ALLEGHENY COUNTY OLMSTEAD PLAN IMPLEMENTATION

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I. OLMSTEAD PLANNING PROCESS:

The Allegheny County Department of Human Services (AC DHS) Office of Behavioral Health (OBH) is committed to assisting the individuals we serve to live in an integrated community setting of their own choosing. There are several different housing options and supports available to consider when individuals receiving mental health services are in need of residential supports. The Office of Behavioral Health is committed to working with individuals receiving services and their families and our network of providers to provide the necessary supports to assist individuals to live successfully in the community.

Planning, development, and delivery of programs requires the valued input of stakeholders. The services/programs listed in this document would not be possible without the collaboration of the following stakeholders:

Advocacy Organizations

- Disability Rights Pennsylvania
- National Alliance on Mental Illness
- Allegheny Family Network

Advisory Bodies

- Allegheny County Human Services Block Grant Advisory Board
- Allegheny County Mental Health and Intellectual Disability Advisory Board
- Allegheny County Drug and Alcohol Planning Council
- City of Pittsburgh – Allegheny County Task Force on Disabilities
- Allegheny County Homeless Advisory Board

Behavioral Health Managed Care Organization

- Community Care Behavioral Health

Contracted Providers

- The Allegheny County Department of Human Services, Office of Behavioral Health is currently contracted with over 100 entities to provide behavioral health services to individuals.

Allegheny County Interdepartmental Collaboration

- Health Department
- Area Agency on Aging
- Office of Intellectual Disability
- Office of Children, Youth, and Families
- Office of Community Services
- Office of Community Relations

II. **SERVICES TO BE DEVELOPED**:

Using information gathered from various sources, such as done in the Consumer Service Planning (CSP) process, identify the services, supports, and infrastructure needed to support individuals transitioning back into the community and individuals in the diversion population who may at times need intervention. Please address each of the following services, including the number of individuals expected to be served, projected timeline for service development, and resources needed:

a) **Prevention and early intervention services and supports** (examples: crisis intervention and mobile treatment services).

At present, no new services are being developed, however, Allegheny County continues to have an array of prevention and early intervention services and supports including those listed below. It is anticipated that number of persons served will be similar to those indicated below.

re:solve Crisis Network – The re:solve Crisis Network provides 24 hours/7 days a week 365 days a year, crisis intervention and stabilization services for residents of Allegheny County including walk-in, mobile, and residential crisis services.

Community Treatment Teams (CTT) is an intensive multidisciplinary team delivered service that merges clinical treatment, rehabilitation and varying levels of support based on individual need. CTT assist individuals with serious mental illness or co-occurring mental and substance use disorders who have a history of hospitalizations or other detention, e.g., incarceration; have not achieved and maintained health and stability in the community and who would continue to experience hospitalization, incarceration, psychiatric emergencies and/or homelessness without these services. Approximately 800 individuals have been served (base and HealthChoices 2015-2016).

Community Treatment Transition Age Transition (CTT-T) is an intensive multidisciplinary team delivered service that merges clinical treatment, rehabilitation and varying levels of support based on individual need. CTT-T serves individuals 16 years of age and older with serious mental illness or co-occurring mental and substance use disorders who have a history of hospitalizations or other detention, e.g., incarceration; have not achieved and maintained health and stability in the community and who would continue to experience hospitalization, incarceration, psychiatric emergencies and/or homelessness without these services. Approximately 100 youth were served in FY 2015-2016.

Mobile Outpatient Services is a specific outpatient service provided in the community to designated individuals in need of a particular service to include but not be limited to:

Psychiatric or psychological therapy;
Supportive counseling for the family members or other involved persons;
Individual, family and group therapy;
Treatment plan development, review and re-evaluation of Eligible Individuals progress;
Psychiatric services, including evaluation, prescribing and monitoring of medication and medical treatment required as part of the treatment of the psychiatric service;

Psychological testing and assessment.
Approximately 500 individuals have been served (HealthChoices 2016).

Mobile Medication Management is a team approach outpatient service for Eligible Individuals who have difficulties managing their illness due to inconsistent adherence to a prescribed medication regime. The team consists of, at a minimum but not limited to, a nurse, clinician who is the team leader and a certified peer specialist. The Mobile Medication Management Team operates 24 hours a day, 7 days a week, 365 days a year. Mobile Medication Management Team will have the capacity to deliver and administer prescribed medications and liaise with the prescriber. The Mobile Medication Management Team will also provide education and training to assist Eligible Individuals and their families develop skills to manage medication effectively and to live successfully in the community. Approximately 138 individuals served (HealthChoices 2016)

Enhanced Clinical Service Coordination (ECSC) is an intensive team delivered outpatient service that merges clinical, rehabilitation and support staff. The team consists of a Master's level team leader that also provides clinical and therapeutic services to Eligible Individuals, a registered nurse(s) who monitors medications and behavioral/physical health care, a service coordinator(s) who coordinates needed services for Eligible Individuals, and a peer specialist(s) who provides support to Eligible Individuals by sharing their own recovery experiences. ECSC is for Eligible Individuals 21 years old and older with serious mental illness or co-occurring mental and substance use disorders who need intensive care to achieve and maintain health and stability in the community, and who may otherwise continue to experience hospitalization, incarceration, psychiatric emergencies and/or homelessness without ECSC. Approximately 183 individuals have been served (HealthChoices 2016).

Mobile Transition Age Youth (MTAY) "Independence Ahead" – A mobile treatment team serving emerging adults 18-25 years of age, consisting of a therapist, service coordinator, psychiatric rehabilitation specialist, and certified peer support. The team assists young adults, approximately 30 a year, to develop close therapeutic relationships focused on wellness and recovery. The team helps them learn to manage their mental health symptoms, builds safe, strong relationships, helps them problem solve, and resolve conflict in their school/employment, community, and relationships. The program works closely with permanent supported housing to allow those who wish to live independently in the community.

Dual Diagnoses Treatment Team (DDTT) is comprised of a specialized mobile team of including a Psychiatrist, a Behavioral Specialist, Recovery Coordinators, a Nurse, and a Pharmacist, providing treatment, support, and education for adults in the community diagnosed with a mental illness and co-morbid developmental disability. Individuals referred to the DDTT are in crisis, at risk of losing community tenure, and/or are transitioning from acute care hospitalization. Approximately 41 individuals have been served (HealthChoices 2016).

Integrated Dual Disorder Teams (IDDT) serve adults age 18 years and over diagnosed with serious and persistent mental illnesses or Post Traumatic Stress Disorder and a co-occurring substance use disorder, along with complex psychosocial, medical and

psychiatric needs. The IDDT goal is to assist individuals to successfully live in the community without the need for hospitalization or other forms of inpatient treatment such as a rehabilitation. The team supports the individuals using a harm reduction model and provides group and individual counseling based on the stage of treatment need using Motivational Interviewing and the Integrated Dual Disorder Model. Approximately 100 individuals have been served (HealthChoices 2016).

Drug and Alcohol Recovery Links Program is a 4 to 6 months service for individuals in recovery that provides mobile, community based supports to successfully live in the community. There is also a 24-hours per week / 7 days per week crisis intervention support. Through strength-based assessment and service planning, the team of case managers work with individuals, 18 years of age and older, who are being discharged from an inpatient level of care and need support with linkage to recovery-oriented services and resources and building self-advocacy skills. Approximately 255 persons were served in 2016. With the anticipated addition of a second team, it is expected than an additional 100 individuals can be served in 2017.

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

Housing First Approaches - Allegheny County made system improvements and added resources to prevent homelessness and housing instability and to continue to increase the degree of prevention and, where homelessness does occur, to employ a Housing First approach. These improvements include:

Coordinated Intake: When people in Allegheny County need housing because of homelessness, they can call the Allegheny Link. The Allegheny Link, commonly referred to as "The Link", started out (and remains) the Aging and Disability Resource Center (ADRC) in Allegheny County but has expanded to function as a coordinated intake unit within the AC DHS. The Link staff began providing coordinated intake for the homeless/ housing system in March 2015 and now use the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) to conduct assessments of the callers' risks, needs, and potential for diversion. The Link staff then help callers access the most appropriate resources from within the local continuum of care, based on the urgency of their need for housing/shelter. The Link uses the automated Homeless Management Information System (HMIS) to refer individuals to resources including prevention and diversion, permanent housing, permanent supportive housing, transitional housing, and shelter. Individuals are then placed on a list for providers to contact in chronological order. AC DHS reviews any referrals that providers deny, to ensure that households are treated fairly and providers are following applicable laws and regulations.
In calendar year 2016, The Link responded to 11,572 unduplicated clients with a housing/homeless related need.

Mental Health (MH) Residential Referrals Process - MH Residential Referrals are managed by the Allegheny County Office of Behavioral Health. Referrals are generated, for the most part, by Hospital Social Workers, Service Coordinators, and Community Treatment Teams. Referrals are reviewed by OBH staff for completeness then added to the waiting list (currently comprised of about 300 people). Individuals remain on this list

for one year from the date of referral (after one year a new referral will need to be made). When a MH residential program reports a bed vacancy from any level of care, the selection process begins. The process has a tier system:

Tier 1. Individuals who are residing in and or involved with the following systems: Transitional Recovery Unit (TRU), Comprehensive Recovery Unit (CRU), Residential Treatment Facility-Adults (RTFA), Extended Acute Care (EAC), Torrance State Hospital-Civil (TSH-C), Torrance State Hospital Forensic (TSH-F) Long-Term Structured Residence (LTSR), Mental Health Housing, Inpatient with a disposition, Deaf, Capitalizing on a Recovery Environment (CORE), Community Support Plan (CSP), Community Integration Team (CIT), Transitional Age- Conferencing and Teaming, Integration and Teaming, and/or Involvement in 2 or more systems.

Tier 2. Individuals who are residing in or involved with the following systems: Criminal Detention (Jail), Diversion and Acute Stabilization, Inpatient Mental Health without a disposition, Transitional Age Youth with Mental Illness who are involved with Children Youth and families, Juvenile Probation, or who are homeless.

Tier 3. Individuals living in the community.

Once the individual has been identified, a referral is sent the residential provider who reported the vacancy. A tour and or interview is arranged. Once all of the necessary admission documentation is received by the residential provider, a move in date is scheduled.

Greater Investments in Rehousing and Permanent Supportive Housing (PSH): To align spending with community needs and HUD priorities, the AC DHS Continuum of Care shifted some funding from transitional housing projects, funded by HUD, to rapid re-housing projects; and some funding from Safe Haven projects to permanent supportive housing (PSH) projects. Additional shifts in funding are expected to occur in the 2016-2017 fiscal year.

Expanded use of Section 8: AC DHS has negotiated with the Housing Authority of the City of Pittsburgh for 200 Section 8 vouchers, and with the Housing Authority of Allegheny County for 50 of these vouchers—for those clients who have successfully completed the services that are part of their transitional supportive housing (TSH) or PSH. As these individuals move into subsidized housing through this opportunity, it opens TSH or PSH to more people in the county who need it.

Prevention and Diversion: Allegheny Link staff actively seek to divert individuals and families to safe options outside of the homeless system—mediating with family members over the telephone, calling landlords, and when required, engaging a local agency to meet with clients face-to-face to assist them in obtaining the resources they need to be able to live in good stead with family and friends and prevent evictions. As part of this prevention/diversion approach, AC DHS has developed a program for clients in subsidized housing, funded by the Block Grant. If the client agrees to pay one-half of the rent that is in arrears on a payment plan, AC DHS will pay the other half, and the housing authorities agree to not move forward with an eviction.

Mental Health Supportive Housing Program (expansion) – The AC DHS is currently working with a contracted provider to expand one of the Mental Health Supportive Housing Programs. The goal of the expansion for this level of housing service is to provide intense coaching towards independent living and create the opportunity for several individuals to move into a less supervised, but supportive, housing option with a focus on gainful employment. This goal of the program is to assist up to 8 individuals toward independent living. The emphasis will be on gainful employment so that individuals will have more income to afford their own apartment. Program staff will assist individuals to seek permanent housing options when appropriate. This expansion will include 8 one bedroom apartments.

b) **Non-residential treatment services and community supports including mobile treatment options**.

Community of Practice (CoP) System of Care (SOC) – AC DHS was awarded a Federal Substance Abuse and Mental Health Services Administration (SAMHSA) cooperative agreement in the amount of $3.62 million over the next 4 years. The awarded project is to expand the current behavioral health (BH) system of care (SOC) for children and adolescents between 5 and 18 years of age, with serious emotional disturbance (SED) and their families, by integrating access, coordination, and infrastructure with the child welfare system in a new Community of Practice (CoP). This model will further expand youth and peer supports, standardize a trauma informed approach to service delivery, address barriers and gaps in crisis services, and build a culturally and linguistically competent, strengths-based, and youth/family driven infrastructure that enhances service coordination and delivery for the population of focus.

Deep Rent Subsidy Program – In the spring 2016, the AC DHS began a "Deep Rent Subsidy" program focused on people living in Community Residential Rehabilitation (CRR) facilities, group homes for people with intellectual disabilities, and youth involved in the Independent Living Program. Twenty permanent housing units in the community are funded under this program, seventeen of which have been used to move single individuals out of CRRs into their own apartments.

The Deep Rent Subsidy program was created to "open up the back door" of CRRs and to create movement within the behavioral health housing system. Local providers have long held that many people living in CRR were there not because they needed that level of MH service provided, but rather, they needed the affordable housing that came with it. The Deep Rent Subsidy program puts focus on those individuals who are living in CRR because they cannot locate appropriate, affordable housing in the community by giving them a housing subsidy so that they can transition into their own apartment without being able to afford the full rent. Much like a Section 8/Housing Choice Voucher, participants in the Deep Rent Subsidy program pay no more than 30% of their adjusted gross income on rent. CRR providers refer consumers who they feel can live independently in the community (with or without supports) to the Deep Rent Subsidy program and work with the Office of Behavioral Health staff at AC DHS to ensure that an appropriate level of supportive services is in place as they transition into an apartment.

In fiscal year (FY) 2016-2017, AC DHS plans to build on the initial success of this program by expanding capacity for additional consumers. Persons living in supported housing and other congregate care facilities will be eligible for these new housing subsidies. AC DHS hopes that these new housing options will further reduce the number of individuals living in institutional and congregate care settings.

Personal Care Home Resident Risk Committee (PCHRR) – The PCHRR committee meets every other month to discuss personal care homes which are closing, have received a provisional license, or concerns for the care provided to residents. The committee consist of representatives from the Allegheny County Department of Human Services Area Agency on Aging, Office of Behavioral Health, and Office of Intellectual Disability. Also on the PCHRR committee are representatives from Disability Rights Pennsylvania, the Allegheny County Health Department and the Pennsylvania Department of Human Services Bureau of Human Services Licensing.

Service Coordinators in Allegheny County Housing Authority (ACHA) High Rises – AC DHS issued a request for proposals to provide service coordinators at four ACHA high rises to assist residents with mental illness in maintaining their tenancy. ACHA has found that many of the residents in their high rises have mental illness and lack services to support them. In some cases, ACHA has had to evict residents when lease violations occur and the effects of a resident's mental illness cannot be remedied through a reasonable accommodation. Imbedding Service Coordinators at these ACHA facilities is intended to stave off these evictions and assist residents with mental health and substance use disorder issues to maintain their current affordable housing.

Pittsburgh Mercy was recently selected in response to this RFP and will provide outreach, education, assessment and referrals for residents living in designated ACHA sites. The two Support Specialists will work on site with the ACHA site mangers to identify and assess residents who may need behavioral health services and supports. AC DHS anticipates that these activities will improve access to supports and in the long run increase self-sufficiency and reduce unnecessary evictions.

Housing Connector - Navigating the housing system can be a complex task. AC DHS and ACTION Housing have begun a "Housing Connector" project in Allegheny County.

The Housing Connector will:
Serve as a repository for information and assistance in navigating the housing system, which will enable people with disabilities to make better connections to independent housing choices. The Housing Connector will be able to map options for individuals and, when units are not yet available, provide them with an estimated timeline, thus reducing uncertainty and the burden of the housing search process.
Manage calls and inquiries from people with disabilities to prevent frustrating those who need housing (or creating another waiting list).

Make finding housing easier and more direct for people with disabilities, which will expand their array of independent living choices.

Create innovative independent living housing models, pilot these approaches, and develop a standard process for bringing them to scale.

Complement and further the work of organizations whose missions encompass ensuring people with disabilities have opportunities for independent living, including Pennsylvania Housing Finance Agency (PHFA), U.S. Department of Housing and Urban Development (HUD), and Allegheny County Department of Human Services (DHS).

Work one on one with a small set of consumers with disabilities to provide assistance in locating affordable and appropriate housing. The intent of this new initiative is increase housing for the general community of people with disabilities by taking promising models to scale.

The Housing Connector will have a Program Administrator, two to three Housing Navigators, and a Housing Innovator, who will be responsible for developing various "toolkits" of new models in Allegheny County. A few innovations that have been identified to date include a mechanism to assist HUD and PHFA in moving people out of wheelchair accessible apartments who do not need the features so that those who do (like those who are currently living in nursing homes or personal care homes) can move in; development of a model Section 8 Home Purchase program that can be used by someone on Supplemental Security Income; and developing a roommate matching and/or brokering service to assist people with disabilities in locating housing or making housing that has been located more affordable.

c) **Peer support and peer-run services** (examples: certified peer specialists, wellness and recovery programs, drop-in centers, warm-lines, etc.).

Forensic Certified Peer Specialist Program – AC DHS has expanded its peer services with the addition of a forensic program. There are currently 60 individuals being served by five Certified Peer Specialists (CPS) and two additional CPSs are in the process of being added to serve more individuals. The forensic CPS will advocate and provide support for adults 18 years old and older with mental illness or co-occurring mental and substance use disorders who are involved in the criminal justice system.

Peer Support Program – Allegheny County has recently expanded its Peer Support Program with the addition of a new team. The capacity in Allegheny County has increased by 40 individuals as a result of the additional team.

d) **Supported Employment Services**

AC DHS began developing its Supported Employment Evidence Based Practice initiative in 2007 with support from the PA Office of Mental Health and Substance Abuse Services but its employment services for adults with mental illness existed long before that. Individuals within our community continue to have access to a robust network. AC DHS Supported Employment network consists of nine evidence-based programs. In calendar year 2015, these nine programs served 687 individuals. 44.5% of those individuals were employed at some point during that timeframe. Over these nine evidence-based programs, there are an average of 17.5 full time equivalent Supported Employment

Specialist. Currently, all Supported Employment programs operate at capacity and do not have waiting lists. Budget cuts over a number of years have limited Allegheny County's ability to expand services beyond its current capacity. Data from Allegheny County's C/FST, CART, indicates between 40%-50% of the people interviewed would like to work in some capacity. To expand services to that degree would require a substantial infusion of funding.

III. HOUSING IN INTEGRATED SETTINGS:

a) **Complete a "housing inventory" of existing housing options available to individuals** (please note that available services may be located in other counties).

Allegheny County residents have the following housing options available to them, however, as noted below, Allegheny has designated some beds for a geriatric population (60+) and transition age youth:

Mental Health	Apts.	Beds
Fairweather Lodge		10
Community Residential Rehabilitation (CRR)		204
Specialized Community Residence		30
Comprehensive Mental Health Personal Care Home		137
Domiciliary "Dom" Care		6
24/7 Supportive Housing		80
24/7 Transition Age Youth		10
Long Term Structured Residences (LTSR)		61
Geriatric LTSR		26
Personal Care Home for Geriatric population		18
Community Supportive Housing	600	
Total Beds/Apts.	600	582

Non-Mental Health	Units	Beds
Permanent Housing	27,736	x
Continuum of Care Permanent Housing	1,148	x
Licensed Personal Care Homes	x	8,077
Transitional Housing	707	x
Emergency Shelters	44	x
Total Units/Apts./Beds	**30,235**	**8,077**

LTSR Expansion – With the use of Reinvestment funds, 2 additional LTSRs for individuals with a serious mental illness or a serious mental illness and a substance use disorder who have been diverted, discharged or released from inpatient or criminal justice facilities. Individuals with a dual diagnosis of intellectual disability are also eligible. Some individuals served may also have current or a history of sexually inappropriate behavior and a history of sexually offending behaviors. The goal of these specialized residential programs will be to provide behavioral and psychiatric stabilization for individuals. One facility will provide services to 8

individuals at any given time and the other is being designed to serve 12 individuals at any given time. The 2 providers are currently developing sites and pursuing required certifications.

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

In addition to the programs described above; the programs described under Special Populations, the programs described below are integrated in local communities or settings or are designed to assist individuals to live and receive services where they choose, such as the deep rent subsidy and HUD 811 program.

Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act - In response to the HEARTH Act, as well the ongoing efforts of our continuum of care programs to provide holistic services of the highest quality to those we serve, there are specific legal and regulatory obligations that AC DHS and its contracted providers must meet. These obligations are outlined as follows.

Involuntary Separation of Family Members - Under the HEARTH Act, "any project sponsor receiving funds under this title to provide emergency shelter, transitional housing, or permanent housing to families with children under age 18 shall not deny admission to any family based on the age of any child under age 18." AC DHS has adopted this standard of care for all AC DHS funded homeless programs. Therefore, providers cannot deny admission to any male child of a household or deny admission of a household with a male child under 18.

Methadone/Suboxone - People with addictive disorders, including those on methadone maintenance or Suboxone treatment for drug addiction are considered disabled under the Fair Housing Act, the Americans with Disabilities Act, and other local fair housing statutes and, as such, cannot be discriminated against based on this treatment. The use of methadone/Suboxone, when prescribed by a qualified practitioner, is both legal, and for many people, essential to recovery. All AC DHS providers must comply with all federal, state, and local ordinances in their policies, practices, and activities and cannot discriminate against any individual with a disability regarding their housing rights. Therefore, all programs must not deny otherwise qualified individuals on the basis of their use of methadone or Suboxone in their treatment of addiction.

Mental Health Disabilities - Similar to above, providers cannot refuse to serve homeless individuals who have significant mental health disabilities unless that disability is causing the individual to be a direct threat to the staff, other program occupants, or him/herself. In the event that an individual is a threat to him/herself or others, AC DHS programs are advised to consult with AC DHSs Information, Referral and Emergency Services (IRES) to determine whether the individual meets criteria for evaluation and/or to offer the individual options for treatment. Otherwise, AC DHS expects that all providers will admit otherwise qualified individuals with mental health disabilities into its programs.
Sexual Orientation, Gender Identity or Expression - The City of Pittsburgh and Allegheny County have Human Relations Acts that prohibit discrimination based on sexual orientation, gender identity, and gender expression. This means that programs cannot discriminate against individuals because of their sexual orientation or gender

identity or expression, including those who are transgender. Homeless shelters, transitional, bridge, and permanent housing programs that have private/separate bathroom and sleeping facilities with locking doors on the units are expected to make accommodations for clients to meet this obligation.

Clean Time Requirements - Historically, programs have set their own eligibility criteria relating to clean time or drug and alcohol abstinence. Some providers have unnecessarily screened out people in recovery if they didn't have long enough clean time. AC DHS recognizes the importance of having a continuum of services to allow those in active addiction and those in recovery to do so in a residential setting that best suits their needs. ~~However,~~ AC DHS also recognizes that individuals in earlier stages of recovery, without substantial clean time, often need housing that supports their continuing recovery. Therefore, AC DHS will work with providers to address the variable needs of people at various stages of recovery. As a first step in this process, AC DHS has required providers to adhere to the following guidelines:

> Clean Time – Providers with clean time requirements must reduce them to no more than 90 days;
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> Urinalysis – Providers who require urinalysis to determine program entry must have a lab verify the results in order to avoid false positives or negatives, which are common in on site urinalysis tests.

Criminal Histories – AC DHS requires programs to assure that their admission criteria regarding criminal histories are reflective of facts. Homelessness actually increases the risk for subsequent re-incarceration. According to the U.S. Interagency Council on Homelessness (USICH), "overly restrictive housing admissions policies not only deny individuals a second chance at becoming productive citizens, but they may actually be increasing costs to communities as these individuals continue to cycle through emergency services and correctional facilities." AC DHS is committed to serving any consumer who approaches us for assistance and, as a result, need to have resources available to serve those with significant barriers like extensive criminal histories.

City-County Task Force on Disabilities - the Task Force on Disabilities, a coalition of organizations working with city and county government to eliminate barriers to full participation in the range of activities and opportunities available throughout the region. The City-County Task Force on Disabilities is a 13-member panel of advocates, service providers, and consumers appointed by the Mayor of the City of Pittsburgh and the Allegheny County Executive who advise the City and County on issues that affect people with disabilities in the region. Six of the members are appointed by the Mayor, six are appointed by the County Executive, and one member is elected and appointed by the members of the Task Force. The Task Force meets monthly to discuss challenges that citizens with disabilities face and to plan advocacy efforts and recommendations for policy leaders. Meetings are public and often there are additional attendees. Over the years, the members have addressed issues including accessibility, ADA compliance, housing needs, safety, and emergency preparedness for citizens.

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

Allegheny County has converted seven CRR beds into ten permanent 24 hours a day/7 days a week supportive housing apartments.

d) **Describe strategies used to maximize resources to meet the housing needs of individuals including: Identifying the Local Lead Agency (LLA) and any agreement with the LLA for referrals and supportive services arrangements**.

811/Local Lead Agency (LLA) - The Pennsylvania Housing Finance Agency (PHFA) included a requirement in the 2011 and 2012 Qualified Allocation Plan (QAP) that at least ten percent (10%) of a PHFA development's units be affordable to households at or below twenty percent (20%) of the area median income (AMI), adjusted for family size. Since 2013, developments must demonstrate that at least 10% of units are affordable to persons at or below 20% AMI for the entire compliance period. Existing developments with 90% or greater occupancy over 5 years may request a waiver from providing 20% AMI units. The QAP specifies the developer enter into an agreement with appropriate referring entities to assure a sufficient number of appropriate tenant referrals are made in a timely manner.

The PA DHS Local Lead Agency Program - The PA Department of Human Services launched the Local Lead Agency (LLA) Program to refer and support people moving into affordable housing programs, including people who qualify for the PHFA low income threshold set-aside units as referenced in the QAP. LLAs are community organizations selected by the community and approved by PA DHS. The majority of LLAs are either County or nonprofit service agencies and, in Allegheny County, the Allegheny County Department of Human Services (AC DHS) performs this role. AC DHS includes the Offices of Behavioral Health; Intellectual Disability; Community Services; Children, Youth and Families and the Area Agency on Aging. As such, cross-agency collaboration both internally and externally with the range of housing and other service partners is already embedded across systems. As the County LLA, the AC DHS is obligated to meet all Pennsylvania Housing Finance Agency (PHFA) requirements. The primary LLA contact in Allegheny County is Chuck Keenan.

Programs are locally or regionally based, provide or arrange services and income support to populations of focus, who qualify for services because of income, health condition and/or disability. A substantial number of people who qualify for services also have an income at or below 20% the area median income.

Local Lead Agencies will:

- Provide a single point of contact for referrals to developments with set-aside units ready for occupancy;
- Assure appropriate referrals are made in a timely manner;
- Assist tenants in securing one-time move in funds, such as security deposits when available;
- Assure tenants receive supports and assistance needed to comply with lease requirements;

- Provide, coordinate and/or contract with agencies that provide direct community-based services to the populations targeted for the set-aside units;

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 Understandings or other agreements.

LLAs are prepared to provide letters of support and enter into an agreement with developers for timely referrals, assuring supportive services are available, and providing a liaison to developers for tenant related issues.

The LLA/AC DHS has an 811 and Homeless Preference Memorandum of Understanding (MOU) with the Allegheny County Housing Authority (ACHA) and a Homeless Preference MOU with the Housing Authority of the City of Pittsburgh (HACP). The LLA/AC DHS has also initiated discussion with HACP regarding the expansion of preferences to include Olmstead populations of focus.

The LLA/AC DHS also serves as the backbone for the 811 program in Allegheny County. The 811 Initiative aims to move persons currently receiving treatment in institutions or at-risk of institutionalization, into the community with permanent supportive housing, through the provision of a housing choice voucher leveraged through the 811 program. These vouchers are available to people with any disability between the ages of 18 and 61, have income below 30% Area Median Income, on or eligible for Medicaid, in need long term services and supports, and meet the respective Housing Authorities' eligibility criteria. Vouchers will be distributed according to the following priority populations:

> *Institutionalized*, but able to live in the community in permanent supportive housing.
> Institutions include but are not limited to: private and public mental health hospitals, nursing facilities and facilities for those with Intellectual Disabilities.
>
> *At-risk of institutionalization* with no permanent supportive housing.
> Including but not limited to: people who are living with caregivers in unstable situations, homeless, people aging out of the Early and Periodic Screening, Diagnosis and Treatment Program with no family supports, and individuals aging out of foster care.
>
> *Congregate Care Setting* and desires to live in community
> *Including but not limited to:* persons in Community Residential Rehabilitation facilities, Long Term Structured Residences, personal care homes and domiciliary care

As part of this initiative, the Allegheny County Housing Authority has committed 25 Housing Choice Vouchers and the Housing Authority of the City of Pittsburgh has committed 25 vouchers as additional leverage to the PHFA dedicated apartments. All 50 of these vouchers support the 811 program.

AC DHS, in its role as Local Lead Agency, will market this program to its internal staff and external partners to ensure that potential consumers who live in institutional settings can be made

aware of this opportunity. AC DHS will also work with local developers and housing providers to make them aware of these programs and to encourage them to participate, along with PHFA, in setting aside an adequate number of apartments to meet the needs of consumers trying to move into the community from institutional settings.

IV. **SPECIAL POPULATIONS**:

Discuss how the following groups of individuals with serious mental illness and their specialized service needs are met.

Unless specifically indicated, services may be accessed by all Allegheny County residents. Please also refer to Section 1 for a range and definitions of services.

a) **Individuals with a dual diagnosis (mental illness/intellectual disability)**

Dual Diagnosis Treatment Team (DDTT) – The DDTT is comprised of a specialized mobile team of professionals including a Psychiatrist, a Behavioral Specialist, Recovery Coordinators, a Nurse, and a Pharmacist, providing treatment, support, and education for adults in the community diagnosed with a mental illness and co-morbid developmental disability. Individuals referred to the DDTT are in crisis, at risk of losing community tenure, and/or are transitioning from acute care hospitalization.

Agreement with the University of Pittsburgh Medical Center (UPMC) Health Plan and Community Care Behavioral Health - In April 2012, AC DHS executed a coordination agreement with UPMC Health Plan and CCBH to improve communication among shared members and services. As part of the agreement, AC DHS Office of Intellectual Disability (OID) partnered with UPMC and local provider organizations on an Integrated Service Delivery and Care Management model. The model's objectives include improving member health, improving satisfaction with services, and coordinating resources for physical and behavioral healthcare for individual with an intellectual disability.

b) **Individuals with co-occurring disorders (mental/substance use disorders)**

Drug and Alcohol Recovery Links Program - The Drug and Alcohol Recovery Links Program is a four to six-month service for recovering individuals that provides mobile, community based services in order to obtain supports to successfully live in the community. There is also 24 hours per week / 7 days per week crisis intervention support. Through strength-based assessment and service planning, the team of Case Managers work with individuals, 18 and older, who are being discharged from an inpatient level of care and need support with linking to community resources and building self-advocacy skills amongst other recovery-oriented services.

Integrated Dual Disorder Teams (IDDT) – The IDDT serve adults age 18 years and over diagnosed with a serious and persistent mental illness or Post Traumatic Stress Disorder and a co-occurring substance use disorder, along with complex psychosocial, medical and psychiatric needs. The IDDT goal is to assist individuals to successfully live in the community without the need for hospitalization or other forms of inpatient treatment such as a rehabilitation. The team supports the individuals using a harm reduction model and provides group and individual counseling based on the stage of treatment need using Motivational Interviewing and the Integrated Dual Disorder Model.

c) Individuals with both behavioral health and physical health needs

Behavioral Health Home Plus (BHHP) - The goal of BHHP is improving the capacity of behavioral health providers to support individuals' whole health and recovery by addressing the health and wellness of individuals with complex physical health conditions, increase individuals' engagement and activation in care and improve collaboration between physical and behavioral health care providers.

Adults living with serious mental illness (SMI) frequently have unmet medical needs which place them at risk for adverse health outcomes. As a group, individuals with SMI have high rates of premature death, dying as much as 15-25 years younger than the general population. Key contributors to the excess morbidity and mortality among this population include modifiable lifestyle choices and behaviors, negative metabolic effects of atypical antipsychotic medications, higher rates of undiagnosed, untreated, or poorly treated medical illnesses, and difficulties obtaining routine preventive and primary care. The existing behavioral health system is looking to be enhanced to support good health outcomes for individuals with SMI and/or substance use disorders, and concurrent serious physical health conditions through the implementation of various strategies to manage and/or prevent serious medical conditions common to individuals living with an SMI through the BHHP implementation.

d) Individuals with a traumatic brain injury

Integrated Care Team – The Integrated Care Team, through Community Care Behavioral Health, works with physical health insurers to coordinate care for those individuals with complex medical and psychological needs.

e) Individuals with criminal justice/juvenile justice history

Justice Related Independent Living (JRS IL) Program - The JRS IL program is a sub group of the JRS unit which works with young adults through the age of 21 who are involved in both the Independent Living Project and the criminal justice system. The goal of the program is to avert these young adults from further entry into the adult criminal justice system and to promote and support their abilities and efforts to live successfully in the community. Currently there is one service coordinator that works with these youth, to date linkages have been made for housing, employment, re-engagement to independent living, education, and behavioral health.

Pennsylvania Commission on Crime and Delinquency (PCCD)/ Frequent Users Systems Engagement (FUSE) Grant - The Allegheny County Jail Collaborative, a partnership of county government, the courts, and the community, proposed to the Pennsylvania Commission on Crime and Delinquency (PCCD) to develop a new program to provide permanent, affordable housing with supports, as well as employment services and service coordination for twenty men and women with serious mental illness/co-occurring disorders (MI/COD) at high risk of returning to jail. In a new approach for Allegheny County, the Jail Collaborative targeted individuals who have been the most frequent users of several systems, mirroring a successful strategy developed by the Corporation for Supportive Housing (CSH). This approach is called "Frequent Users Systems Engagement," or FUSE.

Allegheny County was awarded approximately $150,000 to identify those men and women in its Justice Related Services (JRS) with a history of repeated use of each of the following systems: criminal justice system (jail, courts, police); behavioral health (with a MI/COD diagnosis); and homeless. Allegheny County contracted with a local agency to provide the proposed housing services and supports.

The Jail Collaborative has chosen to focus on the most frequent users of multiple systems because these are the individuals whom these systems continue to fail —either because the referral mechanism is not strong or there is too little invested in support and housing when they are in the community. The FUSE approach allows Allegheny County to steer around the need for a referral mechanism and use administrative data to look across a number of systems to identify those clients with MI/COD and justice involvement who have the greatest need for the services of this project. The program will then determine housing needs, and quickly ensure that they have supported housing first and the array of other services they need, shortly thereafter.

The project's goals are to prevent recidivism and improve the rate at which individuals obtain permanent housing, employment, social connections and community support, and adherence to treatment.

Housing Support Grant – Allegheny County was awarded a Bureau of Justice Assistance grant in the amount of $247,000 over 2 years for this project. The project will target chronic offenders with mental health or co-occurring disorders who are serving a sentence in the county jail, who have faced or could face criminal charges for nonviolent offenses, and whose risk screen indicates that they are at medium-high risk of reoffending. The goal of the grant is to reduce the recidivism of individuals with mental health or co-occurring mental health and substance use disorders who have been chronically-involved with the criminal justice system. The individual is at a high risk of recidivism and has had multiple attempts of programming but has failed on numerous occasions. This serve will be delivered by one of AC DHS' contracted providers.

f) **Individuals with Autism**

DHS and ACTION Housing developed a 40-unit apartment building in Heidelberg, PA where 20 units have been set aside for individuals 18 years old and older with autism. A service provider will be coordinating supportive services for the 20 individuals with a focus on self-sufficiency.

g) **Individuals who are deaf or hard of hearing**

DHS and ACTION Housing were involved in "rehabbing" an existing building and developing a 43-unit apartment building in the Uptown District of Pittsburgh where 10 apartment units have been set aside for individuals age 18 and older who are deaf or hard of hearing. Service providers coordinate supportive services for the 10 individuals with a focus on self-sufficiency.

h) **Individuals who are experiencing homelessness**

Continuum of Care (CoC) Homeless programs - Allegheny County has a variety of programs that serve people experiencing homelessness or at risk of homelessness through the US Department of Housing and Urban Development and the PA Department of Human Services, including prevention, emergency shelter, transitional and bridge housing, rapid re-housing, and

permanent supportive housing. Approximately 62% of the homeless population in Allegheny County has a mental illness, so there is significant overlap between consumers who use the behavioral health system and the homeless system.

In light of this overlap, AC DHS recently applied for and was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) Cooperative Agreement to Benefit Homeless Individuals (CABHI) to address barriers faced by those consumers in accessing or trying to access the homeless system who have mental health and/or substance abuse disorders.

The Healthy Housing Outreach (H2O) project was awarded $2.4 million over 3 years to enhance and expand the infrastructure for and services within the mental health and substance use treatment system in Allegheny County for: 1) individuals experiencing chronic homelessness and 2) families, veterans and youth experiencing homelessness who need behavioral health supports including a substance use disorder (SUD), serious mental illness (SMI), serious emotional disturbance (SED), co-occurring mental and substance use disorders.

The goal of the H2O project is to increase capacity in Allegheny County to provide accessible, effective, comprehensive, coordinated, integrated and evidence-based mental health and drug and alcohol treatment services to the population of focus, thereby eliminating unaddressed behavioral health needs as a barrier to entering and/or sustaining permanent housing. The purpose of Allegheny County's CABHI grant is threefold:

- Engage those chronically homeless individuals living on the street (unsheltered) who have historically been averse to services and try to transition them into permanent housing

- Assist the chronically homeless who are trying to move into permanent housing from the streets or emergency shelter who need assistance in doing so by helping them to get required documentation, fill out applications, and generally navigate the system

- Assist providers in the Continuum of Care that lack the capacity to adequately serve the chronically homeless with MH and/or D&A disorders in order to prevent unnecessary program terminations and returns to homelessness for this population.

Through planning and service delivery, the H2O program will reduce homelessness and increase access to supports for people in or in need of permanent supportive housing by ensuring that the populations of focus receive access to or placement in sustainable permanent housing, treatment, recovery supports and Medicaid and other benefit programs. It is anticipated that H2O will serve 1,143 unduplicated clients over 3 years: 466 in year 1 and 677 over years 2 and 3.

i) **Older Adults**

Allegheny County has two Long Term Structured Residence and one Personal Care Home for older adults who have a behavioral health diagnosis as well as Licensed Nursing Homes.

Within AC DHS Area Agency on Aging (AAA) is housed a behavioral health specialist. The specialist's role is to assist in identifying and linking older adults with the appropriate behavioral

health services, so that individuals' needs are met, and conducting on-going training of AAA staff on behavioral health issues faced by the elderly.

In Allegheny County, there are over 165 subsidized "senior" buildings with less than 20% available through the three local housing authorities. The additional 130 buildings are owned and operated by private landlords. Some buildings have local management or use management companies to monitor the property. Elderly individuals with behavioral health disorders are not excluded from eligibility for any of these options.

j) **Individuals who are Medically Fragile**

Integrated Care Team – The Integrated Care Team works with physical health insurers to coordinate care for those individuals with complex medical and psychological needs. This team is housed within the County's behavioral health managed care organization, Community Care.

k) **Individuals with Limited English Proficiency (LEP)**

LEP - AC DHS maintains department-wide contracts for language assistance services, including in-person interpretation, telephone interpretation and written translation. These contracted services are available for all AC DHS staff to use when interacting with individuals with LEP. AC DHS has arranged with its language providers to extend their contracted rates to AC DHS's wide network of partner agencies to encourage greater use of interpretation and translation services in Allegheny County. The AC DHS Immigrants & Internationals Initiative is available to assist with accessing and utilizing language assistance for staff from AC DHS and its network of providers.

l) **Transition age youth including young adults**

The 412 Youth Zone - The 412 Youth Zone is a one stop shop for Allegheny County's transition-aged youth. The center offers everything from recreation to behavioral health counseling and employment services for youth and young adults ages 16-24. The goal is to help current and former foster youth and youth who are homeless find coordinated, centrally located support in their transition to adulthood.

Downtown Outreach Center (DOCS) - DOCS offers emergency shelter, food and clothing, medical care, and counseling for young adults 18-24 years of age for up to sixty days who are facing homelessness, while identifying and planning for individual needs.

Three Rivers Youth (TRY)'s Projects for Assistance in Transition from Homelessness (PATH) Program: The TRY PATH project provides case management and outreach to 5 homeless young adults with mental health concerns.

Independence Ahead – A mobile treatment team serving emerging adults 18-25 years of age, consisting of a therapist, service coordinator, psychiatric rehabilitation specialist, and certified peer support. The team assists young adults to develop close therapeutic relationships focused on wellness and recovery. The team helps them learn to manage their mental health symptoms, builds safe, strong relationships, helps them problem solve, and resolve conflict in their school/

employment, community, and relationships. The program works closely with permanent supported housing to allow those who wish to live independently in the community.