

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

“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)

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.

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

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 Supreme Court to encourage system-wide collaboration, which led to a Strategic Plan that was adopted by the Court's stakeholders. In 2009 OMHSAS

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

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 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)