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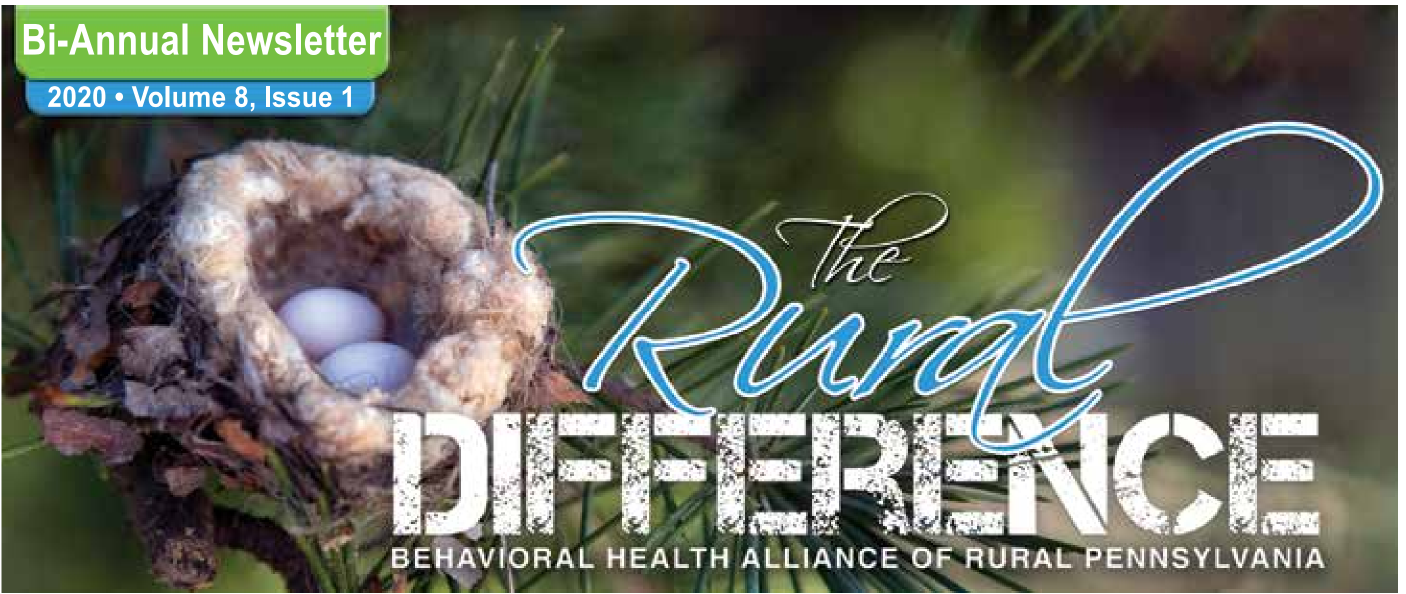

Parenting with Love and Limits in the BHARP Counties

In September 2019, CMSU (Columbia/Montour/Snyder/Union) was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) continuation grant on behalf of the 23 BHARP counties. As with the first SAMHSA grant, the counties are differentiated into Tier-One and Tier-Two counties. There are 14 Tier-One counties, which will be implementing the evidence-based practice targeted in this grant. That practice is the Savannah Family Institute's Parenting with Love and Limits (PLL) program developed by Dr. Scott Sells and it will be implemented within the Intensive Behavioral Health Services (IBHS) level of care within the counties.

PLL is an evidence-based treatment for youth with varied externalized and internalized symptomology. The model is designed to restore the parental and caregiver hierarchy while strengthening the bonding within the family system by utilizing brief and structural strategic family therapy within the home setting. The treatment improves parental and caregiver engagement and assists the youth in decreasing behavioral symptomology and conflict within the home setting while increasing healthy and adaptive behaviors.

PLL is highly effective for diverse populations and symptomology. The treatment is designed for individuals between ages 10-18 who exhibit behaviors including physical aggression, withdrawal, self-injurious, promiscuity, drug and alcohol use, truancy, anxiety, depression, rule breaking, and attention problems. It is effective for youth who live in the home setting with a caregiver/relative, reside in foster care, or in adoptive home settings, as well as those involved in juvenile justice, or with children

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and youth services. PLL can be used as a step-down service for youth in detention or residential treatment as well as a diversionary service for residential services.

The model is highly scripted and approaches treatment in a completely new manner in comparison to typical IBHS services. The initial contact is designed to motivate and assist the family in investing in the service rather than a phone call to schedule an appointment. The communication is designed to identify strengths and family goals from the first family contact which continues throughout treatment.

PLL is strengths-based and works with the family to expand on strengths as well as educate how to move forward with a functional, structured, safe, and nurturing environment in the home setting. In order to fine tune treatment interventions, the treatment plan and family contracts are reviewed for efficacy with the PLL consultant. If the family struggles to commit to treatment, the in-home PLL therapist or "coach" can review the difficulties with the Savannah Consultant for additional assistance in identifying strategies to move the family forward.

"The service is highly effective in treating recent as well as generational trauma which heavily impacts family systems."

The service is delivered by a master's level clinician who has been extensively trained and certified by the Savannah Family Institute's PLL experts. The training is intense, and the model is challenging to implement due to being highly scripted, thus resulting in consistent evidence-based delivery of the model. PLL coaches have access to 24-hour consultation and receive both supervision and consultation from the Savannah Family Institute's clinical staff with PLL expertise. While the commitment to maintain fidelity to the model is extensive, the benefits are immense. The average length of service is 78 days compared to nine months of residential treatment or traditional eclectic mobile therapy. The treatment has a clear beginning, middle and end giving the youth and family hope in making significant improvements within the family system. The service is highly effective in treating recent as well as generational trauma which heavily impacts family systems and significantly impairs the caregiver's ability to parent optimally.

With the implementation of PLL, caregivers and youth can begin to focus on more typical problems faced by families and youth and recover the enjoyment that may have been lost through the conflict previously occurring within the home setting. This is a much-needed approach to enhance the lives of families and youth and to provide the opportunity to continue to develop a healthy and enjoyable relationship where strengths, effort and accomplishments can be the focus of conversation between caregiver and youth.

If you are interested in learning more about Parenting with Love and Limits, please go to www.gopll.com.

New Deal for Housing Plan Introduced

Pennsylvania needs a bold and aggressive plan to address the Commonwealth's affordable housing crisis. This need led Senator Vincent Hughes (D-Philadelphia/Montgomery) to introduce the New Deal for Housing plan, a multi-year effort to transform housing opportunities and conditions for individuals and families struggling across Pennsylvania. This plan focuses on addressing housing issues for domestic violence survivors, homeless veterans, people living in houses with toxic conditions, victims of housing discrimination, and individuals and families seeking affordable housing options.

According to information from the National Low-Income Coalition, Pennsylvania has a shortage of more than 279,000 affordable rental homes. In order to afford a two-bedroom rental at the HUD Fair Market Rent Rate, a family must have an annual income of more than $40,000, which is more than double the annual salary of an individual working at a minimum wage job 40 hours a week, 52 weeks a year.

"The New Deal for Housing plan introduces four proposals to address the need for affordable housing."

The New Deal for Housing plan introduces four proposals to address the need for affordable housing. The first proposal would remove the limit on the amount of money from the Redevelopment Assistance Capital Program (RACP) to fund certain housing projects. In addition, a minimum of 10% of the maximum available for RACP would be dedicated for housing that serves victims of domestic violence, homeless veterans, and affordable housing.

The second proposal would provide up to $10,000 in down-payment and closing cost assistance to individuals purchasing homes in a census tract

that has been designated as a qualified opportunity zone by the Federal Tax Cuts and Jobs Act of 2017. There would be income thresholds for individuals to qualify and assistance would be secured against the property. If an individual remains in the home for at least ten years, the assistance would be in the form of a grant; if the individual sells the property before ten years from the date of purchase, the assistance will have to be repaid. This program would be administered by the Pennsylvania Housing Finance Agency (PHFA) and an initial appropriation would be given to help initiate it. Counties with census tracts designated as a qualified opportunity zone include Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Jefferson, McKean, Montour, Northumberland, Schuylkill, and Warren.

The third proposal aims to enact a State Low-Income Housing Tax Credit (LIHTC) program. This program would aim to close a gap in funding that often exists with the Federal LIHTC program. Sixteen states currently have a State LIHTC program

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Opioid Use Disorder Centers of Excellence Collaborate to Increase Engagement and Retention

In October 2019, Community Care Behavioral Health offered the Opioid Use Disorder (OUD) Centers of Excellence (COE) the opportunity to participate in a Learning Community. The goals of the Learning Community are to share best practices, treatment success stories and lessons learned all in an effort to improve engagement and retention rates in treatment services. While participation is voluntary, many of the COEs are participating in the monthly Learning Community activities which include discussion of treatment strategies and effective techniques as well as information sharing. The main purpose of the sessions is to help agencies maintain and expand the COE program. The Learning Community sessions are facilitated by Dr. David Loveland, PhD who is the Senior Program Director at Community Care Behavioral Health.

In addition to the activities above, the sessions also help agencies learn to use data for quality improvement interventions and prepare for future value-based payment (VBP) models for the COEs. Some of the metrics being considered for VBP are retention and length of stay, access to medications, access to primary care for behavioral health agencies, and social determinants of health.

"There are four stages that need to be considered for OUD treatment."

Across all Community Care contracts many of the COEs are participating including four organizations in the HealthChoices North Central Contract

Community Care began gathering data in the COEs on July 1, 2019. The COE agencies collect data in two main areas: existing clients enrolled prior to July 1, 2019 and new clients which are in the post group. Following are some of the highlights from the data thus far:

- 4,659 unique members received at least one tracked claim from June 2019 to March 2020.
- 54% are male and 46% are female.
- 686 are receiving methadone, 490 are receiving no medications, 349 are receiving buprenorphine, and the remaining clients are receiving naltrexone or a combination of medications from July 2019 to January 2020.
- Age, race, and gender demographics have remained the same over the past several months. Over 40% of the clients are age 28 to 37.
- Newly-enrolled clients who disengage from the COE do so within the first month.
- The 90-day retention rate is approximately 57% overall.
- The Opioid Treatment Programs (OTPs) are approximately 67% and Office-Based Opioid Treatment (OBOT) is about 53%.

Some of the initial trends from the data include the 90-day retention rate and correlation to the type of medication prescribed. Clients on methadone have a longer length of stay compared to all other clients. Within these figures for newly-enrolled individuals, 75% of those taking methadone

reached the 90-day mark in treatment compared to 56% for naltrexone, 45% for buprenorphine, 41% with a combination of medications, and only 32% if they were taking no medications.

To make a difference in treatment retention rates, there will need to be more consideration given for when residential treatment could be needed and what takes place during a person's stay. Individuals who disengaged from the COE were more likely to have received residential treatment prior to, during, and after the COE compared to those who continue to receive some contact from the COE. Individuals who received residential treatment prior to the COE were more likely to receive additional residential days after enrollment as well as disengagement from the COE. Providing agonist medications in residential setting before transferring to the COE could be one option as well as recognizing these individuals may need more resources.

Dr. Loveland believes there are multiple factors that complicate Opioid Use Disorder (OUD) overall and this is the reason we need to do more work. He references a recent publication called, *"Development of a Cascade of Care for Responding to the Opioid Epidemic"* (Williams, Nunes, Bisaga, Levin, Olfson, 2019)[1] that also outlines some of this same information. Basically, there are four stages that need to be considered for OUD treatment. We need to compare these stages to our current system and determine where we can remove barriers.

Stage 1 – Identification and interception of people with an OUD – This often occurs in emergency departments, withdrawal management, jails, or other crisis services including emergency medical services and homeless shelters. Most individuals are referred to a traditional substance use disorder provider, such as a residential program, when the research clearly shows that rapid access to buprenorphine followed by a transfer to a medication assisted treatment (MAT) program to be the most effective intervention. The transfer may be complicated if the outpatient or residential provider does not have medical oversight to maintain agonist medications.

Stage 2 – The standard enrollment process in Substance Use Disorder (SUD) treatment does not require the integration of medications, as it does in medical care. Therefore, most agencies initiate an abstinence-based treatment protocol with a fail-first model before offering medications. Most individuals with an OUD disengage during the fail-first model. The process needs to be reversed in that medications need to be offered first followed by psychosocial services.

Stage 3 – The present SUD system has poor continuity of care because it is designed as a series of disconnected, acute episodes. Sometimes treatment providers have difficulty finding a MAT provider to maintain medications which could lead to the reluctance to start someone on the medications. In addition, sometimes there are medication adjustments that occur, and the daily dosage falls below clinical efficacy, which leads to increased disengagement. People with an OUD have the worst outcomes in the disconnected SUD system compared to all other SUDs and tend to be lost, while beds and chairs remain full. We need to develop processes to support continuity of care, including the mandatory requirement that medications are to be maintained across agencies and following national dosing guidelines.

Stage 4 – We need to develop a range of low and high threshold interventions that can help maintain continuity for many years, as people with an OUD need three to five years of medications and monitoring. There is no Stage 4 in the present system, but we have service models that could be used, such as combining Certified Recovery

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Specialist (CRS) services with primary care physicians (PCPs) or using telehealth with PCPs to maintain people on the path to recovery. The COEs are one of the new options for maintaining people over months or years, though more work is needed.

Finally, there have been some excellent ideas around increasing retention and in looking at this further. Some of these include:

Having rapid access to agonist medications within 24 hours of contact or request for services.

Rapid titration of buprenorphine up to 16 mg. or more and rapid transfer to methadone when other medications are insufficient.

Initiating agonist medications earlier in treatment.

Having community-based services such as case management or (CRS) services in the community more versus at the office.

Triaging more resources towards individuals who have overdosed since they tend to disengage sooner.

The group of agencies coming together for the sessions remain committed in increasing engagement and retention for individuals in need of MAT in the COEs and we are certain to see more improvements in how OUD treatment is delivered.

[1] Williams, Arthur & Nunes, Edward & Bisaga, Adam & Levin, Frances & Olfson, Mark. (2019). Development of a Cascade of Care for responding to the opioid epidemic. The American Journal of Drug and Alcohol Abuse. 45. 1-10. 10.1080/00952990.2018.1546862.

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to compliment the Federal program and enhance investment in affordable rental housing options. Since its inception, the Federal LIHTC program has supported the renovation of more than 45,000 properties and nearly 3,000,000 housing units nationally. PHFA, who is the designated agency to administer the Federal LIHTC program, would be responsible for administering the State LIHTC program.

The final proposal would look to increase the contribution to the Pennsylvania Housing Affordability and Rehabilitation Enhancement Fund (PHARE). In the 2019/2020 budget, the General Assembly increased the annual contribution to PHARE from $25 million to $40 million. While this was admirable, Senator Hughes believes it is not enough to meet the needs of our Commonwealth. With increased funding, PHFA, who administers PHARE, would be able to increase its ability to leverage other public and private funds to invest in new rental units, invest in new single-family homes, and assist homebuyers among other things.

Levana Layendecker, Deputy Director of the Housing Alliance of Pennsylvania, supports this plan, and hopes the legislature will take action to address a crisis that she says has been a long time coming.

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Trauma Institute 2020

BHARP is pleased to announce the 2020 Trauma Institute scheduled for September 1-2, 2020.

This year's conference will be broadcast virtually instead of in-person and highlight an array of important topics focused on trauma-informed care. Day one will feature Tony Valdes, Chief Executive Officer of Children's Crisis Treatment Center (CCTC). Serving in this capacity for the past 20 years, Tony has been a passionate advocate for the mental and behavioral needs of Philadelphia's children and their families. Tony and his staff will give a presentation titled, "Leading Through the Lens of a Trauma-Informed Organization: The Intersection of Culture and Care." Presenters will share their experiences of implementing a trauma-informed care model throughout a behavioral health organization. Highlighted in this presentation will be the critical role of leadership, what involvement of leadership entails, and the overall impact on the organization, its leaders, staff and the children and families served.

The second presenter on Day one will be Lakeside Global Institute. Since 2003, Lakeside began providing professional development to social work, education, and early childhood professionals in the greater Philadelphia region. Today, Lakeside provides over 30 different courses and workshops, keynote addresses, seminars, and trainings at conferences, including several two-hour workshops that educate professionals on some of the basic physical, mental, and social outcomes of trauma.

During this year's conference, Lakeside will be presenting "Trauma 103: Recognizing Vicarious Trauma for Professionals." This training will discuss the emotional and physical cost of being an engaged and empathetic caregiver. Trainers will discuss the impact of vicarious and secondary trauma, compassion fatigue, and burn-out. Practical skills and a commitment to self-care will also be discussed as they play an important role in dealing with vicarious trauma.

Day two of the Institute will feature Lisa Najavits, PhD. Lisa is director of Treatment Innovations and adjunct professor at the University of Massachusetts Medical School. Lisa was on the faculty of Harvard Medical School for 25 years and was a research psychologist at Veterans Affairs Healthcare System, Boston for 12 years. Her major clinical and research interests are substance abuse, trauma, co-morbidity, behavioral addictions, veterans' mental health, community-based care, development of new psychotherapies, and outcomes research.

Lisa is also the developer of Seeking Safety, an evidenced-based present-focused counseling model designed to assist individuals with finding safety from trauma and/or substance abuse. Facilitated in group and individual settings, this model can directly address trauma and addiction without forcing an individual to have to retell certain details of their traumatic events, making it easy to use and relevant to a wide range of individuals.

Lisa will be giving a presentation titled, "Numbing the Pain: Trauma and Addiction." This presentation will provide important background on addiction, including rates, clinical presentation, screening methods, and strategies for treatment. Lisa will discuss key concepts in addiction such as tolerance, withdrawal, telescoped course, clean vs. sober and the impact addiction has on families. Lisa will conclude the presentation by exploring how addiction treatment can be adapted in relation to gender, age, and culture.

Additional information and details regarding this year's Trauma Institute will be forthcoming soon.

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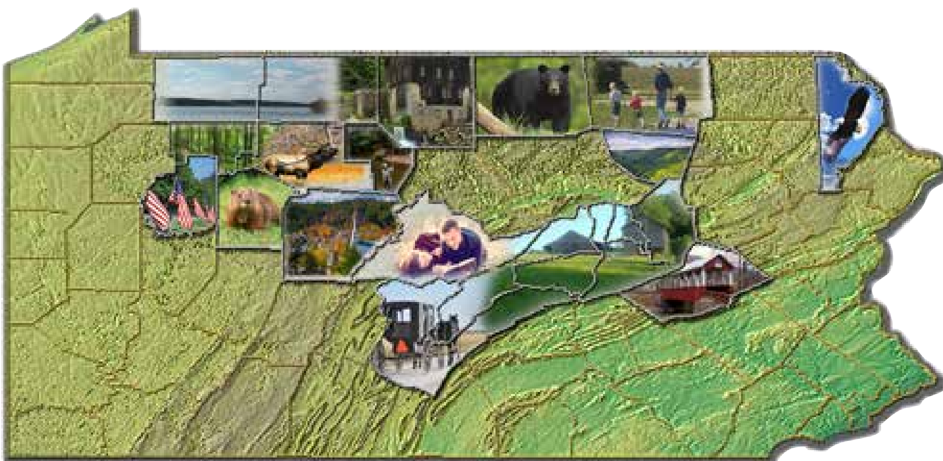
The Behavioral Health Alliance of Rural PA, a Pennsylvania Nonprofit Corporation, was established in the fall of 2006. It is comprised of County MH/ID Administrators, Human Service Directors and Single County Authorities from 23 counties in North Central Pennsylvania. The primary purpose of BHARP is to allow these 23 counties in the North Central region to participate in the implementation and monitoring of DPW's contract with Community Care Behavioral Health for the provision of HealthChoices in the North Central zone of PA.



If you would like to be added to our mailing list please contact us by email at:

TheRuralDifference@bharp.org

We invite your questions and comments.