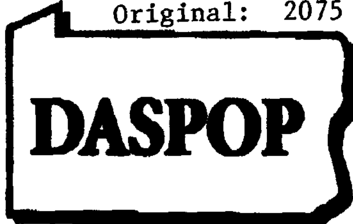
Original: 2075




Drug & Alcohol Service Providers Organization of Pennsylvania

Policy & Legislative Office: 3820 Club Drive Harrisburg, PA 17110 717-652-9128 Fax 717-652-3857
Administrative & Business Office: P.O. Box 20 Torrance, PA 15779 724-459-9700 Fax 724-459-9701

*Organized For Advocacy*

# EMBARGOED MATERIAL

Robert Nyce, Executive Director
Independent Regulatory Review Commission
333 Market Street
14th Floor, Harristown 2
Harrisburg, PA 17101

Dear Robert Nyce,

I am writing on behalf of the Drug and Alcohol Service Providers Organization of Pennsylvania regarding the proposed physical plant regulations for alcohol and other drug addiction treatment. (Title 28, Health & Safety, Part V. Drug and Alcohol Facilities and Services, Chs. 701, 705, 709, 711 and 713.)

DASPOP is a statewide coalition of drug and alcohol prevention and treatment programs, practitioners, employee assistance programs and drug and alcohol associations representing more than 365 organizations, programs and clinics, over 3,000 certified addiction professionals, 1,200 student assistance professionals, 400 prevention specialists and others throughout the state. Our members represent the full continuum of services, including prevention, education, hospital and non-hospital detoxification and rehabilitation, outpatient, intensive outpatient and halfway houses.

These proposed regulations have been under review since November 1999 and we are relieved and appreciative of the provisions recently added including: grandfathering of existing, licensed programs, exclusion of children from the square footage calculations in bedroom areas and a more appropriate approach to provision of food services.

Please also accept our continuing appreciation for the openness of the IRRC process, including engagement of the appropriate committees of the House and Senate and the effected communities. And again, thank you for the patient professionalism of your staff as they worked with us.

However, we continue to be concerned that the square footage requirements in bedroom areas for new or renovated programs may be excessive, hampering future growth and increasing costs of expansion.

A review of standards for square footage requirements in nearby states – with the exception of New Jersey – supports the above concern.

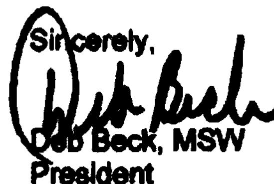
We are puzzled by the regulatory emphasis on square footage in bedrooms. We work hard to keep people in treatment out of the bedroom areas and fully engaged in the therapeutic process throughout the day. This is critical to breaking through the isolation that comes with addiction, it is suicide prevention and it also assists in re-establishing normal sleeping patterns.

In a time of increased pressure on the federal and state levels to "close the treatment gap", to reduce waiting lists and to address a burgeoning heroin problem, the demand for expansion of service and bed space is likely to grow.

With this in mind, we do need to make one additional recommendation that is not intended to interfere with the process underway on December 6, 2001.

We respectfully request that IRRC require as part of this process ongoing annual reports from the Department of Health to the General Assembly and IRRC on the impact of the square footage requirements on growth, renovations and expansion with such reports to include but not be limited to: estimates of the prevalency of untreated alcohol and drug addiction, county by county waiting list numbers and data on the addiction treatment gap in Pennsylvania.

Sincerely,



Deb Beck, MSW
President

December 5, 2001

cc: PA Senate Public Health & Welfare Committee
PA House Health & Human Services Committee
DASPOP Membership

Deb Beck
3820 Club Drive
Harrisburg, PA 17110
Phone: 717-652-9128
Fax: 717-652-3857

# facsimile transmittal

To: IRRC

From: Deb Beck

Date: 12/5/01

Pages: 3 (incl. Cover)

Re:

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Notes: FYI — Any problems with the receipt of this fax, please call Joslen at 717-657-7702

PLEASE MAKE AVAILABLE TO THE COMMITTEE TOMORROW AT THE PUBLIC HEARING. THANK YOU.

2001 DEC -5 AM 11:29

Original: 2075

**ADMINISTRATIVE OFFICE**
**President**
**Lawrence J. Devlin**
**Executive Director**
**Terence McSherry**

499 North Fifth Street
Philadelphia, PA 19123
TEL: (215) 451-7000
FAX: (215) 451-7110

**BEHAVIORAL HEALTHCARE SERVICES**

**PHILADELPHIA AREA**

**Adult Services**

- ☐ Wharton Residential
- ☐ Community Counseling
- ☐ Intensive Outpatient
- ☐ Ambulatory Medical Stabilization

**Youth & Family Services**

- ☐ Children & Youth Dependent Services
- ☐ Juvenile Justice Treatment Services
- ☐ Mental Health Services

**DELAWARE STATE**

**Adult Services**

- ☐ Recovery Center of Delaware
- ☐ Kirkwood Detox Center
- ☐ Alternatives
- ☐ NET Counseling Center
- ☐ Continuum for Recovery
- ☐ Reflections Women's Program
- ☐ CJS Outpatient Services
- ☐ Glasshouse Men's Program

**Youth & Family Services**

- ☐ Kasy Church Day Treatment Center
- ☐ Iron Hill Residential Treatment Services
- ☐ Red Lion Residential Treatment Services
- ☐ Treatment Foster Families

A comprehensive approach to the treatment of behavioral health problems and the provision of social services to adults, youth and families.

Many programs accredited by Joint Commission on Accreditation of Healthcare Organizations

October 2, 2001

Independent Regulatory Review Commission
Attn: Richard Sandusky & Fiona Wilmarth
333 Market Street
Harrisburg, PA 17101

Dear Mr. Sandusky and Ms. Wilmarth:

This letter is to provide comment on the regulation submitted by the Department of Health amending the Physical Plant Standards for Drug and Alcohol Facilities.

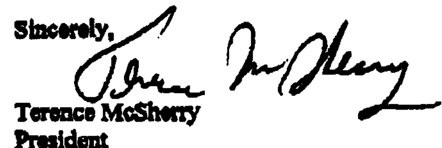
NorthEast Treatment Centers would be adversely affected by the implementation of the sections of the proposed regulations referring to the per person floor space sleeping accommodations. Implementation of the regulations would result in the loss of nine beds of our present capacity, which would entail a loss of revenue per year for this program of $272, 000. The magnitude of this loss would immediately cause the closure of 36 beds. It is highly unlikely that any other funding source would absorb the approximately $30.00 per bed charge increase which would offset this deficit.

The net result therefore would be the loss of the entire 36 bed capacity to the Philadelphia treatment system. For your information the residential program at NET has been in existence at this site and in this configuration for 20 years. We have met occupancy requirements of our Philadelphia Department of Licenses and Inspection and are accredited by the Joint Commission on Accreditation of Health Care Organizations for the services provided in this and other programs.

We understand the implementation of the proposed standards relates to the desire to insure the health, safety and well-being of client in residential facilities, a goal which we share. At the same time, however, we have not experienced any significant health or safety incidents with the current number of beds and the current allocations of floor space for sleeping accommodations. The balance to be struck in your deliberation is between a theoretical harm vs. a certainty that the present delivery system for this service will be very adversely affected by the implementation of these regulations.

Thank you for the opportunity to express our opinions on these regulations. The particular concern which we address regarding this sections regarding sleeping accommodations is not to be considered as any adverse comment on the other areas of the proposed regulation, which have many positive aspects. I also want to thank you for notifying our agency and we stand ready to answer any questions which you might pose.

Sincerely,



Terence McSherry
President

cc: Tim E. Wilson, Philadelphia Alliance
Mark Bencivengo, CODAAP
Lynn Cooper, PCPA

A copy of this letter was also addressed to: Dennis O'Brien, Harold Mowery, Melanie Brown, Scott Johnson, Frank Oliver, Vincent Hughes, Sandra Bennett

**ADMINISTRATIVE OFFICE**
**President**
**Lawrence J. Devlin**
**Executive Director**
**Terence McSherry**

499 North Fifth Street
Philadelphia, PA 19123
TEL: (215) 451-7000
FAX: (215) 451-7110

**BEHAVIORAL HEALTHCARE SERVICES**

**PHILADELPHIA AREA**

**Adult Services**

- ☐ Wharton Residential
- ☐ Community Counseling
- ☐ Intensive Outpatient
- ☐ Ambulatory Medical Stabilization

**Youth & Family Services**

- ☐ Children & Youth Dependent Services
- ☐ Juvenile Justice Treatment Services
- ☐ Mental Health Services

**DELAWARE STATE**

**Adult Services**

- ☐ Recovery Center of Delaware
- ☐ Kirkwood Detox Center
- ☐ Alternatives
- ☐ NET Counseling Center
- ☐ Continuum for Recovery
- ☐ Reflections Women's Program
- ☐ CJS Outpatient Services
- ☐ Glasshouse Men's Program

**Youth & Family Services**

- ☐ Kacy Church Day Treatment Center
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- ☐ Red Lion Residential Treatment Services
- ☐ Treatment Foster Families

A comprehensive approach to the treatment of behavioral health problems and the provision of social services to adults, youth and families.

Many programs accredited by Joint Commission on Accreditation of Healthcare Organizations

October 18, 2001

Niles Schore, Executive Director
PA Senate Public Health & Welfare Committee

Dear Mr. Schore:

The Department of Health has proposed amendments to regulations affecting the Physical Plant Standards for Drug and Alcohol Facilities. The process has moved to the stage where the a review by the Independent Regulatory Review Commission is scheduled and a hearing will take place on November 1, 2001. As detailed in the attached letter of October 2, 2001, the implementation of these regulations, while laudable in their intent, would have an immediate negative impact on the capacity on the drug and alcohol treatment system. NorthEast Treatment Centers would be adversely affected by the loss, projected immediately, of 36 beds and the immediate closure of a program which has operated for 20 years successfully under existing regulations.

I would appreciate it if you would look into this and lend your support to a reconsideration of the regulations such that these adverse affects would be mitigated. Please feel free to contact me at (215) 451-7018, if I could answer any questions with regard to this matter.

Sincerely,

Terence McSherry
President

2001 OCT 19 AM 8:16
INDEPENDENT REGULATORY REVIEW COMMISSION

cc: Tim Wilson, Philadelphia Alliance
Mark Bencivengo, CODAAP
Lynn Cooper, PCPA
Fiona Wilmarth, IRRC

**Behavioral Health & Social Services**

**Administrative Offices of:**
**NorthEast Treatment Centers**
**499 North 5th Street**
**Philadelphia, PA 19123**
**(215) 451-7000 Phone**
**(215) 451-7110 Fax**

# FACSIMILE COVER SHEET

**DATE:** 10-18-01

**Number of Pages:** 3
**(including cover sheet)**

**TO:** Fiona Wilmuth (717) 783-2664

**FROM:** Perry McSherry

**MESSAGE:**

**If you have any problems in the receipt of this message, please contact the sender immediately.**

*This facsimile transmission is intended only for the addressee(s) shown above. It may contain information that is privileged, confidential or otherwise protected from disclosure. Any review, dissemination or use of this transmission or its contents is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone and mail the original to us at the above address. THANK YOU.*

**A COMPREHENSIVE APPROACH TO THE TREATMENT OF BEHAVIORAL HEALTH PROBLEMS AND THE PROVISION OF SERVICES TO YOUTH & FAMILIES IN NEED.**

Original: 2075

DEPARTMENT OF HEALTH
in pursuit of good health

# FAX
717-772-6959

| | | | |
|---|---|---|---|
| **To:** | Scott Johnson | **From:** | Deborah Griffiths |
| **Title:** | Executive Director, Sen. Mowery | **Office:** | Office of Legislative Affairs |
| **Fax #:** | (717) 772-0576 | **Fax #:** | 772-6959 |
| **Phone #:** | (717) 787-8524 | **Phone #:** | 783-3985 |
| **Pages:** | 3, Including fax coversheet | **Date:** | November 7, 2001 |

**Subject: Revised Drug & Alcohol Physical Plant regulations - #10-154**

Deputy Secretary Dick Lee has asked me to send you an early draft of language we have prepared for the resubmission of the final-form Drug and Alcohol Physical Plan Regulations. Since we are now proposing somewhat different words, we wanted to give you a "heads up". This language relates to the grandfather clause for existing bedrooms.

Attached is the language that we discussed during our meeting on October 26, 2001, as well as revised language we prepared on 11/6/01. We believe that the revision does not change the intent of the grandfathering, but does provide clearer, more accurate language. We anticipate submitting the revised regulation package to you on or about November 14, 2001. To meet this deadline, we would appreciate hearing from you by the end of the day on 11/7. Please give me a call at 783-3985.

Thank you

Deborah M. Griffiths, Director

2001 NOV -7 AM 11:01

(2) **HAVE A CERTIFICATE OF OCCUPANCY FROM THE DEPARTMENT OF LABOR AND INDUSTRY OR ITS LOCAL EQUIVALENT.**

(a) (3) The residential facility shall comply **COMPLY** with applicable Federal, State and local laws and ordinances.

(b) The residential facility shall have a certificate of occupancy from the Department of Labor and Industry or its local equivalent.

(c) (4) A residential facility licensed prior to __________ is exempt **BE EXEMPT** from §705.5 (B), (c), (e) and (f) (E), (F) and (I) (relating to sleeping accommodations), **FOR ROOMS THAT ARE BEING USED AS BEDROOMS AS OF [THE EFFECTIVE DATE OF THE REGULATION] IN FACILITIES LICENSED AS OF [THE EFFECTIVE DATE OF THE REGULATION]. IF A FACILITY EXPANDS ITS CAPACITY OR RENOVATES TO RELOCATE OR ADD BEDROOMS, THIS EXEMPTION DOES NOT APPLY TO THE NEW BEDROOMS. IF THE FACILITY RELOCATES OR REBUILDS, THIS EXEMPTION DOES NOT APPLY.**

**§705.2. Building exterior and grounds.**

The residential facility shall:

(1) Maintain all structures, fences and playground equipment, when applicable, on the grounds of the facility so as to be free from any danger to health and safety.

(2) Keep the grounds of the facility in good condition and shall ensure that the grounds are free from any hazard to health and safety **CLEAN, SAFE, SANITARY AND IN GOOD REPAIR AT ALL TIMES FOR THE SAFETY AND WELL-BEING OF RESIDENTS, EMPLOYEES AND VISITORS. THE EXTERIOR OF THE BUILDING AND THE BUILDING GROUNDS OR YARD SHALL BE FREE OF HAZARDS.**

(3) Keep exterior exits, stairs and walkways lighted at night.

(4) Store securely all **TRASH,** garbage and rubbish in noncombustible, covered containers **THAT PREVENT THE PENETRATION OF INSECTS AND RODENTS,** and remove it on a regular basis, at least once every week.

Draft- 10/26/01

(2) **HAVE A CERTIFICATE OF OCCUPANCY FROM THE DEPARTMENT OF LABOR AND INDUSTRY OR ITS LOCAL EQUIVALENT.**

~~(a)~~ (3) ~~The residential facility shall comply~~ **COMPLY** with applicable Federal, State and local laws and ordinances.

~~(b) The residential facility shall have a certificate of occupancy from the Department of Labor and Industry or its local equivalent.~~

~~(c)~~ [4] ~~A residential facility licensed prior to ___ ___ is exempt~~ **BE EXEMPT** from §705.5 (b), (c), ~~(e) and (f)~~ (E), (F) and (I) (relating to sleeping accommodations), **FOR SPECIFIC BEDROOMS INCLUDED IN THE LICENSED CAPACITY AS OF (THE EFFECTIVE DATE OF THIS CHAPTER), IF THE FACILITY WAS LICENSED AS OF (THE EFFECTIVE DATE OF THIS CHAPTER). IF A FACILITY EXPANDS ITS CAPACITY OR RENOVATES THE FACILITY TO RELOCATE OR ADD BEDROOMS, THIS EXEMPTION DOES NOT APPLY TO THE NEW BEDROOMS. IF THE FACILITY RELOCATES OR REBUILDS THE FACILITY, THIS EXEMPTION DOES NOT APPLY.**

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(3) Keep exterior exits, stairs and walkways lighted at night.

(4) Store ~~securely~~ all **TRASH,** garbage and rubbish in noncombustible, covered containers **THAT PREVENT THE PENETRATION OF INSECTS AND RODENTS,** and remove it on ~~a regular basis~~, at least

(717) 787-4525

# FAX Cover Sheet

**Date:** November 7, 2001 10:55 AM

**Subject:** Final-Form Drug and Alcohol Physical Plant Regs-#10-154

**Deliver To:** Jim Smith, IRRC

**Sent By:** Karen Kroh, Policy Office

**Num. of Pages:** 4

**Message:** Please see attached FAX sent to both the House and Senate staff this morning. Please call me at 787-4525 if you have any questions.

2001 NOV -7 AM 11:02

Pennsylvania Department of Health P.O. Box 90, Room 813 Harrisburg, PA 17108-0090

Original: 2075

# The Philadelphia Alliance

*Representing Community Providers for People with Mental Health, Mental Retardation and Chemical Dependency Needs.*

4343 Kelly Drive • 2nd Floor, Suite 1 • Philadelphia, PA 19129 • Tel. 215.438.6400 • Fax. 215.438.6600

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Ken-Crest Services
New Hope of Pennsylvania
NorthEast Treatment Centers
Northern Home for Children
Pennsylvania Mentor
Philadelphia Consultation Center
Philadelphia Developmental Disabilities Corp.
Philadelphia Health Management Corp.
Philadelphia OIC
Programs Employing People
Resources for Human Development, Inc.
Special People in Northeast, Inc.
St. John's Community Services
Step-By-Step
The Association for Independent Growth, Inc.
United Cerebral Palsy Association of Phila.
Walker Memorial Training Center
Wives Self Help Foundation, Inc.
Wordsworth Academy

2001 DEC -4 AM 10:09

December 4, 2001

Honorable John McGinley,
Chairman,
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Chairman McGinley,

The Philadelphia Alliance is an organization of 35 specialized agencies in Philadelphia who serve individuals with needs related to mental retardation, mental health, and chemical dependency. I am writing to you on behalf of individuals served by our member agencies, as well as the Alliance member agencies. The topic of this letter is the "Final Form Regulations" regarding **Physical Plant Standards for Drug & Alcohol facilities**, which have been submitted to your committee by the Department of Health (DOH) for review, subsequently to be reviewed by the IRRC on December 6, 2001.

Those of us who are representing the people needing service and the providers of service are **very appreciative of the openness, reasonableness, and support of the Pennsylvania Senate and House Legislative Committees** in their review and support. Similarly, **the staff of the Independent Regulatory Review Commission, (IRRC)**, have been very fair and helpful in communicating what is going on and how the process works.

We are most thankful that a compromise was forged, that bedrooms in existing facilities will be exempt from the square footage requirements and number per room requirements that we still consider to be unnecessary and somewhat onerous. Our concerns about the kitchens seem to have been resolved. And the **Department of Health** has seen the wisdom in not including children in the count for programs that include women and their children, **for which we are also grateful**.

The most recent version of the "final form" regulations is a significant improvement over earlier versions. The agencies of the Philadelphia Alliance share the desire for good health, safety and well being of people needing drug and alcohol services, as well as their families. For that reason we are so grateful that the service system was not crippled. However, I must communicate to you that we still believe that these two requirements, (square footage and number per bedroom), are inappropriate, unnecessary; and they will increase the cost of future expansion of a treatment system that has difficulty obtaining sufficient funding. Such limits do seem arbitrary. Most all facilities, (now and in the future) meet requirements of L & I, and some are even JCAHCO accredited.

As I said, we are extremely grateful for the "grandfathering", because to not do so would have had terrible immediate affects on the service system; but these two requirements are not really appropriate for new facilities either. The therapeutic environments provided by the drug and alcohol agencies promote many types of interaction with others, preventing isolation as much as possible. Bedrooms are for sleeping only, not a place to "hang out". There should be some measurable improvement in the quality of the program to justify instituting a square feet requirement.

Contrary to DOH responses, the surrounding states do not have higher standards than Pennsylvania. Maryland, Ohio, and Delaware do not have square feet requirements, as Pennsylvania did not. New York requires 80 sq.ft. for single beds, but only 40 sq.ft. when bunk beds are used, and the **maximum dormitory capacity in New York is 24!** Many facilities that could have been affected by the square feet requirements are facilities that have been in operation for many years with no certification /licensure problems. How much will these two space measures improve the services provided? Obviously, the square footage and number per bedroom requirement will increase costs of developing new programs or expanding existing programs.

Please do not equate bed capacity and census, when considering the need for treatment. The initial claims of the DOH did so. It is an incorrect assumption to think that because a bed may be unfilled for a period of time that there is no one who needs that service. DOH offered the reasoning that programs' censuses have been below 100%, so therefore those beds could be eliminated. Any program in any field with a limited licensed capacity cannot go over 100% capacity, so when people move on there are periods of time when beds are empty. That doesn't mean there are not people who need those services. **You will still get a 90% occupancy rate even if a facility only has 10 beds.** Since an agency cannot go over 100% licensed capacity, you will always have something less than 100% of the beds filled at a point in time.

**Given the increased costs of future programs, as outlined above, and the fact that there is great unmet need, it would be prudent to be generous in allowing programs or expansions that are currently underway to also be "grandfathered" in terms of the square footage and number per bedroom requirements. We strongly suggest that such a provision be a condition of approval of these regulations by the IRRC.** Since these regulations sat dormant for two years, agencies planning for expansion or new services could not have anticipated the additional costs for the physical plant; and to impose such requirements now may preclude the development of much needed service.

If you have questions for me, or issues you would like to discuss further with me, please call me. Thank you in advance for your consideration. You can contact me at (215) 438-6400.

Sincerely,

Tim Wilson
Executive Director

[Cc's are listed on the following page.]

cc: Senator Harold Mowery, Chairman, PA Senate Public Health & Welfare Committee
H. Scott Johnson, Executive Director, PA Senate Public Health & Welfare Committee
Senator Vincent Hughes, Chairman, PA Senate Public Health & Welfare Committee
Niles Schore, Executive Director, PA Senate Public Health & Welfare Committee
Rep. Dennis O'Brien, Chairman, PA House Health & Human Services Committee
Melanie Brown, Executive Director, PA House Health & Human Services Committee
Rep. Frank Oliver, Chairman, PA House Health & Human Services Committee
Sandra Bennett, Executive Director, PA House Health & Human Services Committee
Rich Sandusky, Independent Regulatory Review Commission
John Hair, Department of Health
Deb Beck, DASPOP
Lynn Cooper, PCPA

# The Philadelphia Alliance

*Representing Community Providers for People with Mental Health, Mental Retardation and Chemical Dependency Needs.*

4343 Kelly Drive, 2nd Floor, Suite 1, Philadelphia, PA 19129 Tel 215.438.6400. Fax 215.438.6600

**FAX TRANSMISSION**

**Date:** December 4, 2001 **Page** 1 **of** 4

TO: Honorable John McGinley, Chairman, Independent Regulatory Review Commission
Senator Harold Mowery, Chairman, PA Senate Public Health & Welfare Committee
H. Scott Johnson, Executive Director, PA Senate Public Health & Welfare Committee
Senator Vincent Hughes, Chairman, PA Senate Public Health & Welfare Committee
Niles Schore, Executive Director, PA Senate Public Health & Welfare Committee
Rep. Dennis O'Brien, Chairman, PA House Health & Human Services Committee
Melanie Brown, Executive Director, PA House Health & Human Services Committee
Rep. Frank Oliver, Chairman, PA House Health & Human Services Committee
Sandra Bennett, Executive Director, PA House Health & Human Services Committee
Rich Sandusky, Independent Regulatory Review Commission
John Hair, Department of Health
Deb Beck, DASPOP
Lynn Cooper, PCPA

**FROM:** **Tim Wilson, Executive Director**

***Message*:**

**Accompanying this fax is a letter from The Philadelphia Alliance regarding the most recent version of physical plant regulations for Drug and Alcohol facilities, proposed by the Department of Health, (DOH). Please review and consider our position when evaluating the appropriateness of the "final form" regulations.**

**Please call me if there are any questions. Thank you.**

2001 DEC -4 AM 10:09

# GATEWAY
REHABILITATION CENTER

Original: 2075

October 24, 2001

**Kenneth S. Ramsey, Ph.D.**
President and Chief Executive Officer

**Abraham J. Twerski, M.D.**
Founder and Medical Director Emeritus

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Kenneth S. Ramsey, Ph.D.
Jack D. Rice
Daniel M. Rooney
Karen Farmer White
Sally Wiggin

John R. McGinley, Jr. Esq., Chairman
Independent Regulatory Review Commission
333 Market Street
Harrisburg, PA 17101

**RE: *Proposed BDAP Regulations ("Chapter 705. Physical Plant Standards")***

Dear Mr. McGinley:

This letter has two purposes: 1) To note our objections to certain parts of the above, and 2) to request the opportunity to testify at the hearing you are holding on November 1.

The proposed regulations contain three requirements that add no significant value to the consumers of Pennsylvania but would make the delivery of service more expensive. This will have the effect of reducing the number of Pennsylvanians that we serve. The egregious regulations are:

- Requirement that each resident of an inpatient facility be afforded 80 square feet of living space. Residents in our programs, chemical dependency programs, spend very little time in their rooms. Most patient activity is devoted to treatment conducted outside of the residence room. Therefore, the program has a relatively small commitment of space to residence and a larger one to treatment/public space.

- Limiting the number of persons per room to four (4).

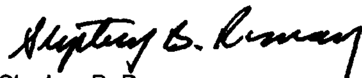
- Requiring that each program provide a "fully operational kitchen." The issue we must respond to here is that of providing adequate nutrition to our residents. The method we use to do this is not important. For example, some of our programs use contracted services that bring food into the program, thus making a kitchen on site unnecessary.

We would appreciate the opportunity to testify in greater detail about the deleterious effect of these rules. Our witness would be:

***Mr. James Aiello***
***Vice President for Treatment Services***
***Gateway Rehabilitation Center***
***Aliquippa, PA***

Thank you so much for your time and attention to our request.

Sincerely,



Stephen B. Roman
Vice President, Administration

pc: Aiello, J.
Cooper, L.
Ramsey, K.
Ramsey, P.
Smith, J. via fax

2001 OCT 25 AM 9:35
REVIEW COMMISSION

H:\user\sbr\msoffice\Winword\irrc letter.doc

GRC Moffett Run Road • Aliquippa, PA 15001 • (412) 766-8700 • FAX (724) 375-8815
www.gatewayrehab.org

Original: 2075

# Keenan House

A Division of Treatment Trends, Inc.

18 South Sixth Street P.O. Box 685 Allentown, PA 18105
Telephone 610-439-8479 Telefax 610-289-1833

October 23, 2001

Fiona Wilmarth, Analyst
Independent Regulatory Review Commission
333 Market Street
14th Floor, Harristown 2
Harrisburg, PA 17101

Dear Madam,

I write regarding proposed changes in physical plant regulations affecting inpatient drug and alcohol treatment facilities throughout the Commonwealth of Pennsylvania.

Modifications to rules to increase required square footage per client most certainly will force some long-established service organizations to close or to lay off employees at a time when our state and our nation is struggling with growing levels of unemployment and shrinking job opportunities. More importantly, fewer remaining facilities ultimately will disadvantage those in need of inpatient addictions treatment, the very people who need our help.

I hope you agree that the solution to these unacceptable outcomes is to exempt existing treatment facilities from any proposed regulatory changes, as past rules have proven sufficient for so many.

I thank you for your service to the people of Pennsylvania and for your assistance in this matter.

Respectfully,

John H. Harter, III – Program Secretary
Treatment Trends, Inc. / Keenan House

JH:jh

Original: 2075

ADDICTION RECOVERY CENTER

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2001 OCT 24 AM 9:03
REVIEW COMMISSION

October 23, 2001

John R. McGinley, Jr. Esq., Chairman
Independent Regulatory Review Commission
333 Market Street 14th Floor
Harrisburg PA 17101

Dear Mr. McGinley,

Thank you for the opportunity to provide input to the proposed regulations for drug and alcohol facilities.

I have reviewed the revised Drug & Alcohol Physical Plant Standards which were resubmitted to the Independent Regulatory Review Commission on October 15, 2001. I have the following concerns:

**705.5 (h) - Each bedroom shall have a window with a source of natural light.**

In our ten-bed residential non-hospital facility, we have ten rooms used for bedrooms. Five of the rooms do not have windows. However, they have lighting and proper ventilation. The structure of our facility is brick and block, and placing windows in those five bedrooms would be difficult and expensive if not impossible. I suggest current facilities be grandfathered for this regulation.

**705.9 - General safety and emergency procedures (4)(III). The evacuation and transfer of residents impaired by alcohol or other drugs.**

Clarification is needed. Is impairment defined as individuals currently under the influence of alcohol or drugs, or is impairment defined as people who have physical, emotional and behavioral impairments as a result of drug and alcohol use?

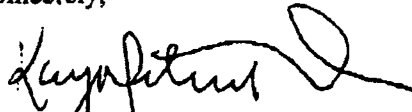
**705.10 - Fire safety (d)(1)(5). Fire drills.**

The standard to conduct fire drills on a monthly basis is excessive. Current regulations require fire drills every two months, and this has been adequate given that the average length of stay is fifteen days.

The regulation requiring facilities to do unannounced fire drills during sleeping hours will be disruptive for clients in treatment. The idea of doing fire drills at various times of the day make sense. Doing it unannounced can, however, create panic, anxiety and difficulty for clients. I suggest being able to announce fire drills in advance during sleeping hours.

I hope that you will consider this input. If you would like to discuss this with me, I can be reached at (724) 548-7607.

Sincerely,



Kay Detrick Owen, M.A.
Executive Director

KO/ds

cc: Lynn Cooper, PCPA
Charlene Givens, Armstrong/Indiana Drug & Alcohol Commission

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Total Pages, Including this one 3

Date: 10/24/01 Time: 9:00 am

To: John McGinley

From: Kay Detrick Owen

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Original letter mailed 10/23/01.

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Original: 2075

# PYRAMID Healthcare

RECEIVED
2001 OCT 24 PM 2:48
REVIEW COMMISSION

October 22, 2001

John McGinley, Jr. Esq.
Chairman
Independent Regulatory Review Commission
333 Market St 14th Fl
Harrisburg PA 17101

Dear Mr. McGinley:

Please accept these comments relative to the **Drug and Alcohol Physical Plant Standards** which were submitted to the IRRC on October 15, 2001. Thank you for your consideration.

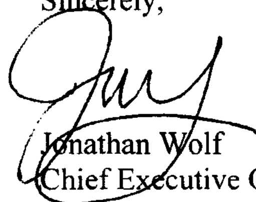
1) 705.5(b) Square footage requirements should also include any closet space in the room in addition to wall to wall measurements.
2) 705.7(1) The requirement for each facility to have a kitchen is unrealistic and does not consider current licensing practices. Often several buildings closely situated make up one facility. D&A licensing treats each facility as a separately licensed entity, however, only one building would require a kitchen for the entire facility. The addition of this regulation would add significantly to the cost of care, renovation and creation of new, un-needed kitchens. At the very least, existing facilities should be grandfathered.
3) 705.5(b) the square footage requirements should be grandfathered in existing facilities. We would need to take beds out of service to meet this requirement, resulting in loss of revenue, and ultimately, increase in rates.
4) 705.5(c) the number of residents sleeping in rooms should be grandfathered in existing facilties. We would need to take beds out of service to meet this requirement, resulting in loss of revenue, and ultimately, increase in rates.
5) 705.10(2)(b)(6) Does this section mean that pulse fire alarms will need to be installed in all facilities? This would be cost prohibitive for all facilities to retrofit. Suggest grandfathering in all existing facitlies.
6) 705.11 Introductory paragraph. Define age limit of "children"
7) 705.11(2)(ii) I believe this section is in conflict with certain fire codes in relation to locking windows in patient rooms.

Administrative Offices
1512 12th Avenue
Altoona, PA 16601
(814) 940-0407 Fax (814) 940-0411

Please be aware that Pyramid Healthcare provides **transitional living (halfway house)** and residential inpatient non-hospital drug and alcohol treatment, and both levels of care would be effected.

Thank you again for your consideration.

Sincerely,



Jonathan Wolf
Chief Executive Officer

Original: 2075

**IRRC**

**From:** Smith, James M.
**Sent:** Friday, October 19, 2001 1:58 PM
**To:** IRRC
**Cc:** de Bien, Kimberly T.; Sandusky, Richard M.; Wilmarth, Fiona E.
**Subject:** FW: Letter re Physical Plant Regulations for D&A Residential Facilities

-----Original Message-----
**From:** Tim Wilson [mailto:timew98@yahoo.com]
**Sent:** Friday, October 19, 2001 1:55 PM
**To:** Smith, James M.
**Subject:** Letter re Physical Plant Regulations for D&A Residential Facilities

Hi Jim,

Here is a letter describing the position of the Philadelphia Alliance about these "final form" regulations. Please share the letter with Rich Sandusky and Fiona Wilmarth. I believe you told me you are not currently wroking on this issue, but I sent the letter to you because I don't have their email addresses. I will be faxing this letter to you all also, but it usually looks better via email. The same letter is also being sent to all four chairs of the Health & Human Services Committees, and to John Hair in DOH.

Please call if you have any questions. Thank you very much! ☺

Tim Wilson
Executive Director
The Philadelphia Alliance
4343 Kelly Drive, 2nd Floor
Philadelphia, PA 19129
215-438-6400
215-438-6600 FAX

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# The Philadelphia Alliance

***Representing Community Providers for People with Mental Health, Mental Retardation and Chemical Dependency Needs.***

4343 Kelly Drive, 2nd Floor, Suite 1, Philadelphia, PA 19129 Tel 215.438.6400. Fax 215.438.6600

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St John's Community Services
Step-by-Step
The Association for Independent Growth
United Cerebral Palsy of Philadelphia
Walker Memorial Training Center
Wives Self Help Foundation
Wordsworth Academy

October 19, 2001

Representative Dennis O'Brien
Chairman, House Health & Human Services Committee
House of Representatives
C/o House Box 202020
Harrisburg, PA 17120-2020

Dear Representative O'Brien,

The Philadelphia Alliance is an organization of 35 specialized agencies in Philadelphia who serve individuals with needs related to mental retardation, mental health, and chemical dependency. I am writing to you on behalf of individuals served by our member agencies, as well as the Alliance member agencies. The topic of this letter is the "Final Form Regulations" regarding **Physical Plant Standards for Drug & Alcohol facilities**, which have been submitted to your committee by the Department of Health (DOH) for review, subsequently to be reviewed by the IRRC on November 1, 2001.

These final form regulations are near approval, and we are hopeful that your committee will recommend either that they not be approved at all by the Independent Regulatory Review Commission (IRRC) or approved with specific revisions. The agencies of the Philadelphia Alliance share the desire for good health, safety and well being of people needing drug and alcohol services, as well as their families. That's precisely what our agencies are about. We are in agreement with the vast majority of the standards stipulated in these regulations, but there are a couple features that we believe are ill-advised and could severely damage the service system for people who need substance abuse services – **(see point # 3)**.

(1) We are concerned about the **limit of 4 people per bedroom**, especially in programs that serve women with children. Many provider agencies who deliver such services find such a provision to be non-therapeutic and unsafe for some children who may be at risk of abuse from their mother, if alone in a secluded room. The problem with this provision is mitigated somewhat by the fact that DOH has included a "grandfather provision for this regulation; but we still find it inappropriate for new programs as well. Even for other programs besides the women and children programs, such a limit seems arbitrary and likely to increase the cost of future residential drug and alcohol programs.

(2) We also believe that the requirement for fully operational kitchens for all residential and non-residential programs is **NOT** well conceived and probably included just because someone thought it sounded good. The equipment for a kitchen should depend on

how the program is designed and what they are trying to provide to the individuals receiving service.

(3) **The absolute worst provision in these regulations is the square feet requirement for bedrooms**. This single provision **will significantly reduce services available in the system by 10 to 15% or more at a time when more services are needed, not less!**

(a) The DOH seems unconcerned about the reduction in service; as they acknowledge that there could be approximately a 10% reduction in beds in the system. They claim that there is severe overcrowding in some facilities, and that they are powerless to do anything about it. If that is the case, there are plenty of standards within these regulations, which could be used to cite an unhealthy environment. Most all facilities meet requirements of L & I, and some are even JCAHCO accredited that will be negatively impacted by this measure. **This measure will do serious damage to facilities and the good agencies that provide such services!** The drug and alcohol service system is not a "deep" system; once damage is done, it will be very difficult to resurrect agencies and facilities.

(b) The worst aspect of the square feet provision and DOH's cavalier attitude toward "losing 10% of the system capacity" is that the end result will be much worse than that. **The end result will be that a number of facilities will lose enough beds that they will be fiscally forced to close the facility and the program**. The agencies within the Philadelphia Alliance who provide such programs are non-profit agencies, and the rates they are paid for such services are not sufficient to provide any cushion or margin to absorb additional costs or losses in revenue. Reducing their capacity will not reduce the costs at all, (they still need the same building, and the same number of staff, etc.), but the income will be less. In many cases a handful of lost beds will result in the whole program being lost because it will not be able to break even any longer.

Another important point needs to be made here. It is unlikely, but theoretically per diem rates could be raised to cover facility costs, keeping a program whole fiscally. **However, that would still not help the people who would not be able to receive services, because an already under funded service system has been crippled even further, so that capacity has been reduced significantly!** The various estimates from provider agencies and DOH suggest that the **loss** in capacity is **between 600 and 900 beds across the state, out of 6,184 beds.**

(c) At the very least the square feet requirements should be "grandfathered" for existing facilities, but that is not really appropriate either. The therapeutic environments provided by the drug and alcohol agencies promote many types of interaction with others, preventing isolation as much as possible. Bedrooms are for sleeping only, not a place to "hang out". There should be some measurable improvement in the quality of the program by instituting a square feet requirement. Contrary to DOH responses, the surrounding states do not have higher standards than Pennsylvania. Maryland, Ohio, and Delaware do not have square feet requirements, as Pennsylvania does not currently. Yes, New York requires 80 sq.ft. for single beds, but only 40 sq.ft. when bunk beds are used, (less than the 50 sq.ft. required by these final form regulations), and the maximum dormitory

capacity in New York is 24! Many facilities that will be severely impacted by the square feet requirements are facilities that have been in operation for many years with no certification /licensure problems. There is no extra funding in sight for such facilities to renovate or move to larger locations. They operate on a shoestring now. **How will this measure improve the services provided?** It won't; **it will only diminish the availability of services for the people who need them.**

(d) DOH had done no assessment or analysis of the impact on the service system until that point was challenged upon the recent resubmission of the regulations. Their research is incomplete and includes incorrect assumptions. I have already noted the imminent closure of entire programs due to a handful of beds lost. DOH may indicate that programs' censuses have been below 100%, so the loss "will not be that great", but it will be! Any program in any field with a limited licensed capacity cannot go over 100% capacity, so when people move on there are periods of time when beds are empty. That doesn't mean there are not people who need those services. **You will still get a 90% occupancy rate at best when these beds are eliminated, but you will have 600-900 less people getting services they need during the year!**

Please consider the impact this **substantial loss of services** will have on the citizens of Pennsylvania. The lack of available treatment for a person who needs it not only **impacts the individual, which is important, but it also has pervasive affects on the person's family and all of us as part of the community**.

**Please recommend that these stipulations within the regulations be removed or significantly modified before the regulations become encoded. Our fellow citizens of Pennsylvania need more services for problems of addiction to drugs and/or alcohol, NOT LESS. Please do not let this valiant service system be crippled!**

If you have questions for me, or issues you would like to discuss further with me, please call me. Thank you in advance for your consideration. You can contact me at (215) 438-6400.

Sincerely,

Tim Wilson
Executive Director

cc: Frank Oliver, Chairman, PA House Health & Human Services Committee
Melanie Brown, Executive Director, PA House Health & Human Services Committee
Sandra Bennett, Executive Director, PA House Health & Human Services Committee
Senator Harold Mowery, Chairman, PA Senate Public Health & Welfare Committee
Senator Vincent Hughes, Chairman, PA Senate Public Health & Welfare Committee
H. Scott Johnson, Executive Director, PA Senate Public Health & Welfare Committee
Niles Schore, Executive Director, PA Senate Public Health & Welfare Committee
Chairman McGinley, Independent Regulatory Review Commission
Fiona Wilmarth and Rich Sandusky, Independent Regulatory Review Commission

Original: 2075

# PACDAA

**Pennsylvania Association of County Drug & Alcohol Administrators, Inc.**
17 North Front Street Harrisburg, PA 17101 (717) 232-7554

October 22, 2001

Representative Dennis O'Brien, Chairman
House Health and Human Services Committee
Harrisburg, Pennsylvania

Dear Representative O'Brien:

We are writing to express concerns on the final form regulations submitted by the Department of Health, amending the physical plant standards for drug and alcohol facilities (Title 28, Health & Safety; Part V, Drug and Alcohol Facilities and Services; 28 PA Code CHS 701, 705, 709, 711, and 713).

Our concerns are as follows:

**Loss of treatment beds**
The regulations as proposed will result in the loss of treatment beds, particularly in specialized services. We are aware of a number of facilities that will lose beds due to the square footage requirements. While, for the most part, this does not affect the short-term residential programs that often have a predominantly commercially insured client population, it will affect programs for women with children, and our traditional long-term residential providers. To lose beds in programs such as those for women with children creates significant problems, as this is an area where we already have insufficient resources.

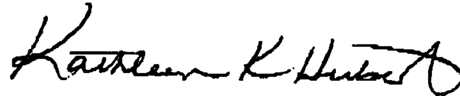
**Financial impact**
The loss of beds also results in the loss of additional treatment slots due to increased costs. The county contracted per diem rates are based on the total costs of the program divided by the available beds. This provides the program with a break-even rate. If the number of available beds decreases, the costs for the remaining beds increase. As a result, we treat less people for the same amount of money.

**Clinical appropriateness**
The Department's response to the comments regarding square footage states that to require less would be "detrimental to the treatment and rehabilitation process". There is, however, no reference to a research basis for this statement. In drug and alcohol treatment the time spent in one's bedroom, besides the hours one is sleeping, is minimal by design. The residential drug and alcohol treatment community itself is a large part of the therapy. The client's interaction within the community is emphasized, and client's spending large amounts of time isolated in their bedrooms would be counterproductive.

This product is made from recycled paper products.

Regarding the non-residential fire drill requirements, we are concerned about the increased frequency required. The frequency of outpatient client attendance typically is one visit per week or every two weeks. Therefore, most clients will not benefit from a drill; it is really the staff knowledge and practice that is essential. While most clients would not benefit from the drill, those that participate have their treatment significantly disrupted. If the client were only at the clinic for an hour, they would benefit little from a session that is interrupted by a fire drill. Additionally, with each fire drill clients have to evacuate into areas that are often very public which impacts on their privacy and confidentiality. This is particularly true when treatment offices are in larger office buildings/parks.

Sincerely,



Kim P. Bowman, Chairperson
PACDAA
and Executive Director, Chester
County Drug & Alcohol Commission

Kathleen K. Hubert, Executive Director
PACDAA

cc: IRRC

# PACDAA FAX COVER SHEET

**PA. Association of County Drug & Alcohol Administrators, Inc.**

17 N. Front St., Harrisburg, PA 17101-1624 717-232-7554 FAX 717-232-2162

3 page(s)

Time: 11:40 am

**To:** Fiona Wilmarth, Analyst
IRRC

**From:** Kathleen Hubert, Executive Director

**Date:** October 22, 2001

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Original: 2075

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106 W. Main Street, Norristown, PA 19401 • (610) 239-9600 • FAX: (610) 239-9324

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Robert P. Kelly
*Chairman of the Board*

Michael Harle, M.H.S.
*President/Executive Director*

Michael Baylson
*Counsel*

October 18, 2001

Independent Regulatory Review Commission
333 Market Street
Harrisburg, PA 17101

Attention: Fiona Wilmarth, Analyst
Fax (717) 783-2664

Re: Proposed Physical Plant Standards

Dear Commission Members:

We understand that the final proposed regulations for Physical Plant Standards, Section 705, Part V. Drug & Alcohol Facilities and Services may be placed before you for your review on November 1, 2001.

While we agree with the majority of the proposed regulations, we do take issue with a few of the provisions. Attached to this letter is our position paper. I have briefly summarized our position below for you convenience. We are objecting to the following provisions:

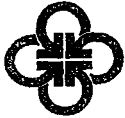
(1) Square footage requirements for bedrooms

(2) Four residents per bedroom

(3) Kitchens in each facility

Our position paper discusses why we object to these proposed regulations in summary as follows:

(1) The Department of Health cites other states regulations. The citation for New York is incorrect and New Jersey has a grand-father clause which was not mentioned. Not mentioned also was Maryland, Ohio and Delaware, contiguous states that have no square footage regulations.

 GAUDENZIA

(2) The Department of Health conducted a telephone survey of fourteen programs in October 2001. We question the scientific basis of the survey. The survey does show that 11% of the treatment beds will be lost. This fact is omitted from the notes to the survey.

(3) Gaudenzia will lose 31 beds which will result in the closure of these five programs if reimbursement rates are not adjusted to reflect the decrease in bed capacity. If these programs close, the actual bed loss is not 31 but 180 plus 80 children's beds.

**Gaudenzia Bed Loss**

| Program | Licensed Capacity | New Capacity | Beds Lost |
|---|---|---|---|
| West Chester | 65 | 59 | 6 |
| Kindred | 16 | 14 | 2 |
| New Image | 17 | 15 | 2 |
| Re-Entry | 22 | 21 | 1 |
| Concept 90 | 42 | 25 | 17 |
| Vantage | 18 | 15 | 3 |
| | 180 | 149 | 31 |

(4) Gaudenzia will lose $1,051,765 in revenue, assuming the Programs would not close. This loss puts Gaudenzia at risk financially.

| Programs | Lost Revenue |
|---|---|
| West Chester | $ 167,535 |
| Kindred | $ 88,111 |
| New Image | $ 88,111 |
| Re-Entry | $ 27,010 |
| Concept 90 | $ 527,425 |
| Vantage | $ 153,573 |
| Total | $1,051,765 |

(5) Renovations to existing buildings to meet the proposed regulations is cost-prohibitive and prohibited because of zoning requirements.

GAUDENZIA

(6) A kitchen at every licensed facility is unrealistic and will result in the closure of programs which share a common kitchen in a campus environment or a common kitchen in a multi-licensed facility.

(7) Limiting four residents per bedroom contradicts the research on Women & Children's Programs.

While we are aware of your limited time frames for review, we hope that you seriously question the concerns we have mentioned. The safety and health of our residents is paramount and we believe that the majority of the proposed regulations advances that purpose. However, the few proposed regulations mentioned above to do not accomplish that goal. We believe that if these regulations are enacted as proposed, health and safety of individuals, their children and the community at large would be seriously affected. This is based on the fact that individuals will have less access to appropriate treatment, putting themselves and others at risk. We are attaching a detailed analysis of these issues and recommend these proposed regulations be rejected. For further information please contact me at 1(610) 239-9600 ext 201.

Sincerely,

Michael Harle

Michael Harle, President/Executive Director

MH/tdm

2001 OCT 24 AM 9:14
REVIEW COMMISSION

# Gaudenzia, Inc.
# Response

## I. Introduction

This is in response to proposed regulations for Physical Plant Standards for Section 705, Part V Drug and Alcohol facilities and services. The initial proposed regulations were published in the Pennsylvania Bulletin Vol. 29, No. 46 dated November 13, 1999. Those proposed regulations have undergone substantial changes since that date. Nevertheless the first revisions of those proposed regulations were submitted to the Independent Regulatory Review Commission and the chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare for review and comment. In August of this year we understand that the Department of Health subsequently withdrew that submission for further amendment and resubmission is pending.

## The Health Departments Response to Comments

## II. Introduction

In August 2001, the Department of Health prepared a response to the comments made by the following:

**IRRC**
**DPW**
**Four Legislators**
**Pennsylvania Halfway House Associates**
**Philadelphia Alliance**
**Seven Providers**

The IRRC and DPW provided comments in the Spring of 2000. The other comments had been received by the Department of Health in November and December 1999. Several Comments were made on the proposed regulations for Sleeping Accommodation, Section 705.5 of the proposed regulation dealing with square footage requirements.

We believe that the response of the Department of Health is oversimplified and lacks the proper research and investigation. The argument below clearly illustrates that the Department of Health assumptions and perceptions are incorrect.

## SPACE FOOTAGE SLEEPING ACCOMMODATIONS

The square footage requirements for sleeping accommodations, Section 705.5 of the proposed regulations reads as follows:

> (b) Each shared bedroom shall have at least 60 square feet of floor space per resident measured wall to wall including space occupied by furniture. When bunk beds are used, each bedroom shall have at least 50 square ft. of floor space per resident measured wall to wall. Bunk beds shall afford enough space in between each bed and the ceiling to allow a resident to sit up in bed. Bunk beds shall be equipped with a securely attached ladder capable of supporting a resident. Bunk beds shall be equipped with securely attached railings on each open end of the bunk. The use of bunk beds shall be prohibited in detoxification programs. Each single bedroom shall have at least 70 square feet of floor space per resident measured wall to wall, including space occupied by furniture.

In its face sheet for filing documents with the Legislative Reference Bureau, the Health Department in its comments on square footage stated as follows:

> Finally, the standards established in other states were reviewed in formulating this subsection. The standard for a majority of states is consistent with this regulation. The following are some examples: New Jersey requires 70 square feet clear floor space for single occupancy and a minimum of 50 square feet of clear floor space per patient, with 3 feet of clear between and at the foot of beds. Rhode Island requires 85 square feet for single occupancy and 60 feet per person for multiple occupancy. Montana requires 100 square feet for single occupancy and 80 square feet per person with no more than 4 persons per room. New York requires 100 square feet exclusive of closet space for single occupancy and 80 square feet per person with a maximum of 4 persons per room, with an exception of 60 square feet per person for alcohol treatment of less than 5 days.

We take issue with the Department of Health readings of other state requirements. The New York standards are incorrectly stated by the Department of Health. The New York requirements For The Operation of Drug Free Substance Abuse Programs, Post 1030, Section 1030 (g) Facility Standards states as follows:

> (1) Each residential program must have safe and adequate physical facilities to carry-out its program. To insure this, programs must adhere to the following minimum space requirements as appropriate to the services provided: sleeping areas: 80 square feet per resident for single beds, or 40 square feet per resident for two deck bunks... maximum dormitory capacity is 24...

The Health Department citation of the square footage requirement for New Jersey is correct. However, New Jersey does have a grandfather clause. That section of the New Jersey regulations was revised in 1999. We have not confirmed whether the representations made by the Health Department for Montana and Rhode Island are correct. We believe requirements in those states are not material.

However, we have reviewed the regulation for the contiguous states of Maryland, Ohio, and Delaware. None of those states have square footage requirements. Those states do require a Certificate of Occupancy. The proposed regulations at Section 705.1 (2) requires such a Certificate of Occupancy from the Department of Labor and Industry or its local equivalent. Why isn't this requirement sufficient to protect the health and safety of the residents?

Our concern is that the Department of Health has misrepresented the New York regulations, omitted the grandfather clause for New Jersey, and has made misrepresentations by omitting a discussion of the regulations of the surrounding states of Maryland, Delaware, and Ohio.

More importantly, a residents' bedroom is not an area where the resident should spend time. Our therapeutic community model does not allow the resident to isolate himself or herself in the bedroom. Our programs and most programs limit the use of the bedroom for sleeping only.

**Health Department's Recent Survey**

Within the past few months the Department of Health has completed an unscientific survey of fourteen (14) programs throughout the Commonwealth. Of the fourteen (14) programs, four are Gaudenzia owned programs. A copy of that survey is attached for your review. In July 2001, Gaudenzia purchased the assets of Serenity Hall, Inc. a provider in Erie, Pennsylvania. Gaudenzia Erie Inc. operates Gaudenzia Crossroads and Gaudenzia Dr. Snow. Gaudenzia Dr. Snow is a Halfway House with the licensed bed capacity of 14. Since the Gaudenzia takeover in July, the census has been at or near capacity.

The licensed capacity of Gaudenzia Crossroads is 42 residents. Prior to July 2001, Serenity Hall, Inc. Board of Directors were in the process of closing the program when the Board asked Gaudenzia, Inc. to investigate how the program could continue in the Erie Community. The result was the takeover of the programs by Gaudenzia. Many years ago the structure where the program is located housed over 70 residents. Gaudenzia is planning to increase licensed bed capacity in the near future and working with the local Single County Authority to insure proper reimbursement rates for the increased capacity.

This explanation of Gaudenzia Crossroads and Gaudenzia Dr. Snow should be remembered when reviewing the Department of Health's survey. The survey oversimplifies the situation at Gaudenzia Crossroads. Currently, the structure is used for the programs is underutilized and Gaudenzia is planning to make a full utilization investigation of the structure.

Let's review the totals of the Department of Health's survey.

| | |
|---|---|
| **Residential Capacity** | **572** |
| **Number of Beds Lost** | **62 (11%)** |
| **New Reg Capacity** | **510** |

Using the figures of the Department of Health's survey the bed loss is 681 statewide.

| | |
|---|---|
| **Total Beds State Wide** | **6,184** |
| **Lost Beds Percentage** | **11%** |
| **Total Beds Lost** | **681** |

The survey document states:

> *"After implementation of the new regulations, the state total residential bed capacity (6,184 beds), will retain excess capacity and 1% of the beds will be lost."*

The Department's own figures prove otherwise. It is not 1% but 11%.

The Department of Health also stated in its comments in August 2001.

> *"It is believed, however, that the actual number and amount will be relatively small to the total number and amount within the entire field."*

A percentage of lost beds of 11% is not "relatively" small.

The August 2001 statement was made without proper research and investigation by the Department of Health. The survey done two months later in October 2001, does not support the August comment.

If a survey was to have been completed with some sense of statistical accuracy, the programs of Malvern Institute, Allentown Rescue Mission and Bowling Green would have been eliminated. Two are 28 day for-profit programs and the third is a mission. The survey leaves the reader to believe that residents from one provider could seek treatment at another provider. This is not true; the providers simply have different services, and residents from one provider cannot be moved to another level of care with different services, **especially women with children** in long term programs.

We have also completed a survey. We used the same methods as the Health Department's and substituted the three programs mentioned above with three programs which are similar to the remaining eleven programs. Those programs and beds lost are as follows:

| | Capacity | Beds Lost |
|---|---|---|
| **Northeast Treatment Center** | **36** | **9** |
| **Gaudenzia Concept-90** | **42** | **17** |
| **DRC** | **187** | **38** |
| **Total** | **265** | **64** |

We have attached a copy of our survey for your review. Our survey shows the following:

| | |
|---|---|
| **Residential Capacity** | **668** |
| **Number of Beds Lost** | **126 (19%)** |
| **New Reg Capacity** | **542** |

Based upon our survey the bed loss statewide is 1175.*

| | |
|---|---|
| **Total Beds Statewide** | **6184** |
| **Lost Bed Percentage** | **x19%** |
| **Total Lost Beds** | **1175 [this represents approx. 4,700 clients]** |

The remaining sections of the Department of Health's survey are also flawed. Using census on a given day does not fully explain the complexity of addiction treatment. Depending on several variables such as time of year, funding sources resources, discharges against staff advice, and no shows, a census of 100% is not achievable over a period of time. Any lost days reduce the 100% capacity and cannot be recouped. Funding sources recognize this and reimbursement rates are set at 85% occupancy. **(Reimbursement rates are discussed later).**

The Department of Health may want to re-think its argument using the census information of the survey. The whole theory of the Department of Health is that there is overcrowding. The Department of Health census survey shows that there is not overcrowding. While we know the census survey is flawed, nevertheless, it does prove our point that the overcrowding theory of the Department of Health is extremely overstated and theoretical.

This illustrates again, the lack of proper research and investigation by the Department of Health. A flawed survey, done two months after the comments were made, does not support the comments.

The following is a summary of beds that would be lost by Gaudenzia if the proposed regulations become law.

**Gaudenzia Bed Loss**

| Program | Licensed Capacity | New Capacity | Beds Lost |
|---|---|---|---|
| West Chester | 65 | 59 | 6 |
| Kindred | 16 | 14 | 2 |
| New Image | 17 | 15 | 2 |
| Re-Entry | 22 | 21 | 1 |
| Concept 90 | 42 | 25 | 17 |
| Vantage | 18 | 15 | 3 |
| | 180 | 149 | 31 |
| | | | [This equates to 124 clients unserved] |

*This does not include the closure of entire programs.

Kindred, New Image, and Vantage are Women and Children's Programs. The beds identified represent the mothers' beds since reimbursement is tied to the mother. Children are not counted for the purposes of reimbursement. The actual total is seven adult beds lost and 13 beds for children lost. The loss of these beds results in an estimated deficit which causes financial viability of these programs to be imperiled. The reality of lost beds is not seven but the closure of these programs, totaling a loss in capacity of 51 slots for Women and Children programs, plus children's beds totaling 80.
These Women and Children Programs would be closed.

Our adult programs in West Chester and Concept 90 have a total capacity of 107 beds. The proposed regulations would reduce those beds by 23 or a 21.5% reduction. This reduction is bed capacity results in an estimated deficit and the eventual closure of these programs. The actual beds eliminated would be 107. **This represents the loss of services for 428 clients.**

## Lost Revenue

A more detailed explanation why these programs would be closed for financial reasons is appropriate. These are publicly funded programs. The reimbursement rates are set by funding sources based upon the licensed capacity of a program. The calculation used state-wide by Single County Authorities requires staffing cost to be based upon the facility license. The reimbursement rate is cost based and does not allow for a surplus. The decreases in bed capacity results in a deficit based upon the current reimbursement rate of the funding source. The deficits which would be sustained in the programs mentioned above is as follows:

| Programs | | Lost Revenue |
|---|---|---|
| West Chester | | $ 167,535 |
| Kindred | | $ 88,111 |
| New Image | | $ 88,111 |
| RE-Entry | | $ 27,010 |
| Concept 90 | | $ 527,425 |
| Vantage | | $ 153,573 |
| | TOTAL | $1,051,765 |

## Reimbursement Rate

This lost revenue is based upon the current cost based reimbursement rates permitted by the governmental funding sources including the several Single County Authorities.* These funding sources would have to raise the reimbursement rates proportionateley to accommodate for the loss of beds. If rates were not increased, the programs would be closed. Gaudenzia could not sustain such a loss in revenue. The reimbursement rate is not negotiated. It is based upon standard calculation and assumes 85% occupancy.

*Some counties and managed care programs have not increased rates in over two years, and have indicated to us that they will not be able to make up the difference.

Reimbursement rates could be increased. That would simply mean that less people get treatment at higher cost. The funding sources and Single County Authorities cannot pay more for less.

Examples of the reimbursement rate increase resulting from lost beds is appropriate. Our Vantage program will loose three (3) beds. The current reimbursement rate fixed by the Single Count Authority is $165.00 per day. The rate would have to be increased to $199.00 per day. With no rate increase, the program would close. Our Concept 90 program will lose seventeen beds. The current reimbursement rate fixed by the Single County Authority is $96.00 per day. The rate would have to be increased to $161.00 per day. With no rate increase, the program would close.

We are not certain whether the Department of Health has an adequate understanding of the reimbursement structure. It is clear that the reduction in beds without the adjustment of reimbursements, does more than merely reduce beds. The reduction of beds, without an adjustment of reimbursement rate, results in the closure of entire programs.

## Census

The licensed capacity of programs is approved by the Health Department and is based on several licensing standards including, but not limited to, staffing requirements and certificates of occupancy. A program is prohibited from having more residents than its licensed capacity. These programs are treating addicts. Some leave treatment against staff advice, others do not show up for treatment when scheduled. Those lost days can not be made up by overcrowding the program with more residents than the licensed capacity. Funding sources and Single County Authorities have recognized this and reimbursement rates are set knowing that these programs can not achieve 100% of licensed capacity in any twelve month period. The providers and the funding sources do recognize that from time to time during a twelve month period these programs are operating at capacity.

The Department of Health cannot use unrealistic occupancy rates equal to 100% capacity. This is fiscally, administratively, and clinically irresponsible. Addicts do not wait on waiting lists.

## Renovations and Zoning Issues

Are renovations of these facilities to accommodate these proposed regulations realistic? In most cases they are not. Renovations are prohibited by the costs and local zoning restrictions. Not for profit providers do not have the funds to make capital improvements without the assistance of funding sources. Even when they do, they are restricted by the size and structure of the existing sites. The Gaudenzia Concept 90 program occupies a structure on the Harrisburg State Hospital grounds. The cost of renovations in the structure is prohibitive. To gain the needed four square feet per room would cost in excess of two million dollars. The Gaudenzia New Image program occupies part of a structure owned by the City of Philadelphia. Again the cost of renovations in that structure is prohibitive. The renovations to the other Gaudenzia facilities would require zoning variances by the local government authorities where these facilities are located. Such variances are seldom permitted. The phrase "NOT IN MY NEIGHBORHOOD" is applicable in hearings before local zoning boards.

## Kitchens

On September 11, 2001 we sent a letter to the Independent Regulatory Review Commission commenting on the proposed regulations. This letter supplements that letter and our previous communications. In that letter we discussed the proposed regulations (Section 705.7 Kitchens) concerning the requirement that each residential facility shall have a kitchen. Many providers have more than one licensed facility housed on a campus or single structure that shares a common kitchen and dining area. This proposed regulation would prohibit the sharing of a common kitchen and dining area in these instances. This proposed regulation again illustrates the Health Department's lack of knowledge of the daily operations of the licensed programs and the current laws regulating these kitchens.

## Four Beds Per Room

The proposed regulations at Section 705.5 (c) states: "No more than four residents shall share a bedroom." Section 705.1 (4) exempts facilities that have been licensed prior to the effective date. This proposed regulations is troublesome in light of research which clearly indicates that in Women's and Children's programs, women may need the added monitoring of their peers to help them with controlling any impulses to use harmful disciplinary practices. Four residents per bedroom when children are counted as residents is contradictory to the research.* A woman with two children would have to be in a bedroom by herself with her children. The second adult resident with a child would result in five residents to bedroom. The supporting research is attached for your review.

*Many of the programs follow the Therapeutic Community model, which requires group living as a therapeutic milieu.

Health Department Survey



# CURRENT CENSUS AND ESTIMATED BED LOSS

| FACILITY NAME | RESIDENTIAL CAPACITY* | NUMBER OF BEDS LOST | NEW REGULATION CAPACITY | CENSUS LAST SURVEY | NET LOSS FROM LAST SURVEY | CURRENT TELEPHONE CENSUS | NET LOSS FROM TELEPHONE CENSUS |
|---|---|---|---|---|---|---|---|
| Gaudenzia Crossroads | 42 | 0 | 42 | 30 | 12 | 48 | *** |
| Gaudenzia - Dr. Snow | 14 | 0 | 14 | 11 | 3 | 13 | 1 |
| Serrara House | 12 | 5 | 7 | 8 | (1) | 12 | (5) |
| Allentown Rescue Mission | 24 | 0 | 24 | 10 | 14 | 12 | 12 |
| Halfway House Lehigh | 36 | 0 | 36 | 23 | 13 | 20 | 16 |
| Harrisburg Teen Challenge | 12 | 3 | 9 | 11 | (2) | 11 | (2) |
| Teen Challenge Training Center** | 80 | 17 | 63 | 60 | 3 | 66 | (3) |
| Teen Challenge Induction Center | 20 | 5 | 15 | 11 | 4 | 16 | (1) |
| Bowling Green | 76 | 0 | 76 | 72 | 4 | 72 | 4 |
| Treatment Trends | 85 | 24 | 61 | 69 | (8) | 77 | (16) |
| Blue Mountain House of Hope | 20 | 0 | 20 | 17 | 3 | 15 | 5 |
| Gaudenzia West Chester | 65 | 6 | 59 | 64 | (5) | 58 | 1 |
| Gaudenzia Kindred House | 17 | 2 | 15 | 15 | 0 | 15 | 0 |
| Malvern Institute | 69 | 0 | 69 | 36 | 33 | 40 | 29 |
| Totals | 572 | 62 | 510 | 437 | 73 | 473 | 41 |

* Includes detox and rehab beds
** This capacity was decresed in 2000 from 100 to 80 beds
*** Cannot exceed residential capacity

Of the total residential bed capacity of commentors (572 beds) using last survey estimates of census, the system will retain 73 beds in excess capacity. Even though 16 (less than 3%) occupied beds will be lost.

Of the total residential bed capacity of commentors (572 beds) using commentators estimates of census, the system will retain 41 beds in excess capacity even though 27 (less than 5%) occupied beds will be lost.

After implementation of the new regulations, the state total residential bed capacity (6,184 beds), will retain excess capacity and 1% of beds will be lost.

** Gaudenzia Survey

| Facility Name | Residential Capacity | Number of Beds Lost | New Regulation Capacity |
|---|---|---|---|
| Gaudenzia-Crossroads | 42 | 0 | 42 |
| Gaudenzia-Dr Snow | 14 | 0 | 14 |
| Samara House | 12 | 5 | 7 |
| Concept 90 | 42 | 17 | 25 |
| Halfway House Lehigh | 36 | 0 | 36 |
| Harrisburg Teen Challenge | 12 | 3 | 9 |
| Teen Challenge Training Center | 80 | 17 | 63 |
| Teen Challenge Induction Center | 20 | 5 | 15 |
| DRC | 187 | 38 | 149 |
| Treatment Trends | 85 | 24 | 61 |
| Blue Mountain House of Hope | 20 | 0 | 20 |
| Gaudenzia West Chester | 65 | 6 | 59 |
| Gaudenzia Kindred House | 17 | 2 | 15 |
| Northeast Treatment Center | 36 | 9 | 27 |
| Totals | 668 | 126 | 542 |

Percentage of the beds that would be lost 19%
Statewide beds lost would be 1175.

** This does not include at least eight other programs that have reported significant loss of capacity based on proposed regulations.

FROM : HAFCI 612 CLAYTON PHONE NO. : 415 864 6162 Oct. 18 2001 08:56AM P2

See page 4 and page 8.



# Challenges in Moving from a Traditional Therapeutic Community to a Women and Children's TC Model†

Vivian B. Brown, Ph.D.*; Suzan Sanchez*;
Joan Ellen Zweben, Ph.D.** & Tanya Aly, Psy.D.**

**Abstract**—With the advent of specialized programs for addicted women and their children, some of the traditional methods used by therapeutic communities have been undergoing significant changes. This article examines the issues that are important for treatment providers to consider as they move from individual client and community orientation to a mother-child/family-centered and community approach. The major adaptations suggested are divided into three categories: structural design issues, including living arrangements and models of childcare; treatment issues, including acting-out behavior by the children; and staff and training issues, including staff composition.

**Keywords**—children, substance abuse, therapeutic community, treatment, women

During the 1960s there was a proliferation of self-help therapeutic communities (TCs) for the treatment of heroin addiction; these long-term residential programs can trace their origins to Synanon, which was incorporated in 1958. Confrontation was the primary therapeutic tool these TCs utilized to help addicted individuals living in them to assume responsibility for their behaviors. The game and the haircut were two of the confrontational strategies employed. With the emergence of these first-generation TCs, there was also an acceptance of the validity of the recovered heroin addict as a catalytic treatment agent. The staff of the TC function as responsible role models who are proof that creative and positive personal change is possible. The function of the social structure of the TC is to break down denial, pathology, and the code of the street; and to replace it with a code of responsibility, honor, trust, and helpfulness to each other.

Within the TC there exists a system of rewards and punishments that facilitates the reeducation and socialization of the residents. Both the staff and residents have explicit job functions. New members are viewed as being irresponsible and immature persons who cannot make productive decisions. After residents demonstrate a degree of competence, they are promoted to more responsible positions, which entails additional privileges. The concept of responsibility and concern is a conscious attempt by the community to overcome the code of the streets, which requires that an individual not disclose the activity of another even when he or she has threatened someone's life. The TC also allows for the repetition of experience and education over and over again; this is how emotional learning becomes ingrained.

As drug use patterns have evolved since the 1960s, TCs have served primary cocaine users and other polydrug users, as well as heroin addicts. Over time, not only has the resident population diversified, but treatment professionals have been integrated and methods have been refined. These programs have been studied continuously since their

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## TABLE I
## COMMUNITY AS METHOD: EIGHT ESSENTIAL CONCEPTS*

**Use of Participant Roles:** Individuals contribute directly to all activities of daily life in the TC, which provides learning opportunities through engaging in a variety of social roles (e.g., peer, friend, coordinator, and tutor). Thus, individuals are active participants in the process of changing themselves and others.

**Use of Membership Feedback:** The primary source of instruction and support for individual change is the TC membership. Providing observations and authentic reactions to the individual is the shared responsibility of all participants.

**Use of the Membership as Role Models:** Each participant strives to be a role model of the change process. Along with their responsibility to provide feedback to others regarding what they must change, members also must provide examples of how they can change.

**Use of Collective Formats for Guiding Individual Change:** The individual engages in the process of change primarily with his or her peers. Educational, training and therapeutic activities occur in groups, meetings, seminars, job functions, and recreation. Thus, the learning and healing experiences that are essential to recovery and personal growth unfold in a social context and through social intercourse.

**Use of Shared Norms and Values:** Rules, regulations, and social norms protect both the physical and psychological safety of the community. However, there are beliefs and values that serve as explicit guidelines for self-help recovery and right living. These guidelines are expressed in the vernacular and the culture of each TC and are mutually reinforced by the membership.

**Use of Structure and Systems:** The organization of tasks (e.g., the varied job functions, chores, and management roles) needed to maintain the daily operations of the facility is a main vehicle for teaching self-development. Learning occurs not only through specific skills training, but in adhering to the orderliness of procedures and systems, in accepting and respecting supervision, and in behaving as a responsible member of the community upon whom others are dependent.

**Use of Open Communication:** The public nature of shared experiences in the TC is used for therapeutic purposes. The private inner life, feelings and thoughts of the individual are matters of importance to the recovery and change process, not only for the individual but for other members. Thus, all personal disclosure eventually is shared.

**Use of Relationships:** Friendships with particular individuals, peers, and staff are essential to encourage the individual to engage and remain in the change process. The relationships developed in treatment are the basis for the social network needed to sustain recovery beyond treatment.

*Adapted from: De Leon, G. 1994. The therapeutic community: Toward a general theory and model. In: F.M. Tims, G. De Leon, & N. Jainchill (Eds.) *Therapeutic Community: Advances in Research and Application.* NIDA Research Monograph 144. NIH Publ. 94-3633. Rockville, Maryland: National Institute on Drug Abuse.

inception and the empirical data confirms that they result in positive outcomes, as measured by reduction of illicit drug use and other criminal activity, an increase in economically productive behavior, and in other positive outcome measures (Gerstein 1994; Gerstein & Harwood 1990; Hubbard et al. 1989). TCs work, but they have not worked equally well for all clients. Historically, less than a third of TC participants have been women, for a variety of reasons.

Addicted women have a myriad of problems: a high frequency of certain psychiatric disorders, poor vocational skills, poor parenting skills, a high probability of physical disorders, and a high probability of histories of physical and sexual abuse. Their children, often prenatally exposed to drugs and growing up with one or more substance-abusing parents, also have needs that are profound and diverse. The complex problems of both are more likely to be addressed in a long-term residential program format designed to meet their special needs.

The TC is certainly a model with many powerful features, particularly when adapted to meet the needs of women and children. Drug abuse is viewed as a disorder of the whole person, affecting some or all of a person's functioning (De Leon 1994a). Treatment must be comprehensive, addressing those psychological problems or social deficits that will undermine the ability to sustain an

alcohol and drug-free lifestyle. Many of the residents have never acquired prosocial skills; hence they can be viewed as habilitative (building what was never there) as well as rehabilitative. Often endorsing an extended family model, TCs have the potential to provide a depth of nurturance and support that many residents have never previously experienced. The essential ingredients that promote change in the TC are summarized in Table I (De Leon 1994b).

Many features of the early TCs did not lend themselves to addressing women's needs. In addition to the gender imbalance in the resident population, reliance on aggressive confrontation produced premature dropout and a treatment environment that might not provide sufficient safety to permit exploration of vulnerable issues. In some programs, the emphasis was on toughness and the emotional range was restricted to some form of anger. The more tender emotions and feelings of sadness, pain, grief, warmth, nurturance, and protectiveness were rarely seen or they were labeled pathological. Baring one's soul without flinching was highly valued (Deitch & Zweben 1981). This was not a climate designed to promote women's healing.

Addicted women are highly likely to be victims of physical and sexual abuse in childhood, and rape and other forms of violence as adults. Eating disorders are common and overlooked. Although a residential setting provides some refuge, treatment methods that exacerbate a woman's sense of powerlessness may discourage her from revealing and exploring key issues. The emphasis on harsh confrontation, copied from the original Synanon model, is particularly problematic in populations with a high frequency of traumatic experiences. In the 1970s, more participation by professionals led to the introduction of Gestalt therapy techniques, cognitive-behavioral strategies, and other approaches that broadened the repertoire of tools. However, there is considerable variability in how well these are integrated, even in programs strong in their determination to move beyond the Synanon model. It is possible that the leadership structure of the TC world, which is still predominantly male, is a factor in perpetuating these practices. One example is the difficulty of persuading existing programs to modify their practice of aggressive confrontation when dealing with residents with a serious psychiatric history, even when one can demonstrate that such clients frequently decompensate and leave treatment. Long waiting lists insure full utilization and reduce the incentive to examine reasons for early dropout more closely. It is possible that the difficulty of modifying long-standing practices is more influential than gender, but many who operate women's programs believe that female leadership must be evident in the authority structure and staff composition should be primarily female.

With the advent of specialized programs for addicted women and for women and their children, some of the traditional methods used by TCs have been undergoing significant changes. The features of the newer TCs that have been designed to meet the needs of women and families are examined here.

A major challenge to the treatment system has been to tailor appropriate and effective intervention strategies for women and their children. The many negative health and social consequences of substance abuse for a woman and her children call for sensitive and comprehensive treatment. For this population of women and their children, including pregnant addicted women, treatment outcome is best assured through provision of a comprehensive array of treatment services that address each woman's medical, psychological, emotional, and practical needs. The Center for Substance Abuse Treatment (CSAT) and the Sub-Group on Substance Abusing Women (1992) have proposed a family-centered comprehensive approach. This approach addresses a woman's substance abuse in the context of her health, her relationship with her children and other family members, and the community. In a comprehensive treatment model, the following services are recommended: medical interventions, substance abuse counseling and psychological counseling, health education and prevention activities, life skills training, other social services, and case management.

While the number of residential treatment programs and TCs established for women and children has increased in response to these identified needs, expansion per se is not the answer, and adding a few child workers is not a sufficient adaptation. There are a number of major adaptations that must occur when a TC includes pregnant women and mothers and children. These issues are important for treatment providers to consider as they move from an individual client and community orientation to a mother-child orientation. These adaptations can be divided into three categories: structural design issues, treatment issues, and staff and training issues (see Table II for a summary of these adaptations).

## STRUCTURAL DESIGN ISSUES

There are a number of questions/decisions regarding the design of the program that need to be addressed when planning for women and children.

### Reconciling the Image of the Immature and Irresponsible Newcomer in Treatment with that of a Mother Who Must Take Care of Her Child(ren)

Addressing this question is critical in deciding the model of childcare to be implemented: one in which the program takes primary care of the children (and "fixes" them) or one in which the program assists the mother in learning enhanced parenting skills.

If the program staff assesses that the women entering treatment need time during which they do not take primary

**TABLE II**
**THERAPEUTIC COMMUNITY ADAPTATIONS FOR MOTHER-CHILD ORIENTATION**

**Structural Design Issues**
Models of childcare
Number of children
Type of housing
Childproof the facility
Scheduling
Mother-infant development
Age-specific groups for children
Diet and nutrition
Evening program
Holidays
Evaluation

**Treatment Issues**
Women confronted with parenting skills
Pregnant women
Drug-affected children
Children testing mothers, acting-out behaviors
Education about child development

**Staff and Training Issues**
All women versus co-ed staff
Training on child development and child abuse
Designated staff as advocates of child
Dual diagnosis/Co-occurring disorders
Countertransference

care of their children, and if the program has sufficient resources for childcare, it may be quite beneficial for both mothers and children to implement a model of primary childcare by the program. However, this model may have licensing implications for the program. A model of supplementary childcare, in which the mother has primary responsibility for the child but is assisted by the parenting or child worker staff, may be more empowering for the women. This model also may have the advantage of simplifying licensing issues, as the mother is responsible for her children.

**How Many Children Can the Mother Bring into the Program?**

Many mothers enter treatment and suddenly want contact with all of their children. Often there have been long separations and the mother, who feels guilty, may see this as an opportunity to start over as a mother. However, it is not in the best interest of the children or the mothers to take on too much responsibility prematurely. An unlimited number of children may mean a diminishment in the optimum therapeutic environment for the women. Limiting the number of children allows the women to be more able to manage, and ensures that the children receive adequate attention. In addition, it allows the women more time for their own recovery and healing.

**Housing: Dormitories Versus Separate Apartments**

Both of these living arrangements have their pros and cons. While separate apartments or rooms for each mother and her children allow the woman a sense of privacy, dormitories provide her with assistance in watching her children. Particularly in the first two phases of treatment, women may need the added monitoring of their peers to help them with controlling any impulses to use harmful disciplinary practices. It can be quite helpful for another woman in the dorm to work with the woman around parenting or to simply get a counselor on duty to assist the woman. Based on the TC principle of giving the resident more responsibility as she learns to become more responsible for her behaviors, the best arrangement may be dormitory-style housing in the first phases and separate housing during the reentry phase.

If the program has been functioning as a traditional TC, staff and participants may have difficulty adjusting to the changes necessary to accommodate children. Suddenly there need to be new rules and safety measures. Even such things as childproofing the facility (e.g., covering electrical outlets, placing gates to keep children out of unsafe areas) and no smoking in areas where children are present can cause significant change in the lifestyle of the facility.

Scheduling activities for all the clients becomes much more complex. The traditional treatment schedule needs to be integrated with the children's schedule. There is a need for activities for women/mothers alone, the children alone, and the mothers with their children. This can add to staff burden. At Project Pride, a recovery program for women and children that provides long-term residential treatment for substance-abusing women and their children, each mother participates in individual and group counseling designed to meet her specific recovery and personal needs. Children participate in the childcare component and receive daily exercise, medical care, and assessments of their psychological, social, and educational needs. The integration of the women's treatment with the children's treatment is accomplished through classes that include the counselor, women, children, and childcare workers. This activity not only brings together the mothers and children, but unites and integrates the childcare workers and counselors. Case presentations usually focused on the women must also include the children, to help staff begin to expand their thinking past the individual to the mother-child dyad.

**Mother-Infant Development Issues**

Infants born to drug-dependent women are often subject to double jeopardy: biological risk combined with the risks associated with a mother who is not likely to have the skills for successful parenting. It is important,

therefore, that treatment programs include strategies designed to facilitate positive mother-infant interactions.

After the birth of the infant, the mother needs to be assisted in getting to know her baby and in familiarizing herself with her infant's unique behavioral characteristics. A common problem of infants exposed to drugs is difficulty in regulating arousal. Mothers need to learn comforting techniques and how to interact with their infants in a positive responsive manner. For example, PROTOTYPES Women's Center—a comprehensive drug abuse treatment facility that provides a range of services to substance-abusing women and their children via three treatment modalities: a long-term residential therapeutic community program integrating a full continuum of services ranging from outreach throughout Los Angeles County to residential care to aftercare, an intensive day treatment program, and an outpatient program—initiated a pilot program in 1993 for infant massage. Infant massage has numerous benefits for both infant and mother. It has been shown to increase weight of the infant, to calm irritability in the drug-exposed infant, and to help alleviate gastric disorders (Field et al. 1986). In addition, it helps the mother learn to soothe her infant and provides a positive bonding experience for the dyad. In the pilot program at PROTOTYPES, the mothers were quite pleased to learn this new strategy for helping their babies. The parenting center staff has been trained to continue the infant massage group.

A children's program, directed by an early childhood specialist, provides a stimulating, responsive, and supportive environment for children and the mothers. The presence of a children's center in the treatment facility ensures that mothers can more fully participate in their treatment. It is important to have the children's center far enough away in the facility that the women in groups cannot hear the children crying. At PROTOTYPES Women's Center, each woman is asked to put in at least two half days per week at the children's center, in order to ensure that there is adequate coverage, that each woman learns new skills in working with children, and that the woman practices her new skills in a safe environment. Some women who have had significant trauma regarding children, such as the death of a child, may not be assigned to the children's center. At Project Pride, women rotate through the childcare area as well, and are given a chance to work with the different age groups. This experience exposes the mothers to different developmental levels, and aids in their understanding of what a child is capable of doing given a particular level of cognitive development. The staff at Project Pride has found that this hands-on teaching helps break down some of the unrealistic expectations a mother may place on her child.

The special needs of the drug-exposed children certainly must be considered in designing the program. However, it is important to keep in mind that the frequency with which severe impairment occurs may have been considerably overstated. It is important to note that the children may not need treatment, and staff should not assume that every child born of an addicted mother is in trouble. However, all of the children do need prevention services, and some of the children will need both early intervention and treatment (e.g., children who are born drug-dependent and physically/sexually abused children).

Age-specific groups of children seem to make the most sense for child programming. In this way, the program exposes each developmental age group (e.g., toddlers) to therapeutic and educational interventions that address their specific needs. With school-age children, the scheduling becomes more complex. The program must schedule around children's school schedules; mothers need to get their children to school and to greet the children when they return. Community outreach with Head Start and elementary schools is important, to inform personnel of what the residential program involves. Advanced warning is helpful to reduce the startle response when children in school announce, for example, "I have ten moms." Mothers need to be couched about how to participate in school events, how to utilize mechanisms such as parent-teacher conferences, and how their own relationship with the school may change as the child develops.

Providing structured visitation by children before they move in would be ideal; this would allow for an important assessment of bonding, parenting skills, and whether the woman has appropriate controls on her impulses when she is frustrated with the behavior of the child. In addition, the assessment should include the foster parents, Child Protective Services, and significant others, if this is possible. However, often the woman entering treatment does not have any other place or safe place to put her children; this is usually the case for homeless women or women who are leaving an abusive home. Under these circumstances, the program may need to take the children before they can do an adequate assessment. Setting up a group home on an adjacent site is one way for the program to begin work with the children immediately and tailor involvement with the child to meet the needs of each mother-child pair.

When possible, giving the woman at least 30 days alone to adjust to the program before the child comes in appears to work best. Clients and staff prefer having an adjustment period for the mother. Once the child or children enter, there needs to be a period of bonding for mother and child. It can be useful to reduce the mother's participation in groups for one to two weeks when the child enters. This makes it easier to deal with the child's sensitivity to abandonment, which can be intense at this time.

Program structure needs to be fluid to accommodate the situations that arise in these families. For example, babies are born, children may come for a weekend visit and have to stay because of signs of abuse, or custodial grandparents may become seriously ill and children have to move in. All of these events may necessitate changes

FROM : HAFCI 612 CLAYTON PHONE NO. : 415 864 6162 Oct. 18 2001 09:00AM P7



in the individual woman's treatment course and/or in the program as a whole.

Food services also become a more complex issue when children are part of a treatment program. Meals have to be regulated; snacks have to be available for the children, for pregnant women, and for sick women and children; and children's nutrition has to be monitored. Nutritional seminars are needed to help the mothers understand why healthy snacks should replace junk food in their children's diets as well as their own. Time spent evolving new and healthier food rituals to replace those learned in childhood increases the chances that nutritional information will be utilized and positive changes will endure.

Evening programs for the women have to be coordinated with children's bedtimes. The program has to decide if the children will go to bed in the children's center/childcare or in their own rooms. This will depend on the configuration and size of the facility, as well as the number of children in residence.

Holidays in a women and children's program must be family centered. Each holiday involves planning for the family, including visits by children who may not be in residence (e.g., those in foster homes). For Easter, there may be an Easter egg hunt for the children and a special Easter brunch for mothers and significant others. At Christmas, Chanukah, and Kwanza time, there is planning for all celebrations and sharing of cultural traditions. In addition, the giving of gifts is handled so that mothers and children all get presents. At PROTOTYPES Women's Center, the women work in the word-processing center making holiday cards for their families, friends, and one another, and work in the kitchen baking holiday cookies and preparing the holiday dinners. The parenting center staff makes Christmas ornaments for each mother; the ornament is a picture of each child that can be hung on a tree.

Evaluation of the program becomes more complex and difficult, since there are now three levels of data collection and analyses: the woman/mother, the children, and the mother-child interaction. Once the program collects the data, it is important to feed back the results to staff on at least an annual basis. At PROTOTYPES Women's Center there are quarterly case management conferences, during which individual client data are presented and integrated. In addition, there is a program evaluation conference where evaluation data on treatment admissions, outcomes, and follow-ups are presented. At this time, staff not only gain more understanding of the information they have been helping to collect, but also have an opportunity to provide additional input into the evaluation process and interpretation of data. In this way, evaluation becomes an integral part of treatment.

## TREATMENT ISSUES

In a program that includes women's children, the women's fear, guilt, and shame about parenting often become a central issue in treatment. Without the children in the program, the women do not have to be confronted daily about their parenting skills. Among other things, mothers need to be assisted in modifying their expectations of simple solutions. Often the women expect immediate success after they attempt a newly learned parenting strategy. They need to understand that it will take time for children to respond to their new behaviors (Pearlman, West & Dalton 1982).

Pregnant women need specialized groups to address special concerns around prenatal care, childbirth, and health issues. These issues become especially complex for women who are HIV-infected. Staff need to address issues of risks to the fetus, AZT protocols, and ongoing health issues for women who are living with HIV or AIDS. PROTOTYPES Women's Center has a specialized HIV/AIDS component within the residential facility for women and their children.

Other issues arise around children who are drug-affected. Fitting these children into the treatment program and addressing their special needs become additional challenges for their mothers and for program staff. Educational lags may be seen and may tend to increase with age. It is important that staff maintain close contact with the school and provide tutors for children who need extra help.

Within the first three months in residence, children usually develop enough trust in the program to exhibit acting-out behavior. As the mother begins to assert herself in the parent role, the child is likely to challenge her and her new behaviors. Children learn that spanking and any physical discipline is not allowed in the facility, and they will test their mothers. Additional support for the mother is important during this time in order to reinforce the new parenting behaviors being learned.

Children may figure out the rules of the program and use them against the mothers. For example, in a traditional TC if there were pieces of paper on the floor, one would give a punishment to the individual who was responsible. In the mother-child model, the child may have thrown the paper on the floor in an attempt to get the mother in trouble. Staff need to assist the mother in understanding this behavior and in learning to set limits with their children in a safe and growth-enhancing manner.

When women are going through emotionally upsetting issues, one may see acting out on the part of the children. Children who are acting out sexually also lead to more upset among the women. Sexuality issues of the children often bring up the mother's own abuse issues. However, it is important for staff to assist mothers in learning about children's normal exploration of sexuality. As discussed by Covington (1991) and CSAT (1993), many women have gone through treatment without the opportunity to address their sexuality and intimacy issues. Specialized groups on sexuality need to include sexual communication styles, dynamics of sex and power, substance

abuse and sexuality, and sexual functioning. In addition, women who have exchanged sex for money and/or drugs need an opportunity to explore their feelings about these experiences and to explore alternative lifestyles.

Discussions of sexuality for women often will lead to issues of violence in intimate relationships, including incest and domestic violence. PROTOTYPES Women's Center has for many years provided specialized survivor groups for women with histories of incest and/or other sexual abuse, and domestic violence groups are provided for women with histories of physical abuse and/or current spouse abuse problems; individual counseling is also available. In addition to the accurate assessment of any history of violence and addressing issues of abuse during treatment, the program should provide the women with information that can be used if abuse recurs, including information about the use of restraining orders, hotlines, and shelters (CSAT 1993).

Medical issues are an important treatment issue for the women, since many of them have relied on emergency rooms for most of the medical care for themselves and their children. For example, at Project Pride many of the women entering the program feel that the only adequate medical care they can get *must* be in an emergency room or other hospital. Unaccustomed to other settings, they lack confidence in the providers. To address this belief, Project Pride initiated a weekly class taught by the on-site registered nurse about basic health care issues ranging from colds, cholesterol, tuberculosis, and scabies, to broader topics such as how to ask the right questions of your physicians. Helping the women become more aware and educated around medical issues has empowered them and helped them become better advocates for their own and their children's medical needs. Both PROTOTYPES Women's Center and Project Pride provide on-site medical care, but also connect the women with outside providers and teach them how to relate to these health care systems.

Integrating the father, female partner and/or other family members can be an important treatment issue. The program may need to incorporate any significant other who has an ongoing, nonabusive relationship with the child and/or the mother. There are a number of strategies for involving family members and/or partners, including educational seminars on chemical dependency or parenting skills training, family counseling, family visits, and family outings.

## STAFF AND TRAINING ISSUES

One of the most important issues programs for women and children face is whether to have any men on staff. Some programs decide to have only women staff members in order to assist the women in dealing with difficult and sensitive issues, such as incest, rape, and battering. If a program decides to include male staff, it is important to ensure that male staff understand the difficulties of being men in a women's treatment program, and that no male staff are left alone on duty at night. All staff need training on issues of boundaries, sexuality, and abuse. It is also important to have more women than men on staff, in order to expose clients to successful female role models. The female role models should be both line-staff and program administrators.

One of the important issues for TC staff is training on how to confront clients without being abusive. Many of the women in treatment have been physically and sexually abused from childhood into adulthood, and these women may have particular difficulties when confronted. Staff training on these issues can lead to understanding and learning new confrontation skills. While confrontation continues to be an important part of programs for women and children, the "new" confrontation does not include threatening or abusive language. It can focus on how to use careful inquiry to produce insight about the negative consequences of certain behaviors. Many staff who do not have formal professional training have not been exposed to methods of inquiry. Motivational enhancement strategies (Miller et al. 1995; Miller & Rollnick 1991) are one example of such tools. Other training activities include instruction and role-plays on how to confront in a manner that is forthright but supportive.

Childcare staff often do not have experience with substance abuse treatment or TCs. They usually come from other fields (e.g., mental health, early childhood education) and therefore need training to understand addiction and the special needs of these women. This is extremely important in order to ensure that the childcare staff do not reinforce the negative stereotypes of addicted women. Sometimes child workers feel they must be advocates for the child even if this means being against the mother; this may give rise to conflicts between childcare staff and women's counselors. Conversely, counseling staff may not have expertise about children's needs. All staff need to be trained in child development so that they can understand what can be expected from the children and at what age.

Another important training issue is child abuse and discipline. While this appears to be self-evident, it is a topic that often leads to important discussions of the staff members' own histories of parenting and being spanked. This training may need to involve a number of sessions to allow staff to deal with their own attitudes and to learn new skills in dealing with the clients.

Learning to identify countertransference issues, personal sensitivities developed through early experiences with parents and other authority figures, is crucial for staff working with the women and children. Although this is a dimension of all therapeutic interactions, it is particularly magnified in residential treatment because of its increased intensity. Thus it is important for all staff to have a safe arena to examine these issues, with appopriate boundaries for what should be dealt with in the workplace problem-

solving arena, and what should be brought to personal therapy. For all counselors, but especially those with abuse histories, it is important to have a time and place set aside to address these issues. The innocence and vulnerability of the child can make it easier to identify with the child than the mother, and the tendency to view the mother as saint or sinner reflects the larger problems in the culture (Harrison 1991). Quality clinical supervision is necessary to insure an ongoing commitment to maintaining a healthy balance and avoidance of bias toward mother or child in the face of daily exposure to stark, emotion-laden issues.

Both PROTOTYPES Women's Center and Project Pride have staff training on dual diagnosis/co-occurring disorders. Many women may have a mental disorder, cognitive impairment, or a medical problem in addition to substance abuse. Although the program may offer a safe and supportive environment, women with severe mental, cognitive, or physical illnesses may be overwhelmed by the program structure and process (Brown, Huba & Melchior 1995). Training in these areas can help staff adjust program procedures to the specialized needs of these clients.

## CONCLUSION

In summary, residential programs for women and their children constitute a new modality with requirements that can be met only by carefully adapting existing models to address the complexities of treating mothers and children together. Program design must meet the needs of the newly abstinent mother, who is expected to focus on herself and her recovery, as well as the needs of her children. The combination has characteristics beyond the sum of the parts. Everything from spatial configuration to program activities should be guided by a perspective on how to meet the needs of both mother and children. Treatment issues become much more complex when parenting behavior and the needs of the children are an immediate reality. Staff training needs are greater than ever, in an era when resources are declining.

These issues of combined treatment for women and their children are particularly important given the increasing interest in these models by both criminal justice and social services systems. These residential programs provide an opportunity to apply the knowledge gained through funding set aside since the 1970s to investigate women's special needs (Brown 1995). It is hoped that this opportunity to demonstrate and evaluate new models will endure through the current transformation of the health care delivery system, as it will not be easily restored if abandoned prematurely.

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Original: 2075

Diagnostic & Rehabilitation Center/Philadelphia
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Irving W. Shandler, President
Kathleen White, Ph.D., COO
Richard V. Cloeren, Chief Fiscal Officer

Joseph Vignola
Chairman of the Board

Title 28, Health & Safety, Chs. 701, 705, 709, 711 and 713 proposed physical plant is ill considered and potentially damaging to residential addiction treatment facilities. If a program stands to lose even 10% of bed capacity, that loss cannot be recaptured by a 10% reduction in staff. It takes the same number of three shift staff to cover 15 people as it does 12 people.

Our organization is currently 2 sq ft short of space in several rooms, which according to these regulations would cause the loss of one space per room. In addition, in therapeutic residential treatment, clients do not spend time isolated in bed rooms. Rather they are busy throughout the day and use bedrooms for sleeping only. Does it not then seem misplaced to jeopardize a program for insufficient reasoning. Our program adheres to the county licensing guidelines regarding space, ventilation and windows, and we also adhere to the very stringent American Correctional Association standards. Why then is there yet another bureaucratic layer being imposed? If any residential programs are out of the required guidelines, then the Department of Health needs to deal with that program. It is detrimental to impose such wide reaching guidelines on everyone.

Please give us your support!! These regulations have a serious impact on already struggling non-profit treatment agencies.

Kathleen White, Ph.D.
Chief Operating Officer

OCT. 19. 2001 3:06PM NO. 725 P. 1

Joseph Vignola
Chaiman of the Board

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# FAX TRANSMISSION COVER PAGE

DATE: October 19, 2001

| TO: | Fiona Wilmarth | FROM: | Kathleen White |
|---|---|---|---|
| COMPANY: | IRRC | COMPANY: | Diagnostic and Rehabilitation Center/Philadelphia |
| DEPT.: | | DEPT.: | Administration |
| FAX #: | | FAX #: | (215) 625-2374 |
| PHONE #: | | PHONE #: | (215) 625-2373 |

SUBJECT: Title 28, Health & Safety

TOTAL NUMBER OF PAGES INCLUDING COVER PAGE (2)

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PLEASE CONTACT ABOVE PERSON IF TOTAL NUMBER OF PAGES ARE NOT RECEIVED

Original: 2075

# Treatment Trends, Inc.

*18-22 S. SIXTH STREET P.O. BOX 685 ALLENTOWN, PA 18105*

*• Confront • Keenan House*
*• Forensic Treatment Services • Richard S. Csandl Recovery House*

Fiona Wilmarth, Analyst
IRRC
333 Market Street, 14th Floor
Harrisburg, PA 17101

10/4/01

Subject: Opposition to proposed regulations Title 28, Part V Drug and Alcohol Facilities and Services

Dear Ms. Wilmarth:

I am writing to object to the proposed regulations concerning physical plant standards (Part V, Drug and Alcohol Facilities). Upon reviewing these proposed regulations one must question Department of Health's purpose for the changes. Section 705.5 (a) (b) Sleeping Accommodations seems to be a bureaucratic attempt at bedroom uniformity across varying facilities, with high costs that yield little real improvement to neither fire safety nor health.

Oddly bedroom square footage has emerged as an inappropriately focused high priority. It seems that if the DOH has a problem with a specific facility that they should have the ability to deal with that problem without making that problem the problem of every facility.

In our 30 years of providing residential (inpatient non-hospital) drug and alcohol treatment services we have never received a single client complaint about the bedroom space. We have been licensed continuously since licensing's inception and have never been cited over bedrooms or space by this very group proposing these changes. Three years ago we proposed renovations including increasing our bed capacity to the DOH Quality Assurance Division (licensing department). We showed them pre-construction blueprints with dorm style bedrooms, which they approved. We renovated our 1st, 4th and 5th floors at a cost of over $500,000. The DOH licensing division came here and conducted a site inspection complimenting the work and gave a final approval of the project (Attachment A).

This building has been renovated several times making efficient use of every space available. It is easily described as a 5 story building; functional, spacious with a beautiful dining area, with lounges on the 2nd, 3rd and 4th floors.

Unlike a personal care home, our clients are ambulatory and there are no services rendered to clients in their bedrooms. They simply sleep there. The client schedule of daily activities has them quite busy from 7:00 AM to 11 PM. Unless sick, clients are not allowed in their bedrooms during the daily schedule. To emphasize the required sq. footage (705.5 (b) space and (705.5 (c) no more than 4 to a room) is purposeless to the task of treatment.

These purposeless regulations have huge consequences. These consequences include:

[1] The sq. footage requirement would reduce our capacity from 85 beds to 58 beds, a loss of 27 beds totaling a loss of revenue of $846,080. This would shut us down.

[2] The four to a room requirement would further reduce our capacity from 85 to 44 beds, a loss of 41 beds totaling a loss of revenue of $1,436,640.

[3] A loss of 41 beds would require us to shut down our services. We would lose so many staff and administrative functions that we could not exist.

[4] Losses of even smaller numbers of beds are catastrophic to the overall budget, 1 bed = $35,040 and 2 untreated clients (6 months each), 2 beds = $70,080. The agency cannot fund raise such large amounts of money.

[5] If capacity is lost we cannot site another program in the City of Allentown due to zoning.

[6] Loss of access of services to this level of care would put people on the streets instead of treatment. This endangers public safety since we work with chronic addicts it would mean continued drug use and continued crime. Research shows hard core addicts commit multiple crimes daily in service of their addiction.

[7] Capacity is important to the anti-drug effort of our community. The City of Allentown has a huge drug epidemic and little ability to meet the actual demand for treatment services as evidenced in a full prison census, huge probation and parole caseloads and a Lehigh County Drug and Alcohol Commission which ran out of inpatient treatment dollars in February; a full 4 and 1/2 months before the end of the fiscal year.

[8] To renovate and accommodate a purposeless regulation would involve huge additional costs that would make our per diem cost excessively high, which would further burden the county's limited resources and reduce the number of addicts we can serve.

In reviewing these proposed regulations there is no provision for exceptions or waivers or grand-fathering. The Dept. of Health seems to care only about compliance without purpose. This creates a hostile situation whereby facilities like ours which the DOH previously, continuously licensed, and recently approved recent costly renovation, then complimented the expansion, are now unacceptable though we remain the same.

It would appear that this is YET another example of bureaucracy run amok, regulation out of touch with the real impact on the facilities they regulate and the communities in which these facilities operate. It would appear the DOH seeks administrative convenience rather than meaningful, purposive change.

Our facilities meet all federal, state and local codes, we have invested in state of the art fire and safety equipment, the building is sprinkled, fire alarm monitored through a central station, has magnetic door releases when a fire alarm goes off. I invite you to visit our facilities and see for yourself. A photo album will be made available to you at the public hearing.

Our recently renovated, inpatient non-hospital center is well maintained, functional, nicely furnished and decorated facility. The renovation design had client comfort in mind. Our sleeping facilities have never received a single complaint on client satisfaction surveys yet this is the area these regulations would cause (sleeping accommodations) the greatest impact. THIS IS A CLASSIC CASE OF FIXING SOMETHING THAT IS NOT WRONG. I must urge you to exercise rational decision-making and curb this proposed abuse of regulatory power. Without regulatory restraint, the Lehigh Valley and the State of Pennsylvania will lose a program that is highly regarded, frequently complimented and seen as one of the better programs.

Thank you for your consideration.

Sincerely,

Robert C. Csandl, MHS, CAC
Executive Director
Treatment Trends, Inc.

Attachments (1)

cc: Charlie Dent, State Senator
Lisa Boscola, State Senator
Pat Brown, State Representative
Jennifer Mann, State Representative
Jeffrey Beard, Executive Deputy Secretary, PA Department of Corrections
Robert S. Zimmerman, Secretary, PA DOH
Tom Rogosky, Director of Community Corrections, PA DOC
Rich Kipp, Member PBPP
Gene Boyle, Director, BDAP
Bruce Groner, Chairperson, TTI
Dorothy Roth, Legislative Committee, TTI
Roy Heffelfinger, Vice Chairperson, TTI
Jane Ervin, County Executive, Lehigh County
John Stoffa, Director of Human Services, Lehigh County
Sue Miosi, Administrator MH/MR/D&A
Margaret Mary Hartnett, Administrator, Lehigh County D&A
Kathleen Kelly, Administrator, MH/MR/D&A, Northampton County
Mary Carr, D&A Administrator, Northampton County
Grayson McNair, County Commissioner, Lehigh County
Jack McHugh, Ph.D., County Commissioner, Lehigh County
John Sikora, Chief Probation Officer, Lehigh County

Mark Mazziotta, Chief Probation Officer, Northampton County
Vicki Liberto, Chairperson, LV Care Association
Michael Harle, Executive Director, Gaudenzia, Inc.
Vince Rossi, Legislative Aide, Sen. Fumo
Bill Stauffer, Director, Lehigh Valley Halfway Home
Deb Beck, Executive Director, DASPOP
Irv Shandler, Executive Director, DRC

(717) 783-8675

February 1, 2000

Theodore Alex, Associate Director
Treatment Trends, Inc.
18-22 South Sixth Street
PO Box 685
Allentown, PA 18105

Re: Facility #391124

Dear Mr. Alex:

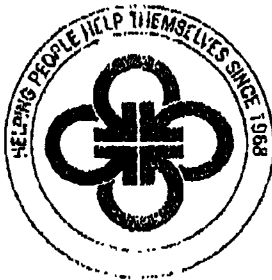
This is in response to your request for an increase in the licensed client bed capacity for Treatment Trends Inc./Keenan House's inpatient non-hospital drug-free activity. Effective January 10, 2000, we are approving the request and are increasing the client bed capacity from 70 beds to 85 beds. To be noted is that this approval is contingent upon your maintaining the appropriate client to counselor ratio as outlined in the staffing regulations.

A new license will not be issued reflecting this increase. The increase will, however, appear on your renewal license. Until the renewal license is issued, this letter serves as official notification of the increase.

Should you have questions, contact the Division.

Sincerely,

Cheryl D. Williams
Director
Division of Drug and Alcohol
Program Licensure




Original: 2075

GAUDENZIA, INC.
106 W. Main Street, Norristown, PA 19401 • (610) 239-9600 • FAX: (610) 239-9324

"Saving lives through treatment, prevention and recovery services for people affected by addiction and mental illness"

Robert P. Kelly
*Chairman of the Board*

Michael Harle, M.H.S.
*President/Executive Director*

Michael Baylson
*Counsel*

October 18, 2001

Independent Regulatory Review Commission
333 Market Street
Harrisburg, PA 17101

Attention: Fiona Wilmarth, Analyst
Fax (717) 783-2664

Re: Proposed Physical Plant Standards

Dear Commission Members:

We understand that the final proposed regulations for Physical Plant Standards, Section 705, Part V, Drug & Alcohol Facilities and Services may be placed before you for your review on November 1, 2001.

While we agree with the majority of the proposed regulations, we do take issue with a few of the provisions. Attached to this letter is our position paper. I have briefly summarized our position below for you convenience. We are objecting to the following provisions:

(1) Square footage requirements for bedrooms

(2) Four residents per bedroom

(3) Kitchens in each facility

Our position paper discusses why we object to these proposed regulations in summary as follows:

(1) The Department of Health cites other states regulations. The citation for New York is incorrect and New Jersey has a grand-father clause which was not mentioned. Not mentioned also was Maryland, Ohio and Delaware, contiguous states that have no square footage regulations.



A copy of the official registration and financial information may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, 1-800-732-0999. Registration does not imply endorsement

(2) The Department of Health conducted a telephone survey of fourteen programs in October 2001. We question the scientific basis of the survey. The survey does show that 11% of the treatment beds will be lost. This fact is omitted from the notes to the survey.

(3) Gaudenzia will lose 31 beds which will result in the closure of these five programs if reimbursement rates are not adjusted to reflect the decrease in bed capacity. If these programs close, the actual bed loss is not 31 but 180 plus 80 children's beds.

**Gaudenzia Bed Loss**

| Program | Licensed Capacity | New Capacity | Beds Lost |
|---|---|---|---|
| West Chester | 65 | 59 | 6 |
| Kindred | 16 | 14 | 2 |
| New Image | 17 | 15 | 2 |
| Re-Entry | 22 | 21 | 1 |
| Concept 90 | 42 | 25 | 17 |
| Vantage | 18 | 15 | 3 |
| | 180 | 149 | 31 |

(4) Gaudenzia will lose $1,051,765 in revenue, assuming the Programs would not close. This loss puts Gaudenzia at risk financially.

| Programs | Lost Revenue |
|---|---|
| West Chester | $ 167,535 |
| Kindred | $ 88,111 |
| New Image | $ 88,111 |
| Re-Entry | $ 27,010 |
| Concept 90 | $ 527,425 |
| Vantage | $ 153,573 |
| Total | $1,051,765 |

(5) Renovations to existing buildings to meet the proposed regulations is cost-prohibitive and prohibited because of zoning requirements.

GAUDENZIA

(6) A kitchen at every licensed facility is unrealistic and will result in the closure of programs which share a common kitchen in a campus environment or a common kitchen in a multi-licensed facility.

(7) Limiting four residents per bedroom contradicts the research on Women & Children's Programs.

While we are aware of your limited time frames for review, we hope that you seriously question the concerns we have mentioned. The safety and health of our residents is paramount and we believe that the majority of the proposed regulations advances that purpose. However, the few proposed regulations mentioned above to do not accomplish that goal. We believe that if these regulations are enacted as proposed, health and safety of individuals, their children and the community at large would be seriously affected. This is based on the fact that individuals will have less access to appropriate treatment, putting themselves and others at risk. We are attaching a detailed analysis of these issues and recommend these proposed regulations be rejected. For further information please contact me at 1(610) 239-9600 ext 201.

Sincerely,

Michael Harle, President/Executive Director

MH/tdm

# Gaudenzia, Inc.
# Response

## I. Introduction

This is in response to proposed regulations for Physical Plant Standards for Section 705, Part V Drug and Alcohol facilities and services. The initial proposed regulations were published in the Pennsylvania Bulletin Vol. 29, No. 46 dated November 13, 1999. Those proposed regulations have undergone substantial changes since that date. Nevertheless the first revisions of those proposed regulations were submitted to the Independent Regulatory Review Commission and the chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare for review and comment. In August of this year we understand that the Department of Health subsequently withdrew that submission for further amendment and resubmission is pending.

## The Health Departments
## Response to Comments

## II. Introduction

In August 2001, the Department of Health prepared a response to the comments made by the following:

**IRRC**
**DPW**
**Four Legislators**
**Pennsylvania Halfway House Associates**
**Philadelphia Alliance**
**Seven Providers**

The IRRC and DPW provided comments in the Spring of 2000. The other comments had been received by the Department of Health in November and December 1999. Several Comments were made on the proposed regulations for Sleeping Accommodation, Section 705.5 of the proposed regulation dealing with square footage requirements.

We believe that the response of the Department of Health is oversimplified and lacks the proper research and investigation. The argument below clearly illustrates that the Department of Health assumptions and perceptions are incorrect.

## SPACE FOOTAGE SLEEPING ACCOMMODATIONS

The square footage requirements for sleeping accommodations, Section 705.5 of the proposed regulations reads as follows:

> (b) Each shared bedroom shall have at least 60 square feet of floor space per resident measured wall to wall including space occupied by furniture. When bunk beds are used, each bedroom shall have at least 50 square ft. of floor space per resident measured wall to wall. Bunk beds shall afford enough space in between each bed and the ceiling to allow a resident to sit up in bed. Bunk beds shall be equipped with a securely attached ladder capable of supporting a resident. Bunk beds shall be equipped with securely attached railings on each open end of the bunk. The use of bunk beds shall be prohibited in detoxification programs. Each single bedroom shall have at least 70 square feet of floor space per resident measured wall to wall, including space occupied by furniture.

In its face sheet for filing documents with the Legislative Reference Bureau, the Health Department in its comments on square footage stated as follows:

> Finally, the standards established in other states were reviewed in formulating this subsection. The standard for a majority of states is consistent with this regulation. The following are some examples: New Jersey requires 70 square feet clear floor space for single occupancy and a minimum of 50 square feet of clear floor space per patient, with 3 feet of clear between and at the foot of beds. Rhode Island requires 85 square feet for single occupancy and 60 feet per person for multiple occupancy. Montana requires 100 square feet for single occupancy and 80 square feet per person with no more than 4 persons per room. New York requires 100 square feet exclusive of closet space for single occupancy and 80 square feet per person with a maximum of 4 persons per room, with an exception of 60 square feet per person for alcohol treatment of less than 5 days.

We take issue with the Department of Health readings of other state requirements. The New York standards are incorrectly stated by the Department of Health. The New York requirements For The Operation of Drug Free Substance Abuse Programs, Post 1030, Section 1030 (g) Facility Standards states as follows:

> (1) Each residential program must have safe and adequate physical facilities to carry-out its program. To insure this, programs must adhere to the following minimum space requirements as appropriate to the services provided: sleeping areas: 80 square feet per resident for single beds, or 40 square feet per resident for two deck bunks... maximum dormitory capacity is 24...

The Health Department citation of the square footage requirement for New Jersey is correct. However, New Jersey does have a grandfather clause. That section of the New Jersey regulations was revised in 1999. We have not confirmed whether the representations made by the Health Department for Montana and Rhode Island are correct. We believe requirements in those states are not material.

However, we have reviewed the regulation for the contiguous states of Maryland, Ohio, and Delaware. None of those states have square footage requirements. Those states do require a Certificate of Occupancy. The proposed regulations at Section 705.1 (2) requires such a Certificate of Occupancy from the Deparunent of Labor and Industry or its local equivalent. Why isn't this requirement sufficient to protect the health and safety of the residents?

Our concern is that the Department of Health has misrepresented the New York regulations, omitted the grandfather clause for New Jersey, and has made misrepresentations by omitting a discussion of the regulations of the surrounding states of Maryland, Delaware, and Ohio.

More importantly, a residents' bedroom is not an area where the resident should spend time. Our therapeutic community model does not allow the resident to isolate himself or herself in the bedroom. Our programs and most programs limit the use of the bedroom for sleeping only.

**Health Department's Recent Survey**

Within the past few months the Department of Health has completed an unscientific survey of fourteen (14) programs throughout the Commonwealth. Of the fourteen (14) programs, four are Gaudenzia owned programs. A copy of that survey is attached for your review. In July 2001, Gaudenzia purchased the assets of Serenity Hall, Inc. a provider in Erie, Pennsylvania. Gaudenzia Erie Inc. operates Gaudenzia Crossroads and Gaudenzia Dr. Snow. Gaudenzia Dr. Snow is a Halfway House with the licensed bed capacity of 14. Since the Gaudenzia takeover in July, the census has been at or near capacity.

The licensed capacity of Gaudenzia Crossroads is 42 residents. Prior to July 2001, Serenity Hall, Inc. Board of Directors were in the process of closing the program when the Board asked Gaudenzia, Inc. to investigate how the program could continue in the Erie Community. The result was the takeover of the programs by Gaudenzia. Many years ago the structure where the program is located housed over 70 residents. Gaudenzia is planning to increase licensed bed capacity in the near future and working with the local Single County Authority to insure proper reimbursement rates for the increased capacity.

This explanation of Gaudenzia Crossroads and Gaudenzia Dr. Snow should be remembered when reviewing the Department of Health's survey. The survey oversimplifies the situation at Gaudenzia Crossroads. Currently, the structure is used for the programs is underutilized and Gaudenzia is planning to make a full utilization investigation of the structure.

Let's review the totals of the Department of Health's survey.

| | |
|---|---|
| **Residential Capacity** | **572** |
| **Number of Beds Lost** | **62 (11%)** |
| **New Reg Capacity** | **510** |

Using the figures of the Department of Health's survey the bed loss is 681 statewide.

| | |
|---|---|
| **Total Beds State Wide** | **6,184** |
| **Lost Beds Percentage** | **11%** |
| **Total Beds Lost** | **681** |

The survey document states:

> *"After implementation of the new regulations, the state total residential bed capacity (6,184 beds), will retain excess capacity and 1% of the beds will be lost."*

The Department's own figures prove otherwise. It is not 1% but 11%.

The Department of Health also stated in its comments in August 2001.

> *"It is believed, however, that the actual number and amount will be relatively small to the total number and amount within the entire field."*

A percentage of lost beds of 11% is not "relatively" small.

The August 2001 statement was made without proper research and investigation by the Department of Health. The survey done two months later in October 2001, does not support the August comment.

If a survey was to have been completed with some sense of statistical accuracy, the programs of Malvern Institute, Allentown Rescue Mission and Bowling Green would have been eliminated. Two are 28 day for-profit programs and the third is a mission. The survey leaves the reader to believe that residents from one provider could seek treatment at another provider. This is not true; the providers simply have different services, and residents from one provider cannot be moved to another level of care with different services, **especially women with children** in long term programs.

We have also completed a survey. We used the same methods as the Health Department's and substituted the three programs mentioned above with three programs which are similar to the remaining eleven programs. Those programs and beds lost are as follows:

| | Capacity | Beds Lost |
|---|---|---|
| **Northeast Treatment Center** | **36** | **9** |
| **Gaudenzia Concept-90** | **42** | **17** |
| **DRC** | **187** | **38** |
| **Total** | **265** | **64** |

We have attached a copy of our survey for your review. Our survey shows the following:

| | | |
|---|---|---|
| **Residential Capacity** | **668** | |
| **Number of Beds Lost** | **126** | **(19%)** |
| **New Reg Capacity** | **542** | |

Based upon our survey the bed loss statewide is 1175.*

| | |
|---|---|
| **Total Beds Statewide** | **6184** |
| **Lost Bed Percentage** | **x19%** |
| **Total Lost Beds** | **1175 [this represents approx. 4,700 clients]** |

The remaining sections of the Department of Health's survey are also flawed. Using census on a given day does not fully explain the complexity of addiction treatment. Depending on several variables such as time of year, funding sources resources, discharges against staff advice, and no shows, a census of 100% is not achievable over a period of time. Any lost days reduce the 100% capacity and cannot be recouped. Funding sources recognize this and reimbursement rates are set at 85% occupancy. **(Reimbursement rates are discussed later).**

The Department of Health may want to re-think its argument using the census information of the survey. The whole theory of the Department of Health is that there is overcrowding. The Department of Health census survey shows that there is not overcrowding. While we know the census survey is flawed, nevertheless, it does prove our point that the overcrowding theory of the Department of Health is extremely overstated and theoretical.

This illustrates again, the lack of proper research and investigation by the Department of Health. A flawed survey, done two months after the comments were made, does not support the comments.

The following is a summary of beds that would be lost by Gaudenzia if the proposed regulations become law.

**Gaudenzia Bed Loss**

| Program | Licensed Capacity | New Capacity | Beds Lost |
|---|---|---|---|
| **West Chester** | **65** | **59** | **6** |
| **Kindred** | **16** | **14** | **2** |
| **New Image** | **17** | **15** | **2** |
| **Re-Entry** | **22** | **21** | **1** |
| **Concept 90** | **42** | **25** | **17** |
| **Vantage** | **18** | **15** | **3** |
| | **180** | **149** | **31** |
| | | | [This equates to 124 clients unserved] |

*This does not include the closure of entire programs.

Kindred, New Image, and Vantage are Women and Children's Programs. The beds identified represent the mothers' beds since reimbursement is tied to the mother. Children are not counted for the purposes of reimbursement. The actual total is seven adult beds lost and 13 beds for children lost. The loss of these beds results in an estimated deficit which causes financial viability of these programs to be imperiled. The reality of lost beds is not seven but the closure of these programs, totaling a loss in capacity of 51 slots for Women and Children programs, plus children's beds totaling 80.
These Women and Children Programs would be closed.

Our adult programs in West Chester and Concept 90 have a total capacity of 107 beds. The proposed regulations would reduce those beds by 23 or a 21.5% reduction. This reduction is bed capacity results in an estimated deficit and the eventual closure of these programs. The actual beds eliminated would be 107. **This represents the loss of services for 428 clients.**

## Lost Revenue

A more detailed explanation why these programs would be closed for financial reasons is appropriate. These are publicly funded programs. The reimbursement rates are set by funding sources based upon the licensed capacity of a program. The calculation used state-wide by Single County Authorities requires staffing cost to be based upon the facility license. The reimbursement rate is cost based and does not allow for a surplus. The decreases in bed capacity results in a deficit based upon the current reimbursement rate of the funding source. The deficits which would be sustained in the programs mentioned above is as follows:

| Programs | Lost Revenue |
|---|---|
| West Chester | $ 167,535 |
| Kindred | $ 88,111 |
| New Image | $ 88,111 |
| RE-Entry | $ 27,010 |
| Concept 90 | $ 527,425 |
| Vantage | $ 153,573 |
| TOTAL | $1,051,765 |

## Reimbursement Rate

This lost revenue is based upon the current cost based reimbursement rates permitted by the governmental funding sources including the several Single County Authorities.* These funding sources would have to raise the reimbursement rates proportionateley to accommodate for the loss of beds. If rates were not increased, the programs would be closed. Gaudenzia could not sustain such a loss in revenue. The reimbursement rate is not negotiated. It is based upon standard calculation and assumes 85% occupancy.

*Some counties and managed care programs have not increased rates in over two years, and have indicated to us that they will not be able to make up the difference.

Reimbursement rates could be increased. That would simply mean that less people get treatment at higher cost. The funding sources and Single County Authorities cannot pay more for less.

Examples of the reimbursement rate increase resulting from lost beds is appropriate. Our Vantage program will loose three (3) beds. The current reimbursement rate fixed by the Single Count Authority is $165.00 per day. The rate would have to be increased to $199.00 per day. With no rate increase, the program would close. Our Concept 90 program will lose seventeen beds. The current reimbursement rate fixed by the Single County Authority is $96.00 per day. The rate would have to be increased to $161.00 per day. With no rate increase, the program would close.

We are not certain whether the Department of Health has an adequate understanding of the reimbursement structure. It is clear that the reduction in beds without the adjustment of reimbursements, does more than merely reduce beds. The reduction of beds, without an adjustment of reimbursement rate, results in the closure of entire programs.

## Census

The licensed capacity of programs is approved by the Health Department and is based on several licensing standards including, but not limited to, staffing requirements and certificates of occupancy. A program is prohibited from having more residents than its licensed capacity. These programs are treating addicts. Some leave treatment against staff advice, others do not show up for treatment when scheduled. Those lost days can not be made up by overcrowding the program with more residents than the licensed capacity. Funding sources and Single County Authorities have recognized this and reimbursement rates are set knowing that these programs can not achieve 100% of licensed capacity in any twelve month period. The providers and the funding sources do recognize that from time to time during a twelve month period these programs are operating at capacity.

The Department of Health cannot use unrealistic occupancy rates equal to 100% capacity. This is fiscally, administratively, and clinically irresponsible. Addicts do not wait on waiting lists.

## Renovations and Zoning Issues

Are renovations of these facilities to accommodate these proposed regulations realistic? In most cases they are not. Renovations are prohibited by the costs and local zoning restrictions. Not for profit providers do not have the funds to make capital improvements without the assistance of funding sources. Even when they do, they are restricted by the size and structure of the existing sites. The Gaudenzia Concept 90 program occupies a structure on the Harrisburg State Hospital grounds. The cost of renovations in the structure is prohibitive. To gain the needed four square feet per room would cost in excess of two million dollars. The Gaudenzia New Image program occupies part of a structure owned by the City of Philadelphia. Again the cost of renovations in that structure is prohibitive. The renovations to the other Gaudenzia facilities would require zoning variances by the local government authorities where these facilities are located. Such variances are seldom permitted. The phrase "NOT IN MY NEIGHBORHOOD" is applicable in hearings before local zoning boards.

## Kitchens

On September 11, 2001 we sent a letter to the Independent Regulatory Review Commission commenting on the proposed regulations. This letter supplements that letter and our previous communications. In that letter we discussed the proposed regulations (Section 705.7 Kitchens) concerning the requirement that each residential facility shall have a kitchen. Many providers have more than one licensed facility housed on a campus or single structure that shares a common kitchen and dining area. This proposed regulation would prohibit the sharing of a common kitchen and dining area in these instances. This proposed regulation again illustrates the Health Department's lack of knowledge of the daily operations of the licensed programs and the current laws regulating these kitchens.

## Four Beds Per Room

The proposed regulations at Section 705.5 (c) states: "No more than four residents shall share a bedroom." Section 705.1 (4) exempts facilities that have been licensed prior to the effective date. This proposed regulations is troublesome in light of research which clearly indicates that in Women's and Children's programs, women may need the added monitoring of their peers to help them with controlling any impulses to use harmful disciplinary practices. Four residents per bedroom when children are counted as residents is contradictory to the research.* A woman with two children would have to be in a bedroom by herself with her children. The second adult resident with a child would result in five residents to bedroom. The supporting research is attached for your review.

*Many of the programs follow the Therapeutic Community model, which requires group living as a therapeutic milieu.

Health Department Survey

# CURRENT CENSUS AND ESTIMATED BED LOSS

| FACILITY NAME | RESIDENTIAL CAPACITY* | NUMBER OF BEDS LOST | NEW REGULATION CAPACITY | CENSUS LAST SURVEY | NET LOSS FROM LAST SURVEY | CURRENT TELEPHONE CENSUS | NET LOSS FROM TELEPHONE CENSUS |
|---|---|---|---|---|---|---|---|
| Gaudenzia Crossroads | 42 | 0 | 42 | 30 | 12 | 46 | *** |
| Gaudenzia - Dr. Snow | 14 | 0 | 14 | 11 | 3 | 13 | 1 |
| Samara House | 12 | 5 | 7 | 8 | (1) | 12 | (5) |
| Allentown Rescue Mission | 24 | 0 — | 24 | 10 | 14 | 12 | 12 |
| Halfway House Lehigh | 36 | 0 | 36 | 23 | 13 | 20 | 16 |
| Harrisburg Teen Challenge | 12 | 3 | 9 | 11 | (2) | 11 | (2) |
| Teen Challenge Training Center** | 80 | 17 | 63 | 60 | 3 | 66 | (3) |
| Teen Challenge Induction Center | 20 | 5 | 15 | 11 | 4 | 16 | (1) |
| Bowling Green | — 76 | 0 — | 76 | 72 | 4 | 72 | 4 |
| Treatment Trends | 85 | 24 | 61 | 89 | (8) | 77 | (16) |
| Blue Mountain House of Hope | — 20 | 0 | 20 | 17 | 3 | 15 | 5 |
| Gaudenzia West Chester | 65 | 6 | 59 | 64 | (5) | 58 | 1 |
| Gaudenzia Kindred House | 17 | 2 | 15 | 15 | 0 | 15 | 0 |
| Malvern Institute | — 69 | 0 — | 69 | 36 | 33 | 40 | 29 |
| Totals | 572 | 62 | 510 | 437 | 73 | 473 | 41 |

* Includes detox and rehab beds
** This capacity was decreased in 2000 from 100 to 80 beds
*** Cannot exceed residential capacity

Of the total residential bed capacity of commentors (572 beds) using last survey estimates of census, the system will retain 73 beds in excess capacity. Even though 16 (less than 3%) occupied beds will be lost.

Of the total residential bed capacity of commentors (572 beds) using commentators estimates of census, the system will retain 41 beds in excess capacity even though 27 (less than 5%) occupied beds will be lost.

After implementation of the new regulations, the state total residential bed capacity (6,184 beds), will retain excess capacity and 1% of beds will be lost.

** Gaudenzia Survey

| Facility Name | Residential Capacity | Number of Beds Lost | New Regulation Capacity |
|---|---|---|---|
| Gaudenzia-Crossroads | 42 | 0 | 42 |
| Gaudenzia-Dr Snow | 14 | 0 | 14 |
| Samara House | 12 | 5 | 7 |
| Concept 90 | 42 | 17 | 25 |
| Halfway House Lehigh | 36 | 0 | 36 |
| Harrisburg Teen Challenge | 12 | 3 | 9 |
| Teen Challenge Training Center | 80 | 17 | 63 |
| Teen Challenge Induction Center | 20 | 5 | 15 |
| DRC | 187 | 38 | 149 |
| Treatment Trends | 85 | 24 | 61 |
| Blue Mountain House of Hope | 20 | 0 | 20 |
| Gaudenzia West Chester | 65 | 6 | 59 |
| Gaudenzia Kindred House | 17 | 2 | 15 |
| Northeast Treatment Center | 36 | 9 | 27 |
| Totals | 668 | 126 | 542 |

Percentage of the beds that would be lost 19%
Statewide beds lost would be 1175.

** This does not include at least eight other programs that have reported significant loss of capacity based on proposed regulations.

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# Challenges in Moving from a Traditional Therapeutic Community to a Women and Children's TC Model[†]

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Joan Ellen Zweben, Ph.D.** & Tanya Aly, Psy.D.**

**Abstract**—With the advent of specialized programs for addicted women and their children, some of the traditional methods used by therapeutic communities have been undergoing significant changes. This article examines the issues that are important for treatment providers to consider as they move from individual client and community orientation to a mother-child/family-centered and community approach. The major adaptations suggested are divided into three categories: structural design issues, including living arrangements and models of childcare; treatment issues, including acting-out behavior by the children; and staff and training issues, including staff composition.

**Keywords**—children, substance abuse, therapeutic community, treatment, women

During the 1960s there was a proliferation of self-help therapeutic communities (TCs) for the treatment of heroin addiction; these long-term residential programs can trace their origins to Synanon, which was incorporated in 1958. Confrontation was the primary therapeutic tool these TCs utilized to help addicted individuals living in them to assume responsibility for their behaviors. The game and the haircut were two of the confrontational strategies employed. With the emergence of these first-generation TCs, there was also an acceptance of the validity of the recovered heroin addict as a catalytic treatment agent. The staff of the TC function as responsible role models who are proof that creative and positive personal change is possible. The function of the social structure of the TC is to break down denial, pathology, and the code of the street; and to replace it with a code of responsibility, honor, trust, and helpfulness to each other.

Within the TC there exists a system of rewards and punishments that facilitates the reeducation and socialization of the residents. Both the staff and residents have explicit job functions. New members are viewed as being irresponsible and immature persons who cannot make productive decisions. After residents demonstrate a degree of competence, they are promoted to more responsible positions, which entails additional privileges. The concept of responsibility and concern is a conscious attempt by the community to overcome the code of the streets, which requires that an individual not disclose the activity of another even when he or she has threatened someone's life. The TC also allows for the repetition of experience and education over and over again; this is how emotional learning becomes ingrained.

As drug use patterns have evolved since the 1960s, TCs have served primary cocaine users and other polydrug users, as well as heroin addicts. Over time, not only has the resident population diversified, but treatment professionals have been integrated and methods have been refined. These programs have been studied continuously since their

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**TABLE I**
**COMMUNITY AS METHOD: EIGHT ESSENTIAL CONCEPTS[a]**

**Use of Participant Roles:** Individuals contribute directly to all activities of daily life in the TC, which provides learning opportunities through engaging in a variety of social roles (e.g., peer, friend, coordinator, and tutor). Thus, individuals are active participants in the process of changing themselves and others.

**Use of Membership Feedback:** The primary source of instruction and support for individual change is the TC membership. Providing observations and authentic reactions to the individual is the shared responsibility of all participants.

**Use of the Membership as Role Models:** Each participant strives to be a role model of the change process. Along with their responsibility to provide feedback to others regarding what they must change, members also must provide examples of how they can change.

**Use of Collective Formats for Guiding Individual Change:** The individual engages in the process of change primarily with his or her peers. Educational, training and therapeutic activities occur in groups, meetings, seminars, job functions, and recreation. Thus, the learning and healing experiences that are essential to recovery and personal growth unfold in a social context and through social intercourse.

**Use of Shared Norms and Values:** Rules, regulations, and social norms protect both the physical and psychological safety of the community. However, there are beliefs and values that serve as explicit guidelines for self-help recovery and right living. These guidelines are expressed in the vernacular and the culture of each TC and are mutually reinforced by the membership.

**Use of Structure and Systems:** The organization of tasks (e.g., the varied job functions, chores, and management roles) needed to maintain the daily operations of the facility is a main vehicle for teaching self-development. Learning occurs not only through specific skills training, but in adhering to the orderliness of procedures and systems, in accepting and respecting supervision, and in behaving as a responsible member of the community upon whom others are dependent.

**Use of Open Communication:** The public nature of shared experiences in the TC is used for therapeutic purposes. The private inner life, feelings and thoughts of the individual are matters of importance to the recovery and change process, not only for the individual but for other members. Thus, all personal disclosure eventually is shared.

**Use of Relationships:** Friendships with particular individuals, peers, and staff are essential to encourage the individual to engage and remain in the change process. The relationships developed in treatment are the basis for the social network needed to sustain recovery beyond treatment.

[a] Adapted from: De Leon, G. 1994. The therapeutic community: Toward a general theory and model. In: F.M. Tims, G. De Leon, & N. Jainchill (Eds.) *Therapeutic Community: Advances in Research and Application*. NIDA Research Monograph 144. NIH Publ. 94-3633, Rockville, Maryland: National Institute on Drug Abuse.

inception and the empirical data confirms that they result in positive outcomes, as measured by reduction of illicit drug use and other criminal activity, an increase in economically productive behavior, and in other positive outcome measures (Gerstein 1994; Gerstein & Harwood 1990; Hubbard et al. 1989). TCs work, but they have not worked equally well for all clients. Historically, less than a third of TC participants have been women, for a variety of reasons.

Addicted women have a myriad of problems: a high frequency of certain psychiatric disorders, poor vocational skills, poor parenting skills, a high probability of physical disorders, and a high probability of histories of physical and sexual abuse. Their children, often prenatally exposed to drugs and growing up with one or more substance-abusing parents, also have needs that are profound and diverse. The complex problems of both are more likely to be addressed in a long-term residential program format designed to meet their special needs.

The TC is certainly a model with many powerful features, particularly when adapted to meet the needs of women and children. Drug abuse is viewed as a disorder of the whole person, affecting some or all of a person's functioning (De Leon 1994a). Treatment must be comprehensive, addressing those psychological problems or social deficits that will undermine the ability to sustain an

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alcohol and drug-free lifestyle. Many of the residents have never acquired prosocial skills; hence they can be viewed as habilitative (building what was never there) as well as rehabilitative. Often endorsing an extended family model, TCs have the potential to provide a depth of nurturance and support that many residents have never previously experienced. The essential ingredients that promote change in the TC are summarized in Table I (De Leon 1994b).

Many features of the early TCs did not lend themselves to addressing women's needs. In addition to the gender imbalance in the resident population, reliance on aggressive confrontation produced premature dropout and a treatment environment that might not provide sufficient safety to permit exploration of vulnerable issues. In some programs, the emphasis was on toughness and the emotional range was restricted to some form of anger. The more tender emotions and feelings of sadness, pain, grief, warmth, nurturance, and protectiveness were rarely seen or they were labeled pathological. Baring one's soul without flinching was highly valued (Deitch & Zweben 1981). This was not a climate designed to promote women's healing.

Addicted women are highly likely to be victims of physical and sexual abuse in childhood, and rape and other forms of violence as adults. Eating disorders are common and overlooked. Although a residential setting provides some refuge, treatment methods that exacerbate a woman's sense of powerlessness may discourage her from revealing and exploring key issues. The emphasis on harsh confrontation, copied from the original Synanon model, is particularly problematic in populations with a high frequency of traumatic experiences. In the 1970s, more participation by professionals led to the introduction of Gestalt therapy techniques, cognitive-behavioral strategies, and other approaches that broadened the repertoire of tools. However, there is considerable variability in how well these are integrated, even in programs strong in their determination to move beyond the Synanon model. It is possible that the leadership structure of the TC world, which is still predominantly male, is a factor in perpetuating these practices. One example is the difficulty of persuading existing programs to modify their practice of aggressive confrontation when dealing with residents with a serious psychiatric history, even when one can demonstrate that such clients frequently decompensate and leave treatment. Long waiting lists insure full utilization and reduce the incentive to examine reasons for early dropout more closely. It is possible that the difficulty of modifying long-standing practices is more influential than gender, but many who operate women's programs believe that female leadership must be evident in the authority structure and staff composition should be primarily female.

With the advent of specialized programs for addicted women and for women and their children, some of the traditional methods used by TCs have been undergoing significant changes. The features of the newer TCs that have been designed to meet the needs of women and families are examined here.

A major challenge to the treatment system has been to tailor appropriate and effective intervention strategies for women and their children. The many negative health and social consequences of substance abuse for a woman and her children call for sensitive and comprehensive treatment. For this population of women and their children, including pregnant addicted women, treatment outcome is best assured through provision of a comprehensive array of treatment services that address each woman's medical, psychological, emotional, and practical needs. The Center for Substance Abuse Treatment (CSAT) and the Sub-Group on Substance Abusing Women (1992) have proposed a family-centered comprehensive approach. This approach addresses a woman's substance abuse in the context of her health, her relationship with her children and other family members, and the community. In a comprehensive treatment model, the following services are recommended: medical interventions, substance abuse counseling and psychological counseling, health education and prevention activities, life skills training, other social services, and case management.

While the number of residential treatment programs and TCs established for women and children has increased in response to these identified needs, expansion per se is not the answer, and adding a few child workers is not a sufficient adaptation. There are a number of major adaptations that must occur when a TC includes pregnant women and mothers and children. These issues are important for treatment providers to consider as they move from an individual client and community orientation to a mother-child orientation. These adaptations can be divided into three categories: structural design issues, treatment issues, and staff and training issues (see Table II for a summary of these adaptations).

## STRUCTURAL DESIGN ISSUES

There are a number of questions/decisions regarding the design of the program that need to be addressed when planning for women and children.

### Reconciling the Image of the Immature and Irresponsible Newcomer in Treatment with that of a Mother Who Must Take Care of Her Child(ren)

Addressing this question is critical in deciding the model of childcare to be implemented: one in which the program takes primary care of the children (and "fixes" them) or one in which the program assists the mother in learning enhanced parenting skills.

If the program staff assesses that the women entering treatment need time during which they do not take primary

**TABLE II**
**THERAPEUTIC COMMUNITY ADAPTATIONS FOR MOTHER-CHILD ORIENTATION**

**Structural Design Issues**
Models of childcare
Number of children
Type of housing
Childproof the facility
Scheduling
Mother-infant development
Age-specific groups for children
Diet and nutrition
Evening program
Holidays
Evaluation

**Treatment Issues**
Women confronted with parenting skills
Pregnant women
Drug-affected children
Children testing mothers, acting-out behaviors
Education about child development

**Staff and Training Issues**
All women versus co-ed staff
Training on child development and child abuse
Designated staff as advocates of child
Dual diagnosis/Co-occurring disorders
Countertransference

care of their children, and if the program has sufficient resources for childcare, it may be quite beneficial for both mothers and children to implement a model of primary childcare by the program. However, this model may have licensing implications for the program. A model of supplementary childcare, in which the mother has primary responsibility for the child but is assisted by the parenting or child worker staff, may be more empowering for the women. This model also may have the advantage of simplifying licensing issues, as the mother is responsible for her children.

**How Many Children Can the Mother Bring into the Program?**

Many mothers enter treatment and suddenly want contact with all of their children. Often there have been long separations and the mother, who feels guilty, may see this as an opportunity to start over as a mother. However, it is not in the best interest of the children or the mothers to take on too much responsibility prematurely. An unlimited number of children may mean a diminishment in the optimum therapeutic environment for the women. Limiting the number of children allows the women to be more able to manage, and ensures that the children receive adequate attention. In addition, it allows the women more time for their own recovery and healing.

**Housing: Dormitories Versus Separate Apartments**

Both of these living arrangements have their pros and cons. While separate apartments or rooms for each mother and her children allow the woman a sense of privacy, dormitories provide her with assistance in watching her children. Particularly in the first two phases of treatment, women may need the added monitoring of their peers to help them with controlling any impulses to use harmful disciplinary practices. It can be quite helpful for another woman in the dorm to work with the woman around parenting or to simply get a counselor on duty to assist the woman. Based on the TC principle of giving the resident more responsibility as she learns to become more responsible for her behaviors, the best arrangement may be dormitory-style housing in the first phases and separate housing during the reentry phase.

If the program has been functioning as a traditional TC, staff and participants may have difficulty adjusting to the changes necessary to accommodate children. Suddenly there need to be new rules and safety measures. Even such things as childproofing the facility (e.g., covering electrical outlets, placing gates to keep children out of unsafe areas) and no smoking in areas where children are present can cause significant change in the lifestyle of the facility.

Scheduling activities for all the clients becomes much more complex. The traditional treatment schedule needs to be integrated with the children's schedule. There is a need for activities for women/mothers alone, the children alone, and the mothers with their children. This can add to staff burden. At Project Pride, a recovery program for women and children that provides long-term residential treatment for substance-abusing women and their children, each mother participates in individual and group counseling designed to meet her specific recovery and personal needs. Children participate in the childcare component and receive daily exercise, medical care, and assessments of their psychological, social, and educational needs. The integration of the women's treatment with the children's treatment is accomplished through classes that include the counselor, women, children, and childcare workers. This activity not only brings together the mothers and children, but unites and integrates the childcare workers and counselors. Case presentations usually focused on the women must also include the children, to help staff begin to expand their thinking past the individual to the mother-child dyad.

**Mother-Infant Development Issues**

Infants born to drug-dependent women are often subject to double jeopardy: biological risk combined with the risks associated with a mother who is not likely to have the skills for successful parenting. It is important,

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FROM : HAFCI 612 CLAYTON PHONE NO. : 415 864 6162 Oct. 18 2001 08:59AM P6
(5)



therefore, that treatment programs include strategies designed to facilitate positive mother-infant interactions.

After the birth of the infant, the mother needs to be assisted in getting to know her baby and in familiarizing herself with her infant's unique behavioral characteristics. A common problem of infants exposed to drugs is difficulty in regulating arousal. Mothers need to learn comforting techniques and how to interact with their infants in a positive responsive manner. For example, PROTOTYPES Women's Center—a comprehensive drug abuse treatment facility that provides a range of services to substance-abusing women and their children via three treatment modalities: a long-term residential therapeutic community program integrating a full continuum of services ranging from outreach throughout Los Angeles County to residential care to aftercare, an intensive day treatment program, and an outpatient program—initiated a pilot program in 1993 for infant massage. Infant massage has numerous benefits for both infant and mother. It has been shown to increase weight of the infant, to calm irritability in the drug-exposed infant, and to help alleviate gastric disorders (Field et al. 1986). In addition, it helps the mother learn to soothe her infant and provides a positive bonding experience for the dyad. In the pilot program at PROTOTYPES, the mothers were quite pleased to learn this new strategy for helping their babies. The parenting center staff has been trained to continue the infant massage group.

A children's program, directed by an early childhood specialist, provides a stimulating, responsive, and supportive environment for children and the mothers. The presence of a children's center in the treatment facility ensures that mothers can more fully participate in their treatment. It is important to have the children's center far enough away in the facility that the women in groups cannot hear the children crying. At PROTOTYPES Women's Center, each woman is asked to put in at least two half days per week at the children's center, in order to ensure that there is adequate coverage, that each woman learns new skills in working with children, and that the woman practices her new skills in a safe environment. Some women who have had significant trauma regarding children, such as the death of a child, may not be assigned to the children's center. At Project Pride, women rotate through the childcare area as well, and are given a chance to work with the different age groups. This experience exposes the mothers to different developmental levels, and aids in their understanding of what a child is capable of doing given a particular level of cognitive development. The staff at Project Pride has found that this hands-on teaching helps break down some of the unrealistic expectations a mother may place on her child.

The special needs of the drug-exposed children certainly must be considered in designing the program. However, it is important to keep in mind that the frequency with which severe impairment occurs may have been considerably overstated. It is important to note that the children may not need treatment, and staff should not assume that every child born of an addicted mother is in trouble. However, all of the children do need prevention services, and some of the children will need both early intervention and treatment (e.g., children who are born drug-dependent and physically/sexually abused children).

Age-specific groups of children seem to make the most sense for child programming. In this way, the program exposes each developmental age group (e.g., toddlers) to therapeutic and educational interventions that address their specific needs. With school-age children, the scheduling becomes more complex. The program must schedule around children's school schedules; mothers need to get their children to school and to greet the children when they return. Community outreach with Head Start and elementary schools is important, to inform personnel of what the residential program involves. Advanced warning is helpful to reduce the startle response when children in school announce, for example, "I have ten moms." Mothers need to be coached about how to participate in school events, how to utilize mechanisms such as parent-teacher conferences, and how their own relationship with the school may change as the child develops.

Providing structured visitation by children before they move in would be ideal; this would allow for an important assessment of bonding, parenting skills, and whether the woman has appropriate controls on her impulses when she is frustrated with the behavior of the child. In addition, the assessment should include the foster parents, Child Protective Services, and significant others, if this is possible. However, often the woman entering treatment does not have any other place or safe place to put her children; this is usually the case for homeless women or women who are leaving an abusive home. Under these circumstances, the program may need to take the children before they can do an adequate assessment. Setting up a group home on an adjacent site is one way for the program to begin work with the children immediately and tailor involvement with the child to meet the needs of each mother-child pair.

When possible, giving the woman at least 30 days alone to adjust to the program before the child comes in appears to work best. Clients and staff prefer having an adjustment period for the mother. Once the child or children enter, there needs to be a period of bonding for mother and child. It can be useful to reduce the mother's participation in groups for one to two weeks when the child enters. This makes it easier to deal with the child's sensitivity to abandonment, which can be intense at this time.

Program structure needs to be fluid to accommodate the situations that arise in these families. For example, babies are born, children may come for a weekend visit and have to stay because of signs of abuse, or custodial grandparents may become seriously ill and children have to move in. All of these events may necessitate changes

in the individual woman's treatment course and/or in the program as a whole.

Food services also become a more complex issue when children are part of a treatment program. Meals have to be regulated; snacks have to be available for the children, for pregnant women, and for sick women and children; and children's nutrition has to be monitored. Nutritional seminars are needed to help the mothers understand why healthy snacks should replace junk food in their children's diets as well as their own. Time spent evolving new and healthier food rituals to replace those learned in childhood increases the chances that nutritional information will be utilized and positive changes will endure.

Evening programs for the women have to be coordinated with children's bedtimes. The program has to decide if the children will go to bed in the children's center/childcare or in their own rooms. This will depend on the configuration and size of the facility, as well as the number of children in residence.

Holidays in a women and children's program must be family centered. Each holiday involves planning for the family, including visits by children who may not be in residence (e.g., those in foster homes). For Easter, there may be an Easter egg hunt for the children and a special Easter brunch for mothers and significant others. At Christmas, Chanukah, and Kwanza time, there is planning for all celebrations and sharing of cultural traditions. In addition, the giving of gifts is handled so that mothers and children all get presents. At PROTOTYPES Women's Center, the women work in the word-processing center making holiday cards for their families, friends, and one another, and work in the kitchen baking holiday cookies and preparing the holiday dinners. The parenting center staff makes Christmas ornaments for each mother; the ornament is a picture of each child that can be hung on a tree.

Evaluation of the program becomes more complex and difficult, since there are now three levels of data collection and analyses: the woman/mother, the children, and the mother-child interaction. Once the program collects the data, it is important to feed back the results to staff on at least an annual basis. At PROTOTYPES Women's Center there are quarterly case management conferences, during which individual client data are presented and integrated. In addition, there is a program evaluation conference where evaluation data on treatment admissions, outcomes, and follow-ups are presented. At this time, staff not only gain more understanding of the information they have been helping to collect, but also have an opportunity to provide additional input into the evaluation process and interpretation of data. In this way, evaluation becomes an integral part of treatment.

## TREATMENT ISSUES

In a program that includes women's children, the women's fear, guilt, and shame about parenting often become a central issue in treatment. Without the children in the program, the women do not have to be confronted daily about their parenting skills. Among other things, mothers need to be assisted in modifying their expectations of simple solutions. Often the women expect immediate success after they attempt a newly learned parenting strategy. They need to understand that it will take time for children to respond to their new behaviors (Pearlman, West & Dalton 1982).

Pregnant women need specialized groups to address special concerns around prenatal care, childbirth, and health issues. These issues become especially complex for women who are HIV-infected. Staff need to address issues of risks to the fetus, AZT protocols, and ongoing health issues for women who are living with HIV or AIDS. PROTOTYPES Women's Center has a specialized HIV/AIDS component within the residential facility for women and their children.

Other issues arise around children who are drug-affected. Fitting these children into the treatment program and addressing their special needs become additional challenges for their mothers and for program staff. Educational lags may be seen and may tend to increase with age. It is important that staff maintain close contact with the school and provide tutors for children who need extra help.

Within the first three months in residence, children usually develop enough trust in the program to exhibit acting-out behavior. As the mother begins to assert herself in the parent role, the child is likely to challenge her and her new behaviors. Children learn that spanking and any physical discipline is not allowed in the facility, and they will test their mothers. Additional support for the mother is important during this time in order to reinforce the new parenting behaviors being learned.

Children may figure out the rules of the program and use them against the mothers. For example, in a traditional TC if there were pieces of paper on the floor, one would give a punishment to the individual who was responsible. In the mother-child model, the child may have thrown the paper on the floor in an attempt to get the mother in trouble. Staff need to assist the mother in understanding this behavior and in learning to set limits with their children in a safe and growth-enhancing manner.

When women are going through emotionally upsetting issues, one may see acting out on the part of the children. Children who are acting out sexually also lead to more upset among the women. Sexuality issues of the children often bring up the mother's own abuse issues. However, it is important for staff to assist mothers in learning about children's normal exploration of sexuality. As discussed by Covington (1991) and CSAT (1993), many women have gone through treatment without the opportunity to address their sexuality and intimacy issues. Specialized groups on sexuality need to include sexual communication styles, dynamics of sex and power, substance

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abuse and sexuality, and sexual functioning. In addition, women who have exchanged sex for money and/or drugs need an opportunity to explore their feelings about these experiences and to explore alternative lifestyles.

Discussions of sexuality for women often will lead to issues of violence in intimate relationships, including incest and domestic violence. PROTOTYPES Women's Center has for many years provided specialized survivor groups for women with histories of incest and/or other sexual abuse, and domestic violence groups are provided for women with histories of physical abuse and/or current spouse abuse problems; individual counseling is also available. In addition to the accurate assessment of any history of violence and addressing issues of abuse during treatment, the program should provide the women with information that can be used if abuse recurs, including information about the use of restraining orders, hotlines, and shelters (CSAT 1993).

Medical issues are an important treatment issue for the women, since many of them have relied on emergency rooms for most of the medical care for themselves and their children. For example, at Project Pride many of the women entering the program feel that the only adequate medical care they can get *must* be in an emergency room or other hospital. Unaccustomed to other settings, they lack confidence in the providers. To address this belief, Project Pride initiated a weekly class taught by the on-site registered nurse about basic health care issues ranging from colds, cholesterol, tuberculosis, and scabies, to broader topics such as how to ask the right questions of your physicians. Helping the women become more aware and educated around medical issues has empowered them and helped them become better advocates for their own and their children's medical needs. Both PROTOTYPES Women's Center and Project Pride provide on-site medical care, but also connect the women with outside providers and teach them how to relate to these health care systems.

Integrating the father, female partner and/or other family members can be an important treatment issue. The program may need to incorporate any significant other who has an ongoing, nonabusive relationship with the child and/or the mother. There are a number of strategies for involving family members and/or partners, including educational seminars on chemical dependency or parenting skills training, family counseling, family visits, and family outings.

## STAFF AND TRAINING ISSUES

One of the most important issues programs for women and children face is whether to have any men on staff. Some programs decide to have only women staff members in order to assist the women in dealing with difficult and sensitive issues, such as incest, rape, and battering. If a program decides to include male staff, it is important to ensure that male staff understand the difficulties of being men in a women's treatment program, and that no male staff are left alone on duty at night. All staff need training on issues of boundaries, sexuality, and abuse. It is also important to have more women than men on staff, in order to expose clients to successful female role models. The female role models should be both line-staff and program administrators.

One of the important issues for TC staff is training on how to confront clients without being abusive. Many of the women in treatment have been physically and sexually abused from childhood into adulthood, and these women may have particular difficulties when confronted. Staff training on these issues can lead to understanding and learning new confrontation skills. While confrontation continues to be an important part of programs for women and children, the "new" confrontation does not include threatening or abusive language. It can focus on how to use careful inquiry to produce insight about the negative consequences of certain behaviors. Many staff who do not have formal professional training have not been exposed to methods of inquiry. Motivational enhancement strategies (Miller et al. 1995; Miller & Rollnick 1991) are one example of such tools. Other training activities include instruction and role-plays on how to confront in a manner that is forthright but supportive.

Childcare staff often do not have experience with substance abuse treatment or TCs. They usually come from other fields (e.g., mental health, early childhood education) and therefore need training to understand addiction and the special needs of these women. This is extremely important in order to ensure that the childcare staff do not reinforce the negative stereotypes of addicted women. Sometimes child workers feel they must be advocates for the child even if this means being against the mother; this may give rise to conflicts between childcare staff and women's counselors. Conversely, counseling staff may not have expertise about children's needs. All staff need to be trained in child development so that they can understand what can be expected from the children and at what age.

Another important training issue is child abuse and discipline. While this appears to be self-evident, it is a topic that often leads to important discussions of the staff members' own histories of parenting and being spanked. This training may need to involve a number of sessions to allow staff to deal with their own attitudes and to learn new skills in dealing with the clients.

Learning to identify countertransference issues, personal sensitivities developed through early experiences with parents and other authority figures, is crucial for staff working with the women and children. Although this is a dimension of all therapeutic interactions, it is particularly magnified in residential treatment because of its increased intensity. Thus it is important for all staff to have a safe arena to examine these issues, with appropriate boundaries for what should be dealt with in the workplace problem-

solving areas, and what should be brought to personal therapy. For all counselors, but especially those with abuse histories, it is important to have a time and place set aside to address these issues. The innocence and vulnerability of the child can make it easier to identify with the child than the mother, and the tendency to view the mother as saint or sinner reflects the larger problems in the culture (Harrison 1991). Quality clinical supervision is necessary to insure an ongoing commitment to maintaining a healthy balance and avoidance of bias toward mother or child in the face of daily exposure to stark, emotion-laden issues.

Both PROTOTYPES Women's Center and Project Pride have staff training on dual diagnosis/co-occurring disorders. Many women may have a mental disorder, cognitive impairment, or a medical problem in addition to substance abuse. Although the program may offer a safe and supportive environment, women with severe mental, cognitive, or physical illnesses may be overwhelmed by the program structure and process (Brown, Huba & Melchior 1995). Training in these areas can help staff adjust program procedures to the specialized needs of these clients.

## CONCLUSION

In summary, residential programs for women and their children constitute a new modality with requirements that can be met only by carefully adapting existing models to address the complexities of treating mothers and children together. Program design must meet the needs of the newly abstinent mother, who is expected to focus on herself and her recovery, as well as the needs of her children. The combination has characteristics beyond the sum of the parts. Everything from spatial configuration to program activities should be guided by a perspective on how to meet the needs of both mother and children. Treatment issues become much more complex when parenting behavior and the needs of the children are an immediate reality. Staff training needs are greater than ever, in an era when resources are declining.

These issues of combined treatment for women and their children are particularly important given the increasing interest in these models by both criminal justice and social services systems. These residential programs provide an opportunity to apply the knowledge gained through funding set aside since the 1970s to investigate women's special needs (Brown 1995). It is hoped that this opportunity to demonstrate and evaluate new models will endure through the current transformation of the health care delivery system, as it will not be easily restored if abandoned prematurely.

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# FAX

**FROM THE DESK OF**
**MICHAEL HARLE**

**PRESIDENT/EXECUTIVE DIRECTOR**
**Gaudenzia, Inc.**
**106 West Main Street**
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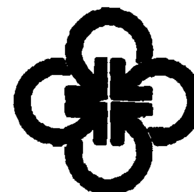

**Fax To:** Fiona Wilmarth, Analyst

**Fax:** (717) 783-2664

**From:** Mike Harle

**Date:** 10/18/01

**Re:** Gaudenzia Response to Proposed Physical Plant Standards

**Pages:** 14 (including cover)

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Coming under separate transmission is eight page research article relating to the use of dormitories in women and children's programs as referenced in our analysis of the regulations.

ADDICTION RECOVERY CENTER

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Original: 2075

September 17, 2001

Independent Regulatory Review Commission
333 Market Street
Harrisburg, PA 17101

Attn: Fiona Wilmarth

I am writing to provide comment on the final form regulations submitted by the Department of Health, amending the physical plant standards for drug and alcohol facilities (Title 28, Health and Safety; Part V. Drug and Alcohol Facilities and Services; 28 PA Code CHS 701, 705, 709, 711, and 713.

First, my overriding concern is the passage of additional regulations when providers are screaming for regulatory relief. At a time when providers are being pushed to provide services of a higher quality at a lower cost, why would the Department of Health put forward additional regulations that will likely increase costs? Unless there has been increase in the number of unusual incidents relating to the physical plant, the timing of these regulations is inappropriate.

Second, I am concerned about the cost of complying with some of these regulations. For many providers, the cost of compliance may actually drive them out of business. This will cause a loss in the number of beds available for drug and alcohol clients. This could happen when our state is facing a huge increase in the demand for residential services because of the insurgence of heroin and other opiates. Again, the timing of imposing these regulations is poor. If these additional regulations are passed, would funds be available to assist providers in their efforts to comply? For example, if capital projects needed done, would special assistance be available?

I am concerned about the square footage requirements for bedrooms. The impact of the requirement may lead to the reduction of beds available for treatment. Since the average length of stay have decreased to less than 28 days and bedrooms are used for sleeping only and clients are encouraged to spend time in the therapeutic community, perhaps these requirements are a bit excessive.

The proposed requirement for each bedroom to have at least one window is of concern as well. Some buildings may have been constructed with the bedrooms on the interior. To get the building in compliance would require major renovations. Again, this adds costs. In the instance of our facility, some of the bedrooms are on the outer walls, yet do not have a window. Because of the brick and block structure, I am not sure the building can be renovated to insure a window in every bedroom. The investigation into this matter alone is time consuming and costly. The fact that every room does not have a window does not effect the quality of the treatment, nor is it a safety hazard. It seems it's more of an aesthetic issue. Some of our clients over the years have actually preferred a room without a window.

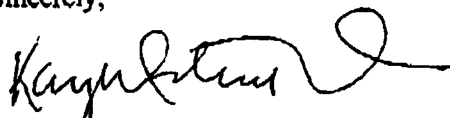
The requirement to have a fire drill in residential facilities every month is excessive. Has any negative thing happened because of the current regulation that fire drills be done every other month? If not, then maintain it as it is. The requirement to have a fire drill every month in a nonresidential facility is very excessive. It is also disruptive to the operation of the programs and would interfere with treatment.

I am concerned with the requirement to install automatic fire alarm systems in residential facilities. These are very costly. Again, where will providers obtain the funds? Using smoke detectors is an adequate alternative.

Lastly, I am concerned with the process of passing these regulations. The last time I heard anything about these was January 25, 2000. The last time I knew they were published in the PA Bulletin was November 13, 1999. These seemed to come out of the woodwork in a very quick manner. This does not allow the provider community much time to comment on these. Did I miss something in the process of publishing these?

Thank you for hearing my concerns.

Sincerely,



Kay Detrick Owen
Executive Director

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From: Kay Ditrick Owen

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# Mid-Atlantic Association of Alcohol & Drug Continuing Care Facilities

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October 22, 2001

John R. McGinley, Jr. Esq., Chairman
Independent Regulatory Commission
333 Market Street 14th Floor
Harrisburg, Pennsylvania 17101

Dear Mr. McGinley,

As the president of the Mid-Atlantic Association of Alcohol and Drug Continuing Care Facilities, I am writing at the request of our membership in support of the Pennsylvania Halfway House Association's comments regarding the proposed physical plant standards for drug and alcohol facilities. Our membership is comprised of licensed halfway house programs from Delaware, Maryland, New Jersey and Pennsylvania.

Our membership's response to the proposed square footage requirement echoes the concerns addressed by Kim Bowman of Chester County in her September 14th letter to the Commission.

However, we would like to re-emphasize that an important facet of the halfway house treatment experience is the environment. Halfway houses are typically operated in a home like environment and located in a residential community. Every effort is made on the part of the program to meet the many architectural and safety needs of the program while keeping the exterior of building looking like just another well kept home in the neighborhood.

The square footage requirement as proposed would force many Pennsylvania halfway houses to either reduce their service capacities or expand their facilities in ways that would change the living environment from home-like to an institution. Neither of these choices would benefit the men and women who need the halfway house program to break the bondage of their addictions. Obviously a reduction in beds would deny some the opportunity of halfway house treatment. Additionally, having halfway house programs operated in buildings that are institutions rather than homes is both less therapeutic and continues the stigma attached to the disease of addiction.

We thank the Commission for taking our comments into consideration as it weighs the positive and negative impact of the square footage requirement on the existing alcohol and drug treatment system in Pennsylvania. We respectfully request that the Commission consider, at a minimum, a grand father clause for the existing licensed halfway house programs.

Sincerely,

Mary L. Malloch, President
MAAADCCF

Enclosure: MAAADCCF Brochure

**ANKH, INC.**
P. O. Box 644
Georgetown, Delaware 19947

# FAX COVER SHEET

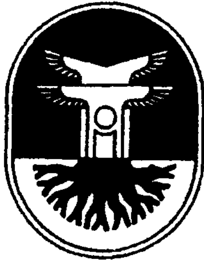
| | | | |
|---|---|---|---|
| **DATE:** | October 24, 2001 | **TIME:** | 11:33 AM |
| **TO:** | John R. McGinley, Jr., Esq. | **PHONE:** | |
| | Chairman, | **FAX:** | 717-783-2664 |
| | Independent Regulatory Review Commission | | |
| **FROM:** | Mary Malloch | **PHONE:** | 302-855-9622 |
| | President, MAAADCCF | **FAX:** | 302-855-9622 |

**RE:** Comments regarding D&A Physical Plant Standards

Hard copy by US Mail.

Number of pages including cover sheet: 2

2001 OCT 24 AM 11:39
REVIEW COMMISSION



# Treatment Trends, Inc.

*18-22 S. SIXTH STREET P.O. BOX 685 ALLENTOWN, PA 18105*

*• Confront • Keenan House*
*• Forensic Treatment Services • Richard S. Csandl Recovery House*

Fiona Wilmarth, Analyst
Independent Regulatory Review Commission (IRRC)
14th Floor, Harristown 2
Harrisburg, PA 17101

October 3, 2001

Original: 2075

Dear Ms. Wilmarth:

I am writing, once again, in response to the physical plant standards (Part V. Drug and Alcohol Facilities and Services) proposed by the Department of Health for the licensure of residential and non-residential drug and alcohol services. The proposed changes that I find most damaging to existing facilities are those discussed in Section 705.5 (b) and (c) Sleeping accommodations:

(b) "When bunk beds are used, each bedroom shall have at least 50 square feet of floor space per resident measured wall to wall; and
(c) No more than four residents shall share a bedroom."

There are several reasons for my writing again, so soon after my letter dated September 12, 2001. First, a survey is being performed by BDAP which may, or may not, demonstrate the impact of these new regulations. My understanding is that if only a few agencies are affected by reducing bed capacity, grandfathering those agencies will not be permitted. Those agencies can either renovate, if their physical locations and/or zoning regulations will allow it, or suffer huge decreases in bed capacity. It doesn't seem to matter that those agencies are community based agencies, such as Gaudenzia, Inc., Treatment Trends, Inc. and others, many of which have been providing services to their respective communities for decades. It also doesn't seem to matter that those agencies have fought for years to increase their treatment capacity in order to meet their communities' needs. Now they are being forced to eliminate beds, which will drastically reduce both treatment and support services offered.

Another concern is that of community safety. If, for instance, bed capacity is reduced at Keenan House, the residential component of Treatment Trends, clients will not be able to access treatment. A chronically addicted individual cannot wait to get treatment. They will inevitably continue their addiction, continue their illegal means of supporting their addiction and potentially end up back in prison, or possibly die. Clients in treatment commit very few crimes, do not tax the court system further, and ultimately save tax dollars and prison days.

Keenan House, under these new regulations could potentially lose beds in two ways. First, under the square footage regulation, Keenan House would lose approximately 17 beds. When annualized, that amounts to 6,205 bed days. Secondly, if the four-clients-to-a-bedroom regulation were enacted, Keenan House would lose approximately 44 beds, over half of our current bed capacity. At $95.00 per day, the lost income alone would be approximately $1.5 million dollars. Lost revenue results in

*•Tel 610-439-8479 • Fax 610-439-0315 • E-mail txtrends@fast.net*

fewer counseling and support staff in a field which is already under funded and under staffed. Loss of revenue hinders an agency's ability to attract and maintain credentialed staff, which are required by managed care, and which are increasingly difficult to find.

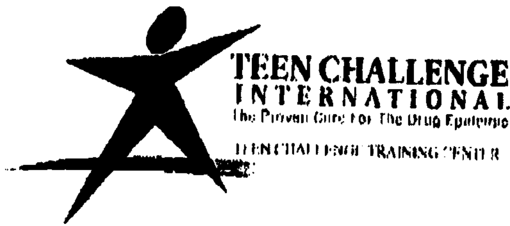
Treatment Trends, Inc. provides its clients with much more than basic drug and alcohol treatment. As appropriate, clients receive GED/ ABE classes, Vocational Education and Job Readiness Training (and an employment rate of 95% for those completing treatment who are eligible to work), specialty groups addressing criminality and violence, educational grants, and much more. These activities require both staff and money. They also mean that clients are not lavished with hours of "play time". The dormitory style bedrooms at Keenan House are not crowded, but modern, comfortable, well-lighted and well-furnished rooms. Clients, after a full day of activities (beginning at 7:00 AM and finishing about 11:00PM), basically use their bedrooms to sleep. They are provided with computers, lounges, a beautiful dining area and recreational activities outside of their bedrooms, which occupy much of their limited free time.

The expense of renovating an existing facility can be overwhelming, as well. For example, Treatment Trends, Inc. renovated four floors of Keenan House over the past four years at a cost of approximately $500,000. The dining area, shower rooms, lounges, bedrooms and offices were modernized to better utilize existent space. In order to provide comfortable and non-institutional facilities, lighting, heating and air-conditioning, and furnishings were improved. During these renovations, we seized the opportunity to help meet the community's increasing treatment needs by increasing our bed capacity from 70 to 85 beds. Lehigh County, for example, received a grant in 1997 from the Pennsylvania Commission on Crime and Delinquency, which added $873,000 for treatment and supervision. Keenan House, which provides the residential drug and alcohol treatment services for that program (TCAP), needed to increase it capacity to meet the demand.

In closing, I would ask minimally that existing programs be granted grandfather status. If that is not possible, I would suggest relaxing the standards by removing the limit of four clients per bedroom and lowering the square footage per client required. These standards exemplify bureaucratic over-regulation that will severely damage treatment capacity and financially burden existing treatment facilities. I would like to thank you for considering my requests and for doing what is best for the treatment field and the clients it serves.

Sincerely,

Theodore Alex, MPA
Associate Director
Treatment Trends, Inc.




Original: 2075

October 19, 2001

2001 OCT 22 AM 9:46

To Whom it may concern:

In a letter faxed to your attention dated September 10, 2001, I addressed the adverse impact that section 705.5 Sleeping Accommodations, subsection (b) concerning square footage per client will have upon Teen Challenge Training Center, Inc. and its related induction centers.

I have received a copy of recent calculations that the Department of Health has produced to suggest that the proposed regulations would result in minimal loss of beds in residential facilities statewide.

I do not know what source the Department drew their information from for their Current Census and Estimated Bed Loss statistics. I do know that there is a mistake or misinformation presented for Teen Challenge Training Center for the 'census last survey' column.

At our most recent inspection by BDAP in May of this year, our census was 66, not 60. The average of the four quarterly census figures for the past twelve months, which I reported to the representative of the Department making the telephone survey, was 74, not 60. Our monthly average census of D&A clients over the past five years has been 70, not 60. The point to be made is that if the new regulation capacity goes into effect, it is more accurate to conclude that Teen Challenge will be forced to accommodate 7 to 11 (10-15%) fewer clients per month.

The Teen Challenge Induction Center referred to on this chart has an ongoing waiting list requiring potential applicants to wait 2-3 weeks for an open bed. The 'census last survey' figure of 11 is very misleading. The capacity for the past year was 16; the Department only approved the figure of 20 since their last inspection in May. While the figure of 11 may have been accurate for the day they made a census survey, the facility is always at capacity as soon as perspective clients can be processed.

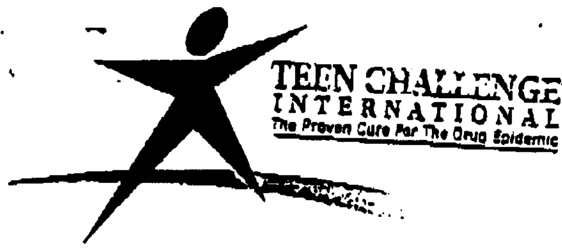
As was stated before, among the three Teen Challenge facilities referred to previously, the proposed legislation will have a combined result in a minimum of a 25% reduction of beds available to clients. We would request that the legislative committee members press the Department to "grandfather" existing programs with respect to the proposed standards, lower the square footage requirement to 45 sq. ft. per client, or reject the Departments legislative proposal completely.

Sincerely,

Richard Weitzel,
Student Services Director

cc: Deb Beck; Sandra Bennett; Melanie Brown; Sen. Vincent Hughes; H. Scott Johnson; Sen. Harold Mowery; Rep. Dennis O'Brien; Rep. Frank Oliver; Niles Schore; Fiona Wilmarth.

33 Teen Challenge Road • PO Box 98 • Rehrersburg, PA 19550
(717) 933-4181 • Fax (717) 933-5919 • Email: mail@teenchallengetc.com
Website: http://www.teenchallenge.com/rehrersburg




Teen Challenge Training Center
PO Box 98, Rehrersburg, PA 19550
717.933.4181 fax: 717.933.5919

Pages, Including this one: 2

Date: 10/22/01

To: FIONA WILMARTH Dept. IRRC

From: RICHARD WETZEL Co./ Dept.: Dir. Student Serv. TCTC

Fax Number: (717) 783-2664

Re:

MEMO:

Confidentiality Notice: This facsimile message contains confidential information which may also be legally privileged and which is intended solely for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, or distribution, or the taking of action based on the contents of this facsimile information is strictly prohibited. If you have received this fax in error or it is not complete, please notify us at once by telephone @ 717.933.4181. Thank you.

# THE COUNTY OF CHESTER

COMMISSIONERS:
Colin A. Hanna, Chairman
Karen L. Martynick
Andrew E. Dinniman

KIM P. BOWMAN, M.S.
Executive Director

DEPARTMENT OF DRUG AND ALCOHOL SERVICES
Government Services Center, Suite 325
601 Westtown Road
P.O. Box 2747
West Chester, PA 19380-0990
ADMINISTRATION:
Phone: 610-344-6620 Fax: 610-344-5743
CASE MANAGEMENT:
Phone: 610-344-5630 Fax: 610-344-5436

Original: 2075
September 14, 2001

Fiona Wilmarth
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Ms. Wilmarth:

I am writing to provide comment on the final form regulations submitted by the Department of Health, amending the physical plant standards for drug and alcohol facilities (Title 28, Health & Safety; Part V. Drug and Alcohol Facilities and Services; 28 PA Code CHS 701, 705,709,711, and 713).

**Loss of Treatment Beds**

Regarding the residential requirements, the regulations as submitted still include provisions that cause considerable alarm. Despite these concerns being raised in the initial comment period there is no evidence that a substantive analysis of the impact these regulations would have on the availability of treatment has occurred. Of primary concern is that these regulations will result in the loss of treatment beds. In Chester County alone we will lose a minimum of 12 beds and as many as 26 beds. This represents losses in 3 of 5 programs we have in the County. Of these, at least 6 and as many as 20 are women's beds in the women with children's programs. It is hard to imagine that similar scenarios would not be repeated in other programs in the Commonwealth.

Unfortunately the Department's response to the comments indicate a lack of understanding of this impact. In response to concerns raised about the square footage requirement, the response inaccurately indicates that "This regulation will not affect programs with women and children." The impact in just one of our women with children's program is a loss of 4 women's beds or 33% of their total capacity. This would in turn increase their per diem rate by $70. Although the per diem increase concern was raised in the initial comment period there is no response to it by the Department.

**Financial Impact**

The loss of beds also results in the loss of additional treatment slots due to increased costs. The county contracted per diem rates are based on the total costs of

the program divided by the available beds. This provides the program with a break-even rate. If the number of available beds decreases, the costs for the remaining beds increase. As a result we treat less people for the same amount of money.

Based on a loss of only 12 beds, there will be a $625,000 increase to treat the same number of clients. **This $625,000 translates into 144 clients that would not receive treatment based on our average cost per client for rehab**.

An additional ripple effect is the probable loss of entire programs. As previously stated, the program's rate is based on the actual expenses of the program and allows them to break even. While a reduction in beds would increase the program's rate, our experience has been that our publicly-funded treatment program does not receive a per diem rate increase in their HealthChoices contracts as their program costs go up. This is already causing problems for the programs. Increasing their costs due to a loss of beds would result in their not being able to cover their expenses; making it difficult, if not impossible, to keep the program open.

**Is There a Need to Change?**

The Department indicates that these regulations are being promulgated in response to health and safety concerns; however, they do not provide any detail regarding the number of adverse incidents that have occurred. These regulations will result in a loss of treatment beds. Given the damage that we know occurs to individuals, families, and communities when addiction is untreated, it seems essential that any reduction in capacity is well researched and the need clearly substantiated with data.

The response to the comments by the Department regarding square footage state that to require less would be "detrimental to the treatment and rehabilitation process". There is, however, no reference to what research this statement is based on. In drug and alcohol treatment the time spent in one's bedroom, besides the hours one is sleeping, is minimal by design. The residential drug and alcohol treatment community itself is a large part of the therapy. The client's interaction within the community is emphasized and client's spending large amounts of time isolated in their bedrooms would be counterproductive.

The response also indicates an attempt to make these regulations consistent with those of other Departments. While I embrace the need for consistency in regulation when appropriate, it should not be done purely for consistency at the expense of clinical appropriateness and system stability. Additionally, it is usually only logical when you are looking at like programs. Residential drug treatment programs are not similar to residential programs in other systems. First and foremost, they are treatment programs, not housing programs, which is a significant difference. Additionally, residents in drug and alcohol treatment are transient, as compared to those who may be in residential housing programs in other systems. In the drug and alcohol system, long-term treatment is by and large only 3-6 months and most residential treatment programs are actually 30 days or less.

**Other Concerns**

In addition to the square footage requirement, I am also concerned about the kitchen requirement [705.7 (1)]. Many programs with individual DOH facility numbers

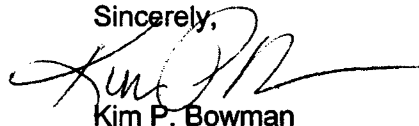
are parts of larger buildings or campuses. In these cases a central kitchen is used for all food preparation. How will this regulation be interpreted? If the kitchen must be in the licensed facility a second women with children's program in Chester County would be affected. They are part of a larger campus that has a central kitchen. If the facility itself were required to have a kitchen, we would lose 17 women's beds as well as those for their accompanying children.

The regulations further require that facilities serving children provide access to outdoor recreational space and equipment. We are concerned with the interpretation of these regulations for programs in urban settings. We have a women with children's program in an urban setting that does not have ground space on the property, but does have several parks within walking distance that are used for outdoor recreation. We are concerned that this regulation be clarified to determine if access does not mean on-site.

Regarding the non-residential fire drill requirements I am concerned about the increased frequency required. The frequency of outpatient client attendance typically is one visit per week or every two weeks. Therefore, most clients will not benefit from a drill; it is really the staff knowledge and practice that is essential. While most clients would not benefit from the drill those that participate have their treatment significantly disrupted. If the client were only at the clinic for an hour they would benefit little from a session that is interrupted by a fire drill. Additionally, with each fire drill clients have to evacuate into areas that are often very public which impacts on their privacy and confidentiality. This is particularly true when treatment offices are in larger office buildings/parks.

Finally, I would like to express my appreciation to the IRRC for notifying me of the filing of these regulations. Had I not been notified by the IRRC, I would not have been aware that the final form regulations had been submitted, given the time that has passed since I commented on the proposed regulations (1999).

Sincerely,



Kim P. Bowman

KPBbew

Cc: Niles Schore, Executive Director
Deb Beck, DASPOP
John Hair, Dept. of Health

Thomas Jefferson University | Jefferson Medical College

Department of Pediatrics
Maternal Addiction Treatment Education & Research

1201 Chestnut Street
9th Floor
Philadelphia, PA 19107
215-955-1951
Fax: 215-568-6414

Original: 2075

October 1, 2001

Independent Regulatory Review Commission
333 Market Street
Harrisburg, PA 17101

Attention: Mr. McGinley, Chairman

Dear Mr. McGinley:

I am writing to provide our comments and concerns on the final form regulations submitted by the Department of Health, amending the physical plant standards for drug and alcohol facilities (Title 28, Health & Safety: Part V. Drug and Alcohol Facilities and Services; 28 PA Code CHS 701, 705, 709, 711, and 713).

**Fire Safety – 705.10(c)(4) – Residential Facilities**

***The instruction of all staff and residents in the use of the fire extinguishers upon resident admission or staff employment. This instruction shall be documented by the residential facility.***

Upon employment, all staff are currently trained in the proper use of fire extinguishers, pull station and smoke detector locations, evacuation procedures, and the proper use of the fire alarm system. All patients in our residential program are required to know where all pull stations and fire exits are located within the building. Additionally, the program is equipped with an Ansul System for the kitchen, smoke detections, and a sprinkler system for the entire building. These systems were installed to provide the utmost protection for clients, their children, and staff.

This new standard may seriously jeopardize the safety and lives of our clients and their children by assuming clients should take it upon themselves to extinguish a fire rather than pulling the alarm and exiting the building quickly. This assumption is dangerous and life threatening. Our program has developed a sophisticated evacuation plan for the patients and their children. Our children range in age from 0 to 6 years. The best practice protocol is to have the families evacuate the facility immediately. Our internal policy and procedures as well as the Thomas Jefferson University Hospital Policy and Procedure, which incorporate JCAHO regulations, do not expect the client/patient to take responsibility to extinguish a fire in the building which requires presence of mind and rational thinking. The protocol is to evacuate the clients/patients to safety first. The first step in RACE (rescue; alarm; confinement; extinguish/evacuate). Hence, this standard is placing the entire residential community of women, infants, and children at high risk for asphyxiation from toxic fumes or smoke and possible death, since a fire can rage out of control very quickly and without warning.

Thomas Jefferson University | Jefferson Medical College

Department of Pediatrics
Maternal Addiction Treatment Education & Research

1201 Chestnut Street
9th Floor
Philadelphia, PA 19107

215-955-1951
Fax: 215-568-6414

**Fire Safety – 705.10(d)(4)**

***Fire drills.***

We concur with the minimum number of fire drills. However, the requirement for a 6-month fire drill to be held during ***sleeping hours*** may not be conducive for women, infants, and children. A determination of what hours fall within ***sleeping hours*** would be useful in terms of meeting this standard, and concern for sick infants and children must be considered when determining ***sleeping hours.*** It seems reasonable to consider 6:00 AM, rather than 3:00 AM, a better time for a fire drill to be scheduled since mothers and their children will be in their rooms at that time and sick children will not be placed in unnecessary risk of further illness.

**Fire Safety – 705.28 (a)(1) (ii) – Non-Residential Facilities**

***Maintain a minimum of two exits on every floor, including the basement, that are separated by a distance of 15 feet.***

This standard is workable for buildings that are converted private residences. However, this is an unattainable standard for programs located in downtown office buildings. Although our Outpatient program, which is located in a city office building, is in compliance with the City of Philadelphia Department of Licenses and Inspection, we cannot and will never meet this standard. An exception needs to be written into the standards for this type of situation.

I would like to extend my appreciation to you for reviewing the above recommendations. I am confident that our concerns and alternative recommendations will be carefully considered before the final standards are implemented.

Very truly yours,

Kate Vandegrift, M.A., C.A.C.
Program Director

Xc: Dr. Karol Kaltenbach – Director MATER- Thomas Jefferson University
Richard Sandusky – Lead Analyst
Fiona Wilmarth

[Click here and type address]

# facsimile transmittal

To: IRRC- Mr McGinley Fax: 717-783-2664

From: Kate Vandegrift, Program Director
Family Center – Thomas Jefferson University

Date:

Re:

Pages: (3) including cover

Fax # 215-568-6414

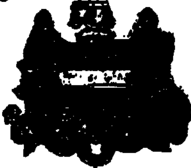
Phone # 215- 955-1954

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments:

CONFIDENTIAL

Original: 2075



DISTRICT ATTORNEY'S OFFICE
1421 ARCH STREET
PHILADELPHIA, PENNSYLVANIA 19102
686-8000

LYNNE ABRAHAM
DISTRICT ATTORNEY

Ms. Fiona Wilmarth, Analyst
IRRC
Fax 717-763-2664

October 18, 2001

Dear Ms. Wilmarth,

I am writing to you to urge rejection of the Department of Health's proposed regulations regarding physical plant standards for alcohol and drug treatment facilities (Title 28, Health and Safety; part V, drug and alcohol facilities and services, 28 PA code, chs. 701, 705, 709, 711, and 713).

Although we certainly understand the Department's need to develop standards, the sections on square footage in the bedroom areas are unduly restrictive. In fact, the loss of residential bed space that will occur under these proposed regulations will greatly impair efforts to address the alcohol and drug problem in the city. These proposed changes will be particularly devastating for addicted mothers with children, who already find it extremely difficult to obtain suitable residential treatment.

Without increased availability of residential addiction treatment services, the District Attorney's function of protecting the public and preventing crime is severely hampered

Ensuring the availability of addiction treatment services before the individual gets involved in the downward spiral of crime is a critical part of our crime prevention strategy. In addition, if the individual is already involved in crime as part of the addictive process, how can we hope to have any long-term impact without widespread access to treatment as part of sentencing?

Philadelphia simply cannot afford to lose the 100 residential treatment beds projected by the City Coordinating Office for Drug and Alcohol Abuse programs (See attached).

We urge your opposition to the proposed regulations.

Sincerely,

Lynne Abraham
District Attorney

Attachment

# CITY OF PHILADELPHIA

BEHAVIORAL HEALTH SYSTEM/
MENTAL RETARDATION SERVICES
[illegible]
[illegible]

COORDINATING OFFICE FOR
DRUG AND ALCOHOL ABUSE PROGRAMS
1101 Market Street, Suite [illegible]
Philadelphia, PA 19107-[illegible]
[illegible]
Executive Director

October 3, 2001

Independent Regulatory Review Commission
333 Market St.
Harrisburg, PA 17101

Dear Chairman McGinley,

Thank you for this opportunity to address a number of significant issues impacting the final form of these proposed regulations submitted by the Department of Health affecting physical plant standards for drug and alcohol treatment facilities (Title 28 Health and Safety, Part V Drug and Alcohol Facilities and Services, 28 PA code CH§701, 705, 709, 711 and 713).

The Coordinating Office for Drug and Alcohol Abuse Programs serves as the Single County Authority (SCA) for the county/city of Philadelphia and as such is responsible for maintaining an appropriate spectrum of treatment services for those citizens who have initiated a course of treatment for their problem. Given the number of persons in Philadelphia who are addicted, the possibility of losing treatment opportunities particularly those which provide residential care, is of great concern to our office. Residential treatment provides the most appropriate intervention for those persons whose addiction had become critical and in many cases life threatening. It also provides opportunities for many in the criminal justice system whose long term abuse has precluded their successful return to society and whose issues and deficits can best be addressed within a residential setting.

After contacting those programs locally and in the surrounding counties which serve a predominantly Philadelphia population, it was established that while not all facilities would be negatively impacted, enough would, resulting in a serious reduction in the number of slots available for residential treatment. The reduction in slots would impact the ability of the programs to earn projected revenue, which in turn would result in whole programs having to close. Calculations as to the number of treatment slots compromised by the institution of the proposed regulations, while not exact, project a loss of over 100 slots at a cost to programs approaching 2 million dollars. It would appear then, that the acquisition of possibly 2 to 3 additional square feet of sleeping room space, which is space only used for sleeping when most of the clients time is spent in

Page Two
Chairman McGinley

other therapeutic activities, is too high a price to pay when compared to the cost of lost services and recovery opportunities.

I urge you and the members of the Commission to carefully weigh the overall negative impact of promulgating these regulations in comparison to the supposedly improved quality of life and effect such small increases in actual living space would have on the treatment experiences of our client populations. For persons working incredibly hard in dealing with one of life's most intransigent diseases, such a loss in treatment opportunities should not be entertained.

Again, thank you for this opportunity to inform you of our concerns and their impact on our community of treatment programs.

Sincerely,

Mark R. Bencivengo
Executive Director

MRB/enb

Cc: Tim Wilson – Executive Director, Philadelphia Alliance
William Thompson – Deputy Director, CODAAP

H:[illegible]

LYNNE ABRAHAM
DISTRICT ATTORNEY

**DISTRICT ATTORNEY'S OFFICE**
**1421 ARCH STREET**
**PHILADELPHIA, PENNSYLVANIA 19102**
**686-8000**

**FACSIMILE TRANSMISSION COVER SHEET**

TRANSMITTED TO:

Tiona Wilmarth
(NAME, TITLE)

(ORGANIZATION)

(ADDRESS)

717-783-2664
(FAX NUMBER)

**TRANSMITTED FROM:**

**GARY TENNIS**
**CHIEF OF LEGISLATION**
**(215) 686-5873**
**(215) 686-9937 FAX**

**NUMBER OF PAGES TO FOLLOW:** 3

CONTENTS/COMMENTS:

Re. Treatment Facility
Physical Plant
Standards

If the correct number of pages did not transmit, please contact the above listed sender.

Original: 2075

# Mid-Atlantic Association of Alcohol & Drug Continuing Care Facilities

REVIEW COMMISSION
2001 OCT 29 AM 8:55

2001 Membership

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Georgetown
Limen House
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Dover

**Maryland**
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Gale House
Frederick
Olson House
Frederick
Quarterway Houses, Inc.
Baltimore
S.A.F.E. House
Baltimore
Samaritan House
Annapolis
"W" House
Hagerstown

**Pennsylvania**
Cove Forge Renewal Center
Cresson
Gate House-Men
Lititz
Gate House-Women
Mountville
Good Friends
Morrisville
Libertae, Inc.
Bensalem

**New Jersey**
Anderson House
White House Station
Crawford House
Skillman
Endeavor House, Inc.
Keyport
Mrs. Wilson's
Morristown

October 22, 2001

John R. McGinley, Jr. Esq., Chairman
Independent Regulatory Commission
333 Market Street 14th Floor
Harrisburg, Pennsylvania 17101

Dear Mr. McGinley,

As the president of the Mid-Atlantic Association of Alcohol and Drug Continuing Care Facilities, I am writing at the request of our membership in support of the Pennsylvania Halfway House Association's comments regarding the proposed physical plant standards for drug and alcohol facilities. Our membership is comprised of licensed halfway house programs from Delaware, Maryland, New Jersey and Pennsylvania.

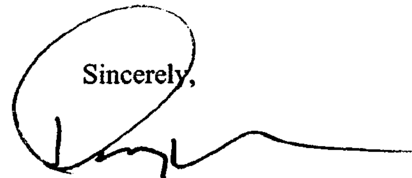
Our membership's response to the proposed square footage requirement echoes the concerns addressed by Kim Bowman of Chester County in her September 14th letter to the Commission.

However, we would like to re-emphasize that an important facet of the halfway house treatment experience is the environment. Halfway houses are typically operated in a home like environment and located in a residential community. Every effort is made on the part of the program to meet the many architectural and safety needs of the program while keeping the exterior of building looking like just another well kept home in the neighborhood.

The square footage requirement as proposed would force many Pennsylvania halfway houses to either reduce their service capacities or expand their facilities in ways that would change the living environment from home-like to an institution. Neither of these choices would benefit the men and women who need the halfway house program to break the bondage of their addictions. Obviously a reduction in beds would deny some the opportunity of halfway house treatment. Additionally, having halfway house programs operated in buildings that are institutions rather than homes is both less therapeutic and continues the stigma attached to the disease of addiction.

We thank the Commission for taking our comments into consideration as it weighs the positive and negative impact of the square footage requirement on the existing alcohol and drug treatment system in Pennsylvania. We respectfully request that the Commission consider, at a minimum, a grand father clause for the existing licensed halfway house programs.

Sincerely,



Mary L. Malloch, President
MAAADCCF

Enclosure: MAAADCCF Brochure

Continuing care facilities are intended to provide a program of re-socialization or socialization which includes some of the protective and supportive elements of family living while encouraging and providing opportunities for independent growth and responsible community living. Some components of these homes are mutual self-help, relapse prevention, direction toward economic self-sufficiency, family reunification and the integration of life skills within a solid program of recovery.

*Mid Atlantic Assoc.* Of A & D C. C. F.

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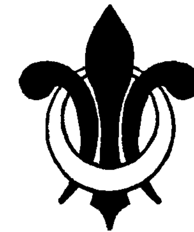
# MID ATLANTIC



ASSOCIATION
OF
ALCOHOL & DRUG
CONTINUING CARE
FACILITIES

Continuing care facilities are intended to provide a program of re-socialization or socialization which includes some of the protective and supportive elements of family living while encouraging and providing opportunities for independent growth and responsible community living. Some components of these homes are mutual self-help, relapse prevention, direction toward economic self-sufficiency, family reunification and the integration of life skills within a solid program of recovery.

Mid Atlantic Assoc. Of A & D C. C. F.

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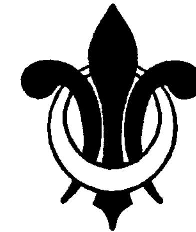
REVIEW COMMISSION

# MID ATLANTIC



## ASSOCIATION OF ALCOHOL & DRUG CONTINUING CARE FACILITIES

Original: 2075

# Mid-Atlantic Association of Alcohol & Drug Continuing Care Facilities

2001 OCT 29 AM 8:55
REVIEW COMMISSION

2001 Membership

**Delaware**
ANKH, Inc.
Georgetown
Limen House
Wilmington
Serenity Place
Dover

**Maryland**
Damascus House
Baltimore
Friendship House
Baltimore
Gale House
Frederick
Olson House
Frederick
Quarterway Houses, Inc.
Baltimore
S.A.F.E. House
Baltimore
Samaritan House
Annapolis
"W" House
Hagerstown

**Pennsylvania**
Cove Forge Renewal Center
Cresson
Gate House-Men
Lititz
Gate House-Women
Mountville
Good Friends
Morrisville
Libertae, Inc.
Bensalem

**New Jersey**
Anderson House
White House Station
Crawford House
Skillman
Endeavor House, Inc.
Keyport
Mrs. Wilson's
Morristown

October 22, 2001

John R. McGinley, Jr. Esq., Chairman
Independent Regulatory Commission
333 Market Street 14th Floor
Harrisburg, Pennsylvania 17101

Dear Mr. McGinley,

As the president of the Mid-Atlantic Association of Alcohol and Drug Continuing Care Facilities, I am writing at the request of our membership in support of the Pennsylvania Halfway House Association's comments regarding the proposed physical plant standards for drug and alcohol facilities. Our membership is comprised of licensed halfway house programs from Delaware, Maryland, New Jersey and Pennsylvania.

Our membership's response to the proposed square footage requirement echoes the concerns addressed by Kim Bowman of Chester County in her September 14th letter to the Commission.

However, we would like to re-emphasize that an important facet of the halfway house treatment experience is the environment. Halfway houses are typically operated in a home like environment and located in a residential community. Every effort is made on the part of the program to meet the many architectural and safety needs of the program while keeping the exterior of building looking like just another well kept home in the neighborhood.

The square footage requirement as proposed would force many Pennsylvania halfway houses to either reduce their service capacities or expand their facilities in ways that would change the living environment from home-like to an institution. Neither of these choices would benefit the men and women who need the halfway house program to break the bondage of their addictions. Obviously a reduction in beds would deny some the opportunity of halfway house treatment. Additionally, having halfway house programs operated in buildings that are institutions rather than homes is both less therapeutic and continues the stigma attached to the disease of addiction.

We thank the Commission for taking our comments into consideration as it weighs the positive and negative impact of the square footage requirement on the existing alcohol and drug treatment system in Pennsylvania. We respectfully request that the Commission consider, at a minimum, a grand father clause for the existing licensed halfway house programs.

Sincerely,

Mary L. Malloch, President
MAAADCCF

Enclosure: MAAADCCF Brochure

Original: 2075

# The Philadelphia Alliance

*Representing Community Providers for People with Mental Health, Mental Retardation and Chemical Dependency Needs.*

4343 Kelly Drive, 2nd Floor, Suite 1, Philadelphia, PA 19129 Tel 215.438.6400. Fax 215.438.6600

**FAX TRANSMISSION**

**Please deliver to the person(s) named below from your agency.**

**Date:** October 19, 2001 **Page** 1 **of** 4

| | | |
|---|---|---|
| **TO:** | **Chairman John McGinley** | **Independent Regulatory Review Commission** |
| | **Mr. Rich Sandusky** | " " " " |
| | **Ms. Fiona Wilmarth** | " " " " |

**FROM:** **Tim Wilson, Executive Director**

## Message:

Attached is a letter from me regarding the Physical Plant regulations fro D & A facilities put forward by the Department of Health. This same letter has been sent to the Chairpersons and Executive Directors of the standing legislative committees, the PA Senate Public Health & Welfare Committee and the PA House Health & Human Services Committee, and it will be sent to John Hair of the Department of Health. I will send you an original as well in addition to the email version that I sent to Jim Smith. I very much appreciate your consideration of this matter. We feel very strongly that these regulations, as they are currently composed, must not be approved. They will do terrible damage to a system in need of expansion, not destruction. Please call me if you have any questions or issues to discuss further. **Thank You.**

# The Philadelphia Alliance

*Representing Community Providers for People with Mental Health, Mental Retardation and Chemical Dependency Needs.*

4343 Kelly Drive • 2nd Floor, Suite 1 • Philadelphia, PA 19129 • Tel. 215.438.6400 • Fax. 215.438.6600

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Barber Resources of the Delaware Valley
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Center for Autistic Children
Children's Crisis Treatment Center
Devereux Community Services of Philadelphia
Elwyn, Inc.
EMAN Community Living, Inc.
Gaudenzia, Inc.
Greenwich Services, Inc.
Horizon House, Inc.
Jewish Employment and Vocational Service
Joseph J. Peters Institute
Kensington Community Corporation for Individual Dignity
Ken-Crest Services
New Hope of Pennsylvania
NorthEast Treatment Centers
Northern Home for Children
Pennsylvania Mentor
Philadelphia Consultation Center
Philadelphia Developmental Disabilities Corp.
Philadelphia Health Management Corp.
Philadelphia OIC
Programs Employing People
Resources for Human Development, Inc.
Special People in Northeast, Inc.
St. John's Community Services
Step-By-Step
Association for Independent Growth, Inc.
United Cerebral Palsy Association of Philadelphia
Walter Memorial Training Center
Wives Self Help Foundation, Inc.
Wordsworth Academy

October 19, 2001

Senator Harold Mowery,
Chairman,
PA Senate Public Health & Welfare Committee
c/o Senate Post Office
Main Capitol
Harrisburg, PA 17120

Dear Senator Mowery,

The Philadelphia Alliance is an organization of 35 specialized agencies in Philadelphia who serve individuals with needs related to mental retardation, mental health, and chemical dependency. I am writing to you on behalf of individuals served by our member agencies, as well as the Alliance member agencies. The topic of this letter is the "Final Form Regulations" regarding **Physical Plant Standards for Drug & Alcohol facilities**, which have been submitted to your committee by the Department of Health (DOH) for review, subsequently to be reviewed by the IRRC on November 1, 2001.

These final form regulations are near approval, and we are hopeful that your committee will recommend either that they not be approved at all by the Independent Regulatory Review Commission (IRRC) or approved with specific revisions. The agencies of the Philadelphia Alliance share the desire for good health, safety and well being of people needing drug and alcohol services, as well as their families. That's precisely what our agencies are about. We are in agreement with the vast majority of the standards stipulated in these regulations, but there are a couple features that we believe are ill-advised and could severely damage the service system for people who need substance abuse services – (see point # 3).

(1) We are concerned about the **limit of 4 people per bedroom**, especially in programs that serve women with children. Many provider agencies who deliver such services find such a provision to be non-therapeutic and unsafe for some children who may be at risk of abuse from their mother, if alone in a secluded room. The problem with this provision is mitigated somewhat by the fact that DOH has included a "grandfather provision for this regulation; but we still find it inappropriate for new programs as well. Even for other programs besides the women and children programs, such a limit seems arbitrary and likely to increase the cost of future residential drug and alcohol programs.

(2) We also believe that the requirement for fully operational kitchens for all residential and non-residential programs is **NOT** well conceived and probably included just because someone thought it sounded good. The equipment for a kitchen should depend on

(3) how the program is designed and what they are trying to provide to the individuals receiving service.

(4) **The absolute worst provision in these regulations is the <u>square feet requirement for bedrooms</u>.** This single provision **will significantly reduce services available in the system by 10 to 15% or more at a time when more services are needed, not less!**

(a) The DOH seems unconcerned about the reduction in service; as they acknowledge that there could be approximately a 10% reduction in beds in the system. They claim that there is severe overcrowding in some facilities, and that they are powerless to do anything about it. If that is the case, there are plenty of standards within these regulations, which could be used to cite an unhealthy environment. Most all facilities meet requirements of L & I, and some are even JCAHCO accredited that will be negatively impacted by this measure. **This measure will do serious damage to facilities and the good agencies that provide such services!** The drug and alcohol service system is not a "deep" system; once damage is done, it will be very difficult to resurrect agencies and facilities.

(b) The worst aspect of the square feet provision and DOH's cavalier attitude toward "losing 10% of the system capacity" is that the end result will be much worse than that. **The end result will be that a number of facilities will lose enough beds that they will be fiscally forced to close the facility and the program.** The agencies within the Philadelphia Alliance who provide such programs are non-profit agencies, and the rates they are paid for such services are not sufficient to provide any cushion or margin to absorb additional costs or losses in revenue. Reducing their capacity will not reduce the costs at all, (they still need the same building, and the same number of staff, etc.), but the income will be less. In many cases a handful of lost beds will result in the whole program being lost because it will not be able to break even any longer.

Another important point needs to be made here. It is unlikely, but theoretically per diem rates could be raised to cover facility costs, keeping a program whole fiscally. **However, that would still not help the people who would not be able to receive services, because an already under funded service system has been crippled even further, so that capacity has been reduced significantly!** The various estimates from provider agencies and DOH suggest that the loss in capacity is **between 600 and 900 beds across the state, out of 6,184 beds.**

(c) <u>At the very least the square feet requirements should be "grandfathered" for existing facilities, but that is not really appropriate either</u>. The therapeutic environments provided by the drug and alcohol agencies promote many types of interaction with others, preventing isolation as much as possible. Bedrooms are for sleeping only, not a place to "hang out". There should be some measurable improvement in the quality of the program by instituting a square feet requirement. Contrary to DOH responses, the surrounding states do not have higher standards than Pennsylvania. <u>Maryland, Ohio, and Delaware do not have square feet requirements</u>, as Pennsylvania does not currently. Yes, <u>New York</u> requires 80 sq.ft. for single beds, but only <u>40 sq.ft. when bunk beds are used, (less than the 50 sq.ft. required by these final form regulations), and the maximum dormitory</u>

capacity in New York is 24! Many facilities that will be severely impacted by the square feet requirements are facilities that have been in operation for many years with no certification /licensure problems. There is no extra funding in sight for such facilities to renovate or move to larger locations. They operate on a shoestring now. **How will this measure improve the services provided? It won't; it will only diminish the availability of services for the people who need them.**

(d) DOH had done no assessment or analysis of the impact on the service system until that point was challenged upon the recent resubmission of the regulations. Their research is incomplete and includes incorrect assumptions. I have already noted the imminent closure of entire programs due to a handful of beds lost. DOH may indicate that programs' censuses have been below 100%, so the loss "will not be that great", but it will be! Any program in any field with a limited licensed capacity cannot go over 100% capacity, so when people move on there are periods of time when beds are empty. That doesn't mean there are not people who need those services. **You will still get a 90% occupancy rate at best when these beds are eliminated, but you will have 600-900 less people getting services they need during the year!**

Please consider the impact this **substantial loss of services** will have on the citizens of Pennsylvania. The lack of available treatment for a person who needs it not only **impacts the individual, which is important, but it also has pervasive affects on the person's family and all of us as part of the community.**

**Please recommend that these stipulations within the regulations be removed or significantly modified before the regulations become encoded. Our fellow citizens of Pennsylvania need more services for problems of addiction to drugs and/or alcohol, NOT LESS. Please do not let this valiant service system be crippled!**

If you have questions for me, or issues you would like to discuss further with me, please call me. Thank you in advance for your consideration. You can contact me at (215) 438-6400.

Sincerely,

Tim Wilson
Executive Director

cc: Senator Vincent Hughes, Chairman, PA Senate Public Health & Welfare Committee
H. Scott Johnson, Executive Director, PA Senate Public Health & Welfare Committee
Niles Schore, Executive Director, PA Senate Public Health & Welfare Committee
Chairman Dennis O'Brien, PA House Health & Human Services Committee
Chairman Frank Oliver, PA House Health & Human Services Committee
Melanie Brown, Executive Director, PA House Health & Human Services Committee
Sandra Bennett, Executive Director, PA House Health & Human Services Committee
Chairman McGinley, Independent Regulatory Review Commission
Fiona Wilmarth and Rich Sandusky, Independent Regulatory Review Commission

Original:2075

# COUNTY OF NORTHAMPTON

## DEPARTMENT OF HUMAN SERVICES

MENTAL HEALTH/MENTAL RETARDATION/DRUG & ALCOHOL DIVISION

**KATHLEEN M. KELLY**
ADMINISTRATOR

October 12, 2001

2001 OCT 16 AM 9:11
REVIEW COMMISSION

Fiona Wilmarth, Analyst
Independent Regulatory Review Commission
333 Market Street
14th Floor, Harristown 2
Harrisburg, PA 17101

Dear Ms. Wilmarth:

I am writing in response to the physical plant standards (Part V. Drug and Alcohol Facilities and Services) proposed by the Department of Health for the licensure of residential and non-residential drug and alcohol services. The proposed changes that I find most damaging to existing facilities are those discussed in Section 705.5 (b) and (c) Sleeping accommodations:

(b) "When bunk beds are used, each bedroom shall have at least 50 square feet of floor space per resident measured wall to wall; and

(c) No more than four residents shall share a bedroom."

A survey is being performed by the Bureau of Drug and Alcohol Programs (BDAP) which may, or may not, demonstrate the impact of these new regulations. My understanding is that if only a few agencies are affected by reducing bed capacity, grandfathering those agencies will not be permitted. Those agencies can either renovate, if their physical locations and/or zoning regulations will allow it, or suffer huge decreases in bed capacity. Many of those agencies are community-based agencies, such as Gaudenzia, Inc., Treatment Trends, Inc. and others, which have been providing services to their respective communities for decades. Those same agencies have fought for years to increase their treatment capacity in order to meet their communities' needs. Now they are being forced to eliminate beds, which will drastically reduce both treatment and support services offered.

Another concern is that of community safety. If, for instance, bed capacity is reduced in a residential treatment facility, clients will not be able to access treatment. A chronically addicted individual cannot wait to get treatment. They will inevitably continue their addiction, continue their illegal means of supporting their addiction and potentially end up back in prison, or possibly die. Clients in treatment commit very few crimes, do not tax the court system further, and ultimately save tax dollars and prison days.

Governor Wolf Building
45 N. Second Street
Easton, PA 18042-3637
Phone: (610) 559-3260
FAX: (610) 559-3755

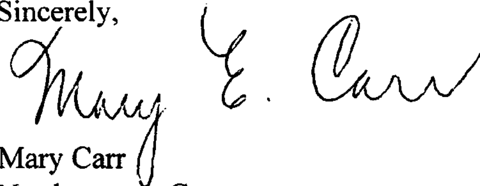
Martin J. Bechtel Building
520 East Broad Street
Bethlehem, PA 18018-6395
Phone: (610) 974-7500 / 974-7555
FAX: (610) 974-7596

Under these new regulations agencies could potentially lose beds in two ways. First, under the square footage regulation, agencies that have built their programs using dormitory type rooms, could lose large numbers of beds. There is nothing inhuman about housing individuals in dormitory style rooms; many college rooms are smaller per student than those of treatment facilities. Secondly, if the four-clients-to-a-bedroom regulation were enacted, many facilities could lose as many as half of their treatment beds. When facilities must renovate, that cost is reflected in their per diem, which lowers the amount of treatment dollars available. Lost revenue results in fewer counseling and support staff in a field which is already under funded and under staffed. Loss of revenue hinders an agency's ability to attract and maintain credentialed staff, which are required by managed care, and which are increasingly difficult to find.

Many facilities provide their clients with much more than basic drug and alcohol treatment. Some offer GED/ ABE classes, Vocational Education and Job Readiness Training, specialty groups addressing criminality and violence, educational grants, and much more. These services could potentially be lost if agencies are forced to reduce bed capacity.

In closing, I would ask minimally that existing programs be granted grandfather status. If that is not possible, I would suggest relaxing the standards by removing the limit of four clients per bedroom and lowering the square footage per client required. These standards exemplify bureaucratic over-regulation that will severely damage treatment capacity and financially burden existing treatment facilities. I would like to thank you for considering my requests and for doing what is best for the treatment field and the clients it serves.

Sincerely,



Mary Carr
Northampton County
Drug & Alcohol Coordinator

Original: 2186

# CITY OF PHILADELPHIA

**BEHAVIORAL HEALTH SYSTEM/
MENTAL RETARDATION SERVICES**
ESTELLE B. RICHMAN
Director of Social Services

**COORDINATING OFFICE FOR
DRUG AND ALCOHOL ABUSE PROGRAMS**
1101 Market Street, Suite 800
Philadelphia, PA 19107-2908
**MARK R. BENCIVENGO**
Executive Director

October 3, 2001

Independent Regulatory Review Commission
333 Market St.
Harrisburg, PA 17101

Dear Chairman McGinley,

Thank you for this opportunity to address a number of significant issues impacting the final form of those proposed regulations submitted by the Department of Health effecting physical plant standards for drug and alcohol treatment facilities (Title 28 Health and Safety; Part V Drug and Alcohol Facilities and Services, 28 PA code CHS701, 705, 709.711 and 713).

The Coordinating Office for Drug and Alcohol Abuse Programs serves as the Single County Authority (SCA) for the county/city of Philadelphia and as such is responsible for maintaining an appropriate spectrum of treatment services for those citizens who have initiated a course of treatment for their problem. Given the number of persons in Philadelphia who are addicted, the possibility of losing treatment opportunities particularly those which provide residential care, is of great concern to our office. Residential treatment provides the most appropriate intervention for those persons whose addiction had become critical and in many cases life threatening. It also provides opportunities for many in the criminal justice system whose long term abuse has prec... th... successful return to society and whose issues and deficits can best be addressed within a residential setting.

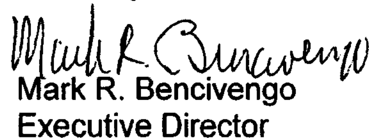
After contacting those programs locally and in the surrounding counties which serve a predominantly Philadelphia population, it was established that while not all facilities would be negatively impacted, enough would, resulting in a serious reduction in the number of slots available for residential treatment. The reduction in slots would impact the ability of the programs to earn projected revenue, which in turn would result in whole programs having to close. Calculations as to the number of treatment slots compromised by the institution of the proposed regulations, while not exact, project a loss of over 100 slots at a cost to programs approaching 2 million dollars. It would appear then, that the acquisition of possibly 2 to 3 additional square feet of sleeping room space, which is space only used for sleeping when most of the clients time is spent in

other therapeutic activities, is too high a price to pay when compared to the cost of lost services and recovery opportunities.

I urge you and the members of the Commission to carefully weigh the overall negative impact of promulgating these regulations in comparison to the supposedly improved quality of life and effect such small increases in actual living space would have on the treatment experiences of our client populations. For persons working incredibly hard in dealing with one of life's most intransigent diseases, such a loss in treatment opportunities should not be entertained.

Again, thank you for this opportunity to inform you of our concerns and their impact on our community of treatment programs.

Sincerely,



Mark R. Bencivengo
Executive Director

MRB/cnb

Cc: Tim Wilson – Executive Director, Philadelphia Alliance
William Thompson – Deputy Director, CODAAP

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