times LCSW appointments fill quickly and doctors may only be in the building one a week. Many providers seek funding from the SCA for these individuals as they cannot be seen for services under Medicare for potentially, months. At times, the individual may also have managed care; however CCBH will deny services automatically if a client has Medicare. As the SCA is the payer of last resort, it is expected that providers utilize every avenue of funding prior to requesting SCA dollars and as such, request denials of insurance coverage prior to payment. Providers state that this is impossible with Medicare as they may never get a denial. The SCA often funds these individuals even though they have insurance coverage and many have even two forms of insurance coverage through both Medicare and CCBH, as services are not available through an LCSW or clinician/doctor schedules do not support the demand for Medicare billing and CCBH refuses to cover.

Lack of Childcare:

The Commission requires that providers who treat Pregnant Women, Women with Dependent Children, and Women Attempting to Regain Custody of Children, treat the family as a unit when

appropriate and shall also provide, or arrange (at a minimum) for the provision of child care while the women are receiving treatment services.

While many resources do exist for day care in both York/Adams Counties, reduced cost child care options often have lengthy waiting lists. Child care for those who do not meet reduced cost options often find child care to be unaffordable. Women are likely to have primary child-care responsibilities and concerns about providing child care and the possibility of losing custody often weigh heavily in whether or not a woman will seek out and be able to attend recommended treatment.

Women with children residential programs offer onsite options for children to attend the program with the mother, thereby alleviating fears of who will care for the child(ren) while the mother attends residential treatment. Unfortunately this option does not exist at the medically monitored inpatient detox level and women with dependent children may be less likely to seek out this service due to child care barriers.

Further, on-site child care is not available at the Outpatient level. Appointment times may be after work hours and day care hours. Women may choose to bring their children with them to Outpatient appointments, which while not optimal for successful treatment engagement, may be the only option the woman has as they are the primary care taker. If unable to secure child care such as a baby sitter, the individual may cancel or no show for their appointment. According to local Outpatient treatment providers, approximately 25-45% of women with dependent children encounter such barriers to treatment due to lack of child care.

Lack of MAT availability

Increasing medical research shows that many individuals addicted to opiates require some form of medication to recover from their addiction.

Methadone:

York and Adams Counties currently house one Methadone clinic. In 2014, the demand for Methadone services saw a sharp increase, in part due to the opiate crisis. The local York County Methadone provider was forced to establish a waiting list for services, which at its peak, topped out at over 120 clients. In recognizing the increased need for this critical service, the Commission in collaboration with the provider developed a plan to address the waiting list, which included increasing the provider's capacity from 175 to 350. This increase has been obtained and the waiting list has been eradicated. There is still a potential that further capacity increase may be warranted if demand continues to rise.

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Further, according to York/Adams HealthChoices, during Fiscal Year 2013-2014, 22 HealthChoices members in Adams County and 30 HealthChoices members in Western York County attended a Methadone Maintenance program. Due to the regularity of which these services are provided and the fact that only one Methadone Maintenance provider exists in both York and Adams County of which is located in Eastern York County and between 30 minutes to almost an hour away for many of these individuals, it can be assumed that access issues are creating a large barrier for individuals receiving this treatment in the Hanover/Western York County region.

Buprenorphine:

As of September 17, 2014 York/Adams HealthChoices reports 113 Buprenorphine prescribers in York/Adams County, not including York County Buprenorphine provider Pyramid HealthCare. Many of these providers boast waiting lists for this service, with Pyramid's wait list in 2015 running on average between 65-100 individuals. The RASE project reports that they have a "long" waiting list and are in the process of hiring a new coordinator and possibly a new prescriber. Limitations on the number of individuals that a doctor can see further compound accessibility issues. Upon initial certification, a prescriber is limited to 30 patients. After a year, they may increase their capacity to 100 patients.

According to the RASE Project, which provides Buprenorphine treatment coordination and support, there are quite a few physicians who prescribe in York/Adams, however not all accept MA or they may have a very high self-pay rate. While the medication may be covered under insurance, mandatory doctor time is rarely, if ever covered by insurance and may average around \$150.00 per session. Fortunately doctor time may only be necessary bi-weekly or even monthly in some cases, but cost can potentially still prohibit affordability. Further, some doctors will not accept certain insurances and will only accept cash.

Vivitrol:

According to the Alkermes, Inc. medical information department, studies have shown to prove Vivitrol's efficacy and safety in opioid dependence as well as positive effects on opioid dependence and craving, in addition to decrease in relapse to physical dependence. Few community agencies currently administer Vivitrol, and individuals may be forced to attend a community provider for ongoing administration of their Vivitrol needs that may be inconvenient for them, thus leading to increased drop-out rates during their treatment period.

Lack of Treatment Providers

Dramatic increases in detox referrals coupled with a lack of available beds across the State has resulted in delayed detox access. While the Commission holds contracts with 13 detox

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providers as of fiscal year 2014-2015, which accounts for a total of 231 beds, the need for services far exceeds availability. According to the White Deer Run Regional Support Center (WDR –RSC), with whom the SCA contracts for detoxification screening and coordination, most individuals are unable to be admitted within the same or next day from the date of initial contact with the WDR-RSC. On average, only 40% of individuals or fewer in the White Deer Run system seeking detox services are able to obtain services within 48 hours, with some waiting up to 7 days for access to services.

Further, Medically Monitored Short and Long Term Residential Treatment is additionally lacking across the State. According to a point in time survey of Medically Monitored Short and Long Term Residential treatment providers contracted with CCBH conducted by York/Adams HealthChoices, in December of 2015, at the time of call, an average of only 23 beds were available out of the 45 facilities queried.

Outpatient services in the Southern part of York County are lacking with only one treatment provider in the area, who only provides outpatient 1A services. Current wait times for services with this provider are approximately 2 months. No Intensive Outpatient Services or Partial Hospitalization services currently exist in this area of York County and some individuals have resorted to attending providers in the greater York area, which may be up to an hour away.

As wait time to access treatment services increases, individuals addicted to opioids/overdose survivors become increasingly vulnerable for failure to follow through with recommended treatment when it does become available, subsequently placing the individuals at an increased risk for overdose. Potential for continued opioid use while awaiting recommended intensive treatment bed availability additionally increases overdose risk.

Lack of Safe/Affordable Housing

At this time, there is an inability to quantify the extent of Recovery Houses within York County. The challenge in how to “investigate” into these establishments persists, as no recovery houses are offering treatment services that would necessitate licensure by the state. Further, the zoning laws of York County do not necessitate registration or monitoring of these establishments. The number of these residences can only be estimated and these estimates vary according to the source. At times, the number of these residences is estimated in the hundreds. Not only is it unclear as to what parameters are instituted in these homes, there exists no information pertaining to the individuals housed in these structures. Therefore, the population served by these establishments remains undocumented. Conversely, at this time, there are no known recovery houses that exist in Adams County.

Stigma

Stigma refers to negative attitudes (prejudice) and negative behavior (discrimination) toward people with substance use problems. Stigma includes: having fixed ideas and judgments—such as thinking that people with substance use problems are not normal or not like them, thinking that they caused their own problems, that they can simply get over their problems if they want to and fearing and avoiding what is not understood. These attitudes and judgments permeate the community at large and systems with which the individual is involved and can counter the intended healthy impact. While it appears that the members of the community have become better educated and speak with a larger substance related vocabulary, stigma and misinformation still remains a barrier.

IDENTIFICATION OF ASSETS AND RESOURCES

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

Definitions:

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

Examples of assets or resources include: Level-1 trauma centers that are now required to implement Screening, Brief Intervention and Referrals to Treatment (SBIRT), funds and/or services available through other systems (i.e., Children, Youth & Families, Office of Vocational Rehabilitation, HealthChoices, PA Commission on Crime & Delinquency, Liquor Control Board, federal grants, Centers for Disease Control, Department of Education, private industry, health care), regional or local partnerships, etc.

TABLE 9: ASSETS/RESOURCES AVAILABLE IN COUNTY OR REGION					
ACA Implementation		Other Grants (please explain)		Other (please explain)	
CAO Collaboration	X				
Experienced Staff					
HealthChoices MCO	X				
MAT Providers					
Mental Health Providers					
Non-DDAP Funding					
Non-Hospital Rehab Availability					
PCCD Grant	X				
Recovery Houses					
Recovery Supports	X				
SBIRT Utilization					
Stakeholder Involvement	X				
Systems of Care County	X				
VA Facility					

CAO Collaboration:

Medical Assistance eligibility can be quite complicated and dependent upon multiple variables. We are fortunate that our local County Assistance office in both York and Adams Counties are incredibly supportive of the Commission and our provider network. York and Adams County Assistance offices have a staff member dedicated to processing drug and alcohol residential medical assistance applications for Medically Monitored Inpatient Detox, Medically Monitored Short and Long Term Residential and Half Way House levels of care. Commission contracted residential providers “flag” applications to the dedicated staff member to ensure proper routing and expedition of the application. On average, this streamlined system results in a 2-3 day turnaround to Managed Care coverage.

Further, this staff person additionally acts a resource to the Commission allowing Commission staff to email directly with questions regarding Medical Assistance application status, updates and additional application questions. This ensures that the Commission does not fund treatment providers if Medical Assistance applications are not processed and followed through appropriately by the treatment provider.

County Assistance Office staff are so supportive that they attend and participate in meetings that are critical to their presence, such as implementation of the jail project as well as offer increased assistance and training during times of transition, such as Healthy PA/Medicaid expansion.

HealthChoices MCO:

The Commission is fortunate to have an incredibly close relationship with York/Adams HealthChoices Management Unit. This is of insurmountable value in that HealthChoices can be seen as the foundation substance abuse treatment providers in that for the Commission to contract with a provider, they must first be in-network with the HealthChoices contracted MCO, Community Care Behavioral Health (CCBH) so that CCBH funding can be utilized prior to SCA dollar, thus ensuring the SCA is the payer of last resort. Further, HealthChoices has the added benefit of reinvestment funding, which can be utilized as start-up funding for community services. It is therefore imperative that HealthChoices collaborate with its local SCA to determine needs, barriers to those needs and solutions. York/Adams HealthChoices has collaborated with the Commission on variety of projects to ensure that substance abuse services meet the needs of York/Adams Counties.

PCCD Grant:

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York and Adams County probation are both recipients of the PCCD (Pennsylvania Commission on Crime and Criminal Delinquency) Grant. This grant allows both York and Adams County to fund substance abuse services under the grant. Specifically, Adams County partially funds a full time position to screen, assess, and coordinate treatment for the probation intermediate punishment identified individuals. York County utilizes the grant to fund the Day Reporting Center intermediate punishment program, which funds a full time Commission Case Management position in addition to treatment funding and other probation positions related to intermediate punishment.

Recovery Supports:

York/Adams Counties have made great strides in incorporating recovery support services and collaborating with existing recovery support services. Some of the services currently available include the RASE Project in York County and the Hanover areas, with intentions of expanding the services to Adams County. The RASE Project provides Buprenorphine Coordination Support services as well as recovery support services designed to assist individuals who are in need of recovery services to assist them to overcome the obstacles that keep them from succeeding in the recovery process. One of support services they offer are child care services in order to promote primary caregiver access to the program.

Additionally, Community Care Behavioral Health has offered a Recovery Oriented Systems of Care Collaborative of which one local provider has taken advantage of. Further, many local providers offer educational groups outside of clinical treatment available to the community.

Many local recovery groups exist in York County. York County has a local Recovery Committee made up of various recovery stakeholders in the community. The Committee hosts a number of events throughout the year to support recovery and hold an annual recovery day event at the York County baseball stadium, with proceeds going directly to support the recovering community. The agency, Not One More , whose mission is to raise awareness and prevent drug abuse in the community through education and community partnership, York Chapter has been extremely active and has coordinated a number of community presentations, Naloxone distribution to the community and recovery houses and is initiating Project Lazarus in York County among many other initiatives. Hope for Today is another recovery group, whose mission is to promote addiction awareness recovery. They recently held their first annual 5K cross country run/health fair. The event raised awareness of substance abuse while raising just under \$10,000 to benefit the recovering community. The run, along with the health fair, provided information on services available to those seeking assistance for loved ones in addiction. These are just a few recovery supports in the area.

Stakeholder Involvement:

The Commission is not a stand-alone agency, in that many agencies work collaboratively to combat the disease of addiction. The importance of collaboration and coordination between the Commission and other related systems in order to improve outcomes cannot be under emphasized. The Commission collaborates with many agencies in the community and within the County Human Services system and strives to continue to reach out to community agencies in an effort to further expand its current collaboration.

The Commission continues its collaborative efforts with the criminal justice system by supporting treatment courts and diversionary programs. The Commission continues its support and collaboration of the York County Treatment Courts, through the assignment of full time designated Case Managers for the following treatment courts (York County Drug Treatment Court, York County Mental Health Treatment Court, York County DUI Treatment Court and Veterans Treatment Court) on a consultative basis. Additionally, the Commission supports a variety of diversionary programs including Intermediate Punishment. Further, the Commission sits on both the York County Intermediate Punishment Board as well as the York County Treatment Court Advisory Board.

The Commission also continues to collaborate with and support York and Adams County Children, Youth and Families, collaborates with prevention and intervention providers, in addition to continuing its collaboration with MH-IDD including attending quarterly Crisis meetings, collaboration of provider monitoring of service quality as well as joint identification of co-occurring programs, service barriers and needs.

The Commission additionally works with treatment providers to not only provide treatment, but to increase their education about Naloxone, the opioid overdose reversal medication. The Commission has met with providers one on one as well as discussed ways to incorporate Naloxone into practice at provider working group meetings. The Commission has also partnered with the local contracted providers to reach out to pharmacies in York/Adams to further educate on Naloxone in addition to providing information to the York County Heroin Task Force and making materials available at the Heroin Task Force town halls. The Commission strives to offer coordination for MAT, such as Suboxone and Vivitrol and forge connections with agencies offering these services, even though YADAC does not currently contract for these services.

Systems of Care County

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System of Care provides a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

The York County System of Care has proven to effectively serve youth with complex behavioral health challenges and involvement in multiple systems. The System of Care has also noted improved outcomes in mental health symptoms and school performance, reduced involvement in child welfare and juvenile justice, and positive family functioning as revealed by the findings from the Joint Planning Team study. These outcomes demonstrate a cost savings – with real, long term benefits because youth and families become more self-reliant.

Structuring the System of Care to focus on relationship building, strategic planning, and implementing a complex architecture of structures, functions, and processes improves the quality of services and supports within the unique context of each community.

To this end, the York County System of Care collaborates with other system partners such as the Commission in order to ensure a mutually beneficial relationship among all partners working toward common goals by sharing responsibility, authority, and accountability for achieving improved outcomes for children, youth, and families.

EVIDENCE BASED PROGRAMS AND PRACTICES

Objective 7: Identify evidence-based programs and practices in the county or region to help respond to emerging trends and treatment demand.

Definitions:

Evidence-Based Program (EBP): There is no universal definition for the term “evidence-based program.” Evidence-based is often used synonymously with research based and science-based programming. Other terms commonly used are promising programs, effective programs, and model programs. Evidence-Based Programs are comprised of a set of coordinated services/activities that demonstrate effectiveness based on research. EBPs may incorporate a number of evidence-based practices in the delivery of services.

Evidence-Based Practice: While many use the terms “programs” and “practices” interchangeably, more and more researchers and practitioners are beginning to differentiate between these terms. A “practice” is defined as a habitual or customary performance that a professional does in order to achieve a positive outcome. Evidence-based practices are skills, techniques, and strategies that can be used when a practitioner is interacting with a consumer of services.

Use of evidence based programs by York/Adams contracted providers is listed below, on Table 10: Evidence-Based Program Utilization, by number of providers utilizing the specific program/practice. As evidenced by this table, the most commonly utilized evidence based programs are Cognitive Behavioral Therapy, Relapse Prevention, and Motivational Interviewing. These programs are reported to be utilized across the full spectrum of level of care, rather than being specific to Outpatient or Residential levels of care. Motivational Interviewing is being utilized additionally by the York County Probation Department. Utilization of this practice across both probation and providers is of benefit to criminal justice clients.

Further, one Outpatient Co-Occurring provider is utilizing the Hazelton Co-Occurring program for seamless integration of Co-Occurring treatment. Upstart funding of this program was provided by the York/Adams Mental Health program with input from the Commission. This program appears to be on the rise, with one other Outpatient Co-Occurring program additionally expressing interest in implementation of the program.

While Commission funds currently do not allow for start up or continual funding for evidence based programs, it does appear that many Commission contracted providers are utilizing evidence based programs. Unfortunately upon discussion with providers, many are not utilizing the program to its full fidelity due to staffing, cost or general lack of knowledge of implementation of evidence based programs.

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TABLE 10: EVIDENCE-BASED PROGRAM UTILIZATION					
Anger Management	8	Medication Assisted Therapy	10	Other (please list)	
Assertive Adolescent & Family Treatment	0	Motivational Enhancement Therapy (Motivational Incentives)	9	Gender Specific Trauma	1
Behavioral Couples Therapy	2	Motivational Interviewing	18	IOP - Living in Recovery	1
Brief Intervention/SBIRT	4	Multidimensional Family Therapy	5	Trauma Recovery Empowerment	5
Cognitive Behavioral Therapy	20	Multisystemic Therapy	2	HOPE Program	1
Community Reinforcement Therapy	3	Relapse Prevention	19	Choice Theory/Reality Theory	2
Contingency Management	2	Therapeutic Community	8	Illness Management and Recovery	1
Dialectical Behavior Therapy	6	12-Step Facilitation	17	Living in Balance	1
Matrix Model	2			Hazeldon - Co-Occurring Program	1
				MATRS	1
				Stages of change	1

IDENTIFICATION OF RESOURCES NECESSARY TO MEET TREATMENT DEMAND

Objective 8: Identify and quantify the resources necessary to meet the estimated treatment demand (identified in Objective 4) and any emerging trends that impact current demand.

Definitions:

Resources: money, staff, providers, Drug Courts, Buprenorphine eligible physicians, inter-systems collaboration, Health Choices implementation, SCA policies & procedures, assessment and treatment capacity, capacity to serve acute need and chronic need, the capability to provide various types, levels, and intensities of care, etc.

TABLE 11: RESOURCES NEEDED TO MEET TREATMENT DEMAND					
Bi-lingual Staff	X	Increase Treatment Capacity	X	Other (please explain)	
Co-Occurring Capable Providers/Staff		Increase Use of Buprenorphine	X		
Detox Unit(s)	X	More MAT Providers	X		
Drug Court		Peer Navigator/Outreach	X		
Funding Increase	X	Permanent Supportive Housing			
Healthcare Navigators		Staffing Increase			
Improved Stakeholder Collaboration		Training	X		
Increase of Recovery Housing Availability		Transportation			
Increase of Recovery Supports in Community		Trauma Informed Care Facilities			

Bi-lingual Staff

As previously evidenced, the Latino/Hispanic population in York and Adams Counties continues to rise. Commission contracted providers struggle to find qualified bi-lingual staff and at times, struggle to retain them. While bi-lingual services are available at the outpatient level in York County for both Outpatient and Intensive Outpatient, the Commission does not hold contracts for Partial Hospitalization or Half-Way House bi-lingual services. Further, Adams County does not house any bi-lingual Commission contracted services. Bi-lingual services for every level of care are necessary to ensure continuity of care access for this population. Partnerships with

provider agencies and the York/Adams HealthChoices Management Unit may assist to ensure that bi-lingual service availability need is met.

Detox Unit(s):

Pennsylvania is currently battling an opiate epidemic. York/Adams Counties are not immune from this epidemic and with York County now tied for fourth place for highest volume of overdose deaths, detox access is critical. Demand for detox beds has increased not only York/Adams Counties, but across the State as well as Counties continue to battle the opiate epidemic. Dramatic increase in detox service demand has in turn resulted in delayed access to Medically Monitored Inpatient Detox services as detox bed capacity cannot support the demand. York/Adams have identified the need to increase local Medically Monitored Inpatient Detox bed capacity from 7 to 21 beds, specifically at the York County housed detox facility, White Deer Run York. A reinvestment plan has been approved for this increase and the expansion is expected to be completed in 2017.

Funding Increase:

Increased treatment demand coupled with decreases in Commission funding have created situations where funding is not available to support treatment need and required supports to ensure treatment is effective. Increased funding is required to ensure continuum of care access in addition to allowing for rate increases at the Outpatient level, thus supporting qualified clinician retention. Further, additional funding increases may allow the Commission to support incentives for bi-lingual staff acquisition and retention. Additional funding may also be utilized to support fidelity of evidence based programming amongst treatment providers as leading causes for lack of adherence to fidelity include staffing, cost, and training.

Increase Treatment Capacity:

Due to the increase in demand for Medically Monitored Inpatient Detox in addition to Medically Monitored Short and Long term Residential services, there is delayed access to these services. The Commission has partnered with the York/Adams HealthChoices Management Unit to increase capacity for both Medically Monitored Inpatient Detox and Medically Monitored Short -Term Residential services based upon identified need. The York/Adams HealthChoices Management Unit has approved reinvestment funds to increase Medically Monitored Inpatient Detox from 7 to 21 beds and Monitored Short -Term Residential services from 17 to 48 beds with 16 “alternate beds” that while not funded under the current York/Adams HealthChoices Management Unit, are anticipated to be needed in the future and shall be included in the design company bid process. All Medically Monitored Short -Term Residential beds shall include bathroom configurations that adhere to Medically Monitored

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Inpatient Detox requirements and can therefore be “flexed” to accommodate detox clients in addition to residential clients.

Further, the Commission has been encouraging all Medically Monitored Inpatient Detox and Medically Monitored Short and Long term Residential facilities to utilize flex beds when appropriate in addition to working with their local SCA/MCO to increase capacity when warranted if their facility cannot afford to invest in such a project without outside support.

The Commission also recognizes the need for increased Outpatient services. While Outpatient services are the second most heavily accessed service among adults, Commission contracted providers at times enact waiting lists due to capacity restraints. At times, 25% of Outpatient providers may have active waiting lists due to capacity. Outpatient provider capacity must be increased to address this concern. Further, no Commission contracted Partial Hospitalization services exist in York or Adams County. These services are necessary to ensure continuum of care at the local level.

Outpatient services in the Southern part of York County are lacking. A capacity increase at the Shrewsbury Outpatient location is necessary to meet demand in addition to adding additional Outpatient services. No Intensive Outpatient or Partial Hospitalization services exist in the Southern part of York County.

Increase Use of Buprenorphine:

Buprenorphine:

As of September 17, 2014 York/Adams HealthChoices reports 113 Buprenorphine prescribers in York/Adams County, not including York County Buprenorphine provider Pyramid HealthCare. Many of these providers boast waiting lists for this service. Limitations on the number of individuals that a doctor can see further compound accessibility issues.

According to the RASE Project, which provides Buprenorphine treatment coordination and support, there are quite a few physicians who prescribe in York/Adams, however not all accept MA or they may have a very high self-pay rate. While the medication is may be covered under insurance, mandatory doctor time is rarely, if ever covered by insurance.

An increase of MA contracted Buprenorphine/affordable prescribers is imperative to meet demand. Further, SCA funding to cover not only the medication, but doctor time would be of additional benefit as this often this is not covered under private insurance and individuals may be unable to afford Buprenorphine services due to this cost.

More MAT Providers:

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Methadone:

Due to the increase in demand for Methadone services, coupled with the fact that York and Adams Counties currently house only one Methadone clinic, it is imperative that Methadone services are available. Demand for Methadone services continues to rise, even with the local York County Methadone increasing capacity from 175 to 350. In order to ensure that continued increased are able to be addressed, the provider, Pyramid Healthcare – York Pharmacotherapy will be relocating their drug free Outpatient clinic from the Methadone building, in order to allow for increased Methadone capacity. Even still, more Methadone clinics are necessary to meet not only demand, but for location convenience for clients, as well, with particular emphasis for Adams County clients, as no Methadone clinic exists in that County. According to York/Adams HealthChoices, during Fiscal Year 2013-2014, 22 HealthChoices members in Adams County and 30 HealthChoices members in Western York County attended a Methadone Maintenance program. York/Adams HealthChoices will be utilizing reinvestment funding to bring Methadone Maintenance services to this region.

Vivitrol:

The Commission is seeking to increase access to this medication to York/Adams residents without insurance coverage. More and more individuals in the community are seeking out Vivitrol. Many are uninsured or underinsured – IE: Vivitrol is not covered by their insurance formulary. Funding is necessary to cover the cost of the evaluation, administration of the medication, cost of the medication as well as costs for all office visits. Additionally, few Vivitrol providers exist, creating a barrier for individuals to access this medication.

The York County-located Commission-contracted detoxification and short term rehabilitation provider, White Deer Run–York is currently administering Vivitrol to opioid addicted individuals with private insurance who attend the facility in addition to referring these individuals to continued substance abuse treatment and established community Vivitrol providers. On average, the facility population consists of 85% York/Adams residents. The facility admitted 119 individuals in 2014 and 117 individuals in 2015 to date that were reliant on funding from the Commission at the time of admission. Estimating a percentage of those individuals will eventually become Medicaid eligible with a physical health plan that covers Vivitrol and also adjusting for the possible increase in beds that may occur over fiscal year 15/16; the Commission is projecting a total of 60 individuals that would be able to receive Vivitrol as identified by White Deer Run York, alone.

Physician outreach and education is necessary to expand the number of community providers willing to administer Vivitrol. Further, stipends to physicians to cover costs of becoming

educated on the administration and benefits of Vivitrol including time spent in educational forums or meetings may be necessary to increase potential participation.

Case Management may be necessary to ensure coordination of Vivitrol and successful outcomes. This may include a coordinator who would:

- 1) Work to identify candidates for Vivitrol.
- 2) Complete necessary steps to obtain funding for the Vivitrol:
 - a. Paperwork required
 - b. Accessing additional funding resources to help cover the cost (i.e. copay assistance through Alkermes).
 - c. Ensuring prescriptions are obtained from physician.
 - d. Working with the specialty pharmacy to obtain the medication.
- 3) Ensure that continuing care appointment is established for subsequent injection
- 4) Provide follow up contact each month with the individual to identify and overcome any barriers to continuing treatment with Vivitrol (i.e. conflict with appointment date/time and work schedule, childcare, transportation issues, etc.).
- 5) Link to resources necessary to ensure that barriers to continued treatment are eradicated.

Peer Navigator/Outreach:

According to a July 2015 Certified Recovery Specialist survey to contracted treatment providers, 66.6% of providers surveyed would be interested in sending staff to a certified recovery specialist training. Of those surveyed, only 16.67% of providers are currently providing Certified Recovery Specialist services and only 33.3% see themselves offering these services in the next 6-12 months. According to the survey, of those not planning on providing these services in the next 6-12 months, 50% of responders cited funding as being a barrier.

Certified Recovery Specialist services may assist in alleviating repeat detox offenders who have a tendency to not follow through with recommended continuum of care. York/Adams Health Choices Management Unit is in discussions to provide funding for these services.

Training:

The Commission hosts an annual training series. Currently, this training series is geared more to provider staff, and not the community at large. Expansion of trainings to include training series to key community members who contribute to the substance abuse recovery network such as school personnel, the medical community and emergency responders remains critical to reducing stigma and increasing the likelihood of an overall healthy recovery environment.

Recovery Support Services:

Recovery Support Services are non-clinical services that assist individuals and families to recover from alcohol and other drug problems. These services complement the focus of treatment, outreach, engagement and other strategies and interventions to assist people in recovery in gaining the skills and resources needed to initiate, maintain, and sustain long-term recovery. While many recovery support services exist in York County, few exist in Adams County. Expansion and support of Adams County chapters of various recovery support agencies, such as Not One More, etc. would be of extreme benefit to the Adams County community.

Appendix A

Estimates of the Prevalence of Substance Use Disorders

The Department of Drug & Alcohol Programs has provided data for each SCA (see table below) based on surveys which yield valid estimates of the prevalence of substance abuse disorders. Only a percentage of the estimated number of dependent people presented in this table would admit to having a substance abuse problem, but the larger number may be thought of as those whose behavior is creating personal consequences and affecting their associates. They are also the pool of people, who eventually, under the right circumstances, may present for treatment services.

These numbers may be used by SCAs to describe need (as distinguished from demand) and the extent of the problem. They show the potential for demand for services.

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**TABLE 1: ESTIMATES OF THE PREVALENCE OF SUBSTANCE USE DISORDERS¹ Pennsylvania, Single County Authorities and State
Based on 2006-2007 National Survey on Drug Use and Health (NSDUH)²**

SCA	Total 2007 Population	Age 12+		Age 12-17		Age 18-25		Age 26+	
		Population	Prevalence (Rate = 7.70%)	Population	Prevalence (Rate = 7.06%)	Population	Prevalence (Rate = 20.35%)	Population	Prevalence (Rate = 5.70%)
Allegheny	1,219,210	1,055,941	81,307	97,296	6,869	134,498	27,370	824,147	46,976
Armstrong / Indiana	156,749	136,000	10,472	12,413	876	22,507	4,580	101,080	5,762
Beaver	173,074	150,428	11,583	13,599	960	16,235	3,304	120,594	6,874
Bedford	49,650	42,514	3,274	3,974	281	4,084	831	34,456	1,964
Berks	401,955	335,630	25,844	34,334	2,424	44,048	8,964	257,248	14,663
Blair	125,527	107,955	8,313	9,821	693	13,098	2,665	85,036	4,847
Bradford / Sullivan	67,671	58,021	4,468	5,993	423	6,251	1,272	45,777	2,609
Bucks	621,144	526,835	40,566	52,095	3,678	55,200	11,233	419,540	23,914
Butler	181,934	154,437	11,892	15,455	1,091	19,285	3,924	119,697	6,823
Cambria	144,995	126,818	9,765	10,858	767	15,368	3,127	100,592	5,734
Cameron / Elk / McKean	81,592	70,745	5,447	6,981	493	7,381	1,502	56,383	3,214
Carbon / Monroe / Pike	286,597	246,375	18,971	25,891	1,828	31,851	6,482	188,633	10,752
Centre	144,658	129,656	9,984	9,710	686	45,675	9,295	74,271	4,233
Chester	486,345	405,651	31,235	43,251	3,054	50,851	10,348	311,549	17,758
Clarion	40,028	34,839	2,683	3,035	214	6,761	1,376	25,043	1,427
Clearfield / Jefferson	126,587	110,300	8,493	9,455	668	12,499	2,543	88,346	5,036
Columbia / Montour / Snyder / Union	164,380	143,742	11,068	12,948	914	26,544	5,402	104,250	5,942
Crawford	88,663	75,664	5,826	7,711	544	9,906	2,016	58,047	3,309
Cumberland / Perry	273,182	236,098	18,180	22,337	1,577	36,776	7,484	176,985	10,088
Dauphin	255,710	215,893	16,624	20,939	1,478	23,785	4,840	171,169	9,757
Delaware	554,399	470,368	36,218	47,983	3,388	65,403	13,310	356,982	20,348
Erie	279,092	238,078	18,332	24,073	1,700	36,093	7,345	177,912	10,141
Fayette	144,556	125,089	9,632	11,346	801	12,675	2,579	101,068	5,761
Forest / Warren	47,941	41,886	3,225	3,873	273	4,608	938	33,405	1,904
Franklin / Fulton	156,604	132,093	10,171	12,295	868	16,236	3,304	103,562	5,903
Greene	39,503	34,656	2,669	2,921	206	4,511	918	27,224	1,552
Huntingdon / Mifflin / Juniata	115,665	98,890	7,615	9,363	661	11,542	2,349	77,985	4,445
Lackawanna	209,330	181,643	13,987	16,299	1,151	23,453	4,773	141,891	8,088
Lancaster	498,465	416,651	32,082	44,953	3,174	57,494	11,700	314,204	17,910
Lawrence	90,991	78,422	6,038	7,522	531	9,574	1,948	61,326	3,496
Lebanon	127,889	109,286	8,415	10,024	708	14,404	2,931	84,858	4,837
Lehigh	337,343	287,324	22,124	29,279	2,067	37,878	7,708	220,167	12,550
Luzerne / Wyoming	340,100	296,267	22,813	25,850	1,825	36,627	7,454	233,790	13,326
Lycoming / Clinton	154,024	133,144	10,252	12,459	880	19,579	3,984	101,106	5,763
Mercer	116,809	100,408	7,731	10,015	707	12,927	2,631	77,466	4,416
Montgomery	776,172	656,374	50,541	61,925	4,372	71,770	14,605	522,679	29,793
Northampton	293,522	250,186	19,264	25,453	1,797	35,389	7,202	189,344	10,793
Northumberland	91,003	78,884	6,074	7,196	508	7,366	1,499	64,322	3,666
Philadelphia	1,449,634	1,217,846	93,774	127,706	9,016	204,338	41,583	885,802	50,491

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Potter	16,987	14,363	1,106	1,433	101	1,613	328	11,317	645
Schuylkill	147,269	128,957	9,930	10,851	766	13,288	2,704	104,818	5,975
Somerset	77,861	68,156	5,248	5,834	412	6,939	1,412	55,383	3,157
Susquehanna	41,123	35,713	2,750	3,662	259	3,847	783	28,204	1,608
Tioga	40,681	34,793	2,679	3,838	271	5,064	1,030	25,891	1,476
Venango	54,763	46,960	3,616	4,625	327	4,656	948	37,679	2,148
Washington	205,553	177,176	13,643	15,687	1,108	21,575	4,391	139,914	7,975
Wayne	51,708	45,322	3,490	3,707	262	4,705	957	36,910	2,104
Westmoreland	362,326	315,441	24,289	27,946	1,973	32,579	6,630	254,916	14,530
York / Adams	521,828	442,718	34,089	43,843	3,095	52,662	10,717	346,213	19,734
Pennsylvania	12,432,792	10,620,636	817,789	1,030,057	72,722	1,411,395	287,219	8,179,184	466,213

1. Substance use disorder is based on definitions found in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

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, non-institutional 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. State level estimates are based on a survey-weighted hierarchical Bayes estimation approach. Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007, Table 78.

Population Data Source: Penn State Data Center 2007 Population Estimates. County-level estimates prepared by the Division of Statistical Support, Pennsylvania Department of Health. Estimates may not sum to totals due to rounding.

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.

Appendix B

Prevalence of Substance Abuse Dependency Disorders in Special Populations

Each SCA will be responsible for developing prevalence estimates of substance abuse disorders (for its service area) for the special population groups listed in the table below. These numbers may be used by the SCA to describe the possible need (as distinguished from demand) and the extent of the problem.

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TABLE 2: LOCAL SPECIAL POPULATION NEED DATA

As reported by York Adams Drug & Alcohol Commission

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 use problems.	(Column 6) Estimated number who have substance use 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 2014) Select County 6) Select Appropriate UCR Codes 7) Click Submit 8) Record Total	1,811 (for the calendar year 2014)	100%	1,811
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	2,686 (for the calendar year 2014)	100%	2,686
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.	11,877 (for the calendar year 2014)	70% (DOC estimate)	8,313
4. County jail population	SCA to provide from local contacts	Contact Local Source	14,061 (for the calendar year 2014)	70% (DOC estimate)	9,843

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TABLE 2: LOCAL SPECIAL POPULATION NEED DATA

As reported by York Adams Drug & Alcohol Commission

5. Persons on state probation or parole in county	SCA to provide from local contacts	Contact Local Source	2,003 (for the calendar year 2014)	70% (DOC estimate)	1,402
6. Reported Substantiated Child Abuse & Neglect Cases (Total)	<p>Pennsylvania Department of Human Services http://www.dhs.state.pa.us/publications/childabusereports/index.htm</p>	<p>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</p>	166 (for the calendar year 2014)	50 % (National Center on Substance Abuse and Child Welfare—April 2005)	83
7. Domestic Violence (PFA)	<p>Administrative Office of Pennsylvania Courts http://www.pacourts.us/T/AOPC/ResearchandStatistics.htm Then click on 2007 AOPC Caseload Statistics</p>	<p>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</p>	207 (for the calendar year 2014)	25% (SAMHSA Substance Abuse Treatment & Domestic Violence TIP 25)	51
8. Other Categories *					

Appendix C

STAR Pattern of Referrals for SCA

This table will present the number and percentage of all first admissions for SCA-paid adult clients for the previous year, broken down by referral source.

Table 4 : SFY 2012-2013			
STAR Pattern of Referrals for SCA (York-Adams)			
SCA Unique Clients			
Referral Source for New Clients	Number of Clients	Percentage of SCA Clients	Percentage of Statewide
Clergy/Religious	0	0.0%	0.1%
Comm. Serv.	16	1.2%	3.4%
Court/Criminal Justice	570	43.3%	37.7%
D&A Abuse Care	124	9.4%	11.6%
Employer/EAP	4	0.3%	0.3%
Family/Friend	18	1.4%	1.8%
Hospital/Physician	54	4.1%	4.4%
Other Non-Voluntary	16	1.2%	1.2%
Other Voluntary	14	1.1%	2.4%
SCA	216	16.4%	15.1%
School/SAP	5	0.4%	1.1%
Self	278	21.1%	20.9%
Unknown	0	0.0%	0.0%
Total:	1315	100.0%	100.0%
Below is for juveniles (17 or younger) only			
Juveniles	20	1.5%	3.3%

Appendix D

Unique Clients Not Referred by a Provider (CJ/ Non-Voluntary)

This table will present an example based on STAR criminal justice referrals (not referred by a provider) to show the differences among SCAs in strategies for identifying and engaging criminal justice clients in need of treatment.

Table 5 : SFY 2012-2013			
Unique Clients Not Referred by a Provider (CJ / Non-Voluntary Proportion)			
SCA	Criminal Justice / Non-Voluntary Client Count	Total Clients	Percent Non-Voluntary
ALLEGHENY	1391	4978	27.9%
ARMSTRONG / INDIANA / CLARION	760	1427	53.3%
BEAVER	300	659	45.5%
BEDFORD	34	121	28.1%
BERKS	481	1556	30.9%
BLAIR	295	800	36.9%
BRADFORD / SULLIVAN	119	185	64.3%
BUCKS	551	1535	35.9%
BUTLER	94	477	19.7%
CAMBRIA	67	790	8.5%
CAMERON / ELK / MCKEAN	257	478	53.8%
CARBON / MONROE / PIKE	470	1054	44.6%
CENTRE	313	551	56.8%
CHESTER	412	1229	33.5%
CLEARFIELD / JEFFERSON	179	522	34.3%
COLUM / MONT / SNYDER / UNION	12	261	4.6%
CRAWFORD	208	357	58.3%
CUMBERLAND / PERRY	275	789	34.9%
DAUPHIN	254	704	36.1%
DELAWARE	426	1636	26.0%
ERIE	525	1080	48.6%
FAYETTE	404	701	57.6%
FOREST / WARREN	80	193	41.5%
FRANKLIN / FULTON	238	439	54.2%
GREENE	7	45	15.6%
HUNTINGDON / MIFFLIN / JUNIATA	46	171	26.9%
LACKAWANNA / SUSQUEHANNA	598	1029	58.1%
LANCASTER	1451	2330	62.3%

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LAWRENCE	577	1044	55.3%
LEBANON	200	431	46.4%
LEHIGH	304	1096	27.7%
LUZERNE / WYOMING	369	832	44.4%
LYCOMING / CLINTON	8	489	1.6%
MERCER	111	260	42.7%
MONTGOMERY	182	840	21.7%
NORTHAMPTON	157	581	27.0%
NORTHUMBERLAND	68	202	33.7%
PHILADELPHIA	1637	3668	44.6%

Table 5 : SFY 2012-2013			
Unique Clients Not Referred by a Provider (CJ / Non-Voluntary Proportion)			
SCA	Criminal Justice / Non-Voluntary Client Count	Total Clients	Percent Non-Voluntary
POTTER	42	94	44.7%
SCHUYLKILL	249	684	36.4%
SOMERSET	113	410	27.6%
TIOGA	19	91	20.9%
VENANGO	257	382	67.3%
WASHINGTON	49	376	13.0%
WAYNE	121	216	56.0%
WESTMORELAND	139	554	25.1%
YORK / ADAMS	586	1315	44.6%
NO SCA, OUT-OF-STATE RESIDENT	4	20	20.0%
NO SCA OR RESIDENCE INFORMATION	23	74	31.1%
	Criminal Justice / Non-Voluntary Client Count	Total Clients	Percent of State
TOTALS	15462	39756	38.9%

Appendix E

Service Strategy for Each SCA (York-Adams)

This table is limited to SCA clients as defined by “Submit to the SCA: item in STAR. It counts treatment admissions that began during the year, rather than individual clients. This report identifies differences in the pattern of services provided by each SCA, compared to statewide pattern.

Table 6 : SFY 2012-2013			
Service Strategy for SCA (York-Adams)			
Level of Care Usage for Treatment Admissions	# of Admissions	% of SCA	% of State
810-Adolescent Intake, Evaluation, and Referral	0	0.0%	0.0%
810-Intake, Evaluation, and Referral	0	0.0%	0.0%
821-Adolescent Inpatient Non-Hospital Detoxification (III.5D)	8	0.4%	0.1%
821-Inpatient Non-Hospital Detoxification (3A)	670	35.2%	13.8%
823-Adolescent Inpatient Non-Hospital Drug-free (III.1)	1	0.1%	0.0%
823-Adolescent Inpatient Non-Hospital Drug-free (III.5)	0	0.0%	0.3%
823-Adolescent Inpatient Non-Hospital Drug-free (III.7)	0	0.0%	0.0%
823-Inpatient Non-Hospital Drug-free (2B)	55	2.9%	2.0%
823-Inpatient Non-Hospital Drug-free (3B)	287	15.1%	13.9%
823-Inpatient Non-Hospital Drug-free (3C)	27	1.4%	2.5%
826-Adolescent Inpatient Non-Hospital Transitional Living	0	0.0%	0.0%
826-Inpatient Non-Hospital Transitional Living Facility	0	0.0%	0.0%
831-Adolescent Inpatient Hospital Detoxification (IV)	0	0.0%	0.0%
831-Inpatient Hospital Detoxification (4A)	0	0.0%	0.9%
833-Adolescent Inpatient Hospital Drug-free (IV)	0	0.0%	0.0%
833-Inpatient Hospital Drug-free (4B)	0	0.0%	0.1%
836-Adolescent Psychiatric Hospital	0	0.0%	0.0%
836-Psychiatric Hospital	0	0.0%	0.0%
853-Adolescent Partial Hospitalization Drug-free (II.5)	0	0.0%	0.0%
853-Partial Hospitalization Drug-free (2A)	26	1.4%	2.0%
854-Adolescent Partial Hospitalization Other Chemotherapy	0	0.0%	0.0%
854-Partial Hospitalization Other Chemotherapy (2A)	0	0.0%	0.0%
861-Adolescent Outpatient Detoxification (I)	0	0.0%	0.0%
861-Adolescent Outpatient Detoxification (II.1)	0	0.0%	0.0%
861-Outpatient Detoxification (1A)	0	0.0%	0.0%
861-Outpatient Detoxification (1B)	0	0.0%	0.0%
862-Adolescent Outpatient Maintenance (I)	0	0.0%	0.0%
862-Adolescent Outpatient Maintenance (II.1)	0	0.0%	0.0%
862-Outpatient Maintenance (1A)	0	0.0%	2.1%
862-Outpatient Maintenance (1B)	0	0.0%	0.2%
863-Adolescent Outpatient Drug-free (I)	5	0.3%	1.3%
863-Adolescent Outpatient Drug-free (II.1)	2	0.1%	0.3%

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863-Outpatient Drug-free (1A)	389	20.4%	29.6%
863-Outpatient Drug-free (1B)	250	13.1%	14.9%
864-Adolescent Outpatient Other Chemotherapy (I)	0	0.0%	0.0%
864-Adolescent Outpatient Other Chemotherapy (II.1)	0	0.0%	0.0%
864-Outpatient Other Chemotherapy (1A)	0	0.0%	0.0%
864-Outpatient Other Chemotherapy (1B)	0	0.0%	0.1%
900-Adolescent Non Treatment Services	3	0.2%	0.6%
900-Adult Non-Treatment Services	181	9.5%	15.2%
Total SCA Admissions	1904	100%	100%

Appendix F

Demand for Service by Primary Substance of Abuse

This table is limited to SCA clients as defined by “Submit to the SCA: item in STAR. It counts treatment admissions that began during the year, rather than individual clients, based on the primary drug of choice at admission. This report identifies differences in the pattern of services provided by each SCA, compared to statewide pattern. The percentage of stateside admission for that substance for age categories: under 18 and age 18+.

SFY 2012-2013			
Treatment Needs Assessment Table 7a			
Demand for Service by Primary Substance of Abuse			
SCA Admissions (Age < 18) for:	SCA (York-Adams)		
Primary Substance of Abuse	Number of Admissions (Age < 18)	Percentage of SCA Admissions (Age < 18)	Percentage of State Admissions (Age < 18)
Alcohol	2	8.3%	14.4%
Barbiturates	0	0.0%	0.1%
Benzodiazepines	0	0.0%	0.6%
Buprenorphine	0	0.0%	0.4%
Cocaine/Crack	0	0.0%	0.3%
Heroin	4	16.7%	4.8%
Inhalants	0	0.0%	0.1%
Marijuana/Hashish	16	66.7%	69.2%
Methamphetamine	0	0.0%	0.1%
None	0	0.0%	1.6%
Non-Prescription Methadone	0	0.0%	1.2%
Not Applicable (None)	0	0.0%	0.2%
Other	0	0.0%	0.9%
Other Amphetamines	0	0.0%	0.8%
Other Hallucinogens	0	0.0%	0.2%
Other Non-Barbiturate Sedatives or	0	0.0%	0.4%
Other Non-Benzodiazepine	0	0.0%	0.1%
Other Opiates and Synthetics	1	4.2%	0.0%
Other Stimulants	0	0.0%	3.6%
Over the Counter	1	4.2%	0.3%
OxyContin	0	0.0%	0.6%
PCP	0	0.0%	0.2%
Unknown	0	0.0%	0.1%
Missing	0	0.0%	0.0%
Total	24	100%	100%

York/Adams Drug & Alcohol Commission

SFY 2012-2013			
Treatment Needs Assessment Table 7b			
Demand for Service by Primary Substance of Abuse			
SCA Admissions (Age 18+) for:	SCA (York-Adams)		
Primary Substance of Abuse	Number of Admissions (Age 18+)	Percentage of SCA Admissions (Age 18+)	Percentage of State Admissions (Age 18+)
Alcohol	640	34.0%	32.9%
Barbiturates	2	0.1%	0.0%
Benzodiazepines	14	0.7%	1.1%
Buprenorphine	3	0.2%	0.5%
Cocaine/Crack	86	4.6%	5.8%
Heroin	817	43.5%	31.3%
Inhalants	0	0.0%	0.0%
Marijuana/Hashish	137	7.3%	12.5%
Methamphetamine	1	0.1%	0.5%
None	5	0.3%	0.4%
Non-Prescription Methadone	4	0.2%	0.2%
Not Applicable (None)	1	0.1%	0.1%
Other	3	0.2%	0.3%
Other Amphetamines	3	0.2%	0.2%
Other Hallucinogens	2	0.1%	0.1%
Other Non-Barbiturate Sedatives or	0	0.0%	0.0%
Other Non-Benzodiazepine	0	0.0%	0.0%
Other Opiates and Synthetics	128	6.8%	11.7%
Other Stimulants	0	0.0%	0.1%
Over the Counter	2	0.1%	0.1%
OxyContin	21	1.1%	0.7%
PCP	0	0.0%	0.4%
Unknown	1	0.1%	0.0%
Missing	10	0.5%	1.0%
Total	1880	100%	100%