




Statewide Comprehensive Plan

2016-2020

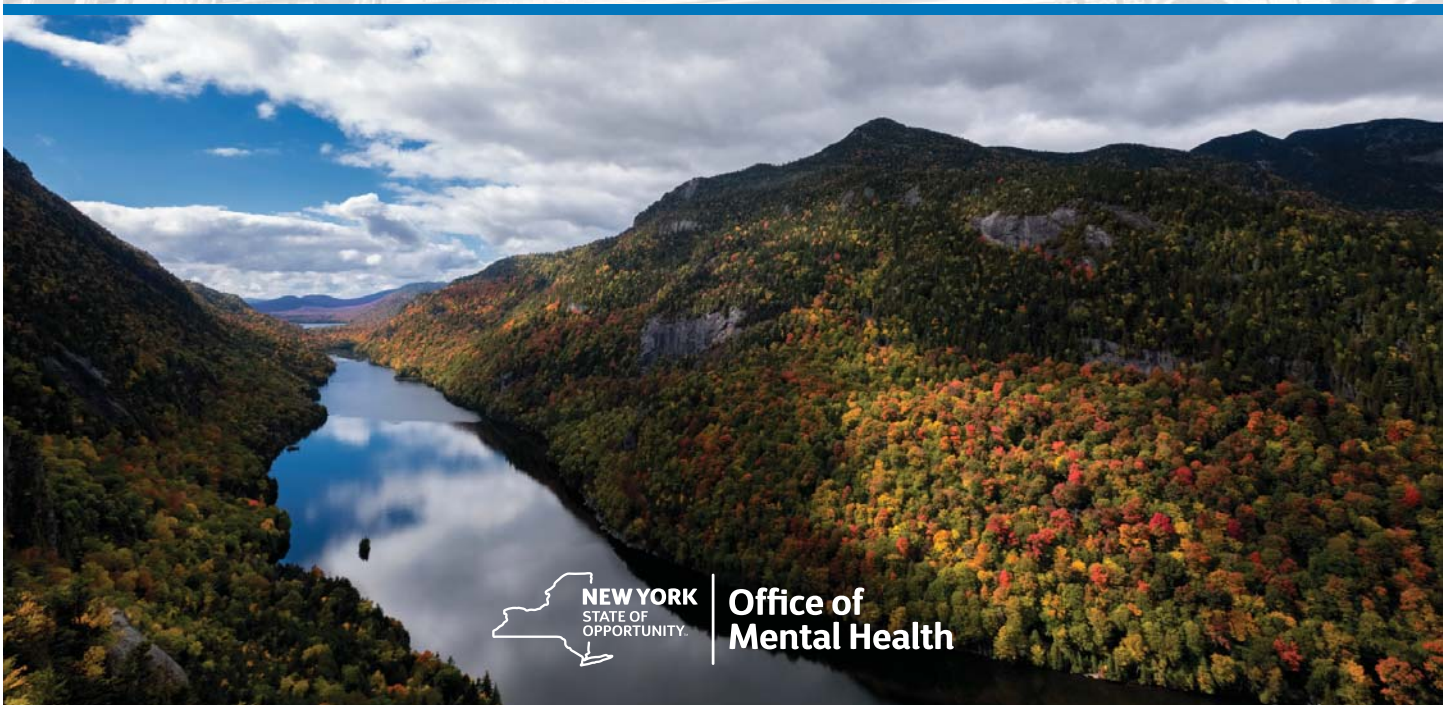

Table of Contents

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Introduction from the Commissioner

I am proud to present to present the Office of Mental Health (OMH) Comprehensive Plan for the years 2016-2020, outlining the significant transition and transformation underway across the agency and the New York State public mental health system. Six years have gone by since the passage of the federal Affordable Care Act and Governor Cuomo's Medicaid Redesign initiative, and the resulting system changes have had some time to develop and mature, while the wheels of change are still in full motion.

This report provides a snapshot of the current State of the public mental health system in New York, including a profile of the diverse populations we serve, a description of the principal initiatives transforming the mental health system, and a review of the workforce challenges and opportunities for serving a diverse and growing consumer population. It is my hope that the information provided in this report will be informative for the general public, and also useful for planners and program leaders who must put all the pieces of the healthcare transformation together, in order to sustain and expand access to quality prevention, support, and treatment services for the 21st century.

While change and transformation have become a constant in the world of health and behavioral health planning, the core mission of OMH - 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 – is still fundamental in our day to day work, and our planning for the future.

Given the increasing and diverse demands and opportunities for the mental health system, it has been helpful to revisit and reaffirm the mission, vision, and values of this agency in order to maintain our obligations to the children, adolescents, adults, and families of New York. The statements below reflect the agency's steadfast commitment to individual and population health, informed by values and a vision for New York where health is promoted, disability is prevented, and illness is treated using the most clinically effective and person centered interventions. As these statements also reflect, we must ensure that the services and systems that individuals interact with are stable, competent, and accessible. In short, these principles should drive everything that we do.

OMH 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.

OMH 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.

OMH 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.

As you read through this report, I hope that our vision and values are reflected in the programs and priorities as they are described throughout. I am pleased that in the upcoming chapters we are able to extensively review the many areas where OMH has developed prevention and early intervention initiatives, and expanded regulatory and technological tools for integrating services with health and substance use disorder treatment. We also provide updates to the ongoing transition of Medicaid behavioral health into managed care statewide, and the continued transformation of the State-operated and community service footprint through reinvestment and regional planning. Finally, we look at the challenges in staffing State and local mental health programs, along with the tools available to support the cultural competence of our existing workforce and access for underserved cultural groups. In sum, the contents of this report should not only give New Yorkers a better understanding of the public mental health system as it currently operates, but also a sense of the future direction for this agency and the entire health care delivery system, for a stronger, healthier tomorrow.

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?

The Office of Mental Health uses the term "public mental health system" to refer to all mental health programs that are licensed, regulated, operated, funded, or approved by the Office of Mental Health (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?

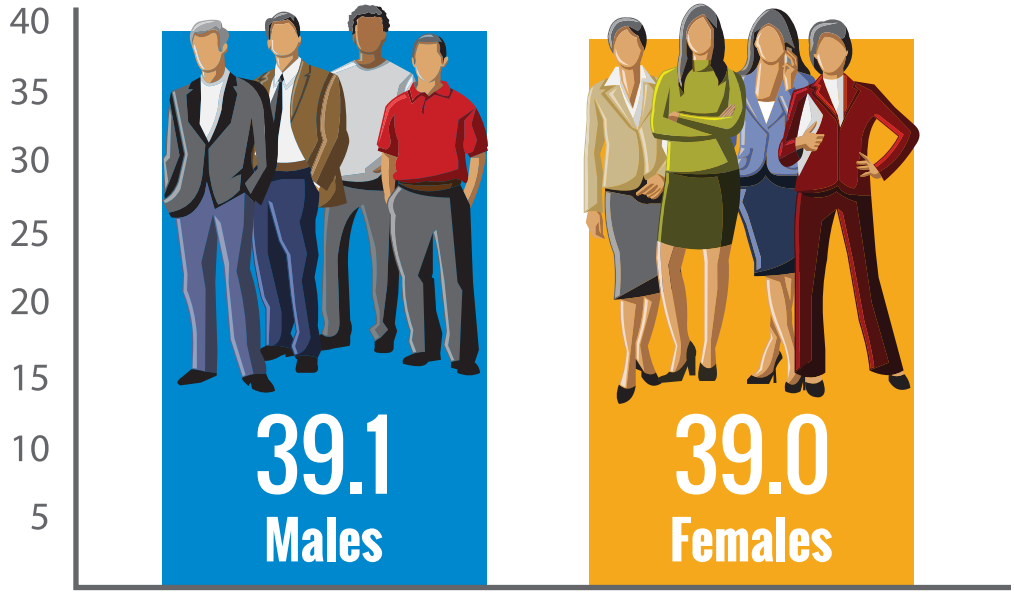
The PCS collects information on consumers of mental health services for a one-week period and standard PCS reporting provides counts of individuals for this one-week timeframe. OMH recognizes the utility of having some of these weekly numbers "annualized". Hence, OMH employs an annualizing algorithm 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.

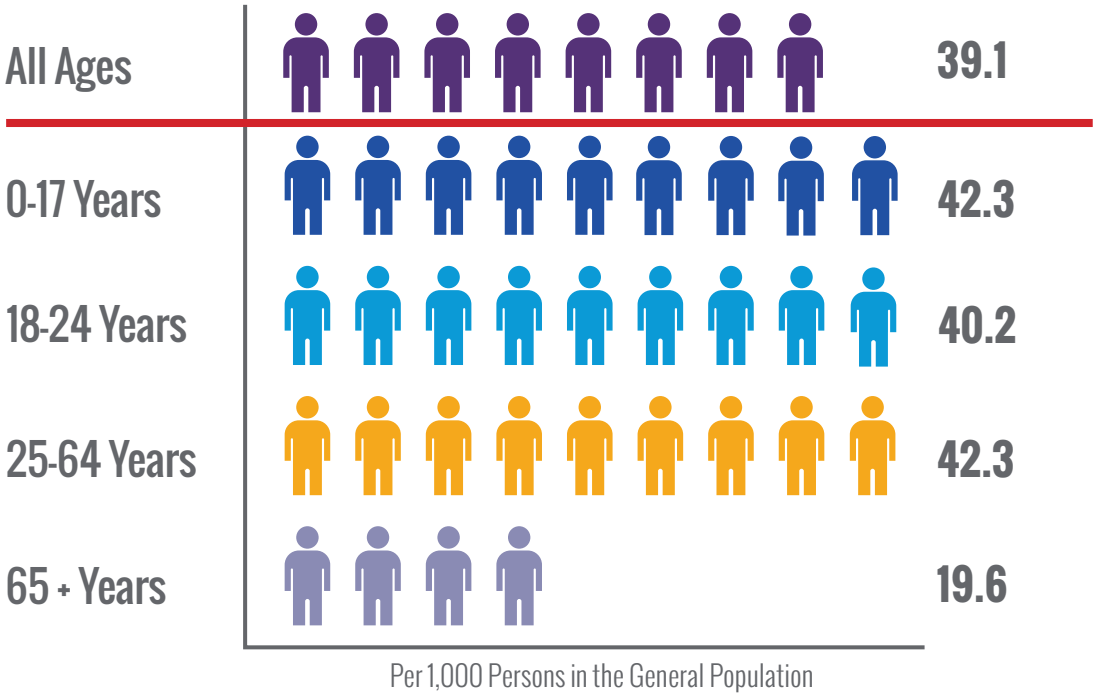
1-1 Rates of Males & Females Served Annually



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]

1-2 Rates of Individuals Served Annually by Age



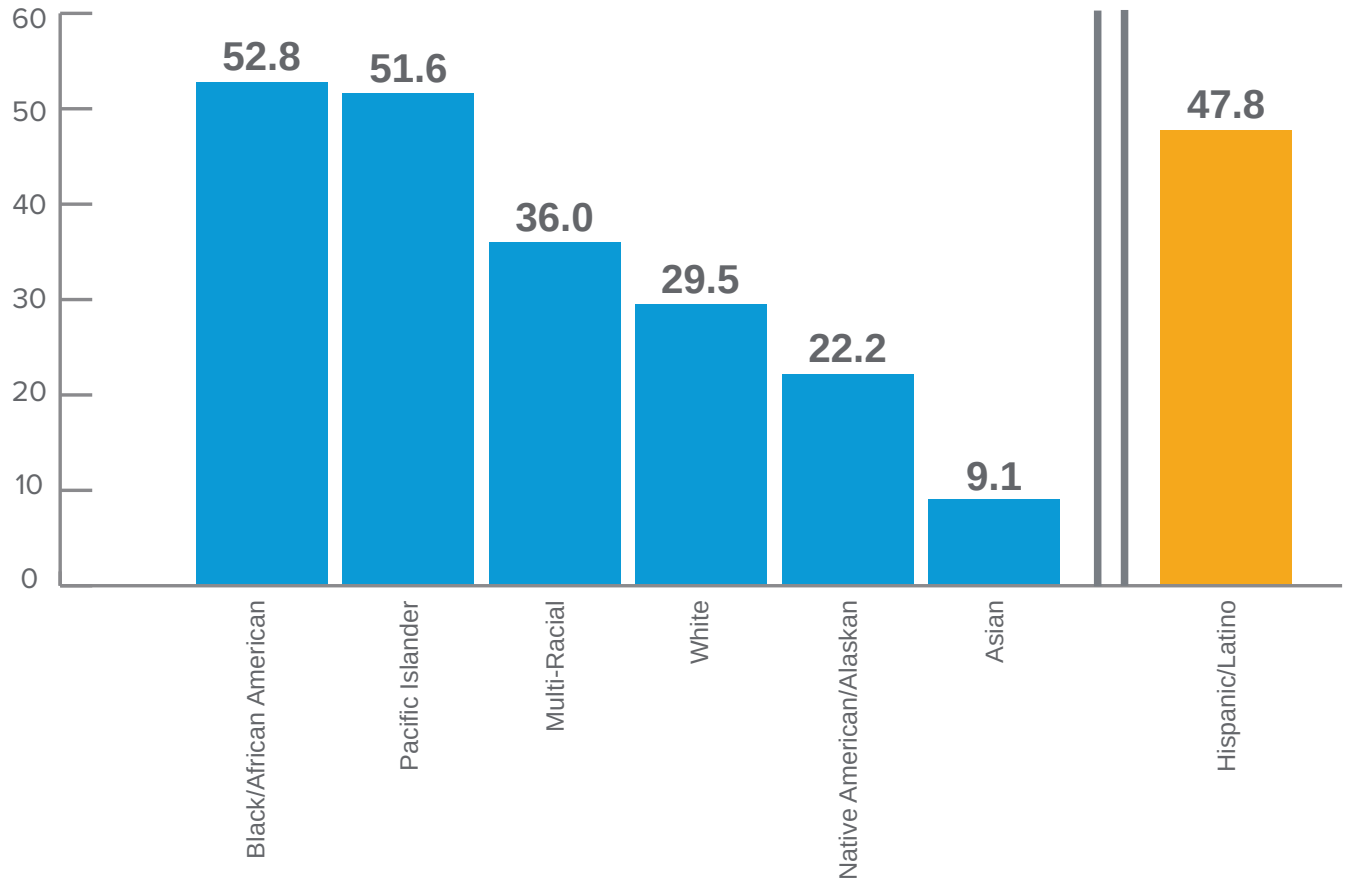
Race & Ethnicity

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/Latino[2], the rate is 47.8 per 1,000.

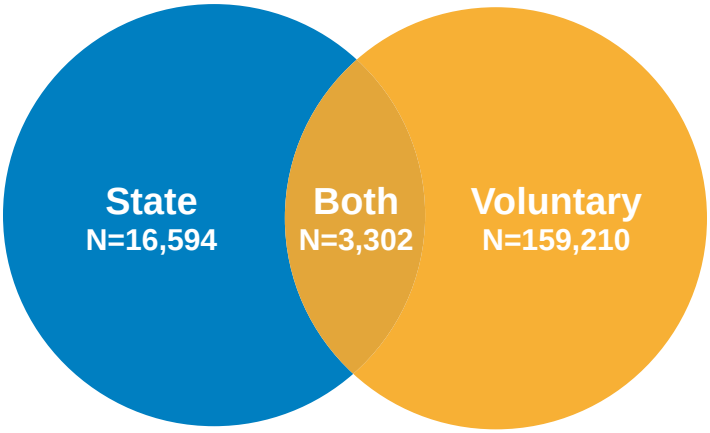
Rates of service by race should be read with some caution due to the small size of some racial groups in the general population and fluctuations in these rates identified through analyses of past PCS populations. However, since rates for most racial groups (e.g., White, Asian, and Black/African American) 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.

1-3 Rates of Individuals Served Annually by Race & Ethnicity



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



Services by Program Auspice

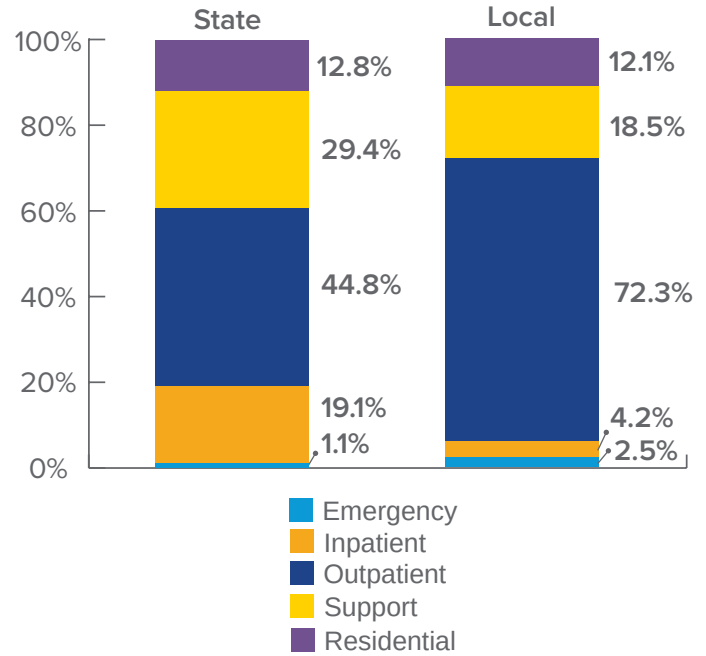
Figures 1-4 and 1-5 show the distribution of access to services in the State-operated and voluntary service sectors during the 2015 PCS one-week survey period. As shown in Figure 1-4, State-operated programs account for approximately one-tenth of individuals served in the public mental health system, 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.

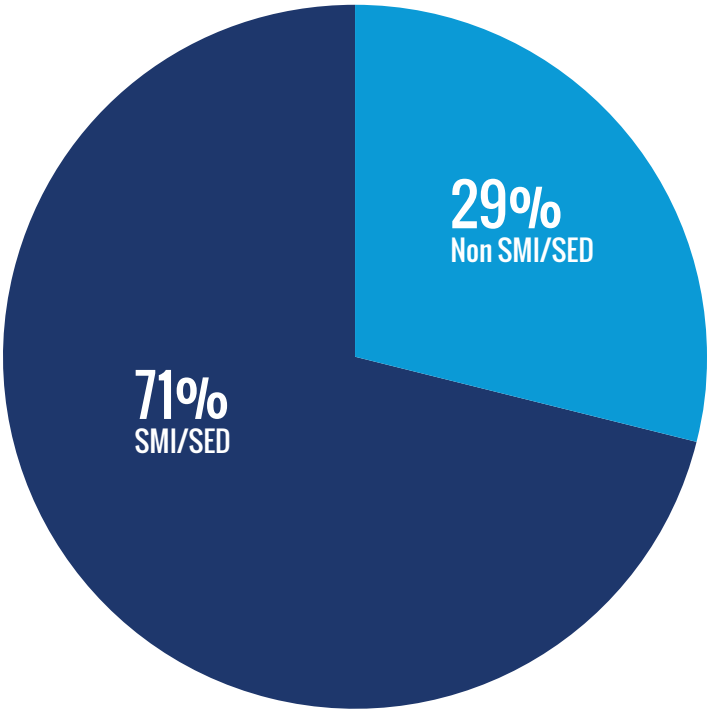
While the State-operated and voluntary service sectors have similar percentages of people accessing emergency and residential program services, there are substantial differences in the utilization of inpatient, outpatient, and support services between the sectors. For example, nearly three quarters (72.3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

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



1-6 Percentage of People Served by Auspice & Program Category



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.

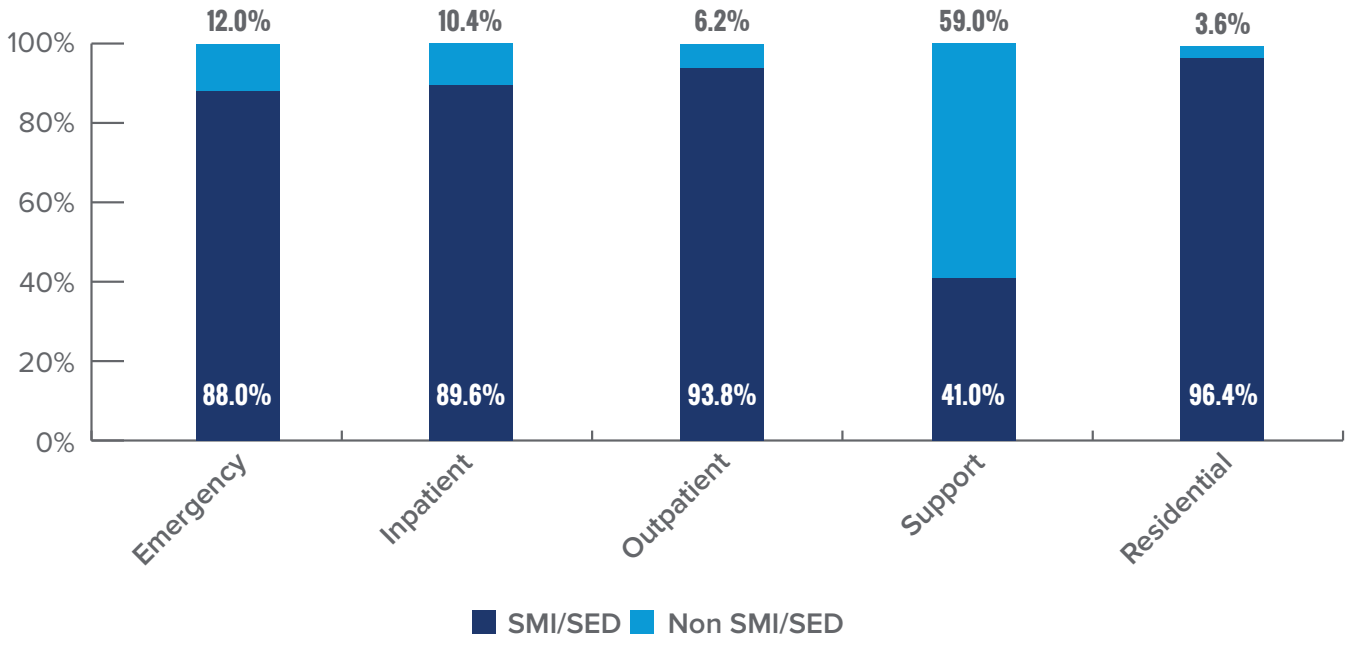
Estimated Percentage of SMI/SED Population Served by Auspice

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).

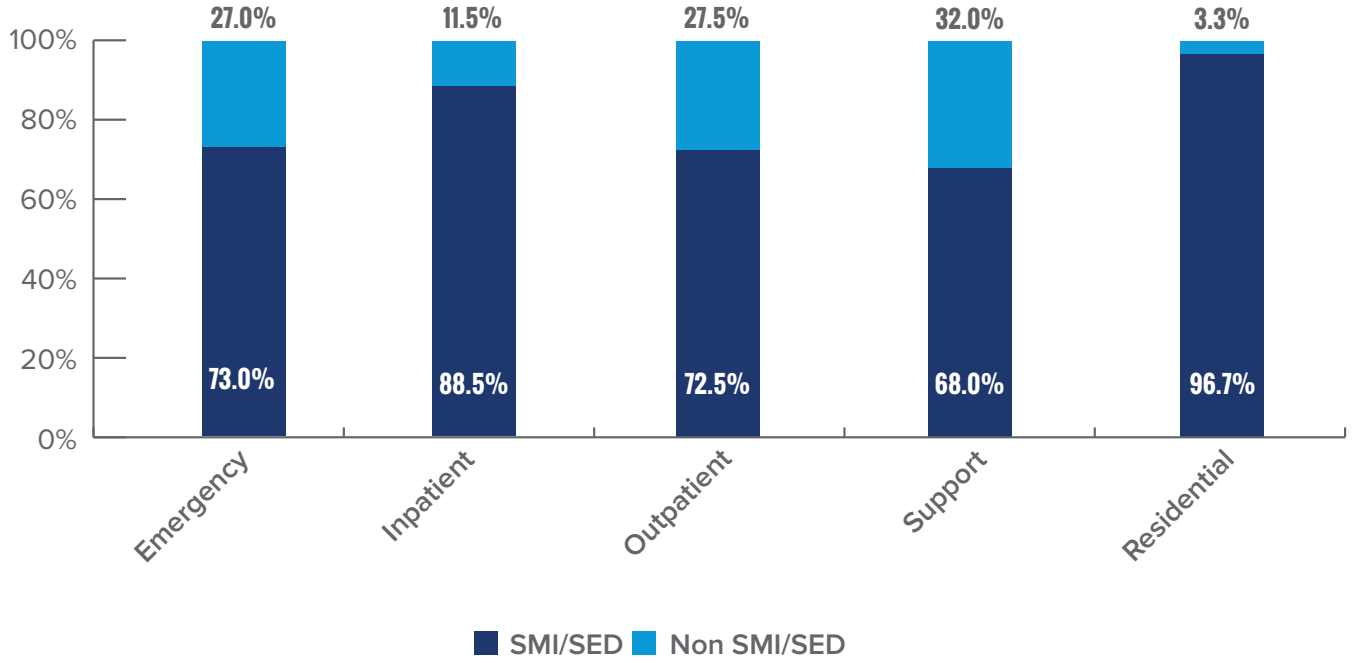
In voluntary-operated settings (Figure 1-8), the percentages of persons with SMI/SED served in inpatient and residential programs are similar to those served in these program types in State-operated settings.

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).

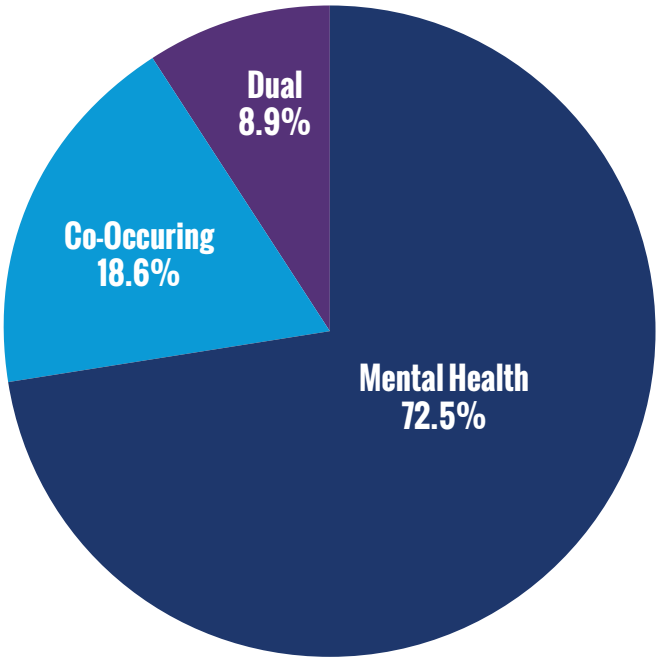
1-7 Percentage of Persons with SMI/SED Served in State-Operated Settings



1-8 Percentage of Persons with SMI/SED Served in Voluntary-Operated Settings



1-9 Statewide Distribution of Co-Occurring and Dual Diagnoses



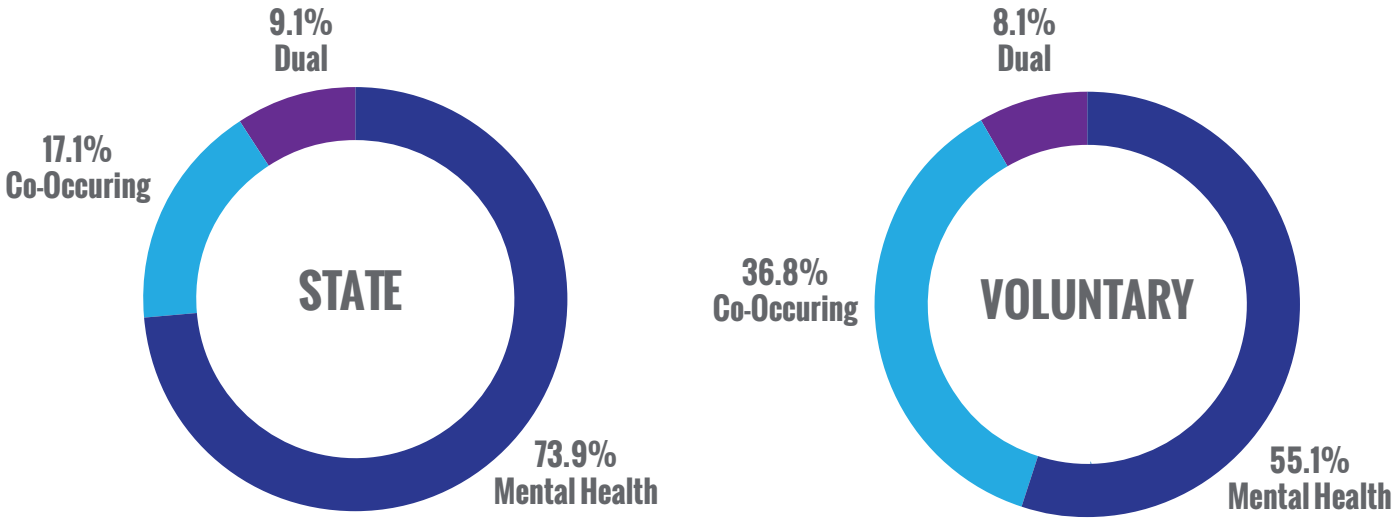
Other Diagnoses of Individuals Served: Co-Occurring Disorders & Dual Diagnoses

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.

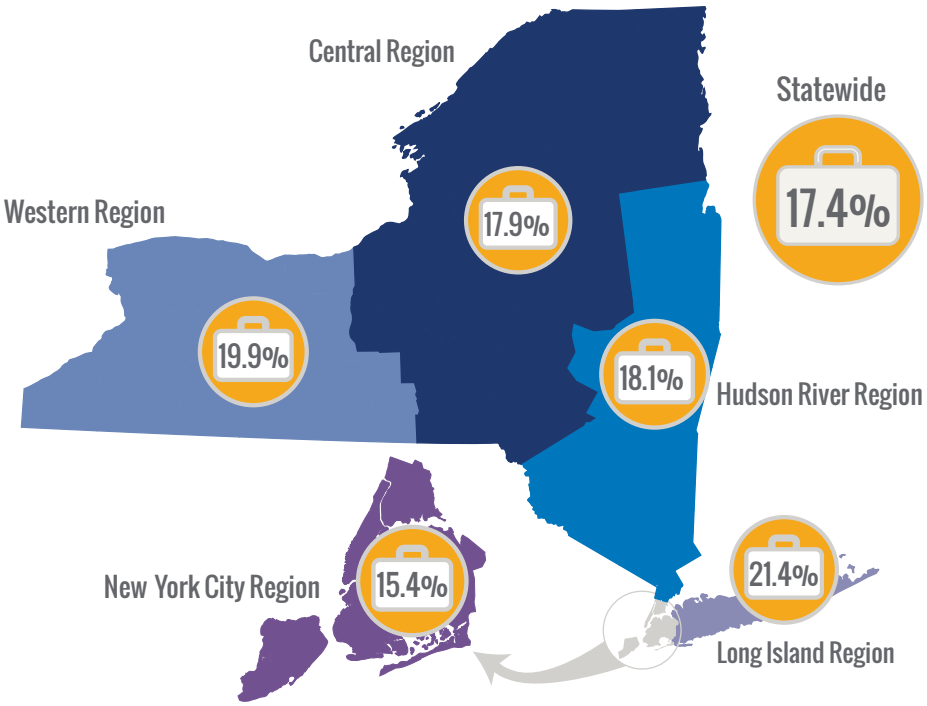
Employment Status

Mental health and mental wellness models emphasize recovery-oriented treatment that support 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 receive services in the public mental health system, and 93,000 of them (17.4 percent) are competitively employed. This competitive employment rate has remained relatively steady over the years, with only small amounts of growth over time.

Figure 1-1 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 State Office of Mental Health (OMH) mission is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults diagnosed with serious mental illness and children diagnosed 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 health.

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 who suffer from 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.

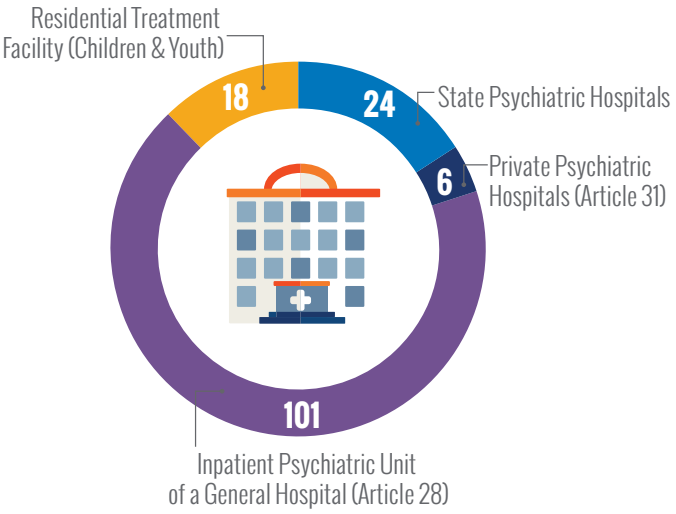
As a provider of services, the Office of Mental Health operates 24 State inpatient facilities for civil, forensic, and research populations, serving approximately 10,000 inpatient individuals each year.[7] OMH also operates dozens of residential, outpatient, and support programs that serve thousands 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 2,000 licensed and 2,600 unlicensed programs which fall into five major categories: inpatient, outpatient, emergency, residential and support programs.

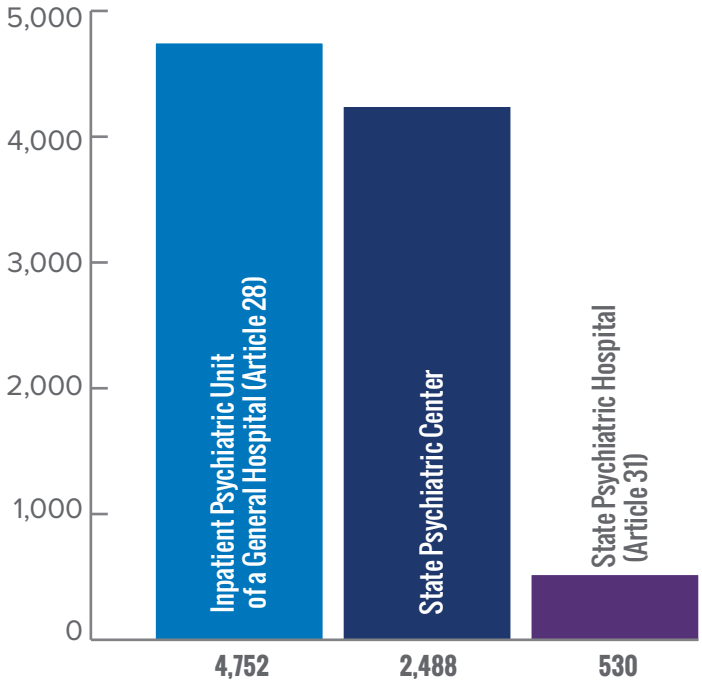
1-12 Inpatient Programs statewide (N=149)



Inpatient

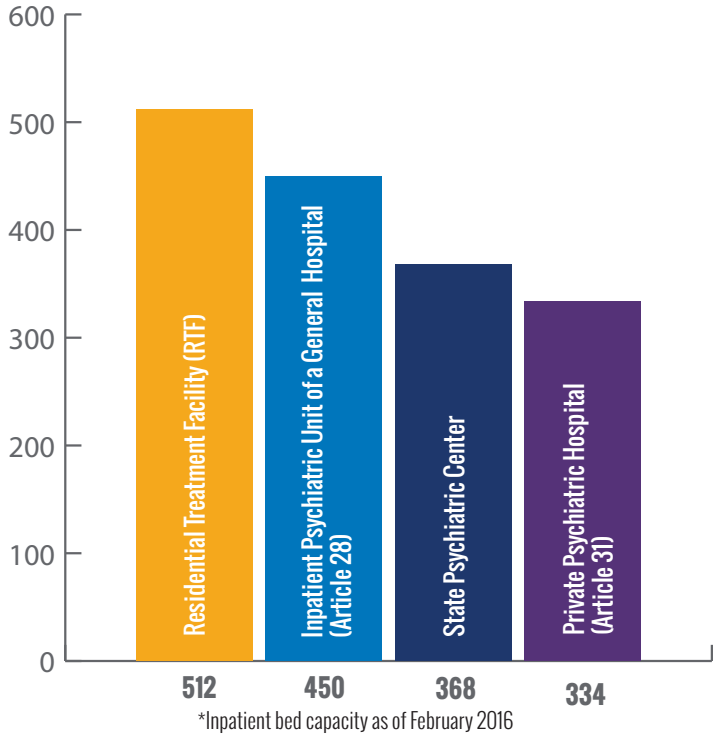
Inpatient Services provide stabilization, intensive treatment and rehabilitation with 24-hour care in a controlled environment. They are the programs of choice only when the required services and supports

1-13 Adult Inpatient Beds (N= 7,770)
*Excludes Forensic Beds**



*Inpatient bed capacity as of February 2016

1-14 Child Inpatient Beds Statewide* (N=1,664)



*Inpatient bed capacity as of February 2016

cannot be delivered in community settings. OMH operates 24 State Psychiatric Centers[8], and licenses over 100 other inpatient programs that collectively operate nearly 10,000 psychiatric inpatient beds statewide.[9]

Overall, OMH accounts for 16 percent of the inpatient programs in the State, including adult and children's facilities.[10] 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 PCs." Most OMH Psychiatric Centers are accredited and regulated by the Joint Commission and the Centers for Medicare and Medicaid Services (CMS); they are not licensed by the State. OMH State PCs account for a smaller share of the total inpatient facilities statewide than they do when measured by bed capacity, where they represent a larger share of beds for both adults (32 percent) and children (22 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

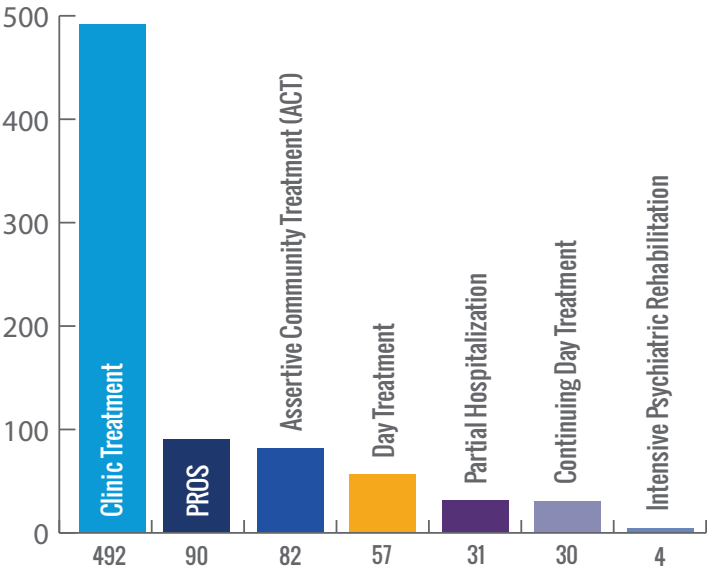
Find a Mental Health Program

Want to find a program in your county described in this chapter? The OMH website houses the Mental Health Program Directory which includes both State-operated and voluntary programs regulated by the agency. The directory includes program details such as county of operation, hours of operation, and program contact information. The directory is maintained by the Office of Mental Health through the CONCERTS program database. All programs discussed in this section can be found at https://my.omh.ny.gov/analytics/saw.dll?PortalPages

Unlicensed Programs

There are 2,600 unlicensed programs which are programs such as care coordination, crisis services, education, forensic programs, general support and education, specific types of housing, self-help, vocational and some emergency programs. Unlicensed programs are usually directly contracted between local governmental units and providers using State Aid funds, while some are directly contracted by OMH.

1-15 Outpatient Statewide



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.

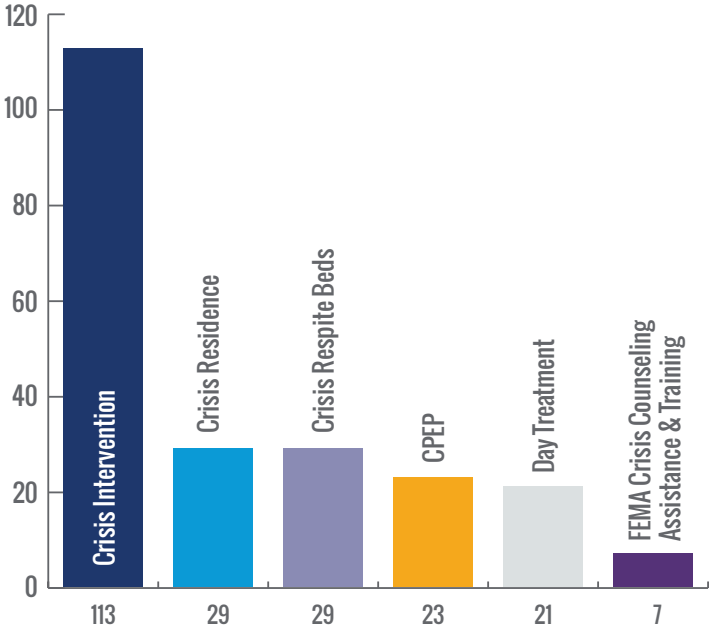
Private psychiatric hospitals, also known as Article 31 hospitals, are 24-hour inpatient treatment programs that are licensed by OMH and operate in private hospitals that exclusively provide behavioral health services. There are currently six Article 31 hospitals statewide, operating a total of 864 beds.

Another type 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 as shown in Figure 1-15.

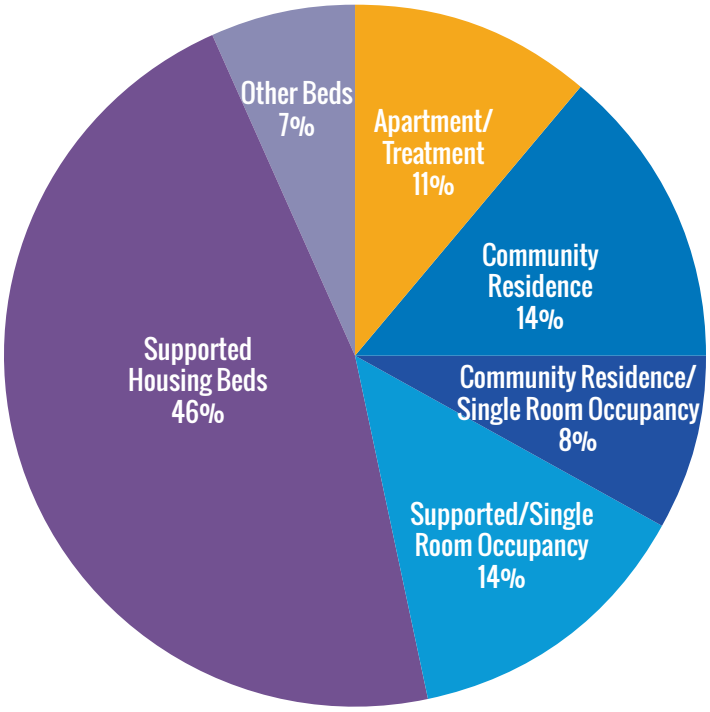
1-16 Emergency and Crisis Programs Statewide



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

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.

Residential

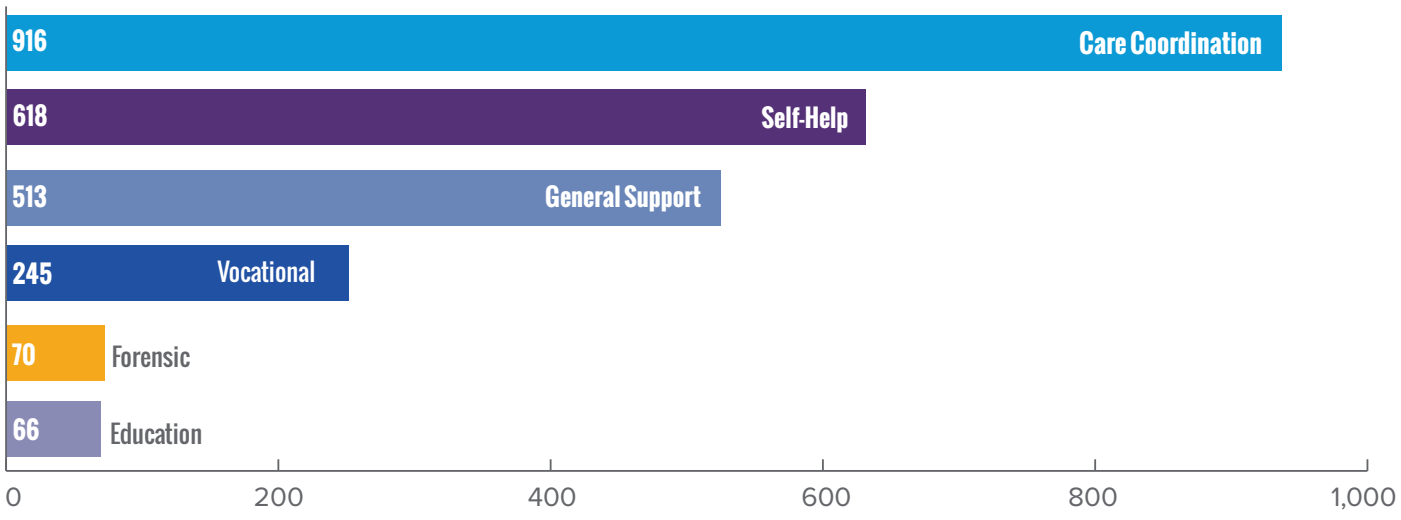
Residential Services are provided to maximize access to housing opportunities, particularly for persons with histories of repeated psychiatric hospitalizations, homelessness, involvement with the criminal justice system, and co-occurring substance abuse. Residential services are also offered to children 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 Mental Health Program Directory on the OMH website at: https://my.omh.ny.gov/analytics/saw.dll?PortalPages

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



Section 3
New York State Mental Health Spending[11]

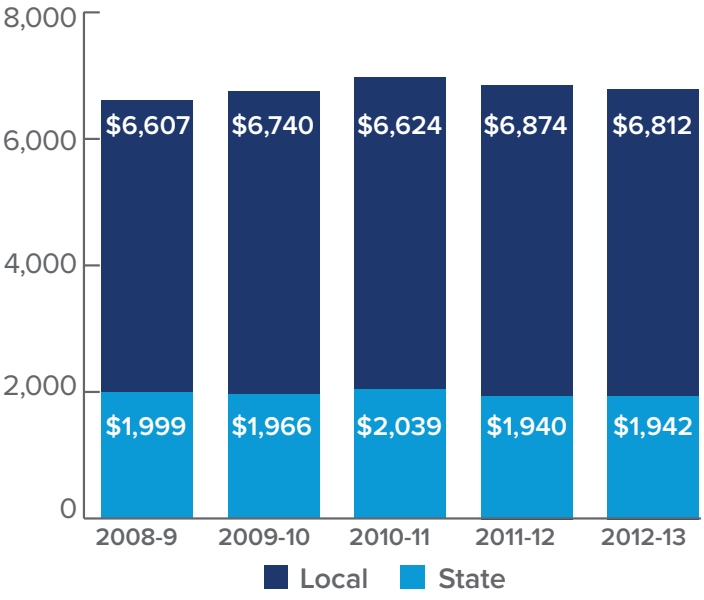
Gross Expenditures:
State and Local Programs

Statewide mental health expenditures from all sources have grown over the most recent five-year period of data available, from $6.7 billion to $6.8 billion, and the share of spending by State and local auspices has remained relatively stable. There was moderate growth in local services, while State operations spending declined slightly in dollars and in the relative share of the total.[12]

Expenditures Service Category:
State and Local

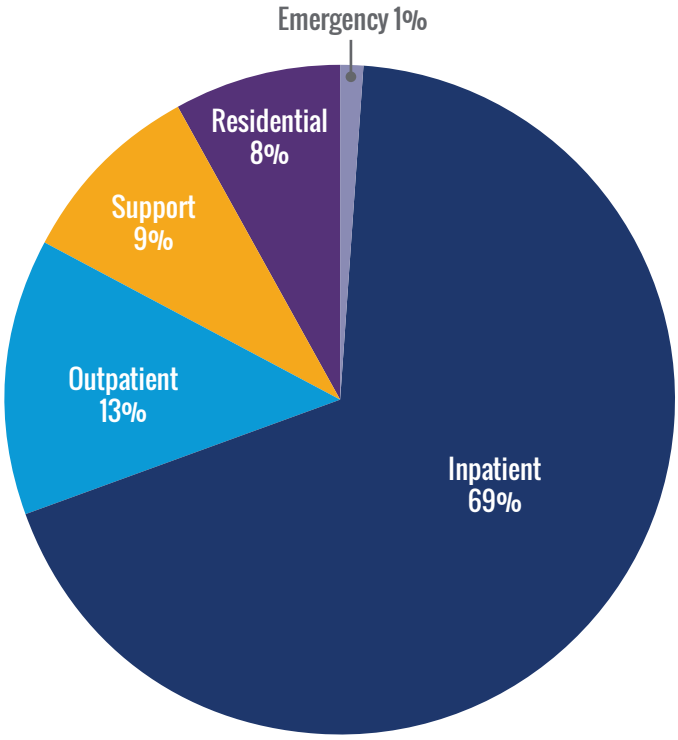
The following tables provide a more detailed one-year view of expenditures by service category, within State and local auspices respectively. When viewed at this level, the large proportion of inpatient spending within State-operated settings is notable, comprising nearly 70

1-19 Annual Mental Health Expenditures by Auspice (in Millions)

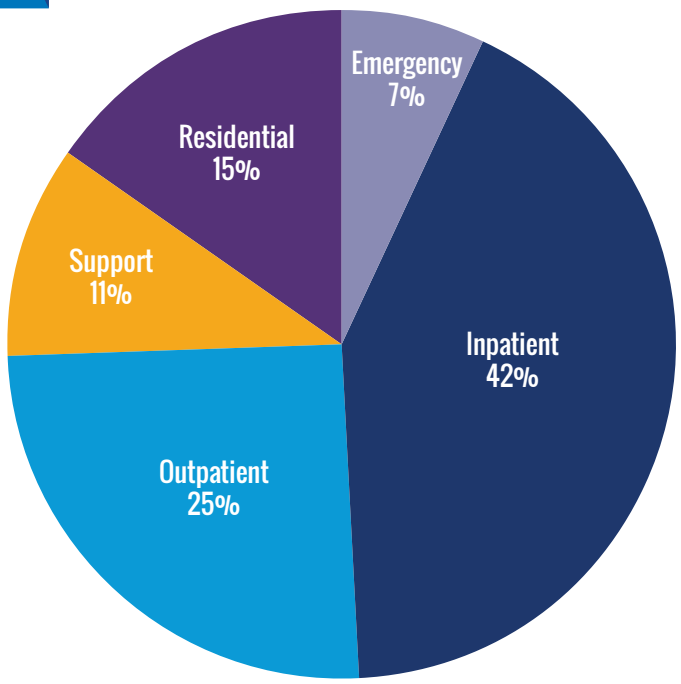


Source: NYS OMH Finance Group: Summary of State Mental Health Expenditures

1-21 State Operations Expenditures SFY 2012-2013 (Total: $1.9 Billion)



1-22 Local Provider Expenditures SFY 2012-13 (Total: $4.9 Billion)



percent of all OMH operations, or $1.3 billion per year. Expenditures on local inpatient services make up a plurality of spending by service category at 42 percent, and exceed State inpatient in raw dollars at $2 billion. However the local system is generally more balanced between community and hospital-based settings.

Under both the OMH Transformation Plan, and the Delivery System Reform Incentive Payment (DSRIP) program, New York State will continue to direct a greater share of our resources to community-based services through savings from avoidable and unnecessary inpatient utilization. In future years, we continue to expect growth in the total expenditure amounts, but with an increasingly greater share of such growth in community-based, non-inpatient service settings.

[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 24 State PCs 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.

[9] The OMH Facilities, Article 28/31 Hospitals and CPEPs in New York State: October 2015 map can be found in Appendix A.

[10] 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.

[11] All data in this section is from the Summary of State Mental Health Expenditures reports prepared by the NYS OMH Finance Group. Data are lagged due to extended reporting and collection timelines for multiple data sources required to present gross expenditures across the entire public mental health system. These data include revenues to all public mental health system providers from all payment sources, including Medicaid, Medicare, deficit funding, SSI, client fees/direct pay, commercial insurance, and local/county funds.

[12] The small reduction in State Operations expenditures was significantly outweighed by over $260 million in growth in local spending during the same period.

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Chapter 2

Mental Hygiene Law Section 5.07 Background and the Local Planning Process

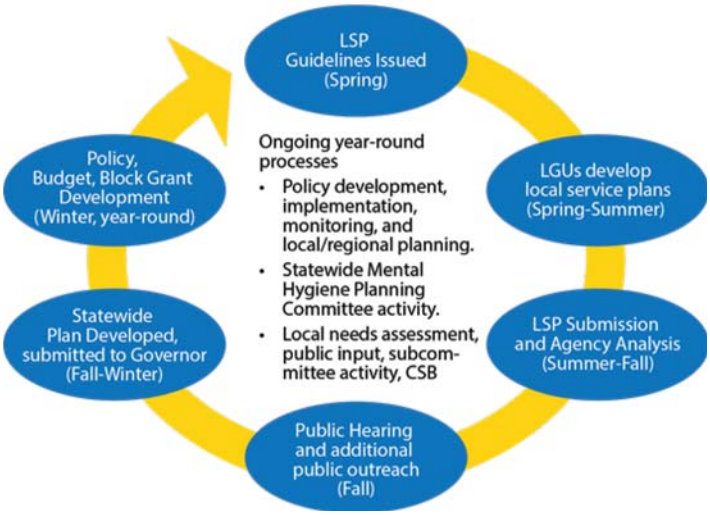
Section 5.07 of Mental Hygiene Law requires OMH to develop a statewide Comprehensive Plan for the provision of State and local services to individuals with mental illness. Some key objectives identified in the statute include: identifying statewide priorities and measurable goals to achieve those priorities, 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 (LSP) 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 (CPS), 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 CPS 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. LSPs for 2016 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 health care 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 (PHIP), the State Health Innovation Plan (SHIP) and the Prevention Agenda 2013-2018.

2-1 The State and Local Planning Cycle



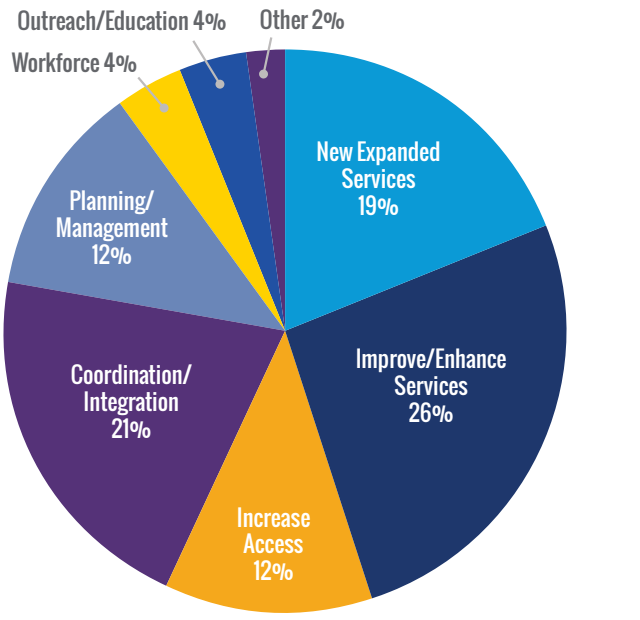
2016 Local Services Plans
Priority Outcome Analysis

Summary analysis from the 2016 Mental Hygiene Local Services Plans (LSPs), which were submitted to the State in the summer of 2015, included identification of mental health service priorities in the community, in addition to county and regional needs assessments. In the 2016 LPS Guidelines, LGUs were asked to state their local priorities by addressing their needs and progress on those priorities. The plurality of county priorities included in the 2016 plans were associated with multiple mental hygiene service systems. Priorities that address cross-system collaboration, service integration, and care coordination represent a common theme also identified in the needs assessment data, while the expansion of services accounted for one-fifth to one-quarter of priorities.

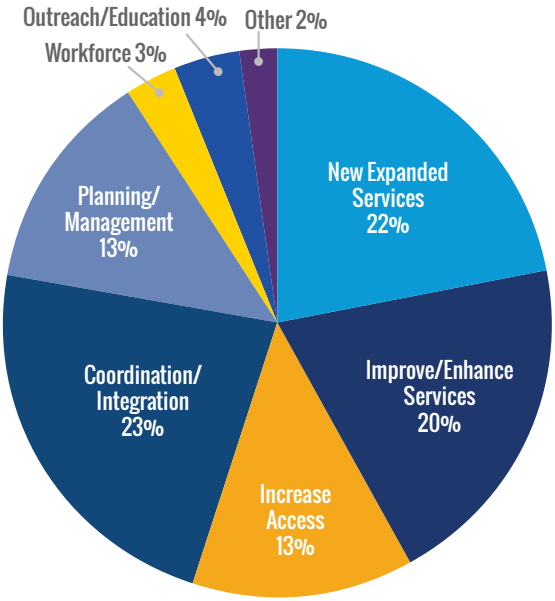
One larger narrative uncovered in the local priority outcome data was that as managed care and DSRIP implement statewide, there is a need for a continuing role and relevance of specialty mental health providers. There is concern that many providers need more support to keep up with the changes and requirements of the healthcare delivery and payment systems of the future in order to be sustainable in the new health care financing environment. Some counties' priorities focus even solely on "keeping up" with what is happening locally, now that other large health care systems are moving into the behavioral health arena and changing the dynamic in mental health planning and local service development.

As Figure 2-4 shows, 57 local services plans included a total of 457 priorities.[1] Of those, 220 (48 percent) were associated with OASAS, OMH and OPWDD systems; 71 were associated with OMH and OASAS; and 22 that were associated with OMH and OPWDD.

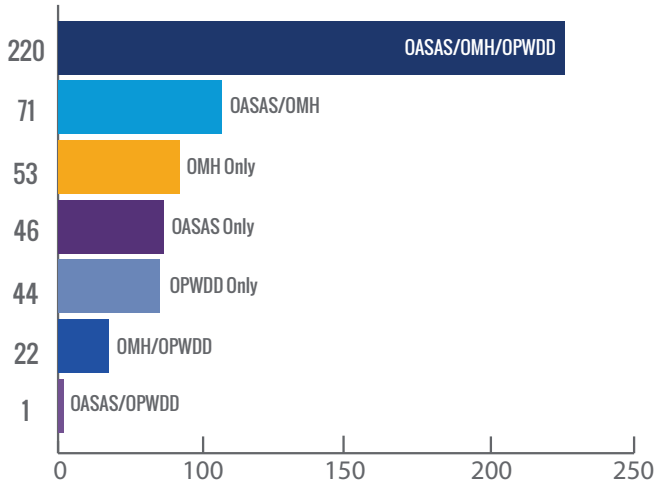
2-2 All Mental Health Priorities



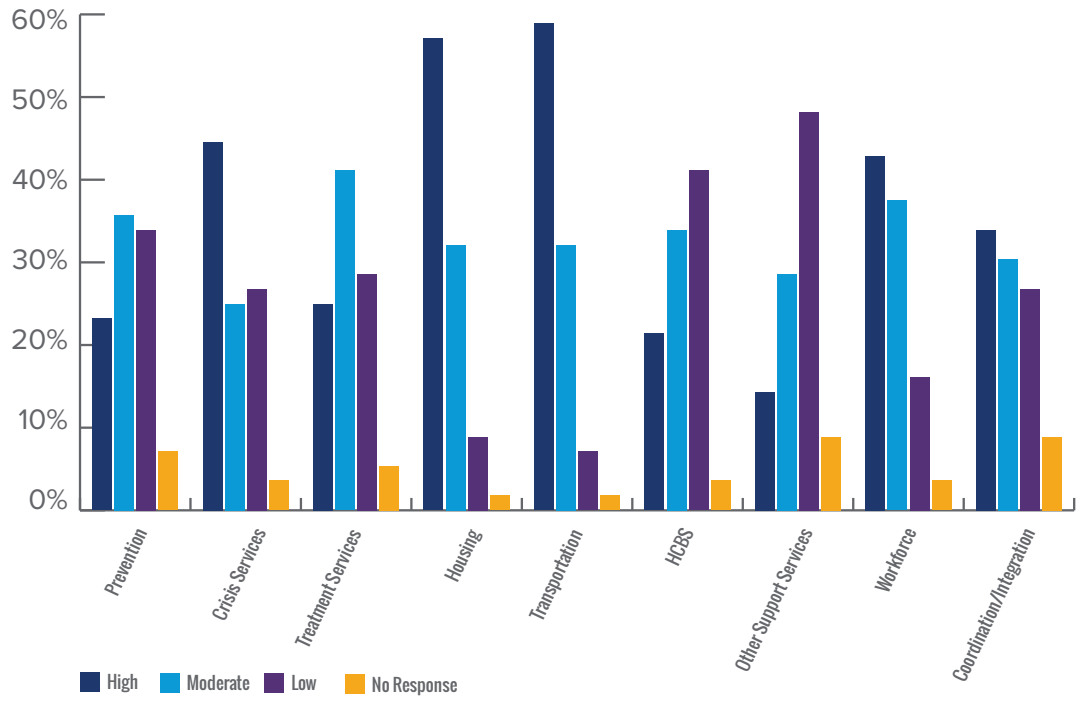
2-3 Top 5 Ranked Mental Health Priorities



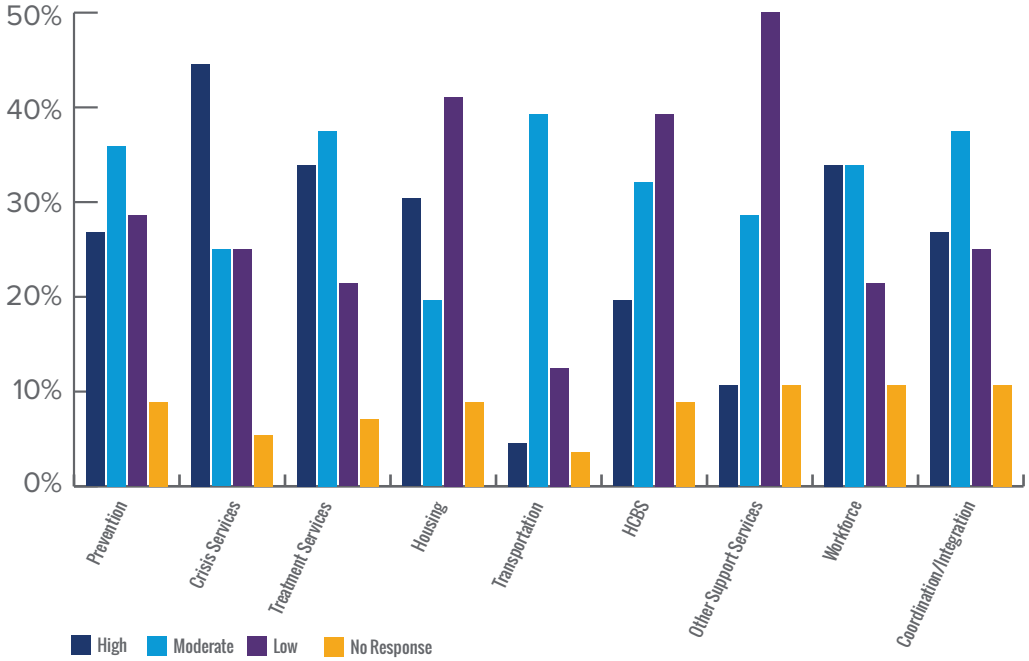
2-4 2016 Local Services Plan Priorities by Disability Agency (N=457)



2-5a LGU Assessment of Needs for Adults, Statewide



2-5b LGU Assessment of Needs for Children & Youth, Statewide



The local services planning process and the priorities identified in county plans, particularly the cross-system priorities, inform each State agency's policy, programming and budgeting decisions in a way that is more timely and comprehensive than previously possible. To help ensure that policies supporting people with mental illness are planned, developed and implemented comprehensively, OMH will continue to look to the local services planning process and the annual plan submissions as important sources of input.

Needs Assessment Analysis

As discussed above, OMH included a subjective needs assessment survey in the 2016 LSP Guidelines to identify unmet needs in several areas. The survey tool used in the 2016 LSP Guidelines was developed jointly with OASAS and OPWDD, with general categories developed to apply to all agency populations. LGUs were asked to assess the level of need for several areas of need related to service access, and additional areas such as workforce and transportation. The survey guidance directed LGUs to consider each category's need level against the other categories, in order to determine the spectrum of unmet needs within an area. Given that the survey is a subjective assessment of need, no definitive conclusions can be drawn on the results by themselves, however they do provide some utility in comparing regions' areas of need, and also help in providing a starting point for data analysis and validation, to support regional and statewide planning efforts.

The results of the 2016 needs assessment have in part validated many of the areas that are already priority areas for the State; but they also identified less visible themes. In the former category, there are indications of a high need for more housing and transportation for people with mental illness, and a serious need for more psychiatry workforce availability in most areas across the State. A few unique themes that came through in the open-ended portion of the survey were related to difficulties in navigating Medicaid transportation services and the need for a more comprehensive and organized crisis response system within counties, including crisis capacity for people with developmental disabilities and the dually diagnosed. Many needs assessment narratives also focused on the need to better align and coordinate service delivery systems to better support individuals and families with complex needs.

While the survey included needs assessment questions to be answered at both the county and regional level, the recent analysis focused on the county-level responses which were then "rolled up" for presentation at a regional level. Efforts to parse differences in individual counties' assessments of need between their own county and that of the Regional Planning Consortium (RPC) region in which they reside did not deliver enough of a response to include in this analysis. The figure presents local needs aggregated at the statewide level. A copy of the survey questions with full category names is provided in Appendix C, along with analyses of these need categories at the RPC regional level.

Given the richness of the data provided through the 2016 plans, OMH developed a series of 2-page summary briefs that provide an overview of those areas that a county identified as "high need" for their mental health population/system locally and for their region, in addition to summaries of the county top five priority areas for 2016. Copies of the individual LGU documents are included in Appendix F of this report.

[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.

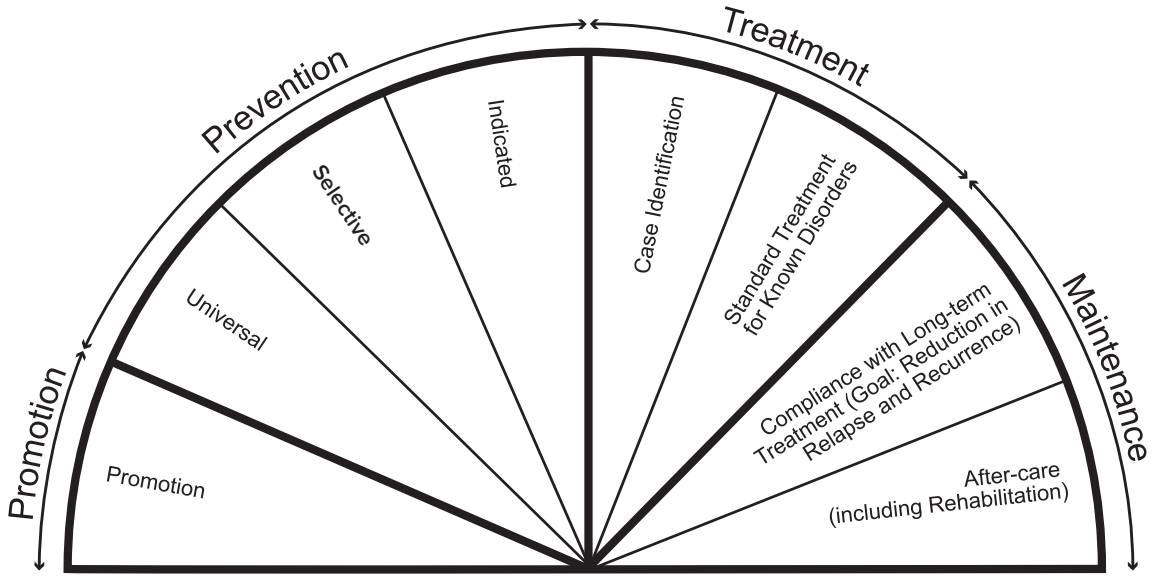
Chapter 3

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

This chapter describes several initiatives aimed at building our capacity as a State to promote mental wellness, prevent disorders, and intervene earlier in the trajectory of mental illness. These efforts can be identified as a progression across the left and central portion of the Institute of Medicine (IOM) mental health intervention spectrum (depicted below) which ranges from the general promotion of mental wellness, prevention of and early intervention with illness, the treatment of conditions, and maintenance and recovery.[1] The Institute of Medicine, and New York State through the DOH Prevention Agenda 2013-18[2] have indicated the importance and value of focusing on promotion and prevention strategies across larger populations, in order to reduce future incidences of mental health disorder. The following sections summarize efforts underway at OMH to reach larger populations earlier in the trajectory of mental wellness and illness in order to improve New York State population health.

Section 1 provides an overview of two strategies to promote mental health and prevent disorders by focusing on early childhood. Section 2 details the OnTrackNY initiative, a targeted strategy to identify and assist individuals at the earliest onset of psychotic symptoms to help better manage the illness, and reduce recurrence and negative impacts in the future. Finally, Section 3 outlines a series of transformational efforts across behavioral health and primary care treatment settings to identify and treat health and behavioral health conditions using a more integrated approach. Together these efforts reflect statewide, interagency collaboration to earlier and more holistically address a range of needs in the total New York State population.

3-1 The IOM Mental Health Intervention Spectrum



Section 1
Early Childhood Prevention and Pediatric Connections

Scientific evidence over the past 30 years shows that behavioral health problems can be prevented. Research has also identified positive attributes and protective environmental influences that buffer or minimize the adverse effects of exposure to risk. In 2010, the Surgeon General issued the following National Prevention Strategy Recommendations:[3]

1. Promote early identification of mental health needs and access to quality services.
2. Promote positive early childhood development, including positive parenting and violence-free homes.
3. Facilitate social connectedness and community engagement across the lifespan.
4. Provide infants, toddlers, young children and their families with the support necessary to maintain positive mental well-being.

The NYS Office of Mental Health has made significant investments in advancing evidence based prevention interventions and mobilizing across disciplines and communities to unleash the power of prevention across New York State. Several OMH initiatives outlined in this section will advance the Surgeon General's preventive strategy recommendations: Healthy Steps and ParentCorps target communities throughout New York State to advance OMH's prevention policy of intervening early to strengthen families and promote children's social emotional wellbeing, and Project TEACH offers child psychiatry consultation services to pediatric providers in order to build primary care capacity for serving children with mental health disorders.

Healthy Steps for Young Children

Primary care settings offer an important opportunity to intervene before a problem has fully manifested and to provide prevention and intervention strategies such as universal screening, early identification, integrated treatment, and parental education and support. In the coming year, OMH is advancing Healthy Steps for Young Children. The Healthy Steps model offers families enhanced primary care visits for children by promoting children's development, addressing parental concerns, and providing supports and linkages as needed from birth to age five.

A recent national study of pediatric practices identified the persistent inability to achieve better linkages with community-based resources as a major challenge yet, pediatric primary care provides a key opportunity to offer families information and support on their child's social-emotional well-being and growth in a non-stigmatizing environment.[4] Healthy Steps builds this capacity and breaks down these barriers to needed supports and linkages for families.

Healthy Steps for Young Children is an evidence-based primary care preventive intervention that enables the primary care practitioner to expand the primary focus of physical health to emphasize social-emotional and behavioral health and to help support family relationships. Healthy Steps infuses mental health and trauma-informed care into the primary care setting and is facilitated by the addition of the Healthy Steps Specialist who is a professional with expertise in child and family development.

Primary care providers are a natural contact for families. Typically an infant has seven well child visits within the first year of life, often before families have contact with other systems of care. This provides many touch points for the Healthy Steps Specialist to support the health care provider in promoting early healthy social and emotional wellbeing. This early access provides opportunities to integrate social-emotional wellbeing with physical health for the youngest of New York's children at a critical time in brain development.

Three related themes inform the Healthy Steps approach to primary care for young children:

1. The first five years of life are critically important for both the child and the family.
2. Key to a young child's healthy growth and development are nurturing relationships between the family and the child and between the practice and the family.
3. Medical care for young children can be enhanced by including the promotion of child development, focusing on the whole child and the whole family.

Healthy Steps has been implemented at numerous sites across the country, and is standardized in its goals in increased caregivers' understanding of development and behavior using a range of tools and strategies. An evaluation by the Johns Hopkins Bloomberg School of Public Health found that Healthy Steps families were more likely than control families to:[5]

- Practice safer and more responsive parenting.
- Avoid harsh disciplinary tactics.
- Openly discuss feelings of sadness with a health care professional.

Given the important correlation of feeling loved and safe to a child's healthy development, these findings are powerful indicators of Healthy Steps' highly desirable effects on parental behavior. The study also reported that Healthy Steps children received regular developmental screenings and were more likely to have current immunizations. Even more impressive, researchers followed Healthy Steps children to age five and a half and found that families continued to use more appropriate disciplinary methods and remained more sensitive to the child's behavioral cues.

Below are the key components of service delivery:

- Staff offers enhanced well child care through well child office appointments where parents can get answers to questions about child development and take advantage of "teachable moments."
- Healthy Steps Specialists make home visits at key developmental points.
- Healthy Steps Specialists staff a child development telephone information line.
- Staff provides child development and family health checkups, with screens to detect signs of developmental or behavioral problems and screen for family health risks such as maternal depression.
- Parent groups offer social support as well as interactive learning opportunities.
- Staff provides linkages to community resources and facilitate parent to parent connections.

Another important component of service delivery is the addition of a parental trauma screen, since caregiver childhood trauma may help to identify children at risk for impaired social-emotional development at a very young age. Given the foundational nature of social-emotional development for future success, it is anticipated that interventions specifically targeting the parenting of caregivers with childhood trauma and the social-emotional development of their children may represent a promising approach to prevent behavioral health challenges.[6]

Implementing Healthy Steps in New York

The Office of Mental Health has selected seventeen pediatric and family medicine practices to implement the Healthy Steps program across New York State. These practices will engage new parents to enroll their infants in the Healthy Steps program by four months of age, and follow them through five years of age. These Healthy Steps sites will have the combined capacity to impact the lives of thousands of children and their families.

The Healthy Steps sites are committed to advance the Healthy Steps model. They are distributed across the State and represent diverse populations and geographical areas. The sites range from Federally Qualified Health Centers, hospital-based clinics, community health centers, and private practices. The sites primarily serve communities in poverty where on average 85 percent of their practices see children that are covered by Medicaid, Child Health Plus or are uninsured. The children served will come from high need communities and are disproportionately at risk for social and emotional concerns.

Healthy Steps brings the opportunity to prevent mental health problems though anticipatory guidance and promotion of healthy lifestyles. While prevention is emphasized, Healthy Steps also incorporates mechanisms to identify and intervene potential problems early on. Universal screening for the child and consideration of the well-being of the family though maternal depression screening and attention to past adversities is included. When needed, facilitated referrals to community resources are provided.

Each site brings a unique and rich perspective to build upon and the collective shared knowledge gained through ongoing learning collaboratives will help to strengthen each program's ability to excel in implementation, to promote the mental health and well-being of our young children. The OMH partnership with this diverse range of primary care practices will inform our efforts and work to bring together multi-payer support to sustain this universal prevention model.

ParentCorps

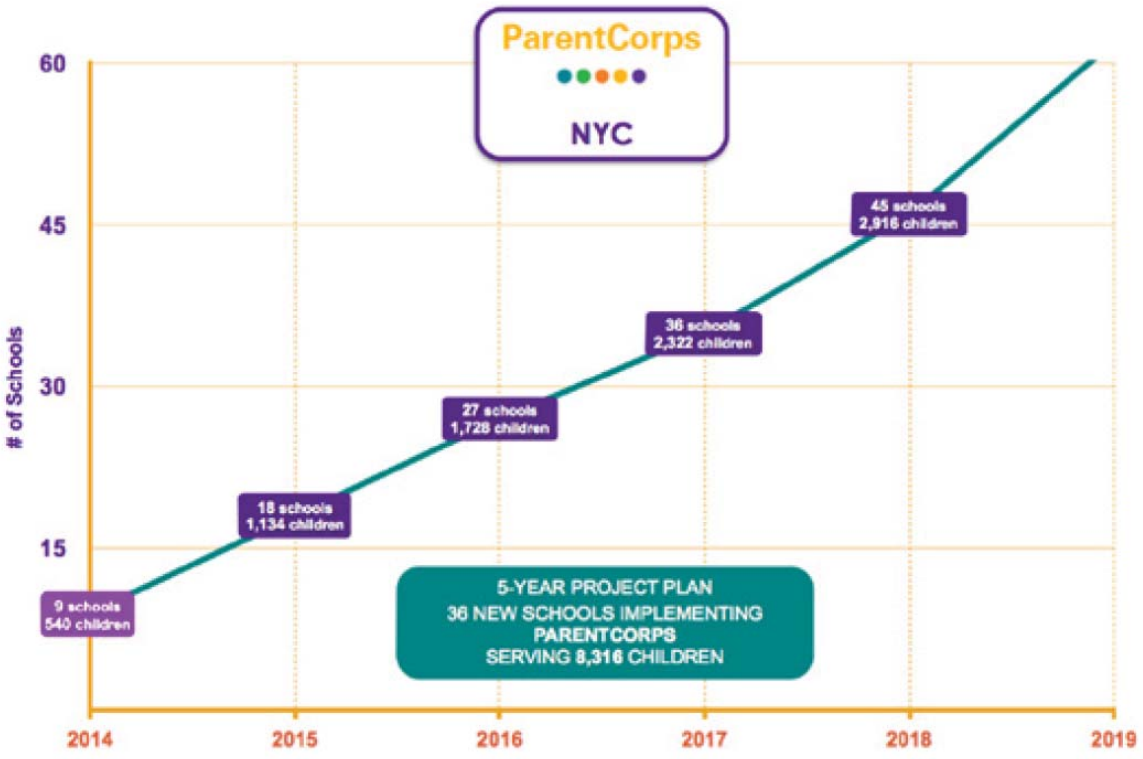
Advances in neuroscience, developmental psychology, and prevention science provide compelling evidence that the foundation for healthy development is established in early childhood. Interactions between biological processes and home and early care environments can impact learning, behavior, and health across the lifespan. The stress of poverty constrains caregivers' ability to provide positive behavior supports, and jeopardizes the development of social, emotional and self-regulatory skills. Collectively, these skills impacting executive functioning are recognized as core components of readiness for school, and a necessary foundation for achievement and well-being. By identifying communities where children are disproportionately exposed to factors that can compromise development, OMH is better able to align and mobilize resources from various service systems to intervene early and make an important public health impact.

ParentCorps is implemented as a universal intervention (i.e., for all children) in early childhood education or childcare settings (collectively referenced as "school"). The school-based delivery model and intervention process were developed to be relevant and engaging for all families as children enter school, recognizing the breadth of diversity found in urban areas. To effectively mitigate the impact of poverty, ParentCorps combines multiple approaches to strengthen parenting, classroom quality, and child self-regulation:

- Family program (14-week behavioral parenting intervention and concurrent group for children);
- Professional development for early childhood educators; and
- Consultation for school leadership.

Two randomized controlled trials with young children entering school in New York City provide evidence in support of ParentCorps' impact on vulnerable children, with replicated studies concluding that ParentCorps engages parents and teachers at very high rates, and

3-2 ParentCorps: 5-Year Project Plan



strengthens parenting and early learning environments necessary to improve children's learning, behavior and health.[7]

Outcome indicators are also very promising: ParentCorps substantially altered the negative developmental trajectory to serious conduct problems for high-risk boys, potentially reflecting an important shift off the early-starter pathway to antisocial behavior. For this high-risk group, ParentCorps also resulted in lower rates of obesity in both girls and boys. In addition, ParentCorps substantially increased each child's quality-adjusted life expectancy.

In 2011 the NYS Office of Mental Health commissioned a cost-benefit analysis to estimate the long-term health and economic effects of ParentCorps, in order to inform policy and investment decisions. This analytic project also supported feasibility testing for ParentCorps implementation model in six NYC schools with Universal Pre-K programs. The results of the cost benefit analyses estimated that ParentCorps can save more than $2,500 per child in health care, criminal justice and productivity expenditures, after factoring in the costs of capacity building and annual programming.

The projected cost savings and increased quality of life are primarily attributable to ParentCorps' benefits for children who are at the highest risk for long-term problems, including impacts on obesity and subsequent diabetes, behavioral problems, criminal justice system involvement, and unemployment.

In 2015, OMH awarded a grant to expand a family-centered, school-based preventive intervention to foster healthy development and school success among young children (ages three to six) living in disadvantaged neighborhoods throughout NYC. ParentCorps was the successful applicant. To scale its impact, ParentCorps developer Dr. Laurie Brotman leveraged foundation dollars with a five-year OMH contract to expand partnerships with policymakers and practitioners to translate findings into broader practice, and advance the model for independent and sustainable implementation. Figure 3-2 highlights the projected growth of ParentCorps throughout New York City.

At the end of the contract, the 36 schools will have the capacity to serve 2,376 Pre-K students annually. Together with the nine schools currently implementing ParentCorps, 45 schools will have the capacity to serve nearly 3,000 Pre-K students and nearly 1,800 families annually. This prevention intervention aligns with State initiatives to support quality in pre-k programs in high-need communities and will yield valuable information to guide practice change to advance a public health approach for promotion, prevention and earlier intervention of children's social emotional development.

Project TEACH

Pediatric primary care provides an enormous window of opportunity to offer families information and support on their child's social-emotional well-being and growth in a non-stigmatizing environment. Further, many children receive mental health counseling and support through their primary care providers (PCPs) with no additional services. PCPs provide mental health support and can prescribe medication, but they may not have access to consultation or the training needed to make decisions for children with mental health needs.

Additionally, while New York State has among the largest number of child and adolescent psychiatrists of any State; there is a significant disparity in distribution. Rural and underserved areas in NYS and elsewhere are particularly hard hit. In a recent study, Kaye and colleagues found:

- 20 percent of 58 counties surveyed reported having no child and adolescent psychiatrist.
- 15 percent reported only one child and adolescent psychiatrist.
- Nearly all counties (53 of 58 surveyed) reported the need for additional child and adolescent psychiatrists.

The American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the National Institute for Health Care Management support providing primary care providers with access to consultation with child and adolescent psychiatrists as a strategy to mitigate the shortage of child and adolescent psychiatrists.

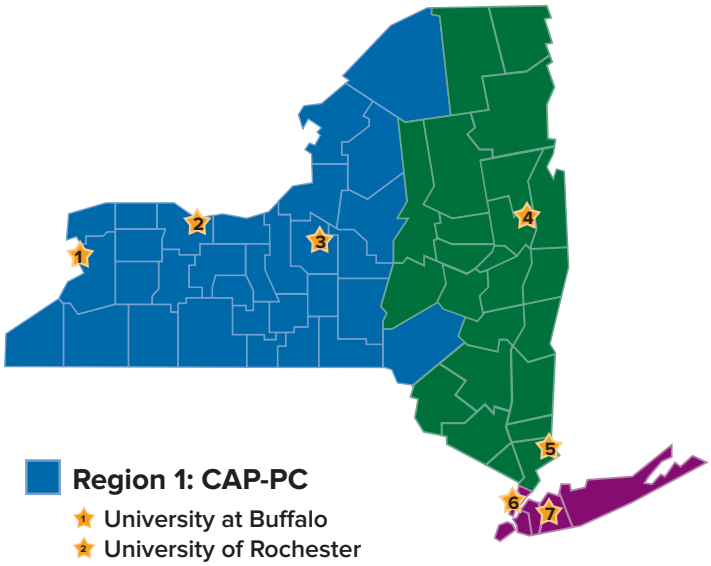
To address many of these issues, in 2010 OMH created a statewide child and adolescent psychiatric consultation and training initiative called Project TEACH. TEACH is a collaborative model that is committed to strengthening and supporting the ability of PCPs to provide mental health services to children, adolescents and their

families. This statewide program is comprised of three interrelated services for primary care providers: rapid access to child and adolescent psychiatric consultation, referral and linkage to assist families and primary care providers to access community mental health and support services and educational based training.

Figure 3-3 highlights the two regional entities that contract with the Office of Mental Health to deliver Project TEACH services in three regions of the State.

Child and Adolescent Psychiatry for Primary Care (CAP-PC) is a collaboration between the Departments of Psychiatry at the University at Buffalo, University of Rochester, Columbia University Medical Center/NY State Psychiatric Center, State University of New York (SUNY) Upstate, and Hofstra Northwell School of Medicine.

3-3 Project TEACH Region Map



Region 1: CAP-PC
- 1 University at Buffalo
- 2 University of Rochester
- 3 SUNY Upstate Medical University

Region 2: C.A.P.E.S.
- 4 Four Winds— Saratoga
- 5 Four Winds— Westchester

Region 3: CAP-PC
- 6 Columbia University Medical Center/ NY State Psychiatric Institute
- 7 Hofstra Northwell School of Medicine

Child and Adolescent Psychiatry Education and Support Program for Primary Care (C.A.P.E.S) The C.A.P.E.S. Program, through the Four Winds Foundation, has been active since 2005.

Since its inception, Project TEACH has provided nearly 10,300 consultations with over 2,300 primary care providers. Additionally, Project TEACH has provided over 3,100 linkage and referral services and over 110 trainings to pediatric PCP providers.

In order to assess the impacts of the Project and any improvements that should be made, OMH in collaboration with key stakeholders began an evaluation in 2012. The evaluation identified positive trends such as improvement in trained PCPs' perception of their ability to address mental health issues. The report cited an increased ability in trained PCPs to initiate and select appropriate psychotropic medications and to adjust doses as well as an increase in the identification of children diagnosed with mental/behavioral health issues following the PCPs participation in Project TEACH trainings. Moreover, a reduction in the utilization of psychiatric emergency services by children prescribed psychotropic medications was noted post PCPs participation in Project TEACH trainings. The recent evaluation findings supported the need to not only continue, but to expand Project TEACH.

Expansion of TEACH: Regional Providers and Statewide Coordination Center

In 2015, funding for Project TEACH was increased by $1.4 million to $2.5 million annually and the Office of Mental Health re-bid contracts for the Regional Provider services through 2020. Additionally, OMH instituted other improvements to Project TEACH including an increase of child and adolescent psychiatry staffing from 2.0 to 5.25 full time equivalents statewide.

The increased funding will enable Project TEACH to triple the number of consultations with pediatric primary care providers provided by child and adolescent psychiatrists, increase trainings for primary care providers, and add staff to provide children and families with linkages and referrals to community supports and services. The increased funding will also support a new site for the program—the seventh site statewide.

Additionally, other providers who offer ongoing treatment to children, such as general (non-child) psychiatrists, may now request a consultation – further improving the quality of care available to New York children already engaged with psychiatric treatment providers.

In addition to expansion of the Project TEACH Regional Provider services, OMH has established the Project TEACH statewide Coordination Center (SCC) to oversee the successful expansion of Project TEACH. The SCC will promote Project TEACH, strengthen the coordination of consultation services to ensure that utilization is at full capacity, expand training on a statewide basis, add specialty consultation for identified areas of need, and oversee the evaluation of services provided by Project TEACH. The SCC will work with other prevention and early identification initiatives, such as suicide prevention and first episode psychosis initiatives (described later in this report) to bring training to pediatric PCPS.

Additionally, the SCC will be a New York State leader in advancing prevention science by serving as a clearinghouse and resource for promising and evidence based practices in promoting children's social-emotional health and preventing and treating disorders, and will support the continued integration of pediatric primary care and behavioral health at a systems level.

Upon full implementation of the expansion, OMH estimates they enroll an additional 3,800 providers and conduct an additional 24,500 consultations over the next five years.

For more information about Project TEACH, including information on how primary care providers can take advantage of this program, please visit: https://www.omh.ny.gov/omhweb/project_teach/.

Section 2
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. In collaboration with OMH leadership, RAISE is a model of how scientific research can be swiftly implemented, or "translated," into community based treatment programs.

OnTrackNY provides recovery-oriented treatment to young people ages 16 to 30 who have recently begun experiencing psychotic symptoms, helping them achieve their goals for school, work, and relationships. This model is now called Coordinated Specialty Care and is being promoted nationally by a funding increase in the Mental Health Block grant to states. In this type of program, a team of specialists work with clients and their families to create personal treatment plans that are based on their individual needs and preferences.

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 serves up to 35 individuals and 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 12 sites throughout

the State, with additional locations planned in the future in order for this service to be available across most areas in the State. The 12 currently operating programs are located in the following areas: Buffalo, Rochester, Syracuse, Albany, Yonkers, New York City (six sites), and Farmingville.

Participating agencies work with county and municipal mental health departments, and receive funds for staff, training, and technical assistance. OnTrackNY will continue to track participants' recovery, including staying in or returning to school or employment, improved control of mental illness, and, reducing the duration of untreated psychosis.

OnTrackNY was developed, and continues to operate under the direction of the Center for Practice Innovations (CPI), which assists OMH in promoting the use of evidence-based practice by using innovative approaches to build collaborations between stakeholders, strengthening the skills of practitioners, and helping agencies develop the means to support such initiatives.

CPI was established in November 2007 with the goals of:

- Promoting the widespread availability of mental health evidence-based practices in New York State.
- Promoting innovations related to emerging promising practices, cultural adaptations, and organizational change approaches that support the implementation of quality services for individuals with serious mental health problems.
- Creating informational and educational resources for the general public as well as users and providers of mental health services.

CPI is located within the New York State Psychiatric Institute (NYSPI) on the New York Presbyterian Hospital/ Columbia University Medical Center campus. NYSPI is one of the Office of Mental Health research institutes, which is also affiliated with Columbia University.

For more information on OnTrackNY and the Center for Practice Innovations, visit http://practiceinnovations.org

Section 3
Integrating Care for Earlier Identification and Treatment of Behavioral and Physical Health Conditions

Since the passage of the federal Affordable Care Act, and the creation of the New York State Medicaid Redesign Team (MRT) shortly thereafter, there has been increasing recognition of the value of integrated behavioral and primary/physical healthcare treatment. This section outlines three of the most significant efforts underway in New York State to more build behavioral health capacity for primary care, and to build primary care capacity for behavioral health. They include Integrated Outpatient Clinic services regulations, Collaborative Care, and the State Innovation Model grant initiative for Advanced Primary Care. This section will also provide an overview of recently adopted telepsychiatry regulations, which are an additional tool to enhance psychiatry services in behavioral health and primary care settings.

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, and the Department of Health 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 indicated above. 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 (SUD) and/or mental health (MH)) are provided in addition to primary health care.
2. **Mental Health Behavioral Care Host Model:** The

3-4 Licensure Threshold Crosswalk for DSRIP Project 3.a.i. Clinics[8]

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.	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. 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.

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 August 26, 2016):

14 OMH host sites total

- 7 with SUD
- 6 with primary care
- 1 with both

8 OASAS host sites total

- 6 with MH
- 2 with primary care
- 0 with both

0 DOH host sites total

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

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 (PPS) to integrate care under DSRIP Project 3.a.i.

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). 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.[9]

Approved DSRIP 3.a.i. integrated clinic sites (as of October, 2016):

14 OMH host sites total

- 7 with SUD
- 6 with primary care
- 1 with both

8 OASAS host sites total

- 6 with MH
- 2 with primary care
- 0 with both

5 DOH host sites total

- 4 with MH
- 0 with SUD
- 1 with both

Collaborative Care

Behavioral health disorders such as depression, anxiety, and substance use disorders are major drivers of disability and health care costs, but only three in ten adults living with a mental health or substance use disorder currently receive care from a mental health specialist.[10] At a time when policy makers and payers are tasked with quickly moving from volume to value-based purchasing of healthcare, there is strong evidence that effectively integrated behavioral health services can help achieve the health care Triple Aim for better care, better outcomes, and lower costs.

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, and utilizes an electronic registry to track each individual's progress and monitor outcomes on the whole patient population. Collaborative Care helps the practice build in-house capacity to treat behavioral health conditions, as well as 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. Rigorously evaluated over the last 20 years, there are now more than 80 randomized controlled trials that have shown Collaborative Care to be significantly more effective than the usual process of referring out to specialty behavioral healthcare.

New York State has been a leader in implementing Collaborative Care, beginning with a two year implementation for depression in 2014 through 19 academic medical centers and 32 primary care training clinics as part of the NYS Department of Health Medical Home Demonstration Project. This project provided grant funding and technical assistance to a limited number of sites to build their capacity and implement Collaborative Care, however the lack of a sustainable financing mechanism to support Collaborative Care had initially threatened the infrastructure developed during the grant.

A critical development in advancing Collaborative Care in New York has been the Governor and Legislature's agreement to allocate at least $11 million to support the model for Medicaid recipients. Using this allocation, OMH created the Medicaid Collaborative Care Depression Program. This program has been offered to sites that demonstrated success in the grant project in order to allow them to both continue and expand the work they have done, while new programs that are equipped to implement Collaborative Care, such as Federally Qualified Health Centers (FQHCs), have also been included. The Medicaid Collaborative Care program continues to provide technical assistance and training to participating practices to help them continue to grow their programs.

Additionally, practices that meet certain process and outcome standards are able to receive a monthly case rate for each program enrollee. Practices submit quarterly outcomes reports to OMH to demonstrate progress and show the model is functioning as designed. OMH will be evaluating the program to support the case for continued expansion of the Collaborative Care model, as well as the case rate financing method. To date, there are 36 active sites, with an additional 18 expected under Delivery System Reform Incentive Payment (DSRIP) project technical assistance efforts.

Many other NYS initiatives are encouraging the implementation of Collaborative Care as part of the increasing emphasis on behavioral health integration including the DSRIP project 3.a.i.[11] and Advanced Primary Care. In conjunction with the Medicaid program, these programs will allow more New Yorkers access to integrated and coordinated care so that behavioral health conditions can be recognized earlier and treated more efficiently, thereby reducing the burden of disease statewide. For information on the Collaborative Care model or the Medicaid program, contact nyscollaborativecare@omh.ny.gov

Advanced Primary Care and the State Innovations Model

In December 2014 New York State DOH, in coordination with Health Research, Inc. was awarded a four-year, $100 million State Innovations Model (SIM) grant by the Centers for Medicare and Medicaid Services. As part of the broader State Health Innovation Plan (NYSHIP), SIM will help New York State integrate care and services by improving access to primary care, and also by integrating primary care into long-term care, behavioral health, specialty care and community supports.

One key strategy and requirement of the SIM grant is the implementation of the Advanced Primary Care (APC) model. The NYS APC model is consistent with principles of NCQA[12] Patient Centered Medical Home criteria; but seeks to move beyond structural criteria to achieve durable, meaningful changes in processes and outcomes. APC seeks to provide patients with access to high quality, integrated care, delivered by teams of providers with the capacity to manage the care of patients with chronic illnesses. SIM support will enable the State to achieve three core objectives within five years:

1. 80 percent of the State's population will receive primary care within an APC setting, with a systematic focus on population health and integrated behavioral healthcare;
2. 80 percent of the care will be paid for under a value-based financial arrangement; and
3. Consumers will be more engaged in, and able to make more informed choices about their own care, supported by increased cost and quality transparency.

To support practices in the evolution to APC status, NYS will support practice transformation including goal-setting, leadership, practice facilitation, workflow changes, measuring outcomes, and adapting organizational tools and processes to support new team-based models of care delivery over the three year implementation period. Operationally, practice transformation expanded clinical prevention services will be driven in party by SIM-funded Public Health Consultants. These consultants will work closely with regional Population Health Improvement Programs (PHIPs), SIM-funded practice transformation teams and Medicaid DSRIP Performing Provider Systems.

Behavioral health integration will be achieved under APC in part through the broader adoption of depression screening and Collaborative Care, and the addition of screening and interventions for substance use disorders, such as SBIRT (Screening Brief Intervention, and Referral to Treatment).

The hallmark of APC is support from payers, including private insurers, in order to reach all populations. Ultimately, primary care practices will have to negotiate alternative payment models with plans to support value-based payment structured around the APC elements. Two proposed metrics related to behavioral health that will be tracked as well are 1) depression screening and management and 2) initiation and engagement in alcohol or substance use treatment.

In December 2015, the State Department of Health submitted the SIM Year Two Operational Report,[13] with detailed project deliverables and core metrics associated with APC. This report makes it clear that the large scale adoption of APC across settings and payers is a multi-level, long term, and complex endeavor that requires significant and sustained attention by practitioners, planners, and policymakers alike. However, the planning underway places New York on a strong footing to advance the behavioral health competencies in primary practice, and impact thousands more individuals who have not previously been identified or treated for mental health conditions.

Telepsychiatry

Technology has made it possible to increase access to health care, including behavioral health care, by utilizing secure interactive communications. Telepsychiatry is the use of electronic communication and information technologies to provide or support clinical psychiatric care at a distance. Telepsychiatry is appropriate in situations where on-site services are not available due to distance, location, time of day, or availability of resources. The many advantages offered through telepsychiatry have led to a rapid expansion of such programs across New York State and the rest of the country. While clinical practice standards are developing along with this proliferation, OMH

regulations currently address the use of telepsychiatry only in OMH licensed clinics.

Recently adopted regulations (Part 596 of the New York Codes, Rules and Regulations Title 14) expand the types of arrangements/sites eligible for telepsychiatry in New York State. Under these new regulations, only one site needs to be a licensed Article 31 program (ACT and PROS programs are excluded), while the other site must only be enrolled as a provider in the Medicaid program.

OMH advises sites seeking approval to utilize telepsychiatry to review all OMH regulations and guidelines, and incorporate relevant provisions into their plans. Additionally, before starting to offer telepsychiatry, policies and procedures should be in place at both the originating/spoke site and the distant/hub site to address:

- General clinic procedures.
- Physical environment.
- Site and check-in procedures.
- Emergency procedures.
- Quality review.
- Prescriptions, labs and orders.
- Patient enrollment for telepsychiatry and informed consent.
- Collaborating with patient's interdisciplinary treatment team.
- Care between telepsychiatry sessions.
- Confidentiality and privacy of health information.

The new regulations now permit telepsychiatry in settings such as Comprehensive Psychiatric Emergency Programs, Emergency Departments, and OMH licensed inpatient hospitals and units. However, the regulations will continue to prohibit the use of telepsychiatry for Mental Hygiene Law Article 9 commitments, medication over objection, and the ordering of restraint and seclusion.[14]

As the adoption and use of telepsychiatry develops and grows, it is important to remember that such technology is to be used in combination with, but not as a replacement for, a broader program and plan for direct treatment and support services. However, with that in mind, the possibility that this technology can and will provide increased access to psychiatric services for individuals and communities across the State, is very promising.

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1 National Research Council and Institute of Medicine. (2009). Preventing mental, emotional and behavioral disorders among young people: progress and possibilities. Washington, DC: The National Academies Press.

2 The Prevention Agenda 2013-18 is New York State plan to improve the health of New Yorkers in five priority areas, one of which is to Promote Mental Health and Prevent Substance Abuse. More information on the mental health action plan is available at: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm

3 National Prevention Council, National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011. This report can be found online at: https://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf

4 Tanner, L., Stein, M., Olson, L., Frinter, M., & Radecki, L. (2009). Reflections on well-child care practice: A national study of pediatric clinicians. Pediatrics, 124, 849-857.

5 Minkovitz C.S, Hughart, N., Strobino, D., et. al. A practice-based intervention to enhance quality of care in the first 3 years of life: The Healthy Steps for young children program. Journal of American Medical Association (JAMA). 2003; 290 (23), 3081-3091

6 Briggs, R.D., Silver, E.J., Krug, L.M., et al (2014). Healthy steps as moderator: The impact of maternal trauma on child social-emotional development. Clinical practice in pediatric psychology 2(2), 166–175.

7 Brotman, L.M., Calzada, E., Huang, K.Y., Kingston, et al (2011). Promoting effective parenting practices and preventing child behavior problems in school among ethnically diverse families from underserved, urban communities. Child Development, 82 (1), 258-276.
Brotman, L.M., Dawson-McClure, S., Huang, K.Y., et al (2012). Early childhood family intervention and long-term obesity prevention among high-risk minority youth. Pediatrics, 129, 621-628.
Brotman, L.M., Dawson-McClure, S., Calzada, E.J., et al (2013). Cluster (School) randomized controlled trial of ParentCorps: Impact on kindergarten academic achievement. Pediatrics, 131, e1521-1529.
Dawson-McClure, S., Calzada, E, Huang, K.Y., et al (2015). A population-level approach to promoting healthy development and school success in low-income, urban neighborhoods: Impact on parenting and child conduct problems. Prevention Science, 16(2), 279-290.

8 Table from link in note below.

9 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

10 Wang, P.S., Lane, M., Olfson, M., et al. (2005). Twelve-month use of mental health services in the United states: Results from the National Comorbidity Survey Replication. Arch Gen Psychiatry, 62 (6) 629-40.

11 Attachment J- NY DSRIP Strategies Menu Metrics (2014, April 14). DSRIP Project 3.a.i is the integration of primary care services and behavioral health. This is a behavioral health, Domain 3, clinical improvement project selected by all Performing Provider Systems (PPS). For more information on DSRIP Projects visit http://www.health.ny.gov/health_care/medicaid/redesign/docs/strategies_and_metrics_menu.pdf

12 NCQA is the name commonly used by The National Committee for Quality Assurance.

13 The current Operational Report can be accessed at https://www.health.ny.gov/technology/innovation_plan_initiative/docs/nys_sim_year2_operational_plan.pdf

14 The Office of Mental Health is piloting the use of telepsychiatry for Article 9 commitments in a small numbers of sites, after which a review and findings will inform any broader use of the technology for these purposes.

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Chapter 4

New York State's Suicide Prevention Plan 2016-17 from the OMH Suicide Prevention Office[1]

Suicide is a significant public health problem in the United states and New York State. The most recent data available indicates that in 2014, 42,773 persons died by suicide in this country. Over the last decade, the nation witnessed the number of annual suicide deaths surpassing deaths by motor vehicle accidents, homicides, and most recently breast cancer. Since 1999 rates of leading causes of death, such as heart disease, stroke, and cancer, have been decreasing, but according to a recent report by the Centers for Disease Control and Prevention (CDC), the suicide death rate in the US increased by 24 percent.[2]

New York State itself has one of the lowest suicide rates in the nation, at 8.6 suicide deaths per 100,000 (vs. 13.4 per 100,000 nationally), however this still reflects an increase of 32 percent over the past decade, amounting to 1,700 deaths by suicide in 2014.[3]

In consultation with a panel of national and State experts on suicide, public health, and prevention, The New York State Office of Mental Health Suicide Prevention Office (SPO) recently 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.

This chapter provides a brief statistical summary of suicide in New York and nationally, followed by an overview of the Suicide Prevention Office strategic plan to prevent suicide in New York State. The full version of the SPO's Suicide Prevention Plan 2016-17 is available at https://www.omh.ny.gov/omhweb/resources/publications/suicde-prevention-plan.pdf

The Data on Suicide in New York

Geography: New York City and the surrounding metropolitan areas (Mid-Hudson and Long Island) have the lowest suicide rates in the State, with Kings County representing the lowest county-level rate at 4.7 deaths per 100,000. The North Country has the highest suicide rate, at 13.8/100,000. The highest suicide rates are in predominantly rural counties.[4]

Means: For 2014, the most prevalent means of suicide lethality in New York are suffocation (37 percent), firearms (28 percent), and poisoning (17 percent).[5] The firearm rate of suicide lethality is significantly below national trends, where more

The Seven Elements of the Zero Suicide Strategy

These seven core elements or processes that drive Zero Suicide systems of care are:

1. Leadership-driven, safety-oriented culture committed to reduce suicides among people in care.
2. A workforce with suicide specific expertise.
3. Suicide risk among people receiving care is identified and assessed.
4. Individualized pathway of care, including safety planning with lethal means reduction.
5. Evidence-based treatments are used to target suicidal thoughts and behaviors.
6. Care transitions include follow-up contact and support, especially after episodes of acute care.
7. Data-driven CQI (continuous quality improvement) processes are applied to inform systems.

than half of all suicide deaths are by firearm.

Demographics: Demographic trends for suicide death in New York are consistent with national data. Based on the CDC data[3] for New York State in 2014:

- Men accounted for 75 percent of all suicide deaths.
- Whites have the highest rates of suicide.
- The 45-64 age group has the highest rate of suicide.

Due to broader national trends consistent with the data above, the middle-aged white male demographic group has come under increased attention since the publication of a major study on the mortality rates that showed escalating rates of death by suicide, drug overdose, and alcoholic liver disease for this population.[6] As suggested by the individual demographic data profiles, New York State rates are consistent with the United states as a whole, with a suicide rate for middle-aged males at 22.3 per 100,000—nearly three times the rate in the general population.[4]

Risk factors: While suicide is relatively rare, and very difficult to predict, there are a few major factors associated with statistically higher risks of suicide, including:

- People with mental illness are more likely to die by suicide than the general population. For New York State, an analysis of individuals receiving services in the licensed mental health system revealed a suicide rate of 38.8 per 100,000; nearly five times greater than the general population.[7]
- Alcohol and drug use is estimated to be associated with as high as 63 percent of all suicides nationally.[8]
- Trauma is associated with up to a twenty-time greater likelihood of suicide.[9]
- History of suicide: A previous suicide attempt indicates a risk of future suicide 30-40 times greater than for people without a past attempt.[10]
- Self-injury: A history of non-suicidal self-injury increases suicide risk more than two-fold.[11]

The NYS Suicide Prevention Strategy

New York's 2016-17 Suicide Prevention Strategy uses a multifaceted systems approach that targets both health/behavioral healthcare and community settings, with a commitment to continuously use data to inform and evaluate the effort over time. Building on the strength of the current foundation for suicide prevention, the New York State strategic framework is divided into three domains or strategies:

1. Prevention in health and behavioral healthcare settings—Zero Suicide in New York State,
2. Lifespan prevention approach in competent, caring communities, and
3. Suicide surveillance and data-informed suicide prevention.

This section provides a brief overview of each domain of the Suicide Prevention Plan. A more thorough description of all sections is included in the full report.

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, Zero Suicide depends on successfully re-engineering healthcare systems in order to identify those in distress and at risk for suicide, and deliver timely intervention.[12] The model is based on three basic observations:

1. Most suicide deaths occur among people recently discharged from care.
2. New knowledge about detecting and treating suicidality is not commonly used.
3. Suicide prevention in healthcare requires a systematic clinical approach.

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. The Suicide Prevention Office developed six guiding principles that will help promote and accelerate the transformation required of health and behavioral health systems to truly integrate Zero Suicide. These principles, which are described in detail in the full report, are summarized below.

Zero Suicide Guiding Principles:

A. Start with the public mental health system, beginning with outpatient clinic care.
B. Invest in trainings that utilize the latest clinical knowledge.

C. Target culture change to move the system towards population-based preventive engagement.

D. Provide a clear definition for "suicide safer care."

E. Integrate lived experience into policy and planning.

F. Capitalize on opportunities to broaden Zero Suicide beyond the public mental health system through government and private sector alliances.

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 seeking to develop 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.

Primary prevention strategies (those that prevent individuals from becoming suicidal in the first place), and secondary prevention strategies (those that intervene at the earliest stages of suicidal crises) offer critically important avenues for reducing the number of suicide deaths in New York State. By targeting the antecedents of suicide and broadly promoting mental health and supportive social connection, several lines of evidence suggest that "upstream" interventions can potentially leave large populations less vulnerable to suicide.

This expanded focus on addressing "upstream" risk and protective processes—before individuals develop entrenched problems or become suicidal—represents a meaningful expansion of the suicide prevention paradigm. Evidence is growing that suicidal behavior can be reduced by successful interventions that promote emotional, social and behavioral health. For example, the Good Behavior Game, implemented by teachers in first and second grade classrooms, reduced suicide attempts fifteen years later by nearly one-half, showing the potential suicide prevention impact from enhancing children's skills for managing their behavior and emotions.[13] Upstream approaches may be particularly important for older adults because of the lethality of suicidal behavior in that segment of the population. Among this population, interventions targeting social isolation seem promising and are currently under investigation for suicide prevention effects.[14]

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":

A. Develop, support, and strengthen community coalitions as the "backbone" of local suicide prevention infrastructure.

B. Create suicide safer school communities.

C. Utilize postvention as prevention.

D. Deliver targeted gatekeeper trainings.

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. First, statistics are most powerful when applied to large populations. While shockingly common, suicide remains statistically rare; what statisticians refer to as a low base-rate phenomenon. Second, population-derived suicide risk factors have not translated readily into accurate prediction at the individual level. Third, the one to two years it generally takes for states to release the most definitive counts of suicides in a given year is too much of a lag for quality improvement initiatives, which require much faster data collection and reporting cycles in order to allow timely mid-course corrections. Finally, while the agency has made great strides in recent years, there is still no clear consensus within the field of suicide prevention on how best to measure progress, and the metric used may depend on the setting and a number of other factors.

All of the above challenges underscore the need to continuously enhance and improve suicide surveillance data.[16] The success of both healthcare and community-based suicide prevention initiatives depend on leveraging the best information available and presenting it to stakeholders in a readily "actionable" form. 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 data and using it to guide quality improvement initiatives:

Guiding principles for "Surveillance and Data-Informed Suicide Prevention:"

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

The NYS Suicide Prevention Infrastructure

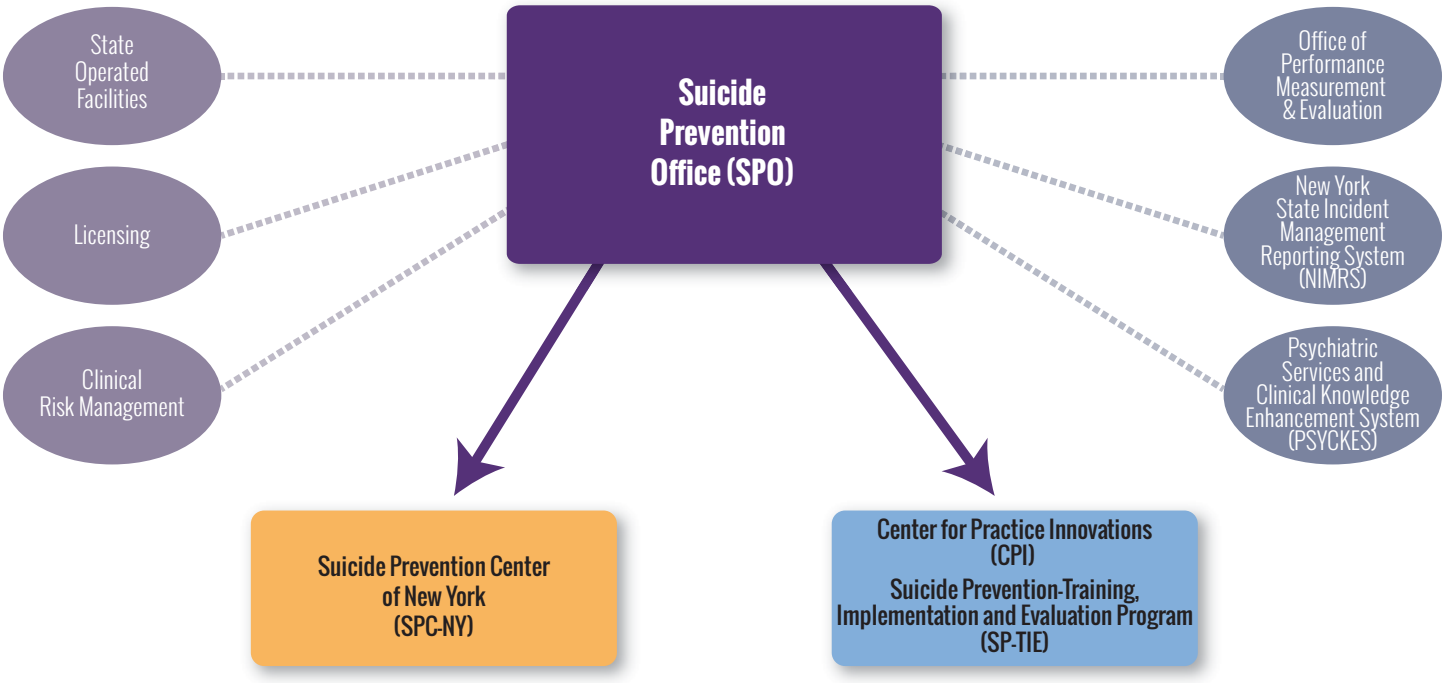
The New York State Office of Mental Health has played a central role in suicide prevention in the State. In order to most effectively advance our efforts as an organization, OMH conducted a review of all OMH supported suicide prevention activities across the agency and our affiliates in 2014. In addition to providing a comprehensive overview of projects, which included a well-established community and gatekeeper training infrastructure, this comprehensive review made recommendations to improve the organizational infrastructure for suicide prevention in New York State, including:

1. Improved coordination and alignment of statewide initiatives,
2. Additional investment in suicide prevention clinical trainings, and
3. The establishment of the Suicide Prevention Office, within the Office of Mental Health.

These recommendations have informed the organizational frameworks for suicide prevention under the Office of Mental Health. Each of the entities described below will fulfill and advance specific components of the Suicide Prevention Plan 2016-17, and in years beyond.

The OMH Suicide Prevention Office

The Suicide Prevention Office (SPO) was created in 2014 to coordinate all OMH-sponsored suicide prevention activities. SPO aims to strengthen suicide safer care across health care settings starting with behavioral health, followed by primary care, emergency rooms, and substance use disorder treatment settings, while continuing to support and strengthen the existing community-based infrastructure. SPO's main partners



in this endeavor are the Suicide Prevention—Training, Implementation, and Evaluation (SP-TIE) program within the Center for Practice Innovations and the Suicide Prevention Center of New York (SPC-NY).

SPO's efforts to date have focused on:

- Collaboration and coordination across the OMH system, including licensing, State operated facilities, and field offices;
- Review of suicide deaths of individuals served by OMH;
- Improved use of existing suicide surveillance data; and
- Establishing a learning collaborative to provide technical assistance to early adopter provider systems interested in implementing current best practices of the Zero Suicide model.

Suicide Prevention Center of New York (SPC-NY)

Founded in 2009 by OMH, SPC-NY is the community-based presence of suicide prevention within the State. It advances statewide and county-specific suicide prevention initiatives. SPC-NY has developed a strong community-based infrastructure that supports local efforts to prevent suicide, including promoting suicide prevention in schools, early identification through gatekeeper trainings, and local support for individuals through fostering competent caring communities.

SPC-NY has supported the development and growth of suicide prevention coalitions in 44 counties across the State and the training of over 30,000 individuals as gatekeepers since 2012. When a community is affected by a suicide death, SPC-NY, through its collaborative efforts with local OMH field offices and local organizations, facilitates postvention responses and activities to address the loss, and limit contagion effects.

Suicide Prevention-Training, Implementation, and Evaluation (SP-TIE)

Established in 2014 at the New York State Psychiatric Institute, SP-TIE is an initiative within the Center for Practice Innovations (CPI), a joint program of OMH and Columbia University. SP-TIE's mission is to increase the capacity of clinicians in the State to assess, manage and treat suicidal individuals. In coordination with the SPO, SP-TIE selects, develops, implements and evaluates evidence-based suicide prevention clinical interventions. It is responsible for developing suicide safer care, clinical training approaches and materials for clinicians across the State (e.g. risk assessment, safety planning, and evidenced-based interventions), identifying and targeting gaps in expertise and training, and conducting ongoing evaluation for both SP-TIE and SPC-NY training offerings.

Summary

New York State OMH has an ambitious goal for suicide prevention across the State in the coming years. The 2016-17 strategic plan outlines the short-term strategy for making progress toward longer-term goals. This strategy focuses on suicide prevention in health, behavioral health, and community settings and will leverage State data and the unique expertise of each of its partners to achieve its goals. The plan was first presented during the first annual statewide suicide prevention conference in September 2016, where presenters highlighted current initiatives within OMH's Suicide Prevention Plan, garnered support among stakeholders, and established an agenda for the coming year.

New York State has one of the lowest suicide rates in the nation. OMH believes it is a reflection of all the collaborative work that has been conducted by communities, providers, public health professionals, suicide prevention experts and policy makers across the State. However, the burden remains high, and 1,700 suicide deaths each year is too many. More coordinated action must be taken to address the significant public health problem of suicide in our communities. This plan represents an important step toward materially reducing the burden of suicide in New York State.

[1] This chapter is excerpted from "1,700 Too Many: New York State's Suicide Prevention Plan 2016-17," by the NYSOMH Suicide Prevention Office, issued in September 2016.

[2] Curtin, S., Warner, M., Hedegaard, H. (2016). Increase in suicide in the United states, 1999–2014. NCHS data brief, no 241. Hyattsville, MD:

National Center for Health Statistics.
[3] Centers for Disease Control and Prevention. Injury prevention and control: Data and statistics (WISQARS). http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html
[4] New York State Department of Health. Suicide mortality rate per 100,000: 2011-2013 vital statistics data as of February 2015. https://www.health.ny.gov/statistics/chac/mortality/d24.htm Regional boundaries are consistent with Regional Planning Consortium (RPC) regions.
[5] Suicide lethality by poisoning is likely underestimated due to the difficulty in distinguishing between accidental and intentional drug overdoses. There were 1,937 overdose deaths in 2014 that were classified as accidental; some may have been undetected intentional overdose.
[6] Case, A. and Deaton, A. (2015). Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century. Proceedings of the National Academy of Sciences of the United states of America, 112 (49) 15078-15083. DOI: 10.1073/pnas.1518393112
[7] New York State Office of Mental Health Incident Management Reporting System (NIMRS), 2015.
[8] Schneider, B. (2009). Substance use disorders and risk for completed suicide. Arch. Suicide Res., 13, 303-316.
[9] Dube, S., Anda, R., Felitti, V., et al. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the lifespan: Findings from the adverse childhood experiences study. JAMA, 286(24), 3089-3096.
[10] Tidemalm, D., Langstrom, N., Lichtenstein, P., et al. (2008). Risk of suicide after suicide attempt according to coexisting psychiatric disorder: Swedish cohort study with long term follow-up. BMJ, 337, a2205.
[11] Whitlock J., Muehlenkamp J., Eckenrode J., et al. (2013). Nonsuicidal self-injury as a gateway to suicide in young adults. J Adolesc Health, (52)4, 486-492.
[12] The Suicide Prevention Resource Center includes a comprehensive overview of the Zero Suicide strategy, at http://zerosuicide.sprc.org/
[13] Wilcox, H., Kellam, S., Brown, C., et al. (2008). The impact of two universal randomized first- and second-grade classroom interventions on young adult suicide ideation and attempt. Drug Alcohol Depend., 95(Suppl1), S60-S73.
[14] Conwell Y. (2014). Suicide later in life: Challenges and priorities for prevention. Am J Prev Med., 47(3S2), S244-S250.
[15] Ribeiro, J., Yen, S., Joiner, T., et al. (2015). Capability for suicide interacts with states of heightened arousal to predict death by suicide beyond the effects of depression and hopelessness. J Affect Disord., 1(188), 53-59.
[16] Crosby, A., Han, B., Ortega, L., et al. (2011) Suicidal thoughts and behaviors among adults aged 18 years and older—United states, 2008-2009. Centers for Disease Control and Prevention MMWR. http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6013a1.htm

Chapter 5
Managed Care of Integrated Behavioral and Physical Health Services

Physical health and mental health are inextricably linked. Data from the 2003 National Co-morbidity Survey Replication show that nearly 7 out of 10 adults with a mental disorder have one or more medical conditions, while 3 out of 10 adults with medical disorders experience at least one mental health condition.[1] Moreover, an estimated 70 percent of primary care visits have been attributed to psychosocial issues, suggesting that office visits by people with physical health ailments may often be prompted by underlying behavioral health issues. The relationship between physical and mental health is further complicated by our knowledge that barriers to primary healthcare services— coupled with challenges in navigating intricate healthcare systems— represent a major obstacle to effective care for people with physical and behavioral health conditions.

In response to these data and emerging evidence about the importance of integrated healthcare, health organizations are striving to shift resources from systems in which care often has been poorly coordinated to ones where the delivery of physical and behavioral healthcare is systematic, well-coordinated and integrated. In New York State, the Office of Mental Health's State and community-based service Transformation Plan is just one example of an effort aimed at addressing the fragmentation of healthcare, improving outcomes, and holding down the costs of care. Nationally, such efforts have been spurred in part by the passage of the federal Affordable Care Act, which is providing incentives and support for the integration of mental health, substance abuse and primary care services for millions of Americans, as well as such forces as mental health parity, State and federal fiscal challenges, and scientific evidence confirming that recovery from mental illnesses and substance use disorders is possible and does occur.

In NYS, the Medicaid Redesign Team (MRT) has been at the forefront of leading change and advancing the State toward the seamless integration of health and mental health- care for beneficiaries of Medicaid. A cornerstone of healthcare transformation in the State public mental health system, Medicaid Redesign aligns with findings from research demonstrating that outcomes improve and healthcare dollars are saved when integrated care approaches are implemented effectively, whether in primary care settings, behavioral health settings or health homes.

The charge of the MRT Behavioral Health Reform Workgroup has been to help establish a framework for the transition to care management for all New Yorkers with mental illnesses and substance use disorders. Its final report issued in October 2011 focused on facets of the charge, including:

- Consideration of delivery and payment mechanisms for the integration of substance abuse and mental health services, as well as their integration with physical healthcare services;
- Examination of opportunities for the co-location of services and peer and managed addiction treatment services and their potential integration with behavioral health organizations (BHOs); and
- The provision of guidance about health homes and proposals of other innovations that lead to improved coordination of care between physical and mental health services.

The MRT process reflected the recognition that the State's behavioral health system was large and fragmented, with then more than 700,000 people with mental illness being served at an estimated annual cost of $6.6 billion. Approximately one-half the spending goes to inpatient care. For substance use disorders, the publicly funded system serves more than 250,000 individuals and accounts for about $1.7 billion in expenditures annually. However, despite the significant spending on behavioral healthcare, comprehensive care coordination for individuals receiving services

(particularly those with the most intensive needs) has been lacking and accountability for outcomes and quality care have been insufficient.

The MRT report also documented the lack of clinical, regulatory and fiscal integration and effective care coordination for behavioral health and physical healthcare. While behavioral health is funded primarily through fee-for-service Medicaid funding, a substantial portion of physical healthcare for people diagnosed with mental illnesses and/or substance use disorders is financed and arranged through Medicaid managed care plans. The result of these funding arrangements is that they inadvertently contributed to fragmented care and a lack of accountability for care. Moreover, this fragmentation and lack of accountability extend well beyond physical healthcare into the education, child welfare, and juvenile justice systems for children and youth under the age of 21, as well as adults who are homeless or involved in the criminal justice system.

When care is not well coordinated, there is greater risk that behavioral health needs will not be identified and people will receive suboptimal behavioral healthcare in primary care settings. Untreated or suboptimal treatment of behavioral health conditions is associated with lower adherence to prescribed medical treatment, higher medical costs, and poorer health outcomes. In particular, adults with mental disorders have a highly elevated risk of premature mortality, largely due to poorer physical health status, as well as accidents or suicides. Given the high prevalence of mental illnesses and co-occurring mental illnesses and substance use disorders among Medicaid beneficiaries, the opportunity for improved clinical and financial outcomes through improved coordination of behavioral and physical health services is strong. The integration of behavioral and physical healthcare via managed care for individuals with substance use disorders, with or without serious mental illnesses is associated with improved access, better monitoring of quality outcomes and a better distribution of services across the entire care continuum.

The MRT has provided NYS 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 experience of care (including quality and satisfaction), 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 State's advancement of the MRT vision and goals, including:

- 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 in ambulatory and community care;
- 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" previously managed care exempt Medicaid services and beneficiaries into a managed, coordinated benefit package.

Adults Transition for Mainstream and Health and Recovery Plans

For adults aged 21 and older, the integration of all Medicaid behavioral health and physical health benefits under managed care will be delivered through two behavioral health managed care models:

A. **Qualified Mainstream Managed Care Organizations (MCOs):** For all adults served in mainstream MCOs throughout the State, the qualified MCO will integrate all Medicaid State Plan covered services for mental illness, substance use disorders and physical health conditions.

B. **Health and Recovery Plans (HARPs):** HARPs will manage care for adults with significant behavioral health needs. These specialized Plans will facilitate the integration of physical health, mental health and SUD services for

individuals requiring specialized expertise, tools and protocols which are not consistently found within most medical plans. In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified HARPs will offer access to an enhanced benefit package comprised of Behavioral Health Home and Community Based Services (BH HCBS) designed to provide the individual with a specialized scope of support services not currently covered under the State Plan. BH HCBS are available to beneficiaries based on their detailed plan of care, which will be informed by a full functional assessment. In order to qualify as HARPs, Plans were required to demonstrate that they have the organizational capacity and culture to ensure the effective management of behavioral health care and facilitate system transformation.

Beginning with adults in New York City, the first phase HARP enrollment letters were distributed between July 2015 and October 2015, followed by staggered enrollments from October 2015 to January 2016. In October 2015, mainstream plans and HARPs implemented non-HCBS behavioral health services for enrolled members, and HCBS service implementation began for the HARP population in January 2016. In the remainder of the State, the first phase of HARP enrollment letters were distributed in April 2016, and in July 2016, mainstream plan behavioral health management and phased HARP enrollment began. Children's implementation will begin in New York City and Long Island in July 2017, followed by the remainder of the State in January 2018. The State agencies are working with plans to ensure that they are ready to implement the requirements included in the request for proposals. Access the full timeline on the DOH website.

The ultimate goal of this transition is to provide New Yorkers with fully integrated behavioral health and physical health services offered within a comprehensive, accessible and recovery oriented system.

Mainstream and Health and Recovery Plan Qualification Process

NYS, in conjunction with the New York City Department of Health and Mental Hygiene ("NYC DOHMH"), engaged in a thorough "Request for Qualification" ("RFQ") Process. The RFQ required all mainstream MCOs operating in NYC to produce a detailed account of their qualifications to provide the general behavioral health managed care benefit. It also required Plans who applied to offer the HARP product line to demonstrate their ability to manage the specialty benefit. NYS evaluated the adequacy of plan capacity to arrange and manage the delivery of covered behavioral health services during a readiness review process. In July 2015, NYS issued an RFQ for plans in the Rest of State, with reviews completed by Spring of 2016.

The RFQ required all plans to show how they will, among other requirements:

- Develop a behavioral health network based on the anticipated needs of special populations;
- Maintain a network of physical health providers that meets the physical health needs of people with serious mental illness and substance use disorders;
- Provide primary care screening for anxiety, depression and substance use disorders; and
- Include a sufficient number and array of providers to meet the diverse needs of the member population, including geographic accessibility, cultural competence and physical accessibility for people with disabilities.

In addition, Plans must comply with the following requirements:

- Contract with behavioral health agencies licensed or certified by OMH or OASAS who serve five or more Medicaid managed care enrolled beneficiaries. Mainstream MCOs and HARPs must offer to contract with these behavioral health agencies for at least the first 24 months of operation;
- Contact with all Essential Community Behavioral Health Programs including offering contacts to all OASAS Certified Opioid Treatment Programs in plan service regions
- Contract with a sufficient array of BH HCBS providers to meet network adequacy. Submit their network plan to the State to ensure adequacy of network. NYS will also review

network compliance on an ongoing basis; and
- Demonstrate that their managerial staff have expertise in network development.

HARP Behavioral Health Home and Community Based Services (Adult BH HCBS)

The Centers for Medicare and Medicaid Services (CMS) authorized various BH HCBS under Medicaid waiver authority. BH HCBS are designed to help adults (21 and over) with serious mental illness and/or Substance Use Disorder remain and recover in the community and reduce preventable admissions to hospitals, nursing homes, or other institutions.

BH HCBS address isolation and promote integration by providing a means by which individuals may gain the motivation, functional skills, and personal improvement to be fully integrated into the community and achieve life goals. The goal of integrating BH HCBS into the managed care environment is to promote significant improvements in the behavioral health system of care and move toward a recovery-based managed care delivery model. The recovery model of care, as envisioned in the HARP and HIV Special Needs Plan (SNP) models, emphasizes and supports an individual's recovery by optimizing quality of life and reducing symptoms of mental illness and Substance Use Disorders through empowerment, choice, treatment, education, employment, housing, and health and well-being.

HARPs and HIV SNPs provide BH HCBS as a covered benefit for qualified members. HARPs and HIV SNPs must create an environment where the plan, service providers, plan members, families and other significant supporters, and government partner to assist members in prevention, management, and treatment of physical and behavioral health conditions, including serious mental illness and Substance Use Disorders.

The following BH HCBS are included in the HIV SNP and HARP benefit package:

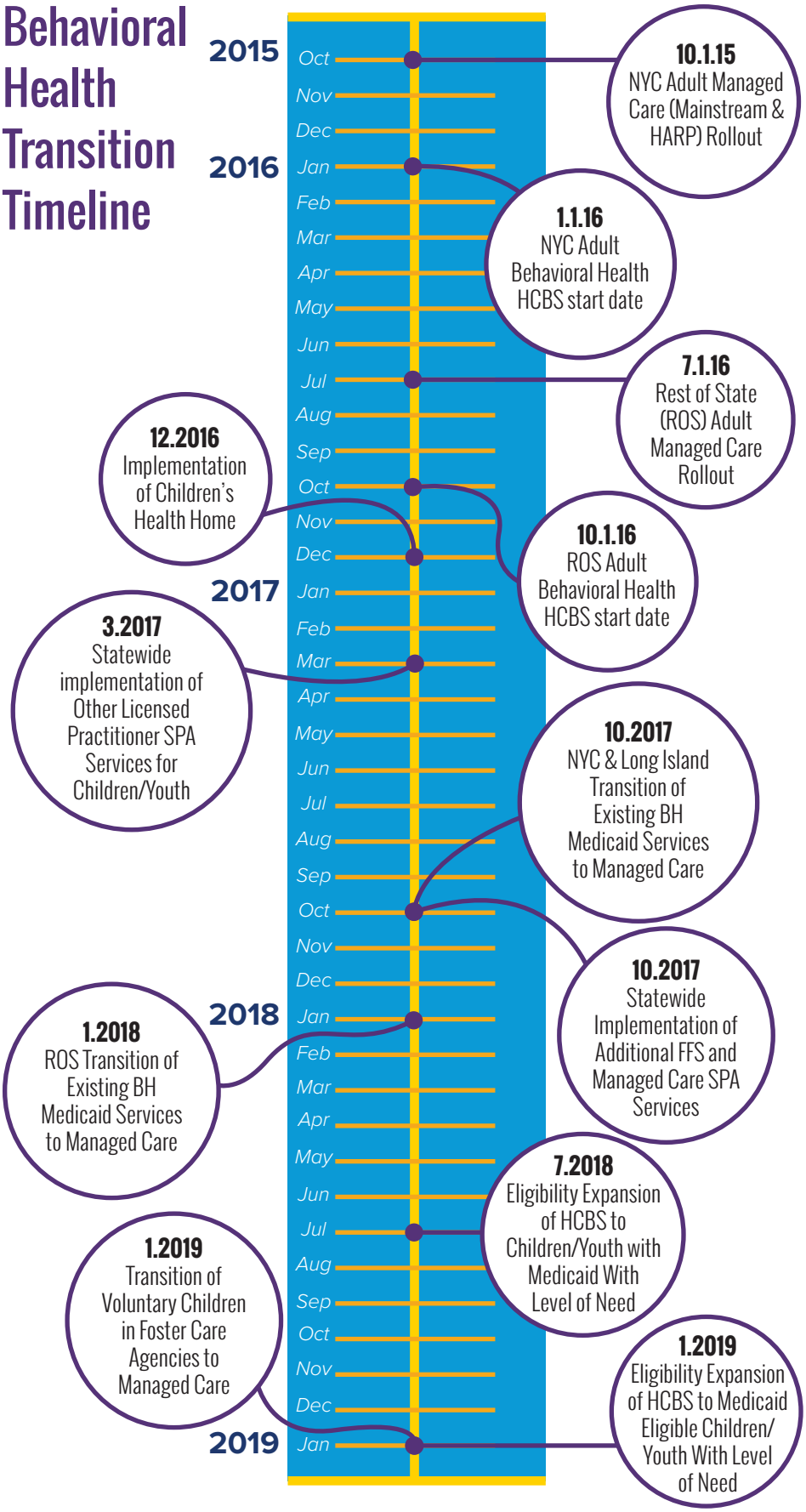
- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment
- Habilitation
- Family Support and Training
- Short-term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Empowerment Services - Peer Supports
- Pre-vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Non-Medical Transportation[2]

The initial designation process for behavioral health HCBS providers was completed in March 2015 for New York City (NYC) and December 2015 for the rest of State. All agencies wishing to provide BH HCBS must apply to be designated for each service they would like to provide. Applicants may apply at any time for a designation, however the State will only update the designation lists quarterly for each area on a periodic basis. Information on providing BH HCBS can be found in the BH HCBS Manual on the OMH website. As of early 2016, NYS had designated approximately 430 adult BH HCBS providers across the State, each for different combinations amounting to nearly 2,400 HCBS program types.[3]

HARP BH HCBS Eligibility and Assessment, and Plan of Care

HARPs and HIV SNPs will coordinate with Health Homes (HH) or another State-designated entity to complete a brief eligibility assessment for BH HCBS for all HARP enrollees or HARP eligible HIV SNP enrollees as required by CMS. The BH HCBS Eligibility Assessment contains some elements from the NYS Community Mental Health Suite of the InterRAI Functional Assessment tool.

For HARP and HIV SNP members receiving HH care management, the HH the care manager utilizes the information in the full assessment to work with the individual to develop a plan of care that meets CMS requirements for HCBS. As part of development of the plan of care, the HH care manager is responsible for assisting the member in selecting providers from his



or her HIV SNP or HARP provider network for each BH HCBS in the individual's plan of care. All BH HCBS provider selections are to be included in the plan of care, including provider selections for other physical and behavioral health services, and non-Medicaid services. The HH care management provider is responsible for ensuring that the individual is given choice of providers in the network.

Children's Transition

The MRT Children's Health and Behavioral Health Team has designed a separate framework for children's integrated health and behavioral health services under managed care. The separate framework is due to recognition of gaps in the current service system, the complexity of multi-systems involvement by children and families, and the fluidity of children's needs and challenges as they develop.

The Children's BH MRT Subcommittee made a recommendation in 2011 that the children's system needed improvement with respect to service access, funding and earlier intervention for children and families. Since then, the Children's Medicaid Redesign Leadership team, with representation from OMH, OCFS, OASAS, and DOH, has been using the transition of behavioral health services to Medicaid Managed Care to achieve significant reforms in the children's behavioral healthcare system. OMH recognizes that, generally, our system in its current form fails to recognize children soon enough to consistently apply effective intervention. Early identification, accurate diagnosis, and effective intervention of behavioral health problems can help keep children and

youth on track developmentally, which in turn prevents expensive, ancillary problems from developing, such as school dropout or involvement in the juvenile justice system. OMH also recognizes that, while we currently offer a continuum of behavioral health services, there are significant gaps in our children's service delivery system, particularly in the area of home and community-based preventive and step-down services.

The leadership team has put together a proposed benefit package which will address these gaps and weaknesses. This package, once approved and implemented, will enable New York State to serve more children and to prevent the need for more restrictive, more expensive services. The design will also break down some of the system's walls that have historically been built up around services, particularly in the Home and Community Based Services (HCBS) that three State agencies offer through 1915c waivers. OMH envisions building a service delivery system in which children and families can access the services they need, when they need them, and in the right amount, regardless of the door through which they have entered.

OMH knows that today, many opportunities are missed early in a child's trajectory of challenges that could prevent a costly path for the child and their family's future. A child and their family, in many cases, must fail through a variety of programs, services and interventions before being determined eligible for an HCBS Waiver. By that time, a child and their family have likely developed a more complex array of challenges which, had they been addressed earlier, may not have occurred.

The shortcomings of our current systems, combined with the vision of earlier intervention, led to a decision to develop a new set of State Plan Medicaid (SPA) Services. This new set of services will enable our providers to focus on prevention and wellness, will allow for better integration of behavioral health services and early pediatric care, and creates improved opportunity for the delivery of evidence-based practices statewide. The proposed services will be available for all children on Medicaid under the age of 21 who meet medical necessity criteria. Delivery of the new services may take place in natural settings where children live and go to school. The six proposed services are:

- Crisis Intervention
- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation Services
- Other Licensed Practitioner
- Family Peer Support Services
- Youth Peer Training and Support Services

In addition to adding State Plan services, we plan to align and transition the existing 1915c Waiver services into one array of HCBS services available for children with measurable functional impairment. This includes all existing children's waivers – OMH HCBS Waiver, OCFS Bridges to Health, and DOH Care At Home.

Unlike the proposed State Plan services, which will be universally available to all children with Medicaid who meet medical necessity, the proposed array of HCBS will be available to children eligible for Medicaid who meet specific target population and functional limitations criteria. The proposed HCBS array was developed by aligning all the services currently offered to children enrolled in the existing 1915c Waivers – services which OMH knows to produce good outcomes, keep children out of long term institutional care, and provide the supports that families need to recover and become more resilient.

New York's vision for the children's system of care integrates physical and behavioral health services within mainstream Medicaid Managed Care Plans. There will be no HARPS for children. When the transition is implemented, services that were previously carved out of managed care and paid on a fee-for-service basis will be included in the Medicaid managed care benefit available to children.

Consistent with the Medicaid Redesign Team's Care Management for All goal, every child that receives Medicaid will be enrolled in a high-quality, fully integrated care management program. Care management will be provided by a range of care management models including Plans, Patient Centered Medical Homes and Health Homes. Children with the highest level of needs, who meet the criteria, will be enrolled in Health Homes.

In an effort to best integrate all care and services, Plans will be required to contract with behavioral health,

foster care agencies, and specific community based providers, as well as pediatric health care and specialty health care providers already in network. OMH anticipates a designation process for providers similar to the adults, with a two year government fee schedule requirement.

Children and their families are involved in a variety of systems and in order to ensure that all care is coordinated, OMH will require Plans to develop and maintain working relationships with school districts, non-Medicaid funded community services and supports, Regional Planning Consortiums, and local governments.

This entire design and plan has been created, discussed, and initiated under the collaboration of the four agencies and in partnership with the Children's Health & Behavioral Health MRT Subcommittee.

Regional Planning Consortiums: Facilitating Oversight and Implementation

In preparation for both the opportunities and challenges the expansion of behavioral health services in Medicaid Managed Care will present at the local level, the State and the counties/New York City collaborated to develop 11 Regional Planning Consortiums throughout the State where key stakeholders can discuss and monitor issues inherent to this type of transition. Each RPC represents natural local patterns of access to care and include representatives from LGUs, the State, mental health, SUD, and primary care service providers, the child welfare/criminal and or juvenile justice/housing/social service systems, Health Homes, hospitals and MCOs, as well as Medicaid recipients and behavioral health service recipients, peers, families, and advocates.

The RPCs are a necessary mechanism for the State and the MCOs to obtain vital, real-time feedback and recommendations for improving the implementation of behavioral health managed care. In addition, the RPC in each region will help align Medicaid managed behavioral healthcare with other system redesign initiatives aimed at improving the quality and integration of the physical and behavioral healthcare delivery systems, as well as strategize ways to use potential future reinvestment funding. The role of RPCs is to complement the existing work of their respective and participating LGUs by guiding behavioral health policy as it relates to Medicaid Managed Care in each region

The following further outlines the specific role and function of all RPCs, in relation to the MCOs, and describes where the New York City RPC (NYC RPC) and the remaining ten New York State RPCs henceforth referred to as the Rest of State RPCs (ROS RPCs), diverge in structure and scope, as relevant to MCO planning and participation.

Scope and Function of RPCs

The core focus areas within the scope of RPC function are:

1. Service access and capacity: monitoring the timely access to services, including BH HCBS, for Medicaid recipients of behavioral healthcare, as well as service gaps.
2. MCO performance: observing MCO actions with respect to their responsibilities to behavioral health service recipients and providers of Medicaid services.
3. System stability and improvement: facilitate collaboration among any and all regional sectors that touch the Medicaid behavioral health system.
4. Service quality, efficiency, and efficacy: improving care of behavioral health service recipients overall by voicing concerns as they arise and making recommendations to State Partner Agencies (DOH, OMH, and OASAS).

All New York State RPCs will share three primary functions:

1. To be the early warning system for locally occurring issues which data would not immediately or necessarily show (such as access to needed services, gaps in services, timeliness of eligibility determinations, and engagement or disengagement in care, etc.); and for ongoing monitoring, deliberation, and forming recommendations to the State in response to issues that arise from stakeholders at the table:

a. Members will be expected to give status updates from the field, especially regarding payment and billing; data needs and Informational Technology (IT); and training and education. Based on issue analyses, the RPC will recommend next steps to the State, which may include:

   i. Identifying systemic and contract related issues, either between the State and the MCOs or the MCOs and service providers, to State partners and recommendations for improvement.

   ii. Convening topic or issue based meetings with MCOs, including HARPs, MMCPs, and HIV SNPs, to address issues at the MCO and local level.

   iii. Establishing and participating in workgroups to address local systems issues in collaboration with the MCOs and State partners.

b. RPCs will make any request for data related to the MCOs' performance to the State partners. Such data might include payment and billing, data and IT needs, and training and education.

2. To understand and improve the parallel process and intersection of the expansion of behavioral health services under Medicaid Managed Care with other system redesign initiatives, especially the Delivery System Reform Incentive Payment (DSRIP) Program and Population Health Improvement Program (PHIP):

   a. All RPCs will include representatives from the DSRIP Performing Provider Systems (PPSs). The RPC, together with the LGU (or in the case of NYC, the NYC RPC), will help create as much continuity and efficiency as possible across multiple MCOs and PPS projects serving the counties and the regions. ROS RPCs will address downsizing and closure of State psychiatric centers.

3. To work with their respective LGUs, which are the points of accountability for MCOs in identifying and addressing local system issues:

   a. In the case of the NYC RPC, the DOHMH will function both as both the LGU and RPC convener. DOHMH will systematically analyze problems identified through the RPC, data reviews, and feedback from other stakeholders, and provide appropriate recommendations to the State via the Quality Steering Committee (QSC).

   b. In the ROS RPCs, the LGUs in each region will participate on the RPC. The ROS RPC shall be the primary point of interaction between the LGUs and the MCOs.

Status and Progress of RPCs

Given the phased schedule of managed care implementations, the New York City RPC began its operations in 2015, integrating many different advisory structures into the RPC process, making this body an integral point in the behavioral healthcare transformation in this area.

Rest of State RPCs began operation in mid-2016 with a series of regional kick-off meetings, to educate all community stakeholders and prospective RPC members on the role and procedures of these bodies. Under the administrative direction of the New York State Conference of Local Mental Hygiene Directors, ROS RPCs were populated with membership and staff throughout the summer of 2016, and are expected to become fully operational across the State by the fall. More information on the Rest of State RPCs can be found at http://www.clmhd.org/rpc/

[1] Kessler R., Chiu W., D emler O., et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62, 617–627.

[2] Non-Medical Transportation will be carved out of the MCO benefit, managed by a Medicaid Transportation Manager based on the Plan of Care, and paid FFS directly to the transportation provider. In addition to Non-Medical Transportation, transportation to BH HCBS included in an individual's Plan of Care will be treated the same way as medically necessary Medicaid Transportation. Please see Managed Care Transition Manual for additional plan requirements for this service.

[3] Not all designated providers will necessarily ultimately opt to provide the HCBS services they indicated during the designation process.

Chapter 6
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 PCs in other urban states and all Mid-Atlantic states. New York's extensive State PC inpatient capacity includes 24 facilities with over 3,500 budgeted beds. Among these are a number of 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. The evidence of this imbalance was demonstrated in the utilization and financing data from Chapter 2 of this report:.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.

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 present, the OMH Transformation Plan has "pre-invested" $81 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.

In the current State fiscal year, OMH is also dedicating 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 PC 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 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 in order 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

Ten Areas of Transformation Plan Pre-investment*

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

1. 1,105 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 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 4,500 individuals statewide.
4. Four new State-operated, child and adolescent crisis/respite houses.
5. Expansion of State and voluntary-operated clinic programs, State-operated school-based clinic satellites, and extended clinic hours to provide services when they would be otherwise unavailable or inaccessible.
6. Staffing support for two of the 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 (ACT) 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.

*NOTE: As of December 2016.

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 Planning, Service Development, and Outcome Measures

OMH has made significant investments in every region of the State in the current, and past two fiscal years to enhance community mental health services designed to reduce the need for unnecessary inpatient hospitalizations at State Psychiatric Centers. The investments were made with input from a broad set of community stakeholders and advisory bodies in every region of the State. The sections below summarize the investments made to date, and exhibit some of the outcomes associated with these investments.

More comprehensive and timely reports are available on the Transformation Plan homepage at http://www.omh.ny.gov/omhweb/transformation/. The monthly and annual reports posted on this page include State Psychiatric Center performance metrics, descriptions and status of community service investments, and psychiatric readmissions to hospitals and emergency rooms for State PC, Article 28, and Article 31 hospital discharges.

Service investments to date have focused on the following areas to be described separately below: State-operated community services, Supported Housing, Home and Community Based Services (HCBS) Waiver for children, and a variety of innovative programs developed through local assistance funding.

State-Operated Community Services: Mobile Integration Teams, Crisis Respite and Outpatient Clinic Expansion

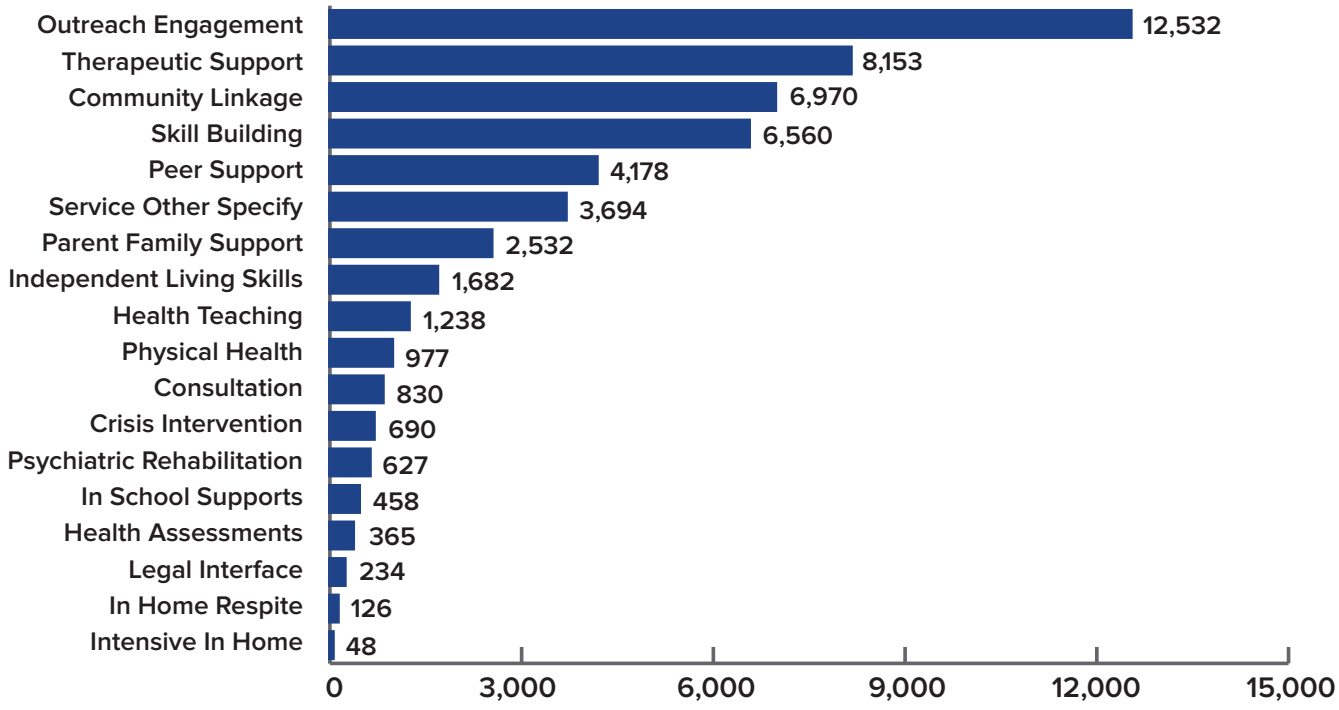
Mobile Integration Teams

As the State inpatient footprint has slowly shifted, OMH has directed an increasing number of State-operated supports toward 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 services being converted to the MIT model.

Examples of services include, but are not limited to, health teaching, assessment, skill building, psychiatric rehabilitation and recovery support, in-home respite, peer support, parent support and skills groups, crisis services, linkage and referral, outreach and engagement. Populations served include children and adolescents, families, and adults. Staff make these services available in a variant of settings including an individual's 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 PC catchment area in any given month. A cumulative statewide count of interventions provided by MITs through SFY 2015-16 is presented in Figure 6-1. Additional data from the same time period on MIT referral sources, service duration, and location are also presented in Figures 6-2 to 6-5.

Another State-operated program developing through the Transformation Plan is the Child & Adolescent Crisis Respite House which provide short term care

6-1 Interventions Provided by MIT (November 2014-March 2016): Count of Services Provided by MIT



6-2 State OMH Mobile Integration Teams in Operation and Development[1]

Team Name	Operating Facility	Adult, Children/Youth or Blended
North Country	St. Lawrence PC	Blended
Southern Tier	Elmira PC, Greater Binghamton Health Center	Blended
Long Island Children's	Sagamore CPC	Child and Adolescent
Rochester	Rochester PC	Child and Adolescent
Western NY Children's	Western NY CPC	Child and Adolescent
Long Island Adult	Pilgrim PC	Adult
Manhattan	Manhattan PC	Adult
New York City Children's	NYC Children's Center	Child and Adolescent
Rockland	Rockland PC	Adult
Kingsboro	Kingsboro PC	Adult
Creedmoor	Creedmoor PC	Adult
Capital District	Capital District PC	Adult
Buffalo	Buffalo PC	Adult
Mohawk Valley	Mohawk Valley PC	Adult
Hutchings	Hutchings PC	Adult
South Beach	South Beach PC	Adult
Bronx	Bronx PC	Adult

residential crisis and respite services in a homelike environment. The purpose of this program is to provide support in a trauma sensitive, safe and therapeutic environment, with the goal of stabilizing the crisis situation, and supporting the family and service provider's efforts to maintain the youth in his or her current residence.

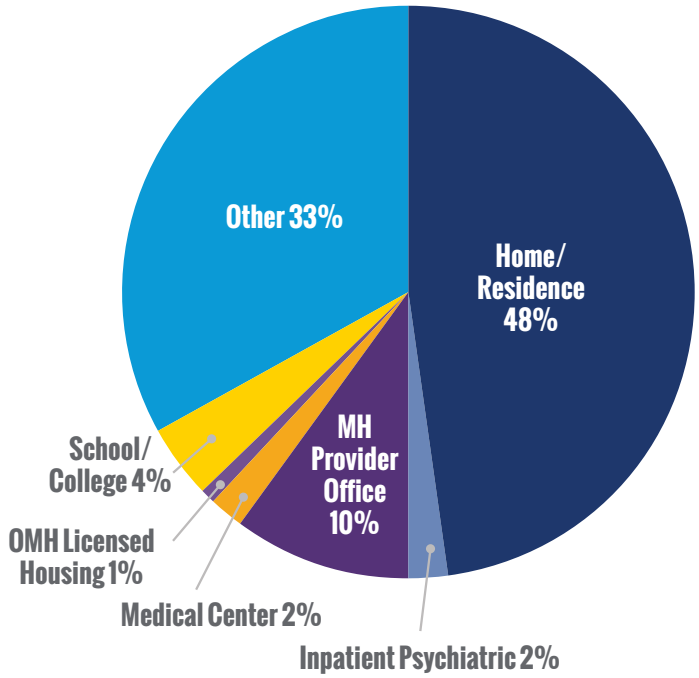
Youth served in this program typically transition back to their home and community after a brief stay at the respite house, lasting up to two weeks. The program is designed to serve youth who currently receive mental health services or who are at risk of, or are currently experiencing, an emotional/behavioral crisis due to events in their environment. Examples of such events include, but are not limited to, family problems, loss of relationships, abuse, neglect and problems in school. This is a voluntary and free service for families. The family and the youth must agree to the admission.

Four new Crisis Respite Houses are now operating on the grounds of Elmira PC in Elmira (eight beds), Hutchings PC in Syracuse (six beds), and Sagamore CPC in Dix Hills (eight beds), and St. Lawrence PC in Ogdensburg (six beds). An additional six bed Crisis Respite beds are currently in development on the grounds of St. Lawrence PC in Ogdensburg, with an anticipated opening in fall 2016.

Targeted Outpatient Clinic Expansion

Additional State-community reinvestments supported the expansion of State-operated clinic programs and school-based clinic satellites, and extended clinic hours to provide services when they would be otherwise unavailable or inaccessible. Adult clinic expansion has occurred in the Greater Binghamton, Elmira, Pilgrim, and Rochester PC catchment areas. Children & youth clinic expansion has occurred in Elmira and St. Lawrence PCs and Sagamore and Western New York CPC areas.

6-3 MIT Service Site

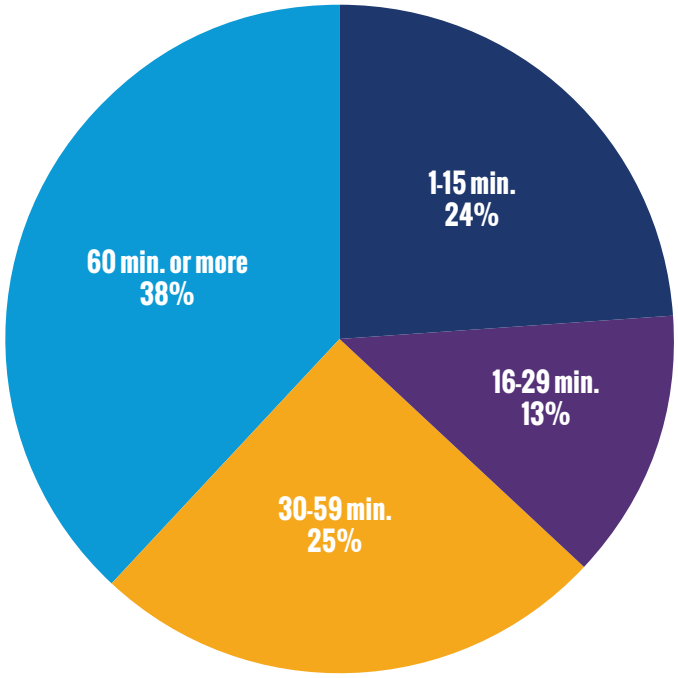


Critical Time Intervention Dissemination

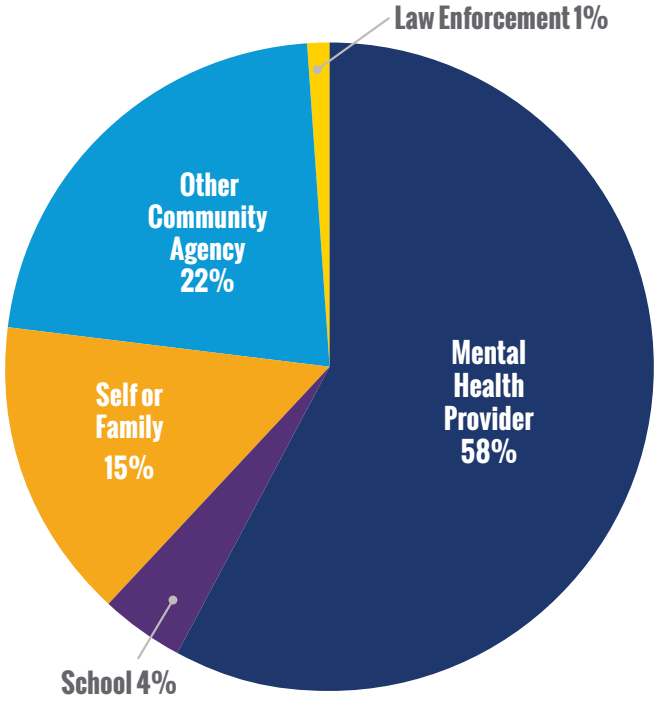
CTI is an evidence-based care management model focusing on high need individuals during key care transitions. For most individuals, the transition from institutional to community living is an extremely vulnerable period during which increased support is vital. CTI is a time-limited intervention, lasting nine months. The phases of CTI, Transition to Community, Try-Out, and Transfer of Care, are each roughly three months; this period should conclude with a network of supports in place to help the individual stay in the community and pursue their recovery goals.

In April 2015 OMH began a large scale adoption of CTI across State-operated Mobile Integration Teams, care management teams, residential programs, and clinics. By December of the same year, over 180 staff across 15 facilities have been trained in the model. Of those trained, approximately 115 have served or are actively serving 270 individuals across 23 counties. Of the 270 individuals who began receiving services using the CTI model, 57 percent or 155 individuals began receiving the CTI model while still admitted to inpatient hospital level of care.

6-4 MIT Service Duration



6-5 MIT Referral Source



The CTI approach has been effective at supporting a number individuals in their transition from State operated transitional and residential programs to Supported Housing. The OMH implementation of the CTI model has shown to be an effective strategy, supporting individuals transition to less restrictive and more integrative and independent living opportunities.

OMH Inpatient and Residential Transitions to Long Term Care Settings

The New York State Office of Mental Health SNF Project effective April 1, 2016 is expanding upon OMH Psychiatric Centers' ongoing efforts to refer and place long stay individuals who require and are eligible for skilled nursing facility (SNF) level of care or enrollment in a Managed Long Term Care program. Through resources included in the SFY 2016-17 Enacted Budget, OMH has allocated $5.5 million (annualized) to provide the resources for the implementation of enhanced discharge and support services for individuals requiring long term care. The enhanced supports are targeted to facilitate the timely discharge of approximately 100 individuals during the first year of program operation. Supports are also intended to provide the SNFs with supports necessary to successfully aid individual recovery, and prevent avoidable hospitalizations.

The project includes the provision of enhanced support services to the SNF to assist their staff in meeting the needs of individuals referred from OMH PCs. The enhanced supports and consultations will be in effect during the transition period, and extended as needed on a case-by-case basis for each individual identified by the State PC.

OMH PCs are establishing and strengthening existing relationships with local SNFs, outlining expectations of both parties, and identifying the supports and services facility staff will provide to aid in these transitions, based on the needs of individuals identified by the State PC.

As this process is further implemented in 2017, OMH will provide updated information on the successes and challenges in serving such high need populations as they move to more appropriate levels of care in communities across the State.

Innovative Locally-Operated Community Programs

In addition to State-operated services, OMH has made significant investments directly through counties, supporting expanded and new services in voluntary-operated, community based settings. Areas of reinvestment include:

- Crisis intervention and mobile crisis 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.
- 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.
- New or expanded Assertive Community Treatment (ACT) teams, accounting for a capacity expansion of 572 slots.
- Forensic programs for both adult and juvenile offenders, developed to link individuals with mental health services, provide specialized assessments for probation and courts, and reduce future recidivism and hospitalization.
- Peer-supported crisis-respite residences (congregate) and short term crisis transitional residential units (scattered) for adults, to help prevent avoidable ER and hospital use. These program provide a safe and supportive environment for adults who require brief crisis intervention and/or respite services on a short term basis.
- Family support and outreach programs to help families and children better manage and address mental health and psychosocial issues that lead to escalation and hospitalization.
- Mobile residential support teams to provide targeted supports for individuals in congregate and scattered site residential programs when a need is indicated. Recent investments have developed specialty support teams to help long stay individuals (one or more years at a State PC inpatient or residential program) transition and remain in supported community environments.

OMH recently issued surveys to all local governmental units through the county planning system to identify impacts of locally-developed services under the Transformation Plan; particularly as it relates to inpatient service demand. After processing, the results will be

used by our facilities, field offices, and planning staff to inform future service development and to identify opportunities for improving existing services and system processes.

Home and Community Based Services (HCBS) Waiver & Supported Housing

The HCBS waiver program is a program designed for children and youth under federal CMS waiver authority with the goals to:

- Enable children to remain at home, and/or in the community, thus decreasing institutional placement.
- Use the individualized care approach to service planning, delivery and evaluation. This approach is based on a full partnership between family members and service providers. Service plans focus upon the unique needs of each child and builds upon the strengths of the family unit.
- Expand funding and service options currently available to children and adolescents with a diagnosis of serious emotional disturbance and their families.

Provide services that promote better outcomes and are cost-effective.

The target population for waiver are children with a diagnosis of serious emotional disturbance who without access to the waiver would be in psychiatric institutional placement. Parent income and resources are not considered in determining a child's eligibility.

The HCBS waiver includes six services that are managed by a care coordinator:

- **Individualized Care Coordination** includes the components of intake and screening, assessment of needs, service plan development, linking, advocacy, monitoring and consultation.
- **Crisis Response Services** are activities aimed at stabilizing occurrences of child/family crisis where it arises.
- **Intensive In-home Services** are ongoing activities aimed at providing intensive interventions in the home when a crisis response service is not enough.
- **Respite Care** are activities that provide a needed break for the family and the child to ease the stress at home and improve family harmony.
- **Family Support Services** are activities designed to enhance the ability of the child to function as part of a family unit and to increase the family's ability to care for the child in the home and in community based settings.
- **Skill Building Services** are activities designed to assist the child in acquiring, developing and addressing functional skills and support, both social and environmental.

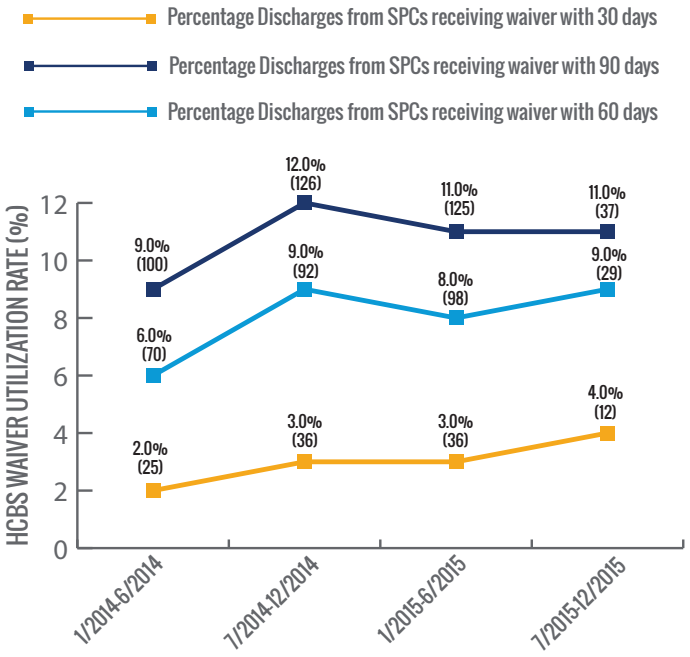
6-6 HCBS Waiver Utilization Rates - 30/60/90 Days Post State IP Discharge for Children: January 2014-September 2015

Percentage Change from January 2014 to September 2015:

30-day: 50.0%

60-day: 50.0%

90-day: 22.2%



Source: CAIRS, MHARS, updated as of Dec 18, 2015

A total of 246 Home and Community Based Services Waiver slots were funded under the Transformation Plan in SFY 2015-16. In addition to funding new capacity, OMH has also focused attention on the waiver program in order to move more children through the program's existing capacity, and increase connectivity between inpatient programs and waiver providers.

Figure 6-6 presents 30-, 60- and 90-day Medicaid HCBS waiver program utilization rates for children discharged from State PC settings from January 2014 to September 2015. During this period, HCBS waiver utilization rates for children discharged from State PC settings increased. Further increases in HCBS waiver utilization are expected as OMH continues its work with localities and providers to identify and improve access for children and families in need.

Supported Housing

Supported Housing is a category of community-based housing that is designed to ensure that individuals who are seriously and persistently mentally ill may exercise their right to choose where they are going to live, taking into consideration the recipient's functional skills, the range of affordable housing options available in the area under consideration, and the type and extent of services and resources that recipients require to maintain their residence with the community. Supported Housing is not as much considered a "program" which is designed to develop a specific number of beds; but rather, it is an approach to creating housing opportunities for people through the development of a range of housing options, community support services, rental stipends, and recipient specific advocacy and brokering. As such, this model encompasses community support and psychiatric rehabilitation approaches.

The unifying principle of Supported Housing is that individual options in choosing preferred long term housing must be enhanced through:

- Increasing the number of affordable options available to recipients;
- Ensuring the provision of community supports necessary to assist recipients in succeeding in their preferred housing and to meaningfully integrate recipients into the community; and
- Separating housing from support services by assisting the resident to remain in the housing of his choice while the type and intensity of services vary to meet the changing needs of the individual.

Recognizing the statewide need for additional Supported Housing to assist with transitions from State-operated settings, OMH has allocated over 1,100 additional units of reinvestment housing through SFY 2016-17 while continuing to expand the pipeline

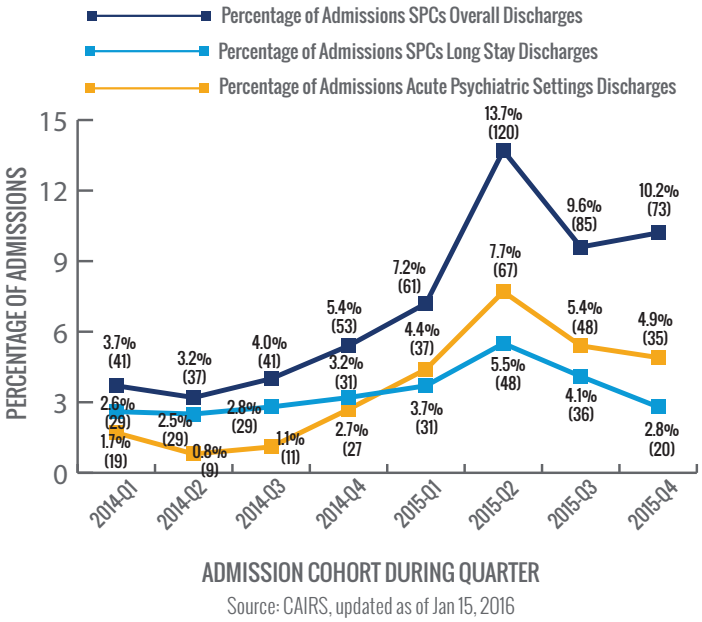
6-7 Supported Housing Admissions from Targeted Populations (State PC Overall and Long Stay and Acute Psychiatric Inpatient Settings): Quarter 1 2014- Quarter 4 2015

Percentage Change from Q1 2014 to Q4 2015:

SPCs Overall: 176%

SPCs Long Stay: 88%

Acute Psychiatric Settings: 65%



Source: CAIRS, updated as of Jan 15, 2016

development outside of reinvestment. In addition to the new capacity, OMH has strengthened the process for referrals from inpatient settings directly to Supported Housing, while working with LGUs, Health Homes, hospitals, and residential providers on a regional basis to improve referral and care management processes across all residential levels. This process has helped strengthen provider communications and improve residential stability for individuals with serious mental illness living in the community.

Figure 6-7 displays the percentages of admissions to supported housing from Quarter 1 2014 to Quarter 4 2015 who were individuals discharged from State PCs and individuals discharged from acute psychiatric settings. During this period of time, utilization of Supported Housing increased in both populations. The spike during the second quarter of 2015 is likely due the convergence of an infusion of additional housing resources, and re-

Vital Access Provider Program: Maintaining Inpatient and Clinic Access

For some Medicaid providers of community mental health services that are at risk of closing or reducing services but are still operating, OMH and the State Department of Health have coordinated a targeted investment strategy to maintain critical access to behavioral health care in areas across New York State, through the Vital Access Provider (VAP) program. VAP funds have been available to Article 28 inpatient and ambulatory providers, and more recently to Article 31 licensed outpatient clinics in recognition of the critical role of outpatient treatment and of the fiscal issues facing many clinics throughout the State. VAP funds are used to enhance community care and to help providers achieve defined financial, operational, and quality improvement goals related to integration or reconfiguration of services offered by the facility.

In the State Fiscal Year 2014-15 budget, the Office of Mental Health initiated the first round of targeted investments under the VAP Program by awarding grants totaling over $13 million over the course of four years to the following Article 28 hospitals; Mary Imogene Bassett, St. Joseph's Arnot, and Oswego Hospital. The grants are used to stabilize the inpatient mental health services available in areas of minimal geographic capacity, and set these hospitals on a more sustainable footing by the completion of the grant period.

Fiscal year 2015-16 expanded the VAP program for preservation of critical access Article 31 mental health clinic services, with a wide distribution of awards across the State to 40 voluntary and county-operated mental clinics that met the VAP eligibility criteria. A table with all clinic VAP awardees is in Appendix D. The main goals of the clinic VAP initiative are to:

- Preserve geographic access and clinic services for specialty populations.
- Financially stabilize at-risk Article 31 freestanding clinics, and restructure financing and operations to attain overall fiscal viability.
- Improve clinic operations and increase efficiencies; including higher productivity and revenue collection, cross agency consolidation of administrative functions, and inter-agency mergers.
- Reduce clinic program costs
- Improve quality and patient outcomes.

$43 million (gross, assuming federal financial participation) has been allocated for VAP Article 31 clinic preservation for over a four year period.

Key criteria providers met for inclusion in VAP program:

1. Financial Viability. For provider agency and/or clinic program:
   - OMH evaluated fiscal viability need using Consolidated Fiscal Report, audited financial statements and Medicaid billing.
   - OMH's determination factored in demonstrated fiscal challenges in the operation of the provider agency in the past three years, and demonstrated fiscal challenges in the mental health clinic in the past three years.
2. Community Service Need: Limited geographic access, special populations.
   - OMH evaluated community service need using Medicaid billing, county data book, Patient Characteristic Survey, and licensing information.
   - OMH's determination factored in the following: Existing service capacity, Market share, minority and special populations served by the applicant, and child and youth and criminal justice populations served by the applicant.
3. Actionable Plan. To preserve services and achieve fiscal viability:
   - The actionable plan was the primary focus of the VAP mini-bid application.
   - VAP application was evaluated to determine the commitment to institute changes and reasonableness of the plan to attain overall fiscal viability.
   - Favorable consideration was given to proposals which include plans for mergers, cross-agency consolidation of administrative functions, and/or demonstrated interest to engage in such activities.

Data and Reporting Requirements:

VAP awardees are required to submit quarterly reports for the life of the award (typically three to four years) in order to demonstrate whether or not the awardee is achieving their performance target. Metrics are reported for three key areas:

- Financial (e.g., increase net revenue, increase collection rate)
- Operating (e.g., increase visit volume, improve billing practices)
- Quality (e.g., improve patient coordination of care, improve consumer satisfaction)

formed discharge processes between PCs and housing providers early in 2015; the subsequent drop still represents a general trend of increased discharges from all inpatient settings to Supported Housing.

Transformation Plan Services Consumer Feedback

From September 14, 2015 through October 9, 2015, 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.

Adult consumers receiving Mobile Integration Team services in St. Lawrence PC, Elmira PC, Greater Binghamton Health Center (GBHC) and Rochester PC service areas, and locally-operated Community Transition and Crisis Services in Bronx, Erie, New York, Queens, Rockland and Steuben Counties were administered the Adult Service Assessment Survey. The survey response rate for adults was 43 percent overall (N=185) and varied by county.

Youth and family members of youth receiving crisis/respite services in Elmira PC, Hutchings PC and Sagamore CPC service areas, Mobile Integration Team services in GBHC, Western New York CPC and Sagamore CPC service areas, and Community Transition and Crisis Services in Erie county were administered the Youth and Family Service Assessment Surveys. The survey response rates for youth and family members were 44 percent (N=52) and 43 percent (N=55) respectively.

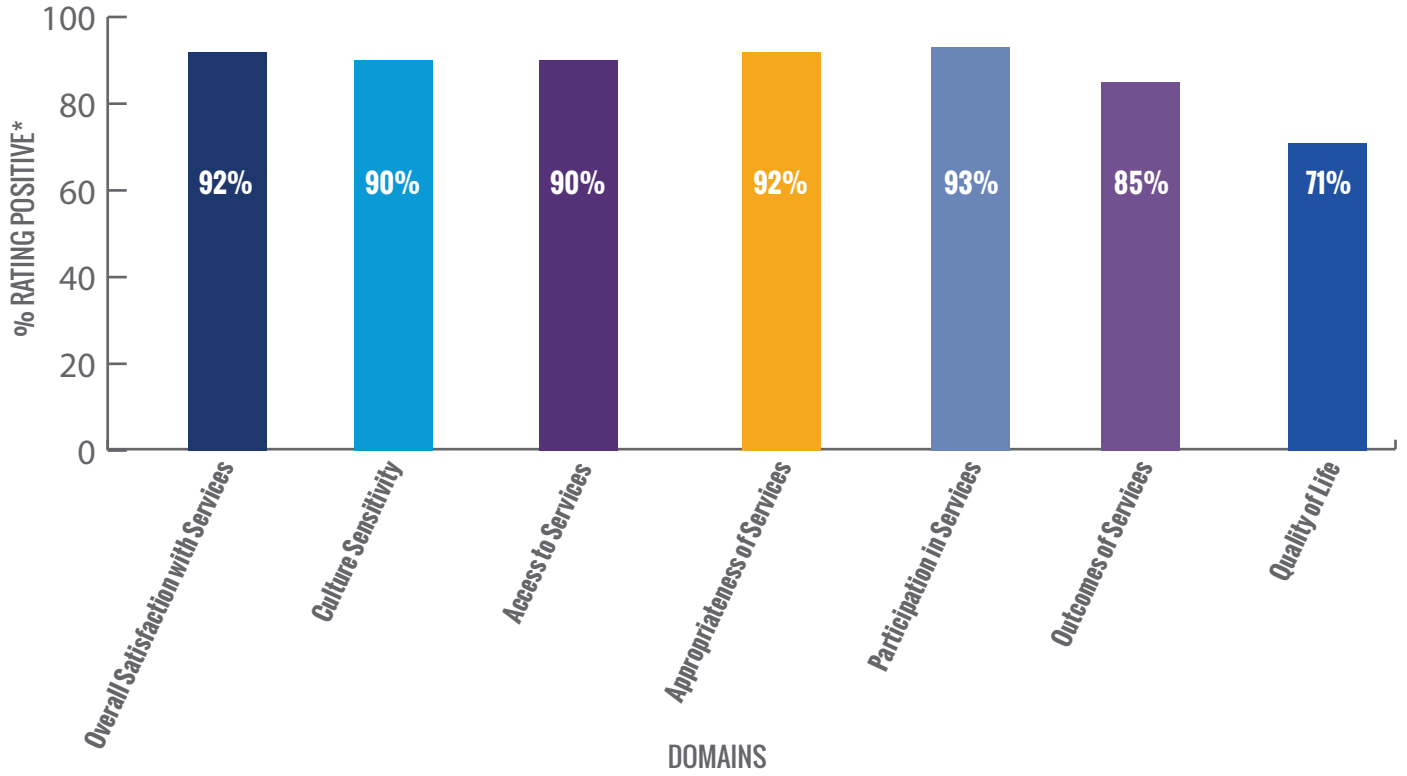
Adult Survey Respondents

Demographics

Half (50 percent) of adult respondents were women and three percent of adult respondents identified as

6-8 Adults' Service Assessment of Transformation Services: Results by Domain (n=185)

* Percent Rating Positive-(Agree+Slightly Agree)/All Respondents



transgender. More than half (53 percent) were above 44 years of age. A majority (65 percent) of adult respondents were White, 22 percent were Black/ African American, and 6 percent Multiracial. Twelve percent were of Hispanic/Latino ethnicity.

Assessment of Care

Overall, adult respondents reported a positive assessment of care they received. The percent positive responses to each domain are displayed in Figure 6-8. Findings showed that the average of the percent positive rating for items in the Overall Satisfaction with Services domain was 92 percent. Average item scores for other domains ranged from 85 percent for Outcomes of Services to 93 percent for Participation in Services. The Quality of Life domain showed an average percent positive rating of 71 percent, which is consistent with prior OMH program survey results, but indicates the ongoing need to focus on supporting individuals personal recovery goals and social connections at the same time that we focus on crisis, treatment, and stabilization.

Youth and Family Members Survey Respondents

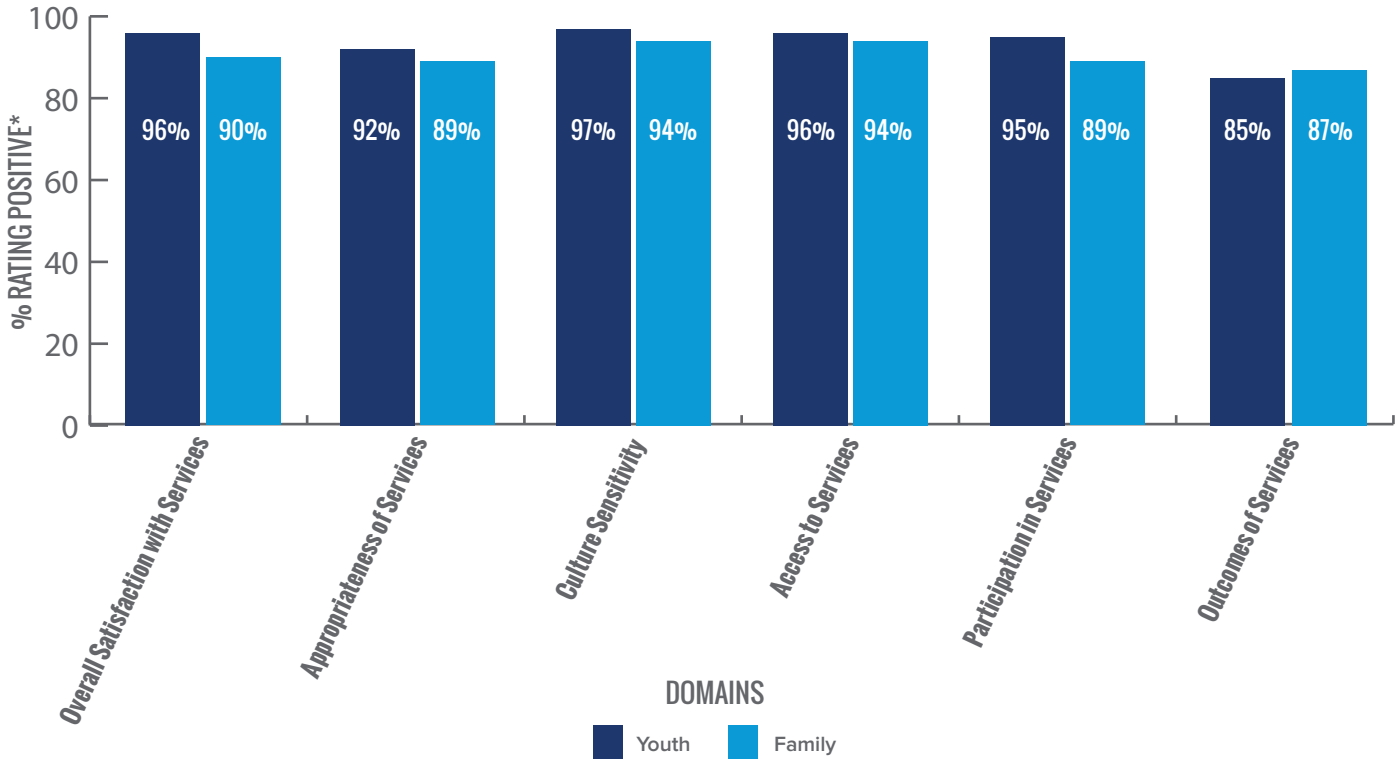
Demographics

Half of youth respondents were male (50 percent). Similarly, more than half (54 percent) of children of family respondents were male. The age distribution of youth respondents was 14 percent aged 9-11, 37 percent aged 12-14 and 49 percent aged 15-18. Seventeen percent of children of family respondents were 5-8 years old or 9-11 years old while 83 percent were 12-14, 15-18 or 19-21. Most responding youth (69 percent) were White, 8 percent were Black/ African American and 12 percent Multiracial. Similarly, 78 percent of children of family respondents were

6-9

Youth and Family Member Service Assessment of Transformation Services: Results by Domain (Youth n=50; Family Members n=53)

* Percent Rating Positive=(Agree+Slightly Agree)/All Respondents



White, 6 percent Black/African American, and 9 percent Multiracial. 14 percent of youth respondents were of Hispanic/Latino ethnicity, although a very small percentage (4 percent) of children of family respondents were of Hispanic/Latino ethnicity.

Assessment of Care

Like adult consumers, youth and family members of youth served reported a positive assessment of care they received (Figure 6-9). Findings showed that the average of the percent positive rating for items in the Overall Satisfaction with Services domain was 88 percent for youth and 96 percent for family members. For youth respondents average item scores for other domains ranged from 87 percent for Appropriateness of Services to 94 percent for Cultural Sensitivity and Access to Services. A similar pattern is seen for the Family Assessment of Services where the average of the percent positive rating ranged from 88 percent for Outcomes of Services to 97 percent for Cultural Sensitivity. The average percent positive rating for items in the Quality of Life domain was 82 percent for youth and 79 percent for family members, both of which are consistent with prior survey results.

Conclusion

Altogether the results from our community pre-investments during the past two years have been very promising. The average daily inpatient census in OMH civil adult and children's Psychiatric Centers reduced by 166 (5.7 percent) during calendar year 2015. Meanwhile, the new and expanded Transformation Plan services have already reached over 18,000 new individuals. These efforts will help put New York State firmly on the path toward balancing our institutional resources more equitably in order to serve more people in more appropriate, effective, and modern community treatment and support programs.

More comprehensive survey results, along with additional impact measures associated with the OMH Transformation Plan are available in the most recent Transformation Plan annual report, which is available at http://www.omh.ny.gov/omhweb/transformation/

[1] Most MITs listed here have been funded with reinvestment resources, while some teams are conversions of earlier State-operated community support teams.

Chapter 7
OMH Forensic Services Initiatives

Individuals with mental illness who are justice-involved or at risk for adverse incidents must be supported during critical transitions in care to ensure their safety and that of our communities. OMH is focusing on the fundamental role as a provider of safety net and forensic services for the most seriously ill and underserved, to continue to build a stronger, safer State of New York. This Chapter outlines three major forensic initiatives underway to support individuals with mental illness who are also involved with the criminal justice system.

SMI-V Initiative

The SMI-V initiative seeks to enhance treatment services provided to inmate-patients who suffer from serious mental illnesses and have histories of violence. The new enhanced treatment services offered by OMH Central New York Forensic Psychiatric Center's (CNYPC) Corrections-Based Operations (CBO) will focus on addressing criminogenic needs with the ultimate goals of:

1. A reduced risk of future violence, and
2. Successful community reintegration through enhanced discharge planning services and community partnerships.

In order to accomplish these goals, a Screening and Assessment unit is being established at Downstate Correctional Facility. This unit will evaluate, for risk of violence, all incoming State prison inmates who have serious mental illness. These individuals will receive enhanced treatment planning that includes programming to reduce their risk of violence. In addition, three Intermediate Care Programs (ICP) will provide specialized violence reduction programming as well as programming to address participants' mental health needs.

The target population for these enhanced ICPs (E-ICPs) are imprisoned individuals with serious mental illness who require an ICP level of care and have histories of interpersonal violence. In addition, two other ICPs will be identified as enhanced discharge ICPs and will provide both specialized violence reduction programming and reentry planning for this high-needs population. The discharge ICPs will provide services to ICP individuals with histories of violence who are within 12 months of their anticipated prison release date. Treatment for individuals identified as SMI-V will be augmented by the services of specialized licensed regional psychologists. These regional psychologists will work in collaboration with the primary treatment providers to assess treatment progress, provide psychological testing services, offer clinical consultation, direct treatment, and other resources, as needed.

Specialized training will be provided to all SMI-V staff to ensure access to evidence-based treatment for violence reduction. Specific training initiatives in the current fiscal year include motivational interviewing, Core Corrections training, interactive journaling, Seeking Safety trauma intervention, START Now, and trauma-informed care. Additionally, SMI-V staff will be trained in specialized assessment tools such as the HCR-20, Violence Risk Appraisal Guide (VRAG), and the Violence Risk Scale (VRS).

Forensic Supported Housing Initiative

OMH is committed to insuring that SMI individuals leaving prison have appropriate housing in the community. The SFY 2015-16 State budget authorized funding for the development of 200 units of Supported Housing allocated to eight Upstate counties (Erie, Oneida, Onondaga, Monroe, Nassau, Suffolk & Westchester) and NYC based on the distribution of SMI inmates returning to the community. In addition, OMH is allocating an additional 200 Supported Housing units for individuals discharged from NYS prisons to a psychiatric hospital for access once the individualized is stabilized for release to the community.

The OMH Forensic Housing Initiative provides support to participating housing providers through access to: enhanced services funding; transitional care coordination; dedicated mental health parole officers; and specialized staff training through the Academy for Justice-Informed Practice. Staff training opportunities include but are not limited to: understanding violence and staff safety; understanding the criminal justice system; working with parole; trauma-informed care for justice-involved individuals; reducing recidivism and promoting recovery; and the clinical impact of incarceration. The OMH Forensic Housing Initiative also offers targeted technical assistance upon request and convenes quarterly meetings with all funded providers and stakeholders to discuss cross-systems coordination challenges and to share information regarding program resources for the target population.

Crisis Intervention Team Initiative

The Crisis Intervention Team (CIT) is a criminal justice diversion model designed to create partnerships between law enforcement, behavioral health professionals, service recipients and their families, and to provide a forum for effective community problem solving and communication. In 2014, the CIT Initiative was implemented in eight local jurisdictions with an additional ten local jurisdictions targeted in 2015.

Implementation of the CIT model includes “systems mapping,” which brings together key stakeholders to detail how the criminal justice and behavioral health systems identify and handle individuals experiencing mental health-related crises. After strengths and gaps in the current system are identified, a model action plan is developed. In each jurisdiction, a 40-hour CIT training is provided to law enforcement personnel who are then assigned to a Crisis Intervention Team.

Additionally, Mental Health First Aid (MHFA), an international training program that teaches participants to identify, understand, and respond to signs of mental illnesses and substance use disorders, is provided to first responders and officers who do not receive the full 40-hour CIT training in each of the participating jurisdictions. To broaden the geographic impact of the initiative, regional Mental Health First Aid trainings also are conducted statewide and are thus available to officers in jurisdictions that have not received CIT training.

Chapter 8

The Mental Health Workforce: Strategies to Address the Shortages and Increase Access to Critical Professional Services

A recent snapshot of the New York State licensed mental health workforce shows a total of 88,194 licensed and/or certified professionals within a mental health specialty. Of this group, licensed master social workers (LMSWs) and licensed clinical social workers (LCSWs) comprise approximately 65 percent of the total licensed mental health workforce, followed by much smaller numbers of psychologists, psychiatrists, licensed mental health practitioners, and nurse practitioners in psychiatry.

These workforce levels adjust to 45 mental health professionals per 10,000 residents statewide; however the uneven distribution of professionals among New York's 62 counties means that workforce availability can range from around ten to one-hundred professionals per 10,000 residents, depending on the county. Many areas across the State have severe shortages of all licensed mental health professionals.

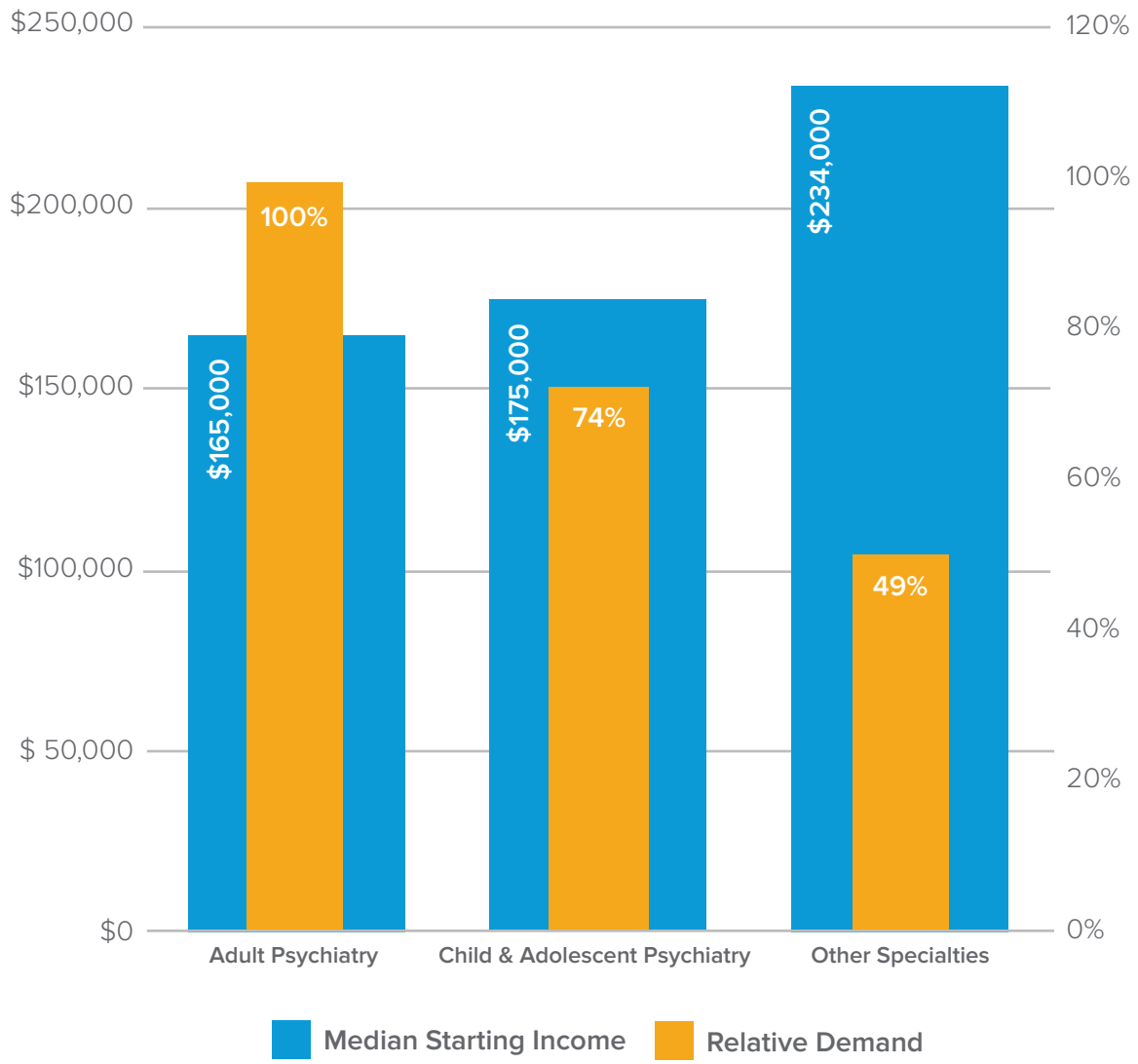
The data presented in Figure 8-1 are based on New York State licensing and specialty board certification information, and do not necessarily reflect the number of professionals practicing in clinical settings in direct or clinical supervisory capacities. However, even with the inclusion of non-practicing mental health clinicians, these numbers translate into many areas of New York State falling within State and federally designated mental health professional shortage areas. For example, as of January 2014, 40 of New York's 62 counties (65 percent) were designated as mental health professional shortage areas under either State or federal designations.

Overall, approximately 3.1 million people in the State live in designated federal and/or State mental health shortage areas. Geographically, the professional shortage is most acute in the OMH Central New York

8-1 Licensed Mental Health Professionals in New York State, 2016

Discipline	Number	% of Total
Licensed Master Social Workers (LMSW)	29,079	33.0%
Licensed Master Social Workers (LMSW)	29,079	33.0%
Licensed Clinical Social Workers (LCSW)	27,945	31.7%
Psychologists	13,593	15.4%
Psychiatrists	6,593	7.5%
Mental Health Counselors (LMHC)	5,832	6.6%
Other (LCAT, LMFT, LPsy)	3,455	3.9%
Nurse Practitioners in Psychiatry (NPP)	1,697	1.9%
Total	**88,194**	**100%**

8-2 Relative Demand and Salary for NYS Workforce Entering Psychiatry vs. Other Specialties, 2014



Relative demand is calculated through a composite score based on a series of survey questions to graduating medical students, where 100% indicates a specialty that is highest in demand, with lower percentages indicating lesser demand compared to the highest demand specialty. The full methodology is explained in *Trends in Demand for New Physicians, 2010-2014. A Summary of Demand Indicators for 35 Physician Specialties*, cited below.

Region, with 77 percent of its population living in areas designated as mental health professional shortage areas. The Central New York Region is followed by the Western New York (39 percent), and Hudson River Regions (17 percent) for percentage of population living in shortage areas. New York City and Long Island counties do not meet any such shortage designations at the county level, however there are census tracts and institutions within these areas that do meet such shortage designations.

As federal healthcare reform drives the expansion of community behavioral health services, and parity increases individuals' eligibility for such services, the demand for New York's existing mental health workforce has increased. Meanwhile, the aging

demographic of our mental health workforce is expected to concurrently decrease the supply of qualified practitioners in the labor force, making few short-term solutions to the workforce shortage viable. 54 percent of the New York State mental health workforce is over the age of 50, and nearly 30 percent are over age 62. For the highly demanded psychiatry workforce, the demographics are even starker: 64 percent are over 50 and 38 percent are at or beyond retirement age.

Addressing the Critical Need for Psychiatry

The New York State public mental health system is particularly challenged by an acute shortage of psychiatrists in many areas across the State, which constricts our ability as a State to meet the current and growing demand for mental health services. While the statewide ratio of residents to psychiatrists falls below the Health Resources and Services Administration (HRSA) health professional shortage areas (HPSA) criterion for psychiatrists, it remains immensely challenging to recruit psychiatrists for the salaries and demands associated with many public mental health settings. As such, the psychiatry workforce available to public mental health providers is likely significantly smaller than the numbers suggest. Without an adequate psychiatry workforce, programs are limited in their ability to meet ongoing demands for diagnosis, treatment planning, and prescribing, in which psychiatrists in particular play a critical role across treatment settings.

Illustrating some of the forces at play in the psychiatry labor market, the SUNY Albany Center for Health Workforce Studies recently published a report providing evidence of both symptoms and causes of shortages in this profession. Data collected each year from 2010 through 2014 show significant wage gaps between psychiatrists (adult and child) and other medical specialties entering the workforce in New York State, while at the same time the relative demand for psychiatrists is far above most other medical specialties (Figure 8-2). , Compared to other specialties and markets in general, where incentives will correspond with demand, the intersection of supply and demand curves for psychiatry have not caught up.

Additionally, during the ten year period between 2004 and 2013 there has been only a minor growth trend in medical school graduates entering adult psychiatry (6.4 percent), with a more positive trend for entrants into the child psychiatry workforce (25.1 percent). However the healthy growth in child psychiatry is nearly outweighed by the still meager size of the highest graduate cohort in 2013: 429 child/adolescent vs. 1,155 adult psychiatrists graduating from Graduate Medical Education (GME) programs nationwide. In total there are 1,063 child and adolescent psychiatrists registered with the American Board of Psychiatry and Neurology as of June 2016.

In order to improve access to timely mental health services, OMH is adopting a multi-tier strategy that will focus both on the full public mental health system, and directly on our State-operated safety net programs.

- Salary enhancements for psychiatrists and nurse practitioners in psychiatry aimed at increasing both recruitment and retention of these essential service providers in OMH;
- Loan repayment program expansion, including eligibility for psychiatrists in all OMH facilities under the Doctors Across New York OMH Psychiatrist Loan Repayment Program;
- Development of affiliation agreements between OMH and academic programs for nurse practitioners pursuing a psychiatry track;
- Peer credentialing for adult and children and family services in order to leverage the unique expertise of individuals with lived experience, while also adding to the mental health workforce.
- Expansion of telepsychiatry through additional reimbursement mechanisms and regulatory expansion.
- Expansion of psychiatric consultation services for primary care practitioners through Project TEACH.

Project TEACH and the expansion of telepsychiatry regulations to additional practice settings are described in detail in Chapter 3 of this report. Additionally, many of the current efforts to integrate behavioral health services with primary care will also help build mental health treatment capacity by leveraging a large, existing primary care system. While primary care itself faces workforce shortages, there are significant opportunities for synergy when we add competency and capacity for PCPs to identify, treat some mental

health disorders—while simultaneously building some physical health assessment and treatment capacity to existing behavioral health providers. All of these efforts are described in Chapter 3, which addresses a series of initiatives that will transform and integrate health and behavioral health practice settings.

Beyond the efforts described in this report, New York State is engaged in long term workforce planning efforts through the DSRIP program and the State Innovation Model grant, and OMH will continue its efforts to ensure that mental health workforce and mental health treatment competencies, are included in these plans.

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[1] Licensed mental health practitioner encompasses the professions of licensed mental health counselors (LMHC), licensed marriage and family therapists (LMFT), licensed creative arts therapists (LCAT), and licensed psychoanalysts (LPsy), which are all licensed under Article 163 of the NYS Education Law.

[2] Psychiatrist data source: American Board of Psychiatry and Neurology, Inc. (ABPN). Data as of June 29, 2016 from https://application.abpn.com/verifycert/verifycert.asp. A small number of psychiatrists in this dataset were listed as "uncertified" at the time the data was accessed. Data for all professions other than psychiatrists is as of January 1, 2016 and was provided by the Office of the Professions at the New York State Education Department.

[3] New York State Office of Mental Health. The Licensed Mental Health Workforce in New York State: Size and Geographic Distribution — August 2014. Available at http://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/professional-shortage.pdf

[4] A primary Health Resources and Services Administration criterion for mental health provider shortage areas is a ratio of residents to psychiatrists exceeding 30,000:1 in a "rational area for the delivery of mental health services," or 20,000:1 in areas with "unusually high needs for mental health services."

[5] Armstrong, D.P., Martiniano, R., Forte, G.J., et al. (2015) Trends in Demand for New Physicians, 2010-2014. A Summary of Demand Indicators for 35 Physician Specialties. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; August 2015.

[6] The number of certified child and adolescent psychiatrists is duplicative of the number of certified psychiatrists in New York, and should not be added to the base number of psychiatrists in this section.

Chapter 9
Cultural Competence

OMH is dedicated to promoting effective policy, procedure, and practice by integrating cultural and linguistic competence throughout New York State's public mental health system. Through the Bureau of Cultural Competence (BCC), OMH seeks to eliminate disparities in care and access to care for people of diverse backgrounds. At an operational level, this mission is active through ongoing training and technical support to all (local and State) providers, and through broader general efforts to promote mental health for all and disparities for none.

OMH integrates cultural and linguistic competence through the following functions:

- Conducting comprehensive trainings on the importance of infusing cultural and linguistic competence throughout agency policies and clinical practices.
- Engagement across all agency functional units to ensure that cultural competence is implemented across all OMH programs and policies.
- Monitoring the advancement of research through the two OMH Research Institute Centers of Excellence for Cultural Competence.
- Providing technical assistance to OMH operated and regulated providers
- Providing cultural and linguistic program evaluations.

This chapter is presented in two sections. Section 1 explains the infrastructure within OMH to promote cultural and linguistic practices, and Section 2 outlines efforts to increase cultural competence through language access, training, assessment, and evaluation to increase cultural competence in the public mental health system.

Section 1
OMH Infrastructure for Promoting Cultural Competence

The infrastructure for developing, promoting, and integrating cultural competence across the public mental health system is supported in New York State through the State and Regional Multicultural Advisory Committees and the Centers of Excellence for Culturally Competent Mental Health. The advisory committees facilitate communication between stakeholders and OMH about community, regional and statewide needs of diverse cultural groups; and the Centers facilitate research on mental health disparities to identify and develop best practices needed to effectively engage diverse groups into treatment, and subsequently reduce disparities.

State & Regional Multicultural Advisory Committees

The State and Regional Multicultural Advisory Committees are comprised of various stakeholders that seek to address racial, ethnic and other cultural disparities that exist within the service system.

The State Multicultural Advisory Committee (SMAC) advises the Commissioner of OMH on the development of policy, programs, and activities that foster recovery and resiliency for individuals with mental illness and families from diverse cultural backgrounds. The SMAC meets quarterly and makes recommendations to improve understanding of the clinical needs specific to diverse populations to ensure that services promote health while eliminating disparities. This is accomplished through efforts to design, develop, and evaluate culturally and linguistically appropriate client and family-centered treatment and support services. In addition, the SMAC creates an annual work plan with goals and objectives that the committee seeks to accomplish during the year.

The Regional Multicultural Advisory Committees (RMACs) are comprised of consumers, peers, family members, providers and other vested stakeholders within specific regions, and are organized to stimulate community action and create systemic change for diverse cultural groups within the mental health system. RMACs are engaged with OMH Field Offices to support effective collaborations and supports to enhance community-based services in their region. Additionally, the RMACs inform the SMAC about the disparities that are unique to a county or region, and about the recommended strategies to address these challenges.

Understanding the Four Levels of Cultural Competence

Cultural competence can be broken into four basic levels for providers of mental health services: organizational, program, client-provider, and community.[1]

1. The organizational level refers to the broader administrative structure of an agency, and the extent to which its budget, vision and mission statements, and policies embed culture and linguistic competence into practices, rules, and procedures. This includes an organization's commitment to language access services, promoting workforce diversity, and implementation of specialized training for the delivery of services to a diverse client population.
2. The program level applies to the organization or agency's provision of diverse programs and services that reflect the needs of the diverse cultural groups that are served, such as spirituality, LGBT or adolescent support groups.
3. The client-provider includes how cultural and linguistic competence is embedded within the client and staff therapeutic relationship in the areas of engagement, outreach and assessment, treatment planning and clinical practices. A cross-cultural exchange occurs when both the client and provider/staff person take into consideration each other's cultural views of mental illness and behavior as it applies to helping clients and their families develop a recovery plan.
4. The community level is the extent to which local community organizations and agencies such as churches, drop-in centers, housing agencies, and food pantries, are utilized as supportive services to the diverse cultural groups served in that geographic region. These stakeholders are valuable community cultural resources and supports for the community to access, and can be integrated into the community's mental health system by establishing relationships and fostering collaboration with these organizations.

RMACs currently exist in the following areas, while work is ongoing to develop and support capacity statewide:

- New York City
- Broome County
- Westchester County
- Suffolk County
- Nassau County
- Western New York

Centers of Excellence for Culturally Competent Mental Health

In 2007 NYS Mental Hygiene Law was amended to establish two Centers of Excellence for Culturally Competent Mental Health. The legislation charged these Centers to identify and disseminate best practices for behaviors, policies, and structures to support culturally competent care. OMH designated its two research institutes, the Nathan Kline Institute for Psychiatric Research and New York State Psychiatric Institute, to house the Centers and conduct research that focuses on disparities in service delivery for marginalized and minority populations.

The Nathan Kline Institute (NKI) Center of Excellence for Culturally Competent Mental Health performs research that identifies and develops culturally competent mental health practices, identifies disparities and culturally competent strategies to reduce these disparities, and creates valid and reliable measures of the cultural competence of practices and organizational structures. NKI also serves as an informational resource on cultural groups and cultural competence to OMH bureaus, State planners, providers and consumers. Community representatives, consumers, and family members serve on an advisory panel and have input into the Centers projects.

The New York State Psychiatric Institute (NYSPI) Center of Excellence for Culturally Competent Mental Health addresses the growing need for culturally and linguistically appropriate mental health care and service integration, including physical and mental health care integration. This Center collaborates with mental health providers, consumers and families, community and faith-based organizations, policy makers, and mental health service researchers to develop, adapt, and evaluate evidence-based approaches aimed at improving access to and the quality of mental health services to underserved populations throughout the State. In addition to its focus on integrated care, the Center is studying cultural brokering and language interpreter services and striving to enhance early intervention, engagement for culturally diverse families whose children have serious emotional disturbances.

Section 2
Creating Culturally Competent Environments through Language Access, Assessment, Evaluation and Training

Language Access Services

New York State is the one the most diverse states in the nation. According to the 2010 U.S. Census data, 21 percent of the U.S. population – and 30 percent of the NYS population – reported speaking a language other than English at home.[2]

Based on this same data, nearly one in five New Yorkers identified their English-speaking ability as "not well" or "not at all", indicating significant Limited English Proficiency (LEP) among the general population.[3] For LEP mental health service recipients, their needs and problems cannot be fully assessed or understood if they are unable to communicate, or if they are not provided with information in their preferred language; leading to treatment attrition, lack of engagement, and reduced utilization of necessary mental health resources.

Research conducted by the Office of Mental Health and by the New York State Psychiatric Institute speak to the disparities in health care related to race and ethnicity, as it relates to the lack of effective communication.[4] The NYSPI Center of Excellence for Cultural Competence has also provided research on the importance of providing appropriate language access services in mental healthcare.[5]

It is essential for mental health providers to establish effective communication with LEP recipients and their family members, in order to provide appropriate and accurate assessments, evaluations, treatment planning, and treatment. When mental health care providers take into consideration the diverse cultural, ethnic and racial groups' views on mental illness, they are able to understand practices that are more effective for diverse populations.

Mental health providers can serve LEP speaking individuals by integrating Language Access Services (LAS) into their practices. This includes having interpreter and/or translator services available in languages that are used by the population in the areas served. Interpreter services consist of a person who provides direct oral interpretation of communication that is spoken between two or more people, and translator services consist of a person providing written translation of documents in another language.

Agencies that receive federal funding such as Medicaid or SAMHSA Block Grant funding, are regulated at both a State and federal level to provide LAS at no cost to individuals receiving care. In order to select the vendor that will meet a provider's language needs, the language population groups of the area should be determined by using U.S. Census Bureau or other data sets, including the OMH Patient Characteristics Survey. Providers and agencies looking for assistance in acquiring LAS that meet the needs of individuals and their families can visit the OMH website.

Types of Interpreter Services

Telephone Interpreter Services are interpreter services that are provided over the phone by a vendor to provide oral interpreter services between two or more people. This is the most commonly used service by providers and it is the least preferred by recipients and family members of mental health services.

In-person Interpreter Services are interpreter services in which an interpreter is present to provide oral interpreter services between two or more people, including American Sign Language interpretation. This is the most preferred service that recipients and family members support.

Interpreter Services are interpreter services in which an interpreter is present through video remote process to provide oral interpreter services between two or more people, including American Sign Language interpretation. This is the second most preferred service that recipients and family members support.

American Sign-Language (ASL) Services are interpreter services that are provided to deaf and/or hard-of hearing individuals who communicate through sign-language. ASL services can be found on the Regfistry of Interpreters for the Deaf website https://myaccount.rid.org/Public/Search/Interpreter.aspx

Cultural Competence Assessment & Evaluation

Community mental health providers can promote and implement cultural and linguistic competence within organizations and programs, but must also foster a culturally competent environment for diverse populations to access services. This can be done by first assessing and evaluating the level of cultural competence, and by providing training consistent with best practices in developing cultural competence among clinical and clerical staff.

OMH's Bureau of Cultural Competence (BCC) provides cultural and linguistic competence review, assessment, and evaluation at both an individual and programmatic level. Individual assessments consist of clinical and clerical staff completing self-report surveys to score their own degree of cultural self-awareness and indicate the extent to which they identify with their own cultural background, values, and of cultural biases. Program assessment and evaluation activities includes assessing the availability of language access services, or surveying the physical environment to determine how child friendly an agency is that generally serves young mothers, or the availability of materials that include images of people who appear similar to the clients being served.[6]

Following an assessment, the BCC provides recommendations to promote and enhance cultural and linguistic competencies and training based on its findings. Providers are then able to receive training in areas identified for growth.

Cultural competence consultations are offered free of charge to OMH licensed mental health providers.[7] Providers that are not OMH licensed, but are seeking to develop and enhance culturally competent mental healthcare settings can find a list of resources on cultural and linguistic competence, best practices, programs, and service delivery for diverse cultural groups at http://www.omh.ny.gov/omhweb/cultural_competence/assessment_tools.html

Training

The BCC provides regular trainings for State and local providers licensed by OMH. These trainings are available to psychiatrists, psychologists, nurses, social workers, residential counselors, and other direct care staff.[8]

In addition to agency training, the Bureau of Cultural Competence has web-based trainings, which explain the difference between diversity and cultural competence, address how to implement culturally sensitive programs into mental health agencies, and discuss strategies to serve and engage members of specific populations, such as the LGBT community.

It is vital that providers develop and implement cultural and linguistic competence training plans to meet the demographic needs of their service recipients and staff. Training should promote and implement cultural and linguistic competence skills into daily practices to create more person centered care into mental health recovery.

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1 These four layers of cultural competence are based on the "Dilemmas of Mono-Cultural Service Design" model presented in Cultural Competence & African-Americans with Mental Illness, cited below. The original model has been modified with the permission of the author.
Davis, K. (2002). Cultural Competence & African-Americans with Mental Illness. [PowerPoint slides]. Retrieved from http://govinfo.library.unt.edu/mentalhealthcommission/presentations/presentations.html

2 United State Census Bureau (2013). Language Use in the United states: 2011. Retrieved from https://www.census.gov/prod/2013pubs/acs-22.pdf

3 LEP refers to individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English

4 New York State Office of Mental Health (2011). Unmet Needs Report: statewide Assessment of Treatment Gaps in Need of Mental Health Services.
NYS OMH Bureau of Cultural Competence and NYS Centers of Excellence in Culturally Competent Mental Health. (2012). Ensuring Cultural Competency in NYS Health Care Reform.

5 New York State Psychiatric Institute (2014). Language Access Needs in NYS Office of Mental Health Facilities prior to implementation of Expanded Language Access Strategies in 2011-2012. The NYSPI link is provided to review the Center's language access research as a best practice for mental health providers: http://nyculturalcompetence.org/

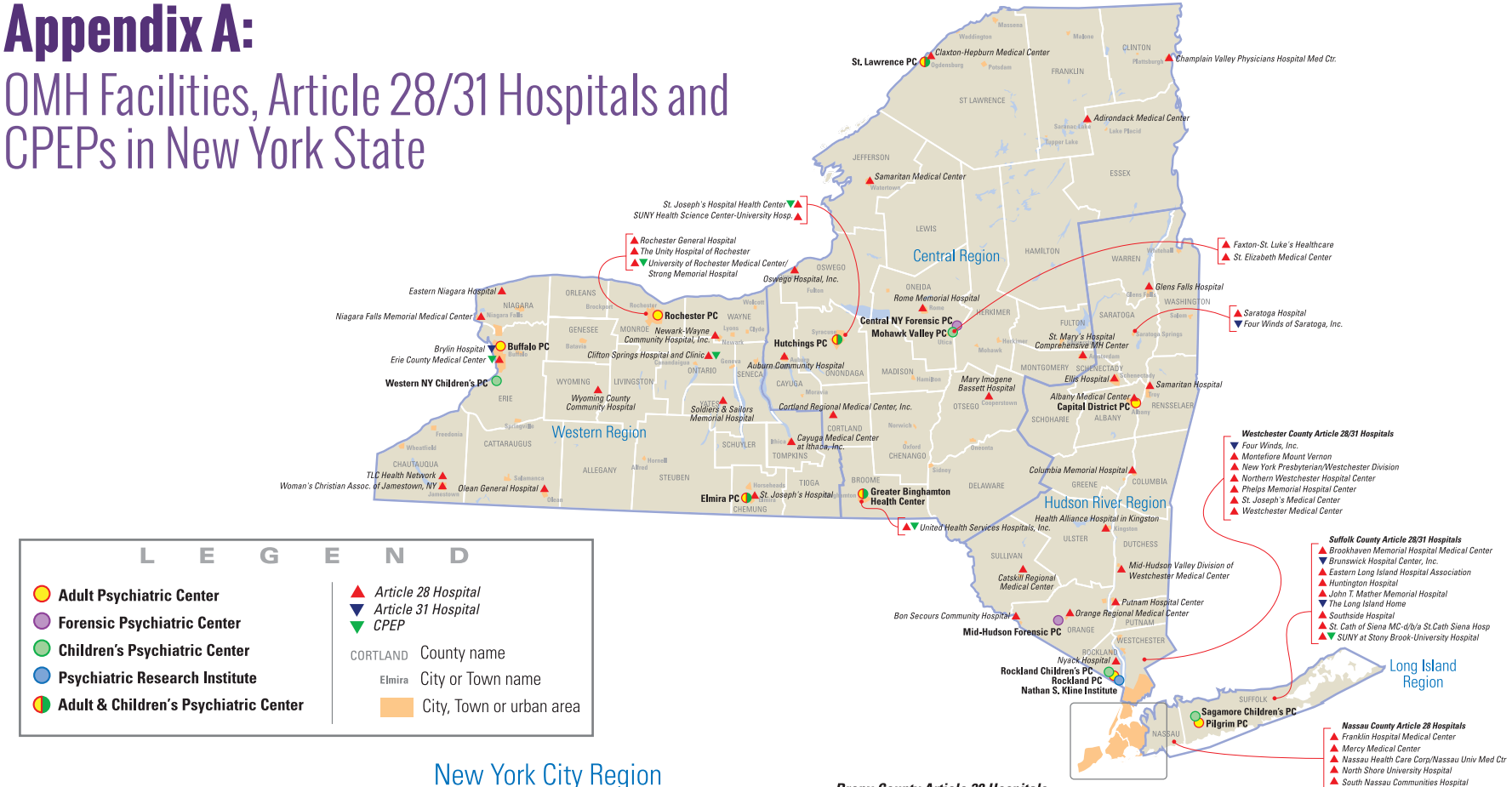
6 The BCC utilizes individual and program assessments provided by Georgetown University National Center of Cultural Competence and Nathan Kline Institute Center of Excellence for Culturally Competent Mental Health

7 Mental health providers who are interested in assessing their staff and programs for cultural competence should contact the BCC for additional information: http://www.omh.ny.gov/omhweb/cultural_competence/

8 CEU and CASAC credit is offered to staff in State and local settings. OMH licensed providers can contact the BCC to request training by visiting the BCC website: http://www.omh.ny.gov/omhweb/cultural_competence/training/

Appendix A:

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

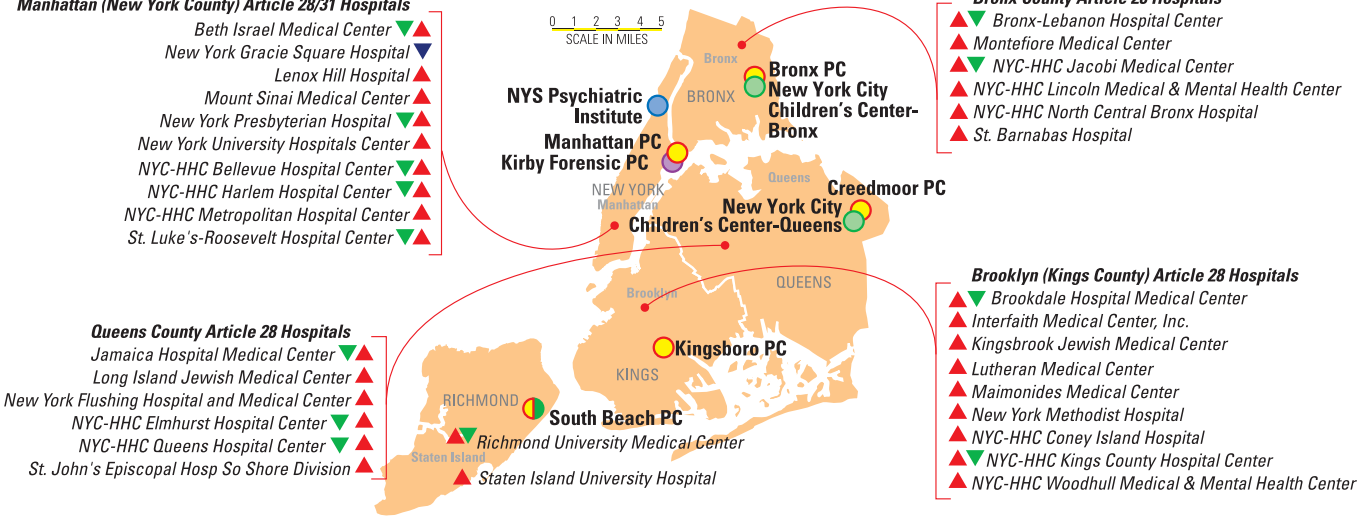


L E G E N D

- Adult Psychiatric Center
- Forensic Psychiatric Center
- Children's Psychiatric Center
- Psychiatric Research Institute
- Adult & Children's Psychiatric Center

- Article 28 Hospital
- Article 31 Hospital
- CPEP
- CORTLAND County name
- Elmira City or Town name
- City, Town or urban area

New York City Region



Manhattan (New York County) Article 28/31 Hospitals

- *Beth Israel Medical Center*
- *New York Gracie Square Hospital*
- *Lenox Hill Hospital*
- *Mount Sinai Medical Center*
- *New York Presbyterian Hospital*
- *New York University Hospitals Center*
- *NYC-HHC Bellevue Hospital Center*
- *NYC-HHC Harlem Hospital Center*
- *NYC-HHC Metropolitan Hospital Center*
- *St. Luke's-Roosevelt Hospital Center*

Bronx County Article 28 Hospitals

- *Bronx-Lebanon Hospital Center*
- *Montefiore Medical Center*
- *NYC-HHC Jacobi Medical Center*
- *NYC-HHC Lincoln Medical & Mental Health Center*
- *NYC-HHC North Central Bronx Hospital*
- *St. Barnabas Hospital*

Queens County Article 28 Hospitals

- *Jamaica Hospital Medical Center*
- *Long Island Jewish Medical Center*
- *New York Flushing Hospital and Medical Center*
- *NYC-HHC Elmhurst Hospital Center*
- *NYC-HHC Queens Hospital Center*
- *St. John's Episcopal Hosp So Shore Division*

Brooklyn (Kings County) Article 28 Hospitals

- *Brookdale Hospital Medical Center*
- *Interfaith Medical Center, Inc.*
- *Kingsbrook Jewish Medical Center*
- *Lutheran Medical Center*
- *Maimonides Medical Center*
- *New York Methodist Hospital*
- *NYC-HHC Coney Island Hospital*
- *NYC-HHC Kings County Hospital Center*
- *NYC-HHC Woodhull Medical & Mental Health Center*

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Appendix B:
Comprehensive Psychiatric Emergency Program 2015 Annual Summary

The Comprehensive Psychiatric Emergency Program (CPEP) program 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 July 2016, 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 2015 calendar year.

Category		Description	Total 2015 Annual Visits
CPEP Component Use	ER	Brief Visits	7,727
		Full Visits	122,659
		Total Visits	130,386
	Extended Observation Beds (EOBs)	Admissions	12,844
		Total Bed Days Occupied	21,408
	Crisis Outreach	Initial Visits	16,436
		Interim Visits	8,342
		Total Visits	24,491
	Crisis Residence	Admissions	3,209
		Total Bed Days	3,179
Waiting and Retention Times	1st Contact with Clinical Staff	Less than 1 hour	107,526
		1+ to 2 hours	11,224
		Over 2 hours	8,451
	1st Contact with MD	Less than 2 hours	81,805
		2+ to 4 hours	15,929
		4+ to 6 hours	7,273
		Over 6 hours	14,332
	Entry to Discharge (Non-EOBs)	Less than 8 hours	55,017
		8+ to 16 hours	20,343
		16+ to 24 hours	17,149
		Over 24 hours	16,562
	Entry to Discharge (EOBs)	Less than 24 hours	9,764
		24+ to 48 hours	5,296
		48+ to 72 hours	3,821
		Over 72 hours	1,335
Diagnosis on Discharge from CPEP Services		Schizophrenia, Other Psychotic Disorders and Mood Disorders	78,005
		Substance-Related Disorders	24,146
		Personality Disorders	4,888
		Dementia & Other Cognitive Disorders	3,163
		Other	32,804
		Total	143,006
Client Demographics	Age Reported for All CPEP Components	Under 18 Years Old	19,935
		18 to 34 Years Old	50,894
		35 to 64 Years Old	60,674
		65 Years Old and Over	6,183
	Gender Reported for All CPEP Components	Male	77,786
		Female	59,779

Appendix C:
Local Services Plan 2016 Needs Assessments

LSP Survey Question 4:
Assessment of Local Issues Impacting Youth and Adults

For each issue listed in this section, indicate the extent to which it is an area of need at the local (county) level for each disability population listed on the right. The online form will have a drop down menu in each box with the options: High Need; Moderate Need; and Low Need. For each issue that you identify as either a "High" or "Moderate" need, answer the follow-up questions to provide additional detail.

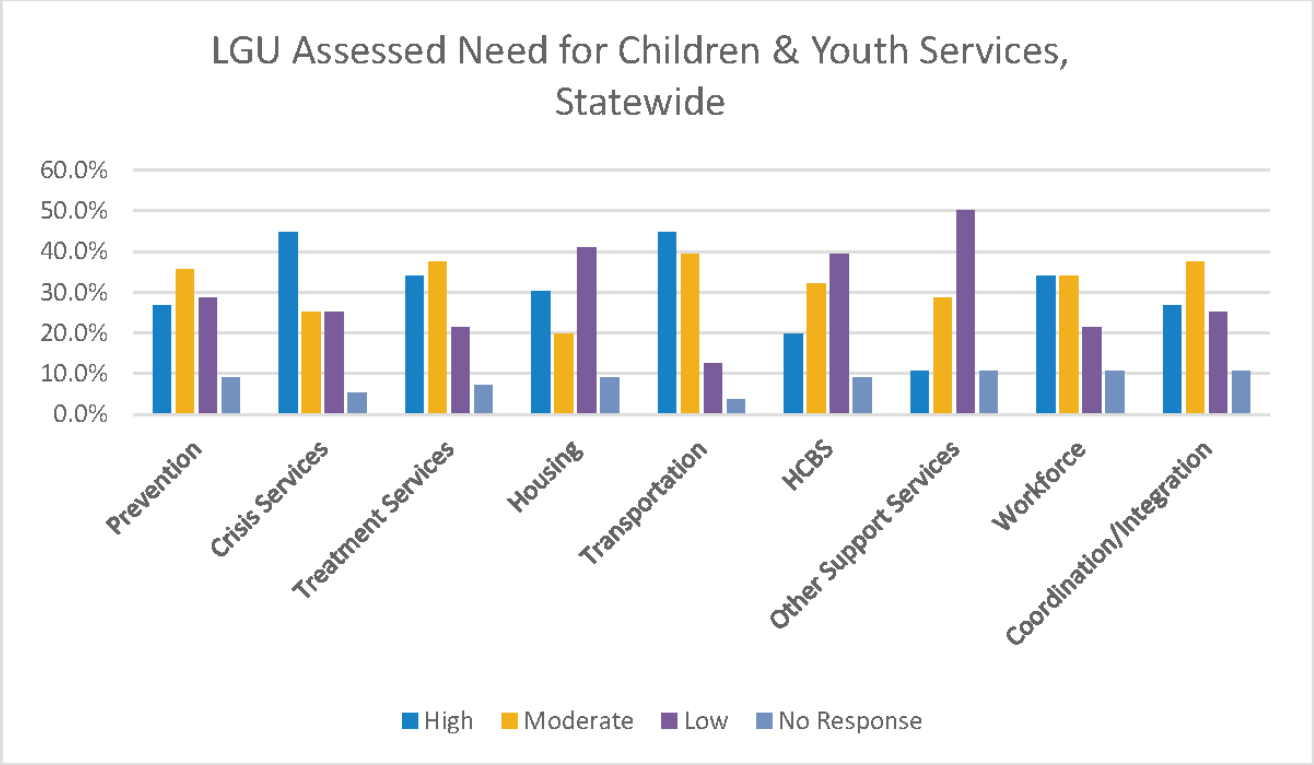
	Youth (Under 21 years)			Adults (21+ years)		
Issue Category	**CD**	**MH**	**DD**	**CD**	**MH**	**DD**
a) Access to Prevention Services						
b) Access to Crisis Services						
c) Access to Treatment Services						
d) Access to Supported Housing						
e) Access to Transportation						
f) Access to Home/Community-based Services						
g) Access to Other Support Services						
h) Workforce Recruitment and Retention						
i) Coordination/Integration with Other Systems						
j) Other (specify):						
k) Other (specify):						

If any of the issue categories listed above is identified as either a "high" or "moderate" county need to be addressed, additional follow-up questions will need to be completed. Provide a brief description of the issue and why it is important to address it at the county level. Identify any strategies that could potentially be pursued to address the issue. If this issue is also included on the Priority Outcomes Form, the outcome statement and strategies should be copied here.

Issue Category: Will automatically appear if a high or moderate need is indicated.

4a1. Briefly describe the issue and why it is a moderate or high need at the county level. If this involves high need populations or special circumstances, clarify those here.

4a2. Identify strategies that could potentially be pursued to address this local issue.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Prevention
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Treatment Services
Housing
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HCBS
Other Support Services
Workforce
Coordination/Integration
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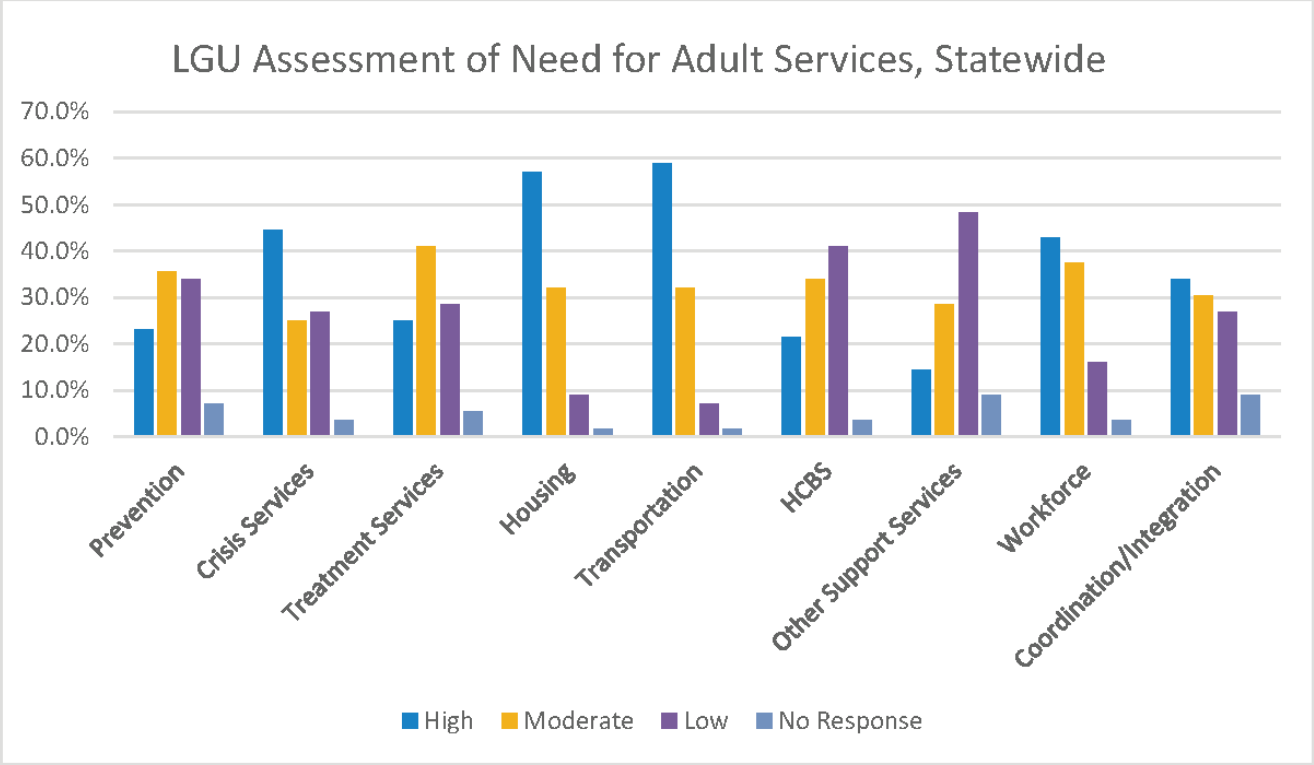
Moderate
Low
No Response


LGU Assessment of Need for Adult Services, Statewide
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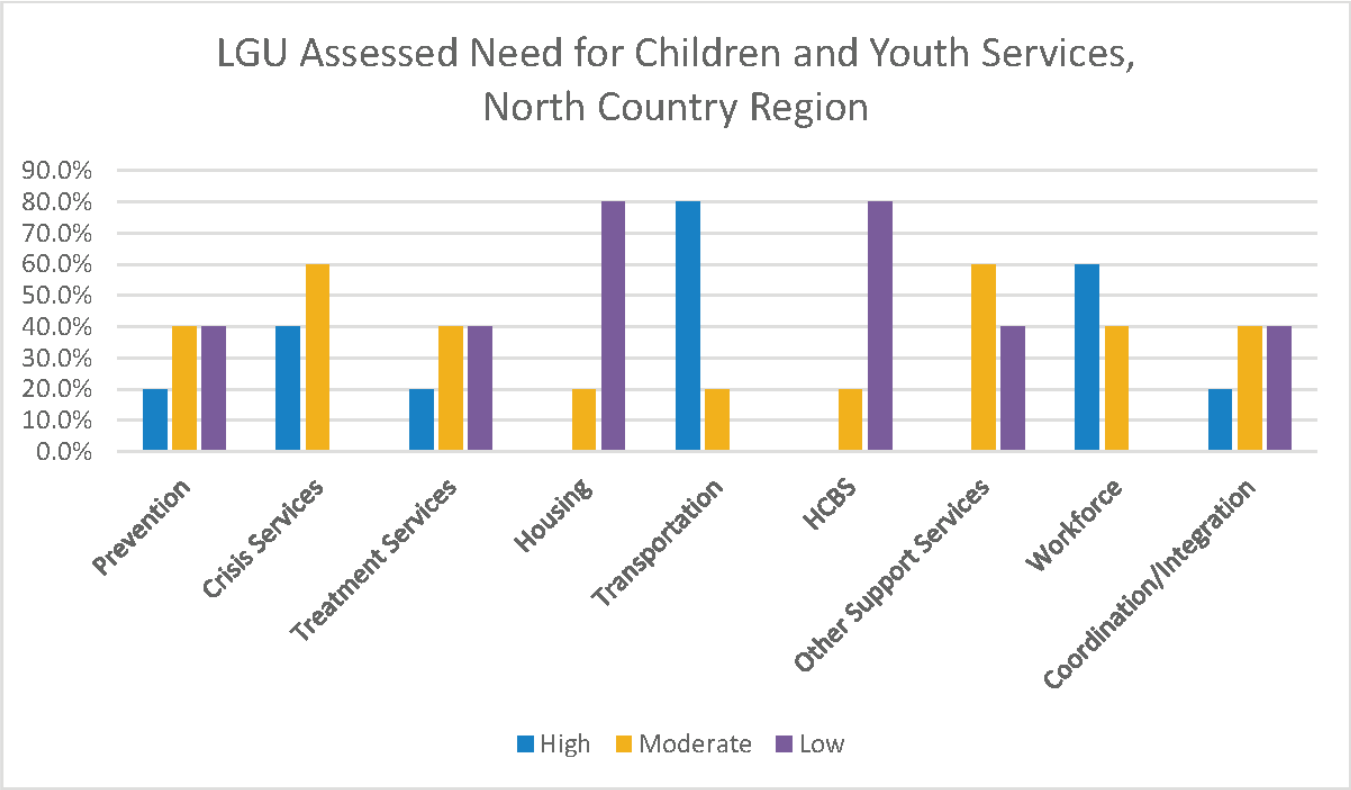
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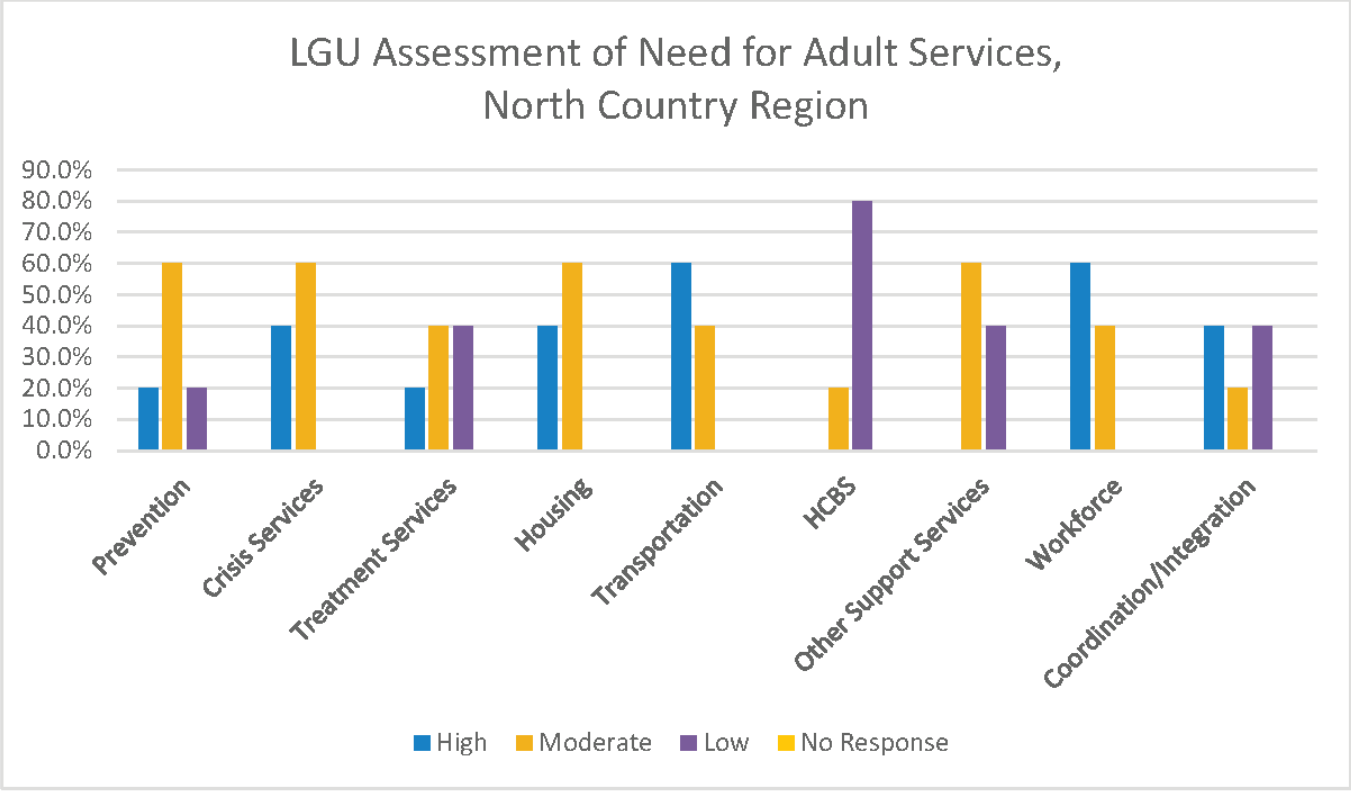
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Coordination/Integration
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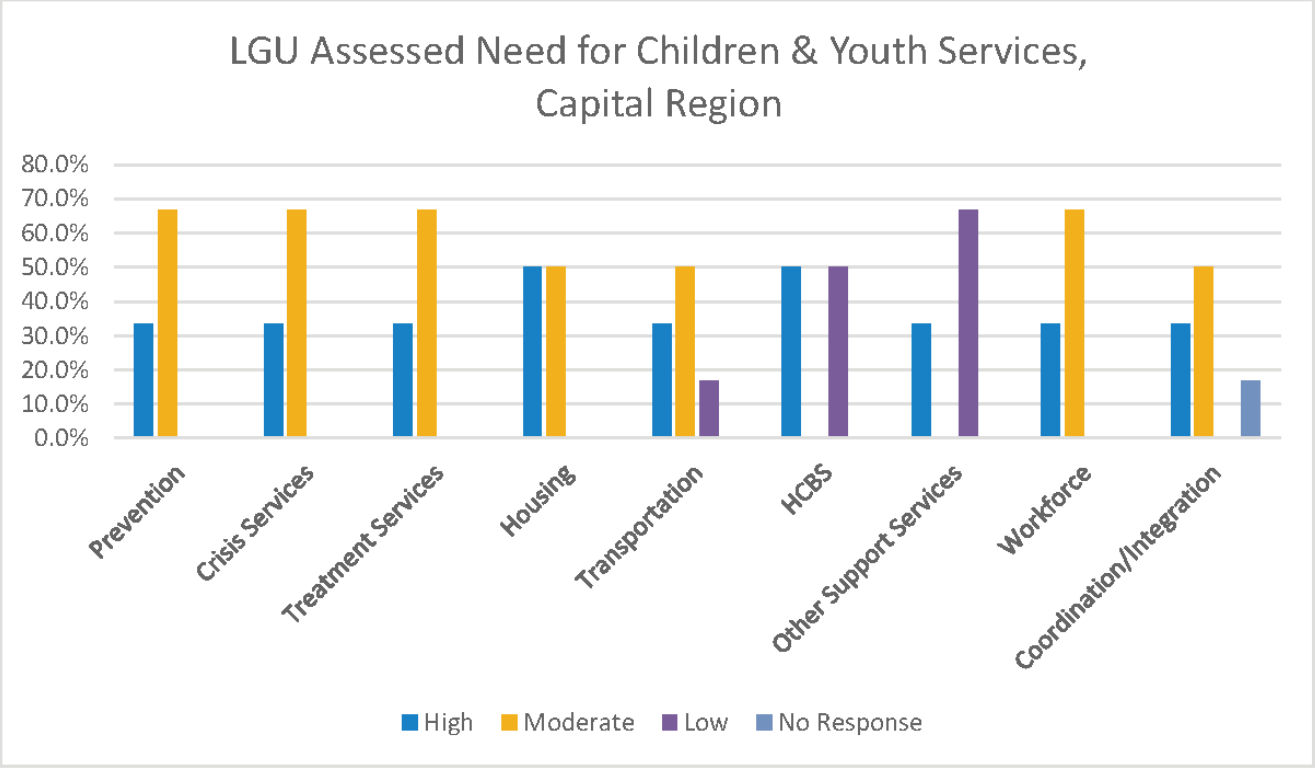
No Response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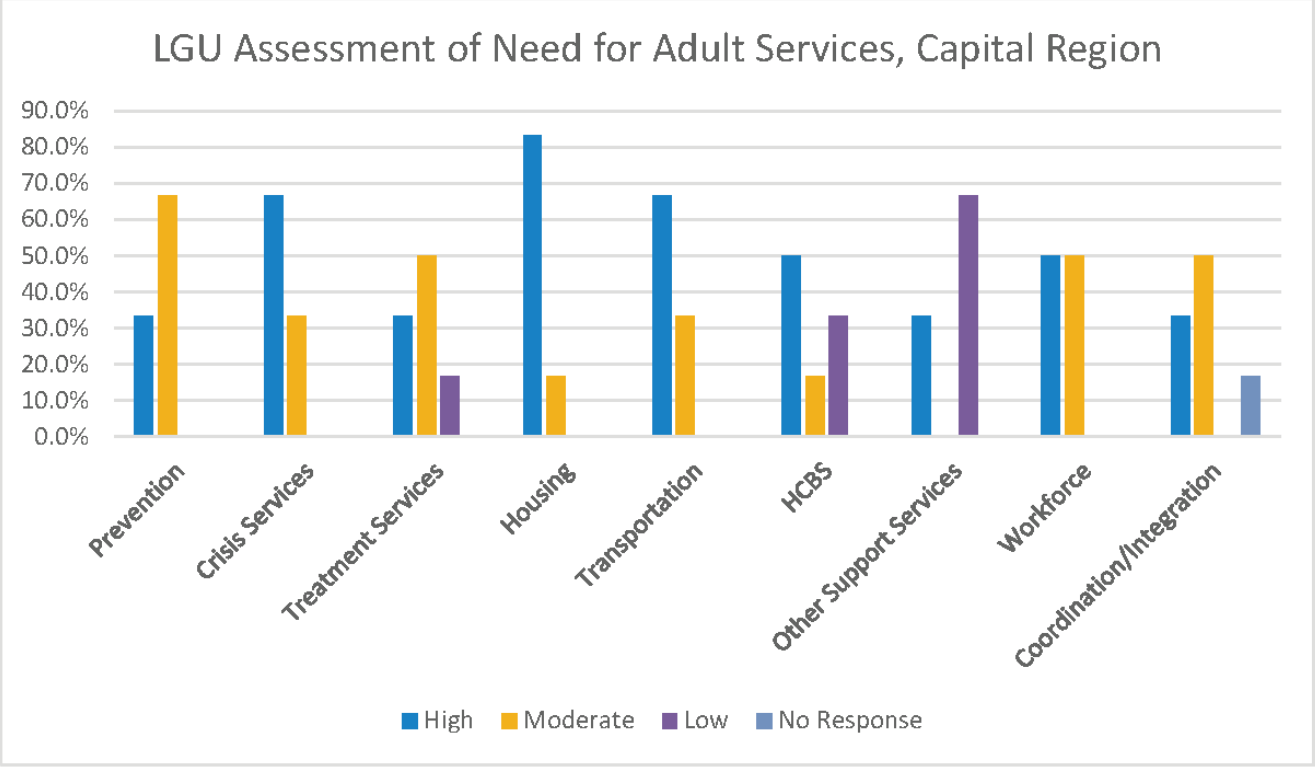
No Response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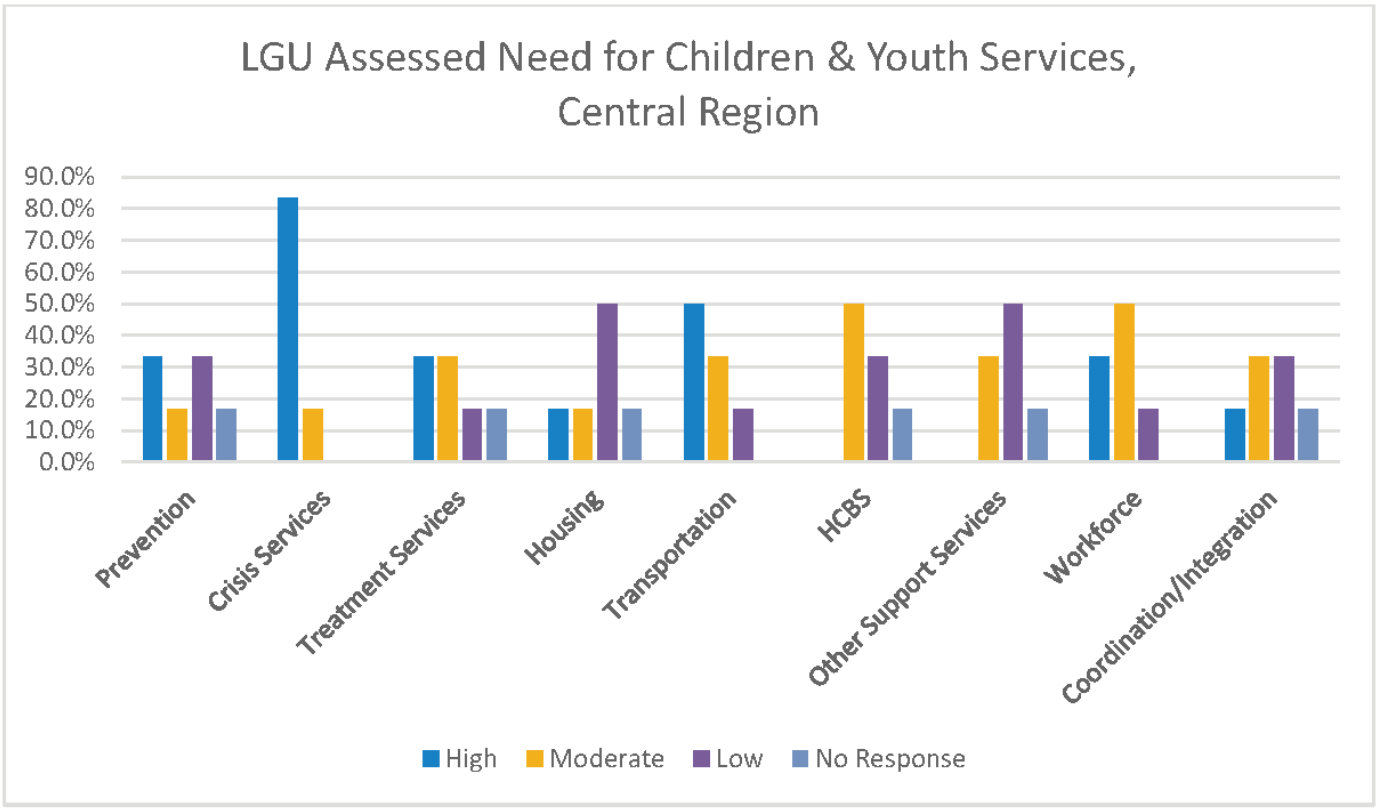
No Response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Workforce
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Moderate
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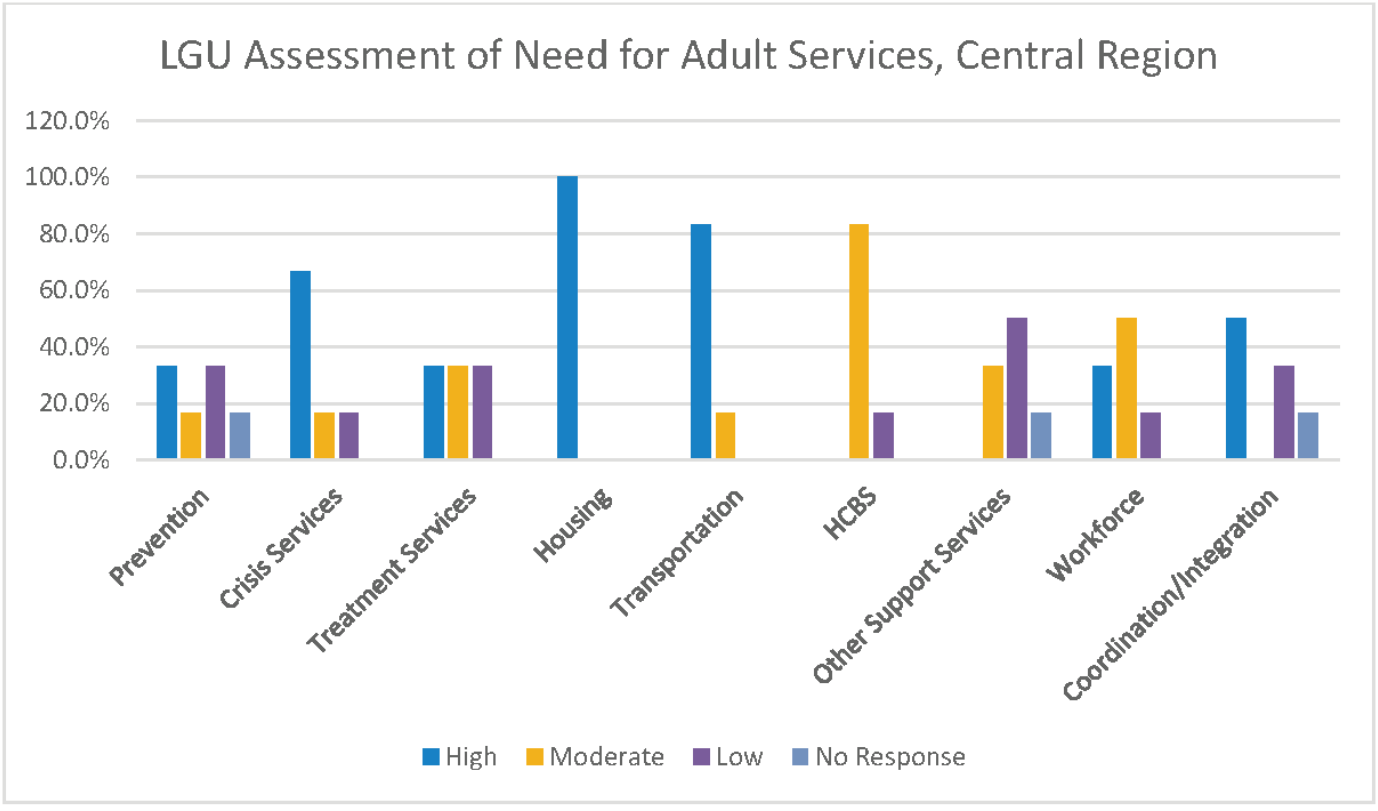
No Response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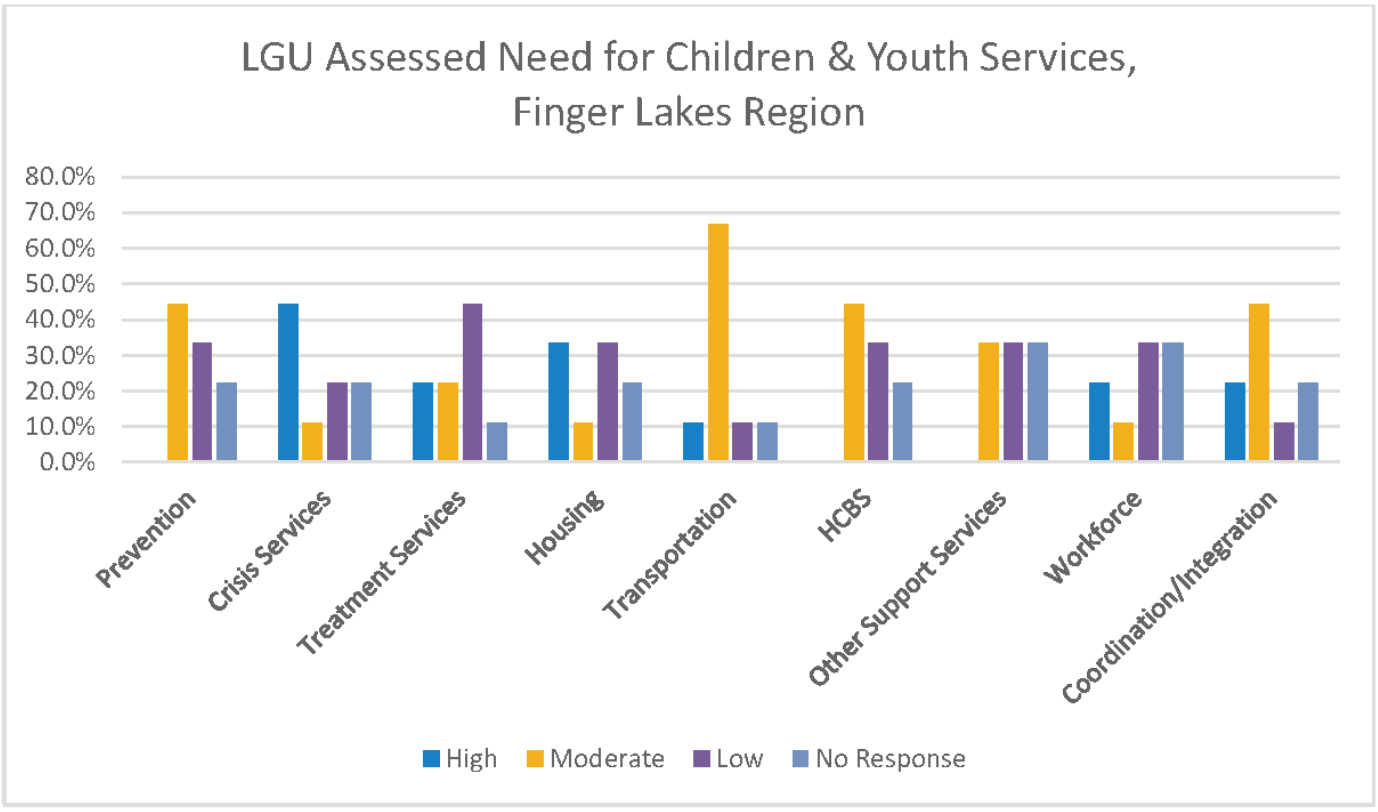
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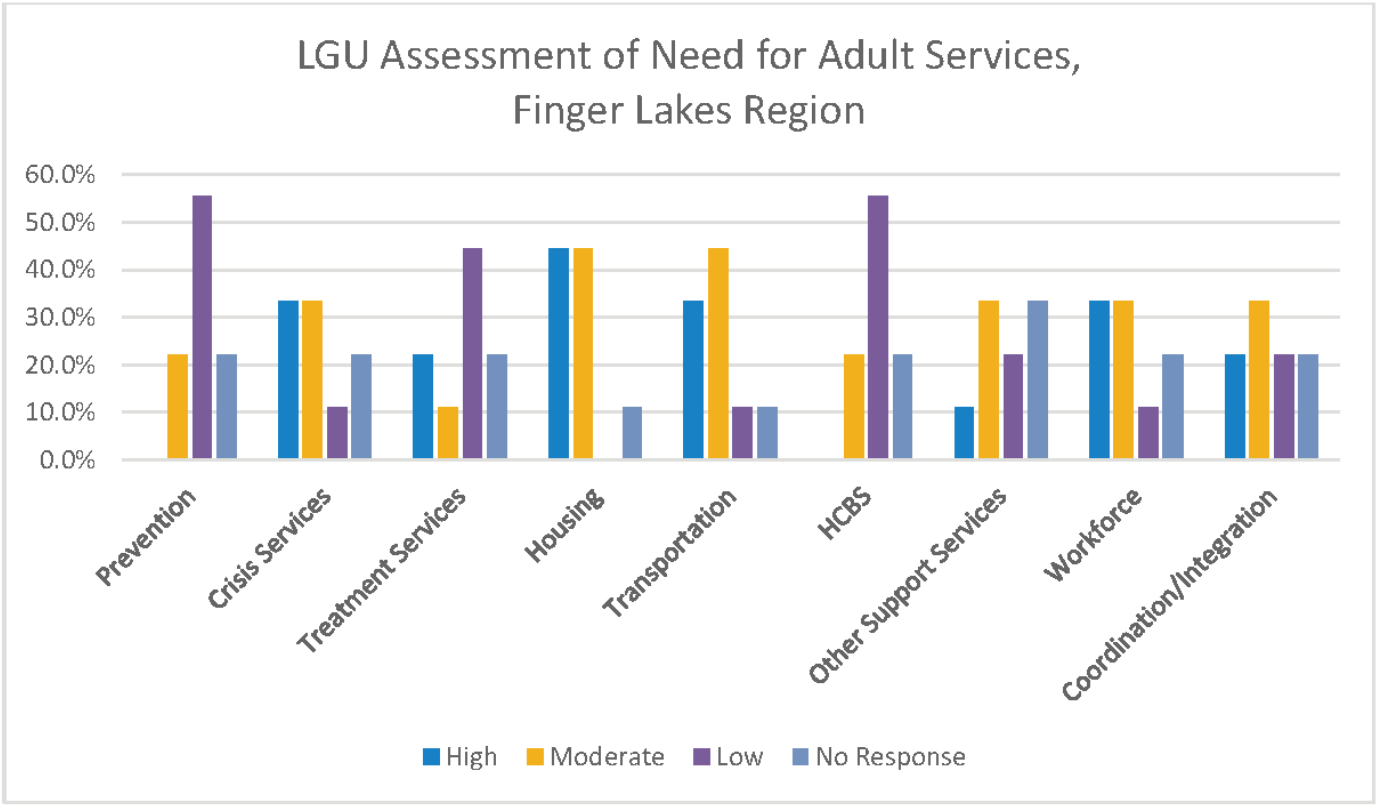
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Coordination/Integration
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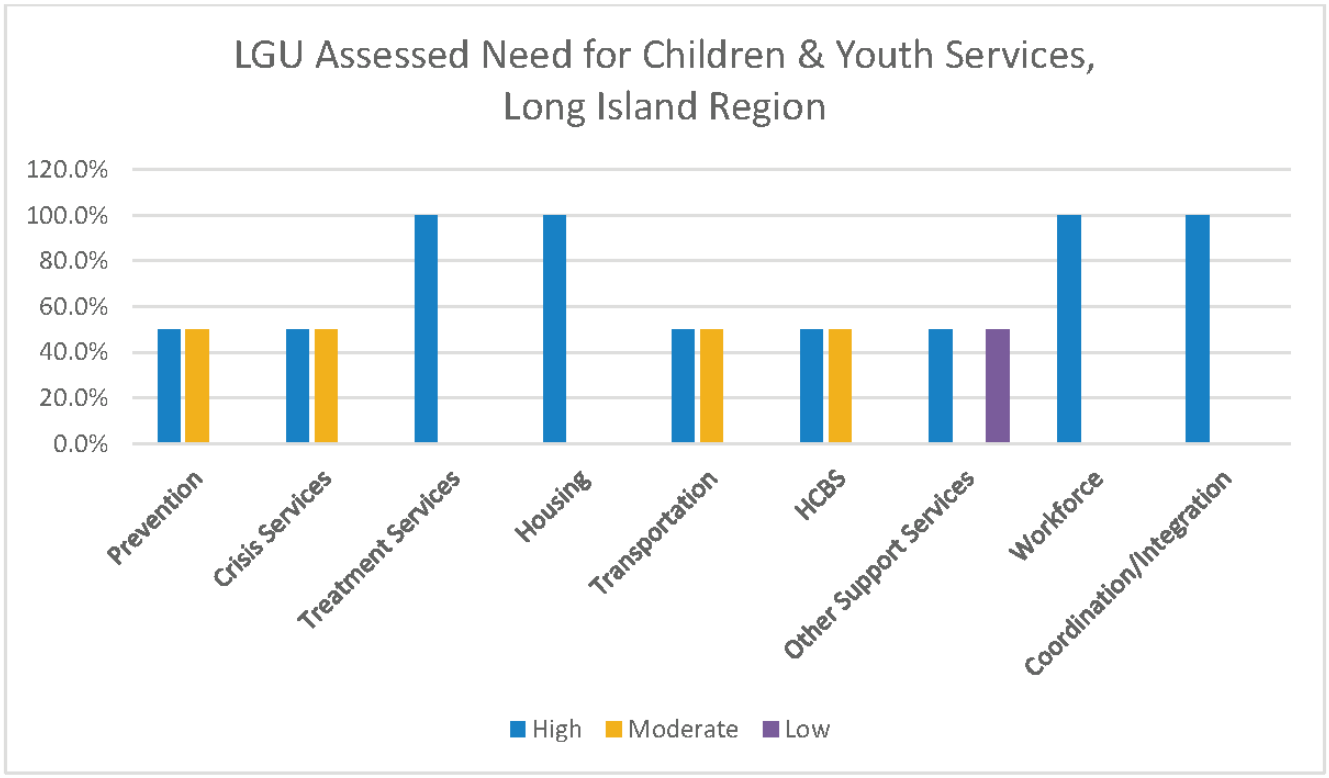
No Response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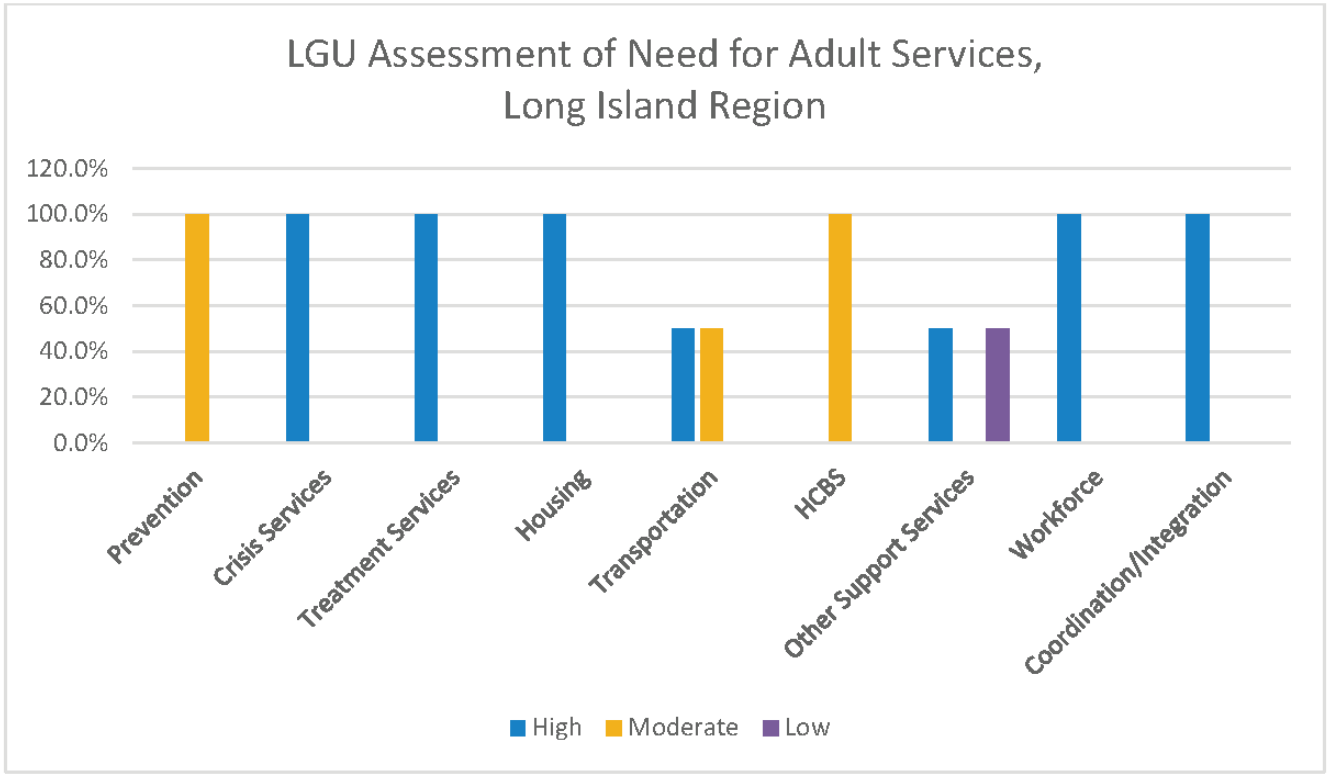
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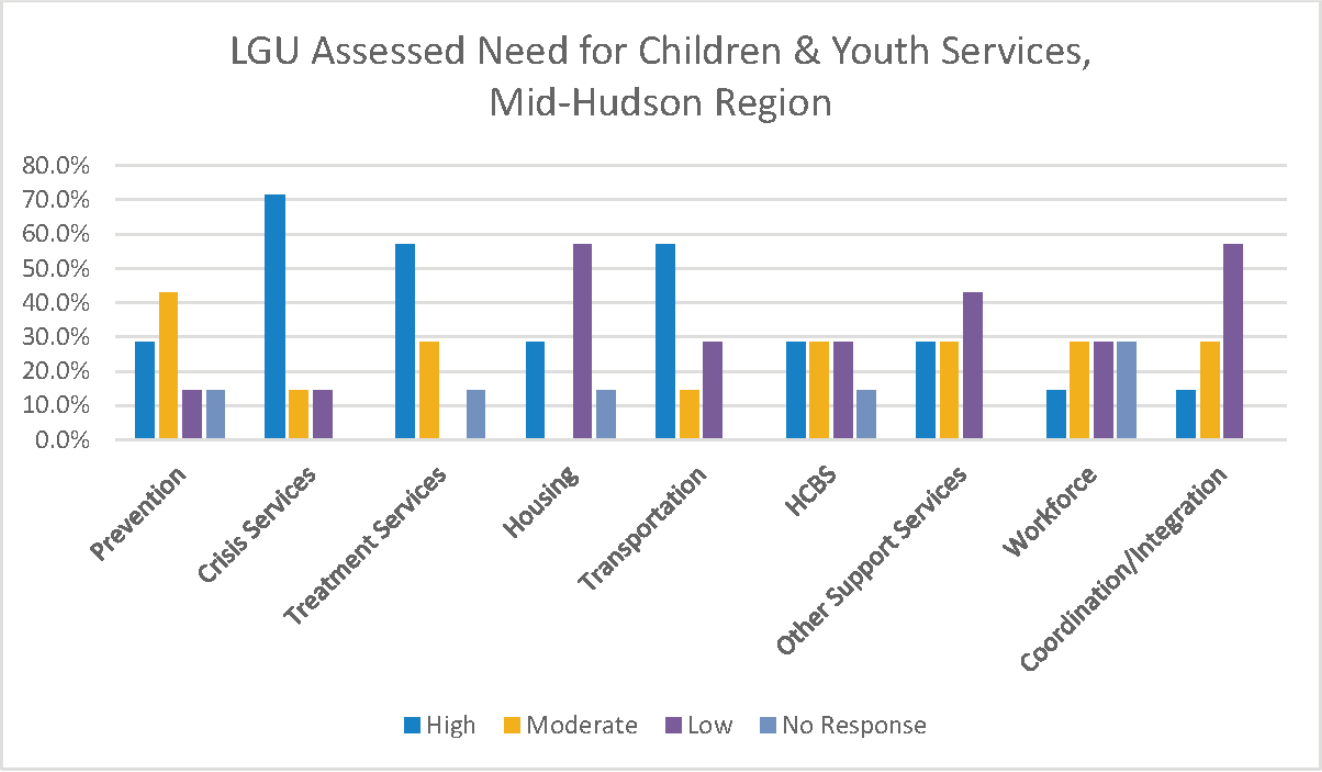
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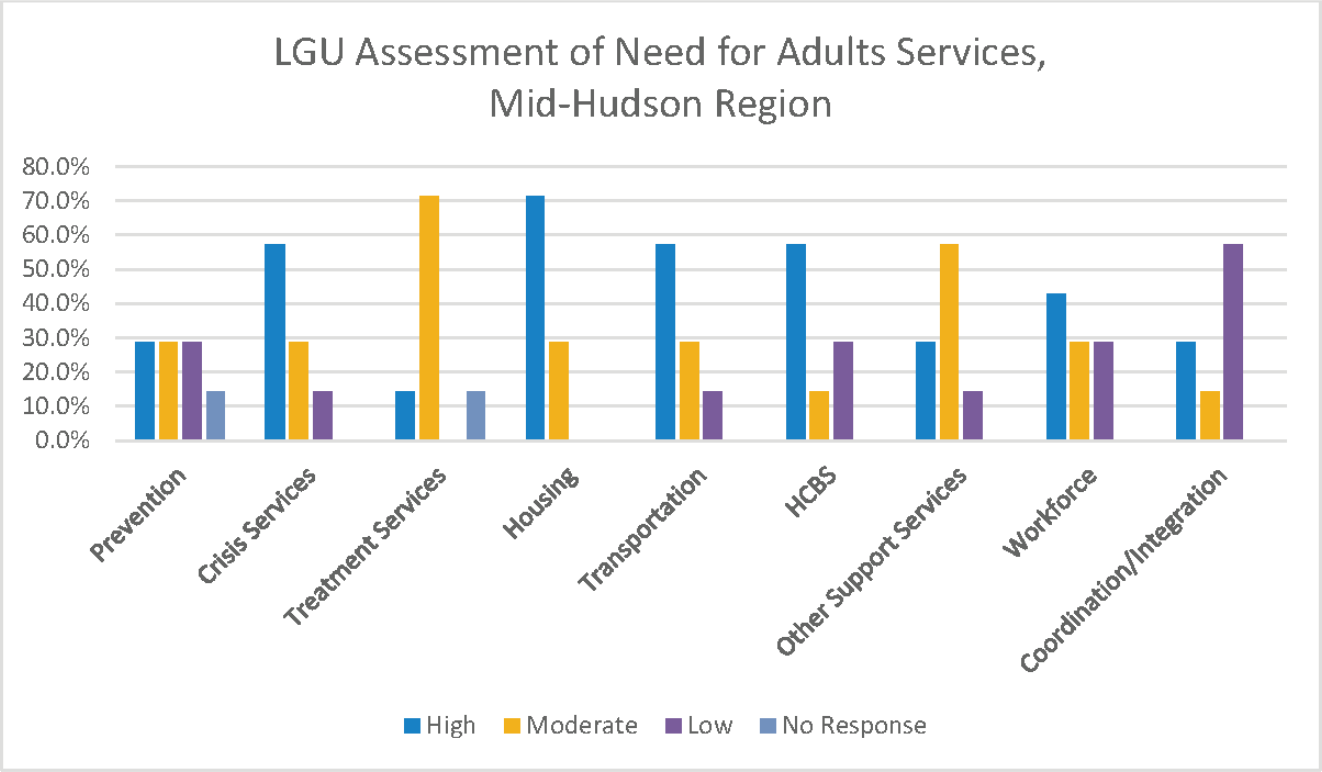
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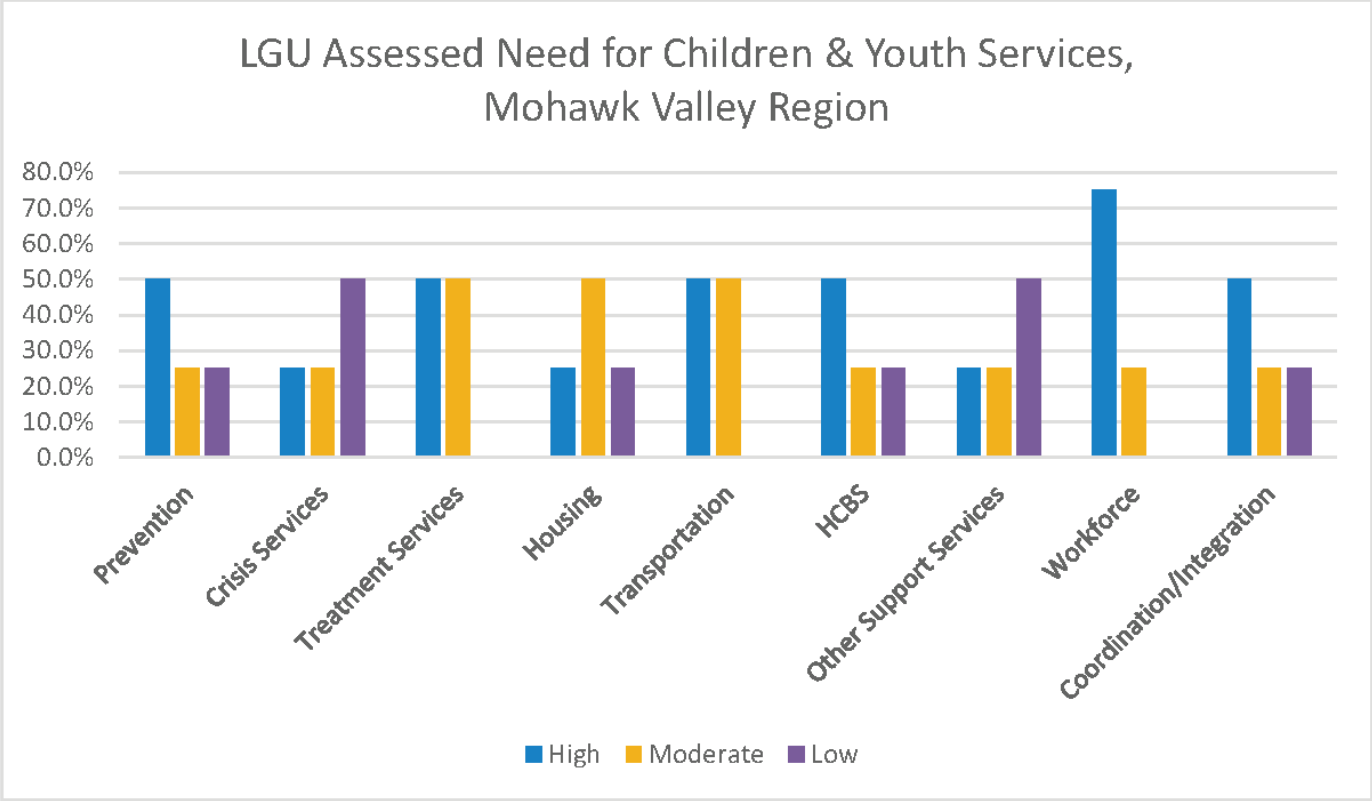
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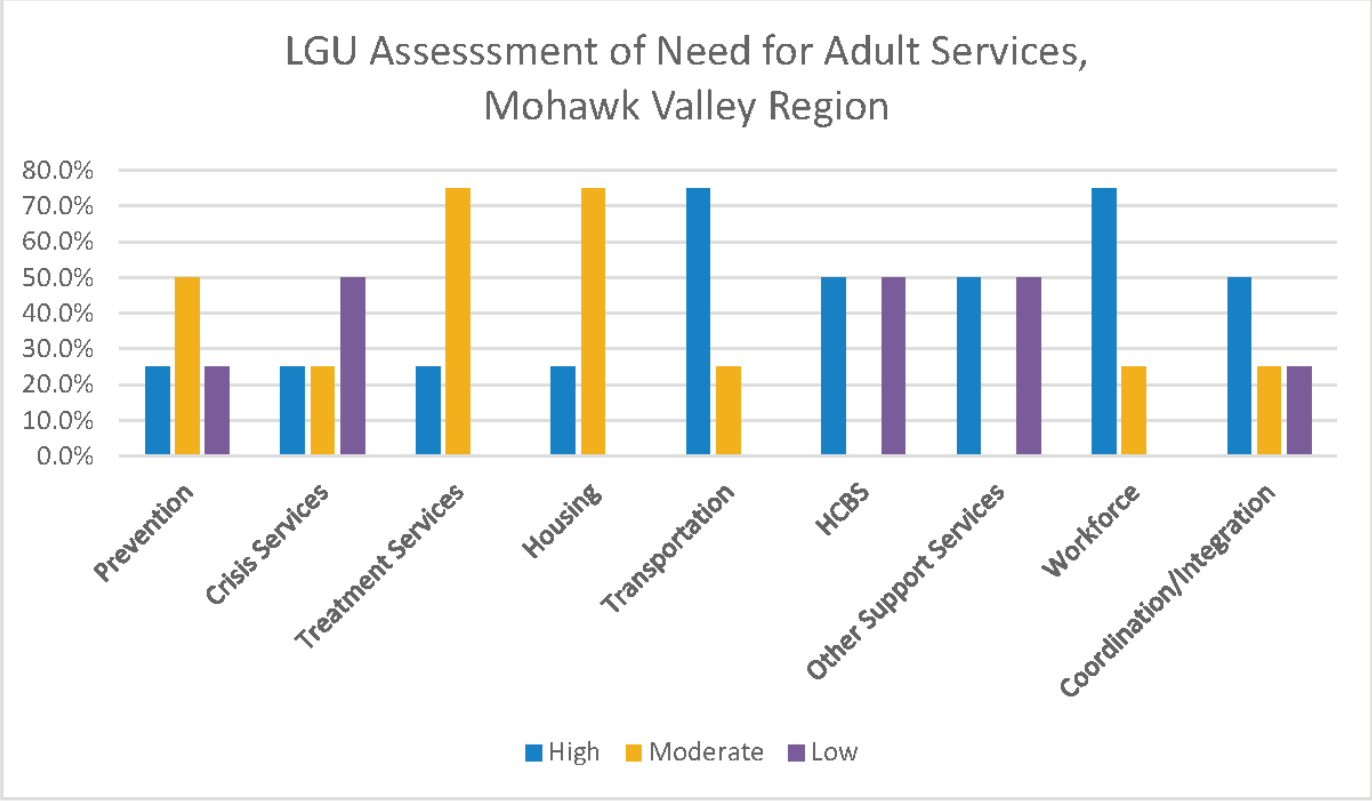
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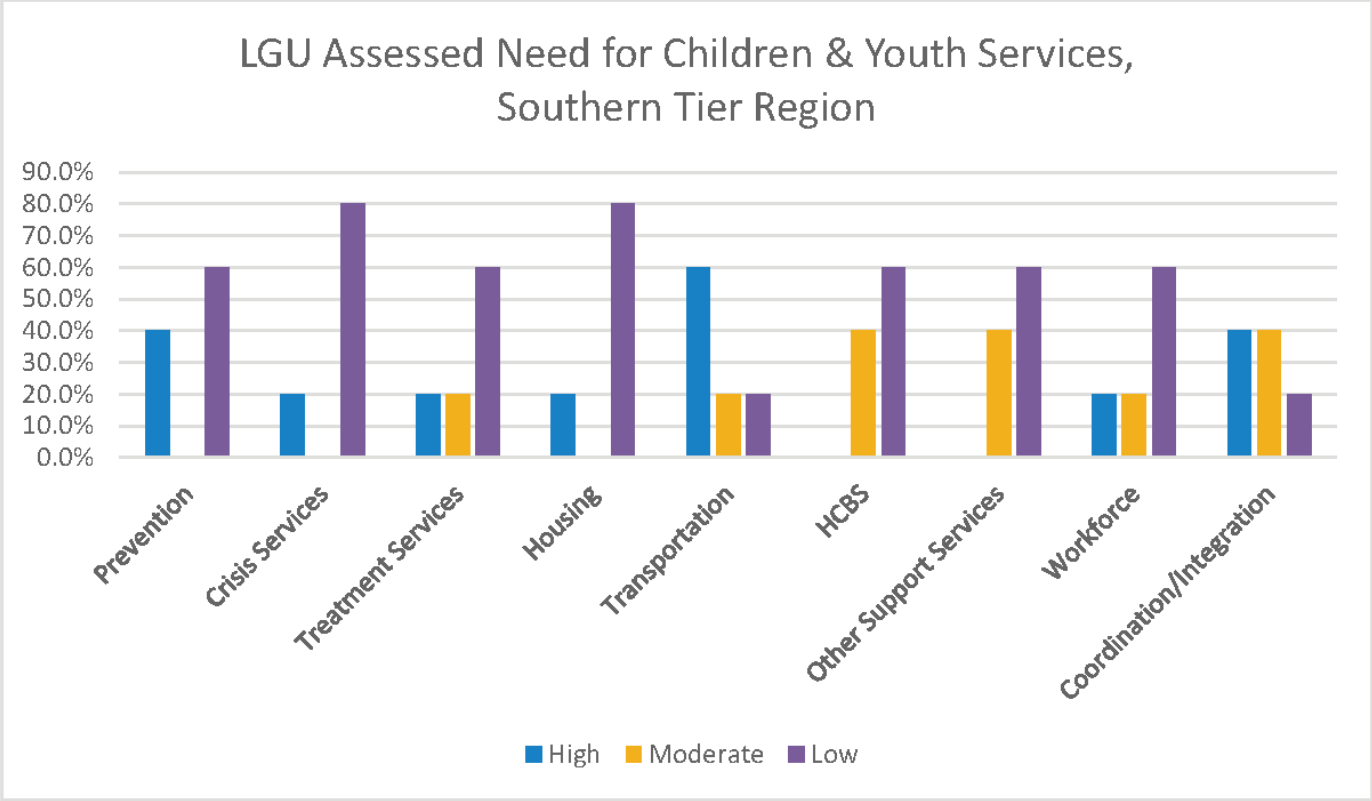
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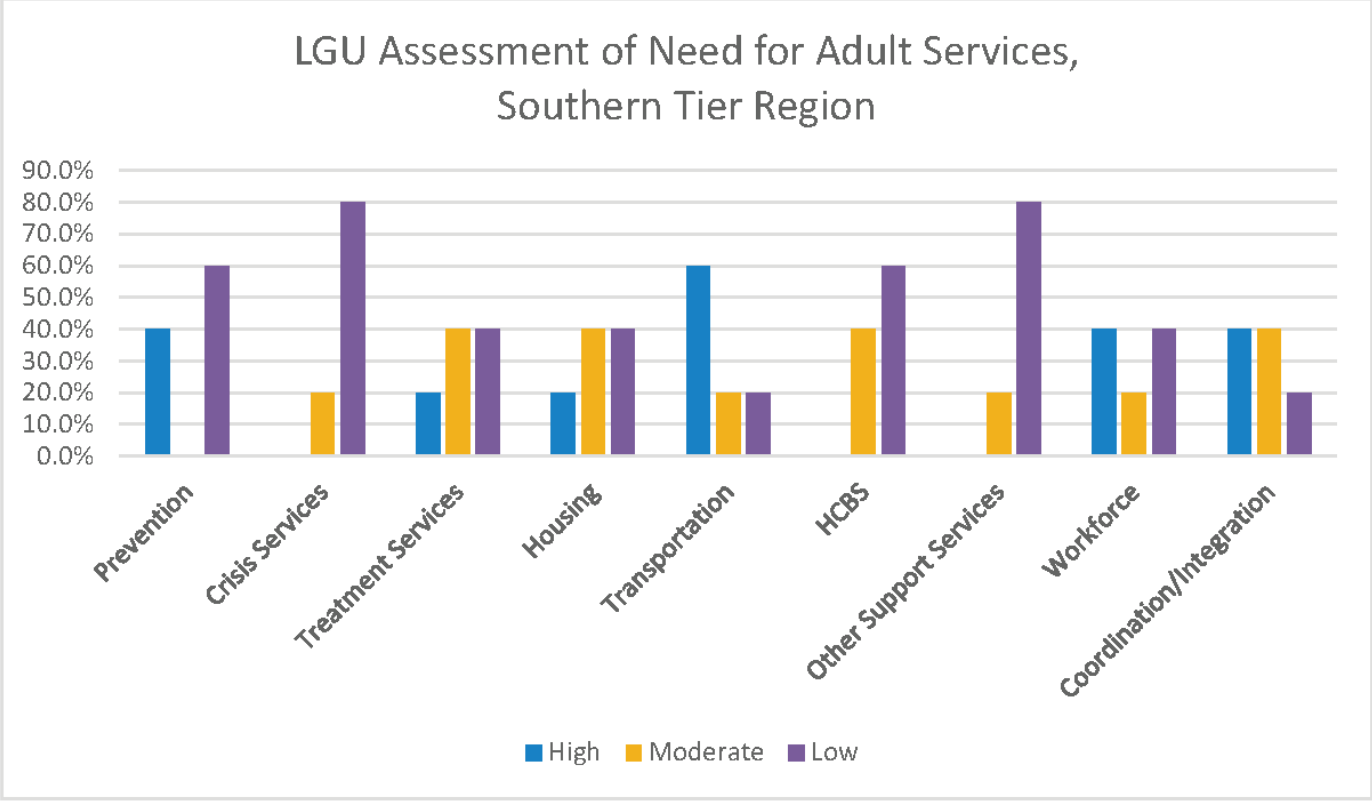
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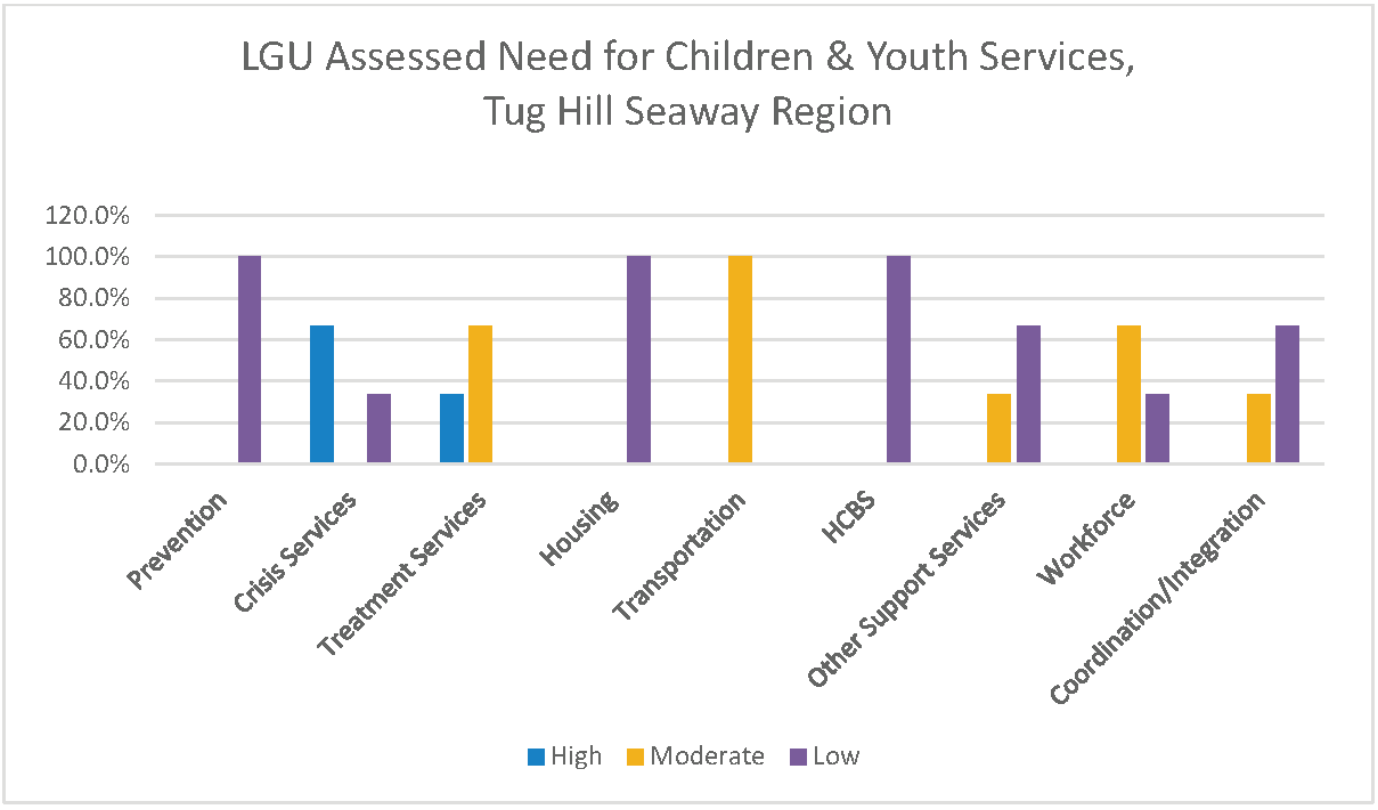
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Tug Hill Seaway Region
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Coordination/Integration
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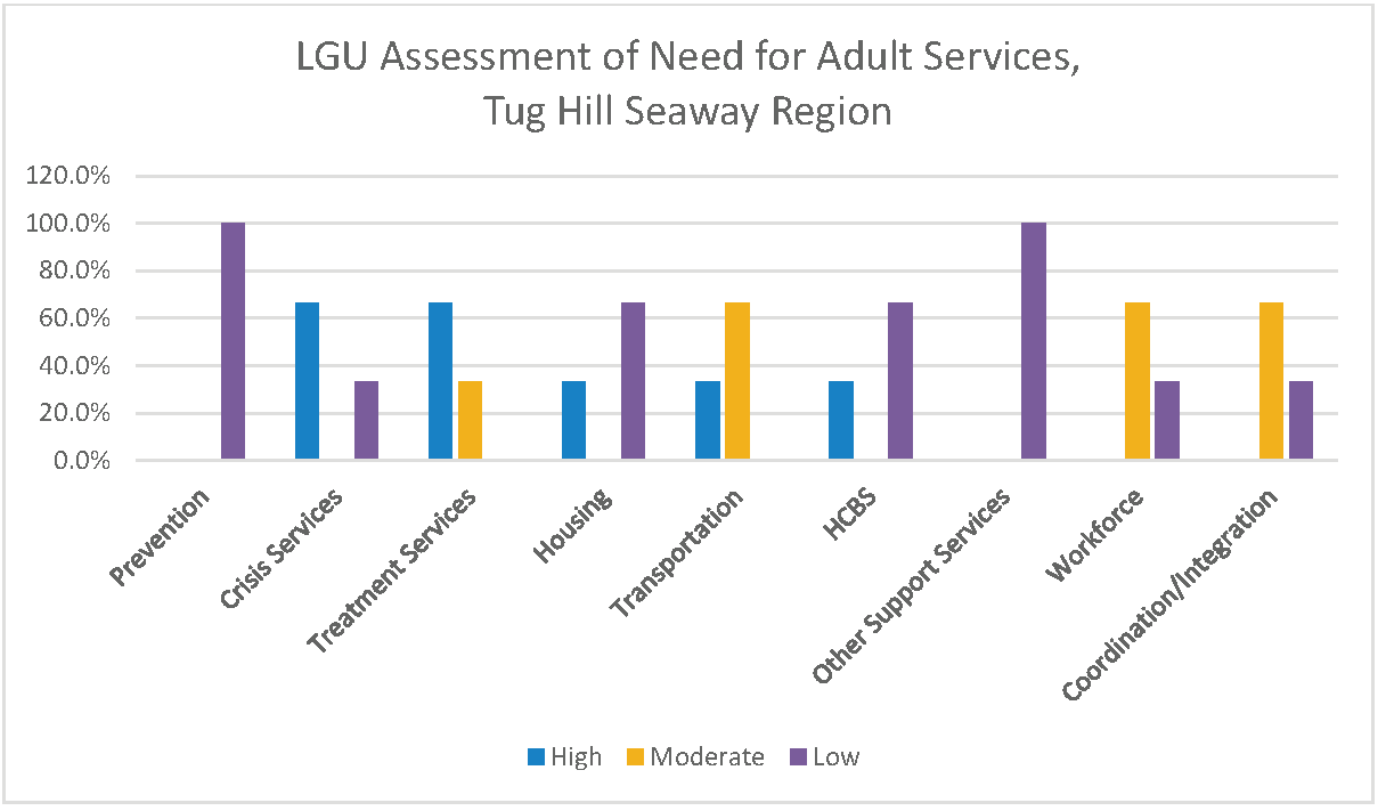
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Tug Hill Seaway Region
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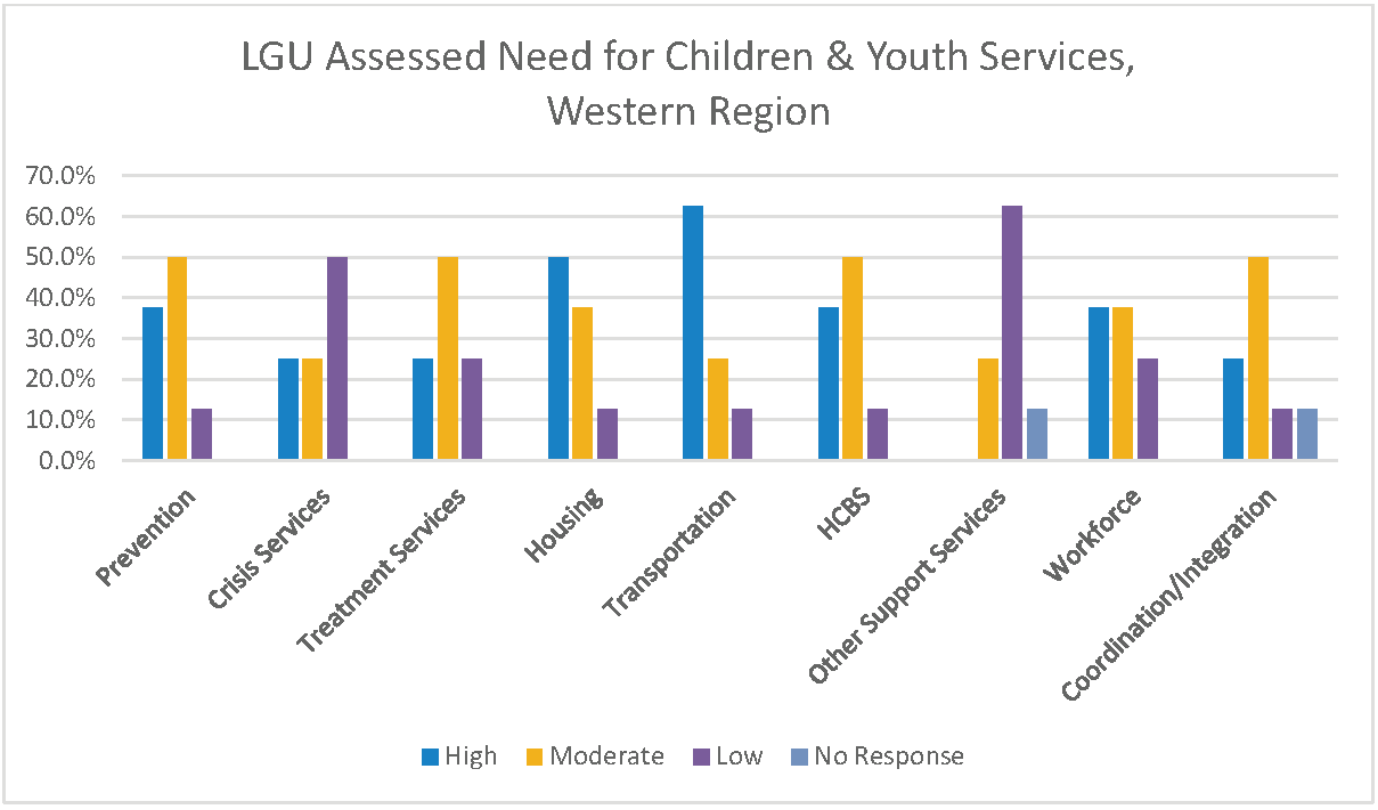
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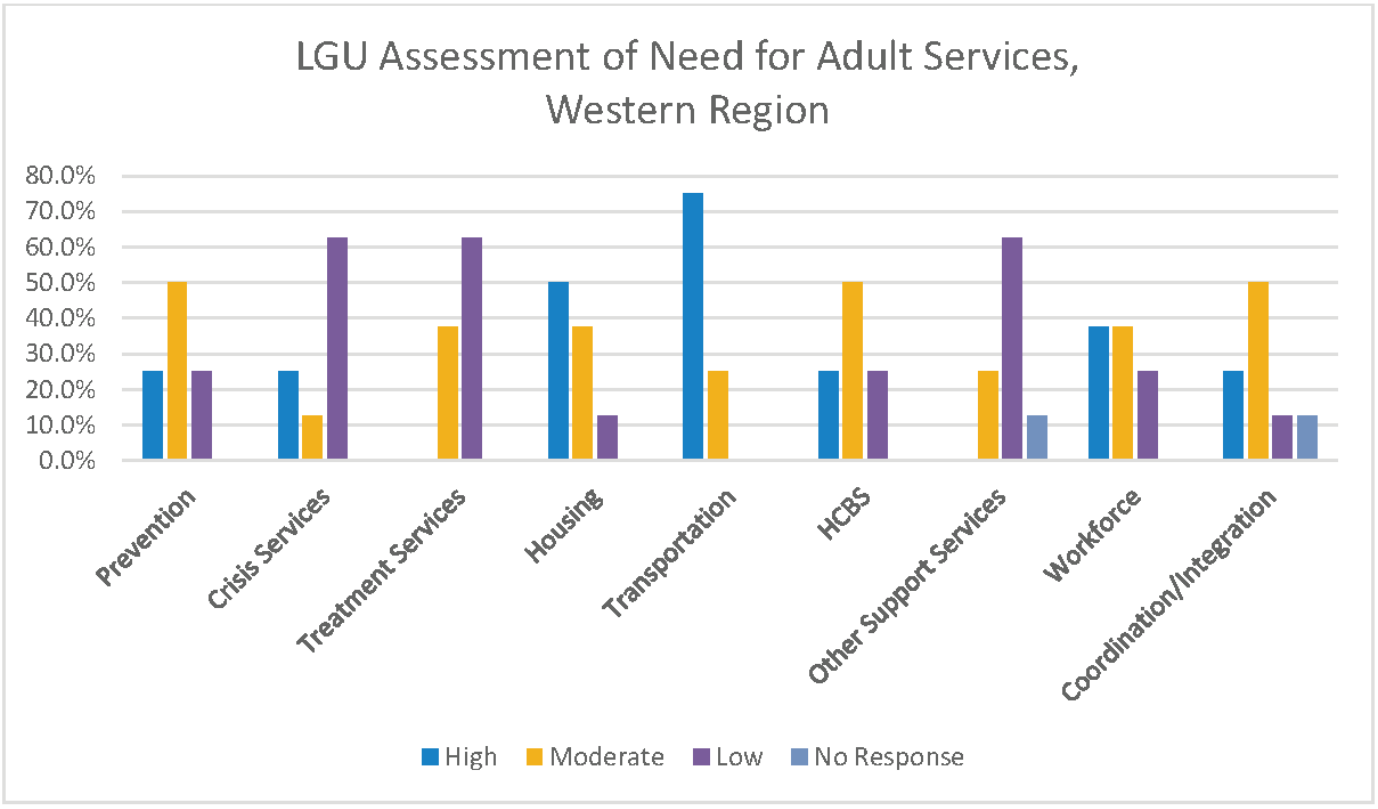
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Other Support Services
Workforce
Coordination/Integration
High
Moderate
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No Response

Appendix D:
Clinic VAP Awards

Listed below are the 40 recipients of the Clinic VAP awards

Central

Cayuga County Community Mental Health Center
Chenango County Community Service Board
Clinton County Community Service Board
Delaware County Community Services
Essex County Mental Health Services
Madison County Mental Health Clinic
The Children's Home of Jefferson County
Upstate Cerebral Palsy, Inc.

New York

Community Association Progressive Dominicans, Inc.
Hamilton-Madison House Inc.
Lexington Center for Mental Health Services, Inc.
Northside Center for Child Development Inc.
Puerto Rican Family Institute
Safe Space NY
Service Program for Older People, Inc.
Staten Island Mental Health Society, Inc.

Hudson River

Albany County of Mental Health
Astor Children and Family Services
Family Services of Westchester, Inc.
Mental Health Assoc. of Westchester County
Northeast Parent & Child Society
Access Support for Living
Schoharie County Community Mental Health Center
Sullivan County Department of Community Services
The Guidance Center Inc.
Westchester Jewish Community Services

Western

Allegany Rehabilitation Associates, Inc.
Catholic Family Center of the Diocese of Rochester
Child & Adolescent Treatment Services, Inc.
Ontario County Department of Mental Health
Schuyler County of Mental Health
Steuben County Community Mental health Center
Tioga County Department of Mental Hygiene
Tompkins County Mental Health Services
Wayne County Mental Health Department

Long Island

Angelo J. Melillo Center for Mental Health
Catholic Charities of the Diocese of Rockville Center
Central Nassau Guidance and Counseling Services, Inc.
NorthShore Child & Family Guidance Association, Inc.
Suffolk County Department of Health Services

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Appendix E:
Database/Terms Glossary

MHARS	Mental Health Automated Record System (MHARS) is an electronic clinical patient record system for New York State psychiatric center programs (inpatient, outpatient & residential).
CONCERTS	Certificate of Need Certification (CONCERTS) application processes information gathered by the Bureau of Inspection and Certification (BIC) on local service providers that are licensed and/or funded by OMH. It captures provider information at the sponsor, agency, facility, program and site levels. Site-specific information includes program capacity, services, population served, and counties served.
CAIRS	Child and Adult Integrated Reporting System (CAIRS) application is a web-based information tracking system that facilitates the processing, managing and coordinating of on-going mental health services to children and adults. It integrates the reporting requirements of state and local level providers in consolidating their reporting needs as well as tracking statewide outcomes.
NIMRS	New York State Incident Management Reporting System (NIMRS) is a secure, web-based, quality management tool used by OMH providers to report incidents. NIMRS allows for reporting of incidents and restraints in a real-time environment and it eliminates the need for excessive paper-based incident management processes. NIMRS features a report generator that can be used to examine trends, providing risk management staff the ability to make program changes and better the quality of the lives of the individuals serve.
PCS Survey	The Patient Characteristics Survey (PCS) is conducted every two years, and collects demographic, clinical and social characteristics for each person who receives a public mental health service during a specified one-week period. The PCS receives data from approximately 5,000 mental health programs serving 178,000 people during the survey week. All programs licensed or funded by the OMH are required to complete the survey.
Transformation Plan Services Consumer Satisfaction Survey	OMH assessed consumer satisfaction with public mental health transformation services by directly surveying adults, youth and their families in targeted counties. The Transformation Plan Services Consumer Satisfaction Survey was administered from September 14, 2015 through October 9, 2015. Tailored questionnaires were developed 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.

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Appendix F:

2016 Local Services Plans: LGU Mental Health Needs and Priorities

The following 2-page needs and priorities documents include:

Needs Assessment Data

OMH includes only areas identified as "high need" for the "mental health population" in the 2016 LSP submissions, with some exceptions:

- When a county did not identify any high local needs, but they did identify moderate local needs, then moderate local needs were listed.
- When a county did not identify any high regional needs, but they did identify moderate regional needs, then moderate regional needs were listed.

The bullets below the text box of needs assessments are a summary of explanations behind the needs identified in the county needs assessment.

Priority Outcomes Data

OMH include all top five rank-ordered priority outcomes, regardless of whether the item was specifically identified as an OMH-related priority (most had some relation). Some county plans had fewer than five priority outcomes, and therefore fewer than five are included in such cases. When more than five priority outcomes were included in a plan, OMH summarized the other priorities to the extent possible.

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LGU: Albany County **RPC Region: Capital Region**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention and other services, SH, HCBS, and workforce recruitment/ retention.**
Adult	**Access to treatment and other services, SH, transportation, HCBS, and workforce recruitment/retention.**
Local vs. Regional	**The same high local needs for youth were identified as regional needs, with the exception of access to prevention services. In addition, access to treatment services, transportation and coordination with other systems were included as high regional needs for youth.** **All local high needs for adults were identified as regional needs, in addition to access to prevention services and coordination/integration with other systems.**

- Limited number of prevention and case management services.
- Capacity issues for treatment services for specialized populations (e.g. those with Medicare and the non-English/ refugee/immigrant individuals).
- Anticipated treatment service capacity issues resulting from expanded eligibility criteria under managed care changes and the implementation of Health Homes.
- Unavailable transportation for non-Medicaid recipients and shortage in Medicab service.
- Lack of preparedness/awareness about the impact of pending changes to existing HCBS programs
- Shortage in psychiatrists, nurse practitioners, therapists and paraprofessional staff due to high work demand and low salary.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Prepare behavioral healthcare providers and the community for systemic change of health care reform, Medicaid Redesign and DSRIP.

- Assist local providers with readiness to change to a managed care environment.
- Encourage providers to seek collaborative opportunities to reduce fixed costs and maximize resources.
- Engage in dialogue with providers, health homes, MCOs, DISCO's and state agencies to participate in planning and implementation of managed care.
- County will participate in the development of local PPS networks.

Priority (Rank #2): Maximize and/or develop safe and affordable housing opportunities across the age continuum.

- Explore the development of a single site, residential program for youth in transition to include wrap around mental health services when relevant.
- Fully implement a mental health community residence/SRO facility.
- Advocate for more forensic beds for individuals being released from prison with mental health diagnoses.
- Explore funding options for additional independent housing generic supported beds for those without financial supports.

Priority (Rank #3): Enhance crisis services.

- Train up to 50 local law enforcement offices in Emotionally Disturbed Persons Response Team (EDPRT).
- Develop an innovative/alternative peer recovery support model that compliments existing crisis services.
- Encourage the development of crisis residential opportunities for individuals of all ages.
- Improve coordination between ERs/EDs and CDPC Crisis Unit.

Priority (Rank #4): Maintain current services and enhance/increase treatment access and capacity where gaps have been identified.

- Increase mental health outpatient clinic treatment capacity across the age continuum.
- Continue to build upon existing peer support services that address needs of individuals who may not benefit from PROS and/or who need additional supports in the community.
- Develop services in rural parts of Albany County to address emerging needs.

Priority (Rank #5): Develop community-wide interventions that include education, prevention and treatment efforts to address emerging behavioral health conditions.

- Collaborate with Albany County Department of Health, OMH and mental health providers to explore and implement evidence based interventions to reduce tobacco use.
- Collaborate with OMH and the Suicide Prevention Center to advance local actions to reduce suicide attempts/ suicide and promote the recovery of persons affected by suicide.

Other unranked priorities include:

- Enhance the quality of screening, treatment and care (integrated care, trauma-informed care, health homes, jail mental health, Sequential Intercept Mapping).
- Peer services, advocacy councils and recovery coaches will be more fully integrated.
- Develop and/or enhance access to treatment services for special populations.

LGU: Allegany County **RPC Region: Western New York**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention services.**
Adult	**Access to prevention services and transportation.**
Local vs. Regional	**The LGU did not identify any regional high or moderate needs.**

- High need for preventative and crisis services due to poverty in the area and the county's rural geography.
- Limited access to and great distances between communities where services are offered.
- Small public transportation system within the county.
- Care managers are not able to assist individuals as often with transportation due to increased case loads.
- The new Medicaid Transportation System is very unreliable and difficult to access.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Expand and increase the use of available mental health services to individuals in Allegany County.

- Counseling Center staff to utilize State initiatives available to them for increased training to improve the availability of evidenced based treatment.
- Expand new programs that are currently offered.
- Ensure successful implementation of new programs such as intensive intervention services, home and community based interventions (HBCI) and children's HH.

Priority (Rank #2): Enhance services for those with co-occurring disorders.

- Increase the number of providers who have been trained in an evidence based method of treating individuals with co-occurring disorders.

Priority (Rank #3): Increase the identification and coordinated treatment of mental health disorders among individuals with developmental disabilities.

- Increase the number of people with intellectual and other developmental disabilities who are participating in well-coordinated integrated treatment for mental health disorders such as, behavior support staff involved in life planning meetings, direct communication between line staff and medication prescribers, and a referral process that reduces duplication of, and fills gaps in, services.

Priority (Rank #4): Allegany County Suicide Prevention Coalition to reduce the incidences of fatal and non-fatal suicide behaviors by providing leadership and networking support to address /identify needs and gaps in services through program development/expansion and service coordination.

- Implement training for recognition of at-risk behaviors and appropriate responses to a variety of audiences.
- Increase partnerships dedicated to implementation and sustaining the Allegany County Suicide Prevention Coalition.
- A part-time Project Coordinator was hired and is leading these efforts.

Priority (Rank #5): Increase access to services.

- Implement/integrate the Individual Placement & Support (IPS) model to be monitored and assessed for fidelity adherence monthly by ARA PROS and Allegany ARC through monthly case conference meetings. The fidelity rating methods included in the IPS model will be observed.

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LGU: Broome County **RPC Region: Southern Tier**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Coordination/integration with other systems.**
Adult	**Access to transportation.**
Local vs. Regional	**Access to crisis and treatment services were identified as regional high needs for both populations.**

- Bus routes have been cut due to funding issues and bus ticket costs have risen to unaffordable amounts.
- Some routes are long and tedious for access to needed services (e.g. routes from Endicott to Binghamton take over an hour).
- Medicaid transportation system has been delegated to the State and consumers are finding it a difficult process.
- Limiting State regulations and lack of additional funding has increased the need for coordination/integration with other systems.
- Funding has been pulled back and converted to Medicaid dollars, and the regulations then often preclude people receiving the services they need.
- With the MRT, clients must have high Medicaid costs to access supportive services such as Health Home. If clients do not have a certain threshold of monetary expenses, they don't qualify for certain services.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Coordination with law enforcement, the community/schools and medical professionals to address the heroin/opioid epidemic.

- Involvement in the Community Coalition.
- Broome Opioid Abuse Council to coordinate efforts with law enforcement, community/school, educating medical professional, monitor treatment, prevention and harm reduction programs.
- Increase resources, access to treatment, prevention, and harm reduction.
- Enhance existing services.

Priority (Rank #2): Increase service options and improve coordination between OMH, OASAS and OPWDD services for adults and children in the areas of co-occurring disorders, forensic, geriatric and veteran services.

- Retain/recruit psychiatrists and psychiatric nurse practitioners to provide necessary services.
- Identify barriers and gaps in services to reduce wait times for various treatments and support services for children and adults with mental health, substance abuse and developmental disabilities and co-occurring disorders.
- Provide specific supports such as more timely access to children's SPOA services.
- OMH licensed outpatient clinics will provide five day priority access to referrals from inpatient psychiatric units, CPEP and corrections.
- Expand community partnerships including utilizing peer services, advocacy councils and recovery coaches while looking for other funding opportunities to enhance services.
- Develop community resources for individuals leaving State institutional settings that are downsizing and closing.
- Improve coordination of services for individuals who require both OPWDD and OMH services.

Priority (Rank #3): Identify the various types of safe and affordable housing.

- The county service board subcommittees, agency provider workgroups and other stakeholders will explore housing options being used in other communities.

Priority (Rank #4): Support community efforts of planning and integration of primary care and behavioral health.

- Participate in the planning and development of the regional DSRIP.

Priority (Rank #5): Increase opportunities for community education and advocacy efforts that promote recovery, productivity and social connectedness.

- Increase awareness of networking opportunities and resources.

Other unranked priorities include:

- Training and education resources provided to the community in their role as providers of care.

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LGU: Cattaraugus County **RPC Region: Western New York**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis services, supported housing, transportation, HCBS, workforce recruitment/retention and coordination/integration with other systems.**
Adult	**Access to crisis services, supported housing, transportation, HCBS, workforce recruitment/retention and coordination/integration with other systems.**
Local vs. Regional	**Regional high needs identified by the LGU were access to crisis services, supported housing, transportation and HCBS for both populations, which were all identified as local high needs.**

- Lack of county based crisis services. All crisis services for youth are provided through WNYCPC. Mobile Intervention Team is based out of northern Erie County and is too far away to provide immediate crisis intervention to youth.
- No crisis respite for youth or adults, and no HCBS respite for children.
- Lack of supported housing for youth/children.
- Limited specialized housing options and many individuals are being placed in housing levels that do not adequately meet their needs.
- Increasing number of homeless transition age youth (18-21) with limited daily living skills.
- Waitlists tend to be long despite the increase in the number of OMH supported housing slots.
- Limited transportation/taxi services even in areas where the population is more condensed (near Olean and Salamanca).
- Limited or no public transportation available for the outlying villages and towns.
- Locally based HCBS units are capped and have long waitlists. MIT HCBS services are distant and are not always available when the immediate crisis is happening.
- Service recipients need more education about using available "self-supports" that are not traditionally accessed.
- Lack of education around the benefits employment has on recovery.
- Lack of coordination has led to limited referral resources for transitional services such as transition age youth services, incarceration/rehab to the community transition, and inpatient to outpatient transition.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Identify, engage, and successfully treat individuals addicted to opioids and heroin through a multisystem approach.

- Ensure access to Narcan Kits.
- Train friends and family to administer Narcan Kits in nasal format.
- Institute policies that will attempt to engage individuals into treatment following the use of Narcan.
- Continue to meet with multiple service systems to strategize ways to achieve the goals or ongoing actions.
- Work with other counties in the Western and Finger Lakes regions to develop inpatient opioid treatment resources.

Priority (Rank #2): Provide person-centered/recovery-oriented services for consumers with mental health, addiction, and/or developmental disability challenges.

- Develop an Integrated Recovery Center with funding from OMH, OASAS and OPWDD. Funding is already secured from OMH.
- Continue to have regular Recovery Task Force Meetings to work on implementation of action plan, established to enhance recovery oriented services, such as WHEET (Wellness, Housing, Employment, Empowerment, and Transportation).
- Increase employability through programs such as PROS, The Rehab Center, Probation, and the Recovery Center.
- Increase employability through programs in Directions in Independent Living and Suburban Adult Services, Inc.

- Provide training for individuals, families and peers to develop the skills needed to advocate, self-direct and receive supports in the community in such programs as Southern Tier Recovery Activities Without Walls and Directions in Independent Living, and Council on Addiction Recovery Services.
- Creatively support individuals with developmental disabilities to move to less restrictive settings.
- Provide community education and media campaigns to increase awareness of treatment options for mental health issues.
- Enhance the county's crisis services by developing alternatives to the Emergency Department.
- Create a "Day-Hab Without Walls" for the developmental disabilities population that is similar to the Recovery Center model.

Priority (Rank #3): Improve integration of behavioral health and physical health.

- Develop mental health satellite clinics in primary care health offices.
- Independent Living is to offer more wellness self-management groups.

Priority (Rank #4): To offset the closing of hospital beds and fewer options for residential or inpatient treatment, ensure services are available in the community.

- Merge the Cattaraugus County PROS and the Rehabilitation Center CDT program.
- Develop emergency respite services for youth in crisis.
- As this option becomes available, transition children's targeted case management program to a Health Home model for children.

LGU: Cayuga County **RPC Region: Central**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to supported housing, transportation and workforce recruitment/retention.**
Adult	**Access to supported housing, transportation and workforce recruitment/retention.**
Local vs. Regional	**All local high needs were also identified as regional high needs.**

- Lack of safe, affordable housing has led to increased homelessness within the MH and CD population (48 currently people living in hotels).
- Limited public transportation in the city due to rural geographic layout.
- Current workforce is unprepared to work in an integrated, managed care, outcome driven system due to lack of integrated training in previous years.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Build and/or increase community competencies by using elements of a public health model.

- Continue training law enforcement on effective strategies for responding to individuals in psychiatric and/or substance abuse crisis or who have a developmental disability.
- Collaborate with Cayuga County Health Department and alcoholism/substance abuse service providers to deliver education and prevention around opiate addiction.
- Formalize the work done in the Youth Suicide Prevention Steering Committee, institutionalizing ED diversion and tracking and the use of the Columbia Suicide Severity Rating Scale (CSSRS).
- Continue to deploy Mental Health First Aid Training.
- Administration of child early identification screening measures in schools and pediatric offices.
- Maintain a Prevention Coalition.

Priority (Rank #2): Improve access to safe and affordable housing.

- Unity House continues to develop mixed use housing.
- Analyze consumers LOS in all disabilities housing to explore stepping down to other housing.
- Increase/market formal and information respite opportunities.
- Advocate for a "Housing First" model.

Priority (Rank #3): Promote and support the development of an integrated recovery based service delivery system.

- Solicit greater consumer/peer participation in the planning process as well as in service delivery
- Integration of the Columbia Suicide Severity Rating Scale (CSSRS).
- Training and technical assistance to develop comm. competencies in person centered planning.
- Use data develop a targeted intervention strategy for persons using the most care and getting the worse outcomes.
- Evaluate current services and identify program or system changes as well as identify training opportunities to increase competencies in recovery oriented practices.
- Operationalize System of Care principles and create 'single door' entry for services for children and adults by braiding funding streams and including youth and family into planning.
- Begin integration of behavioral health and physical health services through co-location in clinics and primary care.
- Promote speedy access to OASAS clinics.

Priority (Rank #4): Help position the mental hygiene treatment community to manage the program and fiscal shift required by managed care.

- Continue to promote the CLMHD white paper on the Local Governmental Unit Role.
- Continue participation with the 5 County Mental Hygiene Services Planning Group.

- Encourage providers to seek collaboration/integration opportunities.
- Develop and implement a Regional Planning Consortium.

Priority (Rank #5): Continue supporting and developing a sustainable quality, comprehensive system of care that meets the complex needs of all consumers

- Continually identify and use appropriate data sources to inform decisions and planning.
- Develop/integrate peer support in care management and other rehabilitative services.
- Expand peer services, transform both SPOA processes to involve more cross-systems representation.
- Continue to expand the identification of health home eligible individuals and work with health homes to increase capacity in the Community Mental Health Center offers same day services.
- Develop non-traditional respite opportunities.
- Continue to deliver geriatric services and to provide support to nursing homes, adult homes, senior citizen housing and seniors living at home.
- Redeploy OMH grant resources into primary care settings.
- Establish a satellite office in a primary care setting to serve seniors.
- Improve inpatient transition to ambulatory care through better coordination.
- Warm handoffs and responsive service delivery.
- Continue to encourage collaboration between service providers and the criminal justice and family court systems.
- Evaluate the current availability of transportation services.
- Increase evening and weekend activities for individuals with developmental disabilities.

LGU: Chautauqua County **RPC Region: Western New York**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention and treatment services, supported housing, transportation, HCBS and workforce recruitment/retention.**
Adult	**Access to supported housing, transportation and workforce recruitment/retention.**
Local vs. Regional	**The LGU did not identify any regional high or moderate needs.**

- Lack of behavioral health, HCBS and child psychiatry for children with mental health difficulties.
- Insufficient supply of safe and affordable housing, especially for inmates leaving the County Jail and transition age youth.
- The majority of the county is rural, and the lack of transportation is an ongoing barrier to service access.
- OMH housing providers do not receive levels of reimbursement currently to offer salary and benefit packages to staff that entice and retain employees.
- Availability of that staff is another barrier because it is difficult to draw professionals to live in rural areas.
- Shortage of psychiatrists, primary care physicians, nurse practitioners and physician assistants, licensed social workers and counselors and registered nurses.
- Urban areas offer salary packages and bonuses that the county cannot match.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Create a seamless, coordinated, integrated outcome based system of care for children.

- Expand the use of high fidelity wrap around as the care coordination model of choice.
- Enhance alternatives in crisis response.
- Enhance collaboration with pediatricians and primary care practices.
- Develop respite alternatives for children and their families.
- Expand the number of community based partners participating in the realist evaluation of services.
- Imbed family support partners in emergency departments and inpatient units of local hospitals.

Priority (Rank #2): Create a seamless, coordinated, integrated outcome based system of care for adults.

- Implement a health home model that is accessible to qualifying residents regardless of where they live in the community.
- Enhance the crisis response system to reduce the number of hospital emergency department evaluations.
- Implement a peer run respite house.
- Expand and enhance the roles of peers throughout the system of care.
- Expand the availability of safe and affordable housing.
- Secure additional prescribers including psychiatrists.

Priority (Rank #3): Reduce deaths and number of residents addicted to opiates and other substances.

- Continue the work of the Steering Committee to develop a comprehensive strategy.
- Create local detox options that include both an inpatient and outpatient program.
- Develop and implement a plan to meet the housing needs of those seeking and in recovery.
- Continue to make Narcan available to first responders, families and consumers.
- Develop a program to address the needs of incarcerated inmates with addiction both during incarceration and during their transition back into the community.
- Continue to engage prescribers and the public in an ongoing dialogue of the dangers of prescription pain killers.
- Explore the feasibility of establishing a 90 day residential rehab program.

Priority (Rank #4): Strengthen preventative services for children and families.

- Expand the number of schools using the Michigan Model curriculum.
- Continue to expand annually the number of children screened by the early recognition and early identification programs.

- Expand the number of schools that are implementing positive behavior interventions and supports.
- Expand the first county wide suicide prevention campaign targeted to both youth and adults.
- Continue Chautauqua Alcoholism and Substance Abuse Council's community education and media campaign.

Priority (Rank #5): Prepare service delivery system for successful transition to and participation in the transforming environment.

- Educate partners about delivery system changes coming over the next three years.
- Assist partners with readiness so that they can thrive through these changes.

LGU: Chemung County **RPC Region: Finger Lakes**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**The LGU did not identify any high needs.**
Adult	**Workforce recruitment and retention.**
Local vs. Regional	**The only regional high need identified was workforce recruitment/retention for the youth population.**

- Lack of available psychiatry services, prescribers, and child psychiatrists, countywide and regionally.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Address the significant housing shortage for individuals with disabilities.

- Develop new housing options that are not licensed or funded by any of the three state agencies.
- Evaluate needs of individuals currently in licensed housing programs across the disabilities.
- Assist with all necessary components of moving individuals identified as ready for transition into less restrictive environments.
- Develop strategy for understanding and addressing hoarding.

Priority (Rank #2): Prepare the community to be informed and proactive in the approach to systemic changes.

- Continue to use the Medicaid Redesign Council to address issues related to the statewide MRT.
- Continue work that was started under Systems of Care regarding system wide changes to children services that also support DSRIP efforts.

Priority (Rank #3): Utilize all resources to maximize available capacities in the system that addresses unmet service needs.

- All behavioral staff at St. Joseph's Hospital will complete FIT training.
- Arnot Ogden Medical Services and Southern Tier Pediatrics in partnership with behavioral health providers will provide mental health and substance abuse assessment within 5 business day to at least 80% of individuals referred to the practice.
- Evaluate opportunities in the community for enhanced coordination and collaboration to decrease hospital presentations and admissions by 25% and to increase access and utilization of services by at least 25%.
- Address avoidable hospitalizations through implementation of the Southern Tier Transformation Plan.
- Explore expansion of school based clinics.

Priority (Rank #4): Address unmet needs of youth across all disabilities in a comprehensive, integrated manner.

- Decrease length of stay in respite programs by 5% for youth with mental illness.
- The developmental disability committee will make formal recommendation for any modifications to the respite program.
- Identify and address unmet needs for individuals with autism or on the autism spectrum.

Priority (Rank #5): Universally focus on expanded prevention efforts.

- The community substance abuse agency, Trinity of Chemung will present training to agencies, schools and the community with a focus on the drug of choice for the majority of users, and on drugs that are dramatically rising in use.
- Work with various stakeholders to develop comprehensive prevention and treatment efforts in addressing the opioid epidemic.
- Work collaboratively with all county departments to initiate a 'county plan' that doesn't exist in silos defined by the licensing/funding state organizations.

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LGU: Chenango County **RPC Region: Southern Tier**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to treatment services and coordination/integration with other systems.**
Adult	**Access to treatment services, workforce recruitment/retention and coordination/ integration with other systems.**
Local vs. Regional	**The local high needs identified above are identical to the regional high needs identified by the LGU**

- Shortage of psychiatric resources pose a challenge, both locally and regionally.
- Meaningful employment remains a challenge for individuals with a mental disability who are living in the community. Beginning to explore options across county lines.
- Multiple changes are occurring across various systems that serve people with disabilities, and it is necessary to work across these systems to meet the needs of individuals with mental disabilities.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Improve access to efficient and effective outpatient behavioral health services.

- Offer same day or next day appointment.
- Improve screening process to assure appropriate access.
- Implement strategies to identify individuals who are considered 'high risk' or 'high need' and prioritize.
- Address transportation barriers.
- As part of the move into a managed care environment, ensure timely access despite delays from pre-authorization from the payer.

Priority (Rank #2): Increase residential opportunities in the community.

- Explore housing needs and opportunities through working with OMH and OASAS Field Offices, Broome Central NY DDSO and DDRO.
- Develop a clean and sober option for those coming out of inpatient rehab or the local county jail.
- Actively participate in the monthly Homeless Coalition meetings.
- It is important for community providers to collaborate with Bassett Health Home.

Priority (Rank #3): Improve crisis services and supports for individuals who are experiencing a behavioral health crisis and who are dually diagnosed or triply diagnosed.

- Provide cross-system training.
- Improve communication and coordination across systems.
- Planning for the needs of individuals who are dually or triply diagnosed at the monthly collaborative meeting involving the OMH Field Office, Broome DDSO, County Directors, UHS and Bassett Hospital.
- Develop strategies to better meet the needs of individuals and family members who are dealing with opioid addiction.

Priority (Rank #4): Improve scope of prevention program.

- Restore school-based prevention worker positions.
- Expand capacity to provide prevention services employing evidenced based environmental strategies.
- Explore the development of a prevention coalition to address substance abuse.
- Increase referrals of adolescents and young adults to for outpatient chemical abuse or addiction.
- Provide school-based prevention strategies for chemical abuse.
- Develop environmental prevention strategies for chemical abuse.

Priority (Rank #5): Coordinate care with mental health, developmental disabilities and chemical dependency providers in order to achieve overall physical health outcomes.

- Complete health screenings and monitor health throughout the course of treatment in outpatient mental health and chemical dependency outpatient clinics.
- Obtain and share information from medical providers.
- Transition from OMH Medicaid case management to care management through health homes.
- Review PSYCKES data and conduct case conferences for those identified as 'high users'.
- Early Recognition Screener will forge collaborative relationships with primary care providers.
- Consideration of behavioral health treatment in medical settings and of medical treatment in behavioral health settings.
- Promote wellness through efforts such as Wellness Self-Management, smoking cessation, exercise, weight control and health living habits.

Other unranked priorities include:

- Continue to improve the quality, efficiency and effectiveness of services.
- Improve system infrastructure and physical environments.
- Improve services and supports for individuals who have a mental disability, who are aging and living in the community.
- Improve cross-systems care for the mentally disabled.
- Improve ability to meet the needs of individuals who have court involvement.
- Improve employment opportunities in the community.

LGU: Clinton County **RPC Region: Adirondacks**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis services and transportation; workforce recruitment and retention.**
Adult	**Access to crisis services, supported housing, and transportation; workforce recruitment and retention; coordination/integration with other systems.**
Local vs. Regional	**All local needs identified above match with the regional needs identified by the LGU, with the exception of supported housing.**

- High ER utilization for psychiatric evaluations that could be curbed by diversion programs.
- Lack of transportation due to centralized Medicaid transportation services and reduced number of public transportation routes.
- An aging core of psychiatrists and a significant problem attracting MSW candidates.
- Lack of coordination between inpatient and outpatient behavioral health services and lack of coordination between primary care and BH services.
- Lack of quality housing.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): In partnership with the Adirondack Health Institute Preferred Provider System (AHI PPS), integration of behavioral health and health on a regional basis

- Utilize DSRIP funding to integrate primary care into BHSN's Center for Well Being.
- Utilize DSRIP funding to integrate behavioral health into seven primary care practices.
- Explore collaborative arrangement for psychiatrists consulting in primary care practices.
- Integrated primary care and behavioral health are sensitive to senior citizens.

Priority (Rank #2): In partnership with AHI PPS, ambulatory detoxification services are integrated on a regional basis

- Utilize DSRIP funding to establish ambulatory detox and respite services.
- Support the integration of recovery coaches into outreach, engagement, treatment and support services.

Priority (Rank #3): In partnership with AHI PPS, integration of crisis stabilization services on a regional basis

- Utilize DSRIP funding to establish mental health crisis stabilization services co-located with ambulatory detoxification program within the county.

Priority (Rank #4): An interdisciplinary action plan is developed to reduce the impact of heroin/opiate use

- Provide local training on SBIRT.
- Training on Narcan.
- Orient schools, families and professionals to the needle exchange program.
- Glamorize recovery through a public awareness campaign.

Priority (Rank #5): Fortification of a transportation system that supports service recipients in following through with outpatient physical and behavioral health

- Public education to Clinton County Public Transit.
- Explore funding opportunities.

Other unranked priorities include:

- A Zero-Suicide system-wide approach to suicide prevention is adopted by the community.
- Developmental disability services will work collaboratively with mental health and addiction providers.
- Affordable, quality housing and the continuum of housing opportunities is enhanced through collaboration with the Clinton County Housing Coalition.
- Current technology is utilized to enhance knowledge of behavioral health service.
- Behavioral health workforce is boosted.

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LGU: Columbia County **RPC Region: Capital Region**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to transportation, prevention and treatment services, and coordination/ integration with other systems.**
Adult	**Access to prevention, supported housing, transportation, and HCBS, and coordination/integration with other systems.**
Local vs. Regional	**Access to crisis services, workforce recruitment, and coordination/integration were identified as high regional needs for both populations. Regional needs mostly deviated from the local needs, with the exception of coordination/ integration with other systems—which was listed as a high local and regional need for both populations.**

- Very limited, if any, access to public transportation.
- A barrier to crisis service development is that State Aid funding permits only 2 FTEs to cover a 1,300 mile area for 12,000 residents, 7 days a week, 8 hours per day.
- Lack of non-Medicaid medical/nonmedical, and Medicaid non-medical transportation services are barriers to recovery and self-improvement (peers services, work education & socialization).
- Shortage in supportive/subsidized housing due to increased fair market rates, unavailable stock and stigma against mentally ill populations.
- High co-pays/deductibles for commercial plans pose unaffordable costs to clients and providers.
- Potential HCBS waiver providers (e.g. peer services) lack preparedness to bill Medicaid and comply with regulations.
- Lack of integration due to few financially affordable plans for providers, lack of incentive, and integration not being deemed as a "medically necessary" service.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Use a public health approach and strategies to discuss mental illness and addiction as chronic illnesses.

- Utilize PSYCKEs in the development and dissemination of county specific data to demonstrate the connection between mental health and addiction treatment and physical healthcare costs.
- The Mental Hygiene Network will identify and partner with the medical field to usher in the use of evidence based screenings such as SBIRT, suicide prevention and/or depression scales in emergency departments, primary care, schools, etc.
- Mental health and substance abuse service providers will partner with physical healthcare providers to improve outcomes with such as DSRIP PPS.

Priority (Rank #2): Pursue the development of residential opportunities with flexible, person centered services to support and encourage independence and community inclusion.

- Examine the various permanent housing models which are available.
- Incorporate local need for hospital diversion and sub-acute care into housing plans.

Priority (Rank #3): Environmental prevention strategies will raise awareness, educate and support the community in addressing identified risk and protective factors and local concerns.

- Expand efforts of the Controlled Substance Awareness Task Force Prevention workgroup to inform the community of issues such as prescription drug abuse, adverse childhood experiences (ACEs), and fetal alcohol syndrome.

Priority (Rank #4): Form a task force to develop a solution focused plan designed to alleviate transportation barriers.

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LGU: Cortland County **RPC Region: Central**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis services and workforce recruitment/retention.**
Adult	**Access to crisis services, supported housing, transportation and workforce recruitment/retention.**
Local vs. Regional	**All local high needs were also identified as regional high needs.**

- Lack of access to community based crisis intervention services.
- Lack of safe and affordable housing options despite increased number of referrals and higher needs individuals moving into the community.
- Lack of emergency housing options and homeless shelters.
- Unreliable Medicaid transportation causing late arrival and no-show rates to increase.
- Reduction in transportation routes and services have made access to services difficult, especially for residents in outlying areas of the county.
- Resources must be expanded so that anticipated growing need for services can be met.
- Limited prescriber access, particularly for children.
- Inability to recruit and retain staff due to increased caseloads, level of acuity of those being served, and expectations related to productivity have all risen at a significantly faster pace than reimbursement for services.
- Lack of training in such evidence based practices as CBT and Trauma Informed Care.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Ensure that safe, affordable housing is available to all.

- Participate in monthly community homeless and housing task force meetings.
- Develop enhanced capacity to respond to emergency housing needs with systems partners.
- Engage, educate and support community providers and resources to encourage them to become information portals to community services.
- Support Catholic Charities of Cortland Co. with planning/development of the River Street Project.

Priority (Rank #2): Develop capacity to respond more immediately with BH assessment and supports.

- Expand and support the Emotionally Disturbed Person Response Team
- Enhance coordination between community providers and Cortland Regional Medical Center emergency department and psychiatric unit regarding "high needs" youth and adults.
- Standardize community use of the Columbia Suicide Severity Rating Scale to support effective communication, coordination and planning for services recipient needs.
- Develop and expand community based crisis response services in collaboration with the Care Compass Network PPS.
- Support the ongoing development of the Community Trauma Response Team.

Priority (Rank #3): Ensure access to care that is timely and effective through the LGU role in the oversight, management, and implementation of BH plans and services to residents across all three BH systems.

- Advocate with OMH, OASAS, OPWDD to obtain meaningful and timely data and statistics on the regional and local level that helps identify service utilization, access issues and other information necessary to achieve stated priority.
- Create a "No Wrong Door" that is capable of outreach to vulnerable populations, utilizes standardized assessment to determine eligibility for services, connects to appropriate services and monitors engagement with and outcomes to care
- Provide local leadership and participation in regional planning, DSRIP, managed care implementation and health homes
- Increase capacity for early identification of BH needs, connectivity and linkage to community based BH services.

- Fully operationalize protocols for transitions for youth and adults.
- Continue to work with community partners to assess and document the impact of funding changes related to public transportation.
- Reconfigure SPOA process for adults and for children to identify and ensure outreach “high needs” populations to promote referral and engagement.

Priority (Rank #4): Support the coordination and development of vocational services and supports that allow for individuals to participate in meaningful activities in the most integrated setting.

- Work with business community and BH providers to expand pre/employment services and integrated competitive employment opportunities.
- Promote cross systems coordination to efficiently link/utilize existing vocational supports.
- Identify/engage “high risk” and underserved populations to connect them to vocational services with the appropriate supports to encourage success.

Priority (Rank #5): Plan a comprehensive strategy to address the issues of opioid and other drug use, through prevention, treatment, and crisis intervention.

- Partner with the Cortland Area Communities that Care to implement the NY Strategic Prevention Framework State Incentive Grant Partnership with Success.
- Promote/support community chemical abuse prevention efforts and education.
- Promote/support the implementation of community chemical abuse harm reduction strategies.
- Encourage, develop and/or enhance community treatment resources to more immediately respond to treatment needs with the appropriate level of care.
- Promote/develop supports to manage emergent crisis needs through the provision of Narcan training, access to detoxification opportunities.
- Timely access to inpatient treatment, and advocacy for insurance companies to pay for clinically necessary treatment.

LGU: Delaware County **RPC Region: Southern Tier**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention and crisis services, transportation and workforce recruitment/retention.**
Adult	**Access to prevention services, transportation, workforce recruitment/retention and coordination/integration with other systems.**
Local vs. Regional	**Regional high needs identified by the LGU were workforce recruitment and retention for both populations.**

- Minimal resources available for community education around wellness and healthy living choices.
- Lack of crisis respite beds for children under 12 years old, and only one regional community residence with a crisis respite bed component for adolescents over 12 years old.
- No public transportation system, and travel from one end of county to the other is close to 2 hours on secondary and tertiary roads during the winter months.
- Not enough qualified staff across all disability areas of care.
- The percentage of the geriatric residents living in the county exceeds the NYS average. This population does not engage with treatment providers due to a variety of barriers including transportation, isolation, and stigma.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): The response to the opiate epidemic will involve a multi-level approach to prevention, treatment and recovery.

- The county heroin and opiate task force will support a variety of community education initiatives and encourage community coalition development.
- Implementation of evidenced based practices in substance abuse treatment programs.
- Develop county wide strategies to encourage increased access for addiction medicine as well as comprehensive community access to Narcan.

Priority (Rank #2): The Mental Health Department will have patient centered and integrated operations.

- Community Services will partner with DSRIP PPS to explore opportunities for integrative models of care with local hospitals and primary care in the community.
- Community stakeholders will be involved in a transparent process to determine relocation site for Mental Health Department.

Priority (Rank #3): A county wide cross system approach to suicide prevention.

- The county wide suicide prevention coalition will continue to strengthen/develop interventions and initiatives that are data driven and will include primary care, schools, veterans and other community stakeholders.
- Community Services will partner with public health, office of aging, law enforcement, schools and other community advocates to develop outreach mechanisms and early identification.
- Stakeholders will explore grant opportunities to increase professional and community wide trainings as well as explore harm reduction opportunities.

Priority (Rank #4): County will have a well-trained health professional workforce.

- Community Services will partner with Binghamton University, Decker School of Nursing and SUNY Delhi nursing program as well as other nursing institutions to promote nursing as a career and increase visibility of nurse practitioner program.
- Regional initiatives as well as local partnerships will be explored regarding developed telehealth and telepsychiatry programs.
- Advocate for opportunities to recruit and retain health professionals and paraprofessional.
- Explore partnerships with Binghamton and Albany Universities and other professional schools.
- All disability agencies will partner to develop marketing strategies in attracting and maintaining a sustainable workforce.

Priority (Rank #5): Improve population health efforts by supporting strong prevention and engagement networks.

- The substance abuse prevention agency, Stop DWI, Youth Bureau, and other prevention advocates will partner with schools, youth leadership groups, and other community stakeholders to support and implement evidence based practices and interventions around critical community issues such as suicide, violence and other issues affecting youth.
- Community stakeholders, including public health and mental health/substance abuse professionals, will develop an action plan for implementing the CHIP plan.
- Active involvement with the southern Tier PHIP

Other unranked priorities include:

- Collaboration across primary care, behavioral health, and developmental disability systems.
- Increase accessibility and availability of addiction recovery support services.
- Adequate and appropriate community supports, including housing respite, and transportation.
- Access to peer support mental health services.

LGU: Dutchess County **RPC Region: Mid-Hudson**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention, crisis and other support, transportation, supported housing and HCBS.**
Adult	**Access to prevention, supported housing, transportation and HCBS.**
Local vs. Regional	**The LGU identified that the local high needs listed above were also recognized as regional high needs.**

- Increased demand, but lack of funding, for youth outpatient services and housing due to decreased inpatient capacity.
- Lack of transportation to inpatient youth programs for families interested in participating in recovery programs, and for outpatient after school programs.
- Lack of peer support, family support and mentoring programs.
- Lack of other support services such as recreational opportunities w/transport, pro-social activities and work readiness education.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Promote/build emotional wellness and prevent the onset of MH/SA symptoms.

- Implement SAMSHA Strategic Prevention Framework model.
- Promote use of evidence based programs in schools that address risk and protective factors.
- Explore community readiness for coalition development (Central Dutchess), train in the Strategic Prevention Framework (Eastern).
- Complete community assessment, create a strategic action plan and identify at least two environmental strategies for implementation (Northern).
- Develop/implement strategy to decrease prescription opiate drug misuse by 5%.
- Develop/implement suicide prevention strategy targeting youth and veterans.
- Use "Texting for Teens" and "chatting" methods of communication in HELPLINE.
- Initiate Mental Health First Aid Training and offer Crisis Intervention Training.
- Train all ED staff at Mid-Hudson Regional and Vassar Brothers Hospitals in SBIRT.
- Continued promotion of Narcan use to community members, families, youth, law enforcement and first responders.
- SBIRT and Teen Intervene training in primary care settings.

Priority (Rank #2): All MH, CD and ID/DD services should be sufficiently accessible, evidence based and meet quality of care standards.

- The LGU and BH providers will ensure that services meet the needs of the population throughout the systemic changes such as managed care, health homes and DSRIP.
- Explore funding availability for HCBS Waiver to enhance the network of community services.
- Collaborate with OPWDD and Mid-Hudson Regional Hospital to develop a crisis supports strategy to divert DD individuals from hospitalization and/or incarceration.
- Create a Crisis Stabilization and Wellness Center that provides 24 hour urgent care BH services.
- Enhance/expand diversion services for youth and adults to reduce IP hospitalization and length of stay.
- Develop inpatient psychiatric beds for adolescents.
- Use of integrated and trauma informed assessments in BH settings.
- BH providers will identify the two most prevalent chronic physical diseases within this population and develop comprehensive wellness treatment plans.
- Training opportunities to improve skills in a variety of recognized practice areas.
- Meet the identified need of school referrals for elementary age youth who need behavioral support (Rockland PC will add an additional elementary school class).

Priority (Rank #3): Increase the number of persons successfully managing their mental illness, addiction and intellectual/developmental disability within a recovery oriented system of care.

- Add 20 supportive apartment beds for individuals in recovery from mental illness and/or CD.
- Seek funding for short term transitional housing for persons who are homeless (youth and adults), recently discharged from jail/prison, recently dropped out of school, and transition age youth.
- Seek funding for increased crisis respite opportunities
- Develop a community housing and treatment strategy that is safe, affordable and supports long term recovery for individuals who are mentally ill and chemically dependent.
- Seek funding for service dollars for necessary support services that are not otherwise funded.
- Encourage agencies serving individuals with ID/DD to develop integrated housing opportunities in communities.
- Implement peer services in the Mid-Hudson Regional Hospital Emergency Department.
- 10% increase in job opportunities for individuals with mental illness or chemical dependence.
- Increase Olmstead compliant job opportunities for individuals with ID/DDs.
- Develop a web-based parent resource directory to assist parents with finding available resources, understanding eligibility criteria, and building individual comprehensive supports/services.

LGU: Erie County **RPC Region: Western New York**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to treatment services, supported housing, and coordination/integration with other systems.**
Adult	**Access to supported housing and coordination with other systems.**
Local vs. Regional	**Regional high needs include, access to supported housing for the adult population and coordination/integration with other systems for both populations. Additionally, the LGU specified the unique high need of development/access/ analyzing data for both populations.**

- A need for community based, targeted and integrated treatment services for youth in the juvenile justice system who have serious emotional disturbance and/or substance use disorders.
- Lack of funding for treatment services for youth in the juvenile justice system. The barriers to this are abundant, with the top ones being regulations and funding resources.
- Lack of access to supportive housing for transition-aged youth.
- A need for stable, safe and appropriate community based housing for individuals with emotional and BH needs.
- Waitlists are long despite the additional OMH supported housing slots given to the county.
- Access to additional emergency homeless shelters are needed.
- Housing accessibility challenges are due to increasing rental costs in Buffalo and long length of stays preventing new individuals from accessing housing.
- Funding barriers, communication among providers and other systems, and access to services have prevented coordination and integration between systems.
- A need to integrate BH and physical health services in order to improve mental health, increase adherence to treatment, improve quality of life, and maximize resources.
- A need for universal MH screening during pediatric appointments to increase parent, youth, and primary care provider willingness to discuss MH, and to support patient and family engagement.
- Difficulty of coordinating care for those in health homes when working with individuals who may not be aware or may be poor historians.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Continue to prepare for conversion of Medicaid Fee for Service to Medicaid Managed Care for adult and children services.

- Engage in dialogue with providers, health homes, managed care organizations, and other county departments involved in the children's system of care and local/state NYS Mental Hygiene Offices regarding: identification of shared expectations, procedures and policies to best serve individuals; identification of collaborative opportunities to better integrate care and enhance access to services; improve behavioral health and physical health integration; provision of policies and procedures which best serve individuals, youth and families; prepare children's SPOA to support community service standards, coordination of services, and efficacy of practice.
- Use all available data sources (Salient, PSYCKES, and other) to identify individuals, and use the integrated SPOA to facilitate access to services for high risk individuals.
- Collaborate with providers to identify and take advantage of DSRIP opportunities, and use. evidenced based practices to promote engagement and appropriate quality services. (e.g. developing OMH service models targeted to individuals at their first psychotic break and emerging peer fidelity practices).
- Actively participate in RPC which addresses transformation challenges.

Priority (Rank #2): Expand access to housing, including housing which is non-licensed.

- The County has implemented a successful pilot initiative that seeks to have a normative length of stay in supported and/or supportive housing of six months while transitioning to successful independent housing with sustainable community tenure. The addition and full utilization of thirty-six supported housing beds targets inpatient residents from BPC and those discharged from Article 31 and 28 hospitals.
- Utilize/integrate critical time intervention models to increase access to housing.

- Solicit proposals through an RFP for existing supported housing services targeted to chronically homeless individuals.

Priority (Rank #3): Coordination/integration of other systems to better link high risk/high need children and youth to community based services.

- Identify risk behaviors at referral and addressing them in a timely and target fashion.
- Enhance the collaborative partnership between the child welfare system and providers of behavioral health service.
- Increase the number of satellite outpatient MH clinic treatment services in public schools through collaboration with county departments, the Buffalo public schools, SAY Yes, the Community Foundation, and providers, with the support of OMH and the County Dept. of Mental Health.
- Collaborate with local juvenile justice, MH partner and other system providers, and state level entities to support informed decisions regarding services provisions and service planning.
- The Department of Mental Health will keep abreast of new and trending information to optimize coordination/ integration in order to aid youth and families.
- Collaboration between Erie County Children's SPOA, health homes and the provider community to ensure appropriate access to services for identified youth.

Priority (Rank #4): Expand chemical dependency system treatment capacity and accessibility.

Other unranked priorities include:

- Risk mitigation and harm reduction for at risk and underserved populations.
- Better integrate BH and psychical health.
- Facilitate OPWDD, community providers, and Erie County workforce department collaboration to coordinate employment opportunities for direct support professionals and individuals with developmental disabilities.
- Focus on the OPWDD Transformation Agenda.

LGU: Essex County **RPC Region: Adirondacks**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention services and access to transportation.**
Adult	**Access to prevention services and access to transportation.**
Local vs. Regional	**Access to transportation and workforce recruitment were identified as high regional needs for both populations.**

- Very few county level public health initiatives to address mental health prevention.
- Low income population in a rural county with sparse population, public transportation is minimal (if at all available), and Medicaid transportation program is poorly managed.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Enhance integration of care.

- Integrate behavioral health and primary care to promote coordination of services.
- Promote expanded use of mental health and wellness screenings in primary care, other healthcare settings and schools.
- Increase the number of substance abuse and mental health clinicians trained to provide integrated care for co-occurring disorders.
- Increase the representation of medical health care and prevention on CSB and subcommittees.
- Identify and inventory barriers to providing services to dually diagnosed individuals.

Priority (Rank #2): Provide appropriate level of services and providers of behavioral health services that are readily accessible.

- Establish a plan to provide crisis stabilization services to include mobile crisis teams, ER diversion protocols and observation/stabilization units.
- Increase availability of respite services for children and families.

Priority (Rank #3): Increase availability of supportive/therapeutic housing for County residents.

- Secure sustainable funding to reestablish MHA's Intensive Supported Housing Pilot Project.
- Monitor initiatives to identify opportunities for development of sustainable housing programs.

Priority (Rank #4): Develop a plan to reduce the impact of the use of heroin/opiates.

- Participate in the Essex County Heroin/Opiate Coalition and the VT-NY Border County Workgroup.
- Establish a CSB workgroup to develop an action plan by the end of the first quarter of 2016.

Priority (Rank #5): Decrease the suicide rate.

- Collaborate with the NYS Suicide Prevention Initiative (NYSSPI) to provide training and technical support for local school districts.
- Collaborate with NYSSPI to provide gatekeeper and community training/education to stakeholders, service providers and community members.

Other unranked priorities include:

- Increase the understanding among consumers of the risks of regular marijuana use
- Increase consumer involvement in the local service system

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LGU: Franklin County **RPC Region: Adirondacks**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to transportation and workforce recruitment and retention.**
Adult	**Workforce recruitment and retention.**
Local vs. Regional	**Access to crisis and transportation services, and workforce recruitment/retention were identified as high regional need for both adult and youth populations.**

- Limited routes and hours of operation of public transportation, and ongoing challenges related to the Medicaid transportation.
- Shortage of psychiatrists, psychiatric nurse practitioners and licensed clinical social workers and has impacted access to services and wait time at local clinics.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Organize and strengthen collaborative partnerships between service systems.

- Franklin County will strengthen the continuum of care through the Youth and Adult SPOAs, Franklin County System of Care Advisory Council, Franklin County DSS and Berkshire Farms, Franklin County CPS, Citizen's Advocates, Community Connection, Adirondack Health Institute, Franklin County LSU, CSB and St. Lawrence Psychiatric Center and OMH Central Field Office, and SLPC Mobile Integration Team and the Franklin County CSB.

Priority (Rank #2): Develop a county wide cross systems approach to suicide prevention, intervention and postvention.

- The Franklin County Suicide Prevention Coalition will develop a comprehensive suicide prevention plan to serve communities and school districts through support of the American Foundation for Suicide Prevention Out of the Darkness Walks, Mental Health First Aid Training, Tri-County Regional Suicide Prevention Conference, a media strategy of education, the Franklin County Suicide Prevention Coalition, partnering with youth service organizations, and education for community agencies.

Priority (Rank #3): Insure transportation is available for consumers.

- Franklin County Community Services and Social Services will convene a group to clearly define areas of concern and create a strategy for resolution.

Priority (Rank #4): Create opportunities in the local communities for those in need of safe and affordable housing to include efficient transitional services upon discharge from regional hospitals.

- The creation of a continuum of housing services through the Franklin and Essex County Housing Coalition and Franklin County Homeless and High Risk Population Task Force, OMH Community Investment Supported Housing quarterly regional meetings, Community Connections, Lakeside House, St. Regis Mohawk Tribe and the Adirondack ARC.

Priority (Rank #5): Create and strengthen existing prevention and engagement strategies to promote overall wellness, recovery, and healthy communities.

- Continue countywide partnerships to advance prevention strategies through Franklin County Prevention Task Force, regional prevention providers' partnership on DSRIP Strengthen Mental Health and Substance Abuse Infrastructure Across Systems, and the Community Health Improvement Plan.

Other unranked priorities include:

- Franklin County providers will insure vocational training opportunities are available to those seeking supported employment.
- Individuals with developmental and/or psychiatric disabilities will learn how to effectively advocate for themselves.

- Franklin County residents will have timely and clinically appropriate access to care.
- The Franklin County CSB, subcommittees and providers will strategize and respond to system transformation as a result of Health Care Reform and Medicaid Redesign.
- Local providers recognize the need to collaborate and pool resources to insure ongoing education, training and professional development of staff.

LGU: Fulton County **RPC Region: Mohawk Valley**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention, crisis, treatment and other support services, supported housing, transportation, workforce recruitment/retention and coordination/ integration with other systems.**
Adult	**Access to prevention, crisis, and other support services, supported housing, transportation, HCBS, workforce recruitment/retention and coordination/ integration with other systems.**
Local vs. Regional	**The LGU did not identify any regional needs.**

- Prevention services are needed to educate the population given its rural, poor nature and its poorly educated population.
- Crisis services only exist through the County Correctional Facility due to the small population and the loss of state operated services for children and adults.
- Changes in reimbursement from FFS to managed care has reduced treatment services.
- The changes in supported housing guidelines has resulted in fewer supported housing opportunities, and now there are waiting lists for slots that were usually available.
- Lack of multi-county bus system and the local transportation systems is not available evenings or weekends. 45% of the population live outside of any public transportation.
- There are waiting lists for all home and community based services, and minimal existence of support and peer services.
- Lack of sufficient professionals in both primary and behavioral health services to serve the population.
- Barriers continue to exist between the State agencies that do not exist at the local level.
- Coordination/integration occurs between provider agencies from different systems, but services that are needed do not exist in rural areas.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): LGU will work with the two DSRIIP proposals in the county.

- Obtain Fulton County specific data from the regional BHO and the SMH Health home in order to focus on the high need/high cost individuals.

Priority (Rank #2): Implementation of a joint Director of Community Services for Fulton and Montgomery Counties.

- Proposal for joint DCS with budget to be presented to both Fulton and Montgomery Counties.

Priority (Rank #3): To develop a single room occupancy for individuals with a mental health diagnosis.

- Use any new supported housing slots to create a serviced enriched SRO.

Priority (Rank #4): The LGU will work to develop a local managed care system with the local ARC for individuals with developmental disabilities.

Priority (Rank #5): To identify what support services are needs for individuals with developmental disabilities to remain with their family of origin.

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LGU: Genesee County **RPC Region: Western New York**

Needs Assessment: The following areas were identified as "Moderate Need" for the local MH population.

Youth	**Access to prevention and treatment services, supported housing, transportation, HCBS workforce recruitment/retention, and coordination/integration with other systems.**
Adult	**Access to prevention and treatment services, supported housing, transportation, HCBS workforce recruitment/retention, and coordination/integration with other systems.**
Local vs. Regional	**Regional moderate needs are identical to the local moderate needs identified above.**

- Lack of funding and access to all services.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Provide ongoing updates and advice on strategies for assisting local providers in readiness for the change to managed care.

- Implement ongoing in-services and meetings specifically targeted towards managed care monitoring.

Priority (Rank #2): Implement integrated behavioral health and physical health.

- Genesee County Mental Health Services will devote an entire wing of its facility to integrated mental health, physical health and substance abuse services and will include a physical health practitioner within the service delivery team.

Priority (Rank #3): Enhanced service provision through peer support services.

- Collaborate with local providers and assist in directing patients to peer supports though the County Clinic, Day Opportunity Center and care management programs.

Priority (Rank #4): Genesee County Mental Health Services will provide referral to the START, which provides emergency treatment and respite strategies for individuals with intellectual disabilities.

- Provide referral to the START program.
- Track linkages for families/persons with intellectual disabilities to determine future trends.
- Due to limited availability of START, Genesee County Mental Health will also advocate for broader services for families.

Priority (Rank #5): Coordinated Care Services Inc. staff will work with the Dual Recovery Coordinator assigned to Genesee, Orleans and Wyoming Counties to coordinate trainings with the Clinical Director of Genesee County Mental Health Services.

- The goal is to train mental health and substance abuse clinicians over the next two years in trauma informed care.

Other unranked priorities include:

- Cross training for the dual diagnosed intellectual/mental health population.
- Establish supportive housing for substance abuse.
- Review use related to prescription substance abuse in Genesee County.

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LGU: Greene County **RPC Region: Capital Region**

Needs Assessment: The following areas were identified as "High Need" for the local MH population, unless otherwise indicated.

Youth	**Access to crisis services.**
Adult	**Access to crisis services.**
Local vs. Regional	**The LGU did not list any regional high needs, but identified regional moderate needs. These include, access to treatment services and supported housing for both populations.**

- A barrier to crisis service development is that State Aid funding permits only 2 FTEs to cover a 1,300 mile area for 12,000 residents, 7 days a week, 8 hours per day.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Safe, stable and affordable housing.

- Work with agencies who can apply for mixed housing grants to build or repurpose buildings. The mixed housing grant application to OMH was not successful.
- Raise awareness of housing needs in Greene County and seek blended funding opportunities and create housing plans that incorporate the need for hospital diversion and sub-acute care.

Priority (Rank #2): Improve transportation availability.

- The ARC of Ulster/Greene will use BIP to advance transportation system within the county.

Priority (Rank #3): Identify MH and addiction as chronic diseases using a public health lens.

- Use of the strengths and difficulties questionnaire (screen used as part of the Early Recognition and Screening grant) in all schools and other child serving entities.
- Coordination with Albany Medical Center DSRIP PPS to advance an integrated delivery system that focuses on the relationship between mental health and addiction treatment, and their connection to physical health and overall healthcare costs.
- Advocate for the use of SBIRT in Columbia Memorial Hospital ER and engage in a pilot program at 1 PCP office.

Priority (Rank #4): Advance the system of care approach to improve service outcomes for children, youth and families.

- Secure training for three parents to serve as peer partners using NY Success Innovations Grant.
- Use SPOA Tier I & II quarterly meetings as a vehicle to promote/build systems of care.
- Greene County MH will spearhead the effort to build a viable support group for parents of children with disabilities.
- Greene County MH will build a Youth Support Group that will provide opportunities for socialization, creativity, support and advocacy.
- Use Dr. Kazi's data analysis through the Children's System of Care to identify success interventions and outcomes.

Priority (Rank #5): Community education that highlights addiction as a chronic illness that can respond to treatment

- Expand efforts of the Columbia/Greene Controlled Substance Awareness Task Force which includes both a Prevention and Practice Guidelines Workgroup to inform the community, provide public education through community forums and involve treatment providers/prescribers in decision makers.
- Expand Greene County PAS It On, a new rapidly growing community based location organization created to reach Greene County residents and professionals. The mission is to raise awareness of serious issues surrounding substance use, promote prevention and provide solutions for those in need.
- Advocate with the six school districts to facilitate the completion of the PRIDE survey.

Other unranked priorities include:

- Enhance the coordination and integration of local OPWDD services within Greene County

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LGU: Hamilton County **RPC Region: Adirondacks**

Needs Assessment: The following areas were identified as "Moderate Need" for the local MH population, unless otherwise indicated.

Youth	**Access to crisis services, treatment services, transportation and other support services, and workforce recruitment and retention.**
Adult	**Access to prevention, crisis and treatment services, access to SH, transportation and other support services, and workforce recruitment and retention**
Local vs. Regional	**The LGU did not identify local high needs, but they identified regional high needs. These include access to crisis services, transportation and workforce recruitment/ retention for both populations, and coordination/integration with other systems for the adults.**

- Sparsely populated rural environment does not allow opportunities for community-based supports such as peer support groups and similar natural supports which impedes access to crisis and other support services.
- Lack of public transportation and unreliable Medicaid transportation services given isolated locations impact access to treatment.
- Lack of housing stock and grant stipulations for supported housing development require levels of housing that cannot be successfully supported in a rural area.
- Professional (and other) positions go unfilled for up to a year, and current programs that provide funds to support staff recruitment have too high a threshold with respect area need.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Develop financially viable program models for services in highly rural areas in coordination with OASAS, OMH, OPWDD and other relevant entities.

- Explore the impact of Medicaid Reform and develop strategies to maintain in-county behavioral health care providers. Specifically, recommendations for enhanced rates for highly rural areas and necessary waivers will be developed.

Priority (Rank #2): Improve access to services.

- Expansion of satellite sites, development of regulations for off-site billing, and support/funding for telepsychiatry. Recommendations for enhanced rates for highly rural areas and necessary waivers will be developed.

Priority (Rank #3): Facilitate cross-system collaboration between human services providers towards the creation of comprehensive service models.

- Utilize existing county initiatives that promote collaboration as examples of success, expansion of successful collaboration, and exploration of opportunities for comprehensive service approaches through collaboration.

Priority (Rank #4): Develop initiative to address staff recruitment and retention.

- County to identify and implement strategies, in conjunction with other county service providers, to promote staff recruitment and retention.

Priority (Rank #5): Implement evidence-based models of prevention, treatment and recovery among county service providers.

- Expectations, as set through county planning, and monitoring through programs reviews conducted by the Community Services CQI Committee.

Other unranked priorities include:

- Develop Suicide Prevention/Postvention Coalition.
- Develop peer support groups.
- Develop an array of services to meet the needs of the aging population.
- Development of an array of in-county programs to support children and adolescents at risk of out of home placement.
- Increase community awareness of consumer's needs and resources available to consumers and providers.
- Improve countywide awareness of disaster mental health services through the county's mental health program.
- Develop a coordinated mental health/developmental disabilities respite program.

LGU: Herkimer County **RPC Region: Mohawk Valley**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to treatment services, transportation, HCBS, workforce retention/ recruitment and coordination/integration with other systems.**
Adult	**Access to treatment services, transportation, HCBS, workforce retention/ recruitment and coordination/integration with other systems.**
Local vs. Regional	**The LGU did not identify any regional needs.**

- Few treatment providers in the area.
- This rural county lacks sufficient public transportation systems beyond the limited options available along the Valley Corridor.
- More home and community based services will make treatment more accessible to those who do not have transportation.
- The county has been designated as a Health Professional Shortage Area (HPSA), and recruitment/retention of qualified staff has been an ongoing issue.
- Financial constraints and dwindling resources make coordination/integration essential at a county level and across service delivery systems to identify, prioritize and address needs while maximizing resources.
- Cross systems needs have increasingly been identified that require a multi-service system response (i.e. mental health and juvenile justice systems).

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Implement new services and supports that will enhance the capacity for integrated care, improve accountability, increase communication among service providers and provide a greater focus on recovery-oriented services.

- Services and supports will be implemented and/or improved by the Herkimer Area Resource Center, Upstate Cerebral Palsy, a Suicide Prevention Community, the Herkimer County Prevention Council, the Herkimer County Community Services Board, IMPACT (a program of the Center for Family Life and Recovery), The Neighborhood Center's intensive case management program, the Leatherstocking Collaborative Health Partners Group, and the Beacon Centers.

Priority (Rank #2): Increase access and availability of services.

- Increase access and availability through the efforts of the Herkimer County Prevention Council, the Community Partnership Coalition of Herkimer County, the Individualized Support Services Program, the Herkimer Image Center, the UCP Medication Grant Program, Upstate Cerebral Palsy, and the Herkimer Area Resource Center.

Priority (Rank #3): Provide individualized services and person centered supports.

- Increase services and supports through the Eastern Region of Central New York DDSO Family Support Advisory Council, the Nichol's House Supportive Living residence, the Beacon Center, the Herkimer Image Center, the United Cerebral Palsy OMH supported housing program, the Herkimer County Mental Health Service, the Neighborhood Center, the Herkimer Area Resource Center, and the Center for Family Life and Recovery.

Priority (Rank #4): Develop housing alternatives for persons with disabilities and their families.

- These housing alternatives will be developed by Upstate Cerebral Palsy and the Herkimer Area Resource Center.

Priority (Rank #5): Develop, expand and enhance employment opportunities.

- These opportunities will be developed, expanded and enhanced by the Upstate Cerebral Palsy and the Herkimer Area Resource Center.

Other unranked priorities include:

- Provide support for families.
- Promote and protect health, safety and wellness.
- Develop and support quality staffing and operating procedures.

LGU: Jefferson County **RPC Region: Tug Hill Seaway**

Needs Assessment: The following areas were identified as "High Need" for the local MH population, unless otherwise indicated.

Youth	**Access to crisis services.**
Adult	**Access to crisis services.**
Local vs. Regional	**The LGU did not list any regional high needs, but identified regional moderate needs. These include, access to crisis and treatment services, transportation, and workforce recruitment/retention for both populations.**

- Need for a transitional or respite care center that would provide an alternative to ER hospitalization or incarceration for consumers in crisis situations.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Develop a short term residence for adolescents.

Priority (Rank #2): Address capacity for outpatient mental health services.

- Develop additional provider options and create satellite options to increase capacity.

Priority (Rank #3): Improve coordination of discharges from inpatient facilities to local providers

- Protocols will be established to provide for advance communication prior to discharge.

Priority (Rank #4): Provide services in collaboration with medical community.

- Work with medical community to provide care coordination with mental hygiene services by attending regular meeting with medical clinic providers group.
- Develop a care coordination certificate program in collaboration with the Fort Drum Regional Health Planning Organization and Jefferson Community College.

Priority (Rank #5): Improve housing options for both transitioning and permanent opportunities for all disability areas.

- Work with housing authorities, landlords, and others to collaborate on finding and maintaining needed housing for the disabled.
- Seek grant funds to support housing efforts and improvements.

Other unranked priorities include:

- Develop an Emergency Response Plan for the community to be available when mental health related incidents occur.
- Enhance recruitment and efforts for all disability efforts for staffing in all disability areas.
- Improve and enhance peer support services.
- Improve available crisis response services.
- Develop direct service providers training program.
- Work with legal system to avoid incarceration.

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LGU: Lewis County **RPC Region: Tug Hill Seaway**

Needs Assessment: The following areas were identified as "High Need" for the local MH population, unless otherwise indicated.

Youth	**The LGU did not identify any local high needs for youth.**
Adult	**Access to treatment services.**
Local vs. Regional	**The LGU did not list any regional high needs.**

- Lack of mental health professionals and a growing wait list in outpatient mental health clinic.
- Instability of services and staff retention challenges in the outpatient settings.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Ensure the continuity of care and increase access to residents.

- Provide education and outreach to local magistrates, county clergy, school districts, physicians and other service providers.
- Offer therapy in primary care offices throughout the county.
- Develop, distribute and maintain list of all behavioral health providers.
- Research access to detox facilities.
- Monitor changes in outpatient caseloads for the both and substance abuse services and mental health services.
- Improve care transitions for residents re-entering the community after inpatient stays.
- Identify barriers to access to care (financial, geographic, psychological, etc.).
- Improve access to ancillary services in the community, such as high school equivalency program, continuing education programs and heating assistance.
- Identify supports for families of developmental disability recipients.
- Provide peer support in jail and enhance transitions out of jail by increasing the number of referral to MICA and transition management programs.

Priority (Rank #2): Individuals will have timely and clinically appropriate access to behavioral health services.

- The LGU will work closely with the Northern Regional Center for Independent living, Transitional Living Services and the Behavioral Health and Wellness Center to assure that performance measures are being adequately met and consumers' needs are being addressed through provision of services.

Priority (Rank #3): Advance the understanding of DSRIP

- Seek out opportunities to further understand Health Homes.
- Seek opportunities for further understanding of the Medicaid restructuring and future of the clinic model.

Priority (Rank #4): Improve awareness of suicide risk in the community.

- Increase participation of suicide prevention coalition.
- Provide education opportunities for community on suicide prevention.

Priority (Rank #5): Increase awareness of individuals who have a dual diagnosis and the need to function collaboratively to better serve the needs of individuals.

- Train/educate clinical and other professional staff about substance abuse, behavioral health, developmental disabilities and elder care fields.
- Organize/ strengthen collaborative partnerships between county departments, school districts, community-based organizations and service providers in order to serve dual diagnosis individuals
- Develop a co-facilitated group for individuals with co-occurring diagnoses.

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LGU: Livingston County **RPC Region: Finger Lakes**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**The LGU did not identify any high needs.**
Adult	**Access to supported housing and transportation.**
Local vs. Regional	**Access to supported housing, transportation, other support services and coordination/integration with other systems were identified as regional high needs for both populations.**

- Lack of stable housing causes other services to be less effective.
- Despite availability of quality services, the lack of transportation makes services inaccessible for clients who are in need of services.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Increased access to transportation resources and services.

- New county plan for public transportation system is currently under development.

Priority (Rank #2): Increase availability of an appropriate range of residential services and income-based housing options.

- Assess, identify and address needs of mental health, chemically dependent and developmental disability populations.
- Actively support development of housing resources via participation in Livingston County Housing Task Force and regional planning process.

Priority (Rank #3): Enhance the range of outpatient, acute and community support resources in local mental health/chemical dependent/developmental disability services system.

- Collaborate with providers and county departments to increase availability of mental health respite services (achieved).
- Collaborate on regional opportunities to secure more affordable housing options.

Priority (Rank #4): Promote mental health and substance abuse prevention activities for adults and children/ youth.

- Support the Health Communities that Care program.
- Collaborate with other county departments and participate in County Health Improvement Plan Subcommittee on Social and Emotional Wellness to help develop a county–wide plan to discourage prescription drug misuse.

Priority (Rank #5): Implement suicide prevention and awareness activities.

- Investigate resources and methods for increasing public awareness of suicide warning signs and prevention methods.
- Collaborate with other county departments and community stakeholders via participation in County Health Improvement Plan's subcommittee for Social and Emotional Wellness.

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LGU: Madison County **RPC Region: Central**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis and treatment services.**
Adult	**Access to supported housing.**
Local vs. Regional	**Regional high needs for the youth population were consistent with local high needs identified for this population. Regional high needs for the adult population were access to crisis and treatment services, and were inconsistent with the identified local high needs.**

- Lack of psychiatric beds.
- CPEP is an unfavorable option because parents are concerned that if their child requires hospitalization, the bed will be located some distance from the community.
- Lack of psychiatry services, especially for children and adolescents. Only one clinic in the region offers child psychiatry.
- Housing is needed for all populations.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Improve access to quality behavioral health services.

- Prepare a comprehensive multi-year plan for the development of integrated housing.
- Active LGU participation in county-wide transportation meeting.
- Promote the development of services accessible to people living in southern Madison County.
- Increase the availability of responsibly delivered medication assisted services.
- Establish standards and reporting metrics to monitor accessibility for existing services.
- Increase the availability of crisis services.

Priority (Rank #2): Increase the efficiency of services.

- Indices and target values for the measuring of the service efficiency.
- Incentivize improvement in service efficiency in subsequent planning years.

Priority (Rank #3): Health service delivery providers will work to assure integrated physical health services.

- DCS participates on Board of Directors for the CNY Care Collaborative (DSRIP) as well as County Project Advisory Committee.
- Treatment plans for individuals and families participating in behavioral health services will include specific and measurable goals and objectives related to improving health status.

Priority (Rank #4): Increase consumer and family member participation in the delivery of integrated behavioral health services.

- The LGU will encourage inclusion of direct service recipients and family members as Board Members and/or participating with direct input to Board of Directors of organization.
- The LGU will identify an instrument(s) for meaningfully measuring consumer satisfaction and encourage provider response to such information.

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LGU: Monroe County **RPC Region: Finger Lakes**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis services, supported housing and coordination/integration with other systems.**
Adult	**Access to crisis services, supported housing and coordination/integration with other systems.**
Local vs. Regional	**The LGU did not identify any regional needs.**

- Crisis respite programming has not been available for youth (both the waiver and non-waiver).
- Lack of access to non-traditional crisis services that can best meet the needs of individuals in crisis outside of ED or hospital based programming is essential.
- Lack of safe, affordable housing. Despite MRT funding and NYS OMH preinvestment funding, additional supported housing is needed in Monroe County.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Ensuring individuals with highest need are appropriately identified, prioritized and linked with services responsive to their identified needs.

- Identify individuals and barriers for those who are high need, and ineffectively engaged.
- Identify reinvestment plans from hospital beds.
- Identify children and youth for diversion from State operated psychiatric inpatient.
- Identify individuals with SUD and/or MH disorders in need of emergency or transitional housing, and provide linkage to appropriate services.
- Link individuals in jail with BH services.
- Support employment opportunities for individuals being discharged from inpatient.
- Assist individuals in non-licensed housing options.
- Work with OMH targeted case management and other deficit-funded care management programs to transition their services to health home care management services.
- Provide high need, non-Medicaid eligible individuals with access to care coordination services.
- Ensure high risk, high need children and youth are planned for.

Priority (Rank #2): Provide better access to coordinated/integrated services and supports for people whose needs cross systems for the following populations

- Individuals with co-occurring mental illness and developmental disabilities, and youth and adults with co-occurring mental illness and SUD.
- Older adults with mental hygiene disabilities, and veterans.
- Individuals with physical health and developmental disabilities.
- Individuals with co-occurring MH/SUD and a history of intimate partner violence.
- Individuals with mental illness, substance use or developmental disabilities who come into contact with the criminal justice system (arrest and/or incarceration).
- Persons with mental illness and/or co-occurring disorders, highest risk, highest need youth, youth linked with the juvenile justice system, and individuals with cross-system needs.

Priority (Rank #3): Ensure a robust provider network.

- Utilize existing databases to collect and analyze utilization data.
- MCO's and BH providers share content expertise regarding BH services and community needs and to understand the service arrays offered by each MCO.
- Educate BH provider community regarding opportunities that exist within NYS initiatives, and regarding HARP changes and opportunities.
- Maximize alternative funding resources for individuals with mental hygiene disabilities.

- Partner with children/youth providers to transition to health homes and Medicaid managed care.
- Regional Planning Consortiums provide a vehicle for understanding the impact of the transition to Medicaid Managed Care.

Priority (Rank #4): Ensure that BH service delivery models are driven by a set of core MCOMH supported values such as trauma-informed, person-centered, strengths-based and recovery oriented, incorporating peer, family and recovery support services.

- Conduct a qualitative research project with Univ. of Rochester to assess/understand impact of NYS initiatives.
- Collaborate with Rochester Psychiatric Center to ensure state-operating services are locally-driven and reflect core principals.
- Partner with local programs serving youth at risk of entering the juvenile justice system.
- Provide linkage to appropriate vocational/employment services and supports, work with others to offer education to consumers and agency staff regarding work and its impact on benefits.
- Work with the FLDDSO, work with PROS providers, continue linkage for individuals to PROS for PROS and employment services, incorporate peer, family and youth voice into systems decision making process.
- Continue activities of the SWAT Youth Council, utilize SOC, make available a System of Care Resource Team.
- Communicate core themes across initiatives, increase capacity through the peer services task group, and meet the MH needs of individuals who are incarcerated.

Priority (Rank #5): Incorporate prevention/education, awareness, early identification and intervention approaches.

- Promote education and awareness of developmental disabilities
- Identify areas of unmet needs for chemical dependence prevention services, and pilot of SBIRT services within school-based health center programs.
- Develop wellness/health promotion activities and undertake MH promotion efforts.
- Collaborate with Monroe County Department of Health to discuss 2015 YRBS survey questions.
- Partner with Nurse Family partnership.
- Identified MCOMH staff will be trained in Youth Mental Health First Aid, and MCOMH to make youth clubhouse model available.

LGU: Montgomery County **RPC Region: Mohawk Valley**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**The LGU did not identify any local needs for youth.**
Adult	**The LGU did not identify any local needs for adults.**
Local vs. Regional	**The LGU did not identify any regional needs.**

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Track healthcare reform.

- Clear up confusion regarding BHO and Health Home.

Priority (Rank #2): Communicate the danger of suicide and the means to address the danger.

- Implement project through the Fulton-Montgomery Suicide Prevention Task Force.
- Implement a local advertising campaign through community forums, outreach activities at schools and the Montgomery County Fair.

Priority (Rank #3): Substance abuse treatment for adolescents.

- Keep the "Adventure" program alive.

Priority (Rank #4): Promote alcoholism and substance abuse prevention to the whole community.

- Reconstituted the Montgomery County Allies in Prevention.

Priority (Rank #5): Monitor needs of people with cognitive limitations not eligible for OPWDD

- Use of the Adult and Children's SPOA

Other unranked priorities include:

- Family care for the Latino population.

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LGU: Nassau County **RPC Region: Long Island**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention, treatment and other support services, transportation, supported housing, workforce recruitment/retention and coordination/integration with other systems.**
Adult	**Access to crisis services, treatment and other support services, transportation, supported housing, workforce recruitment/retention and coordination/integration with other systems.**
Local vs. Regional	**The LGU did not identify any regional needs.**

- School-based prevention has limited funding, no targeted prevention strategies for mentally ill population ages18-25, and lack early identification of emotional distress in children living in homes with mental illness.
- Lack of local crisis services for youth and transition age youth; difficulty accessing these services out of county and out of state.
- There is very limited walk-in capacity for individuals seeking immediate treatment.
- Decreased number of MH clinics and increased waitlists to see a psychiatrist due to funding changes.
- 500 SMI individuals on the SPOA waitlist for housing.
- Difficulty meeting BIP/CMS requirement of a conflict-free structure for the development of HCBS waiver services.
- Aging workforce and staff turnover are increasing the demand for experienced staff who can handle various client needs.
- Coordinated/integrated care for clients with co-occurring disorders (OMH/OASAS providers), but not for clients with dual diagnoses (OMH/OPWDD providers).
- Increasing need for coordinated and integrated care between behavioral and physical health systems.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Provide increased and rapid access to behavioral health services.

- Implement and expand walk-in services.
- Expand the availability of Respiradol Consta, Inveiga and Abilify injectable medications.
- Make available toxicology testing.
- Development of a PROS Readiness Track.
- All outpatient behavioral health agencies with two licenses will apply for the integrated licensure.
- Increased provision of primary medical services in clinics after the availability of integrated licenses.
- Support the development of a peer-run, three bed diversion house.
- Support the delivery of non-Medicaid case management and outreach services for individuals with substance use disorder.

Priority (Rank #2): Provide ancillary withdrawal management programs.

- Investigate and promote the possibility of such programs.
- Provide a stable housing environment through Mary Center Haven of Hope.

Priority (Rank #3): Expand the scope and services of the Assessment and Referral Center.

- Continue the partnership with the lead health homes.
- ARC will be seeking a mental health clinic license to provide short-term, interim clinical services as needed.

Priority (Rank #4): Continue to expand role of SPOA to all clients in need of care coordination, those with a serious mental illness and individuals with two or more chronic medical conditions.

- SPOA will continue to assess, review, and assign clients to the appropriate health home.

Priority (Rank #5): Support the development of safe, stable housing.

- Continue to work toward the implementation of the SPA.
- Develop a mobile residential support team.

Other unranked priorities include:

- Improve access to a more comprehensive transportation system.
- Expand care coordination services in the Mental Health Court.
- Continuation and expansion of the Behavioral Awareness Campaign.
- The LGU will collaborate with the START Services Implementation.
- Begin to enroll children/ youth in the health home.
- Improve discharge planning in the Nassau County Correctional Facility.
- Expand mobile crisis services.

LGU: New York City **RPC Region: New York City**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**The LGU did not identify any high or moderate needs for youth.**
Adult	**Access to supported housing, prevention and crisis services.**
Local vs. Regional	**The LGU and RPC region are coterminous.**

- Fragmentation in the mental health treatment system results in patients lost to care in transitions from hospitalization, and information exchange is unsupported by technology infrastructure or practice.
- Insufficient outreach and follow-up by treatment providers to link patients to community supports.
- Stigma, denial, fear, lack of support, confusion related to benefits and insurance create individual and family challenges that negatively impact trajectory.
- A need for more early intervention services for psychosis to help people in the earlier stages of their illness.
- About 40% of homeless adults suffer from SMI, indicating a need for more supported housing.
- Testimonies gathered at public forums indicate a need for more affordable housing options for people with SMI.
- Parachute NYC program created to address the need for improved and enhanced crisis services including home-like crisis respite centers as an alternative to hospitalizations which is now being funded through State Aid and Medicaid reimbursement.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Reduce fragmentation and improve consumer access to better care in behavioral health service system by implementing Medicaid Redesign initiatives.

- Collaborate into transition into Medicaid managed care, collaborate to provide assistance in implementing DSRIP.
- Collaborate on health homes to increase access to care coordination.

Priority (Rank #2): Promote the mental health and social-emotional development of young children.

- Promote the use of a validated instrument to conduct social emotional development screening
- Provide communication materials and guidance to promote developmental and behavioral screenings among pediatricians.
- Offer parent coaching in high need communities, expand access of family support services by adding a full time bilingual Family Peer Advocate.

Priority (Rank #3): Reduce the number of opioid-related overdose fatalities in NYC

- Promote the establishment of opioid overdose prevention programs.
- Increase the number of naloxone kits distributed.
- Saturate the 6 top overdose neighborhoods with naloxone.
- Promote guideline-concordant opioid prescribing, develop0 prescribing guidelines for particular specialties

Priority (Rank #4): Increase stable housing.

- Increase the number of supportive housing units for people with mental health and substance use disorders.

Priority (Rank #5): Reduce the number of people with SMI involved in the criminal justice system/jail.

- Develop data-driven strategies to reduce the use of arrest, prosecution and incarceration.

Other unranked priorities include:

- Improve utilization and outcomes of mobile crisis services and improve outcomes regarding early onset schizophrenia and other psychoses.
- Train in Mental Health First Aid.
- Expand access to and uptake of medication assisted treatment.

- Increase morbidity and mortality associated with alcohol consumption, and increase the number of adolescents receiving appropriate recovery-oriented services for substance use.
- Develop workforce capacity in specialty care and primary care system in response to opportunities associated with Medicaid Redesign, and increase competitive employment.
- Maintain a stable, well-trained and competent workforce.
- Establish additional housing/residential capacity that offers 24/7 coverage for the developmentally disabled, and enhance support/access to services to sustain families who care for this population.
- Increase employment opportunities, expand transportation options and enhance access to and availability of all services to meet the medical needs of people with developmental disabilities.
- Increase support for dually diagnosed individuals.
- Ensure transition supports for developmentally disabled individuals, and increased information regarding available services for the developmentally disabled.
- Enhance access to timely and appropriate mental health treatment and support for children and youth.
- Shape and transition the NYC's children's behavioral health system in preparation for the implementation of health homes and full managed behavioral healthcare.
- Strengthen the family voice in DOHMH's planning, evaluation and program development.
- Conduct public education on mental health issues and promote positive mental health.

LGU: Niagara County **RPC Region: Western New York**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to transportation.**
Adult	**Access to transportation.**
Local vs. Regional	**Regional high needs identified were access to crisis services and transportation for both populations and access to supported housing for the adult population. Only one of these regional high needs was identified as a local high need.**

- There is a county need for additional transportation services. Niagara County is configured with both urban and rural areas with the majority being urban.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): The LGU and provider agencies will respond to the system transformation that is occurring across the three disabilities.

- Provide leadership for the NYS success System of Care for Children and Families.
- Participate in the Millennium Performing Provider System.
- Keep abreast of Health Home issues.
- Monitor activities of Value Base Payments and the Balancing Incentive Program.
- Pursue being a provider of Home and Community Based Services.
- Explore services for the prevention of out of home placements.
- Pursue managed care readiness.
- Support appropriate provider mergers, acquisitions and partnerships between agencies.
- Explore the expansion of First Step program of the Northpointe Council.
- Agencies will explore agencies' shared resources.

Priority (Rank #2): The LGU will support the evolution of outpatient clinic services to meet the changing service environment.

- Outpatient mental health and substance abuse participation in staff training on integration of multiple chronic diagnoses.
- LGU clinic services efforts regarding integrated care.
- Develop new provider clinic initiatives.
- Advocate with OASAS regarding payments.
- Encourage providers to adapt technology to reach youth, and advocate with OMH and OASAS to develop regulations for the use of technology such as telepsychiatric outside the clinic.
- Support a collaboration of services toward fully integrated care in the North Tonawanda catchment area.
- Explore the addition of new children's clinics in Niagara County.

Priority (Rank #3): Increased implementation, exploration, and development of public and other transportation opportunities.

- Provider agency will explore increased transportation opportunities.
- Develop partnerships and contract development with forms of transportation.
- Assist individuals with developmental disabilities to learn how to drive.

Priority (Rank #4): Expand access to supportive, affordable, integrated and permanent housing options.

- Support providers in increasing supportive, single room occupancy options.
- Keep informed of developments in the housing arena.
- Develop transportation to allow access to housing and other needed services.
- Partnerships with state agencies to enhance funding to programs across the disabilities.

Priority (Rank #5): The LGU will keep abreast of transformational activities in the OPWDD system

- Request information from OPWDD as it meets its Transformational Targets with the Center for Medicare and Medicaid Service.
- Information from OPWDD regarding Rate Rationalization Process.
- Assess integration of OPWDD with DSRIP.
- Monitor the implementation of the OPWDD START program, and the integration of the OPWDD Front Door initiative.
- Request reports on the implementation of a grant to the Niagara Falls Memorial Medical Center.
- Advocate that OPWDD develop a definition of competitive work.
- Advocate with OPWDD and local provider agencies to assist developmentally disabled population, including persons on the autism spectrum.

Other unranked priorities include:

- Resources for those who do not qualify for or elect not to receive health home, Medicaid, or Medicare services.
- Support the development of peer-run services.
- Maintain/expand partnership across agency departments that serve the Mental Hygiene population.

LGU: Oneida County **RPC Region: Central**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis services and transportation.**
Adult	**Access to prevention and crisis services, supported housing, transportation and coordination/integration with other systems.**
Local vs. Regional	**The only regional high need identified supported housing for the adult population, which is consistent with one of the local high needs identified above.**

- Due to rural geography, there are issues with knowing/obtaining/receiving prevention services, and lack of available services.
- Individuals are unaware of what is within their geographic location.
- Access to supported housing is a high need.
- Adults are unable to afford personal transportation due to budget rigidity, and there is lack of public transportation in most rural areas.
- Adults with DD and other diagnosis related to mental health and substance abuse have barriers to benefitting from treatment due to their intellectual ability.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Expand the continuum of housing options and supports.

- Support the joint collaboration between Mohawk Valley Psychiatric Center and Catholic Charities for the long stay supported housing beds.
- Support the efforts of the various coalitions and providers in an effort to reduce incidents of homelessness.
- Work with providers to seek out ways to avoid future homelessness through early engagement, enhance housing opportunities for individuals with developmental disabilities.
- Increase supports to people who desire to live independently, enhance supports to families to enable family members to remain at home in the community.
- Work collaboratively with the DSS to identify and resolve current barriers within the county system that perpetuate homelessness.

Priority (Rank #2): Improve cross system collaboration.

- Continue to promote integration and cross collaboration between OMH and OASAS providers, promote the efforts of the Professional Training Coalition in meeting the identified need of increase access to dual recovery trainings.
- Continue to support the successful inter and intra-agency collaboration through the EPSS 9.41/UR Committee.
- Encourage FIT trainings as a core competency.
- Develop supports to better serve individuals with multiple disabilities.
- All three Directors are convening regular, ad hoc case conferencing at the request of any County provider or law enforcement regarding highest risk individuals and developing collaborative responses.
- Participate in DSRIP workgroup initiatives.
- Continue to provide assessment, monitoring and evaluation related to the provision of mental health services with forensic populations.

Priority (Rank #3): Maintain or improve the availability and access to the continuum of services

- ASPOA/A process will monitor referral distribution and timeframes for openings to better examine barriers to engagement and gaps within the service delivery system.
- Actively monitor the delivery system for examples of barriers to individuals' access to services.
- Continue to monitor waiting lists at all outpatient OMH licensed clinics to ensure compliance with the requirement for 5 day appointments for the highest priority populations while still meeting the needs of lower need clients.

- Work with SUD providers to navigate the changes to Medicaid.
- Meet individually with all contract providers to discuss each contract, programs, fiscal accountability and performance measures.
- Continue to discuss and review data related to admissions, emergency room visits, length of stay and capacity at the 9.39 hospitals.

Priority (Rank #4): Promote and support meaningful employment

- Increase the number of employment opportunities for individuals with developmental disabilities.
- Expand education and employment opportunities for SUD population.
- Increase pre-employment skills development for the developmental disabilities population.
- Expand availability of community inclusion activities.

Priority (Rank #5): Expand services for SUD to include access MAT, OTP and stabilization services.

- Work with local providers and drug representatives to explore the best ways to move forward to meet the needs of the community, continue to chair the Opiate Task Force, promote education and prevention regarding heroin addiction, providers and county will work to implement new residential regulations Part 820, work with providers and OASAS to promote opioid treatment services being available.

LGU: Onondaga County **RPC Region: Central**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention and crisis services, and coordination/integration with other systems.**
Adult	**Access to prevention, crisis and treatment services, supported housing, transportation, and coordination/integration with other systems.**
Local vs. Regional	**Regional high needs were identified as access to crisis services for youth and access to HCBS, crisis and treatment services for adults. These needs are consistent with some of the local high needs identified above.**

- Move toward managed care models creates an opportunity to align incentives/to integrate prevention and treatment.
- A need to develop alternative services (e.g. mobile, respite, outpatient, peer) that can reduce the number of crisis presentations.
- High demand for prescribers and clinic access.
- Lack of quality, affordable housing.
- Disability related poverty, and poor public transportation combine to inhibit social and work opportunities for those seeking recovery.
- A need to expand/develop home based supports to engage those who do not access traditional service models.
- Current emphasis on integrated care requires cross system coordination at all levels.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Improve access to treatment services for adult mental health.

- Clinic expansion, length of stay analysis and quality improvement project, explore medication-only services for children and adults.

Priority (Rank #2): Improve access to crisis mental health services for adults.

- Partner with DSRIP, PPS Central New York Care Collaborative.
- Facilitate dialogue regarding inpatient access with local hospitals.
- Enhance mobile crisis capacity, and reduce unnecessary CPEP and IP admissions.
- Develop a structure for the notifications of outpatient and residential providers regarding inpatient admissions and discharges.
- Develop a web based resource to ensure that CPEP makes appropriate outpatient referrals.

Priority (Rank #3): Improve access to crisis mental health services for children.

- Regional dialogue and analysis.
- Promote family readiness services to support child's successful return home.

Priority (Rank #4): Enhance the quality and availability of residential supports/supported housing.

- Partner with the Residential Coordinator and residential SPOA regarding fidelity to new OMH Supported Housing Guidelines and also for the maintenance of residential service access.
- Ensure adequate recovery supports for individuals with addictions.
- Enhance residential supports through community wide training of residential staff.
- Expand residential SPOA services.

Priority (Rank #5): Improve access to transportation services for adult mental health.

- Engage in a fact finding and planning effort with the community (include developmental disabilities and substance abuse disorders transport needs).

Other unranked priorities include:

- Improve access to developmental disability residential service, promote alignment of community services with systems change initiatives.
- Promote integrated care.
- Reduce isolation among vulnerable populations.
- Improve advocacy for people with developmental disabilities.
- Define/address the mental health needs of seniors.
- Develop plans to address the social determinants of health for those needing behavioral health services.
- Improve health and safety for at risk individuals with behavioral health conditions.
- Enhance school based behavioral health supports.
- Engage in community wide evidence based efforts to prevent substance use.
- Improve level of care transitions.
- Explore the potential for a transition age initiative that brings together child and adult service systems regarding the needs of individuals between the ages of 16 to 25.
- Ensure the adequacy of mental health and substance use services for veterans.
- Enhance community supports to address opiate use.

LGU: Ontario County **RPC Region: Finger Lakes**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis services was the only high need. Access to prevention and treatment services, transportation and coordination with other systems were moderate needs.**
Adult	**Access to crisis services was the only high need. Access to treatment services, supported housing and coordination/integration with other systems were moderate needs.**
Local vs. Regional	**The LGU did not identify any regional needs.**

- Mobile intervention is associated with the County's rural CPEP program, and there is limited capability for immediate response.
- No availability of mental health prevention services.
- Limited access to child psychiatry.
- Youth and adult treatment services have lengthy waiting periods, and services are not provided in a timely manner.
- No access to a bus-system, Medicaid/medical transport or cab services.
- Limited supported housing slots and large demand.
- Difficulty coordinating care due to time availability.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Integrated services for individuals with mental health disabilities or SUDs will have access to integrated treatment; integrated physical health care for individuals with developmental disabilities.

- Complete health monitoring on all clients within Ontario County Mental Health Center.
- Advocate and monitor impact of DSRIP programs to integrate care with the County.

Priority (Rank #2): Children and youth timely access to community supports via the SPOA process.

- Promote an increase in HCBS Waiver, Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT) slots.

Priority (Rank #3): Improve transitional services for individuals with developmental disabilities.

- Continue to communicate with ARC as well as OPWDD to understand transitions and advocate for best practices.

Priority (Rank #4): Access to safe and affordable housing.

- OMH/OASAS/DOH continue to work on proposals to develop regionally based housing alternatives.

Priority (Rank #5): Complete a needs assessment to determine mental health needs of the community.

- CCSI completed a needs assessment in 2014. The final recommendations of the report indicated that OCMHC should continue to provide direct services with a plan to make several improvements.

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LGU: Orange County **RPC Region: Mid-Hudson**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis and other support services, supported housing, transportation, and HCBS**
Adult	**Access to crisis and other support services, supported housing, transportation, HCBS; workforce recruitment/retention and coordination/integration with other systems.**
Local vs. Regional	**The LGU did not identify any regional needs. It was noted that regional meetings have transpired, but a formal regional needs assessment had not been conducted.**

- Difficulty addressing crisis needs of high risk, high needs, co-occurring complex care for youth and adults, despite Mobile MH Team presence.
- Long housing wait list for transition aged youth ages 18-21, and adults.
- Strong need for home and community based services for high need, complex care individuals.
- A need for other support services such as psycho-ed, family and peer support, self-help groups and advocacy.
- Substantial difficulty connecting service recipients to ACCESS VR and other workforce trainings.
- Difficulty recruiting, training and supervising staff for non-certified settings that are generally evening and weekend part-time shifts.
- Continual strides being made to improve integration/coordination especially for complex care and complex need individuals.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Achieve quality improvement, cost containment, and cost savings.

- View and analyze the data provided by department implemented performance based contracting, and use Scorecard to assess overarching goals.
- Collaborate with Joint Membership Mental Health Committee Association and designated Health Home providers to support successful ongoing care coordination.
- Plan for the full implementation of the ACA.
- Monitor/participate in the implementation of Medicaid Redesign Team recommendations.
- Collaborate with OPWDD and providers to shape, support, and monitor implementation of systems transformation.
- Develop ways to identify and monitor individuals with frequent involvement with high touch services and connect them with services.
- Collaborate with the Sheriff and Emergency Services departments to bring Project Lifesaver for 'at risk' individuals with developmental disabilities who are prone to life threatening behavior or wandering.

Priority (Rank #2): Promote BH prevention, early intervention, education and access to appropriate services through a Comprehensive Continuous Integrated System of Car (CCISC) using our WELCOME Orange initiative to work toward population health.

- Promote BH and primary care co-locations.
- Develop a prevention agenda with the local Department of Health.
- Provide public education and awareness of substance abuse via the Orange County Opiate Task Force.
- Support local chemical dependency providers in targeted education on synthetic drugs while also promoting cross system planning with the Orange County System of Care inclusive of the Department of Health.
- Plan for the implementation of the 2016-17 youth risk survey on a countywide level.
- Seek/support certification of more providers in MH First Aid for both adult and youth tracks.
- Collaborate with the Orange County DSS to re-establish cross system case review.
- Train individuals, families, and staff on evidence based practices.
- Work with schools regarding individuals with developmental disabilities.
- Develop capacity through CCISC (a service system that welcomes and expects to address complex needs including co-occurring needs).

- Promote Justice and Mental Health Collaboration Project (JMHCP).
- Develop a specialized clinical course of care to treat individuals experiencing their first psychotic break with the formation of a Community Clinic Learning Collaborative to identify best practices.

Priority (Rank #3): Work collaboratively with federal, state, and local partners to increase stable housing in compliance with Olmstead

- Collaborate with DSS and the Orange County Housing Consortium to explore new community housing options.
- Work jointly with the State to manage housing options as recommended by the MRT, through the Housing Consortium.
- Effectively manage housing working collaboratively with agencies awarded HUD housing.
- Enhance existing housing and supports for transition age youth.
- Support the roll out of the new SPOA process.

LGU: Orleans County **RPC Region: Western New York**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to transportation and HCBS.**
Adult	**Access to transportation and HCBS.**
Local vs. Regional	**Regional high needs identified were access to transportation for both populations and access to HCBS for the youth population.**

- Transportation resources are a critical need in rural counties.
- A need for more home and community based service providers and a wider array of services for youth.
- More social-recreational opportunities needed for both populations.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Help reduce the incidence of suicide.

- Foster the work of the Orleans County Suicide Prevention Coalition which presents trainings on Safetalk and other evidence based practices.
- The Suicide Prevention Coalition will continue to increase awareness and knowledge by developing presentations.

Priority (Rank #2): Develop community based services by establishing satellite mental health clinics in alternative settings.

- Establish two school based satellite clinics in the eastern part of the county.
- Evaluate the operational effectiveness of new satellites.
- Formulate a plan to open two additional school-based clinics in the western part of the county.

Priority (Rank #3): Increase the availability of evidenced-based medication assisted therapy (MAT).

Priority (Rank #4): Desire to offer respite services for families of OPWDD population.

- Reach out to potential providers.

Priority (Rank #5): Meet the mental health treatment needs in partnership with community agencies

- The Mental Health Association will provide a drop-in center for those who choose not to participate in structured settings.
- Orleans LifeLine, a division of Goodwill of the Finger Lakes, will provide telephone suicide and crisis prevention/ intervention.
- Develop and implement a 24 hour mobile crisis.

Other unranked priorities include:

- Address the unmet need for short-term residential care through DePaul Mental Health provision of crisis respite beds.
- Increase the proficiency of clinicians working with co-occurring disorders using the FIT model.
- Educate the community about available mental health resources.
- The ARC of Orleans County will provide employment support to individuals with mental health issues.
- Provide effective chemical dependency education and treatment linkages at the jail.
- Increase awareness and utilization of Gambling Treatment Services.
- Provide continued services at the Alcohol & Substance Abuse Clinic.
- GCASA will increase access for substance abuse services to the Spanish speaking population.
- Reduce the prevalence of nicotine addiction among substance abuse patients.
- Provide vocational services to developmental disability population.
- Desire to meet housing needs of developmental disability population.
- Prepare individuals and family members of developmental disability population for managed care.

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LGU: Oswego County **RPC Region: Central**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to transportation and prevention, crisis and treatment services.**
Adult	**Access to crisis and treatment services, supported housing, transportation and HCBS.**
Local vs. Regional	**Regional high needs were identified as access to crisis services and transportation, and access to transportation, crisis and treatment services for adults. These needs are consistent with some of the local high needs identified above.**

- Lack of mental health clinic services and lengthy waitlists, thus allowing conditions to worsen over time until the most acute level of care is needed.
- No available crisis intervention services in the region is causing the overutilization of ERs.
- A need for more person-centered approaches to reduce clients being excessively labeled as non-compliant, and then being discharged.
- Lack of intensive treatment services for individuals coming out of jail/prison.
- Housing barriers include lengthy waitlists, few available housing slots, and ineligibility of convicted felons to be housed through HUD subsidies.
- Difficulty accessing/unreliable Medicaid transportation, and lack of public transportation.
- A need to increase HCBS services in order to offset the lack/decrease of supervised living opportunities.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Improve access and engagement with behavioral health treatment and supports.

- Increase capacity of outpatient mental health clinic services for children and adults.
- Collaborate on a regional level, to develop and share resources to meet the needs of adults and families with children experiencing behavioral and mental health crises.
- Increase treatment and support services available for criminal justice system involved individuals with behavioral health issues.

Priority (Rank #2): Align housing options and independent living supports with consumer needs and preferences.

- Partner with stakeholders to identify needs and resources, develop 'shovel ready' projects.
- Advocate for home nursing, home health, and consumer directed care services.

Priority (Rank #3): Co-location of behavioral and physical healthcare to meet the needs of individuals with co-morbid conditions.

- Partner with Rural Health Network to promote and support the implementation of initiatives for integrated care.

Priority (Rank #4): Strengthen prevention strategies to reduce substance abuse, suicide, hospitalization and out of home placements for youth.

- Further develop local Coalition to Combat Adolescent Substance Abuse.
- Provide over the counter medication and opiate addiction education in schools.
- Develop local Suicide Prevention Coalition.
- Provide local training opportunities to increase skills within the community to identify and respond to suicidal ideation.
- Apply for Drug Free Communities Grant.
- Implement Collaborative Problem Solving model.

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LGU: Otsego County **RPC Region: Mohawk Valley**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention services, HCBS and workforce recruitment/retention. Two unique high needs specific to the LGU were access to peer support and psychiatry/addiction medicine.**
Adult	**Access to transportation, other support services and workforce recruitment/ retention. Two unique high needs specific to the LGU were access to peer support and psychiatry/addiction medicine.**
Local vs. Regional	**Regional high needs identified were access to treatment services and transportation for both populations. This is consistent with two of the local high needs identified above.**

- Prevention services such as, early identification of at risk youth and early intervention with pro-social behaviors and experiences, are needed to moderate the effects of multi-generational struggles.
- For high needs/at risk families, intensive in home clinical and support services are needed to create change. With an increasing elderly population in the community the ability to provide in home assessments and services is needed.
- Limited public transportation, and Medicaid transportation requires a three day notice which prevents immediate access to services.
- Accessible housing for the homeless, jail, and sex offender populations is needed.
- Continue/expand loan forgiveness programs for MSW, RN, NPP, DO and MDs.
- Lack of funding/reimbursement for peer support services that are typically delivered in non-traditional settings.
- Lack of psychiatrists or addiction medicine specialists.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Successful reform of health care delivery system.

- Participate in DSRIP planning activities.
- Support operational adult health home to include HARP and health homes plus transition to managed care.
- Identify key services.

Priority (Rank #2): Access to appropriate services.

- Promote the use of health homes and SPOA to serve high needs individuals.
- Expand Mobile Crisis Assessment Team early intervention.
- Enhance outpatient services to accept increased demand, and to improve treatment engagement.
- Work with Basset Medical Center to bring rural psychiatry residential program into the region.
- Work with provider systems to enhance clinical experience.
- Work with Basset Medical Center to develop regional addiction medicine services.
- Promote training/internship opportunities across all workforce specialties.
- Build and maintain relationships with educational institutions.
- Maintain Health Professional Shortage Area designation.

Priority (Rank #3): Increase housing opportunities.

- Identify housing options for substance abuse population.
- Work with recovery community to develop sober living options.
- Support expansion of housing via health homes.
- Increase capacity for individuals with co-occurring disorders in mental health housing.
- Identify transportation and employment resources.
- Promote Housing First approach.
- Increase supported housing and linkage to health homes.
- Increase use of in-home stabilization services.
- Increase behavioral management skill building.

- Increase use of warm-line, MCAT and Recovery Coaching.

Priority (Rank #4): Promote recovery support services.

- Provide a variety of peer support opportunities such as expansion of warm line, promote Recovery Oriented Employment Services, integration of peer engagement specialist, engagement of peers in the support and development of community supports, develop peer linkage/coaching, and develop recovery and peer services for youth.
- Educate current provider systems to the engagement and activities of peer/recovery services.

Priority (Rank #5): Promote integrated prevention, treatment and recovery/support services.

- Reduce regulatory and fiscal barrier to person centered integrated care.
- Bring together agencies and services focused on the development and wellbeing of children and families.
- Engage stakeholders in utilizing ACES.
- Implement intervention for youths ages 12-18 who are starting to make poor choices with drugs/alcohol.
- Support and empower teens and parents to direct services.
- Identify and support programs that provide integrated prevention.
- Develop small community network to provide pro-social activities for youth and families.

Other unranked priorities include:

- Reduce premature deaths.

LGU: Putnam County **RPC Region: Mid-Hudson**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention and treatment services.**
Adult	**Access to prevention, crisis and other support services, and coordination/ integration with other systems.**
Local vs. Regional	**The LGU did not identify any regional needs.**

- Need for youth Mental Health First Aid prevention services.
- Insufficient service/residential options for transition/return into the community post- inpatient discharge which is increasing length of stay despite client stabilization.
- Limited availability of youth treatment services due to inadequate number of child psychiatrists.
- Need for coordination/integration between MH and DD treatment providers to help treat dual diagnosis individuals post IP discharge.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Increase suicide prevention and awareness.

- Present SafeTalk (a Means Matters training) PTSD training to mental health and law enforcement personnel, and Mental Health First Aid.
- Obtain information regarding suicides completed in Putnam County through county officials.

Priority (Rank #2): Address unintentional opiate overdose.

- Narcan trainings will be provided to the community.
- Provide a public awareness campaign of the dangers of addiction and resources available.

Priority (Rank #3): Increase supported housing.

- Build supported housing beds by 2 in 2015.

Priority (Rank #4): Facilitate access to services across service systems via interagency collaboration.

- Work with OPWDD to transition individuals with developmental disabilities to crisis or appropriate alternative to psychiatric facilities.

Priority (Rank #5): Ensure mental health training for first responders.

- Offer CIT training.
- Develop training for developmental disability population.

Other unranked priorities include:

- Address mental health issues of veterans, senior citizens, and other special populations.

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LGU: Rensselaer County **RPC Region: Capital Region**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to transportation, HCBS and other support services.**
Adult	**Access to prevention, crisis and other support service, supported housing, transportation and HCBS. Other unique needs specified were access to crisis beds and VNA like supports.**
Local vs. Regional	**All local high needs for both populations were identified as regional needs. Additionally, access to prevention services (youth) and coordination with other systems (both populations) were identified as a regional high needs.**

- Adult mobile crisis team that is in development will have limited hours of operation.
- Lack of mental health provider/services in the NW and SE zones of the county.
- Overall SH shortage, very limited SH for adults with children, and admission barriers through the SPOA referral process due to treatment/medication compliance monitoring.
- Medicaid transportation does not cover same day access to care or siblings traveling with mentally ill youth. This service also tends to pick up clients late.
- HCBSs are not broadly available (e.g. only available for OMH Waiver for SED youth).
- Limited public transportation available in rural areas, therefore rural residents are unable to access urban (Troy) services that serve low income individuals.
- Difficulty recruiting/retaining psychiatrists, lack of Spanish speaking therapists/psychiatry staff, and limited psychiatric nurse practitioner availability.
- Fragmented treatment for individuals with co-occurring and dual diagnoses has resulted in the need for more integration between OMH, OASAS and OPWDD licensed providers.
- Lack of crisis beds.
- Medication/treatment compliance supports needed for State PC discharges with high medical need.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Explore housing options.

- Housing redesign through expanded OMH funded SH beds, increased housing through MRT SH beds, advocacy for enhanced SH, redeployed state aid funding to Unity House, proposal of expanded housing for persons with disabilities, addition of MRT beds and/or SH beds for high end users, affordable rentals for those coming out of supportive or transitional housing, continue to work with FACT team to resettle homeless families, exploration of partnerships with other affordable housing stakeholders and increase OPWDD housing alternatives to congregate care.
- Develop transitional housing program for people ages 16-24 years old with mental health and substance use issues and create a young adult task force.
- Resettle Fawn Ridge Adult Home residents to their county of origin.

Priority (Rank #2): Embrace all initiatives through Medicaid Redesign, DSRIP and Managed Care HCBS waiver.

- Develop integrated care partnerships and cross systems collaborations (e.g. criminal/juvenile justice and BH).
- Plan/implement EHR that meets all current standards including linkage to the RHIO.
- Provide training for county and MH workforces, youth serving and developmental disability workforces, pediatric resources and care coordinators.
- Use of telepsych and primary care integrated satellite clinics to serve rural counties.
- Develop a community based continuum of care for adults, children and families offering comprehensive resources to support living in the least restrictive setting.
- Continue partnership with existing veterans services to promote community awareness and reduce treatment barriers.
- Continue to offer PROS and a Supported Education Program.
- Continue participation in County Health Department Wellness Committee's initiatives.

Priority (Rank #3): Establish an accessible continuum of care for addiction.

- Collaborate with Chemical Dependence/MICA subcommittee, to develop a best practice plan and increase treatment options and access for persons who are opiate addicted.

Priority (Rank #4): Improve population health.

- Reduce suicide and associated stigma.
- Strategic planning/implementation as a result of the biannual Bach Harrison Prevention Needs Survey administered to school children.
- Increase evidence based programming in schools and the community.
- Continue teen pregnancy, STDs, obesity and tobacco use prevention.
- Develop an emergency preparedness plan.

Priority (Rank #5): Develop a regional plan to minimize the harmful effects associated with the introduction of casino gambling in the region.

- Develop/promote a best practices plan to reduce the risk of problem gambling.
- Improving access to intervention and treatment services that are responsive to individual and family needs.

LGU: Rockland County **RPC Region: Mid-Hudson**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to treatment services.**
Adult	**Access to supported housing, HCBS, workforce recruitment/retention, increase funding for supported housing providers, coordination/integration with other systems, and create opportunities for persons currently in the community.**
Local vs. Regional	**The LGU did not identify any regional needs.**

- Families covered by commercial insurance have difficulty accessing youth MH services through in-network providers due to clinic trends toward serving the Medicaid population and high co-pays at private practices.
- Housing barriers include long waiting list (35 individuals), no new bed allocations in the past year and Section 8 being closed for a year.
- A need for habilitation and restorative services that are offered in settings outside of licensed housing for young adults living at home with parents.
- Demand for additional community based skill building/supports for mentally ill individuals in the community which cannot be solely fulfilled by residential providers and care coordination.
- Workforce challenges include high staff turnover in IP unit, lack of men in social work and care coordination positions, and insufficiently trained residential line staff to meet the needs of SMI populations.
- Lack of integrated care coordination and resources between MH and DD.
- Separate funding and licensing silos at the State level for MH, CD, and DD.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Expand the availability/accessibility of safe, adequate and affordable housing in the least restrictive environment through the ARISE Crisis Respite Bed program, St. Dominic's Home, Loch House, Mental Health Association, Rockland Hospital Guild, Bikur Cholim, Open Arms, Blaisdell ATC, ARC, Hamaspik and Camp Venture.

- Develop housing and emergency housing for single homeless adults with SMI.
- Expand crisis respite bed capacity.
- Implement OASAS Residential Redesign.
- Develop/expand housing and renovate existing residence for individuals with substance abuse.
- Increase access to CD housing for individuals with co-occurring illness, and for individuals that have a history of prior non-violent crimes.
- Use Homeless Housing funding to provide integration housing to the DD population.

Priority (Rank #2): Increase vocational/employment and educational opportunities for persons across the MH service system through St. Dominic, MHA, Lexington Center, Open Arms, Haverstraw Center, RILC, the Recovery Task Force, Camp Venture, RCALD, ARC of Rockland, and Jawonio.

- Increase employment and education opportunities SMI, CD or co-occurring populations.
- Increase opportunities for the DD population which decrease enrollment in sheltered workshop programs.
- Provide increased community-based integrated pre-vocational opportunities and job placement for individuals with ID/DD.

Priority (Rank #3): Expand access to culturally and linguistically competent services and supports.

- Increase cultural and linguistic competency at RILC, CANDLE, Bikur Cholim, Lexington Center, Daytop, Mental Health Association, Blaisdell ATC, and Open Arms.

Priority (Rank #4): Promote recovery awareness in the community and create long-term recovery supports (e.g. peer supports for persons with mental illness and chemical dependence) through Jawonio, MHA, RILC, RCADD, Good Samaritan Hospital, St. Dominics, Daytop, Haverstraw Center, and NAMI Rockland.

- "Peer Summit" to identify ways that peers assist in recovery in a managed care environment.
- Collaborate with CD programs to train MH residential staff to provide support in person's with co-occurring mental illness and chemical dependence.
- Promote recovery awareness, create new support groups, and increase self-help options.
- Add an AA meeting and offer volunteer opportunities to persons in recovery from CD.
- Launch family peer advocacy services, establish outreach linkages in schools, and provide an opportunity to create a peer support network for individuals on the autism spectrum.

Priority (Rank #5): Expand access to community habilitation, family support, respite and recreation for persons across the MH service system.

- Bikur Cholim to offer community education to parents of children around MH.
- Lexington Center to begin a family participation phase in system in an adult non-intensive clinic.
- CANDLE to assess needs and barriers for middle school students potentially interested in attending an LGBTQ+ support group.
- Jawonio, Hamaspik, Camp Venture and ARC to offer more community based services for individuals with ID/DD.

Other unranked priorities include:

- Increase availability/accessibility of affordable, recovery oriented, person centered, age appropriate and evidence base treatment, care coordination and habilitative services to all persons, including those with co-occurring disorders.
- Provide prevention, education, and outreach across the MH system and educate community leadership about related BH issues and services.
- Collaborate with the criminal justice system to provide services and offer alternatives to incarceration for persons that are involved in the criminal justice system.
- Prepare the MH system of care in Rockland County for Medicaid Redesign and managed care through coordination and management of all service components.

LGU: Saratoga County **RPC Region: Capital Region**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis and treatment services, supported housing, HCBS, work force recruitment/retention and coordination/integration with other systems.**
Adult	**Access to crisis services, supported housing and workforce recruitment/retention.**
Local vs. Regional	**Two areas were identified as regional high need: workforce recruitment/retention (youth) and access to supported housing (adult). These two areas align with the local high needs.**

- Need for trained behavioral health professionals to respond to crisis situations as opposed to emergency responders and law enforcement.
- Limited supply of qualified prescribers and MH professionals with specialized training for care of youth and children.
- Lack of residential services for transition-aged youth.
- Lack of home and community based, specialized wrap-around services to support children and youth with multiple disabilities.
- Lack of/need for more psychiatrists and child psychiatrists.
- More collaboration is needed to better treat persons with multiple disabilities given the significant overlap in clinical care, social support and overall treatment.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Improve overall quality of care for the Medicaid, Medicare and uninsured population through participation in DSRIP.

- County mental hygiene providers will join a regional PPS.

Priority (Rank #2): Enhance the composition and functioning of the CSB to comply with the standards set for by the NYS Inter-Office Coordinating Council (IOCC).

- Develop the CSB to meet the requirements of the IOCC.

Priority (Rank #3): Continue to develop and sustain local coalitions.

- The Prevention Council will continue to work with local coalition partners in the South Glens Falls, Saratoga Springs and Shenendehowa school districts in addressing substance abuse, bullying and suicide prevention and expand into Galway and Mechanicville school districts.
- Enhance relationships with public stakeholders including Public Health, DSS, the justice system and others.

Priority (Rank #4): Maintain an effective, efficient, accessible continuum of residential and housing services.

- Explore introduction of additional providers of these services to the County.

Priority (Rank #5): Identify and address service needs of young adults transitioning into adult roles in the community.

- Reflections PROS program will develop programs to meet the needs of this population.
- Increased collaboration and integration between the Mental Health Center's mental health and substance abuse services in meeting the needs of this population.

Other unranked priorities include:

- Effectively implement and integrate health homes.

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LGU: Schenectady County **RPC Region: Capital Region**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to supported housing.**
Adult	**Access to crisis and treatment services, supported housing, transportation and workforce recruitment/retention.**
Local vs. Regional	**Two areas were identified as regional high need: workforce recruitment/retention (youth) and access to supported housing (adult). These two areas align with the local high needs.**

- High need for crisis services for individuals with co-occurring disorders and individuals with high acuity behavioral and functional care limits who refuse services from MH system and remain just below the clinical threshold for involuntary service.
- Limited crisis service options for adults with co-occurring disorders.
- Limited treatment services due to medical providers, increasingly higher caseloads for children's service providers, and low staff retention in some agencies.
- Treatment access is difficult for individuals with co-occurring disorders, significant mental health impairments, and behaviors identified as personality based.
- Need for more supported housing to reduce current waitlist, to support transition-age youth, and to support individuals who face chronic homelessness due to eviction.
- Transportation issues for individuals who rely on Medicaid transportation that are having trouble following guidelines for usage.
- Lack of adult and child psychiatrists, and difficulty retaining clinical staff.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Ensure access to required care and service needs for individuals with significant clinical care needs or functional impairments that cause reliance on specialized health care services and/or social supports.

- Cross system forums and training events, ad hoc special conferences and scheduled task force and subcommittee meetings.
- Continue work with state and local partners to seek out opportunities for additional housing and case management resources through grants, state funding, and redesign activities.
- Improve outcomes for justice involved youth via implementation of effective behavioral health interventions.

Priority (Rank #2): Promote person centered recovery oriented system of care through knowledge sharing and monitoring of innovative programming.

- Training focused on trauma informed care.
- Trainings and forums geared toward understanding of eligibility, criteria, and service structures with the Mental Hygiene systems to support linkages and successful transitions within OMH, OASAS and OPWDD service systems.
- Monitor/evaluate pilot programs utilizing peer expertise to support enhanced outcomes.
- Increase SBIRT awareness.

Priority (Rank #3): Sustain system readiness and expand networked crisis response capacity to maintain effective critical incident management.

- Provide training and networking/information sharing forums to ensure ongoing communication for effective critical incident management.
- Continue efforts to prevent violence, including suicide prevention, through information sharing and improved monitoring capacity.
- Maintain current capacity to ameliorate crisis situations with least restrictive and re-triggering response.
- Provide linkages to community and community supports.

Priority (Rank #4): Enhance community of care infrastructure to promote wellness and reduce risks associated with addiction.

- Partner with stakeholders to plan and implement action steps around response to current opiate use trends and impact of addiction related barriers to health and wellness.
- Utilize established committee meetings and network relationships to provide cross systems planning and evaluation of trends impacting care needs in public mental health services

LGU: Schoharie County **RPC Region: Mohawk Valley**

Needs Assessment: The following areas were identified as "Moderate Need" for the local MH population.

Youth	**Access to treatment services, supported housing, transportation and workforce recruitment/retention.**
Adult	**Access to treatment services, supported housing, transportation and workforce recruitment/retention.**
Local vs. Regional	**The regional moderate needs identified are identical to the local moderate needs above, for both populations.**

- Lack of specialized training for staff regarding special populations.
- Concerns that stigma may be discouraging residents from accessing treatment.
- Very limited housing in the county, especially for youth.
- The county covers a large rural area, and public transportation access is difficult for individuals living in outlying areas.
- Difficulty coordinating transportation for parent/guardians and children under 21.
- Children under 18 cannot ride the public bus without a guardian.
- Recruitment is difficult in a rural area; few responses to job positing for both professional and para-professional positions.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Provide better access to services and improve response to the behavioral health community.

- Further develop awareness and visibility of services across all disabilities by increasing internet presence, a local school monthly informational bulletin board, radio public service announcements, participation in local health fairs, conferences and providing community forums and presentations.
- Plan for implementation of meaningful use standards in the electronic medical record.
- Monitor and evaluate programs through the collection of data from service reports, utilization reviews, incident reviews, corporate compliance, staff meetings, surveys and meetings with senior-supervisory staff members.
- Apply for the integrated license to merge the mental health and chemical dependency clinics.
- The Mobile Crisis Assessment Team worker and the peer specialist are embedded in the county clinic.
- Enhance family support services by connecting individuals and families with mental health challenges to supports.
- Train staff on all new initiatives and provide cross training.
- The clinics will create open access hours.
- The START program will provide crisis response and prevention with developmental disabilities.

Priority (Rank #2): Primary care and behavioral health will form a collaborative relationship with regular communication and coordination of treatment plans.

- OCS will join the Mohawk Valley DSRIP as a Leatherstocking PPS.
- Care managers will oversee and provide access to appropriate and needed services.
- ARC, RSS and the county clinics will integrate wellness into the programs treatment.
- Schoharie County will be involved in monitoring the quality of the Bassett Health Home Care Management program.
- The clinics will join HIXNY, which is an online access to a patient's community health record.
- The clinics will employ a nurse who will interview, engage, and screen patients and coordinate and create linkages to providers.

Priority (Rank #3): Enhance services to youth.

- Provide a group for youth at the clinic addressing the topics of addiction, family dynamics, conflict resolution, bullying and healthy coping skills.
- Refer identified adolescents to the clinic for a CD/MH screening and/or Teen Intervene.

- Improve the referral process for the chemical dependency clinic.
- Provide some on-site behavioral health services to students in the Jefferson School District.
- Assign a social worker who will serve as a liaison between OCS and local DSS and provide direct consultation with CPS caseworkers regarding families who might benefit from services along with education and training.
- Participate in the children's health home initiative.

Priority (Rank #4): Reduce the number of attempted and completed suicides in the community.

- Increase public awareness, improve internet presence.
- Embed a MCAT worker in the county clinic.
- Offer a "Live for Today" support group in the county.
- Reduce stigma and offer trainings.

Priority (Rank #5): Increase affordable, safe housing.

- Develop a supported housing program for transitional youth, enhance client support services that provide stabilization.
- Collaborate with surrounding rural counties to develop housing initiatives for the substance abuse population.
- Continue the work of SPOA.

Other unranked priorities include:

- Improve and expand peer recovery supports.
- Increase awareness of opioid misuse/abuse and enhance treatment options for opioid abusing clients.

LGU: Schuyler County **RPC Region: Finger Lakes**

Needs Assessment: The following areas were identified as "Moderate Need" for the local MH population.

Youth	**Access to treatment services and transportation.**
Adult	**Access to supported housing and transportation.**
Local vs. Regional	**The LGU did not identify any regional needs.**

- Limited child and adolescent psychiatric hours in clinical settings.
- Limited/minimal housing options.
- Difficulty accessing designated supported housing beds due to the housing provider's reluctance to serve the more chronic population that is in need of housing.
- Lack of transportation resources due to rural geographic location.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Increase psychiatric hours for the community.

- Recruit a doctor or nurse practitioner for the clinic.

Priority (Rank #2): Reduce and prevent suicide among community leaders.

- Increase community partnerships to increase the work of the Schuyler County Suicide Prevention Coalition.
- The Suicide Awareness for Everyone Coalition will host two events.

Priority (Rank #3): Increase system collaboration between professionals.

- Meet with each local primary care physician to establish a relationship and discuss collaborative efforts.

Priority (Rank #4): Create integrated, sustainable, and self-funded housing for identified priority groups.

- Establish a cross system committee to assess the current housing situation and determine level of need to drive housing.
- Complete valuation of existing traditional and non-traditional housing opportunities, develop a project plan based on the 2014 community assessment, and construct new housing.

Priority (Rank #5): Increase employment opportunities for OMH, OASAS and OPWDD recipients

- The ARC will reinstate a work program.
- Pursue the peer specialist opportunities that is target through the local social club.

Other unranked priorities include:

- Educate the community about the wide reaching system changes.

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LGU: Seneca County **RPC Region: Finger Lakes**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to treatment services, supported housing, workforce recruitment/retention and coordination/integration with other systems.**
Adult	**Access to treatment services, supported housing, workforce recruitment/retention and coordination/integration with other systems.**
Local vs. Regional	**The regional high needs were consistent with the local high needs identified above. In addition, access to transportation also identified as a regional high need for both populations.**

- Lack of access to prescribers is a huge need, especially for children.
- Strict criteria for newly developed supported housing beds that exclusively serve State PC discharges has led to under-utilization of these slots. Widen the criteria to include those who have a history of multiple State PC admissions
- Difficulty recruiting/retaining prescribers for both children and adult populations is causing clinics to rely on distant prescribers for several months.
- A need for more licensed prescribers to be able to sign treatment plans.
- Increase incentivizes for doctors to work in mental health clinics.
- Better coordination/integration of treatment with the school districts
- A need to reduce the number of jail inmates with mental illness.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Continue to increase behavioral health housing options.

- LGU and housing providers to report out to CSB Mental Health and Alcohol and Substance Abuse Committee on utilization.
- LGU to regularly attend the Seneca County Housing Coalition meetings.
- LGU will support utilization of regional housing efforts (i.e. "EPC Transformation" supported housing beds).

Priority (Rank #2): Continue to increase housing options for those with mental illness.

- Transformation transitions from Elmira PC to supported housing bed is reported to SPOA and CSB Mental Health Committee.
- LGU to regularly attend Seneca County Housing Coalition meetings.
- Support and promote utilization of regional supported housing bed increases as part of regional grant application.

Priority (Rank #3): Improved early detection and access to children's mental health services.

- Continue to serve as one of the county leads for the OMH Early Recognition Grant and continue the work after the grant ends.
- Monitor progress of the System of Care initiative to ensure adoption of the "Cares Team Map".
- Implementation of the Prevention Agenda.

Priority (Rank #4): Improved employment opportunities for Mental Hygiene population.

- Require that agencies who provide vocational services through the NYESS system report data.
- Report to CSB MH Committee on status of the peer employee program implementation.
- The LGU will monitor provider agency trends on the NYESS system to establish baseline numbers for each agency.

Priority (Rank #5): Reduce underage drinking, cannabis and prescription and other drug abuse.

- Work with others to implement the Drug Free Communities Grant.
- Monitor heroin/opiate abuse/dependency.
- Implement a plan related to the risk and protective factors.

- Review all substance abuse prevention programs to increase evidence based practices.
- Ensure access to school and community based ATOD prevention services.
- The Seneca County Youth Counseling Program will maintain all school-based counseling services and use an evidence based program.
- The County will continue to work with agencies as they implement their respective substance abuse prevention efforts.

Other unranked priorities include:

- Increase access to services.
- Improved health of residents who receive mental health and chemical dependency services.
- Increase and promote respite services.
- Promote service coordination in a health home environment.
- Implement People First Waiver.
- Develop housing options for developmental disability population.
- Promote housing options for chemically dependent population.
- Reduce heroin and prescription opiates use.
- Reduce incidence of compulsive gambling.
- Increase percentage of non-mandated clients.
- Continue to monitor transitioning developmental disability population, “Front door” eligibility assessment and access to approved services.
- Reporting of START at each CSB developmental disability committee meeting.
- Monitor physical health of developmental disabilities population.

LGU: St. Lawrence County **RPC Region: Tug Hill Seaway**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis services and treatment services.**
Adult	**Access to crisis services, treatment services, supported housing, transportation and HCBS; coordination/integration with other systems.**
Local vs. Regional	**All high local needs listed above were also identified as high regional needs, with the exception coordination/integration for adults.**

- Lack of adequate after hours community based crisis response/mobile crisis services resulting in high ER utilization and unnecessary hospitalization.
- Lack of community based programs possess waiting lists.
- Lack of housing programming/services, and despite funding the county lacks adequate supervised/supportive housing units/premise/community residence/apartments and community based alternatives/supports.
- Rural nature of the county causes issues with access to and from services.
- Shortage of primary care doctors acceptance of Medicaid in the region causing MH consumers to remain untreated, under treated or to over utilize ER services.
- Several clients in the health care system are not being linked to BH services when necessary.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Identify and increase various types of safe and affordable housing in all areas of the housing continuum.

- Address a housing shortage by having the CSB and its subcommittee's workgroups work in collaboration with the Points North Housing Coalition to explore innovative housing options.
- The LGU will continue to work with OMH, OASAS and local housing provider groups to discuss housing redesign projects.

Priority (Rank #2): Enhance exist program options and develop and increase program options among OMH, OASAS and OPWDD

- The County will continue to identify service gaps across all disability groups while encouraging collaborative efforts and program enhancement/development necessary to allow clients access to a full continuum of treatment/ recovery/support services such as forensics and diversion programs.
- Develop a service continuum protocol via SPOA.

Priority (Rank #3): Continue to develop/support employment/vocational opportunities/ alternatives to sheltered workshops for the mental health and developmental disability populations.

- Increase community-wide awareness of networking opportunities and resources designed to promote restoration, remediation, and rehabilitation and thereby increase linkage with appropriate programs/alternatives.
- Continue efforts to initiate potential PROS and/or other alternatives.

Priority (Rank #4): Continue to enhance and increase access to transportation.

- Continue to identify, pursue and align alternative public transportation opportunities.

Priority (Rank #5): Integration of behavioral health and primary care.

- The County will establish together "under one roof" primary care services within behavioral health agencies and/or behavioral health services within primary care facilities with the support/ implementation of DSRIP capital projects.

Other unranked priorities include:

- Continued efforts to guide the design and implementation of managed Medicaid behavioral health services.
- Continue efforts to expand and retain qualified behavioral health care professionals.
- Continued efforts to enhance county-wide cross systems approach to embedding suicide prevention into providers.

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LGU: Steuben County **RPC Region: Finger Lakes**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis services.**
Adult	**Access to crisis services.**
Local vs. Regional	**The LGU identified coordination/integration with other systems for the adult population as the only regional high need area.**

- Recent inpatient closure of St. James Mercy Hospital have caused both adolescent and adult residents to travel significant distances to receive acute inpatient care.
- People with more "chronic" and/or serious conditions are not engaging in outpatient behavioral health services, and continue to have preventable ER use and hospitalization.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Prevent suicide among youth and adults.

- Reinvestment funding will continue to be utilized to support community based crisis response, support for families and bridger care management services.
- Increase partnerships dedicated to the Steuben County Suicide Prevention Coalition.
- Implement training for professionals and non-professionals specific to the recognition of risk behavior and appropriate response to suicide.
- The Community Mental Health Center and the ARC will identify crisis service needs.
- LGU will be lead in regional collaboration in developing a Home Based Crisis Intervention program for children and young adults.
- The Community Mental Health Center Mobile Crisis Team will provide community crisis stabilization services as part of DSRIP.

Priority (Rank #2): Strengthen cross-system collaboration.

- Establish a referral and data tracking system with the regional health home by the end of 2016.
- Health home comprehensive care management services to be provided by previous ICM/SCM.
- Promote health and wellness by ensuring recipients have identified a primary care physician who can provide ongoing physical health care.
- All care management staff will attend local and OMH sponsored trainings focused on person centered treatment.
- Community Mental Health Center care managers will provide transition care to patients for a period of 30 days after hospitalizations for chronic ambulatory care sensitive conditions.
- Integration of behavioral health with primary care services.
- Improve coordination of care between substance abuse and mental health programs.

Priority (Rank #3): Improve coordination and communication between substance abuse agencies and mental health agencies to better provide integrated treatment for individuals with co-occurring disorders.

- Steuben County Alcoholism and Substance Abuse Services will continue with integrated treatment service.
- Implement in-service trainings focused on treatment services offered by mental health and substance abuse programs.
- Counselors will work toward increased communication regarding shared cases of co-occurring treatment.
- CASAC position to be established as part of forensic team in county jail.

Priority (Rank #4): Medically assisted treatment will be available.

- Continue current MOU with an area physician to evaluate, prescribe and monitor medications used in the treatment of addiction.
- Chemical dependency counselors will increase their knowledge of best practice to use when working with individuals receiving medication assisted treatment.
- Increase information available to regional health home service providers, physicians and local businesses to provide education pertaining to addiction and treatment services available.

Priority (Rank #5): Improve the quality of services available to individuals with developmental disabilities.

- The ARC will increase the number of individuals receiving self-directed care plan of service.

Other unranked priorities include:

- County will increase awareness and availability of adolescent chemical dependency services.
- Increase retained employment.
- Provide meaningful activity and education opportunities for individuals with developmental disabilities.

LGU: Suffolk County **RPC Region: Long Island**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis and treatment services, supported housing, HCBS, workforce recruitment/retention and coordination/integration with other systems.**
Adult	**Access to crisis and treatment services, supported housing, workforce recruitment/retention and coordination/integration with other systems.**
Local vs. Regional	**The regional high needs identified were identical to the local high needs identified for their respective populations.**

- Lack of accessible crisis alternatives that are not the highest level of care (e.g. inpatient/ERs).
- Increased demand for treatment services due to long wait lists and long delays before seeing a psychiatrist.
- Supportive housing for all populations is insufficient to meet the growing demand as more people are being discharged from inpatient settings due to bed reductions/closures.
- Lacking home and community based supports for the adult population.
- Limited workforce resources and large number of poor, working poor and undocumented population.
- More collaboration and integration is needed between counties.
- Continuation of collaboration and integration across system.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Modify and develop single point of access.

- Implement additional data fields to tracking databases.
- Increase "front door' staffing for intellectual disabilities and developmental disabilities system.
- Monitor the number and utilization of "legacy slots" to address the needs of clients who will not be receiving their supports through health home care management.
- Utilize system of care meetings to enhance the system of care for youth with behavioral, emotional, and social challenges.

Priority (Rank #2): Attention to housing.

- Address the waitlist for residential developmental disabilities services.
- Increase the number of housing opportunities in the mental hygiene system.
- Increase the number of residential/supportive beds for persons with all levels of disabilities.
- Encourage applications for any available HUD Section 8 housing.
- Increase placement service options for hard to place youth with multi-system and/or cross-system needs.

Priority (Rank #3): Address lengthy wait lists for individuals referred to services.

- Increase efficiency of existing clinical systems.
- Improve overall competence across the chemical dependency treatment system.
- Utilize DSRIP by collaborating with partners in developing and implementing new OTP services in substance abuse system.

Priority (Rank #4): Development of acute care psychiatric beds for dually-diagnosed individuals.

- Convene meeting of all governmental stakeholders to increase capacity at publically operated hospitals in the region.
- Cooperate with OPWDD in establishing the NYS START initiative.
- Specialized training as to the needs and complexities of the dually diagnosed.

Priority (Rank #5): Improved access to evidence based/integrated treatment for individuals with co-occurring disorders.

- Train in Focus on Integrated Treatment (FIT) program.

Other unranked priorities include:

- Restore development of traditional site based day habilitation services in developmental disabilities system.
- Increase access to community-based supports for persons with complex, multiple needs who are in recovery.
- Reduce the wait-lists for children's care management services.
- Promote and build emotional health for all disabilities.
- Improve access to a more comprehensive transportation system.
- Develop a seamless transition for individuals aging out of the children's and youth's systems.
- Explore ways to facilitate and support the increased integration of peers into the mental health workforce.
- Develop family support services for the developmental disabilities population through the RFP process.

LGU: Sullivan County **RPC Region: Mid-Hudson**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis services and transportation.**
Adult	**Access to transportation.**
Local vs. Regional	**All local high needs were also identified as regional high needs.**

- Issues accessing needed services for individuals with co-occurring issues who are taking benzodiazepines and misusing opiates/heroin.
- Difficulty placing transition age youth into crisis services due to age restrictions, parental insurance, or lack of insurance.
- Lack of adequate and cost effective public transportation given rural layout.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Maintain and enhance prevention and outreach programs.

- Provide suicide prevention information at all educational venues and committee meetings.
- Inform community institutions of ability to provide drug and alcohol education at all community venues.
- Utilize Recovery Center model through a proposal to expand peer support assistance to more of a focus on supported education and employment.

Priority (Rank #2): Establish more safe and sober housing.

- Develop and maintain additional transitional, supportive and permanent housing for mental health and substance abuse populations.

Priority (Rank #3): Enhance services to individuals involved in the criminal justice system.

- Enhance needed space and decrease time limitations in current inmate facility.
- Provide information on the Sequential Intercept Model at all community meetings.

Priority (Rank #4): Provide additional treatment services.

- Begin discussion and development of peer advocates, liaisons, coaches and bridgers.
- Enhance integrated treatment approach (i.e. Health Grant).
- Provide education regarding the wellness approach at all community activities and meetings.
- Engage and participate in the monitoring of referrals and discharges under the BHO.
- Develop an ambulatory detox.

Priority (Rank #5): Enhancement of services for emerging adults aging out of residential care.

- Promote policies and practices that address family relationships and permanency.
- Engage youth to work with their case managers in formulating goals to achieve by age 25.
- Ensure that the services available to youth are developmentally appropriate.
- Use federal funding to create programs for older youth and track their outcomes.
- Develop policies and practices that support prevention and development of the specific skills and competencies necessary for adult success.
- Engage with the community to create broad support systems for transitioning youth.

Other unranked priorities include:

- Be actively involved in the governance of health homes, MRT and DSRIP.
- Increase respite beds for children and adults.
- Increase access to children's psychiatric services/assessment through the use of telepsychiatry.

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LGU: Tioga County **RPC Region: Southern Tier**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to transportation.**
Adult	**Access to transportation.**
Local vs. Regional	**Access to transportation.**

- Tioga County no longer has a public transportation system due to changes in funding.

Priorities: The following priorities were identified as related to the OMH service system.

Priority (Rank #1): The county and collaborative partners will assure access to a full continuum of care.

- The CSB and its subcommittees will work to ensure that the community understands the importance of maintaining a comprehensive continuum of care.
- Providers will continue to explore ways of developing increased peer support.
- Partner with the County Health Department to share common goal of increasing visibility of services available.
- Pursue any objectives that relate to mental health or substance abuse as outlined in the Community Health Improvement Plan.
- Explore possibility of transitioning a Social Club to a Recovery Center.

Priority (Rank #2): To oversee the development and implementation of goals and objectives of the Suicide Prevention Coalition.

- Work with OMH to train community school districts, various agencies and clergy in suicide screening.
- Continue to educate the community regarding the risks, warning signs and interventions.

Priority (Rank #3): OPWDD will successfully oversee the development of additional housing opportunities, employment and various needs for developmental disabilities population.

- Work with Broome DDSO and/or voluntary agencies to develop housing opportunities for both the Autism Spectrum Disorder home as well as the home(s) for the medically frail individuals.
- The community will continue to support individuals with the OPWDD system to develop the ability to live independently with supports.
- The OPWDD sub-committee will monitor and identify solutions to the fact that the aging developmental disability population is aging and need housing.
- Will provide input regarding the needs of county residents pertaining to BDC closing.

Priority (Rank #4): Increase awareness of the issue of synthetic and opioid drug use.

- The county prevention program, Probation, the Sherriff's Department and Alcohol and Drug Services form a coalition to research, plan for and provide education to the community.
- Participate in all coalition development and events.
- Will train all staff on the use of Narcan.

Priority (Rank #5): Develop additional employment opportunities for individuals with mental illness or developmental disabilities.

- Bring community providers together to identify barriers to integrated employment.
- Expand existing employment opportunities with campaign of successful consumer stories.
- Provide cultural sensitivity training to the community.

Other unranked priorities include:

- Continued participation in ongoing county disaster planning and emergency preparedness.
- Increase integration of physical health and behavioral health services.
- Support the efforts of TCCASA to seek funding to provide evidence based gambling prevention.
- Create an Open Access program.
- Educate community to changes in behavioral healthcare.

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LGU: Tompkins County **RPC Region: Southern Tier**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention services and supported housing.**
Adult	**Access to prevention services and supported housing.**
Local vs. Regional	**Regional high needs identified by the LGU were workforce recruitment and retention for both populations.**

- There are very few prevention services available, and most resources are targeted at treatment.
- Housing stock is limited and often cost prohibitive due to higher education demands on housing.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Enhance the existing continuum of care to ensure that necessary community based services are available for all Mental Hygiene populations.

- The Mental Health Sub-Committee will plan for supportive housing and the sub-committees will determine other methods that will assist in gathering information from individuals/families who need mental hygiene services.
- Identify services that will provide necessary community based services for individuals who are being discharged from the Local Intensive Treatment Unit at Broome Developmental Center (BDC) and the long stay individuals discharged from the PCs.
- Support and strengthen the role of peers in individuals' person centered plans.
- Identify and work with OASAS providers to establish community detoxification and stabilization services.
- Increase the Mid-Lake ACT Team reach.
- Suicide prevention will maintain adequate funding.
- Increase collaborative efforts between all community agencies.

Priority (Rank #2): The Southern Tier and the Finger Lakes region will continue to have an adequate number of medium to long stay psychiatric beds available.

- OMH PC's will have adequate beds.

Priority (Rank #3): Increase safe, affordable housing throughout the Mental Hygiene system.

- Individuals discharged from BDC Local Intensive Treatment Unit will be successfully housed.
- The provider agencies will work to establish a Halfway House/Community Residence.
- Develop a plan for housing opportunities with appropriate treatment interventions for individuals who experience co-occurring disorders of mental health/chemical dependency.
- OPWDD and the community will develop additional housing opportunities.
- Integrate homeless individuals who have mental illness/chemical dependency into the community.

Priority (Rank #4): Promote the integration of physical and behavioral healthcare.

- County Mental Health will provide health monitoring services for significant health indicators for individuals taking psychotropic medication.
- Continue smoking cessation programs.
- Children, adolescents and adults will be diverted from the emergency department when appropriate. There is community collaboration through DSRIP.
- Address issues regarding access to mental health that was identified in the results of the Community Health Assessment.
- Promote co-location of physical health and mental hygiene services.

Priority (Rank #5): The transitioning mental health and developmental disabilities populations will have supports in place.

- The TCMH will update available resources with 211 including frequently asked questions from parents and providers.

Other unranked priorities include:

- Providers within the Mental Hygiene provider network will provide person-centered care.
- Improve integration of services for individuals with co-occurring disorders.
- Provide adequate respite services.
- Individuals with autism spectrum disorders will receive evidence based treatment.
- Youth will have access to mental health interventions.
- Implement a PROS.
- Increase employment opportunities/meaningful activities.
- Implement trauma informed care.

LGU: Ulster County **RPC Region: Mid-Hudson**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis and treatment services, transportation, HCBS and workforce recruitment/retention.**
Adult	**Access to crisis and treatment services, supported housing, transportation, HCBS and workforce recruitment/retention.**
Local vs. Regional	**Regional high needs identified were access to crisis services, transportation, workforce recruitment/retention and coordination with other systems for both populations. Access to treatment services for youth and access to supported housing for adults were also identified as high regional needs.**

- More crisis services with expanded hours are need to increase access and reduce ED utilization.
- Lack of psychiatric inpatient child bed availability, and lengthy wait time for children in the ED.
- Long wait time for therapy (3-4 weeks) and psychiatric (8-10 weeks) appointments due to high productivity standards and heavy scheduling.
- Housing availability for the mental health population is limited to non-existent.
- Limited transportation has led to difficulty accessing treatment, employment and other services, and limits/prohibits social skill building for adults, children and families.
- Inaccessible treatment increases risk factors for a range of behavioral health issues.
- Health home development has not been a suitable alternative to intensive case management for adults due to less intensive services for SPMI population and increasing caseloads. Concern that this will also be the case for youth and their families when health homes rollout for this population.
- Lack of guidance/guarantee whether State aid will continue to support non-Medicaid individuals.
- Lack of licensed, qualified, and experienced staff which is causing competition between agencies to staff their expanding programs and services.
- Staff retention difficulties due to private agencies' inability to pay competitive salaries.
- Adults and children in treatment are re-assigned multiple times which hinders treatment.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Work with behavioral health providers associated with DSRIP to ensure service access.

- Collaborate with behavioral health providers to facilitate the transition to Medicaid managed care.
- Identify gaps in child and adolescent emergency services and increase access to inpatient psychiatric hospitals.
- Work with RPC to monitor all county residents at that facility.
- Monitor article 31 clinics and PROS to ensure access and quality of service.
- Collaborate with OPWDD providers to identify unmet needs, access and barrier issues.
- Support the establishment of evidence based and promising practices that promote client engagement in treatment and improved measurable outcomes.
- Coordinate adult case management, care coordination and health home resources.
- Develop cross-system education and case review collaboration in the adult services system.
- Work to secure outpatient clinic services in sub area 5, Western Ulster County.
- Expand methadone clinic services.
- Work with OPWDD to identify aging parents in an effort to provide referral and assistance with eligibility prior to urgent need.
- Work with OPWDD licensed residential providers and local hospital EDs to develop a system of information provision on potentially high medical need individuals.
- Receive referral tracking information from OPWDD regarding individuals who have applied for OPWDD eligibility.
- Work closely with child SPOA provides to meet readiness for system transitions.

Priority (Rank #2): Work with Department of Health to implement the Prevention Agenda and the County Health Improvement Plan

- Advocate for sufficient care coordination, other safety net and wrap around resources to reduce utilization of EDs and hospitalization.
- Ulster County SPEAK will sponsor Mental Health First Aid, Youth Mental Health First Aid, Safe Talk and assist trainings.
- Work with county organizations to facilitate county wide mental health and substance abuse prevention initiatives.
- Expansion of Mobile Mental Health Team services.
- Provide trainings in Narcan.
- Coordinate the development of an outpatient restoration/receiving center in an effort to offer immediate psychiatric and medical intervention and follow up treatment as part of DSRIP.

Priority (Rank #3): Improve consumer access to housing.

- Increase alternative housing that offers more support/oversight with behavioral and medical health.
- Support RSS/MCCDC in the development of a licensed community residence for females.
- LGU oversight of unlicensed congregate settings.

Priority (Rank #4): Collaborate with provider agencies and the criminal justice system to identify and fill gaps for individuals involved in the justice system

- Work with the criminal justice system to maintain open and transparent communication, identify training needs and identify service gaps
- Help coordinate a crisis intervention training for law enforcement and correction officers
- Provide Mental Health First Aid training to the police department
- Collaborate with new mobile mental health team, and work with police departments to reduce unnecessary arrests or EDs.
- Develop a project to work with individuals incarcerated in jail to engage these individuals.
- Work to divert individual who have been arrest on a misdemeanor charge and been found incompetent to the HealthAlliance of the Hudson Valley (HAHV).

LGU: Warren/Washington Counties **RPC Region: Adirondacks**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis services, treatment services and transportation, workforce recruitment and retention, and coordination/integration with other systems.**
Adult	**Access to crisis services, treatment services, SH and transportation, workforce recruitment and retention, and coordination/integration with other systems.**
Local vs. Regional	**Access to transportation and workforce recruitment and retention were the only two high regional needs identified by the LGU.**

- A need for alternative community-based crisis services; current over-reliance on ER.
- Limited access to OP mental health services for both adults and youth has caused an issue for individuals seeking services and providers looking to make referrals.
- Waitlist up to a year for individuals in need of SH.
- Lack of public transportation in rural area and higher than statewide average poverty rates contribute to significant transportation needs for residents.
- Lack of access to peer delivered mental health support, respite, transition age services, and day and vocational services.
- Psychiatry, child psychiatry, nurse practitioners, and clinicians are all in demand.
- A need for systems to work closely together to ensure continuity and quality of care now that there is an emphasis integration of primary care and BH services.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Service options for individuals in crisis will be developed/expanded.

- Regional mobile crisis teams for both children and adults will be developed and implemented.
- Meetings with providers to enhance utilization and integration of START team services.
- DSRIP Crisis Stabilization Project, or components thereof, will be developed and implemented.
- Family and peer support personnel will be incorporated into the Glens Falls Hospital Emergency Care Center behavioral health evaluation process.
- Crisis respite services will be developed for youth under the age of 15 years old.
- A Crisis Services Coordination Committee will be established.

Priority (Rank #2): Individuals will have timely access to appropriate supports and services.

- Providers will explore development of appropriate "transition age" services.
- The Office of Community Services (OCS) and the CSB and OPWDD Developmental Disabilities Regional Office will examine the community-wide capacity for eligibility determinations and will make recommendations regarding need and potential solutions.
- Providers in the community will work with OPWDD to develop expanded day habilitation opportunities.
- CSB subcommittee will review the continuum of vocational services within the developmental disabilities community.
- The OCS behavioral health subcommittee will explore expansion of OP clinic services to underserved areas.
- OCS and providers will explore development of OP mental health clinic services within school settings.
- Local OP clinic providers will explore development of "open access" models and improved clinic operational processes to improve access to OP clinic services.
- Convene a Clinic Access Workgroup to explore various clinic operating procedures.

Priority (Rank #3): Integrated models of care will be developed and implemented.

- Explore/promote additional opportunities for integration of BH services in primary care settings.
- DSRIP Integration of Primary Care and BH project, or components thereof, will be implemented including bi-directional integration among several community providers.
- OCS will engage with the local health departments to examine ways to support achievement of positive behavioral healthcare outcomes and improvement in overall population health.

Priority (Rank #4): Individuals will have timely access to appropriate housing options.

- Housing providers will pursue development of residential opportunities as financing is made available and proved by the subcommittees of the CSB.
- Supportive housing for individuals with chemical dependence will be developed in Washington County.
- Establish a process to review quarterly the status of individuals with developmental disabilities requesting an out-of-home residence.
- Reduce the number of community residence beds and increase the number of community apartments with supports.
- Work with OMH Field Office to develop new supported housing resources.

Priority (Rank #5): Optimize provider and system adaption to the changing healthcare environment.

- OCS and the CSB will assist providers with advocating to maintain current critical sources of funding, understand shifting sources of funding, and explore alternative ways to provide and/or fund critical services.
- Promote dialogue within the local service system to discuss feasibility of collaboration among contract agencies and other local providers and strategies to ensure service delivery to the highest need, highest risk populations.
- Develop a dashboard monitoring system to track impact of system changes on local needs and the capacity of local services.

Other unranked priorities include:

- Substance abuse and mental health prevention and education services will be expanded.

LGU: Wayne County **RPC Region: Finger Lakes**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**The LGU did not identify any local needs for youth.**
Adult	**The LGU did not identify any local needs for adults.**
Local vs. Regional	**The LGU did not identify any regional needs.**

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Continue efforts to develop, improve and increase access in services for all behavioral health groups and in particular those dually diagnosed.

- Work with county providers to plan for role in the changing health care environment.
- Further develop the on-going communication forum with local hospital emergency department and psychiatric inpatient units.
- Enhance coordination of primary care providers and other health care partner organizations.
- Work in collaboration with Mobile Integration Teams.
- Develop immediate access services and brief intervention strategies through the OMH VAP initiative.

Priority (Rank #2): Develop safe and affordable housing.

- Partner with a town or village that is willing to accept a Lakeview Health Services housing project.
- Recent launch of a crisis apartment service.
- Continue to increase crisis respite services.

Priority (Rank #3): Continue to expand community support services for teens.

- Create licensed mental health clinics in schools and advocate for the creation of OASAS licensed clinics in school.
- Continue Home and Community Based Services (HCBS) Waiver.
- Expand crisis respite services.
- Add satellite clinics in schools.
- Add a Mobile Integration Team for youth and families.
- Participate with DCJS on the Finger Lakes Youth Justice Team.
- Continue to participate in youth arrest diversion team.
- Develop peer and family training program.
- Continue to provide Youth Mental Health First Aid.

Priority (Rank #4): Collaborate with community partner to increase and education regarding working together with mental health/chemical dependency/developmental disability populations.

- Engage with law enforcement related organizations.
- Increase activities aimed at addressing the rise in heroin use.
- Participate in holding a summit on heroin use.
- Expand Narcan training.
- Advocate to restore and increase funding related to behavioral health services in jails.
- Mental Health First Aid for youths and adults will continue.
- Will partner with schools on Project AWARE.
- Continue with ongoing youth justice services.
- Equip local police with Narcan.

Priority (Rank #5): Assess needs and plan for the geriatric population.

- Evaluate needs and begin to construct models of support, strategies and services.
- Form new relationships with agencies that specialize in providing service to the elderly to gain increased understanding.
- Continue to work with county nursing home.
- Follow nurse family partnership initiative.

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LGU: Westchester County **RPC Region: Mid-Hudson**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis and treatment services.**
Adult	**Access to crisis services and supported housing.**
Local vs. Regional	**Regional high needs identified were access to crisis services for both populations, and access to treatment services for the youth population.**

- Limited number of crisis response and crisis stabilization services, however they are not available 24/7.
- While agencies have engaged in best practice models and open access initiatives,
- Despite best practice models, there are still significant waiting list for outpatient treatment and a significant gap in services for individuals with private, commercial insurance.
- Significant wailing list for housing services for adults with SMI.
- There is a need for alternative levels of care for individuals that are not successful in lower levels of care such as supportive housing.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): DCMH will help to guide transition to managed care/health home approach.

- Retrieve data from PSYKES to track access to services.
- DCMH/CCSI have created a new portal system to track outcomes and monitor services.
- OPWDD's Front Door process provides a process for intake, identification of needs and creation of immediate access.
- Promote self-directed services.
- Utilize the SPOA process for community and legacy referrals.
- Review performance measures to monitor outcomes for those affected by substance abuse.

Priority (Rank #2): Expand access to safe, affordable and appropriate housing.

- Work with OASAS, community providers and Westchester County HUD continuum of care.
- Work closely with the respective health home to overcome barriers to moving individuals into different levels of housing care provided by the MRT beds.
- Regular meetings between the LGU and OPWDD staff to explore if the LGU can maintain its monitoring role with onset of the OPWDD Certified Residential Opportunities Protocol.
- Work with OMH to ensure that new housing is targeted to those most in need.
- DCMH will participate in the OPWDD NYSACRA Housing initiative.

Priority (Rank #3): Create diversion for the Mental Hygiene population from involvement in the criminal justice system.

- Provide outreach to the various systems that serve developmentally disabled individuals who are at risk or involved in the criminal justice system.
- CIT and mental hygiene training for officers and new recruits.
- DCMH has implemented two crisis intervention teams.
- Work with partners to improve processes associated with individuals on a 730 status.
- Treatment Alternative to a Safer Community will provide alternative to incarceration case management services for the substance abuse population.
- DCMH will work with the Reentry Taskforce and Lexington Center for Recovery to implement Thinking for a Change for the substance abuse population.

Priority (Rank #4): Improve outcomes and access for individuals with co-occurring disabilities

- The state agencies and DCMH will help individuals with co-occurring disabilities to get treatment when other options have failed because of policies and practices
- Work with providers to obtain integrated licensure

Priority (Rank #5): Increase access and capacity for appropriate mental health and substance use services for children and their families

- DCMH will work with mental health agencies and schools to increase mental health service capacity.
- Adolescent substance treatment services to be established in Southern Westchester.

Other unranked priorities include:

- Increase the number of providers offering evidence based treatments.
- Implement strategies to promote fiscal viability, positive outcomes and provide more culturally, racially and linguistically competent and person centered care.
- Provide trauma informed care.
- Increase use of person-centered planning and wraparound care for individuals with complex, multiple needs.
- Improve outcomes for individuals transitioning to adult services.
- Increase the number of programs obtaining a 3 year license.
- Participate in the County Emergency Management Initiative.

LGU: Wyoming County **RPC Region: Western New York**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to prevention and crisis services, supported housing, transportation and workforce recruitment/retention.**
Adult	**Access to prevention and crisis services, supported housing, transportation and workforce recruitment/retention.**
Local vs. Regional	**Access to treatment services for youth was the only identified regional high need.**

- There are two prevention programs that are operated in school districts, but not every district agrees to have the programs in their schools.
- Prevention is needed to reduce high rates of suicide rates within this population, but there are no specific prevention programs for adults embedded in clinics.
- No mobile crisis teams are available or housed in the county.
- Wait lists exist for community-based housing such as OMH supported housing programs, treatment apartments and crisis transitional housing.
- Limited transportation opportunities.
- Psychiatric providers and other professionals do not consider living and/or working in Wyoming County a "first choice."

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Promote integrated, person-centered and community based care for recipients of behavioral health, developmental disability and physical health services.

- Adult and children's SPOA will facilitate increased communication strategies from system transformation initiatives.
- Information sharing through the children's Tier II Committee, CSB, leadership meetings, Wyoming County Interagency meeting in order to discuss system transformation initiatives and to foster increased coordination of service to recipients of behavioral health, developmental disabilities and physical health.
- Strengthen adult health home and initiate children's health home.

Priority (Rank #2): The county suicide rate will not exceed the average of all rural counties in Western NY DOH region by the end of 2018.

- Provide suicide education through many venues.
- Professional training scheduled.
- The Dual Recovery Coordinator and/or other Mental Health Department staff will support screenings for mental health and substance abuse disorders in medical settings.
- The Dual Recovery Coordinator and/or other mental Health Department staff will identify school's protocol for response to student's mental health crisis and suicidality.

Priority (Rank #3): Provide expanded housing options.

- Consult with housing providers to apply for additional supported housing units.
- Consult with OPWDD providers to assure that these individuals have access to adequate housing, particularly those coming out of hospital, jail, or higher levels of care.

Priority (Rank #4): Expanded supports for persons in recovery from substance abuse.

- Develop more intensive support services for people in recovery.
- Consider the need for expanded medication management services in outpatient setting.

Priority (Rank #5): Strengthen families, schools and communities and promote an integrated system of care to support children, youth, and young adults.

- Reduce youth use of substances through prevention, coalition, media and environmental strategies.
- Active membership in Tier II Committee will increase by 10%, promote Tier I child/youth referral and provide common sense parenting modules. The Assistant Director of Child/Families will identify areas of most need.

Other unranked priorities include:

- Increase persons with disabilities working in a wider range of work settings.
- Identify specific impediments to adequate transportation.

LGU: Yates County **RPC Region: Finger Lakes**

Needs Assessment: The following areas were identified as "High Need" for the local MH population.

Youth	**Access to crisis and treatment services, supported housing, transportation and workforce recruitment/retention.**
Adult	**Access to treatment and other support services, supported housing, transportation, workforce recruitment/retention, and coordination/integration with other systems.**
Local vs. Regional	**Access to crisis and treatment services, supported housing, transportation, workforce recruitment/retention, coordination/integration with other systems and sex offender treatment for both populations, and access to other support services for the adult population. These needs correlated with mostly all of the local high needs identified above.**

- Crisis services are distant and have time response limitations. The alternative to crisis services provided by individual agencies are services provided in the hospital ED.
- Difficulty recruiting and retaining staff which is reducing access to treatment and resulting in long waiting times for service occur for all populations and age groups.
- Shortage of housing overall.
- Tourist driven market makes supportive housing options within the county sparse, and efforts to identify/develop supportive beds outside of the county are hindered by transportation issues.
- Lack of public transportation and little commercial transportation.
- Limited support resources such as drop in centers, prevention and treatment services due to the county's poor rural nature.
- Child psychiatrists, psychiatrists, addictions physicians, and qualified mental health professionals are in very short supply and are quite mobile.
- Salary rates are uncompetitive which is reducing workforce recruitment and retention.
- Lack of coordination/integration between primary care and behavioral health has led to duplication of effort, poly pharmacy, treatment plan changes and requirements for those in treatment to navigate multiple systems.

Priority Outcomes: The following were identified as the LGU's top five rank-ordered priority outcomes.

Priority (Rank #1): Increase public transportation options.

- Continue as a participant in the ARC small scale public transportation system.

Priority (Rank #2): Housing for individuals with mental illness, in recovery from substance abuse and developmental delays residing with aging parents/other family

- Development of emergency housing option, temporary housing option, transitional beds for individuals with mental health issues exiting inpatients care, adult and children youth crisis beds and adult transition beds, substance abuse supportive beds and crisis beds and residential options under the OPWDD bed reduction planning.
- Increase support staff and transportation to better utilize existing bed resources.
- Advocacy to approve Schedule C for purchase of a structure to run a substance abuse supported housing program and Cadence Square Housing program for veterans in recovery from substance abuse.
- Partnering in the RFP for a mental health SOSCR.
- Partner in the START initiative and the development of unlicensed housing options for individuals for developmental disabilities.

Priority (Rank #3): Enhance collaboration regarding services for individuals with co-occurring disorders.

- Providers of Mental Hygiene will work with each other and primary care providers.

Priority (Rank #4): Improved vocational opportunities for individuals with mental health, substance abuse, and developmental disabilities.

- Monitoring of participant participation in vocational programs and increased dialog between and amongst providers.
- Continue ongoing education of businesses regarding hiring a person with a disability and services that are available post-hiring.

Priority (Rank #5): Continuation of adequate funding for prevention.

- LGU will continue to advocate with OASAS and encourage local legislators to advocate to maintain all prevention funding.