State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State DUNS Number

Number 796567790

Expiration Date

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 Beechmont Bldg #32, PO Box 2675

City Harrisburg

Zip Code 17105-2675

II. Contact Person for the Grantee of the Block Grant

First Name Dennis

Last Name Marion

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

Mailing Address PO Box 2675 #11, DGS Complex, Administration Building

City Harrisburg

Zip Code 17110

Telephone 717-787-6443

Fax

Email Address dmarion@pa.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Jill

Last Name Stemple

Telephone 717-409-3790

Fax 717-772-7964

Email Address jistemple@pa.gov

Footnotes:

State Information

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

Fiscal Year 2016

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**
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

Note: 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 nineteen 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 with the 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

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(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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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 (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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: Dennis Marion

Signature of CEO or Designee[1]: _____

Title: Deputy Secretary

Date Signed: _____

mm/dd/yyyy

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

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	Dennis Marion
Title	Deputy Secretary
Organization	Services/Office of Mental Health and Subs

Signature: _____ Date: _____

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health 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 SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

STRENGTHS AND NEEDS OF THE SERVICE SYSTEM

Legislative Base

The mental health system in Pennsylvania is organized in conformance with the Mental Health/ Intellectual Disabilities (MH/ID) Act of 1966, the Mental Health Procedures Act (MHPA) of 1976 as amended, and the Public Welfare Code. Primary authority for the Commonwealth's public mental health program derives from these two acts. 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. Two more recent statutes, namely, Act 80 of 2012 and Act 55 of 2013 modified the funding mechanism by affording greater flexibility to counties in managing their state allotted dollars.

Role of State Government

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 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 as DHS in September 2014 to be more reflective of the wide array of services provided by the Department. The various program offices under DHS include:

- OMHSAS
- 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 most of the 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; the estimated FY 2015/16 budget for behavioral health is more than $5 billion in state and federal dollars.

The Bureau of Children's Behavioral Health Services (hereafter known as the 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 provides 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 15 counties involved in the High Fidelity Wraparound system, which include the 13 System of Care counties, as well as, Allegheny and Bucks Counties. Over 1500 youth and their families have been served since the initiation of High Fidelity Wraparound in 2008.

Programs in other state agencies, which have a relationship with the mental health system, include the Departments of Aging, Corrections, Education, Drug & Alcohol, and Health, as well as the Office of Vocational Rehabilitation within the Department of Labor and Industry.

OMHSAS utilizes the counsel and recommendations of the Mental Health Planning Council in the planning, provision, and development of behavioral health and substance abuse services in the state. The State's Mental Health Planning Council is comprised of three distinct committees for adults, older adults, and children, as well as a subcommittee for persons in recovery.

State Mental Hospitals

OMHSAS directly operates six state mental 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 with special needs whose needs cannot be met by other community nursing facilities. Children and adolescents are not served in state hospitals. 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 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 closure of Allentown State Hospital in December 2010 is a continuation of the State's plan to create a more unified approach to funding community services and supports for those living with mental illness.

Highlights of the Projected Mental Health Budget for FY 2015/16

- Community Mental Health Services: $629.8 million, that include:
    - Base Funds for Community Programs
    - Children's programs
    - The Community/Hospital Integration Projects Program (CHIPPs)
    - Southeastern Integration Projects Program (SIPPs)
    - Behavioral health Services Initiative (BHSI) - Mental Health
    - Federal MH Block Grant
    - MH allocation of the federal Social Services Block Grant
    - Projects for Assistance in Transition from Homelessness (PATH) federal grant
    - Other federal grants
- State Hospitals: $424.4 million
- OMHSAS Administered BHSI/D&A & Act 152: $43.1 million
- Medicaid: $3.94 billion, including managed care and fee-for-service.
- Special Pharmaceutical Benefits Program (SPBP): $1.4 million

Role of Counties

The Mental Health and Mental Retardation (MH/ID) Act of 1966 requires county governments to provide community mental health services, including short-term inpatient treatment, partial hospitalization, outpatient care, emergency services, specialized rehabilitation training, vocational rehabilitation, and residential arrangements. 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/MR 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, PATH grant, and other federal grants comprise much of the funding pool that County MH/MR programs use to provide services to their consumers. Some other resources available to the counties and providers include OMHSAS funded/sponsored technical assistance (TA) and training on a variety of areas. Some examples are Peer Specialist training, Case Management training, TA in the development of evidence-based practices like Assertive Community Treatment, the Youth and Family Training Institute, and TA for the development of housing options in the counties.

County Human Services Planning Process

In 2012, as part of Department'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 System 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 included specific planning requirements for different service areas, namely, Mental Health, Drug and Alcohol Services under DHS's jurisdiction, Intellectual Disabilities, Child Welfare, and Homeless Assistance Programs. For the mental health part, the counties had 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 managed care was completed in July 2007, when the final set of counties moved to HealthChoices, Pennsylvania's managed care system. In Pennsylvania, behavioral health services are "carved out" from the physical health managed care. The success of the HealthChoices Behavioral Health (HC-BH) managed care program was built in partnership with county governments. County governments were given the right of first opportunity to bid on the HC-BH program to manage risk-based contracts. 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 January 1st, 2015, 1.9 million individuals were enrolled in HC-BH, with a projected funding of $3.9 billion in fiscal year 2015/2016.

New Initiatives

Mental Health Matters

In 2013, DHS/OMHSAS launched a broad, long-term campaign called *Mental Health Matters* to help eliminate mental health stigma and prejudices that prevent people from reaching out for help. The intent was to increase awareness that mental health disorders are real and that they can be treated or managed just like physical illnesses.

The Mental Health Matters campaign builds awareness through multiple efforts, for example:

- **Additional mental health first aid training**: Providing support to enable Counties to sponsor Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) training. The goal is to have MHFA and/or YMHFA available in all counties in the Commonwealth. Part of these efforts also would include training non-professionals such as librarians or soup kitchen volunteers to quickly identify a mental disorder and equip them with the means to help. This training is already provided to many police, medics and school counselors.

- **Families as first responders**: Empower families with the knowledge to identify the early signs of mental illness before a crisis occurs because families are truly on the front lines of mental health awareness.

- **Reduce suicides among veterans:** Pennsylvania has the second highest suicide rate for veterans: 16 a day. A collaborative public-private effort is underway to address the needs of our veterans returning from war.

In FY 2014-15, about half a million dollars were allocated to 45 counties/joinders as part of the Mental Health Matter grants instituted to operationalize various aspects of this campaign.

Service Members, Veterans, Family Members Military Project

This is a project done in collaboration with other state agencies and other entities in the field. The priorities for this project include:

•Suicide Prevention;
•Increasing training for providers;
•Improving behavioral health system to meet the needs of population;
•Developing referral system.

STATUTORY CRITERIA ADDRESSED IN THE STATE PLAN

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

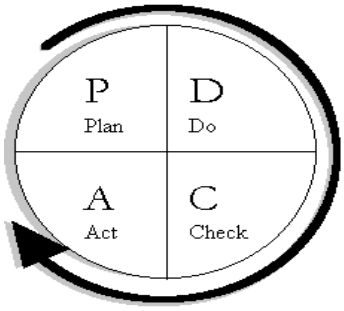
[*The system/services discussed under this criterion apply to both adults as well as children (if the services are age appropriate for children). Services specific to children are discussed under criterion 3]*

(a) Establishment of System of Care

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 family members, consumers, 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 his/her desires, choices, strengths and treatment needs.

Quality Management



OMHSAS has made changes in their Quality Management programming using the continuous quality improvement cycle of PLAN-DO-CHECK-ACT. In December 2014, submitted to DHS a Quality Management Strategy that was reviewed by the OMHSAS Planning Council and published for public comment. It was part of the Medical Assistance Quality Strategy for Pennsylvania and submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. This allows OMHSAS to position itself with respect to the goals, principles and values of itself and DHS, and to align with the healthcare coordination and integration priorities identified in *CMS Quality Strategy 2013-Beyond* and strategies as outlined by SAMHSA in Leading *Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018.*

Performance Measurement Reporting

The performance measurements and the BH-MCO average results for the measurement years 2009-2013 are as follows:

Statewide BH-MCO averages (%)

Performance Measures	2009	2010	2011	2012	2013
Follow up after Hospitalization for Mental Illness-7 days (HEDIS®) (QI-1)[1]	45.2	45.4	45.8	47.2	46.9

[1] CMS Adult Core Measure

Follow up after Hospitalization for Mental Illness-30 days (HEDIS®) (QI-2)[2]	65.4	66.2	66.8	67.8	67.5
PA Specific Follow up after Hospitalization for Mental Illness-7 days (PA Specific Measure) [3] (QI-A)	58.6	57.5	57.6	58.6	57.0
PA Specific Follow up after Hospitalization for Mental Illness-30 days (PA Specific Measure) [4] (QI-B)	74.8	74.1	74.7	75.0	73.4
Readmission within 30 Days of an Inpatient Psychiatric Discharge (REA)	12.3	12.4	12.3	12.7	13.3
Performance Measures	2009	2010	2011	2012	2013*
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)[5]				Initiation[6]	29.9
				Engagement[7]	20.6

* This measure reported in the 2013 Calendar Year

The Statewide BH-MCO averages show consistent, non-significant improvement in 2009, 2010, 2011, a slight improvement in 2012 and a decrease for Follow-up after a Mental Health Hospitalization in QI 1, QI 2, QI-A and QI-B in 2013. The Statewide BH-MCO average for REA is a flat performance for 2009, 2010, 2011 which worsened (increased percentage) in 2012 and 2013.

OMHSAS has collaborated with the EQRO vendor to demonstrate a quality improvement function by requiring that the BH-MCOs (Behavioral Health Managed Care Organizations) would perform a Root Cause Analysis (RCA) if their average (performance) for the first five performance measures above fell into three categories of evaluation. The RCA was required when the BH-MCOs average was:

[2] Ibid

[3] The measure specification for the PA Specific Follow-up after Hospitalization for Mental Illness within Seven and Thirty Days include PA services that are supplemental and recovery-oriented, in addition to the services covered by the HEDIS® specification for Follow-up After Hospitalization for Mental Illness within Seven and Thirty Days After Discharge

[4] Ibid.

[5] CMS Adult Core Measure

[6] Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

[7] Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

1) lower than the prior year,
2) lower than the state BH-MCO average for that particular measurement, or
3) had remained the same when the one year was compared to the former year.

In 2013, OMHSAS made a decision to change the RCA requirements to emphasize improvement for QI-1 and QI-2. These two measures were identified as drivers to improve all four follow up measures after hospitalization for mental illness, and the majority of follow-up visits were for the ages 6-64. (Please refer to footnote "1" above concerning the measurement specifications for QI-1, QI-2, QI-A and QI-B.). The RCA requirements have remained the same for QI-A, QI-B and REA. The IET measure specification includes physical health and behavioral health encounters. OMHSAS is currently in discussions with the Office of Medical Assistance Programs to create performance expectations for both the PH-MCOs and the BH-MCOs to improve this measure.

New 2013 Performance Measure Goal Requirement

The following activities listed below describe five key components of quality improvement: goals, interventions, metrics, targets, transparency and feedback[8] as related to the new performance goal requirements for QI-1(ages 6-64) and QI-2 (ages 6-64).

Quality Activities	Goals	Intervention	Metrics	Targets	Transparency & Feedback
Performance Measurement reporting QI-1 and QI-2 (change)	Yearly Goal setting for HCBH Primary Contractors and BH-MCOs	BH-MCO Root Cause Analysis triggered by performance falling below the 75th Percentile on the HEDIS® MCO Medicaid reporting	Follow-up After Hospitalization for Mental Illness within Seven and Thirty Days After Discharge (ages 6-64)	Target based 75th Percentile on the HEDIS® Quality Compass MCO Medicaid reporting	The EQRO assesses the compliance of the performance measure protocol Results and compliance posted on DHS website in the BH-MCO BBA Technical

[8] See November 22, 2013, Letter to State Health Official and State Medicaid Director

					Report OMHSAS reports the collective semiannual HCBH Primary Contractor results back to the HCBH Primary Contractors and BH-MCOs un-blinded

New 2014 Performance Improvement Project (PIP)

After reviewing the statewide results for Readmission within 30 Days of an Inpatient Psychiatric Discharge, OMHSAS selected a new PIP with the goal of increasing the successful transition of individuals from Inpatient Psychiatric settings to Ambulatory Care. All of the BH-MCOs are required to do the same PIP, and additional Technical Assistance has been provided by the EQRO to meet this CMS requirement.

The following activities listed below describe the five key improvement components to the new PIP.

Quality Activities	Goals	Intervention	Metrics	Targets	Transparency & Feedback
PIP project "Successful Transitions from Inpatient Care to Ambulatory	Reduce BH Readmissions and Substance Abuse (SA) Readmissions post-inpatient	PIP plan interventions as developed from the collaboration between the BH-MCO	BH Readmission within 30 days of MH inpatient discharge	Improvement targets set by selected process measures and PIP measures reassessment	Meetings held with each BH-MCO separately. Included are the EQRO,

Care”	discharge Increase kept ambulatory follow-up appointments post-inpatient discharge Improve medication adherence post-inpatient discharge	and the HCBH Primary Contractors specific to BH-MCO barrier analysis	BH Readmission within 30 days of SA inpatient discharge Adherence to Antipsychotic Medications for Individuals with Schizophrenia Components of Discharge Management Planning	of implementation plan process measures	OMHSAS, and their HCBH Primary Contractor network to review the PIP issues found. (Frequency is TBD.) One QM Directors’ meeting a year will be in person and include all BH-MCOs and HCBH Primary Contractor s to share results across the state. PIP Yearly Report to EQRO and OMHSAS Compliance results reported in the BH-MCO BBA Technical Report and posted on DHS website

Data Strategy

An OMHSAS Data Strategy for Fiscal Years 2009-2011 was the framework that capitalized on the system's data-oriented strengths, while implementing a multi-faceted approach to overcome data-related shortcomings. This document offered a description of the two-year course that OMHSAS charted to maximize the use of data in support of its organizational mission. The data strategy is outlined using five SMART goals (**S**trategic, **M**easurable, **A**ctionable, **R**ealistic, **T**imely). The goals include:

- **Realign Resources to Build Infrastructure:** Realign essential resources in order to build needed data infrastructure;
- **Enhance Data Consolidation:** Enhance the consolidation of data collection and storage processes in order to eliminate redundancies and maximize efficiencies;
- **Improve Data Integrity:** Improve the integrity of behavioral health data to make certain that the data is of an inherent high quality;
- **Enrich Information Sharing:** Enrich the capacity of, and opportunities for, information sharing that support the interests and needs of the varied stakeholders.

To align the data strategy with actions, OMHSAS has embarked on the Consolidated Community Reporting Initiative to build a statewide infrastructure necessary to report consumer level service utilization and outcome information on persons receiving County base-funded mental health services. OMHSAS has also contracted with an External Quality Review Organization (EQRO) vendor to provide a multi-year HealthChoices (HC) encounter data validation process. Quality encounter data serves multiple purposes, such as determining capitation rates, the identification of utilization trends, patterns of care and potential waste.

Other QM Activities

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

- **Focused Studies**
  - **Follow-up after Hospitalization for Mental Illness**– Annual
  - **Joint Physical Health/Behavioral Health Readmission Study**
- **Performance Measures monitoring (other uses)** Semiannually, or as determined by the QM work plans submitted by the HC Contractors. Monitoring the various processes provides current information to the BH-MCO, HC Contracts and to 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 HC

Contracts. This survey is used locally to assess satisfaction with plan, providers, identify service needs, access issues, and areas for improvement or new services. The statewide questions are reported quarterly to OMHSAS and used as an on-going source of information about the satisfaction of adult and children HC members

- **External Quality Review -** The EQR-related activities that must be included in an annual detailed technical report are reviewed to determine MCO compliance with the:
    - structure and operations standards established by the State,
    - validation of performance improvement projects,
    - validation of plan performance measures.
    - In addition, OMHSAS will implement additional voluntary EQR Protocols with BH-MCOs to meet Pennsylvania's data strategic goals & initiatives. These include the following:
        - BH encounter data validation comparing the BH-MCO performance measure submissions to the encounters submitted to OMHSAS.
- **Data analysis (non-claims) - Behavioral Health Denials of Referral Requests** – Annual reviews/quarterly data; Results of the reviews entered into a database and summarized; Findings used to complete the annual Program Evaluation Performance Summary (PEPS) for each County/BH-MCO.
- **Behavioral Health Complaints, Grievances and Appeals Data –** Quarterly data; Used to track and trend denied service grievances and other problems within the system; Can also be used to identify problems with the County, BH-MCO or providers.
- **Health Status/ Outcomes –** Annually; Monitoring and reporting provide ongoing information to the County and BH-MCO regarding the relative impact of activities designed to improve health status and outcomes. At the OMHSAS level, the activity provides a systemic overview of activities at local levels and allows for the identification of areas for improvement and successful/ potential best practices. (This report is currently undergoing a revision as we have moved into a new waiver.)
- **Provider Self Report Data - Survey of Providers** – Annual; Activity provides information related to the provider perspective as to how the BH-MCO manages the network. Analysis of results leads to identification of barriers to quality operation and opportunities to improve provider related processes.
- **Program Evaluation Performance Summary (PEPS) –** Annual; Periodic review of compliance with 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 found to be less than full compliance can result in a Corrective Action Plan (CAP), which is followed until resolution. OMHSAS has implemented a PEPS web-based application to speed the collection of monitoring data and to increase the efficiency of the input of data and data retrieval for program monitoring needs.

(b) Available Services

Health, Mental Health, and Rehabilitation Services

Medical Assistance for Workers with Disabilities (MAWD)

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 steady increase in the number of individuals with disabilities returning to competitive employment in the community workforce.

Assertive Community Treatment (ACT)

Over the past few years, OMHSAS has strongly promoted the expansion of fidelity-based ACT programs in the state. Pennsylvania currently has 41 ACT or ACT-like programs (also called Community Treatment Teams – CTT) in the state. There has been some transition; closures of a few teams, and establishment of some new ones in the past two years. The ACT bulletin issued by OMHSAS in 2008 established the standards for the delivery of ACT services in the state. In late summer 2010, OMHSAS piloted a standard statewide licensing tool, with the intention of using the tool to license ACT teams across the state. This tool is currently being used to license all ACT teams across the state. Licensing began late 2011, and as of July 2015, 36 of 41 teams have been licensed.

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 home in the evening
- An evening service designed for persons working and/or in residential care

- A weekend program

Outpatient Services

Outpatient services are treatment-oriented services provided to consumers 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 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 interested community persons
- 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

OMHSAS recognizes the critical role of a responsive crisis system in reducing the intensity and duration of the individual's distress and utilizing least restrictive options while ensuring safety. Mental Health Crisis Intervention Services are defined as immediate, crisis-oriented services designed to ameliorate or resolve precipitating stress that are provided to adults or children and adolescents and their families who exhibit an acute problem of disturbed thought, behavior, mood or social relationships. These services provide rapid response to crisis situations which threaten the well-being of the individual or others.

Mental Health Crisis Intervention (MHCI) services include intervention, assessment, counseling, screening, and disposition. 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 intervention services as part of the program access standards for members. Within Pennsylvania's mental health service system, telephone, walk-in, mobile and residential 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.

As part of the review of the existing crisis intervention system and the continued transformation of the entire mental health system to a recovery-oriented system, OMHSAS has engaged a stakeholder workgroup to provide recommendations for improving the system.

Understanding that any crisis situation has the potential to traumatize the individual who may be subjected to forcible removal from their home, being taken into police custody, transported to a hospital in a police car or ambulance, involuntarily evaluated in an emergency department of a local hospital, and civilly committed to a psychiatric facility against their will, the need for the delivery of effective crisis intervention services in the community is an essential part of the mental health service system.

Based upon the recommendations of the workgroup, OMHSAS is developing a series of training products that will be available to all county crisis service system and their community partners to ensure that standardized training is provided. The first product developed was a regional training on the Mental Health Procedures Act to address the interpretation and application of voluntary and involuntary treatment. The training included information on crisis diversion services as options to inpatient treatment when appropriate and information from a consumer and peer perspective on the delivery of crisis intervention services.

The second product that is under development is a comprehensive training manual and toolkit that will provide standardized material and information on crisis intervention and emergency response to mental health crisis. The manual will include information related to Pennsylvania law and regulations on crisis intervention and emergency commitment, application and interpretation information, skill building information, research and resource information.

Additionally, a series of webinars will be developed to provide ongoing information related to the Mental Health Procedures Act and other related topics. OMHSAS is exploring options for the development of a series of web-based trainings for community partners as a compliment to the training manual.

OMHSAS was the recipient of a Transformation Transfer Initiative (TTI) grant to infuse peer specialists into crisis intervention services. The project will define appropriate roles for Certified Peer Specialists (CPS) within the delivery of crisis services, develop a comprehensive training program for CPS to enhance their knowledge and skills related to crisis intervention, provide technical assistance to counties interested in utilizing CPS in their existing crisis system, and deliver regional training for the network of current CPS interested in crisis intervention work. The goal of this project is to enhance the existing crisis intervention system by infusing CPS services as a part of the crisis response. This need was identified as part of the ongoing discussion of crisis needs with stakeholders.

Rehabilitation Service

Pennsylvania Psychiatric Rehabilitation Services (PRS) operate under Chapter 5230 the PRS Regulation promulgated in 2013. PRS has expanded from 22 licensed providers in 2005, to 129 licensed providers at the present time. 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.

Fairweather lodges are small groups of four to eight people who share a house and own a small business. Each group must select a business to operate, for which they develop and implement a business plan. 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 38 Fairweather lodges with an additional 10 lodges in various stages of development. Pennsylvania is at the forefront of the development of a nationally endorsed certification plan and process to insure fidelity to the Fairweather lodge standards. Certification of all Pennsylvania lodges, regarding adherence to Fairweather lodge fidelity standards, will be monitored during site visits to existing lodge programs. Pennsylvania recognizes the importance of continued and consistent participation in national outcome reporting by all Pennsylvania lodges. Currently several Pennsylvania lodges participate in national outcome reporting.

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. Pennsylvania will host the National Fairweather Lodge Conference in Pittsburgh in September of 2015.

Membership in the Pennsylvania Clubhouse Coalition (PCC) is contingent upon a clubhouse having or moving toward Clubhouse International certification and fidelity to the clubhouse principles. The PCC has one of the largest number of certified clubhouses of any state in the nation. PCC currently has 22 clubhouses ICCD certified, and all are OMHSAS licensed under Chapter 5230.

Employment Services

Employment First State Leadership Mentoring Program (EFSLMP)

PA received a grant from the Office of Disability Employment Policy (ODEP) for technical assistance on becoming an Employment First State. OMHSAS has partnered with various other State Agencies/Departments to collaborate on drafting a Governor's Executive Order to encourage employment and secondary education of all individuals with disabilities and employment of transition-age youth. PA is also working towards having pilot programs with several different school districts across the Commonwealth to better support transition-age youth by trying two different employment opportunities prior to leaving school.

OMHSAS has been actively involved in the technical assistance from various subject matter experts assigned to help PA reach its goal of becoming an Employment First state. The draft Executive Order will be presented to the Governor in the Fall of 2015. The pilot projects will be under way by late 2015 or early 2016.

Single Point of Contact (SPOC)

In 2013, a stakeholder workgroup was formed to enlist the help of State/County agencies, providers, employment entities, and advocates in assisting the United Cerebral Palsy (UCP) with an employment project for all individuals with disabilities. The co-lead agency for this project, Office of Vocational Rehabilitation (OVR), has become the SPOC for all interested individuals in this initiative. The group worked with the Hershey Company and a few other large corporations, and is still expanding their employer network. The Hershey Company and other companies since have agreed to hire persons with disabilities and provide additional supports, as needed, for qualified individuals. This initiative has slowly been expanding and employers are moving toward company-wide integration. For example, The Hershey Company now has several individuals with disabilities working at all of their plants internationally and this continues to grow.

Housing Services

OMHSAS has implemented an OMHSAS Permanent Supportive Housing Initiative utilizing local, state and federal resources to expand affordable, supportive housing and residential programs for adults. Over the past seven years, this initiative has been instrumental in County MH/IDD/SA (Counties) and Health Choices programs adopting County Program Housing Plans that in turn have led to the creation of exemplary housing programs across the state with participation from qualified housing organizations, consumers, providers and stakeholders

This commitment is based on the principle that where people live matters; it is essential to recovery. It is also a practical commitment. Permanent Supportive Housing (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. It provides the opportunity for consumers to live in more integrated settings which are essential to their quality of life and community sustainability. Based on repeated cost comparisons, it enables Counties to reduce costs of associated with legacy housing programs including CRRS and LTSRs, acute and institutional care. The OMHSAS Initiative was critical to the state's ability to make a competitive application for 811 PRA resources and is essential for OMHSAS and Counties to meet their Olmstead integration obligation.

Fifty nine counties have made Reinvestment resources (capitation savings) available as part of the OMHSAS PSH Initiative. OMHSAS has focused this initiative on the development of integrated housing which is typically either: scattered, clustered or single site housing such as shared housing, with three or less consumers living in a single family setting or rental unit.

PSH is typically created by utilizing and combining fund sources to assure 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, a **housing clearinghouse** to manage outreach and referral to PSH options, **housing support services** and **contingency** funds such as security deposit or payment of back rent. OMHSAS provides limited technical assistance and training for this program.

A significant benefit of the PSH program is the operating principle that no one should pay more than 30% of their income in rent. While OMHSAS and Counties take many steps to assure housing meets this standard, it is difficult to find affordable housing in most Pennsylvania communities. According to *Priced Out in 2014: The Housing Crisis for People with Disabilities,* there are 238,702 people receiving SSI and the SSI payment is equal to just 19.4% of the area median income statewide. The average cost of a one bedroom market rate rental in Pennsylvania was 98% of an individual's monthly SSI check. In three local housing market areas, fair-market rents are above 100% with Philadelphia (and including Wilmington and Camden) being at 129%. With counties in Marcellus Shale impacted areas, rents are going up faster along with a notable decrease in the availability of any housing regardless of its cost or suitability.

The goals of the OMHSAS PSH Initiative are: (1) to create affordable supportive housing for people with disabilities, specifically OMHSAS/DHS target populations, and (2) to use Health Choices Reinvestment, CHIPPS or base funding to access and leverage mainstream housing resources and create partnerships with state and local housing and community development entities. The data collected in April 2012, indicate Counties are having remarkable success achieving these goals and meeting the vast majority of their own local housing targets. There are some indicators the program when fully implemented may exceed expectations.

Summary data for the original fifty three counties from the April 2012 data revealed:

- Health Choices investments leveraged between three and four times the Reinvestment amount in other housing resources including other capital such as HOME funds, ACT

137 and Low Income Housing Tax Credits as well as federally funded tenant- and project-based vouchers.

- Initially, counties expected to serve over 3,300 consumers when funds were fully expended. Since programs will be expanding and some units are set aside for 20-30 years, it is likely Counties will serve significantly more households than expected. This is due in large part to Counties utilizing beneficial leveraging strategies and some counties using funds for helping consumers get into housing including paying deposits and move in expenses even as funds for rental subsidies were already committed or not available.

The fifty three counties represented in 2012, continue to grow their housing programs. From January 2013 through June 2015, a total of $30.6 million was added to PSH. These dollars continue to support the seven housing categories below. Since December 2012, six additional counties have dedicated $3.8 million in reinvestment resources to support PSH. The chart identifies the total reinvestment dollars for each of the seven categories and shows the dollars committed, expensed, and remaining, as of June 2015.

Categories	Bridge	Master Lease	Capital	PBOA	Clearinghouse	Housing. Support	Contingency	Other/ TBD	Total $
Commitment			$ 22,718,213.00					$ 716,234.00	$ 23,434,447.00
Expensed	$ 11,550,165.01	$ 5,307,123.01		$ 6,918,323.00	$ 6,933,749.93	$ 8,356,394.46	$ 5,932,911.55		$ 44,998,666.96
Remaining	$ 32,883,639.25	$ 7,680,532.28		$ 4,903,961.37	$ 3,521,791.91	$ 10,597,455.02	$ 5,224,351.39		$ 64,811,731.22
Total Reinvestment Allocation	$ 44,433,804.26	$ 12,987,655.29	$ 22,718,213.00	$ 11,822,284.37	$ 10,455,541.84	$ 18,953,849.48	$ 11,157,262.94	$ 716,234.00	$ 133,244,845.18

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, are at risk for institutionalization including the homeless, criminal justice, and veterans, and other who live in congregate settings. We have been successful in our endeavor for the past 20 years and will continue that success throughout the state.

Substance Abuse Services

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. The Department was funded and implemented in Fiscal Year 2012/13 state budget. The Department 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. The Department 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 the 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 the Department of Human Services, 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 such as the American Society of Addiction Medicine Patient Placement criteria (ASAM-PPC-2R) for children and adolescents under the age of 21. The Pennsylvania Client Placement Criteria (PCPC) is utilized for adults.

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 granting approvals.

Medical and Dental Services

Medical Provisions

With the Medicaid expansion, more than 439,000 new individuals have been enrolled in HealthChoices Medicaid Program as of July 2015. 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 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 Transport; Family Planning Clinic, Services and Supplies; Renal Dialysis

- **Emergency Services** that include: Emergency Room; Ambulance

- **Hospitalization** that include: 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 that include: Outpatient Psychiatric Clinic; Mobile Mental Health Treatment; Outpatient Drug and Alcohol Treatment; Methadone Maintenance; Clozapine; Psychiatric Partial Hospital; Peer Support; Crisis; Targeted Case Management. Additionally, various cost-effective in-lieu of state plan services are also available to individuals

- **Prescription Drugs**

- **Rehabilitation and Habilitation Services and Devices** that include: Skilled Nursing Facility; Home Health Care including Nursing, Aide and Therapy services; ICF/IID and 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** like Tobacco Cessation, etc**.**

Pennsylvania also has a 100% state-funded medical assistance program "General Assistance (GA-MA). Individuals who do not qualify for Medicaid due to certain reasons other than the income limits 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).

Dental Provisions

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:

- All medically necessary dental services for children under age 21
- Adults (individuals 21 years of age or older) are eligible for the following dental services: diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation.

  Key Limitations: Dentures 1 per lifetime; Exams/prophylaxis 1 per 180 days; Crowns, Periodontics and Endodontics only via approved benefit limit exception

Support Services

Suicide Prevention

Pennsylvania follows the National Action Alliance for Suicide Prevention in advancing suicide prevention throughout the Commonwealth. In 2006, Pennsylvania developed a state plan for suicide prevention among Adults and Older Adults. This Plan governs the work of the state's suicide prevention activities involving multiple state offices including the Department of Aging, Department of Corrections, Department of Health, and State Police, as well as key stakeholder groups throughout the state including the Veterans Affairs. In 2012, the National Strategy for Suicide Prevention was revised. In 2014, a stakeholder workgroup was formed and Pennsylvania's state plan for suicide prevention was updated to include what is in the current National Strategy.

The Pennsylvania Adult/Older Adult Suicide Prevention Coalition is in the process of merging with the OMHSAS Pennsylvania Youth Suicide Prevention Initiative (PAYSPI). Their new combined name is Prevent Suicide PA (PSPA). There is currently an interim Board of Directors, and separate committees to focus on the various ages across the lifespan that are served. The Board also has various Committees for members to serve on: Executive, Finance, Training, Communications, and some additional ones deemed necessary based on the merger. The Communications Committee has been and continues to foster a relationship in facilitating the exchange of information between Prevent Suicide PA and local county task forces across the State.

Prevent Suicide PA has expanded its infrastructure by combining both organization websites into one at, www.preventsuicidepa.org. PSPA also has also a quarterly newsletter. There have been over 20 sponsored Question Persuade and Refer (QPR) trainings in the past

year. Prevent Suicide PA held an OMHSAS sponsored Assessing and Managing Suicide Risk (AMSR) Train-the-Trainer in 2014 for approximately 20 people. PSPA sponsored two baseball nights in June 2015, one at the Harrisburg Senators and one at the Philadelphia Phillies, to raise awareness. PSPA is currently in the process of planning an annual Statewide Conference for 2016. Supporting veterans is also a priority, and PSPA participated in Veteran Conferences in 2014 and 2015.

In September of 2014 Pennsylvania was awarded a new federal Garrett Lee Smith youth suicide prevention grant which focuses on screening and prevention in schools and colleges throughout the Commonwealth. The 5 year grant, Suicide Prevention in Schools and Colleges, was awarded by SAMHSA and provides Pennsylvania with $3.5+ million dollars to promote state-wide, systems-level change to advance suicide prevention efforts across the state.

The Suicide Prevention in Schools and Colleges initiative will provide gatekeeper training, suicide risk management training, standardized screening, and training in empirically supported treatments. The project will raise awareness, increase identification of at risk youth, facilitate referrals to treatment, and improve treatment outcomes among youth. In addition, the grant will work to implement sections of the *2012 National Strategy for Suicide Prevention* in order to reduce rates of suicidal ideation, attempts, and deaths.

Compeer

Compeer is non-profit organization that recruits adult volunteers and matches them in intentional friendship with individuals with serious mental illness. Compeer volunteers provide one to one support, friendship and mentor relationships during an individual's recovery process. Compeer services are considered adjunct to traditional mental health services. **In June 2013, the (National Registry of Evidence-based Programs and Practices (NREPP) approved the inclusion of Compeer in the national registry as an evidence-based practice.** The Compeer program has received the Presidential Recognition Award by the 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.

Pennsylvania's Coalition of Compeer affiliates has started a new pilot program called "Compeer Corps Vet to Vet Program" in 2013/2014. Using the Vet2Vet model developed by Compeer Inc. of Rochester NY, this new PA pilot program will focus on the special needs of the veteran population on their path to mental health recovery now that they are back in civilian life. In the past year Compeer has been working on establishing the groundwork for this program.

The PA Compeer Coalition received a $19,000 grant from The Office of Mental Health and Substance Abuse Services (OMHSAS) to be used during the time period of November 1,

2014 to June 30, 2015. The primary purpose of this grant was for the Compeer programs of Pennsylvania to be strengthened through promotion, collaboration, cultural & linguistic competence, and expansion of services to the veteran population. Another application has been submitted to OMHSAS for 2015/2016 to continue their efforts in the implementation of the Compeer Corp Vet2Vet program in Pennsylvania.

Family Support Services

Family Support Services refers to supportive services provided to persons with mental illness and their families. These services are designed to enable persons with mental illness to live at home with minimal stress or disruption to the family unit, or to enable the person to live independently in the community.

Peer Support Services

Pennsylvania's peer specialist initiative continued to grow and develop over the past year. Currently, more than 3900 individuals have met the 75-hour, 10-day training requirement to become Certified Peer Specialists (CPS) and nearly 1,400 individuals have been trained as supervisors of CPS. Pennsylvania currently has the largest cadre of CPS of all states. An estimated 55% to 60% of CPS are employed either full-time or part-time primarily in Medicaid–funded peer support services; however, CPS are continuing to find other field-related employment opportunities and opportunities for career advancement. As of March, 2014, Pennsylvania has 143 approved and licensed peer support service programs.

Pennsylvania has undertaken multiple peer support initiatives. Pennsylvania has developed a one-day, five-hour documentation training course for CPS to enhance their Medicaid documentation skills. Moreover, Pennsylvania, in collaboration with the Temple University Collaborative on Community Inclusion, administered a survey of 200-300 recipients of peer support services at targeted peer support providers. Pennsylvania intends to use the survey data to refine the delivery of peer support services in the Commonwealth. In addition, Pennsylvania's Department of Corrections instituted the 75-hour, 10-day CPS training program within its facilities and has trained more than 500 CPS so far, 10 percent of whom are serving life sentences. Pennsylvania continues to offer an online training course for CPS in supporting individuals with employment goals. The Certified Older Adult Peer Specialist Initiative continues to expand and over 170 individuals have completed the three-day continuing education training and are working with older adults. Four regional two-day CPS/ID continuing education trainings were provided to over 80 CPS and the Veteran CPS training which is a two day continuing education training and has reached more than 100 CPS with additional trainings planned for the future. Pennsylvania has also produced a policy guidance paper for CPS that identifies Medicaid-reimbursable employment services.

Forensic Services

A Center of Excellence (CoE) for the development and improvement of programs serving adults with mental illness involved in the criminal justice system was established in 2010 through a joint grant to Drexel University and University of Pittsburgh Medical Center to act as a clearinghouse for information and resources related to criminal justice, mental health, and substance abuse. Activities and priorities of the CoE are guided by the Advisory Committee and include cross-systems mapping for counties. To date, 39 counties have successfully completed cross-systems mapping workshops and 6 counties are waiting to complete their session in 2015. In addition the CoE has completed a cross-systems mapping for the PA Department of Corrections as it relates to individuals with mental illness serving a state sentence. The CoE completed a survey of 33 county law enforcement and criminal justice offices. Of those surveyed, 56% identified needs focused on training for behavioral health issues. To date, 21 counties have received Crisis Intervention Team (CIT) Training, and an additional 11 counties are in the development phase to provide CIT training.

In partnership with Pennsylvania Mental Health Consumers Association (PMHCA) and Drexel University, OMHSAS developed a forensic peer support curriculum and trained 162 individuals throughout the state. In addition, a total of 43 individuals have been trained as trainers and 5 advanced level facilitators. In collaboration with Pennsylvania Department of Corrections (DoC), a curriculum for Certified Peer Specialist (CPS) training has been developed. Over 600 incarcerated individuals have been trained as Certified Peer Specialists and more than 400 are currently working in the State Correctional Institutions statewide as a CPS.

Criminal Justice Mental Health Advisory Committee, a collaborative effort between OMHSAS and the Pennsylvania Commission on Crime and Delinquency (PCCD), advocates 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; and (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.

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 an in-plan Medicaid 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 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.

Services under the Individuals with Disabilities Education Act (IDEA): Discussed under Criterion 3.

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).

Administrative Case Management

ACM refers to those activities and administrative functions undertaken to ensure 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

Targeted Case Management

TCM is provided in the Commonwealth of Pennsylvania to adults with severe and persistent mental illness and to children with a serious emotional disturbance, who are eligible

for Medical Assistance under the State Plan. Eligibility is defined as categorically needy (aged, blind, disabled-eligible for SSI, and families and children who are eligible for TANF), and medically needy (aged, blind, disabled, families and children). 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 mentally ill individuals 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 serious and persistent mental illness in a variety of ways and is intended to assist the client to achieve 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 serious and persistent mental illness 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 and needs, and assist the person to access 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 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 need, 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 institutes Drexel University Behavioral Health Education, Penn State Education and Health Services and Western Psychiatric Institute and Clinic provide a 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.

Services for Persons with Co-Occurring (Substance Abuse/Mental Health) Disorders

Co-occurring services continue to be supported the Department of Human Services, Office of Mental Health and Substance Abuse Services 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.

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. Training opportunities to enhance clinical skills related to co-occurring disorders continue to be provided by Drexel University, Western Psychiatric Institute, as well as other entities in a variety of locations across the state.

Various regional coalitions continue to develop co-occurring programming resources and support training opportunities for professionals. The counties and MCOs have partnered to increase access to co-occurring services and supports across the state.

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 (CHIPP) and other funding sources.

The Community/Hospital Program Project (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 be involved in the decision making process.

Details regarding how CHIPPs initiative works:

- County submits a proposal to the state for CHIPP discharges as part of annual plan.
- Assessments are completed with people identified for likely CHIPP discharge
- County submits CHIPP budget to state for approval
- County works with local area provider agencies to begin the discharge process and identify best match of consumers
- 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 worth of startup funding.

History of CHIPPs

- CHIPP builds community capacity and infrastructure through transition of funds to meet consumer needs in the community.
- Approximately 4 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 the end of December 2014, hospital census for the six state hospitals was 1082 in civil, 228 in forensic, 147 in long term care (South Mountain) and 46 in the ACT 21 program; total for all levels of care 1503. This signifies a decrease of 57 from the census (1560) from December 2013. At that time civil census was 1160, forensic 132, long term care 141 and ACT 21, 38
- More than 87% of the state mental health budget is now spent on community- based services.
- With the closure of Allentown State Hospital in December 2010, only six state hospitals remain in Pennsylvania.
- Through CHIPP-funded opportunities, 3324 people have been discharged since inception

- During FY 2014/15, Community Hospital Integration Project Program (CHIPP) funding included annualizing 90 CHIPPs from FY 13/14 as well as start-up funding for 65 new CHIPPs.
- The CHIPP/SIPP funding for FY 2014/15 is $257 million.

Criterion 2: Mental Health System Data Epidemiology

(a) Estimate of Prevalence

The newest federal prevalence estimates released in February 2014 via the National Survey on Drug Use and Health (2011-12 Surveys) indicate that 4.06% of the total civilian population of age 18 and over have Serious Mental Illness in Pennsylvania. In addition, the 2014 Behavioral health Barometer published by SAMHSA indicated that during the period of 2009-2013, approximately 3.8% of all adults had SMI within the year of being surveyed. Conversely over the same time period, approximately 8.5% of adolescents ages 12-17 had a Major Depressive Episode within the year of being surveyed.

The following tables show the number of distinct adults (age 18 and above) and children (age 17 and below) that received mental health services during the state FY periods indicated in the tables:

State Fiscal Year	FFS Claims (Under 18)	FFS Claims (18 & Older)	Managed Care (Under 18)	Managed Care (18 & Older)
2012-2013	7,481	43,712	162,137	313,206
2013-2014	4,382	34,573	166,087	318,722

* Fiscal Year **totals** are unduplicated within each payment stream (i.e. HealthChoices, FFS). There may be some duplication between the two payment streams in the FY totals.

* 2013/14 was the most recent FY for which complete information was available.

(b) Quantitative Targets

OMHSAS continues to encourage the trend towards moving funding from state administration to county administration. For the proposed 2015/16 budget, it is estimated that 90% of state dollars ($4,534,308,504) will be under county administration, with only 10% of funds ($507,214,887) under state administration. During FY 2015/16, Community Hospital Integration Projects Program (CHIPP) funding includes the annualization of the FY 2014/15 CHIPPs, as well as the new CHIPPs initiative for FY 2015/16.

As of January 1, 2015, 1.9 million people were enrolled in HealthChoices –Behavioral Health (HC-BH). The projected HC-BH funding for fiscal year 2014/15 is $2.96 billion.

OMHSAS continues to research the possibility of using a different instrument and mechanism for collecting and reporting outcomes data. Currently, a customized version of the

Mental Health Statistics Improvement Program (MHSIP) report card survey instrument is being utilized to survey adult consumers and family members. In 2014, we sent surveys to 5,000 adults and 5,000 families. Our response rate for those mailings was about 31%; and the overall satisfaction rate was approximately 80%.

Medicaid Targets Specific to Children's Services

Based on the expenditure data from the past fiscal year, it is estimated that $1,221,993,000 of HealthChoices (Pennsylvania's Medicaid Managed Care Program) funding will be spent on inpatient, residential, and community based services for children in FY 2015/16. These numbers do not include services funded fully with state, local, or grant (federal or other) dollars. The following chart shows the breakdown of Medicaid funding for various children's behavioral health services:

Service Name	HC Expenditures
Inpatient Psychiatric	$122,311,000
Outpatient Psychiatric	$179,079,000
Behavioral Health Rehab Services	$529,422,000
RTF - Accredited	$135,854,000
RTF - Non Accredited	$38,674,000
Ancillary Support	$858,712
Other	$26,785
Community Support	$144,680,207
Crisis	$2,702,000
Family Based	$99,347,000
Targeted Case Management	*$46,092,000*
Peer Support Services	*$636,510*
Other Community Support	65,540
Substance Abuse Services	$40,107,000
Total	**$1,221,993,000**

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.

Behavioral Health Rehabilitation Services

Behavioral Health Rehabilitation Services (BHRS) are individualized, based on the specific needs of the child and family, and built on the strengths of the child and family. Specific BHR services available through Pennsylvania's expanded Medical Assistance Program for children up to age 21 include: mobile therapy, therapeutic staff support, behavioral specialist consultation and other unique services developed for individual children/adolescents. Children must be Medical Assistance eligible and a licensed practitioner must establish medical necessity for services. Interagency teams are utilized to review recommendations and plan services for the child and their family. Children and families must be included in the interagency team meeting. Nearly 68,000 children are served in BHRS each year.

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, multi-level 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.

Early Childhood Mental Health

OMHSAS, in collaboration with the Office of Child Development and Early Learning (OCDEL) and the Department of Health has been awarded a Project LAUNCH grant from SAMHSA to promote healthy social-emotional development in young children. A State Young Child Wellness Council has been established, as a subcommittee of the State Early Learning Council. Allegheny Count was selected as the demonstration site due to their commitment to early childhood and their willingness to work with the State. A local Young Child Wellness Council has been established to guide the local LAUNCH effort.

There are 5 Core LAUNCH Strategies: Ensuring young children at risk for poor social/emotional or cognitive outcomes are screened and provided services; Integrating physical health and behavioral health services, Providing Early Childhood Mental Health Consultation in Early Care and Education settings, Providing enhanced Home-visiting, and Family Strengthening and Parent Skill Building.

One of the treatment approaches that will be used is Parent-Child Interaction Therapy (PCIT), an evidence-based practice especially well-suited for work with young children and their families. OMHSAS has been the expansion throughout the Commonwealth of PCIT for the past 5 years. OMHSAS staff are members of a statewide steering committee for a grant from the National Institute of Mental Health that has supported training clinicians from 100 agencies in 60 counties across the state. Behavioral health managed care organizations, and commercial insurers are paying for PCIT.

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 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.

Evidence Based Practices

The Children's Bureau continues to meet with Pennsylvania Commission on Crime and Delinquency (PCCD), Office of Children Youth and Families (OCYF), and the Center for Evidence Based Practices EBP to coordinate roles related to funding, data collection, and technical assistance to providers. The Bureau also works to utilize appropriate resources to identify further Evidence Based Practices (EBP) and promising practices. These meetings have been instrumental in supporting the implementation of EBPs in Pennsylvania and have resulted in the development of a new data system to better monitor the outcomes of EBPs in the Commonwealth. In addition to coordination with state partners for EBPs OMHSAS also conducts annual site visits to ensure providers are meeting Medical Assistance standards, as well as maintaining fidelity to the national models.

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.

Currently there are 40 MST teams serving 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.

Functional Family Therapy

Functional Family Therapy (FFT) is an outcome-driven, evidence-based intervention program that treats at-risk adolescents and their families. The program includes children and adolescents from 11 to 18 years of age. It focuses on targeting risk and protective factors in the family system that can be changed, and then systematically working to make the necessary

modifications. The treatment interventions address known causes of delinquency that are related to peer and family dynamics along with school and community factors.

There are currently 9 FFT providers serving 12 counties in the Commonwealth that have been approved by OMHSAS for Medical Assistance funding. The Children's Bureau, in conjunction with the OMHSAS Field Offices, has conducted site reviews of FFT providers. The reviews are based on an extensive survey tool that assesses compliance with a variety of FFT practices along with state regulations and policies.

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, 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/MR 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. Currently, over 600 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 the 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 do not require 24-hour care, but do require more intensive and comprehensive services than are offered in outpatient clinic programs. Children attending partial programs must have a moderate to severe mental or emotional disorder.

Residential Treatment Facilities

Residential treatment facilities (RTF) provide a 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 serious emotional disorder, 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 so that they may achieve, remain in school and advance. SAP teams use concrete, observable behaviors to identify student's barriers to learning. SAP team members do not diagnose, treat, or refer to treatment; however they may refer a student for a MH or D&A screening to assess the need for further treatment if needed. 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 SAP involvement.

OMHSAS, the Department of Education and the Department of Health collaboratively oversee the Student Assistance Program through the PA Network of Student Assistance Programs (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 IU's.) The Regional Coordinators are responsible for the oversight of county SAP operations, as well as of the Commonwealth Approved Trainers, the statewide training network responsible for training school SAP teams. The Regional Staff members are the most direct source of information and SAP coordination at the County level.

64,236 students state wide were referred to school SAP core teams during FY 13/14. Of those students, 20,038 students were referred for drug and alcohol or mental health assessments. Of those students referred for assessment, 17,731 (88.49%) were assessed.

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.

Individualized Education Plans

An Individualized Education Plan (IEP) is a written education program developed for students eligible for special education services. The IEP addresses the student's needs and the educational supports and services required to meet those needs. The IEP is developed by an IEP team consisting of the student's parents, a regular education teacher, a special education teacher, a representative of the local education agency, a person qualified to interpret test results and other findings relevant to their student, and others who may have special knowledge or expertise about the educational services needed by the student. The collaborative efforts between the Departments of Education and Human Services have been promoting the practice of developing the IEP in conjunction with the Interagency Service Plan or Treatment Plan when appropriate for children and adolescents with serious emotional disturbance.

Criterion 4: Targeted Services to Rural and Homeless Populations and Older Adults
[*The system/services discussed under this criterion apply to both adults as well as children/adolescents (if the services are age appropriate for children/adolescents)]*.

(a) Homeless Outreach and Services

The following guiding principles direct the work of the Commonwealth's Interagency Council on Homelessness:

- Assure that the Commonwealth of Pennsylvania provides a continuum of services, coordinated and delivered by agencies, which offer homeless consumers choices in the manner and amount of assistance they will need to achieve and maintain their maximum level of independence.
- Seek creative ways to utilize current resources and to leverage new resources to prevent homelessness and to assist the homeless population.
- Assure access to supportive services and affordable housing in all areas of the state.
- Assure that the quantity and quality of affordable housing and services meets the needs of the homeless population.
- Assure that each state department and agency, in conjunction with the Council, devises plans and strategies designed to prevent homelessness and address the needs of the homeless population that are consistent with the vision statement and guiding principles.
- Assure that the state departments and agencies identify outcomes and strategies to monitor those outcomes.

- Develop and maintain state and local intergovernmental relationships to coordinate and manage resources to assure access by homeless families and individuals.
- Develop community partnerships with private sector businesses, foundations, lenders, civic organizations, hospitals, childcare, and community based social and treatment services to address local homeless needs.
- Assure the prevention of homelessness through improved discharge planning and other prevention techniques and by expanding the number of affordable accessible housing options.

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 and housing services, and through the utilization of state and federal funds, particularly in the large metropolitan areas of Philadelphia and Pittsburgh. Every county mental health program has identified a housing specialist. The specialists receive technical assistance from OMHSAS.

Projects for Assistance in Transition from Homelessness

Created under the McKinney Act, the Projects for Assistance in Transition from Homelessness **(**PATH) Program is a federal formula grant that supports service delivery to individuals with serious mental illnesses, as well as individuals with co-occurring substance use disorders, who are homeless or at risk of becoming homeless.

OMHSAS contracts with 24 County MH/ID program offices to provide PATH services. These 24 county MH/ID offices, which encompass 36 of the state's 67 counties, are local government entities. 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.

Since 2001, Pennsylvania has employed a full-time State PATH Coordinator (SPC). The SPC oversees all activities related to the PATH program. The SPC monitors county MH/ID programs who receive PATH funds as well as the local programs with whom they sub-contract. Monitoring is done through site visits, quarterly plan review and fiscal reporting, quarterly conference calls, technical assistance and ongoing phone and email contacts, etc.

To further ensure compliance, each county has a County PATH Coordinator. The county PATH coordinators work very closely with the contracted agencies to develop and implement

new programs and provide oversight to the existing programs. Thus, Pennsylvania has a two-tiered oversight mechanism, one at the county MH/ID level and another at the state level.

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.

Alignment with SAMHSA's Strategic Initiative #3: Military Families

OMHSAS has always supported PATH programs that have developed collateral contacts with local veterans' organizations to identify and enroll eligible homeless veterans. Additionally, counties have been establishing partnerships with their local Veterans Affairs (VA) offices and other agencies that serve homeless veterans and their families in to better serve this population within the community. Many PATH programs are prioritizing persons who are not VASH eligible for other resources. Several are participating in collaborations for Supportive Services for Veteran Families Program (SSVF) to provide temporary assistance to veterans during a housing crisis. Programs are aimed at preventing homelessness and improving veteran stability. These services include, but are not limited to outreach, case management, transportation assistance, housing counseling, financial planning, legal services, employment search assistance, life skills training, housing vouchers, temporary financial assistance and assistance with obtaining VA and other public benefits. Assistance for individuals with accessing mental health and drug and alcohol counseling is also provided as needed.

OMHSAS will provide support and leadership through a collaborative and comprehensive approach to increase access to appropriate services, prevent suicide, promote emotional health and reduce homelessness among the veteran population. OMHSAS will continue to encourage the use of PATH funding to facilitate PATH-eligible, innovative community-based solutions that foster access to evidence-based prevention, treatment, and recovery support services for military service members, veterans and their families.

Alignment with SAMHSA's Strategic Initiative #4: Recovery Support

In November 2006, *A Plan for Promoting Housing and Recovery-Oriented Services*, hereafter referred to as The Plan, was drafted with support from consumers, providers, county MH/ID programs and other stakeholders. This document provides guidance to county MH/ID programs for their planning, resource allocation, development of effective supportive housing models and modernization of housing approaches. The Plan spells out specific actions for OMHSAS, its state partners and county MH/ID programs for housing policy and development. With this, many counties began partnering with various supportive housing programs within their boundaries to provide PATH-related services to its PATH consumers.

OMHSAS recognizes that in order to recover, people need a safe and stable place to live. Therefore, many PATH programs provide rental assistance and security deposit payments to aid recipients in securing stable housing and receiving the range of supports they need to manage mental illnesses and/or other disabilities. OMHSAS allocates funds to programs that provide linkage and referral services to PATH consumers.

OMHSAS also recognizes that individuals need to be full, participating members of their communities to achieve full recovery. Individuals with behavioral health conditions do not recover in isolation, they recover with families and in the community. Pennsylvania's PATH programs have formed successful collaborations with other community agencies in an effort to promote rehabilitation and support, as well as to increase and accelerate the likelihood of recovery for those with behavioral health illnesses. Some PATH counties have partnered with local drop-in centers and club houses to provide community-based services to its PATH consumers. In addition, several PATH-funded programs employ a peer support specialist to assist PATH consumers in their recovery journey. All of these collaborative efforts help provide much needed social activity, adequate income, personal relationships, recognition and respect from others in the communities.

Homeless Continuum of Care Steering Committee

The statewide Continuum of Care (CoC) Homelessness Steering Committee serves as the working body to support the efforts of the Pennsylvania Interagency Council on Homelessness, which addresses programs and policies to assist the homeless in Pennsylvania. The Department of Community and Economic Development (DCED) and DHS/OMHSAS continue to chair this committee. The SPC also serves on this committee. This Committee works with and through the four rural Regional Homeless Advisory Boards (RHABs) which develop and maintain a Continuum in each region. Together, the RHABs represent 54 of the state's 67 counties. The HUD direct entitlement communities' Continuums of Care are also represented on the Steering Committee, thus making it a statewide vehicle to end homelessness. The CoC Homelessness

Steering Committee defines and addresses those barriers which could ultimately result in homelessness for individuals and their families.

Local Housing Option Teams

OMHSAS provides technical assistance in formation of Local Housing Option Teams (LHOTs). Currently, there are 44 LHOTs operating in 54 counties (out of a total of 67 counties in the state). County team membership includes representatives from the County Office of Mental Health, 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 the 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.

Any local agency that is willing to dedicate time and administrative support to the LHOT may serve as facilitator. In many of the LHOTs, these roles are assumed by the County Mental Health Housing Specialist (who is also usually the county PATH coordinator if the county receives PATH funding). Many of these LHOTS are also involved in their CoC, thus providing more cooperation between providers and agencies.

Agenda for Ending Homelessness

- In November 2005, The Commonwealth developed the "Agenda for Ending Homelessness in Pennsylvania" to govern the work of the Interagency Council and guide the efforts of the Homeless Steering Committee and local CoC. Pennsylvania's Agenda for Ending Homelessness is based upon three state-driven strategies. These strategies serve as the backbone for the implementation of the Plan's Action Steps, which will occur at both the state and local levels. Those strategies include:

- Improve coordination between state agencies and promote targeting of resources consistent with the state vision and guiding principles. A central part of the Agenda is to assess the effectiveness of the current state and local housing and human service delivery systems, and to ensure that they support the above vision and guiding principles.

- Foster and support local efforts to end homelessness. Given the size and diversity of the Commonwealth, the health of the local network of homeless housing and service providers is a critical factor in successfully implementing the Agenda for Ending Homelessness in Pennsylvania. Since every region of the state is different, the Plan must be designed to support local participation, while accommodating regional differences.

Training and technical assistance are needed to build local capacity, especially in areas of the state where resources are limited.

- Promote recovery-oriented housing and services for homeless individuals with serious mental illness, substance abuse and/or co-occurring disorders. The Commonwealth of Pennsylvania, including OMHSAS, has embraced the recovery model for the provision of housing and services to individuals served through the mental health system, including homeless individuals and families. The goals and objectives for preventing and ending chronic and episodic homelessness reflect the state's commitment to the recovery model for all people with serious mental illness.

Homelessness Statistics

The following table shows the homelessness statistics for various regions of Pennsylvania:

CoCs by REGION	**Number of Homeless with SMI - 2015**
1. Southeast PA	
Philadelphia County	1370
Delaware County	189
Montgomery County	155
Bucks County	78
Chester County	71
Total Southeast PA	**1863**
2. Eastern PA	
Previous Altoona/Central PA CoC (Adams, Bedford, Blair, Cambria, Centre, Clinton, Columbia, Cumberland Franklin, Fulton, Huntingdon, Juniata, Lebanon, Lycoming, Mifflin, Montour, Northumberland, Perry, Snyder, Somerset, and Union Counties) and **previous Northeast PA CoC** (Bradford, Carbon, Lehigh, Monroe, Northampton, Pike, Schuylkill, Sullivan,	345

Susquehanna, Tioga, Wayne, and Wyoming Counties) – As of January 2015, merged into **Eastern PA CoC**	
Berks County	57
Dauphin County	87
Lackawanna County	86
Lancaster County	48
Luzerne County	33
York County	56
Total Eastern PA	**712**
3. Western PA	
Previous Southwest PA CoC (Armstrong, Butler, Fayette, Greene, Indiana, Washington, and Westmoreland Counties) and previous **Northwest PA CoC** (Cameron, Clarion, Clearfield, Crawford, Elk, Forest, Jefferson, Lawrence, McKean, Mercer, Potter, Venango, and Warren Counties)	272
Allegheny County	553
Beaver County	37
Erie County	85
Total Western PA	**947**
PA TOTAL HOMELESS WITH SERIOUS MENTAL ILLNESS	**3522**

The data presented above was collected on a single night during the last week in January 2015, in most cases, the night of January 28, 2015. Each CoC in Pennsylvania provided the data that they assembled for submission to HUD on the 2015 reporting software (HDX) used to report on Housing Inventory and Populations and Subpopulations for the McKinney-Vento/HEARTH CoC application process. The number of homeless people with serious mental illness reported

for each CoC includes all people with serious mental illness who were in an Emergency Shelter, Transitional Housing, or Safe Haven program and those who were unsheltered on the night of each CoCs 2015 Point-in-Time count. The data collected shows a decrease of 112 homeless individuals with serious mental illness from 3634 in 2014 to 3522 in 2015, a 3% decrease.

While the Homeless Subpopulations Chart in the HDX is the primary data source available at the present time, OMHSAS continues to recognize the following limitations:

- This data is collected through a Point-in-Time count and does not reflect the total number of homeless individuals over the course of a year.

- The data is based on HUD's very specific definition of homeless – those living in emergency shelters, transitional housing for the homeless, safe havens for homeless individuals and in places not intended for human habitation (unsheltered).

- The data on the number of homeless who have serious mental illness is often self-reported by the individuals being surveyed or by shelter staff or outreach workers through observation. This can result in inaccuracies and varying assumptions about what constitutes serious mental illness.

We continue to strive toward generating a count of homeless with serious mental illness using the Homeless Management Information System (HMIS) in each CoC; however, the current level of participation is still not adequate for an accurate count. DCED has established an HMIS for the 53 Counties included in the four rural regions of the Commonwealth and Bucks County. The other CoCs have established their own HMIS. The various CoCs have made significant progress in upgrading their systems to meet changing HUD data quality standards and in achieving full participation; however, they still do not have full coverage, especially from emergency shelters and street outreach. Also, many of the rural counties have very limited ability to conduct in-depth street outreach for unsheltered individuals with mental illness. In addition, domestic violence programs are not covered by the HMIS so there will remain a need for a manual Point-in-Time count of a portion of homeless programs in each CoC.

One of the major changes in the HMIS standards was introduced with the implementation of Homeless Prevention and Rapid Rehousing (HPRP), a designation of people who are not homeless but receive homeless prevention services through the Emergency Solutions Grant Program. This will enable the HMIS to better report on people with mental illness who are at risk of homelessness and therefore PATH eligible. Furthermore, there has been a higher level of participation in HMIS by PATH funded programs over the past year.

Finally, through the HMIS we will eventually be able to generate an unduplicated count of all homeless individuals with mental illness served throughout the year in a particular CoC, rather than just a Point-in-Time count. However, since each CoC has its own HMIS, there will

remain the risk of some duplication, since people may be identified in different CoCs over the course of the year.

SSI/SSDI Outreach, Access and Recovery (SOAR)

SSI/SSDI Outreach Access and Recovery (SOAR) is a national initiative designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA). Eligible adults are those who are homeless or at risk of homelessness and who have a physical or mental illness and/or a co-occurring substance use disorder. To date, 13 of the 24 PATH MH/ID counties and 1 non-PATH county have received in-person SOAR training from the State SOAR Team. While the in-person SOAR training historically focused on PATH-funded areas, the state SOAR team has recently made this training available to all counties. SSA and Bureau of Disability Determination (BDD) representatives are invited to participate in these SOAR trainings. The SPC will continue to work with all PATH counties to have at least one SOAR trained staff within each PATH program across the state by the end of SFY 15/16. Additionally, through collaboration with the SAMHSA SOAR Technical Assistance (TA) Center's Liaison, Pennsylvania has increased enrollment in the SOAR online training program approximately 115% since August 2014.

(b) 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 2010, nearly 3.5 million residents, or 27 percent of the state's 12.7 million residents, lived in a rural county. From 2000 to 2010, rural Pennsylvania's population grew about 2 percent. According to the U.S. Census Bureau's 2011 American Community Survey, Public Use Microdata Sample (ACS-PUMS), in 2011, there were an estimated 15% of rural Pennsylvanians with disabilities. Among those, 51% had physical difficulties, followed by cognitive difficulties (43%), and independent living difficulties (34%).

From 2000 to 2010, rural Pennsylvania became more racially diverse. In 2000, there were about 157,200 residents, or 5 percent of the total population, who were non-white and/or Hispanic. In 2010, 260,300 rural residents, or 8 percent of the total population, were non-white and/or Hispanic. At the school district level, 235 of the state's 501 public school districts are rural. In the 2009-2010 academic year, an estimated 451,137 students were enrolled in Pennsylvania's 235 rural school districts. From 2006 to 2010, the number of rural students decreased 5 percent; Pennsylvania Department of Education's enrollment projections predict that total enrollment in rural schools will decline by 7 percent from 2010 to 2020.

Data from the U.S. Census Bureau show that, in 2010, 17 percent of the rural population was 65 years old and older compared to 15 percent of the urban population. Also, the number of rural seniors increased by 5 percent during the period 2000 to 2010, while the number of urban seniors increased by 1 percent. It is estimated that, in 2030, 25 percent of the total rural population will be 65 years old and older, which means that there will be more senior citizens than children and youth in rural Pennsylvania.

Rural counties frequently utilize satellite clinics, mobile teams, or other specialized services designed for that population. Several counties have shortages of dentists, psychiatrists, psychologists, and social workers. 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 advocate 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.

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.

Tele-psych

Tele-psych is the use of electronic communication and information technologies to provide or support clinical psychiatric care and psychological care at distance. Tele-psych is a service that has shown to be effective in rural settings. The service *includes psychiatric diagnostic evaluations, psychological evaluation, pharmacology, consultations (with patient/family), and psychotherapy*. , These services are provided by a psychiatrist or licensed psychologist within their scope of practice using real-time, two-way interactive audio-video transmission. It is appropriate in situations where on-site services are not available due to distance, location, time of day, or availability of resources.

Currently, Pennsylvania has Tele-psych programs serving the counties listed below, several of which also serve children and adolescents.

Adams	Allegheny	Beaver	Bedford
Berks	Blair	Bradford	Bucks

Butler	Cambria	Cameron	Carbon
Center	Chester	Clarion	Clearfield
Clinton	Cumberland	Dauphin	Delaware
Elk	Erie	Fayette	Forest
Franklin	Fulton	Greene	Indiana
Jefferson	Lackawanna	Lebanon	Lehigh
Luzerne	Lycoming	McKean	Mercer
Mifflin	Monroe	Montgomery	Montour
Northampton	Northumberland	Perry	Pike
Potter	Schuylkill	Somerset	Sullivan
Susquehanna	Tioga	Union	Warren
Wayne	Westmoreland	Wyoming	York

(c) Services for Older Adults

Persons aged 65 years and older represent the fastest growing age group in the United States. Estimates of behavioral health disorders in this population range from 15-25% of the total population. However, older persons are less likely to seek treatment from behavioral health professionals for many reasons such as lack of knowledge about the effects of behavioral health treatment; inadequate insurance coverage; a shortage of geriatric mental health providers; denial of problems; the stigmatizing impact of admitting to a behavioral health problem and access barriers such as transportation.

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.

In 2007, PA was approved by CMS to provide Medicaid funded Peer Supports Services (PSS) which are currently offered in all 67 counties in the Commonwealth. As PSS grew and developed in PA, a natural progression in service design and development has been to broaden the availability and scope of Certified Peer Specialist's (CPS) knowledge and skills by providing specialization and employment opportunities for peer specialists working with older adults.

In 2008, the Office of Mental Health and Substance Abuse Services (OMHSAS) Older Adult Planning Council identified the development of Older Adult Certifed Peer Specialists (COAPS) as a priority goal. In addition, PA issued a state Suicide Prevention Plan for Adults and Older Adults. Older adults, particularly white males, are at high risk of suicide (APA 2008). The alarming suicide statistics and the fact that older adults are historically underserved by the mental

health system are two compelling reasons why PSS, provided by non-traditional service providers, are greatly needed for older adults.

The Office of Mental Health and Substance Abuse Services (OMHSAS) dedicated funding from the 2008 Transformation Transfer Initiative Grant (TTI) to develop and launch Older Adult Peer Specialist training. This initiative identified primary goals as follows:

1. Develop an Older Adult Peer Specialist 3-day training curriculum;
2. Create specialized work opportunities for CPSs who completed the older adult curriculum.

A unique aspect to the COAPS Initiative is the collaboration among multiple state departments and academe which includes OMHSAS, PA Department of Aging, Office of Long Term Living and Office of Vocational Rehabilitation as well as the Center for Mental Health Policy and Services Research at the University of Pennsylvania. By the end of the grant period, Pennsylvania created a well-designed 3-day training curriculum for peer specialists working with older adults and successfully piloted the training with 2 classes of PA Certified Peer Specialists. This training model can be replicated in other states.

OMHSAS was fortunate to receive a second TTI Grant in 2010/11 with the following primary goals and accomplishments:

The Older Adult Peer Specialist Train the Trainer Initiative included the following six goals:

1. Develop a train the trainer manual and pre conference training materials.
2. Recruit up to 8 trainer candidates from PA's core of older adult peer specialists and 2 trainer candidates from New Jersey, plus recruit 10 Peer Specialists (age 50+) to participate as students in the 3-day Older Adult training curriculum.
3. Pilot Older Adult Peer Support train the trainer curriculum.
4. Survey trainers and students in follow-up interviews evaluation/data collection/consultation.
5. Ensure that each trainer provides at least two Three-day Older Adult Peer Specialist training classes for up to 25 certified peer specialists (through contractual agreement with OMHSAS).
6. Provide follow-up technical assistance to OA Trainers.

In PA's 3rd and final TTI grant award, in 2011/2012, New Jersey and Pennsylvania collaborated to cross-train an older adult peer specialist workforce to meet the health and wellness needs of older adults who experience mental health and substance use disorders. The TTI Grant also provided peer specialists with opportunities to put their CPS training into practice through supervised internships. University of Pennsylvania staff established a

coaching/mentoring system to provide support and technical assistance to host agencies and CPS serving in internships.

Two Older Adult Peer Specialist internships were offered as part of the 3rd year of the TTI Grant Project. One of the internships was conducted at Project HEALTH, an FQHC in Philadelphia, co-located in a Community Mental Health Center operated by Horizon House Inc. This three month internship included general duties as a peer specialist with older adult clients and managing a wellness group for older adults. A second internship was conducted in Berks County with the Reading Housing Authority. This internship encompassed mental health/wellness peer specialist services in an aging setting. Lessons learned from the TTI internships led to the below described concept design for future expansion of employment opportunities for Older Adult Certified Peer Specialists.

Older Adult Peer Specialist Project Expansion -Experience Works Project FY- 2013/14:

Experience Works is a Senior Community Service Employment Program (SCSEP) which provides paid work-training for individuals age 55 and older that meet the following eligibility requirements: Work is on a part-time basis, on average the work lasts up to 9 months, the program pays at a minimum wage, selected individuals working for a non-profit agency with no benefits.

The Office of Mental Health and Substance Abuse Services (OMHSAS) staff continued working collaboratively with the University of Pennsylvania, The PA Office of Vocational Rehabilitation, PA Department of Aging and added PA Experience Works staff to design a pilot project concept for Older Adults and Certified Peer Specialists (CPS) who are currently unemployed. Under the proposed concept design, Experience Works staff would assign qualified unemployed CPS to participating community agencies in order to gain work-training experience that could potentially lead to employment as a CPS or a variety of other employment positions.

Certified Older Adult Peer Specialists (COAPS) provide a much needed service to older adults with behavioral health diagnoses. The Pennsylvania Certified Older Adult Peer Specialist (COAPS) program address older adult's mental health and wellness issues. COAPS has a successful history of working with older adults; 170 Certified Peer Specialists have been trained as COAPS over the past five years; 90% of them are working in a variety of human services positions that work with older adults. COAPS are specifically trained in issues of normal aging as well as in behavioral and physical health issues of older adults, such as depression, misuse of prescription medications, and wellness approaches to aging. An important skill taught in COAPS training is the use of motivational interviewing to address wellness goals for older adults such as weight loss, smoking cessation or decreased smoking, engaging in regular medical and dental care, and increased attention to known medical conditions that may have been formerly ignored.

COAPS Initiative is in Line with SAMHSA Strategic Initiative Goals:

1. **Promote** health and recovery-oriented service systems for individuals with or in recovery from mental and substance use disorders.
2. **Ensure** that permanent housing and supportive services are available for individuals with or in recovery from mental and substance use disorders.
3. **Increase** gainful employment and educational opportunities for individuals with or in recovery from mental and substance use disorders.
4. **Promote** peer support and the social inclusion of individuals with or in recovery from mental and substance use disorders in the community.

COAPS Initiative Next Steps

- Expand Certified Older Adult Peer Specialist training, concentrating on unemployed or under-employed adults aged 55+
- Develop sustainable internships and employment opportunities for COAPS in older adult service agencies, housing organizations and mental health and substance abuse provider agencies

Criterion 5: Management Systems

[*Most of the discussions under this criterion apply to both adults as well as children/adolescents, while some apply exclusively to adults or children. The ones that apply only to one group are identified as such]*.

(a) Resources for Mental Health Providers

Financial Resources

The general state revenue funds, county funds, Medicaid dollars, Mental Health Block Grant, Substance Abuse Block Grant, Social Services Block Grant, PATH grant, and other federal grants comprise much of the funding pool that County MH/ID Programs use to provide services to their consumers.

Training Resources

OMHSAS sponsors technical assistance (TA) and training on a variety of areas to counties and provider agencies. Some examples are: Peer Specialist training, Case Management training, SSI/SSDI Outreach, Access, & Recovery (SOAR) training, TA in the development of evidence-based practices like ACT, and TA for the development of housing options in the counties.

The State also contracts with three training institutes, namely, Drexel University Behavioral Health Education, Penn State Education and Health Services, and Western Psychiatric Institute and Clinic (WPIC) to provide an array of behavioral health training opportunities to community service providers, consumers, family members, and other stakeholders. Drexel University provides training in the Eastern region of the state, Penn State in the Central region, and WPIC in the Western region. The following is a list of some of the topics on which training is offered by one or more of these institutes:

- Targeted Case Management
- Overview of Major Mental Disorders
- Foundational Concepts of Recovery
- Psychiatric Disorders of Children and Adolescents
- Wellness Recovery Action Plan
- Trauma
- Cognitive Behavioral Therapy
- Ethics
- Forensic Psychiatry
- Assessment and Treatment Strategies
- Crisis Intervention
- Emergency Preparedness
- Evidence-Based Treatment for Addiction and Psychiatric Illnesses
- Motivation Interviewing Skills for Case Mangers
- Cultural Competency
- Psychiatric Rehabilitation

The above list is not comprehensive. The training institutes develop new courses on advanced topics as the needed.

Direct Care Worker Initiative

Beginning in 2001-02, Pennsylvania started a long-term process to support provider efforts to recruit and retain direct care staff in Home and Community Based Programs for the elderly and persons with disabilities. This initiative is based on the belief that local communities can better understand the difficulties of recruiting and retaining staff, and thus be better able to develop strategies to remediate those difficulties. Funding was provided by both the Department of Aging and the Department of Human Services.

Direct care worker funding has been used by the counties to support various initiatives including: increasing wages or benefits; staff recognition awards or events; media campaign for

recruitment; advertising; hiring incentives including sign-on bonuses and employee referral bonuses; longevity awards such as gift certificates; one time bonuses for attendance and performance; and voucher programs for personal expenses such as health care (not covered under health care plans), tuition, and child care.

Cultural Competency Resources

Pennsylvania's *Cultural Competence Strategic Plan* represents OMHSAS' approach to continue raising the level of clinical competency in the Commonwealth's Behavioral Health system and to continue creating the necessary supports needed to provide cultural competency training. OMHSAS has a long history of working to ensure that cultural competency is embedded into all activities within the system. State, regional and local training on cultural competency has been provided to OMHSAS employees, County Administrators, providers, consumers and families. OMHSAS has also used block grant dollars in the past to seed cultural competency pilot projects to address the major cultural groups (Asian, African-American and Latino/Hispanic) experiencing service disparities. Pennsylvania also has a relationship with the Pennsylvania Association of Latino Organizations (PALO). PALO has provided training and technical assistance to Latino organizations and state mental hospitals on cultural competence.

OMHSAS also sponsored a three-day Cultural Competency training for direct service staff during 2010 in conjunction with Drexel University. More than 40 clinicians, case managers, rehabilitation staff, and peer specialists participated in the training. The training included a special emphasis on LGBTQI competencies and many of the participants identified as part of the LGBTQI community and/or were currently serving individuals from those communities. Participants in the training indicated that there was a great need for additional cultural competency training and, in particular, advanced training on LGBTQI issues.

LGBTQI Bulletins

In January 2011, OMHSAS issued two bulletins as a follow-up to the recommendations contained in "Issues of Access to and Inclusion in Behavioral Health Services for Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex Consumers" by the Keystone Pride Recovery Initiative (KPRI). KRPI is a project to develop and establish procedures to help LGBTQI individuals seeking behavioral health services in Pennsylvania. The goal of KPRI is to ensure that individuals are not discriminated against based upon sexual orientation, gender identity, and gender expression, in the behavioral health system. KPRI partnered with OMHSAS to work towards the following: protecting LGBTQI consumers; ensuring culturally-appropriate places of care for LGBTQI consumers; and educating providers around unique issues facing LGBTQI consumers. OMHSAS Bulletin 11-01, "Non-Discrimination Toward Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex People," and OMHSAS Bulletin 11-02, "Guidelines to Ensure Affirmative Environments and Clinically Appropriate Services for Lesbian, Gay,

Bisexual, Transgender, Questioning and Intersex Consumers and Their Family Members," are intended to move the behavioral health system forward in addressing discrimination and the lack of appropriate services for these populations.

KPRI is offering one day trainings “Creating Welcoming and Affirming Services for Persons Who Are Lesbian, Gay, Bi-sexual, Transgender, Questioning or Intersex (LGBTQI)” and three day trainings “Principles and Practice for Clinicians Working with the Lesbian, Gay, Bi-sexual, Questioning and Intersex Individuals (LGBTQI)” throughout Pennsylvania. A 2.5 hour online training titled “Welcoming and Affirming Practices: LGBTQI and Cultural Competency is also available.

The KPRI group of individuals is currently working on completing their strategic plan for moving forward in the next 3-4 years and documenting the goals that still need to be achieved, while continuing to provide training and education to providers of services for a welcoming environment.

Youth and Family Institute *(Children only)*

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 15 counties involved in the High Fidelity Wraparound system, which include the 13 System of Care counties, as well as, Allegheny and Bucks Counties. Over 1500 youth and their families have been served since the initiation of High Fidelity Wraparound in 2008.

(b) Training of Emergency Health Services Providers

OMHSAS is the statewide coordinating agency for mental health disaster 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*. The Plan, following every disaster, is

continually revised and continues to provide a mechanism for state and county response to local, regional, and state level disasters and emergencies using an All Hazards Approach.

The Pennsylvania Mental Health ALL HAZARDS Plan for Disaster/Emergency Response requires the development of county mental health response plans by County Mental Health and Mental Retardation departments. County mental health response plans are flexible documents, which provide a foundation for mental health disaster and emergency response and service provision at the local level.

The Pennsylvania Mental Health ALL HAZARDS Plan for Disaster/Emergency Response specifies the Office of Mental Health and Substance Abuse Services as a supportive component in mental health response. OMHSAS provides County Mental Health and Intellectual Disability Programs assistance when the disaster/emergency situation extends beyond the available resources of the county. The Office provides technical assistance and ongoing training to counties in the development of county mental health response plans and in implementing their response program. The following is a discussion on the available training:

Emergency Service Provider Training

OMHSAS partners with the Pennsylvania Department of Health and with the Pennsylvania Emergency Management Agency to train emergency response providers to address the psychosocial consequences of disasters and emergencies. Using Department of Health funding from the Centers for Disease Control and Prevention (CDC), OMHSAS provides the following training to Emergency Service Providers.

- Psychological First Aid (PFA) training based on National Center for Post-Traumatic Stress Disorder (NCPTSD)
- Disaster Crisis Outreach and Referral Team (DCORT) Training
- Critical Incident Stress Management (CISM) for First Responders

In addition to Emergency Service Providers, the above training opportunities are also offered to other groups listed below by funds provided directly to the counties to promote community resiliency and recovery:

- Leaders of faith based communities
- Leaders of non-English speaking communities
- Consumers
- First responders
- Mental health, drug and alcohol treatment staff
- Others

Emergency Service Providers and local and state mental health DCORT have been attending regional task force meetings, and partnering in table top exercises, as well as full scale exercises. Collaborations and trainings continue.

(c) Intended Use of Block Grant Funds

Pennsylvania's plan for use of its CMHS Block Grant allotment for federal fiscal year 2015-2016 is based on a spending authority of $18,441,000. Based on this, final allocations to county programs will total $17,902,000, with $539,000 set aside for administrative costs.

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. The counties have accounted for their block grant spending as part of the annual Income and Expenditure financial reporting. OMHSAS reviews the information to ensure that block grant expenditures are being made consistent with the federal and state intent of the funds.

• Administrator's Office • Community Services • Targeted Case Management • Outpatient • Day Treatment • Family-Based Mental Health • Resource Coordination • Administrative Management • Emergency Services • Housing Support Services • Crisis Intervention Services • Adult Developmental Training • Community Employment and Employment Related Services • Peer Support Services • Consumer-Driven Services • Transitional and Community Integration Services	• Facility-Based Vocational Rehabilitation • Social Rehabilitation Services • Family Support Services • Community Residential Services • Children's Psychosocial Rehabilitation Services • Children's Evidence-Based Practices • Assertive Community Treatment (ACT) and Community Treatment Teams (CTT) • Psychiatric Rehabilitation Services

Many of those services apply to both adults and children, although there are some services that are meant for adults only and some targeted towards children. A portion of the block grant money will also be used to support some special projects in some of the counties. These special project areas include: *Dual Diagnosis Training, Mental Health Matters, and First Episode Psychosis.*

OMHSAS provides guidance to the counties to utilize funding on the "four purposes" outlined in the SAMHSA guidance. We also strongly encouraged the counties to use the CMHSBG dollars to support the priorities identified in the state MHBG Plan.

The following table shows the projected Block Grant allocations to the counties for fiscal year 2015-16 (also includes some funds not expended in FY 14/15):

County	Non-Categorical Allocation	One-Time Allocation for Supportive Housing	Special Projects	Total Allocation
Allegheny	$1,336,833	$198,366	$5,250	$1,540,449
Armstrong/Indiana	$151,974	$22,551		$174,525
Beaver	$194,379	$28,843		$223,222
Bedford/Somerset	$174,754	$25,931		$200,685
Berks	$262,337	$38,927		$301,264
Blair	$117,288	$17,404		$134,692
Bradford/Sullivan	$92,161	$13,675		$105,836
Bucks	$258,581	$38,369		$296,950
Butler	$193,295	$28,682		$221,977
Cambria	$634,283	$94,118		$728,401
Cameron/Elk	$51,880	$7,698		$59,578
Carbon/Monroe/Pike	$136,604	$20,270		$156,874
Centre	$104,253	$15,470		$119,723
Chester	$215,432	$31,967		$247,399
Clarion	$77,680	$11,527		$89,207
Clearfield/Jefferson	$410,582	$60,924		$471,506
Columbia/Montour/Snyder/Union	$149,678	$22,210		$171,888
Crawford	$64,925	$9,634		$74,559
Cumberland/Perry	$487,380	$72,320		$559,700
Dauphin	$143,545	$21,300		$164,845
Delaware	$350,196	$51,964		$402,160
Erie	$232,459	$34,493		$266,952
Fayette	$204,868	$30,399		$235,267
Forest/Warren	$40,837	$6,060		$46,897
Franklin/Fulton	$94,705	$14,053		$108,758
Greene	$128,264	$19,032		$147,296
Huntingdon/Mifflin/Juniata	$94,322	$13,996		$108,318
Lackawanna/Susquehanna	$701,793	$104,135		$805,928
Lancaster	$278,587	$41,338		$319,925
Lawrence	$597,660	$88,684		$686,344

Lebanon	$84,080	$12,476		$96,556
Lehigh	$163,558	$24,270		$187,828
Luzerne/Wyoming	$281,771	$41,811		$323,582
Lycoming/Clinton	$139,481	$20,697		$160,178
McKean	$58,235	$8,641		$66,876
Mercer	$138,705	$20,582		$159,287
Montgomery	$390,979	$58,015		$448,994
Northampton	$135,673	$20,132		$155,805
Northumberland	$105,063	$15,590		$120,653
Philadelphia	$2,203,831	$327,015		$2,530,846
Potter	$55,099	$8,176		$63,275
Schuylkill	$163,405	$24,247		$187,652
Tioga	$48,440	$7,188		$55,628
Venango	$89,306	$13,252		$102,558
Washington	$564,310	$83,735		$648,045
Wayne	$132,115	$19,604		$151,719
Westmoreland	$453,741	$67,328		$521,069
York/Adams	$289,143	$42,904	$893,500	$1,225,547
County TBD			464,280	
	$13,478,470	**$2,000,000**	**$1,363,030**	**$16,841,500**

The following are the special projects to be funded with block grant funds:			
County	**Allocation**	**Project Name**	**Description**
Allegheny	$5,250	Training	Funding to support the expenses associated with the training and certification for MH case managers.
York/Adams (Philadelphia)	$10,500	Dual Diagnosis Training	The Office of Mental Health and Substance Abuse Services (OMHSAS) and the Office of Developmental Programs (ODP) have been working jointly for one year on a training program for individuals with a dual diagnosis. We are proposing that approximately 8 trainings be held for Certified Peer Specialists for a dual diagnosis curriculum that was developed by a team of OMHSAS/ODP and external stakeholders. The training programs would be facilitated over two days and will offer skills for Certified Peers to work with the dual diagnosis

			population. This program offers opportunity for dually diagnosed individuals to engage with trained Certified Peer Specialists while increasing the skills and educational level of Certified Peer Specialists through the support of both program offices. These trainings will be held over a two year period. Additional funds will be included in the FY 2015-16 primary for trainings held during that fiscal year.
York/Adams (Erie)	$53,000	Survey Project	The survey is a random sample of individuals served through Medical Assistance who received a mental health survey. It went to consumers receiving services through both fee-for-service and HealthChoices. The survey is conducted annually and goes to more than 20000 consumers/families of children/adolescents.
York/Adams	$830,000	First Episode Psychosis	Using the 5% set aside from SAMHSA for Early Intervention, OMHSAS will be funding four First Episode Psychosis programs across the state.
County TBD	$464,280	Mental Health Matters	Mental Health Matters is an initiative of OMHSAS focused on building public awareness and knowledge around mental health. This initiative emphasizes programs for community members that dispels stereotypes and myths about mental illness, enhances mental health literacy, and supports community training as well as endeavors to expand current efforts that address the behavioral health needs of service members, veterans, and their families.
TBD (unobligated at the time of application)	$1,060,500		Funding to support special projects as the need is determined during plan year.

Planning Steps

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

Narrative Question:

This step should identify the unmet services 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 populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, the annual **State and National Behavioral Health Barometers**, and the **Uniform Reporting System** (URS). 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 should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the **National Survey of Substance Abuse Treatment Services** (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the **Behavioral Health Barometers**. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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[18] **http://www.healthypeople.gov/2020/default.aspx**

Footnotes:

UNMET NEEDS AND CRITICAL GAPS

In the Commonwealth's FY 2014-15 Plan, nine priority service areas for adults with SMI and children with SED were identified using (1) data obtained from the County Mental Health Plans, (2) a document developed by the Children's Advisory Committee, *"Call for Change"* document and (3) input from the CMHSBG Plan stakeholder group. The stakeholder workgroup included representation from each of the Planning Council subcommittees (Adult, Older Adult, Children's and Persons in Recovery). These same methods were used to identify and develop Pennsylvania's state priorities for the FY 2016-2017 Plan. The group chose to keep seven of the nine existing priority areas, as the majority of the unmet service needs identified remain salient, and added one new priority.

Unmet Service Needs & Gaps For Adults

In their recent County Mental Health Plans (which are part of the County Human Services Plans), counties were asked to identify recovery-oriented systems transformation priorities they planned to initiate to address unmet needs. The counties also identified the fiscal and other resources needed to implement those priorities. A total of 783 transformation priorities were identified by the counties, an increase from the 251 requests received in the year before that.

Out of the 783 priorities, the highest number of priorities was once again Housing/Housing Supports (129 total requests). Additional identified priorities from the survey included Staff Training, Community Education and Outreach, Cross-System Collaboration, Employment Services, Recovery Based Initiatives, Infrastructure Development, Psychiatric Access, Peer Support Services, Culturally Competent Services, Mobile Services, Transportation, Co-occurring Disorder Treatment, Forensic Services, School Based Services, Trauma Informed Care, Case Management, Inpatient Hospital, Crisis Services, Life Skills Training, Family Support and Respite Services, Physical and Behavioral Health Integration, and Community Integration. OMHSAS convened a workgroup with representation from the Planning Council to choose the priorities that the state should be focusing on in their CMHSBG Plan. After a thorough discussion of identified county priorities, the workgroup chose the following four as the adult priorities that the state should be focusing on in the current CMHSBG planning cycle:

- Promote independent living and the deinstitutionalization of individuals by increasing housing opportunities for persons of all ages with SMI;
- To increase engagement and access to services across systems for older adults;
- Support the employability of Certified Peer Specialists (CPS) throughout the Commonwealth;
- Facilitate the community integration of individuals residing in state hospitals.

Unmet Service Needs & Gaps For Children

The Children's Behavioral Health Taskforce, made up of over 400 stakeholders, released a document titled *"Reaching for the Stars: A Message for Pennsylvania"* which

identified many issues concerning the children's behavioral health system in Pennsylvania. Consistent with Pennsylvania's longstanding practice of integrating stakeholder recommendations into systems change, in 2009, representatives from counties and their behavioral health managed care organizations convened for a retreat on children's services. Staff from the Office of Mental Health and Substance Abuse Services, as well as youth and family representatives from the Children's Advisory Committee also participated. Representatives from Mercer Human Services Consulting, which has provided technical assistance for the HealthChoices initiative, served as retreat facilitators.

The consensus of the group was that while the current children's behavioral health system is quite extensive, access as well as quality could be improved. A number of proposed recommendations came out of the retreat, including recommendations for administrative efficiencies and programmatic improvements. As a direct result of this retreat, the OMHSAS Children's Bureau and the OMHSAS Children's Advisory Committee developed a "***Call for Change – Transformation of the Children's Behavioral Health System in Pennsylvania***", which would serve as a strategic plan to guide the children's behavioral health system toward the goals of improving access and streamlining the process for quality, effective behavioral health services for children and their families throughout the Commonwealth. It provides the principles on which transformation of the children's behavioral health system can occur.

In addition to direct input from key stakeholders, this *Call for Change* also relied on analyses of the many multi-stakeholder initiatives and children's services improvements that have been achieved over the past several years. Moreover, this document also incorporates findings from a review of the current literature on the state of the art in children's behavioral health services. The *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 systems collaborative relationships and initiatives.

The planning priorities pertaining to children identified in this application are again, as in previous Plans, derived from some of the goals outlined in the Children's "*Call for Change"* document. The stakeholder group determined that there continues to

be a need for these priorities. The priority **"Youth and Family Involvement"** was selected based on goal 1 which calls for the development of a youth and family driven system. Similarly, **"Reducing RTF Usage"** springs from goal 2 that strives to ensure that services are comprehensive, integrated, and provided in the least restrictive environment. The priority of **"Prevention"** will support goal 4 which aims to promote the development of a public health approach to social and emotional wellness. In addition, **"Suicide Prevention"** was selected as a new priority area, in line with the state and national focus on this issue, and also supporting goal 4.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's **NBHQF**. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at **http://www.samhsa.gov/data/quality-metrics/block-grant-measures**. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Quality and Data Collection Readiness

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

   Response: Data is reported to and collected in the *Provider Reimbursement Operations Management Information System* (PROMISe) in electronic format. Services at the client, program, and provider level are all reported in detail and available via the *Enterprise Data Warehouse* (EDW) for data reporting and quality measures.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

   Response: The state currently uses a combined reporting system for substance abuse and/or mental health services clients. OMHSAS leverages several enterprise information systems. The main one is the *Client Information System* (CIS), which receives all authorizations, closings, and changes for the entire Medicaid population. The system also houses other Department of Human Services programs. The eligibility information from CIS and our HealthChoices Behavioral Health (Medicaid managed care) and Medicaid Fee-For-Service population's claims/encounters payment information are combined and maintained in PROMISe. The Home and Community Services Information System (HCSIS) contains incident management information, *Community and Hospital Integration Projects Program* (CHIPP) information, state mental hospital closure consumer data, and is also the vehicle by which county base (state funded services) consumer information is added to CIS. Additionally, by the end of the first quarter of 2016 all counties should be capable of submitting state-funded (non-Medicaid) encounters into PROMISe. (At this time data is reported in a separate data system). When completed, we will have the capacity to fully integrate our data collection systems and provide unique client-level data for all populations.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

   Response: The state has been actively involved in the collection of Client level data (CLD) for two years. Our team has successfully implemented accepted hashing techniques to de-identify consumer information.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Response: Overall we have the capability to meet the requirements for data reporting as noted in the application. The one exception, county level encounter date, is expected to be completed in early 2016 so we can successfully integrate all data sets.

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:

Promote independent living and the deinstitutionalization of individuals by increasing housing opportunities for persons of all ages with SMI.

Objective:

Increase by 10% annually the number of individuals served by supportive housing

Strategies to attain the objective:

Increase dollars towards: Capital, PBOA, Bridge, Master Leasing, Clearinghouse, and Fairweather Lodges; Support Olmstead planning process to meet the needs of consumers in the least restrictive setting possible; Continue to provide technical assistance to counties

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage increase of individuals receiving supportive housing services

Baseline Measurement: 7990

First-year target/outcome measurement: 8789

Second-year target/outcome measurement: 9668

Data Source:

OMHSAS Data

Description of Data:

Baseline FY 13/14

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:

To increase engagement and access to services across systems for older adults.

Objective:

Increase by 10% annually the number of older adults receiving community-based mental health services.

Strategies to attain the objective:

Promote outreach and education opportunities for older adults; Increase engagement with Peer Support services; Build interaction between services/systems; Enhance services and service-system development; Integrate physical and behavioral health services; Recruit and train additional

professionals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage increase of older adults receiving community-based mental health services

Baseline Measurement: 12,778

First-year target/outcome measurement: 14,056

Second-year target/outcome measurement: 15,462

Data Source:

OMHSAS Data

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: Peer Support Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Support the employability of Certified Peer Specialists (CPS) throughout the Commonwealth.

Objective:

Increase by 5% the number of certified peer specialists employed by in the mental health field.

Strategies to attain the objective:

Promote the use of CPS for specific populations (Transition-age youth, forensics, older adults, veterans); Track employment outcomes for trained CPS; Support peer specialists in the workplace by providing technical assistance to employers about culture changes needed to ensure their success with peer specialist services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of certified peer specialists employed in the mental health field.

Baseline Measurement: 1091

First-year target/outcome measurement: 1146

Second-year target/outcome measurement: 1203

Data Source:

Surveys of County MH/ID Offices and provider agencies

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Olmstead Planning

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Facilitate the community integration of individuals residing in state hospitals

Objective:

Increase community integration from the State Hospital by 90 individuals annually.

Strategies to attain the objective:

Follow the Commonwealth's Olmstead Plan.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Community Hospital Integration Program Projects (CHIPPs) completed

Baseline Measurement: 3,324

First-year target/outcome measurement: 3,414

Second-year target/outcome measurement: 3,504

Data Source:

OHMSAS Data

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Residential Treatment Facility (RTF) Usage

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Improve the quality of and increase access to community based services to reduce the use of RTF placements.

Objective:

Increase the number of children and youth effectively served through community based approaches by decreasing the number of children/youth placed in both accredited and non accredited Residential Treatment Facilities by 5% annually.

Strategies to attain the objective:

Increase community connections and informal supports through the use of Youth/Family Teams and high Fidelity Wraparound; Monitor use of respite services and solicit feedback from families as to the impact; Research, fund, and expand community evidence-based and promising practices.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of children placed in both accredited and non accredited RTFs

Baseline Measurement: 9323

First-year target/outcome measurement: 8857

Second-year target/outcome measurement: 8414

Data Source:

OMHSAS Data

Description of Data:

FY 13/14

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Youth and Family Involvement

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase youth and family involvement and influence in the mental health system in Pennsylvania.

Objective:

Maintain and expand the number of youth and family members involved in county collaboratives (System of Care), intergrated county plan development, and local and statewide planning/advisory boards by 7% annually.

Strategies to attain the objective:

Recruit and maintain an active youth cohort as part of the OMHSAS Planning Council; Recruit and maintain an active youth and family member composition in the county collboratives formed as part of Systems of Care; Support youth and family participation in state and county sponsored trainings and conferences; Support Cross Systems Collaboration and Integrated Service Delivery reflecting input from youth and family members.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth and family members involved in county collaboratives (System of Care), intergrated plan development, and local and statewide advisory boards annually

Baseline Measurement: 86

First-year target/outcome measurement: 92

Second-year target/outcome measurement: 98

Data Source:

OHMSAS Data

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 7

Priority Area: Prevention

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To increase opportunities for social and emotional wellness for young children and their families in Pennsylvania.

Objective:

Increase the number of children served by Keystone Mental Health consultants by 75 annually

Strategies to attain the objective:

Utilize "The Incredible Years", "Keystone Stars Early Childhood Mental Health", "Nurse Fmily Partnership", "PATHs", and "Strengtheening Families" as models of early BH intervention and as sources of data.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of children served by Keystone Mental Health Consultants Annually

Baseline Measurement: 620

First-year target/outcome measurement: 695

Second-year target/outcome measurement: 770

Data Source:

OCDEL (DHS's Office of Child Development and Early Learning)

Description of Data:

Data issues/caveats that affect outcome measures::

FY year 14-15 was the first full fiscal year ECMHC data was captured in a new database system. This system has allowed us to have cleaner data.

Priority #: 8

Priority Area: Suicide Prevention

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase suicide prevention in educational settings

Objective:

Increase Student Assistance Program referrals by 10% annually

Strategies to attain the objective:

Increase Gatekeeper training, assist schools in the development of suicide prevention policy, and increase screenings.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of children referred to the SAP Program annually

Baseline Measurement: 20,038

First-year target/outcome measurement: 22,042

Second-year target/outcome measurement: 24,246

Data Source:

Student Assistance Program Joint Quarterly Reporting System 2013-14 report

Description of Data:

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	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
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$0	$848,800,000	$0	$0
6. Other 24 Hour Care		$2,665,459	$1,301,851,319	$0	$464,600,756	$11,451,931	$0
7. Ambulatory/Community Non-24 Hour Care		$27,631,890	$3,679,071,884	$0	$725,828,608	$49,904,336	$0
8. Mental Health Primary Prevention**		$2,762,792	$0	$0	$70,477,811	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$870,239	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$583,662	$2,899,076,797	$0	$87,692,825	$9,890,600	$0
13. Total	**$0**	**$34,514,042**	**$7,880,000,000**	**$0**	**$2,197,400,000**	**$71,246,867**	**$0**

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	**$**
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	**$4,721,612**

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	**$**
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	**$680,047**
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	**$4,959,287**
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	**$332,261**
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	**$10,518,816**
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

~~**Recovery Supports**~~	~~**$1,107,988**~~
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	**$**
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	**$715,637**
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	**$1,995,719**
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	**$2,960,209**
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	**$965,364**
Total	**$28,956,940**

Footnotes:
Community Support (Rehabilitation) includes a one time, $2,000,000 allocation for Supportive Housing.

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	$1,078,000
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	$4,847,060
Total Non-Direct Services	$5925060

Comments on Data:

*Planned expenditures span a two year planning period.
*MHA Activities Other Than Those Above include special projects funded through CMSHBG dollars. Descriptions of these projects (Training, Dual Diagnosis Training, Survey Project, First Episode Psychosis, and Mental Health Matters) can be found under "Strengths and Needs of the Service System."

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The **Framingham Heart Study** produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three- fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

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

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state’s EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state’s primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

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

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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

1. The Health Care System and Integration

With the development of HealthChoices, Pennsylvania's mandatory Medicaid managed care program, all Medicaid recipients have access to quality healthcare. In Pennsylvania, behavioral health services are carved out from physical health and this ensures more focused attention on the delivery of behavioral health services, going well beyond simple parity expectations. Medical Assistance recipients in Pennsylvania, including those newly qualifying recipients as a result of Pennsylvania's Medicaid expansion, receive M/SUD services through their county's Behavioral Health Managed Care Organization (BH-MCO). Currently there are no treatment limitations to any of the mental health or behavioral health services in PA Medicaid.

Realizing the interconnection between physical and behavioral health concerns in this context, the integration of services is ensured through the contractual requirements for the MCOs (PH & BH) to coordinate care. HealthChoices further requires that the Physical Health Managed Care Organizations (PH-MCO) and the Behavioral Health Managed Care Organizations meet quarterly to discuss projects including research and program designs that examine and work to resolve coordination issues. Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) has four regional field offices that monitor regional BH-MCOs, ensuring access for individuals and families who require M/SUD services. The level of access and other features of the services delivery system is monitored regularly at quarterly monitoring meetings with the field office representative and representatives from the counties involved, and assessed annually using the standardized Program Evaluation Performance Summary. Any recipient complaints regarding service access issues should go directly to the BH-MCO, and may also be researched and responded to by contractor (county or state) and the regional Field Office in the form of a corrective action plan (CAP).

Pennsylvania creates innovative initiatives to improve the coordination of care between M/SUD and physical health services, and to enhance its relationship with FQHCs. For example, OMHSAS and the Office of Medical Assistance Programs (OMAP), in coordination with the managed care organizations, are working together to create a data set for the sharing of information to enhance coordination of PH/BH services. From its inception, the HealthChoices managed care program has coordinated with FQHCs to ensure coordinated access for dual eligibles (Medicaid and Medicare) and to provide for the highest quality of care to meet consumer preferences. In October 2014, OMHSAS presented information regarding requirements to establish tele-psychiatry services in FQHCs.

Pennsylvania has a continued commitment to provide services that reflect the strong connection between behavioral and physical health needs. One such initiative, Pennsylvania's Department of Health Pre-Approved Tobacco Cessation Registry, accepts referrals from physical and behavioral health providers. Pennsylvania Medicaid recipients also have access to an array of tobacco cessation medication and services included within the State Plan, including: NRT in various forms for administration, Varenicline, Bupropion, group and

individualized counseling, and a quit helpline. Furthermore, the BH-MCOs coordinate with the special needs units of the PH-MCOs plans for all physical health concerns. With the members consent, there is an expectation of strongly coordinated care to address their behavioral and physical needs.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the ***HHS Action Plan to Reduce Racial and Ethnic Health Disparities***[52], ***Healthy People, 2020***[53], ***National Stakeholder Strategy for Achieving Health Equity***[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) 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 recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] 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.[58] 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, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health 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 population 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. 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 being served or 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, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

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

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

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

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

2. Health Disparities

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?

   Response: OMHSAS is able to track consumers by race, ethnicity, age, gender and language only. There is no designation for sexual orientation or tribal connection in our Client Information System or in the Home and Community Services Information System. Neither system allows for transgender designation.

2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.

   Response: If disparities were identified, plans to address the disparities would be accomplished through workgroups involving OMHSAS policy staff and interested stakeholders (e.g., county governments, Behavioral Health Managed Care Organizations and providers). There would also have to be a financial component of these discussions to accommodate the system changes that would have to occur to be able to capture and track these subpopulations with more detail.

3. Are linguistic disparities/language barriers identified, monitored, and addressed?

   Response: Language services for Medicaid consumers are evaluated annually to ensure compliance with oral interpretation, written translation, and phone answering Standards and with LEP Requirements related to Section 601 of Title VI of the Civil Rights Act of 1964.

4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

   Response: Our state's Client Information System contains a language preference code by which Medicaid consumers can request documents in their preferred language. In addition, managed care companies are required to have documents in any language that accounts for at least 5% of the population. Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) has a contract with a translator company that can be used to interpret on the spot by telephone; this agency can also translate documents as requested.

5. Is there state support for cultural and linguistic competency training for providers?

   Response: OMHSAS Bulletin 00-04-13 provides information regarding Title VI of the 1964 Civil Rights Act as it pertains to LEP and notes Federal requirements designed to prohibit discrimination and ensure meaningful access to federally

funded services. The Bulletin provides for State Technical Assistance with policy development, ongoing staff training and quality review.

In January 2011, OMHSAS issued bulletin #11-02 to provide guidelines to ensure *Affirmative Environments and Clinically Appropriate Services for Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex Consumers and their Family Members.* Another bulletin issued at the same time (#11-01) provided guidelines to ensure that LGBTQI staff, consumers, and their family members are protected from discrimination and mistreatment.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, 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 Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds 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[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included 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."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) 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 substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health 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 behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, 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, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

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

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    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 incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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[59] **Ibid, 47, p. 41**

[60] 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

[61] 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 Abuse and Mental Health Services Administration.

[62] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

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

[64] http://psychiatryonline.org/

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

[66] **http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345**

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

3. Use of Evidence in Purchasing Decisions

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.

   Response: Yes, the Bureau of Policy, Planning and Program Development within OMHSAS has a staff position to serve as the lead for adult behavioral health evidence-based practices (EBPs). This position devotes 100% of its time in the implementation or expansion of: (a) Assertive Community Treatment (ACT); (b) Supported Employment (SE); (c) Illness Management Recovery (IMR); and (d) Family Psychoeducation. This individual also coordinates with other bureaus/staff in OMHSAS on other EBPs and promising practices Supported Education and Suicide Prevention. Additionally, this individual also coordinates with OMHSAS Children's Bureau on issues related to EBPs targeted towards children.

2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

   Response: OMHSAS utilizes a variety of mechanisms to collect data on EBPs to help guide our policy directions in this area. This information, coupled with the information collected by other data sources and through targeted studies, has been used in making many policy decisions regarding EBPs.

   Supported employment is another EBP that has received focused attention in the recent years. Information on peer services and supported employment activities collected from counties was used in drafting policy guidance for counties and in designing a training regimen specifically meant for certified peer specialists to assist in their role in supporting the employment goals of the peers they serve.

   Another example is a project that was done in the past couple years, wherein OMHSAS collaborated with Temple University to administer a one-time survey of 200-300 recipients of peer support services to ascertain what areas of concern they have worked with their peer support specialists and what benefits they have derived from receiving peer support services. We also investigated whether there is a significant difference between a recipient's utilization of high-cost mental health services prior to receiving peer support services and afterward. We intend to use the conclusions gleaned from the data to refine the delivery of peer support services in the Commonwealth.

3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?

   Response: Yes.

4. Does the state use a rigorous evaluation process to assess emerging and promising practices?

   Response: No.

5. Which value based purchasing strategies do you use in your state: PA uses a –i (see explanation below)
   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 incentives to drive quality.
   d. Provider involvement in planning value-based purchasing.
   e. Gained consensus on the use of accurate and reliable measures of quality.
   f. Quality measures focus on consumer outcomes rather than care processes.
   g. Development of strategies to educate consumers and empower them to select quality services.
   h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
   i. The state has an evaluation plan to assess the impact of its purchasing decisions.

   Response: OMHSAS uses various data sources for continuous quality improvement. OMHSAS oversees, monitors, and performs many quality activities. It has one performance improvement project (PIP) with three objectives related to improving the transition from inpatient care to ambulatory care for Pennsylvania HC members hospitalized with a mental health or a substance abuse diagnosis. Other activities include performance measure collection and reporting, monitoring of operations and contract compliance, annual surveys of member and provider satisfaction done by the BH-MCOs and satisfaction surveys done by local Consumer/Family Satisfaction Teams (CFSTs) contracted with the HCBH Primary Contractors. The HCBH Program draws from these and other activities to identify additional programmatic goals. OMHSAS incorporates recommendations from the public, the OMHSAS Planning Council, HCBH Primary Contractors, BH-MCOs and the External Quality Review Organization (EQRO) Technical Report in setting new goals and revising the OMHSAS Quality Strategy.

   In complement to the OMHSAS Quality Strategy, each HCBH Primary Contractor maintains and operates a Quality Assessment and Performance Improvement (QAPI) program. The QAPI is subject to the yearly review and approval by OMHSAS quality reviewers. As part of their QAPI responsibility, each HCBH Primary Contractor is expected to improve in their performance measure rates, maintain compliance related to the structure and operations regulations, and to contribute to the planning and

implementation of their specific BH-MCO's PIP strategy to remediate barriers and improve service performance in their HCBH Contract service areas.

OMHSAS uses a monitoring instrument called the Program Evaluation Performance Summary (PEPS) to review the 42 CFR Part 438 sub-parts C, D & F. One hundred and eight (108) PEPS sub-standards are reviewed with multiple crosswalks to the 42 CFR Part 438 sub-part categories and state standards in order to determine federal and state compliance over a rolling three-year period.

The BH-MCO submits the performance measure data to the EQRO on a yearly basis. The EQRO validates the BH-MCO performance measure submissions and determines the compliance status with the federal performance measurement protocol. There are many data displays of the required performance measure results, which OMHSAS uses to monitor the HCBH program's performance measure results and improvement, and HCBH Primary Contractors' performance measure results and improvement.

OMHSAS does not currently use financial incentives to drive quality. Although Behavioral Health Providers were excluded from the Medicare and Medicaid Electronic Health Record (EHR) Incentive program, a significant number of PA behavioral health providers have purchased EHR systems; however, the majority do not have interoperable connectivity to an HIE. The Department of Human Services' goal is to incentivize HealthChoices providers to connect with their regional HIE. The target is to be at 80% connectivity by 2019.

The Department sought additional input on its Quality Strategy from its Medical Assistance Advisory Committee (MAAC) as well as its Consumer and Managed Care Sub-committees. The MAAC advises DHS on issues of policy development and program administration. The MAAC is composed of citizens of the Commonwealth with experience, knowledge, and interest in the delivery of health care services to low income citizens and medically vulnerable groups. The Department also sought feedback through structured discussions with various constituents involved in the specific programs of OMAP, OMHSAS and ODP. These meetings provided a forum for ongoing communication between DHS and constituents to share their key quality priorities. The Quality Strategy also was distributed for stakeholder comment through the OMHSAS Planning Council. This advisory group includes beneficiaries, providers, HCBH Primary Contractors, BH-MCOs and representative organizations. Lastly, the Department sought public comment through posting a Public Notice. The public was allotted 30 days to review and comment.

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

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

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

4. Prevention for Serious Mental Illness

No areas for technical assistance were currently identified for this section.

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded **Recovery After an Initial Schizophrenia Episode (RAISE) initiative**[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

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

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[72] **http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf**

[73] **http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full**

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

5. Evidence-Based Practices for Early Intervention

Schizophrenia is a complex brain disorder with both genetic and environmental factors conferring vulnerability. Typically, the manifestations of psychosis are in late adolescence to early adulthood. A major challenge is to identify vulnerability markers and develop interventions that can build resilience, thus maximizing the potential for healthy development. The period of at-risk signs of psychosis and early psychosis represents a window of opportunity for interventions that may fundamentally change the course of outcome. It is estimated that 3,176 youth across the Commonwealth between the ages of 15 and 26 experience symptoms of early psychosis.

To address the largely unmet needs of this population, Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) has chosen to follow the NIMH recommendation for the Coordinated Specialty Care (CSC) model for First Episode Psychosis (FEP). We will continue to support both the **University of Pennsylvania's Penn Psychosis Evaluation and Recovery Center (PERC)** program and the **University of Pittsburgh's Western Psychiatric Institute and Clinic Services (WPIC) for the Treatment of Early Psychosis (STEP)** to maintain and expand their existing programs. In addition, OMHSAS is planning to expand the availability of FEP treatment within the state by funding two new programs the **Horizon House Psychosis Education, Assessment, Care and Empowerment (PEACE)** Program in Philadelphia and **Safe Harbor Behavioral Health of University of Pittsburgh Medical Center Hamot's Early Onset Psychosis Coordinated Specialty Care Recovery Program** in Erie. Although the four FEP sites in Pennsylvania are not formally connected, OMHSAS is focusing on collaboration between the sites to increase shared knowledge base and allow for better program evaluations. Staff from the four sites will be attending a symposium held by the Healthy Transitions Program with focus on FEP. In addition, OMHSAS will be contracting with PEACE program to collect and evaluate program data for all four programs.

OMHSAS intends to promote the expansion of CSC programs for FEP by setting aside a total of $830,801. The University of Pennsylvania's PERC program and WPIC's STEP program will each receive $85,000 for continuing services. PEACE will receive $201,765 in order to bring their existing program in line with the CSC model. Safe Harbor will receive $308,082 in order to allow them to begin offering FEP services. The remaining $150,954 will be set aside for program evaluation. Individual program budgets are in the process of being finalized and will be provided to SAMHSA when they become available.

Program	Allocation
PERC	85,000
STEP	85,000
Safe Harbor	308,082
PEACE	201,765
Program Evaluation (contract with PEACE to do evaluation of all 4 programs)	150,954
Total	$830,801

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

6. Participant Directed Care

In 2014, OMHSAS submitted a TTI grant application for Self-Directed Care (SDC). PA was one of five states to be awarded $221,000 for projects related to Self-Directed Care (SDC) in Behavioral Health. Over the past 4 years a highly regarded SDC project was created in Delaware County, PA. The team from that project partnered with OMHSAS to develop the grant project concept and outcomes.

Outcomes for the PA grant project included 1) development of a comprehensive manual/toolkit to define the SDC approach used in Delaware County; 2) an evaluation report identifying outcomes of the extended service delivery period of the grant project including financial, community inclusion and recovery-oriented goals; and 3) provide technical assistance to selected PA counties for replication of the SDC model.

Based upon the initial data review for the Delaware County SDC model, approximately 80% of the services were traditional MA reimbursable services while 20% were non-traditional. We anticipate that a variety of funding streams can be braided at the county level to support non-traditional services such as local grant opportunities, county funds, block grant funds, and MCO support. The cost savings from a decrease in the utilization of high cost traditional services would result in savings to support the initial development of the SDC model.

OMHSAS is not requesting any technical assistance in this area.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed 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 behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 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 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG 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 to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible 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 SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. 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 mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required 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 consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

7. Program Integrity

1-2. Does the state have a program integrity program plan regarding MHBG funds? Does the state have a specific policy for assuring that the federal program requirements are conveyed to intermediaries and providers?

Response: Yes, the state clearly conveys the federal and state requirements and expectations regarding MHBG to counties. We have in the past, based on the then prevailing federal guidance, allowed the counties the latitude to plan the MHBG expenditures, provided they ensured compliance with all statutory and regulatory requirements. Also, services and supports for which MHBG dollars could not be expended were always clearly communicated to the counties.

When SAMHSA issued new guidance a few years ago directing that the MHBG expenditures be directed towards the four purposes delineated in the guidance, state used that opportunity to provide more structured guidance to the counties. We also strongly encouraged the counties to utilize the CMHSBG dollars to support the priorities identified in the state MHBG Plan. We also developed a reporting form (see the attachment) to be completed by counties to support the planning and reporting data needs for MHBG. A statewide conference call was also held to convey the new requirements and to provide clarifications. Since 2012, counties have submitted annual reports based on the new reporting requirements.

MHBG Planner is the person responsible for program integrity activities. This individual also collaborates with the Department's Bureau of Financial Operations to ensure integrity of the programs supported with Block Grant funds.

3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:

a. Budget review;
b. Claims/payment adjudication;
c. Expenditure report analysis;
d. Compliance reviews;
e. Client level encounter/use/performance analysis data; and
f. Audits

Response: As indicated earlier, OMHSAS utilizes a new reporting form (see the attachment) to capture the data elements required by SAMHSA for MHBG. This was originally developed in 2012 and was later revised to fix some minor glitches in the original version. The data reported by counties in the form inform us how the block 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. Relevant Purpose (from the "four purposes")
d. Number of Persons Served
e. Target Population
f. Unit Type
g. Number of units of Service
h. Limited English Proficiency Services, if any
i. Reimbursement Method
j. Amount Spent

Additionally, the form also asks the counties to report if any MHBG dollars were spent on the priorities identified in the State's MHBG Plan. By reviewing this form, we will know how the block dollars are used and if those expenditures are consistent with the requirements and guidance the state has provided. Our review of expenditures reported using this form has not revealed any transgressions or inconsistencies.

Over and above the monitoring by the CMHSBG Planner, the Bureau of Financial Operations is available to do audits of CMHSBG-funded programs, if and when requested by OMHSAS.

4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.

Response: Since Pennsylvania has a county based mental health service system, most of the MHBG dollars are allocated by the state to counties, who in turn contract with local agencies to provide services (some counties may provide certain services directly). The counties, through the MHBG reporting form, reports on reimbursement method for each service. The reimbursement methods and rates used by a county would depend on the type of service (cost center) and are generally the same for any class of service within a county, regardless of the source of funding (MHBG, state funds, etc.).

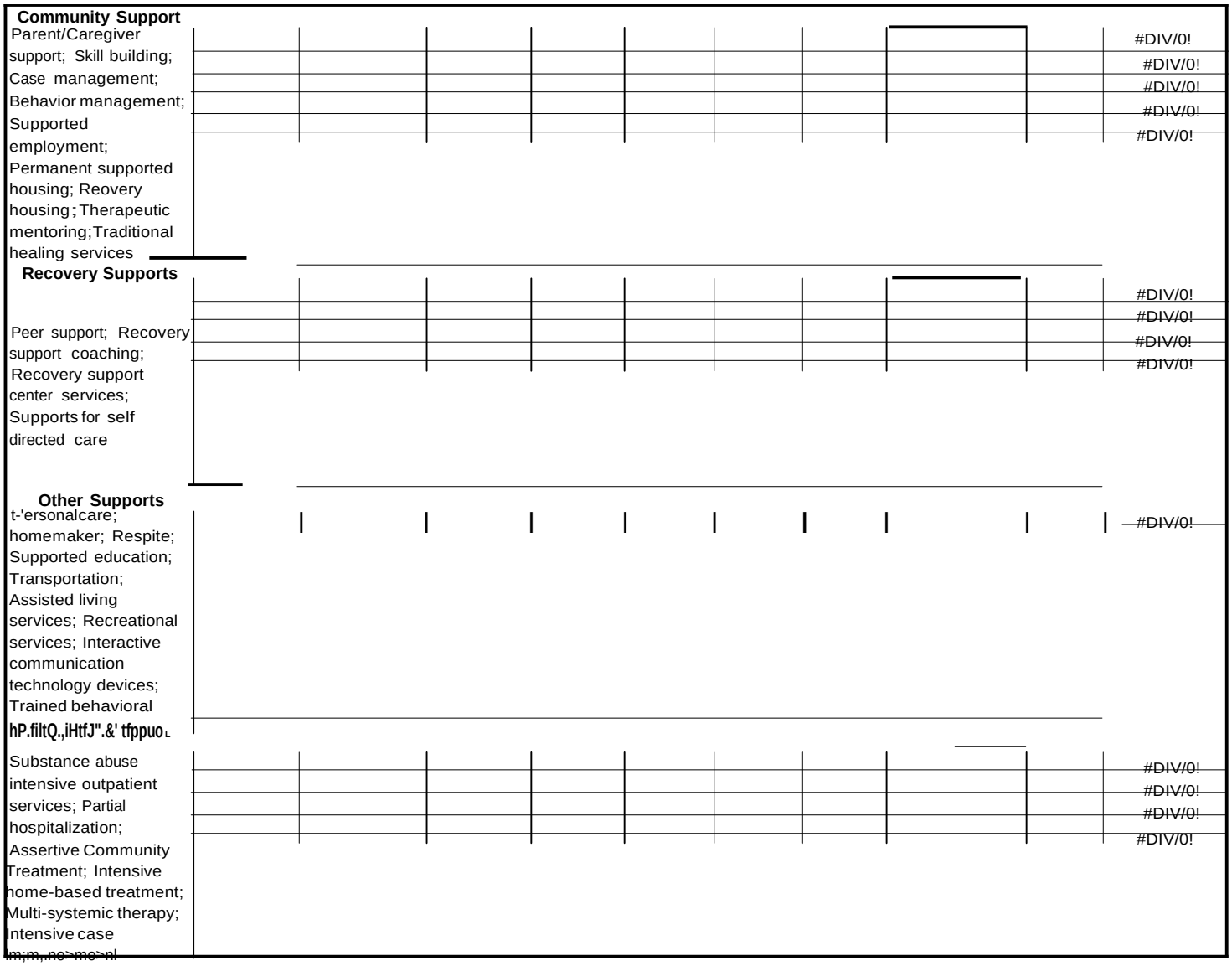
5. Does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

Response: The state provides the counties with a list of cost centers (services or supports) on which MHBG dollars can be expended, provided those expenditures meet one or more of the "four purposes" specified in SAMHSA MHBG guidance. Each cost center corresponds to a specific service or support (or "like" services and supports) with clearly defined attributes (either by regulations or by other means). Most of these services are also licensed by the state. The counties report on MHBG expenditures based on cost centers, and this allows the state to ascertain the exact nature of service delivered.

6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Response: As stated earlier, counties are required to use the MHBG dollars for one or more of the four purposes. Annual reports submitted by the counties show for what "purposes" the dollars were utilized. Meeting the "four purposes" was not a challenge since the historical pattern of expenditures has always matched one or more of those purposes, even before those purposes were laid out in SAMHSA guidance. Pennsylvania has never used MHBG dollars to pay for insured persons for a services that would be covered by the insurances (Medicaid or private insurance). If MHBG funds were used to pay for an individual receiving Medicaid, it was always for a service/support not covered by the state in-plan or supplemental Medicaid services.

County										
Allocation (Enter in cell 83):										
Category	Cost Center • see below	SAMHSA Purpose • see instructions	Number of Persons Served	Target Population	#of Units of Service	Unit of Service Type	LEP Services	Reimbursement Method	Amount Spent	% oftotal funding (auto populates)
Healthcare Home/ Physical Health										
General and specialized outpatient medical services; Acute primary care; General health screens; Comprehensive care management; Care coordination; Comprehensive transitional care; Individual and family										#DIV/0!
Engagement Services										
Assessment; Specialized Evaluation; Services planning; Consumer/Family education; Outreach										#DIV/0!
Outpatient Services										
Individual evidenced-based therapies; group therapy; family therapy; multi-family therapy; consultation to caregivers										#DIV/0! #DIV/0!
Medication Services										
Medication management; Pharmacotherapy; Laboratory services										#DIV/0!


Community Support
Parent/Caregiver support; Skill building; Case management; Behavior management; Supported employment; Permanent supported housing; Reovery housing; Therapeutic mentoring; Traditional healing services
#DIV/0!
#DIV/0!
#DIV/0!
#DIV/0!
#DIV/0!
Recovery Supports
Peer support; Recovery support coaching; Recovery support center services; Supports for self directed care
#DIV/0!
#DIV/0!
#DIV/0!
#DIV/0!
Other Supports
t-'ersonalcare; homemaker; Respite; Supported education; Transportation; Assisted living services; Recreational services; Interactive communication technology devices; Trained behavioral
#DIV/0!
Substance abuse intensive outpatient services; Partial hospitalization; Assertive Community Treatment; Intensive home-based treatment; Multi-systemic therapy; Intensive case
#DIV/0!
#DIV/0!
#DIV/0!
#DIV/0!

~~Out-of-Home~~										
Crisis residential/stabilization; Clinically managed 24hr care; Clinically managed medium intensity care; Adult mental health residential; Children's mental health residential; Youth substance abuse										#DIV/0!
Acute Intensive										
Mobile crisis; Peer-based crisis; Urgent care services; 23 hr crisis stabilization; 24/7 crisis hotline										#DIV/0!
										#DIV/0!
Prevention										
Screening, brief intervention, referral and treatment; Brief motivational interviews; Screening and brief intervention for tobacco cessation; Parent training; Facilitated referrals; Relapse prevention/ Wellness recovery support; Warm line										#DIV/0!
System Improvement										
										#DIV/0!
Other										
										#DIV/0!
										#DIV/0!
	Notes:									

CMHSBG State Priorities	Please indicate in the boxes below whether your county is spending CMHSBG funds on any of the eight state priority areas identified below. If you would like to provide additional information, you may do so in the "notes" section.	
	Yes/No	
Supportive Housing		
Promote independent living by increasing housing opportunities for persons with SMI		Notes:
Co-Ocurring Services		
Promote and support the provision of integrated services across systems for individuals with co-occurring disorders		Notes:
Services to Older Adults		
Increase engagement and access to integrated services across systems for older adults		Notes:
Peer Support Services		
Support the workforce development of Certified Peer Specialists (CPS) throughout the Commonwealth		Notes:
Access to High Fidelity Wraparound		
Ensure that the high fidelity wraparound service model of Youth/Family Teams is available to children and youth with SED and their families		Notes:
Prevention		
Increase the opportunities for social and emotional wellness for families and youth in Pennsylvania		Notes:
Residential Treatment Facility Usage		
Improve the quality of and increase access to community based services to reduce RTF placements		Notes:
Youth and Family Involvement		
Increase youth and family involvement in all levels of participation in the mental health service system		Notes:

*Note: Priorities are not listed in any order of importance										

Environmental Factors and Plan

8. Tribes

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**[74] 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 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. 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.

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

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

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

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[74] **http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president**

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

8. Tribes

Pennsylvania does not have any Federally recognized Tribal Governments or Tribal lands within its borders.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- **Education** builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- **Alternatives** provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- **Problem Identification and Referral** aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does **not** include any activity designed to determine if a person is in need of treatment.
- **Community-based Process** provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- **Environmental Strategies** establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- **Universal:** The general public or a whole population group that has not been identified based on individual risk.
- **Selective:** Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- **Indicated:** Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or

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an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

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

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

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

Footnotes:

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Not applicable to MH Block Grant

Environmental Factors and Plan

10. Quality Improvement Plan

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.

In an attachment to this application, states must submit a CQI plan for FY 2016-FY 2017.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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DRAFT FY 2016/2017 OMHSAS CQI Work Plan

Regulatory Reference	Strategic Quality Initiatives (*Dimensions of Performance*)	Monitoring Frequency	Lead Staff Responsible	Goals (if applicable)	Data Source*; *Sample Size (if applicable)*	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
	Program Structure																
§438.240(a)	*Review & Approval of FY 2017/2018 CQI Work Plan*	Annually	OMHSAS QM Director	Update Annually	n/a	P			D		CA	A					
§438.240(e)	*Review & Approval of FY 2016/2017 OMHSAS QM Evaluation*	Annually	OMHSAS QM Director	Update Annually	n/a												
§438.202(d)	*Review & Update (if needed) OMHSAS Quality Strategy*	Annually	OMHSAS QM Director	Review Annually	n/a	P			D		CA	A					
§438.204(b)	*OMHSAS Oversight of the EQRO contract and work*	Contract work review meetings 2X/month	OMHSAS QM Director/Quality & Data Team members	Work product evaluated as applicable to Objective	n/a	PC	PC	PC	PC	PC	PC	PC	PC	PC	PC	PC	PC
§438.202(b) §438.202(d)	*Stakeholder Review & Input of Evaluation & Work Plan*	Annually	OMHSAS QM/DR Bureau Director	Renew Annually	n/a			P	D	D	CA						
	Program Operations																
Title 42, CFR 438 Parts C,D, and F	*Assessment of Compliance with federal and state requirements (PEPS CY reviews)*	Annually or Triannually dependent on specific PEPS Standard-ongoing	OMHSAS Bureaus: Community Operations, Quality Management/Data Review, Fiscal	Anchors "Met", "Partially Met" or "Not Met" Request of a Corrective Action Plan (CAP) if Compliance Determination is "Not Met" or a decision is made by the OMHSAS reviewer to require a CAP if the determination is a "Partially Met"	Source reporting by PEPS Standard	A						CD	CD	CD	CD	CD	CD
§438.204(b) (3)	*Performance measure reporting -Increase access to followup after Follow up after Hospitalization for Mental Illness-7 days (HEDIS®) All ages, ages 6-20 and ages 6-64*	Yearly	EQRO/QM Division Director	BH-MCO & HCBH Contract results reported using HEDIS Quality Compass Medicaid National HMO Benchmarks (percentile reporting). Improvement goals set for following year, Root cause analysis triggered if improvement goals not met	Performance measure files submitted by BH-MCOs and validated by EQRO		C		A						P	D	
§438.204(b) (3)	*Performance measure reporting -Increase access to followup after Follow up after Hospitalization for Mental Illness- 30 days (HEDIS®) All ages, ages 6-20 and ages 6-64*	Yearly	EQRO/QM Division Director		Performance measure files submitted by BH-MCOs and validated by EQRO		C		A						P	D	
§438.204(b) (3)	*Performance measure reporting -Increase access to followup after Follow up after Hospitalization for Mental Illness- 7 days (PA-Specific) All ages*	Yearly	EQRO/QM Division Director	BH-MCO & HCBH Contract results reported. If BH-MCO performance not statistically significant improvement or decrease from previous year, Root cause analysis triggered.	Performance measure files submitted by BH-MCOs and validated by EQRO		C		A						P	D	
§438.204(b) (3)	*Performance measure reporting -Increase access to followup after Follow up after Hospitalization for Mental Illness- 30 days (PA-Specific) All ages*	Yearly	EQRO/QM Division Director		Performance measure files submitted by BH-MCOs and validated by EQRO		C		A						P	D	
§438.204(b) (3)	*Readmission within 30 days of an Inpatient Psychiatric Discharge*	Yearly	EQRO/QM Division Director		Performance measure files submitted by BH-MCOs and validated by EQRO		C		A						P	D	
§438.424(a)	*Encounter Data validation (Optional EQR Protocol)*	Ongoing	EQRO/System Division Director	Create, monitor, analyze	Encounters	X	X	X	X	X	X	X	X	X	X	X	X

DRAFT FY 2016/2017 OMHSAS CQI Work Plan

Regulatory Reference	Strategic Quality Initiatives (*Dimensions of Performance)*	Monitoring Frequency	Lead Staff Responsible	Goals (if applicable)	Data Source*; *Sample Size (if applicable)*	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
§438.424(a)	*Measure progress in developing data systems*					X	X	X	X	X	X	X	X	X	X	X	
	Access and Availability																
§438.206(c)(1)(i)	*Performance measure reporting -Increase access to followup after Follow up after Hospitalization for Mental Illness-7 days (HEDIS®)*	Semiannual	QM Division	Monitor, report and trend	BH-MCO reporting (claims)			DC	A							DC	A
§438.206(c)(1)(i)	*Performance measure reporting -Increase access to followup after Follow up after Hospitalization for Mental Illness- 30 days (HEDIS®)*	Semiannual	QM Division	Monitor, report and trend	BH-MCO reporting (claims)			DC	A							DC	A
§438.206(c)(1)(i)	*Performance measure reporting -Increase access to followup after Follow up after Hospitalization for Mental Illness-7 days (HEDIS®)*	Semiannual	QM Division	Monitor, report and trend	BH-MCO reporting (claims)			DC	A							DC	A
§438.206(c)(1)(i)	*Performance measure reporting -Increase access to followup after Follow up after Hospitalization for Mental Illness- 30 days (HEDIS®)*	Semiannual	QM Division	Monitor, report and trend	BH-MCO reporting (claims)			DC	A							DC	A
§438.206(c)(1)(i)	*Performance measure reporting -Increase access to followup after Follow up after Hospitalization for Mental Illness- 30 days (PA-Specific) All ages*	Yearly	QM Division	Monitor, report and trend	BH-MCO reporting (claims)			DC	A							DC	A
§438.206(c)(1)(i)	*Readmission within 30 days of an Inpatient Psychiatric Discharge*	Yearly	QM Division	Monitor, report and trend	BH-MCO reporting (claims)			DC	A							DC	A
§438.206(c)(1)(i)	*Measure timely access to services: TSS hrs authorized/TSS Hours paid*	Monthly	QM Division	Monitor, report and trend	HC BH Contract submissions authorizations /claims	X	X	X	X	X	X	X	X	X	X	X	X
	Safety																
§438.400	*Analyze the BH-MCO/HC BH Contractor from Member Complaints, including timeliness of resolution, analysis by County, Service, & Provider*	Bi-annual	OMHSAS Operations and QM Division	OMHSAS monitoring/HCBH Contractor & BH-MCO quality workplans reports. PEPS Standard 68.4	As per BH-MCO/HCBH Workplan				X						X		
§438.230	*Analyze Critical Incidents to identify means of reducing potential risks to Members*	Bi-annual	OMHSAS Operations and QM Division	OMHSAS monitoring/HCBH Contractor & BH-MCO quality workplans reports. PEPS standards 91.8 & 99.2. Monitor that 100% of Critical incidents for member safety are investigated within 48 hours	As per BH-MCO/HCBH Workplan and Quality management Committee report					X						X	
	Appropriateness																
§438.400, §438.408, §438.410, §438.420, §438.424	*Aggregate & analyze data from Denials, timeliness and resolution of the CAP (if issued)*	Quarterly /Yearly	QM Division	"met" compliance with Resolution & Letters (PEPS Standard 72) Monitor CAP resolution if issued. Monitor trends establish denial rates/1000 HCBH eligibles , "act" when BH-MCO rates are outside events are outside of +/- 3 sigma statewide rates	HC BH Contract Denial logs, PEPS Reviews	PDC	A		C			C			C		

DRAFT FY 2016/2017 OMHSAS CQI Work Plan

Regulatory Reference	Strategic Quality Initiatives (*Dimensions of Performance)*	Monitoring Frequency	Lead Staff Responsible	Goals (if applicable)	Data Source*; *Sample Size (if applicable)*	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
§438.400; §438.402, §438.406, §438.408, §438.410, §438.420, §438.424	*Aggregate & analyze data from Complaints and Grievances, timeliness and resolution of the CAP (if issued)*	Quarterly /Yearly		"met" compliance with Complaint, Grievances (PEPS Standards 60, 68, 71). Monitor CAP resolution if issued. Monitor trends establish complaints rates/per 1000 HCBH eligibles , Grievance rates/per 1000 HCBH eligibles, "act" when BH-MCO rates are outside events are outside of +/- 3 sigma statewide rates	HC BH Contract Complaint , Grievance logs, PEPS Reviews	PD C	A		C			C			C		
§438.206(c)(1)(i)	*Review utilization and cost by level of care with ongoing evaluation of potential over and under utilization of identified services*	Yearly	QM Division	Monitor trends-20% variance from baseline will trigger additional discussion/analysis	OMHSAS Dashboard	PD C											
	Diversity and Cultural Competency																
	Analyze Denials to eliminate Disparities in Treatment (Race/County)	Annually	QM Division	(PLANNED) Non-disparate treatment; Statistically significant difference	HC BH Contract Denial, Complaint , Grievance logs		C										
DI-02	*Analyze data on demographics, penetration rates, top diagnoses, and % of foreign language speaking Members to determine focus of prevention efforts*	Annually	BHMCOs-QM monito	Monitor, Trend and report by HCBH Contractor /BH-MCO	HCBH Contract/BH-MCO quality meetings				X								
	Consumer & Family Involvement																
438.10 (f)(i)(3)(iv)	*Review of MHSIP results*	Annually	Systems Division		*Stratified Random Sample*				X						X		
438.10 (f)(i)(3)(iv)	*Summarize results of 3 question Consumer Family Satisfaction Team surveys, trends, interventions; summarize annual C/FST report and identify opportunities for improvement/interventions, if any, based on results*	Quarterly/ Annually	QM Division	Monitor Adult & Child 3 question results, monitor through HCBH Contract quality meetings. Question satisfaction if results fall by <80% per year/question.	(Planned) Statistically reliable survey sampling method (F2F, telephone) by HCBH Contractor			X			X			X			X
	Outcomes and Efficacy																
OE-01	*Monitor Outcomes by Evidences Best Practices*	Annually	QM Division	Determined by OMHSAS Bureau; measurements to be further developed in 2016/2017	n/a		C				X					X	
OE-02	*Review changes in educational/vocational, living status as reported in POMS and Develop a plan to improve POMS reporting throughout the provider network*	Annually	QM Division	POMS reporting	BH-MCO reporting		C		X			C		X			
OE-03	*Monitor outcomes development for Telepsychiatry*	Annually	QM Division	Baseline goal to be determined in 2015 after initial submission of outcomes data by providers	n/a		C		X					X			

Acronyms List

Acronym	Meaning
A	Administrative data
ALOS	Average Length of Stay
BHMCO	Behavioral Health Managed Care Organization
BHRS	Behavioral Health Rehabilitation Services
BSC	Behavior Specialist Consultant
C	Chart Abstract
CCISC	Comprehensive, Continuous, Integrated System of Care
CTT	Community Treatment Team
DOH	Department of Health
F/U	Follow up
FBMHS	Family Based Mental Health Services
H	Hybrid Measures
HEDIS	Healthcare Effectiveness Data and Information Set
ICSI	Integrated Children's Service Initiative
ISPT	Interagency Service Planning Team
LOC	Level of Care
MH IP	Mental Health Inpatient
MH OP	Mental Health Outpatient
MMHT	Mobile Mental Health Treatment
NCQA	National Committee for Quality Assurance
OMHSAS	Office of Mental Health and Substance Abuse Services
PEPS	Performance Evaluation Performance Summary
PH/BH	Physical Health/Behavioral Health
PHMCO	Physical Health Managed Care Organization
PIP	Performance Improvement Project
POMS	Priority Outcomes Measurement System
PSS	Peer Support Specialist
QIA	Quality Initiative Activity
QOCC	Quality of Care Counsel
RTF	Residential Treatment Facility
SA IP	Substance Abuse Inpatient
SBIRT	Screening, Brief Interventions & Referral to Treatment
TSS	Therapeutic Staff Support
UM	Utilization Management
UR	Utilization Review

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. 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, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach". [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

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

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state's policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

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

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75 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.*

76 **http://www.samhsa.gov/trauma-violence/types**

77 **http://store.samhsa.gov/product/SMA14-4884**

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

11. Trauma

Trauma informed care (TIC) is a major initiative in the Commonwealth of Pennsylvania. The Commonwealth has developed and published an informational bulletin that directly references TIC strategies and practices to assist providers and their staff in developing trauma informed treatment programs. The informational bulletin encourages programs to understand each individual's past trauma history and utilize assessment tools to assist in identifying trauma. Pennsylvania has also developed a core competency document for our Alternative to Coercive Techniques initiative that promotes trauma informed care principles as a part of the individual planning for each youth. In addition, as part of our commitment to trauma informed care, the Commonwealth has funded two pilots that provided an opportunity for several residential providers to be trained in two nationally recognized TIC models- the Sanctuary Model and Trauma Focused- Cognitive Behavioral Therapy.

Pennsylvania has established policies in its state hospital system for the screening of individuals for trauma and providing trauma focused interventions. This carries over to discharge planning and arranging for the individual's transition and reintegration into the community through the Community Support Planning process. Guides and practices to reducing the use of restraints have been published for both the state hospitals and community services and this is especially important when considering interventions for individuals with a prior history of trauma. Likewise Bulletin OMHSAS-11-02 was published providing guidelines to ensure affirmative environments and clinically appropriate services for LGBTQI individuals and their families/supports. In the development of newer services such as the Assertive Community Treatment teams the standards and guidelines (found in Attachment B of Bulletin OMHSAS-08-03) training is required in trauma approaches in the care of individuals receiving the service.

Because Pennsylvania's Office of Mental Health and Substance Abuse Services behavioral health services are mostly provided through its mandatory managed care program, HealthChoices, the emphasis on providing trauma-focused care is promoted and monitored through the managed care programs. Trauma focused care is also embedded in the HealthChoices quality management process. The HealthChoices program is monitored through quarterly monitoring meetings and quarterly Quality Management meetings where trauma informed/focused care comes up in work-plan development discussions and emphasized in approaches to treatment. In the management of the HealthChoices program as well as the county reinvestment of funds Evidence-Based Practices (EBPs) are a primary area of promotion for the advancement of behavioral health services. Through the County reinvestment process, Pennsylvania has approved many programs for funding with an emphasis on treating individuals who have experienced trauma as outlined in the SAMHSA resources. Services supporting a trauma focus as developed for reinvestment include Family-Based, Crisis Intervention, Targeted Case Management programs, Outpatient Clinics, Psych Rehab Trauma Intervention, Dual Diagnosis Treatment teams, Community Mental Health Centers, Outpatient Evidence-Based Treatment Services, ACT and more.

Pennsylvania's relationships with Western Psychiatric Institute and Clinic, Drexel and organizations such as the Pennsylvania Behavioral Health and Aging Coalition have resulted in many trauma related trainings being provided across the state. Trainings range from

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Psychological First Aid and critical incident stress debriefing (CISD) to CBT across the lifespan and many other free and low cost trainings provided by Drexel University on trauma related services.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

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

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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

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[79] **http://csgjusticecenter.org/mental-health/**

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

[82] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. **OJJDP Model Programs Guide**

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

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12. Criminal and Juvenile Justice

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?

   Response: In 2015, PA Department of Human Services expanded Medicaid to provide healthcare coverage for a number of individuals, including those involved in the criminal justice system who previously did not qualify for traditional Medicaid. Currently, Pennsylvanians ages 19-64 with incomes up to 138% of the Federal Poverty Level may be eligible for coverage under Medicaid expansion.

2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

   Response: Pennsylvania currently has 100 Problem Solving Courts (January 2015). Of the total courts, 16 are Adult Mental Health Courts, 1 Juvenile Mental Health Court, 19 Veterans Courts, 2 Recovery Courts, 1 Co-Occurring Court, 28 Adult Drug Courts, 9 Juvenile Drug Courts, 1 Juvenile Pre-Adjudication Court and 1 Re-Entry Drug Court. Pennsylvania has utilized the various Problem Solving Courts across the state to divert individuals from incarceration and provide screening and treatment services for those identified by the criminal justice system. Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS) and the Pennsylvania Commission on Crime and Delinquency (PCCD) are involved in a collaborative effort to facilitate the implementation of Mental Health Treatment Courts throughout Pennsylvania as well as Problem Solving Courts as funding is available.

3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

   Response: In Pennsylvania, OMHSAS works collaboratively with the PA Department of Corrections (DOC) to ensure that individuals with mental illness and/or substance use disorders receive services and supports necessary to reentry into the community. Under the Enhanced Re-Entry Initiative, counties are invited to participate in selected planning meetings where specific candidates will be returning to their communities upon release. The group collectively coordinates placements options, benefits accessibility, as well as structured activities that an individual may need upon re-entry.

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Response: Annually PA hosts a Forensic Rights and Treatment Conference that provides training to mental health and justice professionals and practitioners. The conference promotes communication, collaboration and a working knowledge of the mental health and criminal justice systems.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

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

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

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

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[83] **http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf**

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

13. State Parity Efforts

The proposed rule on Parity issued by the Centers for Medicare and Medicaid Services (CMS) in April 2015 would apply provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid and CHIP. While the MHPAEA of 2008 covered Medicaid Managed Care Organizations, the proposed rule, once promulgated, would offer more structured guidance to ensuring parity in the state's Medicaid Managed Care and CHIP programs. The proposed rule would also afford additional flexibility to the states by allowing them to include the cost of services beyond what is specified in the state plan into the capitation if those services are required to be provided to meet parity.

In Pennsylvania, the "carving out" of behavioral health services and establishing a BH-PIHP (Behavioral Health - Prepaid Inpatient Health Plan) network has ensured more focused attention on the delivery of behavioral health services, going well beyond simple parity expectations. **Currently there are no treatment limitations to any of the mental health or behavioral health services in PA Medicaid, and so compliance with parity rules on quantitative limitations is not an issue.**

Some of the impacts of the new rule can be ascertained only after CMS clarifies the language and intent of certain provisions. For example, proposed rules are unclear as to how compliance with non-quantitative treatment limits will be determined in a system where beneficiaries receive MH/SUD services from a PIHP, but are enrolled in multiple MCOs (like in Pennsylvania).

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Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

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

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

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

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[85] **http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939**

[86] **http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214**

[87] **http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131**

[88] **http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380**

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not applicable to MH Block Grant

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Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

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-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

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

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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15. Crisis Services

To assist OMHSAS in transforming the crisis intervention system, we would request technical assistance in the following areas:

- Peer Support/Peer Bridges
- Peer-Run Crisis Respite Programs
- Follow up Outreach and Support
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

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Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health 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 behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

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. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. 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.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

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

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

16. Recovery

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?

   Response: Yes.

2. How are treatment and recovery support services coordinated for any individual served by block grant funds?

   Response: Priorities are established in counties.

3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

   Response: Yes.

4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?

   Response: Yes.

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state’s behavioral health system?

   Response: No.

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).

   Response: OMHSAS planning council meetings are held bi-monthly and regional listening forums are conducted across the Commonwealth.

7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

   Response: Yes

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.

   Response: Not currently measured

9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.

   Response: Wellness is promoted at county level.

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

    Response: Yes.

11. Describe how the state is supporting the employment and educational needs of individuals served.

    Response: A Governor's Executive Order to encourage hiring of individuals with disabilities is currently being drafted.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

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 substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate 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 behavioral health 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 of 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 residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain 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. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
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?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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17. Community Living and the Implementation of Olmstead

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.

Pennsylvania's Mental Health Olmstead Plan, first issued in 2011, revised in 2013 and under current revision in 2015, reflects the Commonwealth's continued progress toward ending the unnecessary institutionalization of adults who have a serious and persistent mental illness. Since it was first issued, the plan has detailed the specific steps that the Commonwealth would take to achieve that goal. The plan has also called for implementation to be reviewed at regular intervals to assess progress and determine the need for revision and updates. This implementation is at the state and regional/county level.

In the last 20 years Pennsylvania made significant strides in providing housing and supports in the most integrated settings possible for people with mental illness consistent with Title II of the Americans with Disabilities Act and the 1999 U.S. Supreme Court Olmstead decision addressing the issue of unnecessary institutionalization of Pennsylvanians with mental illness. As elsewhere in the nation, the census of Pennsylvania's state hospitals has declined dramatically in the last 40 years, from 35,100 in 1966 to 1,082 in civil psychiatric beds in December 2014. Our progress mirrors the national trend which recognizes 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 access to appropriate supports and services.

Pennsylvania's Mental Health Olmstead Plan provides the opportunity for the Commonwealth to honor the letter and spirit of the Olmstead ruling, while maximizing the utilization of its fiscal and other resources. Some of the available resources include:

- **Pennsylvania's mandatory behavioral health managed care program, HealthChoices, provides services to Pennsylvanians enrolled in the Medical Assistance program:** Both the capitation dollars provided by the Commonwealth to the HealthChoices managed care organizations (MCOs) and the reinvestment dollars the HealthChoices MCOs generated are used to: increase capacity, develop services that might not otherwise be available and pay for start-up costs for new programs and other community services. A complete services array, including Pennsylvania Medicaid State Plan services and/or supplemental services that are in lieu of or in addition to a State Plan service(s), are included in the HealthChoices Behavioral Health Managed Care Program. Recovery oriented services include Peer Support Services and Psychiatric Rehabilitation Services. OMHSAS approved County Reinvestment Plans for Housing Support Services that include Housing Development Fund (Capital Projects), Master Leasing, Bridge Subsidy, Clearinghouse, Contingency, Housing Support Services and Project Based Operating Assistance as explained in detail in the Strengths and Needs of Step 1 in the Planning Section.
- **Programs available outside of the traditional mental health system that fund services for our citizens who have a mental illness:** These include home and community-based waivers for people who are eligible (e.g. the Aging Waiver for elderly

individuals and the Attendant Care and Independence Waivers for those with physical disabilities in addition to mental illness); the Consolidated Waiver for individuals who have intellectual disabilities; services provided through the Department of Aging and the Office of Long Term living; publicly-funded housing programs; and veterans' programs. In addition, other federal, state, and private benefit sources may be available to assist these individuals (e.g., Social Security Disability, Supplemental Security Income, Medicare, Medical Assistance, education and veterans' benefits).

- **Federal, state and local housing resources:** These include but are not limited to: federal PATH funds and federally funded Section 8 Housing Choice Vouchers available through local Public Housing Authorities; Pennsylvania Housing Finance Agency Low Income Housing Tax Credit units, especially units made available for people at 20% or below of the Area Median Income, Pennsylvania Housing Affordability and Rehabilitation Enhancement (PHARE) and PennHomes funding, state and local HOME, Community Development Block Grant (CDBG) and Trust fund resources.
- **Housing and Urban Development (HUD) Section 811 Project Rental Assistance (PRA) Demonstration:** Pennsylvania was awarded $5.7 million in new Melville 811 resources in February 2013 and $8.5 million during the second round of Melville 811 funding in March 2015. These resources will be targeted to people with disabilities, including those leaving institutions, as Project Based Rental subsidies for approximately 400 units in Low Income Tax Credit Projects. Local Lead Agencies (LLAs) will manage the referral and service delivery components of this program. This marks a major breakthrough in resources for Olmstead planning.
- **HUD Section 811 PRA Demonstration Mental Health Preference:** As part of Pennsylvania's second 811 PRA request, the state and six Public Housing Authorities have committed to providing 251 Housing Choice Vouchers over the next four years beginning in 2015 for individuals with mental illness, as a disability specific Olmstead preference. These resources will further enable OMHSAS to affirmatively meet its Olmstead commitment. The six Public Housing Authorities include: the Allegheny County Housing Authority, the Housing Authority of Butler County, the Housing Authority of the County of Chester, The Housing Authority of the County of Dauphin, The Housing Authority of the City of Pittsburgh, and Philadelphia Housing Authority.
- **Employment Services:** Opportunities exist to work or experience daytime activities in the community that are integrated and are considered as "real work for real pay". The Community Support Planning (CSP) process is used to identify an individual's preferences including employment and daytime activities and the supports necessary to ensure success.

2. How are individuals transitioned from hospital to community settings?

In the last 20 years, Pennsylvania has made significant progress in developing community alternatives for people who have a mental illness and decreasing reliance on state psychiatric hospitals. Our continuing progress depends on the development of a viable integration plan.

Each consumer's needs are assessed through the CSP process. CSPs define the supports needed for each consumer to live in the most integrated setting appropriate to his or her needs. The CSP process serves as the foundation for successful implementation of Pennsylvania's Mental Health

Olmstead Plan. Pennsylvania's DHS works with counties to plan for the development of a broad array of integrated options to meet the needs of consumers. The CSP process has been vital to the design of individualized services and supports that are consumer-centered, consumer-empowered, and culturally competent. Each person's CSP will:

- Be developed, monitored, and evaluated in partnership with consumers and, as appropriate, with families, involved advocates, specialists (e.g. trauma, spiritual advisors, supports coordinators, for individuals who have an intellectual disability, probation/parole officers), and knowledgeable provider staff;
- Identify and utilize each person's specific strengths;
- Provide services and supports that will meet all of the person's unique needs and preferences, drawing on natural supports, and services and supports outside the mental health system;
- Address the person's special needs (e.g., co-occurring intellectual disabilities, traumatic brain injury) and, when necessary, accommodate those needs (providing effective communication e.g. sign language for consumers who are deaf and interpreting services for non-English speaking consumers);
- Assure that services are flexible, coordinated, and accountable;
- Recognize, respect, and accommodate differences relating to disability, culture, ethnicity, race, religion, gender, gender identify, and sexual orientation; and
- Provide opportunities for individuals to live and work in integrated settings

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?

Pennsylvania's Mental Health Olmstead Plan includes a Section on Local/Regional Olmstead Implementation and Counties will be revising their current Olmstead Plans after the 2015 revised plan is disseminated. The Local/Regional Olmstead Plan must include how the plan is making progress towards integration of housing services as described in Title II of the Americans with Disabilities Act.

4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Currently Pennsylvania is not involved in any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI.

5. Is the state involved in a partnership with other state agencies to address community integration?

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Pennsylvania Department of Human Services Office has existing partnerships with the Pennsylvania Housing Finance Agency (PHFA) and Pennsylvania Commission on Crime and Delinquency (PCCD). These partnerships are integral for addressing community integration.

OMHSAS and PHFA partner together to identify both suitable housing opportunities and community services and supports across the Commonwealth to best serve the needs of the most vulnerable citizens. Examples include Project Based Operating Assistance programs, the development and implementation of the HUD Section 811 PRA Demonstration Project, and identifying accessible units within the Low Income Housing Tax Credit Program. PHFA representatives participate in OMHSAS Annual Regional Housing Meetings and Quarterly Housing Calls with Counties, HealthChoices Behavioral Health Managed Care Programs and Local Lead Agencies.

OMHSAS partners with PCCD on a number of initiatives to identify both suitable housing opportunities and community services and supports to best serve the need of the forensic populations. One such initiative includes a joint Mental Health and Justice Housing Program in which $1 million in Forensic Housing grants was awarded to eight counties.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. 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 mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health 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.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

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.[93] 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 liaison 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 more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

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 substance use disorders and co-occurring disorders 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's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the **National Evaluation of the Children's Mental Health Initiative** (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- 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 behavioral health 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, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

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

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] 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.

[92] 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.

[93] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[94] 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 http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010.

[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

18. Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

   Response: Pennsylvania has several System of Care grants from SAMHSA to establish systems of care e in all counties throughout the Commonwealth. The State Leadership and Management Team has oversight responsibility for the state grants and is working with 2 new community SOC Grants to assure compliance with the State (and federal SOC standards. The SLMT is comprised of leaders from the state child serving systems and an equal number of youth and family representatives.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

   Response: The System of Care expansion plan identifies that the practice model for systems of care will be research-based, individualized care planning practice models such as High Fidelity Wraparound which involve youth and families in equal partnership with systems and natural supports

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

   Response: The System of Care State Leadership and Management Team consists of top officials from Child Welfare, Juvenile Justice, Drug & Alcohol, Education, and Mental Health, along with an equal number of youth and family representatives. A memorandum of Agreement guides the multi-system efforts.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

   Response: The Youth and Family Training Institute provides training, coaching, monitoring, and credentialing for staff involved in High Fidelity Wraparound. In addition, Pennsylvania has supported the development of Multi-Systemic Therapy, Functional Family Therapy, and Parent Child Interaction Therapy, each of which has its own training requirements.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

   Response: The Bureau of Quality Management in OMHSAS has this responsibility.

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

   Response: In Pennsylvania, the Student Assistance Program (SAP) is a process that is designed to assist school personnel in identifying barriers to learning, including D&A and mental health concerns. The core of the program is a professionally trained team, which includes school staff and liaisons from community D&A and MH agencies. SAP team members within the school are trained to identify problems and determine whether or not the presenting issue lies within the responsibility of the school. When the issue is outside the scope of the school, the SAP team will make a referral to a SAP Liaison, who is employed by a community mental health or D&A agency, at which point a screening can take place to determine if additional assessment for treatment is warranted. SAP is currently in its 30th year, and is administered through a joint effort between the PA Department of Education, the PA Department of Human Services, and the PA Department of Drug and Alcohol Programs.

7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

   Response: Individuals can transition from the children's behavioral health system into the adult behavioral health system at the age of 18 through age 22*, depending on the type of services they are receiving.

   The plan for an individual to transition into the adult behavioral health services typically occurs prior to age 18, unless as noted above. The young person, family members and the service provider would work together to ensure that the transition is seamless and any special issues or concerns are addressed. Because the array of services in the children's behavioral health system is very different than the adult behavioral health system, this planning process should be started as early as possible to have sufficient time to identify appropriate services and supports to transition into the adult system and resources based on the individual's needs.

   With regard to transition in the foster care system, at age 18 a youth in custodial care can opt to remain in care, until the age of 21, or can choose to leave care. When preparing to transition out of custodial care, the young person's Independent Living Coordinator (ILC) will work with him/her and the foster care parents to plan for the transition to independent living and identify needed resources.

**PA Medical Assistance Bulletin 01-95-13, 11-95-09, 12-95-05, 13-95-02, 14-95-02, 17-95-06, 41-95-04, 50-95-04, 53-95-02, 1165-95-01*

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant **(Title XIX, Part B, Subpart II, Sec.1922 (c))**. A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at **http://www.samhsa.gov/women-children-families:** *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

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

1. The implementing regulation **requires** the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not applicable to MH Block Grant

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Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised **National Strategy for Suicide Prevention (2012)**.
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document **Guidance for State Suicide Prevention Leadership and Plans**.[96]

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

[96] **http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf**

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Pennsylvania Youth Suicide Prevention Plan

Introduction:

Youth suicide statistics reinforce the need for comprehensive youth suicide prevention efforts. Suicide is one of the leading causes of death for young people age 15-24. (CDC) Suicide rates for those 15-19 have tripled since 1960 (CDC, 1997). The American Association of Suicidology found that 4-8% of adolescents report an attempted suicide within the prior 12 months. Data from the Centers for Disease Control (CDC) indicates that approximately 500,000 teens attempt suicide each year.

Since the 1980's, Pennsylvania has made strong efforts toward the prevention of youth suicide through programs such as the Commonwealth Student Assistance Program (SAP), Services for Teens at Risk (STAR-Center), the Yellow Ribbon Program and a variety of other approaches in local areas.

SAP, a collaborative program started in 1985 between the state Departments of Education (PDE), Health (DOH), and Public Welfare (DPW), exists in all 501 school districts. Every secondary school building is required to have a student assistance program. DPW's Office of Mental Health and Substance Abuse Services (OMHSAS) funds county Mental Health/Mental Retardation (MH/MR) Programs and DOH's Bureau of Drug and Alcohol Programs (BDAP) funds Single County Authorities (SCAs) to provide SAP liaison services to all secondary buildings. Commonwealth Approved Trainers (CATS) provide training for all school core teams and ten Regional SAP Coordinators provide technical assistance to the state's nine regions. The core teams in each secondary building, comprised of teachers, principals, school counselors, school nurses, psychologists, social workers, and community liaisons from the mental health and drug and alcohol agencies, assist in identifying students at risk for suicide or other behavioral health problems.

The STAR-Center began in 1986 in Pittsburgh as a specialty program to address the increasing problems related to adolescent suicide and depression, and youth violence. The services were expanded in 1989 to include consultation and training for schools in the area of crisis responding and school safety. The center publishes STAR-Center Link, a newsletter featuring best practices on mental health treatment and violence prevention and its "Survivors of Suicide" program is nationally recognized.

The Yellow Ribbon Program originated in Colorado in 1994 and is now in every state and 44 countries. Youth are taught how to use "yellow ribbon" cards to ask for help. Some Pennsylvania counties are participating in this program.

In the summer of 2001, various professionals within Pennsylvania inquired as to why Pennsylvania did not have a "formal" youth suicide prevention plan. The professionals had encountered a national website that included plans from many other states. Pennsylvania was listed with two contacts from the Pennsylvania Department of Education (PDE), but has no formal plan. As a result, the Interagency Committee of SAP took the lead in convening a workgroup of

about 50 stakeholders from across the Commonwealth to formalize a plan that includes not only what already exists in Pennsylvania, but also a strategy to address the possible gaps.

The workgroup decided to use the "National Strategy for Suicide Prevention: Goals and Objectives for Action" as a template to begin its work. Pennsylvania has borrowed generously from the national strategy by adopting the 11 national goals, where applicable, and adapting the objectives to fit Pennsylvania's needs. What follows is a summary from the national strategy, Pennsylvania's goals and objectives, and a 5-year work plan to begin to address the objectives.

Summary from the National Strategy for Suicide Prevention: Goals and Objectives for Action:

> *The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description.*
>
> Kay Redfield Jamison

Suicide has stolen lives around the world and across the centuries. Meanings attributed to suicide and notions of what to do about it have varied with time and place, but suicide has continued to exact a relentless toll. In the United States, suicide is the eighth leading cause of death and contributes–through suicide attempts–to disability and suffering for hundreds of thousands of Americans each year. There are few who escape being touched by the tragedy of suicide in their lifetimes; those who lose someone close as a result of suicide experience an emotional trauma that may take leave, but never departs.

Suicide: Cost to the Nation

- Every 17 minutes another life is lost to suicide. Every day 86 Americans take their own life and over 1500 attempt suicide.
- Suicide is now the eighth leading cause of death in Americans.
- For every two victims of homicide in the U.S. there are three deaths from suicide.
- There are now twice as many deaths due to suicide than due to HIV/AIDS.
- Between 1952 and 1995, the incidence of suicide among adolescents and young adults nearly tripled.
- In the month prior to their suicide, 75% of elderly persons had visited a physician.
- Over half of all suicides occur in adult men, aged 25-65.
- Many who make suicide attempts never seek professional care immediately after the attempt.
- Males are four times more likely to die from suicide than are females.
- More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease, **combined**.
- Suicide takes the lives of more than 30,000 Americans every year.

Only recently have the knowledge and tools become available to approach suicide as a preventable

public health problem with realistic opportunities to save many lives. The *National Strategy for Suicide Prevention: Goals and Objectives for Action* (NSSP or *National Strategy*) is designed to be a catalyst for social change, with the power to transform attitudes, policies, and services. It reflects a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behavior in the United States. The effective implementation of the *National Strategy* will play a critical role in reaching the suicide prevention goals outlined in the Nation's public health agenda, *Healthy People 2010*. Representing the combined work of advocates, clinicians, researchers and survivors, the *National Strategy* lays out a framework for action and guides development of an array of services and programs yet to be set in motion. It strives to promote and provide direction to efforts to modify the social infrastructure in ways that will affect the most basic attitudes about suicide and that will also change judicial, educational, social service, and health care systems. The NSSP is highly ambitious because the devastation wrought by suicide demands the strongest possible response.

Because suicide is such a serious public health problem, the *National Strategy* proposes public health methods to address it. The public health approach to suicide prevention represents a rational and organized way to marshal prevention efforts and ensure that they are effective. Only within the last few decades has a public health approach to suicide prevention emerged with good understanding of the biological and psychosocial factors that contribute to suicidal behavior. Its five basic steps are to clearly define the problem; identify risk and protective factors; develop and test interventions; implement interventions; and evaluate effectiveness.

As conceived, the *National Strategy* requires a variety of organizations and individuals to become involved in suicide prevention and emphasizes coordination of resources and culturally appropriate services at all levels of government–Federal, State, tribal and community–and with the private sector. The NSSP represents the first attempt in the United States to prevent suicide through such a coordinated approach.

The *Goals and Objectives for Action* articulates a set of 11 goals and 68 objectives, and provides a blueprint for action. The 11 goals are:

***Goal 1*: Promote Awareness that Suicide is a Public Health Problem that is Preventable**
***Goal 2*: Develop Broad-based Support for Suicide Prevention**
***Goal 3*: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services**
***Goal 4*: Identify, Develop, and Implement Suicide Prevention Programs**
***Goal 5*: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm**
***Goal 6*: Implement Training For Recognition of At-Risk Behavior and Delivery of Effective Treatment**
***Goal 7*: Develop and Promote Effective Clinical and Professional Practices**
***Goal 8*: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services**
***Goal 9*: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media**
***Goal 10*: Promote and Support Research on Suicide and Suicide Prevention**
***Goal 11*: Improve and Expand Surveillance Systems**

The next step for the *National Strategy* will be to prepare a detailed plan that includes specific

activities corresponding to each of the 68 objectives.

Aims of the *National Strategy*

- Prevent premature deaths due to suicide across the life span
- Reduce the rates of other suicidal behavior
- Reduce the harmful after-effects associated with suicidal behavior and the traumatic impact of suicide on family and friends
- Promote opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and communities

Pennsylvania Strategy for Youth Suicide Prevention: Goals and Objectives for Action

Goal 1: Promote Awareness that Youth Suicide is a Public Health Problem that is Preventable

In a democratic society, the stronger and broader the support for a public health initiative, the greater its chance for success. If the general public understands that suicide and suicidal behavior can be prevented, and people are made aware of the roles individuals and groups can play in prevention, the suicide rate can be reduced.

The objectives established for this goal are focused on increasing the degree of cooperation and collaboration between and among public and private entities that have made a commitment to public awareness of suicide and suicide prevention. They include:

- Developing public education campaigns
- Sponsoring state, regional, and local conferences on suicide and suicide prevention
- Organizing special-issue forums
- Disseminating information through the Internet.

Goal 2: Develop Broad-based Support for Youth Suicide Prevention

Because there are many paths to suicide, prevention must address psychological, biological, and social factors if it is to be effective. Collaboration across a broad spectrum of agencies, institutions, and groups–from schools to faith-based organizations to health care associations–is a way to ensure that prevention efforts are comprehensive. Such collaboration can also generate greater and more effective attention to suicide prevention than can these groups working alone. Public/private partnerships that evolve from collaboration are able to blend resources and build upon each group's strengths. Broad-based support for suicide prevention may also lead to additional funding, through governmental programs as well as private philanthropy, and to the incorporation of suicide prevention activities into the mission of organizations that have not previously addressed it.

The objectives established for this goal are focused on developing collective leadership and on increasing the number of groups working to prevent suicide. They will help ensure that suicide prevention is better understood and that organizational support exists for implementing prevention

activities. The objectives include:

- Organizing a state interagency committee to improve coordination and to ensure implementation of the *Pennsylvania Strategy*
- Establishing public/private partnerships dedicated to implementing the *Pennsylvania Strategy*
- Increasing the number of professional, volunteer, faith community and other groups that integrate suicide prevention activities into their ongoing activities, and adopt policies designed to prevent suicide.

Goal 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Youth Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services

Suicide is closely linked to mental illness and to substance abuse, and effective treatments exist for both. However, the stigma of mental illness and substance abuse prevents many youth from seeking assistance; they fear prejudice and discrimination. The stigma of suicide itself–the view that suicide is shameful and/or sinful--is also a barrier to treatment for youth who have suicidal thoughts or who have attempted suicide. Family members of youth suicide attempters often hide the behavior from friends and relatives, and those who have survived the suicide of a loved one suffer not only the grief of loss but often the added pain stemming from stigma.

Historically, the stigma associated with mental illness, substance abuse, and suicide has contributed to inadequate funding for preventive services. It has also resulted in the establishment of separate systems for physical health and mental health care. One consequence is that preventive services and treatment for mental illness and substance abuse are much less available than for other health problems. Moreover, this separation has led to bureaucratic and institutional barriers between the two systems that complicate the provision of services and further impede access to care. Destigmatizing mental illness and substance use disorders could increase access to treatment by reducing financial barriers, integrating care, and increasing the willingness of individuals to seek treatment. SAP is a viable example of how interagency collaboration can reduce barriers for youth services. Although it is very successful, there is still a need to destigmatize seeking mental health and substance abuse services to prevent youth suicide.

The objectives established for this goal are designed to create the conditions that enable persons in need of mental health and substance abuse services to receive them. They include:

- Increasing the number of suicidal youth with underlying mental disorders who receive appropriate mental health treatment
- Transforming public attitudes to view mental and substance use disorders as real illnesses, equal to physical illness, that respond to specific treatments and to view youth who obtain treatment as pursuing basic health care.

Goal 4: Identify, Develop, Implement, and Evaluate Youth Suicide Prevention Programs

Research has shown that many suicides are preventable; however, effective suicide prevention programs require commitment and resources. The public health approach provides a framework for developing preventive interventions. Programs may be specific to one particular organization, such as a university or a community health center, or they may encompass an entire state. A special

emphasis of this goal is that of ensuring a range of interventions that in concert represent a comprehensive and coordinated program.

The objectives established for this goal are designed to foster planning and program development work and to ensure the integration of suicide prevention into organizations and agencies that have access to groups of individuals for other purposes. The objectives also address the need for systematic planning and evaluation at both the State and local levels, the need for technical assistance in the development and evaluation of suicide prevention programs, and the need for ongoing evaluation. Objectives include:

- Increasing the proportion of local communities with comprehensive suicide prevention plans
- Increasing the number of evidence-based suicide prevention programs in schools, colleges and universities, work sites, corrections institutions, aging programs, and family, youth, and community service programs
- Developing technical support activities to build the capacity across the state to implement and evaluate suicide prevention programs.

Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm

Evidence from many countries and cultures shows that limiting access to lethal means of self-harm may be an effective strategy to prevent self-destructive behavior. Often referred to as "means restriction," this approach is based on the belief that a small but significant minority of suicidal acts are, in fact, impulsive and of the moment; they result from a combination of psychological pain or despair coupled with the easy availability of the means by which to inflict self-injury. Thus, a self-destructive act may be prevented by limiting the youth's access to the means of self-harm. Evidence suggests that restricting access to the means for self-harm may have a limited time effect for decreasing self-destructive behavior in susceptible and impulsive youth. Controversy exists about how to accomplish this goal because restricting means can take many forms and signifies different things to different people. For some, means restriction may connote redesigning or altering the existing lethal means of self-harm currently available, while to others it means eliminating or limiting their availability.

The objectives established for this goal are designed to separate in time and space the suicidal impulse from access to lethal means of self-harm. They include:

- Educating parents, health care providers, health and safety officials, and school personnel on the assessment of lethal means in the home, school, and community, and identifying actions to reduce the means of self-harm within their environments
- Implementing a public information campaign designed to reduce accessibility of lethal means.

Goal 6: Implement Training For Recognition of At-Risk Behavior and Delivery of Effective Treatment

Studies indicate that many health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal youth, nor do they know how to refer youth properly for specialized assessment and treatment. Despite the increased awareness of suicide as a

major public health problem, gaps remain in training programs for health professionals and others who often come into contact with youth in need of these specialized assessment techniques and treatment approaches. In addition, many health professionals lack training in the recognition of risk factors often found in grieving family members of loved ones who have died by suicide (suicide survivors).

Key gatekeepers–people who regularly come into contact with youth or families in distress– need training in order to be able to recognize factors that place youth at risk for suicide, and to learn appropriate interventions. Key gatekeepers include parents, teachers and school personnel, clergy, police officers, primary health care providers, mental health care and substance abuse providers, corrections and juvenile justice personnel, and emergency health care personnel.

The objectives established for this goal are designed to ensure that health professionals and key community gatekeepers obtain the training that will help them prevent suicide. They include:

- Improving education for nurses, physician assistants, physicians, social workers, psychologists, addictions and other counselors
- Providing training for clergy, teachers and other educational staff, corrections workers, staff of child-serving systems such as children and youth case workers, child welfare personnel, juvenile justice personnel, and attorneys on how to identify and respond to youth at risk for suicide
- Providing training for leaders of youth, community and faith-based organizations and groups, child care providers, athletic associations, “adult mentors” and “peer mentors” on how to identify and respond to youth at risk for suicide
- Providing educational programs for family members of youth at elevated risk
- Providing educational programs for all students for recognition of at-risk behavior and how to respond.

***Goal 7*: Develop and Promote Effective Clinical and Professional Practices**

One way to prevent youth suicide is to identify youth at risk and to engage them in treatments that are effective in reducing the personal and situational factors associated with suicidal behavior (e.g., depressed mood, hopelessness, helplessness, low academic achievement, alcohol and other drug abuse, among others). Another way to prevent youth suicide is to promote and support the presence of protective factors, such as learning skills in problem solving, conflict resolution, and nonviolent handling of disputes. By improving clinical practices in the assessment, management, and treatment for youth at risk for suicide, the chances for preventing those youth from acting on their despair and distress in self-destructive ways are greatly improved. Moreover, promoting the presence of protective factors for these youth can contribute to reducing their risk.

The objectives established for this goal are designed to heighten awareness of the presence or absence of risk and protective conditions associated with youth suicide, leading to better triage systems and better allocation of resources for youth in need of specialized treatment. They include:

- Changing procedures and/or policies in certain settings, including primary care settings, hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and various institutional treatment settings, to include screening and

assessment of youth suicide risk

- Ensuring that individuals who typically provide services to youth suicide survivors have been trained to understand and respond appropriately to their unique needs (e.g., emergency medical technicians, firefighters, police, funeral directors)
- Increasing the numbers of youth who receive support and continued treatment services (including consistent follow-up) for mood disorders and other behavioral health disorders difficult to detect such as substance abuse
- Ensuring that youth treated for trauma, sexual assault, or physical abuse in all healthcare settings, including in emergency departments receive consultation, referral, mental health services, and/or support services. These support services may include domestic violence centers, rape crisis centers, etc
- Fostering the education by providers of mental health and substance abuse services for family members and significant others of youth receiving care for the treatment of mental health and substance abuse disorders on the risk of suicide.

***Goal 8*: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services**

> *The elimination of health disparities and the improvement of the quality of life for all Americans are central goals of Healthy People 2010.*

Some of these health disparities are attributable to differences of gender, race or ethnicity, education, income, disability, stigma, geographic location, or sexual orientation. Many of these factors place youth at increased risk for suicidal behavior.

Barriers to equal access and affordability of health care may be influenced by financial, structural, and personal factors. Financial barriers include not having enough health insurance or not having the financial capacity to pay for services outside a health plan or insurance program. Structural barriers include the lack of primary care providers, medical specialists or other health care professionals to meet special needs or the lack of health care facilities. Personal barriers include cultural or spiritual differences, language, not knowing when or how to seek care, or concerns about confidentiality or discrimination. Reducing disparities is a necessary step in ensuring that all Pennsylvanians receive appropriate physical health, mental health, and substance abuse services. One aspect of improving access is to better coordinate the services of a variety of community institutions. This will help ensure that at-risk populations receive the services they need, and that all youth receive regular preventive health services.

The objectives established for this goal are designed to enhance inter-organizational communication to facilitate the provision of health services to those in need of them. They include:

- Exploring the benefits for health insurance plans to cover mental health and substance abuse care on par with coverage for physical health care
- Implementing utilization management guidelines for suicidal risk in managed care and insurance plans
- Integrating culturally competent mental health and suicide prevention into health and social services outreach programs for at-risk populations
- Defining and implementing screening guidelines for schools, colleges, state professional

organizations, and corrections institutions, along with guidelines on linkages with service providers
- Implementing support programs for youth who have survived the suicide of someone close.

Goal 9: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in Media and Entertainment

Media and entertainment have a powerful impact on perceptions of reality and on behavior. Research over many years has found that media representations of suicide may increase suicide rates, especially among youth. "Cluster suicides" and "suicide contagion" have been documented, and studies have shown that both news reports and fictional accounts of suicide in movies and on television can lead to increases in youth suicide. It appears that imitation plays a role in certain youth engaging in suicidal behavior.

On the other hand, it is widely acknowledged that the media can play a positive role in suicide prevention, even as they report on suicide or depict it and related issues in movies and on television. The way suicide is presented is particularly important. Changing media representation of suicidal behavior is one of several strategies needed to reduce the suicide rate.

Media portrayals of mental illness and substance abuse may also affect the youth suicide rate. Negative views of these problems may lead youth to deny they have a problem or be reluctant to seek treatment--and untreated mental illness and substance abuse are strongly correlated with suicide.

The objectives established for this goal are designed to foster consideration among media leaders of the impact of different styles of describing or otherwise depicting suicide and suicidal behavior, mental illness, and substance abuse, and to encourage media representations of suicide that can help prevent rather than increase suicide. They include:
- Increasing the number of local television programs and news reports that observe recommended guidelines in the depiction of suicide and mental illness
- Increasing the number of journalism schools that adequately address reporting of mental illness and suicide in their curricula
- Promoting awareness of the influence of the entertainment industry.

Goal 10: Promote and Support Research on Youth Suicide and Youth Suicide Prevention

All suicides are highly complex. The volume of research on suicide and its risk factors has increased considerably in the past decade and has generated new questions about why individuals become suicidal or remain suicidal. The important contributions of underlying mental illness, substance use, and biological factors, as well as potential risk that comes from certain environmental influences are becoming clearer. Increasing the understanding of how individual and environmental risk and protective factors interact with each other to affect a youth's risk for suicidal behavior is the next challenge. This understanding can contribute to the limited but growing information about how modifying risk and protective factors change outcomes pertaining to youth suicidal behavior.

The objectives established for this goal are designed to support a wide range of research endeavors focused on the underlying causes, expression, and maintenance of suicidal behavior across the lifespan. The enhanced understanding to be derived from this research will lead to better assessment tools, treatments, and preventive interventions. The objectives include:

- Promoting youth suicide prevention research
- Evaluating preventive interventions
- Establishing a registry of interventions with demonstrated effectiveness for prevention of suicide or suicidal behavior.

Goal 11: Improve and Expand Surveillance Systems

Surveillance has been defined as the systematic and ongoing collection of data. Surveillance systems are key to health planning. They are used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high risk populations for interventions, and to assess the impact of prevention efforts.

Data on suicide and suicidal behavior are needed at national, State and local levels. National data can be used to draw attention to the magnitude of the suicide problem and to examine differences in rates among groups (e.g., ethnic groups), locales (e.g., rural vs. urban) and whether suicidal individuals were cared for in certain settings (e.g., primary care, emergency departments). State and local data help establish local program priorities and are necessary for evaluating the impact of suicide prevention strategies.

The objectives established for this goal are designed to enhance the quality and quantity of data available on suicide and suicidal behavior and ensure that the data are useful for prevention purposes. They include:

- Improving analysis and availability of statewide child death review data.
- Increasing the number of hospitals that code for external cause of injuries
- Producing an annual report on youth suicide
- Encouraging the development of pilot projects to link and analyze information on self-destructive behavior from various, distinct data systems.

Looking Ahead

The *Pennsylvania Strategy for Youth Suicide Prevention* creates a framework for youth suicide prevention for Pennsylvania. It is designed to encourage and empower groups and individuals to work together. The stronger and broader the support and collaboration on youth suicide prevention, the greater the chance for the success of this public health initiative. Youth suicide and youth suicidal behavior can be reduced as the general public gains more understanding about the extent to which youth suicide is a problem, about the ways in which it can be prevented, and about the roles individuals and groups can play in prevention efforts.

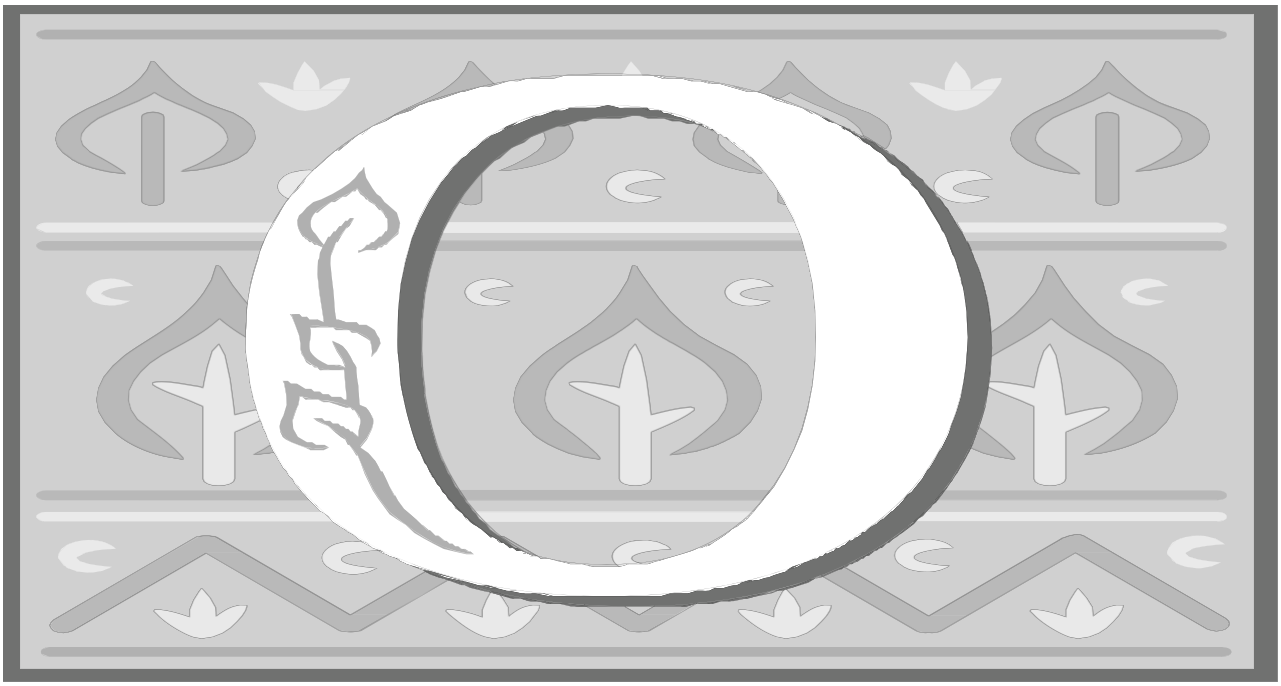
The *Pennsylvania Strategy* is comprehensive and sufficiently broad so that individuals and groups can select those objectives and activities that best correspond to their responsibilities and resources. The plan's objectives suggest a number of roles for different groups. Individuals from a variety of occupations need to be involved in implementing the plan, such as health care professionals, police, attorneys, educators, and clergy. Institutions such as community groups, faith-based organizations, and schools all have a necessary part to play. Sites for youth suicide prevention work include jails, emergency departments and the workplace. Survivors, consumers and the media need to be partners as well, and governments at the Federal, State, and local levels are key in providing funding for public health and safety issues.

Ideally, the *Pennsylvania Strategy* will motivate and illuminate. It can serve as a model and be adopted or modified by local communities as they develop their own youth suicide prevention plans. The *Pennsylvania Strategy* articulates the framework for statewide efforts and provides legitimacy for local groups to make youth suicide prevention a high priority for action.

The *Pennsylvania Strategy* encompasses the development, promotion and support of programs that will be implemented in communities across the Commonwealth designed to achieve significant, measurable, and sustainable reductions in youth suicide and youth suicidal behavior. This requires a major investment in public health action.

Now is the time for making great strides in youth suicide prevention. Implementing the *Pennsylvania Strategy for Suicide Prevention* provides the means to realize success in reducing the toll from this important public health problem. Sustaining action on behalf of all Pennsylvanians will depend on effective public and private collaboration–because youth suicide prevention is truly everyone's business.

Pennsylvania Adult Suicide Prevention Plan



Zero Suicide- Not another life to lose

Contents

INTRODUCTION

Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities nationwide. For every person who dies by suicide, more than 30 others attempt suicide. Every suicide attempt and death affects countless families, friends, coworkers and others who suffer the long-lasting consequences of suicidal behavior.[1] Some studies have consistently found that the overwhelming majority of people who die by suicide (90% or more) had a mental health condition at the time of their deaths. Often, however, these mental health conditions had not been recognized, diagnosed, or adequately treated and 1/3 of people who took their lives did not communicate their suicide intent to anyone.[2] Conversely, the vast majority of individuals do communicate their suicide intent in advance, thereby demonstrating the need for health care, social service, community, faith-based and other agencies and representatives to be trained to recognize and intervene to prevent suicides from occurring.

My mission in life… to promote the awareness and the prevention of suicide. It has been 2 ½ years since I lost my son Desmond. I still cry. I visit the cemetery every single day. I pray for him. I ask why…
Nothing has changed. The only thing that has changed is that I have learned to live better with the pain. The pain does not and will not ever go away. You only learn to live with it.
Suicide has such a ripple effect. Mother, father, brother, friends, aunts, uncles, grandparents, cousins, employers, co-workers… I can go on and on with the list. When someone dies, not by suicide, people say, they lived a good life or now they are not suffering any longer. There is nothing to say or nothing that can be said when someone takes their own life. We all need to work together to get in the minds of those who are contemplating suicide and help them before it's too late.

Mark W. Schantzer

Individuals with a serious mental health condition die by suicide at rates 6 to 12 times higher (especially those with major depression, schizophrenia, bipolar disorder, borderline personality, and anorexia) than the general population. Within the mental health system we have relied on a small group of specialized staff who work in crisis intervention programs to confront the highest risks. However, the bulk of the behavioral healthcare workforce has not received dedicated training in how to help people who are acutely suicidal.[3] Training is essential since research has shown that it is insufficient to treat only the mental health condition. Targeting and treating suicidal ideation and behaviors, independent of diagnosis, hold the greatest promise for care of suicide risk.[4]

While mental health and substance use conditions are closely linked with suicidal behavior, they are not the only factors that increase the risk of suicide. Relationship problems, financial

distress, long-term or debilitating illness, individuals bereaved by suicide or who have made previous suicide attempts -lesbian, gay, bisexual, transgender, questioning and intersex populations, members of the Armed Forces and Veterans, individuals in correctional settings, and middle aged or older men all have a higher risk of suicide than the general population. Appendix A of this plan provides additional information on several high risk groups. Undoubtedly, given the complexity and scope of the issue, suicide must be addressed at various levels of the system by a variety of agencies and groups that are trained to recognize suicidal risks and to provide leadership to work collaboratively to address the problem.

Suicide deaths/behaviors in the United States and Pennsylvania:

Nationally, suicide is the tenth leading cause of death, claiming more than twice as many lives each year as homicide.[5] According to the latest data available from the Centers for Disease Control and Prevention (CDC), 38,364 people died from suicide in the United States in 2010. Within Pennsylvania, 905 people took their own lives in the commonwealth in 2010 (up from 662 suicides in 1999), or nearly a 24% increase.[6] The rate of suicides within PA based upon average CDC data, was 11.18 per 100,000 population.[7] The national average is 12.11. Pennsylvania ranks 37 out of 51 in the number of deaths by suicide as compared to other states. Suicide rates within Potter County (23.79 per 100,000), and Cameron County (22.41 per 100,000), are the highest in the state and almost twice the national average. At the lower end, Union County has a rate of 6.2 per 100,000 and Montour has a 7.82 rate per 100,000.[7] While Pennsylvania may fall into the middle of the pack nationally, these wide ranges from low to high rates of suicide need to be explored and may hold clues to what contributes to and prevents suicide within various counties across the commonwealth. Suicide rates are only part of the picture. Existing data indicate that many people think about suicide and may engage in suicidal behavior which may include such things as collecting pills, writing a suicide note, giving things away, etc. During 2008 and 2009, an estimated 8.3 million adults aged 18 years and older reported having suicidal thoughts in the past year.[8] In addition, an estimated 1 million adults in the United States reported making a suicide attempt in the past year.[8]

> I first became aware of suicide at the age of 11, when I saw my father attempt suicide. I never imagined that I would ever be capable of getting to a place where I could try that, knowing how much that event affected me. Unfortunately, there was a time when I didn't have the will to be here any longer; but I found help, and over the years since then I was able to find knowledge and tools to help me to work through my challenges in a way that I wish my father had been able to do.
>
> Joseph Alex Martin

Age differences [9]:

Suicide is the second leading cause of death among 25-34-year olds and the third leading cause of death among 15-24-year olds. Suicide is also the second-leading cause of death for college students. A recent article in the Philadelphia Inquirer focused attention on suicides among seemingly successful college students at the University of Pennsylvania, Drexel University and Temple University.[10] Dr. Victor Schwartz, a psychiatrist with the Jed Foundation, states that college age is generally the time when many mental health conditions surface, when students are learning independence, testing boundaries and discovering sexual identity. Personal and family relationship disruption can be factors that lead to suicide. Suicide among 45-54-year-olds is a growing problem. The rate of suicide is higher in this age group than any other. Although older adults engage in suicide attempts less than those in other age groups, they have a higher rate of death by suicide. Over the age of 65, there is one estimated suicide for every four attempted suicides (compared to 1 suicide for every 100-200 attempts among youth and young adults ages 15-24). About 60 percent of elderly patients who take their own lives see their primary care physician within a few months of their death, thus demonstrating the critical role that health care professionals play in recognizing the signs of suicide, particularly in older adults.

Gender disparities [9]:

Men die by suicide four times as often as women (representing 78.8% of all U.S. suicides). Women attempt suicide two to three times as often as men. Suicide rates for males are highest among those 75 and older. Suicide rates for females are highest among those aged 45-54. Firearms are the most commonly used method of suicide among males, while poisoning is the most common method of suicide for females.

Racial and Ethnic disparities [9]:

The highest suicide rates are among American Indian/Alaskan Natives and Non-Hispanic Whites. Asian/Pacific Islanders have the lowest suicide rates among males, while Non-Hispanic Blacks have the lowest suicide rates among females.

Suicide and drug use [11]:

A January, 2014 data report from the Substance Abuse and Mental Health Services Administration (SAMHSA), indicates that suicide is a leading cause of death among illicit drug users. While 3.9 percent of adults had serious thoughts of suicide according to the 2012 National Survey on Drug Use and Health, the percentage was higher among adults who used illicit drugs in the same year (9.4 percent). The percentage of adults who had serious thoughts

of suicide varied by the type of illicit drug used. For example, 9.6 percent of marijuana users and 20.9 percent of sedative users (nonmedical use) had suicidal thoughts.

Suicide and problem gambling:

The National Council on Problem Gambling (NCPG) has estimated that one in five problem gamblers have attempted suicide, about twice the rate of other addictions. The NCPG has concluded that the most telling precursor of a problem gambler's impending suicide attempt is the size of their debt. NCPG reports that compounding the issue is the drive problem gamblers feel to keep their problems a secret, further isolating themselves from loved ones. Breaking the cycle of deception and secrecy is a key to addressing this problem.

PROCESS FOR DEVELOPING THE 2014 PENNSYLVANIA SUICIDE PREVENTION PLANS

In October of 2013, the Pennsylvania Adult and Older Adult Suicide Prevention Coalition received a grant from the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) as part of the "Mental Health Matters" initiative, to implement several suicide prevention initiatives including revising the 2005 Pennsylvania Adult and Older Adult Suicide Prevention Plans. In order to guide and direct this effort, a 31 member panel of experts was convened. Representatives were solicited from the Departments of Health, Aging, Corrections, and Military and Veterans Affairs, the Veterans Integrated Service Network, the County Commissioners Association, behavioral health managed care organizations, the OMHSAS Adult and Older Adult Advisory Committees, county suicide prevention taskforces, coroners offices, the National Alliance for the Mentally Ill of PA (NAMI PA), Area Agencies on Aging, the American Association of Retired Persons (AARP), the Rehabilitation and Community Providers Association (RCPA), the Pennsylvania Mental Health Consumers Association (PMHCA), the Keystone Pride Recovery Initiative (KPRI), and the PA Adult and Older Adult Suicide Prevention Coalition (PAOASPC). Although some organizations were unable to send representatives to the table, a diverse statewide committee was convened for its first in-person meeting in December of 2013. Members who participated in the committee are acknowledged for their work in developing the plans in Appendix G.

The current Pennsylvania Adult and Older Adult Suicide Prevention Plans were modeled after the original National Strategy for Suicide Prevention issued more than ten years ago by Surgeon General David Thatcher. Since the National Strategy was revised in 2012, it prompted a desire to update Pennsylvania's plans to reflect current research, prevention strategies, and needs, and to guide suicide prevention efforts within the commonwealth over the coming years. Given the significant amount of work that went into the 2012 National Strategy, it seemed natural to use this document as a template in the development of the 2014 Pennsylvania plans.

To begin the process, the goals and objectives within the 2005 state plans and 2012 national plans were reviewed and cross walked first by the full committee followed by a more intensive review and revision by workgroups assigned to each agreed upon goal. This resulted in the recommendation to use 11 goals within the Pennsylvania plans. The 11 Pennsylvania Adult and Older Adult Goals are parallel in their content; however, specifics related to adults and older adults are identified within the specific objectives and action steps of each respective plan. The 2012 National Strategy was also used to create Pennsylvania's objectives, action steps and some of the narrative. *Like the National Strategy, "the goals and objectives are broad in scope and encompass a wide range of activities. Many different groups at the local, regional and state levels, including counties, managed care organizations, provider organizations, social service agencies, educational institutions, workplaces, and health systems, etc., can play a role in advancing particular objectives. As a result, it is not possible to include specific target dates for the completion of each objective. All groups that have an interest in suicide prevention can use the goals and objectives to identify their own priority areas, thereby contributing to the full implementation of Pennsylvania's plans."*[1]

While the committee recognized the need for a comprehensive suicide prevention effort across the life span, the revised plans focus on adults and older adults due to funding requirements. Efforts are occurring concurrently to update and address suicide prevention efforts for children and youth.

In addition to the leadership provided by the PA Adult and Older Adult Suicide Prevention Plan Advisory Committee, input for the plans was gathered through four regional "Listening Sessions" which were held in early January of 2014 as well as through a questionnaire distributed through "Survey Monkey" during the January-February 2014 timeframe. A summary of comments and input gathered through these means is included in Appendix F.

In June, 2014, the final draft plans were circulated statewide for public comment by the Office of Mental Health and Substance Abuse. One comment on the plans was received from the Acquired Brain Injury Network of Pennsylvania, Inc. This organization indicates that the suicide rate for persons with traumatic brain injury is five times the rate in the general population and is still increasing. Since traumatic brain injury often resembles the symptoms of mental illness, they further recommend that it is important to screen for old and new injuries before proceeding with mental health treatment for suicidality since the injured brain does not benefit from the same medications or therapies as does mental illness.

LANGUAGE IN THE PLAN

Considerable discussion occurred among the Suicide Prevention Plan Advisory Committee in the development of this plan regarding the choice of language to refer to mental health and substance use. In keeping with the below guiding principle of "promoting the use of People First language and the reduction of medical and disease based labels", the preferred language chosen for use throughout the plan is "mental health and substance use". The term "behavioral health" is frequently used to refer to both mental health and substance use but is not used in the plan in order to avoid the misunderstanding that these are behaviors within a person's control. Likewise, we have chosen to take the positive spin on the words, therefore using mental health instead of mental illness and substance use instead of substance abuse. Limited use of the terms "mental health conditions and/or substance use conditions" is used where necessary.

The term, "family of choice" is used throughout the plan to reinforce the belief that individuals should be encouraged to include individuals they have identified as family in all important aspects of support and care.

BENEFITS OF A STATE PLAN:

- To guide the statewide agenda for suicide prevention and to target resources to the highest priority needs.
- To encourage public-private partnerships at the state, county and local level in order to support collaboration and avoid duplication across a broad spectrum of agencies, groups, and community leaders as well as suicide attempt survivors and suicide loss survivors.
- To link information about evidence-based and best practices for prevention, to share data that can be used to track trends, and to share information about training opportunities and resources across the state.
- To create a baseline of efforts within the state and to track success in reaching the goals outlined within the plan.

GUIDING PRINCIPLES FOR THE PLAN

- Design and implement suicide prevention activities in a culturally and developmentally appropriate fashion.

- Eliminate health care, race, ethnic, gender, education, income, disability, age, sexual orientation, gender identity, and geographic disparities that erode suicide prevention activities.
- Emphasize early interventions to promote protective factors and reduce risk factors for suicide.
- Endorse suicide prevention as everyone's business.
- Promote the adoption of "Zero Suicides" as an aspirational goal, particularly within health care settings that provide services and support to defined populations.
- Promote People First language and wellness approaches through the reduction of medical and disease-based labels that promote stigma.
- Advocate for, invest in, and sustain all state suicide prevention efforts.

GOAL 1: **INTEGRATE AND COORDINATE SUICIDE PREVENTION STRATEGIES ACROSS ALL SECTORS AND SETTINGS WITHIN THE COMMONWEALTH.**

Goal 1 of the new Pennsylvania Suicide Prevention Plan is a modified version of Goal 1 from the 2012 National Strategy for Suicide Prevention. The intent of this goal is to promote broad awareness of suicide and suicide prevention and collaboration across a broad spectrum of agencies, institutions, and groups to include state agencies, counties, managed care organizations, mental health and substance use provider organizations, social service agencies, businesses, colleges and universities, law enforcement, the criminal justice system, health care, and individuals that have frontline contact with individuals impacted by suicide including police, emergency management personnel, coroners, and funeral directors. In addition, the hope is to reach the general public who may not be aware of the signs of suicide or what to do if someone they know is at risk of suicide. Public/private partnerships that evolve from collaboration are able to blend resources and build upon each group's strengths while preventing duplication. Broad-based support for suicide prevention may also lead to additional funding through governmental programs, as well as private philanthropy, and to the incorporation of suicide prevention activities into the mission of organizations that have not previously addressed the issue. Integrating suicide prevention into the work of these community partners will promote greater understanding of suicide and help counter the prejudice, silence and denial that can prevent individuals from seeking help.[12]

The following objectives and action steps address the need to first identify what is being done by who at all levels of the system related to suicide awareness and prevention. Once a baseline

is established, the actions include: the creation of a statewide, inclusive, interagency advisory committee; identifying lead staff within each identified agency and to outline their responsibilities related to suicide prevention; and to use this committee to shepherd the work outlined in this plan. Concurrently, county-level suicide prevention taskforces need to expand in number and responsibility, since fewer than half of the counties have an identified taskforce with this focus. Action steps include providing technical assistance and support to these taskforces that play a key role in creating awareness and local responsibility for suicide prevention.

This goal also includes specific collaborative efforts with organizations, and projects that can enhance the suicide prevention agenda within the state. Collaborative efforts should include partnerships with projects such as the Pennsylvania Youth Suicide Prevention Initiative, the Garrett Lee Smith grant (-a youth-focused suicide prevention project), and with Active Minds (-a college-based project designed to address the needs of students with mental health concerns). The intent, however, is not to limit collaboration with just these two initiatives but to work with other suicide prevention efforts that may develop in the future. Finally, health care efforts, including Pennsylvania's managed care program, can be an opportunity to incorporate suicide treatment, prevention and quality improvement into services.

As co-chair to the Chester County Suicide Prevention Task Force and as a mother who lost her son to suicide, I would like to express my own observations about my experience. Losing my son at age 15 to suicide forever changed myself, my family and my world. My other children who were 2 years and 9 years younger than Jimmy experienced great difficultly navigating life, especially through their teen years. My husband eventually left the family and became involved in an addiction. The journey has been daunting, overwhelming and at times almost unbearable. I know that many people including extended family and friends were also profoundly impacted by Jimmy's death.

I am very proud to have become the person that I am today. I work for the cause of suicide prevention and mental health awareness. My work with older adults is very satisfying. Despite the outcome, I would do anything to reverse the events of May 15, 1992. After that day, life would never be the same.

Carol Harkins

OBJECTIVES:

Objective 1.1: Integrate suicide prevention into the values, culture, leadership and work of a broad range of organizations and programs with a role to support suicide prevention activities.

Objective 1.2: Enhance and strengthen collaborations across federal, state, and local agencies to advance suicide awareness and prevention.

Objective 1.3: Develop and sustain public-private partnerships to advance suicide awareness and prevention.

Objective 1.4: Integrate suicide prevention into health care efforts.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 1.1.1: Identify and evaluate suicide awareness and prevention strategies currently in place within the commonwealth.

Action step 1.1.2: Engage community groups to integrate suicide prevention within their respective organizations, including the development of local/agency suicide prevention plans.

Action step 1.1.3: Expand the number and capacity of County Suicide Prevention Taskforces across the commonwealth:

- Revise/re-issue the manual completed in 2009 to help county taskforces with start-up.
- Provide on-site technical assistance from a consultant or other counties (peer-to-peer) on the how to's of a county suicide prevention taskforce.
- Host monthly/quarterly webinars with county taskforces to educate, network, etc.

Action step 1.2.1: Organize an interagency committee, with representation from state and local agencies, to enhance coordination and advance implementation of suicide prevention strategies.

Action step 1.2.2: Identify a lead agency at the state and local levels to bring together agencies/groups that should be involved in suicide prevention and clarify each agency's area of focus/responsibility.

Action step 1.2.3: Collaborate with organizations such as Active Minds to develop a joint agenda to assist with suicide prevention on college campuses.

Action step 1.2.4: Collaborate with the PA Garrett Lee Smith project, and other suicide prevention grants, on joint initiatives, including risk assessments.

Action step 1.4: Ensure suicide prevention is integrated into state policies and program guidance under Medicare and Medicaid, including Pennsylvania's managed care program, Health Choices. This would include sharing the final plan with the Centers for Medicare and Medicaid Services (CMS)/ the Department of Health and Human Services (DHS).

My name is Linda, my 38 year old son completed suicide on July 5, 2012. The emptiness in my life due to his effort to end his pain has made tremendous pain in our lives. He left behind two brothers, two sisters, a twelve year old daughter and a four year old son, and of course, me his mom. I tried to help him all during his teen years calling crisis and having him committed to hospitals. He hid his pain very well in the last few months before his death. No one had a clue that he was preparing to end his life. I can't cry around his siblings, so I cry silently at night in my bed. I can't understand how someone could choose death over life. I can't understand how a child I carried and raised, would choose to end his life. We need to be educated about the warning signs that we somehow missed. I don't want another family or mother to feel the pain and emptiness that is in my heart. I am hyper alert to my other family members, and much to their despair, I need reassurance that they are fine daily. I walk in the "Out of the Darkness" walks, to help raise money to educate everyone and to possibly prevent one other person from feeling that ending their life is the only answer.

Linda Kline

GOAL 2: IMPLEMENT COMMUNICATION AND EDUCATION EFFORTS TO CHANGE THE KNOWLEDGE, ATTITUDES AND BEHAVIORS OF THE PUBLIC IN ORDER TO PREVENT SUICIDE

Goal 2 of the Pennsylvania plan borrows language from goal 2 in the 2012 National Strategy for Suicide Prevention. The intent of this goal is to enhance communication about suicide, warning signs of suicide and suicide prevention resources through a variety of methods. National, state, and local suicide prevention organizations/advocacy organizations and the federal government have done considerable work in creating a wealth of resources that range from research documents, to posters and videos that have been used successfully to inform and educate the public. A list of resources/websites has been attached to this plan with most of these organizations offering low cost or free resources to assist in communication efforts.

The following action steps recommend that state, county and local agencies/organizations add these resources to their websites/materials so that the range of resource material is shared widely across the state. It is also recommended that all communication initiatives be guided by best practices for social marketing to ensure successful outcomes. The actions also single out

policy makers as key change agents for suicide prevention, and recommend providing such leaders with targeted information about state/local statistics and trends, at risk populations along with recommended interventions, and evidence-based practices.

It is paramount to provide individuals at risk, as well as the general population, with information about how and where to get connected to care and support for crises that could lead to suicide, including quick access to local and national crisis lines. Vital to this effort of getting individuals connected to care, are the stories of individuals who have received help and can motivate others to receive the help they need.

OBJECTIVES:

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach all populations within the commonwealth.

Objective 2.2: Reach federal, state, and local policymakers with dedicated communication efforts.

Objective 2.3: Enhance online communication efforts that promote positive messages and support evidence-based and/or effective crisis intervention strategies.

Objective 2.4: Expand knowledge of the warning signs for suicide.

Objective 2.5: Provide knowledge of how to connect individuals in crisis with assistance and care.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 2.1.1: Develop/distribute informational materials (resource materials, flyers, buttons, magnets, etc.) and conduct public education campaigns (speakers bureau, videos, billboards, etc.) on: suicide risk and protective factors; national, state and community resources including crisis lines; anti-stigma messages, etc.

Action step 2.1.2: Inform counties, providers, stakeholders and others of the availability of free/low cost informational material such as articles, research, posters, magnets, videos etc., from sites such as the Substance Abuse and Mental Health Services Administration, and the American Foundation for Suicide, etc. (See resource section of plan for additional information).

Action step 2.1.3: Ensure that resources/materials are culturally and linguistically competent, including availability in other languages and braille.

Action step 2.1.4: Ensure that communication efforts incorporate the principles of effectiveness in the literature; and utilize materials (such as *"Making Health Communication Programs Work"* and *"Gateway to Health Communication and Social Marketing Practice")* as referenced in the 2012 National Strategy for Suicide Prevention.

Action step 2.1.5: Evaluate the success of communication efforts. This may include tracking the number of calls/emails, when contact information is provided.

Action step 2.2: Create targeted resource documents and related materials for federal, state and local policymakers, including material on evidence-based practices, high risk populations, evaluation data, etc., that can be used to impact policy decisions.

Action step 2.3.1: Recommend resources to add to state, county and local websites on suicide prevention (including how to access mental health, substance use and crisis services, risk and protective factors, etc.).

Action step 2.3.2: Provide positive messages through social media including mobile apps to help people with depression chart their moods and access crisis lines, use of the U.S. Department of Veterans Affairs crisis line call center chat line, etc.

Action step 2.4-2.5.1: Increase awareness of the role of crisis lines such as the National Suicide Prevention Lifeline/Veterans Crisis Line (800-273-TALK/8255) and other local crisis services and resources.

Action step 2.4-2.5.2: Incorporate stories of individuals who received and benefited from help into written and online materials, to motivate others to take actions.

GOAL 3: IDENTIFY AND INCREASE KNOWLEDGE OF THE FACTORS THAT PROMOTE RESILIENCY FROM SUICIDE AND THAT PROMOTE WELLNESS AND RECOVERY.

Goal 3 of the state plan is similar to Goal 3 in the 2012 National Strategy for Suicide Prevention, with some revisions made to the language. This revised goal changes the focus from reducing stigma to promoting wellness and recovery from suicidal thoughts and actions. The concepts of wellness, recovery and resiliency are well known in the mental health and substance use fields, but are not well understood by the community at large. These concepts need to be understood

by significant people such as a person's family of choice, friends and staff who may be the first line of contact for individuals at-risk of suicide. Suicide is closely linked to mental health and substance use conditions, and effective treatments exist for both. In addition, the stigma of mental health and substance use conditions prevents many persons from seeking assistance due to fear of prejudice and discrimination.

> Suicide prevention is not just a matter of getting the word out to those who struggle. A change is needed in how would-be supports treat those in emotional anguish. One of my personal goals is to teach appropriate response by sharing my story in print and in person. Family, friends, bosses, and any other acquaintances of potentially suicidal individuals are our front line in this battle. Although I take responsibility for my decision to attempt suicide, I am certain that if there had been a healthier response when I initially tried to express my feelings, it would not have happened.
>
> Nancy Virden

The following objectives and actions are designed to increase knowledge about mental health, substance use, and suicide such that people are not embarrassed to seek help and have a greater understanding that people can and do recover. Presentations by suicide attempt survivors and by individuals bereaved by suicide can be powerful ways to convey the message that, "I've been there, I received help and support and you can too." The actions also promote public education to increase general understanding of mental health, substance use, and suicide in order to dispel myths and eliminate stigma. Recent polls conducted by the Pennsylvania Mental Health Consumers Association (PMHCA) found more stigma directed to people with mental health conditions than toward any other disability. For more information, see http://www.pmhca.org/StigmaProject/media.html and scroll down to information about surveys on stigma. Pre and post tests are recommended to evaluate the impact of any public education efforts so that future efforts can be modified and adapted accordingly.

It is important to recognize and take into account the impact that cultural and religious beliefs can have on protecting individuals from suicide, or how such beliefs might present a barrier to people seeking help. For example, data show that African American women have the lowest suicide rate among females and older adult white males have the highest suicide rate of any other population group, demonstrating the need to understand how race, gender, and other factors impact suicide risk. Likewise, religious beliefs that oppose suicide may help protect individuals from suicide or present barriers to individuals admitting suicidal thoughts and seeking the help they need. Research has also demonstrated that social connections and problem solving skills can help insulate individuals from suicide. Best practices then can be implemented that draw upon what the research indicates will protect individuals from suicide.

OBJECTIVES:

Objective 3.1: Identify and promote effective programs and practices that increase protection from suicide risk.

Objective 3.2: Reduce the prejudice and discrimination associated with suicidal thoughts and actions, and mental health and substance use conditions.

Objective 3.3: Promote the understanding that mental health and substance use recovery is possible for all.

Objective 3.4: Educate the community about the protective factors from suicide risk and the risk factors of suicide.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 3.1.1: Develop measurable criteria, including a survey; to identify effective community based suicide prevention programs and best practices.

Action step 3.1.2: Consolidate survey data and evaluate data for effectiveness, utilizing the above criteria, and communicate survey data through social media, public service announcements, and multiple media outlets.

Action step 3.1.3: Disseminate information on the importance of social connectedness and problem-solving skills as factors that can help prevent suicide.

Action step 3.1.4: Disseminate information on programs that have decreased suicidal thoughts and actions through connectedness.

Action step 3.2.1: Launch public service campaigns to educate communities on the facts related to suicide, mental health, substance use, and how the community can help.

Action step 3.2.2: Expand health education efforts concerning suicide, mental health, and substance use within local community organizations.

Action step 3.2.3: Conduct initial community based surveys assessing stigma and discrimination surrounding suicide, and mental health and substance use conditions prior to targeted health education; conduct follow up surveys to assess the effectiveness of targeted education.

Action step 3.2.4: Develop strategies for better understanding of cultural or religious beliefs that may help protect individuals or present barriers to seeking help.

Action step 3.2.5: Increase awareness of mental health and substance use in order to eliminate barriers to seeking help.

Action step 3.3.1: Launch public service campaigns in order to educate communities on the facts of suicide, mental health, and substance use and how the community can help.

Action step 3.3.2: Expand health education efforts concerning suicide, mental health and substance use within local community organizations.

Action step 3.3.3: Conduct initial community based surveys assessing community understanding of mental health and substance use recovery prior to targeted health education; conduct follow up surveys to assess the effectiveness of targeted education.

Action step 3.3.4: Increase public awareness that individuals living with a mental health or substance use condition can recover and regain meaningful lives, including presentations by significant others including a person's family of choice, friends, peer mentors, and individuals who have attempted suicide or been bereaved by suicide.

Action step 3.4.1: Identify local community organizations that would benefit positively from suicide prevention/intervention training.

Action step 3.4.2: Identify and implement evidence-based and promising practices for suicide prevention/intervention training for community education efforts.

Action step 3.4.3: Conduct pre and post-tests of suicide education efforts to assess knowledge of suicide protective factors and risk factors.

GOAL 4: PROMOTE RESPONSIBLE MEDIA REPORTING AND ACCURATE PORTRAYALS OF MENTAL HEALTH, SUBSTANCE USE, AND SUICIDE IN THE ENTERTAINMENT INDUSTRY, INCLUDING SAFE ONLINE CONTENT.

Goal 4 uses the language in goal 4 from the 2012 National Strategy for Suicide Prevention. This goal addresses the need to impact how suicide, mental health, and substance use are addressed in the media and entertainment industry. This goal has been updated from the prior state and national plans to include the emergence of online content as a new medium for communication. Certain types of news coverage can increase the likelihood of suicide in

vulnerable individuals. Explicit and graphic media reporting sensationalizes and glamorizes death and can even lead to "copycat" suicides. Studies have also shown that fictional accounts of suicide in movies and television can lead to increases in suicide.[13] Careful coverage, on the other hand, can encourage vulnerable people to seek help. Sharing stories of individuals who overcame a crisis and providing information on resources can provide a needed public service.

The following objectives and actions recommend providing guidance and resources to the media, journalism and communication schools on ways to report suicide as well as mental health and substance use issues in an accurate fashion. In addition, the action steps recommend providing guidance to state government press offices who work with the media on an on-going basis. As new media tools or guidelines become available, these recommendations should be applied widely to include the safety of online content and emerging communication technologies and applications. In order to expand online crisis support, the Suicide Prevention Lifeline recently announced an innovative partnership with Facebook to offer crisis services via chat so that people in distress can more easily access the support that they need.[14] Award ceremonies, banquets, etc., is another strategy to recognize the media for accurate portrayals in their reporting.

NAME IT-CLAIM IT- TAME IT-FRAME IT!
It is important to define ourselves and not be labeled by others. An emerging movement of suicide attempt survivors has helped to be open, honest and true to the realities of our experiences. As suicide attempt survivors we are at great risk of re-attempts. Sharing our stories helps others realize they are not alone on our roads to recovery.
I am a proud gay man, an activist artist living with a mental illness (Bipolar II, The Sequel); in recovery from addictions; living with HIV since testing HIV positive September 27, 1988; a prostate cancer survivor; living with deafness, cataracts and hearing distortion; a suicide attempt survivor and suicide loss survivor after my dear sister Jennifer's death by suicide in 1995.
When naming, claiming, taming and framing remember humor is the best medicine because there's no copay. I am Mark Davis and approve this positively inspirited and mutually shared message.

Mark Davis

OBJECTIVES:

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and prominent individuals in the areas of entertainment and sports, who follow media guidelines in sharing their personal stories around mental health and substance use.

Objective 4.2: Disseminate guidance for Pennsylvania's journalism and mass communication schools regarding how to address consistent and safe messaging on suicide, mental health and substance use in their curricula.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 4.1.1: Disseminate recommendations to the media for reporting of suicide using, for example, www.reportingonsuicide.org, www.AFSP.org and training offered by the Carter Center for journalists.

Action step 4.1.2: Sponsor recognition events and incentives to honor the media for responsible reporting of suicide, mental health, and substance use.

Action step 4.1.3: Promote speakers bureaus and encourage consumers, peer leaders and others to share their stories of recovery to increase public awareness.

Action step 4.1.4: Promote guidelines on the safety of online content and for new and emerging communication technologies and applications regarding mental health, substance use and suicide.

Action step 4.2.1: Address responsible depiction of mental health, substance use and suicide in educational curricula of Pennsylvania's schools of journalism, film and other disciplines in the communications field as well as through their ethics governing boards.

Action step 4.2.2: Provide informational material to Pennsylvania state government press offices regarding media reporting of mental health, substance use and suicide.

Action step 4.2.3: Offer training, webinars, etc., to journalism, film and other communications schools on promoting positive messages regarding mental health, substance use, and suicide.

GOAL 5: DEVELOP, IMPLEMENT AND MONITOR THE EFFECTIVENESS OF PROGRAMS AND SERVICES THAT PROMOTE WELLNESS AND PREVENT SUICIDE

New goal 5 addresses the development, implementation, and monitoring of programs and services that promote wellness and prevent suicide. This revised goal emphasizes the importance of wellness in preventing suicide and the concept that even simple and low cost interventions can make a big difference in preventing suicide. For example, data has shown

that individuals who have attempted suicide as well as individuals bereaved by suicide are at increased risk of suicide. However, research suggests that simple efforts to minimize isolation, increase social involvement, and provide follow-up support to people, including visiting individuals at home or providing online support groups, can have a powerful impact in reducing additional suicides.

> I am a survivor. These four words carry such a big meaning. For some, it means strength, determination and power to overcome a tough situation. However, for a survivor of suicide loss, it carries a very different meaning. To me, it symbolizes sorrow, loneliness and hope. Sorrow, for I will never have the chance to say good-bye to my sister. Loneliness, for few understand what it's like to experience sudden tragedy. Hope, for together, we can open the doors of communication, help those in need, and end the stigma. While nothing will bring Jana back, I hope the work I do in her memory through the Jan Marie Foundation can help prevent other siblings and parents from ever experiencing what it is like to be a survivor of suicide loss.
>
> Marisa Brown

The following objectives and action statements recognize the importance of engaging a wide range of community agencies and partners to implement suicide prevention programs and services that take cultural, demographic and geographic issues into account. It is important in developing and implementing programs to use strategies that have been shown to be effective. Several online data bases are available to guide these partners in the development of evidence-based practices and services. The action steps also include providing suicide prevention toolkits, distributing information via websites, posters and resource guides on crisis hotlines, and providing technical assistance to build capacity to both implement and evaluate suicide programs and services. As noted previously, it is important for counties, managed care organizations, educational institutions, and others to have their own suicide prevention plans in place to reduce the incidence of suicide within their jurisdiction.

OBJECTIVES:

Objective 5.1: Promote and encourage the coordination, implementation, and evaluation of comprehensive state, county, and local suicide prevention programming.

Objective 5.2: Encourage county and local services to implement effective programs and provide education that promotes wellness and prevents suicide.

Objective 5.3: Promote policies and practices that intervene to reduce suicidal thoughts and actions in populations with suicide risk.

Objective 5.4: Strengthen efforts to increase access to and delivery of effective treatment and prevention programs for mental health and substance use.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 5.1.1: Engage multiple partners across the lifespan to coordinate culturally, demographically and geographically-appropriate suicide prevention programming within each jurisdiction.

Action step 5.1.2: Evaluate suicide prevention programming according to established standards using, for example, the Best Practice Registry for Suicide Prevention and the National Registry of Evidence-Based Programs and Practices.

Action step 5.2.2: Share information on research-based evidence-based programs with state, county and local service partners.

Action step 5.2.3: Provide education through public awareness, on-going public service announcements, websites, and conferences.

Action step 5.2.4: Develop technical support to build the capacity across the state to implement and evaluate evidence-based suicide prevention programs.

Action step 5.2.5: Increase the number of counties and local communities with comprehensive suicide prevention plans.

Action step 5.3.1: Identify and implement policies and practices that reduce suicidal thoughts and actions including rapid follow-up after hospitalization (visits, calls, emails), outreach to isolated individuals, support groups, etc.

Action step 5.3.2: Encourage community providers, volunteer groups, stakeholders, and others to identify individuals who are isolated and in need of outreach and support and to distribute information to these and other individuals who are at risk of suicide including information on crisis lines, warm lines, warning signs, etc.

Action step 5.3.3: Develop, implement, disseminate and provide training on suicide prevention tool-kits that include assessment and evaluation criteria, to state, county and community providers, to utilize in screening those potentially at-risk of suicide.

Action step 5.3.4: Provide information on specific at-risk populations and interventions and resources for each population as noted in Appendix A of this plan and in Appendix D of the 2012 National Strategy for Suicide Prevention.

Action step 5.4: Encourage the state, counties and local communities to provide referral information to treatment and prevention programs in their jurisdictions through the use of the Network of Care website, social service resource guides, posters, etc.

GOAL 6: REDUCE ACCESS TO LETHAL MEANS OF SUICIDE AMONG INDIVIDUALS WITH IDENTIFIED SUICIDE RISK.

Goal 6 uses language similar to goal 6 in the 2012 National Suicide Prevention Strategy. The intent of this goal is to reduce access to various means of suicide particularly among those individuals identified with high risks. Data indicates that firearms are the most common method of suicide in the United States which account for 56% of male suicides and 30% of female suicides. Among U.S. women, the most common suicide method is poisoning, primarily overdoses of medications, which account for 37% of female suicides, compared to 12% of male suicides.

Many of the following strategies are aimed at helping to minimize the highest risk means among the highest risk individuals. Studies have also indicated that many suicide attempts are not planned and may occur impulsively or before a person has the chance to receive help to get through a temporary crisis. By taking such precautions as having guns or medications locked away, many lives may be saved. Recent news coverage has indicated that in 2013, the Golden Gate Bridge has been the site of the highest number of suicides in its history. Signs with the National Suicide Prevention Lifeline number and telephones have been added to the Golden Gate Bridge and such preventative tools would create opportunities to save lives on bridges in Pennsylvania.

I was only nine years old when my mother abandoned me. I felt angry, sad and lost. What was wrong with me that made her kill herself, did she not know I loved her? Perhaps maybe if I could have stood up to my dad as he beat on her she would not have left me. Despite growing up in a world not knowing when trauma would strike, I wanted to be with my parents. To make things more complicated, I did not know how to deal with the feelings within me, no one to talk to, guide me or comfort me. That's when I build a closet inside to hide all of these dark feelings. Now, four decades later, I am getting the help I so needed as a child. I am a survivor of my own suicide attempts and am glad I learned to choose life. I have hope now, unlike my younger brother who killed himself and my older brother who turned to street drugs. Parents, brothers are gone from my life. Yet, why not me?

Dave Corbin

The following strategies include training mental health and substance use providers, significant people such as a person's family of choice, friends and others in regularly assessing access to lethal means for persons at-risk. Partnerships with firearm dealers and gun owners around suicide awareness and responsible gun ownership may also reduce risk. Likewise, physicians and pharmacists may be in a key position to monitor for risks of prescription overdoses. Valuable training resources, such as the Harvard University "Means Matters" project and the SPRC.org lethal means counseling, are two sources for training. Legislation or policy guidance should be promoted to ensure that firearm dealers as well as prescription managers receive at least brief training, such as "Mental Health First Aid", on recognizing the signs that an individual may be at-risk of suicide.

OBJECTIVES:

Objective 6.1: Encourage Pennsylvanians who interact with individuals at-risk for suicide to routinely assess access to lethal means.

Objective 6.2: Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

Objective 6.3: Research and educate Pennsylvanians' on new safety technologies to reduce access to lethal means.

Objective 6.4: Partner with primary care, mental health, and pharmacies to incorporate suicide awareness as a basic tenet of responsible prescription management.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 6.1.1: Disseminate materials aimed at educating families of choice, friends, physical health, mental health, substance use providers and others on evidence based practices on how to assess and limit access to lethal means among those at-risk of suicide.

Action step 6.1.2: Educate consumers, assessors, physical health, substance use providers and others on *Means Reduction*, which is the process of separating a particularly lethal means of suicide, from those who attempt suicide.

Action step 6.1.3: Develop protocols to disseminate and distribute educational materials to Pennsylvanians who regularly interact with those at-risk of suicide.

Action step 6.1.4: Develop and enhance training initiatives using, for example, the Harvard University Means Matters project, the SPRC.org lethal means counseling, etc., to improve skills related to counseling on reducing access to lethal means through professional training programs, workshops, etc.

Action step 6.1.5: Distribute informational material on means restriction to significant people, including a person's family of choice, friends, and other natural supports, to increase the likelihood of positive outcomes.

Action step 6.2.1: Develop educational materials which promote suicide awareness for dissemination by firearm dealers upon the sale of every firearm. These materials will include of referral and contact information for the National Suicide Hotline.

Action step 6.2.2: Recommend through legislation, regulations or policy statements (executive orders, etc.) that all firearm dealers complete a community-based training on the identification of suicide risk factors (e.g., Mental Health First Aid). This training may be offered to a firearm dealer specific cohort to improve efficacy.

Action step 6.3.1: Develop a means by which research on safety technologies can be encouraged in Pennsylvania.

Action step 6.3.2: Develop a means by which information and research on safety technologies can be disseminated, discussed, and/or implemented.

Action step 6.3.3: Provide an electronic forum (e.g., the Pennsylvania Adult and Older Adult Suicide Prevention Coalition's website with links to other websites such as Department of Public Welfare's website) to allow for ease of access to research findings and educational materials on suicide prevention, reduction of access to lethal means, and safety technologies.

Action step 6.4.1: Develop educational materials which promote suicide awareness, including referral and contact information for the National Suicide Hotline, which will be required for dissemination by the above providers upon the sale of identified medications or prescriptions.

Action step 6.4.2: Recommend through legislation, regulations or policy statements (executive orders, etc.) all prescription management providers to complete a community based training on the identification of suicide risk factors (e.g., Mental Health First Aid). This training may be offered to a provider specific cohort to improve efficacy.

Action step 6.4.3: Encourage the use of electronic pill dispensing lockboxes for people who rely on medication but are at risk of overdosing.

GOAL 7: PROVIDE TRAINING ON THE PREVENTION OF SUICIDE

Goal 7 is similar to National Suicide Prevention goal 7 and focuses on providing training to the community, mental health and substance use providers and others that come into contact with individuals who may be at-risk of suicide. A wealth of training materials and training courses are available, which are targeted to professionals and non-professionals and range from a few hours to several days in length. The action steps recommend that such trainings can be used to help stakeholders recognize the warning signs of suicide and know where to refer a person for services. In the case of mental health or substance use providers, more extensive training may be required including information on providing quality care and services based upon the latest research. State and local conferences and forums are also encouraged to reach large audiences with vital information.

> It is very difficult to put into a few sentences the devastation our son's suicide has had on our lives. I have compared it to being in a horrendous battle, with all of the terrible, debilitating wounds on the inside. We carry on for our other children, for the bit of hope we still have in our lives. To think my son fought this battle of depression alone devastates me. How I wish he had been able to seek and receive help. How I wish I was more informed about the subject of suicide before my son went off to college. How I wish I thought to say, when I knew Tyler was not acting right, "Are you thinking of killing yourself?" Most parents I speak with really can't hear my story- it is their worst nightmare. But I keep talking and hoping my words may help someone seek help instead of suicide.
>
> Sheila Whitman

Recommended mechanisms for ensuring that training is provided routinely across the state and across disciplines include making suicide prevention training a requirement, issuing policies recommending training as part of regulatory requirements and including training through health care professional education (including graduate and continuing education and credentialing and licensing standards). The following action steps also recommend the tailoring of training to focus on age, ethnic, gender, racial, sexual orientation, gender identity, trauma and abuse issues. The inclusion of suicide attempt survivors and suicide loss survivors in trainings is highly recommended to communicate stories that ***individuals can and do recover, leading meaningful lives.***

OBJECTIVES:

Objective 7.1: Provide training on suicide prevention to community groups.

Objective 7.2: Provide training to mental health and substance use providers on the recognition, assessment and management of at-risk behaviors and delivery of effective clinical care for people with suicide risk.

Objective 7.3: Develop and promote the adoption of core education and training guidelines on the prevention of suicide through health care professional education, including graduate, continuing education, and credentialing, accrediting and licensing bodies.

Objective 7.4: Develop and implement protocols and programs for clinicians, clinical supervisors, first responders, crisis staff, and other stakeholders on how to implement effective strategies for communicating and collaboratively managing suicide risk.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 7.1.1: Identify community groups to present information and training.

Action step 7.1.2: Use available training curricula (available at the SPRC Center, QPR [Question, Persuade, Refer], MH First Aid Training, etc.,) to reach various groups.

Action step 7.1.3: Make educational programs available to significant people including a person's family of choice, friends, and others who are in close relationships with those at-risk or who have been affected by suicide.

Action step 7.1.4: Utilize suicide loss survivors and suicide attempt survivors in trainings/presentations.

Action step 7.1.5: Address cultural competency/diversity in training and educational programs geared to the population being addressed.

Action step 7.1.6: Sponsor conferences including an annual state suicide prevention conference.

Action step 7.2.1: Provide training to physical health, mental health and substance use providers on the recognition, assessment and management of at-risk behaviors and delivery of, or referral to, effective clinical care for people with suicide risk.

Action step 7.2.2: Use available training curricula to increase confidence and empowerment in working with people with suicide risk and effective support services for those bereaved by

suicide including trainings such as Assessing and Managing Suicide Risk (AMSR), Applied Suicide Intervention Skills Training (ASIST), etc.

Action step 7.2.3: Promote/sponsor suicide prevention training for physical health, mental health and substance use providers.

Action step 7.2.4: Develop a policy strongly recommending the inclusion of suicide prevention training as part of continuing education requirements within existing provider regulations.

Action step 7.2.5: Provide resource material, journal articles and training to address emotional and legal issues associated with adverse patient outcomes, including death by suicide.

Action step 7.2.6: Educate practitioners on how to exchange confidential patient information appropriately to promote collaborative care, while safeguarding patient rights.

Action step 7.2.7: Address the need for and value of a team based approach to management of suicide risk through the distribution of best practice information on the benefits of this approach.

Action step 7.2.8: Include cultural competency components specifically focused on age/ethnicity/gender/racial identity formation, minority status, LGBTQI identity development and disenfranchised groups such as the homeless.

Action step 7.3.1: Develop and promote the adoption of core education and training guidelines on the prevention of suicides through health care professional education including graduate, continuing education, credentialing, accreditation and licensing bodies.

Action step 7.3.2: Collaborate with academic partners and providers in Pennsylvania to develop and adopt core education and training guidelines addressing the prevention of suicide.

Action step 7.3.3: Collaborate with accrediting and credentialing entities to promote evidence based and best practice suicide prevention training for the organizations they accredit/re-accredit, credential/re-credential and license/re-license.

Action step 7.3.4: Sponsor professional development opportunities including webinars, lunch and learn, etc., for health care professionals.

Action step 7.3.5: Link suicide related curricula with training on trauma, substance use, and interpersonal violence.

Action step 7.3.6: Promote and support the inclusion of protective factors such as learning skills, problem solving, conflict resolution and non-violent handling of disputes in any curricula.

Action step 7.3.7: Distribute *Practical Suicide-Risk Management for the Busy Primary Care Physician* to primary care providers.

Action step 7.4.1: Develop and implement protocols /programs for clinicians and clinical supervisors, first responders, crisis staff and other stakeholder groups on how to implement effective strategies for communicating and collaboratively managing suicide risk.

Action step 7.4.2: Recommend that all persons treated for trauma, sexual assault, or physical abuse, in emergency departments, receive mental health services.

Action step 7.4.3: Encourage communication and collaboration across multiple levels of care, by developing clinical preventative and communication protocols for clinicians, clinical supervisors, first responders, crisis staff and professionals who provide adult and child protective services as well as others who provide support to people with suicide risk.

Action step 7.4.4: Distribute "Lifeline Best Practices for Helping Callers" to all crisis hotlines/warm lines within Pennsylvania to improve competence in handling crisis calls.

GOAL 8: PROMOTE THE EFFECTIVE ASSESSMENT, PREVENTION AND TREATMENT OF SUICIDE AS A CORE COMPONENT OF ALL HEALTH CARE SERVICES.

Pennsylvania's 8th Goal is a combination of goal 8 and goal 9 in the National Strategy for Suicide Prevention. The Pennsylvania Suicide Prevention Plan Advisory Committee recommended the collapsing of these two national goals since the focus of the two goals was perceived as similar in nature. The intent of Goal 8 is to ensure that all health care services effectively assess, prevent and treat suicide. An overarching goal, as reflected in one of the guiding principles of this plan and promoted by the Action Alliance for Suicide Prevention, is "ending suicide in healthcare settings". A recent presentation by Dr. Michael Hogan of Hogan Health Solutions on this issue described this shift in perspective as follows: "rather than accepting suicide as inevitable, ask how many deaths of people in our care are acceptable; rather than having specialty referrals to niche staff, suicide prevention should be part of everyone's job; rather than individual clinical judgment and actions, use standardized screening, assessment, and interventions; rather than hospitalization when people admit they are in crisis, promote collaborative, recovery oriented community care; rather than saying "if we can save one life..", we should say "***Not Another Life to Lose***."[15]

The Action Alliance also identified programs that have garnered attention for their novel approaches and positive outcomes including the U.S. Air Force, Henry Ford Health Systems, Magellan Maricopa Collaborative, Veteran's Health Administration, and the Central Arizona Programmatic Suicide Deterrent System Project. Core components to the success of these systems are reflected in the following objectives and action steps and throughout this plan. Key elements of organizational culture change within these programs include: creating a leadership-driven culture which includes suicide attempt and suicide loss survivors in leadership and planning; same day access to care; email visits; emphasis on means restriction; stratifying levels of risk and establishing associated interventions; safety planning instead of "contracts"; establishing and maintaining a competent and caring workforce; follow-up after acute care by phone, postcards, and visits; treating mental health conditions and suicidality together; and applying a data driven quality management approach.[16] [17]

Hello, my name is Jennifer and I am 32 years old. For 18 years I was suicidal and dependent on the mental health system, medicine, hospitals, and ECT. I used to stand on bridges for comfort, overdose constantly, and wander around high crime neighborhoods wanting to get shot. I felt hopeless, frustrated, alone, scared, and speechless when 2 years ago the next best option suggested to me was experimental brain surgery.
Today, 2 years later, I work as a Peer Specialist in a psychiatric emergency room that I used to frequent. Every time I go to work I fight the stigma of mental illness head on. I relate to the people there to provide comfort, resources, and help them find hope in their lives or be an example of hope when they have nothing in this world to live for. I not only represent recovery there to my peers but the staff that used to treat me. I am truly happy I created a life worth living and thankful I have a future to look forward to.

Jennifer Cherak

The following objectives and action steps emphasize establishing guidelines for assessing and documenting risk factors. It is recommended that primary care practitioners routinely conduct at least brief suicide risk assessments and screen for mental health and substance use, including problem gambling, since research indicates that a large percentage of individuals visited their primary care physician prior to their suicide.[18] A recent study by the Center for Health Policy and Health Services Research at Henry Ford Health System in Detroit, found that 83% of individuals received health care treatment (medical and primary care more frequently) in the year prior to dying, and 20 % had seen a health care worker the week before they died.[19] Studies indicate that the majority of people who die by suicide-90% or more- had a mental health condition at the time of their death.[18] However, in the Henry Ford Health System study, a mental health diagnosis was made in less than half of the cases. While it isn't clear if a mental health condition was present prior to death, it is likely

that at least a percentage of these individuals had a mental health condition that went undetected.[19] In addition to primary care, mental health and substance use systems should be required to assess risk at all intakes and regularly monitor individuals at the highest risk. Risk assessments should be documented according to standards that can lead to tailored interventions based on the level and type of risk.

Timely access to services and rapid follow-up are two additional key components to quality services that can interrupt the cycle of suicide. Hotlines, warm lines, counseling by phone, texting, etc., and having procedures in place to guarantee 24 hour/7 day a week access to services are ways to ensure rapid access. Research has demonstrated that discharge from an inpatient psychiatric facility, emergency department, urgent care facility, or a residential addiction program can be a high risk timeframe for suicide. Therefore, the below actions recommend policies that would require providers to follow-up, by phone or in person, within 24 hours following discharge from these facilities. Case management programs, peer specialist programs and crisis intervention programs have already assumed this responsibility in some parts of the state. Each county/managed care organization should consider assigning lead responsibility for such follow-up within their jurisdiction.

Central to continuity of care, is the sharing of information among caregivers. Mental health and primary care providers should cross-monitor for medication side-effects. Videoconferencing and telemedicine are methods to help assess for risk and share information across systems without the need for travel.

As already noted in many of the goals, it is always good policy to include people who are significant to the individual in the entire process of care. Likewise, suicide attempt survivors and suicide loss survivors can be instrumental in helping others to access/engage in treatment. Providing services in the least restrictive fashion, which balances autonomy with safety, is always the best choice. Many individuals in the system have already experienced past trauma or abuse and alternatives to coercion should be used to minimize re-traumatization.

OBJECTIVES:

Objective 8.1: Promote adoption of zero suicide as an aspirational goal of health care and community support systems.

Objective 8.2: Develop and implement protocols, guidelines and training for assessing and documenting risk and delivering timely and effective services in the most collaborative and least restrictive settings.

Objective 8.3: Promote continuity of care and rapid follow-up among: suicide prevention/intervention programs, health care systems, crisis programs, emergency departments, inpatient units and community based programs (including peer support).

Objective 8.4: Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

Objective 8.5: Promote safe disclosure of suicidal thoughts and actions by all individuals receiving services.

Objective 8.6: Adopt and implement guidelines to effectively engage significant people, including a person's family of choice and friends, when appropriate, throughout the entire episodes of care for persons with suicide risk.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 8.1: Encourage adoption of the goal of "zero suicides" by health and behavioral health systems.

- Encourage managed care organizations, counties, providers, etc., to conduct root cause analysis of suicide attempts and deaths and use findings to improve service quality.
- Distribute Henry Ford Health Systems Perfect Depression Care program as a promising approach.

Action step 8.2.1: Develop and implement protocols for delivering services to persons with high suicide risk that:

- Value shared responsibility, collaborative care and effective communication with individuals, families and significant others.
- Identify alternatives to coercion, restraint, and involuntary treatment while ensuring the safety of individuals in crisis.
- Address issues related to past trauma or abuse that may make individuals reluctant to seek help for fear of being re-traumatized.

Action step 8.2.2: Encourage timely availability of services through the use of crisis hotlines, warm lines, chat services, self-help tools, crisis outreach, and counseling by phone, texting or Internet to allow persons in crisis to access help 24 hours a day, 7 days a week.

Action step 8.2.3: Disseminate and implement guidelines for assessment of suicide risk in primary care, hospitals, and mental health and substance use care and ensuring that treatment plans include information on suicide plans, intent, access to lethal means, previous attempts and presence of acute risk factors.

Action step 8.2.4: Develop and implement strategies for frequent monitoring of persons known to have high risk factors.

Action step 8.2.5: Disseminate and implement clinical practice guidelines for mental health, substance use, and other providers who serve individuals at-risk for suicide.

Action step 8.2.6: Develop protocols for differentiated responses based on clinical needs (e.g., intoxicated and suicidal, chronically suicidal, suicidal with active psychosis).

Action step 8.2.7: Disseminate guidelines and provide training on documentation and treatment of suicide risk including determining the proper level of treatment based on risk, needs and preferences.

Action step 8.2.8: Recommend that state agencies, managed care organizations, and others in an administrative capacity, issue a policy to mental health, substance use, and health providers highly encouraging suicide risk assessments with all intakes.

Action step 8.2.9: Encourage routine and consistent use of brief suicide risk assessments within primary care.

Action step 8.3.1: Establish policies that recommend follow-up outpatient treatment occur within 24 hours of inpatient and emergency department discharge.

Action step 8.3.2: Disseminate information about prototypes for integrating crisis and clinical services such as the VA crisis line relationship with the National Suicide Prevention Lifeline, whereby call responders interact with providers nearest to the individual to arrange and facilitate follow up.

Action step 8.3.3: Encourage primary care, mental health, and substance use programs to establish mechanisms to facilitate rapid access to their services when individuals are in crisis.

Action step 8.3.4: State agencies, managed care organizations, counties, and others in an administrative capacity, should develop policies/protocols for follow-up/continuity of care after periods of high risk for suicide including emergency department visits or hospitalizations.

Action step 8.3.5: Encourage the use of Peer Specialist programs, case management, and/or crisis programs to provide mandatory follow-up within 24 hours following hospital discharge.

Action step 8.3.6: Collaborate with hospital associations to develop tracking procedures for mental health follow-up.

Action step 8.3.7: Promote the role of primary care in collaborating with mental health and substance use providers regarding medication side effects.

Action step 8.3.8: Promote use and development of computerized records systems that would facilitate interdisciplinary team approaches across all treatment providers that the member wants included in his/her treatment.

Action step 8.3.9: Promote collaboration of all treatment providers (substance use, mental health, alternative medicines, pain clinic, etc.) and social supports through phone contact or video teleconferencing when developing discharge plans.

Action step 8.3.10: Encourage interactions from treatment providers/consumers at the next level of care while the member is working on discharge planning from an inpatient facility.

Action step 8.3.11: Reinforce the role of intensive case managers, resource coordinators and others to assist with navigation through mental health and physical health care programs.

Action steps 8.3.12: Distribute suicide risk posters throughout the community such as housing complexes, faith based entities, physician offices, emergency rooms, etc.

Action step 8.3.13: Organize suicide survivors in the community to provide seminars on accessing and engaging in treatment.

Action step 8.4.: Develop policies for public and private managed care companies to conduct root cause analyses of suicide attempts and deaths, supervisory reviews, reviews of aggregate data for trends, and focused quality assurance studies on issues related to suicide risk as part of their continuous quality improvement efforts.

Action step 8.5: Educate and train providers on ways to address the disclosure of suicide risk in order to eliminate provider apprehension and liability.

Action step 8.6.1: Train significant people, including a person's family of choice and friends, to understand, monitor, and intervene with loved ones who are at- risk for suicide.

Action step 8.6.2: Develop guidelines to help providers balance respecting autonomy, versus safety, in their work with individuals with high suicide risk and people significant to them, including family and friends.

GOAL 9: PROVIDE CARE AND SUPPORT TO INDIVIDUALS AFFECTED BY SUICIDE DEATHS AND ATTEMPTS TO PROMOTE HEALING AND IMPLEMENT COMMUNITY STRATEGIES TO HELP PREVENT FURTHER SUICIDES.

Goal 9 of the Pennsylvania plan is identical to goal 10 in the National Strategy for Suicide Prevention. The focus of the goal is on providing effective services and support to those individuals affected by suicide, including individuals who have made a suicide attempt, individuals bereaved by a suicide and community members who are affected by a suicide. These services are referred to as "postvention" services. All too often, individuals are left to themselves to deal with the aftermath of a suicide. Suicide attempt survivors and individuals bereaved by a suicide are both high risk populations for future suicide. Postvention strategies should include the community where individuals live as well as places of worship.

The following objectives and actions include identifying strategies and services available statewide to individuals in the aftermath of a suicide attempt or death and expanding appropriate care to affected individuals in every county. It is recommended that a list of resources be advertised through websites, posters, directories, etc. Information on national best practice interventions and toolkits for providing effective supports should be distributed to counties, providers, and others to guide the development of evolving postvention services in the state. Support groups, memorial services, on-line support and other approaches have been used widely and successfully.

I am a survivor of my mother's suicide in 1966, when I was nine years old. Some things have changed since then, there are support groups, prevention campaigns, but people still avoid the survivors. They still feel isolated. At the time of my loss, no one talked about her, pictures were put away; she was erased from my life. There were no attempts to help me grieve. Many times later in life, I felt "stuck", sometimes depressed. I built great walls around me, I suppose for self-protection. As the years passed, I came to grieve and remember in my own way as an adult. For this reason, I started a support group in my area to give the survivors what I had wished for myself.

Cozette Stoltzfus

Counties and local organizations also need resources to deal effectively with what is known as suicide contagion or clusters, or "copycat" suicides. Proper intervention early in the aftermath of a single or multiple suicides can reduce the trauma and sensationalism that might lead to further deaths. Support is also needed for individuals on the frontlines that have to deal professionally with a suicide, but may need support themselves for what they have experienced. Emergency medical technicians, firefighters, police, funeral directors and other

providers can benefit from training and support to better understand and respond to these situations while ensuring that they receive necessary support for their own needs.

OBJECTIVES:

Objective 9.1: Identify all suicide strategies and services that respond to and care for individuals affected in the aftermath of a suicide attempt or suicide death (postvention) and promote awareness of these resources.

Objective 9.2: Provide appropriate clinical care and support to individuals affected by a suicide attempt or death, including trauma treatment and care for complicated grief as well as peer-to-peer supports.

Objective 9.3: Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.

Objective 9.4: Disseminate, implement, and evaluate guidelines/resources for communities to respond effectively to suicide clusters within their cultural context, and support implementation with education, training and consultation.

Objective 9.5: Provide health care providers, first responders and other stakeholders with care and support when an individual under their care dies by suicide.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 9.1.1: Develop and conduct a county/local survey to identify all suicide postvention strategies currently in place.

Action step 9.1.2: Distribute a directory of resources available to those bereaved by suicide or affected by a suicide attempt.

Action step 9.2.1: Distribute information on best practice interventions through the Best Practices Registry for Suicide Prevention- *http://www.sprc.org/bpr*.

Action step 9.2.2: Publicize information on clinical and support services available to individuals in Pennsylvania affected by suicide through websites, posters, brochures, directories, etc.

Action step 9.4.1: Disseminate the Center for Disease Control recommendations on managing suicide contagion- *http://www.cdc.gov/mmwr/preview/mmwrhtml/00001755.htm*

Action step 9.4.2: Identify experts and funding sources to provide education/training and consultation on suicide clusters.

Action step 9.5.1: Identify ways to provide information/training to emergency medical technicians, firefighters, police, funeral directors, etc., who provide services to suicide attempt survivors, and suicide loss survivors so they can better understand and respond to needs.

GOAL 10: INCREASE TIMELINESS AND USEFULNESS OF DATA REPORTING SYSTEMS RELEVANT TO SUICIDE, AND IMPROVE THE ABILITY TO COLLECT, ANALYZE AND USE THE INFORMATION FOR ACTION.

Goal 10 is similar in focus to goal 11 of the National Strategy for Suicide Prevention. The intent of this goal is to ensure that data regarding suicide is collected and reported in a standardized reporting system for national data collection purposes and that data is utilized to impact suicide prevention policy decisions at the national, state and local levels. A primary source of statewide data on suicide is collected through the submission of death certificates sent from county coroners' offices to the state Department of Health. This data is then transmitted to the Centers for Disease Control. Currently, coroners' offices report their data on violent deaths, which include suicide, through independent reporting systems. Complicating this data reporting, is the fact that suicides may be misclassified as homicides, accidents or death from natural causes. The absence of detailed data, such as data related to sexual orientation and gender identity, provide an incomplete picture of the risk factors for specific population groups.[20] In addition, there is a two year gap between the end of the state reporting period and the year when the data becomes available to the public. The implementation of a standardized reporting system, such as the National Violent Death Reporting System, would greatly enhance the timeliness and consistency of suicide death reporting within the commonwealth. However, the transition would require new state regulations and/or legislation. It is recommended that a report be prepared outlining the barriers and steps necessary for Pennsylvania to participate in the National Violent Death Reporting System.

It is further recommended that similar independent data reporting systems, including the Army National Guard's Critical Incident Management System (CIMS), and the state system be reviewed for data interchange. Governing policies and best practices should guide the reporting system linkage. Data from additional sources such as law enforcement, emergency medical services and inpatient units should be linked to enhance quality care. It should be determined if these independent data systems can be linked and the data utilized at the state level.

The following strategies include the implementation of a data collection system and reporting system within Pennsylvania's HealthChoices managed care program for the purpose of tracking trends and approaches to eliminate suicide.

OBJECTIVES:

Objective 10.1: Identify, evaluate, and disseminate information on current reporting systems, programs, procedures and policies for suicides and suicide related incidents.

Objective 10.2: Improve and expand public health capacity to routinely collect, analyze, report and use suicide-related data to implement prevention efforts and inform policy decisions.

Objective 10.3: Promote and improve the timeliness and accuracy of reporting and disseminating vital data.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 10.1.1: Develop a report identifying the barriers to Pennsylvania participating in the National Violent Death Reporting System.

Action step 10.1.2: Collect current reporting systems, programs, procedures and policies in Pennsylvania. Two examples include the Army National Guard's Critical Incident Management System (CIMS) and the York County Suicide Prevention Coalition.

Action step 10.2.1: Develop state representative surveys and data collection instruments that include questions on suicide, related risk factors, and exposure to suicide.

Action step 10.2.2: Enhance Pennsylvania's death certificate reporting system to include suicide-related information while ensuring data is reported in a timely and consistent reporting system.

Action step 10.2.3: Implement a data collection system within Pennsylvania's HealthChoices managed care program on suicide trends and actions taken to eliminate suicide.

Action step 10.2.4: Identify and disseminate effective data collection efforts at the national, state and community levels.

Action step 10.2.5: Develop community level risk factors to assist communities in implementing suicide prevention efforts.

GOAL 11: PROMOTE AND SUPPORT RESEARCH ON SUICIDE AND SUICIDE PREVENTION

Goal 11 of the Pennsylvania Suicide Prevention Plan is similar to goal 12 in the 2012 National Strategy for Suicide Prevention. This goal promotes the dissemination of suicide and suicide prevention research, including the establishment of a state registry that individuals can use to access information on effective interventions. According to the 2012 National Strategy, research on suicide prevention and treatment of mental health and substance use conditions has increased considerably during the past 20 years. Findings have contributed to the development of assessment tools, resiliency-building interventions, and treatment and symptom-monitoring techniques.[21]

> The impact of my husband's suicide on my life, my children and grandchildren…. I don't think there is one word or even a sentence to describe the profound loss, the emptiness, heartache, loss of my security. In fact, while mourning my husband's death, I also was mourning the death of my life, life as I knew it for 30 years. My husband was a normal everyday middle class man, your neighbor, your friend, a local fireman and the last person on earth you would think to commit suicide, but he did… February 8, 2013.
>
> Cassy Kwaczala

Movement is underway, to develop a research agenda on suicide and suicide prevention that will be available in the future at the state and local level. The following actions support building collaborative efforts with potential Pennsylvania researchers on topics that would promote the goals identified in the state suicide prevention plan. Actions include establishing contacts at major universities and research centers to discuss potential funding sources and ideas that would lead to research grant submissions. Information on grant opportunities, research-based practice standards and evidence-based interventions should be made available through conferences, websites and written materials. Major leaders will be encouraged to attend national and regional conferences to gather information on the current suicide prevention research to share with Pennsylvania constituents at conferences, on websites and in written communication.

OBJECTIVES:

Objective 11.1: Help connect researchers with funding sources.

Objective 11.2: Promote timely dissemination of suicide and suicide prevention research.

Objective 11.3: Establish a registry of interventions with demonstrated effectiveness for prevention of suicide.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 11.1.1: Identify funding sources for suicide prevention research.

Action step 11.1.2: Develop a list of potential research funding opportunities and post information on various web sites such as OMHSAS and the Adult and Older Adult Suicide Prevention Coalition.

Action step 11.1.3: Establish university contacts interested in partnering on suicide research in PA and collaborate on grant opportunities.

Action step 11.2.1: Identify key PA research on suicide and suicide prevention and disseminate information via PA websites.

Action step 11.2.2: Communicate knowledge of state/local suicide and suicide prevention research to the Research Prioritization Task Force and national suicide prevention organizations.

Action step 11.2.3: Attend national/ regional conferences to gather information on suicide and suicide prevention and make latest research information available at state/local conferences, via websites, and through written materials.

Action step 11.3.1: List research-based best practice standards and evidence-based interventions in distributed materials, at conferences, etc., and on web sites.

Appendix A: At Risk Populations

Suicide Prevention and Individuals with Serious Mental Health and or Substance Use Conditions

Mental health and substance use conditions are widely recognized as important risk factors for suicidal behaviors in all age groups. Substance use along with any mood disorder may be particularly likely to increase suicide risk.

In ***Achieving the Promise: Transforming Mental Health Care in America***, the President's New Freedom Commission on Mental Health (2003) noted: "Suicide is a serious public health challenge that has not received the attention and degree of national priority it deserves." This is of concern because suicide gravely impacts those with mental health and/or substance use conditions.

Mental health conditions do not cause suicide. Rather, those individuals with mental health conditions are exposed to more risk factors (including substance use) that raise their vulnerability to suicide. Ironically, the public largely believes that suicide happens mainly to those with mental health conditions, not understanding the potentially lethal combination of substance use co-occurring with mental health conditions. This is one of the many myths of suicide.

Much of what is known about suicide comes from studies of those diagnosed with mental health and substance use conditions. In **Night Falls Fast: Understanding Suicide** (2000), Kay Redfield Jamison tells us that the gap between what we know about suicide and its use in prevention is "lethal." Dr. Jamison is sadly right.

A brief summary of information on suicide risk among those individuals with serious mental health conditions such as Major Depressive Disorder, Bipolar Disorder, Anxiety Disorder, and Schizophrenia, and Substance Use is provided here, along with appropriate resources. For more detailed and extensive information on specific mental health and substance use conditions with highest risk factors for suicide; please see the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A report of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention: www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html, or www.actionallianceforsuicideprevention.org/NSSP or

www.samhsa.gov/nssp. Hard copies may be ordered through SAMHSA Store at www.samhsa.gov/nssp or by calling toll free at 1-877-SAMHSA-7 (1-877-726-4727).

MENTAL HEALTH CONDITIONS:

MOOD DISORDERS

Mood disorders are among the most common and may be the most life-threatening psychiatric illnesses (Goodwin and Jamison, 2007)

Major depressive disorder, also called *major depression* or *unipolar disorder*, is characterized by a combination of symptoms, such as sadness and loss of interest or pleasure in once-pleasurable activities, which interfere with everyday life. It has been estimated that 12 to 17 percent of individuals will experience a major depressive episode with in their lifetime (Rihmer and Angst, 2005). Individuals with major depressive disorder have 21 times more suicide deaths than the general population and 9% - 15% of individuals with major depressive disorder eventually die by suicide.

Bipolar disorder, also called manic-depressive illness, is characterized by dramatic mood swings, going from an overly energetic "high" (mania) to sadness and hopelessness (depression). The estimated lifetime prevalence of bipolar disorders is 1.3 to 5 percent (Rihmer and Angst, 2005). Suicide risk is particularly high among individuals with bipolar disorders, which is strongly associated with suicidal thoughts and actions. Over their lifetime, the vast majority (80 percent) of [people] with bipolar disorders have either suicidal ideation or ideation plus suicide attempts (Valtonen, Suominen, Mantere, Leppamak, Arvilommi, Isometsa, 2005). Approximately 15 to 19 percent of [people] with bipolar disorders die by suicide. The suicide rate among [people] with bipolar disorder is estimated to be more than 25 times higher than the rate in the general population (Tondo, Isacsson, Baldessarini (2003).

ANXIETY DISORDERS

Anxiety disorders affect about 40 million American adults aged 18 and older (about 18 percent) in a given year (Kessler, Chiu, Demler, Merikangas, Walters, 2005). Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance use conditions, which may mask anxiety symptoms or make them worse. The presence of any anxiety disorder in combination with a mood disorder (co-occurring) is associated with a higher likelihood of suicide attempts in comparison with a mood disorder alone (Sareen, Cox, Afifi TO, et al, 2005). Among adults in the general population (i.e. not in the Armed Forces or veterans),

panic disorder and PTSD have been found to be more strongly associated with suicide attempts when there is a co-occurring personality disorder (Napon, Belik, Bolton, Sareen, 2010)

SCHIZOPHRENIA

Schizophrenia is a severe disorder characterized by disturbances in perception, thought, language, and social function. Schizophrenia is involved in up to 15% of all suicides (as many as 4,000 deaths yearly). Individuals with Schizophrenia are at more than 30 times higher risk of suicide than the general population. The greatest indicator of suicide risk among people with schizophrenia is active psychotic illness (e.g. delusions) combined with symptoms of depression. Alcohol use conditions have been reported in studies examining suicide attempts and schizophrenia.

SUBSTANCE USE CONDITIONS

Suicide is the leading cause of death among people with substance use conditions. Substance use may increase the risk of suicide by intensifying depressive thoughts or feelings of hopelessness while at the same time reducing inhibitions to hurt oneself (Skog, 1991). Alcohol and other drugs can cause a "transient depression," heighten impulsivity, and cloud judgment about long-term consequences of one's actions.

Alcohol and drug use conditions are second only to depression and other mood disorders as the most frequent risk factors for suicide (Centers for Disease Control, 2011). According to the data from the National Violent Death Reporting System (NVDRS), in 2008 alcohol was a factor in approximately one-third of suicides reported in 16 states (Karch, Logan, Patel, 2011). Opiates, including heroin and prescription painkillers, were present in 25.5 percent of suicide deaths, antidepressants in 20.2 percent, cocaine in 10.5 percent, marijuana in 11.3 percent, and amphetamines in 3.4 percent. This is especially significant when one considers that individuals with co-occurring mental health and substance use conditions are at higher risk for attempting suicide.

The following suicide risk factors for individuals with serious mental health and substance use conditions include:

- Episodes of hopelessness, anxiety, and depression
- Young age of onset and early stage of illness
- Inadequate treatment and treatment reductions
- Frequent exacerbations/remissions
- Post-relapse improvement periods
- Psychiatric hospitalization(s) (especially the first 30 days after discharge)
- Co-occurring alcohol and other substance use

Individuals with mental health conditions also have risk factors related to race and ethnicity, gender, age, a history of abuse, past suicide attempts, access to firearms, work, school, or legal problems, and others. This accumulation of risk is what accounts for the prevalence of suicide among consumers and which necessitates preventative measures on their behalf.

These are key protective factors that counter the onset and progression of suicidality:

- Treatment adequate to need
- A caring personal support system
- Means restriction/removal (i.e., no guns, controlling medications)
- Ability to seek/accept professional help
- Availability/accessibility of help
- Mutual support for those at-risk

Given what we know about suicide and mental health, what can we do?

All mental health and substance use providers, both public and private, should:

- Know the risk factors, warning signs, and myths of suicide
- Be able to talk about suicide with clients and patients
- As applicable, identify hazards in facilities that may be used for a suicide attempt
- Be trained in crisis intervention
- Educate families about suicide risk

Here are some specific suggestions for county mental health systems: Assure that all providers recognize suicide as a preventable community mental health problem.

1. Assure that county suicide prevention plans (i) exist, (ii) speak to the risk of adults living with serious mental health conditions, and (iii) are being implemented.
2. Assure that county mental health plans recognize the need for aftercare and supports for suicide attempters to deter future suicides.

3. Assure that all mental health providers screen for suicidality at admission, after serious life events or losses, and after changes affecting treatment.
4. Assure that modalities such as cognitive behavioral therapy, which have been found to reduce suicidal behavior, are available.
5. Assure the availability of groups that offer mutual support and "safe places" for individuals who make multiple suicide attempts (e.g., "Suicide Anonymous").

There is much that needs to be done, but these steps would make a real difference.

In closing, bear in mind that nothing is more detrimental to recovery from mental health conditions than suicidality and nothing shatters mental health wellness like losing someone to suicide. Individuals with mental health conditions are far more likely to have experienced the loss of someone they know to suicide because of the high incidence of suicide among those with serious mental health conditions. For this reason, providers should see that consumers who experience the suicide of a loved one or close friend have access to grief support resources.

Pennsylvania Department of Corrections Suicide Prevention Efforts

The latest statistics published by the Centers for Disease Control and Prevention (CDC) and the U.S. Department of Justice confirm that suicide mortality rates per 100,000 state inmates consistently exceed suicide mortality rates in the community (BJS, 2012; Kochanek, Jianquan, Murphy, Miniño, & Kung, 2011; Murphy, Jianquan, & Kochanek, 2012). Indeed, a recent longitudinal study of all 50 state prison systems revealed that suicide was routinely among the five leading causes of death among inmates (BJS, 2012). However, leading experts in the field of suicidology believe that correctional systems can reduce suicide mortality rates by augmenting identification protocols, developing system-wide procedures to enhance suicide prevention policies, and improving continuity of care practices (Hayes, 2013). In response, the Pennsylvania Department of Corrections instituted numerous evidence-based practices for suicide prevention which have resulted in mortality rates *less* than national prison averages 10 of the past 14 years, suicide mortality rates periodically *less* than community mortality rates, and the 18th lowest mortality rate for suicide in the United States (BJS, 2012; Kochanek et al., 2011; Murphy et al., 2012). Pennsylvania's Department of Corrections realized these systemic

reductions despite maintaining the sixth largest state corrections population in the United States (i.e., 50,918 inmates).

RISK FACTORS AMONG INMATES

Suicide and self-injurious acts are serious dangers in any correctional setting. Therefore, early identification, appropriate housing and monitoring, and proper treatment of a potentially self-destructive inmate is critically important, both for the individual in need of service and for the facility charged with his/her care. Suicide potential can be evaluated by using the following criteria.

Suicidal Plan
The potential for suicide is greater when there is a well-organized and detailed plan developed by the inmate. The potential also increases when the means of the suicide identified in the plan is readily available to the inmate and can be lethal.

Prior Suicidal Behavior
The potential for suicide is greater if the individual has experienced one or more prior attempts of a lethal nature or has a history of repeated threats and depression. In addition, individuals involved in many episodes of self-injurious behavior (SIB) are at increased risk of suicide.

Stress
The potential for suicide is greater if the individual is subject to stress from increased pressures such as, but not limited to:

- difficulties in coping with legal problems;
- the loss of a loved one through death or divorce;
- the loss of valued employment (high paying position in Correctional Industries);
- anniversary of incarceration date or offense;
- serious illnesses or diagnosis of terminal illness;
- threats or perceived threats from peers;
- sexual victimization, particularly after the first submission;
- placement in segregation;
- unexpected punishment (misconducts or additional sentence or parole denial);
- cell restriction;
- recent transfer from another state or county facility;
- recently returned to prison due to a parole violation;
- any movement to and from segregation (watch closely for several hours);

- long sentence coupled with poor external supports (family or volunteers) and/or minimal involvement in facility supports (education, treatment, activities, and employment);
- somatic complaints of a vague nature that do not respond to treatment;
- history of violence toward others;
- intellectual/developmental disability
- requesting protective custody;
- deemed to be a "high profile" case;
- long sentence, including life; and/or
- history of alcohol and/or drug use conditions
- Traumatic event, significant wound/injury, physical disability

Prior Suicidal Behavior of Someone Significant to the Individual

The potential for suicide is greater if a parent, spouse or other close relative or a person significant to the individual has attempted or died by suicide.

Symptoms

The potential for suicide is greater if the individual manifests symptoms such as:

- auditory and/or visual hallucinations, particularly command hallucinations ordering the person to harm himself/herself;
- delusions;
- any change from the individual's sleep pattern (this may be manifested by either a decrease or increase in sleep);
- any change from the individual's ordinary eating pattern. (This may be manifested by either a decrease or an increase in the individual's appetite with an accompanied decrease or increase in weight);
- social withdrawal;
- apathy;
- despondency;
- severe feelings of hopelessness and helplessness;
- general attitude of physical and emotional exhaustion;
- agitation through such symptoms as tension, guilt, shame, poor impulse control or feelings of rage, anger, hostility or revenge;
- giving away personal property;
- removal of every visitor from the visiting list;
- changing next of kin notifications;
- sudden elevated mood ("everything's OK attitude"); and/or

- psychic or somatic anxiety.

Personal Resources
The potential for suicide is greater if the person has no family or friends, or his/her family and friends are unwilling to help. Potential is greater if a significant other evidences a defensive, rejecting, punishing attitude, or denies that the individual needs help.

Acute vs. Chronic Aspects
The potential for suicide is greater when there is a sudden onset of specific symptoms. An individual who has recently learned that he/she has a serious disorder is at greater risk than a person who has been coping with the problem for years. The acute risk is higher if the person appears anxious.

Medical Status
The potential for suicide is greater when there is a chronic, debilitating illness, especially when it involves an alteration of body image or life style.

A person considering suicide does not demonstrate all of these signals. Generally, the more characteristics the individual has, the greater the potential for self-harm. Every suicide attempt, including gestures, is taken seriously.

STATISTICS RELATED TO SUICIDE RISK FACTORS IN THE PENNSYLVANIA DEPARTMENT OF CORRECTIONS

- Mental health condition: although inmates on the mental health/intellectual disability roster comprise approximately 22% of the PA state prison population, these individuals comprise approximately 60% of the suicides.
- Substance use condition: approximately 70% of inmates who died by/attempted suicide had histories of substance use conditions.
- Males: males account for approximately 95% of the PA state prison population and account for approximately 98% of suicides.
- Caucasians: although Caucasians comprise only 34% of the PA state prison population, these individuals comprise over 50% of all suicides.
- Older Adults: due to mandatory sentencing and a reduction in parole, the PA state prison population has been getting older. Depression is underdiagnosed among older adults and we are carefully monitoring this population.
- Sex Offenders: this population is a growing risk, possibly related to the increased difficulty of obtaining parole.

- Lifers/Long Term Offenders: although inmates with life sentences comprise 17% of the PA state prison population, they comprise more than 40% of the suicides.
- Parole Violators: these are offenders who are returned to prisons after failing to adjust in the community. In some cases, they may still be under the influence of alcohol or other drugs. Our speculation is that these individuals panic when they realize that their likelihood of being re-paroled might be remote.
- Administrative Segregation: although this population had a high rate in the past it has decreased since new policies have been implemented.

STRATEGIES TO REDUCE DOC SUICIDES

- All Pennsylvania Department of Corrections employees receive at least two hours of suicide prevention training during their basic training regimens, followed by one hour of refresher training annually.

- The Pennsylvania Department of Corrections recently recognized the need for enhanced system-wide suicide prevention training initiatives. Subsequently, the department commenced the delivery of the *Crisis Intervention Team* (CIT) training and *Mental Health First Aid* training for all corrections employees. By the end of 2013, the Department of Corrections trained more than 300 employees in the CIT model. The Department is scheduled to have all DOC staff trained in *Mental Health First Aid* by the end of FY 2014. Additionally, one of the initial CIT trainings was geared toward county employees from around the state. Plans to begin offering CIT regionally (i.e., within SCIs) are also underway. Overviews of the CIT implementation have been provided at various conferences to include NAMI, PPWA, and Forensic Rights and Treatment Conference. All Superintendents were trained in CIT at a two-day meeting in January of 2014. Currently, the DOC has five statewide MHFA trainers who will continue to train staff. However, the Department of Corrections intends to have 30 trainers trained by June of 2014 with the intent of training ALL staff by the end of FY 2014.

- The departmental disciplinary process and suicide prevention has been greatly augmented during this past year regarding inmates with mental health and serious mental health conditions. Our Hearing Examiners received a specialized training on the recent policy amendments and new provisions to the disciplinary process by the Licensed Psychologist Director, the department's Office of Chief Counsel, and the Supervising Hearing Examiner at Central Office. Specific changes included the elimination of disciplinary sanctions for suicide attempts and other intentional self-injurious behaviors, the implements associated with these behaviors, other non-assaultive behaviors associated with these behaviors, and threatening statements made

while engaging in a suicide attempt or self-injurious behavior. The suicide risk associated with segregating inmates (diagnosed with mental health and serious mental health conditions) for extended periods of time was also considered as the following paragraph indicates. Restrictions permitted for this population were increased significantly on the amount and type of disciplinary sanctions for any institutional violation.

- The Pennsylvania Department of Corrections has many suicide prevention protocols in place for all inmates. For example, every inmate who is received by or enters the Department of Corrections, at any time, is assessed for suicide risk by a psychologist and given a pamphlet that describes the stressors associated with incarceration, the risk factors for suicide associated with incarceration, tips on identifying and recognizing a crisis during incarceration, the procedures of how to access mental health services while incarcerated, and what to do if a fellow inmate exhibits emotional distress or is contemplating suicide. Every State Correctional Institution must have a local system in place for the regular distribution of these educational pamphlets for their inmate populations.

- At every State Correctional Institution in Pennsylvania, a locally developed video is aired on the inmate dedicated channel for the purposes of introducing the mental health staff, services offered by this staff, and additional educational material on suicide prevention and suicide risk identification.

- Every State Correctional Institution in Pennsylvania conducts random suicide response drills. Suicide response drills are aimed at improving response times from medical, custody, and other appropriate staff. Summary reports of these drills are submitted to the Institutional Critical Incident Manager to ensure that the Critical Incident Stress Management Team is activated afterward.

- The Pennsylvania Department of Corrections maintains robust pre-placement suicide risk screenings for certain housing placements. For example, before an inmate is placed in segregation for a violent institutional misconduct, pre-placement suicide risk screenings are conducted by a security staff member, a nursing staff member, and a psychologist. Inmates who are identified as being at heightened or imminent suicide risk are immediately diverted to inpatient settings and not placed in segregation.

- The Pennsylvania Department of Corrections has concentrated significant efforts on improving, developing, and implementing additional clinical operations associated with suicide prevention. For example, in 2013, **Suicide Prevention Committees**, consisting of

multidisciplinary professionals, were established at every State Correctional Institution. The committees meet monthly, review critical incidents, recommend policy changes, and evaluate facility processes and procedures as they relate to suicide prevention. Each committee must send monthly reports of updates to Central Office for additional oversight and quality assurance purposes.

- The Pennsylvania Department of Corrections has drastically enhanced the requirements and procedures for clinical reviews of self-injurious behaviors, suicide attempts, and suicides, while acknowledging the increased importance on postvention efforts. Highlights of these changes include requirements for the clinical review team to be chaired by the Licensed Psychologist Manager, the requirement of a clinical review for all serious suicide attempts, and additional Central Office oversight of every clinical review for quality improvement/quality assurance purposes.

- The Pennsylvania Department of Corrections maintains tracking systems of all suicides, attempted suicides, and self-injurious behaviors that occur in all State Correctional Institutions for the specific intent of identifying trending or clustering.

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LAW ENFORCEMENT SUICIDE PREVENTION

Suicide is a silent epidemic that permeates all walks of life and all types of people; it does not discriminate. There are certain populations, however, that are at an elevated risk for suicide. One of these populations is law enforcement personnel. The rate of suicide for police officers is 3 – 4 times higher than the general population and more active law enforcement officers die by suicide than homicide. It is estimated that 300 police officers die by suicide each year, although data is often hard to obtain. One Philadelphia police department was unwilling to share their data when requested and we can only assume many more follow suit. The stigma surrounding suicide continues to be an obstacle for preventing suicide. Therefore more attempts to raise awareness, particularly among law enforcement personnel, need to be made.

Police are at an elevated risk for:

- Divorce
- Post-Traumatic Stress Disorder (PTSD)
- Alcoholism

These factors greatly enhance their risk of suicide. Stress factors, symptoms of PTSD and alcoholism, depression and suicidality, all require recognition and early detection. Effective methods in helping officers with these issues need to be incorporated

My name is Marie Bartos and I am a survivor of suicide loss. My husband, Stephen Milkovits, was a police officer and a United States Marine Corp veteran. Ten years ago, he made the unfortunate decision to take his life, in our home, as I helplessly watched in horror. Since his death, I wondered why am I here, what is my purpose in life? I found my answer through advocacy and survivor outreach with our local chapter of the American Foundation for Suicide Prevention (AFSP). Sharing my story and helping those who are living the hell that I have lived through, has become my passion, my calling, my reason for living. Survivors of suicide loss need to know they're not alone, it's not their fault and there is a light at the end of the darkness. Each of us has to find our own way, on our own terms, in our own time, but knowing that someone knows how we feel is in its own way comforting. I've taken this tragedy and made it my triumph. I've become more compassionate, caring, loving, but most of all, understanding and accepting of life. As painful as it is sometimes, it's given me hope-hope that I've never had before. Hope that anything is possible. It also made me realize the strength that I have within. If I can save one life, it makes it all worth it.

Marie Bartos

into any law enforcement suicide prevention program.

Not surprisingly the leading cause of suicide for police is by firearms, with most suicides occurring at home. Although law enforcement officers have daily access to firearms, restriction to access of them can still be included as part of a suicide prevention training. There are other components of suicide prevention which are gaining more popularity across the country. These methods include:

- (gatekeeper) suicide prevention training in the curriculum of cadets in the police academy
- Creating peer support groups among the departments, and
- Encouraging help seeking behavior

Dr. Joseph Violanti, a leading researcher and expert in police suicide, strongly advocates peers, supervisors, and administrators learn how to detect, intervene and refer a suicidal officer (for help) as part of their training. He believes developing a program that includes psychological assessment, tracking high risk officers, access to firearms, family involvement, and training would ultimately lead to a reduction of suicide among police officers. Dr. Violanti has authored an informational website including a suicide prevention toolkit for use by law enforcement departments that can be found at: http://policesuicide.spcollege.edu/indexIHW.htm.

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Members of the Armed Forces and Veterans

DEPARTMENT OF DEFENSE (DOD)

Suicide prevention is a top priority for the Department of Defense (DoD). Reflecting this, the Secretary of Defense established the Defense Suicide Prevention Office (DSPO) in November 2011 to serve as the focal point for all DoD suicide prevention programs, policies, and surveillance activities.

DSPO oversees all strategic development, implementation, centralization, standardization, communication, and evaluation of DoD suicide risk reduction programs, policies and surveillance activities. To reduce the impact of suicide on Service members and their families, DSPO uses a range of approaches related to policy, research, communications, law, and mental health. DSPO works with the Army, Navy, Air Force, Marine Corps, Coast Guard and National Guard Bureau to support our Service members and strengthen a resilient and ready force. DSPO strives to help foster a climate that encourages Service members to seek help for their mental health conditions.

DSPO is working with its partners to enhance suicide prevention efforts in the military by responding to a range of critical recommendations, including those offered by the DoD's Task Force on the Prevention of Suicide by Members of the Armed Forces. These efforts include establishing, monitoring, and analyzing the results of suicide prevention research and surveillance activities to identify suicide risk factors and translate findings into policy and strategies. DSPO is working with the Department of Veterans Affairs, the Centers for Disease Control and Prevention, and the

Hello, my name is Russell Crupe; I lost my son Russell Jr. to suicide in July 2012. Russell was a decorated combat veteran having served in Iraq.
I will never know why this happened but it has surely changed our lives forever. Parents should never have to bury their children. We are very proud of Russell in that he was never selfish and is missed by a lot of friends and family. My life is changed in that we worked together and will never be the same. When I travel, I no longer have him to call to let him know where we are at. Memories are often a curse because no matter what I do he was always part of it. I hope and pray that the government will look harder at Post Traumatic Stress Disorder (PTSD) and find ways to help our military so other families will not suffer what we are doomed to endure.

Russell Crupe

National Center for Telehealth & Technology (T2), among others, on these surveillance efforts.

The Department of Defense Suicide Event Report (DoDSER) program was launched in 2008 to refine suicide surveillance within DoD. This was one of the surveillance efforts used at DoD to help characterize the suicidal behavior of military personnel. The DoDSER assesses several areas of interest to suicide prevention efforts, including demographics, mental health history, circumstances at the time of the event (e.g., stressors and significant life events), and deployment history.

The DoDSER program is a collaborative effort of the National Center for Telehealth & Technology (T2) and the Services' suicide prevention program offices. Since January 1, 2008, the DoDSER program has standardized suicide surveillance across the Services with the ultimate goal of facilitating the DoD's suicide prevention mission. When a death is ruled a suicide by the Armed Forces Medical Examiner System (AFMES), a designated professional from the respective Service reviews records, conducts interviews when appropriate, and responds to the DoDSER items via the secure web-based DoDSER application (https://dodser.t2.health. mil). As of January 1, 2010, all Services have been collecting data on both suicides and suicide attempts, with some Services collecting data on additional nonfatal suicide events. The DoDSER items collect comprehensive information about the Service Member and the suicide event.

The AFMES indicates that 301 Service Members died by suicide in 2011 (Air Force = 50, Army = 167, Marine Corps = 32, Navy = 52). This number includes deaths strongly suspected to be suicides that are pending final determination. DoDSER Points of Contact (POCs) submitted reports for 100% of AFMES confirmed 2011 suicides (Air Force = 46, Army = 159, Marine Corps = 31, Navy = 51) as of the data extraction date (26 April 2012). A total of 915 Service Members attempted suicide in 2011 (Air Force = 241, Army = 432, Marine Corps = 156, Navy = 86). DoDSERs were submitted for 935 suicide attempts (Air Force = 251, Army = 440, Marine Corps = 157, Navy = 87). Of the 915 Service Members who attempted suicide, 896 had one attempt, 18 had two attempts, and 1 had three attempts.

Department of Defense Resources

Department of Defense's Office of the Under Secretary of Defense for Personnel and Readiness's Defense Suicide Prevention Office (DSPO) http://www.suicideoutreach.org/

Department of Defense Suicide Event Report (DoDSER)
http://www.t2.health.mil/programs/dodser

DoDSER 2011 Annual report
http://www.t2.health.mil/sites/default/files/dodser/DoDSER_2011_Annual_Report.pdf

PENNSYLVANIA NATIONAL GUARD SUICIDE PREVENTION PROGRAM

In calendar year 2012 within the Pennsylvania Army National Guard (PAARNG), there were 52 suicide ideations, 22 suicide attempts and 5 suicides and 1 suicide attempt in the Pennsylvania Air National Guard (PAANG). In calendar year 2013 there were 53 suicide ideations, 15 suicide attempts and 4 suicides in the PAARNG and 2 suicide ideations, and 1 suicide attempt in the PAANG.

The Pennsylvania National Guard (PNG), an organization that is made up of approximately 20,000 Soldiers, Airman and their Families. The sheer size of this organization creates a rather large foot print in the state of Pennsylvania that is directly affected by the implications of suicidal behavior. Unlike active duty military Families, National Guard Families are their communities. National Guardsmen are integrated into society so their neighbors along with their fellow Soldiers and Families feel their struggles. The leadership of the Pennsylvania National Guard, the community, state and federal government agencies, private veteran's organizations, and non-profit agencies all have a vested interest in preventing military suicides.

The PNG is already noticing a decrease in suicides. The number of successful interventions has also substantially increased and evidence supports the reasons because of 1) suicide prevention and intervention education and training initiatives, and 2) the implementation of the Suicide Related Incidents Reporting Regulation. According to the PAARNG DPH, "The Suicide Related Incidents Reporting Regulation and R3SP training program have been pivotal, by requiring units to report suicide ideations, suicide attempts and deaths by suicide when they occur. Leaders are held accountable to ensure these Soldiers receive the care they need. We are teaching leaders how to respond and identify suicidal behaviors before they result in a crisis. This regulation has helped mental health to be taken more seriously in the Pennsylvania National Guard."

Pennsylvania National Guard Resources:

Family Programs (717) 861-2650, Child and Youth Program (717) 861-6289, Yellow Ribbon Program (717) 861-2597, Employment Outreach (717) 861-2640, Employer Support of the Guard and Reserve (717) 861-8782, Resilience, Risk Reduction and Suicide Prevention Programs (717) 861-8976, Psychological Health Program (717) 673-4785, Sexual Assault prevention and Response Program (717) 861-6427, Survivor Outreach Services (814) 533-2481, Transition Assistance (717) 861-2813.

U.S. ARMY SUICIDE PREVENTION PROGRAM

This program uses Applied Suicide Intervention Skills Training (ASIST) to prepare designated gatekeepers to recognize suicide risk and intervene. All Army personnel, including civilians, are required to participate in Ask, Care, and Escort (ACE) suicide prevention and awareness training. The website also includes awareness materials, data, and tools for commanders to develop suicide prevention programs.

The Army Suicide Prevention Program (ASPP), a proponent of Deputy Chief of Staff, G–1 (DCS, G–1), has an Army-wide commitment to provide resources for suicide intervention skills, prevention, and follow-up in an effort to reduce the occurrence of suicidal behavior across the Army enterprise. The ASPP develops initiatives to tailor and target policies, programs, and training in order to mitigate risk and behavior associated with suicide. A function of the ASPP is to track demographic data on suicidal behaviors to assist Army leaders in the identification of trends. The goal is to minimize suicidal behavior by reducing the risk of suicide for Active Army and Reserve Component Soldiers, Army DA civilians, and Army Family members. The ASPP establishes a community approach to reduce Army suicides through the function of the Community Health Promotion Councils (CHPC). The CHPC integrates multidisciplinary capabilities to assist commanders in implementing local suicide-prevention programs, and establishes the importance of early identification of, and intervention with problems that detract from personal and unit readiness. The ASPP has 3 principle phases or categories of activities to mitigate the risk and impact of suicidal behaviors, prevention, intervention, and postvention.

U.S. Army Resources

www.armyg1.army.mil/hr/suicide/default.asp

2012 National Strategy for Suicide Prevention: Goals and Objectives for Action
http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

DA PAM 600_24 Health Promotion, Risk Reduction, and Suicide Prevention RAR 7 September 2010 http://www.apd.army.mil/pdffiles/p600_24.pdf

U.S. AIR FORCE

The AF Suicide Prevention Program is built on the 11 overlapping core elements listed below stressing leadership and community involvement in the prevention of suicides.

1. Leadership Involvement 2. Addressing Suicide Prevention through Professional Military Education 3. Guidelines for Commanders 4. Unit-based Preventive Services 5. Wingman Culture 6. Investigative Interview Policy 7. Post Suicide Response (Postvention) 8. Integrated Delivery System (IDS) and Community Action Information Board (CAIB) 9. Limited Privilege Suicide Prevention Program 10. Commanders Consultation Assessment Tool 11. Suicide Event Tracking and Analysis

U.S. Air Force Resources

Air Force Suicide Prevention Website http://www.afms.af.mil/suicideprevention/index.asp

Air Force Instruction 90-505, 10 August 2012, Special Management Suicide Prevention Program http://www.afms.af.mil/shared/media/document/AFD-130423-030.pdf

U.S. MARINE CORPS

The Marine Corps Suicide Prevention program (MCSPP) establishes policy and provides resources, guidance, and training for suicide prevention programs.

The desired outcome of the MCSPP is a proactive, efficient, and effective strategy to maintain the readiness of both individual marines and their units. This strategy is aligned with the Marine Corps larger, holistic prevention approach to mental health that seeks to develop coping skills, increase resilience, and increase access to and engagement of mental health, healthcare services.

The Marine Corps Manpower and Reserve Affairs website has multiple links to information in reference to the MCSPP.

U.S. Marine Corps Resources

Marine Corps Order 1720.2 Marine Corps Suicide Prevention Program http://www.marines.mil/Portals/59/Publications/MCO%201720.2.pdf

Marine Corps Manpower and Reserve Affairs website. https://www.manpower.usmc.mil/portal/page/portal/M_RA_HOME/MF/G_Behavioral%20Health/BH_Community%20Counseling%20and%20Prevention

U.S. NAVY

The Navy's Suicide prevention website provides links to policies, training, and resources. The Navy Suicide Program focuses at the Commander's level.

Commanders play a crucial role in facilitating the local actions that build lives worth living, enhancing resilience, enabling access to support services, and diverting people from a path to suicide. They also help those left behind to pick up and start to heal if the tragedy of suicide does strike.

The first step is for Commanders to designate a Suicide Prevention Coordinator (SPC) and make sure that person gets training to assist in implementing the following steps. 1. Strengthen Your Foundation 2. Enhance Awareness 3. Build Skills 4. Be Prepared 5. Intervene 6. Reintegrate 7. Respond 8. Report

U.S. Navy Resources

Navy Suicide Prevention Website http://www.public.navy.mil/BUPERS-NPC/support/21st_century_sailor/suicide_prevention/Pages/default.aspx

Commanding Officer's Suicide Prevention and Response Toolbox http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/suicide_prevention/Documents/Suicide%20Prevention%20Commander%20Toolbox%2015%20Nov.pdf

U.S. COAST GUARD

United States Coast Guard website, Office of Work-Life Programs- Suicide Prevention Program, has multiple links that will connect the Coast Guard personnel to available services and resources.

The goals of the Coast Guard's Suicide Prevention Program are to:

a. Minimize suicidal behavior among all Coast Guard employees and their family members by empowering all Coast Guard personnel to recognize persons in distress and to take supportive action to help them, b. Encourage help-seeking behavior by reducing the stigma historically associated with receiving mental health care, and c. Protect those who responsibly seek mental health treatment from unfair actions resulting from seeking help.

Measures of success for the Coast Guard Suicide Prevention Program include:

a. Reduced suicidal behaviors. b. Increased awareness of warning signs and circumstances associated with suicidal behavior. c. Increased number of personnel of all ranks who know what to do to assist distressed individuals, and d. An increase in the number of personnel who understand that mental health care can be obtained without risk to one's career.

The Coast Guard Suicide Prevention Program consists of seven components including Command Climate, Crisis Response, Limit on Command Access to Mental Healthcare Information, Notification and Hand-off in Criminal Investigations, Postvention, Reporting, and Training.

U.S. Coast Guard Resources

Commandant Instruction 1734.1A Suicide Prevention Program
http://www.uscg.mil/HEALTH/cg1122/docs/pdf/CI_1734_1A.pdf

United States Coast Guard website Office of Work-Life Programs- Suicide Prevention Program
http://www.uscg.mil/worklife/suicide_prevention.asp

VETERANS

The suicide rate for active duty military personnel has historically been significantly lower than the rate for a comparable population of civilians. However, the number of suicides and suicide attempts has been steadily growing over the past several years.

There are similar concerns within the veteran population. The Center for Disease Control and Prevention estimates that veteran's account for approximately 20% of the deaths from suicide in America. Some 8,000 veterans are thought to die by suicide each year, a toll of about 22 per day, according to a 2012 VA study. These numbers may be a gross underestimation as this number includes only data from 21 states, not including Texas or California. The number of suicides has grown over 11% in the most recent 4 years. In the most recent date the suicide rates for male Veterans Health Administration patients were approximately 1.4 times greater than for other American men. For female veterans involved in VHA services, rates were approximately twice as high as among American women. Approximately half of all suicides in VHA occurred among patients known to have mental health conditions.

VA suicide prevention began earnestly in 2004 with the inception of the Mental Health Strategic Plan. This plan has assisted in increasing core mental health staff on a national level by 50 percent. In addition, the VA suicide prevention program is based on the principle that prevention requires ready access to high quality mental health services within the health care system, supplemented by public education and awareness, and availability of specific services which address the needs of those at highest risk. Activities which have been sponsored by the

suicide prevention network have included creating a national office for suicide prevention, partnering with SAMSHA and its Lifeline program to add a veteran's call center to its national crisis line, funding suicide prevention coordinators with support staff in each VA medical center and initiating public information forums focused on promoting the use of the of the VA mental health services for those in need.

The Veterans Crisis Line connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline, online chat, or text. Veterans and their loved ones can call 1-800-273-8255 and Press 1, chat online, or send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for deaf and hard of hearing individuals is available.

VA is working to make sure that all Veterans and their loved ones are aware of the Veterans Crisis Line. To reach as many Veterans as possible, VA is coordinating with communities and partner groups nationwide, including community-based organizations, Veteran Service Organizations, and local health care providers, to let Veterans and their loved ones know that support is available whenever, if ever, they need it.

Veterans Resources

Veterans Crisis Line http://www.veteranscrisisline.net/

U.S. Department of Defense/U.S. Department of Veterans Affairs Suicide Outreach http://www.suicideoutreach.org/

Murder-Suicide

Murder-suicide is "a dramatic, violent event" in which a person, almost always a man, commits one murder or multiple murders, and then shortly after dies by suicide.[1] According to the most recent edition (fourth edition published in 2012) of the Violence Policy Center's (VPC), "American Roulette: Murder-suicide in the United States," there was no comprehensive national database to accurately track incidents, fatalities, and survivors of murder-suicide events. However, the data gathered by the VPC is worth noting as those who have committed homicide, followed by suicide within 72 hours, seem to show specific trends.[2] The VPC's analysis may provide the most accurate and current information on murder-suicide in the United States.

The most recent data gathered by VPC from news reports during the first six months of 2011 shows:

- There were 313 murder-suicide events resulting in 691 total deaths (378 were homicides)
- 280 (89.5%) of these events involved firearms
- 283 (90%) of the 313 perpetrators were male
- 288 (76%) of the 378 homicide victims were female
- 225 (72%) of the events involved an intimate partner; of those, 94% of homicide victims were females
- 55 (14.5%) of the homicide victims were under 18
- 66 children were survivors who witnesses some aspect of one of these events
- 80% of the total events occurred in the home, while 84% of intimate partner events occurred in the home
- 25% of these events involved a perpetrator 55 or over
- There is a subcategory of intimate partner murder-suicide events, in which a man (called a "family annihilator") kills his intimate partner and children, as well as other family members, before dying by suicide

The following are conclusions drawn in the VPC report:

- There are significant fatalities of murder-suicide events that go well beyond the suicide itself, including the deaths of family, friends, co-workers and/or strangers.
- There are significant emotional repercussions, including guardianship changes, for the children of those involved in murder-suicide events.
- Domestic violence is associated with a significant number of murder-suicides. Therefore, intervention and legislation related to domestic violence may be a way to address this issue.
- Depression and failing health have been cited as contributing factors to murder-suicide among older persons.
- The overwhelming use of firearms as the weapon in these events points to the need for efforts that will restrict access to those with some of the risk factors listed above.
- A comprehensive national database of murder-suicide events should be established.

References:

Peter M. Murzuk et al., "The Epidemiology of Murder-Suicide," *Journal of the American Medical Association* 267, no. 23 (June 1992): 3179-3183.

American Roulette: Murder-Suicide in the United States, Fourth Edition by the Violence Policy Center, 2012, as well as related publications can be found at http://www.vpc.org/studyndx.htm.

Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex Populations (LGBTQI)

According to the Kaiser Family Foundation Issue Brief of January 2014 entitled Health and Access to Care and Coverage for LGBT Individuals in the U.S. Who Are LGBT, people who are LGBT (and by extension Q and I), have an elevated risk for some mental health, substance use, and physical health conditions.

Attention to elevated risk for suicide in this population is limited because death certificates do not identify decedent's sexual orientation, gender identity or expression. The Kaiser Foundation report finds that individuals who identify as LGBT are 2.5 times more likely to experience depression, anxiety, and substance misuse. The report reveals that 26% of bisexual females, 11% of bisexual males, 6% of gay males and a 3% rate among all other subgroups have recently considered suicide. In addition, anti-gay bias and homophobia put people who are LGBTQI, and those simply perceived to be, at greater risk for physical violence, with people of color who are transgender at particular risk. People who are transgender have faced some type of discrimination when seeking routine medical care. Persons who are LGBTQI report histories of discrimination and stigma at an unacceptable rate of 66%. People who are LGBTQI are present across all religious, cultural, political, ethnic, socio-economic, gender and racial populations. Some may experience double minority stress, stigma and discrimination, a type of "double jeopardy". LGBTQI persons who are older may be excluded from nursing homes and may need to go "back in the closest" although they were previously "out", and there are adverse financial consequences for LGBTQI couples, even if legally married in another state, leaving them vulnerable to poverty. Closing the knowledge gap, addressing homophobia and ensuring equality among all minorities to reduce stigma and discrimination are necessary factors for the prevention of suicide.

Factors that foster and promote resilience in people who are LGBTQ or I include family acceptance, connection with caring others and a sense of safety, positive sexual/gender identity and availability of quality, culturally appropriate mental health treatment. Strategies for preventing suicide and thoughts and actions in people who are LGBTQI include: reducing sexual orientation and gender related prejudice and associated stressors, improving identification of depression, anxiety, substance use conditions and other mental health conditions, increasing availability and access to LGBTQI affirming treatments and mental health services/supports. An addition goal is to reduce bullying and other forms of victimizations and micro-aggressions that contribute to vulnerability within families, schools, workplaces, and congregate care facilities such as nursing homes and hospitals. It is necessary to enhance factors that promote resilience, including family acceptance and public safety, such as changing discriminatory laws and public policies and reducing suicide contagions. These goals will require collaboration between suicide prevention and LGBTQI organizations to ensure the development of culturally appropriate suicide prevention programs, services and materials, and to facilitate access to care for at-risk individuals.

In 2008 The Office of Mental Health and Substance Abuse Services (OMHSAS) convened a group of stakeholders at the request of the Deputy Secretary to address the needs of people who identify as LGBTQI who seek mental health and substance use treatment within the Pennsylvania managed care system. This group sent 3 major recommendations to the Deputy. First is to protect LGBTQI individuals from discrimination and mistreatment. Next, is to ensure that OMHSAS and contracted providers ensure culturally affirmative environments of care for individuals who identify as LGBTQI. Lastly, to ensure clinically competent behavioral health care for individuals who identify as LGBTQ or I. From this effort two bulletins and a white paper were published and can be found on www.parecovery.org. The bulletins address non-discrimination and guidelines to ensure affirmative environments and clinically appropriate services. It was noted that some clinicians were non-discriminatory and would like to be affirmative and competent; however, had a knowledge gap that needed to be addressed. A white paper addressing so-called conversion therapy was also published to highlight the harm that can be done with this method and noted that all major professional therapeutic groups such as the two APA's and NASW rejected this as competent therapy.

The Keystone Pride Recovery Initiative, KPRI, emerged out of this effort and has engaged in developing and implementing a web based and one day training in creating welcoming environments and a two day training for clinicians who wish to provide competent care. The curriculum was developed in partnership with the Pennsylvania Mental Health Consumers Association, (PMHCA), and Drexel University Behavioral Health Education with a grant from SAMHSA. KPRI is also working on public policy to promote equality and changing discriminatory

laws. Data collection that includes sexual orientation gender identity/expression, for more accurate reporting, is also a goal of the group.

Founded in 1972, the Persad Center headquartered in Pittsburgh is the nation's second oldest licensed counseling center whose mission is to strengthen LGBTQ communities. Outreach, training, advocacy and prevention programs are provided. In Philadelphia, the Pink and Blues support group is a valuable resource in the southeast part of the state. The Lesbian, Gay, Bisexual, Transgender Elder Initiative (LGBTEI) serves the Delaware Valley and beyond to protect and expand the rights of LGBTQI older adults as well as advocate for services and resources that are competent, culturally sensitive, inclusive and responsive to the needs of elders who identify as LGBT. There are large areas in Pennsylvania that do not have resources close by, however, resources may be available by contacting the above organizations and there are national organizations listed in the resource section.

Allies have been effective in promoting positive change in the dominant culture on issues of equality. An ally is a person who is a member of the dominant, majority heterosexual group who works to end oppression in his or her professional life through support and advocacy of the minority LGBTQI group. They speak out about discrimination and the denial of legal powers and privileges for people who are LGBTQI. They are a tremendous support and force for justice in the LGBTQI community.

Appendix B: Definitions*

Bereaved by suicide - Family members, friends, and others affected by the suicide of a loved one (also referred to as suicide loss survivors).

Best practices - Activities or programs that are in keeping with the best available evidence regarding what is effective.

Contagion - A phenomenon whereby susceptible persons are influenced toward suicidal behavior through knowledge of another person's suicidal acts.

Culturally competent - A set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures, including the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Means - The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs)

Means restriction - Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Methods - Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).

Older Adults - Persons aged 60 or more years.

Postvention - Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.

Risk factors - Factors that make it more likely that individuals will consider suicide. Risk facts may encompass biological, psychological, or social factors in the individual, family, and environment.

Substance use "condition" - A pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances (such as alcohol); prescription drugs (such as analgesics, sedatives, tranquilizers, and stimulants); and illicit drugs (such as marijuana, cocaine, inhalants, hallucinogens, and heroin).

Suicide - Death cause by self-directed injurious behavior with any intent to die as a result of the behavior

Note: The term "committed" suicide is discouraged because it connotes the equivalent of a crime or sin. The Center for Disease Control has also deemed "completed suicide" and "successful suicide" as unacceptable. Preferred terms are "death by suicide" or "died by suicide"

Suicidal thoughts or actions - Includes thoughts related to suicide, including preparatory acts, as well as suicide attempts and deaths. The term suicidal behavior is commonly used in the field but has been replaced with thoughts and actions throughout the document.

Suicide attempt survivors - Individuals who have survived a prior suicide attempt.

Suicide loss survivors - See bereaved by suicide.

*Definitions taken from the National Strategy for Suicide Prevention and the Suicide Prevention Resource Center.

Appendix C: Risk and Protective Factors

RISK FACTORS FOR SUICIDE

- Previous suicide attempt
- Diagnosis of depression
- Family history of suicide
- Recent loss including one or more of the following: independence, health status, job, home, money
- Death or terminal illness of a loved one
- Divorce or loss of major, significant relationship
- Loss of health, either real or imagined
- Someone close to the person has died by suicide
- Recent disappointment or rejection
- Being expelled from school/fired from job
- Sudden loss of freedom/fear of punishment
- Victim of assault or bullying

PROTECTIVE FACTORS

- Strong bonds with friends and family
- Restricted access to lethal means
- Effective and appropriate clinical care for mental, physical and substance use conditions
- Easy access to a variety of clinical interventions and support for seeking help
- Community support
- Support from ongoing medical and mental health relationships
- Life skills such as decision making, conflict resolution, anger management, non-violent ways of handling disputes and problem solving
- Strong beliefs in the meaning and value of life
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts
- HOPE for the future

Appendix D: Warning Signs of Suicide and What to do:

WARNING SIGNS OF SUICIDE*

- Talking about wanting to die;
- Looking for a way to kill oneself by seeking access to firearms, available pills, or other means;
- Talking or writing about death, dying or suicide;
- Talking about feeling hopeless or having no purpose;
- Suddenly happier and calmer, especially after a period of depression or sadness;
- Giving away prized possessions;
- Getting affairs in order, making arrangements;
- Talking about feeling trapped or being in unbearable pain;
- Talking about being a burden to others;
- Increasing the use of alcohol or drugs;
- Acting anxious, agitated, or reckless;
- Sleeping too little or too much;
- Withdrawing from friends, family and society or feeling isolated;
- Showing rage or talking about seeking revenge; and
- Displaying extreme mood swings.

The more of these signs a person show, the greater the risk of suicide.

WHAT TO DO

If someone you know exhibits signs of suicide:

- Do not leave the person alone;
- Remove any objects that could be used in a suicide attempt;
- Call the U.S. National Suicide Prevention Lifeline at 800-273-TALK/8255; and
- Take the person to an emergency room or seek help from a medical or mental health professional.

*Adapted from Recommendations for Reporting on Suicide website (www.reportingonsuicide.org.; the National Council for Suicide Prevention (www.ncsponline.org/suicide-prevention/warningsigns) and the Pa Adult and Older Adult Suicide Prevention Coalition http://preventsuicidepa.org/

HERE IS AN EASY-TO-REMEMBER MNEMONIC ON THE WARNING SIGNS OF SUICIDE**

IS PATH WARM?

I Ideation
S Substance Abuse

P Purposelessness
A Anxiety
T Trapped
H Hopelessness

W Withdrawal
A Anger
R Recklessness
M Mood changes

If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

** Taken from the American Association of Suicidology (www.suicidology.org)

Appendix E: Resources/Websites

FOR IMMEDIATE HELP OR SUPPORT CALL THE NATIONAL SUICIDE PREVENTION LIFELINE AT 1-800-TALK (8255) or ONLINE at www.suicidepreventionlifeline.org

For direct access to websites below, place your cursor over the website and hit the control button and left mouse button together.

American Association of Suicidology (AAS)
www.suicidology.org

American Foundation for Suicide Prevention (AFSP)
www.afsp.org

Crisis Link: Prevention, Intervention, Support and Training
www.crisislink.org

LGBT Youth Suicide
www.eriegaynews.com

The Link's National Resource Center
www.thelink.org

National Alliance on Mental Illness (NAMI)
www.nami.org

LivingWorks Education Inc.
www.livingworks.net

Means Matter, Harvard School of Public Health
www.hsph.harvard.edu/means-matter

Metanoia
www.metanoia.org/suicide

National Council for Suicide Prevention (NCSP)
www.ncsponline.org

National P.O.L.I.C.E. Suicide Foundation
www.psf.org

Law Enforcement Suicide Prevention
http://policesuicide.spcollege.edu

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org

National Organization of People of Color Against Suicide (NOPCAS)
www.nopcas.com

Norman Institute - gender orientation
1-816-960-7200

QPR Institute
www.qprinstitute.com

Samaritans USA
www.samaritiansnyc.org

Suicide Awareness Voices of Education (SAVE)
www.save.org

Centre for Suicide Prevention
www.suicideinfo.ca

Suicide Anonymous
www.suicideanonymous.net

Action Alliance for Suicide Prevention
www.actionallianceforsuicideprevention.org

Suicide Prevention Resource Center (SPRC)
www.sprc.org

Tears of a Cop
www.tearsofacop.com

Trevor Helpline (LGBTQ Youth)
www.thetrevorproject.org

Veterans
www.veteranscrisisline.net

FEDERAL GOVERNMENT SOURCES:

Centers for Disease Control (CDC)
http://www.cdc.gov/ViolencePrevention/pdf/Suicide-DataSheet-a.pdf

CDC-US Mortality Statistics
www.cdc.gov/ncipc/wisqars/

National Council for Suicide Prevention (NCSP)
www.ncsp.org

National Institute of Mental Health (NIMH)
http://nimh.nih.gov/health/topics/suicide-prevention/index.shtml

Action Alliance for Suicide Prevention (AASP)
www.actionallianceforsuicideprevention.org

The Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov

NATIONAL STRATEGY DOCUMENTS:

National Strategy for Suicide Prevention-National Action Alliance for Suicide Prevention
www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html
www.actionallianceforsuicideprevention.org/NSSP
www.samhsa.gov/nssp

Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead, 2010
Educational Development Center, Inc.
www.sprc.org/library/ChartingTheFuture_Fullbook.pdf

Reducing Suicide: A National Imperative, 2002
Institute of Medicine
http://www.nap.edu/openbook.php?isbn=0309083214

STATE SOURCES:

Pennsylvania Adult and Older Adult Suicide Prevention Coalition
www.PreventSuicidePA.org

Pennsylvania Youth Suicide Prevention
www.payspi.org

PA Recovery
www.parecovery.org

Center for the Prevention of Suicide
www.med.upenn.edu/suicide/

Philly Health Info
http://phillyhealthinfo.org/

Mental Health and Aging
www.mhaging.org

Pink and Blues (LGBTQI resource)
http://www.pinkandblues.info

Pennsylvania Mental Health Consumers Association
Keystone Pride Recovery Initiative- LGBTQI
http://pmhca.org/projects/kpri.html

YOUTH SUICIDE PREVENTION SOURCES:

Active Minds
www.activeminds.org

Jason Foundation
www.jasonfoundation.com

The Jed Foundation
www.jedfoundation.org

School Based Youth Suicide Prevention Guide
http://theguide.fmhi.usf.edu/

Signs of Suicide-Suicide Prevention Program for Secondary Schools (SOS)
www.mentalhealthscreening.org/highschool/index.aspx

Services for Teens at Risk Center (STAR)
www.wpic.pitt.edu/research/star/default.htm

TeenScreen: Adolescent Suicide and Mental Health Screening Programs
www.teenscreen.org

Youth Suicide Prevention Program
www.yspp.org

Yellow Ribbon Youth Suicide Prevention Program
www.yellowribbon.org

MEDIA REPORTING ON SUICIDE:

Picture This: Depression and Suicide Prevention, 2009
www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf

Recommendations for Reporting on Suicide, 2011
www.reportingonsuicide.org

EVIDENCE-BASED AND BEST PRACTICES FOR SUICIDE PREVENTION:

Best Practices Registry for Suicide Prevention
Suicide Prevention Resource Center (SPRC) and American Foundation for Suicide Prevention (AFSP)
www.sprc.org/bpr

National Registry of Evidence-Based Programs and Practices
SAMSHA, HHS
www.nrepp.samhsa.gov

SUICIDE DATA:

National Violent Death Reporting System (NVDRS)
Centers for Disease Control and Prevention (CDC), HHS
www.cdc.gov/injury/wisqars/nvdrs.html

Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0, 2011. National Center for Injury Prevention and Control, CDC, HHS
www.cdc.gov/ViolencePrevention/pub/selfdirected_violence.html

Appendix F: Summary of Four Regional "Listening Sessions" on the Plan and Summary of Survey

The Pennsylvania Adult and Older Adult Suicide Prevention Plan Advisory Committee hosted four regional listening forums, via webinar, during January, 2014. The purpose of the forums was to solicit broad stakeholder input into the revised adult and older adult suicide prevention plans. During these forums, the participants on the line were asked to respond to seven questions. The questions were developed to capture ideas related to the objectives in the 2005 Pennsylvania Adult and Older Adult Suicide Prevention Plans. The same seven questions were asked during each forum and the feedback that was given was incorporated into the revised objectives and action steps within the 2014 Pennsylvania Adult and Older Adult Suicide Prevention Plans. More than 50 individuals attended the listening sessions including state employees, providers, counties, managed care organizations and consumers of service. Listed below are the seven questions used in the forums followed by the major recommendations related to each question.

QUESTION 1: WHAT ARE THE WAYS IN WHICH PENNSYLVANIA CAN PROMOTE AWARENESS THAT SUICIDE IS A PUBLIC HEALTH PROBLEM THAT CAN BE PREVENTED?

- The use of the internet (Facebook, twitter, etc.)
- Billboard campaigns, advertising through the media- radio, television, on buses etc.
- Promote phone numbers for crisis centers, advertise hotlines and chat rooms for crisis intervention, distribute pamphlets/brochures to include statistics and information on prevention and help.
- Encourage health providers and others to talk about suicide prevention and provide more information on the topic.
- Provide continuing education such as Question, Persuade, Refer (QPR) and Mental Health First Aid.
- Celebrity endorsements.

QUESTION 2: HOW CAN PENNSYLVANIA PROMOTE COLLABORATION AMONG A BROAD SPECTRUM OF AGENCIES AND INSTITUTIONS FROM COLLEGES TO FAITH-BASED ORGANIZATIONS TO PREVENT SUICIDE?

- Host the state suicide prevention conference annually
- Provide technical assistance and support to county suicide prevention taskforces including a how-to manual and quarterly networking calls
- Network with the Garrett Lee Smith grant around risk screening
- Consider Applied Suicide Intervention Skills Training (ASIST)

- Identify churches to take responsibility
- Have managed care conduct performance standards

QUESTION 3: WHAT ACTIONS CAN PENNSYLVANIA TAKE TO REDUCE THE STIGMA ASSOCIATED WITH MENTAL "ILLNESS" AND SUBSTANCE "ABUSE" INCLUDING NEGATIVE PORTRAYALS IN THE MEDIA, IN ORDER TO CONNECT PEOPLE WITH SERVICES AND PREVENT SUICIDE?

- Educate through presentations on radio, Lions, Kiwanis, schools, etc.
- Educate staff in emergency rooms, police, corrections officers, etc.
- Use information on AFSP.org on how to work with the media
- Host media awards.
- Have survivors of suicide attempts, suicide loss tell their stories.

QUESTION 4: HOW CAN PENNSYLVANIA INSTILL PREVENTIVE INTERVENTIONS INTO LOCAL COMMUNITIES SUCH AS HEALTH CENTERS, UNIVERSITIES, SENIOR CENTERS, CORRECTIONAL FACILITIES,ETC.?

- Implement risk assessments in physicians' offices.
- Network with Active Minds-that works with college students with mental health issues.
- Have a speakers bureau for presentations
- Provide funding for state lead on suicide
- Engage health providers through the Dept of Health

QUESTION 5: IN WHAT WAYS CAN PENNSYLVANIA REDUCE ACCESS TO LETHAL MEANS AND METHODS OF SELF-HARM?

- Firearms issue is a balancing act between protecting lives and protecting rights.
- Need to look at Harvard University Means Matters project
- Promote voluntary turning in of medications, weapons.
- Need to look at "accidental" medication overdoses among the elderly.
- Gun safes and gun locks are important
- Free resource on lethal means counseling on SPRC.org

QUESTION 6: HOW SHOULD PENNSYLVANIA TARGET TRAINING AND BEST PRACTICE INTERVENTIONS FOR PROFESSIONALS AS WELL AS COMMUNITY GATEKEEPERS SUCH AS POLICE, CLERGY, TEACHERS, ETC., SO THEY HAVE THE SKILLS TO IDENTIFY RISK AND MAKE REFERRALS TO PREVENT SUICIDE?

- Post discharge follow-up is important after a crisis. Is there a way to reinforce through regulations? Could use crisis programs and peer specialists to do.
- Training across the board is needed. Bill in process would require teachers to be trained
- Can we require training such as MH First Aid or QPR for mental health and drug and alcohol providers and others?
- Encourage a variety of training: Mental Health First Aid, Question, Persuade and Refer, ASIST, Means Matters, AFSP training for survivor support groups, etc.
- Lobby credentialing agencies to require training in their standards.

QUESTION 7: WHAT DOES PENNSYLVANIA NEED TO DO TO PROMOTE RESEARCH AND DATA COLLECTION IN ORDER TO BETTER UNDERSTAND SUCH THINGS AS WHY INDIVIDUALS BECOME SUICIDAL, WHERE AND WHY SUICIDES ARE HAPPENING AND WHAT INTERVENTIONS REDUCE SUICIDE?

- Should require consistent reporting by coroners and others
- Suicide rating scale, or something similar, should be required screening with all intakes.
- What is the role of managed care in setting standards?

The above seven questions, plus an additional question listed below, were used to gather statewide input into the Adult and Older Adult Suicide Prevention Plans through "Survey Monkey". The survey was made available during the months of January and February, 2014. A summary of the survey results is listed below. The full survey results will be posted on www.parecovery.org following the publication of this plan.

A total of 154 individuals responded to the survey. Of that total, 69% (100) were females and 28% (44) were males. One person self-identified their gender and two persons choose not to disclose their gender. The largest numbers of respondents (50%) were ages 41-59, while 32% were age 22-40 and 18% were age 60 or older. The vast majority (87%) of individuals completing the survey identified as white (135) and 59% identified as mental health professionals. However, community members, social service employees, state and county employees, suicide loss survivors, suicide attempt survivors, persons in drug and alcohol recovery, emergency workers, veterans and military personnel also participated in the survey.

Participants were asked to choose their top recommendations from the forced choice answers to each question provided in the survey.

QUESTION 1:

Providing public education was the number one recommendation to promote public awareness that suicide is preventable with 114 people identifying this as one of their top three choices. In addition, 86 people recommend targeting policy makers to promote prevention policies and programs while 83 individuals suggest promoting the national and local suicide crisis lines.

QUESTION 2:

In order to promote broad collaboration on suicide prevention, 110 individuals recommend identifying a lead state and local agency to bring together partners to work on suicide prevention. Including suicide prevention as a quality management goal in HealthChoices was prioritized by 88 individuals.

QUESTION 3:

Actions to counter negative portrayals of mental illness and substance use in the media include public awareness campaigns that promote recovery from mental health and substance use disorders as real and possible (121 responses) and the inclusion of survivors and advocates in curriculum development (108 responses).

QUESTION 4:

In order to instill suicide prevention into local organizations, 108 persons recommend promoting suicide risk assessments in community and social service agencies. Increasing the number of suicide prevention plans within these organizations was suggested by 97 individuals.

QUESTION 5:

Education was the overwhelming recommendation to reduce access of lethal means of self-harm. Educating family members (91responses), educating the public (89 responses) and educating health care and safety officials (85 responses) are highly recommended.

QUESTION 6:

Health professionals (102 responses) and the community (110 responses) were the primary audiences targeted to receive training to increase skills to prevent suicide. Regarding best practices, 104 people recommend the implementation of programs for high risk individuals and 102 persons suggest rapid follow-up following crisis inpatient stays.

QUESTION 7:

Regarding data collection, 99 individuals recommend the development of indicators for evaluating the effectiveness of suicide prevention interventions. Increasing the number of jurisdictions that collect information on suicide was recommended by 77 persons.

QUESTION 8: WHAT CAN PENNSYLVANIA DO TO HELP PEOPLE WHO HAVE SURVIVED SUICIDE LOSS?

Question 8 was added to the survey at the request of the Adult and Older Adult Suicide Prevention Advisory Committee. The majority of respondents (100) recommended providing information to first responders on how to deal with the aftermath of suicide including responding to caregivers need for support.

Appendix G: Pennsylvania Adult and Older Adult Suicide Prevention Plan Advisory Committee

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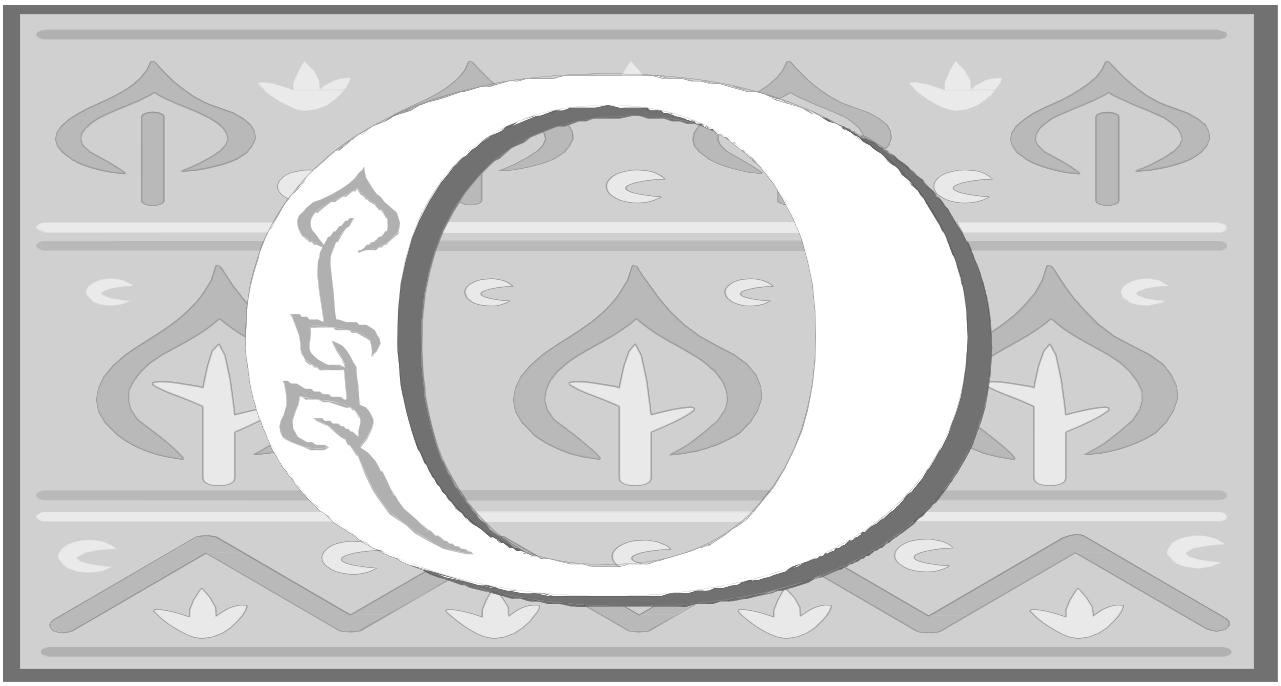
Pennsylvania Older Adult Suicide Prevention Plan



Zero Suicide- Not another life to lose

Contents

INTRODUCTION

In the United States, one of the highest rates of suicide is found among older adults. Suicidal behavior later in life is intentional and lethal, especially among older white males. The risk of dying is greater in suicide attempts made by older adults. Risk factors can be identified; interventions and prevention can be successful. However, increasing awareness of the similarities and the differences of older adult suicide from adult and youth suicide is essential for an effective plan. As the older adult population increases over the next several decades, the numbers of late life suicides will dramatically sky-rocket. "Baby Boomers" (those born from 1945-1964) already have substantially higher suicide rates than the World War II and other generations.

The five-step public health model of prevention is utilized here to identify the problem of suicide in older adults, identify risk and protective factors, develop and test interventions, and implement and evaluate interventions. It should be noted that detection of potential suicide in later life is complicated by the assumption that many of the symptoms, emotions, and circumstances in older persons that might be related to suicide risk, are often thought to be part of the normal aging process or confused with a physical problem.

My mission in life… to promote the awareness and the prevention of suicide. It has been 2 ½ years since I lost my son Desmond. I still cry. I visit the cemetery every single day. I pray for him. I ask why…
Nothing has changed. The only thing that has changed is that I have learned to live better with the pain. The pain does not and will not ever go away. You only learn to live with it.
Suicide has such a ripple effect. Mother, father, brother, friends, aunts, uncles, grandparents, cousins, employers, co-workers… I can go on and on with the list. When someone dies, not by suicide, people say, they lived a good life or now they are not suffering any longer. There is nothing to say or nothing that can be said when someone takes their own life. We all need to work together to get in the minds of those who are contemplating suicide and help them before it's too late.

Mark W. Schantzer

Step 1: Defining the Problem

Older Adult Suicide Data

The older adult population is the fastest growing population in Pennsylvania and the United States. According to the Centers for Disease Control and Prevention (CDC), suicide rates increase with age and are among the highest for those 65 and older. According to the American Association of Suicidology, older adults represent 12.5% of the population; however account for 15.7% of all suicide deaths.

Gender

In the United States, more than 7,000 adults aged 60 years and older die of suicide annually. As the population ages, these numbers are expected to increase.[1] Approximately 83% of those suicide deaths between 2005-2007 were men, with a rate approximately six times that of women. While rates of suicide among women decline from middle age through older adulthood, the opposite pattern is seen with males whose rates increase with age.[1] Older adult male rates of suicide are nearly six times that of females (28.3 and 4.9 per 100,000 population). Male rates of suicide increase dramatically with age from 23.3 per 100,000 for those aged 60-69 years, 26.8 for those aged 70-79 and 35.6 for those aged 80 or older.[2]

Race/Ethnicity

During 2005-2009, the highest suicide rates for males age 65 and older were among non-Hispanic whites (32.37 suicides per 100,000) and the highest rate for females ages 65 and older were among the Asian/Pacific Islanders (6.01 suicides per 100,000).[3]

Means

Between 2005-2009 the greatest percentage of suicides occurred using firearms among all race/ethnic groups for persons 65 years and older except Asian/Pacific Islanders (non-Hispanic whites 74.1%, non-Hispanic blacks 74.8%, Hispanics 51.5%, American Indian/Alaska Natives 75%). For Asian/Pacific Islanders, suffocation accounted for the highest percentage of suicides among those 65 and older (52.4%). For three age groups (10-24, 25-64 and 65+) the greatest percentage of fatal self-harm injuries occurred by the use of firearms, with those 65 and older having the highest percentage of any age group (45.5%, 47%, and 72.1 %, respectively).[3]

Circumstances

Precipitating circumstances were identified for approximately 87% of older adult suicides. Current depressed mood (37.4%) current mental health problems (35.2%) and physical health problems (46.2%) were the most commonly identified circumstances. Older adults who die by suicide are more likely to have depression than individuals who die by suicide at a younger age. Many older adults who die by suicide recently visited a primary care physician: 20% on the same day, 40% within one week and 70% within one month of the suicide. Of those who died by suicide, 30.7 % left a suicide note and 23.4% disclosed their intent to die by suicide.[2] The results of toxicology testing following suicide in older adults indicates that females were more likely than males to be positive for antidepressants (45% and 19% respectively) and for opiates (37% and 18%, respectively). The percentage of positive tests for alcohol, amphetamines, cocaine and marijuana were nearly equal in both sexes.[1]

Pennsylvania Data

Pennsylvania suicide trends for those aged 55-74, has varied from a low of 11.2 per 100,000 in 2001-2002 to a high of 14.7 in 2008-2009 (the most recent data year available). The five-year average suicide rate among Pennsylvanians ages 55 and older is lower than the rate in the 20-54 age group. Pennsylvania's rates are slightly lower than national rates and slightly higher than rates in regions 1-3, (Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode island, U.S. Virgin Islands, Vermont, Virginia, and West Virginia).[4]

I first became aware of suicide at the age of 11, when I saw my father attempt suicide. I never imagined that I would ever be capable of getting to a place where I could try that, knowing how much that event affected me. Unfortunately, there was a time when I didn't have the will to be here any longer; but I found help, and over the years since then I was able to find knowledge and tools to help me to work through my challenges in a way that I wish my father had been able to do.

Joseph Alex Martin

Step 2: Identifying Causes through Risk and Protective Factors Research

Risk Factors for Suicide in Older Adults:

Biological, Psychological and Social Risk Factors

- Depression (including late-onset depression)
- Co-occurring disorders, especially depression, diabetes, heart disease and stroke
- Somatic complaints
- Severe pain
- Frailty and perceived health decline
- Medications (amount and type)
- Burdened caregivers of older adults
- Inflexibility
- Low self-esteem, feelings of loss of dignity or control-sense of "being a burden"
- Anxiety, agitation, traumatic grief
- Isolation- "lack of belonging"
- Marital status (widowed, divorced)
- Race (White)
- Gender (male)
- Sexual orientation and gender identity

- Increased age
- Substance use
- Loss of meaning, sense of hopelessness
- Family/personal history of suicide
- Ongoing stress, high degree of perceived stress
- Past history of mental illness
- Previous suicide attempts
- History of violence

Environmental Risk Factors

- Financial loss
- Residence in a care facility
- Desensitized to the violence of suicide
- Availability of a lethal agent

Social-Cultural Risk Factors

- Isolation
- Poor social support
- Living alone
- Abuse
- Family conflict
- Loss (relationship, role, functional capacity or support, health, work, mobility, finances), cumulative loss
- Barriers to accessing health care, especially mental health and substance use treatment

Protective Factors for Suicide:

- Effective clinical care for mental health, physical and substance use conditions
- Easy access to a variety of clinical interventions and supports in a variety of settings
- Restricted access to highly lethal means of suicide
- Support through ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and non-violent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservations

- Readily available social supports, including family of choice, close friends and confidants

Steps 3 & 4: Develop, institute and implement interventions that can reduce the impact of risk factors or support protective factors:

Principles for reducing risk:

- Suicide prevention program efforts such as addressing mental health and substance use conditions
- Programs must address the needs of people in each stage of life
- Programs must be culturally sensitive
- Prevention programs are most effective when they are long-term, with opportunities for reinforcement of attitudes, behaviors and skills
- Each community must develop a program that meets local needs and builds on local strengths
- Program planning should represent the community with respect to age, ethnicity, faith, occupation, sexual orientation, gender identity, social economic status and cultural identity.
- Older adult specific community groups and organizations should incorporate suicide prevention efforts into their work
- Treatment of depression in late life can decrease suicidal risk.

The differences found in a recent study between older adult males and females who die by suicide may be related to the gender roles and the unique experiences of aging. The National Strategy for Suicide Prevention, Goals and Objectives for Action suggests a number of strategies to reduce suicide including promoting awareness, reducing the stigma of seeking care for mental health and substance use, implementing community based programs, reducing access to lethal means, and providing training for practitioners who care for older adults. Older adult males in particular may benefit greatly from programs that seek to keep them active in later life, facilitate their access to mental health services, assist them in dealing with immediate crises, and evaluate their access to highly lethal weapons. Older adult females on the other hand, may benefit greatly from services to assist them in the earlier stages of the aging process, dealing with widowhood, and close monitoring of prescription medications, particularly opiates. Regardless of sex, an immediate and comprehensive response to suicidal ideation and previous suicide attempts is critical as nearly one in four older adults disclose their intent to take their lives before doing so.[1] The following plan is intended to target these recommended actions for implementation within Pennsylvania.

It should be noted that the issue of "assisted suicide" should be distinguished from suicide. The advocacy group, "Compassion and Choices", shuns the term "assisted suicide" and supports what they call "aid in dying". The group believes that giving a fading patient opportunity for a peaceful and dignified death is not suicide. A recent New York Times article indicates that helping the terminally ill end their lives, condemned for decades as immoral, is gaining traction and several states now have "death with dignity" bills in process. A Gallup poll indicates that terminology is a key factor in this issue. Seventy percent (70%) agreed that when patients and their families want aid in dying with dignity, it should be allowed. Yet in the same 2013 poll, only 51% supported helping a dying patient "commit suicide". [5]

There are evidence-based practices for older adults that address depression, suicide and substance use that can guide the design of services for older adults. The three research studies listed below outline what has been effective for older adults in a variety of community-based settings.

- **PRISM-E (SAMHSA)** – Primary care research in Substance Use and Mental Health for the elderly
  SAMHSA and several federal partners launched a 6 year study in 1998. The goal of the study was to determine if older adults do better when they receive mental health and substance use treatment that's integrated into primary care or when they're referred to specialists. The study screened thousands of older adults for depression, anxiety and at- risk drinking. The study concluded that older adults were more open to receiving mental health and substance use treatment that was integrated within primary care (71%), versus those who engaged in treatment through a referral to a specialist (41%).
- **PROSPECT (NIMH)** – Prevention of Suicide in Primary Care: Elderly Collaborative Trial
  This study which was conducted in 2006 was designed to determine the effect of a primary care intervention on reducing suicidal ideation and depression in older adults. The study found that long-term assessments of depression, hopelessness, anxiety and physical and functional limitations in depressed older adults are critical. Older adults with these symptoms may be candidates for care management or mental health care, since they are at risk of remaining depressed.
- **IMPACT (Hartford Foundation)** – Improving Mood Promoting Access to Collaborative Treatment
  In this study, 1800 older adults with depression received usual care versus collaborative/stepped care disease management of their depression in a

primary care setting. The intervention included an evidence-based algorithm and relapse prevention. Within the study, satisfaction with care increased, physical conditions improved, and the trial intervention had more than double the effectiveness of the usual care for depression.

Step 5: Concurrent Review-/Evaluate Effectiveness

A community should build in an evaluation to determine whether the selected intervention will work under local conditions. Determining the costs associated with the benefits of the program is another important aspect of evaluations.

PROCESS FOR DEVELOPING THE 2014 PENNSYLVANIA SUICIDE PREVENTION PLANS

In October of 2013, the Pennsylvania Adult and Older Adult Suicide Prevention Coalition received a grant from the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) as part of the "Mental Health Matters" initiative, to implement several suicide prevention initiatives including revising the 2005 Pennsylvania Adult and Older Adult Suicide Prevention Plans. In order to guide and direct this effort, a 31 member panel of experts was convened. Representatives were solicited from the Departments of Health, Aging, Corrections, and Military and Veterans Affairs, the Veterans Integrated Service Network, the County Commissioners Association, behavioral health managed care organizations, the OMHSAS Adult and Older Adult Advisory Committees, county suicide prevention taskforces, coroners offices, the National Alliance for the Mentally Ill of PA (NAMI PA), Area Agencies on Aging, the American Association of Retired Persons (AARP), the Rehabilitation and Community Providers Association (RCPA), the Pennsylvania Mental Health Consumers Association (PMHCA), the Keystone Pride Recovery Initiative (KPRI), and the PA Adult and Older Adult Suicide Prevention Coalition (PAOASPC). Although some organizations were unable to send representatives to the table, a diverse statewide committee was convened for its first in-person meeting in December of 2013. Members who participated in the committee are acknowledged for their work in developing the plans in Appendix G.

The current Pennsylvania Adult and Older Adult Suicide Prevention Plans were modeled after the original National Strategy for Suicide Prevention issued more than ten years ago by Surgeon General David Thatcher. Since the National Strategy was revised in 2012, it prompted a desire to update Pennsylvania's plans to reflect current research, prevention strategies, and needs, and to guide suicide prevention efforts within the commonwealth over the coming years. Given the significant amount of work that went into the 2012 National Strategy, it seemed natural to use this document as a template in the development of the 2014 Pennsylvania plans.

To begin the process, the goals and objectives within the 2005 state plans and 2012 national plans were reviewed and cross walked first by the full committee followed by a more intensive review and revision by workgroups assigned to each agreed upon goal. This resulted in the recommendation to use eleven goals within the Pennsylvania plans. The eleven Pennsylvania Adult and Older Adult Goals are parallel in their content. However, specifics related to adults and older adults are identified within the specific objectives and action steps of each respective plan. The 2012 National Strategy was also used to create Pennsylvania's objectives, action steps and some of the narrative. Like the National Strategy, *"the goals and objectives are broad in scope and encompass a wide range of activities. Many different groups at the local, regional and state levels, including counties, managed care organizations, provider organizations, social service agencies, educational institutions, workplaces, and health systems, etc., can play a role in advancing particular objectives. As a result, it is not possible to include specific target dates for the completion of each objective. All groups that have an interest in suicide prevention can use the goals and objectives to identify their own priority areas, thereby contributing to the full implementation of Pennsylvania's plans."*[6]

While the committee recognized the need for a comprehensive suicide prevention effort across the life span, the revised plans focus on adults and older adults due to funding requirements. Efforts are occurring concurrently to update and address suicide prevention efforts for children and youth.

In addition to the leadership provided by the PA Adult and Older Adult Suicide Prevention Plan Advisory Committee, input for the plans was gathered through four regional "Listening Sessions" which were held in early January of 2014 as well as through a questionnaire distributed through "Survey Monkey" during the January-February 2014 timeframe. A summary of comments and input gathered through these means is included in Appendix F.

In June, 2014, the final draft plans were circulated statewide for public comment by the Office of Mental Health and Substance Abuse. One comment on the plans was received from the Acquired Brain Injury Network of Pennsylvania, Inc. This organization indicates that the suicide rate for persons with traumatic brain injury is five times the rate in the general population and is still increasing. Since traumatic brain injury often resembles the symptoms of mental illness, they further recommend that it is important to screen for old and new injuries before proceeding with mental health treatment for suicidality since the injured brain does not benefit from the same medications or therapies as does mental illness.

LANGUAGE IN THE PLAN

Considerable discussion occurred among the Suicide Prevention Plan Advisory Committee in the development of the plans regarding the choice of language to refer to mental health and substance use. In keeping with the below guiding principle of "promoting the use of People First language and the reduction of medical and disease based labels", the preferred language chosen for use throughout the plan is "mental health and substance use". The term "behavioral health" is frequently used to refer to both mental health and substance use but is not used in the plan in order to avoid the misunderstanding that these are behaviors within a person's control. Likewise, we have chosen to take the positive spin on the words, therefore using mental health instead of mental illness and substance use instead of substance abuse. Limited use of the terms "mental health condition and/or substance use condition" is used where necessary. The term, "family of choice" is used throughout the plan to reinforce the belief that individuals should be encouraged to include individuals they have identified as family in all important aspects of support and care.

BENEFITS OF A STATE PLAN:

- To guide the statewide agenda for suicide prevention and to target resources to the highest priority needs.
- To encourage public-private partnerships at the state, county, and local levels in order to support collaboration and avoid duplication across a broad spectrum of agencies, groups, and community leaders as well as suicide attempt survivors and suicide loss survivors.
- To link information about evidence-based and best practices for prevention, to share data that can be used to track trends, and to share information about training opportunities and resources across the state.
- To create a baseline of efforts within the state and to track success in reaching the goals outlined within the plan.

GUIDING PRINCIPLES FOR THE PLAN

- Design and implement suicide prevention activities in a culturally and developmentally appropriate fashion.
- Eliminate health care, race, ethnic, gender, education, income, disability, age, stigma, sexual orientation, gender identity, and geographic disparities that erode suicide prevention activities.

- Emphasize early interventions to promote protective factors and reduce risk factors for suicide.
- Endorse suicide prevention as everyone's business.
- Promote the adoption of "Zero Suicides" as an aspirational goal, particularly within health care settings that provide services and support to defined populations.
- Promote People First language and wellness approaches through the reduction of medical and disease-based labels that promote stigma.
- Advocate for, invest in, and sustain all state suicide prevention efforts.

GOAL 1: **INTEGRATE AND COORDINATE SUICIDE PREVENTION STRATEGIES ACROSS ALL SECTORS AND SETTINGS WITHIN THE COMMONWEALTH.**

Goal 1 of the new Older Adult Pennsylvania Suicide Prevention Plan is a modified version of Goal 1 from the 2012 National Strategy for Suicide Prevention. The intent of this goal is to promote broad awareness of older adult suicide and suicide prevention and collaboration across a broad spectrum of agencies, institutions, and groups to include state agencies, counties, managed care organizations, mental health and substance use provider organizations, social service agencies, businesses, law enforcement, the criminal justice system, health care,
and individuals that have frontline contact with individuals impacted by suicide including police, emergency management personnel, coroners, and funeral directors. In addition, the hope is to reach the general public who may not be aware of the signs of suicide in older adults or what to do if an older adult they know is at risk of suicide. Public/private partnerships that evolve from collaboration are able to blend resources and build upon each group's strengths while preventing duplication. Broad-based support for specific suicide prevention efforts may also lead to additional funding through governmental programs, as well as private philanthropy, and to the incorporation of older adult specific suicide prevention activities into the mission of organizations that have not previously addressed the issue. Integrating suicide prevention into the work of these community partners such as primary care, nursing homes, retirement communities, AAA's, Senior Centers, senior housing, home and community based service providers, veterans organizations, faith-based organizations, transportation services, etc., will promote greater understanding of older adult specific suicide and help counter the prejudice, silence and denial that can prevent individuals from seeking help.[7]

The following objectives and action steps address the need to first identify what is being done by who at all levels of the system related to suicide awareness and prevention. Once a baseline is established, the actions include: the creation of a statewide, inclusive, interagency advisory committee; identifying lead staff within each identified agency and to outline their responsibilities related to suicide prevention; and to use this committee to shepherd the work outlined in this plan. Concurrently, county-level suicide prevention taskforces need to expand in number and responsibility, since fewer than half of the counties have an identified taskforce with this focus. Action steps include providing technical assistance and support to these taskforces that play a key role in creating awareness and local responsibility for suicide prevention.

This goal also includes specific collaborative efforts with organizations, and projects that can enhance the older adult specific suicide prevention agenda within the state. Finally, health care efforts, including Medicare plans in Pennsylvania and Pennsylvania's managed care program, can be an opportunity to incorporate older adult specific suicide treatment, prevention and quality improvement into services.

As co-chair to the Chester County Suicide Prevention Task Force and as a mother who lost her son to suicide, I would like to express my own observations about my experience. Losing my son at age 15 to suicide forever changed myself, my family and my world. My other children who were 2 years and 9 years younger than Jimmy experienced great difficultly navigating life, especially through their teen years. My husband eventually left the family and became involved in an addiction. The journey has been daunting, overwhelming and at times almost unbearable. I know that many people including extended family and friends were also profoundly impacted by Jimmy's death.
I am very proud to have become the person that I am today. I work for the cause of suicide prevention and mental health awareness. My work with older adults is very satisfying. Despite the outcome, I would do anything to reverse the events of May 15, 1992. After that day, life would never be the same.

Carol Harkins

OBJECTIVES:

Objective 1.1: Integrate suicide prevention into the values, culture, leadership and work of a broad range of organizations and programs with a role to support older adult specific suicide prevention activities.

Objective 1.2: Enhance and strengthen collaborations across federal, state, and local agencies to advance older adult specific suicide awareness and prevention efforts.

Objective 1.3: Develop and sustain public-private partnerships to advance suicide awareness and prevention.

Objective 1.4: Integrate suicide prevention into health care efforts.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 1.1.1: Identify and evaluate older adult specific suicide awareness and prevention strategies currently in place within the commonwealth.

Action step 1.1.2: Engage community groups to integrate older adult specific suicide prevention within their respective organizations, including the development of local/agency suicide prevention plans.

Action step 1.1.3: Expand the number and capacity of County Suicide Prevention Taskforces across the commonwealth:

- Revise/re-issue the manual completed in 2009 to help county taskforces with start-up. Include in the manual recommendations for how to incorporate older adult issues in their efforts.
- Provide on-site technical assistance from a consultant or other counties (peer-to-peer) on the how to's of a county suicide prevention taskforce.
- Host monthly/quarterly webinars with county taskforces to educate, network, etc.
- Encourage County Suicide Prevention Taskforces to include older adult issues in their taskforces.

Action step 1.2.1: Organize an interagency committee, with representation from state and local agencies, to enhance coordination and advance implementation of suicide prevention strategies, including older adult specific suicide prevention strategies.

Action step 1.2.2: Identify a lead agency at the state and local levels to bring together agencies/groups that should be involved in suicide prevention and clarify each agency's area of focus/responsibility.

Action step 1.2.3: Ensure suicide prevention is integrated into state policies and program guidance under Medicare and Medicaid, including Pennsylvania's managed care program, HealthChoices. This would include sharing the final plan with the Centers for Medicare and Medicaid Services (CMS)/ the Department of Health and Human Services (DHS).

Action step 1.4: Identify methods to expand suicide prevention into health care by inviting primary care and Medicare representatives to participate in implementation efforts.

My name is Linda, my 38 year old son completed suicide on July 5, 2012. The emptiness in my life due to his effort to end his pain has made tremendous pain in our lives. He left behind two brothers, two sisters, a twelve year old daughter and a four year old son, and of course, me his mom. I tried to help him all during his teen years calling crisis and having him committed to hospitals. He hid his pain very well in the last few months before his death. No one had a clue that he was preparing to end his life. I can't cry around his siblings, so I cry silently at night in my bed. I can't understand how someone could choose death over life. I can't understand how a child I carried and raised, would choose to end his life. We need to be educated about the warning signs that we somehow missed. I don't want another family or mother to feel the pain and emptiness that is in my heart. I am hyper alert to my other family members, and much to their despair, I need reassurance that they are fine daily. I walk in the "Out of the Darkness" walks, to help raise money to educate everyone and to possibly prevent one other person from feeling that ending their life is the only answer.

Linda Kline

GOAL 2: IMPLEMENT COMMUNICATION AND EDUCATION EFFORTS TO CHANGE THE KNOWLEDGE, ATTITUDES AND BEHAVIORS OF THE PUBLIC IN ORDER TO PREVENT SUICIDE IN OLDER ADULTS

Goal 2 of the Pennsylvania plan borrows language from goal 2 in the 2012 National Strategy for Suicide Prevention. The intent of this goal is to enhance communication about older adult suicide, warning signs of suicide and suicide prevention resources through a variety of methods. National, state, and local suicide prevention organizations/advocacy organizations and the federal government have done considerable work in creating a wealth of resources that range from research documents, to posters and videos that have been used successfully to inform and educate the public. A list of resources/websites has been attached to this plan with most of these organizations offering low cost or free resources to assist in communication efforts. Specific resources for preventing suicide in older adults, however, are not readily available.

The following action steps recommend that state, county and local agencies/organizations add these resources to their websites/materials so that the range of resource material, including older adult specific resources, is shared widely across the state. It is also recommended that all

communication initiatives be guided by best practices to ensure successful outcomes. The actions also single out policy makers as key change agents for suicide prevention, and recommend providing such leaders with targeted information about state/local statistics about older adult suicides and trends, at risk populations along with recommended older adult specific interventions, and evidence-based practices.

It is paramount to provide individuals at risk, as well as the general population, with information about how and where to get connected to care and support for crises that could lead to suicide, including quick access to local and national crisis lines. Vital to this effort of getting individuals connected to care, are the stories of individuals who have received help and can motivate others to receive the help they need.

OBJECTIVES:

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach all populations, specifically older adults, within the commonwealth.

Objective 2.2: Reach federal, state, and local policymakers with dedicated communication efforts relating to older adult suicide and suicide prevention efforts.

Objective 2.3: Enhance online communication efforts that promote positive messages and support evidence-based and/or effective crisis intervention strategies.

Objective 2.4: Expand knowledge of the warning signs for older adult suicide.

Objective 2.5: Provide knowledge on how to connect older adults in crisis with assistance and care.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 2.1.1: Develop/distribute informational materials (resource materials, flyers, buttons, magnets, etc.) and conduct public education campaigns (speakers bureau, videos, billboards, etc.) on: older adult suicide risk and protective factors; national, state and community resources including crisis lines; anti-stigma messages, etc.

Action step 2.1.2: Inform counties, providers, stakeholders and others of the availability of free/low cost informational materials such as articles, research, posters, magnets, videos etc., from sites such as SAMHSA, and the American Foundation for Suicide (AFS), etc. (See resource section of plan for additional information)

Action step 2.1.3: Develop resources such as articles, research, videos, etc., specifically designed for older adult suicide prevention efforts.

Action step 2.1.4: Ensure that resources/materials are culturally and linguistically competent, including availability in other languages and braille.

Action step 2.1.5: Ensure that communication efforts incorporate the principles of effectiveness in the literature; and utilize materials (such as *"Making Health Communication Programs Work"* and *"Gateway to Health Communication and Social Marketing Practice")* as referenced in the 2012 National Strategy for Suicide Prevention.

Action step 2.1.6: Evaluate the success of communication efforts. This may include tracking the number of calls/emails, when contact information is provided.

Action step 2.2: Create targeted resource documents specific to older adults, and related materials for federal, state and local policymakers, including material on evidence-based practices, evaluation data, etc., that can be used to impact policy decisions.

Action step 2.3.1: Recommend resources to add to state, county and local websites on suicide prevention (including how to access older adult specific mental health, substance use and crisis services, and information about risk and protective factors, etc.)

Action step 2.3.2: Provide positive messages through social media including mobile apps to help older adults with depression chart their moods and access crisis lines, use of the U.S. Department of Veterans Affairs crisis line call center chat line, etc.

Action step 2.4-2.5.1: Increase awareness of the role of crisis lines such as the National Suicide Prevention Lifeline/Veterans Crisis Line (800-273-TALK/8255) and other local crisis services and resources.

Action step 2.4-2.5.2: Incorporate stories of older adults who received and benefited from help into written and online materials, to motivate others to take actions.

GOAL 3: IDENTIFY AND INCREASE KNOWLEDGE OF THE FACTORS THAT PROMOTE OLDER ADULT RESILIENCY FROM SUICIDE AND THAT PROMOTE WELLNESS AND RECOVERY.

Goal 3 of the state plan is similar to Goal 3 in the 2012 National Strategy for Suicide Prevention, with some revisions made to the language. This revised goal changes the focus from reducing stigma to promoting older adult wellness and recovery from suicidal thoughts and actions. The concepts of wellness, recovery and resiliency are well known in the mental health and substance use fields, but are not well understood by the community at large, especially by older adults. These concepts need to be understood by significant people such as a person's family of choice, friends and staff who may be the first line of contact for older adults at-risk of suicide. Suicide is closely linked to mental health and substance use conditions, and while treatments exist for both, specific services for older adults are not widely available. In addition, the stigma of mental health and substance use conditions prevents many persons, especially older adults, from seeking assistance due to fear of prejudice and discrimination.

The following objectives and actions are designed to increase knowledge about mental health, substance use, and suicide in older adults such that people are not embarrassed to seek help and have a greater understanding that people can and do recover. Presentations by suicide attempt survivors and by individuals bereaved by suicide can be powerful ways to convey the message that, "I've been there, I received help and support and you can too." The actions also promote public education to increase general understanding of mental health, substance use, and suicide in order to dispel myths and eliminate stigma. Recent polls conducted by the Pennsylvania Mental Health Consumers Association found more stigma directed to people with mental health conditions than toward any other disability. For more information, see http://www.pmhca.org/StigmaProject/media.html and scroll down to information about surveys on stigma. Pre and post tests are recommended to evaluate the impact of any public education efforts so that future efforts can be modified and adapted accordingly.

It is important to recognize and take into account the impact that cultural and religious beliefs can have on protecting individuals from suicide, or how such beliefs might present a barrier to

> Suicide prevention is not just a matter of getting the word out to those who struggle. A change is needed in how would-be supports treat those in emotional anguish. One of my personal goals is to teach appropriate response by sharing my story in print and in person. Family, friends, bosses, and any other acquaintances of potentially suicidal individuals are our front line in this battle. Although I take responsibility for my decision to attempt suicide, I am certain that if there had been a healthier response when I initially tried to express my feelings, it would not have happened.
>
> Nancy Virden

people seeking help. For example, data show that African American women have the lowest suicide rate among females and older adult white males have the highest suicide rate of any other population group, demonstrating the need to understand how race, gender, age, and other factors impact suicide risk. Likewise, religious beliefs that oppose suicide may help protect older adults from suicide or present barriers to individuals admitting suicidal thoughts and seeking the help they need. Research has also demonstrated that social connections and problem solving skills can help insulate individuals from suicide. Best practices then can be implemented that draw upon what the research indicates will protect individuals from suicide.

OBJECTIVES:

Objective 3.1: Identify and promote effective programs and practices that increase older adults' protection from suicide risk.

Objective 3.2: Reduce the prejudice and discrimination associated with older adults' suicidal thoughts and actions, and mental health and substance use conditions.

Objective 3.3: Promote the understanding that mental health and substance use recovery is possible for all.

Objective 3.4: Educate the community about older adult protective factors from suicide risk and older adult risk factors of suicide.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 3.1.1: Develop measurable criteria including a survey to identify effective community based older adult suicide prevention programs and best practices.

Action step 3.1.2: Consolidate survey data and evaluate data for effectiveness, utilizing the above criteria, and communicate survey data through social media, public service announcements, and multiple media outlets.

Action step 3.1.3: Disseminate information on the importance of social connectedness and problem-solving skills as factors that can help prevent suicide in older adults.

Action step 3.1.4: Disseminate information on programs that have decreased older adults' suicidal thoughts and actions through connectedness.

Action step 3.2.1: Launch public service campaigns to educate communities on the facts related to older adult suicide, mental health, substance use, and how the community can help.

Action step 3.2.2: Expand health education efforts concerning older adult suicide, mental health, and substance use within local community organizations, including organizations that work with older adults.

Action step 3.2.3: Conduct initial community based surveys assessing stigma and discrimination surrounding older adult suicide and mental health and substance use conditions prior to targeted health education; conduct follow up surveys to assess the effectiveness of older adult specific targeted education.

Action step 3.2.4: Develop strategies for better understanding of cultural or religious beliefs that may help protect older adults or present barriers to seeking help.

Action step 3.2.5: Increase awareness of mental health and substance use in older adults in order to eliminate barriers to seeking help.

Action step 3.3.1: Launch public service campaigns in order to educate communities on the facts of older adult suicide, mental health, and substance use and how the community can help.

Action step 3.3.2: Expand health education efforts concerning older adult suicide, mental health and substance use within local community organizations.

Action step 3.3.3: Conduct initial community based surveys assessing community understanding of mental health and substance use recovery in older adults prior to targeted older adult specific health education; conduct follow up surveys to assess the effectiveness of targeted education.

Action step 3.3.4: Increase public awareness that older adults living with a mental health or substance use condition can recover and regain meaningful lives, including presentations by significant others including a person's family of choice, friends, peer mentors, and older adults who have attempted suicide or been bereaved by suicide.

Action step 3.4.1: Identify local community organizations that would benefit positively from older adult specific suicide prevention/intervention training.

Action step 3.4.2: Identify and implement evidence-based and promising practices for older adult specific suicide prevention/intervention training for community education efforts.

Action step 3.4.3: Conduct pre and post-tests of suicide education efforts to assess knowledge of older adult suicide protective factors and risk factors.

GOAL 4: PROMOTE RESPONSIBLE MEDIA REPORTING AND ACCURATE PORTRAYALS OF MENTAL HEALTH, SUBSTANCE USE, AND SUICIDE IN THE ENTERTAINMENT INDUSTRY, INCLUDING SAFE ONLINE CONTENT.

Goal 4 uses the language in goal 4 from the 2012 National Strategy for Suicide Prevention. This goal addresses the need to impact how older adult suicide, mental health, and substance use are addressed in the media and entertainment industry. This goal has been updated from the prior state and national plans to include the emergence of online content as a new medium for communication. Certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. Explicit and graphic media reporting sensationalizes and glamorizes death, and can lead to "copycat" suicides. Studies have also shown that fictional accounts of suicide in movies and television can lead to increases in suicide.[8] Careful coverage, on the other hand, can encourage vulnerable people to seek help. Sharing stories of individuals who overcame a crisis and providing information on resources can provide a needed public service.

The following objectives and actions recommend providing guidance and resources to the media, journalism and communication schools on ways to report suicide and older adult suicide in particular, as well as mental health and substance use issues in an accurate fashion. In addition, the action steps recommend providing guidance to state government press offices who work with the media on an on-going basis. As new media tools or guidelines become available, these recommendations should be applied widely to include the safety of online content and emerging communication technologies and applications. In order to expand online crisis support, the Suicide Prevention Lifeline recently announced an innovative partnership with Facebook to offer crisis services via chat so that people in distress

NAME IT-CLAIM IT- TAME IT-FRAME IT!
It is important to define ourselves and not be labeled by others. An emerging movement of suicide attempt survivors has helped to be open, honest and true to the realities of our experiences. As suicide attempt survivors we are at great risk of re-attempts. Sharing our stories helps others realize they are not alone on our roads to recovery.
I am a proud gay man, an activist artist living with a mental illness (Bipolar II, The Sequel); in recovery from addictions; living with HIV since testing HIV positive September 27, 1988; a prostate cancer survivor; living with deafness, cataracts and hearing distortion; a suicide attempt survivor and suicide loss survivor after my dear sister Jennifer's death by suicide in 1995.
When naming, claiming, taming and framing remember humor is the best medicine because there's no copay. I am Mark Davis and approve this positively inspirited and mutually shared message.

Mark Davis

can more easily access the support that they need.[9] Award ceremonies, banquets, etc., is another strategy to recognize the media for accurate portrayals in their reporting.

OBJECTIVES:

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and older adult suicide in particular, and prominent individuals in the areas of entertainment and sports, who follow media guidelines in sharing their personal stories around mental health and substance use.

Objective 4.2: Disseminate guidance for Pennsylvania's journalism and mass communication schools regarding how to address consistent and safe messaging on suicide, mental health and substance use in their curricula.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 4.1.1: Disseminate recommendations to the media for reporting of suicide using, for example, www.reportingonsuicide.org, www.AFSP.org and training offered by the Carter Center for journalists.

Action step 4.1.2: Sponsor recognition events and incentives to honor the media for responsible reporting of suicide, mental health, and substance use.

Action step 4.1.3: Promote speakers bureaus and encourage consumers, peer leaders and others, especially older adults, to share their stories of recovery to increase public awareness.

Action step 4.1.4: Promote guidelines on the safety of online content and for new and emerging communication technologies and applications regarding mental health, substance use and suicide.

Action step 4.2.1: Address responsible depiction of mental health, substance use and suicide in educational curricula of Pennsylvania's schools of journalism, film and other disciplines in the communications field as well as through their ethics governing boards.

Action step 4.2.2: Provide informational material to Pennsylvania state government press offices regarding media reporting of mental health, substance use and suicide.

Action step 4.2.3: Offer training, webinars, etc., to journalism, film and other communications schools on promoting positive messages regarding mental health, substance use, and suicide.

GOAL 5: DEVELOP, IMPLEMENT AND MONITOR THE EFFECTIVENESS OF PROGRAMS AND SERVICES THAT PROMOTE WELLNESS AND PREVENT SUICIDE

New goal 5 addresses the development, implementation, and monitoring of programs and services that promote wellness and prevent suicide in older adults. This revised goal emphasizes the importance of wellness in preventing suicide in older adults and the concept that even simple and low cost interventions can make a big difference in preventing older adult suicide. For example, data has shown that individuals who have attempted suicide as well as individuals bereaved by suicide are at increased risk of suicide. However, research suggests that simple efforts to minimize isolation, increase social involvement, and provide follow-up support to people, including visiting individuals at home or providing online support groups, can have a powerful impact in reducing additional suicides.

The following objectives and action statements recognize the importance of engaging a wide range of community agencies and partners, including organizations that work specifically with older adults, to implement suicide prevention programs and services that take cultural, demographic and geographic issues into account. It is important in developing and implementing programs to use strategies that have been shown to be effective. Several online data bases are available to guide these partners in the development of evidence-based practices and services. The action steps also include providing suicide prevention toolkits, distributing information via websites, posters and resource guides on crisis hotlines, and providing technical assistance to build capacity to both implement

> I am a survivor. These four words carry such a big meaning. For some, it means strength, determination and power to overcome a tough situation. However, for a survivor of suicide loss, it carries a very different meaning. To me, it symbolizes sorrow, loneliness and hope. Sorrow, for I will never have the chance to say good-bye to my sister. Loneliness, for few understand what it's like to experience sudden tragedy. Hope, for together, we can open the doors of communication, help those in need, and end the stigma. While nothing will bring Jana back, I hope the work I do in her memory through the Jan Marie Foundation can help prevent other siblings and parents from ever experiencing what it is like to be a survivor of suicide loss.
>
> Marisa Brown

and evaluate older adult specific suicide programs and services. As noted previously, it is important for counties, managed care organizations, educational institutions, aging services organizations, and others to have their own suicide prevention plans in place to reduce the incidence of suicide within their jurisdiction.

OBJECTIVES:

Objective 5.1: Promote and encourage the coordination, implementation, and evaluation of comprehensive state, county, and local older adult specific suicide prevention programming.

Objective 5.2: Encourage county and local services to implement effective programs and provide education that promotes wellness and prevents older adult suicide.

Objective 5.3: Promote policies and practices that intervene to reduce suicidal thoughts and actions in older adults with suicide risk.

Objective 5.4: Strengthen efforts to increase access to and delivery of effective older adult treatment and prevention programs for mental health and substance use.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 5.1.1: Engage multiple partners to coordinate culturally, demographically and geographically-appropriate older adult specific suicide prevention programming within each jurisdiction.

Action step 5.1.2: Evaluate older adult specific suicide prevention programming according to established standards using, for example, the Best Practice Registry for Suicide Prevention and the National Registry of Evidence-Based Programs and Practices.

Action step 5.2.2: Share information on research-based evidence-based older adult specific programs with state, county and local service partners.

Action step 5.2.3: Provide education through public awareness, on-going public service announcements, websites, and conferences.

Action step 5.2.4: Develop technical support to build the capacity across the state to implement and evaluate evidence-based older adult specific suicide prevention programs.

Action step 5.2.5: Increase the number of counties and local communities with comprehensive suicide prevention plans across the lifespan.

Action step 5.3.1: Identify and implement policies and practices that reduce suicidal thoughts and actions in older adults, including rapid follow-up after hospitalization (visits, calls, emails), outreach to isolated individuals, support groups, etc.

Action step 5.3.2: Encourage community providers, volunteer groups, stakeholders, aging services organizations and others to identify older adults who are isolated and in need of outreach and distribute information to older adults who are at risk of suicide including information on crisis lines, warm lines, warning signs, etc.

Action step 5.3.3: Develop, implement, disseminate and provide training on older adult specific suicide prevention tool-kits that include assessment and evaluation criteria, to state, county and community providers, to utilize in screening older adults potentially at-risk of suicide.

Action step 5.3.4: Provide information on specific at-risk populations and interventions and resources for each population as noted in Appendix A of this plan and in Appendix D of the 2012 National Strategy for Suicide Prevention.

Action step 5.4: Encourage the state, counties and local communities to provide referral information to older adult treatment and prevention programs in their jurisdictions through the use of the PA Link to Aging and Disability Resources, Network of Care website, social service resource guides, posters, etc.

GOAL 6: REDUCE ACCESS TO LETHAL MEANS OF SUICIDE AMONG INDIVIDUALS WITH IDENTIFIED SUICIDE RISK.

Goal 6 uses language similar to goal 6 in the 2012 National Suicide Prevention Strategy. The intent of this goal is to reduce access to various means of suicide particularly among older adults identified with high risks. Data indicates that firearms are the most common method of suicide in the United States which account for 56% of male suicides and 30% of female suicides. Among U.S. women, the most common suicide method is poisoning, primarily overdoses of medications, which account for 37% of female suicides, compared to 12% of male suicides. Adults 65 and older consume more prescribed and over-the-counter medications than any other age group. Although they comprise 13% of the population, older adults use 25-30% of the medications. Overuse of medications is one of the fastest growing health problems facing this country and one in five older adults suffers from problems with medications (or alcohol) and may not know it. Medication overuse, along with depression and alcohol overuse are risk factors for suicide among older adults.

Many of the following strategies are aimed at helping to minimize the highest risk means among the highest risk individuals. Studies have also indicated that many suicide attempts are not planned and may occur impulsively or before a person has the chance to receive help to get through a temporary crisis. By taking such precautions as having guns or medications locked away, many lives may be saved. Recent news coverage has indicated that in 2013, the Golden Gate Bridge has been the site of the highest number of suicides in its history. Signs with the National Suicide Prevention Lifeline number and telephones have been added to the Golden Gate Bridge and such preventative tools would create opportunities to save lives on bridges in Pennsylvania.

I was only nine years old when my mother abandoned me. I felt angry, sad and lost. What was wrong with me that made her kill herself, did she not know I loved her? Perhaps maybe if I could have stood up to my dad as he beat on her she would not have left me. Despite growing up in a world not knowing when trauma would strike, I wanted to be with my parents. To make things more complicated, I did not know how to deal with the feelings within me, no one to talk to, guide me or comfort me. That's when I build a closet inside to hide all of these dark feelings. Now, four decades later, I am getting the help I so needed as a child. I am a survivor of my own suicide attempts and am glad I learned to choose life. I have hope now, unlike my younger brother who killed himself and my older brother who turned to street drugs. Parents, brothers are gone from my life. Yet, why not me?

Dave Corbin

The following strategies include training aging service providers, mental health and substance use providers, significant people such as a person's family of choice, friends and others in regularly assessing access to lethal means for persons at-risk. Partnerships with firearm dealers and gun owners around suicide awareness and responsible gun ownership may also reduce risk. Likewise, physicians and pharmacists may be in a key position to monitor for risks of prescription overdoses. Valuable training resources, such as the Harvard University "Means Matters" project and the SPRC.org lethal means counseling, are two sources for training. Legislation or policy guidance should be promoted to ensure that firearm dealers as well as prescription managers receive at least brief training, such as "Mental Health First Aid", on recognizing the signs that an individual may be at-risk of suicide.

OBJECTIVES:

Objective 6.1: Encourage Pennsylvanians who interact with older adults at-risk for suicide to routinely assess access to lethal means.

Objective 6.2: Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

Objective 6.3: Research and educate Pennsylvanians' on new safety technologies to reduce access to lethal means.

Objective 6.4: Partner with primary care, mental health, substance use and aging services providers and pharmacies to incorporate suicide awareness as a basic tenet of responsible prescription management.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 6.1.1: Disseminate materials aimed at educating families of choice, friends, physical health, mental health, substance use, aging services providers and others on evidence based practices on how to assess and limit access to lethal means among those at-risk of suicide.

Action step 6.1.2: Educate consumers, assessors, physical health, mental health, substance use, aging services providers and others, on *Means Reduction*, which is the process of separating a particularly lethal means of suicide, from those who attempt suicide.

Action step 6.1.3: Develop protocols to disseminate and distribute educational materials to Pennsylvanians who regularly interact with those at-risk of suicide.

Action step 6.1.4: Develop and enhance training initiatives using, for example, the Harvard University Means Matters project, the SPRC.org lethal means counseling, etc., to improve skills related to counseling on reducing access to lethal means through professional training programs, workshops, etc.

Action step 6.1.5: Distribute informational material on means restriction to significant people, including a person's family of choice, friends, and other natural supports, to increase the likelihood of positive outcomes.

Action step 6.2.1: Develop educational materials which promote suicide awareness for dissemination by firearm dealers upon the sale of every firearm. These materials will include referral and contact information for the National Suicide Hotline.

Action step 6.2.2: Recommend through legislation, regulations or policy statements (executive orders, etc.) that all firearm dealers complete a community-based training on the identification of suicide risk factors (e.g., Mental Health First Aid). This training may be offered to a firearm dealer specific cohort to improve efficacy.

Action step 6.3.1: Develop a means by which research on safety technologies can be encouraged in Pennsylvania.

Action step 6.3.2: Develop a means by which information and research on safety technologies can be disseminated, discussed, and/or implemented.

Action step 6.3.3: Provide an electronic forum (e.g., the Pennsylvania Adult and Older Adult Suicide Prevention Coalition's website with links to other websites such as the Department of Public Welfare's website) to allow for ease of access to research findings and educational materials on older adult specific suicide prevention, reduction of access to lethal means, and safety technologies.

Action step 6.4.1: Develop educational materials which promote suicide awareness, including referral and contact information for the National Suicide Hotline, which will be required for dissemination by the above providers upon the sale of identified medications or prescriptions.

Action step 6.4.2: Recommend through legislation, regulations or policy statements (executive orders, etc.) prescribers and pharmacists to complete a community based training on the identification of suicide risk factors (e.g., Mental Health First Aid). This training may be offered to a provider specific cohort to improve efficacy.

Action step 6.4.3: Encourage the use of electronic pill dispensing lockboxes for people who rely on medication but are at risk of overdosing.

GOAL 7: PROVIDE TRAINING ON THE PREVENTION OF SUICIDE

Goal 7 is similar to National Suicide Prevention goal 7 and focuses on providing training to the community, mental health and substance use providers, aging services providers and others that come into contact with older adults who may be at-risk of suicide. A wealth of training materials and training courses are available, which are targeted to professionals and non-professionals and range from a few hours to several days in length. Specific training materials targeted to professionals and non-professionals working with older adults and older adults themselves are not as readily available and need to be developed. The action steps recommend that such trainings can be used to help stakeholders recognize the warning signs of older adult suicide and know where to refer an older adult for services. In the case of mental health or substance use providers, more extensive training may be required including information on providing quality care and services based upon the latest research in older adult suicide. State

and local conferences and forums are also encouraged to reach large audiences with vital information.

Recommended mechanisms for ensuring that training is provided routinely across the state and across disciplines include making older adult specific suicide prevention training a requirement, issuing policies recommending training as part of regulatory requirements and including training through health care professional education (including graduate and continuing education and credentialing and licensing standards). The following action steps also recommend the tailoring of training to focus on age, ethnic, gender, racial, sexual orientation, gender identity, trauma and abuse issues. The inclusion of older adult suicide attempt survivors and suicide loss survivors in trainings is highly recommended to communicate stories that ***individuals can and do recover, leading meaningful lives.***

It is very difficult to put into a few sentences the devastation our son's suicide has had on our lives. I have compared it to being in a horrendous battle, with all of the terrible, debilitating wounds on the inside. We carry on for our other children, for the bit of hope we still have in our lives. To think my son fought this battle of depression alone devastates me. How I wish he had been able to seek and receive help. How I wish I was more informed about the subject of suicide before my son went off to college. How I wish I thought to say, when I knew Tyler was not acting right, "Are you thinking of killing yourself?" Most parents I speak with really can't hear my story- it is their worst nightmare. But I keep talking and hoping my words may help someone seek help instead of suicide.

Sheila Whitman

OBJECTIVES:

Objective 7.1: Provide training on suicide prevention to community groups, especially those serving older adults.

Objective 7.2: Provide training to mental health, substance use, and aging services providers on the recognition, assessment and management of at-risk behaviors and delivery of effective clinical care for older adults with a high suicide risk.

Objective 7.3: Develop and promote the adoption of core education and training guidelines on the prevention of older adult suicide through health care professional education, including graduate, continuing education, and credentialing, accrediting and licensing bodies.

Objective 7.4: Develop and implement protocols and programs for clinicians, clinical supervisors, first responders, crisis staff, and other stakeholders on how to implement effective strategies for communicating and collaboratively managing older adult suicide risk.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 7.1.1: Identify community groups to present information and training.

Action step 7.1.2: Use available training curricula (available at the SPRC Center, QPR [Question, Persuade, Refer], MH First Aid Training, etc.,) to reach various groups.

Action step 7.1.3: Make educational programs available to significant people including a person's family of choice, friends, and others who are in close relationships with those at-risk or who have been affected by suicide.

Action step 7.1.4: Utilize suicide loss survivors and suicide attempt survivors in trainings/presentations.

Action step 7.1.5: Address cultural competency/diversity in training and educational programs geared to the population being addressed.

Action step 7.1.6: Sponsor conferences including an annual state suicide prevention conference.

Action step 7.2.1: Provide training to physical health, mental health, substance use and aging services providers on the recognition, assessment and management of at-risk behaviors and delivery of, or referral to, effective clinical care for older adults with suicide risk.

Action step 7.2.2: Use available training curricula to increase confidence and empowerment in working with people with suicide risk and effective support services for those bereaved by suicide including trainings such as Assessing and Managing Suicide Risk (AMSR), Applied Suicide Intervention Skills Training (ASIST), etc.

Action step 7.2.3: Promote/sponsor suicide prevention training for physical health, mental health, substance use, and aging service providers.

Action step 7.2.4: Develop a policy strongly recommending the inclusion of older adult specific suicide prevention training as part of continuing education requirements within existing provider regulations.

Action step 7.2.5: Provide resource material, journal articles and training to address emotional and legal issues associated with adverse patient outcomes, including death by suicide.

Action step 7.2.6: Educate practitioners on how to exchange confidential patient information appropriately to promote collaborative care, while safeguarding patient rights.

Action step 7.2.7: Address the need for and value of a team based approach to management of suicide risk through the dissemination of best practice information on the benefits of this approach.

Action step 7.2.8: Include cultural competency components specifically focused on age, ethnicity/gender/racial identity formation, minority status, LGBTQI identity development and disenfranchised groups such as the homeless.

Action step 7.3.1: Develop and promote the adoption of core education and training guidelines on the prevention of older adult suicides through health care professional education including graduate, continuing education, credentialing, accreditation and licensing bodies.

Action step 7.3.2: Collaborate with academic partners and providers in Pennsylvania to develop and adopt core education and training guidelines addressing the prevention of older adult suicide.

Action step 7.3.3: Collaborate with accrediting and credentialing entities to promote evidence based and best practice older adult suicide prevention training for the organizations they accredit/re-accredit, credential/re-credential and license/re-license.

Action step 7.3.4: Sponsor professional development opportunities including webinars, lunch and learn, etc., for health care professionals and aging service professionals.

Action step 7.3.5: Link older adult specific suicide related curricula with training on trauma, substance use, and interpersonal violence.

Action step 7.3.6: Promote and support the inclusion of protective factors such as learning skills, problem solving, conflict resolution and non-violent handling of disputes in any curricula.

Action step 7.3.7: Distribute *Practical Suicide-Risk Management for the Busy Primary Care Physician* to primary care providers.

Action step 7.4.1: Develop and implement protocols /programs for clinicians and clinical supervisors, first responders, crisis staff, aging services providers and other stakeholder groups on how to implement effective strategies for communicating and collaboratively managing older adult suicide risk.

Action step 7.4.2: Recommend that all persons, regardless of age, treated for trauma, sexual assault, or physical abuse, in emergency departments, receive mental health services.

Action step 7.4.3: Ensure communication and collaboration across multiple levels of care, by developing clinical preventative and communication protocols for clinicians, clinical supervisors, first responders, crisis staff and professionals who provide older adult protective services as well as others who provide support to older adults with suicide risk.

Action step 7.4.4: Distribute "Lifeline Best Practices for Helping Callers" to all crisis hotlines/warm lines within Pennsylvania to improve competence in handling crisis calls.

GOAL 8: PROMOTE THE EFFECTIVE ASSESSMENT, PREVENTION AND TREATMENT OF SUICIDE AS A CORE COMPONENT OF ALL HEALTH CARE SERVICES.

Pennsylvania's 8th Goal is a combination of goal 8 and goal 9 in the National Strategy for Suicide Prevention. The Pennsylvania Suicide Prevention Plan Advisory Committee recommended the collapsing of these two national goals since the focus of the two goals was perceived as similar in nature. The intent of Goal 8 is to ensure that all health care services, especially aging service providers, effectively assess, prevent and treat suicide. An overarching goal, as reflected in one of the guiding principles of this plan and promoted by the Action Alliance for Suicide Prevention, is "ending suicide in healthcare settings". A recent presentation by Dr. Michael Hogan of Hogan Health Solutions on this issue described this shift in perspective as follows: "rather than accepting suicide as inevitable, ask how many deaths of people in our care are acceptable; rather than having specialty referrals to niche staff, suicide prevention should be part of everyone's job; rather than individual clinical judgment and actions, use standardized screening, assessment, and interventions; rather than hospitalization when people admit they are in crisis, promote collaborative, recovery oriented community care; rather than saying "if we can save one life..", we should say "***Not Another Life to Lose***."[10]

The Action Alliance also identified programs that have garnered attention for their novel approaches and positive outcomes including the U.S. Air Force, Henry Ford Health Systems, Magellan Maricopa Collaborative, Veteran's Health Administration, and the Central Arizona Programmatic Suicide Deterrent System Project. Core components to the success of these systems are reflected in the following objectives and action steps and throughout this plan. Key elements of organizational culture change within these programs include: creating a leadership-

driven culture which includes suicide attempt and suicide loss survivors in leadership and planning; same day access to care; email visits; emphasis on means restriction; stratifying levels of risk and establishing associated interventions; safety planning instead of "contracts"; establishing and maintaining a competent and caring workforce; follow-up after acute care by phone, postcards, and visits; treating mental health conditions and suicidality together; and applying a data driven quality management approach.[11] [12]

The following objectives and action steps emphasize establishing guidelines for assessing and documenting risk factors. It is recommended that primary care practitioners routinely conduct at least brief suicide risk assessments and screen for mental health and substance use, including problem gambling, since research indicates that a large percentage of individuals visited their primary care physician prior to their suicide.[13] A recent study by the Center for Health Policy and Health Services Research at Henry Ford Health System in Detroit, found that 83% of individuals received health care treatment (medical and primary care more frequently) in the year prior to dying, and 20 % had seen a health care worker the week before they died.[14] Studies indicate that the majority of people who die by suicide- 90% or more- had a mental health condition at the time of their death.[13] However, in the Henry Ford Health System study, a mental health diagnosis was made in less than half of the cases. While it isn't clear if a mental health condition was present prior to death, it is likely that at least a percentage of these individuals had a mental health condition that went undetected.[14] In addition to primary care, mental health and substance use systems should be required to assess risk at all intakes and regularly monitor individuals at the highest risk. Risk assessments should be documented according to standards that can lead to tailored interventions based on the level and type of risk.

Hello, my name is Jennifer and I am 32 years old. For 18 years I was suicidal and dependent on the mental health system, medicine, hospitals, and ECT. I used to stand on bridges for comfort, overdose constantly, and wander around high crime neighborhoods wanting to get shot. I felt hopeless, frustrated, alone, scared, and speechless when 2 years ago the next best option suggested to me was experimental brain surgery.
Today, 2 years later, I work as a Peer Specialist in a psychiatric emergency room that I used to frequent. Every time I go to work I fight the stigma of mental illness head on. I relate to the people there to provide comfort, resources, and help them find hope in their lives or be an example of hope when they have nothing in this world to live for. I not only represent recovery there to my peers but the staff that used to treat me. I am truly happy I created a life worth living and thankful I have a future to look forward to.

Jennifer Cherak

Timely access to services (specifically designed for older adults) - and rapid follow-up are two additional key components to quality services that can interrupt the cycle of suicide. Hotlines, warm lines, counseling by phone, texting, etc., and having procedures in place to guarantee 24 hour/7 day a week access to services tailored to older adults are ways to ensure rapid access. Research has demonstrated that discharge from an inpatient psychiatric facility, emergency department, urgent care facility, or a residential addiction program can be a high risk timeframe for suicide. Therefore, the following actions recommend policies that would require providers to follow-up, by phone or in person, within 24 hours following discharge from these facilities. Case management programs, peer specialist programs and crisis intervention programs have already assumed this responsibility in some parts of the state. Each county/managed care organization, and senior service organizations, should consider assigning lead responsibility for such follow-up within their jurisdiction.

Central to continuity of care, is the sharing of information among caregivers. Mental health and primary care providers should cross-monitor for medication side-effects. Videoconferencing and telemedicine are methods to help assess for risk and share information across systems without the need for travel.

As already noted in many of the goals, it is always good policy to include people who are significant to the individual in the entire process of care. Likewise, suicide attempt survivors and suicide loss survivors can be instrumental in helping others to access/engage in treatment. Providing services in the least restrictive fashion, which balances autonomy with safety, is always the best choice. Many individuals in the system have already experienced past trauma or abuse and alternatives to coercion should be used to minimize re-traumatization. When adding issues of aging, the balance of autonomy with safety can be particularly difficult to achieve. Significant time should be devoted to ensuring that older adults' wishes are honored, including advance directives, while still considering personal/public safety.

OBJECTIVES:

Objective 8.1: Promote adoption of zero suicide, across the lifespan, as an aspirational goal of health care and community support systems.

Objective 8.2: Develop and implement protocols, guidelines and training for assessing and documenting older adult risk and delivering timely and effective older adult specific services in the most collaborative and least restrictive settings.

Objective 8.3: Promote continuity of care and rapid follow-up among: suicide prevention/intervention programs, health care systems, crisis programs, emergency departments, inpatient units, older adult services, and community based programs (including peer support).

Objective 8.4: Encourage health care delivery systems and aging service systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

Objective 8.5: Promote safe disclosure of suicidal thoughts and actions by all individuals receiving services.

Objective 8.6: Adopt and implement guidelines to effectively engage significant people, including a person's family of choice and friends, when appropriate, throughout the entire episodes of care for older adults with suicide risk.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 8.1: Encourage adoption of the goal of "zero suicides", across the lifespan, by health and behavioral health systems.

- Encourage managed care organizations, counties, and providers, etc. to conduct root cause analysis of older adult suicide attempts and deaths and use findings to improve service quality.
- Distribute Henry Ford Health Systems Perfect Depression Care program as a promising approach.

Action step 8.2.1: Develop and implement protocols for delivering services (including aging service providers) to older adults with high suicide risk that:

- Value shared responsibility, collaborative care and effective communication with individuals, families and significant others.
- Identify alternatives to coercion, restraint, and involuntary treatment while ensuring the safety of individuals in crisis.
- Address issues related to past trauma or abuse that may make individuals reluctant to seek help for fear of being re-traumatized.

Action step 8.2.2: Encourage timely availability of older adult specific services through the use of crisis hotlines, warm lines, chat services, self-help tools, crisis outreach, and counseling by phone, texting or Internet to allow persons in crisis to access help 24 hours a day, 7 days a week.

Action step 8.2.3: Disseminate and implement guidelines for assessment of older adult suicide risk in primary care, hospitals, and mental health and substance use care, and ensuring that aging service treatment plans include information on suicide plans, intent, access to lethal means, previous attempts and presence of acute risk factors.

Action step 8.2.4: Develop and implement strategies for frequent monitoring of older adults known to have high risk factors.

Action step 8.2.5: Disseminate and implement clinical practice guidelines for mental health, substance use, and other providers who serve older adults at-risk for suicide.

Action step 8.2.6: Develop protocols for differentiated responses based on clinical needs (e.g., intoxicated and suicidal, chronically suicidal, suicidal with active psychosis, suicidal with dementia).

Action step 8.2.7: Disseminate guidelines and provide training on documentation and treatment of suicide risk including determining the proper level of treatment based on risk, needs and preferences.

Action step 8.2.8: Recommend that state agencies, managed care organizations and others in an administrative capacity issue a policy to mental health, substance use, health and aging service providers highly encouraging suicide risk assessments with all intakes.

Action step 8.2.9: Encourage routine and consistent use of brief suicide risk assessments within primary care and aging services.

Action step 8.3.1: Establish policies that recommend follow-up outpatient treatment occur within 24 hours of inpatient and emergency department discharge. Such follow-up can include use of peer specialist programs, case management programs, and/or crisis programs.

Action step 8.3.2: Disseminate information about prototypes for integrating crisis and clinical services such as the VA crisis line relationship with the National Suicide Prevention Lifeline, whereby call responders interact with providers nearest to the individual to arrange and facilitate follow up.

Action step 8.3.3: Encourage primary care, mental health, substance use, and aging service programs to establish mechanisms to facilitate rapid access to services when individuals are in crisis.

Action step 8.3.4: State agencies, managed care organizations, counties and others in an administrative capacity should develop policies/protocols for follow-up/continuity of care after periods of high risk for suicide including emergency department visits or hospitalizations.

Action step 8.3.5: Encourage the use of Peer Specialist programs, case management and/or crisis programs to provide mandatory follow-up within 24 hours following hospital discharge.

Action step 8.3.6: Collaborate with hospital associations to develop tracking procedures for mental health follow-up for older adults.

Action step 8.3.7: Promote the role of primary care in collaborating with mental health and substance use and aging service providers regarding medication side effects.

Action step 8.3.8: Promote use and development of computerized records systems that would facilitate interdisciplinary team approaches across all treatment providers that the older adult wants included in his/her treatment.

Action step 8.3.9: Promote collaboration of all treatment providers (substance use, mental health, alternative medicines, pain clinic, aging service providers, etc.) and social supports through phone contact or video teleconferencing when developing discharge plans.

Action step 8.3.10: Encourage interactions from treatment providers/consumers at the next level of care, including nursing home care and community based services, while the member is working on discharge planning from an inpatient facility.

Action step 8.3.11: Reinforce the role of intensive case managers, resource coordinators, certified older adult peer specialists, and others to assist with navigation through mental health, physical health and aging programs.

Action steps 8.3.12: Distribute older adult suicide risk posters throughout the community such as housing complexes, faith based entities, senior centers, physician offices, emergency rooms, etc.

Action step 8.3.13: Organize older adult suicide survivors in the community to provide seminars on accessing and engaging in treatment.

Action step 8.4.: Develop policies for public and private managed care companies to conduct root cause analyses of older adult suicide attempts and deaths, supervisory reviews, reviews of aggregate data for trends, and focused quality assurance studies on issues related to older adult suicide risk as part of their continuous quality improvement efforts.

Action step 8.5: Educate and train providers on ways to address the disclosure of suicide risk in order to eliminate provider apprehension and liability.

Action step 8.6.1: Train significant people, including a person's family of choice and friends, to understand, monitor, and intervene with loved ones who are at- risk for suicide.

Action step 8.6.2: Develop guidelines to help providers balance respecting autonomy, versus safety, in their work with individuals with high suicide risk and people that are significant to them, including family and friends.

GOAL 9: PROVIDE CARE AND SUPPORT TO INDIVIDUALS AFFECTED BY SUICIDE DEATHS AND ATTEMPTS TO PROMOTE HEALING AND IMPLEMENT COMMUNITY STRATEGIES TO HELP PREVENT FURTHER SUICIDES.

Goal 9 of the Pennsylvania plan is identical to goal 10 in the National Strategy for Suicide Prevention. The focus of the goal is on providing effective services and support to those individuals (across the lifespan) affected by suicide, including individuals who have made a suicide attempt, individuals bereaved by a suicide and community members who are affected by a suicide. These services are referred to as "postvention" services. All too often, individuals are left to themselves to deal with the aftermath of a suicide. Suicide attempt survivors and individuals bereaved by a suicide are both high risk populations for future suicide. Postvention strategies should also include communities where older adults live, such as nursing facilities, retirement communities, and senior hi-rises as well as places of worship.

The following objectives and actions include identifying strategies and services available statewide to individuals in the aftermath of a suicide attempt or death and expanding appropriate care to affected individuals in every county. It is recommended that a list of resources be advertised through websites, posters, directories, etc. Information on national best practice interventions and toolkits for providing effective supports should be distributed to counties, providers, and others to guide the development of evolving postvention services in the state. Support groups, memorial services, on-line support and other approaches have been used widely and successfully.

Counties and local organizations also need resources to deal effectively with what is known as suicide contagion or clusters, or "copycat" suicides. Proper intervention early in the aftermath of a single or multiple suicides can reduce the trauma and sensationalism that might lead to further deaths. Support is also needed for individuals on the frontlines that have to deal professionally with a suicide, but may need support themselves for what they have experienced. Emergency medical technicians, firefighters, police, funeral directors and other providers can benefit from training and support to better understand and respond to these situations while ensuring that they receive necessary support for their own needs.

I am a survivor of my mother's suicide in 1966, when I was nine years old. Some things have changed since then, there are support groups, prevention campaigns, but people still avoid the survivors. They still feel isolated. At the time of my loss, no one talked about her, pictures were put away; she was erased from my life. There were no attempts to help me grieve. Many times later in life, I felt "stuck", sometimes depressed. I built great walls around me, I suppose for self-protection. As the years passed, I came to grieve and remember in my own way as an adult. For this reason, I started a support group in my area to give the survivors what I had wished for myself.

Cozette Stoltzfus

OBJECTIVES:

Objective 9.1: Identify all suicide strategies and services that respond to and care for individuals affected in the aftermath of a suicide attempt or suicide death (postvention) and promote awareness of these resources.

Objective 9.2: Provide appropriate clinical care and support to individuals across the lifespan affected by a suicide attempt or death, including trauma treatment and care for complicated grief as well as peer-to-peer supports.

Objective 9.3: Engage suicide attempt survivors, including older adults, in suicide prevention planning including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.

Objective 9.4: Disseminate, implement, and evaluate guidelines/resources for communities to respond effectively to suicide clusters within their cultural context, and support implementation with education, training and consultation.

Objective 9.5: Provide health care providers, first responders and other stakeholders with care and support when an individual under their care dies by suicide.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 9.1.1: Develop and conduct a county/local survey to identify all suicide postvention strategies currently in place.

Action step 9.1.2: Distribute a directory of resources available to those bereaved by suicide or affected by a suicide attempt.

Action step 9.2.1: Distribute information on best practice interventions through the Best Practices Registry for Suicide Prevention- *http://www.sprc.org/bpr*.

Action step 9.2.2: Publicize information on clinical and support services available to individuals in Pennsylvania affected by suicide through websites, posters, brochures, directories, etc.

Action step 9.4.1: Disseminate the Center for Disease Control recommendations on managing suicide contagion- *http://www.cdc.gov/mmwr/preview/mmwrhtml/00001755.htm*

Action step 9.4.2: Identify experts and funding sources to provide education/training and consultation on suicide clusters.

Action step 9.5.1: Identify ways to provide information/training to emergency medical technicians, firefighters, police, funeral directors, etc., who provide services to suicide attempt survivors and suicide loss survivors, so they can better understand and respond to needs.

GOAL 10: INCREASE TIMELINESS AND USEFULNESS OF DATA REPORTING SYSTEMS RELEVANT TO OLDER ADULT SUICIDE, AND IMPROVE THE ABILITY TO COLLECT, ANALYZE AND USE THE INFORMATION FOR ACTION.

Goal 10 is similar in focus to goal 11 of the National Strategy for Suicide Prevention. The intent of this goal is to ensure that data regarding suicide, across the lifespan, is collected and reported in a standardized reporting system for national data collection purposes and that data is utilized to impact suicide prevention policy decisions at the national, state and local levels. A primary source of statewide data on suicide is collected through the submission of death certificates sent from county coroners' offices to the state Department of Health. This data is

then transmitted to the Centers for Disease Control. Currently, coroners' offices report their data on violent deaths, which include suicide, through independent reporting systems. Complicating this data reporting, is the fact that suicides may be misclassified as homicides, accidents or death from natural causes. The absence of detailed data, such as data related to sexual orientation and gender identity, provide an incomplete picture of the risk factors for specific population groups.[15] In addition, there is a two year gap between the end of the state reporting period and the year when the data becomes available to the public. The implementation of a standardized reporting system, such as the National Violent Death Reporting System, would greatly enhance the timeliness and consistency of suicide death reporting within the commonwealth. However, the transition would require new state regulations and/or legislation. It is recommended that a report be prepared outlining the barriers and steps necessary for Pennsylvania to participate in the National Violent Death Reporting System.

It is further recommended that similar independent data reporting systems, including the Army National Guard "Critical Incident Management System (CIMS) and the state system be reviewed for data interchange. Governing policies and best practices should guide the reporting system linkage. Data from additional sources such as law enforcement, emergency medical services and inpatient units should be linked to enhance quality care. It should be determined if these independent data systems can be linked and the data utilized at the state level. The following strategies include the implementation of a data collection system within Pennsylvania's HealthChoices managed care program, as well as in Medicare, in order to track trends and actions that should be taken to eliminate suicide.

OBJECTIVES:

Objective 10.1: Identify, evaluate, and disseminate information on current reporting systems, programs, procedures and policies for suicides and suicide related incidents.

Objective 10.2: Improve and expand public health capacity to routinely collect, analyze, report and use suicide-related data to implement prevention efforts and inform policy decisions.

Objective 10.3: Promote and improve the timeliness and accuracy of reporting and disseminating vital data.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 10.1.1: Develop a report identifying the barriers to Pennsylvania participating in the National Violent Death Reporting System.

Action step 10.1.2: Collect current reporting systems, programs, procedures and policies in Pennsylvania. Two examples include the Army National Guard "Critical Incident Management System (CIMS)" and the York County Suicide Prevention Coalition.

Action step 10.2.1: Develop state representative surveys and data collection instruments that include questions on suicide, related risk factors, and exposure to suicide.

Action step 10.2.2: Enhance Pennsylvania's death certificate reporting system to include suicide-related information while ensuring data is reported in a timely and consistent reporting system.

Action step 10.2.3: Implement a data collection system within Pennsylvania's HealthChoices managed care program on suicide trends and actions taken to eliminate suicide.

Action step 10.2.4: Encourage the Implementation of a data collection system within Medicare managed care programs in the commonwealth on suicide trends and actions taken to eliminate suicide, and explore ways to facilitate data sharing from within Medicare to the state data collection system.

Action step 10.2.5: Identify and disseminate effective data collection efforts at the national, state and community levels.

Action step 10.2.6: Develop community level risk factors to assist communities, in particular, older adult communities, in implementing suicide prevention efforts.

GOAL 11: PROMOTE AND SUPPORT RESEARCH ON OLDER ADULT SUICIDE AND SUICIDE PREVENTION

Goal 11 of the Pennsylvania Suicide Prevention Plan is similar to goal 12 in the 2012 National Strategy for Suicide Prevention. This goal promotes the dissemination of older adult suicide and suicide prevention research, including the establishment of a state registry that individuals can use to access information on effective interventions. According to the 2012 National Strategy, research on suicide prevention and treatment of mental health and substance use conditions has increased considerably during the past 20 years. Findings have contributed to

the development of assessment tools, resiliency-building interventions, and treatment and symptom-monitoring techniques.[16]

> The impact of my husband's suicide on my life, my children and grandchildren…. I don't think there is one word or even a sentence to describe the profound loss, the emptiness, heartache, loss of my security. In fact, while mourning my husband's death, I also was mourning the death of my life, life as I knew it for 30 years. My husband was a normal everyday middle class man, your neighbor, your friend, a local fireman and the last person on earth you would think to commit suicide, but he did… February 8, 2013.
>
> Cassy Kwaczala

Movement is underway, to develop a research agenda on suicide and suicide prevention that will be available in the future at the state and local level. This movement can be strengthened by incorporating older adult specific research as well. The following actions support building collaborative efforts with potential Pennsylvania researchers on topics that would promote the goals identified in the state suicide prevention plan. Actions include establishing contacts at major universities and research centers to discuss potential funding sources and ideas that would lead to research grant submissions. Information on grant opportunities, older adult specific research-based practice standards and evidence-based interventions should be made available through conferences, websites and written materials. Major leaders will be encouraged to attend national and regional conferences to gather information on the current suicide prevention research to share with Pennsylvania constituents at conferences, on websites and in written communication.

OBJECTIVES:

Objective 11.1: Help connect researchers with funding sources

Objective 11.2: Promote timely dissemination of older adult suicide and suicide prevention research

Objective 11.3: Establish a registry of interventions with demonstrated effectiveness for prevention of older adult suicide.

ACTION STEPS TO SUPPORT THE OBJECTIVES:

Action step 11.1.1: Identify funding sources for older adult suicide prevention research.

Action step 11.1.2: Develop a list of potential research funding opportunities and post information on various web sites such as OMHSAS and the Adult and Older Adult Suicide Prevention Coalition.

Action step 11.1.3: Establish university contacts interested in partnering on suicide research in PA and collaborate on grant opportunities.

Action step 11.2.1: Identify key PA research on older adult suicide and suicide prevention and disseminate information via PA websites.

Action step 11.2.2: Communicate knowledge of state/local suicide and suicide prevention research, particularly older adult suicide, to the Research Prioritization Task Force and national suicide prevention organizations.

Action step 11.2.3: Attend national/ regional conferences to gather information on suicide and suicide prevention and make latest research information available at state/local conferences, via websites, and through written materials.

Action step 11.3.1: List research-based best practice standards and evidence-based interventions in distributed materials, at conferences, etc., and on web sites.

Appendix A: At Risk Populations

Suicide Prevention and Individuals with Serious Mental Health and or Substance Use Conditions

Mental health and substance use conditions are widely recognized as important risk factors for suicide in all age groups. Substance use along with any mood disorder may be particularly likely to increase suicide risk.

In ***Achieving the Promise: Transforming Mental Health Care in America***, the President's New Freedom Commission on Mental Health (2003) noted: "Suicide is a serious public health challenge that has not received the attention and degree of national priority it deserves." This is of concern because suicide gravely impacts those with mental health and/or substance use conditions.

Mental health conditions do not cause suicide. Rather those individuals with mental health conditions are exposed to more risk factors (including substance use) that raise their vulnerability to suicide. Ironically, the public largely believes that suicide happens mainly to those with mental health conditions, not understanding the potentially lethal combination of substance use co-occurring with mental health conditions. This is one of the many myths of suicide.

Much of what is known about suicide comes from studies of those diagnosed with mental health and substance use conditions. In **Night Falls Fast: Understanding Suicide** (2000), Kay Redfield Jamison tells us that the gap between what we know about suicide and its use in prevention is "lethal." Dr. Jamison is sadly right.

A brief summary of information on suicide risk among those individuals with serious mental health conditions such as Major Depressive Disorder, Bipolar Disorder, Anxiety Disorder, and Schizophrenia, and Substance Use is provided here, along with appropriate resources. For more detailed and extensive information on specific mental health and substance use conditions with highest risk factors for suicide; please see the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A report of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention: www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html, or www.actionallianceforsuicideprevention.org/NSSP or

www.samhsa.gov/nssp. Hard copies may be ordered through SAMHSA Store at www.samhsa.gov/nssp or by calling toll free at 1-877-SAMHSA-7 (1-877-726-4727).

MENTAL HEALTH CONDITIONS:

MOOD DISORDERS

Mood disorders are among the most common and may be the most life-threatening psychiatric illnesses (Goodwin and Jamison, 2007)

Major depressive disorder, also called *major depression* or *unipolar disorder*, is characterized by a combination of symptoms, such as sadness and loss of interest or pleasure in once-pleasurable activities, which interfere with everyday life. It has been estimated that 12 to 17 percent of individuals will experience a major depressive episode with in their lifetime (Rihmer and Angst, 2005). Individuals with major depressive disorder have 21 times more suicide deaths than the general population and 9% - 15% of individuals with major depressive disorder eventually die by suicide.

Bipolar disorder, also called manic-depressive illness, is characterized by dramatic mood swings, going from an overly energetic "high" (mania) to sadness and hopelessness (depression). The estimated lifetime prevalence of bipolar disorders is 1.3 to 5 percent (Rihmer and Angst, 2005). Suicide risk is particularly high among individuals with bipolar disorders, which is strongly associated with suicidal thoughts and actions. Over their lifetime, the vast majority (80 percent) of [people] with bipolar disorders have either suicidal ideation or ideation plus suicide attempts (Valtonen, Suominen, Mantere, Leppamak, Arvilommi, Isometsa, 2005). Approximately 15 to 19 percent of [people] with bipolar disorders die by suicide. The suicide rate among [people] with bipolar disorder is estimated to be more than 25 times higher than the rate in the general population (Tondo, Isacsson, Baldessarini (2003).

ANXIETY DISORDERS

Anxiety disorders affect about 40 million American adults aged 18 and older (about 18 percent) in a given year (Kessler, Chiu, Demler, Merikangas, Walters, 2005). Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance use conditions, which may mask anxiety symptoms or make them worse. The presence of any anxiety disorder in combination with a mood disorder (co-occurring) is associated with a higher likelihood of suicide attempts in comparison with a mood disorder alone (Sareen, Cox, Afifi TO, et al, 2005). Among adults in the general population (i.e. not in the Armed Forces or veterans),

panic disorder and PTSD have been found to be more strongly associated with suicide attempts when there is a co-occurring personality disorder (Napon, Belik, Bolton, Sareen, 2010)

SCHIZOPHRENIA

Schizophrenia is a severe disorder characterized by disturbances in perception, thought, language, and social function. Schizophrenia is involved in up to 15% of all suicides (as many as 4,000 deaths yearly). Individuals with Schizophrenia are at more than 30 times higher risk of suicide than the general population. The greatest indicator of suicide risk among people with schizophrenia is active psychotic illness (e.g. delusions) combined with symptoms of depression. Alcohol use conditions have been reported in studies examining suicide attempts and schizophrenia.

SUBSTANCE USE CONDITIONS

Suicide is the leading cause of death among people with substance use conditions. Substance use may increase the risk of suicide by intensifying depressive thoughts or feelings of hopelessness while at the same time reducing inhibitions to hurt oneself (Skog, 1991). Alcohol and other drugs can cause a "transient depression," heighten impulsivity, and cloud judgment about long-term consequences of one's actions.

Alcohol and drug use conditions are second only to depression and other mood disorders as the most frequent risk factors for suicide (Centers for Disease Control, 2011). According to the data from the National Violent Death Reporting System (NVDRS), in 2008 alcohol was a factor in approximately one-third of suicides reported in 16 states (Karch, Logan, Patel, 2011). Opiates, including heroin and prescription painkillers, were present in 25.5 percent of suicide deaths, antidepressants in 20.2 percent, cocaine in 10.5 percent, marijuana in 11.3 percent, and amphetamines in 3.4 percent. This is especially significant when one considers that individuals with co-occurring mental health and substance use conditions are at higher risk for attempting suicide.

The following suicide risk factors for individuals with serious mental health and/or substance use conditions include:

- Episodes of hopelessness, anxiety, and depression
- Young age of onset and early stage of illness
- Inadequate treatment and treatment reductions
- Frequent exacerbations/remissions

- Post-relapse improvement periods
- Psychiatric hospitalization(s) (especially the first 30 days after discharge)
- Co-occurring alcohol and other substance use

Individuals with mental health conditions also have risk factors related to race and ethnicity, gender, age, a history of abuse, past suicide attempts, access to firearms, work, school, or legal problems, and others. This accumulation of risk is what accounts for the prevalence of suicide among consumers and which necessitates preventative measures on their behalf.

These are key protective factors that counter the onset and progression of suicidality:

- Treatment adequate to need
- A caring personal support system
- Means restriction/removal (i.e., no guns, controlling medications)
- Ability to seek/accept professional help
- Availability/accessibility of help
- Mutual support for those at-risk

Given what we know about suicide and mental health, what can we do?

All mental health and substance use providers, both public and private, should:

- Know the risk factors, warning signs, and myths of suicide
- Be able to talk about suicide with clients and patients
- As applicable, identify hazards in facilities that may be used for a suicide attempt
- Be trained in crisis intervention
- Educate families about suicide risk

Here are some specific suggestions for county mental health systems: Assure that all providers recognize suicide as a preventable community mental health problem.

1. Assure that county suicide prevention plans (i) exist, (ii) speak to the risk of adults living with serious mental health conditions, and (iii) are being implemented.
2. Assure that county mental health plans recognize the need for aftercare and supports for suicide attempters to deter future suicidal behavior.
3. Assure that all mental health providers screen for suicidality at admission, after serious life events or losses, and after changes affecting treatment.
4. Assure that modalities such as cognitive behavioral therapy, which have been found to reduce suicide, are available.
5. Assure the availability of groups that offer mutual support and “safe places” for individuals who make multiple suicide attempts (e.g., “Suicide Anonymous”).

There is much that needs to be done, but these steps would make a real difference.

In closing, bear in mind that nothing is more detrimental to recovery from mental health conditions than suicidality and nothing shatters mental health wellness like losing someone to suicide. Mental health consumers are far more likely to have experienced the loss of someone they know to suicide because of the high incidence of suicide among those with serious mental health conditions. For this reason, providers should see that consumers who experience the suicide of a loved one or close friend have access to grief support resources.

Pennsylvania Department of Corrections Suicide Prevention Efforts

The latest statistics published by the Centers for Disease Control and Prevention (CDC) and the U.S. Department of Justice confirm that suicide mortality rates per 100,000 state inmates consistently exceed suicide mortality rates in the community (BJS, 2012; Kochanek, Jianquan, Murphy, Miniño, & Kung, 2011; Murphy, Jianquan, & Kochanek, 2012). Indeed, a recent longitudinal study of all 50 state prison systems revealed that suicide was routinely among the five leading causes of death among inmates (BJS, 2012). However, leading experts in the field of suicidology believe that correctional systems can reduce suicide mortality rates by augmenting identification protocols, developing system-wide procedures to enhance suicide prevention policies, and improving continuity of care practices (Hayes, 2013). In response, the Pennsylvania Department of Corrections instituted numerous evidence-based practices for suicide prevention which have resulted in mortality rates *less* than national prison averages 10 of the past 14 years, suicide mortality rates periodically *less* than community mortality rates, and the 18th lowest mortality rate for suicide in the United States (BJS, 2012; Kochanek et al., 2011; Murphy et al., 2012). Pennsylvania's Department of Corrections realized these systemic reductions despite maintaining the sixth largest state corrections population in the United States (i.e., 50,918 inmates).

RISK FACTORS AMONG INMATES

Suicide and self-injurious acts are serious dangers in any correctional setting. Therefore, early identification, appropriate housing and monitoring, and proper treatment of a potentially self-

destructive inmate is critically important, both for the individual in need of service and for the facility charged with his/her care. Suicide potential can be evaluated by using the following criteria.

Suicidal Plan

The potential for suicide is greater when there is a well-organized and detailed plan developed by the inmate. The potential also increases when the means of the suicide identified in the plan is readily available to the inmate and can be lethal.

Prior Suicidal Behavior

The potential for suicide is greater if the individual has experienced one or more prior attempts of a lethal nature or has a history of repeated threats and depression. In addition, individuals involved in many episodes of self-injurious behavior (SIB) are at increased risk to complete suicide.

Stress

The potential for suicide is greater if the individual is subject to stress from increased pressures such as, but not limited to:

- difficulties in coping with legal problems;
- the loss of a loved one through death or divorce;
- the loss of valued employment (high paying position in Correctional Industries);
- anniversary of incarceration date or offense;
- serious illnesses or diagnosis of terminal illness;
- threats or perceived threats from peers;
- sexual victimization, particularly after the first submission;
- placement in segregation;
- unexpected punishment (misconducts or additional sentence or parole denial);
- cell restriction;
- recent transfer from another state or county facility;
- recently returned to prison due to a parole violation;
- any movement to and from segregation (watch closely for several hours);
- long sentence coupled with poor external supports (family or volunteers) and/or minimal involvement in facility supports (education, treatment, activities, and employment);
- somatic complaints of a vague nature that do not respond to treatment;
- history of violence toward others;
- intellectual/developmental disability;
- requesting protective custody;

- deemed to be a “high profile” case;
- long sentence, including life; and/or
- history of alcohol and/or drug use conditions.
- Traumatic event, significant wound/injury, physical disability

Prior Suicidal Behavior of Someone Significant To the Individual

The potential for suicide is greater if a parent, spouse, close relative or a person significant to the individual has attempted or died by suicide.

Symptoms

The potential for suicide is greater if the individual manifests symptoms such as:

- auditory and/or visual hallucinations, particularly command hallucinations ordering the person to harm himself/herself;
- delusions;
- any change from the individual’s sleep pattern (this may be manifested by either a decrease or increase in sleep);
- any change from the individual’s ordinary eating pattern. (This may be manifested by either a decrease or an increase in the individual’s appetite with an accompanied decrease or increase in weight);
- social withdrawal;
- apathy;
- despondency;
- severe feelings of hopelessness and helplessness;
- general attitude of physical and emotional exhaustion;
- agitation through such symptoms as tension, guilt, shame, poor impulse control or feelings of rage, anger, hostility or revenge;
- giving away personal property;
- removal of every visitor from the visiting list;
- changing next of kin notifications;
- sudden elevated mood (“everything’s OK attitude”); and/or
- psychic or somatic anxiety.

Personal Resources

The potential for suicide is greater if the person has no family or friends, or his/her family and friends are unwilling to help. Potential is greater if a significant other evidences a defensive, rejecting, punishing attitude, or denies that the individual needs help.

Acute vs. Chronic Aspects

The potential for suicide is greater when there is a sudden onset of specific symptoms. An individual who has recently learned that he/she has a serious disorder is at greater risk than a person who has been coping with the problem for years. The acute risk is higher if the person appears anxious.

Medical Status

The potential for suicide is greater when there is a chronic, debilitating illness, especially when it involves an alteration of body image or life style.

A person considering suicide does not demonstrate all of these signals. Generally, the more characteristics the individual has, the greater the potential for self-harm. Every suicide attempt, including gestures, is taken seriously.

STATISTICS RELATED TO SUICIDE RISK FACTORS IN THE PENNSYLVANIA DEPARTMENT OF CORRECTIONS

- Mental health conditions: although inmates on the mental health/intellectual disability roster comprise approximately 22% of the PA state prison population, these individuals comprise approximately 60% of the suicides.
- Substance use conditions: approximately 70% of inmates who died by/attempted suicide had histories of substance use conditions.
- Males: males account for approximately 95% of the PA state prison population and account for approximately 98% of suicides.
- Caucasians: although Caucasians comprise only 34% of the PA state prison population, these individuals comprise over 50% of all suicides.
- Older Adults: due to mandatory sentencing and a reduction in parole, the PA state prison population has been getting older. Depression is underdiagnosed among older adults and we are carefully monitoring this population.
- Sex Offenders: this population is a growing risk, possibly related to the increased difficulty of obtaining parole.
- Lifers/Long Term Offenders: although inmates with life sentences comprise 17% of the PA state prison population, they comprise more than 40% of the suicides.
- Parole Violators: these are offenders who are returned to prisons after failing to adjust in the community. In some cases, they may still be under the influence of alcohol or other drugs. Our speculation is that these individuals panic when they realize that their likelihood of being re-paroled might be remote.

- Administrative Segregation: although this population had a high rate in the past it has decreased since new policies have been implemented.

STRATEGIES TO REDUCE DOC SUICIDES

- All Pennsylvania Department of Corrections employees receive at least two hours of suicide prevention training during their basic training regimens, followed by one hour of refresher training annually.

- The Pennsylvania Department of Corrections recently recognized the need for enhanced system-wide suicide prevention training initiatives. Subsequently, the department commenced the delivery of the *Crisis Intervention Team* (CIT) training and *Mental Health First Aid* training for all corrections employees. By the end of 2013, the Department of Corrections trained more than 300 employees in the CIT model. The Department is scheduled to have all DOC staff trained in *Mental Health First Aid* by the end of FY 2014. Additionally, one of the initial CIT trainings was geared toward county employees from around the state. Plans to begin offering CIT regionally (i.e., within SCIs) are also underway. Overviews of the CIT implementation have been provided at various conferences to include NAMI, PPWA, and Forensic Rights and Treatment Conference. All Superintendents were trained in CIT at a two-day meeting in January of 2014. Currently, the DOC has five statewide MHFA trainers who will continue to train staff. However, the Department of Corrections intends to have 30 trainers trained by June of 2014 with the intent of training ALL staff by the end of FY 2014.

- The departmental disciplinary process and suicide prevention has been greatly augmented during this past year regarding inmates with mental health and serious mental health conditions. Our Hearing Examiners received a specialized training on the recent policy amendments and new provisions to the disciplinary process by the Licensed Psychologist Director, the department's Office of Chief Counsel, and the Supervising Hearing Examiner at Central Office. Specific changes included the elimination of disciplinary sanctions for suicide attempts and other intentional self-injurious behaviors, the implements associated with these behaviors, other non-assaultive behaviors associated with these behaviors, and threatening statements made while engaging in a suicide attempt or self-injurious behavior. The suicide risk associated with segregating inmates (diagnosed with mental health and serious mental health conditions) for extended periods of time was also considered as the following paragraph indicates. Restrictions permitted for this population were increased significantly on the amount and type of disciplinary sanctions for any institutional violation.

- The Pennsylvania Department of Corrections has many suicide prevention protocols in place for all inmates. For example, every inmate who is received by or enters the Department of Corrections, at any time, is assessed for suicide risk by a psychologist and given a pamphlet that describes the stressors associated with incarceration, the risk factors for suicide associated with incarceration, tips on identifying and recognizing a crisis during incarceration, the procedures of how to access mental health services while incarcerated, and what to do if a fellow inmate exhibits emotional distress or is contemplating suicide. Every State Correctional Institution must have a local system in place for the regular distribution of these educational pamphlets for their inmate populations.

- At every State Correctional Institution in Pennsylvania, a locally developed video is aired on the inmate dedicated channel for the purposes of introducing the mental health staff, services offered by this staff, and additional educational material on suicide prevention and suicide risk identification.

- Every State Correctional Institution in Pennsylvania conducts random suicide response drills. Suicide response drills are aimed at improving response times from medical, custody, and other appropriate staff. Summary reports of these drills are submitted to the Institutional Critical Incident Manager to ensure that the Critical Incident Stress Management Team is activated afterward.

- The Pennsylvania Department of Corrections maintains robust pre-placement suicide risk screenings for certain housing placements. For example, before an inmate is placed in segregation for a violent institutional misconduct, pre-placement suicide risk screenings are conducted by a security staff member, a nursing staff member, and a psychologist. Inmates who are identified as being at heightened or imminent suicide risk are immediately diverted to inpatient settings and not placed in segregation.

- The Pennsylvania Department of Corrections has concentrated significant efforts on improving, developing, and implementing additional clinical operations associated with suicide prevention. For example, in 2013, **Suicide Prevention Committees**, consisting of multidisciplinary professionals, were established at every State Correctional Institution. The committees meet monthly, review critical incidents, recommend policy changes, and evaluate facility processes and procedures as they relate to suicide prevention. Each committee must send monthly reports of updates to Central Office for additional oversight and quality assurance purposes.

- The Pennsylvania Department of Corrections has drastically enhanced the requirements and procedures for clinical reviews of self-injurious behaviors, suicide attempts, and suicides, while acknowledging the increased importance on postvention efforts. Highlights of these changes include requirements for the clinical review team to be chaired by the Licensed Psychologist Manager, the requirement of a clinical review for all serious suicide attempts, and additional Central Office oversight of every clinical review for quality improvement/quality assurance purposes.

- The Pennsylvania Department of Corrections maintains tracking systems of all suicides, attempted suicides, and self-injurious behaviors that occur in all State Correctional Institutions for the specific intent of identifying trending or clustering.

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LAW ENFORCEMENT SUICIDE PREVENTION

Suicide is a silent epidemic that permeates all walks of life and all types of people; it does not discriminate. There are certain populations, however, that are at an elevated risk for suicide. One of these populations is law enforcement personnel. The rate of suicide for police officers is 3 – 4 times higher than the general population and more active law enforcement officers die by

suicide than homicide. It is estimated that 300 police officers die by suicide each year, although data is often hard to obtain. One Philadelphia police department was unwilling to share their data when requested and we can only assume many more follow suit. The stigma surrounding suicide continues to be an obstacle for preventing suicide. Therefore more attempts to raise awareness, particularly among law enforcement personnel, need to be made.

Police are at an elevated risk for:

- Divorce
- Post-Traumatic Stress Disorder (PTSD)
- Alcoholism

These factors greatly enhance their risk of suicide. Stress factors, symptoms of PTSD and alcoholism, depression and suicidality, all require recognition and early detection. Effective methods in helping officers with these issues need to be incorporated into any law enforcement suicide prevention program.

Not surprisingly the leading cause of suicide for police is by firearms, with most suicides occuring at home. Although law enforcement officers have daily access to firearms, restriction to access of them can still be included as part of a suicide prevention training. There are other components of suicide prevention which are gaining more popularity across the country. These methods include:

- Gatekeeper suicide prevention training in the curriculum of cadets in the police academy

My name is Marie Bartos and I am a survivor of suicide loss. My husband, Stephen Milkovits, was a police officer and a United States Marine Corp veteran. Ten years ago, he made the unfortunate decision to take his life, in our home, as I helplessly watched in horror. Since his death, I wondered why am I here, what is my purpose in life? I found my answer through advocacy and survivor outreach with our local chapter of the American Foundation for Suicide Prevention (AFSP). Sharing my story and helping those who are living the hell that I have lived through, has become my passion, my calling, my reason for living. Survivors of suicide loss need to know they're not alone, it's not their fault and there is a light at the end of the darkness. Each of us has to find our own way, on our own terms, in our own time, but knowing that someone knows how we feel is in its own way comforting. I've taken this tragedy and made it my triumph. I've become more compassionate, caring, loving, but most of all, understanding and accepting of life. As painful as it is sometimes, it's given me hope-hope that I've never had before. Hope that anything is possible. It also made me realize the strength that I have within. If I can save one life, it makes it all worth it.

Marie Bartos

- Creating peer support groups among the departments, and
- Encouraging help seeking behavior

Dr. Joseph Violanti, a leading researcher and expert in police suicide, strongly advocates peers, supervisors, and administrators learn how to detect, intervene and refer a suicidal officer (for help) as part of their training. He believes developing a program that includes psychological assessment, tracking high risk officers, access to firearms, family involvement, and training would ultimately lead to a reduction of suicide among police officers. Dr. Violanti has authored an informational website including a suicide prevention toolkit for use by law enforcement departments that can be found at: http://policesuicide.spcollege.edu/indexIHW.htm

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Members of the Armed Forces and Veterans

DEPARTMENT OF DEFENSE (DOD)

Suicide prevention is a top priority for the Department of Defense (DoD). Reflecting this, the Secretary of Defense established the Defense Suicide Prevention Office (DSPO) in November 2011 to serve as the focal point for all DoD suicide prevention programs, policies, and surveillance activities.

DSPO oversees all strategic development, implementation, centralization, standardization, communication, and evaluation of DoD suicide risk reduction programs, policies and surveillance activities. To reduce the impact of suicide on Service members and their families, DSPO uses a range of approaches related to policy, research, communications, law, and mental health. DSPO works with the Army, Navy, Air Force, Marine Corps, Coast Guard and National Guard Bureau to support our Service members and strengthen a resilient and ready force. DSPO strives to help foster a climate that encourages Service members to seek help for their mental health conditions.

DSPO is working with its partners to enhance suicide prevention efforts in the military by responding to a range of critical recommendations, including those offered by the DoD's Task Force on the Prevention of Suicide by Members of the Armed Forces. These efforts include establishing, monitoring, and analyzing the results of suicide prevention research and surveillance activities to identify suicide risk factors and translate findings into policy and strategies. DSPO is working with the Department of Veterans Affairs, the Centers for Disease Control and Prevention, and the

Hello, my name is Russell Crupe; I lost my son Russell Jr. to suicide in July 2012. Russell was a decorated combat veteran having served in Iraq.
I will never know why this happened but it has surely changed our lives forever. Parents should never have to bury their children. We are very proud of Russell in that he was never selfish and is missed by a lot of friends and family. My life is changed in that we worked together and will never be the same. When I travel, I no longer have him to call to let him know where we are at. Memories are often a curse because no matter what I do he was always part of it. I hope and pray that the government will look harder at Post Traumatic Stress Disorder (PTSD) and find ways to help our military so other families will not suffer what we are doomed to endure.

Russell Crupe

National Center for Telehealth & Technology (T2), among others, on these surveillance efforts.

The Department of Defense Suicide Event Report (DoDSER) program was launched in 2008 to refine suicide surveillance within DoD. This was one of the surveillance efforts used at DoD to help characterize the suicidal behavior of military personnel. The DoDSER assesses several areas of interest to suicide prevention efforts, including demographics, mental health history, circumstances at the time of the event (e.g., stressors and significant life events), and deployment history.

The DoDSER program is a collaborative effort of the National Center for Telehealth & Technology (T2) and the Services' suicide prevention program offices. Since January 1, 2008, the DoDSER program has standardized suicide surveillance across the Services with the ultimate goal of facilitating the DoD's suicide prevention mission. When a death is ruled a suicide by the Armed Forces Medical Examiner System (AFMES), a designated professional from the respective Service reviews records, conducts interviews when appropriate, and responds to the DoDSER items via the secure web-based DoDSER application (https://dodser.t2.health. mil). As of January 1, 2010, all Services have been collecting data on both suicides and suicide attempts, with some Services collecting data on additional nonfatal suicide events. The DoDSER items collect comprehensive information about the Service Member and the suicide event.

The AFMES indicates that 301 Service Members died by suicide in 2011 (Air Force = 50, Army = 167, Marine Corps = 32, Navy = 52). This number includes deaths strongly suspected to be suicides that are pending final determination. DoDSER Points of Contact (POCs) submitted reports for 100% of AFMES confirmed 2011 suicides (Air Force = 46, Army = 159, Marine Corps = 31, Navy = 51) as of the data extraction date (26 April 2012). A total of 915 Service Members attempted suicide in 2011 (Air Force = 241, Army = 432, Marine Corps = 156, Navy = 86). DoDSERs were submitted for 935 suicide attempts (Air Force = 251, Army = 440, Marine Corps = 157, Navy = 87). Of the 915 Service Members who attempted suicide, 896 had one attempt, 18 had two attempts, and 1 had three attempts.

Department of Defense Resources

Department of Defense's Office of the Under Secretary of Defense for Personnel and Readiness's Defense Suicide Prevention Office (DSPO) http://www.suicideoutreach.org/

Department of Defense Suicide Event Report (DoDSER)
http://www.t2.health.mil/programs/dodser

DoDSER 2011 Annual Report
http://www.t2.health.mil/sites/default/files/dodser/DoDSER_2011_Annual_Report.pdf

PENNSYLVANIA NATIONAL GUARD SUICIDE PREVENTION PROGRAM

In calendar year 2012 within the Pennsylvania Army National Guard (PAARNG), there were 52 suicide ideations, 22 suicide attempts and 5 suicides and 1 suicide attempt in the Pennsylvania Air National Guard (PAANG). In calendar year 2013 there were 53 suicide ideations, 15 suicide attempts and 4 suicides in the PAARNG and 2 suicide ideations, and 1 suicide attempt in the PAANG.

The Pennsylvania National Guard (PNG), an organization that is made up of approximately 20,000 Soldiers, Airman and their Families. The sheer size of this organization creates a rather large foot print in the state of Pennsylvania that is directly affected by the implications of suicidal behavior. Unlike active duty military Families, National Guard Families are their communities. National Guardsmen are integrated into society so their neighbors along with their fellow Soldiers and Families feel their struggles. The leadership of the Pennsylvania National Guard, the community, state and federal government agencies, private veteran's organizations, and non-profit agencies all have a vested interest in preventing military suicides.

The PNG is already noticing a decrease in suicides. The number of successful interventions has also substantially increased and evidence supports the reasons because of 1) suicide prevention and intervention education and training initiatives, and 2) the implementation of the Suicide Related Incidents Reporting Regulation. According to the PAARNG DPH, "The Suicide Related Incidents Reporting Regulation and R3SP training program have been pivotal, by requiring units to report suicide ideations, suicide attempts and deaths by suicide when they occur. Leaders are held accountable to ensure these Soldiers receive the care they need. We are teaching leaders how to respond and identify suicidal behaviors before they result in a crisis. This regulation has helped mental health to be taken more seriously in the Pennsylvania National Guard."

Pennsylvania National Guard Resources

Family Programs (717) 861-2650, Child and Youth Program (717) 861-6289, Yellow Ribbon Program (717) 861-2597, Employment Outreach (717) 861-2640, Employer Support of the Guard and Reserve (717) 861-8782, Resilience, Risk Reduction and Suicide Prevention Programs (717) 861-8976, Psychological Health Program (717) 673-4785, Sexual Assault prevention and Response Program (717) 861-6427, Survivor Outreach Services (814) 533-2481, Transition Assistance (717) 861-2813.

U.S. ARMY SUICIDE PREVENTION PROGRAM

This program uses Applied Suicide Intervention Skills Training (ASIST) to prepare designated gatekeepers to recognize suicide risk and intervene. All Army personnel, including civilians, are required to participate in Ask, Care, and Escort (ACE) suicide prevention and awareness training. The website also includes awareness materials, data, and tools for commanders to develop suicide prevention programs.

The Army Suicide Prevention Program (ASPP), a proponent of Deputy Chief of Staff, G–1 (DCS, G–1), has an Army-wide commitment to provide resources for suicide intervention skills, prevention, and follow-up in an effort to reduce the occurrence of suicidal behavior across the Army enterprise. The ASPP develops initiatives to tailor and target policies, programs, and training in order to mitigate risk and behavior associated with suicide. A function of the ASPP is to track demographic data on suicidal behaviors to assist Army leaders in the identification of trends. The goal is to minimize suicidal behavior by reducing the risk of suicide for Active Army and Reserve Component Soldiers, Army DA civilians, and Army Family members. The ASPP establishes a community approach to reduce Army suicides through the function of the Community Health Promotion Councils (CHPC). The CHPC integrates multidisciplinary capabilities to assist commanders in implementing local suicide-prevention programs, and establishes the importance of early identification of, and intervention with problems that detract from personal and unit readiness. The ASPP has 3 principle phases or categories of activities to mitigate the risk and impact of suicidal behaviors, prevention, intervention, and postvention.

U.S. Army Resources

www.armyg1.army.mil/hr/suicide/default.asp

2012 National Strategy for Suicide Prevention: Goals and Objectives for Action
http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

DA PAM 600_24 Health Promotion, Risk Reduction, and Suicide Prevention RAR 7 September 2010 http://www.apd.army.mil/pdffiles/p600_24.pdf

U.S. AIR FORCE

The AF Suicide Prevention Program is built on the 11 overlapping core elements listed below stressing leadership and community involvement in the prevention of suicides.

1. Leadership Involvement 2. Addressing Suicide Prevention through Professional Military Education 3. Guidelines for Commanders 4. Unit-based Preventive Services 5. Wingman Culture 6. Investigative Interview Policy 7. Post Suicide Response (Postvention) 8. Integrated Delivery System (IDS) and Community Action Information Board (CAIB) 9. Limited Privilege Suicide Prevention Program 10. Commanders Consultation Assessment Tool 11. Suicide Event Tracking and Analysis

U.S. Air Force Resources

Air Force Suicide Prevention website http://www.afms.af.mil/suicideprevention/index.asp

Air Force Instruction 90-505, 10 August 2012, Special Management Suicide Prevention Program http://www.afms.af.mil/shared/media/document/AFD-130423-030.pdf

U.S. MARINE CORPS

The Marine Corps Suicide Prevention program (MCSPP) establishes policy and provides resources, guidance, and training for suicide prevention programs.

The desired outcome of the MCSPP is a proactive, efficient, and effective strategy to maintain the readiness of both individual marines and their units. This strategy is aligned with the Marine Corps larger, holistic prevention approach to mental health that seeks to develop coping skills, increase resilience, and increase access to and engagement of mental health, healthcare services.

The Marine Corps Manpower and Reserve Affairs website has multiple links to information in reference to the MCSPP.

U.S. Marine Corps Resources

Marine Corps Order 1720.2 Marine Corps Suicide Prevention Program http://www.marines.mil/Portals/59/Publications/MCO%201720.2.pdf

Marine Corps Manpower and Reserve Affairs website https://www.manpower.usmc.mil/portal/page/portal/M_RA_HOME/MF/G_Behavioral%20Health/BH_Community%20Counseling%20and%20Prevention

U.S. NAVY

The Navy's Suicide prevention website provides links to policies, training, and resources. The Navy Suicide Program focuses at the Commander's level.

Commanders play a crucial role in facilitating the local actions that build lives worth living, enhancing resilience, enabling access to support services, and diverting people from a path to suicide. They also help those left behind to pick up and start to heal if the tragedy of suicide does strike.

The first step is for Commanders to designate a Suicide Prevention Coordinator (SPC) and make sure that person gets training to assist in implementing the following steps. 1. Strengthen Your Foundation 2. Enhance Awareness 3. Build Skills 4. Be Prepared 5. Intervene 6. Reintegrate 7. Respond 8. Report

U.S. Navy Resources

Navy Suicide Prevention Website http://www.public.navy.mil/BUPERS-NPC/support/21st_century_sailor/suicide_prevention/Pages/default.aspx

Commanding Officer's Suicide Prevention and Response Toolbox http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/suicide_prevention/Documents/Suicide%20Prevention%20Commander%20Toolbox%2015%20Nov.pdf

U.S. COAST GUARD

United States Coast Guard website, Office of Work-Life Programs- Suicide Prevention Program, has multiple links that will connect the Coast Guard personnel to available services and resources.

The goals of the Coast Guard's Suicide Prevention Program are to:

a. Minimize suicidal behavior among all Coast Guard employees and their family members by empowering all Coast Guard personnel to recognize persons in distress and to take supportive action to help them, b. Encourage help-seeking behavior by reducing the stigma historically associated with receiving mental health care, and c. Protect those who responsibly seek mental health treatment from unfair actions resulting from seeking help.

Measures of success for the Coast Guard Suicide Prevention Program include:

a. Reduced suicidal behaviors. b. Increased awareness of warning signs and circumstances associated with suicidal behavior. c. Increased number of personnel of all ranks who know what to do to assist distressed individuals, and d. An increase in the number of personnel who understand that mental health care can be obtained without risk to one's career.

The Coast Guard Suicide Prevention Program consists of seven components including Command Climate, Crisis Response, Limit on Command Access to Mental Healthcare Information, Notification and Hand-off in Criminal Investigations, Postvention, Reporting, and Training.

U.S. Coast Guard Resources

Commandant Instruction 1734.1A Suicide Prevention Program
http://www.uscg.mil/HEALTH/cg1122/docs/pdf/CI_1734_1A.pdf

United States Coast Guard website Office of Work-Life Programs- Suicide Prevention Program
http://www.uscg.mil/worklife/suicide_prevention.asp

VETERANS

The suicide rate for active duty military personnel has historically been significantly lower than the rate for a comparable population of civilians. However, the number of suicides and suicide attempts has been steadily growing over the past several years.

There are similar concerns within the veteran population. The Center for Disease Control and Prevention estimates that veteran's account for approximately 20% of the deaths from suicide in America. Some 8,000 veterans are thought to die by suicide each year, a toll of about 22 per day, according to a 2012 VA study. These numbers may be a gross underestimation as this number includes only data from 21 states, not including Texas or California. The number of suicides has grown over 11% in the most recent 4 years. In the most recent date the suicide rates for male Veterans Health Administration patients were approximately 1.4 times greater than for other American men. For female veterans involved in VHA services, rates were approximately twice as high as among American women. Approximately half of all suicides in VHA occurred among patients known to have mental health conditions.

VA suicide prevention began earnestly in 2004 with the inception of the Mental Health Strategic Plan. This plan has assisted in increasing core mental health staff on a national level by 50 percent. In addition, the VA suicide prevention program is based on the principle that prevention requires ready access to high quality mental health services within the health care

system, supplemented by public education and awareness, and availability of specific services which address the needs of those at highest risk. Activities which have been sponsored by the suicide prevention network have included creating a national office for suicide prevention, partnering with SAMSHA and its Lifeline program to add a veteran's call center to its national crisis line, funding suicide prevention coordinators with support staff in each VA medical center and initiating public information forums focused on promoting the use of the of the VA mental health services for those in need.

The Veterans Crisis Line connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline, online chat, or text. Veterans and their loved ones can call 1-800-273-8255 and Press 1, chat online, or send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for deaf and hard of hearing individuals is available.

VA is working to make sure that all Veterans and their loved ones are aware of the Veterans Crisis Line. To reach as many Veterans as possible, VA is coordinating with communities and partner groups nationwide, including community-based organizations, Veteran Service Organizations, and local health care providers, to let Veterans and their loved ones know that support is available whenever, if ever, they need it.

Veterans Resources

Veterans Crisis Line http://www.veteranscrisisline.net/

U.S. Department of Defense/U.S. Department of Veterans Affairs Suicide Outreach http://www.suicideoutreach.org/

Murder-Suicide

Murder-suicide is a "dramatic, violent event" in which a person, almost always a man, commits one murder or multiple murders, and then shortly after dies by suicide.[1] According to the most recent edition (fourth edition published in 2012) of the Violence Policy Center's (VPC), "American Roulette: Murder-suicide in the United States," there was no comprehensive national database to accurately track incidents, fatalities, and survivors of murder-suicide events. However the data gathered by the VPC is worth noting as those who have committed homicide, followed by suicide within 72 hours, seems to show specific trends.[2]

The most recent data, gathered by VPC from news reports during the first six months of 2011 shows:

- There were 313 murder-suicide events resulting in 691 total deaths (378 were homicides)
- 280 (89.5%) of these events involved firearms
- 283 (90%) of the 313 perpetrators were male
- 288 (76%) of the 378 homicide victims were female
- 225 (72%) of the events involved an intimate partner; of those, 94% of homicide victims were females
- 55 (14.5%) of the homicide victims were under 18
- 66 children were survivors who witnesses some aspect of one of these events
- 80% of the total events occurred in the home, while 84% of intimate partner events occurred in the home
- 25% of these events involved a perpetrator 55 or over
- There is a subcategory of intimate partner murder-suicide events, in which a man (called a "family annihilator) kills his intimate partner and children, as well as other family members, before dying by suicide

The following are conclusions drawn in the VPC report:

- There are significant fatalities of murder-suicide events that go well beyond the suicide itself, including the deaths of family, friends, co-workers and/or strangers.
- There are significant emotional repercussions, including guardianship changes, for the children of those involved in murder-suicide events.
- Domestic violence is associated with a significant number of murder-suicides. Therefore, intervention and legislation related to domestic violence may be a way to address this issue.
- Depression and failing health have been cited as contributing factors to murder-suicide among older persons.
- The overwhelming use of firearms as the weapon in these events points to the need for efforts that will restrict access to those with some of the risk factors listed above.
- A comprehensive national database of murder-suicide events should be established.

References:

1. Peter M. Murzak et al., "The Epidemiology of Murder-Suicide," *Journal of the American Medical Association* 267, no. 23 (June 1992): 3179-3183.

2. American Roulette: Murder-Suicide in the United States, Fourth Edition by the Violence Policy Center, 2012, as well as related publications can be found at http://www.vpc.org/studyndx.htm.

Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex Populations (LGBTQI)

According to the Kaiser Family Foundation Issue Brief of January 2014 entitled Health and Access to Care and Coverage for LGBT Individuals in the U.S. Who Are LGBT, people who are LGBT (and by extension Q and I), have an elevated risk for some mental health, substance use, and physical health conditions.

Attention to elevated risk for suicide in this population is limited because death certificates do not identify decedent's sexual orientation, gender identity or expression. The Kaiser Foundation report finds that individuals who identify as LGBT are 2.5 times more likely to experience depression, anxiety, and substance misuse. The report reveals that 26% of bisexual females, 11% of bisexual males, 6% of gay males and a 3% rate among all other subgroups have recently considered suicide. In addition, anti-gay bias and homophobia put people who are LGBTQI, and those simply perceived to be, at greater risk for physical violence, with people of color who are transgender at particular risk. People who are transgender have faced some type of discrimination when seeking routine medical care. Persons who are LGBTQI report histories of discrimination and stigma at an unacceptable rate of 66%. People who are LGBTQI are present across all religious, cultural, political, ethnic, socio-economic, gender and racial populations. Some may experience double minority stress, stigma and discrimination, a type of "double jeopardy". LGBTQI persons who are older may be excluded from nursing homes and may need to go "back in the closest" although they were previously "out", and there are adverse financial consequences for LGBTQI couples, even if legally married in another state, leaving them vulnerable to poverty. Closing the knowledge gap, addressing homophobia and ensuring equality among all minorities to reduce stigma and discrimination are necessary factors for the prevention of suicide.

Factors that foster and promote resilience in people who are LGBTQ or I include family acceptance, connection with caring others and a sense of safety, positive sexual/gender identity and availability of quality, culturally appropriate mental health treatment. Strategies for preventing suicide and thoughts and actions in people who are LGBTQI include: reducing sexual orientation and gender related prejudice and associated stressors, improving identification of depression, anxiety, substance use and other mental health conditions, increasing availability and access to LGBTQI affirming treatments and mental health services/supports. An addition goal is to reduce bullying and other forms of victimizations and micro-aggressions that contribute to vulnerability within families, schools, workplaces, and congregate care facilities such as nursing homes and hospitals. It is necessary to enhance factors that promote resilience, including family acceptance and public safety, such as changing discriminatory laws and public policies and reducing suicide contagions. These goals will require collaboration between suicide prevention and LGBTQI organizations to ensure the development of culturally appropriate suicide prevention programs, services and materials, and to facilitate access to care for at-risk individuals.

In 2008 The Office of Mental Health and Substance Abuse Services (OMHSAS) convened a group of stakeholders at the request of the Deputy Secretary to address the needs of people who identify as LGBTQI who seek mental health and substance use treatment within the Pennsylvania managed care system. This group sent 3 major recommendations to the Deputy. First is to protect LGBTQI individuals from discrimination and mistreatment. Next, is to ensure that OMHSAS and contracted providers ensure culturally affirmative environments of care for individuals who identify as LGBTQI. Lastly, to ensure clinically competent behavioral health care for individuals who identify as LGBTQ or I. From this effort two bulletins and a white paper were published and can be found on www.parecovery.org. The bulletins address non-discrimination and guidelines to ensure affirmative environments and clinically appropriate services. It was noted that some clinicians were non-discriminatory and would like to be affirmative and competent; however, had a knowledge gap that needed to be addressed. A white paper addressing so-called conversion therapy was also published to highlight the harm that can be done with this method and noted that all major professional therapeutic groups such as the two APA's and NASW rejected this as competent therapy.

The Keystone Pride Recovery Initiative, KPRI, emerged out of this effort and has engaged in developing and implementing a web based and one day training in creating welcoming environments and a two day training for clinicians who wish to provide competent care. The curriculum was developed in partnership with the Pennsylvania Mental Health Consumers Association, (PMHCA), and Drexel University Behavioral Health Education with a grant from SAMHSA. KPRI is also working on public policy to promote equality and changing discriminatory

laws. Data collection that includes sexual orientation gender identity/expression, for more accurate reporting, is also a goal of the group.

Founded in 1972, the Persad Center headquartered in Pittsburgh is the nation's second oldest licensed counseling center whose mission is to strengthen LGBTQ communities. Outreach, training, advocacy and prevention programs are provided. In Philadelphia, the Pink and Blues support group is a valuable resource in the southeast part of the state. The Lesbian, Gay, Bisexual, Transgender Elder Initiative (LGBTEI) serves the Delaware Valley and beyond to protect and expand the rights of LGBTQI older adults as well as advocate for services and resources that are competent, culturally sensitive, inclusive and responsive to the needs of elders who identify as LGBT. There are large areas in Pennsylvania that do not have resources close by, however, resources may be available by contacting the above organizations and there are national organizations listed in the resource section.

Allies have been effective in promoting positive change in the dominant culture on issues of equality. An ally is a person who is a member of the dominant, majority heterosexual group who works to end oppression in his or her professional life through support and advocacy of the minority LGBTQI group. They speak out about discrimination and the denial of legal powers and privileges for people who are LGBTQI. They are a tremendous support and force for justice in the LGBTQI community.

Appendix B: Definitions*

Bereaved by suicide - Family members, friends, and others affected by the suicide of a loved one (also referred to as suicide loss survivors).

Best practices - Activities or programs that are in keeping with the best available evidence regarding what is effective.

Contagion - A phenomenon whereby susceptible persons are influenced toward suicidal behavior through knowledge of another person's suicidal acts.

Culturally competent - A set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures, including the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Means - The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs)

Means restriction - Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Methods - Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).

Older Adults - Persons aged 60 or more years.

Postvention - Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.

Risk factors - Factors that make it more likely that individuals will consider suicide. Risk facts may encompass biological, psychological, or social factors in the individual, family, and environment.

Substance use "condition" - A pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances (such as alcohol); prescription drugs (such as analgesics, sedatives, tranquilizers, and stimulants); and illicit drugs (such as marijuana, cocaine, inhalants, hallucinogens, and heroin).

Suicide - Death cause by self-directed injurious behavior with any intent to die as a result of the behavior

Note: The term "committed" suicide is discouraged because it connotes the equivalent of a crime or sin. The Center for Disease Control has also deemed "completed suicide" and "successful suicide" as unacceptable. Preferred terms are "death by suicide" or "died by suicide"

Suicidal thoughts and actions - Includes thoughts related to suicide, including preparatory acts, as well as suicide attempts and deaths. The term suicidal behavior is commonly used in the field but has been replaced by thoughts and actions throughout the document.

Suicide attempt survivors - Individuals who have survived a prior suicide attempt.

Suicide loss survivors - See bereaved by suicide.

*Definitions taken from the National Strategy for Suicide Prevention and the Suicide Prevention Resource Center.

Appendix C: Risk and Protective Factors

RISK FACTORS FOR SUICIDE

- Previous suicide attempt
- Diagnosis of depression
- Family history of suicide
- Recent loss including one or more of the following: independence, health status, job, home, money
- Death or terminal illness of a loved one
- Divorce or loss of major, significant relationship
- Loss of health, either real or imagined
- Someone close to the person has died by suicide
- Recent disappointment or rejection
- Being expelled from school/fired from job
- Sudden loss of freedom/fear of punishment
- Victim of assault or bullying

PROTECTIVE FACTORS

- Strong bonds with friends and family
- Restricted access to lethal means
- Effective and appropriate clinical care for mental, physical and substance use conditions
- Easy access to a variety of clinical interventions and support for seeking help
- Community support
- Support from ongoing medical and mental health relationships
- Life skills such as decision making, conflict resolution, anger management, non-violent ways of handling disputes and problem solving
- Strong beliefs in the meaning and value of life
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts
- HOPE for the future

Appendix D: Warning Signs of Suicide and What to do:

WARNING SIGNS OF SUICIDE*

- Talking about wanting to die;
- Looking for a way to kill oneself by seeking access to firearms, available pills, or other means;
- Talking or writing about death, dying or suicide;
- Talking about feeling hopeless or having no purpose;
- Suddenly happier and calmer, especially after a period of depression or sadness;
- Giving away prized possessions;
- Getting affairs in order, making arrangements;
- Talking about feeling trapped or being in unbearable pain;
- Talking about being a burden to others;
- Increasing the use of alcohol or drugs;
- Acting anxious, agitated, or reckless;
- Sleeping too little or too much;
- Withdrawing from friends, family and society or feeling isolated;
- Showing rage or talking about seeking revenge; and
- Displaying extreme mood swings.

The more of these signs a person show, the greater the risk of suicide.

WHAT TO DO

If someone you know exhibits signs of suicide:

- Do not leave the person alone;
- Remove any objects that could be used in a suicide attempt;
- Call the U.S. National Suicide Prevention Lifeline at 800-273-TALK/8255; and
- Take the person to an emergency room or seek help from a medical or mental health professional.

*Adapted from Recommendations for Reporting on Suicide website (www.reportingonsuicide.org.; the National Council for Suicide Prevention (www.ncsponline.org/suicide-prevention/warningsigns) and the Pa Adult and Older Adult Suicide Prevention Coalition http://preventsuicidepa.org/

HERE IS AN EASY-TO-REMEMBER MNEMONIC ON THE WARNING SIGNS OF SUICIDE**

IS PATH WARM?

I Ideation
S Substance Abuse

P Purposelessness
A Anxiety
T Trapped
H Hopelessness

W Withdrawal
A Anger
R Recklessness
M Mood changes

If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral

** Taken from the American Association of Suicidology (www.suicidology.org)

Appendix E: Resources/Websites

FOR IMMEDIATE HELP OR SUPPORT CALL THE NATIONAL SUICIDE PREVENTION LIFELINE AT 1-800-TALK (8255) or ONLINE at www.suicidepreventionlifeline.org

For direct access to websites below, place your cursor over the website and hit the control button and left mouse button together.

American Association of Suicidology (AAS)
www.suicidology.org

American Foundation for Suicide Prevention (AFSP)
www.afsp.org

Crisis Link: Prevention, Intervention, Support and Training
www.crisislink.org

LGBT Youth Suicide
www.eriegaynews.com

The Link's National Resource Center
www.thelink.org

National Alliance on Mental Illness (NAMI)
www.nami.org

LivingWorks Education Inc.
www.livingworks.net

Means Matter, Harvard School of Public Health
www.hsph.harvard.edu/means-matter

Metanoia
www.metanoia.org/suicide

National Council for Suicide Prevention (NCSP)
www.ncsponline.org

National P.O.L.I.C.E. Suicide Foundation
www.psf.org

Law Enforcement Suicide Prevention
http://policesuicide.spcollege.edu

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org

National Organization of People of Color
Against Suicide (NOPCAS)
www.nopcas.com

Norman Institute - gender orientation
1-816-960-7200

QPR Institute
www.qprinstitute.com

Samaritans USA
www.samaritiansnyc.org

Suicide Awareness Voices of Education (SAVE)
www.save.org

Centre for Suicide Prevention
www.suicideinfo.ca

Suicide Anonymous
www.suicideanonymous.net

Action Alliance for Suicide Prevention
www.actionallianceforsuicideprevention.org

Suicide Prevention Resource Center (SPRC)
www.sprc.org

Tears of a Cop
www.tearsofacop.com

Trevor Helpline (LGBTQ Youth)
www.thetrevorproject.org

Veterans
www.veteranscrisisline.net

FEDERAL GOVERNMENT SOURCES:

Centers for Disease Control (CDC)
http://www.cdc.gov/ViolencePrevention/pdf/Suicide-DataSheet-a.pdf

CDC-US Mortality Statistics
www.cdc.gov/ncipc/wisqars/

National Council for Suicide Prevention (NCSP)
www.ncsp.org

National Institute of Mental Health (NIMH)
http://nimh.nih.gov/health/topics/suicide-prevention/index.shtml

Action Alliance for Suicide Prevention (AASP)
www.actionallianceforsuicideprevention.org

The Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov

NATIONAL STRATEGY DOCUMENTS:

National Strategy for Suicide Prevention-National Action Alliance for Suicide Prevention
www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html
www.actionallianceforsuicideprevention.org/NSSP
www.samhsa.gov/nssp

Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead, 2010
Educational Development Center, Inc.
www.sprc.org/library/ChartingTheFuture_Fullbook.pdf

Reducing Suicide: A National Imperative, 2002
Institute of Medicine
http://www.nap.edu/openbook.php?isbn=0309083214

STATE SOURCES:

Pennsylvania Adult and Older Adult Suicide Prevention Coalition
www.PreventSuicidePA.org

Pennsylvania Youth Suicide Prevention
www.payspi.org

PA Recovery
www.parecovery.org

Center for the Prevention of Suicide
www.med.upenn.edu/suicide/

Philly Health Info
http://phillyhealthinfo.org/

Mental Health and Aging
www.mhaging.org

Pink and Blues (LGBTQI resource)
http://www.pinkandblues.info

Pennsylvania Mental Health Consumers Association
Keystone Pride Recovery Initiative- LGBTQI
http://pmhca.org/projects/kpri.html

YOUTH SUICIDE PREVENTION SOURCES:

Active Minds
www.activeminds.org

Jason Foundation
www.jasonfoundation.com

The Jed Foundation
www.jedfoundation.org

School Based Youth Suicide Prevention Guide
http://theguide.fmhi.usf.edu/

Signs of Suicide-Suicide Prevention Program for Secondary Schools (SOS)
www.mentalhealthscreening.org/highschool/index.aspx

Services for Teens at Risk Center (STAR)
www.wpic.pitt.edu/research/star/default.htm

TeenScreen: Adolescent Suicide and Mental Health Screening Programs
www.teenscreen.org

Youth Suicide Prevention Program
www.yspp.org

Yellow Ribbon Youth Suicide Prevention Program
www.yellowribbon.org

MEDIA REPORTING ON SUICIDE:

Picture This: Depression and Suicide Prevention, 2009
www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf

Recommendations for Reporting on Suicide, 2011
www.reportingonsuicide.org

EVIDENCE-BASED AND BEST PRACTICES FOR SUICIDE PREVENTION:

Best Practices Registry for Suicide Prevention
Suicide Prevention Resource Center (SPRC) and American Foundation for Suicide Prevention (AFSP)
www.sprc.org/bpr

National Registry of Evidence-Based Programs and Practices
SAMSHA, HHS
www.nrepp.samhsa.gov

SUICIDE DATA:

National Violent Death Reporting System (NVDRS)
Centers for Disease Control and Prevention (CDC), HHS
www.cdc.gov/injury/wisqars/nvdrs.html

Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0, 2011. National Center for Injury Prevention and Control, CDC, HHS
www.cdc.gov/ViolencePrevention/pub/selfdirected_violence.html

Appendix F: Summary of Four Regional "Listening Sessions" on the Plan and Summary of Survey

The Pennsylvania Adult and Older Adult Suicide Prevention Plan Advisory Committee hosted four regional listening forums, via webinar, during January, 2014. The purpose of the forums was to solicit broad stakeholder input into the revised adult and older adult suicide prevention plans. During these forums, the participants on the line were asked to respond to seven questions. The questions were developed to capture ideas related to the objectives in the 2005 Pennsylvania Adult and Older Adult Suicide Prevention Plans. The same seven questions were asked during each forum and the feedback that was given was incorporated into the revised objectives and action steps within the 2014 Pennsylvania Adult and Older Adult Suicide Prevention Plans. More than 50 individuals attended the listening sessions including state employees, providers, counties, managed care organizations and consumers of service. Listed below are the seven questions used in the forums followed by the major recommendations related to each question.

QUESTION 1: WHAT ARE THE WAYS IN WHICH PENNSYLVANIA CAN PROMOTE AWARENESS THAT SUICIDE IS A PUBLIC HEALTH PROBLEM THAT CAN BE PREVENTED?

- The use of the internet (Facebook, twitter, etc.)
- Billboard campaigns, advertising through the media- radio, television, on buses etc.
- Promote phone numbers for crisis centers, advertise hotlines and chat rooms for crisis intervention, distribute pamphlets/brochures to include statistics and information on prevention and help.
- Encourage health providers and others to talk about suicide prevention and provide more information on the topic.
- Provide continuing education such as Question, Persuade, Refer (QPR) and Mental Health First Aid.
- Celebrity endorsements.

QUESTION 2: HOW CAN PENNSYLVANIA PROMOTE COLLABORATION AMONG A BROAD SPECTRUM OF AGENCIES AND INSTITUTIONS FROM COLLEGES TO FAITH-BASED ORGANIZATIONS TO PREVENT SUICIDE?

- Host the state suicide prevention conference annually
- Provide technical assistance and support to county suicide prevention taskforces including a how-to manual and quarterly networking calls
- Network with the Garrett Lee Smith grant around risk screening
- Consider Applied Suicide Intervention Skills Training (ASIST)

- Identify churches to take responsibility
- Have managed care conduct performance standards

QUESTION 3: WHAT ACTIONS CAN PENNSYLVANIA TAKE TO REDUCE THE STIGMA ASSOCIATED WITH MENTAL "ILLNESS" AND SUBSTANCE "ABUSE", INCLUDING NEGATIVE PORTRAYALS IN THE MEDIA, IN ORDER TO CONNECT PEOPLE WITH SERVICES AND PREVENT SUICIDE?

- Educate through presentations on radio, Lions, Kiwanis, schools, etc.
- Educate staff in emergency rooms, police, corrections officers, etc.
- Use information on AFSP.org on how to work with the media
- Host media awards.
- Have survivors of suicide attempts, suicide loss tell their stories.

QUESTION 4: HOW CAN PENNSYLVANIA INSTILL PREVENTIVE INTERVENTIONS INTO LOCAL COMMUNITIES SUCH AS HEALTH CENTERS, UNIVERSITIES, SENIOR CENTERS, CORRECTIONAL FACILITIES,ETC.?

- Implement risk assessments in physicians' offices.
- Network with Active Minds-that works with college students with mental health issues.
- Have a speakers bureau for presentations
- Provide funding for state lead on suicide
- Engage health providers through the Dept of Health

QUESTION 5: IN WHAT WAYS CAN PENNSYLVANIA REDUCE ACCESS TO LETHAL MEANS AND METHODS OF SELF-HARM?

- Firearms issue is a balancing act between protecting lives and protecting rights.
- Need to look at Harvard University Means Matters project
- Promote voluntary turning in of medications, weapons.
- Need to look at "accidental" medication overdoses among the elderly.
- Gun safes and gun locks are important
- Free resource on lethal means counseling on SPRC.org

QUESTION 6: HOW SHOULD PENNSYLVANIA TARGET TRAINING AND BEST PRACTICE INTERVENTIONS FOR PROFESSIONALS AS WELL AS COMMUNITY GATEKEEPERS SUCH AS POLICE, CLERGY, TEACHERS, ETC., SO THEY HAVE THE SKILLS TO IDENTIFY RISK AND MAKE REFERRALS TO PREVENT SUICIDE?

- Post discharge follow-up is important after a crisis. Is there a way to reinforce through regulations? Could use crisis programs and peer specialists to do.
- Training across the board is needed. Bill in process would require teachers to be trained
- Can we require training such as MH First Aid or QPR for mental health and drug and alcohol providers and others?
- Encourage a variety of training: Mental Health First Aid, Question, Persuade and Refer, ASIST, Means Matters, AFSP training for survivor support groups, etc.
- Lobby credentialing agencies to require training in their standards.

QUESTION 7: WHAT DOES PENNSYLVANIA NEED TO DO TO PROMOTE RESEARCH AND DATA COLLECTION IN ORDER TO BETTER UNDERSTAND SUCH THINGS AS WHY INDIVIDUALS BECOME SUICIDAL, WHERE AND WHY SUICIDES ARE HAPPENING AND WHAT INTERVENTIONS REDUCTE SUICIDE?

- Should require consistent reporting by coroners and others
- Suicide rating scale, or something similar, should be required screening with all intakes.
- What is the role of managed care in setting standards?

The above seven questions, plus an additional question listed below, were used to gather statewide input into the Adult and Older Adult Suicide Prevention Plans through "Survey Monkey". The survey was made available during the months of January and February, 2014. A summary of the survey results is listed below. The full survey results will be posted on www.parecovery.org following the publication of this plan.

A total of 154 individuals responded to the survey. Of that total, 69% (100) were females and 28% (44) were males. One person self-identified their gender and two persons choose not to disclose their gender. The largest numbers of respondents (50%) were ages 41-59, while 32% were age 22-40 and 18% were age 60 or older. The vast majority (87%) of individuals completing the survey identified as white (135) and 59% identified as mental health professionals. However, community members, social service employees, state and county employees, suicide loss survivors, suicide attempt survivors, persons in drug and alcohol recovery, emergency workers, veterans and military personnel also participated in the survey.

Participants were asked to choose their top recommendations from the forced choice answers to each question provided in the survey.

QUESTION 1:

Providing public education was the number one recommendation to promote public awareness that suicide is preventable with 114 people identifying this as one of their top three choices. In addition, 86 people recommend targeting policy makers to promote prevention policies and programs while 83 individuals suggest promoting the national and local suicide crisis lines.

QUESTION 2:

In order to promote broad collaboration on suicide prevention, 110 individuals recommend identifying a lead state and local agency to bring together partners to work on suicide prevention. Including suicide prevention as a quality management goal in HealthChoices was prioritized by 88 individuals.

QUESTION 3:

Actions to counter negative portrayals of mental illness and substance use in the media include public awareness campaigns that promote recovery from mental health and substance use disorders as real and possible (121 responses) and the inclusion of survivors and advocates in curriculum development (108 responses).

QUESTION 4:

In order to instill suicide prevention into local organizations, 108 persons recommend promoting suicide risk assessments in community and social service agencies. Increasing the number of suicide prevention plans within these organizations was suggested by 97 individuals.

QUESTION 5:

Education was the overwhelming recommendation to reduce access of lethal means of self-harm. Educating family members (91responses), educating the public (89 responses) and educating health care and safety officials (85 responses) are highly recommended.

QUESTION 6:

Health professionals (102 responses) and the community (110 responses) were the primary audiences targeted to receive training to increase skills to prevent suicide. Regarding best practices, 104 people recommend the implementation of programs for high risk individuals and 102 persons suggest rapid follow-up following crisis inpatient stays.

QUESTION 7:

Regarding data collection, 99 individuals recommend the development of indicators for evaluating the effectiveness of suicide prevention interventions. Increasing the number of jurisdictions that collect information on suicide was recommended by 77 persons.

QUESTION 8: WHAT CAN PENNSYLVANIA DO TO HELP PEOPLE WHO HAVE SURVIVED SUICIDE LOSS?

Question 8 was added to the survey at the request of the Adult and Older Adult Suicide Prevention Advisory Committee. The majority of respondents (100) recommended providing information to first responders on how to deal with the aftermath of suicide including responding to caregivers need for support.

Appendix G: Pennsylvania Adult and Older Adult Suicide Prevention Plan Advisory Committee

Rebecca May-Cole
Chair, PA Adult and Older Adult Suicide Prevention Plan Coalition
PA Behavioral Health and Aging Coalition

Lynn Patrone
PA Office of Mental Health and Substance Abuse Services

Angela Roland
PA Office of Mental Health and Substance Abuse Services

Peggy Thatcher
PA Mental Health Consumers Association (PMHCA) and Pa Adult and Older Adult Suicide Prevention Coalition (PAOASPC)

Joseph Alex Martin
Keystone Pride Recovery Initiative (KPRI) and PMHCA

Mark Davis
KPRI and PMHCA

Carol Baker
OMHSAS Older Adult Advisory Committee

Susan Bartholomew-Palmer
OMHSAS Older Adult Advisory Committee

Ginny Dikeman
PA Office of Mental Health and Substance Abuse Services
KPRI

Leslie Coombe
PA Department of Health

Amy Comarnitsky
PA Department of Aging and PAOASPC

Kelly Jean McEntee
PAOASPC

Betty Simmonds
PAOASPC

Saya Krebs
PAOASPC

Deb Shoemaker
PA Psychiatric Society
PA Adult Advisory Committee

Sol Vazquez
PA Adult Advisory Committee

Sarah Lambert
Department of Military and Veterans Affairs

Mark Todero
Department of Military and Veterans Affairs

Lisa Kugler
Value Options

Dawn Diehl
Value Options

Olga Thornton
Delaware County Suicide Prevention Taskforce

Steve Seitchik
Department of Drug and Alcohol Programs

Steve Nevada
Franklin County Mental Health/Intellectual Disabilities

Jerold Ross
Chief Deputy Coroner, Lycoming County

Tim Boyer
Lehigh County MH/ID

Bob Marsh
Department of Corrections

Lucas Malishchak
Department of Corrections

Karen Mallah
Community Care Behavioral Health

Harold Jean Wright
Philadelphia Dept. of Behavioral Health and Intellectual Disability Services

Joan Stakem
Bureau of Veterans Homes
PA. Dept. of Military and Veterans Affairs

Angela Keen
Veterans' Integrated Service Network 4

Carol Ward-Colasante
Project Consultant

Appendix H: References

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12. What is Zero Suicide? National Action Alliance For Suicide Prevention, www.zerosuicide.com
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Prevention: Goals and Objectives for Action. Washington, DC: HHS, September, 2012 Pg. 67

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20. Suicide Prevention

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised **National Strategy for Suicide Prevention (2012).**

   Response: Pennsylvania's Suicide Prevention Plans for Adults, Older Adults, and Youth are each attached as separate documents.

2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.

   Response: Many different at-risk populations are addressed in Appendix A of the Pennsylvania Suicide Prevention State Plan, including individuals with mental health and/or substance use, individuals involved with the Department of Corrections or law enforcement, members or the armed forces and veterans, LGBTQI individuals, etc. This appendix is not an all-inclusive list. Eliminating health care, race, ethnic, gender, education, income, disability, age, sexual orientation, gender identity, and geographic disparities that erode suicide prevention activities, is a key priority in Pennsylvania.

3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document **Guidance for State Suicide Prevention Leadership and Plans.**[100]

   Response: Pennsylvania does not have a specific strategic plan separate from the Suicide Prevention State Plan.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG 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 SMA 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 justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

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

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

21. Support of State Partners

Pennsylvania enjoys a large and diverse Advisory structure. Comprised of an Adult, Children's, and Older Adult Committee, as well as a "*Persons in Recovery"* Subcommittee, the cumulative membership exceeds 90 individuals. The Advisory Committee draws membership from consumers/survivors, family members, county officials, behavioral health providers, advocates, and other professional mental health and state agencies. The Committee deliberates on issues and initiatives related to OMHSAS's mission that "Every individual served by the Mental Health and Substance Abuse Service 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 members and friends."

The Commonwealth recognizes the importance of bringing a multitude of stakeholders to the Committee and has partnered with The Office of Medical Assistance Programs (the State's Medicaid Authority), The Office of Children, Youth and Families (the State's child welfare agency), The Office of Vocational Rehabilitation, The Pennsylvania Department of Corrections, The Pennsylvania Department of Education, The Bureau of Drug and Alcohol Services (the State's substance abuse agency), The Pennsylvania Housing Finance Agency, and the Pennsylvania Department of Aging.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[97]

Additionally, **Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51)** applicable to the SABG and the MHBG, requires that, 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.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

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.

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

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
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.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] **http://beta.samhsa.gov/grants/block-grants/resources**

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Community Mental Health Block Grant Work Group

Agenda July 6, 2015

- Introductions
- Grant Overview
- Needs Assessment Report
- Review Past Priorities
- Discussion: Setting priorities for 2016-2017

In attendance: Joseph Martin (Adult Committee), Elizabeth Leen (Adult Committee), Carol Baker (Older Adult Committee), Gloria McDonald (Children's Committee), and OMHSAS Staff (Benny Varghese, Amanda Roth, Jill Stemple, Jamey Welty and Howard Biederman).

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22. State Behavioral Health Advisory Council

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

   Response: A stakeholder workgroup was convened with representation from each of the committees (Adult, Older Adult, Children's and Persons in Recovery) to identify and develop Pennsylvania's state priorities. Meeting Agenda and attendees attached.

2. What mechanism does the state use to plan and implement substance abuse services?

   Response: Pennsylvania's Mental Health Planning Council has a subcommittee charged with bringing the issues and needs relevant to the co-occurring population before the Adult, Older Adult, and Children's committees. Members of the Persons in Recovery subcommittee are voting members that sit on each of three aforementioned committees. The Bureau of Drug and Alcohol Programs (the State's substance abuse agency) also has representation on the Advisory Committee and is able to advise on initiatives, regulations, and licensure as it pertains to integrated treatment for individuals with co-occurring disorders.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

   Response: The Commonwealth's Mental Health Planning Council has a "*Persons in Recovery"* (PIR) subcommittee whose primary focus is on substance use issues and co-occurring psychiatric and substance use issues. They are currently engaged in promoting recovery awareness for both disorders and exploring opportunities to increase public awareness of the resources available in the state to support prevention, treatment and recovery from substance use and co-occurring disorders. At each quarterly committee meeting, a representative from the Persons in Recovery (PIR) subcommittee provides an update on the work and initiatives currently in progress. At the September meeting, the PIR subcommittee engages the entire Planning Council in "Celebrating Recovery," which promotes further awareness and education of substance abuse issues in recognition of SAMHSA's National Recovery Month. This provides an opportunity to showcase the work that has been accomplished in the state at agency, county, and individual levels. The PIR subcommittee has been part of the Planning Council for the past two years and continues to identify substance use and co-occurring issues that impact the work of the Council. The PIR sub-committee provides voices for individuals in recovery, family members, and recovery organizations across the state.

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

   Response: Yes.

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.

   Response: The responsibilities of the Mental Health Planning Council are outlined in the OMHSAS Advisory Committee Protocol. The protocol states, "It is the responsibility of all Committee members to be cognizant of and actively participate in fulfilling expectations as representatives of the broad range of individuals served by PA Office of Mental Health & Substance Abuse Services – Advisory Committees' Protocol 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; and
   C. To monitor, review, and evaluate, not less than once every year, the allocation and adequacy of mental health services within the State.

   The document can be accessed in its entirety at:
   http://www.parecovery.org/advisory_materials/Advisory_Committee_Protocols.pdf

   OMHSAS and the Planning Council seek meaningful input from consumers and stakeholders around the development and delivery of behavioral health services in the Commonwealth during the regular meetings of the Council. All meetings are open to the public and individuals who are not committee members, called "sunshine members", also have the opportunity to participate in discussions and provide feedback directly through evaluation forms available at every meeting. OMHSAS also sends out information and solicits feedback via a listserv that includes stakeholders, consumers, family members, and professionals from every area of the state.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Marilyn Baker	Family Members of Individuals in Recovery (to include family members of adults with SMI)	No agency/organization affiliation	PO Box 1024 Paoli, PA 19301 PH: 610-296-0377	mvbaker@verizon.net
Carol Baker	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	No agency/organization affiliation	70 Swarmers Lane Lewistown, PA 17044 PH: 717-645-5622	sdb5@psu.edu
Jazmin Banks	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Foster, Adoptive and Kinship Support (FAKS)	PO Box 23144 Philadelphia, PA 19124 PH: 215-744-0402	jazmin.banks@comcast.net
Susan Bartholomew-Palmer	Family Members of Individuals in Recovery (to include family members of adults with SMI)	No agency/organization affiliation	63 Covell St. Wilkes-Barre, PA 18702 PH: 570-262-6760	barth@epix.net
Thomas Brandon	Family Members of Individuals in Recovery (to include family members of adults with SMI)	No agency/organization affiliation	28 Pennsylvania Ave. Brookville, PA 15825 PH: 814-849-3228	tpbrandon@windstream.net
Diana Brocious	Parents of children with SED	Western PA Partnership for Family Support	431 Dever Hollow Rd. Templeton, PA 16259 PH: 800-947-4941	pasocdianna@hotmail.com
Gail Cash	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health Assn of NW PA (MHANP)	1038 Newton Ave. Erie, PA 16511 PH: 814-899-0997	wooledge001@juno.com
Tim Connors	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health Assn of SE PA (MHASP)	37 State Rd Apt A-11 Media, PA 19063 PH: 610-721-9773	tjconnors@magellanhealth.com
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Lisa Fox	Providers	The Bradley Center	5180 Cambells Run Rd Pittsburgh, PA 15205 PH: 412-788-8219	lfox@thebradleycenter.org
Jim Gavin	Providers	Community Care Behavioral Health (CCBH)	One Chatham Ctr Ste. 700 Pittsburgh, PA 15219 PH: 412-454-2146	gavinjg@ccbh.com
Sandra Goetze	Family Members of Individuals in Recovery (to include family members of adults with SMI)	No agency/organization affiliation	416 E. New Castle Zelienople, PA 16063 PH: 724-452-4279	sgoetze@zoominternet.net
Keith Graybill	State Employees	Juvenile Court Judge's Commission	PA Judicial Center 601 Commonwealth Ave, Suite 9100, PO Box 62425 Harrisburg, PA 17120 PH: 717-705-9006	kgraybill@pa.gov

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Denise Holden	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	RASE	100 North Cameron Street Harrisburg, PA 17101 PH: 717-232-8535	sasirase@aol.com
Darryl Holts	Others (Not State employees or providers)	Disability Rights Network of PA	701 Law & Finance Bldg, 429 Fourth Ave Pittsburgh, PA 15219 PH: 412-258-2129	dholts@drnpa.org
Robin Horst-Spencer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Message Carriers of PA	5907 Penn Ave, Suite 215 Pittsburgh, PA 15206 PH: 412-363-5468	messagecarriers50@gmail.com
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Lynn Keltz	Others (Not State employees or providers)	PA Mental Health Consumers Assn (PMHCA)	4501 Derry St Harrisburg, PA 17111 PH: 717-564-4930	lynn@pmhca.org
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Sharon LeGore	Family Members of Individuals in Recovery (to include family members of adults with SMI)	MOMSTELL	PO Box 450 Mechanicsburg, PA 17055 PH: 717-730-2020	ssmith@momstell.org
Denise Stewart	Providers	Delaware County Office of Services for the Aging (COSA)	206 Eddystone Ave. 2nd Fl Eddystone, PA 19022 PH: 610-565-3044	stewartdv@co.delaware.pa.us
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Julie Weaver	Providers	PA Community Providers Assn (PCPA)	320 Highland Drive Mountville, PA 17554 PH: 717-285-7121	weaveri@csgonline.org
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David Wooledge	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	PA Mental Health Consumers Assn (PMHCA)	c/o Mental Health Association of Northwestern Pennsylvania, 1101 Peach Street Erie, PA 16501 PH: 814-602-0510	wooledge001@juno.com
Harry Barr	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	No agency/organization affiliation	364 Jefferson Avenue Sharon, PA 16146 PH: 724-342-3716	hdb1948@yahoo.com
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Jamie Buchaneaur	Others (Not State employees or providers)		PO Box 8600 PA PH: 717-561-5308	jbuchaneaur@haponline.org
Rob Feguer	State Employees	OMAP, Bureau of Policy, Analysis and Planning	116 East Azalea Drive, Room 158 Harrisburg, PA 17110 PH: 717-409-3460	rfeguer@pa.gov
Douglas Hickey	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		347 Fulton Street South Waverly, PA 18840	
Donna Mick	State Employees	DHS, Office of Children, Youth and Families	625 Forster Street, Room 105 Harrisburg, PA 17102 PH: 717-409-3310	domick@pa.gov
Debra Tack	Family Members of Individuals in Recovery (to include family members of adults with SMI)		276 Montbello Farm Road Duncannon, PA 17020 PH: 717-919-6319	dtack@commonsenseadoption.org
Elizabeth Zeisloft	State Employees	Department of Education, Bureau of Special Education	333 Market Street, 7th Floor Harrisburg, PA 17126 PH: 717-783-6894	ezeisloft@pa.gov

Barbara Deppen	State Employees	Department of Aging, Bureau of Aging Services	PH: 717-425-5115	bdeppen@pa.gov

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	**63**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	15	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	14	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)		
Others (Not State employees or providers)	12	
Total Individuals in Recovery, Family Members & Others	**42**	**66.67%**
State Employees	7	
Providers	14	
Federally Recognized Tribe Representatives	0	
Vacancies		
Total State Employees & Providers	**21**	**33.33%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Persons in recovery from or providing treatment for or advocating for substance abuse services		

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Substance Abuse and Mental Heallh Services Administrati on
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 6 2015

Mr. Dennis Marion
Office of Mental Health and Substance
Abuse Services
20 Azalea Drive
Harrisburg, PA 17110

Dear Mr. Marion:

The Substance Abuse and Mental Health Services Administration 's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy ofthe authorizing legislation (42 USC§ 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/TetTitory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment ofthe FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BOAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regard ing the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(l) and 1932(a)(1) of Title XIX, Pmi B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Mm·yland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BOAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respecti ve State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

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pce

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Jill Stemple
Donis Arena
Lynn Keltz
David Wooledge

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory