

# SOUTHEAST REGIONAL OLMSTEAD PLAN

FOR

BUCKS COUNTY

CHESTER COUNTY

DELAWARE COUNTY

MONTGOMERY COUNTY

PHILADELPHIA COUNTY

Original Submission: NOVEMBER 1, 2016

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SE Regional Olmstead Plan

SOUTHEAST COUNTIES REGIONAL OLMSTEAD PLAN

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(BUCKS, CHESTER, DELAWARE, MONTGOMERY, PHILADELPHIA COUNTIES)

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## I. OLMSTEAD PLANNING PROCESS

The Southeast Region did not use a separate planning process to develop this plan. Rather, we view this plan as an integral part of the individual county plans submitted in July 2016. Philadelphia submitted a coordinated Health and Human Services plan while the four suburban counties submitted block grant plans. These plans were developed with broad input from all stakeholders and were subject to community hearings at which individuals and organizations provided comment and testimony. The plans are available from each county office. Several counties post their plans on the county website.

Stakeholder involvement in the various County planning processes has included:

**Intra-system stakeholders** Community Support Program (CSP) Committees, local chapters of the National Alliance on Mental Illness (NAMI), Consumer and Family Satisfaction Teams, Consumer/Family Advisory Committees, Managed Care Organizations (MCOs), Mental Health/Intellectual Disability/Developmental Disability (MH/ID/DD) Advisory Boards, mental health (MH) and drug and alcohol (D&A) behavioral health providers, Norristown State Hospital (NSH), Drug and Alcohol Planning Councils

**Inter-system stakeholders:** Criminal Justice Advisory Boards, Homeless Services Coalitions, Older Adults Task Forces, Transition-Age Task Forces and Workgroups, AIDS Coalitions, MH/ID Workgroups, etc.

Additionally, county Behavioral Health (BH) offices develop committees, task forces and other work groups addressing specialized issues. These groups almost always include representation from affected individuals and their family members as well as county staff, providers, representatives from other service areas, as appropriate. Planning is an ongoing effort culminating in annual block grant or categorical plans, reports and recommendations for reorganizing, expanding or otherwise changing systems and services.

Philadelphia Department of Behavioral Health and Intellectual DisAbilities (DBHIDS) has placed an emphasis on a population health approach as a cornerstone of its continuing transformation efforts. This expanded orientation transcends behavioral health and intellectual disability to include population health promotion, community wellness and a focus on social determinants of health. Two key reasons for this shift: First, it is the natural continuation of the important work DBHIDS has done over the past 10 years to transform the system of care to one that not only ensures that people with behavioral health challenges and intellectual disability live in the community but also become active members in their communities. With the increased work in the communities it was recognized that communities were struggling with issues of violence, poverty, inadequate housing etc. and that there were many individuals who were not reached by current efforts. Second, was the national shift in the United States (US) healthcare system to one that is moving in the direction of containing costs and achieving better outcomes. This requires attention to currently identified behavioral health/ID population and an increased focus on resources to promote optimum health among a whole population. DBHIDS has worked to engage provider partners and expanded our stakeholder network through community collaboration opportunities including local business, faith based communities, Lesbian, Gay, Bi-Sexual, Transgender, Questioning (LGBTQ) communities, physical health care providers, arts and cultural entities, real estate/landlords, etc.

Current planning has focused on working with the PA Office of Mental Health and Substance Abuse Services (OMHSAS) on implementation of the settlement agreement in the American Civil Liberties Union (ACLU) lawsuit vs. the PA. Department of Human Services (DHS) concerning the services available to individuals with mental illness in the criminal justice system. This problem was identified in the Southeast (SE) Region's Olmstead Plan submitted in 2012. It has only increased since that time. The lawsuit involves Norristown State Hospital and Torrance State Hospital where the state's forensic units are located.

The settlement agreement, signed in January 2016, requires significant development of resources for the forensic population. The population is defined as persons in county or state correctional facilities waiting for admission for a competency evaluation to NSH or Torrance and individuals in forensic units whose

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competency was not restored or is unlikely to be restored and who should be transferred to other services.

As noted in the 2012 plan, civil admissions requested by one of the Southeast Counties to NSH have declined dramatically over the past several years. Admissions for the past four years have been as follows:

County Authorized Admissions to NSH Civil Section					
County	FY 12/13	FY 13/14	FY 14/15	FY 15/16	Census 8/17/2016
Bucks	0	1	1	1	19
Chester	0	1	1	1	9
Delaware	1	1	0	0	14
Montgomery	1	5	3	3	24
Philadelphia	0	0	0	0	56
Total	2	8	5	4	122

As the number of admissions requested by County MH-BH programs has decreased, transfers from the NSH forensic unit to the civil unit and direct court orders to the civil unit have increased, as shown in the following chart:

Forensic/Criminal Justice Admissions & Transfers to NSH Civil Unit				
County	FY 12/13	FY 13/14	FY 14/15	FY 15/16
Bucks	0	3	1	2
Chester	0	0	0	1
Delaware	1	0	5	1
Montgomery	0	0	2	1
Philadelphia	7	7	17	19
Total	8	10	25	24

In light of the diminishing resource at NSH, the four suburban counties along with Magellan and Community Care Behavioral Health released a Request for Proposals RFP for development of extended acute inpatient care (EAC). In FY 14/15, Brooke Glen was selected to develop the EAC which is licensed for 16 beds, although only 15 beds are routinely available to the MCOs/Counties with one bed held in reserve for emergencies. Four beds each are allocated to Bucks, Delaware and Montgomery counties with Chester having access to three beds. These allocations can be adjusted temporarily based on emergency needs.

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The Unit opened in October 2014 and has served a total of 59 people, with only three people being readmitted to the EAC. The average length of stay for the 49 people who have been discharged was 172 days. As of this writing, there are 14 people on the unit: five from Bucks and Montgomery and four from Delaware. Three Montgomery County residents have been accepted for admission, pending the availability of a bed and five people are in the referral process –two each from Bucks and Chester and one from Montgomery. There is routinely a waiting list of approximately four to five people. This unit has provided an alternative to admission to Norristown State Hospital for the four suburban counties.

Between December 2015 and October 2016 there has been a slight decline in the total number of individuals waiting for admission to the NSH Forensic Unit and a larger decline in the number of people waiting for transfer from the forensic unit to the civil section:

County	As of December 2015			As of October 2016		
	Waiting for Forensic Admission	Waiting for Transfer to Civil	Total Waiting	Waiting for Forensic Admission	Waiting for Transfer to Civil	Total Waiting
Bucks	14	1	15	10	0	10
Chester	0	0	0	4	2	6
Delaware	32	2	34	26	0	26
Montgomery	11	1	12	3	0	3
Philadelphia	118	33	151	117	7	124
Total	175	37	212	160	9	169

The decline in individuals waiting for transfer from the forensic unit to civil can be attributed to the number of individuals at NSH discharged since the signing of the settlement agreement. Further information on this issue will be provided in the next section on proposed service development.

As an initial strategy to increase resources for the justice involved population, OMHSAS has proposed converting 60 beds in the civil unit to a program specifically for individuals being transferred from the forensic unit. Most of these individuals will have been determined incompetent to stand trial. In order to achieve this objective, the SE region proposed the establishment of a Mobile Clinical Assessment Team (MCAT) that would evaluate most if not all of the individuals in the NSH Civil Unit. OMHSAS agreed to fund this proposal and, in May 2016, contracts were awarded to Elwyn for the MCAT and to John Markey, PhD for independent assessments of individuals waiting in county correctional facilities for admission to the NSH forensic unit.

Because Philadelphia County has the majority of individuals in the forensic unit and waiting for admission, Philadelphia DBHIDS developed its own assessment process. Assessors are Master’s level clinicians under the supervision of a licensed psychologist. These personnel conduct record reviews and clinical assessments of individuals at Norristown State Hospital, step-down units, residential facilities, and other forensic/service placement locations. Their goal is to facilitate flow through the forensic service system, promoting de-institutionalization and community integration.

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In addition, DBHIDS secured a contract for 2016 and 2017 with Dr. Kirk Heilbrun to work with residents under his supervision to complete reviews and screenings on all individuals who are on the NSH Forensic Unit waiting list from Philadelphia. The DBHIDS Assessment and Discharge Planning Team (ADAPT) Unit also provides assessments of NSH Civil population.

All five counties are participating in the program development process. Counties are using several strategies, including new program development and enhancement of existing programs. Please see the charts under Section IIB – Non institutional housing options.

In addition to non-institutional housing options, Philadelphia established a new 29 bed Extended Acute Care unit at Girard Medical Center. 20 beds are dedicated for individuals from NSH by the ACLU settlement. This additional capacity will alleviate some of the backlog in forensic admissions and transfers.

**II. SERVICES TO BE DEVELOPED**

Unless a specific age group is identified, all services are designed for individuals age 18 or older.

a) Prevention and early intervention

All five counties have made significant investments in Mental Health First Aid (MHFA). The Director of the SE Regional Mental Health Coordination Office is a certified MHFA trainer for both adults and youth curriculum and coordinates and delivers trainings on behalf of several of the Counties. There are approximately 250 Adult and Youth MHFA instructors in the SE region counties who provide MHFA trainings to schools, public safety and law enforcement, colleges and universities, healthcare professionals, faith communities and community members at large. The Counties continue to build upon this investment and expand MHFA Adult and Youth trainings. Philadelphia has its own MHFA Unit ([www.healthymindsphilly.com](http://www.healthymindsphilly.com)) which consists of staff and volunteer instructors, including some fluent in Spanish. To date Philadelphia has trained over 17,500 Mental Health First “Aiders”, with the goal of 20,000 persons by end of FY 16/17.

Efforts by all counties continue in providing community education and training for suicide prevention. All Counties have a Suicide Prevention Task Force which focuses on community awareness, prevention and education addressing “at risk populations”. Question, Persuade, Refer (QPR), an evidenced based suicide prevention model, is taught in the majority of counties along with ASIST (Applied Suicide Intervention Skills Training). Several Counties have expanded their education and awareness initiatives this coming year to increase trainings and activities.

The following chart shows proposed developments by county in prevention and early intervention:

County	Type of Program	# to be served	Timeline	Resources Needed	Comments
Bucks	Mobile Outreach to Judges	300	FY17 & 18	OMHSAS, Pennsylvania Commission on Crime and Delinquency (PCCD) Grant & HealthChoices	Start up
Chester	Crisis Intervention Team (CIT)	100 police	FY 17	PCCD Grant	
Chester	Critical time Intervention	100	FY 17	Reinvestment	Acute homeless case management using Evidence Based Practice (EBP)
Delaware	Mobile Crisis Team (Delaware County Crisis Connections Team - CCCT)	1500	FY 16	OMHSAS & HealthChoices (HC)	
Montgomery	Increased Police Training	Increase current police trng by 250 officers	FY 17 & 18	Realigning priorities for training  Seek PCCD grant	
Montgomery	QPR Suicide Prevention Training	15 new trainers = 500 persons trained	FY 17/18	Human Services Block Grant	
Philadelphia	Post Arrest Crisis Screening	@ 2500	FY 17	OMHSAS	Expansion of 2 more (from one to three) Police Districts in Philadelphia. See further info under Special Populations.

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Non-institutional housing options

More recent development has focused on addressing the needs of:

- individuals in the NSH forensic unit
- individuals with criminal justice history in the NSH civil unit
- individuals on the waiting list for NSH forensic unit.

The following table presents proposals for FY 15/16 and FY 16/17.

County	Type of Program	# to be Served	Time Line	Resources Needed	Comment
Bucks	Residential Treatment Facility – Adults (RTFA)	2	FY 17	OMHSAS, HealthChoices,	Elwyn Natale North (NN)
Chester	Community Residential Rehabilitation (CRR)	2	FY 16	OMHSAS	Operational
Chester	Specialized Sexual Offender Program	1	FY 17	OMHSAS	Expansion of existing program
Delaware	RTF-A	12	FY 16	Start up: OMHSAS; Operation: HealthChoices	Elwyn NN
	Master Lease	5	FY 16	OMHSAS	
	Transitional Housing*	12	FY 16	OMHSAS	Housing First Model
Montgomery	RTF-A	2	FY 17	OMHSAS, HealthChoices	Elwyn NN
Philadelphia	RTF-A	15	FY 16	Start up: OMHSAS; Operation: Health Choices	New Vitae
	RTF-A	14	FY 16	Start up: OMHSAS; Operation: Health Choices	Gaudenzia
Philadelphia	RTF-A	12	FY 17	Start up: OMHSAS; Operation: OMHSAS and Health Choices	New Vitae
	RTF-A	12	FY 18	OMHSAS and Health Choices	New Vitae
	Specialized residence Dialectical Behavior Therapy (DBT)	~6	FY 17	OMHSAS, HealthChoices	Horizon House
	Specialized residence Traumatic Brain Injury (TBI)	~4	FY 17	OMHSAS, HealthChoices	Volunteers of America
	Housing Subsidies*	100	FY 18, 19	HealthChoices Reinvestment	
	Residential rehabilitation	TBD	FY 17, 18	OMHSAS, HealthChoices	Focus on recovery from opioid addiction
	Spec. Residence	3	FY 17	OMHSAS	Focus on sex. Offenders Horizon House
<b>Total</b>		<b>~217</b>			

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\*Housing Subsidies in Philadelphia and Transitional Housing in Delaware are intended to support individuals ready for discharge, primarily from licensed residential programs. The resources created by this movement will then be available for individuals being discharged from NSH and/or on the waiting list for the Forensic Unit.

Below is a recap of number of people to be discharged from NSH each year by County:

County	Fiscal Year	# Planned Discharges	Discharged as of 10/19/2016
Bucks	16/17	5	2
Chester	15/16	3	2
Delaware*	15/16	10	10
Montgomery	16/17	4	0
Philadelphia	15/16	49	52
Philadelphia	16/17	31	0
Total		102	66

\* In addition, Delaware provided residential services to seven individuals from the County Correctional Facility who were on the waiting list for NSH Forensic Unit. Delaware County will continue discharging individuals when appropriate. More specifically, those individuals at the NSH Forensic Unit, appropriate for the RTF-A level of care will be discharged to the Forensic RTF-A program as openings occur.

The discharges from NSH eased the situation for individuals waiting for transfer from the forensic unit to the civil unit, reducing that number from 37 in December 2015 to 9 in October 2016. Philadelphia, with the largest number of individuals in the region’s forensic mental health system, reduced its number from 33 to 7. This movement eased admissions to the NSH Forensic Unit as the following chart demonstrates:

NSH Forensic Unit admissions					
County	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17 (up to 10/2016)
Bucks	5	5	9	8	1
Chester	3	4	5	1	0
Delaware	22	15	21	25	4
Montgomery	13	9	4	6	11
Philadelphia	58	32	26	40	17
Total	101	65	65	80	33

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b) Non Residential treatment and community supports.

The following chart shows proposed development by County

County	Type of Program	# to be Served	Time Line	Resources Needed	Comment
Bucks	Assertive Community Treatment (ACT)	100	FY 17,18	OMHSAS & Health Choices	
Bucks	Mobile Crisis	75	FY 17,18	OMHSAS & Health Choices	Expansion to 24/7
Bucks	Psychiatric Rehabilitation	75	FY 17,18	OMHSAS & Health Choices	New development & to serve non-HC
Bucks	Contingency Funding/Housing Clearinghouse	@150	FY 17	HealthChoices Reinvestment	In partnership with the Bucks County Opportunity Council.
Bucks	Capital Funding	8-12	FY 17	OMHSAS & HC Reinvestment	We anticipate the Capital Development Fund (CDF) Administrator will obtain additional funding such as Low Income Housing Tax Credits (LIHTC) credits, housing choice vouchers, etc.
Chester	Mobile outpatient	80	FY 17 and beyond	HealthChoices & County Base financial sustainability	
Delaware	Forensic ACT	90	FY 16	HealthChoices, Reinvestment & OMHSAS	Team Expansion
Montgomery	Crisis Residential Program (CRP)	350	FY 17	Reinvestment (already approved); HealthChoices; OMHSAS	CRP will add to the crisis continuum in Montgomery County and help to divert individuals from hospitalization.
Montgomery	Blended Case Management (BCM) – Forensic Specialization	150-200	FY 17	Reinvestment funds (plan submitted); HealthChoices; OMHSAS	This BCM service will work to divert individuals from jail and reduce jail days.
Montgomery	Blended Case Management – Transition Age Specialization	20	FY 17	HealthChoices	Expansion of new BCM service for transition age young adults that utilizes evidence based Transition to Independence Program (TIP) model.
Philadelphia	Various rehabilitation and clinical interventions	TBD	FY 17,18	OMHSAS, HealthChoices	Focus on recovery from opioid addiction
Philadelphia	Probation navigation and treatment	@1500	FY 17,18	MacArthur Grant	Based at Adult Probation & Parole. To include a Masters' level clinician.

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County	Type of Program	# to be Served	Time Line	Resources Needed	Comment
Philadelphia	Housing First-Medication Assisted Treatment and other clinical interventions	60	FY 2017	Health Choices	Focus on recovery from opioid addiction.
Philadelphia	Behavioral Health Services Initiative (BHSI) CM	100	FY 2017	Health Choices BHSI	Expansion of existing capacity with enhanced team to address more challenged co-occurring population

c) Peer support and peer-run services. The following chart shows proposed development by county:

County	Type of Program	# to be Served	Time Line	Resources Needed	Comment
Bucks	Certified Peer Specialists	50	17/18, 18/19	OMHSAS	To serve non-HC
Chester	Early engagement/intervention	150-170	16/17 & beyond	HealthChoices & County Base financial sustainability	Hospital based
Chester	Early engagement/intervention		16/17 & beyond	HealthChoices & County Base financial sustainability	Forensic jail based
Delaware	Certified Peer Specialists	25	15-16	HealthChoices & OMHSAS	Forensic focus
Delaware	WARM LINE	100	15-16	BH Funding	
Montgomery	Peer Specialists	75	16-17	HealthChoices	
Philadelphia	Peer Specialists	120	16-17	OMHSAS & Health Choices	Forensic focus
Philadelphia	Recovery Specialists	~300	FY 17	HealthChoices	Co-occurring focus

d) Supported Employment Services. The following chart shows proposed development by county:

County	Type of Program	# to be Served	Time Line	Resources Needed	Comment
Chester	Community based; clubhouses; PA Employment 1 <sup>st</sup>	75-80	FY 17 & beyond	Additional staff OVR Partnership MH Base financial sustainability	Added another full time staff to contract for FY 17
Delaware	Supportive employment	20-25	FY 17	OMHSAS	Forensic focus
Montgomery	Supported Employment/Education	90	FY 17	Health Choices; Reinvestment (approved); OMHSAS	Two new Career Centers which utilize Evidenced Based practices.

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Philadelphia is proposing an employment and educational planning initiative to begin in 2017 with an initial focus directed toward permanent supported housing efforts and forensic activity. While formalizing a more systemic plan incorporating multiple collaboratives, they may select a 'pilot' initiative to address a targeted population from the two areas as their focus.

Bucks County contracts with three independent Supported Employment (SE) agencies that support approximately 150 individuals at this time. In addition, the County's ACT/FACT/CTT treatment teams have employment specialist staff embedded in the teams who work with individuals on supported employment goals. Furthermore, Bucks County MH/DP contracts with an agency that provides two different psych-rehab services, both of which support individuals with SE goals and one of which has a contract with OVR to provide Supported Employment Services. One service utilizes the Boston University model and the other utilizes a Clubhouse model. These models support approximately 120 individuals.

**III. HOUSING IN INTEGRATED SETTINGS**

a) Housing Inventory. The following charts show programs of housing in integrated settings in each County, including number served and County MH/BH partners, if any.

County	Type of Program	Housing First? Yes or No	# served	County MH/BH Partners	Comment
Bucks	Supported Living Program (SLP)	No	71		All of Bucks County residential programs prioritize persons who are homeless or forensically involved.
Bucks	SLP	No	8	PCCD Grant	Forensic Focus
Bucks	SLP	No	24	Housing Authority	Homeless population served
Bucks	SLP	No	45	Housing and Urban Development (HUD)	All of Bucks County's housing programs prioritize individuals who are homeless and/or forensically involved. Also some beds are specifically designated to support individuals with drug & alcohol co-occurring diagnosis (COD).
Bucks	Transition Age Youth (TAY) Shared Living	No	12	Now is the Time for Healthy Transition Grant	TAY focus
Bucks	Master Lease	No	16		Permanent Housing
Chester	Project based housing choice voucher-MH Set Aside	Yes	6	Cobler Realty Chester County Department of Community Development (DCD) Housing Authority of Chester County (HACC)	Roymar Hall
Chester	Public Housing MH Set Aside	Yes	8	HACC Chester County DCD	Denny Reyburn, Maple & Spruce Court, Church St.
Chester	Project based housing choice voucher- MH Set Aside	Yes	6	Pennrose, HACC Chester County DCD	Fairview Village
Chester	Shelter+Care	Yes	11	Chester County DCD	Scattered apartments
Chester	Shelter+Care	Yes	59	Chester County DCD Open Hearth	Scattered apartments

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County	Type of Program	Housing First? Yes or No	# served	County MH/BH Partners	Comment
Chester	Public Housing	Yes	16	HACC	Preference points for people identified though Mental Health Options Team
Chester	Tenant based housing choice voucher	Yes	12	HACC Chester County DCD	
Chester	Master lease	No	16		Marchwood/Golf Club
Chester	Single Room Occupancy (SRO) mod	No	28 (SRO)	Pennrose	Liberty House
Chester	Project based rental assistance	Yes	14 (one bedroom) 7 (two bedroom)	Pennrose	Liberty House
Chester	SRO	Yes	8	Chester County DCD	Matlack St.
Chester	Permanent Supportive Housing	Yes	22	Holcomb Chester County DCD	
Chester	Project based housing choice voucher-MH Set Aside	Yes	6	Chester County DCD, HACC and Petra Housing	Steel Town Village-targeted to rent up Summer 2018
Chester	Project based housing choice voucher-MH Set Aside	Yes	4	Chester County DCD, HACC and Red Clay Manor	Red Clay Manor targeted to rent up Spring 2018
Delaware	Three-Person Residence	No	12		
Delaware	Supportive Living (Clustered)	No	8		Site-based program
Delaware	Supportive Living(Scattered)	No	70		
Delaware	Supportive Living(Master Lease)	No	119		Includes forensic/transition-aged pop.
Delaware	Transitional Housing	No	111	Children & Youth services (CYS)	
Delaware	Shelter+ Care 67	Yes	42	Housing Authority	
Delaware	Fair weather Lodge	No	4	Veterans Administration (VA)	
Delaware	Permanent Supportive Housing (HUD SLS)	Yes	379	Housing Authority	Clustered & Scattered Sites Includes singles/family

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County	Type of Program	Housing First? Yes or No	# served	County MH/BH Partners	Comment
Delaware	Rapid Re-housing	Yes	190	Housing Authority	
Montgomery	Tenant Based Rental Assistance (TBRA)	Yes	41	Housing & Community Development	MH/MR TBRA
Montgomery	Permanent Supportive Housing – Master Leasing	Yes	40	HUD and Columbus Property Management (CPM)	Permanent Solutions
Montgomery	Rental Assistance (TBRA)	Yes	23	HUD	3 Shelter Plus Care
Montgomery	Medium Term TBRA	No	34	CPM	
Montgomery	Affordable Housing	No	18	PHFA (LIHTC), Advanced Living, Ingerman, Housing Visions and Elon	Capital Units at North Penn Commons, Reliance Crossings, Beech Street Factory, and Montgomery Park.
Montgomery	TBRA	No	40	OMHSAS (HealthChoices Reinvestment) and CPM	Housing Reinvestment Initiative (HRI)
Montgomery	Medium term subsidy	No	7		PCCD
Montgomery	Rapid Re-Housing	No	4		Emergency Solutions Grant (ESG)
Philadelphia	Safe Haven	No	240		Transitional entry level housing for individuals who are chronically street homeless
Philadelphia	Safe Haven	No	24		Transitional entry level housing for individuals who are chronically street homeless and Transition age youth with LGBTQ capacity
*Philadelphia	Rapid Rehousing	No	TBD	Phila Office of Homeless Services	
*Philadelphia	Transitional Housing	No	300	Phila Housing Authority	
Philadelphia	Journey of Hope	No	124		Focus on recovery from substance abuse

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County	Type of Program	Housing First? Yes or No	# served	County MH/BH Partners	Comment
*Philadelphia	Permanent Supportive Housing	No	2400 units	HUD Homeless Assistance, Department of Human Services and AIDS Activities Coordinating Office	Not all units are for individuals with MH and/or SA issues
Philadelphia	Permanent Supportive Housing	Yes	450	HUD	
Philadelphia	Bridge Vouchers	No	~470	PHFA, OHS	Permanent Supported Housing subsidies, 4yr. Length of stay (LOS)
Philadelphia	Housing First	Yes	TBD	OHS	PSH opportunity with Housing First CTT supports
Philadelphia	SIL Subsidy	No	~800	1260	

NOTE: \*Philadelphia - these items are not DBHIDS driven. They are elements of the Health and Human Services Department (Office of Homeless Services predominantly). For the Permanent Supported Housing with 2300 units, DBHIDS has 28% or 670 slots.

\*\* Bucks County does not currently have a program that follows a Housing First Model within our continuum. However, one program has a low barrier threshold for acceptance and participation. The low barriers include residents not being screened out based on having little or no income, having a criminal record, or history of domestic violence. Additionally, residents are not discharged for failure to participate in supportive services, failure to make progress on service plan, loss of income or failure to improve income.

b) Progress towards integration of housing services as described in Title II of ADA. See previous section for inventory of integrated housing resources available to individuals with mental health challenges. Please also see sections under special populations for more individualized county efforts to address homelessness among residents with mental illness.

In accordance with the ADA, sites are located in the general community and are not specifically for individuals with disabilities. Individuals can access the community resources at their own choice of time and frequency. Individuals have choice in their daily activities and have opportunities to interact with individuals without disabilities. Some sites are barrier free. Mental health supports are provided based on individual need and desires.

c) Community Residential Rehabilitation (CRR) Conversion Plans

- **Bucks County** converted CRRs in the past, but does not have current plans to convert any additional CRRs. Bucks County has invested in training and consultation to enhance the skill level of staff in CRRs so they may support individuals with complex needs.

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- In **Chester County**, a CRR was converted in 2010. Through this conversion, ten independent and permanent apartments along with an intensive supported living program became available to assist adults with serious mental illness to live independently in the community.

At this time Chester County does not have plans to do additional CRR conversion. As subsidized housing is more available, Chester has focused on developing more specialized CRR programs for the medically and/or elderly population; forensically involved and those with trauma.

- **Delaware County** does not have plans to convert CRRs. Rather, it has relied on expanding resources in independent, integrated settings. Delaware County has also worked to enhance the skill level in CRRs toward serving individuals with more complex needs.
- **Montgomery County** used Health Choices reinvestment funds to support rental assistance (33 people), security deposits (41 people) and furniture (49 people) which enabled people living in congregate mental health residential facilities, primarily CRRs, to move to independent living situations. Two Moderate Care CRRs were converted in this process. The funds will support ongoing rental assistance for individuals who cannot transition from a bridge subsidy provided through reinvestment.

Currently, Montgomery County is using a “housing first” approach in evaluating residential facilities. All referrals to residential programs must identify why that individual cannot live in a more independent setting. All of the CRRs now have a 12 month target for supporting individuals to move on to more independent living situations and are referred to locally as Transitional Rehabilitative Residences. Additionally the county has worked to create clinical liaisons within its Community Behavioral Health Centers and a dedicated care manager at Magellan Behavioral Health to assure that there is coordination between clinical and residential services to support each individual’s ongoing work toward transitioning to community living.

Montgomery County has also done extensive work with remaining residential programs to strengthen the programs’ capabilities to use a psychiatric rehabilitation approach. Most of the programs now have at least one Certified Psychiatric Rehabilitation Practitioner on staff.

- **Philadelphia County** has both a housing plan adopted and state approved in 2010 and a residential transformation strategic plan being developed simultaneously. The residential transformation plan was focused on working with the provider network to “shift” business strategies and practices that would begin to align with the overall goal of investing in permanent supportive housing opportunities and moving from a predominantly congregate community rehabilitative residential programming model. The historical residential programming which they had supported and grown within the county was particularly challenged by the new attention to “housing” needs separate and apart from “residential support” needs. They were no longer talking about residential services as an all-encompassing concept. Their planning addressed: the transition of CRR’s and other established fully supported residential programs to transitional short term “flow” models promoting independent living and community integration, the closure of programs to develop mobile services to support individuals moving to permanent supported housing options, the sustaining of a percentage of residential services to address individuals who required either a maintenance level of care or an intensive 24/7 services support design.

In addition, DBHIDS made adjustments in the following areas: Financial Management: OMH/Office of Addiction Services (OAS) contracts and budget realignment, Data Tracking and trending, Management: Analytic Planning inclusive of ongoing needs assessment and outcome evaluation, Quality assurance and management and Technical Assistance and Readiness reviews. This challenged the housing resources to “rethink” their current activities and begin to move toward a more defined “niche” within a new system design. In addition to care and service coordination and ongoing utilization management, all of the above needed to be informed by ongoing field monitoring and technical assistance, program assessment and evaluation, data collection and outcome evaluations.

Both providers and DBHIDS staff needed to understand that all of this required a certain level of fluidity and transitional thinking. Each of the following key components were included in the Philadelphia strategic approach and design:

- Agency focus - changing business strategies to align with a permanent supported housing goal, services development, technical assistance, management of residential program
- Person focus - intake, care and service coordination, utilization management and concurrent review: change/benchmarks
- System focus - needs assessment, data tracking and monitoring, outcomes evaluation, feedback, review

The first phase of the transformation was an intensive three year pilot involving three of the largest residential providers. It resulted in 17 residential program closures along with an additional seven (7) service conversions/closures of existing programs. Approximately 350+ people transitioned to permanent supportive housing. Transformation activities remain ongoing though less intensive than the pilot phase due to a City wide dedicated effort – the *Mayor's Plan to End Homelessness* - which was accompanied by a substantial percentage of PSH resources being redirected to the chronic street homeless population.

The housing plan referenced above will be addressed in the next section “Strategies”.

- d) Strategies to maximize resources to meet housing needs, including Local Lead Agency agreements and partnerships with PHA, Regional Housing Coordinators Community, Housing and Redevelopment Authorities and Local Housing Option Teams.

For all the counties, further information may be found in the Special Populations section on Homelessness.

**Bucks County Mental Health/Developmental Programs Department** is an active participant on the Housing Continuum of Care Committee (HCoC-BC). This broad community stakeholder group focuses its efforts towards the prevention and elimination of homelessness throughout Bucks County. The MH/DP Department's collaboration with the Housing and Community Development of Bucks County and MH providers as part of the HCoC-BC has resulted in several providers receiving HUD Continuum of Care Grants. At this time, there are active grants which support both Transitional Supportive Housing and Permanent Supportive Housing including a portion of operating expenses. These grants have the capacity to serve up to thirty two individuals at any given time and are spread amongst two different programs across the county.

MH/DP staff continue to chair an HCoC-BC subcommittee known as the Local Housing Options Team (LHOT). This committee provides a forum for representatives of organizations serving individuals with behavioral health challenges as well as multiple special needs. Most recently a subcommittee of the LHOT has been working on identifying accessible housing for individuals with disabilities, including communications with the Housing Authority of Bucks County. This has resulted in discussions on simplifying the application process with rolling out one application for all units, creating online application access and better identification of how individuals are prioritized for entry into an accessible unit. The LHOT more recently began a training initiative with the Self Determination Housing Project of PA to bring the Prepared Renters Education Program (PREP) to various agencies supporting people in locating and maintaining housing. It is anticipated that this training will not only better prepare individuals in becoming renters, but will also engage with landlords and expand the County's landlord base.

The Bucks County Department of MH/DP is the identified contact for the Local Lead Agency (LLA) for Bucks County, specifically Joyce Schug, MH Housing Specialist. While Bucks County has not had the benefit of 811 Project Rental Assistance vouchers, MH/DP staff has kept apprised of this project and is prepared to provide referrals. Additionally, the current HealthChoices Reinvestment Capital Development project will coordinate with the LLA process once referrals are being accepted through this project.

**Chester County** - Chester County Departments of Human Services and MH/IDD have a written Memorandum of Understanding with the Chester County Department of Community Development (DCD) to oversee and manage the dollars allocated for the MH Supported Housing Plan, which includes the employment and supervision of the MH Housing Coordinator. This close partnership ensures that planning for any affordable and permanent housing in Chester County includes discussion of the MH priority to make more affordable integrated housing available to our priority populations. As Housing Developers make successful application for PHFA tax credits and the MH Supported Housing Plan supports additional “set aside units”. Memorandums of Understanding are then signed between the housing developer, the property management company and the County to ensure long term success of these partnerships.

As the Housing Authority of Chester County is one of the six housing authorities in PA that have committed to providing Housing Choices vouchers or public housing units for individuals with mental illness as a disability-specific Olmstead preference. The Chester County LLA contact is the Mental Health Housing Coordinator who works for the Chester County Department of Community Development and participates on the Local Housing Options Team (LHOT). The LHOT manages all referrals and service delivery components for specific permanent supportive housing vouchers for adults with disabilities including persons with mental illness and includes the new Section 811 PRA Program. The Mental Health Housing Coordinator is also the liaison for mental health referrals to the Housing Authority of Chester County (HACC), with which there is a formal relationship, via a memorandum of understanding, which includes assisting PHA to meet its requirements. This relationship targets the Olmstead goal to “*establish cross-system partners to increase the availability of affordable, safe, quality housing that is integrated into the community*”. Chester County is working with PHA and has established an "admission preference" for people with mental disabilities who are included in the PHFA-DPW 811 PRA Priority Target Populations and who also are in one or more of the *Olmstead* target populations identified by OMHSAS. The Housing Coordinator is also a point of contact for targeted housing management companies, landlords and affordable housing property managers developed through the MH Supported Housing Plan.

.Additionally, there are key representatives from the Departments of MH and Human Services who participate on the LHOT, as well as other committees of the County's Decade to Doorways Initiative to prevent and end homelessness and to increase options for more permanent supportive housing.

**Delaware County** – Delaware County Office of Behavioral Health serves as the Local Lead Agency for Delaware County. The LLA Coordinator is responsible for managing referrals, service delivery and serve as the liaison between property managers, residents receiving MH services. As the LLA, our office works collaboratively with members of the Local Housing Options Team (LHOT) to ensure affordable housing and services are provided to individuals in need. The Delaware County Office of Behavioral Health worked diligently to support HUD initiative to end homelessness for veterans.

Delaware County continues to partner with the Delaware County Housing Authority (DCHA). DCHA is the grantee for 4 HUD Continuum of Care Grants that have a total of 120 tenant-based vouchers. DCHA also holds over 80 Veterans Assistance Supported Housing (VASH) vouchers for homeless veterans into and works with the Continuum Care for homeless to “graduate” successful participants mainstream Housing.

**Montgomery County** - The MH Office is the Local Lead Agency for Montgomery County. Staff from the BH/DD Department sit on both the Leadership Council and the Operations Team of Your Way Home, the county's public/private partnership to end homelessness in Montgomery County. Currently the group is working with the Montgomery County Housing Authority to develop preferences on the Housing Choice Voucher Program.

**Philadelphia County** – The Office of Homeless Services is the LLA (Local Lead Agency) for Philadelphia County.

The Housing Authority of Philadelphia is one of the six housing authorities in PA that have committed to providing Housing Choices vouchers or public housing units for individuals with mental illness as a disability-specific Olmstead preference. Philadelphia County has a strong commitment to make more

## SE Regional Olmstead Plan

affordable integrated housing available to our priority populations. The City of Philadelphia has established a formal relationship, via a memorandum of understanding, with Philadelphia Housing Authority (PHA), which includes assisting PHA to meet its requirements. This relationship targets the Olmstead goal to *“establish cross-system partners to increase the availability of affordable, safe, quality housing that is integrated into the community”*.

DBHIDS is committed to working with PHA to establish an "admission preference" for people with mental disabilities who are included in the PHFA-DPW 811 PRA Priority Target Populations and who also are in one or more of the *Olmstead* target populations identified by OMHSAS. DBHIDS and the Housing Authority have a signed Memorandum of Understanding that memorializes this agreement.

The housing plan referenced above in the CRR conversion section, has had two updates, the most recent in March 2015 with additional reinvestment identified and approved for Bridge voucher expansion, increased contingency funds and funding for EBP implementation. Over the years of the housing plan, the City of Philadelphia has developed and strengthened partnerships, most notably with the Philadelphia Housing Authority, to expand housing availability for individuals and families with behavioral health challenges.

Initially through the Mayor's Plan, the City has expanded alternatives for individuals with behavioral health needs; increased the City's inventory of permanent housing; and leveraged services to help individuals and families attain and sustain housing stability. Of particular note are two PSH initiatives that DBHIDS has undertaken since their initial County Housing Plan was submitted.

In May 2008, the Office of the Deputy Mayor for Health and Opportunity forged a renewed partnership with the Philadelphia Housing Authority (PHA) providing a critical infusion of affordable housing targeted to individuals with behavioral health challenges. The PHA partnership provided up to 200 single individuals with behavioral health challenges access to Housing Choice Vouchers (HCV) every year. DBHIDS also was able, through this City-PHA partnership, to refer family and senior households with behavioral health challenges - up to 75 a year - for housing in PHA's conventional unit resources.

Second, the Pennsylvania Housing Finance Agency (PHFA) Initiative (proposed in the initial County Housing Plan) is a collaborative effort among OMHSAS, PHFA, and local property developers and managers. Initially the PHFA Initiative was projected to support up to 63 individuals at one time by subsidizing their housing costs in private-market apartments of their choice. They have used this resource to increase their capacity to provide permanent supportive housing, as well as to support the conversion of (to date) one Community Rehabilitative Residence to mobile supports and subsidy for rental housing of the individuals' choice. The majority of the developments that participate in the PHFA Initiative were developed with the support of Low Income Housing Tax Credit (LIHTC) funding or other local, state, or federal sources. However, in order to maximize the units that individuals can choose from, DBHIDS has partnered with and continues to seek private-market landlords whose units are affordable but were not created using LIHTC funding.

DBHIDS and their partners continue their efforts to:

- increase the availability of resources that support the creation of affordable housing;
- access those resources for affordable housing (directly and with partners);
- facilitate individuals' direct access of affordable housing and subsidies; and
- provide services to support individuals in the housing of their choice.

DBHIDS is currently using reinvestment funds for the PHFA Initiative, the Housing Contingency Fund, Program Management/Clearinghouse, Bridge Subsidy Program, Housing Supports/Support Services and a Capital Investment Fund, all of which leverage LIHTC and other local, state, and federal investments already made in affordable housing in Philadelphia.

Please see the section on Homelessness in the following section on Special Populations. The section on Transition Age Youth also addresses efforts to prevent homelessness among young people aging out of the DHS – Children and Youth system.

#### IV. SPECIAL POPULATIONS

Unless a specific age group is identified, all services are designed for individuals age 18 or older

##### **BUCKS COUNTY – HOW NEEDS ARE MET FOR:**

- a) **Mental Health/Intellectual Disability.** In August 2016, Bucks County provided training for Certified Peer Specialists (CPS) in working with individuals with Intellectual Disability and MH issues. The objective of the training was to enable CPS to engage and goal plan with such individuals. A total of 20 CPS and 3 CPS supervisors were trained by Philadelphia Coordinated Health Care (PCHC). Plans are in the works to meet with the DP Supports Coordination Programs to introduce them to the work of the CPS, describe the specialized training and encourage referrals.
- b) **Mental Health/Substance Use Disorders**
- c) A detox/rehabilitation program was developed in Bucks County, which also supports the coordination of care for individuals who are diagnosed with co-occurring mental health/substance use disorders. This program has the capacity to serve up to 23 individuals for detoxification or rehabilitation treatment.

The Outpatient Enhancement Initiative has created a strong collaboration among the behavioral health system in order to enhance the quality of outpatient services for individuals receiving co-occurring treatment.

Bucks County was awarded funding for two Centers of Excellence, one in Upper and one in Lower Bucks County. Centers of Excellence help ensure that people with opioid-related substance use disorder, including co-occurring MH/opioid disorders, stay in treatment to receive follow-up care and are supported within their communities. The Centers coordinate care and treatment, is team-based and “whole person” focused, with the explicit goal of integrating behavioral health and primary care.

Bucks County has two Supported Living Programs serving eight people each, one for men and one for women with co-occurring disorders. They provide a supportive, recovery-oriented environment for individuals dealing with MH and SU challenges, toward successful reentry into the community.

Health providers are pursuing dual licensure in order to clinically support individuals with a Co-occurring Disorder (COD).

Bucks County has two Supported Living Programs serving eight people each, one for men and one for women with co-occurring disorders. They provide a supportive, recovery-oriented environment for individuals dealing with MH and SA challenges, toward successful reentry into the community.

- d) **Behavioral Health and Physical Health needs**

Bucks County Health Connections (BCHC) Program – The MH Outpatient providers continue to have success with the Nurse Navigator programs that focus on coordinating behavioral health and physical health. The Nurse Navigators perform nursing assessments with members to identify recent health concerns, gaps in care (mammogram, colonoscopy, etc.), monitor changes with vitals/weight/BMI, and to help inform goal development of integrated wellness plans. The Nurse Navigators often provide wellness education opportunities within the agencies. In 2015, there was a focus on the nurse navigators working with the rest of the team within the MH providers (outpatient therapists and case managers) to coordinate care for individuals.

As part of the Case Management Transformation Initiative (CMTI), regular training for Blended Case Managers (BCM) and D&A case managers includes information about physical health issues common in people with serious mental illness. There are two levels, one given during the first six

months of employment, which includes a presentation by Magellan explaining the Nurse Navigator supports described above and contact information for each agency's Nurse Navigator. The second level training is more advanced and focuses on understanding co-occurring issues, motivational interviewing and other skills designed to support individuals in making healthy changes.

In October 2015, Bucks County and Magellan arranged for the National Council of Community Mental Health Centers training on Case to Care Management. It was attended by staff from BCM, BCM supervisors, ACT, FACT and CTT teams. This training is again being offered in November 2016 with a second, more advanced training in January 2017 for Supervisors to help them fully incorporate this concept into their various programs.

**e) Traumatic Brain Injury (TBI)**

In an effort to support individuals with Traumatic Brain Injury, Bucks County has worked collaboratively with providers, helping them access the CommCare Waiver. Thus, providing the individual the opportunity to access appropriate supports. This has often been a difficult and lengthy process that has had varying levels of success. Additionally, the Traumatic Brain Injury Network provides technical assistance when an individual with traumatic brain injury is identified as needing additional care.

**f) Criminal justice/juvenile justice history**

Crisis Intervention Team (CIT) – The Bucks County CIT Task Force continues to provide the 40-hour training to law enforcement throughout Bucks County semi-annually. As of April 2016, 291 officers have graduated. Other graduates include Correction Officers, Probation Officers, County Dispatch, and Hospital Security. The Task Force continues its efforts to have 20% of each department trained in this CIT class. In June 2015, members of the Task Force were the keynote speakers at the Missouri State CIT Conference and presented on “Suicide by Cop”. They were also invited to do an encore presentation at the International CIT Conference in April 2016. The CIT Task Force continues to recognize the importance of collecting outcomes data to evaluate the efficacy of the trainings. To this end, the Task Force applied and was selected to participate in a state-wide CIT study in partnership with University of Pittsburg Medical Center. A total of 700 police reports were collected from both CIT and non-CIT officers from selected police departments throughout Bucks County. The data will be collected and reviewed by University of Pittsburg Medical Center. The CIT Task Force continues to provide course evaluations throughout the training in an effort to respond to the feedback from the evaluations. Thus far feedback received from the evaluations has been positive and police officers have recognized the importance of the CIT trainings.

Crisis Response Training (CRT) for Bucks County Correction Officers – A three day training was developed to train Correction Officers on crisis intervention techniques. Two classes were offered and a total of 54 Correction Officers were trained from both the Correctional Facility and Community Corrections. The goal of the training is to reduce crisis situations, improve safety, and promote better outcomes for individuals with a behavioral health challenge. The training provides tools, strategies and techniques that will allow Correctional Officers the ability to work collaboratively to implement comprehensive services for inmates with a mental illness.

911 Dispatcher Training - 911 Dispatchers requested a modified Crisis Response Training. The curriculum and schedule is developed. The training will be four hours and include an overview of CIT, an overview of mental health and de-escalation, an overview of behavioral health services including the Mental Health Procedures Act and consumer perspective. Four trainings will be offered in early 2017 to emergency management personnel including 911 dispatchers and supervisors. It is our goal to have at least 90% of emergency management personnel receive this training.

Criminal Justice Advisory Board (CJAB) - The CJAB approved the establishment of a CJAB Human Services Subcommittee in 2015. The subcommittee supports the activities and programs that enhance integration of criminal justice and human services system in Bucks County. The Subcommittee updated the Cross-Systems Mapping that was completed in 2010. The purpose of the Cross System mapping is to develop a comprehensive picture of how people with mental illness

and/or substance use disorders and/or developmental disabilities move through or interface with the Bucks County criminal justice system along the five distinct intercepts.

The subcommittee has established the following priorities: intercept 2 diversion options and resources, education and training, pre-trial services early on in the continuum, a warm hand off into treatment, housing, transportation, and exploring the need for mental health court. A survey has also been developed for the Magisterial District Justices (MDJ) to complete in an effort to identify supports, and resources that are needed at Intercept 2.

A Long Range Planning Committee has been addressing the overcrowding at the jail and has asked the Subcommittee to transform our Sequential Intercept Mapping work into a series of recommendations to also address the overcrowding issue. We anticipate recommendations will be provided to the Long Range Planning Committee by mid-summer 2016.

Pennsylvania Commission on Crime and Delinquency (PCCD) Grant - MH/DP was awarded a grant from PCCD known as the Forensic Support Program (FSP) Bridge Housing Subsidy. The FSP Bridge Housing Subsidy's goal is to develop a program that will provide safe, affordable, and appropriate housing to individuals with mental illness / co-occurring diagnosis (MI/COD) reentering the community from incarceration or divert individuals with MI/COD from incarceration, both while maintaining public safety. This goal is to be accomplished by: 1) developing permanent supportive housing for the identified population; 2) sustaining developed programs beyond grant funding; 3) increasing the number of housing opportunities and support county MH and criminal justice collaboration; and 4) creating and continuing sustainable, affordable housing opportunities for justice involved individuals at any intercept point in the criminal justice system.

Penndel Mental Health Center (PMHC), in collaboration with Bucks Co MH/DP, Bucks County Correctional Facility (BCCF), Probation and Parole and the Bucks County Housing Group (BCHG) are currently serving 3 individuals who were diverted from incarceration into community based care. The program is based in an apartment complex owned by the BCHG. This project has provided for a successful transition from incarceration through engagement and supports for treatment and housing. The collaboration between all parties have allowed for successful interventions to help individuals gain skills to transition successfully to the community. All individuals have transitional plans in place to work on recovery goals to allow them to take the next step towards greater independence and give them the time they need to have resources available for finding/sustaining permanent housing in the community thus extending the operation of the grant period.

**g) Deaf or hard of Hearing**

PAHrtners Deaf Services is under contract to provide residential and case management services to individuals who are deaf or hard of hearing. Additionally, Sign Language interpreters are able to be contracted for specific events when needed.

**h) Homeless**

Penndel Mental Health Center PATH Program Projects for Assistance in Transition from Homelessness (PATH) – This program assists individuals who have a Serious mental Illness (SMI) and/or COD who are homeless or in imminent danger of becoming homeless to obtain or maintain the housing of their choice. In August 2015 this program was monitored by the Department of Human Services (DHS). This was a one day review, which included a visit to the residence of several PATH participants in addition to an interview with two participants. The findings of this visit were positive in all areas. The only concern that was noted was what would occur if the landlord was no longer available to rent to PATH residents.

MH Housing Reinvestment Plan – In spring 2015 a \$1.4 million reinvestment plan received approval from the OMHSAS. This plan is intended to provide funds, which will address immediate housing

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needs in addition to increasing the availability of and access to long term, safe, affordable permanent housing. This plan includes goals to develop a Tenant Based Rental Subsidy Program, a Housing Clearinghouse, Contingency Funding and a Capital Development Fund (CDF).

Over the past year numerous meetings have occurred between the Bucks County Department of MH/DP administrative staff and the leadership of the Department of Housing and Community Development (HCD). The primary focus of these meetings have been in the development of an Inter-Department Agreement with regard to HCD's administration and oversight of the CDF project.

The CDF will support the development of 8-12 new units of affordable permanent supportive housing targeted to MH/DP priority consumers over a three to five year period. As the CDF Administrator, HCD will strategically use CDF resources to leverage other affordable capital development funding, including federal discretionary supportive housing programs, state and locally controlled affordable housing funding, and other funds available for affordable housing development. To meet this challenge, the HCD will develop and cultivate relationships with other affordable housing development funders [including local community development departments and public housing authorities (PHAs)], stay abreast of federal affordable housing development policies and programs and recruit and work effectively with prospective permanent supportive housing developers. Upon implementation of the Inter-Department Agreement HCD will adhere to a timetable that will include project start up, construction phase and leasing of the individual units.

With regard to the other three areas of the Housing Reinvestment Plan, MH/DP staff have partnered with the Bucks County Opportunity Council (BCOC), a nonprofit agency whose mission is to "reduce poverty and partner with our community to promote economic self-sufficiency". BCOC provides a broad range of services including emergency and preventative assistance, financial literacy and asset development, food assistance, home energy conservation services, and the Economic Self-Sufficiency Program, which is the cornerstone of their service provision. We anticipate our partnership providing positive outcomes for individuals and a new way of thinking in how we provide housing supports to individuals.

Over the past six months MH/DP and BCOC have been meeting to conceptualize our partnership and to develop an agreement of service and the MH Housing Coach Job description. The Housing Coach will play an integral role in the identification of affordable housing and to assist individuals with maintaining their housing. Outcomes will include the prevention of homelessness and reduced length of stay in mental health residential programs, inpatient psychiatric hospitalization, extended acute care settings and other more restrictive settings.

We also anticipate the creation of the Housing Coach functions will allow individuals to move from MH residential housing thus increasing access for individuals who are currently in more restrictive settings.

Homeless Outreach Support and Transition (H.O.S.T.) – Identifying and addressing the needs of individuals who are homeless and have a serious mental health diagnosis or co-occurring mental health and substance use disorder is critical in Bucks County. In November 2015, the Mental Health Association of Southeastern PA implemented a one year grant in Bucks County to focus on addressing this need. HOST consists of a team that provides access to housing through peer-delivered engagement, assistance and direction. At this time extension of the grant funding is unknown.

Bucks County also has an SSI/SSDI Outreach, Access and Recovery (SOAR) team.

In an effort to create additional housing resources for participants of HOST, the Family Service Association of Bucks County applied for the Permanent Supportive Housing Bonus with Bucks County's Continuum of Care annual Consolidated Application. However, the funding was not awarded.

Bucks County has a Leadership committee that meets on a quarterly basis to review our outcomes, identify challenges and problem solve around those challenges and identify/plan how to improve

SE Regional Olmstead Plan

SOAR process throughout Bucks County. Participants in the Leadership committee include staff representation from MH/DP, Social Security, Bucks County Housing Continuum of Care, Bucks County Correctional Facility, PATH program and other community agencies that have significant interaction with the homeless community. Our outcomes are entered into the national database OAT (Online Application Tracking). In FY 14-15 Bucks County's average days to decision and approval rating was better than the National average. For FY 15-16 Bucks County had an average of 58 days to decision and an approval rating of 62% (the National outcomes are not currently available).

- i) **Older Adults** – Bucks County works with the local Area Agency on Aging to provide a Senior Empowerment for Life Fulfillment (SELF) Program. SELF is a co-funded service between MH/DP and Bucks County Area Agency on Aging (AAA) that began in July 2009. It is a community based support serving individuals 60 years of age or older who are experiencing mental health and/or drug and alcohol problems but are not connected to traditional behavioral health supports. SELF utilizes a team approach that includes medication management, clinical interventions, case management and peer support. The team works together with each individual to improve their quality of life by connecting them to needed supports that help decrease their symptoms. A key support in achieving this is the peer support. SELF has a certified peer specialist (CPS) who engages directly with the individual in their home or out in the community. The CPS completes strength based assessments along with assisting participants with developing recovery goals, organization of their home, appointment dates etc., explaining different resources and what their rights are, along with accompanying participants when out in the community. All the time sharing their journey and empowering them to further their own journey. The MH/DP and AAA departments collaborate as needs arise to plan for the older adult population. Aside from this, all MH services, treatment and supports currently serve this population and there is not a wait list for this demographic.
  
- j) **Medically Fragile** – Bucks County has a specialized supported living program based in apartments that serves 10 individuals with a variety of medical needs. The program interfaces with the Area Agency on Aging to obtain supports as needed.

The SE Regional Medically Fragile program, known as NOVA II, can be used by all counties. It is a program which provides specialized supports to 22 individuals living in their own apartments. It provides assistance with medical needs, coordination of appointments, and community integration to access therapeutic and community resources. Bucks County currently has four individuals in this program.

**k) Limited English**

In-Network Linguistic Providers	Magellan has in-network provider linguistic competencies reflecting the county's minority populations.
Bucks County MH/DP	MH/DP contracts with three translation services to support intake and monitoring needs across the Department.
Bucks County Contracted Agencies	In order to provide services and supports, Bucks County contracted providers have translation services available to meet the needs of linguistic minorities,

- l) **Transition Age Youth including young adults - Now is the Time (NITT): Healthy Transitions** – The purpose of the Pennsylvania Healthy Transitions Partnership is to develop a coordinated and comprehensive approach to the provision of supports and services to address serious MH conditions,

CODs, and risks for developing serious MH conditions among youth 16-25 years old, during the five year grant.

The goals of the Pennsylvania Healthy Transitions Partnership include:

- Increase awareness about early indications of signs and symptoms for serious MH concerns
- Identify action strategies to use when a serious MH concern is detected
- Enhance peer and family supports for TAY; link existing and develop effective services and interventions for transition age youth/young adults (TAY-YA) and their families
- Develop coordinated care models that will address key life domains such as behavioral health services and supports, housing, employment, vocational training and higher education
- Develop models of service delivery that can be replicated across the Commonwealth

As a result of these goals, the County established three subcommittee workgroups to represent each target area of the Grant, which include community education and awareness, outreach to hard-to-reach and at-risk transition age youth, and coordinating care for transition age youth identified with a serious mental health condition.

Bucks County has also increased its efforts at suicide prevention focusing on transition age youth. In June 2016, Bucks County sponsored an “Out of the Darkness” event attended by many of the area high schools. A second event is planned for calendar year 2017.

Finally, training is being provided in the Question, Persuade, Refer (QPR) strategy designed to increase skills of young people to intervene with peers who may be contemplating self-harm or suicide.

Shared Living – The Shared Living model was implemented for individuals receiving support through the Access Services Transition to Independence Progress (TIP) model. Four individuals were placed in apartment living and there are two other individuals referred for this unique residential model. The Bucks County Housing Group, Inc. provides rental assistance and assists individuals in locating affordable housing, with the goal of decreasing rental support as individuals learn the skills to maintain their housing independently.

In FY 15/16, the “Independent Living Model” was offered for specialized respite care for TAY and young adults aged 16 to 25. This model utilizes the Casey Life Skills assessment to target areas of need. The identified individuals will develop an individualized goal plan which will be implemented over the course of in-home respite. Six individuals will be identified for the pilot and evaluate outcomes as part of the NITT: Healthy Transitions Grant. Currently, two individuals have been identified and referrals are being sought out to reach the targeted outcomes. A personalized plan of care is developed and specific activities are completed during respite events to support skills acquisition aligned with the independent living skills goals identified in the youth’s plan of care. The ongoing need for TAY Habilitative Respite services is assessed every three months and additional services are authorized as needed.

**CHESTER COUNTY – HOW NEEDS ARE MET FOR:**

**a) Mental Health/Intellectual Disability (MH/ID)**

MH and ID supports have been blended to support several individuals in CRRs.

The Crisis Intervention Team has a staff member who specializes in behavior supports for individuals with ID. This position also provides support to the crisis residential program.

Projects utilizing the partnership of MH/IDD such as discharge planning from an inpatient setting and Employment First.

Cross system trainings have been conducted to learn how to access services. These are ongoing.

Sharing and implementing tools such as Person Centered Planning, Biographical Timelines, Single Plans of Care, WRAP and Peer Specialists

**b) Mental Health/Substance Use Disorders (MH/SA)**

Co-occurring competence in Core Providers allows integration up to a point in the evaluations/assessments of individuals with co-occurring disorders.

County has access to some inpatient/residential co-occurring treatment facilities.

Actively collaborate with D&A and providers on initiatives to promote a recovery-oriented system of care.

**c) Behavioral Health and Physical Health needs**

The Patient Centered Outcomes Research Institute (PCORI) initiative led to the development of a Home Health Wellness Model. Three Core MH Providers will have staff trained as wellness coaches to assist individuals in navigating the behavioral health and physical health care systems. Core Providers will also have the option of hiring Wellness Nurses to support and assist this Health Home Model. This initiative is being expanded to three MH providers specifically for adolescents

**d) Traumatic Brain Injury (TBI)** All Counties are able to utilize the Pennsylvania CommCare TBI waiver program through the Office of Long Term Living. This program provides needed and appropriate supports to individuals who meet criteria for TBI. These supports may include personal care services, therapeutic and counseling services, community integration, employment training, and service coordination, just to name a few. It is the goal of the counties to have individuals remain independent in their home and community. Access to waiver supports such as the CommCare waiver allows this.

**e) Criminal Justice/Juvenile Justice History**

MH Diversion Court has existed for several years with good outcomes.

MH Protocol program exists for individuals discharged from Chester County Prison who are still on probation or parole.

“Forensic” House caters to a small number of individuals released from Chester County Prison who have a mental illness and are eligible for homeless funding.

Ongoing collaboration with Adult Probation on prison reentry issues.

In partnership with Police Chiefs, Crisis Intervention Program, and D&A, we are planning to develop a Crisis Intervention Training (CIT) approach for police response to community problems involving mental illness. We are currently applying for a Pennsylvania Commission on Crime and Delinquency (PCCD)

grant to support the next steps of this initiative. As a result of the partnerships to date, at least one police department has already developed new internal policies to address community policing approaches when dealing with individuals who may be mentally ill.

Continued a Mental Health Court Prison Diversion program and participated on a Prison Reentry Work Group.

**f) Deaf or hearing impaired**

Chester County has a contract with an agency called DeafCan. They provide training and support to individuals who are deaf/hard of hearing.

The MCO contracts with Milestones for a variety of mental health services for adults who are deaf or hearing impaired.

**g) Homeless**

A Critical Time Intervention (CTI) team was implemented in October 2015 to engage and provide supports and services per the evidenced based model.

The local drop in center, Community Crossroads Recovery Center, serves the homeless population by providing resources, food, a washer and dryer along with a shower. Engagement is done throughout the day in an effort to connect individuals to MH and D&A services as well as benefits.

An ongoing partnership between the Departments of Human Services, Mental Health, Drug and Alcohol and all of the local homeless shelters and providers to create better communications and referral process. This partnership has created a cross systems educational and resources guide to support this initiative.

Staff from DHS, MH and D&A participates in the Department of Community Development's 10 year plan to end homelessness. The project is called Decades to Doorways. Committees were formed to address different areas and MH staff members participate on several of the committees.

**h) Older adults**

Collaboration with the Department of Aging Services to supporting older adult Peer Support Specialists in our Core Providers.

Implementation of Mobile Outpatient services will help engage older adults.

Updating of the existing Memorandum of Understanding between the Departments of Aging, MH/IDD and D&A.

**i) Medically fragile**

The SE Regional Medically Fragile program, known as NOVA II, can be used by all counties. It is a program which provides specialized supports to 22 individuals living in their own apartments. It provides assistance with medical needs, coordination of appointments, and community integration to access therapeutic and community resources. Chester County currently has two individuals in this program.

**j) Limited English**

Increasing number of professional staff who speak a language other than English (Spanish is the primary need) and who have experienced other cultures.

**k) Transition age Youth**

Individualized residential and treatment program(s) for two young men with sexually problematic behaviors continues with good outcomes. Program has been able to serve a new resident.

## SE Regional Olmstead Plan

Continue to operate a Transition-Aged Youth (TAY) supported living program and a TAY Assertive Community Treatment (ACT) Team.

TAY group is offering support groups at the Peer Center.

**Now is the Time (NITT): Healthy Transitions** – The purpose of the Pennsylvania Healthy Transitions Partnership is to develop a coordinated and comprehensive approach to the provision of supports and services to address serious MH conditions, CODs, and risks for developing serious MH conditions among youth 16-25 years old, during the five year grant

**DELAWARE COUNTY –HOW NEEDS ARE MET FOR:**

**a) Mental Health/Intellectual Disability (MH/ID).**

Forums	OBH and OID both participate on the Delco Block Grant Advisory Committee and in the Human Services Administrators meetings for joint planning/information sharing.
MH/ID Case Review	OBH and OID participate in ongoing case review forums for children and adults to identify needed services and plan joint service delivery for Dual Diagnosis clients.
Inter-system Training	OBH, OID, and Magellan provided a series of best practice Dual Diagnosis trainings for inter-system personnel. The first training was attended by Psychiatrist, Blended Case Managers and Supports Coordinators attended the second training and MH & ID Residential staff attended the third round of training.
CIT Training	A consultant from PCHC provides instruction in MH/ID Dual Diagnosis curriculum content area to police officers attending the semi-annual certification program.
Joint programming	OBH, OID, and their respective state offices have met to plan potential jointly funded RTF-A services using Reinvestment funds for start-up.

**b) Mental Health/Substance Use Disorders (MH/SA)**

Illness Management & Recovery (IMR)	Delco has contracted with Dartmouth Psychiatric Center for several years to implement the Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based IMR approach in several provider programs including Dual Diagnosis, intensive Outpatient (IOP), Community Residential Services (CRS), ACT, Crisis Residential Program (CRP), and Halfway House serving the Co-occurring Disorders (COD) population. Illness Management Recovery (IMR) also has the new COD enhanced tool kit (Enhanced-IMR) which is being implemented in Delco at 8 providers. Currently 2 of these providers are piloting Integrated-IMR which addresses physical health as well.
Integrated Dual Diagnosis (IDD) Treatment	Magellan and OBH continue efforts to increase provider competency in integrated screening, assessment, and intervention for individuals with COD. Five provider sites are using the DDCAT (Dual Diagnosis Capability in Addiction Treatment) and DDCMHT (Dual Diagnosis in MH Treatment) tools developed by Dartmouth’s Dr. Mark McGovern. Magellan and OBH continue to monitor COD competency through targeted audits and focused reports.
COD Collaborative	Magellan, OBH, and providers have resumed meetings of the COD collaborative to provide support, as providers implement changes based on the above audit results. The COD collaborative, facilitated by Magellan’s Dr. Kerry King, attended by MH and D&A providers alike, remains a vehicle to discuss best practices, program updates and specialties.

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COD Treatment	There are 3 providers with multiple IOPs, Three - 24 hour Inpatient units, and 1 Halfway House in the county serving the COD population. Magellan is working with several providers to develop Smoking Cessation programs, and one provider is developing a Health Home to include 4 nurses to conduct smoking cessation groups that will target this population.
CIT Training	There is a strong COD component presented by both MH and D&A faculty in the semi-annual CIT certification classes for law enforcement personnel.
System Training	In 2012, Magellan trained 3 providers in Dialectical Behavioral Therapy (DBT), an evidenced-based program proven extremely effective with individuals diagnosed with Borderline Personality, Eating Disorders, and Substance Abuse many of whom have COD.
CRS COD Housing	OBH maintains a 10-bed CRR and a 3-bed Three Person Residence (TPR) targeted to the COD population. The CRR program has linkages to Dual Diagnosis IOP treatment programs.
Inpatient DBT program	The county's only D&A inpatient Dialectical Behavioral Therapy (DBT) program continues with praises. This provider also offers outpatient substance abuse DBT programming creating a seamless transition at discharge. This program has reduced persons leaving treatment AMA by 30%.
Specialty Courts	There is a D&A Treatment Court with a largely COD population and a MH and Veterans Court that also has a high level of COD clients in its initial caseload.

### c) Behavioral Health and Physical Health needs

Delco completed its contract with the National Council (NC) on this evidence-based approach to improving healthcare outcomes for persons with SMI in December 2015. The Learning Community continued in 2016 with combined leadership and planning from OBH and Magellan. The focus continues to be provider networking, best practices, data collection, and outcomes, as well as regulatory updates. All 3 Blended Case Management providers participate monthly in face to face or teleconference meetings to strengthen implementation and collaboration. Blended Case Management Model (BCM), is a case management that model allows the consumer to keep the same" case manager" even when there is a change in the level of service needs. This model does not change the case management services being delivered, but it does change the manner in which these services are delivered. It was theorized that, by permitting the blended case manager to adjust service intensity based on consumer needs, there would be improved continuity of care and enhanced support for recovery/resiliency concepts. In essence, the blended case manager would provide ICM or RC level of service as needed, essentially eliminating the distinction between RC and ICM in terms of service delivery.

### d) Traumatic Brain Injury (TBI)

All Counties are able to utilize the Pennsylvania CommCare TBI waiver program through the Office of Long Term Living. This program provides needed and appropriate supports to individuals who meet criteria for TBI. These supports may include personal care services, therapeutic and counseling services, community integration, employment training, and service coordination, just to name a few. It is the goal of the counties to have individuals remain independent in their home and community. Access to waiver supports such as the CommCare waiver allows this.

### e) Criminal justice/juvenile justice history

Administrative Forums	The Criminal Justice Advisory Committee (CJAC), Cross-System Strategic Planning Committee (CSSPC), and Delco Cares are the primary administrative forums for inter-system forensic planning and service development.
Cross-System	In 2010, OBH and criminal justice partners participated in a MH Justice

## SE Regional Olmstead Plan

Mapping	Center of Excellence (COE) led Cross-System Mapping to identify strengths and gaps and create a prioritized strategic action plan to develop and enhance forensic services in the county.
Crisis Intervention Team (CIT)	The CIT program has trained and certified 251 officers from 35 municipal police departments, 17 county park police, 4 university security officers, 2 state police officers, and 5 SEPTA transit officers. CIT certification classes are held semi-annually and faculty is comprised of consumers, families, providers, and county personnel.
Transitional Housing Program (THP)	The new forensic THP, operated by the provider of the county's prison and Community Corrections Center facilities, opened in March 2014. This 9-bed program is targeted exclusively to the forensic population. This program will be expanded by 12 beds for a total of 24 in FY 16-17.
Forensic ACT (FACT) Team	Delco converted a CTT program to a FACT model with technical assistance from the University of Rochester Medical Center. The Rochester R-FACT model is an evidence-based forensic intervention model that collaborates with the MH Court.
Treatment Courts	Delco has a MH Court, a D&A Court and a Veterans' Court

### f) Deaf or hearing impaired

Deaf Services	Contracts for Wrap-Around, Case Management, and BHRS in the children's system, and socialization and sign language interpreters in the adult system. Magellan has several in-network providers to serve the deaf and hard of hearing population giving participants a measure of choice.
In-Network	
Deaf Providers	

### g) Homeless

Continuum Of Care (COC) Planning	OBH has several staff who maintain leadership roles in the COC planning process and Homeless Services Coalition that has operated successfully for 24 years.
Homeless Emergency Assistance and Rapid Transition to Housing Act	In FY 13-14 a Governance Charter was drafted and a Governing Board constituted to comply with Federal HEARTH Act requirements.
HEARTH Act Governance	
COC Services	The county's COC has services for homeless SMI that include: Outreach, Emergency Shelter, Supportive Services, and Transitional and Permanent Housing.
Local Match Commitment	DelCo has long provided required federal match funding for homeless initiatives. Reinvestment funds have also been used when other match sources have ended.
PATH	OBH has maintained federal PATH grants through OMHSAS for many years to provide homeless street outreach and a Chronic Homeless Housing First program.
Shelter Plus Care (S+C)	OBH has also maintained two S+C grants for years that provide housing for the Chronic Homeless population. HUD recently consolidated these into one S+C grant.
SOAR	OBH worked with OMHSAS SOAR trainers to train 30 homeless case managers in the SOAR homeless model of expedited SSI/SSDI benefit application and awards.
Families	The Continuum of Care for homelessness is striving to end family homelessness by 2020 as directed by HUD. All transitional housing programs for households with children have been converted to Rapid-Rehousing housing first model. In addition,

the CoC is working to reduce the length of time persons remain homeless as well as ensure there is a low recidivism rate.

**h) Older adults**

GATEWAY	Longstanding, jointly-funded, inter-system partnership between Delaware County Office of Services for the Aging (COSA) and OBH that targets and identifies isolated at risks older adult with behavioral health issues and connects them with appropriate formal and informal community resources.
Aging/Disability Resource Center (ADRC)	Partnership between OBH, COSA, and other organizations serving older adults that provides training, screening, outreach and linkages to housing and other community-based services combined with the City of Philadelphia.
Specialized Personal Care Homes (SPCH)	SPCH programs were designed to meet the housing needs of the elderly/medically fragile target population. The 30-bed capacity provides a barrier-free housing environment for older individuals with high-level mobility and personal care needs.
Therapeutic Counseling	Therapeutic counseling is provided for identified homebound older adults with behavioral health needs who otherwise would go untreated. The capacity of the program is 25
Older Adult Task Force	Delco specific group of OBH, COSA, and providers that does case reviews and develops best practice service plans to meet the needs of older adults with SMI.

**i) Medically fragile**

The SE Regional Medically Fragile program, known as NOVA II, can be used by all counties. It is a program which provides specialized supports to 22 individuals living in their own apartments. It provides assistance with medical needs, coordination of appointments, and community integration to access therapeutic and community resources. Delaware County currently has one individual in this program.

**j) Limited English**

In-Network Linguistic Providers	Magellan has in-network provider linguistic competencies reflecting the county's minority populations. Intercultural Family Services staff speak over 20 languages. Some providers offer Spanish speaking telephone options and staff interventions.
System Trainings	Cultural competency trainings have been provided to contracted agency staff for several years. Magellan has online training content available to provider staff online.
Documents and Interpreter Services	OBH has procured a telephonic interpreter service via Language Line which allows staff to use during phone calls and or face to face meetings coordinated by OBH staff. The use of an IPAD with immediate access to video interpreting is also available for OBH as well as all Human Services offices. Magellan is able to provide interpreters for members who call our Member Services Line; Magellan has translated letters based on a member's primary language; Member handbook and Newsletters are printed in Spanish.

**k) Transition age youth, including young adults**

ACT Team Expansion	OBH and Magellan are expanding ACT services to include a new 100 member team for MA eligible persons. 25-30% of the new caseload will be targeted to the transition age youth population. As of 4/30/16, 53% of the caseload or nine of the 17 were transition age youth.
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<p>Consumer Recovery Investment Fund – Self Directed Care (CRIF- SDC) Expansion Transition-Age CRR</p>	<p>The county is increasing the CRIF SDC II census by 20%, adding 10 new transition age consumers to the program caseload. Making this experimental recovery-oriented service available to transition age youth will be an important part of overall SDC research and study. The county has operated a dedicated 6-bed CRR and a 5-bed SLS subsidy program for transition age youth for about 10 years. There is also a 4-bed component of an adult CRR targeted to the transition age youth population.</p>
<p>MY LIFE and MY Fest</p>	<p>The Magellan Youth Leaders Inspiring Future Empowerment program has grown significantly since its inception. My Life meetings are held monthly with this year's focus on developing a play and raising awareness of such topics as Bullying Prevention. MY Fest event and MY LIFE Leadership events are held annually to build youth leadership capacity. The 2016 event MY FEST fall event will be held in Bucks County.</p>
<p>Hi-Fidelity Wrap Around</p>	<p>Team-based collaboration serving children including transition age youth up to 21 years of age and their families. The Delco Team served 42 families in FY 15/16 and we expect to service 14 new families in FY 16-17.</p>
<p>Transition to Independence</p>	<p>Evidenced supported model for ages 16-26, that is licensed as a Blended Case Management Program with an additional Certified Peer Specialist, currently serving 57 out of 60 (full census).</p>
<p>TAY w/Autism Spectrum Disorders</p>	<p>A new program called CREATE has been developed and will begin in FY 16-17 for ages 3-21 with an ASD diagnoses. CREATE is a year round peer-centered service. Clients will build social and communication skills, improve problem solving and emotional regulation, and enhance flexibility and motivation.</p>
<p>First Episode Psychosis</p>	<p>Delaware County and Child &amp; Family Focus applied for a state grant in 2016 for the First Episode Psychosis, Coordinated Specialty Care Programs. FEP is a Coordinated Specialty Care (CSC) approach to treating young people who have recently experienced their first episode of psychosis (FEP). The FEP Team offers young people an array of services, including low-dose medication management, Cognitive Behavioral Treatment for Psychosis, Family Education, Case Management, Supported Education and Employment, and peer support services. Service coordination is guided by the young person's voice and choice. FEP seeks to improve the quality of life of young people by instilling hope through empowerment to guide their own treatment, educating them about their psychosis, re-establishing relationships, and re-integrating them back into the community whether it's attending school or working.</p>

## **MONTGOMERY COUNTY – HOW NEEDS ARE MET FOR:**

- a) Mental Health/Intellectual Disability (MH/ID) –** Montgomery County has a Dual Diagnosis Treatment Team (DDTT) for individuals with intensive support needs. The service includes a team approach, delivered by behavior therapists, psychiatrists/Certified Registered Nurse Practitioner (CRNP), and psychiatric nurse. The service acts as a consultative support to residential and other services the individual receives.
- b) Mental Health/Substance Use Disorders (MH/SA) –** Montgomery County has several co-occurring residential programs. Eagleville Hospital provides acute inpatient treatment for individuals with co-occurring MH/SA needs.
- c) Behavioral Health and Physical Health needs** The Community Behavioral Health Centers employ Nurse Navigators. Additionally, the County is looking to provide mental health services at the Federally Qualified Health Centers.
- d) Traumatic Brain Injury (TBI) –** The Traumatic Brain Injury Network provides technical assistance when an individual with traumatic brain injury is identified as needing additional care. In addition, all Counties are able to utilize the Pennsylvania CommCare TBI waiver program through the Office of Long Term Living. This program provides needed and appropriate supports to individuals who meet criteria for TBI. These supports may include personal care services, therapeutic and counseling services, community integration, employment training, and service coordination, just to name a few. It is the goal of the counties to have individuals remain independent in their home and community. Access to waiver supports such as the CommCare waiver allows this.
- e) Criminal Justice/Juvenile Justice History**

OMH has a long-standing partnership with the criminal justice system to reach the unified goal of assuring community safety by appropriately diverting individuals with mental illness from correctional institutions into community based treatment. When diversion is not possible, the goal is to provide treatment and re-entry support planning within the correctional facility. The benefits to individuals and the community as a result of the extensive efforts of these systems are evidenced by reduced length of stays in the correctional facility.

Over the years, links between the courts, probation, police departments, and the correctional facility have been connected to the community mental health system in a variety of ways to assist with diversionary and community re-entry interventions. Montgomery County participated in a National GAINS Center Sequential Intercept Mapping session in 2008 and has just recently in 2015 remapped the sequential intercepts for the county. The Office of Mental Health has developed comprehensive services under within each intercept. The strategies that have been developed to address criminal justice issues complement OMHSAS's Recommendations to Advance Pennsylvania.

The Montgomery County partnership led to the development of a Behavioral Health Court (BHC) in 2009. The court has further strengthened the collaboration between the criminal justice and mental health system. BHC continues to provide benefits to individuals with MH challenges as evidenced by reduced rates of incarceration, improved quality of life and reduced or dismissed legal charges.

Montgomery County has developed the Justice Related Services (JRS) team to provide case management services for individuals who are involved in the criminal justice system. JRS works to divert individuals with a mental health diagnosis from incarceration. They also work with incarcerated individuals on re-entry and community support plans. The service is focused on engaging individuals in the Montgomery County Correctional Facility (MCCF) who experience mental health challenges and are homeless. These services are supported by a SAMHSA Programs for the Assistance in Transition from Homelessness (PATH) grant.

Montgomery County has a new Forensic Coalition which was formerly known as the Montgomery County Forensic Task Force. The Coalition is comprised of a diverse group of organizations, departments,

individuals, families, and advocates representing the behavioral health and criminal justice systems who are working to effect systems change in Montgomery County. The Forensic Coalition is part of a long-standing effort by the Forensic Task Force to bring together Montgomery County stakeholders to provide recommendations which bring about improvements in the county mental health system for individuals with mental health challenges who are involved in the criminal justice system. The Coalition's focus is to develop measures which will prevent individuals with mental illness from being incarcerated, improving mental health treatment while individuals are incarcerated and diverting individuals from jail into housing, treatment and recovery supports.

The impetus for creating the new Forensic Coalition was an announcement in December 2014 on Capitol Hill of the "Stepping Up Initiative – A National Initiative to Reduce the Number of People with Mental Illnesses in Jails." This project is sponsored by The National Association of Counties (NACo), the Council of State Governments (CSG) Justice Center, the American Psychiatric Association, and the National Alliance on Mental Illness (NAMI). The Montgomery County Forensic Coalition has aligned with the 4 goals of the National Stepping Up Initiative which are, to reduce the number of individuals with mental illness being booked into county jails, to reduce the length of stay in jail, to increase the number of individuals connected with MH services upon jail release and to reduce the recidivism rate to jail for individuals with MH challenges. To accomplish these goals the Forensic Coalition has 3 active workgroups which focus on Diversion, Data collection and Re-entry services. Each workgroup reports their recommendations to the coalition on a quarterly basis for review and implementation discussions.

**f) Deaf or hearing impaired** – PAHrtners Deaf Services is under contract to provide residential, treatment and case management services to individuals who are deaf or hard of hearing.

**g) Homeless** – OMH funds the Coordinated Homeless Outreach Center Coordinated Homeless Outreach Center shelter, Critical Time Intervention program and holds five HUD Permanent Housing rental Assistance Grants. OBH/DD is a major partner/funder for the Your Way Home initiative which is Montgomery County's program to end homelessness in the County.

**h) Older adults**

OMH and the Office of Aging and Adult Services have continued to partner to determine how best to serve the older adult population in Montgomery County. OMH funds outreach services to engage the older adult population. The Office of Aging and Adult Services continues to partner with OMH to provide CPS services to the older adult population. This includes the Peer Support Talk Line and mobile peer support. OMH and AAS anticipate that the strategy of utilizing peer specialist will be successful in engaging the older adults that are experiencing mental illness. As noted in the housing section OMHJ has had success in building relationships with developers of housing for older adults. There is one project with 3 units under construction and another two projects, with 3 units each, that Montgomery County OMH committed dollars toward that have submitted applications in PHFA's current Low Income Housing Tax Credit funding application process.

**i) Medically fragile**

The SE Regional Medically Fragile program, known as NOVA II, can be used by all counties. It is a program which provides specialized supports to 22 individuals living in their own apartments. It provides assistance with medical needs, coordination of appointments, and community integration to access therapeutic and community resources. Montgomery County currently has six individuals in this program.

**j) Limited English** – Central Behavioral Health in Norristown provides clinical and case management services for Spanish speaking individuals. Magellan Behavioral Health network includes several providers who can treat individuals with who speak various languages.

**k) Transition Age Youth including young adults**

In order to engage and address the needs of the young adult population, Montgomery County has created a wide variety of supports specifically targeted to young adults. This includes Peer Mentoring support for the transitional age; an intensive residential service for transition age only; Supported

Education at the local community college; the Intensive Psychiatric Rehabilitation model modified to target young adults; and an enhanced Blended Case Management program specifically for young adults. In addition, competency in serving this unique age group was emphasized in the 2015 Request for Proposals (RFP) and contract renewal process with all of the county's regional Community Behavioral Health Centers (CBHC).

Magellan Behavioral Health, Montgomery County's managed care organization, remains committed to supporting Transition Age Youth through the ongoing work of the MY LIFE (**M**agellan **Y**outh **L**eaders **I**nspiring **F**uture **E**mpowerment) group. MY LIFE helps youth who have been connected with the mental health, substance abuse, juvenile justice or foster care systems use their experiences to help others. It gives these youth the chance to use their voice to improve the programs and systems that serve young people through events such as a regional "MY FEST" event, as well as a Youth Day on the Capital event that the youth helped to organize.

Montgomery County and Magellan partnered to implement the Transition to Independence Program (TIP) in summer 2015. The TIP model is an evidence-supported practice that demonstrates improvement in real-life outcomes and futures planning for youth and young adults. The Montgomery County TIP Program serves members from all regions of the county ages 16-25 with emotional and behavioral challenges through a case management platform and is inclusive of peer support. The outcomes observed in the first implementation audit earlier this year highlight TIP's success in supporting young people to achieve independence and wellness goals.

Montgomery County has implemented mobile psychiatric rehabilitation teams that can support individuals in the community. Although these teams work with every adult priority population, they have additional training and expertise for the young adult population.

The goal of all of the above interventions is to ensure that supports are available to allow young adults to develop the tools necessary to support their wellness and achieve their life outside of the mental health system. Recognizing that transition age youth constitute a unique population with specific strengths, challenges, and needs, Montgomery County coordinates a provider workgroup and new system of information distribution. The goal of these efforts is to foster communication, information sharing, and problem-solving among children, adult, and TAY-specific providers. By working together, providers are able to increase their knowledge of what supports already exist, and as a team identify areas of challenge and need. The MONTCO TAYYA Provider Workgroup includes participants from mental/behavioral health providers, schools, Office of Children and Youth, community support groups, career centers, residential settings and Montgomery County Community College. The workgroup meets quarterly, and 2016 topics include: Dating and Relationships, Health and Wellness, Youth Leadership and Empowerment, and Education. Additionally, the County coordinates and information sharing website, The Y.A.R.N. (Young Adult Resource Network), as well as sends monthly "Quick Stitches," both of which include TAY-specific information, local happenings, and opportunities for youth.

**PHILADELPHIA COUNTY – HOW NEEDS ARE MET FOR:**

- a) **Mental Health/Intellectual Disability (MH/ID)** - The DBH/IDS Workgroup is composed of staff from the following: Pa Office of Developmental Programs (ODP), Philadelphia Mental Health Care Connections (PMHCC), IDS, DBH and Community Behavioral Health (CBH). The group meets quarterly to review the work of the DBHIDS CTT team as well as other related MH/IDS issues. The BH/ID CTT team was established to address the individuals with ID who are high users of crisis and psychiatric inpatient services. The team includes psychiatric time, time from a psychologist and behavior specialists. The team is intended to support the ID individual as well as support staff from the residential program, family/significant others and the ongoing support team. This CTT team is intended to be a short term intervention with intense focus on what interventions are needed long term, an action plan for change and ultimately (re)introduction back to program capable of supporting the individual's needs. The team has the capacity to serve 100 individuals.

Recently two DBHIDS staff and one CBH staff were identified to participate in the yearlong Institute which is a joint initiative by ODP and OMHSAS to build clinical capacity and knowledge based collaboration for individuals with complex and difficult needs as well as system strategies. The first session occurred in October 2016.

- b) **Mental Health/Substance Use Disorders (MH/SA)** - A pilot project was initiated in FY 2014 to convert existing mental health case managers and under-utilized caseload capacity to specialized co-occurring Targeted Case Management (TCM) services for persons with both mental illness and addictions challenges. The pilot was initiated to: address a waiting list that was potentially affecting PSH movement, assess if training enhancements with existing seasoned MH case management staff would be adequate in addressing skill sets needed for working with a co-occurring population and determine if a centralized gatekeeping for behavioral health case management would be a more effective process for service management and utilization.

Two providers were engaged to participate in a year-long pilot for 100 participants (50 for each provider) which concluded with an analysis of service utilization and effectiveness. DBHIDS developed a co-occurring training curriculum to introduce new expectations and skill trainings for case managers transitioning into these new roles. Assessment tools, technical assistance, and monitoring protocols were also established. Four case managers and supervisors from each of the two agencies participated. Referral review and authorization processes were also initiated to insure that these resources were targeted to individuals most in need of co-occurring case management supports. Referrals to these caseloads began in March 2014 and the pilot concluded after 9 months when the two agencies maxed out with 114 individuals being served. A subsequent group of co-occurring individuals was identified during this pilot period, entering the system as a mental health case management referral. This subset of 37 individuals (across 10 agencies) was also tracked.

Lessons learned from the pilot highlighted that co-occurring training, additional personnel/supervisory supports, co-occurring resources (housing, treatment options, etc.), adjusted caseloads, and more accurate matching of participant to case management service would be the necessary changes/additions to advance us toward a true behavioral health response.

The pilot prompted further exploration of a “centralized gatekeeping” process that would ultimately eliminate the multiple entry points that resulted in denials, people being approved for less than optimal services, people not receiving services, and/ or people being lost in the multiple referral processes. As a result, centralized gatekeeping with a single referral/intake form was initiated in 2015 and BHSI Case Management has realigned its team structure and is in current negotiations for expanded capacity with a specific focus on a specialty team of skilled case managers to address more challenging individuals.

In 2015 a RFP was issued for an Adult Partial Hospital program to accommodate persons with co-occurring mental health and addiction issues who are stepping down from inpatient treatment. A vendor was recently selected to provide this service and start up is projected for FY17.

A major focus of attention for 2016 and 2017 will be addressing the identified system wide Opioid Epidemic. It is anticipated that TCM programs, detox, housing, rehabilitation and recovery supports will be in expansion mode to address the increasing demands of this identified population. Outreach, CTT/Housing First Services, and medication assisted treatment options have already been increased. Training and educational opportunities have begun on both a small and larger scale with further attention to be paid throughout the fiscal year.

- c) **Behavioral Health and Physical Health needs-** PH/BH activity for the DBHIDS is occurring under the direction/purview of CBH. There are an array of components to address the access and coordination of care issues for member with co-occurring physical and behavioral healthcare needs to improve clinical outcomes.
- Special Needs Team – within the Clinical Management Department, this team works directly with the PH – MCOs and high-risk members with co-occurring behavioral health and physical health needs to ensure seamless coordination of care across both systems. Year to date, the special needs team has done outreach to approximately 2000 unique members.
  - Community Based Care Management Team (CBCMT). This team works specifically with the Health Partners Plan (HPP) members who represent the top 5% of medical costs for the plan. The teams consist of a CPS and a Care Manager Specialist under the supervision of a BH Nurse Specialist with the goal of helping to improve recognition, treatment and management of psychosocial/behavioral problems that impact medical conditions. The integration of behavioral health staff into the community based care teams is seen as essential to ensure the effectiveness and impact of the interventions that are identified.
  - Integrated Care Pay for Performance (P4P) Program (ICP). This involves a stratification of all members into one of 4 designated quadrants of PH/BH. CBH will complete an assessment of the Social Determinants of Health for new members and existing high risk members with SPMI. Members with high PH/BH needs will be targeted for Integrated Care treatment plans that will be used to guide care for the member. Care Management Specialist thru the Special Needs unit will coordinate care for these members in collaboration with the PH – MCOs.
  - Joint PH/BH MCO Quality Activities and initiatives related to best practices in clinical care.
  - Development of Integrated Care Provider Service Delivery systems inclusive of but not limited to: Behavioral Health Consultant (BHC) Model in primary care settings, Co-Located BH Services in Primary Care Sites, Behavioral Health Homes, Integrated Children’s Services and Peer Recovery Specialists for individuals with Substance Use disorders.
  - PH/BH Data Analysis and Program Evaluation – CBH continues to conduct and support research and program evaluation related to the intersection of PH and BH, the quality and access of service for the Medicaid population through the Program Evaluation Analytics and Research (PEAR) Unit and the University of Pennsylvania’s Evaluation and Research Center.
  - Other PH/BH Initiatives – Cross System Collaborations that include but are not limited to: Tobacco Recovery Wellness Initiative, Perinatal depression project, HPP Health Learning Collaborative, Fetal Infant Mortality Review/HIV, Child Non-Homicide Review, Homeless Death review, etc.
- d) **Traumatic Brain Injury (TBI) –** BHSIDS established a contract with the Brain Injury Association for a training series with plans to address certification. We conducted a system’s basic “101” training on working with someone with TBI and also conducted a more targeted training with a provider agency that was willing to address the needs of an individual with extensive TBI challenges. There is also some conversation occurring as part of the recent activity with the NSH forensic population with respect to a population that has neurocognitive challenges that will require placement opportunities within the community. New residential options are being explored.

In addition, all Counties are able to utilize the Pennsylvania CommCare TBI waiver program through the Office of Long Term Living. This program provides needed and appropriate supports to individuals who meet criteria for TBI. These supports may include personal care services, therapeutic and counseling services, community integration, employment training, and service coordination, just to name a few. It is

the goal of the counties to have individuals remain independent in their home and community. Access to waiver supports such as the CommCare waiver allows this.

- e) **Criminal Justice/juvenile justice history** - Extensive planning and activity is occurring specific to the NSH ACLU lawsuit. A reinvestment plan was submitted and recently approved for the services identified in Section II – Services to be developed. These new services and the initiatives detailed below are designed to benefit the Incompetent to Stand Trial (IST) population and to establish a broader network of services to increase flow through the behavioral health and criminal justice systems so that forensically involved individuals can pursue legal and behavioral health goals.

Infrastructure development- several new DBHIDS positions were determined as necessary to support the network of forensic services designed to improve policies and programming for justice-involved individuals with behavioral health needs. These include:

- The Forensic Services Manager is a licensed, Juris Doctorate level staff member, who is responsible for implementing and overseeing efforts to hasten the flow of justice-involved Philadelphians through the behavioral health and criminal justice systems. The Forensic Services Manager is responsible for translating proposed initiatives into action, overseeing program development, and managing these forensic initiatives.
- The Forensic Data Coordinator is a Bachelor's level position with extensive research experience, responsible for building and maintaining a data system to identify, track, and monitor forensic populations who interact with the local behavioral health network of care, including individuals found IST. This position will work to ensure that forensically-involved persons receive services in a timely manner. Location and lengths of stay will also be monitored (e.g., incarcerated, inpatient treatment, detox, etc.). Additionally, this position will establish and maintain a data system to document and evaluate outcomes.
- The Data Analyst, a Bachelor's level position, will partner closely with the Forensic Data Coordinator. The Data Analyst will be responsible for data entry as well as reviewing behavioral health and criminal justice databases to ensure the comprehensive collection and management of relevant information.

Forensic Training: Specialized training, consultation, and technical assistance will be provided for key behavioral health and criminal justice stakeholders to promote best practices across the behavioral health continuum of care. Training will be extended to service providers, administrators, service recipients, family members, the courts, jails, hospitals, and other community members. The needs of persons deemed to be IST will constitute a training priority. Training topics will include best practices related to competency evaluations, competency restoration, evidence-based treatment, criminogenic factors, local law and practice, substance use, and trauma, as well as organizational planning and implementation.

This multifaceted initiative is designed to improve policies and services for justice-involved individuals with behavioral health needs. Goals and outcome indicators associated with the aforementioned initiatives include the following:

- Reduce time required to achieve competency restoration.
- Reduce criminal justice recidivism.
- Reduce use of crisis services and inpatient treatment.
- Increase diversion from Norristown State Hospital.
- Reduce the Norristown State Hospital waiting list.
- Increase movement to community based services including Permanent Supported Housing.

See bullet under TAY section relative to DHS/DBHIDS partnership for youth

**f) Deaf/hearing impaired.** Community Behavioral Health has the following services in its network:

- Family-Based program for children (home-based therapy, including intensive individual and family therapy in the child's home, and case management services for up to nine months)
- Outpatient counseling services to all ages, individuals, groups, couples, and families.
- CATIPIHLER Services: Adjustment to Hearing Loss Family Consultations, behavior consultations (birth – Kindergarten), school, and behavioral health provider clinical consultation
- Evaluation and medication management of ADHD in deaf and hard of hearing children
- Child abuse/neglect evaluations
- Mental Health Outpatient for adults
- Intensive Case Management
- Partial Hospitalization Program
- Residential services for adults; Residential Treatment facility (RTF) for child/adolescent
- Peer Support for adults
- Behavioral Health Rehabilitation Services (BHRS) ("wraparound" services) for deaf and hard of hearing children (including behavior consultation, therapeutic support, mobile therapy) in the five-county region
- Independent Psychiatrist who provides outpatient therapy including evaluation, counseling and medication management
- Outpatient & Intensive Outpatient (IOP), interpreter-assisted drug and alcohol counseling
- Early Intervention Program, Kindergarten through 12<sup>th</sup> grade education in a signing-rich environment
- Information, referral, and school-based behavior health services for deaf and hard of hearing

In Philadelphia, PAHrtners, Deaf Hearing Center is under contract to provide an array of services to individuals who are deaf or hard of hearing. PAHrtners is developing site based and mobile PRS programs as well as freestanding CPS services. These services are anticipated to provide supports to individuals in SIL or independent living on a fee for service basis. PAHrtners - Philadelphia site with plans to expand with additional apartments in early next year. The new site will fall under their current contract with CBH for residential services.

**g) Homeless**

The City of Philadelphia's overall strategy for meeting priority homeless needs is guided by the goals outlined in "Creating Homes, Strengthening Communities, and Improving Systems: Philadelphia's Ten Year Plan to End Homelessness." The Plan was developed by a broad group of stakeholders, endorsed by then Mayor Street in 2005, and recalibrated in 2008 under Mayor Michael A. Nutter with a specific focus on increasing housing and treatment opportunities.

In concert with the City's 10 Year Plan to End Homelessness, Office of Homeless Services (OHS), in partnership with the Office of the Deputy Mayor for Health and Opportunity (HHS) and the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), implemented the Mayor's Homeless Housing Strategy, which included a commitment to provide housing opportunities for homeless individuals and families. Since the end of the Federal American Recovery and Reinvestment Act (ARRA) funding of \$23 million from 2009 – 2012 for Prevention, Rapid Re-Housing and Housing Stabilization services there has been a dramatic decrease in the numbers of families and persons assisted to prevent homelessness and to move out of homelessness into permanent housing. Rapid re-housing is the practice of focusing resources to help households (individuals and families) to quickly move out of homelessness and into permanent housing and reduce the amount of time experiencing homelessness. Participants receive financial assistance to move back into the community and housing stabilization services, which is a type of case management focused on helping participants to maintain their housing, such as managing the household budget, making timely rent and utility payments and being a good tenant and neighbor. OHS continues to seek and utilize all available local, state and federal homeless rapid re-housing funding and assure that residents in Emergency and Transitional Housing are able to connect with all mainstream benefits for which they qualify and connect them to resources and opportunities to increase their skills, education and income

### Street Outreach

This activity focuses on the vulnerable men and women living outdoors in Philadelphia, including 24 hour a day, 7 days a week, 365 days a year street outreach teams who locate and engage individuals living on the streets and encourage them to accept services, treatment, and housing. The Outreach Coordination Center, located at Project HOME and funded by the City's Department of Behavioral Health and Intellectual disAbility Services (DBH), provides a central "dispatch" to coordinate outreach efforts and respond to citizen calls to an outreach hotline. The outreach team capacity was just expanded by two additional teams with a focus on coverage to the lower Northeast/Kensington area – an identified "hotspot" as related to the opioid crisis.

### Safe Havens

Safe Havens are entry-level programs that serve hard-to-reach homeless persons who have severe mental illness, are living on the streets, and have been unable or unwilling to participate in supportive services. They provide a 24-hour residence for an unspecified duration, and do not require participation in services or referrals as a condition of occupancy. After a period of stabilization in a safe haven, residents are often willing to participate in services and often become ready to move to treatment or more permanent housing. DBH funds the Safe Haven system. Recently two safe havens were transitioned to meet the growing needs of the TAY homeless population. The first site is a 10 bed male site that also addresses a LGBTQ population, the second site – newly established – is a 14 bed female site.

### Transitional Housing

Transitional housing is defined as time-limited housing with supportive services to encourage homeless individuals and families to live more self-sufficiently. This semi-independent form of supportive housing is used to facilitate movement from emergency to permanent housing. Transitional housing is primarily provided by non-profit partners and faith-based organizations, and supportive services may be offered by the organization managing the housing facility or by other public or private agencies. HAP Bridge funds are allocated to 5 transitional housing programs, and to case management services at 3 of the 5 programs. PennFree funding is allocated to 2 transitional housing programs. In addition, HAP funds are allocated for case management for families embarking on the Blueprint Program, a partnership with the Philadelphia Housing Authority (PHA) through which PHA provides up to 300 units of family housing annually to the City for homeless families. To date, the City and PHA report more than 1,690 families housed.

### Drug/Alcohol Treatment for Chronically Homeless Individuals

More than 120 treatment slots have been created and funded by DBH to assist men and women with long histories of chronic homelessness to embark on recovery from addiction through the Journey of Hope Program. At the end of the program, successful graduates may be able to obtain a Housing Choice Voucher or other resource to support housing stability and continued recovery.

### Permanent Supportive Housing

Permanent supportive housing refers to long-term (not time-limited), safe, and decent living arrangements that are linked to supportive services for homeless and disabled individuals and families. Permanent supportive housing enables homeless persons to live independently, which is the ultimate goal of the homeless Continuum of Care. This inventory includes more than 2,400 units, primarily funded through the HUD Homeless Assistance Program. Matching funds are provided by the DBHIDS, the Department of Human Services, and the AIDS Activities Coordinating Office. Philadelphia's permanent supportive housing inventory also includes 450 units of the evidence-based model called Housing First, with housing funded primarily through HUD and services through Medicaid.

- h) **Older adults** - The Department continues efforts to serve older adults in normalized settings including supportive housing arrangements. In FY14, 56 older adults transitioned from congregate, mental health residences to more independent, shared apartment-based living arrangements. Mobile supports including Psychiatric Rehab, Certified Peer Specialists and Case Management were added to the complement of services available to sustain participants in supportive housing. In FY 16, the last mental health congregate care residence, that housed 18 older adults, was converted to Permanent Supportive Housing (PSH). Twelve (12) of these residents were successfully transitioned to permanent supported housing in FY16. The remaining residents were moved to smaller, homelike congregate settings with

supports tailored to their individual levels of need. The Philadelphia Corporation for Aging (PCA) will be providing in-home medical supportive services for these individuals via a waiver process. The intent is to blend a mix of financial resources to offer a full array of physical and behavioral health supports.

In FY15, a pilot was initiated to partner with a Home Health Care agency to serve older and/or medically challenged adults. The prospect of movement from congregate, mental health residences to house-based living arrangements that can accommodate 2-3 residents in each home is also being considered. These semi-independent housing accommodations will accommodate on-site behavioral and physical health supports.

Research and local data show increasing incidents of hoarding among several populations including older adults. Hoarding within the elderly community has become a major concern in the Philadelphia area, being that Pennsylvania has one of the highest older adult populations in the nation. In FY 2014 Philadelphia launched a Hoarding Task Force to address the growing impact of hoarding behaviors on quality life and housing stability. This task force resulted in a FY16 hoarding initiative pilot program which includes both mobile case management and therapeutic supports as well as a training component that address both system and provider specific needs.

- i) **Medically fragile** - The SE Regional Medically Fragile program, known as NOVA II, can be used by all counties. It is a program which provides specialized supports to 22 individuals living in their own apartments. It provides assistance with medical needs, coordination of appointments, and community integration to access therapeutic and community resources. Philadelphia County currently has nine individuals in this program. See also section on PH/BH initiatives.
- j) **Limited English proficiency** - DBHIDS recently hired a Director of Immigrant Affairs and Language Access Services. This new position will focus on addressing the needs of immigrant communities across Philadelphia and will develop a plan to promote health, wellness, and self-determination among these populations. Efforts are also underway to fill another newly created position focusing specifically on issues impacting Latino individuals and communities (Director of Latino Affairs).

In partnership with the Mayor's Office of Immigrant and Multicultural Affairs, DBHIDS has begun to translate printed materials into the Russian language to accommodate this large and growing population in Philadelphia. Translated items include the DBHIDS Resource Guide, Healthy Minds Philly screening and information documents, and content corresponding to Mental Health First Aid trainings. Plans are underway to translate these and other materials into additional languages.

- k) **Transition age youth including young adults** - DBH maintains TAY specific case management services.

The Children's Workgroup was convened by OHS to develop and implement strategies aimed at preventing children from becoming homeless and to better assess and address the needs of children who are homeless and residing in emergency, transitional, and supportive housing. The workgroup consisted of representatives from DHS and DBH as well as the Philadelphia School District, children's health care providers, family shelter operators, and advocates. The workgroup focused specifically on defining and collecting needed data for a "report card" on children in the specified settings, insuring assessment for and connection to early intervention services, and improved connections to the School District. The workgroup also made recommendations for provider staff training to understand better the use of Title I funds and create partnerships and planning between homeless service providers and School District staff around youth and teen programs.

DBH has established a First Episode Psychosis Program (recently awarded a FEP Site Grant) to provide FEP services through the Coordinated Specialty Care (CSC) model in accordance with the FEP Program Site RFI Guidelines and all CMHSBG requirements.

The Department of Human Services (DHS) and the Department of Behavioral Health and Intellectual disAbility Services (DBH) continue joint planning and program development to insure adequate services for youth aging out of the child welfare system who have behavioral health or intellectual disability issues.

DHS has continued to assess and identify needed services for older youth through partnerships with Family Court and the respective advocacy agencies (Defenders Association and the Support Center for Child Advocates). Given the large number of young adults aging out of the DHS system, an Older Youth Workgroup was created to identify areas of strength and areas in which work was needed to improve the outcomes of young adults in DHS' care. Further, meetings facilitated by the Juvenile Law Center are targeted at assisting young adults with behavioral health needs as they transition out of the child welfare system and are confronting challenges related to transition and discharge or are facing challenges related to their current placement that are impacting their readiness for transition.

DHS and OHS have a long history of partnership in Philadelphia. The latest example of this is their collaboration on a two-year federal planning grant from the Administration for Children and Families Children's Bureau to develop interventions that might prevent homelessness for youth who age out of the foster care system. DHS, OHS, and non-profit agency partners are utilizing data to develop a protocol to assess risk and protective factors that impact youth and young adults at-risk for homelessness, establish a mechanism to identify youth aged 14 through 21 currently in the system and at risk for homelessness whose risk factors outweigh their protective factors, establish a mechanism to identify young adults aged 22 through 24 who have exited care, but cycle through the homeless system, and define the pipeline processes that will allow youth and young adults to move through all systems into stable housing.

Early Trauma Intervention (Healing Hurt People - HHP): Healing Hurt People is a hospital and community-based intervention located in medical emergency departments. This resource provides assistance for individuals and families victimized by physical violence. Youth and young adults who present in Emergency Rooms with violence-precipitated injuries are screened to assess levels of need for behavioral health and other follow up supports. Licensed social workers and Community Hospital Responders assist young victims of intentional injury to access services designed to moderate the impact of trauma. Follow-up supports are provided in hospitals, homes and other community locations to decrease repeat victimization, prevent acts of retaliation, increase community engagement and facilitate behavioral health service linkages. In 2015 this partnership became fully operational in three hospital emergency rooms (Temple University, Einstein, and Pennsylvania-Presbyterian). Hahnemann and St. Christopher's hospitals continue to provide this service.

Certified Peer Specialists: Young adult Certified Peer Specialists (CPS) have been added to Targeted Case Management and Mobile Psychiatric Rehabilitation teams working with this transition age population. Residential treatment programs for young adults (RTFA) have also added CPS staff.

Enhancement of Residential Treatment for Young Adults (RTFAs): RTFA programs are being progressively transformed to better meet the unique needs presented by young adults. Enhancements include the addition of attachment therapies and increased emphasis on increasing social integration. One RTFA, Project Transition, also added a Dialectical Behavior Therapy (DBT) component to promote stress management and coping skills. Trauma Focused Cognitive Behavioral Therapy and creative arts programming are provided for young adults with co-occurring intellectual disAbility (ID) and mental health challenges.

Non-Fidelity ACT/CTT: A specialized Non-Fidelity Assertive Community Treatment Team/CTT has been established to serve young adults with intellectual disabilities and co-occurring mental illness. This team provides a range of services including assessments, recovery planning, intellectual disability registration linkages, and individual therapeutic supports.

In addition to the CTT capacity, DBHIDS maintains TAY specific case management for 120 individuals.

Webinars are being conducted in partnership with DBHIDS, the Juvenile Law Center and the Support Center for Child Advocates to promote best practice transition planning for transition age youth. This 10 part series covers multiple disability areas and available resources. 228 people registered for a Webinar conducted on May 17, 2016. This statewide effort includes multiple counties and staff from a diverse array of disciplines.

Safe Haven for Transition Age Youth: A Safe Haven residence serves 10 transition age men between the ages of 18-24 who present mental health challenges and who were previously living in shelters or on the

## SE Regional Olmstead Plan

street. Interventions include integrated assessments, mobile psychiatric rehabilitation, case management and an employment component. Twenty (20) individuals are projected to transition from this Safe Haven to permanent supported housing during the first year operation. A female counterpart is currently under development to serve 14 individuals in the first year. This program will be partnering with the provider for men to develop a learning collaborative.

Chester County

Local/Regional Olmstead Plan- Appendix A

November 1, 2016

This addendum, dated November 1, 2016 is to be included in the Southeast Regional Olmstead Plan.

The County of Chester is committed to providing increased opportunities for permanent, affordable housing, integrated in communities of a person's choice. This housing shall be made available to priority populations which have been designated through cross systems collaboration and stakeholder involvement.

The Chester County Department of Human Services (DHS), Department of Community Development (DCD), Department of Mental Health/Intellectual & Developmental Disabilities (MH/IDD) coordinate to leverage resources and relationships to further opportunities for the mutual consumers to whom our systems serve.

These collaborating departments established an agreement with the Housing Authority of Chester County (HACC). The agreement includes the Departments support of HACC in utilizing preference points to service adults with the most critical housing needs. These can be applied to specified HACC programs, including designated public housing sites and tenant based housing vouchers, providing vouchers for rental subsidies to our priority populations. The aforementioned departments are committed to working with HACC to establish an admission preference for people eligible clients referred by Chester County's mental health housing options team who are included in the PHFA-DPW 811 PRA Priority Target Populations and who are also in one or more of the Pennsylvania Olmstead target populations as listed below.

The three priority target groups that include individuals with emotional, intellectual, mental or physical disabilities:

1. Persons with disabilities ages 18-61, who are institutionalized, but are able to live in the community with permanent supportive housing.
2. Persons with disabilities ages 18-61, at risk of institutionalization, without permanent supportive housing
3. Persons with disabilities ages 18-61 who are living in congregate settings who desire to move to the community.

These priority groups are also identified in the approved Chester County Mental Health Supported Housing Plan.

### ***I. Olmstead Planning Process:***

There have been several initiatives which contributed to the Olmstead Planning Process in Chester County.

Beginning in fiscal year 2014/15, the Chester County Department of Human Services Recovery Oriented System of Care (ROSC) Leadership Group conducted an extensive Asset Mapping Project of the mental health and substance abuse services and system throughout Chester County. Key stakeholders included the provider network, peers, individuals receiving services, county staff, family members and community member's County wide focus groups were held with these stakeholders to obtain feedback on strengths and recommendations for the mental health and drug & alcohol systems, as well as assessing the current systems ability to support individuals in their long term recovery. The data was collated and is being incorporated in behavioral health service system planning, including the Olmstead Plan and the CHIPP's plan.

In addition to the ROSC initiative, other existing committees have been asked for input regarding the Olmstead plan and service system needs in Chester County. The other groups include:

- Block Grant Planning
- MH/IDD Advisory Board
- Adult Mental Health Board Subcommittee
- Equal Voices (transition age youth focused)
- Employment First Taskforce
- Outreach Committee
- CFST interviews through Voice and Vision
- Decade to Doorways various committees, The Department of Community Development's 10 year plan to end and prevent homelessness. MH/IDD participates on various committees to address the goal in the plan to prevent and end homelessness by developing more affordable, permanent housing, using the overarching philosophy of Housing First.
- Collaboration and guidance from Pennsylvania Housing and Finance Agency (PHFA).

These committees have representation from a variety of stakeholders, including providers, families, consumers, the Veterans Administration as well as representatives from local universities.

### ***Prevention, Outreach, & Engagement Services***

#### Community Education Opportunities:

##### Mental Health First Aid

The county contracts with an agency to organize and conduct trainings throughout the year. Upon conclusion of the last fiscal year we conducted an instructor course to expand the number of trainers within Chester County, in partnership with West Chester University. As a result, we have an additional 20 trainers, all of whom are conducting trainings as required to maintain certification. Over the next 9 months there will be up to 35 Mental Health First Aid trainings offered to the community, including training in Spanish to support the Latino community here in Chester County.

##### Hearing Distressing Voices

The county continues to offer training upon request.

##### Question, Persuade, Refer (QPR)

The QPR program is designed to reduce suicidal behaviors and save lives by providing innovative, practical and proven suicide prevention training. This type of quality education empowers people, regardless of their background, to make a positive difference in the lives of those around them. The Chester County Suicide Prevention Task Force collaborated with the West Chester Area School District to deliver the QPR program to approximately 900, ninth grade students, to help them to recognize warning signs of a suicidal crisis and how to help.

The QPR program continues to be an effective program based on extensive research offered as part of our training curriculum.

## 2017 Training Curriculum

In collaboration with the Department of Human Services, Chester County is developing a training series provided to focus on both non-clinical and clinical opportunities for staff growth and enhancement. Training needs were identified through a number of projects; to enhance the competencies of residential staff to support individuals within the community and working toward independence, to expand training for clinicians around evidence-based practices, and to support case managers in fostering independence and empowerment. Trainings will focus on trauma, motivational interviewing, crisis de-escalation, co-occurring treatment planning, service delivery integration and approaches, and creating healing environments.

### Community Conversations

There have been approximately 30 Community Conversations held throughout the Chester County area. These are continuing to be held as there has been a great deal of interest. Five new facilitators are being trained to meet the demand.

### Crisis Intervention Training (CIT)

A strong partnership has been developed with the Chester County Police Chiefs Association. This has led to a collaborative grant application for funding to support Crisis Intervention team (CIT) training for police in 2017, as well as to a group of police officers attending the MHFA Instructor training at WCU. The ultimate goal of CIT is to divert individuals committing low-level offenses into treatment and away from incarceration, as well as protecting the safety and dignity of the individual.

### Certified Recovery Specialists

The Council of Southeast PA is implementing a new program to support adults with substance abuse disorders and those with co-occurring MH and D&A disorders. This new program is supported through HealthChoices reinvestment dollars. A priority population will be those adults with complex circumstances who are at high risk. One of the new CRS staff has been dually trained as a Certified Peer Specialist, making the work for those with co-occurring needs seamless.

### Professional Development Group

Continuous education and outreach is provided for CPS's through a Professional Development Group, allowing the opportunity to for training, fellowship, and support. The 13<sup>th</sup> class was held in May 2016, adding new CPS graduates. The CPS certification training has been offered since 2001, training 200+ CPS's. To insure that CPS's are offered additional training to maintain their accreditation, the county has offered scholarships through the Copeland Center collaboration.

### Hospital-based Certified Peer Specialists

Reinvestment funds have been allocated to support peer specialist positions within inpatient psychiatric hospital settings. These CPS's will facilitate continuity of care at discharge by connecting to community service providers for appointments and by following up with consumers around missed appointments.

### Suicide Prevention Taskforce

Chester County Suicide Prevention Taskforce has been instrumental in their education and outreach efforts to bring awareness to the community in a variety of ways, through concerts, events, and trainings. As suicide has become a national public health concern, with the number of completed suicides rising annually, and the 10<sup>th</sup> leading cause of death in the United States. The County is dedicated to strengthening the efforts of the taskforce in the upcoming year by engaging the support of community stakeholders to partner together to develop a strategic plan around how to enhance and expand the efforts throughout Chester County around Suicide Prevention.

***Non-institutional, community integrated housing options, with a focus on independent and shared living arrangements. Identify existing Housing First approaches and discuss plans to develop future approaches.***

- Chester County has an approved MH Supported Housing Plan, which was collaboration between MH/IDD, DHS and DCD. Priority MH populations were identified in the plan. Chester County continues to develop partnerships with housing developers through our partnership with DCD. Chester County networks with affordable housing developers to identify potential opportunities, and monitors existing collaborations to ensure successful tenancy and responsive supportive services in existing “set aside units”
- By implementing Critical Time Intervention housing choice and access is optimized while education to tenants and landlords is maximized for successful tenancy.
- The current non-institutional MH housing options include 11 Community Residential Rehabilitations (CRR) operated by 4 providers; 4 specialized housing programs; 4 Supported Living providers (including Intensive Supported Living and Transition Age Supported Living), and 7 slots in Regional Programs, which includes 4 slots in a Regional LTSR program.
- The County currently has 34 units of supported housing with rental subsidies developed through the Mental Health Supported Housing Plan targeting the priority populations. Two new supportive housing projects have recently been approved for PHFA Tax Credits and will include twelve additional set aside units specifically for adults with mental illness. Supports such as SLA will need to expand in order to meet the needs of individuals in this additional housing. Peer supports are another service that can be accessed by those living in the set aside units.
- Local Housing Options Team (LHOT). Chester County’s Local Housing Options Team (LHOT) is a network of stakeholders dedicated to furthering housing opportunities for people with disabilities. LHOT also manages referrals for the Shelter+Care program which serves 75 individuals, 70 which qualify due to a mental health disability. This program offers vulnerable (Homeless and disabled) individuals and families a subsidy to be used with a private landlord in the community of their choice.
- Voice and Vision (Chester County’s CFST provider) conducted a survey with CRR residents and staff which identified training needs for staff and consumers to help with moving towards independence and staff support in empowering consumers to meet this goal. A Training need that was identified was Motivational Interviewing. Providers

developed specific action plans, and a Champion group who will further the goals of the project.

### ***Non-residential treatment services and community supports***

The Core Provider network includes an array of services and supports for individuals, including:

- Outpatient (DBT, Trauma-focused CBT, TREM and M-TREM)
- Mobile Mental Health Services
- Psychiatric Rehabilitation, site-based, mobile, & Clubhouse models
- Certified Peer Specialist Services
- Administrative, Blended, and Resource levels of Case Management Services

#### Additional Services and Supports within the network

- Supported Employment
- Valley Creek Crisis Center
  - Mobile Crisis Intervention
  - Warmline Services
  - Telephone Crisis Services
  - Walk-in Crisis Services
  - Crisis Residential Program
- Mental Health Clubhouse Programs
- Extended Acute Inpatient Program
- Assertive Community Treatment (ACT)
- Compeer
- ChescoLife-Family Mentor/Support
- NAMI
- Behavioral Consultation

### ***Peer Support and peer run services***

#### Crossroads Recovery Center

Provides early engagement and outreach to the homeless community in Chester County, and has been successful in helping people engage with mental health services, including access within the center to Compeer Services, NAMI, Supported Employment Services, and MH Supportive Housing services, and Stages, a program to encourage, develop, and enhance an individual's recovery through creative expression. The Recovery Center also offers an array of groups, including Double Trouble in Recovery (DTR), Depression Bipolar Support Alliance (DBSA), Transitional Age DBSA, Nicotine Anonymous, Anger Management, Individual/ Small Group Support for D&A rehab, Alcoholism, Detox, Family issues, Relationships, Homeless issues, Mental illness Symptoms, Medications, Personal Medicine, Recovery, Legal issues, Financial issues, Personal Hygiene. Additionally they offer connection through transportation to the County Assistance Office (CAO), intake appointments, and job interviews.

#### Outpatient/Case Management Programs

Certified Peer Specialists (CPS) attached to Core Providers both within the Decision Support Centers to facilitate Commonground™ to support individuals in preparation for shared decision making within the Outpatient program, as well as within the continuum of case management services to present the opportunity for increased independence and support within the community.

#### Mental Health Court

Additionally we have Forensic Peer Specialist services as part of the Mental Health Court program, to engage individuals during incarceration and provide continuity with the transition back into the community.

#### Crisis Intervention Services

Valley Creek Crisis Center our county's Crisis Intervention Program has a complement of CPS's that staff the Warm line, Mobile Outreach Team, and Crisis Residential programs.

#### Supported Employment Services

The contract for Supported Employment Services has been expanded to include the addition of Peer Specialists to the team of job coaches and trainers.

#### Additional Planning:

Through the Stepping Up Initiative, ROSC Initiative, and CHIPP planning processes we have identified the need to expand the utilization of Certified Peer Specialists across the service/support system. Areas of expansion include additional capacity at all of the Core Providers, Forensic Peer Specialist to support the work with the criminal justice system, and cross-training CPS's and CRS's to build a level of competency to support those with co-occurring needs.

#### ***Supported Employment***

- Chester County Departments of MH/IDD and the Department of Community Development have existing programs that include services for transition age youth. CareLink provides an evidence-based supported employment program for adults with serious mental illness. The County also has two Psychiatric Rehabilitation Clubhouses that provide supported employment in addition to transitional employment services. The clubhouses also collaborate with the Office of Income Maintenance (OIC) and the local Careerlink to assist members. Creative Health Services operates a CPS- run Career Service program within the Core Provider operations.
- Chester County is partnering with the PA Office of Vocational Rehabilitation (OVR) to explore a pilot program to increase resources for employment services for transition age youth and adults with serious mental illness and co-occurring illnesses.
- Chester County MH/IDD has an existing Employment First workgroup consisting of supported employment providers, OVR, schools and adults with lived experience to increase employment opportunities by partnering with employers and community services such as Department of Community Development and CareerLink.

**Housing in Integrated Settings:**

***Complete a housing inventory of existing housing options available to individuals.***

Please refer to Attachment A for a housing inventory. In addition to the attachment there are two person-centered specialized programs provided by Resources for Human Development. 1) trauma- centered program; 2) a residential treatment program for individuals with problematic sexual behaviors. CHIPP planning also identified the need for specialized programs so these two programs will be enhanced to increase capacity.

***Discuss the progress made toward integration of housing services as described in Title II of the ADA.***

Chester County is dedicated to providing safe, affordable and permanent housing in integrated settings. CRR's are single-family homes and apartments in non-clustered areas of the county. Supportive living services are available to assist with landlords/tenant relationships and Fair Housing. Chester County MH/IDD monitors contract requirements, policies, deliverables, and outcomes, which includes a review of each provider's compliance with the ADA.

***Describe the plans for Community Residential Rehabilitation (CRR) conversion.***

Chester County's most recent CRR conversion occurred in 2010, and there are currently no plans for an additional conversion. In 2010, the county developed five single and 3 shared permanent housing units combined with intensive supported living services to assist adults with serious mental illness lived independently in the community.

As more opportunities are made available for mainstream affordable housing, Chester County is afforded opportunity to develop more specialized CRR programs for the designated populations such as forensic, sexually problematic behavior, co-occurring, etc.

***Identify the LLA and any agreements with the LLA for referrals and supportive services arrangements.***

The Housing Authority of Chester County is one of the six housing authorities in PA that have committed to providing Housing Choices vouchers or public housing units for individuals with mental illness as a disability-specific Olmstead preference. The Chester County LLA contact is the Mental Health Housing Coordinator who works for the Chester County Department of Community Development and participates on the Local Housing Options Team (LHOT). The LHOT manages all referrals and service delivery components for shelter plus care for adults experiencing homelessness with disabilities. LHOT will be involved in the Section 811 PRA Program.

***Describe existing partnerships with local Public Housing Authorities, Regional Housing Coordinators, Community, Housing and Redevelopment Authorities, and Local Housing Options Teams including any specific referral and/or management Memorandums of Understanding or other agreements.***

Chester County Departments of Human Services and MH/IDD have a written Memorandum of Understanding with the Chester County Department of Community Development (DCD) to oversee and manage the funds allocated for the MH Supported Housing Plan. This also includes the hiring and supervision of the MH Housing Coordinator. This close partnership ensures that planning for any affordable and permanent housing in Chester County includes the discussion for the MH priority populations. Through this partnership, units in specified affordable housing properties have been secured as “set asides” for adults from the MH priority populations. Two new housing developers have recently been approved for PHFA tax credits and will support twelve additional “set aside units”. Memorandums of Understanding are then signed between the housing developer, the property management company and the County to ensure long term success of these partnerships. There are key representatives from the Departments of MH and Human Services who participate in the LHOT, as well as other committees of the County’s Decade to Doorways Initiative to prevent and end homelessness and to increase options for more permanent supportive housing.

## ***II. Special Populations***

Chester County providers and systems work collaboratively as a Recovery Oriented System of Care, designed to support the long term recovery of people receiving services, through the delivery of exceptional treatment paired with an intentional focus on the multiple life domains: Health, Home, Purpose, & Community. Encompassing a whole-health focus, recovery from mental health and/or substance use disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

### ***Individuals with dual diagnosis (mental health/intellectual disability)***

- MH and ID have collaborated to blend supports on a case by case basis, with several individuals in various settings in the community, including CRR’s and individual apartments.
- Valley Creek Crisis Intervention has a specialized staff position with expertise in behavioral supports, services, and resources for individuals with an Intellectual Disability. The role of this individual spans the scope of intervention and residential services within the program as well as training colleagues to create programmatic competencies.
- Cross-system projects utilizing the partnership of MH/IDD include, discharge planning, community services, and Employment First initiatives.
- Our collaboration extends to sharing and implementing tools such as Person Centered Planning, Biographical Timelines, Single Plan of Care, WRAP, and Peer Specialists
- A multi-county stakeholder planning group will be convening to learn more about the Community of Practice core principles and framework. Participants will be engaged to begin thinking about how to forge this transformational effort. A commitment by the County’s Quality Subcommittee of the Board and Core Provider network have agreed in principal to be representative stakeholders to join with us as we explore to improve our strategies for supporting individuals and families.

## ***Individuals with co-occurring disorders***

### Recovery Oriented System of Care (ROSC)

This initiative has been rolled out in Chester County to address and implement strategies for the development of services and natural supports to enhance long term recovery management for people with co-occurring disorders. The County has a ROSC Leadership Committee and has developed a ROSC Action Committee to address the top four priorities that were established during an extensive Asset Mapping Process in 2014 and 2015. The 4 priority areas are: 1) Peer Culture, Leadership and Support, 2) Person-Centered Recovery Planning, 3) ROSC Clinical Supervision and 4) Assertive Outreach and Engagement.

Through our Recovery Oriented System of Care (ROSC) Initiative, a process by which our partnership with Drug and Alcohol has strengthened to support the growing number of individuals with co-occurring needs; we have identified two key areas of focus, which has been and will continue to drive the work that we do. The first is access and engagement, as we recognize the importance of engaging individuals as early as possible in the treatment process and making services and supports readily accessible. Our providers are working in tandem to implement strategies to outreach to individuals seeking services, build a rapport, and use motivational interviewing skills to engage them prior to entering the door.

The second area of focus is building a “peer culture.” Our system is strengthened by not only training Certified Peer Specialists, but by including Certified Recovery Specialists and encouraging cross training to equip them with the tools necessary to work with any individual’s needs, meeting them where they are. As our pool of specialists expands, we must consider the need for fellowship and support amongst those providing services. Additionally we have identified a need for developing a continuum of training opportunities for those gaining certification. By developing an interim phase to employment through internships, this would provide on-the-job skill building and preparation for successful future employment.

## ***Individuals with both behavioral health and physical health needs***

The Patient Centered Outcomes Research Institute (PCORI) initiative led to the development of a Home Health Wellness Model. Three Core MH Providers will have staff trained as wellness coaches to assist individuals in navigating the behavioral health and physical health care systems. Core Providers also have Wellness Nurses to support and assist this Health Home Model. This initiative is being expanded to three MH providers specifically for adolescents. The MH/IDD contracts focus on the coordination of behavioral and physical health care with a measureable deliverable that is monitored annually. Residential, outpatient and case management services have now included this as part of their service delivery.

## Adult Health Home

PCORI Optimal Health Study: UPMC Center for High-Value Health Care and Community Care Behavioral Health. There are 8 community behavioral health centers in PA, of which three are located in Chester County, all are involved with a research project to compare the effectiveness of two different interventions: 1) Patient self-directed care and 2) Provider supported integrated care, and the impact on health, wellness, and recovery for adults with serious mental illness who are also at risk for chronic medical conditions. Providers and individuals are involved in extensive training, navigation, and supports to assist with the engagement in behavioral and physical health care.

Population Management- three adult core providers are participating in training nurses and staff in two health care target areas 1) smoking and 2) hypertension. There is a Learning Collaborative to support and build on the Health Home model specifically targeting adults who smoke or who have high blood pressure.

Adolescent Health Home- the health home training is being expanded to support interventions at three outpatient mental health providers to serve adolescents with high-risk health concerns. This includes hiring a nurse to provide health education, navigation, and support to adolescents, families, and treatment teams.

## ***Individuals returning from incarceration***

### Prison Re-entry Project

The County just completed an Asset Mapping and Strategic Planning process for Prison Re-entry. The departments of MH and D&A were active participants in this process and will continue to be involved as the initiatives are implemented.

### Stepping Up Initiative

Through participation of the national Stepping Up Initiative to reduce the number of adults with mental illness in our prison system, the County has worked in collaboration with the criminal justice system to conduct a re-mapping of the 2010 Sequential Intercept Mapping. The key findings and recommendations have resulted in a joint application for a grant to implement Crisis Intervention Training with local law enforcement.

### Mental Health Court

Mental Health Court is a joint effort between the Chester County Department of Mental Health and the County Criminal Justice System to address the needs of offenders with serious and chronic mental illness. Participants are offered a treatment based sentence, which utilizes judicial oversight as a component of the program. The MHRC coordinates an array of services designed to address the many needs of this population.

The goals of the Mental Health Recovery Court are to preserve public safety, divert offenders with mental illness from incarceration into community treatment, maintain the participant's treatment, housing, benefits & community support services, to reduce recidivism, and support

effective communication between the criminal justice and mental health systems.

### Re-entry Services/Supports:

#### Mental Health Protocol

Mental Health Protocol is a post-conviction program designed for individuals with serious mental illness who are currently on probation. The program works collaboratively with treatment providers to ensure that individuals in the program are engaged in treatment and stabilized in the community.

#### Regional Forensic Coordinator

Regional Forensic Coordinator acts as a liaison between the Department of Corrections, the State Correctional Institutions, and the County to facilitate connection to re-entry treatment and housing supports and services by utilizing video conferencing to conduct re-entry planning, intake assessment, and system of care planning.

### ***Individuals who are deaf or hearing impaired***

#### Education, Outreach, & Service Connection

Deaf CAN provides both education and outreach for individuals who are deaf/hearing-impaired. The goals of the program are to engage individuals to build an understanding of the human services systems, and assist with navigating the system and service connection. Services are focused on empowerment, and assisting the individuals with becoming more self-sufficient within the System of Care framework in Chester County.

#### Treatment Services

Community Care Behavioral Health contracts with Milestones for a variety of mental health services for adults who are deaf or hearing impaired.

### ***Individuals who are experiencing homelessness***

#### Critical Time Intervention

Over the past year we have implemented an EBP around needs identified through our partnership with the Department of Community Development. This program has been working closely with those individuals with chronic homelessness who are at risk of losing their housing, by taking an assertive approach to engage individuals and develop a plan around housing retention, while connecting to services and supports to maintain stability upon transition.

During this process we recognized a gap in services for those who are currently in our county shelter system who too have historically been chronically homeless and in need of services, and so we are in the process of implementing a continuum of acute case management services staffed by individuals with housing expertise, as well as the tools to provide the intensive level of engagement and support. This work supports the recent shift in the shelter system eligibility

criteria being utilized through ConnectPoints, the VI-SPDAT, which serves to shelter those with the highest level of need, the most vulnerable individuals.

### Cross System Partnership

A partnership comprised of the Departments of Human Services, Mental Health, Drug & Alcohol, Community Development, and all of the local homeless shelters and treatment and community support providers to create better communications, cross system resource knowledge through building a partnership. Each region of Chester County has regularly occurring meetings and continues to recruit and expand their partnership to better assist those we serve.

### Decades to Doorways

Staff from DHS, MH and D&A participates in the Department of Community Development's 10 year plan to end homelessness, Decades to Doorways. MH staff members participate on several of the committees, including Housing Stabilization Action Team and Systems Change Action Team as we continue to explore the development of services to support those experiencing homelessness to ensure a connection to services and supports.

### ***Older Adults***

The Chester County Department of Mental Health/Intellectual and Developmental Disabilities (MH/IDD) and the Chester County Department of Aging collaborate to meet the needs of older adults with serious and persistent mental illness. This effort began formally in 2007 as a result of a memorandum which was developed and signed by MH/IDD, the Department of Aging and the Chester County Department of Drug and Alcohol (D&A) Services. Collaboration between the departments has evolved and is documented in the revised MOU dated May, 2016.

- MH/IDD and Aging (and Dept. of D&A) participate in monthly Technical Assistance Calls with the PA Behavioral Health and Aging Coalition. This offers the opportunity to join statewide, educational discussions and review challenging cases of older adults. Also emphasized are issues across systems where collaboration is needed.
- MH/IDD and Aging (and Dept. of D&A) hold monthly interdepartmental meetings to coordinate system planning, discuss case reviews and plan cross system education
- MH/IDD and Aging (and Dept. of D&A) participate in Chester County's Hoarding Task Force which is currently meeting monthly with a focus on prevention and intervention.
- MH/IDD and Aging (and Dept. of D&A) participate in the Local Housing Options Team to address cross systems needs for supporting people in accessing and maintaining affordable, safe housing.

### ***Individuals with limited English proficiency***

All contracted providers are required to serve individuals speaking any language through the utilization of interpreter services and Language Line.

### *Transition age youth including young adults*

#### Student Assistance Program (SAP)

SAP provides early identification and service connection to students in grades 6th through 12th who have been identified by school personnel as experiencing or at risk of experiencing mild to moderate social, emotional, or mental health distress; their parents and/or caregivers. The Student Assistance Program will serve approximately 300 students, either directly or indirectly, identified by their building's Student Assistance Team as being at risk for social, emotional or mental health problems.

#### Children's Review Team (CRT)

CRT serves children who are considered high risk for out-of-home placement at Residential Treatment Facilities, Therapeutic Foster Care, and D&A Non-Hospital Rehab facilities, as well as those children in juvenile justice placements who are in need of Mental Health and/or Drug and Alcohol services while in placement or upon discharge from placement. CRT works collaboratively utilizing a System of Care approach to developing a plan to address the needs of the child and their family/support network and serves approximately 225 children annually.

## Housing in Integrated Settings

This chart is to display existing programs housing options. Do not include licensed programs, such as CRR, LTSR.

Indicate whether or not the program is considered a "Housing First" model.

County	Type of Program	Housing First? Yes or No	Number served	County MH/BH Partners	Comments
Chester	Project based housing choice voucher-MH Set Aside	y	6	Cobler Realty Chester County DCD Housing Authority of Chester County (HACC)	Roymar Hall
Chester	Public Housing MH Set Aside	y	8	HACC Chester County DCD	Denny Reyburn, Maple&Spruce Court, Church St.
Chester	Project based housing choice voucher- MH Set Aside	y	6	Pennrose, HACC Chester County DCD	Fairview Village
Chester	Shelter+Care	Y	11	Chester County DCD Horizon House	Scattered apartments
Chester	Shelter+Care	Y	59	Chester County DCD Open Hearth	Scattered apartments
Chester	Public Housing	Y	16	HACC	Preference points for people identified though MHOT
Chester	Tenant based housing choice voucher	Y	12	HACC Chester County DCD	
Chester	Master lease	N	16	Holcomb	Marchwood/Golf Club
Chester	SRO's	N		Evans Management	Jefferson Place
Chester	SRO mod rehab	N	28 (SRO)	Pennrose Human Services, Inc.	Liberty House
	Project based rental assistance	y	14 (one bedroom) 7 (two bedroom)	Pennrose Human Services, Inc.	Liberty House
Chester	SRO	Y	8	Chester County DCD Human Services, Inc.	Matlack St.
Chester	Permanent Supportive Housing	y	22	Holcomb Chester County DCD	
Chester	Project based housing choice	Y	6	Chester County DCD, HACC and Petra	Steel Town Village-targeted to rent up

### Housing in Integrated Settings

	voucher-MH Set Aside			Housing	Summer 2018
Chester	Project based housing choice voucher-MH Set Aside	y	4	Chester County DCD, HACC and Red Clay Manor	Red Clay Manor targeted to rent up Spring 2018