Cumberland/Perry Counties

OLMSTEAD PLAN

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INTRODUCTION

Cumberland and Perry (C/P) Counties' Mental Health program embraces our mission to "*Support all people with mental illness to live and participate fully as valued, integrated members of our communities with the choices, responsibilities, dignity, respect, and opportunities afforded all citizens."* As such, we strive to provide services and supports within our communities that uphold these values.

At the time of the Harrisburg State Hospital closure announcement, C/P was utilizing 35 of our allocated 47 beds. In 2005, with CHIPP (Community Hospital Integration Project Program) closure funding, we significantly expanded available community supports so that 27 individuals from Cumberland or Perry Counties were able to be discharged from the state hospital to community settings. C/P's overall state hospital census decreased to 15 individuals total during the closure transition – 7 of which were admissions to Danville State Hospital in lieu of Harrisburg State Hospital and 8 who were then transferred from Harrisburg to Danville State Hospital for further inpatient treatment.

The development of significant infrastructure was imperative in supporting not only those individuals discharged from the state hospital, but also individuals within the community so as to not need more intensive levels of care. Supports that were implemented or expanded at that time included Certified Peer Specialists, Psychiatric Rehabilitation, Social Rehabilitation, WarmLine, Supported Employment, Fairweather Lodges, Extended Acute Care (EAC) Unit, Specialized Community Residences, Supported Housing Apartments, and Supported Living services. Initially, the expansion of available services was able to support numerous individuals to remain in the community and/or be diverted from a state hospital referral.

However, over the last several years, our population growth has been rising consistently. Cumberland County is the fastest growing county in the Commonwealth with a projected increase of over 6% by 2020. Additionally, it is projected that Cumberland County may have increases in population by almost 19% by year 2040. (Beheney, M., Copella, S., Shultz, J., Bowalick, D., Koontz, A., Meyers, L., & Kotovsky, M (2014), p.16). Since 2011, budget cuts and constraints have negatively impacted service availability and delivery such that referrals and admissions to the state hospital have significantly increased. Diversions have been limited due to the availability of the needed services within the community. Our current state hospital census has doubled in the last 5 years to 19. The needs of those individuals currently at the state hospital are severe and unable to be met by our current array of services.

In addition, at the time of the closure in 2005, only 29% of Cumberland/Perry (C/P) residents in the state hospital were eligible for Medical Assistance (MA). This meant that county base funds were utilized to provide services that would have been otherwise MA-reimbursable had those consumers been MA eligible. Currently the majority of C/P residents at Danville State Hospital have MA eligibility, however in most cases, the type of MA only covers the Medicare premium and not direct services through Medical Assistance. This ratio is a critical factor in developing and funding community supports and services as significant base funds will be needed to meet the needs of those consumers given the lack of MA eligibility or MA Health Care Benefit (HCB) Package codes that cover services provided within the community.

With regard to the planning process, it is clear that there are significant needs; however, adequate resource must be available to address these needs. Certainly resource includes funding and with the past 10% cut and previous budget impasse and current budget constraints, community providers are reluctant to consider expansion and/or new development. Resource also includes staffing. Human service work is demanding and challenging with high expectations and can be emotionally taxing for typically low compensation and minimal benefits. Providers are finding it increasingly more difficult to hire and retain competent and committed staff. Increasing access to behavioral health services is a critical need, especially in rural areas as well.

Access to services is an issue regardless of payor source. Medicare and private insurers must look at their networks to improve access as well. Many contracted providers only work with private insurers. If the public system is the only

one that is working to support prompt access, it will fail. Private insurers do little to expand or look at alternatives to meet the needs. The public system cannot support the entirety of the needs of the community.

In addition to behavioral health supports, access to physical health care is crucial. Physical health issues directly impact behavioral health needs and overall wellness as well as providers' ability to support individuals within the community. Availability of primary care providers as well as physical health specialists is a critical component for successful transition. Locally we work closely with Partners for Better Health to attempt to address these needs in Cumberland and Perry counties. Partners for Better Health conducts community needs assessments and engages local community members and providers to develop strategies to attempt to address these physical health needs.

I. OLMSTEAD PLANNING PROCESS:

Describe how stakeholders were involved in the development of the Plan. Counties should engage consumers, family members, advocacy groups, providers, behavioral health managed care representatives, and cross-systems partners in the planning process. Stakeholders should be included in the development of the local/regional implementation plan, monitoring of community services and supports, and in providing ongoing input into the county's system for recovery-focused services. Counties should document and demonstrate in their plan how they outreached to and meaningfully engaged their stakeholders.

An Olmstead Planning meeting was held on 9/23/16 with provider, consumer, and family representatives. We reviewed the plan guidelines and expectations as well as discussed the current array of mental health services and needs. While we have participated regularly in the Service Area Planning process, covering such a large geographic region with Danville State Hospital being 85 miles away makes it difficult to consider joint projects given individuals' desires to be in their home communities. Smaller joint projects with those counties closest geographically were accomplished during the Harrisburg State Hospital closure and additional local projects are currently being considered during this planning process.

Locally, as the lead in our overall mental health planning process, the Cumberland-Perry Community Support Program holds monthly meetings during which strong consumer and stakeholder involvement occurs in reviewing needs and opportunities within the counties to support individuals with mental illness. Mental Health system planning is a standing agenda item which provides for invaluable discussions regarding individual and community needs and the education regarding available services and supports as well as larger system and budgetary issues and concerns. This consumer-driven planning process includes consumers (adults, older adults, and transition age youth) with serious mental illness and/or co-occurring substance abuse disorders, certified peer specialists, consumer staff, family members, service provider staff, Managed Care staff, and county MH staff. More information is available in the Mental Health component of the Cumberland and Perry Counties' Human Services Plans.

The individualized Community Support Planning (CSP) process is used to discuss the needs of individuals receiving treatment in the state hospital. The CSP process is also utilized in the community with EAC discharges, to provide follow-up from inpatient discharges, to discuss diversion alternatives, and any time more comprehensive team planning is needed. Data from those discussions is used to formulate plans for the broader development of needed services and supports within the community. Currently the needs that have arisen from the individual CSP planning processes for C/P residents indicate the need for intensive levels of support in the community due to the severity of symptoms and needs. Current recommendations for the Specialized Community Residence (SCR) and the Long Term Structured Residence (LTSR) due to more than half of the individuals from C/P currently in the State Hospital needing these levels of support in order to be successful in the community setting.

In addition, Cumberland-Perry Child & Adolescent Service System Program (CASSP) brings together the expertise of county human services, families, providers, the education system, and other involved parties to develop plans focused on resiliency and recovery for children and adolescents and their families. Those individualized plans identify both strengths and needs of each family in order to assist in meeting needs creatively, offering excellent support through the use of community resources, treatment services and rehabilitation supports while embracing CASSP principles. Again, data from these planning meetings is utilized in broader service planning and development.

The CASSP core teams for both counties also meet to discuss larger system needs and explore creative solutions to meeting those needs. The Perry County Integrated Children's Services Plan (ICSP) team meets monthly to discuss current trends and issues (i.e. needs of transition age youth, drug and alcohol addiction within family systems) to develop specific initiatives.

Other stakeholders are regularly involved in the planning process as a function of ongoing collaboration. Data from these meetings is regularly discussed and utilized in planning and decision-making. Service needs and system

enhancements with regard to mental health planning are discussed at the following regular meetings, many of which involve consumers and various community service agencies:

- Cumberland County Community Needs meetings (Carlisle and West Shore)
- Shippensburg Human Service Council meetings
- Perry County Family Partnership Board meetings
- Cumberland-Perry Housing Initiative (CPHI) meetings
- Cumberland-Perry Local Housing Options Team (LHOT) meetings, which includes the Cumberland County Housing & Redevelopment Authority
- Cumberland & Perry Counties' CASSP Core Teams
- Perry County Integrated Children's Service Plan meetings
- Cumberland-Perry Community Support Program (CSP) meetings
- NAMI PA-Cumberland-Perry Counties' meetings
- Cumberland & Perry MH Provider and Base Service Unit (BSU) meetings
- Behavioral Health Managed Care committee meetings including Quality Improvement/Utilization Management (QI/UM), Clinical, and Consumer & Family Focus Committee (CFFC) with Capital Area Behavioral Health Collaborative (CABHC) & PerformCare
- Human Service Policy Team – internal county meetings
- Criminal Justice Policy Team & Mental Illness Sub-Committee – internal county meetings
- Behavioral Health Sub-Committee of the South Central Counter Terrorism Taskforce (SCTF)

This plan identifies the current needs and some potential solutions to address those needs if additional funding was made available.

II. SERVICES TO BE DEVELOPED:

Using information gathered from various sources, such as done in the CSP process, identify the services, supports, and infrastructure needed to support individuals transitioning back into the community and individuals in the diversion population who may at times need intervention. Please address each of the following services, including the number of individuals expected to be served, projected timeline for service development, and resources needed:

Several charts with all existing Mental Health services, Evidence Based Practice services, Recovery Oriented and Promising Practices services currently available in Cumberland and Perry Counties are attached at the end of this plan.

a) Prevention and early intervention services and supports (examples: crisis intervention and mobile treatment services): Prevention and Early Intervention services are accomplished through community presentations and speakers, Mental Health First Aid Trainings, QPR (Question, Persuade, Refer) Suicide Prevention Awareness, Family-to-Family and Peer-to-Peer classes through the National Alliance on Mental Illness (NAMI), CASSP Elementary School Based services, Transition Age Youth Coordinator, TeenLine, Student Assistance Program (SAP) and WarmLine. Most of these services utilize county funds as available. It is necessary to look at how to improve support to family members as well, since family member involvement and support is often imperative for all to be successful in the transition. Expansion in all of these areas is needed due to significant increase in population as well as an increased need for awareness and education.

We also have a strong focus on working with natural community supports and other services available in our communities. Partnerships with Project Share food bank, Nurse Family Partnership, Homeless Assistance Program, Helping Hands, Tri-County Community Action, local schools, the Housing & Redevelopment Authority to name a few have been invaluable to supporting consumers to integrate and maintain in community settings.

Access to outpatient behavioral health services in all areas is critical. Tele-psychiatry has been implemented by one agency and has been useful and effective in providing evaluation and medication management services. The Behavioral Health Workgroup of the Perry County Health Coalition has begun to explore options to expand Telepsychiatry for rural areas. Additional strategies are needed for initial psychiatric evaluations as well as expansion of the medication management services. Rapid Access models are being explored at this time by at least one provider. A plan for recruitment and retention of psychiatrists is being explored utilizing Reinvestment funds. Also work is beginning with existing Physical Health/Behavioral Health providers to strengthen services as a Reinvestment project.

In addition, a Suicide Prevention Task Force has been initiated within our counties with our Preventing Unnecessary Loss through Suicide Education (PULSE) Initiative that was developed jointly with county and Managed Care funds through AmeriHealth Caritas and PerformCare. Several community partners are involved as well including Please Live, Holy Spirit Crisis Intervention Services, the American Foundation for Suicide Prevention (AFSP), the Cumberland County Coroner's office, a local pastor, and several local consumers and family members. A Forum was held and posters and billboards were developed and implemented. Additional meetings are being scheduled.

1) Number of Individuals Expected to be Served: Many of the previously mentioned efforts will impact the entire community, such as the Suicide Prevention Initiative, Teenline & Student Assistance, WarmLine, and CASSP. Specific to other areas, in one year, these initiatives would expect to impact:

Additional Service/Expansion	Number Impacted	Age Served
Psychiatric Outreach	200	All ages
MH First Aid training	30-60	All ages
QPR training	20-40	All ages

NAMI - Family-to-Family; Peer-to-Peer	25-50	All ages
Transition Age Youth Coordinator	20	Age 16 - 24

2) **Projected Timeline for Services Development:** Continuation of existing services is planned ongoing; however expansion or new development is heavily dependent on resource availability. Timeline would be 12-18 months should adequate resource become available.

3) **Resources Needed:** Existing funds as currently allocated will be utilized as they are available. Additional funding needed is estimated at:

Additional Service/Expansion	Estimated Costs
Psychiatric Outreach	$140,500
MH First Aid training	$1,000
QPR training	$500
NAMI - Family-to-Family; Peer-to-Peer	$5,000
Transition Age Youth Coordinator	$90,000

b) Non-institutional housing options, with a focus on independent and shared living arrangements. Identify existing "Housing First" approaches and discuss plans to develop future approaches: Housing First has recently been implemented through the Cumberland County Housing and Redevelopment Authority (CCHRA). Two locations currently utilize this approach. While the Housing Authority embraces this philosophy, it has been difficult to engage landlords. The current properties utilizing Housing First are CCHRA-managed.

Our county mental health office continues to work closely with the Housing Authority who offers voucher preference to individuals coming out of a state hospital and/or Community Residential Rehabilitation (CRR) program. County funding is provided through the county Mental Health office to the Housing Authority for a Mental Health Housing Specialist as well as Shelter-Plus Care Coordinator positions. And we have utilized Reinvestment funds through our Behavioral Health – Managed Care Organization (BH-MCO) oversight (Capital Area Behavioral Health Collaborative CABHC) to leverage additional funding in the development of several integrated community housing initiatives in conjunction with CCHRA. In addition we have 3 Fairweather Lodges in our counties, one of which was a result of a CRR conversion.

Through the CHIPP process in 2005, we had also developed two Supported Housing Apartments and three Specialized Community Residences to meet the residential needs of 40 individuals. These programs are typically full to capacity. All of these programs were developed to support individuals with long-term state hospital experiences when increased, and sometimes immediate, community supports are needed. Both programs offer 24/7 staff. The Supported Housing Apartments each have a 10 person capacity and two respite beds. These apartments allow more independent living within the community, while having direct and immediate staff support available. Specialized Community Residences (SCR, licensed as Personal Care Homes) were developed to meet the physical health and mental health needs of individuals with a long-term state hospital experience. These 4 – 8 person homes are each staffed with a Licensed Practical Nurse (LPN) and staff who have all received additional training specific to mental health needs.

Currently nineteen Cumberland/Perry citizens are receiving treatment in the state hospital. At least three or four of these individuals would benefit from the higher level of support an SCR offers as independent living is not recommended by their Community Support Plan (CSP) due to their physical health needs as well as inability to care for their personal needs independently. Little transitional movement occurs within the SCR's due to the needs of the current SCR residents, which then slows down new referrals/admissions. There is an obvious need to expand one of the current SCR's to accommodate additional residents. Currently 4 individuals live in this residence that can accommodate 8; however environmental issues with the soil are impeding the ability to

expand the septic system which is required to expand occupancy. Lack of funds to address that concern has compromised our current ability to do so.

Additionally, more intensive residential needs are addressed at the end of the Housing Inventory on page 12.

1) **Number of Individuals Expected to be Served:**
    a. Expansion of an existing Specialized Community Residence (SCR) to accommodate at least 4 additional residents age 18 and above.

2) **Projected Timeline for Services Development:** Continuation of existing services is planned ongoing; however expansion or new development is heavily dependent on resource availability. Timeline would be 12-18 months should adequate resource become available.
    a. 12 months due to working with other governmental entities for permits, approvals, etc.

3) **Resources Needed:**
    a. $60,000 for special septic system and fees – one-time cost; $45,000 – annual additional staffing with expansion

c) **Non-residential treatment services and community supports including mobile treatment options (examples: outpatient and mobile outpatient services, the 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):** A vast array of non-residential services have been established and are operational in our counties. A chart that lists these services and funding sources is attached. A comprehensive explanation of these services is found in the Mental Health portion of the County Human Services plan. This infrastructure is imperative in supporting individuals within the community and assisting to divert individuals from more intensive levels of service. Expansion of many of these services is needed due to programs being at capacity and unable to accept new referrals. Access to needed services is critical. Funding new and/or additional staff positions is imperative to address these systemic hardships. The following are needed:

- Crisis Intervention – an additional mobile crisis intervention worker – the ability to provide additional mobile services at this crisis intervention level is key to aiding in accessing needed higher levels of care in a timely manner. The addition of a crisis intervention worker would aid greatly to improve prompt access to assessment and potential diversion as well decrease wait times in the emergency setting.
- Assertive Community Treatment Team (ACT) – an additional case manager, additional psychiatric hours (6), and an additional therapist are needed. As our population continues to grow, the needs of those individuals returning to the community from an institutional or longer term setting are growing as well therefore preparation to expand ACT is needed. The plan would be to become licensed as a modified program within the next 5 years. Due to the rural nature of the counties, this program spends an inordinate amount of time on the road to rural areas, sometimes to find no one home. This extensive amount of time spent greatly impacts the team's ability to effectively support all of the individuals in need of this intensive service. The plan would also include expansion to more effectively serve the forensic population.
- Medication Management – quicker access to psychiatrists for initial eval and subsequent follow-up for medication management is needed. Tele-psychiatry has been implemented by one agency and has been useful and effective in providing medication management services in that area. Additional strategies are needed for initial psychiatric evaluations as well as expansion of the medication

management services. Rapid Access models are being explored at this time by at least one provider. See previous section (**II. a**) for more information regarding plan for Psychiatric Outreach.

- Intensive Case Management – increase by 2 the number of intensive case management positions to better support the increasing need for this service. Individuals returning from a state hospital setting often require increased support, especially during the initial transition, as well as ongoing depending on their needs within the community setting. In addition, in order to utilize diversion strategies away from longer term institutionalization, immediate access to intensive case management is necessary.
- Administrative Case Management – increase the number of administrative case management positions by 2 in order to better provide intake, assessment, and case management through the Base Service Unit (BSU). As populations within these two counties have significantly increased, so has the demand for mental health services through the community mental health system. These additional positions would allow improved access and ability to better direct individuals in need of services.
- Supported Living – this service has been effective in supporting individuals within the community. Expansion of staff would allow increased flexibility around the needs of individuals to provide a more comprehensive service. Expansion would include weekend and evening availability. Plan would be to utilize existing providers and offer an increased rate for expanded service.

1) Number of Individuals Expected to be Served:

Additional Service/Expansion	Number Impacted	Age Served
Crisis Intervention	120	All ages
ACT	20	Adults 18 + above
ICM	40	All ages
ACM	200	All ages
Supported Living	25	Adults 18 + above

2) Projected Timeline for Services Development: Continuation of existing services is planned ongoing; however expansion or new development is heavily dependent on resource availability. Timeline would be 4 - 6 months for expansion of each of these services should adequate resource become available.

3) Resources Needed: Existing funds as currently allocated will be utilized as they are available. Additional funding needed is estimated at:

Additional Service/Expansion	Estimated Costs
Crisis Intervention	$65,000
ACT	$172,000
ICM	$82,000
ACM	$82,000
Supported Living	$100,000

d) Peer support and peer-run services (examples: certified peer specialists, wellness and recovery programs, drop-in centers, warm-lines, etc.): Peer Support and WarmLine are both operational programs within our counties that are peer-driven as are the Social Rehabilitation programs. The Community Support Program is also peer-driven with paid consumer employees. Two additional Certified Peer Specialists (CPS) would greatly improve immediate access to this needed service.

1) Number of Individuals Expected to be Served: approximately 20, Adults 18 + above

2) **Projected Timeline for Services Development:** Continuation of existing services is planned ongoing; however expansion or new development is heavily dependent on resource availability. Timeline would be 4 - 6 months for expansion of each of these services should adequate resource become available.

3) **Resources Needed:** Existing funds as currently allocated will be utilized as they are available. Additional funding needed is estimated at approximately $60,000 for 2 CPS positions.

e) **Supported Employment Services:** Implemented in 2008, our Supported Employment program follows the fidelity standards established by the Substance Abuse Mental Health Services Administration (SAMHSA). 51% of the individuals enrolled in the program have become competitively employed. The 2 Employment Specialists carry full caseloads per the fidelity standards and there is currently a several week wait for this service. An additional Employment Specialist would allow increased access and service delivery. An increase in the number of employment specialist positions practicing the evidence based practice of supported employment is needed in order to better support the growing need for this service. Employment is a significant focus in providing community supports so more immediate access is needed for this service. In addition, we would be interested in adding a Supported Education specialist to our program to support those individuals with education needs in the pursuit of eventual employment.

1) **Number of Individuals Expected to be Served:** Fidelity standards establish a caseload of 15 – 20, Adults 18 + above.

2) **Projected Timeline for Services Development:** Continuation of existing services is planned ongoing; however expansion or new development is heavily dependent on resource availability. Timeline would be 4 - 6 months for expansion of this service should adequate resource become available.

3) **Resources Needed:** Existing funds as currently allocated will be utilized as they are available. Additional funding needed is estimated at approximately $50,000 for an Employment Specialist position; $50,000 for a Supported Education position.

III. HOUSING IN INTEGRATED SETTINGS:

a) Housing Inventory of existing housing options available to individuals (please note that available services may be located in other counties) (acronym list at bottom of chart)

This list contains housing options as well as various Mental Health residential programs:

Housing Name	Type of Housing	Owner/ Manager of Property	Service Provider Name	Target Group	Capacity: Units; Slots; People	Services Funding	Housing Funding	Additional Information
Deerview Specialized Community Residence (SCR)	Licensed Personal Care Home	New Visions	New Visions	MH (Priority 1)	8	CHIPP or Base Funding; USDA; HOME	SSI personal care supple-ment & % of income	
Orange Street	CRR	New Visions	New Visions	MH (Priority 1)	10	Base funding	% of income (client liability)	PHFA
Hollar Avenue	Supported Apartment	New Visions	New Visions	MH (Priority 1)	10 + 2 Respite Beds	Base funding, CHIPP	Section 8	
Hanover Street	Supported Apartment	New Visions	New Visions	MH (Priority 1)	10 + 2 Respite Beds	Base funding, CHIPP	Section 8	
Fairweather Lodge, Newport (Perry County)	Fair-weather Lodge	New Visions	New Visions	MH (Priority 1)	5	Base funding, CHIPP	Built-in Subsidy	
Fairweather Lodge, CRR Conversion, Penn St, Shippensburg	Fair-weather Lodge	New Visions	New Visions	MH (Priority 1)	5	Base funding, CHIPP	Built-in Subsidy	CRR > Lodge
Fairweather Lodge, South East Street Carlisle	Fair-weather Lodge - PSH/SRO	New Visions	New Visions	MH (Priority 1)	4	McKinney; Base Funding	McKinney	HealthChoices Reinvestment funds utilized
Pomfret Street	CRR	NHS- The Stevens Center	NHS-The Stevens Center	MH (Priority 1)	6 + 1 Respite Bed	Base funding	% of income (client liability)	
Louther Place	CRR	NHS- The Stevens Center	NHS-The Stevens Center	MH (Priority 1)	10	Base funding, CHIPP	Section 8	

Supported Living Support Services	PSH	Independent landlords in the community	New Visions	MH (Priority 1)	16	Base funding, CHIPP	S+C, Section 8	
Supported Living Support Services	PSH	Independent landlords in the community	NHS-The Stevens Center	MH (Priority 1)	80	Base funding, CHIPP	S+C, Section 8	
Gardners SCR	Licensed Personal Care Home	Keystone	Keystone	MH (Priority 1)	8	Base funding, CHIPP	SSI, personal care supplement	
Silver Spring SCR	Licensed Personal Care Home	Keystone	Keystone	MH (Priority 1)	8	Base funding, CHIPP	SSI, personal care supplement	
Progress Avenue Long Term Structured Residence (LTSR)	LTSR	Keystone	Keystone	MH (Priority 1)	3	Base funding, CHIPP	% of income (client liability)	
Section 8 – Preference for MH Populations - D/C from State Hospital or CRR	PSH - TRA	CCHRA	Various community service providers	MH (Priority 1)	Approx 58 Vouchers and 8 Certificates	MA/Health Choices or Base funding	Section 8	
Public Housing – General	PSH	CCHRA	Various community service providers	People with Disabilities	33	MA/Health Choices or Base funding	Section 8 PBA	
Supportive Living Program – Lemoyne	PSH	CPHI	Various community service providers	MH/IDD	2	MA/Health Choices or Base funding	Built-in Subsidy	
Supportive Living Program – New Bloomfield	PSH	CPHI	Various community service providers	MH/IDD	3	MA/Health Choices or Base funding	Built-in Subsidy	
Brethren House Apartments	PSH	CPHI	Various community service providers	MH/IDD	5	MA/Health Choices or Base funding	Built-in Subsidy	
Enola Chapel	PSH	CPHI	Various community service providers	MH (Priority 1)	6	MA/Health Choices or Base funding	Section 8 PBA	PHFA, LHTC approval

Carlisle SHP	PSH	CPHI	CCHRA/ Various community service providers	MISA - HM	4	McKinney and/or MA/Health Choices	HUD McKinney	PHFA, LHTC approval
Veterans' SRO	PSH/SRO	New Visions	New Visions	MISA - HM	6	McKinney and/or MA/Health Choices	HUD McKinney	
Shepherd's Crossing	Voucher Set-aside	Shepherd's Crossing, L.P., CCHRA	CCHRA/ Various community service providers	MH	3 Vouchers	MA/Health Choices or Base funding	TBRA	
Cumberland/ Perry Shelter Plus Care	PSH – TRA	CCHRA	CCHRA/ Various community service providers	MISA/IDD/ HM	30	McKinney	HUD McKinney	
Perry Transitional		CPHI	CCHRA/ Various community service providers	MISA/IDD/ HM	10	McKinney	HUD McKinney	

CCHRA – Cumberland County Housing and Redevelopment Authority
CHIPP – Community Hospital Integration Project Program
CPHI – Cumberland Perry Housing Initiative
CRR – Community Residential Rehabilitation
D/C - Discharge
HM – Homeless
HOME – HOME Investment Partnerships Program
HUD – Housing and Urban Development
IDD – Intellectual and Developmental Disabilities
LHTC – Low Income Tax Credits
LTSR – Long Term Structured Residence
MA – Medical Assistance
MH – Mental Health
MISA – Mental Illness Substance Abuse
NHS – Northwestern Human Services
PHFA – Pennsylvania Housing Finance Administration
PSH – Permanent Supportive Housing
S+C – Shelter Plus Care
SCR – Specialized Community Residence
SHP – Supportive Housing Program
SRO – Single Room Occupancy
SSI – Supplemental Security Income
TBRA – Tenant Based Rental Assistance
TRA - Transitional
USDA – United States Department of Agriculture

****Residential Needs**:** Through the CHIPP process in 2005, a joint Long Term Structured Residence (LTSR) was developed. Currently we "share" space with 2 other counties for 3 slots at this LTSR. This level of care was implemented as a measure to reduce state hospital admissions. It provided diversion as well as a discharge resource from the state hospital. Over the last several years, with the decreasing community resource, we have had a significant increase in our state hospital population. Those LTSR slots have been full with little transfer movement. Through the assessment phase of the state hospital CSP process, at least 10 – 13 C/P individuals' needs have been identified as severe with significant concern for safety, self-harm, or harm to others, therefore the LTSR program has been identified as the recommended level of residential support for placement. In addition, individuals within the forensic population would benefit from this level of service. As we are at capacity for the existing program with little transfer movement, the development of an LTSR is imperative at this time to meet those needs.

1) **Number of Individuals Expected to be Served:**
    a. A 16-bed LTSR is needed. Approximately 10-13 individuals currently receiving treatment at the state hospital, several of whom have forensic involvement, have been identified as meeting LTSR criteria. In addition the 3 individuals at the current LTSR would be transferred to this program. Adults 18 + above

2) **Projected Timeline for Services Development:** Continuation of existing services is planned ongoing; however expansion or new development is heavily dependent on resource availability. Timeline would be 12-18 months should adequate resource become available.
    a. 12 – 18 months

3) **Resources Needed:**
    a. $1.8 million – start up and annual estimated costs

b) **Progress made towards integration of housing services as described in Title II of the ADA:** Cumberland County continues to make strides in achieving integration of housing services as described in Title II of the ADA. All new properties placed in service by CCHRA include fully accessible units in compliance with the Americans with Disabilities Act (ADA) and are integrated into the community. In addition, CCHRA utilizes Capital Funds from the United States (US) Department of Housing and Urban Development to convert existing public housing units to ADA accessible units as funding is available. There are units scheduled for conversion at Two West Penn in the current year. BH-MCO Reinvestment funds have been utilized in the development of Shepherd's Crossing which has provided "set aside" vouchers for 3 apartments for individuals with mental health or substance abuse disabilities that are "integrated" and accessible housing within the work force setting apartments. Community resources are readily accessible in these settings. The various Permanent Supportive Housing (PSH) programs throughout the communities are integrated and accessible as well.

c) **Describe the plans for Community Residential Rehabilitation (CRR) conversion:** We do not plan to convert any CRR programs at this time. Previously in 2006 during the Closure, a CRR was converted to a Fairweather Lodge program and continues today. Two additional Fairweather Lodges were subsequently implemented. We currently have 3 CRR programs with 26 beds. At this time due to the lengthy wait lists for Housing Vouchers, the demand for CRR beds is high in our counties. In addition we are working with one CRR provider by funding specific training and providing enhanced staffing to address the growing needs of the transition age young adult population within the current CRR structure.

d) **Describe strategies used to maximize resources to meet the housing needs of individuals including:**

1) **Identifying the Local Lead Agency (LLA) and any agreement with the LLA for referrals and supportive services arrangements:** Our Local Housing Options Team (LHOT) serves as our Local Lead Agency and has been helpful in connecting landlords and tenants as openings arise. The LHOT coordinator, employed by the Cumberland County Housing and Redevelopment Authority (CCHRA), serves as the point person for the LLA, under the supervision of the CCHRA Executive Director. The LHOT coordinator maintains relationship with local landlords and disseminates information on available rental units to an email distribution list of supportive service providers. The landlords all accept and are approved for various voucher programs including Section 8 and Tenant-based Rental Assistance Programs. The LHOT committee and sub-committees hold regular meetings of service providers and conduct training programs to promote the services of LHOT providers and improve understanding of sound landlord-tenant relations.

2) **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: As stated previously, the county Mental Health office contract to provide partial funding for 4 Special Needs Housing Support positions including the Mental Health Housing Specialist at Cumberland County Housing and Redevelopment Authority (CCHRA). Also CCHRA has worked in cooperation with the county MH office and our Behavioral Health Managed Care Organization (Capital Area Behavioral Health Collaborative - CABHC) to utilize Reinvestment funds to leverage significant additional funding in the development of integrated housing projects, such as Shepherd's Crossing in Mechanicsburg. In addition, CCHRA offers preference for a housing voucher to those individuals leaving the State Hospital or CRR settings to obtain housing in the community. The county Mental Health office provides services in kind that serve as matching funds toward the county's Continuum of Care Application to the US Department of Housing and Urban Development to assist homeless individuals who often experience mental health and other co-occurring disorders.

IV. SPECIAL POPULATIONS:

Discuss how the following groups of individuals with serious mental illness and their specialized service needs are met: ALL individuals of any age or population category with severe mental illness have access to the same mental health services and supports in our communities.

a) **Individuals with a dual diagnosis (mental health/intellectual disability)** – A Dual Diagnosis (MH/ID) Mobile Behavioral Support team is currently being implemented via Reinvestment funds. This team will work with existing service providers to develop strategies to address behavioral concerns on an individual basis. In addition, training is being planned through the HealthCare Quality Unit (HCQU) to address concerns with this population on the following topics:
   1) Target Symptoms of Mental Health Challenges vs Challenging Behavior;
   2) Intellectual Disabilities and Psychiatric Disorders;
   3) Communicating with Psychiatrist/Psychotropic Medications;
   4) Crisis Supports and Debriefing; and
   5) The Roles of Everyday Lives and Recovery

   In addition, changes are currently underway through the Office of Developmental Programs (ODP) for serving the Autism population even if the IQ criteria are not met. We await those changes and recommendations for planning for that population as well.

b) **Individuals with co-occurring disorders (mental health/substance use disorders)** - Individuals with co-occurring disorders have been identified as an underserved population through managed care data. Two of the county-contracted outpatient providers – NHS Stevens Center and Diakon Family Life Services – are dually licensed to provide mental health and substance abuse outpatient treatment. Through PerformCare's Enhanced Care Management program, county representatives from MH and D&A meet monthly with PerformCare care managers to review and discuss needs of those individuals. Efforts to have trained co-occurring capable and competent providers continue but are difficult without combined regulations from the state. In addition, several years ago OMHSAS was supportive of this initiative; however co-occurring capable and co-occurring competent trainings have not been made readily available making it an unrealistic expectation even with dual licensing.

c) **Individuals with both behavioral health and physical health needs** - 3 Specialized Community Residences (SCR's) offer support to those individuals with significant physical and behavioral health needs that qualify for personal care level of support. As previously stated, physical health needs can seriously impact behavioral health needs and are critical to have addressed. Timely access to Personal Care Physicians (PCP) and Healthcare Specialists are crucial to be effective with this population, however that access is dependent on one's health insurance. Some are not able to afford needed physical health care due to high deductibles and co-pays.

d) **Individuals with a traumatic brain injury (TBI)** - All individuals with severe mental illness have access to the same mental health services and supports in our communities. Individuals with TBI are often referred to the Brain Injury Association for access to additional supports as the community mental health system is not equipped to address these needs. The Brain Injury Association of Pennsylvania maintains a database of resources that may be of help to the person with brain injury and/or their family. The Brain Injury Resource Line (BIRL) is a toll free number, maintained by the Brain Injury Association of Pennsylvania. It is designed to give resource information to all who call. Since its inception. in 2002, volunteers have handled over 2,000 phone calls.

A call to this number will connect you to a recording which invites you to leave your telephone number (including area code). These calls are then assigned to a volunteer who will return the call to provide resource information. The goal of the BIRL volunteers is to return all calls within three work days.

Professional brain injury staff and trained volunteers respond to callers, utilizing the on-line database of resources and information, specific to the caller's area of the state. The BIRL volunteers offer support, compassion, and expert information tailored to the caller's needs. Follow-up calls are provided where indicated, and all calls are logged on a database for ensuring follow-up and for further developing assessments of need. An electronic and printed literature library is maintained for distribution of TBI materials to callers, including a website, resource directory, and TBI links so that all people who are affected by TBI are able to efficiently and effectively get the information they need to deal with the injury. The Brain Injury Association of Pennsylvania will look to start new support groups in areas where there is a demonstrated need. Families with similar needs will be networked through a peer-mentoring system.

e) **Individuals with criminal justice/juvenile justice history** - For persons with a mental illness being diverted or released from jail, forensic case management services are available to assist with linkage to needed services and community supports. The Sequential Intercepts for Developing Criminal Justice/Mental Health Partnerships model is minimally in place in Cumberland and Perry Counties to support justice involved individuals.

C/P Mental Health Office representatives participate in Criminal Justice Advisory Board (CJAB) meetings. The Mental Illness (MI) Sub-committee is an offshoot of the CJAB and meets quarterly specific to mental health concerns. This sub-committee has identified housing options for the forensic population as a priority need area, however criminal history and credit history/income have presented challenges in working with landlords. The CJAB with the Steering Committee and the MI Subcommittee are currently in a data review process of Cumberland County inmates with Serious Mental Illness (SMI). Initial data has been reviewed and a subset of individuals selected for an in-depth review to look at missed opportunities, barriers, and successes in the current system. This will allow for more specific programming to be developed and implemented.

Our forensic case management (FCM) program assists with diversionary efforts as well as ongoing collaboration with county prison mental health liaison to address reintegration needs after incarceration. The needs of this population however are great and more options for community services and housing are needed. Half of the mental health liaison position at each prison is funded through county base dollars to aid in connecting individuals with serious mental illness to the mental health services that are needed.

In addition, the C/P MH Program funds half of the sex offender therapist position as well as half of the salary and benefits for the MH liaison at both prisons. In addition, County MH staff and Mobile Crisis Intervention Staff have provided education to incarcerated individuals at the Camp Hill State Correctional Institution (SCI) with regard to community mental health services as part of their Transitional Housing Unit program. In conjunction with the PA Board of Probation & Parole and Department of Corrections, this program provides reentry services to offender participants. This partnership in providing information to inmates readying for release will continue as staffing is available.

The forensic population has access to a forensic certified peer specialist as well as community peer support and all other community services and supports as needed/requested. Existing residential programs also support this population as available. Community housing is an area of critical need however as most residential programs are designed to be transitional. These CRR programs are short-term (6-9 months). Most of the housing programs have extensive waiting lists for vouchers and openings, therefore additional options are needed for this population.

Although we have been involved in all intercept points within the system, forensic mental health services have focused on the last 2 intercept points (re-entry to jails and community corrections & supports). Statistics continue to show that forensic mental health services have not only been more involved, but more effective at the 2 earlier intercept points (post arrest and post initial hearing). Through education and relationship building with public defenders and district attorneys, both have accessed forensic mental health services earlier in the process, which has significantly reduced the number of jail days for those individuals involved. Positive outcomes are evident such as over 3000 prison days being saved per year (using maximum sentencing guidelines) in the cases where forensic mental health services are involved. A concerted effort has been put in place to increase familiarity with all of the district justices, public defenders, and district attorneys to increase earlier forensic mental health involvement when appropriate.

Work continues with the State Correctional Institutions (SCI) to improve the coordination of services for individuals being released. Since the Department of Corrections expanded their classifications of behavioral health disorders to include non-Serious Mental Illness (SMI) diagnoses, the lists have become much longer while the funds to community mental health continue to decrease. In addition, it is not known as yet what impact the Supreme Court decision re: juveniles tried as adults who received life sentences will have. These concerns increase the challenge to provide appropriate treatment and supports in the community. The forensic case manager monitors the list of anticipated releases with SMI to more effectively plan for reintegration needs. Although we are provided minimum and maximum dates from the SCI's, we can still only facilitate discharge plans if and when the SCI makes us aware that there will be an early release. Senator Pat Vance's bill SB 1279 (that allows Medical Assistance to be suspended rather than terminated upon incarceration) will go far to rectify the needs for prompt access to services and medications for inmates upon their release.

Due to budget constraints, we have been unable to re-instate training previously provided to local police and correction officers on effective strategies in dealing with individuals with mental illness. This training had proven beneficial in the past to improving interactions and awareness with law enforcement.

In addition, grant funding remained unavailable for the Crisis Intervention Team (CIT) Training that focuses on improving police officer response to individuals with mental illness and/or drug and alcohol issues. We are continuing to look for options.

f) Individuals who are deaf or hearing impaired – All providers are expected to access Interpreter services when needed. It is noted however that access to hearing aids is extremely difficult as it is not covered by most insurances. Many consumers are unable to manage the out-of-pocket expenses. Untreated hearing impairment may have negative impact on communication as well as behavior. Additional training and awareness is needed. All individuals with severe mental illness have access to the same mental health services and supports in our communities.

g) Individuals who are experiencing homelessness – We work closely with the County Housing Authority as well as the Homeless Assistance Program and Emergency Shelters in our county to connect individuals, children and families with the appropriate mental health supports. All individuals with severe mental illness have access to the same mental health services and supports in our communities. Through the LHOT partnerships, we seek to provide information on accessing available mental health supports and participate in case scenario discussions to strategize appropriate ways to make those connections. In addition, an Education for Children and Youth Experiencing Homelessness (ECYEH) coordinator participates in our LHOT meetings and committees to improve understanding and collaboration on these issues.

h) Older adults - We continue to participate in the Geriatric Assessment conference calls with Linda Shumaker, which offer the opportunity for representatives of older adult serving agencies, including Area Agency on Aging, Mental Health BSU providers, C/P MH/IDD county program staff and community

providers to review complex situations affecting consumers of these services and to develop options to meet the needs of these older adults. Cooperative relationships have been an outgrowth of these meetings.

A Certified Peer Specialist continues to be funded by the Cumberland County Office of Aging to provide peer support services to older adults who do not qualify under HealthChoices. Also, a Senior Care Manager works with a Psychiatrist who is a Geriatric Specialist to address older adult needs at one local mental health provider agency. Mobile Crisis also plays a key role in supporting nursing homes, personal care homes and families around assessment and referral in order to meet the needs of the older adult.

Specialized Community Residences (SCR) are in place to support individuals with severe mental illness when they develop significant physical health needs, often with age, in order to support them in the community. Licensed as a personal care home and enhanced with a nurse and specially MH trained staff, these three SCR's are full to capacity. The need for this type of living environment is significant especially as the population continues to age and develop additional medical needs.

Older Adults have access to all of the services that all adults have within our communities. When Medicare is the insurer however, access to those services becomes more difficult. There has been a significant decrease in the number of outpatient community providers accepting Medicare. While this is less of an issue for those who are dual eligible [Medicare and Medical Assistance (MA)], those having Medicare without MA have significant difficulty in accessing services. Since Medicare is the primary funder of treatment for many older adults in our counties, this significantly impacts service options as well as access to care. Also as previously noted, the Health Care Benefit (HCB) Package code may be the type of MA which only covers the Medicare premium and not direct services through Medical Assistance. This ratio is a critical factor in developing and funding community supports and services as significant base funds will be needed to meet the needs of those consumers.

i) **Individuals who are medically fragile -** All individuals with severe mental illness have access to the same mental health services and supports in our communities. Minimal in-home services are available through Mobile Mental Health Treatment when medically necessary.

j) **Individuals with limited English proficiency -** All providers are expected to access Interpreter services when needed. In addition, individuals in this population have access to any and all services and supports that anyone else with a severe mental illness has in our communities. We do encourage and expect providers to obtain training in cultural competence to improve the provision of services to all consumers. Cultural Competency training has been provided through our managed care entity. Information regarding available training opportunities is shared with all providers. Ongoing funding for training specific to cultural competence is needed.

k) **Transition age youth including young adults** - A Transition Age Youth Coordinator continues to assist in addressing the needs of youth ages 16–23 as they transition from the child to the adult mental health system of care. This position is available through Managed Care Reinvestment funds to support youth in planning for employment, housing, education, and other life activities that support them in functioning safely within the community. The biggest issues these individuals face are a lack of housing supports (vouchers, especially) and employment opportunities. Graduates of the program have been utilized as peer mentors and volunteers which has been beneficial.

In addition, our Cross-System Coordinator works with the juvenile probation department to link youth to the needed supports within the community.

Outpatient services are available and connections with natural and community supports are vital in providing the positive support that is needed for transitional age population. Supporting youth to find jobs and become productive citizens is paramount as opposed to allowing young adults to become entrenched in the public welfare system with Supplemental Security Income (SSI) and publicly funded services.

Transition age youth (TAY) aging out of Behavioral Health Rehabilitative Services (BHRS) or Residential Treatment Facilities (RTF) often do not meet the diagnostic criteria of serious and persistent mental illness (SMI), which the state has established as eligibility criteria for county base-funded adult services. Some of these young adults have historically been successful in transitioning away from mental health services. A smaller subset of those young adults who have spent their youth in institutional environments and have not had more normalizing experiences also present with significantly challenging circumstances, such as serious self-harm behaviors. These transition age youth present the biggest challenge as to keeping them safe and supporting them in their recovery and independence in a community setting, especially in a time that financial resources to provide for supports within the mental health system are dwindling.

Planning to meet the needs of these youth is difficult, often due to loss of connections and normalizing experiences that that children would typically attain within the family setting. Expansion of transition age programs to consider and/or include short-term residential options is needed to improve resiliency and support recovery in these young adults. Programs are also needed that provide Supported Education as well as teaching fundamental skill sets about living independently in the community, including such basics are interacting with others and boundaries due to the lack of parental-like supports in their lives. Additionally, some young adults are not interested in continuing mental health services, but lack the skills to live independently in a successful manner. Another challenge in providing support to this population is in building values at a younger age to be productive, contributing citizens within the community. Connecting with natural community supports and having typical expectations (such as work and school) are imperative to improving outcomes with this population. In addition, supporting those individuals with an autism diagnosis within the mental health system is problematic. The Adult Community Autism Program (ACAP) waiver does not start until age 21 which provides a huge gap especially when schools graduate students based off of their Individualized Education Program (IEP) goals and not at a specific age. One provider does not serve Perry County which further increases this gap as lengthy waiting lists (approximately 4 years) exist for the remaining provider.

CUMBERLAND – PERRY EXISTING MENTAL HEALTH SERVICES

SERVICE CATEGORY	CATEGORY DESCRIPTION	CONSUMER OUTCOME	MH SERVICES AVAILABLE IN C/P COUNTIES	FUNDING SOURCE County, HealthChoices, or Reinvestment			PRIORITY POPULATION: Adult, Older Adult, Transition Age Youth, Child			
				C	HC	R	A	OA	TAY	CH
Treatment	Alleviating symptoms and distress	Symptom Relief	Outpatient							
			Telepsychiatry							
			Psychotropic Medications							
			Inpatient Psychiatric Hospitalization Acute & Extended							
			Partial Hospitalization							
			Family Based Services							
			Assertive Community Treatment (ACT)							
			Residential Treatment Facility – Accredited and Non-Accredited							
			Mobile Psychiatric Nursing/Support Services							
Crisis Intervention	Controlling and resolving critical or dangerous problems	Personal Safety Assured	MH Crisis Intervention (Mobile, Walk-in, Phone)							
			Emergency Services							
Case Management	Obtaining the services consumer needs and wants	Services Accessed	Intensive Case Management							
			Resource Coordination							
			Administrative Case Management							
			Forensic Case Management							
			State Hospital Liaison							
			Transition Coordinator (youth ages 16-24)							
			Assertive Community Treatment							

SERVICE CATEGORY	CATEGORY DESCRIPTION	CONSUMER OUTCOME	MH SERVICES AVAILABLE IN C/P COUNTIES	FUNDING SOURCE County, HealthChoices, or Reinvestment			PRIORITY POPULATION: Adult, Older Adult, Transition Age Youth, Child			
				C	HC	R	A	OA	TAY	CH
Rehabilitation	Developing skills and supports related to consumer's goals	Role Functioning	Psychiatric Rehabilitation – site-based							
			Supported Employment							
			Community Residential (CRR) Services- Adult							
			BHRS for children & adolescents							
Enrichment	Engaging consumers in fulfilling and satisfying activities	Self-Development	Social Rehabilitation							
			Stigma Busting Activities held during Mental Health Awareness Month & Mental Illness Awareness Week							
Rights Protection	Advocating to uphold one's rights	Equal Opportunity	Community Support Program (CSP)							
			National Alliance on Mental Illness NAMI							
			Consumer Family Satisfaction Team CFST Consumer Satisfaction Services CSS							
			Administrator's Office: Legal Rights – Civil Commitment Process							
			County Participation in Grievance & Appeals Processes							
Basic Support	Providing the people, places, and things consumers need to survive (e.g., shelter, meals, healthcare)	Personal Survival Assured	Respite Services Brokerage							
			Supportive Living							
			Housing Support Services: MH Housing Specialist & Shelter Plus Coordinator positions							
			Fairweather Lodge Coordinators							
			Specialized Community Residences (SCR) staff							
			County Transportation							

SERVICE CATEGORY	CATEGORY DESCRIPTION	CONSUMER OUTCOME	MH SERVICES AVAILABLE IN C/P COUNTIES	FUNDING SOURCE County, HealthChoices, or Reinvestment			PRIORITY POPULATION: Adult, Older Adult, Transition Age Youth, Child			
				C	HC	R	A	OA	TAY	CH
Self Help	Exercising a voice and a choice in one's life	Empowerment	Certified Peer Specialists							
			Warm Line							
			CSP							
			NAMI							
			CFST – CSS							
Wellness/ Prevention	Promoting healthy life styles	Health Status Improved	WRAP training							
			Family to Family (NAMI)							
			Peer to Peer (NAMI)							
			CSP							
			NAMI							
			Candlelight Vigil, MH Awareness Walk, and other educational activities (stigma busting) in the community –							

Evidence Based Practices Survey:

*This chart includes both county and Medicaid/HealthChoices funded services.

Evidenced Based Practice	Is the service available in the County/ Joinder? (Y/N)	Number served in the County/ Joinder (Approx.)	What fidelity measure is used?	Who measures fidelity? (agency, county, MCO, or state)	How often is fidelity measured?	Is SAMHSA EBP Toolkit used as an implementation guide? (Y/N)	Is staff specifically trained to implement the EBP? (Y/N)	Comments
Assertive Community Treatment (ACT)	Y	43	Tool for Measure-ment of ACT - TMACT	Deloitte, CABHC	Quarterly	Y	Y	No evidence base exists for this service; locally trying to develop outcome data
Supportive Housing	Y	106	None Available	N/A	N/A	N/A	N/A	Vague guidelines, but no toolkit is available
Supported Employment	Y	71	SAMHSA	Agency	Annually	Y	Y	
Integrated Treatment for Co-occurring Disorders (MH/SA)	Y	Unknown	None Available	N/A	N/A	N/A	Y	2 providers
Illness Management/ Recovery	N							Previously provided thru Soc Rehab, but no longer is due to addition of Psych Rehab
Medication Management (MedTEAM)	N							
Therapeutic Foster Care (CRR-Intensive Treatment Program ITP)	Y	6	None	N/A	N/A	N/A	N/A	CRR-ITP – 1 Providers
Multisystemic Therapy	Y	41	Annual Managed Care Contract	Agency & CABHC	Quarterly	N	N/A	Also provided through Children &Youth/Juvenile Probation Needs Based Budget
Functional Family Therapy	N							Currently in process of development & implementation Reinvestment Funds
Family Psycho-Education	Y	65	None	N/A	N/A	N	N/A	NAMI – Family to Family; Peer to Peer; Hearts & Minds; Support Group

Recovery Oriented and Promising Practices Survey:

*This chart includes both County and Medicaid/HealthChoices funded services.

Recovery Oriented and Promising Practices	Service Provided (Yes/No)	Number Served (Approximate)	Comments
Consumer Satisfaction Team	Y	338	Through Managed Care Contract
Family Satisfaction Team	Y	209	Through Managed Care Contract
Compeer	N	-	
Fairweather Lodge	Y	19	
MA Funded Certified Peer Specialist	Y	28	
Other Funded Certified Peer Specialist	Y	17	
Dialectical Behavioral Therapy	Y	unknown	Many therapists provide this therapy as OP service but do not track specific modality
Mobile Services/In Home Meds	Y	18	Mobile Psychiatric Nursing
Wellness Recovery Action Plan (WRAP)	Y	unknown	WRAP development is offered in all levels of service but completion of a WRAP is not tracked
Shared Decision Making	N	-	Plan to Implement FY 16/17
Psychiatric Rehabilitation Services (including clubhouse)	Y	109	
Self-Directed Care	N	-	
Supported Education	N	-	
Treatment of Depression in Older Adults	Y	450	Geriatric Psychiatrists & Social Worker
Consumer Operated Services	Y	N/A	Community Support Program (CSP)
Parent Child Interaction Therapy (PCIT)	Y	10	
Sanctuary	N	Unknown	C/P residents have access to residential providers outside the county that are sanctuary certified
Trauma Focused Cognitive Behavioral Therapy	Y	Unknown	Many therapists provide this therapy as OP service but do not track specific modality
Eye Movement Desensitization And Reprocessing (EMDR)	Y	Unknown	2 providers offer this therapy, but do not track specific modality utilization
Other (Specify): Multi-Systemic Therapy (MST) Problem Sexual Behavior	Y	6	

References:

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