NEW YORK STATE | Office of Mental Health

OMH News

February 2017

ANN MARIE T. SULLIVAN, M.D.
Commissioner

Reinvestment:

Building Community Mental Health Resources Throughout New York State.

Reinvestment is a key strategy of the OMH Transformation Plan, the method by which New York State is refocusing its mental health resources on prevention, early identification and intervention, and evidence-based clinical services and support.

For years, New York State had disproportionately high state-operated inpatient per-capita costs. State-operated inpatient facilities served approximately one percent of the total number of people served in the public mental health system, yet they accounted for 20 percent of gross annual system expenditures.

Including other acute inpatient facilities, such as Article 28 or 31 psychiatric hospitals, inpatient psychiatric costs accounted for nearly half of the total spending on public mental health services.

The Transformation Plan is changing this. After extensive and ongoing consultation with advisory bodies, community stakeholders, local government units, OMH field offices, and psychiatric centers in every region of the state, OMH has reduced inpatient capacity during the past three fiscal years and made investments in every region of the state to strengthen community mental health services and reduce the need for unnecessary inpatient hospitalizations.

These community investments have continued to yield positive results. The average daily census in OMH civil psychiatric centers declined by 3.5 percent during calendar year 2016, while respective state-operated community service expansion increased the number of people served by 94 percent when compared to the same period in 2015.

While institutional care still plays a key role in the recovery process for some, hundreds of children and adults are now receiving quality and effective care in their communities, and no longer have to be separated from families and friends in a psychiatric center to recover from mental illness.

In this edition of *OMH News,* we'll show you where Reinvestment funding is going and how these programs are helping people in our communities.

We encourage you to share your comments and stories with us. Contact us at: omhnews@omh.ny.gov.

OMH Transformation Plan: Success by the Numbers

As the Transformation Plan wraps up its third year, OMH has dedicated nearly **$100 million** to create several new and expanded community-based programs and services.

These investments are directly associated with, and funded through, reduced costs associated with lower inpatient psychiatric center census and from individuals who no longer need to be placed in a hospital.

Reinvestments include:

- **1,105 supported apartments** with appropriate wrap-around services to serve individuals in the community and avoid future homelessness.
- **246** additional **Home and Community Based Services (HCBS) waiver** slots to provide respite services for children and families, skill building, crisis response, family support, intensive home support, and care coordination.
- **12** state-operated **mobile integration teams (MIT)** to provide services and supports for youth and adults – including on-site crisis assessment, skill building, family support, and respite. To date, all MIT are operational and have provided critical supports to more than **4,500** new individuals statewide. **Five** other current state-operated community support services will be converted to MITs. MITs can serve hundreds of individuals each month, and are scaled and located to community need.
- **Four** new state-operated, child and adolescent **crisis/respite houses**.
- Expansion of state and voluntary-operated **clinic programs**, state-operated and **school-based clinic satellites**, and extended clinic hours to provide services when they would be otherwise unavailable or inaccessible.
- Staffing support for three **first episode psychosis** programs being implemented statewide through OnTrackNY.
- **16** new and expanded **crisis intervention** programs, many with extended-hour coverage, mobile capacity, and peer-support components.
- **More than a dozen** new **advocacy, outreach,** and **bridger** programs, to guide individuals through transitions from inpatient settings into integrated, clinically-supported community living, and linking them to various community based supports.
- **10** new or expanded **Assertive Community Treatment** (ACT) teams, accounting for a capacity expansion of **572** slots.
- **Forensic** programs for both adult and juvenile offenders, developed to link individuals with mental health services, provide specialized assessments for probation and courts, and reduce future recidivism and hospitalization.
- **14 long-stay teams** to assist with the transition of individuals whose lengths of stay in state psychiatric centers or residential facility have exceeded one year, into structured community settings. OMH has also developed more resources outside of state psychiatric centers to aid in the transition of long-stay inpatients requiring skilled nursing facility or managed long-term care services in the community.

In all, these programs have allowed OMH and its partners to provide services to more than **28,000** individuals — people it never would have reached without reinvestment. Monthly and annual reports on the progress of the Transformation Plan are available online at: http://omh.ny.gov/omhweb/transformation.

Supported apartments

Mobile Integration Teams

Respite houses

Community clinics

Long Island:
Bringing Mental Health Services Back to Long Beach After Sandy

In late October 2012, Superstorm Sandy devastated parts of New Jersey, New York City, and Long Island. Lives were lost, homes and vehicles were damaged, and families were left homeless.

One of the worst-hit areas was Nassau County. Long Beach Medical Center was severely damaged by flood waters. The hospital's mental health clinic was temporary relocated, but was later closed. Although its clients could receive care at other clinics, these facilities were outside their local communities. For many, this was a considerable hardship, because they didn't have transportation.

During this time, there was a major gap in services, individuals and families were left on their own to deal with increased stress, loss, and frustration. Eventually, some individuals never returned.

Although the Red Cross provided counselors during this time, a permanent solution was needed.

"The emotional and mental health of people in these communities needed to be addressed," said Roseann Avella, Director of Licensing in OMH's Long Island Field Office. "We all realized that we had to help the Long Beach community put their lives back together."

OMH Field Office staff held a series of meetings with Dr. Joseph Smith, Executive, Director of

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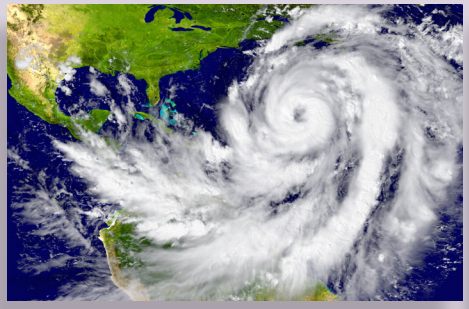

Superstorm Sandy and its aftermath.

Reinvestment & Planning: Long Island

OMH has made an annualized amount of $14.1 million available in this region. Investments include:

- 178 new supported housing units.
- 54 HCBS waiver slots.
- Eight children's crisis/respite beds on the grounds of Sagamore Children's PC.
- State-operated MITs for adults and children across Long Island.
- Three long-stay teams. These teams will help long stay individuals transition into community settings through collaborative discharge planning and linkages to community supports

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Long Beach Reach Inc., a local health care agency that runs several area programs and clinics; and Nassau County local government officials to discuss the needs of the Long Beach community.

After a great deal of planning, the group filed an application in 2015 with OMH for a license to operate a clinic treatment program.

OMH reinvested funding that had been used to support the psychiatric units at Long Beach Medical Center and Glen Cove Hospital, both of which were closed.

A total of $2.7 million in state funding was secured to re-establish the clinic and fund other community based mental health programs such as mobile residential support teams, on-site rehabilitation programs, urgent care capacity at two local counseling centers, and advocacy for the families and their children who may be in the emergency room or child inpatient unit at Nassau University Medical Center.

The Long Beach Reach Counseling Center was finally opened on August 18, 2016. It serves adolescents, adults, and children.

For the past six months, the clinic staff have been busy with providing urgently needed services for the area's clients.

"The opening of this clinic was long-awaited and very welcome," Avella said. "Superstorm Sandy took a toll on this community and a lot of people are still recovering — inside as well as outside. There's been a lot of catching up to do. But we're really proud of how a lot of different groups pulled together to get this center open and re-establish mental health services in our community."

LONG BEACH REACH
Youth and Family Services

For more information about Long Beach Reach, visit: http://www.longbeachreach.com.

- Mobile crisis and mobile residential support teams operated out of Suffolk County, and an expanded crisis program in Nassau County will work with long stays from Pilgrim PC.
- Expansions of separate state-operated adult and children's outpatient clinics.
- Two ACT teams, serving 48 and 68 individuals, respectively.
- 72 non-Medicaid care coordination slots to link children with serious emotional disturbances and their families to the mental health service system and coordinating these services to promote successful outcomes with continuity of care and service.
- 18 child and family intensive case management slots to promote optimal health and wellness for children diagnosed with severe emotional disturbance.
- Mobile residential support teams to focus on helping adults living in supported housing apartments to make the transition into community living.
- Hospital alternative respite center to provide a viable option to inpatient hospitalization for individuals experiencing psychiatric distress.
- A recovery center in Riverhead, to help individuals living with psychiatric diagnosis to live, work and fully participate in their communities.

OMH and DOH are reinvesting $2.9 million associated with inpatient psychiatric reductions at Long Beach Medical Center and North Shore University Hospital, and a Pederson-Krag partial hospitalization program:

- Six mobile residential support teams to help with discharge and community residential support for high-risk individuals.
- Funding for additional mobile crisis team staff and transportation to increase its coverage hours to 10 a.m. to 11 p.m., seven days per week.
- A family advocate to work in the Emergency Room and child and adolescent inpatient units to provide support, crisis diversion, and service planning assistance.
- Six additional HCBS waiver slots.
- Three different programs to serve individuals who have not this been able to make use of existing treatment services.
- Peer counselor to provide outreach to high-risk individuals and, when needed, with the mobile crisis team, hospital diversion program, and in other crisis settings.
- Clinic treatment expansion for three Nassau County clinics:
  - North Shore Child and Family Guidance Center is developing a bi-lingual open-access children's urgent and emergency services unit, and a short -term intensive group therapy and parent psycho-educational support group.
  - Central Nassau Guidance and Counseling Services is developing an open access model of urgent psychiatric care focusing on stabilization to avoid emergency room and inpatient services.
  - Catholic Charities is providing comprehensive walk-in services combined with consumer advocate outreach services.

New York City:
Helping Individuals Develop the Skills They Need for Independence

Pathway Home

"If an adult with serious mental illness is discharged back into the community without being effectively connected to ambulatory care and treatment, they're at risk for being readmitted," said Barry Granek, Program Director of Pathway Home in New York City. "We believe this is avoidable and that people can stay in the community and out of the hospital with the right community based support."

Pathway Home is a program of Coordinated Behavioral Care that offers services in Brooklyn, Manhattan, Queens, and the Bronx for adults with serious mental illness. Its goal is to strengthen the system of care for those making the transition from institutional settings to a community setting — providing support and facilitating a smooth transition.

It started in October 2014 through a grant from the New York State Balancing Incentive Program. After the grant's initial 18 months, the program was picked up through Reinvestment funding. Since April 2016, the program has worked with 313 individuals, and some of the program's original 302 participants were continued into the new grant.

An Immediate Focus

Pathway Home teams are multi-disciplinary, staffed by masters-level clinicians, case managers, registered nurses, and peers. Teams follow the evidence-based practice of the critical time intervention model of care, engaging clients intensively during the first 30 days. The team will work clients until they have settled back into the community and are linked with the services they need. While every situation is unique, this takes about six to nine months on average.

"Because of our nature of being a short-term program, we're required right away to think about what we need to do to help prepare our clients to assume responsibility for their treatment, to be accountable for making appointments, managing medications, and to become productive in the community," Granek said. "It's always in the back of our minds that we will need to help this person develop the tools, skills, and the internal self-concept and motivation to do things for themselves."

Although it focuses mostly on discharges from state psychiatric centers or state operated community residences, teams can also be used as a bridge service for individuals being discharged from acute care hospitals as a way to provide more intensive support while a recipient is being engaged in outpatient clinic and other services.

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Reinvestment & Planning: NYC

OMH has made an annualized amount of $16 million available in this region. Investments include:

- 294 new supported housing units.
- 63 new HCBS waiver slots.
- Three state-operated MITs for adults and children across the city.
- Five transition in care teams focused on state psychiatric center and acute care discharges.
- A long-stay transition team operated by the Pathway Home.
- A crisis pilot program.

OMH and the New York State Department of Health are reinvesting $10.3 million associated with inpatient psychiatric reductions at Holliswood, Stony Lodge, and Mount Sinai hospitals.

Associated with Holliswood:

- 15 additional HCBS waiver slots for intensive home-based services for children.
- Crisis respite beds for short-term overnight respite of up to 21 days for children ages 4 to 18. This capacity in Queens and the Bronx from 16 to 21 beds.

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Building Trust

Barry Granek

"We pride ourselves in building relationships early on," Granek said. "Weeks, even months before hospital discharge, we introduce ourselves to the support network and develop a therapeutic rapport with the individuals, so that they'll feel more comfortable with us." Teams are involved in discharge planning and often offer suggestions to the inpatient teams on what a discharge plan should include

"Our services are designed to ensure a safe transition to more independent, less restrictive housing," Granek said. Teams will work with supportive housing partners to help them through the intake and placement process.

Teams will help with medication management and reconciliation support, substance use counseling, wellness self-management, linkages with community providers, skills-building and engagement, expediting housing placement, and collaborating with providers to assist clients in overcoming barriers to treatment and community living.

Teams then support individuals after discharge. "We'll help ensure that they have the supplies they need to live comfortably in their homes and stay out of the hospital," Granek said.

Pathway Home was one of two care transition programs in New York City to receive Reinvestment funding. OMH is also funding two teams through Parachute NYC. Both programs have become a critical part of addressing what had been missing in the crisis management system in the City.

Although run by different providers, the basic aim is similar – providing time-limited support in care transitions to prevent future crises, and the use of costly inpatient and psychiatric emergency services.

CBC
TRANSFORMING COMMUNITY HEALTHCARE

For more information on Pathway Home, visit CBC's website at: http://www.cbcare.org.

- Rapid access mobile crisis teams for short-term crisis response for children and adolescents up to age 17 in Brooklyn, Queens, Staten Island, and Manhattan. This adds a total of 4.5 new teams.
- Family advocates to work with children and families accessing services in community hospitals.
- Three family resource centers to strengthen parent and child relationships, and to promote healthy social and emotional development in children age five and under from high risk families in the Bronx and Harlem.
- High fidelity wraparound (HFW) is a youth-guided, family-driven program allowing youth and their family achieve treatment goals with assistance from their natural supports and system providers.
- Child specialist staff to assess and divert children from inpatient admissions and develop linkages to home-based crisis intervention and other intensive services in Queens.

Associated with Stony Lodge:

- An HBCI team to provide intensive crisis intervention for families whose children are at-risk of inpatient admission. These funds will be used to support the Bellevue HCBI team in Manhattan.
- Partial hospitalization and day treatment programs to serve as an alternative to inpatient hospitalization and provide intensive services for children. This funding will enable Bellevue Hospital to convert its existing 25-slot day treatment program to a 27-slot partial hospitalization program and retain nine slots for day treatment. The program is the only existing comprehensive psychiatric emergency program for children in New York City and receives referrals from all five boroughs.
- Family resource centers and HFW: A portion of the Stony Lodge Hospital resources will also support three family resource centers and wraparound services described above.

Associated with Mount Sinai Hospital:

- Partial hospitalization to serve as an alternative to inpatient hospitalization and provide intensive services for children.
- Five ACT teams, four of which serve 68 individuals each, and one that serves 48 individuals.
- Expanded respite services that stabilize individuals in the community rather than utilize hospital or long-term, out of home services.

Services funded in this region were determined through ongoing consultation with community stakeholders, including the New York City Department of Health and Mental Hygiene.

Southern Tier-Finger Lakes: Reaching Out to Local Youth Through OnTrackNY

Reinvestment is funding the expansion of the OnTrackNY program into Broome, Chenango, Delaware, Otsego, Tioga, and Tompkins counties.

A service of the Greater Binghamton Health Center, OnTrackNY-Southern Tier is located in a satellite clinic at the Community Treatment and Recovery Center across town. The program has received its operating certificate and is accepting its first referrals. There is already a waiting list.

"OnTrackNY is an innovative program for adolescents and young adults 16 to 30, who have recently started experiencing first-episode psychosis — such as experiencing unusual thoughts or behaviors or hearing or seeing things that others do not," said Karen Witbeck, GBHC Chief of Child and Adolescent Services.

The program is designed to provide early intervention. A multi-disciplinary team works with young people to identify and achieve their recovery goals and to help them with school, work, and relationships. Teams put an emphasis on a variety of supportive services, such as individual and family therapy, education and employment assistance, family education, and medication management and education.

"Patricia Deegan an American psychologist and mental health advocate, once said: 'The goal of recovery is not to become normal. The goal is to embrace the human vocation of becoming more deeply, more fully human,'" Witbeck said. "And that's the belief upon which our work is based."

"The job of the team is to engage the energy, youth, hope, promise, and human potential," she added. "We help participants move from passive recipients of care to people who actively collaborate with the team through shared decision."

The OnTrackNY-Southern Tier team. Back row, from left: Jennifer Martin,Team Leader/Primary Clinician; Patty LoVoulo RN; Dave Kudgus Supported Employment and Education Specialist; and Karen Witbeck, Chief of Service. Seated are, from left: Cheryl DeRosa, Outreach and Recruitment Coordinator/Primary Clinician; and Kristin Buono, NPP.

Offering inspiration at the clinic's entrance is the "Tree of Life," a universal symbol that represents humans as we develop roots, strengthen our trunks, and branch out to a wider vision of life as we grow.

OnTrackNY
My health. My choices. My future.

For information on OnTrackNY, visit: http://www.ontrackny.org.

Reinvestment & Planning: Southern Tier-Finger Lakes

OMH has made an annualized amount of $9.4 million available in this region. Investments include:

- 154 new supported housing units.
- 24 new HCBS waiver slots.
- A long-stay team. Expanding a community support program in Chemung County will help transition long stay individuals from Elmira PC into community settings through collaborative discharge planning and linkages to community supports.
- Eight children's crisis/respite beds on the grounds of Elmira PC.
- State-operated mobile integration teams operating out of hubs at Elmira PC and Greater Binghamton Health Center.
- Transportation supports for individuals and families accessing crisis or respite beds.
- Adult crisis transitional housing and the increased use of state-operated community residential services for crisis or respite.
- Expanding family and peer support services, including support for peer training and certification, and peer support services for adults utilizing state-operated crisis/respite services.
- Mental health clinical staff support to work with the Broome County Crisis Intervention Team forensic program to help prevent involvement in the criminal justice system and hospitalization.
- Respite services to stabilize individuals in the community rather than using hospital or long-term, out-of-home services.

Central NY:
Returning Long-Stay Inpatients to the Community

For most inpatients, a return to the community gives them the best opportunity for recovery. But making the transition can be tough.

In Central New York, the Hutchings Psychiatric Center Collaborative Transition Team is helping individuals make the transition by giving them the support services they need to succeed.

Lynn Chapman

"Institutional care can be an essential part of treatment, but the last thing some individuals need is for a short-term intervention to turn into a long stay or re-admission," said Lynn Chapman, Hutchings Deputy Director of Operations-Adult Services. "Some individuals may indeed be at-risk for this. So we've established this team to identify individuals who need support and make sure they get it."

The Collaborative Transition Team is operated in partnership with Central New York Services, Inc., a regional, private, not-for-profit that works with individuals and families affected by mental illness and substance abuse.

The multi-disciplinary team has two master social workers, one registered nurse, and one peer specialist. Team members are experienced mental health professionals who understand the complex symptoms of behavioral and medical issues, and how these factors relate to an individual's capability to live in a community setting. "This gives the team the capacity to address medical complexities, mediate risks related to behavioral concerns, and build trust so that an individual can make the transition gradually," Chapman said.

Building Skills for Living in the Community

Team members regularly attend inpatient meetings to identify individuals who may have had difficulty integrating into the community. Starting at the third month of admission, the team assesses whether an individual is in need for additional intervention at the facility. Then they start the engagement process, determining the individual's barriers to discharge and building their skills to help overcome them. The team works with Hutchings administration and service providers to plan, coordinate services, strategize, and manage any crises. "Their goal is to promote a positive working relationship that promotes successful integration and recovery," Chapman said.

After discharge, the team stays involved and continues to work with these individuals to help them integrate into the community. The team is available to work evenings and weekends to accommodate the needs of participants.

So far, the team is off to a good start. In just four months of operation, the team is already working with 16 individuals.

"The behavioral health industry landscape of service delivery is changing rapidly," Chapman said. "So it's crucial that behavioral health providers ensure that we're providing rapid access to high quality, comprehensive services that support resiliency, recovery, and help individuals to live independently again."

Reinvestment & Planning: Central NY

OMH has made available an annualized amount of $2.8 million. Investments include:

- 28 new supported housing units.
- 18 new HCBS waiver slots.
- Six children's crisis/respite beds on the grounds of Hutchings PC.
- A state-operated first episode psychosis team under the OnTrackNY initiative.
- A long-stay team. This long stay reduction transition team operates out of Onondaga County and helps transition long stay individuals from Hutchings PC into community settings through collaborative discharge planning and linkages to community supports.

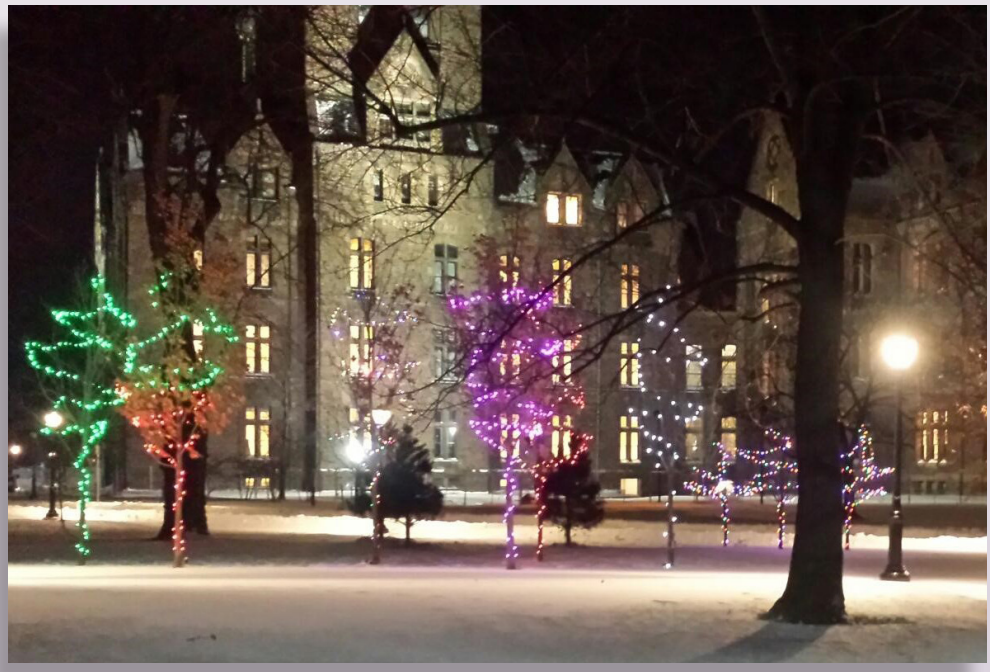
For more information on Central New York Services, visit: http://www.cnyservices.org.

Western NY:
Expanding Community-Based Mental Health Resources

Children who are experiencing serious emotional disturbance do best when they remain with their families and in their own schools, supported by appropriate services.

This is why OMH is focusing on expanding the availability of community-based mental health resources that will enable families to participate in their children's care.

OMH has pre-invested more than $1.7 million in anticipated savings into child and family services in Western New York – allowing more than 1,000 additional children and families to have access to care.



The historic Richardson Building, site of a new commercial and hotel complex that will be adjacent to the new children's facility. Lights were installed by Buffalo PC electrician Darrell Opiela, who also took this photo.

Best Use of Funds

A key part of this plan is to relocate children and youth services from the Western New York Children's Psychiatric Center (WNYCPC) in suburban West Seneca to a new facility on the Buffalo Psychiatric Center campus.

In order to maintain operations in the WNYCPC building over a longer time span, more than $40 million in capital projects would be needed.

OMH is responsible for using its funding efficiently. Reutilizing an already a significantly renovated building on the Buffalo PC campus is the most prudent option.

New, Secure Facility for Youth

Separate from the adult facilities, the new center at the Buffalo campus has been carefully designed for youth, with extensive outdoor and indoor recreation space. There will also be completely separate inpatient space, with separate elevators, entrances, and parking areas.

There will be no layoffs as a result of the relocation. The same high-quality services will continue to be provided by the same clinical staff, and facility will retain the same number of inpatient beds.

"OMH understands that the move has been a cause for concern among some families and advocates," said OMH Commissioner Dr. Ann Sullivan. "So every precaution is being taken to protect the safety of patients. There will be no sex offenders at the Buffalo campus when the children's building is ready to open in 2019, and no mixing of children and adults on the campus. This is consistent with the other OMH campuses that operate both children and adult services."

Relocation to Buffalo will be beneficial because the largest share of admissions to WNYCPC are from the city.

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Reinvestment & Planning: Western NY

OMH has made an annualized amount of $5.6 million available in this region. Investments include:

- 108 new supported housing units.
- 24 new HCBS waiver slots.
- State-operated MITs for children and youth.
- A state-operated MIT for adults.
- A long-stay team. This community integration team in Erie County will help transition long-stay individuals from Buffalo PC into community settings through collaborative discharge planning and linkages to community supports.
- State-operated children's outpatient clinic expansion.
- An expanded state-operated mobile mental health-juvenile justice team.
- Mobile transitional supports.
- Crisis intervention team.

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The new Children's Center on the Buffalo PC campus will be located in a hub of recreational, cultural, and educational activity.

"These children would be closer to their families, and families would have more opportunity to participate in their child's education, treatment, meals, and bedtime routines," Commissioner Sullivan said. "The children will also be closer to their community providers, their schools, referring hospital and support systems."

This plan will also bring youth closer to the Albright-Knox and Burchfield-Penney art galleries, Delaware Park, the Buffalo History Museum, and the Buffalo Zoo. The Buffalo PC even has a broadcast studio that will allow kids to produce their own news and entertainment shows and learn all about video production and editing.

Families not from Buffalo will have greater access to accommodations and public transportation systems than are currently available in West Seneca.

Designed with the Help of the Community

Regional mental health providers, advocates, state and local elected officials, and community leaders played an important role in designing this expansion of services. OMH executive staff, including the Commissioner, have traveled to Western New York multiple times since 2014 to seek public input firsthand. OMH held two public forums in Buffalo in September 2015 that were attended by approximately 90 people. OMH also created a website for the public to provide comments on the capital plans.

Once completed, reinvestment will total $3.2 million, enabling OMH to provide services to an additional 1,000 children who would not have otherwise had access. Remaining reinvestment funds after relocation will be used to create a crisis/respite residence, additional mobile treatment and supports, and intensive in-home services.

"These changes under the Transformation Plan will allow us to maintain the same high-quality inpatient care while greatly expanding services to more children and families," Commissioner Sullivan said. "This is truly the best situation for everyone."

- Peer respite center hospital diversion program. These peer-run respite centers provide recovery-based alternatives for adult consumers. The centers' services are designed to enhance engagement in community service supports, help maximize community tenure and avoid inpatient hospitalizations.

OMH and the New York State Department of Health (DOH) are reinvesting $1.1 million associated with inpatient psychiatric reductions at Medina Memorial Hospital and St. James Mercy Hospital in Hornell:

- Funding for enhanced mobile crisis outreach.
- Intensive intervention services.
- Post-jail transition coordination.
- Home Based Crisis Intervention (HBCI) program.

Reinvestment & Planning: Hudson River, North Country, and Rochester Regions

Hudson River:

OMH has made an annualized amount of $8.7 million available in this region. Investments include:

- 177 new supported housing units.
- 12 new HCBS waiver slots.
- A state-operated MIT for adults, serving the Capital District PC service area.
- A state-operated MIT for adults, serving the Rockland PC service area.
- Six long-stay teams.These outreach teams will help long-stay individuals from transition into community settings through collaborative discharge planning and linkages to community supports. Teams in Albany and Schenectady counties will work with long-stays discharged from Capital District PC and teams in Dutchess, Orange, Rockland, and Westchester counties will work with long -stays discharged from Rockland PC.
- A self-help program offering short-term care and interventions in response to a behavioral health crisis event that creates an imminent risk for an escalation of symptoms without supports.
- Outreach programs to help locate and secure housing of a service recipient's choice and to access the supports necessary to live successfully in the community.
- Advocacy and support services to help assist consumers in protecting and promoting their rights, resolving complaints and grievances, and accessing services and supports of their choice.
- Mobile crisis intervention programs to provide the clinical intervention and support necessary to successfully maintain children in home or community-based settings and prevent inpatient hospitalizations.
- ACT teams to deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings rather than in hospital or clinic settings.
- Adult outreach services to engage and access individuals potentially in need of mental health services.
- Children's crisis intervention/mobile mental health team to provide clinical interventions and supports to successfully maintain children in home or community-based settings and prevent inpatient hospitalization.

OMH and DOH are reinvesting $4.6 million associated with inpatient psychiatric reductions at the Stony Lodge Children's Psychiatric Hospital and the intermediate care Hospital at Rye:

- Respite services to stabilize individuals in the community rather than utilize hospital or long-term, out-of-home services.
- HBCI services to provide intensive in-home crisis services to children ages 5 to 17.
- Mobile crisis intervention to prevent or limit inpatient hospitalization or emergency room use for adults, adolescents, and children experiencing acute symptoms.
- 18 additional HCBS waiver slots.
- Supported housing and community supports to enable people to live independently and reduce the utilization of more costly Medicaid services.
- Children and youth family support to provide core services of family/peer support, respite, advocacy and skill building, and educational opportunities.
- Self-help program. A peer-operated alternative to hospitalization that provides supports to individuals in crisis or emotional distress.

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North Country:

OMH has made an annualized amount of $4.2 million available in this region. Investments include:

- 53 supported housing units.
- 12 HCBS waiver slots.
- Six children's crisis/respite beds on the grounds of St. Lawrence PC.
- A state-operated MIT for children and adults.
- A state-operated children's outpatient clinic expansion.
- Outreach and support services in Clinton, Essex, Franklin and Lewis counties, connecting individuals to community-based services, offering quicker access to mental health services and supporting peer engagement in the recovery process.
- A self-help program to connect adults to community mental health services, offer short-term emergency housing, and provide other incidental services to support recovery.
- Enhanced crisis outreach/respite programs. Expanding capacity, after-hour services, and increasing support staff to expand existing mobile crisis and crisis intervention programs in Essex, Franklin and St. Lawrence counties.
- Forensic program expansion to support local jail discharge planning for individuals with serious mental illness and reduce recidivism among this population.
- Crisis intervention team training will also be administered to help prevent future criminal justice involvement and to promote successful community tenure maintenance.

Rochester Area:

OMH has made an annualized amount of $6.3 million available in this region. Investments include:

- 113 new supported housing units.
- A state-operated MIT for adults.
- A state-operated first break psychosis team.
- A state-operated adult outpatient clinic expansion.
- A long-stay team. Expanding a community support program in Chemung County will help transition long-stay individuals from Elmira PC into community settings through collaborative discharge planning and linkages to community supports.
- Community support teams for individuals in supported housing. These teams meet the complex needs of individuals who move directly into supported housing after discharge from Article 28 hospitals and the Rochester Psychiatric Center.
- Peer-run respite diversion, providing an alternative to emergency room service or inpatient admission for individuals experiencing a psychiatric crisis.
- Adult crisis transitional housing, providing short-term crisis transitional housing following a psychiatric hospitalization.
- Two ACT teams to deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their homes rather than in hospitals or clinics.
- Peer bridger program, working with individuals transitioning from psychiatric inpatient units into supported housing.
- Enhanced recovery supports to expand existing peer-operated programs in Wyoming County.

OMH News

OMH News **is produced by the OMH Public Information Office for people served by, working, involved, or interested in New York State's mental health programs. Contact us at: omhnews@omh.ny.gov.**