

Department of Public Welfare

Office of Mental Health and Substance Abuse Services

Olmstead Plan for Pennsylvania's State Mental Health System

"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. (p1), July, 2003].

This Olmstead Plan for the Pennsylvania State Mental Health system was developed to reflect the Commonwealth's decision to end the unnecessary institutionalization of adults who have a serious and persistent mental illness. The Plan details the specific steps that the Commonwealth will take to achieve that goal within a reasonable time frame.

Pennsylvania's Progress

Pennsylvania has made significant strides to address the unnecessary institutionalization of Pennsylvanians who have a mental illness in state-operated psychiatric hospitals. As elsewhere in the nation, the census of Pennsylvania's state hospitals has declined dramatically in the last 40 years -- from 35,100 in 1966 to less than 1,600 in 2010. Our progress mirrors the national trend which recognizes that many individuals, who have a disability, including individuals who have a serious and persistent mental illness, can live successfully in the community if they have appropriate supports and services.

A successful model of Pennsylvania's effort to develop community alternatives for state hospital residents arose out of the closure of Philadelphia State Hospital (PSH) in 1990. The PSH closure was unique because, for the first time, the Commonwealth assured that the funding that had been used to support the hospital was used to create a network of new and innovative community residential and non-residential programs for the over 500 consumers who were institutionalized at PSH as well as individuals who, but for its closure, would have been institutionalized in PSH (i.e., the diversion population). Virtually all of the PSH residents were ultimately discharged to the community. Studies of those discharged by Dr. Trevor Hadley and Dr. Aileen Rothbard and their colleagues at the University of Pennsylvania found that the individuals were able to live successfully in the community and the fears of many -- that these individuals would become homeless or lack access to proper care -- proved unfounded.

Since the PSH closure, the Commonwealth has used a similar funding strategy to close four additional state psychiatric hospitals -- Haverford State Hospital in 1998, Harrisburg State Hospital in 2006, Mayview State Hospital in 2008 and Allentown State Hospital in December, 2010. The closures of Haverford, Harrisburg, Mayview and Allentown State Hospitals have supported the discharge of nearly 800 individuals with a range of community-based services, including residential supports (ranging from specialized community residential facilities with 24-hour staff; an array of supported housing options; and independent housing), intensive case management, extended acute care services, crisis services, mobile psychiatric services, psychiatric rehabilitation services, peer support programs, and consumer-run services.

The funding of these closures -- as well as the downsizing of other state hospitals -- has been accomplished primarily through the Community Hospital Integration Project Program or "CHIPP." The CHIPP initiative transfers the funding used to support individuals in the state hospitals to the counties to develop community supports and services for both the state hospital residents and the diversion population with the understanding that the state hospital beds that supported the individuals will be closed and unavailable to the counties following the discharge. This allows the counties to build community capacity while assuring that the state's obligation to finance state hospitals is decreased due to the bed closures. The CHIPP initiative has historically targeted the "long-stay" consumers of the state hospital system; individuals who have been in residence for at least two years. To date, the Commonwealth has supported the CHIPP initiative with the closure of 2909 beds in the state mental hospital system by transferring \$249,030,560 to fund and support the development of an array of community-based services.

In addition to the state hospital closures and downsizing funded by the CHIPP initiative, the Commonwealth has taken other important steps to support community alternatives for state hospital residents, including

- Initiation of the Service Area Planning (SAP) process in 2002, which requires counties served by each state hospital and other stakeholders to work together to develop Community Service Area Plans for their regions.
- Development of community programs based on the Community Support Planning process which ensures that consumer, family members, and other persons involved in the recovery process are also able to participate in decision-making.
- It is indisputable that Pennsylvania has in the last 20 years made great strides in developing community alternatives for people who have a mental illness and decreasing its reliance on state psychiatric hospitals. Our continuing progress requires that Pennsylvania develop a viable integration plan for state hospital residents, for those individuals who live in other congregate settings (such as personal care homes) and for those at risk of institutionalization (including, the homeless, people who have a criminal justice history, returning veterans, and others).

- This Olmstead Plan acknowledges that the need for long-term institutionalization in state mental hospitals is long past. New evidence-based practices and medications mean that individuals who have a mental illness are able to live in the community successfully with, at most, the need for relatively short periods of hospitalization to become stabilized. Pennsylvania has adequate capacity within community hospitals which are more than capable of meeting these needs. This means that the need for state hospitals, which were designed to house people on a long-term basis, has been decreased considerably, if not altogether, while the need for community supports and services has grown.
- This Olmstead Plan provides the opportunity for the Commonwealth to maximize its fiscal resources in addition to those realized by the closure and downsizing of state hospitals. The available resources include and are not limited to:
 - HealthChoices -- the mandatory managed care program that provides behavioral health services to Pennsylvanians enrolled in the Medical Assistance Program. Both the capitation rates provided by the Commonwealth to the HealthChoices managed care organizations (MCOs) and the reinvestment dollars the HealthChoices MCOs generate will be used to increase capacity, to develop services that might not otherwise be available and to pay for start-up costs for new programs and housing options.
 - Many programs are available outside of the traditional mental health system that will be used to fund services for our citizens who have a mental illness. These include home and community-based waivers for people who are eligible (e.g., the Aging Waiver for elderly individuals and the Attendant Care and Independence Waivers for those with physical disabilities in addition to mental illness); the Consolidated Waiver for individuals who have intellectual disabilities; services provided through the Department of Aging and the Office of Long Term Living; publicly-funded housing programs; and veterans' programs. In addition, other federal, state, and private benefit sources may be available to assist these individuals (e.g., Social Security Disability, Supplemental Security Income, Medicare, Medical Assistance, education, federal housing programs, and veterans' benefits).

GUIDING PRINCIPLES

A number of principles inform this Olmstead Plan. The following core principles, which serve as the foundation for Pennsylvania's mental health system, guide this undertaking.

- **Recovery from mental illness is possible. People who have a mental illness can and do recover.**

Treatment, services, and supports must facilitate recovery. As stated in Commonwealth's Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults:

"[r]ecovery is a self-determined, holistic journey that people undertake to heal and grow. It is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members."

- **People with Mental Illness Can Be Served in Community-Based Settings**

The evidence clearly affirms the findings that people who have a mental illness, with appropriate supports and services, can live as productive, successful, involved members of their communities and do not need to be institutionalized in large congregate settings.

- **Each Consumer's Needs will be assessed through the Community Support Planning (CSP) Process. CSPs define the supports needed for each consumer to live in the most integrated setting appropriate to his or her needs.**

The CSP process will serve as the foundation for successful implementation of this Olmstead Plan. The CSP process in Pennsylvania has been vital to the design of individualized services and supports that are consumer-centered, consumer-empowered, and culturally competent. Each person's CSP will:

- be developed, monitored, and evaluated in partnership with consumers and, as appropriate, with families, involved advocates, specialists (e.g., trauma, spiritual advisors, supports coordinators for individuals who have an intellectual disability; probation/parole officers), and knowledgeable provider staff;
- identify and utilize each person's specific strengths;
- provide services and supports that will meet all of the person's unique needs, drawing on natural supports, mental health services and supports, and services and supports outside the mental health system;
- address the person's special needs (e.g., co-occurring intellectual disabilities, traumatic brain injury) and, when necessary, accommodate those needs (e.g., sign language programs for consumers who are deaf);
- assure that services are flexible, coordinated, and accountable; and
- recognize, respect, and accommodate differences relating to disability, culture, ethnicity, race, religion, gender, gender identity, and sexual orientation.

- **DPW will work with Counties to Plan for the Development of a Broad Array of Integrated Options to Meet the Needs of Consumers**

Each state hospital's Service Area Counties will assure the development of a comprehensive array of integrated supports and services to meet the needs of its constituents. The Service Area Planning process will address individual counties as well as needs within the entire Service Area so that resources can be pooled to maximize the available dollars and develop the types of services and supports needed by consumers in each region. This principle also requires recognition of the following:

- The Regional Service Area Planning process will include participation by the Department of Public Welfare's Office of Mental Health and Substance Abuse Services (OMHSAS), each county mental health program in the region, consumers, families, advocates, regional providers, HealthChoices HMOs and Behavioral Health Managed Care Organizations (BHMCOs) that serve the regions.
- Service Area Counties will develop services that focus on prevention and early intervention.
- Services will include an array of non-institutional housing options, focusing on independent and shared living arrangements and, to the extent possible, will separate housing from services.
- Services will include an array of non-residential community supports, including, for example, Assertive Community Treatment (ACT) models of case management; extended acute care centers; psychiatric rehabilitation services; medication management; mobile and crisis services; and employment opportunities ("real work for real pay").
- Peer support and peer-run services (e.g., Certified Peer Specialists, Drop-in Centers, and Wellness Centers) will be central components in our community-based service system. These peer supports and services have yielded successful outcomes in assisting consumers in building skills, developing and sustaining social relationships, providing supportive environments, and providing opportunities for gainful employment.

- **Funding Must be Re-directed from State Hospitals to the Community**

Funding for community services must keep pace with the increasing number of persons needing support in the community. The fiscal and social costs of failing to provide necessary supports and services--increased homelessness, unemployment, incarceration, and clinical relapse and de-compensation -- far exceed the costs of paying for the needed services. As units and facilities close the funds and resources that support the operation of the state mental hospital system will be used to expand the community-based infrastructure to enable individuals who have serious mental illness to be served and supported in their home communities among their family members and friends.

- **Stakeholders Must Be Involved at All Levels in the Integration Plan**

Individuals who have a mental illness, family members, advocates, service providers, county mental health officials, state officials and other stakeholders will be involved early and continually in the process to develop and implement the Olmstead Plan. This includes not only the "big items" that will be discussed at the state level (e.g., closure of the hospitals and funding reforms), but also at the regional level through the SAP process and implementation of specific closure plans (e.g., Steering and Advisory Committees), and at the individual level through, for example, use of peer and family assessments, discharge planning, and monitoring contacts.

Pennsylvania's Olmstead Plan

Based on the principles outlined above, the Commonwealth adopts the following Plan to provide services to adults with mental illness in the most integrated settings appropriate to their needs:

The goal will be to return all individuals residing in state psychiatric hospital units to their communities.

In support of this objective:

- The DPW-OMHSAS will request funding to reduce the state hospital civil bed capacity by closing at least 90 beds each fiscal year through the discharge of at least 90 state hospital residents each fiscal year beginning in Fiscal Year 2010--2011.
- As state hospital units are closed, the state funds used to support those units will be provided to the Counties to develop and support necessary community services and infrastructure.
- OMHSAS will use the CSP process to assess the needs of the individuals who are receiving services in the state hospitals, and the services and supports individuals are provided upon discharge will be consistent with their CSPs and adequate to assure their successful reintegration into community life.
- OMHSAS will review the implementation of the Olmstead Plan at regular intervals to assess and determine the need for revision and updates.
- OMHSAS will provide regular reports on the implementation this Olmstead Plan to the OMHSAS Advisory Committees.

The components of Pennsylvania's Olmstead Plan are as follows:

- 1. Through the Service Area Planning Process, each County will develop, no later than June 30, 2012, a Comprehensive Service Area Integration Plan that identifies with specificity all types of services, supports, and infrastructure that it will need to develop to meet the needs of individuals discharged from state hospitals and the diversion population; will set timelines for when each service will be developed and will identify funding sources it will use or seek to make that plan a reality.**
 - Using the CSPs developed for all state hospital residents from the Service Area as a starting point, each County will identify what services, supports, and infrastructure will be needed for those individuals.
 - Beginning January 2011, each Service Area will conduct an environmental scan and gather information from all involved sources -- including, but not limited to, consumers, families, advocates, providers, counties, HealthChoices MCOs and BH-MCOs, drug and alcohol programs, homeless shelters, housing authorities, prisons, jails, and courts -- and, based on that information, the Service Area will identify the additional supports, services, and infrastructure to be developed during the course of the implementation of the Olmstead Plan.
 - The Comprehensive Service Area Plan must address, at minimum, the following:
 - ◆ Housing -- Stable, affordable housing certainly is one of the key needs of people who have a mental illness to have a successful life in the community. In addressing housing needs, each Comprehensive Service Area Plan should include an array of housing options to meet the needs of its consumers. Programs with 24-hour supports (such as Long Term Structured Residences, Community Residential Rehabilitation Facilities, and programs that serve people who are medically fragile) are likely to be needed. It is expected, however, that the majority of the housing services will be independent or supported living options, particularly those that separate housing from services to allow greater flexibility and individualization.
 - ◆ "Housing First" models that do not require consumers to participate in services, including housing funded through the mental health system and the types of housing that can be funded through other systems (such as public housing or subsidized housing). The Plan will identify with specificity each type of program that will be developed, the number of consumers to be served by each program, and the timeline for development of each program. The Plan will also set forth the strategy the Service Area Counties will use to maximize resources to meet the housing needs of consumers (e.g., partnerships with local Housing and Redevelopment Authorities, use of Local Housing Options Teams, use of HealthChoices reinvestment funds).

- ◆ Specific Non-Residential Supports and Services that will be developed over the course of the implementation of the Plan, the timelines for development; the number of consumers to be served; the peer supports and peer-run services; and the anticipated funding sources.
- ◆ The manner in which the Service Area Counties will meet the specialized needs of the following groups: consumers who have a dual diagnosis of mental illness and an intellectual disability; consumers who have a dual diagnosis of mental illness and substance abuse; consumers who have a dual diagnosis of mental illness and a physical disability; consumers who have a dual diagnosis of mental illness and traumatic brain injury; consumers returning from incarceration; consumers who are deaf; consumers who are homeless; consumers who are elderly; consumers who are medically fragile; and consumers who do not speak English.
- If a Service Area identifies a need for a particular service or support for some of its consumers but the demand is not sufficient to develop the service, OMHSAS will facilitate inter-regional planning to support the development of regional services.

2. The Commonwealth and the Service Area will develop by June 30, 2012 a Plan to create a variety of residential housing options, thereby reducing the reliance on congregate settings of more than sixteen (16) beds for persons with mental illness.

- A large number of individuals who have a mental illness live in Personal Care Homes in the Commonwealth. Large personal care homes are rarely the most integrated setting for people with mental illness.
- The Personal Care Home Integration Plan will identify the number of individuals who have a mental illness who live in person care homes that exceed sixteen (16) individuals; the location of those homes; the services which are offered and provided; and the services which are needed.
- The Personal Care Home Integration Plan will identify specifically the policy changes that the Commonwealth and/or Service Area Counties will implement to fulfill the Plan. These may include, for example, providing the SSI Supplement to any individuals who live in the community with supports, rather than limiting it to personal care home residents; engaging peer advocates to visit personal care homes to engage the residents and make them aware of their options; providing consumers with limited "start-up" funding for rent or utility down payments, the purchase of furniture, or other items needs to set up housekeeping.

3. The Commonwealth and Service Area Counties will work together to develop a written Comprehensive Funding Strategy no later than June 30, 2012 to permit full and timely implementation of the Comprehensive Service Area Plans.

- The Comprehensive Funding Strategy will assume that all money used to support the state hospitals remains in the mental health system and is not diverted elsewhere. The money saved by the closures of the state hospital units will be the foundation for full implementation of the Plans.
- The Comprehensive Funding Strategy will assume that all revenues from the sale or other disposition of the state hospital properties remain in the mental health system.
- The Comprehensive Funding Strategy must address how HealthChoices capitation rates and reinvestment funds can be used to expand mental health services.
- The Comprehensive Funding Strategy will identify other potential public and private funding sources available to serve the needs of consumers, such as: Medical Assistance; Medical Assistance Home and Community-Based Waivers (including existing Waivers and assessing whether a Waiver specifically for medically fragile individuals with mental illness would be feasible); Medicare; services provided through the Pennsylvania Department of Aging and Office of Long Term Living; federal, state, and local housing agencies (e.g., HUD, the Pennsylvania Housing Finance Agency, Local Housing Team Options, and local housing and redevelopment authorities); and private foundations.

State Mental Hospital Consolidation and Closures—Future Capacity

The implementation of this Olmstead Plan will result in a decreasing reliance upon state hospital resources. Accordingly, the Department will implement its decision-making protocol and approach to consolidate and close hospitals during the implementation of the Plan.

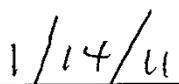
At this time, it is estimated that 5% to 7% of the current population in the civil sections of the state hospitals may require stay in supervised, structured settings because of their presenting clinical and/or criminal histories. This includes consumers who have a sex-offender history; consumers who have a history of arson; consumers who have been found Not Guilty by Reason of Insanity (NGRI); and other individuals who may present special challenges for service and support in an open integrated community without substantial risk to themselves and/or the general public and at extraordinary expense.

It is the Mission and Vision of the Office of Mental Health and Substance Abuse Services ...”*For every individual served by the Mental Health and Substance Abuse Service system to have the opportunity for growth, recovery and inclusion in their community, have access to culturally competent services and supports of their choice, and to enjoy a quality of life that includes family members and friends.*” This Plan will help to make that vision a reality.

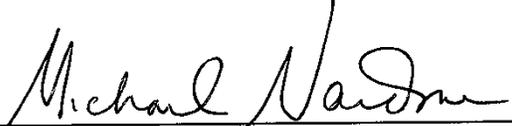
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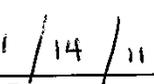
Sherry Snyder, Acting Deputy Secretary
Office of Mental Health and Substance Abuse Services



Date:



Michael P. Nardone, Acting Secretary
Department of Public Welfare



Date: