



SUPPORTING THE JOURNEY

*Transforming Pennsylvania's Behavioral
Health System*

Office Of Mental Health and Substance Abuse Services

2010

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- VII. **State Hospital Services** – Changes in the State Hospital system, including patient census, community transition services, and financing the transformation.
- VIII. **Quality Management** –OMHSAS efforts to monitor services to ensure quality, access, and consumer satisfaction.

I hope *Supporting the Journey* serves both to inform its readers and to stimulate dialogue about a vision for transitions yet to come.

Sherry H. Snyder
Acting Deputy Secretary

- 1994 **Therapeutic Staff Support (TSS), Mobile Therapy, and Behavioral Specialist consultant services** - Added to the fee schedule for Medicaid funding
- 1995 **OMH Vision Statement** - Vision Statement adopted that embraces the concept of recovery and a life in the community for all
- 1995 **Farview State Hospital** - Closed
- 1996 **ACT 152 Administered by OMHSAS** – Funding for D&A Medicaid service prior to MA enrollment
- PMHCA Founded** – Pennsylvania Mental Health Consumer Association founded
- 1996 **Somerset State Hospital** - Closed
- 1997 **HC BH Program Begins** -Health Care Finance Agency (HCFA), now Center for Medicaid and Medicare Services (CMS), approves initial HealthChoices Behavioral Health Medicaid managed care program in 5 southeast counties
- Behavioral Health Service Initiative (BHSI)** - Established and administered by OMHSAS to fund D&A services for individuals who are not eligible for Medicaid
- Eastern State School and Hospital** - Closed
- 1998 **OMHSAS Name Change** – Office of Office of Mental Health changes name to add “Substance Abuse Service” in recognition of its administration of D&A funds
- Haverford State Hospital** – Closed
- Family Based Mental Health Services** – Created for children under 21 and their families
- 1999 **Southwest HC BH zone** - 10 SW counties begin HC BH program. C/FST required for HC program to measure member satisfaction
- U.S. Supreme Court Olmsted Decision** – Affirmed the right of individuals with disabilities to live in the community
- U.S. Surgeon General Report on Mental Health** – Stated recovery should be an expectation not the exception in mental health care

CHIPP Guidelines - OMHSAS issued Community Hospital Integration Projects Program (CHIPP) final guidelines and formalized program, information, and financial requirements to promote the discharge of individuals in state hospitals and to build community infrastructure

MISA Consortium Report – Written recommendations for a system of care for persons with co-occurring mental illness and substance use disorders (MISA)

2000 **Innovations in American Government Award** – OMHSAS initiative to eliminate use of seclusion and restraint in state hospitals was recognized by the Harvard Kennedy School

Youth Suicide Prevention Task Force – Created to develop Youth Suicide Prevention Plan

2001 **Lehigh/Capital HC BH Zone**- Ten counties in Lehigh/Capital begin HC BH program

Presidents New Freedom Initiative (NFI) - Nationwide effort to remove barriers to community living for people of all ages with disabilities and long-term illnesses

MISA Pilot Projects - Solicitation for Pilot Projects that Integrate Services and Systems of Care for Persons with Co-occurring Mental Health and Substance Abuse Disorders – 5 MISA pilot projects funded to develop services models

Co-occurring Core Training Curriculum - Developed a Co-occurring Core Training Curriculum for professionals in partnership with Drexel University

2003 **Achieving the Promise: Transforming Mental Health Care in America** – Final New Freedom Initiative (NFI) report issued. Concludes system is not oriented to single most important goal – the hope of recovery

OMHSAS Guiding Principles – Stakeholder partnered with OMHSAS to establish a set of guiding principles that would direct future priorities

Community/Hospital Integration Plan- OMHSAS implements Service Area Planning (SAP) to target discharge of persons in state hospitals over two years

Co-occurring State Incentive Grant (COSIG) – SAMSHA grant awarded to implement integrated mental health/drug and alcohol treatment programs and policies; five MISA/COD pilots awarded

2004 **OMHSAS Statewide Advisory Committee** – Restructured to be more inclusive and responsive to stakeholder community; children, adult and older adult sub-committees establish priority objectives

OMHSAS Recovery Workgroup – Established to develop blueprint for a more recovery-oriented service system

DPW Integrated Children’s Service Plan (ISCP) – Established guidelines for integrated plan across all child-serving systems

Centers for Medicare and Medicaid Services Mental Health Systems Transformation Grant - \$300,000 awarded to OMHSAS for the development and refinement of a training curriculum and peer certification process known as the Pennsylvania Peer Specialist Initiative (PSI)

Performance Based Contracting – Issued baseline report of selected performance measures for the HC-BH program in the SE, SW and Lehigh/Capital zones (25 counties)

Transition Age Youth Pilot – Project funds awarded to five counties

Autism Task Force – Published final report recommending the creation of an autism program office in Pennsylvania

Co-Occurring Disorder Professional Credential (CCDP) – Credential developed in collaboration with the Pennsylvania Certification Board for competency-based certification for professionals working with persons diagnosed with mental health and substance abuse disorders

2005 **A Call for Change: Toward a Recovery Oriented Service System for Adults** -OMHSAS publishes recommendations of Recovery Workgroup. Creates a mandate for system transformation and definition for recovery

Report for Pennsylvania Office of Mental Health and Substance Abuse Services for Deaf and Hard of Hearing People in Pennsylvania – OMHSAS commissioned report to identify the additional services necessary to meet the needs of deaf, hard of

hearing and deaf-blind populations with mental illness and substance use **disorders**.

OMHSAS Quality Management Committee – statewide QM committee established in partnership with behavioral health stakeholders.

Multisystemic Therapy (MST) and Functional Family Therapy (FFT) – evidence based practices for children and adolescents are funded by Medicaid

2006 **Harrisburg State Hospital (HSH) Closed** – Five counties served by HSH develop a Service Area Plan resulting in the closure of HSH and consolidation with Wernersville State Hospital

Northeast HC BH zone - Four NE counties begin HC BH program

Behavioral Health Fee-for-Service – OMHSAS assumes management of utilization review for the BH FFS program

OMHSAS Forensic Workgroup Recommendations – Report to advance responsiveness to people with mental illness and/or substance use disorders involved in the criminal justice system

Centers of Excellence – Stakeholder workgroup developed guidelines for establishing Centers of Excellence

Co-Occurring Disorder Competency Approval Criteria Bulletin – Established a single set of criteria for any facility licensed by the Department of Health, Division of Drug and Alcohol Program Licensure or the Department of Public Welfare, Office of Mental Health and Substance Abuse Services to become approved as a Co-Occurring Competent Program

COSIG Co-Occurring Executive Report – Stakeholder document providing recommendations for infrastructure implementation to support a co-occurring system of care

Early Childhood Mental Health (ECMH) Consultation – funded by Heinz Foundation for three of the PA Key regions, administered by OCDEL in partnership with OMHSAS

2007 **A Plan for Promoting Housing and Recovery Oriented Services** – OMHSAS outlines important guidelines for implementing supportive housing models and modernizing housing approaches

Youth and Family Training Institute established – University of Pittsburgh awarded contract to train all counties on strategies to implement High Fidelity Wraparound

Guidelines for respite for families of children in the behavioral health system- budget allocation approved to fund respite services.

Office of Autism Affairs – DPW created the OAA to develop and manage services and supports to enhance the quality of life for Pennsylvanians living with Autism Spectrum Disorders and to support their families and caregivers

School Wide Positive Behavioral Supports (SWPBS) – first established in 25 schools

OMHSAS Youth Subcommittee – added to OMHSAS Advisory Committee with two voting members on both the Children’s and Adult Advisory Committees

2008 **OMHSAS County Housing Policy** – OMHSAS issues statewide policy to increase the development of supported housing, and counties required to develop housing plans in County Mental Health Plan

Statewide HC BH Implementation achieved with North/Central Zone – 42 remaining counties implement HC BH program, completing statewide implementation

Pay for Performance (P4P) – OMHSAS developed P4P measurement criteria in 25 HealthChoices BH counties to reward gains in quality of care.

Bureau of Autism Services – Established from Office of Autism Affairs in the Office of Developmental Programs (ODP)

Positive Practices Resource Team - OMHSAS and ODP partner to provide technical assistance to serve persons with intellectual disabilities with at-risk behavioral challenges

Co-Occurring Disorder Certification – Pennsylvania process becomes the international standard of competency for professionals treating individuals with co-occurring mental health and substance use disorders

Mayview State Hospital – MSH closure; SAP for five county region establishes mental health system without future use of state hospital

Special Pharmaceutical Benefits Program - OMHSAS assumes responsible for administration of SPBP

Certified Peer Specialist and Mobile Mental Health Treatment- Amended Medicaid State Plan to add Certified Peer and MMH treatment reinforcing commitment to recovery-oriented service array

Act 62 Enacted – Autism Insurance Act requires many private health insurance companies to cover up to \$36,000 per year of commercial insurance coverage for diagnosis and treatment services for children under age 21

Trauma Informed Care Initiative, Sanctuary Model – Twenty-one Residential Treatment Facilities receive training and consultation to implement this organizational trauma informed care model

Multidimensional Treatment Foster Care (MTFC) – Components funded by Medicaid

Assertive Community Treatment – OMHSAS issues statewide standards for licensure of ACT programs in the Commonwealth

A Call for Change: Employment, A Key to Recovery – OMHSAS establishes the goal of increasing the number of persons served by the behavioral health system who are competitively employed

SMI Innovations – Center for Health Care Strategies grant, Rethinking Care program, to improve quality and reduce expenditures to MA members with complex medical and behavioral health needs

Youth and Family Training Institute – Intergovernmental Agreement with University of Pittsburgh to train all counties on High-Fidelity Wraparound

Systems of Care Initiative –SAMHSA grant awarded to OMHSAS to create system of care partnerships to serve youth 8-18 in or at-risk of out-of-home placement

Garrett Lee Smith Youth Suicide Prevention Program Grant – Implemented an early identification system within primary care medical systems for youth at high risk for suicide

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 – Signed into law on October 3, 2008

Integrated Treatment Standards Workgroup – Convened a time-limited stakeholder group to develop integrated treatment standards for outpatient providers to treat persons with co-occurring disorders under a single license

Drug and Alcohol Coalition – DOH/DPW supported stakeholder coalition charged with making recommendations to enhance the system of care to address the needs of individuals with substance use and co-occurring disorders based on best science and practice guidelines

Expedited Enrollment – Established process for Single County Authorities to assist individuals in need of drug and alcohol residential treatment to apply for Medical Assistance and expedite enrollment in HealthChoices upon verification of eligibility.

2009 **Pennsylvania Peer Support Coalition** – Statewide peer-run coalition established

LGBTQI Workgroup – Issues recommendations to OMHSAS addressing access and inclusion in behavioral health services for lesbian, gay, bi-sexual, transgender, questioning, and intersex individuals

SMI Innovations – Pilot project launched in the Southwest and Southeast to enhance coordination of physical and behavioral health services for person with serious mental illness

Forensic Center of Excellence – OMHSAS and Pennsylvania Commission on Crime and Delinquency jointly funded Center of Excellence

Recovery-Orient System Indicators (ROSI) – OMHSAS contracts for study of consumer perception of care by adults enrolled in HC-BH program

Functional Behavioral Assessment Bulletin – DPW issued a bulletin declaring the use of an FBA during assessment and intervention as the standard of care for treating children and adolescents who have behavioral health needs compounded by developmental disorders

Persons in Recovery Sub-Committee – Established a subcommittee of the OMHSAS Advisory Committee to provide feedback, input and recommendations on systemic issues related to integrating co-occurring care, substance use program development and implementation, and transformation to a recovery oriented system

2010 **Allentown State Hospital Closed** - OMHSAS closes the Allentown State Hospital on December 15, 2010

SAMHSA System of Care Grant – OMHSAS awarded five year federal grant to establish cross-system evidence-based practices for children’s systems in Pennsylvania

Psychiatric Rehabilitation Services – OMHSAS submits state plan amendment to CMS for PRS inclusion as a Medicaid state plan service

Parent-Child Interaction Therapy (PCIT) – Heinz endowment grant provides funds for this evidence-based practice for young children and their families

The success of the HC-BH program was built in partnership with county government, which is legally responsible for providing and managing mental health services under the MH Act of 1966. County government is given the “right of first opportunity” to bid on the HC-BH program to manage risk-based contracts. HC-BH unifies service development and financial resources at the local level closest to the people served. Medicaid eligible individuals enrolled in the program are automatically enrolled in the BH program in the county of their residence. A risk-based contract allows flexibility to make decisions that meet the unique needs of the county and, if savings are created, the county must reinvest the money in approved programs and supports that meet the needs of people served. The HC-BH model has lived up to its mission and fostered counties’ success in controlling the growth of Medicaid spending while increasing access and improving quality.

Increasing Access

The HC-BH program ensures choice, flexibility, and cost-effective alternative services. For example:

- Standards require a choice of two providers for each in-plan service (e.g., outpatient services) and access within 30 minutes for urban areas and 60 minutes for rural areas.
- HC-BH includes services such as drug and alcohol non-hospital residential rehabilitation services that are not available in the Medicaid fee-for-service program.
- People enrolled in HC-BH can go to the provider closest to their home, even if it is in a different county.
- Behavioral Health Managed Care Organizations (BH-MCOs) have the flexibility to contract with individual practitioners and to develop “supplemental services”, which are cost-effective alternatives to in-plan services (i.e., psychiatric rehabilitation services).

Over its 12 year history, approximately \$446M (3.1%) of the HC-BH dollars have been reinvested into the expansion of service options in the community. In planning for reinvestment funds, counties analyze trends and consult with local stakeholders to determine reinvestment priorities. Priorities have targeted unmet or under-met needs and focused interventions to increase quality outcomes, such as reduction of psychiatric inpatient admissions. Reinvestment has been used for start-up funds to develop services targeted for special populations, including persons with autism, Latinos, intellectually disabled individuals, and persons who are deaf

or hard of hearing, among others. Start-up funds to expand substance abuse services resulted in increased access as the program has matured. Consumer-run services such as warm-lines, Certified Peer Specialists, and peer mentors have been created with reinvestment funds.

Reinvestment funds can be used to fund non-medical services and supports such as supportive housing. In partnership with the Pennsylvania Housing Finance Agency (PHFA), reinvestment funds were used to leverage safe, affordable housing options for people with a serious mental illness. Non-medical services have included development of mental health forensic sequential intercept models for people with a serious mental illness involved in the criminal justice system.

Improving Quality

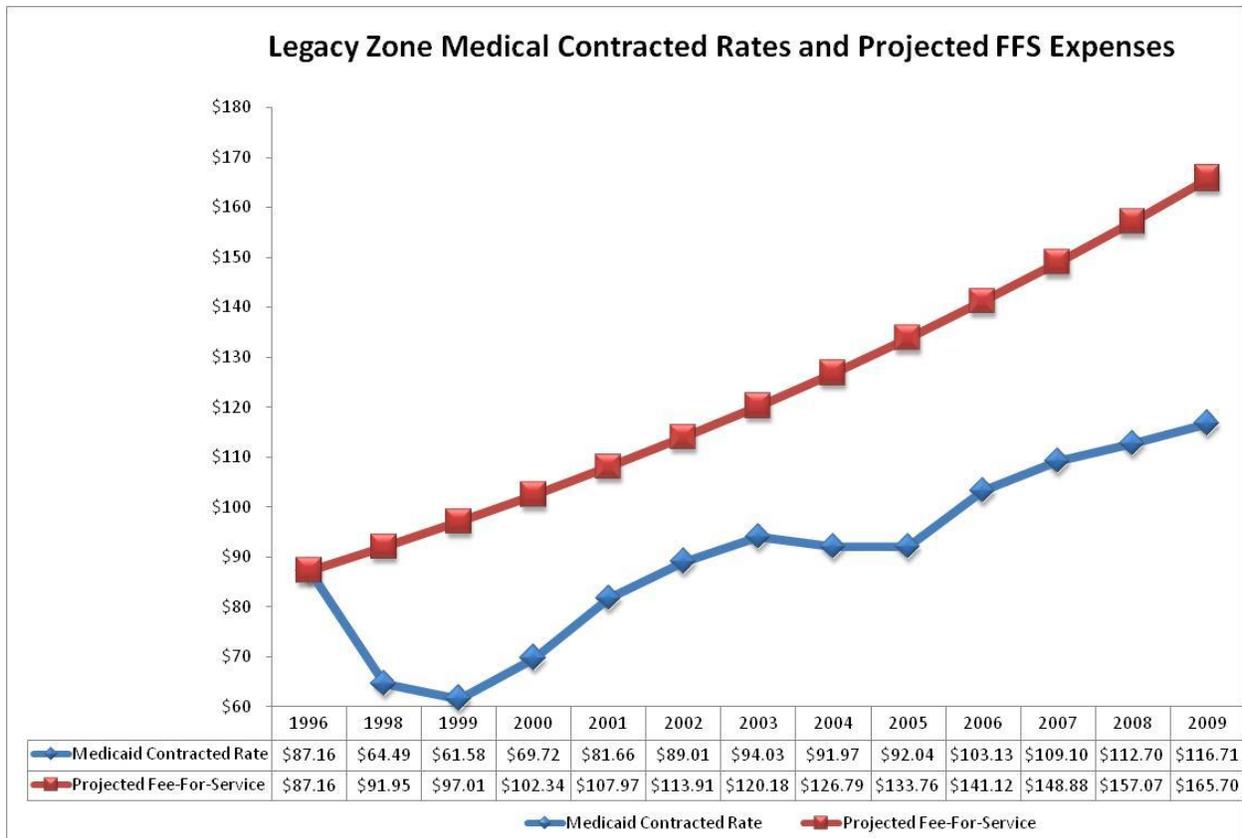
HC-BH contracts are built on recovery and resiliency principals. Consumers and families serve on the evaluation committee that selects the BH-MCO and are members of the Quality Management Committee established under each contract to oversee the program. Counties and BH-MCOs are required to establish Consumer/Family Satisfaction Teams (C/FSTs) that conduct face-to-face surveys to determine if the program is meeting the needs of people served.

The HC-BH Performance report, published annually, presents the results of C/FST survey questions and 29 quality indicators. The program is reviewed annually by an external quality management organization which submits a report to the Center for Medicare and Medicaid Services (CMS) regarding the effectiveness of the state's oversight. HC-BH contractors are required to develop performance improvement plans and have recently participated in a Pay-For-Performance initiative.

The OMHSAS Advisory Council and the DPW Medical Assistance Advisory Committee (MAAC) receive regular updates about the HC-BH program and provide feedback from stakeholders about how the program is working. Each contract has an OMHSAS contract monitoring team in the regional field office.

Controlling Costs

The HealthChoices Behavioral Health program has been able to decrease the rate of medical cost increases over projected FFS costs (see chart below).



Some of the savings have been achieved by ensuring that services are delivered in the least restrictive setting which can meet the needs of the consumer. The flexibility and accountability of the program have reduced the use of intensive and expensive services and increased the use of community-based services. For example, in the HC Southeast Zone in 1996, 38% of all fee-for-service dollars were spent on inpatient hospitalization and 4.4% on community support services (CSS). In HealthChoices in 2008, 16.2% was spent on inpatient hospitalization and 9.5% on CSS. The HC-BH contractors may provide supplemental, cost-effective alternative services that are not in the Medicaid State Plan. One example is the use of Assertive Community Treatment teams that reduce the use of higher cost inpatient psychiatric stays. Another example is the use of non-hospital based drug and alcohol services that reduce the use of higher cost inpatient services. The types of cost effective alternative services and expenditures are detailed by OMHSAS and its actuaries in the CMS actuarial certification letter.

Program Accountability

OMHSAS, through the HealthChoices Behavioral Health Program, has systematically increased accountability for the management of behavioral health services and financial resources throughout Pennsylvania by instituting the requirements described below.

- Financial Reporting Requirements: The counties and their BH-MCO partners (contractors) submit monthly, quarterly, and annual financial reports to ensure that solvency, financial, and reporting requirements are met. The OMHSAS financial team reviews the reports and conducts quarterly meetings with plans to determine if programmatic or policy changes are required.
- In 1998, contractors submitted ASCII files which OMHSAS entered into a database. Audit Adjustments were data entered manually. In 2004, a new COGNOS database was developed where reports are uploaded by the contractors directly into the database via the internet. The data is imported into a multidimensional data base known as a “cube” that allows extraction and manipulation of the data based on specific criteria and allows for detailed analysis as needed. Contractors also submit audit/prior year adjustments using the new database. Two additional cubes were developed that include detailed information on the persons served and the services rendered (Person Level Encounter data). These cubes offer the ability to analyze specific eligibility and levels of service by person.
- Audit Requirement: Each HC-BH contract is required to have an annual audit that attests to the accuracy of the information contained in its financial reports. In addition, within the audit, management must attest to compliance factors and management assertions. Typically, there are very few audit findings.
- Solvency Standards: Three solvency standards are required for each HC-BH contractor:
 - Risk Protection for High Cost Cases (Reinsurance)
 - Insolvency Protection (Secondary Liability) – A minimum of 60 days’ worth of paid claims in a restricted fund, via a letter of credit, performance bond, or parental guaranty. These funds are attached by the Department only in the event of insolvency and must be maintained at full value at all times.
 - Equity Requirement – A minimum of 5% of annual net HealthChoices capitation, in conjunction with any equity

requirements by the Pennsylvania Insurance Department, where applicable.

- An annual approval of each Contractor's plan to meet the standards is performed by OMHSAS. The plan is monitored on a monthly and quarterly basis to ensure continued compliance. To date, all of the contractors have met or exceeded these requirements, with very few corrective action plans required.
- Claims Processing Timeliness: The contractors are required to adjudicate 90% of clean claims within 30 days, 100% of clean claims within 45 days, and 100% of claims must be adjudicated within 90 days. Each County/BH-MCO submits a quarterly report that is monitored by OMHSAS. Contractors have met or exceeded these requirements with very few exceptions.
- Waiver Cost-Effectiveness Requirement: The Department operates the HealthChoices behavioral health program under 1915(b) waiver authority granted by CMS for a two-year period. CMS reviews the technical and cost-effectiveness waiver components and resolves any concerns prior to approval or implementation. OMHSAS and the Office of Medical Assistance Programs complete the cost effectiveness test quarterly and address areas of concern. The Department has met the cost-effectiveness requirements of all waiver submissions since 1997.
- Use of Actuaries in Rate Setting: CMS requires that capitation rates (fees paid to the contractors on a per member per month basis) be actuarially sound. DPW and CMS receive a certification from DPW's actuaries that assures that the capitation rates were developed using actuarial standards and that the rate setting meets the CMS requirements. CMS has approved all rate submission packages since the inception of the HC-BH program.
- Program Evaluation Performance Summary (PEPS) – The PEPS is a review of contractual and program standards of the HC-BH program conducted over a three-year cycle. HealthChoices monitoring teams in the regional field offices issue plans of corrective action when warranted. OMHSAS reports are submitted to an external quality review organization (EQRO), as required by the waiver. The EQRO reports to CMS annually on the effectiveness of the state's oversight.

(5) culturally competent, and (6) least restrictive/least intrusive. These core principles continue to guide system change.

“Achieving the Promise: Transforming Mental Health Care in America”, a 2003 publication of the President’s New Freedom Commission on Mental Health, called for continued system transformation. Focusing on the fragmentation of mental health and broader human service systems, OMH’s subcommittee on children’s services called for services based on a system of care approach. This approach included an array of services and supports provided in the home, school, and community, in partnership with the family and consistent with the culture, values, and preferences of the child and the family.

In 2005, the OMHSAS Children’s Advisory Committee established an overarching goal of transforming the children’s behavioral health system to one that is family-driven and youth guided.

Children, Youth, and Families Initiatives

1. Establish child and family teams and implement High-Fidelity Wraparound through the work of the Youth and Family Training Institute
2. Create home and community-based alternatives to residential treatment
3. Partner with the Department of Education to support the development of effective school-based supports and interventions
4. Develop a process for identifying and implementing evidence-based practices and promising practices as well as culturally relevant practices
5. Incorporate a systems approach and evidence-based practice to create models for Youth in the Child Welfare and Juvenile Justice Systems
6. Gain a better understanding of and develop programs to address autism
7. Create behavioral health competency to address the unique needs of early childhood including infants and toddlers
8. Develop programs which will address more effectively the issue of teen suicide

OMHSAS recognized that collaboration with other DPW offices and other child-serving agencies is a critical element of transformation. The OMHSAS Advisory Committee further emphasized the need for a financing strategy to ensure long-term sustainability of the services. These changes led to organizational support for broader stakeholder involvement.

Child and Family Teams and High Fidelity Wraparound

High Fidelity Wraparound (HFW) emphasizes the use of child and family teams to engage and empower families to be the primary determinant of services in the treatment and recovery process. Initially, HFW was established in five counties and used family teams to reduce the use of residential placement and other intensive services. Currently, nine counties are implementing HFW, with nearly 300 youth and families served. In 2009, OMHSAS received a \$9M five-year Substance Abuse and Mental Health Services Administration (SAMHSA) System of Care grant that will allow 15 more counties to develop HFW services.

The goal is to have HFW available in all county mental health programs. In support of that goal, the Youth and Family Training Institute was established in 2007 through an agreement with the University of Pittsburgh. The Youth and Family Training Institute provides training and credentialing oversight for HFW staff in partnership with youth and family leaders and trains counties to implement HFW. In addition, the Youth and Family Training Institute partners with the University of Washington to monitor fidelity to the model and with the Western Psychiatric Institute and Clinic to identify the best outcome measures to assess improvements in HFW.

Home- and Community-based Alternatives to Residential Treatment and Out-of-Home Placement

OMHSAS partners with the Office of Children, Youth and Families (OCYF), family members, advocates and BH-MCOs to develop community- and family-based services in order to reduce out-of-home placements and to stop out-of-state placements. Efforts have included work with OCYF and the Bureau of Juvenile Justice Services to divert youth with predominant mental health issues away from juvenile justice placements and into community-based programs. OMHSAS created a white paper, "Assessment of Residential Treatment Facility Use and Needs in Top Using Counties and Regions," which addressed the current environment, needs, and recommendations for alternatives to residential treatment. As a result of the focus on community and family-based alternatives, the number of youth in out-of-state placements has decreased.

Pennsylvania has joined the nationwide movement to enhance trauma-informed care and services within residential facilities by implementing Alternatives to Coercive Techniques (ACT). By 2010, the Sanctuary Model for trauma-informed care had been implemented at 29 residential providers with a total of 2,397 beds. A ban on prone restraints was implemented in 2009 and the OMHSAS ACT committee has a goal of elimination of all unnecessary restraints in residential facilities.

Casey Family Programs has committed to safely reduce the number of children in foster care nationwide by 50% by 2020. The Office of Children Youth and Families was selected by the National Governor’s Association (NGA) to participate in an NGA/Casey Foundation initiative to safely reduce the number of children in foster

care. Pennsylvania’s reduction plan includes the bold goal of reducing by 20% in 3 years (by 20,000) the number of children in foster care by increasing safety, improving permanency and reducing re-entry into the system. The Pennsylvania NGA Leadership Team involves staff from the OMHSAS Bureau of

Children’s Behavioral Health Services who are working with 16 counties to develop specific reduction plans that can be replicated throughout the Commonwealth. The early results are very promising.

Out of home placements for dependent youth (16 counties)

October, 2008 -12,239
April 1, 2010 - 10,180

Respite

In July 2007, the Bureau of Children’s Behavioral Health Services received approval to distribute \$500,000 toward development of respite services for children. Every county received funds, ranging from \$5,000 to \$112,000 depending on the percentage of youth served. The Bureau solicited input from stakeholders to develop [Guidelines for Respite for Families with Children in the Behavioral Health System](#) and the guidelines were distributed to each county.

Counties used this allocation to create a respite program for the families living in their county or to expand the current respite services provided. In FY 2008-2009, 1,559 children and families received 54,038 hours of respite services.

School-based Supports and Interventions

There is a growing recognition that behavioral health services alone are insufficient, and that it is critical to have a school culture that is supportive of social, emotional, and behavioral development. Counties and managed care organizations partnered with school districts throughout Pennsylvania to develop an array of school-based behavioral health services, including outpatient services, partial hospital services, and one-to-one support. As part of the advisory process, the OMHSAS Children's Advisory Committee engaged school-age youth to get their perspective on school-based behavioral health services.

The School Wide Positive Behavioral Supports (SWPBS) initiative is a mechanism for implementing such a culture in schools in partnership with families, while respecting the family's culture, values, and preferences. The effort is being led by a State Leadership Team composed of individuals from the Departments of Education, Health, and Public Welfare; providers; advocates; family members and behavioral health managed care organizations. SWPBS is being developed in more than 100 school districts. In addition, there have been several recent programs to expand the use of Dr. Nicholas Hobbs' Re-Ed model, an approach that blends quality education and mental health services in school classrooms.

In the Pocono Mountain School District, positive behaviors are recognized by being given a "paw" pass. The paws become a form of currency in the school and are used to buy items and participate in special activities.

Evidence-Based Practices and Promising Practices

Efforts by OMHSAS and counties to improve access to evidence-based and culturally relevant mental health treatment have focused on three highly recognized programs that work within the context of the youth's support system: Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Multidimensional Treatment Foster Care (MTFC). All three programs help divert culturally diverse youth with severe behavioral issues from residential and juvenile detention placements.

- Functional Family Therapy (FFT) is a research-based family program for at-risk adolescents between the ages of 11-18 and their families. It has been shown to be effective for adolescent problems such as violence, drug abuse/use, conduct disorder and family conflict. FFT

targets multiple areas of family functioning and features well-developed protocols for training, implementation and quality assurance and improvement. Since its inception in 2005, FFT has grown to 11 providers who are approved to serve 23 counties and over 1,000 children/youth each year.

- Multisystemic Family Therapy (MST) is an intensive home-based service model provided to families in their natural environment. MST is intensive and comprehensive, with low caseloads and varying frequency, duration, and intensity levels. Since the first MST provider was enrolled in September 2005, the number of MST providers has grown to 12 providers with a total of 47 teams. Currently, over 10% of the world's MST teams are located in Pennsylvania.
- Multisystemic Treatment Foster Care (MTFC) initiatives began in 2007 with designing service definitions and standards. Since 2007, the Pennsylvania Commission on Crime and Delinquency (PCCD) has awarded grants to seven providers to serve 12 counties.

The OMHSAS Bureau of Children's Behavioral Health Services works with national certification bodies to establish, train, and/or certify providers to offer FFT, MST, and MTFC. Fidelity to the model is a requirement for OMHSAS approval and is monitored on a continuous basis. The Bureau also participates in meetings with OCYF and the PCCD to guide the newly-created EPIS Center at Penn State to support new providers and to support collaboration on funding, technical assistance, and monitoring efforts.

Youth in the Child Welfare and Juvenile Justice Systems

In 2005, Pennsylvania was one of eight states selected to participate in a Policy Academy with the National Center for Mental Health and Juvenile Justice. The Policy Academy includes representatives from the Juvenile Court Judges Commission; Office of Children, Youth, and Families; Juvenile Detention Centers' Association; Department of Health's Bureau of Drug and Alcohol Programs; as well as families and youth representatives. The Policy Academy work was adopted by the MacArthur Foundation Model Systems Project.

Pennsylvania was the first state chosen by the MacArthur Foundation to be part of a "Models for Change" initiative. Models for Change is an ambitious effort to build a "comprehensive model system" for responding to court-involved youth with behavioral health disorders. It focuses on early identification, prevents unnecessary system penetration, and provides for timely access to appropriate treatment in the least restrictive setting

consistent with community safety. This initiative has involved top-level representatives of the state's juvenile justice, mental health, child welfare, drug and alcohol, and education systems.

One of the hallmark developments of the MacArthur Models for Change initiative was a "Mental Health/Juvenile Justice Joint Policy Statement", formally committing the Commonwealth to the goal of having statewide:

- Routine screening and assessment of youth for behavioral health problems utilizing the Massachusetts Youth Screening Instrument (MAYSI)
- Appropriate continuum of programs and services for diversion and treatment (for example, MST, FFT, and MTFC)
- Opportunities for family involvement in their treatment, appropriate protections for their privacy, and other legal interests
- Sustainable funding mechanisms that support all of these practices

System of Care

The 2009 SAMHSA System of Care grant focuses on services to youth (ages 8-18) with multi-system involvement (mental health, child welfare, juvenile justice) and are in or at-risk of out-of-home placement. The grant covers six years and will be implemented in 15 Pennsylvania counties. The initial year of the grant is to be a strategic planning year to develop criteria for selection of counties. For the grant, a State Leadership Team comprised equally of youth and family representatives and top officials from mental health, child welfare, and juvenile justice was established. With the Governor's Commission on Youth and Families, the Leadership Team will be responsible for the Pennsylvania System of Care Partnership, and the Youth and Family Training Institute will support, monitor, and evaluate the System of Care development in the counties. The 15 counties identified during the planning year (based on need, commitment, and readiness) will establish the infrastructure to build systems that work with the youth and family, integrate professional services, and utilize the natural supports that exist in families and communities in Pennsylvania.

The System of Care Partnership builds on and enhances cross system efforts that have been underway for several years to integrate and more effectively provide services to youth.

Autism

In response to the dramatic increase in the number of children being diagnosed with autism spectrum disorders, the DPW Autism Task Force was created in 2003. The Task Force included over 250 family members of people living with autism, service providers, educators, administrators, and researchers, and was charged with developing a plan for a new system that would make Pennsylvania a national model of excellence in autism service delivery.

In 2004, the Autism Task Force published its final report and recommended creating a program office within DPW to focus on the challenges faced by individuals with autism spectrum disorders. DPW created the Office of Autism Affairs, which in early 2007 became the Bureau of Autism Services within the Office of Developmental Programs. The Bureau of Autism Services successfully established statewide diagnostic, assessment, training and intervention standards, and offers training to meet the lifetime needs of Pennsylvanians living with autism. A website with up-to-date information and training material is available to family members, friends, neighbors, or others who support individuals with autism in everyday life.

In 2009 OMHSAS published guidance for conducting functional behavioral assessments (FBA) establishing that the use of an FBA is the current standard of care for treating children and adolescents with behavioral health needs compounded by developmental disorders such as autism spectrum disorder. In 2009 training in the use of the FBA was provided to almost 200 Behavioral Specialist consultants and over 800 Therapeutic Staff Support workers. In calendar year 2008 the behavioral health system served 20,031 children with an autism diagnosis.

Early Childhood

There are about 900,000 children under age six in Pennsylvania; more than 450,000 are infants and toddlers. An active and energized statewide Early Childhood Mental Health (ECMH) Advisory Committee provides guidance to the child and family-serving agencies and has spearheaded the development of early childhood services in Pennsylvania. ECMH consultation is available in early learning facilities enrolled in the DPW Office of Child Development and Early Learning's (OCDEL) Keystone STARS program. Consultation services were provided in 48 of the 67 counties in Pennsylvania to 244 early learning facilities and 837 early childhood educators. In 2008-2009, 434 children also received early childhood mental health consultation services. In addition, cross-system initiatives included

- Pilot projects for screening in pediatric offices
- Mandated screening using Ages and Stages Questionnaire–Social-Emotional (ASQ-SE) in all OCYF child welfare facilities

Suicide Prevention

Suicide is the third leading cause of death among youth age 15-24, accounting for more deaths than cancer, heart disease, AIDS, birth defects, stroke, pneumonia, the flu, and chronic lung disease combined. During the past half century, the incidence of suicide among adolescents and young adults has nearly tripled. In 2001, OMHSAS and its stakeholders developed the PA Youth Suicide Prevention Plan to promote awareness that youth suicide is a preventable public health problem and to develop strategies to reduce youth suicide.

The Youth Suicide Prevention Advisory Group developed a five year plan to reduce youth suicide by improving access to non-stigmatizing prevention and mental health and substance use treatment. To implement the plan, the Suicide Prevention Monitoring Committee was established to monitor five year plan goals. The tasks listed below have been the focus of the group, with new tasks and activities targeted on design of specific services throughout Pennsylvania.

The Pennsylvania Youth Suicide Prevention Plan (based on the United States Surgeon General's National Strategy for Suicide Prevention)

- Promote awareness that youth suicide is a preventable public health problem.
- Develop broad-based support for youth suicide prevention.
- Design and implement strategies to reduce the stigma associated with being a youth consumer of mental health, substance abuse, and suicide prevention services.
- Identify, develop, implement, and evaluate youth suicide prevention programs.
- Promote efforts to reduce access to lethal means and methods of self-harm.
- Implement training for recognition of at-risk behavior and delivery of effective treatment.
- Develop and promote effective clinical and professional practices.
- Improve access to community linkages with mental health and substance abuse services.
- Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in media and entertainment.
- Promote and support research on youth suicide and youth suicide prevention.
- Improve and expand surveillance systems.

Transition Age Youth

It is essential that the system tailor itself to the developmental needs of transition age youth, helping them to successfully enter adulthood and avoid admission to inpatient or residential treatment facilities.

To help understand these needs, OMHSAS created five pilot programs in 2004 and dedicates one full-time staff person to support initiatives for transition age youth and young adults. Pilot projects were established in seven counties: Allegheny, Chester/Delaware, Clearfield/Jefferson, Dauphin, and Westmoreland. The pilot projects successfully tested approaches to enhance community-based supports for transition-aged individuals with

A Memorandum of Understanding, established in 1998, and updated in 2006, by the Departments of Education, Labor and Industry, Public Welfare, and Health expresses the commitment to “work together in supporting youth and young adults with disabilities transitioning into adult life in the achievement of their desired post school outcomes, with a focus on post-secondary education, training and lifelong learning, community participation, and healthy lifestyles”.

behavioral health challenges. In recognition of the unique needs of youth and young adults who are transitioning to adulthood, in 2009 OMHSAS created a Transition Age Youth Subcommittee of the OMHSAS Advisory Committee. In addition, OMHSAS and its collaborators implemented a training curriculum for peer specialists who work with transition age youth. While the focus on transition age youth is relatively new, the youth and young adult subcommittee has become an important voice helping the behavioral health system understand the needs of this population.

Progress

- In 2001, OMHSAS and its stakeholders developed the PA Youth Suicide Prevention Plan.
- In 2003, the Autism Task Force was created.
- Beginning in 2005, Pennsylvania implemented an expanded array of evidence-based practices (MST, FFT, and MTFC) for children and youth to create alternatives to residential placements.
- In early 2007, the Bureau of Autism Services was created within the Office of Developmental Programs.
- In 2007, the Youth and Family Training Institute was established through an agreement with the University of Pittsburgh.
- In 2007, OMHSAS awarded funds for respite services and issued guidelines for respite care
- In 2008, Pennsylvania received the Garrett Lee Smith Youth Suicide Prevention grant to implement an early identification system for youth at high risk for suicide (ages 14-24 years). The primary aims were to reduce death and hospitalization from self injury in three counties in northern Pennsylvania.
- OMHSAS issued a bulletin in 2009 on the ban of prone restraints in all children's residential facilities effective June 2010.
- In 2009, OMHSAS published a bulletin on conducting functional behavioral assessment for children with an autistic disorder.
- In 2009, OMHSAS created a Transition Age Youth subcommittee of the OMHSAS Advisory Committee

- A child, youth and family “Call for Change”, a strategic plan to transform the children’s behavioral health system to one that is youth-guided and family-driven, will be issued in 2010.

Resources

- PA CASSP Newsletters
(<http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003670143.htm>) not a valid link any more.
- Volume 18, Number 1, March 2009 – Creating a Sanctuary for Trauma Informed Care
- Early Childhood Mental Health, A periodic update on early childhood mental health initiatives in Pennsylvania, Number 4, April 2010
(http://parecovery.org/documents/ECMH_Initiatives_040110.pdf)
- Report and Recommendations of the DPW ECMH Advisory Committee, September 1, 2009
(http://parecovery.org/documents/ECMH_Adv_Recommendations.pdf)
- Bureau of Autism
(<http://www.dpw.state.pa.us/dpworganization/officeofdevelopmentalprograms/bureauofautismservices/index.htm>)
- Pennsylvania Youth Suicide Prevention Plan
(http://www.parecovery.org/services_suicide_prevention.shtml)

III. Adults – Recovery Oriented Services

Background

In 2005, the OMHSAS Advisory Committee established an overarching goal of system transformation for adults. The foundation of the change involved a systemic focus on the concept of “recovery.” Recovery is a highly individualized journey toward health and healing. It is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that enable people to reach their full potential as individuals and community members. *A Call for Change–Toward a Recovery-Oriented Mental Health Service System for Adults* was published by OMHSAS in 2005 and became a guide to stimulate thinking, generate discussion, and serve as a foundation for more targeted strategic planning throughout Pennsylvania.

“People with serious mental illness do, in fact, recover. Some become fully symptom-free with time, while others live rich and fulfilling lives while still experiencing some psychiatric problems. One of the basic premises of this (recovery) movement is that the role of a mental health system is not to “do for” or “do to” but to “do with.” *A Call For Change*

Snapshot –Adults Recovery Oriented Services

- 1,160 Certified Peer Specialists (CPS) and 720 Certified Peer Specialists Supervisors (CPSS) have been trained
- Forty-three ACT or ACT-like teams serve about 3,400 consumers throughout Pennsylvania
- Twenty-six clubhouse programs are operational throughout Pennsylvania, the second largest number of clubhouses in any one place in the world
- 1,752 individuals are working competitively, through supported employment programs in 34 counties
- Forty-six County MH/MR programs (serving 53 counties) have housing programs funded by HealthChoices reinvestment dollars (2010)
- By the end of 2010, Pennsylvania will have over 40 Fairweather lodges

The priority projects endorsed by the Advisory Committee set an agenda to create consumer-run services, reduce reliance on large institutional settings, create housing and employment opportunities, and develop integrated services for co-occurring mental health and substance use disorders. This ambitious agenda required strong partnerships with other Department of Public Welfare (DPW) offices, such as the Office of Medical Assistance Programs and Office of Developmental Programs, as well as other systems, including the criminal justice system and Department of Health offices

among others. The Advisory Committee recognized the importance of having a financing strategy for initiatives to ensure long-term sustainability, including changes in the state's Medicaid plan to support a recovery and resiliency orientation.

Projects and actions identified to support a recovery-oriented system included:

- Expand and support consumer-run services and supports
- Develop a Center of Innovation for Promising and Evidence-Based Practices
- Support community reintegration for individuals who have been in the state hospital over two years
- Implement an integrated system of services and supports for co-occurring mental health/drug and alcohol recovery
- Implement housing workgroup
- Implement forensic workgroup
- Develop employment opportunities
- Restructure Medicaid State Plan to support recovery and resiliency

Consumer-run services

Peer support is a system of giving and receiving help by and from individuals in recovery. It is founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. In 2004, OMHSAS received a three year Mental Health Systems Transformation Grant from the Centers for Medicare and Medicaid Services (CMS) to implement a Medicaid- funded Peer Support service. Peer support services are provided by individuals who utilized services in the behavioral health system and are trained and certified as Certified Peer Specialists (CPS). Peer support is not based on psychiatric models and diagnostic criteria but rather on empathetic understanding of another's situation through the shared experience of emotional and psychological pain. The mutual experience creates a connection without the constraints of a traditional expert/patient relationship. The trust that is engendered results in hope and allows people to move beyond self-concepts built on disability, diagnosis and trauma.

The Mental Health Association of Southeastern Pennsylvania partnered with OMHSAS to develop a statewide CPS training curriculum. The curriculum, recently adopted by the Veterans

Administration, has specialized training for transition-age youth, adults, older adults, justice-involved, and bilingual individuals. In 2006, CPS services were added to Pennsylvania's Medicaid State Plan, allowing federal match for these important services. Pennsylvania added "Certified Peer Specialist" as a civil service classification in 2008, the first new civil service class in 12 years.

"On June 6, 2005, I became a member of The Dauphin Clubhouse. For the first time, I was asked what I wanted to do, not told what to do. Within two weeks, I was at the clubhouse five days a week, from morning to night. The clubhouse had given me something that I had wanted my whole life: a sense of belonging to something noble, with no judgment. These people that I was ready to look down upon accepted me as me. They didn't care that I felt I was broken. They just cared. More importantly, that taught me to care. Today I work at The Dauphin Clubhouse as a peer support specialist. I carry the lessons I have learned from all my peers. That is the secret to being a peer support specialist. I love walking with other peers on their journey to do what they want to do with their lives. My favorite time is when a peer tells me, "Tom, I can take it from here." Certified Peer Specialist

In 2009, Pennsylvania had almost 600 people employed as peer specialists, more than any other state. Of the 21 other states that employ peer specialists, none had over 400, and only two had more than 300. In Pennsylvania, 100 programs are licensed to provide peer support services. Not only do peer specialists impact the culture of the service system, these CPS positions offer employment, recognition, and incomes. And, peer specialists contribute to the compelling stories of recovery throughout the Pennsylvania.

Assertive Community Treatment (ACT)

It is challenging to implement promising and evidence-based practices that have good outcomes, address the diversity of Pennsylvania's population, and meet national guidelines. In 2006, a stakeholder workgroup developed guidelines for establishing Centers of Excellence and identifying other experts to provide technical assistance on the expansion of promising and evidence-based practices. Implementation of promising and evidence-based practices has resulted in a greater array of services that help adults recover

from mental illness. Assertive Community Treatment (ACT) is an example of an evidence-based practice.

Assertive Community Treatment employs a multidisciplinary team of mental health staff, including peer specialists, that provides community-centered treatment, rehabilitation, and support services for consumers with severe and persistent mental illness. ACT has been in Pennsylvania since the mid 1990s. In 2008, OMHSAS conducted a study of community treatment team programs in order to better understand how fidelity to the ACT model impacted outcomes. The study found that high-fidelity ACT had better outcomes and was more efficient than low-fidelity programs, including having more people employed; more living independently or with their families; and having fewer people living in shelters, on the street, or in nursing homes. Average overall costs of high-fidelity ACT teams were lower than for consumers served by low-fidelity teams.

As a result of the study, OMHSAS issued an ACT Bulletin in 2008 stipulating the standards and procedures for developing, administering, and monitoring ACT programs in the Commonwealth. In July 2009 OMHSAS convened a stakeholder group to formulate plans to move towards full ACT fidelity. One of the key recommendations from this meeting was to select existing teams as pilot programs to receive intensive technical assistance and training to transition to full ACT fidelity. All counties having operational programs submitted Fidelity Action Plans which were reviewed by the workgroup and are monitored by OMHSAS

Psychiatric Rehabilitation

Psychiatric rehabilitation services offer people opportunities to recover from their mental illness and co-occurring substance use disorders through learning skills that enable them to live, learn, make friends, and work in their communities. Recognizing that psychiatric rehabilitation is a key ingredient to recovery, OMHSAS promoted the expansion of these services throughout Pennsylvania through targeted use of state funds and securing Medicaid reimbursement for these services. Psychiatric rehabilitation is a key element of community support services, emphasizing the empowerment of consumers and promoting hope and recovery. Each program model – clubhouse, site-based drop-in centers, and mobile psychiatric rehabilitation – tailors services to the individual's expressed goals and needs.

A clubhouse is a community-based social and vocational rehabilitation program based on the "Fountain House" model. Fountain House opened in 1948 in New York City and has become a model that has been emulated

internationally. The model features "work" and "membership," providing participants with opportunities for employment, housing, education, skill development, and social activities. The Pennsylvania Clubhouse Coalition (PCC) follows the International Clubhouse Standards published by the International Center for Clubhouse Development (ICCD) which is located in Fountain House. In Pennsylvania, these clubhouses meet the criteria for community support programs and psychiatric and psychosocial rehabilitation services. Mental health consumers throughout Pennsylvania experience the

"After seeing my future as a mentally ill inmate going from jail to a state institution I knew I had to turn my life around before I became trapped. The next week I started at Wellspring Clubhouse, where I met ... Marie. Marie ... was the first to see enormous potential in my eccentric personality... In just six months, I started my education and recovery at community college...College has taught me to never underestimate yourself and always push to become a better person. The classes ... reminded me of how important it was to inform people that mental illness is not a death sentence... This May, I graduate from community college, and in August, I start at college. My dream is to become a Special Education Teacher who challenges students with mental retardation, mental illness, and autism to reach their full potential." Wellspring Member

process of mental health recovery through the personal empowerment achieved through clubhouse membership. Above all, clubhouses are a place of hope.

Over 175 psychiatric rehabilitation providers are members of the Pennsylvania Association of Psychosocial Rehabilitation Services (PAPSRS) that is affiliated nationally with United States Psychiatric Rehabilitation Association (USPRA). PAPSRS was organized to promote and support the philosophy, values, and practices of psychiatric rehabilitation for people in recovery from mental illness and to exercise leadership and encourage the development of continually improving concepts and practices of psychiatric rehabilitation in Pennsylvania. Psychiatric Rehabilitation includes clubhouse, site-based and mobile services.

Employment

In 2005, unemployment in Pennsylvania among those with psychiatric disabilities was found to range from 75% to 85%, in spite of long-standing evidence that the majority of consumers would not only benefit from competitive employment, but were also eager to work. The OMHSAS

Employment Transformation project (2006–2007) worked with 15 counties to assess existing employment systems and implement supported employment, an evidence-based practice. For fiscal year 07-08, 10,929 individuals were served in sheltered employment, while only 3,196 individuals were engaged in competitive employment. In March 2008, *A Call for Change: Employment, A Key to Recovery* established the goal of “significantly increasing the number of persons served by the behavioral health system who are competitively employed”. Eleven counties identified employment in their FY 08-09 county plans as their top need for new funding.

In 2009 OMHSAS established the Employment Outcomes Workgroup, facilitated by the University of Pennsylvania Collaborative on Community Integration, to help develop policies that re-emphasize the importance of employment in the lives of people with psychiatric disabilities.

The Workgroup recommended that OMHSAS require the counties to develop a separate plan to promote competitive employment by expanding supported employment, using the Substance Abuse and Mental Health Services Administration (SAMHSA) tool kit for this evidence-based practice. Supporting people to work on the job is far more effective than training people in a sheltered setting. In recognition of this important evidence-based practice, OMHSAS required every county to develop a supported employment plan as part of their FY 11-12 County Mental Health Plan Update that was submitted in May 2010.

Blueprint for transforming services to better support people with mental illness in obtaining competitive work involves seven principles:

1. Eligibility is based on the person’s interest in working.
2. Supported employment is integrated with mental health treatment.
3. Competitive employment is the goal.
4. A job search starts soon after a person expresses interest in working.
5. Supported employment providers continue to help an individual as long as he or she wants assistance and support.
6. Supported employment is individualized.
7. Supported employment provides benefits counseling.

Housing

Supportive housing is permanent, affordable housing that is linked to flexible, voluntary supports necessary for people with serious mental illness

and co-occurring disorders to obtain and maintain the housing of their choice. In 2004-2005, the County MH/MR programs identified housing as one of the greatest needs of persons with serious mental illness and co-occurring conditions. In 2006, OMHSAS issued *A Plan for Promoting Housing and Recovery Oriented Services* based on the findings of the OMHSAS Advisory Committee's Housing Workgroup. The plan recognized housing as an essential component of recovery and outlined important guidelines for implementing supportive housing models and modernizing housing approaches. In response, counties developed housing plans for their priority groups. OMHSAS and the Pennsylvania Housing Finance Agency (PHFA) established a partnership for supportive housing to finance permanent, affordable supportive housing identified in the counties' plans. OMHSAS and the counties also targeted HealthChoices reinvestment funds to support county housing initiatives. Between 2005 and 2010, OMHSAS leveraged over \$65.9M for a variety of housing options. In 2010, over 1,600 units or subsidies are being developed at a cost of \$41.7M and more than \$10.4 M is targeted to other housing and supports.

"Having housing makes me hope again and set more goals for myself. It is nice knowing that someone is there for me when I need them. I can always reach the staff and have someone to talk with... and the staff has helped me with accessing the Food Bank and setting up an appointment with the Office of Vocational Rehabilitation." York/Adams County Supportive Housing resident.

Examples of current supported housing efforts include:

Erie County's Fairweather Lodge started when Stairways Behavioral Health developed one lodge nearly 10 years ago. The Fairweather Lodge focuses on self governance, peer support, interdependence, and employment to help people have a stable home and earn a living wage. After almost 10 years, Stairways has nine lodges in Erie County while other providers throughout Pennsylvania operate another 21 lodges. In addition, 23 more lodges are currently in development, with technical assistance provided by Stairways and funded by OMHSAS. By the end of 2010, Pennsylvania will have over 40 lodges. Erie County's Fairweather Lodge staffing includes one program manager, four certified peer specialists and 55 lodge members.

Allegheny County's Permanent Supportive Housing Support

program, operated by Transitional Services, Inc., was recognized by the National Council for Behavioral Healthcare magazine in 2009. As a scattered site, low density program, the Housing Support Team offers "bridge" rental subsidies until a person can access rental subsidies offered through the local housing authority. Since 2008, over 50 people have maintained their housing for more than one year at an average cost of \$1,764 per person per month for rental subsidies, housing support team services, and behavioral health treatment. This is significantly less than other residential models and inpatient care costs which can range from \$4,000 to \$15,000 per month.

The York/Adams County Joinder targeted the development of supportive housing in their 2008–2009 reinvestment plan for people with serious mental illness and co occurring conditions, including adults, transition age youth ages 18–25, and individuals with involvement in the criminal justice system. Their strategies to provide permanent affordable housing and essential supports include capital investments, operating subsidies through PHFA, master leasing, program management/clearinghouse activities (i.e., housing coordinator), housing support services, and contingency funds. Today, in the midst of implementing these strategies, 36 people have housing where they pay about 30% of their income and receive subsidies for the remaining housing costs. The stories of these 36 residents are remarkable and attest to the positive changes in their lives due to having a home and support.

Progress

- In 2009, OMHAS funded the creation of a Pennsylvania Peer Support Coalition, a peer-run coalition with six chapters throughout the Commonwealth to support peer specialists.
- In 2009, Pennsylvania scored 95 on the peer specialist checklist/report card at the Pillars of Peer Support Summit in Atlanta, Georgia.
- OMHSAS and the Office for Vocational Rehabilitation (OVR) are finalizing an agreement to fund training and placement for Certified Peer Specialists. A pilot in Philadelphia will link 15 district OVR offices with training vendors to educate Certified Peers.

- OMHSAS recognized the high fidelity of Lenape Valley Foundation's ACT program and designated the Teams as consultants for other programs.
- OMHSAS engaged Pennsylvania and national experts on ACT to provide training and technical assistance, including The Washington Institute for Mental Health Research & Training (University of Washington) for training on the Tools for Measurement of ACT (TMACT).
- The OMHSAS Psychiatric Rehabilitation Workgroup revised standards for psychiatric rehabilitation services and is in the process of developing regulations.
- OMHSAS contracted with Drexel University College of Medicine to provide a continuing education training program to Certified Psychiatric Rehabilitation Practitioners (CPRP), approved by the United States Psychiatric Rehabilitation Association, to enhance the skills of psychiatric rehabilitation services providers.
- OMHSAS provided technical assistance to 15 counties to implement strategies to expand evidence-based supportive employment services.
- Guidelines were published for the submission of Supplemental Employment Plans by each county as part of their FY 11-12 County Mental Health Plan Update.
- November 7, 2007, OMHSAS distributed a Housing Workgroup document, *A Plan for Promoting Housing and Recovery Oriented Services*.
- In August 2007, OMHSAS issued *County Housing Plan Policy* that requires each county to develop a county housing plan as part of 2009–2012 County Plan Guidelines.
- OMHSAS issued guidelines in August 2009 on referral to Personal Care Homes to avoid use of large institutional settings.

Resources

- Peer Support Services – Revised OMHSAS Bulletin 09-07
- (<http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?BulletinDetailId=4516>)

- Project Concept: Peer Support for Older Adults in PA
(http://www.parecovery.org/documents/TTI_Project_Concept.pdf)
- Civil Service classification for Certified Peer Specialist (2008).
(http://www.portal.state.pa.us/portal/server.pt/gateway/PTARGS_0_7_3945_689697_0_0_18/2009-003CertifiedPeerSpecialists.htm)
- 26-state checklist standards for peer support programs: Pillars of Peer Support: Transforming Mental Health Systems of Care Through Peer Support Services
(http://www.parecovery.org/documents/Pillars_of_Peer_Support.pdf)
- OMHSAS Peer Specialist Initiative, July 1, 2006
(http://www.parecovery.org/documents/PA_Peer_Specialist_Initiative.pdf)
- Pennsylvania OMHSAS Bulletin 08-03: ACT and Related Attachments
(<http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?BulletinDetailId=4390>)
- Fidelity, Cost, and Outcomes Analyses of Pennsylvania ACT/CTT Teams
(http://www.parecovery.org/documents/ACT_CTT_Report_042009.pdf)
- ACT/CTT Providers by County in Pennsylvania
(http://www.parecovery.org/documents/ACT_Providers_County.pdf)
- Standards for mobile, site-based and clubhouse psychiatric rehabilitation,
(http://www.parecovery.org/documents/Psych_Rehab_Standards.pdf)
- SAMHSA Tool Kit on Supported Employment
(<http://homeless.samhsa.gov/Resource/Supported-Employment-Evidence-based-Practice-Toolkit-48852.aspx>)
- A Plan for Promoting Housing and Recovery-Oriented Services, November 7, 2006; prepared by the Housing Work Group (HWG) of the Adult Advisory Committee of the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS)
(http://www.parecovery.org/documents/OMHSAS_Housing_Report_Final_110706.pdf)

- OMHSAS County Housing Plan Policy, August 2007
(http://www.parecovery.org/documents/County_Housing_Plan_Policy_082007.pdf)
- Faces of Recovery: Supporting People in Housing, Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS), prepared by Diane T. Meyers and Associates, August 2007
(<http://www.pahousingchoices.org/documents/Faces.pdf>)
- Template for Housing Plan
- (<http://www.pahousingchoices.org/county-housing-planning/housing-planning-documents/>)
- Housing and the Sequential Intercept Model: A How-to Guide for Planning for the Housing Needs of Individuals with Justice Involvement and Mental Illness
(http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/manual/s_002552.pdf)

IV. Adults – Targeted Services and Approaches

Background

A Call for Change—Toward a Recovery-Oriented Mental Health Service System for Adults, published by OMHSAS in 2005, acknowledged the need for targeted strategic planning to meet the unique needs of Pennsylvania’s diverse population. A recovery-oriented system must acknowledge a person’s individualized path to recovery, so it is important to have an understanding of the different ways in which people experience services or look for change in their lives. OMHSAS has engaged in a number of initiatives to seek input from consumers about how they want the system to look and how it needs to be structured to meet their needs. Groups who have expressed a need for targeted services or who have presented with unique challenges for service systems include persons who

- are deaf, hard of hearing, or deaf-blind
- are members of sexual minorities
- have co-occurring behavioral health and physical health needs
- have co-occurring behavioral health and substance use needs
- are involved in the criminal justice system

Hearing Impaired/Deaf

The incidence of moderate hearing loss and deafness is low, yet the need to provide accessible behavioral health services to people who are deaf and hard of hearing is essential. In Pennsylvania and throughout the country, it is a challenge to find professionals who are trained in American Sign Language (ASL) and use of other tools that enhance access. To improve access to services, in 2003 OMHSAS established a workgroup on mental health and the deaf, hard of hearing, and deaf-blind. The workgroup

Snapshot – Targeted Services & Approaches

- The life expectancy for persons with serious mental illness is 25 years shorter than for persons without serious mental illness
- Due to barriers in effective diagnosis only 2% of the 5 million individuals in the US who are deaf and need mental health treatment receive appropriate treatment
- Attempted suicide rates of lesbian, gay, and bisexual young people are four times higher than for heterosexual youth
- Over 1,000 behavioral health professionals are certified to provide integrated behavioral health and substance use treatment for adults and adolescents
- Fifty-eight (58) counties report active participation on local Criminal Justice Advisory Boards (CJABS)

included representatives from provider organizations, consumers, advocates, and interpreters. The purpose of the workgroup was to improve access to behavioral health services by developing a training plan that strengthens the workforce and a monitoring plan to review progress. By 2004, OMHSAS began implementing the workgroup's recommendations and also incorporated the workgroup into the formal OMHSAS Advisory Committee structure.

"There is a significant deaf culture in the United States, one that is often invisible and misunderstood but that nevertheless is as vibrant and substantial as that of any other minority group." *Cultural Diversity: Meeting the Mental Health Needs of Persons Who Are Deaf*, May 2002, National Technical Assistance Center for State Mental Health Planning (NTAC)

In 2005, OMHSAS commissioned a report to identify the additional services necessary to meet the needs of deaf, hard of hearing and deaf-blind populations with mental illness and substance use disorders. The report emphasized the importance of recognizing the deaf culture and the need for

- improved access to providers skilled with ASL capabilities
- engaging consumers in the process
- increasing access to housing
- increasing programs such as inpatient or peer services for persons who are deaf or hard of hearing

The report noted the value of using telepsychiatry and existing video conferencing systems for clinical applications, especially in reaching out in rural areas of the state. It also noted the importance of establishing a statewide toll free crisis line with TTY access that provides linkages to crisis services.

In 2006, the Legislative Budget and Finance Committee issued Commonwealth Services for the Deaf and Hearing Impaired that outlines resources and goals for Pennsylvania that crossed all relevant state agencies. The OMHSAS 2007-08 County Mental Health Plan Guidelines require development of services and supports for adults with serious mental illness who are also deaf or hard of hearing. OMHSAS sponsors training for intermediate and advanced interpreters including a focus on mental health services and Pennsylvania law as it applies to interpreters in the mental

health setting. OMHSAS also has developed a telepsychiatry protocol that allows use of telepsychiatry services that can expand access to professionals with ASL expertise. Video and email communications are also utilized by Intensive Case Managers at the Deaf Services Center.

OMHSAS' efforts to address the needs of persons who are deaf or hard of hearing have included initiatives related to treatment services for children. Since 2004, the OMHSAS Children's Bureau has facilitated a workgroup in southeast Pennsylvania that was established to develop services for youth that are deaf or hard of hearing. The group consists of representatives from five counties, BH-MCOs, school district representatives, provider agencies and advocates. The discussions resulted in the creation of a small (3-4 bed) facility that was established in Montgomery County and will soon be accepting children. The program allows for close contact with families so a smooth transition can be in place as children are ready to move home. In addition to the residential services, community-based services have expanded as a result of the group's work. A resource directory for the five county area has also been developed, and discussions are being held with the state Office for the Deaf and Hard of Hearing about creating a statewide resource directory. (Additional information on children's services can be found in the Children, Youth and Families section of Supporting the Journey.)

Lesbian, Gay, Bi-sexual, Transgender Questioning and Intersex (LGBTQI)

Although OMHSAS's work has only begun, there is a clear need for expanded and improved programs and supports for individuals who may be lesbian, gay, bisexual, transgender, questioning or intersex. In 2008, OMHSAS invited representatives of the LGBTQI consumer communities and their advocates to form a workgroup to develop recommendations on how to improve access and quality of treatment, unimpeded by differences of sexual orientation, gender identity, and gender expression. Broad goals identified by the workgroup were to

"A consumer's physical and behavioral health challenges can be compounded when negative behaviors and attitudes are perpetuated by those responsible for representing and implementing public health programs and behavioral health treatment." LGBTQI Workgroup Report, July 2009

- Protect LGBTQI consumers from discrimination and mistreatment

- Ensure that OMHSAS and contracted providers provide culturally affirmative environments of care for LGBTQI consumers
- Ensure clinically competent behavioral health care for LGBTQI consumers

Members of these populations, whether in urban, suburban, or rural areas of Pennsylvania, frequently cannot find providers of care for their mental health or substance-related issues who are skilled at incorporating the clinical concerns particular to LGBTQI people.

OMHSAS adopted the following goals in 2010

- Adopt a non-discrimination policy that includes sexual orientation, gender identity, and gender expression, covering staff and all people receiving services
- Adopt a policy clarifying that OMHSAS does not endorse or pay for conversion therapy
- Amend language in current and future OMHSAS policies, regulations, training materials, and contracts to ensure protection from discrimination based on sexual orientation, gender identity, and gender expression
- Establish mechanisms for consumers, families, providers, and staff to report and follow up on violations of the non-discrimination and anti-conversion therapy policies

Physical and Behavioral Health Co-Occurring Conditions

Among Medicaid consumers there are significant numbers of people with mental illness, co-occurring substance abuse and serious physical disorders. The presence of multiple health issues compounds the negative effects of mental illness and a recent analysis of Medicaid data showed that among the chronically ill, the addition of one behavioral health condition doubles medical expenditures, emergency room use and hospital admissions. In 2006, a National Association of State Mental Health Program Directors (NASMHPD) report, *Morbidity and Mortality in People with Serious Mental Illness*, found that the life expectancy for persons with serious mental illness is 25 years shorter than for persons without serious mental illness.

For the past several years, DPW has pursued enhanced coordination between the physical health and behavioral health systems as an opportunity to improve the quality of care. In 2008, the Center for Health Care Strategies (CHCS) selected Pennsylvania to participate in a multi-state effort to improve quality and cost effectiveness for Medicaid beneficiaries with complex medical and behavioral needs. The “SMI Innovations” initiative involved the Office of Medical Assistance Programs (OMAP), OMHSAS, health plans, counties, primary care and behavioral health providers, and HealthChoices members. It is developing new collaboration models and tools to assist persons with complex needs and is testing and evaluating the models for quality improvement and return on investment.

This new initiative seeks to build on these past efforts and take them to the next level to find cost-effective approaches for high-risk, high-cost individuals. A Consumer Health Inventory, an assessment tool that helps identify the health care needs of people with serious mental illness, was implemented. Member Health Profiles and data exchange processes have been developed which give both behavioral health (BH) and physical health (PH) providers a more complete clinical picture of the member. Provider relationship building and communication have allowed for enhanced service and care linkages for the programs’ enrollees. Integrated provider health navigator teams and participating primary care physicians perceive value in the process and have remained enthusiastic about the pilot programs. DPW expects that the relatively small investment required for this pilot program will pay off in decreased hospitalizations and reduced inappropriate use of the emergency room. In addition, a stronger connection between primary health care

It had been years since Charlotte had seen a doctor. Charlotte feared her abdominal pain meant that she had the cancer that killed her mother. She avoided all contact with healthcare providers and rarely left home. A navigator, Sonja, spoke with Charlotte over the phone several times and after a few weeks, they met in a coffee shop. Charlotte agreed to meet with an OB/GYN specialist who arranged for all testing to be completed on the same day of the visit. Following her examination and testing, Charlotte required immediate treatment. Charlotte has been regularly attending both her medical and behavioral healthcare appointments and is actively engaged in her treatment. As Charlotte learns healthy ways to monitor and manage her depression, anxiety, and substance use, Sonja’s role will diminish but be available to help if needed. As Charlotte stated, “I was scared but relieved. If it wasn’t for her (Sonja), I wouldn’t have gone to the doctor.” SMI Innovations Participant

providers and individuals with mental illness and physical health co-morbidities translates into better quality and more cost-effective care.

DPW incentive funds are available to the behavioral health counties, behavioral health subcontractors and physical health managed care contractors based on their performance. Partners in the pilot are being evaluated based on performance on a series of measures including implementation of planned interventions, development of joint BH-PH care plans, BH-PH hospital admission and readmission rates, emergency department use, appropriate prescribing patterns and consumer satisfaction.

Co-occurring Mental Health/Substance Use Recovery

Services for individuals with co-occurring mental health and substance use disorders have the best outcomes when treatment is integrated. Similar to other states, Pennsylvania's mental health and substance abuse systems face significant challenges in identifying and treating individuals with co-occurring disorders (COD). The Department of Health (DOH), Bureau of Drug and Alcohol Programs (BDAP) is the Single State Authority for substance abuse policy and provides federal block grant and state funds to each of the 67 counties for substance abuse prevention, intervention, and treatment services. OMHSAS manages drug and alcohol services delivered through the Medical Assistance program and the Behavioral Health Services Initiative.

For many years, each system treated co-occurring disorders using the traditional clinical interventions and program services developed specifically for either the mental health or substance use disorder but not both disorders. Although these efforts were well-intended, they were not effective in treating the simultaneous presence of co-occurring mental health and substance use disorders. The collaborative efforts of DOH/BDAP and DPW/OMHSAS began in 1997 with the creation of a statewide Mental Illness and Substance Abuse (MISA) Consortium (now called the COD Consortium) to address the needs of people with co-occurring mental illness and substance use disorders.

In 2003, OMHSAS obtained one of 15 COSIG (Co-occurring State Incentive Grant) grants awarded nationally from SAMHSA to increase the capacity of states to provide effective, coordinated, and integrated treatment services to persons with COD. This grant initiated a pilot program to increase payment flexibility across the mental health and substance abuse systems, designed a cross-systems licensing project, and implemented five MISA/COD pilot projects (four programs for adults and one program for adolescents). The lessons learned from these initiatives have been implemented statewide

since the award of the COSIG grant. From a fragmented approach to treatment of COD, Pennsylvania is now a leader in provision of integrated treatment.

Sixteen programs throughout Pennsylvania are licensed as Co-Occurring Competent Programs, deemed competent to serve individuals with COD. A training curriculum on COD was developed and annual regional training is available, resulting in training thousands of behavioral health professionals and certified peer specialists. A COD competency-based credential for clinical professionals was developed in collaboration with the Pennsylvania Certification Board and over 1,000 behavioral health professionals were certified. In January of 2007, the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (IC&RC) announced it would offer an international and reciprocal certification for clinicians working with co-occurring/concurrent substance use and mental disorders. This credential is based upon the Pennsylvania certification model and today is used in many states.

Forensic/Justice Systems

"A commitment to transforming mental health service and substance abuse delivery is only part of the solution for the high numbers of individuals with mental illness and/or substance use disorders involved in the criminal justice system. For these individuals, collaboration between the mental health/substance abuse and criminal justice systems is paramount to the recovery process." *Recommendations to Advance Pennsylvania Responses to People with Mental illness and/or Substance Use Disorders Involved in the Criminal Justice System, 2006*

In late 2005, OMHSAS convened a Forensic Workgroup whose main objective was to design a mental health and substance abuse system in which services and supports enable people to reduce involvement with the criminal justice system, be diverted from incarceration, receive adequate treatment services while incarcerated, and plan for successful return from incarceration.

OMHSAS published its Forensic Workgroup recommendations in 2006: *Responses to People with Mental Illness and/or Substance Use Disorders Involved in the*

Criminal Justice System. The major recommendation was to implement the Sequential Intercept Model, a research-based approach for meeting the needs of justice-involved individuals at every point of contact with the

justice system. OMHSAS initiated a planning process with counties to develop Forensic Plans using the Sequential Intercept Model.

The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems. The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points (based on the work of Munetz and Griffin) are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support.

In an OMHSAS forensic survey conducted in 2009, counties reported implementation of the following intercept points:

- Intercept 1, Law enforcement and emergency services: 35 counties
- Intercept 2, Initial hearing and initial detention; 30 counties
- Intercept 3, Jails and courts – 42 counties (10 counties have implemented treatment courts)
- Intercept 4, Reentry from jails, prisons, and hospitals – 35 counties
- Intercept 5, Community corrections and community support services – 31 counties

Fourteen of the 48 county/county joinder MH/MR offices report services in all five intercepts.

State and local leadership has been instrumental in fostering ongoing collaboration with criminal justice systems and improving the lives of individuals who come into contact with both of these systems. In 2008, OMHSAS partnered with the Pennsylvania

The Allegheny County Forensic Program was winner of the 2005 Innovations in American Government Award which noted

- rate of recidivism of less than 10% on average, compared to a national recidivism rate of about 60%
- average cost of \$3,000 per participant, compared to national cost of \$25,000
- supported by the Department of Corrections
- improved relationships with providers of community services

Supreme Court to encourage system-wide collaboration, which led to a Strategic Plan that was adopted by the Court's stakeholders. In 2009 OMHSAS and the Pennsylvania Commission on Crime and Delinquency (PCCD) jointly funded a Forensic Center of Excellence (COE) with Drexel University and the University of Pittsburgh. The COE is in the process of establishing a listing of all forensic services available throughout Pennsylvania. The focus of the COE over the next 18 months is to train 20 counties on the Sequential Intercept Model's first intercept point, Crisis Intervention/Law Enforcement. The goal of this initiative is to increase diversion of individuals when they first come into contact with the justice system. Also in 2009, PCCD partnered with OMHSAS to jointly fund county grants for jail diversion and Mental Health Courts totaling \$6.5M of the American Recovery and Reinvestment Act (ARRA) funds. To qualify for PCCD grants, counties must have a local coordinating group with the representation from the police chief, jail, judges, parole/probation, the public defender, and human services agencies. OMHSAS continues its collaboration with other state agencies through its participation on the Governor's cross-systems task groups related to forensic services.

Progress

- OMHSAS provided start-up money for Montgomery County to develop a Deaf/Hard of Hearing Warmline utilizing videophone connection which will be managed by deaf certified peers and will be available to consumers across the state.
- The HC BH-MCOs have toll-free 24-hour telephone lines with TTY availability that can provide access to emergency, urgent, and routine services throughout Pennsylvania. Most county MH/MR offices also have TTY lines.
- Persons who are deaf or hard of hearing have been trained as Peer Support Specialists and Peer Support Supervisors in order to increase access.
- OMHSAS has provided start-up funding to develop a website www.healthbridges.info, which has reliable health and mental health information for consumers who are deaf, deaf-blind and hard of hearing, and their families.
- The Connected Care pilot, for SMI Innovations was established between UPMC for You, Allegheny County, and Community Care Behavioral Health.

- The *HealthChoices HealthConnections* pilot for SMI Innovations was established among Bucks, Delaware and Montgomery Counties, Magellan Behavioral Health of Pennsylvania, and Keystone Mercy Health Plan.
- Pennsylvania published the Co-Occurring Disorder Competent Bulletin, jointly signed by the DOH and DPW to establish statewide policy and criteria for a system of integrated care.
- A dedicated Co-Occurring website was established at www.pa-co-occurring.org to promote statewide information dissemination of resources and goals.
- OMHSAS developed resources to expand the Certified Peer Specialist Program for justice involved individuals in partnership with the Pennsylvania Mental Health Consumers Association (PMHCA).
- In early 2010 OMHSAS and PCCD released a funding announcement for a statewide forensic peer specialist training program and development of a statewide curriculum on mental health law and procedures to promote a better understanding of diversion options.

Resources

- PA Office for the Deaf & Hard of Hearing
(http://www.dli.state.pa.us/portal/server.pt/community/office_for_the_deaf_hard_of_hearing/10371)
- *Commonwealth Services for the Deaf and Hearing Impaired*, Report of the Legislative Budget and Finance Committee, 2006, Conducted Pursuant to Senate Resolution 76 of 2005.
(http://lbfc.legis.state.pa.us/factsheets/2006/385_deaf.pdf)
- An Accommodation Card can be created on [healthbridges.info](http://www.healthbridges.info) to facilitate communication in an emergency.
(http://www.healthbridges.info/?page_id=36)
- Office of Mental Health and Substance Abuse Services LGBTQI Workgroup, Issues of Access to and Inclusion in Behavioral Health Services for Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex Consumers, July 2009
(http://www.parecovery.org/documents/OMHSAS_LGBTQI_Recommendations.pdf)

- Co-Occurring Disorder Competent Bulletin OMHSAS 06-03 (<http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?BulletinId=1308>)
- Co-Occurring Interpretive Guidelines for 06-03 (<http://pa-co-occurring.org/resources/COD-CompetencyBulletinIntGuidelines.pdf>)
- Co-Occurring Competency Readiness (<http://pa-co-occurring.org/resources/COD-Comp-FAQs.pdf>)
- Certified Co-Occurring Disorder Professional (CCDP) criteria (<http://www.pacertboard.org/Cert-CCDP.asp>)
- Forensic Workgroup Recommendations: Recommendations to Advance Pennsylvania Responses to People with Mental Illness and/or Substance Use Disorders Involved in the Criminal Justice System, September 2006. (http://www.parecovery.org/documents/Forensic_Workgroup_Final_Report_111406.pdf)
- Munetz, M.R. & Griffin, P.A. Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services* 57:544–549, 2006. (<http://psychservices.psychiatryonline.org/cgi/reprint/57/4/544>)
- Mental Health & Justice Center of Excellence (www.pacenterofexcellence.pitt.edu)

V. Older Adult Services

Background

Over two million people over age 60 live in Pennsylvania, and studies indicate that 10% — 30% of the elderly population has a mental health disorder. However, the elderly are less likely to seek treatment from mental health professionals due to stigma. Older adults with behavioral health disorders who do not receive treatment are at increased risk of hospitalization, reduced physical functioning, and mortality.

Of Americans 65 and older, “twenty percent (6.6 million) are estimated to experience problems serious enough to put them at risk of psychiatric hospitalization or premature nursing home placement.”

[Behavioral Health and Aging Resource Manual](#)

Snapshot – Older Adults

- Approximately 2.5 million persons over age 60 reside in Pennsylvania, giving the state the third highest percentage of older adults in the U.S.
- Over 26,000 older adults received behavioral health services in 2009
- Of the older adults who received services in 2009, over 3,500 were over age 80
- 80 Certified Peer Specialists have been trained to serve older adults

Older adults with mental illness have traditionally been underserved for a variety of reasons—lack of mobility and access to services, stigma, and services that are designed for younger populations. Recognizing the unique needs of older adults, OMHSAS established an Older Adult Subcommittee of its Advisory Committee in 2004. In 2005, the OMHSAS Statewide Advisory Committee established two over-arching older adult goals for system transformation:

- Implement services and policies to support recovery and resiliency in the adult behavioral health system
- Assure that behavioral health services and supports recognize and accommodate the unique needs of older adults

In response to these concerns, OMHSAS developed Bulletins 06-01 and 06-02 to emphasize the importance of ensuring adequate service provision for older adults. Additionally, in February 2006 OMHSAS and the Department of Aging developed state-wide Memoranda of Understanding (MOU) between county mental health offices and Area Agencies on Aging that detailed how

the two agencies would partner to further support older adults with behavioral health needs. Specifically, the MOUs continue to create a platform for a clear understanding of each agency's commitment to developing infrastructure, sharing resources and resolving systems differences when needed. OMHSAS developed and continues to support training statewide to bring both agencies together to foster relationship building and offer support for complex case resolution.

The Older Adult Subcommittee works to tailor specific goals and strategies to improve services for older adults. The supporting projects and actions adopted by the Subcommittee and OMHSAS described below required strong partnerships with other DPW offices and service systems such as the Office of Medical Assistance Programs, Office of Developmental Programs, Department of Aging and Long Term Living, and the Department of Health, among others.

Older Adult Supporting Projects and Actions

- Expand older adults' access to services with the flexibility to provide services wherever needed, such as Mobile Mental Health Treatment and other supports
- Increase awareness of, planning for, and evidence-based training on suicide prevention for older adults
- Review the impact of Medicare primary and Medical Assistance as secondary payor on service provision
- Expand access to the interagency planning project for older adults with complex needs
- Expand development of peer support services specifically targeted to the needs of older adults
- Increase awareness of needs of older adults for substance abuse treatment and programs structured to accommodate those needs in a culturally competent manner
- Ensure community consumer involvement by providing support to individuals transitioning from South Mountain Restoration Center into the community
- Continue to assure appropriate mental health services for older adults experiencing dementia who have behavioral health problems
- Develop effective collaboration across systems with partners such as The Department of Aging, The Department of Health, The Behavioral Health and Aging Coalition, The Office of Medical Assistance Programs, Visiting Nurses Association, and others to promote more effective integration among behavioral/physical programs for older adults
- Continue collaborative efforts to promote "Share the Care" between OMHSAS and the Department of Aging which seek to create a statewide network to resolve complex cases related to older adults

One of the most significant innovations in the development of supports for older adults is the ongoing work with “Share the Care,” the collaboration between the county mental health offices and the Area Agencies on Aging to improve consumer services and outcomes for older adults. Initially begun in 2005, it was a complex care review process between Aging and OMHSAS to assist with complex care resolution in three specific counties. Share the Care evolved into a statewide initiative to foster county/AAA partnership to address broader needs of older adults with behavioral health and other social needs.

An example of the effective working partnership between OMHSAS and Aging in Columbia, Montour, Snyder and Union counties is a program named “Project HELP (Helping Elders Live Productively). Project HELP focuses on three key concepts:

- Mental Health and AAA consumers have unique needs
- Staff need ongoing training, education and support
- Outreach to older adults is critical to providing effective care

A Resource Coordinator serves as a liaison between the two systems to create awareness of service gaps and identify opportunities to promote better understanding of the unique and often complex needs of older adults. The Resource Coordinator engages other service systems and provides training on protective services, depression screening, music therapy and other supports that assist caretakers for older adults.

Progress

- The Older Adult Subcommittee of the OMHSAS Advisory Committee was established as a significant step in assuring appropriate, adequate services that promote recovery for older adults.
- Bulletins 06-01 (Memorandum of Understanding Between The Office of Mental Health and Substance Abuse Services and The Pennsylvania Department of Aging) and 06-02 (Service Priority For: Older Adult Population) were developed to outline services for older adults.
- The MOU “Share the Care” trainings occurred statewide.
- The development of “Attachment I” in the County Plan requires counties to attest to the development and existence of an MOU with their Area Agency on Aging.

- The curriculum for Certified Peer Specialists includes specialized training on support for older adults.
- The addition of Mobile Mental Health Treatment and Certified Peer Specialist services to the Pennsylvania Medical Assistance State Plan as in-plan services allows services to be provided in homes and other community based settings which are easier to access and less stigmatizing for older adults.
- Education and advocacy efforts include the promotion of a Wellness Recovery Action Plans (WRAP) and psychiatric advance directives for older adults.
- Network of Care and www.parecovery.org contain information targeted to older adults.

Resources

- Building A Recovery–Oriented Service System for Adults – Toward a Blueprint for Pennsylvania
(http://www.parecovery.org/principles_change.shtml)
- Pennsylvania Older Adult Suicide Prevention Plan
(http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/s_002544.pdf)
- Behavioral Health and Aging Resource Manual
(http://www.parecovery.org/documents/BH_Aging_Resource_Manual_Final.doc)

VI. Substance Use Disorder Services

Background

In Pennsylvania, administration of services for persons with substance use disorders (SUD) is shared by the Bureau of Drug and Alcohol Programs (BDAP) in the Department of Health and OMHSAS in the Department of Public Welfare. BDAP is the Single State Authority for substance abuse policy and provides federal block grant and state funds to each of the 67 counties for substance abuse prevention, intervention, and treatment services. DPW is the Medicaid authority for the Centers for Medicare and Medicaid Services (CMS) and OMHSAS is responsible for managing the Medical Assistance services for the treatment of substance use disorders. In addition, OMHSAS manages the BHSI and ACT 152 funding that goes to the counties as a part of their base funding allocation.

Snapshot – Substance Use Disorder Services

- In HealthChoices in 2008-2009
 - 1,708 consumers received inpatient detox or rehabilitation
 - 22,361 consumers received non-hospital residential drug and alcohol services
 - 57,512 consumers received outpatient drug and alcohol services
- Access to SUD services in 2008-2009 increased between 6% and 11% from the prior year across the various services
- HealthChoices funding for SUD services was more than \$230M in 2008-2009

“Substance abuse and addiction constitute the nation’s number one public health problem, contributing to ... the five leading causes of death. Our failure to prevent and treat it costs society more than \$600 billion each year.”
Joseph A. Califano, Chairman and President, Columbia University, 2009

Within OMHSAS, the bulk of the SUD services are within the HealthChoices program. The Medicaid state plan has limited services in Fee for Service and does not include some of the primary

services that are deemed needed: non-hospital detoxification, non-hospital rehabilitation, and half-way house. All three of these services are covered in the HealthChoices plan. From the beginning of the HealthChoices Medicaid managed care program, OHMSAS has been committed to a program that increases the quality of, access to, and cost-effectiveness of drug and alcohol services. Because of the known negative consequences for the individual and society of substance use disorders, access to drug and alcohol services has been monitored closely. OMHSAS has assured and maintained

this focus through continuous data analysis, stakeholder feedback and program monitoring.

Funding for SUD Services in OMHSAS

OHMSAS has three different funding mechanisms to fund services to treat substance use disorders in Pennsylvania. These include Medical Assistance, Act 152 funds, and BHSI funds.

- Medical Assistance –In FY 08-09, the last year for which full data is available, total spending in Medical Assistance for SUD services was almost \$233M. Of that \$6.5M was for inpatient services, \$146.5M for non-hospital residential services, and \$80M for outpatient services. HealthChoices became statewide in 2007 and all zones provide services for substance use disorders, accounting for the vast majority of SUD funding. Of those totals, FFS accounted for approximately \$800,000 in inpatient services and \$1M in outpatient spending. As noted earlier, FFS does not cover non-hospital D&A services.
- Act 152 Funding - In 1988 Act 152 provided state funding for non-hospital residential detoxification and rehabilitation services for individuals eligible for Medical Assistance. The intent of Act 152 was to provide state funds to pay for residential rehabilitation, detoxification, and halfway house services not available under Fee-For-Service Medicaid. Act 152 funds are allocated by OMHSAS to the Single County Authorities (SCAs), and in FY 10-11, the Department approved over \$16M in Act 152 funds to serve an estimated 6,000 individuals.
- Behavioral Health Service Initiative (BHSI) – BHSI was established at the request of the Department of Public Welfare to provide a safety net of state funding for individuals with the most serious mental health and substance use disorders that were impacted by Act 35 (welfare reform initiative) and are not eligible for MA. BHSI funds are allocated by OMHSAS to the Single County Authorities (SCAs), and in FY 10-11, the Department approved almost \$32M in D&A BHSI funds to serve an estimated 46,000 individuals.

HealthChoices Services

To determine the impact of HealthChoices on SUD services, OMHSAS conducted an assessment of utilization of services in the three initial HealthChoices zones, looking at changes in persons served as well as overall funding for services between 2001/2002 and 2006/2007. The analysis time frame was chosen because the three zones were all in place by 2001 and

five years of data was available. A detailed trend analysis of the new zones will be undertaken in the near future when a sufficient number of years have elapsed since the implementation of those zones in 2006 and 2007.

“Through the efforts of our HealthChoices behavioral program, we have realized an improvement in access to substance abuse services for adults and adolescents, with the greatest increase occurring with our youth,” Administrator, HealthChoices Multi-County Collaborative

In each of the three initial zones, the number of persons receiving services and funding for services increased substantially. As the most mature zone (1997), the Southeast increased the least, having already expanded access to services prior to 2001. In spite of that, between 2001 and 2007, persons served increased by 33.4% and funding by 30.3%.

The Southwest zone was implemented later than the Southeast (1999), and the increase in treatment for SUDs increased more dramatically. Persons served increased by 111.7% and funding increased by 154.6%. As expected, the newest zone (Lehigh/Capital) showed the greatest increase, with persons served increasing 127.5% and funding increasing 229.8%.

HealthChoices SUD Users and Expenditures

	Average Annual Users 2001/2002	Average Annual Users 2006/2007	Average Annual Expenditures 2001/2002	Average Annual Expenditures 2006/2007
Southeast	24,654	32,889	\$69,644,164	\$90,729,562
Southwest	8,992	19,038	\$16,573,933	\$42,194,216
Lehigh/Capital	4,447	10,119	\$7,388,862	\$24,365,260

Note: For the SE and SW, the average of 2001 and 2002 was used as the base; The Lehigh/Capital zone was being implemented during 2001 so 2002 was used as the base. All three zones show the average annual expenditure for calendar years 2006 and 2007

OMHSAS also looked at utilization of non-hospital residential services. Increases were seen in all areas of the state with the exception of the Southeast where residential rehabilitation units per user decreased. This was driven primarily by Philadelphia where the length of residential rehab decreased and outpatient increased. Even with the decrease, average days per consumer remained greater than 30.

Utilization of SUD Residential Services

		Average Units per User 2002	Average Units per User 2007	Average Expenditure per User 2002	Average Expenditure per User 2007
Southeast	Detox	4.5	4.8	\$968	\$1,207
	Residential	42.8	34.4	\$7,074	\$7,024
	Half-way House	53.8	55.5	\$3,759	\$5,012
Southwest	Detox	3.1	3.8	\$522	\$715
	Residential	25.2	29.1	\$3,791	\$4,614
	Half-way House	62.5	67.1	\$4,644	\$5,386
Lehigh/Capital	Detox	3.9	4.8	\$671	\$958
	Residential	23.0	31.0	\$3,610	\$5,331
	Half-way House	45.7	55.0	\$3,281	\$4,779

OMHSAS continues to monitor trends in access to treatment for substance use disorders. The trend of increasing funding for these needed services has continued as shown in the tables below which track funding through the most recent complete data set for 2008/2009. Overall in HealthChoices, including all six zones, expenditures in HealthChoices in 2008/2009 for SUD services were \$230,595,929.

HealthChoices SUD Funding

	Average Annual Expenditures 2001/2002	Average Annual Expenditures 2006/2007	Annual Expenditures 2008/2009
Southeast	\$69,644,164	\$90,729,562	\$117,530,006
Southwest	\$16,573,933	\$42,194,216	\$51,892,390
Lehigh/Capital	\$7,388,862	\$24,365,260	\$30,086,030

Note: The Lehigh/Capital zone was implemented in 2001 and data was incomplete. For Lehigh/Capital 2002 was used as the base. All three zones have an average expenditure for calendar years 2006 and-2007 and annual expenditures for SFY 2008-2009.

Clearly, the HealthChoices program has been successful in improving access to drug and alcohol services for Medicaid-eligible persons in the

Commonwealth. OMHSAS continues to monitor service availability and delivery to ensure high quality, cost-effective programs.

Recovery-Oriented System of Care

The recovery movement for substance use is similar to that occurring in the mental health field. Although substance use treatment and recovery stakeholders have discussed and lived recovery for decades, the development of a common understanding of a recovery-oriented system of care in the substance use

“What better partnership than treatment professionals who, ideally, stay abreast of the very latest in treatment techniques ... and persons in recovery who, too often, have themselves been knocked to their knees only to get back up, dust themselves off and try again, one day or minute at a time.
Addictions Recovery, When Knowing the Facts Can Help in Pennsylvania, Institute for Research, Education and Training on Addictions, 2009

community is a recent phenomenon. OMHSAS has supported the transformation of the behavioral health system to a recovery-oriented model and continues to be an active participant in the process. The model includes the concept that there is no wrong door for recovery, giving individuals a genuine choice of pathways that meet their needs.

OMHSAS works in collaboration with key state stakeholders on developing and sustaining a Recovery-Oriented System of Care (ROSC) for Pennsylvania. Developing a ROSC may involve changes in the content, service delivery/infrastructure, outcomes and financing mechanisms of the current drug and alcohol treatment system. As discussed later in this section, development of the ROSC requires cooperation and collaboration among a variety of organizations, funders, and advocates to ensure a unified approach that maximizes resources for consumers.

Co-occurring Mental Health/Drug and Alcohol Recovery

For many years, providers treated co-occurring disorders (COD) using the traditional clinical interventions and program services developed for either a mental health or substance use disorder. In 1997, a statewide Mental Illness and Substance Abuse (MISA) Consortium (now called the COD Consortium) was established to identify integrated approaches to treat people with co-occurring mental illness and substance use disorders.

In 2003, OMHSAS obtained one of 15 COSIG (Co-occurring State Incentive Grant) grants to increase the capacity of states to provide effective, coordinated, and integrated treatment services to persons with COD. This grant initiated a pilot program to increase payment flexibility across the mental health and substance abuse systems, designed a cross-systems licensing project, and implemented five MISA/COD pilot projects.

For additional information on Co-occurring capabilities, see expanded discussion in the section *Adults – Targeted Services and Approaches*.

Working with Our Partners

In order to ensure the most coordinated service delivery, it is important for OMHSAS to work closely with its partners, including other commonwealth departments as well as stakeholders in the community. Among the joint activities include

- Drug and Alcohol Coalition – OMHSAS, in collaboration with the Department of Health/Bureau of Drug and Alcohol Programs, convened a Drug and Alcohol Coalition comprised of key stakeholders to identify and build a coordinated system of care to address substance use and co-occurring disorders. The Coalition includes representatives from government, advocacy, providers, families, and persons in recovery. Subcommittees include Workforce Development, Accessibility and Standardization, Finance and Funding, Recovery-Based Issues, Criminal Justice, and Prevention.
- Workforce Development - OMHSAS sponsors annual trainings and webinars to expand and support the Commonwealth’s addictions workforce. Trainings are designed to promote evidenced-based practices in partnership with Drexel University and the Institute for Research, Education and Training in Addictions (IRETA). Workforce trainings are approved by the Departments of Health and Public Welfare, and meet the requirements of the Pennsylvania Certification Board for certified addiction professionals. OMHSAS has also collaborated with the PCB to develop a co-occurring disorder professional credential (CCDP) that has become the international standard.
- PCPC and ASAM - OMHSAS participates on the Clinical Standards Committee convened by BDAP to review and revise the Pennsylvania Client Placement Criteria for Adults (PCPC). The PCPC is contractually required in the HealthChoices program. For children, the American Society of Addiction Medicine (ASAM) Patient Placement Criteria –

Revised is the required medical necessity criteria for all adolescents being assessed for substance use treatment in the state. Both BDAP and OMHSAS require providers to use ASAM criteria.

- Persons In Recovery Committee – The Persons in Recovery Committee was formed to ensure that the voice of recovery from substance use and/or co-occurring psychiatric disorders was represented in the OMHSAS Advisory structure. The committee is responsible to BDAP and OMHSAS to provide input, feedback, and recommendations pertaining to developing and implementing substance use programs, integrating co-occurring services, and transforming to a recovery-oriented system of care. The members represent persons with co-occurring psychiatric and substance use conditions, persons in recovery, family members and other interested stakeholders.
- D&A Program Licensing - OMHSAS works collaboratively with the Department of Health’s Division of Drug and Alcohol Program Licensure to ensure coordination of responsibilities, maximize efficiency and reduce duplication of efforts for programs licensed by both departments. The departments have developed a Memorandum of Understanding to continue the collaboration.
- Pennsylvania Recovery Organizations Alliance - OMHSAS supports the voices of recovery by partnering and collaborating with the Pennsylvania Recovery Organizations Alliance (PRO-A) and its affiliates across the state. PRO-A represents the face and voice of recovery by providing education on the disease of addiction, reducing stigma associated with substance use, and advocating in the best interest of the recovering community. OMHSAS works with PRO-A to build partnerships and resources within the recovering community.
- MOMSTELL - OMHSAS recognizes the significant impact of substance use disorders on the family. By supporting MOMSTELL, a non-profit advocacy organization comprised of parents and family members, OMHSAS provides resources to assist families in their struggle to access appropriate services and supports for family members with substance-related disorders. MOMSTELL promotes awareness of substance use and works to reduce stigma through advocacy and education to families attempting to negotiate a complex service system. The Director of MOMSTELL is a member of the OMHSAS Advisory Committee and a member of the OMHSAS Quality Management Committee.

HealthChoices Initiatives

One of the important features of the HealthChoices program is its ability to develop services that are not specifically identified in the Medicaid State Plan but which serve as an alternative to State Plan services. Since 2005, there were 144 approved requests for drug and alcohol supplemental services.

- Drug and alcohol services in the schools – Often, youth are reluctant to enter substance use treatment through a traditional clinic program, but are more open to receive the services if they are available in schools. In 2009, OMHSAS issued a policy clarification specifying that licensed D&A clinics enrolled in HealthChoices could offer treatment services in a home or school setting as a supplemental service.
- Buprenorphine Coordinator - The Buprenorphine Care Coordination Program is an innovative and unique approach designed to assist individuals who are being prescribed buprenorphine in the HealthChoices program. The primary objective is to ensure that substance use treatment is coordinated among the individual, treating physician, and D&A treatment provider to support recovery.
- Intensive Outpatient Programs - For some people with substance use disorders, traditional outpatient treatment may be insufficient, but residential care is either more intensive than needed or too disruptive to their lives in the community. Through HealthChoices, OMHSAS has funded outpatient programs that allow the person to get intensive treatment while remaining in the community.
- Expedited Enrollment – Because of the limited set of services available for SUD treatment in Fee for Service, OMHSAS and the Office of Income Maintenance (OIM) developed a pilot program in 2008 to expedite enrollment of consumers into HealthChoices. By late 2010, nineteen counties participated and over 1,000 consumers were enrolled in HealthChoices in an expedited manner in order to allow them to receive non-hospital residential services.
- D&A Transitional Housing for Men and/or Women - This program serves MA eligible adult men and/or women 18 years of age and older diagnosed with substance abuse or co-occurring disorders who have successfully completed a substance abuse treatment program such as D&A half-way house. The program offers transitional housing and support in securing permanent housing, finding and maintaining employment, and maintaining sobriety.

- D&A Outpatient Forensic Core Program - This program provides community treatment and transition assistance to adults with SMI and co-occurring substance abuse addiction involved with the criminal justice system. It focuses on people who are being discharged from state hospitals, jails, prisons, or being diverted from possible admissions. The Re-Entry Liaison provides recovery-oriented support, advocacy, and assistance in accessing needed services and resources.
- D&A Recovery Specialist - Recovery Specialists provide peer support and guidance to MA eligible adults struggling with addiction issues and co-occurring issues. It offers outreach, mentoring and peer support at all stages of recovery. The services are developed within the Best Practice Guidelines of a Recovery-Oriented System of Care (ROSC) and the Specialists receive certification from the Pennsylvania Certification Board (PCB).
- Recovery-Oriented Methadone Pilot Project - OMHSAS supported a recovery focused methadone pilot project in southwest Pennsylvania. Using a multi-stakeholder approach and consensus development, the group made recommendations regarding clinically-based, recovery-oriented approaches to the delivery of opiate treatment programs using methadone.

Buprenorphine Services

OMHSAS supports the prescribing of buprenorphine by behavioral health physicians as well as by physicians funded by the Office of Medical Assistance Programs (OMAP). Of all illicit substances, addiction to heroin arguably has the greatest stigma and is seen as a moral failing best addressed in the criminal justice system. Often, it leads to doing whatever is needed to get the money to purchase the drug, and prison can be the end result. HIV is also a significant risk due to sharing needles. For many years, the only choice for persons with opioid dependence was methadone.

On October 2002, the Federal Food and Drug Administration approved the use of buprenorphine for the treatment of opioid addiction. Buprenorphine treatment can be provided in a physician's office, and although many people feel "back to normal" within a week, a period of maintenance therapy and counseling is recommended to solidify gains and ensure that the individual is establishing healthy life routines. OMHSAS recognizes buprenorphine as a best practice pharmacologic approach to opioid dependence, and as an effective adjunct to counseling and therapy.

OMHSAS, OMAP, BDAP and stakeholders participated in a Buprenorphine Workgroup to discuss best practices. OMHSAS and OMAP work together to review buprenorphine prescribing patterns to ensure that providers are meeting the requirements as well as to monitor prescribing patterns to prevent abuse. DPW released a buprenorphine bulletin that required that persons receiving buprenorphine have documentation of “referral to or participation in a substance abuse or behavioral health (BH) treatment program” in order to improve the likelihood that recovery will be maintained.

Progress

- In 1997, the first HealthChoices zone is implemented in the Southeast and includes a full range of drug and alcohol services including non-hospital residential treatment.
- The use of buprenorphine to treat opioid addiction was approved by the FDA in October 2002.
- Pennsylvania is one of 15 states to receive a COSIG grant to develop an approach to persons with co-occurring disorders.
- In 2007 the final HealthChoices zones were implemented, ensuring statewide access to non-hospital residential services for substance use disorders through Medical Assistance.
- In 2008 the Drug and Alcohol Coalition was formed, bringing together government agencies and other interested parties to help form recommendations to enhance SUD services in Pennsylvania.
- OMHSAS was successful in creating a cost model to allow Children in Substitute Care who received SUD services out-of-zone to remain in HealthChoices.
- In 2010 the Persons in Recovery Subcommittee was added to the OMHSAS Advisory Committee.

Resources

- DPW Substance Abuse Services site (<http://www.dpw.state.pa.us/foradults/substanceabuseservices/index.htm>)

- PA Department of Health Bureau of Drug and Alcohol Programs
(<http://www.portal.state.pa.us/portal/server.pt?open=512&objID=14221&mode=2>)
- A Collaborative Plan and Metrics to Improve Substance Use Related Care for Pennsylvanians
(http://www.ireta.org/ireta_main/Drug_and_Alcohol_Coalition_Final_Report.pdf)
- Certified Recovery Specialist Information
(<http://www.pro-a.org/about-certified-recovery-specialist.html>)
- Recovery Oriented System of Care White Paper
(http://www.facesandvoicesofrecovery.org/pdf/White/rosc_community_perspective_2010.pdf)

VII. State Hospital Services

Background

Although state hospitals were once thought of as places of asylum, the new vision of a mental health system does not include long-term stays in state hospitals. We now know that with the right services and supports, all individuals can have hope for a life in the community. In 2005, the President's New Freedom Initiative challenged states to strive for this goal, and the U.S. Supreme Court's 1999 decision in *Olmstead v. L.C.* affirmed the right of people who have a disability to live in community settings.

"After a year of study, and after reviewing research and testimony, the Commission finds that recovery from mental illness is now a real possibility. The promise of the New Freedom Initiative - a life in the community for everyone - can be realized."
"Achieving the Promise; Transforming Mental Health Care in America", July 2003

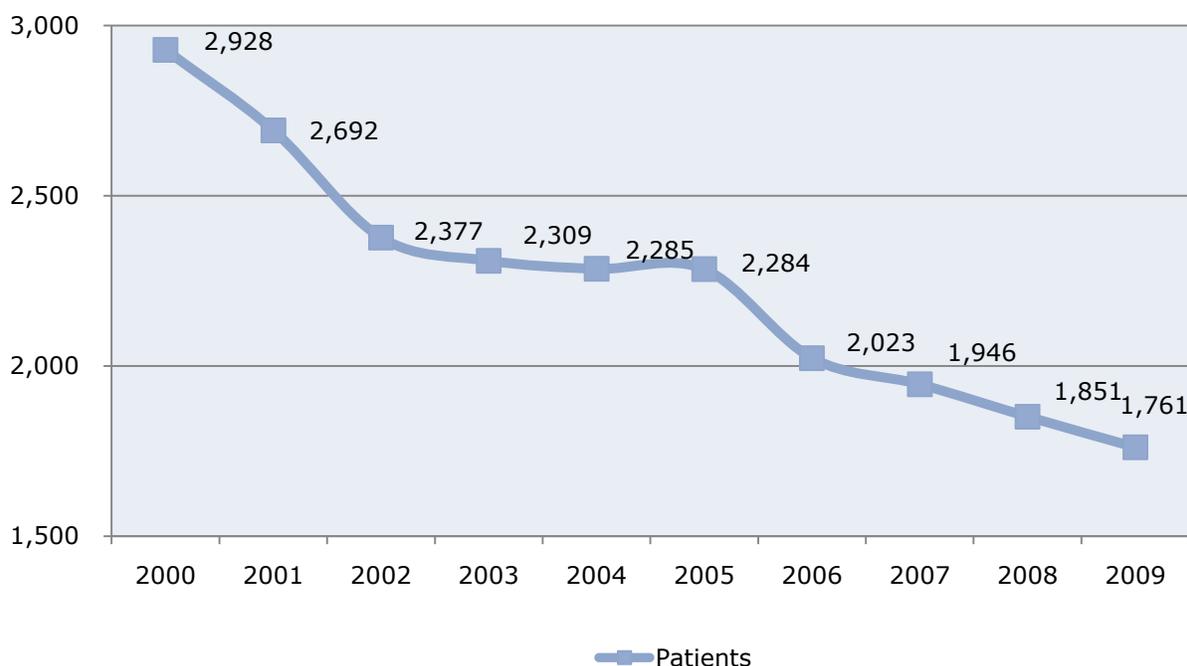
All OMHSAS state hospitals are accredited by the Joint Commission (JCAHO), and in 2009 and 2010, the South Mountain Restoration Center (nursing home) was recognized as one of the top state nursing homes in the country by *US News & World Report*. In 2000, the Commonwealth received the Innovations in American Government Award, sponsored by Harvard University Center of Excellence in Government and the Ford Foundation, for its successful initiative to eliminate the use of seclusion and restraint in all its state hospitals.

The table below highlights the reduction in census from 2,928 patients in FY 2000 to 1,761 patients in 2009 as a result of hospital closures, consolidations, and Community Hospital Integration Projects Program (CHIPP). In 2010 it was reduced further to 1,341 with the Allentown State Hospital consolidation. The bed reduction has allowed over 1,500 individuals to return to lives in the community and many more to be served with state hospital funds for diversion services in the community.

Snapshot – State Hospital Services

- 2000 – nine state hospitals, 2,928 beds
- 2010 - six state hospitals (capacity: 1,341 beds) and one long-term nursing care facility (capacity: 159)
- \$404M annual state hospital budget (2009)
- 49% of all consumers had a length of residence less than 2 years
- Nearly 50% of all individuals admitted to a psychiatric bed had a co-occurring substance use disorder

State Hospital Patient Census End of Year Totals



Beginning in 1991, the Community Hospital Integration Projects Program provided funding for community services for discharged persons, provided diversionary services for at risk persons in the community, and reduced state hospital bed utilization. CHIPP creates services to support persons with a long-term history of hospitalization or other complex needs so that they can live successfully in the community.

In February 2002, OMHSAS convened a broad-based workgroup to plan the future of Pennsylvania's mental health system and refocus institutional resources to home- and community-based services for persons across all disabilities. The resultant report, [Community/Hospital Integration Plan](#), called for the development of five-year regional Service Area Plans (SAP) that would look at the long term role of the hospital, plan for services in the community, assure the quality of services, and address financing plans.

The SAP guidelines charged counties with implementing plans to progress toward three goals:

- **Goal 1:** Within five years, no person will be hospitalized in a state hospital beyond two years

- **Goal 2:** Within five years, no person will be involuntarily committed to a community hospital more than twice in one year
- **Goal 3:** Within five years, the incarceration of the target population will be reduced

In 2004, the OMHSAS Statewide Planning Council was restructured to be more inclusive and responsive to stakeholders. The Planning Council affirmed the priority: "To assure that individuals receiving behavioral health treatment and supports have the opportunity to live and thrive in open integrated community settings through building community partnerships and integrating funding." The Planning Council called for the redesign of the state hospital system to develop community resources to support the discharge of any individual who has been in the state hospital for over two (2) years. Since then, three state hospital consolidations/closures were completed.

"After 17 years and 48 psychiatric hospitalizations, I got a call from Harrisburg State Hospital – I thought they wanted me to come back as a patient – but they offered me my first job as a peer support specialist to help people move to the community ...

Perhaps the greatest lesson I have learned is that, if we view each person through eyes seeking abilities, and develop environments where each person's abilities are embraced, we can create a ripple effect of people believing in people. In a world that often asks, "What's wrong?" I challenge us to ask a second question: "What's right?"

Gina Kaye Calhoun, Certified Peer Support Specialist
& Recovery Trainer

With the first SAP submissions (2004), the seven-county Capital Region developed a community-based services plan for people residing in Harrisburg State Hospital (HSH), a 251 bed facility. The HSH regional SAP efforts resulted in the successful closure of the hospital in January 2006. The HSH closure process established many best practices, including a discharge planning meeting called a Community Support Plan (CSP), which includes consumer, family, and clinical assessments to understand, from the

consumer's perspective, what s/he needed to live successfully in the community. Gina Kaye Calhoun's story about her move to the community highlights the importance of understanding people's goals and hopes.

The plan to close Mayview State Hospital was announced in 2007. The counties pooled funds to facilitate independent CSP assessments, develop an integrated funding strategy, and manage the closure process. The Mayview closure built on the lessons learned from past closures and developed new management tools, such as a web-based "early warning" tracking system. The CSP identifies the medical home for each individual for coordination with the physical health managed care organization or primary care physician. Each individual discharged has a crisis plan developed by the individual and responsible providers. The Mayview region is the first region to affirmatively plan for a service system without a state hospital, fulfilling the promise of the New Freedom Commission of "a life in the community for everyone." A report on lessons learned can be found on their website at www.mayview-sap.org.

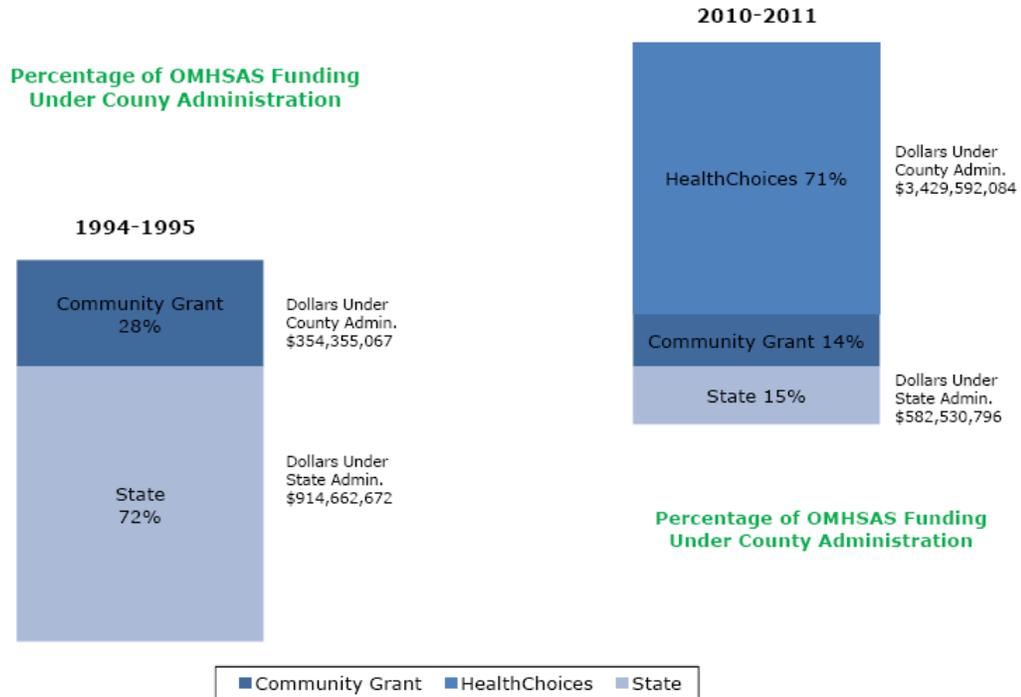
On January 28, 2010 OMHSAS announced the consolidation of Allentown State Hospital, a 175 bed hospital serving Lehigh, Northampton, Carbon, Monroe, and Pike Counties in northeast Pennsylvania. Funds from the closure were braided with resources from the HC-BH program, the Home and Community Based and Consolidated Waivers, and Money Follows the Person to support 125 individuals living in their community. Allentown was closed December 15, 2010, and consolidated with Wernersville State Hospital. With the Allentown closure, Pennsylvania has closed 13 hospitals since the first closure of Hollidaysburg State Hospital in 1979.

Financing the Transformation

Supporting the journey to achieve a life in the community is not an easy task; it requires vision and commitment. A key component for transformation is financing strategy to shift funds from the state hospital to the community with a plan for sustainability for the community service infrastructure.

The financing strategy to reduce reliance on institutional services reflects a unified systems approach. When developing their CHIPPs budget, counties include all county, state, and federal funds. CHIPP funds are used to pay for services and supports that are not Medicaid eligible, such as housing and non-clinical support services, or for services for people who are not Medicaid eligible. The HealthChoices behavioral health managed care waiver program rate setting methodology recognizes the costs for covered services identified

in a member’s Community Support Plan (CSP). HealthChoices and CHIPP also include funding for diversionary services for people who may be at-risk of state hospital admission.



Note: State Mental Hospital and Medicaid Fee-For-Service Funding are under State Administration

Additionally, HealthChoices reinvestment funds have been used for start-up costs and to develop supported housing options. CSP assessments determine if individuals are eligible for DPW Home and Community-Based Waiver services, and OMHSAS funds have been used to match Office of Developmental Program waiver funds to draw down additional federal dollars.

“The closure of Harrisburg State Hospital provided substantial resources to develop infrastructure and services. To give it a bit of perspective, it would cost approximately \$2.5 M to provide treatment in a state hospital for 12 individuals for one year...we approximate that this (HSH) resource provides opportunity for over 500 people to receive services in the community.”
Perspective: The Closure of Harrisburg State Hospital – A Four Year Report, January 23, 2010 Cumberland and Perry Counties Mental Health Program

Other Hospital-Community Initiatives

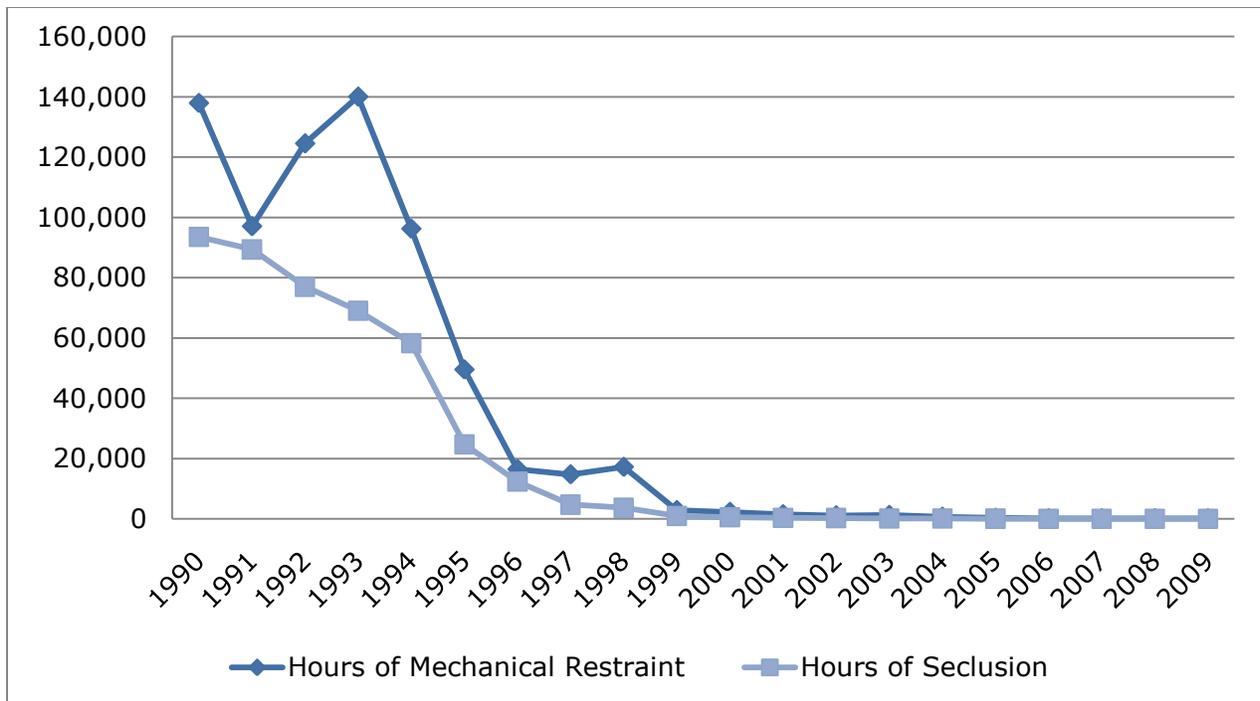
- State Hospital Training Initiatives – State hospital staff provide enhanced training to county staff and community providers in Dialectical Behavioral Therapy (DBT), medication management, mental health advance directives, psychotropic medications, and other areas that are identified by the counties.
- Disaster Crisis Outreach and Referral Team (DCORT) – Three of the state mental hospitals serve as emergency communication/call centers to support the Commonwealth’s emergency services plan and to provide critical information to residents when needed.
- Certified Peer Specialists – Peer Specialists hold staff positions at state hospitals, serve on community outreach teams, provide role models in recovery, train other staff in recovery and develop educational programs.
- Positive Practice Resources Team (PPRT) - The PPRT is a joint initiative of OMHSAS and the Office of Developmental Programs (ODP) to serve individuals with a dual MH/ID diagnoses. Staff from the OMHSAS state hospitals and ODP state centers partner for community outreach to build capacity within Pennsylvania’s provider network to serve individuals who are dually diagnosed and to decrease state hospital admissions. PPRT consultative services assist community providers to continue serving consumers in their home environments.
- Unified Practices - In an effort to streamline practices and increase efficiency and cost effectiveness, the hospitals have formed a workgroup to assure consistent and coordinated practices among the hospitals. These include standardized policies and procedures, use of shared services and coordination of forensic practices.

Progress

- State Hospital Census Reduction – FY 1994-95 to FY 2009-10: 69% reduction in the state hospital census, 55% decrease in staff complement.
- Harrisburg State Hospital closed – December 29, 2006, 132 individuals discharged to the community.
- Mayview State Hospital closed – December 29, 2008, 225 individuals discharged to the community.

- Allentown State Hospital closed - December 15, 2010, 125 individuals discharged to the community.
- Community Support Planning (CSP) and follow-up – Readmission rate for persons with CSP is less than one-tenth the rate of those without a CSP (.4% vs. 5.1%).
- Decreasing length of stay – decreased the percentage of persons with a stay of over two (2) years by 30% between 2003 and 2010. The two year mark is a significant milestone, as data show that those who pass that length of stay are likely to stay for much longer periods than those who are discharged before two years.
- Elimination of seclusion and restraints –The hospital system has decreased the use of seclusion in both civil and forensic sections by more than 99% since 2000. During 2009, seclusion was used only 13 times in the system for a total of 13 hours. Mechanical restraint usage has declined by more than 97% since 2000.

Pennsylvania State Hospital System (Civil & Forensic)
Hours of Seclusion and Mechanical Restraint
1990 Through 2009



Resources

- "Achieving the Promise; Transforming Mental Health Care in America" July 2003 (www.mentalhealthcommission.gov)
- Positive Practices Resource Team – (<http://www.dpw.state.pa.us/communitypartners/informationforadvocatesandstakeholders/positivepracticesresourcetemprrt/index.htm>)
- Toward Recovery and Hope: Building a Community System with the Closure of Mayview State Hospital (http://www.mayview-sap.org/documents/misc/AHCI_MayviewSummary_1004-nobleeds.pdf)
- State Hospital Information available at (<http://www.dpw.state.pa.us/forfamilies/statehospitals/index.htm>)
- Seclusion and Restraint information – (http://www.parecovery.org/services_seclusion.shtml)

VIII. Quality Management

Background

The OMHSAS Quality Management program ensures public accountability and continuous quality improvement of OMHSAS programs and services. The OMHSAS Quality Management Committee includes consumers, advocates, providers, counties and managed care organizations in addition to OMHSAS staff. It includes representation for adults, children and older adults as well as for mental health and substance use disorders. The Committee also ensures participation by members of ethnicities and minority groups served by OMHSAS. OMHSAS engaged families and consumers to develop and establish the following Guiding Principles for the provision of quality services and supports.

Snapshot – Quality

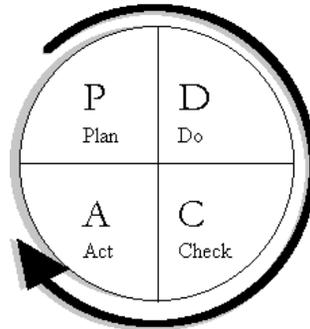
- HealthChoices (HC) Performance Report of 29 indicators published annually
- Recovery-Oriented Systems Indicators implemented in 24 counties in 2009
- External Quality Review of HealthChoices program conducted annually and submitted to Centers for Medicare and Medicaid Services (CMS)
- Consumer/Family Satisfaction Teams survey consumers and submit quarterly reports

Guiding Principles for Quality Services and Supports

The mental health and substance use treatment system will provide quality services and supports that

- Facilitate recovery for adults and resiliency for children
- Are responsive to individuals' unique strengths and needs throughout their lives
- Focus on prevention and early intervention
- Recognize, respect, and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity, and sexual orientation
- Ensure individual human rights and eliminate discrimination and stigma
- Are provided in a comprehensive array by unifying programs and funding that build on natural and community supports unique to each individual and family
- Are developed, monitored and evaluated in partnership with consumers, families, and advocates
- Represent collaboration with other agencies and service systems

OMHSAS established an overarching quality framework that relies on consumers and families, combined with the participation of the counties, providers and BH-MCOs to continuously improve services and supports.



Key objectives of the OMHSAS (P-D-C-A) Quality framework include:

- Increasing access to community- and family-based services and supports
- Providing high quality services
- Improving consumer satisfaction
- Obtaining stakeholder feedback to continuously improve OMHSAS services

The Bureau of Quality Management and Data Review measures HealthChoices' success in improving the value and quality of behavioral health services in the following areas:

Increased Access to Community and Family-based Services

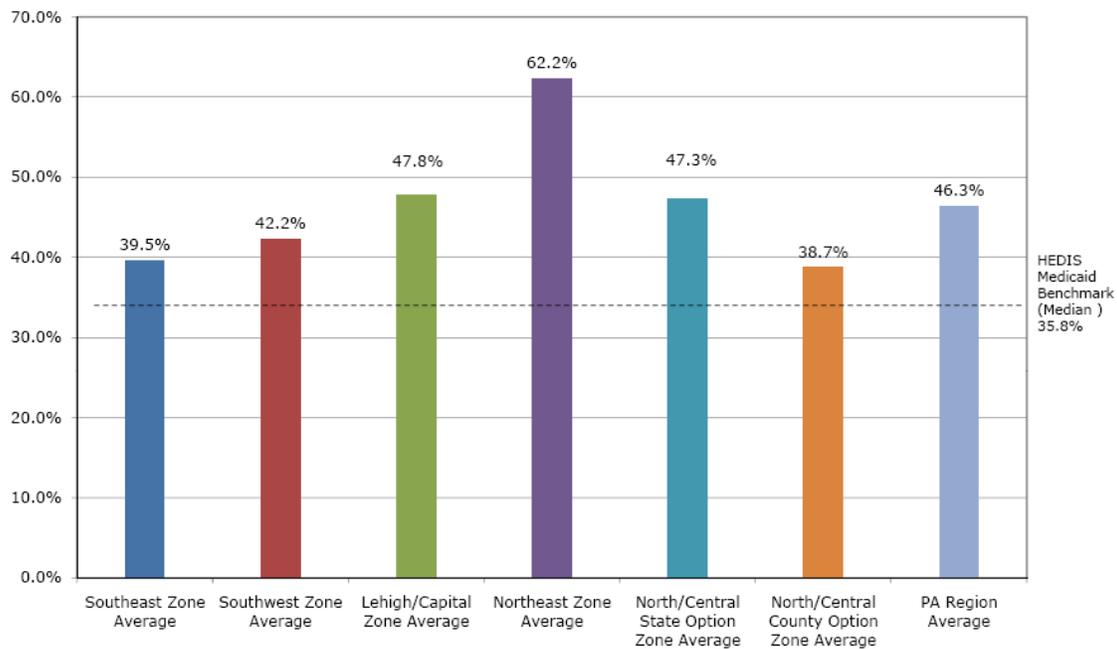
An important goal of OMHSAS is to ensure that adults, children, and families have good access to services. OMHSAS uses data to determine changes in access and has identified the following:

1. The percent of HealthChoices adults (ages 18-64) receiving MH services increased from 25.0% in 2007, to 26.0% in 2008. The Southwest region has consistently shown the highest utilization rates, with 29.8% of eligible adults receiving MH services in calendar year (CY) 2008.
2. In 2008, the percent of HealthChoices eligible adults who were identified as having a serious mental illness and were receiving community-based services was 7.0%, significantly higher than the

estimated national average of 3.1% in the general population. We believe this demonstrates that the HealthChoices program has been successful in identifying persons with serious mental illness and in providing community-based services which support their lives in the community.

3. Adults (ages 18-64) receiving drug and alcohol services remained unchanged at 7.0% of eligible members in 2007 and 2008. While there are no reliable estimates for the number of persons in a Medicaid program who might need substance abuse services, the estimated national need for all populations is 4.8%.
4. Adults with serious mental illness and a co-occurring substance disorder who received services remained constant at 2.0% of eligible members from 2004 to 2007. This was below the national estimated need of 3.1% and is an area for improvement.
5. Utilization of mental health services by African-American adults (ages 18-64) increased from 18% of eligible members in 2004 to 22% in 2008.
6. Utilization of drug and alcohol services by African-American adults (ages 18-64) increased from 7% of eligible members in 2004 to 8% in 2008.
7. Utilization of outpatient mental health services for Medicaid-eligible children, adolescents, adults, and older adults within 7 days of discharge from a psychiatric hospital was at 43.8%, exceeding the Health Effectiveness and Data Information Set (HEDIS) national benchmark of 35.8% for a Medicaid-covered population. As illustrated below, every HealthChoices Zone exceeded the HEDIS benchmark.

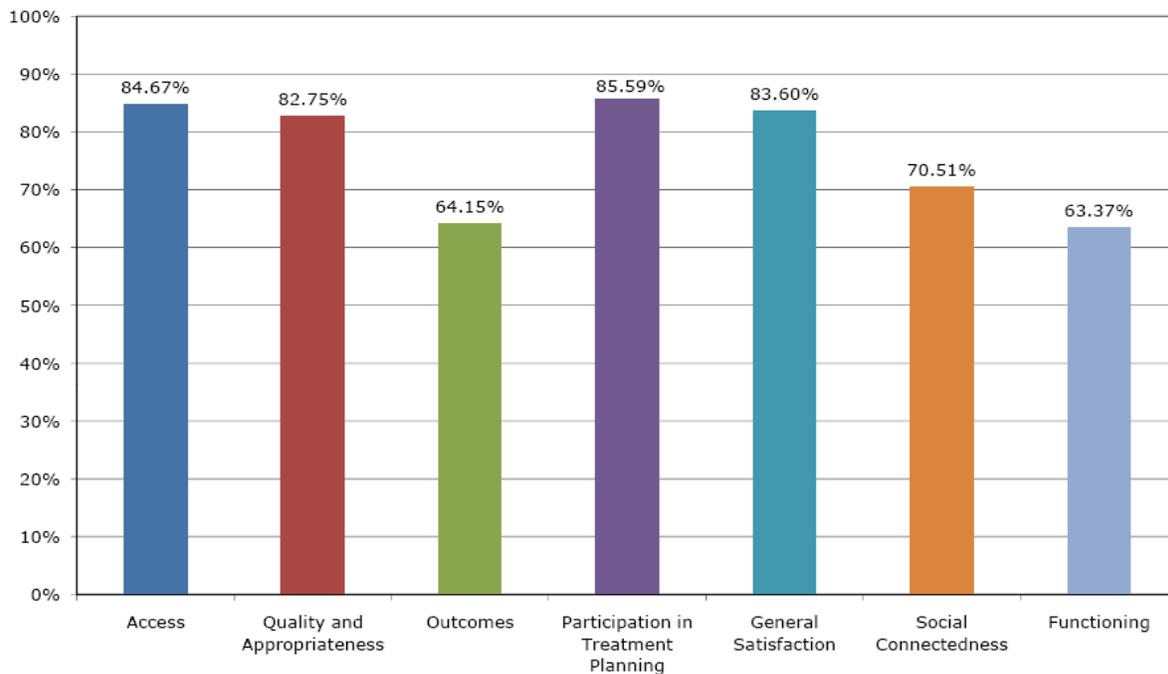
**Pennsylvania Office of Mental Health and Substance Abuse Services (2008 Rates)
7 Day Follow-up Services after Discharge from Psychiatric Inpatient Treatment by
Zone**



Providing High Quality Services

OMHSAS uses a variety of measurements to assess the quality of services. One important method to determine quality is to ask those who received services and OMHSAS uses both face-to-face and mailed surveys to reach consumers and families. The SAMHSA Mental Health Statistics Improvement Program (MHSIP) is a nationally endorsed survey conducted annually by OMHSAS that includes adults as well as children and their families. The MHSIP survey for adult recipients categorizes the results into seven “domains” which are reported to the federal government.

**Pennsylvania Consumer Perception of Care 2009:
Adult Survey Respondents Reporting Positively on MHSIP Domains**



The 2009 MHSIP findings showed that families surveyed feel most positively about two key items regarding their child’s care: Cultural Sensitivity of the staff and Participation in their child’s treatment planning. In addition, 62.4% of families surveyed believed that their child’s outcomes were improved as a direct result of services received.

Ensuring Community Life with Community-Based Services

For a behavioral health system to be successful, it should assist people to stay in their communities and minimize the time they spend in institutional care. In FY 07/08, for 719 people who were discharged from the state hospitals, only 37 people were readmitted for inpatient treatment. A 5.1% readmission rate is very low and points to success in the community re-entry process.

Success is even greater when individuals have a Community Support Plan (CSP) that includes consumer and family input. CSPs were developed for 123 (17%) of the people discharged. Readmission rates for people discharged with a CSP during this same period were 0.4%. This difference between the two readmission rates (5.1% and 0.4%) reinforces the value and importance of a CSP in supporting recovery.

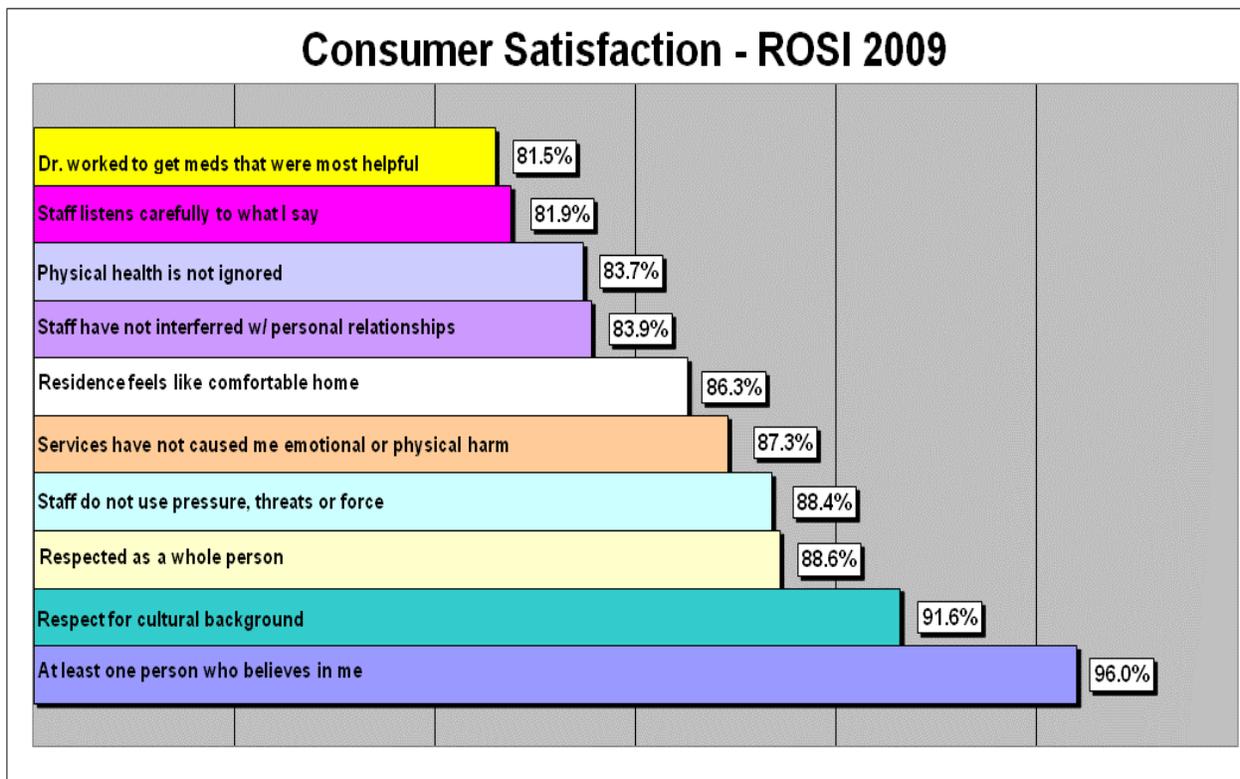
Quality Assurance

Quality Assurance is part of Quality Improvement. OMHSAS has a rigorous review process for its HealthChoices county contractors as well as for the behavioral health managed care partners.

1. The Performance-Based Contracting (PBC) initiative began in 2004 as a “baseline” for the HC counties to develop improvement targets for later years. PBC relies on performance indicators such as Medicaid benchmarks from the HealthCare Effectiveness Data and Information Set (HEDIS), the Substance Abuse and Mental Health Services Administration (SAMHSA) National Outcome Measures (NOMS), and other indicators developed specifically for the HC-BH program. OMHSAS included “national norms” and developed “gold standards” as a way of comparing performance among the HealthChoices counties. The 2009 Performance Report includes all 67 HC-BH counties.
2. On-site triennial reviews of the BH-MCOs evaluate clinical operations and care management records. These reviews, initiated in 2001, include a team of psychiatrists, psychologists, and other behavioral health and quality management professionals. The teams conduct interviews with clinical operations staff and conduct care management record reviews to assess the program including customer/member services, care management, utilization management, quality management, network management, complaints and grievances, and appeals. A report of findings, requirements for corrective action, and recommendations for improvement are issued after the on-site review.
3. IPRO, an independent quality review organization, performs a review on HC BH-MCOs as required by the Center for Medicare and Medicaid Services (CMS). IPRO also measures Performance Improvement Projects (PIPS) related to the findings of their reviews. In 2008, the BH-MCOs were required to implement Root Cause Analyses related to psychiatric inpatient care. A corrective action was required if their follow-up rate after psychiatric hospitalization (7 & 30 days) was lower than 2007 or their re-admission rate within 30 days after discharge was higher than 2008. This requirement has continued in subsequent years and has been made a part of the Pay for Performance initiative.
4. Consumer/Family Satisfaction Teams (CFST) throughout Pennsylvania conduct surveys with consumers and families on their satisfaction with services and supports. In 2009, OMHSAS reported data from all 67 HC-BH counties.

Improving Consumer Satisfaction

After workgroup meetings with consumers and advocates, OMHSAS adopted the Recovery-Oriented Systems Indicators (ROSI) Consumer Survey as a baseline indicator for consumer satisfaction. In 2009, OMHSAS commissioned a study of the perception of care by adults who have Serious Mental Illness enrolled in the HC-BH program. The Consumer Satisfaction Team Alliance of Pennsylvania (CSTAP) contracted with local consumer teams to conduct face-to-face ROSI surveys in 24 counties. Satisfaction based on 720 surveys completed by the consumer measurement teams is shown below.

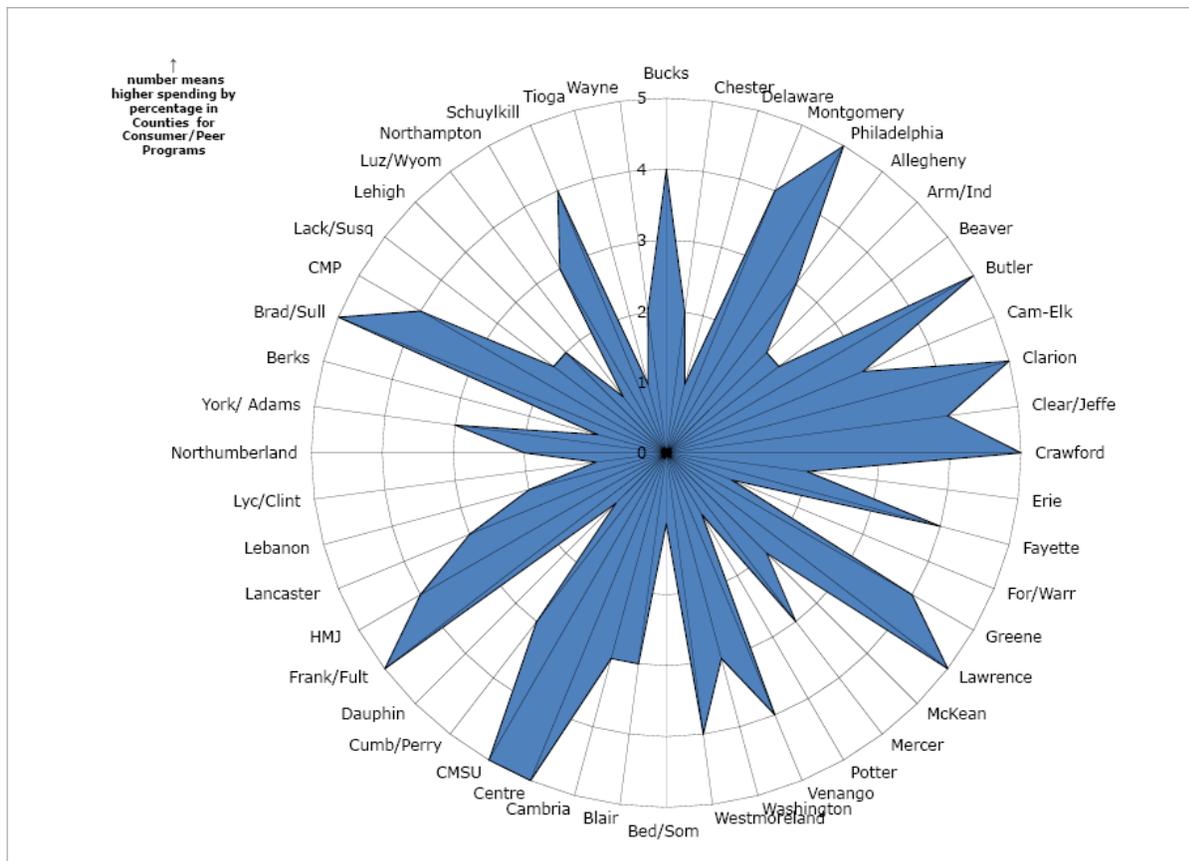


Obtaining Stakeholder Feedback

Under the auspices of the Bureau of Policy & Program Development, counties surveyed their providers about administrative activities that supported and promoted recovery. The survey was part of the ROSI administrative measures, ensuring a coordinated approach with the consumer survey. Results were reported to the counties for them to incorporate into improvement plans. The surveys found improvements in the following administrative activities including:

- Availability of peer/consumer programs
- Jail diversion
- Affirmative action hiring policies by providers
- Recovery-oriented mission statements
- Consumers serving on provider governing boards

The diagram below demonstrates counties' progress in funding consumer/peer programs. A higher number indicates higher spending by percentage for Consumer/Peer Programs.



SAMHSA Mental Health Block Grant Review

In addition to federal oversight from CMS, the Substance Abuse and Mental Health Services Administration (SAMHSA) also reviews the work of OMHSAS. In 2009, the SAMHSA Mental Health Block Grant site reviewers commended

OMHSAS for its commitment to the quality improvement process, using data to make informed decisions, and using the input of consumer and family teams as part of the monitoring process with the counties. The report noted that “One of the greatest strengths of the system is the follow through by OMHSAS on input received from system stakeholders”. Furthermore, OMHSAS was commended for:

- “Its commitment to the implementation, dissemination, and fidelity to standards for EBPs, such as Assertive Community Treatment, Psychiatric Rehabilitation Services, and Peer Support Services”
- “The level of integration between mental health and substance abuse services (including OMHSAS’ initiative to train and certify workers in both mental health and addictions) on behalf of individuals with co-occurring disorders that could serve as a model for other states”
- “Statewide implementation of Peer Support Services and Mobile Mental Health Treatment in an effort to provide access to recovery services to older adults wherever they are”
- “Progress toward a transformed system of care for children, young adults, adults, and older adults. The OMHSAS appears to have the leadership, commitment, and expertise to drive transformation to new levels within the State”

Resources

- “Increased ACCESS to Care” (March 2010)
(http://www.parecovery.org/documents/QUIC_Facts_032010.pdf)
- IPRO Follow Up After Inpatient Hospitalization Measurement Year 2008
(http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/report/p_002961.pdf)
- The Recovery-Oriented Systems Indicators (ROSI) Measure Consumer Survey (http://parecovery.org/omhsas_rosi.shtml)
- HealthChoices Behavioral Health Performance Report – 2009: Commonwealth of Pennsylvania
(http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/s_002762.pdf)

