COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

September 3, 2013

Dear Colleagues:

Enclosed is the Commonwealth's revised Mental Health Olmstead Plan. This revised plan retains the core elements from the original plan, first issued in 2011. The Office of Mental Health and Substance Abuse Services (OMHSAS) continues to work diligently toward ending unnecessary institutionalization of adults who have a serious and persistent mental illness. This revised plan details specific steps the Commonwealth, in partnership with the counties, will take to ensure essential and appropriate community supports are in place to serve individuals as they transition from institutions to communities of their choice.

Section IV of the Olmstead Plan outlines the parameters for the Local/Regional Implementation Plan. Counties may submit plans independently or collaborate in partnerships with other counties of their choosing. The Local/Regional Implementation Plan will identify in detail the services, supports, and infrastructure needed to support individuals discharged from state hospitals and other segregated congregate settings. There is no plan due at this time. OMHSAS will communicate, with sufficient notice, to counties on the timelines for the submission of their Local/Regional Olmstead Implementation Plans.

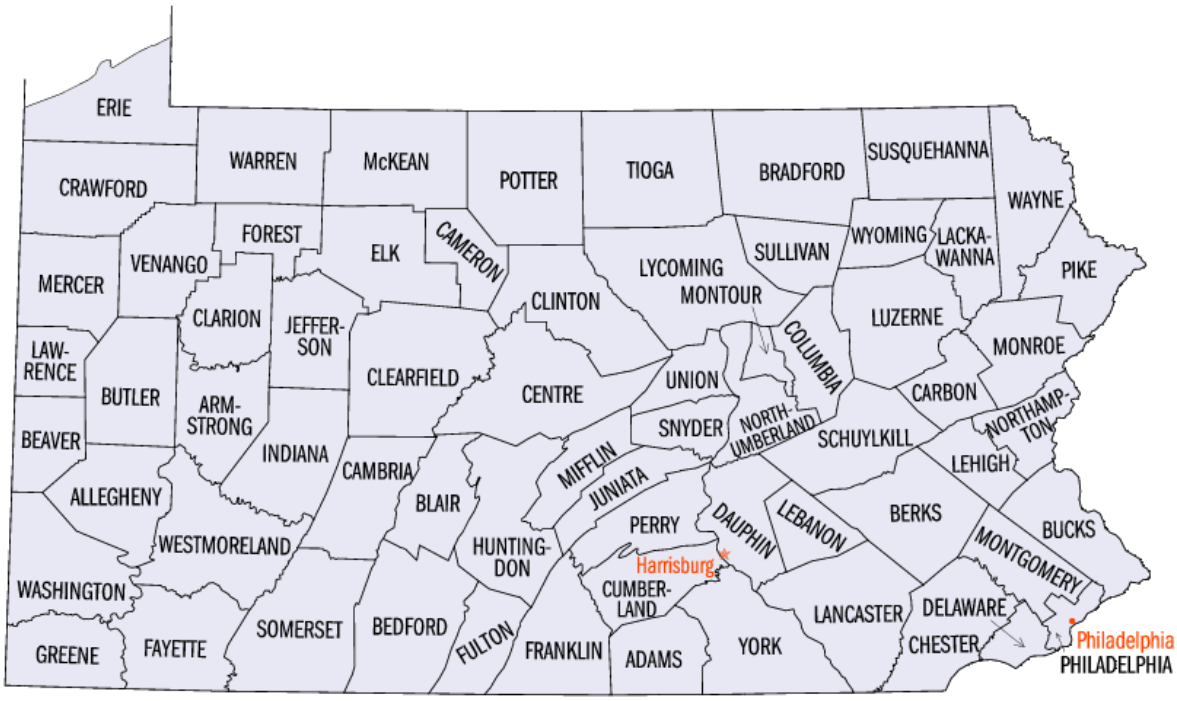
Please contact Jennifer Parker, jenparker@pa.gov, with any questions regarding the Olmstead Plan. Thank you for your continued partnership.

Sincerely,

Dennis Marion
Deputy Secretary

Enclosure

Updated Olmstead Plan
For
Pennsylvania's State Mental Health System



Office of Mental Health and Substance Abuse Services
Department of Public Welfare
Commonwealth of Pennsylvania

Issued: August 2013

SECTION I: BACKGROUND

The Pennsylvania State Mental Health Olmstead Plan, first issued in 2011, reflects the Commonwealth's continued progress toward ending the unnecessary institutionalization of adults who have a serious and persistent mental illness. Since it was first issued, the plan has detailed the specific steps that the Commonwealth would take to achieve that goal. The plan has also called for implementation to be reviewed at regular intervals to assess progress and determine the need for revision and updates. This revised plan retains the core elements from the original plan, with a revision to one of the principles outlined in the original plan. Additionally, this revised plan also includes updates and discussion of new steps to help accomplish the goal of ending unnecessary institutionalization of adults who have a serious and persistent mental illness.

Pennsylvania has made significant strides in addressing the issue of unnecessary institutionalization of Pennsylvanians with mental illness. As elsewhere in the nation, the census of Pennsylvania's state hospitals has declined dramatically in the last 40 years, from 35,100 in 1966 to less than 1,400 civil psychiatric beds in 2013. Approximately 200 beds have closed since 2010. Our progress mirrors the national trend which recognizes that many individuals who have a disability, including individuals who have a serious and persistent mental illness, can live successfully in the community if they have access to appropriate supports and services.

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

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

The primary source of funding for these closures, as well as for the downsizing of

other state hospitals, has been the Community Hospital Integration Project Program or "CHIPP." The CHIPP initiative provides the funding used to support individuals in the state hospitals to the counties to develop community supports and services for both the state hospital residents and the diversion population with the understanding that the state hospital beds that supported the individuals will be closed and unavailable to the counties following the discharge. This allows the counties to build community capacity while assuring that the state's obligation to finance state hospitals is decreased due to the bed closures. The CHIPP initiative has historically targeted the "long-stay" consumers of the state hospital system, who are individuals that have been in residence for at least two years. As of March 2013, the Commonwealth has supported the CHIPP initiative with the closure of 3,134 beds in the state mental hospital system by transferring $244,194,745 in SFY 2012/13 to fund and support the development of an array of community-based services.

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

- Initiation of the service area planning (SAP) process in 2002, in which counties served by each state hospital and other stakeholders work together to develop community service area plans for their regions. The regional service area planning process includes participation by the Department of Public Welfare's Office of Mental Health and Substance Abuse Services (OMHSAS), county mental health programs in the region, consumers, families, advocates, regional providers, physical health managed care organizations (PHMCOs), and behavioral health managed care organizations (BHMCOs) that serve the regions.

- Development of community programs based on the community support planning process which ensures that consumer, family members, and other persons involved in the recovery process are also able to participate in decision-making.

In the last 20 years, Pennsylvania has indisputably made significant progress in developing community alternatives for people who have a mental illness and decreasing reliance on state psychiatric hospitals. Our continuing progress depends on the development of a viable integration plan for state hospital residents, for those individuals who live in other large congregate settings, and for those at risk of institutionalization, including, the homeless, people who have a criminal justice history, returning veterans, and others.

This Olmstead Plan acknowledges that unwarranted long-term institutionalization in state mental hospitals and the use of large segregated and congregate settings do not belong to the modern times. This plan also advocates that opportunities and viability for permanent supportive housing be explored for all individuals. New evidence-based practices and medications enable individuals who have a mental illness to live in the community successfully with, at most, the need for relatively short periods of hospitalization to become stabilized. Pennsylvania has extensive capacity within community hospitals which are more than capable of meeting individual's acute

hospitalization needs. This means the need for state hospitals, which were designed to house people on a long-term basis, has decreased considerably, while the availability of community-based supports and services has grown substantially.

This Olmstead Plan provides the opportunity for the Commonwealth to honor the letter and spirit of the Olmstead ruling, while maximizing the utilization of its fiscal and other resources. Some of the available resources include:

- Pennsylvania's mandatory behavioral health managed care program, HealthChoices, provides services to Pennsylvanians enrolled in the Medical Assistance program. Both the capitation dollars provided by the Commonwealth to the HealthChoices managed care organizations (MCOs) and the reinvestment dollars the HealthChoices MCOs generate are used to: increase capacity; to develop services that might not otherwise be available, and; to pay for start-up costs for new programs and other community services.

- Programs available outside of the traditional mental health system that fund services for our citizens who have a mental illness. These include home and community-based waivers for people who are eligible (e.g., the Aging Waiver for elderly individuals and the Attendant Care and Independence Waivers for those with physical disabilities in addition to mental illness); the Consolidated Waiver for individuals who have intellectual disabilities; services provided through the Department of Aging and the Office of Long Term Living; publicly-funded housing programs; and veterans' programs. In addition, other federal, state, and private benefit sources may be available to assist these individuals (e.g., Social Security Disability, Supplemental Security Income, Medicare, Medical Assistance, education and veterans' benefits).

- Federal, state and local housing resources including, but not limited to: federal McKinney funds and federally funded Section 8 Housing Choice Vouchers available through local Public Housing Authorities; Pennsylvania Housing Finance Agency Low Income Housing Tax Credit units, especially units made available for people at 20% or below of the Area Median Income, Phare and PennHomes funding, state and local HOME, CDBG and Trust fund resources.

  Pennsylvania was awarded $5.7 million in new Melville 811 resources in February 2013. These resources will be targeted to people with disabilities, including those leaving institutions, as Project Based Rental subsidies for units in Low Income Tax Credit Projects. Local Lead Agencies (LLAs) will manage the referral and service delivery components of this program. This marks a major breakthrough in resources for Olmstead planning.

- Counties are also encouraged to accelerate the transformation of existing programs, both housing and treatment services, to newer, more evidenced-based models that promote integration and recovery.

SECTION II: GUIDING PRINCIPLES

A number of principles guide this Olmstead Plan. The following core principles that serve as the foundation for Pennsylvania's mental health system provide the philosophical framework for this plan.

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

   Treatment, services, and supports must facilitate recovery. As stated in the Commonwealth's Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults: "recovery is a self-determined, holistic journey that people undertake to heal and grow. It is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members."

2. **People with mental illness can be served in community-based settings.**

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

3. **Each consumer's needs will be assessed through the community support planning (CSP) process. CSPs define the supports needed for each consumer to live in the most integrated setting appropriate to his or her needs.**

   The CSP process serves as the foundation for successful implementation of this Olmstead Plan. DPW will work with counties to plan for the development of a broad array of integrated options to meet the needs of consumers. The CSP process in Pennsylvania has been vital to the design of individualized services and supports that are consumer-centered, consumer-empowered, and culturally competent. Each person's CSP will:

   - Be developed, monitored, and evaluated in partnership with consumers and, as appropriate, with families, involved advocates, specialists (e.g., trauma, spiritual advisors, supports coordinators for individuals who have an intellectual disability; probation/parole officers), and knowledgeable provider staff;

   - Identify and utilize each person's specific strengths;

   - Provide services and supports that will meet all of the person's unique needs and preferences, drawing on natural supports, mental health services and supports, and services and supports outside the mental health system;

- Address the person's special needs (e.g., co-occurring intellectual disabilities, traumatic brain injury) and, when necessary, accommodate those needs (providing effective communication e.g. sign language for consumers who are deaf and interpreting services for non-English speaking consumers);

- Assure that services are flexible, coordinated, and accountable;

- Recognize, respect, and accommodate differences relating to disability, culture,ethnicity, race, religion, gender, gender identity, and sexual orientation; and

- Provide opportunities for individuals to live and work in integrated settings.

SECTION III: PENNSYLVANIA'S OLMSTEAD PLAN

Based on the principles outlined above, the Commonwealth adopts this updated plan to provide services to adults with mental illness in the most integrated settings appropriate to their needs. The priorities of the plan are to: (1) return individuals residing in state psychiatric hospital units to a community of their choice, (2) provide individuals residing in other institutions or large segregated and/or congregated settings the opportunity to live in more integrated settings, and (3) diverting individuals from institutions and large segregated congregate settings.

Integrated settings are those that enable people with disabilities to interact with people who are not disabled to the fullest extent possible. This means individuals with behavioral health needs have opportunities to live in housing where non-disabled persons reside. It also means opportunities exist to work or experience daytime activities in the community- not in special programs or jobs primarily created for persons with disabilities.

In support of the above priorities:

- The DPW-OMHSAS will request funding to reduce the state hospital civil bed capacity by closing at least 90 beds each fiscal year through the discharge of at least 90 state hospital residents each fiscal year.

- As state hospital units are closed, state funds used to support those units will be provided to the counties, as dedicated CHIPP funds, to develop and support necessary community services and infrastructure.

- As part of the planning process, counties should gather information annually from all involved sources, including, but not limited to: consumers, families, advocates, providers, counties, PHMCOs and BHMCOs, drug and alcohol programs, homeless shelters, housing authorities, prisons, jails, and courts. Based on that information, the county will identify the additional supports, services, and infrastructure to be developed during the course of the

implementation of the Olmstead Plan.

- OMHSAS will use the CSP process to assess the needs of the individuals who are receiving services in the state hospitals or other institutions, and the services and supports individuals are provided upon discharge will be consistent with their CSPs and adequate to assure their successful reintegration into community life.

- OMHSAS will provide technical assistance and support to counties, service providers, and stakeholders to assure integration opportunities are made available with existing and new resources.

- OMHSAS will provide necessary supports and assistance to counties to create a variety of residential housing options, further reducing the reliance on congregate settings of more than sixteen (16) beds for persons with mental illness.

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

- Counties should identify other potential public and private funding sources available to serve the needs of consumers, such as: Medical Assistance; Medical Assistance Home and Community-Based Waivers; Medicare; services provided through the Pennsylvania Department of Aging and Office of Long Term Living; federal, state, and local housing agencies (e.g., HUD, PHAs, the Pennsylvania Housing Finance Agency, Local Lead Agencies, and local housing and redevelopment authorities); and private foundations.

- OMHSAS will review the implementation of the Olmstead Plan annually to assess and determine the need for revision and updates.

- Stakeholders will be involved in the planning and implementation at all levels of the plan. Individuals who have a mental illness, family members, advocates, service providers, county mental health officials, state officials, and other stakeholders will be involved early and continually in the process to develop and implement the Olmstead Plan.

- OMHSAS will provide regular reports on the implementation this Olmstead Plan to the Mental Health Planning Council.

SECTION IV: LOCAL/REGIONAL OLMSTEAD IMPLEMENTATION

Through the Olmstead Planning Process, counties will develop and submit a Local/Regional Olmstead Implementation Plan at a date prescribed by the Department. Counties may submit the plans either individually, as joinders, or in partnerships with other counties of their choosing. The plan will identify with specificity all types of services, supports, and infrastructure that will need to be developed in order to meet the needs of the individuals discharged from state hospitals, the diversion population, and individuals living in other segregated and congregated settings including Personal Care Homes. This Local/Regional Implementation Plan will set timelines for when each service will be developed or transformed and will identify funding sources it will use or seek to implement the plan. OMHSAS will communicate, with sufficient notice, to counties on the timelines for future updates to their Local/Regional Olmstead Implementation Plans. The bullets below provide guidance for the development of the Local/Regional Olmstead Implementation Plan. The template for the Implementation Plan is included as Appendix A of this document.

- Using the CSPs developed for all state hospital residents from the service area as a starting point, counties will identify what services, supports, and infrastructure will be needed for those individuals, such as:

  Services and supports that focus on prevention and early intervention.

  - An array of non-institutional housing options, focusing on independent and shared living arrangements and, to the extent possible, services will be separated from housing.

  - An array of non-residential treatment services and community supports, including mobile treatment options; case management; extended acute care centers; psychiatric rehabilitation services; medication management; mobile and crisis services; and employment opportunities ("real work for real pay").

  - Peer support and peer-run services (e.g., certified peer specialists, drop-in centers, and warmlines) - these peer supports and services have yielded successful outcomes in assisting consumers in building skills, developing and sustaining social relationships, providing supportive environments, and providing opportunities for gainful employment.

- The Local/Regional Olmstead Implementation Plan should address, at minimum, the following:

  - **Stable, affordable housing in integrated settings:** In addressing housing needs, the Local/Regional Olmstead Implementation Plan

should describe the process for the majority of housing services in the service area becoming "integrated" in accordance with Title II of the ADA including separating housing from services to allow greater flexibility and individualization.

- **Incorporation of "Housing First" approaches.** "Housing First" models do not require consumers to participate in other services. This includes housing funded through the mental health system and the types of housing that can be funded through other systems (such as public housing or subsidized housing). "Housing First" models are being implemented in many jurisdictions for people with serious and complex housing needs including people who are living in segregated housing programs and institutions.

  Consumers are not required to participate in services as a condition of tenancy; however, typically a majority of the consumers do participate in services in effective "Housing First" programs. The major characterization and distinction of "Housing First" programs is that they do not require consumers to be made "ready" for housing as required in continuum models. Staff are skilled in motivational interviewing and other engagement strategies, wellness coaching, relapse prevention, personal assistance, illness self-management and tenancy support. Most "Housing First" programs serve people in non-segregated settings consistent with Title II of the ADA. People meet all the terms of tenancy and hold their own lease to the extent possible.

- The plan will identify with specificity any changes to or new programs to be developed, the number of consumers to be served by each program, and the timeline for development of each program.

- The plan will set forth the strategies used to maximize resources to meet the housing need of consumers. Each plan will specify the Local Lead Agencies (LLA) in their service area, how the counties will support their LLA, and how individuals will be referred to the LLAs (e.g., using the CSP process). Each plan will also specify the counties' partnerships with local Public Housing Authorities (PHAs), Regional Housing Coordinators, Community and Housing and Redevelopment Authorities, Local Housing Options Team, where applicable, and other resources.

- The plan will include any plans for CRR conversions as set forth in guidance for CRR conversions outlined in *County Housing Plan Policy*[1].

- Each plan will include a status update of the services which are offered to assist residents to move into more integrated settings, and the

[1] Office of Mental Health and Substance Abuse Services, *County Housing Plan Policy.* Issued August 2007. [Available at: http://www.parecovery.org/documents/County_Housing_Plan_Policy_082007.pdf]

services provided to residents with mental illness outside the home.

- The plan will set forth the strategies for specific non-residential supports and services. In updating this section of the plan it is important to recognize that true integration applies to all types of daily activities and work opportunities. Thus the plan should reference the timelines for development; the number of consumers to be served; the peer supports and peer-run services; and the anticipated funding or other resources for these opportunities.

- The plan will identify how services are meeting the specialized needs of the following groups: consumers who have a dual diagnosis of mental illness and an intellectual disability; consumers who have a dual diagnosis of mental illness and substance abuse; consumers who have a dual diagnosis of mental illness and a physical disability; consumers who have a dual diagnosis of mental illness and traumatic brain injury; consumers returning from incarceration; consumers who are deaf; consumers who are homeless; consumers who are elderly; consumers who are medically fragile; and consumers who do not speak English.

- As stated in the initial plan, if a service area identifies a need for a particular service or support for some of its consumers, but the demand is not sufficient to develop the service, OMHSAS will facilitate inter-regional planning to support the development of regional services.

SECTION V: STATE MENTAL HOSPITAL CONSOLIDATION

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

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

As encapsulated in OMHSAS' vision and mission statement, *"Every individual served by the mental health and substance abuse service system will have the opportunity for growth, recovery and inclusion in their community, have access to culturally competent services and supports of their choice, and enjoy a quality of life that includes family and friends".* This plan is a blueprint to make that vision a reality.

APPENDIX A

LOCAL/REGIONAL OLMSTEAD PLAN IMPLEMENTATION PLAN TEMPLATE

(Please see *Section IV: Local/Regional Olmstead Implementation* of the guidance)

I. OLMSTEAD PLANNING PROCESS:

Describe how stakeholders were involved in the development of the plan. Counties should engage consumers, family members, advocacy groups, providers, behavioral health managed care representatives, and cross-systems partners in the planning process. Stakeholders should be included in the development of the local/regional implementation plan, monitoring of community services and supports, and in providing ongoing input into the county's system for recovery-focused services. Counties should demonstrate and document in their plan how they outreached to and engaged the stakeholders.

II. SERVICES TO BE DEVELOPED:

Using information gathered from the CSPs, identify the services, supports, and infrastructure needed to support individuals as they transition to the community. **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.

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

c) Non-residential treatment services and community supports (examples: mobile treatment options; case management; extended acute care centers; psychiatric rehabilitation services; medication management; mobile crisis services; and employment opportunities).

d) Peer support and peer-run services (examples: certified peer specialists, drop-in centers, warmlines, etc.).

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).

b) Discuss the progress made towards integration of housing services as described in Title II of the Americans with Disabilities Act (ADA).

c) Please describe the plans for Community Residential Rehabilitation (CRR) conversion.

d) Identify the Local Lead Agency (LLA) and describe existing partnerships with local Public Housing Authorities (PHAs), Regional Housing Coordinators, Community, Housing, and Redevelopment Authorities, and Local Housing Options Teams (LHOTs).

IV. SPECIAL POPULATIONS:

Discuss how the specialized needs of the following groups are met:

a) Individuals with a dual diagnosis (MH/ID)

b) Individuals with co-occurring disorders (MH/SA)

c) Individuals with both behavioral health and physical health needs

d) Individuals with a traumatic brain injury

e) Individuals returning from incarceration

f) Individuals who are deaf or hearing impaired

g) Individuals who are homeless

h) Older Adults

i) Linguistic minorities

Approved:

Dennis Marion, Deputy Secretary
Office of Mental Health and Substance Abuse Services

8-29-13
Date

Beverly Mackereth

Beverly D. Mackereth, Secretary
Department of Public Welfare

9/4/13
Date