DAUPHIN COUNTY
PENNSYLVANIA

DEPARTMENT OF
MENTAL HEALTH / AUTISM / DEVELOPMENTAL PROGRAMS

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ANDREA KEPLER

08/30/2022
RE: PA Behavioral Health Commission 9/1/22 Meeting

Dr. Adair, Mr. Humphreys, and Members of the Pennsylvania Behavioral Health Commission,

Thank you for your service to Pennsylvania, taking the time to listen to the concerns of Dauphin County and permitting us input into the use of this funding opportunity. I am Andrea Kepler, the Dauphin County Mental Health/ Autism/ Developmental Programs Administrator. I have worked in mental health services since 1976. The Dauphin County MHADP program maintains administrative oversight for all publicly funded mental health services in Dauphin County. Several funding streams finance the public Mental Health system administered by the Counties. Opportunities for federal funds are infrequent and are typically restrictive leaving little flexibility. The largest funds, County base funds are state dollars directly allocated to each county to administer. Funding for base dollar services was cut in 2012 by 10% has not increased since. Dauphin County Mental Health base dollars fund:
1.) Adult Residential Services: 224 beds across a varying range of supervision and intensity including community residential rehabilitation (CRR) beds, Long Term Structured Residential beds, specialized CRR beds for those leaving long term incarceration, Crisis and Diversion beds which are short term and licensed Personal Care homes. These housing supports are in high demand and waiting lists exist for all levels. Those services affording the most structure and supervision tend to be reserved for those with higher needs for life skill assistance.
2.) Clinically necessary behavioral health services for the uninsured and under insured including case management, outpatient, partial hospitalization and/or inpatient services. While treatment services including intensive case management and certified peer services are funded through Health Choices in PA for those who meet Medicaid eligibility criteria, treatment services for persons who are uninsured or underinsured are paid for by the county through base dollars.
3.) Transportation services to treatment appointments for those not eligible for Medicaid covered transportation.
4.) Administrative case management services for those who have just completed intake, or are in jail, in a state facility such as state hospital or, those who have refused Targeted Case Management or ACT services. Administrative case managers participate in key Stepping Up initiatives to include Team MISA, reentry planning, and MH Court. Administrative Case Management services are critical to our mission to decrease those with serious mental illness from being criminally justice involved.
5.) Crisis emergency services and any crisis service for those who are privately insured which are not reimbursable. Emergency services is the work that pertains to hospital admissions and bed searches.

6.) Student Assistance Services available in all schools in all school districts at all levels: elementary, middle, and high school.
7.) Civil commitment costs to assure the protection of rights and adherence to the Mental Health Procedures Act for those in the county as well as residents who find themselves outside of the county.
8.) Consumer run drop in services
9.) Family support services- family to family support and education.

Today's Challenges:

1.Staffing Retention: The experience of the pandemic has left human services with an inadequate work force and numerous vacant positions. Without workers our services have no capacity to serve people. Vacancies exist throughout the residential support system and case management and crisis intervention services. Retaining our remaining experienced workers has become a top priority but difficult to achieve without additional funds. Workers in residential programs support people with serious mental illness, to help people shop, prepare food, cook, shower, dress and get to their daily routines on time. Some earn $12 per hour. These workers have left their positions in large numbers during the pandemic when many better paying opportunities became available. Our providers have demonstrated tremendous creativity with managing staffing and often are making continuous changes within each day to assure adequate staffing support. Supervisors and managers continue to cover shifts.
Crisis Workers are required to have a four-year degree but at the current rate of pay compete with far too many better paying opportunities. Next week our last full time third shift crisis employee will be resigning leaving no regular third shift staff. Of a total staff complement of 23 we will have 7 vacancies as of 9/3/22 and no third shift staff.
Case management services have also been impacted by staff members leaving for other industries and better paying opportunities resulting in larger caseloads and in many situations, supervisors maintaining caseloads. Of 187 positions our CMU has 49 vacant.
Across our system base funded programs are facing staffing challenges. Providers have recommended some residential programs be closed or consolidated if adjustments to salaries cannot be supported as they cannot hire necessary staff. Without additional funding to boost salaries to address provider workforce retention we most certainly will need to close residential programs and will be unable to respond to current and future waiting list demands. Sustaining the necessary case management commitment to programs such as re entry and MH Court aimed to reduce those with serious mental illness in the jail will also become a concern.
2. Staffing Development: We need to develop workers to meet evolving needs, standards and fill roles associated with new models of support. Providers need to have sufficient staffing to implement training. We need to commit to developing our current crisis workforce to implement a Crisis Response System model that does not rely on emergency rooms and is open 24x7 to whoever walks through the door and partners with law enforcement. (national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (samhsa.gov)).This will require additional prescribers, licensed Mental Health practitioners, certified peer specialists and recovery specialists.
2. Emergency Room Boarding- We need to develop alternatives to Emergency Rooms that are seen as welcoming places where help is available 24x7 and decrease the use of ERs for all crises and non-crises.
3. Develop alternatives to reliance on Emergency Rooms and eliminate the use of incarceration as a backup for people with serious mental illness who are criminally justice involved. Intercept

0 of the Sequential Intercept Model is community services to divert people into local crisis care services ([The Sequential Intercept Model (SIM) | SAMHSA]). Again, an alternative to emergency rooms that is available 24x7 in the form of a warm welcoming place is needed. Reliance on emergency rooms continues to result in incarceration being used as a backup when hospitalization does not occur.
4. Develop and commit to an action plan to implement a more robust behavioral health crisis care continuum that includes:

1. **Pilot Warm lines and hotlines** operated by certified peers and others which can link people to clinical treatment providers and services without the involvement of law enforcement.
2. **Mobile crisis outreach teams** allow behavioral health clinicians to respond to people in crisis in the community. In situations involving a public safety concern, a behavioral health practitioner may accompany law enforcement. Mobile crisis teams can stabilize a person in crisis, identify underlying reasons for the person's symptoms (for example, the person stopped taking medication), and initiate or link the person to case management services. Mobile crisis teams can also reconnect an individual with mental and substance use disorders to case managers or treatment providers who have already worked with them.
3. **Law enforcement-friendly crisis services**. Instead of arresting people in crisis or bringing them to a hospital emergency department, law enforcement officers can bring them to locations such as stabilization units, crisis living rooms, or respite centers. Processes that allow quick and simple drop-offs make this diversion option more effective. They could also have access to case management to obtain assistance with getting temporary housing.
4. **Peer-operated crisis response support and/or respite** is provided by people with lived experience with a mental or substance use disorder. They may also have been involved in the criminal justice system. Peers can provide helpful information and support that is shaped by their own experience to help people with a mental health or substance use disorder. Programs run by peers and services employing peers have shown promising results in helping people recover.
5. **Substance use-focused early diversion strategies**. Our crisis services need to be equipped to assess and address persons who use substances. We need to partner mental health with drug and alcohol expertise to provide life-saving treatments and support.

Recommendations for Funding:

- Fund County Mental Health programs to stabilize the workforce in base funded programs: residential services, case management, treatment services for the uninsured and underinsured and crisis emergency services.

- Fund County Mental Health programs to develop the existing crisis intervention workforce to meet emerging standards for mobile crisis services with licensed mental health practitioners and certified peer specialists.
- Fund County Mental Health programs to support training and development of existing case managers to enhance engagement with persons with serious mental illness to include verbal de escalation skills, motivational interviewing, and critical time intervention case management.
- Fund the start- up of county specific and/or regional crisis response centers consistent with the SAMHSA National Behavioral Health Crisis Care Guidelines staffed with licensed practitioners including psychiatrists, nurse practitioners, and licensed Mental Health Practitioners with dual certifications to address substance users' needs, Certified Peer Specialists, and Recovery Specialists with 24x7 capability to offer response and respite to those not requiring hospital based services and committed to accepting all referrals and walk ins and first responder drop offs for a 24 hour or less period. This funding priority would directly impact the overcrowding of emergency departments and those being incarcerated instead of treated. It is an initiative that could long term be Health Choices funded.
- Provide performance incentives to counties who develop plans for comprehensive behavioral health crisis response systems incorporating the elements of the SAMHSA Guidelines and become sustainable via Health Choices funding and successfully re direct base dollars to other needed improvements.

Resource List

- The Sequential Intercept Model (SIM) | SAMHSA).
- national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (samhsa.gov)
- Motivational Interviewing: Stages of Change - Recovery First Treatment Center
- Critical Time Intervention | Background | Critical Time Intervention

Thank you for your time.

Sincerely,

Andrea Kepler, LCSW, 08/30/2022