Pennsylvania Olmstead Plan Service Area Planning Response

Centre, Columbia, Montour, Snyder, Union (CMSU), Lycoming, Clinton (L/C), Huntington, Mifflin, Juniata (HMJ), Northumberland, Schuylkill Counties

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I. Olmstead Planning Process:

Within the Danville State Hospital catchment area, there are four primary methods for identifying and discussing needed services, supports, and infrastructure that will need to be developed in order to meet the needs of individuals discharged or diverted from state hospitals, and individuals living in other institutions, or congregate and segregated settings, including personal care homes. These methods for discussion include Community Support Plan meetings (which include consumers, family members, representatives from advocacy groups, providers, behavioral health managed care reps, and cross system partners), Base Service Unit Liaison meetings, Service Area Planning meetings(which include state hospital staff, county representatives, representatives from advocacy groups, behavioral health managed care reps, and cross system partners), and direct communication between service providers with the counties. By utilizing these forms of communication, we are able to gather input from a wide variety of stakeholders including individuals that utilize services, family members, advocacy groups, providers, behavioral health managed care representatives, and a wide variety of representatives of various systems depending upon the individualized support needs of individuals.

The Counties in Danville State Hospital's catchment area work conjointly on projects to maximize the discharge of Danville State Hospitals Patients in providing Housing opportunities and service provision. It is possible as a result for individuals to access services across county lines. This is especially evident when an individual has Medicaid and Managed Care as the funding source follows the individual and choice is dependent upon the individual's decision. Many of the catchment areas counties are adjacent to each other geographically allowing shared services if an individual chooses.

II. Services to be developed

As services continue to be expanded in the community the underlying goal would be to reduce utilization of both Residential Treatment Facilities (RTF) and State Hospital beds. For current utilization numbers see Section III.

Prevention and Early Intervention Services and Supports (Examples: Crisis Intervention and Mobile Treatment Services)

County	* Indicates any age group is served (age specified) Current Services Offered	Additional Services that Need to be Developed				
		Services to be developed	Expansion of Current Service or New Service	Number of Individuals Expected to be Served	Projected Timeline for Service Development	Resources to be used / Needed
Centre	*Crisis Intervention-face to face, phone, mobile * Mobile Medication Management *Crisis Intervention Team (CIT) *Suicide Prevention- American Foundation for *Suicide Prevention (AFSP) *Suicide Prevention Task Force (SPTF) * Zero Suicide	Crisis Residential Respite Services	New Service	50 annually 30 initially	Service implementation target of FY 18-19	Provider would be determined via RFQ process. Ongoing program funding would need to be secured (County Base, County Block Grant and Health Choices Reinvestment funding)

Lycoming / Clinton	*Telephone/Walk-in/Mobile Crisis Intervention Services *Wellness Recovery Action Plan (WRAP) *Certified Peer Specialist *Certified Recovery Specialist	Training and Recruitment of Certified Peer and Recovery Specialists	Expansion of existing service	30	Expansion with existing provider agency. Expected implementation May 2017 with full caseload by December 2017.	Medicaid funding via HealthChoices
CMSU	*Crisis Intervention, Walk-in, Phone, Mobile Peer to Peer mobile free standing (Age 18+) Systems of Care (Birth to age 21)	System of Care is a new and ongoing effort for CMSU to reduce RTF and Increase Family Stability	Expansion	101 annually	4 year SMAHSA Grant	SAMHSA Grant
HMJ	*Telephone and Mobile Crisis * Blended Case Management * Certified Peer Specialist * Suicide Prevention Task Force	Mobile Medication Management	New Service	50 30 initially	Implementation with provider-ongoing Accept referrals by 1/1/17	HealthChoices reinvestment start-up moving to medical spend.
Northumberland	*Mobile, Telephone, Walk-in Crisis Intervention *Medication Management *Certified Peer Specialist	Hire a Part time System of Care (SOC) Coordinator	New technology for crisis workers funded by carry over	80	December 2016	Continued funding
Schuylkill	*Telephone/Mobile Crisis Intervention Services *Suicide Prevention Task Force *Out-Patient (Wellness Recovery Action Plan-WRAP) *Certified Peer Special Specialist	Based on reports received from the Crisis provider, the current staffing is meeting the needs related to mobile and delegate activity. The Suicide Prevention Task Force continues to meet and provides services and group activity in the community.				
		Mobile Medication Management	New Service	50	Implementation with provider ongoing. Referral implementation to begin 3/2017	Health Choices Reinvestment start-up initially

Non-institutional housing options, with a focus on independent and shared living arrangements. "Housing First" – (models that do not require individuals to participate in services)

County	Existing "Housing First" approaches	Additional Services that Need to be Developed				
		Services to be developed	Expansion of Current Service or New Service	Number of Individuals Expected to be Served	Projected Timeline for Service Development	Resources to be use / Needed
Centre	Pennsylvania Housing Affordability and Rehabilitation Enhancement Funding (PHARE) x4 811 Section 8 Housing Contingency County Housing Specialist Representative Payee Money Management	7 additional Permanent Supportive Housing (PSH) beds	Expansion	Currently, 19 PSH beds are available. 7 additional to be developed	November 1, 2016 (2 additional beds will be added). June 30, 2017 (2 additional beds will be added). June 30, 2018 (3 additional beds will be added.	Funding is necessary to achieve the June 30, 2018, deadline.
Lycoming / Clinton	Independent Living Services Transitional Housing Services Mobile Psych Rehab PHARE Housing Programs	Supportive Housing	New	Currently 16 served. Will serve up to 50.	Began January 2017	Reinvestment through Health Choices.
CMSU	Bridge Rental Subsidy (18+) Contingency Funds (18+) Justice Bridge (Union County) (18+) Supported Housing (18+) Representative Payee (18+)	Site Based Psych Rehab for Transition age skill development	Expanded	30	July 2017	Program Development/Enrollment Managed Care Organization (MCO)/Staff Training
HMJ	Master Leasing for Forensic and Non-Forensic Populations, Permanent Supported Housing, Section 8 and Public Housing	Site-based MHOP in Juniata County.	Geographic expansion of existing service to underserved area.	150+	Start date July 1, 2017	HealthChoices reinvestment start-up/medical spend.
Northumberland	Bridge Rental Subsidy Frontier House Sharing Support	Northumberland County continues to expand housing opportunities for individuals served through behavioral health. The need for housing continues and additional opportunities are continually sought after.				
Schuylkill	Permanent Supportive Housing Transitional Housing Support Services Contingency Funds County Housing Specialist Section 8 Representative Payee Services Bridge Rental Subsidy	The county Housing Specialist continues to facilitate our local LHOT (Local Housing Options Teams) and also our annual Point in Time homeless count for HUD. Barefield Project is a joint effort with Service Access & Management (SAM) and our office with Barefield, a local housing provider. We have increased housing stock by up to 10 units locally.				

Non-residential Treatment Services and Community Supports including Mobile Treatment Options (Examples: Outpatient and Mobile Outpatient Services, Full Range of Crisis Intervention Services including mobile outreach, Assertive Community Treatment Teams (ACT), medication management, case management, psychiatric rehabilitation services, community services for youth and young adults including Multi-Systemic Therapy and Functional Family Therapy, and services to develop and provide competitive employment opportunities

		Additional Services that Need to be Developed				
County	**Current Services Offered**	Services to be developed	Expansion of Current Service or New Service	Number of Individuals Expected to be Served	Projected Timeline for Service Development	Resources to be use / Needed
Centre	*Out-patient (OP) Mental Health (MH), Drug and *Alcohol (D&A), Co-Occurring *Telepsychiatry *Trauma-focused Cognitive Behavioral Therapy, *Eye Movement Desensitization and *Reprocessing *Crisis Intervention (face to face, phone, mobile) *Certified Peer Support *Site-based and Mobile Psych Rehab *Case Management (admin, blended, resource coordination) *Mobile Medication Management	Home aides to come in briefly to help with immediate post-hospital transition.	Expansion of service—proposed service expansion based on feedback from local Community Support Program (CSP)	Not known	Currently exists and will be expanded	This service is available through local home health agencies located in Centre County and can be accessed with a variety of insurances.
Lycoming / Clinton	*Medical Assisted Substance Abuse (SA) treatment *Co-occurring OP services *Mobile Psychiatric Rehabilitation *Dialectical Behavior Therapy *Administrative/Targeted Case Management *Clubhouse Psych Rehab Model	Assertive Community Treatment (ACT) Teams	New	25	Development with local provider as funding becomes available	SAMHSA grant application prepared by River Valley Health & Dental Center (FTCA)
CMSU	*Mobile Outpatient Patient Child Interactive Therapy (PCIT) (2-7) Co-Occurring Pre-Motivational Group (18+) *Trauma Therapy Common Ground Decision Center (18+) Union/Snyder (U/S) Recovery Center (18+) Mobile Psychiatric Rehabilitation (18+) Intensive Case Management (2+) Resource Coordination (2+) Physical Health/Behavioral Health Wellness (2+) *Nurse Family Based Mental Health Services (FBMHS) (2 to 21) Social Rehabilitation (18+)	Child Psychiatry	Expansion	98	July 2017	Lack of available child psychiatrists, exploring telepsychiatry

HMJ	*Mobile and Telephone Crisis *Certified Peer Specialist *Supported Living Program *Site-based and Mobile Psychiatric *Rehabilitation programs *Clubhouse *Blended Case Management *Physical Health (PH) /Behavioral Health (BH) *Nurse Navigator	While no new services are planned, HMJ has recently been working with PMHCA and local consumers and advocates to re-start Community Support Program. CSP in HMJ will be under the auspices of the MHA of 7 Mountains which will also be the fiduciary. CSP will be instrumental in the development of any new services through the input of consumers, family members and community.
Northumberland	*Crisis Intervention (mobile, walking, telephone) *Medication Management *Administrative Case Management *Blended Case Management *Mobile Psych Rehab *Vocational Services *Clubhouse	Through CFST surveying of consumers, we are told needs are being met adequately.
Schuylkill	*MH, D&A Out- Patient (including telepsychiatry) *Crisis Intervention (phone/mobile) *Certified Peer Specialist *Case Management (Targeted and Psych Rehab (site based and mobile) *Transition Age Youth/Family Support Services *Multi-Systemic Family Therapy	We are currently working on providing a joint training with the Office of Vocational Rehabilitation (OVR) to train more Certified Peer Specialists to be used locally. We are recognizing the need from questionnaires supplied from forums we have held. Mobile psych rehab will be starting shortly through a contract with Resources for Human Development (RHD). RHD has also provided an additional 12 apartments in Schuylkill County. We have also provided a case manager on the local inpatient unit one day per week to get individuals open for funding as well as outpatient services upon their discharge. The Systems of Care (SOC) coordinator position facilitates trauma training for staff throughout the human service system as well as with out-patient providers.

Peer Support and Peer-Run Services (Examples: Certified Peer Specialists, Wellness and Recovery Programs, Drop-In Centers, and Warm-Lines, Etc.)						
		Additional Services that Need to be Developed				
County	**Current Services Offered**	Services to be developed	Expansion of Current Service or New Service	Number of Individuals Expected to be Served	Projected Timeline for Service Development	Resources to be use / Needed
Centre	*Certified Peer Support *Wellness Coaching through peer * Case Management and Psych Rehab *Consumer and Family Satisfaction Team Program (C/FST) *Community Service Program (CSP) *Mental Health Association (MHA)	Peer Group activities to include peers leading a cooking class and teaching knitting (a meet up for peers)	Expansion	N/A	N/A	This feedback can be offered to site based psych rehab or peer programs as an expansion of their community service programs. Some similar volunteer/desired activity programs exist in the community.
Lycoming / Clinton	*Certified Peer Specialist *Certified Recovery Specialist *Beacon Hub Drop In Center	Peer groups and activities on computer skills, community outings, fundraising for NAMI and other community interests, wellness activities.	Expansion	N/A	N/A	Offered at the Beacon Hub Drop in Center.
CMSU	*Certified Peer-to Peer free standing program (18+) *Social Rehabilitation(18+) *Recovery Centers (2) (18+) *Common Ground Decision Center(18+)	Companion services-being part of natural community supports Living Room (Peer Operated)	New	24	July 1, 2017	Certified Peer Specialists/Managed Care approval/Start Up Dollars
HMJ	*3 Drop-in Centers *Certified Peer Specialist (3 providers) *Mental Health Association of 7 Mountains *CFST	Continue to support existing services.				
Northumberland	*Peer Support *Wellness Coaching *Psychiatric Rehab *C/FST *Recovery Committee	Through CFST surveying of consumers, we are told needs are being met adequately.				
Schuylkill	*Certified Peer Specialist *Community Support Program (CSP) *Schuylkill Recovery Task Force	Active recruitment of interested consumers to become Certified Peer Specialists (CPS) is ongoing based on the demand for these services. Currently we have three providers supplying certified peer specialist services				

Supported Employment Services

Anyone receiving either SSD or SSI in any county has the option of independently applying for the SSA Work Incentive Planning and Assistance (WIPA) program.

County	Current Services Offered	Additional Services that Need to be Developed				
		Services to be developed	Expansion of Current Service or New Service	Number of Individuals Expected to be Served	Projected Timeline for Service Development	Resources to be use / Needed
Centre	*Vocational Training *Competitive Supported Employment *Career Discovery *Transitional Employment Placement (TEP)	Centre County does not have a wait for these services and does not receive feedback that service expansion is needed				CHIPP Base MH Funds Provider Capacity Employer Resources
Lycoming / Clinton	*Clubhouse; prevocational / vocational *Transitional Employment Program *Vocational Rehabilitation Services *Mobile Psych Services * Reentry Program	Site-based Psych Rehab Service in Clinton County	Expansion	40 participants	July 2017	Medicaid Funding via HealthChoices, MH Base Funds
CMSU	*Pre-Employment Training via Recovery Centers *Employment via Recovery Centers (18-26 Transition/18+ Adult)	Psych Rehab	Expansion	29	01 Mar 2017	Transition Age focus plus adult service Psych Rehab. Managed Care and County Base
HMJ	*Clubhouse *TEP *Supported Employment	Continue to support existing services.				
Northumberland	*Clubhouse; prevocational / vocational *TEP	Continue to support existing services.				
Schuylkill	*TEP *Vocational Rehabilitation Services *Supported and Competitive Employment	Transitional employment placements within our Clubhouse program operated by CSG (Community Services Group) have grown during the past fiscal year. Additional local providers (Habilitation and REDCO) have consistent flow of consumers seeking employment opportunities. Two employment providers (AHEDD and Goodwill) have established strong working relationships with local employers allowing for more opportunities for job placement within the consumer community.				

III. Housing in Integrated Settings:

- Sites listed below are utilized when planning for community integration from RTF or State Hospital
- Sites listed below are located in mainstream society and offer the individuals access to community resources
- Individuals can access the community resources at opportunities, frequencies and timing of their choosing
- Individuals have choice in their daily activities and have the opportunity to interact with others who do not have disabilities to the fullest extent possible
- People with a disability have equal access to the program and/or activity as other members of the community.
- Units are accessible/barrier free
- Please note that available services may be located in other counties

Housing Inventory of existing Housing Options :

County / Joinder	RTF - shared by 23 counties (current number served)	State Hospital (current number served)	Independent Living (Number of Units / Capacity)	Supportive Living (Number of Units / Capacity)	Fair-Weather Lodge (Number of Units / Capacity)	Community Residential Rehab (CRR) * (Number of CRRs and capacity at each)	Enhanced Personal Care Home	Personal Care Home
Centre	0	9	X	X	X	X	X	X
Columbia/ Montour / Snyder / Union	15	21	X (Practically Unlimited) Cost and location dependent	X 2/filled	0	X CMSU has a six bed CRR filled remaining from an original 12 bed CRR with 6 beds converted to Respite and Supported Living	X (two) EPCBH (15 bed each/filled) Developed conjointly with other DSH Counties	X
Huntington / Mifflin / Juniata	0	9	X	X	0	X	X	X
Lycoming / Clinton	8	14	81	24	0	3 Sites 20 beds total (8, 6 & 6)	2 sites 4 Beds	8
Northumberland	16	7	X	X 22 units	0	No CRR's in Northumberland County	X	X
Schuylkill	33	35	X	X 23 beds (will be 28 by fiscal year end) Also 2 supported living providers serving 155 people.	0	X 2 CRRs serving 20 people	X 2 homes serving 4 people	X

***Plans for CRR conversions:** At this time there are no plans for CRR conversions within the Danville State Hospital catchment area.

Progress Made Towards Integration of Housing Services as Described in Title II of the ADA.

Centre - Centre County has a full time, Housing Program Specialist, through the Centre County Office of Adult Services. This position currently manages Housing Contingency Funding program and PHARE. The position serves on local committees and participates in provider meetings.

CMSU has a full-time Housing Coordinator who managers the Bridge Housing and Contingency Funding via Managed Care Reinvestment. In addition, he serves on the following: Low Income Service Committee (Union/Snyder Counties), Housing Task Force (Columbia County), Behavioral Health Administration Unit (BHAU)/BHARP Housing Committee, Provider Meetings, Justice Bridge Advisory Committee (Union County), Justice Master Leasing Committee (Columbia County) and PHARE Grant Advisory Committee (Columbia County). CMSU staff members are part of the Union / Snyder and Columbia / Montour Criminal Justice Advisory Board (CJAB) and a Mental Health Court is planned in Columbia County. the Housing Coordinator also serves as a resource for all CMSU staff and individuals served accessing resources relating to housing and maintaining a list of landlords throughout the four counties who participate in HUD and also who provide competitive housing to facilitate housing resources to individuals needing community housing. As the conduit to community landlords this ensures individuals served have access to integrated housing in their community of choice. In addition, CMSU has assisted an individual providing support and guidance in purchasing his own home in the community. We are making an effort to explore home ownership as an option for individuals served and actively seeking sources of funding for this effort. Bridge and Contingency funds are Reinvestment allocated as a priority by CMSU and other DSH Counties in the North Central Managed Care Contract.

HMJ has developed a Master Leasing Program as a scattered-site model close to resources and services to encourage integration with the community. This includes re-integration of the forensic population through the development of six forensic master leasing units. The Supported Living Program provides assistance to individuals so that they can maintain their current housing by working on issues that can jeopardize housing stability.

Lycoming – Clinton is committed to increasing the integrated housing opportunities in the community for individuals with mental health disabilities who are transitioning from hospitals, institutions, prisons, personal care homes, CRR, and other restrictive and non-restrictive settings, program and shelters. Individuals with disabilities have over the previous years faced discrimination that may have limited their opportunities for independent living situations in the community. Individuals with disabilities, similar to individuals without disabilities, should have choice and self-determination in housing and support services. Lycoming-Clinton MH/ID and our providers are committed to assist individuals with mental health disabilities to live independently in their community residence of choice with support services of their own choice also. Individuals in State Hospital or institution or other segregated setting also have the right to meaningful choice among housing options. The Lycoming- Clinton Joinder has a McKinney Grant to provide housing for single adults with a disability. The apartments located are scattered throughout Lycoming and Clinton Counties and usually with input with the consumer that will be entering the permanent supported housing program. This program is also a housing first program. Services and supports offered by the Lycoming –Clinton MH/ID program and our providers must have the characteristics that provide individuals we serve with opportunities to live, work, and receive these services in the community the same as individuals without a disability. Our consumers must be in the mainstream society, offer access in the central community and community activities. Housing must be integrated in our communities. Individuals with mental health disabilities must be offered choice to lease housing in integrated public, multi-family housing developments and tenant based rental settings. There cannot be rules or restrictions that limit consumer activities or their interactions with other community members. The next section will more fully explain the housing options in the bi-county area which offer a wide array of choice and equal opportunity.

Northumberland – Continues to expand inclusive housing opportunities for individuals involved in behavioral health services. Our housing coordinator manages contingency funds, coordinates monthly LHOT meetings, and is a consistent resource for behavioral health case management staff. The most recent opportunity created for housing will be the Phoenix house, with one home being utilized specifically for an individual with a behavioral health diagnosis.

Schuylkill **-** Schuylkill County is keenly aware of the need to protect qualified individuals with disabilities from discrimination on the basis of disability in services, programs, and activities provided by our housing programs. So that individuals with mental health illnesses have access to apartments that are appropriate to their needs, we have invested funds (including Reinvestment Funds) in partnering with real estate developers to create the most appropriate housing opportunities. Since 2011, Schuylkill County has designated 21 beds in a variety of apartment buildings solely for individuals with mental health illnesses.

Currently, two additional single bedroom apartments are being fully renovated for this same population. Another five apartments will become available in this same apartment building in future years. Prior to selecting the site and designing the apartments, we sought input from many individuals with disabilities. Their input was critical in identifying a location, selecting a building and providing direction to the architect.

Schuylkill County employs three Housing staff to support the needs of individuals with mental health illnesses. In addition, all current mental health case managers have been trained in strategies to address housing needs. New case managers, when hired, receive the same training.

Housing staff advocate on behalf of individuals with mental health illnesses to ensure that they have every opportunity to secure housing in the community of their choice. We do this in a number of ways:

- Housing staff work closely with colleagues and other entities in identifying individuals with mental health illnesses who are living in restrictive environments and pursue options in the community for those individuals.
- Housing staff monitor the housing market and respective landlords.
- Housing staff educate landlords as new housing is pursued for our consumers.
- Prior to providing financial supports for consumers, such as rental payments and security deposits, Housing staff meet with the landlord and inspect the apartment selected by the consumer.
- In many cases, to enhance successful tenancy, individuals with mental health illnesses are provided multiple supports during their transition into housing including: rental payments, payments of security deposits, new furniture delivered and set-up, delivery of basic needs and grocery vouchers.
- In addition to financial supports, individuals with mental health illnesses who are seeking housing and transitioning into housing are supported by a variety of staff including the County Mental Health Office Administrator and Deputy Administrator, the Service Access and Management, Inc. (SAM) Housing Director, SAM Housing Coordinator, SAM PATH (Projects for Assistance in Transition from Homelessness) master case manager, SAM Mental Health Director, SAM Mental Health supervisors and SAM Mental Health case managers. Our approach is integrated across professional staff positions and individualized based on each consumer's needs.
- Should tenancy issues arise, Housing staff intervene and seek resolutions to the issues.

- Our Housing Coordinator serves as a single point of contact for all tenants. Should a consumer choose to dis-enroll from mental health case management services upon securing housing, those former consumers are encouraged to contact the Housing Coordinator should unanticipated issues arise.

In addition to our internal operations and actions, we rely heavily on the City of Pottsville Housing Authority and Schuylkill County Housing Authority to offer housing opportunities to individuals with mental health illnesses. Both Housing authorities are very receptive to our consumers and have developed a clear understanding and acceptance of their disabilities.

Strategies Used to Maximize Resources to Meet the Housing Needs of Individuals Including:

- **Identifying the Local Lead Agency (LLA) and any agreement with the LLA for referrals and supportive services arrangements.**

Centre County currently has identified the Behavioral Health Administrative Unit (BHAU) to be the LLA. This responsibility is transitioning to Centre County's Housing Specialist by the end of the calendar year. The current LLA has been instrumental in moving the 811 Project forward in Centre County. The project is nearing implementation.

CMSU - CMSU has just recently taken over being the Local Lead Agency. As such, the CMSU Housing Coordinator has access to the full array of services available in the CMSU area and has working relationships with Housing Developers and Housing Authorities. The Coordinator is currently working with both to increase opportunities for both individuals and families to decrease homelessness and lack of affordable and adequate community housing of their choice. Efforts should show results by 01 December 2017.

Lycoming / Clinton -The LLA in Clinton County is the Clinton County Housing Authority. Clinton County also is beginning an 811 Project. Current access to Lycoming County LLA is to contact PA Department of Human Services Jonathan McVey at 717.395.9435 or jomcvey@pa.gov. Both counties have collaborative board meetings for referrals and supportive services. Each County has monthly meetings with human service agencies as well as county housing authorities and various first responder entities that attend. Additionally each county has a Criminal Justice Advisory Board (CJAB) with active Mental Health Sub Committees. A grant was recently applied to the PA Commission on Crime and Delinquency (PCCD) for the 2015/2016 Justice Assistance Grant (JAG) by the Lycoming and Clinton Joinder as part of a collaborative effort for the creation and implementation of a Crisis Intervention Team (CIT). The CIT will benefit both counties with training opportunities for first responders to decrease arrests of mental health consumers, and increase the number of referrals for other community services such as health care and housing services and supports.

Northumberland – BHARP is currently identified as the LLA, the responsibility will be transitioning to Northumberland County.

Schuylkill - The current Local Lead Agency (LLA) in Schuylkill County is Kristi Shuster from the Behavioral Health Alliance of Rural Pennsylvania (BHARP). It is anticipated that a transition will occur and that Schuylkill County will assign its own Local Lead Agency (LLA). This transition process is in place. The County Mental Health Administrator and County Administrator will soon name a Local Lead Agency (LLA).

- **Describing existing partnerships with local Public Housing Authorities, Regional Housing Coordinators, Community, Housing, and Redevelopment Authorities, and Local Housing Options Teams including any specific referral and /or management Memorandums of Understandings or other agreements.**

Centre - Housing program specialist, through Centre County Office of Adult services acts as liaison for all housing matters. This position also Chairs the local Housing Options Team

CMSU Behavioral Health & Developmental Services has a housing specialist that serves on many committees and task forces within the community to ensure collaborative efforts are made to meet the needs of the population. CMSU Behavioral Health & Developmental Services is represented on the Columbia County Housing Task Force, Union County Low Income Supports Committee, RHAB, Columbia County Justice Master Leasing Committee, and the Union County Justice Bridge Housing Committee. In addition, the housing specialist has frequent communication and meetings with the Housing Authorities' and Redevelopment Authorities' executive directors and directors of Section 8 Choice Voucher programs to discuss the needs of our population and to work on collaborative grant efforts to include PCCD and PHARE Funding. The housing specialist maintains relationships with other community resources that can provide rental assistance such as Central Susquehanna Opportunities and Community Action Agency, AGAPE, and Human Services for our counties.

Increased housing opportunities for CMSU Behavioral Health & Developmental Services' population, has occurred thru relationships with private landlords and community resources. The housing specialist receives lists of available units at site-based subsidies from managerial staff to ensure that access is given to our population. Private landlords are willing to work with our individuals, removing the boundaries related to behavioral health bias that are often there in the private rental sector. These same private landlords have also given their units for utilization in programs such as the Union County Justice Bridge Program and Columbia County Justice Master Leasing Program.

Jim Meehan is the Regional Housing Coordinator for CMSU's counties. Jim has been active in the Homeless Task Force meetings and PHARE selection committees. Jim has assisted our counties with providing feedback and information on homeless tracking efforts that have taken place among his counties of oversight.

Currently CMSU Behavioral Health & Developmental Services' housing specialist is involved with consulting both Union and Columbia Counties in their 2016 PHARE application process to ensure program development for the grant would assist in serving the unique populations in need. CMSU has D & A Recovery Housing Funds that can be utilized to assist individuals with obtaining/maintaining permanent, secure, affordable housing, providing emergency rent, eviction reversal, and utility assistance.

HMJ has a contractual relationship with Shelter Service, Inc. which provides emergency shelter primarily to individuals who reside in Huntingdon, Mifflin and Juniata Counties. Shelter Service, Inc. provides emergency shelter to those with mental illness for a per diem rate and is also the fiduciary for Family Support Services (FSS) funds that can be used to provide tangible assistance for those in need. Shelter Service, Inc. also operates a great funded permanent supportive housing program that can accommodate up to six males. HMJ also contracts with Keystone Human Services to provide 11 Community Residential Rehabilitation beds at two sites in the joinder. These are the most intensive from of on-site housing support contracted by the joinder and are used to divert or step-down individuals from in-patient hospitalizations and/or institutional settings.

HMJ uses the BHARP as its Local Lead Agency. Also, Juniata Valley Behavioral and Developmental Services currently has a presence on the board of directors of the Mifflin County Housing Authority.

Lycoming / Clinton - Collaboration is the key element for both Lycoming and Clinton Counties. The housing specialist and the mental health program specialist for the Joinder meet frequently throughout the year with various key staff and the executive directors for the public housing authorities in each county to discuss progress in grants and housing programs the Joinder has under its auspices. Additionally, the Public Housing Authorities (PHA'S) communicate areas of concern and need that case managers and the housing specialist can possibly assist them with. These collaborative efforts lead to keeping MH consumers in their PHA units in the event of crisis, hospitalization and times of lost income. Additionally, the Clinton County PHA executive director is very active with the Clinton County PHARE funding and the North Central Regional Homeless Advisory Board (RHAB) which the Joinder housing specialist is also an active participant. The Lycoming County PHA in 2017 is initiating a homeless preference for public housing units. The

preference was requested to their board after a review of the success of the McKinney Grant the Joinder has been operating since 2011 for single homeless adults with a mental health disability. Additionally in Lycoming County we have been able to receive a disability preference for individuals that are disabled but not receiving SSI or SSDI that are deemed disabled through documentation in the McKinney program.

The regional housing coordinator (RHC) is James Meehan and he makes himself available to the area whenever called upon. Both Lycoming and Clinton Counties have private developers and housing options for low to moderate income. The Joinder Housing Specialist keeps an updated list of these options for case managers to assist consumers to review their housing choices as to where they can apply for housing in the community to best fit their circumstance and choice. There are several private landlords that will contact the Joinder Housing Specialist with open units seeking a consumer through the MH/ID Agency. These private landlords report they appreciate the supportive services that are readily available to the consumer and actively respond to the consumer if needed. The Joinder also has a small contingency fund program available to consumers that may be in need of emergency rent/utility/furnishings. These are zero percent loans to ensure that housing isn't lost in case of emergency situation and no other resources are available in the community.

There are several local housing options team operating in Lycoming – Clinton Counties. There is the Regional Housing Advisory Board which meets monthly and has representation from both counties. This group has representation from all entities that deal with all homeless providers in each county. In Clinton County there is a Clinton County Housing Coalition which is a 501c3. In Lycoming County there is a Lycoming County Housing Alliance which mainly focuses on a transitional family program, Journey House. This is 4 apartments for families experiencing homelessness.

The Lycoming County Housing Coalition meets monthly and concentrates on educating the community and private landlord sector on various options and opportunities for landlords and their properties. Jim Meehan (RHC) was instrumental in getting this group together and set up. They have held two landlord forums with presentations and meet and greet sessions with the local human services agencies to encourage rental to individuals with disabilities. Additionally, this was an opportunity for the private sector landlords to learn about services in the community that individuals participate in with various disabilities. These forums were quite successful and well attended.

Lycoming and Clinton County are both recipients of Pennsylvania Housing Affordability and Rehabilitation Enhancement (PHARE) funding. In Clinton County for 2015 MH/ID was awarded $8,264.00 of the total $57,750 the county received for 2015. Clinton County PHARE is a partnership between the county government and multiple human services agencies to provide shelter costs and/or rental assistance to the counties most vulnerable populations. The MH/ID population targeted the monies for rental assistance, security deposits and emergency needs. The 2016 grant request through PHARE the target MH/ID allotment is $7,000.00 to be used for the same needs and these include the justice involved individuals as well as those to be discharged from State Hospital. Lycoming County earmarked a portion ($500,000) of their PHARE monies for the human service contingent to one central provider and created a Supported Housing Program (SHP) which is administered by STEP, Inc. It is designed to be an 18 month housing initiative to assist renters in danger of being evicted, home owners in danger of foreclosure, and homeless County residents to secure stable housing. Lycoming Clinton MH/ID is a referral partner agency. A documented referral partner agreement is in place with the administrative entity, STEP Inc.

A new Supported Housing Service has recently begun operation as of January 1, 2017 by the American Rescue Workers. This housing support service is funded through $40,000 of reinvestment monies. Recipients of this supported housing program are assisted with access and choice locating decent and affordable housing. They are to receive support services to retain their housing to include budgeting, life skills, crisis management and renter skills.

Other housing and housing support services in the bi-county area include but are not limited to:

- 20 CRR beds
- Independent Living Support services
- Mobile Psychiatric Rehabilitation Services
- Homeless Assistance Program (HAP) monies
- Emergency Food and Shelter Program monies (EFSP)
- MH/ID McKinney Housing First Permanent Supported Housing Program (serves 8-10)
- 2 Homeless shelters in Lycoming County (Saving Grace and ARW)
- 1 Shelter/Transitional Program in Clinton County (Life Center)
- 1 homeless family program (Family Promise)
- 1 homeless transitional 4 family program (Journey House)
- Shelters for domestic violence in both Counties
- Transitional housing program for woman &children, Lycoming County(Liberty House)
- 811 PRA Permanent Supportive Housing Initiative in Clinton County

Northumberland County Supported Housing Programs, Keystone Service Systems Inc. opened its doors on April 1st, 2008, and supports 12 people currently. This project has staff that is available twelve hours daily with each person receiving approximately 1 hour of support per day. The program utilizes master leasing which allows people graduating from the program to move taking their lease with them to their housing the location. Since this is a permanent housing program individuals can stay as long as necessary. Each of these programs have very little turnover, at approximately 20% annually.

Northumberland County has an active organized Local Housing Options Team (LHOT) which meets the third Wednesday of every month. The LHOT utilizes the expertise of the LHOT team members and stakeholders to develop a plan to address the issues that many of the rural counties in Pennsylvania face. We have a diverse group of team members with includes a planning team, landlords, service providers, Regional Housing coordinators and also the United States Department of Agriculture (USDA). The LHOT will help steer the members of the team to focus on working with the most extreme cases and issues which often arise in the housing arena. Sharing ideas, brainstorming and networking are the main areas discussed during the approximate 1 hour monthly meetings.

Homeless assistance services: services for individual and families who are homeless or in treat of becoming homeless are cooperatively provided by Northumberland County Human Services and Central Susquehanna Opportunities, Inc., A community Action Agency (CSO). When a customer requests emergency services, CSO takes this opportunity to provide access to the full menu of programs that we provide. In other words, while addressing the crisis at hand, CSO also hopes to introduce the client to programs and practices that will help avoid future emergencies.

Recognizing the need for expediency, a Case Manager will meet with a prospective client as soon as possible, sometimes off-site to accommodate the client. The individual will be instructed to bring identification and income documents so that eligibility may be determined according to state regulations. If the individual is homeless, efforts are made to provide temporary, immediate shelter. Some options include staying with family or friends; using a homeless shelter, if available; or identifying rooms that may be rented per day or per week using HSDF. We also ensure that other basic needs are being met: food, clothing, and toiletries. When appropriate, the customer will be referred to the County Assistance Office for Emergency Shelter Assistance, or to the County Housing Coordinator (also on CSO staff) for BHARP funds. Many times, it is through a combination of

resources that we are able to provide the most desirable outcome. During the assessment process, the Case Manager will determine the cause(s) of the crisis and develop a strategy for self-sufficiency. As a "one-stop", CSO is positioned to provide a wide array of services including, but not limited to:

- Resolution of the immediate crisis
- Goal planning to avoid future crises, including financial literacy
- Verification of affordability moving forward
- Employment search and related services
- Easy access to COMPASS services
- Advocacy and referral to other agencies, as needed
- Rental assistance is available for first month's rent, security deposit, or rental arrears to stop an eviction. The cap of $1000 per individual and $1500 per family includes any federal assistance received in the past 24 months. In addition, if the consumer is moving into subsidized housing which is paying for a portion of the first month's rent, HAP funds may only be used to help with security deposit.
- The Emergency Shelter component of the program includes the same assessment and case management services as HAP. Emergency shelter is sought in several ways: through family and/or friends; at a local housing shelter; or at an affordable local hotel/motel. Emergency Shelter is temporary, so every effort is made to secure permanent housing while the consumer is in the interim housing. Like the rental assistance program, success is measured by permanency and self-sufficiency.
- Utility costs will be paid as a last resort to prevent and/or end homelessness or near homelessness by maintaining individuals and families in their own residences.
- Permanency and self-sufficiency, our program goals, are tracked through personal follow-up with the Case Manager.

Schuylkill County relies on multiple resources and partnerships within the county to facilitate integrated housing options. Much progress has occurred in this area within the past few years.

A significant strategy has been the development of permanent supportive housing apartments. We have learned from many discussions with our consumers that their preference in location is the City of Pottsville. So, we have focused on that geographic area. through the combined resources of Block Grant monies, Reinvestment Funds and real estate development companies, we now have twenty-one (21) permanent supportive housing beds available. by June 2017, we will add two (2) more beds. We anticipate another five (5) beds being added during 2017-2018. Our total will then be twenty-eight (28) permanent supportive housing beds. This is a significant number based on the fact that such development did not begin until 2011.

Since November 2015, our consumers have had the option of participating in My Father's House homeless day program. With the assistance of three case managers and many volunteers, individuals who may have been forced to remain in or return to segregated settings are now provided a variety of supports by My Father's House such as housing searches, short term emergency housing options, employment searches and transportation. Individuals who are homeless and in need of mental health services are first

referred to the county mental health case management provider, Service Access and Management, Inc. they are then offered shelter in a rooming house. Throughout the day, they work with mental health providers and search for employment and housing with the assistance of My Father's House case managers and volunteers. Ultimately, success is achieved when employment is attained and permanent, integrated housing is secured.

Much credit also goes to the City of Pottsville Housing Authority and Schuylkill County Housing Authority. Both Authorities have a firm and committed relationship with the county's mental health case management provider, Service Access and Management, Inc. The Housing Department staff at Service Access and Management, Inc. communicate on an almost daily basis with the Housing Authorities. Applications are reviewed together, preferences are verified and all options are considered. Even in cases where an application is denied, Housing Department staff from Service Access and Management, Inc. will attend the appeal hearing and, oftentimes, have the denial overturned after new information is presented.

Barefield Development Corporation is also an integral component in offering center city, integrated living opportunities. Barefield Development Corporation owns and operates the Necho Allen, a former hotel. The Necho Allen is home to sixty-two individuals, all of whom are either disabled or elderly. Barefield Development Corporation employs a site manager who, among other duties, is assigned the role of liaison to Housing Department staff at Service Access and Management, Inc. work together in resolving those issues so tenants who are disabled or elderly, and suffer from mental health illnesses, remain in their independent apartment rather than being placed in a hospital=type setting.

The residents in our county's two CRRs and Danville State Hospital are monitored closely with there being a focus on transitioning from the CRRs and Danville State Hospital into permanent supportive housing. When two of our Reinvestment Funds' Housing Plans were written, those Housing Plans specifically targeted the residents in our county's two CRRs and Danville State Hospital. The goal was to transition those residents into permanent supportive housing as soon as reasonably possible. The Service Access and Management, Inc. Housing Coordinator chairs multiple ad-hoc permanent supportive housing committees each year that review and approve transitions into permanent supportive housing. As applications for permanent supportive housing are reviewed, there is always an emphasis on those individuals living in CRRs or Danville State Hospital.

Our county also takes great pride in the work we do during the annual unsheltered (street) Point in Time Count. We look to achieve certain goals through the annual unsheltered (street) Point in Time Count. First, we hope to immediately respond to the needs of the homeless that we locate and develop an instant plan so that they are not hospitalized for reasons of safety. A more global goal is to use the unsheltered (street) Point in Time Count data to pursue funding to develop integrated housing options. This recently occurred when, as a result of the unsheltered (street) Point in Time Count, the Resources for Human Development (RHD) company was awarded funding to develop eight (8) master leasing options for chronically homeless. This is a population so desperate that often hospitalization becomes an option to assure the health, safety, and welfare of these individuals.

Although small and economically depressed, Schuylkill County has capitalized on many opportunities to develop and manage integrated housing options for individuals with mental health illnesses.

IV. Special Populations:

Systems are already in place for the majority of these bullet points. The challenge is the adequacy and consistency of funds to help people successfully live in their home communities, which allow citizens to begin the road of developing trust and recovery. The Commonwealth of Pennsylvania already has various waiver programs available as well as forensic services, services for non-English speaking citizens, services for individuals who have experienced a traumatic brain injury, services for individuals who are deaf and hard of hearing, services for individuals who are homeless or at risk of homelessness, services for individuals who are aging, etc. The key issue is fiscal resources to consistently and adequately support not only individuals who are presently in the state hospital system, but also to make sure that the community system has an array of services and

intervention strategies so individuals never reach the point of illness that necessitates long term state hospitalization. We recognize that the Olmstead decision is the result of litigation primarily because for many communities, the adequacy of fiscal resources doesn't exist. For age specific services refer to Section II. An * indicates that any age group is provided the service. For those that limit services to specific age groups, the age is specified with the parenthesis following the name of the service.

- **Individuals with a dual diagnosis (mental health / intellectual disability) –** Services available to all ages.
  Individuals who are dual diagnosed require services from both systems equally and at the same time. Each system needs to afford the individual services and financial support to ensure the individual is successful in the community. This needs to take place while the individual is still in the State or Acute hospital setting in a timely manner for the individual to be supported in the community by themselves or with the help of others. The dual diagnosed individuals continue to be the hardest to serve, but with cooperation from all parties can be the most successful in the community. Discharge planning starts the day the individual enters the hospital for all individuals, this population needs to have all agencies, hospital, and community support staff involved at this point. Within the North central region (23 counties) two treatment teams that specialize in dual diagnosis have been developed and are capable of providing services for up to 24 individuals.

  Centre -utilizes the CSRU (Community Stabilization and Reintegration Unit) and the DDT (Dual Diagnosis Treatment Team). MH/ID maintains a strong partnership in supporting individuals that carry a dual diagnosis. MH is represented on the Positive Practices Resource Team (PPRT). MH is actively involved in the Transition Age Employment Coalition which supports services for individuals with a dual diagnosis

  CMSU also utilizes the CSRU (Community Stabilization and Reintegration Unit) and the DDT (Dual Diagnosis Treatment Team). Additionally, CMSU has two Psychiatrists who specialize in Dual MH/ID individuals. Mobile Psychiatric Rehabilitation has been utilized when appropriate to assist with skill development and increased planning for socialization and community integration.

  HMJ is currently awaiting the formation of a Dual Diagnosis Treatment Team in the central region of the BHARP geographic area that will be provided by Beacon Light. The joinder also uses the Beacon Light Community Stabilization and Reintegration Unit located in McClure, PA for longer term stabilization for dual diagnosed individuals. In reality, many dual diagnosed individuals take part in traditional mental health services such as Clubhouse, psychiatric rehabilitation, peer specialist, and drop-in centers. While dual diagnosed individuals sometimes require much more support and resources to address behavioral needs, many people thrive in traditional services.

  Lycoming-Clinton Counties are utilizing the Beacon Light Community Stabilization and Reintegration Residential Program, our Community Residential rehabilitation programs, Clubhouse, Beacon Hub drop in center, Clinton Count Community Connections, Independent Living Services, Peer Support, Center for Independent Living-Roads to Freedom, mobile psychiatric Rehabilitation program and nurse navigator programs to serve our dual populations.

  Northumberland –utilizes the Beacon Light Community Stabilization and Reintegration Residential program for individuals that need this level of service. Additionally, integration of System of Care cross systems treatment teams is utilized to provide best practice services.

  Schuylkill -works co-jointly with NHS using their Dual Diagnosis Treatment Team; targeting difficult cases.

- **Individuals with co-occurring disorders (mental illness/ substance use disorders) -** Services available to all ages.
  Many years ago, significant effort among a range of stakeholder went into designing a common understanding for diagnosing and treating persons with a serious mental illness and a substance use disorder. This service design is consistent with national standards, research, and evidenced based programming. The Departments of Human Services (DHS), Office of Mental Health Substance Abuse Services (OMHSAS), and Drug and Alcohol spearheaded the effort and one outcome was a dual licensing of outpatient programs. Some pilot programs evolved and eventually the State abandoned dual licensure; some pilot clinics still exist but there is consensus that the bureaucratic roadblocks with two State departments in licensing and practice seriously limit the opportunities for persons to seek out and be successful at integrated care. Medicaid managed care has not broken through these barriers to offer assessment and treatment other than parallel or sequential treatment. Overuse of emergency rooms and acute psychiatric inpatient care abound for this population without the benefits that are well-documented as best practice. Mental health agencies are fully engaged to see changes in the bureaucratic burden of State departments, DHS's OMHSAS, and the newly organized State Department of Drug and Alcohol Services. Professional training and or co-occurring certification has been available for clinicians.

  Centre - Centre County Mental Health (CCMH) contracts with a local provider that provides outpatient psychiatric and therapy services to individuals that are diagnosed with a co-occurring disorder. There is a strong mental health and drug and alcohol partnership in Centre County Student Assistance Program (SAP) and CASSP Advisory. CCMH and Drug and Alcohol share office space which enhances collaboration and access to services to the individuals we serve. CCMH provides Administrative Case Management (ACM) services to individuals that are receiving co-occurring services to ensure continuity of mental health and drug and alcohol services. CCMH supports individuals who are eligible for mental health services by offering and activating them for Mental Health TCM Services when there is a wait list for Drug and Alcohol TCM Services. Co-occurring services are delivered to individuals that are incarcerated in the county jail via individual and group treatment options.

  CMSU offers MH and D&A Services from the same location and provides case work, care coordination, assessment and referral as well as providing services from both components simultaneously. Medication Assisted Treatment (MAT) is a current effort in conjunction with the Center of Excellence at Geisinger Medical Center as well as a mobile MAT service currently under consideration. Certified Recovery Specialists working for local providers are accessible to both D&A and Co-occurring identified individuals as well as peer-to Peer for MH and Co-occurring individuals. CMSU operates a Pre-Motivational Co-Occurring Group for Individuals not fully engaged in Co-occurring services.

  HMJ is a Projects for Assistance in Transition from Homelessness (PATH) grant recipient joinder and uses those resources to support individuals who have both a mental health diagnosis and substance abuse issues. PATH resources provide case coordination for participants that intensively supports participants with obtaining and maintaining safe and affordable housing. The grant also provides resources for participants to access first month's rent, security deposit and items needed to establish residency in a new home. through PATH, HMJ also provides for drug and alcohol assessments, individual and group D&A therapy milieus, and anger management counseling as needed.

  Lycoming-Clinton currently has one provider with a dual drug and alcohol and mental health license. This provider also has Certified Recovery Specialists as an additional resource, as well as a Community Based Drug and Alcohol Program for co-occurring adolescents and their families. Utilization of outpatient services has also increased significantly under Medical Assistance expansion.

Lycoming-Clinton has been experiencing a serious and ever increasing impact of heroin use. The Methadone clinic in Lycoming County opened in FY 2013-14 and has rapidly reached capacity and expanded several times over the course of the past year. There is also a need for additional non-hospital detox services in Pennsylvania, and development of local resources.

Northumberland – has behavioral health and Drug and Alcohol Services within the same building as provides case management, care coordination, assessment and referral and unified treatment through all systems by way of system of care implemented treatment team meetings. Medication Assisted Treatment is a current effort along with the Center of Excellence at Geisinger, Danville. Certified Recovery Specialists working for local providers are accessible to both D&A and co-occurring individuals.

Schuylkill works with Lehigh Valley Health Care Network (a local D&A provider) and is setting up an aftercare program for individuals discharged from the in-patient units. They are also targeting the smoking cessation program for individuals receiving services for mental illness.

- **Individuals with both behavioral health and physical health needs -** Services available to all ages.
  While there is an ongoing initiative to address the general physical well-being of persons with serious mental illness a need still exists for services to those individuals who suffer from more long-term and debilitating disablements and/or diseases. While a personal care home may not adequately meet their physical and psychological needs, a skilled nursing placement may impede their ability to have any semblance of independent living. A statewide database of specialized care residences would be beneficial in developing living plans for individuals with debilitating diseases.

  There is large focus in the community on overall wellness that approaches a person as a whole versus their individual parts. It is important for people to acknowledge their mental health in equal importance to their physical health. This philosophy with the addition of wellness tools and resources that are being embedded within services delivery systems (case management, peer support, psychiatric rehabilitation, nursing support embedded within behavioral health programs:, is helping to further people on their path to recovery and reduce the stigma associated with mental illness. Individuals have the tools to enhance their health care services independently or with supports of their choosing.

  Centre - Centre has been involved in the ongoing Wellness Initiatives offered through Community Care Behavioral Health (CCBH) to include Wellness coaching, Pat Deegan Wellness Initiatives, and Patient Centered Outcome Research Institute (PCORI). Wellness nurses are available through several providers within the community. CCMH is working to develop stronger relationships with physical health providers.

  CMSU employs a full time Wellness Registered Nurse to address high users of BH/PH Services. All CMSU Staff have undergone training to be Health Care Navigators. These efforts are in conjunction with Community Care Behavioral Health (CCBH). The CMSU and 23 County Managed Care Organization. Both Recovery Centers provide groups and education on exercise, nutrition, cooking, recreation and health as well as chronic condition management. Under review is the consideration to employ a consulting PCP. A goal of all CMSU Programs is to ensure that all individuals served by CMSU have a Primary Care Physician (PCP) on record and appointments on a regular basis. CMSU has staff trained in smoking cessation for individuals who desire to engage in harm reduction/smoking cessation.

  HMJ contracts with Community Services Group (CSG) to provide a Mobile Psychiatric Rehabilitation program with a Nurse Navigator Model. CSH also operates a wellness center located at their site-based psychiatric rehabilitation program that is accessible to any individual in the joinder who is open with the Base Services Unit.

Lycoming-Clinton utilize Mobile Psychiatric Rehabilitation, Nurse Navigator, Wellness Nurse, Peer Support, Beacon Hub, Clubhouse, Clinton County Community Connections, Community Residential Rehabilitation Program, Center For Independent Living- Roads to Freedom and Independent Living services and STEP transportation to assist our individuals with Behavioral health and psychical health needs.
Access to services could be improved. There are a multitude of requirements to qualify for most services.

Northumberland – participates in behavioral health home plus with all blended case manager's participating and trained as health navigators. In addition, a full time registered Nurse is housed within the BCM office to consult with staff and individuals in recovery and provide ongoing training for improved physical health and education.

Schuylkill –Access to services could be improved. We are currently exploring options of adding a navigator nurse to mobile psych rehab which would enable them to address both physical and mental health needs.

- **Individuals with a traumatic brain injury (TBI) –** Limited to adult waiver process
  The identification of a traumatic brain injury is often the most important first step in establishing an integrated team of professionals and a treatment/support approach. Access to neurological assessments can be limited and time-consuming. This results in the use of crisis services and psychiatric inpatient care until a comprehensive clinical picture evolves and treatment planning can occur. This may involve the prison system with this population as well. While typically, programming needs to be highly individualized, there has been some success in developing a very small specialized care residence (five beds) and working with the CommCare TBI Waiver to meet the needs of individuals with a serious mental illness and traumatic brain injury. The services and supports for this population are very expensive.
  Access to services could be improved by consolidating some of the requirements to qualify for most services.

  Centre - An annual TBI training is provided to staff in support of individuals that have a TBI in addition to mental illness. CCMH has recently learned the avenue to secure TBI waivers.

  CMSU -has provided traditional MH services to several individuals who are identified as having a traumatic brain injury. Working to diagnose with neurologists and psychiatrists and neuropsychiatrists is difficult and not an exact science in some instances. The CommCare Waiver is inadequate and extremely restrictive in eligibility criteria and without an adequate provider system to be of as much use as the need would indicate. Traditional MH services need to be modified and specialized to be of assistance to this population. Funding inadequacy as well as treatment expertise lack is also problematic. Traumatic brain injury is not one condition in regard to symptomology but many. Interventions must be tailored to the deficits and increased use of cognitive retraining and occupational therapy are of a great assist.

  Lycoming / Clinton - The Joinder assessment unit provides an individual assessment to each case and referrals to community services identified throughout this plan. Additionally, a referral source for this population utilized is Living Unlimited Inc. Living Unlimited provides head injury services to those with brain injuries and related neurological challenges. Services ae designed to assist individuals with maximizing independence in their home and community. Additional Supports and services for this population are very much needed.

Schuylkill -Providing updated Information to staff as well as treatment and behavioral health providers can be improved. Additional supports, resources and specialized services to this population are very much needed

- **Individuals with criminal justice/juvenile justice history -** Addresses all age groups
  Counties first obligation is to work with the county prison system on jail diversion, MH Courts and re-entry programs to assist non-violent offenders with a serious mental illness who can benefit from alternative interventions and programming to remain as productive community residents. Counties document these efforts to better serve their residents in a Forensic Plan added to Annual County Plan or Block Grant Plan requirements. Counties do experience success when providing case management services directly within the local county jail system. The success of counties providing case management specific to the forensic population is also noticed in the State Correctional System. Most Counties can demonstrate a better use of mental health programming in collaboration with the Court and probation thereby decreasing future criminal involvement not necessarily saving money. There is noticeable improvement in collaboration with police departments within counties that are developing Crisis Intervention Teams (CIT) through behavioral health training of first responders. Persons returning from incarceration in the State correctional system have a different criminal history and may have been removed from community living for an extended period of time. Typically, re-entry is not as directly related to established community or family links. Barriers for County mental health systems include: the volume of persons in re-entry from state correctional institutions, the role and function of the community correctional centers/ their lack of health/mental health linkages, inconsistent classification system on needs and issue related to treatment, unpredictable sentencing to release aftercare planning at DOC, discharge resources and poor planning for person who may have been convicted from a county jurisdiction but have no sources of support in that county, and the misunderstanding about the role of County MH in residential support and housing issues. State correctional re-entry is a statewide issue. Counties and State Correctional Facilities need to work together to develop early coordinated re-entry plans.

  Centre - CCMH provides continuity and collaboration with the forensic population by supplying a forensic program on-site at the Centre County Correctional Facility a half of a work day five days per week. CCMH contracts with a local provider to provide mental health treatment and education groups in the Centre County Correctional Facility with block grant funds. CCMH contracts with a provider who renders individual outpatient and consultation services to individuals who are incarcerated at the Centre County Correctional Facility. This service is provided solely with county funds. Currently, there are sixteen individuals who are active with CCMH and are incarcerated.

  CMSU's engagement in Systems of Care SAMHSA Grant activities has engaged the Criminal Justice and Juvenile Probation Departments in Trauma Awareness Training and has also solidified a working relationship which will be strengthened by ongoing Systems of Care activities. CMSU has a dedicated Forensic Case Manager who has weekly visits to the County Jails and coordinates discharges from State Prisons for CMSU Residents. Additionally, CMSU Provides Psychiatry Services to three of the four County Jails. Columbia County in conjunction with CMSU Staff are planning a Mental Health Court which should start in the winter of 2016. CMSU staff are members of both the U/S CJAB and the C/M CJAB. CMSU also provides annual training for all county prison guards, local police and state police on various topics such as suicide awareness, psychological first aid, motivational interviewing, trauma awareness, etc. topics vary each year.

  HMJ also utilize the CIT model in Mifflin County and has currently trained two classes of police officers, probation officers, correctional officers, sheriff deputies, and other human service individuals. Also in Mifflin County, through a Pennsylvania Commission on Crime and Delinquency (PCCD) grant, the joinder coordinates re-entry services for individuals housed at the Mifflin County Correctional Facility. There is also a dedicated administrative case manager position at the Joinder Base Services Unit that works with individuals within both the Mifflin and Huntingdon County Jails. This position authorizes any psychiatric services being received in the jails and also assists with re-entry planning.

Lycoming-Clinton Counties both have well established Criminal Justice Advisory Boards (CJAB), each with a Mental Health Sub-committee. The Lycoming-Clinton Joinder Board (LCJB) has submitted an application to develop a Crisis Intervention Team (CIT) Training and Coordination Project in Lycoming and Clinton Counties. The proposal supports the PCCD 2016-2020 Strategic Framework objective to increase the efficacy of state and local planning efforts through interagency planning and collaboration by providing support for county (CJAB) priorities. One of the major deliverables associated with the CIT Training and Coordination Project include using the seven (7) individuals who have already completed the 40 hour CIT training in a "train the trainer" model to provide local training for up to 75 criminal justice representatives over the course of the grant period. This groundwork of recruiting individuals to complete the training has been laid over the past two years through our local collaborative planning efforts. Our research has shown that a formal commitment to community partnerships is the foundation of a successful CIT initiative. The training will not be limited to law enforcement, although they will be the major focus of this project. CIT is an innovative first-responder model of police based crisis intervention with community, health care, consumer and advocacy partnerships. As such, we have included representatives from Police Departments, Adult Probation, Prison Counselors and Department of Public Safety 911 Training Coordinators as trainers.
The second deliverable is to hire a CIT Coordinator. This position will oversee the training process, collect and analyze data related to CIT calls from local law enforcement and responders establish lines of communication with agencies and providers of mental health services and the criminal justice system, coordinate our efforts with NAMI Lycoming-Clinton and promote CIT throughout Lycoming and Clinton Counties. We have made a great deal of progress in obtaining broad based community buy in for CIT through the efforts of the CJABs and their Mental Health Sub-Committees. Much more needs to be done to integrate CIT constructs into developing a seamless crisis response system that provides individuals with mental illness access to treatment instead of incarceration. The CIT Coordinator position is a key component of this strategy. The anticipated impact associated with the CIT Training and Coordination Project include both process/systemic outcomes and individual consumer quality of life outcomes. Our intent is to develop a larger pool of CIT trained police officers and first responders and to develop a crisis response that tracks diversion of individuals with a mental illness from the criminal justice system.

Lycoming-Clinton has made services for justice involved individuals a priority in the past several years. Currently there is a need for housing resources for county jail discharge planning, although PHARE projects in both counties and a HealthChoices Housing Reinvestment plan will provide additional resources. The State Forensic Hospitals have long wait list for evaluations/treatment which ultimately strains our local county jail staffing and other resources.

Northumberland - PCCD grants have given us the opportunity to create treatment courts. A case manager is responsible for coordinating support for individual's participant in treatment courts. System of Care treatments teams are coordinated between the cross system agencies, to include the court/probation department to assure best practice services are provided so to ensure the best possible outcomes for individuals in recovery. Behavioral Health/Drug and Alcohol/ID departments work closely with the prisons housing Northumberland County residents, acting as boundary spanners for individuals being released from prison, with the goal of having services set up and successfully in place upon release of the individual from prison.

Schuylkill has developed a sub-committee to our Criminal Justice Advisory Board the focuses on Mental Health issues and works together on specific cases to do re-entry as well as treatment services and housing for people leaving prison/jail.

- **Individuals who are deaf or hearing impaired -** Services available to all ages.
Individuals, who have a mental illness and are deaf, face challenges within the mental health service delivery system. There are communication barriers, a shortage of mental health professionals who are American Sign Language fluent, a deficiency of interpreters, deafness not being a traditional thought or priority when addressing cultural competence in the mental health arena, a lack of local resources, and a lack of funding for communities to provide such a specialized service. A commonality

between the two populations is the fact that both experience stigma and discrimination. It is imperative for both the mental health and deaf community providers to work together to improve service delivery. Involving individuals who are deaf at every step in planning and development is essential for the delivery of quality mental health services and supports to this population. Developing and accessing statewide resources can be more economically feasible. Access to services is improved through the use of Telecommunications Relay Services. The mental health system needs to take into account the deaf community culture and be creative and flexible in their service delivery system.
A Statewide resource system would allow for services to be utilized in a more timely and efficient manner.

Centre - CCMH links with resources that are provided through Penn State University who can competently support individuals with these specific needs.

CMSU utilizes sign language interpreters and has oriented each staff member (who has a deaf individual in service) on communication protocols when using an interpreter. Touch Teletype (TTY) Relay services are utilized for phone conversation.

Lycoming County has utilized the Center for Independent Living- Roads to Freedom to utilize adaptive devices and the basic sign language classes. One of our CRR programs has multiple staff members who utilize sign language.

Northumberland - typically we seek the support of natural supports to assist with providing services to individuals that are deaf, but will utilize resources as needed to assure the best quality service is provided to everyone, regardless.

Schuylkill contracts with Berks Deaf & Hard of Hearing Services for assistance.

- **Individuals who are experiencing homelessness -** Addresses all age groups
Homelessness with individuals is addressed in many and various ways. These range from homeless shelters to counties that use vouchers for short-term hotel/motel stays. Rental subsidies are used that assist in paying for rent, rent in arrears or security deposits. Many counties participate in PATH (Projects for Assistance in Transition from Homelessness). PATH also assists with emergency housing, accessing food, doing apartment searches, etc. Some counties use McKinney-Vento programs which provide rental assistance/subsidies. There are permanent supportive housing programs in which rent and utilities are limited to 30% of their income and have a variety of support staff available. Many counties also have staff that is devoted only to working on and preventing homelessness.

Centre - Centre County continues to deal with affordability housing issues that affect our residents. We provide a continuum of services in the county to assist homeless and/or prevent homelessness when achievable. We continue to struggle with the loss of affordable units competing with new student housing development. As our inventory decreases, our providers work harder to establish and maintain positive working relationships with our landlords to provide affordable housing. We have a minimum of a nine month wait list for Housing Choice Voucher program so we maximize all housing program opportunities in the county, especially those related to sub- populations (mental health, children and youth involvement, etc.). As of May 2016, Centre County did not receive renewal of the Shelter Plus Care Grant through HUD. This grant provided 32 vouchers for homeless individuals and/or single parents with a significant mental illness. This loss will further extend the wait list for Housing Choice Vouchers and is a loss for our shelters to refer for this service. Centre County will look for options to reapply and/or recreate a similar program.

We continue to utilize our Disabled Residents Team to assist families during housing crises. All Human Service Block Grant providers in HAP and HSS

participate in this team. We mobilize and meet with families as soon as possible to discuss their housing needs, basic needs, transportation, employment, budget and family concerns. We then work with the family as a team with caseworkers focusing on housing, basic needs, etc. to assist the family during this transition. Centre County recently lost a tax credit development that will be re-developed into student housing. Ninety two family units will have to be relocated to other affordable housing opportunities. Housing Case Management will take the lead on assisting these families over the next year.

Housing for the criminal justice population remains an area of interest for our providers, leaders, and residents. As part of strategic planning and mapping opportunities, housing has been highlighted as a high need for successful reentry. PREP training was provided to a variety of human service and criminal justice agencies to promote this program. Centre County will look for opportunities to assist residents currently incarcerated and/or previously incarcerated to provide permanent housing opportunities.

Bridge Housing:

Bridge Housing allows homeless residents and families the opportunity to live in an apartment while working on their goals toward interdependence living over a twelve to eighteen month period.

○ Centre County currently has five Bridge Housing units, two with one provider and three with the domestic violence provider. The providers maintain the leases on four of the five units in the county. The tenant based rental unit has proved successful for clients looking to establish credit, landlord references, etc. The domestic violence provider offers the tenant based rental unit.

○ Centre County Office of Adult Services meet with Bridge Service Providers monthly to discuss participants, vacancies, applications, and overall needs of the program. The office also conducts annual on-site monitoring to include chart reviews, fiscal reviews, and staff interviews.

Case Management:

Housing Case management is the keystone service for residents in Centre County seeking affordable housing.

○ Housing Case management provides support, resources, budgeting skills, and advocacy for our residents. Housing Case management works with the homeless shelters, Housing Authority of Centre County, human service agencies, developers, landlords, county agencies, and faith based organizations all for the need to find housing.

○ Housing Case management has two elements: client based services and information and referral. Residents seeking client based services meet with the case manager, establish goals, budget, needs, etc. and actively work with the case manager on finding housing. Information and referral allows residents simply seeking rental information to contact the case worker and receive up to date listings of units located throughout Centre County.

○ Housing Case Management maintains a Housing Resource Guide available to residents, human service agencies, businesses, etc. to assist in finding affordable housing.

○ Our county continues to struggle with the availability of affordable housing. The services of Housing Case Management have been instrumental in assisting residents in finding safe, accessible, and affordable housing. Housing Transitions, Inc. is the provider for Housing case Management services.

○ Centre County Office of Adult Services meets with Housing Case Management Provider monthly to discuss participants, housing concerns, and overall needs of the program. The office also conducts annual on-site monitoring to include chart reviews, fiscal reviews, and staff interviews.

Rental Assistance:

Rental/Mortgage Assistance Program (RAP) provides rental or mortgage assistance to homeless or near homeless eligible residents in Centre County. RAP

referrals come from human service agencies across the county and the provider completes the necessary intake paperwork and works with the landlords and/or mortgage companies to provide the assistance. The provider can meet with residents at various locations throughout the county to assist with transportation costs and concerns.

- Interfaith Human Services is the provider for RAP services.
- Centre County Office of Adult Services receives monthly updates from the RAP Provider on clients, availability of funding and needs of the program. The office also conducts annual on-site monitoring to include chart reviews, fiscal reviews, and staff interviews.

Emergency Shelter:

No funding is provided for this service as the providers receive funding from other local, state and federal programs. Centre County has three permanent homeless shelters and one weather related shelter:

- Centre House which provides for men, women and children;
- Centre County Women's Resource Center for women and children fleeing from domestic violence;

CMSU's Housing Coordinator participates in the annual count of local homelessness to access funding to address homelessness. Shelters across the state are utilized. Two local shelters are available sporadically in Danville and Sunbury. These shelters provide emergency Housing with the goal of permanent housing for families with children. The Reinvestment Bridge and contingency funds have assisted in preventing Homelessness and securing housing for the homelessness when an income is present. Homelessness when no income is available to the individual remains a difficult issue in the area. CMSU also has a sizable population of individuals who "couch surf", stay with friends and relatives who are not technically homeless but in need of safe and secure housing. Coordination with the County Housing Authorities and AGAPE in Columbia County provide access and assistance to permanent stable and safe housing for children and their families.

HMJ- See previous remarks regarding Shelter Services, Inc. and PATH programs.

Lycoming-Clinton county housing and housing support services that help address homelessness include but are not limited to PHARE monies and programs, Supportive Housing Service, CRR beds, Independent Living Support services, Mobile Psychiatric Rehabilitation Services, Homeless Assistance (HAP) monies, Emergency Food and Shelter Program monies (EFSP),MH/ID McKinney Housing First Permanent Supported Housing Program (serves 8-10), 2 Homeless shelters in Lycoming County (Saving Grace and ARW), 1 Shelter/Transitional Program in Clinton County (Life Center), 1 homeless family program (Family Promise), 1 homeless transitional 4 family program (Journey House), Shelters for domestic violence in both Counties, Transitional housing program for woman &children, and Lycoming County(Liberty House).

Northumberland - does have one homeless shelter within its county limits and will often need to seek other facilities as needed. Through McKinney Vento grants, we have been able to establish community settings for individuals that would otherwise be homeless. Case management staff also participates in the homeless counts. Grasping the true population of homeless individuals in Northumberland County remains a difficult task, as individuals often seek shelter through various friends, family and other natural resources.

Schuylkill County, we also focus on Veterans through our Supportive Services for Veterans Families (SSVF) program. Staff and funding are available to assist veterans and their families when confronted with housing issues. Participants must either be homeless or at risk of homelessness. This assistance may include, but is not limited to, intensive case management; rental assistance in the form of security deposits, first month's rent or payments of arrears; moving expenses; basic household necessities; child care expenses and assistance with utility payments. All assistance is tailored to the individual's specific needs.

- **Older Adults**

  There are two segments of this population—(1) individuals who have been serviced through the mental health system and "age" into this group and (2) those who have not been served through mental health system and instead rely on their primary care physicians (physical health care system).
  For some in the former segment, the reality of fewer natural supports (through the death of parents, family members and friends) places a greater demand on the local mental health system to step in and provide meaningful support. For some of those in the latter segment, there is a stigma about mental illness that needs to be addressed through various forms of outreach and education both to the elderly themselves and to the providers of physical health care. Additionally, education about mental illness needs to be made available to family members, staff of residential facilities which house the elderly, senior centers and Area Agencies on Aging personnel. Senior Centers and Mental Health: Activities, Resources and Education (SHARE) programs which provide education and further support the mental health needs of older adults is a good example as to how education is provided within communities. This is accomplished through providing mental health resources to each of the local senior centers on a monthly basis and through mental health participation in Senior Center Director staff meetings. The creation and utilization of comprehensive Memorandum of Understanding (MOUs) between County MH and Aging Offices which clearly delineate roles, responsibilities and opportunities is critically important. Time and energy invested in establishing collaborative relationships between these agencies will be extremely beneficial. The ongoing availability of adequate funding to pay for both mental health and physical health treatment is vital. This portion of the general population is also addressed in the Annual Mental Health or Block Grant Plans which are written by each county or county joinder.

  Centre - CCMH and the Centre County Office of Aging (OOA) align crisis and protective services when older adults are suspected to be in need of services and supports. CCMH maintains a liaison specific to (OOA). CCMH and OOA are meeting routinely to discuss services, provide updates, further establish working relationships and identify service and support needs that we share. CCMH and OOA have re-establish Project SHARE (Senior Centers and Mental Health: Activities, Resources and Education) to provide education and to further support the mental health needs of the older adult population by providing education and resources to each of the local senior centers on a monthly basis. Meet with each of the six senior centers to maintain Project SHARE by providing a liaison to Senior Center staff and members. Establish a routine for the liaison to participate in activities at three of the Senior Centers per month. CCMH is attending quarterly Senior Center Director staff meetings. This was identified by OOA as beneficial for relationship building. Centre County has recently established an Older Adult Task Force which includes representatives from CCMH and other community agencies.

  CMSU and the two Aging Offices co-sponsor an annual local conference to educate both agencies staff on issues pertinent to the older adult. It is also a practice that in certain instances both CMSU and Aging staff will make a joint home visit to assess and plan for needs of the older adult. CMSU annually holds depression screening in all Senior Citizen's Centers in conjunction with Danville State Hospital Staff and has discovered depression and made treatment arrangements.

  Lycoming-Clinton MH/ID and the Office of Aging are working on an update to their Letter of Agreement currently in place and work cooperatively to meet cross system's needs. The Community Relations Coordinator and Health Choices BH-MCO provided Outreach and education for Older Adult. Mobile Psychiatric Rehabilitation, Nurse Navigator, Wellness Nurse, Peer Support, Beacon Hub, Clubhouse, Clinton County Community Connections, Community Residential Rehabilitation Program, and Independent Living services have been utilized by Older Adults. STEP transportation does assist our Older Adults with transportation.
  Access to services could be improved for our older adults. There are a multitude of requirements to qualify for most services. Transportation can be a challenge as the public transportation in Lycoming County does not travel throughout the entire county. Clinton County does not have public transportation.

Northumberland - System of care treatment team meetings affords the opportunity to meet with Northumberland County aging staff to discuss best practice services to provide to individuals in recovery meeting criteria for aging services as well.

Schuylkill – MH/ID works with the Office of Long-Term Living and provides in home case management for those who choose to stay at home, although require nursing home level of care, as well as working with the local OSS. SAM is one of the providers for this.

- **Individuals who are medically fragile -** Services available to all ages.
  Programs, supports, and services have been and continue to be designed to eliminate people who are considered to be medically fragile from living in an institution or institution-like environment. They support people in their own home with waivers such as the AIDS waiver, Attendant care waiver, and independence waiver or in a home-like setting in their own communities so they can be close to their natural supports such as family, friends, and loved ones. They are more convenient and can be less expensive than the cost of living in an institution or skilled nursing home. All programs are designed to enhance the quality of a person's life, foster successful community living, and achieve optimum independence. They allow a person choice in where they reside and from whom they receive home health care services. They assist people in providing and coordinating all health care needs. They link and coordinate individual's behavioral and physical health care services.
  Access to services can be challenging due to mandated requirements and transportation needs.

  Centre - CCMH was able to create an enhanced personal care home with 14-15 CHIPP funding. Targeted Case Management staff has been trained in wellness coaching. Wellness nurses can be accessed through several local providers.

  CMSU employs a full time Wellness RN (Nurse) to address high users of BH/PH Services. All CMSU Staff have undergone training to be Health Care Navigators. These efforts are in conjunction with CCBH, The CMSU, and 23 County Managed Care Organization. Both Recovery Centers provide groups and education on exercise, nutrition, cooking, recreation and health as well as chronic condition management. Under review is the consideration to employ a consulting PCP. A goal of all CMSU Programs is to ensure that all individuals served by CMSU have a PCY on record and appointments on a regular basis.

  Lycoming-Clinton counties utilize Mobile Psychiatric Rehabilitation, Nurse Navigator, Peer Support, Independent Living services and STEP transportation to assist our medically fragile individuals. Access to services can be challenging due to mandated requirements and transportation needs.

  Schuylkill MH/ID works with the Office of Long-Term Living and provides in home case management for those who choose to stay at home, although require nursing home level of care, as well as working with the local OSS. SAM is one of the providers for this.

- **Individuals with limited English proficiency -** Services available to all ages.
  Rural counties outside the reach of Pennsylvania's larger metropolitan areas have a great need for bilingual services in order to reach out to an increasingly diverse population. Access to translation services, therapists, psychiatrists etc… needs to extend beyond the chance opportunity that the county may already have bi-lingual personnel on staff for assistance. Regional resources should be identified to provide services across county lines and county transportation services need to be on board to provide services across those same lines for non-English speaking individuals.

Centre - CCMH has an array of providers that are racially, ethnically and linguistically competent in their service delivery that people of all ages are able to access with their private or public insurance and/or county funds. Penn State University brings people to Centre County with a wide variety of backgrounds and minorities which CCMH recognizes and supports competently with delivered services.

CMSU has both a Therapist and a Case Manager who are native Spanish speaking who provide services to those Spanish speaking individuals with limited English proficiency. When other languages are encountered, Geisinger has several interpreters and when not available or not the language needed, Language Line is utilized for communication.

HMJ - While the county joinder in HMJ does not provide direct services, the agencies do use interpreter services as needed. These can consist of face-to-face interpreters or telephonic resources.

Lycoming / Clinton - Lycoming-Clinton does not employ any direct service staff who can act as an interpreter, but they do contract for interpreter services as needed via local colleges and social service agencies. These can consist of face-to-face interpreters or telephonic resources.

Northumberland - contracts with two interpreters along with having a Spanish speaking case manager on staff.

Schuylkill uses Interpri-Talk services. Interpri-Talk Services is the contracted provider for the BSU and Case management Programs .Service Access and Management employs a Spanish speaking TCM case manager for individuals needing a Spanish speaking case manager. Contracted behavioral health providers are requested to have linkages with services providers in the event special accommodations are requested.

- **Transition age youth including young adults -** Services aimed towards those between 18 years of age thru mid- twenties

Centre County: Individuals in this population face many challenges as they mature and adapt to adulthood and the independence that it brings. Much effort and many services and resources are built around individuals between the ages of 18 and 26 to help them develop skills to meet these challenges. Partnerships are built between the educational and community-based systems in order to collaborate and further enhance the support provided. These partnerships are certainly developed for individuals that experience trauma, mental illness, learning disabilities, dual-diagnosed or co-occurring difficulties as these disabilities add layers to the challenges that already exist. Transition events are held for individuals and their families as they transition through grades in school and graduate. Transitional and independent living and homeless shelter programs offer residential, activities of daily living and skill building supports. Child and Adolescent Services System Program (CASSP) involvement throughout this age range focus on the growth of services and support options that are mad available to this population. This is accomplished through state and local forums such as the Transition-Age Youth and Young Adult Workgroup, Community Support Programs and community-based programming. A strong connection between child and adult-based services, affordable housing, life skills mentoring and accessible transportation are essential pieces in making transitions for individual in this population successful.

CMSU has two current plans to address the specific needs of Transition Age Youth. The first is to assign specific case managers to work with age 16 to 24 (approx.) individuals. Additionally, we plan to engage First Psychosis Protocols when indicated with this population training one of the existing psychiatrists on the protocol. Second in transitioning part of both Recovery Centers to site based psych rehabs, a specific skill development tract is being developed for this population. The

contingency and bridge housing funds will be utilized in a housing first initiative with transiting age youth. Finally, the Systems of Care efforts will also be used to identify, support and engage the transitioning age individuals. All programs will be based upon the Oregon Model which was presented as a model at the Systems of Care Conference in Tampa.

Lycoming-Clinton works closely with Lycoming and Clinton County CYS Independent Living Programs to identify youth who will be transitioning to the adult mental health system. The Children's Review Teams in both Counties also work collaboratively to develop treatment plans for the youth. We have had youth utilize the Community Residential Rehabilitation Program, Independent Living Program, Clubhouse, and/or Clinton County Community Connections while in high school and beyond. The McKinny program and the PHARE grant in Clinton County have also been beneficial to assisting this population with housing. Many of these youth are also connected with the Office of Vocational Rehabilitation (OVR) which assist with further education and employment.
Housing and related support remains the highest need for this population. The Community Residential Rehabilitation Program is utilized however many of these youth decides the program to be too restrictive and tend to leave before they have achieved their desired goals. Youth transitioning out of Residential Treatment Facilities remain quite challenging to reintegrate into the community and require intensive support.

Northumberland - implements System of Care treatment team meetings with our local CYS department to problem solve and work together to provide best practice services to youth in our county in need of behavioral health/ID/ Drug and Alcohol services.

Schuylkill County- implemented a transition age youth project in August 2015. To date, we have served fourteen (14) transition age your ages 18 through 25. Our intent is to seek out and provide a stable home for transition age youth (TAY), ages 18 through 25, who are homeless or at risk of homelessness. Those in the targeted population must be identified as being in need of mental health services. Eleven committee members evaluate the needs of each TAY enrollee. Various case management services are provided to TAY enrollees along with multiple months of rental assistance, a security deposit, new furniture, household supplies, payment to secure critical identification documents, and other identified needs such as moving costs. In most cases, we have been able to assist the enrollees in securing Housing Choice (Section *) Housing Vouchers. Through our project, we have served individuals, couples and transition age youth who are parents.

Schuylkill County's Targeted Case Management provider, Service Access and Management, Inc. employs a dedicated BCM for children in Residential Treatment Facilities. The BCM works closely with family and individuals who are supporting the child while in placement via visits, meetings, linking family members to services. The BCM also has monthly contact with individuals who are receiving services in the RTF and collaborative communication with treatment staff. These interventions provided to family members and the child while in placement are key components for shortened placement stays and improved reunification back to the community. Service Access and Management is currently implementing a data collection system to track placement admissions and discharges. Schuylkill County is aware of the rate of use for RTF's (Residential Treatment Facilities) and is addressing it. Weekly CASSP(Child and Adolescent System Service Plan) meets with members from Children & Youth Services, Mental Health, case management, the various providers working with the transition age youth as well as school representatives. They address alternatives in the community to consider before a doctor makes a referral to an RTF.

Recently using Block Grant funds, we have also started two new programs. The first is the Seed Mentor Program which pairs transition age youth with a mentor who works with them for up to 6 months. The purpose is to help the TAY interact with their environment with assistance and guidance from an individual who can help them in different ways. The second program is the Family Support Unit which works with families who are having a child return from an RTF and help with the transition for all parties.