



Office of
Mental Health



Statewide Comprehensive Plan 2016-2020

2017 Interim Report to the Statewide Comprehensive Plan



Office of
Mental Health

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Introduction from OMH Commissioner Dr. Ann Marie T. Sullivan

New York State’s public mental health system continues to undergo a significant transformation, changing the way that New Yorkers of all ages access services, find hope, and realize recovery from mental illness. 2017 marked the fourth year of the Office of Mental Health’s (OMH) Transformation Plan and the seventh year of New York’s Medicaid Redesign program, both of which have helped drive a comprehensive vision of a future where health is promoted, disability is prevented and illness is treated with person centered, clinically effective interventions. As this report shows, OMH is driving the ongoing evolution of the healthcare safety net and the development of innovative new services for New Yorkers in need.

The 2017 Interim Report to the OMH Statewide Comprehensive Plan contains valuable new data from the Master Provider Directory (CONCERTS), additional data on New York’s forensic mental health system, and helpful information on Integrated Services Sites across New York State. Notably, the 2017 Interim Report contains a new chapter detailing OMH’s progress in rebalancing institutional resources to develop and enhance community-based mental health services in New York State via the OMH Transformation Plan. Through the reinvestment of over \$100 million annually, OMH is supporting eleven critical community-based service areas with savings from state and community inpatient programs. As evidenced in this report, these new services are

effectively promoting the coordination of care and the integration of a recovery-centered service delivery system to help the public mental health system achieve the “Triple Aim” of better care, better health and better lives for those whom we serve at lower costs.

While the 2017 Interim Report provides a good snapshot of where we’ve been and where we are, OMH is currently working on a comprehensive strategic plan to better determine where we are going. To better align agency resources and efforts with our broader mission, vision and values, OMH has determined nine major goal areas to focus on over the next several years. The following goals will serve as a roadmap for the agency’s future activities:

- Transform Mental Health Systems to Make Community-Based Recovery a Reality
- Promote Children’s Mental Health and Access to Services and Prevent the Incidence of Disorders
- Expand Early and Preventive Interventions Statewide
- Provide Housing for All Mentally Ill Individuals in Need
- Improve Safety, Reentry, and Recovery for High-Risk Individuals with Serious Mental Illness
- Developing the Public Mental Health and Health Care Workforce

- Mental Health Promotion, Awareness, and Social Inclusion
- Advance Research, Research-to-Practice and Evidence-Based Practices
- Develop and Advance Information Technology Infrastructure and Information Management Capabilities

In anticipation of our future actions, OMH is envisioning a new, centralized internal structure to advance the clinical and programmatic quality of care and expand the coordination between prevention, primary care, and behavioral health throughout New York State. To better address the social determinants of behavioral health, OMH will leverage the broad expertise within our agency and cut across divisions to drive breakthroughs in social inclusion and economic parity, develop new approaches for care and best practices, improve behavioral health outcomes through performance measurement, and support the efforts of our employees and stakeholders to maximize value for our consumers and save taxpayer dollars.

In addition to the topical areas covered within this interim report, OMH plans to provide updates regarding other key agency initiatives in future reports, including:

- The ongoing development of Medicaid behavioral health services, such as Health and Recovery Plans (HARP), Health Homes, and Home and Community-Based Services.
- The integration of physical and behavioral health services through Behavioral Health Care Collaboratives, in preparation for the transition to a value-based care business model.

- The expansion of forensic services to both improve care for justice-involved individuals with mental illness, strengthen the overall forensic mental health service system, and develop comprehensive community-based services to divert individuals with mental illness from the criminal justice system, when appropriate.

It is our hope that these new plans and structures will enable OMH to achieve significant milestones, institute meaningful performance measurements, and hold our agency and our stakeholders accountable. They will require regular updates, revisions and improvements as our efforts move forward. Your involvement and the input of consumers, families, providers and other stakeholders is crucial to meeting these goals and to the overall success of New York's mental health system.

I look forward to working with you as we continue our efforts to promote the behavioral health of all New Yorkers.

Ann Marie T. Sullivan, MD
Commissioner

Chapter 1

The New York State Public Mental Health System

Chapter 1 is an overview of the New York State public mental health system. It describes individuals receiving services in the system by their demographic characteristics, severity of diagnoses, incidence of co-occurring disorders, employment status, and where they receive services. This chapter also reviews the programmatic footprint of all OMH operated and regulated programs, and a summary of State mental health expenditures.

Section 1

People Served: Estimated Number of Individuals Served

The characteristics of adults and children served in New York's public mental health system are described here using data from the OMH Patient Characteristics Survey (PCS). OMH conducts the PCS during a one-week period on a biennial basis to gather clinical and demographic information for people who receive mental health services from programs the agency operates, funds or licenses. The most recent PCS includes over 200,000 survey submissions by programs providing direct services during a one-week period in October 2015. Unless otherwise indicated, all data presented is annualized data from the 2015 PCS.

OMH estimates the number of people served annually in the public mental health system using data from the PCS. Annual estimates are prepared using a statistical methodology developed at the Nathan Kline Institute for Psychiatric Research. Annual estimates are valuable for local and State-level decision making, and for directing the development of policy in the areas of planning, service delivery, resource management, finance, evaluation and ongoing monitoring.

In 2015, an estimated 772,000 individuals were served in the New York State public mental health system. This estimate is a significant increase from those based on prior PCS surveys, which estimated annual service numbers of 729,000 in 2013 and 717,000 in 2011.

What is the Public Mental Health System?

OMH uses the term “public mental health system” to refer to all mental health programs that are licensed, regulated, operated, funded, or approved by OMH. What this definition excludes are programs and services operated outside of OMH authority, including federally-operated programs, private practices, and primary care settings that provide mental health services (such as Federally Qualified Health Centers and DOH licensed primary care clinics). While many such programs provide mental health services, they do not fall within the direct purview of OMH unless they are otherwise jointly authorized or funded by OMH.

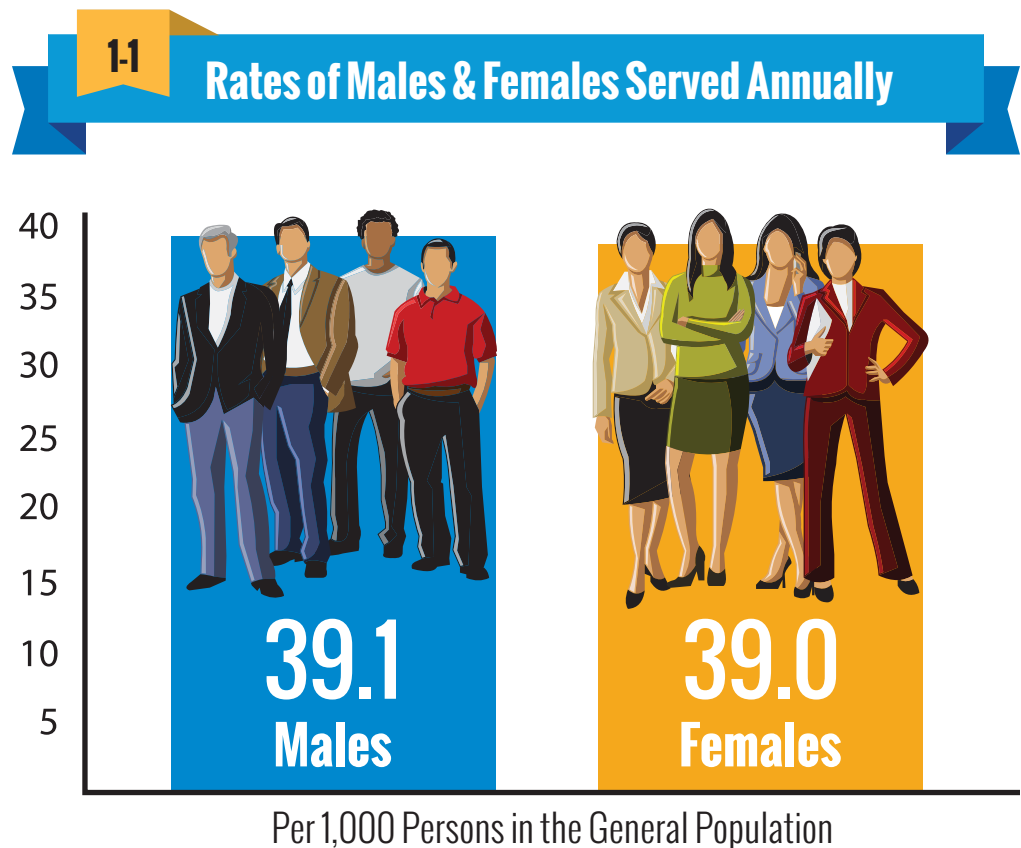
What Are Annualized Estimates?

The PCS collects information on consumers of mental health services for a one-week period and standard PCS reporting provides counts of individuals for this one-week timeframe. OMH recognizes the utility of having some of these weekly numbers “annualized”. Hence, OMH employs an annualizing algorithm developed at the Nathan Kline Institute (Laska, Meisner, Wanderling, Siegel, Statistics in Medicine, 2003; 22:3403–3417) to estimate the number served annually from these weekly numbers. Each point estimate has a range of uncertainty referred to as a “confidence interval”. Confidence intervals are disproportionately larger when the number of persons in the interest group is relatively small. For simplicity, only the point estimates are presented here.

Analysis of Medicaid data suggests that the number of people served in the public mental health system may be higher than what is captured by the PCS data. Possible reasons for this data limitation include the one-week survey period, and individuals served before or after the survey period not being captured in the data. Another explanation is that not all individuals who receive mental health services access them in primary mental health settings, and instead may be receiving them in primary care settings. Finally, there are people in need of mental health services that have not engaged in them and are not captured in the PCS data. Therefore, the annualized number of people served reported in this chapter represents a subset of individuals in need of and/or accessing mental health services.

Sex and Gender Identity

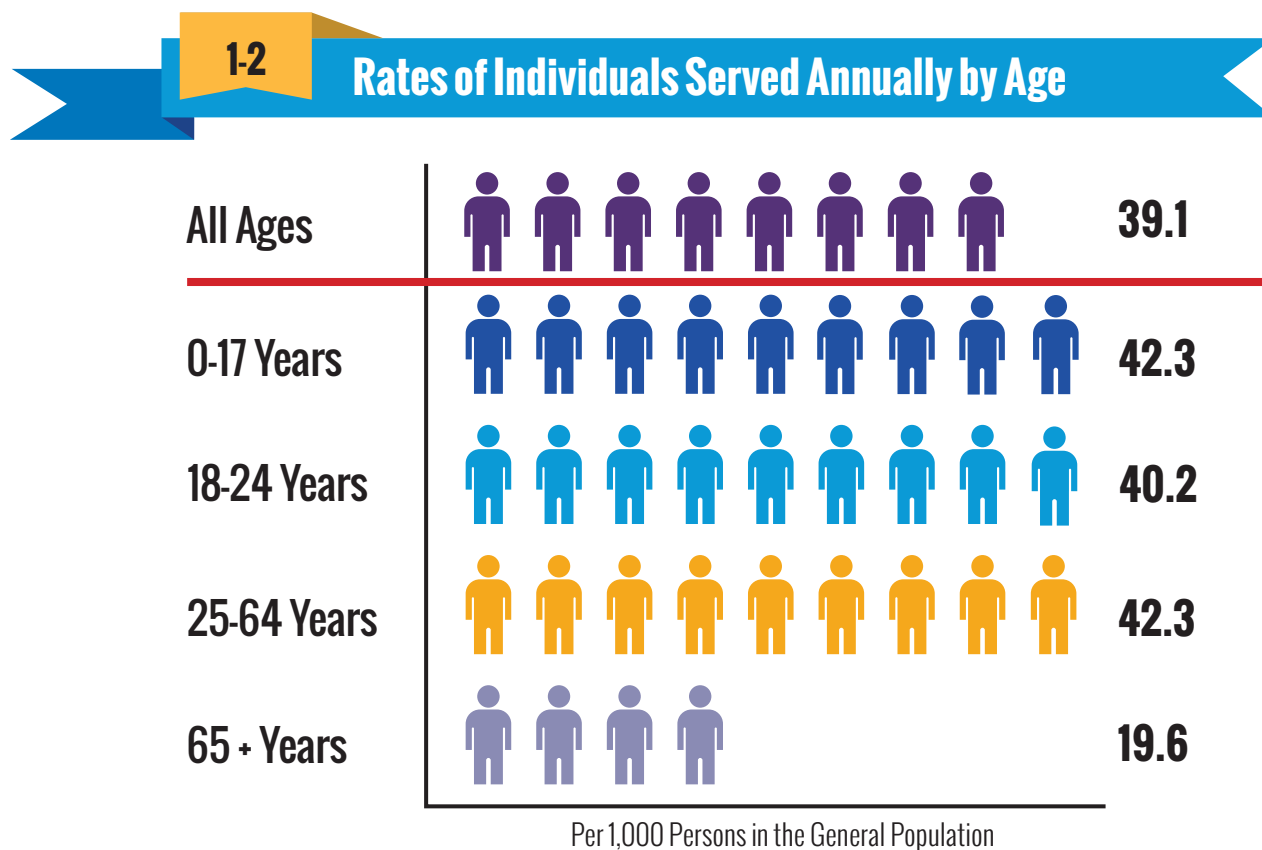
Figure 1-1 describes the sex of persons served in the public mental health system. Overall, males were served at a rate of 39.1 per 1,000 males in the general population, and females at a similar rate of 39.0 per 1,000 females in the general population. In an effort to more accurately capture data on gender identity, OMH included additional measures in the 2015 PCS to identify the number of transgender individuals who are served. OMH will make these data available in the near future.



Age

The age distribution of individuals served per 1,000 persons in that age group in the general population is displayed in Figure 1-2. The highest annual rate of service utilization is among individuals 25 to 64 years of age (42.3 per 1,000). In comparison, the rate of service utilization is lowest for adults ages 65 and older (19.6

per 1,000). This lower service rate may be related in part to older individuals receiving services in primary care and long-term care settings when they present with signs of mental disorders, rather than receiving services in primary mental health settings.¹



Race & Ethnicity

Figure 1-3 presents the race and ethnic distribution of people served per 1,000 persons of that race or ethnicity in the general population. By race, the highest annual rate of service utilization is among Black/African Americans (52.8 per 1,000), followed by Pacific Islanders (51.6 per 1,000), Multi-Racial (36.0 per 1,000), Whites (29.5 per 1,000), Native American/Alaskan (22.2 per 1,000) and Asians (9.1 per 1,000). Among those identifying as Hispanic/Latino², the rate is 47.8 per 1,000.

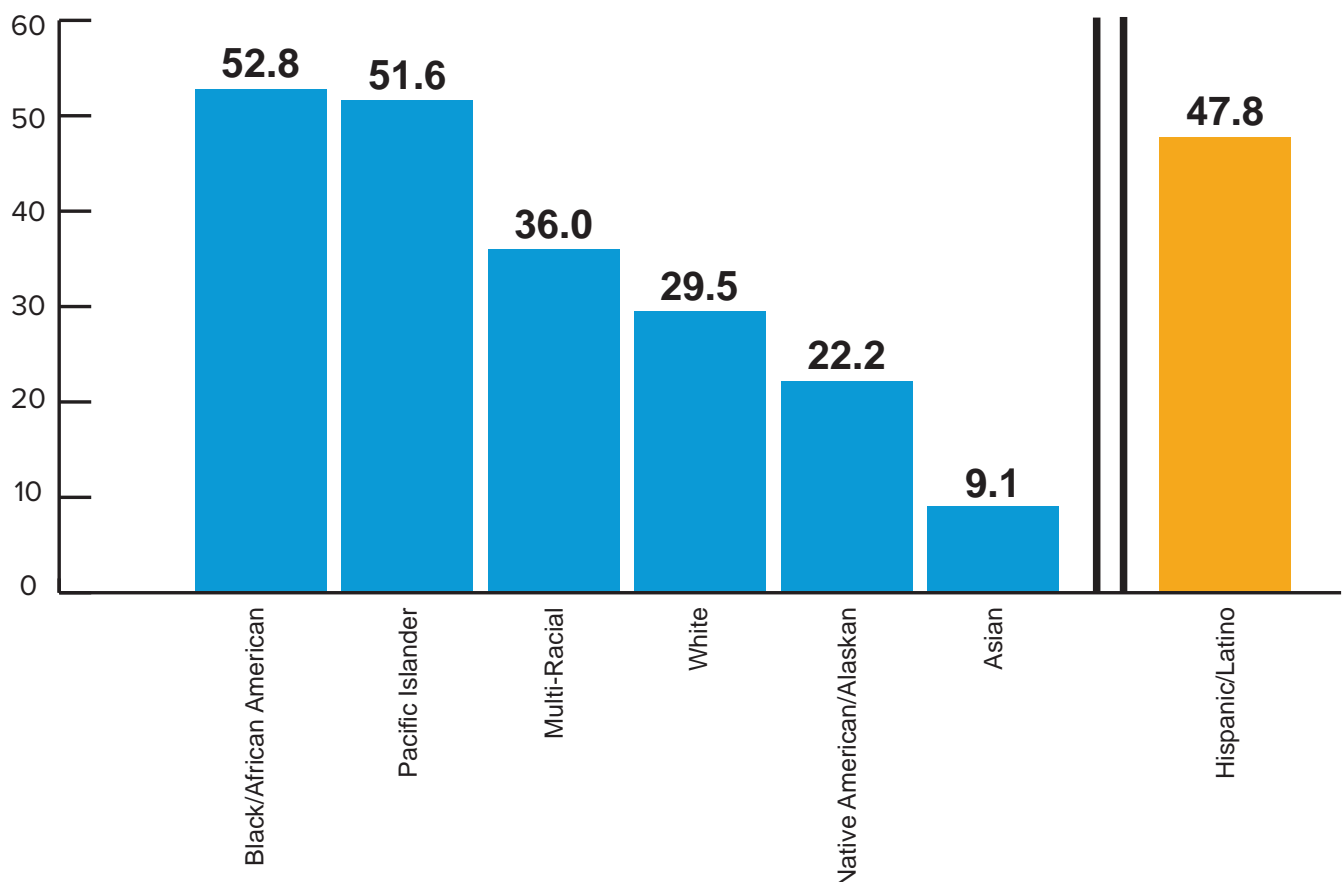
Rates of service by race should be read with some caution due to the small size of some racial groups in the general population and fluctuations in these rates

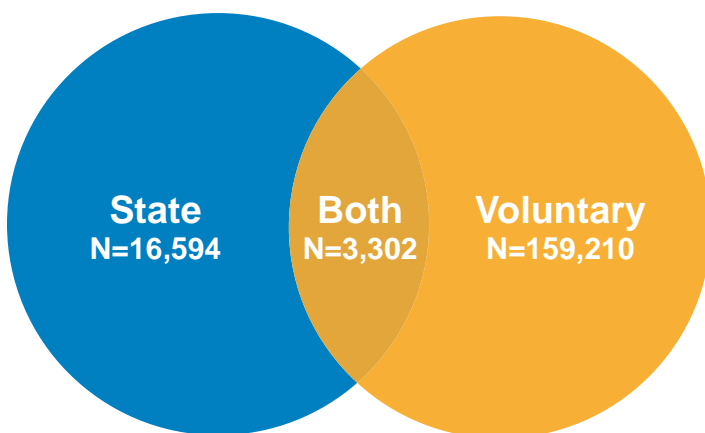
identified through analyses of past PCS populations. However, since rates for most racial groups (e.g., White, Asian, and Black/African American) and for Hispanic/Latino ethnicity have been relatively stable across multiple PCS collection years, there do appear to be real differences in rates of service between racial groups.

Differences in service rates may be explained in ways that are both directly and indirectly related to race and ethnicity, including factors that influence access to public mental health services rather than settings such as primary care and private practices. These factors may include insurance type (private, public, or uninsured), language access, and cultural differences.

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Rates of Individuals Served Annually by Race & Ethnicity



1-4**Number of People Served in the Public Health System by Auspice**

percent) of persons utilizing State-operated programs. Outpatient programs include major program types such as clinic, Personalized Recovery-Oriented System (PROS), and Assertive Community Treatment (ACT).

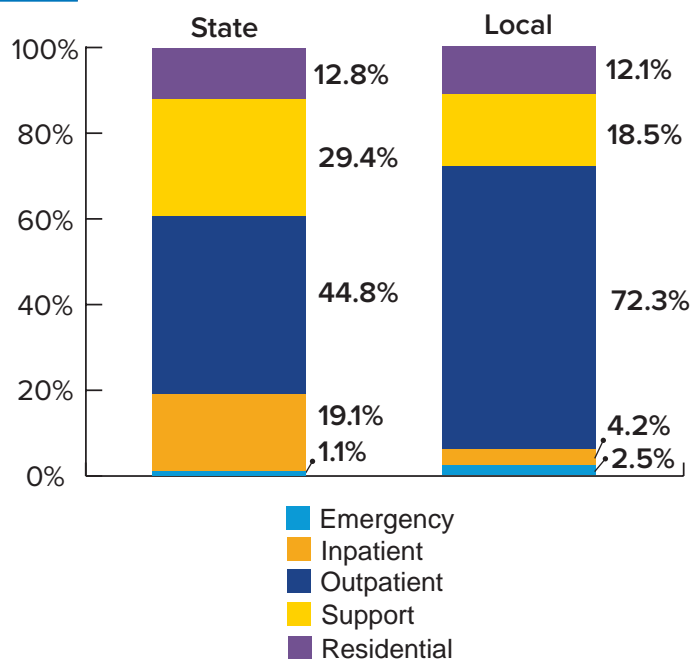
The percentage of people in the State-operated sector utilizing inpatient programs (19.1 percent) is far greater than the percentage of persons in the voluntary sector utilizing these programs (4.2 percent). Finally, 29.4 percent of people served in the State-operated sector receive support services compared to 18.5 percent of persons utilizing services in the voluntary sector. This signifies a newer trend in the growth of State-operated share of support programs which has occurred since the last PCS survey, and appears to be largely due to increases in State-operated forensic transition services and Mobile Integration Teams, which together served thousands of new individuals in 2015.³

Services by Program Auspice

Figures 1-4 and 1-5 show the distribution of access to services in the State-operated and voluntary service sectors during the 2015 PCS one-week survey period. As shown in Figure 1-4, State-operated programs account for approximately one-tenth of individuals served in the public mental health system, while voluntary programs (including county-operated) account for the vast majority of utilization of public mental health services statewide. As indicated in Figure 1-4, there is a small degree of overlap in program auspice access, indicating individuals who received services in both State-operated and voluntary programs.

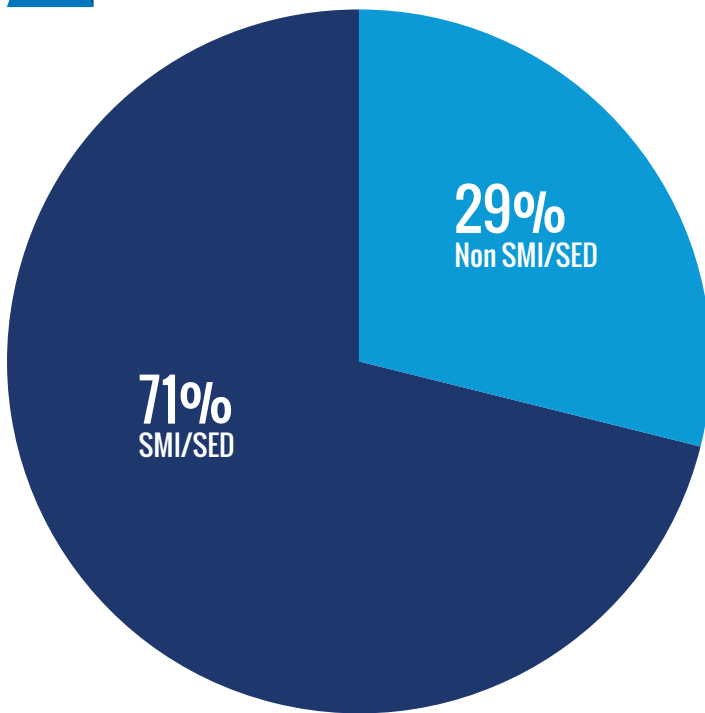
Figure 1-5 compares the percentages of people served by program type in the State-operated and voluntary service sectors. Individuals may access more than one type of service within a sector.

While the State-operated and voluntary service sectors have similar percentages of people accessing emergency and residential program services, there are substantial differences in the utilization of inpatient, outpatient, and support services between the sectors. For example, nearly three quarters (72.3 percent) of people utilizing voluntary-operated programs are in outpatient programs compared to less than half (44.8

1-5**Percentage of People Served by Auspice & Program Category**

1-6

Percentage of People Served with Serious Mental Illness and Serious Emotional Disturbance



Severity of Diagnosis: Serious Emotional Disturbance and Serious Mental Illness

Many adults and children served in the New York State public mental health system are engaged in services because they experience symptoms that impede their ability to function day-to-day. Serious mental illness (SMI) occurs in individuals diagnosed with mental illness who experience significant impairment in functioning. Serious emotional disturbance (SED) in children is characterized by a diagnosable mental disorder and impairment that substantially limits their functioning in school, family or community activities.⁴

By applying prevalence rates supplied by the U.S. Department of Health and Human Services to the State's population, it is estimated that there are approximately 264,000 children and youth (ages 9 to 17) with SED and 865,000 adults with SMI in New

York State.⁵ SED is not estimated for children under nine years of age. Based on annualized PCS data, it is estimated that 71 percent (N=550,424) of individuals who received services in the public mental health system have SMI or SED (Figure 1-6).

It is important to note that actual prevalence levels may not be wholly consistent with estimates derived by applying a standard rate to whole populations, and there may also be differences in rates and actual prevalence by region.⁶ Additionally, the estimated number of individuals with mental illness receiving care in the public mental health system may be underestimated because not all individuals receiving care would be captured during the PCS one-week survey period. Finally, individuals who receive mental health services in primary care or other settings not considered part of the public mental health system are not included in these analyses.

Estimated Percentage of SMI/SED Population Served by Auspice

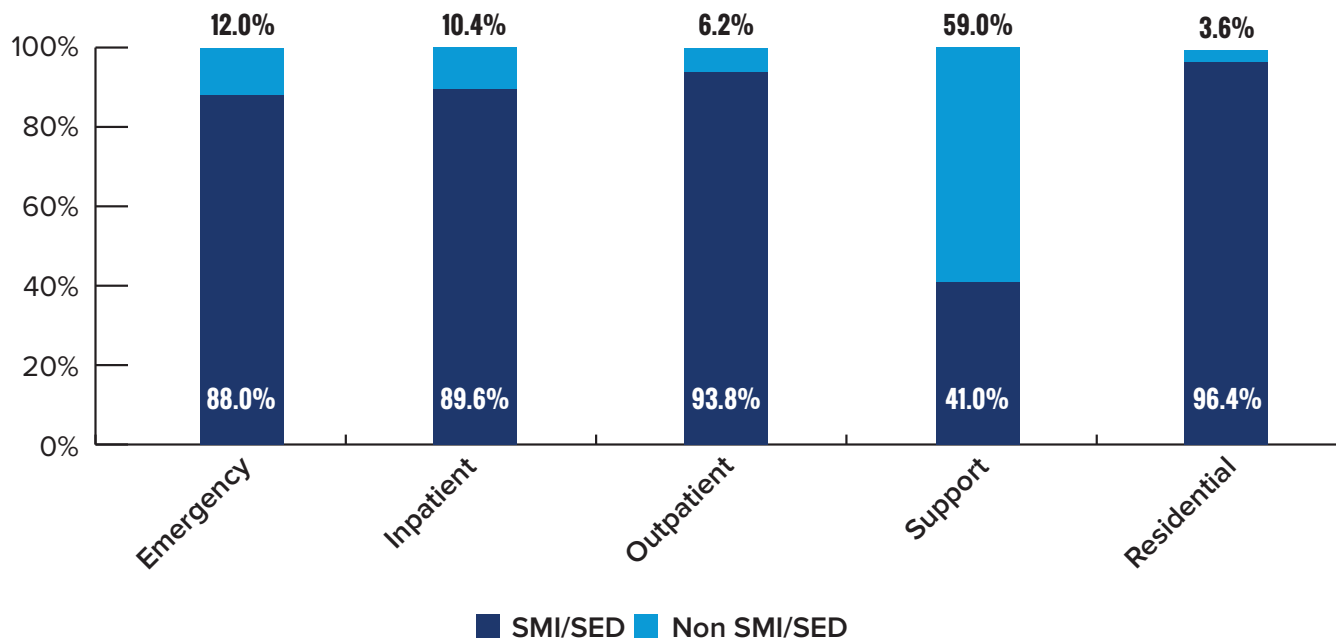
Figures 1-7 and 1-8 describe the percentages of people with SMI/SED served by program type in the State-operated and voluntary service sectors. In State-operated settings (Figure 1-7), the majority of clients served are part of the SMI/SED population, with the exception of those served by support programs (41 percent).

In voluntary-operated settings (Figure 1-8), the percentages of persons with SMI/SED served in inpatient and residential programs are similar to those served in these program types in State-operated settings.

Voluntary-operated emergency and outpatient programs tend to serve a lower percentage of SMI/SED individuals compared to these program types in State-operated settings while voluntary support programs serve a significantly higher percentage of persons with SMI/SED (68 percent) than do State-operated support programs (41 percent).

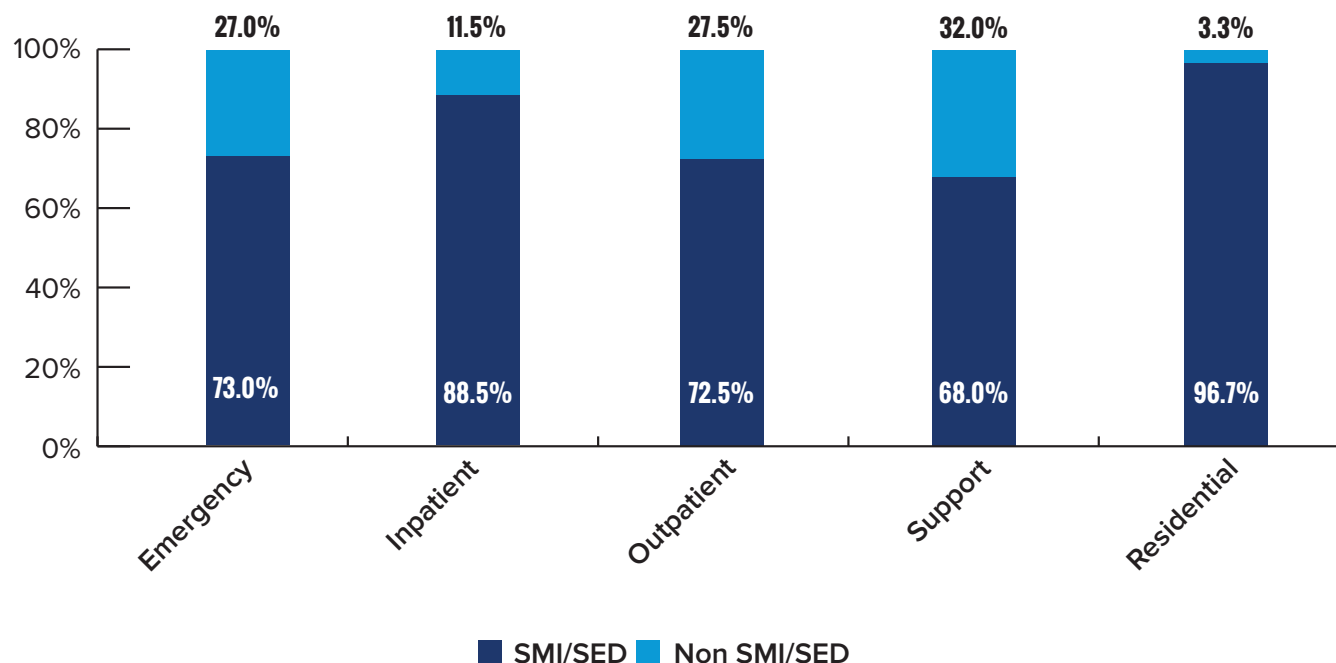
1-7

Percentage of Persons with SMI/SED Served in State-Operated Settings



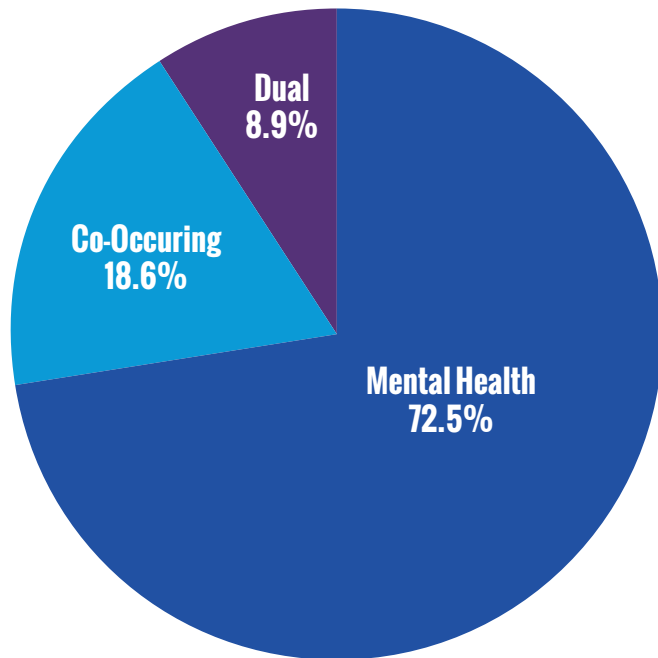
1-8

Percentage of Persons with SMI/SED Served in Voluntary-Operated Settings



1-9

Statewide Distribution of Co-Occurring and Dual Diagnoses



Other Diagnoses of Individuals Served: Co-Occurring Disorders & Dual Diagnoses

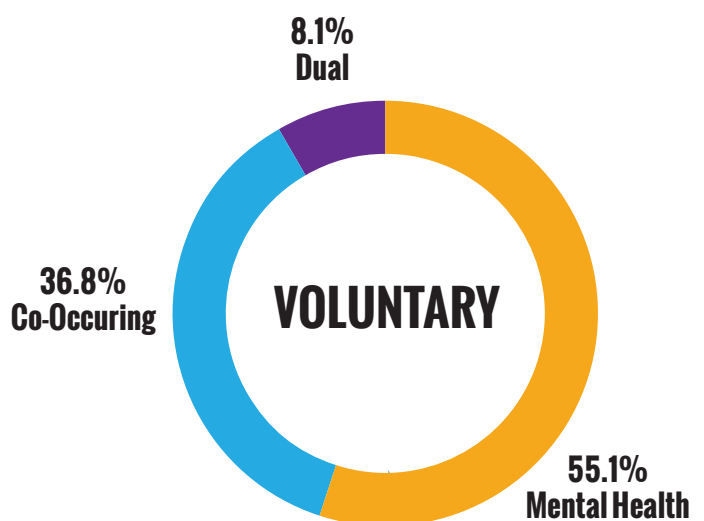
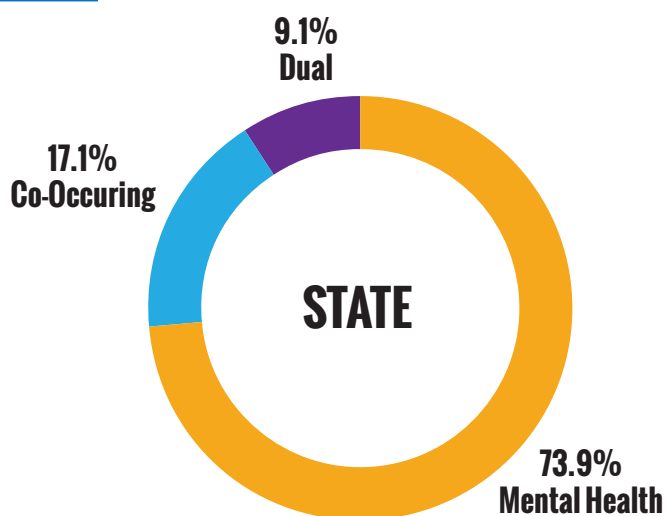
Mental health diagnoses do not exist independently of other diagnoses that service recipients may have. Approximately 28 percent of individuals served in the public mental health system have a *co-occurring diagnosis* of mental health and substance use disorder or a *dual diagnosis* of mental health and developmental disability (Figure 1-9).

Figure 1-10 describes where service recipients with co-occurring or dual diagnoses are treated in the public mental health system by auspice. State-operated and voluntary settings treat similar percentages of individuals with a dual diagnosis of mental health and developmental disability.

However, the percentage of people in the voluntary sector with a co-occurring diagnosis of mental health and substance use disorder (36.8 percent) is more than twice the percentage in the State-operated sector (17.1 percent). In contrast, the percentage of service recipients in the State-operated sector with a mental health diagnosis only is substantially larger (73.9 percent) than the percentage in the voluntary sector (55.1 percent).

1-10

Distribution of Treated Co-Occurring and Dual Diagnoses by Auspice



Thousands of individuals receiving services in the public mental health system have a co-occurring diagnosis of substance use disorder and/or a dual diagnosis of developmental disability. The data presented here support the continuation of collaborative, interdisciplinary efforts across New York State Department of Mental Hygiene agencies; a theme that is also strongly communicated through the local services plans developed by local governmental units.

Employment Status

Mental health and mental wellness models emphasize recovery-oriented treatment that supports opportunities for individuals with mental illness to transition from inpatient mental health settings, and return to and thrive in their communities. Employment in the community is a key component of recovery. Individuals with severe mental illness who hold competitive jobs for an extended period of time frequently experience a

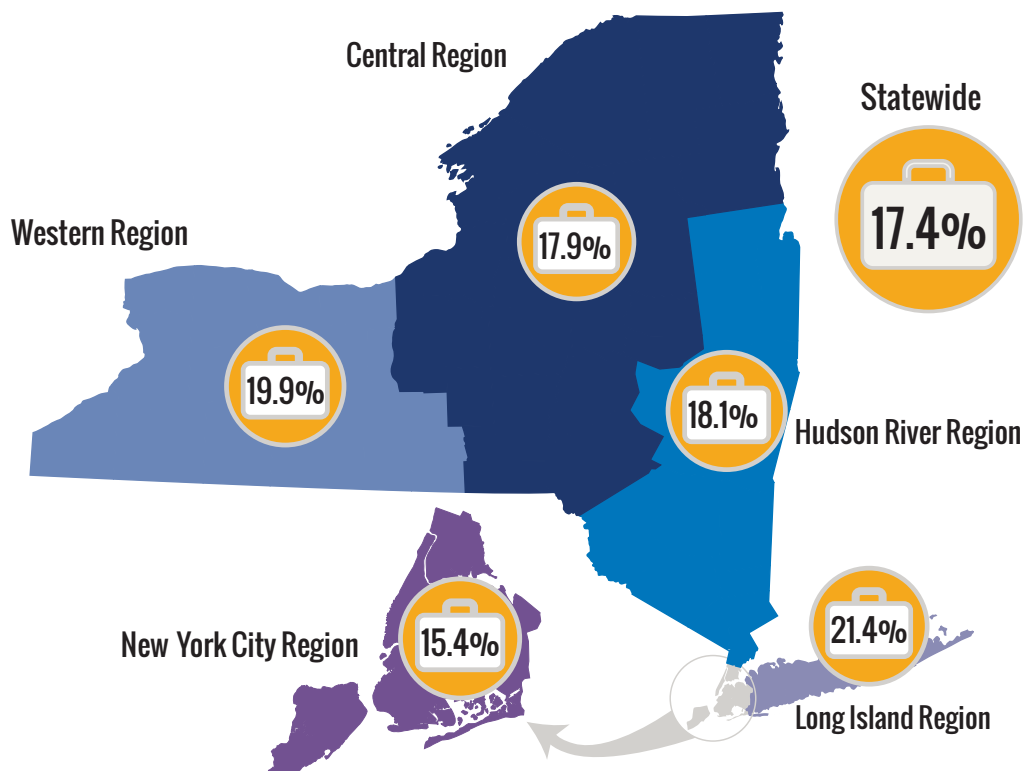
number of benefits, including improvements in their self-esteem and symptom control.

In New York State, approximately 535,000 individuals 18–64 years of age received services in the public mental health system, and 93,000 of them (17.4 percent) were competitively employed. This competitive employment rate has remained relatively steady over the years, with only small amounts of growth over time.

Figure 1-11 shows the New York State regional competitive employment rates for adults receiving services in the public mental health system. Competitive employment rates range from a low of 15.4 percent in New York City to a high of 21.4 percent in the Long Island region. By continuing to expand recovery-oriented services and confronting stigma, OMH is optimistic that a greater amount of progress will be made in coming years to increase rates of competitive employment among adults with mental illness.

1-11

Competitive Employment Rates among Adults Receiving Services in the NYS Public Health System



Section 2

The Office of Mental Health and the Statewide Public Mental Health System

The OMH mission is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbance. In order to promote this mission, OMH has a role as the State's lead mental health authority in managing, regulating, and funding the public mental health services, and directly operating services. Two other primary lines of business of the agency are to advance research and to promote overall prevention of mental illness.

As a regulatory agency, OMH maintains oversight of over 4,500 State, voluntary, and county-operated mental health service and support programs. Pursuant to Article 31 of the NYS Mental Hygiene Law, the Commissioner of the Office of Mental Health has the authority and responsibility to set standards for the quality and adequacy of facilities and programs that provide services for the treatment and recovery of persons diagnosed with mental illness. The standards governing the operation of facilities and programs are contained in various sections of Title 14 of the Codes, Rules, and Regulations of the State of New York or the 14 NYCRR.

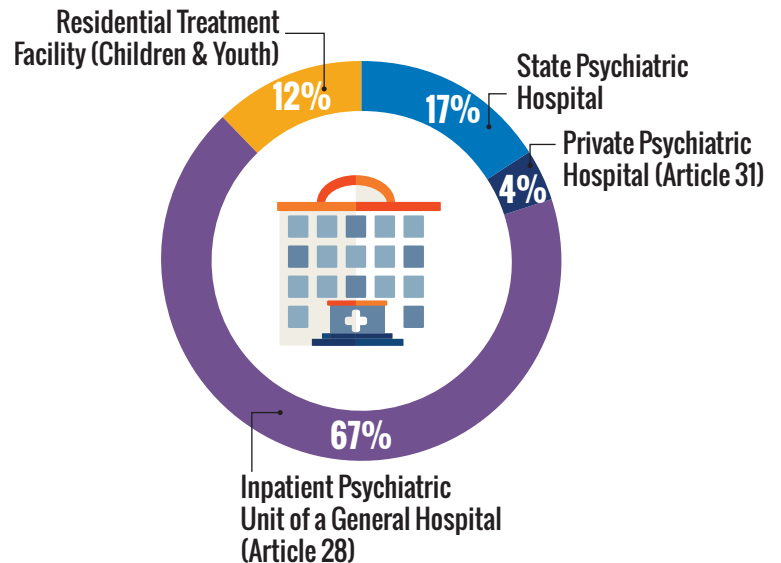
As a provider of services, OMH operates 24 State facilities for civil, forensic, and research populations, serving approximately 10,000 inpatient and 25,000 outpatient individuals each year.⁷ OMH also operates dozens of residential and support programs that serve thousands of children, adults, and families in communities across the State. The following section describes the various programs that make up the NYS public mental health system.

The Mental Health Service System

The NYS public mental health system is comprised of mental health programs that are licensed, funded or operated by OMH. Currently, OMH oversees over 1,500 licensed and 3,000 unlicensed programs, which fall into five major categories: inpatient, outpatient, emergency, residential and support.⁸

1-12

Inpatient Programs statewide (N=149)



Inpatient

Inpatient Services provide stabilization, intensive treatment and rehabilitation with 24-hour care in a controlled environment. They are the programs of choice only when the required services and supports cannot be delivered in community settings. OMH operates 24 State Psychiatric Centers⁹, and licenses over 100 other inpatient programs that collectively operate nearly 10,000 psychiatric inpatient beds statewide.¹⁰

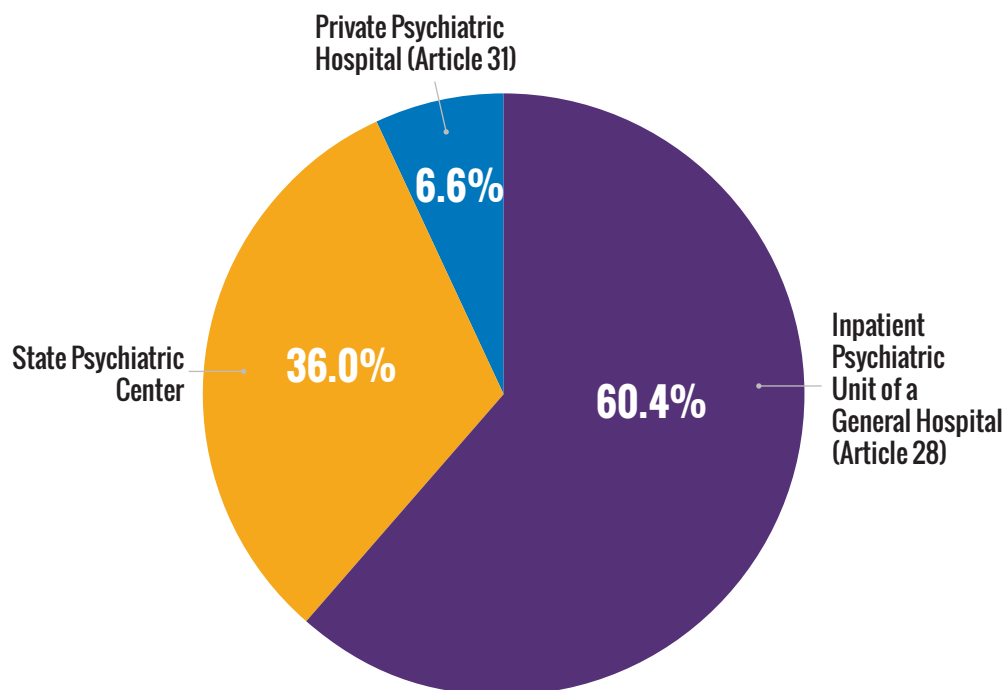
Overall, OMH accounts for 16 percent of the inpatient programs in the State, including adult and children's facilities.¹¹ Inpatient services are also provided on inpatient psychiatric units of general hospitals, at private psychiatric hospitals, and in residential treatment facilities.

State Psychiatric Centers are 24-hour psychiatric inpatient treatment programs that are operated by the New York State Office of Mental Health and are often referenced as "State Psychiatric Centers." Most OMH Psychiatric Centers are accredited and regulated by the Joint Commission and the Centers for Medicare and Medicaid Services. OMH State Psychiatric Centers account for a smaller share of the total inpatient facilities statewide than they do when

1-13

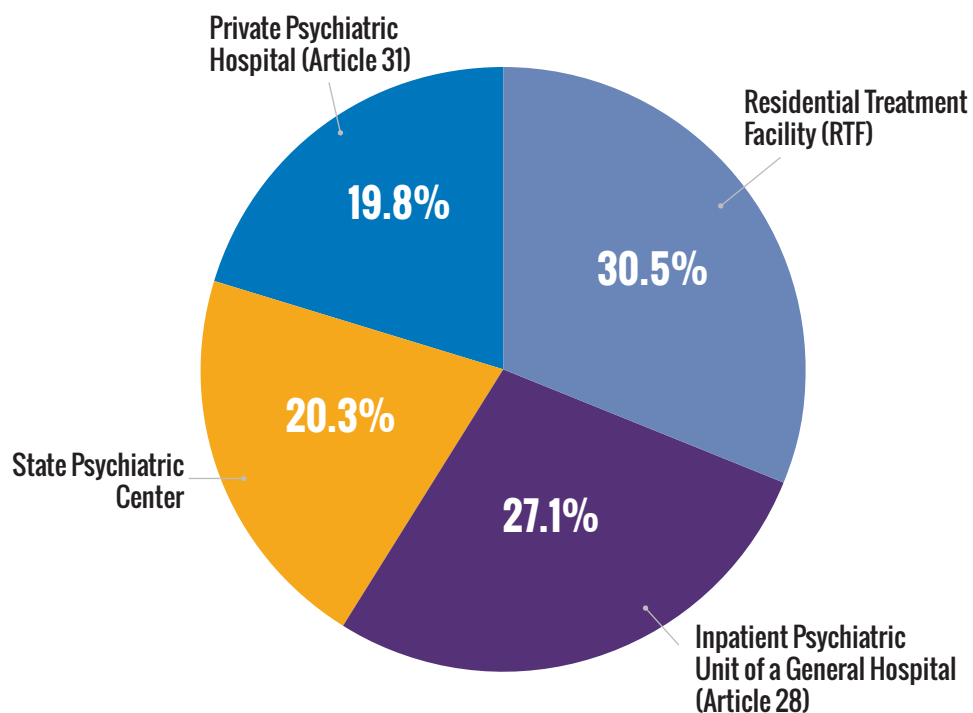
Adult Inpatient Beds (N= 7,770)

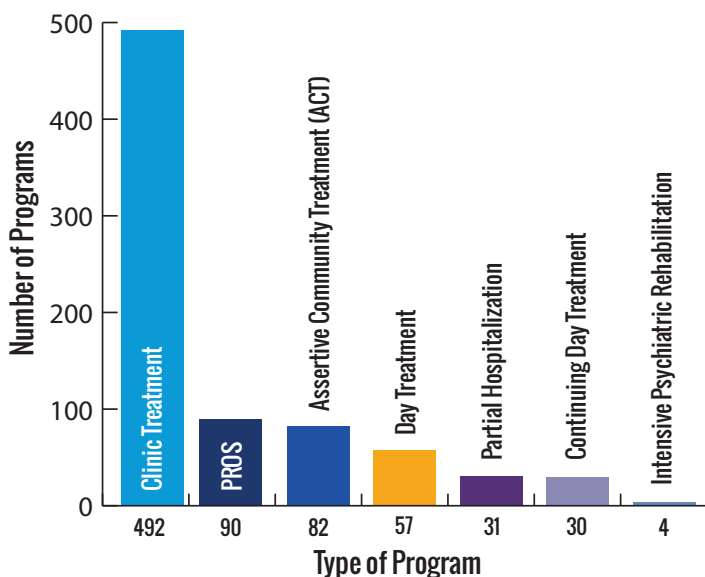
*Excludes Forensic Beds**



1-14

Child Inpatient Beds Statewide* (N=1,664)



1-15**Outpatient Statewide**

measured by bed capacity, where they represent a larger share of beds for both adults (36 percent) and children (20 percent). In addition to the nearly 3,000 budgeted adult and child beds, OMH also operates over 700 adult beds in forensic facilities, which are not included in the bed counts in Figure 1-13. Inpatient psychiatric units of general hospitals, also referred to as Article 28 hospitals, are licensed, 24-hour inpatient treatment programs that are operated in a medical hospital, and include full-time medical, psychiatric services, social services and around-the clock nursing services for individuals with mental illness. Jointly licensed by OMH and the New York State Department of Health, there are approximately 100 Article 28 psychiatric inpatient units operating over 5,000 beds throughout New York State.

Private psychiatric hospitals, also known as Article 31 hospitals, are 24-hour inpatient treatment programs that are licensed by OMH and operate in private hospitals that exclusively provide behavioral health services. There are currently six Article 31 hospitals statewide, operating a total of 864 beds. Other types of inpatient psychiatric facility are Residential Treatment Facilities (RTF). RTFs provide fully-integrated mental health treatment services to seriously emotionally disturbed children and youth between five and 21 years of age. These services are provided in 14-61 bed facilities which are certified by both OMH and either the Joint Commission or the Council on Accreditation (COA). Sometimes classified as residential, RTFs are less intensively staffed than inpatient units,

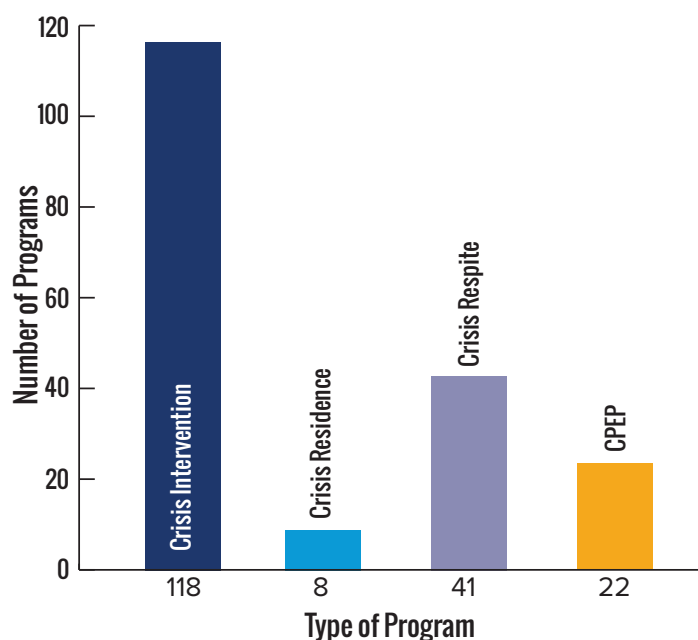
but provide a much higher level of services and staffing than community residences, group homes, or child care institutions. There are currently 18 RTFs operating approximately 500 beds throughout the State.

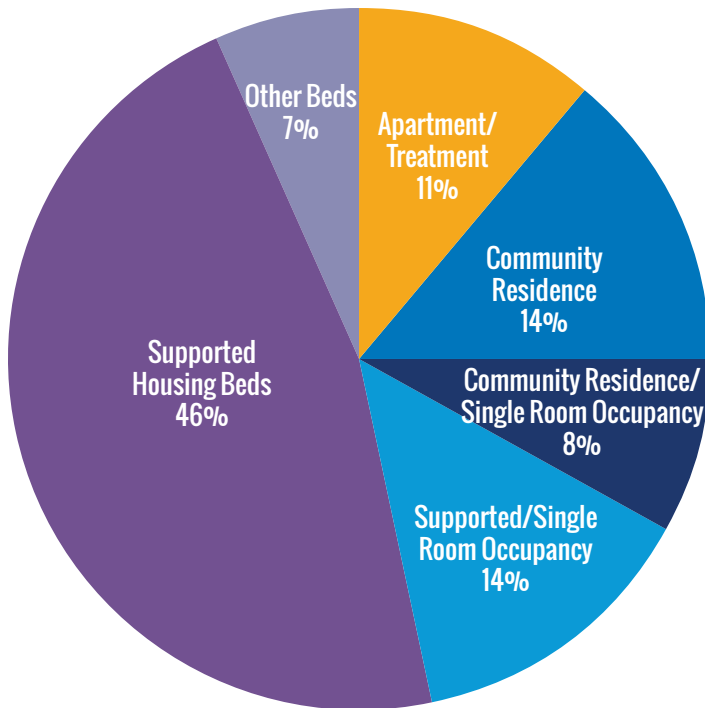
Outpatient

OMH operates and regulates nearly 800 outpatient programs. Assertive Community Treatment (ACT) teams, Personalized Recovery-Oriented Services (PROS) programs, Article 31 clinics, and Day Treatment provide treatment and rehabilitation to service recipients in need of community based support to maintain mental health. The most common, largely utilized outpatient services are clinic treatment services which make up 63 percent of all outpatient services.

Emergency

Emergency programs provide rapid psychiatric and/or medical stabilization. They ensure the safety of persons who present a risk to themselves or others. The program types range from crisis counseling and residential services to Comprehensive Psychiatric Emergency Programs (CPEP). Home-based crisis intervention services for children are designed to provide crisis services to families when a child is imminent risk

1-16**Emergency and Crisis Programs Statewide**

1-17**Residential Beds Statewide (N=39,970)**

**Other Beds* are beds in Family Care and State-operated Residential Care Centers for Adults (RCCA) programs.

for psychiatric hospitalization. For a more detailed description of the CPEP program, including service-level data for all programs statewide, see Appendix B.

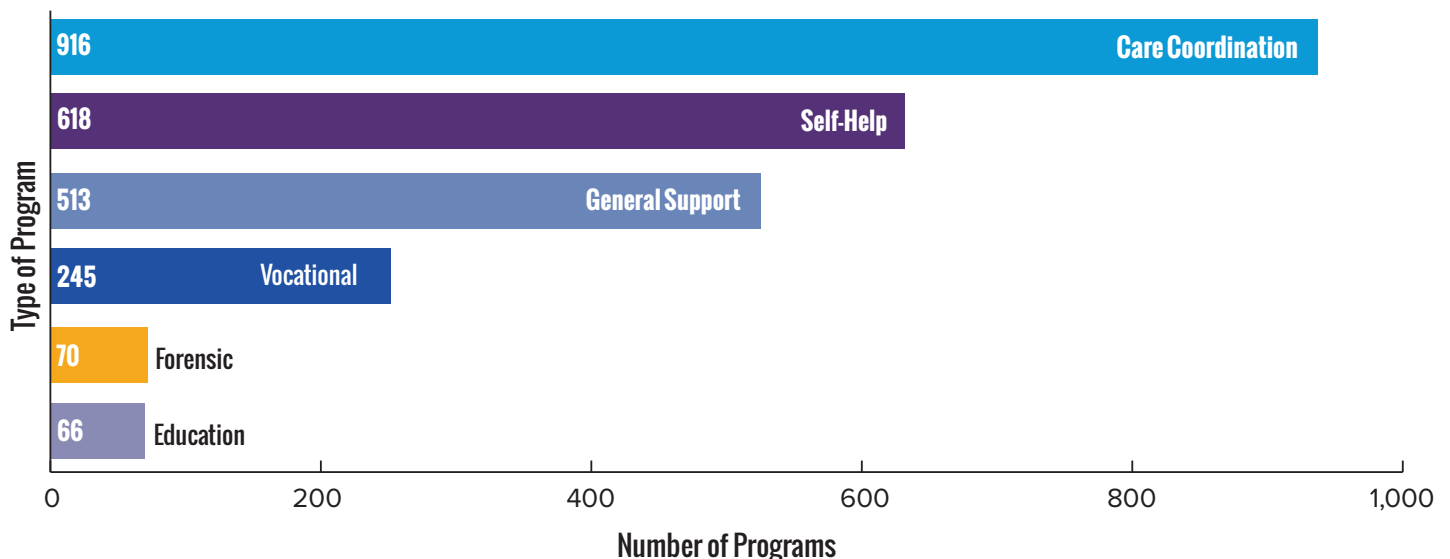
Residential

Residential Services are provided to maximize access to housing opportunities, particularly for persons with histories of repeated psychiatric hospitalizations, homelessness, involvement with the criminal justice system, and co-occurring substance use disorder. Residential services are also offered to children to provide short-term residential assessment, treatment, and aftercare planning. There are approximately 600 residential programs, amounting to nearly 40,000 beds statewide.

Support

Support programs are based in the community and help adults diagnosed with serious mental illnesses to live as independently as possible and help children with serious emotional challenges to remain with their families. These services include family support case management and vocational, self-help and other support services. While the array of services varies between adults and children, the goal is to support successful and full community living.

For a full list of each program described above, visit the Find a Program portal on the OMH website at: <https://my.omh.ny.gov/bi/pd>

1-18**Support Programs Statewide (N=2,428)**

This section provides an overview of the forensic inpatient and outpatient services operated by OMH, the principal forensic populations served in OMH forensic facilities and other settings, and a detailed description of both new and existing OMH-operated and supported community-based forensic services and supports.

OMH Forensic Psychiatric Centers, Regional Forensic Units, and Secure Treatment Facilities

Forensic Psychiatric Centers and Regional Forensic Units

OMH operates three Forensic Psychiatric Centers: Central New York Psychiatric Center, Kirby Forensic Psychiatric Center, and Mid-Hudson Forensic Psychiatric Center; and two Regional Forensic Units: Rochester Regional Forensic Unit at Rochester Psychiatric Center and the Northeast Regional Forensic Unit at Central New York Psychiatric Center.

OMH Forensic Programs (FPCs, RFUs, STFs and Prison-Based Programs)

- ✿ Forensic Psychiatric Center
- ▼ Regional Forensic Unit
- Secure Treatment Facility/Secure Treatment Unit
- ★ Satellite Unit
- ◆ Mental Health Unit



Forensic Psychiatric Centers and Regional Forensic Units serve individuals admitted under one or more of the following laws and regulations: Correction Law 402, Correction Law 508, Criminal Procedure Law 330.20, Criminal Procedure Law 730, and New York State Codes, Rules and Regulations Part 57.

New York's total Forensic Psychiatric Center and Regional Forensic Unit capacity is currently 720¹⁹. Kirby Forensic Psychiatric Center opened a new 25-bed ward in November 2018 to accommodate additional individuals admitted under Criminal Procedure Law 730.

Secure Treatment Facilities

OMH operates two Secure Treatment Facilities for services rendered under Article 10 of the Mental Hygiene Law: St. Lawrence Psychiatric Center Secure Treatment Facility and Central New York Psychiatric Center Secure Treatment Facility. OMH also operates a Secure Treatment Unit at Manhattan Psychiatric Center which provide services for Article 10 residents who have court proceedings pending in New York City.

New York's total Secure Treatment Facility and Secure Treatment Unit capacity is 390.¹⁹

Populations Served in OMH Forensic Psychiatric Centers, Regional Forensic Units, and Secure Treatment Facilities

Persons served within OMH forensic and Article 10 Secure Treatment Facilities fall primarily into five legal admission categories under Mental Hygiene Law, Criminal Procedure Law, or Correction Law.

These admission types are summarized below:

Criminal Procedure Law § 330.20 (CPL 330.20): Not Responsible for Criminal Conduct by Reason of Mental Disease or Defect

Individuals who are judged as not responsible for criminal conduct by reason of mental disease or defect and who require secure hospitalization are admitted to a Forensic Psychiatric Center or Regional Forensic Unit for care and treatment.

Criminal Procedure Law § 730 (CPL 730) Temporary Orders of Observation and Orders of Commitment: Incompetent to Stand Trial

Individuals who are charged with a felony and judged not fit to proceed to trial due to mental disease or defect are admitted to a Forensic Psychiatric Center or Regional Forensic Unit for care and treatment under court order until they are judged competent to proceed to trial.

Correction Law § 508 (CL 508): Involuntary Admission of Pre-sentenced Inmates

Pre-sentenced individuals within county correctional facilities who are deemed to require psychiatric hospitalization during the course of their incarceration are admitted to a Regional Forensic Unit.

Correction Law § 402 (CL 402): Involuntary Admission of Sentenced Inmates

Sentenced individuals within state and local correctional facilities who are deemed to require psychiatric hospitalization during the course of their incarceration are hospitalized at Central New York Psychiatric Center.

Mental Hygiene Law § 10 (MHL Article 10): Persons subject to Civil Management

Sex offenders who are nearing discharge from prison, parole supervision or OMH or Office for People with Developmental Disabilities inpatient care following commitment under the Criminal Procedure Law, and for whom the court has found probable cause that the individual requires civil management under Article 10, are admitted for care and treatment within an OMH Secure Treatment Facility. They will remain at the facility until such time that they are adjudicated as not meeting Article 10 civil management criteria or are deemed to not require secure treatment and are able to receive treatment in the community under Strict and Intensive Supervision and Treatment (SIST).

Additional information regarding the populations served in OMH Forensic and Sex Offender Treatment Program Facilities is available, here: https://www.omh.ny.gov/omhweb/forensic/populations_served.htm

Forensic Populations Served in Other Settings

OMH serves, directly and in concert with other providers, additional forensic populations apart from those served in forensic and Secure Treatment Facilities.

State Psychiatric Centers (Non-Forensic)

OMH's non-forensic State Psychiatric Centers serve a variety of individuals for whom forensic histories predicate their hospitalization, including:

Criminal Procedure Law § 330.20 (CPL 330.20):

Individuals judged not responsible for criminal conduct by reason of mental disease or defect are admitted to a non-forensic State Psychiatric Center when they are deemed to be mentally ill but without a dangerous mental disorder, either at the time of the CPL 330.20 adjudication or after a period of inpatient care at an OMH forensic facility.

Criminal Procedure Law § 730 (CPL 730) Final Orders of Observation:

Individuals who are charged with a misdemeanor and are judged not fit to proceed to trial due to mental disease or defect are evaluated for inpatient admission at a non-forensic State Psychiatric Center. These persons, upon being found not fit to proceed to trial, have the charges against them dismissed and are transported to a State Psychiatric Center for evaluation and admission under Mental Hygiene Law. They must be evaluated and within 72 hours of admission, and either be civilly committed under Mental Hygiene Law, or admitted voluntarily, or released.

Correction Law § 402 (CL 402):

Sentenced individuals requiring hospitalization under CL 402 and who have completed their sentence at a Department of Corrections and Community Supervision (DOCCS) correctional facility are transferred to non-forensic State Psychiatric Center for care and treatment until they no longer require psychiatric hospitalization.

Central New York Psychiatric Center Outpatient Program¹⁹

The Central New York Psychiatric Center outpatient program provides clinical services to individuals with mental illness who are incarcerated within DOCCS correctional facilities. Over 10,400 incarcerated individuals receive mental health services from OMH in 28 correctional facilities. These services range in intensity from clinic based services to 205 crisis beds and 1,087 mental health residential program beds across the DOCCS system.

Prison-Based Sex Offender Treatment Program

Individuals incarcerated within DOCCS prisons who have been classified as high risk for committing a sexual offense upon release from prison are provided treatment in the Prison-Based Sex Offender Treatment Program. This treatment program focuses on addressing dynamic risk factors associated with sexual recidivism, helping individuals to develop viable community supervision and treatment plans, and providing for continuity of treatment for individuals who are later deemed in need of civil management.

Strict and Intensive Supervision and Treatment (SIST)

Sex offenders who are determined, through Article 10 proceedings, to have mental abnormalities that predispose them to commit sexual offenses, but whose level of dangerousness is deemed by the court to be such that they can be treated and supervised in the community, are placed on SIST. SIST is jointly operated by OMH and DOCCS. OMH develops the treatment components of the SIST community plans and provides clinical oversight of treatment programming and progress for SIST participants.

OMH also provides extensive discharge planning for individuals with mental illness transitioning from DOCCS correctional facilities to the community. In addition, OMH offers services designed to divert criminal justice-involved individuals with mental illness to treatment, when appropriate. These population specific community-based services are detailed later in this section.

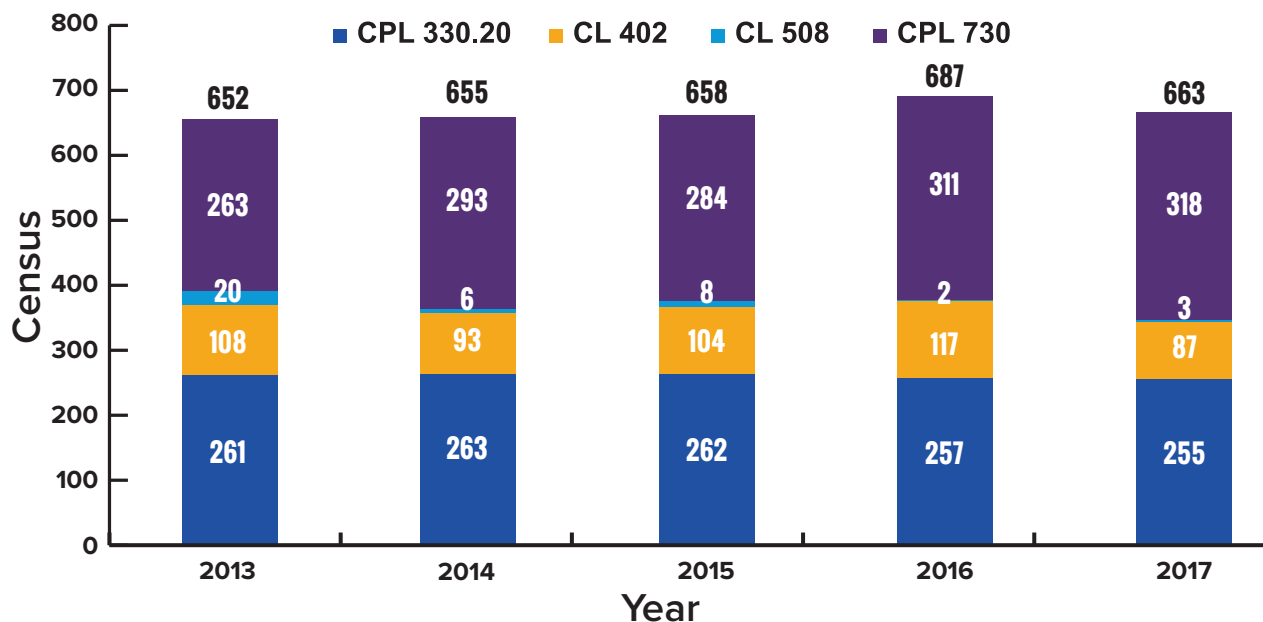
1-19**OMH Forensic Psychiatric Center Inpatient Census¹²**

Figure 1-19 shows the inpatient census within OMH's State-operated Forensic Psychiatric Centers and Regional Forensic Units by the legal status of the individual at the time of their admission, as of December 31 of each year. The inpatient census of OMH State-operated forensic facilities remained relatively stable

from 2013 to 2017, increasing two percent.

However, notable shifts in the composition of the forensic inpatient census have occurred during this period. Most notably, the CPL 730 census increased by 21 percent during this period.

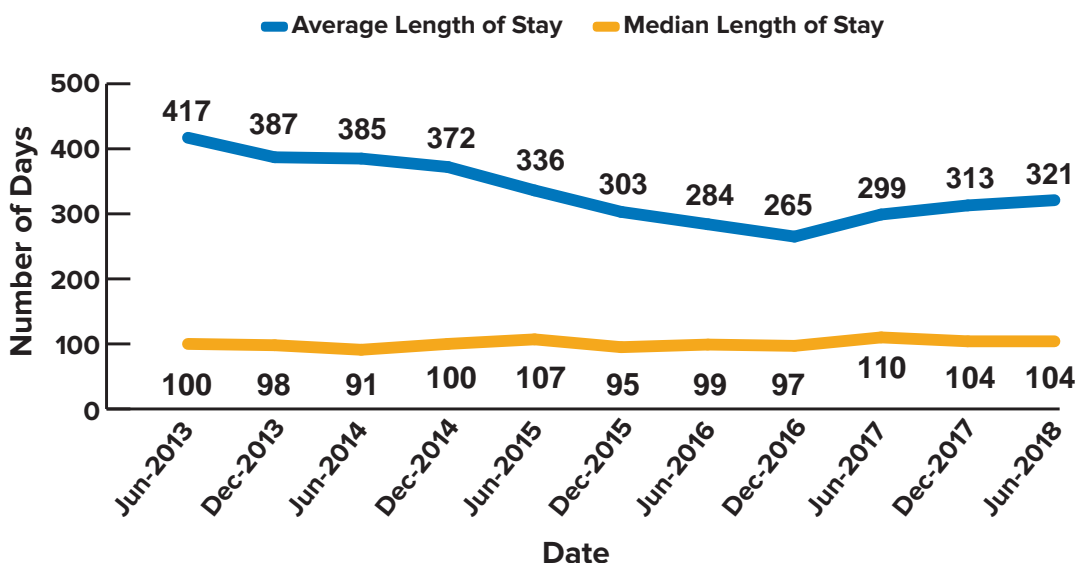
1-20**OMH Forensic Inpatient Length of Stay (CPL 730 Census)¹²**

Figure 1-20 presents the average and median lengths of inpatient stay for the CPL 730 population in OMH Forensic Psychiatric Centers and Regional Forensic Units, measured biannually on June 30 and December 31 of each year.

Among the CPL 730 population, the average length of stay decreased by 23 percent from 2013 to 2018, and the median length of stay remained relatively stable, increasing by four percent.

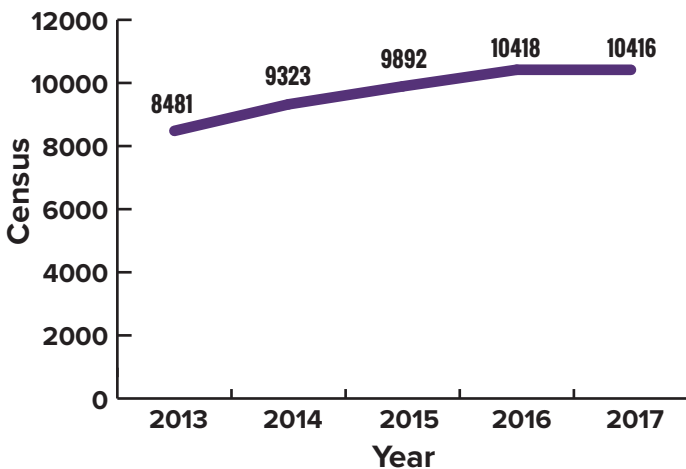
1-21**Central New York Psychiatric Center
Outpatient Census¹²**

Figure 1-21 shows the CNYPC outpatient census, which is comprised of incarcerated individuals receiving prison-based mental health services from OMH in DOCCS correctional facilities, as of December 31 of each year. The number of DOCCS incarcerated individuals on the CNYPC outpatient census increased by 23 percent from 2013 to 2017.

Figure 1-22 illustrates the type of placement at release for individuals with serious mental illness (SMI) who were receiving prison-based mental health services from OMH in DOCCS-operated prisons. In 2017, 81 percent of DOCCS incarcerated individuals with SMI were released to the community after appropriate mental health discharge planning, while 12 percent were discharged to State Psychiatric Centers. The remaining seven percent were discharged to other institutional settings or jurisdictions.

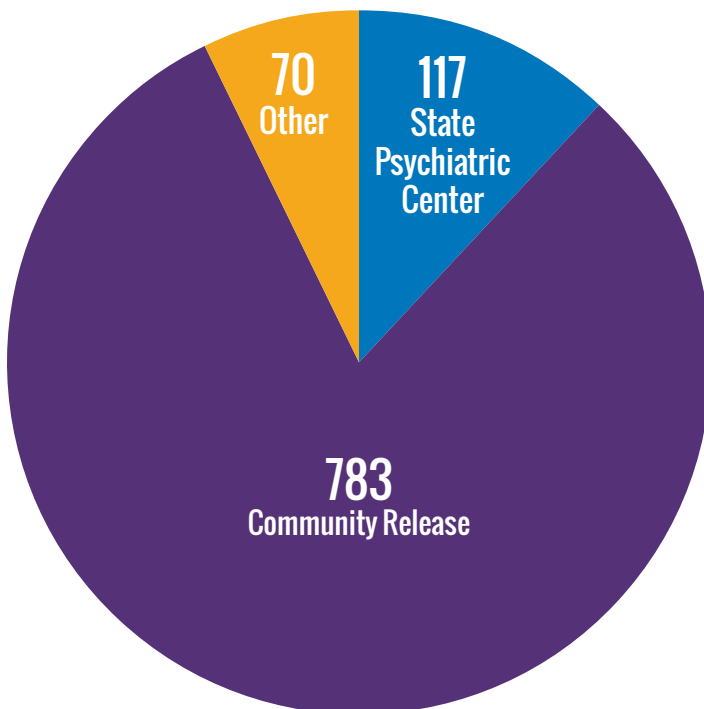
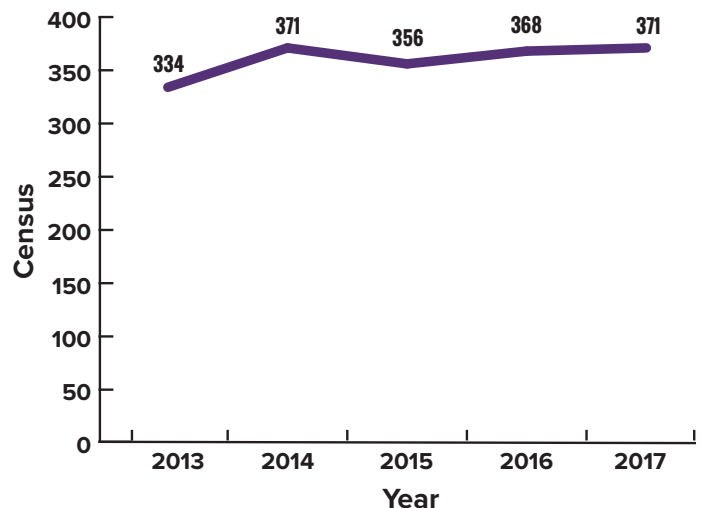
1-22**Releases of CNYPC Prison-Based Service
Recipients with Serious Mental Illness by
Discharge Placement Type, 2017¹⁵**

Figure 1-23 displays the OMH Sex Offender Treatment Program (SOTP) census of sex offenders admitted to Secure Treatment Facilities under Article 10 of the Mental Hygiene Law, by calendar year. The SOTP census increased by 11 percent from 2013 to 2017. A four percent decrease occurred from 2014 to 2015, primarily due to the New York State Court of Appeals Matter of Donald DD decision which placed certain limitations on the types of psychiatric disorders considered appropriate for sex offender civil management, and resulted in challenges to civil management proceedings brought by the State²⁰.

1-23**Sex Offender Treatment Program Census¹³**

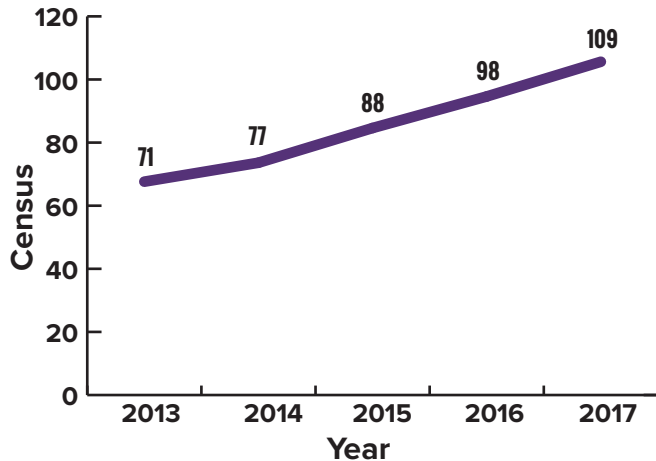
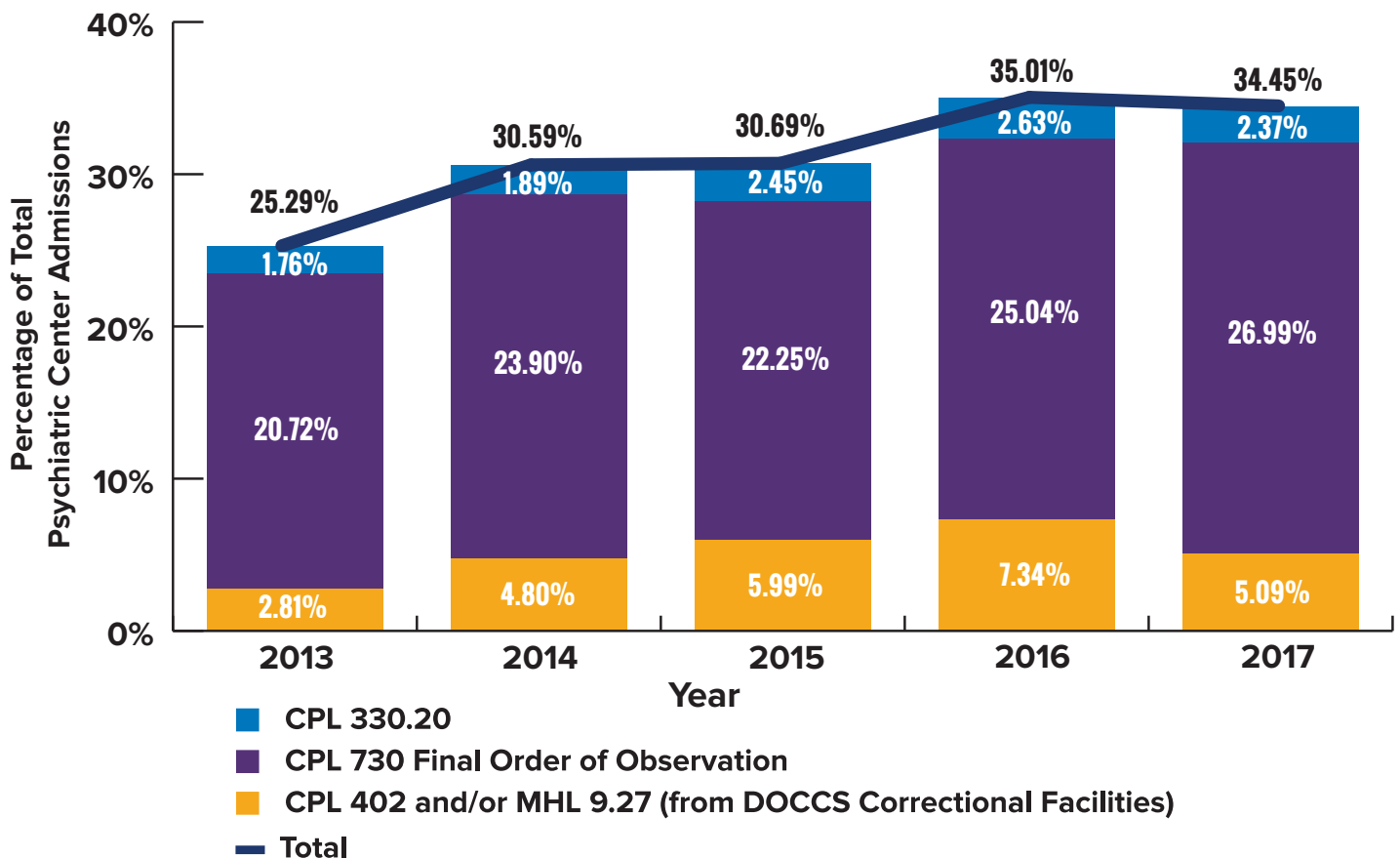
1-24**Strict and Intensive Supervision and Treatment (SIST) Annual Census¹³**

Figure 1-24 presents the census of the Strict and Intensive Supervision and Treatment (SIST) program, which provides for court ordered community-management of sex offenders whose level of dangerousness is deemed by the court to be such that they can be treated and supervised in the community. The SIST census has increased by 54 percent from 2013 to 2017.

Figure 1-25 shows the percentage of individuals with forensic designations who are admitted to non-forensic State Psychiatric Centers, by calendar year. The combined percentage of individuals with forensic designations admitted to State PCs increased by nine percent from 2013 to 2017, with percentage growth occurring across CPL 330.20, CPL 730.40, and 2PC/CL 402 designations. Admissions of individuals with CPL 730.40 designations increased by the largest margin, from 21 percent in 2013 to 27 percent in 2017.

1-25**OMH Psychiatric Center Annual Forensic Admissions by Forensic Designation Type^{12,14}**

Transitional Forensic Services and Supports

Individuals with serious mental illness leaving state prisons may require specialized programming to assist in their transition to community life, reduce the likelihood of recidivism, and promote continued recovery.

To aid in this transition, OMH has developed a roster of specialty services and supports aimed at helping formerly incarcerated individuals find stable housing, receive comprehensive case management services, and access the treatment and supports necessary for recovery upon release from prison.

This service development complements the full range of public mental health services outlined earlier in this chapter which are available to, and often serve, criminal justice-involved individuals with mental illness (see Figure 1-26). Additional recent service development includes several programs supported by OMH reinvestment funding, which are detailed further in Chapter Four of this report.

Housing¹⁹

Forensic Supported Housing:

OMH currently funds 418 supported housing beds (328 in New York City) dedicated to individuals with serious mental illness who are released from prison, and an additional 168 supported housing beds serving individuals discharged from civil State Psychiatric Centers after a direct admission from prison.

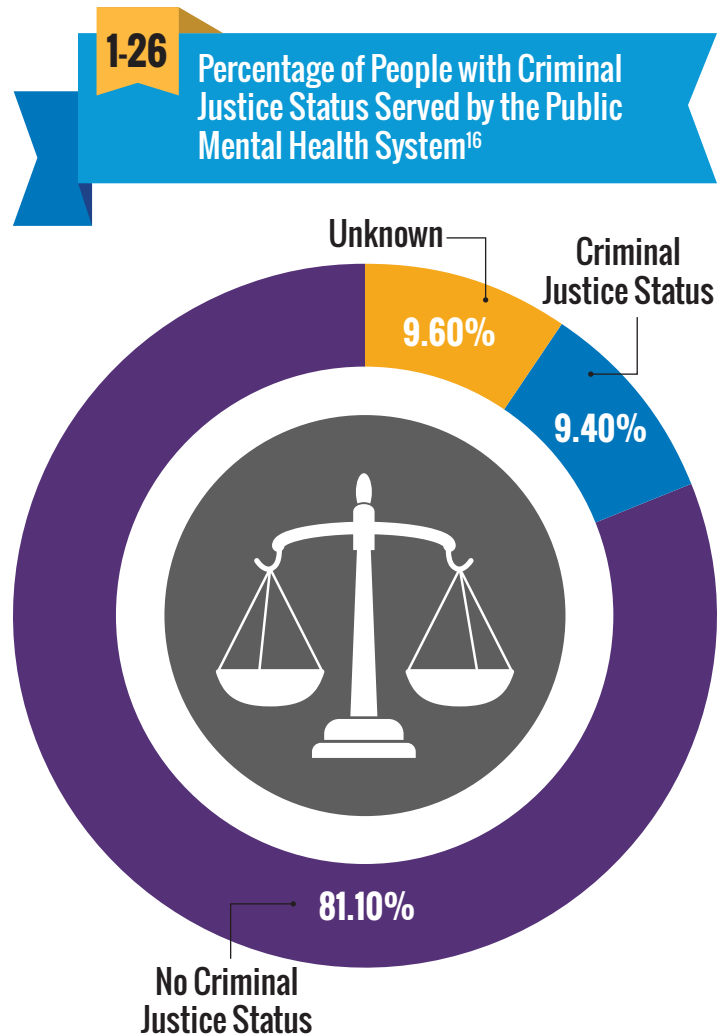
Parole Support and Treatment Program:

OMH funds a 110-bed supported housing program which is linked directly to a specialized Intensive Case Management Program, serving individuals with serious mental illness who are released from prison under DOCCS Community Supervision (parole).

Case Management and Treatment

Forensic Case Management Teams:

OMH operates a dedicated team responsible for providing transitional case management (3 to 12 months post-prison release) for individuals with serious mental illness leaving prison. In addition, OMH funds a case management team for individuals leaving prison and returning to the New York City shelter system.



Statewide Forensic Assertive Community Treatment (FACT):

OMH funds FACT teams in New York City and Erie, Monroe, and Suffolk counties. FACT provides coordinated behavioral health and social support services to justice-involved individuals, including individuals with serious mental illness released from prison, using an adapted Assertive Community Treatment model.

Prison In-Reach and Transition Services

Community Orientation and Re-Entry Program:

OMH operates a prison in-reach program providing intensive discharge planning services to men with serious mental illness leaving Sing Sing Correctional Facility, within 90 days of their release.

Safe Transition and Empowerment Program:

OMH funds a prison in-reach and transitional Intensive Case Management program for women with serious mental illness leaving Bedford Hills Correctional Facility, within 90 days of their release.

Discharge Intermediary Care Program:

OMH operates specialized re-entry programs at Sing Sing and Auburn Correctional Facilities for men with serious mental illness and histories of violence, within 12 to 18 months of their release.

Enhanced Intermediary Care Program:

OMH operates specialized re-entry programs at Elmira, Fishkill and Green Haven Correctional Facilities for men with serious mental illness and histories of violence, within 18 to 36 months of their release.

Criminal Justice Diversion and Intervention Programs

Figure 1-26 shows the percentage of individuals served during the 2017 Patient Characteristics Survey week who had a criminal justice status¹⁷ at the time they received services. In 2017, 9.4 percent of individuals served by the public mental health system had a criminal justice status.

To improve outcomes and reduce recidivism for individuals diagnosed with serious mental illness who become involved in the criminal justice system, OMH is developing and expanding programs designed to divert these individuals from incarceration. OMH's criminal justice diversion and intervention efforts are focused on services developed using the Sequential Intercept Model and the related Crisis Intervention Team Model, described below.

Sequential Intercept Model

Developed by the United States Substance Abuse and Mental Health Services Administration (SAMHSA), the Sequential Intercept Model¹⁸ identifies key points for “intercepting” individuals with behavioral health issues, linking them to services and preventing further penetration into the criminal justice system. Points of intercept include, but are not limited to: pre-arrest, pre-booking, post-booking, pre-sentencing, post-sentencing, pre-release from incarceration, and post-release for incarceration.

Specialized Programming for Incarcerated Juveniles

Quickly identifying and assisting state incarcerated juveniles with mental illness can help a young person avoid future incarceration. Central New York Psychiatric Center prison-based services evaluates each juvenile entering Hudson Correctional Facility (the reception facility for all incarcerated juveniles) within 24 hours of entry. Each individual meets with a mental health counselor, and a full mental health evaluation and risk assessment takes place through a structured interview.

For individuals identified as needing mental health treatment, individual and group therapy sessions are provided weekly, monthly or as needed, and a psychiatric evaluation is completed every 4 to 6 weeks. All OMH mental health staff are trained to use the “Think Trauma” model, which is focused on the impact of trauma on individuals in juvenile justice residential settings. Family contact is maintained throughout treatment and therapeutic phone calls with family members are also provided.

OMH is supporting local projects across New York State to better connect criminal justice-involved individuals to treatment. To ensure county or city-wide coordination of comprehensive diversion services, projects are being developed with input from local re-entry task forces, departments of mental health, probation and court systems.

Examples of recently funded diversion projects include:

- An initiative for individuals booked into jail for violations or non-violent misdemeanors. Individuals with mental health diagnoses and/or co-occurring substance use disorders will be assessed, provided with any needed prescriptions, and released from custody to a care coordinator who can link each individual to community-based services.
- A jail diversion drop-off center for individuals with mental illness at the pre-booking, post-booking, and pre-sentencing intercept points. The center will operate 24/7 and be available to individuals of all ages, accepting direct drop-offs from law enforcement. Connecting individuals to jail diversion alternatives, the center will provide evaluation, assessment, and referral to mental health and substance use disorder services, with embedded peer supports.
- A parole diversion program to divert individuals on parole who are diagnosed with serious mental illness from reincarceration due to parole violations. The parole diversion program will work with those individuals who are struggling to comply with conditions of parole and who have become disengaged from community-based mental health treatment. This program will engage community-based treatment providers and coordinate mental health care and treatment for parolees to ensure communication and coordination with community supervision to avoid violation of parole, when possible.
- A pretrial services screening and supervision release pilot program where the probation department will work across the criminal justice system to identify individuals with mental illness and/or co-occurring substance use disorders, at post-booking and pre-sentencing intercept points, who are deemed to be appropriate for community release. Probation Officers will work with the individual, their families and appropriate parties, and treatment providers to develop assessment-based case plans, with short and long-term goals.

Crisis Intervention Teams

The OMH Crisis Intervention Team (CIT) initiative promotes collaboration and partnership amongst law enforcement, the mental health system, criminal justice representatives, emergency services, and consumer and family advocacy groups. The overall mission of the CIT program is to improve interactions between police, individuals with mental illness and mental health treatment providers with an emphasis on diversion from the criminal justice system and into mental health treatment²¹.

At the center of the CIT program is an exercise which identifies all local stake holders needed to successfully implement this initiative, along with gaps in the current processes and points in the local criminal justice continuum where crisis intervention is most needed. In addition, patrol officers and supervisors receive a 40-hour training on mental illness, including:

- Signs and symptoms of mental illness;
- Contributing factors to emotional disturbance;
- State Mental Hygiene Law;
- Communication skills and intervention techniques;
- Scenario-based training to practice skills;
- Experimental exercises;
- Presentations and discussions with local treatment providers, emergency facilities, and consumers and families living with a mental illness

Additionally, OMH offers training entitled “Mental Health First Aid” for other law enforcement personnel, corrections personnel, first responders and 911 operators.

Section 4

Data Inventory

Data-driven and evidenced-based programs are at the center of healthcare reform to ensure the provision of quality behavioral healthcare. This section provides an outline of the different publicly available data resources that OMH publishes for community providers, local governmental units, and other stakeholders to support planning and understanding of mental health services statewide.

Both data portals and data books are presented in this section. Data portals are interactive reports that are updated on periodic basis, and allow different filters to be applied to the data based on user preference. Data books are prepared reports containing static data, and do not require additional user prompts. All data portals and data books described in this section can be found on the main OMH website (omh.ny.gov) or on the OMH Statistics and Reports webpage: <https://www.omh.ny.gov/omhweb/statistics/index.htm>

Find a Program Portal

The Find a Program portal provides information on all mental health programs in New York State that are operated, licensed or funded by OMH. Program information is generated from the OMH CONCERTS database. CONCERTS is maintained by OMH, with most of the data entered directly by providers via the Mental Health Provider Data Exchange.

The Find a Program portal allows you to search for mental health programs using a set of geographic and programmatic criteria. Program details include provider contact information, program characteristics, populations served, and capacity levels (for certain licensed programs).

The directory includes three search options:

- **Basic Search** allows you to click on any county to view all the programs in that county.
- **Full Directory Search** allows you to view programs by adding filters on county, program category and/or subcategory.

- **Advanced Search** allows you to search programs by multiple criteria, including: population served, special population, hours of operation, whether program is recipient run, location (e.g., city or zip code), provider or program name, and/or additional services provided.

Find a Program can be accessed from the main OMH website (omh.ny.gov) or directly at: <https://my.omh.ny.gov/bi/pd>

Psychiatric Services & Clinical Knowledge Enhancement System – PSYCKES Portal

The Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid or PSYCKES (pronounced “sigh-keys”) is a Health Insurance Portability and Accountability Act-compliant, web-based portfolio of tools designed to support quality improvement and clinical decision-making in the New York State Medicaid population. Providers with access to PSYCKES can access a portfolio of quality indicator reports at the state, region, county, agency, site, program, and client level to review performance, identify individuals who could benefit from clinical review, and inform treatment planning. Quality reports in PSYCKES are updated monthly, and clinical information is updated weekly.

Developed by OMH, PSYCKES uses administrative data from the NYS Medicaid claims database to generate quality indicators and summarize treatment histories. This administrative data is collected when providers bill Medicaid for services. All states are required by the federal government to monitor the quality of their Medicaid programs, and many states are using administrative data such as Medicaid claims to support quality improvement initiatives. Quality indicators were developed in consultation with a scientific advisory committee of national experts in psychopharmacology and a stakeholder advisory committee of providers, family members, consumers, and professionals. Since all reports are based on Medicaid data, no data entry by providers is required.

Access to PSYCKES requires the use of user ID and passcode, which is managed through OMH.

County Mental Health Profiles Portal • **Priority Admissions Reports** display the priority admissions as a percentage of the total number of admissions for each program type at the county, regional and statewide level.

The County Mental Health Profiles portal was designed to facilitate local planning through a collaboration between OMH, the NYS Conference of Local Mental Hygiene Directors, and the interagency Mental Hygiene Planning Committee, which is composed of representatives from the Office for People with Developmental Disabilities (OPWDD), the Office of Alcoholism and Substance Abuse Services (OASAS). The portal consolidates utilization, expenditure, and other data from an array of OMH and non-OMH data systems, and presents content in a standard format that enables responsive and effective local, regional, and statewide planning.

The County Mental Health Profiles portal can be accessed at: <https://www.omh.ny.gov/omhweb/tableau/county-profiles.html>

Adult Housing Portal

Housing is a priority concern for all people. For individuals with mental illness, safe and affordable housing is a cornerstone of recovery. However, stable access to good housing is a fundamental problem for many people with mental illness because of their low incomes, the limited supply and rising costs of low-income housing, and discrimination. To reduce stigma and provide opportunities for recovery, it is preferable that individuals with mental illness live in mixed-use settings.

OMH is committed to maximizing access to housing opportunities for individuals with diverse service needs. OMH funds and oversees a large array of adult housing resources and residential habilitation programs in New York State, including congregate treatment, licensed apartments, single room occupancy residences, and supported housing.

The **Adult Housing Portal** includes four types of reports described below:

- **Residential Program Indicator Reports** describe the aggregate number of beds in each program type across a set of performance indicators, and are displayed at the county, regional, statewide and Psychiatric Center catchment area level.
- **Length of Stay Reports** present the length of stay for each program type at the county, regional and statewide level.

- **Occupancy Rate Reports** describe the occupancy rate for each program type at the county, regional and statewide level.

The Adult Housing Portal can be accessed at: <https://www.omh.ny.gov/omhweb/statistics/AdultHousingRedirect.html>

County Capacity & Utilization: Calendar Years 2016-2017

OMH's County Capacity and Utilization Data Book includes inpatient and community-based psychiatric service utilization and capacity statistics for calendar years 2016-2017, displayed at the statewide, region, and county levels. The County Data Book also summarizes service utilization based on per capita rates from the US Census population estimates. Inpatient service utilization is summarized separately by provider county of location and by patient county of residence. Community-based service utilization is summarized by provider county only. Both inpatient and community-based service capacity and utilization are displayed separately for the adult (18 and older) and child (under 18) populations, where appropriate. The data presented come from Child and Adult Integrated Reporting System, CONCERTS, Institutional Cost Report, Medicaid, Mental Health Automated Record System, PCS, and New York State Department of Health Statewide Planning and Research Cooperative System. This data book can be found at: <https://www.omh.ny.gov/omhweb/special-projects/dsrip/ccudb.html>.

Mental Health and Substance Use Disorders Needs Assessment Regional Data Books

The OMH Needs Assessment regional data books present mental health and substance use disorder resources, service utilization, barriers to care and unmet needs in each NYS Regional Planning Consortium region by county. Comparisons are made across counties and regions. The data included are intended to enable behavioral health care providers, planners and others to identify service gaps and disparities and plan for improved service delivery. This data books can be found by visiting: <https://www.omh.ny.gov/omhweb/special-projects/dsrip/mh-substance-use-disorders.html>

¹ Karel, M. J., Gatz, M., & Smyer, M. (2012). Aging and mental health in the decade ahead: What psychologists need to know. *American Psychologist*. Vol. 67 (184-198).

² Please note that the Hispanic/Latino data includes individuals of all racial identities.

³ Just as there is overlap between service access by auspice, individuals also access multiple program types within auspice during the survey week. Therefore the number of individuals served by program category should not be added together due to duplicated counts.

⁴ Serious emotional disturbance (SED) means a child or adolescent has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) and has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. Full criteria can be found on the OMH website (<http://www.omh.ny.gov/omhweb/bho/content/guidance/task2.pdf>). Serious mental illness (SMI) applies to adults 18 and older who meet criteria for designated mental illness and are currently enrolled in SSI/SSD due to mental illness or have extended impairment in functioning due to mental illness or rely on psychiatric treatment, rehabilitation and supports. Full criteria can also be found on the OMH Website (http://www.omh.ny.gov/omhweb/guidance/Serious_Persistent_Mental_Illness.html)

⁵ Data Sources: Population Estimates - U.S. Census Bureau. 12 percent rate of serious emotional disturbance (SED) for children ages 9-17 and 5.4 percent rate of Serious Mental Illness (SMI) among adults age 18 and over - U.S. Department of Health and Human Services Mental Health - A Report of the Surgeon General. Rockville MD. A prevalence rate for children under age 9 has not been estimated.

⁶ Other prevalence estimates vary from those derived using the HHS percentage. The National Survey on Drug Use and Health (NSDUH) 2010-2012 survey data indicate a 3.56 percent statewide prevalence and the SMI for adults 18 and over (ranging from 3.11 percent to 4.52 percent by region). These suggest a lower overall total number of people with serious mental disorders.

⁷ New York State OMH State Facility Enterprise Reports, 2015.

⁸ The number of unlicensed programs is skewed upward by the way the OMH supported housing program is recorded in the CONCERTS system. Each set of of supported housing admission criteria is treated as a unique "program" for each provider; and therefore, supported housing accounts for 745 programs statewide (with nearly 20,000 beds). Since supported housing is managed centrally by local single point of access (SPOA) in most places, one could count the program only once for each county and once for New York City.

⁹ The 24 State Psychiatric Centers operated by OMH is an aggregate number of adult, children & youth, and forensic psychiatric centers. Nathan S. Kline and NYS Psychiatric Research Institutes are also included in this count.

¹⁰ The OMH Facilities, Article 28/31 Hospitals and CPEPs in New York State: October 2017 map can be found in Appendix A.

¹¹ OMH inpatient services are not licensed by the State. The Joint Commission and Center for Medicare and Medicaid Services (CMS) jointly accredit and oversee State inpatient facilities, along with the oversight of the OMH Division of Quality Management.

¹² OMH State Facility Enterprise Reports

¹³ "Sex Offender Management and Treatment Act (SOMTA) Annual Reports", Office of Mental Health, accessed on July 20, 2018, <https://www.omh.ny.gov/omhweb/forensic/bsoect>

¹⁴ Admissions to Research Units, Sex Offender Treatment Programs, and Regional Forensic Units were excluded

¹⁵ OMH Re-Entry Management System data

¹⁶ 2017 OMH Patient Characteristics Survey

¹⁷ Within the 2017 Patient Characteristics Survey, individuals with criminal justice status are defined as people who received services from the public mental health system in OMH Forensic Psychiatric Centers, OMH Forensic Units, OMH Secure Treatment Facilities, OMH State Psychiatric Centers with a CPL 330.20 admission, DOCCS Correctional Facilities, jails, court detention or police lockup. This definition also includes individuals under court ordered parole or probation, Persons in Need of Supervision, adjudicated juvenile delinquents or offenders, individuals with alternative to incarceration status or who are involved in a mental health court, court diversion program, and/or other criminal justice status.

¹⁸ "SAMHSA's Efforts on Criminal and Juvenile Justice Issues", The Substance Abuse and Mental Health Services Administration, accessed July 20, 2018, <https://www.samhsa.gov/criminal-juvenile-justice/samhsa-efforts>

¹⁹ Data is current as of July 2018

²⁰ Matter of State of New York v. Donald DD., 24 NY3d 174 (Court of Appeals, Oct. 28, 2014).

²¹ "Crisis Intervention Team Core Elements", The University of Memphis, last modified September 2007, <http://cit.memphis.edu/pdf/CoreElements.pdf>

Chapter 2

Mental Hygiene Law Section 5.07 Background and the Local Planning Process

Section 5.07 of Mental Hygiene Law requires OMH to develop a statewide Comprehensive Plan for the provision of State and local services to individuals with mental illness. Some key objectives identified in the statute include: identifying statewide priorities and measurable goals to achieve those priorities, proposing strategies to obtain those goals, identifying specific services and supports to promote behavioral health wellness, analyzing service utilization trends across levels of care and promoting recovery-oriented State-local service development.

This statewide Comprehensive Plan is developed in part from the analysis of local services plans submitted by each local governmental unit (LGU) (57 counties and New York City), in addition to a considerable amount of outreach and discussion with other stakeholders across the State, including consumers, families, providers, and other State, local, and federal agencies. Facilitating the process of county-State communication is the New York State Conference of Local Mental Hygiene Directors Mental Hygiene Planning Committee, which brings together LGUs with the three State Department of Mental Hygiene agencies to address ongoing planning needs.

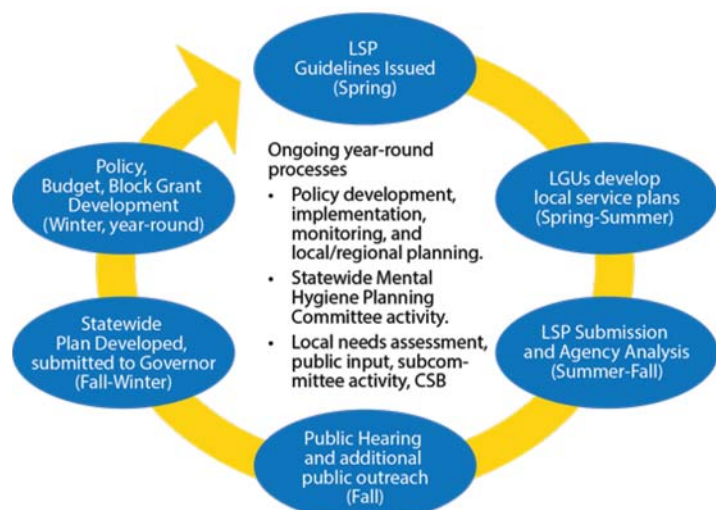
The planning process begins in March of each year with the posting of planning guidelines issued jointly by OMH, the Office of Alcoholism and Substance Abuse Services (OASAS), and the Office for People With Developmental Disabilities (OPWDD). The Local Services Plan Guidelines project each agency's key policy developments and strategic direction, in addition to more technical survey tools and guidance for the submission of local plans. Utilizing the OASAS-operated County Planning System, LGUs develop their local services plans in consultation with their local Community Services Board and other local advisory bodies. The LGUs then submit their final local services plans during the month of June. All local services plans are fully available to the public without a County Planning System account, through the NYS Conference

of Local Mental Hygiene Directors website, allowing for greater access to local services plans to help further educate and engage community stakeholders. Local service plans for 2018 are available by selecting any county on the following web page: http://www.clmhd.org/contact_local_mental_hygiene_departments/

Due to both county and State-level decisions, local needs priorities have changed over the past several years to reflect the rapidly changing landscape of healthcare reform. Statewide initiatives to improve population health, transform healthcare delivery, and eliminate healthcare disparities are reflected in local priorities and strategies that focus on service integration and care coordination. In addition, most counties are addressing service needs and gaps through activities around the Medicaid Delivery System Reform Incentive Payment (DSRIP) Program, the Population Health Improvement Program, the State Health Innovation Plan and the Prevention Agenda 2013-2018.

2.1

The State and Local Planning Cycle



2017 Local Services Plans

Priority Outcome Analysis

Summary analysis from the 2017 Mental Hygiene Local Services Plans, which were completed by local governmental units between March and June 2016, included identification of mental health service priorities in the community, in addition to county needs assessments. In 2017, LGUs were asked to state their local priorities by addressing their needs and progress on their priorities. The plurality of county priorities included in the 2017 plans were associated with multiple mental hygiene service systems.

As displayed in figure 2-2, 57 LSPs included a total of 455 priorities.¹ Of those, 231 (51 percent) were associated with OASAS, OMH and OPWDD; 68 (15 percent) were associated with OMH and OASAS; 15 (three percent) were associated with OMH and OPWDD; and 50 (11 percent) were associated with OMH only. In other words, a total of 364 (80 percent) of priority areas were associated with mental health outcomes.

In addition to identifying priority areas, counties were

asked to rank order their top priorities on a scale of one through five, with one as the highest. Counties were also given the option to leave priority outcomes unranked. Unlike previous years, counties were not asked to place their priorities into specific categories, thus increasing the degree of variation between priorities. However, common themes did arise, and are described in the next section.

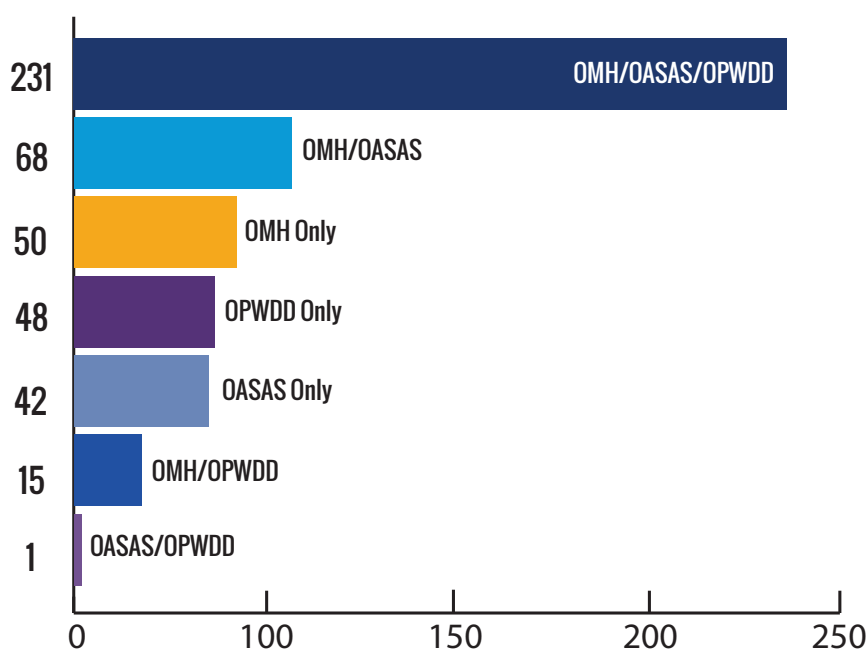
Top Five Mental Health Priorities

Counties identified a total of 364 priority outcomes related to mental health, with 248 counties (68 percent) ranked as one of the top five priority outcomes, and the remaining 116 (32 percent) left unranked.

Common themes found in top five mental health priorities include: increased accessibility and availability of housing, implementation of suicide prevention and awareness efforts, and increased access to behavioral health care in rural areas.

2-2

2017 Local Services Plan Priorities by Agency (N=455)



Another common theme was counties' prioritization of healthcare system reform moving toward integrated, coordinated care through statewide initiatives or more local initiatives. Statewide initiatives appearing in county priorities include Delivery System Reform Incentive Payment (DSRIP) Program and partnership with local Performing Provider Systems, involvement with Systems of Care, partnership with Health Homes and Medicaid Managed Care readiness. Other local priorities included mental health care integration with substance use treatment, developmental disability and/or primary care, and collaboration with local law enforcement, departments of aging, and other local agencies.

An emerging theme of public health strategies for mental health prevention can also be seen in this year's priority outcomes. For example, one county identified the utilization of public health models for education, training, early identification, prevention and treatment to deal with emerging behavioral health issues, while another reported its priority to create and strengthen existing prevention and engagement strategies to improve social determinants of health.

Several counties identified the role of peers in recovery, and identified priority outcomes supporting the development, enhancement and expansion of peer support and peer run services. Counties specified that peer support such as warm lines, home visits, education and training can all be used as vehicles for improved mental wellness and improvement in psychiatric symptoms. Beyond standalone peer services, some plans identified the importance of integrating peers into the full continuum of mental health services.

Special Populations

In addition to the themes listed above, several counties specified special populations in their ranked and unranked priorities. Below are the most common special populations that were identified.

Priority outcomes to enhance, promote and/or increase treatment services for children were commonly identified statewide. Priority outcomes related to adding more support programs for children and families. Other emphasized areas included the development of more rural specific programs, and more group services for children and youth.

Another area frequently ranked as a high priority outcome was increased housing options for children and adolescents. In subsequent discussions with local planners, specific example included children at risk of foster care placement due to the home environment, and transition-age youth aging out of the foster care system without permanent housing in place.

Several counties identified improving and expanding coordination and collaboration to assist the forensic population at various points in which they may encounter the justice system. One county identified working on the front end by increasing law enforcement training and education on working with mentally ill individuals, while another identified expansion of care coordination services within the mental health court. Two other counties identified assisting the forensic population during incarceration by increasing and implementing clinical services within local jails. Finally, other counties' priority outcomes related to assisting forensic clients post discharge, by providing supports for persons transitioning back into the community from prisons and jails and strengthening partnerships with probation, parole reentry, the county sheriff and the county jail to develop quality programs following incarceration.

¹ There are 58 local governmental units, but only 57 LSPs are submitted due to the joint leadership of two LGUs (Warren and Washington) by a single DCS.

Chapter 3

Public Health and Clinical Strategies to Prevent and Intervene Throughout the Trajectory of Mental Health and Wellness

Individuals with serious mental illnesses (SMI) and those experiencing acute episodes of mental illness are much more likely to die early than the general population; mostly due to undiagnosed and/or un(der)-treated medical illnesses. This is largely because this population is:

- A. Disproportionately overburdened by diverse social determinants of poor health (e.g., low income, unemployment and underemployment, poor housing quality and housing instability, food insecurity, stigma and discrimination); therefore
- B. At higher risk for chronic stress and adverse health behaviors (e.g., adverse life events and trauma, physical inactivity, cigarette smoking, poor diet, alcohol/drug misuse/abuse); and

- C. Less likely to access adequate primary care and preventive medical services.

The last of these may have two solutions, which should not be seen as mutually exclusive:

- 1. Integration of medical care into mental health services for persons with SMI, and
- 2. Robust care coordination in primary care settings, that takes the needs of those with SMI into account.

This chapter will focus on a few signature efforts in New York State to better integrate and coordinate care across treatment areas in order to support greater individual and population health.

Section 1

Integrated Outpatient Clinic Services

On January 1, 2015, New York witnessed the culmination of a four-year effort to further the integration of physical and behavioral health services in clinic settings across the State. The new authorization establishes the licensure category “Integrated Outpatient Services” (IOS) and appears identically within regulations for OMH licensed providers (14 NYCRR Part 598), OASAS-licensed providers (14 NYCRR Part 825), and DOH-licensed providers (10 NYCRR Part 404).

Over the past four years, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Department of Health (DOH) have uniquely partnered in the development, implementation and oversight of the “Integrated Licensure Project.” This collaboration resulted in the development of clinical and physical plant standards, staffing requirements, and a single application and review process – all with the goal to reduce the administrative burden on providers and to improve the quality of care provided to consumers with multiple needs by improving the overall

coordination and accessibility of care.

Participating facilities in the Project have been overseen by a single State (“host”) agency, which monitors for compliance with standards at the single site. Therefore, though an agency may have multiple licenses, they are only subject to one survey. Further, the Project has promoted the use of an integrated physical and behavioral health record for recipients.

The now-established IOS regulations further the core principles of the Project, which are:

- 1. Allowing a provider to deliver the desired range of cross-agency clinic services at a single site under a single license;
- 2. Requiring the provider to possess licenses within their network from at least two of the three participating State agencies;
- 3. Allowing the site’s current license to serve as the “host”; and

4. Facilitating the expansion of “add-on” services through a request to the State agency that is principally responsible for oversight of such services.

Applicable Sites for Integrated Outpatient Services

Providers eligible to become IOS providers under the uniform regulations must already possess licenses within their network from at least two of the three participating State agencies, as previously indicated. In addition, the provider must be in “good standing” with the agencies for whom it will be operating integrated services, and must be affiliated with a Health Home (DSRIP Performing Provider System network status is not a sufficient substitute for Health Home affiliation).

Integrated outpatient clinics fall into three main categories that are organized under “host” models. The host model refers to the lead agency which oversees and is the primary point of contact for all of the integrated services:

1. **Primary Care Host Model:** The State Department of Health is the lead oversight agency, and behavioral health services (substance use disorder and/or mental health) are provided in addition to primary health care.
2. **Mental Health Behavioral Care Host Model:** The State Office of Mental Health is the lead oversight agency, and primary health care and/or substance use disorder services are provided in addition to mental health care.
3. **Substance Use Disorder Behavioral Care Host Model:** The State Office of Alcoholism and Substance Abuse Services is the lead oversight agency, and primary health care and/or mental health services are provided in addition to substance use disorder care.

Applications to become an IOS provider are made on a clinic-specific basis, and therefore the agency under which the applicant clinic is originally licensed determines the host site status. For example, an Article 31 mental health clinic applying to become an IOS clinic providing substance use disorder services in addition to those on its original license, will have the State Office of Mental Health as its primary State oversight agency and point of contact.

Services Provided by Integrated Outpatient Clinics

Any clinic that operates as an IOS provider must continue to offer those services required under their host model agency regulations, in addition to those services required under the regulations of the secondary and tertiary licensing agencies.

Any behavioral health care host model must also complete treatment plans for clinic enrollees, which must include physical health, behavioral health, and social service needs. Treatment plans must be completed within 30 days of admission to the clinic. Primary care host models must complete treatment plans for behavioral health services only after a patient has been advanced beyond assessment and pre-admission services. In such cases, a treatment plan is required within 30 days after a decision has been made to begin post-admission behavioral health services.

Adoption of Integrated Outpatient Services by Clinics Statewide

Since the final adoption of the IOS regulations on January 1, 2015, those clinics that were included in the pilot project for integrated outpatient services have continued providing integrated services consistent with the regulations. Additional providers that were not included in the pilot have also since received approval to provide integrated services. The following statistics reflect the number of IOS sites by type, including both grandfathered sites and those approved under the new IOS regulations (as of December 2017):

50 OMH host sites total

- 40 with substance use disorder
- 7 with primary care
- 3 with both primary care and substance use disorder

22 OASAS host sites total

- 19 with mental health
- 2 with primary care
- 1 with both primary care and substance use disorder

5 DOH host sites total

- 4 with mental health
- 1 with both mental health and substance use disorder

Integration of Primary and Behavioral Health Care under DSRIP: Project 3.a.i.

The Medicaid Delivery System Reform Incentive Payment (DSRIP) Program is part of New York State’s plan to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with a primary goal of reducing avoidable hospital use by 25 percent over five years. Built on the “Triple Aim” of better care, better health, and better lives for those we serve at lower costs, DSRIP is focusing on the provision of high quality, integrated primary, specialty and behavioral health care in community settings. In addition to the opportunity to provide integrated behavioral health and primary care services under the IOS regulations, the DSRIP Program has provided another avenue for clinics within Performing Provider Systems to integrate care under DSRIP Project 3.a.i.

DSRIP Project 3.a.i. is addressing the link between comorbid physical and behavioral health needs, through the development of integrated systems of physical and behavioral health care by Medicaid providers, using three distinct models of integration.

- Behavioral Health integrating into a Primary Care site
- Primary Care integrating into a Behavioral Health site
- The IMPACT (Improving Mood-Providing Access to Collaborative Treatment) Model, which integrates depression treatment into primary care, with the goal of improving physical and social functioning while lowering costs.

OMH, OASAS, and DOH collectively agreed to raise the current licensure thresholds associated with clinics in order to allow a greater number of secondary and tertiary services at existing sites, for those clinics that are part of a DSRIP Project 3.a.i. (which was chosen by all 25 PPSs).

3-1

Licensure Threshold Crosswalk for DSRIP Project 3.a.i. Clinics²

Existing Licensure Thresholds	DSRIP Project 3.a.i Licensure Thresholds
A PHL Article 28 provider that has more than 2,000 total visits per year must be licensed by OMH if it has more than 10,000 annual visits for mental health services or more than 30 percent of its total annual visits are for mental health services.	A PHL Article 28 provider that has more than 2,000 total visits per year must be licensed by OMH if more than 49 percent of its total annual visits are for mental health services.
No existing Licensure Threshold. A PHL article 28 provider may not provide substance use disorder services without being certified by OASAS pursuant to MHL Article 32.	A PHL Article 28 provider must be certified by OASAS if more than 49 percent of its total annual visits are for substance use disorder services.
A MHL Article 31 provider or MHL Article 32 must be licensed by DOH if more than 5 percent of its total annual visits are for primary care services or if any visits are for dental services.	A MHL Article 31 provider or MHL Article 32 must be licensed by DOH if more than 49 percent of its total annual visits are for primary care services or if any visits are for dental services.
No existing Licensure Threshold. A MHL Article 31 provider or MHL Article 32 is able to integrate mental health and substance use disorder services pursuant to a Memorandum of Agreement between OMH and OASAS.	<p>A MHL Article 31 provider must be certified by OASAS if more than 49 percent of its total annual visits are for substance use disorder services.</p> <p>A MHL Article 32 provider must be certified by OMH if more that 49 percent of its total annual visits are for mental health services.</p>

However, it is important to note that any clinic providers operating within the existing licensure thresholds or the DSRIP Project 3.a.i. licensure thresholds must also meet certain regulatory requirements outlined by the host model.¹

Approved DSRIP 3.a.i. integrated clinic sites (as of December 2017):

22 OMH host sites total

- 12 with substance use disorder
- 8 with primary care
- 2 with both primary care and substance use disorder

10 OASAS host sites total

- 1 with mental health
- 3 with primary care
- 6 with both primary care and mental health

1 DOH host sites total

- 1 with both mental health and substance use disorder

Section 2

Collaborative Care

Among models of behavioral health integration, Collaborative Care (also known as the IMPACT model) stands apart through a large evidence base, and a significant potential impact on population health. This model of care brings the individual together with the primary care provider, a care manager, and a consulting psychiatrist to treat depression and other common mental health diagnoses in the primary care environment. An electronic registry is used to track each individual's progress and to monitor outcomes on the whole patient population. Collaborative Care helps a practice build the capacity in-house to treat behavioral health conditions, and enhances the ability to manage co-morbid chronic diseases, such as diabetes or hypertension, by addressing some of the behavioral factors impacting physical health outcomes.

New York has continued to be a leader in the promotion of the Collaborative Care model for integration of behavioral health into primary care. The model is supported by more than 80 randomized controlled trials that demonstrate that patients achieve better outcomes when their behavioral health needs are addressed in their primary care practice with Collaborative Care.

With a legislative allocation of at least \$10 million annually to support the New York State Collaborative Care Medicaid Program (CCMP), more than 2,000 Medicaid patients have benefited from receiving treatment for their depression in primary care since the program began in 2015. There are now more than 50 primary care practices participating across the State, including hospital-affiliated clinics, federally qualified health centers and independent provider practices. CCMP continues to provide technical assistance and training to participating practices to help them continue to grow and sustain their programs.

In addition to the training and support practices receive, New York State has designed an innovative payment model to advance sustainability for practices in CCMP.

Reimbursement is one of the principal barriers to adoption of the Collaborative Care model, since it does not fit in a typical fee-for-service structure. New York State has developed a value-based formula that uses a monthly case-rate payment. This allows practices

to provide necessary services flexibly, without being limited by fee-for-service billing. The monthly payment also helps to support crucial infrastructure, such as the addition of behavioral health care management staff to provide counseling and care coordination as well as maintenance of a population-health registry system that allows for tracking of patient progress.

The value-based payment model emphasizes frequent telephonic contacts with the patient, recurring in-person sessions, and virtual consultation with an off-site psychiatrist for caseload support focused on patients who are not improving. To receive the monthly payment, the practice needs to have had contact with patients and completed a PHQ-9 depression screening to track patients' depression symptoms.³ Twenty-five percent of the payment is withheld each month, and can be paid retroactively after six months if the practice can attest that the patient has improved, or that they have intervened and adjusted the patient's treatment plan to address the lack of improvement. Participating sites report process and outcomes data on a quarterly basis. These measures hold providers accountable so that patients do not remain in ineffective treatment for too long.

The combination of financial and training support has resulted in positive outcomes for participating sites. As of June 2016, 53 percent of patients being treated for depression in CCMP sites have shown improvement after 10 weeks or more of treatment. CCMP sites are screening an average of 80 percent of their patients for depression. Sites have also seen an increase in the number of patients who are not improving that have had changes made to their treatment plan and/or their case reviewed by the psychiatric consultant -- which indicates practices are intervening earlier to improve outcomes.

In addition to CCMP, other major NYS initiatives support the implementation of Collaborative Care as part of the increasing emphasis on behavioral health integration, including the DSRIP program project 3.a.i. (described previously) and Advanced Primary Care.⁴ In concert with the Medicaid program, these programs stand to materially improve access to integrated and coordinated behavior healthcare for New Yorkers. In doing so, NYS seeks to reduce the burden of disease for common, disabling behavioral health conditions, such as depression, anxiety and substance use disorders. For information on the Collaborative Care model or its role in the Medicaid program, contact: nyscollaborative-care@omh.ny.gov

Certified Community Behavioral Health Clinics (CCBHC)

OMH, the Office of Alcoholism and Substance Abuse Services (OASAS) and the Department of Health (DOH) have been selected to participate in a two-year demonstration program to better integrate community-based physical and behavioral healthcare services and promote access to improved primary care, mental health, and substance-use disorder services.

New York is one of only eight states selected to participate in the demonstration phase of this federal initiative, awarded by Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS). New York was originally one of 24 states selected to receive planning grants in the winter of 2015, to strengthen community-based mental health care and substance use disorder programs through the development of new Certified Community Behavioral Health Clinics in pilot sites across the state.

New York's application for the demonstration phase highlighted 13 regional CCBHC sites that were identified during the planning phase. Site selection reflects the regional diversity of the state's population, including rural and underserved populations, and service delivery systems. These 13 existing community-based clinics established themselves as CCBHCs in order to begin the two-year demonstration. These sites are broken down by region below:

Upstate

Central Region

Syracuse Behavioral Healthcare - Syracuse
Citizen Advocates, Inc. - Malone

Western

University of Rochester, Strong Memorial Hospital - Rochester
Spectrum Human Services - Orchard Park
Lake Shore Behavioral Health, Inc. - Buffalo
Mid-Erie Mental Health Services, Inc. - Cheektowaga

Hudson River

Bikur Cholim, Inc. - Monsey

For more information on the Certified Community Behavioral Health Clinic Demonstration Program, please visit: <http://www.samhsa.gov/section-223>.

As a part of a collaborative effort under the first round of grant awards, OMH, OASAS, DOH, and community stakeholders have developed a program model for CCBHC that will improve the State's behavioral health system, by:

- Addressing unmet needs identified through comprehensive community needs assessments,
- Enhancing statewide healthcare integration and coordination efforts among behavioral health and physical health care providers, and
- Ensuring the accessibility and availability of behavioral health services that are person-centered, trauma-informed, culturally competent, and recovery-oriented for all who need them—particularly vulnerable and needy populations, including: people with opioid addictions, people who are dually eligible for both Medicaid and Medicare, non-English speakers, and people with low socio-economic status.

Downstate

Long Island

Central Nassau Guidance & Counseling Services - Hicksville

New York City

New Horizon Counseling Center - Ozone Park
PROMESA, Inc. - Bronx
VIP Community Services - Bronx
Samaritan Daytop Village - New York
Services for the Underserved, Inc. - New York

Section 3

Statewide Expansion of Systems of Care through ACHIEVE

The Systems of Care (SOC) principles are rooted in a philosophy, set of values, and a framework through a coordinated network of community-based services and supports. This model is organized to meet the physical, behavioral, social, emotional, educational, and developmental needs of children and their families in a process that is youth and family guided. Integral to the SOC approach is the promotion of wellness of children and youth across the lifespan by providing supports that build on the strengths of individuals and those that care about them, while addressing each person's cultural and linguistic needs. SAMHSA currently funds over 190 SOC communities nationwide, with several New York counties being current awardees.

For over 30 years, New York has been committed to SOC principles and practices, which has been demonstrated through state, local and federally-funded initiatives that have produced transformational changes in the state's child-serving systems. For the first time, OMH has applied for and received a Statewide SOC grant that will be piloted with demonstration projects in three counties – Erie, Rensselaer and Westchester. This pilot project is known as Advancing Care through Health Integration and Evidence-based Effort, or ACHIEVE, which has a project goal of integrating an evidenced based High Fidelity Wraparound (HFW) model with Health Homes Serving Children (HHSC) developed under the Medicaid Redesign and rolled out in December 2016. Under this program, eligible children and youth receive care coordination and access to services.

NYS ACHIEVE is a four-year initiative that integrates the HFW model with the HHSC program for youth and young adults ages 12 to 21, with serious emotional disturbance and high, complex needs. ACHIEVE partners include the Research Foundation for Mental Hygiene, State and local child-serving agencies, family representatives, and youth partners involved with SOC efforts throughout the State. These partners will serve a sub-group of youth and families who have more intensive needs such as placement or risk of placement that can be met through the HHSC's standard care

management and benefit package.

The ACHIEVE initiative's demonstration projects in Erie, Rensselaer and Westchester counties, will work with two HHSCs per county and four care management agencies. When fully operational, the local demonstrations are expected to serve 60 youth and their families, totaling 191 youth/families over the four-year project period, as seen in Figure 3-2.

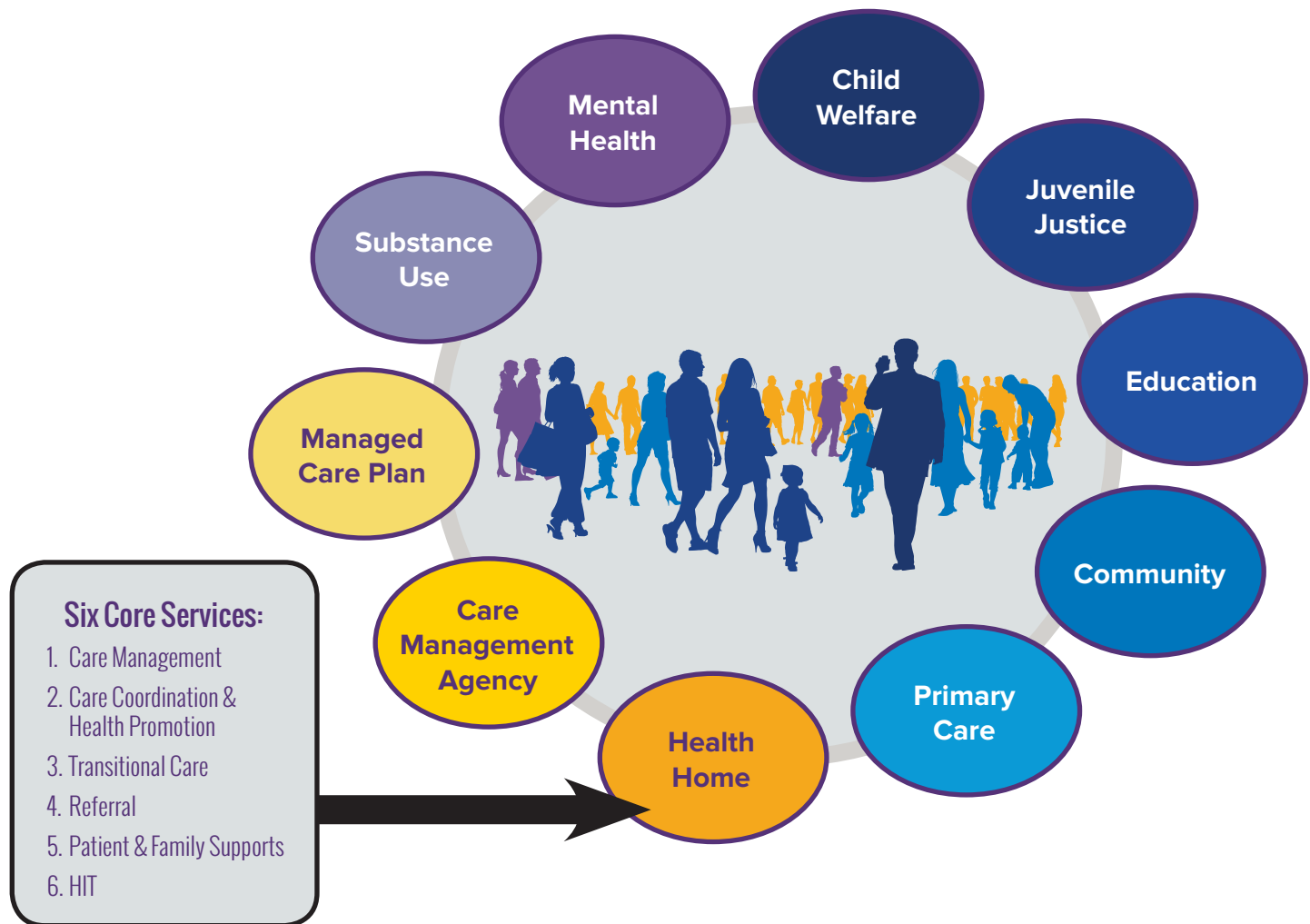
3-2 ACHIEVE High Fidelity Wraparound Capacity for Families Served

	Year 1	Year 2	Year 3	Year 4	Total
Erie	7	20	20	20	67
Westchester	7	20	20	20	67
Rensselaer	0	17	20	20	57
Total					191

Each child and family simultaneously works with a triad team composed of a Health Home care manager, a family peer and a youth peer, who will all be trained in the HFW model. The team will also be trained using a model developed by the Nathan Kline Institute to maintain fidelity to the SOC principle of meeting the child and family's cultural and linguistic needs. The triad's responsibility is to carry out the planning process per the HFW model, in the context of HHSC and to assist in access to and building of both informal and formal supports from a variety of service systems. Figure 3-3 models how the child, their family and the triad team, who appear at the center, interact with each other with wraparound services and supports.

3-3

Child & Family, Health Home HFW Care Manager, Family Peer and Youth Peer



Through these local demonstrations and by the project's fourth year, NYS will have identified and refined key components, policies and practices necessary to provide culturally competent, family-driven and youth-guided:

1. Care planning,
2. Intensive, integrated and comprehensive services, and
3. Flexible funding, which, in turn, will produce positive outcomes for the youth in the population of focus and their families.

The findings and lessons learned through full integration of HFW, SOC and HHSCs in these counties will provide the basis for dissemination and implementation of the ACHIEVE model in other parts of the State. These findings may also have national implications because ACHIEVE aims to attain sustainability of the model by impacting the Medicaid system; thus, having the potential to serve as a model for other states involved in healthcare reform and Medicaid redesign efforts.

Section 4

The OnTrackNY First Episode Psychosis Program

OnTrackNY is New York's model early psychosis intervention program, which was built on the National Institute of Mental Health-funded Recovery After an Initial Schizophrenia Episode (RAISE) Implementation and Evaluation Study. The RAISE Connection program study developed and tested the outcomes and implementation challenges of a team-based approach to providing an array of pharmacologic and psychosocial services to help young people with recent-onset psychosis keep their lives on track after an initial psychotic episode. The RAISE Connection program had very high rates of engagement, doubled rates of participation in school and work, and increased rates of remission from psychotic symptoms.

The OnTrackNY program treatment teams consist of a team leader, primary clinicians, a supported employment/education specialist, an outreach and enrollment specialist, a psychiatrist and nurse. Each team provides a range of services, including relapse prevention, illness management, medication management, integrated substance use treatment, case management, family intervention and support, supported employment, and education. Results from the OnTrackNY program include improvements in engagement, functioning and symptoms that are comparable to the RAISE Connection program findings.

OnTrackNY is currently operating at 21 sites throughout New York State, with 9 new sites opening since 2016. The 21 currently operating programs are located in the following areas: Albany, Binghamton, Buffalo, Farmingville, Garden City, Middletown, New York City (12 sites), Rochester, Syracuse, and Yonkers.

Section 5

Suicide Prevention

In 2015, 1,639 New Yorkers died of suicide⁵. To address this significant public health problem, Governor Cuomo has formed the New York State Suicide Prevention Task Force, which includes leaders from state agencies, local governments, not-for-profit groups, and other recognized experts in suicide prevention.

First announced in Governor Cuomo's 2017 State of the State, the Task Force will examine and evaluate current suicide prevention programs services, and policies. Members will then make recommendations to increase access, awareness, and support for children, adolescents and adults in need of assistance.

The Task Force is also focusing on suicide prevention that targets high-risk demographic groups and special populations, including members of the Lesbian, Gay, Bisexual, Transgender (LGBT) community, veterans, and Latina adolescents. Veterans in New York State represent more than 15 percent of suicides, while nationally, LGBT adolescents are four times more likely to have attempted suicide than their non-LGBT peers; and Latina adolescents have the highest suicide attempt rates when compared to non-Hispanic peers.

In addition to the ongoing work of the Task Force, OMH's Suicide Prevention Office (SPO) has developed a comprehensive Suicide Prevention Plan that addresses the problem at three levels:

1. Implementation of the Zero Suicide strategy for preventing suicide for individuals in health and behavioral health care settings;
2. A lifespan prevention approach to foster competent and caring communities; and
3. Suicide surveillance and data-informed suicide prevention.

The full version of the SPO's Suicide Prevention Plan 2016-17 is available at <https://www.omh.ny.gov/omhweb/resources/publications/suicide-prevention-plan.pdf>.

This section provides an update on the ongoing implementation of the SPO's Suicide Prevention Plan.

Preventing Latina Adolescent Suicide

Suicide is the second leading cause of death among Latina adolescents in New York State at a rate of 2.6 per 100,000 individuals. Latina teens currently have the highest rate of suicide attempts among all adolescent groups according to the Center for Disease Control and Prevention's 2015 Youth Risk Behavior Survey, which reported that 15 percent of Latina adolescents in the United States have attempted suicide.

In addition to New York State's comprehensive efforts to prevent adolescent suicide, OMH provided initial seed funding for the development of the Life is Precious program, a culturally-sensitive program aimed at addressing the unique needs of Latina adolescents at risk for suicide. Life is Precious helps to reduce suicidal behavior by decreasing risk factors and increasing protective factors through a wide range of traditional and non-traditional services for Latina adolescents receiving mental health treatment, including: art therapy, music education, family mediation, academic support, case management, and linkages to care.

Operating after-school programs in the Bronx, Brooklyn, and Queens and offering weekend hours, Life is Precious is showing promising results. An initial evaluation by the Office of Mental Health's Center of Excellence for Cultural Competence at the New York State Psychiatric Institute found that participants had fewer suicidal thoughts and depressive symptoms when engaged with the program, as well as better communication and relationships with family and peers.

Most importantly, during the evaluation period, no participant attempted suicide.

Strategy 1: Prevention in Health and Behavioral Healthcare Settings – New York State Implementation of Zero Suicide

Developed under the National Action Alliance for Suicide Prevention, the Zero Suicide model depends on successfully re-engineering healthcare systems in order to identify those in distress and at risk for suicide, and deliver timely intervention. Under the New Yorkers Advancing Suicide Safer Care (NYASSC) initiative, Zero Suicide implementation in New York State offers a strategic approach for reaching many high-risk populations, given their contact with the health and behavioral healthcare systems.

With a \$3.5 million Substance Abuse and Mental Health Services Administration (SAMHSA) grant, SPO will be implementing the Zero Suicide model statewide through partnerships with large health systems in each mental health service region. Through NYASSC, SPO has a goal of assessing 280,000+ people over five years and providing nearly 200,000 suicide-specific interventions. Supported by the \$3.5 million SAMHSA grant, SPO has also launched the Attempted Suicide Short Intervention Program pilot program in Onondaga County, which reframes how suicide attempts are examined in order to develop individualized prevention strategies. Developed in Switzerland, this program is based on the belief that it is more helpful to view suicide as an action taken in order to reach a goal, rather than simply a symptom of mental illness. Only by understanding the very individualized path to a suicide attempt can one develop effective prevention strategies.

SPO, along with its partners, launched the Suicide Prevention Continuous Quality Improvement (CQI) project in 2016, which represents the largest implementation of Zero Suicide in the United States. By working directly with clinics serving individuals with mental illness, CQI aims to reduce suicide and deaths by suicide through the implementation of the Assess, Intervention & Monitor for Suicide Prevention (AIM-SP) clinical model, which includes the following:

- All clients receive suicide-specific screening (C-SSRS), risk assessment, and Health Home referral (if appropriate);
- Clients who are identified as High Risk are put on a Suicide Care Pathway and receive enhanced interventions, including the Stanley-Brown Safety Plan and more frequent contact; and

- PSYCKES is used to identify risk at intake; positive C-SSRS scores and Safety Plans are entered/uploaded and available to any other treating provider.

Currently, the CQI project is comprised of 165 participating clinics, with 280 associated satellites, in 37 counties across New York State.

Strategy 2: Prevention across the lifespan in competent, caring communities

Community settings offer opportunities to detect and intervene with high risk populations, including some of which may not be easily reached through the health and behavioral healthcare system. New York State is developing programming that covers the lifespan. From school-aged children to young and middle-aged adults to seniors, the collective goal is to reduce risk factors and bolster protective factors among those at risk.

Four principles guide New York State's approach to develop competent, caring communities with the ultimate goal of leaving community members less vulnerable to suicide across the lifespan. These are explored in detail in the full Suicide Prevention Plan 2016-17, and summarized below.

Guiding principles for "Prevention across the lifespan in competent, caring communities":

- Develop, support, and strengthen community coalitions as the "backbone" of local suicide prevention infrastructure.
- Create suicide safer school communities.
- Utilize postvention as prevention.
- Deliver targeted gatekeeper trainings.

The development of competent, caring communities for suicide prevention is a central focus of Governor Cuomo's Suicide Prevention Task Force's ongoing activities. Upon the issuance of the Task Force report, OMH will look to share best practices and encourage the adoption of Suicide-Safer Communities approaches across New York State.

Strategy 3: Surveillance and Data-Informed Suicide Prevention in New York State

Preventing suicide is difficult, in part, because of the inherent challenges of measuring progress, due to the statistical rarity of suicide, the difficulty of population-

School-Based Suicide Prevention

The Centers for Disease Control and Prevention's 2015 Youth Risk Behavior Survey showed that nearly 16% of New York State high school students reported seriously considering suicide in the past year, and nearly 10% said they had attempted suicide. In 2017, OMH supported a number of evidence-based and best practice programs for students, families and faculty members, including the Creating Suicide Safety in Schools, Sources of Strength, Lifelines Postvention, and Suicide Safety for Teachers.

The Creating Suicide Safety in Schools Workshop is a one-day workshop that uses a problem-solving approach to build school professionals' confidence and facilitate improved readiness in the event of a suicidal crisis.

695 professionals trained in 2017.

Sources of Strength is a universal public health-oriented suicide prevention program developed to utilize the influence of natural adolescent opinion leaders (Peer Leaders) working in partnership with adults, who provide mentoring and guidance. ***Since the program began in 2016, approximately 36,247 students have been impacted by Source of Strength suicide prevention programming through peer-led prevention messaging and increased student-adult connections.***

Lifelines Postvention: After Suicide and Traumatic Death program prepares school crisis teams, community services, and administrators to support recovery after loss. It focuses on three main principles: Grief support, crisis management, and contagion prevention. ***199 professionals trained in 2017.***

Suicide Safety for Teachers is a training to address the suicide awareness needs of teachers and school staff, providing an orientation to suicide prevention. ***2652 professionals trained in 2017.***

derived suicide risk factor translation to the individual level, the lag in suicide data reporting, and a lack of consensus in the field of suicide prevention on how to best measure progress. However, New York State is fortunate to have a good foundational surveillance infrastructure on which to build.

The following principles illustrate the New York State approach to enhancing and improving suicide surveillance and using it to guide quality improvement initiatives:

- Enhance and improve suicide surveillance data.
- Disseminate surveillance data to stakeholders in readily usable forms to support quality improvement work.
- Perform in-depth reviews of suicides occurring within the public mental health system.
- Promote a research agenda that leverages the use of technology and large-scale trials.

The Governor's Suicide Prevention Task Force, in concert with SPO, is currently examining various methodologies to strengthen the suicide surveillance data collection process and leverage existing data systems, improve the timeliness and quality of suicide surveillance data, and support health systems and health care professionals in active utilization of suicide surveillance data in treatment. Influenced by the work of the Governor's Task Force, OMH and DOH recently unveiled a suicide dashboard that highlights state and county level suicide data. The overall aim is to support groups involved in suicide prevention programming across the state by centralizing the most relevant information in an easily accessible format, which will be expanded in the future with additional data.

¹ The host model can be found on the Department of Health website at http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/licensure_thresholds.htm

² Table from link in note above.

³ The Patient Health Questionnaire, or PHQ-9 is a widely-used nine-question depression screening tool.

⁴ Advanced Primary Care is a model of primary care advanced under the State Department of Health NYS Health Improvement Plan (NYSHIP) and State Innovations Model (SIM) grant, which includes integrated behavioral health treatment at the highest level of this primary care practice model.

⁵ New York State Vital Statistics

Chapter 4

The OMH Transformation Plan: *Advancing a Progressive Behavioral Health System*

Background

New York currently exceeds both the national average inpatient utilization rate at State-operated Psychiatric Centers, and per capita inpatient census levels at State-operated Psychiatric Centers in other urban states and all Mid-Atlantic states. New York's extensive State Psychiatric Center inpatient capacity includes 24 facilities with over 3,500 budgeted beds. Among these are several hospitals operating with fewer than 100 beds.

This situation had led to disproportionately high State-operated inpatient per capita costs as more individuals

with mental illness are supported successfully with community-based mental health services, while the inpatient footprint has remained disproportionately large. While New York's State-operated inpatient facilities serve approximately one percent of the total number of people served in the public mental health system, they account for 20 percent of gross annual system expenditures. With the inclusion of other acute inpatient facilities (Article 28 or 31 psychiatric hospitals), inpatient psychiatric costs amount to approximately half of the total spending on public mental health services.

Eleven Areas of Transformation Plan Pre-Investment*

These are eleven major service areas supported through the Transformation Plan investment:

1. 1,305 units of Supported Housing with appropriate wrap-around services to ensure individuals can be served safely in the community, and avoid potential future homelessness.
2. 246 additional Home and Community Based Services (HCBS) Waiver slots which provide children and their families with respite services, skill building, crisis response, family support, intensive home support and care coordination.
3. Twelve State-operated Mobile Integration Teams (MIT) which provide an array of mobile services and supports for youth and adults, including on-site crisis assessment, skill building, family support, and respite. Additional existing State-operated community support services will also be converted to a MIT model. MITs can serve hundreds of individuals each month, and are scaled and located to community need. To date, MITs have provided critical supports to over 5,600 individuals statewide.
4. Four new State-operated, child and adolescent crisis/respite houses.
5. Expansion of State and voluntary-operated clinic programs to provide services when they would be otherwise unavailable or inaccessible.
6. Staffing support for State-operated First Episode Psychosis programs being implemented statewide under the nationally recognized OnTrackNY initiative.
7. Sixteen new and expanded crisis intervention programs, many with extended hour coverage, mobile capacity, and peer-support components in order to best meet the needs of individuals in times of crisis.
8. Over 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.
9. Ten new or expanded Assertive Community Treatment teams, accounting for a capacity expansion of 572 slots.
10. 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.
11. Fourteen long stay teams to assist with the transition individuals with State Psychiatric Center or residential lengths of stay exceeding one year, into structured community settings. OMH has also developed more resources out of the State Psychiatric Centers to aid in the transition of Psychiatric Center long-stay inpatients requiring skilled nursing facility or managed long term care services in the community.

*NOTE: As of December 2017.

The OMH Transformation Plan aims to re-balance the agency's institutional resources by further developing and enhancing community-based mental health services throughout New York State. By doing so the Plan will strengthen and broaden the public mental health system to enhance the community safety net; allowing more individuals with mental illness to be supported with high quality, cost-effective services within home and community-based settings and avoid costly inpatient psychiatric stays.

Beginning in State Fiscal Year (SFY) 2014-15 and continuing through SFY 2017-18, the OMH Transformation Plan has committed \$92 million annualized in State-operated inpatient savings into priority community services and supports, with the goals of reducing State and community-operated facilities' inpatient psychiatric admissions and lengths of stay. Nearly \$19 million in additional Article 28 reinvestment funds have also been directed across the State as the result of unnecessary community inpatient bed reductions over the past several years. These funds have further developed the critical community services and supports needed to prevent inpatient hospitalization, transition individuals from inpatient settings, and strengthen the community mental health safety net.

OMH has also dedicated a share of pre-investment funding to support transitions for State long-stay inpatients to the community through managed long term care and skilled nursing facility bridging. Nearly 50 percent of OMH adults on census have been at a State Psychiatric Center for over a year, and a large portion have even been with us for several years. By helping move long-stay individuals with complex medical and behavioral health needs to more integrated and less restrictive community settings, OMH will free up inpatient capacity that has otherwise been unavailable for admissions from the community; this will effectively increase our capacity to provide intermediate care.

In addition to expanded financial resources, the Transformation Plan has also convened groups consisting of local governmental units, OMH Field Offices and psychiatric centers, providers, and other stakeholders to engineer other systems changes to better serve individuals in communities and hospital settings. These systems-level planning efforts have worked to improve pathways through levels of housing,

increase engagement in clinic and other outpatient services, and expand access to existing and new children's Home and Community Based Services (HCBS) waiver capacity.

The recent carve-in of most Medicaid behavioral health services into managed care, the Delivery System Reform Incentive Payment (DSRIP) program, and the Prevention Agenda 2013-2018 are timely and direct drivers of reform to the State and community-based systems of care. Together these initiatives will further coordinate care across clinical modalities and levels of government by developing an integrated, recovery-centered service delivery system designed to improve consumer care and population health—the means to achieve the “Triple Aim” of better care, better health and better lives for those whom we serve—at lower costs.

The OMH Transformation Plan is consistent with these ongoing reforms in health care policy and financing. As the market for health care services becomes more consumer-directed, integrated and community-oriented, OMH must advance in step with the people we serve in order to be relevant and sustainable in the future. The OMH Transformation Plan will create the mental health system that New York needs in the 21st Century—a system focused on prevention, early identification and intervention, and evidence-based clinical services and recovery supports.

Regional Reinvestment and Systems Planning

With the passage of the SFY 2014-15 budget, planning for pre-investment funding began in all areas of the State: Western New York, the Rochester area, the Southern Tier/Finger Lakes region, the North Country, Central New York, the Hudson River region, New York City, and Long Island. Local government units, OMH Field Offices, and State Psychiatric Center directors have continued working collaboratively to operationalize the goals of a broad set of community stakeholders who participated in regional advisory bodies initiated in the fall of 2013. The goals of the regional advisory bodies focused on the following resources: Supported Housing, Medicaid Home and Community Based Services Waiver, State-operated community enhancements, and Aid to Localities funding—in addition to overall systemic reforms required to most effectively use these resources.

As regional investments approach a fifth year of planning, OMH and its stakeholder partners are further reviewing the effectiveness of all services to ensure that they are having the originally stated impact to reduce inpatient utilization and optimize community living. Some programs and services that have matured in implementation have been modified from their original concepts when utilization has been low or if the design did not have the desired impacts on our target populations. OMH will continue working with local and regional stakeholders to develop, implement, and improve services as we study the data in this report, and the additional monthly reports that are distributed widely within and outside of the agency.

The regional summaries below include information for all reinvestment programs funded through December 2017.

Western New York Reinvestment and Planning Progress

OMH has made funding available for the counties served by Western New York Children's Psychiatric Center and the Buffalo Psychiatric Center in an annualized amount of \$5.7 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS Waiver, State-operated community service expansion, and Aid to Localities. The geographic and programmatic

specifications for the services funded in this region that are listed below were determined through on-going consultation with community stakeholders, including the local governmental units (LGUs).

- 112 Supported Housing units.
- 24 Home and Community Based Services Waiver slots.
- A State-operated Mobile Integration Team for children and youth.
- A State-operated Mobile Integration Team for adults.
- State-operated children's outpatient clinic expansion.
- An expanded State-operated Mobile Mental Health-Juvenile Justice Program.
- 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.
- Mobile Transitional Supports provide mobile clinical intervention and support with follow-up during the time when discharged individuals are transitioning to engagement in the community-based services and supports identified on their discharge plan. This program will provide mobile interventions during hours when community-based clinical services are largely unavailable, care management may not be immediately available, and crisis outreach is not appropriate.
- Crisis Intervention Team. This team provides clinical intervention and supports to successfully maintain each person in his/her home or community by providing the level of clinical care, community-based supports and supervision that are needed to maintain community tenure.
- Long Stay Team. This community integration team operated out of Erie County will help transition long stay individuals from Buffalo Psychiatric Center into community settings through collaborative discharge planning and linkages to community supports.
- Crisis Diversion Services provided under the "living room" model, with add-on clinical capacity.

In addition to these Transformation Plan services, OMH and the New York State Department of Health are funding the following services with \$1.1 million in reinvestment funds associated with the closure of inpatient psychiatric units at Medina Memorial Hospital and St. James Mercy Hospital:

Medina Memorial Hospital:

- Crisis Services and Housing have enhanced community crisis response capabilities, including expanded crisis assessment, establishment of a Family Assistance Crisis Team (FACT), new crisis apartments, development of a suicide prevention coalition and crisis lifeline, and enhancement of existing community supports.
- Crisis Response Practitioner in Niagara County covers high volume late afternoon and evening crisis calls and provide follow-up and linkage to community services.

St. James Mercy Hospital:

- Enhanced Mobile Crisis Outreach is a multi-faceted approach that includes crisis and support services such as enhanced family support, bridger care management, county-targeted mental health response and training for local law enforcement.
- Intensive Intervention Services include community-based assessment, development of crisis plans, and frequent face-to-face intervention for adults at high risk of hospitalization.
- A Post Jail Transition Coordinator/Forensic Therapist in Livingston County Jail to reduce recidivism by providing individuals with mental health services and discharge planning for linkages to community behavioral health and residential services.
- Home Based Crisis Intervention (HBCI) to provide intensive in-home crisis intervention for families whose children are at risk of inpatient admission within the tri-county area (Steuben, Allegany, and Livingston counties) previously served by the St. James Mercy psychiatric unit.

Rochester Area Reinvestment and Planning Progress

OMH has made funding available for the counties served by the Rochester Psychiatric Center in an annualized amount of \$6.3 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS waiver, State-operated community service expansion, and Aid to Localities. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through ongoing consultation with community stakeholders, including the LGUs.

- 125 Supported Housing units.
- A State-operated Mobile Integration Team for adults.
- A State-operated First Episode Psychosis Team under the OnTrackNY initiative.
- Adult outpatient clinic expansion.
- 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. These individuals are assessed on an ongoing basis to determine their service needs. The level of supports available from the community support teams will match the level of identified needs.
- Peer-Run Respite Diversion provides an alternative to emergency room service or inpatient admission for individuals experiencing a psychiatric crisis. This program will provide a home-like environment with peer-directed mental health services and supports.
- Adult Crisis Transitional Housing provides short-term intensive supports following a psychiatric hospitalization. In addition, these units are available to individuals already in the community who are experiencing a behavioral health crisis, are at risk of being homeless, or may be at risk of a psychiatric inpatient admission. The units have enhanced staffing available to support the intensive support needs of this population.
- Two Assertive Community Treatment (ACT) Teams: ACT Teams are evidence-based programs that deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings rather than in hospital or clinic settings. These teams have been found to improve recipient outcomes with studies showing greater reductions in psychiatric hospitalization rates, emergency room visits, and higher levels of housing stability after receiving ACT services.
- Peer Bridger Program to work with individuals transitioning from psychiatric inpatient units into Supported housing. Bridger staff offer shared experience and information with the individuals transitioning to the community, using a person-centered approach to best meet each person's needs.
- Enhanced Recovery Supports to expand existing peer-operated programs in Wyoming County. These programs support the recovery goals of individuals in community-based settings by promoting consumer empowerment, education, skill development, peer

support, advocacy, and community integration.

- Long Stay Team. This community support team operated out of Monroe County helps transition long stay individuals from Rochester Psychiatric Center into community settings through collaborative discharge planning and linkages to community supports.

Finger Lakes and Southern Tier Reinvestment and Planning Progress

OMH has made funding available for the counties served by Elmira Psychiatric Center and Greater Binghamton Health Center in an annualized amount of \$9.4 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS waiver, State-operated community service expansion, and Aid to Localities funds. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through ongoing consultation with community stakeholders, including the LGUs.

- 170 Supported Housing units.
- 24 Home and Community-based Services Waiver slots.
- Eight Children's Crisis/Respite beds on the grounds of Elmira Psychiatric Center.
- A State-operated Mobile Integration Team for adults operating out of hubs at Elmira Psychiatric Center and Greater Binghamton Health Center.
- A State-operated First Episode Psychosis Team under the OnTrackNY initiative.
- Transportation supports for individuals and families who must access crisis/respite beds.
- Adult Crisis Transitional Housing and the increased utilization of State-operated community residential services for crisis/respite.
- Family and Peer Support service expansion, including support for peer training and certification, and peer support services for adults utilizing State-operated crisis/respite services.
- Forensic Staff Support. Mental health clinical staff support to work with local law enforcement on the Broome County (Binghamton PD) Crisis Intervention Team forensic program to help prevent criminal justice involvement and subsequent hospitalization of individuals with serious mental illness.
- Respite Services to stabilize individuals in the

community rather than utilize inpatient or long term out of home services.

- Long Stay Transition Services. The expansion of a community support program operated out of Chemung County will help transition long stay individuals from Elmira Psychiatric Center into community settings through collaborative discharge planning and linkages to community supports.

Central New York Reinvestment and Planning Progress

OMH has made funding available for the counties served by Hutchings Psychiatric Center in an annualized amount of \$2.8 million. Pre-investment resources will support services in several programmatic areas including HCBS waiver, State-operated community service expansion, and Aid to Localities funds. The geographic and programmatic specifications for the services funded in this region and listed below were determined through ongoing consultation with community stakeholders, including the LGUs.

- 42 Supported Housing units.
- 18 Home and Community-based Services Waiver slots.
- A State-operated First Episode Psychosis Team under the OnTrackNY initiative.
- Six Children's Crisis/Respite beds on the grounds of Hutchings Psychiatric Center.
- Long Stay Team. This long stay reduction transition team operates out of Onondaga County and helps transition long stay individuals from Hutchings Psychiatric Center into community settings through collaborative discharge planning and linkages to community supports.

North Country Reinvestment and Planning Progress

OMH has made funding available for the counties served by the St. Lawrence Psychiatric Center in an annualized amount of \$4.2 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS waiver, State-operated community service expansion, and Aid to Localities funds. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through ongoing consultation with community stakeholders, including the LGUs.

- 55 Supported Housing units.
- 12 Home and Community-based Services Waiver slots.
- Six Children's Crisis/Respite beds on the grounds of St. Lawrence Psychiatric Center.
- A State-operated Mobile Integration Team for children and adults.
- School-based 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. Capacity expansion, after hour services and an increase in support staff to enhance 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.

Hudson River Region Reinvestment and Planning Progress

OMH has made funding available for the counties served by Capital District Psychiatric Center, Rockland Psychiatric Center and Rockland Children's Psychiatric

Center in an annualized amount of \$9.2 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS waiver, State-operated community service expansion, and Aid to Localities funds. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through ongoing consultation with community stakeholders, including the LGUs.

- 229 Supported Housing units.
- 12 Home and Community-based Services Waiver slots.
- A State-operated Mobile Integration Team for adults, serving the Capital District Psychiatric Center service area.
- A State-operated Mobile Integration Team for adults, serving the Rockland Psychiatric Center service area.
- A Self-Help Program to offer short-term care and interventions in response to behavioral health crises that create an imminent risk for escalation without supports.
- Outreach Programs to assist in locating and securing housing of a service recipient's choice and in accessing the supports necessary to live successfully in the community. Outreach programs are intended to engage children, adults, and families who are potentially in need of mental health services.
- Advocacy and Support Services to assist consumers in protecting and promoting their rights, resolving complaints and grievances, and accessing services and supports of their choice. A self-help component of the program provides rehabilitative and support activities based on the principle that people who share a common condition or experience can be of substantial assistance to each other. These programs include mutual support groups and networks, self-help organizations and/or specific educational, recreational and social opportunities.
- 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.
- An Assertive Community Treatment (ACT) Team. ACT Teams are evidence-based programs that deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings rather than in hospital or clinic settings.

These teams have been found to improve recipient outcomes with studies showing greater reductions in psychiatric hospitalization rates, emergency room visits, and higher levels of housing stability after receiving ACT services.

- Adult Outreach Services intended to engage and access individuals potentially in need of mental health services.
- A Children's Crisis Intervention/Mobile Mental Health Team to provide the clinical interventions and supports necessary to successfully maintain children in home or community-based settings and prevent inpatient hospitalization.
- Six Long Stay Teams. These outreach teams will help long stay individuals transition into community settings through collaborative discharge planning and linkages to community supports. Teams operated out of Albany and Schenectady counties will work with long stays discharged from Capital District Psychiatric Center and teams operated out of Dutchess, Orange, Rockland and Westchester Counties will work with long stays discharged from Rockland Psychiatric Center.

In addition to these Transformation Plan services, OMH and the New York State Department of Health are funding the following services with \$4.6 million in reinvestment funds 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.
- Home Based Crisis Intervention (HBCI) Services to provide intensive in-home crisis services to children aged 5-17.
- Mobile Crisis Intervention Services to prevent or Mobile Integration Team inpatient hospitalization or emergency room use for adults, adolescents and children experiencing acute symptoms. This service will operate late in the day and in the evenings.
- 18 Home and Community Based Services (HCBS) Waiver Slots for intensive home based services to enable children to live and receive services in their homes and avoid inpatient hospitalizations.
- Supported Housing and Community Support to enable people to live independently and reduce the utilization of costlier Medicaid services. These funds support at least 10 additional supported housing units with community supports for targeted populations, including

transitional youth (aging out) at risk of hospitalization.

- Children and Youth Family Support to provide core services of family/peer support, respite, advocacy and skill building, and educational opportunities. This is a cost-effective and evidence-based method of reducing the need for inpatient services.
- Self-Help Program. A peer-operated alternative to hospitalization that provides supports to individuals in crisis or emotional distress.

New York City Reinvestment and Planning Progress

OMH has made funding available for New York City in an annualized amount of \$17.6 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS waiver, State-operated community service expansion, and Aid to Localities funds. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through ongoing consultation with community stakeholders, including the New York City Department of Health and Mental Hygiene.

- 364 Supported Housing units.
- 63 Home and Community-based Services Waiver (HCBS) slots.
- Three State-operated Mobile Integration Teams for adults and children across the City.
- Transitions in Care Teams focused on State Psychiatric Center and acute care discharges. OMH is funding two types of transitions in care teams known as the Pathway Home and Parachute teams, partly focused on assisting recipients in the transition from a State Psychiatric Center to a community setting. These teams will become a critical part of what is missing in the crisis management system in the City. While partly focused on State Psychiatric Center discharges, these teams can also be used as a bridge service for individuals being discharged from an acute care hospital as a way to provide more intensive support while a recipient is being engaged in outpatient clinic and other services. Both teams are focused on recipient engagement through a multi-disciplinary mobile team consisting of peer specialists and nurses, social workers and part-time physician staff and have as their goal the collaboration with treatment and housing providers to facilitate timely, safe discharge to the community with ongoing support. Although run by different providers, the basic aim is similar – providing time-

limited support in transitions in care to prevent future crises, and costly inpatient and psychiatric emergency services use. The team support is very patient-centered and depending on the recipient's needs can extend from 3 months to year. An important part of the engagement is the use of recipient wrap-around dollars.

- A Crisis Pilot Program to develop a new, enhanced model of mobile crisis that will partner with providers to increase rapid appointments for individuals in need of services. During this pilot, performance will be measured on response time, continuity of care and number of patient hospitalizations to help better understand future need for similar services in NYC and rest of state.

In addition to these Transformation Plan services, OMH and the New York State Department of Health are funding the following services with \$10.3 million in reinvestment funds associated with inpatient psychiatric reductions at Holliswood, Stony Lodge, and Mt. Sinai Hospitals:

Holliswood Hospital:

- 15 Home and Community Based Services (HCBS) Waiver Slots for intensive home based services targeted at children who would otherwise require hospitalization or residential treatment.
- Children's Crisis Respite Beds to offer short-term overnight respite of up to 21 days for relief from a current stressful living situation children aged 4-18. This funding increases bed capacity in Queens and Bronx Counties from 16 beds to 21 beds.
- Rapid Access Mobile Crisis Teams provide short-term crisis response and management for children and adolescents aged 0-17 in Brooklyn, Queens, Staten Island, and Manhattan. This funding adds a total of 6.5 new teams.
- Family Advocates to work with children and families accessing community hospital emergency departments and inpatient and outpatient units by advocating for their needs and assisting them in accessing and navigating services and supports in the community. Family advocates are family members with a child with emotional challenges who have experienced firsthand the services offered through the community mental health system.
- Three Family Resource Centers to strengthen secure attachment between parent and child relationships, and to promote healthy social-emotional development in children ages five and under from high risk families residing in the Bronx and Harlem.

- High Fidelity Wraparound (HFW), a youth-guided, family-driven planning process that allows youth and their family achieve treatment goals that they have identified and prioritized, with assistance from their natural supports and system providers, while the youth remains in his or her home and community setting.
- Child Specialist Staff to assess and divert children from inpatient admissions and develop linkages to Home Based Crisis Intervention and other intensive services.

Stony Lodge Hospital:

- Home Based Crisis Intervention (HBCI) Team provides intensive in-home crisis intervention for families whose children are at risk of inpatient admission. These funds will be used to establish an HBCI team at Lincoln Hospital in Bronx County and to support the Bellevue HBCI Team in New York County.
- Partial Hospitalization and Day Treatment Programs serve as alternatives to inpatient hospitalization and provide intensive services for children. This funding will enable Bellevue Hospital in New York County to convert its existing 25 slot day treatment program to a 27 slot Partial Hospitalization Program and retain 9 slots for Day Treatment. The program is the only Comprehensive Psychiatric Emergency Program (CPEP) for children in New York City and receives referrals from all five boroughs.
- Family Resource Centers and High Fidelity Wraparound services supported by a portion of the Stony Lodge Hospital resources described above.

Mount Sinai Hospital:

- Partial Hospitalization to serve as an alternative to inpatient hospitalization and provide intensive services for children.
- Five Assertive Community Treatment (ACT) Teams, four of which serve 68 individuals each, and one that serves 48 individuals. ACT Teams are evidence-based programs that deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings rather than in hospital or clinic settings. These teams have been found to improve recipient outcomes with studies showing greater reductions in psychiatric hospitalization rates, emergency room visits, and higher levels of housing stability after receiving ACT services.
- Expanded Respite Services that stabilize individuals in the community rather than utilize hospital or long-term, out of home services.

Long Island Reinvestment and Planning Progress

OMH has made funding available for Long Island in an annualized amount of \$14.1 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS waiver, State-operated community service expansion, and Aid to Localities funds. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through ongoing consultation with community stakeholders, including the LGUs.

- 208 Supported Housing units.
- 54 Home and Community-based Services (HCBS) Waiver slots.
- Eight Children's Crisis/Respite beds on the grounds of Sagamore Children's Psychiatric Center.
- A State-operated Mobile Integration Team for children and youth.
- A State-operated Mobile Integration Team for adults.
- Adult and children's outpatient clinic expansion.
- Two Assertive Community Treatment (ACT) Team. Two ACT Teams serving 48 and 68 individuals, respectively. ACT Teams are evidence-based programs that deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings rather than in hospital or clinic settings. These teams have been found to improve recipient outcomes with studies showing greater reductions in psychiatric hospitalization rates, emergency room visits, and higher levels of housing stability after receiving ACT services.
- Non-Medicaid Care Coordination for Children. 72 Non-Medicaid Care Coordination slots aimed at linking 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. While children with Medicaid may receive services from this program, it is open to all children and families meeting the criteria for service provision.
- Child and Family Intensive Case Management. 18 Child and Family Intensive Case Management slots will promote optimal health and wellness for children diagnosed with severe emotional disturbance. These case management services will help children and families with linkages to and coordination of essential mental health services and community resources, allowing the children served to live successfully in the community.
- Mobile Residential Support Teams to focus on transitioning adults living in supported housing apartments into community living. Once these individuals are living in the community, the Mobile Residential Support Teams will visit them in their homes to help ensure that their basic needs are being met.
- A Hospital Alternative Respite Center to provide a viable option to inpatient hospitalization for individuals experiencing psychiatric distress. In many cases, an individual with psychiatric challenges might not require inpatient psychiatric admission, but could benefit from a break from daily stressors in a non-hospital environment that supports recovery and allows for a renewed perspective and wellness plan. A respite setting will not only prevent avoidable emergency room and inpatient hospitalization usage, but also provide care in a less stigmatizing and low stress environment.
- A Recovery Center in Riverhead, NY to help individuals living with psychiatric diagnosis to live, work and fully participate in their communities. This center will focus on programs that will build on existing best practices in self-help, peer support, and mutual support.
- Three Long Stay Teams. These teams will help long stay individuals transition into community settings through collaborative discharge planning and linkages to community supports. 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 Psychiatric Center.

In addition to these Transformation Plan services, OMH and the New York State Department of Health are funding the following services with \$2.9 million in reinvestment funds associated with inpatient psychiatric reductions at Long Beach Medical Center and North Shore University Hospital, and a Pederson-Krag partial hospitalization program.

- Mobile Residential Support Teams (6): These teams assist with discharge and community residential support for high risk individuals (e.g., those with co-morbid medical conditions and dual diagnoses of mental illness and developmental disability).
- Mobile Crisis Team Expansion. Funding for additional staff and transportation enables existing mobile crisis team to increase its coverage hours to 10:00 a.m. to 11:00 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.

- 6 Additional Home and Community-based Services (HCBS) Waiver slots.
- Satellite Clinic. Funding for a satellite clinic in Long Beach or for an agency interested in adding mental health services to an existing operation.
- Onsite Rehabilitation Services. Funding for three different programs to serve individuals who have not been able to make use of existing treatment services. The services would provide specific skill building to allow individuals to transition into traditional PROS programs.
- Peer Counselor to provide outreach to high risk individuals. This peer will be able to work when needed with the Mobile Crisis Team, Hospital Diversion Program and other crisis settings.
- Clinic Treatment Expansion for three Nassau County clinics:
 - ◆ North Shore Child and Family Guidance Center will develop 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 plans to develop an open access model of urgent psychiatric care focusing on stabilization to avoid emergency room and inpatient services; and
 - ◆ Catholic Charities will provide comprehensive walk-in services combined with consumer advocate outreach services.

Statewide Reinvestment Initiatives: Forensics, Suicide Prevention, Skilled Nursing Facility Transitions, and Risk Monitoring

OMH has made \$13.7 million available for initiatives that are not isolated to a specific region. Pre-investment resources will support several programmatic areas including suicide prevention, forensics, skilled nursing facility transition supports, engagement of high-risk individuals, and residential rate adjustments.

Suicide Prevention

Funding has been allocated to the Statewide Suicide Prevention Center to develop and promote evidence based practices in suicide prevention and identification of individuals at risk of suicide attempts. These efforts will help drive the strategic direction of OMH's newly

created Suicide Prevention Office and its strategic planning efforts under the "Zero Suicide" initiative with the goal of zero suicides for individuals receiving health or behavioral health care.

Additionally, the Suicide Prevention Center has expanded the reach of its population-level prevention efforts through targeted technical assistance to local health departments and local governmental units that have identified suicide prevention as a priority under the New York State Prevention Agenda 2013-2018 initiative.

Forensics

Funding has been allocated for the expansion of community-based interventions to support individuals with mental illness in the criminal justice system through earlier identification and diversion to treatment, and more active discharge and service referrals to reduce recidivism and promote recovery. OMH is currently developing several initiatives to enhance forensic services in the community, including expanded care coordination, Forensic Assertive Community Treatment (ACT) teams, and supported housing units. Within State operations, OMH is expanding its clinical staff in prisons to conduct risk of violence assessments and violence reduction treatment, and to expand clinical treatment services and discharge planning. OMH will also be expanding civil capacity at State Psychiatric Centers for a 20-bed inpatient secure intensive care unit and a 20-bed transitional living residence (TLR) to focus on forensic status individuals.

Skilled Nursing Facility (SNF) Discharge Supports

A portion of reinvestment funds has been used to develop State-operated transition and support services for individuals discharged from State Psychiatric Centers to skilled nursing facilities or managed long term care settings in the community. Many individuals who are eligible for nursing home care but no longer require inpatient psychiatric treatment, may need some enhanced support during the transition to a nursing home. In addition, nursing homes have indicated a need for continuing engagement and consultation from OMH facility staff with expertise in managing complex comorbid conditions. The SNF Support initiative provides the necessary State staffing supports and psychiatric consultation services to help individuals successfully transition to and remain in the appropriate level of nursing or long term care in the community

rather than an inpatient institutional setting.

Sustained Engagement Support Team

A new unit has been created to monitor and engage all State Operated adult clinic unsuccessful discharges to ensure re-engagement or appropriate hand-off or case closure. Funding has been allocated for the development of IT solutions and program staffing for engagement, retention and quality assurance. This effort is currently serving all adult State operations with the potential to expand to licensed clinics in the future.

Residential Stipend Adjustments

OMH has directed a portion of reinvestment funds for targeted Supported Housing stipend and Single Room Occupancy (SRO) model adjustments to address funding gaps. Similar to residential investments in the prior budget cycles, OMH has targeted the resources using data to identify the highest priorities.

Reinvestment Outcome Measures

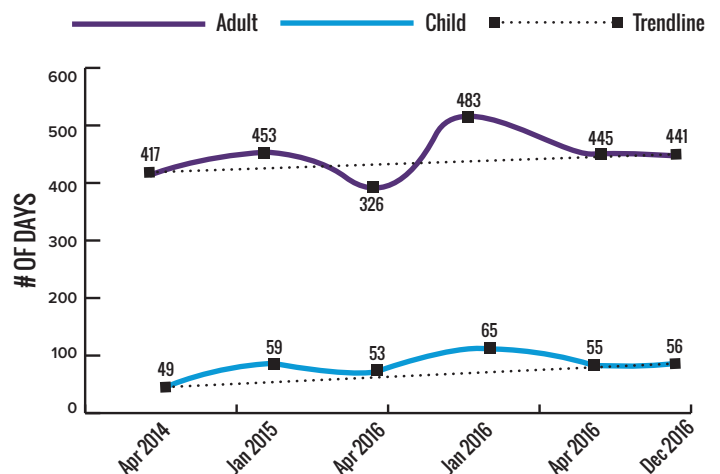
This section highlights several key outcome measures tracked by OMH as system changes roll out across the State. Outcome measures presented below include average length of stay of State Psychiatric Center inpatients on census at the time of data collection and individuals discharged from State Psychiatric Centers. Additional measures included are the number of adult and children aging into long stay, continuity of care for children and adults discharged from State Psychiatric Centers, and psychiatric readmissions of adults and children. This section also includes feedback from adults, children and their families on satisfaction of care while receiving services from programs funded through Transformation reinvestment.¹

State Psychiatric Center Inpatient Average Length of Stay

The discharge average length of stay (ALOS) in days in State Psychiatric Centers from April 2014 to December 2016 fluctuated for adults and was relatively stable for children (Figure 4-1). For adults, the spikes in ALOS are largely reflective of discharges of individuals with long lengths of stay (greater than one year). Figure 4-2 shows the ALOS for State inpatient census at the end of each month, which has declined for both adult and child populations since April 2014.

41

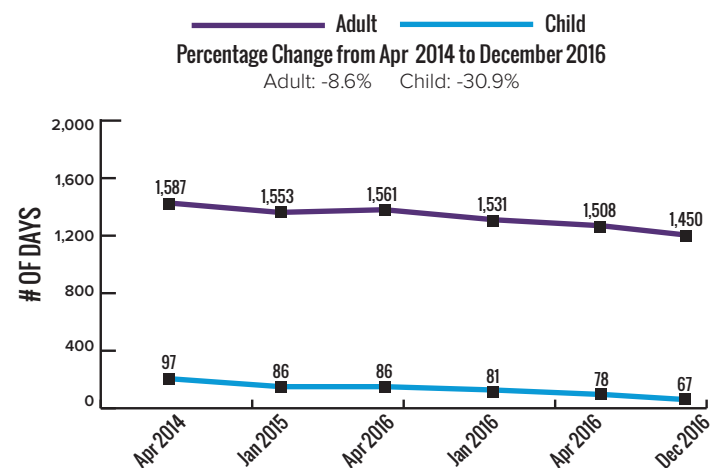
State Psychiatric Center Inpatient Discharge Average Length of Stay: April 2014 - December 2016



DISCHARGE COHORT DURING THE MONTH
Source: MHARS, updated as of January 24, 2017

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State Psychiatric Center Inpatient Census Average Length of Stay: April 2014 - December 2016



THE LAST DAY OF THE MONTH
Source: MHARS, updated as of January 24, 2017

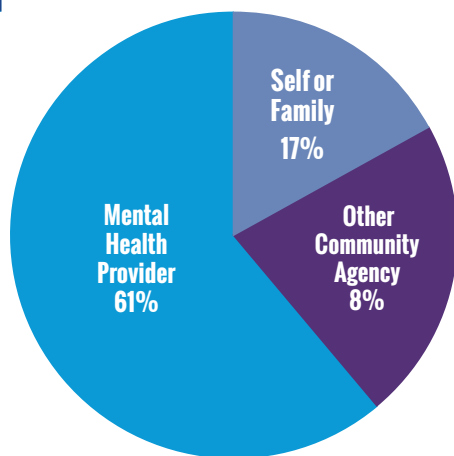
Mobile Integration Teams

As the State inpatient footprint has slowly shifted, OMH has directed more of its State-operated resources to community based services and support programs. One program model developed out of the Transformation Plan is the Mobile Integration Team (MIT). MITs provide an array of mobile services and supports for youth and adults, including on-site crisis assessment, skill building, family support, and respite. MITs can serve hundreds of individuals each month, and are scaled and located to community need. To date, there are thirteen State-operated MITs in operation, and several other existing State-operated community support teams being converted to the MIT model.

Populations served include children and adolescents, families, and adults. Services can be delivered wherever the individual requires them, including a private residence, schools, or integrated with other program settings as needed. Depending on their staffing and service intensity, MITs can serve hundreds of individuals within a State Psychiatric Center catchment area in any given month. Statewide data on MIT referral sources and service location from MITs initiation in November 2014 through March 2017 are presented in Figures 4-3 to 4-6.

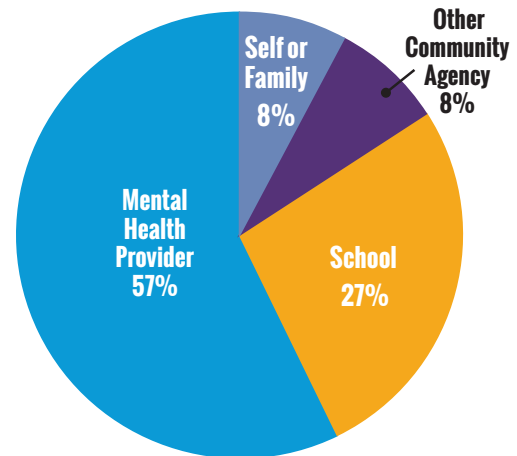
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MIT Referral Source - Adults



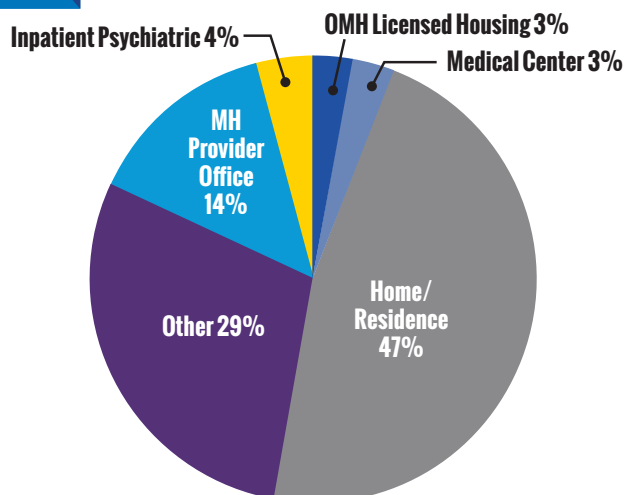
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MIT Referral Source - Children & Youth



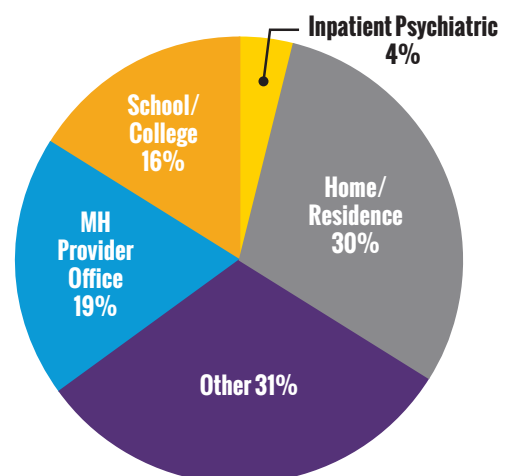
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MIT Service Site - Adults



46

MIT Service Site - Children & Youth

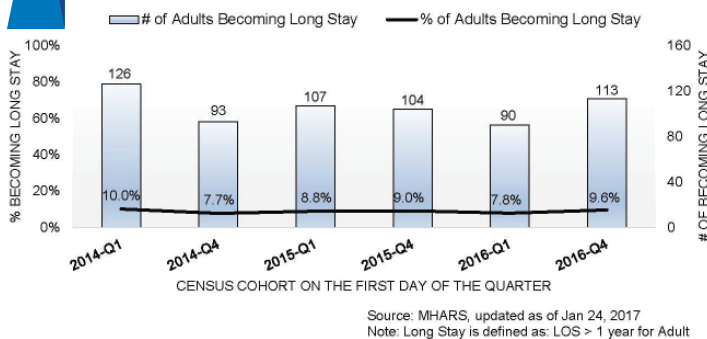


State-Operated Psychiatric Inpatient Long Stay Trends

A “long stay” is defined as an inpatient length of stay (LOS) greater than one year for an adult and greater than 90 days for a child. Figures 4-7 and 4-8 show that the percentage of the State Psychiatric Center inpatient census that became long stay between Quarter 1, 2014 and Quarter 4, 2016 remained stable for adults and declined for children.

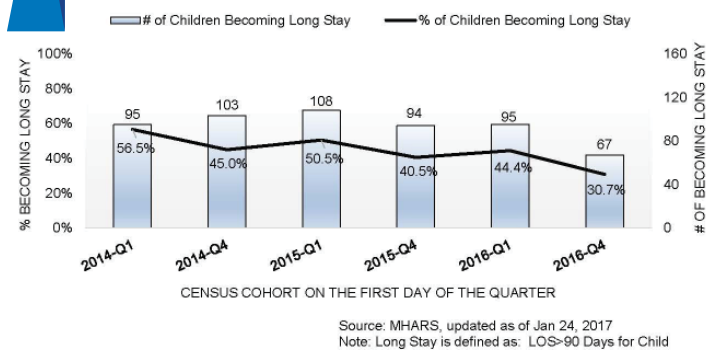
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State Psychiatric Center Adult Inpatient Census Becoming Long Stay: Quarter 1, 2014 - Quarter 4, 2016



48

State Psychiatric Center Child Inpatient Census Becoming Long Stay: Quarter 1, 2014 - Quarter 4, 2016

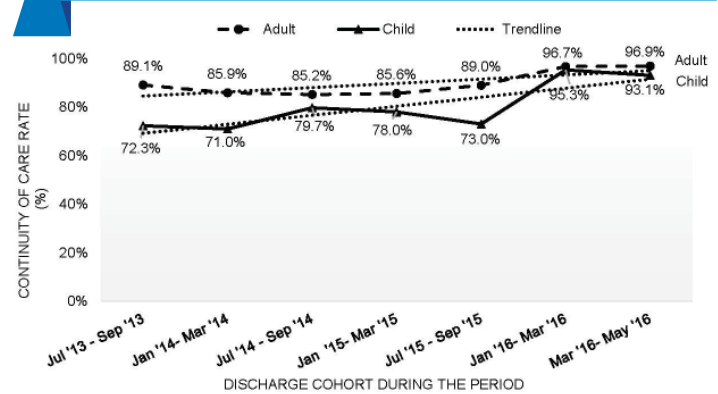


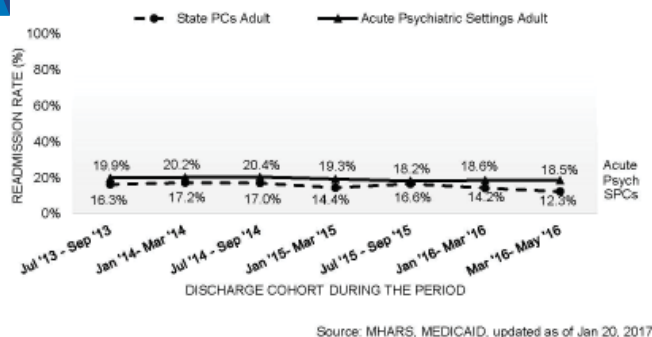
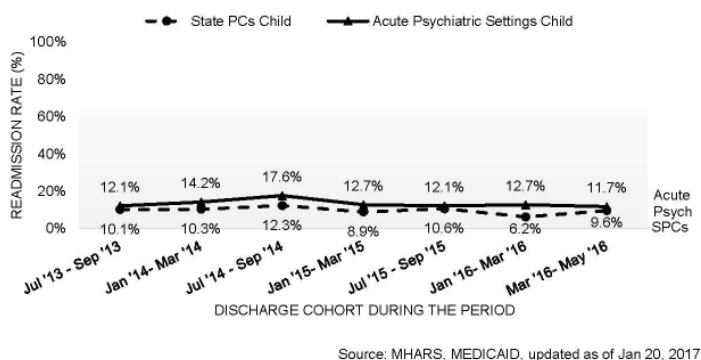
Continuity of Care

Proper follow-up care is associated with lower rates of readmission, and with a greater likelihood that gains made during hospitalization are retained. From July 2013 to May 2016, the percentage of State Psychiatric Center discharges receiving outpatient visits for mental health treatment (including specialty mental health services and non-specialty services for mental health reasons) increased for both adults and children (Figure 4-9). The rate increased dramatically starting with the November 2015 – January 2016 data point due to the addition of follow-up appointment tracking data for State inpatient discharges.

49

State Psychiatric Center Inpatient Discharges 30-Day Continuity of Care Rates: July 2013 - May 2016



4-10**Adult Psychiatric Readmission 30-Day Post-Discharge Rates: July 2013 - May 2016****4-11****Children Psychiatric Readmission 30-Day Post-Discharge Rates: July 2013 - May 2016**

Psychiatric Readmissions

Figure 4-10 presents 30-day psychiatric readmission rates for adults discharged from State Psychiatric Center settings in comparison to adults discharged from acute psychiatric settings from July 2013 to May 2016. During this time-period, 30-day readmission rates of adults discharged from either State Psychiatric Center settings or acute psychiatric hospital settings remained stable. In addition, psychiatric readmission rates for adults discharged from State Psychiatric Center settings were consistently lower in comparison to the readmission rates among adults discharged from acute psychiatric settings.

Figure 4-11 presents 30-day psychiatric readmission rates for children discharged from State Psychiatric Center settings in comparison to children discharged from acute psychiatric settings from July 2013 to May 2016. During this time-period, 30-day readmission rates

of children discharged from State Psychiatric Center settings trended downward slightly in recent cohorts, but remained stable for those from acute psychiatric settings. In addition, psychiatric readmission rates for children discharged from State Psychiatric Center settings were consistently lower in comparison to the readmission rates among children discharged from acute psychiatric settings.

Consumer Satisfaction

From September 19, 2016 through October 14, 2016, OMH assessed consumer satisfaction with OMH Transformation Plan services by directly surveying adults, youth and their families in targeted programs and counties. Questionnaires were customized for each service population and included the following domains: access to services, appropriateness of services, cultural sensitivity, participation in services, outcomes of services, overall satisfaction with services, and quality of life.

The Adult Service Assessment Survey was distributed to adult consumers who received Mobile Integration Team, community transition, and crisis services. The survey response rate for adults was 48% overall (n=755) and varied by county.

The Youth Service Assessment Survey was distributed to youths aged 9-21 years, and the Family Service Assessment Survey was distributed to the family members of children aged 21 years or younger. Surveys were targeted to these populations accessing crisis/respite homes, Mobile Integration Team, and community transition services. The survey response rates were 45% (n=112) for youth respondents and 43% (n=71) for family members.

Adult Assessment of Care

Demographics

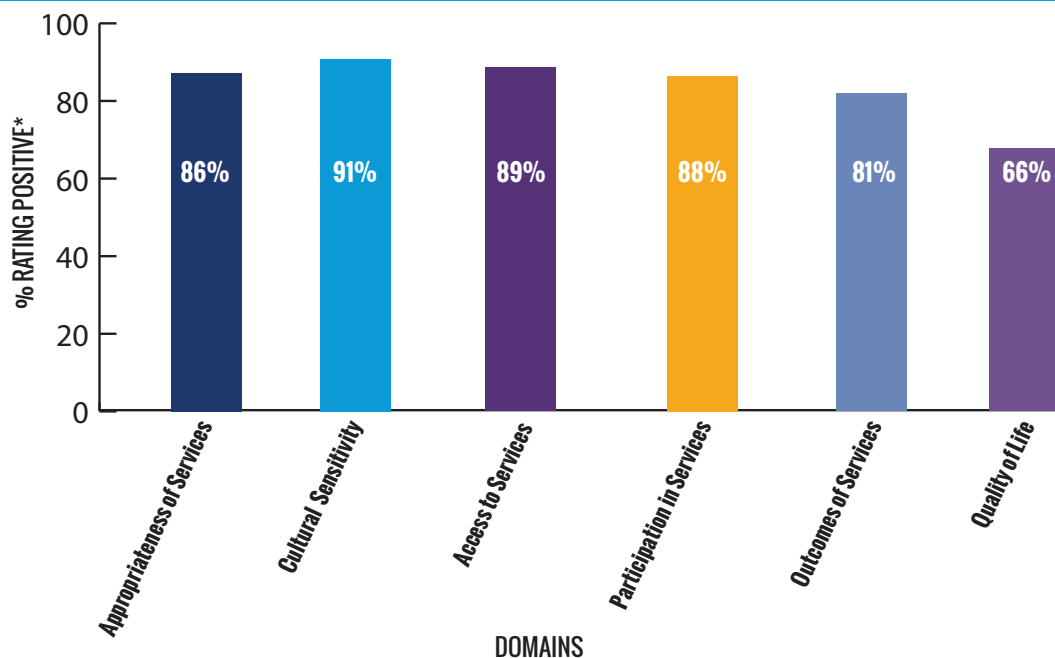
Over half (58%) of adult respondents were male, with three percent identifying themselves as transgender. More than half (56%) were aged 45 years or older. A majority (52%) of adult respondents were White, with 26% reporting themselves as Black/African American, and 4% as Multiracial. 15% of respondents reported themselves as being Hispanic/Latino.

4-12

Adult Assessment of Transformation Services: Percent Rating Positive by Domain*

* Percent Rating Positive-(Agree + Slightly Agree) and/or (Usually + Always)/All Respondents

Source: 2016 Transformation Plan Services Consumer Satisfaction Survey, updated as of November 21, 2016.

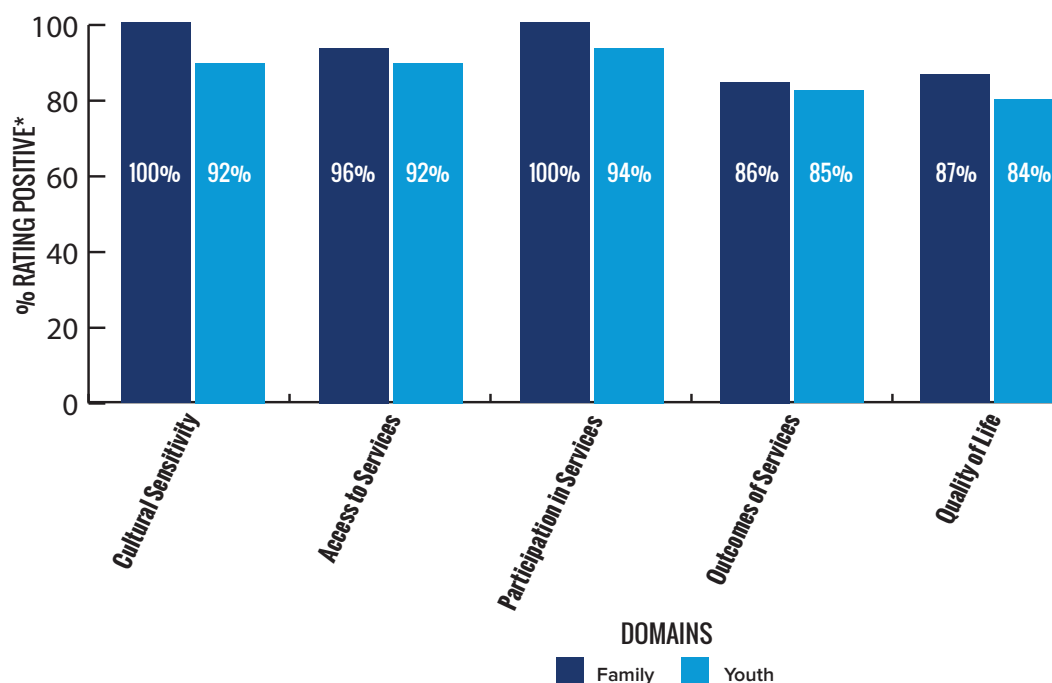


4-13

Youth and Family Member Assessment of Transformation Services: Percent Rating Positive by Domain*

* Percent Rating Positive-(Agree + Slightly Agree) and/or (Usually + Always)/All Respondents

Source: 2016 Transformation Plan Services Consumer Satisfaction Survey, updated as of November 21, 2016.



Assessment of Care

Adult respondents reported positive overall satisfaction with program services. When asked to rate the services they received using a scale of 0 (worst) to 10 (best), 80% of respondents responded with an 8, 9 or 10. Figure 4-13 displays the percent of adult consumers who rated services positively for the additional six domains. The majority of the positive response rates for these domains were above 80%, with the cultural sensitivity domain having the highest positive response rate of 91%. The quality of life domain had the lowest positive response rate at 66%, which is consistent with findings for this domain in prior years. 12% of adult respondents reported that culture-related issues (such as language, race, religion, ethnic background, or culture) made a difference in the kind of service they needed. Of these individuals, 88% reported that the services they received were responsive to those needs.

rates for all domains were above 80%. For the youth respondents, the participation in services domain received the highest positive response rate at 94%. For the family respondents, the cultural sensitivity and participation in services domains both had the highest positive rating at 100%. The lowest positive response rates were the quality of life domain for youth (84%), and the outcomes of services for family (86%).

¹ To view all outcome measures associated with Transformation Reinvestment, view the 2016-2017 Transformation Plan End of Year Report at <https://www.omh.ny.gov/omhweb/transformation/docs/2016-report.pdf>

Youth and Family Assessments of Care

Demographics

Approximately half of youth respondents were female (52%). Over half (63%) were aged 9-14 years. Most responding youth (76%) were White, with 8% reporting themselves as Black/African American, and 8% as Multiracial. 11% of youth respondents reported being Hispanic/Latino.

For the children of family respondents, more than half (65%) were male. Over half (68%) were aged 9-14 years, with 21% aged 15-21 years. Similar to the youth survey, 74% of the children of family respondents were White, 7% were Black/African American, and 12% Multiracial. 10% of children of family respondents were reported as having a Hispanic/Latino ethnicity.

Assessment of Care

Both youth and family respondents reported positive overall satisfaction with program services. When asked to rate the services youth received, using a scale of 0 (worst) to 10 (best), 82% of youth and 91% of family respondents responded with an 8, 9 or 10. Figure 4-13 displays the percent of youth and family respondents who rated services positively for the additional five domains. For both populations, the positive response

Chapter 5

Managed Care of Integrated Behavioral and Physical Health Services

Overview

Governor Cuomo's Medicaid Redesign Team (MRT) provided New York State with a blueprint and action plan for reforming Medicaid services and optimizing health-system performance through alignment with what the Institute of Healthcare Improvement calls the "Triple Aim": improving the patient's experience of care, improving the health of populations, and reducing the per-person cost of healthcare. Overall, the design and operational components of the newly configured behavioral health system for Medicaid beneficiaries address the MRT vision and goals through:

- Improved access to appropriate behavioral and physical healthcare services for individuals with mental illnesses and/or substance use disorders;
- Better management of total medical costs for individuals diagnosed with co-occurring behavioral and physical health conditions;
- Improved health outcomes and increased satisfaction among individuals engaged in care;
- Transformation of the behavioral health system from one dominated by inpatient care to one based more strongly in ambulatory and community care; and
- Enhanced service delivery system that supports employment, success in school, housing stability and social integration.

The centerpiece of the MRT vision is the expansion and redesign of the State's behavioral health Medicaid program through a broader managed care strategy and "carving in" Medicaid services and beneficiaries that had previously been exempt from managed care, into a coordinated benefit package. This chapter reviews some of the key requirements for successful behavioral health care delivery system transformation through an integrated managed care benefit, including:

- i. Ensuring that Medicaid Managed Care plans have the organizational capacity and culture to manage behavioral health benefits, serve specialized populations, and develop specialty Health and

Recovery Plans (HARPs) for people with serious mental health conditions and substance use disorders. This includes implementing a new recovery-oriented suite of services to support people in their communities and homes.

- ii. Preserving the behavioral health safety net through contractual provisions that promote access to care, maintain provider financial stability, and preserve patient-provider treatment relationships without disruption.
- iii. Maintaining a strong behavioral health managed care oversight and monitoring infrastructure that not only ensures a smooth transition to this new system, but also positions New York State to remain anchored in the vision of the MRT.
- iv. Improving community engagement and developing strategies to strengthen partnerships among stakeholders through training, technical assistance, start-up funding, and the creation of Regional Planning Consortia to discuss, identify, and address issues related to implementation.

Values Guiding the Transition

New York State has aimed to seamlessly transition the behavioral health service system into Medicaid managed care in a manner that will increase recovery outcomes, stabilize the behavioral health care system, and maintain access to care. New York is working to create an environment in which managed care plans, service providers, peers, families, and governmental entities partner to help enrollees prevent chronic health conditions and recover from serious mental illness and substance use disorders. This partnership shares the following core values:

1. **Person-Centered:** Care should be self-directed whenever possible and emphasize shared decision-making approaches that empower enrollees, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the entirety of the person.

2. **Recovery-Oriented:** The system should include a broad range of services that support recovery from mental illness and/or substance use disorders. These services support the acquisition of living, vocational, and social skills, and are offered in settings that promote hope and encourage each enrollee to establish an individual path towards recovery.
3. **Integrated:** Service providers should attend to both physical and behavioral health needs of enrollees, and actively communicate with care coordinators and other providers to ensure health and wellness goals are met. Care coordination activities should be the foundation for care plans, along with efforts to foster individual responsibility for health awareness.
4. **Data-Driven:** Providers and plans should use data to define outcomes, monitor performance, and promote health and well-being. Plans should use service data to identify high-risk/high-need enrollees in need of focused care management. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.
5. **Evidence-Based:** The system should incentivize provider use of evidence-based practices (EBPs) and provide or enable continuing education activities to promote uptake of these practices.¹ NYS has partnered with plans to educate and incentivize network providers to deliver EBPs. The NYS Office of Mental Health provides technical assistance through entities such as the Center for Practice Innovations at Columbia University/New York State Psychiatric Institute, and the Managed Care Technical Assistance Center (a partnership between the McSilver Center at NYU and the National Center on Addiction and Substance Abuse Columbia). Additionally, the Northeast Addiction Technology Transfer Center provides technical assistance with EBPs for substance use disorder programs.

The Infrastructure to Administer Adult Behavioral Health Services

New York is taking a two-pronged approach to incorporate adult behavioral health services into Medicaid managed care:

1. **Qualified Mainstream Medicaid Managed Care Organizations (MCOs):** For all adults served in mainstream MCOs throughout the State, qualified MCOs now integrate all Medicaid State Plan covered services and new demonstration services for mental

illness, substance use disorders (SUDs), and physical health conditions. Plans are required to meet strict criteria set by the State before administering the BH benefit. Premiums for mainstream plans have been adjusted to reflect the additional BH benefits of mainstream enrollees.

2. **Health and Recovery Plans (HARPs):** In order to address the unique needs of adults with serious mental health conditions and serious substance use disorders, the State developed a new managed care product called a Health and Recovery Plan. HARPs administer the full continuum of physical health, mental health, and substance use disorder services covered under the Medicaid State Plan, as well as additional rehabilitative services, called Behavioral Health Home and Community Based Services. HARPs also provide enhanced care management for enrollees to help them coordinate all their physical health, behavioral health and non-Medicaid support needs. HARPs have an integrated premium established for this behavioral health population. They have specialized staffing requirements and qualifications along with focused behavioral health performance metrics and incentives to achieve health, wellness, recovery, and community inclusion for their enrollees.

To ensure that MCOs developed the organizational capacity and culture necessary to effectively administer the adult behavioral health benefit, the State released a Request for Qualification (RFQ) that established key program requirements involved in managing the behavioral health benefit. Program requirements ranged from recruiting staff with demonstrated behavioral health experience, updating clinical and utilization management policies and procedures mandating the use of the Level of Care for Alcohol and Drug Treatment Referral application or other State approved tool for Substance Use Disorder level of care determinations, and updating claims systems to include the new behavioral health services.² All Medicaid MCOs in the State, including HIV Special Needs Plans (HIV SNPs) were required to respond to the RFQ. The qualification process consisted of a document review, onsite interview, and a corrective action process requiring MCOs to address identified gaps.

MCOs that chose to qualify as a HARP had the option of responding to enhanced standards reflected in the RFQ to demonstrate specialized expertise, tools, and protocols that were not common in most medical MCOs.

As of May 2017, 18 MCOs in the state have qualified

to manage the adult behavioral health benefit; 15 of which are also qualified to operate a HARP. A list of those MCOs can be found below. Additional details on the qualification process or the adult behavioral health transition can be found at <https://www.omh.ny.gov/omhweb/bho/plan-qualification-process.html>.

Table 1: Medicaid Managed Care Organizations

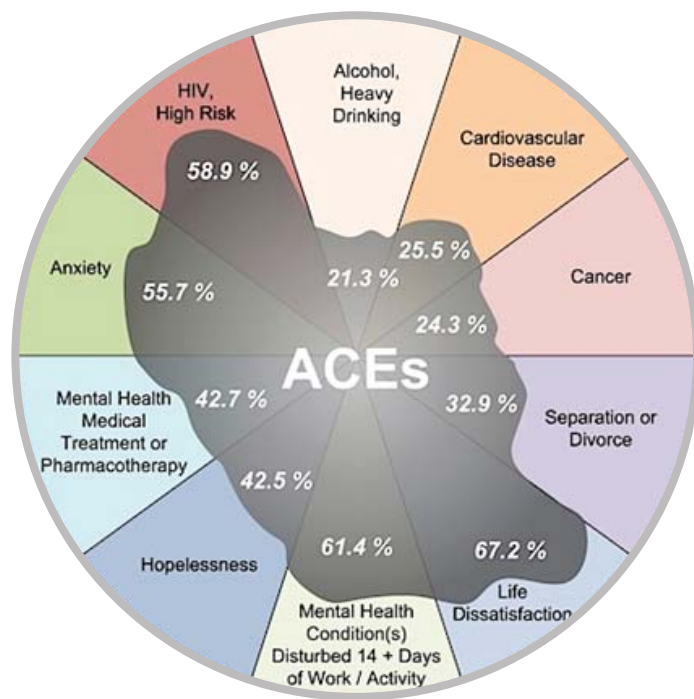
Region	Plan Name	Specialty Designation Status
NYC Only	AmidaCare Inc.	HIV-SNP
NYC Only	MetroPlus	HIV-SNP and HARP
NYC Only	VNS Choice Select Health SNP	HIV-SNP
NYC and Upstate	Affinity Health Plan Inc.	HARP
NYC and Upstate	Empire Blue Cross Blue Shield HealthPlus (Formerly Amerigroup)	HARP
NYC and Upstate	Health Insurance Plan of Greater New York (Emblem)	HARP
NYC and Upstate	HealthFirst PHSP Inc.	HARP
NYC and Upstate	NYS Catholic Health Plan Inc. (Fidelis)	HARP
NYC and Upstate	United Healthcare Of NY Inc.	HARP
NYC and Upstate	WellCare of New York	Mainstream
Upstate Only	Capital District Physicians Health Plan	HARP
Upstate Only	Excellus	HARP
Upstate Only	Independent Health Association	HARP
Upstate Only	MVP	HARP
Upstate Only	TotalCare (A Today's Option)	HARP
Upstate Only	YourCare (Formerly Univera)	HARP
Upstate Only	Crystal Run	Mainstream
Upstate Only	HealthNow	Mainstream

Transitioning Children's Services to Medicaid Managed Care

The Children's Health and Behavioral Health MRT Subcommittee, comprised of stakeholders including providers, family members, youth, advocacy groups, State and local government representatives, and MCOs, offered a specific set of Medicaid managed care recommendations designed to improve service access and provide earlier intervention for children/youth and families. These recommendations envision an integrated children's healthcare system where there is "no wrong door" for children with complex needs, including those with serious comorbid medical conditions. Similar to the adult system, the children's public healthcare system includes a wide range of providers and services that are often disjointed and inefficient, with few incentives for effective care coordination and person-centered care. A comprehensive cross-system approach is needed to diminish silos of care and improve health outcomes for children well into adulthood to further the MRT goals. Key principles of children's Medicaid redesign include:

- Early identification and intervention
- Family-driven and youth-guided care planning
- Focus on resiliency for children and recovery for young adults building resilience
- Culturally and linguistically competent services and providers
- Limit progression into high intensity and acute service
- Individualized and flexible care
- Availability of evidence-based, evidence-informed, and promising practices
- Establish Trauma Informed Care principles across the entire service delivery system
- Maintaining children at home with support and services or in the least restrictive community based settings
- Integrate the delivery of behavioral health and health benefits

5-1

Outcomes of Adverse Childhood Experiences⁵

The Adverse Childhood Events (ACEs)³ study showed powerful associations between childhood trauma and the onset of chronic conditions and associated functional deficits which persist into adulthood. Importantly, the study also showed that often, the impact of childhood adverse events is not evident until well into adulthood (Figure 5-1). Individuals with childhood trauma have a much higher risk of developing chronic medical and behavioral health conditions that are primary drivers of morbidity and mortality as well as high healthcare costs (Figure 5-2). These findings underscore the critical need for a redesigned system of care that emphasizes early identification and integrated service delivery. These children deserve to grow into healthy adults and live full and satisfying lives.

Today, two million children in New York State receive their physical health services through Medicaid managed care which emphasizes coordination, health outcomes, and quality of care. While much progress has been made, children and youth mental health and substance use disorder services are still delivered through a fee-for-service model that reimburses based upon volume of services delivered and offers limited incentives for quality of care. New York State plans to leverage the Medicaid managed care program to transform the children's system of care. An effective partnership between Medicaid managed care and providers will support delivery system transformation promoting early identification, prevention, and treatment and, in turn, will reduce the need for intensive services, acute levels of care, and out-of-home placements. A well-functioning children's health system of care will not only benefit children and families, but will also provide important opportunities for improved quality and cost savings in the adult healthcare system. Managed care plans should view efforts to support and intervene with children and their families as a key element of value based initiatives aimed to limit the prevalence of negative physical, emotional, and social outcomes associated with chronic conditions in adults.

To support this integration, create better health outcomes for children and youth, and lay the groundwork for better health outcomes for adults, New York State is making 3 key policy steps to stimulate the transformation:

1. NYS will make available via a State Plan Amendment, new services that were either not available in NYS previously or only available to children who met narrow eligibility criteria.

5-2

Potential Influences Throughout the Lifespan of Adverse Childhood Experiences⁶

2. NYS is establishing “Level of Care” and “Level of Need” criteria to identify subpopulations of children who are likely to benefit from an array of home and community-based services. The Level of Need subpopulation will identify children prior to needing institutional care or as a step down from Level of Care. This population is at risk by virtue of exposure to adverse events or symptoms leading to functional impairment in their home, school, or community.
3. NYS is simplifying the five existing children’s 1915(c) waivers into one integrated array of home and community-based services for an expanded number of Medicaid-eligible children, allowing more children to stay in their home communities and avoid residential and inpatient care.

An estimated 65,000 children and youth will be eligible for Medicaid Home and Community Based Services (HCBS) benefits at full implementation across the State. Approximately 10% of the more than two million children and youth eligible for Medicaid will likely need the new State Plan services at some point in time. Further, the addition of approximately 18,000 foster care children to managed care greatly enhances the availability of services and the use of managed care tools to efficiently serve children and youth.⁴

New York State remains strongly committed to expanding Medicaid behavioral health services for children, and the Office of Mental Health is working closely with advocates, stakeholders and our partner agencies to ensure adequate service capacity among not-for-profit providers. The State is prioritizing and expediting the most critical components of this expansion, and is moving as quickly as possible towards full implementation.

¹ For review of EBPs for individuals with serious mental illness see: Dixon LD, Schwarz EC: Fifty years of progress in community mental health in US: the growth of evidence-based practices. *Epidemiology and Psychiatric Sciences*, published online November 12, 2013, DOI: 10.1017/S2045796013000620

² LOCADTR stands for Level of Care for Alcohol and Drug Treatment Referral.

³ Felitti, Vincent J et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventative Medicine*, Volume 14, Issue 4, p.245-258.

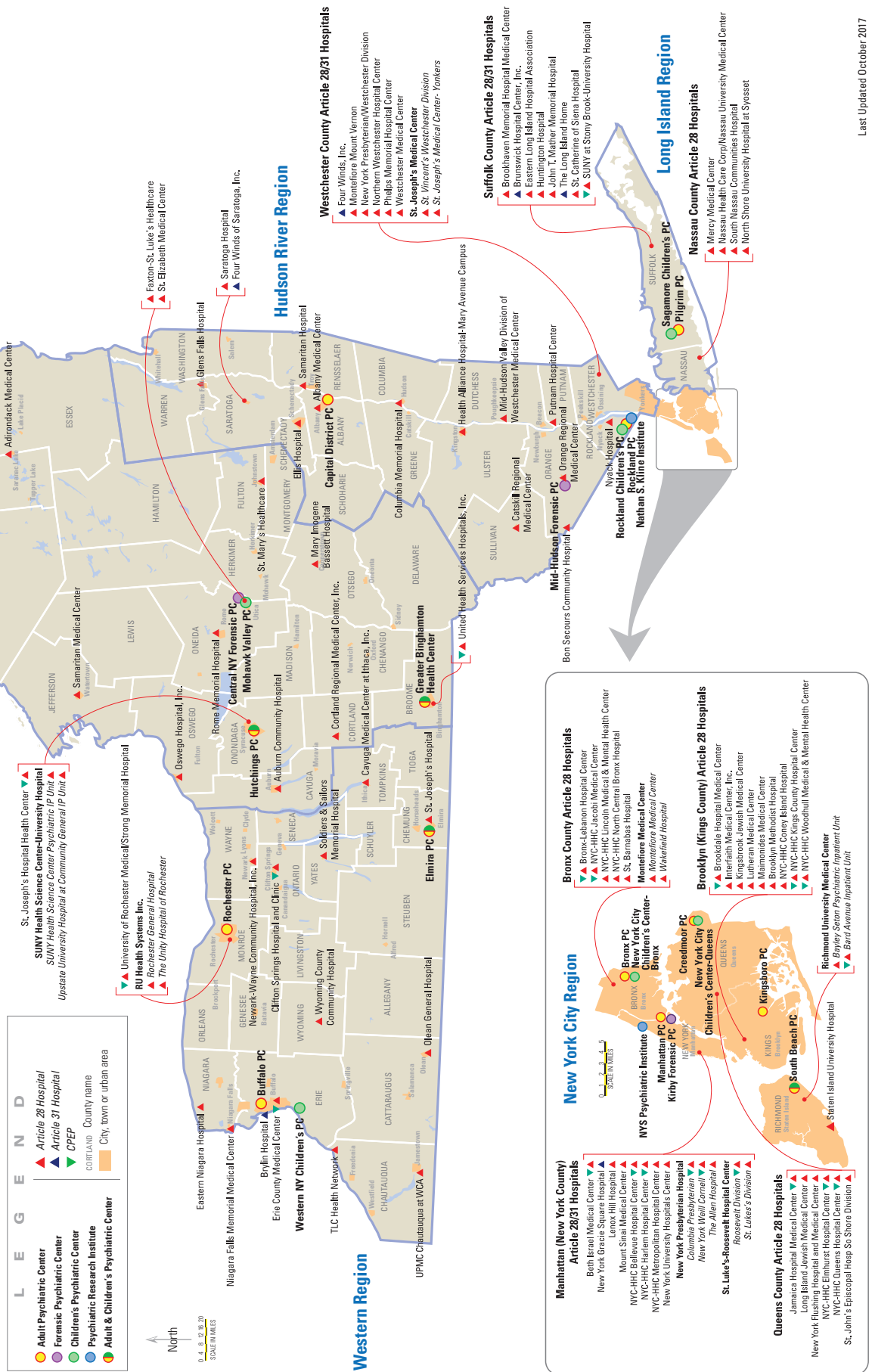
⁴ More information on the children’s transition can be found at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/2015-11_concept_paper.htm

⁵ ACESTooHigh.

⁶ Substance Abuse and Mental Health Services Administration.

Appendix A

OMH Facilities, Article 28/31 Hospitals and CPEPs in New York State



Appendix B

Comprehensive Psychiatric Emergency Program 2016 Annual Summary

The Comprehensive Psychiatric Emergency Program (CPEP) is a set of hospital-based services that include emergency observation, evaluation, and care and treatment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further evaluation or treatment activities, or discharge to another level of care. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination.

Program objectives include: providing timely triage, assessments, and interventions; controlling inpatient admissions; providing crisis intervention in the community; and providing linkages to other services. CPEPs are designed to directly provide or ensure the provision of a full range of psychiatric emergency services, seven days a week, for a defined geographic area. Brief and full emergency visit services are Medicaid reimbursable.

The four CPEP service components are:

1. Hospital-Based Crisis Intervention Services: The psychiatric emergency room is the setting for CPEP hospital-based crisis intervention services and is available 24 hours per day, seven days a week. Services offered in the emergency room include triage, referral, evaluation and assessment, stabilization, treatment, and discharge planning. These services are provided by a multi-disciplinary team consistent with CPEP regulations. Enhanced staffing is necessary for timely and thorough assessments and more appropriate clinical decision making, especially as high risk or high cost decisions are frequently made. CPEPs help ensure individual and community safety and appropriate inpatient admissions and outpatient referrals.
2. Extended Observation Beds are intended to provide recipients a safe environment where staff can continue to observe, assess, diagnose, treat, and develop plans for continued treatment as needed in the community or in a hospital or other setting. By regulation, CPEPs may be licensed for up to six extended observation beds. The number of beds per site varies based on geographical need and the CPEP's physical plant. Extended observation beds are usually located in or adjacent to the psychiatric emergency room, allowing recipients to remain in the emergency room area for up to 72 hours. Extended observation beds enable staff to assess and treat recipients who need short term care and treatment rather than inpatient hospitalization. In addition, the availability of extended observation beds assists in diverting avoidable short term inpatient admissions.
3. Crisis Outreach Services are designed to provide mental health emergency services in the community. The two objectives of this component of service are to provide initial evaluation, assessment and crisis intervention services for individuals in the community who are unable or unwilling to use hospital-based crisis intervention services in the emergency room, and to provide interim crisis services for emergency room recipients who require follow up. Interim crisis services are mental health services provided in the community for recipients who are discharged from a CPEP emergency room, and include immediate face-to-face contacts with mental health professionals to facilitate community tenure while waiting for a first visit with a community-based mental health provider.
4. Crisis Residence Services are designed to offer residential and other necessary support services for up to five days to recipients who recently experienced a psychiatric crisis or were determined to be at risk of an emerging psychiatric crisis. Most CPEPs have provided crisis residence services through linkages with State psychiatric centers or other local service providers.

CPEP Provider Performance Data

In addition to providing or ensuring the provision of required services, each CPEP is also responsible for submitting quarterly reports to OMH including: the number of visits or admissions to each of the four required components of service; timeliness/length of stay and disposition data related to emergency room evaluations and extended observation beds; disposition data related to crisis outreach and crisis

residence services; discharge diagnoses; and recipient demographic characteristics. As of December 2017, there were 22 CPEPs operating in four OMH Field Office regions; there are no CPEPs in the Hudson River region.

CPEP Regional Count:

- 3 in Western New York
- 2 in Central New York
- 16 in New York City
- 1 on Long Island

The following table provides statewide aggregated CPEP data for the 2016 calendar year.

Category		Description	Total 2016 Annual Visits
CPEP Component Use	ER	Brief Visits	16,157
		Full Visits	117,218
		Total Visits	113,375
	Extended Observation Beds (EOBs)	Admissions	13,624
		Total Bed Days Occupied	23,723
	Crisis Outreach	Initial Visits	15,561
		Interim Visits	7,891
		Total Visits	23,452
	Crisis Residence	Admissions	350
		Total Bed Days	3,638
Waiting and Retention Times	1st Contact with Clinical Staff	Less than 1 hour	115,822
		1+ to 2 hours	11,805
		Over 2 hours	6,133
	1st Contact with MD	Less than 2 hours	87,094
		2+ to 4 hours	21,858
		4+ to 6 hours	10,622
		Over 6 hours	9,229
	Entry to Discharge (Non-EOBs)	Less than 8 hours	52,553
		8+ to 16 hours	25,769
		16+ to 24 hours	16,017
		Over 24 hours	18,025
	Entry to Discharge (EOBs)	Less than 24 hours	9,725
		24+ to 48 hours	6,534
		48+ to 72 hours	3,976
		Over 72 hours	1,370
Diagnosis on Discharge from CPEP Services		Schizophrenia, Other Psychotic Disorders and Mood Disorders	77,097
		Substance-Related Disorders	24,511
		Personality Disorders	5,144
		Dementia & Other Cognitive Disorders	2,203
		Other	38,414
		Total	147,369
Client Demographics	Age Reported for All CPEP Components	Under 18 Years Old	21,594
		18 to 34 Years Old	55,385
		35 to 64 Years Old	63,200
		65 Years Old and Over	6,740
	Gender Reported for All CPEP Components	Male	94,420
		Female	62,992

Appendix C

OMH Mission, Vision, and Values

Mission

The Mission of the New York State Office of Mental Health is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbances.

Vision

In order to accomplish the broad mission of this agency, we need to know what success will look like at many levels, including systems, programs, communities, and individuals. The Office of Mental Health envisions a future for the public mental health system and our citizens that will result in:

1. Integrated, accessible, and sustainable systems of high quality, person-centered, resiliency-and recovery-focused health and behavioral health supports and services.
2. Mental and physical wellbeing, and community and social environments that reduce the incidence of disorders, eliminate stigma, and foster community inclusion.
3. Population health, without disparities.

Values

Informing the vast portfolio of work under the Office of Mental Health is a set of core values that are infused in the regulation and direct provision of services, research, planning, consumer empowerment, and quality advancement. These values can help the OMH and broader community mental health workforce at all levels relate together to a basic set of principles to drive excellence in a modern, progressive mental health system.

1. Person-centered care and systems.
2. Recovery is individual, and possible for everyone.
3. Community inclusion and positive environments for social and emotional development and resiliency.
4. Excellence in the design and delivery of mental health services and supports.
5. Cultural competence and reduction of disparities in care and health status.
6. Safety for consumers, staff, and community.
7. Respect for the worth and dignity of every person, including the prevention and rejection of stigma.
8. Scientific discovery and the translation of science to practice.
9. OMH has a fundamental role in ensuring a safety net for all people in need.
10. Health, engagement, and competence in the workforce.

Appendix D

Acronym Directory

ACEs:	Adverse Childhood Events	HARP:	Health and Recovery Plans
ACT:	Assertive Community Treatment	HBCI:	Home Based Crisis Intervention
AIM-SP:	Assess, Intervention and Monitor for Suicide Prevention	HCBS:	Home and Community Based Services
ALOS:	Average Length of Stay	HFW:	High Fidelity Wraparound
CAIRS:	Child and Adult Integrated Reporting System	HHSC:	Health Homes Serving Children
CCBHC:	Certified Community Behavioral Health Clinic	HIPAA:	Health Insurance Portability and Accountability Act
CCMP:	New York State Collaborative Care Medicaid Program	HIV SNP:	HIV Special Needs Plan
CLMHD:	New York State Conference of Local Mental Hygiene Directors	ICR:	Institutional Cost Report
CMA:	Care Management Agency	IOS:	Integrated Outpatient Services
CMS:	Centers for Medicare and Medicaid Services	OASAS:	New York State Office of Alcoholism and Substance Abuse Services
COA:	Council on Accreditation	OMH:	New York State Office of Mental Health
CONCERTS:	OMH's Master Provider Directory	OPWDD:	Office for People with Developmental Disabilities
CPEP:	Comprehensive Psychiatric Emergency Programs	PCS:	Patient Characteristics Survey
CPS:	County Planning System	PHIP:	Population Health Improvement Program
CQI:	Continuous Quality Improvement	PROS:	Personalized Recovery-Oriented Services
DOH:	New York State Department of Health	PSYCKES:	Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid
DSM:	Diagnostic and Statistical Manual of Mental Disorders	LGBT:	Lesbian, Gay, Bisexual, and Transgender
DSRIP:	Medicaid Delivery System Reform Incentive Payment Program	LGU:	Local Governmental Unit
EBP:	Evidence Based Practices	LOS:	Length of Stay
EOB:	Extended Observation Beds	LSP:	Local Services Plan
FACT:	Family Assistance Crisis Team		

MCO:	Managed Care Organization	SMI:	Serious Mental Illness
MHARS:	Mental Health Automated Record System	SNF:	Skilled Nursing Facility
MHPD:	Mental Health Provider Data Exchange	SOC:	Systems of Care
MIT:	Mobile Integration Team	SPO:	Suicide Prevention Office
MRT:	Medicaid Redesign Team	SRO:	Single Room Occupancy
NKI:	Nathan Kline Institute	SUD:	Substance Use Disorder
NSDUH:	National Survey on Drug Use and Health	TLR:	Transitional Living Residence
NYASSC:	New Yorkers Advancing Suicide Safer Care		
NYCRR:	New York Codes, Rules and Regulations		
NYS:	New York State		
NYSHIP:	New York State Health Improvement Plan		
PPS:	Performing Provider Systems		
RAISE:	Recovery After an Initial Schizophrenia Episode		
RCCA:	Residential Care Centers for Adults		
RFQ:	Request for Qualification		
RPC:	Regional Planning Consortium		
RTF:	Residential Treatment Facilities		
SAMHSA:	United States Substance Abuse and Mental Health Services Administration		
SFY:	State Fiscal Year		
SHIP:	State Health Innovation Plan		
SPARCS:	New York State Department of Health Statewide Planning and Research Cooperative System		
SED:	Serious Emotional Disturbance		
SIM:	State Innovations Model		