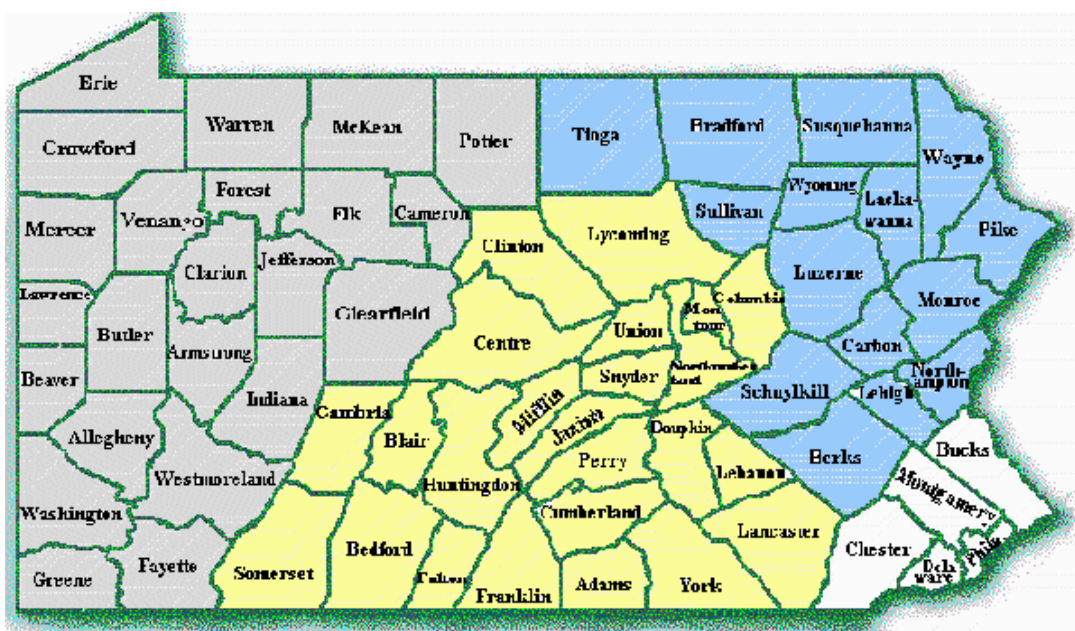


# Guidelines

## County Mental Health Plan For Adults, Older Adults and Transition-Age Youth with Serious Mental Illness and Co-occurring Disorders



**FISCAL YEARS 2009-2012  
(2009/2010, 2010/2011, 2011/2012)**

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

September, 2007

# COUNTY MENTAL HEALTH PLAN

## GUIDELINES FOR FISCAL YEARS 2009-2012

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**COUNTY MENTAL HEALTH  
PLAN**

**Fiscal Years 2009-2012**

**GENERAL INFORMATION**

**Office of Mental Health and Substance Abuse Services Vision, Guiding Principles, and Goals**

**Vision 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 members and friends.**

**Guiding Principles**

The Mental Health and Substance Abuse Service System will provide quality services and supports that:

- Facilitate recovery for adults and resiliency for children;
- Are responsive to an individual's unique strengths and needs throughout their lives;
- Focus on prevention and early intervention;
- Recognize, respect and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity and sexual orientation;
- Ensure individual human rights and eliminate discrimination and stigma;
- Are provided in a comprehensive array by unifying programs and funding that build on natural and community supports unique to each individual and family;
- Are developed, monitored and evaluated in partnership with consumers, families and advocates, and
- Represent collaboration with other agencies and service systems.

**OMHSAS Goals**

- Treatment, services and supports are provided where, how and when needed.
- A qualified and competent workforce is recruited and retained.
- Funding will support the OMHSAS Vision.
- Services and supports will be monitored, evaluated and managed for quality outcomes.

## **I. Background to the Plan Guidelines**

The Mental Health County Plan Guidelines for FY 2009-2012 establish a newly designed and streamlined planning process built upon a three year planning cycle. During 2007, OMHSAS convened a broad-based stakeholder committee to again redesign the county mental health planning process. This redesign was based upon feedback received from counties and other stakeholders that the county mental health planning process needed to be streamlined to focus on a few targeted priorities relevant to each county. These newly revised county plan guidelines are for a three year planning cycle - Fiscal Years 2009-2010, 2010-2011, and 2011-2012. Counties will be required to submit a full three year plan the first year, with updates in the following two years. The focus of the guidelines has also changed to highlight county driven needs. Each county will identify 3-5 systems change efforts around which the plan will be developed. Most of the state-level requirements for data and tables have also been eliminated. On occasion, requests by the Commonwealth for ad-hoc reports may occur.

The county mental health plan will continue to focus on adults, older adults and transition-age youth (18-26) with serious mental illness, including individuals with co-occurring substance use disorders, served by both the county based system and HealthChoices managed care delivery system. Individuals with co-occurring substance use disorders, who represent a large percentage of persons with serious mental illness, should be a focus of planning. Planning for children is to be included in the Integrated Children's Service Plan.

The plan should describe the status of, plans for, and any modifications to the county's efforts to enable adults, older adults and transition-age individuals with serious mental illness, including individuals with co-occurring substance use disorders, to "live, work, learn, and participate fully in their communities" as described in the President's New Freedom Commission on Mental Health Report released in July of 2003 titled *Achieving the Promise: Transforming Mental Health Care in America*. The report suggests that transformation can occur by designing treatment and services that are person and family centered that focus on increasing the person's ability to successfully cope with life's challenges, facilitating recovery, and building resilience.

The legal purpose of the annual plan is to meet the requirement in the MH/MR Act of 1966 to review and approve an "annual plan and estimated costs" by local authorities and to transmit that plan to the Department of Public Welfare.

## **II. General Expectations**

In order to complete the Mental Health Plan the county should:

1. Engage the target planning populations: adults, older adults and transition-age youth with serious mental illness, including individuals with co-occurring substance use disorders and individuals that reflect the cultural makeup of the county. Other stakeholders should include family members, providers, behavioral health managed care representatives, and cross-systems partners. Stakeholders should be included in the development of the county plan, monitoring of community treatment programs, services and supports, and in providing ongoing input into the county's system for recovery-focused services.

2. Work with their counterparts in mental retardation, drug and alcohol, county probation, state and county corrections, aging, housing, vocational rehabilitation, and representatives of the behavioral health managed care organization, etc., to develop a plan for services that integrates federal, state and county funding sources to make the most effective use of public funds.
3. Describe the strategy to continue to shift the mental health service delivery system away from reliance on large institutions and towards an array of community services and supports to address the needs of adults, older adults and transition-age individuals with serious mental illness and co-occurring substance use disorders.

### **III. Packaging/Submission Requirements**

The plan should be a brief, readable document that communicates the county's vision for meeting the treatment, services and support needs of adults, older adults, and transition-age youth with serious mental illness and co-occurring substance use disorders and their family members. Counties are encouraged to use bulleted lists, charts or tables to summarize information and to cross reference larger reports/documents, if necessary.

Descriptions requested in each section of the plan outline, should be brief, concise and summarize the information requested.

#### **A. General Formatting Instructions**

- The plan narrative must be single-spaced and should use Time New Roman 12 point font size. Font size **not** smaller than Times New Roman 8 point font may be used for charts and spreadsheets
- If acronyms are used, please define the acronym the first time it is used.
- The County Plan must have a table of contents indicating topic and page numbers. Each section should be divided and labeled for easy reference.
- The county plan narrative response must be numbered consecutively.
- The emailed plan document must be a Word document. PDF files will not be accepted, except where indicated in the guidelines. If at all possible, the plan should be in one file. If the document is too large, the document should be separated into two sections, one file with the narrative and a second file with the Attachments. Attachments may be emailed in separate files if they are named as listed on the guidelines index outline. Should you have questions regarding packaging and emailing of the plan as a word document, please contact Natalie Shaffer at 717-346-2614 or by email at [natshaffer@state.pa.us](mailto:natshaffer@state.pa.us).

Three (3) hard copies of the plan must be submitted in a binder as indicated under "Distribution." A copy of the plan information must also be provided by email as described in the "Distribution" section.

## **B. Packaging**

The plan should be organized and submitted in the following order:

1. Narrative
2. Signatures of Local Authorities (Attachment A)
3. Public Hearing Notice (Attachment B)
4. PATH intended use plan notice (Attachment C) - Required for counties that receive PATH funds
5. Completed and signed CSP Plan Development Process Review Form (Attachment D)
6. Existing County Mental Health Services Form (Attachment E)
7. Evidence Based Practices Survey (Attachment F)
8. County Development of Recovery-Oriented/Promising Practices (Attachment G)
9. Service Area Plan Chart (Attachment H)
10. Older Adults Program Directive (Attachment I)
11. Top Five Transformation Priorities (Attachment J)
12. Top Five New State Funding Requests for Recovery-Oriented Systems Transformation Priorities (Attachment K)
13. Expenditure Tables and Charts (Attachment L)
14. Housing Plan (Attachment M)
15. Forensic Plan (Attachment N)
16. County Plan Feedback Form (Attachment O) - Optional
17. County Mental Health Plan Review Form (Attachment P) – To be completed by OMHSAS staff

## **C. Distribution**

One electronic copy of the plan must be emailed and one hard copy of the plan in a binder must be mailed or delivered to the OMHSAS Field Office Manager and to the CEO of the state hospital(s) that serve the county.

One electronic copy must be emailed and one hard copy of the plan in a binder must be mailed or delivered to **Natalie Shaffer, OMHSAS Bureau of Policy and Program Development, 21 Beech Drive, 2<sup>nd</sup> Floor Beechmont, Harrisburg, PA 17105**. Email copy to [natshaffer@state.pa.us](mailto:natshaffer@state.pa.us) .

**All copies of the 2009-2012 plan must be received by OMHSAS no later than May 30, 2008.**

### **Mailing addresses, Email addresses and telephone numbers of field office managers:**

#### **Mike Orr**

Office of Mental Health and Substance Abuse Services  
Northeast Field Office  
Scranton State Office Building, Rm. 321  
100 Lackawanna Avenue  
Scranton, PA 18503  
Phone: (570) 963-4944  
Email: [morr@state.pa.us](mailto:morr@state.pa.us)

**Ms. Thomasina Bouknight**

Office of Mental Health and Substance Abuse Services  
Southeast Field Office  
Norristown State Hospital, Bldg. 57  
Stanbridge & Sterigere Streets  
Norristown, PA 19401  
Phone: (610) 313-5844  
Email: [tbouknight@state.pa.us](mailto:tbouknight@state.pa.us)

**Ms. Valerie Vicari**

Office of Mental Health and Substance Abuse Services  
Western Field Office  
413 Pittsburgh State Office Building  
300 Liberty Avenue  
Pittsburgh, PA 15222  
Phone: 412-565-7824  
Email: [vavicari@state.pa.us](mailto:vavicari@state.pa.us)

**Ms. Linda Zelch (Acting)**

Office of Mental Health and Substance Abuse Services  
Harrisburg Field Office  
2<sup>nd</sup> Floor Logan Building  
P. O. Box 2675  
Harrisburg, PA 17105  
Phone: (717) 265-7693  
Email: [lbashore@state.pa.us](mailto:lbashore@state.pa.us)

**Mailing and Email Addresses of State Hospital Chief Executive Officers (CEOs):**

NAME	HOSPITAL	ADDRESS	EMAIL ADDRESS
Greg Smith	Allentown	1600 Hanover Avenue Allentown, PA 18109-2498	<a href="mailto:grsmith@state.pa.us">grsmith@state.pa.us</a>
Thomas Comerford	Clarks Summit	1451 Hillside Drive Clarks Summit, PA 18411-9505	<a href="mailto:tcomerford@state.pa.us">tcomerford@state.pa.us</a>
Donna Ashbridge	Danville	200 State Hospital Drive Danville, PA 17821-9198	<a href="mailto:dashbridge@state.pa.us">dashbridge@state.pa.us</a>
Mary Jeanne Serafin	Mayview	1601 Mayview Road Bridgeville, PA 15017-1599	<a href="mailto:mserafin@state.pa.us">mserafin@state.pa.us</a>
Gerald Kent	Norristown	1001 Sterigere Street Norristown, PA 19401-5397	<a href="mailto:gkent@state.pa.us">gkent@state.pa.us</a>

NAME	HOSPITAL	ADDRESS	EMAIL ADDRESS
Edna McCutcheon	Torrance	PO Box 11 Torrance, PA 15779-0111	<a href="mailto:emccutcheon@state.pa.us">emccutcheon@state.pa.us</a>
David Kucherawy	Warren	33 Main Drive North Warren, PA 16365-5099	<a href="mailto:dkucherawy@state.pa.us">dkucherawy@state.pa.us</a>
Andrea Kepler	Wernersville	PO Box 300 Wernersville, PA 19565-0300	<a href="mailto:akepler@state.pa.us">akepler@state.pa.us</a>

#### **IV. Review Process**

OMHSAS field office and Bureau of Policy and Program Development staff will review the County Plan based on the County Mental Health Plan Review Form (**Attachment P**).

A copy of the completed Attachment P will be provided to the County Administrator, the local CSP, and other local stakeholders as requested.

A statewide report summarizing community treatment and services requests, systems change activities, quality management activities, trends, barriers, and other items will be issued by the state.

#### **V. Time Frames**

The County Mental Health Plan for FY 2009-2012, **must be received by OMHSAS no later than May 30, 2008. Update plans are due May 30, 2009 and May 30, 2010.** The time frames to fully implement the guidelines are as follows:

- September 2007 - Release of the FY 2009-12 Guidelines for the County Mental Health Plan.
- May 30, 2008 - Submission of FY 2009-12 County Mental Health Plan
- June-Aug, 2008 - Field office and Bureau of Policy review of plans. Feedback and plan approval provided to Counties.
- August 2008 - FY 2010-11 County Mental Health Plan update Guidelines are released.
- August 2008 - Submission of requests for Governor's budget consideration based on county plan information.
- Sept/Oct 2008 - Preparation & distribution of statewide aggregate report summarizing county plans.
- May 30, 2009 - Submission of the FY 2010-11 County Mental Health Plan update.

- June-Aug, 2009 - Field Office review of plans. Feedback and plan approval provided to counties.
- August 2009 - FY 2011-12 County Mental Health Plan update Guidelines are released.
- August 2009 - Submission of requests for Governor's budget consideration based on county plan information.
- Sept/Oct 2009 - Preparation and distribution of statewide aggregate report summarizing county plans.
- May 30, 2010 - Submission of FY 2011-2012 County Mental Health Plan update.
- June-Aug, 2010 - Field Office review of plans. Feedback and plan approval provided to counties.
- August 2010 - FY 2013-2016 County Plan Guidelines released.
- August 2010 - Submission of requests for Governor's budget consideration based on county plan information.
- Sept/Oct 2010 - Preparation and distribution of statewide aggregate report summarizing county plans.

**VI. Technical Assistance/Feedback**

Please contact your regional Field Office staff for questions or further guidance. Feedback on the County Plan Guidelines (optional) may be submitted using **Attachment O**.

**COUNTY MENTAL HEALTH  
PLAN  
Fiscal Year 2009-2012**

**OUTLINE**

**1. Executive Summary**

**The Executive Summary should be a brief, stand-alone, easy to understand, overview of the plan that counties can use as a public handout to summarize the plan's content.**

**Instructions for update years 2010-11 and 2011-12:** An updated Executive Summary should be included in 2010-11 and 2011-12

**2. Vision & Mission Statements**

**Include the county's Vision & Mission Statements that clearly indicate the goal of recovery for adults, older adults and transition-age youth with serious mental illness and co-occurring substance use disorders within your county mental health program. The Vision and Mission Statements should be two separate and distinct statements.**

The Vision Statement should incorporate the core beliefs of the County Mental Health Program. It should be an image of the future where the counties see themselves in 10-20 years from now.

The Mission should state how the vision will be achieved. It should be the purpose and function of the County Mental Health Program.

The vision and mission statements should be included in each planning year. If any changes to the vision/mission occur in the planning year, this section should describe what changed and the process of stakeholder involvement in the changes. The description of the stakeholder involvement in the changes should provide specific information about the participation of each target population, namely, adults, older adults, and transition-age youth, in the development or revision of the vision or mission statement.

**Instructions for update years 2010-11 and 2011-12:** The vision and mission statement should be included in each year's update. If changes occur, they should be noted as indicated above.

**3. Process Used for Completing the Plan**

**In this section, the counties should indicate who and through what means they involved a broad range of constituents in the planning process including consumers, families, providers, managed care representatives, cross-systems agencies, etc.**

The county should conduct a public hearing, acquire approval of local authorities (**Attachment A - Form I or II as applicable**) and submit the notice of the public hearing (**Attachment B**) with the plan as described in the Pennsylvania Code, Title 55. Public Welfare, Department of

Public Welfare, Chapter 4215 - Annual Plan and Estimates of Expenditures. Counties that receive Projects for Assistance in Transition from Homelessness (PATH) funding must include their PATH Intended Use Plan and PATH budget as **Attachment C**. While these are the *minimal* legal requirements, OMHSAS expects counties to engage stakeholders in the development and monitoring of the plan in a variety of ways beyond the public hearing.

The county should submit the CSP Plan Development Process Review form with original signatures of CSP members who were involved in the plan development process as (**Attachment D**).

**Submission Instructions:** The public hearing notice and any public testimony that the county includes with the plan may be sent in PDF format. The signed CSP Plan Development Process Review Form, and signatures of the county authorities must be included in the hard copy. Typed signatures may be included in the email copy.

**Instructions for update years 2010-11 and 2011-12:** Counties must involve stakeholders, hold a public hearing and complete the CSP Plan Development Process Review form for all three years of the planning process.

#### **4. Overview of the Existing County Mental Health Service System**

**This section should list current mental health services, including any co-occurring services in the community for older adults, adults and transition-age youth using Attachment E (Existing Mental Health Services). Attachment E displays county mental health services using the Recovery Model Crosswalk from William Anthony’s article, “A Recovery-Oriented System: Setting Some System Level Standards.” This article is included in the county plan guidelines diskette. For this section of the plan, counties must also complete the Evidence Based Practices survey (Attachment F), and Recovery-Oriented/Promising Practices chart (Attachment G)**

For this section, counties may include a brief narrative explaining the Attachments E, F and G, and may also include highlights of achievements and other programmatic improvements that enhanced their systems during this period.

**Instructions for update years 2010-11 and 2011-12:** Attachments E, F, and G must be included in all three planning years. Updates/changes should be noted in bold in years 2010-11 and 11-12.

#### **5. Identification and Analysis of Service System Needs**

**The purpose of this section is for counties to analyze both the strengths and gaps in their current service system in order to identify the county transformation priorities to be included in section 6 below.**

**This section should include:**

- Current resources and strengths that the county can use/build upon.

- An analysis of the unmet needs and service gaps for adults, older adults and transition-age youth with serious mental illness and co-occurring substance use disorders.
- A description of the data and stakeholder input that was used to identify what is and is not working.
- A description of the regional/county treatment services and supports/needs identified for individuals assessed in the Service Area Plan. The Service Area Plan Chart (**Attachment H**) should be completed to reflect progress towards meeting the three planning goals. Work on the Service Area Plan should continue either through each state hospital's Continuity of Care Committee meetings or through another process that the counties and regions have established.
- The target groups that are underserved including special populations and cultural groups, how these groups have been identified, and reasons why their service needs aren't being met.
- A statement affirming the existence of a current Memorandum of Understanding (MOU) between the County Office of Mental Health/Mental Retardation and the County Office of Aging (**Attachment I – Older Adults Program Directive**).
- This section may also include (optional) a description of systemic or other barriers/problems that the county has identified which stakeholders may not have identified, for which solutions may or may not have been identified, and which may be beyond the control of the planning process.

**The data listed below is included on the disk provided to the county.** This limited data set has been recommended by the counties as useful to the planning process. Counties should use this and similar data to help guide the process of identifying issues and gaps within the service system. OMHSAS welcomes feedback on the usefulness of this data and will use feedback to determine if such data should be included in subsequent planning years.

- HealthChoices Person Level encounter data
- MA Fee for Service Paid claims data
- CCR-POMS Summary Data
- Link to the Census data

The above data and similar types of data should be utilized by the county in completing this section of the plan.

**Instructions for update years 2010-11 and 2011-12:** For 2010-11 and 11-12, counties should include a brief update of any changes that occurred during the planning year. The Service Area Plan chart (Attachment H) should be included in all three planning years, with updates/changes noted in bold in 2010-11 and 11-12 updates.

## **6. Identification of the Recovery-Oriented Systems Transformation Priorities**

This section should include a description and time line for moving the county administration, and treatment services and supports from a system of care or maintenance to a recovery-oriented system. The plan should consider recovery-oriented services as well as the county's administrative and program practices and policies.

The section must include:

- ❑ A minimum of three (3) and a maximum of five (5) recovery-oriented systems transformation priorities required to accomplish the county’s vision and mission. This information must be provided using **Attachment J (Top Five Transformation Priorities)**.
- ❑ An explanation of how these three or more transformation priorities and related activities will address the service system needs identified in Section 5 above.
- ❑ A time line to accomplish the transformation priorities and related activities.
- ❑ Fiscal and other resources needed to address the goals and source of funding, if identified.
- ❑ Completed **Attachment K** to reflect the **Top Five New State Funding Requests for Recovery-Oriented System Transformation Priorities**.  
*Please note that requests for new state funding do not have to be necessarily tied to the items listed in Attachment J - Top Five Transformation Priorities. Only if new state funds (NOT any other funding source) are needed for an item listed in Attachment J, should that item be listed in Attachment K also. Those items in Attachment J that the County plans to fund through sources other than new state funding **should not be** listed in Attachment K.*
- ❑ Quality management plan for tracking implementation/outcomes.

OMHSAS recommends the below listed resources for completion of this section of the plan. **Copies/web-links of all articles are included on the county plan diskette.**

- William Anthony’s article, **A Recovery-Oriented System: Setting Some System Level Standards**, Table 3 – Characteristics of a Recovery-Oriented System, Psychiatric Rehabilitation Journal, Fall 2000, Volume 24 Number 2.
- **“A Call for Change: Toward Recovery Oriented Mental Health Service System for Adults”** issued by Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS), available at <http://www.dpw.state.pa.us/Resources/Documents/Pdf/Publications/ACallForChange.pdf>.
- **Comprehensive, Continuous, Integrated System of Care Model – Kenneth Minkoff, M.D.**, available at <http://www.kenminkoff.com/ccisc.html>
- **Older Adult Resources**
  - Geriatric Mental Health Foundation – [www.gmhfonline.org](http://www.gmhfonline.org)
  - Positive Aging Resource Center – [www.positiveaging.org](http://www.positiveaging.org)
  - Centers for Disease Control and Prevention Health Aging - [www.cdc.gov/aging](http://www.cdc.gov/aging)
  - Family Caregiver Alliance – [www.caregiver.org](http://www.caregiver.org)
- **Transition-age Resources**
  - **University of Mass. Medical School -Center for Mental Health Services Research** - <http://www.umassmed.edu/cmhsr/publications>

- **National Center on Youth Transition** - <http://ntacyt.fmhi.usf.edu/index2.cfm>

Additionally, this section may also include the following or any other relevant information:

- New, expanded or converted services to support a recovery –oriented service system
- Changes in policies, procedures, or regulations
- Approaches to more effectively serve/outreach to underserved/unserved populations including identified cultural groups
- Activities to address provider performance expectations
- Actions to address human resource issues or to accomplish other changes that are needed to improve service access, service quality and adult/older adult /transition-age outcomes.

**Instructions for update years 2010-11 and 2011-12:** In planning years 2010-11 and 2011-12, counties should provide a brief narrative status report on the 3-5 transformation goals. This update should include accomplishments achieved, fiscal resources received, what the quality management plan is tracking/finding, and any changes in the goals or activities.

## **7. Fiscal Information**

This section of the plan should provide the following:

- a. A visual display, using charts, of how county-based and HealthChoices funds are used to support mental health services within the county. Beginning with the 2009-2012 planning cycle, budget forms will no longer be required. Instructions for completion of the fiscal information using the charts are included as **Attachment L**.
- b. A brief narrative explaining the charts and how current funding is making a difference or how funding needs to be redirected, or increased to address needs and priorities identified in sections 5 and 6 above.
- c. A brief narrative explaining requests for new state funding included on Attachment K.

## **8. Supplemental Planning Guidelines**

OMHSAS is in the process of developing topic-specific planning guidelines for counties including planning guides for three major system priority areas: housing, forensics and employment. As these guides are developed, they will be included as attachments to the county Mental Health planning guidelines. For this year, the Housing Plan guidelines and the Forensic Plan guidelines are included as **Attachments M** and **N** respectively.

9.

**ATTACHMENTS TO THE COUNTY PLAN**

- A. Signatures of Local Authorities
- B. Public Hearing Notice
- C. PATH intended use notice
- D. Completed and signed CSP Plan Development Process Review Form
- E. Existing county Mental Health Services
- F. Evidence Based Practices Survey
- G. County Development of Recovery-Oriented/Promising Practices
- H. Service Area Plan Chart
- I. Older Adults Program Directive
- J. Top Five Transformation Priorities
- K. Top Five New State Funding Requests for Recovery-Oriented Systems Transformation Priorities
- L. Expenditure Tables and Charts
- M. Housing Plan
- N. Forensic Plan
- O. County Plan Feedback Form (Optional)
- P. County Mental Health Plan Review Form (To be completed by OMHSAS)

**SIGNATURES OF LOCAL AUTHORITIES**

**INTENT OF SECTION**

The intent of this section is to provide the necessary signatures of the local authorities as required by Chapter 4215 of the Pennsylvania Code. “Local authorities” are defined as, “the county commissioners or county executives of a county, or the city councils and the mayors of first class cities, or two or more of these acting in concert.”

**REQUIREMENT**

Please provide appropriate signatures on the attached form (Form I or Form II) that best corresponds with your county program structure. If the counties are not able to send the signature page(s) electronically they may indicate that here. The hard copy of the plan must contain the Attachment A with all the required signatures.

**-LOCAL AUTHORITY SIGNATURES: COUNTIES**

I/We assure that I /we have reviewed and approved the attached FY\_\_\_\_\_ County Mental Health Plan.

**COUNTY 1**\_\_\_\_\_

**Chairperson/County Commissioner:**

**Name**\_\_\_\_\_ **Signature**\_\_\_\_\_ **Date**\_\_\_\_\_

**County Commissioner:**

**Name**\_\_\_\_\_ **Signature**\_\_\_\_\_ **Date**\_\_\_\_\_

**County Commissioner:**

**Name**\_\_\_\_\_ **Signature**\_\_\_\_\_ **Date**\_\_\_\_\_

**COUNTY 2**\_\_\_\_\_

**Chairperson/County Commissioner:**

**Name**\_\_\_\_\_ **Signature**\_\_\_\_\_ **Date**\_\_\_\_\_

**County Commissioner:**

**Name**\_\_\_\_\_ **Signature**\_\_\_\_\_ **Date**\_\_\_\_\_

**County Commissioner:**

**Name**\_\_\_\_\_ **Signature**\_\_\_\_\_ **Date**\_\_\_\_\_

**-LOCAL AUTHORITY SIGNATURES: COUNTIES- (cont.)**

**COUNTY 3** \_\_\_\_\_

**Chairperson/County Commissioner:**

**Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**County Commissioner:**

**Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**County Commissioner:**

**Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**COUNTY 4** \_\_\_\_\_

**Chairperson/County Commissioner:**

**Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**County Commissioner:**

**Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**County Commissioner:**

**Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**-LOCAL AUTHORITY SIGNATURES: FIRST CLASS CITIES-**

I/We assure that I /we have reviewed and approved the attached FY \_\_\_\_\_  
County Mental Health Plan.

**CITY** \_\_\_\_\_

**Title** \_\_\_\_\_

**Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Title** \_\_\_\_\_

**Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Title** \_\_\_\_\_

**Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Title** \_\_\_\_\_

**Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Title** \_\_\_\_\_

**Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**FY \_\_\_\_\_ County Plan**

**PUBLIC HEARING NOTICE**

Please list here the name(s) of the publications and the date(s) when the notice was published.  
Copy of the actual public notice must be submitted with the hard copy of the County Plan.

FY \_\_\_\_\_ County Plan

**PATH INTENDED USE PLAN AND BUDGET**

(Only for those counties that receive the PATH grant. If the county does not receive the PATH grant, please indicate that here)

**COMMUNITY SUPPORT PROGRAM (CSP) COUNTY PLAN DEVELOPMENT  
PROCESS**

**Instructions:** The following checklist should be completed by County CSP Committees to guide and document their input into the development of the County Annual Mental Health Plan. Check the appropriate “Yes” or “No” column to indicate sources of information or completion of each task. Use the “Comments” section to qualify your answers.

**YES NO**

1. Representatives of what group (s) below provided reports/information to help the CSP develop its recommendations for the County Mental Health Plan?

- Consumer Satisfaction Team
- County Office of Mental Health
- Consumer groups
- Family groups
- Provider organizations
- Mental Health Association
- Other (\_\_\_\_\_)

**Comments:**

2. The CSP Committee prioritized at least one or more CSP service components and exemplary practices they would like the county to develop.

- 

**Comments:**

3. The CSP Committee held meetings with county Office of Mental Health representatives to discuss CSP recommendations for the mental health plan prior to public hearing sessions.

- 

**Comments:**

4. The CSP Committee received written notification of when and where the public hearings on the mental health plan will be held.

- 

**Comments:**

**YES NO**

5. The CSP Committee endorses the County's Annual Mental Health Plan.

**Comments:**

6. The CSP Committee sees evidence that the CSP Recovery Model Wheel and/or "Call for Change" is used by the County Management Office to guide planning activities.

**Comments:**

7. The CSP Committee members are invited to attend the OMHSAS review of the County's Annual Mental Health Plan if the review occurs.

**Comments:**

8. The county office of Mental Health responded to the County CSP Committee outlining how it intends to implement the Committee's recommendations.

**Comments:**

9. The County CSP Committee and the County Office of Mental Health have jointly developed a process to report on progress in implementing the current year's Plan.

**Comments:**

Name of CSP Committee \_\_\_\_\_

CSP Committee Chair: \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

E-Mail \_\_\_\_\_ Date \_\_\_\_\_

**SIGNATURES:**

Member(s) Representing Consumers: \_\_\_\_\_

Member(s) Representing Families: \_\_\_\_\_

Member(s) Representing Professionals: \_\_\_\_\_

Names of other participants:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

FY \_\_\_\_\_ County Plan

**EXISTING COUNTY MENTAL HEALTH SERVICES**

<b>SERVICE CATEGORY</b>	<b>CATEGORY DESCRIPTION</b>	<b>CONSUMER OUTCOME</b>	<b>SERVICES AVAILABLE IN THE MH/MR</b>	<b>FUNDING SOURCE * (County, HC, or Reinvestment)</b>	<b>PRIORITY POPULATION</b>
Treatment	Alleviating symptoms and distress	Symptom Relief			
Crisis Intervention	Controlling and resolving critical or dangerous problems	Personal Safety Assured			
Case Management	Obtaining the services consumer needs and wants	Services Accessed			
Rehabilitation	Developing skills and supports related to consumer's goals	Role Functioning			
Enrichment	Engaging consumers in fulfilling and satisfying activities	Self Development			
Rights Protection	Advocating to uphold one's rights	Equal Opportunity			
Basic Support	Providing the people, places, and things consumers need to survive (e.g., shelter, meals, healthcare)	Personal Survival Assured			
Self Help	Exercising a voice and a choice in one's life	Empowerment			
Wellness/ Prevention	Promoting healthy life styles	Health Status Improved			
Other	Anything not addressed above	Specify			

**Note:**

- (a) The “**Service Category**”, “**Category Description**”, and “**Consumer Outcome**” described above are based on *Table 2 “Essential Services in a Recovery-Oriented System”* in the Bill Anthony article “**A Recovery-Oriented System: Setting Some System Level Standards**” available in the data disk provided.

(b) For information on what “**Services Available in the MH/MR**” could be grouped under a “Service Category” for **County funded** services, please refer to the table below.

<b>Service Description/Cost Center (Bulletin OMH-94-10)</b>	<b>Service Category</b>
<ol style="list-style-type: none"> <li>1. Outpatient (3.6)</li> <li>2. Psych Inpatient Hospitalization (3.7)</li> <li>3. Partial Hospitalization (3.8)</li> <li>4. Family-Based MH Services (3.17)</li> <li>5. Community Treatment Teams (3.23)*</li> </ol>	Treatment
<ol style="list-style-type: none"> <li>1. MH Crisis Intervention Services (3.10)</li> <li>2. Emergency Services (3.21)</li> </ol>	Crisis Intervention
<ol style="list-style-type: none"> <li>1. Intensive Case Management (3.4)</li> <li>2. Resource Coordination (3.19)</li> <li>3. Administrative Management (3.20)</li> </ol>	Case Management
<ol style="list-style-type: none"> <li>1. Community Empl &amp; Empl Related Srvcs (3.12)</li> <li>2. Community Residential Services (3.16)</li> <li>3. Psych Rehab (3.24)</li> <li>4. Children’s Psychosocial Rehab (3.25)</li> <li>5. Other Services (3.98)</li> </ol>	Rehabilitation
<ol style="list-style-type: none"> <li>1. Adult Developmental Training (3.11)</li> <li>2. Facility Based Vocational Rehab Srvcs (3.13)</li> <li>3. Social Rehab Services (3.14)</li> </ol>	Enrichment
<ol style="list-style-type: none"> <li>1. Administrator’s Office (3.1)</li> </ol>	Rights Protection
<ol style="list-style-type: none"> <li>1. Housing Support Services (3.22)</li> <li>2. Family Support Services (3.15)</li> </ol>	Basic Support
Specify if used	Self Help
<ol style="list-style-type: none"> <li>1. Community Services (3.2)</li> </ol>	Wellness/Prevention
Any services not identified above	Other

\* Please also report Assertive Community Treatment (ACT) and Programs for Assertive Community Treatment (PACT) under the Community Treatment Team cost center (3.23).

(c) For information on what “**Services Available in the MH/MR**” could be grouped under a “Service Category” for **HealthChoices funded** services, please refer to the table below.

<b>Service Description/HealthChoices Rate Code Service Grouping</b>	<b>Service Category</b>
1. Inpatient Psychiatric (provider type 01 - specialties 010, 011, 022, 018) 2. Outpatient Psychiatric (provider type 08 – specialties 110, 074, 080; provider type 11 – specialties 113, 114; provider type 19 – specialty 190) 3. RTF – Accredited (provider type 01 – specialties 013, 027) 4. RTF – Non-Accredited (provider type 56 – specialty 560; provider type 52 – specialty 520) 5. Family Based Services for Children and Adolescents (provider type 11 – specialty 115)	Treatment
1. Crisis Intervention (provider type 11 – specialty 118)	Crisis Intervention
1. Targeted CM, ICM (provider Type 21 – specialties 222) 2. Targeted CM, blended (provider type 21 – specialty 222) 3. Targeted CM, RC (provider type 21 – specialty 221) 4. Targeted CM, ICM-CTT (provider type 21 – specialty 222)*	Case Management
1. BHRS for Children & Adolescents (all BHRS provider types and specialties under HC Behavioral Health Services Reporting Classification Chart) 2. Rehabilitative Services (provider type 11, specialty 123)	Rehabilitation
Specify if used	Enrichment
Specify if used	Rights Protection
1. Residential and Housing Support Services (provider type 11 – specialty 110) 2. Family Support Services (provider type 11 – specialty 110)	Basic Support
1. Peer Support Services (provider types 08, 11, 21 – specialty 076)	Self Help
1. Mental Health General (provider type 11 – specialty 111)	Wellness/Prevention
Any services not identified above	Other

\* Please note that Community Treatment Team (CTT) is grouped under the Service Category “Case Management” in the above HealthChoices table although CTT is not case management, and should ideally be grouped under the “Treatment” category. However, since HealthChoices Service Rate Coding identifies CTT as Targeted Case Management, CTT had to be classified under the category “Case Management”. Due to this reason, until further notice, please report CTT under “Case Management” in this Attachment if it is HealthChoices’ funded. Please also report HealthChoices’ funded Assertive Community Treatment (ACT/PACT) under this category until further notice.

(d) **For services provided with reinvestment funds**, based on the service description and expected consumer outcomes, please use your best judgment to choose a service category,.

(e) In the “**Funding Source**” column, specify if the funding for the service is through County funds, HealthChoices, or Reinvestment funds [list one or more funding source(s) for each service description as applicable].





## **EVIDENCE-BASED PRACTICES – DEFINITIONS & GUIDELINES**

The guidance and definitions identified below are not intended to be prescriptive or de-limiting. Rather, they indicate whether the services being reported conform broadly to evidence-based practices. As reporting occurs, these guidelines are expected to be revised and refined over time. Please note that the definitions and guidelines below were provided to the State by the Substance Abuse and Mental Health Services Administration (SAMHSA) as part of the guidelines for the FY 2008-2010 Community Mental Health Block Grant Application.

### **ASSERTIVE COMMUNITY TREATMENT**

#### **I. DEFINITION**

A team based approach to the provision of treatment, rehabilitation and support services. ACT/PACT models of treatment are developed using a self-contained multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, most readily used with clients co-existing with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. Key aspects are low caseloads and the availability of the services in a range of settings. The service is a recommended practice in the PORT study (Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations, Lehman, Steinwachs and Co-Investigators of Patient Outcomes Research Team, Schizophrenia Bulletin, 24(1):1-10, 1998) and is cited as a practice with strong evidence based on controlled, randomized effectiveness studies in the Surgeon General's report on mental health (Mental Health: A Report of the Surgeon General, December, 1999, Chapter 4, "Adults and Mental Health, Service Delivery, Assertive Community Treatment"). Additionally, CMS (Centers for Medicare & Medicaid Services - formerly HCFA) recommended that state Medicaid agencies consider adding the service to their State Plans in a HCFA Letter to State Medicaid Directors, Center for Medicaid and State Operations, June 07, 1999.

#### **II. FIDELITY MEASURE**

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/>

#### **III. MINIMUM REQUIREMENTS FOR REPORTING ACT**

- **Small caseload:** Client/ provider ratio of 10:1 or fewer is the ideal.
- **Multidisciplinary team approach:** This is a team approach rather than an approach which emphasizes services by individual providers. The team should be multidisciplinary and could include a psychiatrist, nurse, substance abuse specialist. For reporting purposes, there should be at least 3 FTE on the team
- **Includes clinical component:** In addition to case management, the program directly provides services such as: psychiatric services, counseling / psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.

- Services provided in community settings: Program works to monitor status, develop community living skills in the community rather than the office.
- Responsibility for crisis services: Program has 24-hour responsibility for covering psychiatric crises.

#### **IV. ACT IS NOT INTENSIVE CASE MANAGEMENT**

Note: If specific EBPs are provided as a component of ACT, they should be reported under ACT and not separately under other practices.

### **SUPPORTED EMPLOYMENT**

#### **I. DEFINITION**

Mental Health Supported Employment (SE) is an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illnesses. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client: staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

#### **II. FIDELITY MEASURE**

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment/>

#### **III. MINIMUM REQUIREMENTS FOR REPORTING SUPPORTED EMPLOYMENT**

- Competitive employment: Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status. Employment is competitive so that potential applicants include persons in the general population.
- Integration with treatment: Employment specialists are part of the mental health treatment teams with shared decision making. They attend regular treatment team meetings (not replaced by administrative meetings) and have frequent contact with treatment team members.
- Rapid job search: The search for competitive jobs occurs rapidly after program entry.
- Eligibility based on consumer choice (not client characteristics): No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning, and mild symptoms.

- Follow-along support: Individualized follow-along supports are provided to employer and client on a time-unlimited basis. Employer supports may include education and guidance. Client supports may include crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes (medication), and, networked supports (friends/family).

#### IV. **SUPPORTED EMPLOYMENT IS NOT:**

- Prevocational training
- Sheltered work
- Employment in enclaves (that is in settings, where only people with disabilities are employed)
- [If an employment specialist is part of an ACT team, this should be reported under ACT and not separately as supported employment.]

### **SUPPORTED HOUSING**

#### I. **DEFINITION**

Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity pre-supposes that certain clients are able to live independently in the community if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assists clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation.

Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability.

#### II. **FIDELITY MEASURE** (Not currently available)

#### III. **MINIMUM REQUIREMENTS FOR REPORTING SUPPORTED HOUSING**

- Target population: Targeted to persons who would not have a viable housing arrangement without this service.
- Staff assigned: Specific staff are assigned to provide supported housing services.
- Housing is integrated: That is, supported housing provided for living situations in settings that are also available to persons who do not have mental illnesses.
- Consumer has the right to tenure: The ownership or lease documents are in the name of the consumer.

- Affordability: Supported housing assures that housing is affordable (consumers pay no more than 30-40% on rent and utilities) through adequate rent subsidies, etc.

#### **IV. SUPPORTED HOUSING IS NOT:**

- Residential treatment services.
- A component of case management or ACT.

### **FAMILY PSYCHO-EDUCATION**

#### **I. DEFINITION**

Family psycho-education is offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family psycho-education programs may be either multi-family or single-family focused. Core characteristics of family psycho-education programs include the provision of emotional support, education, resources during periods of crisis, and problem-solving skills.

#### **II. FIDELITY MEASURE**

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/family/>

#### **III. MINIMUM REQUIREMENTS FOR REPORTING FAMILY PSYCHO-EDUCATION**

- A structured curriculum is used.
- Psycho-education is a part of clinical treatment.

#### **IV. FAMILY PSYCHO-EDUCATION IS NOT:**

Several mechanisms for family psycho-education exist. The evidence-based model, promoted through SAMHSA's EBP implementation resource kit ("toolkit") involves a clinician. Do not include family psycho-education models not involving a clinician as part of clinical treatment.

**Note: Some states are providing NAMI's Family-to-Family program and not the family psycho-education EBP described above. If a state is providing NAMI's Family-to-Family program, this should be reported under family psycho-education with an asterisk and a note indicating that the numbers reflect the NAMI program and not the EBP described above.**

## **INTEGRATED TREATMENT FOR CO-OCCURRING DISORDER (MENTAL HEALTH / SUBSTANCE ABUSE)**

### **I. DEFINITION**

Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

### **II. FIDELITY MEASURE**

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/>

### **III. MINIMUM REQUIREMENTS FOR REPORTING INTEGRATED TREATMENT**

- Multidisciplinary team: A team of clinicians, working in one setting provides MH and SA interventions in a coordinated fashion.
- Stagewise interventions: That is, treatment is consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention)

### **IV. INTEGRATED TREATMENT IS NOT:**

- Coordination of clinical services across provider agencies

## **ILLNESS MANAGEMENT / RECOVERY**

### **I. DEFINITION**

Illness Self-Management (also called illness management or wellness management) is a broad set of rehabilitation methods aimed at teaching individuals with mental illness, strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and re-hospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psycho-education about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.

### **II. FIDELITY MEASURE**

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/>

### **III. MINIMUM REQUIREMENTS FOR REPORTING ILLNESS MANAGEMENT & RECOVERY**

- Service includes a specific curriculum that includes mental illness facts, recovery strategies, using medications, stress management and coping skills. It is critical that a specific curriculum is being used for these components to be counted for reporting.

### **IV. EVIDENCE-BASED ILLNESS MANAGEMENT IS NOT:**

- Advice related to self-care but a comprehensive, systematic approach to developing an understanding and a set of skills that help a consumer be an agent for his or her own recovery.

## **MEDICATION MANAGEMENT**

### **I. DEFINITION**

In the toolkit on medication management, there does not appear to be any explicit definition of medication management. However, the critical elements identified for evidence-based medication management approaches are the following:

1. Utilization of a systematic plan for medication management
2. Objective measures of outcome are produced
3. Documentation is thorough and clear
4. Consumers and practitioners share in the decision-making

### **II. FIDELITY MEASURE**

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/>

### **III. MINIMUM REQUIREMENTS FOR REPORTING MEDICATION MANAGEMENT**

- Treatment plan specifies outcome for each medication.
- Desired outcomes are tracked systematically using standardized instruments in a way to inform treatment decisions.
- Sequencing of anti-psychotic medication and changes are based on clinical guidelines.

### **IV. EVIDENCE-BASED MEDICATION MANAGEMENT IS NOT:**

- Medication prescription administration that occurs without the minimum requirements specified above.

## **MULTISYSTEMIC THERAPY (MST)**

### **I. DEFINITION**

Multi-systemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior. The multi-systemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer,

school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. The goal is to facilitate change in this natural environment to promote individual change. The caregiver is viewed as the key to long-term outcomes.

## **II. MINIMUM REQUIREMENTS**

- Services take into account the life situation and environment of the child / adolescent and involve peers, school staff, parents, etc.
- Services are individualized
- Services are provided by MST Therapists or masters-level professional
- Services are time-limited
- Services are available 24/7

### **THERAPEUTIC FOSTER CARE**

#### **I. DEFINITION**

Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In addition, therapeutic foster parents are given a higher stipend than traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed.”

#### **II. MINIMUM REQUIREMENTS FOR REPORTING**

- There is an explicit focus on treatment
- There is an explicit program to train and supervise treatment foster parents
- Placement is in the individual family home

#### **III. THERAPEUTIC FOSTER CARE IS NOT:**

- An enhanced version of regular foster care.

### **FUNCTIONAL FAMILY THERAPY (FFT)**

#### **I. DEFINITION**

Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. Treatment occurs in phases where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family. The phases are engagement, motivation, assessment, behavior change, and generalization.

## **II. MINIMUM REQUIREMENTS**

- Services are provided in phases related to engagement, motivation, assessment, behavior change, etc.
- Services are short-term, ranging from 8-26 hours of direct service time

Flexible delivery of service by one and two person teams to clients in-home, clinic, juvenile court, and at time of re-entry from institutional placement.

County Program

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FY \_\_\_\_\_ County Plan

**COUNTY DEVELOPMENT OF  
RECOVERY-ORIENTED/PROMISING PRACTICES\*\***

	Services Exist (Check all appropriate)	Services Planned (Check all appropriate)	#s Served	\$\$ Existing	\$\$ Planned
Consumer Satisfaction Team					
Family Satisfaction Team					
Compeer					
Self Help / Advocacy (Specify)					
Outreach for Older Adults					
Warm Line					
Mobile Services/In Home Meds					
Fairweather Lodge					
Medicaid Funded Peer Specialist Program					
Dialectical Behavioral Therapy					
Other					

\*\*This form is an effort to identify the existence of or plans for some of the services that traditionally have been under-developed and that adults, older adults, and transition-age youth with serious mental illness and family members would like to see expanded. Current cost centers do not capture this level of detail. Please report on both County & HealthChoices funding.

*Reference: Please see the County Mental Health Plan Outline Section 4.*

FY \_\_\_\_\_ County Plan

**SERVICE AREA PLAN CHART**

Service Area Plan Goals	Update for County Plan- Request for County specific information																								
<p>Goal 1: Within five years no person will be hospitalized at a State Mental Hospital for more than two years.</p>	<p>Please review attached data regarding length of stay prior to answering the following questions. How many of the individuals with length of stay greater than 2 years have gone through Community Support Plan (CSP) process with a peer-to-peer assessment*, clinical assessment, and family assessment* and have had CSP meetings? <input type="checkbox"/> How many of those individuals have a targeted discharged date during FY08-09? <input type="checkbox"/> FY09-10? <input type="checkbox"/>. * If applicable.</p>																								
<p>Goal 2: Within five years no person will be committed to a community hospital more than twice in one year.</p>	<p>Number of individuals as of December 31, 2007 who have been admitted more than twice to a community hospital? If the data are not available please check no data.</p> <table border="1" data-bbox="446 827 1432 1022"> <thead> <tr> <th colspan="2">Public Funded</th> </tr> <tr> <th>7/1/05-6/30/06(FY05-06)</th> <th>7/1/06-6/30/07 (FY06-07)</th> </tr> </thead> <tbody> <tr> <td>Involuntary Admissions-</td> <td>Involuntary Admissions-</td> </tr> <tr> <td>Voluntary Admissions-</td> <td>Voluntary Admissions-</td> </tr> <tr> <td>All Admissions-</td> <td>All Admissions-</td> </tr> <tr> <td>No Data-</td> <td>No Data-</td> </tr> </tbody> </table> <table border="1" data-bbox="446 1052 1432 1247"> <thead> <tr> <th colspan="2">Private Funded</th> </tr> <tr> <th>7/1/05-6/30/06(FY05-06)</th> <th>7/1/06-6/30/07 (FY06-07)</th> </tr> </thead> <tbody> <tr> <td>Involuntary Admissions-</td> <td>Involuntary Admissions-</td> </tr> <tr> <td>Voluntary Admissions-</td> <td>Voluntary Admissions-</td> </tr> <tr> <td>All Admissions-</td> <td>All Admissions-</td> </tr> <tr> <td>No Data-</td> <td>No Data-</td> </tr> </tbody> </table>	Public Funded		7/1/05-6/30/06(FY05-06)	7/1/06-6/30/07 (FY06-07)	Involuntary Admissions-	Involuntary Admissions-	Voluntary Admissions-	Voluntary Admissions-	All Admissions-	All Admissions-	No Data-	No Data-	Private Funded		7/1/05-6/30/06(FY05-06)	7/1/06-6/30/07 (FY06-07)	Involuntary Admissions-	Involuntary Admissions-	Voluntary Admissions-	Voluntary Admissions-	All Admissions-	All Admissions-	No Data-	No Data-
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All Admissions-	All Admissions-																								
No Data-	No Data-																								
<p>Goal 3: Within five years the incarceration rate of the target population will be reduced.</p>	<p>How many individuals are currently incarcerated in the county jail in the target population?</p> <table border="1" data-bbox="446 1276 1432 1375"> <thead> <tr> <th>As of 6/30/07</th> <th>As of 12/31/07</th> </tr> </thead> <tbody> <tr> <td># individuals</td> <td># individuals</td> </tr> <tr> <td>No data</td> <td>No data</td> </tr> </tbody> </table> <p>How many individuals are going to max-out from the county jail in the target population during FY 07/08? <input type="checkbox"/></p> <p>How many individuals is the county planning for the possibility of parole from the county jail in the target population during FY 07/08? <input type="checkbox"/></p> <p>How many individuals are currently incarcerated in the State Correction Institution from your county in the target population?</p> <table border="1" data-bbox="446 1598 1432 1696"> <thead> <tr> <th>As of 6/30/07</th> <th>As of 12/31/07</th> </tr> </thead> <tbody> <tr> <td># individuals</td> <td># individuals</td> </tr> <tr> <td>No data</td> <td>No data</td> </tr> </tbody> </table> <p>How many individuals are going to max-out from a SCI in the target population during FY 07/08? <input type="checkbox"/></p> <p>How many individuals is the county planning for the possibility of parole from a SCI in the target population during FY 07/08? <input type="checkbox"/></p>	As of 6/30/07	As of 12/31/07	# individuals	# individuals	No data	No data	As of 6/30/07	As of 12/31/07	# individuals	# individuals	No data	No data												
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County Program

FY \_\_\_\_\_ County Plan

**OLDER ADULTS PROGRAM DIRECTIVE**

The Memorandum of Understanding (MOU) / Letter of Agreement is a collaboration between the County Office of Mental Health and Mental Retardation and the County Office of Aging.

Is a current, dated and signed MOU in place affirming this collaborative relationship between the county office of MH / MR and the county Office of Aging?

Yes \_\_\_\_\_

NO \_\_\_\_\_

---

County Program

FY \_\_\_\_\_ County Plan

**TOP FIVE TRANSFORMATION PRIORITIES**

	TRANSFORMATION PRIORITY
1	
2	
3	
4	
5	

Reference: County Plan Guidelines Section 6 – *Identification of Recovery-Oriented Systems Transformation Priorities*

FY \_\_\_\_\_ County Plan

**TOP FIVE NEW FUNDING REQUESTS FOR RECOVERY-ORIENTED SYSTEM TRANSFORMATION PRIORITIES**

	Target Group Population 1 or as noted*	Brief Description of Infrastructure Support or Enhancement of Service Capability That Requires New State Funds	Cost Center**	6 Month Cost	Annualized Cost
<b>1</b>					
<b>2</b>					
<b>3</b>					
<b>4</b>					
<b>5</b>					

*Reference: Please see the County Mental Health Plan Outline Section 6.*

\* The funding requests must be prioritized for Adult Priority Target Population 1. However, counties are permitted and strongly encouraged to target one of the top five requests to older adults for identification/intervention services or transition-age youth. This request can include any target population group.

\*\* This column should indicate the cost centers for the new services (as defined in OMHSAS bulletin OMH-94-10).

**EXPENDITURE TABLES AND CHARTS**

Information requested in this Attachment is intended to provide stakeholders with a better understanding of resource/funds utilization in the County mental health program. OMHSAS will NOT use the information provided in this section to make any funding decisions/or for audit purposes. Also, although children are not a target population for the purpose of County Plans, please include all services in this section, including children's services.

**Instructions for Services Funded with County Funds**

The table below shows Service Description/OMHSAS FFS cost centers and the corresponding Service Categories (as defined in Bill Anthony's article "*A Recovery-Oriented System: Setting Some System Level Standards*" available in the data disk provided. Please list the expenditures for **each service category** in the table format provided below and create *Expenditure and Percentage charts* (samples/instructions on pages 45-46). Please clearly label the table and charts as "County Funds Data" and indicate the fiscal year. This table and charts must be completed for the current fiscal year (actual/estimated), and the plan fiscal year (estimated).

<b>Service Category/Service Description Table for County Funds</b>		
<b>Service Description/Cost Center (Bulletin OMH-94-10)</b>	<b>Service Category</b>	<b>Expenditure (in 1000s of \$)</b>
6. Outpatient (3.6) 7. Psych Inpatient Hospitalization (3.7) 8. Partial Hospitalization (3.8) 9. Family-Based MH Services (3.17) 10. Community Treatment Teams (3.23)	Treatment	\$800
3. MH Crisis Intervention Services (3.10) 4. Emergency Services (3.21)	Crisis Intervention	\$300
4. Intensive Case Management (3.4) 5. Resource Coordination (3.19) 6. Administrative Management (3.20)	Case Management	\$400
6. Community Empl & Empl Related Svcs (3.12) 7. Community Residential Services (3.16) 8. Psych Rehab (3.24) 9. Children's Psychosocial Rehab (3.25) 10. Other Services (3.98)	Rehabilitation	\$500
4. Adult Developmental Training (3.11) 5. Facility Based Vocational Rehab Svcs (3.13) 6. Social Rehab Services (3.14)	Enrichment	\$200
2. Administrator's Office (3.1)	Rights Protection	\$100
3. Housing Support Services (3.22) 4. Family Support Services (3.15)	Basic Support	\$150
Specify if used	Self Help	\$50
2. Community Services (3.2)	Wellness/Prevention	\$100
Any services not identified above	Other	\$0

**Note:** Figures provided in the table above are sample figures used to create the sample charts. Counties will provide their actual or estimated figures, as applicable, in this column, to create the Expenditure and Percentage charts.

**Instructions for Services Funded Thru HealthChoices**

The table below shows Service Description/HealthChoices Rate Code Service Groupings and the corresponding Service Categories (as defined in Bill Anthony’s article “*A Recovery-Oriented System: Setting Some System Level Standards*” available in the data disk provided. Please list the expenditures for **each service category** in the table format provided below and create *Expenditure and percentage charts* (samples/instructions on pages 45-46). Please clearly label the table and charts as “HealthChoices Data” and indicate the calendar/fiscal year. This table and charts must be completed for the current calendar (or fiscal) year (actual/estimated), and the plan calendar (or fiscal) year (estimated).

<b>Service Category/Service Description Table for HealthChoices Funds</b>		
<b>Service Description/HealthChoices Rate Code Service Grouping</b>	<b>Service Category</b>	<b>Expenditure (in 1000s of \$)</b>
6. Inpatient Psychiatric (provider type 01 - specialties 010, 011, 022, 018) 7. Outpatient Psychiatric (provider type 08 – specialties 110, 074, 080; provider type 11 – specialties 113, 114; provider type 19 – specialty 190) 8. RTF – Accredited (provider type 01 – specialties 013, 027) 9. RTF – Non-Accredited (provider type 56 – specialty 560; provider type 52 – specialty 520) 10. Family Based Services for Children and Adolescents (provider type 11 – specialty 115)	Treatment	\$800
2. Crisis Intervention (provider type 11 – specialty 118)	Crisis Intervention	\$300
5. Targeted CM, ICM (provider Type 21 – specialties 222) 6. Targeted CM, blended (provider type 21 – specialty 222) 7. Targeted CM, RC (provider type 21 – specialty 221) 8. Targeted CM, ICM-CTT (provider type 21 – specialty 222)	Case Management	\$400
3. BHRS for Children & Adolescents (all BHRS provider types and specialties under HC Behavioral Health Services Reporting Classification Chart) 4. Rehabilitative Services (provider type 11, specialty 123)	Rehabilitation	\$500
Specify if used	Enrichment	\$200
Specify if used	Rights Protection	\$100
3. Residential and Housing Support Services (provider type 11 – specialty 110) 4. Family Support Services (provider type 11 – specialty 110)	Basic Support	\$150
2. Peer Support Services (provider types 08, 11, 21 – specialty 076)	Self Help	\$50
2. Mental Health General (provider type 11 – specialty 111)	Wellness/Prevention	\$100
Any services not identified above	Other	\$0

**Note:** Figures provided in the table above are sample figures used to create the sample charts. Counties will provide their actual or estimated figures, as applicable, in this column to create the Expenditure and Percentage charts.

**Sample Expenditure Chart for County and HealthChoices’s funded services – Counties should create the Expenditure (Column) Charts as shown in the sample below to display the information provided in the tables for County as well as HealthChoices funds:**

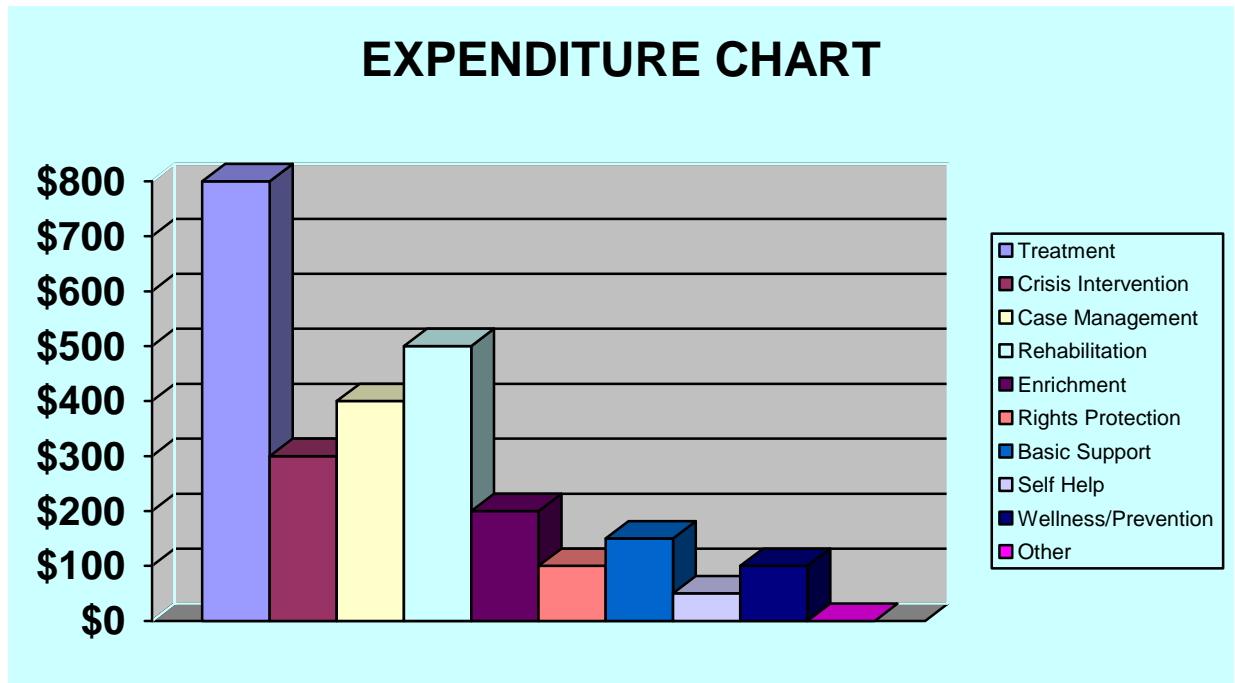
**Create four column charts to include:**

**Expenditure Chart 1:** Expenditure chart for **County Funds** for the **current** fiscal year. (Should be labeled clearly as Expenditure Chart 1 and displayed under the *Service Category/Service Description Table for County Funds* for the **current** fiscal year)

**Expenditure Chart 2:** Expenditure chart for **County Funds** for the **plan** fiscal year (Should be labeled clearly as Expenditure Chart 2 and displayed under the *Service Category/Service Description Table for County Funds* for the **plan** fiscal year)

**Expenditure Chart 3:** Expenditure Chart for **HealthChoices** for the **current** calendar or fiscal year (Should be labeled clearly as Expenditure Chart 3 and displayed under the *Service Category/Service Description Table for HealthChoices Funds* for the **current** calendar or fiscal year)

**Expenditure Chart 4:** Expenditure Chart for **HealthChoices** for the **plan** calendar or fiscal year (Should be labeled clearly as Expenditure Chart 4 and displayed under the *Service Category/Service Description Table for HealthChoices Funds* for the **plan** calendar or fiscal year)



Service Categories in the order shown in the legend on the right

Values on Y Axis in 1000's of dollars

**Sample Percentage Chart for County and HelathChoices’ funded services – Counties should create the Percentage (Pie) Charts as shown in the sample below to display the information provided in the tables for County as well as HealthChoices funds.**

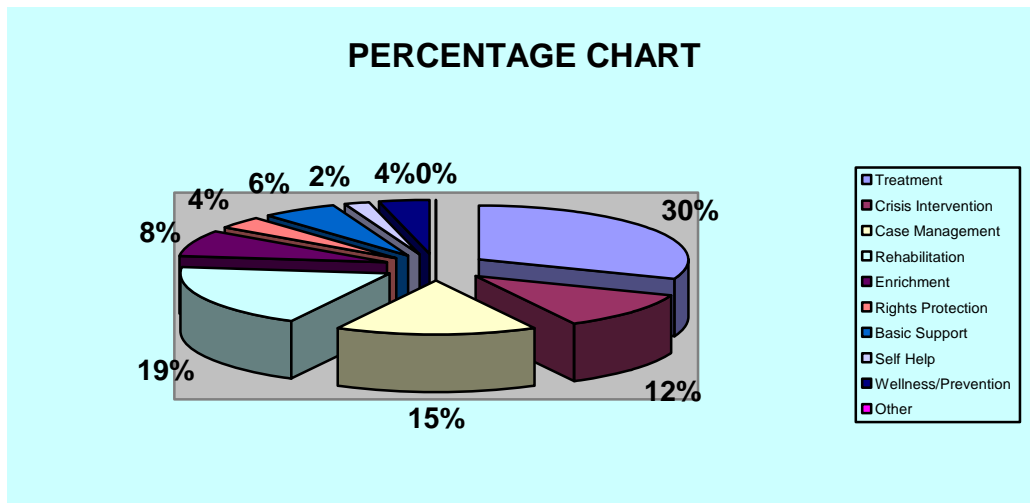
**Create four pie charts to include:**

**Percentage Chart 1:** Percentage chart for **County Funds** for the **current** fiscal year. (Should be labeled clearly as Percentage Chart 1 and displayed directly below Expenditure Chart 1)

**Percentage Chart 2:** Percentage chart for **County Funds** for the **plan** fiscal year (Should be labeled clearly as Percentage Chart 2 and displayed directly below Expenditure Chart 2)

**Percentage Chart 3:** Percentage Chart for **HealthChoices** for the **current** calendar or fiscal year (Should be labeled clearly as Percentage Chart 3 and displayed directly below Expenditure Chart 3)

**Percentage Chart 4:** Percentage Chart for **HealthChoices** for the **plan** calendar or fiscal year (Should be labeled clearly as Percentage Chart 4 and displayed directly below Expenditure Chart 4)



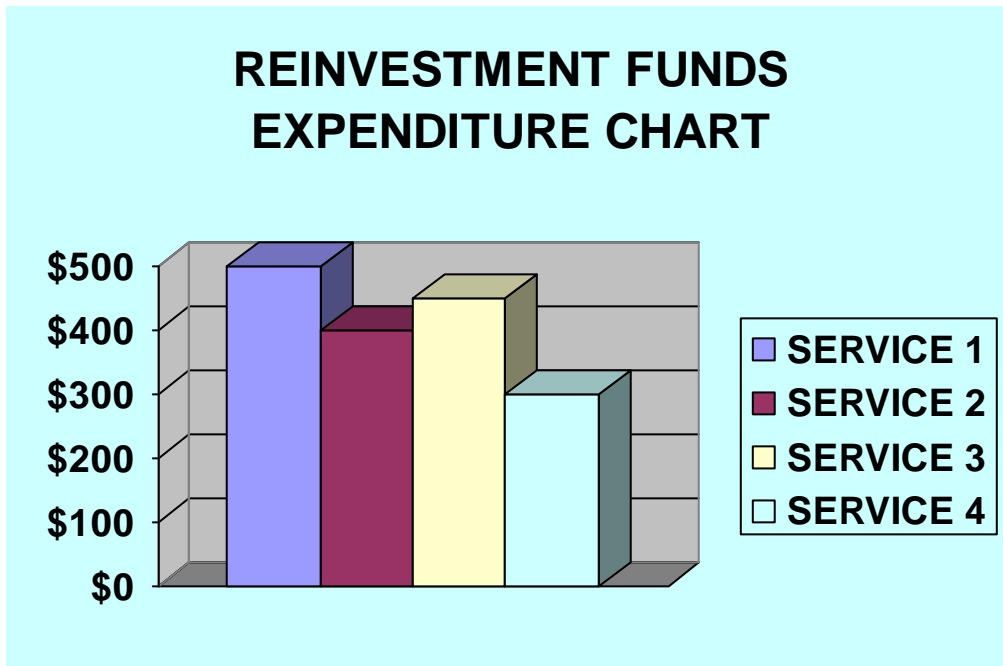
Shows the % expenditure for each service category

**Instructions for Services Funded with Reinvestment Funds**

Please list the name of each service funded with reinvestment funds and the corresponding dollar amounts for the current year (specify if it is calendar or fiscal year) in the following format, and create a column chart for expenditures (see the sample below), and label it as **Expenditure Chart 5**.

	<b>EXPENDITURE (in 1000s of dollars)</b>
SERVICE 1	\$500
SERVICE 2	\$400
SERVICE 3	\$450
SERVICE 4	\$300

**Note:** Figures provided in the table above are sample figures used to create the sample chart. Counties will provide their actual figures in this column to create the Expenditure chart.



Service Categories in the order shown in the legend on the right

Values on Y Axis in 1000's of dollars

FY \_\_\_\_\_ County Plan

**HOUSING PLAN GUIDELINES**

**Office of Mental Health and Substance Abuse Services  
County Housing Plan Policy  
August, 2007**

**In the fall of 2006, the Office of Mental Health and Substance Abuse Services (OMHSAS) in the Pennsylvania Department of Public Welfare issued “A Plan for Promoting Housing and Recovery-Oriented Services” consistent with the OMHSAS landmark 2005 document entitled *A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults*.**

“A Plan for Promoting Housing and Recovery-Oriented Services,” drafted with support from consumers, providers, County MH/MR programs and other stakeholders, provides guidance to County MH/MR Programs for their planning, resource allocation and development of effective supportive housing models and modernization of housing approaches. The Plan spells out specific actions for OMHSAS, its state partners and County MH/MR Programs for housing policy and development. Subsequently OMHSAS has increased technical assistance to counties in Housing Plan development, and specifically provided guidance on the allocation of HealthChoices Reinvestment funds for supportive housing.

With these endeavors underway, OMHSAS is requiring that any county seeking to utilize HealthChoices Reinvestment, Community Hospital Integration Program Project (CHIPP) or Base Funds for any housing activity, must prepare a Housing Plan utilizing the OMHSAS Housing Plan template. All planning must identify the priority group most in need of permanent housing by age, type of disability/need or other designation. This priority group must include the housing needs of persons currently being served in state psychiatric hospitals. The Housing Plan must be reviewed and approved by OMHSAS. In addition, every county will be required to move forward in developing a County Housing Plan as a requirement of the 2009/2012 County Plan Guidelines.

Housing activities requiring submission of a plan must include:

- Development of any services, management, rental or capital resources for supportive housing including Fairweather Lodges or other evidence based supportive housing approaches (Attachment A);
- Allocation of resources to purchase, build or to substantially modify or convert Community Residential Rehabilitation Services (see specific Guidance below) or Long Term Structure Residences;

- Allocation of resources for contingency funds (move-in or eviction prevention assistance);
- Allocation of resources for staff including housing specialists, program or project managers and time limited technical consultation; and/or
- Development of Enhanced Personal Care Boarding Homes.

## Requirements

1. Counties shall submit their County Housing Plans to Shelley Bishop, Executive Assistant to the OMHSAS Deputy Secretary for Consumer and Family Issues ([shebishop@state.pa.us](mailto:shebishop@state.pa.us)) with a copy to the Program Manager in the appropriate Field Office. Each County will be offered technical assistance prior to formal submission to OMHSAS.
2. OMHSAS will review and approve housing plans. Plan approval notices will be forwarded to the County MH/MR Administrator.
3. Upon Housing Plan approval, counties will make formal request for use of these funds.

HealthChoices Reinvestment – Counties shall briefly summarize their request as a single HealthChoices Reinvestment Plan priority using Attachment 3 and 4 of Appendix N, extracting information from their approved Housing Plan to complete the following categories: Target Population, Description of Program or Service, Description of Fund Expenditures, Data Analysis and Stakeholder Involvement in Decision Making.

- Counties must also submit Attachment 5 if their Housing Plan includes development costs including real estate pre-development, purchase, new construction or rehabilitation. OMHSAS is updating Attachment 5 to provide relevant guidance for counties entering into partnerships with housing organizations for real estate purchases, new construction or rehabilitation. A draft of this new guidance will be forwarded to you under separate cover.

CHIPP Funds Counties shall briefly summarize their housing and service requests in the CHIPP Letter of Agreement. The description of housing development to be funded by CHIPP can be extracted from their approved Housing Plan to complete the Agreement in the following categories as applicable: program objectives, staffing, service development (services and housing), budget, and implementation timeframes.

4. Counties that have identified housing as a priority for HealthChoices Reinvestment or CHIPP funds, but have not completed their Housing Plan within the required timeframe for these requests, must submit their projected requests for housing in the following manner:

HealthChoices Reinvestment Funds – Counties shall submit their projected reinvestment request for housing as part of their single reinvestment plan that commits reinvestment funds. This Reinvestment Plan should identify the target population, identify the timeframe for completing a housing plan, broadly identify the housing activities anticipated and state the total dollars targeted for reinvestment. The Housing Plan, once

completed and approved by OMHSAS, will document the specific fund expenditures and housing development to be accomplished. Implementation can occur for multiple years.

CHIPP Funds Counties shall describe their projected housing and service requests in the CHIPP Letter of Agreement. The Agreement will broadly identify the housing activities anticipated in the following categories as applicable: program objectives, staffing, service development (services and housing), budget, and implementation timeframes. As part of the CHIPP Agreement the county must also commit to and establish a timeframe for the development of an approved housing plan for OMHSAS review and approval.

5. Additional guidance will be forthcoming for counties to report progress on implementation of their Housing Plans as well as in regard to Quality Assurance requirements, to include Consumer Satisfaction surveying.
6. Given that new housing resources from other sources may become available during the period of time covered by the Housing Plan, County MH/MR Programs have the opportunity to expand or modify their Housing Plans to match resources. If the county is going to make a substantial change which is the greater of 25% or \$50,000 of the amount allocated for the Housing Plan priority, requires the County MH/MR office to submit a modified housing plan for approval to Shelley Bishop, using the same Housing Plan template. A County's Housing Plan modification must be approved by OMHSAS before submitting a change in the Reinvestment Plan or CHIPPS proposal.
7. OMHSAS has partnered with the Pennsylvania Housing Finance Agency to create a new Project Based Operating Subsidy Program. Separate guidelines and application process is required for access to this program. Please contact Shelley Bishop at the above email address for more information on that program.
8. Any county plan that includes the development of a "bank trust" fund must be approved by OMHSAS in the overall County Housing Plan.
  - A bank trust is not considered a Housing Trust Fund, defined distinctly as a trust created by legislation or ordinance.

#### Community Residential Rehabilitation Services Guidance

1. All requests to de-license CRRS beds must be submitted to OMHSAS in a Housing Plan using the OMHSAS Housing Plan template. There is a formal process for conversion of a CRRS program to supported housing, and this process coupled with the required conversion documentation will be provided to counties through OMHSAS funded Technical Assistance.
2. OMHSAS will only approve CRRS conversions to Supported Housing (as defined in Appendix A of the OMHSAS Housing Plan) or other Evidence Based Housing Practice.
3. There are three approvable CRRS de-licensing/conversion choices, which are listed below. A combination of these choices will also be allowed.

- a. **Conversion of the program AND the site** from a residential services program to one of supported housing. The site would become simply a rental unit, where the residents would have a standard tenant landlord lease, either as a family of unrelated individuals; or each tenant would have a separate lease, similar to what college roommates would have. Documentation must be provided that residents of the CRRS, prior to conversion, were offered the opportunity to move to other rental units, with rental support if needed.
- b. **Closure of the Program and the site.** Documentation must be provided that residents of the CRRS were afforded support in developing workable and affordable community based housing choices, and will have necessary housing support services. Evidence of appropriate use or disposal of the site for non-residential purposes must be provided as well as a budget indicating the alternate use of these funds.
- c. **Transition of the site and the program to a congregate living venue that is an evidence-based practice, such as a Fairweather Lodge.** (Note: if any congregate living situation is proposed other than Fairweather Lodge, documentation that the proposed venue is an evidence based practice must be documented.) Documentation must be provided that residents of the CRRS, prior to conversion, were offered the opportunity to move to other rental units, with rental support if needed. Provider must adhere to the Evidence Based Fidelity Standards (for Fairweather Lodge, these are the Lodge Fidelity Standards), and the Evidence Based Practice consumer outcomes must be tracked. If not a Fairweather Lodge, then evidence based practice fidelity standards must be provided, and adhered to; and consumer outcomes must be documented and be tracked.

Appendix A from the Housing Workplan

Definition of Supportive/supported Housing:

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 is not 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 they abide 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 are not 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.

FY \_\_\_\_\_ County Plan

**FORENSIC PLAN GUIDELINES**

**In November 2006, The Office of Mental Health and Substance Abuse distributed its Forensic Agenda Workgroup’s *Recommendations to Advance Pennsylvania: Responses to People with Mental illness and/or Substance Use Disorders Involved in the Criminal Justice System*. This dissertation discussed the Workgroup’s goals, priorities, and strategies for improving the response to people with mental illness and/or substance use disorders involved in the criminal justice system. Please briefly describe your county or service area’s current forensic activities and your county or service area’s “Forensic agenda”, by framing your discussion in relation to the Report Recommendations and Action Items listed below.**

Section	Page	Report Recommendation	Proposed Action Items
IV.A	5 – 6	<i>Develop communication strategies and opportunities for cross-training</i>	<p>OMHSAS should work with its counterpart departments and agencies in the criminal justice system to develop communication strategies and opportunities for cross-training between the staffs of both systems</p> <ul style="list-style-type: none"> <li>• Hire and train case managers/boundary spanners who can provide transition services inside the county jail and into the community.</li> <li>• Develop system to secure documentation of identity and citizenship at no cost to inmate</li> <li>• Streamline benefits application process to ensure access to treatment at time of release</li> <li>• Develop a system with OIM/OMHSAS that suspends rather than terminate benefits during incarceration</li> <li>• Increase access to crisis intervention and treatment within county jails</li> <li>• Provide access to training for to corrections and law enforcement on mental illness and/or substance use disorders, suicide risk screening, and substance abuse screening</li> <li>• Work with criminal justice partners to develop a system for unified data sharing</li> </ul>

			<ul style="list-style-type: none"> <li>• Determine how OMHSAS training priorities are identified, what resources will focus on forensic diversion</li> <li>• Create web-based training options</li> <li>• Develop letters of agreement to increase continuity of approach</li> </ul>
IV.C	7	<i>Promote local mental health system participation on CJABS</i>	<p>OMHSAS should support and promote mental health system participation on the Pennsylvania Commission on Crime and Delinquency (PCCD)Criminal Justice Advisory Boards (CJABS) to foster communication and opportunities for cross-training at the county level</p> <ul style="list-style-type: none"> <li>• Recommend creation of CJAB in counties where there is not an existing CJAB</li> <li>• Ensure that Mental Health and Substance Abuse agencies have membership on all existing Criminal Justice Advisory Boards</li> <li>• Develop information sharing mechanism between county mental health staff and CJABs and PCCD</li> </ul> <p>Provide information and technical assistance to CJABs to assist in development of training and support for law enforcement and first responders, development of mental health / treatment courts, and development of collaborative re-entry transition planning</p>
IV.C	7	<i>Incentivize OMHSAS-funded providers</i>	<p>OHMSAS should prioritize efforts that focus on individuals with mental illness and/or substance use disorders involved—or at risk of involvement—with the criminal justice system by incentivizing these efforts among the providers that it funds.</p> <ul style="list-style-type: none"> <li>• Increase access to and quality of ongoing and crisis treatment in county jails, SCIs and state hospital forensic centers.</li> <li>• Provide training for law enforcement/first responders, probation and parole</li> <li>• Create central location for law enforcement to take individual for immediate assessment</li> <li>• Develop uniform screening tool to be used upon incarceration to identify special needs</li> <li>• Promote pre and post-booking diversion options, including mental health/treatment courts</li> <li>• Promote peer specialist/consumer-run programs</li> <li>• Development of a uniform re-entry checklist to be used by county MH/MR, OMHSAS, PBPP, County Jails, and</li> </ul>

			<p>SCIs</p> <ul style="list-style-type: none"> <li>• Develop transitional and permanent housing through local collaboration with Local Housing Options Teams for individuals who are being released from state prison or county jails</li> </ul>
IV.E	9	<i>Develop Pennsylvania CCoEs</i>	<p>The executive-branch-level workgroup should develop Coordinating Centers of Excellence (CCoEs) modeled after Ohio's CCoEs to administer, support, and monitor the joint OMHSAS/DOC/PBPP grant program;</p> <ul style="list-style-type: none"> <li>• Identify and promote best practices through evaluation and training.</li> <li>• Develop web-based directory / inventory of specialized services</li> <li>• Develop Forensic Services Manual</li> <li>• Develop standards and guidelines for training and program development of diversion and re-entry programs and core competencies for treatment programs</li> </ul>

**COUNTY PLAN FEEDBACK FORM (OPTIONAL)**

**FY \_\_\_\_\_ County Plan**

**Please use this form to provide feedback regarding the County Plan document and process.**

1. What comments do you have on the overall design of the annual plan and budget?
  
2. What sections of the plan provided value to the process? What sections of the plan did not?
  
3. What sections of plan were unclear?
  
4. Do you have any comments regarding the field office review process?
  
5. Do you have any recommendations regarding the use and content of the CSP Plan Development forms?
  
6. Do you have any other comments?

**FY 2009 -2012 COUNTY MENTAL HEALTH PLAN  
REVIEW FORM**

(To be completed by OMHSAS Staff)

**FY \_\_\_\_\_ County Plan**

\_\_\_\_\_  
**County Program**

**BPPD Reviewer** \_\_\_\_\_

**Field Office Reviewer** \_\_\_\_\_

**Directions: Please refer to the FY 2009-2012 Plan Guidelines**

<b>TOPIC</b>	<b>Note: In each area briefly explain and describe areas of strength and areas where improvement is needed</b>
<b>SUBMISSION</b>	
The plan is submitted on time (Y/N)	
The plan has been distributed electronically and in hard copy to the Field Office, to the Bureau of Policy and Program Development and to the State Hospital CEOs.	
<b>EXECUTIVE SUMMARY</b>	
Does the Executive Summary summarize the plan as a stand-alone document?	
<b>VISION &amp; MISSION STATEMENT</b>	
Does the Vision & Mission Statement clearly indicate the goal of recovery for adults, older adults, and transition-age youth with mental illness and co-occurring substance use disorders within the county mental health program?	

TOPIC	<u>Note:</u> In each area briefly explain and describe areas of strength and areas where improvement is needed
<b>PROCESS USED FOR COMPLETING THE PLAN</b>	
The process for completing the plan is described.	
There is evidence of inclusive, open, accessible meetings	
Identifies how OMHSAS feedback was addressed	
Please note impressions of the process	
Required signature page is attached ( <b>Attachment A</b> )	
Public Hearing notice attached ( <b>Attachment B</b> )	
If the County receives the Projects for Assistance in Transition from Homelessness (PATH) funding, PATH Intended Use Plan and Budget are attached ( <b>Attachment C</b> )	
CSP Plan Development Process Review checklist ( <b>Attachment D</b> ) was received and signed as required.	
Please note overall impression from checklist.	
CSP Committee endorses County Plan (Question #5 in Attachment D) [If no to #5, indicate reason]	
List corresponding #'s of "No" responses from the CSP Plan Development checklist.	
<b>OVERVIEW OF EXISTING COUNTY MENTAL HEALTH SERVICE SYSTEM</b>	
Existing mental health services are described using the <b>Attachment E</b> as per the guidelines provided in the Attachment.	
Please note any comments on the existing services	
Evidence-based Practices Survey ( <b>Attachment F</b> ) is included.	
Please note any comments	

TOPIC	<u>Note:</u> In each area briefly explain and describe areas of strength and areas where improvement is needed
Recovery-oriented/Promising Practices Chart has ( <b>Attachment G</b> ) been completed  Please note any comments	
The county has included a brief narrative (optional) explaining Attachments E, F, and G	
<b>IDENTIFICATION AND ANALYSIS OF SERVICE SYSTEM NEEDS</b>	
Describes the resources and strengths in the current system that the county can use/build upon	
Includes an analysis of the unmet needs and service gaps for adults, older adults, and transition age youth with serious mental illness/co-occurring substance use disorders	
Provides a description of the data and stakeholder input that was used to identify what is working and what is not	
The Service Area Plan Chart ( <b>Attachment H</b> ) is completed and reflects the progress towards meeting the Service Area Planning goals	
Addresses target groups that are underserved including special populations and cultural groups – describes how these groups have been identified and why their service needs are not being met	
Older Adults Program Directive ( <b>Attachment I</b> ) is included	
The Plan includes (optional) description of systemic or other barriers, which the county has identified (which stakeholders may not have identified), which may be beyond the control of the planning process	
<b>IDENTIFICATION OF RECOVERY-ORIENTED SYSTEMS TRANSFORMATION PRIORITIES</b>	
<b>Attachment J</b> is completed and identifies three to five recovery-oriented systems transformation priorities required to accomplish the county’s vision and mission	
Includes an explanation of how these transformation priorities and related activities will address the service system needs identified in the previous section	

TOPIC	<b>Note: In each area briefly explain and describe areas of strength and areas where improvement is needed</b>
<i>(Identification and Analysis of Service System Needs section)</i>	
Includes a time line to accomplish the transformation priorities and related activities	
Addresses fiscal and other resources needed	
<b>Attachment K</b> is completed to reflect the Top Five New State Funding Requests for Recovery-Oriented System Transformation Priorities.	
Describes the Quality Management plan for tracking implementation/outcomes	
<b>FISCAL INFORMATION</b>	
Expenditure Tables and Charts ( <b>Attachment L</b> ) completed as per the guidelines  Please note your comments	
Includes a narrative explaining the charts in Attachment K and how funding is making a difference or how funding needs to be redirected to address the needs and priorities identified in the <i>Identification and Analysis of Service System Needs</i> section, and the <i>Identification of Recovery-Oriented Systems Transformation Priorities</i> section	
Includes a brief narrative explaining requests for new state funding included on Attachment K	
<b>SUPPLEMENTAL GUIDELINES</b>	
Housing Plan ( <b>Attachment M</b> ) included Y/N). Please note your impressions of the Housing Plan  Forensics Plan ( <b>Attachment N</b> ) is included (Y/N). Please note your impressions of the Forensics Plan	
<b>COUNTY PLAN FEEDBACK FORM (OPTIONAL)</b>	
If the County has completed The County Plan Feedback Form ( <b>Attachment O</b> ), please	

<b>TOPIC</b>	<b>Note: In each area briefly explain and describe areas of strength and areas where improvement is needed</b>
summarize the feedback here	
<b>OVERALL IMPRESSIONS/REMARKS ON THE PLAN</b>	