OPENING THE DOOR TO COMMUNITY:

Transitions to Community Living[1]

June 8, 2021

The stories shared here are from North Carolina's Local Management Entities/Managed Care Organizations. They are living examples of efforts underway to provide essential services to people living with serious and persistent mental illness so that they may reside in and experience the full benefit of inclusive communities.

Beneficiaries are 18 or older and eligible for publicly funded services provided through the NC Department of Health and Human Services, and Transitions to Community Living (TCL), North Carolina's implementation of a 2012 *Olmstead*[2] settlement agreement with the U.S. Department of Justice. The agreement makes sure that eligible adults have the opportunity to live in settings integrated into North Carolina's neighborhoods and communities.

TCL promotes recovery through the provision of long-term housing, community-based services, supported employment and community integration. Key tools and partnerships are critical to TCL's the success and to the people it serves.

To guard individuals' identities, real names are not used, but details about their situations are authentic.

[1] In 2021, TCL stopped referring to its work as an "initiative." Today, TCL's approach is increasingly the way NCDHHS does business.

[2] In 1999, the United States Supreme Court held in Olmstead v. L.C. that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. www.ada.gov/olmstead/olmstead_about.htm

FACTS ABOUT TCL's Work Across the State

TCL is a stabilizing force in people's lives. In fact, 79.8% of all participants live in supportive housing for at least a year.

TCL is about robust engagement with participants. As of 4/30/21, TCL supported 2906 individuals in the community. And there are another 547 individuals in the process of transitioning to the community

TCL offers accessible, affordable housing. In fiscal year 20/21, 756 individuals were approved for housing. Over the life of the program, 5,466 people have received housing slots.

TCL is effective at giving people viable community options for community living. With the adoption of the RSVP online referral and diversion system, the percentage of people with serious mental illness who entered adult care homes dropped from 59.7% to 20.1% in fiscal year 20/21.

TCL is creative and flexible. Working collaboratively with Local Management Entities/Managed Care Organizations, TCL developed a bridge housing program, saving taxpayer dollars by reducing hospital days and giving people a safe place to live while looking for a home of their own in the community.

TCL works. Ninety percent (90%) of people who enter bridge housing go on successfully to Permanent Supportive housing.

TCL is opening the door to community.

Stories from
LOCAL MANAGEMENT ENTITIES/
MANAGED CARE ORGANIZATIONS (LME/MCO)

Moving out of an Adult Care Home and finding community…

Partners Behavioral Health Management

Melissa was at an assisted living facility when she was referred to TCL. Finding the right home in the right community was important to her. She wanted to continue being part of a Psychosocial Rehabilitation (PSR) group, where she was already working on regaining the skills needed to live successfully in the community. A TCL transition coordinator assisted her every step of the way, down to helping her pick the furniture and household goods for her apartment – and her provider helped her get a companion dog. Once settled with her pup, Melissa began saving money. She'd decided that she wanted to move to a nearby town where she knew more people. She worked with TCL to find another apartment. Without anyone's help, she got herself connected with the local PSR group and had her Special Assistance transferred to the new community. On moving day, her friends showed up to lend a hand with the move. In the new community, this self-advocate reached out to TCL for emotional support. TCL was there for Melissa when it counted, wherever she made her home.

Vaya Health

When Transitions to Community Living (TCL) met Jack and Sara, the older, married couple were living in an Adult Care Home. They'd been told they couldn't make it in the community. Both, they were reminded, had serious mental health and physical health conditions and, besides, Sara was blind. TCL's In-Reach and Peer Support Services weren't deterred and were convinced that with a robust, personalized array of services and supports, the couple could succeed in a home of their own. During the pandemic, the Community Support Team met with landlords to gauge the physical accessibility of properties. They shared pictures of different homes and neighborhoods with the couple through a window in the Adult Care Home, where the two were recovering from COVID-19. Just as Jack and Sara got better, the team, using a housing voucher, found the kind of place that the couple wanted, an affordable, accessible home in wooded surroundings with "respectable" neighbors. With the lease signed, TCL connected the couple to The Lions Club, known for its assistance to people who are blind; found a physician to manage the couple's complex health needs; secured a free, Silver Sneakers gym membership; identified public transportation assistance; engaged Services for the Blind to work with Sara on cooking and selfcare goals; and tapped Medicaid waiver services to assist Jack with his physical health issues. With the addition of a Braille computer to help the couple track finances, make phone calls, and send texts, Jack and Sara were ready for their golden years. Today, the couple delights in their front porch view of the mountains and looks forward to family coming to visit their "forever home."

Trillium Health Resources

Ginny had been in an assisted living facility for 22 months when her therapist gave her the number for Transitions to Community Living. "I laid it on the nightstand and just kept looking at it. One day I decided to call," she said. "Within two days, someone was out to talk to me." Working with staff from Trillium Health Resources, RHA Health Services and Peer Support, Ginny began the process of transitioning to a life in the community. Staff that she called "compassionate and helpful" took her to look at places to live in a neighborhood she had picked out. Together, using her housing voucher, they found a home. Ginny summed up her experience with these words: "When I walked through the door of that house, I knew it was for me."

LME/MCO Regional Map:
www.ncdhhs.gov/providers/lme-mco-directory

At risk of entering an institution but diverted into permanent, supported housing

Cardinal Innovations Healthcare

Jerry heard about Transitions to Community Living while chatting with a friend at a food bank. His first reaction was disbelief: "I thought, 'Really? That sounds too good to be true.'" At the time, Jerry was homeless. He'd been sleeping on friends' couches or in his car. His hopes were, in his words, "dwindling." Once linked to TCL through a peer counselor and a provider, Carolina Therapeutic, Jerry met a team that "made me feel like someone cared." He moved into his new home, complete with the mental health services he needed, about a month later. Said Jerry's TCL transition coordinator, "He went from worrying about getting warm to worrying about when his grandkids could visit."

Sandhills Center

Before Dominique met the TCL team, she was homeless and had been in and out of mental health facilities, shelters and group homes. She had no family, no income and couldn't afford a hot meal. At night, under bridges or on the streets, she would imagine finding a place to live. One day, she followed a woman she'd seen near a bus stop into the local Social Services office. Using RSVP, TCL's online referral portal, Social Services connected Dominque to Sandhills Center. The TCL Diversion Team introduced Dominque to a provider, Monarch NC, and its Assertive Community Treatment (ACT) Team. The ACT Team put together an array of services and supports, all carefully tailored to Dominique's needs. Her TCL transition coordinator worked with her to choose a place to live. When she moved into the second-floor home she had dreamed of having, got a new doctor and access to the bus line, Dominique was ready to start work. Today, her job at a local Goodwill Store offers her the chance to give back to a community that now sees her as a valued member.

Eastpointe

Aliyah's recurring struggle with depression, Post-Traumatic Stress Disorder (PTSD) and thoughts of suicide put her in a Psychiatric hospital four times. Her diagnosis of serious mental illness and her desire to live in the community made her a candidate for Transitions to Community Living (TCL). Her Supported Employment provider used the online Referral Screening Verification Process (RSVP) to put her in touch with TCL staff. Working with TCL and the County Housing Authority, Aliyah became a participant in the Mainstream Voucher Program, receiving a TCL subsidy for non-elderly people with disabilities who are transitioning out of an institution or other segregated setting or who are at risk of institutionalization or homelessness. The housing subsidy helped Aliyah get a home. Next, she got her driver's license. When her first apartment didn't work out, Aliyah knew TCL was there, but chose to handle the move to a different unit herself, with little assistance. Aliyah continues to receive ongoing treatment as part of her recovery from mental illness. She's managing more of life's ups and downs on her own and living in the community because she now has the services and the supports she needs. Those who know Aliyah say her journey gives meaning to the word "resilience."

Discharging from a State Psychiatric Hospital into permanent, supported housing...

Alliance Behavioral Healthcare

When TCL met Carolyn, a person living with both serious mental illness and intellectual disabilities, she was a patient at Central Regional psychiatric hospital. She'd experienced years of abuse and some involvement with the criminal justice system. After the charges against her were dropped, the TCL team began working with the hospital to support her move to the community. Carolyn's first-grade reading level meant that the team had to be sure she had the support to make informed decisions and that she had the life skills she'd need to succeed in the community. Before leaving the hospital, Carolyn began learning to use a cell phone. The TCL nurse worked closely with the hospital to develop a plan for managing her diabetes. Carolyn decided to return to the community where she'd grown up. The TCL team helped her find an apartment she liked, close to a bus line and in walking distance of a grocery store. Her team was there to support Carolyn with both formal services and natural supports. Thanks to Carolyn's referral to TCL, she got reacquainted with the neighborhood, rekindled old friendships and was welcomed back to her church.