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I. INTRODUCTION

Transformation at Work: A Summary Report of the Fiscal Year 2008-2009 County Mental Health Plans for Adults, Older Adults, & Transition-Age Youth with Serious Mental Illness provides a snapshot of the planning efforts underway in the counties to support adults, older adults, and transition-age individuals with mental illness to have the opportunity for growth, recovery and inclusion in their community. This document is intended to present some of the statewide trends in county mental health planning, and serve as encouragement for readers to become active participants in their own county planning process.

The summary report being presented here is based on the Fiscal Year 2008-2009 plans submitted by the 48 County MH/MR Program Offices in May 2007. These plans were developed by the counties based on the guidelines issued by the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) in October 2006¹. As stated in the guidelines to the County Plans, counties were expected to consider the implementation of the concepts and approaches identified in the landmark OMHSAS document, *A Call for Change: Toward a Recovery-Oriented Mental Health Service Delivery System for Adults*,² which provided the philosophical framework for the transformation of Pennsylvania's mental health service delivery system to one that is recovery-oriented. All County Plans were evaluated by a team of trained OMHSAS staff, and written feedback was given to each county.

II. PLANNING AS A CHANGE AGENT

County Mental Health Plans

The legal purpose of the County Mental Health Plan is to meet the requirement in the MH/MR Act of 1966 that the local authorities review and approve an "annual plan and estimated costs" and transmit that plan to the Department of Public Welfare. However, its real value surpasses any legislative mandate. It is through this instrument that the counties articulate their vision and roadmap for accomplishing the transformative changes for a recovery-oriented system.

The county mental health plans continued 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 as well as the managed care system. Consistent with the expectations in the guidelines, the counties outlined their strategies to continue to transition from reliance on large institutions towards an array of community services and supports designed to facilitate the recovery of individuals with serious mental illness and co-occurring substance use disorders.

¹ Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services, *County Mental Health Plan for Adults with Serious Mental Illness, Fiscal Year 2008/2009 Guidelines*. Issued October 2006.

² Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services, *A Call for Change: Toward a Recovery-Oriented Mental Health Service Delivery System for Adults*. [Available at <http://www.dpw.state.pa.us/Resources/Documents/Pdf/Publications/ACallForChange.pdf>]

The report by the President's New Freedom Commission on Mental Health³ states in no uncertain terms that offering a full range of community-based alternatives is more effective than hospitalization and emergency room treatment. The report also ardently advocates for a range of effective, community-based treatment options that are critical for community participation and integration, and which are crucial in the recovery journey of consumers. The mental health plans submitted by the counties bear testimony to the fact that their planning efforts center around the development of community-based treatment options with focus on evidence-based and promising practices.

While the county planning process is an effective tool to assist the counties and the state in their commitment to re-design the mental health service system, development of the plan in itself should not be construed as the ultimate goal or solution. Keenly monitored plan implementation, including the coordination and integration of relevant services and supports, is vital to bring about the transformative changes envisioned in the plan.

Increased Emphasis on Collaboration

OMHSAS unequivocally acknowledges the fact that “the rallying cry of *nothing about us without us* has heralded extensive involvement of consumers of mental health services, families affected by mental illness, and families of children with serious emotional disorders, together with other advocates, in the improvement of the public mental health system in the United States”⁴. In recognition of the underlying spirit of self-determination that drives “*nothing about us without us*”, the county plan guidelines were unambiguous in the call for meaningful engagement of 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, in all steps of the planning process.

In addition to public hearings and the use of the Internet and electronic document exchange to solicit input into the plans, many counties held stakeholder-specific focus groups and/or subject-related forums as methods of maximizing the public's opportunity to not merely be informed of the plan, but also to play a role in its development.

OMHSAS and the counties also realize that, in the planning process, the realm of collaboration can not be limited to entities working within the mental health system. To that effect, the counties also partnered with their counterparts in mental retardation, drug and alcohol, county probation, state and county corrections, aging, housing, and vocational rehabilitation in the development of their mental health plans in order to harness the best integration and utilization of federal, state, county, and other resources.

³ New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*. DHHS Pub. No. SMA-03-3832. [Available at www.mentalhealthcommission.gov/reports/reports.htm]

⁴ Mental Health America, *Position Statement: Participation in Planning, Advisory, and Governance Boards*. [Available at <http://www.nmha.org/go/position-statements/63>]

III. CHANGES ON THE HORIZON

Evidence-Based Practices (EBPs)

Pennsylvania's commitment to promote the development of EBPs was reinforced in the White Paper "*Strategies for Promoting Recovery and Resilience and Implementing Evidence Based Practices*" released in October 2006. This document was a companion work to OMHSAS' "*A Call for Change*" document to continue the work in developing recovery-oriented services and supports.

It was evident from the majority of the County Plans that many counties have implemented evidence-based practices, and many more have commenced the adoption of Evidence-Based Practices (EBPs). Evidence-Based Practices can be described as those interventions for which there are consistent empirical evidence to demonstrate that they improve consumer outcomes. Also, EBPs represent one of the ten National Outcome Measures (NOMs) that the Substance Abuse & Mental Health Services Administration (SAMHSA) utilizes to evaluate and quantify the outcomes accomplished by the states. "NOMS embody meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in the communities"⁵. The counties were asked to report on the existence of or plan to develop the following seven specific EBPs:

1. Family Psychoeducation
2. Integrated Treatment for Co-Occurring Disorders
3. Illness Management and Recovery
4. Supported Housing
5. Supported Employment
6. Assertive Community Treatment
7. New Generation Medications

Many counties reported that they are planning for and/or are implementing at least some of the EBPs. However it was also obvious that many counties are still grappling with understanding the distinction between EBPs and other emerging practices. Also, some counties apparently have challenges when it comes to recognizing and embracing the concept of fidelity to nationally accepted standards for evidence-based practices. Technical assistance and information-sharing/networking with counties and programs that have successfully implemented EBPs can play a critical role in addressing this need.

Recovery-Oriented/Promising Practices

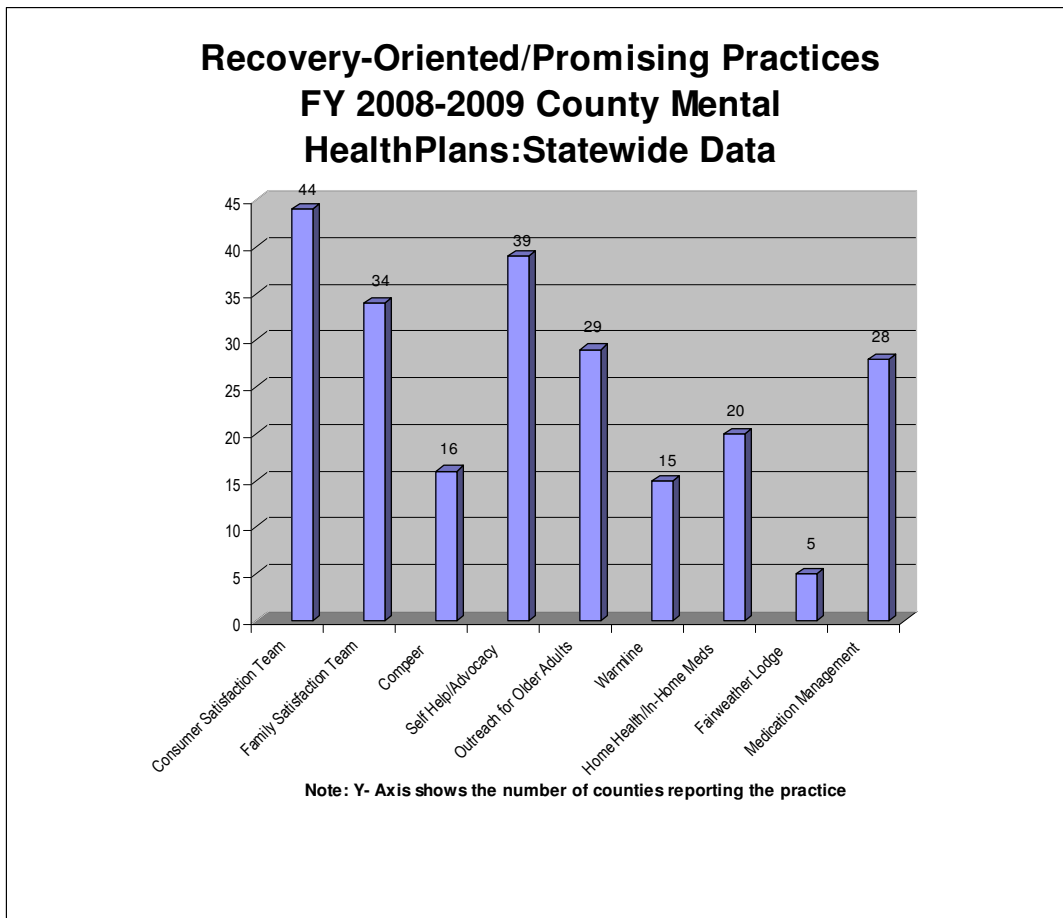
The FY 2008/2009 County Plans demonstrated the continued efforts in the counties to expand the development of Recovery-Oriented/Promising Practices as evidenced by the data presented in the *County Plan Attachment J: Recovery Oriented/Promising Practices*. The

⁵ Substance Abuse & Mental Health Services Administration, *National Outcome Measures*. [Available at www.nationaloutcomemeasures.samhsa.gov]

counties had been asked to report on the development of the following recovery-oriented/promising practices:

1. Consumer Satisfaction Team
2. Family Satisfaction Team
3. Compeer
4. Self Help/Advocacy
5. Outreach for Older Adults
6. Warm Line
7. Home Health/In-Home Meds
8. Fairweather Lodge
9. Medication Management

The chart below illustrates how counties reported on the development of the recovery-oriented/promising practices (existing as well as planned) identified above:



It was encouraging to note that the FY 2008-2009 plans reported increased availability of all but two of the practices listed above compared to the FY 2007-2008 plans. As an example, 34 counties reported either the existence of, or plans to develop Family Satisfaction Teams, compared to 28 counties from last year. Another example is the increase in “Outreach for Older

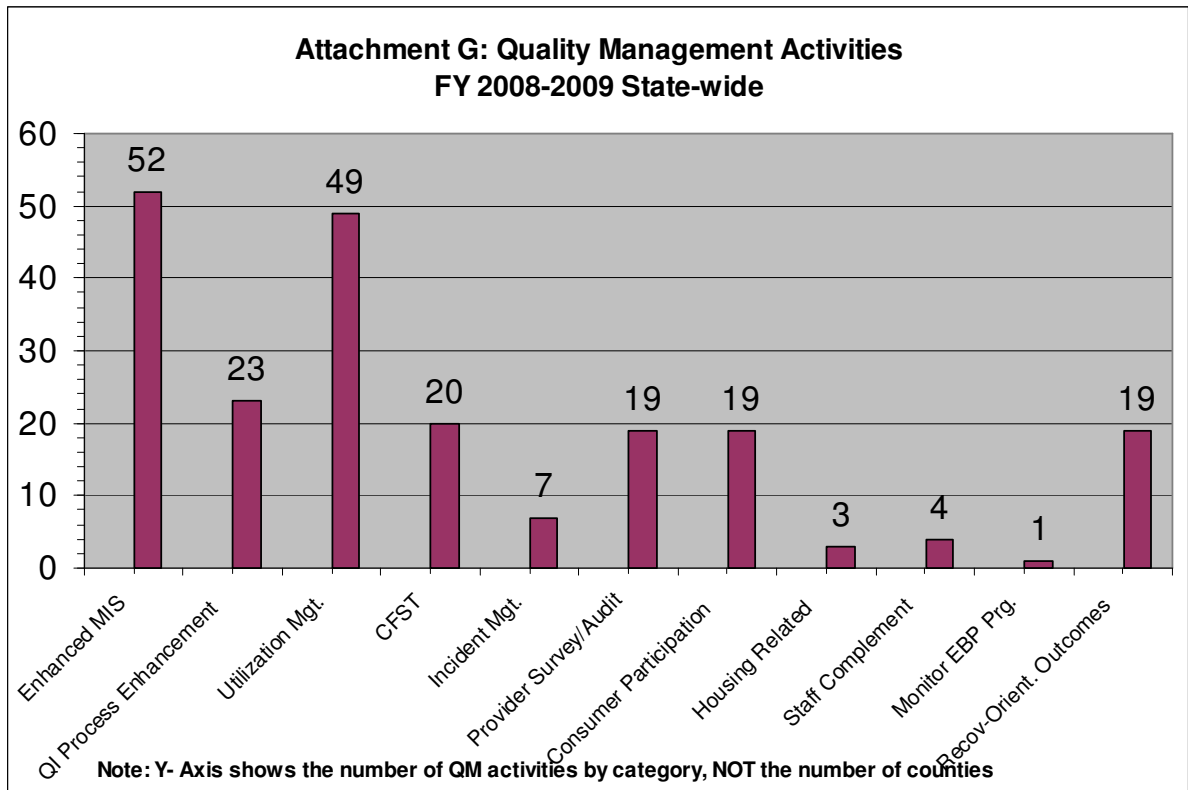
Adults”, from 24 counties to 29. This increase was consistent with our expectation that the counties would continue to create new opportunities for serving older adults, considering the fact that Pennsylvania has one of the highest percentages in the country of residents aged 65 and over (15.3% of the total Commonwealth population versus 12.4% nationally).

Quality Management Activities

The FY 2008-2009 guidelines required that counties provide updates on their quality management (QM) activities in *Attachment G* of the County Plan. These activities could include development of tools/procedures to track outcomes, or plans/action steps required to accomplish the county’s expectations of quality of care. A total of 216 QM activities were reported by the 48 County MH/MR Program offices. OMHSAS compiled and organized the data submitted by the counties on their *Quality management Activities* under the following categories:

- Enhanced Management Information Systems (MIS)
- Quality Improvement (QI) Process Improvement
- Utilization Management
- Consumer/Family Satisfaction Teams (CFST)
- Incident Management
- Provider Survey/Audit
- Consumer Participation
- Housing Related
- Staff Complement
- Monitoring of Evidence-Based Practices (EBP)
- Recovery-Oriented Outcomes

As indicated in the chart below, many counties identified the enhancement of Management Information Systems (MIS) as a quality improvement priority, and so were grouped under the category of “Enhanced MIS”. Similarly, other QM activities were also grouped under the categories that best matched their description. The total number of QM activities exceeds the number of reporting County MH/MR Offices since the counties reported on more than one QM activity, with an overwhelming majority identifying five activities. The following chart summarizes the state-wide data for quality management activities:



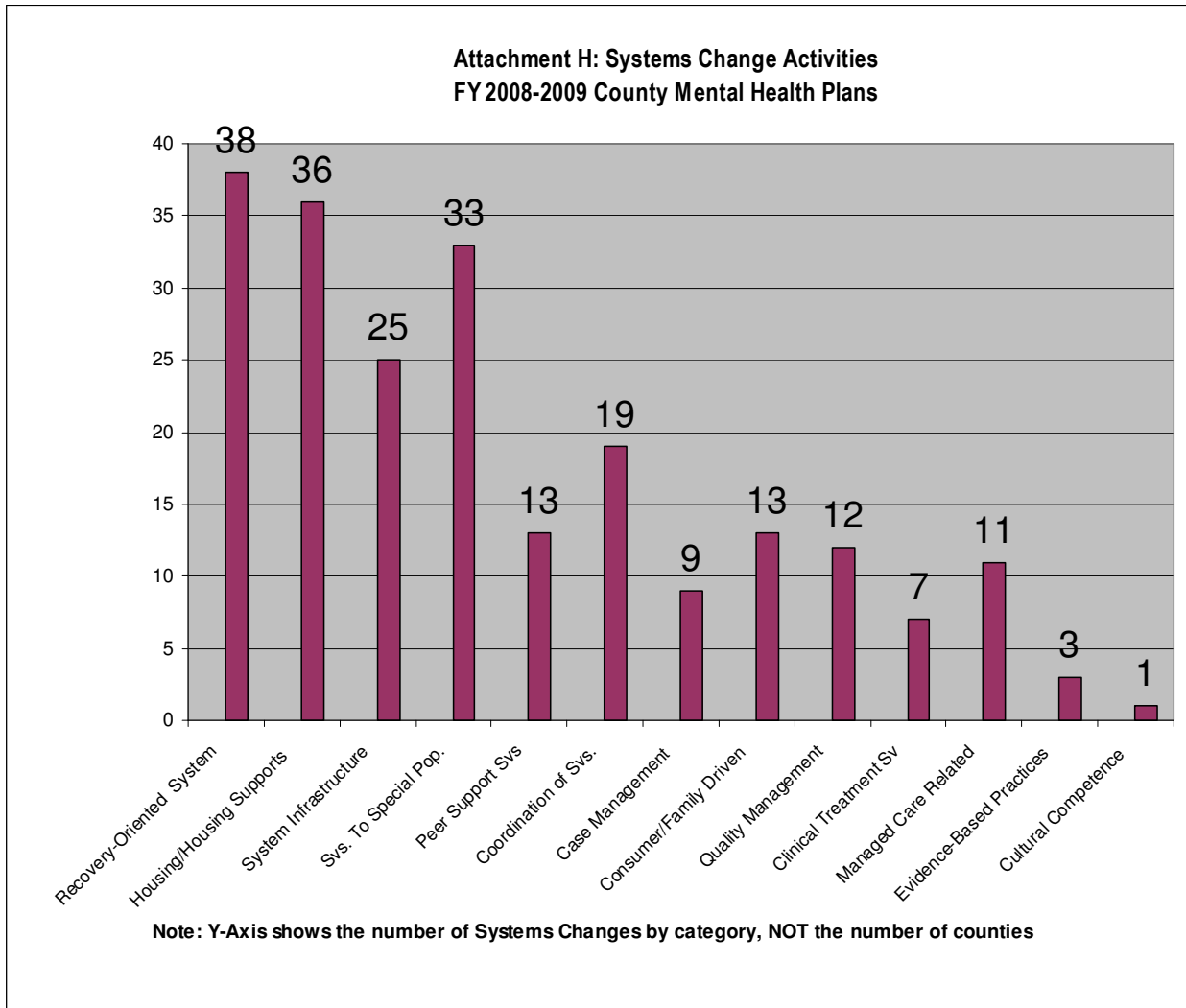
Systems Change Priorities

As evidenced by the FY 2008-2009 County Plan *Attachment H: Top Five Systems Changes*, counties have thoughtfully identified the priorities to bring about transformational changes in the system. In this attachment, the counties prioritized their recommendations for the top five system changes that included efforts to facilitate recovery, improve service access, and address quality and outcomes. OMHSAS compiled and organized the data submitted by the counties on their *systems changes* plans under the following categories:

- Recovery-Oriented System
- Housing/Housing Supports
- System Infrastructure
- Services to Special Populations
- Peer Support Services
- Coordination of Services
- Case Management
- Consumer/Family Driven Services
- Quality Management
- Clinical Treatment Services
- Managed Care related
- Evidence-Based Practices
- Cultural Competence

For example, counties identified 38 separate system change plans which could be codified as recovery-oriented in nature and so were grouped under the category of “Recovery-Oriented System”. Similarly, other *systems changes* plans were also grouped under the categories that best matched their description. One of the Systems Change categories that merits special mention is the “Housing/Housing Supports” category, which registered significant increase from the previous year’s plans (177 % increase, from a count of 13 to 36). The reason

for increased focus on housing can possibly be attributed to “*A Plan for Housing and Recovery-Oriented Services*” issued in the fall of 2006. In total, there were 220 *systems changes* identified by the 48 County MH/MR program offices. The following chart summarizes the state-wide summary data for *systems changes*:



Enhancing Infrastructure & Service Capacity

County Plan Attachment K: Top Five Funding Requests for Infrastructure Support or Enhancement of Service Capacity that Require New State Funds was utilized by counties to identify prioritized funding needs designated to create, sustain or enhance services. These requests were targeted toward services for adults with serious mental illness, with most counties targeting at least one of the new funding requests to older adults or to transition age youth.

The types of services/supports identified that require new state funds included, but were not limited to: Supported Housing, WarmLine, Peer Specialist Services, Psychiatric

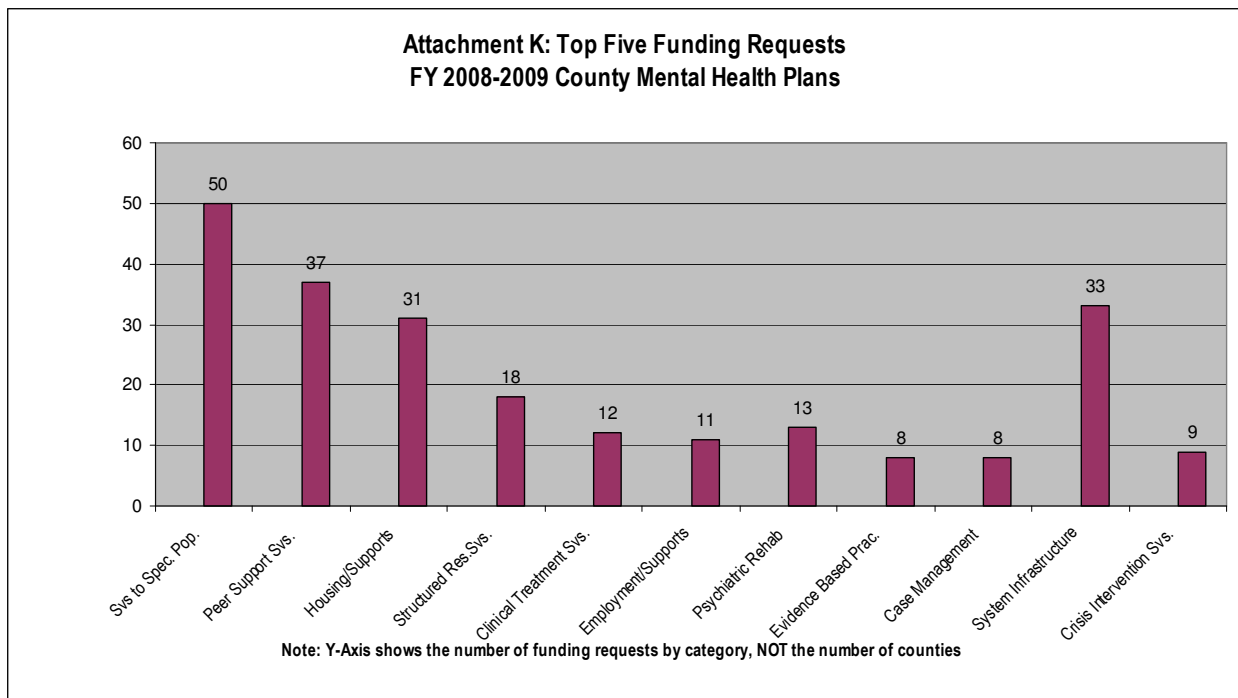
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Rehabilitation, Drop-In Center, Clubhouse, Mobile Services, etc. In total, there were 230 new funding requests identified by the 48 County MH/MR program offices.

OMHSAS compiled the data submitted by the counties on *Top Five Funding Requests for Infrastructure Support or Enhancement of Service Capacity that Require New State Funds* and grouped the requests under the following categories:

- Services to Special Populations
- Peer Support Services
- Housing/Supports
- Structured Residential Services
- Clinical Treatment Services
- Employment/Supports
- Psychiatric Rehabilitation
- Evidence-Based Practices
- Case Management
- System Infrastructure
- Crisis Intervention Services

The following chart summarizes the state-wide data for *Top Five Funding Requests for Infrastructure Support or Enhancement of Service Capacity that Require New State Funds*:



The highest unmet category of service need identified by the counties for the third year in a row was for Supported Housing or Residential Services (49 total requests), followed by Peer Support Services (37 requests) and Psychiatric Rehabilitation (13 requests). Many counties identified the need for service for special populations (50 requests), which include transition-age youth, persons with co-occurring disorders, the forensic population, and older adults. While the requests for special populations varied significantly, many of the requests were for housing/residential services.

Performance Measures

The County Plans for FY 2008-2009 also included the following performance measures that were linked to financial incentives:

- a) **Recovery Orientation:** Inclusion of a Vision and a Mission Statement in the County Plan that supports the facilitation of recovery. This measure also required evidence of consumer involvement representing all target groups, namely adults, older adults, and transition-age youth, in the development of/and concurrence with the Vision and Mission statements. Once the plans were submitted to OMHSAS, a workgroup comprising of a broad array of stakeholders evaluated the Vision and Mission statements of all counties and made recommendations to OMHSAS as to which counties satisfactorily met the requirements for “recovery orientation” in the Mission and Vision statements.
- b) **Peer Specialist Services:** Counties with at least one provider that had submitted a Service Description for the provision of Peer Specialist services qualified for financial incentives under this quality measure.

OMHSAS allocated \$1,765,000 in financial incentives, with counties receiving awards ranging from \$7935 to \$84,353 based on their performance in the above two factors. These awards are to be utilized by counties to support the Systems Change activities identified in their Plans.

IV. SUMMARY

The 2008-2009 County Mental Health Plans provided detailed narratives of the efforts underway in the counties to carry on the journey toward the realization of the goals envisioned for a transformed mental health service delivery system. The County Plans were the product of collaborative efforts involving consumers, family members, and other stakeholders who worked with the counties to develop these blueprints for a recovery-oriented system.

The commitment to transformation was manifested in many ways in the County Plans, including the implementation of Evidence-Based Practices and the leveraging of many other recovery-oriented/promising practices to facilitate the recovery of individuals with serious mental illness and co-occurring substance use disorders. Also evident from the County Plans is the increased emphasis on housing initiatives with the renewed impetus provided by “*A Plan for Promoting Housing and Recovery-Oriented Services*” issued by OMHSAS in the fall of 2006.

The County Plans also addressed the various quality management initiatives that the counties have undertaken that included improved checks and balances in the system, as well as outcome measures that help evaluate the effectiveness of various practices. Also, as demonstrated in the County Plans, counties understand that the success of transformation is inherently tied to the process of bringing about needed changes to some components of the existing systems.

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OMHSAS recognizes that the journey towards transformation is far from over and that counties face many challenges as they strive diligently to develop systems that are built around the principles of recovery. In partnership with other stakeholders, we will continue to manage and overcome those challenges, and identify new opportunities to support the realization of our transformational agenda that draws inspiration from the conviction that individuals with serious mental illness can and do recover.