ADULT TREATMENT SERVICES CONTINUUM OF CARE

More intensive levels of care → **Based on individual needs, a person can move from a higher or lower level of care in any order** → **Less intensive levels of care**

OUT-OF-HOME SERVICES						COMMUNITY BASED SERVICES				OFFICE BASED SERVICES IN COMMUNITY LOCATIONS	
State Hospital (1)	**Inpatient Hospital (2)**	**Extended Acute Centers (EAC) (3)**	**Long-Term Structured Residence (LTSR) (4)**	**Diversion and Stabilization Unit (DAS) (5)**	**Non-Hospital Rehabilitation (3C): CORE (6)**	**Community Treatment Team (CTT)/ Assertive Community Treatment (ACT) (7)**	**Enhanced Clinical Service Coordination (ECSC) (8)**	**Mobile Medication Program (9)**	**Comprehensive Dialectical Behavior Therapy (CDBT)**	**Partial Hospital Program (10)**	**Outpatient/ IOP (11)**
Torrance	Alle-Kiski Medical Center Forbes Regional Jefferson Regional Ohio Valley St. Clair UPMC- McKeesport Western Psychiatric Hospital (WPH)	TRU and CRU: provided by WPH EAC and RTF-A: provided by Pittsburgh Mercy Behavioral Health (MBH)	Chartiers Manor Journey Home (MBH) Monarch Springs (MBH) Pioneer (MBH) Russellton (Merakey) RISE (Merakey) Pathways (WPH) Glassport (RHD)	Chartiers (RTP) Wesley Family Services Pittsburgh Mercy Turtle Creek Valley (TCV)	CORE: Capitalizing on a Recovery Environment-Resources for Human Development (RHD)	Pittsburgh Mercy: 4 adult teams WPH: 1 adult teams and 1 transition age team **Other similar models:** *MBH: *Integrated Dual Diagnosis Treatment (IDDT)* *Merakey: *Dual Diagnosis Treatment Team (DDTT)*	Pittsburgh Mercy - 2 teams TCV	WFS WPH	"ASCEND"- Staunton Clinic "ADAPT"- WPH	Chartiers (RTP) WFS Mercy TCV WPH *AGH* *Renfrew Center* *St. Clair Hospital*	Chartiers Family Links Wesley Family Services Pittsburgh Mercy Milestone Mon Yough Staunton TCV WPH Persad *PAAR* *Renewal*

Description of Services: *Criteria are condensed and generalized.*

1. **Torrance State Hospital:** Civil commitments and forensic. Used for competency evaluations and stabilization. Providers must exhaust all community resources-used as a last resort.
2. **Inpatient Hospital:** Provides high security and high intensity treatment interventions in psychiatric units of general hospitals. Individuals can be admitted involuntarily (302) or voluntarily (201).
3. **Extended Acute Care (EAC) Centers: Transitional Recovery Unit (TRU):** 31 beds, inpatient setting, referrals thru inpatient disposition meeting, individual demonstrates need for extended hospital stay, working on medication management and self-identified goals, expected length of stay is 180 days. **Extended Acute Care (EAC):** 16 beds, referral thru inpatient disposition meeting, individuals no longer require inpatient setting but continue to need long-term interventions in a locked residential facility, working on medication management and self-identified goals, expected length of stay is 180 days. **Comprehensive Recovery Unit (CRU):** 10 beds, referrals thru inpatient disposition meeting or TRU disposition meeting. Inpatient setting, individuals that are actively working toward community integration, individual is able to participate in assisted medication program, connected to community supports, housing plan identified, expected length of stay is 90 days (included in continuous episode of 180 EAC days) *Only CCBHO clients for CRU.* **Residential Treatment Facility- Adults (RTF-A):** 16 beds, hospital setting, referrals thru inpatient disposition meeting, individual does not require inpatient services but do require additional short-term interventions in a secure facility, ability to be cooperative with program guidelines and actively participate in treatment, expected length of stay 45-60 days.
4. **Long Term Structured Residence (LTSR):** Highly structured residential treatment facility, individuals do not require an inpatient setting, but do require ongoing 24 hour supervision, admission may occur voluntarily or involuntarily.
5. **Diversion and Stabilization Unit (DAS):** Respite/Treatment Services for those who can be diverted from inpatient care or are stepping down from inpatient care. **Central Recovery Center (CRC):** 12 beds, 72 hours crisis program designed for individuals from the justice system while providing treatment and stabilization, referrals from JRS, CIT and special cases with county approval, voluntary program.
6. **CORE/CROMISA:** 16 beds, 6 to 9 month voluntary program, support services for men with co-occurring mental and substance use disorders that are on county/state probation or parole, referrals from JRS and county D&A. *(Licensed thru DDAP)*
7. **Community Treatment Team (CTT)/Assertive Community Treatment (ACT):** A team that's comprised of a psychiatrist, nurse, therapist, service coordinator, vocational/educational specialist, team leader, and certified peer specialist. Must have primary diagnosis of chronic major mood d/o, psychotic d/o or schizophrenia, had numerous hospitalizations/ incarcerations and inability to remain in traditional community-based services. All necessary services are delivered to the consumer in the community where they reside. Caseload size 100 individuals ***all referrals are handled through Community Care Behavioral Health (CCBH)***

(CTT continued)

***Integrated Dual Diagnosis Treatment (IDDT)** Must have a primary diagnosis of Major Depressive Disorder, Bipolar Disorder, Psychosis NOS, Schizophrenia, Schizoaffective Disorder, or PTSD **and** a co-occurring Substance Use Disorder. Must have chronic street homelessness, and willing to participate in IDDT treatment. Team consists of team leader, clinical lead, therapist, certified peer specialist, integrated TX specialists, nurse. Uses community psychiatrist and medical doctor. Average length of stay 36 months. *CCBH eligible and referrals handled by CCBH*

***Dual Diagnosis Treatment Team (DDTT)** Must have significant MH diagnosis **and** Intellectual Developmental Disability of 70 or less and diagnosed prior to age 18, high utilizer of crisis/hospitalization, risk of losing housing/supports. Team consists of: psychiatrist, nurse, licensed director, coordinators, behavior specialist and psycho-pharmacologist consultant. Average length of stay is 12 to 18 months and will service 20 annually. *CCBH eligible and referrals handled by CCBH.*

service
individuals

8. **Enhanced Clinical Service Coordination (ECSC):** A team delivered service comprised of nurse, therapist, service coordinator, peer specialist and a team leader. The service is intended for individuals who are interested in or need a more intensive level of service than blended case management/service coordination, with a community clinical component. All necessary services are delivered to the consumer in the community where they reside. ***all referrals are handled through CCBH***
9. **Mobile Medication Program:** Community delivered program designed for individuals that have a history of not taking medications or encounter medication errors. Team consists of nurses and peer supports. Must have service coordinator for this program and currently being prescribed psychotropic medications. Average length of stay is 6-9 months.
10. **Comprehensive Dialectical Behavior Therapy (CDBT):** The program offers comprehensive dialectical behavior therapy (C-DBT) to adults who have not responded to traditional therapy and treatment available in standard clinics. The program includes learning skills to help manage distress and emotions. Eligibility criteria: Allegheny County residents ages 18 or older with a history of pervasive emotion dysregulation that has caused significant impairment in functioning. Eligible participants must have a history of high-risk behaviors including, but not limited to, self-harm and/or suicidal behaviors resulting in high use of treatment resources such as multiple inpatient hospitalizations, emergency room visits, and utilization of crisis services.
11. **Partial Hospitalization: (short-term):** Mental Health treatment intervention delivered in a clinic, to assist an adult in transitioning from inpatient treatment or for prevention of psychiatric hospitalization.
12. **Outpatient:** Community-based treatment interventions usually delivered in a clinic setting including: individual, group, family and medication management. Some agencies offer mobile MH outpatient- each agency develops criteria for target population and service delivery.

Updated: 7/23

ANCILLARY SERVICES FOR ADULT MENTAL HEALTH

Service Coordination (SC)/*Acute	Certified Peer Specialist (CPS)	Administrative Case Management: (Forensic and Hospital Liaisons)	Justice Related Services	Psychiatric Rehabilitation	Social Rehabilitation	Supported Employment	Peer Run Services	Crisis Services	Other Supports
Chartiers Center* Wesley Family Services (WFS)* Milestone Centers Pittsburgh Mercy* Staunton Clinic TCV Community Services* Western Psychiatric Hospital (WPH)* PAHrtners- Salisbury BH (deaf)	Milestone Centers Peer Support and Advocacy Network (PSAN) Pittsburgh Mercy Staunton Clinic UPMC/WPH/MYCS Forensic Peer -Resources for Human Development (RHD)	Chartiers Center Wesley Family Services (WFS) Milestone Centers Pittsburgh Mercy Staunton Clinic TCV Community Services UPMC Western Behavioral at Mon Yough (MYCS) Western Psychiatric Hospital (WPH)	Human Services Administration Organization (HSAO) **Other Resources:** Drug Court Mental Health Court Veterans Court DUI Court	Chartiers:mobile WFS: mobile Pittsburgh Mercy RHD – only mobile WPH **Clubhouses:** Sally & Howard Levin Clubhouse-Jewish Residential Services (JRS)	Chartiers Community Human Services (CHS) WFS Milestone Centers People's Oakland Pittsburgh Mercy MYCS Staunton Clinic TCV	MYCS Mercy	PSAN: -Warm line -Warm and Friendly program **Drop-In Centers:** Chain of Hope- Milestone Centers Olive Branch- FSWPA New Horizons – PSAN Wellsprings- MBH Turtle Creek Valley	988: (1-800-273-8255) 24/7 Suicide and Crisis Lifeline - call or text Pittsburgh Mercy: Central Recovery Center (CRC) Resolve: -walk in -mobile -24/7 call in -emergency residential	Community Support Plan (CSP) / Acute Community Support Plan (ACSP) _____ Disposition Meetings _____ County Integrated Service Planning

Description of Services: Criteria are condensed and generalized

1. **Service Coordination (SC)**: Individual has a diagnosis of Schizophrenia, Mood Disorder or any other Axis I diagnosis in the DSM V, has had contact with crisis services, inpatient, police, ER visits and has a GAF of 60 or below. Service is community based and works with individuals to assess, plan and link to resources to meet basic needs. If individual does not meet eligibility criteria and could benefit from service, a waiver can be discussed with county monitors. ***Acute SC**: Member must have Community Care eligibility, but can also have commercial or Medicare coverage in addition to Community Care , Community Care Care Managers assign to members with at least 1 inpatient readmission within 30 days who are at risk for readmission; multiple risk factors; co-occurring SUD; lack of engagement with traditional case management services; unstable housing; lack of social supports, Member cannot have a current SC, ECSC, or ACT/CTT (unless he/she is in the process of transitioning to these services)
2. **Certified Peer Specialists (CPS)**: Community based service performed by a person with lived experience who has received or is receiving MH/SUD services. CPS is trained and certified to assist with community integration and recovery. Focus on engagement and providing helpful information about recovery, wellness and linkage to resources.
3. **Administrative Service Coordination (ASC)**: Typical ACM services are office-based and tend to be on an as -needed basis. **Forensic Liaison**: Support for individuals with mental illness and/or substance use disorders and who are involved with the criminal justice system. Provide support during and following court proceedings and during and following incarceration. Promote successful transition back into the community and reduce re-incarceration by providing access to treatment, supports and recovery-oriented programs. **Hospital Liaison:** Support for individuals who are inpatient at the various hospitals throughout Allegheny and other surrounding counties- in the event all beds are filled in AC. Will provide case management and disposition planning in collaboration with the inpatient provider, individual and community providers.
4. **Justice Related Services (JRS):** An array of supports designed to work with the jail, district courts and community providers to assist individuals with MH and SUD who encounter the criminal justice system. **Diversion Services**: Provide coverage from jail intake and coordinate services for individuals released from jail prior to preliminary hearing; develop and present service plans to District Courts. **County Support Services**: Provides service coordination from the point of formal arraignment to the time of sentencing. Develop and present service plans (which include treatment and other supportive services) and work with County jail, Court of Common Pleas and Service Coordination Units and other community providers to ensure transition into the community. **State Support Services**: Provides service coordination for individuals with MH referred from Department of Corrections at the expiration of a maximum prison sentence for up to 90 days after release from a State Correctional Institution. Services can include contingency for food, clothing and transportation and linking to community providers and services.
5. **Psychiatric Rehabilitation**: Services can be site-based, clubhouse or mobile. Individual must have a MH diagnosis that interferes with at least one domain: educational, social, vocational, self-maintenance or relative to the person's ethnic/cultural environment. Services are collaborative, person directed and individualized. The focus is to develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.
6. **Supported Employment**: Programs assist individuals 18 years and older diagnosed with mental illness find get and maintain employment. Once employment is obtained, the supported employment program continues to provide support to the person as long as it is needed.
7. **Social Rehabilitation**: Program designed to assist with social skills and support. Individuals have the opportunity to interact with others, develop leisure skills and participate in activities that can enhance socialization, increase independence, assist in managing symptoms and promote community awareness.
8. **Peer Run Services**: Mental health programs where the staff uses information, skills and resources they have gained in their recovery to help others. Peer services are based on principles of empowerment, choice, mutual help and recovery.
9. **Drop- In Center**: is a central place for self-help, advocacy, education and socialization. Generally, provides an opportunity for socializing and networking.
10. **CSP/ACSP:** Comprehensive support and resource planning process that is driven by a blending of the consumers, families, and treatment/service coordination team's preferences. Through this process specific recommendations for services that are holistic in nature are developed based upon the needs and wishes of the consumer. Prior to the closure of Mayview State Hospital the CSP process was used. ACSP is now used for planning for consumers who are currently inpatient have had multiple hospitalization and though which previously tried supports have been unsuccessful. Community Integration Team (CIT) follow these individuals.
11. **Disposition Meetings:** A meeting with the patient, inpatient treatment team, representative from Allegheny County, community provider(s) and Community Care (as appropriate) to discuss and coordinate discharge planning for the inpatient unit. This meeting will only be initiated once a consumer has been inpatient for 2 weeks by the inpatient social worker.
12. **County Integrated Service Planning:** Designed for individuals/families with a high level of need that is not addressed by a provider's services. A team of representatives from the County Department of Human Services and the individual meet to brainstorm about solutions which may or may not currently exist through a specific DHS unit. *Referrals are sent to Allegheny County DHS.*

CHILD/ADOLESCENT SERVICES CONTINUUM OF CARE

MOST RESTRICTIVE → **LEAST RESTRICTIVE**

OUT-OF-HOME SERVICES			COMMUNITY BASED SERVICES									
INPATIENT HOSPITAL (1)	**(RTF) RESIDENTIAL TREATMENT FACILITY** (2) **(CRR) / (IRT) COMMUNITY RESIDENTIAL REHABILITATION INDIVIDUALIZED RESIDENTIAL TREATMENT**	**(DAS) DIVERSION and STABILIZATION UNIT** (3)	**(PHP) PARTIAL HOSPITAL PROGRAM** (4)	**CTT-T** (5)	**MTAY** (6)	**(FBMH) FAMILY BASED MENTAL HEALTH** (7)	**(MST) MULTI-SYSTEMIC THERAPY** (8)	**(FEP) FIRST EPISODE PSYCHOSIS** (9)	**CSBBHT** (10) ***For specific schools – see below***	**(FFSB) FAMILY FOCUSED SOLUTION BASED** (11)	**IBHS** (12)	**OP/ SBMH** (13)
- (WPH) Western Psychiatric Hospital -Southwood	(RTF) Residential Treatment Facility (CRR) / (IRT) - Pressley Ridge - Merakey	- Pittsburgh Mercy - 8-14 yr.	**After School:** - Community Empowerment Assoc. - (WBH) Western Behavioral Health **Day Programming:** - Pittsburgh Mercy - (WFS) Wesley Family Services - (WBH) Western Behavioral Health **IN SCHOOL PhP:** - Pressley Ridge - Friendship Academy - PACE School - FamilyLinks (K-5th) - Wesley Family Services at Deer Lakes	-(WBH) Western Behavioral Health	-(PR) Pressley Ridge – Independence Ahead -Auberle – MITY – Mobile Interventions for Transition Age Youth	-(ACI) Allegheny Child Initiative -(EC) Every Child, Inc -(FL) FamilyLinks -(FR) Family Resources -(GRLS) Glade Run Lutheran Services -(PR) Pressley Ridge -Southwood -(WFS) Wesley Family Services -(WBH) Western Behavioral Health	- (MHY) Mars Home for Youth	-(WBH) Western Behavioral Health – STEP -(WFS) Wesley Family Services - ENGAGE	- (WFS) Wesley Family Services -(PR) Pressley Ridge -(WBH) Western Behavioral Health -Every Child	- (HFI) Holy Family Institute	-27 Providers – Individual, Group, ABA, CSBBHT	

OUT-OF-HOME SERVICES

(1) INPATIENT HOSPITAL:
Provides high security and high intensity treatment interventions in psychiatric units of general hospitals, licensed psychiatric hospitals, and state mental hospital units.

(2) (RTF) RESIDENTIAL TREATMENT FACILITY:
Residential treatment setting certified by the Office of Mental Health, serving the intensive treatment needs of children and adolescents. IRT is 24 treatments provided in a family setting.

(3) (DAS) DIVERSION AND STABILIZATION UNIT:
Respite/Treatment Services for those who can be diverted from inpatient care or are stepping down from inpatient care.

COMMUNITY BASED SERVICES

(4) PARTIAL HOSPITAL PROGRAM:
Mental Health treatment intervention delivered in a clinic or school setting, to assist a child in transitioning from inpatient treatment or for prevention of psychiatric hospitalization.

(5) (CTT-T) COMMUNITY TREATMENT TEAM-TRANSITION AGE:
A team delivered service comprised of psychiatrist, nurse, therapist, case manager, and vocational specialist. All necessary services are delivered to the consumer in the community where they reside.

(6) (MTAY) Mobile Transition Age Youth Treatment Team:
A team delivered service that provides assistance to transitioning young adults who are focused on wellness and recovery while managing their mental health and/or D&A substance abuse issues all while acquiring life skills i.e., employment, education, conflict resolution, etc.

(7) (FBMH) FAMILY BASED MENTAL HEALTH:
Provides intensive in-home interventions designed to prevent out-of-home placement.

(8) (MST) MULTISYSTEMIC THERAPY:
This is a multi-faceted, short-term, home and community-based intervention for families of youth with severe psychosocial and behavioral problems

(9) (FEP) FIRST EPISODE PSYCHOSIS:
Team delivered coordinated specialty care for individuals experiencing their first episode of psychosis.

(10) (CSBBHT) Community School Based Behavioral Health Team:
A school-based team delivered service comprised of 2 (MHP) Mental Health Professionals and 3 (BHW) Behavioral Health Workers which provide family and individual therapy, service coordination, 24/7 crisis management. WFS – Pittsburgh Public Schools; Pressley Ridge – Pittsburgh Public Schools, Sto-Rox; WPH – Woodland Hills and McKeesport.

(11) (FFSB) FAMILY FOCUSED SOLUTION BASED:
FFSB is an in-home intervention structured to meet the Treatment/Support Services needs of both parents.

(12) (IBHS) INTENSIVE BEHAVIORAL HEALTH SERVICES:
Individualized strengths-based mental health services delivered in non-traditional settings, such as: home and school to promote the child receiving services in the least restrictive setting possible.

(13) OUTPATIENT SERVICES/SBMH:
Community-based treatment interventions usually delivered in a clinic or school setting including individual, group, family, and play. Therapies and medication management.

OVER →

ADJUNCTS TO TREATMENT

(1) (ASC) ADMINISTRATIVE SERVICE COORDINATION:
This is usually a starting point for most families. If a child is registered with any Service Coordination Unit in Allegheny County, an administrative service coordinator will help someone get into services, assess needs, make referrals and help search for appropriate providers and services.

(2) (BSC) BLENDED SERVICE COORDINATION:
If a child is experiencing more significant serious emotional disturbances that interfere with his or her ability to function at home and he or she needs to receive treatment from two or more mental health providers or publicly funded systems (such Education, Child Welfare or Juvenile Justice), a blended service coordinator would assist the family and child in coordinating these services. A blended service coordinator will also serve as a link and advocate between multiple systems to ensure the child gets the services that he or she needs.

(3) (SAP) STUDENT ASSISTANCE PROGRAM:
This is a prevention program provided in every middle and senior high school in Allegheny County. Through this program, school personnel are trained to identify potential emotional or behavioral issues that may be causing a child to experience barriers to learning. In collaboration with the family and school personnel, a SAP liaison will provide treatment suggestions and offer assistance in obtaining mental health services, if needed. The goal of the program is to improve the child's success at school.

(4) MOBILE CRISIS SERVICES:

RESOLVE
The goal of this program is to work with the child with emotional disturbances during a crisis (in the home, at school, or in the community) in order to prevent injury or hospitalization. When called, a crisis intervention team will come to assess, coordinate, treat and refer for appropriate services, if necessary. This service is voluntary and provided free of charge 24 hours a day, 7 days a week. RESOLVE Crisis Network 1-877-7-YOU CAN (1-888-796-8226).

CACTIS
CACTIS provides the same crisis services as RESOLVE. However, this is a service for children with a mental health diagnosis who have already registered for CACTIS services. A crisis safety plan has already been developed with the child, family, and a team from RESOLVE. When a family calls CACTIS in a crisis situation, the CACTIS staff is already familiar with the child and family, and they will follow the steps that were developed in the crisis plan.

(5) (JPT) JOINT PLANNING TEAM:
The Joint Planning Team utilizes the principles of the High-Fidelity Wraparound model where services are highly collaborative, and family driven. The Joint Planning Team is not a program or type of service, but a process that is used to support children with complex needs and their families. The process develops a highly individualized plan that addresses the child's complex emotional issues and focuses on needs rather than services.

(6) (CPS) CERTIFIED PEER SPECIALIST (14-18 YEARS):
Support offered by an individual who has lived experience

(7) (YSP) YOUTH SUPPORT PARTNER:
Support offered by an individual who has lived experience

RESIDENTIAL SERVICES FOR ADULT MENTAL HEALTH

Long Term Structured Residence (LTSR) [1]	Community Residential Rehabilitation (CRR) [2]			Specialized Residence (SR) [3]	Comprehensive Mental Health Personal Care Home (CMHPCH) [4]	Domiciliary Care (Dom Care) [5]	Personal Care Home (PCH) [6]	Supportive Housing (SH) [7]			CMI Bridge Housing [8]
Chartiers Manor Glassport (RHD) Journey Home (Pittsburgh Mercy) Monarch Springs (Pittsburgh Mercy) Pathways (Western Psychiatric Hospital (WPH) Pioneer (Pittsburgh Mercy) Russellton (Merakey) RISE (Merakey)	**CRR Group:** Community Human Services (CHS) Milestone Centers Mon Yough Community Services (MYCS) Residential Care Services (RCS) Turtle Creek Valley (TCV) Transitional Services Incorporated (TSI)	**CRR Apartment** Chartiers Milestone Centers RCS TSI		Fayette Resources Pittsburgh Mercy RCS Resources of Human Development (RHD)	Keystone MYCS Merakey Pittsburgh Mercy	CHS	MYCS (elderly only-60 years +)	**24/7 Supportive Housing** CHS Passavant Pittsburgh Mercy TCV WPIC	**Community Based SH** Chartiers CHS Jewish Residential Services (JRS) Milestone Centers Pittsburgh Mercy RCS TSI TCV UPMC Western Behavioral at Mon Yough (MYCS) Wesley Family Services (WFS) WPH	**Permanent Supportive Housing** TSI _____ *Deep Rental Assistance Program- CHS	Bethlehem Haven CHS-Wood St. Commons L2 (Light of Life)

Service Description: ***Criteria are condensed and generalized and unless noted is part of the County centralized referral system.***

1. **Long Term Structured Residence (LTSR):** Highly structured secure residential treatment facility, individuals do not require an inpatient setting, but do require ongoing 24 hour supervision. Admission may occur on a voluntary or involuntary commitment.
2. **Community Residential Rehabilitation (CRR):** A transitional residential program based in the community that services adults with MH diagnosis. Designed to assist individuals to live as independently as possible through training, skill building and medication education. Discharge planning begins upon admission and average length of stay is 18 months. **CRR Group Home:** Requires 72% of income for room and board. All meals are prepared by residents that live in the group home**. CRR Apartment:** Requires 40% of income and the individual is responsible for maintaining the apartment, cooking, cleaning and shopping with assistance.
3. **Specialized Residence**: These facilities are designed for individuals that require a structured setting and in some cases 1:1 staff supervision on a 24/7 basis. Behavioral assessments and plans are very common. The programs are designed as housing as home and not a focus on discharge- unless that is the individual's goal. Close communication with SC and CTT is required.
4. **Comprehensive Mental Health Personal Care Home (CMHPCH):** Permanent housing that is designed and operated to assist individuals with a MH diagnosis and complex needs that typically require assistance with dressing, bathing, selecting food, self-administering medications and managing finances. Staffed 24/7, housing as home model, has single room occupancy.
5. **Domiciliary Care:** Permanent Housing. Can provide up to 24 hours supervised housing in a homelike setting to individuals who need assistance with daily living activities, meals, supervise medications, offer companionship and support. CHS operates one Domiciliary Care program with 6 beds.
6. **Personal Care Home (PCH):** Permanent housing setting where food, shelter and personal assistance or supervision is provided for a period exceeding 24 hours. Designed for 4 or more adults, who are not relatives of the operator, who do not require services in or of a licensed long-term care facility, but do require assistance or supervision of activities of daily living.
7. **24/7 Supportive Housing:** Permanent housing located in an apartment building setting where staff have an office on-site 24/7. Services and supports should be provided in an organized, planned manner and should be consistent with individual's overall goals. Supports and services should be flexible and personalized for success in the community. **Community Based Supportive Housing:** Services are delivered to the person's independent apartment or home. Staff are not on-site at all times but can be available 24/7 via on-call. **Not part of County centralized residential referral system.* **Permanent Supportive Housing:** Permanent housing that is safe, secure and affordable. Provides temporary rental subsidies that assure that the individual does not pay more than 30% of their monthly income on rent until they qualify for a permanent rental subsidy like Section 8. Has a team that helps individuals find the housing, negotiate leases and support services. **Not part of County centralized residential referral system.*
8. **CMI Bridge Housing**: Designed to serve homeless adults that have MH diagnosis or exhibits behaviors which indicate the presence of a MH disorder. The rehabilitation process in many cases is extremely slow and there are no time limits. *Not part of County centralized residential referral system*