Pennsylvania

UNIFORM APPLICATION
FY 2024/2025 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 08/01/2023 3.50.54 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State Unique Entity Identification

Unique Entity ID FYVAZVJGDFA4

I. State Agency to be the Grantee for the Block Grant

Agency Name Department of Human Services

Organizational Unit Office of Mental Health and Substance Abuse Services

Mailing Address PO Box 2675

City Harrisburg

Zip Code 17105-2675

II. Contact Person for the Grantee of the Block Grant

First Name Jennifer

Last Name Smith

Agency Name Office of Mental Health and Substance Abuse Services, Dept. of Human Services

Mailing Address PO Box 2675

City Harrisburg

Zip Code 17101

Telephone 7177053879

Fax 717-772-2062

Email Address jensmith@pa.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name Dawn

Last Name Comly

Telephone 717-409-3792

Fax 717-772-7964

Email Address dcomly@pa.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

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Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name

Jen Smith

Title

Deputy Secretary

Organization

DHS-Office of Mental Health and Substance Abuse Services

Signature: Date:

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Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

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Footnotes:

Legislative Base

The mental health system in Pennsylvania is organized in conformance with the Mental Health/ Intellectual Disabilities (MH/ID) Act of 1966 and the Mental Health Procedures Act (MHPA) of 1976 as amended. Primary authority for the Commonwealth's public mental health program derives from these two acts, along with the Human Services Code (most recent amendment October 2022). The location of the Office of Mental Health and Substance Abuse Services (OMHSAS) and the state hospitals within the Department of Human Services is established in the Pennsylvania Code. Three more recent statutes, namely, Act 80 of 2012, Act 55 of 2013, and Act 153 of 2016 modified the funding mechanism by affording greater flexibility to counties in managing their state-allotted dollars.

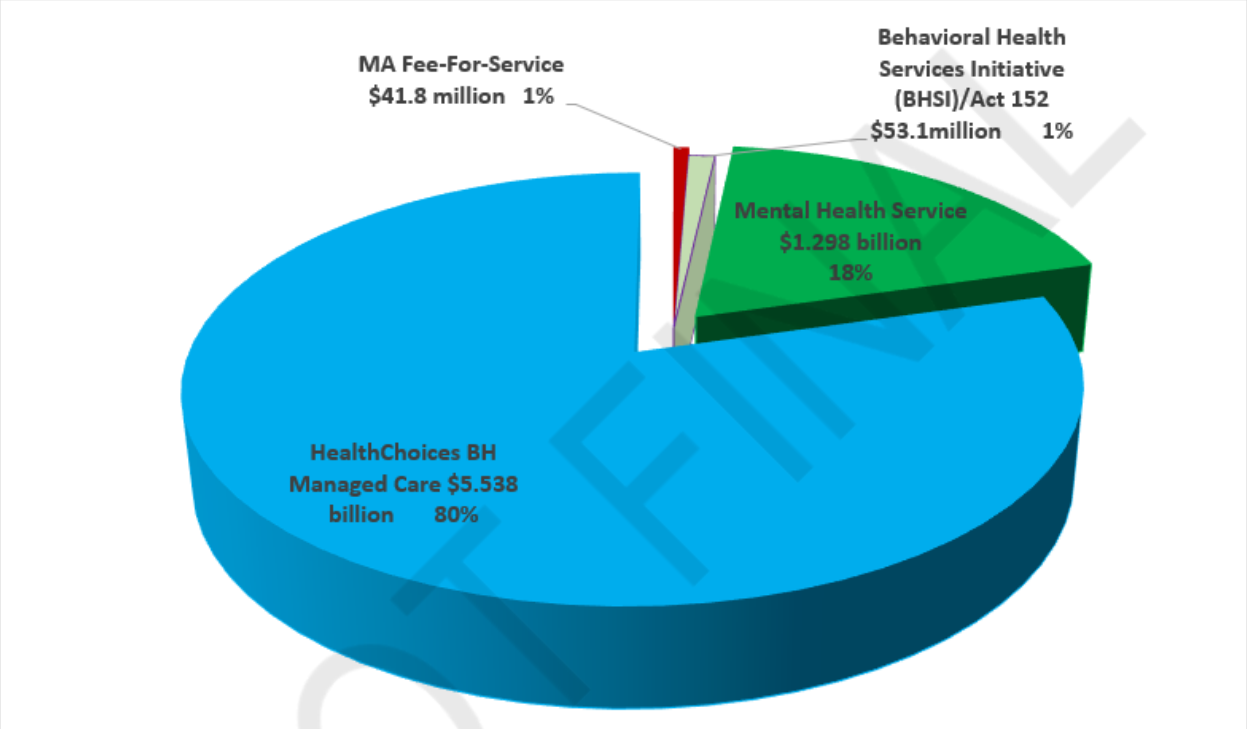
Role of State Government

The state government has the statutory responsibility to oversee the provision of community mental health services in the Commonwealth and has direct operational responsibility for the state mental hospitals. Responsibility for the operation of the state mental hospitals and oversight of the public mental health system is vested in OMHSAS, which is a program office within the Department of Human Services (DHS). DHS is a multi-program human services agency headed by a cabinet-level secretary. DHS was formerly known as the Department of Public Welfare; it was renamed DHS in September 2014 to be more reflective of the wide array of services provided by the Department. In addition to OMHSAS, the various program offices under DHS include:

- Office of Developmental Programs (ODP)
- Office of Children, Youth, and Families (OCYF)
- Office of Child Development and Early Learning (OCDEL)
- Office of Long-Term Living (OLTL)
- Office of Income Maintenance (OIM)
- Office of Medical Assistance Programs (OMAP)

Through OMHSAS, the state develops programs and policy, licenses many service components, allocates funds for services, and develops guidelines for county service planning. OMHSAS administers behavioral health Medicaid, community mental health funds, Behavioral Health Services Initiative (BHSI) funds for both mental health and

substance abuse services for individuals no longer eligible for Medical Assistance, and Act 152 funds to provide non-hospital residential substance abuse services. OMHSAS is also responsible for the administration of the state hospitals. Pennsylvania prides itself in its innovative efforts to support a robust mental health service system. As illustrated below, the estimated SFY23-24 budget for behavioral health services is $6.79 billion in state and federal dollars.



Over the last two and a half decades there has been significant movement of funding from the direct control of the state government to county administrations, allowing increased flexibility at the local levels to manage resources to address the service needs of their communities. In addition to overseeing the mental health services funded with the appropriated state funds, the vast majority of the counties also serve as the primary contractors for the Behavioral Health Medicaid Managed Care Program known as Behavioral Health HealthChoices.

Services for Children

The Bureau of Children's Behavioral Health Services (Children's Bureau) within OMHSAS helps ensure focused attention on the behavioral health needs of children and adolescents. Children's Bureau provides leadership in the planning, program development, and implementation of a comprehensive statewide behavioral health services plan for children and adolescents with serious emotional disturbance (SED). The Bureau collaborates with state, county, and local agencies in the development of programs to support the best provision of care to children and families. The Bureau oversees an array of children's behavioral health services that are comprehensive and community-based and that express the importance and continuous application of the Child and Adolescent Service System Program (CASSP) principles.

OMHSAS has an Intergovernmental Agreement with The University of Pittsburgh to operate the Pennsylvania Youth and Family Training Institute. The Youth and Family Training Institute is a major component of the effort to transform Pennsylvania's Children's Behavioral Health System. The vision of the transformed system is one which will engage and empower child and family teams as the primary determinants of service. The Institute is responsible for extending the practice of the nationally recognized High Fidelity Wraparound model across the Commonwealth. It provides and coordinates training, coaching, credentialing, evaluation, and technical assistance to engage and empower youth and their families in the treatment and recovery process.

There are currently 16 counties involved in the High Fidelity Wraparound system, which include the 13 System of Care counties: Chester, Crawford, Delaware, Erie, Fayette, Greene, Lehigh, Luzerne, Montgomery, Northumberland, Philadelphia, Venango, and York, as well as Allegheny, Bucks, and Northampton counties. Over 2,200 youth and their families have been served since the initiation of High Fidelity Wraparound in 2008. Youth and Family Training Institute, in collaboration with the System of Care, also provides training for family peer support, with more than 300 family members and 80 supervisors trained to date.

Other Partner State Agencies

Programs in other state agencies that have a relationship with the mental health system include the Department of Drug and Alcohol Programs, Departments of Aging, Department of Corrections, Department of Education, Department of Health, Department of Insurance, and Department of State as well as the Office of Vocational Rehabilitation within the Department of Labor and Industry. Many of these partners have staff representatives appointed to the Mental Health Planning Council, in addition to partnerships on other state efforts. OMHSAS utilizes the council and recommendations of the Mental Health Planning Council in the planning, provision, and development of behavioral health and substance abuse services in the state.

State Hospitals

OMHSAS directly operates six state mental health hospitals and one long-term nursing facility. The six hospitals are general-purpose psychiatric hospitals for adults. The long-term nursing facility, South Mountain Restoration Center, provides licensed skilled nursing and intermediate long-term care services to elderly individuals with special needs whose needs cannot be met by other community nursing facilities. Children and adolescents are not served in state hospitals with the rare exception in the forensic units when individuals under the age of 18 are being charged as an adult. Each state mental hospital has a nine-member citizen advisory board of trustees, the members of which are appointed by the Governor and confirmed by the State Senate.

For the past three decades, Pennsylvania has been on the leading edge of developing local partnerships and community-based service options that promote recovery for people living with mental illness. The State continues to fund community services and support those living with mental illness through closures and funding of Community Hospital Integration Participation Program (CHIPP) slots. CHIPP slots support the development of needed community infrastructure and residential services.

In keeping with the OMHSAS commitment to reducing reliance on institutional care and improving access to home and community-based services for Pennsylvanians living with mental illness, Norristown State Hospital’s civil section was closed in 2019.

Impact of COVID-19 on State Hospitals

In order to reduce exposure and spread of COVID-19, admissions and discharges were paused for short periods of time during the COVID-19 Public Health Emergency (PHE) in 2020. In order to mitigate the spread and comply with CDC guidelines, quarantine units were developed for those who tested positive and for new admissions.

Expanded video capabilities were implemented in order to maintain visitation with family and friends while in-person visitation was paused. Video resources were grown through purchasing iPads for use and expanding internet and WIFI capabilities throughout the facilities. These resources have proven successful and will remain in place to give residents expanded access to visitation past the PHE. These expanded resources have also proven helpful for remote court appearances, as well as virtual treatment sessions for social work, psychology, and other therapies.

In-house COVID testing was also implemented to control COVID-19 spread. Testing capabilities will remain, and there are plans to use in-house testing for other contagious diseases, such as the flu and RSV. Vaccinations were provided to individuals in treatment and staff members in the first wave of vaccinations in Pennsylvania. Learning from the COVID-19 pandemic, the state hospitals in Pennsylvania now have policies in place to mitigate the further spread of viruses in the future.

Role of Counties

The Mental Health and Intellectual Disability (MH/ID) Act of 1966 requires county governments to provide community mental health services, including short-term inpatient treatment, outpatient services, partial hospitalization services, emergency services, aftercare services for individuals released from state and county facilities, specialized rehabilitation training, vocational rehabilitation, and intake services. Services may be operated directly by the county or contracted out to provider agencies, with many counties utilizing a combination of both. The 67 counties in the state are grouped into 48 single-county or multi-county MH/ID Program Offices that operate under the direction of the County MH/ID Administrators. The county commissioners hire and supervise the MH/ID County Administrator, who has a board of 13 individuals to provide advice and consultation in the operation of the program. All County Administrators also

function as the directors of the county Intellectual Disability programs and, in 35 counties, as the Drug and Alcohol (D&A) Program Administrators.

OMHSAS allocates funds to the county governments for the provision of community mental health services. County MH/ID and D&A Programs are uniquely positioned to coordinate behavioral health services with other county human services programs. This control and authority over necessary ancillary services such as housing, family courts, and welfare programs are pivotal to a working infrastructure that is capable of providing a seamless system of care. Counties also take leadership roles in their communities by promoting activities aimed at increasing awareness of mental illness among community human service agencies, professional personnel, and the general public.

Funding and Other Resources for Counties

The general state revenue funds, county funds, Medicaid dollars, Mental Health Block Grant, Substance Abuse Block Grant, Social Services Block Grant, Projects Assisting the Transition from Homelessness (PATH) grant, and other federal grants comprise much of the funding pool that County MH/ID programs use to provide services to individuals in need. Some other resources available to the counties and providers include OMHSAS funded/sponsored technical assistance (TA) and training in a variety of areas. Some examples are Peer Specialist training, Case Management training, training and TA provided to PATH providers, TA in the development and advancement of evidence-based practices such as the Heads Up First Episode Psychosis technical assistance center at the University of Pennsylvania, Assertive Community Treatment training, the Youth and Family Training Institute, and TA for the development of housing options in the counties. Additionally, OMHSAS has commissioned an Electronic Learning Management System to centralize the existing state trainings and to expand training opportunities available to counties, provider agencies, and other interested stakeholders.

County Human Services Planning Process

In 2012, as part of DHS's continuing efforts to streamline the planning and reporting requirements for county human services programs, the County Mental Health Planning

process and the Integrated Children's Services Planning process were replaced with a County Human Services planning process. The Human Services Planning guidance issued by the Department asked that the counties in their leadership role, with input from their stakeholders, identify local needs, develop goals, create strategies, and identify and track outcomes that support the implementation of quality, cost-effective, and efficient services. Each county had to create a county planning team that also included representatives of other aspects of the human services system and individuals who receive services and their families. Many counties utilized their existing groups developed through Systems of Care, Integrated Children's Services, Community Support Programs, or other multi-system initiatives to assist with the planning process.

The new planning process, while consolidated to present a holistic view of the human services system, also includes specific planning requirements for different service areas, namely, Mental Health, Drug and Alcohol Services under DHS's jurisdiction, Intellectual Disabilities, and Homeless Assistance Programs. For the mental health portion of the plan, the counties are required to identify the strengths and needs of various populations and describe the recovery-oriented systems transformation efforts the county plans to initiate in the current year to address concerns and needs. The counties are expected to review data and various indicators to determine local needs and develop a plan to meet those needs. The plans also need to contain strategies to be implemented including specific activities to monitor and improve outcomes.

HealthChoices: Pennsylvania's Medicaid Managed Care Program

Implementation of behavioral health Medicaid managed care in HealthChoices, Pennsylvania's managed care system, began with the Southeast zone in 1997 and was completed in July 2007, when the final set of counties moved into HealthChoices. In the Pennsylvania managed care model, behavioral health services are "carved out" from the management of physical health services. The success of the HealthChoices Behavioral Health (HC-BH) managed care program was built on partnering with county governments. County governments were given the right of first opportunity to bid on managing the HC-BH risk-based contracts for their respective areas. HC-BH unifies service development and financial resources at the local level, closest to the people

served. Individuals receiving Medicaid are automatically enrolled in the BH program in the county of their residence. A risk-based contract allows flexibility to make decisions that meet the unique needs of the county and, if savings are created, the county must reinvest the money in approved programs and supports that meet the needs of people served. The HC-BH model has achieved its mission and fostered counties' success in controlling the growth of Medicaid spending while increasing access and improving quality. As of March 2023, there were 3,499,276 individuals covered by the Pennsylvania Behavioral Health HealthChoices program, a 6% enrollment increase from March 2022(3,300,114). Among Pennsylvania's 67 counties, Philadelphia had the highest enrollment with 732,985 individuals, followed by Allegheny County with 279,740 enrollees.

Community HealthChoices

Community HealthChoices (CHC) is Pennsylvania's mandatory managed care program for dually eligible (Medicaid and Medicare) individuals and individuals with physical disabilities— serving more people in communities, giving them the opportunity to work and experience an overall better quality of life. CHC is available in all counties within Pennsylvania. CHC uses managed care organizations (CHC-MCOs) to coordinate physical health and long-term services and supports (LTSS) for participants. CHC is working to (1) enhance access to and improve coordination of medical care; and (2) create a person-driven, long-term support system in which people have choice, control, and access to a full array of quality services that provide independence, health, and quality of life. OMHSAS has partnered with the DHS Office of Long Term Living to ensure that behavioral health care needs will be met for all individuals enrolled in CHC. Behavioral Health will continue to be offered through the existing network of behavioral health managed care organizations (BH-MCOs). CHC-MCOs and BH-MCOs will work together to ensure that all participants receive the coordinated services they need. Implementation of Phase 1 of CHC was completed in January 2018 in 14 counties in the southwest part of the state. Phase 2 of the implementation covered the counties in the southeast. With the implementation of Phase 3 in January 2020, all 67 counties of the

state have CHC. Total CHC enrollment as of March 2023 was 417,571 up from 413,941 in February 2023.

New Initiatives

- OMHSAS is currently in the process of drafting and promulgating regulations for behavioral health crisis intervention services. The purpose of this proposed rulemaking is to add Chapter 5250 to 55 Pa. Code, to codify standards that a licensee must meet to provide behavioral health crisis intervention services. The proposed regulation is to also establish new requirements related to physical site, emergency planning, quality monitoring, security personnel, staffing qualifications, and training. The draft is currently under review with the Department's Legal team.
- MyOMHSAS is a web-based training platform that will provide a one-stop for online training and resources. It is aimed toward internal OMHSAS staff and both internal and external stakeholders such as service providers, state hospitals, counties/joinders, individuals, families, peers, etc. The development of MyOMHSAS is a collaboration among the Office of Developmental Programs (MyODP), the University of Massachusetts Medical School (UMass), and OMHSAS. MyOMHSAS will offer training modules and content developed by subject matter experts (SME), user experience and reporting capabilities, documentation of progress, certificates of completion where applicable, and additional resources, toolkits, webinars, and other communication media. The initial soft launch of MyOMHSAS occurred in late 2022 with a limited number of inaugural course modules, including Assisted Outpatient Treatment (AOT) and the Children's Hospital of Philadelphia (CHOP) transgender webinar series. First Episode Psychosis (FEP) introduction and Child and Adolescent Service System Program (CASSP)/System of Care (SoC) training content will be published in the near future. Additional offerings are undergoing development and include telehealth training modules, cultural and linguistic competence, trauma-informed approaches, and others. A crisis worker certification curriculum, under development in partnership with Temple University, will be launched in early

2024 and will provide a pathway for entry-level crisis workers to achieve accreditation.

MyOMHSAS functionality includes a one-stop resource repository where documents, frequently asked questions (FAQ), recorded meetings, and other communications can be disseminated to registered users. A dedicated MyOMHSAS resource account is available for questions, feedback, suggestions, and other communication related to the platform.

- Through the Consolidated Appropriations Act, OMHSAS was able to fund eight types of projects:
  1. Nine counties took part in the Mobile Crisis projects, serving a total of 8712 unique individuals. Funding usage includes increasing the number of teams, adding peer services, and adding diversion services.
  2. Eight counties participated in Student Assistance Programs (SAP), serving 1708 unique individuals. The funding was used to expand SAP into grades or buildings that did not currently have programs as well as enhance already existing programs.
  3. Two counties started Residential Treatment Facilities that served 12 unique individuals.
  4. Seventeen counties had 18 projects in Crisis Services that served 7204 unique individuals. Some services include crisis co-responder teams, peer-run warmlines, and walk-in centers.
  5. Two counties started Peer Run Crisis Stabilization Units, one county has not yet opened its unit, but the other has served 126 unique individuals.
  6. Four counties took part in Crisis Planning projects that included crisis workforce stabilization and development, 988 implementations of a comprehensive crisis response system, and enhancement of current crisis services.
  7. Five counties worked on Technical Infrastructure projects such as installing GPS units for Mobile Crisis, buying new Tablets, purchasing software licenses, hiring consultants, and enhancing their growing Telehealth services.
  8. Two counties are implementing Assisted Outpatient Treatment.

- OMHSAS revised the Mental Health Emergency Services: Applying the 120-hour timeframe for Emergency Involuntary Commitments Bulletin in November 2022.

  This revision provides specificity on the two-hour timeframe outlined in the MHPA for examination by a physician.

- OMHSAS is currently in the process of revising the Psychiatric Rehabilitation Services (PRS) regulations to allow individuals ages 14 through 17 to receive PRS. Additionally, the eligibility diagnoses are expanding, and wellness is being added as a domain that can be worked on in PRS. The revised regulation was published in the Pa Bulletin as proposed on July 9, 2022.
- OMHSAS is working to establish Family Peer Services for youth and adults as a viable service within the next three years.
- OMHSAS is working to expand Peer Run Crisis Stabilization Units, previously referred to as Peer Run Crisis Residential (PRCR) program. The expansion is focused on other counties within the state in the next three years. The first PRCR program in Pennsylvania, The Path Home, in the Columbia/Snyder/Montour/Union County Joinder, was provided initial startup funding in SFY18-19 through CMHSBG and has demonstrated successful services filling a much-needed gap in a primarily rural area of the state. Based on this success, OMHSAS will be funding a second PRCR using CMHSBG COVID-19 Relief Funding from the Consolidated Appropriations Act of 2021. This program will be located in Allegheny County, the second largest urban area in Pennsylvania, with the City of Pittsburgh.
- OMHSAS has maintained allowability for telehealth servicespost-COVID-199 Public Health Emergency (PHE). During the COVID-19 PHE, OMHSAS rapidly expanded the allowability of telehealth services within the behavioral health system to ensure continuity of care during stay-at-home orders and for individuals requiring quarantine, issuing a memorandum Telehealth Guidelines Related to COVID-19 within 11 days of the initial Pennsylvania Governor’s Emergency Disaster Declaration (initial issue date 3/15/20, update re-issued

5/5/20). OMHSAS has taken steps to make the expansion of telehealth service delivery sustainable past the PHE in order to preserve the increased access to services that have resulted. OMHSAS is currently updating the guidance around telehealth to clarify standards post-PHE.

- Using CMHSBG Early Serious Mental Illness (EMSI) set aside funds, OMHSAS established two additional First Episode Psychosis (FEP) Programs in SFY22-23. s of SFY23-24, Pennsylvania will have 18 total FEP Programs serving 21 Counties which, are geographically distributed in each region of the state and represent a mix of rural, suburban, and urban areas.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

[The system/services discussed under this criterion apply to both adults as well as children (unless specified in the sub-heading as adult only) Services specific to children are discussed under criterion 3]

Community Support Program

Pennsylvania is guided by the Community Support Program (CSP) principles for the development and delivery of mental health services for adults. Pennsylvania's public mental health system is shaped by a strong influence of individuals with lived experience, family members, and advocacy groups, who provide valuable input into the development of programs and policies that shape changes in the public mental health system throughout the Commonwealth. The CSP philosophy embraces the notion that services should be provided in such a way as to maintain the dignity of the individual and respect the individual's desires, choices, strengths, and treatment needs.

Call for Change

In July 2004, the OMHSAS Adult Advisory Committee (now a part of the Mental Health Planning Council) called for a workgroup to guide the recovery transformation efforts in Pennsylvania. In November 2004, the workgroup held its first meeting and a steering committee was formed to move forward with recommendations. In 2005, A Call for

Change was published and has since that time been a foundational document for the Pennsylvania mental health system.

A Call for Change offers a basic framework for transformation, including indicators of a recovery-oriented system. In addition, it discusses some of the implications of these changes and recommends some approaches for using the indicators to initiate changes in local, county, and statewide systems. It is to be considered a “living-breathing” document and not a “set-in-stone” plan.

In September 2018, the Mental Health Planning Council requested that OMHSAS revisit A Call for Change and provide the council with a status report on the progress made since its publication. Although this project has faced delays due to the COVID-19 PHE, following extensive stakeholder input from across the system and across the state, OMHSAS provided the MHPC with a 15-year look back at the behavioral health system, A Call for Change: 15 Years of Progress in HealthChoices Behavioral Health (HC BH), in June 2021. This document assessed the progress made in the system since 2005 and served as a foundation for Advancing the Call for Change Action Plan. In collaboration with the MHPC, a steering committee of 20 individuals was assembled to include individuals with lived experience, HC BH providers, community organizations, and subject matter experts. The steering committee met 13 times between March 2022 and November 2022 to develop a future-oriented document by setting new priorities focused on the advancement of the recovery and resiliency-based system over the next five years. OMHSAS will publish Advancing the Call for Change Action Plan on behalf of the MHPC who will in turn use the action plan to drive the priorities of the council.

Available Services: Mental Health and Rehabilitation Services

Medical Assistance for Workers with Disabilities *(Adult only)*

Pennsylvania’s Medical Assistance for Workers with Disabilities (MAWD) Program is a medical insurance program that supports individuals with disabilities to obtain employment, earn more money and still maintain their Medicaid coverage. Through MAWD availability, individuals with disabilities desiring to return to work can do so

without fear of losing their medical benefits. A key and continued goal in the MAWD program is a steady increase in the number of individuals with disabilities returning to competitive employment in the community workforce.

On July 1, 2021, Act 2021-69 was passed adding an eligibility group to MAWD called Workers with Job Success (WJS). This additional eligibility group is a state-funded MA program that further expands and protects health coverage for working disabled individuals. WJS will allow individuals who made more money during the PHE to remain on Medical Assistance for their healthcare needs.

To qualify for coverage in the WJS eligibility group, individuals must:

- Be at least age 16 and under age 65.
- Be working and earning income.
- Participate in any MAWD eligibility group for the previous 12 consecutive months.
- Have countable monthly income that is more than 250 percent of the Federal Poverty Income Guidelines (FPIG) and is less than or equal to 600 percent of the FPIG.
- Have countable assets less than or equal to $10,000 at initial eligibility.

Assertive Community Treatment (Adult only)

Pennsylvania currently has 45 licensed Assertive Community Treatment teams, and 1-3 new teams are in development. Pennsylvania had up to 48 teams over the last year, but some ACT programs closed recently due to the inability to remain staffed.

OMHSAS surveys the ACT teams annually to gather a graphical snapshot of key performance indicators including employment and inpatient hospitalizations. Point-in-time data collected in February of 2023, shows that Pennsylvania's rate of Competitive Integrated Employment (CIE) for individuals served by ACT teams is 10% for both full-time and part-time employment. Of the 3,158 individuals enrolled in ACT for at least 14 consecutive days in 2022, 28% were admitted for at least one day to a psychiatric inpatient hospital setting while enrolled in ACT in 2022, which is down from 30% in 2021. In 2022, 1,883 psychiatric ER visits made by ACT team clients resulted in 1,123

psychiatric inpatient hospitalizations, meaning that 33% of the time the individuals were able to be supported without the need for hospitalization.

OMHSAS permitted the use of telehealth in ACT during the PHE including the use of audio-video or telephone communication when working with clients in order to ensure continuity of services which are particularly critical for the high acuity individuals served by the ACT program. Providers may continue to use telehealth to provide ACT consistent with OMHSAS's guidelines on the use of telehealth.

First Episode Psychosis

OMHSAS approved funding for 2 new First Episode Psychosis programs in 2022. The new sites included the expansion of 1 existing site into Bucks County and one site in Lycoming Clinton. Pennsylvania now has a total of 18 FEP programs throughout the state that will continue to receive funding in FY 2023-2024.

One difficulty that remains true for FEP in Pennsylvania is the expansion of FEP into rural counties. OMHSAS is prioritizing the COVID ARPA funding to specifically target rural counties for new FEP programs.

In addition, OMHSAS provides funding through the CMHSBG to HeadsUp at the University of Pennsylvania to help support statewide access to FEP services. HeadsUp has created a comprehensive website HeadsUp | Focused on ending the stigma around psychosis (headsup-pa.org). Due to COVID-19 PHE, the 2022 Annual conference was held virtually; however, the 2023 conference will have one day in person. HeadsUp was able to resume in-person Fidelity Reviews in 2023.

OMHSAS purchased grant management software from Wizehive in the Fall of 2022. This software allows OMHSAS to streamline the entire funding process as the application/renewal, updates, awards, quarterly reporting, and notices can all be done in one place. This has greatly reduced the need for emailing back and forth. Once OMHSAS has amassed data in the system, then it will be able to be analyzed through Wizehive. FEP was one of our first funding opportunities to be completed entirely through Wizehive.

Partial Hospitalization

Partial Hospitalization is a non-residential treatment service licensed by OMHSAS for persons with mental illness who require less than 24-hour continuous care but require more intensive and comprehensive services than are offered in outpatient treatment. Partial hospitalization services may be:

- A day service designed for persons able to return to their homes in the evening
- An evening service designed for persons working and/or in residential care.
- A weekend program.

While partial hospitalization programs did shift to offering services through telehealth delivery early in the COVID-19 PHE in 2020, both anecdotal reports from stakeholders and results from a large-scale OMHSAS Telehealth Survey of individuals and families raised concerns about the effectiveness of partial hospitalization services when delivered through telehealth. The second telehealth steering committee provided recommendations regarding the use of telehealth in high-intensity services. The committee recommended that PH remain primarily in person. The committee also recognized that telehealth can be a helpful tool when an individual is returning back to work or school to maintain continuity of services. Post-PHE, OMHSAS telehealth standards stress that services delivered through telehealth be clinically appropriate for both the individual and the service.

Outpatient Services

Outpatient behavioral health services are treatment services provided to individuals living in the community. The services, which are directed by the client's treatment plan, are provided to the individual and/or the family. Outpatient services are intended to prevent the need for a more intensive level of care and also act as a follow-up to inpatient services. The services include:

- Psychiatric, psychological, or psycho-social therapy
- Supportive counseling for the client's family, friends, and other relevant individuals

- Individual or group therapy
- Treatment plan development, review, and reevaluation of a client's progress
- Psychiatric services, including evaluation, medication clinic visit, and medical treatment required as part of the treatment of the psychiatric service
- Psychological testing and assessment

Mental Health Crisis Intervention Services

Currently, under the Mental Health and Intellectual Disability Act of 1966, counties are responsible for providing mental health crisis intervention services. The Department of Human Services' Office of Mental Health and Substance Abuse Services (OMHSAS) is responsible for the oversight and licensing of crisis intervention services. There are five modalities of crisis services licensed through OMHSAS: telephone crisis call centers, mobile crisis team services, medical mobile crisis team services, crisis walk-in centers, and crisis stabilization units.

OMHSAS recognizes the critical role of a responsive crisis system in reducing the intensity and duration of the individual's distress and utilizing the least restrictive options while ensuring safety. Crisis Intervention Services are defined as a service array that includes immediate, crisis-oriented services provided to a beneficiary and their family, who exhibits an acute problem of disturbed thought, behavior, mood, or social relationships. Crisis intervention services include screening, assessment, intervention, counseling, and disposition services.

Telephone crisis services must be available 24 hours a day, seven days a week to screen incoming calls and provide appropriate counseling, consultation, and referral. Additionally, HealthChoices, the mandatory Medicaid managed care behavioral health program, requires access to mobile crisis team services as part of the program access standards for members. Within Pennsylvania's mental health service system, telephone, walk-in, mobile, medical mobile, and stabilization unit crisis services are provided to all

individuals who need the service regardless of funding resources or established connections to the behavioral health service delivery system.

The current county-based service delivery system lacks uniform standards and consistency resulting in potential quality-of-care concerns and varying availability and access to the different modalities of crisis intervention services across all 67 counties. OMHSAS is currently drafting and promulgating regulations for crisis intervention services which comply with SAMHSA's national guidelines, as these are composed of core elements and key components of a good crisis care system. Regulations are needed to codify the necessary oversight health and safety protections for individuals who access mental health services in a crisis situation. The regulations codify the minimum requirements for building, equipment, operation, staffing, and training for entities providing these services. In addition, the regulations provide clear and consistent standards for licensure or approval of all modalities of crisis intervention services.

While funding is vital to a comprehensive and sustainable crisis system, clarity on policies and procedures, collaboration with stakeholders, and removing barriers to providing services are equally important. To this end, OMHSAS has undertaken several policy and stakeholder engagement initiatives.

- Coordination with the Pennsylvania Insurance Department on how to increase private insurance payment for crisis services. These efforts will resume once crisis regulations are promulgated.
- Promotion of licensed Bachelor-level social workers to enhance the crisis workforce and meet the Medicaid requirement for a licensed professional to recommend service.
- Creation of a crisis worker certification program in partnership with Temple University to reduce the regulatory burden of staff training requirements and provide no-cost continuing education to licensed providers.

- Revising 302 procedures for involuntary commitment to better protect civil liberties and enhance professional collaboration between county mental health and local law enforcement.
- Developing a crisis resource database to create linkages between county crisis resources and regional 988 call centers.
- Preparing and submitting a Medicaid State Plan Amendment to remove the requirement that peer support specialists be diagnosed with serious mental illness (SMI) and to reduce restrictive employment requirements.
- 988 planning and coordination (e.g., with 911, counties, and crisis services providers).
- Enhancing law enforcement crisis response by working with the Pennsylvania Commission on Crime and Delinquency (PCCD), and other stakeholders.

Psychiatric Rehabilitation Services

Pennsylvania Psychiatric Rehabilitation Services (PRS) operate under Chapter 5230. Psychiatric Rehabilitation Services regulations were promulgated in 2013. PRS has expanded from 22 licensed providers in 2005, to 116 licensed providers with 35 satellite locations as of October 2022. Pennsylvania has the largest chapter of the Psychiatric Rehabilitation Association (PRA) in the country, the Pennsylvania Association of Psychiatric Rehabilitation Services (PAPRS). The Commonwealth also has the largest number of Certified Psychiatric Rehabilitation Practitioners (CPRP) of any state in the nation, with over 500 individuals who hold a CPRP credential. Pennsylvania is currently working to update the psychiatric rehabilitation regulations to allow for individuals ages 14 through 17 to receive PRS. Additionally, the eligibility diagnoses are expanding, and wellness is being added as a domain that can be worked on in PRS. The regulation revisions were published as proposed in the Pennsylvania Bulletin on July 9, 2022. During the 30-day public comment period that followed OMHSAS received approximately 370 comments from 30 commentators. OMHSAS continues to work on the final form regulation.

OMHSAS permitted the use of telehealth in PRS during the public health emergency including the use of video or phone communication when working with clients. Providers may continue to use telehealth to provide PRS consistent with OMHSAS's guidelines on the use of telehealth.

Employment Services

OMHSAS endorses the following employment resources for individuals with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED):

- SAMHSA's Supported Employment Toolkit
- Peer Support Services
- Fairweather Lodges
- Psychiatric Rehabilitation Services to include Clubhouse model
- Assertive Community Treatment
- First Episode Psychosis
- Supported Education

OMHSAS supports the belief that every person with an SMI or SED is capable of working competitively in the community provided the right job and work environment is available. The goal of employment supports for those with SMI or SED is to develop resources that help individuals find and keep jobs that capitalize on individual strengths and skills while accommodating needs with support services as necessary. OMHSAS promotes Supported Employment and although more limited, Supported Education, for individuals with SMI which focuses on community integrated employment.

OMHSAS is currently working with Montgomery County Behavioral Health and the Montgomery County Community College in developing a supported education approach in order to keep community college students in the classroom during stressful and mentally challenging days in order to successfully graduate.

OMHSAS is emphasizing training and certification to increase the number of Certified Peer Specialists (CPS), including additional sub-specializations (called enhancements) for young adults, families, Veterans, forensic, and older adults. As OMHSAS builds the capacity of peer services across Pennsylvania, an intended outcome is to increase the employment rate of CPSs and grow this workforce.

OMHSAS is anticipating increasing collaboration with the Office of Vocational Rehabilitation through the development of Memorandums of Understanding for the purpose of gaining data to identify areas of need in service capacity and innovation.

Housing Services

The Department of Human Services (DHS) Five-Year Affordable Housing Strategy has been in place since 2018. DHS is currently in the process of updating this plan. The 5-year Housing Strategy is a comprehensive plan to connect Pennsylvanians to affordable, integrated, and supportive housing through a partnership effort between DHS, the Pennsylvania Housing Finance Agency (PHFA), and the Pennsylvania Department of Community and Economic Development (DCED).

OMHSAS continues to implement a successful Permanent Supportive Housing (PSH) Strategy utilizing local, state, and federal resources to expand affordable, supportive housing and residential programs for adults with SMI. This commitment is based on the principle that where people live matters; it is essential to recovery. It is also a practical commitment and addresses a key Social Determinant of Health (SDoH). PSH, an evidence-based practice, enables each consumer to make informed choices about their own housing and to retain more of their income than if residing in congregate facilities or their own residence without rental support. Based on repeated cost comparisons, it enables counties to reduce costs associated with legacy housing programs including Community Residential Rehabilitation (CRR) and Long-Term Structured Residences (LTSRs), acute and institutional care. The OMHSAS Initiative was critical to the state's ability to make two competitive applications for 811 PRA resources and is essential for OMHSAS and Counties to meet their Olmstead integration obligation.

To further support the integration of individuals with SMI/SUD with the general population, OMHSAS provided additional guidance to counties when making any commitment of reinvestment for capital development on the percentage of units in a building/project that could be targeted to individuals with SMI/SUD. This guidance is included in the document titled Utilizing HealthChoices Reinvestment Funds to Create Permanent Supportive Housing, Revised October 4, 2018.

PSH is typically created by utilizing and combining funding sources to ensure housing is affordable, sustainable, and meets a person's individual housing needs and choices. OMHSAS provided Counties an opportunity to invest in seven interconnected housing strategies:

- Capital or equity investment in development projects
- Project-based operating assistance (PBOA) in tax credit developments in collaboration with the Pennsylvania Housing Finance Agency (PHFA)
- Short-term bridge rental assistance
- Master leasing for consumers with criminal or poor tenancy histories
- Housing clearinghouse to manage outreach and referral to PSH options
- Housing support services
- Contingency funds such as security deposit or payment of back rent.

OMHSAS provides some technical assistance and training for this program through individual conference calls specific to individual county reinvestment plans, quarterly OMHSAS Housing calls, and Annual OMHSAS Regional Housing meetings. A significant benefit of the PSH program is the operating principle that no one should pay more than 30% of their income in rent. The Pennsylvania Housing and Affordability and Rehabilitation Enhancement (PHARE) Act 105 of 2010 was established to provide certain allocated state or federal funds to be used to assist with the creation, rehabilitation, and support of affordable housing throughout the Commonwealth.

The goals of the OMHSAS PSH Initiative are unchanged from the start of the initiative:

1. To create affordable supportive housing for people with disabilities, specifically
OMHSAS/DHS target populations
2. To use HealthChoices Reinvestment, CHIPPS or base funding to access and leverage mainstream housing resources and create partnerships with state and local housing and community development entities.

Low-Income Housing Tax Credits (LIHTC) and HOME funds continue to be extremely important to housing development. County MH/ID programs are becoming more comfortable working with private landlords and property managers to build confidence and thereby gain access to housing for consumers who would have been denied in the past, as well as working to sustain consumers in their housing.

During the COVID-19 PHE, there was a tremendous spike in unemployment with the temporary and permanent closure of many businesses, raising concerns that individuals and families would be unable to pay rent, which was addressed at the federal level and by many local jurisdictions by enacting moratoriums on evictions. In different areas, motels were repurposed to function as shelters to house the homeless and ensure social distancing. Some motels and hotels were used to help infected individuals to isolate themselves. DHS activated the Commonwealth's Sheltering Taskforce made up of local, county, and state agencies and other partners to work on the issues of sheltering individuals around the state. This included DCED planning the issuance of Emergency Solutions Grants to facilitate rapid rehousing efforts. Federal funding was important from spring through the fall of 2020, as it continues to be important at this time while Pennsylvania has begun to reduce the restrictions due to the pandemic. The funds have helped people retain housing, and landlords receive financial relief. Grants have been distributed to the counties through PHFA and other agencies with the counties directly, including:

- Act 24 Coronavirus Relief Funds (CRF)
- CARES Act funding provided $10M to counties to fund the Homeless Assistance Programs

- Consolidated Appropriations Act of 2021 provided Pennsylvania with approximately $569 million to administer assistance to renters, landlords, and utility providers affected by COVID-19.

Our progress with the development of housing options continues to recognize that many individuals who have a disability, including individuals who have a serious and persistent mental illness, can live successfully in the community if they have appropriate supports and services. We are continuing our progress to develop a viable integration plan for Pennsylvanians with mental illness and the need to have community alternatives in place for those who reside in the state hospitals or experience homelessness, as well as individuals with criminal justice histories, veterans, and others who live in congregate settings. We have been successful in advancing our endeavor and will continue to pursue opportunities to further Permanent Supportive Housing across Pennsylvania.

Fairweather Lodge (Adult only)

Fairweather lodges are small groups of four to eight people who share a house and own a small business or work in the community. Fairweather Lodges (FWL) foster mental well-being, independence, and community connection for four to eight people with serious mental illness in a shared living arrangement known as a lodge. These individuals, also known as lodge members, agree to live collectively in a lodge/house and either collaboratively own a small business or work in competitive integrated employment in the local community. Lodge businesses include lawn care, custodial or laundry services, printing, furniture building, shoe repair, catering, and other services. Lodge members assume specific positions of responsibility within the household and the business.

Pennsylvania currently has 22 Fairweather lodges and two Training lodges, of which three are veteran-centric. There will be two more veteran-centric lodges opening soon. Pennsylvania recognizes the importance of continued and consistent participation in national outcome reporting by all Pennsylvania lodges. Pennsylvania has a statewide

coalition of Fairweather lodge coordinators. The Fairweather Lodge program coordinators hold regional meetings to further the growth of the lodge principles and practices among the Pennsylvania lodges.

Vouchers for use by veterans are becoming a reality; there have been two referrals to lodges recently. The vouchers help offset some of the costs incurred through the model.

Case Management Services

In Pennsylvania mental health case management services are categorized as Administrative Case Management (ACM) and Targeted Case Management (TCM). TCM includes Intensive Case Management (ICM), Resource Coordination (RC), and Blended Case Management (BCM).

ACM refers to those activities and administrative functions undertaken to ensure the intake of clients into the county mental health system so that they can access available resources and specialized services. The activities include, but are not limited to:

- Processing intake into the Base Service Unit
- Verifying disability
- Determining liability
- Authorizing services
- Maintaining records and case files

TCM is provided in the Commonwealth of Pennsylvania to adults with serious mental illness (SMI) and to children with a serious emotional disturbance (SED), who are eligible for Medical Assistance under the State Plan. Clients who meet the medical necessity criteria for TCM but who are not eligible for Medicaid and do not have other means to pay could be eligible for TCM services paid for with state funds. TCM services are administered either directly by the County MH/ID administrations or by the providers contracted by the County MH/ID administrations. TCM services are available throughout the state.

Authorized under Section 1915(g) of the Social Security Act, Case Management services are services that will assist individuals with mental illness eligible under the

State Plan in gaining access to needed medical, social, educational, and other services. OMHSAS continues to introduce innovative case management practices to facilitate recovery for adults and resiliency for children. This is consistent with the guiding principle to provide services that are responsive to an individual's unique strengths and needs. The following are the categories of Targeted Case Management services provided in Pennsylvania:

- Intensive Case Management: ICM provides assistance to persons with SMI or SED in a variety of ways and is intended to assist the client in achieving specific outcomes such as independent living, vocational/educational participation, adequate social supports, and reduced hospitalization. Intensive Case Managers coordinate efforts to gain access to needed resources such as medical, social, educational, and other resources through natural supports, generic community resources, and specialized mental health treatment, rehabilitation, and support services.
- Resource Coordination: RC is targeted to individuals with SMI or SED who do not need the intensity and frequency of contacts provided through ICM, but who do need assistance in accessing, coordinating, and monitoring resources and services. RC services assess an individual's strengths/needs and assist the person in accessing resources and services in order to achieve stability in the community.
- Blended Case Management: In the BCM model, an individual is able to keep the same "blended case manager" despite a change in the level of service need, from ICM to RC level or from RC to ICM level. This model does not change the Case Management services being delivered but rather how these services are delivered. It was theorized that by permitting the blended case manager to adjust service intensity based on client needs, there would be improved continuity of care for the individual receiving services. In essence, the blended case manager would provide either ICM or RC level of service, essentially eliminating the distinction between RC and ICM.

There are other types of case management services that do not distinctly identify with the Case Management system previously described and are therefore not captured as Case Management by existing data collection systems. These services are provided by community treatment teams, primary therapists, peers, friends, families, natural supports, and other human services systems.

OMHSAS believes Case Management is a core service, and much emphasis is placed on training case managers. The training institute, Western Psychiatric Institute and Clinic, provides mandated state-approved core Case Management training to all new case managers. Additionally, biennial “refresher” training is required for all current case managers as of 2012. OMHSAS will also be offering training for case managers through **MyOMHSAS**, which is the *Electronic Learning Management System* (ELMS) commissioned by OMHSAS to provide training on a variety of behavioral health areas to providers, certain stakeholders, and OMHSAS staff.

Available Services: Substance Use Disorder/Co-Occurring

With the passage of Act 50 of 2010, the Commonwealth of Pennsylvania established the Department of Drug and Alcohol Programs (DDAP) with the statutory authority for administering all substance use services. DDAP was funded and implemented in Fiscal Year 2012/13 state budget. DDAP maintains responsibility for the development of the State Plan and for the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of substance use issues. DDAP is responsible for the allocation of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) in combination with state appropriations to the Single County Authorities (SCAs). The SCA system provides administrative oversight to local substance use programs that are required to provide prevention, intervention, and treatment services. The SCA system contracts with the local licensed treatment providers for the availability of a full continuum of care for individuals who qualify for substance use services within their geographical region. The continuum of substance use services includes outpatient, intensive outpatient, partial, non-hospital detoxification, non-hospital residential, halfway house, medically managed detoxification, and medically managed residential treatment.

Within DHS, OMHSAS is responsible for the oversight of two state funding streams to support substance use services. Additionally, OMHSAS oversees the statewide mandated Medicaid behavioral health managed care program (mental health and substance use services) known as HealthChoices, as well as the Medicaid fee-for-service funds for mental health and substance use services.

For HealthChoices members, the continuum of care provides an array of treatment interventions as well as additional ancillary services to support a recovery environment. Clinical services are determined based upon the comprehensive assessment process and the application of standardized placement criteria, the American Society of Addiction Medicine Criteria (ASAM), Third Edition, 2013, for all individuals seeking substance use treatment services.

Within HealthChoices, substance use service expansion opportunities are provided through reinvestment dollars (unexpended capitation money). Counties, in partnership with their stakeholders and managed care organizations, identify service gaps in their continuum of care and community recovery support resources and develop plans for the use of reinvestment funds to support additional services. All the plans are reviewed by OMHSAS for various factors before being granted approval.

Co-occurring services for individuals with both a substance use disorder (SUD) and Mental Health disorder continue to be supported by recognizing the need for providers to have competencies in co-occurring disorders. A bulletin outlining the core competency criteria for any licensed treatment program to be certified as a co-occurring competent program continues to be utilized as a minimum standard for the delivery of these services. With the transition to the use of the ASAM criteria for placement, the bulletin was revised in 2023 for consistency with ASAM criteria. This was a joint initiative between OMHSAS and DDAP.

There is a Co-Occurring Disorders Professional certification for clinicians offered by the Pennsylvania Certification Board (PCB), which became the model for the International Certification and Reciprocity Consortium in 2007. Professionals continue to meet the criteria and test for this credential. The counties and BH-MCOs have partnered to increase access to co-occurring services and supports across the state.

Available Services: Medical and Dental Services

Medical Provisions

As of March 2023, approximately 3.6 million individuals were enrolled in the Pennsylvania Medicaid Program. More than 21% of Pennsylvania's population is covered by either Medicaid or the Children's Health Insurance Program (CHIP). Now more people in the commonwealth have access to critical health care services including preventative care than ever before. The services covered under Pennsylvania's Medicaid program for adults include:

- Various ambulatory services that include: Primary Care Provider; Physician Services and Medical and Surgical Services provided by a Dentist; Certified Registered Nurse Practitioner; Federally Qualified Health Center/Rural Health Clinic; Independent Clinic; Outpatient Hospital Clinic; Podiatrist Services; Chiropractor Services; Optometrist Services; Hospice Care; Radiology; Dental Care Services; Outpatient Hospital Short Procedure Unit (SPU); Outpatient Ambulatory Surgical Center (ASC); Non-Emergency Medical Transportation; Family Planning Clinic, Services and Supplies; Renal Dialysis
- Emergency Services that include Emergency Room, Ambulance
- Hospitalization that includes Inpatient Acute; Inpatient Rehab; Inpatient Psychiatric; Inpatient Drug & Alcohol
- Maternity and Newborn Services that include Physician Certified Nurse Midwives, Birth Centers
- Mental Health and Substance Abuse (Behavioral Health) Services include Psychiatric Inpatient, Drug & Alcohol Inpatient, Outpatient Psychiatric Clinic; Mobile Mental Health Treatment; Outpatient Drug and Alcohol Treatment; Methadone Maintenance; Clozapine; Psychiatric Partial Hospitalization; Peer Support; Crisis Intervention; Targeted Case Management; Family Based Mental Health Services for Children and Adolescents; Residential Treatment Services for Children, as well as all medically necessary Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) behavioral health services for children under

21. Additionally, various cost-effective in-lieu-of state plan services are also available, including, but not limited to Assertive Community Treatment, Drug & Alcohol Non-Hospital Residential, Psychiatric Rehabilitation, Certified Drug & Alcohol Recovery Specialists, First Episode Psychosis programs, etc.

- Prescription Drugs, including all drugs used in opioid use disorder treatment
- Rehabilitation and Habilitation Services and Devices that include Skilled Nursing Facility; Home Health Care including Nursing, Aide, and Therapy services; Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and Intermediate Care Facility/Other Related Condition (ICF/ORC); Durable Medical Equipment; Prosthetics and Orthotics; Eyeglass Lenses; Eyeglass Frames; Contact Lenses; Medical Supplies; Therapy (Physical, Occupational, Speech)- Rehabilitative; Therapy (Physical, Occupational, Speech)-Habilitative
- Laboratory Services
- Preventative/Wellness Services and Chronic Care such as Tobacco Cessation, etc.
- Dental Services that include diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics, and sedation. The availability of dental benefits that a Medical Assistance (MA) recipient is eligible for has been standardized under the HealthChoices Expansion. MA provides coverage for the following dental services:
    - Children under age 21.
        - All medically necessary dental services.
    - Adults (individuals 21 years of age or older)
        - Eligible for the following services; however, certain services require a benefit limit exception (BLE) request as noted on MA Program Dental Fee Schedule at https://www.humanservices.state.pa.us/OUTPATIENTFEESCHEDULE/Home/Submit: diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation.

- Key Limitations: Dentures 1 per lifetime; Exams/prophylaxis 1 per 180 days; Crowns and adjunctive services, Periodontics and Endodontics only via approved BLE.
- The Department developed a BLE process for scenarios where a beneficiary is outside the age limit for a specific service or has already met the limit for that service. The Department will grant benefit limits exceptions to the dental benefit limits when one of the following criteria is met:
    1. The Department determines the recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the recipient.
    2. The Department determines the recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the recipient.
    3. The Department determines that granting a specific exception is a cost-effective alternative for the MA Program.
    4. The Department determines that granting an exception is necessary in order to comply with Federal law.
- If a dental BLE request identifies that the beneficiary has one of the conditions set forth below, as part of the dental BLE review process, the Department will review the MA beneficiary's claim history to determine if the condition was previously identified on a claim. If one of the following conditions has been previously identified the BLE request will be granted:
    1. Diabetes.
    2. Coronary Artery Disease or risk factors for the disease.
    3. Cancer of the Face, Neck, and Throat (does not include stage 0 or stage 1 non-invasive basal or sarcoma cell cancers of the skin).
    4. Intellectual Disability. 5. Current Pregnancy including post-partum period.

Pennsylvania also has a 100% state-funded medical assistance program known as General Assistance (GA-MA). Individuals who do not qualify for federally funded Medicaid due to nonfinancial reasons may receive Medical Assistance under this program if they meet the eligibility requirements for GA-MA (example: qualified aliens with a five-year bar to receive federally funded Medicaid).

Available Services: Integrated Services

Pennsylvania ended its participation in the CCBHC Demonstration effective June 30, 2019. This was due to the uncertainty of continued funding at the federal level at that time and because the data did not overwhelmingly support continuing or ending the demonstration. In an effort to implement a sustainable coordinated care model, Pennsylvania developed the Integrated Community Wellness Centers (ICWCs), which was implemented on January 1, 2020. The Department of Human Services (DHS) defines Integrated Community Wellness Centers (ICWC) as a service delivery model that requires coordinated, comprehensive, and quality care. Additional requirements include the provision of nine (9) core services:

1. Crisis Mental Health Services, including 24- hour mobile crisis team, emergency crisis intervention, and crisis stabilization
2. Targeted case management
3. Outpatient mental health and substance use services
4. Patient-centered treatment planning, including risk assessment and crisis planning
5. Screening, assessment, and diagnosis, including risk assessment
6. Psychiatric rehabilitation services
7. Peer support and counselor services and family support
8. Intensive, community-based mental health care for veterans and members of the military
9. Outpatient clinic primary care screening and monitoring of key health indicators and health risk

The ICWC populations being served are adults with serious mental illness, children with serious emotional disturbance, and those with long-term and serious substance use disorders, as well as others with mental illness and substance use disorders. Data will be analyzed to evaluate the outcomes of the ICWC and will also be compared to the outcomes of the 2-year CCBHC Demonstration.

Support Services

Suicide Prevention

In 2019, Governor Tom Wolf announced the formation of a statewide Suicide Prevention Task Force created to develop a new, comprehensive statewide suicide prevention plan. The Task Force included representatives from the Departments of Aging, Human Services, Drug and Alcohol Programs, Health, Military and Veterans Affairs, Education, Corrections, Transportation, PA State Police, and the PA Commission on Crime and Delinquency, as well as members of the General Assembly. From August through December 2019, the Task Force hosted a series of 10 listening sessions attended by over 800 stakeholders throughout the Commonwealth, who provided feedback and recommendations that were incorporated into the goals and objectives of the statewide plan. The 2020-2024 Pennsylvania Suicide Prevention Plan, released in September 2020, is aligned with the 2012 National Action Alliance for Suicide Prevention's National Strategy but reflects Pennsylvania's areas of priority. Since then, the Task Force has continued to meet under the guidance of a cross-agency leadership team, working to track current suicide prevention initiatives and strategies for implementation and monitoring of the plan's goals and objectives.

Pennsylvania's statewide suicide prevention organization, Prevent Suicide PA, has been a partner in the ongoing efforts of the Governor's Suicide Prevention Task Force. Training, screening, and awareness initiatives have been ongoing but were impacted by the COVID-19 pandemic. In May 2022, Prevent Suicide PA partnered with the Pennsylvania Higher Education Suicide Prevention Coalition to hold their annual Statewide Suicide Prevention Conference in a hybrid format (i.e., virtual, and in-person options in Pittsburgh, PA). Plenary sessions were provided by Dr. John Draper, focusing

on 988 implementation and roll-out, and by representatives from the Pennsylvania Suicide Prevention Task Force to provide updates on cross-agency initiatives from the statewide suicide prevention plan. A range of breakout sessions covered topics such as 'CAMS on campus', addressing burnout through community-focused self-care, and veteran suicide prevention. Prevent Suicide PA has continued to host the annual Suicide Prevention Night at the Ballpark events with the Philadelphia Phillies and Pittsburgh Pirates. They also oversee an annual suicide prevention PSA contest for high school students. The PSA posters, video, and audio clips are publicly available and widely promoted throughout the Commonwealth.

Since the formation of the Governor's Task Force, Pennsylvania's suicide prevention efforts have been largely focused on infrastructure development and the identification and engagement of key partners to support the statewide plan. Pennsylvania has received multiple grants through DHS and other agencies to support the ongoing expansion of statewide suicide prevention efforts.

Since 2008, OMHSAS has received four Garrett Lee Smith (GLS) grants from SAMHSA, to implement suicide prevention and early intervention strategies for youth between the ages of 10 and 24. The core goal of the current grant (2019-2024) involves the use of the Zero Suicide framework to improve continuity of care across youth-serving systems for youth at risk of suicide and their families. Additionally, the project builds upon prior GLS grants through continued development and dissemination of suicide prevention resources statewide, including through the Suicide Prevention Online Learning Center (https://pspalearning.com/) and Higher Education Suicide Prevention Coalition (https://hespc.org/). OMHSAS has also had a National Strategy for Suicide Prevention grant (2020-2023) focused on suicide prevention efforts in adults ages 25 and above. OMHSAS has received a nine-month 988 grant from Vibrant in 2021 and a two-year 988 implementation grant from SAMHSA (2022-2024).

Implementation of 988

Since the implementation and launch of 988 in July of 2022, OMHSAS has continued to work toward building, integrating, and improving crisis intervention services around 988. OMHSAS is working to ensure ongoing coordination and communication with 988 call

centers and the crisis services providers, county mental health systems, 911 leadership, law enforcement, and other partners involved in the crisis services system.

Funding is a key component of 988 and the crisis services system around it. To that end, OMHSAS actively identifies new funding opportunities and directs funding to the mental health crisis system. Utilizing funding provided through the 988 Capacity Building Grant, American Rescue Plan Act (ARPA) and Consolidated Appropriations Act (CAA), and other funding initiatives, OMHSAS is working to address workforce issues in 988 and ensure the availability of robust crisis services across the continuum. The commonwealth is also beginning efforts on 988 legislation, which, if passed, may provide a sustainable funding stream to cover some 988 costs.

Ahead of the forthcoming 988 national marketing campaign, OMHSAS is making efforts to improve linkages between 988 call centers and crisis services and develop a communications strategy. OMHSAS is currently in the process of building and implementing a crisis resources database for 988 call centers. This database will provide 988 call centers with vetted, regularly updated information about referral resources directly from county mental health programs. OMHSAS has also partnered with a university to conduct market research which will help develop its 988 communications strategy in partnership with Vibrant and SAMHSA.

Compeer

Compeer is an award-winning, non-profit organization that recruits, screens, and matches trained adult volunteers and mentors in one-to-one supportive friendships with individuals who are navigating through their recovery pathway and striving for good mental health. Compeer services are evidenced-based and considered adjunct to traditional mental health services. Compeer knows the healing power of friendships and seeks to offer those supports with a variety of programs. The Compeer program has received the Presidential Recognition Award from the U.S. Department of Health and Human Service, the first Eleanor Roosevelt Community Service Award, the Presidential

Volunteer Action Award, four Points of Light awards, and recognition from the American Psychiatric Association.

The Pennsylvania Compeer Coalition offers several programs, including but not limited to: Compeer Friend, CompeerCORPS, Compeer Calling, E-Buddy, Pen-Pal, offering small groups, socialization opportunities at recreational centers, and Student for a Semester. Pennsylvania's coalition of Compeer affiliates launched a CompeerCORPS veteran's program in 2013-2014, based on the Vet2Vet model developed by Compeer, Inc. This program focuses on the unique mental health needs of veterans transitioning back to civilian life.

COMPEER is celebrating their 50th anniversary in 2023 while continuing to work as a complement to psychiatric and therapeutic environments for people in recovery from behavioral health challenges. COMPEER has appointed a new Chief Executive Officer, Cheri Alvarez, who has a goal of building on the success of COMPEER and taking it to the next level while making a positive difference for individuals.

Family Support Services

Pennsylvania (PA) identified the need for and importance of peer support services for families of individuals with behavioral health diagnoses since it was nationally recognized by national agencies and research entities as far back as the 1970s. Throughout a ten-year period, 1979 through 1989, Pennsylvania families advocated for and assisted in the founding of the National Alliance on Mental Illness organization, as well as a national parent-run organization, and the establishment of what is now known as the Federation of Families of Children's Mental Health. Family peer support services (FPSS) help build effective engagement and can facilitate more positive outcomes for a family. This face-to-face intensive work is usually provided in the family's home and community based on the family's schedule and preference. Sessions and length of service can vary based on the needs of the family, programmatic guidelines, and funding requirements. The peers providing the FPSSs can be employed in positions across the spectrum of service intensity levels, from training and community education

to individual family support and care coordination, to functioning members of a treatment team in a crisis, residential, or inpatient setting.

In 2017, funds from PA Care Partnership Pennsylvania's State System of Care Cooperative Agreement, Philadelphia System of Care Cooperative Agreement, and Pennsylvania's Certified Community Behavioral Health Clinic to purchase the Family-Run Executive Director Leadership Association's (FREDLA) Parent Peer Support Practice Model curriculum. The purpose of purchasing the FREDLA curriculum was to use it to train primary caregivers interested in providing family peer support services (FPSS) to families of child, youth, or young adults who are presently involved or has previous involvement with the mental health or behavioral health system. The curriculum focuses on how to serve families whose children are between the ages of 0 to 26 with Serious Emotional Disturbances (SED), Serious Mental Illness (SMI), or MH/SUD Co-Occurring Disorders (COD). The Parent Peer Support Practice Model continues to be trained throughout Pennsylvania to individuals and/or agencies that are interested in or are providing peer support services to families in advance of a formal statewide certification being established.

In order to ensure that the implementation of FPSS reflects the needs of families and other stakeholders, OMHSAS established a Family Peer Support Services (FPSS) Steering Committee in 2021 to assist in the creation and implementation of a statewide family peer services certification. The FPSS Steering Committee currently meets monthly and provides recommendations and feedback at every step of the process. The FPSS Steering Committee focuses on building consensus amongst its members, ensuring that established timelines are being met and that all committee members advocate in a unified voice for certified FPSS across systems and across the lifespan. The FPSS Steering Committee will assist with and support several tasks, which are, but are not limited to, the following: national and state research as it pertains to FPSS, establishing a certification with the Pennsylvania Certification Board, creating sustainable funding mechanisms, and creating formal guidance. OMHSAS continues to support the Mental Health Planning Counsel's recommendation for creating and

expanding FPSS and continues to have a Community Mental Health Services Block Grant priority related to FPSS in this application.

Peer Support Services

Pennsylvania continues to work on multiple initiatives that focus on advocating for, strengthening, and expanding Peer Support Services (PSS) across the state. In 2021, PSS stakeholders were identified and brought together to form a committee for the purpose of identifying, evaluating, and discussing PSS across Pennsylvania and making informed recommendations regarding expansion and enhancement strategies. The Peer Stakeholder Committee started by discussing and evaluating PSS across the state, including collecting data from two surveys distributed to all Certified Peer Specialists (CPSs) and licensed PSS organizations. After completing research and analyzing data, the Peer Stakeholders Committee identified the following three goals to strengthen PSS in Pennsylvania: increasing access to PSS and CPSs, expanding specialization in the delivery of PSS, and diversifying PSS modalities. The Peer Stakeholders Committee then identified specific ways in which each of the three goals could be achieved, creating a plan of action to start immediately and span over the next several years.

Also, in 2021, while the Peer Stakeholders Committee was identifying areas and ways to strengthen PSS, a steering committee was created to expand PSS across Pennsylvania to the families of individuals diagnosed with behavioral health concerns. The focus of the Steering Committee is to create statewide guidelines and standards for PSS provided to families that will be referenced by the Pennsylvania Certification Board (PCB) in the creation of a family peer services certification, with the objective of adding it as a billable Medicaid service.

Moving forward to 2022 to the present day, the Peer Stakeholders Committee focuses on creating specialized skill enhancement training for CPSs, such as working with the older population or in a crisis setting, which will be called endorsement training. The endorsement trainings will be approved, monitored, and tracked through the PCB and

these training hours can be used as part of the required continuing education credits that CPSs need to obtain for re-certification.

Working concurrently with the Peer Stakeholder and Family Peer Committees, Pennsylvania continues to glean data and provide guidance to Peer Run Crisis Stabilization Units (PRCSU), previously called peer run crisis respites, while providing education and support to counties/joinders that are interested in opening PRCSU. The goal of the PRCSU continues to be to offer an alternative, to individuals with behavioral health concerns, to waiting in emergency rooms/departments and an inpatient stay. The PRCSU has a critical role in an individual's continuum of care, as well as being identified as a critical component in the rehaul of our crisis systems.

In the calendar year of 2023, Pennsylvania recognizes the need to increase and enhance PSS in Pennsylvania based upon continued research and experience showing that PSS has a transformative effect on both individuals and systems; CPSs increasingly being embedded within behavioral health services; the national call for crisis expansion in each state, to include PSS; and the need to help address the fundamental gaps in the behavioral health system, with the increased number of individuals reaching out for services since the pandemic. The high demand for behavioral health services continues to increase, particularly as the change in the economy continues to impact unemployment and a lack of basic resources for so many. Enhancing and strengthening the PSS workforce can not only address the immediate and growing behavioral health needs in Pennsylvania, but it can also help shape a future system of services rooted in empowerment, hope, connection, human rights, and lived experience. With a focus on the entire person and empowering individuals to take ownership of their own well-being, peers help those they support to stay engaged in monitoring and improving their overall health.

Focusing on the need to enhance the behavioral health workforce, it has been identified that the CPS workforce can be increased more quickly than other behavioral health professions because their primary value comes from their lived experience. Their firsthand knowledge of the healing process, pathways to recovery, and sustained recovery provide CPSs with years of informal training in building their perspective and

therefore require less intensive formal training. While a CPS does not substitute or replace behavioral health treatment, they offer a unique layer of support.

The Department is working to revise specific qualifications of CPSs to remove barriers that hinder an individual with lived experience, without harming the fidelity of the work, from becoming a CPS.

Moving PSS forward over the next three (3) years, Pennsylvania will continue each of these initiatives and will include the following projects: creation and implementation of standardized mandated training for individuals who want to become a CPS; additional endorsement training opportunities; developing a career ladder for CPSs as well as commensurate wages, as well as continue to diversify modalities where CPS play a critical role such as: drop in-centers, PRCSU, and all areas of the crisis continuum.

Cultural and Linguistic Competence in Mental Health Services

OMHSAS has identified Cultural and Linguistic Competence (CLC) as an important priority for both OMHSAS staff and the state mental health system. In 2018, the OMHSAS CLC workgroup identified a need to obtain improved data regarding the status of CLC services across the state as an important step in planning system improvements. OMHSAS has taken several steps in improving data collection since that time, including enhancing CLC Reporting from the Counties as a part of the Human Services Planning Process. In addition, the collection of demographic information on OMHSAS surveys and programmatic reports for CMHSBG-funded projects has been updated to include options for reporting non-binary gender, transgender identity, and sexual orientation data.

In addition to broad CLC efforts, OMHSAS has partnered with CHOP's Gender & Sexuality Development Clinic to provide training to mental health providers to increase their comfort and competence when working with transgender and gender-expansive clients. These webinars address specific supports in the area of medical care, psychiatry support, sexuality and relationship support, and school-based advocacy.

These trainings are housed on OMHSAS' Electronic Learning Management System (ELMS) entitled MyOMHSAS.

OMHSAS has two bulletins addressing the needs of the LGBTQIA+ community in the behavioral health system, OMHSAS-11-01 Non-Discrimination Toward Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex People and OMHSAS-11-02 Guidelines to Ensure Affirmative Environments and Clinically Appropriate Services for Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex Consumer and their Family Members. OMHSAS is currently working on the development of a single combined guidance bulletin that will enhance our ability to ensure non-discrimination for the LGBTQIA+ community and to enhance our ability to offer culturally competent services in the behavioral health system. OMHSAS, along with the full Department of Human Services, has been actively focused on Diversity, Equity, and Inclusion (DEI) during SFY20-21. At the direction of former DHS Secretary Teresa Miller, DHS Executive Staff were engaged to enhance DEI work in each program office, convened a DHS Racial Equity Steering Committee, and increased training for commonwealth employees.

Forensic Services

The Mental Health and Justice Advisory Committee (MHJAC) is a collaborative effort between OMHSAS and the Pennsylvania Commission on Crime and Delinquency (PCCD). This advisory committee provides guidance and structure to ensure that Pennsylvania's criminal justice/mental health activities are coordinated statewide and ensures that counties receive the guidance and support necessary to implement effective evidence-based or promising practices. In partnership with DHS/OMHSAS, the advisory committee includes representatives from state agencies, county leadership, the courts, district attorneys, public defenders, individuals and families with lived experience, and other criminal justice and mental health advocates and practitioners from across the Commonwealth.

MHJAC recognizes the

“Sequential Intercept Model” as a best practice for mental health consumers in the criminal justice system. This model delineates five points of interception:

1. Law Enforcement and Emergency Services
2. Initial Detention and Initial Hearings
3. Jail, Courts, Forensic Evaluations, and Forensic Commitments
4. Reentry from Jails, State Prisons, and Forensic Hospitalization
5. Community Corrections and Community Support.

Each point of contact provides an opportunity to divert mental health consumers from funneling further into the criminal justice system.

MHJAC formally recognizes Stepping UP Pennsylvania as a committee priority and has deemed it appropriate for the Council of State Governments (CSG) to provide technical assistance to counties for the advancement of the Stepping Up Initiative. Funding is provided through MHJAC to support a multi-pronged approach to support counties’ Stepping Up related work including, but not limited to, the implementation of a cohort approach to technical assistance, the identification and use of best practices, and the creation of a central information bank on the intersection of serious mental illness and criminal justice. To date 35 of 67 Pennsylvania counties have signed a Stepping Up Resolution. Pennsylvania has 5 counties recognized by Stepping Up as Innovator Counties: Berks, Montgomery, Dauphin, Cumberland, and Philadelphia, more than any other state. To be recognized as an innovator county a three-step approach to data collection must be implemented:

1. Establish a shared definition of SMI for your Stepping Up efforts that is used throughout local criminal justice and behavioral health systems
2. Use a validated mental health screening tool on every person booked into the jail and refer people who screen positive for symptoms of SMI to a follow-up clinical assessment by a licensed mental health professional
3. Record clinical assessment results and regularly report on this population.

The MHJAC subcommittee reviewed the full report and prioritized the recommendations that met the following criteria: medium to high scale of impact, low resource need, and short-term plausibility. Focusing on these recommendations will allow the state to make significant progress even while facing substantial budget constraints.

MHJAC supports the development of CIT. Grants for CIT training have been distributed multiple times through the MHJAC. The last round of CIT funding occurred in May 2022 and was $130,000 in federal and state funds to support Crisis Intervention Team (CIT) training and promote the use of CIT in Pennsylvania communities.

OMHSAS standard of practice is to complete court-ordered competency evaluations for individuals who are incarcerated at a PA county prison. OMHSAS established the Outpatient Competency Evaluation Program (OCEP) which serves as an alternative to inpatient services so individuals who are incarcerated can receive services in a timely manner. As of April 30, 2023, 2,888 competency evaluations have been completed on an outpatient basis through this program.

OMHSAS Staff represent the mental health system at an interagency coordinating committee for the forensic population. The Pennsylvania Forensic Interagency Task Force (FITF) is a group of committed professionals, family members, and consumers who have met for over twenty years and currently meet every other month to address issues related to the care of persons with serious mental illness who are involved in the criminal justice system. Past initiatives have had effective outcomes for this population in both community mental health services and in state and county correctional institutions.

Mobile Mental Health

Mobile Mental Health Treatment (MMHT) is an array of services for individuals who have encountered barriers to or have been unsuccessful in receiving services in an outpatient clinic. MMHT has been a Medicaid state plan service since 2006. The purpose of MMHT is to enhance the array of services by providing treatment traditionally offered in an outpatient clinic in the least restrictive setting possible to

reduce the need for more intensive levels of service. MMHT encompasses evaluation and treatment, including individual, group, and family therapy, as well as medication visits, in an individual's residence or other appropriate community-based settings.

Adult Developmental Training (Adult only)

Adult Developmental Training (ADT) programs are community-based programs designed to facilitate the acquisition of prevocational skills, enhance activities of daily living, and improve independent living skills. As a prerequisite for work-oriented programming, ADT programs concentrate on improving cognitive development, communication development, physical development, and working skills development. Adult development training programs are provided in facilities licensed under Adult Day Centers regulations.

Other Activities Leading to Reduction of Hospitalization

Pennsylvania has two approaches for impacting the rate of hospitalization: 1) the development of new services designed specifically to meet the needs of persons with serious mental illness or serious emotional disturbance, and 2) the allocation of state mental hospital financial resources through the Community Hospital Integration Program Project and other funding sources.

Community/Hospital Integration Projects Program

The Community/Hospital Integration Projects Program (CHIPP) is a state initiative, in partnership with local county mental health programs, that enables the discharge of people served in Pennsylvania state hospitals who have extended lengths of stay or complex service needs to less restrictive community-based programs and supports. CHIPP was designed to develop the needed resources for successful community placement of individuals that include: Case Management services, residential services, and rehabilitation/treatment services. CHIPP was created to build local community capacity for diversionary services to prevent unnecessary future hospitalizations. CHIPP is dependent on the involvement of the consumer and family in the design,

implementation, and monitoring of individual Community Support Plans. CHIPP was built upon Community Support Program principles that require consumers, family members, and persons in recovery to be involved in the decision-making process.

History of CHIPPs

- Approximately 3 people can be served in the community with the funds needed to support 1 person in a state hospital. Started in fiscal year 1991/92 with an initial funding of $6.5 million.
- As of April 10, 2023, the hospital mental health census for the six state hospitals and South Mountain Restoration Center was a total of 1,470 individuals.
- 974 Civil (1.3% increase from 2021 census reported in prior CMHSBG application)
- 97 Long-Term Care
- 337 Forensic
- 62 Act 21 Sexual Responsibility and Treatment Program
- More than 87% of the state mental health budget is now spent on community-based services.
- Through CHIPP-funded opportunities, 3,621 people have been discharged since inception.
- The CHIPP/SIPP funding for SFY22-23 is $299,805,245.

Details regarding how the CHIPPs initiative works:

- County submits a proposal to the state for CHIPP discharges as part of the annual plan.
- Assessments are completed with people identified for likely CHIPP discharge.
- County submits CHIPP program description and budget to state for approval.

- County works with local area provider agencies to begin the discharge process and identify the best match for consumers
- A portion of the state hospital civil beds are closed as people are discharged
- State transfers state hospital funds to the county budget to support those discharged
- CHIPP funding is annualized
- Process takes approximately 12 months to complete and traditionally has included the allocation of 6 months of startup funding.

AOT

Assisted Outpatient Treatment (AOT) was signed into law on October 24, 2018 as Act 106 of 2018 (P.L.690, No.106). AOT took effect on April 22, 2019, and amended the Mental Health Procedures Act (MHPA) to add AOT as an alternative for involuntary outpatient treatment under Sections 303, 304, and 305. The addition of AOT does not eliminate or modify existing voluntary or involuntary mental health treatment procedures. AOT is an outpatient treatment ordered by the court for a person who is determined to be severely mentally ill. AOT is provided in a community setting and is not an inpatient treatment. AOT services are unique to each individual and are based on an AOT Plan designed in collaboration with the person. AOT is “treatment” under the MHPA that includes care and other services that supplement treatment (of mental illness) and aid or promote such recovery which may include substance use disorder (SUD) treatment or support service recommendations.

During 2019, OMHSAS offered two webinars regarding AOT. In March, a webinar that focused on the overall provisions as required by AOT was offered to county administrators. Later in November of that year, a webinar that focused on the implementation of AOT was also offered to county administrators. In addition, OMHSAS Bulletin-19-04 (Guidelines for Implementing Assisted Outpatient Treatment) was released in November as well.

AOT services are offered in almost all 50 states. In Pennsylvania, each county/joinder must decide whether or not to provide AOT annually; counties electing to opt out of providing AOT must submit the MH-791 form on or before December 31 of each year. To date, only Bucks County has opted to provide AOT services since its implementation. All other counties/joinders do not offer AOT services. If implemented successfully, AOT may assist with connecting and engaging with treatment and support services that will help those who qualify to move forward in their recovery process. AOT may also help to decrease hospitalization, decrease incarceration, decrease stress on crisis and emergency services with fewer police calls for behavioral health reasons, and perhaps improve the quality of life for individuals in need of mental health treatment. Counties/joinders have been hesitant to implement AOT as there will need to be extensive training for everyone who will be involved in the process, including police, district magistrates, judges, district attorneys, public defenders, behavioral health providers, hospital staff, and county personnel. In addition, there have been concerns about the strain it may cause the county/joinder mental health system, both in a fiscal and workload capacity.

Medicaid Targets Specific to Children's Services

The following chart shows the breakdown of Medicaid funding for various children's behavioral health services:

SFY 2021–2022 Children's Summary

Total Dollars			
Category of Service	**PLE**	**FFS**	**Total**
Inpatient Psychiatric	$ 186,905,784	$ 1,351,340	$ 188,257,124
Outpatient Psychiatric	$ 168,031,668	$ 459,475	$ 168,491,143
RTF-Accredited	$ 119,705,546	$ 460,889	$ 120,166,435
RTF-Non Accredited	$ 38,382,822	$ 4,064	$ 38,386,886
Ancillary Support	$ 153,595	$ 5,964	$ 159,559
Other Services	$ 39,105,071	$ -	$ 39,105,071
ABA	$ 159,753,960	$ 555,845	$ 160,309,805
Individual Services	$ 106,092,523	$ 369,136	$ 106,461,659
Group Services	$ 5,968,839	$ 20,768	$ 5,989,607
Other IBHS	$ 94,941,907	$ 181,460	$ 95,123,366
IBHS Total	**$ 366,757,229**	**$ 1,127,209**	**$ 367,884,438**
Crisis Services	$ 14,588,861	$ 11,353	$ 14,600,213
Family-Based Services	$ 81,394,008	$ 328,349	$ 81,722,358
Targeted Case Management	$ 24,072,056	$ 69,105	$ 24,141,161
Peer Support Services	$ 996,996	$ 304	$ 997,300
Other Community Support	$ -	$ -	$ -
Community Support Total	**$ 121,051,921**	**$ 409,111**	**$ 121,461,032**
Substance Abuse	$ 17,739,902	$ 107,048	$ 17,846,950
Total	**$ 1,057,833,538**	**$ 3,925,100**	**$ 1,061,758,638**

Notes:

1. The summary above reflects statewide SFY 2021–2022 HealthChoices Behavioral Health PLE and Behavioral Health FFS data with runout through December 2022 for those under age 21.
2. The PLE is not fully inclusive of all APA arrangements (including COVID gap payments) and therefore the dollars and users specific to those arrangements are not reflected in this summary with the exception of certain school based APAs that were added to Other IBHS.
3. The breakout for FFS IBHS subservices is based on IBHS subservice splits observed in the PLE data.
4. The Substance Abuse category includes Inpatient D&A, Non-Hospital D&A, and Outpatient D&A.

Criterion 2: Mental Health System Data Epidemiology Quality Management

Performance Measure Reporting:

The External Quality Review Organization validated performance measurements and Behavioral Health HealthChoices (BH HC) average results for the measurement years (MY) 2021 – 2023.

In MY 2021, OMHSAS's HC Quality Program required MCOs to run three Performance Measures (PMs) as part of their quality assessment and performance improvement

(QAPI) program: the HEDIS Follow-Up After Hospitalization for Mental Illness (FUH), a PA-specific Follow-Up After Hospitalization for Mental Illness, and a PA-specific Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were remeasured in 2021. The EQRO validated all three PMs reported by each Managed Care Organization (MCO) for MY 2021 to ensure that the PMs were implemented to specifications and state reporting requirements (Title 42 CFR § 438.330[b][2]).

OMHSAS has also implemented a 3-year plan to improve and sustain performance for Follow-Up after Hospitalization (FUH) for Mental Illness. The 3-year plan includes performance goals that are largely based on the national Healthcare Effectiveness Data and Information Set (HEDIS) benchmarks for Follow-Up after Hospitalization for Mental Illness (ages 6 and over). The 3-year plan also provides the opportunity to more closely evaluate, and address frequency (access) and quality (establishment of statewide best practices) issues related to FUH. The intended impact is to enhance the effectiveness of transition supports and services for HealthChoices members with mental illness and reduce statewide 30-, 60- and 90-day readmission rates.

In addition, OMHSAS and the Office of Medical Assistance Programs (OMAP) created a pay for performance (P4P) expectation for both the Physical Health Managed Care Organizations (PH-MCOs) and the BH-MCOs to improve the overall health of those with Serious Persistent Mental Illness (SPMI). The program measures Benchmark Performance and Improvement Performance for each PM as appropriate.

Performance Improvement Project (PIP)

In 2019, OMHSAS identified a new Performance Improvement Project. The topic is “Prevention, Early Detection, Treatment and Recovery (PEDTAR) for Substance Use Disorders”. The PIP will extend from 2021 through 2023, including the final report to be submitted in 2024. The aim of the project is to “Significantly slow (and eventually stop) the growth of SUD prevalence among HC members while improving outcomes for those individuals with SUD, and also addressing racial and ethnic health disparities through a systematic and person-centered approach.”

OMHSAS selected three common (for all BH-MCOs) clinical objectives and one non-clinical population health objective:

1. Increase access to appropriate screening, referral, and treatment for members with an Opioid and/or other SUD;
2. Improve retention in treatment for members with an Opioid and/or other SUD diagnosis;
3. Increase concurrent use of Drug & Alcohol counseling in conjunction with Pharmacotherapy (Medication-Assisted Treatment); and
4. Develop a population-based prevention strategy with a minimum of at least two activities across the MCO/HC BH Contracting networks.

Additionally, OMHSAS identified the following core PMs for the PEDTAR PIP:

1. Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)
2. Substance Use Disorder-Related Avoidable Readmissions (SAR)
3. Mental Health-Related Avoidable Readmissions (MHR)
4. Medication-Assisted Treatment for Opioid Use Disorder (MAT-OUD) counseling.
5. Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD)

Consolidated Community Reporting Initiative

OMHSAS' Consolidated Community Reporting Initiative was established to build a statewide infrastructure to report consumer-level service utilization and outcome information on persons receiving County base-funded mental health services. CCRI provides the only statewide data infrastructure for client-level data (CLD) reporting of county-based mental health services. Data received through CCRI is used for trending and analysis to identify opportunities for increased access to quality services within the Pennsylvania behavioral health system. Through collaboration with counties, CLD data can support additional and targeted state and federal funding opportunities that best meet the needs of Commonwealth citizens. The receipt of CLD ensures compliance with Federal reporting requirements and keeps the Commonwealth in good standing as

a grant recipient and a national contributor of data that provides for the direction of future federal funding opportunities.

External Quality Review Organization

OMHSAS uses the External Quality Review Organization (EQRO) vendor to provide this multi-year HealthChoices (HC) encounter data validation process. Quality encounter data serves multiple purposes, such as determining capitation rates, identifying utilization trends, patterns of care, and potential waste for the HC BH managed care program.

Other QM Activities

The following is a discussion of some of the other QM activities utilized by OMHSAS:

- **Performance Measures Monitoring (other uses) –** The Department of Human Services/OMHSAS monitors performance by measuring the various processes. This function provides current information to the BH-MCO, BH HC Contracts, and OMHSAS to identify areas of compliance, needed improvement or to initiate corrective action plans.

- **Behavioral Health Consumer/ Beneficiary Focus Groups – Consumer/Family Satisfaction Surveys** - The local surveys are conducted quarterly with a small subset of questions asked of all consumers and family members across the BH HC Contracts. This survey is used locally to assess satisfaction with the BH-MCO, providers, identified service needs, access to care issues, and areas for improvement or new services. The statewide questions are reported quarterly to OMHSAS and used as an ongoing source of information about the satisfaction of adult and children BH HC members.

- **Mental Health Statistics Improvement Program (MHSIP)** - annual adult consumer and family member perception of care surveys are conducted to assess

a variety of individual and system domains. The nationally recognized domains and the surveyed population (in parentheses) are identified below:

- Access to Care (Adult Consumer, Family Member of Child or Adolescent Consumer)
- Cultural Sensitivity of Staff (Family)
- Functioning (Adult, Family)
- General Satisfaction (Adult, Family)
- Outcomes of Care (Adult, Family)
- Participation in Treatment Planning (Adult, Family)
- Quality and Appropriateness (Adult)
- Social Connectedness (Adult, Family)

The surveys also address the following consumer-level outcomes of care:

- Arrests, pre- and post-mental health services (Adult, Child)
- School Attendance (Child)

The adult survey includes eight (8) questions from the Centers for Disease and Prevention's Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS questions address the linkage between adult consumer mental health and comorbid physical health concerns.

- **External Quality Review** - The EQR-related activities are included in an annual detailed technical report and are reviewed to determine MCO compliance with the following:
  - structure and operations standards established by the State,
  - validation of performance improvement projects,
  - validation of the BH-MCO performance measure submissions.

  In addition, OMHSAS will implement voluntary EQR Protocols with BH-MCOs to meet Pennsylvania's data strategic goals & initiatives. These include the validating BH encounter data by comparing the BH-MCO performance measure submissions to the encounters submitted to OMHSAS.

- **Data analysis (non-claims) - Behavioral Health Denials of Referral Requests** – OMHSAS conducts annual reviews of quarterly data submitted by the BH-MCOs. The review results are summarized and used to assess compliance in the Program Evaluation Performance Summary (PEPS) for each BH HC Primary Contractor /BH-MCO.

- **Behavioral Health Complaints and Grievances Data** – OMHSAS conducts annual Reviews of quarterly data submitted by the BH-MCOs. The review results are summarized and subsequently used to assess compliance in the Program Evaluation Performance Summary (PEPS) for each HCBH Primary Contractor/BH-MCO. The results may also be used to track and trend complaints and grievances to identify systematic deficiencies.
- **Provider Self Report Data - Survey of Providers** – An annual survey is performed to garner provider insight about the management and interaction with Behavioral Health Manage Care Organizations. Analysis of the results leads to the identification of barriers to quality operation and opportunities to improve provider-related processes. This is reported through the Program Evaluation Performance Summary (PEPS) process described below.

- **Program Evaluation Performance Summary (PEPS)** – The PEPS process is housed in the Medicaid Enterprise Monitoring Module (MEMM). The SMART application of this module allows OMHSAS to track the annual and triennial compliance reviews of programmatic standards. Reviews are conducted using the federal & state standards and findings are applied to maintain the expected standard for a state Medicaid Managed Care program. PEPS review findings identify non-compliance and partial compliance and can result in a Corrective Action Plan (CAP), which is followed until resolution. OMHSAS has implemented the MEMM/SMART web-based application to streamline the collection of its PEPS monitoring data; to increase the efficiency of data entry and retrieval to meet program monitoring needs.

Criterion 3: Children's Services

Child and Adolescent Service System Program

Pennsylvania is guided by the Child and Adolescent Service System Program (CASSP) principles for the development and delivery of services to children and adolescents with serious emotional disorders and their families. The CASSP principles require that services provided be child-centered, family-focused, community-based, multi-system, culturally competent, and least restrictive/intensive. County Mental Health programs are expected to have a person identified as a CASSP or children's behavioral health coordinator who serves as the contact person for children with multi-system needs. This comprehensive and effective system of care recognizes that children and adolescents with severe emotional disorders and behavioral health needs often require services from more than one child-serving system.

Pennsylvania System of Care Partnership

Pennsylvania has been awarded several grants from SAMHSA to develop Systems of Care to serve youth ages 8-18 that have serious mental health needs and their families. These youth are often involved with child welfare or juvenile justice and are in, or at risk of, out-of-home placement. Pennsylvania is part of the national movement to utilize organized, multilevel, and multi-disciplinary systems, in partnership with youth and families, to more effectively serve multi-system youth with serious behavioral health challenges and their families.

The System of Care Partnership builds on and enhances cross-systems efforts that have been underway for several years to integrate and more effectively provide services to youth. Each participating county will utilize High Fidelity Wraparound (HFW), or another validated cross-system planning model, as the engagement and care planning process for youth involved in multiple systems. The Youth and Family Training Institute, a division of the University of Pittsburgh and Western Psychiatric Institute and Clinic of UPMC, will train, support, monitor, and evaluate the HFW teams in each county and will provide training and support for other cross-system planning models.

Intensive Behavioral Health Services

Intensive Behavioral Health Services (IBHS) are individualized, based on the specific needs of the child, youth, or young adult, and built around the strengths of the individual and their family. IBHS are available through Pennsylvania's expanded Medical Assistance Program for children up to age 21 and include services such as mobile therapy, behavior consultation, behavioral health technician, applied behavior analysis (ABA) services, a variety of evidence-based therapies, and group services. Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Parent-Child Interaction Therapy (PCIT) are all approved programs under IBHS. Children, youth, and young adults must have a behavioral health diagnosis and a written order from a licensed practitioner which establishes why IBHS is medically necessary. Interagency teams are utilized throughout the treatment process and are expected to include the child, youth, or young adult and their family.

Multisystemic Therapy

Multisystemic Therapy (MST) is an intensive family and community-based treatment program that works with youth who are at risk for out-of-home placements. It is a time-limited therapeutic program that typically provides services for four to six months. MST's distinctive characteristics include 24-hour availability of staff and delivery of services in the home, school, and community. The program focuses on making improvements in the psychosocial functioning of the youth and family. Family interventions are aimed at promoting parental capacities to monitor the adolescent's behaviors and to provide effective discipline. MST peer interventions focus on removing youth from their deviant group of peers and encouraging pro-social peer relationships.

As of July 1, 2021, there are 42 MST providers serving over 54 counties in Pennsylvania. All of these programs are enrolled in Medical Assistance. The target population is adolescents who exhibit severe or chronic acting out behaviors, many of whom have been involved with Juvenile Probation due to delinquent activities.

Family-Based Mental Health Services

Pennsylvania's model of intensive in-home services is called Family-Based Mental Health Services (FBMHS). Family-Based services are team-delivered, rapid response, time-limited, holistic treatment and support that provide clinical intervention for families including skill building, crisis management, linkages to community services, and family support services. The guiding principle is that children thrive in their own homes and communities. Families are partners and resources in treatment planning and delivery. FBMHS teams are available 24 hours a day, seven days a week. They also ensure coordination of services among all child-serving agencies. Children must have a serious emotional disturbance and be determined at risk for out-of-home placement, and at least one adult member of the child's family must agree to participate in the service.

The OMHSAS Children's Bureau has been collaborating with the three approved FBMHS trainers to strengthen the role of the clinical supervisor in the model which will in turn strengthen the clinical service delivery to families. The process involves intensifying the role of the supervisor within the training program, requiring all staff to pass certification requirements and modifying the exam process to reflect the certification requirements.

Respite Services

Respite care is defined as temporary short-term care that helps a family take a break from the daily routine and stress associated with caring for a child with serious emotional and/or behavioral disorders. Respite care can be provided to families on either a planned or unplanned basis and can take place in the family's home or in a variety of out-of-home settings. Respite care is used to help prevent family disruptions and allow families the time they need to renew their energy. It also enables them to continue caring for their children at home and prevent out-of-home placement of a child with serious emotional disturbances and behavioral difficulties. Many County MH/ID Programs in Pennsylvania provide some respite services for families whose children receive behavioral health services. OMHSAS wants to continue to support counties in their efforts to better meet the respite needs of families.

School Based Behavioral Health

The Children's Bureau is working in conjunction with the Department of Education to ensure that schools are supportive environments that maximize learning and promote healthy social, emotional, and behavioral development. School Based Behavioral Health (SBBH) brings together schools, county mental health programs, and community resources to develop a continuum of services that enable children to have their educational and mental health needs met within their school districts. The Children's Bureau is moving forward in several areas of the state to support school-based mental health initiatives.

Pennsylvania began implementing School-Wide Positive Behavioral Interventions and Supports (SWPBIS) through a small pilot project 8 years ago. As of the 2019-2020 school year, 2,701 schools in Pennsylvania are in some stage of the implementation process. In addition, the Commonwealth has been supporting the growth of program-wide PBIS in Early Childhood learning settings.

Outpatient Psychiatric Clinic Services

Outpatient mental health services are delivered in a community treatment setting under medical supervision. Services include examination, diagnosis, and treatment for children and adolescents with serious emotional disturbance. Outpatient services are delivered on a planned and regularly scheduled basis. Satellite outpatient clinics may provide services to children in schools, detention centers, or childcare facilities.

Partial Hospitalization Services

Partial hospitalization is a nonresidential form of treatment in a freestanding or school-based program providing 3-6 hours per day of structured treatment and support services to enable children to return to or remain at home, in school, and in their community. Activities include therapeutic recreation, individual, family, and group therapies, and social skill development. Persons receiving this level of care require more intensive and comprehensive services than are offered in outpatient clinic

programs but do not require a 24-hour level of care. Children attending partial programs must have a moderate to severe mental or emotional disorder.

Residential Treatment Facilities

Residential treatment facilities (RTF) provide 24-hour care where children and adolescents receive intensive and structured comprehensive behavioral health services. The RTF works actively with the family and other agencies to create brief, intense treatment that will result in the child's successful return home or to a less restrictive community living setting. The child/adolescent must have a SED, be Medical Assistance eligible, and have the medical necessity for that level of care.

Psychiatric Inpatient Hospitalization

Psychiatric inpatient hospitalization is the most intensive and restrictive treatment setting for treating children and adolescents. This highly structured environment provides acute treatment interventions, diagnostic evaluations, stabilization, and treatment planning so that the child can be quickly stabilized and appropriately discharged to less restrictive services. The child/adolescent must have a serious emotional disturbance or mental illness.

Crisis Intervention and Emergency Services

These services are designed to provide a rapid response to crisis situations that threaten the well-being of children, adolescents, and their families. Crisis services include intervention, assessment, counseling, screening, and disposition.

Commonwealth Student Assistance Program

The Commonwealth Student Assistance Program (SAP) is a state-mandated multidisciplinary school-based program for students from kindergarten through grade 12. It is a systematic process designed to assist school personnel in identifying students who are experiencing behavioral and/or academic difficulties which pose a barrier to

learning and academic success. The primary goal of SAP is to help students overcome barriers to learning. SAP teams use concrete, observable behaviors to identify students' barriers to learning. SAP team members do not diagnose or treat; however, they may refer a student for an MH or D&A screening or assessment to identify appropriate school and community-based recommendations, including treatment. SAP Liaisons from county MH and D&A agencies are contracted by the schools to perform the screening and assessments and refer to treatment as necessary. Parents and guardians are vital members of the team and must give written permission for their child's SAP involvement.

OMHSAS, the Department of Education (PDE), and the Department of Drug and Alcohol Programs collaboratively oversee the Student Assistance Program through the PA Network of Student Assistance Services (PNSAS), and representatives from each agency make up the SAP Interagency Committee. The Interagency Committee meets regularly to discuss and problem-solve issues as they arise. In addition, there are 10 regional coordinator positions, 5 of which are funded by OMHSAS (PDE funds the remaining 5 through a contract with the Intermediate Units (IUs.)) The Regional Coordinators are responsible for the oversight of county SAP operations, as well as of the Pennsylvania Approved SAP Training Providers (PASTPs), the statewide training network responsible for training school SAP teams. The Regional Coordinators are the most direct source of information and SAP coordination at the county level.

92,912 students statewide were referred to school SAP core teams during FY 21/22. Through the Joint Quarterly Reporting System (JQRS) maintained by OMHSAS, SAP liaison agencies reported that 33,199 screenings or assessments were conducted, including 16,308 suicide screens or assessments. Of those students referred for assessment, 72.1% were identified with a mental health concern, 12.5% were identified with a drug or alcohol concern, and 15.3% were identified with a co-occurring concern.

Services Provided Under Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act (IDEA), first signed into law in 1975, established that all children with disabilities have a right to a free, appropriate public

education. It offers funding and policy assistance to states in providing appropriate support services (e.g., counseling, transportation) to students with special needs. In light of significant amendments to the Act in 1997 (known as IDEA 97), Pennsylvania developed a Memorandum of Understanding (MOU) between the Departments of Education, Public Welfare (now Human Services), Health, and Labor and Industry that defines the way those departments must work together to ensure appropriate educational services for children with disabilities. The reauthorization of IDEA in 2004 along with the No Child Left Behind provisions, have strengthened the partnerships created by the MOU.

Criterion 4: Targeted Services to Rural and Homeless Populations and Older Adults

The system/services discussed under this criterion apply to both adults and children/adolescents where the services are age appropriate for children/adolescents.

Homeless Outreach and Services

Pennsylvania's approach to providing services to persons who are homeless or at risk of becoming homeless is to expand and improve the community programs in each locality, especially those critical support services such as housing, crisis outreach, and benefit acquisition. Pennsylvania has also focused specific attention on the homeless population by developing specialized outreach and supportive housing services and through the utilization of state and federal funds. Every county mental health program has identified a housing specialist who receives technical assistance from OMHSAS.

Homelessness continues to be an issue in many communities across the Commonwealth, including most rural counties. On any given day, over 15,000 Pennsylvanians are known to be homeless, including over 8,000 individuals in the more rural regions. Individuals who are homeless include individuals living on the streets, doubling up with family or friends, or in shelters. The homeless count includes both children and adults.

DCED administers Emergency Solutions Grant (ESG) funds that support homeless services and facilities across Pennsylvania. Priority is given to the non-entitlement

municipalities of the state; all areas may apply for funding. In 2021 DCED funded 28 counties with awards totaling $5,772,551. Projects included:

- 34 Rapid Rehousing
- 24 Homeless Prevention
- 27 Emergency Shelter
- 14 Street Outreach Activities

Additional services and facilities are funded directly by the direct entitlement jurisdictions with their own ESG funding.

In addition to federal funding, the Commonwealth has a number of programs through DHS to address the needs of individuals experiencing homelessness. The ones most often leveraged with ESG funding in Pennsylvania are the Projects for Assistance in Transition from Homelessness (PATH) program, Homeless Assistance Program (HAP), and SSI/SSDI Outreach, Access, and Recovery (SOAR).

Projects for Assistance in Transition from Homelessness

OMHSAS contracts with 25 County MH/ID program offices to provide PATH services. These 25 county MH/ID offices provide PATH services in 37 of the state's 67 counties. Many of the MH/ID program offices that receive PATH funds then sub-contract with local community sources to provide PATH services. While most of the PATH programs provide services to all PATH-eligible adults ages 18 and over, some focus on transition-age youth and forensic populations that meet the PATH eligibility criteria.

Pennsylvania has a two-tiered oversight mechanism, one at the county MH/ID level through PATH Coordinators and another at the state level through the State PATH contact (SPC). The SPC oversees all activities related to the PATH program and monitors county MH/ID programs that receive PATH funds as well as the local programs with whom they subcontract. The county PATH coordinators work very closely with the contracted agencies to develop and implement new programs and provide oversight to the existing programs.

The counties and contracted providers have developed innovative PATH programs to best serve the needs of the SMI homeless population in their geographical areas. Some

recent programs have adopted evidence-based practices such as Critical Time Intervention (CTI), a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition. It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods. In general, the services provided for PATH-eligible individuals include outreach, screening and diagnostic treatment, habilitation/rehabilitation, community mental health services, alcohol and/or drug treatment, staff training, case management, supportive and supervisory services in residential settings, referrals for primary health, job training, educational services, and allowable housing services.

PA Housing Advisory Committee

The PA Affordable Housing Act of Dec 18, 1992, P.L. 1376, No. 172 emphasized the writing and yearly updates of The Commonwealth's Statewide Comprehensive Housing Affordability Strategy (CHAS) as established by the Cranston-Gonzalez National Affordable Housing Act (Public Law 101-625, 42 U.S.C. § 12701 et seq.), also known as the National Affordable Housing Act of 1990 (NAHA). As a result, the PA Housing Advisory Committee (PHAC) was established, with the primary mission of preparing and maintaining The Consolidated Plan for the Commonwealth of Pennsylvania (Consolidated Plan). The PHAC is responsible for reviewing statewide housing, community development, and support services, needs, and priorities, as well as advising the DCED in the preparation of the Consolidated Plan, annual action plans, and the coordination of federal, state, and local resources to manage the implementation of these plans. Legislation dictates the composition of the PHAC.

Consolidated Plan

The Consolidated Plan for Housing and Community Development (Consolidated Plan) details the efforts of the Commonwealth in addressing the housing, community, homeless, and economic development needs of its constituents, with a specific focus on extremely low-, low-, and moderate-income persons and communities. The Consolidated Plan is intended to outline the goals, strategies, and resources to be utilized in addressing those needs as well as related information on performance in

realizing these goals. This Consolidated Plan is developed for a five-year period encompassing Fiscal Years 2019 through 2023. Each year, the Commonwealth is required to submit an Annual Action Plan based on the goals of the Consolidated Plan as part of its application process to the U.S. Department of Housing and Urban Development (HUD).

The Consolidated Plan covers the needs of the residents that are not directly funded with HUD funding and is submitted to HUD on a five-year cycle. In Pennsylvania, the Department of Community and Economic Development (DCED) is responsible for the Consolidated Plan, and OMHSAS provides input and support into the development.

The Commonwealth's overarching direction for its Consolidated Plan is outlined in the mission of DCED. The mission is applicable to the Commonwealth's efforts to provide housing, homelessness, and community and economic development assistance through both federal and state resources. "The Department of Community and Economic Development's mission is to encourage the shared prosperity of all Pennsylvanians by supporting good stewardship and sustainable development initiatives across our commonwealth. With a keen eye toward diversity and inclusiveness, we act as advisors and advocates, providing strategic technical assistance, training, and financial resources to help our communities and industries flourish."

In order to fulfill this mission for housing, homeless, and community and economic development programs, the Consolidated Plan establishes six goals:

1. Affordable Housing
2. Community Stabilization
3. Public Facility and Infrastructure
4. Public Services
5. Economic Development
6. Community Planning and Capacity Building

In pursuing these goals, the Commonwealth has also established priorities for the use of its resources. Those priorities emphasize targeting activities, leveraging other resources and public investments, and promoting community-changing impact. The

Action Plan for FFY 2022 continues allocating the state's resources toward these priorities and achieving the goals set forth in the Consolidated Plan.

To achieve the Consolidated Plan's goals, DCED relies on the interaction of the following entities: PA Housing Finance Agency (PHFA), Regional Housing Advisory Committees (RHACs), PA Housing Advisory Committee (PHAC), PA's 16 Continuums of Care (CoCs), Housing Alliance of PA, PA Emergency Management Agency, and The Governor's Office of Broadband Initiatives. The latest work is in draft form as the 2019-2023 Consolidated Plan and 2020 Annual Action Plan (dated April 26, 2021).

PA Coordinated Entry

The CoC Homelessness Steering Committee was restructured in 2019 with the implementation of local-level CoC meetings as the new governing method. Included are the 14 county based CoCs and 2 regional CoCs, which are collectively known as the "Balance of State." The Balance of State covers 53 of Pennsylvania's 67 counties. Each CoC Board has quarterly meetings that are open to stakeholders and the public. Coordinating entry ensures prioritization of housing and services for families and individuals based on vulnerability and severity of need. The individuals with the most need are considered for housing opportunities first.

Local Housing Option Teams (LHOT)

There are currently 44 LHOTs operating in 54 counties. County team membership includes representatives from the County Office of Mental Health, the Public Housing Authority, and other public and private agencies. The groups meet regularly to plan for increased availability of accessible, affordable housing opportunities for people with mental illness. The major purpose of LHOT is to bring together the key stakeholders in the community to identify the housing needs of people with disabilities and to take action to meet those needs.

2022 Point in Time Count PA Data

CoCs by Region	Number of Homeless Individuals with SMI - 2022
1. Southeast PA	
Philadelphia County	1,559
Delaware County	17
Montgomery County	90
Bucks County	99
Chester County	40
Total Southeast PA	**1,805**
2. Eastern PA	
Eastern PA CoC (Adams, Bedford, Blair, Bradford, Cambria, Carbon, Centre, Clinton, Columbia, Cumberland, Franklin, Fulton, Huntingdon, Juniata, Lebanon, Lehigh, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming Counties)	290
Berks County	133
Dauphin County	93
Lackawanna County	27
Lancaster County	63
Luzerne County	31
York County	80
Total Eastern PA	**717**
3. Western PA	
Western PA CoC (Armstrong, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Venango, Warren, Washington, and Westmoreland Counties)	121
Allegheny County	351
Beaver County	20
Erie County	164
Total Western PA	**656**

PA TOTAL HOMELESS WITH SERIOUS MENTAL ILLNESS (SMI) **2,178**

SSI/SSDI Outreach, Access, and Recovery (SOAR)

Pennsylvania has a history of a strong SOAR (SSI/SSDI Outreach, Access, and Recovery) program. In 2022, 18 of the 34 PATH providers had at least one SOAR-

trained staff member. The State PATH Contact, who is also the SOAR State Lead, will continue to work with all PATH providers to encourage having at least one SOAR-trained staff within each PATH program across the state or to have an established system in place to access SOAR services when needed.

In the 2022 SOAR Outcomes, PA was recognized for several achievements: over 4,000 decisions, over 2,000 approvals, having a top nationwide approval rate, and consistent capacity.

There are currently eight strong SOAR local leads throughout the state, including the Philadelphia and Pittsburgh areas. Quarterly SOAR local lead conference calls have been implemented to promote information sharing and ensure statewide cohesion of the SOAR process. Recent collaboration with the Social Security Administration and Disability Determination Services will serve to improve the implementation of the model in PA.

The creation of a SOAR database had been approved for funding through Community Mental Health Services Block Grant funds. The database will feature essential SOAR provider information such as location, the scope of SOAR practice, organization name, contact information, etc., to efficiently match those in need with proper SOAR resources. Similar information on PATH providers would also be included to heighten the effectiveness of the data to be queried, as well as for more efficient distribution of materials and procedural updates. This project had been initiated but was placed on hold due to the COVID-19 pandemic. It will be reevaluated and commenced in the future.

Various funding streams continue to be taken advantage of to develop SOAR initiatives. In the past, sources such as the Staunton grant, Substance Abuse and Mental Health Services Administration's Cooperative Agreements to Benefit Homeless Individuals (CABHI), and various foundations have been sources of SOAR initiative funding.

Homeless Assistance Program (HAP)

HAP is a county-directed program that offers a variety of supportive services to individuals and families experiencing or at risk for homelessness and who can demonstrate that, with HAP intervention, they will be able to meet their basic housing needs in the near future. HAP includes five components:

1. Bridge Housing
2. Case Management
3. Rental Assistance
4. Emergency Shelter
5. Innovative Supportive Housing

A county may choose to provide one, some, or all of the components as part of its program, depending upon its unique regional needs. HAP gives counties flexibility in creating their programs because human service agencies based at the local level are intimately acquainted with the local human services network and the needs of the community. The department expects that counties will select the components necessary to create a homeless assistance program that meets the following HAP objectives:

1. Provide homelessness prevention services that assist clients in maintaining affordable housing.
2. Help people experiencing homelessness find refuge and care.
3. Assist people experiencing or near homelessness in attaining economic self-sufficiency.

Criterion 5: Management Systems

Intended Use of Block Grant Funds

As instructed by SAMHSA, OMHSAS based the CMHSBG FY24-25 application on the FY2023 President's Budget which would bring Pennsylvania's allocation to $32,388,348 annually.

SFY24-25 CMHSBG Pennsylvania Budget

	Annual Funds	BSCA Funds
County Funding- Non-Categorical	$18,543,438	
County Funding- Categorical Allocations (General Training Fund)	$480,000	
Special Projects		$1,814,693
Crisis Funding	$1,382,834	
First Episode Psychosis	$3,238,835	$201,633
OMHSAS Administrative Costs	$979,000	
FY24-25 CMHSBG Budget	$32,388,348	$2,016,326

OMHSAS encourages counties to utilize CMHSBG for SAMHSA-identified purposes. We also strongly encouraged the counties to use the CMHSBG dollars to support the priorities identified in the state MHBG Plan. Most of the county allocations will be allocated as non-categorical, which technically allows the counties to expend the Block Grant funds in any of the allowable service areas listed below.

CMHSBG Allowable Cost Centers	
Administrator's Office	Family-Based MH Services
Community Services	Administrative Management
Targeted Case Management	Housing Support Services
Outpatient	ACT and CTT
Partial Hospitalization	Psychiatric Rehabilitation Services
MH Crisis Intervention Services	Children's Psychosocial Rehabilitation
Adult Developmental Training	Children's EBPs
Community Employment Services	Peer Support Services
Facility Based Vocational Rehabilitation	Consumer Driven Services
Social Rehabilitation Services	Other Services*
Family Support Services	

Source: OMHSAS Bulletin *Cost Centers for County Based Mental Health Services OMHSAS-12-02*

SFY 23-24 CMHSBG County Allocations

County	Non-Categorical Allocation	County Categorical Allocation (Training Funds)	First Episode Psychosis	Special Projects	Total Allocation
Allegheny	$1,529,185	$10,000	$284,000	$5,250	**$1,828,435**
Armstrong/Indiana	$197,276	$10,000			**$207,276**
Beaver	$213,174	$10,000			**$223,174**
Bedford/Somerset	$177,304	$10,000			**$187,304**
Berks	$514,303	$10,000			**$524,303**
Blair	$158,861	$10,000			**$168,861**
Bradford/Sullivan	$93,542	$10,000			**$103,542**
Bucks	$781,561	$10,000	$180,000		**$971,561**
Butler	$229,828	$10,000			**$239,828**
Cambria	$637,157	$10,000			**$647,157**

Cameron/Elk	$52,880	$10,000			**$62,880**
Carbon/Monroe/Pike	$365,575	$10,000	$360,000		**$735,575**
Centre	$192,488	$10,000	$187,114		**$389,602**
Chester	$623,608	$10,000	$180,000		**$813,608**
Clarion	$78,680	$10,000			**$88,680**
Clearfield/Jefferson	$413,119	$10,000			**$423,119**
Columbia/Montour/Snyder/Union	$212,764	$10,000	$0	$175,000	**$397,764**
Crawford	$110,956	$10,000			**$120,956**
Cumberland/Perry	$493,008	$10,000			**$503,008**
Dauphin	$335,125	$10,000	$140,744		**$485,869**
Delaware	$698,724	$10,000	$150,000		**$858,724**
Erie	$350,708	$10,000	$145,852		**$506,560**
Fayette	$207,600	$10,000			**$217,600**
Forest/Warren	$61,914	$10,000			**$71,914**
Franklin/Fulton	$205,579	$10,000			**$215,579**
Greene	$129,264	$10,000			**$139,264**
Huntingdon/Mifflin/Juniata	$146,539	$10,000			**$156,539**
Lackawanna/Susquehanna	$706,949	$10,000			**$716,949**
Lancaster	$649,306	$10,000			**$659,306**
Lawrence	$599,482	$10,000			**$609,482**
Lebanon	$166,960	$10,000			**$176,960**
Lehigh	$436,871	$10,000	$120,000		**$566,871**
Luzerne/Wyoming	$436,493	$10,000	$180,000		**$626,493**
Lycoming/Clinton	$194,186	$10,000	$180,000		**$384,186**
McKean	$59,235	$10,000			**$69,235**
Mercer	$145,797	$10,000			**$155,797**
Montgomery	$999,843	$10,000			**$1,009,843**
Northampton	$372,169	$10,000	$120,000		**$502,169**
Northumberland	$118,160	$10,000			**$128,160**
Philadelphia	$2,234,351	$10,000	$550,000		**$2,794,351**
Potter	$56,099	$10,000			**$66,099**
Schuylkill	$185,361	$10,000			**$195,361**
Tioga	$52,476	$10,000			**$62,476**
Venango	$90,406	$10,000			**$100,406**
Washington	$568,466	$10,000			**$578,466**
Wayne	$133,171	$10,000			**$143,171**
Westmoreland	$456,461	$10,000	$180,000		**$646,461**
York/Adams	$670,474	$10,000			**$680,474**
Statewide Total	**$18,543,438**	$480,000	**$2,957,709**	**$180,250**	**$22,161,397**

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

UNMET NEEDS AND CRITICAL GAPS

The Office of Mental Health and Substance Abuse Services (OMHSAS) utilizes data from a number of sources in order to set priorities for the Community Mental Health Services Block Grant (CMHSBG) including:

- County Level Data from the County Human Services Plans
- OMHSAS Data
- Stakeholder Feedback from the Public Meetings
- Call for Change
- Consultation with Subject Matter Experts for each priority area

County Human Services Plans

In their annual County Mental Health Plans, which are included in the County Human

Services Plans, counties are asked to identify their top recovery-oriented systems transformation.

The counties also identified the fiscal and other resources needed to implement those priorities. The top priority for FY 22-23 was Evidence-based practices; the second highest-ranked priority was Housing and Homeless Services, with Forensic, and Community education/outreach close behind.

Other important priorities which were mentioned at a lesser frequency included Crisis Services, Inpatient/Residential Services, Suicide Prevention, Cultural and Linguistic Competence, Data Infrastructure, Integrated Physical Health Services, Education and Employment Services, Peer support, trauma-informed care, and Psychiatry access.

Mental Health Planning Council/Public Feedback

In April 2023, OMHSAS requested the MHPC select representative members from each of the subcommittees to convene a CMHSBG Application Workgroup. The MHPC met throughout May of 2023 to review the current CMHSBG priorities and make recommendations for the current application. OMHSAS and the MHPC worked together to take a close look at the priorities and create goals and outcomes that are realistic and will show progress in the Pennsylvania System of Mental Health. OMHSAS staff from

CMHSBG, Children's Bureau, and other subject matter experts routinely attended MHPC workgroup meetings in order to support the council with requested data and program information. The final recommendations of the MHPC CMHSBG Application Workgroup were presented to the larger MHPC council at the August 2023 Quarterly Meeting. MHPC Quarterly Meetings are open to the public, and both appointed members and public attendees were given the opportunity to provide feedback. Meeting Outcomes for each committee are attached to this application.

Call for Change

OMHSAS initially developed the *Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults (Call for Change)* document in 2005 in partnership with a wide array of stakeholders, including representation from the MHPC. The *Call for Change* addressed the following domains towards creating a recovery-oriented mental health system:

1. Validated Personhood
2. Person-Centered Decision-Making and Choice
3. Connection—Community Integration and Social Relationships
4. Basic Life Resources
5. Self-Care, Wellness, and Finding Meaning
6. Rights and Informed Consent
7. Peer Support/Self-Help
8. Participation, Voice, Governance, and Advocacy
9. Treatment Services
10. Worker Availability, Attitude, and Competency
11. Addressing Coercive Practices
12. Outcome Evaluation and Accountability

This was followed in 2010 with a *Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania (Children's Call for Change)* developed in

partnership with the Children's Behavioral Health Taskforce, made up of over 400 stakeholders. The *Children's Call for Change* focuses on the following goals:

1. Develop the capacity for the system to be youth and family driven.

2. Ensure ready access to a cost-effective array of quality services, including assessment, treatment, and support services that help to sustain and nurture family and community ties. Quality services are comprehensive, integrated, and provided in the least restrictive environment as defined by the needs of the youth.

3. Establish the infrastructure (financing, policies, training, etc.) to implement a system of comprehensive, integrated, cost-effective array of services.

4. Develop a public health approach to social and emotional wellness for children, youth, and families.

5. Develop increased capacity for service systems to meet the needs of transition-age youth and young adults through cross-system collaborative relationships and initiatives.

Each of the priorities in the FFY24-25 CMHSBG application works to continue making progress in the domains identified during the Call for Change process. Supportive Housing works to ensure individuals have access to basic life resources now referred to as Social Determinants of Health. Having calls to the Suicide Prevention Lifeline answered in state works to ensure both children with SED and adults with SMI are appropriately connected within their own communities. Family Peer Support Services, Peer Run Crisis Respite Services, and employing more peers to work in Mobile Crisis Teams will continue to grow the impact that peer support services have had on pushing the behavioral health system to be recovery-oriented and value the wisdom and knowledge gained from the lived experience of SMI/SED. Family Peer Support Services also help to ensure that the child-serving system is youth and family driven. Working to ensure mental health professionals can respond in the community to mental health crisis situations through Mobile Crisis Teams, reducing the need for police responses and emergency room boarding, making progress to reducing coercion in the mental health system, and working to ensure that individuals are able to receive the care they need in the least restrictive environment. Both First Episode Psychosis (FEP) Programs

and Service Access for Older Adults work to ensure that, across the lifespan, individuals have access to the treatment services that they need in order to pursue their recovery. FEP programs also, along with Student Assistance programs, are important services within the Pennsylvania mental health system in ensuring access to cost-effective, quality services for youth and children in the least restrictive environment.

OMHSAS and the MHPC will continue to work to ensure that CMHSBG priorities in the future align with the recovery and resiliency efforts and continue to work towards Pennsylvanians with SMI/SED having access to quality services that empower them to live full and fulfilling lives within their communities of choice.

Services in Rural Areas

Pennsylvania has a large number of residents living in rural areas, which are consistently distributed across the state. According to the Center for Rural Pennsylvania, a legislative agency of the Pennsylvania General Assembly, Pennsylvania has 48 rural counties and 19 urban counties. In 2020, nearly 3.4 million people, or about 26 percent of the state's 13 million residents, lived in Pennsylvania's 48 rural counties. This was 2 percent less than the 2010 census. Since 2000, rural Pennsylvania's population became more racially diverse. In 2000, there were about 168,114 residents, or 5 percent of the total population, who were non-white and/or Hispanic, whereas, in 2020, 394,533 rural residents, or 12 percent of the total population, were non-white and/or Hispanic. On average, rural Pennsylvania residents are older than urban Pennsylvania residents. In 2020, 20 percent of the rural population was 65 years old or older compared to 18 percent of the urban population. It is projected that, by 2040, Pennsylvania rural counties will have a total population of 3.61 million people, a 4 percent increase from 2010.

At the school district level, 238 of the state's 501 public school districts are rural. In the 2020-2021 academic year, an estimated 374,732 students were enrolled in rural school districts, which is 25 percent of the state's nearly 1.41 million public school students. From 2010 to 2018, the number of rural students decreased by 10 percent. From 2010

to 2018, there was a 1 percent decline in enrollment. Enrollment projections by the Pennsylvania Department of Education show enrollment continuing to decline for the next 10 years. From 2019-20 to the 2028-29 academic years, rural school districts are projected to decline by 7 percent.

Several counties have shortages of psychiatrists, psychologists, and social workers, as well as physical health providers including dentists and specialist physicians. Pennsylvania is, like much of the country, experiencing a shortage of both general healthcare professionals and mental healthcare professionals. The Health Professional Shortage Areas (HPSAs) for both general and mental health in Pennsylvania significantly impact the rural areas of the state (Pennsylvania State Health Assessment 2021 Update). Rural counties frequently utilize satellite clinics, mobile teams, or other specialized services designed for that population. Services are generally more decentralized, and outreach is more evident since transportation and distance are obstacles. OMHSAS has worked collaboratively with the Office of Medical Assistance Programs (OMAP), Medical Assistance Transportation Program (MATP) providers, and consumer advocacy organizations to review and assess Medical Assistance Transportation Program services, standards, and county practices, in order to improve statewide access to transportation. In many areas, mobile behavioral health services are being offered to assist individuals who may not have access to transportation. In addition, the rapid expansion of telehealth services during the COVID-19 PHE offered additional options for individuals in rural areas to access services. However, OMHSAS is mindful of the limitations of broadband access in some areas of the state, particularly in the most rural areas of Pennsylvania. In order to ensure ongoing access post-PHE, OMHSAS would like to see ongoing support from partner agencies and the federal government in order to continue expanding internet access. In the interim, OMHSAS also is advocating for the continued allowability for telephone-only service delivery when a lack of internet/devices would prevent an individual from receiving the behavioral health care they need.

Managed Care provides many opportunities for rural counties. Under managed care, there are required services and access standards. In rural areas, services must be

available within 60 minutes of travel time. In addition, emergency services must be available in one-hour, urgent services in 24 hours, and routine services in 7 days. Rural counties, in order to come into compliance with managed care standards are required to increase both the number and array of service providers.

Telehealth

Prior to the COVID-19 PHE, OMHSAS was in the process of expanding the allowability of telehealth within the Pennsylvania Behavioral Health Medicaid System. On February 20, 2020, OMHSAS-20-02 Guidelines for the Use of Telehealth Technology in the Delivery of Behavioral Health Services, which expanded both the allowable practitioner types and service types that could be offered through telehealth, for the first time in Pennsylvania allowed telehealth in community settings in some services and simplified the provider process for participating in the telehealth program.

However, on March 6, 2020, Governor Tom Wolf issued the initial Proclamation of Disaster Emergency due to the novel coronavirus COVID-19 in Pennsylvania. On March 15, 2020, OMHSAS issued a memorandum Telehealth Guidelines Related to COVID-19, which temporarily expanded telehealth services significantly to ensure the continuity of critical behavioral health services during stay-at-home and quarantine conditions. OMHSAS processed over 2,300 provider attestations in March 2020 alone, with over 3,000 completed by the end of CY2020, as the behavioral health system in Pennsylvania rapidly transformed temporarily to the majority of services being offered through telehealth. This memorandum was reissued on May 5, 2020, with additional guidance added for two specific children's services, Behavioral Health Rehabilitation Services, and Intensive Behavioral Health Services, along with OMHSAS-20-03 Instructions and Guidelines for the Delivery of BHRS and IBHS Through Telehealth.

On June 10, 2021, the Pennsylvania Legislature enacted a concurrent resolution, House Resolution 106 of 2021, immediately ending the COVID-19 Disaster Emergency Declaration for Pennsylvania. In addition, House Bill 854 of 2021 was enacted, allowing agencies under the Governor's jurisdiction to extend flexibilities related to the Governor's Emergency Disaster Declaration through September 30, 2021.

On August 26, 2021, OMHSAS bulletin 21-09 was issued. This bulletin expanded upon guidelines from bulletin 20-02. Key changes included permitting the delivery of audio-only services, expanding the use of telehealth to drug and alcohol providers, expanding the use of telehealth to include services provided by unlicensed staff working through a licensed provider agency, and permitting the delivery of services in a community setting.

In July of 2022, OMHSAS bulletin 22-02 was issued to include the billing codes for Place of Service 02, telehealth provided in a location other than the home of the individual being served, and 10, telehealth provided in the home of the individual being served.

OMHSAS is in the process of developing a revised post-PHE telehealth bulletin.

Services for Older Adults

In 2019, Pennsylvania ranked 7th in the United States with the largest number of adults 65 and older. In the U.S., between 2020 and 2030, the number of older adults is projected to increase by almost 18 million, a 39% increase. The fastest-growing segment of the population during the next two decades is expected to be in the age 85 and older group. Social isolation and limited access to supports negatively impact the well-being of older adults.

Unfortunately, older adults with behavioral health disorders who do not receive treatment increase their risk of hospitalization, reduced physical functioning, and earlier death. In addition to the general population of older adults who have never received services, many current recipients of behavioral health services are aging and in need of more specialized services for older adults.

OMHSAS supports the use of the Certified Older Adult Peer Specialists (COAPS) program, which is a much-needed service for older adults with behavioral health diagnoses. The COAPS program addresses older adults' mental health and wellness issues. COAPS program is in line with SAMHSA's strategic initiative goals:

- Promote health and recovery-oriented service systems for individuals with or in

recovery from mental and substance use disorders.

- Ensure that permanent housing and supportive services are available for individuals with or in recovery from mental and substance use disorders.
- Increase gainful employment and educational opportunities for individuals with or in recovery from mental and substance use disorders.
- Promote peer support and the social inclusion of individuals with or in recovery from mental and substance use disorders in the community.

Although the COAPS program was not able to offer training during the COVID-19 PHE, there are currently plans underway to revitalize the program.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Supportive Housing

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Enhance the available data on supported housing services for individuals with SMI and children with SED as a step towards ensuring adequate supportive housing services across Pennsylvania.

Strategies to attain the goal:

Work with county partners and MHPC to develop and use the reporting form.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Plan for enhanced supportive housing data collection

Baseline Measurement: No county reporting form on supportive housing work.

First-year target/outcome measurement: Develop reporting form.

Second-year target/outcome measurement: Collect data from counties using the reporting form.

Data Source:

New reporting form

Description of Data:

New reporting form will be developed by OMHSAS and MHPC. The reporting form will encompass data that will be useful to OMHSAS and MHPC to measure the supportive housing services that are being provided by each county and their effectiveness.

Data issues/caveats that affect outcome measures:

Priority #: 2

Priority Area: Services to Older Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Enhance the available data on Older Adults for individuals with SMI as a step towards ensuring adequate service across PA.

Strategies to attain the goal:

Work with the MHPC Older Adult Committee to develop and use a new reporting form.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Plan for enhanced Older Adult data collection

Baseline Measurement: No Older Adult Reporting form available

First-year target/outcome measurement: Develop reporting form

Second-year target/outcome measurement: Collect data from the counties using the reporting form

Data Source:

New reporting form

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 3

Priority Area: Family Peer Support Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Expand peer services across the state by developing peer services for families of individuals with an SMI or SED

Strategies to attain the goal:

OMHSAS will continue collaborations with Family Peer Services stakeholders from across the Commonwealth, via regular meetings, to create recommendations for certification and submit to the Pennsylvania Certification Board, including identifying a mandated curriculum to be trained; as well as establishing formal, written policies for peer services for families of individuals with an SMI or SED.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Planning and Implementation of Family Peer Support Services in Pennsylvania

Baseline Measurement: Family Peer support training and services are offered in limited Pennsylvania counties, and a workgroup has been held for the last three years.

First-year target/outcome measurement: Develop a certification for peer services for families of individuals with an SMI or SED

Second-year target/outcome measurement: Identify and implement the mandated training for peer services for families of individuals with an SMI or SED

Data Source:

OMHSAS Division of Policy and Children's Bureau Policy staff

Description of Data:

Year 1: OMHSAS will continue collaborations, via workgroups and a Steering Committee, with Family Peer Services stakeholders from across the state, including the Pennsylvania Certification Board, to create and implement a certification for peer services for families of individuals with an SMI or SED.
Year 2: The Workgroups and Steering Committee will also identify and implement standard training requirements for individuals who want to become certified in working with families of individuals with an SMI or SED.

Data issues/caveats that affect outcome measures:

Priority #: 4

Priority Area: OMHSAS certified Residential Treatment Facilities to be designated Trauma Sensitive

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To have all OMHSAS-certified Residential Treatment Facilities (RTFs) become trauma sensitive by the end of FY 2023-24, based on the Pennsylvania Department of Human Services developed criteria.

Strategies to attain the goal:

Provide additional funding and technical assistance to OMHSAS-certified RTFs to conduct assessments and provide staff training.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of OMHSAS-certified RTFs that become designated trauma-sensitive providers

Baseline Measurement: There currently are no designated trauma-sensitive programs

First-year target/outcome measurement: 60% of OMHSAS-certified RTF providers will complete trauma-sensitive assessments and be designated trauma-sensitive RTFs

Second-year target/outcome measurement: 100 % of OMHSAS-certified RTF providers will complete trauma-sensitive assessments and be designated trauma sensitive RTFs

Data Source:

Children's Bureau

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Number of OMHSAS-certified RTFs that have completed trauma-sensitive staff training

Baseline Measurement: There currently are no designated trauma-sensitive programs.

First-year target/outcome measurement: 60% of OMHSAS-certified RTF providers will provide trauma-sensitive staff training for all staff

Second-year target/outcome measurement: 100 % of OMHSAS-certified RTF providers will provide trauma-sensitive staff training for all staff

Data Source:

Children's Bureau

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 5

Priority Area: Suicide Prevention

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Maintain suicide prevention efforts across the lifespan in Pennsylvania

Strategies to attain the goal:

To achieve these objectives, OMHSAS will directly promote the 988 lifeline through awareness activities as well as through partnerships with state and local suicide prevention organizations (e.g., Prevent Suicide PA, county Suicide Prevention Task Forces). OMHSAS will also maintain a partnership with contacts at the National Suicide Prevention Lifeline in reaching out to county crisis centers to encourage affiliation with the Lifeline. OMHSAS will also maintain a partnership with contacts at the National Suicide Prevention Lifeline in reaching out to county crisis centers to encourage affiliation with the Lifeline.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of 988 Calls answered in-state

Baseline Measurement: 76%

First-year target/outcome measurement: 80%

Second-year target/outcome measurement: 80%

Data Source:

988 Lifeline Data

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 6

Priority Area: Peer Run Crisis Stabilization Unit (PRCSU)

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Divert individuals from unnecessary emergency department utilization and inpatient admission through increased community-based, peer-run services.

Strategies to attain the goal:

OMHSAS will be continuing to provide CMHSBG funding to the Path Home, a peer run crisis stabilization unit serving the Columbia/Montour/Snyder/Union County Joinder. OMHSAS has provided start up funding to one additional peer run crisis stabilization unit through the County Funding opportunity offer with a combination of annual CMHSBG funding and CMHSBG COVID-19 relief funds from the Consolidated Appropriations Act of 2021. OMHSAS is continuing to monitor both homes for FY 24-25 and 25-26.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Peer Run Crisis Respite Admissions total guest stays

Baseline Measurement: 94 stays

First-year target/outcome measurement: 116 stays

Second-year target/outcome measurement: 151 stays

Data Source:

CMHSBG Quarterly reporting survey (Peer Run Crisis Respite Awards)

Description of Data:

Data issues/caveats that affect outcome measures:

Year one target anticipates a small increase in the current PRCR program. The PRCSU program will be serving individuals in late SFY 23-24, limiting admissions. Year two target anticipates both programs being fully operational for the entire year two period.

Priority #: 7

Priority Area: Mobile Crisis Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Strategies to attain the goal:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Utilize ARPA funding to increase peer FTEs employed in mobile crisis and walk-in centers in counties participating in the CAA Mobile Crisis Funding Opportunity

Baseline Measurement: 0

First-year target/outcome measurement: 17

Second-year target/outcome measurement: 34

Data Source:

ARPA surveys for Armstrong/Indiana Walk-in Center, Bucks County Mobile Crisis, Carbon/Monroe/Pike/Lackawanna/Susquehanna/Wayne Walk-in Center, Cumberland/Dauphin/Perry Walk-in Center, and Washington Mobile Crisis.

Description of Data:

Projects will hire a minimum of 17 Peer FTEs
FTEs Year 2: Projects will hire a minimum of 34 Peer FTEs including the Peer FTEs for year 1

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Monitor number of 302s issued in counties awarded ARPA funding

Baseline Measurement: 0

First-year target/outcome measurement: establish baseline

Second-year target/outcome measurement: maintain baseline

Data Source:

ARPA surveys

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 8

Priority Area: First Episode Psychosis

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Connect individuals with early psychosis to services more timely, reducing the duration of untreated psychosis by increasing the number of individuals served and the number of admissions referred from community sources.

Strategies to attain the goal:

Offer increased training and support through OMHSAS contracted Early Psychosis technical assistance center, HeadsUp, at the University of Pennsylvania. Implement screening pilot for primary care physicians in select counties (Philadelphia and surrounding suburban counties) and expand out to other areas of the state if successful. Increase the number of counties/joinders with access to FEP services by providing start-up funding to additional program sites.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Community Based Referrals

Baseline Measurement: 2992.51

First-year target/outcome measurement: 3566.037

Second-year target/outcome measurement: 4139.54

Data Source:

HeadsUp Technical Assistance Center Program Evaluation Data

Description of Data:

a) Description of data: Baseline: July 1, 2023 (point-in-time count)
b) Year 1 Target: July 1, 2024 (point-in-time count)
c) Year 2 Target: July 1, 2025 (point-in-time count)
Data includes referrals from: Outpatient Mental Health Providers, Self/family or Caregivers, Other, Schools, Community organizations, unknown, other agency programs. and primary care physicians.

Data will include all FEP admissions statewide in the 18 CMHSBG funded FEP Programs referred from schools, self, families, community healthcare providers, and other community referral sources. Inpatient referrals and Emergency Room referrals will be excluded, along with any admission with an unknown referral source.

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Increase Number of individuals served statewide in all CMHSBG funded FEP CSC Programs

Baseline Measurement: 530

First-year target/outcome measurement: 560

Second-year target/outcome measurement: 590

Data Source:

HeadsUp Technical Assistance Center Program Evaluation Data

Description of Data:

Baseline: PIT Count: July 1, 2023
Year 1: PIT Count July 1, 2024
Year 2: PIT Count July 1, 2025

Data issues/caveats that affect outcome measures:

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: Planning Period End Date:

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]											
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital											
8. Other 24-Hour Care											
9. Ambulatory/Community Non-24 Hour Care											
10. Crisis Services (5 percent set-aside)[f]											
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]											
12. Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total			**$**	**$**

Please wait while data loads...

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

a) Adults with serious mental illness

Pennsylvania has expanded its Medical Assistance for Workers with Disabilities (MAWD) to cover individuals who have previously been covered by MAWD and have had an increase in income. This program helps support the neediest Pennsylvanian's maintain their health insurance while bettering their lives through better-paying positions. In addition, Pennsylvania has aggressively marketed the ending of continuous Medicaid coverage in the hopes that individuals on MA will maintain continuous coverage. OMHSAS has utilized CMHSBG funding to expand community health services across the state, most notably through the CAA and ARPA allocations of funding. These funding streams have helped to fund innovative projects such as Mobile Crisis expansion, Crisis Walk-in Centers, SAP services, and more.

b) Pregnant women with substance use disorders

Pennsylvania has expanded Medicaid services for pregnant women who are eligible for Medicaid. The "Healthy Beginnings Plus" program was designed to assist women in having a positive prenatal care experience. Through this program, women can receive behavioral health and substance use services as well as traditional physical health services.

Through Act 65-1993, the PA General Assembly authorized the Department of Health, Bureau of Drug and Alcohol Programs, (predecessor of the Department of Drug and Alcohol Programs (DDAP)) to provide funding for non-hospital residential services for pregnant women at treatment facilities throughout the Commonwealth. There are currently 33 treatment programs that serve pregnant women. Each Single County Authorities (SCA) is required to spend a portion of its annual allocation on services for pregnant women. As a priority population, services are provided immediately. Additionally, case management services are offered at the time of assessment.

c) Women with substance use disorders who have dependent children

Pennsylvania has extended Post Partum coverage from 60 days to one year for mothers covered through Pennsylvania Medicaid, which includes substance use identification counseling.

Through Act 65-1993, the PA General Assembly authorized DDAP to provide funding for non-hospital residential services for treatment facilities throughout the Commonwealth. There are currently 36 treatment programs that serve women with dependent children. The SCAs are required to spend a portion of their annual allocation on services for women with dependent children. As a priority population, services are provided immediately. Additionally, case management services are offered at the time of assessment. DDAP has also convened a workgroup of providers who specialize in providing services to women with dependent children. This workgroup provides feedback to DDAP on issues and challenges facing women with children.

d) Persons who inject drugs

Each SCA in the Commonwealth has instituted a Warm Handoff (WHO) program with hospitals in its catchment area to provide a direct referral to treatment, case management, and recovery support services for individuals who have overdosed. As a priority population, services are provided immediately. This initiative is designed to help people access treatment after an overdose. Additionally, case management services are offered at the time of assessment. In addition to WHO, SCAs are responsible for the coordination of care between therapeutic and pharmaceutical interventions. SCAs are required to educate clients about Medication-Assisted Treatment (MAT) and ensure medication and clinical therapeutic interventions are available in all levels of care, even if the SUD treatment provider is not the prescriber of the medication.

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

DDAP has an agreement with the PA Department of Health to provide education, training, and resources to the SCAs and their contracted providers for services to individuals who are at risk for HIV, Hepatitis, and TB.

f) Persons with substance use disorders in the justice system

Through various agreements with the PA Commission on Crime and Delinquency and the PA Department of Corrections, DDAP provides funding for treatment and MAT services to i individuals who are incarcerated and those recently released. Additionally, each SCA sits on its county's Criminal Justice Advisory Board. The Criminal Justice Advisory Boards are designed to improve the effectiveness and efficiency of county criminal justice systems by bringing together a diverse representation of community members to discuss justice-related issues at the county and local levels.

g) Persons using substances who are at risk for overdose or suicide

DDAP provides funding for the purchase of Naloxone as well as fentanyl and xylazine test strips. These are distributed through County Coordinating Entities, via the Naloxone for First Responders Program online portal, or the Naloxone can also be distributed through a statewide mail to home program.

h) Other adults with substance use disorders

Screening for Substance Use Disorder is provided by the SCAs or a subcontracted provider 24 hours a day, 7 days a week. An assessment must occur within 7 days of the screening and the individual must be admitted to treatment within 14 days.

Additionally, case management services are offered at the time of assessment.

i) Children and youth with serious emotional disturbances or substance use disorders

OMHSAS was awarded the System of Care (SOC) Partnership grant by SAMHSA and CMHS. SOC is defined as a comprehensive spectrum of mental health and essential support services organized into a coordinated network to address and meet the varied needs of children, youth, and young adults at risk for or with SED, their families, and their caregivers. Through the SOC grant, Pennsylvania is able to provide coordinated care across various child-serving systems and with system partners.

Additionally, screening for substance use disorder is provided by the SCAs or a subcontracted provider 24 hours a day, 7 days a week. An assessment must occur within 7 days of the screening, and the individual must be admitted to treatment within 14 days. Additionally, case management services are offered at the time of assessment. Additionally, there is a hotline that operates 25 hours a day, 7 days a week, that can assist individuals with making connections to services that are most appropriate to meet their individualized needs.

j) Individuals with co-occurring mental and substance use disorders

The Department of Human Services (DHS) and DDAP issued a joint bulletin to SCAs, substance use disorder treatment providers, county mental health agencies, mental health treatment providers, etc. providing guidance on co-occurring capable and co-occurring enhanced treatment services, as per ASAM recommendations.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

In the fall of 2016, Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) established a cross-agency workgroup tasked with conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) compliance analysis. The workgroup included representatives from Pennsylvania Department of Human Services (DHS) offices involved in the administration of the Commonwealth's Medicaid program, namely OMHSAS, the Office of Medical Assistance Programs (OMAP), and Office of Long Term Living (OLTL).

DHS's approach to conducting the parity analysis followed Centers for Medicare and Medicaid Services (CMS) guidance as outlined in the final Parity rule and the CMS parity toolkit, "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs". Based on the findings from the analysis, the DHS offices updated Managed Care contracts, issued policy directives, and implemented system changes to ensure compliance with MHPAEA. DHS also collaborated with and provided input to the Pennsylvania Department of Insurance in their efforts to ensure compliance with MHPAEA in the commercial insurance sector.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

HealthChoices contracts establish the requirement for BH and PH to coordinate care for their clients. Physical health MCOs have a Special Needs Unit to serve and ensure individuals with special needs, including behavioral health, have care coordinated between their primary care provider and the other providers involved in their care. The Behavioral Health MCOs specifically serve a special need population and have a corresponding requirement to ensure coordination of care between the providers of behavioral health services and individuals' physical health providers. All individuals have the right to decide the type and amount of coordination they wish to have. PH-BH coordination meetings occur regionally to problem solve and engage in efforts to ensure care coordination that fits local circumstances. Similarly, the monthly Managed Care Delivery System Sub-committee of the Medical Assistance Advisory Committee also works to discover, examine and advise on systemic issues of coordination of care. An outcome of this committee was the development of the Telephonic Psychiatric Consultation Service Program (TiPS). This is available at no cost to primary care practitioners. Pennsylvania also received a SAMHSA demonstration grant to develop Certified Community Behavioral Health Clinics (CCBHCs) which are designed for the effective service coordination. OMHSAS has also supported efforts on the local level to provide such programs as Behavioral Health Navigators, BH-PH integration programs, Community and School-Based programs, Assertive Community Treatment, Community Treatment Teams, Coordinated Specialized Care for First Episode Psychosis, Mobile Medication Programs, and expanding Case Management programs. In addition, co-location of programs has been allowed since the 2016 publication of the Medical Assistance Bulletin #MAB 99-16-04. The co-location of different providers/provider types was made even easier with the regulatory changes that have happened since then. With the advent of COVID-19 the availability of services using technology, often referred to as telehealth or telemedicine, has expanded, making services more widely available and accommodating to alternative locations.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

In Pennsylvania, mental health services are administered on a county level through each county's base service unit. Various levels of care coordination are available based on the individual's and family's needs and the level of seriousness and complexity of their mental health issues. Case management services are offered at various levels, such as Intensive Case Management, Blended Case Management, Resource Coordination, and Administrative Case Management.

A comprehensive and effective system of care recognizes that children and youth with social, emotional, behavioral, and/or physical health needs often require services from more than one child-serving system. Effective planning takes into account the strengths of the child and family, the multitude of needs, and engages the various human service agencies responsible for assisting the child and family. At the state level, there is a Complex Needs Team that is composed of State-level individuals from various child-serving systems (OCYF, OMHSAS, ODP, and the Secretary's Office, etc.)

b) Adults with substance use disorders

As Pennsylvania is a Commonwealth, DDAP allows the SCAs to determine how best to implement care coordination within their counties if it is within the parameters set forth by our agency. The SCAs determine the intensity of service for each individual based upon their needs and provides appropriate services as necessary.
DDAP provides funding to the SCAs for case management services, which encompasses care coordination. Some SCAs are also enrolled in the networks of l Behavioral Health Managed Care Organizations (BHMCOs) in the Medicaid program and may bill for services provided to Medicaid beneficiaries.
Each SCA offers care coordination to all individuals who are referred for treatment services. SCAs determine how best to provide care coordination, but they must complete a Case Management Service Plan (CMSP) for every individual who accepts care coordination services. The CMSP is an assessment of treatment-related needs and is updated no less than every 60 days. Each SCA must also have a Coordination of Services Policy in place that includes tracking individuals, assisting individuals in arranging healthcare coverage, completing continued clinical stay reviews, etc.

c) Children and youth with serious emotional disturbances or substance use disorders

In Pennsylvania, mental health services are administered on a county level through each county's base service unit. Various levels of care coordination are available based on the individual's and family's needs and the level of seriousness and complexity of their mental health issues. Case management services are offered at various levels, such as Intensive Case Management, Blended Case Management, Resource Coordination, and Administrative Case Management.
A comprehensive and effective system of care recognizes that children and youth with social, emotional, behavioral, and/or physical health needs often require services from more than one child-serving system. Effective planning takes into account the strengths of the child and family, the multitude of needs, and engages the various human service agencies responsible for assisting the child and family. At the state level, there is a Complex Needs Team that is composed of State-level individuals from various child-serving systems (OCYF, OMHSAS, ODP, and the Secretary's Office, etc.)
Additionally, each SCA offers care coordination to all individuals who are referred for treatment services. SCAs determine how best to provide care coordination, but they must complete a Case Management Service Plan (CMSP) for every individual who accepts care coordination services. The plan must be tailored to the individuals' specific needs, which should address any serious emotional disturbances or substance use. The CMSP is an assessment of treatment-related needs and is updated no less than every 60 days. Each SCA must also have a Coordination of Services Policy in place that includes tracking individuals, assisting individuals in arranging healthcare coverage, completing continued clinical stay reviews, etc.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Schools across Pennsylvania provide Student Assistance Program (SAP) Services to students in secondary school. SAP services are one approach for early screening and assessment to identify the need for mental health and/or substance abuse services. This screening and assessment process then allows school personnel to refer families and students to providers and services that can provide treatment to address their needs.

Pennsylvania has implemented a coordinated System of Care approach in working with youth and their families. This allows for systems to work closely together in providing integrated services and support to children, youth, and young adults. Pennsylvania also utilizes a state-level Complex Needs process that allows for an integrated systems approach in determining what supports and services are needed by individuals and families with complex needs, particularly those individuals who are "aging out", individuals who are dually diagnosed (with behavioral health and intellectual disabilities), and youth being discharged from residential treatment facilities and inpatient psychiatric hospitals.

Additionally, DHS and DDAP issued a joint bulletin to SCAs, substance use disorder treatment providers, county mental health agencies, mental health treatment providers, etc. providing guidance on co-occurring capable and co-occurring enhanced treatment services, as per ASAM recommendations.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes	( ) No
b) Ethnicity	(•) Yes	( ) No
c) Gender	(•) Yes	( ) No
d) Sexual orientation	( ) Yes	(•) No
e) Gender identity	( ) Yes	(•) No
f) Age	(•) Yes	( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? (•) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? (•) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? (•) Yes ( ) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? (•) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? (•) Yes ( ) No

7. Does the state have any activities related to this section that you would like to highlight?

OMHSAS has continued to support training for the Behavioral Health Workforce to better serve the LGBTQIA+ Community through a partnership with the Gender and Sexuality Development Clinic at Children's Hospital of Philadelphia (CHOP). In SFY22-23, OMHSAS developed a virtual Transgender resources training that is housed on the OMHSAS Electronic Learning Management System.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

[4] National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☑ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Coordinated Specialty Care Model (CSC)	18

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
2957709	3253480

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

All services that can be billed must be billed as opposed to using Block Grant funding.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

Pennsylvania requires all CMHSBG-funded First Episode Psychosis (FEP) programs to utilize the Coordinated Specialty Care Model (CSC). FEP programs are also required to utilize Certified Peer Support (CPS) Specialist services.

5. Does the state monitor fidelity of the chosen EBP(s)?

(•) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(•) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

FEP programs use the evidence-based coordinated specialty care model to wrap around individuals who have experienced their first episode of psychosis. The teams use this comprehensive approach providing therapy, pharmacotherapy, case management, supported employment and education, peer support services, family education and support, and primary care coordination. If an individual needs a service that the team does not provide, the team will help get the individual connected to the needed service.

The service the team provides significantly improves client outcomes. Program evaluation data from January 1st, 2017 – July 1st, 2022 shows the following outcomes:

86% decrease in number of participant hospitalizations by 24-month follow-up

Employment rates increased by 86% at 24-month follow-up

School enrollment increased by 64% in those over age 18 by 24-month follow-up

82% decrease in individuals attempting suicide at 24-months

50% decrease in homelessness by 24-months follow-up

Decreased adverse behaviors and legal issues

Decreased substance use

Significantly improved positive and negative symptoms, role and social function, self-reported recovery, and services satisfaction by 6-month follow-up and maintained through 12-months

Significantly reduced medication side effects by 6-month follow-up and maintained through 12-months

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

Pennsylvania will continue to fund First Episode Psychosis at 18 existing program sites. The state is also focused on developing the sustainability of FEP beyond grant funding and will continue to work to develop FEP Services as a bundled case rate service billable as an in-lieu of service under Pennsylvania's 1915B Waiver. Five FEP Programs are currently operating under the bundled case rate, one program is in the final stages of being approved for bundled case rate, and additional programs are exploring this as an option. Pennsylvania has contracted for seven years with the University of Pennsylvania to conduct statewide training and a statewide program evaluation that has enhanced sustainability and fidelity. With funding support from the CMHSBG, The University of Pennsylvania has consolidated these efforts under HeadsUp (formerly known as the Pennsylvania Early Intervention Center (PEIC)). In addition to offering statewide training, program evaluation, and fidelity monitoring, HeadsUp is currently in the process of implementing screeners within Primary Care offices to increase referrals from non-hospital sources. HeadsUp has also created an Early Psychosis Mentor program to answer questions submitted by clinicians treating patients with early psychosis in Pennsylvania. With the additional funding, Pennsylvania plans to streamline efforts

to bring FEP to rural counties in Pennsylvania through targeted outreach.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Pennsylvania has not established a statewide diagnostic category list for the FEP Program sites at this time. Individual programs may limit admission based on diagnostic criteria.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

Based on the 2020 census, Pennsylvania has a population total of 13,002,700.

Using the calculator, the high incidence rate is 3900, the first medium rate 3250, and the second medium rate is 2600.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

HeadsUp, our collaborating organization, provides outreach assistance to all 18 FEP program sites as well as doing outreach on their own. They also have a helpful website that gives an overview of FEP and can help direct individuals, families, and organizations to various resources.

Outreach activities are encouraged at secondary schools, universities, churches, hospitals, jails, primary care practitioners, and youth organizations, for example.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

PA-FEP Program Evaluation: Quarterly Report
January 1st, 2017 – July 1st, 2022

September 6th, 2022

To the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS):

The following is the quarterly program evaluation report of the fifteen First Episode Psychosis (FEP) Programs in Pennsylvania receiving funding through the federal SAMSHA block grant. Participant characteristics at the time of admission have been summarized for all enrolled (n=1254) in an FEP program between January 1st 2017 and July 1st 2022. This information was collected using de-identified data through REDCap. When available, the report includes follow-up data up to 24 months with group mean comparisons to participant data at admission, modeling of participant outcomes for those who completed 1-year in the program, and findings on stepped care program transitions and continued outcomes. Additionally, with the launch of Tableau, we have integrated Tableau output into this report. As with past quarterly reports, the data demonstrate a pattern of improved outcomes for those in Pennsylvania's FEP programs, in particular:

- **86% decrease in number of participant hospitalizations by 24-month follow-up**
- **Employment rates increased by 86% at 24-month follow-up**
- **School enrollment increased by 64% in those over age 18 by 24-month follow-up**
- **82% decrease in individuals attempting suicide at 24-months**
- **50% decrease in homelessness by 24-months follow-up**
- **Decreased adverse behaviors and legal issues**
- **Decreased substance use**
- **Significantly improved positive and negative symptoms, role and social function, self-reported recovery, and services satisfaction by 6-month follow-up and maintained through 12-months**
- **Significantly reduced medication side effects by 6-month follow-up and maintained through 12-months**

The number of programs has expanded, with data collection commencing in five new PA sites in January 2021, three new sites in January 2022, and two newly funded sites in late 2022. As data collection continues at existing sites and new sites, further descriptions of outcomes will be made available. We additionally plan to expand the data presented from Tableau. Thank you to all FEP programs and their staff for their contributions to this effort. We look forward to providing more information as it becomes available.

Sincerely,

Megan Westfall, M.Sc.
Monica E. Calkins, Ph.D.
Christian Kohler, M.D.

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Program Characteristics and Enrollment Progress

1. Programs Overview

Nineteen Pennsylvania First Episode Psychosis (PA FEP) programs offer services for 2 years with flexibility to extend past on a case-by-case basis. 8 sites offer Step Programs after 2 years, which allows for continued treatment at a lower intensity of care. 5 new programs were established in late 2020, 3 additional programs were established in late 2021, and 2 more in summer 2022. The 2 newest programs have not yet started enrollment and will be included in subsequent reports. Data are limited for new programs but will continue to grow in following quarterly reports.

Programs provide Coordinated Specialty Care (CSC) services to a range of Pennsylvania's population, including urban, suburban, and rural counties. Each program may determine its own inclusion/exclusion criteria; however, most programs align in such criteria. Almost all programs accept participants who experienced a first episode of psychosis within the last 18-24 months. Diagnostic exclusionary criteria frequently exclude intellectual disabilities or IQ under 70, moderate to severe autism, severe substance abuse and/or substance-induced psychosis, and psychosis due to dementia/delirium. Acceptable ages for enrollment primarily range from 15-30 years old, with a few programs accepting ages outside this range. Many programs accept most insurances or are Medicaid only and will assist participants in obtaining Medicaid and financial assistance, if needed and when appropriate.

Programs are allowed to follow the Coordinated Specialty Care model/s that best suits their needs and requirements of their parent agency and resident county. A few programs (STEP, Safe Harbor, CAPSTONE) follow the NAVIGATE model, but most follow the PA FEP model, a hybrid model of essential CSC services. All programs are evaluated annually for fidelity to Coordinated Specialty Care through the Pennsylvania First Episode Psychosis Fidelity Scale (PA-FEP-FS).

While current PA FEP programs provide CSC services to a large portion of Pennsylvania, it is important to note that large geographic areas of Pennsylvania still do not have FEP services available. We hope that with continued evidence of FEP program efficacy and improved outcomes for participants, we will support the ongoing expansion of programs and increased availability of FEP care across our state.

Inclusion/Exclusion Criteria

Table 1. Program Inclusion/exclusion Criteria for Admission

Program	Catchment Area	Age Range	FEP Occurred within	Insurance Accepted
CAPSTONE	Dauphin, Cumberland and Perry County	16 - 30	24 months	All
CHOP	Philadelphia County	14 - 18	12 months	As accepted by CHOP [c]
CMSU - C2E†	Columbia/Montour/Snyder/ Union	14 – 30	24 months	All
ENGAGE – Westmoreland	Westmoreland County	15 – 30	24 months	Health Choices-CCBHO
ENGAGE†	Allegheny County	15 - 30	24 months	Health Choices-CCBHO
HOPE – C/M†	Carbon & Monroe County	15 [b] - 25	24 months	All
HOPE – L/W†	Luzerne & Wyoming County	15 [b] - 25	24 months	All
HOPE – W/P†	Wayne & Pike County	15 [b] - 25	24 months	All
InSight	Centre County	14 – 30	24 months	All
On My Way - Chester†	Chester County	15 - 30	18 months	Medicaid
On My Way – Delaware†	Delaware County	15 - 30	18 months	Medicaid
On My Way - Lehigh†	Lehigh County	15 - 30	18 months	Medicaid
On My Way - Northampton	Northampton County	15 – 30	18 months	Medicaid
PEACE†	Philadelphia County	15 - 30	18 months	Medicaid
PERC†	Pennsylvania	16 - 30	24 months	As accepted by UPHS [a]
Safe Harbor†	Erie County	15 - 35	24 months	All
STEP†	Pennsylvania	14 - 40	60 months	All

Admission criteria that vary across FEP programs. † Site offers Step-Down program following 2 years of primary program. [a] UPHS=University of Pennsylvania Health System; insurances accepted are Community Behavioral Health/Medicaid for Philadelphia residents, Medicare Parts A and B, Aetna, Blue Cross/Blue Shield except when Magellan handles claims for the behavioral health plan, Penn Behavioral Health. [b] HOPE has enrolled participants under age 15 on a case-by-case basis. C CHOP = Children's Hospital of Philadelphia; insurances accepted are ABH, Aetna, CBH, Cigna, ComPsych, Health Partners, Highmark, Humana Military, IBC/Magellan, Keystone First, Magellan, MAPA, Medicaid NJ, Quest, and UBH.

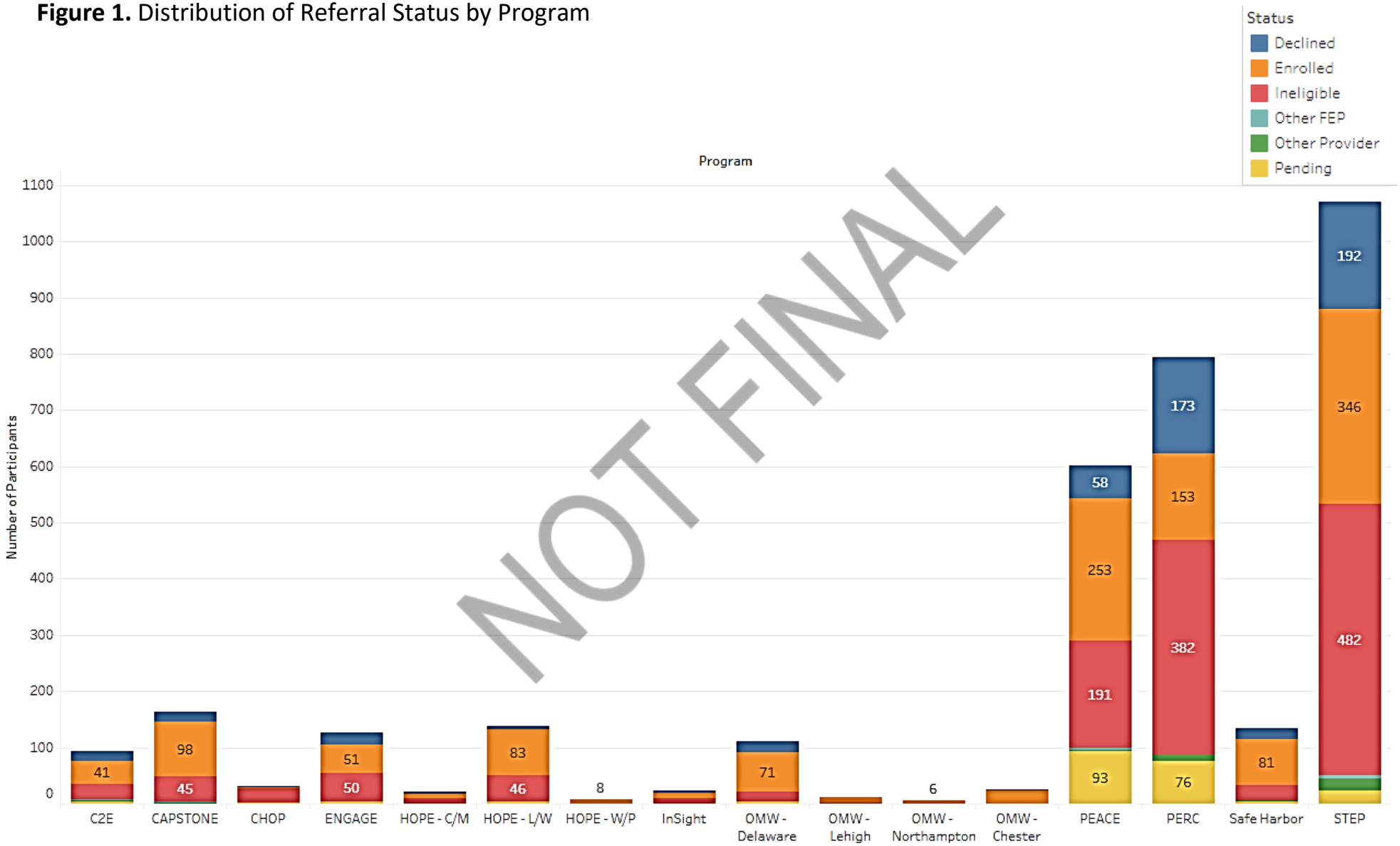
Enrollment Progress

Table 2. Enrollment in FEP Programs

Program	Overall FEP Enrollment					
	Enrollment Start Date	Currently Enrolled Adults*	Currently Enrolled Children*	Adults Enrolled to Date†	Children Enrolled to Date†	Total Enrollment to Date†
CAPSTONE	March 1st 2017	22	1	93	12	**105**
CHOP‡	Jan 1st 2022	2	9	11	1	**12**
CMSU - C2E	Dec 1st 2017	18	3	44	10	**54**
ENGAGE	June 1st 2017	20	3	35	17	**52**
ENGAGE- Westmoreland‡	Feb 1st 2022	1	0	1	1	**2**
HOPE – C/M	Jan 1st 2021	5	1	5	4	**9**
HOPE – L/W	Jan 1st 2017	20	14	18	54	**72**
HOPE – W/P	Jan 1st 2021	3	2	7	2	**8**
InSight	Jan 1st, 2021	8	0	8	2	**10**
OMW - Chester	Jan 1st 2021	19	3	16	8	**24**
OMW - Delaware	Jan 3rd 2017	34	1	56	17	**73**
OMW - Lehigh	Jan 1st 2021	9	0	9	2	**11**
OMW - Northampton	July 1st 2022	4	0	6	0	**6**
PEACE	March 9th 2015	96	11	157	77	**234**
PERC	March 1st 2015	53	5	132	29	**161**
Safe Harbor	Oct 1st 2015	14	2	67	9	**76**
STEP	Jan 1st 2014	127	13	292	52	**344**
TOTAL		**455**	**68**	**942**	**312**	**1254**

Overall enrollment across FEP programs as of July 1st, 2022. Determination of children was based on their age at admission into the program. *Based on Program Director/Coordinator report. †Based on available admission data in REDCap as of July 1, 2022. ‡Program was being established and was not yet enrolling participants for the time frame reviewed.

Figure 1. Distribution of Referral Status by Program



Distribution of referral status by program as of July 1st, 2022.

Referrals

Table 3. Non-Enrolled Referrals Status

Status of Non-Enrolled Referrals as of July 1st 2022						
FEP Program	**Total**	**Ineligible**	**Declined**	**Pending**	**Referred elsewhere**	**Unable to Contact**
	N	**%**	**%**	**%**	**%**	**%**
CAPSTONE	80	56.3	23.7	0.0	2.5	17.5
CHOP	33	84.9	3.0	3.0	0	9.1
CMSU - C2E	57	49.1	29.8	5.3	3.5	12.3
ENGAGE	80	65.0	27.5	1.3	0	6.2
ENGAGE - W	3	0	66.7	33.3	0	0
HOPE – C/M	14	64.3	28.6	0	0	7.1
HOPE – L/W	64	81.3	9.4	0	0	9.4
HOPE – W/P	0	-	-	-	-	-
InSight	14	64.3	35.7	0	0	0
OMW – Chester	3	0	33.3	66.7	0	0
OMW – Delaware	42	40.5	45.2	2.4	0	11.9
OMW - Lehigh	2	50.0	0	0	50.0	0
OMW - Northampton	0	-	-	-	-	-
PEACE	315	62.2	20.0	1.0	1.6	15.2
PERC	651	60.4	26.6	0.0	1.7	11.4
Safe Harbor	75	38.7	30.7	0.0	1.3	29.3
STEP	1023	51.4	20.8	2.2	2.6	23.0
TOTAL	**2458**	**56.4%**	**23.1%**	**1.3%**	**2.0%**	**17.2%**

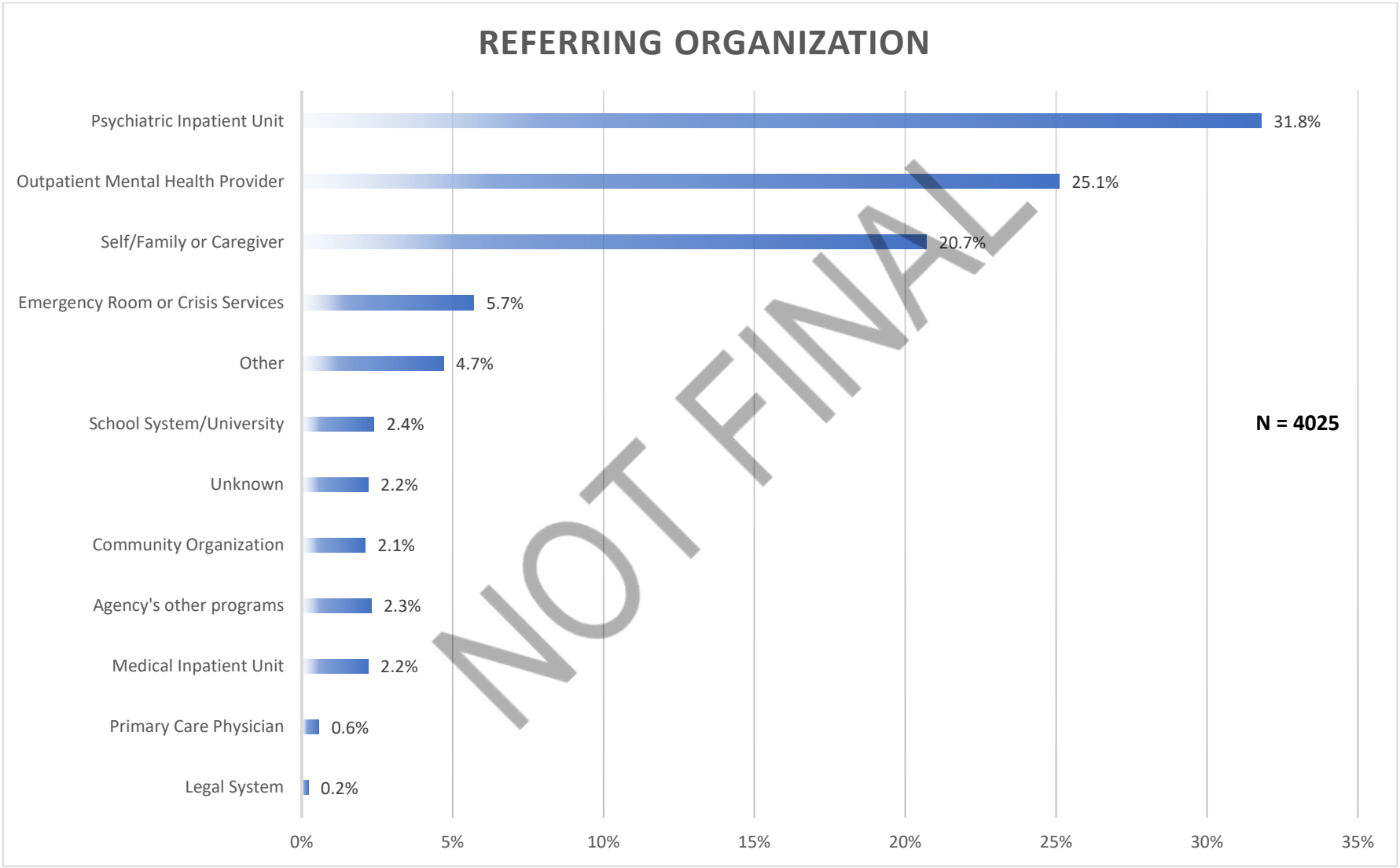
Status of non-enrolled referrals by program. The percent of reported reasons for non-enrolled referrals by program as of July 1st, 2022.

Table 4. Reasons for Ineligibility

Multiple Reasons for Ineligibility of Non-Enrolled Referrals							
FEP Program	**Total**	**Age**	**Diagnosis**	**Length of DUP [a]**	**Catchment Area**	**Insurance**	**Other**
	N	**%**	**%**	**%**	**%**	**%**	**%**
CAPSTONE	45	6.7	44.4	28.9	8.9	0	11.1
CHOP	28	50.0	0	0	25.0	0	25.0
CMSU - C2E	28	10.7	35.7	32.1	14.3	0	7.1
ENGAGE	52	3.9	38.5	19.2	19.2	0	19.2
ENGAGE - W	0	-	-	-	-	-	-
HOPE – C/M	9	11.1	77.8	0	0	0	11.1
HOPE – L/W	49	4.1	51.0	20.4	6.1	0	18.4
HOPE – W/P	0	-	-	-	-	-	-
InSight	9	0	0	0	11.1	0	88.9
OMW – Chester	0	-	-	-	-	-	-
OMW – Delaware	17	0	17.7	70.6	0	0	11.8
OMW - Lehigh	1	-	-	-	-	-	100
OMW - Northampton	0	-	-	-	-	-	-
PEACE	193	2.1	15.5	56.5	3.1	8.8	14.0
PERC	392	22.2	9.4	39.5	24.2	2.3	2.3
Safe Harbor	29	10.3	41.4	41.1	0	0	6.9
STEP	521	7.3	67.6	9.4	3.3	2.7	9.8
TOTAL	**1374**	**10.9%**	**37.6%**	**27.8%**	**10.5%**	**2.9%**	**10.4%**

Total number of ineligible referrals and multiple reasons for ineligibility by FEP program reported between January 1st 2017 and July 1st, 2022. [a] DUP = Duration of Untreated Psychosis. Some individuals had multiple reasons of ineligibility.

Figure 2. Types of Referring Organizations to PA-FEP Programs



Percent of referrals to any FEP program by organization as of July 1st, 2022.

Table 5. Time to Complete Screening

Time in Days to Screening	N	Mean	Median	SD	Min	Max
CAPSTONE	161	6.9	5.0	8.6	0	58
CHOP	25	0.7	0	0.9	0	3
CMSU- C2E	77	4.4	3.0	4.6	0	18
ENGAGE	93	2.4	1.0	3.5	0	22
ENGAGE – W	5	14.2	9.0	16.3	1	42
HOPE – C/M	10	2.9	2.0	2.3	1	7
HOPE – L/W	60	4.1	3.0	4.8	0	24
HOPE – W/P	10	22.6	14.5	18.1	9	67
InSight	3	2	2	1	1	3
OMW – Chester	24	8.2	6.5	6.9	1	29
OMW – Delaware	85	5.6	2.0	12.6	0	88
OMW – Lehigh	9	4.7	5.0	2.3	1	7
OMW - Northampton	6	8.67	6.5	5.4	4	19
PEACE	386	23.4	4.5	46.2	0	227
PERC	785	1.5	0.0	4.6	0	59
Safe Harbor	43	5.7	2.0	9.2	0	37
STEP	1123	0.7	0.0	2.6	0	70
TOTAL	**2906**	**4.91**	**0.00**	**19.06**	**0**	**227**

Time in days to screening after first contact of referral to FEP program as of July 1st, 2021.

Table 6. Time to Determine Eligibility

Time in Days to Eligibility Determination	N	Mean	Median	SD	Min	Max
C2E	66	9.4	7.0	10.8	0	47
CAPSTONE	112	19.1	15.0	13.5	1	67
CHOP	22	1.3	0.5	2.3	0	8
ENGAGE	66	8.8	7.5	6.1	0	30
ENGAGE – W	2	17.0	17.0	9.9	10	24
HOPE – C/M	8	11.5	6.5	13.6	1	43
HOPE – L/W	110	5.6	3.0	6.7	0	32
HOPE – W/P	10	8.8	8.5	8.4	0	28
InSight	22	4.7	3.0	5.8	0	20
OMW – Chester	24	12.8	12.0	7.4	4	29
OMW – Delaware	87	8.6	5.0	15.1	0	91
OMW – Lehigh	10	11.0	8.5	10.2	2	38
OMW - Northampton	6	8.8	7.5	5.7	4	20
PEACE	348	10.9	7.0	15.9	0	143
PERC	149	22.7	20.0	20.1	0	105
Safe Harbor	54	6.6	5.0	7.2	0	28
STEP	577	10.8	7.0	11.2	0	150
TOTAL	**1674**	**11.57**	**7.00**	**13.80**	**0**	**150**

Time in days to eligibility determination after first contact of referral to FEP program as of July 1st, 2022.

Table 7. Reasons for Discharge by Program

	Discharge Reason			
Program	Client is no longer available to participate	Program completion or graduation	Program termination by client	Program termination due to disengagement
C2E	5 (23.81%)	7 (33.33%)	5 (23.81%)	7 (33.33%)
CAPSTONE	19 (20.21%)	18 (19.15%)	21 (22.34%)	37 (39.36%)
ENGAGE	7 (24.14%)	7 (24.14%)	9 (31.03%)	6 (20.69%)
HOPE - C/M	1 (33.33%)		1 (33.33%)	1 (33.33%)
HOPE - L/W	10 (19.61%)	28 (54.90%)	11 (21.57%)	2 (3.92%)
HOPE - W/P	2 (66.67%)		1 (33.33%)	
InSight				2 (100.00%)
OMW - Dela..	6 (13.64%)	22 (50.00%)	8 (18.18%)	9 (20.45%)
OMW - Lehi..			1 (50.00%)	1 (50.00%)
OMW - Nort..				1 (100.00%)
OMW -Ches..				1 (100.00%)
PEACE	26 (18.57%)	44 (31.43%)	26 (18.57%)	47 (33.57%)
PERC	7 (9.46%)	28 (37.84%)	30 (40.54%)	9 (12.16%)
Safe Harbor	15 (26.32%)	13 (22.81%)	15 (26.32%)	22 (38.60%)
STEP	58 (23.77%)	67 (27.46%)	62 (25.41%)	61 (25.00%)

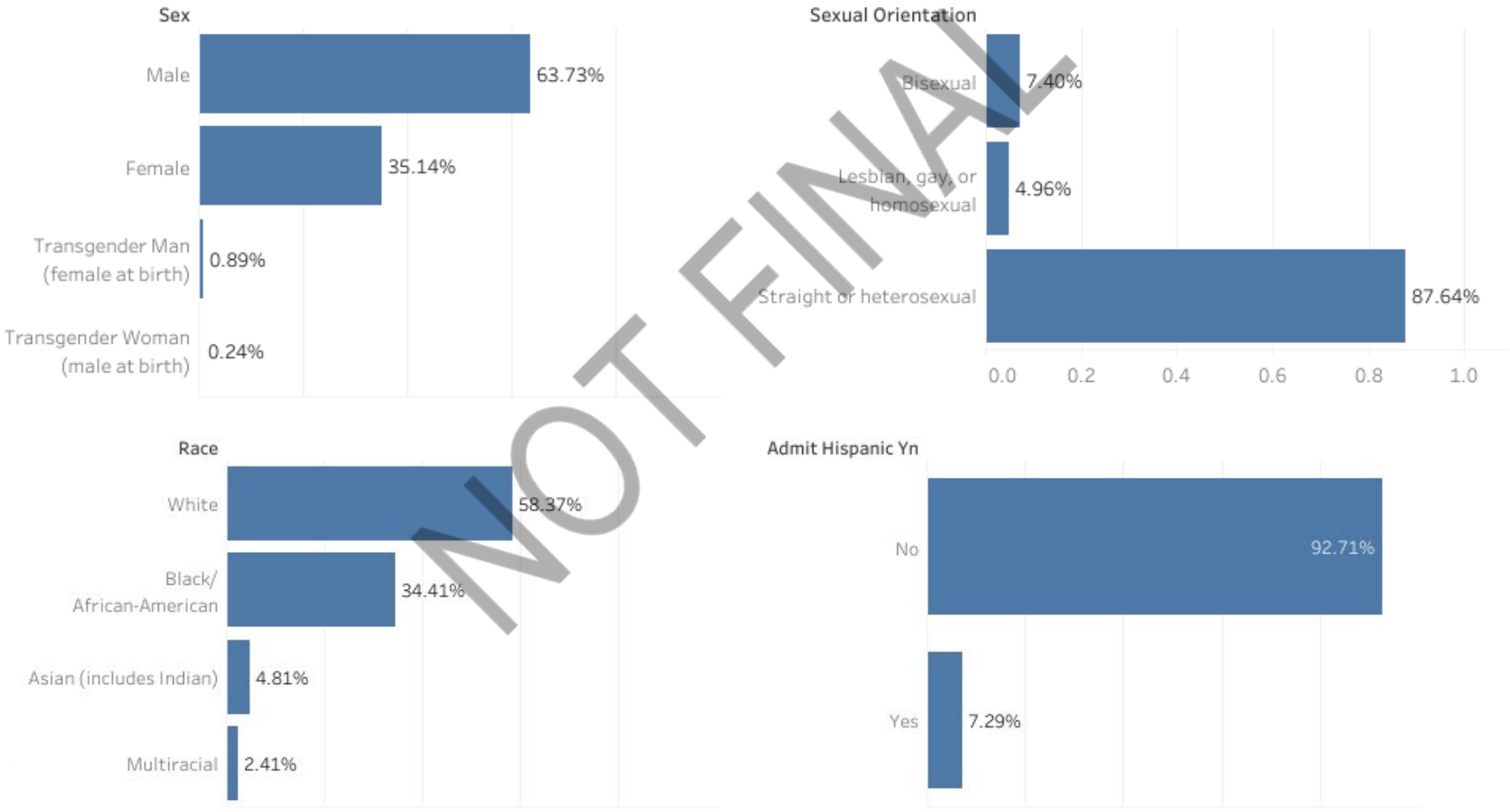
Total number of participants discharged with reasons for discharge by FEP program between January 1st 2017 and July 1st 2022. [a] Participants who were no longer eligible (moved out of a catchment area or a change in diagnosis/length of DUP or were enrolled in a different service or program). Discharge definitions were collapsed from previous reports to follow updates to PE discharge measures.

The average length of time spent in FEP programs, from admission to discharge, was 14.99 months (N=773, standard deviation = 11.3 months, minimum = 0, maximum = 51 months).

Participant Characteristics

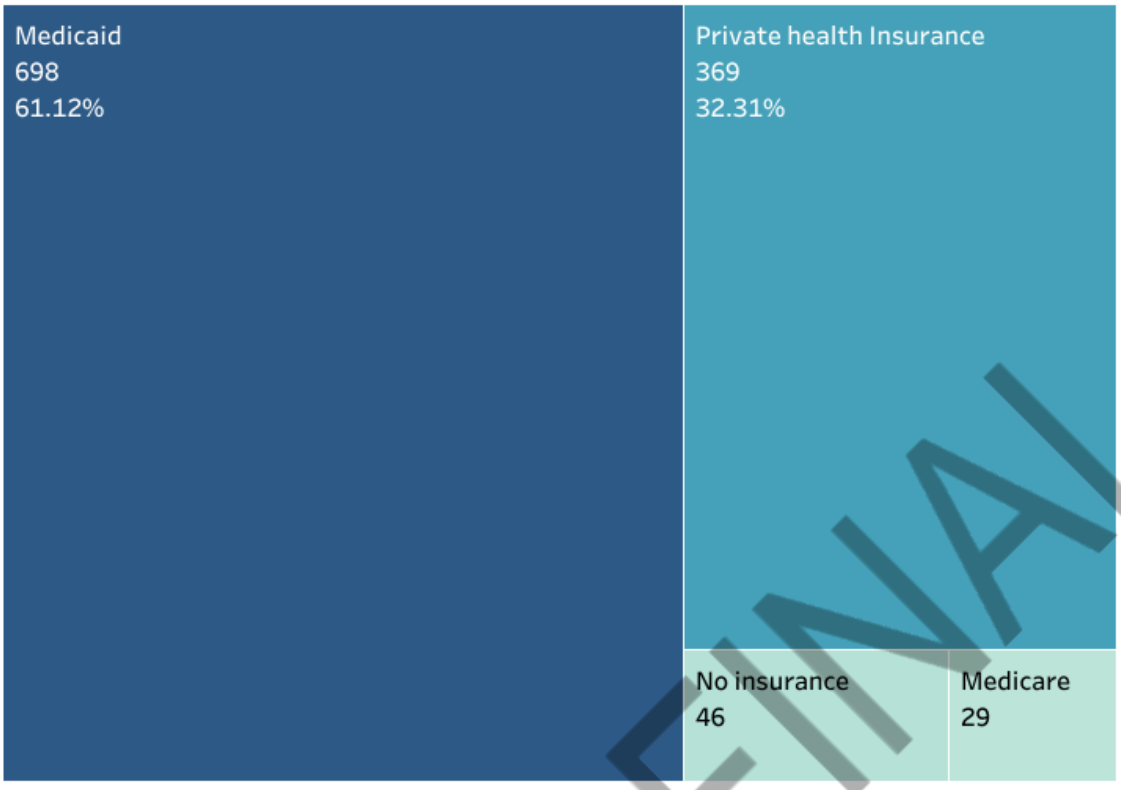
Participants' characteristics reflect any reported data from the total 1254 program evaluation admissions. This includes participants who have been discharged prior to program completion or participants who are still in the process of completing forms and assessments for program evaluation in REDCap. When possible, preliminary follow-up characteristics are provided from available reported data.

Figure 3. Demographics



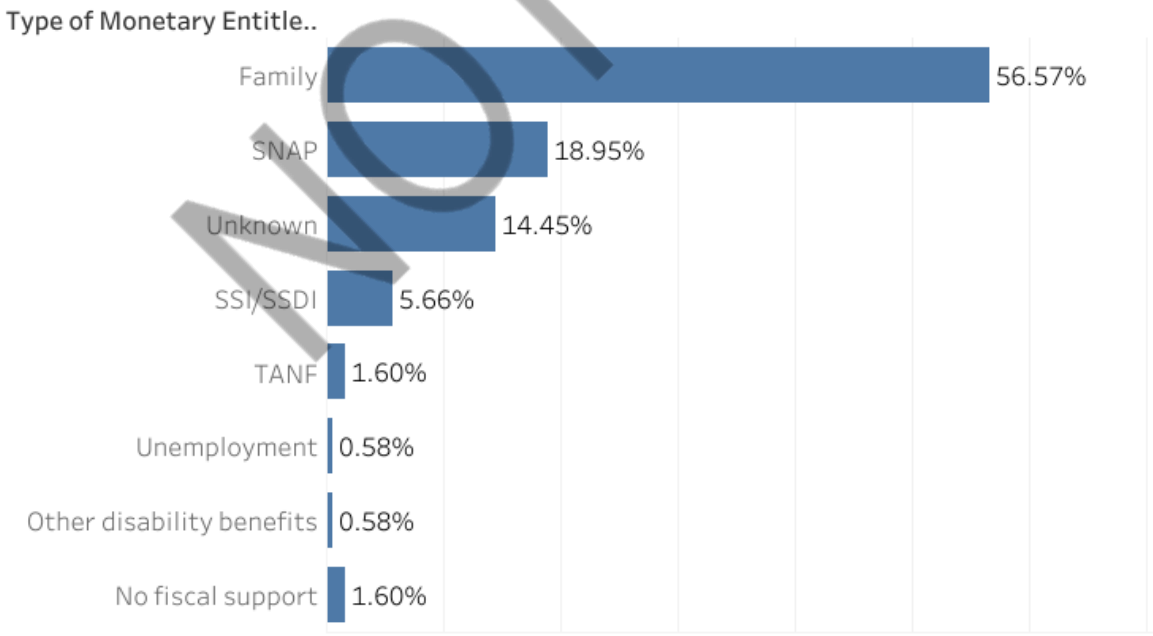
Participant demographics at the time of admission to a PA FEP Program, including gender, sexual orientation, race, and Hispanic ethnicity.

Figure 4. Insurance at Admission



Participant insurance at the time of admission to a PA FEP Program.

Figure 5. Fiscal support at Admission



Participant fiscal support reported at the time of admission to a PA FEP Program. SSDI = supplementary security income; SSI = social security disability; SNAP = supplementary nutrition assistance program; TANF = temporary assistance for needy families.

Table 8. Participant Preference on Family Involvement

	Preference of Family Involvement		
Frequency of family contact	Prefers no family involvement	Prefers family be involved with some restrictions	Prefers family be involved with no restrictions	Grand Total
About daily	45	162	305	512
About monthly	2	6	2	10
About weekly	13	29	13	55
Less than monthly	6	5	2	13
Never	6	1		7
Grand Total	72	203	322	597

Participant's preferences on family involvement with their care and the approximate frequency of contact between the participant and family at admission.

Pathways to Care

Table 9. Time in Pathways to Care

Pathways to Care	N	Mean	SD	Min	Max
Age (in years) at…					
Time of referral	3439	21.59	5.32	5.00	68.33
Admission to FEP program	1254	21.16	4.35	11.75	40.58
Onset of qualifying symptoms	1138	20.17	4.44	5.83	39.50
1st MHT for Any Reason	1023	18.42	5.44	2.00	40.33
1st MHT for Psychosis	1139	20.46	4.48	2.33	40.33
Time (in months) from…					
Referral to Admission	1254	2.28	6.17	0	74
1st MHT for any reason to Admission	1022	33.84	50.24	0	338
Onset of Psychosis* to Admission	1138	12.22	18.33	0	176
1st MHT for psychosis to Admission	1135	9.66	18.59	0	203

Summary of participants at different points of contact with Mental Health services. MHT = Mental Health Treatment. * Estimated onset of qualifying symptoms of psychosis for admission to FEP program.

Table 10. Duration of Untreated Psychosis by Program

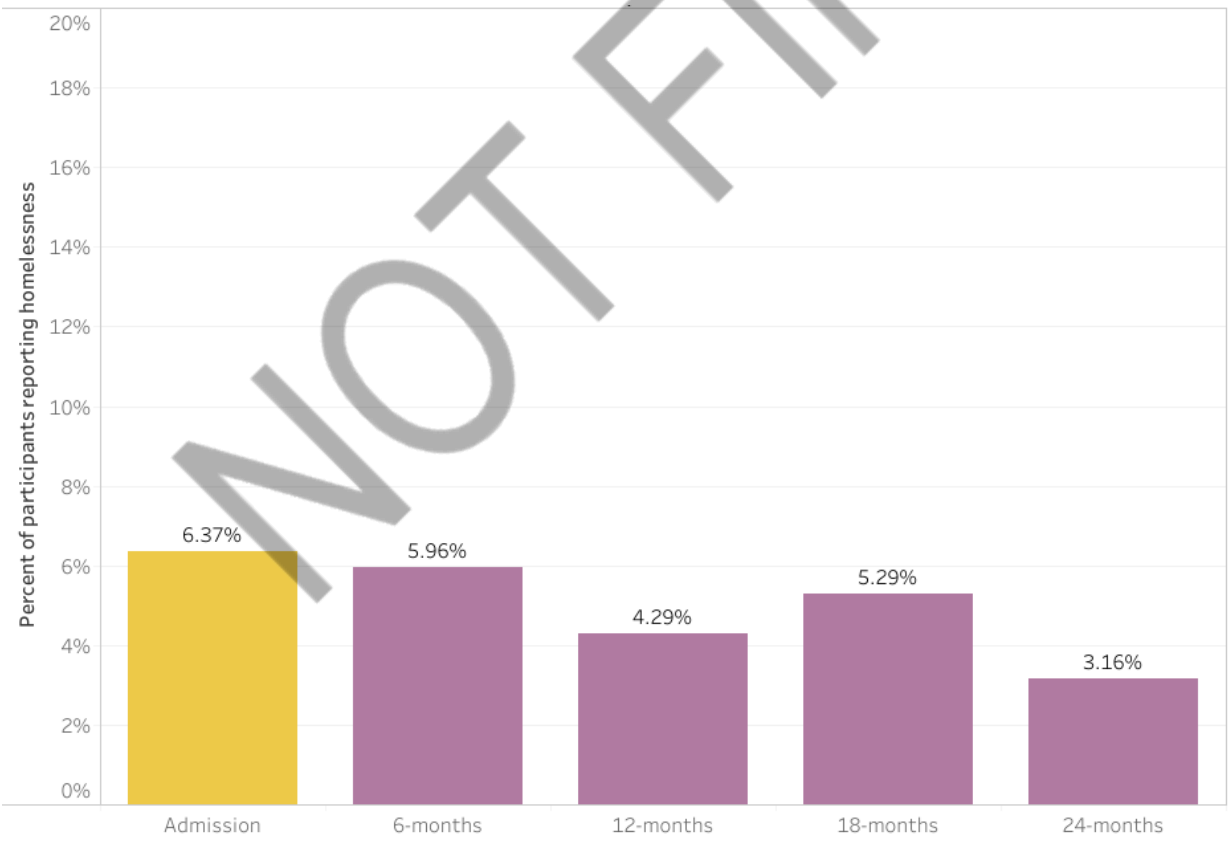
Duration of Psychosis (in months) Prior to Enrollment						
FEP Program	**N**	**Mean**	**Median**	**SD**	**Min**	**Max**
CAPSTONE	105	9.76	5.0	14.14	0	111
CHOP	14	5.14	4.0	3.80	1	12
CMSU - C2E	48	31.63	21.5	38.23	1	176
ENGAGE – Allegheny	44	7.89	5.0	8.73	0	36
ENGAGE - Westmoreland	2	28.5	28.5	2.12	27	30
HOPE C/M	8	16.88	12.5	16.31	2	51
HOPE L/W	51	19.76	6.0	29.22	0	121
HOPE W/P	11	12.27	6.0	15.20	0	42
InSight	10	10.00	6.5	9.64	0	30
OMW - Chester	14	15.36	14.0	13.01	0	45
OMW - Delaware	59	5.88	3.0	7.92	0	34
OMW - Lehigh	9	9.67	7.0	10.95	1	34
OMW - Northampton	6	8.17	9.5	5.07	2	14
PEACE	210	7.77	4.0	12.15	0	106
PERC	156	7.89	5.5	8.66	0	59
Safe Harbor	62	10.73	4.5	18.43	0	112
STEP	328	16.10	9.0	20.10	0	163

Duration of psychosis from estimated onset of qualifying symptoms to admission enrollment in an FEP program, by program. Maximum DUPs by site may exceed eligibility criteria because some participants' age of onset changes after admission as new information becomes available. Programs who had not yet enrolled participants were excluded from the table (CHOP and ENGAGE Westmoreland County).

Longitudinal Outcomes – Full Participant Sample

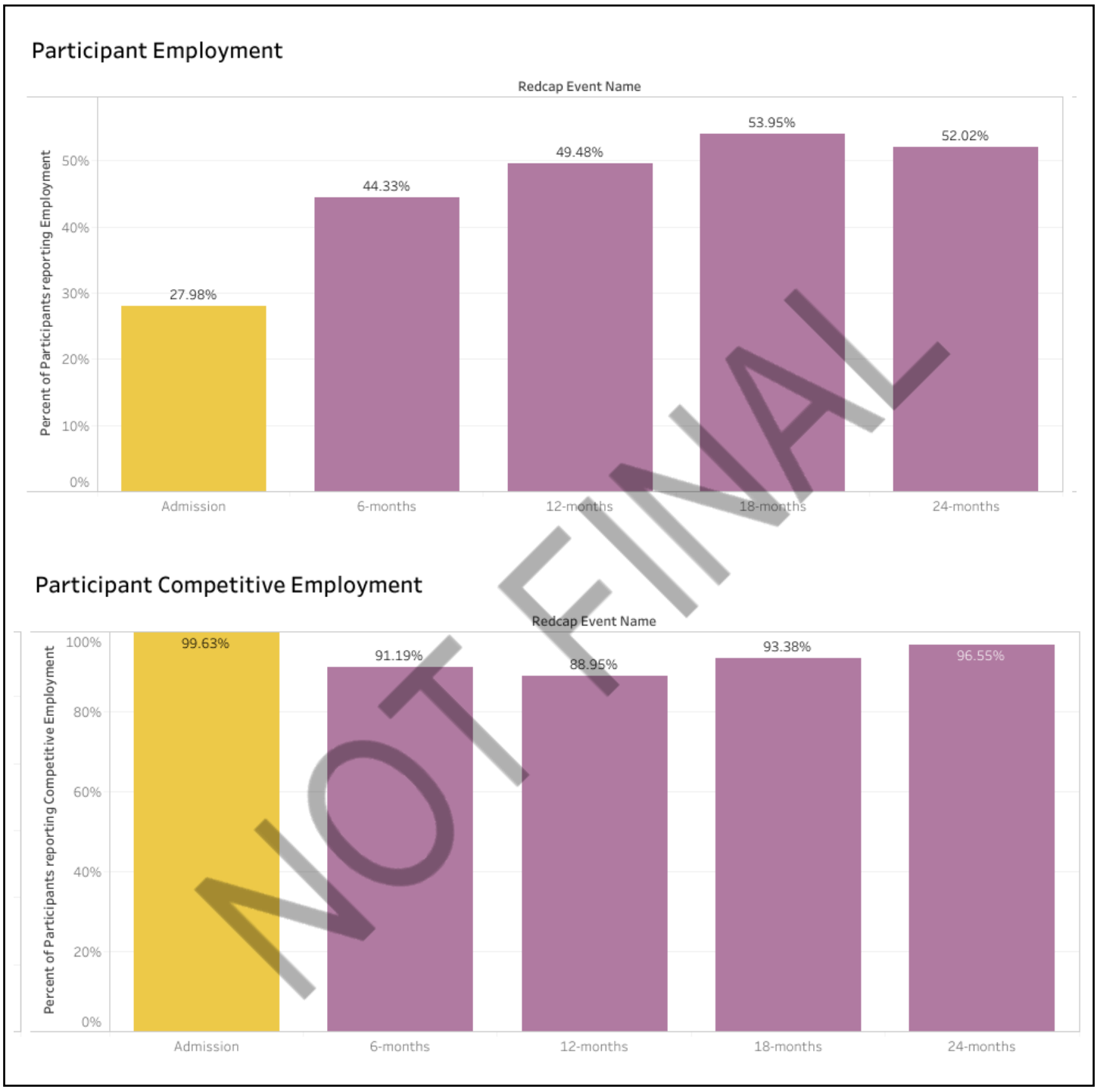
An important part of evaluating PA FEP programs includes examining how participants progress over time in the program across varying measures and outcomes. The following longitudinal graphs in this report display all available participant data at each time point, that is, they reflect group level values at that timepoint, and should not be interpreted as reflecting individual progress or outcomes. Due to rolling admissions at programs and the longitudinal nature of the data, later assessment periods have smaller sample sizes than admission. Currently, small sample sizes at later assessment periods could skew findings, as it is possible that not enough participant data are available to represent the means. As data collection continues, values at later time points will more accurately represent group level outcomes on average for that assessment period. Also, data at later timepoints may be biased because they only represent participants who are retained in the programs for longer periods of time, and these individuals may differ in important ways from individuals who are discharged sooner (but whose data are currently shown in the earlier timepoints). Later in this report, we subset outcome data for only participants who have data at all timepoints and plan to report on predictors of early discharge in future reports.

Figure 6. Participant Homelessness



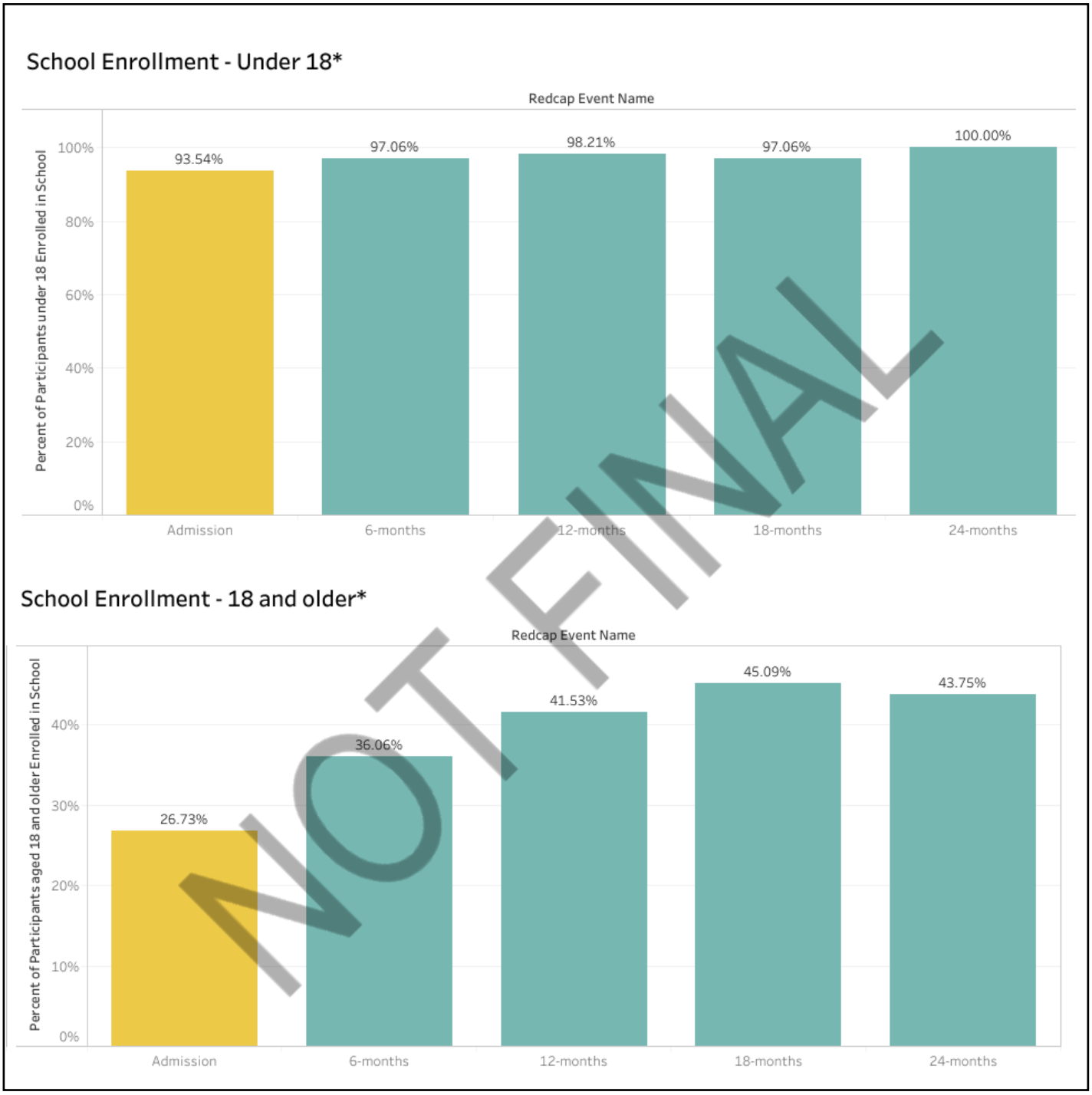
Participants' homelessness status at admission and subsequent follow-up periods, up to 24 months. Homelessness was defined to include any time spent sleeping a homeless shelter, on the street, or in a temporary place that is not the participant's residence (e.g., couch surfing, temporarily living with family or friends).

Figure 7. Participant Employment



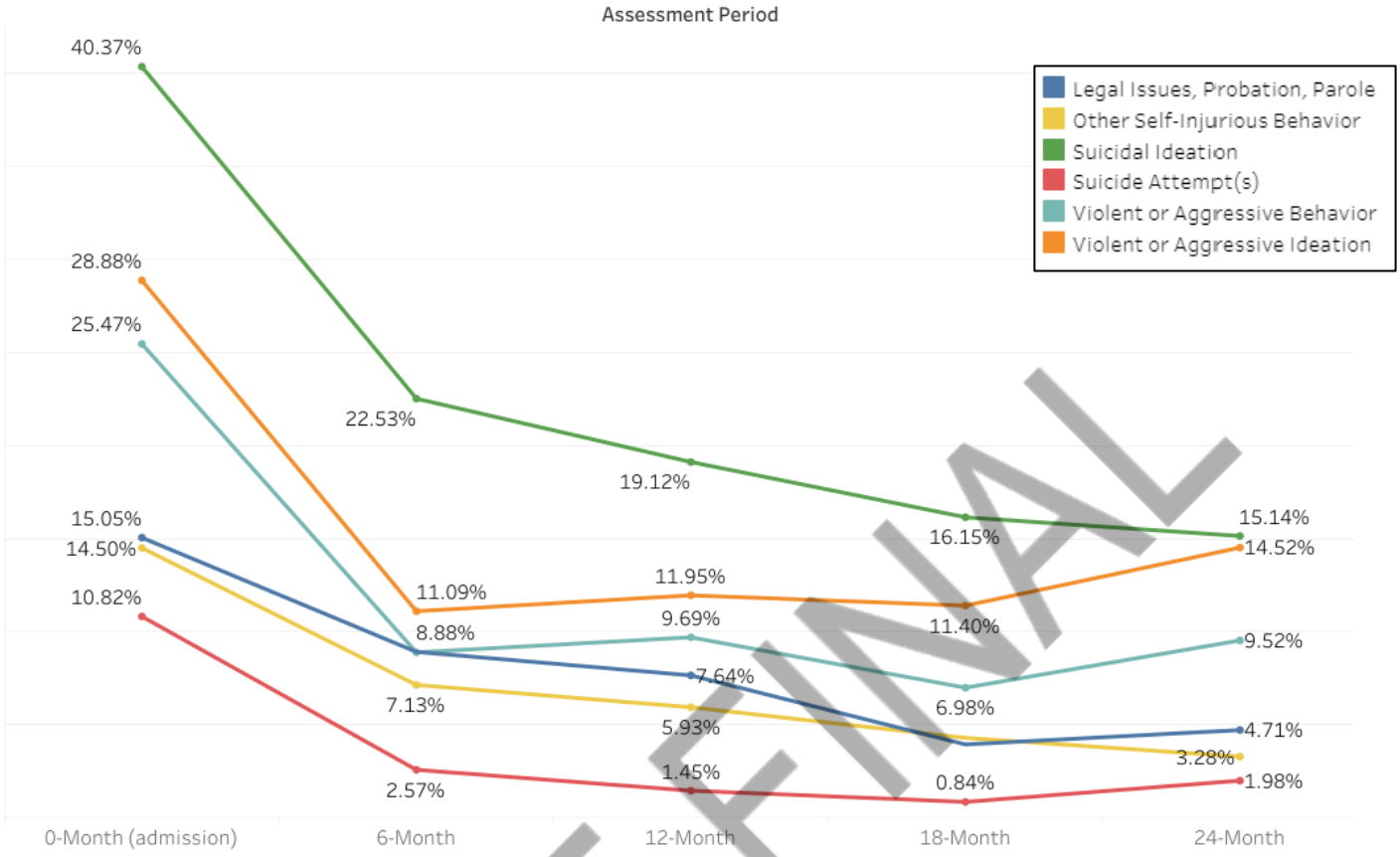
Participant employment over time in PA FEP Programs, including general employment rate and competitive employment rates of those who were reported to be employed. To count as a competitive job, the job must pay at least minimum wage, be supervised by an employee at the place of work (not by an employee of an outside mental health agency or other 'sheltered' work situation) and be open to anyone rather than being reserved for people with behavioral health problems. Additionally, the paycheck must be from the employer and reported for tax purposes.

Figure 8. Participant School Enrollment by Age Group



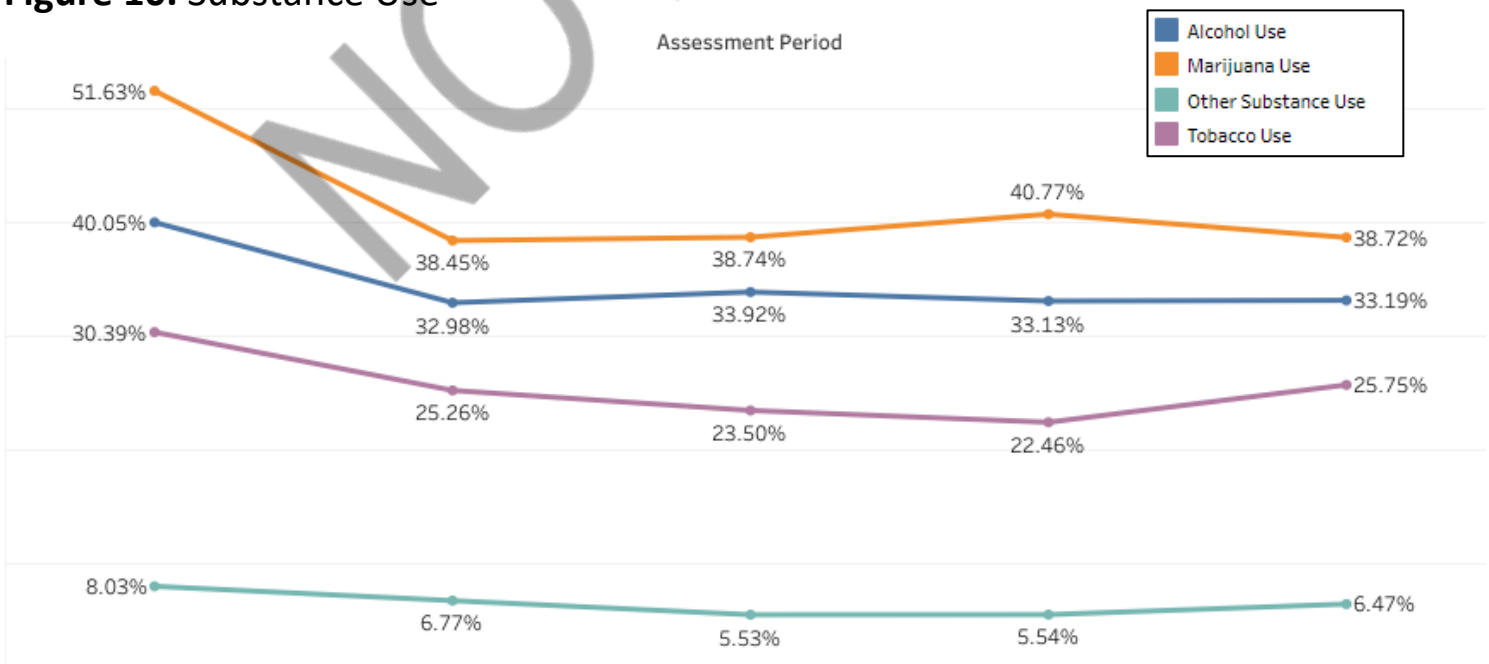
Participant school enrollment over time in PA FEP Programs, by age group.

Figure 9. Adverse Behaviors



Percentage of participants with reported adverse behaviors at admission and subsequent follow-up periods.

Figure 10. Substance Use



Percentage of participants who reported substance use at admission and subsequent follow-up periods.

Hospitalizations

In addition to reducing the DUP, a second important function of FEP programs is to reduce the high numbers of costly hospitalizations that often occur within this population. This can be done by diverting individuals from hospitalizations to enrollment in an FEP program or by reducing the likelihood of hospitalizations after enrollment in an FEP program by providing intensive outpatient services.

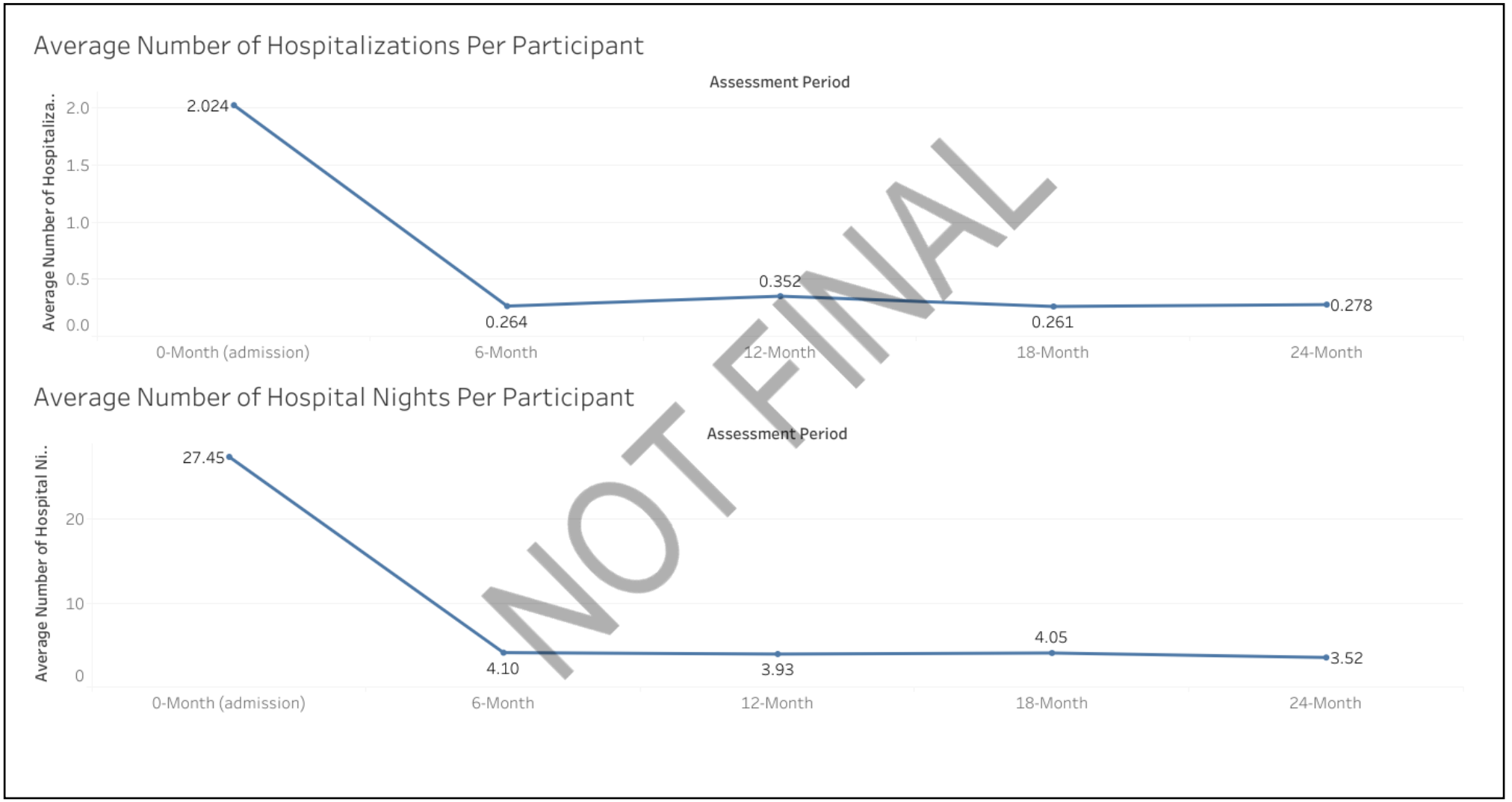
- 79.8% of 1239 participants had at least one hospitalization prior to enrollment in an FEP program (see Table 11). Following admission, both the number of hospital admissions and the nights spent in the hospital decrease (see Figure 11).

Table 11. Psychiatric hospitalization history at admission

Hospitalizations	Mean	SD	Min	Max
Age (in years) of First hospitalization (N=915)	20.15	4.49	6	38.3
Any Prior to Admission to FEP Program				
Number of Hospitalizations per participant (N=932)	2.03	2.28	0	42
Number of Nights in Hospital per participant (N=826)	27.61	33.06	0	253
90 Days Prior to Admission to FEP Program				
Number of Hospitalizations per participant (N=930)	1.25	3.67	0	6
Number of Nights spent per participant (N=567)	15.59	17.46	0	90

Summary of psychiatric hospitalization history reported at the time of the admission.

Figure 11. Hospitalizations post-admission to FEP Program



Hospitalizations per participant over time in PA FEP Programs, including average number of hospitalizations and average number of nights in hospitalization.

Table 12. Measures Collected by PA FEP Programs

Measure	Scale Description			
	N items	Min	Max	Higher scores reflect greater…
Self-Report Surveys				
Beck Depression Inventory - 7 (BDI-7)	7	0	21	…depressed mood
Happiness Scale	4	4	16	…happiness
Hopelessness Scale	8	0	8	…hopelessness
Beck Self-Esteem Scale – Revised (BSES-R)	11	0	33	…self-esteem
Loneliness Scale	3	3	9	…loneliness
Defeatist Beliefs Scale (DBS)	5	5	35	…defeatist beliefs
Quality of Life (QOL)	11	11	77	…participant rated quality of life
Questionnaire About the Process of Recovery (QPR)	15	0	60	…participant rated recovery
Glasgow Antipsychotic Side Effects Scale (GASS)	20	0	63	…participant rated side effects. 0-21= absent/mild; 22-42=moderate; 43+= severe
Youth Services Satisfaction Survey	21	21	105	…participant rated satisfaction with mental health services
Systematic Clinical Outcome Routine Evaluation (SCORE)-15	15	15	75	…family problems or worse family functioning
Beck Collection – Revised 9 (BC-r9)	9	2	32	…negative affect
PTSD Symptom Scale (PSS)				
Experienced Traumatic Events	12	0	12	…number of experienced traumatic events
PTSD Symptom Severity	17	0	51	…severity of PTSD symptoms
Adherence Estimator	3	0	36	…risk for adherence problems
Adverse Childhood Experiences (ACE)	10	0	10	… risk for mental, physical, behavioral, and productivity challenges in adulthood
CollaboRATE	3	0	12	… shared decision making
Modified Colorado Symptom Index	14	0	56	… emotional distress and symptomology
Minimal Insomnia Symptom Scale (MISS)	3	0	12	…symptoms of insomnia
Intent to Attend and Complete Treatment Scale	2	0	18	…likelihood to attend and complete treatment
Clinical Assessments				
Brief Psychiatric Rating Scale (BPRS) [§]	24	0	168	…severity of psychiatric symptoms
Brief Psychiatric Rating Scale - Positive Symptoms (BPRS-P) [§]	5	0	35	…severity of psychosis symptoms
Global Function: Role - Current Role - Lowest Past Year Role - Highest Past Year	1	1	10	…role function. 10= Superior; 5=Serious impairment; 1=Extreme impairment
Global Function: Social - Current Social – Lowest Past Year Social – Highest Past Year	1	1	10	…social/interpersonal function. 10= Superior; 5=Serious impairment; 1=Extreme social isolation
COMPASS-10	10	0	60	…psychiatric symptom severity
RAISE CP Negative Symptom Scale	3	3	18	…negative symptom severity
Brief Adherence Rating Scale (BARS)	1	1	4	…difficulties with oral medication adherence
RAISE EPS Tool	4	4	20	…extrapyramidal symptom severity
TAIT – Service Engagement Scale	14	0	42	…service engagement difficulties
Intent to Attend and Complete Treatment Scale	2	0	18	…likelihood to attend and complete treatment

Description and parameters of measures collected in the PA FEP CAB, including clinician-rated scales (Clinical Assessments) and participant self-rated scales (Self-report Surveys). [§] Data no longer collected for these scales as of January 2021.

Table 13a. Baseline Self-report Measures

Selfreport Metrics	Count of Selfreport Values	Avg. Selfreport Values	Max. Selfreport Values	Min. Selfreport Values	
ACE	161	2.763975155	10	0	Abc
Adherence Estimator	178	7.056179775	36	0	Abc
BDI	396	5.343434343	19	0	Abc
BSESR	380	19.834210526	33	3	Abc
CollaboRATE	84	9.178571429	12	0	Abc
DBS	392	23.267857143	35	5	Abc
GASS	564	15.265957447	66	0	Abc
Happiness	387	10.749354005	16	4	Abc
Hopelessness	387	2.834625323	8	0	Abc
Intent for Treatment	129	15.379844961	18	3	Abc
Loneliness	394	5.939086294	9	3	Abc
MISS	181	3.436464088	12	0	Abc
PSS	403	19.486352357	51	0	Abc
QOL	653	49.617151608	77	11	Abc
QPR	653	39.869831547	60	0	Abc
SCORE-15	643	36.183514774	75	15	Abc
Traumatic Events	652	1.618098160	11	0	Abc
YSS	544	81.840073529	105	18	Abc

Baseline aggregate self-report scale scores. Count of SelfReport_Values = number of participants. Avg. SelfReport_Values = total score that FEP participants received on average. Min. SelfReport_Values = minimum score that participant(s) received. Max. SelfReport_Values = maximum score that participant(s) received.

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Table 13b. Baseline Clinical Assessment Measures

Clinical Metrics	Count of Clinical Values	Avg. Clinical Values	Max. Clinical Values	Min. Clinical Values
Global Role Function	1,022	4.723091977	10	1
Global Social Function	1,021	5.359451518	10	1
Intent for Treatment	253	14.450592885	18	3
Negative Symptoms Scale	246	6.780487805	18	3
Total BPRS	697	54.593974175	123	0
Positive BPRS	703	14.972972973	34	0
RAISE EPS Tool	152	5.105263158	28	4
TAIT SES	142	12.690140845	36	0

Baseline aggregate clinical assessment scores. Count of Measure values = number of participants. Avg. Measure values = total score that FEP participants received on average. Min. Measure_values = minimum score that participant(s) received. Max. Measure_values = maximum score that participant(s) received.

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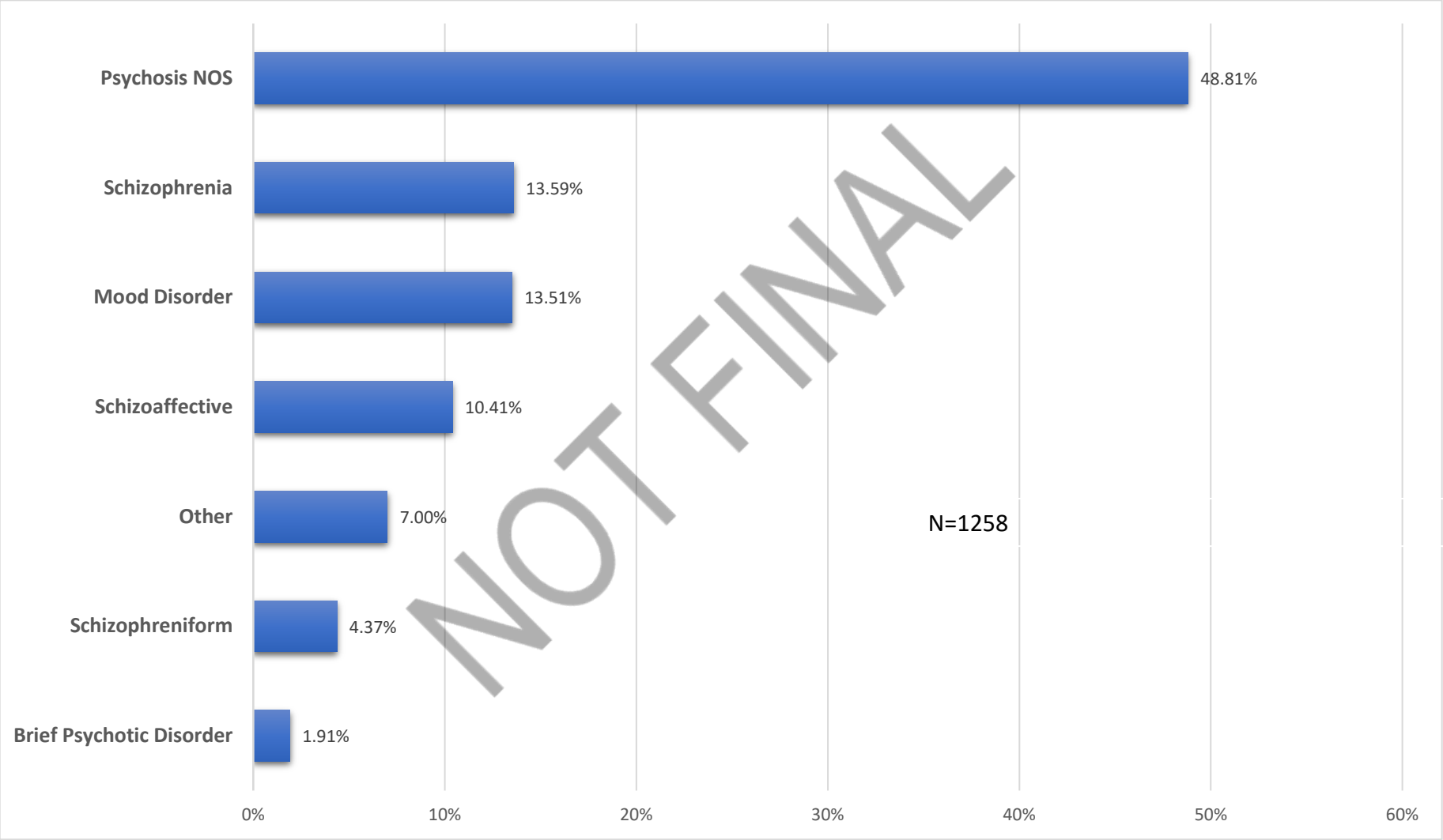
Figure 12. Primary Qualifying Diagnosis at Admission



Primary qualifying diagnoses for participants at admission to a PA FEP Program. Psychosis NOS = Psychosis Not Otherwise Specified; Mood Disorder includes Depression and Bipolar disorders with psychotic features; Schizoaffective includes bipolar, depressive, and unspecified types; Other includes delusional disorder and substance-induced psychosis.

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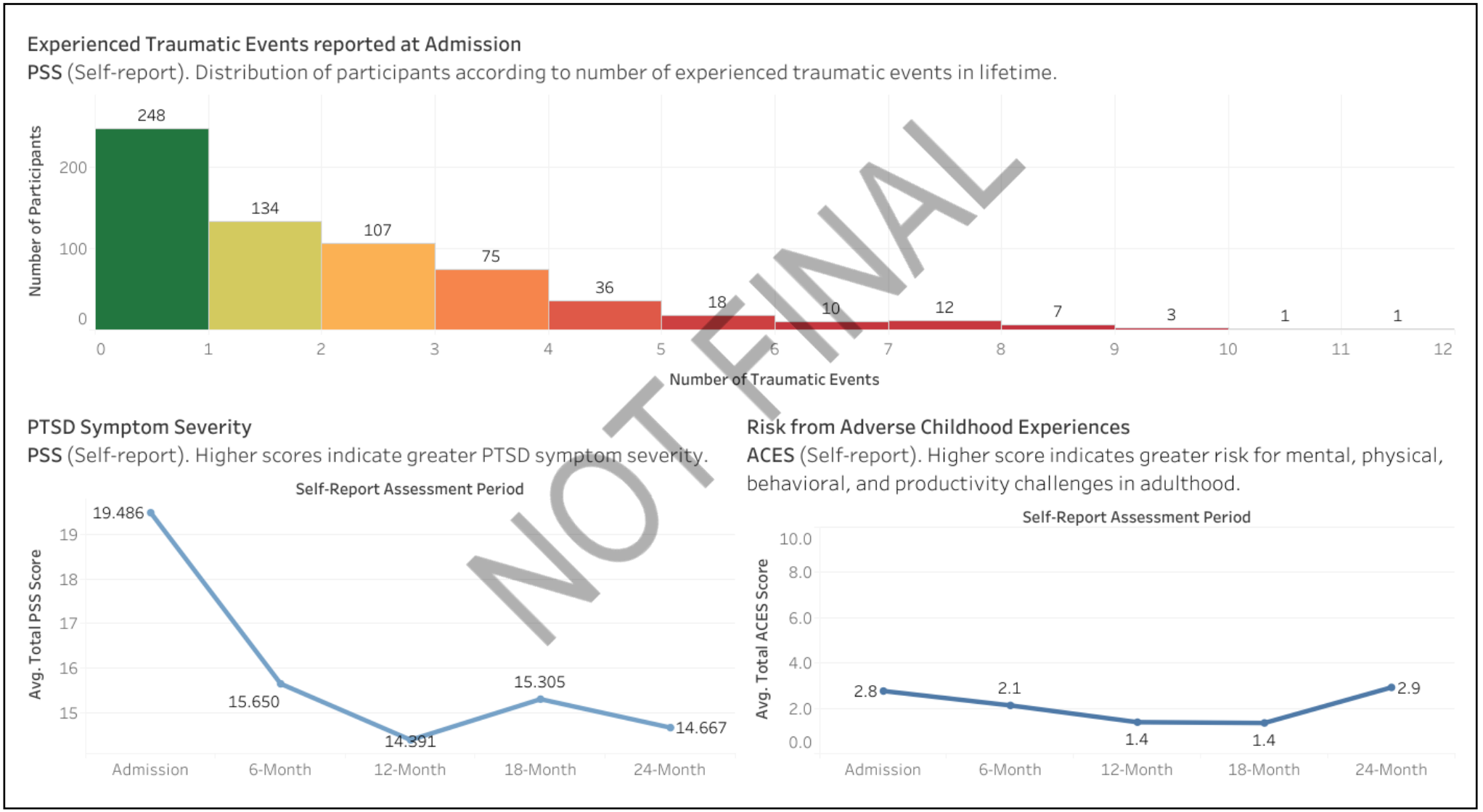
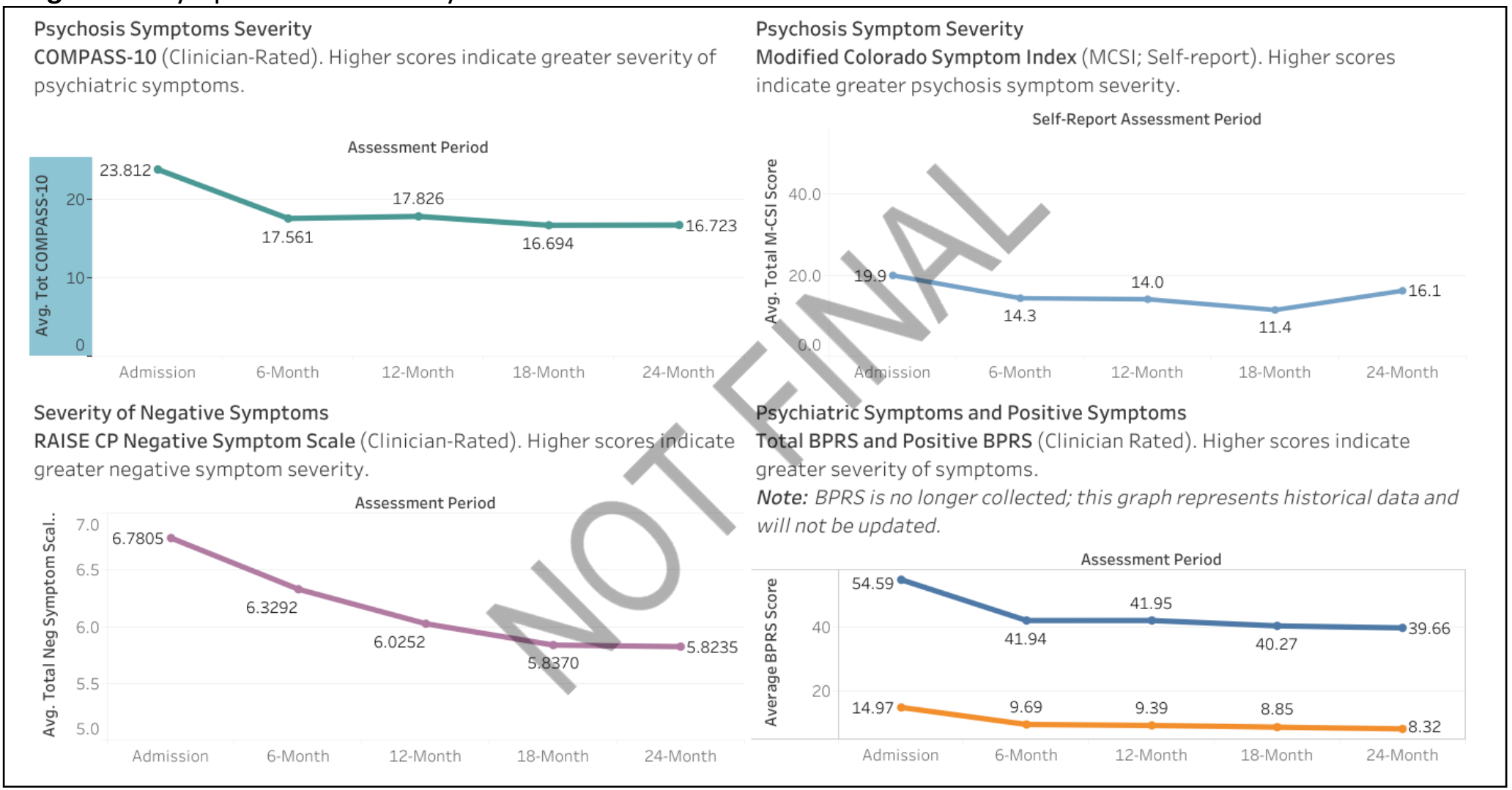
Figure 13. Trauma and related symptoms



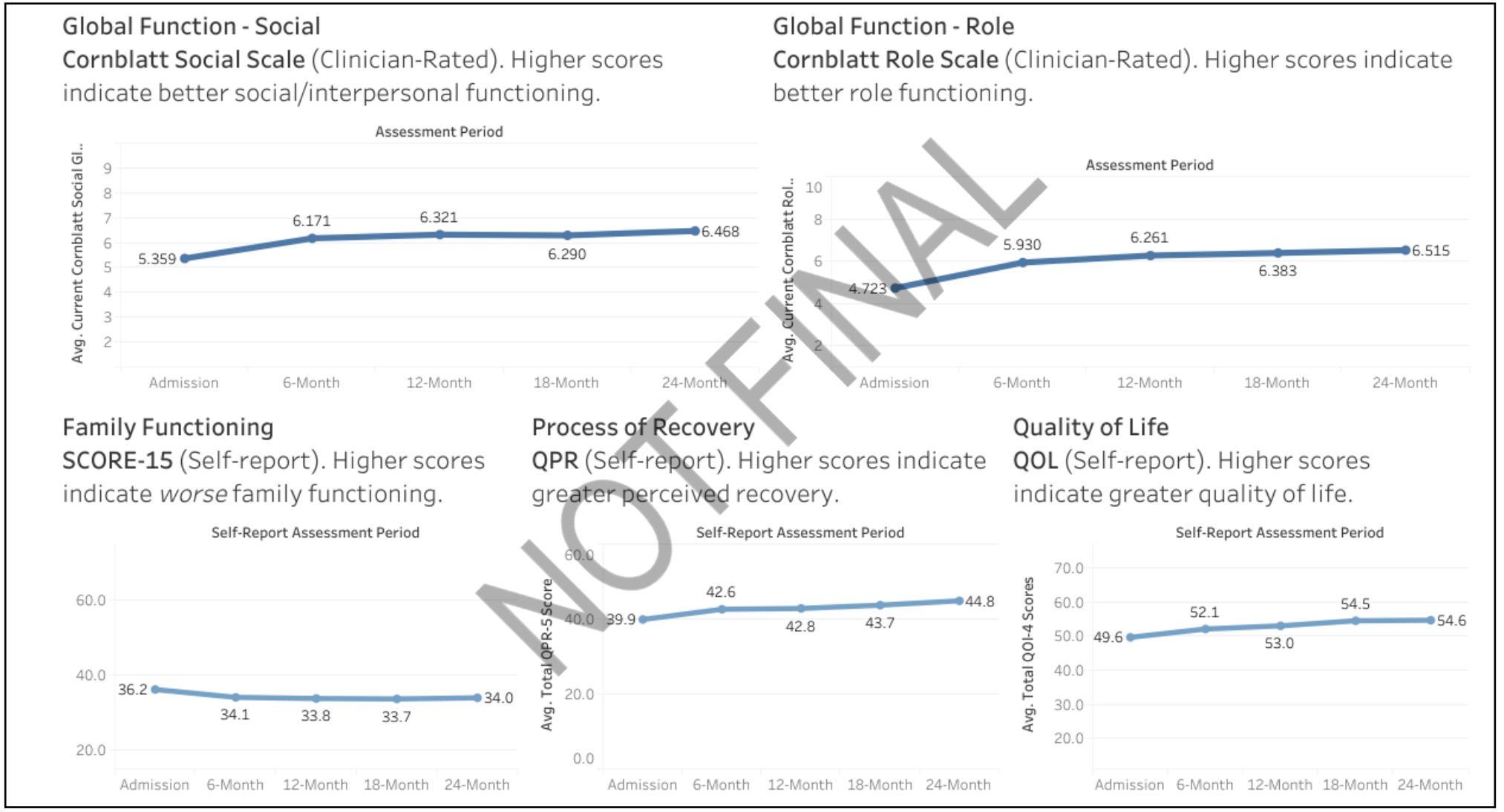
Participant-reported traumatic events prior to admission and related PTSD symptoms over time in PA FEP Programs, collected in the PSS. Note, sample sizes at later assessments periods are small and may skew results until more data are collected.

Figure 14. Symptoms and Severity



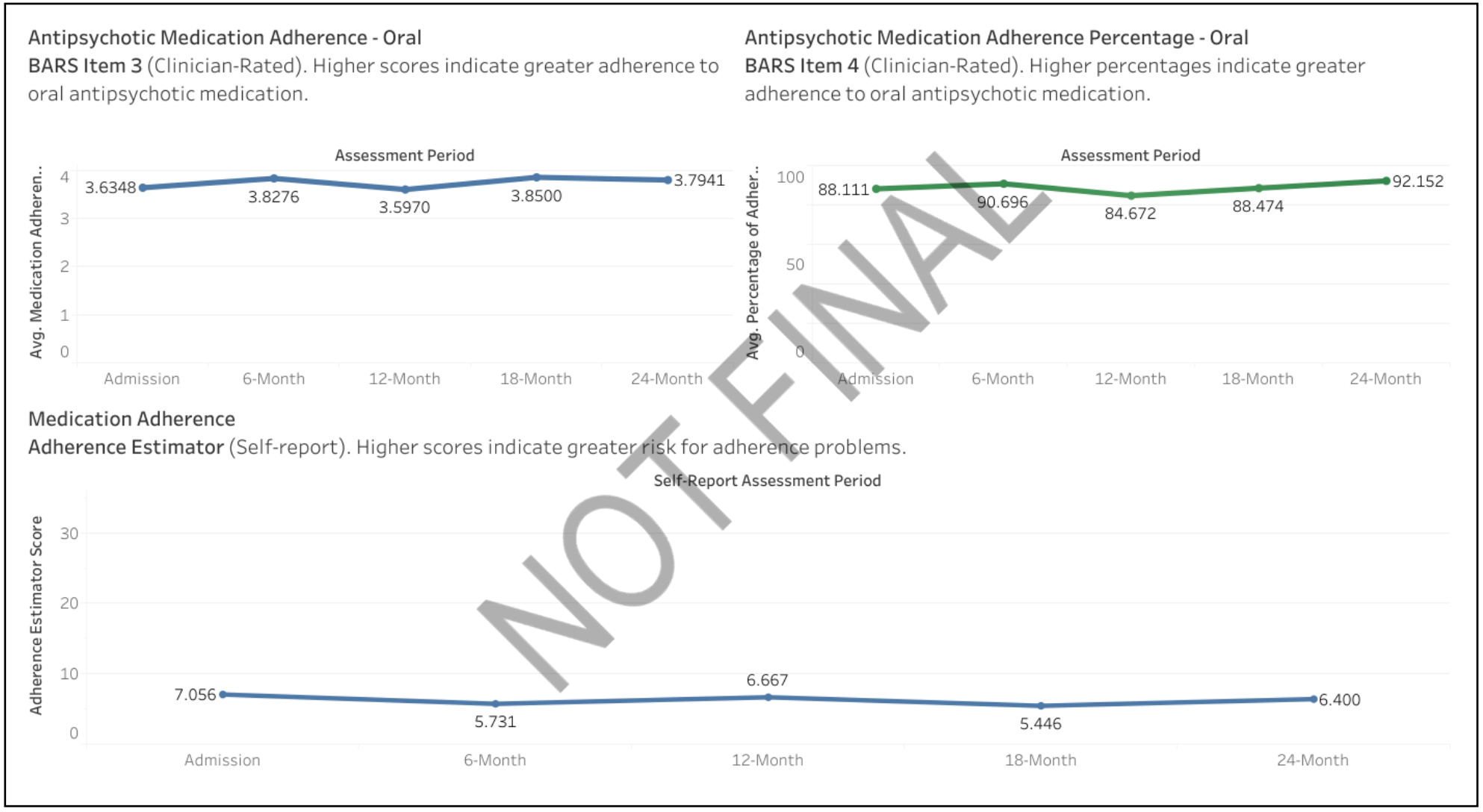
Participant psychiatric and psychosis symptom severity, including negative and positive symptoms, over time in PA FEP Programs. Scales include the Clinical Assessments (COMPASS-10, RAISE CP Negative Symptom Scale, Total BPRS, Positive BPRS) and a self-report measure (Modified Colorado Symptom Index). Note, sample sizes at later assessments periods are small and may skew results until more data are collected.

Figure 15. Psychosocial functioning and recovery



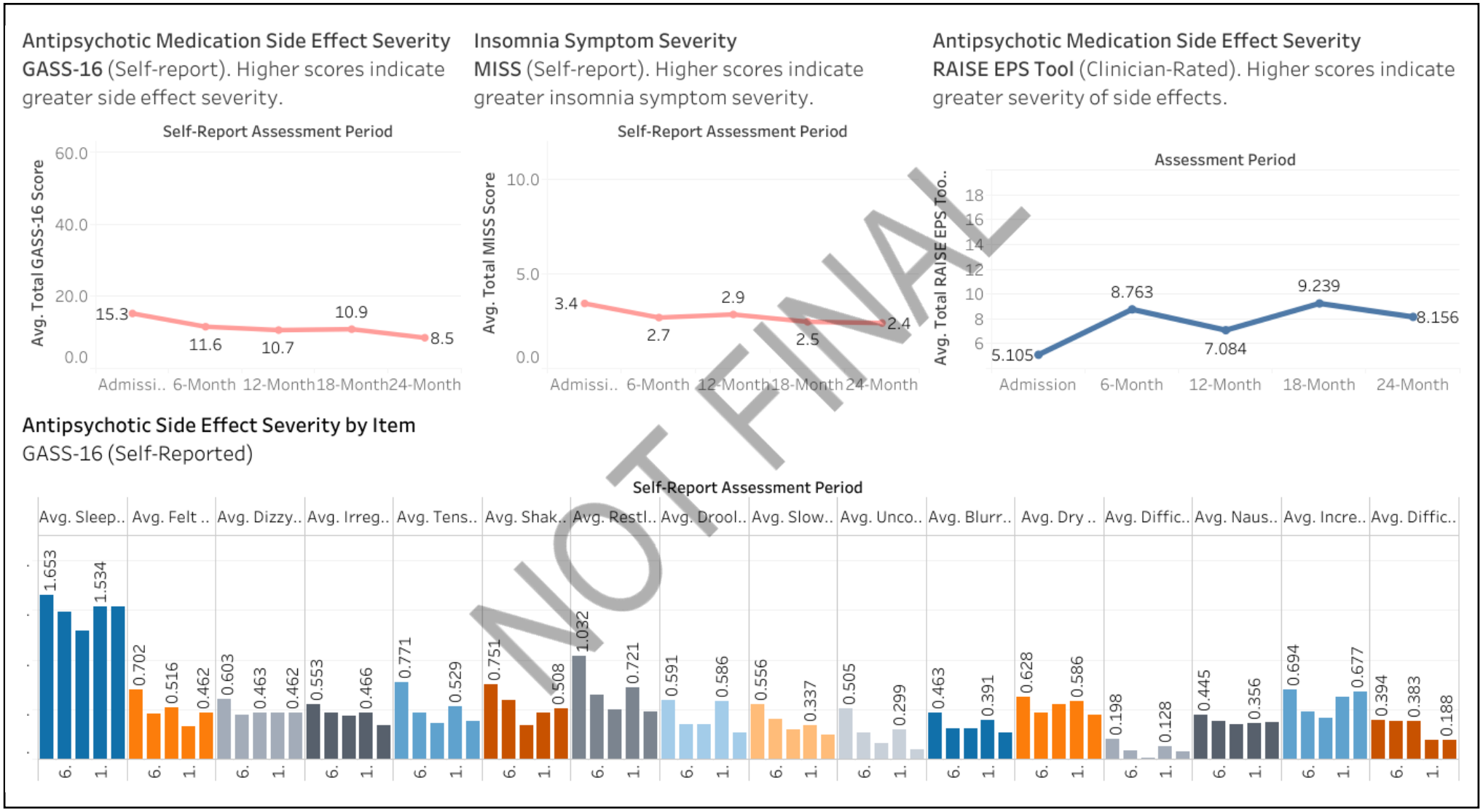
Participant psychosocial functioning and recovery over time in PA FEP Programs. Measures include the Clinical Assessments (Global Function: Role and Social scales) and self-report measures (SCORE-7, QPR-5, QOL-4). Note, sample sizes at later assessments periods are small and may skew results until more data are collected.

Figure 16. Medication adherence



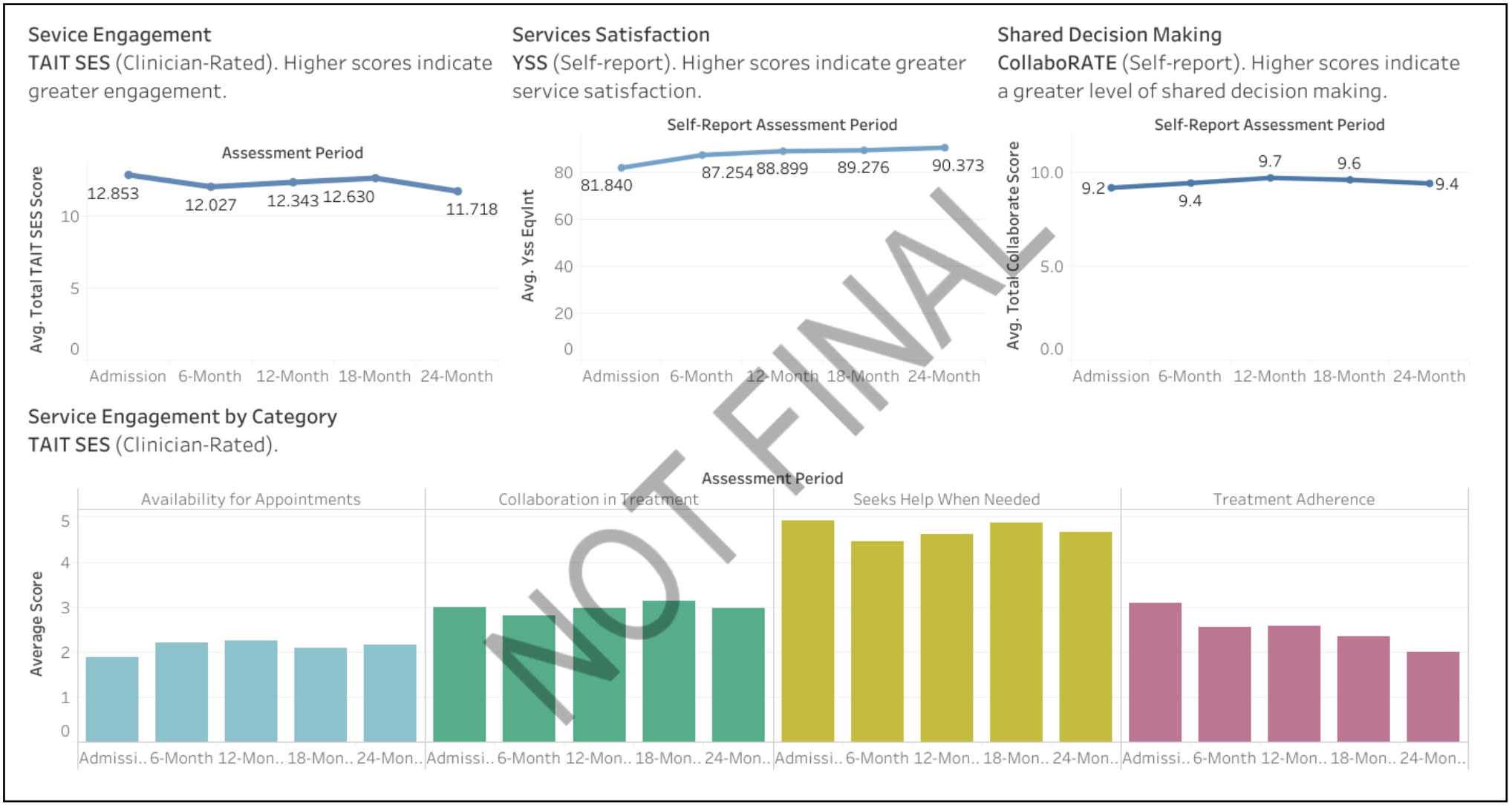
Participant medication adherence, for any medication and for antipsychotics, over time in PA FEP Programs. Measures include the Clinical Assessments (BARS item 3 and 4) and self-report measures (Adherence Estimator). Note, sample sizes at later assessments periods are small and may skew results until more data are collected.

Figure 17. Antipsychotic medication side effects



Antipsychotic medication side effects over time in PA FEP Programs. Measures include self-report measures (GASS-16 and MISS). Note, sample sizes at later assessments periods are small and may skew results until more data are collected.

Figure 18. Service engagement and satisfaction

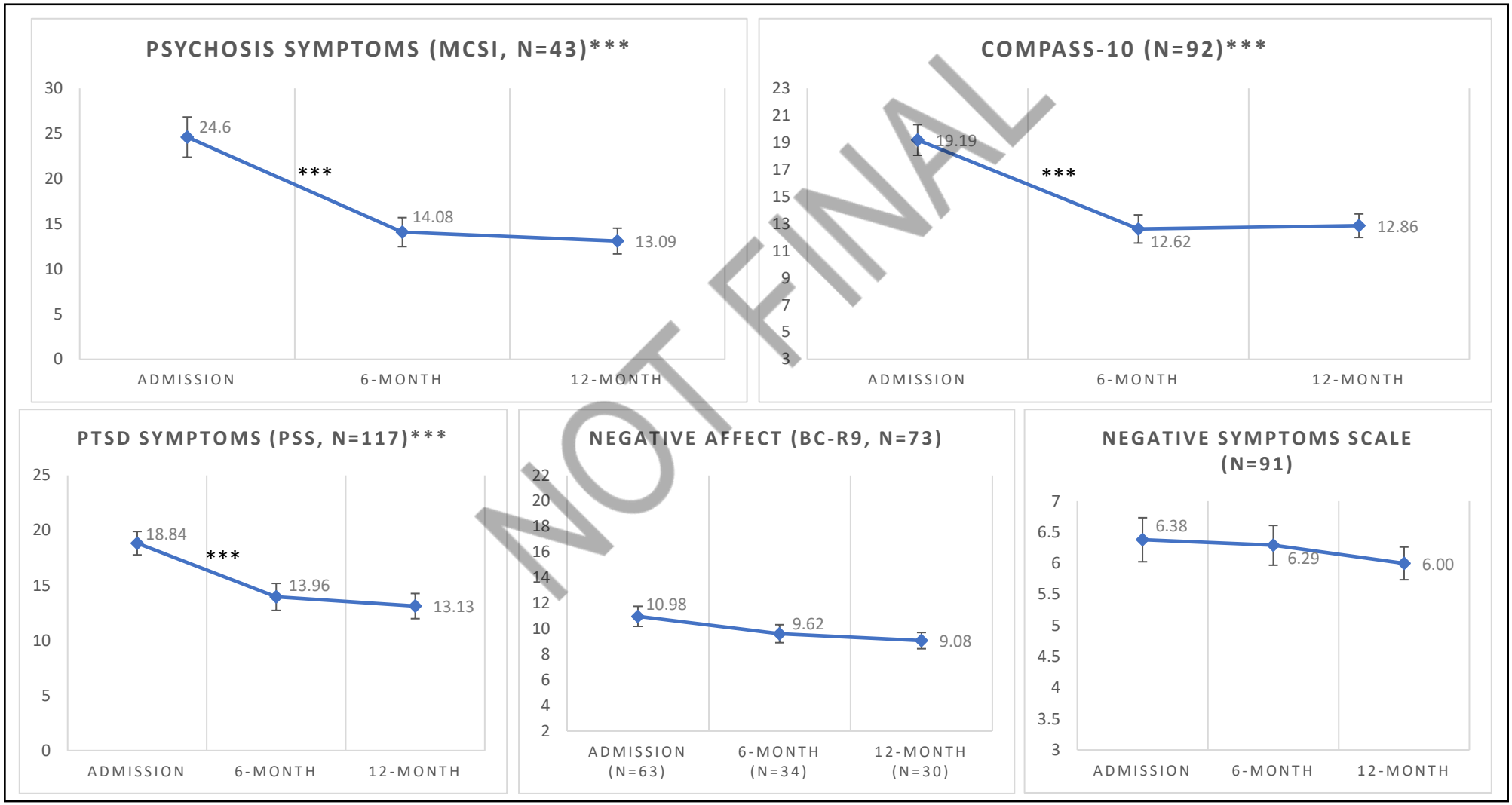


Service engagement and satisfaction over time in PA FEP Programs. Measures include a clinical assessment (TAIT SES) and self-report measures (YSS-6 and CollaboRATE). Note, sample sizes at later assessments periods are small and may skew results until more data are collected.

Longitudinal Outcomes – Participants completing at least 1 year in PA FEP Programs

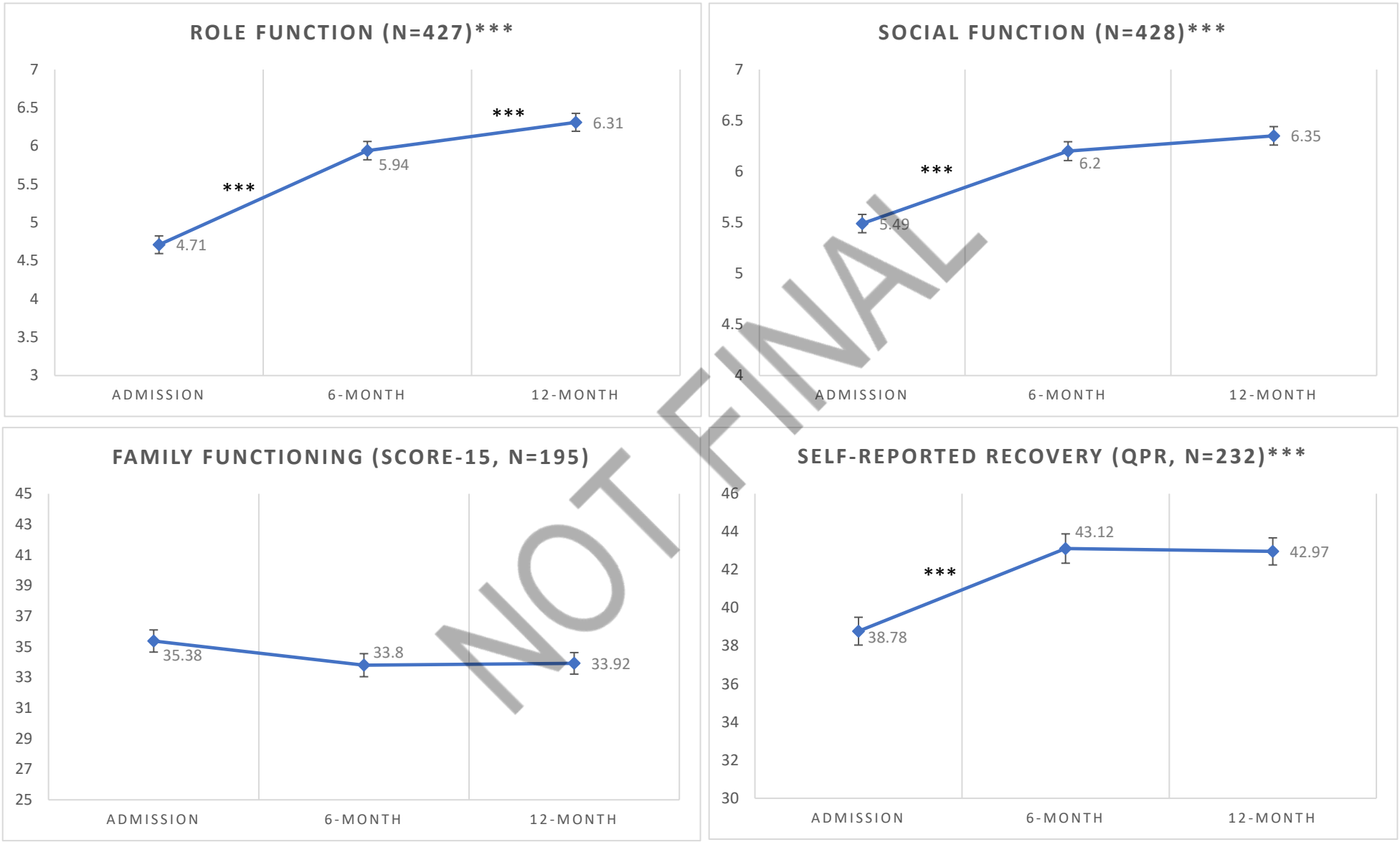
An important part of evaluating PA FEP programs includes examining how participants progress over time in the program across varying measures and outcomes. The following longitudinal graphs in this report display only participant data of individuals who completed at least 12-months in PA-FEP programs.

Figure 19. Symptoms and Severity for 1-year completers



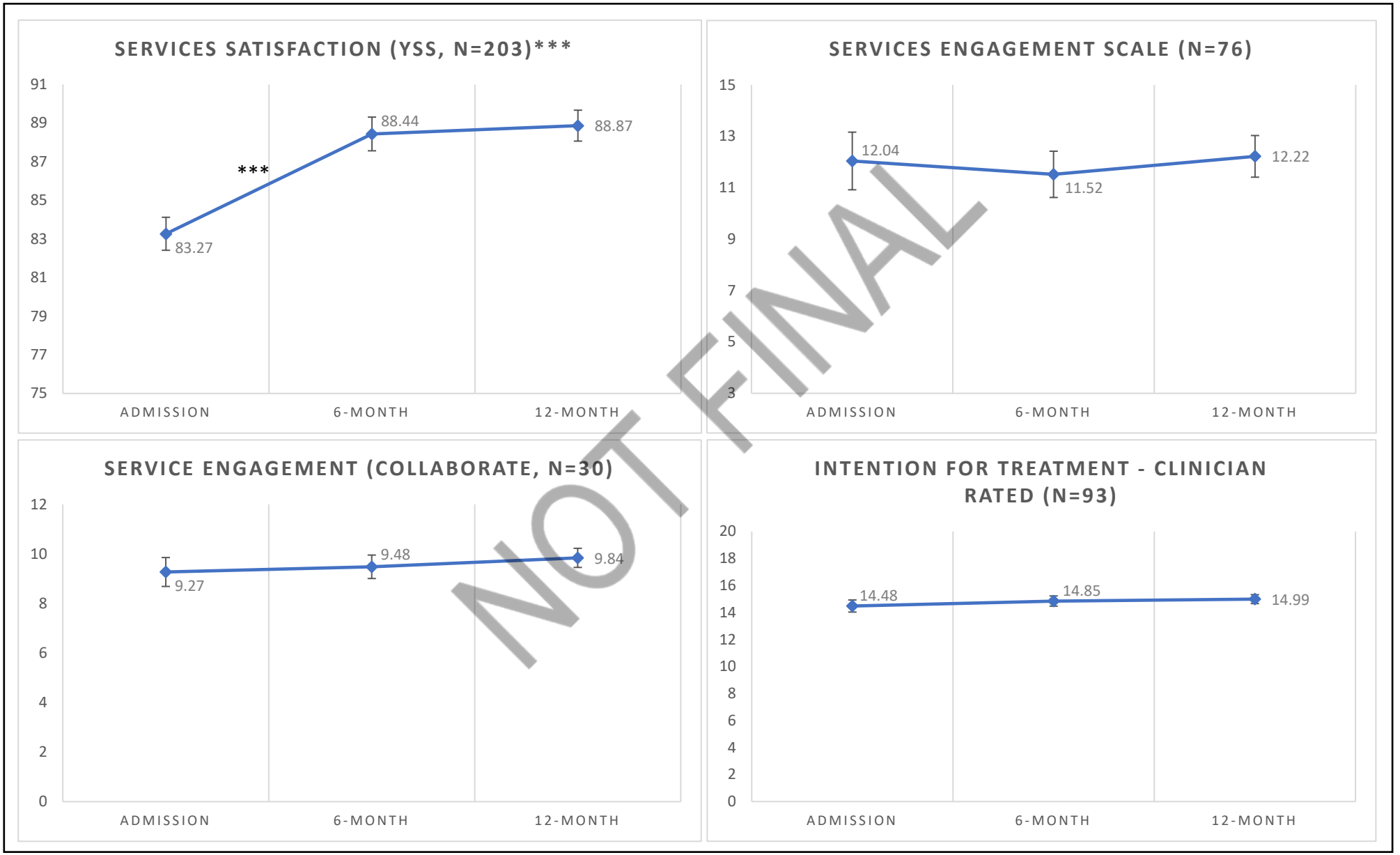
Psychiatric and psychosis symptom severity, including negative and positive symptoms, over time for participants completing at least 1-year in PA FEP Programs. Scales include the Clinical Assessments (COMPASS-10, RAISE CP Negative Symptom Scale) and a self-report measure (Modified Colorado Symptom Index, (MCSI)). Outcomes were modeled in a Repeated Measures ANOVA with an alpha-level of 0.05; *p < 0.05, **p<0.01, ***p<0.0001.

Figure 20. Psychosocial functioning and recovery for 1-year completers



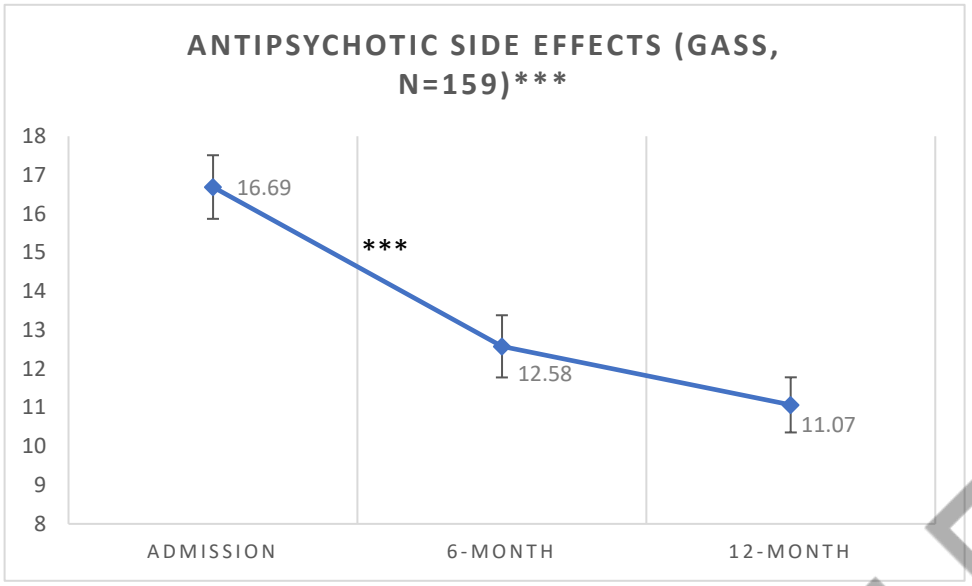
Psychosocial functioning and recovery over time for participants completing at least 1-year in PA FEP Programs. Measures include the Clinical Assessments (Global Function Role and Social scales) and self-report measures (SCORE-15, QPR). Outcomes were modeled in a Repeated Measures ANOVA with an alpha-level of 0.05; *p < 0.05, **p<0.01, ***p<0.0001.

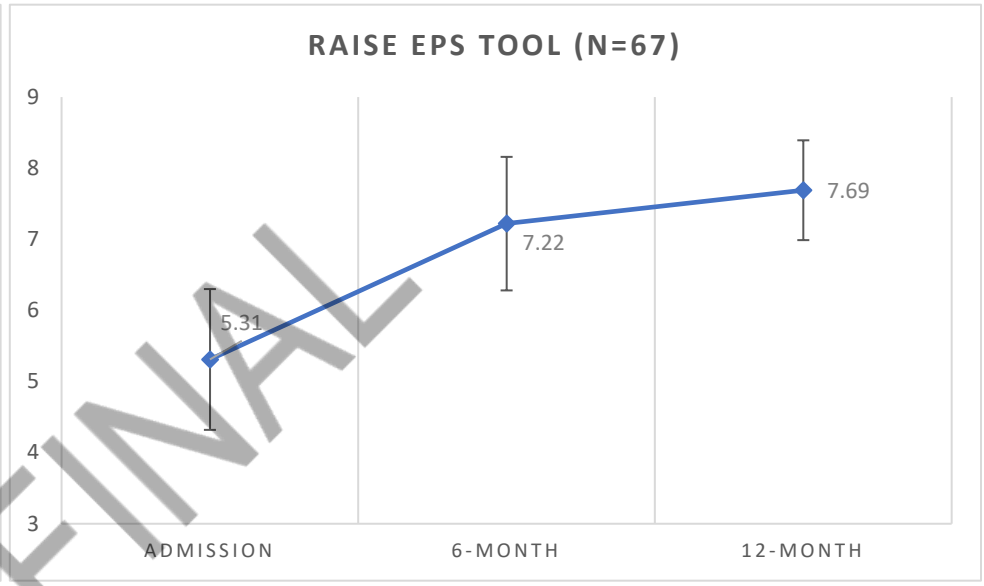
Figure 21. Service engagement and satisfaction

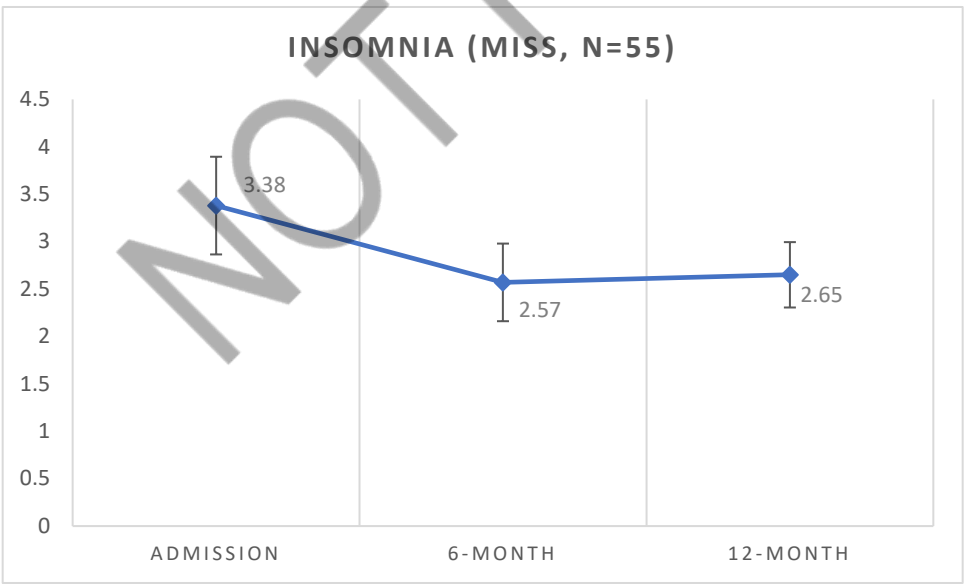


Service engagement and satisfaction over time for participants completing at least 1-year in PA FEP Programs. Measures include a clinical assessment (TAIT SES and Intent to Attend and Complete Treatment Scale) and self-report measures (YSS and CollaboRATE). Outcomes were modeled in a Repeated Measures ANOVA with an alpha-level of 0.05; *p < 0.05, **p<0.01, ***p<0.0001.

Figure 22. Antipsychotic medication side effects for 1-year completers







Antipsychotic medication side effects over time for participants completing at least 1-year in PA FEP Programs. Measures include clinical assessments (RAISE EPSE Tool) and self-report measures (GASS-16 and MISS). Outcomes were modeled in a Repeated Measures ANOVA with an alpha-level of 0.05; *p < 0.05, **p<0.01, ***p<0.0001.

Step Down Programs

8 sites offer Stepped Care or Step-Down programs following completion of the primary FEP program, which allows for continued treatment at a lower intensity of care. Criteria for transitioning into Stepped Care vary by program. Most programs require a specified amount of time in the primary FEP program, but a few programs allow early transition into Stepped Care on a case-by-case basis for participants who improved quickly in the primary program.

Data are currently available on 171 participants who have been reported to transition into stepped care since March 2020. Additionally, data reveals that 16 participants have transitioned into higher intensity care since joining step down and 43 have been discharged after stepping down. As stepped care programs continue to grow and data collection continues, further descriptions of will be made available.

Table 14. Step Down Program Characteristics and Enrollment

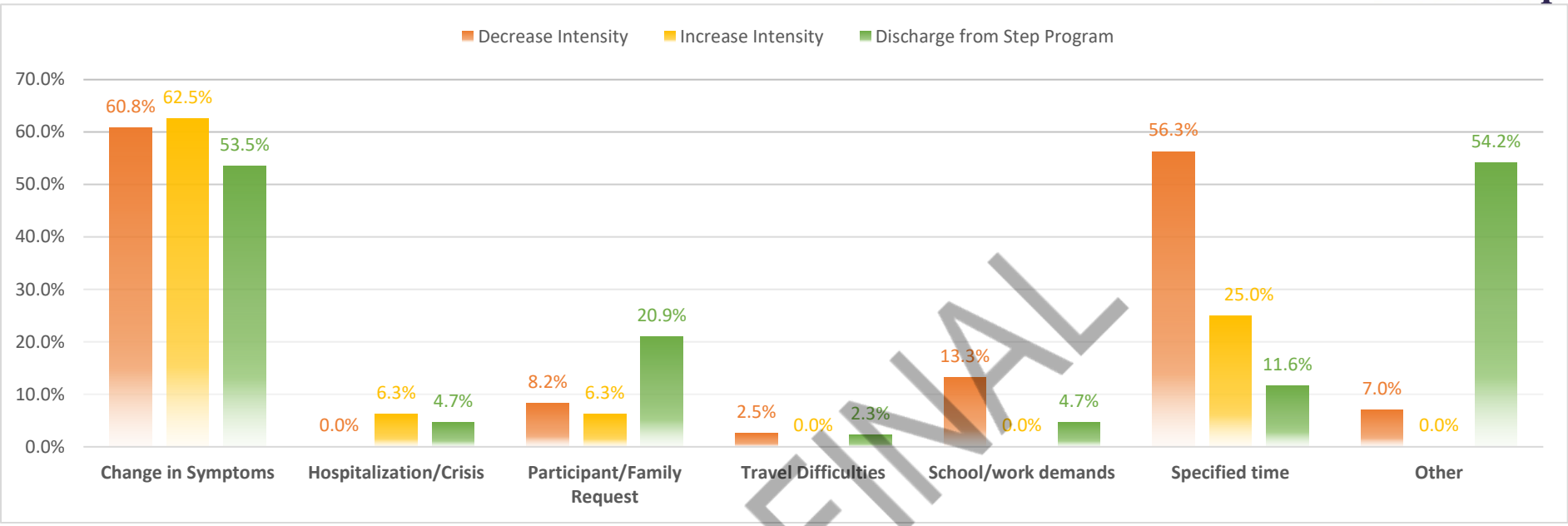
Program	Catchment Area	Age Range	Insurance Accepted	Time required in Primary FEP Program	Defined criteria for steps	Participants transitioned to Stepped Care[a]
PEACE	Philadelphia County	15 - 30	Medicaid	12 months	☐	34
PERC	Pennsylvania	16 - 34	As accepted by UPHS [b]	When clinically ready	☑	12
On My Way - Delaware	Delaware County	15 - 30	Medicaid	24 months	☑	15
On My Way – Chester	Chester County	15 – 30	Medicaid	24 months	☑	0
Safe Harbor	Erie County	15 - 35	All	When clinically ready	☐	18
HOPE	Luzerne/Wyoming County	15 [c] - 25	All	24 months	☑	25
ENGAGE	Allegheny County	15 - 30	Health Choices	When clinically ready	☐	12
STEP	Pennsylvania	14 - 40	All	24 months	☑	51
CMSU - C2E	Columbia/Montour/ Snyder/Union	16 – 30	All	24 months	☐	4

Admission criteria *and characteristics of* FEP programs that offer Step-*Down care* programs following primary *FEP* program. [a] *Based-on available data in REDCap*. [b] UPHS=University of Pennsylvania Health System; insurances accepted are Community Behavioral Health/Medicaid for Philadelphia residents, Medicare Parts A and B, Aetna, Blue Cross/Blue Shield except when Magellan handles claims for the behavioral health plan, Penn Behavioral Health. [c] HOPE has enrolled participants under age 15 on a *case-by-case* basis.

Table 15. Step Down Criteria by program

Program	Stepped Care - Moderate Intensity				Stepped Care - Low Intensity			
	Criteria to Step Down	**Service**	☐	**Frequency**	**Criteria to Step Down**	**Service**	☐	**Frequency**
PEACE	Completed 2 years of CSC program or at least 1 year and clinically ready for reduction in services. Treatment plan to be re-evaluated every 6 months	Individual Therapy	☑	Meet with at least two services Monthly	PEACE does not offer another step down of reduced services			
		Medication Mgmt	☑					
		Case Mgmt	☑					
		SEE Services	☑					
		CPS	☑					
		Family therapy/groups	☑					
PERC	Chronic residual symptoms or remission less than 6 months	Individual Therapy	☑	Bi-weekly, then monthly	In remission greater than 6 months	Individual Therapy	☑	Monthly during first 3 months
		Medication Mgmt	☑	Transferred externally within 3 months		Medication Mgmt	☐	
		Case Mgmt	☑	Bi-weekly, then monthly		Case Mgmt	☑	Monthly during first 3 months
		SEES/ SEE-like Services	☑	First 3 months, then as needed		SEES/ SEE-like Services	☑	As needed
		CPS	☑	First 3 months, then as needed		CPS	☑	As needed
		Family therapy/groups	☑	First 3 months, then as needed		Family therapy/groups	☑	As needed
On My Way Delaware & Chester	Not currently suicidal/homicidal, no inpatient hospitalization within the 2 months prior, secured or are interested in securing employment/ continuing their education, commitment to continuing treatment. Re-evaluated every 90 days	Individual Therapy	☑	Bi-weekly	Not currently suicidal/homicidal, have maintained Moderate Level of care successfully for at least 6 months and have remained stable, requiring no inpatient hospitalization for at least one year. Re-evaluated every 120 days.	Individual Therapy	☑	Bi-weekly
		Medication Mgmt	☑	Monthly		Medication Mgmt	☑	Monthly
		Case Mgmt	☑	Monthly		Case Mgmt	☑	Monthly
		SEE Services	☑	Monthly		SEE Services	☐	
		CPS	☑	Bi-weekly		CPS	☑	Monthly
		Family therapy/groups	☐			Family therapy/groups	☐	
Safe Harbor	Completed 2 years of treatment or deemed ready for step down	Individual Therapy	☑	Bi-weekly	Clinically ready.	Individual Therapy	☑	Bi-weekly to monthly
		Medication Mgmt	☑	Every 6 - 8 weeks		Medication Mgmt	☑	Every 8 - 12 weeks
		Case Mgmt	☑	Bi-weekly		Case Mgmt	☐	
		SEE Services	☑	Weekly		SEE Services	☑	Weekly
		CPS	☑	Bi-weekly		CPS	☑	Bi-weekly
		Family therapy/groups	☑	Weekly		Family therapy/groups	☑	Monthly
HOPE	Improved functioning in daily living, academics/employment. Social engagement. Decrease in frequency of service visits. Independently uses family and community supports.	Individual Therapy	☑	Bi-weekly	Functioning well w/ minimum staff interaction. Employed/Volunteer work. Academically stable. Symptom control. Continuing to use family/ community supports independently.	Individual Therapy	☑	Monthly
		Medication Mgmt	☑	Monthly		Medication Mgmt	☑	Monthly to bi-monthly
		Case Mgmt	☑	Monthly		Case Mgmt	☑	Monthly as needed
		SEE Services	☑	Monthly		SEE Services	☑	Monthly as needed
		CPS	☑	Monthly		CPS	☑	Monthly as needed
		Family therapy/groups	☑	Bi-weekly		Family therapy/groups	☑	Monthly as needed
ENGAGE	Clinical indication; sustaining life goals in terms of education, work and relationships.	Individual Therapy	☑	Weekly	Clinically ready.	Individual Therapy	☑	Weekly to bi-weekly
		Medication Mgmt	☑	Monthly		Medication Mgmt	☑	Monthly
		Case Mgmt	☑	Weekly		Case Mgmt	☑	Weekly to bi-weekly
		SEE Services	☑	Weekly		SEE Services	☑	Weekly to bi-weekly
		CPS	☑	Weekly		CPS	☑	Weekly to bi-weekly
		Family therapy/groups	☐			Family therapy/groups	☐	
STEP	Reductions in symptoms, developed a safety plan and practice coping skills, they have identified recovery goals with continued progress and active participation in treatment.	Individual Therapy	☑	Monthly	Goals related to functioning, have stable relationships and housing, and are focused on continued maintenance of wellness	Individual Therapy	☑	Every 2 months
		Medication Mgmt	☑	Monthly		Medication Mgmt	☑	Every 2 months
		Case Mgmt	☑	Monthly		Case Mgmt	☑	Every 2 months
		SEE Services	☑	Monthly		SEE Services	☑	Every 2 months
		CPS	☑	Monthly		CPS	☑	Every 2 months
		Family therapy/groups	☐			Family therapy/groups	☐	

Figure 23. Reasons for step transitions by step direction



Reasons for participant to enter reduced intensity stepped care as reported at the time of the step transition. Step transitions occur at various times depending on individual program structure and individual participant progress. *Specified time* indicates that the participant was mandated to enter stepped care based on program criteria for length of time in the program. Percentages may exceed 100% as more than one reason could be selected. Decrease intensity N=158, increase intensity N=16, discharge N=43.

Table 16. Months in program at step transition

Step	N	Mean	SD	Min	Max
Initial Transition	162	25.90	8.10	4	51
Second Transition	15	35.47	14.16	7	60
Discharge from step	41	38.63	12.17	11	63

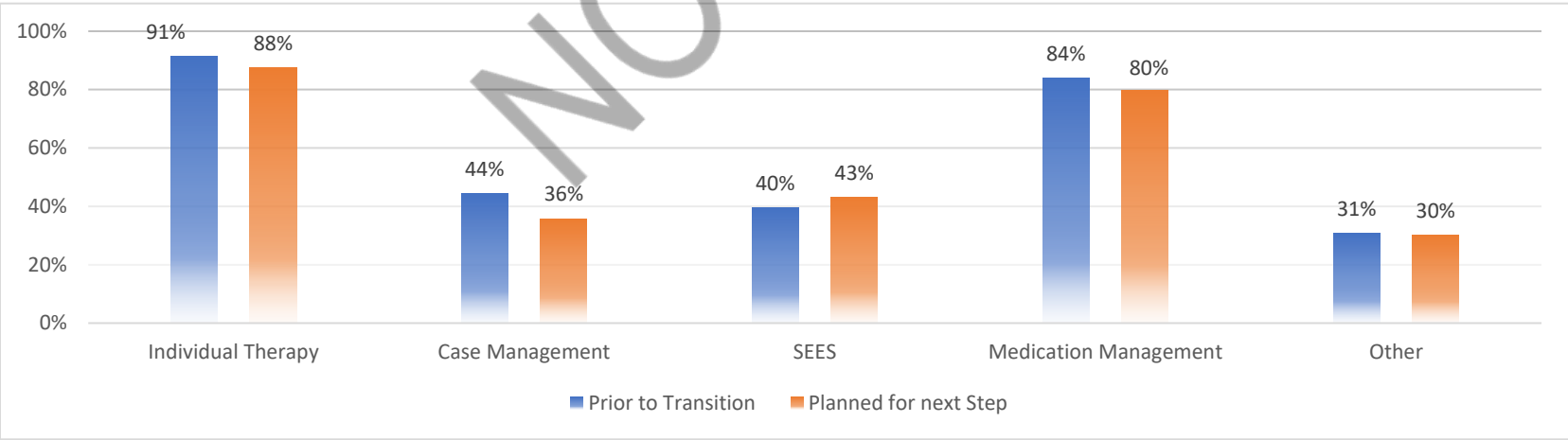
Number of months participants were in an FEP programs, as reported at the time of a step transition. Step transitions occur at various times depending on individual program structure and individual participant progress. Some sites have been conducting stepped care before data collection began. SD = Standard Deviation, Min = Minimum, Max = Maximum.

Table 17. Clinical features at step transitions

Measure	Scale Description			PA FEP Stepped Care Programs						
	Min	Max	Higher scores reflect greater…	Step Transition	N	Mean	Median	SD	Min	Max
Global Function: Role - Current	1	10	…role function. 10= Superior; 5=Serious impairment; 1=Extreme impairment	Initial	149	7.11	8	1.85	1	10
				Second	15	5.87	6	2.35	1	9
				Discharge	25	7.76	9	1.98	2	10
Global Function: Social - Current	1	10	…social/interpersonal function. 10= Superior; 5=Serious impairment; 1=Extreme social isolation	Initial	150	6.94	7	1.8	1	10
				Second	15	5.53	6	2.07	2	9
				Discharge	25	7.68	9	2.09	2	10
Clinical Global Impression - Global Improvement (CGI -I) Scale:	1	7	…increased symptoms and worsening functioning compared to baseline. 7 = Very much worse; 4 = No change; 1 = Very much improved	Initial	150	2.43	2	0.94	1	6
				Second	15	3.87	4	1.51	1	6
				Discharge	27	2.33	2	1.39	1	6

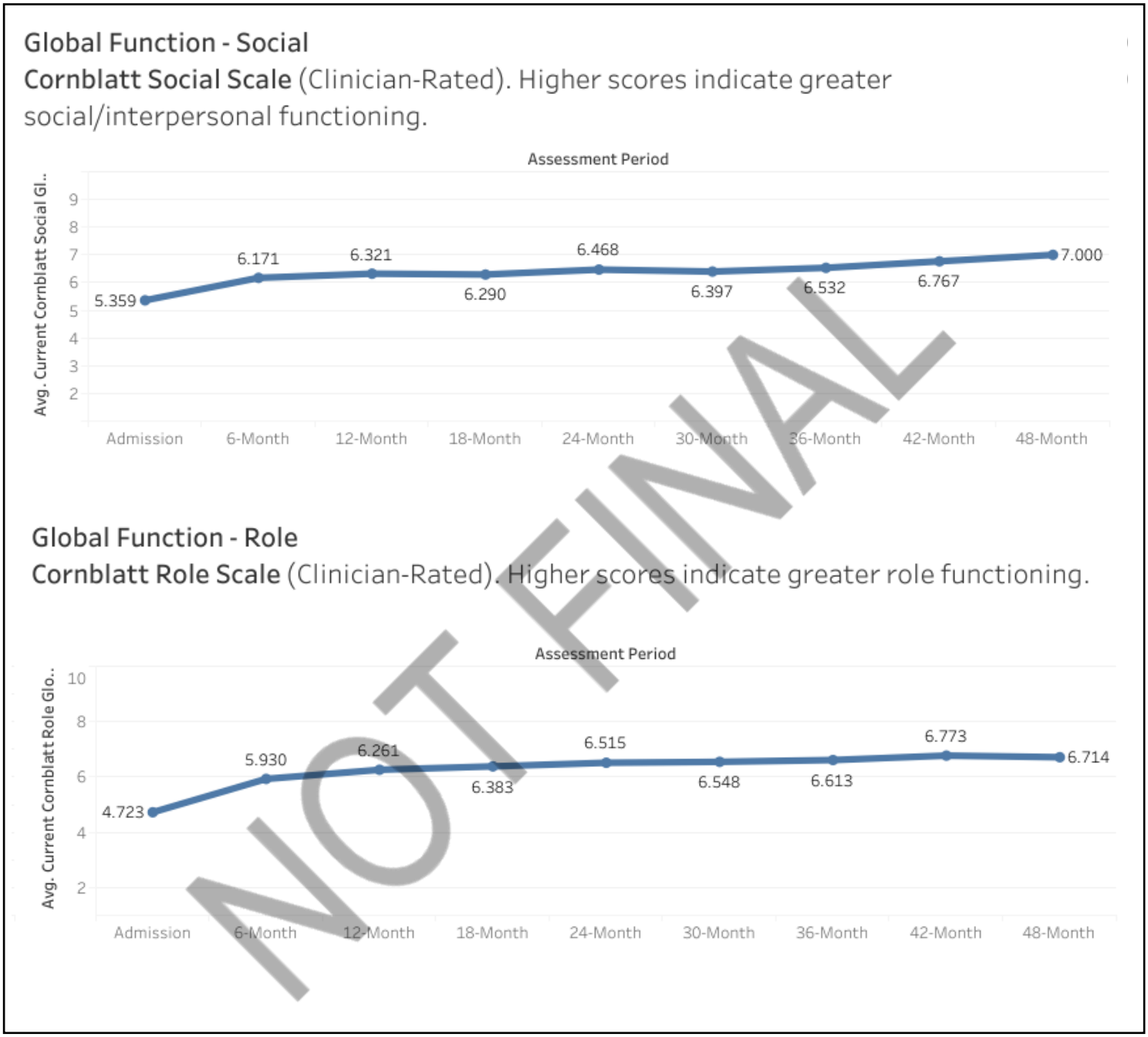
Participant clinical features at step down as assessed by selected measures. Data are scaled as indicated. Scales are clinician rated. N=number; Min= minimum score; Max=maximum score; SD=standard deviation.

Figure 24. Previous and planned service use at transition into Stepped Care



Percent of stepped care participants using FEP Services prior to step down and as planned for during the next step of care, as reported by treatment team. SEES = Supported Employment and Education Services. N=130. Other includes Case Management as time of report.

Figure 25. Psychosocial functioning continued through stepped care

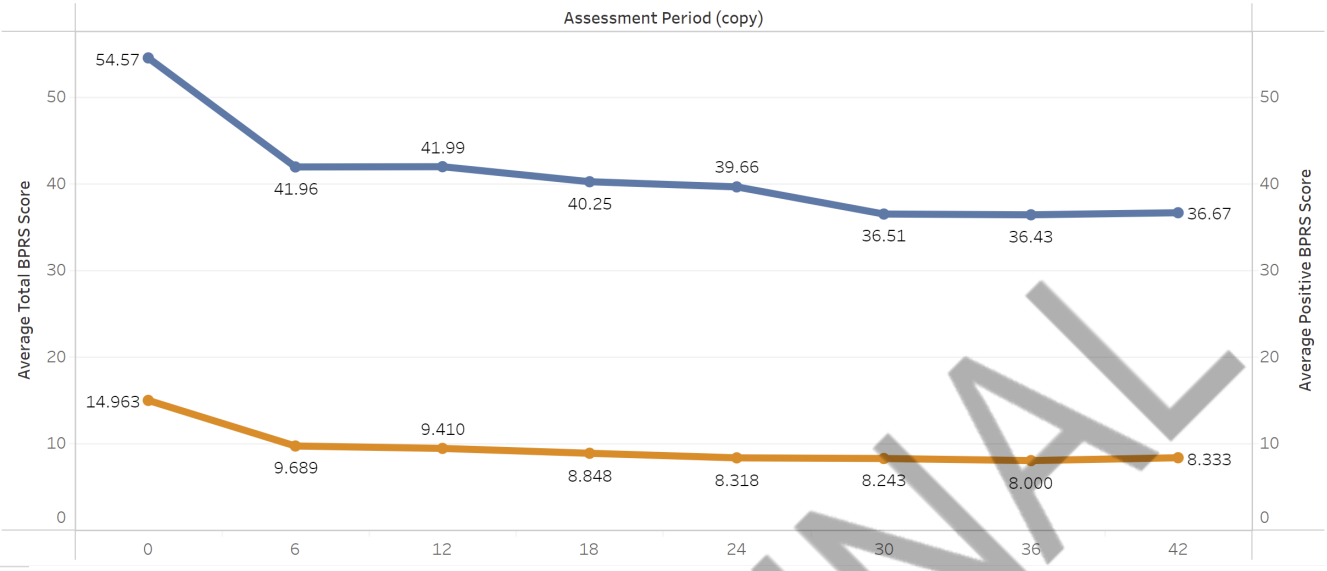


Psychosocial functioning, as measured in the Global Function Role and Social scales, over time in PA FEP Programs including 24 months of stepped care. Note, sample sizes at later assessments periods are small and may skew results until more data are collected.

Figure 26. Psychiatric symptom severity continued through stepped care

Total BPRS and Positive BPRS (Clinician Rated). Higher scores indicate greater severity of symptoms.

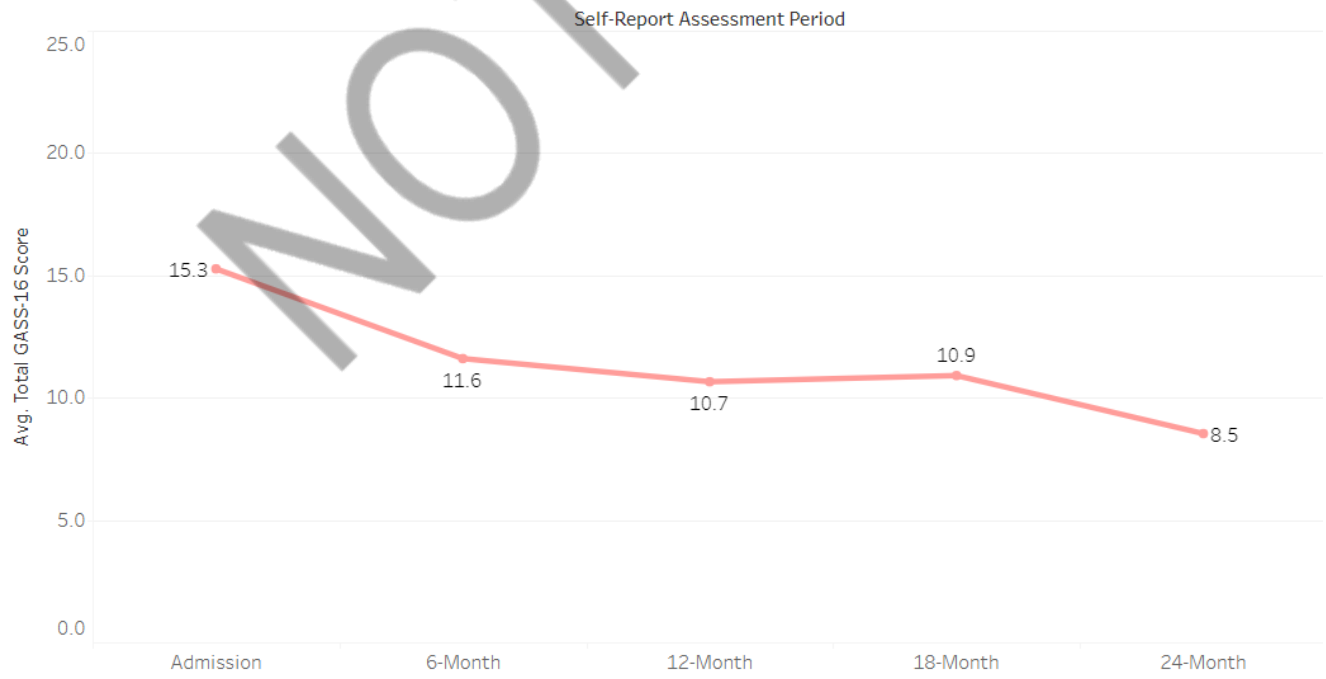
Note: *BPRS is no longer collected; this graph represents historical data and will not be updated.*



Psychiatric symptoms, as measured in the BPRS and Positive BPRS, over time in PA FEP Programs including 18 months of stepped care. Note, sample sizes at later assessments periods are small and may skew results.

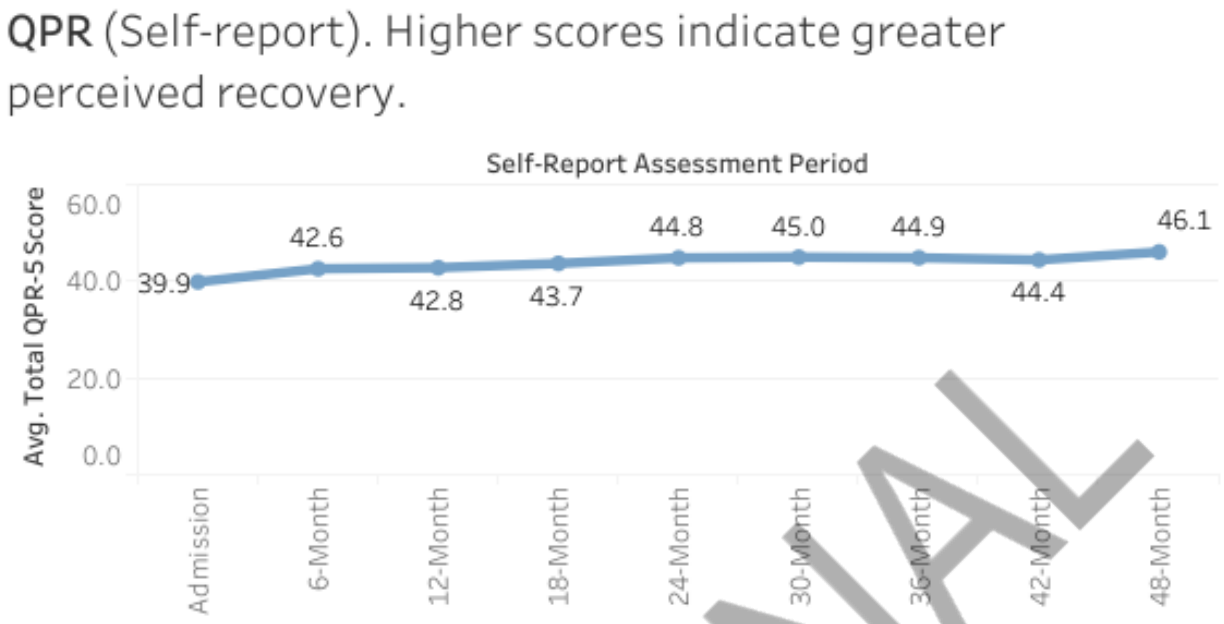
Figure 27. Antipsychotic medication side-effect severity continued through stepped care

GASS-16 (Self-report). Higher scores indicate greater side effect severity.



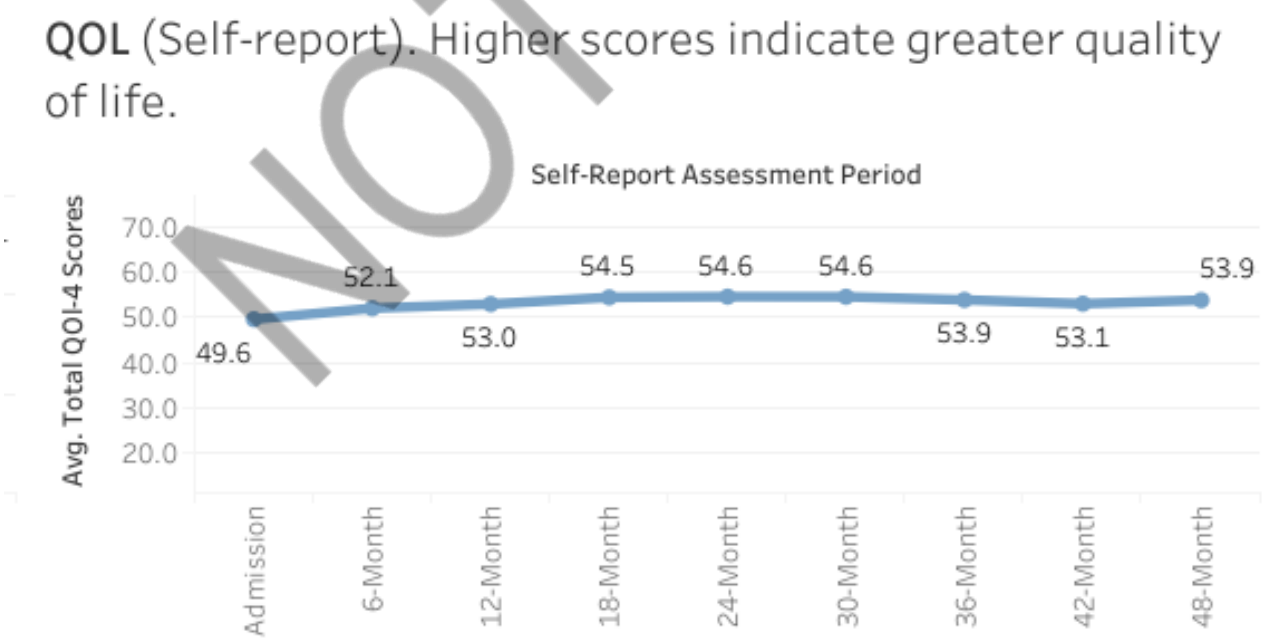
Antipsychotic medication side effects, as measured in the GASS-16, over time in PA FEP Programs including 24 months of stepped care. Note, sample sizes at later assessments periods are small and may skew results until more data are collected.

Figure 28. Process of recovery continued through stepped care



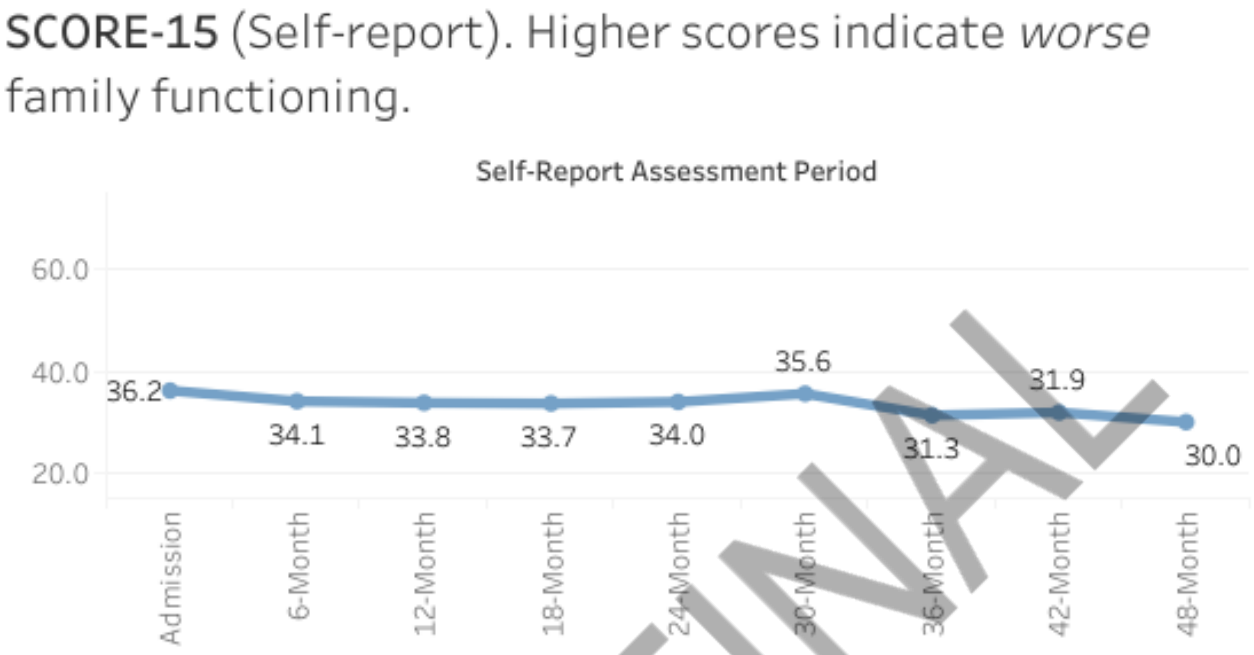
Participant-perceived recovery, as measured in the QPR-5, over time in PA FEP Programs including 12 months of stepped care. Note, sample sizes at later assessments periods are small and may skew results until more data are collected.

Figure 29. Quality of Life continued through stepped care



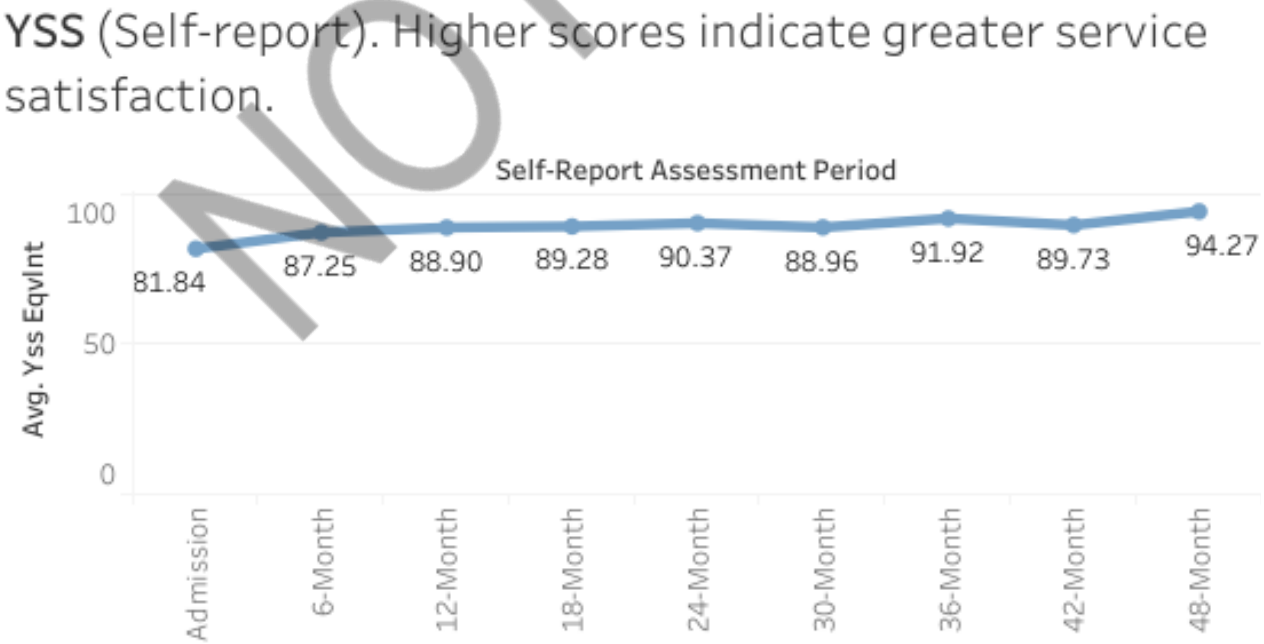
Participant-perceived quality of life, as measured in the QOL-4, over time in PA FEP Programs including 12 months of stepped care. Note, sample sizes at later assessments periods are small and may skew results until more data are collected.

Figure 30. Family functioning continued through stepped care



Participant-perceived family functioning, as measured in the SCORE-7, over time in PA FEP Programs including 12 months of stepped care. Note, sample sizes at later assessments periods are small and may skew results until more data are collected.

Figure 31. Services satisfaction continued through stepped care



Participant-reported services satisfaction, as measured in the YSS-6, over time in PA FEP Programs including 12 months of stepped care. Note, sample sizes at later assessments periods are small and may skew results until more data are collected.

Concluding Summary

When comparing group means at each time point, Pennsylvania FEP program data are encouraging in demonstrating reduced number of hospitalizations, increased employment, and occupational and social functioning, improved clinical symptoms and medication adherence over time. Data supports improvements in suicidal ideation and attempts, and other adverse behaviors including substance use, and increased quality of life, recovery, and satisfaction with mental health services.

Following individual participants' trajectories, participants who completed 1 year in the PA FEP programs showed significant improvements by 12-month follow-up in role and social functioning, PTSD symptoms, self-reported psychosis symptoms, self-reported recovery, service satisfaction, and self-reported antipsychotic medication side effects.

Data on stepped care participants in PA FEP programs indicate the potential for continued positive outcomes with reduced intensity services following the completion of the primary FEP program. Participants exhibit continued use of FEP services despite reduced frequency and/or intensity of treatment. Participants are engaging in stepped care programs on average 12.7 months at the time of discharge from the step program. Step transitions during the program occur at various times depending on individual program structure and individual participant progress.

PA FEP reporting has been updated with new measures since joining EPINET in January 2021, as well as updated graphics and visual displays with the integration of Tableau. We look forward to expanding sample sizes at later time points on new measures to allow for modeling and expanded analyses, in addition to exploring more ways to visualize PA FEP data through Tableau. Tableau allows almost real-time updates of these measures, and we encourage PA-FEP staff, as well as FEP-dedicated OMHSAS personnel, to visit Tableau for more interactive views of the data.

As FEP program efforts continue to expand in newly established programs, we expect that the summary data will become more representative of constituents in each program's region, which may explain observed site differences. In 2021, five new programs began collecting PE data, three more programs began data collection January 2022, and an additional 2 programs were newly funded in summer 2022 to begin data collection in the coming months. These programs are still developing and increasing recruitment of participants; therefore, data are limited at this time from our newest programs. As data collection continues and expands, we will be interested in seeing if results are maintained or improved further with the addition of new programs.

As outreach efforts and catchment areas expand in existing programs and with new programs, the continued longitudinal collection of referral and admission data of all programs is expected to continue to reflect changes in pathways to care and duration of untreated psychosis. Longitudinal data analyses will continue to provide more detail on the progress of individual participants and the effect of programs individually and in aggregate. This information will be useful in providing feedback to stakeholders at all levels including participants, their families, clinicians, community behavioral health organizations and state level policy and funding bodies.

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Pennsylvania has implemented the Community Support Program (CSP), a coalition of mental health consumers, family members, and professionals working to help adults with serious mental illnesses and co-occurring disorders live successfully in the community. The CSP Plan facilitates open communication between consumers, providers, families, and advocates regarding treatment services and supports offered to consumers to allow them to live successfully in the community. Treatment services and supports are coordinated on both the local system level as well as the individual consumer basis to reduce fragmentation and improve the efficiency and effectiveness of service delivery. Coordination includes linkages with consumers, families, advocates, and professionals at every level of the system of care.

The CSP Wheel

For over 20 years, the national CSP Principles have had a dramatic impact on the way systems planners conceptualize organizing services, supports, and opportunities to help mental health consumers reach their full potential in our society.

The Wheel is designed to meet the needs of people with mental illness as well as those who suffer from co-occurring disorders (e.g., mental illness and substance use disorders). The central focus of community support programs is to facilitate the recovery process and personal growth of each mental health consumer.

Please see the Attachments section of the application for a graphic depiction of the CSP Wheel.

4. Describe the person-centered planning process in your state.

In Pennsylvania, this process is known as Community Support Program (CSP) planning.

The CSP planning process includes individuals who are served in the Mental Health system and who are able and willing to participate in the process. A general principle guiding CSP planning is “Nothing about me without me!” The CSP planning process in Pennsylvania is consumer-centered and consumer-empowered. CSP planning also entails flexibility and coordination of treatment services and supports. Service providers are also accountable to the users of services and include consumers and families in the planning, development, implementation, monitoring, and evaluation of services.

The Community Support System (CSS) which is integral to CSP planning, includes the following components which are essential resources to recovery:

• Treatment and Support

• Family and friends

• Peer support

• Meaningful work

• Income support

• Community mobility• Community groups and organizations

• Protection and advocacy

• Psychiatric rehabilitation

• Leisure and recreation

• Education

• Housing

• Healthcare

Individuals who participate in the CSP planning process undergo a Family Assessment completed by a family member or significant other of his or her choice. This assessment, in conjunction with other assessments conducted, is analyzed in preparation for the planning process. An opportunity is provided to the person to express his/her needs and wants for life in the community as well as participate fully in the development of the CSP. All CSP team members are allowed the opportunity to understand the person's unique strengths and challenges before developing preliminary strategies for assisting the person to move to the community. The CSP is developed with the intention of being congruent with the person's opinions and goals and is constructed in such a way as to encourage success.

Meetings are conducted as part of the CSP planning process. Assessments are completed and/or updated prior to each CSP meeting. Participants are expected to be present in person at the meeting. Exceptions may be made for family or significant others to participate via phone or Skype. Each meeting embraces a Positive Practice approach that supports the individual's strength and focuses on the services needed to safely support the individual's wishes and desires. CSP meeting participants include the person and anyone she/he wishes to invite, including, but not limited to, family members and/or family representatives, members of the hospital treatment team, Peer Mentor/Specialist, advocates from the community, county representatives including case managers, potential providers, and administrators, the Facilitator and the Record, and others identified by the assessment summary and/or who were present in previous meetings. Community providers and case managers are required to attend the discharge CSP meeting.

There are role expectations placed on participants in the CSP planning meetings. The individual needs to offer as much information about her/himself as possible. They also validate the summary of information from the assessments, assist in the development of a strengths list, share information for each domain of the CSP, ask questions about what has been done and what services are available, and provide information about any place she/he has visited or would like to visit. Family members and significant others assist in the presentation of additional and pertinent information about the person, assist in the development of the strengths list, and offer ideas about supports they believe are necessary. The Facilitator and Recorder are present to support the CSP Team members in order to focus on the tasks associated with the development of the CSP.

During the CSP meeting, participants discuss and share information and ideas relevant to each life domain and the services and supports needed for the individual to move to a community setting. The meeting concludes with the development of a specific plan and a list of tasks and assignments toward accomplishing the plan. A tentative date is then scheduled for a follow-up CSP meeting. During the follow-up CSP meeting, assigned tasks are reviewed with updates on any changes or pertinent information since the last meeting. Information is shared by the CSP Team members who may have already had discussions with the person. The goal is to locate or create service options that are congruent with the person's stated needs and wishes. A list of strengths is developed, and risk factors are identified.

The final CSP meeting conducted is the discharge CSP meeting. The plan created during this meeting identifies the discharge activities of both the person who will be discharged and the staff. The person may have visited and used services in the community and will be asked to share her/his opinions of those services. The person may be encouraged to share the content of her/his Wellness Recovery Action Plan (WRAP) and/or Crisis/Safety Plan but should not be pushed to do so. A checklist of tasks for the person to complete prior to discharge will be created and finalized. All Community Support plans are reviewed and approved by State Hospital CEOs.

At all times during the CSP planning process, the individual for whom the planning is being conducted is in charge.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

A guide was created by Pennsylvania Mental Health Consumers' Association, Pennsylvania Protection & Advocacy / Disabilities Law Project, and Mental Health Association in Pennsylvania that provides information about the forms and how to complete them. It includes the forms?and?instructions, answers frequently asked questions and is?available in?English?or?Spanish.

Instructions Forms - English.pdf (pa.gov)

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Community Support Program Wheel

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

CMHSG Planner and the CMHSBG Engagement and Monitoring Lead Staff are responsible for program integrity activities related to MHBG. They also collaborate with the Department's Bureau of Financial Operations to ensure the integrity of the programs supported with MHBG funds. The position of CMHSBG Engagement and Monitoring Lead Staff is a new position created in 2020. The individual hired to fill the position assumed duties in March 2021. This position focuses on engaging and monitoring CMHSBG sub-recipients, including County Mental Health Authorities and behavioral health providers, to increase the availability of evidence-best services, evaluate the appropriateness of services provided through grant funds, and ensure compliance with state and federal requirements. Initial on-site CMHSBG monitoring began in February 2022, and as of May 2023, OMHSAS has completed on-site monitoring of 60 among 67 total counties.? The results of monitoring thus far indicate counties/joinders are leveraging CMHSBG appropriately to target SMI/SED populations within the CMHSBG limitations and restrictions and in support of statewide CMHSBG priorities.? The remaining seven counties will be monitored in the coming months, at which point OMHSAS will review and assess the cumulative statewide results.?

Additionally, the state clearly conveys the federal and state requirements and expectations regarding MHBG to counties when the funds are allocated. OMHSAS utilizes a reporting form completed by each county annually that identifies how the MHBG dollars are expended and for what purposes. For each service, the following data are collected:

a. Name of Service (cost center)

b. Category of Service

c. Number of Persons Served

d. Number of Service Hours

e. Amount Spent

f. MHBG Priority (as identified in the State MHBG Plan)

g. Relevant Purpose (from the "SAMHSA MHBG purposes")

h. Target Population

The information reported on this form helps the state to ensure that the MHBG expenditures are consistent with the requirements and guidance that SAMHSA and the state have provided.

Please indicate areas of technical assistance needed related to this section

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Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   Pennsylvania does not have any Federally recognized Tribal Governments or Tribal lands within its borders. No consultation sessions were conducted by the state with federally recognized tribes.

2. What specific concerns were raised during the consultation session(s) noted above?

   Not applicable, as no consultation sessions with tribes were held.

3. Does the state have any activities related to this section that you would like to highlight?

   The state does not have any activities related to this section.

   Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Commonwealth of Pennsylvania strives to provide residents with a full spectrum of community-based services, with emphasis given to Evidence-Based, Recovery Oriented, and Promising Practices. The strengths and needs section of this application includes an in-depth overview of the community services available, including outpatient, employment services, housing, crisis intervention, CPS, and case management, as well as many specialty services such as ACT and FEP. Services are made available to individuals with co-occurring disorders by mental health providers, including by providers who are dually licensed for substance abuse services. Mental Health Providers without proper substance abuse licensure will make referrals to appropriate substance abuse providers as needed.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Availability of services varies by County.

3. Describe your state's case management services

In Pennsylvania, mental health case management services are categorized as Administrative Case Management (ACM) and Targeted Case Management (TCM). TCM includes Intensive Case Management (ICM), Resource Coordination (RC), and Blended Case Management (BCM). Each of these services is fully described in the strengths and needs section of this application.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Please indicate areas of technical assistance needed related to this section.

As required by the Community Mental Health Block Grant, OMHSAS prioritizes CMHSBG funding to provide and develop community-based mental health services. A strong spectrum of community services can be utilized to divert hospital admissions and discharge planning.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	555,513	
2.Children with SED	168,632	

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Pennsylvania utilizes prevalence data from the National Research Institute (NRI). Pennsylvania does not track incidence data at this time.

For planning purposes, in addition to the prevalence data from the URS Table, OMHSAS utilizes a number of data sources and seeks broad stakeholder input, as outlined in Planning Step 2. These include:

• County-level data from the County Human Services Plans

• OMHSAS Data (inclusive of both Medicaid and State funded services)

• Stakeholder feedback from the public meetings

• Consultation with subject matter experts for each priority area

Please indicate areas of technical assistance needed related to this section.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDEA	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such systems	(•) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

Managed Care provides many opportunities for rural counties. Under managed care, there are required services and access standards. In rural areas, services must be available within 60 minutes of travel time. In addition, emergency services must be available in one hour, urgent services in 24 hours, and routine services in 7 days. Rural counties, in order to come into compliance with managed care standards, are required to increase both the number and array of service providers.

Some rural areas of Pennsylvania have also developed partnerships with neighboring Counties/Mental Health Authorities to provide additional specialized services and trainings, such as Behavioral Health Alliance of Rural Pennsylvania (BHARP), which represents 24 rural counties in north central Pennsylvania. BHARP has provided extensive training on Trauma Informed Care to providers in their area, worked towards System of Care development, and hosts various cross-county workgroups on priority issues, such as housing.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

Pennsylvania has a strong focus on housing and addressing homelessness, including the Department of Human Services Five Year Housing Plan, which OMHSAS assisted in developing. OMHSAS homeless services focus on the PATH (Projects Assisting in the Transition from Homelessness) Grant and SOAR (SSI/SSDI Outreach, Access, and Recovery) Initiative. Pennsylvania has PATH services available in 37 counties through 25 County MH/ID Program Offices, covering both urban and rural areas of the state. Services provided for PATH-eligible individuals include outreach, screening and diagnostic treatment, habilitation/rehabilitation, community mental health services, alcohol and/or drug treatment, staff training, case management, supportive and supervisory services in residential settings, referrals for primary health, job training, educational services, and allowable housing services. In 2022, PA's SOAR program was recognized nationally for several achievements: over 4000 decisions, over 2000 approvals, having a top nationwide approval rate, and consistent capacity.

OMHSAS is currently focused on spreading SOAR beyond PATH counties into other geographic areas of the state. OMHSAS is also working to develop greater SOAR capacity for veterans (both the Veterans Administration and partnering nonprofits) and within the criminal justice system.

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

Two major priorities that OMHSAS supports for Older Adults are a series of specialized trainings through the Pennsylvania Behavioral Health and Aging Coalition and Certified Older Adult Peer Specialist (COAPS) Training. Pennsylvania Behavioral Health and Aging Coalition receives OMHSAS support to provide various trainings to mental health providers, many of which are focused on issues of aging, including Dementia Live, Compassionate Touch, Ageless Grace Brain Health, and WISE. The COAPS training is a three-day continuing education training for CPSs who wish to specialize in peer services to the older adult population. CMHSBG funding has been utilized to support additional COAPS trainings throughout the Commonwealth to build the capacity of this service.

Please indicate areas of technical assistance needed related to this section.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

Training for providers of emergency mental health services regarding SMI/SED

The Office of Mental Health and Substance Abuse Services (OMHSAS) is the statewide coordinating agency for Emergency Behavioral Health (EBH) response. The Pennsylvania Mental Health Plan for Disaster/Emergency Response was first published in September 1994. The next update occurred following the terrorist attacks of September 11, 2001. Subsequent to the 9-11 Disaster Response Plan, OMHSAS was given guidance by the SAMHSA to develop an ALL HAZARDS PLAN. Over time, and in alignment with federal guidance, the plan is now titled "Office of Mental Health and Substance Abuse Services Emergency Behavioral Health Plan". This EBH Plan is updated every two years and provides a mechanism for state response to local, regional, and/or state-level disasters and emergencies using an All Hazards Approach.

In the commonwealth, each county has an EBH Coordinator who provides oversight and direction to their EBH Team. Each county functions at its own level, with some being more robust than others. The county EBH plans are intended to provide guidance for their response effort at the local level.

Office of Mental Health and Substance Abuse Services Emergency Behavioral Health Plan specifies the OMHSAS as a supportive component in emergency behavioral health response. The OMHSAS provides technical assistance and ongoing training to counties in the development of county EBH plans and in implementing their response program. The following is a discussion of the available training:

Persevere PA – The Commonwealth's Crisis Counseling Assistance and Training Program (CCP)

On May 14, 2020, the Immediate Services Program (ISP) Application was submitted to FEMA and SAMHSA in order to provide SAMHSA Approved Psychological First Aid (PFA) to the citizens of the Commonwealth. The application was approved with a total award of $309,455. The CCP is intended to provide SAMHSA Approved Crisis Counseling to the citizens of the Commonwealth. Persevere PA provided SAMHSA Approved crisis counseling services to 17,848 citizens of the Commonwealth.

Emergency Behavioral Health Trainings

OMHSAS, in partnership with the Pennsylvania Department of Health (PADOH), Bureau of Public Health Preparedness (BPHP), offers training to emergency response providers to address the psychosocial consequences of disasters and emergencies. COVID-19 significantly impacted the EBH Training Program this year. In accordance with the Subgrant guidance, PADHS exceeded the required deliverables and provided nine virtual trainings in the Commonwealth. Emergency Behavioral Health Responder and Coordinator Trainings, Psychological First Aid (PFA), Critical Incident Stress Management (CISM), and various Advanced Skills trainings were provided to first responders and other personnel in the virtual environment to increase their capability to respond to the psychosocial needs of others, relative to disasters and other public health emergencies. Using BPHP funding from the Centers for Disease Control and Prevention (CDC), OMHSAS provides the following training to Emergency Behavioral Health Responders:

Psychological First Aid (PFA) training endorsed by Substance Abuse and Mental Health Services Administration (SAMHSA)

Emergency Behavioral Health Responder and Coordinator Trainings explore the roles and responsibilities of Crisis Counselors deployed to support individuals with immediate behavioral health needs after a disaster.

Critical Incident Stress Management (CISM) for First Responders

Group Crisis Intervention: a core course in the CISM model designed to address the needs of small and large groups of people impacted by the crisis. This course provides the foundational theory of the effects of trauma; it also focuses on skill development in 3 basic intervention techniques, specifically, Crisis Management Briefings (CMB), Defusing, and Critical Incident Stress Debriefings (CISD).

o Assisting Individuals in Crisis: a core course in the CISM model designed to address the needs of individuals in crisis. This course provides the foundational theory of crisis communications and focuses on skill development using a specific protocol that can be adapted for use with suicidal individuals.

o Assisting Individuals in Crisis and Group Crisis Intervention: combines the Group and Individual courses in a 3-day format. This training is especially recommended when a group is just starting a CISM team or when participants have time constraints but would like to develop skills for dealing with groups and individuals in crisis.

o Advanced Group Crisis Intervention: This course is designed to provide guidance when dealing with complex crisis situations (i.e., completed suicides, line of duty death, mass casualty incidents, etc.). This course builds upon the skills developed in the Group Crisis Intervention course.

Skills for Psychological Recovery

Advanced Skills Trainings including:

o Active Shooter 2.0 – The Evolution of the Active Shooter Risk and Community Response

o Behavioral Management of CBRNE* Terrorism (Chemical, Biological, Radiological, Nuclear, and Enhanced Conventional Weapons)

o Responder Safety and Preventing Collective Violence: Group, Crowd, and Mob Aggression

o Working with the Community in the Wake of Violent Eventso Mental Health Response to Mass Violence

o Extremism and Targeted Violence: The Evolving Threat Landscape Time

o Operational Stress Control & Strategies for Team Support: Psychological Force Protection for Crisis Responders

o Vehicular Terrorist Attacks: Prevention, Response & Recovery

o A Disaster Behavioral Health Responder's Guide to Intelligence

o Human Trafficking Recognition, Response & Recovery: Managing the Emotional Consequences of Human Trafficking

Through the county Emergency Behavioral Health Teams, these training opportunities are also offered to partners and stakeholders to promote community resiliency and recovery.

EBH Coordinators are encouraged to attend Health Care Coalition and regional task force meetings, to partner in a variety of exercises, and to participate in committees and meetings as their schedule allows. Collaboration and training will continue.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Pennsylvania currently allows all Mental Health providers to use telehealth as it aligns with the standards or regulations for the specific service being provided. Pennsylvania's Behavioral Health telehealth guidance, OMHSAS Bulletin 22-02, currently permits the delivery of audio-only services, permits the use of telehealth by drug and alcohol providers, permits the use of telehealth by unlicensed staff working through a licensed provider agency, and permits the delivery of services in a community setting. The guidance stresses that the services delivered through telehealth must be both clinically appropriate and appropriate for the individual receiving services. Providers delivering services through telehealth must develop policies around telehealth that ensure both the provider and individual being served are adequately prepared to deliver and receive telehealth. In Pennsylvania, telehealth is used to provide services to individuals across the spectrum of mental health diagnoses including those with SMI or SED. OMHSAS is in the process of developing a comprehensive post PHE telehealth bulletin to standardize telehealth requirements for behavioral health providers in Pennsylvania.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

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12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	○ Yes ◉ No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	○ Yes ◉ No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	◉ Yes ○ No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	◉ Yes ○ No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	○ Yes ◉ No
6.	Does the state use an evidence-based intervention to treat trauma?	◉ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight.

1A. Using the PA Comprehensive RTF Trauma-Informed Care Audit Tool developed by the Bureau of Children's Behavioral Health Services, OMHSAS was able to guide all of Pennsylvania's MA-funded Child and Adolescent Residential Care and Treatment Facilities through the audit processes necessary to become designated as "Trauma-Aware" according to the Trauma-informed PA (TIPA)/ DHS continuum developed jointly with the Office of Advocacy and Reform under Governor Wolf and which is being implemented by both government and community stakeholders through the HEAL-PA Action Committees. Beginning in May of

2023, MA-funded RTFs will begin to conduct audits to establish the designation of "Trauma-Sensitive" RTFs. These designations will require a higher level of Trauma-informed care implementation and documentation. The OMHSAS Children's Bureau will be providing technical assistance and support for these RTFs as they work to meet the requirements for a "Trauma-Sensitive designation, as defined by the PA Comprehensive RTF TIC Audit Tool. The Children's Bureau TIC consultants have developed a number of tools specifically for use by RTFs in gathering observations and data about the TIC functioning of their programs. These tools are still in the pilot phase but are free for facilities to use at their discretion.

Survey of Youth Satisfaction with Trauma-Informed Care and Residential Culture Tool- Comprehensive and Short versions

PA Parent and Caregiver Satisfaction with Trauma-Informed Care and Residential Culture Survey

The Trauma-Informed Beliefs and Behaviors Survey for Residential Staff

The Trauma-Informed Interactions Observation and Training Tool for use with Residential Staff

1B. OMHSAS is formally collaborating on TIC with Healthchoices/BH Managed Care Organizations. OMHSAS Children's Bureau Director and TIC Consultants met with the Trauma-informed care leadership of each of the BH-MCOs to learn more about the efforts of each one to implement TIC both within the BH-MCO organization and across the associated provider networks and in February and March, representatives from each of the 5 BH-MCOs came together to plan a Trauma-Informed Care "Summit" for sharing information and best practices to promote collaboration and consistency in how the 5 organizations promote Trauma-Informed Care within their provider networks and across the service system. The TIC Summit will take place in June 2023 and will address trauma-informed care practices not only in the child and adolescent serving mental health service systems but also in the adult mental health and substance abuse services systems and across all levels of services.

1C. In addition to the above initiatives, DHS has been convening TIC leaders from OMHSAS and OCYF as well as from the Office of Advocacy and Reform to share resources and coordinate efforts in the promotion of TIC in human services and across the state. This year, there has been increased participation in these collaborative discussions as representatives from OCDEL, ODP, OIM, OLTL, and other offices within DHS have begun to attend and share information about their efforts to promote trauma-informed practices in their program areas.

2. OMHSAS staff representatives continue to be involved with the HEAL PA Initiative and are representing DHS on a number of action committees, as well as on the National Governors Associations Pennsylvania ACES team. OMHSAS Children's Bureau is currently represented in the leadership team of HEAL PA and in the Co-leadership of the Trauma Training and Organizational Support Action Team (TAOS) with the goal of supporting individuals, organizations, and communities in Pennsylvania on their journey to move along the continuum from trauma-aware to healing-centered. The TAOS Action Team is a resource hub that identifies and shares information about training opportunities and tools and strategies to foster trauma-informed organizational and system change.? One of its primary accomplishments in the past year is the development of a list of official training and learning objectives that provide the foundational basis of training that can help establish "Trauma-Awareness" as a first step on the path to Healing Centered practice. The team has also created a survey trainers can use to describe the HEAL PA Trauma-Awareness Learning and Training Objectives covered in their trainings for an opportunity to be listed as a training resource on a HEAL PA website.

3. OMHSAS partnered with OCDEL to develop a cohort of behavioral health providers and supervisors to participate in a three year -long study of changes in the Attitudes Regarding Trauma-Informed Care Survey (administered through the Klingberg Institute), among those providing behavioral health services to children in the 0-8 age range, in response to the various TIC initiatives and training opportunities being offered by a variety of organizations across the state. We have now completed 3-time point surveys in this study, and results show steady improvement in scores over the last 18 months, with indicators suggesting very positive attitudes towards trauma-informed care in the population surveyed.

4. OMHSAS has been working on developing our capacity to provide effective and actionable technical assistance and training in the area of trauma-informed care, and we are currently developing a plan for how to use these capacities and resources most efficiently and strategically. We now have seven individuals who have completed a "train the trainer" program through Lakeside Global Institute, and we are looking to keep our current training efforts focused on offices within DHS that are not yet able to access such training through other sources. Several "Trauma 101" trainings have been conducted with OMHSAS staff, and there are plans for scheduling monthly opportunities for training.

5. The PA Cares Partnership has been curating speakers and programs for their Webinar Series, which are very much focused on issues related to Trauma and Cultural, Racial, and Historical trauma and the impact of these factors on mental health in diverse and vulnerable populations. Speakers are addressing many issues related to complex trauma, attachment, resiliency, and so on.

6. OMHSAS has also provided training in trauma-informed care principles to peer support professionals using a curriculum we adapted from the "Trauma-sensitive Schools" online curriculum called the TRAUMA SENSITIVE PEER SUPPORT FIRST STEP TRAINING PACKAGE. This training package was adapted specifically for peer support practitioners by a small collaborative "community of practice" group made up of peers, policymakers, educators, a variety of clinicians from various disciplines, families, and young adults. Members of the practice group included representatives from the larger Pennsylvania Community of Practice on Trauma-

Informed Care, Pennsylvania Mental Health Consumers Association, Pennsylvania Peer Support Coalition, Pennsylvania's Department of Human Services' Office of Mental Health and Substance Abuse Services, Youth MOVE PA, Drexel University, Georgetown University, Community Care Behavioral Health, PA Care Partnership, and National Association of Directors of Special Education.

Trauma Training Narrative on OCYF and PA Care Partnership Training.

The PA Care Partnership, in collaboration with Lakeside Global Institute, has provided trauma training across PA since 2018. These trainings have helped thousands of people learn about the basic concepts of trauma, and many have advanced their knowledge and skills to become trainers. This year, The Office of Mental Health and Substance Abuse Services (OMHSAS) has joined forces with The Office of Children, Youth, and Family (OCYF) to further extend the impact of these trainings. Data collected since 2018 shows that over 1,000 people have participated in the workshop training that has been funded by the PA Care Partnership. Thanks to the increased funding from the partnership between OMHSAS and OCYF that joined to support Lakeside Global Institute in providing workshop training, the data collected indicates that more than 2,000 individuals from various parts of PA attended the training between September 2022 and April 2023. The training aims to enhance the skills and knowledge of the participants in various fields to better serve the youth and young adults in the commonwealth who live with a mental health diagnosis and/or have a connection with the child welfare serving system.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- ☑ Coordination across mental health, substance use disorder, criminal justice and other systems
- ☑ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- ☑ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- ☑ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- ☑ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- ☑ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- ☑ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- ☑ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- ☑ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- ☑ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- ☑ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- ☑ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- ☑ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- ☑ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- ☑ Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. ◉ Yes ○ No

The Stepping Up framework offers a solid foundation to effect more racially equitable outcomes, specifically among individuals with serious mental illnesses in the criminal justice system. Stepping Up is helping counties apply the tools they already have in place to incrementally build policies, programs, and practices that increase racial equity and mitigate disparities.

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? ◉ Yes ○ No

4. Does the state have any activities related to this section that you would like to highlight?

Pennsylvania's Projects for Assistance in Homelessness (PATH) grant highly recommends CIT coordination between its 40 providers and their respective communities. The numbers of CIT-trained officers and emergency personnel across the State continue to grow.

Pennsylvania, as a whole, has several methods in place to minimize the challenges and foster support for PATH clients with a criminal history. Most programs employ elements of diversion, specialized forensic case management, forensic peer support, trainings, and/or developing working relationships with the local jails, state correctional facilities, local probation and parole officers, as well as landlords. Endeavors revolve around both paroled and maxing-out individuals in both county jails and state

correctional institutions.

As a result of information collected during PATH site visits, the PA SPC has become involved with the statewide Forensics Interagency Task Force (FITF). The group's focus is to allay any avoidable hurdles in the reentry process. The SPC chairs the Housing Reentry sub-committee in its efforts to streamline reentry methodology from PA Department of Corrections procedures to housing options and supports. The SPC chaired the Housing sub-group of the Reentry Committee and presented at the 24th Annual Forensics Rights and Treatment Conference Nov 30-Dec 1, 2016. The FITF core groups spoke on "Collaboration: The Essential Tools for System Change."

In 2017, the SPC completed the 40-hour Crisis Intervention Team (CIT) training in Franklin Co, PA. The SPC was then certified as a CIT trainer by the originators of the Memphis CIT model with a focus on verbal de-escalation techniques and coordination with law enforcement to curb recidivism.

Allegheny County received one of six national technical assistance awards to advance SOAR use in the criminal justice environment. The TA will include all steps needed to implement, maintain, and increase SOAR use at the Allegheny County Jail. This project will enhance SOAR progress already being made by the Bucks Co Jail in the eastern part of the state.

Justice-involved programs differ based on local needs within PA counties. Lehigh County has one of the premier workgroups in the state. Lehigh County, with 48% of its enrolled PATH consumers being criminally involved and/or having a criminal history, has developed a program called Team MISA (Mental Illness Substance Abuse). Team MISA is comprised of a variety of disciplines within the County, including the District Attorney's Office, Lehigh Valley Pre-Trial Services, MH/ID, SPORE, D&A, Lehigh County Prison (treatment, administration, and case managers), Probation/ Parole and the Public Defender's Office. The meeting is chaired by the first Assistant DA. The success of the group results from the collaboration and participation of department heads, as well as front-line staff, at the table. The team meets weekly to discuss new referrals and any updates on ongoing cases that are involved in the criminal justice system. Members collect and present pertinent information from their office which the team discusses to develop the most appropriate plan to address the individual's situation in the most clinically appropriate manner.

The Commonwealth has a well-developed system of problem-solving courts. This includes Adult Drug Courts, Re-entry Drug Courts, Recovery Drug Courts, Adult Drug/DUI Hybrid Courts, DUI Courts, Family Drug Courts, Adult Mental Health Courts, Juvenile Mental Health Courts, Veterans Courts, Juvenile Drug Courts, Co-occurring Courts, Domestic Violence Courts, Sexual Offense Court, Prostitution Courts, and Northwestern PA Treatment Court Consortium. In total, there are 132 specialty courts across the Commonwealth.

Criminal Justice Advisory Boards (CJABs) are another venue for discussion of forensic programs. In Crawford Co, The Crawford County Mental Health Awareness Program (CHAPS) Executive Director is an active member of the County's CJAB and is able to share challenges and suggest solutions to judges, probation, and other stakeholders. Also, CHAPS staff actively participates in a Mental Health Forensic Subcommittee, where best practices, barriers, and solutions are discussed. CHAPS has very positive working relationships with our police departments, probation offices, and District Justices.

CHAPS has had significant success working with forensic-related individuals. Some examples include master leasing units for diversion or returning to the community, coordination with the jail to ensure a smoother re-entry to the community, writing letters and appearing in court to testify on behalf of clients, which result in jail diversion, and immediate engagement upon release from jail (utilizing a Mental Health Court Model).

All of these justice-involved programs, despite different approaches, share the same goal of reducing barriers for those reentering communities from incarceration.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

The Mental Health and Intellectual Disabilities Act requires all counties in Pennsylvania to make crisis services available. However, the availability and extent of services varies greatly from county to county. Efforts are underway to develop services in all counties which will meet SAMHSA Best Practices Toolkit minimum standards.

Crisis call center services are available statewide through both local crisis lines and National Suicide Prevention Lifeline (NSPL) call centers within the 988 network. Pennsylvania has greatly increased its in-state answer rate over the past several years, regularly

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis lifeline network

ii. Not in the suicide lifeline network

b. Number of Crisis Call Centers with follow up protocols in place

c. Percent of 911 calls that are coded as BH related

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of first responder structures (police, paramedic, fire)

b. Integrated with first responder structures (police, paramedic, fire)

c. Number that employs peers

3. Safe place to go or to be:

a. Number of Emergency Departments

b. Number of Emergency Departments that operate a specialized behavioral health component

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☑	☐	☐
Safe place to go or to be	☐	☐	☐	☑	☐	☐

b. Briefly explain your stages of implementation selections here.

Data currently available in the state:

Due to Pennsylvania's county-led mental health system, some data is not currently available at the state level. The Commonwealth of Pennsylvania used a portion of funding from the Consolidated Appropriations Act (CAA) to fund nine mobile crisis projects that span twelve Pennsylvania counties. All of the CAA-funded projects are required to submit quarterly data, and some of this data is reflected below. All programs receiving crisis set-aside funding will be required to submit data as a condition of receiving the funding. Further,

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

The Commonwealth of Pennsylvania is utilizing SAMHSA's guidelines as well as implementation tools provided by NASMHPD to develop a full crisis continuum of services across our county-based delivery system. The Commonwealth has developed draft regulations that adhere to SAMHSA's guidelines that are currently in legal review and will be presented for public comment shortly.

The Commonwealth is also utilizing CMHSBG ARPA funds to assist counties in the planning for and development of mobile crisis teams and crisis walk-in centers. Both of these services are significantly limited in many counties, and the current operation of existing

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

The Commonwealth requested proposals from counties to fund crisis system building activities through ARPA funding. Four counties were awarded grants for planning and development. These grantees are smaller, rural counties without much-existing crisis services infrastructure. Five counties were awarded funds to build mobile crisis team services capacity. The majority of funding was awarded to develop crisis stabilization services, with awards going to five groups of counties. One urban county is utilizing the funding to increase crisis stabilization capacity, while others are establishing services. Encouragingly, two groups of counties are collaborating on regional models which will develop sustainable services outside of urban population centers. One grantee will be serving six counties

Please indicate areas of technical assistance needed related to this section.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(•) Yes ( ) No
b)	Required peer accreditation or certification?	(•) Yes ( ) No
c)	Use Block grant funding of recovery support services?	(•) Yes ( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(•) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (•) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Peer Support Services

Peer Support Services (PSS) are for individuals 14 years of age and older. PSS are specialized therapeutic interactions conducted by self-identified current or former consumers of behavioral health services who are trained and certified to offer support and assistance in helping others in their recovery and community integration process. Peer support is intended to inspire hope in individuals that recovery is not only possible but probable. The service is designed to promote empowerment, self-determination, understanding, coping skills, and resiliency through mentoring and service coordination supports that allow individuals with severe and persistent mental illness and co-occurring disorders to achieve personal wellness.

Compeer

Compeer is a service of volunteers with lived experience. Compeer recruits, screens, and matches trained volunteers and mentors in one-to-one supportive relationships with individuals who are striving for good mental health. Compeer volunteers provide support, friendship, and mentoring during an individual's recovery process. These services are considered additional support to traditional behavioral health services.

Psychiatric Rehabilitation Services

Psychiatric rehabilitation services (PRS) are collaborative, person-directed, individualized, and evidence-based in their approach. PRS focuses on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social domains of their choice. They help the individual cope with the stressors and barriers encountered when recovering from their disabilities.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

Certified Recovery Specialist

The Certified Recovery Specialist credential is for individuals with personal, lived experience of their own recovery from drugs and alcohol. The peer has been trained to help others move into and through the recovery process.

5. Does the state have any activities that it would like to highlight?

The state would welcome technical assistance for creating services related to recovery, such as family peer support that addresses peer services across the lifespan.

The Office of Mental Health and Substance Abuse Services is working on developing Family Peer Support Services that would employ family members with lived experience to assist parents or caregivers of those with a behavioral health diagnosis.

Please indicate areas of technical assistance needed related to this section.

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Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	(•) Yes ( ) No
Home and community-based services	(•) Yes ( ) No
Peer support services	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

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18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED?	◉ Yes	○ No
b) The resilience of children and youth with SED?	◉ Yes	○ No
c) The recovery of children and youth with SUD?	◉ Yes	○ No
d) The resilience of children and youth with SUD?	◉ Yes	○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare?	◉ Yes	○ No
b) Health care?	◉ Yes	○ No
c) Juvenile justice?	○ Yes	◉ No
d) Education?	◉ Yes	○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization?	◉ Yes	○ No
b) Costs?	◉ Yes	○ No
c) Outcomes for children and youth services?	◉ Yes	○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?	◉ Yes	○ No
b) Mental health treatment and recovery services for children/adolescents and their families?	◉ Yes	○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system?	◉ Yes	○ No
b) for youth in foster care?	◉ Yes	○ No
c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?	◉ Yes	○ No
d) Does the state have an established FEP program?	◉ Yes	○ No
Does the state have an established CHRP program?	◉ Yes	○ No
e) Is the state providing trauma informed care?	◉ Yes	○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Pennsylvania has been awarded several grants from SAMHSA to develop Systems of Care to serve youth ages Birth to age 21 with serious mental health needs and their families. These youth are often involved with child welfare and/or juvenile justice and are in, or at risk of, out-of-home placement. Pennsylvania is part of the national movement to utilize organized, multi-level, and multi-

disciplinary systems, in partnership with youth and families, to serve multi-system youth and their families more effectively.

The PA Care Partnership, the Statewide System of Care Grant, builds on and enhances cross-systems efforts that have been underway for several years to integrate and more effectively provide services to youth. The grant currently works with nine counties utilizing High Fidelity Wraparound (HFW), or another validated cross-system planning model, as the engagement and care planning process for youth involved in multiple systems.

The state also has a State Leadership and Management Team, which meets monthly cross-system participation and equal family and youth voice as voting members. The systems involved are mental health, education, child welfare services, juvenile justice services, early childhood, autism, substance use disorders, and county commissioners associations.

The Youth and Family Training Institute, a division of the University of Pittsburgh and Western Psychiatric Institute and Clinic of UPMC, provides training and support, as well as evaluation of the HFW teams in each county. Additionally, they provide support and training to counties and providers related to data collection and analytics of the data for the cross-system planning models.

7. Does the state have any activities related to this section that you would like to highlight?

The PA Care Partnership provides technical assistance and training in the following domains.

a. Trauma-Informed Care through the Lakeside Global Trauma Training and Train the Trainer program.

b. System of Care Implementation through the PA Care Partnership.

c. Youth and Family Empowerment through the Youth and Young Adult Roadmap and the Family Roadmap.

d. Coaching and Leadership through the Coach Approach to Adaptive Leadership and Adaptive Leadership for System Change.

e. Family Engagement through the PA Parent and Family Alliance and the Family Support Partners.

Please indicate areas of technical assistance needed related to this section.

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19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

Current activities include training/technical assistance, screening, awareness/outreach, and partnership/infrastructure development. Continued efforts to improve collaboration among state agencies through the stateside Suicide Prevention Task Force has been a priority, as has collaboration with SAMHSA and the Suicide Prevention Resource Center through a variety of grant-related efforts and involvement in cross-state learning collaboratives.

3. Have you incorporated any strategies supportive of Zero Suicide? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ◉ Yes ○ No

If yes, please describe how barriers are eliminated.

Through the current Garrett Lee Smith Youth Suicide Prevention Grant awarded to OMHSAS (2019-2024), the grant team is working with 15 target counties to improve the continuity of care for youth at risk of suicide using the Zero Suicide Framework. Within this cross-systems project, counties identified key stakeholders in youth-serving systems (including schools, primary care, law enforcement, crisis, emergency rooms, inpatient, and outpatient) and had organizations complete the Zero Suicide Organizational Self-Study to identify strengths and needs. The project team analyzed each county's data and partnered with county leadership to engage stakeholders in a discussion about the county's data, leading to the development of county-specific strategic plans to address youth suicide prevention in a cross-systems manner. Each county identified specific barriers that are identified within their plans, as well as resources to build from in addressing implementation with support from the grant team.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? ◉ Yes ○ No

If so, please describe the population of focus?

DHS-OMHSAS was awarded a two-year 988 implementation grant by SAMHSA in April 2022 that is focused on building statewide capacity for Pennsylvania to respond to calls/chats/texts to 988 by the general population and increase the in-state response rate by crisis centers within Pennsylvania.

Please indicate areas of technical assistance needed related to this section.

DHS currently receives technical assistance from SAMHSA and the Suicide Prevention Resource Center. No additional technical assistance is needed at this time.

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20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ○ Yes ◉ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ○ Yes ◉ No

If yes, with whom?

The Pennsylvania Office of Mental Health and Substance Abuse Services continues to work with partners, including the Department of Aging, the Department of Corrections, the Department of Drug and Alcohol Programs, the Department of Health, various program offices within the Department of Human Services and all relevant public stakeholder groups including our county partnership, Behavioral Health Managed Care Organizations, Advocacy Groups, and other interested Pennsylvanians.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

OMHSAS works closely with all county mental health authorities to ensure the behavioral health needs of Pennsylvanians are met. It is a high priority for Pennsylvania that our individuals are provided the best care in the community possible. Each Pennsylvania

county receives a yearly allocation of CMHSBG funding to provide and develop community-based services for its residents. Counties submit a yearly plan that describes all Behavioral Health Services provided by each county. OMHSAS reviews each plan individually and monitors the changes from year to year. OMHSAS also monitors the cost-effectiveness of services provided through our behavioral health health choices program on a regular basis.

A member of the OMHSAS Bureau of Children's Behavioral Health Services serves on the Special Education Advisory Panel (SEAP), housed under the Pennsylvania Department of Education. The SEAP: advises the Secretary of Education and the Department of Education on the unmet needs of students with disabilities, on corrective action plans, and on developing and implementing policies and programs to improve the coordination of services of these students. In addition, the OMHSAS Children's Bureau oversees the Student Assistance Program, which provides leadership for mental health and wellness in schools across the Commonwealth. SAP works to remove barriers to learning for all students so that academic success will be achieved through collaborative prevention, intervention, and postvention services.

Please indicate areas of technical assistance needed related to this section.

No TA requested.

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21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Mental Health Planning Council (MHPC) consists of up to 75 members in three age group-specific committees (Children, Adult, and Older Adult) representing mandatory state agencies, individuals with lived experience (of mental illness or co-occurring mental illness/substance use disorder), family members (including the parents of children with SED), advocacy agencies, providers, and local government officials. The MHPC holds public meetings once per quarter in order to discuss feedback on the mental health system throughout the state and provide substantive recommendations to the Deputy Secretary for the Office of Mental Health and Substance Abuse Services (OMHSAS) and additional ad hoc meetings as needed. The mental health planning council has a strong focus on ensuring that the behavioral health system in Pennsylvania is recovery and resiliency oriented and the recovery and resiliency services are prioritized.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

While OMHSAS has authority over Medicaid reimbursement for SUD services, the majority of oversight for the SUD system falls under a separate cabinet-level agency, the Department of Drug and Alcohol Programs (DDAP). DDAP and OMHSAS work closely together on a number of initiatives, and DDAP has an appointed representative to the MHPC.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ◉ No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ◉ Yes ○ No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

MHPC quarterly meetings are open to the public and are well attended by interested stakeholders, including individuals who have received services and their families. The MHPC provides counsel and guidance to the OMHSAS Deputy Secretary in order to ensure an infrastructure and full array of mental health and co-occurring services which comply with the mission, vision, and guiding principles of OMHSAS, as well as core principles of the Community Support Program (CSP), Child and Adolescent Service System Program (CASSP), and Diversity, Equity, and Inclusion principles. The MHPC also provides a forum for youth, adults, and family members with lived experience to work side-by-side with advocates, providers, administrators, and OMHSAS leadership to provide recommendations regarding important statewide policy and programmatic issues. Quarterly MHPC meetings are open to the public and are generally well attended by individuals and family members from the public who offer additional perspectives on the needs of the community. During the COVID-19 Public Health Emergency, all MHPC meetings shifted to a web-based platform, which has enhanced the ability of individuals from across the state to participate in the council meetings. Additional information regarding the structure and operation of the MHPC is included in the attached MHPC Advisory Protocol.

OMHSAS is currently working in partnership with the MHPC Executive Council to enhance the functionality and ensure that the council structure supports providing meaningful input from people in recovery, families, and other important stakeholders and that the MHPC is fully equipped to effectively advocate for individuals with SMI/SED.

The current membership of the Mental Health Planning Council does represent each region throughout Pennsylvania, a mix of rural, suburban, and urban counties; has an excellent representation of individuals from the LGBTQIA community; and closely mirrors the racial/ethnic demographics of the state, both OMHSAS and the counsel are continually seeking to improve the representative nature of the council and ensure that we follow solid principles for diversity, equity, and inclusion in all operations.

Please indicate areas of technical assistance needed related to this section.

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The Office of Mental Health & Substance Abuse Services (OMHSAS)
Mental Health Planning Council

PROTOCOL

Introduction

In March 2004, members of the Office of Mental Health and Substance Abuse Services (OMHSAS) Mental Health Planning Council (MHPC) arrived at consensus on an advisory structure to ensure that:

1. Individuals who have received services, family members, and other stakeholders have the opportunity for meaningful, effective participation in advising OMHSAS.
2. Information is shared broadly and in a timely manner from stakeholders to OMHSAS and from OMHSAS to stakeholders.
3. Valuable networking opportunities are available among stakeholders.
4. There are productive partnerships between OMHSAS and the Planning Council.

The OMHSAS Mental Health Planning Council is comprised of three committees and one subcommittee: Children's Behavioral Health Committee, Adult Behavioral Health Committee, Older Adult Behavioral Health Committee, and Persons in Recovery Subcommittee. These committees will advise on a broad behavioral mandate to include, but not be limited to, mental health, substance abuse, behavioral health disorders, and cross-system disability.

The OMHSAS Mental Health Planning Council will directly advise the Deputy Secretary.

The OMHSAS Mental Health Planning Council will link to related state departments, advisory committees, and OMHSAS stakeholder workgroups.

The OMHSAS Mental Health Planning Council will assume the role of State Mental Health Planning Council within its scope of responsibility.

I. Purpose

The purpose of the OMHSAS Mental Health Planning Council shall be to provide counsel and guidance to Pennsylvania Department of Human Services' (DHS) OMHSAS in order to ensure an infrastructure and a full array of mental health, substance abuse, and behavioral health services which comply with the mission, vision, and guiding principles of OMHSAS, as well as core principles of the Community Support Program (CSP), Child and Adolescent Service System Program (CASSP), Cultural Competency, and Department of Drug and Alcohol Programs (DDAP).

OMHSAS Mission

OMHSAS, in collaboration with other appropriate commonwealth offices, will ensure local access to a comprehensive array of quality mental health and substance abuse services that are reflective of the needs of Pennsylvania citizens, effectively managed and coordinated, and responsive to a dynamic and changing health care environment.

OMHSAS Vision

Every individual served by the mental health and substance abuse services system will have the opportunity for growth, recovery, and inclusion in their community, have access to culturally competent services and supports of their choice, and enjoy a quality of life that includes family and friends.

OMHSAS Guiding Principles

The mental health and substance abuse services system will provide quality services and supports that:

- Facilitate recovery for adults and resiliency for children.
- Are responsive to individuals' unique strengths and needs throughout their lives.
- Focus on prevention and early intervention.
- Recognize, respect, and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity, and sexual orientation.
- Ensure individual human rights and eliminate discrimination and stigma.
- Are provided in a comprehensive array by unifying programs and funding that build on natural and community supports unique to each individual and family.
- Are developed, monitored, and evaluated in partnership with individuals who have received services, families, and advocates.
- Represent collaboration with other agencies and service systems.

State Mental Health Planning Council

It is the responsibility of all OMHSAS Mental Health Planning Council members to be cognizant of and actively participate in fulfilling expectations as representatives of the broad range of individuals served by OMHSAS, as well as to meet the three primary duties assumed by these committees as the State Mental Health Planning Council. The Federal Public Health Services Act defines the duties below, and in the excerpts from the Public Health Service Act (Attachment 1).

A. To review plans provided to the Council pursuant to Section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modification to the plans.

B. To serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems.

C. To monitor, review, and evaluate, not less than once every year, the allocation and adequacy of mental health services within the State.

See Attachment 1 for further information on the State Mental Health Planning Council.

II. Membership

A. The OMHSAS Mental Health Planning Council Advisory Committees will be composed of individual representatives of youth, adult, and older adult individuals who have been served by the behavioral health system, family members of such youth and adults, providers, advocates, professionals, their respective organizations, as well as governmental

organizations. At least 51% of the members will be individuals who have received services and family members. The size of each committee will be a minimum of 20 members, but not to exceed 25 members, who shall be appointed by the OMHSAS Deputy Secretary.

1. Receiving input from Youth and Young Adults is a priority of the OMHSAS MHPC and a Youth/Young Adult Workgroup is being established to identify the best youth-friendly way to ensure that their feedback is being received. It is the intention of the MHPC Executive Committee to ensure that the result of this workgroup includes prioritized seats on the council for Youth/Young Adult members.

2. The Persons in Recovery (PIR) Subcommittee will be composed of up to ten voting members, including:

- Up to 3 Appointed members of the Children's Committee
- Up to 3 Appointed members of the Adult Committee
- Up to 3 Appointed members of the Older Adult Committee
- The appointed MHPC Department of Drug and Alcohol Programs Staff Person

It will be the responsibility of the MHPC committee co-chairs to recruit members to fill the three seats available to each committee. The recommended members will be approved by a vote of the MHPC Executive Committee.

Every attempt will be made to ensure that cultural and demographic diversity of the subcommittee reflects that of individuals served in the Commonwealth and to maintain an equitable representation of individuals and/or family members of individuals who have received Substance Use Disorder (SUD) services or co-occurring (SUD/MH) services. If at all possible, 51% of the committee's membership will have lived experience of SUD or SUD/MH. However, membership on the PIR does not required lived SUD/MH experience of all subcommittee voting members and participation in the group should not be assumed to be self-disclosure of lived experience.

B. The goal in appointing members is to reflect the cultural and demographic diversity of individuals served in the Commonwealth and to maintain an equitable representation among individuals who have received services, family, advocate, and professional representatives to the fullest extent possible, while assuring 51% membership of individuals who have received services and family members.

C. Members should be current residents of Pennsylvania or be able to document substantial current involvement in the Pennsylvania mental health system.

D. In order to fulfill the federal requirements for the Community Mental Health Services Block Grant, the MHPC will ensure representation from five service areas of the state (Medical Assistance, Social Services, Vocational Rehabilitation, Criminal Justice, and Mental Health). The MHPC has set aside 11 permanent state agency seats to meet this requirement and ensure representation among the committees. The OMHSAS representative for mental health will be expected to refrain from voting as appropriate due to conflict of interest.

E. In January of each year the Executive Committee of the OMHSAS Mental Health Planning Council, in collaboration with OMHSAS staff, shall be responsible for soliciting candidates for committee membership. Individuals are encouraged to apply for membership; in addition, representative constituent organizations may recommend individuals for membership. All candidates must complete a membership application form. Applications will be held as active candidates for two years from the date of receipt.

The Executive Committee shall submit recommendations to the Deputy Secretary of persons to be appointed as members of advisory committees. The number of names to be recommended for membership will be equal to or greater than the number of positions to be filled during each year. Appointment to membership will be confirmed by an appointment letter from the Deputy Secretary in May of each year.

F. Nominees appointed by the Deputy Secretary will serve a three-year term, beginning in July of the year in which the individual was appointed. Individuals may serve two full consecutive three-year terms. After serving two full consecutive terms, individuals must wait one year before becoming eligible to reapply to become a voting member.

G. In the event of a vacancy in membership, the unexpired portion of the term shall be filled by a person to be recommended by the Executive Committee and appointed by the Deputy Secretary. If an individual fills an unexpired term for a member that is unable to complete their term, that individual may then apply to complete two full consecutive three-year terms.

H. An orientation for newly appointed members will be conducted when new members are appointed. One co-chair and one advisory committee member will conduct outreach to new members that will address such matters as the composition and purpose of the committees, the public behavioral health system, service array, OMHSAS structure, and cultural competency.

I. New members will receive an appointment letter and an advisory committee orientation packet within one month after being appointed to an advisory committee.

III. Structure

Council Co-Chairs

A. The Mental Health Planning Council will have co-chairs, who must both have lived experience as a consumer and/or family member. MHPC members shall elect co-chairs of the Council for a two year term, who shall serve until a successor has been duly appointed. Co-chairs can be re-elected for a maximum of one additional two year term, after which there must be a minimum of a two year hiatus before being considered again for the position of co-chair.

- Co-chair positions can only be held by a member of the MHPC who has served at least one year as a regular member and attended the required 3 out of 4 meetings annually. Under no circumstance will Pennsylvania commonwealth employees serve in co-chair positions.

B. In January of each year, the Executive Committee shall be responsible for soliciting nominations of individuals who are qualified and willing to serve as a co-chair. One Council Co-chair position will be up for re-election annually. Election of co-chairs shall be conducted by ballot in the Joint Session of the final MHPC meeting of the state fiscal year (typically held in May or June), with the term of office to begin July 1. Election shall be by a simple majority vote of those present and voting, providing a quorum has been reached.

C. Responsibility of Co-Chairs:

- Establish joint session agendas and consult with committee co-chairs as needed for committee agendas.
- Chair joint sessions of the MHPC
- Participate in MHPC Executive Committee meetings.
- Provide timely review and necessary response to correspondence.
- Provide liaison with the Deputy Secretary and the OMHSAS staff.
- Determine, in conjunction with OMHSAS staff, the need for workgroups.
- Ensure correspondence necessary to the function of the MHPC is completed.
- Ensure obligations of the Federal Block Grant are met, including but not limited to participating in Block Grant review meetings and Block Grant conferences.
- Participate in additional activities as requested by the Deputy Secretary, such as OMHSAS Executive Committee strategic planning sessions.

D. Co-Chair Vacancy:

In the event of a vacancy in a Council Co-chair position, the unexpired portion of the term will be filled by a person selected in a Special Election.

- The Executive Committee will solicit nominations of individuals qualified and willing to serve as a co-chair.
- A ballot of nominees will be presented to the MHPC membership during a joint session.
- Election shall be by a simple majority of those present and voting, providing a quorum has been reached.

Committee Co-Chairs

A. Each committee will have co-chairs, one of which at all times will be an individual who has received services and/or family member. Committee members shall elect co-chairs of each committee for a two year term, who shall serve until a successor has been duly appointed. Co-chairs can be re-elected for a maximum of one additional two year term, after which there must be a minimum of a two year hiatus before being considered again for the position of co-chair.

- Co-chair positions can only be held by a member of the committee who has served at least one year as a regular member and attended the required 3 out of 4 meetings annually. Under no circumstance will Pennsylvania commonwealth employees serve in co-chair positions.

B. In January of each year*, the Executive Committee shall be responsible for soliciting nominations of individuals who are qualified and willing to serve as a co-chair. One co-chair position on each committee will be up for re-election annually. Election of co-chairs shall be conducted by ballot in the committee session of the final MHPC meeting of the state fiscal year (typically held in May or June), with the term of office to begin July 1. Election shall be by a simple majority vote of those present and voting, providing a quorum has been reached.

** Note: A special election was conducted in 2006 electing one co-chair for a one year term and one co-chair for a two year term to provide continuity in committee leadership.*

C. Responsibility of Co-Chairs:

- Establish committee session agendas.
- Chair committee meetings
- Participate in Executive Committee meetings.
- Provide timely review and necessary response to correspondence.
- Provide liaison with the Deputy Secretary and the OMHSAS staff.
- Determine, in conjunction with OMHSAS staff, the need for workgroups.
- Ensure correspondence necessary to the function of the committee is completed.
- Ensure obligations of the Federal Block Grant are met, including but not limited to participating in Block Grant review meetings and Block Grant conferences.
- Participate in additional activities as requested by the Deputy Secretary, such as OMHSAS Executive Committee strategic planning sessions.

D. Co-Chair Vacancy:

In the event of a vacancy in a committee co-chair position, the unexpired portion of the term will be filled by a person selected in a Special Election.

- The Executive Committee will solicit nominations of individuals qualified and willing to serve as a co-chair.
- A ballot of nominees will be presented to the committee membership where the vacancy is held.
- Election shall be by a simple majority of those present and voting, providing a quorum has been reached.

Executive Committee

An Executive Committee of the OMHSAS Mental Health Planning Council will be comprised of the Council Co-Chairs and Co-chairs of the Children's, Adult, and Older Adult Committees to provide a structure for the coordination of the OMHSAS Mental Health Planning Council's activities, concerns, and issues. The Executive Committee will be responsible for development of agendas, completing required correspondence, making recommendations of specific tasks, and assignment of workgroups to develop information and recommendations on these issues, and making decisions on behalf of the Committee between meetings. The co-chairs are to assure Committee members are informed of actions taken by the Executive Committee between regularly scheduled Committee meetings.

The Executive Committee will act as the Membership Committee, having the authority to recommend to the Deputy Secretary persons to be appointed to the three advisory committees.

Committee Workgroups

A. Committee Workgroup Structure and Membership

The formation and purpose of Committee Workgroups will be the determination of the Executive Committee in conjunction with OMHSAS Staff to assist in issue-focused, task-oriented, time-limited work of the committees. OMHSAS Mental Health Planning Council and non-OMHSAS Mental Health Planning Council members may be selected to participate in workgroups, to ensure the necessary representation and expertise needed to meet the goals of the workgroup. When establishing workgroups, attention will be given to workgroup membership composition, with the goal of achieving appropriate representation of stakeholders as well as geographical and cultural representation of members.

B. Committee Workgroups

- Individual Committee or Joint Session establishes need for workgroup by a vote of appointed members. Workgroups will be time limited and have a specific area of focus.
- A current Council or Committee Co-Chair will lead the workgroup or the leadership of the workgroup will be assigned by a co-chair to another appointed MHPC member who will report back to the co-chair and MHPC Executive Committee.
- Workgroup develops draft timeline and a defined work product.
- Timeline and draft work product are distributed to the committee for comment via email or at regularly scheduled meeting of the committee.
- Comments considered in final product, and final product distributed to the committee.

IV. Conduct of Business

A. The business and affairs of the OMHSAS Mental Health Planning Council and workgroups shall be managed by the Council and Committee Co-Chairs. Administrative support and technical assistance will be provided by OMHSAS.

B. Notice of meetings, including the agenda for the meeting, shall be distributed to the membership not less than five working days if written, or not less than 48 hours if electronically, prior to the meeting.

C. Voting – Only appointed committee members may vote on council/committee issues. Any action before the council/committees will be presented by formal motion, seconded, and voted on by members. For voting purposes, 1/3 of all voting committee members will constitute a quorum. A simple majority of the quorum will constitute approval of any motion.

Meetings and Attendance

The OMHSAS Mental Health Planning Council can only be effective if members attend regularly and participate in discussion, development of issue statements and recommendations, and respond to requests from OMHSAS.

Meetings will occur four times per year. During the last meeting of the calendar year meetings will be scheduled for the next calendar year. The Executive Committee has the prerogative of rescheduling meetings for legitimate reasons such as scheduling conflicts or weather.

Members must RSVP promptly when notified of meetings in order to allow for adequate copies of materials. All members are expected to attend at least 3 of the 4 regularly scheduled meetings annually. If members fail to RSVP and do not attend the required meetings, the Committee Co-Chair(s) will contact the member to determine their interest in continuing on the Committee. At the discretion of the Executive Committee, members may be dismissed for lack of attendance and unexplained absences.

Attendance alone does not make a good Council member. Assisting the co-chairs in keeping the council/committees focused on the task at hand, respectful participation in discussion, and support of consensus decisions are valuable assets in Council members.

VI) Staff Support

A. OMHSAS will provide adequate staff to ensure effective committee, subcommittee, and workgroup coordination.

B. OMHSAS staff leads the development and submission of the Block Grant proposal.

C. OMHSAS will provide, at a minimum, the following support functions:
   1) Meeting arrangements
   2) Distribution of mailings
   3) Set-up for meetings
   4) Records of expenses
   5) Attendance and recording of meeting outcomes
   6) Travel reimbursement
   7) Inter-office distribution of committee business
   8) Liaison with Council and Committee Co-chairs
   9) Liaison with Executive Committees
   10) Sunshine notification

D. OMHSAS staff will support council, committee and workgroup functions and business as required. This includes responding to requests for information on any pertinent issues. Appropriate OMHSAS staff are expected to attend committee meetings.

VII) Conflicts of Interest

A. Definitions
   a. Covered Person: all appointed MHPC Members, Co-Chairs and Staff

b. Significantly Connected Person/Entity: an individual or entity connected personally and/or financially to a covered person including, but not limited to, family members and employers
c. Conflict of Interest: a situation in which a covered person or the significantly connected person/entity of a covered person has a personal or financial interest that compromises or could compromise their independence of judgement in exercising their responsibilities to the MHPC

B. Each covered person will perform their duties for the OMHSAS MHPC in good faith for the benefit of the OMHSAS MHPC, meaning that no person may take advantage of their position on the OMHSAS MHPC for personal advantage or the advantage a significantly connected person/entity. While it is expected that the work of the OMHSAS MHPC members will broadly contribute to an improved mental health system, from which covered persons and significant people/entities may generally benefit, no covered person shall direct MHPC activity to specifically benefit themselves and/or significantly connected people/entities.
C. Potential conflicts of interest related to the MHPC include, but are not limited to, voting on MHPC business, voting on recommendations to the Deputy Secretary, and reviewing applications for MHPC membership appointments.
D. All Covered persons must avoid both actual conflicts and the appearance of conflicts of interest.
    a. If a covered person has an actual or potential conflict of interest, they may voluntarily recuse themselves from deliberations, voting, or any other MHPC activity related to the conflict of interest by reporting the conflict to a member of the MHPC Executive Committee.
    b. If a covered person has a potential conflict of interest and they do not wish to voluntarily recuse themselves, they may report the potential conflict of interest to any member of the MHPC Executive Committee immediately upon discovering the potential conflict. The potential conflict of interest will be reviewed by the MHPC Executive Committee and a determination returned to the individual within two weeks. The individual with a potential conflict of interest will refrain from taking any action related to the potential conflict during the review period.
    c. Any person, public or covered, who is concerned that a covered person may have an unreported potential conflict of interest can inform a member of the MHPC Executive Committee of their concern. The covered person will be contacted by the MHPC Executive Committee to provide background information. The MHPC EC will then review the potential conflict and advise the covered person within two weeks of their determination. The individual with a potential conflict of interest will refrain from taking any action related to the potential conflict during the review period.

VIII) <u>Travel and Reimbursement</u>- *Provided for individuals who have received services and family members.*

A. If individuals are members based on organization nomination, the member organizations are expected to pay for attending members' expenses for participation at Council meetings.

B. For individuals who are participants and not connected to an organization that has adequate resources to support reimbursement, expenses for ordinary travel and lodging for OMHSAS Mental Health Planning Council meetings will be reimbursed by the Commonwealth, subject to the specific guidelines for these reimbursements and availability of funds.

C. Commonwealth rules for documentation, utilization of vouchers, and adherence to state rates apply in all cases.

See Attachment 2 for further policy and procedures outlining Travel and Reimbursement.

IX) Sunshine Laws

A. Council meetings are subject to the Sunshine Law and notification under the law.

B. The general public, interested individuals, and organizations are welcome to attend Council meetings. Members of the public, commonly referred to as "Sunshine Attendees," may participate in public comment periods. At the discretion of the Co-Chairs, "Sunshine Attendees" may participate in general meeting discussions. "Sunshine Attendees" may not participate in any votes held by the MHPC.

X) Protocol Revision

A. This protocol will be reviewed annually by the Executive Committee, and recommended amendments will be submitted to the committees for approval if changes are indicated.

Updated: The annual protocol review conducted by the Mental Health Planning Council Executive Committee on 10/22/19 and a member comment period was held from 11/12/19 through 12/3/19. No updates were suggested. The MHPC voted to affirm the MHPC protocol with no revisions on 12/3/19. The MHPC voted to accept changes to the Person-in-Recovery Subcommittee Guidelines and Travel Protocol on 2/25/20.

Attachment 1

Excerpts from the

PUBLIC HEALTH SERVICE ACT

STATE MENTAL HEALTH PLANNING COUNCIL

(a) In General – A funding agreement for a grant under section 1911 is that the State involved will establish and maintain a State mental health planning council in accordance with the Conditions described in this section.

(b) Duties – A condition under subsection (a) for a Council is that the duties of the Council are:
- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance and other individuals with mental illnesses or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State

(c) Membership
- (1) In General – A condition under subsection (a) is that the Council be composed of residents of the State, including representatives of
  - (A) the principal State agencies with respect to –
    - (i) mental health, education, vocational rehabilitation, criminal justice, housing and social services; and
    - (ii) the development of the plan submitted pursuant to title XIX of the Social Security Act;
  - (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services
  - (C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
  - (D) the families of such adults or families of children with emotional disturbance.

- (2) Certain Requirements – A condition under subsection (a) for a council is that –
  - (A) with respect to the membership of the Council, the ratio of parents of children with a serious

emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of The Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State Employees or providers of mental health services.

(c) Definition-For purposes of this section, the term "Council" Means a State mental health planning council.

Attachment 2

MHPC Travel Reimbursement Protocol

Overview

- Travel, meal, and lodging reimbursement is provided for individuals who received services/family members/persons in recovery for Mental Health Planning Council meetings.
- If individuals are MHPC members based as organizational representatives, the member organizations are expected to pay for attending members' expenses.
- In order to receive reimbursement, Council members must complete and return the MHPC SAP Number Request Form that was sent to them with their appointment letter. Members without SAP numbers will not be able to receive reimbursement.
- For reimbursement of hotel/motel and car rentals, they must be booked by OMHSAS directly to receive the State Preferred Rate.
- OMHSAS will contact members 4-6 weeks prior to meetings. Members who wish to have travel arrangements made for them must respond at least one week prior to the meeting. If requests are made with less than one week's notice, OMHSAS will make every attempt to book the travel, but cannot guarantee travel arrangements.
- OMHSAS cannot arrange travel for additional individuals who are not currently appointed members or for members who have not registered for an SAP number.
- OMHSAS cannot reimburse expenses for any individual who is not a currently appointed member or for members who have not registered for an SAP number. If members chose to bring a family member or another individual with them during travel, that individual is responsible to pay their own expenses.
- OMHSAS cannot arrange travel for any additional days. If members wish to stay in the hotel/motel additional nights, they need to book these directly with the hotel/motel. If members wish to stay additional days in the Harrisburg area, they must drive their own vehicles, rent a vehicle at their personal expense, or otherwise arrange their own transportation. OMHSAS rented vehicles must be returned timely to Enterprise.
- OMHSAS cannot reimburse members for expenditures outside of the meeting dates/travel dates. For typical quarterly MHPC meetings, members approved for overnight travel can request expenses reimbursed on the day prior to the meeting (travel day) and the day of the meeting. For any other situations, the member should contact the OMHSAS MHPC Lead Staff person in advance to discuss the travel request.
- OMHSAS cannot reimburse expenses for travel that is not directly required by the Mental Health Planning Council. Outside of the standard quarterly MHPC Meetings and MHPC annual orientation, members must have advanced approval from the OMHSAS MHPC Lead Staff person to request any travel arrangements/reimbursements. These requests are approved only if the activity relates directly to MHPC Business (such as Federal CMHSBG Meetings that require MHPC Representation).
- OMHSAS can only reimburse expenses directly incurred by the member. OMHSAS cannot reimburse expenses that were paid by an employer, another agency, grant funding, or other government funds, including expenses paid using Supplemental Nutrition Assistance Program (SNAP) benefits.

- Members must attach itemized register receipts, hotel/motel receipts (with proof of payment through last 4 digits of the credit card number used), and any vehicle rental invoices to your request for reimbursement.
- General credit card receipts that are not itemized will not be accepted.
- Submission of all reimbursement requests must occur within **60 days after a meeting**.
- As long as OMHSAS makes the rental vehicle and hotel/motel reservations, they will be made with no up-front cost to the traveler. However, the traveler may be required to submit a personal credit card for incidentals.
- Any questions about reimbursement protocol should be directed to the OMHSAS Lead staff person or Travel Arranger. Individuals should not attempt to contact Enterprise or the hotel/motel directly about travel issues.
- OMHSAS is only able to reimburse individuals for their expenses; no advance payments will be given.

Transportation

- If you are traveling 75 miles or fewer (round trip), you may travel in your personal vehicle. You will be reimbursed at the current U.S. General Services Administration's (GSA) per mile rate ($0.575 as of January 1, 2020). The most up to date rate can be found at: https://www.gsa.gov/travel/plan-book/transportation-airfare-rates-pov-rates-etc/privately-owned-vehicle-pov-mileage-reimbursement-rates
- If you are traveling more than 75 miles (round trip), OMHSAS will offer to arrange a rental car for you. The car may not be used for non-Commonwealth business, and must be picked up and returned by the agreed-upon, designated times. Your travel time will be taken into consideration, but we ask that rental vehicles are returned directly following the MHPC meeting.
- If you are traveling more than 75 miles (round trip) and you choose to use your personal vehicle, you can only be reimbursed the lowest GSA mileage rate ($0.17 as of January 1, 2020).

Lodging

- Hotel/Motel: If you are travelling 200 miles or more (round trip), you are eligible to stay at a hotel/motel. OMHSAS will offer to arrange hotel/ motel accommodations for you for the night before the MHPC meeting takes place.
- You will not be reimbursed for hotel/motel arrangements unless OMHSAS makes the arrangements for you.
- You must provide a hotel/motel receipt with your reimbursement documentation that confirms payment (the last four digits of the credit card).
- Hotel rooms booked for Commonwealth business are tax exempt. Individuals are required to present a tax exempt form when checking in, to ensure that the state tax charge is taken off the bill.
- Additional night stays in the hotel/motel, beyond what is covered for the Council meeting, will not be paid for, or arranged by, OMHSAS.
- Any incidental expenses incurred at the hotel/motel will be the responsibility of the individual. Reimbursements are not provided for alcohol, phone calls, room service, or rented movies/games.

Meals

Non-Overnight Status

- If you are travelling 100 miles or more (round trip), you are eligible to be reimbursed for lunch on the meeting day, up to $8.00.

Overnight Travelers

- The maximum reimbursement is not to exceed the GSA rate when qualified for overnight travel (200 miles or more, round trip).
- Allowance for subsistence are not flat rates and only amounts actually expended may be claimed. Itemized receipts must be provided.
- A day for reimbursement purposes is a calendar day.
- First and last day of travel are eligible for 75% of the full per diem amount. For typical MHPC Quarterly meetings, travel approved members in overnight status will be eligible for two 75% days (travel day/first day, meeting day/last day). As of January 1, 2020 the maximum allowable amount is $41.25 for each the first and last day. This amount includes all tips (both on food and incidentals such as hotel housekeeping tips). Members can look up the current rate at https://www.gsa.gov/travel/plan-book/per-diem-rates.
- Reimbursements are not provided for alcohol.

Additional Travel Information

Pennsylvania is currently in the process of implementing the SAP Concur travel system, which includes a travel app. The App is anticipated to be available to MHPC Members by the end of calendar year 2020. OMHSAS will provide travel approved members information about how to register when the app is available.

The MHPC Travel Reimbursement Protocol is based on the Commonwealth Travel Policy. The Commonwealth Travel Policy will be utilized to make determinations on travel reimbursement not specifically covered in the MHPC Travel Reimbursement Protocol. Current Commonwealth Travel Policy is available at: http://www.oa.pa.gov/Policies/Documents/m230_1.pdf

*All rates listed in the MHPC Reimbursement Protocol are based on the U.S. General Services Administration (GSA) rate and are subject to change. The GSA Per Diem tool is available at: https://www.gsa.gov/travel-resources

pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES

MHPC CMHSBG Application Workgroup
Meeting Minutes

Date:	May 2, 2023		
Location:	Microsoft Teams		
Facilitator(s):	Kayla Sheffer & Dawn Comly		
Attendance			
MHPC:	Jason Rilogio	Ruth Fox	Kathy Quick
	Linda Shumaker		
OMHSAS:	Lindsay Graves		

Agenda:

How to determine a measurable priority

Review of previous priorities- 1-4

Notes:

Kayla opened the meeting with an explanation of the CMHSBG and how to determine a good priority. Kathy asked if the Counties had to use their CMHSBG funding toward the priorities. As the answer is no, she then asked if that was something that could be mandated in the future.

P1: Supportive Housing

The workgroup would like a reporting document for the Counties in order to acquire housing support data

They would also like a webinar developed for case managers and other staff on Supportive Housing

P2: Older Adults

How can we improve upon reaching and helping OA, especially ones who don't leave the house; suggestions included newspaper ads and AARP magazine

Would like to see a data report from Counties on who & how many are using services and would also like info from Long Term Living Behavioral Health Collaborative

Needs assessment

Are concerned with Medicare issues related to peer services, asked if CMHSBG $ can be used for Peer services for Family support

Follow Up Item	Person(s) Responsible	Due Date
Send out Cost Center Bulletin and prior CMHSBG submission to the workgroup	Dawn	5/2/23

Next meeting 5/9/23 9:00-10:00

pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES

MHPC CMHSBG Application Workgroup
Meeting Minutes

Date:	5/9/23		
Location:	Microsoft Teams		
Facilitator(s):	Kayla Sheffer & Dawn Comly		
Attendance			
MHPC:	January Abel	Jason Rilogio	
OMHSAS:	Doris Arena	Treasure Gallagher	Lindsay Graves

Agenda: Continue going through priorities, starting with Priority 3

Notes:

Kayla gave a brief overview of the previous meeting.

P3: Family Peer Support Services

Treasure gave an overall update on the new structure & workgroups

Because of the separation of adults & children programs, there will be 1 indicator for each

It will be much easier to get the children part into the State Plan, possibly within the year. Hope is to get the Adults part into State Plan in 2-3 years

There is a meeting 5/10/23 with both Children's & adults policy to learn more about how everything will proceed which will help with developing the indicators

P4: Student Assistance Program

Due to the Funding opportunity ending, we will no longer have data for this, so we must create new priority for children; Doris has asked that we postpone discussion of this priority as Children's bureau has a meeting regarding this coming up

P5: Suicide Prevention

Concern that the 988 structure is based on area code as opposed to Geo Location. Kayla stated there has been discussion on this & will look into any updates. She did note that all 988 operators have access to all resources in all counties. It was commented that geo location was important as 988 calls often triggers a Mobile Crisis Response Team.

May be useful to know what kind of demographic info 988 collects

May be interesting to look at number of calls before 988 availability vs after 988 to see if more people are being reached

Suggestion to expand First Aid trainings to include MH training

Suggestion to ask 988 operators on what would be helpful to them to increase the success of 988

Include Suicide prevention trainings in ELMS

P6: Peer Run Crisis Respite Services

These are now called Peer Run Crisis Stabilization Units or PRCSU

Did not meet previous indicator 2 goal due to the new site taking so long to get up & running.

Treasure gave an update on PRCSUs in the State: A private, non OMHSAS licensed site opened in Bucks County & have agreed to share their data, although we will not be able to use it in grant data

A Forensic PRCSU was also opened in Philly & they will share data, although, again we can't use that in our grant data

How to make PRCSU sustainable is an issue, Kayla stated that they have added a section the crisis regs to address PRCSU, so if the regs go through, it will be funded

Suggestion to tie PRCSU admission data to Psych boarding issue in ER departments, also would like to know how many are referred to PRCSU from ER depts. We can look at how many PCRSU admits are referred from ER, but not how many referrals the ER depts actually make

Suggestion that instead of only looking at unique individuals admitted, look at all admits when looking at cost savings

Follow Up Item	Person(s) Responsible	Due Date
Update on 988 area call vs Geo location structure	Kayla	
What 988 demographic info is available	Kayla	

Next meeting 5/10/23 2-3

pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES

MHPC CMHSBG Application Workgroup
Meeting Minutes

Date:	5/10/23		
Location:	Microsoft Teams		
Facilitator(s):	Kayla Sheffer & Dawn Comly		
Attendance			
MHPC:	January Abel	Lisa Kennedy	Andrew Kind Rubin
	Ruth Fox	Linda Shumaker	
OMHSAS:	Doris Arena	Lindsay Graves	Jenna Mehnert Baker

Agenda: Continue reviewing priorities, starting with Priority 7

Notes:

P7: Mobile Crisis Services

Kayla explained that the 4 indicators in the previous priority were based on data we would be collecting from projects that were funded by CAA money & these projects are wrapping up which means we will not be collecting that data. She explained that there are crisis projects being funded by ARPA money that we will be collecting data from, so we could create new indicators based on that data. Some ideas that she suggested were then discussed:

The data for the number of 302s should be differentiated between issued & upheld, and if police involvement was just transportation based

The number of Mobile Mental Health Teams per county, their response time, hours of operation, number & type of staff (do they use CPS)

The number of walk-in centers per county, how many 302s are brought there, how many & type of staff (do they use CPS)

Discussion on the shortage of CPS causes, changing PA eligibility requirements to match National standards

Discussion on crisis training for First Responders and the need to include those with lived experience and family members in the CIT training standards

Workgroup members would like to see qualitative data from counties & consumers to support the quantitative data

P8: FEP

The workgroup agrees to keep these indicators to focus on building capacity.

Sustainability was questioned: counties are working toward case rate agreements and the CMHSBG 10% set aside should continue for the foreseeable future

The meeting wrapped up with Doris asking the group if there were any possible priorities they would like her to take back to the Children's Bureau meeting, where they will discuss what priority to replace the current Student Assistance Program with. The only immediate suggestion was High Fidelity Wraparound, but they would consider the question for the next meeting

Other topics of interest for new Priorities to discuss: Trauma Informed Care, and Equity/DEI, gender-affirming treatment

Follow Up Item	Person(s) Responsible	Due Date
Review the notes for all 8 priorities that we have discussed to determine if there are any more comments/suggestions/questions	workgroup	5/12/23

Next meeting 5/16/23 9-10

pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES

MHPC CMHSBG Application Workgroup
Meeting Minutes

Date:	5/16/23		
Location:	Microsoft Teams		
Facilitator(s):	Kayla Sheffer & Dawn Comly		
Attendance			
MHPC:	Lisa Kennedy	January Abel	Ruth Fox
	Kathy Quick	Andy Kind Rubin	
OMHSAS:	Lindsay Graves	Doris Arena	

Agenda: Review of previous meetings notes

Notes:

It was again suggested to mandate that counties use at least a portion of CMHSBG funding on Priorities; would like to see CSP be involved in approving any future county plans

Review of May 2nd, P1 Supportive Housing & P2 Older Adults: Focus to be on data collection; question if we could get CST data included; MHPC Older Adult Committee sending out a survey, would like to see/use that data

Review of May 9th, P3 Family Peer Support Services, P4 Student Assistance Program, P5 Suicide Prevention, P6 Peer Run Crisis Respite Services, now called Peer Run Crisis Stabilization Units

P3: Priority will have 2 yet to be determined indicators, one for Adults, one for Children

P4: SAP program removed as a priority; Doris, from Children's Bureau, will give an update on the new priority (did not get to today, will discuss at next meeting)

P5: The questions that were raised last time are not able to be answered at his time, but we will update when able

Question on whether the general repository of county resources will be available to the public, or just 988 operators and also who will be responsible for updating it

Suggestion to get suicide data from BHMCOs

P6: Will be using demographic data from CMSU & Allegheny counties; particularly interested in how many go on to the ER after PRCSU, how many are unique Vs readmissions, how were they referred to PRCSU

Review of May 10th, P7 Mobile Crisis Services, P8 FEP

P7: Overall agreement that the indicators should include data on 302s, Mobile Mental Health Treatment Teams, Walk-in Centers, and CIT/First responder training (not just how many trained, but how many programs enacted)

P8: we did not get to today, but there had been overall agreement at the May 10th meeting to continue this one as is

Follow Up Item	Person(s) Responsible	Due Date
Development of final priorities doc	Kayla & Dawn	6/23/23

Next meeting 6/23/23 11-12

pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES

MHPC CMHSBG Application Workgroup
Meeting Minutes

Date:	5/23/23		
Location:	Microsoft Teams		
Facilitator(s):	Kayla Sheffer & Dawn Comly		
Attendance			
MHPC:	**Kathy Quick**	Ruth Fox	Linda Shumaker
	Andy Kind Rubin		
OMHSAS:	Doris Arena	Lindsay Graves	

Agenda: Finish reviewing Priorities

Notes: Kayla gave an update on the 988 repository; it will not be publicly accessible; if you want information added or deleted contact your County administrator

P8 FEP review: agreement to keep priority & indicators, but would like to see support for provider burnout added, also consider Coordination among multiple counties, Communities of Practice.

P4 Trauma Sensitive Certified RTFs: Doris gave the presentation of what the Children's Bureau would like to make the new Priority; the indicators would be:

1. Number of OMHSAS certified RTFs that become designated trauma sensitive providers and

2. Number of OMHSAS certified RTFs that have completed trauma sensitive staff training

The workgroup would like to know what criteria is used for certification; Doris will find out & get back to them

They would also like to see outcomes measured instead of just the number of trainings & certifications

They would also like to see Family Peer Support & Youth Peer Support added

Follow Up Item	Person(s) Responsible	Due Date
Will send out Priorities doc when indicators for Priority 3 are received	Kayla & Dawn	5/31/23
RTF Trauma Certification criteria	Doris	5/31/23

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
January Abel	Providers		Lancaster County PA,	
Rebecca Bonner	Providers		Philadelphia PA,	
Tracy Carney	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Montour County PA,	
Heidi Champa	State Employees		Dauphin County PA,	
Greg Cherpes	State Employees		Allegheny County PA,	
Lynn Cooper	Providers		Imperial PA,	lcooper@p4a.org
Kathyann Corl	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Dauphin County PA,	episfrn@aol.com
Julie Dees	Providers		Montgomery County PA,	jdees@fsabc.org
Shashi Dehaen	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Montour County PA,	025services@gmail.com
Alfred Derro IV	Others (Advocates who are not State employees or providers)		Souderton PA,	alfred.derroiv@sluhn.org
Amanda Dorris	State Employees		Dauphin County PA,	adorris@pa.gov
Keith Elders	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Cambria County PA,	keithrelders@gmail.com
Marjorie Faish	State Employees		Dauphin County PA,	mfaish@pa.gov
	Family Members of Individuals in			

Debbie Ference	Recovery (to include family members of adults with SMI)		Butler County PA,	dference@namikeystonepa.org
Dave Fetterman	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Schuylkill County PA,	dfet@ptd.net
Ruth Fox	Parents of children with SED		Allegheny County PA,	rfox@alleghenyfamilynetwork.org
Kathleen Ganely	Others (Advocates who are not State employees or providers)		Allegheny County PA,	kganley@peer-support.org
Sandra Goetze	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Butler County PA,	sgoetze@zoominternet.net
Beverly Haberle	Providers		Bucks County PA,	bhaberle@councilsepa.org
Tara Harper	Others (Advocates who are not State employees or providers)		Wallingford PA,	harper611@comcast.net
Mary Jones	State Employees		Dauphin County PA,	mjones1@pa.gov
Anne Katona-Linn	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Northumberland County PA,	akatonalinn15@gmail.com
Lisa Kennedy	Parents of children with SED		York County PA,	lmkennedy1@yahoo.com
Andrew Kind-Rubin	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Delaware County PA,	akindrubin@cgrc.org
Alex Knapp	Others (Advocates who are not State employees or providers)		Allegheny County PA,	acknapp.2014@gmail.com
Jackie Kreshock	Providers		Camp Hill PA,	jackiek@pccyfs.org
Robin Kunkel	State Employees		Dauphin County PA,	ekunkel@pa.gov
Joe Labosky	Providers		Northumberland PA,	joe.labosky@norrycopa.net
Kathy Laws	Parents of children with SED		Montgomery County PA,	kathylaws33@gmail.com
Diane Lichtman	Others (Advocates who are not State employees or providers)		Allegheny County PA,	dsl456@gmail.com
Minta Livengood	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Indiana County PA,	livengoodminta@gmail.com
Lisa Lowrie	Others (Advocates who are not State employees or providers)		Pittsburgh PA,	llowrie@thebradleycenter.org
Karen Mallah	Providers		Cumberland County PA,	mallahk@ccbh.com
Stephanie Meyer	State Employees		Harrisburg PA,	stmeyer@pa.gov
Dana Milakovic	State Employees		Dauphin County PA,	damilakovi@pa.gov
Thomas Mirabella	Others (Advocates who are not State employees or providers)		Lehigh County PA,	tmirabella@eastpennsd.org

Grace Moore-Mattes	Others (Advocates who are not State employees or providers)		Bethlehem PA,	gmooremattes@gmail.com
Andy Natalie	Providers		Berks County PA,	anatalie@trsinc.org
Audrey O'Connor	State Employees		Harrisburg PA,	auoconnor@pa.gov
Sandy Paradis	State Employees		Harrisburg PA,	sparadis@pa.gov
Hope Pesner	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Lancaster County PA,	hopepesner@gmail.com
Kevin Puskaric	Providers		Claysville PA,	kevin@pmhca.org
Kathy Quick	Parents of children with SED		Schuylkill County PA,	kathy@pmhca.org
Jason Rilogio	Providers		Johnstown PA,	jason@papsc.org
Tracey Riper-Thomas	Providers		Norristown PA,	triperthomas@montcopa.org
Tristan Schnoke	Others (Advocates who are not State employees or providers)		Schuylkill County PA,	Tristan@youthmovepa.org
Jim Sharp	Providers		Dauphin County PA,	jsharp@paproviders.org
Linda Shumaker	Providers		Dauphin County PA,	optimizeaging@gmail.com
Karen Steele	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Westmoreland County PA,	karan.steele@beaconhealthoptions.com
Jill Valiant	Providers		Bucks County PA,	jill.valiant@sluhn.org
Becky Van de Groef	Providers		Adams County PA,	rvandergroef@hoffmanhomes.com
Jackie Weaknecht	State Employees		Dauphin County PA,	jweaknecht@pa.gov
Denise Whalen	Providers		Pottsville PA,	denisewhalenlpc@gmail.com

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	6	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	6	
Parents of children with SED	4	
Vacancies (individual & family members)		
Others (Advocates who are not State employees or providers)	9	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**25**	**47.17%**
State Employees	11	
Providers	17	
Vacancies		
Total State Employees & Providers	**28**	**52.83%**
Individuals/Family Members from Diverse Racial and Ethnic Populations		
Individuals/Family Members from LGBTQI+ Populations		
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**53**	

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

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Footnotes: