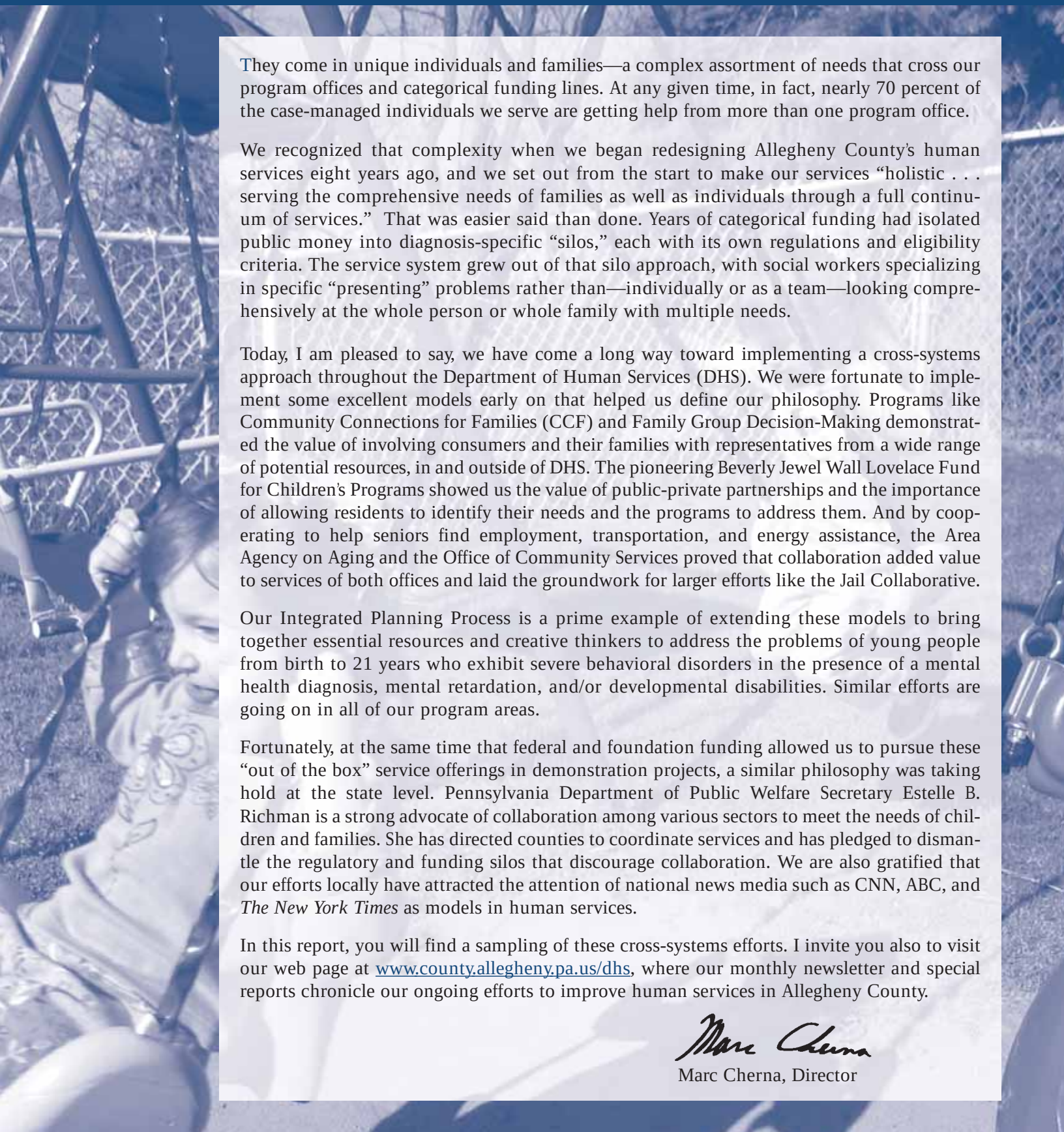
The challenges of humanity don't come in neat packages

labeled "child neglect and abuse," "mental illness," "mental retardation," "disability," "addiction," "homelessness," "old age," "incarceration," and "poverty."



They come in unique individuals and families—a complex assortment of needs that cross our program offices and categorical funding lines. At any given time, in fact, nearly 70 percent of the case-managed individuals we serve are getting help from more than one program office.

We recognized that complexity when we began redesigning Allegheny County's human services eight years ago, and we set out from the start to make our services "holistic . . . serving the comprehensive needs of families as well as individuals through a full continuum of services." That was easier said than done. Years of categorical funding had isolated public money into diagnosis-specific "silos," each with its own regulations and eligibility criteria. The service system grew out of that silo approach, with social workers specializing in specific "presenting" problems rather than—individually or as a team—looking comprehensively at the whole person or whole family with multiple needs.

Today, I am pleased to say, we have come a long way toward implementing a cross-systems approach throughout the Department of Human Services (DHS). We were fortunate to implement some excellent models early on that helped us define our philosophy. Programs like Community Connections for Families (CCF) and Family Group Decision-Making demonstrated the value of involving consumers and their families with representatives from a wide range of potential resources, in and outside of DHS. The pioneering Beverly Jewel Wall Lovelace Fund for Children's Programs showed us the value of public-private partnerships and the importance of allowing residents to identify their needs and the programs to address them. And by cooperating to help seniors find employment, transportation, and energy assistance, the Area Agency on Aging and the Office of Community Services proved that collaboration added value to services of both offices and laid the groundwork for larger efforts like the Jail Collaborative.

Our Integrated Planning Process is a prime example of extending these models to bring together essential resources and creative thinkers to address the problems of young people from birth to 21 years who exhibit severe behavioral disorders in the presence of a mental health diagnosis, mental retardation, and/or developmental disabilities. Similar efforts are going on in all of our program areas.

Fortunately, at the same time that federal and foundation funding allowed us to pursue these "out of the box" service offerings in demonstration projects, a similar philosophy was taking hold at the state level. Pennsylvania Department of Public Welfare Secretary Estelle B. Richman is a strong advocate of collaboration among various sectors to meet the needs of children and families. She has directed counties to coordinate services and has pledged to dismantle the regulatory and funding silos that discourage collaboration. We are also gratified that our efforts locally have attracted the attention of national news media such as CNN, ABC, and *The New York Times* as models in human services.

In this report, you will find a sampling of these cross-systems efforts. I invite you also to visit our web page at www.county.allegheny.pa.us/dhs, where our monthly newsletter and special reports chronicle our ongoing efforts to improve human services in Allegheny County.

Marc Cherna

Marc Cherna, Director

Meeting the multiple needs of children and youths…

Growing up—particularly during the teenage years—can be a difficult time for young people, but for those with serious behavioral problems coupled with mental illness or mental retardation diagnoses, the problems can seem insurmountable.

Take Katie, for example.

Referred at age 15 to the DHS Office of Children, Youth and Families (CYF) for chronic truancy, Katie was neither simply a defiant teenager nor the victim of neglect or abuse. The aunt and uncle with whom she had lived since her mother's death two years earlier were at their wit's end. Unable to keep her in school regularly, they didn't consider mental health services until a suicide threat placed her in a psychiatric hospital. Discharged with wraparound services from behavioral specialists, Katie continued to miss school—even after she was ordered by the court to attend. She was placed in a shelter, where her psychiatric symptoms stabilized with a change in medication and her school attendance improved—although she was sleeping through some classes. How could she return home and be assured of continued progress?

Katie's situation triggered an Allegheny County Interagency Review involving a cross-systems planning group convened by the Department of Human Services (DHS) Office of Behavioral Health (OBH) in partnership with the Offices of Children, Youth and Families (CYF) and Mental Retardation/Developmental Disabilities (MR/DD). When traditional methods of intervention have failed, consumers and their families, as well as any natural supports identified by the family, are brought together with other representatives of the child-serving systems—including juvenile justice, the managed care organization, education, and direct service providers—to ensure that the comprehensive needs of the individual are addressed through a continuum of services and tangible assistance when needed. In fiscal year 2003-2004, 109 such meetings were convened to develop plans for 94 individual consumers. Like Katie, all were involved in multiple systems.

The interagency meeting with Katie and her aunt and uncle revealed a host of issues including serious communication difficulties. Katie's tendency to fall asleep in class was reported to her CYF caseworker but not to the psychiatrist who prescribed the new medication. The aunt and uncle confessed that they did not understand her depression and anorexia, that no one had received grief counseling after the death of Katie's mother, and that earlier wraparound services had been sporadic and ineffective. A school representative suggested that Katie might have a learning disability, but her absences had made testing impossible. The outcome of the meeting was a plan for comprehensive wraparound services, consultation with the psychiatrist for a medication review and possible referral to an acute partial program or a family-based mental health service, and initiation of educational assessment and meetings with school special education professionals.

The 30-day follow-up showed that the plan was working for Katie and her family as it does for most consumers. At times, though, the team encounters roadblocks that obstruct putting the plan into action. In these instances, the case is referred to the Multi-System Rapid Response Team (RRT). Composed of a professional "family member" and representatives from juvenile justice, the managed care organizations, and all relevant DHS offices (including adult services), the RRT convenes to address the individual's complex needs that are not adequately addressed by the existing array of services. They have the authority to research, negotiate, and pool resources to find or create solutions that result in viable short- and long-term plans and services for young people with multiple disabilities and serious behavior problems.

Sean is an example of the Rapid Response Team's target population.

Rapid Response Team Meeting

At 16, Sean was diagnosed with bipolar disorder, intermittent explosive disorder, and moderate mental retardation, and he was court-involved in two counties as a result of assaults on the personnel in the group homes where he lived. A consulting forensic psychologist concluded that the group home was not an appropriate level of care for Sean, who continued his assaultive behavior and was admitted three times in a 12-month period to a psychiatric hospital. After many futile attempts to resolve placement issues at the county interagency level, Sean's case was referred to RRT for review and planning. Representatives from OBH, CYF, and MR/DD worked closely with the probation officers from both counties to find an appropriate residential setting that could manage his severe acting-out behaviors.

Sean's history of multiple hospitalizations, failed placements, dual diagnosis of MH and MR/DD with severe behavioral acting out, and referral denials qualified him for Residential Enhancement Service Planning Opportunities for New Directions (RESPOND). This unique residential program for young people dual-diagnosed with MR/DD and severe behavioral difficulties is a new resource and a product of RRT planning for a population previously underserved. The program consists of three group homes, each limited to two residents with a staff-to-child ratio of 2:1 or 3:1. The program is supported by a mobile treatment team of psychiatric and behavioral clinicians.

Sean's family approved the placement, and during his stay in RESPOND, Sean had no hospitalizations. He demonstrated tremendous success with self-regulation through behavioral interventions and neurological and medical consultations that actually resulted in a decrease in his overall medications. After 20 months in RESPOND, Sean was discharged to a community residential program with 1:1 staff/child ratio. He currently attends a partial school program with the support of a classroom aide, participates actively in Special Olympics, and spends time with his peers and family. The Rapid Response Team follows up periodically to assure that Sean's needs continue to be met and a successful transition is achieved.

During FY 2003-2004, 13 cases were processed by the RRT. By "braiding" funding from several systems to establish individualized supports for especially challenging youths, the RRT achieved remarkable success. Prior to the team's intervention, all of the youths had significant histories of multiple hospitalizations. In the year since discharge, none have been re-hospitalized.

Integrated Children's Service Plan/ System of Care

This integrated approach to planning and service delivery for young people reflects the growing movement toward cross-systems involvement in all aspects of the DHS Integrated Children's Services Plan and in other DHS program areas as well. The collaboration among DHS offices, across a wide range of public and private agencies, and with our consumers and their families evolved over time, the result of successful demonstration projects like the Systems of Care Initiative.

Funded for six years by the Substance Abuse and Mental Health Services Administration (SAMHSA), Community Connections for Families (CCF) provided a family-driven cross-systems practice model for serving children between the ages of 6 and 14 with serious emotional disturbances. Emphasizing partnerships between the families and the communities where they live, CCF won national awards for innovation, for reducing racial disparities in access to mental health care, and for its anti-stigma communications campaign. CCF also received top ratings in its evaluation by SAMHSA.

CCF's unique systems of care model formed the basis for Partnerships for Youth Transition (PYT), a federally funded companion initiative for adolescents and young adults from age 14 to 21 with serious mental illnesses. Even after it has become a standing DHS program within OBH, CCF continues to provide valuable information and experience for the integration of children's services countywide. As has happened with CCF, the goal for PYT, when federal funding ends, is to sustain the program with mental health and third party funds. Both programs continue with plans to expand and serve the entire county.

—and the needs of seniors…

Senior Living Enhancement Program

Taking on the responsibilities of child care at age 60 or older isn't easy, but increasingly, seniors are finding themselves full-time parents again. When parental crises—mental illness, addiction, or abusive behavior, for example—place children at risk, the only safe alternative may be foster care. The least disruptive setting is often within the extended family, frequently with grandparents or other older relatives.

With support from the Pennsylvania Department of Aging and the National Family Caregiver Support Program, the DHS Area Agency on Aging (AAA) works with CYF and individual families to ensure that senior caregivers receive the help they need to sustain themselves and their young charges. The Elder Caregiver of Children 18 and Younger Program draws upon the resources of all DHS offices as well as many community service providers to meet the participating elders' individual needs as assessed by the care manager, the caregiver, and the family. Needs may include access to camps and tutoring for the children receiving care; furniture, linens, food, and other tangible items for the home; energy assistance and transportation; and caregiver training; benefits counseling, support groups, and financial reimbursement for related supplies and services. Approximately one-third of the families are involved in multiple systems.

As with many cross-systems initiatives, this program benefited from experience with earlier models—caregiver support programs for families caring for functionally impaired older relatives and caregivers of 18-59-year-olds medically diagnosed with irreversible dementia—that are designed to reduce caregiver stress and reinforce the quality of care.

A new collaboration to promote wellness, socialization, community building, and empowerment among residents of public housing senior high-rise buildings is also indebted to a successful model program for children. The Senior Living Enhancement Program, serving more than 1,000 seniors in 12 sites, is—like its prototype, the Beverly Jewel Wall Lovelace (BJWL) Fund for Children's Programs—a partnership of DHS, Allegheny County Housing Authority (ACHA), and The Pittsburgh Foundation.

Both of these public housing programs grew out of the expressed needs and wishes of the community residents,

both emphasize capacity building within the resident councils, and both reach out to other DHS offices and to community-based organizations to provide services.


Jail collaborative professionals

While CYF is the primary DHS program office involved in the BJWL program, AAA represents the department in the new initiative, which is funded as a two-year demonstration project. In each high rise, nurses from the Northern Area Multi-Service Centers offer health and wellness services, and social workers from the Lutheran Service Society encourage residents to participate in socialization and recreational activities.

The University of Pittsburgh Center for Healthy Aging works with resident councils on community building, with a focus on the Center's "Ten Keys to Healthy Aging." Screenings and education sessions address common health problems of older people (e.g., high blood pressure, blood glucose and cholesterol levels, bone loss, cancer, immunizations, depression, smoking, social contact, and physical activity.)

Currently operating in 12 ACHA high rises across the county, the Senior Living Enhancement Program may be extended to Housing Authority of the City of Pittsburgh (HACP) communities in the future.

Helping to turn lives around and make neighborhoods safer…

Most inmates of correctional institutions bring with them a plethora of challenges. For many, it is addiction, poverty, or homelessness, and is accompanied by chronic mental or physical illness. Most lack the education or work history to equip themselves to compete for jobs. Without active intervention, these problems still exist at the time of release.

Small wonder, then, that the jail door becomes a revolving one, and communities are victimized by re-offenders. Nationally, the recidivism rate is more than 60 percent; locally, it was 70-75 percent before the Jail Collaborative, a joint effort by DHS, the Allegheny County Jail, and the Allegheny County Health Department, began its intensive reintegration efforts in 2000. The rate has dropped to as low as 12 percent in the program since 18 service providers have been providing intensive pre- and post-release services to volunteer participants like Robert.

When Robert, 43, was jailed on drug and robbery charges during a visit to Pittsburgh, he was homeless and virtually without a local support system. Despite a history of abuse as a child and long-term addiction, he had never received treatment or counseling for either. His sporadic work history as a short order cook grew out of training he acquired during four years in the Army. Hopeless as the future seemed, Robert nevertheless volunteered for the Reintegration Program at the Allegheny County Jail. While still incarcerated, Robert worked with his Reintegration Specialist (RS) to create a service plan for wellness and employment, addressing his addiction through group sessions and honing his résumé and interviewing skills. As his release date neared, Robert's plan expanded to include housing, transportation, and tangible aid, and his RS arranged for his parole to the County SAVE Program at Gateway Braddock rehabilitation center, meeting his need for both continued drug counseling and for housing.

Comprehensive case management doesn't end with release from incarceration; it follows the participants into the community, drawing on cross-systems cooperation to ensure that public assistance or disability payments begin immediately and those who require psychiatric or other critical medications have access to them. Tangible needs (for transportation and clothing, for example) are addressed, and assistance in finding housing and employment continues. For Robert, "reentry" went like this:

Robert's RS closely monitored his progress at Gateway and subsequently at First Step (a half-way house), and when Robert was ready to live independently, the RS secured rental assistance from the Urban League for him. Counseling and support meetings helped him address his addiction and abuse issues, and with help from Goodwill, Inc., and CareerLink, he found a job as a cook and has since been promoted within the company. Local foundations provided a bus pass and vouchers for clothing and furniture to ease his transition to independent living. His RS and other staff continued to provide monitoring and support.

Reintegration efforts like these have not only reduced recidivism and its associated costs; they have also improved access to care for those with mental health or drug and alcohol problems, both within the jail and after release. Meanwhile, pre-sentencing reviews before Drug Court and Mental Health Court have diverted many non-violent offenders to sources of help rather than jail cells. The outcome for both the diversionary and reentry initiatives is enhanced public safety.

The Jail Collaborative includes representatives from the courts, probation and parole, the state correctional system, relevant public agencies, service providers, the DHS Office of Community Services, OBH, and CYF. Monthly meetings are trouble-shooting sessions and an exploration of new ideas and approaches. To assess the ways that race impacts the adjustment to life after jail, the University of Pittsburgh's Center on Race and Social Problems is currently conducting a three-year study of 300 County Jail inmates.

Jail collaborative consumer

Similar in intent and services to the reintegration efforts at the County Jail, the Allegheny County State Forensic Program addresses the myriad basic needs of individuals with behavioral health disorders as they return to Allegheny County after release from state prisons. Among the 347 offenders who have participated in this program since its start in 1999, the recidivism rate (10.4 percent) is one-sixth the national rate (61 percent) for individuals released from state prisons with a behavioral health diagnosis. The program's cost-effectiveness is evident in the comparison of the average yearly cost for a prison inmate ($25,000) with the average amount the program spends on each participant ($3,000).

An effective collaboration between DHS, the Pennsylvania Department of Corrections (including psychologists in the state's 26 penitentiaries who refer eligible inmates), and local social service agencies, the program has received national kudos from *New York Times* reporter Fox Butterfield. In a May 4, 2004 article, Butterfield—who spent a day with DHS Director of Forensic Services Amy Kroll—observed, *"Nowhere has the effort to improve the re-entry process been more successful, and had more bipartisan support, than here in Pittsburgh."* The program was also chosen as one of 18 finalists for a 2005 Innovations in American Government Award, which recognizes and honors "outstanding examples of public sector creativity and effectiveness."

Measuring our accomplishments…

Families enter the CYF system for a variety of reasons, often a combination of factors that place children at risk for neglect and abuse. Two of the most frequent problems are parental substance abuse and the lack of adequate housing. In an effort to address these key issues, DHS contracts with two community organizations to provide direct services: Pennsylvania Organization for Women in Early Recovery (P.O.W.E.R.) and the Urban League of Pittsburgh, Inc.

The P.O.W.E.R. Connection

This program for women with the disease of addiction who have children in the CYF system or who are at risk of having the children enter the system is conducted jointly with CYF, the Bureau of Drug and Alcohol Services in OBH, and Magee Womens Hospital. A continuum of services is provided to support the women in treatment and recovery so that they are able to keep their children at home or reunify with those who were already in placement.

Initial results from a five-year longitudinal evaluation of the program for the six-month period from January 1 to June 30, 2003, showed a success rate of 96 percent in preventing foster placement of children at risk. Positive results also occurred in the more complex situations where families were striving for reunification. Although these preliminary findings are based on a relatively short time span, the second year evaluation will follow the cases to determine the longer term impact of the program on family preservation and reunification.

Urban League Housing Assistance Program

This CYF contract with the Urban League provides housing counseling and cash assistance in the form of subsidies, usually for the first month's rent and security deposit, to prevent placement of children in foster care or to facilitate reunification for those in placement. A two-year evaluation by the DHS Office of Information Management (OIM) showed results similar to those of the P.O.W.E.R. initiative: a 90 percent success rate in preventing foster placement within six months after the subsidy was issued as well as significant progress in family reunification over the same period.

Even more impressive was OIM's cost benefit analysis of the program: based on average subsidy amounts ($685) and the average cost per day of foster care ($50). Evaluators reported that in prevention cases—those cases where placement was avoided—the program saved $12 for every $1 spent (a total of nearly $2 million) for the 251 families with no children in placement at the time of referral. For the 138 families who had had children in placement and were subsequently reunified, the savings were more than $335,000-or a return of $4.57 for every dollar spent.

Outcome analyses like these are invaluable, and we will continue to include solid evaluation components in everything we do. Such information indicates what does and doesn't work, provides documentation to leverage essential (if sometimes non-traditional) funding, and provides direction to future planning.

We are heartened by our successes over the last eight years—by the strong evidence that prevention *does* work and by the recognition we've garnered from such sources as CNN and ABC News as a "model" for child welfare services. We are grateful to our many partners in the public and private sectors who support the cross-systems approach philosophically and financially, and we are counting on their continued collaboration as we address the many challenges ahead in pursuing our goal of a comprehensive, seamless human service system in Allegheny County.

Allegheny County Department of Human Services

Guiding Principles

All services will be:

- **High quality** — reflecting best practices in case management, counseling, and treatment.
- **Readily accessible** — in natural, least-restrictive settings, often community-based.
- **Strengths-based** — focusing on the capabilities of individuals and families, not their deficits.
- **Culturally competent** — demonstrating respect for individuals, their goals, and preferences.
- **Individually tailored and empowering** — by building confidence and shared decision-making as routes to independence rather than dependency.
- **Holistic** — serving the comprehensive needs of families as well as individuals through tangible aid and a full continuum of services —

Information Exchange ▪ Prevention ▪ Early Intervention ▪ Case Management & Crisis Intervention ▪ After Care

Vision

To create an accessible, culturally competent, integrated, and comprehensive human services system that ensures individually tailored, seamless, and holistic services to Allegheny County residents, in particular, the County's vulnerable populations.

Department Overview

231,400 persons served annually

Total Staff: 1,052

Service Providers: 384

Total Budget: $757.4 million *(only 3.6% is County funds)*
Total includes the Allegheny HealthChoices Program

Funding Sources: 80
Each with separate laws, regulations and reporting requirements

Allegheny County Department of Human Services (DHS) is responsible for providing and administering human services to County residents through its five program offices:

Area Agency on Aging (AAA)
Office of Behavioral Health (OBH)
Office of Children, Youth & Families (CYF)
Office of Community Services (OCS)
Office of Mental Retardation /Developmental Disabilities (MR/DD)

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