Quarterly Newsletter
February 2016 • Volume 4, Issue 1

BEHAVIORAL HEALTH ALLIANCE OF RURAL PENNSYLVANIA

Budget Impasse

For many months no one could get away from hearing two words throughout Pennsylvania - "Budget Impasse." It all began July 1, 2015 when the State legislators failed to come to agreement on the 2015/2016 state budget. As lawmakers talked about how far apart the two sides were, the rural counties began to discuss how they would manage the impact of not having state funding for human services for some of the most vulnerable populations. This article highlights the strategies employed, as well as the impact of the impasse on two of our rural county's Drug and Alcohol programs.

Potter County is one of our most rural areas and the Human Services program has always worked along with their providers to assure services were available to residents throughout the area. The results of not having a state budget or funding for Human Services was felt hard by the Drug and Alcohol Program and the providers of services.

As a result of not having the state allocation of funds the County Drug and Alcohol program had to make some tough decisions. Payments to providers for services rendered were held until state funding was received. They had to furlough the Drug and Alcohol Prevention Specialist leaving the five Potter County School Districts without Student Assistance Program (SAP) services. The "Too Good for Drugs" and the Tobacco Cessation and Tobacco Education programs were stopped in the school districts in November 2015. With the current epidemic of opiate abuse, leaving children and adolescents without services and supports was a tough decision for the county to make. Additionally, Certified Recovery Specialists services were stopped in December which left those in recovery without vital supports and services.

Other changes made to help offset the lack of state funding included travel restrictions for County staff, a hold on purchasing necessary equipment and supplies and no funding for training for staff. Through it all the County Human Services Department worked to try to maintain the safety net for individuals in need of drug and alcohol services.

> *With the current epidemic of opiate abuse, leaving children and adolescents without services and supports was a tough decision for the county to make.*

The Tri County Drug and Alcohol Commission saw similar effects from the budget impasse. They furloughed one Drug and Alcohol Case Manager and reduced the hours worked each week for their Fiscal Officer and their Prevention Specialist. The remaining staff was scheduled to ensure that their office could remain open for their regular business hours. Because of the cuts to staffing, the timeliness of drug and alcohol assessments was impacted. The Commission had one remaining Case Manager to cover the three counties they serve.

The Commission also reduced payments to their Outpatient providers and held payments for their Inpatient providers. They used all available cash resources prior to

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Budget Impasse Continued. . .

accessing their existing line of credit and arrangements were made to increase that line of credit in the event the impasse continued. Again, as a small rural Commission, Tri County was left with some difficult choices.

The ongoing effects of the budget impasse on both these rural regions were significant. For Potter County their Prevention Specialist could not afford to wait out the impasse and took employment elsewhere. The County now has the added expense of recruiting and training a new employee for that position.

The Tri County Drug and Alcohol Commission works with limited resources under normal circumstances and felt that their providers were very vulnerable during the time they couldn't pay for services. As we know in the rural counties it is very difficult to try to rebuild programs if they are discontinued.

This article was written to not only highlight the impact of a state budget impasse on the rural counties, but also the tough decisions they are faced with to assure that individuals receive services. During the impasse, the counties featured in this article worked very hard to ensure that services continued and individuals with drug and alcohol addictions could still access necessary services. They felt the pressure of the impasse and agree that it not only jeopardizes providers and individuals seeking treatment but also the communities in which we live and work. ■

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BHARP Children's Workgroup Initiative

Over the past few years, the BHARP Children's Workgroup, which is comprised of members representing County Administration, CASSP, Early Intervention, Juvenile Probation, Community Care Behavioral Health and BHAU, has developed several subgroups to discuss service development and access issues within our BHARP counties. One of those subgroups was developed to address the need of youth who do not meet medical necessity for Residential Treatment (RTF) and/or do not wish to be placed in a Therapeutic Family Care/Individualized Residential Treatment (TFC/IRT) home.

Our first meeting was held in June 2015 and the group was tasked with discussing differences and barriers within the RTF and TFC settings, as well as, possible alternatives to those services. The subgroup hosted a presentation from a CRR Group Home provider who detailed their program description, activities, and successes. Our group then decided to pursue more information on this model and ways to create a space for youth who could experience a safe living environment while being connected to a community. The group focused on the need for transitional services, including, but not limited to, independent living skills, daily living skills, education, and therapy.

In August of 2015, the subgroup met with representatives from OMHSAS and the Children's Bureau to discuss possible options for these youth who do not require the intensive level of a RTF and who are not well suited for a foster care placement. The group was encouraged to speak with several departments including Licensing, OCYF, Education and OVR. After several months of discussions the group was ultimately encouraged to develop a service description based on specific needs in the rural counties. We are currently in the process of working with key stakeholders to develop the service description and we hope to reconvene our subgroup in the next few weeks to look at next steps for moving forward with this important initiative. ■

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Zero Suicide: A HealthCare Approach

Is it surprising to know that of those who died by suicide, almost half saw a general practitioner and about one in five saw a mental health professional within the month? Furthermore, older adults who have died by suicide have an even higher rate of general practitioner engagement in this time frame. [1] The data is clear; health care systems can and need to dramatically improve suicide care. Dr. Mike Hogan of the NY Office of Mental Health says, “Suicide represents a worst case failure in mental health care. We must work to make it a ‘never event’ in our programs and systems of care”. Yet, over a third of licensed behavioral health clinicians report they don’t have the skills to engage and assist those at risk, and almost half say they don’t have adequate training.

> ***BHARP is working hard to educate communities, better equip the behavioral health system and support those affected by suicide.***

Zero Suicide is a framework for systematic, clinical suicide prevention in behavioral health and health care systems, with a focus on safety and error reduction. It consists of a set of best practices and tools for health systems and providers. The core components of Zero Suicide address 1) screening and risk assessment 2) suicide care management planning 3) effective and evidenced based treatment and 4) improved care transitions. These four components are supported by workforce development and training, ongoing quality improvement and data collection, and must be protected by a strong leadership commitment.

Zero Suicide is a priority of the National Action Alliance for Suicide Prevention, a goal of the National Strategy for Suicide Prevention, and a project for the Suicide Prevention Resource Center. The Pennsylvania Adult Suicide Prevention Plan, as well as the Pennsylvania Older Adult Suicide Prevention Plan promotes adoption of Zero Suicide as Objective 8.1 under goal 8: Promote the Effective Assessment, Prevention and Treatment of Suicide as a Core Component of All Health Care Services. [2]

The BHARP is working hard to educate communities, better equip the behavioral health system and support those affected by suicide. When Zero Suicide was being presented at a nearby medical school, a few counties and administrative unit staff attended the events. It quickly became clear that Zero Suicide could be an avenue to improve care and reduce deaths in our regions of rural Pennsylvania. Zero Suicide has become a focused subgroup of the BHARP Recovery Workgroup and is open to all county human services, providers, families, individuals and advocacy groups of BHARP. Currently we have a robust membership and work is being done to form implementation, leadership and/or advocacy teams. The groups are performing organizational self-studies and are looking at the current health care systems of our communities. There is much work to be done, but it is clear that improving care to reduce those lost to suicide is a priority of BHARP. It is also clear Zero Suicide is feasible and producing results. To learn more about what BHARP is doing, contact Julianne Hayes at: jhayes@bharp.org. For additional details on Zero Suicide please visit: www.ZeroSuicide.com. ■

[1] http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.159.6.909
[2] http://www.sprc.org/states/materials/plans

Housing

With freezing winter temperatures it often seems unbearable to walk from our offices to our cars. We complain about the cold and look forward to the warm weather spring brings. Now think of our short walk to and from our cars, and then think of the individuals who wander around in those freezing temperatures all day, only to then have to look for a warm place to stay that night. Thousands of people face this challenge every day, no warm home to go to and no idea where they will sleep at night.

According to the 2015 Annual Homeless Assessment Report (AHAR) 564,708 people in the United States were homeless on the night of the point in time survey. Nearly 7 in 10 (69%) people experiencing homelessness were staying in sheltered locations, and 31% were unsheltered. On the night of the point in time survey in Pennsylvania, there were 15,421 reported on homeless. Although homelessness declined by 2% between 2014 and 2015 nationally, it is still an issue on a local level.

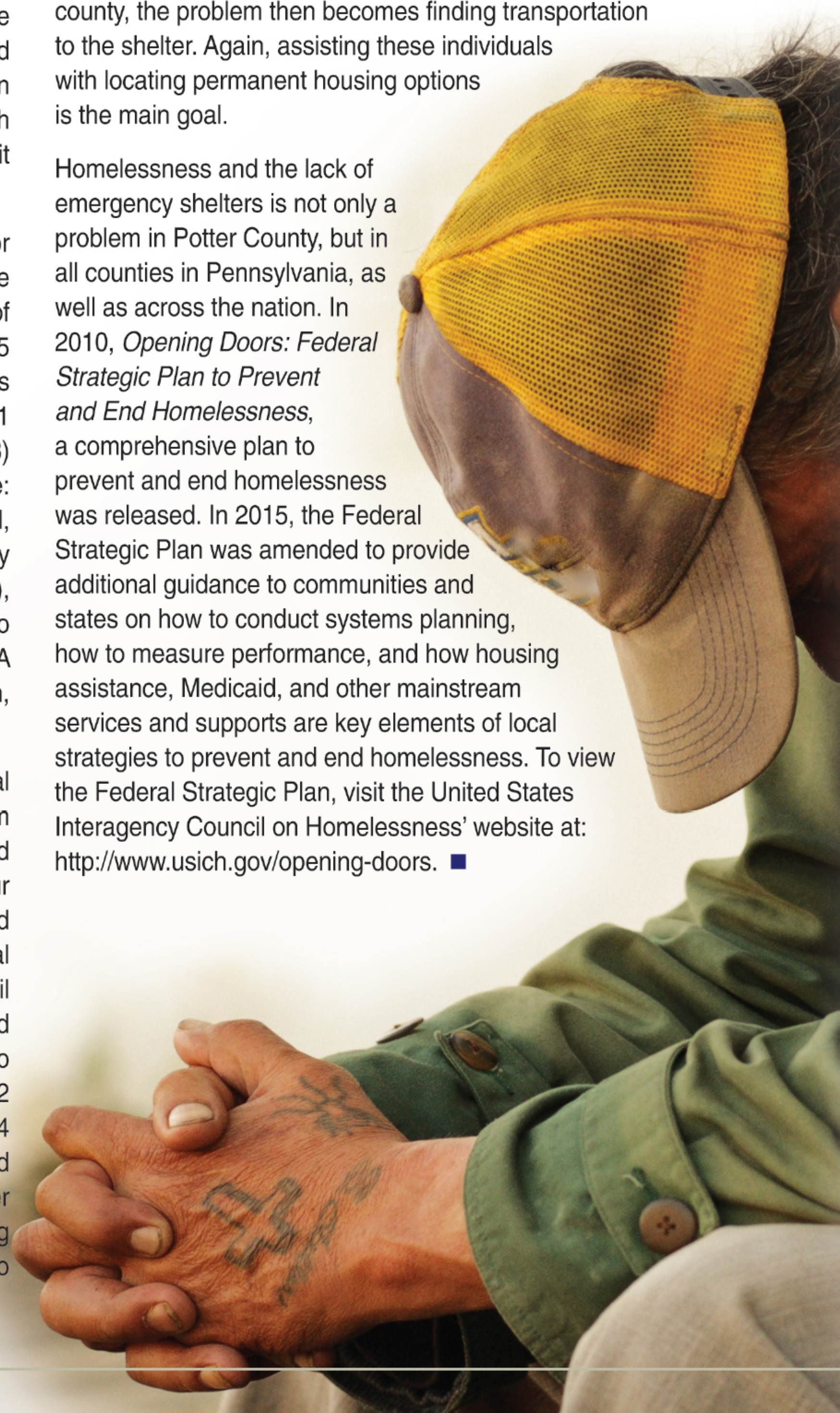
Finding housing, even if for one night, is not only a daunting task for the individuals facing homelessness but for counties as well. There are many challenges to housing the homeless, including lack of available shelters. According to Diana T. Myers and Associates' 2015 Emergency Shelter Inventory Chart, 15 of the 23 BHARP counties have Emergency Shelters. These shelters provide a total of 1,971 year round shelter beds. The majority of these available beds (1,303) are located in the counties in the Eastern PA Continuum of Care: Columbia, Juniata, Mifflin, Montour Northumberland, Schuylkill, Snyder, and Union (Central Valley Regional Homeless Advisory Board (RHAB), Bradford, Sullivan, and Tioga (Northern Tier RHAB), Centre and Huntingdon (South Central RHAB), and Wayne (Pocono RHAB). The remaining beds (668) are located in the Western PA CoC: Cameron, Clarion, Clearfield, Elk, Forest, Jefferson, McKean, Potter, and Warren (Northwest RHAB).

The need for shelter beds in Centre County has led one local program starting a somewhat unconventional homeless program called Out of the Cold. The Out of the Cold Program was established in February 2011 with a mission to "provide the homeless in our community with a warm and safe overnight accommodation and nourishment within a welcoming atmosphere, as a supplemental option to locally established shelters." From November 2011 until March 2012, four congregations were part of the program and served 27 individuals. Each year after, the numbers served continued to grow, with the Out of the Cold Program providing shelter for 42 individuals the second year and 51 in the third year. By October 2014 there were 12 participating congregations and 74 individuals served from October until May 2015. The program opened again in October 2015 with 13 congregations participating. All participating congregations are in the State College area; however, the hope is to start a satellite program in the Bellefonte area.

Pastor Monica Ouellette, Program Coordinator, states that the most difficult part of the program is helping their guests find a place to live when the program closes every spring. The program would need to double the number of congregations involved to remain open year round.

While the Out of the Cold program struggles with finding housing for individuals after the program closes, finding shelter, even if for one night, is a constant struggle for other counties. For example, the lack of an emergency shelter in Potter County has presented many problems. Individuals are typically assisted by the Potter County Human Services' Coordinated Services Department for up to three nights in one of the local motels. During this time individuals are assisted with finding other housing arrangements. Family members may also be contacted in an attempt to provide temporary shelter or the county may reach out to neighboring counties that have shelters. In the case where a shelter is available in a neighboring county, the problem then becomes finding transportation to the shelter. Again, assisting these individuals with locating permanent housing options is the main goal.

Homelessness and the lack of emergency shelters is not only a problem in Potter County, but in all counties in Pennsylvania, as well as across the nation. In 2010, *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, a comprehensive plan to prevent and end homelessness was released. In 2015, the Federal Strategic Plan was amended to provide additional guidance to communities and states on how to conduct systems planning, how to measure performance, and how housing assistance, Medicaid, and other mainstream services and supports are key elements of local strategies to prevent and end homelessness. To view the Federal Strategic Plan, visit the United States Interagency Council on Homelessness' website at: http://www.usich.gov/opening-doors. ■



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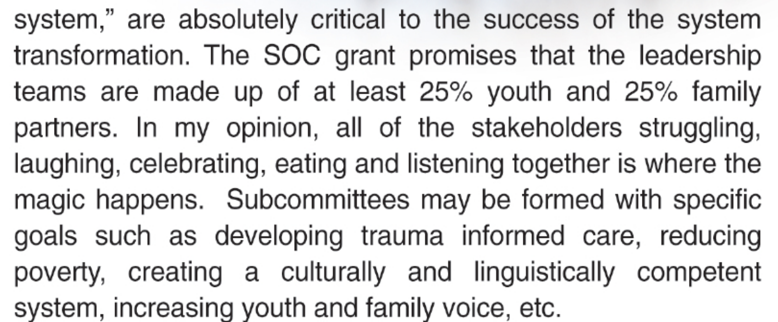

BHARP
System of Care Project
BEHAVIORAL HEALTH ALLIANCE OF RURAL PENNSYLVANIA

The Importance of County Leadership Teams in System of Care

The formation of County Leadership Teams (CLTs) in System of Care is one of the first steps in transforming local systems. It is one of the deliverables identified in the BHARP System of Care grant – that each of the Tier 1 counties (or joinders) will establish a CLT.

What are county CLTs? The county CLT is a group of people with an interest in the wellbeing of children and youth who guide, monitor, respond, create, and implement the philosphy and mission established by system of care locally.

How do these teams come together? Often people in leadership positions within the county system (administrators, Human Services Directors, etc.) demonstrate the earliest commitment to transformating their systems. It is truly all about relationships after that. The relationships that those administrators have with one another and how in touch they are with their community's needs and champions for children will directly affect the process of CLT formation.

Who should be part of CLTs? CLTs typically include representation from all of the child serving social services agencies such as child welfare, behavioral health, drug and alcohol programs, and juvenile justice, along with representatives from education, the court system, and service providers. The people mentioned so far are considered to be the system partners. Family and youth partners, those who represent families and youth with lived experience in "the system," are absolutely critical to the success of the system transformation. The SOC grant promises that the leadership teams are made up of at least 25% youth and 25% family partners. In my opinion, all of the stakeholders struggling, laughing, celebrating, eating and listening together is where the magic happens. Subcommittees may be formed with specific goals such as developing trauma informed care, reducing poverty, creating a culturally and linguistically competent system, increasing youth and family voice, etc.

What do CLTs do? CLTs bring the stakeholders together as a group. The intent is for regular meetings. Again, it really is all about relationships which require an intentional process to develop.

When do they meet? This is a tricky subject. System partners typically are most available during work hours, family partners are available during the middle of the day when children/youth are in school, and youth (as much as they like to get out of school…) choose to meet late afternoon or early evening. Collaborating around the "when" to meet can be a good exercise for CLTs around "listening."

Where do they meet? This too is a tricky subject. Some folks hate to come into the "county buildings" (though we hope not the staff…). Others may not mind, and free or in-kind space is always good. This is another opportunity for collaboration. Meetings can always be mobile as well, moving to various locations from month to month. This is a good way to keep people involved and truly share ownership in the CLT.

For those of you who are part of the developing County Leadership Teams, I hope this article might be helpful in your recruiting efforts. For those not currently on a CLT, I hope this discussion helps you respond with "yes!" when asked to be part of your local System of Care process. If you have questions about CLTs or any other part of the SOC grant, please don't hesitate to contact me (Chris Minnich - cminnich@bharp.org). I'd also like to recommend you contact Judy Davis, former Northumberland County BH/IDS Administrator, and our new Social Marketer (judydavis@bharp.org), for any help you need in supporting families and youth to be part of System of Care. ■

BHARP

Behavioral Health Alliance of Rural Pennsylvania

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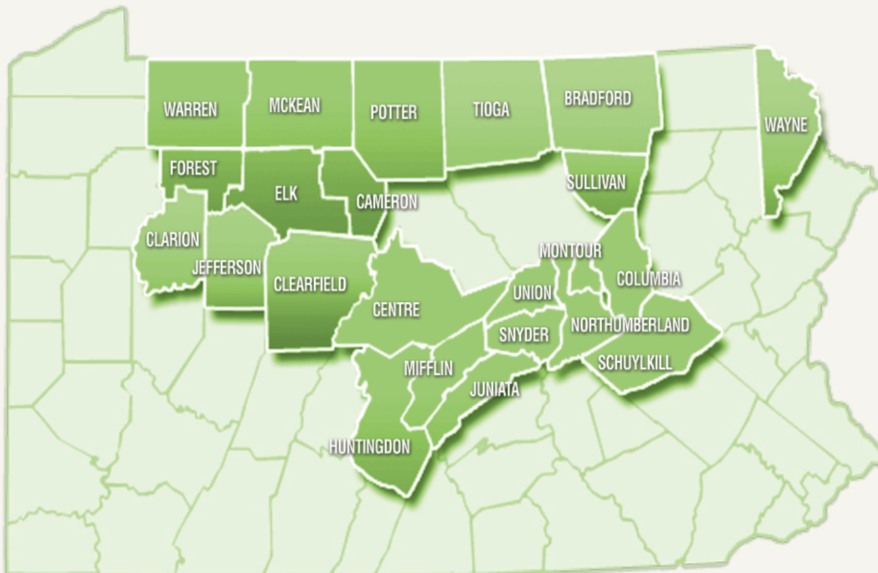
The Rural DIFFERENCE

Behavioral Health Alliance of Rural PA

The Behavioral Health Alliance of Rural Pennsylvania, established fall 2006, is comprised of County MH/ID Administrators, Human Service Directors and Single County Authorities from 23 counties in north central PA.

The primary purpose of the BHARP is to allow the 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 Health Choices in the north central zone.



For questions and comments, or if you would like to be added to our mailing list, please contact us at:
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