LEGISLATIVE BUDGET AND FINANCE COMMITTEE

A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY

A Study in Response to House Resolution 515 (2019):

Community Mental Health Services

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Patricia A. Berger, Executive Director
Christopher R. Latta, Deputy Executive Director

Phone: 717.783.1600 Email: lbfcinfo@palbfc.us Or find us here:

Web: http://lbfc.legis.state.pa.us/ Facebook: PA Legislative Budget and Finance Committee Twitter: @PA_lbfc

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REPORT SUMMARY

Why we did this study…

- *HR 515 of the 2019 session, requires the LBFC to conduct an expansive information gathering study on Pennsylvania's county-managed community mental health (MH) system.*
- *With such a broad mandate, we focused on creating data summaries of various MH-related data obtained from the Department of Human Services (DHS), the Department of Health (DOH), the Department of Corrections (DOC), and the Pennsylvania Health Care Cost Containment Council (PHC4).*
- *We also conducted a survey of county MH administrators to learn where there were service delays and to obtain thoughts and opinions about the COVID-19 pandemic on MH service delivery. Consistent with the requirements of HR 515, we also sought position statements from 11 stakeholder groups; however, only two responded.*

Introduction

In 2019, the Pennsylvania House of Representatives adopted House Resolution (HR) 515, which requested a broad-based study focused on collecting and presenting data on matters related to Pennsylvania's county-managed community-based mental health system. HR 515 outlined 10 comprehensive and complex data requests, some of which included sub-elements, further complicating the collection and presentation of the intended data analysis. The resolution also sought information from fiscal year (FY) 2010-11 through FY 2017-18.

In response to HR 515, and to further develop the planned scope and objectives required therein, on January 7, 2020, the officers of the Legislative Budget and Finance Committee (LBFC) adopted the following objectives:

1. To develop appropriate summaries and analysis regarding contracted county-based community mental health services, including but not limited to, the following: the amount allocated by county for various services, the number of units provided by contract entities, the number of people served, and the amount spent by each county to administer its county mental health program. Further, to the extent possible, document the outcomes, to include living conditions and the mental health status, of individuals who were transferred out of community residential rehabilitation services.

2. To document and provide appropriate context on the number of individuals with mental illness in county jails, or who may have accessed emergency rooms suffering from a mental health crisis.

3. To develop appropriate summaries and analysis on the use of short-term private psychiatric facilities in each county.

4. To document issues that may be present within the county-based mental health services framework, including delays in intake and psychiatric evaluations, and as appropriate to develop any recommendations that may benefit the delivery of mental health services in the commonwealth.

Scope Adjustments and Limitations

As we started this project, we encountered an issue with certain data that caused us to reevaluate the scope of this project. As discussed later in this report, on July 1, 2012, the Department of Human Services (formerly the Department of Public Welfare), redefined and realigned its cost centers used to track county mental health program costs. The net effect of this occurrence was that many of the services specifically named in HR 515 were merged into newly defined cost centers and/or renamed. As a result, tabulating and developing data summaries, as defined in HR 515, would have been overly time consuming and likely lacked the precision to reveal meaningful results. Due to these accounting changes, and to ensure that we could make "apples to apples" comparisons from year-to-year, which was the intent of HR 515, we changed the scope of our review to be July 1, 2012, through June 30, 2018.

Another issue presented itself when we tried to answer the objective of obtaining follow-up information on the "living conditions and mental health status" of individuals who transferred out of community residential rehabilitation. We learned from experts in the field there is no data that tracks such status. Furthermore, we were informed that the premise of this objective may be misstated, because for many individuals mental health disorder recovery can be a lifelong endeavor. Consequently, to just measure a program by mental health status or living condition would not yield meaningful measurements, even if data existed to do so. Therefore, our analysis did not include these sought-after outcomes; however, we do include data on expenditures and the number of clients served within the Community Residential Services cost center.

Finally, while we were able to present data points regarding how county MH agencies spent their MH dollars, and the number of clients served, we also found that much of the data is self-reported by county agencies using templated "income and expense" reports. These reports provide uniformity for reporting purposes to DHS; however, the data is also self-reported and with respect to "clients served" may be interpreted differently from county-to-county. For this reason, the data lacks the precision from which to draw hard conclusions about a particular program's true cost or to make comparisons from cost center to cost center. Despite these limitations, the information does provide an interesting perspective as to the trend in spending, purchased services, and the number of clients served within the state.

Section II - Background Information about Pennsylvania's Community Mental Health Services

Any discussion about Pennsylvania's county managed community-based mental health service framework must begin with a short discussion about the historical perspectives surrounding mental health services. Stated simply, for most of our history, mental health treatment was largely non-existent and what did exist was centered on institutions, which were often poorly run and provided less than optimal care and treatment.

A paradigm shift occurred in 1963 with the passage of the Community Mental Health Act of 1963 (CMHA). This landmark legislation altered how mental health patients were cared for, and how mental health clinics would be established and funded. The CMHA was the first federal initiative to tackle mental health, and it provided uniform oversight into facility care, which had been previously left to the states. A cornerstone of the CMHA was that it empowered states to create community-based treatment centers.[1]

The shift from institutions to community-based services would allow for better quality of care for patients, prevent overcrowding and sanitary problems, and ensure that discharged patients had a better chance at eventual reintegration. Patients under guardianship could be treated while living or working from their homes. Further, providing funding and resources to local communities by allowing communities to create targeted treatment plans for their patients, which would evolve as the understanding of a social environment's impact on mental health improved. Through the subsequent decades additional legislation was passed to build upon the tenets of the CMHA. States also began to look at mental health services differently as well.

As a result of the CMHA, states were directed to create organizational infrastructures and systems of care to combat mental illnesses and deliver services to patients. Community mental health services needed to be transitioned from statewide institutional facilities to more localized county-level services. These county offices were to be overseen by a county administrator. This eventually resulted in a formal response in 1966 with the Mental Health and Intellectual Disability Act (MH/ID).[2]

[1] *See* Gerald N. Grob, *Government and Mental Health Policy*, 1994.

[2] The Act was originally known as the Mental Health and Mental Retardation Act of 1966. In 2011, the Act was updated by Act 105 to change the terminology.

The MH/ID required county mental health and developmental service offices to provide targeted services including, but not limited to the following:

- short-term inpatient treatment,
- partial hospitalization,
- outpatient care,
- emergency services,
- specialized rehabilitation training,
- vocational rehabilitation, and
- residential services.

The blueprint established in the MH/ID is still operational today. A majority of these services are paid for by public and private providers, the Pennsylvania Medical Assistance Program, and Medicaid through the Pennsylvania Health Marketplace.[3]

In many states, intake and referral programs for public mental health services determine whether people are eligible for services based on their diagnoses and the severity of their mental health conditions. In Pennsylvania, county mental health offices and base service units determine a person's eligibility for financial assistance but provide referral services to local programs even for people who do not qualify for financial assistance. In many cases, contracted providers accept a wide range of insurance plans and offer sliding scale fees to people without insurance even when they do not qualify for financial assistance from the state.[4]

Pennsylvania state legislation and court decisions have also impacted community-based mental health services. Most recently, the 1999 *Olmstead* decision by the U.S. Supreme Court required public entities to provide community-based services when (1) appropriate; (2) the affected person does not oppose such treatment; and (3) those services can be reasonably accommodated. In 2012, Pennsylvania introduced block grant funding for certain county-based human service programs. The Human Services Block Grant (HSBG) was created to streamline the allocation of state and federal funds to select county governments that required assistance to service the needs of residents. For example, under the HSBG counties have more flexibility to use funding across various program needs (e.g., mental health, intellectual development, substance abuse, etc.) Originally the HSBG allowed for 20 counties to qualify for needs-based allocation. Because of the apparent success of the HSBG, it was revised in 2013 to allow for funding to 30 counties, and in 2016, that cap was removed altogether, meaning all counties within the state could

[3] *See* "Resources to Recover" at www.rtor.org/directory/mental-health-pennsylvania. Resources to Recover is a non-profit gateway organization that helps families and individuals connect with local guidance and mental health support resources.
[4] Ibid.

qualify for block grant funding. DHS releases an annual report detailing the allocations and expenditures by fiscal year.[5] DHS is required to disclose details on block grant funds by county governments. Per DHS' FY 2018-19 annual report, in that year alone 73 percent ($370.0 million) of the total block fund expenditures were for mental health services.[6]

Section III - Mental Health Services Data Collection and Analysis

HR 515 requested specific data collection on various MH services provided by county MH service agencies. Although these services are provided by counties, certain data elements are reported to DHS. To this end, DHS uses a standardized cost center structure to track MH services, and uses templated spreadsheets from county MH agencies to track key items like: total expenditures, purchased services (which are a portion of total expenditures), and the number of clients served within each of the cost centers. These were the areas we used as a focus for our report.

There are 25 DHS-defined MH cost centers, which cover a wide variety of services and activities. Some examples include providing community information about MH awareness, providing emergency commitments for MH illness, and case management services. We obtained six years of data from every county MH agency. From this data we were able to pinpoint specific points to answer the objectives; however, there are caveats with the data. For example, the data is self-reported and while it is reviewed by DHS, it is not audited. As a result, there can be inconsistency from county-to-county or year-to-year. Further, we could identify which of these counties may have had a reporting inconsistency, but we could not determine the cause for the potential inconsistency. Nevertheless, the information is helpful in providing a context for MH service activity and spending, but caution should be exercised in drawing hard conclusions from the data.

As might be expected with the large number of cost centers, there was variability with expenditures and clients served. For example, for the period FY 2012-13 through FY 2016-17, with respect to the number of clients served, the Administrative Management cost center had the greatest number of clients served with over 665,000 clients. Conversely, the cost center with the fewest clients was Adult Development Training with just 57 clients. With respect to purchased services, which are part of a county's total MH expenditures (and cover contract services), Community Residential Services was the most expensive cost center at more than

[5] Under Act 153, in FY 2017-18 counties were able to retain up to five percent of the state block grant funds to be used during the next fiscal year.
[6] Pennsylvania Department of Human Services, *Human Services Block Grant Program Expenditure Report,* 2018-19.

$1.52 billion in purchased services over the six years reviewed, and Children's Evidence-based Practices had the lowest amount spent at $1.3 million.

In looking at overall trends for the six-year period, we found significant increases in the number of clients served for these cost centers: Assertive Community Treatment/Community Treatment Teams (210 percent); Psychiatric Inpatient Hospitalization (164 percent); and Peer Support Services (128 percent). In areas where county MH agencies were increasing spending, we saw growth in these cost centers: Assertive Community Treatment/Community Treatment Teams (92 percent); Transitional and Community Integration Services (87 percent); and Mental Health Crisis Intervention Services (71 percent). However, it must be reiterated that these figures are self-reported--and specifically with the number of clients served--there may be inconsistency in how those numbers are reported.

Section IV - Other Mental Health Data Collection and Analysis

In addition, the specific DHS cost center data presented in Section III, HR 515 requested other data collection and analysis of several mental health services. In particular, HR 515 sought statewide summaries for the following: the use of short-term private psychiatric facilities; data on the number of inmates with mental illness in county jails; and data on the use of emergency rooms by individuals with mental illness in mental health crisis.

Although tasked with collecting data on short-term private psychiatric facilities, we found that this term is not recognized by state regulatory agencies; consequently, no specific data exists. However, we were able to find limited data on *private psychiatric facilities* in Pennsylvania. These facilities are free-standing, or stand-alone facilities that offer a wide range of psychiatric services. We were able to extract data on capacity, occupancy rates, and length of stay. We found that in 2018, seven of 19 facilities had occupancy rates above 90 percent. We also found there is variability in the average length of stay from facility to facility; however, owing to the complexity of individual patient needs, we found that facility-to-facility comparisons may not be a reliable measure.

With respect to data on the number of inmates with mental illness in county jails,[7] we worked with data obtained from DOC. Using this data,

[7] According to DOC, the term "county jail" and "county prison" may be used interchangeably within Pennsylvania. These facilities are run by county governments and are different from state-run correctional institutions. DOC does not operate county jails or county prisons but does collect certain data on how these facilities operate.

we were able to determine mental health caseloads, which we compared to each facility's capacity and average in-house population. While this data is self-reported it nevertheless presents a reasonable perspective of the MH caseloads occurring at these facilities, which we found increased by more than 40 percent over a five-year period—despite decreases in jail capacity and average in-house population.

Finally, and with respect to the objective of obtaining information on the "use of emergency rooms by individuals with mental illness in mental health crisis," we obtained medical discharge information from the PHC4. Using this data, we could discern the number of hospitalizations that occurred for certain mental health conditions. We were also able to determine the number of emergency room visits that occurred and which resulted in the patient being admitted to the hospital.

While the information only pertains to the number of cases and not individuals, which results in some double counting (e.g., an individual could represent two or more cases over the period reviewed), the data revealed that hospitalizations have been increasing. Specifically, hospitalizations grew by 17.2 percent from FY 2012-13 through FY 2017-18. For emergency room (ER) visits, the growth rate was 5.2 percent over the same period. Here too, certain data limitations are present. For example, PHC4 staff indicated that ER revenue codes may not be used uniformly by hospitals, which could undercount the number of cases. Additionally, just because a patient accessed the ER for a mental health issue does not necessarily mean that the patient was "in crisis," which was the level of specificity sought by HR 515. In these cases, there may be some over counting present.

Section V – Survey Results and Stakeholder Policy Statements

HR 515 requested us to obtain information from various MH stakeholders and to obtain information on delays for access to MH services. To meet this objective, we conducted a two-pronged outreach effort. First, working with representatives from the Pennsylvania Association of County Administrators of Mental Health and Developmental Services (PACA MH/ID), we surveyed all 48 county MH administrators (note: some counties co-administer their MH services across multiple county lines). We sought information on specific delays for services within the DHS-designated MH cost centers. We also asked questions about issues that were leading to potential delays in accessing services, as well as other trends in the MH service community, including potential impacts from the COVID-19 pandemic. We had an excellent response rate from these entities—100 percent responded.

From the MH administrators' review of their wait times, we found that "crisis services" are generally the most accessible services. This is an encouraging result given the critical nature of these services to individuals who may be in a mental health crisis. However, administrators also reported significant delays for access to community residential services, which are a type of housing support service for individuals with severe MH issues. Administrators reported a median average wait time of 6 weeks for this service, but when looking at the *longest* wait times (i.e., the longest any individual had to wait for services), the median wait time was 16 weeks.

Regarding the COVID-19 pandemic, 64 percent of administrators reported an increase in crisis calls since the pandemic began in early 2020. Further, 74 percent indicated that they expected crisis calls to increase in the next 6-12 months. Administrators also noted an overwhelming increase in the use of telehealth/telemedicine for MH services (98 percent), to which some administrators expressed concerns about access to broadband services in rural areas for these purposes. Interestingly, in terms of having adequate resources to deal with the pandemic, 35 percent of the responding administrators said they did not have adequate resources, while 31 percent said they did. Another 33 percent indicated "other," and expressed concerns about funding and a lack of a psychiatric services in their respective areas.

Finally, we sent information request letters to eleven MH stakeholder groups seeking their input on eight mental health issue areas. Unfortunately, our response rate in this area was less than anticipated. We received just two responses. One from the County Chief Adult Probation and Parole Officers Association of Pennsylvania (CCAPPOA), and one from the Pennsylvania Psychiatric Society (PPS), which is a district branch of the American Psychiatric Association (APA). We have included the responses in their entirety, but in summary, the CCAPPOA favors expanding mental health services to help keep individuals out of the criminal justice system. They also support additional training for police officers, probation officers, and prison staff to identify individuals in crisis. As stated by the CCAPPOA, "the goal is to connect the justice-involved individuals with the mental health services in the community that will support successful reintegration." The PPS provided us with several position statements which are supported by the PPS and the larger APA. These issues included a wide variety of important topics including criminal justice/MH issues, access to services, use of medications, and principles of recovery.

SECTION I
OBJECTIVES, SCOPE, AND METHODOLOGY

Why we conducted this study…

House Resolution 515 of the 2019 legislative session directed us to conduct a broad-based study of Pennsylvania's county-managed community mental health system.

On January 7, 2020, the officers of the LBFC adopted the study's objectives and scope.

Introduction

Estimates vary, but most experts agree that one in five individuals will need treatment for mental illness during his or her lifetime. For Pennsylvania and its nearly 12.9 million residents, this statistic equates to nearly 2.6 million individuals who may require mental health treatment.

In response to this concern, on December 17, 2019, the Pennsylvania House of Representatives adopted House Resolution (HR) 515, which directed the Legislative Budget and Finance Committee (LBFC) to conduct a broad-based and comprehensive study of changes in the availability of county-managed community mental health programs between fiscal years (FY) 2010 through 2018. Further, HR 515 required us to identify and track certain metrics on mental health spending as well as obtain opinions from various stakeholders involved with mental health issues.

Objectives

After a resolution is adopted, as a matter of practice the LBFC's officers also adopt objectives for the proposed study. Study objectives allow us to more precisely answer the requirements of the resolution, while providing an outline from which to guide the various study phases.

As directed by the officers of the LBFC, on January 7, 2020, the following objectives were approved:

- To develop appropriate summaries and analysis regarding contracted county-based community mental health services, including but not limited to, the following: the amount allocated by county for various services, the number of units provided by contract entities, the number of people served, and the amount spent by each county to administer its county mental health program. Further, to the extent possible, document the outcomes, to include living conditions and the mental health status, of individuals who were transferred out of community residential rehabilitation services.

- To document and provide appropriate context on the number of individuals with mental illness in county jails, or who may have accessed emergency rooms suffering from a mental health crisis.

- To develop appropriate summaries and analysis on the use of short-term private psychiatric facilities in each county.

- To document issues that may be present within the county-based mental health services framework, including delays in intake and psychiatric evaluations, and as appropriate to develop any recommendations that may benefit the delivery of mental health services in the commonwealth.

Scope

According to *Government Auditing Standards*, issued by the Comptroller General of the United States through the Government Accountability Office (GAO), scope refers to the boundary of a study and is directly tied to the audit objectives. Scope defines the subject matter that will be reported on, such as a particular program or aspect of a program, the necessary documents or records, the period reviewed, and the locations that will be included.[8]

As outlined in HR 515, the scope, or time period to be reviewed, for this study was defined as fiscal years 2010 through 2018. The Commonwealth's fiscal year runs from July 1 through June 30; therefore, the fiscal years to be reviewed were FY 2010-11 through FY 2017-18.

As we started this project, we encountered another issue which caused us to reevaluate the scope of this project. As discussed later in this report, on July 1, 2012, the then named Department of Public Welfare, redefined and realigned the cost centers used to track county mental health program costs. The net effect of this occurrence was that many of the services specifically named in HR 515 were merged into newly defined cost centers and/or renamed. As a result, tabulating and developing data summaries, as directed in HR 515, would have been overly time consuming and likely lacked the precision to reveal meaningful results.

Because of these accounting changes, and to ensure that we could make "apples to apples" comparisons from year-to-year, which was the intent of HR 515, we changed the scope of our review to be July 1, 2012, through June 30, 2018.

[8] *See* Comptroller General of the United States, Government Accountability Office, Government Auditing Standards, 2018 revision, paragraph 8.10.

Finally, we must also highlight the unprecedented impact caused by the coronavirus pandemic. In response to orders from the Governor, on March 16, 2020, our offices were closed, and we immediately shifted to telework procedures. This change in protocols did not limit our ability to answer the objectives; however, certain technological limitations did present challenges to the timely completion of procedures necessary to answer the objectives.

Methodology

To understand Pennsylvania's county-based community mental health system, we conducted several informative teleconferences with members from the Pennsylvania Association of County Administrators of Mental Health and Developmental Services (PACA MH/DS). Additionally, we obtained briefing documents and white papers from PACA MH/DS to better inform our understanding.

We conducted an extensive review of federal and state legislation to provide a historical context on how Pennsylvania's MH system evolved, developed, and progressed through recent decades.

We also reviewed reports issued by the Joint State Government Commission, which conducted similar research on MH issues in Pennsylvania. These reports included the following:

- *Pennsylvania Mental Health Care Workforce Shortage: Challenges and Solutions*, June 2020.
- *Behavioral Health Care System Capacity in Pennsylvania and Its Impact on Hospital Emergency Departments and Patient Health, Report of the Advisory Committee on Emergency Department Treatment and Behavioral Health*, July 2020.
- *Mental Health Services and the Criminal Justice System in Pennsylvania*, May 2014.

To understand the procedures, processes, and practices used to account and track county MH services, we conducted interviews with staff from various bureaus and offices within the Pennsylvania Department of Human Services (DHS). We also obtained and reviewed relevant bulletins issued by the Office of Mental Health and Substance Abuse Services (OMHSA) within DHS. Finally, we obtained six years of MH cost center data, which was used as a basis for MH service category analysis.

We also worked extensively with staff from the Pennsylvania Health Care Cost Containment Council (PHC4) to obtain data on hospitalizations and emergency room use for MH cases.

We worked with representatives from the Pennsylvania Department of Corrections to obtain data on mental health caseloads in Pennsylvania's county jails.

We obtained data on the number and location of private psychiatric hospitals in Pennsylvania, which we obtained from DHS. We used "hospital utilization reports," which we obtained from the Pennsylvania Department of Health (DOH) to calculate occupancy rates for these facilities.

We conducted an extensive survey of county MH administrators on various issues related to community MH services, including funding, wait times, and access to services. We also sought out their thoughts/opinions about the COVID-19 pandemic and its impact to community MH services.

Finally, we requested policy statements from various MH stakeholder groups on these issues:

- Barriers that prevent individuals with mental health issues from receiving and/or accessing the right treatment and services in a timely manner or not at all.
- Law enforcement and its ability to appropriately respond to and possibly redirect individuals with mental illness from the criminal justice system.
- Homelessness and its impact on individuals suffering from mental illness.
- Access to mental health services for children and/or the delivery of school-based mental health services.
- Perspectives on the need for psychiatric services, including any delays for access. Additionally, the need for psychiatric facilities (long-term or short-term).
- The need for expanded community residential rehabilitation services and the outcomes of individuals receiving these services.
- The impact of COVID-19 on mental health services.
- Any other issues (specific to mental health) warranting the attention of the Pennsylvania General Assembly.

Frequently Used Abbreviations and Definitions

Throughout this report, we used several abbreviations for government-related agencies, terms, and functions. These abbreviations are defined as follows:

Abbreviation	Name	Definition
HR	House Resolution	Non-binding bills passed by the Pennsylvania General Assembly to address issues of collective interest or concern.
FY	Fiscal Year	12-month organizational period used for government budgeting and accounting
GAO	Government Accountability Office	Agency of Federal legislative branch tasked with auditing, evaluation, and investigative services for the United States Congress
DHS	Pennsylvania Department of Human Services	State agency with seven separate program offices responsible for providing care and support to PA's most vulnerable citizens.
OMHSAS	Office of Mental Health and Substance Abuse Services	One of the seven DHS program offices; primarily focused on providing support and facilitating recovery resources for victims suffering from substance abuse
CMHA	Community Mental Health Act (1963)	Pioneering federal legislation signed by President Kennedy in 1963 seeking to deinstitutionalize America's mental healthcare system and redirect resources towards more humane community-based facilities.
MHSA	Mental Health Systems Act (1980)	Federal law signed by President Carter in 1980 intended to strengthen the CMHA by providing larger, more targeted grants to community mental health centers. It was shortly repealed a year later by President Reagan in favor of a block grant program.
NIH	National Institute of Health	A branch of the United States Department of Health and Human Services located in Bethesda, MD. The NIH is responsible for conducting medical research and is one of the largest, most renowned scientific organizations in the world.
HSBG	Human Services Block Grant Program	Part of President Reagan's omnibus fiscal budgeting policy shift away from targeted funding towards a more generalized method of funding where states and counties are given large chunks of funding to be used at their discretion
TCM	Targeted Case Management	Services provided only to specific classes of mental health patients, or to individuals who reside in specified areas of the state.
AOP	Alternative Outpatient Therapy	Full service mental health treatment programs that typically require 10-12 hours a week visiting a community treatment center.
ADT	Adult Development Training	Community based services and programs designed to facilitate the acquisition of prevocational, behavioral activities of daily living, and independent living skills.
SAMHSA	Substance Abuse and Mental Health Services Administration	A branch of the United States Department of Health and Human Services. They are responsible for leading public

		health efforts to understand and tackle behavioral health issues and reducing the impact of substance abuse in American communities.
PCH4	Pennsylvania Health Care Cost Containment Council	Independent state agency tasked with addressing the commonwealth's rapidly increasing cost of health care. The council collects data and publishes annual reports on a variety of topic including hospitals, policymakers, researchers, physicians, insurers amongst other things.
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders (4th Edition)	A publication by the American Psychiatric Association. Originally released in 1952, the DSM provides a classification of mental disorders using a common language and standard criteria.
ICD-9	International Classification of Diseases (9th Edition)	A list of codes developed by the World Health Organization and modified within the United States intended for the classification of diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease.
ACT	Assertive Community Treatment	An intensive and highly integrated approach for community mental health service delivery. These service deliveries do not take place in traditional hospital or residential settings. Community reintegration is a primary goal for Assertive Community Treatment programs.
GAF	Global Assessment of Functioning	A numeric scale from 100-1 used by mental health clinicians and physicians to rate subjectively the social, occupational, and psychological functioning of an individual and the severity of their mental illness.
CTT	Community Treatment Team	Community based mental healthcare professionals who work with severely mentally ill patients to ensure continuity of care from a hospital to an outpatient practice. They are vital to improving a patient's ability to function within the community, thus reducing the need for future hospitalization.
PACA (PACA MH/DS)	Pennsylvania Association of County Administrators of Mental Health and Developmental Services	Agency representing county mental health and intellectual disability program administrators from all of Pennsylvania's counties.
CCAPPOA	County Chief Adult Probation and Parole Officers Association of Pennsylvania	Agency responsible for monitoring the commonwealth's adult probation system with the eventual goal of promoting inmate reintegration efforts and reducing recidivism.
PPS	Pennsylvania Psychiatric Society	A non-profit organization representing the state's Psychiatrists in advocating for their profession and their patients to assure access to psychiatric services of high quality, through activities in education, shaping of legislation and upholding ethical standards.
APA	American Psychiatric Association	Founded in 1844 in Philadelphia, the APA is currently the largest psychiatric organization in the world with just under 40,000 members. The APA's mission statement is to promote the advancement, communication, and application of psychological science through research and advocacy to benefit society and improve lives.
PE	Psychiatric Evaluation	A formal assessment, or psychological screening with the intent of gathering information about a person within a psychiatric service, in order to make an accurate diagnosis.

Acknowledgements

We thank the executive staff of the PACA MH/DS. Their insights and assistance were instrumental in allowing us to obtain and process the information contained in the report. We also thank each of the county MH administrators who responded to our survey.

We also wish to extend thanks to the staff of the Pennsylvania Health Care Cost Containment Council, which shared critical health record data with us. Additionally, we thank staff from the Department of Human Services and the Department of Corrections, who also aided us in obtaining information presented in this report.

Important Note

This report was developed by the staff of the Legislative Budget and Finance Committee, including project manager, Stephen Fickes and staff analysts, Rebanta Mukherjee and Joseph Asare. The release of this report should not be construed as an indication that the Committee as a whole, or its individual members, necessarily concur with the report's findings, conclusions or recommendations.

Any questions or comments regarding the contents of this report should be directed to the following:

Patricia A. Berger, Executive Director
Legislative Budget and Finance Committee
P.O. Box 8737
Harrisburg, Pennsylvania 17105-8737
717-783-1600
email: lbfcinfo@palbfc.us

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SECTION II
BACKGROUND INFORMATION ABOUT PENNSYLVANIA'S MENTAL HEALTH SERVICES

Fast Facts…

- *Over the past 50 years, mental health services have evolved from primarily institutional-based services to community-based services.*
- *In Pennsylvania, sweeping changes in mental health policy occurred with the 1966 Mental Health/Intellectual Disabilities Act. This Act created a county-based service system, delineated responsibilities between the state and counties, and mandated core services. Most of the funding for these services is through the Department of Human Services and its Office of Mental Health and Substance Abuse.*
- *There are 48 county program offices or county joinders that implement the 1966 Act locally either directly or contractually with other counties.*

Introduction

In 1963, President John F. Kennedy signed into law sweeping changes to the provision and administration of mental health (MH) services in the United States. Known formally as the Community Mental Health Act, this legislation laid the basis for reforming public mental health systems by shifting resources away from large institutions and toward community-based mental health treatment programs.

Prior to this shift in MH service delivery, most resources to combat MH-related problems were directed only toward centralized institutional-based care centers. By the mid-20th century, however, public opinion towards these institutions had begun to shift. For example, large mental hospitals became known as "snake pits"--a term borrowed from the 1948 film "The Snake Pit," which painted bleak pictures of life in the nation's mental hospitals. These hospitals highlighted cruel and inhumane conditions for many of the residents who were sent there. Other factors that shifted public support away from these institutions were the development of evidence-based treatments and psychiatric medication to improve patient outcomes.

In the sections that follow, we present background information about the delivery of MH services in Pennsylvania, as well as contextual information that supplements the information discussed in later report sections. Before presenting this information, it is important to highlight that if you or someone you know is experiencing mental health crisis or is considering suicide, help is available. Reach out to the *National Suicide Prevention Lifeline* at **1-800-273-TALK (8255)** or contact *Crisis Text Line* by texting **PA** to **741-741**.

Historical Perspectives Surrounding Mental Health Services

America's understanding of mental health illness and treatments have evolved considerably over the past 200 years. In the early 19th century, mental health treatment was nearly non-existent. Patients were often misunderstood, misdiagnosed, and subsequently mistreated. Any medical treatment, if provided, was usually relegated to solitary prison type

confinements. Few treatment options designated specifically to tackle mental health existed; moreover, those that did exist were based on archaic medical procedures such as bloodletting or purgatives. These medical practices had been prominent in Western societies since the 1600s and originated from the idea that mental health illnesses were caused by biochemical imbalances in a patient's blood. Another psychotherapeutic approach to combatting mental illnesses in the 19th century were so called "moral treatments." These practices focused on strengthening a patient's behavioral discipline and were largely influenced by the cultural and religious context of American society at that time. It was commonly thought during this period that mental health issues and socially deviant behavior such as alcoholism resulted from weak hereditary factors.

Moral Treatments and Institutionalization

The moral treatment movement was introduced in the United States by Dr. Benjamin Rush, who eventually went on to play a foundational role in constructing the first hospital designated specifically for mental health patients.[9] The Quaker hospital was called the Friends Asylum and was located in Frankford, Pennsylvania, where it still operates today. Following the opening of this institution, several similar asylums began opening in the United States throughout the 19th century. However, by the late 1800s, the conditions of these centralized mental health institutions began to deteriorate significantly. Although there are several reasons for this deterioration, a primary reason was the lack of operating standards and regulatory oversight.

Without appropriate oversight and management, these facilities became overcrowded and underfunded. It was not uncommon for 100 patients to share a single room. Conditions were largely unsanitary and inhumane for the residents. This trend, unfortunately, continued well into the 20th century. In addition to poor sanitary conditions, medical practices by the 20th century began changing as well. During this period, doctors were treating mental health illnesses with physical methods, which were often cruel and unnecessary. Some of these methods included shock therapy, ice baths, restraints, and lobotomies.

The practices and rapid deterioration of conditions in such facilities led to these institutions being nicknamed "snake pits," after a 1948 film by the same title, which depicted the abhorrent circumstances within the clinics. The film served as a turning point in the way Americans viewed mental health illnesses and treatments.[10] Where mental health patients were historically stigmatized and viewed as dangerous or possessed, The

[9] University of Toledo Libraries, *19th Century Mental Health,* July 1, 2019.
[10] Los Angeles Times, *Mental Health Hospital Sheds Image of Grim 'Snake Pit',* March 9, 1986.

Snake Pit film brought new awareness to mental health and the need to empathize with those who were battling mental health issues.

In addition to this change in public sentiment there was a growing problem regarding the reintegration of mental health patients back into society. Many soldiers returning from World War II required treatment for psychiatric symptoms. The post-war American social climate emphasized the significance of community relationships. The institutionalization and potentially abusive life within the mental health hospitals would oftentimes mean discharged patients would have an impossible challenge of readjusting to civilian life once released from a facility. In turn, a "revolving door" syndrome existed, which led to a growing and ultimately unsustainable number of patient readmissions.

By the early 1960's, there was a public desire to see poorly run facilities shut down and for mental health treatments to be provided with more care. In response to this societal shift, the Congressional Joint Commission on Mental Illness and Mental Health, which had been established just a few years prior, released a groundbreaking report in 1961 that called for the deinstitutionalization of existing facilities. This report was the beginning foundation for the eventual drafting and passage of the Community Mental Health Act, which President Kennedy signed into law on October 31, 1963.

Community Mental Health Act of 1963 and Mental Health Systems Act of 1980

The Community Mental Health Act of 1963 (CMHA) was a landmark piece of legislation that altered how mental health patients were cared for, and how mental health clinics would be established and funded. The CMHA was the first federal initiative to tackle mental health, and it provided uniform oversight into facility care, which had been previously left to the states.

CMHA, in accordance with the Joint Commission's report, which allowed for a more localized and targeted approach to combatting mental health problems. Rather than continuing the trend of a few large centralized treatment facilities in each state, CMHA empowered states to create community-based treatment centers.[11] This shift from institutions to community-based services would allow for better quality of care for patients, prevent overcrowding and sanitary problems, and ensure that discharged patients had a better chance at eventual reintegration. Patients under guardianship could be treated while living or working from their homes. Further, providing funding and resources to local communities

[11] Gerald N. Grob, *Government and Mental Health Policy*, 1994.

enabled communities to create targeted treatment plans for their patients, which would evolve as the understanding of a social environment's impact on mental health improved.

The issue of mental health care was personal for President Kennedy, because his sister Rose was institutionalized after a failed lobotomy. In President Kennedy's words, he described the outlook for the bill by stating, "Reliance on the cold mercy of custodial isolations will be supplemented by the open warmth of community concern and capability." From 1964-1980, the federal government funded a total of $2.7 billion to 789 various community mental health centers throughout the country. In that same time period, patients in state mental health hospitals dropped by approximately 75 percent.[12] While the act was a big transitional step forward for mental health treatment, it was not without its flaws. Many of the proposed community health centers were never built, particularly in more rural areas of the country.

In 1980, President Jimmy Carter sought to strengthen the CMHA through the passage of the Mental Health Systems Act (MHSA). This act attempted to overcome some of the inadequacies of the CMHA by improving services, creating additional federal entitlement programs, and mitigating bureaucratic inefficiencies. President Carter's commitment to mental health healthcare advocacy was apparent in his days as Georgia's governor, where he created the Commission to Improve Services to the Mentally and Emotionally Retarded. During his term, Georgia saw a 30 percent decrease in hospitalized patients as the Community Mental Health Centers were established.[13]

MHSA included language to prioritize access and delivery of care to particularly underserved groups such as individuals with chronic mental illnesses, children, the elderly, racial or ethnic minorities, women, low income, and rural citizens. The legislation provided for more federal oversight and created prerequisite performance contracts as a condition for federal funding. The MHSA also attempted to reduce bureaucratic inefficiencies by creating new intergovernmental relationships with closer links between the mental health and general health care systems. Ultimately the MHSA although well-intentioned, contained too many vague generalizations about the kind of specific services and treatments required to dramatically alter America's mental healthcare system. More consequential for the MHSA, however, was the inauguration of Ronald Reagan in 1981 who would go on to all but end the MHSA and redefined how funding toward mental health programs would be delivered heading into the 21st century.

[12] Wall Street Journal, *Fifty Years of Failing America's Mentally Ill,* February 5, 2013.

[13] Gerald N. Grob, *Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health,* 2005.

Reagan Omnibus and Mental Health Block Grant Funding

By the 1980s, the shortcomings of the CHMC's and MHSA's lack of funding was exacerbated by President Reagan's decision to create block grant federal funding to states for mental health care centers. According to the National Institute of Health (NIH), in 1981 President Reagan signed the Omnibus Budget Reconciliation Act (Omnibus), which repealed the Mental Health Systems Act and consolidated treatment and rehab programs into a single block grant, enabling each state to administer its allocated funds. The new budget was part of a larger effort to reduce the size and role of the federal government.[14]

Experts have presented pros and cons to a block grant funded system. Those in favor argue that block grants save taxpayer dollars with lower federal costs and by empowering state officials to root out fraud. Additionally, a block grant system would drive more people towards the private sector for healthcare coverage. A block grant also allows state governments to disperse funds based on the specific needs of the state, where funding is liquid enough to be transferred from one department to another. Those against block grant funding argue that it undercuts the need for resources across communities.

It is generally thought that a successful community treatment approach regarding mental health management, is one that can integrate psychiatric treatment with social services, housing, and social support networks. However, once the Omnibus passed, the federal government was only providing mental health funding at about 75 to 80 percent of what states would have received under the MHSA. These cuts were especially troubling for large urban areas because additional funding, which was needed to successfully manage the complex social, economic, and medical needs of the community, was no longer present.

While our understanding of mental health has evolved since the 1980s, this general process of funding flowing from the federal government to the states, and from the states to communities is largely how public resources are delivered. Many of the questions posed from 40 to 50 years ago remain relevant today. These questions include how best to create mental health policy, either independently, or as part of a larger healthcare policy, and how to fund those policies.

[14] Bruce M. Logan, *Block Grants for Mental Health: Elements of State Response,* 1985.

Pennsylvania's Response to Federal Changes

As a result of the 1963 Community Mental Health Act, states were directed to create organizational infrastructures and systems of care to combat mental illnesses and deliver services to patients. Community mental health services needed to be transitioned from statewide institutional facilities to more localized county-level services. These county offices were to be overseen by a county administrator. This eventually resulted in a formal response in 1966 with the Mental Health and Intellectual Disability Act (MH/ID).[15]

The MH/ID required county mental health and developmental service offices to provide targeted services including, but not limited to the following:

- short-term inpatient treatment,
- partial hospitalization,
- outpatient care,
- emergency services,
- specialized rehabilitation training,
- vocational rehabilitation, and
- residential services.

The blueprint established in the MH/ID is still operational today. Many of these services are paid for by public and private providers, the Pennsylvania Medical Assistance Program, and Medicaid through the Pennsylvania Health Marketplace.[16]

According to Opencounseling.com,[17] in most cases, community mental health programs serve as alternative providers for people who lack the means to access services in the private sector. However, Pennsylvania's multifaceted system, which includes small private practices as well as large non-profits, can blur the lines between the public and private sectors. County databases list specialized providers and programs that can meet the diverse needs of many people.

In many states, intake and referral programs for public mental health services determine whether people are eligible for services based on their

[15] The Act was originally known as the Mental Health and Mental Retardation Act of 1966. In 2011, the Act was updated by Act 105 to change the terminology.
[16] *See* "Resources to Recover" at www.rtor.org/directory/mental-health-pennsylvania. Resources to Recover is a non-profit gateway organization that helps families and individuals connect with local guidance and mental health support resources.
[17] OpenCounseling.com is a web site that offers comparative information about state public mental health resources. The goal is to serve as a single resource for each state. As of October 2020, the site was still updating information on other states. *See* www.opencounseling.com/public-mental-health-pa.

diagnoses and the severity of their mental health conditions. In Pennsylvania, county mental health offices and base service units determine a person's eligibility for financial assistance but provide referral services to local programs even for people who do not qualify for financial assistance. In many cases, contracted providers accept a wide range of insurance plans and offer sliding scale fees to people without insurance even when they do not qualify for financial assistance from the state.[18]

Contemporary Evolutions in Mental Health

As understanding of mental health and wellness has evolved into the 21st century, Pennsylvania has worked to continue progress on mental health treatments and systems of care. In 2011, as an ongoing response to the 1999 Supreme Court *Olmstead* decision, the state instituted the Olmstead Plan for the Pennsylvania State Mental Health System. As we noted in a 2015 report on *Olmstead*, public entities are required to provide community-based services when (1) appropriate; (2) the affected person does not oppose such treatment; and (3) those services can be reasonably accommodated.[19]

The program was then subsequently revised and readopted in 2013 and then again in 2016, each time updating the plan's goals and the specific steps to achieve those goals. The 2016 plan for example, emphasized a need for community integration for discharged patients through employment opportunities and utilizing natural support resources to aid patients in recovery. The Olmstead Plans are largely credited with Pennsylvania drastically improving patient housing support services over the past 10 years.[20]

In terms of block grant funding, the Pennsylvania legislature passed Act 80 in 2012, which established a Human Services Block Grant Program (HSBG). The program was created to streamline the allocation of state and federal funds to select county governments that required assistance to service the needs of residents. For example, under a block grant scenario counties have more flexibility to use funding across various program needs (e.g., mental health, intellectual development, substance abuse, etc.). Originally the HSBG allowed for 20 counties to qualify for needs-based allocation. Because of the apparent success of the HSBG, it was revised in 2013 to allow for funding to 30 counties, and in 2016, that cap was removed altogether, meaning all counties within the state would qualify for block grant funding.

[18] Ibid.

[19] This report is available from our web site at LBFC report at http://lbfc.legis.state.pa.us/Resources/Documents/Reports/530.pdf. This report was also recognized by the National Legislative Program Evaluation Society for its impact to program evaluation.

[20] Department of Human Services, *Olmstead Plans for Mental Health Services,* May 1, 2016.

The funds within HSBG make up a significant portion of Pennsylvania's mental healthcare funding. DHS releases an annual report detailing the allocations and expenditures for the fiscal year.[21] DHS is required to disclose details on block grant funds by county governments. Per DHS' FY 2018-19 annual report, in that year alone 73 percent ($370.0 million) of the total block fund expenditures were for mental health services.[22]

Pennsylvania Mental Health Structure

Within Pennsylvania there are a multitude of different public and private agencies that are responsible for mental health policy development, implementation, and service delivery. For purposes of this report, the primary agencies include, but are not limited to, the following:

DHS Office of Mental Health and Substance Abuse Services (OMHSAS). OMHSAS is the primary oversight authority for the delivery of mental health services in Pennsylvania. According to the Governor's Executive Budget, OMHSAS provides for an integrated behavioral health system addressing mental health treatment and support services, as well as substance abuse services. The objective of these services is to promote individual movement toward recovery. Community mental health funds, behavioral health services funds for both mental health and substance abuse services, Act 152 funds that provide non-hospital residential substance abuse services, and federal grant funds are distributed to counties, county joinders, and single county authorities to provide behavioral health services. OMHSAS manages the delivery of community mental health services administered by counties under the Pennsylvania Mental Health and Intellectual Disability (MH/ID) Act and the Mental Health Procedures Act. Medicaid-funded behavioral health services are provided through the state-administered fee-for-service behavioral health system or the Medicaid HealthChoices Behavioral Health Managed Care program either through county contracts or by direct contract with a behavioral health managed care organization.

County Mental Health and Developmental Services Program Offices. County MH/DS offices administer mental health services in Pennsylvania. Actual mental health services are delivered by county-employed professionals or local provider agencies under contract with the county MH/DS office. The county MH/DS office determines a person's eligibility for service funding, assesses the need for treatment or other services and makes referrals to appropriate programs to fit service needs. Community services are targeted to adults with serious mental

[21] Under Act 153, in FY 2017-18 counties were able to retain up to five percent of the state block grant funds to be used during the next fiscal year.
[22] Pennsylvania Department of Human Services, *Human Services Block Grant Program Expenditure Report,* 2018-19.

illness and children and adolescents with or at risk of serious emotional disturbance. Key provisions of service include recovery-oriented treatment, community care, and support services that enable individuals to live in the community and lead independent and productive lives. Non-residential services include family-based support, outpatient care, partial hospitalization, emergency and crisis intervention, peer to peer support, and after care. Community residential services include housing support, residential treatment, inpatient care, crisis services, and mobile therapy.

Services are administered by single counties, county joinders, or through contracts with private, nonprofit organizations or agencies. Services, with some exceptions, are funded with federal, state, and county matching funds. As listed in Exhibit 1, there are 48 mental health program offices, with some offices having multiple county boundaries. Mental health offices may also be combined with more than one program, such as intellectual disabilities or early intervention.

Exhibit 1

Pennsylvania County Mental Health Program Offices

County/Counties	Administering Agency
Adams/York	Adams/York Mental Health/Intellectual Developmental Disabilities
Allegheny	Allegheny County Department Of Human Services
Armstrong/Indiana	Armstrong/Indiana Behavioral and Development Health Program
Beaver	Beaver County Behavioral Health
Bedford/Somerset	Bedford-Somerset Developmental and Behavioral Health Services
Berks	Berks County Mental Health and Developmental Disabilities
Blair	Blair County Mental Health/Behavioral Health/Intellectual Disabilities
Bradford/Sullivan	Bradford/Sullivan Mental Health/Intellectual Disabilities
Bucks	Bucks County Department of Mental Health/Development Program
Butler	Butler County Mental Health/Early Intervention/Intellectual Disabilities Program
Cambria	Cambria County Behavioral Health/Intellectual Disabilities Program
Cameron/Elk	Cameron/Elk Counties Behavioral and Development Programs
Carbon/Monroe/Pike	Carbon-Monroe-Pike Mental Health and Developmental Services
Centre	Centre County Mental Health/Intellectual Disabilities/Early Intervention
Chester	Chester County Dept. of Mental Health/Intellectual and Developmental Disabilities
Clarion	Clarion County Mental Health/Developmental Disabilities
Clearfield/Jefferson	Community Connections of Clearfield/Jefferson Counties
Lycoming/Clinton	Lycoming-Clinton Mental Health/Intellectual Disability Program
Columbia/Montour/Snyder/Union	Columbia-Montour-Snyder-Union Behavioral Health and Developmental Services

Exhibit 1 Continued

Crawford	Crawford County Mental Health Service
Cumberland/Perry	Cumberland/Perry Mental Health/Intellectual Developmental Disabilities
Dauphin	Dauphin County Mental Health/Intellectual Disabilities Program
Delaware	Delaware County Behavioral Health/Intellectual Disabilities Program
Erie	Erie County Mental Health/Intellectual Disabilities
Fayette	Fayette County Behavioral Health Administration
Forest/Warren	Forest-Warren Human Services
Franklin/Fulton	Franklin-Fulton Mental Health/intellectual Disabilities/Early Intervention
Greene	Greene County Human Services
Juniata/Mifflin/Huntington	Juniata Valley Behavioral and Developmental Services
Lackawanna/Susquehanna	Lackawanna-Susquehanna Behavioral Health/Intellectual Disabilities/Early Intervention
Lancaster	Lancaster County Behavioral Health and Developmental Services
Lawrence	Lawrence County Mental Health and Developmental Services
Lebanon	Lebanon County Mental Health/Intellectual Disabilities/Early Intervention
Lehigh	Lehigh County Mental Health/Intellectual Disabilities/Drug and Alcohol/Early Intervention
Luzerne/Wyoming	Luzerne-Wyoming Counties Mental Health and Developmental Services
McKean	McKean County Mental Health/Developmental Services
Mercer	Mercer County Mental Health/Developmental Services
Montgomery	Montgomery County Mental/Developmental Disabilities/Early Intervention
Northampton	Northampton County Mental Health/Early Intervention/Developmental Program Division
Northumberland	Northumberland County Behavioral Health and Intellectual Developmental Services
Philadelphia	Philadelphia Dept. of Behavioral Health/Intellectual Services
Potter	Potter County Human Services
Schuylkill	Schuylkill County Administrative Offices of Mental Health/Developmental Services/Drug and Alcohol
Tioga	Tioga County Department of Human Services
Venango	Venango County Mental Health and Developmental Services
Washington	Washington County Behavioral Health and Developmental Services
Wayne	Wayne County Behavioral and Developmental Programs/Early Intervention
Westmoreland	Westmoreland County Behavioral Health and Developmental Services

Source: Developed by LBFC staff from information provided by the Pennsylvania Association of County Administrators of Mental Health and Developmental Services.

Pennsylvania Mental Health Planning Council. This council consists of three committees: Children's Advisory Committee, Adult Advisory Committee, and the Older Adult Advisory Committee. Collectively, these committees form the MHPC whose purpose is to advise OMHSAS on a broad mandate including but not limited to mental health, substance abuse, behavioral health disorders, and cross-system disability. The council's membership consists of representatives of youth, adult and older adult individuals who have been served by the behavioral health system, family members of such youth and adults, providers, advocates, professionals, their respective organizations, as well as governmental organizations. At least 51 percent of the members are current or former behavioral health consumers and family members. Members are appointed by the DHS deputy secretary of OMHSAS.

State Hospitals. While the trend mentioned earlier in the report has been a shift away from these large statewide mental health institutions, some remain operational today. DHS currently operates six state hospitals in Clark Summit, Danville, Norristown, Torrance, Warren, and Wernersville (and a restoration center at South Mountain). Such state hospitals are reserved for patients with very serious mental health illnesses and are far from the abhorrent conditions of the 1960s and earlier. Per DHS' website, "the State Hospital system adheres to a "No Wrong Door" approach in order to include integrated services related to mental health, physical health and substance abuse disorders." The evolution of the state hospital system over the past decades has seen it grow into an institution that places greater value on the quality of life for its patients. As of July 2019, the total population at the state hospitals and South Mountain was 1,488.

Pennsylvania Mental Health Statistics and Current Issues

A current snapshot of mental health in Pennsylvania from the United States Department of Health and Human Services' branch of the Substance Abuse and Mental Health Services Administration (SAMHSA), reveals that approximately four percent of adults in the state live with serious mental health illnesses such as schizophrenia, bipolar disorder, and major depression. The Treatment Advocacy Center notes that as of 2017, Pennsylvania had 112,000 patients with schizophrenia and 223,000 patients with severe bipolar disorder.[23]

[23] The Treatment Advocacy Center is a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illness.

In total, about 17.5 percent of Pennsylvania adults have some form of mental illness, where the national average is 18.3 percent. SAMHSA estimates that 46.7 percent of mental health patients in Pennsylvania receive treatment services from public or private providers.[24] The remaining 53.3 percent receive no mental health treatment at all.

While state and federal laws have had a dramatic impact on improving housing support systems, there is still a long way to go. The Treatment Advocacy Center notes that a minimum of 50 beds per 100,000 people is considered necessary to provide minimally adequate treatment for individuals with severe mental illness. As it stands, Pennsylvania does not currently meet this standard, with only about 10.4 beds per 100,000 people. However, it is worth mentioning for context that currently none of the other states in the nation meets these standards either. Another troubling statistic is that Pennsylvania, like every other state, incarcerates more individuals with severe mental illness than it hospitalizes.[25]

However, when looking at Pennsylvania's system of care in relation to other states, the picture becomes more optimistic. A non-profit mental health advocacy organization, Mental Health America, releases an annual ranking and methodology of how capable each state is performing in tackling the needs of their respective mental health patients and systems of care. Mental Health America uses 15 metrics to determine the methodology for their rankings including the number of people with mental illness, the number of patients with needs unmet, mental health workforce availability, the number of uninsured patients, and other factors. In their latest ranking, Pennsylvania ranked 9th nationwide for adult mental health patients and 1st overall for all patients. A higher ranking indicates a lower prevalence of mental illnesses and higher rates of access to care.[26] The important note from these rankings is that Pennsylvania is performing well relative to other states in combatting mental illness and creating effective systems of care, but collectively, as a nation, there is still much that can be improved.

This point is further emphasized within the context of 2020, as Pennsylvania, along with the rest of the world is forced to adjust with and respond to the ongoing COVID-19 pandemic. While data on how the pandemic has impacted individuals and American society as a whole are still being collected, researchers and medical professionals agree there is little doubt that there will be a relationship between the two. The preventative measures to control the spread of the virus are bound to produce some behavioral consequences. For example, ongoing social distancing and self-isolation is severely mitigating face-to-face social contact, a widely known factor understood to help in reducing the risk of depressive disorders. Additionally, the extreme conditions towards vigilance for hygiene,

[24] SAMHSA, *Behavioral Health Barometer (Pennsylvania),* 2014
[25] *See* https://www.treatmentadvocacycenter.org/storage/documents/grading-the-states.pdf.
[26] MentalHealthAmerica, *State Rankings,* 2020.

cleanliness, and safety coupled with the risk and fear associated with contracting the virus is sure to lead to a greater level of anxiety for patients who struggle with anxiety, and for the larger society in general. The National Institute of Health has observed a rise in anxiety and depression amongst the general population, with an estimated 1 in 3 experiencing some level of anxiety, and 1 in 5 for depressive disorders.[27]

The most vulnerable populations are those people with pre-existing, severe psychiatric disorders. Researchers have noted in the past for example, that after a natural disaster, people suffering from schizophrenia and bipolar disorder tended to worsen. Makeshift telehealth or telemedicine services may be insufficient for providing certain patients with the treatments they require. Without the requisite access to care, during the pandemic, and after, these are the Pennsylvanians who will require the most urgent assistance.

In January 2020, the County Commissioners Association of Pennsylvania advocated for state lawmakers to provide a $42 million increase towards mental health services, with a 3 percent annual increase to keep up with rising costs and inflation.[28] The financial impact of the virus and resulting pandemic will undoubtedly have a lasting impact on the country and Pennsylvania. It remains to be seen how the economic impacts from the COVID-19 pandemic will impact the state budget and by extension, funding for community mental health services.

[27] Imran Ijaz Haider, National Institute of Health, *Impact of the Covid-19 Pandemic on Adult Mental Health,* May 2020.
[28] County Commissioners Association of Pennsylvania, *Priorities Status Report,* August 2020.

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SECTION III
MENTAL HEALTH SERVICES DATA COLLECTION AND ANALYSIS

Fast Facts…

- *Counties play an integral role in administering public MH services in their boundaries. DHS provides guidance to the counties on how service utilization is to be reported.*
- *DHS uses 25 cost centers to classify MH services in Pennsylvania. Counties use DHS-templated "income and expense" reports to account for how state funds are distributed within the MH program. The data within these reports is self-reported.*
- *Using these reports over a six-year period, we plotted three variables: total expenditures, purchased services (which are a portion of total expenditures), and number of clients served. We found reporting inconsistencies within these categories, but especially within the category of clients served.*

Overview

HR 515 requested specific data collection on various mental health (MH) services provided by county MH service agencies. Although these services are provided by counties, certain data elements are reported to the Pennsylvania Department of Human Services (DHS). To this end, DHS uses a standardized cost center structure to track MH services. Unfortunately, we found that beginning in FY 2012-13, DHS changed its cost center reporting structure. As a result, certain mental health service categories were renamed or otherwise categorized, which made year-to-year comparisons prior to FY 2012-13 (an objective of HR 515) impossible; therefore, our analysis addressed the period FY 2012-13 through FY 2017-18.

In performing our analysis, we were able to use DHS-provided "income and expense reports," which are templated spreadsheets used to track key items like: total expenditures, purchased services (which are a portion of total expenditures), and the number of clients served within each of the cost centers. We focused on these three categories within each cost center as they were also part of the requested data points outlined within HR 515. Although the cost center spreadsheets provided uniformity in data presentation, unfortunately, we found the data was also self-reported and likely contained reporting inconsistencies that skewed meaningful analysis of the data. This occurrence was especially true for the number of clients served category, as we found instances in several cost centers where the clients fluctuated significantly from year-to-year. DHS noted that it can be difficult to obtain accurate client numbers, in part because of the variability of the type of services provided. As such, while we provide detailed exhibits about each of the cost centers, caution should be exercised in drawing hard conclusions from the exhibits, as the underlying data from the source documentation may have been reported inconsistently. We highlight these inconsistencies where possible.

There are 25 DHS-defined MH cost centers, which cover a wide variety of services and activities. Some examples include providing community information about MH awareness, providing emergency commitments for MH illness, and case management services. As might be expected with the large number of cost centers, there was variability in terms of expenditures and clients served. For example, for the period FY 2012-13 through FY 2016-17, with respect to the number of clients served, the

Administrative Management cost center had the greatest number of clients served with over 665,000 clients. Conversely, the cost center with the fewest clients was Adult Development Training with just 57 clients. With respect to purchased services, which are part of a county's total MH expenditures and generally cover contract services, Community Residential Services was the most expensive cost center at more than $1.52 billion over the six years reviewed, and Children's Evidence-based Practices had the lowest amount spent at $1.3 million. Finally, when looking at total expenditures across all the cost centers, Community Residential Services was again the most expensive cost center at $1.53 billion, while Adult Development Training had the lowest expenditures, with slightly more than $291,000.

Issue Areas

A. County Mental Health Services Data

Within this issue area, we discuss the 25 DHS cost centers used for tracking county-based mental health services. DHS cost centers were established in FY 2012-13 and provide a uniform data reporting structure for counties that use state and county funding for community mental health services.

Before discussing these cost centers further, it is important to review why we presented the data in the manner we did. As discussed in Section I, HR 515 asked us to present specific data over a specific time frame (2010-2018). More precisely, we were tasked with obtaining information on five key areas:

1. Amounts allocated by each county for contracted services for certain MH services.
2. Units of service provided by each contracted entity for certain MH services by county.
3. Number of people receiving MH services by type and by county.
4. The amount spent on administering the county mental health program by county.
5. Follow-up information on the living conditions and MH status of individuals transferred out of community residential rehabilitation services.

We were unable to fully answer these items because of data changes with how DHS tracks the information and with how data is reported by the county MH agencies. For example, as mentioned above, in FY 2012-13 DHS started using new cost centers to track MH spending and clients

served. In concert with this change, DHS had counties complete "income and expense" reports for each fiscal year, which provided a uniform reporting structure for not just MH spending, but also other programs such as intellectual disability, children and youth services, and drug/alcohol services.

The income and expense reports provide a templated reporting structure for the counties; however, we faced complications in trying to identify and provide the above requested information. First, as a result of DHS issuing, through its Office of Mental Health and Substance Abuse (OMHSAS), Bulletin 12-02, several MH services that were used prior to 2012 were either consolidated or were no longer used. As a result, although HR 515 asked us to obtain data from 2010-2018, to ensure that we had an "apples-to-apples" comparison we could only capture data from FY 2012-13 through FY 2017-18. Consequently, with the multitude of exhibits that are presented we limited our scope to just this range.

Second, while the income and expense reports are based on templates in a spreadsheet format, the data within the spreadsheets is entirely self-reported. DHS conducts some limited review of the data, but as shown in the exhibits that follow, we found some variances that are a result of reporting inconsistencies. This occurrence is especially at issue with "clients served," which might show variation from year-to-year because counties may include public outreach and education activities in their totals. For example, if 1,500 copies of a brochure explaining the county MH program and available MH services is printed and distributed at a community event, the county MH agency may consider that reaching 1,500 clients. Similarly, if a speaker presents to a crowd and the number of attendees is estimated, this estimate will result in a larger number being reported in one year, but not the next. We highlight these reporting variances within each of the cost centers, but time did not allow us to determine why certain counties had a reporting fluctuation. Because of these irregularities reported to DHS, we exercise caution in drawing hard conclusions from the data, especially in relation to the category "clients served."

Third, although HR 515 asked for certain data elements, the actual data is not tracked in a manner to answer the objective. For example, allocations are not made by specific MH contracted service. However, we could determine the amount that was spent on "purchased services" within each cost center. We learned that purchased services are amounts that were spent by the counties for contractors/vendors to perform the services within the cost center. Similarly, we could track "total expenditures" within the cost center, which provided an overview of how much was spent on contractors versus spent by in-house county MH staff.

Fourth, no data existed at DHS to determine the "units of service" provided by the contract entity (see item number two on the previous page).

This data is likely maintained by the respective county MH agencies; however, we had no uniform way of accessing the data in a timely manner which would result in meaningful analysis. Consequently, we purposefully excluded this area from our analysis.

Finally, with respect to the objective of obtaining follow-up information on the "living conditions and mental health status" of individuals transferred out of community residential rehabilitation, based on several discussions we had with officials from DHS, as well as the representatives from the Pennsylvania Association of County Administrators of Mental Health and Developmental Services, there is no data that tracks such status. Further, we were informed that the premise of this objective is misstated, because mental health recovery can be a lifelong endeavor for many individuals. Consequently, to just measure a program by mental health status or living condition would not yield meaningful measurements, even if data existed to do so. Therefore, our analysis did not include these sought-after outcomes; however, we do include data on spending within the cost center of Community Residential Services.

In conclusion, we obtained six years of income and expense reports from every county MH agency. From these reports we were able to pinpoint specific data points to answer the objectives. For example, to answer the question how much was spent on contractors within a specific cost center, we used "purchased services." We also used "total expenditures" as a measure of the county's overall spending within each specific MH cost center. Finally, we overlaid the number of "clients served" across the purchased services and total expenditures axis to provide a visual representation of the trend up or down among all three variables. The information in the income and expense reports, although self-reported, provides uniformity in data, especially where some counties may have been enrolled in block-grant funding.

In the end, what is presented is most likely the first-ever presentation of the type of county MH services available in Pennsylvania, the amount spent on those services, and the number of clients served. In Exhibit 2, we present a high-level summary of this information.

Exhibit 2

DHS MH Cost Center Summary
Clients, Purchased Services, and Total Expenses*
(Dollar amounts rounded to thousands; client numbers are actual; Years are fiscal years)

Cost Center	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	Total
Administrator's Office							
Total Exp.	$50,989.1	$51,763.6	$51,560.2	$53,504.5	$54,711.7	$53,194.6	**$315,723.8**

Exhibit 2 Continued

Cost Center	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	Total
Community Services							
Clients	28,233	40,682	47,470	35,355	30,102	38,778	**220,620**
Prchsed Srv.	$27,654.7	$29,770.6	$34,262.6	$37,649.0	$40,410.0	$40,203.9	**$209,950.7**
Total Exp.	$29,473.1	$31,541.4	$35,967.1	$39,333.2	$42,137.6	$41,890.3	**$220,342.7**
Targeted Case Management							
Clients	28,120	23,711	21,631	18,122	18,341	19,067	**128,992**
Prchsed Srv.	$33,820.3	$25,400.0	$28,083.8	$26,425.9	$26,750.8	$23,968.5	**$164,449.4**
Total Exp.	$54,262.2	$44,252.5	$47,038.2	$45,388.1	$46,758.5	$43,635.0	**$281,334.5**
Outpatient							
Clients	75,178	69,963	63,143	54,860	52,967	46,545	**362,656**
Prchsed Srv.	$62,063.7	$63,613.0	$45,651.2	$39,687.1	$39,502.9	$41,487.6	**$292,005.3**
Total Exp.	$67,150.3	$65,129.9	$50,546.7	$44,655.9	$44,694.8	$46,968.3	**$319,145.9**
Psychiatric Inpatient Hospitalization							
Clients	837	3,020	2,860	2,534	2,225	2,215	**13,691**
Prchsed Srv.	$4,443.5	$5,468.8	$4,758.0	$3,771.5	$3,007.6	$5,283.1	**$26,732.5**
Total Exp.	$4,466.8	$5,469.9	$4,773.5	$3,791.6	$3,238.5	$5,289.6	**$27,029.5**
Partial Hospitalization							
Clients	2,126	2,479	1,939	890	735	689	**8,858**
Prchsed Srv.	$3,575.3	$2,534.0	$1,867.4	$1,490.4	$1,312.8	$1,216.6	**$11,996.6**
Total Exp.	$4,539.8	$3,501.4	$2,807.1	$2,520.8	$2,134.0	$1,843.0	**$17,346.1**
Mental Health Crisis Intervention Services							
Clients	70,845	83,435	78,128	99,086	84,489	65,612	**481,595**
Prchsed Srv.	$21,479.2	$38,174.6	$37,906.7	$39,425.7	$40,801.0	$40,712.6	**$218,499.8**
Total Exp.	$26,678.8	$43,363.5	$42,731.5	$44,004.1	$45,622.5	$45,697.2	**$248,097.6**
Adult Developmental Training							
Clients	8	6	6	5	15	17	**57**
Prchsed Srv.	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
Total Exp.	$63.0	$45.6	$16.1	$16.3	$73.4	$77.5	**$291.8**
Community Employment and Employment Related Services							
Clients	3,078	7,821	3,206	5,065	2,938	2,929	**25,037**
Prchsed Srv.	$7,489.8	$8,143.7	$8,068.7	$8,161.7	$8,481.8	$8,108.5	**$48,454.2**
Total Exp.	$7,708.8	$8,429.1	$8,324.7	$8,434.6	$8,731.9	$8,273.2	**$49,902.2**
Facility-Based Vocational Rehabilitation Services							
Clients	976	916	736	651	585	561	**4,425**
Prchsed Srv.	$5,820.8	$4,198.8	$3,895.3	$3,707.8	$3,574.3	$3,125.3	**$24,322.2**
Total Exp.	$5,854.5	$4,256.5	$3,955.2	$3,795.5	$3,635.7	$3,185.2	**$24,682.6**
Social Rehabilitation Services							
Clients	17,136	18,392	15,790	14,878	13,891	11,793	**91,880**
Prchsed Srv.	$28,638.5	$20,693.7	$25,174.3	$24,826.1	$23,092.4	$22,819.6	**$145,244.5**
Total Exp.	$28,883.3	$20,933.6	$25,171.0	$25,118.7	$23,367.5	$23,179.1	**$146,653.2**
Family Support Services							
Clients	8,880	8,880	10,417	7,161	9,543	17,170	**60,743**
Prchsed Srv.	$6,837.0	$7,456.4	$7,437.4	$5,707.1	$5,378.7	$5,341.7	**$38,158.4**
Total Exp.	$7,073.1	$8,505.6	$7,559.0	$5,895.7	$5,753.3	$5,796.7	**$40,583.3**
Community Residential Services							
Clients	7,171	7,633	7,209	7,094	7,224	6,331	**42,662**
Prchsed Srv.	$251,016.3	$241,860.4	$255,521.0	$261,099.0	$259,663.1	$254,540.3	**$1,523,700.0**
Total Exp.	$253,117.0	$248,943.5	$257,266.1	$263,425.7	$256,521.8	$256,500.5	**$1,535,774.5**
Family-Based Mental Health Services							
Clients	944	1,018	881	1,347	781	697	**5,668**
Prchsed Srv.	$7,482.3	$7,956.0	$9,357.7	$7,220.9	$6,973.7	$6,828.2	**$45,818.8**
Total Exp.	$8,493.5	$8,684.4	$9,956.4	$7,678.0	$7,585.7	$7,389.6	**$49,787.7**

Exhibit 2 Continued

Cost Center	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	Total
Administrative Management							
Clients	110,245	107,168	103,832	104,307	121,556	118,412	**665,520**
Prchsed Srv.	$48,022.9	$47,029.8	$49,569.4	$46,552.9	$46,552.9	$46,318.1	**$285,925.2**
Total Exp.	$60,251.8	$58,908.1	$61,126.1	$58,862.5	$57,577.3	$60,267.8	**$356,993.6**
Emergency Services							
Clients	54,358	44,462	50,676	45,290	37,585	43,708	**276,079**
Prchsed Srv.	$31,954.2	$9,824.3	$11,928.6	$11,438.1	$10,880.6	$10,788.5	**$86,814.2**
Total Exp.	$38,588.1	$13,338.6	$19,339.8	$18,362.0	$17,621.4	$17,508.6	**$124,758.4**
Housing Support Services							
Clients	7,094	9,993	6,877	7,713	7,583	7,877	**47,137**
Prchsed Srv.	$49,172.3	$60,838.6	$51,854.1	$53,637.7	$62,619.3	$71,812.9	**$349,935.0**
Total Exp.	$50,302.1	$62,044.8	$53,307.4	$54,878.0	$63,963.4	$73,356.3	**$357,852.1**
Assertive Community Treatment Teams and Community Treatment Teams							
Clients	740	4,438	1,713	1,605	1,200	2,294	**11,990**
Prchsed Srv.	$9,026.9	$13,089.9	$12,810.6	$12,799.3	$15,109.0	$17,041.9	**$79,877.6**
Total Exp.	$9,026.9	$13,089.9	$12,872.0	$12,850.4	$15,199.6	$17,290.9	**$80,329.7**
Psychiatric Rehabilitation							
Clients	3,395	3,254	3,602	3,306	3,243	2,744	**19,544**
Prchsed Srv.	$9,034.4	$9,479.3	$10,886.0	$10,692.2	$10,458.7	$10,167.4	**$60,718.0**
Total Exp.	$10,029.2	$10,593.3	$12,088.2	$12,017.6	$11,630.7	$11,478.4	**$67,837.3**
Children's Psychosocial Rehabilitation Services							
Clients	1,884	2,309	1,878	444	444	404	**7,363**
Prchsed Srv.	$713.2	$2,251.2	$449.7	$1,145.5	$1,086.0	$877.7	**$6,523.2**
Total Exp.	$713.2	$2,251.2	$449.9	$1,145.6	$1,086.0	$877.7	**$6,523.4**
Children's Evidence-Based Practices							
Clients	254	254	254	225	262	300	**1,549**
Prchsed Srv.	$370.5	$376.6	$333.2	$45.0	$88.2	$126.3	**$1,339.7**
Total Exp.	$427.1	$441.0	$384.9	$92.2	$168.9	$227.1	**$1,741.2**
Peer Support Services							
Clients	876	2,479	1,040	1,202	1,220	1,986	**8,803**
Prchsed Srv.	$2,370.7	$2,460.3	$2,550.3	$2,534.9	$2,216.0	$2,684.0	**$14,815.9**
Total Exp.	$2,588.3	$2,621.5	$2,703.8	$2,681.2	$2,450.0	$2,837.2	**$15,882.1**
Consumer-Driven Services							
Clients	19,627	11,647	13,130	13,127	15,201	14,032	**86,764**
Prchsed Srv.	$4,894.1	$4,629.8	$5,093.3	$5,204.5	$6,005.5	$6,001.6	**$31,828.8**
Total Exp.	$4,894.1	$4,693.1	$5,093.3	$5,340.1	$6,389.5	$6,048.4	**$32,458.5**
Transitional and Community Integration Services							
Clients	8,905	7,465	20,655	17,452	18,630	12,777	**85,884**
Prchsed Srv.	$6,778.8	$8,528.3	$10,587.9	$10,880.7	$11,467.3	$12,025.1	**$60,268.1**
Total Exp.	$7,265.3	$9,019.8	$11,195.5	$11,557.0	$12,719.1	$13,561.3	**$65,317.8**
Other Services							
Clients	275	110	34	0	0	0	**419**
Prchsed Srv.	$3,032.9	$2,923.8	$40.0	0	0	0	**$5,996.7**
Total Exp.	$3,055.1	$2,943.3	$40.0	0	0	0	**$6,038.4**

Note: */Totals may not sum due to rounding.

Source: Developed by LBFC staff from information provided by DHS.

As shown above, Community Residential Services had the greatest amount of expenditures among the 25 cost centers. This occurrence is

not surprising given the nature of the cost center, which as discussed in more detail later, provides treatment, care, rehabilitation, habitation, and social and personal developmental services. As might be expected, these are primarily purchased (contracted) services. While this is an expensive service delivery area ($1.53 billion), it is not the cost center serving the most clients. Administrative Management, which is a cost center that covers essentially case management services, had the most clients served at 665,520.

1. Administrator's Office

Cost Center Description. According to DHS, this cost center is used to track activities and services provided by the Administrator's Office of the County MH Program. The Administrator's Office activities include the following:

- The general administrative, programmatic, and fiscal responsibility for the county MH program.
- Development of planning documents addressing the county program needs, local planning efforts, and other information pertinent to planning for and providing a more adequate service delivery system.
- Research projects, the evaluation of program effectiveness, the analysis of programmatic needs of specific target groups, and the determination of the availability of services to the general public.
- Continuing relationships with the county MH board, the OMHSAS regional field office and OMHSAS central office, contracted service providers, and family/consumer groups.
- The initiation of guardianship proceedings.
- The activities of the County MH Board.

Information on year-to-year spending within this specific cost center by the county MH offices is presented on Exhibit 3.

Exhibit 3

Administrator's Office Expenditures
(by Fiscal Year)

County	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	Total
Adams/York	$955,817	$945,118	$992,733	$1,024,036	$1,072,645	$1,117,738	**$6,108,087**
Allegheny	8,438,368	9,392,576	9,300,018	9,709,483	8,439,432	4,960,915	**50,240,792**
Armstrong/Indiana	664,759	634,030	705,543	700,102	798,982	863,717	**4,367,133**
Beaver	1,038,916	1,199,288	1,209,378	1,154,010	1,111,997	1,138,399	**6,851,988**
Bedford/Somerset	526,733	472,886	502,049	562,625	484,093	497,096	**3,045,482**

Exhibit 3 Continued

County	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	Total
Berks	1,090,352	1,289,044	974,369	691,519	774,026	793,555	**5,612,865**
Blair	388,752	440,881	424,613	477,689	497,591	460,331	**2,689,857**
Bradford/Sullivan	118,814	90,965	116,544	114,825	133,979	122,860	**697,987**
Bucks	1,261,440	1,414,265	1,500,536	1,610,039	1,564,756	1,724,487	**9,075,523**
Butler	399,218	420,061	509,164	526,495	432,046	439,003	**2,725,987**
Cambria	525,317	554,952	533,812	535,630	504,800	482,044	**3,136,555**
Cameron/Elk	540,377	489,866	605,639	633,827	572,977	558,789	**3,401,475**
Carbon/Monroe/ Pike	200,977	207,538	219,415	260,145	271,967	372,703	**1,532,745**
Centre	422,709	100,921	136,744	195,988	214,240	287,524	**1,358,126**
Chester	989,596	991,294	1,009,272	1,009,102	870,136	789,929	**5,659,329**
Clarion	259,855	317,443	213,538	193,089	151,963	198,537	**1,334,425**
Clearfield/Jefferson	809,517	744,156	749,437	475,823	557,739	566,424	**3,903,096**
Lycoming/Clinton	223,767	255,574	256,847	242,549	325,432	278,744	**1,582,913**
Columbia/Mon-tour/Snyder/Union	226,637	216,709	369,088	316,793	326,597	397,402	**1,853,226**
Crawford	572,851	542,481	448,268	445,339	465,598	550,925	**3,025,462**
Cumberland/Perry	651,381	647,573	627,500	687,447	668,335	686,606	**3,968,842**
Dauphin	1,012,180	886,419	890,344	918,558	926,834	1,022,492	**5,656,827**
Delaware	1,488,607	1,596,857	1,518,200	1,441,794	1,571,931	1,341,223	**8,958,612**
Erie	264,651	288,462	289,154	285,696	276,932	288,615	**1,693,510**
Fayette	1,042,364	816,266	763,493	1,021,969	1,097,245	909,496	**5,650,833**
Forest/Warren	176,523	163,470	179,946	182,570	204,589	186,965	**1,094,063**
Franklin/Fulton	756,599	731,156	666,676	664,164	708,485	683,339	**4,210,419**
Greene	749,917	682,329	723,296	832,755	828,596	805,480	**4,622,373**
Juniata/Mifflin/ Huntington	271,548	288,527	275,946	396,347	350,473	361,518	**1,944,359**
Lackawanna/ Susquehanna	118,057	131,332	114,193	98,157	91,994	140,547	**694,280**
Lancaster	1,828,851	1,926,764	1,784,243	1,583,046	1,689,253	1,738,533	**10,550,690**
Lawrence	331,979	357,941	334,008	472,103	407,358	438,985	**2,342,374**
Lebanon	480,712	544,759	611,518	648,680	655,928	714,778	**3,656,375**
Lehigh	1,047,347	1,136,799	1,144,370	1,322,831	1,245,662	1,358,105	**7,255,114**
Luzerne/Wyoming	849,476	826,636	1,019,009	921,185	783,871	755,538	**5,155,715**
McKean	172,434	283,330	276,013	236,136	178,594	154,430	**1,300,937**
Mercer	158,424	193,851	183,969	211,428	206,250	247,785	**1,201,707**
Montgomery	1,138,376	1,272,148	1,533,215	1,400,131	1,430,259	1,746,296	**8,520,425**
Northampton	1,047,347	748,362	724,693	721,505	726,792	684,283	**4,652,982**
Northumberland	673,345	521,380	518,668	716,230	642,789	568,923	**3,641,335**
Philadelphia	12,282,915	12,750,547	12,346,942	13,251,765	15,956,271	17,616,198	**84,204,638**
Potter	171,379	174,512	197,380	232,612	255,842	141,117	**1,172,842**
Schuylkill	496,567	504,982	493,561	573,916	655,560	689,035	**3,413,621**
Tioga	233,745	210,967	240,900	220,243	181,668	175,593	**1,263,116**
Venango	763,914	267,271	353,432	380,315	381,168	421,761	**2,567,861**
Washington	2,078,183	1,994,990	1,952,005	1,985,387	1,846,236	1,560,957	**11,417,758**
Wayne	211,403	181,200	210,044	244,803	230,044	248,568	**1,326,062**
Westmoreland	836,098	914,745	810,478	973,593	941,789	906,332	**5,383,035**
Total	**$50,989,094**	**$51,763,623**	**$51,560,203**	**$53,504,474**	**$54,711,744**	**$53,194,620**	**$315,723,758**

Source: Developed by LBFC staff from information provided by DHS.

As depicted above, spending within the administrator's office cost center averages approximately $52.6 million per year. Over the period we reviewed, there was a 4.6 percent increase in spending (not accounting for inflation). Philadelphia County is the largest MH administrator office with total spending that accounts for 26.7 percent of all spending over the period reviewed.

2. Community Services

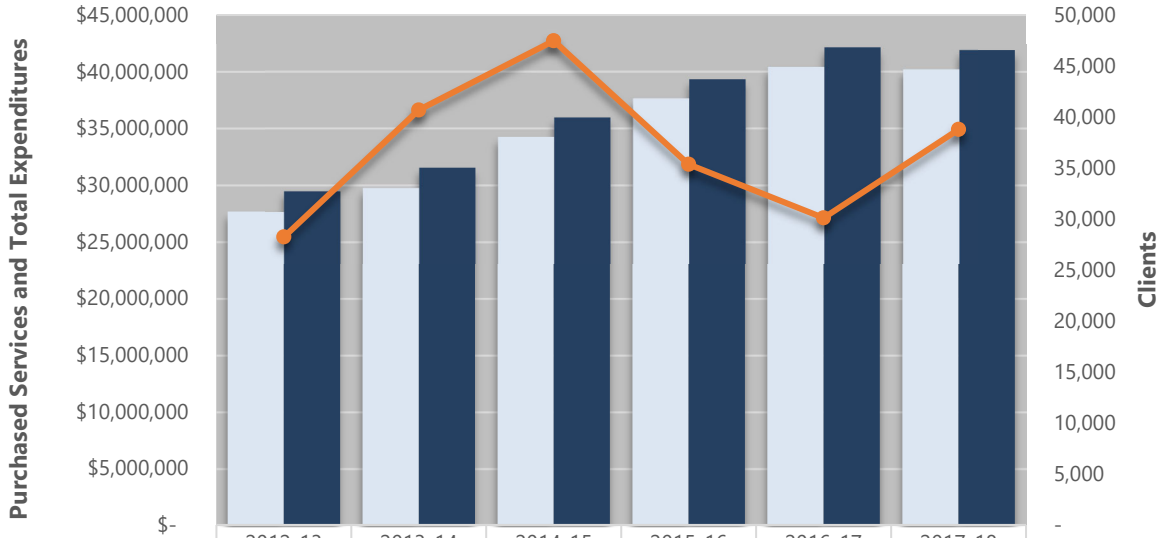
Cost Center Description. According to DHS, the community services cost center includes the cost of programs and activities made available to community human service agencies, professional personnel, and the general public concerning the mental health service delivery system and mental health disorders. Prevention, consultation and education services are also included within this cost center. Specific examples of community services activities include:

- Advice and expertise given to professionals or other human service agencies concerning mental health disorders and services in order to expand knowledge concerning same.
- Educational information given and disseminated to the general public or community agencies concerning the services available from the county program.
- Activities and programs developed to reduce the incidence of mental health disorders, such as community awareness and prevention programs designed to promote mental health, resiliency and recovery.
- Activities designed to build community awareness and acceptance.
- Activities designed to develop community resources.

Information on purchased services spending, total expenditures, and the number of clients served is presented in Exhibit 4.

Exhibit 4

Community Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$27,654,710	$29,770,555	$34,262,592	$37,648,999	$40,409,967	$40,203,897
Total Expenditures	$29,473,140	$31,541,413	$35,967,104	$39,333,195	$42,137,595	$41,890,271
Clients	28,233	40,682	47,470	35,355	30,102	38,778

Source: Developed by LBFC staff from information provided by DHS.

As shown above, within the community services cost center, we found that total expenditures grew by 42.1 percent. This increase occurred consistently throughout the period reviewed. Not surprisingly, the number of clients also increased throughout the period, although there were decreases reported in FYs 2015-16 and 2016-17. These decreases were attributable to significant decreases that occurred at the Wayne County MH Office.[29] Another decrease was also seen at the Cambria County MH Office, which reported 1,886 clients in FY 2015-16 and just 90 clients in FY 2016-17. Overall, for the period, clients increased by 37.3 percent.

3. Targeted Case Management

Cost Center Description. Targeted Case Management (TCM) services provide assistance to persons with serious mental illness and children diagnosed with (or at risk of) serious emotional disturbance in gaining access to needed medical, social, educational, and other services through natural supports, generic community resources and specialized mental health treatment, rehabilitation and support services. TCM staff

[29] In FY 2014-15, Wayne County reported 11,193 clients. In FY 2015-16, that number decreased to 1,265, and in FY 2016-17 it was just 170 clients. Refer to the introduction of this section for more information on the limitations of this data.

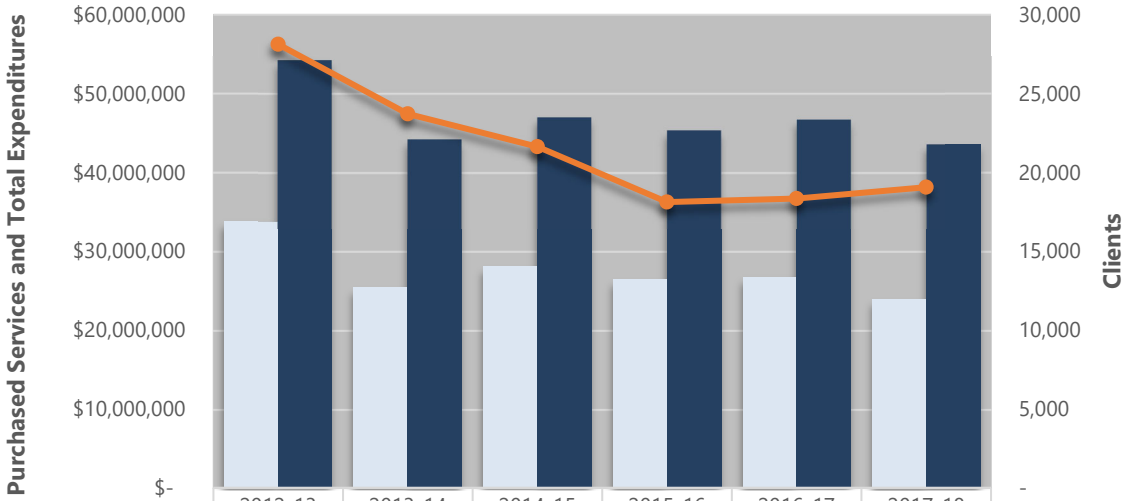
operate in identifiable units, such as: Intensive Case Management, Blended Case Management, or Resource Coordination. Only those services that are part of an approved budget/county plan may be reported under this cost center. TCM services are expected to help consumers/clients achieve specific outcomes of independent living, vocational/educational participation, adequate social supports, and reduced hospitalization. Examples of TCM activities include:

- Assessment and understanding of the consumer's history and present life situation.
- Service planning based on the consumer's strengths and desires, to include any activities necessary to enable the consumer to live as an integral part of the community.
- Assertive and creative attempts to help the consumer gain access to resources and required services identified in the treatment or service plan.
- Monitoring of service delivery.
- Problem resolution, to include active efforts in advocacy to assist the consumer in gaining access to needed services and entitlements.
- Assistance to persons in identifying, accessing and learning to use community resources.
- Informal support network building.
- Linking with services.

Information on purchased services spending, total expenditures, and the number of clients served is presented in Exhibit 5.

Exhibit 5

Targeted Case Management



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$33,820,323	$25,399,963	$28,083,846	$26,425,906	$26,750,777	$23,968,546
Total Expenditures	$54,262,205	$44,252,544	$47,038,228	$45,388,088	$46,758,467	$43,634,995
Clients	28,120	23,711	21,631	18,122	18,341	19,067

Source: Developed by LBFC staff from information provided by DHS.

TCM saw an overall decrease in total expenditures of 19.6 percent over the period reviewed. Similarly, the number of clients decreased by nearly a third, or 32.2 percent. More recently, the number of clients has flattened, with a slight increase of four percent from FY 2016-17 to FY 2017-18.

4. Outpatient

Cost Center Description. This cost center applies to treatment-oriented services provided to a consumer who is not admitted to a hospital, institution, or community mental health facility for twenty-four hour a day service. These services may be provided to an individual or his/her family and may include services prior to or after inpatient or institutional care has been provided; outpatient treatment would be specified on a consumer's treatment plan. Outpatient activities include:

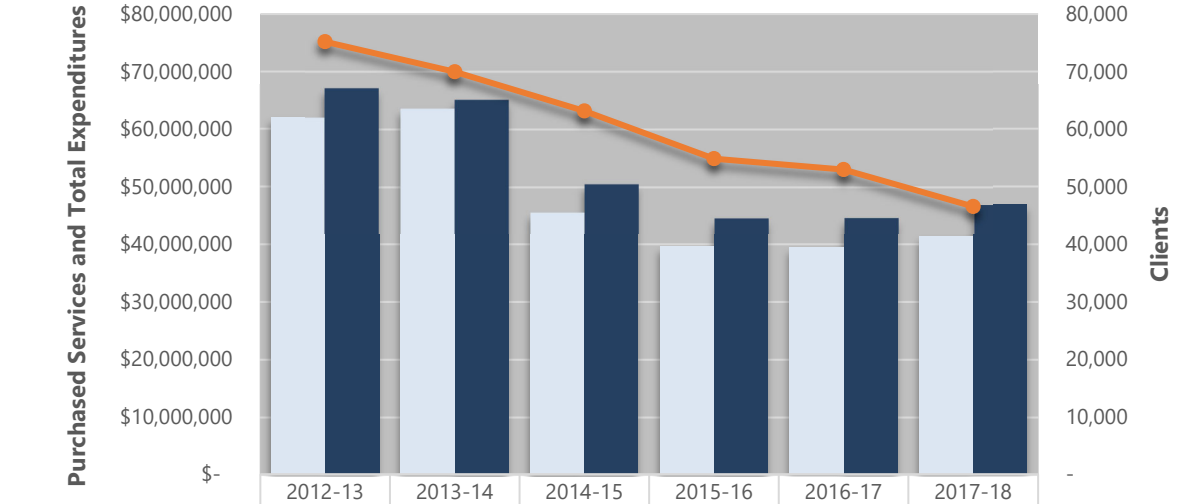
- Psychiatric or psychological therapy.
- Supportive counseling for the consumer's family members or other involved persons.
- Individual or group therapy.
- Treatment plan development, review and re-evaluation of a client's progress.

- Psychiatric services, including evaluation, medication clinic visit, and medical treatment required as part of the treatment of the psychiatric service.
- Psychological testing and assessment.
- Mobile mental health treatment and mobile medication management.
- Telepsychiatry.
- Alternative Outpatient Therapy (AOP).

As presented in Exhibit 6, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 6

Outpatient



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$62,063,675	$63,612,958	$45,651,169	$39,687,086	$39,502,909	$41,487,550
Total Expenditures	$67,150,304	$65,129,890	$50,546,661	$44,655,974	$44,694,779	$46,968,281
Clients	75,178	69,963	63,143	54,860	52,967	46,545

Source: Developed by LBFC staff from information provided by DHS.

As shown above, the number of clients has consistently decreased over the period reviewed. For example, we found that clients decreased by 38.1 percent, and there was a similar decline of 30.1 percent in total expenditures by county MH agencies.

5. Psychiatric Inpatient Hospitalization

Cost Center Description. The Psychiatric Inpatient Hospitalization cost center applies to treatment or services provided to an individual in need of twenty-four hours of continuous psychiatric hospitalization.

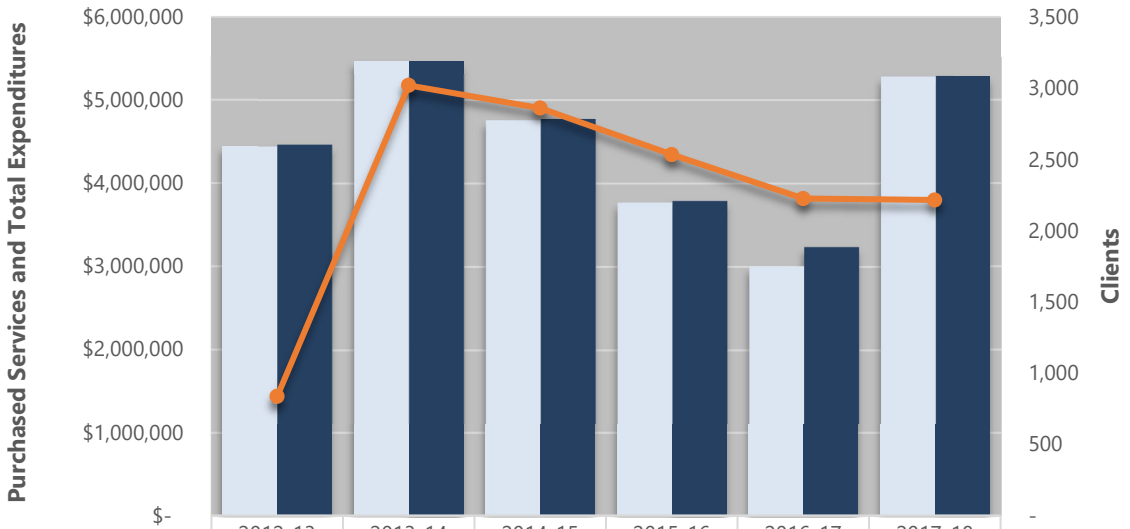
The activities involve care in a licensed psychiatric inpatient facility. The Psychiatric Inpatient Hospitalization activities include:

- Diagnostic study or evaluation.
- Intensive psychiatric inpatient treatment at the onset of an illness, or under periods of stress.
- Close supervision necessitated by the inability of a person to function independently.
- Treating medical needs associated with the psychiatric inpatient treatment, medication stabilization, and intensive services required as part of the psychiatric inpatient treatment program.
- Extended acute care.

As presented in Exhibit 7, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 7

Psychiatric Inpatient Hospitalization



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$4,443,490	$5,468,754	$4,757,991	$3,771,535	$3,007,575	$5,283,106
Total Expenditures	$4,466,757	$5,469,883	$4,773,488	$3,791,159	$3,238,543	$5,289,619
Clients	837	3,020	2,860	2,534	2,225	2,215

Source: Developed by LBFC staff from information provided by DHS.

As shown above, there was a substantial spike in clients from FY 2012-13 to FY 2013-14. The reason for this anomaly was because Philadelphia County reported zero clients served in FY 2012-13, as a result comparison before FY 2013-14 are not accurate.[30] More recently, in FY 2017-18 there

[30] Refer to the introduction of this section for more information on the limitations of this data.

was an increase in expenditures for psychiatric inpatient hospitalizations among MH county agencies. This reversed a three-year trend of decreased spending within this cost center. Lastly, as might be expected with the nature of this cost center (inpatient hospitalizations), almost all the expenses are for purchased services.

6. Partial Hospitalization

Cost Center Description. This cost center is used for non-residential treatment services licensed by OMHSAS for persons with moderate to severe mental illness and children and adolescents with serious emotional disturbance, who require less than twenty-four hour continuous care but require more intensive and comprehensive services than are offered in outpatient treatment. Partial hospitalization services may be:

1) A day service designed for persons able to return to their home in the evening.
2) An evening service designed for persons working and/or in residential care.
3) A weekend program.
4) A day or evening program in conjunction with school.

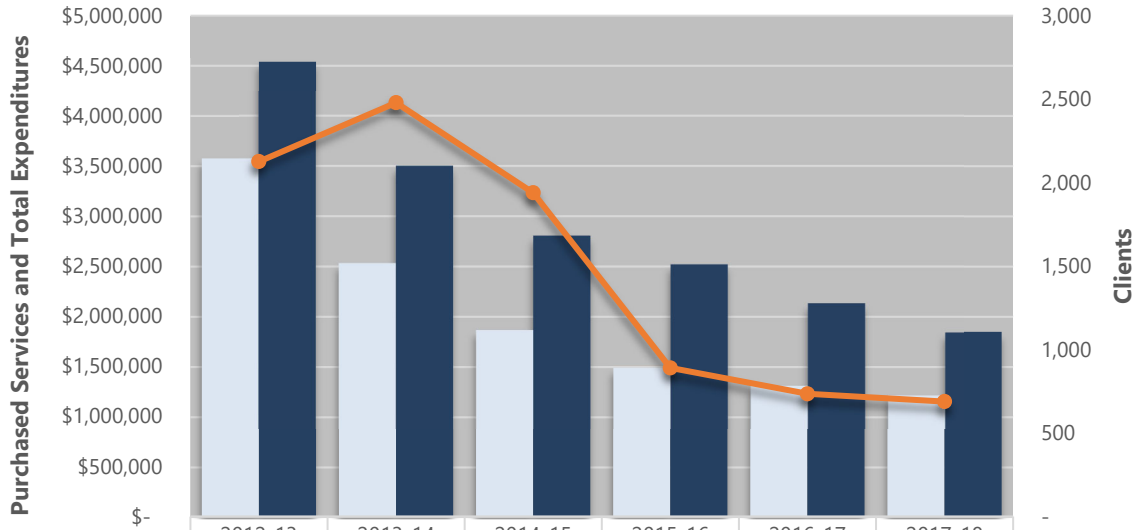
Specific activities and costs falling under Partial Hospitalization include:

- Medical, psychiatric, psychological and psychosocial treatment services, including individual, family, and group psychotherapy.
- Health education, to include basic physical and mental health information; nutrition information and assistance in purchasing and preparing food; personal hygiene instruction; basic health care information; childcare information and family planning information and referral; and information on prescribed medications.
- Instruction in the basic care of the home or residence for daily living, and in age appropriate developmental skills.
- Instruction in basic personal financial management for daily living.
- Medication administration and evaluation.
- Social interaction and pre-vocational service instruction.
- Crisis counseling.
- Acute partial programs that are generally three (3) weeks or less in duration.

As presented in Exhibit 8, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 8

Partial Hospitalization



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$3,575,343	$2,533,974	$1,867,420	$1,490,438	$1,312,773	$1,216,614
Total Expenditures	$4,539,845	$3,501,364	$2,807,080	$2,520,784	$2,133,991	$1,843,034
Clients	2,126	2,479	1,939	890	735	689

Source: Developed by LBFC staff from information provided by DHS.

As depicted above, within the partial hospitalization cost center there is a steady decrease in clients served since FY 2013-14. Over the full period reviewed, clients decreased by 67.6 percent. Similar decreases were also seen with purchased services and total expenditures. These decreases were primarily attributable to the declines seen at two county joinders: the Cumberland-Perry County MH Agency, and the Luzerne-Wyoming County MH Agency. Other counties which also had declines contributing to the overall decline in clients, purchased services, and total expenditures included Lackawanna-Susquehanna Behavioral Health Agency, the Montgomery County MH Agency, and the Allegheny County MH Agency.[31]

7. MH Crisis Intervention Services

Cost Center Description. MH Crisis Intervention Services are immediate, crisis-oriented services designed to ameliorate or resolve precipitating stress, which are provided to adults or children and their families who exhibit an acute problem of disturbed thought, behavior, mood

[31] Refer to the introduction of this section for more information on the limitations of this data.

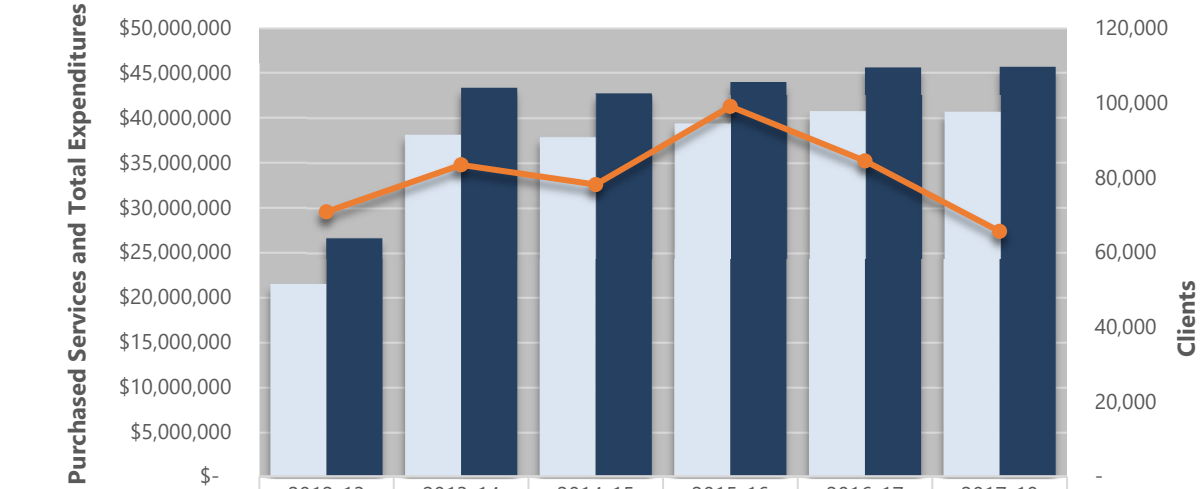
or social relationships. The services provide rapid response to crisis situations, which threaten the well-being of the individual or others. Activities include: intervention, assessment, counseling, screening and disposition services in the following categories:

- Telephone crisis services.
- Walk-in crisis services.
- Mobile Crisis services (Individual-Delivered).
- Mobile Crisis services (Team-Delivered).
- Medical Mobile Crisis services (Team-Delivered).
- Crisis Residential services.
- Crisis In-Home Support services.

Consistent with our review of other cost centers, we reviewed clients served, purchased services, and total expenses within the MH crisis intervention services cost center. Our results are presented in Exhibit 9.

Exhibit 9

MH Crisis Intervention Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$21,479,19	$38,174,64	$37,906,72	$39,425,70	$40,800,99	$40,712,56
Total Expenditures	$26,678,76	$43,363,54	$42,731,46	$44,004,09	$45,622,52	$45,697,23
Clients	70,845	83,435	78,128	99,086	84,489	65,612

Source: Developed by LBFC staff from information provided by DHS.

Within this cost center, a more disjointed trend is observed with respect to clients served. As shown above, despite up and down growth in clients from FY 2012-13 to FY 2015-16, which also saw the peak at just under 100,000, there has been a steady decline in the last two years (FY 2016-17 and FY 2017-18). Some of this disjointedness is explained by Philadelphia County, which did not report any clients served in FY 2012-

13, but did report clients in FY 2013-14, and fewer clients in each of the fiscal years that followed.

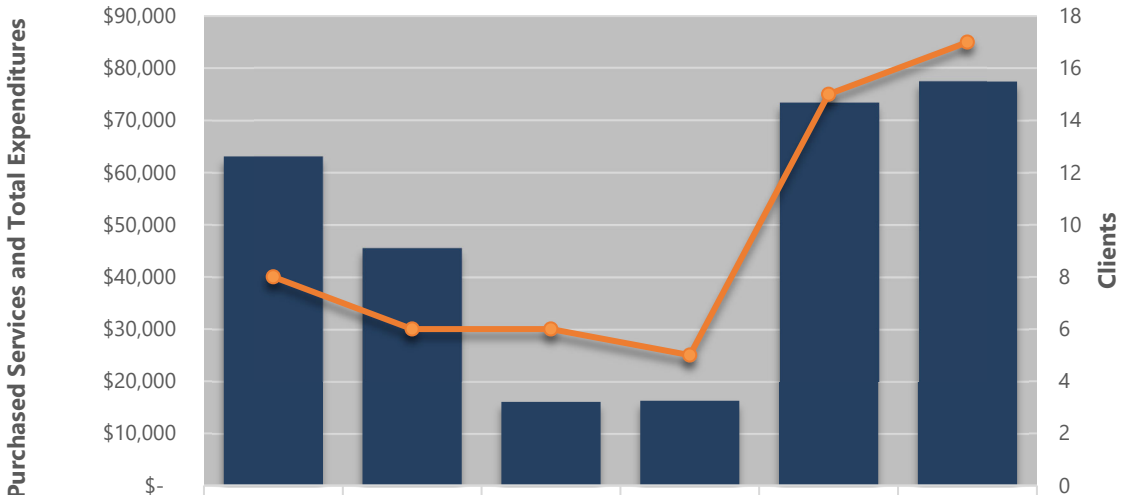
8. Adult Developmental Training

Cost Center Description. Adult Developmental Training (ADT) services are categorized as those community-based programs designed to facilitate the acquisition of prevocational, behavioral activities of daily living, and independent living skills. As a prerequisite for work-oriented programming, ADT programs concentrate on cognitive development, affective development, communication development, physical development, and working skills development.

As presented in Exhibit 10, we reviewed only two variables, clients and total expenditures. We presented just these categories because all the expenditures were for purchased services.

Exhibit 10

Adult Developmental Training*



	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017 - 18
Total Expenditures	$63,082	$45,581	$16,050	$16,265	$73,358	$77,450
Clients	8	6	6	5	15	17

Note: */There were no purchased services for this cost center; therefore, only total expenditures are shown.
Source: Developed by LBFC staff from information provided by DHS.

As shown above, this cost center is small and rarely used by county MH agencies. We found that only six of the 48 county MH offices used this cost center. The largest of these counties was Montgomery County.

9. Community Employment and Employment-Related Services

Cost Center Description. This cost center includes employment in a community setting or employment-related programs, which may combine vocational evaluation, vocational training and employment in a non-specialized setting such as a business or industry.

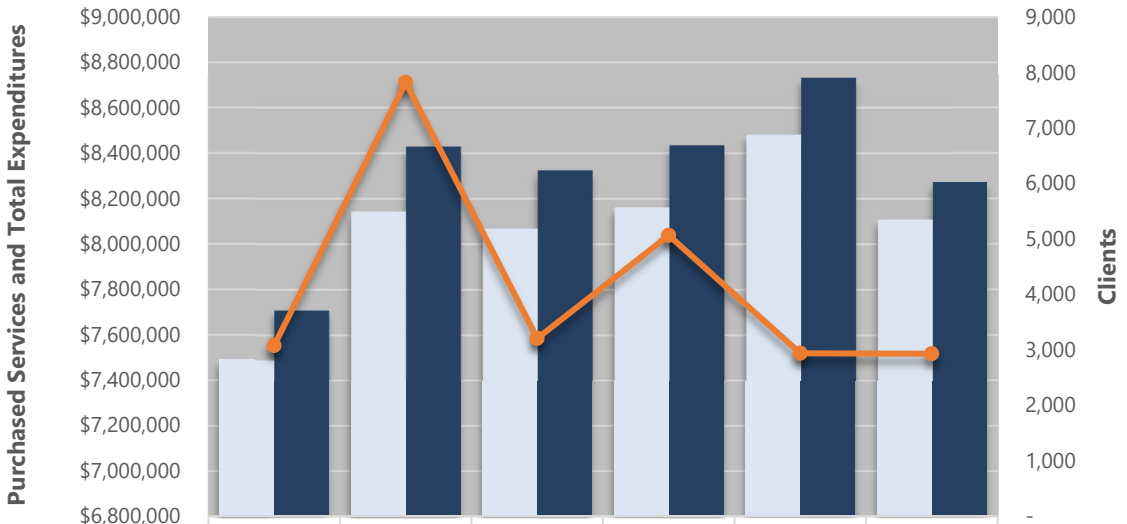
There are two different types of employment services included in this cost center. The first is employment in a community or employment setting, which combines vocational training in a business or industry setting. This activity includes transitional employment, industry-integrated vocational programs, mobile work forces, enclaves, and affirmative industries or businesses.

The second type is supported employment, which is an evidence-based practice recognized by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA). This activity involves community-based job placements other than sheltered workshops. Employment specialists work as a team with consumers from intake through follow-up. Team-delivered contacts occur at the consumer's home, at the job site or in the community. The employment is competitive, and eligibility is based on consumer choice and readiness, and involves rapid job search and follow-along supports.

As presented in Exhibit 11, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 11

Community Employment and Employment-Related Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$7,489,832	$8,143,703	$8,068,668	$8,161,731	$8,481,823	$8,108,446
Total Expenditures	$7,708,809	$8,429,060	$8,324,675	$8,434,634	$8,731,871	$8,273,154
Clients	3,078	7,821	3,206	5,065	2,938	2,929

Source: Developed by LBFC staff from information provided by DHS.

As shown above, there were large variations from year-to-year in the number of clients. As we found with some other cost centers, the initial year spike from FY 2012-13 to FY 2013-14 was caused by Philadelphia County reporting zero clients served in FY 2012-13. Interestingly, the county reported 4,820 clients served in the next year (FY 2013-14). In the following year (FY 2014-15) Philadelphia reported just 84 clients, which again explains the precipitous drop seen in the above line graph. Because of these variations, we did not conduct any further analysis within this cost center.[32]

10. Facility-Based Vocational Rehabilitation Services

Cost Center Description. This cost center includes programs designed to provide paid development and vocational training within a community-based, specialized facility (sheltered workshop) using work as the primary modality.

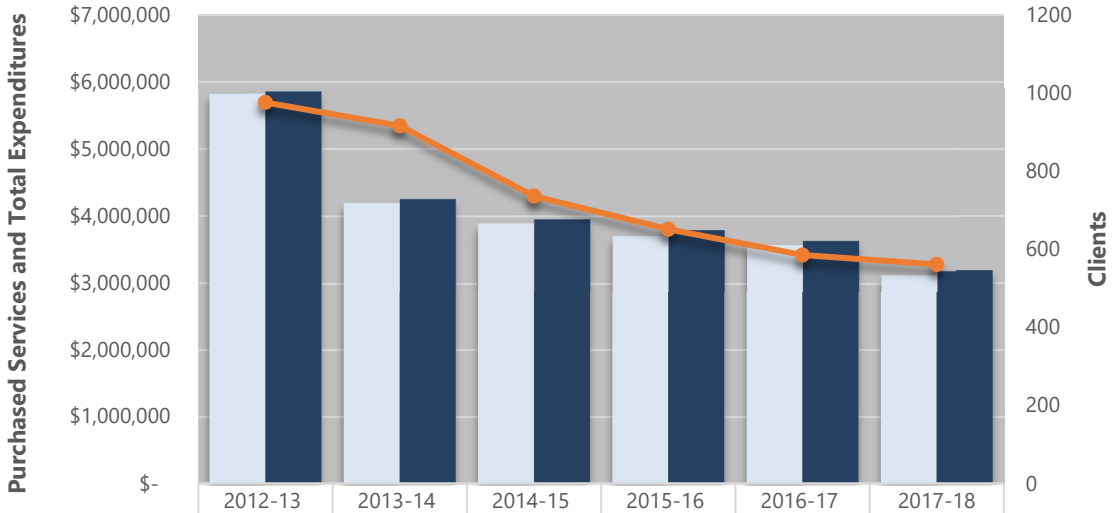
[32] Refer to the introduction of this section for more information on the limitations of this data.

Sheltered workshop programs include vocational evaluation, personal work adjustment training, work activity training, and regular work training and are provided in licensed vocational facilities.

As we did with the other cost centers, we plotted purchased services, total expenditures, and clients. Our results are shown in Exhibit 12 .

Exhibit 12

Facility-Based Vocational Rehabilitation Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$5,820,810	$4,198,777	$3,895,250	$3,707,805	$3,574,281	$3,125,316
Total Expenditures	$5,854,480	$4,256,473	$3,955,200	$3,795,490	$3,635,736	$3,185,218
Clients	976	916	736	651	585	561

Source: Developed by LBFC staff from information provided by DHS.

Within this cost center there has been a steady decline in clients, purchased services, and total expenditures. As might be expected with the nature of this cost center, which relies upon contracted entities, purchased services were nearly all the total expenditures for reporting county MH agencies. For the period, there was a 42.5 percent decline in clients and a 45.6 percent decline in total expenditures.

11. Social Rehabilitation Services

Cost Center Description. This cost center refers to programs or activities designed to teach or improve self-care, personal behavior and social adjustment for adults with mental illness. Social rehabilitative activities are intended to make community or independent living possible by increasing the person's level of social competency and by decreasing

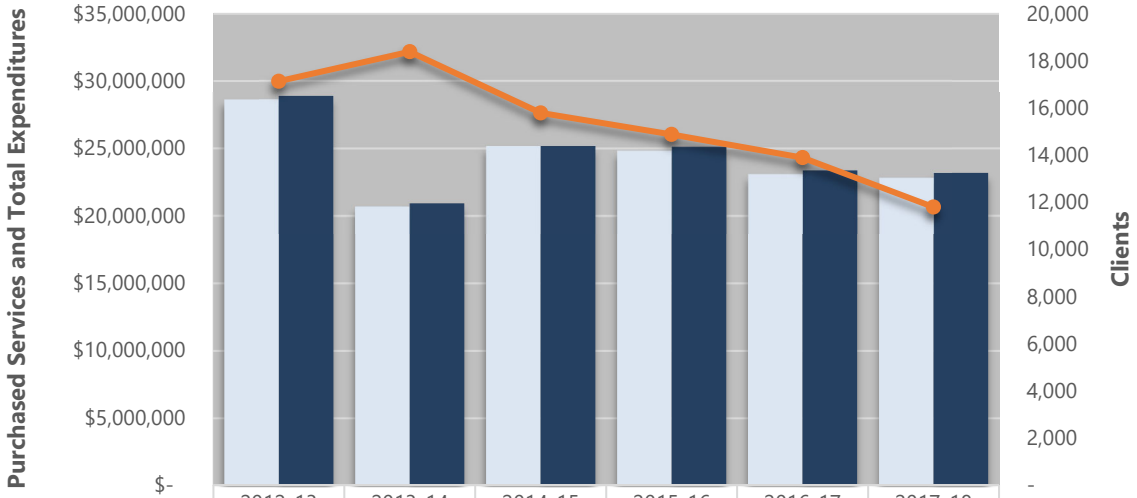
the need for structured supervision. Activities within this cost center include:

- Social skills development to enhance habits, attitudes, and social skills.
- Cognitive development, affective development, communication development, and physical skills development services.
- Activities of daily living skills development.
- Educational services and general skill levels to enhance employability.
- Drop-In Centers.

Information on purchased services spending, total expenditures, and the number of clients served is presented in Exhibit 13.

Exhibit 13

Social Rehabilitation Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$28,638,474	$20,693,720	$25,174,278	$24,826,082	$23,092,367	$22,819,614
Total Expenditures	$28,883,322	$20,933,564	$25,170,991	$25,118,679	$23,367,491	$23,179,137
Clients	17,136	18,392	15,790	14,878	13,891	11,793

Source: Developed by LBFC staff from information provided by DHS.

Within this cost center we found that FY 2013-14 was an outlier year. In that year, there was an increase in clients, but decreases in total expenditures. As a result, this year likely reflected data reporting inconsistencies by some county MH agencies. Further, as we found with some other cost centers, which substantially relied upon contractors to provide highly specialized MH services, purchased services accounted for nearly all of the total expenditures. Over the full period reviewed, clients decreased by 31.2 percent and total expenditures decreased by 19.7 percent.

12. Family Support Services

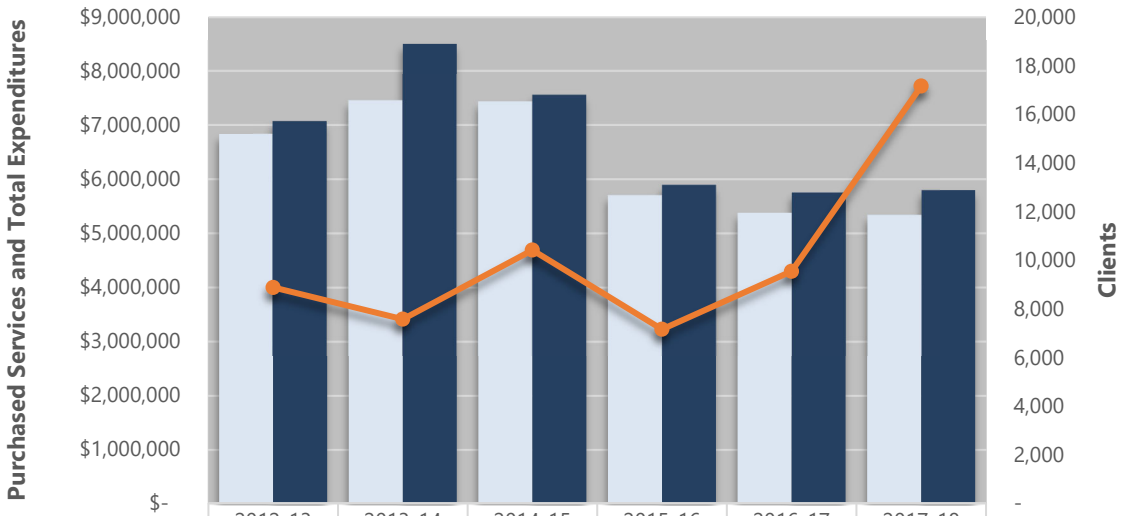
Cost Center Description. This cost center refers to supportive services designed to enable persons with serious mental illness, children and adolescents with or at risk of serious emotional disturbance, and their families, to be maintained at home with minimal disruption to the family unit. The following list, which is not exhaustive, outlines the variety of activities that may be reported in the Family Support Services cost center:

- Homemakers, family aides.
- Art classes.
- Sign Language interpreting services and related equipment.
- Furnishing of apartment for individuals discharged from an institution.
- Travel by family members to visit loved ones placed in a remote facility.
- Bus passes, YMCA/YWCA memberships.
- Specialized summer camps.
- Attendance at conferences or meetings.
- Legal advocacy.
- Resource materials and training for family members to care for consumer.
- Non-emergency transportation.

As presented in Exhibit 14, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 14

Family Support Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$6,837,037	$7,456,417	$7,437,422	$5,707,097	$5,378,669	$5,341,717
Total Expenditures	$7,073,057	$8,505,619	$7,558,956	$5,895,650	$5,753,312	$5,796,702
Clients	8,880	7,572	10,417	7,161	9,543	17,170

Source: Developed by LBFC staff from information provided by DHS.

As shown above, there has been an inverse relationship between spending and clients within this cost center. For example, the number of clients has grown rather dramatically over the period, from 8,880 in FY 2012-13, to 17,170 in FY 2017-18—an increase of 93.4 percent over the period. Conversely, total expenditures have decreased over the period by 18.0 percent. We reviewed this trend more closely and found that in FY 2017-18, the Montgomery County MH office and the Erie County MH office reported significantly higher numbers of clients than they did in previous years. As a result, this trend may be the result of a data reporting inconsistency.[33]

13. Community Residential Services

Cost Center Description. This cost center accounts for one of the larger service categories within the MH services continuum. The Community Residential Services cost center applies to care, treatment, rehabilitation, habilitation, and social and personal development services provided to persons in a community-based residential program, which is a Department-licensed or approved community residential agency or home. Community residential services are intended for persons capable

[33] Refer to the introduction of this section for more information on the limitations of this data.

of benefiting from social and personal development services away from their homes or families, or for children and adolescents with serious emotional disturbance who cannot be maintained in their own home. Included in this category are the room and board costs associated with residence, including costs for food, clothing, shelter, child care, personal incidentals for children, liability insurance with respect to the child, and reasonable travel for the child to visit family and school supplies. The settings include, but are not limited to:

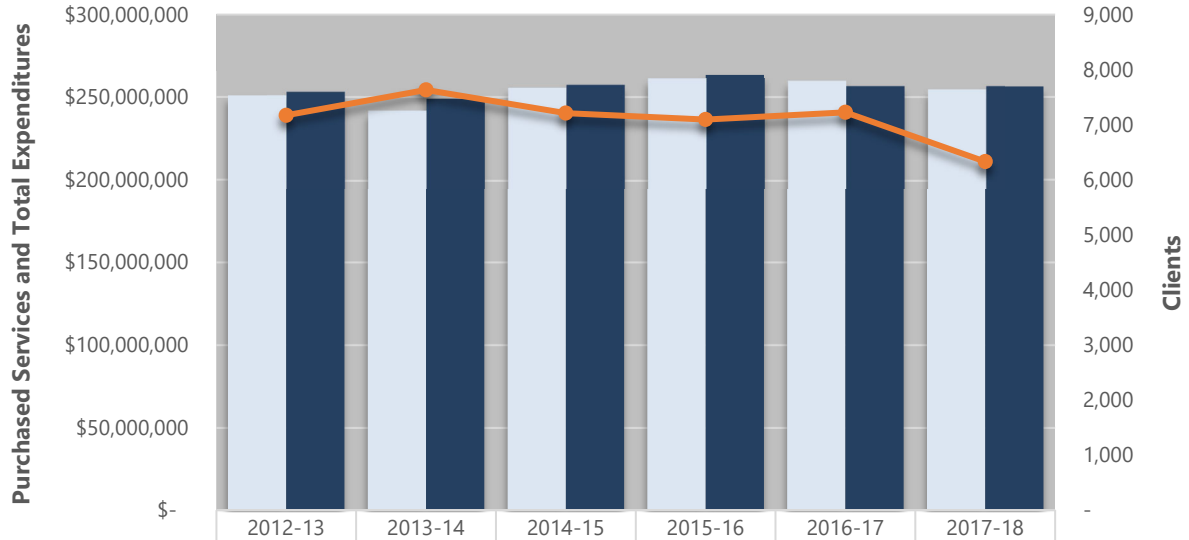
- Community Residential Rehabilitation Services (CRRS).
- Personal Care Homes.
- Family living homes and host homes.
- Long Term Structured Residence (LTSR) facilities.
- Residential Treatment Facilities.
- Enhanced/Specialized Personal Care Homes.
- Non-hospital acute care.

This cost center does not include MH Housing Support Services or Crisis Residential Services.

As presented in Exhibit 15, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 15

Community Residential Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$251,016,277	$241,860,402	$255,520,958	$261,098,969	$259,663,050	$254,540,335
Total Expenditures	$253,116,996	$248,943,482	$257,266,103	$263,425,653	$256,521,812	$256,500,486
Clients	7,171	7,633	7,209	7,094	7,224	6,331

Source: Developed by LBFC staff from information provided by DHS.

Within this cost center, the number of clients served has seen a steady decline. Over the period, clients served declined by 11.7 percent; yet, expenditures remained relatively flat with total expenditures increasing by 1.3 percent. As noted previously, this cost center is one of the larger spending areas for county agencies. In fact, based on FY 2017-18 data, per client spending equals $40,515. As depicted above, nearly all spending was for purchased services.

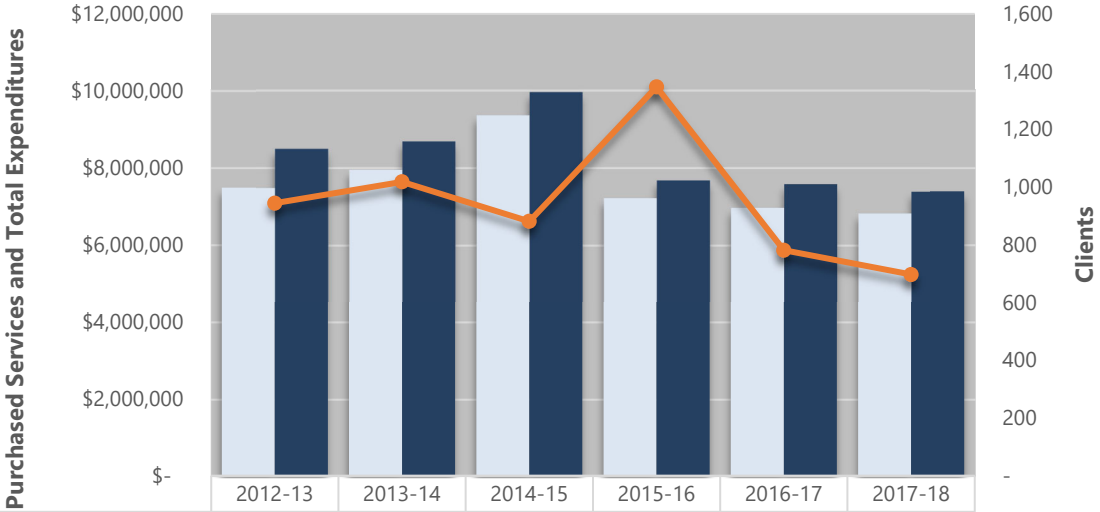
14. Family-Based Mental Health Services

Cost Center Description. This cost center covers comprehensive services designed to assist families in caring for their children or adolescents with emotional disturbances at home. These services include OMHSAS-licensed programs, which offer mental health treatment, casework services, and family support. Services are available 24 hours a day, seven days a week, for up to 32 weeks – or longer, if deemed medically necessary. Family-based mental health services are team-delivered by mental health professionals and mental health workers, primarily in the family home. As with other similar cost centers which rely on providing specialized services, most of the expenses are for purchased services.

As presented in Exhibit 16, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 16

Family-Based Mental Health Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$7,482,308	$7,955,938	$9,357,737	$7,220,940	$6,973,669	$6,828,183
Total Expenditures	$8,493,526	$8,684,377	$9,956,399	$7,678,046	$7,585,701	$7,389,633
Clients	944	1,018	881	1,347	781	697

Source: Developed by LBFC staff from information provided by DHS.

As shown above, despite an uptick in clients which occurred in FY 2015-16, the number of clients served has been on a downward trend. We found that over the period, the number of clients fell by 26.2 percent, with total expenditures also declining by 13 percent. We found the uptick in clients that occurred in FY 2015-16, was likely due to a reporting inconsistency in Greene and Lawrence counties, which reported a significantly higher number of clients in that year than in previous years.[34]

15. Administrative Management

Cost Center Description. The Administrative Management cost center applies to those activities and administrative functions undertaken by staff in order to ensure intake into the county mental health system and the appropriate and timely use of available resources and specialized services to best address the needs of individuals seeking assistance. Services are available for all persons who have a mental health diagnosis, as identified within the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or a subsequent revision; or within the International Classification of Diseases, Ninth Edition (ICD-9) or a subsequent revision.

Services are delivered for the purposes of facilitating and monitoring a person's access to mental health services and community resources. The activities include:

- Processing of intake into the Base Service Unit, which includes assessments, development of a care plan and referrals to services.
- Verification of disability.
- Liability determination.
- Authorization for services.
- Monitoring of service delivery through review of evaluations, progress notes, treatment/service plans, and other written documentation of services.
- Maintenance of records and case files.

On an occasional and situational basis, administrative case managers may provide some direct service to individuals as described below:

- Coordination of service planning with state mental hospitals and other out-of-home placement facilities with other systems.
- Provision of supportive listening and guidance in problem-solving to consumers, their families and significant others.

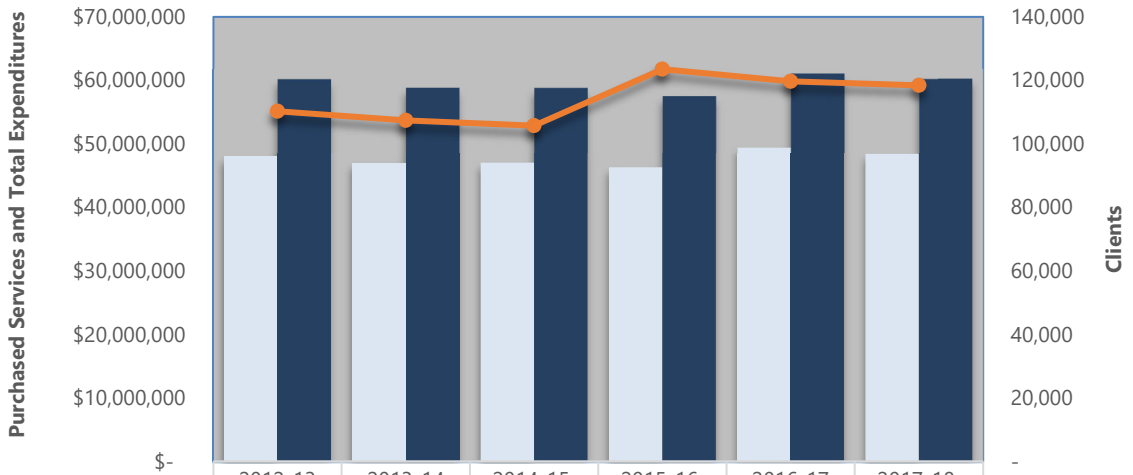
[34] Refer to the introduction of this section for more information on the limitations of this data.

- Contact with family, friends, school personnel and significant others to develop or enhance the consumer's natural support network.
- Advocacy efforts to improve consumer's life situations, promote consumer choice, improve services, eliminate stigma, etc.

As presented in Exhibit 17, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 17

Administrative Management



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$48,022,879	$47,029,812	$47,047,522	$46,318,112	$49,569,350	$48,432,170
Total Expenditures	$60,251,829	$58,908,121	$58,862,523	$57,580,757	$61,126,060	$60,267,751
Clients	110,245	107,401	105,737	123,495	119,666	118,412

Source: Developed by LBFC staff from information provided by DHS.

This cost center reflects an entry point into the county MH system, as such it is reasonable that it would also be the cost center that served the greatest number of clients. As shown above, despite relatively level spending in total expenditures, there was an increase in clients that occurred in FY 2015-16. When we reviewed the data closer we were able to attribute this increase to variability in the number of clients reported from Delaware County.[35] Although Delaware County reported fewer clients in subsequent years, the difference was offset by increases in Philadelphia, Montgomery, and the Luzerne-Wyoming joinder in FY 2016-17 and FY 2017-18.

[35] In FY 2014-15 Delaware County reported 3,521 clients, and in FY 2015-16 it reported 12,654 clients. Refer to the introduction of this section for more information on the limitations of this data.

16. Emergency Services

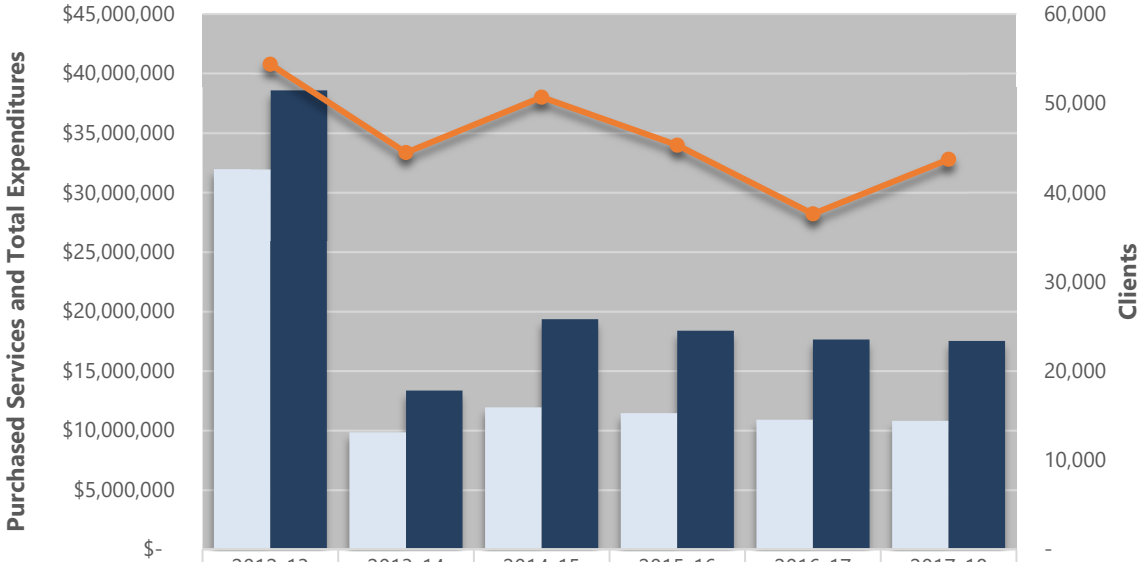
Cost Center Description. This cost center applies to those emergency-related activities and administrative functions undertaken that proceed after a petition for voluntary or involuntary commitment has been completed, including any involvement by staff of the county administrator's office. Activities include:

- Mental health delegate services.
- Emergency psychiatric evaluations provided to a consumer to determine the need for psychiatric inpatient care.
- Searches for placement in an inpatient facility (bed searches).
- Emergency transportation.
- Legal fees associated with the commitment process.

As presented in Exhibit 18, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 18

Emergency Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$31,954,19	$9,824,305	$11,928,59	$11,438,05	$10,880,57	$10,788,46
Total Expenditures	$38,588,07	$13,338,57	$19,339,78	$18,362,01	$17,621,37	$17,508,56
Clients	54,358	44,462	50,676	45,290	37,585	43,708

Source: Developed by LBFC staff from information provided by DHS.

As highlighted above, over the period reviewed, the number of clients decreased by 19.6 percent. In some respects, this could be considered a

positive trend for this cost center, as it involves providing services for voluntary and involuntary commitments. It is not clear; however, whether the decrease in services is attributable to a decrease in total expenditures, which we found fell by 54.6 percent over the period. In the next section of this report, we also discuss a possible explanation for this decrease in spending, which is the lack of access to psychiatric evaluations.

17. Housing Support Services

Cost Center Description. This cost center is used for services provided to mental health consumers that enable the recipient to access and retain permanent, decent, affordable housing. Services are provided by county MH program housing specialists or other staff designated by the county program.

This cost center encompasses two unique services. The first is Supported Living, which is provided to an individual in a setting in which the recipient does not hold a lease and as a condition of retaining the housing, the individual must receive community-based behavioral health services. The setting may be a private residence, apartment, host home or foster home, and the services may include life skills or treatment.

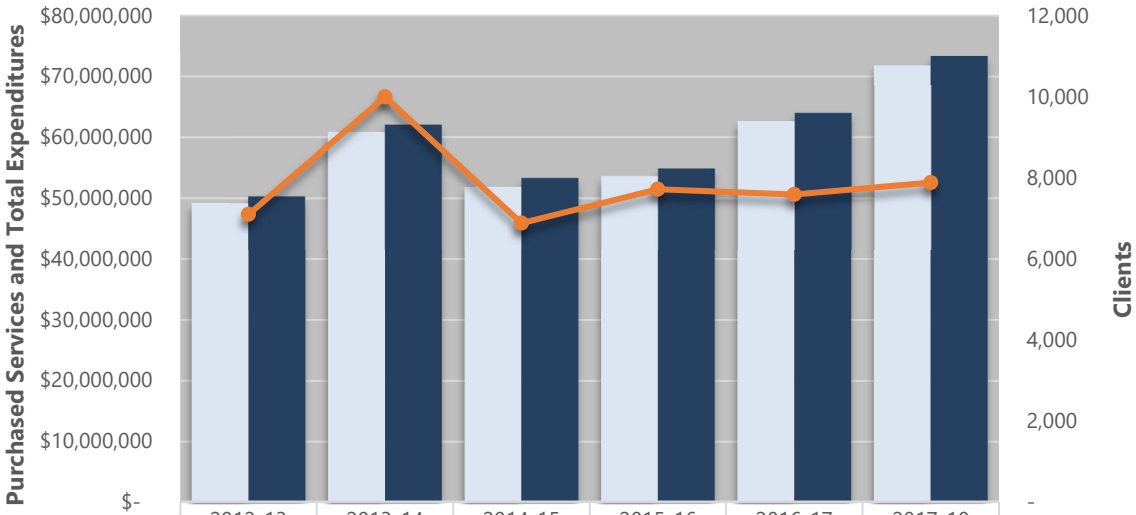
The other service, Supportive Housing, is a SAMHSA-recognized evidence- based practice. The services are provided in a setting for which the consumer does hold a lease and has no requirement that behavioral health services must be received to retain housing. Housing Support Services include the following:

- Housing location/re-location assistance.
- Roommate assistance.
- Renter skills training.
- Emergency rent or utility payments.
- Landlord/tenant negotiations.
- Rent guarantees.
- Security deposits for rent or utilities.
- Furniture and household goods.
- Moving assistance.
- Repair guarantees.
- Interim rent assistance.
- Assistance in obtaining housing benefits.
- Life skills training.
- Tenant rights and responsibilities.

As presented in Exhibit 19, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 19

Housing Support Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$49,172,308	$60,838,597	$51,854,094	$53,637,728	$62,619,337	$71,812,944
Total Expenditures	$50,302,140	$62,044,830	$53,307,426	$54,877,978	$63,963,444	$73,356,284
Clients	7,094	9,993	6,877	7,713	7,583	7,877

Source: Developed by LBFC staff from information provided by DHS.

As depicted above, there was a spike in the number of clients in FY 2013-14. We reviewed the data and found this spike was attributable to potential data inaccuracy from Philadelphia and Delaware Counties. For example, in FY 2012-13, Philadelphia reported zero clients; yet, in FY 2013-14 that number rose to 2,531, before it fell again to zero in FY 2014-15 and FY 2015-16.[36] Similarly, in Delaware County in FY 2012-13, 298 clients were reported, and in FY 2013-14, 850 clients were reported.[37] Despite these anomalies, we found the number of clients increased by 11 percent over the period, and total expenditures increased by 45.8 percent.[38]

18. Assertive Community Treatment and Community Treatment Teams

Cost Center Description. Assertive Community Treatment (ACT) is a SAMHSA-recognized evidence-based practice delivered to individuals with serious mental illness who have a Global Assessment of

[36] In FY 2016-17 Philadelphia reported 200 clients served, and in FY 2017-18 it reported 218 clients served.
[37] Other fiscal year reporting for Delaware County was: FY 2014-15: 9; FY 2015-16: 882; FY 2016-17: 9; FY 2017-18: 9.
[38] Refer to the introduction of this section for more information on the limitations of this data.

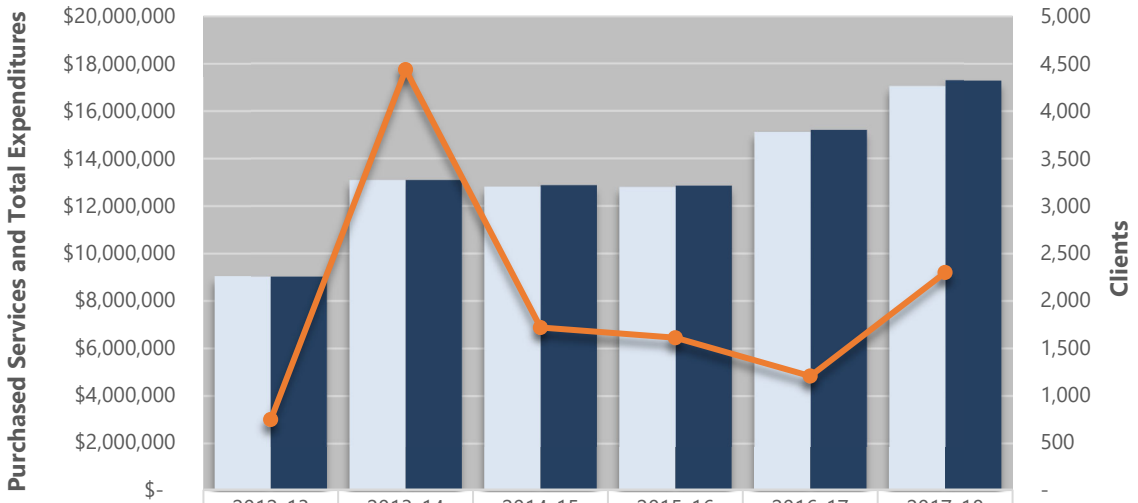
Functioning (GAF) score of 40 or below and meet at least one other eligibility criteria (psychiatric hospitalizations, co-occurring mental health and substance abuse disorders, being at risk for or having a history of criminal justice involvement, and a risk for or history of homelessness). ACT teams are a self-contained program where individuals receive a comprehensive array of services from a multidisciplinary team. ACT teams must adhere to such requirements as outlined within OMHSAS Bulletin 08-03: Assertive Community Treatment. Pennsylvania's ACT teams are monitored for fidelity to the Dartmouth Assertive Community Treatment Scale.

Community Treatment Team (CTT) services merge clinical, rehabilitation and support staff expertise within one service delivery team. CTT services are targeted for those persons who have not achieved and maintained health and stability in the community, and who would continue to experience hospitalization, incarceration, psychiatric emergencies and/or homelessness without these services.

As presented in Exhibit 20, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 20

Assertive Community Treatment and Community Treatment Teams



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$9,026,934	$13,089,860	$12,810,599	$12,799,316	$15,109,001	$17,041,882
Total Expenditures	$9,026,934	$13,089,860	$12,871,985	$12,850,400	$15,199,563	$17,290,926
Clients	740	4,438	1,713	1,605	1,200	2,294

Source: Developed by LBFC staff from information provided by DHS.

As was the case with other data representations, as shown above there was a spike that appears in FY 2013-14. Here again, this spike is explained by data omission, which occurred in FY 2012-13 with Philadelphia County. In that year. Philadelphia reported zero clients and zero expenditures for this cost center. Yet, in FY 2013-14, Philadelphia reported 3,678 clients, with total expenditures of more than $2.7 million. A similar anomaly was also noted for the Luzerne-Wyoming County MH office, which reported wide variability from year-to-year.[39] Because of this variation in data, we did not perform further calculations to determine overall trends.[40]

19. Psychiatric Rehabilitation

Cost Center Description. Psychiatric Rehabilitation Services assist persons with long-term psychiatric disabilities. Services are designed to develop, enhance, and/or retain: psychiatric stability, social competencies, personal/emotional adjustment, and/or independent living competencies, so that consumers may experience more success and satisfaction in the environment of their choice, and can function as independently as possible. Interventions may occur within a program facility or in community settings. This cost center applies to site-based and mobile services specifically and is intended primarily for adults.

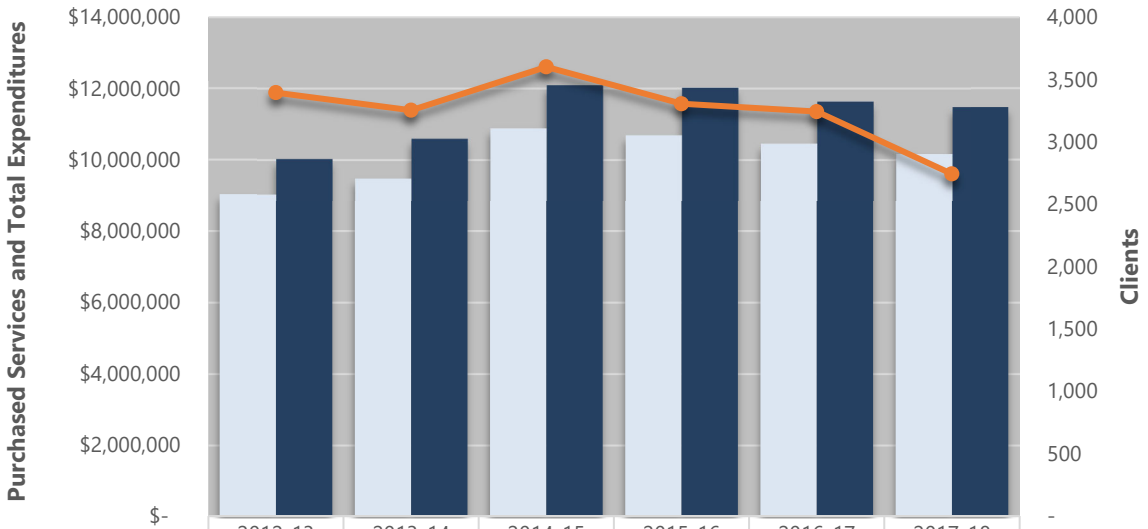
As presented in Exhibit 21, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

[39] As an example of this variability, the Luzerne-Wyoming MH joinder reported to DHS the following information: FY 2012-13: 1 client; $563 total expenditures. FY 2013-14: 27 clients; $683,199 total expenditures. FY 2014-15: 46 clients; $255,879 total expenditures. FY 2015-16: 33 clients; $857,206. FY 2016-17: 463 clients; $1,163,940. FY 2017-18: 0 clients; $891 total expenditures.

[40] Refer to the introduction of this section for more information on the limitations of this data.

Exhibit 21

Psychiatric Rehabilitation



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$9,034,359	$9,479,274	$10,886,006	$10,692,193	$10,458,706	$10,167,434
Total Expenditures	$10,029,189	$10,593,264	$12,088,151	$12,017,623	$11,630,667	$11,478,416
Clients	3,395	3,254	3,602	3,306	3,243	2,744

Source: Developed by LBFC staff from information provided by DHS.

As shown above, there has been an overall decrease in the number of clients. For the period, clients decreased by 19.2 percent; yet, total expenditures increased by 14.5 percent. This trend is consistent with trends regarding access to psychiatric services, which, as discussed in Section V, are becoming increasingly more difficult due to shortages in the number of practicing psychiatrists.

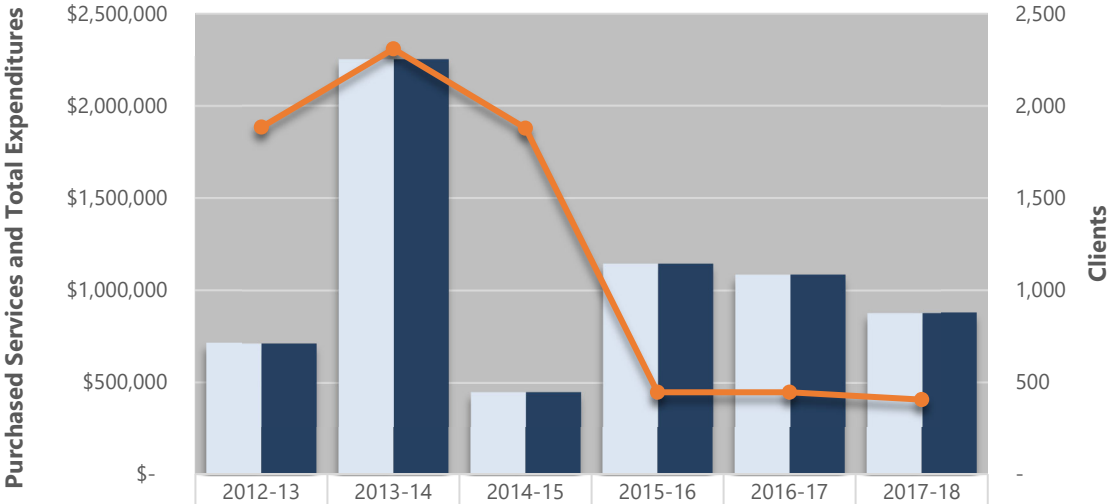
20. Children's Psychosocial Rehab Services

Cost Center Description. Within this cost center are services designed to assist a child or adolescent (i.e., a person aged birth through 17, or through age 21 if enrolled in a special education service) to develop stability and improve capacity to function in family, school and community settings. This may occur through training, support or intervention in the areas of problem solving and coping skills; social and interpersonal relationship skills; effective and appropriate communication of emotions, concerns and personal issues; behavior management; and community living. Services may be delivered to the child or adolescent in the home, school, community or a residential care setting. Among these services are after-school programs that include professional mental health staff.

As presented in Exhibit 22, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 22

Children's Psychosocial Rehabilitation Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$713,190	$2,251,170	$449,666	$1,145,459	$1,086,005	$877,660
Total Expenditures	$713,190	$2,251,170	$449,936	$1,145,459	$1,086,005	$877,660
Clients	1,884	2,309	1,878	444	444	404

Source: Developed by LBFC staff from information provided by DHS.

As shown above, there was a substantial drop in the number of clients over the period reviewed. This drop is due to Philadelphia County, which reported zero clients in FY 2012-13, but 410 clients in FY 2013-14. We also found a similar decline in Erie County, which reported approximately 1,600+ clients per year in FY 2012-13 through FY 2014-15, but in subsequent years reported only 300+ clients per year. Lastly, with respect to total expenditures in FY 2013-14, we found that there was a reporting inconsistency with Delaware County, which reported over $1.2 million in expenditures with 152 clients served. By way of comparison, in FY 2012-13, Delaware County reported $292,323 in total expenditures and 158 clients served, and in the other fiscal years it reported zero clients and zero total expenditures. As a result, the trend of clients depicted above may not be accurate for earlier years.[41]

21. Children's Evidence-Based Practices

Cost Center Description. This cost center refers to the array of practices for children and adolescents that by virtue of strong scientific

[41] Refer to the introduction of this section for more information on the limitations of this data.

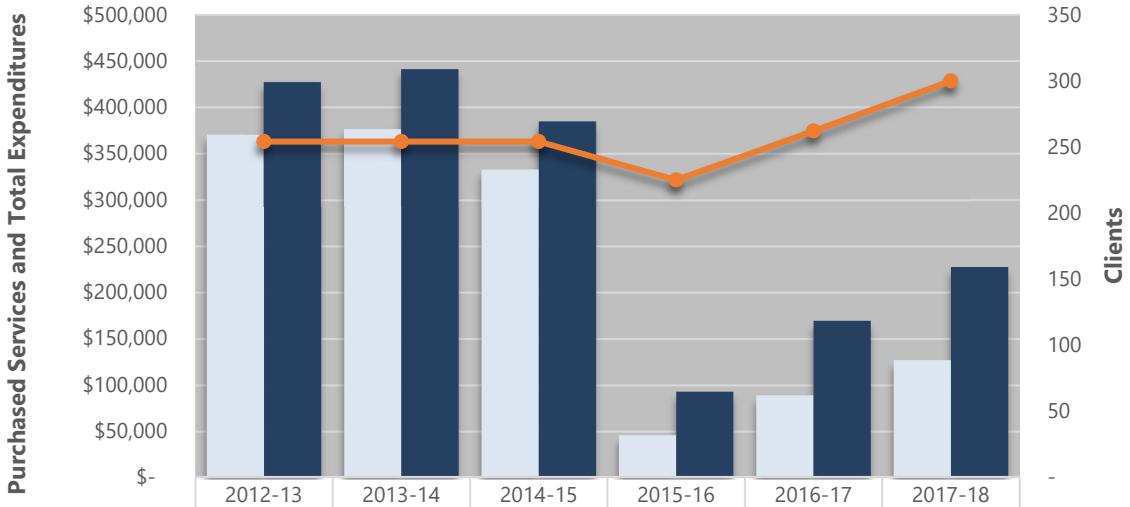
proof are known to produce favorable outcomes. A hallmark of these practices is that there is sufficient evidence that supports effectiveness. According to the Institute of Medicine, evidence-based practice integrates research evidence with clinical expertise and patient values. Some examples of programs currently in practice include:

- Multi-Systemic Therapy.
- Functional Family Therapy.
- Therapeutic Foster Care.

As presented in Exhibit 23, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 23

Children's Evidence-Based Practices



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$370,500	$376,557	$333,168	$44,976	$88,166	$126,337
Total Expenditures	$427,149	$441,013	$384,869	$92,165	$168,897	$227,057
Clients	254	254	254	225	262	300

Source: Developed by LBFC staff from information provided by DHS.

As shown above, there was a dramatic drop in expenditures beginning in FY 2015-16. We reviewed this data closely and found the drop was attributed to the Delaware County MH office, which up until that year accounted for most of the spending within this cost center.[42] Because this

[42] Delaware County Office of Behavioral Health reported the following information to DHS: FY 2012-13: 35 clients; $343,620 in total expenditures. FY 2013-14: 32 clients; $336,700 in total expenditures. FY 2014-15: 30 clients; $307,473 in total expenditures. FY 2015-16: 0 clients; $0 in total expenditures. FY 2016-17: 0 clients; $0 in total expenditures. FY 2017-18: 1 client; $18,000 in total expenditures. Refer to the introduction of this section for more information on the limitations of this data.

cost center was so heavily dependent on just one county, we did not perform additional trend analysis.

22. Peer Support Services

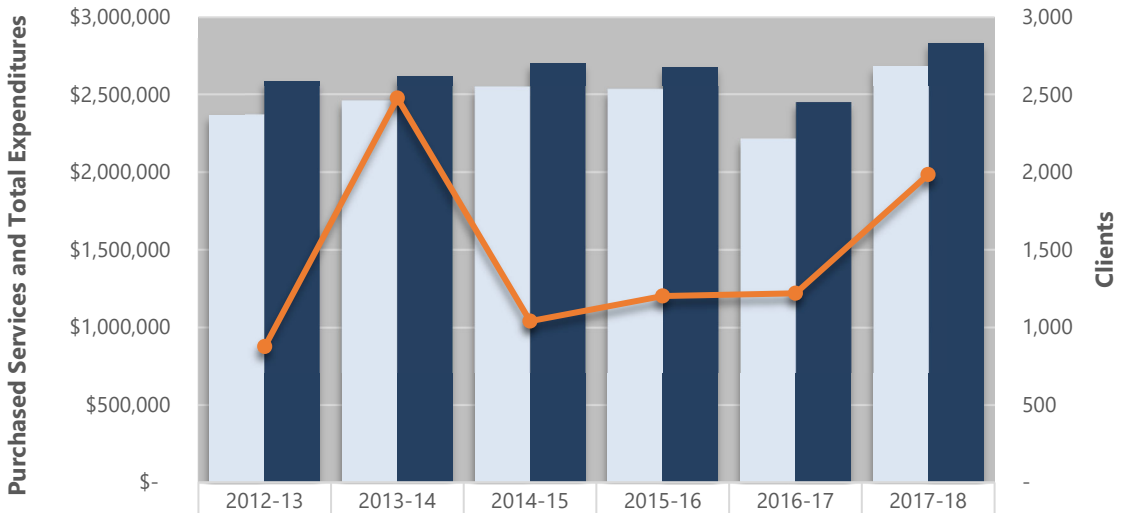
Cost Center Description. This cost center is used for activities which are specialized therapeutic interventions conducted by self-identified or former consumers of behavioral health services. Providers are trained and certified to offer support and assistance in helping others in their recovery and community-integration process. Peer support is intended to inspire hope in individuals that recovery is not only possible, but probable. Activities are designed to promote empowerment, self-determination, understanding, coping skills, and resilience through mentoring and service coordination supports that allow individuals with severe and persistent mental illness and co-occurring disorders to achieve personal wellness and cope with stressors and barriers encountered when recovering from their disabilities. All peer support providers must:

- Be licensed by OMHSAS.
- Be enrolled in the Department's Provider Reimbursement and Operations Management Information System in electronic format (PROMISe) as a Medicaid provider of peer support services.
- Have an approved peer support service description.
- Have a letter of approval from OMHSAS to operate a peer support services program.

As presented in Exhibit 24, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 24

Peer Support Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$2,370,746	$2,460,327	$2,550,329	$2,534,933	$2,216,032	$2,683,499
Total Expenditures	$2,588,318	$2,621,489	$2,703,788	$2,681,231	$2,450,038	$2,837,239
Clients	876	2,479	1,040	1,202	1,220	1,986

Source: Developed by LBFC staff from information provided by DHS.

As shown above, there was a significant spike in clients during FY 2013-14. Upon further review of the data, we found this spike was attributable to a data reporting inconsistency within the Chester County Office of MH. In that year (FY 2013-14), the County reported 1,159 clients, which accounted for approximately half of all the clients served in that year. In the previous year (FY 2012-13), Chester County reported 90 clients; and in the subsequent year (FY 2014-15), it reported only one client. As a result, we do not believe the data is accurate for that year.[43] Over the period reviewed, the number of clients did grow steadily by 126.7 percent, while total expenditures had a modest increase of 9.6 percent.

23. Consumer-Driven Services

Cost Center Description. This cost center refers to a host of services that do not meet the licensure requirements for psychiatric rehabilitation programs, but which are consumer-driven and extend beyond social rehabilitation services. Examples of services that fit within this category are:

- Fair-weather lodge programs.

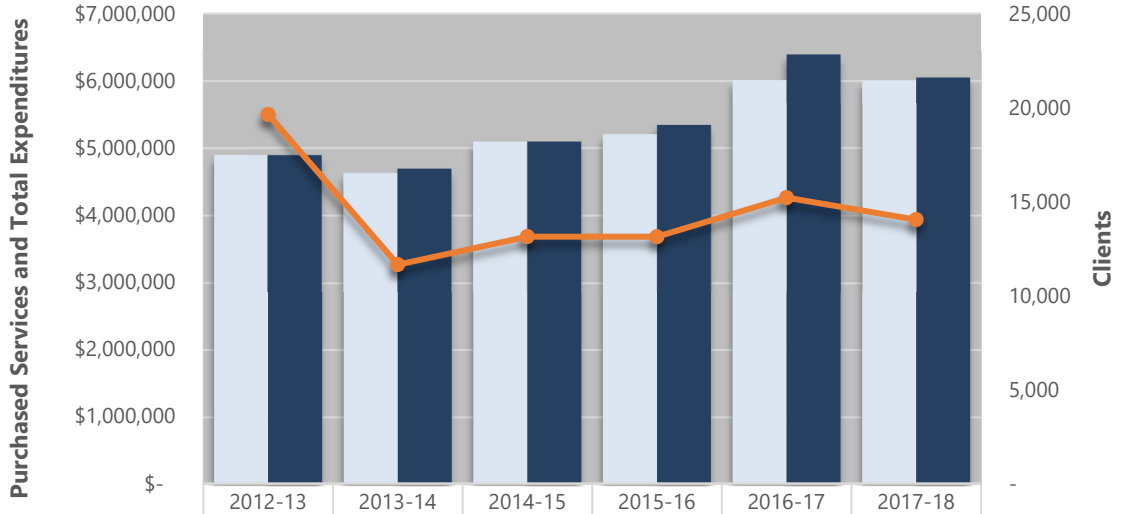
[43] Refer to the introduction of this section for more information on the limitations of this data.

- Peer programs that do not meet the guidelines established in the Peer Support Services Bulletin (i.e., are not Medicaid-enrolled and OMHSAS-licensed).
- Compeer programs (community-based mentoring programs).
- Peer-to-peer programs.
- Clubhouses that do not have OMHSAS licensure or International Center for Clubhouse Development credentials.
- Warm lines (a type of telephone service where individuals can discuss their mental health concerns).
- Peer monitoring services.

As presented in Exhibit 25, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

Exhibit 25

Consumer-Driven Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$4,894,143	$4,629,778	$5,093,308	$5,204,517	$6,005,499	$6,001,586
Total Expenditures	$4,894,143	$4,693,081	$5,093,308	$5,340,066	$6,389,511	$6,048,384
Clients	19,627	11,647	13,130	13,127	15,201	14,032

Source: Developed by LBFC staff from information provided by DHS.

As depicted above, and as was the case in other cost centers we plotted, data errors explain the variability with clients served. For example, in FY 2012-13, we found that Butler County MH Office reported a total of 12,676 clients served, which was 65 percent of the total clients served for

the entire state. Yet, in FY 2013-14, the Butler County MH Office reported only 1,578 clients.[44] We did not note variability in the reporting of total expenditures. Total expenditures over the period grew by 24 percent, of which most were for purchased services.

24. Transitional and Community Integration Services

Cost Center Description. This cost center includes services that are provided to individuals who are residing in a facility or institution as well as individuals who are incarcerated, diversion programs for consumers at risk of incarceration or institutionalization, adult outreach services, and homeless outreach services. Services may have a dual focus such as helping the individual to reintegrate into the community or services directed to the underserved and or atypical populations. This cost center captures services and activities that cannot be appropriately billed as case management. Activities include the following:

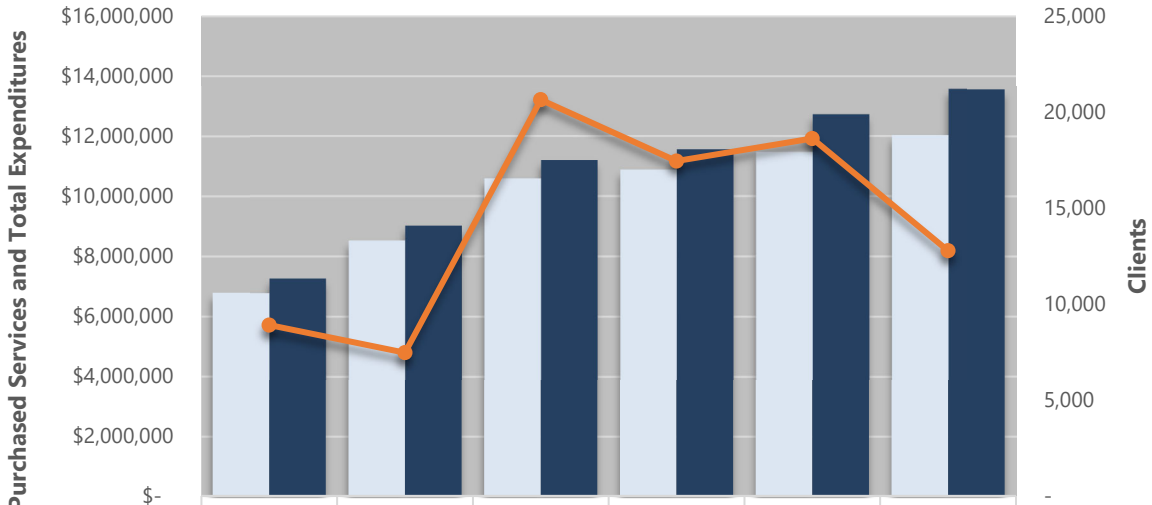
- Forensic services may include mental health court activities not otherwise characterized and services that are provided in jail settings both to the general prison population and to those housed in inpatient/crisis units within the prisons.
- Geriatric services include assessment, service plan development. Services may be provided in a variety of settings such as a nursing home, personal care home or the individual's home.
- Continuity of Care team activities include the monitoring of admissions and discharges from state hospitals and community hospitals. These teams work with the consumers to ensure that the necessary services are provided to prevent further hospitalizations. They also monitor consumer compliance with agreed-upon treatment plans.

As presented in Exhibit 26, we reviewed three variables within this cost center: clients, purchased services, and total expenditures.

[44] In subsequent years, the highest number of clients reported served by Butler County was 1,937. Refer to the introduction of this section for more information on the limitations of this data.

Exhibit 26

Transitional and Community Integration Services



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Purchased Services	$6,778,810	$8,528,284	$10,587,891	$10,880,738	$11,467,298	$12,025,089
Total Expenditures	$7,265,286	$9,019,762	$11,195,475	$11,556,927	$12,719,052	$13,561,328
Clients	8,905	7,465	20,655	17,452	18,630	12,777

Source: Developed by LBFC staff from information provided by DHS.

As shown above, there was variability in the number of clients from year-to-year, while there was a consistent growth in total expenditures. We found the variability was caused by Philadelphia County, which reported zero clients and zero total expenditures in both FY 2012-13 and FY 2013-14. In subsequent years, Philadelphia reported much higher amounts, which skewed the analysis.[45]

25. Other Services

Cost Center Description. This cost center refers to those activities or miscellaneous programs that could not be appropriately included in any of the previously cited cost centers. The specific activity or activities reported in this cost center must be described on all reporting forms submitted to DHS. Use of this cost center requires prior approval from the Department. It is a rarely used cost center among the county agencies.

[45] For example: FY 2014-15, 7,429 clients and $1.8 million in total expenditures; FY 2015-16, 6,935 clients and $1.9 million in total expenditures; FY 2016-17, 9,226 clients and $2.7 million in total expenditures; and FY 2017-18, 3,610 clients and $2.5 million in total expenditures. Refer to the introduction of this section for more information on the limitations of this data.

The cost center was not used in FY 2015-16 through FY 2017-18. Data from the three years when this cost center was used (FY 2012-13 through FY 2014-15) is presented in Exhibit 27.

Exhibit 27

Other Services

Fiscal Year	Purchased Services	Clients	Total Expenditures
2012-13	$3,032,893	275	$3,055,140
2013-14	2,923,795	110	2,943,290
2014-15	40,000	34	40,000
2015-16	0	0	0
2016-17	0	0	0
2017-18	0	0	0
Total	**$5,996,688**	**419**	**$6,038,430**

Source: Developed by LBFC staff from information obtained from DHS.

SECTION IV
OTHER MENTAL HEALTH SERVICES DATA COLLECTION AND ANALYSIS

Fast Facts…

- *In 2018, seven of the 19 private psychiatric facilities located in Pennsylvania had occupancy rates above 90 percent (most recent data is from 2018).*
- *Using data from the Department of Corrections, we found that MH caseloads in Pennsylvania's jails increased by more than 40 percent over a five-year period.*
- *Using data obtained from the PA Healthcare Cost Containment Council, we found that hospitalizations for certain MH conditions grew by 17.2 percent from FY 2012-13 through FY 2017-18. For emergency room visits, the growth rate was 5.2 percent over the same period.*

Overview

In addition to the specific Department of Human Services (DHS) cost center data presented in Section III, HR 515 requested other data collection and analysis of several mental health services. In particular, HR 515 sought statewide summaries for the following: the use of short-term private psychiatric facilities; data on the number of inmates with mental illness in county jails; and data on the use of emergency rooms by individuals with mental illness in mental health crisis.

Answering these data inquiries proved to have unique challenges. For example, with respect to the use of "short-term psychiatric facilities," we found that this term is not recognized by DHS or the Department of Health (DOH); however, we were able to find limited data on private psychiatric facilities in Pennsylvania. These facilities are free-standing, or stand-alone facilities. From this data, we were able to extract data on capacity, occupancy rates, and length of stay. We found that in the most recent year for which we were able to obtain data (2018), seven of 19 facilities had occupancy rates above 90 percent. We also found there is variability in the average length of stay from facility to facility; however, owing to the complexity of individual patient needs, we found that facility-to-facility comparisons may not be a reliable measure.

With respect to data on the number of inmates with mental illness in county jails,[46] we worked with data obtained from the Department of Corrections. Using this data, we were able to determine mental health caseloads for a certain point in time (January 31 of each year), which we compared to each facility's capacity and average in-house population. However, as with the DHS cost center data certain caveats need to be applied because the data is self-reported by the jails and is not checked for accuracy. Nevertheless, the data presents a reasonable perspective of the MH caseloads occurring at these facilities, which we found increased by more than 40 percent over a five-year period—despite decreases in jail capacity and average in-house population.

[46] According to DOC, the term "county jail" and "county prison" may be used interchangeably within Pennsylvania. These facilities are run by county governments and are different from state-run correctional institutions. DOC does not operate county jails or county prisons but does collect certain data on how these facilities operate.

Finally, and with respect to the objective of obtaining information on the use of emergency rooms by individuals with mental illness in mental health crisis, we obtained medical discharge information from the Pennsylvania Health Care Cost Containment Council (PHC4). Using this data, we could discern the number of hospitalizations that occurred for certain mental health conditions. We were also able to determine the number of emergency room visits that occurred and which resulted in the patient being admitted to the hospital. While the information only pertains to the number of cases and not individuals, which results in some double counting, the data revealed that hospitalizations have been increasing. Specifically, hospitalizations grew by 17.2 percent from

FY 2012-13 through FY 2017-18. For emergency room (ER) visits, the growth rate was 5.2 percent over the same period. Here too, certain data limitations are present. For example, PHC4 staff indicated that ER revenue codes may not be used uniformly by hospitals, which could undercount the number of cases. Additionally, just because a patient accessed the ER for a mental health issue does not necessarily mean that the patient was "in crisis" (which is the level of specificity sought by HR 515). In these cases, there may be some over counting present.

Issue Areas

A. Data on "Short-Term" Private Psychiatric Hospitals

HR 515 tasked us with obtaining data on the use of short-term private psychiatric facilities. The term "short-term private psychiatric facility" is not a term that is defined or recognized by the Department of Human Services or the Department of Health; consequently, no data exists to define these facilities. However, after consulting with representatives from DHS' Bureau of Community and Hospital Services, we were able to obtain a listing of *private* psychiatric facilities in Pennsylvania. These facilities are free-standing institutions, as opposed to a psychiatric wing or unit that is contained within a larger hospital. Additionally, while these facilities are private, the operating status may be "for-profit" or "not-for-profit." Finally, patients in these facilities are not limited to short-term or long-term status, but rather by the type of care best suited to the individual patient's needs.

Private Psychiatric Facilities

Based on information we obtained from DHS, there are 24 facilities meeting the description of a private psychiatric facility. Using data obtained

from DHS, we also linked these facilities to the annual specialty hospital reports published by the Department of Health (DOH). Exhibit 28 below lists these facilities in greater detail.

Exhibit 28

Private Psychiatric Facilities
(August 2020)

Facility Name	Region	County	Licensed Beds*	Beds Setup and Staffed*
Lancaster Behavioral Health Hospital	Central	Lancaster	126	48
PA Psychiatric Institute - Inpatient	Central	Dauphin	89	84
Philhaven Hospital	Central	Lebanon	118	103
Roxbury Treatment Center - Inpatient	Central	Franklin	112	112
The Meadows Psychiatric Center	Central	Centre	119	119
First Hospital	Northeast	Luzerne	149	149
Haven Behavioral Hospital of Eastern PA	Northeast	Berks	67	67
Kidspeace Children's Hospital	Northeast	Lehigh	120	120
Tower Behavioral Health [a/]	Northeast	Berks	n/a	n/a
Belmont Behavioral Hospital	Southeast	Philadelphia	n/a	n/a
Brooke Glen Behavioral Hospital	Southeast	Montgomery	146	146
Fairmount Behavioral Health System	Southeast	Philadelphia	239	235
Foundations Behavioral Health System	Southeast	Bucks	60	60
Friends Hospital	Southeast	Philadelphia	192	192
Girard Medical Center	Southeast	Philadelphia	218	211
Haven Behavioral Hospital of Philadelphia	Southeast	Philadelphia	36	36
Malvern Behavioral Health [b/]	Southeast	Philadelphia	n/a	n/a
Montgomery County MH/MR Emerg. Service	Southeast	Montgomery	81	81
St. John Vianney Center	Southeast	Chester	50	50
The Devereux Children's Health Institute	Southeast	Chester	49	49
The Horsham Clinic	Southeast	Montgomery	206	206
Clarion Psychiatric Center	Western	Clarion	112	96
LifeCare Behavioral Health Hospital of Pgh.	Western	Allegheny	49	49
Southwood Psychiatric Hospital	Western	Allegheny	68	64

Notes:
*/ This information was provided by DOH for 2018. Licensed beds do not necessarily equate to capacity.
a/ Facility opened in July 2020. DHS lists its capacity as 144.
b/ Licensed beds for this facility was unavailable; however, DHS reports capacity as 22.

Source: Developed by LBFC staff from information provided by DHS and DOH.

As shown above, most of these facilities are in the southeastern part of the state. There are 12 facilities located within the Greater-Philadelphia

area, with half of the facilities (six) located within Philadelphia County itself. Reporting information was unavailable for all the facilities; however, of those that reported, the largest of these facilities had 239 beds, and the smallest had a capacity of 22 (as reported by DHS).

Using the facilities reported by DHS in 2020, we also sought historical information on occupancy rates and average length of stays from DOH and its Division of Health Informatics. This latter information is reported to DOH through the annual specialty hospital questionnaire. We were only able to capture three years of data, as prior to 2016 the data was reported on a fiscal year basis. As a result, we are only reporting data for calendar years 2016, 2017, and 2018, which is presented in Exhibit 29.

Exhibit 29

Private Psychiatric Facilities
Occupancy Rates and Average Length of Stay*
(Occupancy rates above 90 percent are listed in red)

Facility Name	2016 Occ. Rate (%)	2016 Avg. Stay (Days)	2017 Occ. Rate (%)	2017 Avg. Stay (Days)	2018 Occ. Rate (%)	2018 Avg. Stay (Days)
Lancaster Behavioral Health Hospital	n/a	n/a	n/a	n/a	49.7	7.82
PA Psychiatric Institute - Inpatient	94.1	10.73	87.1	11.20	90.3	12.05
Philhaven Hospital	91.3	14.22	80.0	14.48	90.0	16.39
Roxbury Treatment Center - Inpatient	87.0	14.48	78.9	14.23	80.7	13.02
The Meadows Psychiatric Center	89.7	12.86	90.7	12.83	91.2	14.00
First Hospital	82.6	9.68	69.6	10.22	64.2	9.99
Haven Behavioral Hospital of Eastern PA	91.5	11.09	92.7	12.15	95.0	12.94
Kidspeace Children's Hospital	65.8	10.98	58.1	11.36	62.0	11.75
Tower Behavioral Health	n/a	n/a	n/a	n/a	n/a	n/a
Belmont Behavioral Hospital	93.3	12.23	91.3	13.16	n/a	n/a
Brooke Glen Behavioral Hospital	87.8	13.32	87.8	13.6	87.8	13.58
Fairmount Behavioral Health System	92.8	14.96	92.1	14.23	91.1	11.55
Foundations Behavioral Health System	81.1	16.18	88.1	13.63	92.0	21.04
Friends Hospital	84.7	12.78	78.6	13.94	n/a	n/a
Girard Medical Center	n/a	n/a	87.1	84.66	n/a	n/a
Haven Behavioral Hospital of Philadelphia	82.2	12.28	87.9	13.9	95.0	12.94
Malvern Behavioral Health	n/a	n/a	n/a	n/a	n/a	n/a
Montgomery County MH/MR Emerg. Service	53.5	11.82	62.4	11.34	68.4	12.18
St. John Vianney Center	78.0	119.04	62.5	102.73	67.7	115.01
The Devereux Children's Health Institute	66.6	30.64	67.6	26.79	59.4	28.49
The Horsham Clinic	92.8	11.97	91.5	12.08	91.1	12.78
Clarion Psychiatric Center	93.6	n/a	91.7	11.89	85.2	11.85
LifeCare Behavioral Health Hospital of Pgh.	24.9	18.26	55.2	17.08	65.8	20.44
Southwood Psychiatric Hospital	71.0	10.15	84.1	16.36	88.7	21.04

Note:
*/Occupancy rate is calculated from patient days of care divided by available bed days. Average length of stay is calculated from total discharge days divided by total discharges.
Source: Developed by LBFC staff from DOH Hospital Utilization reports for 2016, 2017, 2018 (latest data available).

Owing to the complexity of mental health treatment and individual patient needs, facility-to-facility comparisons may not be a reliable measure for average length of stay. However, in looking at the facilities in terms of occupancy rates, we see that over the three-year period most of the facilities operated below a 90 percent occupancy rate. For example, in 2016, of those facilities where data was available, 7 of the 20 facilities had occupancy rates above 90 percent. In 2017, this same metric was 6 of 21 facilities. And, in 2018, 7 of 19 facilities had occupancy rates above 90 percent.

B. Inmates with Mental Illness in County Jails

Another survey aspect of HR 515 was to determine the number of individuals with mental illness who were incarcerated in county jails. To answer this objective, we referred to data maintained by the Pennsylvania Department of Corrections (DOC).

To be clear, the Department of Corrections is not responsible for the operation and maintenance of county jails; however, DOC does regularly inspect the facilities and it maintains certain statistics on inmates housed within the jails. To this latter point, since 2014 DOC has published mental health statistics for these facilities.[47] We also learned that, like the DHS county data, the information is entirely self-reported by the county jails and is not verified for accuracy.

Although the data is self-reported and further only reflects a point-in-time, we believe the data is a "best available option" to provide perspective on the number of county jail inmates with mental illness.[48]

Pennsylvania Data

As stated previously, DOC collects various statistical data on county prisons. Specific to mental health matters, counties report data to DOC on items including, but not limited to, the number of MH commitments, the number of MH hospitalizations, inmates on psychotropic medication—and specific to this report—the MH caseload for inmates. We chose to use this latter field because it was the most inclusive MH category reported to DOC. For example, not all inmates with mental health issues

[47] We contacted research staff from DOC and tried to obtain data that preceded 2014; however, we were informed that 2014 was the furthest year for which data was available.

[48] DOC staff informed us that the county jail statistics are the only source of data they maintained to answer the objective, and that it would be a reasonable source to answer the question of the number of inmates with mental illness incarcerated in county jails.

may be prescribed psychotropic drugs or are involuntary/voluntary committed; therefore, only using these categories as a basis for analysis would provide a limited perspective.

MH caseload data is reported as a "snap-shot" of the inmates incarcerated as of January 31 for the preceding year. For instance, the 2019 county statistics lists data as of January 31, 2018. Furthermore, male and female inmates are reported separately for some county prisons, while for other county prisons, males and females are not separated for reporting purposes. For consistency purposes, we consolidated these figures.

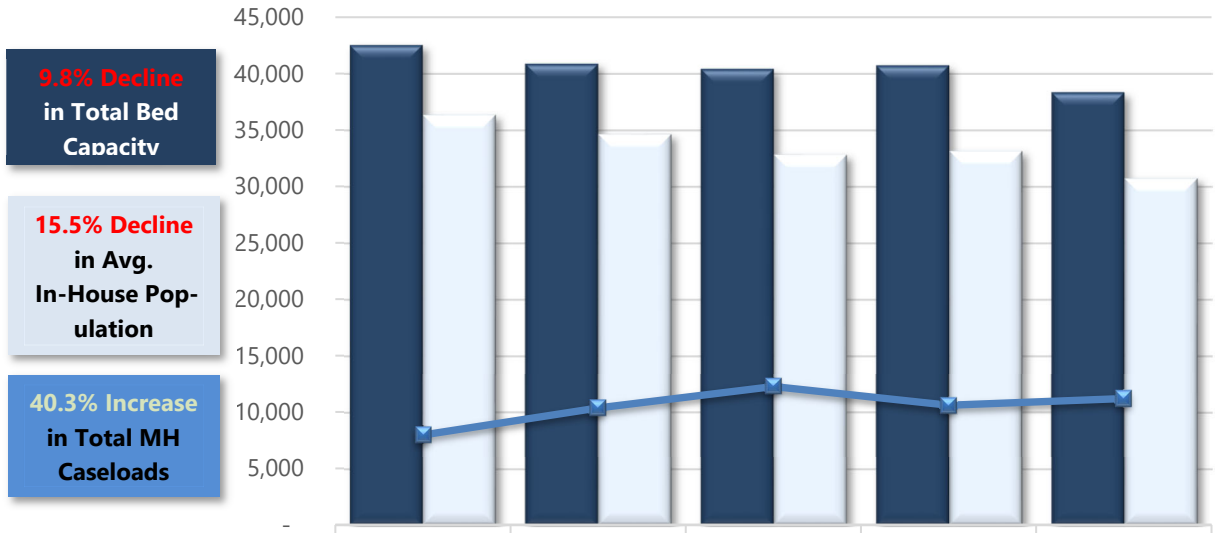
Additionally, not all counties reported data to DOC in the period we reviewed (2014-2018). This occurrence could happen if the county had no cases to report or the county did not report information to DOC for that year.

We also included the "total bed capacity," as well as the "total average in-house daily population" in our analysis. It is important to highlight that these figures represent totals for the entire year, whereas MH caseload data is just one day of the year (January 31). Nevertheless, comparing MH caseload data to these totals provides additional context as to how many inmates may be suffering from mental illness while incarcerated in county prisons. Our results are presented in Exhibit 30.

Exhibit 30

Total Bed Capacity[a/], Average In-House Population[b/], and MH Caseloads[c/] Pennsylvania County Prisons

(2014-2018)



	2014	2015	2016	2017	2018
Total Bed Capacity	42,529	40,874	40,422	40,728	38,341
Avg. In-House Pop.	36,347	34,638	32,848	33,152	30,731
Total MH Caseloads	7,976	10,353	12,263	10,601	11,190

Notes:
[a/] Total bed capacity reflects the sum of all beds including day beds for the year.
[b/] Average in-house population does not include county inmates that may be housed elsewhere or on work-release.
[c/] MH Caseload data is as of January 31 of each year.

Source: Developed by LBFC staff from DOC Annual County Prison Statistics.

As shown above, while the overall bed capacity at Pennsylvania's county prisons has remained relatively stable, falling from a high of 42,529 in 2014 to a current low of 38,341 in 2018—or a 9.8 percent decline—there has been a steady growth in MH caseloads. Over the period reviewed, MH cases grew by 40.3 percent, which is especially noteworthy in that the average in-house population has declined by 15.5 percent. Again, while the above is comparing only a "date in time" to the averages that occurred over the entire year, the comparison indicates that while county prison populations have decreased, the MH status of those being incarcerated is increasing. This conclusion may be indicative of the need for more MH services within the county prison system.

We discussed this conclusion with DOC's Director of Research, who agreed that these trends may be indicative of the need for more MH services within the county jails. However, he also added a caveat needs to

be added that the increased number of MH caseload may be due to better reporting by the counties rather than an actual trend. He noted that reporting accuracy is always a potential concern when looking at county jail numbers in aggregate.

C. Emergency Room Use by Individuals with Mental Illness in Mental Health Crisis

HR 515 asked us to obtain data on the "…use of emergency rooms in hospitals by individuals with mental illness in mental health crisis in each county…" Answering this request was difficult because of the nature of mental health illness and mental health crisis. To this point, it is important to present additional information about these terms.

According to the National Alliance on Mental Illness (NAMI), a mental health crisis involves a better understanding of mental health *illness*. More specifically, NAMI cites the following:[49]

> Mental health illnesses are medical conditions that disrupt a person's thinking, feeling, mood, daily functioning and ability to relate to others. There are no blood tests or tissue samples that can definitively diagnose mental illness. Diagnoses are based on clinical observations of behavior in the person and reports from those close to the person. Symptoms vary from one person to another, and each person responds differently, which complicates getting an accurate diagnosis. The most common mental illness diagnoses include depressive disorder, bipolar disorder, schizophrenia and anxiety disorders, but there are many others.

As a result, the symptoms of mental health illness can be difficult to diagnose, and especially so if there are no previous medical interactions, or if there are co-morbid conditions (i.e., there is more than one condition causing health difficulties). Further, because there are no simple tests to make a diagnosis, a proper diagnosis of mental illness can take weeks, months, or years—and may change as the patient reacts to different treatments.

A *mental health crisis* may be the first indication of mental illness in an individual, but not necessarily so. According to NAMI, a mental health crisis is any situation in which a person's behavior puts them at risk of hurting themselves or others and/or prevents them from being able to

[49] National Alliance on Mental Illness, *Navigating a Mental Health Crisis*, 2018.

care for themselves or function effectively in the community.[50] Obviously this definition is somewhat broad because it is unclear what can lead or contribute to a crisis. NAMI cites several examples including stressors from one's home, environment, school, work, or other influences.

Equally important in understanding mental health crisis is identifying warning signs; however, according to NAMI, warning signs are not always present when a mental health crisis is developing. Common actions that may be a clue that a mental health crisis is developing include the following:

- Inability to perform daily tasks like bathing, brushing teeth, brushing hair, changing clothes.
- Rapid mood swings, increased energy level, inability to stay still, pacing; suddenly depressed, withdrawn; suddenly happy or calm after period of depression.
- Increased agitation verbal threats, violent, out of-control behavior, destroys property.
- Abusive behavior to self and others, including substance use or self-harm (cutting).
- Isolation from school, work, family, friends.
- Loses touch with reality (psychosis) - unable to recognize family or friends, confused, strange ideas, thinks they're someone they're not, doesn't understand what people are saying, hears voices, and sees things that are not there.
- Paranoia.

Pennsylvania Data

To answer this objective, we obtained data from the Pennsylvania Health Care Cost Containment Council (PHC4), which is an independent state agency that collects inpatient hospital discharge and ambulatory/outpatient procedure records from hospitals and freestanding ambulatory surgery centers in Pennsylvania. This data, which includes hospital charge and treatment information as well as other financial data, is collected on a quarterly basis and is then verified by PHC4 staff.[51]

Data that is reported to PHC4 comports with standards developed by the World Health Organization (WHO) and the United States Centers for Disease Control (CDC), and the International Classification of Diseases, Clinical Modification (ICD-CM).[52] The ICD-CM is the official system of assign-

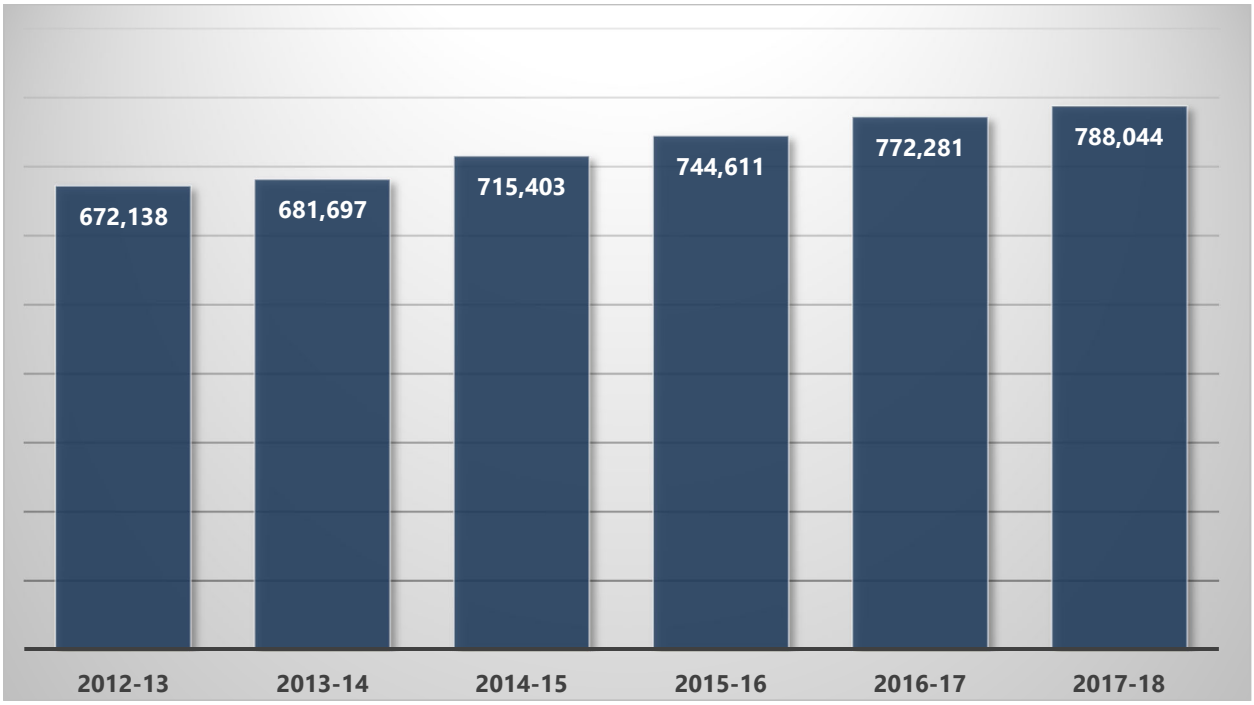
[50] Ibid.
[51] *See* PHC4.ord/council/mission.htm
[52] Over the course of the period reviewed there were two ICD-CMs used, the ninth and tenth revisions.

ing codes to diagnoses and procedures associated with hospital utilization in the United States; consequently, it provides a uniform way of querying data to identify specific illness, including mental health diagnoses.

Mental and Behavioral Health Hospitalizations. Using PHC4's data, we obtained records on the number of hospitalizations that occurred during the period FY 2012-13 through FY 2017-18, and that had either a primary or secondary diagnosis of "Mental and Behavioral Health Disorder." The data was further grouped by the patients' county of residence. In the end, this analysis gives a fair representation of the incidences of mental health disorders for which a patient required hospitalization, whether as a primary diagnosis or as a secondary (related) diagnosis of mental illness.[53] The results are summarized in Exhibit 31.

Exhibit 31

Mental and Behavioral Health Disorders - Hospitalizations
FY 2012-13 through FY 2017-18*



Counties	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Adams	4,959	5,020	5,475	5,127	4,824	4,413
Allegheny	78,002	81,367	81,407	83,472	84,063	87,025
Armstrong	4,589	4,646	4,246	4,204	4,362	4,115
Beaver	9,274	9,737	9,590	9,275	9,473	9,549
Bedford	2,373	2,567	2,706	3,183	2,937	3,094

[53] It is important to note that individual patient records were not reviewed, only aggregated data. To ensure confidentiality and fidelity, PHC4 staff conducted all data retrievals.

Exhibit 31 Continued

Counties	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Berks	20,720	20,478	22,214	22,590	24,801	26,150
Blair	7,889	8,359	9,253	10,496	9,744	10,346
Bradford	3,297	2,992	3,046	3,709	2,732	3,186
Bucks	30,231	29,228	30,910	32,316	32,430	32,639
Butler	9,629	10,101	10,879	11,330	12,062	12,091
Cambria	9,672	9,273	9,772	10,016	10,167	11,183
Cameron	428	405	392	376	385	435
Carbon	4,628	4,734	4,483	5,027	5,660	5,790
Centre	5,798	6,229	7,881	7,278	7,366	7,511
Chester	17,536	18,231	19,733	20,811	21,617	22,644
Clarion	2,409	2,364	2,205	2,276	2,330	2,298
Clearfield	4,320	4,304	4,206	4,892	5,128	5,486
Clinton	2,300	2,254	2,232	2,129	2,329	2,021
Columbia	5,302	4,603	5,188	5,466	5,801	5,218
Crawford	4,158	4,010	4,449	5,106	6,635	7,634
Cumberland	10,951	11,345	13,027	12,696	13,526	14,929
Dauphin	12,838	13,598	17,891	19,304	19,551	20,899
Delaware	30,238	29,708	30,017	32,473	33,377	35,122
Elk	2,146	2,278	2,299	2,264	2,282	2,278
Erie	14,626	15,885	16,905	17,753	18,489	18,873
Fayette	7,950	8,196	8,427	8,237	8,721	9,027
Forest	424	420	456	434	475	435
Franklin	5,892	6,267	6,087	5,473	5,786	6,968
Fulton	548	669	622	602	559	601
Greene	2,170	1,552	1,629	1,630	1,476	1,407
Huntingdon	2,282	1,901	2,290	2,482	2,367	3,080
Indiana	5,523	5,735	5,892	5,694	5,541	4,906
Jefferson	3,126	3,093	2,883	3,094	2,970	2,873
Juniata	1,184	1,168	1,306	1,241	1,346	1,347
Lackawanna	12,390	14,455	15,824	15,789	15,418	15,005
Lancaster	22,970	22,915	23,638	21,917	23,979	24,119
Lawrence	7,121	7,231	7,412	7,236	7,338	6,516
Lebanon	5,344	5,168	6,068	7,191	8,078	8,727
Lehigh	22,159	20,643	20,859	24,873	28,577	28,556
Luzerne	16,523	16,639	18,271	18,005	19,262	21,163
Lycoming	7,692	6,835	7,042	6,378	6,862	6,998
McKean	2,093	2,142	1,994	2,166	2,618	2,897
Mercer	8,209	8,634	9,266	9,833	10,167	9,402
Mifflin	3,513	3,160	3,334	3,051	3,466	3,556
Monroe	5,815	6,041	6,652	7,339	6,805	8,035
Montgomery	35,284	35,162	36,588	38,654	39,948	40,862
Montour	931	1,010	1,310	1,467	1,807	1,745
Northampton	24,163	23,647	22,693	26,674	30,352	29,325
Northumberland	5,113	5,020	6,137	7,493	8,756	8,033
Perry	2,065	2,111	2,577	2,860	2,671	2,820
Philadelphia	81,098	82,413	85,900	87,442	88,739	89,175
Pike	1,131	1,231	1,360	1,226	1,329	1,534
Potter	567	573	628	702	769	875
Schuylkill	9,489	9,306	8,878	9,381	10,429	10,415
Snyder	1,385	1,420	1,541	2,233	2,399	2,205
Somerset	3,535	3,612	3,978	4,325	3,840	4,088
Sullivan	496	473	409	385	365	455

Exhibit 31 Continued

Counties	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Susquehanna	1,317	1,346	1,357	1,646	1,649	1,633
Tioga	1,432	1,446	1,428	1,581	1,683	1,793
Union	1,338	1,349	1,545	1,675	1,818	1,799
Venango	4,177	4,222	4,387	4,645	4,863	4,909
Warren	1,924	1,774	1,889	2,247	2,676	1,881
Washington	11,278	11,321	11,158	11,162	10,829	11,479
Wayne	2,221	2,467	2,480	1,848	1,969	2,018
Westmoreland	21,930	23,279	22,995	25,031	25,263	25,827
Wyoming	1,670	1,757	1,719	1,624	1,795	2,127
York	18,353	20,088	24,088	24,076	24,450	22,499
Total	**672,138**	**681,607**	**715,403**	**744,611**	**772,281**	**788,044**

Note: */Data includes medical records that originated from inpatient and outpatient facilities and were coded with either a primary or secondary diagnosis involving a mental health disorder.

Source: Developed by LBFC staff from information provided by the PHC4.

To be clear, the above data does not reflect individuals, but rather hospital records. Stated differently, if the same patient had two hospitalizations for mental illness in the same year, those two hospitalizations would each be counted in the total for that year, even though they involved one (the same) patient. As a result, there could be some double counting that is present, if trying to isolate "individuals" (as outlined in HR 515). Further, the data does not necessarily indicate that these records were from individuals who were in "mental health crisis." One could argue that a hospitalization might fit NAMI's criteria, but in cases where the secondary diagnosis is mental illness that may not be the case. Finally, the records also only indicate that an admission occurred, if the patient was treated and later discharged from the facility, the record would not be captured for PHC4 purposes, nor would it appear in the above tabulations.

During the period FY 2012-13, through FY 2017-18, there were on average 729,000 hospitalization cases for mental and behavioral health illnesses among Pennsylvania residents. As listed on the previous exhibit, the high year was FY 2017-18 with 788,044 cases. Further, there was a rather substantial increase of 17.2 percent in cases from FY 2012-13, through FY 2017-18. Not surprisingly, given the larger population centers in Philadelphia and Allegheny Counties, these counties had the higher number of cases.

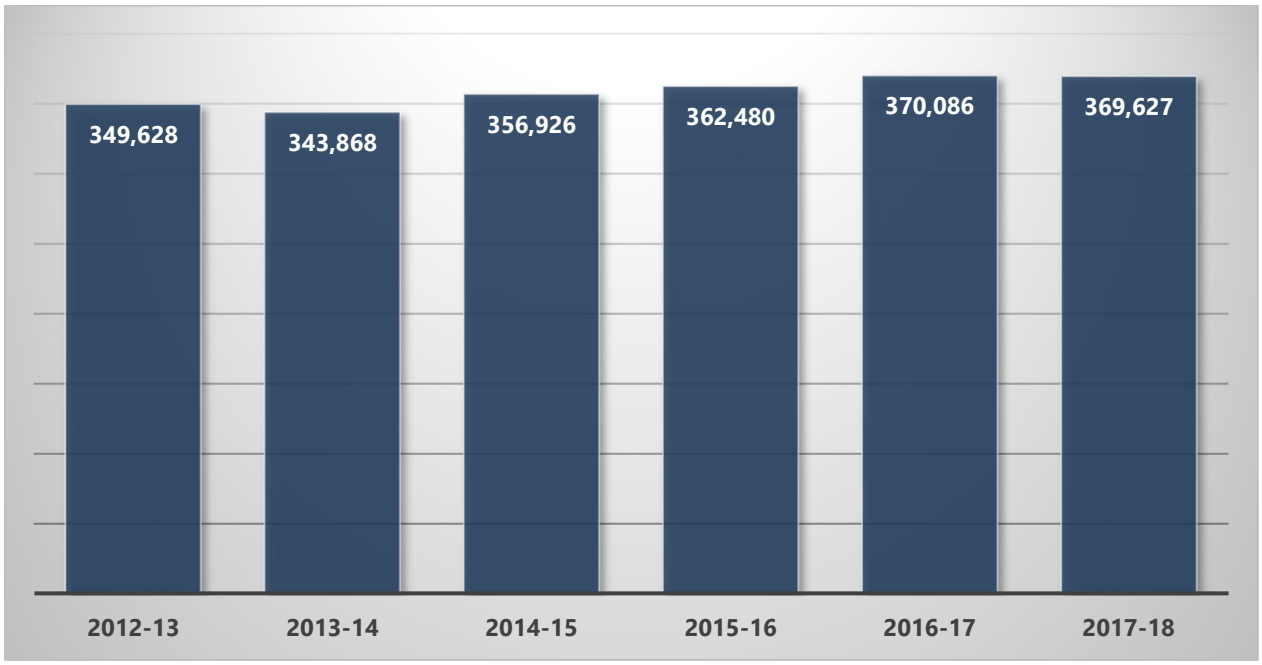
Emergency Room Use. To get to the matter of mental health crisis and emergency room (ER) use, we used similar data from PHC4, but looked at ER revenue codes. Revenue codes, which are part of the discharge record, inform an insurance company or payer as to where ser-

vices were provided. Consequently, by querying these codes it is possible to determine if patients—for our purposes those who were admitted to the hospital for mental illness—did so via an emergency room setting.

Here again, we used a wide aperture in collecting cases involving ER usage for mental health reasons. Specifically, we included cases that had either a primary or secondary diagnosis of mental or behavioral health disorders and that were from either an inpatient or ambulatory care facility. As with the hospitalization records presented in the last exhibit, ER records are only counted if the patient was admitted to the hospital. If the patient had been discharged without an admission, the record would not have been counted. The results are presented in Exhibit 32.

Exhibit 32

Mental and Behavioral Health Disorders – Emergency Room Records
FY 2012-13 through FY 2017-18*



Counties	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Adams	1,836	1,851	1,974	1,927	1,893	1,800
Allegheny	40,775	41,249	41,081	40,440	41,335	42,080
Armstrong	2,117	1,988	1,970	1,918	2,047	1,809
Beaver	5,524	5,848	5,909	5,697	5,707	5,713
Bedford	746	731	707	740	771	928
Berks	11,024	10,336	10,668	10,875	12,145	13,064
Blair	3,773	3,876	3,857	4,231	4,470	4,636
Bradford	1,799	1,541	1,581	2,214	1,549	1,720
Bucks	15,560	15,440	16,189	17,569	18,111	17,551
Butler	4,953	4,951	5,033	4,827	5,385	5,438
Cambria	5,823	5,578	5,899	5,512	5,296	5,340
Cameron	215	205	149	151	136	115

Exhibit 32 Continued

Counties	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Carbon	2,259	2,556	2,203	2,515	2,786	2,895
Centre	3,385	3,676	4,849	4,032	3,764	3,331
Chester	10,085	9,819	10,366	10,896	11,144	11,151
Clarion	1,130	1,083	1,035	1,029	1,042	936
Clearfield	2,167	2,034	2,137	2,118	2,237	2,169
Clinton	624	601	731	646	603	371
Columbia	3,148	2,617	2,926	2,998	2,814	2,311
Crawford	2,258	2,116	2,389	2,757	3,249	3,530
Cumberland	5,953	4,974	4,868	4,286	4,847	5,265
Dauphin	5,764	3,852	5,408	5,723	6,548	7,023
Delaware	17,041	15,785	15,539	15,538	16,027	16,840
Elk	1,113	1,125	971	890	787	630
Erie	8,739	9,283	8,559	9,285	9,543	9,844
Fayette	5,256	5,073	5,207	5,106	5,354	5,337
Forest	176	198	217	181	196	153
Franklin	3,220	3,299	3,462	3,185	3,186	3,102
Fulton	130	258	318	280	213	164
Greene	1,242	1,013	1,054	843	827	800
Huntingdon	786	714	956	911	969	979
Indiana	2,952	2,949	3,226	2,908	2,930	2,696
Jefferson	1,423	1,459	1,465	1,397	1,384	1,316
Juniata	560	534	560	629	634	602
Lackawanna	6,824	8,158	9,522	9,472	8,290	7,257
Lancaster	11,655	11,305	11,700	11,297	11,705	11,766
Lawrence	3,850	3,778	3,718	3,005	2,834	2,425
Lebanon	2,434	2,303	2,620	2,964	2,998	2,968
Lehigh	10,355	10,389	10,475	11,629	13,193	13,464
Luzerne	8,122	8,044	9,128	9,238	8,935	9,479
Lycoming	1,984	632	667	587	596	609
McKean	1,091	1,005	985	1,012	1,172	1,045
Mercer	3,976	4,021	4,290	4,399	4,209	3,997
Mifflin	1,530	1,462	1,530	1,645	1,697	1,737
Monroe	3,160	3,081	3,468	3,705	3,083	3,728
Montgomery	17,057	16,594	17,473	17,710	17,684	17,926
Montour	615	644	767	802	795	778
Northampton	12,390	12,272	11,579	13,363	15,447	15,544
Northumberland	3,208	3,076	3,603	4,543	5,052	4,043
Perry	1,059	800	836	764	938	1,113
Philadelphia	43,155	43,913	46,435	46,576	45,861	45,780
Pike	584	600	640	599	546	659
Potter	128	118	124	129	137	128
Schuylkill	5,273	5,039	4,364	4,933	5,209	5,274
Snyder	809	831	883	1,337	1,284	1,077
Somerset	2,065	2,151	2,356	2,496	1,925	1,908
Sullivan	259	207	152	140	115	118
Susquehanna	494	484	531	654	615	654
Tioga	191	145	172	256	205	196
Union	822	748	893	957	949	883
Venango	1,931	1,937	2,059	2,013	1,887	1,814
Warren	1,055	908	1,002	960	1,135	911
Washington	6,967	6,986	6,940	6,585	6,464	6,593
Wayne	1,232	1,308	1,391	875	883	928

Exhibit 32 Continued

Counties	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Westmoreland	12,006	12,197	11,952	12,505	12,490	12,166
Wyoming	960	1,008	952	896	942	1,193
York	8,831	9,112	10,256	10,180	10,882	9,827
Total	**349,628**	**343,868**	**356,926**	**362,480**	**370,086**	**369,627**

Note: */Data includes medical records that originated from inpatient and outpatient facilities and were coded with either a primary or secondary diagnosis involving a mental health disorder and a revenue code based on ER services.
Source: Developed by LBFC staff from information provided by the PHC4.

As shown in Exhibit 32, ER usage has been increasing since FY 2012-13. In that year, 349,628 cases were reported; however, by FY 2017-18 that number had risen to 369,627 cases, a 5.7 percent increase, which is a smaller increase than what we found with respect to the broader category of hospitalizations for mental and behavioral health disorders. Over the period, the average was approximately 359,000 cases. Philadelphia County continued to lead the state with the number of cases. Here too, this occurrence is a result of the larger population residing in the county.

Some caution needs to be given in reviewing the numbers in this section. PHC4 staff informed us that ER revenue codes may not be entirely accurate, because it is not clear whether hospitals are using these codes accurately. The PHC4 does not use ER codes in its analysis and could not make any statement regarding the codes' value or accuracy. Additionally, as with hospitalizations, just because a patient accessed the ER does not necessarily mean that the patient was "in crisis"—although it could be reasonable to assume so. Finally, while there are ICD codes for suicide and suicidal ideation, we chose not to focus just on suicide cases, as mental health crisis is more encompassing than just suicide (see NAMI description). In the end, on the balance of what we were asked to present, and the availability of data to answer the objective, we believe the above information is a reasonable basis to be used as a longitudinal depiction of ER usage involving mental and behavioral health disorders.

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SECTION V
SURVEY RESULTS AND STAKEHOLDER POLICY STATEMENTS

Fast Facts...

- *We surveyed the administrators of Pennsylvania's county-based MH service agencies, and we sought policy statement letters from various MH stakeholders.*
- *We asked administrators to provide information on wait times for services. Administrators indicated that community residential services had the longest wait times. Fortunately, administrators reported no wait times for important crisis services.*
- *Administrators also provided comments on the COVID-19 pandemic and its impact on MH services. 64 percent reported an increase in crisis calls since the pandemic started--a number which is expected to increase.*

Overview

HR 515 requested that we obtain information from various MH stakeholders and to obtain information on delays for access to MH services. To meet this objective, we conducted a two-pronged outreach effort. First, working with representatives from the Pennsylvania Association of County Administrators of Mental Health and Developmental Services (PACA MH/ID), we surveyed all 48 county MH administrators.[54] We sought information on specific delays for services within the DHS-designated MH cost centers (see Section III). We also asked questions about issues that were leading to potential delays in access to services, as well as other trends in the MH service community, including potential impacts from the COVID-19 pandemic. We had an excellent response rate from these entities—100 percent.[55]

With respect to our survey, we found that crisis services are generally the most accessible services. This is an encouraging result given the critical nature of these services to individuals who may be in crisis. However, administrators reported significant delays for access to community residential services, which are a type of housing support service for individuals with severe MH issues. Administrators reported a median average wait time of 6 weeks for this service, but when looking at the *longest* wait times (i.e., the longest any individual had to wait for services), the median wait time was 16 weeks. With respect to the COVID-19 pandemic, 64 percent of administrators reported an increase in crisis calls since the pandemic, and 74 percent indicated that they expected crisis calls to increase in the next 6-12 months. Administrators also noted an overwhelming increase in the use of telehealth/telemedicine for MH services (98 percent), to which some administrators expressed concerns about access to broadband services in rural areas for these purposes. Interestingly, in terms of having adequate resources to deal with the pandemic, 35 percent of the responding administrators said they did not, while 31 percent said they did. Another 33 percent indicated "other," and expressed concerns about funding and a lack of a psychiatric services in their respective areas.

[54] Some counties form "joinders" which may consist of two or more counties.
[55] While all county administrators responded to the survey, not every question was answered by the respondents.

Finally, we sent information request letters to eleven MH stakeholder groups seeking their input on eight mental health issue areas. Unfortunately, our response rate in this area was less than anticipated. We received just two responses. One from the County Chief Adult Probation and Parole Officers Association of Pennsylvania (CCAPPOA), and one from the Pennsylvania Psychiatric Society (PPS), which is a district branch of the American Psychiatric Association (APA). We have included the responses in their entirety, but in summary, the CCAPPOA favors expanding mental health services to help keep individuals out of the criminal justice system. They also support additional training for police officers, probation officers, and prison staff to identify individuals in crisis. As stated by the CCAPPOA, "the goal is to connect the justice-involved individuals with the mental health services in the community that will support successful reintegration." The PPS provided us with several position statements which are supported by the PPS and the larger APA. These issues included a wide variety of important topics including criminal justice/MH issues, access to services, use of medications, and principles of recovery.

Issue Areas

A. Survey Results

With assistance from the Pennsylvania Association of County Administrators of Mental Health and Developmental Services, we surveyed all county MH administrators. We used SurveyMonkey, the online survey tool, to develop a short questionnaire about access to services, opinions about the recent COVID-19 pandemic and its impact to MH services, as well as other questions that impact the MH community. We had an excellent response rate of 100 percent, and with that achievement we thank the administrators for their time in answering our questions.[56] Within this issue area, we present and discuss the results of our survey of the county MH administrators.

Questions about MH Access

Question 1: Based on your experience with your current county/joinder area, and using a scale of 1 to 10 (one not accessible and 10 being extremely accessible) how accessible are the following services in your area?

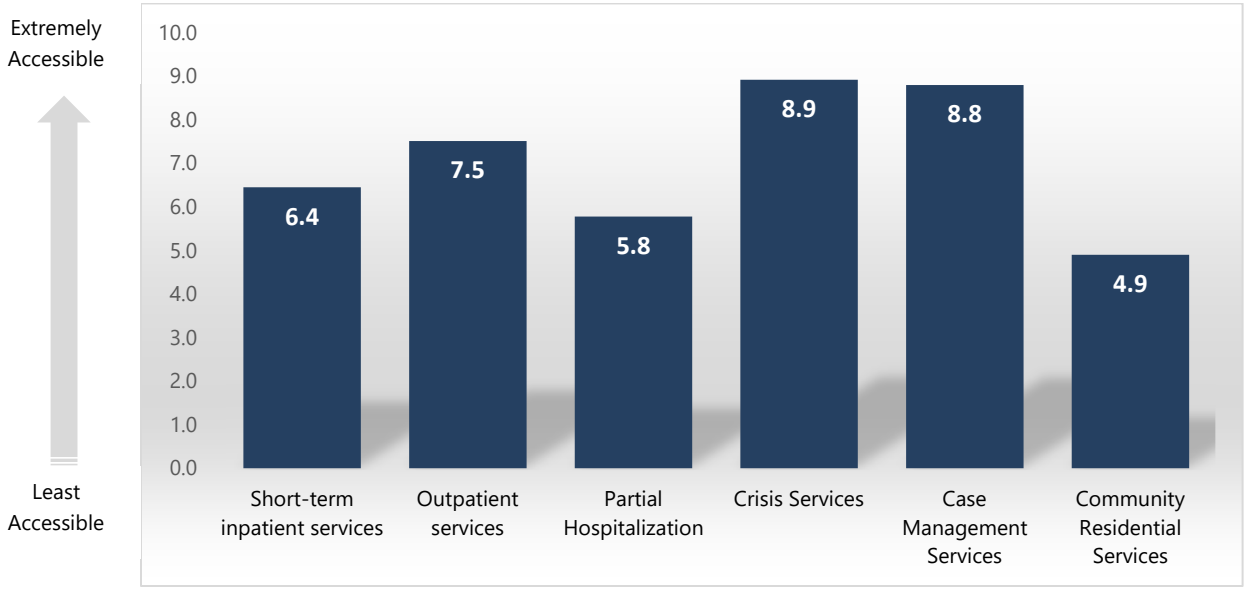
- Short-term inpatient services

[56] We received a response from every administrator; however, one county MH administrator that covered two counties split their response and provided a response for each respective county. Consequently, the actual number of responses is more than the number of county MH agencies/joinders.

- Outpatient services
- Partial Hospitalization
- Crisis Services
- Case Management Services
- Community Residential Services

Exhibit 33

How accessible are the following services in your area?



Source: Developed by LBFC staff from survey responses of county MH administrators.

Discussion and Analysis. As shown in Exhibit 33, county MH administrators selected Crisis Services as the most accessible service in their county/joinder area. On a scale of 1-10, with "1" being not accessible and "10" being extremely accessible, the weighted average from all responses was 8.9 for this service area. This was an encouraging response; however, we expected the number to be much closer to 10 given that this service area includes intervention-type activities. Case Management Services was a close second, with a score of 8.8. In terms of the least accessible area, of those administrators responding to the question, Community Residential Services was the least accessible. As noted later in this section, this service area also had the longest actual wait times.

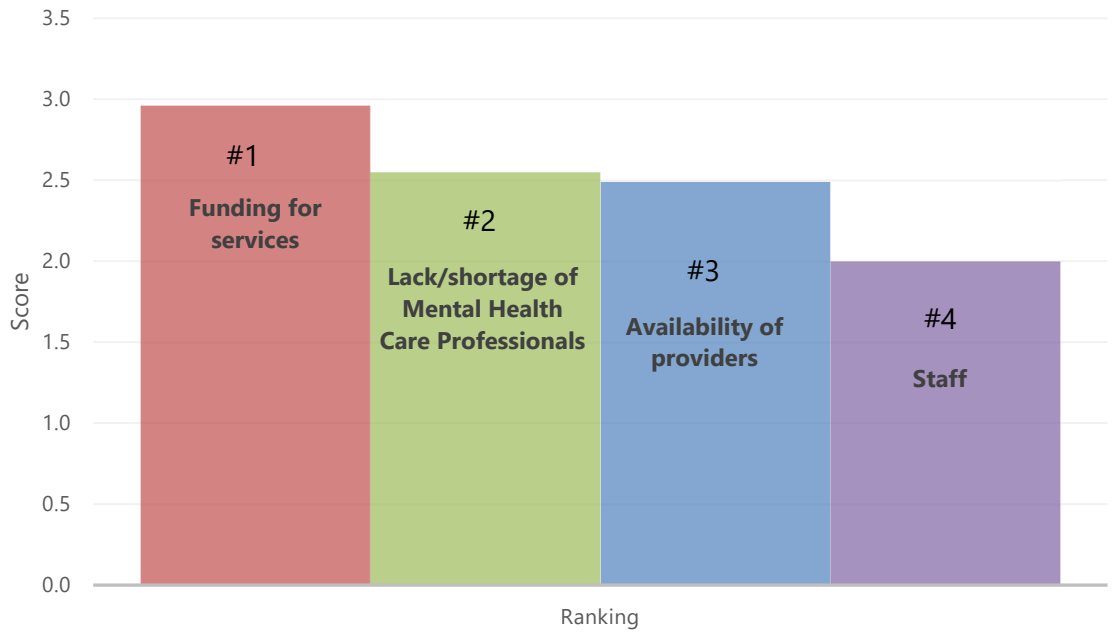
Question 2: For the previously listed services, what factors contribute to inaccessibility? Please rank in order.

- Funding for Services

- Availability of Providers
- Staff
- Lack/Shortage of Mental Health Care Professionals

Exhibit 34

Most Common Factors Contributing to MH Service Inaccessibility



Source: Developed by LBFC staff from survey responses of county MH administrators.

Discussion and Analysis. Respondents ranked the above four factors in order of its impact to inaccessibility. As shown in Exhibit 34 above, the most highly ranked factor contributing to service inaccessibility was funding. Nearly half of the respondents (48 percent) listed "funding" as the primary factor. With respect to the least contributing factor, "staff" was cited by 36 percent of the respondents. As discussed further later, these results are generally consistent with comments we received on our open-ended questions.

Question 3: Using the array of MH services defined by DHS, please indicate the current AVERAGE wait time (in weeks) for the following services.

Discussion and Analysis. Using the 25 cost centers defined by DHS (see Section III), we asked MH administrators to review their records and provide us the average wait time (in weeks) for the array of MH services. This was a two-part question as we asked respondents to separate

the information for adults and for children/adolescents. The results are shown in Exhibit 35.

Exhibit 35

Average Wait Time for MH Services*
(shown in weeks)

Mental Health Service	Adult Median Average Wait Time	Child Median Average Wait Time
Targeted Case Management	1.0	1.0
Outpatient Services	3.0	2.0
Psychiatric Inpatient Hospitalization	1.0	0.0
Partial Hospitalization	1.0	2.0
MH Crisis Intervention Services	0.0	0.0
Adult Developmental Training	2.0	2.0
Comm. Employment and Employment-Related Services	2.0	2.5
Facility-Based Vocational Rehab Services	2.0	2.0
Family Support Services	1.0	1.0
Community Residential Services	6.0	6.0
Family-Based MH Services	2.0	2.0
Emergency Services	0.0	0.0
Housing Support Services	2.0	1.0
Assertive Community Treatments	2.0	0.5
Psychiatric Rehabilitation	1.0	1.0
Children's Psychosocial Rehabilitation Services	1.5	2.0
Children's Evidence–Based Practices	2.0	2.0
Peer Support Services	2.0	1.5
Consumer-Driven Services	1.0	1.0
Transitional and Community Integration Services	2.0	1.0

Note: */Respondents were asked to list the "average" wait time by cost center. We then calculated the median, or the middle-reported figure among all the responses.

Source: Developed by LBFC staff from survey responses of county MH administrators.

A reporting error likely occurred in the above results because some adult services are not available to children, and similarly, some child-based services are not available to adults. Yet, administrators reported non-conforming wait times within these age-specific services. We suspect that administrators comingled their responses within the instrument and merely reported total times without segregating the information by adult/child. Regardless, we believe the above information still provides perspective as to where the longest wait times are for MH services.

For example, as shown above, the highest median average wait time reported was for community residential services for both adults and children. As we highlighted in Section III, this cost center provides residential services, and it is one of the highest cost service areas for MH agencies. At 6.0 weeks, the median average wait time for community residential services was twice as much as outpatient services, which had the second highest median average wait time reported at 3.0 weeks. Outpatient services pertains to treatment-oriented services provided to a consumer who is not admitted to a hospital, institution, or community mental health facility for twenty-four hour a day service

Emergency services and mental health intervention services had the lowest median average wait time with 0.0 weeks reported. These results were encouraging, because these services target adults or children who exhibit an acute problem of disturbed thought, behavior, mood or social relationships. The services provide rapid response to crisis situations, which threaten the well-being of the individual or others.

Question 4: Using the array of MH services defined by DHS, please indicate the LONGEST wait time (in weeks) for the following services.

Discussion and Analysis. In addition to the average wait time, we also asked MH administrators to list the longest wait time that any of their clients had experienced in obtaining the designated services. We also asked administrators to separate the data by adults and children/adolescents. As with the previous question, we suspect there is a certain amount of reporting error because not all the services apply to adults or children, yet we saw evidence of non-conforming wait times listed. The results are presented in Exhibit 36.

Exhibit 36

Longest Wait Time for MH Services*
(shown in weeks)

	Adults		Children	
Mental Health Service	**Median**	**Max Reported**	**Median**	**Max Reported**
Targeted Case Management	3.0	24.0	2.0	12.0
Outpatient Services	6.0	52.0	6.0	52.0
Psychiatric Inpatient Hospitalization	1.0	20.0	1.0	21.0
Partial Hospitalization	2.0	20.0	4.0	52.0
MH Crisis Intervention Services	0.0	2.0	0.0	2.0
Exhibit 36 Continued				
Adult Developmental Training	4.0	104.0	2.0	8.0

Exhibit 36 Continued

Comm. Employment and Employment-Related Services	4.0	104.0	2.5	12.0
Facility-Based Vocational Rehab Services	4.0	104.0	2.0	30.0
Family Support Services	2.0	24.0	1.0	52.0
Community Residential Services	16.0	241.0	8.0	52.0
Family-Based MH Services	3.0	12.0	4.0	52.0
Emergency Services	0.0	2.0	0.0	4.0
Housing Support Services	4.0	52.0	2.0	48.0
Assertive Community Treatments	7.0	48.0	1.0	4.0
Psychiatric Rehabilitation	3.0	21.0	2.0	16.0
Children's Psychosocial Rehabilitation Services	1.5	8.0	3.5	52.0
Children's Evidence–Based Practices	1.5	8.0	3.0	52.0
Peer Support Services	4.0	48.0	4.0	12.0
Consumer-Driven Services	2.0	52.0	2.0	12.0
Transitional and Community Integration Services	3.5	24.0	2.0	12.0

Note: */Respondents were asked to report the longest wait time by cost center. We then calculated the median, or the middle-reported figure among the responses. We also identified the maximum reported figure from the responses.

Source: Developed by LBFC staff from survey of county MH administrators.

As shown above, administrators reported community residential services as having the longest wait time experienced by adult clients. The maximum reported wait time for the service by a county MH administrator was a staggering 241.0 weeks (or more than 4.5 years). The median wait time reported was 16.0 weeks for the service, which was the highest reported.

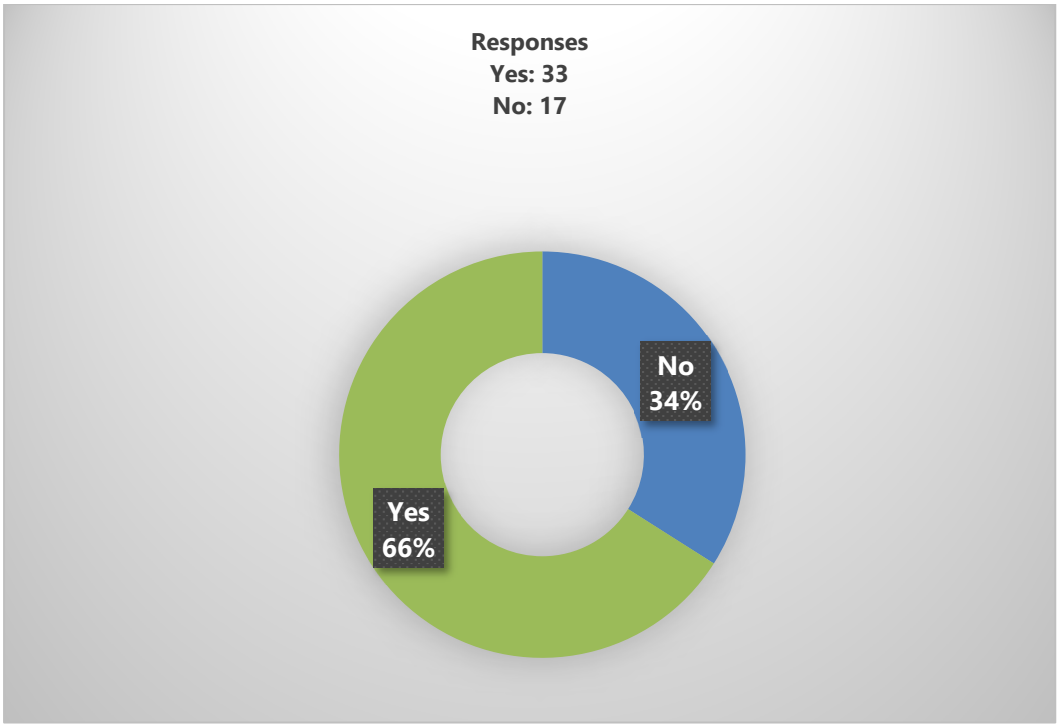
The maximum wait experienced by children/adolescents' clients was 52.0 weeks for multiple services. Outpatient, family support services, community residential services, family-based MH services, children's psychosocial rehabilitation services and children's evidence–based practices reported 52.0 weeks as the maximum wait time.

Question: With respect to intake and psychiatric evaluations, does your county/joinder currently have a delay (for all clients)?

Discussion and Analysis. We specifically asked this question of MH administrators because it was outlined as a data item within HR 515. As shown in Exhibit 37, 66 percent of the respondents indicated that there was a delay for intake and psychiatric evaluations; 34 percent said there was not a delay.

Exhibit 37

Does your county/joinder currently have a delay for psychiatric intake?



Source: Developed by LBFC staff from survey of county MH administrators.

Most administrators indicated that they are currently experiencing a delay with psychiatric intake. Simply put, administrators stated that there are not enough psychiatrists. From the 33 administrators that stated that they currently have a delay, 23 administrators indicated that the lack of psychiatric time is due to the limited number of doctors. For example, we noted the following comments:

- *We do not have enough Psychiatrists willing to work in community mental health centers due to the Medicaid rate of pay.*
- *This is what made the Outpatient questions above difficult. The long 8-week delays are about lack of psychiatric/med mgt/psych eval capacity, not therapy capacity. Stable psychiatric staffing complement is difficult for providers and also VERY expensive: lack of psychiatrists and can't afford them.*
- *Lack of psychiatric time, lack of psychiatrists. The lack of psychiatric time due to the limited number of psychiatrists in our rural area, and the psychiatrists not willing to do multiple consecutive PE's [psychiatric evaluations] in one day.*

- *Psychiatric evaluation waits are due to availability of appointments. Not enough psychiatrists and not enough appointments.*

Opinions About the COVID-19 Pandemic and the Impact to County MH Services

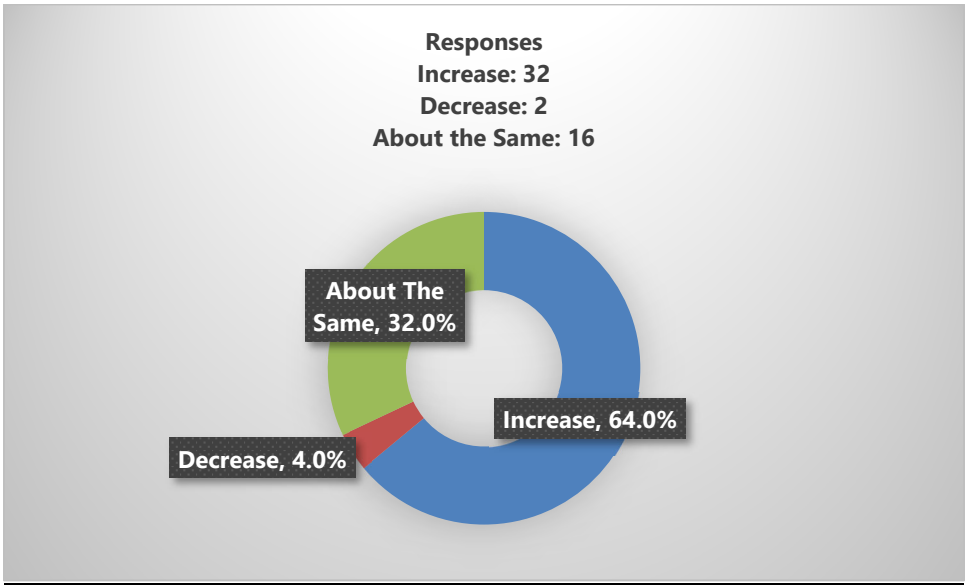
As we began this project, Pennsylvania and much of the world was in the midst of a global pandemic caused by the novel coronavirus and the resulting disease caused by that virus, COVID-19. In our discussions with community MH stakeholders, we were frequently informed of the potential impacts to the MH community caused by the pandemic (e.g., isolation, depression, panic attacks, suicide, etc.). While Pennsylvania continues to deal with the pandemic—and the aftereffects may be felt for some time in the future—we felt it was necessary to explore the thoughts and opinions about the pandemic from experts in community MH. Consequently, we expanded our survey to include additional questions about the impacts to county MH services.

Questions: (1) With regard to crisis calls, since May 1, 2020, has your county/joinder seen an increase, decrease, or remained about the same? (2) Projecting forward to the next six to twelve months, do you expect crisis calls to increase, decrease or remain the same?

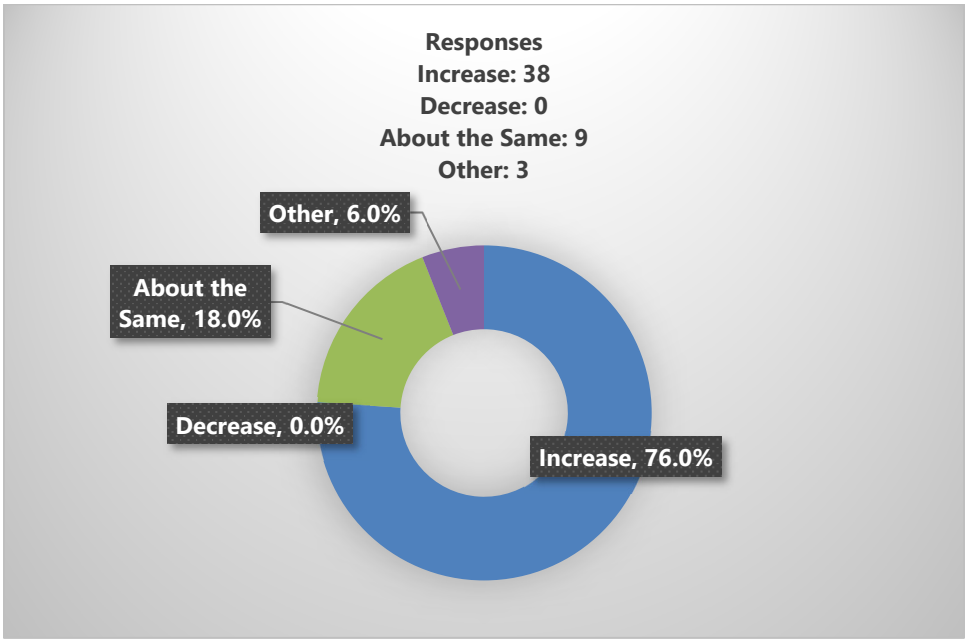
Discussion and Analysis. We chose May 1, 2020, as the date to measure crisis call activity as it was a point in time when the commonwealth was well into the pandemic, and further it was also a time when the commonwealth was beginning a process to emerge from lockdowns. We plotted the results to this question in Exhibit 38. There was an overwhelming response (64 percent) that since May 1, 2020, there had been an increase in crisis calls.

Exhibit 38

Crisis Calls Since May 1, 2020 – Increase, Decrease, or About the Same?



Crisis Calls In Next 6 to 12 months – Increase, Decrease, or About the Same?



Source: Developed by LBFC staff from survey of county MH administrators.

As shown above, when we asked if crisis calls were expected to increase in the next 6-12 months, that percentage grew to 76 percent. Further, none indicated that they expected crisis calls to decrease. Three respondents indicated "other" to which they noted the following:[57]

- *There are many factors, but the main variable would be related to the stabilization of COVID virus.*
- *[Calls will] get back to pre-COVID levels*
- *Unpredictable due to COVID. For a couple of months our Crisis provider shut their doors and only provided tele crisis. Walk-ins were not accessible, and mobile was extremely limited. Who knows what the true numbers were and are going to be?*

As highlighted by the last comment above, the issue of telemedicine or telehealth during the pandemic came to the forefront. In fact, during our stakeholder interviews we frequently heard about the importance of expanding telemedicine access. To that end, we sought opinions from MH administrators if they had expanded the use of telemedicine/telehealth.

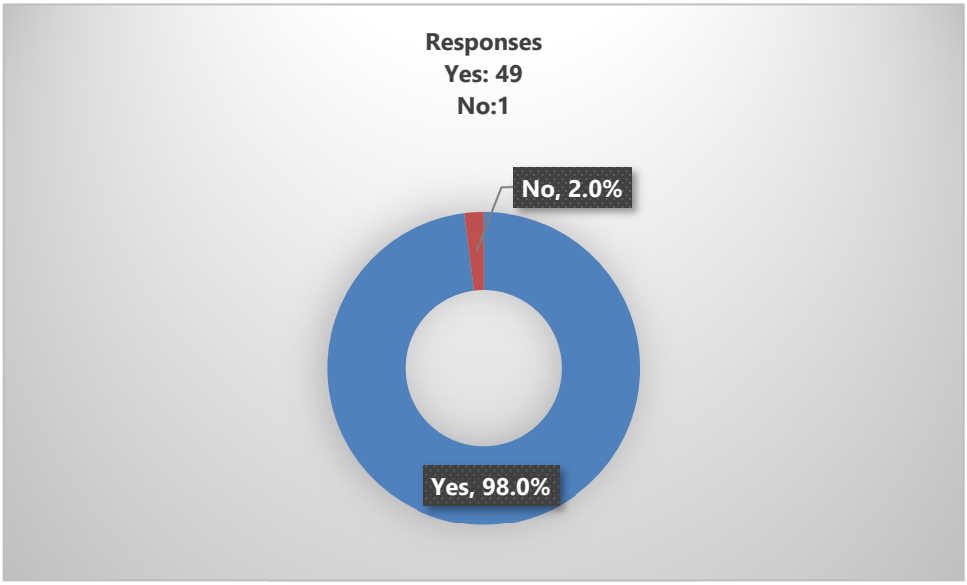
Question: In regard to telemedicine, has your county/joinder expanded the use of telehealth during the ongoing COVID 19 pandemic?

Discussion and Analysis. As shown in Exhibit 39, MH administrators indicated overwhelmingly that there has been an increase in telehealth. Fully 98 percent of the responding administrators indicated that telehealth was being expanded in their areas.

[57] It is important to reiterate that our survey was distributed during the timeframe of August - November 2020. At that time, Pennsylvania's confirmed COVID cases were lower and had not reached the increased levels that were seen in later months.

Exhibit 39

Telehealth – has your county/joinder expanded the use of these services during the COVID-19 pandemic?



Source: Developed by LBFC staff from survey of county MH administrators.

As indicated above, it is apparent that telehealth within the community MH service framework will be an ongoing issue. To that end, it will be imperative to ensure that providers in rural areas and clients residing in rural areas have access to reliable broadband services. The issue of broadband deployment was also recently reviewed by the LBFC in a report released in June 2020.[58] Additionally, as part of SR 2019-47, a legislative task force has been created to look at this issue further.

Beyond the issues of crisis calls and telehealth, we also asked MH administrators more broadly about residents seeking MH resources, as discussed in the next questions below.

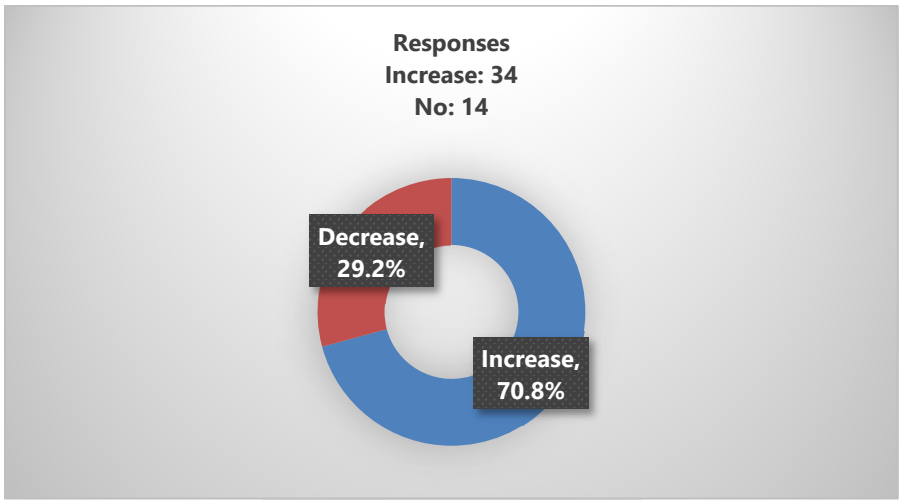
Questions: (1) Has your county/joinder seen an increase of residents seeking mental health resources during the ongoing COVID-9 pandemic? (2) If you selected "increase" for the prompt above, for the residents seeking mental health resources, does your county/joinder have adequate resources to provide the necessary mental health services during the ongoing COVID-19 pandemic?

[58] *See* "Pennsylvania ILEC Broadband Deployment Mandates" link here.

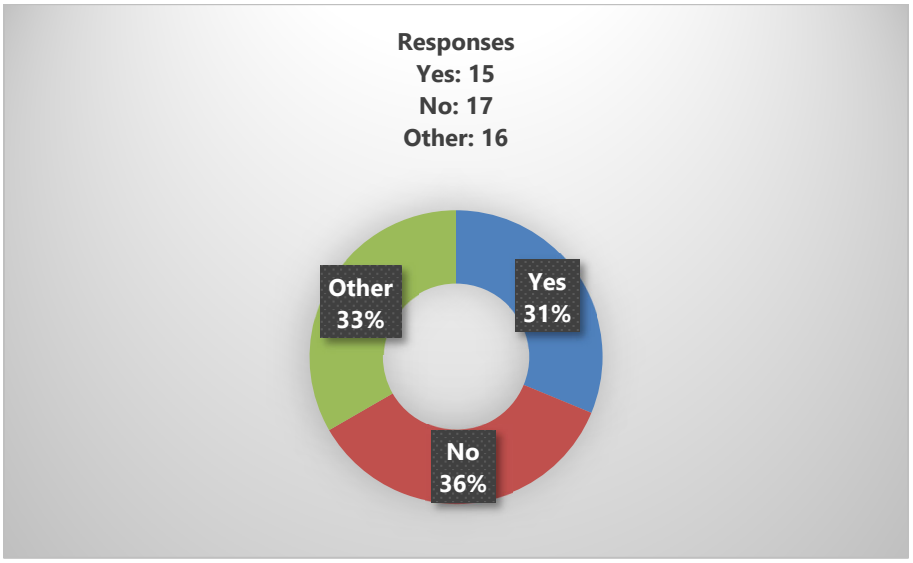
Discussion and Analysis. We asked this series of questions to gauge whether there had been an overall increase in the need for MH services, and whether county administrators felt they had the resources necessary to meet that increased need. The results are shown in Exhibit 40.

Exhibit 40

During COVID-19 pandemic – Has your county/joinder seen an increase in residents seeking MH resources?



If yes – does your county/joinder have adequate resources to meet the need for MH services?



Source: Developed by LBFC staff from survey of county MH administrators.

Administrators that selected "other" generally indicated that the uncharted territory of a pandemic has heightened challenges that the county/joinder were already facing. Funding and lack of psychiatrist resources were included when responding.[59] Administrators included notable comments such as:

- *We do not have the relevant financial resources to deal with the pandemic's implications in the medium to long-term.*
- *Any wait time provides the potential for crisis, so a system that had wait times before COVID is one that would benefit from increased resources.*
- *Like all counties, we struggle with psychiatric time and recruitment for direct positions in the field. Over 30% of our county population has Medical Assistance. The increase of MH BASE funded persons is small compared to that population's growth.*
- *We are limited in our resources. We do not have a large array of services located in the county and people often have to travel to get their services. Even outpatient services are limited, especially for individuals with Medicare.*
- *Our county has several providers that can handle some additional capacity at this time.*
- *We recently experienced a loss of psychiatrists and the current APA does not allow for expansion of services.*

Lastly, with respect to COVID-19 pandemic issues, we asked county MH administrators what other challenges they thought were important to express.

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[59] The capacity of Pennsylvania's MH system and the lack of psychiatric resources specifically, was studied extensively by the Joint State Government Commission (JSGC) in a series of recent reports. For example, in July 2020, the JSGC released the "Behavioral Healthcare System Capacity in Pennsylvania and Its Impact in Hospital Emergency Departments and Patient Health." In June 2020, the JSGC released another report titled, "Pennsylvania Mental Health Care Workforce Shortage: Challenges and Solutions." These are excellent companion pieces to this important issue, and we encourage readers to access the reports from the JSGC's web site (click link) for further information.

Question: With regard to mental health services and mental health, what other challenges has COVID-19 presented that the public and General Assembly may not be aware?

Discussion and Analysis. This question was an open-ended question designed to highlight the key points that administrators felt were important to express in their own words. Using a word cloud, we diagrammed their responses, as shown in Exhibit 41.

Exhibit 41

MH services and COVID-19 – what other challenges does it present that need to be known?

Source: Developed by LBFC staff from survey of county MH administrators.

As shown above, the word cloud enlarges words that are more frequently cited. To that end, words such as "services," "access," and "internet providers" were frequently cited. Some examples of comments supporting the word cloud depiction, included the following:

- *With limited numbers being served at one time, providers are having difficulty meeting financial thresholds. This also deters the ability to expand needed services.*

- *Rural Communities struggle with internet access and cell phone reception which is a challenge when trying to provide tele services.*

- *The challenges have been difficulty securing adequate broadband services in the rural areas as well as consumers not having the equipment to utilize the services.*

- *Some individuals do not have/cannot afford the technology needed to access telehealth services.*

Other Survey Topics

In addition to the aforementioned issue areas, we asked county administrators about the issues they felt were most important within their county/joinder, as well as to Pennsylvania's overall community mental health framework. Those topics are discussed within this final segment.

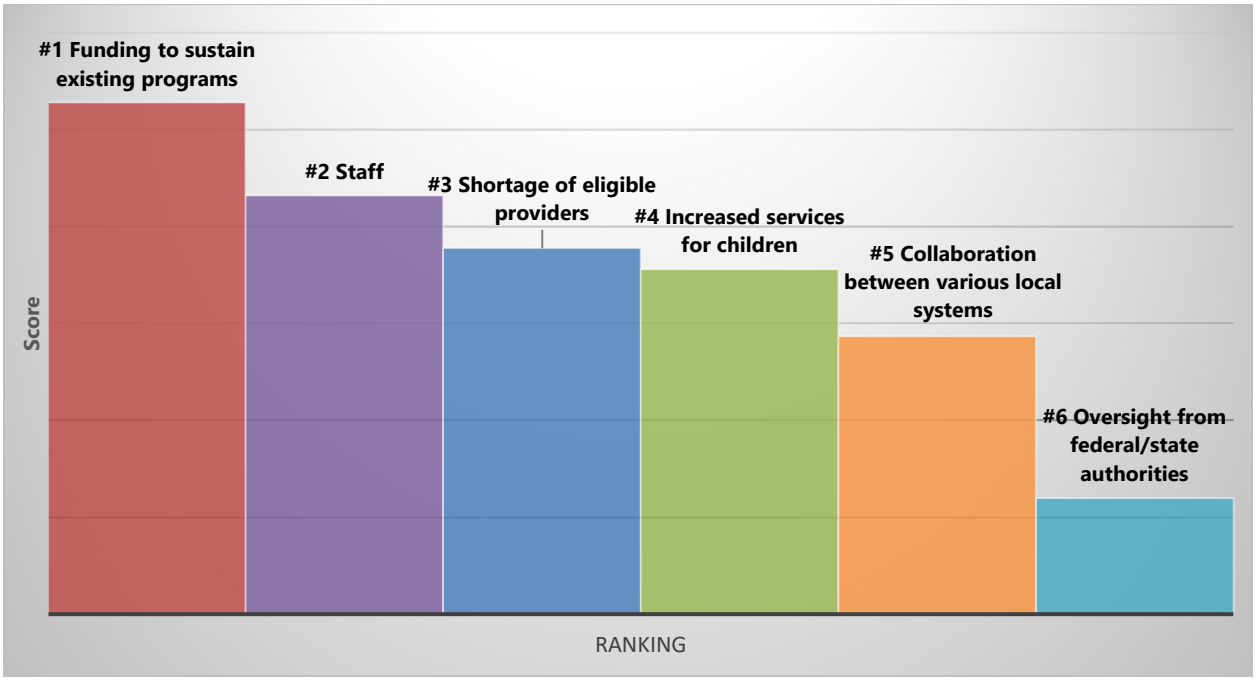
Questions: (1) Based on your experience for <u>your county/joinder</u>, please rank the areas of mental health services that need immediate attention. (2) Based on your experience for <u>Pennsylvania</u>, please rank the areas of mental health services that need immediate attention. (1 needs most attention, 6 needs least attention).

- **Shortage of eligible providers**
- **Funding to sustain existing programs**
- **Increased services for children/adolescents**
- **Staff recruitment/training/development**
- **Oversight from federal/state authorities**
- **Collaboration between various local systems (e.g., judicial, substance abuse, police).**

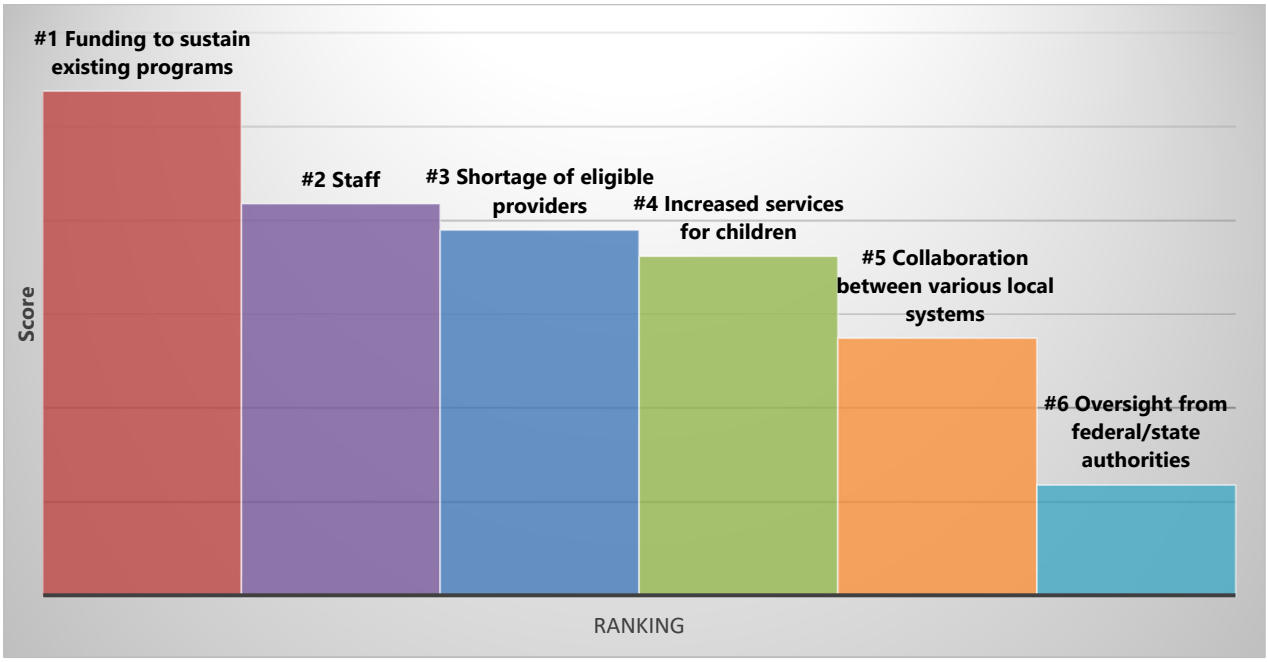
Discussion and Analysis. There are numerous areas that could have been chosen to be ranked; however, based on our discussions with stakeholders, the above six areas seemed to be at the forefront. As shown above, we asked this question in two parts—first for the respondent's experience with their county/joinder, and then secondly for Pennsylvania overall. We asked these questions in this order to see if there was variability between how respondents viewed the needs vis-à-vis their county and Pennsylvania overall. The results are presented in Exhibit 42.

Exhibit 42

MH Services - Areas Needing Immediate Attention (Respondent's County)



MH Services - Areas Needing Immediate Attention (Pennsylvania)



Source: Developed by LBFC staff from survey of county MH administrators.

This ranking question asks respondents to compare items to each other by placing them in order of preference. Ranking questions calculate the average ranking for each answer choice; thus, allowing us to determine which answer choice was most preferred overall. We calculated a scoring average for these responses, which were based on how respondents ranked the areas. The answer choice with the largest average ranking is the most preferred choice. As shown above, interestingly, there was little distinction between how respondents ranked the areas between their county and Pennsylvania overall.

Administrators selected "funding to sustain existing programs" as the mental health area that needed the most attention on a county/joinder and state level. On average, funding to sustain existing programs was ranked at 5.3 for county/joinder level and 5.4 for the state. The highest the ranking could be was 6. Interestingly, administrators selected that oversight from federal/state authorities was the area that needed the least attention for county/joinder and state level.

Based on our discussions and research, we predicted that "funding" would likely be the most highly ranked area. Consequently, in our final survey question we asked an open-ended question of MH administrators about what <u>other</u> issues (besides funding) they felt were important for the General Assembly to know. The results of that question follow next.

Question: Besides funding concerns, what issues do you feel are important for the General Assembly to know?

Discussion and Analysis. This open-ended question elicited a diverse set of responses ranging from a need for greater/better staffing, addressing other social determinants of mental health, and an increased emphasis on community residential/housing services. Administrators in rural counties also mentioned the lack of reliable transportation for residents that are in need of MH treatment. As shown in Exhibit 43 we created a word cloud of the responses, with the most common responses appearing in larger font.

Exhibit 43

Other than Funding Concerns – What should the General Assembly Know?

Source: Developed by LBFC staff from survey of county MH administrators.

Selected comments supporting the above, included the following:

- *The lack of staff is probably the biggest issue the MH system is facing. There's no real monetary incentive for anyone coming out of college to enter the field. The pay has not adjusted to inflation/the times. Those who do take jobs often don't stay because they can make more money doing something else. The productivity demands for many staff also tends to burn them out. They give it their all but it's more for making productivity so that they can keep their job. We've definitely seen the quality of some services suffer because of this. Lack of staff also impacts wait times for people to be able to access services. This is the case with children in need of BHRS services. Lack of staff causes long wait times for services to begin. Additionally, there is a shortage of providers and staff that can adequately serve individuals that are dually diagnosed with an intellectual disability and a mental health diagnosis. These individuals often times sit in an emergency room for days and even weeks before they can get inpatient treatment. Inpatient psychiatric hospitals often exclude these patients from being admitted because they do not have the expertise to serve them. Residential ID providers often refuse to take these individuals back after going to the ER because they can no longer serve them. They cannot afford*

to hire mental health professionals or qualified staff who could better meet these consumers specialized needs.

- *Recruitment and retention of staff is important. County agencies know their areas best and work with other agencies to try to meet these needs. Collaboration within counties is the key and needs to be encouraged.*

- *While we have the majority of major MH services available in the County, accessing the services remains an issue for many who live in more rural areas. Lack of reliable and affordable transportation is still a key issue.*

B. Policy Statements from Other MH Service Stakeholders

In accordance with the requirements of HR 515, we sought input from eleven stakeholder groups on the following topic areas:

- Barriers that prevent individuals with mental health issues from receiving and/or accessing the right treatment and services in a timely manner or not at all.
- Law enforcement and its ability to appropriately respond to and possibly redirect individuals with mental illness from the criminal justice system.
- Homelessness and its impact on individuals suffering from mental illness.
- Access to mental health services for children and/or the delivery of school-based mental health services.
- Perspectives on the need for psychiatric services, including any delays for access. Additionally, the need for psychiatric facilities (long-term or short-term).
- The need for expanded community residential rehabilitation services and the outcomes of individuals receiving these services.
- The impact of COVID-19 on mental health services.
- Any other issues (specific to mental health) warranting the attention of the Pennsylvania General Assembly.

Of the eleven stakeholder groups from which we sought input, only two replied: the County Chief Adult Probation and Parole Officers Association of Pennsylvania (CCAPPOA) and the Pennsylvania Psychiatric Society (PPS), which is a district branch of the American Psychiatric Association (APA).

In short, the CCAPPOA favors expanding mental health services to help keep individuals out of the criminal justice system. They also support additional training for police officers, probation officers, and prison staff to identify individuals in crisis. As stated by the CCAPPOA, "the goal is to connect the justice-involved individuals with the mental health services in the community that will support successful reintegration."

Finally, the PPS provided us with several position statements that are supported by the PPS and the larger APA. These issues included a wide variety of important topics including criminal justice/MH issues, access to services, use of medications, and principles of recovery to name a few.

We thank each of these stakeholders for providing additional commentary to these important issues, and list their full responses in the final two exhibits that follow:

Exhibit 44

Comments Received from the County Chief Adult Probation and Parole Officers Association of Pennsylvania

HR 515 Position Statement on behalf of CCAPPOAP

In recent years, state and local jurisdictions have made great strides to address the influx of individuals with a mental illness within the criminal justice system, but we still have much to accomplish. Individuals with serious mental illness are often overrepresented and vastly underfunded in the criminal justice system.

The voluntary nature of the mental health system means individuals that refuse treatment or do not comply with treatment end up in jails and prisons and under local community supervision (probation or parole) as a result of behaviors related to their mental illness and/or drug addiction. This criminalizes mental illness and addiction. The criminal justice system has become the treating agency in place of the mental health system.

The following barriers need to be addressed on a statewide level from a county probation and parole perspective:

- Significant delays with referrals to services to begin treatment
- Delays with activating health benefits/insurance
- Lack of mental health hospital beds; especially long-term residential facilities and dual diagnosis inpatient facilities; especially in rural areas
- Lack of mental health resources for the homeless community
- HIPAA barriers create a difficult situation in working relationship with offender, service provider and probation officer
- Need for better transitioning from jail/prison to the community for mental health treatment services and medication
- Eliminate the stigma placed on criminal justice involved

Many working in the criminal justice system, from law enforcement to courts and probation officers, are frustrated with the lack of mental health services. The inability to access these services often leads to incarceration, rather than getting individuals with mental illness into treatment services, crisis services, or case management services. Breaking down the barriers associated with getting proper mental health treatment for individuals in the system is essential to implementing long term behavior change. Probation officers must be able to assist this population with the critical mental health resources needed to effect change.

Pennsylvania needs to target mental health diversion programs and services (prior to arrest) so these individuals do not get stuck in the criminal justice system. Funding and resources should be dedicated to train police officers to identify individuals with mental illnesses in crisis. Probation officers and prison staff should also receive training to aid in identifying justice-involved individuals who need crisis intervention. The goal is to connect the justice-involved individual with the mental health services in the community that will support successful reintegration.

Source: CCAPOA.

Exhibit 45

Comments Received from the Pennsylvania Psychiatric Society

Subject Area: Barriers that prevent individuals with mental health issues from receiving and/or accessing the right treatment and services in a timely manner or not at all.

APA Position Statement- Access to Care for Transgender/Gender Diverse Individuals: 2018

1. Recognizes that appropriately evaluated transgender and gender diverse individuals can benefit greatly from medical and surgical gender-affirming treatments.

2. Advocates for removal of barriers to care and supports both public and private health insurance coverage for gender transition treatment.

3. Opposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician.

4. Supports evidence-based coverage of all gender-affirming procedures which would help the mental well-being of gender diverse individuals.

APA Position Statement on Emergency Boarding of Patients with Acute Mental Illness: 2016

Prolonged boarding of patients with acute mental illness in emergency departments leads to inadequate care, may be harmful, and is unacceptable. All efforts should be made to help place each patient at the appropriate level of psychiatric care. When boarding is unavoidable, the emergency department should ensure that the patient is receiving active, appropriate, and humane mental health treatment in a safe setting with periodic re-evaluation for any emerging physical health problems. Depending on the needs of each patient, this treatment may include appropriate interventions for agitation and other acute symptoms, supportive therapy, and initiation of medications for their primary mental illness. Attention should also be paid to patient comfort and the ED staff should provide regular updates for the patient and family. All emergency settings should have access to psychiatrists, on-site or via telepsychiatry, to assist in conducting an adequate evaluation and in providing optimal care.

Subject Area: Law enforcement and its ability to appropriately respond to and possibly redirect individuals with mental illness from the criminal justice system.

APA Position Statement on Competence Evaluation and Restoration Services and the Interface with Criminal Justice and Mental Health Systems: 2020

1.It is the position of the APA that the current system for assessing competence of defendants under criminal charge and for providing treatment to those found incompetent requires fundamental reform in many jurisdictions. The process of carrying out judicial orders for competency assessments and treatment to restore a defendant's competence should be overhauled as an integral component of a comprehensive plan for providing mental health services to persons with serious mental illness, including those charged with criminal offenses who are in jail or at risk of pretrial detention. Reforms of the current system for assessing competence of defendants under criminal charge and for providing treatment to those found incompetent should be guided by the following principles:

(i) Community-based services and supports for individuals with serious mental illness and other conditions affecting cognitive capacities should be sufficiently funded and resourced to prevent many of these individuals from entering the criminal justice system in the first place;

(ii) Individuals who have been ordered to undergo competence to stand trial assessments should be evaluated in a timely manner;

(iii) Jail diversion services should be available for all individuals with mental illness and intellectual and developmental disabilities who have become involved with the criminal justice system and are eligible for pretrial release;

(iv) Individuals found incompetent to stand trial should have timely access to the level of psychiatric treatment that they need for restoration and maintenance of competency, including outpatient care, hospital care and jail-based care.

Individuals should not be disadvantaged from alternatives to detention solely due to their mental illness.

APA Position Statement on Police Interactions with Persons with Mental Illness: 2017

Law enforcement officers play a critical role as first responders to crisis events who need to be able to perform safely and successfully under stress. The American Psychiatric Association (APA) strongly supports efforts to enhance the ability of law enforcement to manage crises involving emotionally disturbed persons and persons with serious mental illness, developmental or intellectual disabilities, neurocognitive disorders, or substance use disorders.

Such efforts should include:

1) Implementation of a curriculum for law enforcement officers that includes basic information about mental disorders and their symptom presentations, specific de-escalation techniques, and increased awareness of the impact of personal biases related to the stigma surrounding mental disorders, race, and other factors, as well as the role of trauma for all involved in these encounters. Formalized Crisis Intervention Team (CIT) training is an example of an important model with a growing evidence base, though there remain questions about how best to measure its impact. Regardless of model, training should extend to all

levels of law enforcement, including new recruits, veteran officers, and police leadership. Because of its importance, efforts should be made to prioritize this type of training and maximize its accessibility.

2) Creation of partnerships between local behavioral health and law enforcement systems to develop policies regarding their respective roles and responsibilities in managing mental health crises within and across communities and regions. Such policies should give priority to treatment over arrest of emotionally disturbed persons and persons with mental disorders, to the extent that is appropriate and safe. Ongoing and regular cross-training, including refresher trainings, in such policies and protocols between local law enforcement and emergency mental health services should be encouraged and supported. These partnerships should address the need for innovative approaches to shared information systems that address confidentiality concerns.

3) Behavioral health system partnerships with law enforcement that maximize clinical crisis response capacity should be prioritized, including providing settings that facilitate police diversion from arrest and proper clinical assessment and treatment of the person in crisis.

Subject Area: Perspectives on the need for psychiatric services, including any delays for access. Additionally, the need for psychiatric facilities (long-term or short-term)

APA Position Statement on the Need to Maintain Intermediate- and Long-Term Inpatient Care Access for Persons with Serious Mental Illness: 2019

1. The APA recognizes and supports continued development and implementation of comprehensive and innovative programs and treatment modalities for persons with serious mental illness in all locations.

2. The APA asserts that it is imperative that intermediate- and long-term inpatient treatment and care, as part of a full spectrum of service levels, remain readily accessible to persons with serious mental illness who require such levels of service.

3. Community mental health centers, integrated health care centers, and allied community resources shall have sufficient funding and staffing to provide comprehensive wrap-around services to persons with serious mental illness who can successfully reside in their communities when receiving such services.

Subject Area: Any other issues (specific to mental health) warranting the attention of the Pennsylvania General Assembly).

APA Position Statement on Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health: 2018

The American Psychiatric Association:

1. Supports current and future actions to eliminate racism and racial discrimination by fostering a respectful appreciation of multiculturalism, diversity, and efforts of greater inclusion
2. Encourages mental health professionals to be mindful of the existence and impact of racism and racial discrimination in the lives of patients and their families, in clinical encounters, and in the development of mental health services
3. Supports member and public education on impacts of racism and racial discrimination, advocacy for equitable mental health services for all patients, and further research into the impacts of racism and racial discrimination as an important public mental health issue
4. Recognizes the detrimental effects that racism has on the mental health of people of color and supports policies and laws which would reduce further harm.

APA Position Statement on Safe Prescribing: 2018

1) The treatment with medication of patients with mental illness requires a foundation of medical education, training, supervision, and care of patients with a broad range and severity of medical problems.
2) The safety of patients and the public must be the primary consideration of each state's licensing agencies and legislature.

APA Position Statement on Prior Authorizations for Psychotropic Medications: 2014

The American Psychiatric Association is opposed to any requirement of prior authorization for psychotropic medications prescribed by psychiatrists prior to payment by insurers, except for instances of clear outlier practices or an established evidence base which implicates concern for patient safety. In those instances, the decision to require prior authorization or documentation should be made only by a Board-Certified Psychiatrist.

APA Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health: 2018

The American Psychiatric Association:

• Supports legislation and policies that promote mental health equity and improve the social and structural determinants of mental health, and formally objects to legislation and policies that perpetuate structural inequities.

• Advocates for the dissemination of evidence-based interventions that improve both the social and mental health needs of patients and their families.

• Urges healthcare systems to assess and improve their capabilities to screen, understand, and address the structural and social determinants of mental health.

• Supports medical and public education on the structural and social determinants of mental health, mental health equity, and related evidence-based interventions.

•Urges medical school and graduate medical education accrediting and professional bodies to emphasize educational competencies in structural and social determinants of mental health and mental health equity.

• Urges psychiatry residency training directors and other psychiatric educators to use systematic approaches to teaching about structural and social determinants of mental health.

•Supports the training of psychiatrists, in graduate and continuing medical education, in best practices to address the structural and social determinants of mental health and promote health equity.

• Advocates for increased funding for research to better understand the mechanisms by which structural and social determinants affect mental illness and recovery and to develop new evidence-based interventions to promote mental health equity.

APA Position Statement on Peer Support Services: 2018

The American Psychiatric Association supports the value of peer support services and is committed to their participation in the development and implementation of recovery-oriented services within systems of care. APA also advocates for appropriate payment for these services. Peer support personnel should have training appropriate to the level of service they will be providing.

Psychiatrists should be knowledgeable of the value and efficacy of the wide array of peer support services in recovery and support the integration of these services into the comprehensive continuum of care.

APA Position Statement on Leadership of State Behavioral Health Services: 2019

All state mental health and addiction authorities that provide, administer, and have regulatory authority for the prevention, treatment, and recovery support services for persons with mental illness, substance use disorders, and/or developmental disabilities must be under the direction of a qualified psychiatrist or include a qualified psychiatrist at the senior management level.

APA Position Statement on Use of the Principles of Recovery: 2018

The American Psychiatric Association endorses and strongly affirms the application of the principles of recovery to the comprehensive care and treatment of individuals with mental illness across the lifespan. Recovery emphasizes a person's capacity to have hope and lead a meaningful life and suggests treatment be guided by attention to life goals and ambitions. Recovery recognizes that individuals with mental illness often feel powerless or disenfranchised, that these feelings can interfere with initiation and maintenance of psychiatric and medical care, and the best results come when individuals feel treatment decisions are made in ways that are collaborative and consistent with their cultural, spiritual, and personal ideals. Recovery should include the following elements: communicating hope; treating individuals with respect; meeting them where they are in awareness and readiness; sharing information and ensuring decision-making with individuals; using a strengths-based approach to assessment and treatment; shaping treatment, services and supports around life

goals and interests and providing opportunities to include family and other close supporters as essential partners in recovery. For children, these principles are adapted to place priority on building capacity for healthy development and resilience, and to provide treatment that is family centered.

Recovery enriches and supports medical and rehabilitation models. By applying the principles of recovery and encouraging others who treat mental illness to adopt these principles, psychiatrists can enhance the care of individuals served in all settings where psychiatric services are provided.

These principles value and maximize the individual's autonomy, dignity and self-respect, integration into full community life, and full development. They focus on increasing the individual's ability to successfully adapt to life's challenges, and to collaborate with the psychiatrist to optimally manage symptoms, improve functioning, and improve health. Recovery requires a commitment to a broad range of necessary medical and mental health services. It should not be used to justify retraction of resources or reduction in access to skilled professionals and high-quality care. Recovery is predicated on the partnership between the individual, psychiatrist, and other practitioners in constructing and directing all services aimed at maximizing hope and quality of life.

Source: PPS and APA.

Appendix A - House Resolution 515 of 2019

PRIOR PRINTER'S NO. 2539 PRINTER'S NO. 2894

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 515 Session of 2019

INTRODUCED BY MURT, HENNESSEY, POLINCHOCK, SCHLOSSBERG, KENYATTA, RYAN, MILLARD, JONES, DeLUCA, READSHAW, GALLOWAY, GAYDOS, HILL-EVANS, OTTEN, KAUFER, KIM AND CALTAGIRONE, SEPTEMBER 23, 2019

AS REPORTED FROM COMMITTEE ON HUMAN SERVICES, HOUSE OF REPRESENTATIVES, AS AMENDED, NOVEMBER 18, 2019

A RESOLUTION

Directing the Legislative Budget and Finance Committee to conduct a comprehensive study of changes in ~~access to~~ AVAILABILITY OF county-managed community health services between fiscal years 2010 through 2018~~; and establishing an advisory committee~~.

WHEREAS, One in five individuals in the United States needs treatment for mental illness during his or her lifetime; and

WHEREAS, Fifty percent of mental health cases in our nation begin by 14 years of age; and

WHEREAS, Seventy-five percent of these cases begin by 24 years of age; and

WHEREAS, Delayed treatment of mental illness increases severity of symptoms and difficulty of treatment; and

WHEREAS, Each year, tens of thousands of families in this Commonwealth struggle to gain timely access to services and support for family members with serious mental illness; and

WHEREAS, Since 1966, county-managed community mental health agencies have established community-based residential

rehabilitation and a range of other support and treatment services in response to the reduction of beds in the State mental hospital system; and

WHEREAS, The cost of providing treatment and services in community-based settings is significantly less than the cost of treatment in State mental hospitals or private psychiatric hospitals; and

WHEREAS, Without sufficient residential rehabilitation and mental health treatment services in our communities, individuals with serious mental illness all too often become homeless or become inmates in county jails; and

WHEREAS, Some county mental health programs have reported a reduction in school-based mental health services since 2010; and

WHEREAS, Some county mental health programs have reported a reduction in residential and treatment services for the seriously mentally ill since 2010; therefore be it

RESOLVED, That the Legislative Budget and Finance Committee conduct a comprehensive study of changes in ~~access to~~ AVAILABILITY OF county-managed community mental health programs between fiscal years 2010 through 2018; and be it further

RESOLVED, That, in furtherance of its study, the Legislative Budget and Finance Committee determine, ~~at a minimum~~ FOR EXAMPLE, the following:

(1) the amount allocated by each county for contracted services in each fiscal year from fiscal year 2010 through 2018 for each of the major community mental health services, including community residential rehabilitation, inpatient psychiatric services, emergency and crisis intervention, peer counseling, drop-in centers, outpatient services, partial

hospitalization, day treatment, community employment, facility-based vocational rehabilitation, psychiatric rehabilitation, long-term residential services, social rehabilitation, intensive case management, case management, community treatment teams, family-based services and family support services, and set forth a Statewide summary of this data;

(2) the number of units of service provided by each contracted entity in each county in each fiscal year from fiscal year 2010 through 2018 for each of the above community mental health services and set forth a Statewide summary of this data;

(3) the number of people receiving each of the above community mental health services in each county in each fiscal year from fiscal year 2010 through 2018 and set forth a Statewide summary of this data;

(4) the amount spent by each county mental health agency to administer the county mental health program in each fiscal year from fiscal year 2010 through 2018;

(5) follow-up information on the living conditions and mental health status of individuals transferred out of community residential rehabilitation services used during fiscal years 2010 through 2018 and set forth a Statewide summary of this data;

(6) data on the use of short-term private psychiatric facilities in each county in each fiscal year from fiscal year 2010 through 2018;

(7) information on any delays in ~~access to~~ intake for new admissions to mental health treatment services and

delays, if any, ~~in access~~ to psychiatric evaluations and medications in each county's community mental health system that have occurred during fiscal years 2010 through 2018;

(8) data on the number of inmates with mental illness incarcerated in county jails in each fiscal year from fiscal year 2010 through 2018; and

(9) data on the use of emergency rooms in hospitals by individuals with mental illness in mental health crisis in each county in each fiscal year from fiscal year 2010 through 2018;

and be it further

RESOLVED, That the Legislative Budget and Finance Committee seek information regarding access in mental health treatment and services, in each fiscal year from fiscal year 2010 through 2018, from the following entities in each county:

(1) county jail wardens;

(2) county probation officers;

(3) school superintendents;

(4) county homeless program managers;

(5) local representatives of mental health consumer groups;

(6) local representatives of mental health associations;

(7) local representatives of the National Alliance for Mental Illness;

(8) local representatives of psychiatric associations;

(9) local representatives of pediatric associations;

(10) representatives of primary care physicians; and

(11) representatives of emergency room physicians;

and be it further

~~RESOLVED, That the Legislative Budget and Finance Committee be authorized to establish an advisory committee of stakeholders, including:~~

~~(1) county mental health administrators;~~

~~(2) providers of community-based mental health services;~~

~~(3) advocates for people with mental illness;~~

~~(4) members of families that include people with mental illness; and~~

~~(5) individuals with mental illness;~~

~~and be it further~~

RESOLVED, That the Legislative Budget and Finance Committee submit a report of its findings AND, AS APPROPRIATE, RECOMMENDATIONS to the House of Representatives by December 31, ~~2019~~ 2020.