PUBLICATION SERIES

Office of Mental Health and Substance Abuse Services

SERVICES FOR TRANSITION AGE YOUTH:
How Two Counties Implemented Pilot Project Funding

By Susan Schoolfield for the
Chester County Department of Mental Health/Mental Retardation and
the Delaware County Office of Behavioral Health

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Originally published in 2006 by the former PA CASSP Training and Technical Assistance Institute
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Introduction

Many adolescents and young adults with mental illness age out of children's services without any transitional planning and lack the skills and community linkages necessary to manage their illnesses and accomplish their goals. These youth face the challenge of entering adulthood without appropriate services and supports. They are most at risk without solid, individualized transition planning and coordination of supports. The effects of mental illness and substance abuse on the developmental issues experienced by adolescents and young adults include: independence, employment, education choices, life skills/activities of daily living, recreation and leisure, sexuality, health care, and family and interpersonal relationships. Young adults are often unemployed, unable to participate in continuing education, and lack successful skills necessary for independent living (Hagner, Cheney & Malloy, 1999).

Other challenges include the onset of mental illness and/or substance abuse disorders in late adolescence or early adulthood. There is also an underutilization of services based on the stigma that is often associated with mental illness and mental health services (SAMHSA, 1999). Transitioning to adulthood may result in an increase in anxiety and/or depression for the youth, often evidenced by increased intensity of symptoms and increased risk of suicide.

A multitude of system gaps and barriers exist, including: the absence of a full array of treatment services and supports specifically designed for this population; the absence of a highly individualized, approach to developing life plans that promote an individual's successful transition from adolescence to adulthood; and a shortage of expertise in the mental health system in addressing the unique needs of transition age youth. There is inconsistent coordination of services and a lack of standardized protocol for individuals who are eligible for services and supports through the child and adult mental health and other social service systems, as well as a shortage of written resource materials to support the transition age youth. There are also limited housing resources available to young adults who do not have the financial means to cover security deposits and upfront rental costs needed for independent living.

Statewide Transition Age Project Pilots

Given the realities described above, the state Office of Mental Health and Substance Abuse Services (OMHSAS) provided funding for five pilot projects on transition. The goal was for these pilot projects to "support the development or expansion of their community's capacity to provide services to transition age youth with serious mental illness or serious emotional disturbance as they transition into adulthood." The ultimate goal was "to enhance youths' employment, education, living situations, and community participation as they transition into adulthood" (Pilot Project Summary Findings Report, 2004).

Five counties or joinders received funding: Allegheny, Westmoreland, Clearfield/Jefferson, Chester/Delaware (separate projects, with split funding), and Dauphin. The pilot projects were slated to begin in January 2002. Each project had several goals but they all shared the following seven core components:

- Transition case managers, facilitators or coordinators;
- Specialized groups, such as social rehabilitation, recreational/social, psycho-education, independent living skills;
- Individualized skills training;
- Training for transition case managers on the child and adult mental health systems;
- Cross-systems committees;
- Peer mentoring, and family support activities.

Throughout the grant process, the following six outcomes were identified by each project to be key components when working with this population of youth:

- Establish a coordinated set of activities that prepares youth for adult life
- Establish a partnership of youth who are using mental health services
- Establish joint planning with the family and the supporting agency to make sure school experiences for adolescents contribute directly to achieving what is necessary for academic success
- Provide continuous engagement with youth
- Provide continuous outreach and collaboration with other systems, individuals, and organizations relevant to this population
- Provide services that increase decision-making skills, self-assessment skills, and work skills (Pilot Project Summary Findings Report, 2004).

Summary of pilot projects

The Allegheny County project serves individuals between 18 and 25 years of age. The program developed a community treatment team (CTT) for transition age youth in partnership with Community Care Behavioral Health and Western Psychiatric Institute and Clinic. The CTT uses enhanced case management and a treatment model that wraps comprehensive services around the individual and family. Rent subsidies are provided to assist families and individuals in finding permanent, affordable housing in communities where they wanted to live.

In Westmoreland County, youth ages 16 to 24 are served in New Kensington where there was a great need; there is a vocational-technical school in the area that serves four school districts, and branch offices of the county's Base Service Unit, a larger mental health provider, the Office of Vocational Rehabilitation, juvenile justice, as well as a strong CASSP team. The program uses a person-centered planning approach, which is supported by a large task force. The program has also used two peer support positions.

Clearfield/Jefferson Counties focus on youth at least 16 years of age who are in out-of-county placements in residential treatment facilities. While the youth are in residential treatment, a transition case manager attends discharge planning meetings and helps to develop a person-centered plan to address housing, education and employment, community integration and socialization needs.

Dauphin County's program, the JEREMY Project (Joint Efforts Reach and Energize More Youth), targets youth between 14 and 18 (or 21 if in special education). A transition coordinator serves as the main point of contact and agent of change for services for transition age youth. In addition to conducting a person-centered planning process, the transition coordinator helps to identify and implement community-based services and supports in behavioral health, education, employment, vocational and community areas. Another feature of

the program is a site-based social rehabilitation group activity for youth, as well as for parents.

The fifth project, in Chester/Delaware Counties, is described in more depth in the remainder of this paper, as one example of what has been accomplished through the transition pilot projects.

Knowing the issues faced by transition age youth, a needs assessment was done regionally. In 2001, the Chester and Delaware Counties Offices of Mental Health, through a collaborative effort, jointly wrote a concept paper for the Transition Age Project (TAP) in response to this need. Thus, they became one of the five pilot projects to be funded.

The Chester/Delaware TAP Project

Chester and Delaware County chose to collaborate with one another and enhance the existing Intensive Case Management (ICM) services in their respective counties. The TAP project in Delaware County is based at CCMC-Community in Chester, PA; it is part of the Crozer-Keystone Health System, which is a large health network. The TAP project in Chester County is based at Human Services Inc., a large mental health provider. TAP generates its own revenue and is self-supporting. Key project components are the following: the use of the Person-Centered Planning process in service planning and delivery; information and resource sharing via the Project Advisory Panels; and consultation to county mental health providers, other child and adult serving systems and agencies and the general public regarding planning for transition age individuals.

Population Served

Both counties have the capacity to serve 15 adolescents and young adults between the ages of 14 and 22 who have been diagnosed with serious emotional disturbance or chronic mental illness and are currently receiving Intensive Case Management Services.

Admission Criteria

Priority groups are the following: individuals being discharged from inpatient psychiatric hospitals or mental health residential treatment facilities; individuals aging out of the child welfare or juvenile justice systems; individuals with a dual diagnosis (mental illness and mental retardation or mental illness and substance abuse disorder); individuals in their last year of high school or in the process of completing their GED; and individuals who are homeless or at risk of homelessness. Delaware County views youth who are homeless or homeless and expecting a child as the highest priority group for admission. Chester County gives special priority to participants who reside in Coatesville. TAP participants in the Delaware County Program are from both suburban and urban areas; participants in Chester County are primarily from suburban areas. Participation in the project is voluntary. As of this writing, Delaware County has 15 enrolled in the program; they also have 22 referrals on a waiting list. Chester County has 16 adolescents enrolled in their program and does not have a waiting list.

Some examples of TAP participants:

- BN, a homeless 19-year-old young man living on the streets in Delaware County after getting into an altercation with his mother.
- DB, a 20-year-old single mother who is unemployed and has been using drugs and alcohol, who recently lost custody of her daughter.
- BD, a 21-year-old male recently transitioned from Elwyn into a CRR entering the adult system.

Discharge Criteria

There is some variation in the discharge criteria between the two projects; however, the standard criteria is the following: the participant no longer

qualifies for ICM services, moves out of the area, reaches his or her 22nd birthday, or requests to terminate services. Participants can return to the program at any time.

Service Delivery Model

The TAP project in both counties is based on an enhanced Intensive Case Management model. Traditionally, Intensive Case Management is targeted to assist children, adolescents and adults with serious mental illness or emotional disturbance to obtain the treatment and supports necessary to maintain a healthier and more stable life in the community, with a focus on disease management, treatment services, housing, education and employment.

The TAP project's enhanced Intensive Case Management model is specialized to focus on the unique needs of adolescents and young adults transitioning to the adult system, identification of resources in the areas of housing, education and employment, as well as collaboration with service providers to develop and access those services. The project uses a Person-Centered Approach to do service planning which is a model rooted in the values, goals, and outcomes that are important to the individual; it also takes into account other critical factors that have an impact on the individual's life, including family and other support systems, funding issues, as well as the individual's disability and the community (Holburn, 2000). Person-Centered Planning (PCP) will be discussed in much more detail later in the paper.

Psycho-educational Groups

Another feature of the project is a psycho-educational group for the participants. In spite of the project's participants' interest, Chester County has not been successful in sustaining a group due to the busy schedules of the participants and competing priorities; a number of the participants are in school as well as employed after school and/or attend already existing support groups. However, Delaware County has had much success with their weekly group. The group has been opened up to any transition age youth in the Adult, Children's or Drug and Alcohol Services at CCMC. The group's focus is both psycho-educational and therapeutic. A master's level therapist facilitates the group. On average, 6-10 clients attend each session. Group discussions have covered banking, voting and voter registration, family issues, self-esteem, effective communication, completing work applications, interviewing skills, and the effects of street drugs on psychotropic medications. The TAP project also includes a socialization component, called "Pizza and a Movie Night," held once a month. Transportation tends to be an obstacle to attending the group; however, limited transportation is available. Through this group many of the CCMC-TAP participants have formed friendships and use one another as supports. This remarkable sense of group camaraderie might in part be due to the longevity of its members.

Some participant feedback on the group includes:

- BN, a 19-year-old male living with Tourette's Syndrome has had multiple hospitalizations and RTF placements in the past; he has been attending the group regularly. He shared at the time of a group interview that he has really benefited from the support and strategies to dealing with his anger that the group has offered him.

- ZB, 21-year-old male living with an Anxiety Disorder recently graduated from high school and has been attending Delaware County Community College. Recently ZB was placed at the University of Pittsburgh via Job Corps and he is awaiting his specific assignment. ZB has been working full time, and attends the TAP group regularly He reported feeling less anxious and more confident since he began participating in the TAP groups at CCMC.

Project Staffing

Each Project consists of a Project Manager and an Intensive Case Manager. The Project Manager directly supervises the Intensive Case Manager and also has a small caseload. The Intensive Case Manager has a caseload of no more than 10-12 clients. In both counties, the Project Manager supervises other Intensive Case Managers in addition to carrying out that role with the TAP Project ICM. The CCMC Project also has a part time master's prepared therapist facilitating the groups.

Advisory Panel

The two Advisory Panels are made up of representatives from numerous child and adult serving systems and agencies. The Advisory Panels have served as a vehicle for information, resource sharing and a springboard for discussion around cross system issues.

Chester County Advisory Panel

Chester County's Advisory Panel is made up of a number of different agencies and systems. Membership includes:

- Two representatives from the Chester County Intermediate Unit. One is a mental health specialist who provides individual therapy in an emotional support learning environment and the other is the ALTA (Accommodations for Learning for Technical Assistance) consultant.
- A representative from Parents Involved Network, who fields inquiries from individuals looking for assistance for their children in the mental health field and directs them to potential resources and or agencies.
- A representative from Children, Youth, and Families. This person runs the Independent Living Skills program through CYF.
- Office of Vocational Rehabilitation supervisor for Chester County.
- The Chester County Department of Community Development. This representative works with housing, specifically grants from the state.
- Mental health agencies in Chester County. A child specialist works specifically with adolescents who are in residential treatment facilities and follows the adolescents while they are in the Residential Treatment Facility and coordinates the appropriate referrals at the time of discharge.
- The director of a mental health agency that serves both adults and adolescents.
- A registered nurse for a Crisis Residential program; they provide adults in crisis with an alternative to hospitalization.
- The supervisor of the Student Assistant Program, who works in the school districts, identifying "at risk youth" and also facilitates groups on anger management.

The Project team is keenly aware that in order to round out the panel there needs to be a representative from the Drug and Alcohol system, and an invitation has been extended to Chester County Department of Drug and Alcohol Services to join the Advisory Panel.

The Advisory Panel has been used as a forum to discuss cross-systems issues related to transition age individuals due to solid multi-system representation and interest. Standing agenda items include brief updates on the project participants' status and related system or resource issues. The Advisory Panel has identified resource gaps and barriers to service and provided system recommendations. For example, housing has been identified as an issue for transition age individuals. As a result, a subcommittee was formed to discuss viable options for transition age housing.

The project team has learned of additional resources through the Advisory Panel, which has allowed for better service delivery. Cross-systems

collaboration for developing individual case plans has included talking with the Advisory Panel members who have knowledge of school programs that can be accessed for project participants when a current school placement is not successful, and learning more about Office of Vocational Rehabilitation services, including what testing can be done for project participants to assist them with obtaining their individual goals. This information sharing is critical to providing good case management to the project participants and is also useful on a larger scale from a cross collaborative perspective.

Delaware County Advisory Panel

The Delaware County TAP Advisory Panel includes:

- individuals from the Delaware County Office of Behavioral Health Adult and Child Services who advise on mental health issues and changes
- a representative from the Department of Public Welfare who advises on issues within the Department of Public Welfare including SSI and MA as well as on issues or changes
- Delaware County Intermediate Unit representatives who advise on educational issues, changes and Transition ER and IEP process
- a representative from the Office of Vocational Rehabilitation
- a representative from the Child Guidance Resource Center
- a representative from a housing program to advise on availability, the application process, issues and changes in the Housing System
- TAP Team members.

The systems/agency representatives on the Panel serve as liaisons to the Project Team for their respective system/agency.

The Advisory Panel has been used as a forum for exchange of information among the various systems. The Advisory Panel has also been used as a forum for training in systems such as Education, Mental Retardation, and Housing. The Advisory Panel has been primarily a forum to discuss cross-system difficulties, changes and availability of services as well as how to access those services. In addition, the Advisory Panel has been extremely helpful in expediting Medical Assistance applications and obtaining services via the Department of Public Welfare and Housing. The training received during Advisory Panel meetings has helped in the process of linking clients to resources and services. The training has also helped in advocating for TAP participants in obtaining the services that are most needed.

Person-Centered Planning

Overview

Person-Centered Planning (PCP) originated in the 1980s and was adopted initially by the Mental Retardation system. The tenets of Person-Centered Planning are the following: to see individuals as people first; to ensure that activities, services and supports are based upon his/her hopes, dreams, preferences and interests as well as strengths and capacities; and to ensure that the voices of the individual and those who know him/her best are heard; and finally to ensure that the planning process and the plan uses ordinary language rather than diagnostic labels and professional jargon (Holburn, 2000).

Person-Centered Planning is a process for learning what a person wants for his or life, what needs to be done (and what needs to be maintained) to achieve that. Good plans are rooted in what is important to the individual while taking into account all the other factors that have an impact on the person's life—the effects of the disability, the views of those who care about and know the individual, and the opportunities as well as the limitations.

The process usually includes a C*ircle of Support*, a committed team of people who are close to that individual. This could be family, friends, community members, school and professional staff who help to identify supports that will allow that person to develop this life. Group graphics and facilitation techniques assist a person in describing the kind of life that he or she wants to live.
The resulting plan is a written description of what is important to the individual in how he or she wants to live his or her life, any critical issues that must be addressed, and what needs to happen to support that person in his/her desired life. The plan cannot be separated from the process. Person-centered planning is a means not an end. The life that a person wants is the outcome, not the plan that describes it. Implementing the plan means moving forward from planning to action, reflection and back to action. In earlier efforts of Person-Centered Planning, the assumption was made that the hard work was in developing the creative plan that truly represented the person. The assumption was made that once the plan was in place, implementation would be straightforward (Holburn, 2001).

Advantages of PCP for the Mental Health Population

Research shows positive benefits associated with using this model with the mental health population. First, the model promotes the inclusion of people most involved in the client's life to aid in the planning process, thus helping to insure that the client fulfills his or her goals and has a better quality of life (Till, 2004). Second, the use of PCP empowers the client to take more control of his or her life by promoting an environment that assists the client in attaining his or her goals and educating him or her in a way that decisions made can be carried out. Third, if done well, PCP fosters a greater respect for the client and recognition of his or her individual needs. Finally, some clients report appreciating and valuing the added independence and sense of equality that the approach provides (Till, 2004).

Challenges in Using PCP with the Mental Health Population

Some general concerns exist about using the Person Centered Planning Process. Research indicates that some clients' communication skills may impede the collaborative teamwork required for the Person-Centered Planning process. The client may be too withdrawn or anxious to speak in the presence of a team and may do better one-on-one (Till, 2004). The client's behavior may also interfere with the planning process. Depending on the severity of the client's mental illness, it may be difficult to get family, friends and community members involved with the planning process.

Scheduling may also be an issue where it is difficult for all members of the circle of support to be present. Time may also be perceived as a barrier, including the lengthier process required to engage in PCP. The high level of paperwork that case managers and other staff may experience in their jobs and the perception that the system may not value this type pf planning as necessary are additional barriers (Till, 2004).

There are also attitudinal barriers, including the view that "we are already doing it" without understanding the fundamental shifts in values and support structures that true person-centered planning demands. Other attitudinal barriers are a lack of alignment among all participants and a resistance to change (Holburn, 2000). Finally, without sufficient training and support staff, may misapply the Person-Centered Planning model. There is great risk that a service provider may talk the talk, but not walk the walk (Holburn, 2000).

The TAP Project and Person-Centered Planning

Person-Centered Planning is a method used by several of the transition age pilot projects. In some counties this method is a requirement of being in the project. Locally, participation in this process is voluntary; each transition age participant is offered the opportunity to develop a Person-Centered Plan in lieu of a traditional service plan. In preparation

for application to the Person-Centered Planning Process, both project teams underwent training. Both projects have struggled with getting participant buy-in to participate in the process but have had some success. Some team members have found that because the focus is person-centered it does give the youth a voice and a sense of empowerment in setting goals that are truly their own. The Person-Centered model can be quite flexible as it meets individual needs.

Some Successes

Circles of Support and Goals

LT

LT is a 19-year-old female who lives with her mother and maternal grandmother. LT recently graduated from a partial hospitalization program based on her Individualized Education Plan (IEP) goals. LT is interested in working with animals, specifically, becoming a veterinarian. She also wants to attend the Clubhouse program for socialization and plans to continue with outpatient treatment including psychiatric and therapeutic appointments. LT's Circle of Support as she saw it was small; her mother and boyfriend attended along with her transition ICM and the Transition Project Manager.

The goals that were identified by LT and her Circle of Support were obtained over a one-year period. The main goal and dream of LT was to find employment and/or a way to volunteer with animals. This includes researching and attending possible classes to help secure employment with animals. LT's other goals were more relationship-based, working on her communication skills between herself and her mother. The Person-Centered Planning process allowed LT and her Circle of Support to visualize through graphics on paper what positive factors have assisted her in reaching her goals in the past and also what has not worked for her. Through this process LT was also able to see how these factors have influenced her relationships with her mother and other people around her.

For LT, visualizing what has worked and what has not worked for her in the past by drawing on a big piece of paper was helpful. She has been working towards her goal of working with animals, currently through volunteer organizations. Her ICM is helping with this process by working with LT on finding volunteer organizations and supporting her as she investigates available opportunities. The goal of improving her relationships is one that LT works on every day. For this goal, LT is using the assistance of her mother, the ICM, and therapist. The ICM and therapist are working with LT on improving coping mechanisms such as anger management. LT's mother is working on taking ownership of her role in the communication problems. During the actual Person-Centered Planning meeting, LT realized that she could somewhat dictate what could happen in her life based on setting goals and having a plan to obtain them.

HF

HF is a 20-year-old male with Bi-polar Disorder, Explosive Anger, Impulse Control Disorder and Moderate Mental Retardation. Before entering the Transition Age Project, he was living with his father, receiving respite care through the County Office of Mental Retardation, and was in a life skills classroom. HF was waiting to be placed in a Residential Treatment Facility and receive home and community-based services via mental health services. He had a very small support system. He could not identify anyone besides his father and teacher to be in his Circle of Support. HF was not in therapy, receiving psychiatric care or on medication management. He had difficulty expressing that he was unable to do things himself, and was at extreme high risk of out-of-school placement due to inappropriate behavior at school as well on the bus. When HF was not at school, he remained alone in his room all day listening to music or watching TV.

During the Person-Centered Planning process, HF identified his hopes and dreams to his Circle of Support. HF wanted to have his own place and he now resides in a CLA (Community Living Arrangement—supervised group housing) with a

roommate. One of HF's goals was to graduate from high school and he graduated in June 2003. He has been learning new skills in a psychosocial program, and entered a workshop program in the fall of 2003. HF also had a dream to "go places." In his Person-Centered Planning meeting HF told his team he wanted to go out to eat, be able to purchase CDs and listen to music, watch movies, go to the beach, and travel. Since HF now resides in a CLA, he has a roommate who he considers a good friend. HF frequently goes to the mall with staff and friends as well as sporting events and has even traveled to Universal Studios in Florida.

Since entering the Transition Project and going through the Person-Centered Planning (PCP) process, HF has expanded his Circle of Support. Expanding his Circle of Support was also one of HF's Person-Centered goals. Although HF's relationship with his father remains strained, he is in contact with him. HF now sees his mother regularly and she has taken on a more active role in his life. She has attended all of HF's meetings and program visits. She promised to take him out at least once a month and has followed through with her promise. His mother, who is Asian, has also been teaching HF about his Chinese culture. HF has become re-acquainted with other members of his family. HF's main goal was "just to be happy," and he reports feeling "very happy!"

HF now has a larger Circle of Support. He attends Psych-Social Rehabilitation Monday through Friday, goes to a weekly group and sees a psychiatrist monthly for medication management. HF can now recognize a few of the triggers when he begins to get angry. He can ask for help when he needs assistance to complete a task. HF will be transitioning into adult mental health services on his 22nd birthday. He will enter his new services as a Resource Coordination client, a lower level of case management services than he is currently receiving.

Barriers to Implementation

The TAP Projects have had difficulty getting the participants to buy into the Person-Centered Planning process for a variety of reasons. For example, many youth are not comfortable having their families involved with their Circle of Support due to strained relationships or because developmentally the adolescents are striving towards greater independence. Other adolescents and young adults find the team brainstorming process intrusive and anxiety-producing. They related that they do much better with traditional planning and interacting one-on-one with their case manager. Still others reported the process as being "not cool" or "hokey."

The leadership at Human Services, Inc. believes that their current service plan is person-centered with the individual always being at the center. The staff felt in some situations that they were forcing individuals to participate in a process that makes them feel uncomfortable and that this is not person-centered. At this time all of the current participants have declined the formal process and opted for the traditional ICM service plan at Human Services, Inc. The CCMC Team has had greater success with the model but has also met with participant resistance for some of the same reasons. Both teams felt strongly that they are already providing person centered planning and services.

CT is an example of a more difficult fit.

Youth Circle of Support

CT is a 19-year-old female diagnosed with Major Depression who had brain surgery due to a history of seizures. She displays Borderline Personality traits but there is not a professional consensus and she has not been formally diagnosed. CT resides at home with her parents. She attends a four-year college full time. CT's professional supports include an Intensive Case Manager, a Psychiatrist and a Mobile Therapist. She also seeks out counseling from the college that she attends. CT lacks natural supports such as peers. This is attributed to the symptoms of her mental illness and self-consciousness about her history of a seizure disorder. CT's family has specific ideas about her social relationships and treatment related supports.

She displays resistance when asked to use community resources that she feels are below her standards. This resistance is hindering much progress towards the independence she desires.

Goals and Dreams

The Person-Centered Planning process has taken place in several stages for CT. The first stage was making her aware of the Person-Centered Plan. CT was asked to think about the supports she would like to have involved in the process. She named the professional supports. The ICM contacted each support to coordinate services and to inquire what goals and interests CT had expressed wanting to pursue with them. A meeting was then scheduled to discuss current treatment goals. The attendees at the planning meeting were the ICM, Mobile Therapist, CT's mother, the case manager for mental health services provided in the home and community, and CT. The main goal was for CT to become more independent and establish more natural supports. CT was uncomfortable expressing her goals in front of others at the meeting but was able to draw from the content of the meeting to express her concerns and wishes when alone with the ICM. The ICM was able to assist CT in becoming a better self-advocate through methods not specific to the PCP process. The ICM continues to re-visit the plan created with CT to monitor her progress in achieving her goals. There continue to be challenges in assisting CT to achieve her goals due to several personal and family issues.

TAP Project Team Enhancements

Each Project Team needs to assess how to integrate the basic tenets of Person-Centered Planning into their service planning process with the transition age youth. A team building process needs to occur where team definitions, assumptions and perceptions regarding PCP can be flushed out and tested as a team. The team and the project manager have four important interfaces: with the individuals they support, with the people who know the individual well, with the community, and with the system. Person-Centered Team characteristics should reflect the values, skills, and understanding required to support people effectively, build bridges into the community and support each other and influence organizational and system change. To become an effective person-centered team, the leaders need to identify their coaching and training needs and identify their own strategies for building a person-centered team. The elaborate circles of support, drawings, and flip charts with all of the trappings are not the requirements of a good PCP process; they are just techniques to enhance the process. The approach varies depending on the person's needs, desires and individual situation; accommodations must also be made for the individual's developmental stage and communication capabilities.

Organizational and System Changes

In order to overcome some of these barriers, changes need to be made both on an organizational and systems level. Leadership has to buy in and understand what real PCP is all about, along with the necessary changes in thinking, control and providing service. Person-Centered Planning identifies what needs to be done but not how to do it; thus service providers; county offices, regulators and funders have to develop new strategies and resources for providing supports based on different expectations.

Measurable Outcomes

To date there have been no formal studies on outcome measures and the effectiveness of the project, with the exception of the quarterly reports that provide descriptive statistics on the status of the individual participants at the end of each quarter. Informally, the projects have looked at such indicators as:

- Reduction in the number of days in the hospital;
- Number of linkages to systems and services;
- Improved relationships and support systems;

- Successful vocational placements in the community;
- The number of participants who pursued educational opportunities;
- Secured housing.

There is good anecdotal information from clients to support positive outcomes in the areas of empowerment and decision-making abilities, increased understanding of mental illness, improved self esteem, friendships, and a decreased need for professional support.

Individuals who have achieved successful outcomes include:

- BN, a 19-year-old male living with Tourette's Syndrome has had multiple hospitalizations and RTF placements in the past. BN is now a volunteer fire fighter. He will be graduating this June. BN has plans to enter the armed forces or become a welder.

- AS, an 18-year-old female living with Trichotillomania and Depressive Disorder has been able to obtain a part-time job and be promoted to shift supervisor.

- BF, an 18-year-old female with a history of Depression came to the United States as a refuge from Africa after her family was killed. Once in the United States she was rejected by her stepmother and placed in foster care. BF is now a member of the National Honor Society and will graduate in June. BF will begin attending Widener University in the fall on a partial academic scholarship.

- BD, 19-year-old male living with ODD and Intermittent Explosive Disorder came to TAP from RTF. BD is now living comfortably in a Community Rehabilitative Residence.

- TD, a 19-year-old male, living with Major Depression, Oppositional Defiant Disorder, a history of Drug and Alcohol issues and multiple RTF placements, has now obtained his own apartment and car.

Client Satisfaction

One of the requirements of the project was to assess the satisfaction of the participants with a formal survey and focus groups at the time of discharge, and at six months, one year and two years. A survey design has been completed and initial surveys have been mailed out; to date no surveys have been returned. For the Chester County Project, the project's assessment of the poor response was that the primary reason for discharge has been relocation and it is difficult to track the whereabouts of the former participants. Consideration should be given to developing a survey process while a participant is still active in the project at three-month intervals and at the time of discharge. Both counties' Consumer Family Satisfaction Teams will be assisting the project with this process in the future.

As part of the research for this paper, interviews were conducted with four individual clients and with six participants in the CCMC group. When asked about satisfaction with the program all said they liked the fact that the TAP Case Manager could spend more time with them than the traditional ICM Case Manager and felt that the team was always there for them. One young woman stated that the Project Manager was the only person who believed in her and stood by her even when she went astray. Another young man who had been homeless said if it were not for the Case Manager he would have never found a place to live after his mother threw him out on the streets.

TAP Project Role with the County Offices and Social Service System

The TAP projects in both counties meet with each other and the county offices quarterly and have regular contact with the CASSP Coordinators to

discuss ongoing individual and systems issues. A quarterly program review and individual status report is sent to the county offices and state that includes progress on the project, number of individuals served, and outcomes.

During the start-up phase of the project, both counties worked with their identified providers to develop their project based on the model outlined in the Concept Paper. The provider agencies were given full autonomy in hiring staff for the project teams and in determining responsibility for their own agency's administrative oversight of the project. The providers were allowed to shape their projects based on existing agency practices, policies and procedures. As a result, providers, largely independent of the county offices, developed intake and assessment procedures, parameters for ongoing service delivery and discharge protocols. This autonomy has been positive in many ways from a service delivery perspective. However, it has had a negative effect from an administrative standpoint on building the necessary internal systems, standards and procedures critical to a successful program.

Consultation and Outreach

The TAP project teams' efforts in community education through workshops, speaking engagements and local presentations has helped to raise awareness of the special needs of the transition age population. Due to the TAP's community education, many service providers and systems have sought input from the county offices and TAP teams in looking at the needs of transition age youth within their systems. Project teams have been successful in laying the preliminary groundwork to build the necessary bridges between the adult and child systems in the respective counties. Transition Age Project staff have established significant relationships in both counties, through networking with the Advisory Boards and by serving in the role of "informal consultants" to others in the field by building good will and sharing resource information.

Collaborative efforts with adult service providers have been underway to develop protocols for accessing services. A goal for this year is to work in collaboration with the county offices and service providers to develop "age-based" tracks within the existing adult systems.

Aged-Based Tracks

The majority of the existing services are designed for the population of adults who are chronically mentally ill. An age-based track dedicated to the needs of the transition age population should focus more on the young adult's developmental, socialization, vocational, educational and housing needs.

In both counties several age-based programs have been or are in the process of implementation.

<u>Chester County</u>:

- Holcomb Behavioral Health Systems has an apartment-based Community Rehabilitative Residence dedicated to the needs of the young adult. The challenges and issues that they have confronted are not so different from other congregate living situations with young adults such as dormitory living at a college.

- Horizon House Drop-In Center will sponsor a "Youth Night" once a month for young adults that focuses on recreational, psycho-educational, vocational and relationship issues. This program will start in late February 2006.

- As part of Human Services Inc. Partial Hospitalization Program, a young adult age-based psycho-educational group focuses on such topics as peer relationships, sexuality, drug and alcohol issues, job seeking and preparation and housing issues.

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Delaware County:

- A Transitional Youth Program (TYP) was developed as a component of an existing CRR program at Child Guidance Resource Centers. This specially designed program focuses on the needs of transition age young adults in a CRR setting.
- Delaware County has also created a Community Residential Rehabilitation (CRR) expansion program for the transition age population. This program, which is being provided by Carelink, offers site based services and will soon also offer scattered site apartments

The development of any new program's success requires recognition that young adults need to be placed with their peers. They need peer support. The peer specialist model could be easily adapted for this population. The focus of the transition age programs should be on psycho-educational, vocational, relationship and housing needs of the young adult population.

Additionally, program staffs require specific training in order to sufficiently address the needs of this population and to understand the challenges that these young adults may confront. The Transition to Independence Process Model (TIP) may be a good one to use as part of the training curriculum. The TIP model was developed to engage youth and young adults in planning their own futures, provide them with developmentally appropriate services and supports, and involve them and their families and other informal key players in a process that prepares and facilitates them in their movement toward greater self-sufficiency and successful achievement of their goals related to each of the transition domains: employment, career-building education, living situation, personal-effectiveness and quality of life, and community-life functioning (Clark, H. & Davis, M., 2004)

Project teams from both programs act as consultants to their own internal Child and Adult Intensive Case Management, Resource Coordination and Administrative Case Management, as well as to Children's and Adult Outpatient Therapists. In addition, they provide consultation to the Intermediate Units and other agencies in Delaware and Chester Counties regarding any issues of linking, monitoring and coordination of care of any transition age individual. Both project teams have done a great deal to raise public awareness. The Project Manager from Human Services, Inc. sits on several committees including the Transition Coordinating Council, Children's Collaborative Meetings and the Local Housing Options Team (LHOT). The Project Manager in Delaware County has taken on a larger role as consultant with the CCMC Staff at the Delaware County Intermediate Unit Alternative Schools, the CCMC Student Assistant Program. On an individual level, she has also extended her outreach to include meeting with several parents and youth not in the CCMC System regarding transition issues.

Resource Development

Through cross collaboration with existing adult and children's services, the TAP project's goal is to expand capacity within existing services. For example, in conjunction with the county offices, teams are presently looking at developing a transition age track in the partial hospitalization program, and further expanding more age-appropriate Community Rehabilitative Resident (CRR) resources. Several of the TAP participants are on a CRR waiting list. Further evaluation of the housing need of this population is being championed by the Local Housing Options Team, which works on meeting housing needs through grants. In addition, two critical needs are developing a protocol for coordinating and accessing the adult service system and partnering to create a transition age track within the county mental health system.

Many service gaps still remain. The system overall needs to develop greater resources for this population that will meet their unique needs in the following areas: managing their illness, fostering

independence, education, job placement and housing.

Building Capacity

The project itself should be open to a larger number of transition age individuals; 30 slots are not sufficient to meet the demands of the current population. In the long run, a systematic and standardized protocol for this age group transitioning to the adult system needs to be routinized on a county, regional and state level, and resources such as CRRs need to be expanded as well as other developmental supports.

Costs

Additional costs of the Transition Age Program have been minimal. The costs were limited to the Intensive Case Management Supervisor time for the additional responsibilities of staffing the Advisory Committee, which amounted to several thousand dollars a year. The majority of the other costs such as the psycho-educational groups was billed as group therapy and is therefore not an additional cost. In Chester County, Intensive Case Managers, Resource Coordinators and their supervisors were able to participate in Person-Centered Training offered by the Mental Retardation Department at no cost.

Lessons Learned

- The age group was found to be too broad; adolescents at 14 are dealing with very different issues than they are between the ages of 17- 22.
- Roles should be more clearly defined and differentiated from traditional ICM roles.
- The Project Manager should not have a caseload and should be freer to focus on some of the administrative tasks associated with the project.
- Program demand exceeds resources. Given the demand for service it would be helpful to have larger program capacity.
- Lack of resources specific to the needs of transition age young adults have made planning difficult for some TAP participants, but working with the TAP Advisory Boards has been extremely helpful.
- There needs to be more tailored training in Person-Centered-Planning to meet the needs of the mental health transition age population.
- The Person-Centered-Planning model needs to be adapted better to the transition age population. Because there are a variety of approaches to Person Centered Planning, it is imperative to be flexible and individualized in the model that is selected as one considers the needs of the young adult.

Recommendations

Program Recommendations

- Develop a clearer vision for the project and how it can be better integrated into the existing Intensive Case Management structure without losing the integrity of the project.
- Develop clear roles and responsibilities for project staff, minimizing competing priorities that will allow them to be successful in their jobs.
- Develop policies, procedures and protocols for the TAP project that are consistent and insure quality of service.
- Assist county offices in taking more of a hands on role in the technical assistance they provide and assist the projects in developing the administrative structure and defining the programmatic aspects of the project.
- Improve the training in PCP and explore how the model might be adapted to fit the needs of

the TAP population; perhaps use the expertise of the trainer as a facilitator and mentor in difficult situations.

- Ensure that leadership in both organizations buys in and understands what true PCP is all about, along with the necessary changes in thinking, control and providing service.

- Formalize outcome studies and a database to track the effectiveness of the project with documented results.

System Recommendations

- Improve the overall expertise in the mental health system in addressing the unique needs of transition age youth.

- Develop consistent protocols for the transition age population and their service providers to navigate and access the adult system.

- Enhance or develop more transition age resources on a local and state level.

Final Learnings

- As a system we need to focus more on transition age housing initiatives that foster young adults living with other young adults.
- We need to offer transition age peer specialists programs that provide support to young adults in the system.
- We need to develop Intensive Case Managers and Resource Coordinators who specialize in working with young adults who are familiar with their needs and aware of the available resources.
- Ongoing relationship building, resource sharing and networking are cornerstones of the ongoing success of the existing and for future programs.
- A multi-system approach is critical to designing new systems and services.
- Staff training is critical and needs to be tailored to the needs of the young adult population.
- Person Centered Planning is an effective model to use with this population if it is tailored to meet the individual needs of the young adult. There are a variety of approaches to Person Centered Planning. It is therefore important to have flexibility in whatever approach is selected in order for it to be successful.
- Training for Person Centered Planning is also critical. There are a variety of resources and technical assistance available. Research available trainings and find the approach that best meets your needs.
- Agency-wide and management buy-in is key to the success of Person Centered Planning. Without such an endorsement, the model will more than likely fail.

Conclusion

Although state funding for the five pilot projects will end with the 2005-2006 fiscal year, counties have the option, based on the success of their transition projects, to find other funding within their county budgets, to continue the projects. In fact, the project manager within OMHSAS has recommended that the pilots continue if at all possible. Reviewers from the federal Community Mental Health Block Grant program have noted that these projects are examples nationally of what can be done to create service systems for the transition age population. They also recommended the continuation of the projects, and even if that is not possible, it is very important that Pennsylvania use what has been learned as a foundation for future program development (Pilot Project Summary Findings Report, 2004).

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Interviews:

CCMC TAP Participants and Group

Human Services, Inc. TAP Participants

CCMC TAP Project Team and Administration

Human Services, Inc. TAP Project Team and Administration

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