FACES OF RECOVERY:

Supporting People in Housing

Pennsylvania Office of Mental Health and Substance Abuse Services

Prepared by
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FACES OF RECOVERY: Mary S….

I was diagnosed with mental illness in the 1970's and at that time I saw someone in Lebanon County Office of MH/MR. I had been stabilized on meds for a while but then I got sick and had to go to Wernersville State Hospital for about one month. When I came out I was receiving out-patient services through MH/MR – I was seeing a therapist and a doctor who helped me with my meds. I was then assigned to an intensive case manager and she really helped me get my life on track. I met with her once a week for about three or four years. She helped me get my benefits and the supports I needed to get Section 8 housing. When I came out of the hospital, she said I could go on SSI or get a job. I opted to work full time cleaning floors every night at K-Mart because I could earn more money than what I would get on SSI. I worked there for two years but then my mental and physical health started to deteriorate. My case manager was then able to get me on SSDI because I was not able to work anymore. I became stable and after a while I 'advanced' to a resource case manager who I see once a month. These recovery oriented services have helped me see that people with mental health challenges can do anything that anyone else can do – I can do things and live independently even if I have mental illness. Recovery is great – it gets people to do as much as they can possibly do. There are even different options for treating mental illness; some people take meds and some people are trying self-help techniques. I take meds but I am no longer taking my psychotropic meds – I worked really closely with my doctor to make this happen. I am now a peer specialist and work 15 hours a week. I haven't been hospitalized since I was at Wernersville. I am now very much in control of my life. I do drive, I have lived in my one bedroom A-Frame bungalow since the 1980's and I have two cats. Pets are important to help people relax. I didn't always have good social skills but the Halcyon Activity Center – it's a drop-in center where I work- has been really helpful. We have monthly evening activities. We go on trips occasionally to the shore or even Canada, and we have formed the Community Support Program in Lebanon County where providers, family

members and consumers meet and talk about the steps to recovery. My job is challenging – I am a consumer helping consumers. We are starting a new program called WRAP, the Wellness Recovery Action Plan, which will help people understand symptoms that may trigger a relapse. Part of what I and other consumers do now is go to the state hospital and tell our story. We tell people that they can be in the community. And people have come out of the hospital and have come to Halcyon. They see me and – "a big grin".

Background

In the fall of 2005 the PA Office of Mental Health and Substance Abuse Services (OMHSAS) unveiled a landmark document entitled *A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults.* This document establishes a firm foundation for the Pennsylvania transformation to a mental health system for adults that is "integrated, uses best practices and most importantly, is recovery-oriented." The report goes on to define recovery as "a self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that allow people to reach their full potential as contributing community members."

During that same time, the county mental health offices submitted their 2005-06 Plans to OMHSAS. A review of the Plans revealed that for the second year in a row, the county offices identified housing as one of the greatest needs they face in serving persons with serious mental illness and co-occurring disorders.

In response to this need, the OMHSAS Adult Advisory Committee formed a Housing Work Group to develop a set of principles, strategies and action plans for expanding housing with recovery-oriented services for consumers. The group was charged with developing a document that addresses housing with recovery-oriented services for *all adults* with serious mental illness and co-occurring disorders, which is consistent with the guiding principles set forth in *A Call for Change.* Finally, the document was to be used by OMHSAS and other Commonwealth agencies to set priorities and target resources, and by the county mental health offices to address the housing needs of their consumers.

The document was completed in September 2006, presented to the Joint OMHSAS Advisory Committees in October 2006 and approved in November 2006. The full text of the Housing Work Group report can be accessed through OMHSAS's website, www.PaHousingChoices.org.

Since they are essential underpinnings for this publication--- *Faces: Supporting People in Housing and Recovery*--- the sections of the Housing Work Group Report on Philosophy, Goal, Benefits and Principles of Recovery follow.

Philosophy

Stable housing is an essential component of mental health recovery. People with serious mental illness and co-occurring disorders must have access to a comprehensive array of permanent, affordable, barrier free housing options as well as the supports necessary for them to obtain and maintain the housing of their choice. This philosophy is supported by the National Association of State Mental Health Program Directors *"Position Statement on Housing and Supports for People with Psychiatric Disabilities,"* which reads:

Housing Options

It should be possible for all people with psychiatric disabilities to have the option to live in decent, stable, affordable and safe housing that reflects consumer choice and available resources. These are settings that maximize opportunities for participation in the life of the community and promote self-care, wellness and citizenship. Permanent housing options should not have time limits for moving to another housing arrangement. People should not be required to change living situations or lose their place of residence if they are hospitalized. People should choose their housing arrangements from among those living environments available to the general public. State mental health authorities have the obligation to exercise leadership in the housing area, addressing housing and support needs and expanding affordable housing stock. This is a responsibility shared with consumers and one that requires coordination and negotiation of mutual roles of mental health authorities, public assistance and housing authorities, and the private sector.

Provision of Services

Necessary supports, including case management, on-site crisis interventions, and rehabilitation services, should be available at appropriate levels and for as long as needed by persons with psychiatric disabilities regardless of their choice of living arrangements. Services should be flexible, individualized and promote respect and dignity. Advocacy, community education and resource development should be continuous.

Goal

OMHSAS' goal is to ensure that all Pennsylvanians with serious mental illness and co-occurring disorders have access to a range of decent, safe, affordable housing options and recovery-oriented services.

In order to accomplish this goal, Pennsylvania needs OMHSAS and its Regional Offices as well as county offices and providers to embrace the concept of recovery and to organize and deliver services in ways that support recovery. It needs public and private housing developers to partner with the counties and service providers in offering a range of affordable housing options. Although outside the charge of this work group, it needs a mental health system that supports individuals in securing employment and meaningful activities. And for all of this to happen effectively, it needs people with serious mental illness and co-occurring disorders to provide direction and to be involved in every step along the way.

Permanent Supportive Housing

Although there are a variety of housing options that can be considered by persons with serious mental illness and co-occurring disorders, most have the characteristics of "supportive housing" or permanent, affordable housing that is linked to flexible, voluntary supports. Following is a complete definition of supportive housing as offered by the Corporation for Supportive Housing and as adopted by the Housing Work Group: Supportive housing is a successful, cost-effective combination of affordable housing with services that helps people live more stable, productive lives. Supportive housing works well for people who face the most complex challenges—individuals and families who have very low incomes and serious, persistent issues that may include substance use, mental illness, and HIV/AIDS; and may also be homeless, or at risk of homelessness.

A supportive housing unit is:

- Available to, and intended for a person or family whose head of household is experiencing mental illness, other chronic health conditions including substance use issues, and/or multiple barriers to employment and housing stability; and may also be homeless or at risk of homelessness;
- Where the tenant pays no more than 30%-50% of household income towards rent, and ideally no more than 30%;
- Associated with a flexible array of comprehensive services, including medical and wellness, mental health, substance use management and recovery, vocational and employment, money management, coordinated support (case management), life skills, household establishment, and tenant advocacy;
- Where use of services or programs <u>is not</u> a condition of ongoing tenancy;
- Where the tenant has a lease or similar form of occupancy agreement and there are not limits on a person's length of tenancy as long as he/she abides by the conditions of the lease or agreement; and
- Where there is a working partnership that includes ongoing communication between supportive services providers, property owners or managers, and/or housing subsidy programs.

Supportive Housing is:

1. Safe and Secure
2. Affordable to consumers
3. Permanent, as long as the consumer pays the rent and honors the conditions of the lease.

Supportive Housing is linked to support services that are:

1. Optional. People **<u>are not</u>** required to participate in services to keep their housing, although they are encouraged to use services
2. Flexible. Individualized services are available when the consumer needs them, and where the consumer lives.

Benefits

There are numerous studies that demonstrate the benefits of supportive housing for individuals with serious mental illness and co-occurring disorders. Specifically, these studies have found that the number of hospitalizations as well as emergency room and shelter bed use are dramatically reduced, and the ability to obtain and sustain employment is significantly increased. In fact, decent housing and supports are not only essential to recovery, but also cost effective alternatives to homelessness, incarceration and other undesirable alternatives. Statistics from several recent studies are striking:

- Residents of supportive housing increased their earned income by 50% and their employment rate by 40%.[1]
- Prior to living in permanent supportive housing, homeless people with mental illness used an average of $40,449 per person per year in shelters, hospitals and correctional institutions. After living in supportive housing for six months or more those costs dropped an average of $16,282 per person per year.[2]
- Medicaid costs for mental health and substance abuse treatment decreased by $760 per service user and costs for in-patient and nursing home services decreased by $10,900 per service user six months following their move into permanent housing.[3]
- In 2004, Pennsylvanians receiving SSI would have had to spend 98.4% of their income to rent a one-bedroom apartment.[4]

Principles

The Housing Work Group was charged with developing housing strategies for people with mental illness that are consistent with the 10 fundamental elements and guiding principles of mental health recovery set forth in OMHSAS' *"A Call for Change: Toward a Recovery-Oriented Mental Health Service System."* Recovery:

- Is self-directed
- Is individualized and person-centered
- Is empowering
- Is holistic
- Is non-linear
- Is strengths-based
- Embraces peer support
- Fosters respect
- Encourages responsibility and
- Hope.

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[1] Culhane, Dennis, Metreaux, S.: Hadley, Trevor (2001). The impact of supported housing for homeless persons with severe mental illness on the utilization of public health, corrections, and public shelter systems: the New York/New York Initiative, Philadelphia, PA: The University of Pennsylvania: Center for Mental Health Policy and Services Research.
[2] Culhane, Dennis, Metreaux, S.: Hadley, Trevor (2001)
[3] The Connecticut Corporation for Supportive Housing
[4] Priced Out in 2004, Technical Assistance Collaborative, Boston, MA

These principles served as the foundation for the Housing Work Group's efforts and were used in the development of strategies and recommendations for providing people with mental illness and co-occurring disorders access to permanent, affordable housing and recovery-oriented supports. (See Appendix A for additional information on application of these principles by the Housing Work Group.)

Purpose of this Publication

This publication is for counties; provider agencies; Local Housing Option Teams (LHOT's) or other local housing coalitions; and consumers and family members that are interested in addressing the priorities and objectives set out in the Housing Work Group Report. It provides definitions and examples of services that are helpful in supporting individuals with serious mental illness and/or co-occurring disorders in securing and maintaining the home of their choice. It includes both services that offer one-on-one assistance to consumers in locating a home, negotiating a lease, and setting up a household as well as services that create a "service rich environment" for supporting individuals in recovery and in their homes such as peer supports, mobile psychiatric rehabilitation and mobile medication services.

Specifically, the publication contains:

- **Definitions and examples of Recovery-Oriented Services…**
  The recovery-oriented services described in this publication incorporate the principles of mental health recovery. Each service is defined and followed by a description of at least one program in Pennsylvania that uses that service. Contact information for obtaining additional information is also provided. While mindful of the fact that to some degree all recovery-oriented mental health services help to support individuals living in the community, the focus of this publication is on those services that have the most direct impact on an individual's ability to obtain and maintain the housing of his/her choice. Further, although we recognize that meaningful work or daily activity is critical to recovery, a separate OMHSAS Work Group is focusing on this issue, so vocational services are not addressed in this document.

- **Case Studies of Two Counties that have Recovery-Oriented Mental Health Systems...**
  Descriptions of the current mental health systems in Erie and Bradford County are provided. Although different, both counties provide a range of supportive housing options with recovery-oriented services.

- **Testimonies…**
  Featured in the publication are three compelling testimonies of individuals who have participated in recovery-oriented services in finding and keeping the homes of their choice.

FACES OF RECOVERY: Debbie S.…

I have basically suffered from manic depression my entire life. I was physically and mentally abused as a child and my twin brother committed suicide because he wasn't treated for his mental illness. I took my mother's abuse for many years. I somehow went to Community College and then buried myself in my work. I was a certified dental assistant and was very successful in my career, but because of my illness I lost my job. I had no family support and I was hospitalized over 20 times. I went into a partial hospitalization program and it was suggested that I go to the Unity House Clubhouse. I joined the clubhouse last September and it has been a life changing experience for me. The staff greeted me, accepted me for who I am and got me feeling better about myself. I have learned new skills such as using the computer, I have learned how to get back into society and I have developed good relationships with everyone at the clubhouse because everyone understands where I am coming from. Since I have been in recovery I was offered an executive position but my psychiatrist felt it would be too stressful. Part of what the clubhouse has done is teach me how to pace myself. Although they do not monitor my meds, the clubhouse staff indirectly helps with med management, because if we don't take them we could be suspended. They have a great outreach system and they even provide me with transportation to and from my home. I live in my own home with my husband and daughter and since I have been going to the clubhouse (about 3 – 5 times a week) I am now able to do more at home such as help my daughter with her homework and make dinner. My family is very supportive of my participation in the Clubhouse. The Clubhouse has helped me to be where I am today and they have also helped me be a good mom. The one problem is that the drugs I take are very expensive and this is a really big financial burden. I would like to see more programs that could help offset those expenses. My participation in the clubhouse has helped me become more confident in myself. The staff is wonderful and the members put together a newsletter every month. I have written a lot of articles and I have also been asked to speak on several occasions at NAMI and the Allentown State Hospital. If I can share my story and reach just one person with it, then I have done my job.

Recovery-Oriented Services

Following are definitions of Recovery-Oriented Services that will support individuals in obtaining and maintaining homes of their choice. Each definition is followed by an example of how that service is currently carried out in at least one County in Pennsylvania. A second example is provided when two counties have significantly different approaches to providing the same type of service.

Type of Service: Housing Support

Definition of the Service:

Individuals are assisted in securing and maintaining safe, affordable community housing, and in developing the daily living and other skills necessary to remain in their home. Two alternative service models can be used in providing housing support. The first is an *integrated approach* that ensures that housing support to help individuals get and keep housing is included as part of the service component within all or a number of existing services. The second model establishes a separate *housing support team* whose sole purpose is to help individuals obtain and remain in housing.

Example: Clearfield/Jefferson County (Integrated Approach)

The Housing Support program in Clearfield/Jefferson County is an integrated approach that ensures that housing support to help individuals get and keep housing is included as part of the service component within appropriate existing services.

Clearfield/Jefferson MH/MR has developed a mental health service matrix called "The Golden Grid". This matrix enumerates approved providers and agencies that offer a variety of support services in order to provide housing supports to consumers so that they can live independently in permanent housing in the community of their choice. The agencies and providers listed are under contract with MH/MR to provide the services in which they have expertise.

Case managers use agencies from the matrix to provide housing support to each consumer based on the needs identified in his/her service plan. Staff of the agencies in the Golden Grid connects consumers with services that assist them to obtain and maintain housing, including medication monitoring, independent living skills, and a representative payee. Consumers receive regular evaluations if they have an intensive case manager. If not, ongoing monitoring occurs through the consumer's service provider, and then the case manager and the consumer review their service plan once every six months.

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Housing support has helped people live more independently in their own homes. It has also reduced the number of hospitalizations and in some cases, the amount of supports needed to live independently. In other cases, people have moved into other permanent housing without supports. Supported Living providers offer home visits once a week to help the consumer with living skills, to encourage them to be part of the community, and to help them to organize that transition.

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Example: Erie County (Housing Support Team Approach)

The Independent Living Services program provides rehabilitative and supportive services to adults with serious mental illness based on the principles and practices of psychiatric rehabilitation, as well as recovery focused approaches. Their focus is to provide the skills training and environmental supports that an individual needs in order to be successful and satisfied in the living, learning, social and working environments of his or her choice. Further, their approach fosters the concepts of recovery by developing recovery plans that connect the person to various community and natural supports. The services provided are all based on individual need and include, but are not limited to, the following: securing and maintaining safe, affordable community housing; developing the daily living skills necessary for maintaining a home and for establishing healthy life routines, often including some level of medication management &/or medication education; developing social and interpersonal skills and establishing a healthy connection to those individuals and community organizations of choice; and, developing and/or enhancing pre-employment and/or job readiness skills to prepare for volunteer positions or employment.

The program operates seven days per week, with available direct-care staff in the field from 8am until 9pm. Each of the 15 direct care staff are responsible for making routine contact to work on identified areas with the consumers assigned to their individual caseloads. Independent Living has three Recovery Specialists, who are Certified Psychiatric Rehabilitation Professionals, and whose responsibility it is to meet individually with each consumer to develop an individualized Recovery Plan & periodic review. The program also employs three Licensed Practical Nurses, who conduct community-based & medical contacts as needed, and who coordinate a large portion of the programs' medication monitoring service. Consumers are initially authorized for 6 months of service, and frequently are re-authorized thereafter when they remain active with the program by pursuing individual goals, or by utilizing the supports offered to remain in the community.

For More Information contact:

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Type of Service: Crisis Intervention/Mobile Crisis

Definition of the Service:

Crisis intervention/mobile crisis is a global term that includes varying services to provide immediate intervention to assure safety for individuals experiencing moderate to severe distress including telephone, walk-in, and mobile crisis services provided in the community.

Example: Clearfield/Jefferson County

Crisis Intervention/Mobile Crisis, a component of the Clearfield/Jefferson Mental Health/Mental Retardation Program, is a telephone and mobile crisis service. The purpose of the program is to promote recovery and keep people in their own homes. The service is available 24 hours per day 7 days per week for people with symptoms of mental illness. There are two crisis counselors on call around the clock and three crisis counselors on-call from 8 a.m. to 8 p.m. Their function is to: help alleviate the symptoms; bring the person back to a baseline level of functioning in the least restrictive way; assure the person's safety and the safety of others and; reduce future occurrences. On-call staff has access to consultation from a psychologist and psychiatrist. If a problem cannot be resolved by phone, counselors are available to meet individuals and/or their families wherever they are within the two-county region.

Between 350 and 450 calls come in per month and mobile crisis providers are dispatched about 140 times per month. Ninety-eight percent of the time, service is provided wherever needed within one hour of the call. The program is administered by the Jefferson Community Mental Health Center, licensed by the Department of Public Welfare and funded by the County. If a consumer has medical assistance, this covers half of the cost and the county pays the remainder. If a consumer does not have medical assistance, the county covers the full cost.

Prior to implementation of the program, there were 630 – 650 involuntary hospitalizations per year; this number has been reduced to about 230 per year. One of the biggest challenges is providing accessibility to all people. Because suicide rates have not dropped, the program is doing aggressive outreach to two target populations: it is distributing postcards to school children and reaching out to the elderly through their primary care physicians. A video done by kids for kids and produced by Noodlehead was aired on the Adelphia Cable as part of a mass public service campaign. DPW commended the program for having multiple referral sources such as physicians, schools and cable T.V. watchers.

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Example: Dauphin County

Crisis Intervention is the 24-hour emergency service component of the Dauphin County Mental Health/Mental Retardation Program. Professional mental health workers provide counseling, outreach, and other services to individuals experiencing an emotional crisis or difficulty in coping with a personal problem. Anyone in Dauphin County is eligible for assistance, which is provided in English and Spanish. The program has two offices, one in Harrisburg and a Crisis satellite office in the Upper Dauphin Human Services Building, which is located in a rural area. OMHSAS base funding, PATH and the county drug and alcohol program help to fund this program.

Intervention is provided within the community, over the telephone and in the office. In addition to working directly with individuals in crisis, staff collaborates with other professionals such as police officers and emergency room staff in an attempt to stabilize an individual in crisis. The staff of the program makes approximately 4,000 contacts per year. The desired impact of this program is to help consumers safely pass through a time of crisis.

In addition to providing a 24-hour presence for Dauphin County's MH/MR consumers, the Crisis Intervention team is on-call to local EMS, schools, police and fire departments to provide critical incident stress management. It is also part of the County's disaster preparedness plan. Through the Crisis Intervention program, the mental health system has been woven into the fabric of the community.

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Type of Service: Crisis Residential Services

Definition of the Service:

Sometimes called a "diversionary unit," crisis residential services provide 24-hour intervention and crisis beds to people experiencing severe emotional distress. It is a step down and “diversion” from local inpatient psychiatric services.

Example: Erie County

The Erie County Crisis Residential Program was one of three recovery–oriented demonstration programs funded by OMHSAS in the early 1990’s. The 6-bed Crisis Residential Program is located in a residential building indistinguishable from other houses in the neighborhood. The residence provides short term housing, typically three to four days, after which the individual is assisted in returning to his or her home or family, making maximum use of natural supports. Approximately 40% of the utilization of the Crisis Residence is for homeless individuals who are assisted in locating an appropriate housing resource such as a Shelter Plus Care rental assistance voucher or a shelter bed.

The Erie County Crisis Team is the “gate-keeper” for all admissions to the Crisis Residential Program. When contacted for crisis services, the team conducts an initial assessment to determine the most suitable placement and transports the individual to the residence if appropriate. The Residence staff conducts a more complete assessment upon intake.

The Crisis Residential Program staffing is state regulated. The program has two therapists and four caseworkers, assuring 24/7 coverage. Within 24 hours of intake, staff works with the individual to complete a treatment plan and begin addressing immediate needs. In addition, a nurse practitioner is on-site two days per week and a psychiatrist is on-site one day per week. Because there is frequent turnover of beds, this program is very labor intensive.

While at the Residence, residents participate in two groups per day, focusing on such areas as skill building, assertiveness, and anger management. They are also referred to individual therapy. Because the stay at the Residence is short, it is also important for the individual to develop connections with outside resources during that time.

This program reduces the number of admissions to community and state hospitals and frequently prevents individuals with mental illness from becoming homeless or entering the criminal justice system. Crisis Residential services are reimbursable through Medical Assistance.

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Type of Service: Assertive Community Treatment (ACT)

Definition of the Service:

The goal of Assertive Community Treatment (ACT) is to help people stay out of the hospital and to develop skills for living in the community, so that their mental illness is not the driving force in their lives. Assertive community treatment offers services that are customized to the individual needs of the consumer, delivered by a team of practitioners, and available 24 hours a day. An assertive community treatment team is made up of practitioners who have training and experience in psychiatry, nursing, social work, substance abuse treatment, and employment. Rather than sending people to different agencies or providers for services, members of the team work closely together to provide individuals with a highly integrated array of services that best meet their needs.

Example:

Assertive Community Treatment is recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an Evidenced Based Practice (EBP.) OMHSAS is working with national experts to assist current community teams who want to meet fidelity standards to the ACT model, thereby being recognized as an EBP. To learn more about SAMHSA Evidence Based Practices, go to http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/default.asp.

Type of Service: Community Treatment Team (CTT)

Definition of the Service:

A Community Treatment Team (CTT) is a self-contained program staffed by multi-disciplinary staff who function interchangeably as a team to ensure ongoing individualized treatment, rehabilitation and support services in the community for individuals with severe and persistent mental illness. The Community Treatment Team provides most of these services in the consumer's natural setting to maximize access and ensure clinical benefit. Accordingly, there will be minimal referral of consumers to other program entities for treatment, rehabilitation and support services. Some of the various treatment, rehabilitation and support activities will be assumed by virtue of a staff person's specialty area (e.g. employment, substance abuse, nursing), while other more generic activities can be carried out by most staff (e.g., providing support services).

Example: Dauphin

Dauphin County's Community Treatment Team (CTT) is contracted through Northwestern Human Services and is part of the Edgewater Psychiatric Center. Mobile teams of therapists and counselors monitor and support persons with mental illnesses living in the community, either independently of in a supervised setting, in Dauphin County. The target population for this program includes people with dual problems, including mental health coupled with substance abuse, criminal justice and/or homelessness. This program works

with approximately 100 people, many of whom were discharged from the Harrisburg State Hospital.

Although most services occur in the home, CTT has begun to build a sense of community among consumers through fellowship and Community Support Programs. Basic CTT services include Mobile Case Management, Mobile Psychiatric Services, 24/7 Crisis Management and Intervention, Medication Monitoring, Mobile Therapy, Group Activities, Recovery Groups and Socialization. The team includes the Director, Team Leader, Co-Occurring Therapist, Peer Support Specialist, 2 Psychiatrists, 4 Case Managers, 2 Bilingual Case Managers, an RN Supervisor and 2 LPNs. Dauphin County's CTT services are paid for through Medical Assistance or through the County's base funding.

Dauphin County's CTT has embraced the Recovery Principles. They have been successful in increasing community tenure and decreasing institutionalization (prison, rehabs, inpatients) among the individuals they serve; including many successful transitions from the Harrisburg State Hospital to the community. The most recent outcomes for this program have shown that 97% of the consumers served by the CTT remained out of the psychiatric hospital, D&A rehab, and Prison (1st quarter, 2007).

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Example: Northampton

Northampton's target population served by CTTs are adults, 18 years and older, who have a serious and persistent mental illness, sometimes accompanied by substance abuse issues. This population has used frequent and long-term inpatient care, may be requiring extraordinary amounts of crisis services, and may be at risk of clinical decompensation. Often these individuals have not responded well to more traditional mental health services.

Each CTT team has the ability to connect individuals with other mental health and community resources. They can also assist the consumer with housing, vocational opportunities, and social pursuits. Some of the unique features offered by the ACT/CTT teams are 24-hour crisis intervention, the capacity for daily medication monitoring, and in-home therapy and psychiatric visits if needed.

Northampton County contracts with three different CTT providers; Northwestern Human Services (NHS), Elwyn and Lehigh Valley ACT (LVACT). Each provider offers its own unique approach to CTT services. LVACT specializes in serving individuals with a diagnosis of Borderline Personality Disorder as their staff has been trained in Dialectical Behavioral Therapy. This approach can often be applied to other personality disorders as well. Northwestern Human Services has applied a Psychiatric Rehabilitation approach to their team with all team members being fully trained in the Psychiatric Rehabilitation model. Elwyn offers a more traditional ACT approach. While NHS and LVACT assign consumers

to a particular case manager, Elwyn does not do this with the expectation that each team member knows the individual and has the ability to assist in whatever capacity is needed. Elwyn is the newest and smallest team serving approximately 50 individuals, while LVACT and NHS serve around 120 individuals each.

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Type of Services: Psychiatric Rehabilitation and Mobile Psychiatric Rehabilitation

Definition of the Service:

Psychiatric Rehabilitation is a comprehensive strategy for meeting the needs of individuals with severe and persistent mental illness. The goal of psychiatric rehabilitation is to enable individuals to compensate for, or eliminate the functional deficits, interpersonal barriers, and environmental barriers created by the disability, and to restore the ability for independent living, socialization, and effective life management. Psychiatric Rehabilitation Services are provided to assist individuals to develop, enhance, and/or retain psychiatric stability, social competencies, vocational competencies, educational competencies, and independent living competencies.

Mobile Psychiatric Rehabilitation services are provided to the individual in the community rather than in a medical or site based setting.

Example: Lackawanna County

The purpose of Psychiatric Rehabilitation and Mobile Psychiatric Rehabilitation in Lackawanna County is to teach individuals with serious and persistent mental illness the skills necessary to live more independently. This includes the teaching of interpersonal and social skills such as how to initiate conversations, life skills such as housekeeping, and how to maintain living in the community.

In 2003, Allied Services applied for a challenge grant from the Lackawanna Susquehanna Mental Health/Mental Retardation to participate in a Psychiatric Rehabilitation Pilot Program through Drexel University that was funded by OMHSAS. Allied Services received funding to educate consumers on the Psychiatric Rehabilitation process. The six month program was both site-based and delivered in the community. The pilot program was very successful and consumers asked to have it continued. Therefore, after the pilot program ended, Drexel University continued to provide in-kind time to Allied Services staff for the educational component of the program.

In 2006, because Allied Services did not have additional funding to create a separate Psychiatric Rehabilitation program, they decided to incorporate the Psychiatric Rehabilitation services for individuals into their Community Residential Program (CRR), their Supportive Living Program and their Intensive Supportive Living Program. The program is voluntary. Certified practitioners who have gone through a 12 hour training at Drexel and others in the mental health division who have received certification in Psychiatric Rehabilitation implement the program on a weekly basis or as needed depending on the person to about 20 – 30 people. This on-site program teaches individuals independent living skills, how to remain psychiatrically stable and how to function effectively in the community.

Certified practitioners from Allied Services will provide off site mobile psychiatric rehabilitative supportive living and social skill development in Bradford and Sullivan Counties in their Residential Program.

Allied Services use the Psychiatric Rehabilitation Practitioner Tools developed at the Center for Psychiatric Rehabilitation at Boston University, which includes lesson plans both for practitioners and consumers that are designed to improve consumers' participation in the psychiatric rehabilitation process.

Allied Services has also developed their Psych Rehab program in their residential programs in order to get it up and running with the possibility of getting it funded through HealthChoices.

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Type of Service: Clubhouse

Definition of the Service:

Clubhouse is a specific type of site-based psychiatric rehabilitation program that is an evidence-based practice. It is designed to assist people with mental illness to recover social and vocational functioning and to lead full and satisfying lives that are free of isolation and stigma. Based on the successful model established by Fountain House in New York City in 1948, the unique feature of clubhouses is the focus on work as the primary rehabilitative tool through which members are engaged and recover functioning. Member participation and involvement in all aspects of clubhouse operation, functions, and decision-making is integral to the clubhouse model, as are peer support, education, self-determination, responsibility, and the opportunity to be employed in real work settings.

Example: Bucks County

Wellspring Clubhouse strives to provide people recovering from a mental illness with opportunities to learn skills, such as vocational and social, through a “work-ordered day,” so that they regain self-worth, purpose, and confidence. Established by Penn Foundation in 1994, the program follows the International Clubhouse Standards and is certified by the International Center for Clubhouse Development (ICCD) since 1998. The Clubhouse is funded through program allocations from the Bucks County Office of MH/MR Services, the Montgomery County Office of MH/MR/Substance Abuse Services, and a grant from The Pew Charitable Trusts. Transportation is provided by Bucks & Montgomery County Transport for those members enrolled in HealthChoices, or by the clubhouse van for those in the surrounding five towns.

Wellspring Clubhouse has three work units: the KAM Unit (Kitchen, Agriculture, and Maintenance), the MAP Unit (Membership, Administration, and Publication) and the Employment & Education Unit. The job related activities offered within the Clubhouse vary in skill level, however all work is valued as equally important. Wellspring Director, Lu Mauro, believes that through the work-ordered day, members enjoy the naturalness of creating relationships around work and not problems (such as illness and symptoms). This allows members to create a role for themselves beyond that of patient.

The KAM Unit (Kitchen, Agriculture, and Maintenance) is responsible for preparing the daily lunch, maintaining the grounds and garden, and general maintenance & cleaning of the clubhouse. The MAP Unit (Membership, Administration, and Publication) is responsible for giving tours, greeting visitors, answering the phone, new member procedures, maintaining & monitoring member records, daily/monthly data collection, publishing the newsletter & literary magazine.

The third work unit is the Employment & Education Unit, which is responsible for coordinating five Transitional Employment Placements as well as the Supported, and Independent Employment Programs. This unit works closely with the Office of Vocational Rehabilitation and the Social Security Work Incentive Program. They assist members with many aspects of job readiness, such as, identifying vocational skills and interests, writing a resume, completing employment applications, targeting employers, and practicing for job interviews. This unit also provides tutoring and support services for members interested in furthering their education. Through mini-educational scholarships, members are also taking education courses in the community.

In addition to the employment and educational opportunities, the Wellspring also promotes recovery though health and wellness. Services include meditation, spirituality group, wellness, weight loss and nutrition, smoking cessation sessions and exercise class.

“Our Clubhouse is more of a community than a program, it is a place for people to come and feel comfortable and totally welcome” says Director, Lu Mauro. Wellspring has over 100 active members with an average daily attendance of 25 – 30 members who live in the Upper Bucks County and nearby Montgomery County mental health service areas.

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Type of Service: Mobile Nursing

Definition of the Service:

Mobile nursing is a service provided in the community by a registered nurse who specializes in mental health. The service can include the monitoring and administration of medication, nutrition counseling, weight management and monitoring vital signs. An especially important service can be mobile medication management, a medication monitoring system where medications are delivered to the client in their home on a daily, weekly or monthly basis, based upon individual need. Education is provided with the goal that consumers will acquire the skills to eventually manage their medications independently.

Example: Lancaster County

In efforts to support participants of the Community Hospital Integration Projects Program Service (CHIPP), Lancaster County offers mobile nursing. By providing in-home services, staff has the opportunity to work with consumers in a location that is comfortable and removes barriers such as access to services. Lancaster County provides services to 80 CHIPP participants through six nurses (5FT, 1PT). The county funds this program through CHIPP funds.

In Lancaster County the mobile nurses are Registered Nurses (RN) who specialize in mental health, including symptoms, medications and possible side effects. They also provide nutrition counseling, weight management and monitor vital signs. Each nurse has a caseload of 20-25 consumers. Although most visits occur through appointment, the mobile nurse program is available 24 hours per day. The goal of the mobile nurse program is to support the medication and health needs of people in recovery and to help them remain out of the hospital.

Lancaster County has evaluated the success of this program by the number of hospital visits by consumers each year. Individuals in the program were evaluated during the 2002-2003 fiscal year and again in 2005-2006. In 2002-03, a group of program participants who left the hospital in 1997 each averaged 14.25 days per year in the hospital. By 2005/06, those same consumers were averaging 2.05 days in the hospital per year. The second round of participants, who left the hospital in 1999, have also experienced less hospitalization time. In 2002-03, the average number of hospitalization days per year for each consumer was 53.85, by 2005-06 the average fell to 1.75. Similar trends have been recorded for more recent participants.

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Type of Service: Mobile Medication Management

Definition of the Service:

A medication monitoring system is based upon individual need such that medications are delivered to the client in their home on a daily, weekly or monthly basis. The goal is for clients to acquire the skills during this education process to eventually manage their medications in their own homes effectively. Services are designed to ensure that an individual takes his/her medication as needed, and manages his/her medication.

Example: Berks County

One of the programs offered through the Berks County Supported Living Services (SLS), which is funded by the County Office of Mental Health/Mental Retardation, is Mobile Medication Management. The purpose of this program is to promote independence in the community by helping individuals learn how to manage their medication. The program serves the mental health population who are receiving case management services. The two providers that implement the program are Supportive Concepts for Families and Threshold Rehabilitative Services.

The consumer chooses where to receive the services, which can include monitoring the medication taken, getting prescriptions filled, accompanying the consumer to the doctor or pharmacy and/or visiting the consumer as needed (sometimes twice a day) to deliver medication and insure there is no confusion about which medication and dosage is taken. Most consumers choose to have the staff come to their home. All of the visits have been face to face.

Approximately 150 consumers are participating in the SLS program, and medication monitoring is the most common service. On average, a consumer receives 2 to three visits per week. The goal is for consumers to become more independent and monitor their medications on their own.

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Type of Service: Case Management

Definition of the Service:

Case management services are designed to assist targeted adults with serious and persistent mental illness and targeted children with a serious mental illness or emotional disorder and their families to gain access to needed resources such as medical, social, educational and other services. There are three types of case management services that vary in intensity and frequency of face-to-face contact: Intensive Case Management, Targeted Case Management and Resource Coordination.

Intensive Case Management

Example: Somerset County

The purpose of Intensive Case Management in Somerset County is to provide services to individuals with a mental health diagnosis or treatment history in the least restrictive environment. These services, offered to consumers in the community and/or their home, include helping them obtain psychiatric and mental health treatment. The Intensive Case Manager (ICM) also provides assistance to the consumer with doctor appointments, remembering to take medication and becoming educated about medication. The ICM also helps the consumer establish a connection with the community.

Referrals for Intensive Case Management come through the County Base Service Unit, from medical providers, clinical and hospitals settings, etc. The goal is to keep the consumer out of the hospital and in the community. Currently there are six Intensive Case Managers who are serving approximately 95 consumers. The state requires that a consumer is seen once every two weeks, but usually case managers visit on average once a week, depending on the needs of the consumer.

Medical Assistance dollars are used to fund the program with additional state and county matching funds. However, it is not necessary to have medical assistance insurance in order to receive Intensive Case Management Services.

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Targeted Case Management

Example: Westmoreland County

The Westmoreland Case Management and Supports, Inc. (WCSI) Mental Health Department Targeted Case Management (TCM) model was part of the core group of pilot programs to test this model in Pennsylvania and is now offered throughout the state as the "new face" of mental health case management.

TCM is a licensed, regulated service with certain eligibility criteria, but all programs are flexible and meant to serve the individual needs of the client. All levels of case management provide services that include but are not limited to the following: identifying and accessing resources; providing crisis intervention/prevention; maintaining contact with providers/clients; community outreach and education; advocacy; and overall system navigation (DPW, SSI, SSDI, etc.).

TCM blends two case management models - the more concentrated Intensive Case Management (ICM), and the more baseline Resource Coordination (RC) - into one unique client focused model, allowing the clients to remain with the same case manager as their needs increase or decrease. This model has been shown to increase continuity of care and satisfaction with services.

The MH Department is a member of the Value Behavioral Health (VBH) Network for ICM/RC and Intake services provided to Westmoreland and surrounding western region residents. Additionally, the Department is a member of the Community Care Behavioral Health Network (CCBH), enabling WCSI to bill for services provided to Allegheny County clients wishing to exercise their right to choose their case management provider as outlined in HealthChoices, the Pennsylvania Department of Welfare (DPW) managed care plan. The MH Department also receives county funding for many services.

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Resource Coordination

Example: Clarion County

The purpose of the Resource Coordination program in Clarion County is to help individuals live in the community as independently as possible. The program serves children and adolescents with a mental health diagnosis or who are at risk of a mental health diagnosis and adults with a mental health diagnosis who have gone through the intake process through the County Base Service Unit.

There are two resource coordinators (RC) who serve approximately 35 adults and 20 youth. The program is highly individualized and the RCs assist consumers in developing goals based on their strengths and needs. The services and supports provided by the RC are less intense than those provided by the intensive case manager. The RC focuses on everything involved with independent living with the goal of "working themselves out of a job". RCs help consumers look for housing, tour apartments, and make sure that all of the consumer's needs are being met through a recovery oriented approach. RCs help consumers to develop their financial, vocational, medical, mental health, education, leisure, recreation and social skills. This may include meeting with the consumer to make sure he or she is paying bills or has a representative payee, taking medications on time, getting to doctor and counseling appointments, etc. There is county transportation available to take consumers to doctor and therapy appointments. In addition, consumers are linked to the Drop-In Center.

RCs are required to have face to face visits with consumers every other month and telephone contact on the alternative month. However, RCs may meet more frequently with consumers based on their individual needs. Because Clarion is a small, rural county, everyone knows everyone and the counselors and RCs work closely together to support the consumers and make sure that all of their needs are addressed.

Resource Coordination services are billable to medical assistance, which goes through the Community Care Behavioral Health company. If individuals do not have medical assistance, they are still served and the funding comes from the Base Funds from the State.

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Type of Service: Peer Support Services

Definition of the Service:

Peer Support Services are specialized therapeutic interactions conducted by trained professionals who are self-identified current or former consumers of behavioral health services. On an ongoing basis, individuals receiving the service are given the opportunity to participate in and make decisions about the activities conducted. Services are self-directed and person-centered with a recovery focus. Peer support services facilitate the development of recovery skills. Specific service goals are based on individual needs and personal aspirations which may be in the areas of: wellness and recovery, education/employment, crisis support, housing, social networking, self determination and individual advocacy. Services are multi-faceted and include, but are not limited to, individual advocacy, crisis management support, and skills training. The Pennsylvania Medicaid State Plan has been amended to allow Peer Support Services to be paid through Medicaid funds.

Example: Montgomery County

Using Reinvestment Funds, Montgomery County MH/MR/D&A/ Behavioral Health began its Peer Specialist initiative in June 2004. The initial 13 FTE positions have grown to 16 FTEs with placements at provider agencies throughout the county. Since then, providers have received funding from the Pew Charitable Trusts for additional employment opportunities for Peer Specialists.

The County worked with the Mental Health Association of Southeastern PA to develop a 75 hour Certification Training for Peer Specialists. They conducted 6 training sessions over the past 2 years, training approximately 100 individuals as Certified Peer Specialists and are currently part of a national effort to establish credentials for Peer Specialists.

The philosophy behind this initiative is for mental health consumers to be able to find peer support through any door they walk in, especially the front door. The Peer Specialists provide models of hope and recovery for people who experience mental illness. Peer Specialists work at the places where people go for treatment. They also provide mobile services, helping people to get out into the community and take advantage of social, cultural, educational, and employment opportunities. Further, a Peer Specialist participates on all ACT Teams, and this function has been written into standards for the ACT program in Montgomery County.

Along with the support and advocacy provided by the Peer Specialists, there are numerous other advantages to this program. It provides employment opportunities for individuals with mental illness and is a mechanism for them to continue to advance in their own recovery. In addition, other employees at provider agencies who work alongside a Peer Specialist receive first-hand knowledge about the concept of recovery and witness the ability of people with mental illness to move forward with their lives.

The Peer Specialists, as key service providers in the County's mental health system, have professional development meetings and receive technical assistance and on-going training from the Mental Health Association. In addition, there are bi-monthly meetings for supervisors at participating agencies to help them understand the role of Peer Specialists and to integrate them into their agencies' service program.

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Type of Service: Social Rehabilitation

Definition of the Service:

Social rehabilitation includes programs or activities designed to teach or improve self-care personal behavior and social adjustment for persons with a mental disability who are age 21 and over. Activities are intended to make community or independent living possible by increasing the person's level of social competency and by decreasing the need for structured supervision.

Example: Erie County Center for Arts and Humanity

The arts community is a natural setting for people on the road to recovery. It both accepts and celebrates differences. In 2005, Stairways Behavioral Health opened its Center for Arts and Humanity in which professional artists-in-residence provide instruction on various art forms including sculpture, painting, writing, music and jewelry making. Instruction includes the basics of the art form, safety issues, and how to use art to visualize recovery. The message is always one of positive reinforcement.

The program operates under an open-door policy and is available to all who want to participate. It was approved by the County as a site-based psychiatric rehabilitation program and is therefore a billable service for individuals who receive services through the county mental health system.

The Center provides a setting for people in recovery to spend time with others who share their enjoyment of art, and creating a quality of life to which many have never been exposed before. It also provides an opportunity for the participants to take control of their lives, as they are in control of their art work. Through this experience consumers develop the confidence to enter other social settings more comfortably.

The Center also operates a gallery in which participants' work is sold. The proceeds of the sale are shared with the participants, providing yet another source of self-esteem---from both the experience of having their work valued by others and by generating a source of income.

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Type of Service: Drop-in Center

Definition of the Service:

A drop-in center is a social club offering peer support, a flexible schedule of activities. It may operate on evenings and/ weekends. Many centers are run by and for their members, and provide an accepting, caring, non-clinical atmosphere where the participants feel they belong. Drop-ins help consumers take responsibility for their own mental health through self-help, and provide support in times of crisis and social isolation allowing consumers to improve social skills and develop and maintain healthy relationships.

Example: Bradford County

The Main Link has two sites in Bradford County located about 20 miles apart. The first center was opened in 1995 as a consumer-run drop-in center open only in the evenings. Since then it has evolved into a consumer-run agency that provides quality assurance services and peer support services and is the home of the Bradford & Sullivan County Community Support Program (CSP). The second center opened in 2004 using Human Service Development Funds. Both centers offer drop-in during the day and some evenings. Their membership base has grown to over 200 members. All programs are consumer driven and consumer run.

In addition to drop-in, the Main Link's two locations also offer a daily meal prepared by members, an Art Studio, WRAP classes, wellness classes, a nutrition group, spontaneous socialization, computer classes and internet access, self-help and support groups, CSP and advocacy meetings, and recreational opportunities in the community. The Main Link recently added a weekly youth drop-in at each location for teens ages 13-17.

The Main Link is well known for its art program, which features a studio that is open two days per week in each location. Many people have developed their artistic ability through this program, while others attend for the socialization. Members can show and sell their work in either of the center's galleries.

Members volunteer as "hosts", who open and close the center on a rotating basis. Their duties include welcoming new members, making coffee, collecting money for beverages, making sure the center is clean and locked at the end of the night, and troubleshooting any situations that may arise.

The Bradford County Office of Mental Health contracts with the Main Link to provide recovery-oriented consumer-run services. Members of the center operate a toll-free warm line daily from 4-9 pm for people to call when they are lonely or need a peer to talk to. Members also provide callers with information about local resources. The Main Link's peer support teams also provide outreach to consumers incarcerated in the county correctional facility, older adults in proprietary care, and Bradford & Sullivan County residents in the state hospital. The income generated through these members' services now covers 95% of the cost of the center. The remaining costs are covered by income/grants from the Art Studio.

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Case Study: Bradford County

Since 1997, Bradford County's Office of Mental Health has been developing a recovery-oriented mental health system that features community-based housing options and flexible services. The goal is to enhance the quality of life of consumers with chronic and persistent mental illness through facilitating their tenure in the community and enabling them to secure residences of their choice. With the assistance of staff, peers and other supports, consumers live in individual and shared apartments.

Many of these services are funded with Bradford County CHIPP (Community Hospital Integration Program Project) dollars, which the County has been receiving since 2002. Although those funds were initially allocated to support *eight (8)* individuals moving from the state hospital to the community, the County is currently supporting a total of *seventy-four* (74) individuals with those dollars. The funds are used for mobile nursing and medical support, housing supports, supportive living, transportation, peer support and mentoring. In addition, Bradford County Mental Health's CHIPP supports individuals in Family Living Arrangements and provides assistance and education to both consumers and staff of Personal Care Boarding and Domiciliary Care Homes.

<u>An Innovative Initiative</u>

Recently, with the assistance of the Pennsylvania Office of Mental Health and Substance Abuse Services, the Bradford County Department of Mental Health acquired a two-family home at 12 Mix Avenue in Towanda Borough, the County seat. The property had previously been owned by the Bradford County Housing Authority and used as a group home for up to twelve individuals. It was operated by a local provider agency and was supervised 24 hours a day, 7 days per week.

When the Housing Authority offered the property to the County Office of Mental Health, they took the opportunity to reevaluate the property's use and to consider alternatives. Working closely with members of the local drop-in center, the Main Link, they determined that the best use would be for transitional housing for up to six people. Target populations include individuals leaving the state hospital, those moving from their family homes into the community, and others who need a limited time to learn independent living skills in a supportive environment. The program is coordinated and operated by the Main Link, which has been certified as a provider agency. There is no live in staff since residents rely on peer support.

As transitional housing, an important component of the program is the successful transition to affordable permanent housing. It is therefore critical that viable housing choices be available. As such the County has worked hard to develop working relationships with local landlords who can serve as on-going resources for permanent rental housing for people moving from Mix Avenue. It is also recognized, however, that most individuals will have SSI as their primary source of income and will not be able to afford private market housing. They will require rental assistance through Section 8/Housing Choice Vouchers, public housing, Section 811 or other subsidized housing programs. The County Office of Mental Health works closely with the Housing Authority to ensure that all residents sign up for the Section 8/Housing Choice Voucher Program waiting list upon entry to the transitional housing program.

In addition, the County has requested that the Housing Authority amend its Administrative Plan to ensure a preference in its voucher program to people with disabilities, thus potentially reducing their time on the waiting list.

However, even with a voucher preference, it may still take applicants two or three years to reach the top of the list. Therefore the County Department of Mental Health has initiated a Bridge Subsidy Program to fill the gap between the time an individual is ready to leave the transitional housing program and the time his/her name reaches the top of the Section 8 waiting list. The County has allocated $22,500 of their fiscal year 2005-2006 CHIPP allocation for Bridge Subsidies for individuals who have been diagnosed with and in treatment for a chronic mental illness with priority for individuals leaving Mix Avenue. An additional $7,500 will be made available to pay for the costs of establishing a household, such as for security deposits, utility hook-ups and household supplies, as well as for emergencies such as fuel assistance. The County CHIPP Coordinator coordinates the program.

Bradford County has clearly taken the lead in expanding housing options and flexible services for its consumers. By utilizing mainstream housing resources, they have been able to use resources available through both CHIPP and base service funding to maximize community-based services to support consumers in securing and maintaining the housing of their choice.

Case Study: Erie County

Erie County executed a Community Hospital Integration Program Project in the mid 1990's to return people back to their home community from the state hospital. Individual client assessments occurred to include an individual housing plan for each consumer. Based upon these needs assessments, plans were made to develop multiple levels of community based housing. This activity was the inception of a housing continuum in Erie for persons with serious mental illness. This early planning also laid the foundation for our current mental health service delivery continuum. Several decisions were made at that time that ultimately made a critical difference in the level of housing and support services that exist today in Erie County. These early decisions include the use of housing funding resources for the production of housing for persons with mental illness; separation of landlord and service provider and the development of adequate housing support services to successfully support consumers in housing of their choice.

Grant applications were made to housing funders to include Federal Home Loan Bank, Department of Community Affairs now known as DCED and to HUD. As a result, Erie County was able to maximize its use of mental health funding to develop a wide range of services to include a consumer run drop-in center, representative payees, mobile crisis

supports and multiple providers of housing support services to ensure client choice. Key traditional supports such as case management and out patient psychiatric services were integrated into the service delivery continuum. Data collected revealed that for every person coming out of the state hospital, three people could be served in the mental health system in Erie County, thereby significantly increasing our service capacity. As a result, Erie County has created a service-rich environment for its mental health consumers that supports a range of supportive housing options.

Concurrently, the Erie County mental health office listened to the voices of its consumers and families. Consumers expressed concern about losing their housing if they made a choice to decline to participate in service. As a result all supportive housing projects that were developed in Erie County were structured with two primary entities; a housing provider and a lead service provider. Our housing partners include a local not for profit developer, Housing and Neighborhood Development Services, the Housing Authority of the City of Erie and the Redevelopment Authority of the City of Erie. Finally, in order to insure success for the consumer and for the development of future housing projects, it was agreed by all stakeholders that no housing projects for persons with mental illness would be pursued or developed without the provision of adequate support services.

The latest evolution in housing and support services in Erie County is the development of the Fairweather Lodge program. This model is considered as an evidenced based practice for recovery. The model is consumer run and addresses the two most important needs of consumers; housing and employment. To date, 5 lodges are operational in Erie with another 6 lodges being planned for development over the next several years.

As evidenced by these practices, the mental health system in Erie County has operated for many years in a manner that is value driven. This clear understanding of roles and responsibilities has lead to the continued development of 20+ supportive housing projects serving 200 + persons with mental health care needs. Some of these projects have received national awards from HUD and the National Association of Housing and Redevelopment Officials.

FACES OF RECOVERY: Glenn M.…

My story of recovery is different and not one I would recommend to everyone. When I was 19 years old I was diagnosed with a mental illness. I have been in and out of the state hospital about 20 times, I was in jail a couple of times, and at one point I was told that I might spend the rest of my life in the hospital, in jail or end up dead. After my last hospitalization, which lasted four years, I was hooked up with a doctor through the Dickinson Mental Health Center and he prescribed me the medication Clozaril. I was then provided with a case manager who helped me monitor my medication and adjust into the community. The medication really turned my life around. I spent one year in a group home and was then able to move into my own apartment. What makes my recovery unique is that I was able to do it on my own BUT I am a huge proponent of recovery-oriented services. My recovery really happened by attending meetings about recovery such as the Drop-In Center Conference and the Pennsylvania Mental Health Consumer Conference. I learned that recovery is a personal journey towards wellness, we don't have to live by our diagnosis, we are people *with* a diagnosis. I now provide recovery-oriented services. I run a Drop-In Center, I am a trained Peer to Peer Specialist, I am on the local county mental health advisory board, I participate in the Consumer Family Satisfaction Team, I teach other consumers about recovery and I work every day with others who provide recovery-oriented services. I have participated in panels and work groups with the Consumer Support Program and helped other consumers become integrated back into the community. I helped to get a grant and did fundraising to start a Drop-In Center located in a small apartment. Since then, the Dickinson Mental Health Center took it over and moved it to a much better space. I work there part time and we also have a full time Unit Coordinator. She, in addition to the doctor who prescribed the proper medication for me, have encouraged and supported me in my recovery. I also volunteer quite a bit to help others with their recovery at the Drop-In Center, where we provide living and socialization skills, encouragement, empowerment and education. As I said, I really did my recovery on my own, which is not easy, and I now help provide support

services to others. I live independently, and it is 14 years since I have been sober and in a hospital. I teach recovery and want others to know that recovery is very possible, it is the greatest thing to shoot for. Recovery means your independence and life.

Preparing for Change

By now you are probably thinking "This is all very interesting, but what are the specific steps I can take in my county to work towards transforming our mental health system into one that supports housing choice and is truly recovery-oriented?"

You know that unmet housing and support needs in your county are great, but you also know that the resources at your disposal are extremely limited. There are few new mental health dollars available for housing or supports other than the CHIPP dollars for people leaving state hospitals. While some counties have Health Choices reinvestment dollars that can be used for housing and supports, many others do not.

It is critical that you maximize the use of existing resources and that you pursue every opportunity to generate new resources. If necessary and desirable, this may mean shifting dollars from more expensive to less expensive programs that have demonstrated results commensurate to or more effective than some of the more expensive services in place today as described below. It may also mean forging or expanding relationships with agencies and individuals in the affordable housing industry. Generating new resources may also mean working closely with your local housing authority and housing and community development department as well as state agencies such as the Pennsylvania Housing Finance Agency and the Department of Community and Economic Development that have targeted programs for people with disabilities.

In short, you and your local partners must figure out how to use your limited mental health dollars to leverage these new housing dollars. The challenge is to use generic or mainstream housing dollars to the maximum extent possible so that you can maximize the use of mental health dollars for the types of supports described in this report.

There are two critical actions your county must take to ensure success in expanding housing and support options and to take advantage of new housing resources being made available through state agencies:

1- LHOT- You need to either continue working closely with your Local Housing Options Team (LHOT) or you need to form one. If your county does not have an LHOT or other housing coalition that focuses on housing for people with serious mental illness and co-occurring disorders, technical assistance is available from OMHSAS to establish one. A Question and Answer Sheet that defines and describes an LHOT is found in Appendix B.

2- Housing Staff- Every county should designate at least one staff person to serve as housing specialist with responsibility for housing and supportive services for persons with serious mental illness and co-occurring disorders. The housing specialist can be someone within the mental health system who has specific responsibility for housing, an individual from a county housing agency, or an individual from a private nonprofit housing entity with this role. A housing specialist is critical not only because this person increases the county's capacity to expand housing options, but also because this position will likely be required in order to

qualify for new state housing resources for people with serious mental illness and co-occurring disorders.

Technical Assistance

Finally, there are a number of strategies that you can use to address housing and recovery oriented services in your county. The formulation of a housing strategy is part of a more comprehensive housing assessment and planning process that each county should undertake. If you need assistance in forming an LHOT, hiring housing staff, conducting a housing needs assessment, undertaking a planning process or initiating a specific housing program/project, technical assistance is available from OMHSAS. Please contact John Ames OMHSAS at 717-705-9510 to request assistance.

Appendices

A- Principles

B- Questions and Answers on Local Housing Option Teams

Appendix A

PRINCIPLES

A Call for Change: Toward a Recovery-Oriented Mental Health Service System contains ten fundamental elements and guiding principles of mental health recovery. The Housing Work Group has applied these principles to recovery–oriented housing as follows:

Principle 1- Self-Direction

Practice- Consumers exercise choice in determining where they want to live. There is agreement among all stakeholders that consumers have a right to live in the housing of their choice. Consumers are educated about the housing options/choices available and the means to access housing and supports. Tenant based housing is available that is independent of MH services (i.e. not contingent on service compliance is the primary housing option or goal with flexible mobile staffing supports available to support individuals in housing as needed.)

Outcome- Consumers are satisfied with their current living situation.

Principle 2- Individualized and Person-Centered

Practice- Consumers express their needs for supportive services. There are a range of affordable and accessible housing and support options available that can meet individual needs and preferences.

Outcome- Consumers plan for housing and services with appropriate support service providers.

Principle 3- Empowerment

Practice- Consumers are involved in all decision making regarding their housing and support services. Consumers receive assistance and training on assessing options and determining personal preferences, strengths and needs related to housing including the full range of issues and concerns that all individuals must consider in deciding where they will live, (e.g. location, household composition, finances, safety, access to transportation and resources, skills and supports needed).

Outcome- Consumers obtain control of their housing choices.

Principle 4- Holistic

Practice- Consumers have access to a wide range of supportive services beyond traditional mental health services. Consumers interact with all as individuals, not a diagnosis. Housing supports to individuals include assisting individuals to build competencies, enhancing their interpersonal capabilities and developing personal support systems that enable them to be successfully housed, and to live satisfying, meaningful lives.

Outcome- Consumers live in housing of their choice, and are effectively involved with supportive services that relate to physical health, dental health, employment, social and spiritual needs.

Principle 5- Non-Linear

Practice- Consumers will choose from a range of available housing options, which can be entered at any point on the recovery continuum. It is not expected that consumers must move through each step of a continuum to obtain permanent housing (e.g. shelter housing to CRRS or transitional housing to permanent housing). Supports to consumers are flexible and can be adjusted to meet the needs as they change. Consumers do not have to move to another housing option simply because their needs change, rather supports are moved in and out of the person's life as needed. Mainstream natural supports are to be utilized whenever possible.

Outcome- Each consumer's recovery journey is unique. Housing and support practices will be flexible to reflect changes in needs and desires of the individual during the journey.

Principle 6- Strengths Based

Practice- Housing choices and supports reflect and build upon consumer strengths rather than deficits. Consumers will focus on building and enhancing their strengths through developing and achieving housing goals and planning to utilize effective services which support housing choices.

Outcome- Consumers thrive and grow in their living, working and learning and participate fully in their community.

Principle 7- Peer Support

Practice- Consumers will have access to self-help, peer support and consumer operated services. Peer supports are available to consumers in all housing options.

Outcome- Consumers are able to provide support to each other resulting in secure and stable housing and mental wellness.

Principle 8- Respect

Practice- The consumer is validated as a person. Those who help or support the journey of consumers will respect diverse cultural backgrounds, ethnicity, sexual orientation and personal life experiences. Housing options reflect respect and dignity for the individual including safe, healthy environments free of stigma and discrimination. Housing options are integrated and compatible with the neighborhoods/communities where they are located.

Outcome- Consumers experience improved self-esteem.

Principle 9- Responsibility

Practice- Consumers are strongly supported in their life decisions. Supports are available to assist individuals to build competencies that will enable them to successfully assume responsibility for choices even when professionals do not agree with the choice. Consumers are educated about the responsibilities associated with options and choices and the potential risks, rewards and consequences; however, consumers have the right to make bad decisions, from which they can learn and grow.

Outcome- Consumers accept responsibility for their life decisions.

Principle 10- Hope

Practice- Consumers will always be met with a positive attitude by helpers and supporters. Supporters, teachers, professional staff and friends will demonstrate their belief that individuals with MH disabilities can succeed in the housing of their choice. The options, supports, and practices reflect this belief. Individuals are not limited to housing options based on their illness, but rather are supported in living the life they choose.

Outcome- Consumers have a positive attitude about their life and have hope for continued recovery.

Appendix B

QUESTIONS AND ANSWERS ABOUT LOCAL HOUSING OPTION TEAMS (LHOTS)

1. What is an LHOT (pronounced L-HOT)?

An LHOT is a Local Housing Option Team (LHOT). LHOTs, which are forming throughout the Commonwealth of Pennsylvania, are composed of agencies and individuals that are coming together on the county or multi-county level to expand housing opportunities and to seek long term solutions to the housing needs of people with disabilities.

2. Who are the members of or participants in an LHOT?

All agencies and individuals who are key stakeholders in the disability, housing and human service industries participate in the LHOT. Although the specific members vary with the community or communities it serves, following are participating agencies:

County mental health/mental retardation departments
Service providers
Housing authorities
Housing providers
Disability organizations
County housing/community/economic/business development
County office of human services
County children and youth services
Community action agencies
County aging and adult services
County assistance office/DPW
Housing developers
PATH program
U.S Department of Housing and Urban Development
County drug and alcohol programs
CASSP/Cross Systems
Consumer Satisfaction Team
Redevelopment authorities
Lenders
Foundations
Health Center/Behavioral Health Services
Employment and training agencies

Fair housing councils
County adult probation and parole
County prison
County government
County planning
CSP
CHIPP Coordinator
Housing Assistance Program
Builder
Realtor
Consultant
United Way
Hispanic American Program
Legal services
County Development Corporation
USDA Rural Development
Veterans Administration

3. Are there any specific groups or individuals that are critical to the success of an LHOT?

Yes. Since local housing authorities have direct access to many federal housing resources, it is critical that they be active participants in the LHOTs.

4. What is the purpose of an LHOT?

Although the specific mission, goal and priorities of the LHOT vary with the county or counties involved, the major purpose of an LHOT is to bring together the key stakeholders in the community to identify the housing needs of people with disabilities and to take action to meet those needs.

5. In what kinds of activities are LHOTs generally involved?

LHOTs engage in a wide range of activities including the following:

- Networking among local agencies
- Educating other members and sharing information
- Troubleshooting/problem solving (using individual case studies)
- Conducting needs assessments
- Developing housing strategies
- Creating partnerships to address problems

- Planning and financing specific housing programs or projects

6. What is the defining characteristic of an LHOT?

Each LHOT is unique. Its composition varies with the key stakeholders in the community that are concerned with housing and disability issues. The LHOT also addresses the unique needs and takes advantage of the unique resources of each community it serves.

7. Who is responsible for convening or facilitating the LHOT?

Any local agency that is willing to dedicate time and administrative support to the LHOT may play these roles. In many of the LHOT's these roles are assumed by the county mental health housing specialist from the county department of mental health/mental retardation.

8. How often does an LHOT meet?

Although this is up to each LHOT, most meet monthly as a full group. A number of the LHOTs also have committees that meet periodically to accomplish specific tasks or projects.

9. Who sets the LHOT agenda and priorities?

The members of each LHOT determine its agenda and priorities for action. A high priority local need that requires immediate action is often identified early on. Progress on a high priority community need keeps members engaged and actively involved in the work of the LHOT.

10. Which counties in Pennsylvania have active LHOTs?

There are currently 30 LHOTs that cover 39 of the Commonwealth's 67 counties.

11. What are examples of specific accomplishments of an LHOT? LHOTs have:

- Completed Quantitative Housing Needs Assessments of People with Disabilities (Dauphin, Franklin, Northwest)
- Conducted Focus Groups on Needs Identification (Dauphin, Monroe)
- Successfully Applied for and/or Operate Shelter Plus Care Programs for Homeless Persons with Disabilities (Dauphin, Delaware, Monroe, and Northwest Consortium)
- Successfully Applied for Supportive Housing Program Funds for Transitional and Permanent Housing and Case Management Services for Homeless People with Disabilities (Dauphin, Monroe Montgomery, Northwest)
- Instituted Local Housing Authority Set-Asides (Bucks, Dauphin, Delaware, Monroe)
- Designated Preferences for Homeless and People with Disabilities in the Housing Authority Housing Voucher Programs (Montgomery, Lebanon)
- Collaborated with Local Housing Authorities to Apply for the HUD Section 8 Mainstream Program (Monroe, Delaware)
- Successfully Applied for HUD Section 811 Program (Northwest)
- Conducted Educational Forums on Fair Housing, Home Modification and Section 8 Programs (Delaware)
- Obtained Funding for LHOT Staff/Coordination (Dauphin, Montgomery, Delaware)
- Initiated Landlord Outreach Programs (Dauphin, Delaware, Montgomery)
- Developed a Pilot Project to Identify Specific Housing Options for Individuals with Disabilities and to Test and Inform the County Service System (Montgomery)
- Assisted in the Development of a Housing Cooperative for People with Mental Illness (Montgomery)

12. Is technical assistance available to form, facilitate, or advise an LHOT?

Yes. The Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) offers technical assistance through its staff and through a private consultant that specializes in planning and developing housing for people with disabilities. Technical assistance is offered in the following areas:

- Determining whether the LHOT should be established as a new entity or as part of an existing entity
- Identifying the necessary organizations and individuals to participate in the LHOT
- Mentoring the LHOT convener on how to facilitate a group with differing perspectives
- Ensuring that the key members are active participants in the LHOT
- Developing a mission statement
- Formulating and reviewing goals, objectives, and action steps
- Planning and conducting a needs assessment including:
  - Conducting a focus group
  - Developing and editing questionnaires
  - Reviewing and analyzing survey results
- Formulating housing strategies that utilize local strengths and resources and bypass major obstacles
- Identifying priorities for action
- Presenting viable available resources and the best time to start planning and/or applying
- Providing information on the pros and cons on the use of specific approaches and/or resources
- Identifying specific housing programs and projects to be developed
- Sharing examples of activities occurring in other LHOT's and providing sample documents
- Facilitating the group process, especially during the initial meetings before the group "gels"

13. Are there any requirements for groups seeking technical assistance?

Yes. In order to receive free technical assistance through OMHSAS, the county office of mental health must make a written request for assistance and must agree to play an active role in the LHOT. In addition, the LHOT must prioritize the housing needs of people with mental illness, especially through the use of the recovery model.

14. Who should we contact about receiving technical assistance?

Contact John Ames, PA Office of Mental Health and Substance Abuse Services at 717-705-9510.