Commonwealth of Pennsylvania

Behavioral Health Council **ACTION** Plan

Mental health and addiction touch nearly every family in Pennsylvania. But getting help is often confusing, expensive, or simply not available nearby. Governor Josh Shapiro is committed to reducing barriers to treatment and recovery supports. This plan sets out six goals for building a system that works, developed with expertise and feedback of experienced professionals and people with lived experience, with real steps behind each one.

August 2026

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Commonwealth of Pennsylvania

Introduction

Behavioral health

is a key component of every Pennsylvanian's overall health.

It touches every corner of the state, from large urban cities to small rural towns and everything in between.

Used in this report as an umbrella term, behavioral health encompasses both mental health and substance use, along with the associated diagnoses and conditions. Mental health exists on a continuum that everyone shares, while mental illnesses and substance use disorders are diagnosable conditions that affect individuals and families across the Commonwealth. While individuals and families are impacted in varying degrees by behavioral health challenges, a common thread is the need for a more comprehensive, accessible, and affordable system of resources to help address those challenges and promote sustained recovery. To more clearly understand this need, it is important to consider the impacts of behavioral health on individual health outcomes, community wellness, and stigma.

Living with a mental health condition or SUD dramatically increases the risk of physical illness, hospitalization, homelessness, incarceration, and suicide. Pennsylvania has a vibrant and diverse behavioral health system, with dedicated providers, innovative local programs, and strong community partnerships. However, the Commonwealth's behavioral health system does not fully meet the scale of need: more than half of adults with a mental illness do not receive care, and nearly one in four cannot access the treatment they need. Young people face challenges similar to those of older adults. Suicide has become one of the leading causes of death for young Pennsylvanians, while adults aged 55 and older account for 47 percent of all suicides in the state, with growing numbers of older adult suicides reported, especially among older men.[1] More than half of youth with major depressive disorders receive no treatment, and the Safe2Say program has logged more than 185,000 tips from students and educators seeking help. The COVID-19 pandemic intensified isolation, trauma, and stress, particularly among youth, older adults, and people with physical, intellectual, and developmental disabilities (IDD). Primary care practices and community-based medical settings increasingly serve as the first and most consistent point of contact for individuals with behavioral health needs, particularly those with co-occurring medical conditions.

SUDs pose unique challenges for Pennsylvania residents. While the state's

NOTE:

1. Commonwealth of Pennsylvania, Department of Health: "Selected Causes of Death by Age, Race, Sex and Hispanic Origin Pennsylvania Residents, 2023." Division of Health Informatics. 2023

fatal overdose rate rose significantly since 2012, Pennsylvania Department of Health (DOH) data show meaningful recent progress, with overdose deaths declining approximately 29 percent in 2024 compared to 2023. However, the crisis is far from over. In 2024, 67 percent of overdose deaths involved synthetic opioids like fentanyl.[2] These fatalities occur in rural counties, like Fayette and Lawrence, as well as urban Philadelphia and Allegheny, reflecting the widespread impact of substance use across the state's varying geographies. The composition of the substance use crisis continues to evolve, with stimulant use on the rise, requiring adaptability in prevention and treatment approaches. Notably, while the overall rate has declined, fatal overdose rates among older adults have continued to increase, and Black Pennsylvanians continue to bear a disproportionate burden. Despite the availability of free overdose reversal medication (naloxone) in each county and through mail order, barriers to its use remain, including stigma, misinformation, and racial disparities in access. More than half of fatal cases had a bystander present, while nearly three-quarters of those who died had at least one opportunity for intervention. To end these preventable deaths, Pennsylvania must strengthen harm reduction and SUD treatment and integrate those services with mental health care.

Co-occurring mental health and substance use disorders deserve focused attention. Nationally, 90 percent of people with co-occurring conditions do not receive treatment for both, even though comorbidity increases the risks of hospitalization, suicide, and overdose.[3] Delivering immediate SUD treatment while integrating into mental health care across the continuum is therefore essential. Integrated co-occurring disorder (COD) care has been shown to be more effective than providing care separately for mental health and substance use.[4]

Connecting people to the right treatment at the right time is critical for long-term recovery. Yet systemic barriers make care hard to obtain. Severe staffing shortages limit the availability of psychiatrists, therapists, and detox, including withdrawal management beds. Navigating the system is confusing because there is no single intake process or unified directory and even when people find services, out-of-pocket costs are often prohibitive. Gaps in Medicare coverage make access extremely difficult for many older adults. As a result, many individuals engage with care only when their symptoms have become crises, leading to reactive rather than preventive and stabilization interventions. A fragmented system leaves too many Pennsylvanians without the help they need, and the consequences are felt across families, schools, workplaces, and communities.

Recognizing the urgency of this crisis, Governor Shapiro established the Behavioral Health Council (Council) to chart a new course for mental health and SUD care. The Council brought together leaders from government, health care, communities, and individuals and families with lived experience to develop a statewide action plan that ensures every resident, regardless of where they live or who they are, can access timely, affordable, and high-quality behavioral health care. The Council's mission was ambitious and necessary: to examine innovative care delivery models, assess workforce needs and funding sources, improve regulations and payment systems, and integrate mental health and SUD care with primary care while addressing health-related social needs. By analyzing successful local programs and replicating effective partnerships, the Council aimed to build goals and recommendations that bring seamless, coordinated care across all levels of government and services. There is also an Advisory Committee, which was formed to support the work of the Council by sharing their expertise, knowledge, and input from the communities they serve. Working collaboratively with state agencies, counties, community organizations, and individuals and families with lived experience, the Council and the Advisory Committee developed specific recommendations for legislation, regulation, funding, and administrative actions for implementation.

NOTES:

2. Pennsylvania PDMP Drug Overdose Surveillance Interactive Data Report (Tableau dashboard): https://public.tableau.com/app/profile/pennsylvania.pdmp/viz/PennsylvaniaODSMPDrugOverdoseSurveillanceInteractiveDataReport/Contents

3. SAMHSA. PEP20-02-01-004. https://library.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01_004.pdf

4. Bahji, A. (2024). "Navigating the complex intersection of substance use and psychiatric disorders: A comprehensive review." Journal of Clinical Medicine, 13(4), 999.

Vision

The future envisioned by the Council and the Advisory Committee is one where behavioral health care is no longer fragmented or difficult to navigate.

People in crisis can access the services they need from trained call center professionals, mobile crisis teams, or walk-in emergency behavioral health centers 24/7 and be connected to ongoing care, including telehealth services, instead of waiting weeks or landing in emergency rooms or jails. Children and teens receive mental health education, screenings, and on-site services at school, supported by peer-led programs and school-based clinicians. Older adults receive the behavioral health services they need, whether living in the community or in a nursing facility. Primary care visits include behavioral health screenings with rapid access to treatment. Families experience whole-person care that integrates physical and behavioral health when possible, and as residents age throughout their life span, their care is coordinated through life transitions. People with lived experience offer guidance through a network of peer-run centers, warm lines, and recovery communities. A diverse, well-paid workforce with salaries commensurate with other fields is built through paid training, student debt relief, efficient licensing processes, and clear career pathways that support retention at every career stage. Real-time data and public dashboards show where services are most needed and help leaders allocate resources wisely and remain accountable. At the heart of this transformation is a commitment to the timely treatment of mental health and SUD care as a necessity rather than a privilege. With strong leadership and collaboration across the Commonwealth, with stakeholder partnership, this vision can become a reality.

How the Action Plan Was Developed

This plan reflects recommendations formed after a series of monthly meetings held by the Behavioral Health Council and its Advisory Committee.

Created by Executive Order, the Council brings together leaders from government, health care, individuals and families with lived experience, and community organizations to develop a statewide strategy that ensures every Pennsylvanian can access timely, affordable, and high-quality mental health and SUD care. Its mission includes examining new care delivery models, assessing workforce needs and funding sources, improving regulations and payment systems, and integrating mental health and SUD care with primary care while addressing social needs gaps. In their monthly sessions, Council members analyzed successful local models and discussed how to replicate effective partnerships across the Commonwealth.

The Advisory Committee membership includes hospital and community behavioral health organizations, county administrators, primary care practices, substance use disorder treatment providers, insurers, and advocacy groups. Both the Council and the Advisory Committee met monthly to provide detailed input. Members shared stories from the front lines, asked clarifying questions, and proposed specific actions to improve the system. Their perspectives were critical for highlighting barriers such as workforce pay, cultural competence, and reimbursement. This plan reflects extensive deliberation by the Council and Advisory Committee and is grounded in the voices of people who provide and receive care. The Council recognizes that broader public and stakeholder input, including from people with lived experience and organizations such as the Mental Health Planning Council, is essential as these recommendations move toward implementation.

Pennsylvania's behavioral health system encompasses multiple state agencies, providers, insurers, and distinct networks of care.

Funding for services offered within the system comes from a variety of sources. For individuals who are Medicaid-eligible, the Department of Human Services' (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracts with counties or entities organized by counties, known as primary contractors, to administer the provision of mental health and SUD treatment. Primary contractors then subcontract with Behavioral Health Managed Care Organizations (BH-MCOs) to manage and provide behavioral health services. For individuals who are underinsured or uninsured, OMHSAS allocates funding to county mental health offices for mental health services and the Department of Drug and Alcohol Programs (DDAP) allocates funding to county Single County Authorities (SCAs) for SUD services. Additionally, OMHSAS operates state psychiatric facilities that provide direct inpatient care, a function unique among state agencies in the behavioral health system.[5]

Licensing is likewise a function performed across several state agencies: the DHS licenses mental health facilities; DOH licenses hospitals with psychiatric beds and skilled nursing facilities; DDAP licenses SUD treatment facilities and recovery houses; and the Department of State (DOS) licenses mental health professionals. Federal confidentiality rules, such as HIPAA and 42 CFR Part 2, protect behavioral health information, adding complexity when providers share data across systems. State laws addressing confidentiality and other aspects of behavioral health care must also be followed. As a result, people with mental health conditions or SUDs often must navigate parallel systems that lack coordination at many points.

Several challenges flow from this structure. Care availability is limited in many communities due to funding constraints, gaps in health care coverage (including significant gaps in Medicare), and provider shortages. System operations are opaque because data are siloed across agencies and counties, technical capacity varies, and privacy laws hinder information sharing.

Pennsylvania's Medicaid carve-out model separates physical and behavioral health coverage. The behavioral health carve-out has improved the availability and quality of behavioral health services for Medicaid enrollees. However, opportunities exist to strengthen coordination between physical and behavioral health systems. At the practice level, this separation complicates care coordination, limits shared accountability, and creates barriers for practices attempting to integrate behavioral health services. This structure highlights the need to reassess tools such as Integrated Care Plans (ICPs) and data sharing between BH-MCOs and Physical Health Managed Care Organizations (PH-MCOs); current ICP requirements are limited, and stronger expectations could better support

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5. See Appendix B on Page 45: Pennsylvania Health Funding Map

integrated care. Many individuals receiving Medicaid are unaware that they have separate health care delivery systems for physical and behavioral health, underscoring the need for clear education on care navigation and public awareness that behavioral health services are also available to individuals enrolled in Medicaid.

The behavioral health workforce is understaffed. Low pay, particularly at the mid-career level, complex professional licensure requirements, and high training costs deter clinicians from entering or staying in the field. Care delivery is siloed, with physical health, mental health, and SUD providers operating separately; people must often retell their stories because providers cannot access one another's records.

Access is uneven. Rural residents, children, older adults, people with low incomes, those involved in the criminal justice system, and other marginalized groups encounter distinct barriers. Special populations highlight the system's fragmentation. Youth receive services through a patchwork of programs, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, early intervention, child welfare support, and developmental disabilities waivers, managed by different government offices. Older adults navigate a complex array of Medicare, Medicaid, and long-term care programs designed to keep them living in the community. Crisis services and nursing facilities are often not well equipped to accept

older adults with complex mental health and SUD needs, resulting in prolonged inappropriate hospital stays. Crisis services, withdrawal management beds, and mobile units are especially scarce in rural areas; people often travel long distances, wait weeks for appointments, or face limited funding. Bringing services to older adults in familiar settings, such as Area Agencies on Aging (AAAs) and Senior Centers, presents additional opportunities.

People involved in the criminal justice system interface with behavioral health services at multiple "intercepts," from crisis lines and co-responder programs during law enforcement encounters to treatment courts, jail-based medication programs, and re-entry supports. There are severe service shortages at each intercept, and the behavioral health crisis cuts across all court sectors. Social determinants of health, housing, employment, and family stability compound these challenges. Each of these network systems operates largely on its own, creating gaps during transitions.

These systemic challenges, compounded by an evolving federal fiscal landscape, including changes to Medicaid funding, demonstrate the need for a more accessible, integrated, and equitable behavioral health system. The goals and recommendations that follow address limited availability, confusing operations, workforce shortages, siloed care, and challenging distribution of resources.

The Ideal Mental Health and Substance Use Disorder Treatment Care System

Pennsylvania envisions an ideal behavioral health system as a seamless, person-centered network that supports every resident's mental health and SUD care needs throughout their life span.

This system is built on the principle that no matter where or when someone seeks help, whether at a clinic, school, crisis center, nursing facility, or community organization, they are quickly connected to the care they need. While the American Society of Addiction Medicine (ASAM) models the SUD care delivery continuum, behavioral health, as a whole, needs but lacks a similar model. Figure 1 below illustrates a possible mapping of this model, showing how services across the behavioral health continuum should be integrated, flexible, and easy to navigate.

Rather than viewing care in rigid phases, this model emphasizes three core functions: supporting people early on to stay well, helping them through times of crisis, and ensuring strong recovery support. These functions reflect a dynamic care journey rather than a one-way path. Services range from prevention and early intervention to higher-intensity crisis response and stabilization, and ultimately to recovery-oriented supports like outpatient therapy, peer-led programs, housing, and reintegration services.

A joint session of the Behavioral Health Council and the Advisory Committee was convened to discuss a proper intake process within the context of an ideal system. The group identified opportunities to streamline intake processes and facilitate transitions between services while maintaining high-quality care, equity, and accessibility. An ideal system of care starts with a streamlined intake process that connects people to the right service at the right time with the right response, without bias or prejudice. An intake should be easily accessible and available through multiple entry points, such as online, walk-in, phone, or referral. Each step of the process should be trauma-informed and culturally responsive. A comprehensive intake balances efficiency and thoroughness, ideally enabling providers to accurately identify needs while minimizing duplication and administrative burden. Sometimes, additional intakes are clinically appropriate as individuals move through different levels of care. However, to support continuity of care, information must be portable to the extent allowable by law and shared securely across systems. Metrics of success tied to intake processes should track access, timeliness, care quality outcomes, satisfaction, engagement, and equity.

At the heart of this model is a "no wrong door" philosophy: any service entry point connects individuals to a coordinated network of supports. Care teams communicate, share data (with appropriate protections), and co-develop plans that follow each person through their journey. This approach is both more effective and more humane: it treats people with dignity, responsiveness, and continuity.

This vision of integration, accessibility, and respect guides the goals and recommendations in the following section, which outlines the specific policy changes needed to make this system a reality across Pennsylvania.

Data Confidentiality, Data Sharing, and Integration

Integrated care depends on providers, payers, state agencies, and overall

systems of care sharing critical information while protecting individual privacy. The legal framework governing behavioral health information is layered, involving federal and state laws that set different standards for different types of records.

Federal law establishes the foundation. The Health Insurance Portability and Accountability Act (HIPAA) permits sharing of protected health information for treatment, payment, and health care operations without individual authorization. SUD records receive heightened protection under 42 CFR Part 2, as amended in 2024, which now permits patients to provide a single consent for all future clinical uses, substantially reducing a longstanding barrier to integrated care. Part 2 continues to prohibit the use of SUD records in legal proceedings without a court order or patient consent, a restriction directly relevant to criminal justice integration. In February 2026, the federal Office for Civil Rights launched a new civil enforcement program for SUD record confidentiality, adding accountability through civil penalties for violations.

Pennsylvania has taken important steps to align state law with these federal standards. Act 32 of 2022 amended the Mental Health Procedures Act (MHPA) to permit disclosures in accordance with HIPAA, In addition, Act 33 of 2022 amended DAACA to permit disclosures in accordance with 42 CFR Part 2. Together, these reforms removed state-level barriers to disclosures already permitted under federal law. However, some implementing regulations predating these Acts may not yet fully reflect the updated standards and should be reviewed and updated. Additional frameworks, including Pennsylvania's Public School Code for student records and the Criminal History Record Information Act (CHRIA) for criminal history information, impose separate requirements that affect school-based coordination and criminal justice data sharing, respectively. CHRIA's express exclusion of treatment information from criminal history repositories presents a specific challenge for re-entry planning efforts that depend on linking behavioral health data to jail admissions.

The recommendations under Goal 4 of this plan build on recent reforms to close remaining gaps, develop model data-use agreements for each sharing context, and ensure compliance with the evolving federal enforcement landscape.

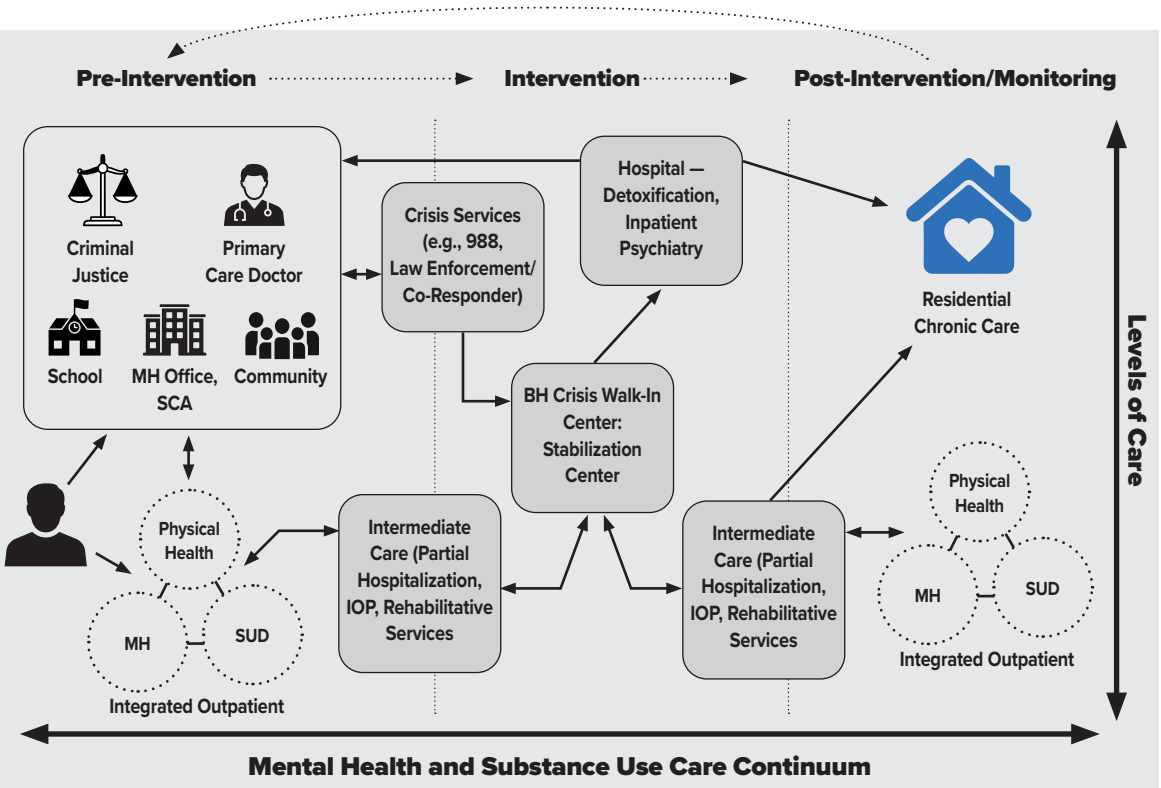
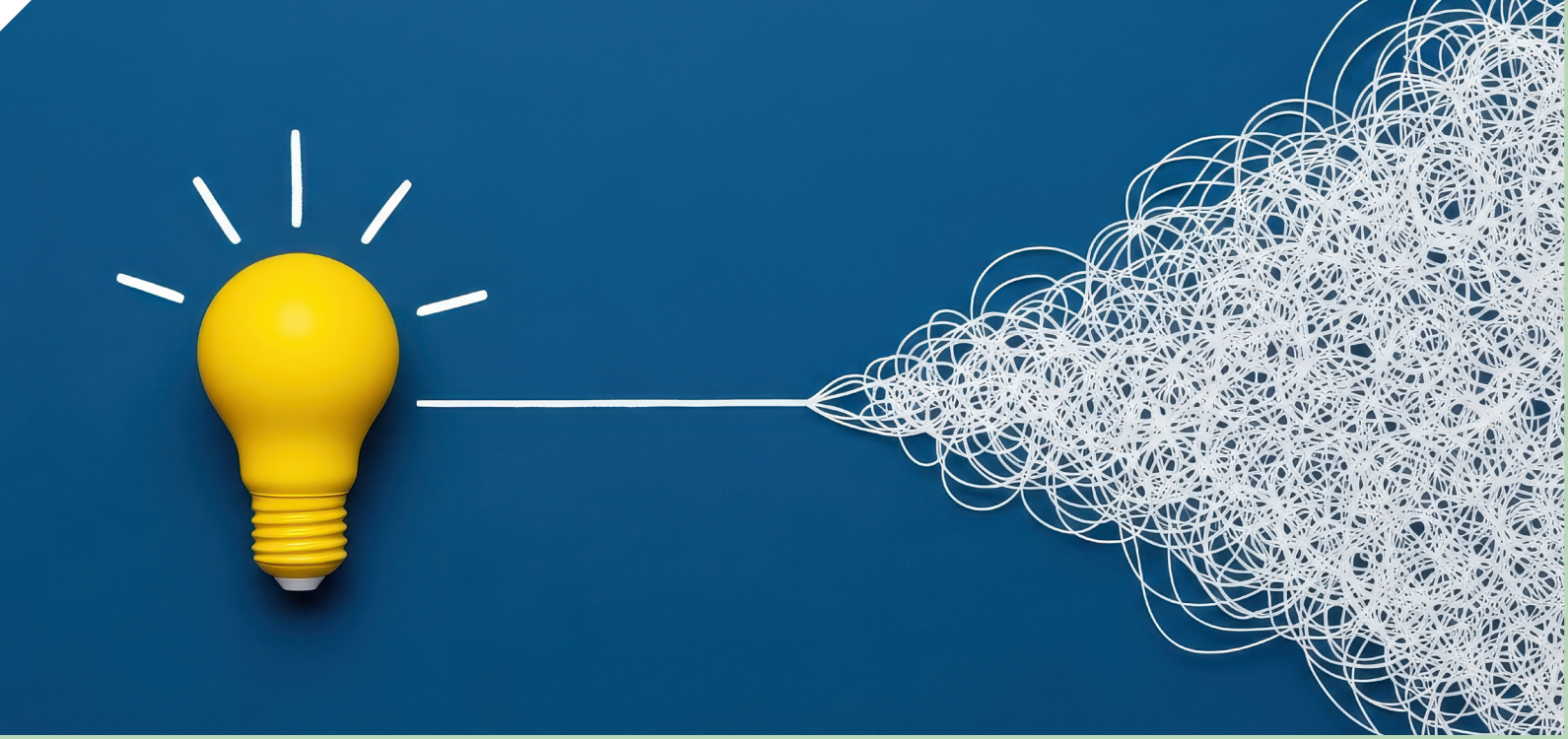


Figure 1
Ideal System of Care Model

This model illustrates the dynamic, non-linear nature of treatment and recovery. Individuals may enter at any point and move fluidly between levels of care. Peer support is embedded across all levels. Distinct pathways exist for individuals with lower-acuity needs versus those with high-acuity serious mental illness, SUD, or complex medical comorbidity. Integrated care models must explicitly incorporate physical health management, recognizing the high burden of chronic disease and premature mortality among individuals with serious mental illness and SUDs.



Goals + Recommendations

The Governor's Behavioral Health Council, in collaboration with a diverse Advisory Committee, convened throughout 2024-2025 to chart a statewide action plan for transforming Pennsylvania's behavioral health system. Their discussions yielded numerous recommendations, organized under six major Goals. Each goal below includes a brief context reflecting Council and Advisory Committee insights, followed by a table of specific recommendations with high-level action steps, performance measures, and the policy lever(s) (such as Funding Needed, Regulatory Changes, Interagency Coordination, or Legislative Action) identified for implementation. This comprehensive approach will help ensure that every Pennsylvanian has timely access to high-quality mental health and SUD treatment services, regardless of who they are or where they live. The Council recognizes that implementation must be realistic given fiscal constraints, phased strategically, and accompanied by ongoing stakeholder engagement to avoid unintended consequences.

Goal #1

Develop an Integrated Care System

Council members frequently noted that Pennsylvania's care is fragmented — people with mental health and SUD needs often navigate multiple siloed systems for support. Currently, different providers, health care coverage payers, and state agencies operate in parallel, making it hard for individuals to get all necessary services seamlessly. An ideal future system envisions "no wrong door," where care for physical health, mental health, and SUD is fully coordinated. Integrated models of care, including the Collaborative Care Model and the Primary Care Behavioral Healthcare (PCBH) Model, both recognized by the Centers for Medicare and Medicaid Services (CMS) and reimbursable under Medicaid. Pennsylvania would allow individuals to access a continuum of services without duplication or gaps. By breaking down silos and fostering collaboration across providers and agencies (including Medicaid, Medicare, counties, and commercial insurers), Pennsylvania can improve outcomes and reduce costs. Whatever integrated system is created, it must be easily accessible and available to families. Integrated primary and behavioral care services should be regularly assessed for effectiveness by families with lived experience and people who use services, and best practices must be made available statewide. Implementation guidance should reflect staffing, visit length, and care coordination capacity limitations commonly faced by primary care practices.

To achieve this goal, the recommendations in Table 1 focus on expanding proven integrated care models, improving linkages between crisis and law enforcement and behavioral health services, and aligning payment incentives with integrated care delivery. These steps will help unify the system so that Pennsylvanians receive holistic, coordinated care for both mental and physical health needs.

Integrated Care Highlights and Accomplishments

- **Behavioral Health Home Plus (BHHP)**
  Behavioral health facilities (Community Mental Health Centers, Opioid Treatment Programs, and Psychiatric Residential Treatment Facilities) that support preventive care and physical health needs for people via a wellness nurse and educational materials. People reported higher confidence in managing their health and remained connected to outpatient treatment, while emergency room visits decreased.
- **Centers of Excellence**
  Health care entities (FQHCs, SCAs, SUD providers) designated to provide whole-person care for people with opioid use disorder (OUD). This involves coordinating treatment across physical, mental, and SUD health care while engaging the person with peers and other community supports.
- **Nurse and Medical Licensing Compacts**
  The Shapiro Administration has fully implemented multistate licensure compacts for nurses and physicians, helping ease workforce shortages and facilitate cross-state practice.
- **Coordinated Licensing Reviews**
  OMHSAS and DDAP launched coordinated licensing reviews for facilities providing both mental health and SUD treatment, reducing administrative burden. These are currently separate reviews conducted simultaneously; the goal is to move toward unified licensing over time.
- **Mobile Clinics and Telehealth Expansion**
  DDAP licensed four mobile clinics providing medications for opioid use disorder (MOUD), including in rural areas, many also providing wound care and naloxone. DDAP has also made licensing exceptions to allow telehealth-only SUD outpatient services for individuals for whom in-person treatment is not feasible.

Goals + Recommendations

Table 1: Improving cross-system coordination so people get care seamlessly across mental health, substance use, and physical health services.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
1. Develop an evidence-based integrated care model that is recognized by providers and payers. Integrate mental health and SUD treatment into primary care settings and other care hubs (e.g., expand Certified Community Behavioral Health Clinics and health home models) by identifying quality, evidence-based models of care to develop a statewide model while aligning regulations, updating outdated rules, and standardizing definitions across agencies. Implementation guidance should reflect the staffing, visit length, and care coordination capacity limitations commonly faced by primary care practices.	a. Evaluate outcomes and costs of current integrated care programs across agencies. Compare regulations and MH/SUD definitions across agencies and federal guidelines, and update and align them where possible. Engage health care coverage payers, including commercial insurers, to secure buy-in and develop strategies for achieving cost savings. b. Create a repository of high-quality models, including the Collaborative Care Model and Primary Care Behavioral Healthcare (PCBH) Model. c. Redirect funding and waivers to expand the best models statewide. Provide clear guidance for the General Assembly on the redirection of funding. d. Develop a unified, integrated model of care guidance and training informed by input from consumers and families to help mental health, SUD, and primary care providers adopt collaborative care approaches. Training should include evidence-based practices for SUD and for supporting individuals with SMI, so that treatment can be provided in a single location. e.Define applicability to counties and outline support for successful implementation, including technical assistance, ongoing support mechanisms, and dedicated funding beyond base funds. Review civil service classifications to ensure integrated positions are recognized within the civil service framework.	• **Access points:** Number of primary care practices, community clinics, and behavioral health sites offering integrated services that include physical health and behavioral health screening and treatment. • **Utilization:** Increase in people receiving both physical and behavioral health care in one setting. • **Education:** Number of health professional training programs incorporating an integrated behavioral health curriculum. • **Payer engagement:** Number of commercial insurers and Medicaid managed care plans that have adopted or are piloting integrated care reimbursement models.	Interagency Coordination, Funding Needed, and Regulatory Changes
2.Strengthen crisis response integration (911/988). Improve how people in crisis are guided to care by linking emergency 911 dispatch with the 988 behavioral health crisis line and expanding crisis services capacity. Legal liability related to call transfers between 911 and 988 remains a primary barrier; interagency work involving DHS, Pennsylvania Emergency Management Agency (PEMA), counties, and legal representatives is ongoing to resolve this challenge.	a. Assess each county's 911 and 988 call data and protocols. b. Implement statewide guidelines for transferring 911 calls involving behavioral health to 988 responders or co-response teams. As part of this effort, evaluate existing 911 statutes and protocols to address liability barriers and ensure legal language provides appropriate reciprocity between 911 and 988 systems. c. Invest in expanding 988 call center staffing and mobile crisis teams where capacity is lacking. d. Develop a sustainable, long-term funding model for 988 operations, building on pending legislation. Identify the appropriate mix of state appropriations, federal grants, Medicaid billing, and dedicated revenue sources. e. Fund promotion and community awareness of 988 as a behavioral health crisis resource and ensure its connectivity with SUD crisis centers, f. Coordinate pediatric crisis response with age-appropriate 988 services and explore collaboration between 988 and Poison Control Centers at the University of Pittsburgh Medical Center (UPMC) and the Children's Hospital of Philadelphia (CHOP), given the connection between attempted poisonings and suicide.	• **Crisis connection:** Percentage of relevant 911 calls successfully connected to 988 or mobile crisis response. • **Coverage:** 988 service availability and response times by county. • **Public awareness:** Percentage of Pennsylvania residents who can identify 988 as the behavioral health crisis number.	Interagency Coordination, Funding Needed, and Legislative Action

Table 1: Improving cross-system coordination so people get care seamlessly across mental health, substance use, and physical health services.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
3. Expand local law enforcement and clinical co-responder programs where practical, including local police departments, peers, and families. Pair police and other first responders with behavioral health professionals, peers, and family advocates to jointly respond to people with mental health or SUD needs, diverting them from justice involvement. Build upon the current work that DDAP does on referrals to treatment by law enforcement.	a. Engage municipalities, counties, law enforcement agencies, and emergency medical services (EMS) providers to review the outcomes of existing co-responder teams and gather input on implementation considerations. b. Identify best practices and develop a rollout plan for municipalities and counties without co-responder programs. For jurisdictions where co-responder models are not feasible, particularly in rural areas with small police departments, identify and promote alternative models such as the Lehigh CIS Model, Armstrong Boundary Spanner, high-quality de-escalation training, and single-point-of-contact approaches. c. Allocate grants for program start-up, training, and equipment for new co-responder and alternative deflection programs. d. Encourage law enforcement and behavioral health professionals to participate in the Crisis Intervention Team Technical Assistance Center (CIT TAC) to expand training and the development of co-responder models statewide	• **Diversions:** Number of law enforcement encounters resulting in referral to treatment or services instead of arrest. • **Co-responder adoption:** Number of counties and municipalities implementing co-responder team programs. • **Alternative model coverage:** Number of jurisdictions implementing alternative deflection or diversion models where full co-responder programs are not feasible.	Interagency Coordination, Funding Needed, and Legislative Action
4. Align payment systems to support integrated care. Adjust Medicaid, and commercial insurance health care coverage payment reimbursement to incentivize whole-person care (blended payments, collaborative care billing codes, value-based models). Address the gap between the richer array of services available through the public system and the more limited coverage typically offered by commercial insurers.	a. Conduct an inventory of current payment arrangements across Medicaid, Medicare, and commercial Insurers. Identify duplications, gaps, and misalignments between existing reimbursement structures and the integrated care model developed under Recommendation 1. b. Provide technical assistance so providers and payers can implement integrated care billing, including collaborative care codes and blended payment models. c. Engage commercial insurers to align behavioral health reimbursement with Medicaid rates and covered service arrays. Where voluntary alignment is insufficient, pursue regulatory or legislative action to require parity in reimbursement and covered services across all payer types. d. Simplify provider enrollment and billing processes across payer types, with particular attention to providers serving older adults and those billing across multiple systems. Coordinate with enrollment streamlining efforts under Goal 3, Recommendation 4. e. Ensure that when Medicaid or commercial health care coverage reimbursement rates increase, state base funding allocations to counties are adjusted correspondingly so that uninsured and underinsured individuals receive equivalent services.	• **Payment reform:** Introduction of new payment models or codes for integrated care. • **Provider uptake:** Number of providers billing for integrated care or collaborative care services. • **Payer alignment:** Comparison of behavioral health reimbursement rates and covered service arrays across Medicaid, Medicare, and commercial payers, with year-over-year narrowing of gaps.	Regulatory Changes, Funding Needed, and Policy Changes

Table 1: Improving cross-system coordination so people get care seamlessly across mental health, substance use, and physical health services.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
5. Create coordinated mental health-SUD treatment provider networks. Foster partnerships between mental health providers and substance use treatment providers to ensure that individuals with co-occurring disorders can access both services through coordinated or co-located care rather than navigating separate systems. Continue expanding "one-stop" coordinated care hubs.	a. Inventory existing mental health-SUD coordination efforts and gaps at the county level, identifying areas where providers operate in silos without cross-referral or co-location arrangements. b. Facilitate agreements or partnerships where mental health clinics and addiction treatment programs can cross-refer or co-locate, with priority given to counties with the greatest service fragmentation. c. Target funding to support joint programs in areas with identified service silos. d. Advocate for regulatory and licensure changes to support providers offering both mental health and SUD services under a single program structure, building on unified licensing efforts under Goal 3, Recommendation 1.	• **Coordination:** Number of formal partnerships between mental health and SUD treatment providers. • **Co-location:** Number of sites where mental health and SUD services are physically co-located or share integrated intake processes. • **Client outcomes:** Improved retention or completion rates for individuals receiving services from both systems. • **Court-system coordination:** Number of coordinated providers serving court-involved populations, including truancy and treatment courts.	Funding Needed, Interagency Coordination, and Regulatory Changes

Goal #2

Expand Access to Services

Pennsylvanians have voiced that services are not always accessible when and where they need them. Long wait times, provider shortages (especially in rural or underserved areas), complex referral processes, and cost barriers prevent people from getting timely care. Families shared stories of driving for hours to an appointment or turning to emergency rooms during a crisis because of a lack of community options. Affordability is another critical component of access: even when services exist, high out-of-pocket costs or insurance denials can prevent people from continuing care. To address these issues, the Commonwealth must increase the supply of services (beds, community programs, outpatient clinics, and outpatient providers), simplify how people navigate the system, strengthen health care access across the continuum of payers, and reduce financial barriers. Funding must be sustainable and adequate. Without ongoing funding that increases with the cost of living, providers will struggle to participate and retain staff. Schools and communities also play a key role in early identification and support, so bringing services to these settings can catch problems before they escalate.

Table 2 outlines recommendations to make behavioral health services more available, easier to find, and affordable. They include efforts to reduce wait times for care, invest in preventive and community-based programs, improve housing supports, expand evidence-based overdose prevention and harm-reduction services and treatment access, strengthen parity of health care services across the continuum of payers, and use schools and public education campaigns to help people access care sooner. By implementing these strategies, Pennsylvania can ensure the right care is available at the right time for anyone in need.

Access Highlights and Accomplishments

- **Peripartum Depression Screening**
  DDAP provided funding to the PA PQC to implement the Moving on Maternal Depression initiative, advancing statewide development of quality measures, guidance and a toolkit for maternal care providers to support peripartum depression screening and connection to treatment. DOH will build on this foundation through the statewide Peripartum Depression Implementation Plan. The plan aims to improve early identification of peripartum depression through consistent screening across the perinatal care continuum and to strengthen connections to treatment through closed-loop referral systems. It also seeks to reduce access disparities in rural and resource-limited communities and align provider training, payer policy, and quality improvement efforts to support timely care.

Table 2: Making behavioral health services available when and where people need them.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
1. Ensure rapid access and stabilization for people in crisis by expanding crisis services. Reduce wait times for mental health or SUD treatment (especially after acute events like overdose or psychiatric hospitalization) and improve transitions between levels of care. Funding must be consistent, adequate, sustainable, and include built-in cost-of-living considerations. Greater geographic and cost specificity should guide where new capacity is developed	a. Work with county mental health offices, SCAs, and people and families who have used crisis services to investigate causes of delays including bed shortages (such as extended acute care beds), heavy emergency department use, and referral bottlenecks and conduct a comprehensive needs assessment for the crisis continuum of care. b. Support and expand the crisis continuum of care to include 24/7 walk-in centers, mobile crisis services, and suicide prevention. Engage PID with respect to commercial insurance and advocate for regulatory or legislative changes requiring private payers to reimburse crisis services. Expand use of behavioral health crisis billing codes in emergency departments so that crisis providers can bill commercial payers. c. Implement quality improvement plans to cut delays, such as expanding community crisis centers or same-day appointment programs. d. Provide technical assistance and targeted funding to counties identified through the needs assessment as having the greatest gaps in crisis capacity, with clear geographic prioritization criteria. e. Ensure crisis services are designed to be accessible to older adults, including mobile crisis teams trained in geriatric behavioral health and crisis protocols tailored to nursing facilities and homebound individuals. f. Establish behavioral health walk-in or drop-off centers in communities with high emergency department use and frequent law enforcement involvement for behavioral health crises. Design centers for rapid police and EMS handoffs with multidisciplinary staffing, start-up and sustained funding, and 24/7 operations.	• **Timeliness:** Average time from a crisis event to appropriate follow-up care along with well established warm hand off protocols (tracked by county and by EDs). • **Emergency burden:** Reduction in avoidable emergency department visits for behavioral health crises (target of 5% or greater annual decrease).	Interagency Coordination, Funding Needed, and Legislative Action
2.Invest in prevention and early intervention. Direct more resources toward community-based prevention, wellness, and early treatment programs to address issues before they become severe. Focus on both early identification at the first point of contact and building infrastructure to reduce escalation and unmet needs.	a. Review current funding streams (Medicaid, state grants, school-based mental health and safety grants, Violence Intervention and Prevention (VIP), Building Opportunities through Out-of-School Time (BOOST), etc.) to assess the scope of current investments in preventive services and identify gaps. b. Seek opportunities (federal waivers, grants) to fund upstream programs. Implement reimbursement for pediatric preventive mental health services in primary care using Z-codes prior to a DSM diagnosis, building on emerging best practices from other states. c. Develop incentives for both physical and behavioral health providers to offer wellness and early intervention, such as bonus payments or tiered reimbursements for screenings and brief interventions. d. Launch pilot programs in high-need communities including school-based mental wellness classes, outreach in housing programs, and prevention and early intervention programming for older adults and evaluate their impact. Ensure the role of families and primary caregivers is included in program design. e. Integrate peer-to-peer programming into prevention efforts where appropriate.	• **Preventive care usage:** Increase in utilization of preventive mental health and SUD services (screenings, early counseling, evidence-based programs that increase protective factors). • **Family engagement:** Percentage of preventive programs that include structured parent/ caregiver engagement components. • **Crisis reduction:** Decrease in acute crisis events (overdoses, psychiatric hospitalizations) as preventive efforts expand. • **Pilot outcomes:** Number of pilot prevention programs evaluated, with successful models identified for statewide expansion.	Interagency Coordination, Funding Needed, and Legislative Action

Table 2: Making behavioral health services available when and where people need them.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
3. Expand housing and residential support options. Increase the availability of supportive housing and residential treatment facilities for people with chronic mental health and SUD conditions, including long-term structured residences (LTSR), community residential rehabilitation (CRR) programs, recovery houses, transitional housing, and other low-barrier housing. Medical respite and low-barrier shelter models with embedded medical services should be considered core access strategies for individuals with high behavioral health acuity.	a. Work with counties, Housing Authorities, and AAAs to conduct a comprehensive gap analysis of residential treatment programs and housing supports for people with behavioral health needs including older adults requiring nursing-level care with co-occurring mental health/SUD conditions. Include a target completion date. b. Build a shared database of available beds and housing units to facilitate cross-county referrals where local supply is low. Develop reciprocal agreements between counties for accessing housing resources across jurisdictions. c. Dedicate funding (and potentially reallocate unused resources) to create new LTSR/CRR beds and supportive housing in regions with shortages. d. Increase the capacity of staff in existing programs, including training and support for staff to become Certified Psychiatric Rehabilitation Practitioners. Support rental subsidies so individuals can afford to transition from CRR and LTSR levels of care, creating flow in existing residential systems. e. Partner with housing agencies and nonprofits to establish low-threshold housing (such as "Housing First" models) for those experiencing homelessness with behavioral health needs. f. Address residential treatment and nursing facility needs for older adults with SMI and SUDs by expanding specialized capacity and ensuring these populations are visible in planning and funding decisions.	• **Capacity:** Number of residential treatment beds and supportive housing units available and percentage utilization. • **Coverage:** Percentage of counties meeting defined benchmarks for housing options for behavioral health populations. • **Waitlist reduction:** Average time on waitlists for LTSR, CRR, and supportive housing placements, with year-over-year decrease. • **Housing stability:** Percentage of individuals placed through Housing First or low-threshold programs who maintain stable housing at 12 months.	Funding Needed, Interagency Coordination, and Legislative Action (including local zoning)
4. Expand harm-reduction initiatives statewide. Support and introduce programs that reduce SUD-related harm (such as naloxone distribution, syringe services, and other evidence-based strategies, including fentanyl test strips and medications for opioid use disorder) in every county, with a recovery-oriented framework. Build on existing work through DDAP's Overdose Prevention Program and Life Unites Us Stigma Reduction Campaign.	a. Survey current harm reduction efforts by county and identify areas with no or limited programs. Assess available data from DDAP's Overdose Prevention Program and Life Unites Us – Stigma Reduction Campaign and other existing initiatives. b. Assist counties in launching or expanding needed services by sharing best practices from successful programs and identifying existing grant funds or state resources for naloxone training and distribution. c. Where legal barriers exist (e.g., paraphernalia laws restricting certain programs), develop proposals to modify those regulations to allow life-saving interventions. d. Pursue expanded access to medications for opioid use disorder, including pharmacy-based methadone dispensing, to reduce barriers in rural areas. Ensure all medication-based approaches are offered within a recovery-oriented framework that includes behavioral treatment, peer support, and pathways to sustained recovery.	• **Program availability:** Number of counties with core harm-reduction and overdose prevention and treatment access services in operation. • **Impact:** Overdose rates and other substance-related harm indicators (tracked yearly, aiming for reductions in newly served areas). • **Treatment access:** Number of Medications for Opioid Use Disorder (MOUD) prescribers and dispensing locations per county, with year-over-year increase in underserved areas.	Funding Needed and Regulatory Changes

Table 2: Making behavioral health services available when and where people need them.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
5. Boost public awareness and navigation assistance. Launch educational initiatives and tools to help individuals and families understand how to get help and build skills to support behavioral health. Engage families, consumers, and advocacy groups in developing, distributing, and educating community members.	a. Develop public education campaigns, led by DHS in partnership with the Departments of Health, Education, Drug and Alcohol Programs, Labor and Industry, Aging and the AAAs, that teach community members how to recognize signs of mental illness or substance misuse and how to access treatment. Implement skills-based suicide prevention curricula in schools and community centers. b. Create or enhance a statewide behavioral health navigation resource such as an expanded website, hotline that guides people to appropriate services. Integrate with the statewide provider directory developed under Goal 4, Recommendation 1, to ensure navigation tools reflect real-time provider availability. c. For people completing residential treatment, provide life-skills training (job readiness, budgeting) as part of discharge planning to ease their transition back into the community. Address the implementation gap for providers who cannot afford dedicated life-skills staff by identifying reimbursement pathways or partnerships with community organizations.	• **Public engagement:** Number of schools or communities implementing mental health education programs; number of people reached through outreach campaigns. • **Navigation effectiveness:** Percentage of individuals using the navigation resource who are successfully connected to a service appointment within 14 days. • **Utilization:** Traffic to helplines or resource websites and successful linkages made.	Interagency Coordination and Funding Needed
6. Enable flexible staffing models. Allow providers to use a wider range of qualified staff and innovative staffing arrangements to meet local needs, particularly in underserved areas.	a. Analyze workforce gaps by region using data such as behavioral health clinicians per population and waitlist lengths as a starting point. Use findings to prioritize regions for flexible staffing interventions. b. For areas with severe shortages, develop plans to broaden who can provide care under supervision. For example, permit telehealth providers from other regions to fill gaps, allow credentialed bachelor's-level counselors to deliver certain supports under oversight, or expand telephonic psychiatric consultation programs such as the Telephonic Psychiatric Consultation Service Program (TiPS). c. Pursue legislative changes to expand scopes of practice, reciprocal licensing, and additional license types as appropriate (such as associate licenses) without compromising quality. Any new licensure classes must go through the DOS sunrise review process. d. Require commercial insurers to reimburse alternate providers (such as certified recovery specialists or case managers) for designated services. e. Offer grants to providers to pilot creative staffing models such as hiring paraprofessionals, deploying mobile teams, or establishing shared employee arrangements and evaluate impacts on access. f. Ensure adequate time and reimbursement for higher-level practitioners to supervise and mentor lower-level practitioners, including working with payers to allow billing for supervision and oversight activities.	• **Workforce sufficiency:** Behavioral health staff-to-population ratio in targeted shortage areas (improvement over baseline). • **Access:** Reduction in wait times for services in regions using new staffing models. • **Parity in providing reimbursement of same scope of health care services by health care coverage payers:** Number of payer types reimbursing certified recovery specialists, case managers, and other alternate providers for designated behavioral health services.	Funding Needed and Regulatory Changes

Goal #3

Strengthen the Workforce and Provider Support

A robust, supported workforce is the backbone of an effective behavioral health system. Across Pennsylvania, provider organizations struggle with staff burnout, high turnover, and difficulty recruiting new professionals. Council discussions highlighted low wages, overwhelming administrative burdens (excessive paperwork, duplicative audits), and limited career pipelines as key factors. Mid-career retention is a particularly acute challenge once professionals have families of their own, inadequate compensation, and demanding hours drive them away from the field. At the same time, demand for services is rising while there are not enough clinicians, peer specialists, and other workers, and people end up on waiting lists. The system also needs to be flexible with the workforce and optimize their skills: leveraging peers or community health workers and enabling professionals to practice at the top of their license. The recommendations under this goal aim to reduce bureaucratic hurdles for providers, improve working conditions and pay, and invest in training and career development.

By streamlining regulations and paperwork, providers can spend more time with clients instead of on compliance tasks. Improving salaries and offering loan forgiveness or scholarships will make the field more attractive to new graduates and support mid-career retention. Expanding training opportunities and career pathways (especially for young people and non-traditional workers like veterans) will ensure a diverse new generation is ready to step into these critical roles.

Workforce and Support Highlights and Accomplishments

- **DDAP Student Loan Repayment Program**
  Awarded on average $68,000 in loan repayment support to 274 care staff across the SUD care continuum in Round 1 and awarded on average $56,000 to 345 participants in Round 2.
- **DOH Primary Care Loan Repayment Program (LRP)**
  For clinical staff working in designated Health Professional Shortage Areas or with a low-income population, DOH provides loan repayment up to $80,000 for physicians and psychologists while Certified Registered Nurse Practitioners (CRNPs) can receive up to $48,000.
- **Coordinated Inspections Process**
  DHS and DDAP launched a new initiative to coordinate annual inspections for SUD and mental health treatment providers licensed by both agencies, reducing administrative burdens and increasing health and safety protections.

Table 3: Supporting and growing the behavioral health workforce.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
1. Streamline and unify licensing and oversight Simplify the regulatory burden on providers by coordinating licensing processes and aligning requirements across state agencies. Address root causes of long licensing review and approval wait times.	a. Review all mental health and SUD treatment facility licensing regulations across DHS, DDAP, DOH, and DOS to identify duplicative or conflicting rules. b. Implement a "one-stop" online licensing platform where providers can submit information once for multiple licenses. c. Update statutes and regulations so that providers offering integrated services meet one coordinated set of standards (for example, allow a single survey or audit in place of separate audits for each program). Clarify applicability to individual practitioners regulated by DOS versus facilities regulated by other agencies. d. Prioritize adoption of current evidence-based standards such as the latest ASAM criteria across all licensing bodies, while preserving provider clinical discretion in individual treatment decisions. Note that implementing the current ASAM criteria requires statutory change. e. Pursue specific statutory and regulatory and process improvements: create a single license for co-occurring disorder programs, align license renewal and inspection schedules across agencies, and streamline the process for obtaining Provider Reimbursement and Operations Management Information System (PROMISe) IDs and related licenses. f. Investigate and address root causes of long wait times for licensing review and approval, including staffing levels at licensing agencies, process bottlenecks, and re-review requirements.	• **Administrative efficiency:** Reduction in the number of separate licenses or audits required per provider. • **Provider feedback:** Improvements in provider satisfaction survey scores regarding regulatory burden. • **Processing time:** Average time from license application submission to approval, with year-over-year reduction target.	Regulatory Changes, Funding Needed, and Legislative Action
2. Consolidate reporting and auditing requirements. Unify provider data reporting and audits within a single channel. Adopt principles of deemed status for licensed and accredited providers to reduce duplicative quality audits across multiple BH-MCOs and SCAs.	a. Assemble a cross-agency administrative review team (including DHS, DDAP, county oversight entities, BH-MCOs, SCAs, and commercial insurers) to catalog all reporting forms and audit schedules imposed on providers. b. Design a unified reporting system or portal that can feed necessary data to all relevant agencies, so providers submit information once. c. Coordinate with BH-MCOs to adopt standardized audit protocols so that providers are not audited separately by each MCO for similar quality measures. Where a single audit cannot satisfy multiple payers due to contractual or privacy constraints, standardize audit tools, timelines, and criteria to minimize variation and reduce provider burden. d. Update any regulations or contracts needed to permit joint audits and data sharing among oversight bodies. e. Evaluate the feasibility of establishing deemed status for providers that maintain current licensure in good standing and hold nationally recognized accreditation (such as CARF or Joint Commission), whereby accreditation satisfies quality audit requirements. Conduct a legal analysis to determine whether privacy rules and contractual obligations permit cross-payer audit recognition.	• **Duplication reduction:** Decrease in the total number of reports or audits a provider must complete annually. • **Time savings:** Self-reported reduction in hours spent on administrative compliance. • **Multi-payer audit burden:** Number of separate quality audits per provider per year from distinct BH-MCOs and SCAs (with reduction target).	Interagency Coordination, Funding Needed, and Regulatory Changes

Table 3: Supporting and growing the behavioral health workforce.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
3. Simplify administrative requirements and paperwork. Undertake a comprehensive review of clinical and administrative mandates to eliminate unnecessary or redundant tasks that contribute to provider burnout. Include BH-MCOs and SCAs in this process.	a. Convene a working group of frontline clinical practitioners, facility administrators, state agency staff, BH-MCOs, and SCAs to map out all major administrative procedures (intake forms, treatment plans, authorizations, etc.) and identify where requirements vary across payers. b. Standardize core documentation requirements including intake forms, treatment plan formats, authorization procedures, and billing protocols across all BH-MCOs and SCAs so that providers use one set of processes regardless of payer. Prohibit BH-MCOs and SCAs from unilaterally imposing new documentation requirements without a cost-impact assessment and adequate implementation lead time. c. Ensure that any requirement that is outdated or not clearly tied to better outcomes is modified or removed. Preserve MCO authority to audit for fraud, waste, and abuse while targeting reductions in duplicative quality and documentation requirements. d. Maintain a permanent feedback mechanism so providers can continuously flag new administrative burdens as they arise, with a required state response timeline.	• **Paperwork reduction:** Fewer total documentation pages required per episode of care. • **Provider capacity:** Increase in the percentage of staff time available for direct care versus administrative tasks. • **Documentation uniformity:** Percentage of core administrative procedures standardized across all BH-MCOs and SCAs.	Regulatory Changes
4. Simplify provider enrollment and billing. Make it easier for qualified professionals to become approved providers across Medicaid, Medicare, and commercial insurance and clarify billing rules for emerging service models.	a. Work with the Centers for Medicare and Medicaid Services (CMS) and the state Office of Medical Assistance Programs (OMAP) to streamline the enrollment process for mental health and SUD clinicians so they can bill Medicaid with less delay. b. Issue clear state guidance on billing for modern service modalities like mobile treatment, peer support services, and telehealth-delivered care so providers know how to get reimbursed and are encouraged to offer them. c. Explore adding those services explicitly to the Medicaid state plan or managed care contracts if not already covered. d. Provide technical assistance sessions for providers on how to enroll and bill correctly, reducing administrative friction across all payer types. e. Consider legislation to require commercial insurers to accept behavioral health providers into their networks if they are willing to accept the insurer's standard terms and conditions (Any Willing Behavioral Health Provider)	• **Network growth:** Increase in the number of individual practitioners enrolled as Medicaid providers. • **Service billing:** Uptick in claims for mobile treatment, peer support, and telehealth services (indicating those services are being provided and reimbursed more widely).	Interagency Coordination, Funding Needed, Legislative Action and Regulatory Changes

Table 3: Supporting and growing the behavioral health workforce.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
5. Integrate peer specialists into care teams. Expand the use of Certified Peer Specialists, Certified Recovery Specialists, and family peers, particularly in crisis response and high-need settings, and secure adequate reimbursement for their services. Establish clear boundaries and supervision standards.	a. Expand the deployment of peer specialists across the behavioral health continuum including mobile crisis units, crisis centers, emergency departments, outpatient clinics, residential programs, and re-entry services partnering with county programs to prioritize placement in high-need settings. b. Formally recognize certified recovery specialists in state Medicaid policy. Address the current reimbursement gap where peer specialist earnings exceed Social Security and Medicaid eligibility thresholds but are insufficient to cover living expenses and health care coverage by pursuing reimbursement rate increases and advocating for legislative changes requiring private insurers to reimburse peer services at rates sufficient to attract and retain a qualified workforce. c. Develop statewide standards defining the scope of practice, professional boundaries, and supervision requirements for peer specialists working within clinical teams. Establish regularly occurring training and credentialing frameworks to ensure consistent quality and clear role expectations. d. Extend peer navigator and family peer support roles into court settings, partnering with counties to make these services available across all court sectors. Coordinate with court-based programming under Goal 6, Recommendation 2.	• **Peer workforce:** Number of peer support specialists employed in mental health and SUD programs across the continuum. • **Health care coverage:** Percentage of payers that reimburse for peer support services. • **Rate adequacy:** Average reimbursement rate from all payers for peer services compared to a livable wage threshold sufficient to cover living expenses and health care coverage. • **Supervision compliance:** Percentage of peer specialists receiving supervision consistent with statewide standards.	Funding Needed, Legislation Needed and Regulatory Changes
6. Increase workforce compensation. Make behavioral health fields more attractive by improving pay and benefits for clinicians and frontline staff, supported by higher reimbursement rates. Address pay disparities across disciplines and ensure compensation reflects education and qualifications.	a. Conduct a market analysis of behavioral health salaries in Pennsylvania relative to comparable health care roles and neighboring states. b. Use that data to advocate for Medicaid rate increases targeted at services with the largest staffing shortfalls. c. Ensure that when commercial insurance reimbursement rates increase, base funding increases correspondingly so counties can pay comparable rates for uninsured individuals. d. Engage commercial insurers in discussions about adequate reimbursement for behavioral health providers. Consider legislation or contract requirements that set minimum payment levels for critical services. e. Require providers to use enhanced funding to boost wages, offer retention bonuses, and improve working conditions for staff who handle challenging caseloads.	• **Rate improvement:** Average Medicaid reimbursement rate for targeted behavioral health services compared to baseline, with year-over-year increase. • **Retention:** Annual staff turnover rate at community behavioral health agencies (with contextual analysis distinguishing involuntary attrition from career advancement). • **Provider network:** Increase in the number of clinicians practicing in high-need specialties.	Interagency Coordination (Contract reviews), Funding Needed and Regulatory Changes

Table 3: Supporting and growing the behavioral health workforce.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
7. Secure sustainable funding for the crisis services workforce. Ensure crisis response programs (suicide hotlines, mobile crisis teams, warm lines, walk-in centers, etc.) have stable, long-term funding to offer competitive wages and retain skilled staff.	a. Evaluate current crisis services funding which often relies on short-term grants and produce a crisis funding gap analysis with specific dollar amounts by county. b. Provide sustained state funding to raise compensation for crisis counselors and technicians to competitive levels, with built-in cost-of-living adjustments. c. Incorporate crisis services into state and county budgeting as essential services rather than pilot programs. Expand Medicaid billing for crisis intervention to create sustainable revenue for crisis services providers. d. Require commercial insurers to cover behavioral health crisis services provided through, e.g., telephone, mobile, medical mobile, walk-in, and stabilization services so that crisis providers can bill commercial insurance across all payer types. Provide technical assistance to crisis services on billing and credentialing requirements. e. Pursue legislation establishing a formulaic investment strategy representing each payer's local population share of crisis system funding. f. Monitor staffing levels and service outcomes annually to adjust funding over time, ensuring resources keep pace with demand.	• **Stability:** Vacancy and turnover rates in crisis response positions. • **Service continuity:** Percentage of 988 calls answered in-state within target time; mobile team response times. • **Funding stability:** Percentage of crisis programs operating with multi-year funding commitments versus single-year grants.	Funding Needed and Legislative Action
8. Establish a Behavioral Health Workforce Pipeline Program. Encourage school students and other new entrants to join the behavioral health field. There are currently programs for tuition reimbursement for current professionals for higher education, but the pay increase does not match the credentials gained.	a. Partner with educational institutions, community organizations, and the Governor's Advisory Commission on Next Generation Engagement to create clear pathways into behavioral health careers, including targeted curricula, internships, and mentorship programs aligned with the interests and values of younger workers. b. Conduct targeted outreach to non-traditional entrants, including veterans, second-career individuals, rural residents, and individuals with lived behavioral health experience, to broaden the talent pool beyond traditional academic pathways. Coordinate diversity-focused recruitment with Goal 5, Recommendation 8. c. Fund pipeline entry points such as paid internships, clinical rotation stipends, and tuition support for students committing to behavioral health careers in Pennsylvania. Promote these opportunities through high schools, vocational programs, community colleges, and the State System of Higher Education (PASSHE). d. Attract behavioral health professionals to court-related agencies, including probation, re-entry programs, and treatment courts, by partnering with the judiciary's national Behavioral Health Initiative to add behavioral health concentrations in degree and certificate programs statewide. e. Work with provider organizations to align compensation structures with credentialing, ensuring that professionals who obtain advanced degrees or certifications through pipeline programs see meaningful pay increases. Coordinate with workforce compensation efforts under Recommendation 6.	• **Pipeline participation:** Number of students or trainees enrolled in behavioral health career pipeline initiatives. • **Long-term growth:** Trend in new professionals entering Pennsylvania's behavioral health workforce (tracked through licensure data and public sector employment). • **Conversion rate:** Percentage of pipeline program participants who enter the behavioral health workforce within two years and remain for at least three years.	Funding Needed and Interagency Coordination

Table 3: Supporting and growing the behavioral health workforce.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
9. Provide specialized training for the fiscal and management staff. Build capacity in counties and provider agencies to manage complex funding streams and programs effectively. Build on existing fiscal, reporting, and invoicing training that is already in place.	a. Create a comprehensive funding flow map showing all major streams of behavioral health funding (Medicaid, state general funds, federal block grants, county match funds, opioid settlement funds, etc.) and what they support. Update annually. b. Build upon existing training curricula for county mental health and SUD program fiscal officers, administrators, and program managers. Collaborate with the Governor's Center for Local Government Services to host workshops or online training series, piloting in a few counties before statewide rollout. Encourage peer learning through a network of county fiscal officers and include perspectives from individuals and families with lived experience to connect fiscal management to service delivery impact. c. Gather input from counties and providers on funding restrictions or overlaps and identify opportunities for more flexible or braided use of funds. d. Hold annual cross-agency budget coordination meetings, convened by the Governor's Office, including DHS, DDAP, DOH, and county representatives, to align spending plans for new initiatives and publish a joint spending outlook for the coming fiscal year.	• **Financial acumen:** Number of county behavioral health agencies completing fiscal training. • **Reporting quality:** Percentage of counties submitting required fiscal reports on time and without material errors. • **Efficient use of funds:** Improvement in timely utilization of allocated funds and reduced lapses. • **Transparency:** Completion and annual update of the statewide behavioral health funding flow map.	Interagency Coordination
10. Expand loan repayment and tuition assistance programs. Attract new talent and support the current workforce by reducing the financial burden of training. Include geographic equity safeguards to prevent disproportionate benefit to certain regions while leaving rural or underserved areas at a disadvantage.	a. Increase state funding for loan repayment awards and scholarships targeting behavioral health professionals who commit to working in Pennsylvania, especially in underserved areas as defined by the Health Resources and Services Administration (HRSA) and state-identified shortage criteria. b. Broaden eligibility to include more types of behavioral health workers and paraprofessionals. c. Promote loan repayment and tuition assistance opportunities through colleges, training programs, and professional associations so graduates and current professionals are aware. Streamline the application process across state agencies to maximize uptake. Coordinate with the Grow PA Scholarship Grant Program to align efforts and avoid duplication. d. Review and reform loan repayment program design to remove structural barriers, including restrictions that limit recipients per site, exclusions based on past payment difficulties, and geographic eligibility formulas that disqualify professionals serving disadvantaged populations in settings not technically classified as shortage areas. e. Explore incorporating loan repayment or debt reduction into standard hiring packages for behavioral health professionals employed by state and county government agencies, with retention incentives tied to years of service.	• **Participation:** Number of practitioners receiving loan repayment or stipend support. • **Retention:** Percentage of supported professionals who remain in the state's workforce for 3 to 5 years. • **Geographic equity:** Distribution of loan repayment recipients by county and shortage designation, with targets ensuring rural and underserved areas receive proportional support.	Funding Needed and Legislative Action

Table 3: Supporting and growing the behavioral health workforce.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
11. Enhance mental health training for law enforcement and first responders. Ensure police, EMS, and other first responders are prepared to handle behavioral health crises safely and effectively. Extend relevant training to judges and court staff who make decisions affecting individuals with behavioral health conditions.	a. Build on findings and recommendations from the recently completed statewide inventory of Crisis Intervention Teams (CIT) training programs. Identify implementation gaps by county, with ongoing needs assessment supported through the PA CIT Technical Assistance Center and Pennsylvania Commission on Crime and Delinquency's (PCCD) Mental Health and Justice Advisory Committee (MHJAC). b. Continue to allocate funding to expand training and implementation supports to underserved areas, adapting formats for small departments. c. Develop a standard toolkit or curriculum on mental health first aid and de-escalation techniques for distribution to all law enforcement agencies. For departments where full CIT training is not feasible, create alternative training models such as modular or shortened formats. Establish community-based committees to address local resource gaps and improve deflection outcomes. d. Require or incentivize all law enforcement officers to complete training in crisis intervention, mental health core concepts, trauma-informed approaches, and de-escalation techniques. Include specialized modules for responding to individuals with Autism Spectrum Disorder (ASD), Intellectual and Developmental Disabilities (IDD), and dementia. e. Provide education for judges and other court personnel on mental health diagnoses, Traumatic Brain Injury (TBI), ASD, IDD, and other conditions that may impact decisional capacity and behavior, particularly as these relate to sentencing and alternative placement decisions.	• **Coverage:** Proportion of law enforcement and EMS personnel who have completed approved mental health and crisis intervention training. • **Safety:** Reduction in injuries, use of force, or adverse incidents during police responses to mental health emergencies. • **Specialized competency:** Percentage of law enforcement agencies with personnel trained in responding to individuals with ASD, IDD, and dementia	Funding Needed, Legislative Action and Interagency Coordination
12. Improve training for health care professionals to work with populations with co-occurring disorders (COD). Equip mental health and SUD treatment providers with consistent education on co-occurring disorder. Measure effectiveness by outcomes for individuals served, not just training completion.	a. Inventory COD education requirements across both individual practitioner licensing boards (regulated by DOS) and facility licensing standards (regulated by DHS, DDAP, and DOH). Include professionals working with older adults in long-term care settings. b. Based on identified gaps, allocate funding to develop a standard COD curriculum with modules tailored to different provider types and care settings. c. Develop incentive structures for health care professionals to complete COD training, such as tiered reimbursement for COD-trained providers, professional recognition programs, or employer-based requirements. Where mandatory Continuing Education (CE) requirements are not feasible due to legislative constraints or the inability of licensing boards to track by specialty, pursue voluntary credentialing pathways that signal COD competence to employers and payers. d. Partner with universities, provider associations, and state agencies to deliver COD training through accessible channels, including online modules, regional workshops, and integration into existing continuing education offerings. Prioritize delivery in regions with high COD prevalence and limited provider capacity.	• **Staff participation:** Number of mental health or SUD care professionals completing COD training. • **Adoption:** Relevant health care licensing boards adopting COD curricular standards. • **Outcomes:** Improvement in treatment outcomes for individuals served in COD programs.	Funding Needed and Interagency Coordination

Goal #4

Enhance Accountability and Transparency

Accountability Highlights and Accomplishments

- **Medicaid Monitoring Enterprise Module (MEMM)**
  Cross-agency database that will display all mental health and SUD providers in Pennsylvania covered by Medicaid.
- **Electronic Prior Authorization System**
  Through Act 146 of 2022, insurers under PID jurisdiction must electronically post their medical necessity policies and list of services requiring prior authorization, enabling a more transparent view of commercial insurance coverage.

To build trust and continually improve, the behavioral health system must be accountable for outcomes and transparent in its operations. Data on quality and access is often hard to find or spread across siloed systems. Currently, there is no single source of truth for what services exist, how well they perform, or how funds are used. Inconsistent processes breed confusion and inequity. The Council emphasized the need for better data infrastructure, including dashboards and directories, to monitor progress and highlight gaps. By improving transparency for example, clearly reporting wait times, provider networks, and insurance claims data the system can hold itself accountable and empower leadership to address problems in real time.

Table 4 presents recommendations to create a more data-driven, transparent, and quality-focused system, including building unified databases (like a comprehensive provider directory and an All-Payer Claims Database), enforcing parity of health care service coverage and consistency across payers, simplifying funding flows, aligning regulations and standards, and implementing outcome metrics.

Table 4: Creating a data-driven system with clear metrics, unified regulations, and transparent reporting to improve quality in behavioral health care systems across the state.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
1. Develop a statewide behavioral health provider directory. Create a public, up-to-date directory encompassing all mental health and SUD services across Pennsylvania. Align this effort with the Enterprise Licensing System (ELS) project already underway and evaluate existing tools such as PA Navigate to avoid creating duplicate databases.	a. Build on existing resources such as county provider lists, Treatment Atlas for SUD providers to define the service types, locations, specialties, availability, etc. b. Work with county mental health offices and SUD authorities to collect and update provider data. Develop robust mechanisms to keep information accurate and current. Leverage Agency Digital, Information Technology and CODE PA resources to build a user-friendly online platform. c. Allow AOPC to provide feedback on information useful to courts, such as designating providers that work with the justice system and CCBHCs. d. Engage consumers and family members in designing the public-facing directory.	• **Transparency:** The directory's coverage (percentage of licensed behavioral health providers listed). • **Utilization:** Number of searches or visits and successful connections to services reported.	Interagency Coordination

Table 4: Creating a data-driven system with clear metrics, unified regulations, and transparent reporting to improve quality in behavioral health care systems across the state.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
2. Implement an All-Payer Claims Database for Behavioral Health. Collect data on service utilization, payments, and outcomes across all payers (Medicaid, Medicare, commercial plans, etc.) to inform policy and ensure parity of covered services across the continuum of care providers and payers.	a. Convene stakeholders from the Pennsylvania Health Care Cost Containment Council (PHC4), PID, DHS, and major payers to design de-identified data submission requirements (key metrics: service denial rates, reimbursement levels, treatment outcomes by diagnosis). b. Secure legal authority via legislation to mandate that payers submit de-identified claims data related to behavioral health services. c. Invest in a secure data system to compile and analyze claims, use the database to conduct payment disparity analysis, identifying areas where reimbursement for behavioral health services is lower than for comparable physical health treatments or varies significantly between payers. d. Publish regular reports on findings and use them to drive adequate reimbursement.	• **Data completeness:** Percentage of payers submitting required data. • **Parity outcomes:** Identification and reduction of payment gaps or higher denial rates in behavioral health vs. physical health across the continuum of care providers and payers. • **Policy impact:** Number of rate adjustments, or legislative proposals directly informed by APCD findings.	Interagency Coordination, Legislative Action, and Funding Needed
3. Improve cross-agency information sharing. Build on recent federal and state reforms including the 2024 amendments to 42 CFR Part 2 and Pennsylvania's Acts 32 and 33 of 2022 to further facilitate appropriate sharing of behavioral health information between systems while protecting privacy. This work must include people with lived experience, given the history of behavioral health information being used to harm, discriminate, and punish.	a. Conduct a comprehensive review of remaining barriers to information exchange under federal law (HIPAA, 42 CFR Part 2, Family Education Rights and Privacy Act (FERPA)) and state law (Mental Health Procedures Act, DAACA, CHRIA, and implementing regulations), identifying where Pennsylvania regulations have not yet been updated to reflect Acts 32 and 33 of 2022 or the 2024 Part 2 Final Rule. b. Develop model data use agreements tailored to each sharing context including criminal justice (CHRIA constraints), courts (truancy, dependency, juvenile justice, domestic relations, AOT), schools (Family Educational Rights and Privacy Act requirements), and health care transitions that maximize permissible sharing under current law while maintaining appropriate protections. Establish quality standards for the information being shared. c. Where statutory barriers remain, particularly CHRIA's exclusion of treatment information from criminal history repositories and restrictions on the use of SUD records in legal proceedings under 42 U.S.C. § 290dd-2(c), develop targeted legislative proposals through the Office of Legislative Affairs. Include the Department of Corrections (DOC), especially regarding information sharing at intake and discharge. d. Ensure all information-sharing initiatives account for the heightened enforcement environment under OCR's new civil enforcement program for SUD record confidentiality (effective February 2026) by providing technical assistance and training to participating agencies on compliance requirements.	• **Data-sharing agreements:** Increase in executed data use agreements linking behavioral health with criminal justice, courts, schools, corrections, and health care entities tracked by court sector (truancy, dependency, juvenile justice, domestic relations, AOT). • **Outcomes:** Track service completion rates, recidivism, subsequent court involvement, employment, and family reunification for individuals in cross-system data-sharing programs. • **Compliance:** Number of agencies completing technical assistance or training on 42 CFR Part 2 and OCR enforcement requirements. Zero reportable confidentiality breaches attributable to new sharing agreements. • **Justice system integration:** C&D roster data-sharing agreements executed between county jails/prisons and courts; percentage of counties with active cross-system data exchange.	Interagency Coordination and Legislative Action

Table 4: Creating a data-driven system with clear metrics, unified regulations, and transparent reporting to improve quality in behavioral health care systems across the state.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
4. Enforce and strengthen behavioral health coverage. Ensure insurers and other payers across the continuum of care comply with coverage laws, eliminate unjust coverage barriers, and standardize behavioral health benefits across all payers.	a. Require insurers to regularly report behavioral health denials, appeals, and outcomes data to PID. b. Require standardized definitions of medical necessity and uniform standards of care for behavioral health services. c. Conduct routine coverage reviews of insurers, involving regulators, providers, and consumers. Formalize this group as a "BH Care Coverage Taskforce." d. Require insurers to eliminate prior authorization requirements for routine behavioral health outpatient treatments with historically high approval rates. e. Require county mental health and SUD offices to refer parity concerns for underinsured individuals directly to PID for review.	• **Fair coverage:** Decrease in behavioral health service denial rates over time. • **Consumer protection:** Decrease in number of appeals resulting in overturned denials or decrease in need for appeals.	Interagency Coordination and Legislative Action
5. Implement standardized quality metrics and monitoring. Define a core set of performance measures for mental health and SUD outcomes that unifies measures across agencies and tracks them transparently. Involve people with lived experience and family members in developing metrics.	a. Work with stakeholders (including county agencies, providers, people with lived experience, family members, and national experts) to select key process and outcome metrics for example, follow-up after hospitalization, treatment engagement rates, symptom improvement scales, or satisfaction. b. Build on existing OMHSAS performance monitoring with IPRO. Require BH-MCOs, county programs, and commercial insurers to collect and report metrics uniformly. c. Build a central dashboard highlighting successes and areas needing improvement.	• **Transparency:** Publication of an annual behavioral health quality report. • **Quality improvement:** Year-over-year improvements on core metrics. Engagement: Percent of counties reporting core set of measures.	Legislative Action and Funding Needed
6. Strengthen county data infrastructure and reporting. Improve the Commonwealth's ability to understand mental health/SUD service utilization, care availability, and the use of state-appropriated and opioid settlement funds by establishing standardized data governance frameworks and supporting county data capacity.	a. Develop a consolidated list of mental health/SUD data reporting requirements across agencies, identifying a core set based on actionability and state/federal requirements. Include use of opioid settlement funding and any similar future awards. b. Working within the cross-agency data-sharing framework established under Recommendation 3, develop standardized governance templates for county-level reporting applicable across state agencies, counties, MCOs, and providers. c. Formalize a partnership with the County Commissioners Association of Pennsylvania (CCAP) to provide counties with centralized privacy guidance and standardized processes for data sharing approvals. d. Explore shared or regional data warehousing models for counties with targeted grant funding to support data integration, reporting capacity, and long-term infrastructure sustainability. e. Engage counties to survey data collection needs and create data infrastructure improvement plans. f. Allocate funding for technical assistance and dedicated county data staff. Use annual data reports to inform future resource allocation decisions and identify counties needing additional support.	• **Engagement:** Percent of counties reporting state appropriated fund spending, mental health/SUD service utilization, and care availability. • **Transparency:** State appropriated funding spending by county and insurance status. • **Infrastructure:** Number of counties with dedicated data management capacity. • **Completeness:** Percentage of required data elements reported accurately and on time.	Funding Needed, Interagency Coordination, Regulatory Changes, and Legislative Action

Goal #5

Advance Equity in Behavioral Health

Every Pennsylvanian, regardless of race, sex, ethnicity, income, age, or location, should have the support they need to thrive. The Council underscored that equity must be a guiding principle. Currently, there are stark disparities: rural communities often lack nearby services, youth and older adults have specialized needs that are not fully met by the adult-centric system, and the workforce does not always reflect the communities it serves. Additionally, marginalized groups sometimes face stigma or systemic barriers that impede access and quality of care. Achieving equity means tailoring strategies to reach underserved populations, expanding mobile services to remote areas, ensuring services are culturally competent, and addressing social determinants like transportation. Specialized geriatric behavioral health services are sorely lacking and require focused attention comparable to the youth-focused recommendations in this plan.

The recommendations in Table 5 aim to close gaps and ensure fairness, including expanding rural service delivery, enhancing youth services and school-based programs, improving continuity of care for older adults, diversifying the workforce, and addressing social media impacts on youth behavioral health.

Equity Highlights and Accomplishments

- **Targeting Disproportionate Opioid Overdose Burden**
  DDAP provided $6 million in grants for organizations providing SUD services to communities of color.
- **Strengthening Behavioral Health Staff in Schools**
  Governor Shapiro's Administration allocated $100 million each year for schools to employ behavioral health counselors and staff.
- **Expanding SBAP for All Students**
  DHS received a grant to expand the School-Based ACCESS Program (SBAP) for non-Individualized Education Plan (IEP) students.
- **Increasing Access to Psychiatric Rehabilitation Services**
  DHS promulgated regulations expanding access to Psychiatric Rehabilitation Services (PRS) by lowering the age of eligibility to 14, including four new eligible diagnoses, and reducing administrative burden for providers.

Table 5: Ensuring all populations and regions have access to effective behavioral health care tailored to their needs.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
1. Expand care in rural areas via mobile services. Increase the use of mobile health units to deliver critical behavioral health treatments to people in remote or underserved regions. Rural counties face challenges due to limited tax bases, workforce shortages, and operational costs. Without coordinated state leadership and dedicated funding, rural counties may be unable to equitably participate in mobile care expansion.	a. Convene leaders from rural counties and existing mobile unit programs to develop a statewide expansion plan identifying priority areas. Incorporate Rural Health Transformation grant initiatives and existing DDAP mobile clinic models into the plan. b. Establish state-led or regional mobile behavioral health units that counties can opt into, rather than requiring counties to independently develop, staff, and operate mobile services. Provide dedicated, multi-year state funding to cover core operating costs including staffing, medications, vehicles, technology, and compliance without requiring county matching funds. c. Pursue regulatory waivers to allow mobile clinics to dispense medications and operate across multiple counties. Pursue legislative action where required, particularly for expanded teletherapy and tele-pharmacy. d. Create regional staffing and prescriber support models, including telehealth integration and broadband prioritization, to address workforce shortages and ensure consistent service availability in rural areas. e. Standardize state-issued referral, data-sharing, and care coordination protocols to integrate mobile units with local hospitals, primary care providers, and county human services, reducing county-level administrative burden. f. Engage counties in planning and geographic prioritization while ensuring fiscally constrained counties are not disadvantaged in access to mobile services or funding. g. Ensure mobile units offer a comprehensive service array including psychiatric medication dispensing, MOUD, naloxone distribution, behavioral health screening, and telephonic peer support and navigation. Extend mobile service models to include in-home visits for homebound older adults unable to travel due to medical concerns.	• **Service reach:** Number of counties with mobile behavioral health clinics in operation. Treatment uptake: Increase in rural residents receiving MOUD or other services. • **Court involvement:** Track whether clients are court-involved or recidivate. • **County participation:** Number of counties participating in state-led or regional models versus independently operating. • **Access:** Reduction in average travel distance and wait time for behavioral health services in targeted rural areas.	Funding and Interagency Coordination Needed. Legislative Action (required for expanded teletherapy and tele-pharmacy)
2. Address transportation barriers. Provide transportation support for individuals seeking treatment, especially when distance is a major obstacle.	a. Evaluate utilization and gaps in Pennsylvania's existing transportation programs, including the Medical Assistance Transportation Program (MATP), to identify where current services fall short for behavioral health appointments. b. Assess network adequacy based on travel time and distance to behavioral health providers. Use findings to target pilot programs in the highest-need areas. c. Pilot transportation support solutions such as bus passes, gas vouchers, and mileage reimbursement for individuals traveling long distances to care. Coordinate with PennDOT and local transit authorities to extend routes or on-demand shuttle services to treatment facilities. Address regulatory safeguards to prevent self-referral concerns with provider-arranged transportation. d. Inventory community volunteer organizations that provide transportation. Develop a pilot grant program to organize and sustain volunteer driver networks for behavioral health appointments. e. Promote telehealth as a transportation alternative where clinically appropriate, connecting to the teletherapy and tele-pharmacy expansion efforts under Recommendations 1 and 3.	• **Mobility support:** Increase in use of transportation assistance programs for behavioral health appointments. • **Impact:** Reduction in no-show rates in rural or underserved areas.	Funding Needed, Interagency Coordination and Regulatory Changes (MATP and BH-MCO transportation contract modifications)

Table 5: Ensuring all populations and regions have access to effective behavioral health care tailored to their needs.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
3. Strengthen SUD services in high-need areas. Close treatment gaps in regions with limited SUD providers using innovative models (telehealth, regional hubs, street medicine) and reduce wait times. Ensure quality controls as services expand, particularly regarding cash-pay and for-profit treatment providers.	a. Engage providers, counties, and individuals seeking services to assess SUD service supply versus demand and overall network adequacy, including waitlist lengths, geographic coverage, and insurance acceptance. b. Identify successful models from other states such as hub-and-spoke treatment networks, bridge clinic rapid access programs, or expanded telemedicine for addiction treatment that could be replicated in Pennsylvania. c. Provide grants or technical support to launch these models in counties with the longest waits or highest unmet need. d. Build telehealth infrastructure (broadband access, equipment, training) to support remote counseling and medication management. Pursue legislative changes required to authorize expanded teletherapy and tele-pharmacy for applicable licensee types. e. Integrate street medicine models to reach people not accessing facility-based care. Coordinate with mobile service expansion under Recommendation 1 to avoid duplication. f. Establish quality standards and oversight mechanisms for expanding SUD providers, particularly cash-pay and for-profit treatment programs, to ensure accountability and protect individuals seeking care.	• **Availability:** Decrease in the number of people on waitlists for SUD treatment in targeted areas. • **Utilization:** Increase in treatment initiation rates in rural or underserved regions. • **Telehealth uptake:** Number of SUD treatment episodes initiated or maintained via telehealth in targeted areas. • **Quality:** Percentage of newly expanded SUD providers meeting state licensing standards and maintaining good standing within two years of launch.	Interagency Coordination, Funding Needed, and Legislative Action (required for expanded teletherapy and tele-pharmacy)
4. Improve specialized behavioral health services for youth with complex needs. Bolster the system of care for children and adolescents with complex needs by improving coordination, complex care availability, and coverage.	a. Implement recommendations from Pennsylvania's Blueprint for Youth with Complex Needs by creating a cross-agency workgroup with the Blueprint's Steering Committee to prioritize and operationalize its recommendations. b. Allocate funding to expand complex regional care planning pilot models and support county care facilitators (e.g., Child and Adolescent Social Service Program). c. Conduct a gap analysis of the youth care continuum, with a focus on youth in inappropriate settings. Support development of youth-specific crisis services, step-down programs, and expanded waiver capacity to reduce waitlists for youth with co-occurring mental health and intellectual disability needs. d. Engage youth voices in shaping improvements through advisory councils or partnerships.	• **System coordination:** Number of counties with active cross-agency care planning teams for youth with complex needs. • **Outcomes for high-need youth:** Reduced out-of-home placements, improved stability, and fewer crises for youth receiving coordinated complex care services.	Funding Needed and Interagency Coordination

Table 5: Ensuring all populations and regions have access to effective behavioral health care tailored to their needs.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
5. Improve behavioral health support in schools. Treat schools as a critical entry point for care. Pennsylvania implements this through Multi-Tiered System Supports (MTSS). All school services should coordinate with county BH programs and BH-MCOs to prevent duplication and parallel systems.	a. Expand SBAP Medicaid reimbursement for non-IEP Medicaid-eligible students, including expanding the types of behavioral health staff covered (peer specialists, community health workers). b. Require commercial insurers to cover school-based behavioral health services for students. c. Continue to provide funding and implementation supports for evidence-based tiered prevention models, including PBIS and MTSS. Strengthen Student Assistance Programs (SAP) by establishing statewide best practices, inventorying existing school programs that work with courts and offer family peer support, and expanding adoption at lower grade levels. d. Issue guidance encouraging the use of preventive care Medicaid coding (Z-codes), with reimbursement in both schools and primary care settings. e. Require formal memoranda of understanding between school districts, county BH programs, and BH-MCOs to define roles, referral pathways, and data-sharing protocols for school-based services. f. Pursue legislation setting caseload limits for school social workers. Designate a point person in each district to interface with courts regarding families involved in truancy, dependency, and juvenile justice. g. Coordinate with CASSP expansion efforts under Recommendation 4 to ensure school-based services connect to county-level complex care planning for youth with the highest needs.	• **School coverage:** Percentage of districts with dedicated behavioral health support teams and programs. • **Early identification:** Number of students screened and referred for services; changes in Pennsylvania Youth Survey (PAYS) data on student mental health and substance use. • **Overall trends:** Incarceration and juvenile programming rates among school-age youth.	Legislative Action, Funding Needed, and Interagency Coordination
6. Mitigate social media impacts on youth mental health. Promote education and implement safeguards to reduce the negative mental health effects of social media and AI chatbots on children and adolescents.	a. Partner with the Governor's Next Generation Engagement Commission and mental health experts to gather input from youth about how social media, cyberbullying, and certain online content affect their well-being. b. Develop educational campaigns targeted at students and parents about healthy social media use, digital literacy, and coping strategies. c. Collaborate with lawmakers and technology companies to advocate for features that protect youth, including default safety settings, content warnings for suicide or self-harm content, limits on harmful AI chatbot interactions with minors, and mental health resources integrated into social media algorithms. d. Pass a state law requiring social media platforms to implement basic safeguards for users under 18 including warning labels as recommended by former Surgeon General Vivek Murthy informed by outcomes from jurisdictions that have implemented youth social media restrictions.	• **Awareness:** Number of schools implementing social media mental health curriculum or workshops. • **Safety measures:** Number of major social media platforms adopting new youth protections or complying with proposed standards. • **Youth outcomes:** Trends in reported anxiety, depression, or incidents linked to social media use (monitored via youth mental health surveys over time).	Interagency Collaboration and Legislative Action

Table 5: Ensuring all populations and regions have access to effective behavioral health care tailored to their needs.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
7. Provide training for providers and caregivers of older adults. Ensure health care providers, aging services staff, and family caregivers are equipped to address mental health and SUD in older populations, and build the capacity needed to serve older adults with complex behavioral health needs, including dual diagnosis (mental illness and dementia) and co-occurring medical conditions.	a. Develop cross-training programs for geriatric care providers including primary care physicians, neurologists, psychologists, neuropsychologists, and nursing home staff strengthening their ability to distinguish between Alzheimer's disease, other cognitive conditions, and SUDs while building broader knowledge of mental health in older adults. b. Expand the use of Healthy Ideas, an evidence-based program, to screen for depression and promote social connections for older adults. c. Create state-supported continuing education courses on topics such as suicide prevention for older adults, managing alcohol or medication misuse, and trauma-informed care. d. Provide educational resources to family members and caregivers, including workshops and online guides on supporting an aging loved one with mental health or addiction challenges. e. Launch public awareness campaigns to help communities identify signs of mental health conditions or SUD in older adults and connect them to available resources. f. Consider incentives or regulatory requirements for health care facilities to ensure staff complete specialized trainings. Solicit stakeholder input from nursing homes and long-term care facilities to assess capacity and feasibility before imposing new mandates. Provide financial incentives to address staff turnover and retain trained staff. g. Develop specialized facilities or units across the state to serve geriatric individuals with complex presentations, including those with dementia, co-occurring conditions, and histories of incarceration. h. Expand contracts with private agencies that provide in-house behavioral health services to nursing homes and long-term care facilities.	• **Competency:** Number of health care and caregiving staff completing specialized older-adult behavioral health training. • **Quality of care:** Improvement in detection and appropriate referral rates for mental health or SUD in older adults. • **Capacity:** Number of specialized geriatric behavioral health facilities or units operational statewide. • **Integration:** Number of long-term care facilities with contracted in-house behavioral health services.	Regulatory Changes, Legislative Action, and Funding Needed
8. Build a diverse and culturally responsive workforce. Increase workforce diversity and ensure providers are trained in cultural competence and humility to better serve all communities. All policies and programs under this recommendation should emphasize equality of opportunity, professional competence, and individualized need consistent with constitutional and statutory requirements.	a. Incorporate diversity and underserved-area criteria into the loan repayment and scholarship programs established under Goal 3, Recommendation 10. Coordinate recruitment with HBCUs and other minority-serving institutions to build a pipeline of diverse providers. b. Strengthen training curricula with Cultural and Linguistic Appropriate Services (CLAS) standards. Require or incentivize all behavioral health provider organizations to integrate cultural competency, language access, and anti-stigma training as part of staff development. c. Encourage provider organizations to adopt inclusive hiring practices and track workforce demographic data. Support development of career advancement pathways for bilingual and bicultural staff. d. Ensure all diversity and cultural responsiveness initiatives are designed consistent with constitutional and statutory requirements, emphasizing equality of opportunity and individualized assessment rather than prescriptive demographic targets.	• **Training completion:** Percentage of behavioral health provider organizations with staff completing CLAS-standards cultural competency and anti-stigma training. • **Language access:** Number of counties with behavioral health services available in non-English languages relative to community need.	Funding Needed and Regulatory Changes

Goal #6

Improve Criminal Justice and Behavioral Health Integration

A significant number of individuals with mental health conditions or SUDs become involved in the criminal justice system, often because appropriate care was not accessible at the right time. The Council noted that jails and prisons have become "de facto" treatment providers for many, which is neither appropriate for the individual nor cost-effective for society. Discussions highlighted several critical points: police and other first responders need better options beyond arrest when encountering someone in a behavioral health crisis; historically, lengthy delays in competency evaluations and restoration services leave people with mental illness languishing in jail awaiting treatment; and upon re-entry from incarceration, people often lack continuity of care, leading to relapse or recidivism. Additionally, the MHPA sets rules for involuntary treatment; however, limited access to community services, additional strains on hospitals and courts, and ongoing debates about balancing individual rights with public safety continue to challenge its effective implementation. Data on the justice-behavioral health overlap is limited — improving data collection and sharing is key to driving change.

This goal builds on Pennsylvania's current efforts to improve justice system responses to behavioral health concerns and focuses on strategies to divert individuals to treatment instead of incarceration when safe and appropriate, improve services within the justice context, and support people returning to the community. By relying on Pennsylvania's strong track record of collaboration between behavioral health and justice agencies, the Commonwealth can reduce unnecessary justice system involvement and improve outcomes for some of its most vulnerable citizens.

Criminal Justice and Behavioral Health Highlights and Accomplishments

- **Guiding Statewide Coordination**
  Since 2009, in partnership with OMHSAS, PCCD's MHJAC has supported the Commonwealth's initiatives to expand evidence-based practices for justice-involved individuals with mental illness and co-occurring SUDs.
- **Improving Continuums of Care**
  Pennsylvania Courts in partnership with PCCD held the first statewide summit on Behavioral Health in the Courts. Seven regional councils were created to help counties implement this initiative beginning in Fall 2025.
- **CIT Technical Assistance Center**
  PCCD started a first-of-its-kind statewide Crisis Intervention Team Technical Assistance Center (CIT TAC).
- **Expanding Access to Medications**
  Act 45 of 2025 expanded access to FDA-approved agonist forms of Medication-Assisted Treatment (MAT) through PCCD's MAT in County Jails Grant Program during FY 2025-26. Previously only naltrexone could be purchased.

Table 6: Integrating behavioral health at every intercept of the criminal justice system.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
1. Improve the competency evaluation and restoration process. Reduce the time individuals with mental illness spend incarcerated awaiting evaluation or treatment to become competent for trial. Prioritize community-based restoration over expanding institutional capacity.	a. Build on the recently completed analysis of bottlenecks in the competency evaluation system and establish a short timetable for implementation, given that barriers are well documented. b. Scale existing mobile forensic evaluation programs statewide, deploying clinicians to jails to conduct competency assessments on-site rather than waiting for transport to distant facilities. Train local treatment providers to deliver the educational component of competency restoration. c. Expand community-based restoration programs, drawing on successful models such as Allegheny County's mobile restoration unit and the Miami model for diverting cases from the competency track through community treatment and reintegration. Allocate resources to move individuals through the forensic system more efficiently through community-based pathways rather than increasing institutional bed capacity. d. Encourage counties to establish dedicated competency dockets to ensure efficient case processing. Update court procedures to fast-track cases once a person is restored to competency. e. Pursue legislative and regulatory changes to expand the permitted professional credentials for completing evaluations and consider establishing a 30-day maximum wait time for competency evaluations as a statutory requirement in the Mental Health Procedures Act.	• **Timeliness:** Average wait time for court-ordered competency evaluations and restorations (goal: no individual waiting more than 30 days) • **Throughput:** Number of individuals undergoing restoration services in community settings versus institutional settings. • **Restoration outcomes:** Percentage of individuals successfully restored to competency through community-based programs, and average time to restoration.	Funding Needed and Legislative Action
2. Strengthen county-level criminal justice-behavioral health programs. Map and enhance diversion and treatment programs at each "intercept" of the Sequential Intercept Model (SIM). The state team should facilitate SIM mapping for both adult criminal justice and upstream systems.	a. Require counties to adopt the SIM framework to plan improvements, with state-provided technical assistance, templates, and funding to support adoption. b. Facilitate a cross-agency state team including mental health officials, substance use authorities, courts, corrections departments, and hospitals to assist counties in developing or expanding the SIM Model through technical assistance, seed grants, and connections to federal grant opportunities. c. Enact legislation requiring regular annual reporting from counties on programming at each intercept and outcomes achieved. d. Use findings from county SIM mapping to identify the need for alternative treatment settings such as specialized forensic group homes or supervised supportive living with enhanced treatment for individuals who can be served in community settings rather than incarcerated, particularly those with ASD or IDD. e. Dedicate funding to pilot programs identified through SIM mapping, with sustained funding for models that demonstrate reduced recidivism and improved outcomes.	• **SIM adoption:** Percentage of counties that have completed formal SIM mapping and submitted improvement plans. • **Program coverage:** Percentage of counties with at least one diversion or support program at each major intercept (pre-arrest, post-booking, courts, incarceration, re-entry). • **Outcome improvement:** Reduction in recidivism rates or jail days for individuals in specialized programs compared to baseline.	Legislative Action, Interagency Coordination, and Funding Needed

Table 6: Integrating behavioral health at every intercept of the criminal justice system.

Recommendation	High-Level Action Steps	Performance Measures	Policy Lever
3. Expand re-entry support through Medicaid waiver. Leverage Medicaid to provide care for incarcerated individuals nearing release and extend that support to all counties. Ensure continuity of primary care, psychiatric medications, and chronic disease management at the point of re-entry to reduce recidivism and acute care utilization.	a. Implement and monitor Pennsylvania's "Keystones to Health" 1115 Medicaid waiver in initial participating counties. Collect data on enrollment timelines, service utilization, and care continuity to inform statewide expansion. b. Working within the cross-agency data-sharing framework established under Goal 4, Recommendation 3, ensure health information flows appropriately from correctional facilities to community providers in compliance with HIPAA, 42 CFR Part 2, and CHRIA. c. Expand adoption of PCCD's Reentry Coalition Minimum Operating Standards. Require correctional facilities participating in the Medicaid waiver to develop individualized transition plans for every individual with a behavioral health condition, including scheduled community appointments and transferred medical records prior to release. d. Accelerate the connection between pre-incarceration behavioral health data and jail admissions to support early identification of individuals with serious and persistent mental illness (SPMI) for re-entry planning. e. Standardize staff qualifications and training requirements for post-release care coordination, informed by consultation with reentry coalitions and examination of effective models such as GEO Reentry.	• **Continuity of care:** Percentage of individuals enrolled in Medicaid and linked to a community behavioral health provider on the day of release. • **Re-incarceration:** 12-month recidivism rate for individuals receiving pre-release Medicaid-covered services compared to those who did not. • **SPMI identification:** Percentage of individuals with SPMI identified at jail admission and connected to re-entry planning within 30 days of incarceration. • **Post-release outcomes:** Treatment engagement, housing stability, and employment at one year post-release.	Interagency Coordination, Legislative Action and Funding Needed
4. Expand SUD and MH service availability for people who are incarcerated. Ensure adequate behavioral health treatment during incarceration across county and state facilities. The ultimate goal is effective treatment during incarceration that supports successful re-entry and community-based recovery.	a. Conduct a comprehensive review of mental health and SUD service availability during incarceration across jails, state prisons, and probation/parole identifying gaps in capacity, regulatory barriers, and funding shortfalls by county and facility type. b. Propose legislation or allocate funding to expand mental health/SUD services in high-need facilities, particularly MAT across all jails and prisons. Continue to support legislation making MAT agonist access permanent in county jails. c. Ensure discharge planning begins early in the incarceration period, particularly for individuals with SMI or complex histories, addressing transportation, housing, community appointments, and employment before release. Coordinate with re-entry planning efforts under Recommendation 3. d. Annually review mental health/SUD programming across incarceration and supervision systems. Ensure that services are accessible to all incarcerated individuals regardless of facility size, location, or the complexity of their behavioral health needs.	• **Capacity:** Percentage of county and state correctional facilities meeting defined minimum standards for mental health/SUD service availability. • **Quality:** Standardized mental health/SUD process and outcome measures for incarcerated individuals (treatment engagement rates, medication continuity). • **Post-release safety:** All-cause mortality rate within 6 months of release for individuals with SUD, tracked through DOH overdose surveillance and DOC records, with comparison between those who received MAT during incarceration and those who did not.	Legislative Action, Funding Needed, and Interagency Coordination

Closing

Creating the ideal behavioral health care system in Pennsylvania

will require collaboration among agencies to unify and focus efforts on evidence-based, high-quality practices.

The state's vision is to build seamless service delivery through the mental health and SUD care continuum, where any person can access the appropriate level of care they need from any entry point into the system. State agencies and counties have been working towards this goal by promoting transparency, accountability, quality-based system improvements, and equity initiatives; however, these efforts need to be synthesized and integrated. By expanding effective models of care, identifying regulatory alignment opportunities, and enhancing data sharing, state agencies can lead the charge to achieve an ideal system of mental health and SUD care in Pennsylvania.

The above goals and recommendations form a comprehensive statewide action plan to transform Pennsylvania's behavioral health system. By focusing on integration, access, workforce, accountability, equity, and criminal justice, the plan addresses the system's most pressing challenges. These strategies will help create a behavioral health system that is easier to navigate, more person-centered, and outcomes-driven, reflecting Governor Shapiro's commitment to breaking down silos and delivering results for Pennsylvanians.

Implementation will require ongoing collaboration across state agencies, counties, providers, payers (including insurers), communities, and people with lived experience. Broader deliberative stakeholder input is warranted before final implementation to avoid unintended consequences that could create additional barriers to the delivery of care. Moving forward, strong leadership and multi-sector engagement will be key, including phasing initiatives, securing necessary funding, enacting policy changes, and rigorously evaluating progress. By pursuing these recommendations, Pennsylvania can become a national leader in behavioral health, ensuring that every resident has the opportunity to lead a healthy, full life.

Acknowledgement

The Pennsylvania Behavioral Health Council Action Plan reflects months of meetings, discussions, and critical analysis of the Commonwealth's behavioral health system. The Council and its Advisory Committee brought diverse perspectives, professional expertise, and personal commitment to developing a bold, results-driven plan for transforming mental health and substance use disorder care across Pennsylvania.

We thank the members of the Behavioral Health Council and the Advisory Committee for their time, diligence, and candor throughout this process. We also express gratitude to the Department of Human Services, the Office of Mental Health and Substance Abuse Services, the Department of Drug and Alcohol Programs, the Department of Health, the Pennsylvania Insurance Department, and the Department of Aging for their support throughout the development of this plan. This work would not have been possible without the leadership and guidance of Lindsey Mauldin, Deputy Chief of Staff for Health and Human Services, and Meghna Patel, Deputy Secretary for Policy and Planning.

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Pennsylvania Behavioral Health Council

- **Dr. Christina Finello,** *PhD, Esq. Executive Director of PA Behavioral Health Council*
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Behavioral Health Council Members

Commonwealth Representatives

- **Akbar Hossain,** *Secretary of Policy and Planning and Chair*
- **Dr. Valerie Arkoosh,** *Secretary of the Department of Human Services and Co-Chair*
- **Dr. Debra Bogen,** *Secretary of the Department of Health*
- **Michael Humphreys,** *Commissioner of the Pennsylvania Insurance Department*
- **Jason Kavulich,** *Secretary of the Department of Aging*
- **Dr. Latika Davis-Jones,** *Secretary of the Department of Drug and Alcohol Programs*
- **Cathy Hall,** *MPA, Special Assistant to the Secretary, on behalf of Dr. Carrie Rowe, Acting Secretary of the Department of Education*
- **John Noll,** *Executive Assistant to the Adjutant General, on behalf of Major General John Pippy, Adjutant General of the Department of Military and Veterans Affairs*
- **Captain Leslie Barr,** *Policy and Legislative Affairs Office Director, on behalf of Lt. Colonel George Bivens, Acting Commissioner of the Pennsylvania State Police*
- **Dr. Elicia Stein,** *Regional Licensed Psychologist Manager, on behalf of Dr. Laurel Harry, Secretary of the Department of Corrections*
- **Al Schmidt,** *Secretary of the Department of State*
- **Sara Gligora,** *Regional Program Outreach Coordinator, on behalf of Russell Redding, Secretary of the Department of Agriculture*
- **Kirsten Kenyon,** *Executive Director, Pennsylvania Commission on Crime and Delinquency*
- **Denise Verchimak,** *Bureau Director, Office of Vocational Rehabilitation, on behalf of Nancy Walker, Secretary of the Department of Labor and Industry*
- **Toni McIntyre,** *on behalf of Annie Newman, Director of Digital Strategy*
- **Brittney Kline,** *Director, Attorney General's Safe2Say Something Program*
- **Jennifer Smith,** *Deputy Secretary, Department of Human Services, Office of Mental Health and Substance Abuse Services*

Representatives with Lived Experience and Family Members

- **Robert Hamilton,** *MPPM, Director, Westmoreland County Department of Human Services*
- **Kate Favata,** *Community Engagement Manager, Crossroads Treatment Center*
- **Jennifer Wilt,** *President, NAMI of Cumberland and Perry Counties*

County Representatives

- **Tina Clymer,** *County Mental Health Office, Carbon, Monroe, and Pike Counties*
- **Pam Howard,** *County Mental Health Office, Montgomery County*
- **Kristin Varner,** *Single County Authority, Dauphin County*
- **Lynn Deardorff,** *Area Agency on Aging, Adams County*
- **Dr. Shannah Gilliam,** *Area Agency on Aging, Allegheny County*

Clinical Representatives

- **Dr. Amy Kim**
- **Dr. Margaret Jarvis**
- **Dr. Jack Todd Wahrenberger**
- **Dr. Wendy Ross**

Legislative Representatives from the Pennsylvania General Assembly

- **Representative Mike Schlossberg (D)**
- **Representative Jim Struzzi (R)**
- **Senator Maria Collett (D)**
- **Senator Michele Brooks (R)**

Advisory Committee Members

- **Robert J. Tomassini**
- **Eric Kiehl**
- **Matthew Hurford, MD**
- **Annie Strite, MA**
- **Commissioner George Hartwick**
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- **Michele Denk**
- **Laurie Friedman, PhD, MPA, LCSW**
- **Michael Harper, Esq.**
- **Erich Curnow**
- **Richard Edley, PhD**
- **Molly Cowan, PsyD**
- **Jennifer Passaniti**
- **Jessica Fenchel**
- **Roxanne Elizabeth Epperson**
- **Joyce Lukima**
- **Lynn Cooper**
- **Mitchell Crawford, DO**
- **Sandy Swogger**
- **Amanda Kingston, MD**
- **Jennifer Jordan**
- **Frederick Ramirez**
- **Sally Walker**
- **Matthew Wintersteen, PhD**

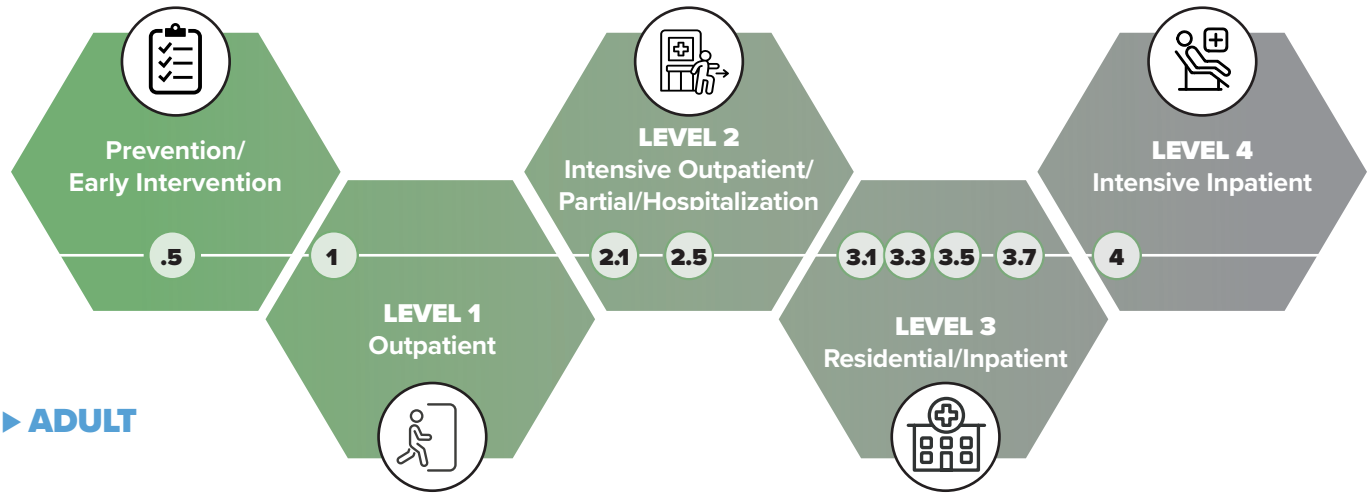
Appendices

Systems of Care Visuals
Pennsylvania Behavioral Health Funding Acronyms

Appendix A: Systems of Care Visuals

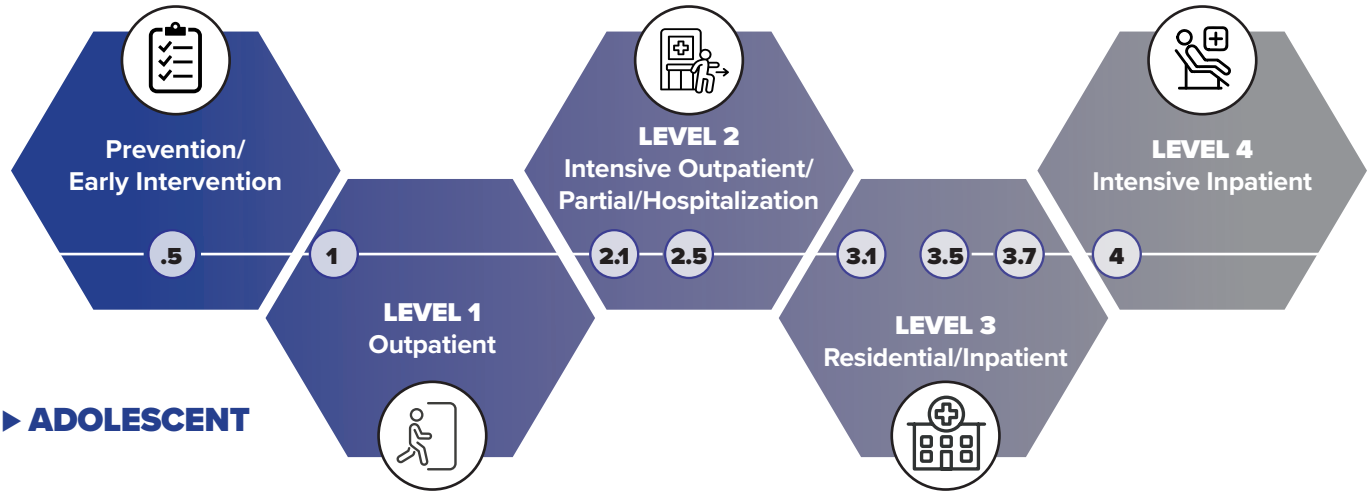
Substance Use Disorder System

ASAM 3rd Edition Continuum of Care Graphic with Levels of Care for Adult and Adolescents[6]



▶ **ADULT**

- .5 Early Intervention
- 1 Outpatient Services
- 2.1 Intensive Outpatient Services
- 2.5 Partial Hospitalization Services
- 3.1 Clinically Managed Low-Intensity Residential Services
- 3.3 Clinically Managed Population-Specific High-Intensity Residential Services
- 3.5 Clinically Managed High-Intensity Residential Services
- 3.7 Medically Monitored Intensive Inpatient Services
- 4 Medically Managed Intensive Inpatient Services



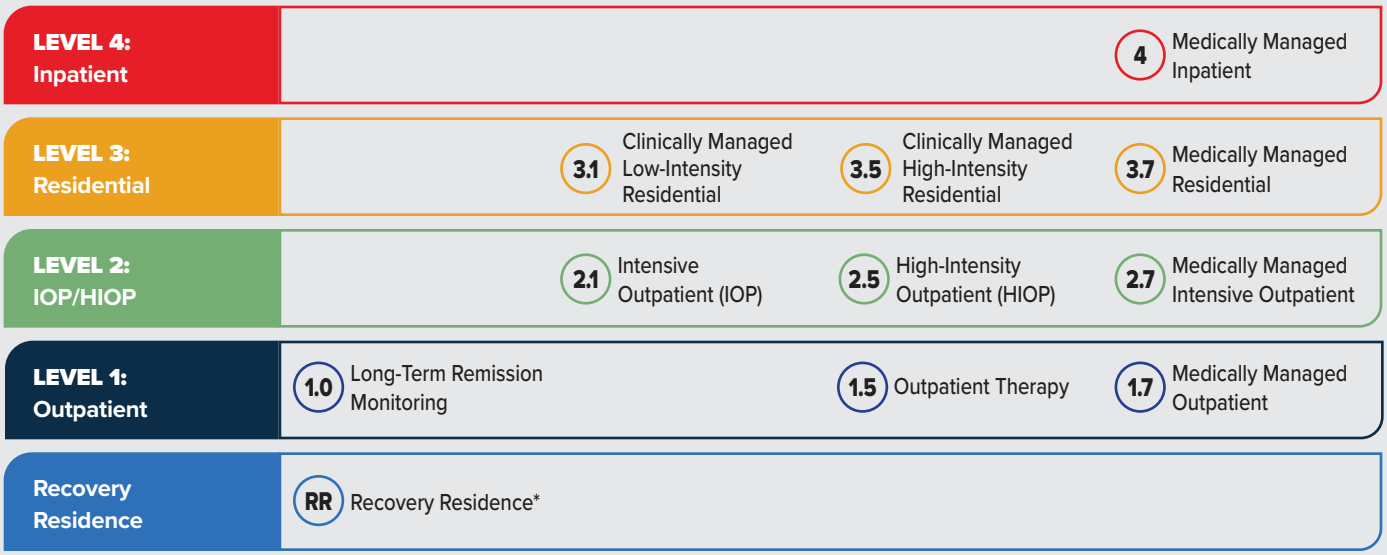
▶ **ADOLESCENT**

- .5 Early Intervention
- 1 Outpatient Services
- 2.1 Intensive Outpatient Services
- 2.5 Partial Hospitalization Services
- 3.1 Clinically Managed Low-Intensity Residential Services
- 3.5 Clinically Managed High-Intensity Residential Services
- 3.7 Medically Monitored Intensive Inpatient Services
- 4 Medically Managed Intensive Inpatient Services

NOTE: 6 — https://www.asam.org/asam-criteria/asam-criteriB-3rA-edition

ASAM Criteria Continuum of Care for Adult Addiction Treatment

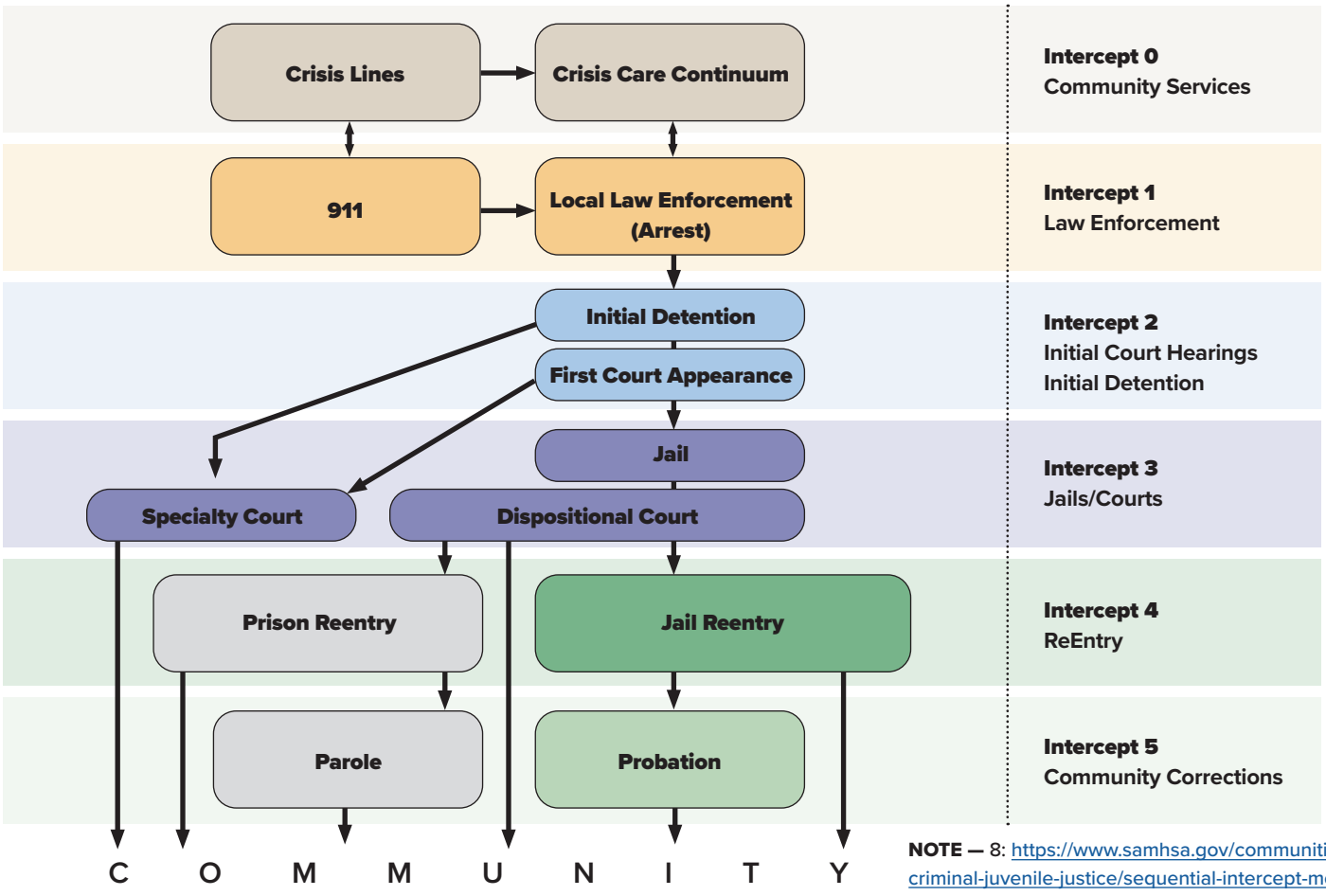
ASAM 4th Edition Continuum of Care Graphic for Adult Addiction Treatment.[7]



NOTE: 7 — https://www.asam.org/asam-criteria/asam-criteria-4th-edition

Criminal Justice System

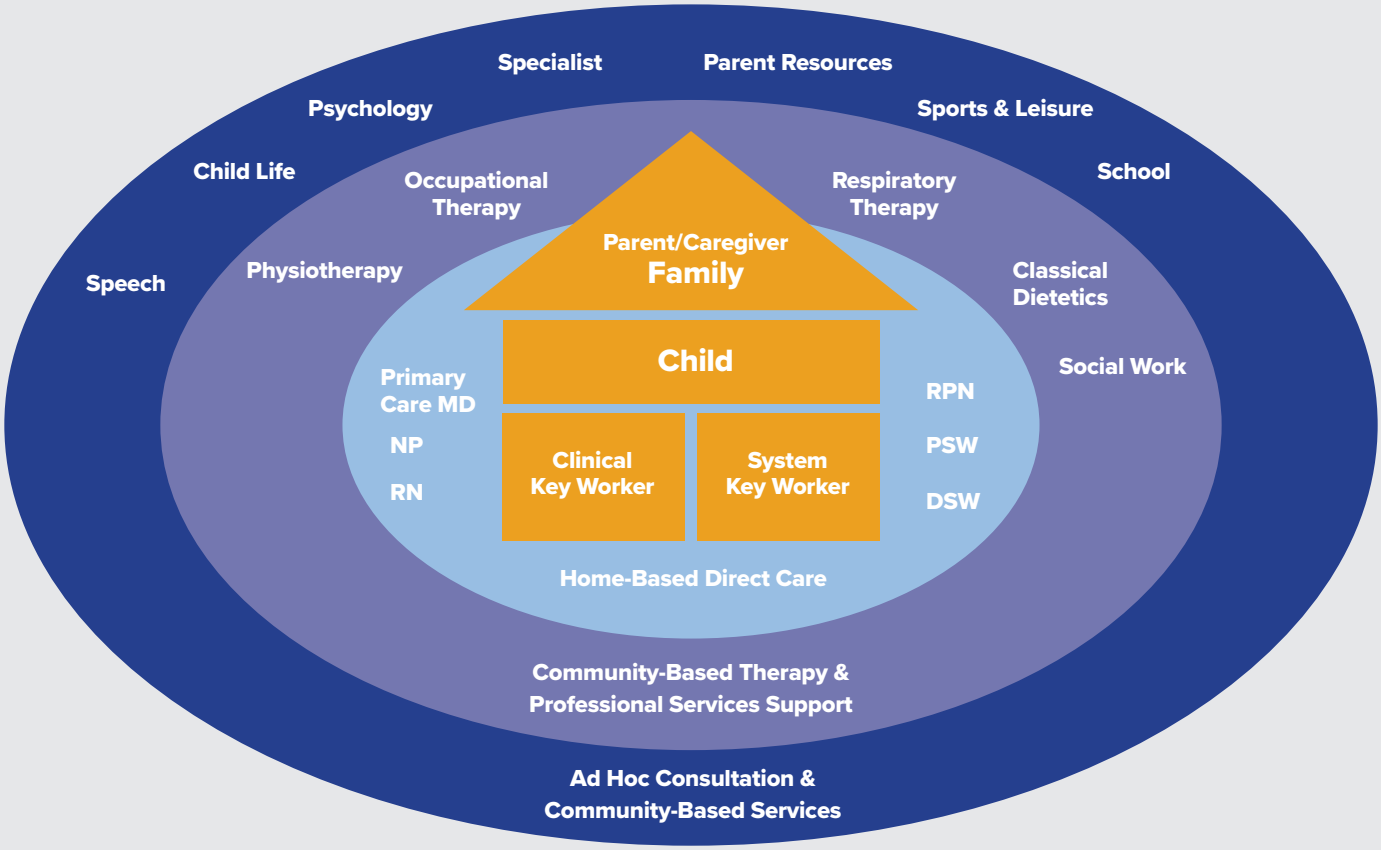
SAMHSA Sequential Intercept Model (SIM) For Resource Mapping. [8]



NOTE — 8: https://www.samhsa.gov/communities/criminal-juvenile-justice/sequential-intercept-model

Youth Complex Care Model

Conceptual Model of Integrated Care for Youth with Complex Care Needs[9]



Definitions: DSW — Developmental Services Worker; MD — Physician; NP — Nurse Practitioner; PSW — Personal Support Worker; RN — Registered Nurse; RPN — Registered Practical Nurse

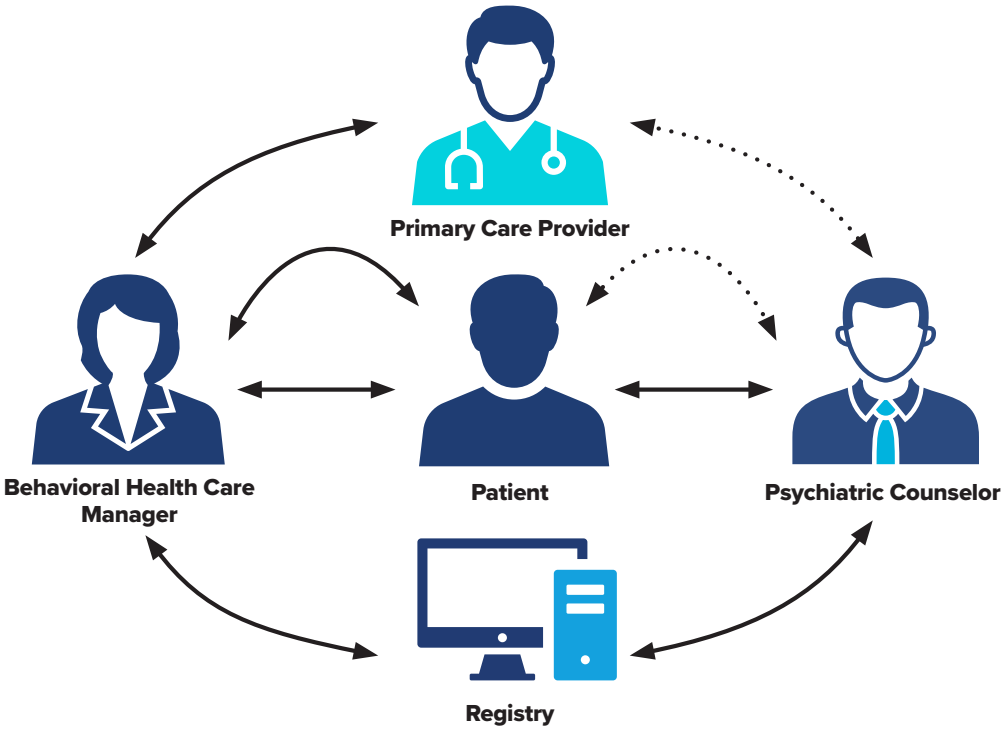
NOTE: 9 — Cohen E, Bruce-Barret C, Kingsnorth S, et al. "Integrated Complex Care model: Lessons Learned from Inter-organizational Partnership". Healthcare Quarterly. October 2011. 14(3). p.64-70. doi:10.12927/hcq.0000.22580

The Collaborative Care Model

Collaborative Primary Care-Behavioral Health Delivery.[10]

Frequent Contact

Infrequent Contact



NOTE: 10 — https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrateA-care/learn

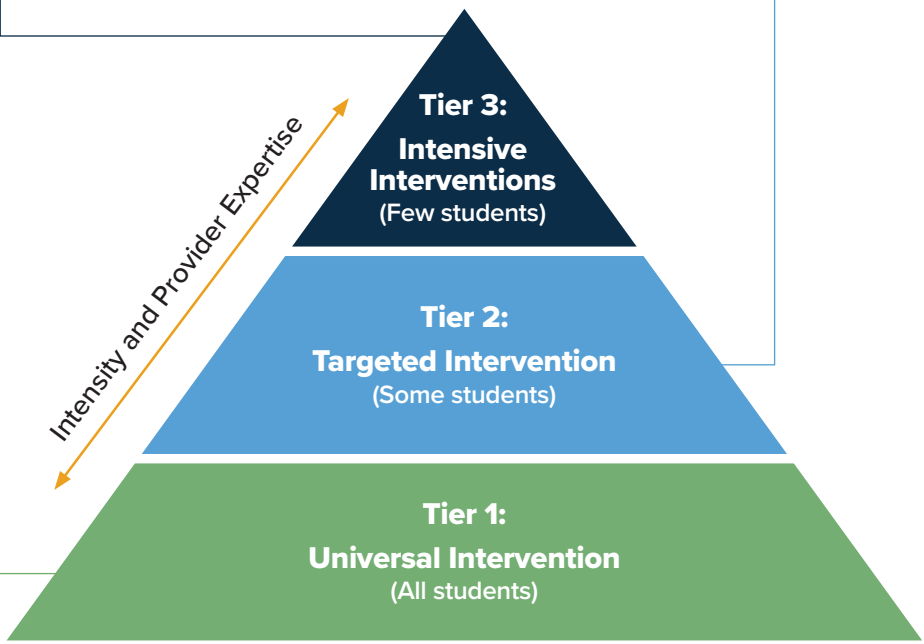
School-Based Behavioral Health Model

Comprehensive Model for School-Based BH Prevention and Intervention.[11] *Note: Pennsylvania implements this system called Multi-Tiered System Supports (MTSS).*

Source: *Adapted from the Colorado Education Initiative's Colorado Framework for School Behavioral Health Services and Boston Public Schools' Comprehensive Behavioral Health Model.*

- Intended for students who have not responded to well-implemented Tier 1 or 2 supports.
- About 1-5% of students will require this level of assistance.
- Services should be individualized to meet the student's need, such as lessons, intervention or treatment for anger, depression, or anxiety.

- Intended for students who have not responded to well-implemented Tier 1 supports.
- About 5-10% of students may need these supports.
- Services are short-term, such as social skills groups, anxiety groups, and other evidence-based interventions.

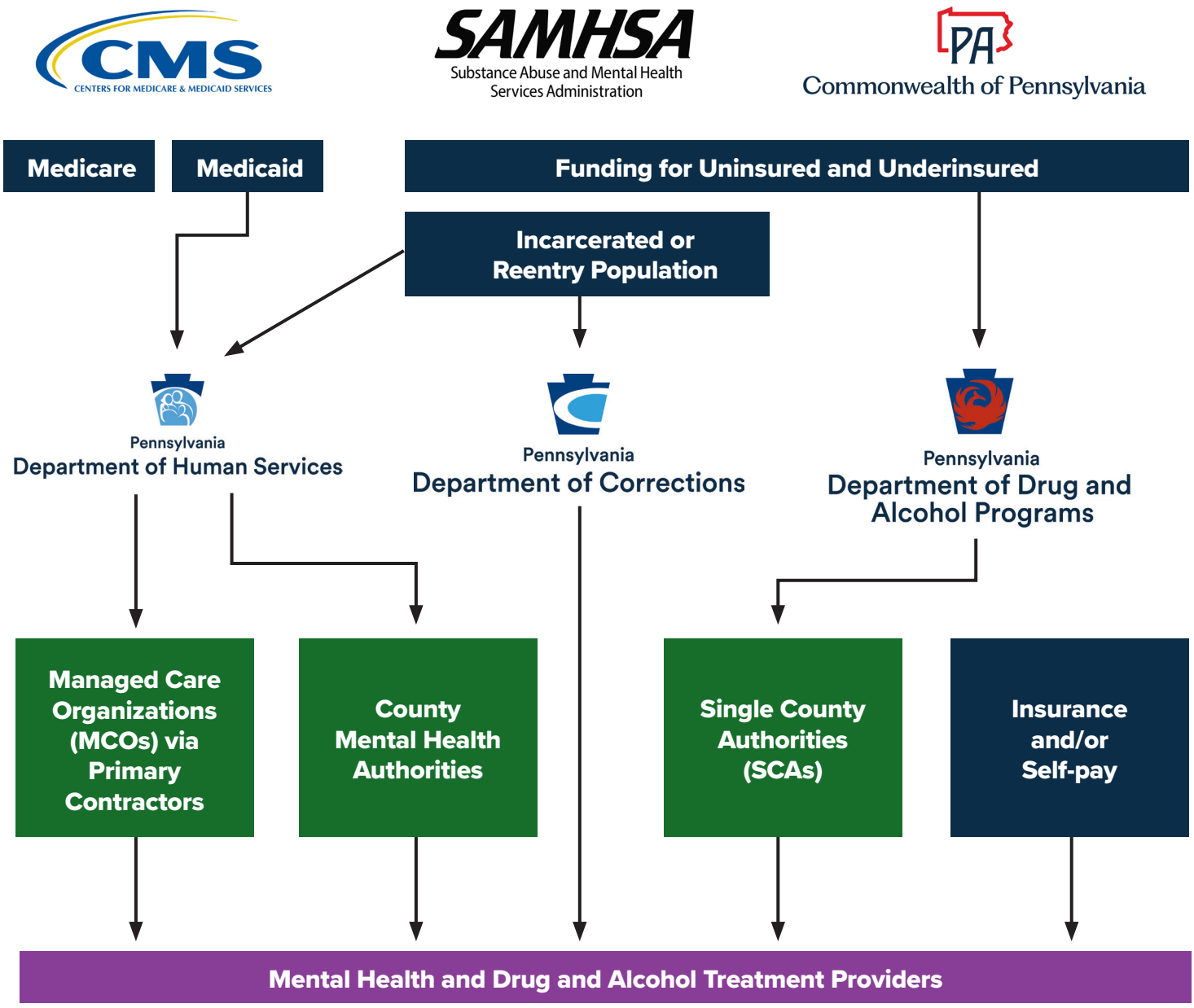


- Intended to be delivered to all students.
- Most students will be successful with these services and do not need Tier 2 or 3 supports.
- Services are preventive and proactive, such as positive behavioral supports, social and emotional learning opportunities, behavioral health screening, and referral processes.

NOTE: 11 — https://www.coloradohealthinstitute.org/research/reaching-kids-crisis

Appendix B: Pennsylvania Behavioral Health Funding Map

Behavioral Health Funding in Pennsylvania



Appendix C: Acronyms

AAA: Area Agency on Aging

AI: Artificial Intelligence

AOPC: Administrative Office of the Pennsylvania Courts

AOT: Assisted Outpatient Treatment

APCD: All Payers Claims Database

ASAM: American Society of Addiction Medicine

ASD: Autism Spectrum Disorder

BH: Behavioral Health

BHHP: Behavioral Health Home Plus

BH-MCO: Behavioral Health Managed Care Organization

BOOST: Building Opportunities through Out of School Time

CARF: Commission on Rehabilitation Facilities

CASSP: Child and Adolescent Social Service Program

CCAP: County Commissioners Association of Pennsylvania

CCBHC: Certified Community Behavioral Health Clinic

CE: Continuing Education

CFR: Code of Federal Regulations

CHOP: Children's Hospital of Philadelphia

CHRIA: Criminal History Record Information Act

CIS: Community Intervention Services

CIT: Crisis Intervention Team

CIT TAC: Crisis Intervention Team Technical Assistance Center

CLAS: Cultural and Linguistic Appropriate Services

CMS: Centers for Medicare and Medicaid Services

COD: Co-occurring disorders

CODE PA: Commonwealth Office of Digital Experience

CRNP: Certified Registered Nurse Practitioner

CRR: Community Residential Rehabilitation

DAACA: Drug and Alcohol Abuse and Control Act — Pennsylvania

DDAP: Pennsylvania Department of Drug and Alcohol Programs

DHS: Pennsylvania Department of Human Services

DOC: Pennsylvania Department of Corrections

DOH: Pennsylvania Department of Health

DOS: Pennsylvania Department of State

DSM: The Diagnostic and Statistical Manual of Mental Disorders

ELS: Enterprise Licensing System

EMS: Emergency Medical Services

EPSDT: Early and Periodic Screening, Diagnostic, and Treatment

FDA: Food and Drug Administration

FERPA: Family Educational Rights and Privacy Act

FQHC: Federally Qualified Health Centers

HB: House Bill

HBCU: Historically Black Colleges and Universities

HIPAA: Health Insurance Portability and Accountability Act

HRSA: Health Resources and Services Administration

ICP: Integrated Care Plans

IDD: Intellectual and Developmental Disabilities

IEP: Individualized Education Program

LRP: Pennsylvania Department of Health Primary Care Loan Repayment Program

LTSR: Long-term Structured Residences

MAT: Medication-Assisted Treatment

MATP: Medical Assistance Transportation Program

MCO: Managed Care Organization

MEMM: Medicaid Monitoring Enterprise Module

MH: Mental Health

MHJAC: Mental Health Justice Advisory Committee

MHPA: Mental Health Procedures Act

MOUD: Medications for Opioid Use Disorder

MTSS: Multi-Tiered System Supports

OCR: Office for Civil Rights

OMAP: Office of Medical Assistance Programs

OMHSAS: Office of Mental Health and Substance Abuse Services

OUD: Opioid Use Disorder

PA PQC: Pennsylvania Perinatal Quality Collaborative

PASSHE: Pennsylvania State System of Higher Education

PAYS: Pennsylvania Youth Survey

PBIS: Positive Behavior Intervention Support

PCBH: Primary Care Behavioral Healthcare

PCCD: Pennsylvania Commission on Crime and Delinquency

PDMP: Prescription Drug Monitoring Program

PEMA: Pennsylvania Emergency Management Agency

PENNDOT: Pennsylvania Department of Transportation

PHC4: Pennsylvania Health Care Cost Containment Council

PH-MCO: Physical Health Managed Care Organization

PID: Pennsylvania Insurance Department

PROMISe: Provider Reimbursement and Operations Management Information System

PRS: Psychiatric Rehabilitation Services

SAMHSA: Substance Abuse and Mental Health Administration

SAP: Student Assistance Program

SB: Senate Bill

SBAP: School-Based ACCESS Program

SCA: Single County Authority

SIM: Sequential Intercept Model

SMI: Serious Mental Illness

SPMI: Serious and Persistent Mental Illness

SUD: Substance Use Disorders

TBI: Traumatic Brain Injury

TiPS: Telephonic Psychiatric Consultation Service Program

UPMC: University of Pittsburgh Medical Center

VIP: Violence Intervention and Prevention

Behavioral Health Council Action Plan 2026

Commonwealth of Pennsylvania