2004-2008

New York State Office of Mental Health Statewide Comprehensive Plan for Mental Health Services

January 2004

New York State
George E. Pataki, Governor

Office of Mental Health
Sharon E. Carpinello, RN, PhD, Acting Commissioner

Message From the Acting Commissioner

IT IS WITH GREAT PLEASURE that I introduce the Statewide Comprehensive Plan for Mental Health Services for the 2004-2008 planning period developed in accordance with Section 5.07 of the Mental Hygiene Law. The 2004-2008 Statewide Comprehensive Plan represents an energetic, innovative, and transparent approach to quality and collaboration—both hallmarks for OMH's planning and service design. We have also taken this opportunity to present the agency's report of progress between 2001 and 2003. Although progress reporting is not required for compliance with Section 5.07, it is our intent to provide readers with an overview of significant agency accomplishments as they relate to continuing implementation of our commitment to scientifically validated, consumer-oriented mental health services for adults, children, and their families.

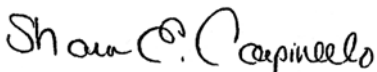
As Acting Commissioner, I am proud to offer the Plan to New Yorkers whose lives are in some way touched by mental health issues. Readers will find that the Plan is rich in factual information and clearly delineates current and future challenges. They will also find that it addresses both the major clinical program areas as well as important public mental health topics such as suicide prevention, eating disorders, and disaster preparedness. This dual focus is consistent with this agency's role as the State's mental health authority, which necessitates that state and local governments address a wide range of public mental health needs.

The Plan's publication comes at a particularly crucial time. OMH will be proposing, through legislation submitted to the 2004 Legislature, a plan to embark on an important new phase in policy development. The pivotal change is to propose legislation to establish the Commission for the Closure of State Psychiatric Centers, a bipartisan commission to debate and recommend a plan to eliminate excess capacity in State-operated inpatient facilities. Elimination of excess capacity will increase the flexibility of the State to fund the development of additional community-based mental health services.

Our enhanced management information capacity, described in great detail throughout the Plan, represents our commitment to a data-driven approach to decision-making. We are particularly proud of the "infrastructure" gains we are making through building a data warehouse and implementing a performance measurement system. Use of data is critical to our commitment to advancing an evidence-based quality agenda.

Chapters in the Plan describing adult, children, and public mental health promotion activities all highlight our commitment to integrate the best scientific thinking within daily practice. We continue, in this Plan, to draw our strategies and objectives from our strategic planning framework of "Accountability, Best Practices, and Care Coordination," and call the reader's attention to both the beginning and ending chapters, which describe our policy framework and major directions for the next five years.

The Office of Mental Health will continue to be guided by strategies and governing principles that promote wellness, and reduce the burden of mental illness. We will continue to be guided by the belief that service delivery that is consumer and family focused, responsive to individual needs and respectful of culture and language, will have the best opportunity to help people recover from their psychiatric illnesses. Recovery is real.



Sharon E. Carpinello, RN, PhD
Acting Commissioner
NYS Office of Mental Health

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Executive Summary

THIS STATEWIDE COMPREHENSIVE PLAN for Mental Health Services 2004-2008 is prepared in compliance with Mental Hygiene Law, Section 5.07. It represents a continuation of the Office of Mental Health's commitment to insure that New Yorkers have appropriate access to the highest possible quality of mental health care.

The Plan represents a departure from previous documents in two important respects. First, it combines future planning directions as required by statute with a description of agency progress during the period 2001-2003. Second, it encompasses a broad range of topics beyond the scope of services to adults with serious mental illness and children with serious emotional disorders. In addition to describing program initiatives and future plans for both of these major target groups, the Plan provides valuable information concerning a broader agenda of public mental health promotion through education and advocacy. These dual agency functions of ensuring access to high quality, science-based interventions for people with major service needs while promoting positive mental health is a departure from previous plans, which have mainly addressed the operations of State Psychiatric Centers and outlined anticipated improvements in building a community-based system of care.

It is the intent of the Plan to broaden the planning horizon. Building a community-based system of care continues to be a priority in New York State and will continue to be a major focus for program and policy development during the 2004-2008 planning period. To reinforce the intent to create holistic, person-centered systems of local care, it is necessary to develop a planning platform that is wider ranging than those used in the past. Throughout the Plan, the factual information presented is supported by important supplemental materials and statistical information contained in a series of appendices. In the appendices State and local data are displayed in an integrated fashion and shown at county-specific levels. The data are also displayed by auspice (e.g., private, general, and State-operated hospitals) where helpful.

These layers of detail are intended to generate interest toward an analytical, population-based planning approach, which is

used in some areas of public health but is not widespread in public mental health. Population-based planning is described in Chapter 2 and embedded in discussions on service utilization, inpatient care, performance measurement, and adult and children services. These examples are intended to generate interest in localities toward developing data-driven, results-oriented specific plans for different target groups and services throughout the State.

A starting point for this planning approach is presented in Chapter 4, which includes considerable detail on issues concerning inpatient capacity, utilization, costs, and preliminary outcome measurement indicators for both State and local sectors. The Plan's discussion of inpatient services is a way to introduce a new series of local planning forums intended to create a collaborative and transparent approach to determining how resources are currently used and can best be used to maximize outcomes. A focus on positive social outcomes such as recovery and community integration is the motivation for proposing this person-centered, location specific approach to service-system planning.

The Plan is presented with the perspective that readers will review certain areas and be inspired to request further inquiry and insight concerning the nature of mental health care in New York State. There are specifics in the Plan on how the OMH strategic planning framework, the ABC's of mental health, is being implemented, with discussion of accountability structures at the local-level, ongoing commitment to the evidence-based practice initiatives both underway and anticipated in adult and children's arenas, and care coordination efforts through new advances in technology and decision support. These advances are all informed by a series of guiding principles, which stress the importance of community inclusion, community integration, and the highest possible standards of care. The Plan also presents detailed discussion on advances in management information, research, and emerging ideas in public mental health promotion – particularly plans for a new statewide suicide prevention campaign. While the Plan's chapters all describe activities anticipated to occur during the 2004-2008 planning period, Chapter 10 summarizes how the major ideas presented throughout the document are integrated within OMH's strategic planning framework and specific, strategic initiatives delineated for accomplishment by 2008.

CHAPTER 1
Commitment to Quality: 2004-2008

THE FUNDAMENTAL GOAL of the Office for Mental Health (OMH) for the next five years is to maximize access to quality mental health care. This commitment to quality has been the cornerstone of OMH planning initiatives and is consistent with a sweeping national agenda for improving quality in health care. The national agenda envisions a health care system with a renewed focus on innovation and quality, based on scientifically proven 'evidence-based' treatments and practices as the foundation of routine health care. This agenda is also integral to the promotion of recovery and community integration for individuals with mental illness, because without quality services and appropriate access to care, it is unlikely that the full potential for recovery can be realized.

The New York State Office of Mental Health's Role as the Public Mental Health Authority

New York is recognized as a national leader in the mental health quality agenda, and its progress has been followed in a number of national publications and journals.[1] OMH's commitment to enhanced quality in New York State's mental health system has been embodied in "Winds of Change," a strategic quality improvement initiative now in its third year. The Winds of Change campaign is discussed later in this Chapter and refer-

Table 1-1
Reform Phases in the Mental Health System

Reform	Era	Setting	Focus of reform
Moral treatment	1800-1850	Asylum	Humane, restorative treatment
Mental hygiene	1890-1920	Mental hospital & clinic	Prevention, scientific orientation
Community mental health	1955-1970	Community mental health center	Deinstitutionalization, social integration
Community support	1975-1995	Community support	Mental illness as a social welfare problem (e.g., housing, employment)
Pursuing quality	2000-ongoing	All mental health & health settings	Access to quality services for everyone

Adapted from: "Mental Health: A Report of the Surgeon General" (1999)

Notes

1 These publications include Psychiatric Services, 2002 and Schizophrenia Bulletin, 2002.

enced throughout this Plan. Much of this Plan chronicles agency progress at quality improvements in day-to-day operations as well as those directly connected to the Winds of Change campaign. As presented in Table 1-1, when viewed in a historical context, this strategic focus on quality can be seen as the most recent phase of reform in the mental health system.

The existing framework for the OMH quality agenda was established in a strategic plan unveiled in 2000, which updated and focused the agency's mission, vision, and values.

OMH Mission, Vision, and Values

Mission

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

Vision

The New York State Office of Mental Health will work toward a more effective public mental health system, which values recovery, hope, excellence, respect, and safety.

OMH is achieving its mission and vision by using a framework known as the "ABC's of mental health care," which the agency uses to plan and manage performance in its day-to-day operations. The ABC's are:

- **Accountability for Results**, whereby a clearly defined entity or individual is responsible for the effectiveness of services delivered. Services are designed and delivered to achieve specific outcomes, which are measured by performance indicators.
- **Best Practices**, whereby service design and delivery is based on the best research and evidence available and best practice guidelines are incorporated into treatment practices. Adherence to these guidelines is measured as part of the accountability process.

Values

- **Recovery** is the process of gaining control over one's life in the context of the personal, social and economic losses that may result from the experience of psychiatric disability. It is a continuing, non-linear, highly individual process that is based on hope and leads to healing and growth;
- **Hope** is the belief that one has both the ability and the opportunity to engage in the recovery process;
- **Excellence** is the state of possessing superior merit in the design, delivery and evaluation of mental health services;
- **Respect** is esteem for the worth of a person including recognition of dignity, diversity and cultural differences; and
- **Safety** is an environment free from hurt, injury or danger.

- **Coordination of Care**, whereby coordinated, comprehensive networks of providers deliver a balanced array of medical, self-help, social, supportive and rehabilitative services and programs. These services are focused on rehabilitation and recovery, and individualized service plans are designed around the needs and desires of the individual.

A Brief Overview of the State Mental Health Authority's Primary Functions

OMH has two primary functions as the State mental health authority. OMH promotes overall public mental health through education and advocacy for all New Yorkers. For adults with severe mental illness and children with serious emotional disturbance, OMH ensures access to high quality services. The overall goal is to help individuals diagnosed with mental illness to live productive, full lives in their communities.

OMH strives to achieve its dual purpose through an evolving and integrated results-oriented oversight of State and local resources. Performance measurement, described in greater detail in Chapters 4 and 8, is focused on the key areas of access to services, service quality and appropriateness, outcomes, and cost. OMH is committed to the use of accurate, timely, and meaningful performance indicators to guide management decisions. To effectively carry out its dual functions, OMH has organized its operations in four primary business lines.

1. Regulation, Certification, and Oversight of New York's Public Mental Health System

OMH is responsible for the regulation and licensing of more than 2,500 mental health programs operated by local governments and private agencies. The services provided by these programs include inpatient, outpatient, emergency, residential, and community support. The focus on ensuring quality care continues, but the methods are changing. OMH has begun to use its certification standards as an impetus for improving clinical service and quality. The agency evaluates the performance of the public mental health system on an ongoing basis, and has made substantial investments in information technology and data analysis for this purpose. Results are documented in routine publications, and in the future, will be documented on the OMH Web site. Performance indicators and program evaluation findings help to summarize the extent to which OMH is achieving its policy objectives.

2. Direct Provision of State-operated Inpatient and Outpatient Mental Health Services

State-operated inpatient services consist of a network of 26 psychiatric centers that include 17 psychiatric centers serving adults with severe mental illness, six serving children with severe emotional distress, and three serving forensic patients involved with the criminal justice system. State-operated inpatient services are typically reserved for individuals who require longer lengths of stay than what is offered in locally-operated community hospitals, which generally provide only short-term inpatient care.

State-operated outpatient services are similar to those provided by locally-operated agencies, and are primarily used by individuals who are also users of State inpatient services. Each year, approximately 34,500 individuals use OMH-sponsored outpatient services. This includes an active caseload of over 7,400 inmates/patients incarcerated in Department of Correctional Services facilities in over 33 sites statewide.

3. Conduct of Basic and Applied Research to Advance Prevention, Treatment, and Recovery

Continued emphasis on research to develop better methods of prevention and treatment is an important part of OMH's effort to identify interventions that have been proven by scientific research to be effective, and incorporate them into mainstream practice throughout the mental health system. In addition to the 26 psychiatric centers discussed above, OMH also operates two internationally renowned research facilities, the Nathan S. Kline Institute for Psychiatric Research (NKI) and the New York State Psychiatric Institute (NYSPI). The institutes conduct research in basic science to understand the biochemical and genetic mechanisms underlying mental illness, as well as clinical trials to develop and evaluate new treatments and services. OMH researchers have been participants in numerous collaborative, multi-site clinical trials that have led to U.S. Food and Drug Administration (FDA) approval of new medications for schizophrenia, bipolar disorder, depression, and anxiety states. OMH clinical and services researchers also focus on outcome studies to determine better methods of service delivery, and recognize the importance of involving consumers from diverse cultural communities at every stage of the process of recovery. OMH's research activities are described in greater detail in Chapter 9.

4. Public Mental Health Promotion

In an effort to increase the general public's awareness and understanding of mental health, OMH routinely conducts a variety of educational activities that focus on the nature and impact of mental illness, effective treatments and services, useful preventive and coping strategies, and how to get help. These activities include development and distribution of educational materials such as informational booklets, information dissemination through the OMH Web site (http://www.omh.state.ny.us/omhweb/resources/) and mass media campaigns. Since the September 11, 2001 terrorist attacks, OMH mental health promotion activities have focused primarily on the mental health impact of terrorism, including common signs and symptoms of psychological trauma, how to differentiate normal from abnormal reactions, effective personal coping strategies, and where to get additional help. In addition to continuing these activities, this year OMH will launch a collaborative statewide prevention effort to reduce the number of deaths due to suicide in New York State. OMH's public mental health promotion activities are described in greater detail in Chapter 7.

Emphasis on Recovery Oriented Services

Central to the mission and vision of OMH is an understanding that people with psychiatric disabilities can and do recover, and that services can be designed to enhance

this possibility. Recent research shows high rates of recovery for people with even the most serious diagnoses. New studies documenting the effectiveness of self-help and rehabilitation demonstrate that it is possible to help people move away from long-term dependence on expensive and intrusive services and toward hope, empowerment, and recovery.

Recovery-oriented services are characterized by a commitment to promoting and preserving wellness, to expanding choice and minimizing coercion, and to providing the least intrusive services in the most inegrated environments. This approach promotes maximum flexibility and choice to meet individually defined goals and to permit person-centered rather than program-centered services.

OMH's commitment to expanding the recovery-oriented approach to service design and delivery is grounded in empirical data demonstrating that people can and do recover from diagnoses of serious mental illnesses. The approach is influenced and informed by people who have been diagnosed with mental illness, recognizing that they have valuable knowledge and insights about healing, coping, and recovery that can help shape service delivery systems. The agency's commitment to a quality improvement agenda is only meaningful when viewed against a recovery "lens." Recovery provides the perspective for hope and meaning in each person's life, and also for a system of care which sees itself as instrumental to improving the quality of life for individuals and their families. While quality improvement activities exist in all business domains, the role of OMH as the State mental health authority is to promote the recovery "lens" within its own constituencies and elsewhere in State government.

Participating in Inter-agency Efforts to Support Recovery for Individuals with Disabilities

New York State has also taken steps to create a more supportive environment for people with psychiatric and other disabilities, helping them to reach their highest potential. The State's Medicaid Buy-in Program[2] enables New Yorkers with disabilities to return to work while keeping the medical supports necessary to be successful. The New York State Most Integrated Setting Council has been established to explore and recommend ways to ensure that New Yorkers with disabilities receive services in the most appropriate settings to meet their individual needs. The Council's membership is comprised of representatives from agencies and organizations serving New Yorkers with disabilities. Additional information about the Council is included in Chapter 2.

Major Opportunities Exist to Improve the Quality of Health and Mental Health Care

The National Perspective

Across the nation, medical leaders and research scientists are making discoveries every day to improve the quality of health care. Yet, routine medical practice does not rapidly assimilate these ongoing opportunities. This gap between research and medical practice is evident across the nation and across the full spectrum of health care. While there are many reasons why this gap exists, it is imperative that it be addressed. The following examples illustrate the national emphasis on a quality agenda in health care

Notes

2 More information about the Medicaid Buy-in is available on the Web at http://www.health.state.ny.us/nysdoh/mancare/omm/2003/jul2003.htm#buyin

and the need for substantial reform in the nation's mental health care system.

Institute of Medicine of the National Academies

The scope of the issue was made clear in the Institute of Medicine's ground breaking 2001 report entitled, "Crossing the Quality Chasm: A New Health System for the 21st Century." In the executive summary, the authors state: "The American health care delivery system is in need of fundamental change. Many patients, doctors, nurses and health care leaders are concerned that the care delivered is not, essentially, the care we should receive." The report goes on to state: "Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge. Yet there is strong evidence that this is frequently not the case."

Web site: http://www.iom.edu/

President's New Freedom Commission on Mental Health

The systemic problems related to quality are equally present in the national mental health system. In April 2002, the Commission identified three obstacles preventing Americans with mental illness from getting the excellent care they deserve: stigma surrounding mental illnesses; unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance; and fragmentation in the mental health service delivery system. President Bush established the New Freedom Commission on Mental Health as part of a commitment to eliminate inequality for Americans with disabilities.

In July 2003, the New Freedom Commission's Final Report confirmed that "...there are unmet needs, and many barriers impede care for people with mental illnesses. Mental illnesses are shockingly common; they affect almost every American family. It can happen to a child, a brother, a grandparent, or a co-worker. It can happen to someone from any background – African American, Alaska Native, Asian American, Hispanic American, Native American, Pacific Islander, or White American. It can occur at any stage of life, from childhood to old age. No community is unaffected by mental illnesses; no school or workplace is untouched."

The Commission recommends a fundamental transformation of the nation's approach to mental health care to ensure that mental health services and supports actively facilitate recovery and build resilience to face life's challenges. Its Final Report states: "Far too often, treatments and services that are based on rigorous clinical research languish for years rather than being used effectively at the earliest opportunity."

Web site:
http://www.mentalhealthcommission.gov/

Substance Abuse and Mental Health Services Administration Leadership

Charles Curie, Administrator of the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) has called for a science to practice agenda at the national level. SAMHSA is a primary sponsor of the National Evidence-Based Practices Project that is designed to promote widespread use of evidence-based practices within the public mental health system. SAMHSA is also sponsoring a National Evidence-Based Practices Center, operated by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute. The Center is designed to stimulate the

interest of states and their stakeholders in the use of the resource kits and the adoption of evidence-based practices.

In addition, OMH is currently implementing family psychoeducation throughout New York State. OMH recently received a grant award from SAMHSA to develop family psychoeducation, a major example of evidence-based protocols with significant positive outcomes. This grant will be used to create family psychoeducation sites in three culturally diverse communities within New York State. The 2001 Surgeon General's Report indicates that the disparity between research and practice is worse for racial and ethnic minorities because of a failure to analyze treatment efficacy by ethnicity or race.

Web site: http://www.samhsa.gov/

Mental Health: A Report of the Surgeon General

The first Surgeon General's Report on Mental Health was issued in 1999. In the report, the Surgeon General observes: "State-of-the-art treatments, carefully refined through years of research, are not being translated into community settings. As noted throughout this report, a wide variety of community-based services are of proven value for even the most severe mental illnesses. Exciting new research-based advances are emerging that will enhance the delivery of treatments and services in areas crucial to consumers and families – employment, housing, and diversion of people with mental disorders out of the criminal justice systems. Yet a gap persists in the broad introduction and application of these advances in services delivery to local communities, and many people with mental illness are being denied the most up-to-date and advanced forms of treatment."

In 2001, *Mental Health: Culture, Race and Ethnicity*,[3] was issued as a supplement to the 1999 Surgeon General's report on mental health. This supplement focuses on the role of culture in mental health to highlight the disparities experienced by racial and ethnic minorities, and describes resources for next steps in eliminating these disparities. As presented in Appendix 1, eliminating disparities in mental health care is a goal of quality improvement initiatives on both the national and state levels.

Web site:
http://www.surgeongeneral.gov/library/mentalhealth/home.html

Schizophrenia Patient Outcomes Research Team (PORT)

A seminal research study conducted by the Schizophrenia Patient Outcomes Research Team (PORT) developed and disseminated recommendations for the treatment of schizophrenia based on existing scientific evidence.[4] The PORT treatment recommendations focus on treatments for which there is substantial evidence of efficacy, and are organized according to categories of interventions: antipsychotic medications, adjunctive pharmacotherapies, electroconvulsive therapy, psychological interventions, family interventions, vocational rehabilitation, and assertive community treatment/assertive case management. Released nearly ten years ago, the PORT study documented that only about half of people with schizophrenia receive guideline based care. As described in Chapter 5, OMH is working to close this quality gap by developing and disseminating guideline-based recommendations for managing schizophrenia and other clinical decision support tools.

Notes

3 The 2001 Supplement is available on the Internet at http://www.surgeongeneral.gov/library/ mentalhealth/cre/

4 Lehman A.F., & Steinwachs D.M. (1998). Translating research into practice: the Schizophrenia Patient Outcomes Research Team (PORT) treatment recommendations. Schizophrenia Bulletin, 24(1): 1-10.

Web site:
http://www.ahcpr.gov/clinic/schzrec.htm

Accreditation
National accrediting bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), are moving towards mandating that hospitals use evidence-based practices. Currently, JCAHO requires hospitals to consider the use of evidence-based practices and document a rationale for using or not using them. In addition, in February 1997 JCAHO launched an outcome measurement initiative to evaluate and improve healthcare organizations' processes, functions, and outcomes of patient care. The measurement system, which is headed under JCAHO, is the ORYX initiative. JCAHO is moving towards requiring hospitals to use core ORYX measures, some of which are based on evidence-based practices.

Web site: http://www.jcaho.org/

What is New York State Doing to Improve Quality?

Over the past three years, OMH's management emphasis has been largely focused on the "Best Practice" component of our strategic planning framework. OMH's commitment to improving the quality of care in our public mental health system is exemplified in our evidence-based practices initiatives, the work in our research division, and participation in outcomes measurement activities.

Evidence-based Practice Initiatives

Over the past decade, research in the field of mental health has demonstrated that some specific practices work well in improving outcomes in the lives of individuals diagnosed with a severe mental illness. These specific practices are called 'evidence-based' and are interventions for which there is consistent, scientific evidence showing that they improve consumer outcomes. Research indicates that adherence to specific programmatic standards (referred to as fidelity to implementation) is required to produce desired outcomes for recovery.[5]

National studies have shown that a majority of individuals diagnosed with a severe mental illness do not have access to evidence-based practices (EBP). OMH's Winds of Change campaign is dedicated to providing mental health services that are based on the best evidence available. The overall goal is to promote recovery for individuals with mental illness and to enable them to live full lives within their communities. OMH believes that when given a choice, recipients of mental health services will choose to take part in evidence-based practices. The agency also believes that exposure to evidence-based practices will improve the individual's chances for recovery because there are consistent findings that use of these interventions reduces the duration and frequency of inpatient hospitalizations and improves quality of life.

OMH's Winds of Change campaign contains interventions designed for adults with schizophrenia and other major mental illnesses and also contains proven interventions available for children with serious emotional disorders. The campaign was initiated in 2001 with an internationally recognized conference attended by well over 700 people. Evidence-based practices

Notes

5 Torrey, W.C., Drake, R.E., Dixon, L., Burns, B.J., Flynn, L., Rush, A.J., Clark, R.E., & Klatzker, D. (2001). Implementing evidence-based practices for persons with severe mental illnesses. Psychiatric Services, 52 (1), 45-50.

Figure 1-1
Winds of Change Web Page

for adults and children were identified. In June and December of 2002, OMH sponsored four dialogues as a way of bringing outside experts together with the system's senior administrators, and advocates and providers. Since the goal of the dialogues was for the assembled stakeholders to offer advice to OMH on its current initiatives, particularly Winds of Change, the four dialogues examined dissemination of evidence-based practices in different components of the system. The first focused on the integration into the community of individuals with mental health conditions; the second concentrated on creating work opportunities for those individuals; the third examined issues related to children and families; and the fourth discussed cultural differences and cultural competence in mental health treatment. A summary of the dialogues is included in Appendix 2-1.

OMH's Winds of Change campaign is proceeding to roll out individual interventions such as assertive community treatment and functional family therapy. The campaign also has a philosophical underpinning of cultural change for State and local service providers to adopt continuous quality improvement and data-driven decision making as routine, core practices. More information about the campaign is available on the OMH Web site at http://www.omh.state.ny.us/omhweb/ebp/ (Figure 1-1).

Outcomes Measurement Activities

The principal value of adopting a science to service agenda as exemplified by the Winds of Change campaign is that use of evidence-based treatments is associated with improved outcomes. Therefore, success for a public mental health authority can best be demonstrated by how effectively the application of these services improves outcomes for persons with serious mental illness and the extent to which these individuals achieve successful integration into community roles and activities. Chapter 8 offers an overview of the agency's current efforts at implementing a performance measurement model. Although all states have to comply with Federal performance measurement requirements, it is the intent of New York State to use the national performance measurement framework at multiple levels of analysis within the State and to provide significant opportunities for its customized use by local governments.

The Importance of State and Local Collaborations in Advancing the Quality Agenda

OMH and local mental health departments are working together to overcome and remove barriers to successful community living for persons with severe mental ill-

ness. These efforts are supported by Governor Pataki's Enhanced Community Services Program, which was implemented to expand access to community-based interventions and assure a better-coordinated system of care that gives priority access to those with the greatest need. The overall goal is to promote recovery and full community living for individuals with severe mental illness, while preserving public safety, and ensuring that respect, empowerment, and quality of life are incorporated into every aspect of care.

As part of its Winds of Change quality improvement agenda, OMH is working with local governments to implement a number of initiatives that utilize evidence-based practice. Examples include, but are not limited to:

- The number of children receiving Home and Community-Based Services (HCBS) Waiver has nearly tripled, serving approximately 900 children each year. This innovative program offers families traditional and non-traditional mental health treatment and support, and allows seriously emotionally disturbed children to remain at home rather than undergo institutional placement.

- The number of adults receiving case management services has increased by almost 13,000; more than 25,000 adults now receive case management services. This includes the more than doubling of availability of assertive community treatment (ACT), a mobile team-based approach that is documented to produce superior outcomes for individuals with the most serious impairments and the greatest need for community support.

- Kendra's Law created assisted outpatient treatment (AOT) in New York State. The law establishes a procedure for certain individuals to receive and accept outpatient treatment for their mental illness. Under the Governor's leadership, New York State committed $32 million in new resources to implement Kendra's Law and expand critical services to ensure timely and appropriate treatment for those who require close supervision to live successfully in the community. To date, nearly 3,000 individuals have received court-ordered AOT and close to 2,000 are also receiving enhanced case management services due to an AOT referral.

More information about these and other evidence-based practice initiatives is included in Chapters 5 and 6.

Looking to the Future of New York State's Public Mental Health System

In the future, the consistent application of initiatives to advance accountability, evidence-based practices, and care coordination, as well as the introduction of emerging treatment technologies, will continue to increase the community integration opportunities for individuals with serious mental illnesses. This will help to lessen the demand for inpatient psychiatric treatment, and allow for some shift of resources away from inpatient settings to community services.

OMH believes that the best way to predict the future is to "invent it" during the present, with concerted efforts to include full planning involvement of local governmental partners, stakeholders, other State agencies and the public. The hallmark of a quality mental health system is the degree of transparency it maintains for its planning

and decision-making processes. During the 2004-2008 planning period, OMH will continue to carry out its functions as State mental health authority to ensure appropriate access to quality services in both State and local sectors and to monitor and manage performance against outcomes. Concurrently, it will collaboratively develop a new, broadly inclusive planning platform to guide the State along a path toward improved quality of care and promotion of positive mental health for all New Yorkers.

To begin this public dialogue, OMH is articulating a vision for the future of the public mental health system. The vision is presented in Table 1-2 as a set of nine guiding principles or goals, each of which contributes to recovery and full community integration.

Chapter 10 describes several new, collaborative strategic actions OMH intends to complete during the 2004-2008 planning period. These actions will continue to implement the Accountability, Best Practice, and Care Coordination framework and will be accomplished in addition to the agency's ongoing work in planning, inpatient and community-based service delivery, public mental health promotion, performance measurement, and research. Each of the new strategies in Chapter 10 is multiply connected to the guiding principles. When the new strategies are collectively accomplished, they will significantly advance this vision.

Table 1-2

Guiding Principles for Planning Process

1. All persons will have the opportunity to live, work, and socialize in the most integrated settings.
2. The burden of illness, disability, and injury will be reduced.
3. Disparities in access, service utilization, and outcomes disparities based on culture, race, ethnicity, language, age, and gender will be eliminated.
4. Continue advocacy for enhanced Federal flexibility that will promote innovations in service delivery.
5. The proportion of mental health care that is community-based will continue to increase.
6. Advances in science, technology, and informatics will be used to improve the outcome of care.
7. Future mental health funding methodologies and levels will support the ability to recruit and retain skilled staff able to deliver the effective, evidence-based services available now and in the future.
8. Partnerships with higher education institutions will provide impetus for sustaining education, clinical practice, and research.
9. Single points of access (SPOA) will ensure better outcomes.

During this planning period, it is anticipated that all who embrace this vision will debate and discuss the guiding principles, and that this public dialogue will generate many additional examples of how State and local governments, as well as all affected stakeholders, can further promote quality mental health care.

Use of Resources to Support this Vision for the Future

New York State should continue to maintain its current status as a national leader in per capita and total State spending for mental health care for its citizens. In the future, the distribution of mental health funding should shift to support existing and emerging treatment and support technologies that are most effective at supporting individual attainment of community integration. Funding should increase over time in the early intervention and prevention, residential, outpatient, and community support areas. Funding should decrease over time for inpatient services. As this transition occurs, new and different strategies should be developed to continue accessing the hospital industry's extraordinary clinical and administrative skills and resources that facilitate effective, integrated, community-based service delivery approaches.

Many of these changes could be achieved by modifying the method of reimbursement to create a more effective focus on the needs of the individual receiving services. Reimbursement should become outcome-oriented – tied to the relative effectiveness of interventions in helping the individual achieve and maintain personal goals related to community integration. These changes must be designed and implemented carefully, incrementally, and collaboratively to avoid substantial disruption to the service delivery system during the transition.

Planning, Process, and Implementation

The programatic and fiscal vision described here has to be examined and debated at a local level. A systematic, multi-site, broad stakeholder planning process and implementation plan is currently being developed. More information about this effort is presented in Chapter 2 and Appendix 2.

CHAPTER 2

Building a Stronger Planning Process

A STRONG COLLABORATION between the State, local governments, and stakeholders is integral to implementing the quality mental health initiatives planned during 2004-2008. In reviewing feedback on the mental health planning process, OMH has identified a call from multiple stakeholders to revitalize the process by emphasizing the commitment to local planning input and data driven approaches. We acknowledge these needs and are engaging in sustained and ongoing efforts to respond to them.

As the cornerstone of an improved planning process, OMH is committed to population-based planning, forecasting, and management that utilizes relevant data gleaned from agency performance measurement activities to enable data-driven decision-making. Population-based planning is the foundation for customized care because it identifies the near term and future needs of both communities and target groups at risk. Movement toward a population-based planning system is necessary to fulfill both the State and national commitments to improving the quality of mental health services by focusing on the needs of each individual. It is also fully consistent with input received from key stakeholders during this year's planning process, which is summarized in this Chapter and in Appendix 2. Given this commitment, population-based planning will be integrated into future statewide comprehensive plans for mental health services.

Population-based planning tools do not rely primarily upon historical provider and program utilization data, but instead look at the needs of the groups in question based on demographics, disease prevalence and severity, stakeholder satisfaction, and appropriateness of care. This type of planning requires that policy makers know the unique characteristics of the groups being served and what current and future resources will be required to serve them. Population-based plans normally include descriptions of the services that should be provided, the demand capacity for these, and the types of facilities and services that will best meet that demand. Population-based plans should also emphasize linkages between formal mental health services and other community services and supports that can facilitate recovery and mitigate inappropriate or unnecessary mental health service use.

Population-based planning in the public mental health system requires that communities identify the types of mental health and health care services that are needed in their service areas based on the specific groups who need service, including age, sex, ethnicity, and growth projections within the population. Use of a population base to determine needs also requires that planners consider screening for the disease, severity of symptoms and functional impairments, mortality and morbidity rates, and individual strengths and community supports available to the individual in addition to trends in services utilization. Because of its focus on individual needs and resources, this type of planning has a powerful correlation potential to resource allocation based on performance measures such as access, appropriateness, clinical outcomes, community integration, and cost.

The Relationship Between Population-Based Planning and Prevalence

Population-based planning does take estimates of the prevalence of mental disorders into account; however, prevalence estimates must be interpreted with caution for a number of reasons. First, and perhaps most significant, is the fact that the field of psychiatric epidemiology continues to evolve rapidly, and thus prevalence estimates for serious and persistent mental health conditions remain the subject of frequent revision, debate and discussion. At the national level, the Federal Center for Mental Health Services developed and published a national prevalence methodology in 1996.[1] These estimates should be used with caution because they are based on rates for all adults (including those who are institutionalized in correctional facilities, prisons, or serving with the military) and because they consider such broad social indicators as age, race, sex, marital status, socio-economic and immigration status, and urbanicity. Prevalence rates have wide estimation ranges based on the use of these indicators.

In mental health planning, "unmet need" is often simplistically defined as the difference between prevalence estimates of the number of individuals having a disorder and utilization data based estimates of the number of individuals who actually receive treatment (the latter is sometimes labeled "treated prevalence"). However, a gap between prevalence and treated prevalence cannot simply be labeled an "unmet need" that must be met by expansion of the public mental health system, for a variety of factors.

For instance, people routinely receive their mental health care from any number of settings outside the publicly funded mental health system, including private psychiatrists and other physicians operating outside of specialty mental health programs (e.g., private practitioners). New York State currently licenses over 6,200 psychiatrists, many of whom do not practice within the public mental health system funded and/or licensed by OMH. Also, instead of traditional mental health services, individuals may choose to use other forms of assistance such as pastoral counseling, alternative medicine, and self-help.

In addition, some proportion of individuals who meet the diagnostic criteria for a severe mental illness as operationalized in current epidemiologic surveys may nevertheless not experience their symptoms as sufficiently disabling to motivate them to seek treatment. This final caution concerning the use of prevalence estimates for planning purposes should also be used to inform local deliberations – the diagnostic

Notes

1 Kessler, R. C., P. A. Berglund, E. E. Walters, P. J. Leaf, A. C. Kouzis, M. L. Bruce, R. M. et al. (1998). A methodology for estimating the 12-Month prevalence of serious mental illness. In Mental Health, United States 1998, edited by R. W. Manderscheid and M.J. Henderson, pp. 99-109. Washington, DC: U.S. Government Printing Office

criteria used to develop the prevalence estimates may not adequately reflect the dimension of severity reflected in the actual population for which the plan is being conducted. As the Surgeon General's Report acknowledges: "Current epidemiological estimates therefore cannot definitively identify those who are in need of treatment.... In the absence of valid measures of need, rates of disorder estimated in epidemiological surveys serve as an imperfect proxy for the need for care and treatment."

A transition to population-based planning will require that both local and statewide plans are developed, updated, and evaluated on an ongoing basis through a process that involves all major system stakeholders. Actively engaging the full range of interests and perspectives in a locally initiated planning process will help ensure mutual understanding and agreement on the specific changes which must take place. Our goal is to move this and future plans in a direction that results in a county-centered approach, maximizing local and stakeholder participation. We recognize that this entails an investment over time and are committed to that investment.

To initiate these activities, OMH is currently collaborating with the Conference of Local Mental Hygiene Directors (CLMHD, Appendix 11) to strengthen and improve the mental health planning process. This multiphase, long-term effort is described in the August 13, 2003 letter from OMH and CLMHD to local mental health directors in Appendix 2-2.

Incorporating Local Input into this Year's Plan

In shaping this comprehensive five-year plan, OMH received and considered a range of local input, both specific to the planning process and to the development and provision of mental health services. Appendix 2 of this document provides information regarding local input, highlighting: testimony from public hearings, the Mental Health Services Council statement regarding Statewide Goals and Objectives, and the advice and guidance received from advisory groups and their membership.

The Mental Health Planning Process

OMH engages in a broad-based, multifaceted planning process and provides reports to the public, the executive branch and the legislature on this process. Figure 2-1 shows how OMH shapes its comprehensive five-year plan and yearly updates using a complex process of opinion gathering.

The Inter-Office Coordinating Counsel

As can be seen in Figure 2-1, OMH is part of the Department of Mental Hygiene, a State agency re-organized in 1978 to reflect three distinct offices: the Office of Alcoholism and Substance Abuse (OASAS), the Office of Mental Retardation and Developmental Disabilities (OMRDD) and OMH. The Inter-Office Coordinating Council (IOCC) was established under the New York State Mental Hygiene Law to coordinate certain activities involving the three State mental hygiene agencies. The members of the IOCC are the Commissioners of these three agencies, one of whom acts

as Chairperson. Currently, the Commissioner of OMH is the Chairperson.

While the IOCC agencies function independently, they also coordinate their efforts in a variety of ways. For example, OMH and OASAS are involved in a multi-year initiative to better serve individuals recovering from both mental illness and chemical abuse (see Chapter 5). As part of this effort, a task force under the joint leadership of OMH and OASAS issued a report delineating pilot criteria to identify and make eligible for services those individuals with the most severe and persistent level of co-occurring disorders. Additionally, this initiative has produced recommendations for system wide interventions to create more responsive systems of care for everyone with co-occurring disorders.

The three members of the IOCC are in frequent communication regarding issues of mutual concern. During 2002, OMH worked closely with OMRDD and the Developmental Disabilities Planning Council on the selection and awarding of statewide training grants for services for individuals with dual diagnosis. In addition, OMH and OASAS have developed a joint work force training plan that has identified the core competencies necessary for treating persons with co-occurring disorders, and have developed training curricula to support those competencies.

The 5.07 Planning Process

The enabling legislation for reorganizing the Department of Mental Hygiene, in addition to creating an oversight body in the IOCC, also established the basis for a statewide comprehensive planning process involving each separate office of the Department and coordinated at a local level through the CLMHD. This process is described in Section 5.07 of the Mental Hygiene Law and is therefore frequently referenced as the 5.07 planning process. This 2004 2008 statewide comprehensive plan is the statutorily-defined product of this planning process. Under the Mental Hygiene Law, the planning process begins with a statement of Statewide Goals and Objectives from the Mental Health Services Council (MHSC). County and New York City mental health plans are developed consistent with these goals and objectives. The counties and New York City then provide input to OMH based on their local planning efforts. (Table 2-1)

As is shown in Figure 2-1, OMH also gathers input from many other sources, including appointed policy advisory boards, oversight bodies, the courts, the legislature, stakeholder groups, and professional and trade associations. Additionally, OMH has a Federal mandate to plan and evaluate its

Table 2-1

The 5.07 Required Planning Process

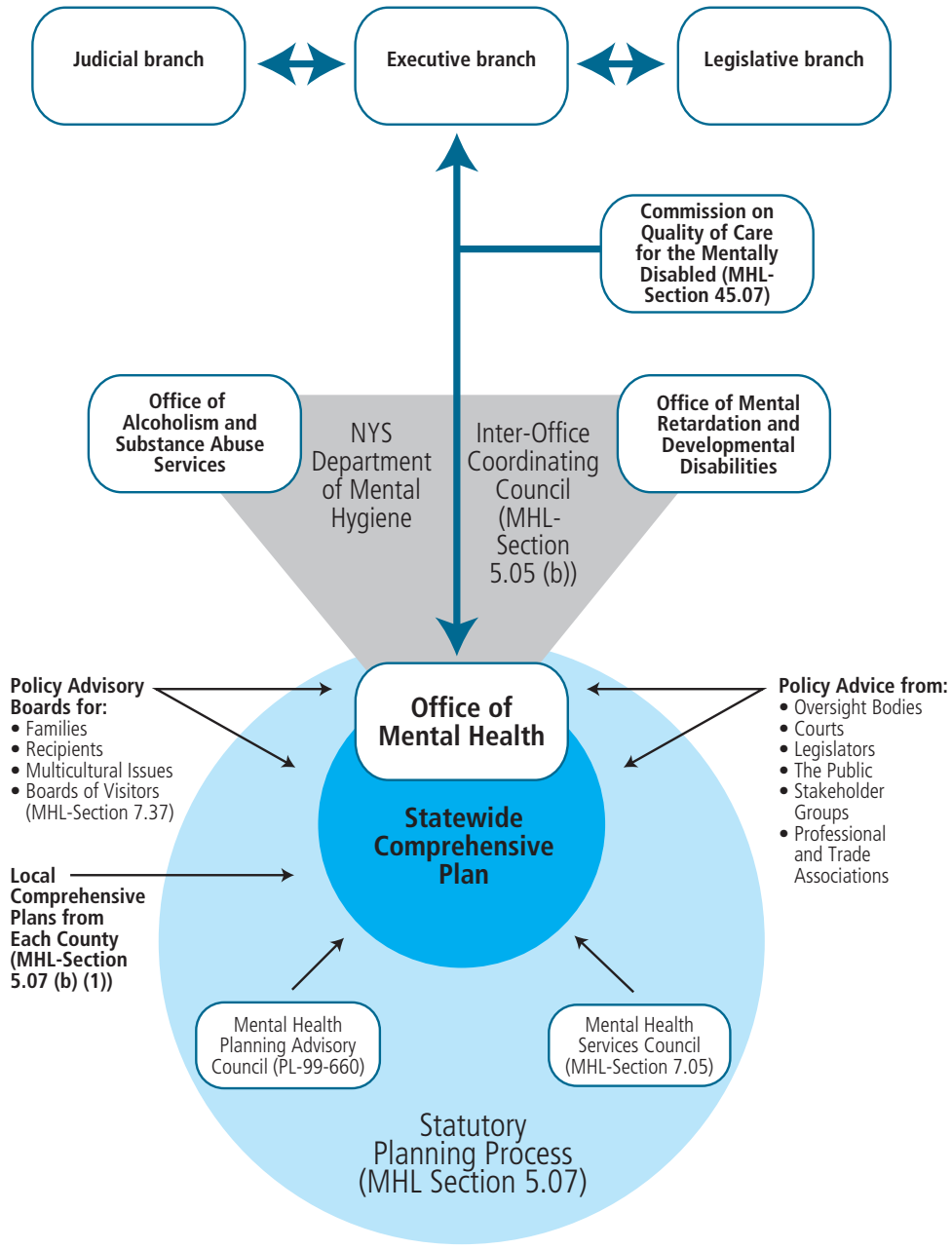
1. Mental Health Services Council establishes Statewide Goals and Objectives as the basis for local service plan development.

2. In the counties and New York City, the local planning process includes consumers, families, providers, local criminal justice agencies, and other stakeholders in the development of local service plans consistent with the Statement of Goals and Objectives.

3. OMH develops a Statewide Comprehensive Five Year Plan for Mental Health Services based on the review of submissions from advisory groups, counties and New York City, other stakeholders, and OMH field offices.

FIGURE 2-1

Statutory, Oversight and Administrative Functions Which Contribute to the Planning Process



services according to the provision of the Public Health Services Act. This Act (usually referred to as PL-9960) governs state receipt of Federal Block Grant Funding. In New York State, OMH uses a Mental Health Planning Advisory Council (usually referred to as MHPAC) to guide its policy development and planning efforts in satisfaction of the Federal mandate.

In June 2003, the MHSC held a hearing in New York City to gather public input about issues, goals, and objectives for OMH statewide planning. A summary of the testimony from that hearing, as well as input regarding goals and objectives, were provided in a letter (included as Appendices 2-3 and 2-4) from the MHSC to OMH, dated July 21, 2003. Additional local information was obtained from county plans and from public hearings held after the release of last year's plan. The following is a compilation of major points from the MHSC hearing, its transmittal to OMH and other sources of public input.

- Effective statewide and local mental health planning requires the consistent compilation and availability of current data on resources, needs, and financing.

- Statewide plans should include an analysis of the role and future of State operated psychiatric centers, forensic psychiatric programs, and research institutes collectively and with reference to each facility. Suggestions included a task force charged with developing and implementing an assessment tool to gather data and prepare a report on the need for State operated inpatient beds for adults and children.

- Services for sub-populations of adults with mental illness (e.g., prisoner mental health services) and children should be explicated in statewide plans, and this presentation should also focus on issues generated by location (i.e., rural, suburban, and urban). Service gaps should be identified and special attention should be directed at small sub-populations (e.g., young adults with mental illness who are also homeless) for whom targeted service design historically has been lacking.

- The services provided by Article 28 general hospitals should be included in planning processes; likewise OMH should have a formal linkage (i.e., liaison) to this service sector.

- Service design should be culturally competent. Consumer and family input is invaluable to service design. The critical role of employment in recovery must be recognized. Employment must be highlighted and real meaningful work opportunities developed.

- More emphasis on early identification and prevention protocols, a plan for suicide prevention, and opportunities to impact individual and community mental health through a variety of non-mental health venues.

As described in Chapter 10, OMH has incorporated the input it has received regarding these themes to the extent practical in this year's plan. Strategies are being developed to address them more thoroughly over the coming year and in future plans. A more comprehensive review of these considerations is included in Appendix 2.

The new planning process will address the concerns identified by the Mental Health Services Council and other stakeholder input concerning the planning process.

Bipartisan Commission for the Closing of State Psychiatric Centers

An important addition to the planning process, subject to Legislative approval, will be initiated in 2004 through the formation of a special Commission for the Closure of State Psychiatric Centers. This bipartisan commission will develop recommendations for reducing unneeded inpatient capacity. Both formal advisory boards, stakeholder groups, trade associations, and interested citizens will all have the opportunity through public hearings to inform this significant new component of the planning process. Recommendations from the Commission would then be implemented so that, over the next several years, there can occur an orderly realignment of the system of care to more accurately reflect state and national commitments to community-based care.

The Work of Policy Advisory Boards

As shown in Figure 2-1, OMH maintains policy advisory boards and related staff functions for individuals receiving services (the Recipient Advisory Committee), for families, (the recently constituted Commissioner's Committee for Families), and for people who represent ethnic minorities (the Multicultural Advisory Committee). Additionally, the Mental Hygiene Law (Section 7.37) authorizes Boards of Visitors to represent the interest of persons served at each State-operated psychiatric center and a statewide association of Boards of Visitors.

Recipient Involvement in Planning and Delivery of Services

Over the past decade, the public mental health field has become increasingly aware of the value of involving people who have used mental health services in decision-making at all levels. OMH has been a national leader in this effort, recognizing that recipients' experiential knowledge and perspectives add a dimension to the decision-making process that results in more effective problem solving. People who have used services know what has been helpful, what has been harmful, and what has given them hope and fostered their recovery.

OMH supports recipient involvement and maintains an active Bureau of Recipient Affairs. The Bureau is directed and staffed by people who have used mental health services, with the goal of expanding avenues for recipient input into planning, policy-making, program development, and evaluation throughout the system. OMH has a Recipient Advisory Committee, which meets quarterly to advise the Bureau of Recipient Affairs and OMH senior management. Recipients serve on OMH planning and advisory bodies including the Mental Health Services Council and the Mental Health Planning Advisory Council. OMH has actively promoted the growth and expansion of self-help groups, peer advocacy, and recipient-run programs in the community.

In 2002, the Bureau of Recipient Affairs worked in partnership with People Inc., a not-for-profit, recipient run mental health agency, to facilitate 13 consensus building dialogues that would create a collective definition of quality through the eyes of past and current recipients of mental health services. Over 400 individuals participated in shaping and refining this definition, which will be released in the form of a white paper in Winter 2004. In 2003, the Bureau also held a series of local dialogues with past and current recipients of mental health services to obtain broader grassroots participation and solicit input into the Bureau and OMH operations. To date, dialogues have been held with over 3,000 individuals across New York State.

The Bureau of Recipient Affairs' priorities and objectives for the planning period include:

- Foster inclusiveness and responsiveness to individual recipients and grassroots networks.
- Identify a collective vision through consensus building processes that will assist with the prioritization of needs within the mental health service system.
- Foster and increase opportunities for recipients to speak for themselves.
- Create and offer technical assistance on opportunities for individuals to achieve greater independence and integration into the social fabric of the communities in which they wish to live.
- Support the expansion of self-help along the continuum of activities that an individual accomplishes on his/her own, to self-help groups, then to peer run self-help agencies.
- Expand knowledge and access to information that will support recipients to achieve their goals.
- Build a support and technical assistance system for peer-run initiatives.
- Create networking opportunities for recipients and recipient organizations across New York State.

Family Involvement in Planning and Delivery of Services

Family and friends are an important source of support for all people, including adults diagnosed with serious mental illness and children and adolescents diagnosed with serious emotional disturbance. Each family defines its concept of family, and services should take into account the uniqueness and the diversity of these relationships. Treatment plans need to ensure that services are developed based on needs as articulated by an individual in the context of his unique family unit.

Research has demonstrated that individuals who have support networks of family and friends are less likely to experience serious relapse and are more likely to experience successful outcomes from treatment and rehabilitation. OMH encourages family involvement, with the permission of the adult service recipient, in the planning and delivery of mental health treatment and support services. The agency also recognizes the unique challenges that families of children and adolescents experience in providing a continuum of service coordination among the various systems involved in their child's life. Therefore, OMH supports and encourages the integral involvement of families in the treatment process, from childhood through adulthood. As discussed in Chapter 1, family psychoeducation, an identified evidence-based practice (EBP) with documented positive outcomes, is currently being implemented statewide. A senior OMH official has been designated as Family Liaison, and the OMH Commissioner's Committee for Families will be working closely with OMH Executive Staff on best practices to improve the quality of mental health care in New York.

By the end of 2003, 18 agencies will be engaged in introducing the evidence based family psychoeducation model to their consumers and their families. OMH's recent grant award from SAMHSA to develop three family psychoeducation sites in communities with large African American, Asian, and Hispanic/Latino populations

will bring more effective services to communities that have typically been underserved in the area of mental health services.

Cultural Competence in Planning and Delivery of Services

The Surgeon General's 2001 report "Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General," speaks to the disparities in mental health care for minorities. OMH is committed to eliminating disparities in mental health care for minorities by improving cultural competence throughout New York State's mental health service delivery system. OMH's Multicultural Advisory Committee (MAC), serving at the discretion of the Commissioner, advises the Commissioner on policies, programs, and activities regarding service access and provision to individuals diagnosed with serious mental illness who are from diverse ethnic and cultural backgrounds. The MAC is composed of consumers, family members, and providers representative of communities throughout New York State. It includes members of the African American, Latino, Asian American/Pacific Islander, and Native American communities, as well as diversity in the representation of gender, age, spirituality, and primary language.

The Committee meets with the Commissioner four times a year and makes recommendations to improve the understanding of the clinical needs of ethnically and culturally diverse populations, and to assist with the design and development of culturally appropriate treatment and support strategies. Its priorities include evidence-based practices, children and families, and advancement of the national agenda to eliminate disparities based on culture, race, ethnicity, language, age, and gender.

OMH's Cultural Competence Coordinator acts as a direct link for the MAC to access OMH Executive Staff at any time. Executive Staff regularly brief the Committee on specific issues for discussion and feedback. In addition, the MAC maintains linkages with other planning councils through joint membership, presentations, and partnering for specific initiatives. It also maintains connection to national groups such as the Association of Hispanic Mental Health Professionals, the Leadership Council on African American Mental Health, and the National Asian American Pacific Islander Mental Health Association.

During the past year, the MAC has provided OMH with input regarding Personalized Recovery Oriented Services (PROS), forensic issues, search policies in State Psychiatric Centers, enhanced case management, Project Liberty, and further development of cultural competence performance measures for use in service programs. During the 2004-2008 planning period, specific MAC activities will include efforts to:

- Increase the skills and effectiveness of mental health practitioners and programs in cross-cultural situations
- Continue to inform the "science to practice" quality improvement agenda regarding inclusiveness
- Support and guide agency efforts to address disparities as outlined by the President's New Freedom Commission on Mental Health
- Provide technical assistance to develop cultural competence strategic plans at the service provider level

More information about cultural competence is included in Appendix 1.

Activities that will Influence the Future Planning Process

OMH's Winds of Change Campaign

Since 2001, OMH has embarked on its Winds of Change campaign to improve the quality of treatment services offered to both adults and children. While this campaign is an ongoing initiative, it has many ramifications for local governments, including impacts on the local planning process while new programs are being piloted and new evaluation studies of efficacy are being conducted. As more and more practitioners are exposed to evidence-based protocols and begin to adopt them into their practices, the demand for these more effective services will change the nature of service configurations and costs at both State and county levels.

Demand for evidence-based interventions is also being fostered in the Winds of Change campaign aimed at the general public and interested stakeholders. During the awareness "phase" of the campaign, basic educational information has reached many stakeholders within local communities. This phase consisted of 240 presentations or meetings held for approximately 3,700 people between May 2002 and May 2003. Awareness is also achieved through ongoing outreach to interested stakeholders on topics such as ACT team development, medications guidelines and prescribing practices for adults and children, family psychoeducation for adults, functional family therapy for children and families, and Home-based Crisis Intervention Services.

Each of the specific evidence-based initiatives also contains a set of community-oriented briefings and presentations, which are critical to success during the implementation stages of each project. County level policy makers and stakeholders have also participated in these sessions during the past two years.

Personalized Recovery Oriented Services (PROS)

Stakeholders throughout the State's local government structure are currently engaged in a comprehensive needs assessment and planning process for the implementation of Personalized Recovery Oriented Services (PROS), a new type of outpatient treatment and rehabilitation program which will integrate several of the adult evidence-based practices into a single modality. Since March 2003, 37 public forums have either been sponsored through OMH or attended by OMH Executives. These engagements augment the ongoing county and provider level technical assistance and support being provided throughout the PROS planning process, which culminates in Winter 2004.

Project 2015

OMH is also engaged in statewide interagency planning initiatives which address the needs of New York State citizens with disabilities as well as the needs of all New Yorkers as reflected by expected changes in demographics over the next decade.

In Project 2015, OMH and 35 other State agencies were directed by Governor Pataki to consider what New York State's demographic makeup will be by 2015, and identify strategies for assuring that the State is prepared to recognize the opportunities and meet the challenges presented by its changing population. By 2015, it is projected that the State's population will be older, more ethnically and culturally diverse, and

experience greater variations in income and education levels, family configurations, living arrangements, and health. Project 2015 resulted in each agency identifying three priority issues related to understanding and preparing for these projected changes.[3] The three issues identified by OMH are:

1. Research, develop, and disseminate appropriate home and community based models of care that incorporate culturally competent and cost effective evidence-based practices.

2. Design and implement an effective community outreach and public awareness campaign that is culturally relevant to all ethnic and religious communities, and makes people across communities aware of available treatments and supports and motivated to seek help.

3. Enhance OMH's informational infrastructure to support analyses of individual level outcomes and coordination of services among providers. OMH needs these data to understand what progress is being made and to be fully accountable for results.

Addressing these issues will require actions that are aimed at producing measurable progress towards an improved public mental health system. Newer, more cost-effective program and treatment models that are evidence-based and culturally sensitive will replace those that are less effective, and these transitions will be based on using individual level outcomes data available through OMH's improved decision-support capacity described elsewhere in this Chapter and Plan. OMH will provide highly targeted, culturally appropriate, content rich information and outreach services to a more diverse customer base. Many public mental health events will be established and become regular components of a continuous campaign to improve understanding of mental illness. The OMH Web site (http://www.omh.state.ny.us/) will be a clearinghouse for mental health ideas and information, available to all.

As they become available, the results of the Winds of Change campaign, PROS, and Project 2015 will be integrated into the statewide mental health planning process.

Community Integration Initiatives

The Most Integrated Setting Coordinating Council

The U.S. Supreme Court held in *Olmstead vs. L.C.* (1997) that persons with mental disabilities have a right under the Americans with Disabilities Act to receive services in an integrated community setting when appropriate. OMH is involved in two planning efforts designed to assess the implications of the Olmstead decision in New York. The first, The Most Integrated Setting Coordinating Council (MISCC), was established by Chapter 551 of the Laws of 2002 and became effective December 16, 2002. The MISCC oversees the development and implementation of a statewide plan for providing services to individuals of all ages with disabilities in the most integrated settings.

As a part of the MISCC, OMH plans to work collaboratively with the State Education Department (SED) to improve and streamline processes that affect individuals served jointly by both Departments. The discussions around this process will ultimately involve consumers, families, advocates, providers, and other stakeholders in

Notes

3 The full range of issues considered in this inter-agency effort are captured in a document released by the New York State Office for the Aging entitled "Project 2015-State Agencies Prepare for the Impact of an Aging New York-White Paper For Discussion," which is available at http://aging.state.ny.us/explore/project2015/report02/index.htm

systems improvement activities at the local level. Currently pilots are being conducted in Broome and Tioga Counties on the Mental Health Technical Assistance Brief, which is the framework for much of the collaboration. Other issues from the following collaboration goals with SED will be discussed and work plans developed.

OMH Collaboration Goals with the State Education Department

- Identify methods to streamline the application and screening process.
- Promote the availability of alternative GED testing sites in the community that are able to provide individualized assistance to persons receiving mental health services, and that are amenable to testing modification if needed as a reasonable accommodation. Types of accommodations that should be available include extra time for test taking, alternative testing room (quiet area), and extended time for completion of GED requirements.
- Explore methodology to provide smoother transition for school aged youth returning to community schools from State hospitals. Include opportunities to involve and engage teachers in the process.
- Explore methods of enabling adult learning programs and literacy programs to better accommodate the specific needs of individuals with mental health disabilities.
- Explore the possibility of training to enable peer organizations and advocates to assist individuals in navigating the vocational rehabilitation system.
- Explore opportunities to increase practical education for individuals with mental illness in the areas of: conversation skills, English as a second language, completing applications, basic skills in banking and math, budgeting, reading travel maps and information, and understanding community resources.
- Expand the community dialogue process to more local communities in an effort to identify and improve VESID processes and outcomes at the local level. OMH will provide "Respect Seminar/ Listening to Others" and staff to support each local opportunity to provide feedback and build collaborative partnerships with local VESID staff, county mental health officials, State Psychiatric Center staff, local providers, advocates, and consumers and families. Each local process will be used to identify local issues and solutions that will improve access, quality, and outcomes.
- Facilitate five regional dialogues with Independent Living Centers (ILCs) to build greater understanding about how people who receive mental health services can be collaborated with and served by ILCs. Attendance will include representatives from ILCs (Executive Directors, systems advocates, and a staff member familiar with services and/or advocacy for mental health recipients) and recipients active in self-help who have been involved in various peer programs and projects in the catchment areas of the participating ILCs. The regional dialogues will provide a forum to network and to become familiar with respective needs, services, and gaps, and will create opportunities to collaborate in a facilitated discussion designed to lay the foundation for coalition building and future creative programming.

Coalition to Promote Community-Based Care

The second planning effort involves a three year grant OMH received from the Federal Center for Mental Health Services (CMHS) in 2000 to establish and facilitate the work of a Coalition to Promote Community-Based Care. The purpose of the Coalition is to assist in finding resources and opportunities for people with serious mental illnesses and children with severe emotional disturbances to live in their home communities. To date, the Coalition's activities have focused on reviewing and guiding OMH efforts to facilitate community reintegration of adults who have been long-stay inpatients in State Psychiatric Centers. OMH has recently been advised that CMHS will provide funding for an additional three years. The Coalition anticipates focusing future efforts on an assessment of how to maximize access to "generic" housing and funding for housing initiatives that are or should be available to complement OMH housing initiatives.

More detailed information on these multi-agency planning initiatives is included in Appendix 3.

Improvements in Decision Support for Local Planning

As discussed earlier, OMH has been working closely with CLMHD and individual counties to strengthen the local planning process. A key objective of these efforts is to create an information-sharing environment that is relevant and responsive to local needs. Appendix 4 describes a Data Warehouse designed with Web-based access that provides State and local mental health administrators with relevant and timely information about the quality and efficacy of mental health programs. Several key components of the Data Warehouse can be used by localities to inform and enhance local planning efforts and others are in various stages of development. Available data marts include:

- Summary information about Medicaid claims and payment for mental health services beginning January 1995
- Demographic, clinical, and service data as reported on the biannual Patient Characteristics Survey
- Detail level information about services, clinical, demographic, and fiscal factors while preserving individual level confidentiality
- Information about mental health services provided to individuals experiencing trauma as a result of the September 11, 2001 terrorist attacks

During 2003, county access to the Data Warehouse has been rolled out in phases, which have included training and support for counties. Feedback from county users regarding the Warehouse is both welcomed and encouraged.Individually identifiable health information in the Data Warehouse that is created by OMH, individual counties, and providers is protected under both State (New York State Mental Hygiene Law Section 33.13) and Federal law (HIPAA or 45 CFR Parts 160 & 164). These laws are intended to ensure that, to the greatest extent possible, consumers of mental health care are able to control the use and disclosure of their sensitive health care information. Therefore in order to access this information, the applicant would need to be entitled to do so under law, whether because an individual patient has specifically authorized such access to

his/her information or because a specific exception in the law exists which would enable access without patient authorization.

Public Input

During the public hearings conducted by OMH on last year's Statewide Comprehensive Plan for Mental Health Services (2002-2006), strong support was expressed for holding regional hearings to provide even greater opportunity for people to provide comment. OMH is pleased to expand the hearing schedule, and five public hearings will be scheduled across the State for the 2004-2008 plan. Public notice will be provided, including Internet notification, of future hearing dates.

OMH will draw heavily from the testimony submitted at these public hearings and the ongoing advice of established advisory groups, advocates, and provider groups. Input from other parties interested in helping develop and implement these quality initiatives is always encouraged and welcomed. Comments may be submitted directly through the OMH Web site, or sent to:

Office of the Commissioner
NYS Office of Mental Health
44 Holland Avenue
Albany, NY 12229

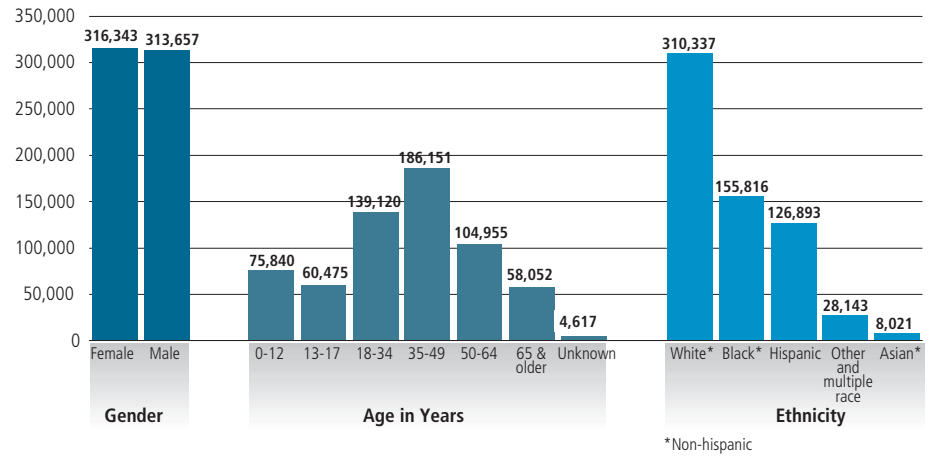
CHAPTER 3

Brief Overview of the Public Mental Health System

Who do We Serve?

IN 2001, the most recent year for which complete data are available, the New York State public mental health system provided services to approximately 630,000 people.[1] Twenty two percent of this population is under 18 years of age, 22% are young adults aged 18-34, 30% are aged 35-49, 17% are aged 50-64, 9% are over 65 years of age, and for 1%, the age is unknown. Across age groups, approximately 50% are male and 50% female. This ethnically diverse population is 49% White non-Hispanic, 25% Black non-Hispanic, 20% Hispanic, 5% American Indian, Hawaiian or other Pacific Islander, multiracial or another race, and 1% Asian non-Hispanic (Figure 3-1).

Figure 3-1
Total Number of Persons Served Annually By Age, Ethnicity and Gender



Notes

1 OMH derives its estimates of the number of people served annually by the public mental health system from its Patient Characteristics Survey (PCS). The PCS, which is administered every other year, gathers information about the demographic and clinical characteristics of persons receiving mental health services in programs operated, funded, or certified by OMH during a one-week period. The one-week data are then used to estimate the total number of people served annually and their characteristics. OMH uses estimates rather than actual counts because the variety of administrative data systems used today in the public mental health system does not allow a complete enumeration across all service sectors of the number of persons served. The data presented in this chapter are derived from the 2001 PCS, which is the most recent available.

Chapter 3

Brief Overview of the Public Mental Health System

Sixty two percent of adults (aged 18 years and older) and 77% of children (aged 17 years and younger) served live in a private residence (with or without supports).

Figures 3-2 and 3-3 depict persons served annually in the public mental health system with a population-based approach that utilizes 2002 U.S. Census data. On an annual basis, 32.14 females per 1,000 females in the general population and 34.34 males per 1,000 males in the general population receive services in our public mental health system. By age group, the rates are highest among 13-17 year olds (46.71) and 35-49 year olds (41.55), and lowest among children aged 0-12 years (22.40) and those 65 years and older (23.69). By race, the rates

Figure 3-2

Number of Persons Served Annually, Rate Per 1,000 Persons in the General Population

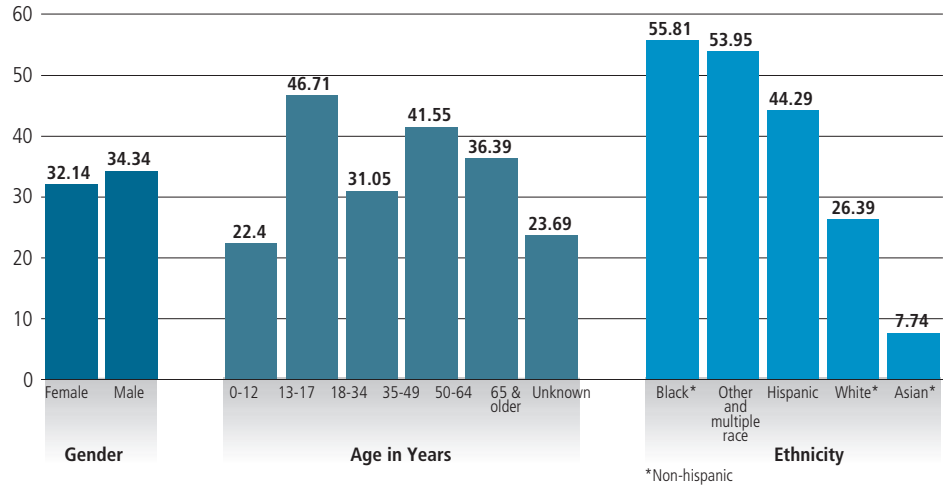
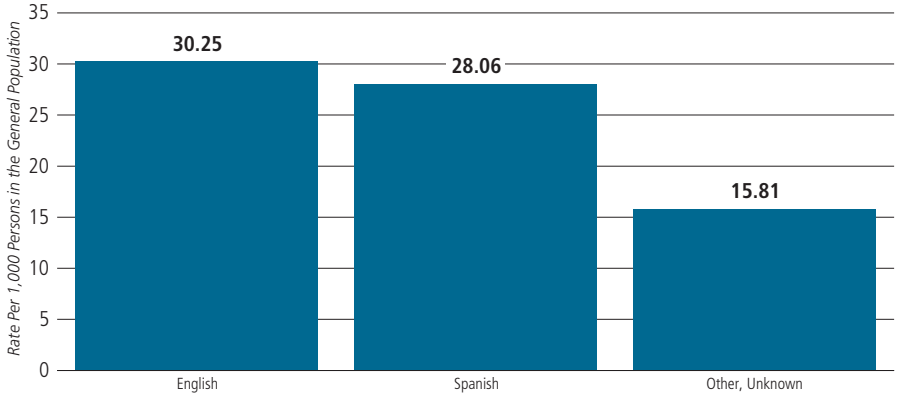


Figure 3-3

Number of Persons Served Annually By Primary Language (PCS), Rate Per 1,000 Persons in the General Population



are highest among Black, non-Hispanics (55.81) and those of other and multiple races (53.95), and lowest among Asian, non-hispanics (7.74) and White, non-hispanics (26.39).

By primary language, the estimated rate among populations speaking English is 30.25, among populations speaking Spanish is 28.06, and among populations speaking other languages is 15.81.

Disability and Diagnosis

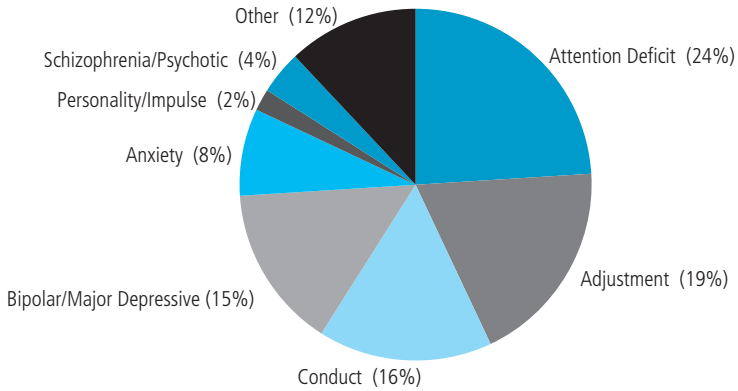
The majority of individuals in New York's public mental health system receive services because they are diagnosed with a mental disorder where their symptoms have led to serious impairment of their day-to-day functioning. This combination of a mental disorder and serious impairment of function is referred to as severe mental illness.[2] In the United States, mental illnesses rank first among illnesses that cause disability.[3] The disabling effects of mental illness in adults can result in homelessness, joblessness, health problems, and social isolation. In children, the effects are often serious and long lasting, leading to poor academic achievement, failure to complete high school, substance abuse, involvement with the correctional system, lack of vocational success, inability to live independently, and health problems.

According to SAMHSA's National Household Survey on Drug Abuse (NHSDA) report, fewer than half of adults with a serious mental illness received treatment or counseling for a mental health problem during the previous year.[4] The NHSDA was conducted in 2001, and defined mental health treatment or counseling as having received inpatient care, outpatient care, or using prescription medications for emotions, nerves, or mental health.

Diagnoses Among Age Groups Served

Among persons 17 years old and younger served annually in New York's public mental health system, 24% have Attention Deficit Disorder, 19% have an adjustment disorder, 16% have a conduct disorder, 15% have a bipolar or major depressive disorder, 12% have some other mental disorder, 8% have

Figure 3-4
Children Under 18 Years Old Served Annually By Diagnosis



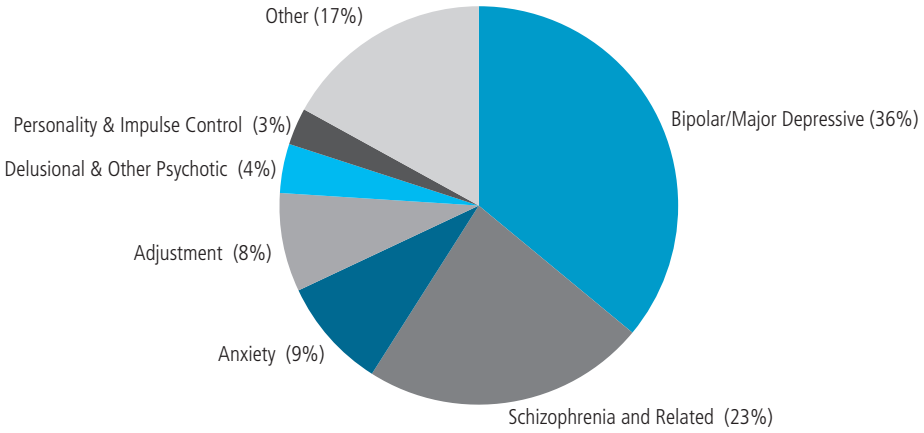
Notes

2 Throughout this document, we use the term "severe mental illness" to refer to what in epidemiological studies is called "severe and persistent mental illness" in adults and "serious emotional disturbance" in children.

3 World Health Organization. (2001). The World Health Report 2001 - Mental Health: New Understanding, New Hope. Geneva: World Health Organization.

4 The full NHSDA report is available on the Web at http://www.samhsa.gov/oas/nhsda.htm

Figure 3-5
Adults 18-64 Years Old Served Annually By Diagnosis

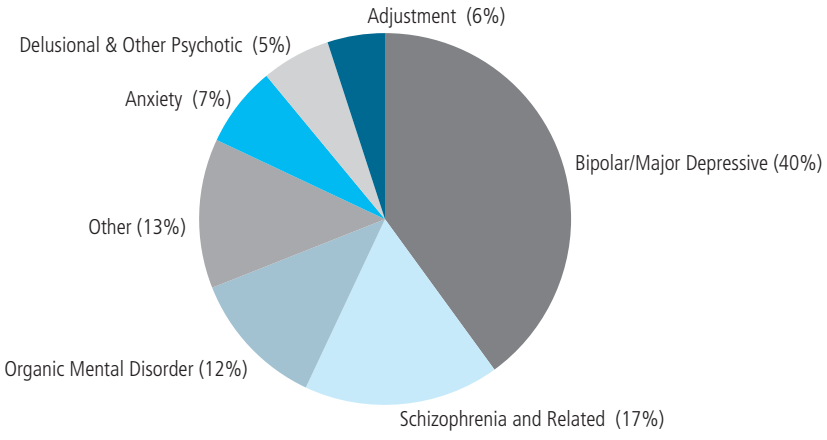


an anxiety disorder, 4% have a schizophrenic/psychotic disorder, and 2% have personality/impulse disorder (Figure 3-4).

Among the population 18-64 years of age, 36% have a bipolar or major depressive disorder, 23% have schizophrenia and related disorders, 17% have some other mental disorder, 9% have an anxiety disorder, 8% have an adjustment disorder, 4% have delusional or other psychotic disorder, and 3% have a personality and impulse control disorder (Figure 3-5).

Among elderly adults (over 65 years of age), 40% have a bipolar or major depressive disorder, 17% have schizophrenia and related disorders, 13% have some other mental disorder, 12% have an organic brain disorder, 7% have an anxiety disorder, 6%

Figure 3-6
Adults Over 65 Years Old Served Annually By Diagnosis



have an adjustment disorder, and 5% have a delusional or other psychotic disorder (Figure 3-6).

What Types of Services are Available?

To live successfully in our communities, most individuals with severe mental illness need both treatments that control or eliminate their psychiatric symptoms and a range of support services that meet the complex needs caused by the disabling effects of their illness. For adults, this range of services can also include a combination of health care, financial assistance, and employment and housing supports, as well as supports for developing skills in social relationships, and perhaps most importantly, for recovering their sense of self-esteem and self-efficacy. For children and their families, these services can include family treatment and supports that enable children to live at home and in the community, helping them and their families to lead more normal lives.

Historically, public mental health services have been grouped in four major categories: emergency, inpatient, outpatient, and community support. All four categories include both State and locally-operated programs. Individuals may receive services from more than one category depending upon need. The overall goal is to promote recovery and full community living for individuals with severe mental illness, while preserving public safety, and ensuring that respect, empowerment, and quality of life are incorporated into every aspect of care.

- **Community support** helps individuals diagnosed with severe and persistent mental illness live as independently as possible in the community, and helps children with serious emotional disturbance to remain with their families. These programs provide case management, vocational, self-help, residential and other support services. Although the specific array of community support services differs for adults and children, the goal is always to support successful and full community living.

- **Outpatient services** provide treatment and rehabilitation in an ambulatory setting, including clinics, partial hospital, continuing day treatment, Assertive Community Treatment (ACT), and Personal Recovery Oriented Services (PROS).

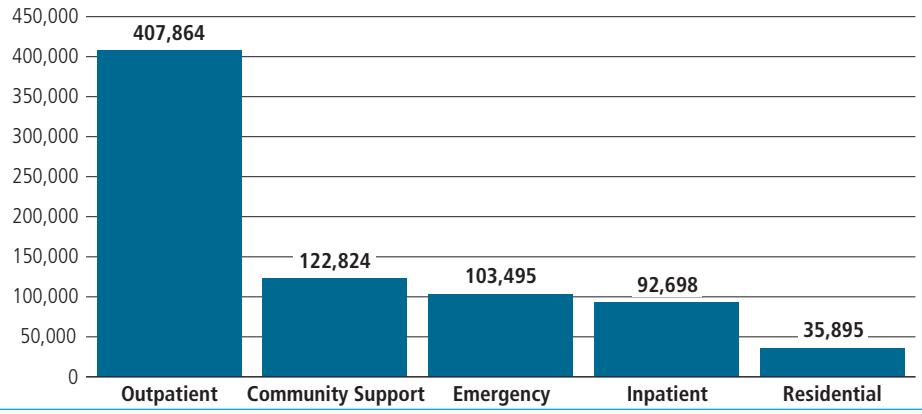
- **Inpatient services** provide acute stabilization and intensive treatment and rehabilitation with 24-hour care in a controlled environment. They are the programs of choice only when the required services and supports cannot be delivered in community settings.

- **Emergency services** provide rapid psychiatric and/or medical stabilization and ensure the safety of individuals who present a risk to themselves or others. These programs include a range of crisis counseling and residential services, as well as comprehensive psychiatric emergency programs.

On an annual basis, among persons receiving services in New York State's public mental health system, 65% are served in outpatient programs, 20% in community support programs, 16% in emergency programs, and 15% in inpatient programs. Six percent are also served in residential programs, a Community Support Service. Totals exceed 100% because persons attend multiple programs (Figure 3-7).

Figure 3-7

Persons Served Annually by Program Category



As OMH embarks on its strengthened, collaborative planning process, these questions as well as others that emerge from review of this data will form the basis for ongoing local level discussion.

Implications of These Data on State and Local Planning

As public mental health authority, OMH is responsible for ensuring appropriate access to services and has an ongoing commitment to monitor utilization of services toward that end. Questions and issues that emerge from the 2001 PCS data presented in this chapter include:

- How do patterns of service usage by sex, age, ethnicity, and diagnosis compare across regions and counties? Are there specific disparities that should be noted and addressed?
- How do patterns of service usage by the major service categories (inpatient, outpatient, community support, and emergency) compare across regions and counties? Are there specific disparities that should be noted and addressed?
- How have patterns of utilization changed over time for both those who are served and the services that they use? Are there significant regional and/or county level disparities? Are there services or clusters of services that appear to produce better outcomes? Are there clusters or concentrations of service usage either by population group or by geography that differ significantly from statewide averages? Do these suggest either the overuse, underuse or misuse of services? Do they suggest that certain areas of the state or population groups within the State or both are being under or over served?

  For example, there appear to be emerging issues regarding young adults with serious emotional disturbance as they age out of children's programs at the age of 18. Some of these individuals experience difficulty obtaining appropriate services in the adult service delivery system, some have difficulty adjusting, and some tend to drop out of programs designed to meet the needs of older individuals with chronic mental illness. Questions include how activities can be designed to engage young adults more fully in programs that have more relevance for them and address the specific issues they face such as housing, and vocational and skill development for independent life.

CHAPTER 4
Utilization of Inpatient Beds

IN CHAPTER 1, a future vision of the public mental health system was presented. This vision is based on a commitment to quality care and use of evidence-based services, an emphasis on providing services in the most integrated, community-based settings possible, and an operating policy to foster community integration for individuals in educational, employment, social, and recreational activities in their own neighborhoods. It is predicated on the public policy goal of maintaining the locus and continuity of care for individuals within their home communities. OMH's commitment to a new, statewide collaborative planning process that maximizes local input was described in Chapter 2. Chapter 3 provided an overview of the public mental health system that depicts who uses services across all regions, populations, and program types.

Relying on this framework, Chapter 4 presents the first step toward beginning a series of statewide policy-development conversations concerning the utilization of inpatient services within a recovery-oriented continuum of treatment, rehabilitative, and supportive services. The inpatient utilization issue is an appropriate starting point for these discussions for several reasons:

- Research indicates that evidence-based practices can decrease inpatient utilization and increase community tenure. Therefore, greater access to evidence-based practices has implications for future inpatient service capacity planning.

- Inpatient services represent the most expensive, restrictive, and intrusive level of care. The need for this level of care indicates a high level of distress and disruption to an individual's personal, family, and community roles. In addition, the long-term use of inpatient care must be considered with regard to the 1997 U.S. Supreme Court decision in *Olmstead vs. L.C.*, which held that persons with mental disabilities have a right under the Americans with Disabilities Act to receive services in an integrated community setting when appropriate.

- For some time, the mental health community has maintained a position that development of supportive and preventive outpatient services can diminish the need for inpatient care. Commitment to a quality improvement agenda necessitates a careful examination of the degree to which this assumption is accurate, and

is particularly relevant during an era of substantial growth in community-based treatment and support programs and housing opportunities.

- Stakeholder interest in public policy decisions regarding the appropriate capacity, location, and utilization of inpatient beds is very high. There is a broad spectrum of opinions on these issues and no commonly shared consensus.

- Inpatient capacity and utilization are correlated in geographic areas where there is State-operated capacity.

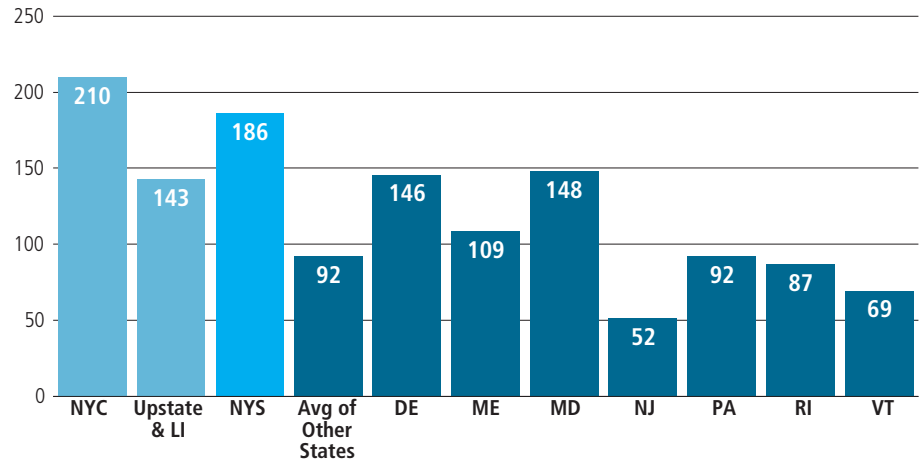
This Chapter first describes the historic and current utilization of inpatient beds within the context of the national perspective. It then presents a framework for further analysis using OMH's performance measurement system and some comparative examples of utilization, cost, and readmission outcomes. The Chapter concludes with observations about the data presented and their implications. This content represents a significant departure from previous plans, in that the data are made available for all operating auspices, with detailed county-level data presented in Appendix 5.

Comparing New York to the National Experience

Over the last 15 years, trends in inpatient psychiatric care in New York State have mirrored those of the nation: the steady decrease in the utilization of inpatient psychiatric care across the United States has resulted in closing and reorganizing state psychiatric hospitals. In August 2000, the National Association of State Mental Health Program Directors' Research Institute (NRI) published their findings that:

- In the United States, more state psychiatric hospitals were closed in the 1990s than in the 1970s and 1980s combined

Figure 4-1
Mental Health Inpatient Days in State and General Hospitals per 1,000 General Population: 2001-2002



- During the 1990s, 50% of states were reorganizing their state hospital systems
- From Fiscal Years 1993 to 1997, the number of patients in state-operated psychiatric hospitals decreased by 25%, while state psychiatric hospital expenditures decreased by only 4%
- In Fiscal Year 1997 for the nation as a whole, state mental health agency controlled expenditures for community mental health services exceeded state-operated inpatient services by over $2.5 billion

As shown in Figure 4-1, despite New York State's community integration efforts over the past years, the use of inpatient beds within both State and local sectors continues to be above that of other mid-Atlantic states. Although national discussions generally describe inpatient usage within both state-operated and general hospital sectors, of particular concern to state mental health directors is the utilization of state-operated inpatient beds, because this commitment of resources has historically been excluded from Federal cost sharing through Medicaid reimbursement.

The NRI 2000 study had a particular focus on state psychiatric center experiences and summarizes state psychiatric hospital closures by state. It noted that Pennsylvania had 21 state psychiatric hospitals in 1955 and nine in 2000. California had 10 in 1958 and four in 2000. Illinois had 12 facilities in 1993 and four in 2000. Ohio had 25 in 1956 and had five located at nine sites in 2000. These and similar findings demonstrate that across the United States, the provision of psychiatric care has moved from state-operated institutions to community settings. States can no longer afford to operate and maintain costly inpatient facilities that are underutilized.

Although most of the current interest at both national and state levels concerns the utilization and cost of state-operated inpatient psychiatric facilities, there is increasing attention at the national level to examination

Figure 4-2

Inpatient Care for Adults in New York State (2003 data) vs All US States (1997 Data) per 100,000 Adult Population by Hospital Type

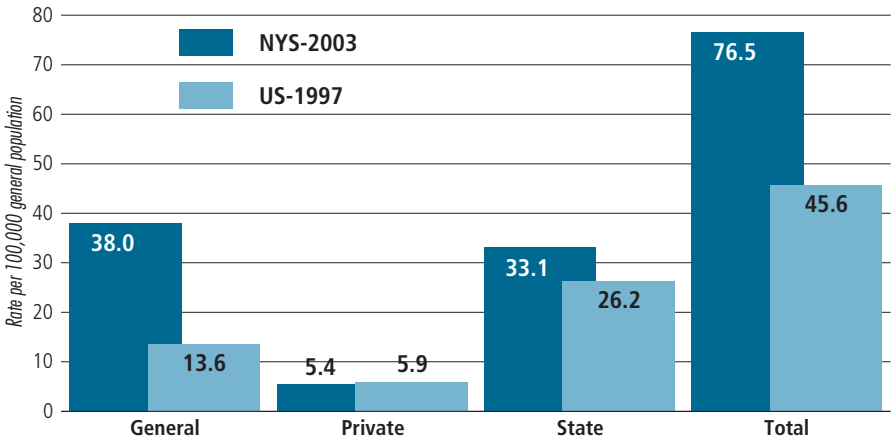
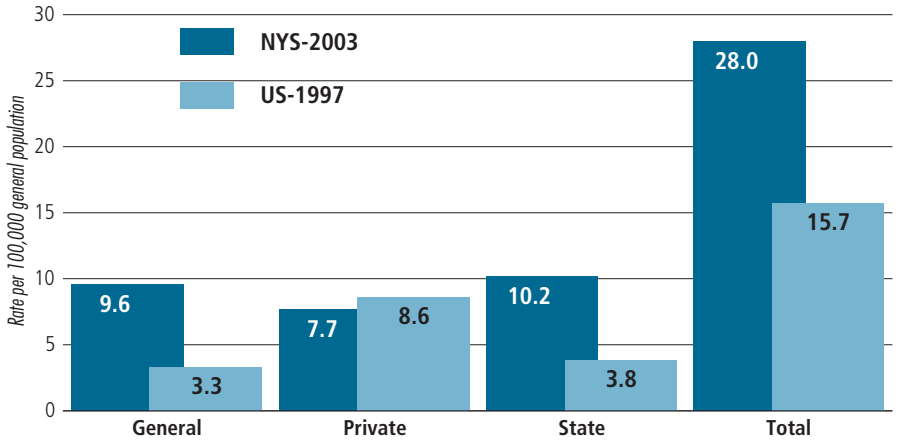


Figure 4-3

Inpatient Care for Children Under 18 Years Old in New York State (2003 data) vs All US States (1997 Data) per 100,000 Population under 18 by Hospital Type



of the overall utilization of inpatient care across sectors. The study, Mental Health, United States, 2000, describes the numbers of inpatients under care nationally using adult and child age groupings and examining usage by the auspice of care.[1] Using State and local information systems, New York is able to compare these data with 2003 data on bed usage. In Figures 4-2 and 4-3, the numbers of adult and child psychiatric inpatients are measured by rates of 100,000 within the civilian population and displayed by auspice of inpatient program.

These graphs show that for inpatients under care, New York had more psychiatric inpatients per capita in 2003 than the nation as a whole had in 1997. In 2003, New York had 76.5 adult psychiatric inpatients per 100,000 adult civilian population as compared to a 1997 national rate of 45.6, and 28 child/adolescent inpatients per 100,000 civilian population under 18 years old as compared to a 1997 national rate of 15.7. In 2003, New York's general hospital usage for adults was nearly three times that of the United States in 1997 (38 to 13.6). New York's 2003 State hospital usage for adults also exceeded the 1997 national usage, however, this sector's difference (33.1 to 26.2) is not as dramatic as that of general hospital usage for adults. For children, however, New York's 2003 State hospital usage far exceeded the 1997 United States' rate (10.7 to 3.8), and the State's 2003 general hospital usage was also dramatically higher than the 1997 national rate (9.6 to 3.3). Actual data for these graphs are included in Appendix 5.

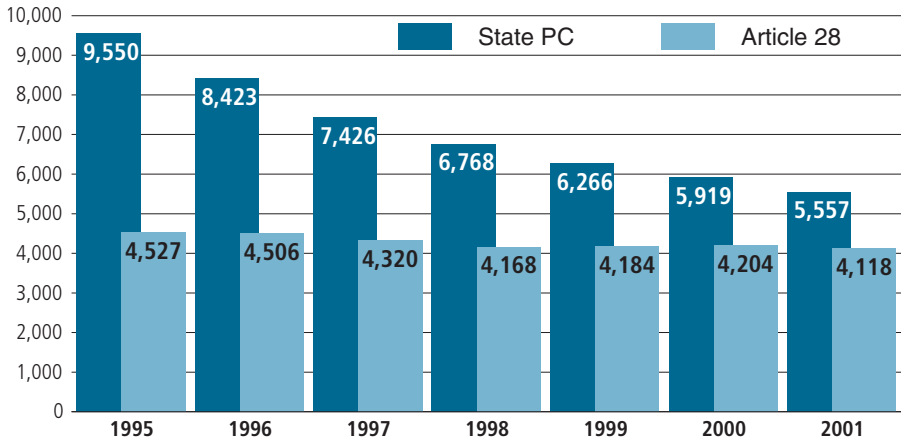
Since 1995, New York State's bed usage in the State Psychiatric Centers and in general hospital units has been declining steadily. Figure 4-4 shows this decline, and Appendix 5 contains the average daily census data used to develop this graph. From 1995 to 2001, the decline in State Psychiatric Center census accounted for most of the combined census drop. State census declined by almost 4,000 (43%) from 9,550 to 5,557.

Notes

1 Mental Health, United States, 2000. Ronald W. Manderscheid, Ph.D. and Marilyn J. Henderson, M.P.A. (Eds.) U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (Rockville, MD: 2001). Retrieved December 19, 2003 from http://www.mental-health.org/publications/allpubs/SMA01-3537/default.asp

Figure 4-4

Average Daily Inpatient Census of New York State Psychiatric Centers vs Article 28 Hospitals*



Average daily usage in general hospitals (Article 28) declined by 9% from 4,527 to 4,118. As described in Figure 4-5, the decline in census for general hospitals, while modest, has significant regional variation.

All regions showed decline in general hospital usage from 1995 to 2001. The Western region demonstrated the largest decline at 24%, followed by the other regions. Overall, the decline in bed usage from 1995

Figure 4-5

Reduction in Census at General Hospitals Between 1995 and 2001 by OMH Region

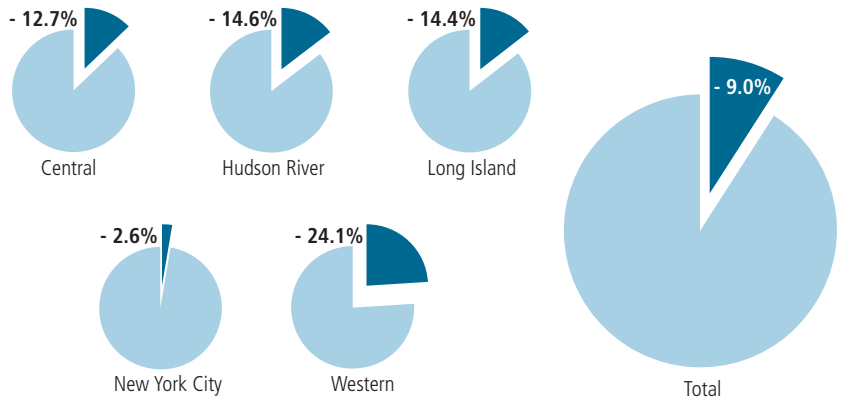
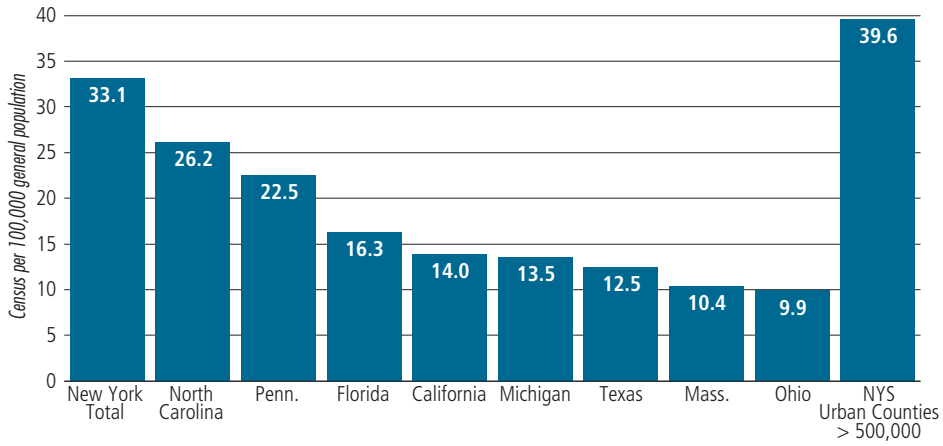


Figure 4-6

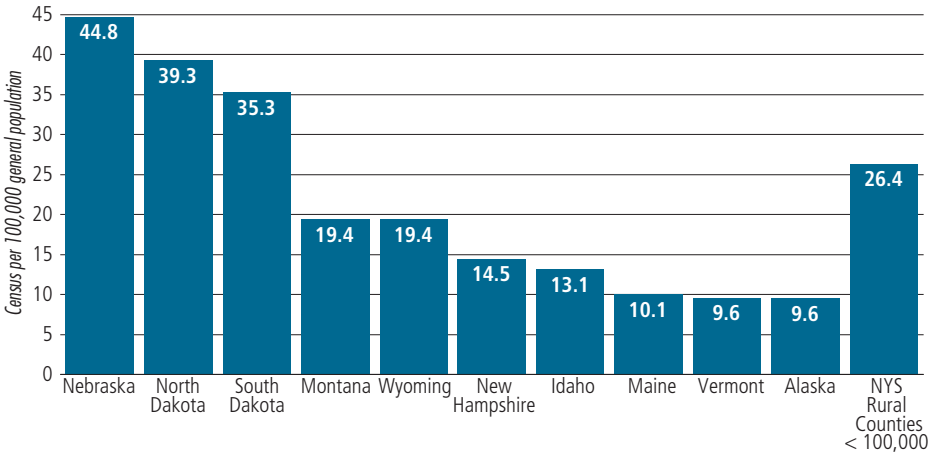
New York State Psychiatric Center Inpatients per 100,000 General Population Compared with Other Urban States and Large Urban Counties in New York*



to 2001 in New York State has been substantial. On a typical day, the numbers of people using either State Psychiatric Center or general hospital inpatient beds declined during this period by 31%, from about 14,100 to just under 9,700. Despite these census reduction efforts, New York's use of state-operated beds continues to

Figure 4-7

New York State Psychiatric Center Inpatients per 100,000 General Population Compared with Other Rural States and Rural Counties in New York*



Notes

* Data Sources: Additions and Residents at End of Year, State and County Mental Hospitals by Age and Diagnosis, by State, United States, 2000

require further examination because it is higher than the total per capita bed usage in the United States and also higher than the per capita usage of state-operated beds in states with similar demographic features.

New York's State-operated inpatient bed usage has been examined using nationally available data that reflect the unique population characteristics of the State. Since New York is a particularly dramatic mix of rural and urban population centers, this analysis compares State inpatient bed usage in two ways. First, the State's usage is compared to that of other states with similar demographic features. Because the comparative data sets available do not display information at the county level, Figures 4-6 and 4-7 show similarly urban states against New York State counties with high concentrations of urban population bases above 500,000. As can be seen in Figure 4-6, New York's bed usage per capita is higher than other, similar urbanized states such as California, Michigan, Texas, and Ohio.

Second, as shown in Figure 4-7, New York State inpatient bed usage is compared with states having high concentrations of counties with less than 100,000 in population.

While State Psychiatric Center inpatient usage in large urban counties in New York State far exceeds usage in other states with large urban populations, usage in New York's rural counties is more similar to that of more rural states.

State-Operated Psychiatric Center Inpatient Bed Trends and Forecasts

An examination of New York State inpatient bed usage with national rates suggests that the State has a need to continue reducing inpatient bed usage. Table 4-1 shows the decline of State inpatient census and attendant workforce reductions that have occurred since the peak of inpatient usage in the 1950's. Although adult inpatient census has declined drastically from 93,197 in 1955, the number of adult centers has remained nearly the same (17 instead of 20). Since 1955, the average size of an adult psychiatric center has declined from about 5,200 patients to 250 patients in 2003. In addition, since 1955 the system has changed from having no small facilities (under 150 beds) to having seven that size

Table 4-1
The Shrinking Size of New York State Adult Psychiatric Centers

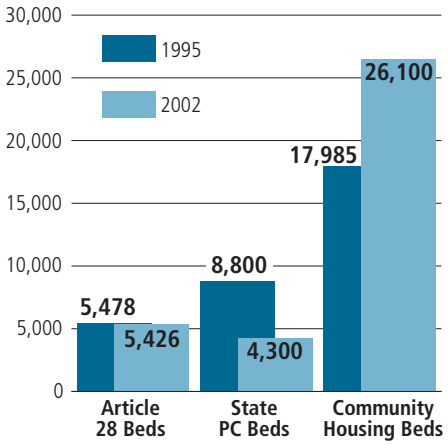
	1955 (Peak)	Dec. 31,1993	Dec. 31,1998	October 2003
Total Census	93,197	10,162	5,309	4,223
Number of Centers	20	21	17	17
Average Size of Centers	5,178	484	312	248
Largest	14,325	1,167	1,077	703
Smallest	2,164	107	95	71
Workforce	24,500	20,900	13,600	11,225

during the past five years. Appendix 5 includes facility specific census, census trends, and surrounding service system capacity within each county catchment area served by each State facility.

Between 1986 and 1996, the adult inpatient census at State Psychiatric Centers decreased dramatically. This census decline was the direct result of policy initiatives regarding placement of geriatric, long-stay patients into nursing homes where they could receive more intensive and appropriate physical health related services, the introduction of a newer, more effective generation of anti-psychotic medications, the growth of the community based outpatient mental health system, and a shift in treatment emphasis from acute to intermediate care within the psychiatric center system. At the same time, the decline in beds for State inpatients has been balanced with significant growth in community housing, as described in Figure 4-8.

Figure 4-8

Changes in Inpatient and Community Residential Beds: 1995-2002



The adult inpatient census was approximately 4,366 on April 1, 2001, a decrease of 2,083 from 1997. This census level was within the range of 3,700 to 4,700 envisioned in OMH's 1997-2001 Five Year Plan. More recent statewide plans have documented that further census reductions have been modest, with virtually all of the census reduction related to "long-stay" individuals who had been inpatients for more than one year.

It should be noted that while New York has reduced the overall number of beds in the State system, it has not reduced community access for people who continue to require inpatient services. This is possible because OMH has significantly reduced the average inpatient length of stay by successfully integrating more long-stay inpatients back into community settings, thereby freeing up beds to serve multiple intermediate-stay individuals each year. New treatment services, changes in community care, support services, patient mix, and the extent and timing of new quality initiatives are all likely to continue this trend.

Over the past five years, admissions to State adult psychiatric centers have remained nearly constant and OMH assumes that this trend is likely to continue for the next three years. A direct consequence of this assumption is that no substantial change in adult short stay (under 1 year) census should be expected in the near future. For the past several years, the adult short stay census has been around 1,850, and it is expected to remain at this level. However, the OMH adult census is still projected to decline because there will be a continued reduction in the adult population whose length of stay is greater than one year. Since 1997, reduction in the total adult census is the result of the diminishing size of this group of inpatients. From 1997 to

Table 4-2

Licensed Program Expansion between 1998 - 2002

	Number of Programs		
	Inpatient	Community Residence	Outpatient
1998	4	10	21
1999	7	20	28
2000	5	19	31
2001	3	10	50
2002	4	15	88
Total:	23*	74	218

*added 306 inpatient beds

Grand Total: 315

2002, the annual rate of census reduction in this group ranged from 0 to 17%, and in the past year, reduction slowed to an annual rate of 4%. OMH projects that the census for the next three years will be 4,130 in 2004, 4,030 in 2005, and 3,980 in 2006.

This census reduction has been occurring with a concomitant emphasis on having community-based service options grow in local areas. As displayed in Figure 4-8, during the period of census reduction the State has continued to develop community living options for people who might otherwise need to use State-operated inpatient services on an extended basis and has been rapidly developing a range of community-based programs. Table 4-2 shows that OMH has added 315 new programs to its certified provider base between 1998 and 2002.

With an estimated State-operated inpatient census of fewer than 4,000 by 2006, New York State must reconsider the role of State-operated inpatient care within the broader continuum of community-based treatment, rehabilitation, and support services available within each county. The benefits of maintaining the current State system infrastructure for the number of individuals served may not justify the associated costs. During this planning period, OMH intends to utilize information developed by the Commission for the Closure of State Psychiatric Centers (described in Chapter 2) to develop and implement long-term plans for the use of State operated inpatient facilities.

This new Commission will host a series of public hearings and will afford an opportunity for concentrated local-level planning efforts toward the most efficient use of resources given the needs and landscape of each community being served. During the period in which the Commission is in existence, selection criteria for making recommendations on State facility closures will be utilized to guide the development of closure recommendations. There is one facility where the case is so compelling that OMH is recommending moving forward with closure at this time. As presented in Table 4-3, the recommendations for closing the Middletown Psychiatric Center describe how some of these selection criteria can be used

to analyze and develop closure recommendations that demonstrate fiscal accountability while maintaining the agency's commitment to quality care for all individuals who require services.

Table 4-3

Middletown Psychiatric Center Key Facts Concerning the Recommendation for Closure

- Size of the facility. The Middletown Psychiatric Center (MPC) is serving a small number of individuals and this number continues to shrink. It is therefore difficult to justify the $27.8 million capital investment that would be required to maintain certification compliance for the MPC infrastructure when the facility currently has a budgeted inpatient capacity for 115 people. MPC's inpatient service loss is largely attributable to significant gains made in reintegrating people with longer stays into the community.
- The current inpatient use is limited. While during any month there are approximately 80 people who are extended stay users of the facility, there are only approximately ten new admissions. It is difficult to justify continued use of an inpatient service for so few new admissions, especially when resources could be reinvested in community services.
- The planning process that will be utilized to close MPC will provide a case by-case analysis of these users – both those on extended stay and the patterns of new admissions. We will be particularly concerned with the level of care needs for these new admissions, since we assume that they require intermediate or extended care in order to qualify for admission to the facility, although it is possible that some of the new admissions might be better served through acute care facilities.
- Assuming that the needs for inpatient services stemming from the closure of MPC are all for intermediate or extended care needs, we have two options. First, some individuals may be transferred to nearby Rockland PC, which has a steady pattern of significant census reduction and available code compliant space. When we look at the overall "small facility" issue in the State (seven out of 18 adult facilities have a census lower than 150), the travel distance for people in the affected counties (Orange and Sullivan) is relatively small. Most of the people who use the MPC come from Orange County and the travel distance between the geographic center of Orange County and Rockland PC is only 27 miles. Second, some individuals who are using inpatient services may be able to be served in local general hospitals where there is availability of beds because of underutilization of authorized bed capacity. There are 100 Article 28 inpatient beds in the immediate vicinity. While it is generally assumed that most of these beds are used for acute admissions, there is the potential to look at the occupancy rates for these nearby hospitals and convert some unused capacity.

  It is possible that some of these individuals' needs for inpatient treatment could be better served by a combination of supervised congregate living treatment and licensed outpatient services. In Orange and Sullivan Counties there is licensed capacity for 197 congregate treatment options and 38 partial hospitalization slots. There are also 260 slots available for continuing day treatment and 43 for intensive psychiatric rehabilitation treatment.

Use of a Performance Measurement Framework and Conceptual Model of a Continuum of Care

The data on inpatient usage in New York State speaks clearly to the need for an ongoing State and local capacity to routinely monitor and manage the use of inpatient services against community needs and the availability of other supportive resources. As described in Chapter 2, the new planning process will begin the concentrated State and local government effort to monitor care, and will be enhanced by recent decision-support tools made available to the State.

In 2001, the Center for Mental Health Services (CMHS) articulated the Federal government's commitment to quality improvement through issuance of three-year state grants for building performance measurement data infrastructures. These Data Infrastructure Grants (DIGS) assist all states in reporting on federally required performance measures. As a condition for receiving Federal Block Grant funding, states are expected to develop implementation plans and report yearly on specific measures. CMHS requires that the states, in developing their multi-year plans, select specific measures yearly to chart their own progress at systems development. It also requires that a state's use of selected measures is system-wide, and not restricted to block grant related activities. Appendix 5 contains the federally-required list of performance measures along with OMH's 2003 2004 implementation plan timetable. Further information about the national performance measurement initiative can be found at http://www.samhsa.gov/centers/cmhs/content/blockgrants.

OMH's performance measurement system, which will include but not be limited to the federally required measures, is a major quality improvement activity envisioned for the 2004-2008 planning period. The agency is addressing the domains in the CMHS required construct and is considering additional domains. During this developing process, it is anticipated that many stakeholders will offer ways to measure performance that are also useful. The State plans to begin the assessment of inpatient services by focusing on the following domains:

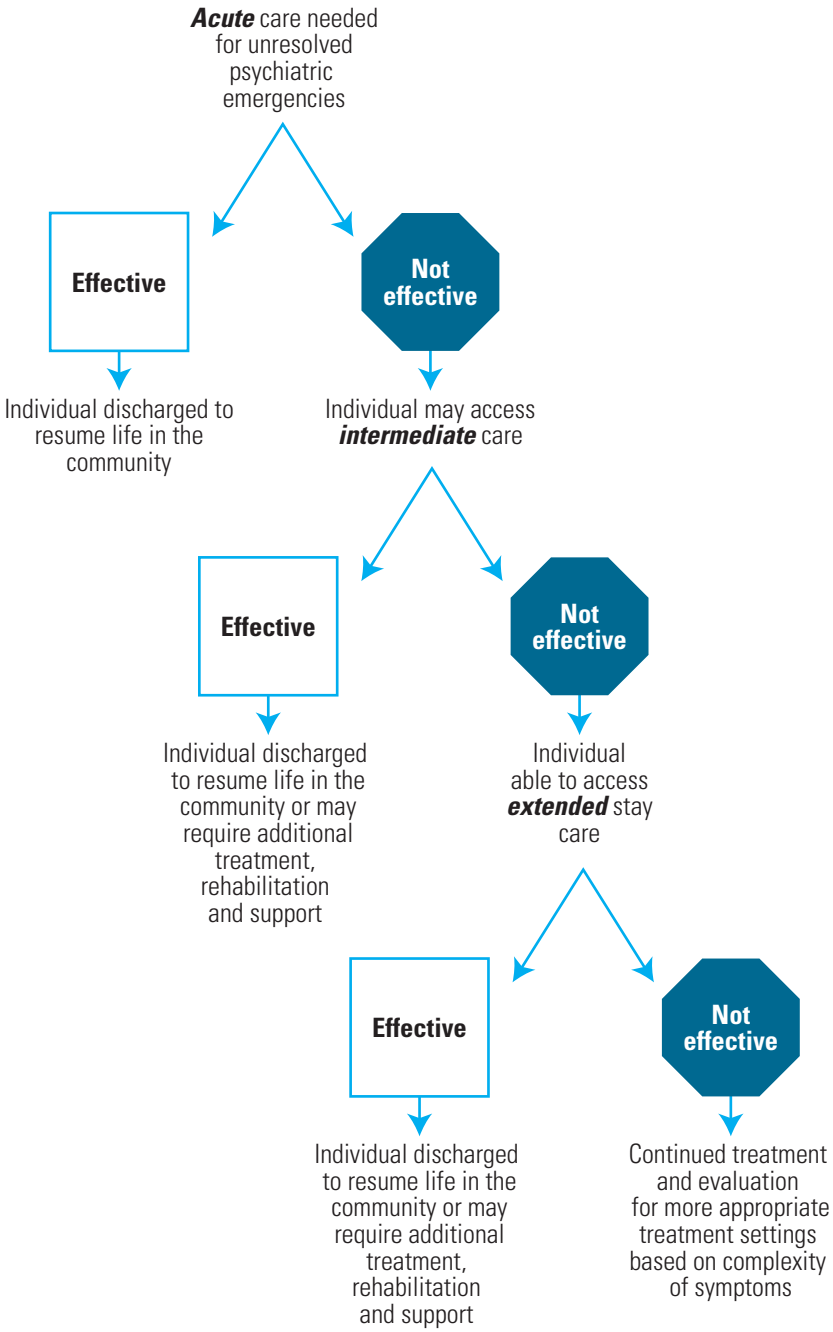
- Access
- Utilization
- Costs
- Outcomes

This 2004-2008 plan begins the public conversation on performance measurement with some preliminary examples of data describing performance in each of these domains. There will be additional data provided during the planning process. During the planning process, it may be helpful to consider measurement of these domains against the desired "system flow" of inpatient service usage depicted in Figure 4-9.

This simple model provides a conceptual framework for public discussion on the role of inpatient care in supporting an adult's course of treatment and recovery from mental illness or a young person's experience with serious emotional disturbance. It assumes a continuing maintenance of effort to keep the individual's primary locus of care in home communities and in home settings. This is consistent with the findings from OMH's most recent Patient Characteristics Survey (PCS) that while receiving

Figure 4-9

Conceptual model of inpatient access and utilization



services, the majority of adults (62%) and children (77%) are living in private residences rather than in institutional settings.

This conceptual model assumes that inpatient services are but one of the services available within an individual's home community, and that this range of services constitute for that individual an appropriate continuum of care. The model assumes that in a new population-based planning process, the resources associated with inpatient services could be decentralized and allocated to communities on a need-driven, person-centered basis. This might mean that inpatient care could be managed according to both personal preferences and clinical needs determined through an objectively measured assessment of acuity. By combining the concepts of person-centered care with level of need based on acuity, even individuals with acute levels of need might be able to be served in settings consistent with their histories and preferences.

For example, people who have had significant experiences with service at an intermediate-care level with a set of trusted providers and clinicians might be able to reenter the system of care at that level rather than having to first access emergency or inpatient care. Currently, the system of care requires that every individual returns to the beginning of the continuum of care (emergency or inpatient) each time their mental health symptoms become exacerbated. This current access method is system-centered rather than person-centered and may create both frustration and lack of continuity for individuals and their families.

The conceptual model presented here implies that there could be a new "re entry at level of need" access method, which might mean that people could activate care directives when symptoms exacerbate and entirely avoid using either emergency or inpatient services. As an outgrowth of this concept, individuals at varying stages of their recovery process could have options beyond the existing inpatient hospitalization to include innovations such as peer operated crisis residences, intermediate care residences with treatment capacity provided

Table 4-4

Key Comparisons by Percentage of Individuals Served

Population Differences	State Psychiatric Centers	General Hospitals
Ages		
18 - 34	19%	29%
35 - 49	40%	34%
Gender		
Male	66%	52%
Ethnicity		
White	50%	54%
Black	33%	30%
Diagnosis		
Schizophrenia	71%	26%
Affective Disorders	12%	41%

in home-like, assisted living environments, and access to specialized diagnostic treatment centers for persons with mental health conditions who have been historically unresponsive to traditional therapies.

In addition, as the OMH planning process becomes population-based, it will be necessary to consider admission to inpatient services against historical patterns of usage by different groups. This new planning process could also include reviews of the respective roles of State and local inpatient services in the delivery of acute, intermediate, and extended stay levels of care. According to the 2001 PCS, there are several seemingly significant differences in the populations that use inpatient services. Table 4-4 describes several areas of difference among adults using State-operated psychiatric centers and general hospital inpatient units that need to be further explored and discussed during the planning process.

Examples of Inpatient Performance Measurement

Access to State and Local Beds for Adults and Children

A basic way to consider system performance in the area of access to services is to look at a system's capacity for delivering that service. For inpatient bed use, individuals and their families are unlikely to be able to use beds when needed if capacity is inconsistent with local need. Throughout this chapter, it has been shown that New York State has bed capacity in excess of the nation and other comparable states. It is useful to examine this excess against county-specific capacities in the State.

In Appendix 5, Tables 1 and 3 show the existing bed capacity for each county for adults and children. The county-level tables are all presented by showing capacity as a rate per 100,000 of the county's population. Examination of the county-level capacity level data shows that there is little in the way of a discernible pattern for bed allocation over time. During the new planning process, it is likely that counties and other stakeholders will be able to describe the factors that have led to their current capacity patterns. The set of descriptive statistics for both adults and children in Table 4-5 demonstrates the extreme degree of variability within these data.

Utilization of State and Local Children's Inpatient Beds

Another important measure for determining the degree to which inpatient services are being adequately provided to meet commu-

Table 4-5
County-Level Bed Census

Adults:	Children:
Range= 14.1-89.8 per 100,000	Range+ 8.5-54.6 per 100,000
Median = 37.3 per 100,000	Median = 24.4 per 100,000
Mean rate = 40.6 per 100,000	Mean rate= 26.5 per 100,000
Standard deviation = 16.5	Standard deviation = 11.6

nity need is to examine the degree to which the current bed capacity is actually being used. The concept, which is referred to here as "census," reflects the daily bed use for the inpatient units. In Appendix 5, Tables 2 and 4 display these data by county, showing that the rate per 100,000 of actual utilization of beds is also highly variable by county. The descriptive statistics in Table 4-5 demonstrate that making comparisons about county-level utilization may not be useful. Comparison in general will however show that utilization rates are lower than capacity and that, because utilization data is based on the county of residence of the individual using the service, there is in the lower Hudson River counties, significant out-of-county usage of both adult and children's inpatient services.

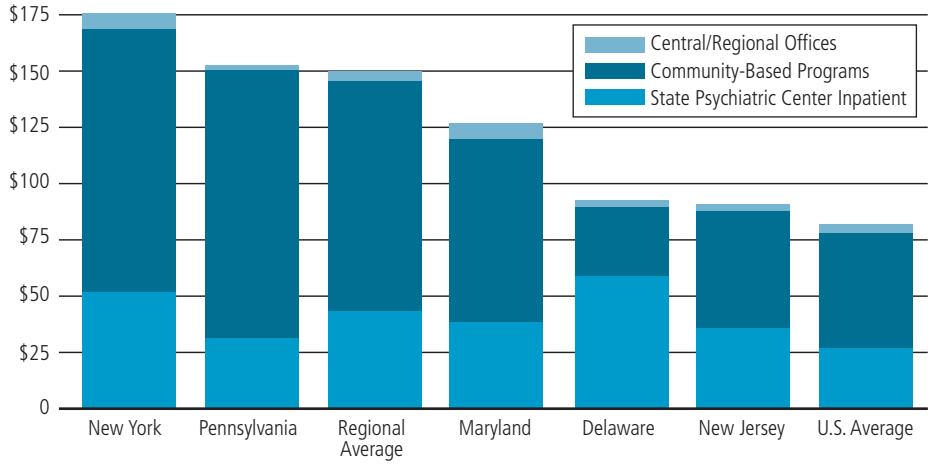
Cost of Inpatient Services

From a fiscal perspective, New York State continues to lead the nation in its commitment to provide funding for mental health programs such as inpatient care. Data compiled in 2003 by the National Association of State Mental Health Program Directors (NASMHPD) shows that since the mid-1990s, New York State mental health agency controlled expenditures exceeded those of any other state, both in total dollars and when adjusted for differences in population. For example, New York led the nation in 1993, spending almost $2.4 billion or $130 per capita on mental health services. In 2001, New York continued to lead the nation, spending over $3.3 billion or $175 per capita. Figure 4-10 shows how New York's 2001 per capita total expenditures compare to other mid-Atlantic states, the averages for all states in the region, and the national average for both community-based programs and state psychiatric hospitals.

Reflecting national trends, there has been a significant, concurrent shift in emphasis away from state psychiatric hospital-based care to community based programs. NASMHPD data show that in 1993, New York spent $87 per capita on inpatient care and less than $44 per capita on community-based care. By 2001, per capita spending on

Figure 4-10

Fiscal Year 2001 SMHA-Controlled Per Capita Expenditures By Type in Mid Atlantic States*

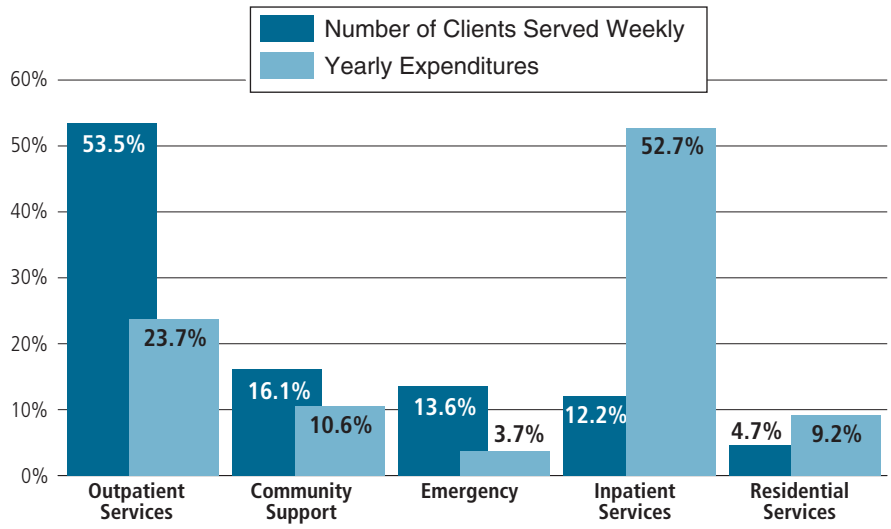


Notes

* Source: NASMHPD, 2003.

Figure 4-11

Percent of Clients Served vs Percent of Expenditures



inpatient care had dropped by half to $53, while per capita spending on community-based care more than doubled to $117. Much of this shift in spending in New York was driven by reinvesting savings derived from the reduction in State inpatient capacity into community-based programs. The State will continue to examine the underlying reasons why its public mental health inpatient usage and costs are so significantly different from national averages while maintaining a commitment to the highest possible quality of care.

Figure 4-11 provides an indication of why the issue of inpatient bed utilization is important for OMH by describing the relative distribution of expenses compared with utilization of key service areas. It shows that while relatively few New Yorkers are using inpatient services, the costs for these services account for more than half of the agency's expenditures. For example, an OMH retrospective review of 2002 Medicaid data revealed that 1% (3,000) of the total number of individuals (259,000) accessing licensed mental health services accounted for 14% of the total mental health Medicaid costs for these services. The primary service driving these expenditures was hospital inpatient utilization. This is significant to consider against the framework of policy commitments to bring more effective, evidence-based interventions to individuals in their own neighborhoods through an improved array of community-based services. As New York State continues its efforts to realize this shift in the quality of and locus for effective interventions, it must look for ways of realigning resources to support this commitment. Appendix 6 contains a list of all revenues and expenditures for the State by all major program categories.

Patterns of Usage: Costs Associated with Inpatient Care

It is also useful to examine one important variable within costs for inpatient care - the degree of frequency with which individuals

use the service. At present, OMH is not routinely able to analyze individual-level outcomes based on either the diagnosis or level of functioning of individuals. With the increasing use of the Child and Adult Integrate Reporting System (CAIRS) described elsewhere in this Plan, it will be possible to determine more information about the patterns of inpatient usage for persons deemed to have multiple and intense service needs. At this time it is possible, however, to analyze important information about this potential cohort of individuals by examining patterns of multiple inpatient service usage over a given year's period of time. This examination might infer that individuals with high rates of inpatient usage may have service needs that are not easily met through traditional courses of treatment either in the inpatient or community care settings.

One Outcome of Using Inpatient Services: Rates of Readmission Within 30 and 180 Days

There are several potential, key ways to think about both the patterns of using inpatient services and intended outcomes. As OMH considers domains for a performance measurement system, it is useful to look at just one of the most basic measures of both appropriateness and outcomes: the degree to which individuals who use inpatient services return to inpatient services within relatively short periods of time. The Federal indicators for time frames of readmission call for measurement at 30 and 180-day intervals. Additional work will be done during the development of the agency's performance measurement system to review readmission data by level of care (acute inpatient, intermediate, and extended care). OMH will also be producing reports on admissions and discharges to these levels of care by all relevant auspices, geographic distributions, and population groups, and plans to examine population-and sector specific readmission rates in the future.

Using data from the DOH Medicaid Management Information System, Table 4 6 presents rates of readmission to inpatient psychiatric units statewide and by auspice among mental health recipients who were

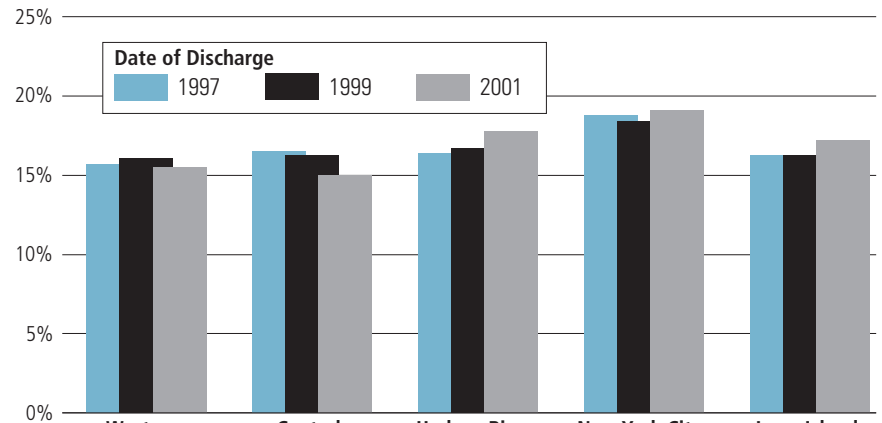
Table 4-6

Rates of Readmission to Inpatient Psychiatric Units Among Mental Health Recipeients Discharged During Calendar Year 2001 in Medicaid Claim Data

Provider Type	Discharges	Readmitted Within 30 Days Number	Readmitted Within 30 Days Percent	Readmitted Within 180 Days Number	Readmitted Within 180 Days Percent
Statewide Total	66,659	12,187	18.3%	26,572	39.9%
General Hospital	60,985	11,135	18.3%	24,453	40.1%
Private Hospital	3,571	516	14.4%	1,287	36.0%
State PC	1,683	351	20.9%	592	35.2%
RTF	420	185	44.0%	240	57.1%

Figure 4-12

30 Day Readmission Rates for Medicaid Recipients to Inpatient Settings by Region 1997 to 2001



discharged during calendar year 2001. The following graphs display rates of readmission to inpatient services in all service sectors by 30 and 180-day measures also using data from the system. Figure 4-12 displays the 30-day rates of readmission to inpatient services for Medicaid recipients by OMH region from 1997 to 2001. Figure 4-13 displays the 180-day rates of readmission to inpatient services for Medicaid recipients by OMH region from 1997 to 2001.

Figure 4-13

180 Day Readmission Rates for Medicaid Recipients to Inpatient Settings by Region 1997 to 2001

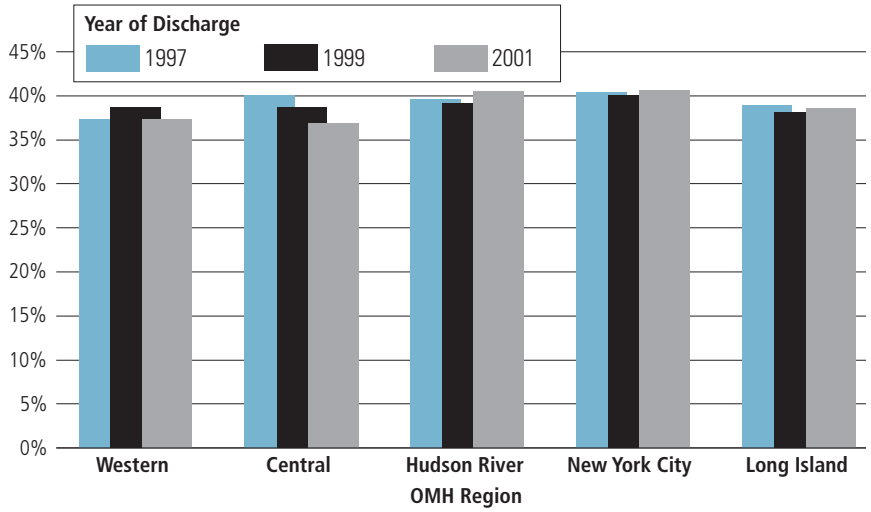


Table 4-7
Readmissions in 2001

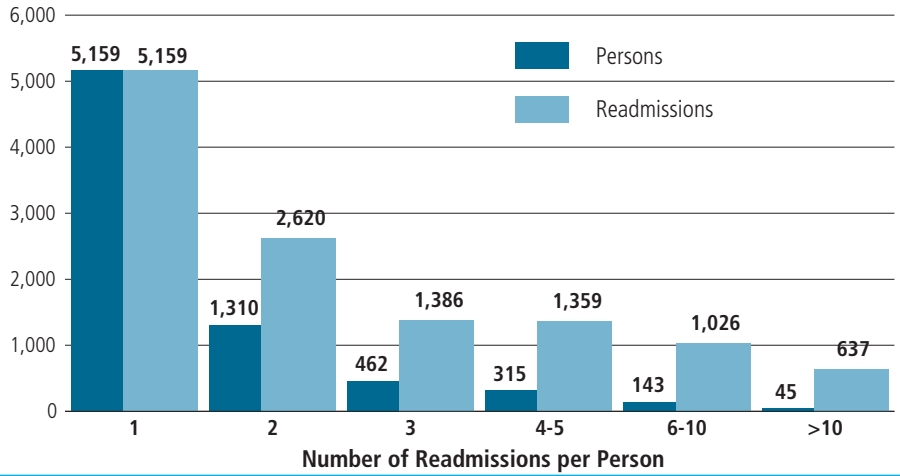
Readmissions Per Person	Persons	Readmissions	Percent of Persons	Percent of Readmissions
1	5,159	5,159	69%	42%
2	1,310	2,620	18%	21%
3	462	1,386	6%	11%
4-5	315	1,359	4%	11%
6-10	143	1,026	2%	8%
>10	45	637	1%	5%
Total	**7,434**	**12,187**	**100%**	**100%**

Appendix 5 contains more specific county readmission profiles.

Readmission Patterns Among Users of Inpatient Services

The use of inpatient services over time is not presented with the judgment that repeated use represents either an ineffective course of care during inpatient treatment or ineffective outpatient care. The intent of displaying information on readmission rates is to provide the mental health community with management information, which may be useful for planning and monitoring purposes. To further the intended use of these

Figure 4-14
Identifying Frequent Users of Inpatient Services



data, it is helpful to provide one additional way of looking at the information on inpatient service usage – a look at the patterns of use by individuals, and their specific episodes of inpatient treatment.

In 2001, there were 66,659 psychiatric inpatients who were discharged from all inpatient settings combined. This includes people using State Psychiatric Centers (1,683), private hospitals (3,571), general hospitals (60,985), and residential treatment facilities for children (420). For 12,187 (18%) of these episodes, the individual's discharge was followed by an inpatient readmission within 30 days of the discharge. In total, 7,434 persons accounted for these readmissions, but some persons were readmitted more frequently than others. Figure 4-14 presents the number of readmissions in 2001 per person. Approximately 5,200 persons were readmitted once, accounting for 5,200 (42%) readmissions; 1,300 persons were readmitted twice, accounting for 2,600 (21%) readmissions; and 45 persons were admitted over 10 times during the year, accounting for 637 (5%) of the readmissions. Expressed differently, 13% of the persons readmitted accounted for 35% of the inpatient readmissions.

Part of the anticipated statewide planning discussions will focus on ways to further analyze these data, including an understanding of the course of service delivery associated with repeated inpatient admissions. It is necessary to conduct additional analysis of these rates and patterns of use because their underlying factors are not readily discernible. There are many reasons for these data being what they are and their relative use as performance measures is still in its early stages of development.

Discussion and Questions for Consideration

Inpatient Care

The information presented in this Chapter and its accompanying appendices shows that there are disparities in the use of inpatient care among population groups, providers, service sectors, regions, and counties. Factors influencing the differences in use are not necessarily obvious. A number of questions, some of which are outlined below, need to be considered before the appropriateness of the observed differences can be assessed. These questions and the issues that they raise can be discussed and prioritized as part of the planning process.

- What type of variation is there across counties by region and by comparable county? Are there some counties in the different regions or counties of similar demographics with similarly high or low rates? If so, do they share similar service system characteristics?
- Are there any other demographic or service variables that might account for the observed differences or similarities in inpatient use by region, county size, and utilization group? For example, the correlation of factors associated with severe mental illness (poverty rates, unemployment, education levels, percent Caucasian, etc.) with inpatient use should be considered.
- Is the pattern of inpatient use by region and county demography similar for all types of

inpatient care (i.e., State Psychiatric Centers and general hospital units)? Are there particular characteristics associated with general hospital units that may influence frequency and duration of service use?

- What are the patterns of use and capacity in other 24-hour mental health care settings (e.g., community residences, supported housing, adult homes, transitional housing, and family care)? Does the availability of these options influence inpatient service use?
- Do inpatient rate levels suggest overuse, under use, or misuse of this most costly service and if they do, how can the State and county governments address these while continuing to build capacity for community based treatment, rehabilitative, and support services? Are there benchmarks for assessing the appropriateness of readmission and do these benchmarks need to be adjusted for differences in level of care, auspice, geography or population sub-groups? Do specific individuals or cohorts of individuals account in large part for some of these differences?
- Are there reliable prediction models of psychiatric inpatient use? How can such models be used in developing a person-centered continuum of community-based care where both need and personal preference can be concurrently and equitably addressed?

CHAPTER 5

Adults: at Home, at Work and in the Community

OMH HAS A STRONG COMMITMENT to meeting the mental health needs of adults with mental illness. New York State's public mental health system serves approximately 490,000 adults with serious mental illness each year. The majority of this population receives services in community-based programs that provide easy access for individuals in need. By working closely with the departments of mental health in our counties and New York City, we ensure that public mental health services are responsive to local needs. By focusing on individual and system level outcomes, we ensure accountability for results.

OMH is continuing the redesign and expansion of the mental health system that is part of Governor Pataki's Enhanced Community Services initiative. The 1999 Enhanced Community Services Program afforded OMH an unprecedented opportunity to create major inroads for improved access to effective, community-based services. Using OMH's strategic planning framework of accountability, best practices and coordination of care, OMH has implemented several essential "building blocks" with this funding, notably in the areas of care coordination and housing. These are foundations supporting OMH's intent to transform the public mental health system.

The transformation effort is aimed at creating a culture among managers and providers that embraces continuous quality improvement and the use of evidence-based practices to improve the effectiveness of service delivery. The use of evidence-based practices has been demonstrated to substantially reduce either hospital inpatient utilization and/or societal burden. On a national level, OMH is participating in the Center for Mental Health Services (CMHS) of SAMHSA and the New Hampshire-Dartmouth Psychiatric Research Center's collaborative national evidence-based practices demonstration project, which is utilizing implementation resource kits at over 50 mental health sites in eight states to effectively implement evidence-based practices. OMH is involved in two collaborative projects – implementing Assertive Community Treatment and Wellness Self-Management, as well as an expansion of a Federally funded initiative targeted in this State to Family Psychoeducation.

Chapter 5

Adults: at home, at work and in the community

This Chapter highlights OMH's evidence-based services and administrative care coordination processes for adults with severe mental illness. The combination of science-based services and care coordination increases the likelihood that most individuals will be able to successfully reside in the community. Chapter 5 also identifies key accomplishments that have furthered the mission and program priorities of OMH, and explains how OMH has targeted investments to maximize value and achieve positive performance results. It concludes with a brief review of forensic mental health services and the agency's plan for the future.

Decision-Support Infrastructure for Care Coordination

Through the single point of access process (SPOA), local departments of mental health across the State have changed business practices by creating centralized intake and referral systems to prioritize access to services based on need level. The SPOA infrastructure is designed to improve and prioritize access for individuals with the greatest need, and enables county mental health departments to manage resources by being actively aware of who is being referred and who is receiving services. Counties have considerable flexibility in structuring their SPOA systems, as long as the general purposes of SPOA are addressed. They currently have the ability to use the CAIRS (Child and Adult Integrated Reporting System) for decision support in managing this process.

SPOA for adults in the areas of housing and case management are now operational in all counties. OMH will continue to provide technical assistance to localities as they refine their local systems. Two current OMH evaluation studies indicate that Assisted Outpatient Treatment (AOT) and SPOA are effectively serving those with the most challenging needs. The studies are OMH's AOT evaluation and the Brooklyn Housing SPOA study.

Care Coordination Programs

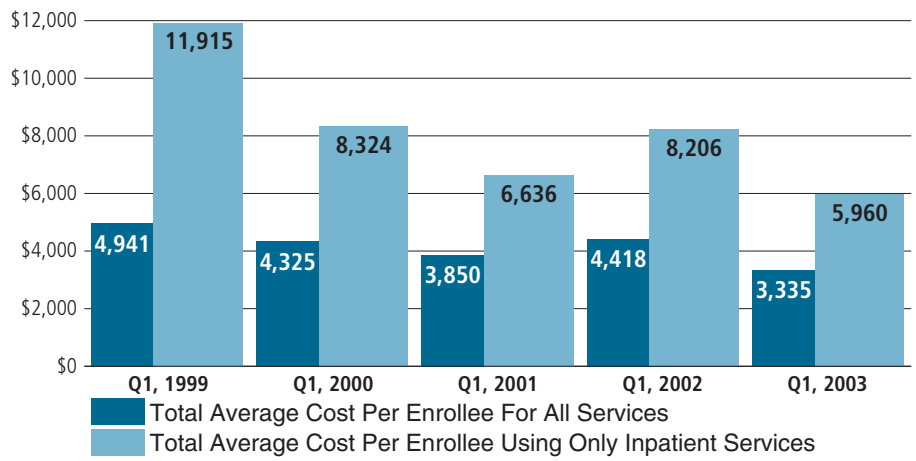
Western New York Care Coordination Program

The Western New York Care Coordination Program (WNYCCP) is designed to increase the flexibility and responsiveness of mental health services for individuals diagnosed with serious mental illness who need clinical and social support services, and who could benefit from an individualized service plan (ISP) to improve their quality of life. The program is a collaboration of Chautauqua, Erie, Genesee, Monroe, Onondaga, and Wyoming Counties.

The WNYCCP uses an interrelated set of clinical, fiscal, and regulatory initiatives to improve and expand the capacity of community mental health systems. Program goals include improved system performance achieved through provision of evidence-based practices, need-based resource allocation, and increased coordination of services, recipient empowerment and choice, and accountability.

The program establishes care coordination as one of the options for an individual going through the SPOA process for case management services. Each participating county has designated some of its case management slots for care coordination. Care coordinators differ from traditional

Figure 5-1
Medicaid Claims Data Analysis of WNYCC Enrollees



case managers by their added authority in developing a person's ISP, and ensuring that providers' treatment plans support the goals of that plan. They also have more flexibility in purchasing services and supports.

Accountability will be achieved through systematic monitoring of key indicators of the individuals well being and safety, housing, employment, access to services, criminal justice system involvement, satisfaction, and service utilization. Performance outcomes will be monitored throughout the implementation and operation, allowing counties to make adjustments based on real life experience. Additionally, counties and providers participating in the program will pilot the provision of specific evidence-based practices shown to be effective in an individual's recovery.

Approximately 1,200 individuals with mental illnesses have enrolled in the program across the six participating counties. The initial impact on the cost of care has been significant, as illustrated in Figure 5-1. During the first quarter of 2003, the total average cost per enrollee for all services was 32% less than during the first quarter of 1999, and during the same time period, the total average cost per enrollee using inpatient services declined by 50%.

Staten Island Behavioral Network

The Staten Island Behavioral Health Network (SIBHN) is a network of six community-based providers that has created a not-for-profit organization to provide care coordination services. The program has 220 care coordination slots provided through five blended case management teams. The goals and approach of SIBHN are similar to the Western Care New York Coordination Program:

- Utilize Care Coordinators to minimize service fragmentation and ensure access to care

- Establish "enhanced case managers" as the foundation for an integrated system in a fee-for-service environment
- Empower the case manager to manage care across the six member agencies
- Ensure choice and collaboration with the recipient in the development of the Individualized Service Plan
- Monitor outcomes and results through a performance management system

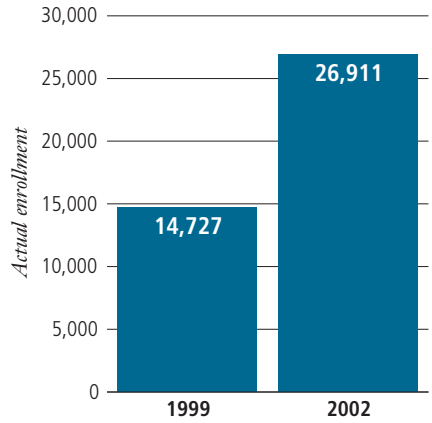
Changing Business Practices: An Evidence-Based Agenda

OMH's priority set of practices for adults reflect consistent research findings that are specific enough to permit the assessment of the quality of the practice rendered as well as outcomes. Research demonstrates that these practices are enhanced when used in combination. OMH is implementing the following set of services for adults with serious mental illnesses, each of which is designed to significantly improve quality of life outcomes. In addition, OMH is using their positive performance results to inform implementation and operations of several key, targeted initiatives.

Priority set of practices to keep adults in the community, at work, and connected with family and friends

Case Management – Supporting Successful Community Living: Case management services are available for adults and children, and have the overall aims of fostering independence and improving the quality of life. Case managers help individuals with mental illness to access mental health services and benefits including entitlements, employment, and housing. They provide linking, advocacy, coordination and problem resolution services, and coordinate comprehensive and individualized service packages that address an individual's complex needs.

Figure 5-2
Growth in Adult ICM, SCM, ACT



The Enhanced Community Services Program has dramatically expanded case management services statewide to enable thousands of additional individuals with severe mental illness to receive these effective services. In 1999, our public mental health system had the case management capacity to serve 14,727 adults at any one time. In 2002, as a result of increased resources allocated to counties and New York City, the system can now serve 26,911 adults, an increase of 83% over 1999 levels (Figure 5-2).

Assertive Community Treatment (ACT) – Reducing Psychiatric Hospitalizations and Improving Housing Outcomes: OMH is expanding ACT, which research has consistently shown to more effectively decrease psychiatric hospitalizations and

improve housing stability among individuals with mental illness than other forms of case management.[1] New York's ACT initiative is unique because it utilizes the ACT program as a platform for implementing other evidence-based practices. ACT is distinguished from more traditional case management by several important features.

Rather than a case manager coordinating services, a multi-disciplinary team provides ACT services, and typically includes members from the fields of psychiatry, nursing, psychology, and social work, with increasing involvement of substance abuse and vocational rehabilitation specialists. Based on their various areas of expertise, team members collaborate to deliver integrated services of the individual's choice that are tailored to meet his or her specific needs. The team monitors the clients' progress toward goals and adjusts services over time to meet their changing needs. The staff-to-client ratio is small, and services are provided 24-hours a day, seven days a week, for as long as they are needed.

ACT is documented to be effective by the National Institute of Mental Health's Schizophrenia Patient Outcomes Research Team (PORT) study,[2] and is endorsed as an essential treatment for severe mental illness in the Surgeon General's 1999 report on mental health. The Centers for Medicare and Medicaid Services have authorized ACT as a reimbursable treatment, and the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) has designated access to ACT as a measure of the quality of a state's mental health system.

New York State is ensuring the ACT program's maximum effectiveness with a licensing protocol and by continuously measuring the program's services. As of June 2003, 44 ACT teams were licensed; another 26 teams are in the licensing process. When all ACT teams are fully licensed, they will collectively serve approximately 5,000 individuals, an increase of 36% from current levels of 3,684 individuals. OMH will continue to evaluate use and outcomes of ACT and case management programs with the potential for conversion of appropriate case management services into the ACT model.

More information about ACT as an evidence-based practice is available on the OMH Web site at http://www.omh.state.ny.us/omhweb/ebp/adult_act.htm.

Medication Management

Medications are the cornerstone of the treatment of severe mental illness. Over the past decade, increasing numbers of new "atypical" medications have helped advance the pharmacological treatment of psychosis. These medications have advantages over their predecessors including fewer side effects, and provide individuals with mental illness with increased hope for better outcomes in cognitive functioning and community integration.

The American Psychiatric Association and the National Association of State Mental Health Program Directors have acknowledged the effectiveness of atypical medications in improving outcomes by endorsing access to atypicals as a measure of quality for health care systems. However, the landmark PORT study documented that only about half of people with schizophrenia receive guideline-based care.

OMH is attempting to close this quality gap. The 2001 Progress Report described how OMH increased the use of atypical

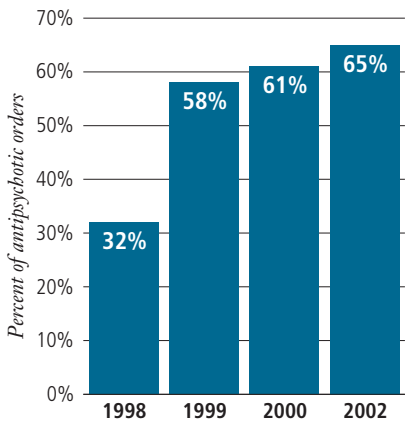
Notes

1 Phillips, S.D., Burns, B.J., Edgar, E.R., Mueser, K.T., Linkins, K.W., Rosenheck, R.A., et al. (2001). Moving assertive community treatment into standard practice. Psychiatric Services, 52(6), 771-779.

2 Lehman, A.F., & Steinwachs D.M. (1998). Patterns of usual care for schizophrenia: initial results from the Schizophrenia Patient Outcomes Research Team (PORT) client survey. Schizophrenia Bulletin, 24(1), 11-20.

Figure 5-3

State Psychiatric Center use of atypical medications for adult inpatients has increased 103%



antipsychotic medications in State Psychiatric Centers serving adults by 91% from 1998-2000. By 2002, the use of atypical antipsychotic medications in State Psychiatric Centers serving adults had further increased to more than twice (103%) that of 1998 levels (Figure 5-3).

Recommendations for Managing Schizophrenia with Medications

Over 13 different clinical practice guidelines have been published that address the pharmacological treatment of schizophrenia, but many of them are difficult to use in day-to-day practice. Using a methodology developed by the RAND Corporation, OMH has identified recommendations that have a wide base of support across these guidelines, and developed a pocket reference booklet that makes the guideline recommendations more easily accessible.

This reference, *Recommendations for the Pharmacological Management of Schizophrenia*, offers an approach to best practices for medication management, summarizes key guideline recommendations, and offers helpful reference tables on management of side effects, comorbid symptoms, and medication information including pill sizes, dosing, and side effects. This booklet has been widely distributed in the State-operated treatment system and to governmental and non-governmental providers across the country. Copies of the booklet can be requested by contacting OMH's Center for Information Technology and Evaluation Research.

Automated Clinical Decision Support Tools

In chronic conditions such as schizophrenia, it is often difficult for clinicians to determine a patient's treatment history-including basic information about past medication trials and what has been successful or ineffective in the past. In an effort to overcome this barrier to quality care, OMH is developing a new centralized database for pharmacy information, known as the Pharmacy Service and Clinical Knowledge Enhancement System (PSYCKES). It will allow clinicians, managers, pharmacists, and researchers to generate ad hoc and standardized reports of pharmacy data. It will provide detailed views of inpatient and outpatient prescribing histories for patients, and help clinicians to develop new best practices by evaluating the relationship between practice and outcomes.

To date, PSYCKES pharmacy data has been used to generate concise reports that are designed to help clinicians rapidly review medication histories, identify deviations from guideline recommended care,

and make prescribing decisions based on the best available data. The reports are presented on hyper-linked Web pages so that physicians and clinical supervisors can easily switch between detailed views for individual patients, to the high-level overview of their caseload, to quality indicator reports aggregated at the State-operated facility level. More information about PSYCKES is included in Chapter 10.

OMH is successfully using administrative and pharmacy data bases to develop evidence-based clinical support tools for schizophrenia. Information and educational efforts are only the first step toward meaningful quality improvements. To further support change in medication practices, OMH has developed a medication guideline implementation program that focuses on State psychiatric hospital inpatients – who are among the most disabled of mentally ill populations. This quality improvement initiative includes clinical evaluation and review of psychiatric and medical diagnosis; review of past treatments using the automated reports described above; measuring symptoms to quantify response to treatment in an ongoing fashion; and optimal application of treatment recommendations based on the individual's personal preferences, diagnosis, and prior response to treatment. The guideline implementation program combines a number of intervention strategies known to be effective, including training with ongoing supervision, prompts and reminders to use guidelines, and feedback on practices.

Family Psychoeducation

Many family members and other persons are involved in the lives, care, and support of adults who have serious mental illness. For those with mental illness, these relationships play an extremely important role in their lives and can be instrumental to their recovery. Family Psychoeducation programs (FPE) are a major example of evidence-based protocols with significant positive outcomes.They provide education, support, and coping skills to members of an individual's support network with the aim of assisting that individual and his or her family in the recovery process (Table 5-1).

Studies have shown reductions in the rate of relapse and rehospitalizations, higher participation in vocational rehabilitation, and decreased costs of care among individuals whose families receive FPE.[3] FPE also improves outcomes by instilling hope and reducing distress, stigma, and isolation. An OMH survey conducted in May 2003 indicated that approximately 123 agencies statewide are offering FPE services.

Table 5-1

Adult Family Education Topics and Skills

- What we know about schizophrenia: diagnosis to recovery
- Evidence based treatments and treatment alternatives for schizophrenia, including self-help
- Relapse prevention and crisis management activities
- Understanding and negotiating the mental health system
- Community resources and supports for recipients and families, including self-help
- Advocacy skills
- Communication skills to enhance family relationships
- Problem-solving skills
- Coping skills and strategies

Notes

3 Dixon, L., McFarlane, W.R., Lefley, H., Lucksted, A., Cohen, M., Falloon, I., et al. (2001). Evidence-based practices for services to families of people with psychiatric disabilities. Psychiatric Services, 52(7), 903-910.

OMH has established a partnership with the University of Rochester to train mental health professionals across the State in evidence-based FPE protocols promulgated by William R. McFarlane, MD. This partnership has resulted in the establishment of the Family Institute for Education, Practice, and Research, which is New York State's first such institute in the mental health field. In 2002, the Family Institute and OMH, in collaboration with NAMI-NYS and the Conference of Local Mental Hygiene Directors (CLMHD), held a series of informational forums with 545 providers, families, and consumers across the State concerning the need for FPE services.

As a result of feedback received in these forums, in April 2003 the Family Institute released an RFP offering mental health providers 18 months of intensive consultation and supervision in the delivery of the McFarlane FPE model. A total of 18 providers and provider organizations, involving over 30 agencies and programs across the State, are participating in this project and by the first quarter of 2004, each will be engaged in introducing the model to their consumers and families. Additional OMH activities in FPE include a SAMHSA funded project to create FPE sites in three culturally diverse New York State communities (described in Chapter 1).

More information about FPE as an evidence-based practice can be found on the OMH Web site at http://www.omh.state.ny.us/omhweb/ebp/ adult_familyeducation.htm.

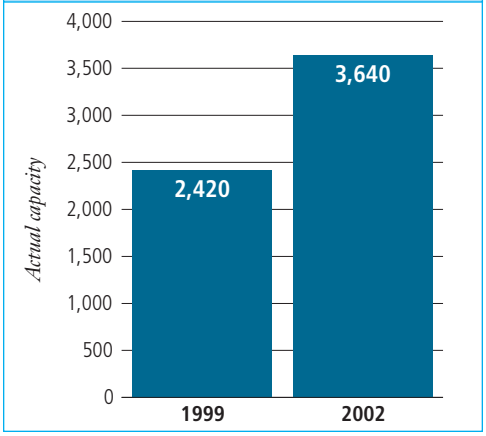
Integrated Employment Services

Although the great majority of adults with severe mental illness identify competitive employment as one of their main life goals, they have historically faced barriers in accessing that employment. In 2001, a survey conducted by OMH showed that approximately 17% of adults served in non-institutional mental health settings are competitively employed either full or part time.

Traditional vocational services for persons with mental illness have been limited to extensive pre-employment experiences such as skills training, sheltered work experiences, and work trials prior to placement in a competitive job. However, research has found that interventions that do not target job placement directly have very little impact on employment outcomes. At the same time, the evidence base is clear that rapid attachment to the work force produces improved employment outcomes for individuals with severe mental illness.[4]

The supported employment model of vocational rehabilitation includes: rapid job searches and placement in competitive employment; ongoing follow-along supports after placement; integration of vocational and clinical services; and placing consumers in jobs that match their preferences.

Figure 5-4
Supported Employment Opportunities Growth



Notes

4 Bond, G.R., Becker, D.R., Drake, R.E., Rapp, C.A., Meisler, N., Lehman, A.F., et al. (2001). Implementing supported employment as an evidence-based practice. Psychiatric Services, 52(3), 313-322.

Supported employment helps consumers secure and maintain jobs in the community.

OMH is expanding innovative and evidence-based service options to support the direct placement of adults with severe mental illness in competitive jobs to improve their employment outcomes. From 1999 to 2002, employment opportunities increased 80%, from 2,420 to 3,640, for individuals using OMH and VESID (Vocational and Educational Services for Individuals with Disability) services that were included in the New York Interagency Supported Employment Report (Figure 5-4).

Post-Traumatic Stress Disorder (PTSD) Treatment

PTSD is a psychiatric disorder that can occur following the experience or witnessing of life threatening events such as military combat, natural disasters, terrorist incidents, serious accidents or violent personal assaults like rape. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. These symptoms can be severe enough and last long enough to significantly impair the person's daily life. OMH activities in the area of PTSD include:

- OMH is testing a new protocol for identifying trauma survivors and assessing symptoms using nationally validated assessment instruments in select psychiatric centers serving adults and children. The results of these pilot tests will determine whether or not this new protocol is adopted statewide.

- In 2001 and 2002, OMH sponsored intensive trainings on Dialectical Behavior Therapy (DBT), an evidence-based approach for the treatment of individuals diagnosed with Borderline Personality Disorder who are suicidal or parasuicidal and often trauma survivors. The programs established as a result of the training, which include inpatient services, OMH-operated outpatient services, locally-operated outpatient services, and forensic mental health programs, are currently undergoing an outcome evaluation.

- OMH has also received a grant from CMHS to hold a symposium on evidence-based treatments and promising practices for PTSD and trauma-based disorders. The program is scheduled to be held in New York City in Spring 2004, and will include treatments for survivors of unexpected events like disasters and ubiquitous traumatic experiences such as repeated child sexual abuse.

Integrated Treatment for Co-Occurring Substance Abuse and Mental Health Disorders

Co-occurring mental health and substance abuse disorders are common. Half of the adults with serious mental illness have co-occurring substance abuse disorders. Individuals with co-occurring disorders are at high risk for hospitalization, overdose, victimization, violence, legal problems, homelessness, HIV infection, and hepatitis. However, research has found that approaches such as cross-referral and linkage, co-operation, consultation, collaboration, and especially integrated treatment result in better outcomes.[5] Recipients with co-occurring disorders have high rates of recovery when provided integrated treatment, an evidence-based practice in which

Notes

5 Drake, R.E., Essock, S.M., Shaner, A., Carey, K.B., Minkoff, K., Kola, L., et al. (2001). Implementing dual diagnosis services for recipients with severe mental illness. Psychiatric Services, 52(4), 469-476.

Table 5-2
Integrated Treatment Services and Interventions

- Screening
- Assessment
- Stage-wise interventions
- Motivational interventions
- Interventions to promote health
- Access to comprehensive services
- Outreach
- Pharmacological treatment
- Counseling
- Group dual disorders treatment
- Family psychoeducation
- Self-help groups

the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion (Table 5-2). Integrated treatment combines mental health and substance abuse interventions at the level of the clinical interaction. It also involves not only combining appropriate treatments for both disorders but also modifying traditional interventions. Viewing treatment of co-occurring disorders as an expectation, OMH recommends that all programs serving adults with serious mental illness should have the ability to deliver integrated treatment within their existing program structures.

OMH-OASAS Collaboration

OMH and the Office of Alcoholism and Substance Abuse Services (OASAS) have collaborated for many years to provide services to individuals diagnosed with co-occurring mental health and substance abuse disorders. In 1998, their Memorandum of Understanding established an ongoing Interagency Workgroup on Co-occurring Disorders whose initial work focused on joint screening and assessment, joint training curricula, inter-system collaboration at the local level, and the needs of recipients with serious mental health and substance abuse disorders. In 2001, the collaboration produced *Treating Co-Occurring Mental Health and Addictive Disorders in New York State: A Comprehensive View*, the Quadrant IV Taskforce report based on a co-occurring disorders conceptual framework developed in New York State, and endorsed by the National Association of State Mental Health Program Directors, the National Association of State Alcohol and Drug Abuse Directors, and SAMHSA. Six regional forums were held to solicit feedback on the report, and a *Co-occurring Mental Health and Substance Abuse Disorders Barrier Analysis*, based largely on the written comments of those who attended the forums, was developed in 2002. Current OMH/OASAS collaborative efforts include:

- Interagency Workgroup on Co-occurring Disorders, which meets monthly to oversee the development, implementation, and evaluation of joint agency initiatives

- Twelve Dual Recovery Coordinators, funded jointly by OMH and OASAS to address issues of coordination of care within the context of local service system structures in New York City and Broome, Columbia, Erie, Genesee/Orleans/Wyoming, Oneida, Onondaga, Schenectady, Suffolk, Tompkins, Warren/Washington, and Westchester Counties

- Screening instruments validation testing of the Dartmouth Assessment of Lifestyle Inventory (DALI) for substance abuse screening in mental health settings and the Mini-International Neuropsychiatric Interview (MINI) for mental health screening in substance abuse settings

Expanding Integrated Treatment

Since integrated treatment for mental health and substance abuse disorders was identified as an evidence-based practice by a consensus panel of recipients, clinicians, administrators, and researchers convened by the Robert Wood Johnson Foundation in 1998, there has been increasing interest in the utilization of evidence-based practices in efforts to overcome barriers and enhance services for individuals with co-occurring disorders. OMH and OASAS both have active "Science-to-Services" initiatives. New York is one of eight states participating in SAMHSA's Implementing Evidence-Based Practices for Severe Mental Illness Project to develop implementation resource kits to promote the delivery of evidence-based practices at the state and local levels, and one of four states to develop a statewide Practice Improvement Collaborative.

OMH is committed to the expansion of integrated treatment for co-occurring mental health and substance abuse disorders in the State, initially focusing on outpatient services. Expansion will build upon the considerable number of accomplishments and works in progress in the State related to individuals diagnosed with serious co-occurring mental health and substance abuse disorders and on the increased utilization of evidence-based practice modalities as a highly effective way to update those efforts. Doing so is also consistent with OMH's priority to base service design and delivery on the best research evidence possible and incorporate best practice guidelines into treatment practices. Related to the expansion of integrated treatment in 2003, OMH:

- Visited a variety of licensed outpatient programs throughout the State to learn more directly how programs approach treating individuals with co-occurring disorders, assess the degree to which they provide integrated treatment, and determine what they need to improve or expand integrated treatment
- Conducted nearly two dozen introductory sessions on the elements of integrated treatment for community-based clinical and supervisory staff
- Sponsored, in collaboration with a number of local governments and service providers, six day-long integrated treatment workshops throughout the State for more than 600 participants
- Trained all Assertive Community Treatment (ACT) teams on integrated treatment training
- Included integrated treatment for co-occurring mental health and substance abuse disorders in the service array of a planned Personalized Recovery-Oriented Services (PROS) outpatient program

Future plans include focusing the utilization of training monies for co-occurring disorders on integrated treatment to promote staff training and cross-training in this evidence-based practice.

Wellness Self-Management

Recovery following a psychiatric diagnosis is the process of regaining control over one's personal, social, and economic life. It is what occurs when people with a psychiatric diagnosis discover or rediscover their strengths and abilities, pursue goals, and develop a sense of identity that allows that person to grow beyond his or her diagnosis. Wellness self-management encompasses

Table 5-3

Wellness Self-management Interventions

Education: Basic information about mental illness from diagnosis to recovery including characteristic symptoms of the individual's mental health diagnosis, effects and side effects of medications, the principles of recovery, management of stress, and early warning signs of relapse.

Skills Training: Learning activities that enable recipients to acquire interpersonal, self-care, and coping skills.

Cognitive Therapy: Helps clients to evaluate his or her belief system and explore and/or formulate alternative, more viable explanations when faced with evidence that is inconsistent with their beliefs.

education, skills training, and cognitive therapy strategies (Table 5-3) that are designed to help individuals with severe mental illness manage their symptoms, prevent relapse,[6] and improve their recovery. Skills training clearly improves social functioning, including social relationships, leisure and recreation skills, and self-care ability. Cognitive therapy has been demonstrated to decrease the severity of psychotic symptoms, and may decrease the need for psychiatric services.[7]

New York State is presently conducting a demonstration project for wellness self-management that is associated with CMHS and the New Hampshire-Dartmouth Psychiatric Research Center. Specifically, OMH has provided a number of expert consultants and research staff to study the implementation of wellness self-management in five programs in New York State. Plans are under way to expand the availability of technical assistance and clinical consultation to wellness self-management providers across the State.

More information about wellness self-management as an evidence-based practice can be found on the Web at http://www.omh.state.ny.us/omhweb/ebp/adult_wellness.htm.

Self-Help and Peer Support Services

Self-help is a broad, national movement that encompasses a wide variety of activities, structures, and networks that form a continuum of techniques and activities from those an individual uses to improve his or herself, to formal and informal peer support and/or self-help networks. These networks are based on research that shows that people who share a common bond of similar experiences can effectively use their experiential knowledge to help one another cope, recover, and grow. OMH has included self-help and peer support in its priority set of evidence-based practices in recognition of how they complement treatment, and as a life long support which promotes the process of recovery. More information about self-help and peer support as an evidence-based practice is available on the Web at http://www.omh.state.ny.us/omhweb/ebp/adult_selfhelp.htm.

As OMH advances evidence-based practices, many techniques of self-help and empowerment are deeply embedded into their domains. The agency's evidence-based practice domain on wellness self-management provides a series of weekly sessions for individuals to develop personal strategies for coping with mental illness and moving forward in their lives. These sessions also provide many self-help techniques in handouts and other tools for providers to utilize in clinical practice. The focus of the curriculum includes recovery strategies, social supports, relapse prevention, stress management, and coping strategies.

Notes

6 Drake, R.E., Mueser, K.T., Torrey, W.C., Miller, A.L., Lehman, A.F., Bond, G.R., et al. (2000). Evidence-based treatment of schizophrenia. Current Psychiatry Reports, 2 (5), 393-397.

7 Zygmunt, A., Olfson, M., Boyer, C.A., & Mechanic, D. (2002). Interventions to improve medication adherence in schizophrenia. American Journal of Psychiatry, 159(10), 1653-64.

OMH uses a variety of approaches to assure ongoing input from individuals with mental illness into its "Winds of Change" quality improvement campaign (described in Chapter 1). These include input from an Evidence-based Practice and Recovery Recipient Steering Committee and numerous evidence-based practices related recipient advisory committees, subcommittees, statewide dialogues, and workgroups. These vehicles have enabled OMH to achieve the goal of incorporating involvement from individuals with mental illness in all areas of policy development, planning, and implementation. Additionally, a series of regional dialogues have been held with individuals with mental illness to assist in creating a values-based definition of quality. Over 400 individuals participated in the first set of dialogues that created quality indicators for mental health services. As this process continues, the goal is to create a grassroots demand within the community of individuals living with mental illness for quality-based mental health services.

OMH has prioritized the development of a self-help and empowerment toolkit among the goals for the evidence-based practices self-help and empowerment domain. An inclusive, grassroots effort is underway to design this toolkit, and stakeholders have identified the importance of spotlighting self-help and peer support-related research, supporting new, innovative research methods, and offering tools to interested practitioners on how to effectively infuse self-help and empowerment into routine mental health settings. The toolkit will enhance self-help related research by assisting initiatives run by individuals with mental illness with examining, developing, and systematizing data collection.

By definition, peer support and self-help are peer-run, autonomous, and participation is completely voluntary. OMH offers technical support to self-help and peer run programs that strengthens the provision of quality services with measurable outcomes, while maintaining internal controls that support program integrity. The agency continues to hold dialogues with staff and participants of programs run by individuals with mental illness, and places high value on continuing to work with peer-run programs to identify quality indicators for the services that they offer. A directory of self-help groups and programs is available on the Web at http://www.omh.state.ny.us/omhweb/ebp/selfhelp.htm.

Community Based Services and Supports to Other Populations

Services to Individuals with Mental Illness Who Reside in Adult Homes

Adult homes are residences in the community licensed by the New York State Department of Health (DOH). Adult home 2002 census data indicate that there are 540 adult homes with 40,495 licensed beds in New York State; data also indicate that there are 12,586 recipients of mental health services residing in those homes. The majority of these individuals reside in a cluster of adult homes often referred to as impacted adult homes, meaning that either 25 residents or 25% of the total resident population receive mental health services. Among the 540 adult homes, 219 are impacted homes which have 10,971 residents receiving mental health services. Currently, services provided to adult home residents rely on the traditional model of individual and group psychotherapy provided by licensed treatment programs – primarily clinic and continuing day treatment.

New York State is strengthening oversight of adult homes through an Interagency Adult Home Initiative that includes OMH, DOH, the New York State Commission on Quality of Care for the Mentally Disabled, and the New York State Office for the Aging. Consistent with the recommendations for change made by an adult home workgroup formed by Governor Pataki, OMH and its sister agencies have developed a comprehensive service package to support adult home residents, improve service access for residents with mental illness, and help them meet their recovery goals. It includes provisions and activities that focus on health and safety, appropriateness of care, quality of care, quality of life, housing, and public awareness. A detailed overview of this service package is included in Appendix 7.

Long Term Shelter Stayer Initiative

Since 2002, OMH has participated in a State and local government initiative to target housing resources to mentally ill long-term stayers in New York City's adult shelter system. The initiative was established in response to the number of adults with severe and persistent mental illness (SPMI) who have utilized the New York City shelter system for more than 720 nights during the past four years. According to the New York City Department of Homeless Services, approximately 35% of the longest stayers have utilized the system for more than five years.

In 2000, a New York City Department of Homeless Services study found that the long-term stayer population (17% of the total shelter population) was utilizing more than 50% of bed-nights in the shelter system, and that more than 40% of the long-term stayer population has a diagnosis of a severe mental disorder. A collaborative State and local Task Force (Table 5-4) was established to address these issues by developing strategies that identify housing alternatives for the long-term stayer population and engage them in services available within the New York City mental health system.

Table 5-4

Long Term Shelter Stayer Initiative Task Force Members

- NYS Office of Mental Health (co-chair)
- NYC Department of Homeless Services (co-chair)
- NYS Office of Temporary and Disability Assistance
- NYC Department of Health and Mental Hygiene
- NYC Human Resources Administration
- Corporation for Supported Housing

The Task Force is identifying and matching new and available New York City housing for long-term stayers to shelters with large numbers of these individuals. Long-term stayers are engaged, their applications for housing are facilitated, other needed resources are identified, and they are assisted with moving into the available housing. Long-term stayers who have previously not qualified for or succeeded in supportive housing are being identified, as well as the associated barriers that must be overcome.

As additional new housing is completed, the Task Force plans to establish a connection to the long-term shelter stayers population by giving tours and showing individual apartments. Task Force participants will continue working with shelter staff and clinical providers to help the long-term stayers realize they are able to be housed and assist in maintaining motivation and engagement in this population.

To further support these initiatives, OMH and the New York City Departments of Health and Mental Hygiene and Homeless Services have established ACT teams combined with Section 8 housing targeted to the long-term stayer population. Already underway, two ACT teams serving 136 long-term stayers have been funded, licensed, and are beginning staff hiring, orientation, and initial shelter in-reach.

Assisted Outpatient Treatment (AOT): Kendra's Law

New York State's assisted outpatient treatment statute, known as Kendra's Law, is designed to ensure that individuals with severe mental illness and a history of hospitalizations or violence participate in community-based services appropriate to their needs. The statute defines criteria that, if met, can result in the issuance of a court-ordered treatment plan which requires an individual to participate in needed services, if it is determined that less restrictive alternatives would not be effective. Kendra's Law charged OMH with responsibility for developing AOT program guidelines and for monitoring AOT statewide. It also required that each county in New York State and New York City establish AOT programs to implement the statute's requirements. The AOT program's goals are summarized in Table 5-5.

Table 5-5
AOT Goals

- Identify individuals with severe mental illness in each locality who have high needs, but who are not currently participating in the services necessary to ensure their safety in the community
- Rapidly assess these individuals to determine whether they require court-ordered treatment
- Ensure that individuals determined to be in need of AOT get priority access to services
- Closely monitor the results of treatment

As of August 2003, nearly 8,000 individuals had been referred for AOT and nearly 2,800 individuals were determined to need court-ordered treatment. This has resulted in the issuance of more than 3,300 court orders since the implementation of Kendra's Law. In addition, localities have also chosen to provide enhanced services to 2,026 indi-

Figure 5-5
New York State Court Orders and Service Enhancements

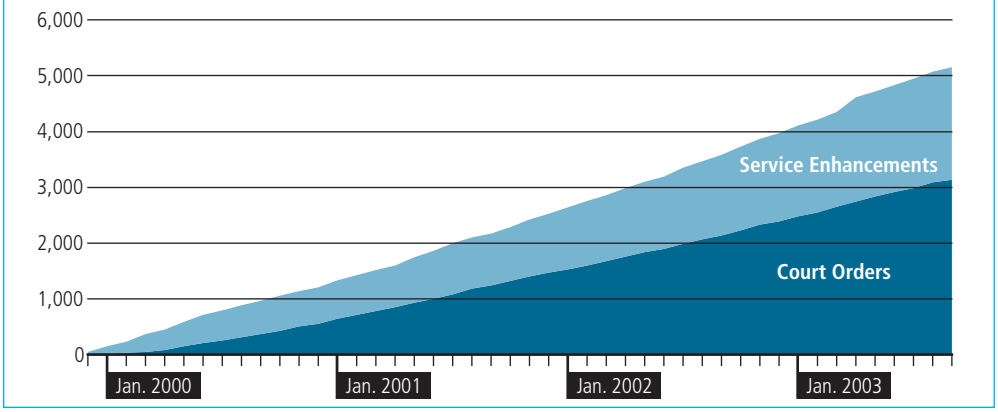


Table 5-6

AOT Improvements to Local Mental Health Service Delivery Systems

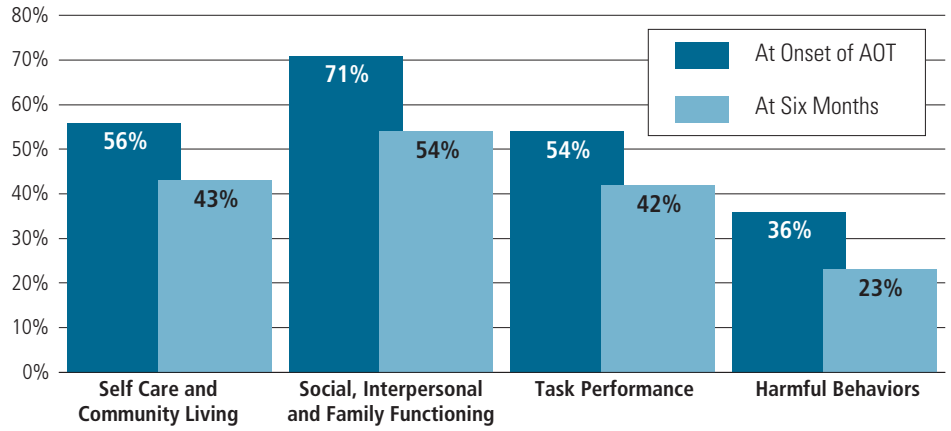
Accountability	AOT has increased accountability at all levels regarding delivery of services to individuals who have high needs or who are at high risk to themselves or others.
Access to Services	AOT has resulted in increased outreach to individuals who were previously difficult to engage in mental health services. Local mental health systems can better recognize the potential risk posed by not responding to an individual's situation. The improved ability to mobilize around the needs of these individuals has resulted in greater access to services.
Treatment Plan Development and Discharge Planning	Processes developed for AOT have resulted in improved treatment plans which more appropriately match the challenging needs of individuals who had been previously difficult to engage. Clinicians are developing sound comprehensive treatment plans that will best ensure success in the community.
Coordination of Service Planning	AOT provides mechanisms for high-level representatives of appropriate service providers to consider strategies for service delivery to AOT eligible individuals resulting in more effective service planning and coordination.
Collaboration between Mental Health and Court Systems	Staffs from the local mental health systems have developed better relationships with the court system resulting in an enhanced efficiency in the conduct of AOT hearings and greater likelihood that clinical needs of individuals are met.

viduals who have been identified through the assisted outpatient treatment process as being in need of services, but who may not meet criteria for court-ordered treatment (Figure 5-5).

To improve AOT's accountability, OMH has been conducting an ongoing evaluation of the program's impact on local mental health systems and on the individuals who are receiving court-ordered services. Improvements to local mental health systems that have come about as a result of the AOT program are summarized in Table 5-6.

Evaluation of the first six months of court-ordered treatment for AOT consumers has shown that these individuals engage in substantially fewer harmful behaviors than prior to AOT involvement, and on all measures of functioning, they also show significant improvements while receiving services (Figure 5-6). More of these individuals are now taking their psychiatric medications as prescribed and are better engaged in services (Figure 5-7). In addition, significant declines in psychiatric hospitalizations, incidence of homelessness, arrests, and incarcerations are also evident after six months of treatment under an AOT court order (Figure 5-8). Two-thirds of individuals whose court-orders have expired have improved to the degree that they are no longer in need of court-ordered AOT treatment (Figure 5-9). The next most frequently cited reason for terminating an AOT court order is that the individual is hospitalized at the end of

Figure 5-6
Severe Difficulty in Areas of Functioning and Harmful Behaviors for People in Assisted Outpatient Treatment has Declined



the court order and a long stay in the hospital is anticipated (14%).

Continuous monitoring of outcomes has shown that even as more individuals have received services under AOT, positive outcomes reported early in the program have either been exceeded or maintained. Additional information on AOT can be found on the Web at http://www.omh.state.ny.us/omhweb/Kendra_web/KHome.htm.

Figure 5-7
Participation in Services: Rates Prior to and When Under Court Order

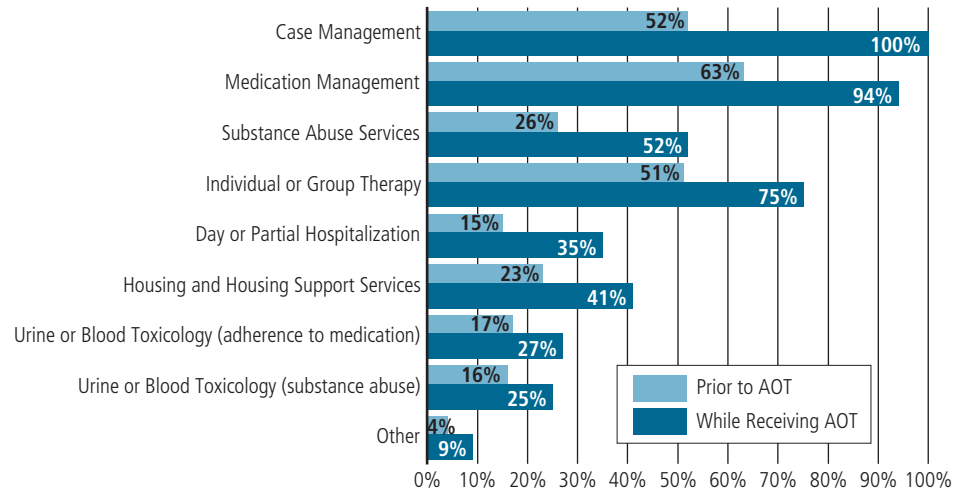


Figure 5-8
Incidence of Significant Events Have Decreased Following the Onset of Court Order

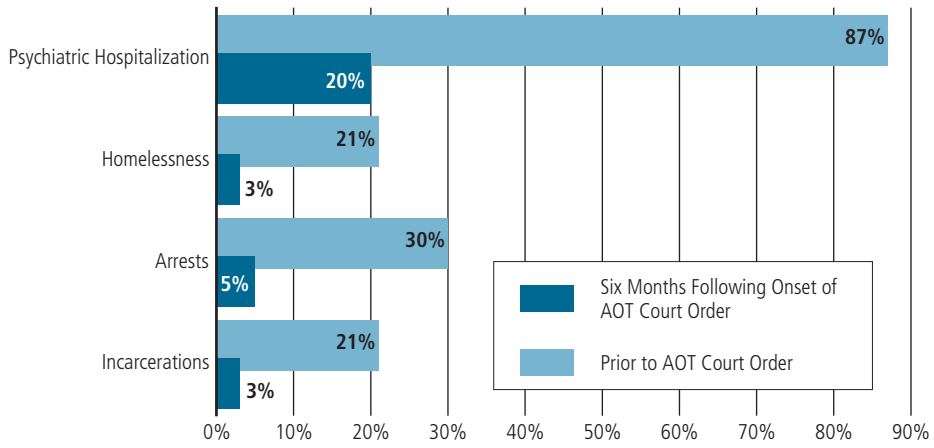
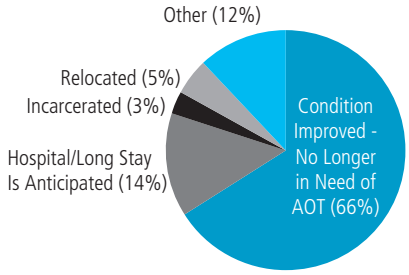


Figure 5-9
Reasons for Court Order Termination



Housing Services

OMH funds an extensive system of community-based housing for adults and children with mental illness. Housing within this system is operated by not-for-profit provider agencies or by New York State, and is available in a wide variety of options including:

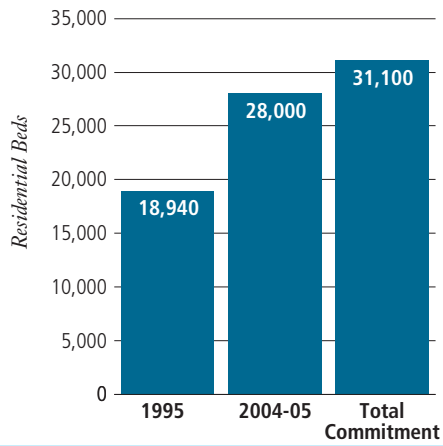
- Apartment rental assistance with flexible supportive services
- Single room occupancy (SRO) housing with private living units and 24-hour staffing to provide on-site supportive services and coordinate with community based services
- Transitional housing with shared living areas, 24-hour staffing, and individualized rehabilitative services
- Housing in family settings

OMH is committed to maximizing access to housing opportunities for individuals with diverse histories and service needs, including those with histories of repeated psychiatric hospitalizations, homelessness, involvement with the criminal justice system, and co-occurring substance abuse, as well as those moving from Adult Homes or receiving treatment under Assisted Outpatient Treatment (AOT) court orders. With good supports, the vast majority of individuals living in OMH funded housing remain successfully housed and are better able to manage their mental illness and lead productive lives. Increasingly, persons living in OMH funded housing are able to benefit from the various case management and crisis intervention services available to anyone in the community who needs those services. OMH's housing initiatives are described below.

Housing Development

OMH funded housing has expanded dramatically from 18,940 units in 1995 to more than 26,700 in 2003. Providers statewide continue to work with OMH and local governments to develop additional housing that has been authorized beyond the current 26,700 units. Units in the pipeline include rental apartments, SRO housing, and children's congregate treatment programs. Also included is housing which is being developed under the New York/New York II Agreement, a joint initiative between New York State and New York City to provide comfortable, safe housing and supportive services to homeless people with mental illness. When all of these units are operational, approximately 31,100 units of community-based housing will be available to New Yorkers with mental illness (Figure 5-10).

Figure 5-10
Community-Based Housing Growth: 60% Increase Since 1995



Housing Access

OMH, local governments, and providers are participating in the implementation of the single point of access (SPOA) process to identify and prioritize individuals' housing and service needs, and to coordinate housing placement accordingly. OMH is able to monitor housing utilization through the Residential Client Tracking System, the LS3-6 (in the process of being incorporated into CAIRS), and to review indicators including occupancy level, length of stay, admissions, and percentage of priority populations in housing programs throughout the State.

Repairs to Existing Housing Programs

Many OMH funded housing programs are in buildings that were acquired and renovated more than 15 years ago and now need repair. OMH works with not-for-profit providers to identify the scope of needed repairs and to fund the work. For the past four fiscal years more than $40 million has been made available for such repairs and renovations.

The Home of Your Own (HOYO) Mortgage Program

In the mid 1990's, the State of New York Mortgage Agency (SONYMA) and the State Office of Mental Retardation and Developmental Disabilities developed the Home of Your Own (HOYO) mortgage program for persons diagnosed with a developmental disability or traumatic brain injury. In 1997, as a result of discussions between OMH and SONYMA, the HOYO mortgage program was expanded and made available to persons with mental illness. Individuals who do not have a "traditional" credit history may still qualify for a HOYO mortgage. The program's features include: a 4% fixed rate of interest for a 30-year term; financing of as much as 100% of the purchase price; and assistance with most or all of the closing costs.

Integrated Employment Services

Performance Based Contracting-Improving Employment Outcomes

In June 2003, OMH completed an evaluation of a Performance Based Contracting (PBC) demonstration project in collaboration with the Workplace Center at the Columbia University School of Social Work. Over a two-year period, the PBC project's seven demonstration sites served over 300 individuals with severe mental illness. All participants faced serious challenges to mainstream, competitive employment including poor recent work history (78% had not worked in the prior five years), substance abuse (48%), and diagnosis of schizophrenia (33%). The purpose of the demonstration project was to examine whether outcome-based payment for vocational services would change provider behavior to improve employment outcomes consistent with evidence-based practice.

Final evaluation results showed that over the course of the PBC project, 75% of program participants found competitive employment and an average of 47% were working at any point in time. In addition, 70% of PBC program participants reported a positive change in their perception of their quality of life as a result of program participation. The average number of weeks of individual employment was 38.2.

The program fared well compared to national standards for evidence-based practice and supported employment. Participants averaged only 10.2 weeks between program entry and job placement. By comparison, national standards for rapid attachment to the work force look for this goal to be achieved within six months of program entry. In addition, the PBC project surpassed results obtained from the Federally-sponsored Employment Intervention Demonstration Project (EIDP)[8] in a number of areas including time from enrollment to employment, average hourly wage, and hours worked per week (Table 5-7).

Innovative County Vocational Project

In 1999, OMH began a major systems change initiative through the Innovative County Vocational Project (ICVP), which provides supplemental funding to counties to plan for an integrated system of employment supports and to develop specific innovative vocational programs. The 25 counties involved in the ICVP were all required to follow the principles of best practice determined through the national research demonstration on supported employment. Independent evaluation of these programs has shown significant achievement in performance outcomes.

Notes

8 Cook, J.A., (2003). Results of a Multi-Site Clinical Trials Study of Employment Models for Mental Health Consumers. EDIP Coordinating Center, Department of Psychiatry, National Research and Training Center on Psychiatric Disability, University of Chicago.

Table 5-7

OMH Employment Programs Compared to other State and Federal Employment Programs

Indicators of Program Effectiveness	OMH PBC	OMH ICVP	VESID Supported Employment	EIDP Study*
Average number of weeks between enrollment and employment	10.2	12.1	N/A	26
Average wage per hour	$7.50	$7.11	$6.94	$5.91
Average number of hours worked per week	22	24.7	22.7	19.4
Average number of days from plan development to 90 days of continuous employment	N/A	175	402	N/A

The EIDP was a two-year study funded by CMHS that compared the efficacy of various models of employment service delivery in eight states. Models compared included: Clubhouse, ACT, Individual Placement and Support, Family Psycho-education.

Table 5-7 also compares the performance of the OMH ICVP to VESID Supported Employment and the National Employment Intervention Demonstration Program (EIDP). It demonstrates the ICVP's success on several nationally recognized performance indicators used to assess the effectiveness of vocational services: wages, hours worked, time between intake and job placement, and job "stabilization."

While State employment programs will be integrated with the new Personal Recovery Oriented Services (PROS) program that is described below, these performance improvements will be maintained.

Medicaid Buy-In

As described in Chapter 1, New York State's Medicaid Buy-In program, which began on July 1, 2003, will empower working individuals with disabilities to pursue their livelihood while continuing to receive comprehensive State health insurance coverage. In support of this program, OMH has assisted community agencies to arrange for staff training on benefits management and added Buy-in related resources to its Web site at http://www.omh.state.ny.us/omhweb/ticket/index.htm.

OMH has worked with the State Department of Health to identify a number of issues that have impeded successful application for the Buy-in. To address these concerns, the agencies have collaborated to develop a plan that includes a toolkit to

help potential applicants. A draft of the toolkit is included as Appendix 8.

Personalized Recovery Oriented Services

OMH has developed and will begin converting programs to Personalized Recovery Oriented Services (PROS), a comprehensive outpatient service which integrates treatment, rehabilitation and support, and also incorporates accountability, best practices, and coordination of care. Research studies have shown that providing clinic, rehabilitation, and support services in an integrated, coordinated manner can have a marked impact on an individual's recovery. Each service has merit and positive results, but when delivered together, benefits and recovery improve dramatically.

PROS' individualized service model includes an array of services that address family understanding, how best to live with mental illness and its symptoms, knowledge about medication and its benefits, and treatments which use the best scientific approaches available. The PROS model coordinates services to meet an individual's multiple goals in areas including housing, education, employment, family, etc.

Expected outcomes for individuals include improved functioning, reduced need for inpatient care and emergency services, increased employment, higher levels of education, safer housing, and reduced contact with the criminal justice system. When fully implemented, PROS will replace Intensive Psychiatric Rehabilitation Treatment (IPRT), psychosocial clubs, and most vocational services. On an optional basis, PROS programs may also provide clinical treatment services. Continuing Day Treatment programs also have the option of converting to a PROS license. PROS is another step toward simplifying the community-based mental health system, making it more customer-oriented, and meet-

Table 5-9
PROS Implementation Questions and Answers

Question	Answer
Does the staffing ratio for Intensive Rehabilitation (IR) (i.e., 1-to-8) apply in the Limited License PROS?	The IR staffing ratio is applicable to all IR components, whether part of a Comprehensive PROS program, or a Limited License PROS program.
If a CDT is converting to a PROS and the CDT will close, how many Prior Approval Review (PAR) applications will be required?	One PAR application will be required. Approval of the PAR application for the PROS will result in termination of the CDT license.
Will OMH be developing a Uniform Case Record for the PROS license?	OMH is not developing a mandatory Uniform Case Record format for PROS programs, but will be providing prototype examples of case record contents.

ing the spectrum of outpatient mental health needs.

After considerable dialogue and input from numerous stakeholders and groups, PROS implementation has begun. To support that process, answers to various PROS implementation questions are posted on the OMH Web site at http://www.omh.state.ny.us/omhweb/pros/qa/. Examples are provided in Table 5-9.

Initial licensure of PROS programs is expected to begin in early 2004.

Including the Consumer's Voice

OMH-Operated Outpatient Services

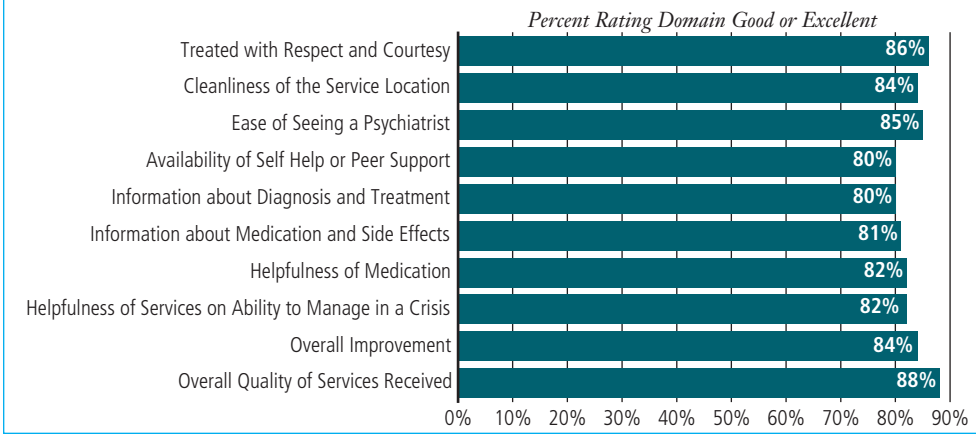
As part of our efforts to improve quality of care and promote recovery from severe mental illness, OMH is continuing to survey adults who receive services from our State-operated programs. We are particularly interested in how satisfied people are with our services and their perceptions of how those services have impacted their quality of life. Satisfaction is related to effectiveness of treatment services,[10] treatment continuity, and quality of life.[11]

The OMH Downstate Alliance, a consortium of nine State-run psychiatric centers in New York City and the surrounding counties, has developed a standardized set of behavioral health outcome measures to improve care, support recovery, and provide a basis for quality improvement within and between facilities. Among these instruments is the Consumer Assessment of Care (CAC) survey, which measures satisfaction with psychiatric services and personal satisfaction within different areas of one's life.

The results of a CAC survey of 2,171 outpatients (Figure 5-11), showed that almost 90% rated the psychiatric services they received as good or excellent. Over 80% rated their overall improvement as good or excellent.[12]

Quality of life assessments are frequently used to evaluate therapeutic interventions and predict patient outcomes.[13] CAC survey results show the percentage of individuals rating their quality of life as good or

Figure 5-11
Assessment of Service Quality in State-Operated Programs



Notes

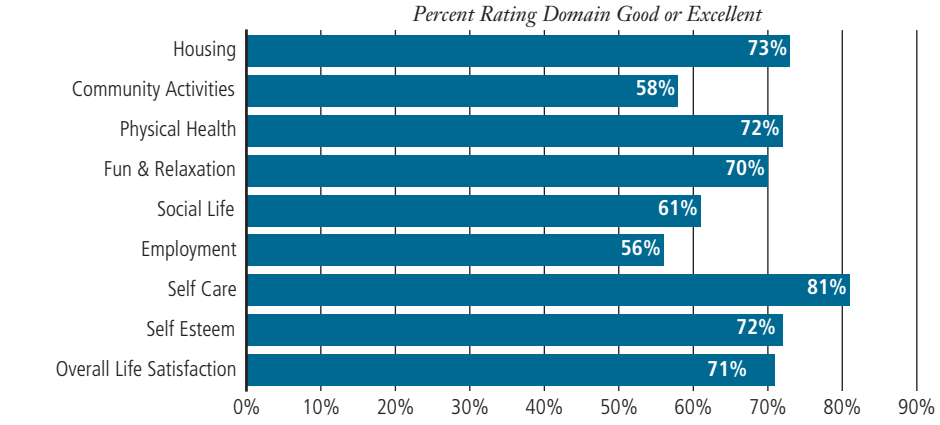
10 Rohland, B.M., Langbehn, D.R., & Rohere, J.E. (2000). Relationship between service effectiveness and satisfaction among persons receiving medicaid mental health services. Psychiatric Services, 51(2), 248-250.

11 Berghofer, G., Schmidl, F., Rudas, S., Steiner, E., & Schmitz, M. (2002). Predictors of treatment discontinuity in outpatient mental health care. Social Psychiatry and Psychiatric Epidemiology, 37(6), 276-282.

12 Uttaro, T. (2003). The development and administration of the consumer assessments of care by the New York State Office of Mental Health downstate facilities. Evaluation and Program Planning, 26(2), 143-147.

13 American Psychiatric Association. (2000). Handbook of Psychiatric Measures. Washington, DC: American Psychiatric Association.

Figure 5-12
Assessment of Quality of Life in State-Operated Programs



excellent ranged from 56% to 81% across domains (Figure 5-12). These ratings indicate a moderately high level of quality of life in most life domains with lower quality of life in the areas of employment, community activities, and social life. These are important areas of quality of life that are frequently identified as unmet needs among persons with severe mental illness. These ratings indicate the need for additional efforts in these areas.

CAC survey results have already been used extensively in reporting and performance improvement activities within and between Downstate Alliance facilities. The Alliance plans to administer the surveys on an annual basis and will use the results for ongoing program evaluation and performance improvement. OMH has adopted the CAC inpatient survey for use in statewide performance management, so we can better understand consumers' opinions regarding the quality of the inpatient services they receive in State facilities.

Community-operated Outpatient Services

In Spring 2003, OMH partnered with peer advocacy programs to sponsor a pilot consumer assessment of care in five counties. Funded by a Federal Center for Mental Health Services (CMHS) grant, the pilot assessed both the value of the evaluation questionnaire and the partnership approach with consumers in the conduct of the survey. The overall goal was to develop a basis for quality improvement in the full spectrum of community-operated public mental health services for adults.

One county was selected randomly in each of New York's five regions. A peer program in each county chose two consumers who received one day of training and assisted OMH staff in administering the surveys in one or more accessible locations. The anonymous survey was conducted as part of a social event including refreshments and group discussion, for which participants (a maximum of 50 at each site) were required to pre-register. A stipend was provided as acknowledgement of the value of the participant's time and to defray travel and child

care expenses. In addition, mail-in surveys with self-addressed stamped envelopes were left with staff at each survey site.

OMH and peer program partners, enlisted consumers from a stratified sample of 18 different types of non-residential community programs including case management, outpatient clinics, drop-in centers, MICA programs, clubhouses, etc. The Mental Health Services Survey (MHSS), developed by OMH with extensive consumer participation, was used to assess the quality of services in four domains: access, appropriateness, global satisfaction, and outcomes.

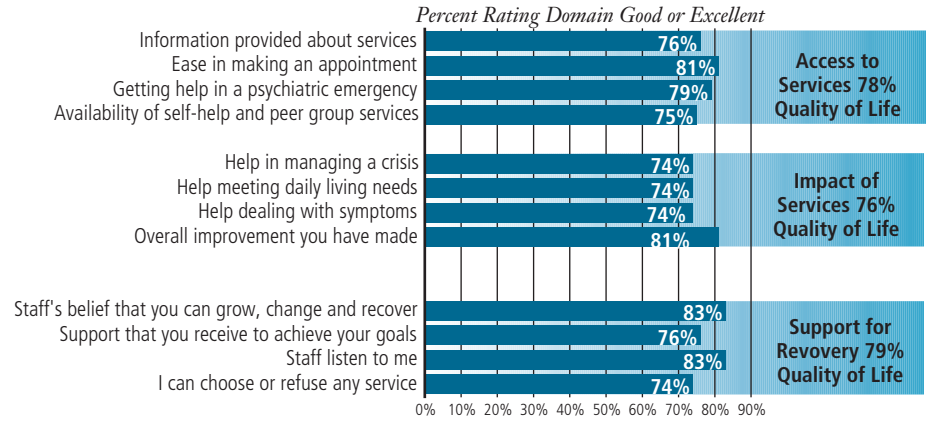
Early results indicate that the pilot was successful in both the consumer partnership and its data collection methods. Looking more closely at access (Figure 5-13), individuals were most satisfied with ease in making an appointment (81%) and with getting help in a psychiatric emergency (79%), and least satisfied with information provided about services (76%) and availability of self-help and peer group services (75%). In the area of impact of services, 81% rated their overall improvement as good or excellent, but only 74% stated that they had adequate help in managing a crisis, meeting daily living needs, or dealing with symptoms. The widest range of results related to support for recovery. While 83% stated that staff believed they can grow, change, and recover, only 74% agreed that they can choose or refuse any service. Overall, 84% of the 263 survey participants rated their community-operated services as either good or excellent.

These results present several questions for further investigation. For example, in comparison to traditional satisfaction surveys, does peer program sponsorship and an informal atmosphere in a peer-run setting account for a wider range of responses, including a greater expression of dissatisfaction? Does a survey design that includes individuals with mental illnesses as both evaluators and consumers of services contribute to more objective assessments? Does the provision of a stipend bias the sample or responses of participants?

These and other questions will be addressed in future usage of the MHSS.

Figure 5-13

Consumer Assessment of Community-Operated Outpatient Services*



Notes

* Source: Mental Health Services Survey pilot of non-residential programs in five counties

OMH also plans to review the feasibility of applying this approach to the evaluation of community programs on an annually rotating basis in other counties.

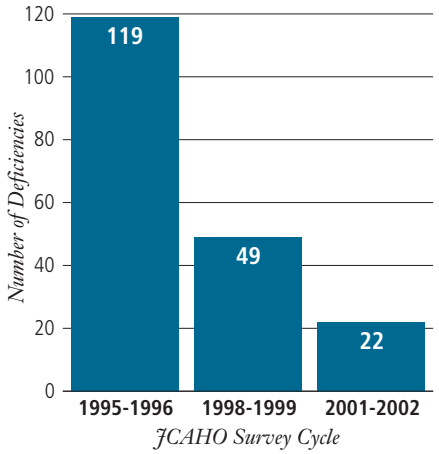
State-Operated Services – National Accreditation and Certification

All OMH inpatient programs are regularly evaluated by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS). Positive findings from these evaluations are important both clinically and financially.

JCAHO is an independent, not-for-profit organization that sets the standards by which health care quality is measured, and evaluates the quality and safety of care for nearly 17,000 health care organizations. To maintain and earn JCAHO accreditation, New York State's psychiatric centers must have an extensive on-site review by a team of JCAHO health care professionals, at least once every three years. The purpose of the review is to evaluate the center's performance in areas that affect patient care. Accreditation is awarded based on how well the hospital met JCAHO standards. In addition to providing an overall check on quality, JCAHO accreditation enhances OMH's ability to recruit and maintain high-caliber clinical staff and increases customer confidence in the services provided.

All OMH psychiatric centers have passed their JCAHO surveys with continuing improvement and outstanding success. As described in Figure 5-14, during the 1995-96 JCAHO survey cycle, OMH facilities received 119 Type I Recommendations (deficiencies requiring a written plan of correction). During the 1998-99 surveys, OMH facilities achieved a 60% reduction in Type I's (49). In the most recent survey cycle, OMH again reduced the Type I's received by 55% (22) and achieved an average hospital survey score of 96 for its 27 facilities-the highest in OMH's JCAHO survey history and exceeding the national average of 90. Additionally, 20 OMH facilities with day treatment programs were surveyed separately under JCAHO's behavioral standards. All 20 facility outpatient programs were accredited with an average score of 98.

Figure 5-14
Continuing Improvement in OMH Inpatient Facilities' JCAHO Survey Results



Forensic Mental Health Services

OMH provides services to individuals incarcerated in the State correctional system who require mental health services on either an inpatient or ambulatory basis. It is also responsible for the treatment of individuals remanded by the court system for

mental health care. In addition, OMH assists local law enforcement and correctional systems of care.

Over the past three decades, the forensic services program operated by OMH has grown to become a nationally respected system of mental health care that provides a full range of services to individuals who are involved in the criminal justice system. New York State's correctional mental health system was the first, and until 2003, the only such system in the United States to be fully accredited by JCAHO.

Client and public safety are of paramount importance in the planning and delivery of forensic mental health services. OMH forensic services and programs work to:

- Provide treatment and rehabilitative services to inmates of the State prison system, as well as individuals remanded by the court to OMH for treatment.
- Provide planning for re-entry to the community and aftercare support.
- Divert individuals with mental illness to a mental health treatment environment rather than a correctional one.
- Provide technical assistance and specialized forensic training to State and local mental health and criminal justice agencies.

State-Operated Services

Almost without exception, individuals who receive services from OMH forensic programs are involuntarily committed as outlined by the Mental Hygiene, Criminal Procedure or Correction Law. These laws, as well as case law, outline the processes and procedures that determine where the individual receives treatment, the terms and length of confinement, and the goals of treatment. Any movement of recipients from specialized forensic facilities to a State civil psychiatric center is governed not only by clinical need, but also by court order.

OMH provides three categories of institutional services for persons involved in the criminal justice system.

Treatment in a specialized forensic system for inmates confined in State correctional facilities
OMH provides a comprehensive range of mental health services in State correctional facilities. These services include operation of a 206 bed maximum security forensic hospital and 23 corrections-based satellite and mental health units consisting of 151 crisis beds and 565 Intermediate Care Program (ICP) beds. In addition, the agency provides services to disciplinary housing units and clinic services for 7,400 inmates generating in excess of 300,000 treatment contacts and 3,700 admissions each year to the mental health caseload through New York State Department of Correctional Services (DOCS) reception centers. OMH is committed to providing a continuum of care for all inmates with mental illness in the State correctional system.

OMH has been expanding opportunities for incarcerated individuals to access mental health services. Over the last eight years, corrections-based staffing has increased by more than 55%, and OMH plans to continue building on this service expansion with the establishment of new satellite and ICP units at Mid-State Correctional Facility (medium security-male) and Albion Correctional Facility (medium security-female).

An intensive risk assessment initiative has been undertaken to train OMH forensic clinicians to administer a comprehensive battery of risk assessment instruments including the Historical, Clinical, Risk Assessment Instrument (HCR-20) and Psychopathy Checklist Revised (PCL-R). The initiative is designed to more accurately aid in risk reduction strategies within the system, as well as to assist in program placement decisions within the system and prerelease discharge planning.

Mental health services to Disciplinary Special Housing Units (SHU). This issue has attained national prominence in the professional literature, and OMH is at the forefront of designing and operating programs to meet the mental health needs of this correctional sub-population. In collaboration with the DOCS, OMH has established access to private interview rooms for all mental health caseload inmates in SHU, which resulted in a 49% increase in private treatment sessions in 2003. In addition to existing services, OMH screens all new admissions to SHU and a designated OMH clinician makes daily rounds in the SHU to visit all inmates confined there. In each satellite correctional facility, Case Management Committees will be established that will be co chaired by designated OMH and DOCS senior staff to monitor and document management decisions concerning inmates with mental illness in SHU, and when appropriate, arrange for alternate corrections-based services and placements. OMH will also have expanded clinical input into the disciplinary hearing process during which DOCS hearing officers will routinely request information from OMH clinicians to aid in an appropriate disposition for mental health caseload inmates.

OMH's intensive initiative to improve mental health services to inmates confined to SHU and to create alternatives for this population will continue. In response to the need for increased therapeutic time out of SHU for a designated group of mental health caseload inmates, OMH developed two Special Treatment Programs (STPs) specifically designed to enhance services for this population. Evaluations of two existing STPs at Attica and Five Points Correctional Facilities found that program participants experienced a dramatic reduction (62%) in disciplinary infractions and a significant increase in all aspects of program participation, treatment compliance, and improved functioning (Global Assessment of Functioning [GAF] scores improved by 16% and Functional Quality of Life in Prison Instrument scores improved by 42%). Additionally, there was a 73% reduction in inpatient admissions and a 68% reduction in the use of satellite residential crisis beds for STP participants. Approximately 50% of the participants completed the STP program and were transferred to ICPs or general population without restrictive status.

Performance-based measurements and outcome studies have been conducted and resulted in several plans for forensic systems modification and improvement. For 18 years, OMH, in cooperation with DOCS, has operated nationally recognized Intermediate Care Programs (ICPs) for seriously mentally ill persons. In an effort to continuously improve this program, an extensive program review occurred in 2003 which resulted in the implementation of a standardized core curriculum of treatment interventions based on the principles of Psychiatric Rehabilitation. For all ICPs, a minimum standard of 20 hours per week of programming has been adopted.

OMH also operates 151 Residential Crisis Treatment Program beds located in 11 designated satellite units. In an effort to opti-

mize utilization of this resource, OMH undertook a study to standardize admission, retention, and discharge guidelines for these beds and to assure that inmate patients were provided with appropriate clothing and amenities while on suicide precaution watch or observation.

Since 1980, the number of women incarcerated in DOCS facilities has more than tripled. In 2001, women accounted for 7.3% of all new DOCS commitments. To address the needs of this growing population, OMH will open a new satellite unit at Albion Correctional Facility in 2005. In addition, OMH implemented its Creating Options to Manage Painful Emotions Program (COPE) in recognition of the prevalence of trauma histories among female inmates in 2003. The OMH satellite unit at Bedford Hills, a maximum security prison for females, is one of five OMH programs trained in the delivery of dialectical behavior therapy.

Pre-release Planning and Transitional Services are integral to continuity of care upon release and to ensure the public safety. OMH provides discharge planning for all inmates on the OMH caseload via a designated discharge planning clinician. Since 1996, there has been a three-fold increase in the number of comprehensive discharge plans which to date averages 1,500 annually. Each year, several hundred mental health caseload inmates participate in the DOCS Work Release Program in the New York City area, which helps transition inmates on parole to housing, work, and treatment programs. Discharge options include referral to intensive case management, community residence, outpatient, and Specialized Parole Mental Health Caseload Programs.

In 2003, the Community Oriented Reentry Program, a Transitional Unit, opened at the Sing Sing Correctional Facility to enhance care coordination for individuals returning to metropolitan New York City from State correctional facilities. This program is a joint venture of OMH, DOCS, the Division of Parole, and a consortium of community providers. Inmates are transferred to the unit during the last three months of their sentence and receive "in reach" services in the prison from community providers to ease their transition to the community. Many will be released to parole supervision with access to ACT services and scattered site supportive apartments, funded through a grant from the Division of Parole.

OMH's Forensic Telepsychiatry Consultation (FTC) program serves as a national model for providing case consultation to remote correctional facilities. Telepsychiatry services currently in place link the New York State Psychiatric Institute with the Attica and Clinton Correctional Facilities. In late 2003, a planned FTC expansion will link the Central New York Psychiatric Center to its satellites in the Attica, Clinton, Elmira, Five Points, and Sing Sing Correctional Facilities.

Community-Based Criminal Justice Initiatives

Local mental health services for persons involved with the criminal justice system are provided by OMH and by programs administered by New York State counties. In OMH's community criminal justice programs, support and technical assistance are provided in collaboration with a variety of partners including: the Conference of Local Mental Hygiene Directors

(CLMHD), the Law Enforcement Training Director's Association, and the State Commission of Correction (SCOC), Division of Criminal Justice Services (DCJS), Division of Parole, Division of Probation and Correctional Alternatives (DPCA), and Office of Alcoholism and Substance Abuse Services (OASAS). The remainder of this section provides highlights of OMH community-based programs and activities that support and promote the diversion of persons with mental illness from the criminal justice system to mental health and other human services systems when appropriate.

Police Mental Health Program

The Police Mental Health Program (PMHP) is an interagency program co administered by OMH and the DCJS Office of Public Safety. Its major goals are to establish appropriate program linkages between law enforcement and mental health systems in the State and to provide police officers with training to facilitate their safe handling of situations involving persons with mental illness. Since PMHP was introduced in 1986, New York State has gained national leadership status for this program, with many police agencies throughout the United States requesting and adopting various aspects of the program. The PMHP includes:

1. A 14-hour mental health training program which meets the Municipal Police Training Council's requirement for police recruit training. Since 1986, this training has been given to more than 11,000 recruits from upstate New York and Long Island police departments and the New York State Police.
2. Annual 'Train the Trainer' workshops to certify local instructors to present the required recruit training. More than 700 local instructors have been certified since the program's inception.
3. A coordination project to encourage development of effective linkages between local law enforcement agencies and mental health services. Small development grants were provided to 15 counties to initiate linkage projects which have developed local interagency procedures and, in some areas, a form for clear and effective communication between police and crisis mental health services providers. In several counties the linkage project groups continue to meet to coordinate the mutual activities of police and mental health services.

Police Mental Health In-service Training Project

The Police Mental Health In-service Training Project responds to expressed need by local police departments for some "refresher" or in-service training modules regarding mental health topics as a follow-up to the mandated Police Mental Health Recruit Training. Development was initiated in early 2003 by OMH, and supported by the DCJS Office of Public Safety. The purpose of this project is to provide local police departments and zone police training academies with a series of modules and other training materials that can be used for a variety of in-service training needs.

Information is being collected regarding learning needs through a series of focus groups throughout the State, involving representatives of police departments, mental health services, families, and recipients.

This information will be compiled and analyzed to determine the topics and formats most needed by localities. A statewide Advisory Committee, comprised of representatives of administrative level staff of various disciplines, as well as families and recipients has been formed to review the focus group results and advise the coordinators on the format for the final products. Preliminary information obtained from focus groups indicates that it may also be helpful to provide other types of materials to localities in the form of a "tool kit" (i.e., models for local interagency coordination, forms for improved communication) to ensure the safe and effective response to people who are emotionally disturbed.

The New York State Local Correctional Suicide Prevention Crisis Service Program

For persons detained in local correctional facilities, suicide is a major risk. Since 1984, New York State has successfully reduced the number of suicides in jails and police lockups in upstate New York counties through collaboration between State and local governments. The rate of suicide in upstate jails and lockups has decreased from an average of 303 per 100,000 of average daily census in 1977 and 1986 to an average of 73 per 100,000 for the period 1987-2000. This decline in suicides has occurred despite the increase in total admissions to these facilities from approximately 250,000 in 1987 to 331,600 in 2000.

New York State has gained national leadership status for its accomplishments in jail suicide prevention through the New York State Local Correctional Suicide Prevention Crisis Service Program, which is being adopted as a model by the National Institute of Corrections. This multi faceted program includes suicide prevention training, screening, and coordination and is designed to facilitate the identification and treatment of prisoners who are suicidal and/or seriously mentally ill. It provides materials for training both police officers and mental health service personnel in the identification and management of high-risk prisoners, and clearly defines the roles and responsibilities of mental health and local correctional agencies regarding these pris-

Table 5-10

Local Correctional Suicide Prevention Crisis Service Program Curriculum

1. An Eight-Hour Training Program for jail and lockup officers in Suicide and Suicide Prevention.
2. A Mental Health Resource Manual which can be used to familiarize local mental health personnel with mental health and operational issues relevant to police lockups and county jails.
3. Policy and Procedural Guidelines for county jail, police lockup, and mental health agency personnel. The policies and procedures outline administrative and direct service actions to enable staff to identify, manage, and serve high-risk mentally ill and suicidal inmates.
4. Suicide Prevention Intake Screening Guidelines that can be administered during the intake process to facilitate identification of high-risk inmates.
5. A Four-Hour Refresher Training Program for Jails and Lock-up Officers.
6. A Fourteen Hour Criminal Justice System Training for Mental Health Services Providers to provide mental health staff and other service providers with basic knowledge of the criminal justice system, suicide prevention, New York State Mental Hygiene Law, and alternatives to incarceration.

oners. The Local Correctional Suicide Prevention Crisis Service Program is specifically structured to establish administrative and direct service linkages among county jails, police lockups, and local mental health programs. Its curriculum is designed for implementation based on adoption of six interrelated program components, none of which is intended to be freestanding (Table 5-10).

OMH supports the New York State Local Correctional Suicide Prevention Crisis Service Program by:

- Conducting periodic training of trainers to ensure that there are certified instructors for the program
- Updating the training as needed
- Providing technical assistance to localities implementing the entire program and materials for the participants in the training sessions
- Providing local counties with specific technical assistance regarding individuals with mental illness who are in custody

Meeting the Behavioral Health Needs of Jail Inmates

This project was initiated as a response to requests from local correctional, medical, and mental health personnel for expanded training on mental illness as a supplement to suicide prevention training. Development was initiated in mid-2001 through a process co-sponsored by OMH and the SCOC. Information was collected regarding learning needs through a series of five focus groups involving varying sized correctional facilities and representatives of corrections, medical, and mental health services. Using information obtained from the focus groups, a workshop learning plan was designed with the purpose of improving the response to people with mental illness in the jail setting through a twofold approach:

1. Providing correctional and medical staff with information about mental illness and how to more effectively manage people with mental illness within local correctional facilities.

2. Facilitating improved coordination among the service providers within the jail setting.

The program consists of a three-day workshop curriculum for teams from local jails, each team being comprised of at least one representative of corrections, mental health, and medical personnel. The workshops are a combination of presentation of information about mental illness, medications, the law, and exercises designed to facilitate coordination among the three professional groups.

The Brooklyn Mental Health Court

The Brooklyn Mental Health Court (BMHC) is one of many currently emerging jail diversion projects around the State. It is a joint project of OMH, the New York State Unified Court System (UCS), and the Center for Court Innovation. This is the first court in New York State dedicated to handling criminal cases of defendants with serious and persistent mental illness. In an effort to craft a more meaningful response to the problems posed by mentally ill defendants, the BMHC judicially monitors mental health treatment as an alternative to

incarceration in both misdemeanor and low-level felony cases.

Participation in the program is voluntary for cases screened eligible for the court and is based on a plea of guilty from the defendant, who agrees to a course of treatment in lieu of incarceration. The sentence is then deferred until the defendant demonstrates successful long-term compliance with a court-mandated treatment program and other conditions, at which time the charges are either reduced or dismissed. BMHC's goal is to use the authority of the court to link mentally ill offenders to treatment, stabilize their illness, and prevent their return to the criminal justice system.

As of September 2003, 170 referrals had been made to the BMHC and 134 clinical evaluations were completed. There are 53 participants and another 14 persons whose eligibility is pending. Three participants have graduated from the program. Primary diagnoses include schizophrenia (27%), major depression (23%), and bipolar disorder (23%), and 48% of participants have a co-occurring substance abuse disorder. Felony offenses include drug sale/possession, criminal contempt, assault, robbery, and burglary among others.

There are now four Mental Health Courts operating in New York State. In addition to Brooklyn, there are Mental Health Courts in Buffalo, Bronx, and Niagara Falls. There is increasing interest in the mental health court approach in many New York State communities. Inquiries and communications regarding BMHC and other Mental Health Courts throughout the State are coordinated through the community criminal justice component in OMH's Division of Community Care Systems Management.

Meeting the Behavioral Health Needs of Parolees

The OMH and the Division of Parole have a long-standing relationship established through an Memorandum of Understanding (first written in 1986 and revised in 1994) which has resulted in numerous programs and services which have benefited persons with mental illness on parole in the community. The following are several examples of these programs and services:

- The OMH LINK Program – a short-term intensive case management program in New York City
- The Rikers Island Parole Violation Diversion Initiative for Persons with Serious Mental Illness – a program to divert violated parolees to appropriate mental health treatment
- Project Caring Community – is a re-entry initiative for women with mental illness being released from the Bedford Hills and Taconic Correctional Facilities

Planning for the Future

OMH's commitment to a quality agenda is a driving principle behind planned actions within adult services. In both State and local sectors significant systems reform and planned improvements are envisioned in the following areas during 2004-2008.

1. Continued Emphasis on Effectively Serving Those with the Highest Service Needs

The use of evidence-based practices has proven to be effective at reducing the frequency and duration of inpatient episodes

as well as improving individual perceptions concerning their quality of life. OMH will continue to roll out its evidence-based practice agenda with particular emphasis on making sure that adults with the highest levels of service need have access to the most effective treatments. Several initiatives will be strengthened to promote this goal.

First, OMH will work to identify people who have had multiple inpatient admissions on a yearly basis with little connection to community based care. This information will be shared with county governments and will be used within county SPOA care coordination and housing processes. With the additional focus of ACT team referrals being accomplished within the SPOA process, some of these individuals may be able to benefit from effective engagement by ACT teams or other forms of case management. Work will also proceed to review the case management profiles of people who are using services to determine whether or not some of these individuals may be better served through participation in ACT teams. Based on these identified needs, there is likely to be conversion of some existing case management capacity into ACT teams.

Increased, targeted interventions to bring evidence-based services into community based and State-operated outpatient programs will also help to maximize positive community living outcomes for individuals with high needs, particularly for those who will be receiving wellness management and recovery evidence-based practices, integrated treatment for dual disorders and effective medication prescribing practices. Planned implementation of the PSYCKES decision support software will further improve the prospects for people receiving effective treatment for major mental illnesses. Adult service providers will increasingly be expected to deliver these evidence based practices since fidelity standards governing their practice will be incorporated within revised, tiered certification protocols for program licensure. This incorporation of fidelity standards within licensing reviews has already been accomplished for ACT teams. This important "structural" improvement, coupled with ongoing utilization of performance data on inpatient admissions, readmissions, and continuity of care, should yield improved outcomes for those who have been having difficulties accessing and/or using effective community-based care.

2. Breaking Down Barriers for the Coordination of Care

During this planning period, OMH will be embarking on a strengthened local planning process. Adult services will be particularly concerned with refining and strengthening the role that the SPOA plays in ensuring appropriate access for people with the highest level of service needs. Because the new planning process will be population based, field office and county directors will be able to collaboratively review existing SPOA processes and outcomes to determine the efficacy of existing referral processes and care coordination amongst State and local mental health services providers.

The new planning process will also require that care coordination, access to service, and service outcomes be person-centered. This means that the individual, not the service provider, occupies the "customer" role in determining a course of service provision. Because person-centered planning is a holistic approach, service needs outside of the mental health system (for inter-agency services or services within the community such as health care or transportation) must

also be factored into the planning process. There are many layers of inter-agency and community living environments which would be affected by this shift in focus. During 2004-2008, it is anticipated that significant efforts in this area will focus on people whose service needs require integrated services for the treatment of both mental illness, substance abuse and/or alcoholism disorders. As more agencies and counties begin to use automated reporting systems, including OMH's Child and Adolescent Integrated Reporting System (CAIRS), holistic care coordination will become increasingly feasible.

3. Implementing a Continuous Quality Improvement Framework for Operations

Within an effective public mental health system, the capacity to deliver the best treatment interventions and the best care coordination are necessary but insufficient conditions for success. Perhaps the most important condition for success is having system capacity for measuring it! During the planning period, OMH will be embarking on a major campaign to institute routine use of performance measurement into daily operations at State, county and provider levels. The newly developed outpatient program PROS and a revised State-operated PMHP program for community care both will both contain significant administrative requirements for continuous quality improvement protocols and use of performance data at all levels of decision making.

OMH is committed to making its service effectiveness "transparent" to all stakeholders and this commitment begins with revising our current expectations concerning monitoring,oversight and the publication of performance results. The evidence-based practice agenda and the revised approach to tiered certification are planned initiatives that will run concurrently with implementation of PROS and PMHP—OMH's two major outpatient program reforms. The convergence of all of these major initiatives will provide significant opportunities for continuous quality improvement. Introduction of administrative protocols such as utilization review and routine surveys of customer satisfaction are potential by-products of these new implementation efforts.

CHAPTER 6

Children: at Home, in School, and in the Community

OMH HAS A STRONG COMMITMENT to meeting the mental health needs of children and adolescents with serious emotional disturbances (SED). New York State's public mental health system serves approximately 140,000 children and adolescents each year. Most of this population receives services in community-based settings and a minority receive services in inpatient settings. Over the past 20 years, the system of care for children and adolescents with SED has evolved gradually from a system based primarily on inpatient treatment to a system that provides treatment primarily in the community. This shift to a community-based system of care has been made possible by advances in psychotropic medications, emerging scientific evidence about the effectiveness of home-based clinical interventions, and the infusion of new resources into community-based mental health programs. It embodies the philosophy that the family, defined in its broadest sense, is the best place to raise children with SED so that they can stay at home and in school.

As part of the Winds of Change campaign, OMH is committed to identifying and providing the most effective, science-based services and interventions to children and adolescents with SED. Research demonstrates that a consistent evidence base currently exists in some but not all areas of children's services.[1] OMH has identified a set of services deemed effective for children as part of its Winds of Change campaign that are at varying stages of clinical evidence on effectiveness (Table 6-1).

The agency continues to study recommendations on how to interpret the research base on effective children's treatments and will rely on those recommendations to shape the nature and extent of implementation of these interventions within the State.

Notes

1 Hoagwood, K., Burns, B.J., Kiser, L., Ringeisen, H., Schoenwald, S.K. (2001). Evidence-based practice in child and adolescent mental health services. Psychiatric Services, 52(9), 1179-1189.

Chapter 6

Children: at Home, in School and in the Community

Table 6-1.

OMH Priority Set of Effective Services for Children

1. Clinical treatments for ADHD, oppositional disorders, conduct disorders, adolescent depression, panic disorders, obsessive compulsive disorder, and general anxiety.
2. Family-based treatments of disruptive behaviors (functional family therapy).
3. Home-based therapies, nurse visitation models (for young children), therapeutic foster care, and intensive case management.

In 1999, OMH commissioned the Institute for Health Services Research and Policy Studies of Northwestern University to study New York State's child and adolescent mental health system.[2] Through a review of nearly 2,000 patient charts from every licensed mental health program in the State, the Northwestern study found that although the New York State children's system was comprehensive and well developed, it was not well coordinated. Coordination problems identified included: high rates of children and families dropping out of clinics prematurely; children entering community hospitals without demonstrating risk factors associated with criteria of medical necessity; and antipsychotic medications being prescribed for children to address aggressive and assaultive behavior. At the same time, the study found that community-based interventions such as community residences and Kids Oneida successfully serve severely disabled children.

In a series of nine regional public forums across the State, OMH presented information from the Northwestern study to key stakeholders in the children's mental health system including family members, providers, county mental health directors, and other child-serving agencies. Working collaboratively, OMH and these stakeholders crafted a comprehensive, Multi-Year Strategic Plan for Children to guide the future of the children's mental health system. Table 6-2 presents the principles that shape the Strategic Plan, which was released in January 2002 and is currently being implemented.

The Plan's strategic directions and progress made to date on their implementation are described below.

Table 6-2

Principles of Multi-Year Strategic Plan for Children

- Families are full participants in all aspects of the planning, delivery, and evaluation of services and need to be represented and treated as full partners.
- Increased emphasis is needed on early identification and intervention services.
- Children and families should have access to a comprehensive and well-coordinated array of services that address the child and families' physical, emotional, social, and special needs.
- Services should be provided in the most integrated and normative setting that is clinically appropriate.
- Services should be integrated with all other child-serving programs, agencies, and systems.
- Services should be responsive to the experiences, linguistic needs, norms, and values of each child and family.

Notes

2 Lyons, J. (2000). Matching the Needs of Children and Families to Mental Health Services. Unpublished manuscript. Institute for Health Services Research and Policy, Northwestern University.

Multi-Year Strategic Plan for Children

Strategic Direction 1.
Outpatient and community services need to be restructured to be mobile, flexible, and more responsive to children and adolescents with the highest needs.

Implementation Progress:

Reducing Outpatient Clinic Dropout Rates

OMH has a number of initiatives that encourage families to stay engaged in community-based treatment, so that outpatient clinic dropout rates among children and families can decrease and inpatient hospitalizations may be avoided. In 2002, OMH received a New York State Division of Criminal Justice Services (DCJS) grant to support 15 new Functional Family Therapy (FFT) teams in selected areas of the State with the specific purpose of addressing high dropout rates from outpatient clinics. To date, 11 new FFT teams have been developed. In addition, OMH has introduced a second new family engagement pilot project for clinics in various areas of the State to train clinic personnel in engagement practices, and is supporting several county initiatives for new mobile approaches to replace more traditional office-based clinic treatment.

Strategic Direction 2.
Improve clinical services, drawing on state-of-the-art research in evidence-based practices.

Implementation Progress:

- *School Support Projects*

OMH has received three-year grants from the New York State Education Department and the Department of Health (DOH) to support an affiliation with the Center for the Advancement of Children's Mental Health at Columbia University. This affiliation has introduced evidence-based clinical assessments and treatment protocols in OMH's school support projects in New York City and in several school support projects upstate. Clinicians have been trained and supervised in the evidence-based interventions and their impact on the outcomes of children is being evaluated. More information about school based mental health services is presented later in this Chapter.

- *Functional Family Therapy*

As described above, Functional Family Therapy (FFT), an evidenced-based clinical intervention, has been introduced in clinics to improve treatment and engagement of families. More information about FFT as an evidence-based practice is available on the OMH Web page at http://www.omh.state.ny.us/omhweb/ebp/children_fft.htm.

- *Residential Treatment Facilities*

OMH has engaged in a system-wide quality improvement effort to address the problems of children waiting to get into Residential Treatment Facilities (RTFs). In 2001, 45 transition coordinator positions were added to facilitate linkages between RTFs and communities of origin in order to assist in reducing RTF length of stays. A quality improvement project has been designed to address clinical interventions needed by individual RTFs to focus on the issues identified. In addition, an RTF wait list management protocol has been developed to address and reduce the length of time children wait for RTF beds.

- *TRAAY (Treatment Recommendations for the use of Antipsychotics for Aggressive youth)*

Although psychiatric medications are widely used as part of the treatment for aggressive and assaultive behavior in adults and children and new antipsychotic medications are being used increasingly for this purpose, the scientific evidence supporting this clinical practice in children is limited. OMH is addressing this issue through an initiative called TRAAY (Treatment Recommendations for the use of Antipsychotics for Aggressive Youth). TRAAY is improving the quality of care for seriously disturbed children and adolescents by applying rational prescribing principles to psychopharmacologic treatment of aggression, and using the existing scientific evidence-base to inform these prescribing decisions and practices. More information about TRAAY appears later in this Chapter.

Strategic Direction 3.
Enhance accountability for serving high need children in community settings and for improving clinical outcomes.

Implementation Progress:

- *Child and Adult Integrated Reporting System (CAIRS)*

In 2002, OMH implemented a new information system called CAIRS. Almost all licensed children's providers are now entering data into CAIRS and OMH is incorporating the data to develop a statewide management indicator report card. The report card will be made public to assist with planning, funding, and policy decisions, and in the oversight of the programs providing services to seriously emotionally disturbed children. More information about CAIRS is presented in Chapter 8.

- *Evaluating the effectiveness of community-based programs.*

OMH is collaborating with the Department of Psychiatry Division of Health Systems Research at the Mount Sinai School of Medicine to evaluate the effectiveness of the Home and Community Based Services Waiver (HCBS) and compare its outcomes with the Intensive Case Management (ICM) and Kids Oneida (KO) programs. The study is scheduled for completion in Spring 2004.

Strategic Direction 4.
Improve and expand crisis management services.

Implementation Progress:

- *Expansion of Home Based Crisis Intervention*

Home Based Crisis Intervention (HBCI) provides crisis services to families where a child is at imminent risk of psychiatric hospitalization or out-of-home placement. Modeled on the Homebuilders Family Preservation Program developed by Kinney and colleagues in 1977, New York State's HBCI programs are linked to emergency rooms, providing intensive in-home intervention for four to six weeks with the goals of hospital admission diversion, teaching problem solving skills to the family, and linking the child and family with community-based resources and supports. The target population for the HBCI service is families with a child or adolescent up to 17 years of age, who is experiencing a psychiatric crisis so severe that unless immediate effective intervention is provided, the child will be removed from the home and admitted to a psychiatric hospital. Families referred to the services often have had contacts with the juvenile justice system and the Office of

Children and Family Services (i.e., county social services departments). Critical components of family preservation services and essential elements of the HBCI model include:

- A short-term crisis oriented service that provides intense treatment as soon as possible, but no later than 24 hours of referral to the program
- Flexible staff hours including 24 hour response capability
- An intake and assessment process designed to ensure that no family is left in a dangerous situation
- An approach to treatment that focuses on the family, both its strengths and its needs
- A multi-faceted approach that includes education, skills building treatments, and concrete services
- A small caseload with each staff working with only two families at any one time
- Brief duration – usually four to six weeks

New York State currently supports 20 HBCI programs. The Surgeon General's 1999 report on Children's Mental Health recognized the strong record of effectiveness for home based services. In their review of the OMH's children's service system, the Institute for Health Services Research and Policy Studies of Northwestern University found that the HBCI model effectively reduced inpatient hospitalizations for an at risk population and recommended expansion of the program. The three newest HBCI programs have been developed in New York City and an evaluation of their effectiveness is currently being conducted by the Center for Mental Health Policy at Vanderbilt University.

More information about HBCI as an evidence-based practice can be found on the OMH Web page at http://www.omh.state.ny.us/omhweb/ebp/children_hbci.htm

- *Creating Crisis Bed Capacity*

Children in crisis cannot always remain at home even with extensive clinical support for the child and his family. In some cases, the availability of a safe environment for a short stay, coupled with clinical supports, can effectively address the crisis and avoid a hospitalization. An out-of-home crisis stay does require the availability on an as needed basis of a bed, and it has been found that an efficient and effective way to address this short term need is the purchase of an existing vacant bed from a treatment facility, foster home, or community residence.

Strategic Direction 5.
Expand alternatives to inpatient and residential treatment services.

Implementation Progress:

The Enhanced Community Services Program and related initiatives have expanded the community-based service delivery system in the following ways.

- Case management services for children have more than doubled from a capacity of 1,880 in 1999 to a capacity of 4,326 in 2002.
- Family support services have nearly doubled throughout the State, increasing from a capacity of 4,000 in 1999 to a

capacity of 7,900 in 2002.

- The number of children receiving Home and Community-Based Waiver Services (HCBS) has increased more than 400% with 900 children served in 2002.

- Over 40 school-based mental health programs have been developed in New York City and other areas of the State. As a result, State-operated day treatment and intensive day treatment programs now provide support services to children in over 500 school districts throughout the State.

- Mobile mental health teams serving children and adolescents in juvenile detention facilities operated by the OCFS have been expanded to five additional facilities.

- There are 312 community residence beds and additionally 125 Family-Based Treatment beds were recently opened.

Strategic Direction 6.
Enhance linkages between institutional and community-based services, and establish single points of access (SPOA) to identify and develop individual service plans (ISPs) for youngsters with the highest risk of placement out of home to assist with supporting them to stay at home.

Implementation Progress:

Single Points of Access (SPOA)
SPOAs have been set up in every county and New York City is working to establish SPOAs in each borough to improve coordination in the service delivery system. In 2002, nearly 6,000 children were referred through SPOAs in New York State. The purpose of SPOA is to identify and plan for services for children who are at risk of residential treatment. By identifying and planning for children and families who are at risk earlier in the treatment process, it is anticipated that the need for inpatient hospitalization will be reduced. To date, SPOAs have reported that when identified children are evaluated and planned for early, they are less likely to need residential treatment services. They have also reported that less intensive, in-home supportive services provided to families are working.

Strategic Direction 7.
Develop local systems of care integrating mental health with other child serving systems.

Implementation Progress:

- *Coordinating care across child serving systems in counties*

Operating in approximately 50 New York State counties, the Coordinated Children's Services Initiative (CCSI) is a State and local interagency partnership that requires cross agency planning to assist children and families to maintain stability in their home communities and to avoid hospitalization. In 2002, legislation was passed to support opportunities to blend funds across categorical funding streams. This legislative authority formalizes the efforts of several pioneering counties to blend funding across systems to improve service delivery for high-risk children. Examples of coordinating care across child serving systems in counties include:

- Kids Oneida is a successful program that blends mental health and DSS funds in a case rate to provide children at risk of residential and hospital placement with supports they need to stay at home and in community.

- Erie County has successfully used TANF funds to augment services provided to children requiring case management and now operates its own system of care by managing an array of services (including access to residential treatment facilities) through the SPOA process.

- Suffolk and Onondaga Counties have developed comprehensive plans to improve crisis services and systems that involve State, local community hospital, and agency partners.

- Westchester County was recognized by SAMHSA (Substance Abuse and Mental Health Administration) for a multi-year system of care grant and is now in the final stages of implementation.

- Rensselaer County has improved stability for foster care children who have multiple placements per year by adding in-home mental health services for children in need, resulting in fewer moves for the children and reduced hospital and residential placements.

- *Coordinating care across child serving systems in State agencies*

OMH is currently engaged in discussions with OCFS and DOH to identify a process that will enable county Social Services commissioners to purchase mental health services such as Home and Community Based Waiver Services (HCBS) using Social Services Preventative funds. When approved, this will result in a cross-system expansion of the delivery system to accommodate larger numbers of children with multiple treatment needs.

Strategic Direction 8.

Improve responsiveness to and support for families and community caretakers of children with serious emotional disturbance to enhance engagement as partners in care.

Implementation Progress:

- *Enhancements to family support services*

In addition to adding new interventions to improve the engagement of families in community-based treatment, OMH is enhancing family support services throughout the State. Expanded family resource centers operating in New York City provide families with information, support, and assistance in obtaining services for their children. A compendium of family support services was completed and made available on the OMH Web site. (http://www.omh.state.ny.us/omhweb/ebp/fss_directory.htm). Five new school-based parent advisors were added to ensure that family voice was represented in all school support projects. OMH also initiated Common Sense Parenting® (CSP) training, which has trained 80 individuals who are now in the process of training families throughout the State. CSP is an evidence-based family education and support service that is adapted from the Boys and Girls Town Family Home Program. More information about CSP is provided below.

Strategic Direction 9.
Improve transitions from child mental health services to independent living to enhance opportunities for recovery for young adults, especially in the area of work and employment retention skills.

Implementation Progress:

- *Improving Work and Employment Retention Skills*

In 2002, OMH commissioned a study by the Educational Development Center, Inc. to assist in the planning of services to youth in transition. The study highlighted the need to more adequately facilitate the transition to adulthood and independent living, for children and adolescents who need services beyond age 18. Although more attention to vocational, educational, and life skill development is needed in order to build resiliency, self sufficiency, recovery and a sense of hope, OMH has a good start in this area. Since 1999, OMH has funded nine innovative vocational programs for youth in locations throughout the State, including two RTFs. These programs are demonstrating that young adults with SED are able to fully and actively participate in career planning, skill development, and hold down jobs.

Strategic Direction 10.
Develop and integrate systems of care which are sensitive to and address the trauma needs of children and their families.

Implementation Progress:

- *Trauma-based treatment initiatives*

In the aftermath of September 11, 2001, OMH has had the opportunity to examine the ways in which services to children and families experiencing trauma may be improved. Additional funding through Project Liberty made it possible to support a new evidence-based trauma treatment initiative in clinics in New York City. We expect that information learned from this initiative will assist OMH to more adequately address the trauma treatment needs of children, and will be particularly helpful in developing treatment methods for children suffering the consequences of abuse, neglect, and violence in the home. More information about Project Liberty is included in Chapter 7.

OMH continues to meet with all New York State system partners and stakeholders (Office of Children's and Family Services, State Education Department, Department of Health, Council on Children and Families, Families Together in New York State, OMRDD, OASAS, Division of Criminal Justice Services, and Division of Probation and Correctional Alternatives) to review progress on the plan and to solicit input for further policy development. The agency also meets with the Children's sub-committee of the Mental Health Planning and Advisory Committee (MHPAC) about child and adolescent policy development, meets quarterly with the Conference of Local Mental Hygiene Directors (CLMHD), and participates in regional SPOA coordinator and provider meetings throughout the year.

Highlights of Progress to Date

Well into this multi-year strategic plan, communities across New York are working to enhance their capacity to serve emotion-

ally disturbed children in the community, as well as build systems of care that integrate the various child serving systems. New York State is so diverse that no single approach to service delivery will work everywhere, and every locality is developing an approach that is responsive to its individual needs, capacities, interests, and opportunities. This section highlights significant progress that has been made in expanding and restructuring the children's mental health system.

The Home and Community-Based Services Waiver

The Home and Community-Based Services (HCBS) Waiver has added flexibility to our State Medicaid Plan by allowing payment for an expanded list of community-based services (Table 6-3). These expanded services are designed to better serve the specialized needs of families with children who are diagnosed with serious emotional disturbance and at risk of hospitalization or placement.

Flexible service funds are available for each child to purchase items and services needed to achieve service plan goals that are not available any other way. Families direct the priority for services, and the child and family may receive any or all of HCBS services based upon need. Children who reside in foster family homes and receive Medicaid are also eligible for Waiver services.

Table 6-3

Additional services available under HCBS Waiver

- Individualized care coordination
- Family support services
- Respite care
- Intensive in home services
- Crisis response services
- Skill building services

Since 1999, when HCBS had a capacity for 178 children, the Enhanced Community Services Program has expanded its capacity dramatically. In 2002, the HCBS Waiver program had the capacity to serve more than 900 children and adolescents statewide, an increase in capacity of more than 400%.

OMH's ongoing evaluation of the HCBS Waiver program continues to show a positive impact on the children and adolescents served by the program. Among children served by the HCBS Waiver program, functional impairment has decreased 20% and symptoms of mental illness have decreased 17%. In addition, the annual cost of Waiver services at home is 75% less than providing care at a residential treatment facility (RTF). More information about HCBS as an evidence-based practice can be found on our Web page at http://www.omh.state.ny.us/omhweb/ebp/children_hcbs.htm.

In 2001, we conducted a survey of parents and guardians of children who received Waiver services. The Parents Assessment of Care Survey (PACS) was designed specifically for use in the children's mental health system with input from focus groups that included children, families, providers, and advocates. It gives parents the opportunity to provide feedback about access, appropriateness, outcomes, and satisfaction with HCBS program. Because these surveys were conducted in all of the waiver programs and completed by the majority of families, norms could be generated for each rating scale. Individual program scores were compared to the statewide norms to see how each program ranked and opportunities were identified for improvement. Preliminary results show that over 75% of HCBS

Table 6-4

Parents' Ratings of HCBS

- 78% rated quality of HCBS services received as good or excellent.
- 85% rated their trust in HCBS staff as good or excellent.
- 83% rated likelihood of continuing with HCBS services as good or excellent.

Source: 2001 Parents Assessment of Care Survey (PACS)

families who completed the survey rated their overall rating of service quality as good or excellent (Table 6-4 and Figure 6-1).

Family Support Services

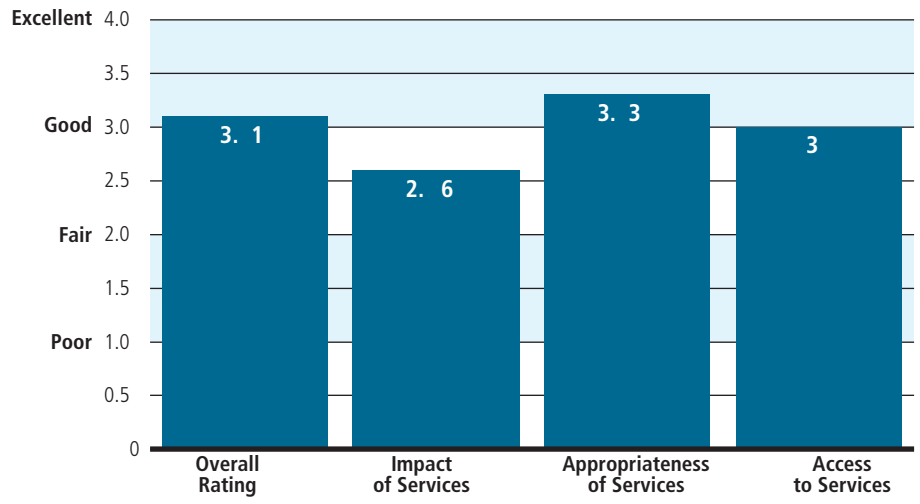
All families need a wide range of supports as they work to effectively raise their children. When families have children who have serious emotional disturbance, their natural support systems may be overwhelmed and require greater coordination of services.[2] OMH is committed to the development of a community-based system of care where families are full partners and services are driven by family needs.

Family support services are an array of formal and informal services that emphasize full parent participation in service planning and evaluation, services in the child's own home whenever possible, and flexibility and responsiveness from the formal service system. They enhance coordination of services and often enable children to live at home and attend school, assisting their families to balance their lives and give attention to the needs of all family members.

Families have reported benefits from family support services that include increased access to information, improved problem-solving skills, and more positive views about parenting and their children's behavior.[3] The Enhanced Community Services Program has expanded access to these valuable services. From 1999 to 2002, family support services increased 98%, with services being provided to 7,900 families.

Figure 6-1

Average Parent's Rating of HCBS

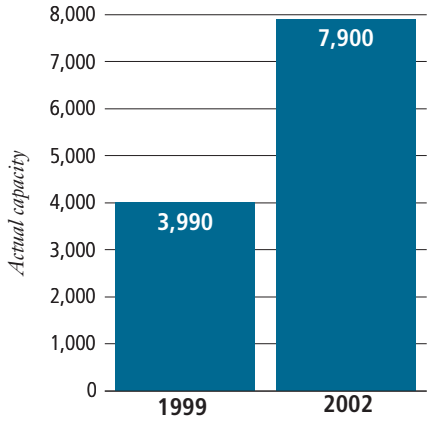


Notes

2 Burns, B., Hoagwood, K., & Mrazek, P.J. (1999). Effective Treatment for Mental Disorders in Children and Adolescents. Clinical Child and Family Psychology Review, 2(4), 199-254.

3 Friesen, B.J., & Koroloff, N.M. (1990). Family-centered Services: Implications for Mental Health Administration and Research. Journal of Mental Health Administration, 17, 13-25.

Figure 6-2
Family Support Services Growth



Evidence-Based Family Education and Support Services

Common Sense Parenting® is an evidence-based family education and support service that is adapted from the Boys Town Family Home Program. Based on a social learning/behavioral model that aims to support parents in their role as "teacher of their children," it consists of six two-hour skill teaching sessions led by a certified trainer that are designed to assist parents in developing and enhancing their skills to encourage positive and discourage negative behaviors in their children.

Evidence of the effectiveness of Common Sense Parenting® has been researched by Boys and Girls Town over the course of approximately five years. Outcome studies have indicated that parents report significantly fewer child behavior problems and improved parent and family satisfaction after participating in the program. The program has shown benefits for parents from a wide variety of cultural backgrounds and various socioeconomic groups.[4, 5]

Table 6-5
Family Education and Support Services Programs Principles

- Decisions are based upon family preference, choice, and values
- Families are the primary resource and decision makers
- Families have access to a flexible, affordable, individualized array of supports
- The family's strengths are the foundation upon which all supports are provided
- Support services are culturally, linguistically, and geographically sensitive
- Services are affordable, well coordinated, accessible, and available to all families
- Parents are in partnership with professionals providing services

In New York State, Common Sense Parenting® classes were first offered at two children's psychiatric centers approximately five years ago to provide continuity of treatment for children making the transition from inpatient or day treatment programs to their homes. Over time, the program has attracted families from the larger community. In the past year, training has been held both for State children's psychiatric center

Table 6-6
Primary Goals of School Support Project

1. To integrate mental health services and supports that address the needs of students into regular school processes
2. To develop strategies to involve parents/guardians of children with emotional and behavioral issues
3. To train both school staff and parents in mental health topics and practical skills related to children with emotional and behavioral issues
4. To link students with community-based clinical services as necessary

Notes

4 Thompson, R.W., Grow, C.R., Ruma, P.R., Daly, D.L., & Burke, R.V. (1993). Evaluation of a practical parenting program with middle and low-income families. Family Relations, 42, 21-25.

5 Ruma, P.R., Burke, R.V., & Thompson, R.W. (1996). Group parent training: is it effective for children of all ages? Behavioral Therapy, 27, 159-169.

Table 6-7

Common Sense Parenting® Program Skills

1. Clear communication
2. Effective praise
3. Preventive teaching-teaching expectations in order to assist children to avoid problems and to be successful
4. Corrective teaching-correcting misbehaviors and teaching children what to do instead
5. Teaching Self-Control/Staying Calm-a process for helping children to calm down when they are upset and teaching them ways to remain calm in future intense situations

facilitators and facilitators from the community to make the Common Sense Parenting® program available throughout the State. Support and feedback has been consistently strong among parents, parent advocates, and mental health providers who describe improved parenting skills, family satisfaction, and communication between parents and children.

More information about family support services as an evidence-based practice can be found on the OMH Web page at http://www.omh.state.ny.us/omhweb/ebp/children_familyed_supportsvc.htm.

School-Based Mental Health Services

OMH is collaborating with the New York State Departments of Education and Health (DOH) in a series of school-based mental health initiatives known as the School Support Projects. The School Support Projects help schools to identify and assess students who need mental health assistance and, in conjunction with the child's family, develop a plan that coordinates school, mental health, and health supports. They emphasize the importance of family-focused and strengths-based planning, and are intended to improve service delivery and decrease reliance on out-of-home placement of children with emotional and behavioral issues.

The four primary goals of the School Support Projects focus on ensuring that mental health professionals, educators, and parents work together to assist students with emotional and behavioral issues to succeed in school. Services are provided to children in schools through programs and/or clinics, and address the needs of a range of children and adolescents, from those diagnosed with a serious emotional disturbance to those who have begun to exhibit symptoms of emotional and behavioral disorders. Interventions available to participants include: evidence-based clinical treatments, family support, coordination with community-based services, advocacy and case management, educational services, and referrals for more intensive services and supports as needed.

In New York State, a total of 46 school-based programs now serve over 5,000 children annually. Seven sites in New York City also work with DOH to integrate health and mental health services, and emphasize the use of evidence-based treatments. Columbia University's Center for the Advancement of Children's Mental Health has assisted their providers in selecting and implementing the evidence-based treatments that would best meet their students' needs.

School Support program outcomes available for the period of April 2000 and December 2001 showed a high degree of success for students. Student outcome measures at pro-

gram intake and termination showed a decrease over time in students' levels of social and emotional withdrawal and behavioral disruption. Special Education classifications of students were also compared between intake and termination. The program showed a high retention of children who continued in General Education Classes (98%), and that 31% of the students who were enrolled in Special Education classes at intake had been transferred to General Education classes at termination.

Families who have participated in annual reviews of School Support programs have expressed support for the school-based mental health model, particularly for encouraging the active participation of families in both project-wide and child-specific decision-making processes, as well as for helping to improve communication between the school and the family. Parents have also noted the lack of stigmatization of children who receive mental health services in the school environment.

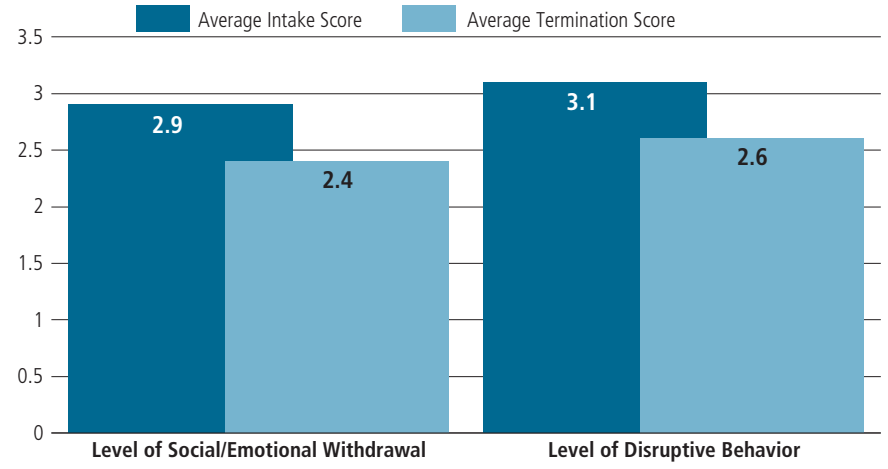
The School Support Projects reflect many of the recommendations in the Surgeon General's National Action Agenda for children's mental health. These include training for all persons who interact on a regular basis with children (including families and teachers) to recognize early indicators of mental health problems; education for providers in scientifically proven prevention and treatment services; destigmatization and elimination of racial, ethnic, and socioeconomic disparities in access to mental health care; use of common descriptors and universal measurement system across disciplines; and improved assessment tools.

Functional Family Therapy (FFT)

Functional family therapy (FFT) is a family-based prevention and multi-systemic intervention program that has been applied successfully in a variety of situations to assist youth and their families. FFT is based on

Figure 6-3

Students' Level of Social/Emotional Withdrawal and Disruptive Behavior at Program Intake and at Termination



30 years of clinical research, which supports its foundation as an evidence-based practice. The FFT program has been applied to a wide range of youth and their families in various multi-ethnic, multicultural contexts, and with preadolescents and adolescents diagnosed with conduct disorders, violent acting out, and substance abuse.[6]

By following key principles, FFT can reduce or prevent recidivism and delinquency at treatment costs well below those of traditional services and interventions. FFT provides short-term, family-based therapy that can be conducted in a clinic setting, as a home based model or as a combination of clinic and home visits. A specially trained FFT therapist meets with the youth and family together, for an average of 12 sessions, applying the three phases of the FFT model in sequence to: 1) engage and motivate the youth and family, 2) promote behavior change, and 3) support generalization of learned skills and behaviors. The therapist can adjust and adapt the goals of each phase to meet the individual needs of the family, and should consider working with interventions that have made a positive difference in the family. It is also important that the focus of this model needs to be on the total family, not just the young person's issues.

Two years of intensive training for an agency-based team of FFT therapists is delivered by national consultants and funded by OMH. An FFT team is made up of three to eight clinicians who receive intensive, sustained training and ongoing phone supervision over a 12-month period.

Currently there are 15 FFT sites in New York State that are in the start-up phase, and therapists report promising preliminary results. In other programs across the United States, FFT has yielded 80% completion rates, 50% reduction in recidivism, and documented reductions in system costs.[7]

Evidence-Based Prescribing Practices

Psychiatric medications are widely used as part of the treatment for aggressive and assaultive behavior in adults and children, and new antipsychotic medications are being used increasingly for this purpose. However, the scientific evidence supporting this clinical practice with children is limited.[8] In response, OMH and experts at Columbia University's Center for the Advancement of Children's Mental Health have collaborated to create TRAAY (Treatment Recommendations for the use of Antipsychotics for Aggressive Youth) to prevent the overuse of antipsychotic medications for the treatment of children and youth (Table 6-8).

TRAAY's purpose is to examine the use of antipsychotic medications in State-operated inpatient and day treatment programs for children and youth, and to develop evidence-based treatment recommendations for their use. The project's recommendations are based on the existing evidence base[9] and reflect a comprehensive and systematic approach to diagnosing, assessing, and treating children and adolescents who present with aggressive behavior. TRAAY's recommendations include consideration of the client's perspective, as well as cultural factors in the development of a prescription plan.

OMH is developing TRAAY educational materials. A comprehensive TRAAY manual has been created for the training and supervision of physicians in State-operated programs, and Columbia University has developed a supporting curriculum to instruct them regarding TRAAY principles

Notes

6 Sexton, T.L., & Alexander, J.F. (December, 2000). Functional Family Therapy. Office of Juvenile Justice & Delinquency Prevention, Juvenile Justice Bulletin, 3-7

7 Loughran, E.J. (April 2002). King County's Family Functional Therapy Approach is Working. Council of Juvenile Correctional Administrators (CJCA) Newsletter (phone at 508-238-0073) or Web site http://www.corrections.com/cjca/

8 Pappadopulos, E., Jensen, P.S., Schur, S.B., MacIntyre, J.C., II, Ketner, S., Van Orden, K., et al. (2002). "Real World" atypical antipsychotic prescribing practices in public child and adolescent inpatient settings. Schizophrenia Bulletin, 28(1), 111-121.

9 Pappadopulos, E., MacIntyre, J.C., II, Crismon, M.L., Findling, R.L., Malone, R.P., Derivan, A., et al. (under revision). Treatment recommendations for the use of antipsychotics for aggressive youth (TRAAY) Part two. Journal of the American Academy of Child & Adolescent Psychiatry.

Table 6-8

TRAAY Principles

Before using medications—

- Complete a diagnostic assessment
- Use psychosocial treatment interventions with the child and family

Before treating aggression—

- Treat co-existing or primary psychiatric disorders

When using medications—

- Use a conservative dosing strategy
- Carefully monitor for side effects and effectiveness

When managing acute aggression—

- Minimize use of emergency (STAT) or as needed (PRN) medications

and implementation. OMH has also developed a series of quality indicators to facilitate the evaluation of TRAAY's impact on prescribing practices. A *Parent Guide to Inpatient Treatment* is being prepared for the parents of hospitalized children and adolescents. *Choice Thru Voice*, a publication for youths about medication decisions, is a project of the OMH Youth Advisory Council and is available for use in State-operated child and adolescent settings.

State-Operated Services for Children and Adolescents

OMH operates six children's psychiatric centers and six units for children located within adult psychiatric centers. State-operated inpatient capacity currently is 498 children statewide; many more are served in any given year, however, because more than 75% of those who require inpatient hospitalization at a State facility have a length of stay less then six months. State-operated children's services vary in response to local need, but each location has an inpatient component as well as an outpatient component. More information about children's inpatient services is presented in Chapter 4.

State-operated mental health services for children and their families are integral components of county-based planning and service delivery systems. Through participation in local planning groups, State-operated programs are changing and adapting to respond to newly emerging community needs. Based upon this local need, facilities are reconfiguring State outpatient resources, or developing new services that supplement existing community-based programs. Children with the greatest needs have tended to be the focus of these services.

State-operated facilities for children are also incorporating evidence-based practices into everyday operations wherever possible. Examples include:

- A program to oversee, monitor, and evaluate prescriptive protocols for the administration of medications has been developed and is being implemented at all facilities.
- Several best practices have been identified in pre-vocational and vocational services for adolescents. Pilot programs will be implemented in the near future, and evaluations are expected to begin in 2004.
- Best educational practices for working with high need and varied populations are being identified for use in a preferred curriculum for the facilities' instructional programs. Evaluation of all facility educational programs is currently underway, and training in identified practice areas is slated to begin early in 2004.

- Preliminary planning is beginning in an effort to identify evidence-based, non-medical practices with effective outcomes for children and adolescents with high needs.

Many of the State-operated children's facilities use the psychoeducational model, an interactive teaching model with documented success. By reinforcing positive behaviors and helping children develop positive social skills, direct care staff can actively foster clinical objectives for each child. Staff at the children's psychiatric centers are now providing parent training on an ongoing basis.

Serving the Juvenile Justice System

Under Governor Pataki's Enhanced Community Services program, OMH continues to expand the delivery of treatment services to children and adolescents being served in the Office of Children and Family Services' (OCFS) juvenile justice system. There are now seven operational mobile mental health teams from State-operated facilities that provide clinical services to children in OCFS non-secure, limited-secure, and secure residential facilities, and in OCFS group homes, aftercare offices, and reception facilities. Mobile mental health teams provide evaluation, treatment, and discharge planning to adjudicated youth who experience severe emotional disturbance (SED). The teams are also deployed to OCFS reception facilities where they provide comprehensive psychological evaluations of youngsters entering the OCFS system.

OMH is now finalizing two training curricula for use by OCFS employees. One curriculum provides an overview of mental health issues, conditions and behaviors, and provides insight regarding the mental health needs of the specific population. The other curriculum focuses on mental health issues related to trauma, and guidance on how to interact with and respond to children and adolescents who have been exposed to trauma. Training in both areas is expected to begin by the end of 2003.

Additional Improvements

We are just beginning to see the impact these innovative programs are having on the children's mental health system. In addition to the progress described earlier, length of stay in Residential Treatment Facilities has decreased system wide from 18 to 14 months. Single point of access (SPOA) systems are reporting a reduction in time from referral to receipt of services, an increase in the proportion of high need individuals receiving priority services, improved coordination of services, increased community tenure and integration for high risk youth, shortened wait time for services, improved collaboration among system partners at the local and State levels, and improved planning with the use of a standardized assessment instrument to chart functional improvement over time.

For outpatient programs using evidence based engagement strategies, a reduction in dropout rates is being documented. The central intake process in New York City is a collaborative effort by OMH, the New York City Department of Health and Mental Hygiene, and the New York City Health and Hospitals Corporation that has resulted in a significant reduction in the amount of time it takes for children to gain access to State psychiatric facilities. Length of stay in State Children's Psychiatric Centers has dropped to an all time low rate of 45 days,

which has resulted in the capacity to serve greater numbers of children.

Areas for further improvement include the need for more families and children to actively participate in SPOA meetings, a further reduction in length of stay in Residential Treatment Facilities and community residential programs to facilitate return to communities of origin more quickly, improved coordination and discharge planning for children being discharged from hospital and residential systems, and improved planning for children with special/multiple needs that cross agency boundaries.

Planning for the Future

OMH is committed to working with localities to continue to build on system improvements and to use what we have learned to plan for the future. There are three primary areas of focus for this planning period:

1. Prevention and Early Intervention

The 1999 Surgeon General's Report on Mental Health found that implementing a public health model of prevention and early intervention can result in improved outcomes for at-risk children. By focusing on at-risk youth in general, employing preventive and healthy development technologies, valuing health promotion and encouraging early intervention, communities can contribute to reducing the prevalence of serious emotional disturbance among children and adolescents.[10] This is a somewhat different focus for mental health treatment professionals since traditionally, mental health services are initiated at the point when children first demonstrate symptoms of serious emotional disturbance.

Numerous effective interventions have been documented in the research to offset risk factors and may change a child's developmental trajectory.[11] Promoting resilience among high-risk youth (e.g., Big Brothers Big Sisters of America) is another example of how concepts from the public health system can be used to build a child's strengths and offset the effects of risks in life. Use of professional mentors from within a child's natural environment underscore community-wide involvement in the therapeutic and preventive process. OMH is in the process of identifying how principles of positive youth development and the concept of resiliency can be incorporated into children's mental health services system-wide.

2. Evolving the System of Care

The more severe a child's emotional difficulties, the more likely it is that these difficulties will interfere with a broad range of activities at home, in school, and in the community. Contributions to a child's health development need to come from home, school, other community agencies such as child welfare and juvenile justice, and the education system since all these systems have an impact on a child's life. Over the past two decades, the literature has clearly documented the importance of a coordinated system of care to promote recovery for children.

The Coordinated Children's Services Initiative (CCSI) is an important interagency initiative implemented by State and local governments that was designed to build the system of care for children and families. Following on the success and strength of CCSI, the SPOA system was implemented to build coordination at the local leve, first with mental health agencies, and then with

Notes

10 Burns, B.J. & Hoagwood, K. (2002). Community Treatment for Youth: Evidence-based Interventions for Servere Emotional and Behaviorial Disorders. New York: Oxford University Press.

11 Examples include: First Step to Success, Project Head Start, Elmira Pre-Natal Early Infancy Project, and Primary Mental Health Project.

other system partners that affect a child and family's life. SPOA is considered the primary vehicle to coordinate mental health services for SED children at the county level. It should be the catalyst for systems change and coordination in each county as well as the entry point into the system for all high-risk, high need children. All counties should have SPOAs in place that accomplish that objective.

OMH's goal for SPOA is to see all system partners at the table organizing individualized service plans (ISPs) for high-risk, high needs youth and their families. Youth and family members being planned for should be active participants and be present at the meetings involving them. All partners having responsibility for aspects of the treatment plan should be part of SPOA. This includes community inpatient acute care hospitals, State-operated inpatient and outpatient partners, and Residential Treatment Facility (RTF) partners. For example, the Rockland Children's Intensive Day Treatment program staff participate in county SPOAs within the facility's catchment area. SPOAs should be used both for admission to programs and discharge back to home from hospital inpatient units and RTFs. Before considering referral to a RTF, county SPOAs should review the referral to ensure that there is no other community-based service that can meet the child or family needs.

3. Refining Service Delivery for Highest Risk Children

Children with severe psychiatric symptoms may require intermediate-level hospital care or residential placement. A small but significant number of children in New York State present with a constellation of high risk symptoms and behaviors which may be associated with massive trauma, parental deprivation, prenatal injury, genetic predisposition to mental illness, and/or negative psychosocial sequella to urban terror and poverty. Some of these children have experienced multiple residential and/or academic placements, and many have been removed from the home for at least short periods of time. Children with complex, specialized treatment needs require a highly intensive, comprehensive, and well-coordinated approach to care.

Programs such as State-operated inpatient facilities and RTFs are committed to serving these children. Intensive treatment units and specialized treatment programs provided by a number of RTFs provide treatment for youngsters with special needs. State-operated inpatient programs are responsive to local and regional needs in relation to this group of children, and serve as the community's safety net for mental health care and treatment.

State hospitals have developed evidence based interventions and expertise in a wide range of areas including: prescribing practices for psychotropic medications; the development of a comprehensive trauma assessment program that provides standardized evaluations for all incoming children; specialized treatment services to address the needs of special populations such as children in the juvenile justice system and adolescent sexual offenders; vocational, prevocational and educational services; meeting educational needs; system-wide use of the Psycho-Educational Model (PEM) developed by Girls and Boys Town; and statewide training in the Common Sense Parenting® curriculum.

CHAPTER 7

Promoting Mental Health for All New Yorkers

OMH PROMOTES public mental health through education and advocacy for all New Yorkers, while maintaining a particular focus on the needs of adults with serious mental illness and children with serious emotional disorders.

Rationale for Promoting Public Mental Health

The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being – not merely the absence of disease or infirmity.[1] National and international leaders recognize that ensuring health should be a shared societal goal because many aspects of human potential such as employment, social relationships, and political participation depend on it.[2] Both the WHO and the Federal Centers for Disease Control (CDC) have found that the impact of mental illness on overall health and productivity in the United States and throughout the world often is profoundly under recognized. In the United States, mental illness is on a par with heart disease and cancer as a cause of disability.[3]

Among social scientists, there is a general consensus that the public's health is dependent on both psychological and physical well-being, and that psychological disorders are determined by a combination of physical, psychological, and social factors.[4] Although psychological health has not traditionally received the same consideration or support as physical heath by government, health care providers, or the general public,[5] national and international leaders now call for the promotion of psychological well-being as an integral part of public health efforts.

Leaders including the WHO,[1] the United States Surgeon General,[4] and the President's New Freedom Commission on Mental Health[6] have identified a need for a public mental health approach to mental illness that expands efforts beyond treatment for the most severely affected individuals. Healthy People 2010 has identified mental health among ten high-priority public health issues in the United States and acknowledges the need for improving

Notes

1 Department of Mental Health and Substance Dependence. (2002). Prevention and Promotion in Mental Health. Geneva: World Health Organization.

2 IOM (Institute of Medicine). (2003). The Future of the Public's Health in the 21st Century. Washington, D.C., The National Academies Press.

3 Murray, C.J.L., and Lopez, A.D. The Global Burden of Disease. Cambridge, MA: Harvard University Press, 1996.

4 United States Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

5 IOM. (2003). Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy. Washington, D.C., The National Academies Press.

6 President's New Freedom Commission on Mental Health. (2003). Achieving the Promise: Transforming Mental Health Care in America. Retrieved October 10, 2003 from http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html

Chapter 7

Promoting Mental Health For All New Yorkers

the availability and dissemination of mental health-related information.[7]

The public health field assures conditions in which people can be healthy by using health promotion and disease prevention interventions designed to improve and enhance quality of life.[8] These include organized, interdisciplinary efforts that address the physical, mental, and environmental health concerns of communities and populations at risk for disease and injury.[9] In the past, the mental health field often focused principally on mental illness in order to serve individuals who were most severely affected. As the field has matured, it has begun to respond to intensifying interest and concerns about disease prevention and health promotion.

OMH Prevention and Promotion Activities

OMH is increasing the general public's awareness and understanding of mental health by developing and distributing information about the nature and impact of mental illness, effective treatments and services, useful preventive and coping strategies, and how to get help when it is needed. The agency's information dissemination strategies are designed to reach as many New Yorkers as possible, with a particular focus on high-risk groups. Educational information is shared through informational booklets, the OMH Web site (http://www.omh.state.ny.us/), mass media campaigns aimed at building public awareness, and at health, community development, and governmental functions. Through a collaborative effort with the National Institute of Mental Health (NIMH), new OMH mental health promotion materials will be available on the OMH Web site in Spring 2004.

Annual events that OMH participates in around the State as part of its prevention and promotion activities include: the New York State Martin Luther King Jr. Observance, the Governor's Healthy Community Expo, Governor Pataki's Women's Health Expo, the Community Development Conference (sponsored by the Governor's Office for Small Cities), the Puerto Rican and Hispanic Legislative Conference, the Multicultural Family Festival (sponsored by the Office of General Services) and the New York State Fair. Events held every three years that the agency participates in include: the Governor's Conference on School Violence Prevention, the Governor's Interfaith Summit, and the Governor's Leadership Forum. These venues assist OMH to reach targeted audiences with mental health and mental illness information. Representation at these events also helps to build awareness of OMH programs and services among constituent groups.

Since the September 11, 2001 (9/11) terrorist attacks on the World Trade Center (WTC), a major focus of OMH prevention and promotion activities has been public education concerning the mental health impact of terrorism, including common signs and symptoms of psychological trauma, how to differentiate normal from abnormal reactions, effective personal coping strategies, and where to get additional help. These activities have taken place within Project Liberty, New York State's response to the mental health needs of New Yorkers that have resulted from the 9/11 terrorist attacks and their aftermath.

Notes

7 Healthy People 2010. (2003). Leading Health Indicators. Retrieved October 10, 2003 from http://www.healthypeople.gov/LHI/lhiwhat.htm and http://www.healthypeople.gov/Document/ HTML/Volume2/18Mental.htm

8 IOM. (1988). The Future of Public Health. Washington, D.C., The National Academies Press.

9 Association of Schools of Public Health. What is Public Health? Retrieved October 10, 2003 from http://www.asph.org/document.cfm?page=300

Project Liberty

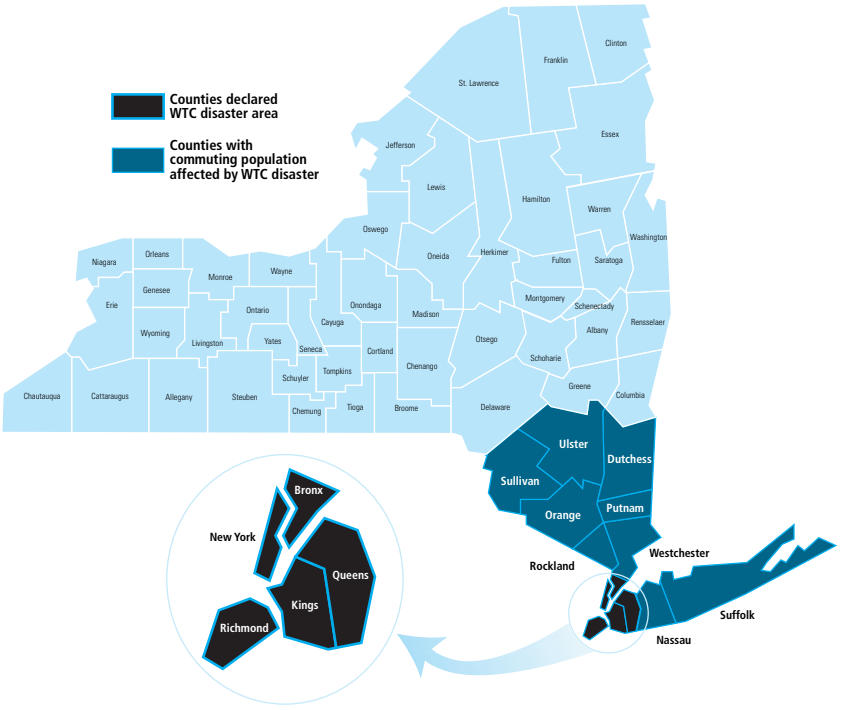
OMH collaborated with the New York City and county mental health departments to address mental health needs stemming from the 9/11 tragedy through the Project Liberty Crisis Counseling Program. Funded with $155 million from the Federal Emergency Management Agency (FEMA), Project Liberty has been a successful collaboration of OMH, local governments, and more than 100 local provider agencies that produced the single largest and most rapidly implemented public mental health program in the history of the United States. Program services have been offered throughout the Presidential declared disaster area that included the five boroughs of New York City and Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster, and Westchester counties (Figure 7-1). OMH's role in the project has been to create a supportive environment that made it possible for the New York City and county mental health authorities and provider agencies to deliver the widespread interventions necessary to meet the disaster-related mental health needs in their communities.

What Did Project Liberty Do?

Project Liberty's overall goal was to alleviate the psychological distress that affected

Figure 7-1

Crisis Counseling, Education and Referral Services for New York State Counties Affected by the World Trade Center Disaster



Chapter 7

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New Yorkers experienced as a result of the 9/11 disaster. Operating on the assumption that most individual reactions to the disaster were normal responses to a traumatic event and would be short in duration, the program delivered free short-term outreach and educational counseling services to affected individuals and groups and made referrals to longer term mental health services when necessary. Project Liberty's crisis counselors provided face-to-face disaster-related services by outreaching to those in need in their homes, businesses, schools, and places of religious worship, and in recovery centers, shelters or community centers. Nearly 85% of all Project Liberty services were delivered at such easily accessible locations within the community.

What did Project Liberty Achieve?

In the aftermath of 9/11, Project Liberty provided free crisis counseling, outreach, and public education services to more than 1,100,000 residents of New York City and the surrounding counties (by comparison the total number of individuals served in the New York State public mental health system in 2001 is estimated to be 630,000).

Figure 7-2
Ethnicity of People Receiving Project Liberty Services

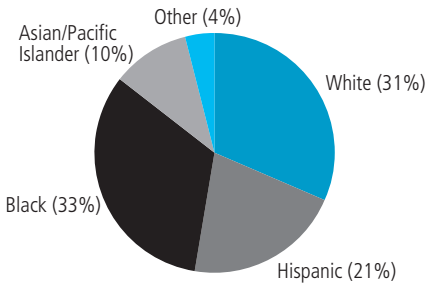
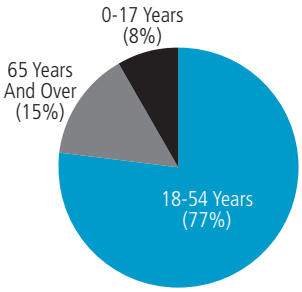


Figure 7-3
Ages of of People Receiving Project Liberty Services



Those served included individuals who lost a family member in the attacks and members of other priority, high-risk populations including evacuees, disaster rescue and recovery workers, persons with physical injuries, displaced employed and unemployed, and schoolchildren.

Project Liberty services were provided to individuals who are diverse in terms of age, race, culture, education, and primary language (Figures 7-2 and 7-3). In addition to English, Spanish and Chinese, counseling services were provided in languages including American Sign, Russian, Haitian Creole, Hebrew, Polish, Italian, French, Arabic, and a variety of Asian languages. Using the project's outreach model, the State's public mental health system integrated crisis counseling services into the fabric of the community in non stigmatizing ways that encouraged people to seek help. Detailed data regarding Project Liberty services is included in Appendix 9.

A major component of Project Liberty's outreach and public education strategy was a media campaign aimed at building public awareness of the program. Highlights of this campaign included 30-second TV spots featuring Yankees manager Joe Torre

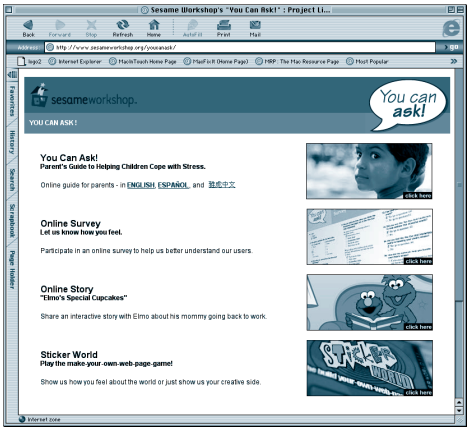
and actress Susan Sarandon, similar radio spots in English and Spanish, and subway and bus placards developed by the New York City Department of Health and Mental Hygiene featuring verbatim statements from New Yorkers detailing their personal 9/11 coping strategies. Unifying elements of all media activities included the Project Liberty logo, advertisement of a central crisis counseling and referral hotline (1-800-LIFENET, operated by the New York City Mental Health Association), the slogan "Feel Free to Feel Better," and the project's Web site.[10] These media efforts and the following Project Liberty educational outreach efforts serve as a model for ongoing and future OMH mental health prevention and promotion activities

- **20 million pieces of educational material have been distributed in English, Spanish, Chinese, Korean, Haitian-Creole, and Russian.**[11] Large type versions were made available for the visually impaired in English, Spanish, and Chinese, and audiotape versions for the blind were made available in English and Spanish.

- **A special children's initiative was conducted in partnership with the Sesame Workshop that included print, online,[12] and outreach components designed to effectively reach millions of children aged three to eight and the adults who care for them (Figure 7-4).** Materials were made available in English, Spanish, and Chinese, and provided children with culturally appropriate lessons, skills, and tools to deal with their responses to the 9/11 attacks.

- **Project Liberty built mental health awareness by working collaboratively with other State agencies to reach special populations through their agency networks and affiliate groups.** These agencies included the Department of Health, Office of Children and Family Services, Office of Temporary and Disability Assistance, Office for Aging, Thruway Authority, and Office of Office of Alcoholism and Substance Abuse Services.

Figure 7-4
You Can Ask! Web Page



- **Comprehensive information about Project Liberty has been made available on the Web at http://www.projectliberty.state.ny.us/.** The site has included information in English and Spanish about project services, eligibility, access, and educational materials for both consumers and providers. The site has been visited approximately 1,000,000 times since its launch in December 2001 (Figure 7-5).

Through these activities, Project Liberty achieved its goal of making the general population aware of what constitutes normal reactions to the events of 9/11 and how to access services. According to the New York Academy of Medicine, awareness of Project

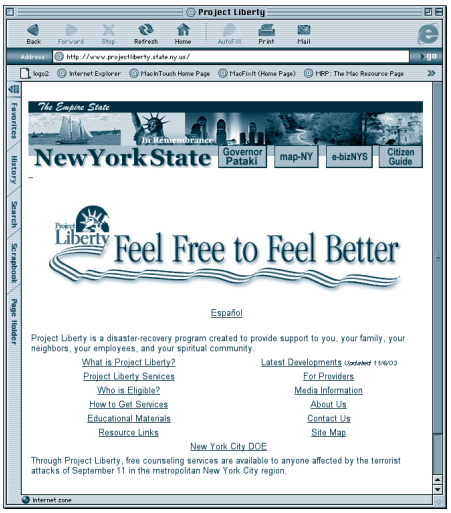
Notes

10 Project Liberty media files can be viewed online at http://www.projectliberty.state.ny.us/media.htm.

11 These brochures can be viewed online at http://www.projectliberty.state.ny.us/educational.htm

12 The Sesame Workshop online component is located on the Web at http://www.sesameworkshop.org/youcanask/

Figure 7-5
Project Liberty Home Page



Liberty among New York City residents surveyed increased more than 100% between January 2002 and January 2003, from approximately 25% to more than 50%.

Ongoing Evaluation of Project Liberty

OMH, in collaboration with New York City, the participating counties, and academic partners, has been conducting a multifaceted, evaluation of Project Liberty. This ongoing evaluation has provided useful information that has assisted in decision-making and informed disaster preparedness efforts. When completed, the evaluation will describe the implementation process used, identify best practices and obstacles encountered, and based on the lessons learned, make recommendations about how to organize a mental health response in the future.

It is now more than two years since the tragic events of 9/11. Through Project Liberty and related initiatives, OMH is helping New Yorkers to improve their abilities to cope with the events of 9/11 and enhancing preparedness in the event of future disasters. Project Liberty is currently authorized to deliver services to two highly impacted populations, the Fire Department of the City of New York and New York City schoolchildren, through February 28, 2004, and a request to run through June 2004 has been submitted to the Federal government.

Disaster Response and Preparedness

OMH is responsible for coordinating New York State's emergency mental health response and insuring that mental health services are available for those in need. In the aftermath of the 9/11 disaster, OMH has assumed an expanded role in disaster preparedness and response, which includes reviewing emergency mental health response systems through a comprehensive disaster preparedness planning process that includes other State and local agencies. OMH is also providing leadership in disaster mental health planning with other State and Federal agencies in coordination with the American Red Cross in New York State (ARCNYS) and the New York State Conference of Local Mental Hygiene Directors (CLMHD), which represents all 57 county governments and the City of New York. Through these processes, OMH recognizes the complementary roles, shared commitment, and the mutual advantage of an integrated approach to improving emergency mental health services for all New Yorkers.

These efforts recently culminated in OMH, CLMHD, and ARCNYS signing a Statement of Understanding (attached as Appendix 9) outlining the roles, responsibilities, and expectations of each organization when responding to a moderate or severe disaster. The Statement of Under-

standing recognizes that during a large-scale disaster, an immediate, coordinated and effective response by multiple government and private sector organizations will best meet the medical, logistical, and emotional needs of affected people. It also recognizes that each county's disaster-related mental health activities are a component of larger county-wide and statewide emergency disaster response plans.

The Statement of Understanding outlines the authority of OMH, CLMHD, and ARCNYS during a mental health disaster response, and describes a number of coordinated and cooperative efforts in the areas of:

- Communication
- Training and response efforts
- Joint recruitment, training, and mobilization of mental health responders
- Provision of public mental health information both prior to and following disasters

The Statement of Understanding promotes the availability of qualified mental hygiene staff to assist in appropriate coordination with the local ARC chapter, and the recruitment, training, and retention of locally-based mental health professionals to work as disaster mental health volunteers. It also formalizes the process of compiling a comprehensive database of disaster mental health responders, which will be jointly updated and shared on a regular basis.

OMH is also collaborating with the Department of Health (DOH) to develop public mental health education materials that will be included in a Bio-Terrorism Toolkit. The Toolkit is designed to facilitate local disaster planning with a focus on preparing families and communities for the potential effects of a biological weapons attack, and will include fact sheets about smallpox and anthrax, vaccination information, and how to cope during these uncertain times. Toolkits will be distributed to every local health department in New York State.

Future Activities

Eating Disorders

One example of a public heath problem that affects the mental health field is eating disorders, which affect young girls especially hard. The National Institute of Mental Health (NIMH) reported in 1996 that more than five million Americans suffer from eating disorders, and the problem manifests at a young age. The Council on Size and Weight Discrimination reported that 80% of ten year old girls had dieted, and a study done by Steiner and Adair (1992) found 31% of ten year old girls are afraid of being fat. According to the Harvard Eating Disorders Center (HEDC), full-blown eating disorders are now the third most common chronic illness among American females, and growing among teens and pre-teens. The Center found that 80% of women in America, across race, class and ethnic differences report that the experience of being female means "feeling too fat."

In New York State, F•E•G•S is offering a program, in cooperation with HEDC, to foster self-esteem and promote positive body image in girls called *Full of Ourselves: Advancing Girl Power, Health and Leadership* to select schools and programs.[1] OMH is developing a public health education and

Notes

13 The F•E•G•S NoBody's Perfect Program. F•E•G•S Long Island, Syosset, NY.

advocacy approach to the growing problem of eating disorders, which will be implemented during the 2004-2008 planning period. It is anticipated that this approach will draw upon exemplary programs and curricula designed to provide eating disorders prevention programming to promote the healthy development of girls' minds and bodies.

Preventing Suicide in New York State

Suicide is a leading cause of death and injury in New York State, the nation, and the world. According to the 2002 WHO World Health Report, each year, violence against self claims nearly as many lives (815,000) as violence against others in war and by homicide combined (830,000). The Substance Abuse and Mental Health Services Administration (SAMHSA) has characterized suicide as a far more common problem than many people realize: for every two homicides in the United States, there are three suicides; for every person who dies from HIV/AIDS, two people die by suicide. Approximately 30,000 Americans lose their lives each year to suicide, but some 650,000 attempt it. Because of the stigma attached to both suicide attempts and completions, these numbers may represent an underreporting, lessening the perceived dimensions of the problem.

In New York State, approximately 1,200 deaths occur each year due to suicide. According to the CDC, in New York State suicide is the third leading cause of death among those aged 15-24; fifth for those aged 25-44; sixth for those aged 10-14; and eighth for those aged 45-54. Overall, there were 25% more suicides than murders in New York in 2000.

The relationship between suicide and mental illness is not well understood. In the United States, although 90% of suicides are associated with mental illness and/or alcohol or drug abuse, only about 5% of those with a diagnosed psychiatric illness will die by suicide and as many as 10% of people who complete suicide do not have a known psychiatric diagnosis.[14] According to NIMH, no annual national data on all attempted suicides are available. However, research indicates that in the United States there are an estimated eight to 25 attempted suicides to one completion; the ratio is higher in women and youth and lower in men and the elderly. More women than men report a history of attempted suicide, with a gender ratio of three to one.[15] These data suggest that while prevention efforts should concentrate on identifying and treating those with a diagnosable mental illness or addiction, focusing too narrowly on those with a mental health diagnosis and ignoring the general population is not the answer.

Reaching individuals and groups with elevated risks for suicidal behavior will require concerted action at the community level. To be meaningful, behavioral change must originate in the community in people's homes, worksites, businesses, and unions; in the courts, criminal justice system, jails, and prisons; in non-government organizations, community and faith-based agencies, and in local government agencies. OMH has taken the lead in developing a framework for a statewide suicide prevention plan directed at all New Yorkers. The project is a collaborative effort of OMH, the New York State Suicide Prevention Council, DOH, the New York City Department of Health and Mental Hygiene, the University of Rochester Center for the Study and Prevention of Suicide, and OMH's New York State Psychiatric Institute. The statewide prevention effort will offer a pub-

Notes

14 IOM. (2002). Reducing Suicide: A National Imperative. Washington, DC: The National Academies Press.

15 National Institute of Mental Health. Suicide facts. Retrieved November 3, 2003 from http://www.nimh.nih.gov/ research/suifact.cfm

lic health strategy and action steps to reduce the number of deaths due to suicide in New York State.

The statewide prevention plan will be developed with a public health perspective to suicide prevention across the lifespan, and will integrate population-based public health prevention measures with clinical and medical interventions designed to address the needs of individuals at greater risk. It will build awareness of the need for suicide prevention, and will contain concerted actions that actually reduce the loss of life. The plan will be flexible enough to reach citizens living in both rural settings and in densely populated metropolitan areas, yet consistent enough to guarantee availability of evidence-based or best practices, regardless of location. Appendix 10 contains information about innovative suicide prevention programs and mental health interventions for self-harming behaviors.

Next steps will involve a collaboration of OMH, suicide prevention experts, and other key stakeholders to pilot suicide screening and early intervention efforts and incorporate them into routine clinical settings serving adults and children with mental illness. It is hoped that this pilot will result in a reduction of suicide attempts, as well as reduce the need for emergency room and inpatient services.

Resiliency

OMH is developing public mental health education and community outreach programs that build on Project Liberty's education and outreach efforts[16] in the 9/11 Presidential declared disaster area,[17] and plans to integrate them into community mental health settings statewide. As part of these efforts, the agency is developing a formal disaster preparedness education and outreach program for the remainder of the State, and is focusing more proactively on mental health awareness and promotion for the general public. Much of this work is designed to foster and support resiliency among New York State residents.

Resiliency is the human capacity to face, overcome, and be strengthened by experiences of adversity. It is closely tied to good mental health promotion, stress prevention, and enhancing individual strengths and skills. Interventions that foster resiliency promote mental health by educating people about what to expect of their feelings and behaviors in times of crisis, what they can do for themselves and their families, and where they can go when they need additional help. Resiliency interventions also help communities to identify their strengths and resources and develop ways to access needed resources.

OMH plans to apply knowledge gained from Project Liberty in the design and implementation of effective community outreach and mental health promotion models such as an Internet-based clearinghouse of mental illness and mental health information tailored to specific populations, and culturally relevant public awareness campaigns that inform individuals and families from a wide range of diverse communities about effective mental health treatment and supports.

Sharing Information

OMH recognizes that the Internet is an excellent vehicle for disseminating information to mental health service recipients and

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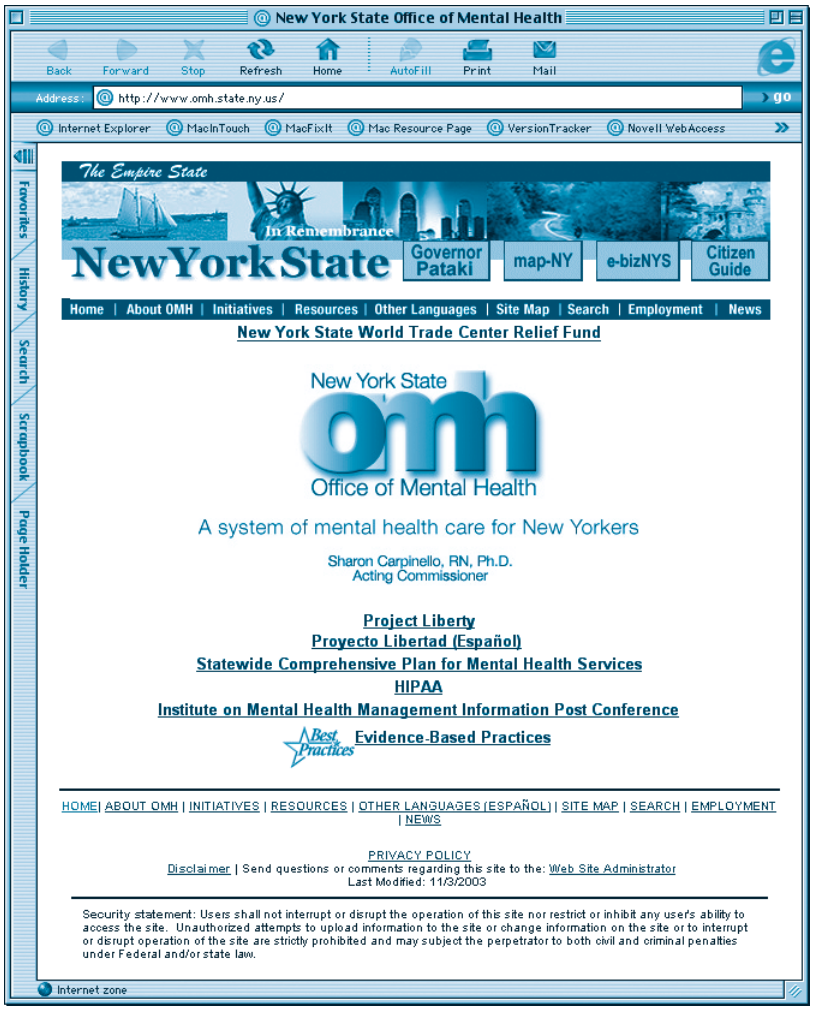
16 A summary of Project Liberty's education and outreach efforts is contained in Chapter 7, with additional information available on the Project Liberty Web site at http://www.projectliberty.state.ny.us/

17 The 9/11 Presidential declared disaster area included the five boroughs of New York City, and Delaware, Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster, and Westchester Counties.

providers, researchers, clinicians, state and Federal government employees, and the general public. The OMH Web site (http://www.omh.state.ny.us) offers visitors information about OMH's structure, functions, and priority initiatives, copies of agency publications and reports, and links to other important sources of mental health information. Each week, approximately 6,000 unique visitors arrive at the OMH Web site to find useful information that is available in English and Spanish. Keeping the site current and timely is part of the OMH pledge to promote and enact positive changes to ensure the highest quality and most effective mental health service system possible.

Figure 7-1
Office of Mental Health Web Page



CHAPTER 8
Management Information

OMH HAS DEVELOPED a sophisticated and comprehensive system for measuring public mental health system performance. This system, developed over a number of years, allows for data-driven decision-making across all major sectors of the mental health system. Chapter 8 describes the OMH performance management system and provides specific examples of how this system has been used to improve efficiency and outcomes.

The OMH Performance Management Model

OMH first developed its model for performance management during the late 1990s as part of the implementation of the Prepaid Mental Health Plan, which is a State-operated program of comprehensive outpatient services. In the OMH model, performance management is an ongoing set of processes for identifying critical performance areas and indicators in order to measure and analyze actual performance and improve services and outcomes. These processes include, but are not limited to: gathering input from stakeholders (service recipients, their families, mental health providers, etc.) on relevant areas of performance, collecting and analyzing data, reporting performance results, and refining programs and services based on user feedback. Together, these processes form a continuous quality improvement cycle.

Data Sources and Performance Indicators

Performance indicators, which are numerical summaries of performance, are critical to measuring performance and improving services and outcomes. OMH developed numerous indicators currently being used to manage performance in the following keys areas: service access, service quality and appropriateness, outcomes, and cost. OMH is committed to the use of accurate, timely, and meaningful performance indicators to guide management decisions. The indicators being used are continuously monitored and evaluated for utility. Specific indicators are added, dropped or modified as necessary. OMH uses a variety of data sources to create performance indicators that are described in Table 8-1.

Figure 8-1

OMH data sources used for performance management

Data source	Type of System	Coverage	Data included	Performance Indicators	Frequency of data updates
Patient Characteristics Survey (PCS)	Survey, paper-based	All programs in public mental health system	Demographic, diagnoses, program utilization, living arrangement, criminal justice status, GAF, alcohol and drug disability, employment	Penetration, employment, living situation and out-of home placements, rural access, receipt of evidence-based supported housing and supported employment, contact with criminal justice system, co-morbidity (screening), cross-sectional measure of functioning	One week survey done every two years
Child and Adult Integrated Reporting System (CAIRS)	Electronic, web-based; OMH-operated information system	Assertive community treatment, case management, supportive housing, AOT	Demographic, clinical, program utilization, living arrangement, contacts with criminal justice, extensive functioning and behavior ratings, alcohol & drug use, employment, plans for SA services	In addition to PCS measures, annual estimation, reduced substance abuse impairment, improvement in functioning, symptom relief, school improvement	Continuously, at admission, annually, discharge
MH Services Survey (MHSS)	Survey, paper-based	Adult consumer survey across sample of programs	Demographic, satisfaction ratings similar to MHSIP consumer survey	Adult consumer perception of access, quality and outcomes, consumer involvement in treatment planning	Biennial
MH Parent Assessment of Care	Survey, paper-based	Child and families' survey across sample of programs	Demographic, satisfaction ratings similar to MHSIP consumer survey	Child and family perception of access, quality and outcomes, family involvement in treatment planning	Biennial
Incident Reporting System (NIMRS)	Electronic, web-based; OMH-operated information system	Licensed inpatient and outpatient	Demographic, description of incident	Consumer injuries, mortality	Continuously
NY Interagency Supported Employment Reporting System (NYISERS)	Electronic; OMH-operated information system	Ongoing Integrated Supported Employment, Assisted Competitive Employment, Transitional Employment Programs	(OMR, SED, VESID) Demographic, program admission and discharge, type of job, wages, hours	Status in employment, retention in employment, change in employment, wages and hours.	Continuously
State pharmacy system (Meds Solutions)	Electronic; OMH-operated information system	State inpatients and outpatients	Demographic, medication fill-orders	Receiving 'atypical' medications	Continuously
State patient information systems (DMHIS, MHARS)	Electronic; OMH-operated information systems	Inpatient, outpatient, community support programs	Demographic, clinical, program utilization, living arrangement, legal status, functioning	In addition to PCS measures, reduced substance abuse impairment, improvement in functioning, inpatient readmission, 1st outpatient visit following inpatient discharge	Continuously, at admission, discharge
Medicaid Claims	Electronic; data extracts from non-OMH operated information system	Inpatient, outpatient, community support, some housing	Age, gender, race, program utilization, dates of service, diagnoses	Annual estimation, inpatient readmission, 1st outpatient visit following inpatient discharge	Received from Department of Health monthly
Statewide Planning and Research Cooperative System (SPARCS)	Electronic; data extracts from non-OMH operated information system	Inpatient discharge abstracts	Age, gender, race, dates of hospitalization, diagnoses	Annual estimation, inpatient readmission	Received from Department of Health annually

OMH Enterprise Data Warehouse

The OMH Enterprise Data Warehouse is a repository of data from a wide variety of sources that are strategically important to the agency. The Data Warehouse organizes and integrates these data to facilitate rapid ad-hoc analysis and reporting. Over the several years of its development, the OMH Enterprise Data Warehouse has become a cornerstone of the agency's increasing capacities for data-driven performance-based management.

Over the past two years, OMH has opened up much of the Enterprise Data Warehouse for use by authorized staff at local mental health authorities around the State. This unprecedented data sharing and decision-support initiative is designed to provide local mental health administrators with access to relevant and timely information about quality and efficacy of mental health programs, and is intended to enhance and expand dialogue between the State and localities in order to improve the delivery of mental health services.

OMH also produces a variety of performance management-related reports and publications, all of which rely on data from the Data Warehouse. These include management indicator reports for OMH-operated services and community residential programs, and evaluation documents such as the OMH Progress Report (2001)[1] and the Assisted Outpatient Program (AOT) Legislative Report (2003).[2] The Data Warehouse is also the mechanism used by OMH to meet externally mandated performance indicator reporting requirements from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Federal Center for Mental Health Services (CMHS).

Performance Management System: Real-world Examples

Prepaid Mental Health Plan

An early example of the use of the OMH performance management system was in the Prepaid Mental Health Plan. Between 1996 and 1998, plan members were surveyed to assess satisfaction with services, functioning, and quality of life. Their clinicians were also surveyed to assess client functioning and clinical status. The results of these surveys were displayed in a Web-based report card. Each facility was compared to statewide averages for a range of more than 100 performance indicators. The report card showed, by means of graphical icons, which differences were large enough that they were statistically significant, indicating either better or worse performance than average.

One important finding was that many respondents statewide reported physical health problems. This finding led to an overall quality improvement effort to expand access to physical health care, including expanding the use of staff to transport individuals directly to health care providers, and public education efforts directed at local physicians and dentists (stigma appeared to be a barrier to medical care in some cases). A second important finding was that self-help group participation rates varied substantially from one region of the State to another. In response, the OMH Bureau of Recipient Affairs developed regional self-help development plans to increase awareness of the benefits of self-help participation and to expand the number of groups available.

Notes

1 The 2001 Progress Report is available on the OMH Web page at http://www.omh.state.ny.us/omhweb/ progressreport/PrgRptLR.pdf

2 The AOT report is available on the OMH Web page at http://www.omh.state.ny.us/omhweb/Kendra_web/interimreport/AOTReport.pdf

OMH Management Indicators Report

Disseminated quarterly, the OMH Management Indicators Report compares and ranks the performance of all OMH operated psychiatric centers on a variety of cost, clinical, and safety indicators (e.g., data on staffing levels, overtime utilization, employee injury and lost time rates, expenditures, etc.). Performance data are also included such as census levels, length of stay indicators, and rates of admission and discharge, incidents, restraint and seclusion, use of atypical antipsychotic medications, utilization of outpatient and residential services, and escaped, endangered, and missing patients. Comparing and sharing performance data has been a powerful incentive for hospital bench marking, improvement, and Central Office oversight.

An example of the use of management indicators in influencing facility performance is the use of length of stay data in children's facilities and units. Through ongoing monitoring and discussion about the factors that drive length of stay, the overall median length of stay for State children's beds has dropped from a high of 58 days in September 2000 to an all time low of 38 days in June 2002. Other examples of how the indicators have influenced facility performance and/or have been used to drive quality include:

- A 93% decline in the number of escapes and leaves without consent
- A 43% decline in the use of restraint and seclusion
- A 103% increase in the use of newer, more effective medications for schizophrenia

Residential Program Indicators Report

The Residential Program Indicators Report provides information concerning residential programs funded through OMH, and is distributed to voluntary residential provider agencies, county mental health directors, and OMH staff. It draws on data available in OMH's Residential Client Tracking System, and is intended to provide benchmarks regarding certain measures of program performance that users can reference in evaluating agencies' residential programs, based on county, psychiatric center catchment area, and regional and statewide averages.

As delivery of mental health program services are increasingly managed through single point of access (SPOA) systems, this information will help to identify programs that may be experiencing difficulty in some aspects of operations (e.g., a low occupancy rate may be an indication that an agency is not getting sufficient referrals), which can be addressed through an action plan developed in conjunction with the county and OMH field office.

Use of Medicaid Data for Planning and Cost Analysis

Service claims for all specialty mental health services provided under Medicaid since 1990 are included in the OMH Data Warehouse. Analysis of these data, which number in the hundreds of millions of records, can now be performed in minutes. Many complex analyses can now be conducted that could not be performed at all before the Warehouse was developed. These data are used to track trends in mental health service expenditures, to look at patterns of service use, and for plan-

ning. Currently, OMH is working with the Department of Health (DOH) to better understand the factors driving growth in Medicaid expenditures between 1997 and 2001.

The Medicaid claims data can also be used to identify cohorts of individuals who are repeatedly hospitalized. Frequent re-hospitalizations are an indicator of poor engagement in community support services such as case management, which can prevent such re-hospitalization, and are extremely expensive. While many thousands of individuals are already engaged in case management and other services often needed to live successfully in the community, OMH is using the Data Warehouse to identify additional cohorts of individuals not yet engaged who could benefit from intensive case management or assertive community treatment (ACT).

CAIRS is Replacing Paper-based Reporting with Web-based Reporting

In developing its performance management system, OMH has been leveraging technology to replace outmoded, cumbersome, labor-intensive, and costly paper-based reporting systems with electronic Web-based alternatives. Notable among these is the Child and Adult Integrated Reporting System (CAIRS). CAIRS is a Web-based information system developed to replace a paper-based outcomes reporting process in which locally-operated children's specialty service providers completed paper admission, follow-up, and discharge assessments and submitted them to OMH. Providers were included in the design of CAIRS, and consequently, are now enthusiastic users of this Web-based system. With CAIRS, OMH, local mental health departments, and provider agencies now have instant access to data, which includes the ability to view and print numerous performance indicator reports as well as downloading data for additional analysis.

The CAIRS system has been operational in the children's sector for one year, and has been so successful that it is now being expanded to replace and consolidate similar adult outpatient service reporting systems into one electronic system. As a result of CAIRS, OMH staff will be able to spend more time on analysis and reporting, and less time on data management and processing of paper and manual follow-ups with providers. Time lags between the receipt of data and their availability for analysis will be eliminated, and incomplete data rates drastically reduced.

Use of Wireless Tablet PCs to Improve Patient Care

OMH is constantly reevaluating and piloting new technologies with the ultimate goal of improving patient care. Recently, OMH created the New York State Incident Management & Reporting System™ ℠ (NIMRS™ ℠) to replace the paper-based process and to facilitate the reporting, tracking, and analysis of incidents that endanger the safety and well being of patients. In a recent pilot project, NIMRS™ ℠ was successfully modified to run on Tablet PCs – wireless computers that allow a user to take notes using natural handwriting with a stylus or digital pen on a touch screen. OMH deployed Tablet PCs to State Psychiatric Center clinical staff responsible for managing incident reporting and investigations to help them to easily access NIMRS™ ℠ when they need it –

while dealing with the immediate aftermath of an incident.

Instead of recording findings onto paper that are later manually keyed into a computer database, clinicians and clinical risk managers can carry the Tablet PC into the examination room or ward to gather and record information. Mobile access to OMH's incident management and reporting system ensures that users efficiently and accurately collect incident findings and that incident information is saved as soon as it is collected. These data collection processes are designed to streamline the incident management workflow, facilitate incident investigations, and improve quality assurance by making a cumulative, real-time record of the incident management process available to management with the requisite security.

Other ways that OMH is using Tablet PCs to improve patient care include a pilot project with county mental health authorities where clinicians will carry Tablet PCs that contain ink-enabled assessment forms, and a calendaring function to help them coordinate services and create individual care plans for individuals living in the community who require intensive mental health services. The pilot will assess the utility of the Tablet PC and the ink-enabled assessments to facilitate care coordination by field-based clinicians.

Project Liberty

An example of data-driven program management is Project Liberty, New York's 9/11 mental health response program. As part of program implementation, OMH staff developed service encounter log forms that crisis counselors and outreach workers used to record basic data on each counseling or public education service they provided. The logs captured demographic information, the geographic location where the service was provided, the emotional, cognitive, and physical reactions to the trauma reported by consumers, and whether or not service referrals to other services were made. All data from the logs were incorporated into the OMH Data Warehouse and were used continuously to evaluate the success of the emergency mental health response effort and to fine-tune service delivery. Geomaps and other reports from the Data Warehouse portrayed the geographic penetration of the response effort (Figure 8-2), the racial and ethnic diversity of individuals and communities served, service volume by region and provider, the number of unique individuals served, and the mental health status of individuals over time.

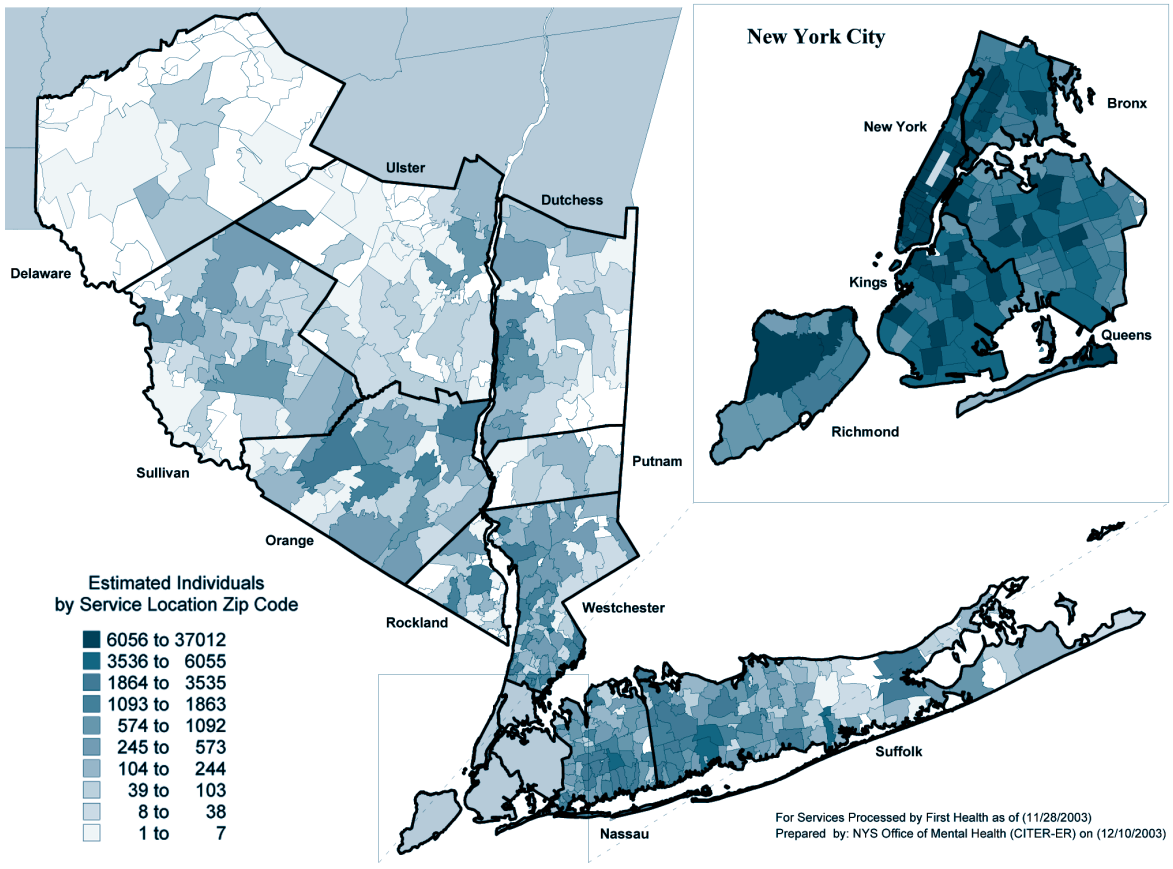
While geomapping was utilized significantly for Project Liberty, OMH has an ongoing commitment to its in-house geomapping capacity and to providing this type of data for planning and management purposes.

Project Liberty data represent the first systematic evaluation ever done on a FEMA-funded crisis counseling program. One important finding from the logs data was that approximately 50% of individuals encountered were experiencing persistent distress at levels that were interfering with their daily functioning. Using this information, OMH was able to gain permission from the Federal government to adapt Project Liberty's array of services to include evidence-based cognitive behavioral interventions with demonstrated efficacy in the treatment of trauma-related disorders. These adapted 'Enhanced Services' continue to be available for New York City schoolchildren.

This use of the OMH performance management system to monitor the 9/11 response has enabled these important positive changes in the Federal disaster response model, which is the first time that an expansion of crisis counseling services has been authorized under a FEMA grant. They will also benefit victims of future disasters, who will have a more complete array of disaster-related mental health services available to them.

Figure 8-2

Geomap Showing Individuals Served by Project Liberty, 2001-2003



CHAPTER 9

Adding to Our Knowledge Base: OMH Research

RESEARCH IN MENTAL HEALTH and the neurosciences is accelerating, and it continues to identify the potential for recovery where none had been expected or anticipated before. Studies of complex psychiatric disorders such as schizophrenia and bipolar disorder have led to effective community-based treatment and rehabilitation for thousands of individuals with mental illness previously relegated to long-term institutional care. Some people, however, do not benefit from currently available treatments, or they experience intolerable side effects. Recently, entire new classes of medications have been developed that offer renewed hope to those individuals and their families.

OMH researchers have been participants in numerous collaborative, multi-site clinical trials that have led to U.S.Food and Drug Administration (FDA) approval of new medications such as clozapine, risperidone, olanzapine, quetiapine and ziprasidone for schizophrenia; valproate for mania; fluoxetine, sertraline, paroxetine, fluvoxetine, citalpram and other "selective serotonin reuptake inhibitors" for depression and anxiety states; donezepil for Alzheimer's disease; and many others. Other new antipsychotics, mood stabilizers, antidepressants, antianxiolytics, and drugs to combat Alzheimer's disease are in the pipeline; some are still in early development, and others are expected to receive FDA approval soon, in part as a result of work by OMH researchers.

Along with this surge of progress in new treatments, major technological advances are occurring in brain imaging, molecular genetics, and neurobiology. New findings by OMH researchers have clarified crucial abnormalities of neurotransmitter levels, such as serotonin, in the brains of individuals at high risk for suicidal or violent behavior, and better case finding, intervention and treatment are now possible.Through major brain technology, neuroreceptors can now be visualized, and medications are being developed which are targeted to specific sites of brain action, providing new hope for treatments of major mental illness and of combined disabilities such as psychiatric disorders and alcoholism or substance abuse.

Parallel to this progress in neurobiological research, OMH clinical and services researchers are focusing on outcome studies to determine better methods of service delivery. There is now appreciation of the impor-

tance of psychiatric rehabilitation and of better partnerships with recipients at every stage in the process of treatment and recovery.

Mission and Goals of the OMH Research Division

The mission of OMH's Research Division is to develop better methods of prevention and treatment of serious and persistent mental illness. The research goals are to:

- Learn more about the causes of mental disabilities
- Evaluate the effectiveness of existing and emerging treatment methods
- Determine new and better models of service delivery which are planned with input from consumers and are culturally relevant
- Quickly and effectively disseminate the results of research findings to State and local clinicians, providers, recipients, families, and other stakeholders
- Make the expertise of research scientists available to practitioners in the OMH system through continuous education and consultation
- Delineate the magnitude of social cost and burden of mental disorders in order to prioritize utilization of resources

OMH research is performed primarily at two locations: Nathan S. Kline Institute (NKI) in Orangeburg New York and New York State Psychiatric Institute (NYSPI) in New York City. Evaluation research is conducted at OMH Central Office in Albany.

In addition, some research activities are carried out at other OMH facilities.

No research can be done without first receiving approval from the facility Institutional Review Board, which is in turn overseen by the Director of the Research Division, with the assistance of staff from the Research Foundation for Mental Hygiene, Inc.

Fields of Research

Examples of promising research currently underway at OMH include:

- Research in adolescent and childhood suicide has demonstrated a "contagion effect," leading to rapid spread of such incidents among those exposed to sensationalized media coverage; such research has led to the identification of preferable ways of responding to such events, in both the press and community at large. Other researchers in this field have developed a "Teen Screen," now utilized at 50 sites in 20 states, that promotes early intervention and suicide prevention strategies for adolescents identified as suffering with suicidal thoughts.
- Researchers who assessed New York City school children for effects of stress reactions stemming from the events of September 11, 2001, received substantial Federal funding to enhance assessment and treatment initiatives.
- Research in the basic biological mechanisms underlying adult suicide has led to the identification of a deficiency in a neurotransmitter (serotonin), which leads to a reduction in control of impulsivity, and thus a greater risk of acting

on the self-destructive impulses that may accompany depression. In the near future it may be possible to assess patients for this risk by a currently available type of brain imaging.

- Imaging research in schizophrenia has identified target areas of the brain responsible for the debilitating symptoms of cognitive and motivational impairment, and thus opened up the possibility of targeted treatments for them.

- Research on Alzheimer's disease has identified a likely basic mechanism underlying this disease—the accumulation of known offending proteins—by looking at animal and cell models. Potential treatment interventions designed to prevent the build-up of these proteins have also been identified.

Mental health research is ongoing in many different fields and areas. Those described below illustrate the wide scope of these focus areas, but are not meant to be an all-inclusive list of research projects underway.

Alzheimer's Disease and other Memory Disorders

Dementia, a syndrome characterized primarily by loss of memory for recent events, is a disorder that strikes late in life, robbing the elderly of what should be their "golden years." As present, 20% of persons over 85 years old suffer from dementia. As our population lives longer, it becomes increasingly important that we learn how to identify and treat dementia. Alzheimer's disease (AD) is by far the most common form of dementia among the elderly. Other common causes of dementia include vascular dementia and dementia due to Parkinson's disease. The OMH Research Division is making important headway in identifying risk factors and early indicators of AD, with the goal of being able to identify persons at risk and develop ways of preventing the emergence of full-blown dementia. For those who already have dementia, promising new treatments are being offered and rigorously evaluated for efficacy.

Anxiety Disorders

NYSPI's Anxiety Disorders Clinic continues to focus on the advancement of the understanding of the diagnosis, etiology and treatment of anxiety disorders. Efforts continue in the areas of panic disorder and agoraphobia, social phobia, obsessive-compulsive disorder, generalized anxiety disorder, hypochondriasis, post-traumatic stress disorder, neuropsychiatric sequelae of Lyme disease, mixed anxiety and depression, and cross-cultural studies. The Hispanic Treatment Program studies anxiety disorders in Latino/Latina patients.

In a joint effort, the Anxiety Disorders Clinic and the Biological Studies Unit anticipate funding of a proposal to study the optimal duration of paroxetine treatment of panic disorder. The goal is to determine the minimal length of treatment necessary to be able to successfully stop paroxetine treatment without substantial relapse.

The Psychophysiology Laboratory collaborates with staff from the Anxiety Disorders Clinic in studies of neurocognitive function in anxiety disorders.

Brain Imaging

Basic neuroimaging research focuses on the development and application of Magnetic Resonance Imaging (MRI) methods for the assessment of brain function, particularly in the application of MRI methodology to the study of schizophrenia and related brain disorders. Particular studies look at the mechanism of action of antipsychotic medications; others are meant to elucidate the role of antipsychotic drug therapy on brain structure and dopamine release, or look at the influence of stress and alcohol on developmental anatomy. Other projects involve using state of the art imaging in assessment of stroke.

Clinical neuroimaging research advances understanding of the causes and effective treatment of serious mental illnesses using state of the art methods for the structural and functional imaging of the human brain. Ongoing research spans multiple diagnostic entities, including schizophrenia, bipolar disorder, depression, dementia, HIV/AIDS and drug abuse. Additional investigations focus on understanding brain mechanisms among healthy individuals to help develop applications that will increase understanding of severe mental disorders and their treatments. Multiple studies now incorporate examination of treatments to help understand how new psychopharmacologic strategies may ameliorate brain dysfunction associated with mental illness.

Child Psychiatry

Located at NYSPI, the OMH Division of Child and Adolescent Psychiatry is the largest and most productive of all child research programs in the country. It plays a significant role in research training and currently provides mentored research career training opportunities for a large number of young scientists who hold career development awards from various branches of the National Institute of Health. It has long been a center for research on adolescent suicide and now holds grants from the National Institute of Mental Health (NIMH) and the Centers for Disease Control to explore different aspects of suicide prevention. The Division's Child Neuropsychiatry Unit is engaged in studies of the causes of behavior and learning difficulties that are common in very low birth weight children and into the causes and mechanisms of biologically determined conditions such as Tourettes disorder, Obsessive Compulsive Disorder and certain aspects of Attention Deficit Hypertensive Disorder (ADHD). A large, NIMH-funded project is investigating the specific pattern of development of conduct problems in Hispanic youth.

Much of the Division's resources are devoted to investigating new treatments. There are over 15 externally funded psychotherapy and psychopharmacological research projects. This research is facilitated by the Division's NIMH Child Psychiatry Intervention Research Center, one of only two such centers in the country. The Division has several other major centers, such as the Center for the Advancement of Children's Mental Health, focusing on translating scientific findings into clinical practice in settings such as child psychiatric inpatient and day treatment centers, school mental health clinics, and juvenile justice settings. These centers pursue a range of projects in direct collaboration with the OMH Division of Research, and in response to critical OMH research needs. Some of the prominent research areas include anxiety disorders, ADHD, treatment development and test-

ing, mood disorders and suicide, epidemiology and translating research into practice.

Depression and other Mood Disorders

NYSPI's Depression Evaluation Service (DES) is an outpatient research and treatment program in operation since 1977. The program is nationally recognized for its research in the treatment of depression and has received numerous NIMH grants. The major interest of DES continues to be identification of depressive subtypes, psychopharmacological approaches to treatment of dually diagnosed patients, and developing a better understanding of placebo response and spontaneous remission in depressive illness.

Numerous studies are underway at DES. In 1999, DES entered a Federally-funded collaboration with three other universities to study treatment-resistant depression. This is a five-year effort of unparalleled scope to develop systematic data to guide the treatment of patients who do not respond to the first treatment of depression.

The Late Life Depression Research Clinic specializes in the pharmacological treatment of depression in the elderly. Ongoing studies are examining the relationship between cerebrovascular disease and late-onset depression.

A research program on ECT was started in 1979 and continues to be recognized internationally for improving the understanding of the treatment, and for identifying the alterations in ECT technique that enhance efficacy, prevent relapse, and minimize adverse cognitive effects.

A salivary melatonin assay has been developed and is being tested as a possible aid in the diagnosis and treatment of Seasonal Affective Disorder (SAD). Several potential treatments for SAD are being studied, including post-awakening bright light therapy, dawn simulations, and high-intensity negative air ionization. Light therapy is being tested as an alternative to medication in women who become depressed during pregnancy.

Related research is ongoing in other NYSPI divisions including the Brain-Behavior Clinic, the Psychophysiology Laboratory and the Department of Communication Sciences, and the Research Assessment and Training Department.

Developmental Psychobiology

The Department of Developmental Psychobiology at NYSPI is studying effects of early life events on subsequent development. A central tenet of developmental psychobiology is that experiences of early life have effects lasting into adulthood. These effects can lead to altered responses to stress, increased or decreased risk of cardiovascular disease, and the shaping of emotional states.The search for mechanisms that underlie the transduction of early experiences is a focus of much of the work in this department.

Eating Disorders

The Clinical Psychopharmacology Department at NYSPI is conducting a controlled treatment study to compare the relative effectiveness of three treatments for women with bulimia nervosa: guided self-help,

antidepressant medication and guided self-help plus antidepressant medication, in a primary care setting. Additionally, a pilot study is examining the efficacy of cognitive behavioral therapy (CBT) plus antidepressant medication in adolescent girls with bulimia nervosa.

Other studies include a controlled study comparing the efficacy of CBT with or without antidepressant medication in preventing post-hospitalization relapse of anorexia nervosa; a controlled treatment study to determine the relative and additive efficacy of two contrasting treatments for women and men with binge eating disorder – standard group behavioral weight-control treatment and individual CBT and antidepressant medication; a collaborative study examining the disturbances of eating behavior in bulimia nervosa, binge eating disorder and anorexia nervosa; and a large scale study of risk factors for the range of eating disorders.

Epidemiology

NYSPI's Department of Clinical and Genetic Epidemiology was established in 1987 to gain an understanding of the rates and risk factors for mood and anxiety disorders and to apply these findings in order to develop and test empirically-based treatment and prevention interventions. The research program has projects ongoing in four areas: epidemiologic and high risk studies; family genetic studies; treatment efficacy studies; and health services studies.

Genetics

Since its inception in 1983, the goal of the Neurobehavioral Genetic Research Program at NKI has been to develop strategies for the identification of individual genes that shape complex phenotypes, and to create advanced genetic animal models of neurobehavioral disorders. Ongoing research includes genetics of the mesotelencephalic dopamine system, and genetics of alcohol preference.

At NYSPI, the Molecular Genetics Laboratory has expanded and continues its work on bipolar disorder. The search for genes that predispose individuals to panic disorder also continues, as does the search for genes for late onset Alzheimer's disease.

Geriatrics

The Late Life Depression Center was established at NYSPI in 1991 to study the phenomenology, biology, and treatment of depressed older adults. The Center is the only research clinic focusing on depression in the elderly in New York City, and is the lead site in the first multi-center study of treatment of depression in patients over 80 years of age.

A number of other studies related to older adults are also underway, including objective measures of functional impairments in daily living and their underlying neurophysiological mechanisms. This study is focusing on early changes in functioning in dementia, some of which may be subclinical, and on the relationship between subjective and objective aspects of disability.

Schizophrenia

NKI's Schizophrenia and Bipolar Disorder Research program focuses on assessment and effective treatment for patients diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder. Its cognitive neuroscience and schizophrenia research program focuses on determining the brain mechanisms underlying the cognitive deficits in chronic mental illnesses, and other programs aim to develop optimal treatment strategies for treatment-resistant schizophrenia and to determine the comparative efficacy of typical and selected atypical antipsychotic drugs. In addition, the program is involved in multi-center clinical trials of novel antipsychotic medications.

NYSPI's Clinical Research Center in Schizophrenia Studies has five cores: Administrative and Biostatics; Diagnosis and Treatment; Brain Imaging Research; Neurodevelopment and Genetic Epidemiology Research; and Genomics and Neurobiology Research.

Services Research

Services research works toward the development of outcome measures, cost/benefit comparisons, cost/offset studies, and comparisons of different mental health service delivery systems. Services research overlaps with clinical research, but is more focused on programs and systems.

For example, the OMH Central Office is coordinating a study of outcomes associated with New York's assisted outpatient treatment (AOT) initiative (See Chapter 5). The study is focusing on incidence of violent behaviors, arrests, victimization, homelessness, service utilization and hospitalization, medication and treatment adherence, violence risk assessment, clinical status, therapeutic alliance between recipients and service providers, recipient quality of life, and recipient perceptions of AOT.

The Center for the Study of Issues in Public Mental Health (CSIPMH) was established in 1993 at NKI and is supported by a grant from NIMH. Research studies aim to increase the general knowledge of how to organize, deliver, evaluate, and finance services for persons with severe mental disorders with major emphasis on the provision of relevant information for the development of effective mental health policy. The Center is a collaboration of researchers, planners, and policy makers from NKI, OMH, the Nelson A. Rockefeller College of Public Affairs and Policy of the University at Albany, and the Robert F. Wagner Graduate School of Public Service of New York University. In addition, research collaborations are ongoing with the Florida Mental Health Institute, the Muskie Institute of the University of Southern Maine, and the Mental Health Empowerment Project.

At NYSPI, the Department of Social Psychiatry is conducting a culturally-sensitive diagnostic interview research project; the Department of Child Psychiatry is conducting a variety of school based projects to assess the need for services in public schools and high schools; and the Center for Advancement of Children's Mental Health is examining different ways of making evidence-based treatment known to the professional community and to the public at large.

Substance Abuse

NKI is part of the Dual Diagnosis and Addiction program, which was established in 1987 and is one of the leading research and training programs in the nation. It includes an affiliated faculty of 32 at New York University, and it has six affiliated academic/clinical units. Research activities focus on family and peer support for substance abuse treatment, and integration of treatment for dually diagnosed mental illness and substance abuse.

NYSPI also has a number of projects underway looking at various aspects of substance abuse, including antecedents and consequences of substance abuse, medications development, imaging studies, drug dependence and dual diagnosis, alcohol dependence and the course of drug use disorders.

Violence

Work continues on the connection between psychosis and violent behaviors, and future research is planned that will focus on determining the clinical significance of epidemiological findings showing such a connection.The relationship between genetics and violent behavior in patients with schizophrenia is also being explored.

In addition to the above-listed areas of research, other fields in which research is underway include: analytical psychopharmacology, data management, movement disorders, neuroscience, personality studies, somatoform disorders, services research, statistical sciences and trauma. More information about OMH research and the research institutes, including more detailed information about ongoing research projects, is available online at the NKI Web site (http://www.rfmh.org/nki/) and the NYSPI Web site (http://www.nyspi.cpmc.columbia.edu/).

Future of Research

As clinical researchers continue to identify new treatments and interventions, sophisticated evaluation research will be necessary to assess their effectiveness. The continued success of providing mental health services in community settings requires research targeted specifically on identified challenges and on newly required skills. At the same time, ongoing research will continue the search for causes of major mental illness. Ongoing emphasis on research to improve treatment and services is an important part of OMH's quality agenda, and the agency continues to explore the application of new and existing technologies in local community systems of care.

CHAPTER 10

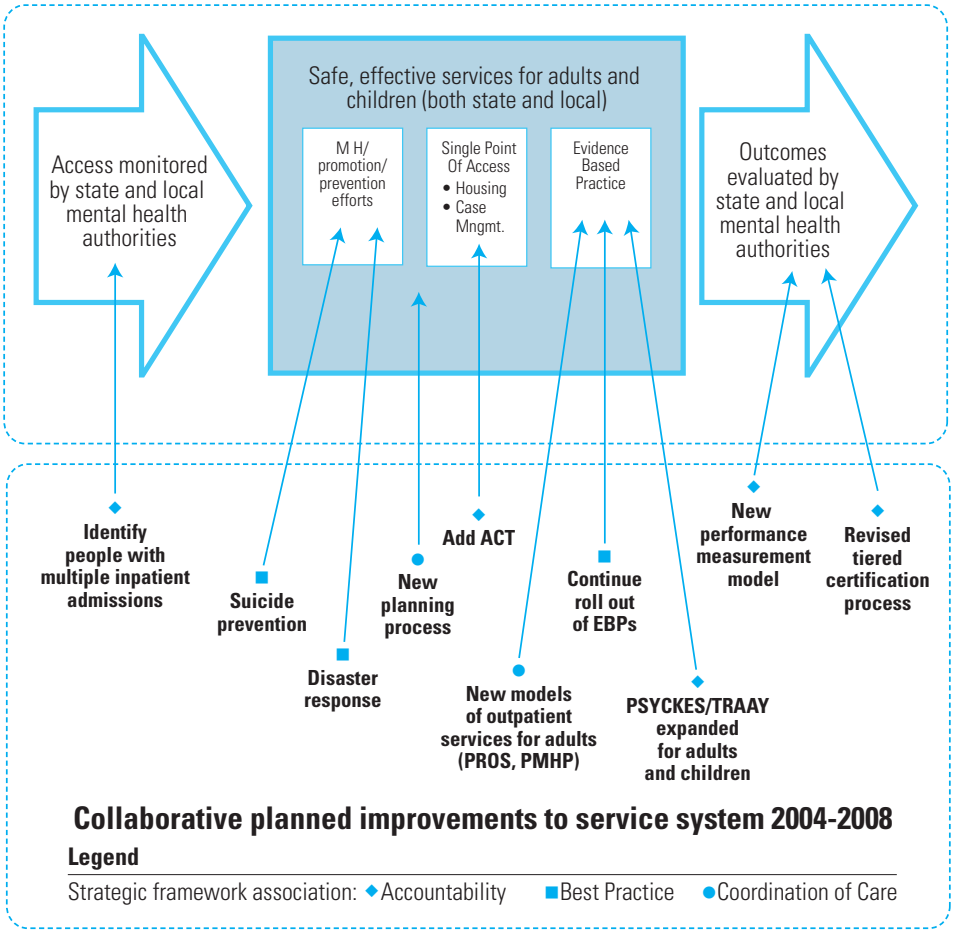
How Using the ABC's as a Strategic Planning Framework will Advance OMH's Quality Agenda

LOOKING TO THE FUTURE, the planning process will enable OMH to effectively carry out its primary functions of ensuring appropriate access to proven treatments for serious mental illness and promoting public mental health. The series of measurable actions that must be undertaken to meet these responsibilities will utilize our strategic planning framework – accountability for positive outcomes, use of evidence-based practices, and effective care coordination – the ABC's of mental health care. These actions must also take into account the primary role of the counties and New York City in planning and managing mental health services delivery, recognizing that:

- The vast majority of services for children and adults with mental health conditions are delivered in communities and overseen by county governments; and
- County governments also have responsibilities for public mental health promotion for citizens who live in their communities who do not have severe mental illness, but who nevertheless have needs for educational and preventative interventions, and/or mental health services.

Given these parameters, OMH is proposing a series of specific collaborative activities with county governments and stakeholders to take place during the 2004-2008 planning period, which are described in detail below. These activities will promote OMH's primary functions without compromising resources needed to address the challenges that have been identified in serving high priority population groups, nor will they diminish the importance of agency achievements in ongoing areas of responsibility. Figure 10-1 summarizes the relationships of these collaborative activities to the ABC's of mental health care strategic planning framework.

Figure 10-1
Overview of Current State and Local Mental Health Service Provision in New York State



Accountability

Improved Service System Performance

Over the past three years, OMH and the counties and New York City have made significant progress in establishing single point of access (SPOA) processes for adults and children. These referral and care coordination mechanisms enable people with the most serious service needs to access needed housing and case management services on a priority basis. Over the next five years, these SPOA systems will be modified so that:

1) Referrals to Assertive Community Treatment (ACT) teams are also made through the SPOA process.

2) County government mental health man-

agers are using the Child and Adolescent Integrated Reporting System (CAIRS) to routinely monitor access to services and service outcomes for individuals with intensive service needs.

The use of county-level mechanisms for ensuring access represents an important milestone in the development of statewide accountability for successful service system outcomes, particularly as they affect access to critical community support services. The SPOA process addresses the needs for individuals and their families, providers, and county governments to attend to the access issue. However, for OMH and the counties to fulfill their functions, a statewide performance measurement system that includes the capability to address access needs and capacity must also be in place.

OMH, in collaboration with the counties and stakeholders, will refine and fully implement its performance measurement system during the 2004-2008 planning period. As indicated in Chapter 4, this system will initially focus on performance related to access, utilization, appropriateness, outcomes, and costs for children and adults using inpatient services. During this period, actual performance information will be disseminated relating to both State-operated and local inpatient providers. As a priority focus, OMH will share information with county governments to help them engage in evaluating inpatient services delivered to an identified cohort of individuals who repeatedly use inpatient services over relatively short periods of time, without strong connections to community services.

Improved Service Provider Performance

Throughout the next five years, there is a need to further promote accountability by having a strengthened process for measuring the performance of licensed agencies and for ensuring that the service system has an appropriate, needs-driven balance of State and local facilities and services. While strengthening and revising the existing planning process, OMH will develop, with county governments and affected stakeholders, ways to transform some current approval and review processes associated with opening, closing or modifying licensed programs based on OMH's commitment to data-driven decision making. In addition, the existing tiered-certification process will be revised to allow for evaluation of compliance with licensing standards based on actual provider performance in the domains of access, utilization, appropriateness of care, outcomes, and cost. This new tiered-certification system will be developed in collaboration with county governments, the State's Medicaid authority, and stakeholder groups. While the new system is developing, existing provider performance using the current certification tiers will be displayed on the OMH Web site so that recipients, family members, and other stakeholders will have greater access to existing performance information.

During 2004-2008, OMH will also strengthen its efforts to provide county governments with effective new tools for assessing provider performance in engaging people in service. These efforts will require focused attention during routine program inspections to ensure that programs both employ culturally diverse and appropriate levels of staffing, and maintain hours of operation and outreach activities to ensure that individuals who need services have appropriate means of accessing them.

Improved Individual Clinician Performance

Given the scope and complexity of evidence-based interventions available to clinicians, and the extensive body of knowledge now available regarding best practices in the area of psychopharmacology, OMH will initiate a performance improvement action plan in this area. During this planning period, OMH will refine and utilize an important decision support tool for clinical prescribing practices in both State and local sectors. The Pharmacy Service and Clinical Knowledge Enhancement System (PSYCKES) decision support software enables individuals, providers, program managers, and State and local leadership to understand the range of medications prescribed, their relationship to best practice guidelines, and their course of effectiveness in treating the individual's health and mental health needs. PSYCKES will first be implemented for State Psychiatric Center inpatients, and then implemented for State Psychiatric Center outpatients. An assessment will also be made and plans developed regarding persons using Medicaid services who are seen through county-governmental auspices within the voluntary (including Article 28 hospitals) sector.

PSYCKES is designed to improve both the quality of clinical supervision and the individual clinician's ability to successfully serve individuals. It presently incorporates best practice standards for psychotropic medications for adults with schizophrenia. During the planning period PSYCKES will be modified to incorporate accepted prescribing practices for medications associated with other major adult mental illnesses and physical health care medication prescribing guidelines. It will eventually contain recommendations for children's medication services.

Best Practices

During the past three years, OMH's quality improvement agenda has promoted a cultural shift toward the use of evidence-based practices. The Winds of Change campaign described in this Plan will continue throughout 2004-2008, with planned implementation activities for adults in the areas of medication prescribing guidelines, ACT team operations, family psychoeducation pilot training projects in 21 provider agencies, several nationally-partnered wellness self-management pilots, and further refinement of work already in progress on supported employment, integrated treatment for dual disorders, trauma response, and self-help.

For children, OMH is continuing its major commitments to expansion of the Home and Community Based Services Waiver, school support projects, functional family therapy, Home Based Crisis Intervention services, and medication prescribing guidelines (treatment recommendations for the use of antipsychotics for aggressive youth [TRAAY]). The agency will also be adding to the base of nationally important services evaluation research by participating in multi-state, multi-site studies on parent empowerment strategies, screening for maternal depression, organizational readiness to accept implementation of best practices, investigation of how managed care companies address childhood depression, and how services research nationally can form a knowledge sharing and development network.

In the implementation of both adult and children's evidence-based practices, OMH will continue to utilize its nationally recognized planning matrix (Table 10-1), which emphasizes an incremental approach to structural and cultural changes through

Table 10-1
OMH Planning Matrix For Evidence-Based Practice Implementation

Change Strategies	PHASE I: Consensus Building	PHASE II: Enacting	PHASE III: Sustaining
AWARENESS: Encouragement and collaboration with stakeholders	Identify and use a network of champions from local government, stakeholders, and advising groups	Using formal consensus-building projects to create a set of evidence based demonstrations throughout the state (including Drake pilot sites)	Evaluate for widespread replication
EDUCATION: Introduction and development of new quality initiatives	Produce introductory materials, include national EBP toolkits and quality outcome measures	Develop several 'Centers for Excellence' for ongoing research and education	Secure permanent funding for 'Centers for Excellence' statewide
STRUCTURAL & CLINICAL IMPROVEMENT: Incorporation of quality measures into both individual practitioner and provider performance	Develop and test quality outcome measures using network of champions and demonstration sites	Develop fiscal and regulatory changes indicated during development and testing	Create a local level evaluative capacity to monitor performance against outcomes
CONTINUAL IMPROVEMENT & SUPPORT: Monitoring of the quality measures and means for continuous upgrading	Use existing progress report structure to 'test' an initial series of performance reviews in selected EBP areas	Use performance data in selected EBP areas to make regulatory and funding decisions	Periodically revisit consensus building stages to identify and promote innovations

public awareness, education of key stakeholders and providers, changes in funding and licensure mechanisms to allow practice modifications to occur, and continual quality improvement based on performance feedback. This framework will also be employed for the agency's emerging areas of interest in new, promising "best practices" – suicide prevention, eating disorders, and public resiliency as a method of coping with and responding to disaster.

During 2004-2008, OMH will also undertake specific activities with county governments and provider groups on three foundational topics necessary for a cultural acceptance of the shift to science-based practice. These topics are: adoption of a continuous quality improvement process within provider agencies; a diverse and skilled workforce capable of effective engagement and building sustained, trusting relationships; and ongoing clinical

supervision. During OMH's planning forums with county governments, specific strategies will be discussed to marshall existing resources for technical assistance and support in these areas.

Coordination Of Care

The stakeholder comments included in Chapter 2 regarding the existing planning process and needed improvements contained several important recommendations that are the focus of OMH's plans for the next five years.

A Revised Planning Process

OMH's efforts to ensure more effective coordination of care will be strengthened by a shift to population-based planning. This will promote focused attention on care coordination across disability groups (e.g., people with mental illness and mental retardation or substance abuse), State agency lines, and age group distinctions (children to youth, youth to adult, adult to senior citizen). At a systems level, OMH is currently engaged in collaborative planning activities concerning Medicaid clients who use mental health services both within our formal system of care and within New York State's health and human service system as a whole.

OMH is also part of the multi-agency planning process for integration of all people with disabilities into the most integrated settings within their own communities of care. At a county level, work is already underway to address the needs of people who use multiple interagency services because of their involvement with the criminal justice system. Children's services in New York State have had a significant history of multi-agency collaboration at both State and local levels. During this planning period, a similar multi-agency focus will begin for adults, starting with individuals who use both mental health and substance abuse services.

A Revised System of Outpatient Care

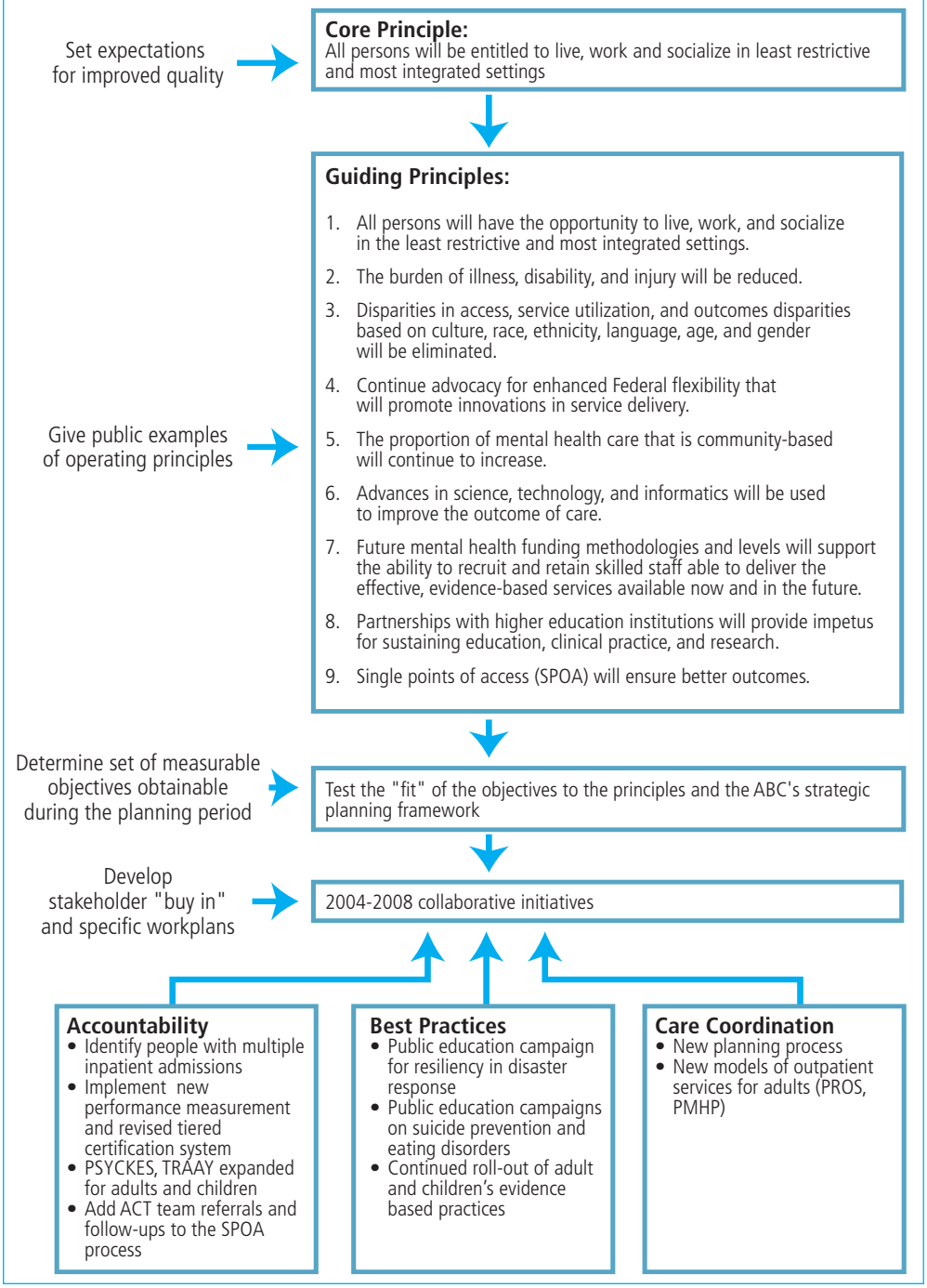
Since 2000, OMH has made significant strides in improving access to both case management and housing services. During 2004-2008, OMH will further refine its community-based programs to provide a more comprehensive and person-centered approach to service delivery, beginning with the integration of treatment, rehabilitation, and other community support services in the newly established Personalized Recovery Oriented Services (PROS, see Chapter 5) and an improved program focus for the State-operated Prepaid Mental Health Plan (PMHP) programs. OMH will engage in collaborative planning discussions with local governments, stakeholders, and relevant State agencies on ways to more thoroughly integrate both case management and health care services into an individualized service planning process (ISP). We will concurrently explore flexible financing methods so that individual funding is "wrapped around" a comprehensive ISP. This concept of integrated service delivery is consistent with one of the major recommendations of the President's New Freedom Commission on Mental Health, and is strongly indicated by research as the most efficient method of insuring sustainable community tenure.

Summary

Throughout this 2004-2008 Statewide Comprehensive Plan for Mental Health

Figure 10-2

Advancing the Quality Agenda During 2004-2008



Chapter 10

How Using the ABCs as a Strategic Planning Framework will Advance OMH's Quality Agenda

Services, OMH has stressed the significance of a shift in policy and culture toward continuous quality improvement.

The quality improvement agenda is the theme for this planning period because without it the State will be unable to determine the degree to which people using public mental health services are benefiting from these interventions. As summarized in Figure 10-2, in this Plan OMH has articulated a shared vision of community integration for people who use mental health services, a set of guiding principles that can shape both public planning and participation, an ongoing reliance on the ABC's construct to guide strategic planning, and a strong set of 2004-2008 collaborative initiatives designed to significantly advance the quality of public mental health services in New York State.

All of these broad-based, system-improving activities cut across State and local sectors, include all auspices OMH funds or licenses, address all population groups, have measurable outcomes associated with their implementation, and are in addition to the population or sector specific activities described elsewhere in this Plan. Outcome measures for each activity will be the basis for progress reporting, which OMH will share in Web-based updates that will describe the agency as it fulfills its commitment to improve the quality of New York State's public mental health system through accountability, best practices, and coordination of care.

During 2004-2008, OMH's major lines of business will see the following improvements.

For OMH's direct service and regulatory oversight responsibilities there will be:

- A performance measurement system in place with initial emphasis on inpatient indicators.
- A new tiered-certification system based on performance measurement.
- Continued implementation of adult and child evidence-based practices.
- A planned phase in of community-based program reforms.
- A new local planning process.
- PSYCKES, a major piece of decision-support software, will be available for evaluating medication prescribing practices.

For OMH's role as the State leader in basic and applied research there will be:

- Additions to the body of research knowledge on child and adult evidence-based service interventions and contributions to research in the areas of disaster response and suicide prevention.

For OMH's role in promoting positive mental health through education and advocacy there will be:

- Major public education campaigns in the areas of suicide prevention, eating disorders, and disaster response.

2004-2008

New York State
Office of Mental Health
Statewide Comprehensive Plan
for Mental Health Services

Appendix

New York State
George E. Pataki, Governor

Office of Mental Health
Sharon E. Carpinello, RN, PhD, Acting Commissioner

Table of Contents

Cultural Competence

President's New Freedom Commission on Mental Health

Achieving the Promise: Transforming Mental Health Care in America

Goals: In a Transformed Mental Health System

Goal 1
Americans Understand that Mental Health Is Essential to Overall Health.

Goal 2
Mental Health Care Is Consumer and Family Driven.

Goal 3
Disparities in Mental Health Services Are Eliminated.

Goal 4
Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.

Goal 5
Excellent Mental Health Care Is Delivered and Research Is Accelerated.

Goal 6
Technology Is Used to Access Mental Health Care and Information.

The Surgeon General's report on Culture, Race, and Ethnicity in Mental Health can be accessed on the Internet at http://www.surgeongeneral.gov/library/mentalhealth/cre/

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care can be accessed on the Internet at http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf

Cultural Competence, Evidence-Based Practices and Planning Fact Sheet

What is Cultural Competence?

Cultural competence is provision of effective and respectful care that is compatible with the cultural health and mental health beliefs, practices and languages of the people receiving services.

Cultural Competence occurs when, "Knowledge information and data about individuals and groups is integrated and transformed into clinical standards, skills, service approaches, techniques and marketing programs that match the individual's culture and increase both the quality and appropriateness of health care and health outcomes." (Davis, 1997)

Cultural competence:

- Is a continual developmental process to provide culturally relevant services.
- Promotes treatment that is community based, consumer driven and family oriented.
- Addresses access to mental health services, cultural adaptation of services and equity in service benefit.
- Is an active process to encourage mental health treatment and services that are effective across cultures.
- Is integrated throughout the service delivery system-needs assessment, information exchange, service design and development, hiring practices, staff development and supervision, outcome measurement, policy and governance.

Why Cultural Competence?

"…culture bears upon whether people even seek help in the first place, what types of help they seek, what coping styles and social supports they have and how much stigma they attach to mental illness." DHHS, 2001

- Mental illnesses are real, disabling conditions affecting all populations, regardless of race or ethnicity.
- Disparities impose a greater disability burden for minority populations.
- Language barriers exist.
- Misunderstanding expressions of distress occur.
- Stigma, mistrust and discrimination are pervasive.
- There is lack of information about mental health services and recovery available at the community level.
- Minorities are under represented in the scientific literature underpinning much of the current mental health system.

Cultural Considerations:

Ethnicity, age, gender, primary language, spiritual practices, English proficiency, literacy levels, geographic location, sexual orientation, education, employment, income, immigration status, country of origin, physical limitations or disabilities, and criminal justice involvement.

Maintaining the Asking Stance:

- What is the service intent?
- What are the cultural norms and values of the person, family and community who is being served?
- Is there evidence services are effective across cultural groups?
- Are there disparities?
- What can be done differently to reach people based upon information from and about the community?
- How can community data be utilized to plan for the future?

Planning Guides To Incorporate Cultural Competence…

Domains to Guide Planning: Needs Assessment; Information Exchange; Services Design, Development and Delivery; Human Resources; Policy and Governance; Outcomes

- Develop a written strategic plan to address disparities.
- Know and understand the various cultural groups present in the community served.
- Recruit and retain a diverse staff that are representative of the community.
- Plan to include readily accessible bilingual/bicultural staff or translators.
- Provide language assistance at all points of contact as needed.
- Provide translated vital service documents, program documents, and rights and grievance information.
- Provide ongoing training about the cultural groups served and assure strategies employed are effective across cultures.
- Include assessment of cross-cultural interactions as part of the employee evaluation and supervisory processes.
- Consider various methods and media for mental health information exchange and education and promotion.
- Adapt service environments, practices and delivery to match the individuals and families served.
- Collect demographic data about the community at large and service recipients to determine future directions for program development.
- Develop partnerships with community leaders, cultural brokers and natural networks to facilitate increased service access and to provide feedback that will guide service design.
- Examine agency and individual outcomes to determine whether specific groups within the service population are over or under represented, to track consumer satisfaction, and to promote consumer driven services.

Bridging Cultural Competence and Evidence-Based Practices

- Cultural Competence activities need to be imbedded within all stages of development, implementation and evaluation of evidence-based practices.
- Readiness for implementation needs to include skill development and policy guidance to ensure clinical and administrative practices are responsive to the diversity of the population served.
- Assess the effectiveness of evidence-based practices across cultural groups.
- Continue to build the evidence base for strategies demonstrated to be effective for everyone receiving the service.
- Disseminate and share "what works."

For additional information and assistance, contact:

Cathy Cave
Cultural Competence Coordinator
44 Holland Avenue
Albany, New York 12229

Phone: (518) 408-2026
Fax: (518) 473-7926

Local Input to the Statewide Planning Process

OMH is fortunate to have on-going dialogue with the Conference of Local Mental Hygiene Directors (CLMHD), the individual county and New York City Mental Hygiene Directors, and several advisory groups, who collectively represent a broad range of perspectives that form the foundation of the comprehensive statewide plan. Appendix 2 provides an overview of the input received from these groups and other mental health stakeholders. It includes:

- A summary of the OMH sponsored dialogues held in June and December of 2002 that examined dissemination of evidence-based practices as regards issues related to children and families, community integration of individuals with mental health conditions and work opportunities for those individuals, and cultural differences and cultural competence in mental health treatment; (Appendix 2-1)
- The 8/13/03 letter from OMH and CLMHD announcing the beginning of a new, strengthened State/local planning process and requesting plans and input from local governments for inclusion in the 2003-2008 plan; (Appendix 2-2)
- The letter of 7/21/03 from Mental Health Services Council (MHSC) Chairman, Dr. Barry B. Perlman, which contains input regarding Statewide Goals and Objectives from MHSC, providing the foundation of local and State planning efforts; (Appendix 2-3)
- A summary of 6/13/03 testimony presented at a MHSC hearing held in New York City on the mental health planning process; (Appendix 2-4)
- A summary of the comments received by OMH from hearings held on the 2002-2006 Statewide Comprehensive Plan for Mental Health Services; (Appendix 2-5)
- The 9/12/03 letter prepared by the Mental Health Planning Advisory Committee providing comments on OMH's application for federal Community Mental Health Block Grant Funds; (Appendix 2-6) and
- The authorization, purpose, and members of the major OMH advisory committees:
  - The Multicultural Advisory Committee (MAC) (Appendix 2-7)
  - The Recipient Advisory Committee (RAC) (Appendix 2-8)
  - The Mental Health Services Council (Appendix 2-9)
  - The Mental Health Planning Advisory Council (Appendix 2-10)
  - Commissioner's Committee for Families (Appendix 2-11)
  - New York State Suicide Prevention Council (Appendix 2-12)
- An 11/14/03 letter from the Association of Boards of Visitors of New York State Facilities for the Mentally Disabled inviting OMH to their February 2004 Executive Board meeting and planning session; (Appendix 2-13)
- An 11/7/03 letter from the Tioga County Department of Mental Health that presents the 10-County Finger Lakes Counties submission for this 5.07 plan detailing areas of concern and common need for these 10 counties. (Appendix 2-14)

Summary of Dialogues: Implications and Future Directions

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Introduction

This paper will review several recent reports on the quality of the United States healthcare and mental health systems, and will summarize highlights of the four Dialogue Groups the New York Office of Mental Health (OMH) held between June and December of 2002. These groups were held as part of the *Winds of Change* campaign under way in New York State. *Winds of Change* is a broad-based effort focused on expanding implementation of evidence based practices throughout the state. Key researchers and administrators responsible for the initiative have not only publicized it through a media campaign but have also documented it for the academic community in numerous articles written and published over the past few years.[1]

This paper will focus, as did the dialogues, on the potential for implementation in the mental health system of some of the quality initiatives that are proposed for or under way in the larger healthcare system, and will conclude with implications for future directions in the New York State mental health system and in other systems across the country.

Recent Reports Have Proposed Visions of Transformed Healthcare Systems

Three recent reports, all completed since 1999, have analyzed the state of our health and mental healthcare systems; while each, of course, has its own themes and conclusions, they share a key area of agreement, namely that those systems are in need of major improvement. The earliest of these, *Mental Health: A Report of the Surgeon General*[2], describes the tremendous advances that have been made in understanding disorders of the brain and in developing effective methods for treating them, while acknowledging that the service system does not always meet the needs of those with the most severe illnesses. The other two reports, that of the Institute of Medicine (IOM), *Crossing the Quality Chasm: A New Health System for the 21st Century* [3], and that of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* [4], focus more explicitly and in greater detail on the deficits of, respectively, our current healthcare and mental healthcare delivery systems. Both conclude that those systems are "in need of fundamental change,"[5] and each offers a vision of a new system. As the first page of the IOM report emphasizes,

> Health care today harms too frequently and routinely fails to deliver its potential benefits . . . Between the health care we have and the care we could have lies not just a gap, but a chasm.[6]

The Institute of Medicine report proposes six "aims for improvement" in, or fundamental goals of, the healthcare system, namely that healthcare should be:

- Safe
- Effective
- Patient-centered
- Timely
- Efficient and
- Equitable

It goes on to suggest as the single, overarching purpose of the healthcare system that,

> All health care organizations, professional groups, and private and public purchasers should adopt as their explicit purpose to continually reduce the burden of illness, injury and disability, and to improve the health and functioning of the people of the United States[7].

The New Freedom Commission makes a parallel case that,

> More individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs. . . To improve access to quality care and services, the Commission recommends fundamentally transforming how mental health care is delivered in America.[8]

and offers the following vision:

> . . . a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community.[9]

Consistent with New York State's overall goals for its mental health system, the New Freedom Commission suggests that,

> Successfully transforming the mental health service delivery system rests on two principles: First, services and treatments must be consumer and family centered, geared to give consumers real and meaningful choices about treatment options and providers – not oriented to the requirements of bureaucracies. Second, care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.[10]

New York is Moving Forward

At nearly the same time the President's New Freedom Commission on Mental Health was conducting its series of meetings (June 2002 through March 2003), in which it heard from diverse stakeholders in the national mental healthcare system, New York State's Office of Mental Health (OMH) held a series of four Dialogues, each with about 35 participants (June through December 2002). The President's charge to his Commission was to "study the problems and gaps in the mental health system and make concrete recommendations for immediate improvements that the Federal government, State governments, local agencies, as well as public and private health care providers, can implement."[11] Similarly, OMH was embarked on a mission to promote Accountability, Best Practices and Coordination throughout New York State's mental health system, which serves approximately 400,000 adults and 100,000 children and adolescents each year within more than 2,500 mental health programs. In order to advance this process, OMH brought together groups of experienced and knowledgeable individuals, ranging from consumers to providers and administrators to researchers, seeking the best ways of adapting some of the ideas in *Crossing the Quality Chasm* to mental healthcare in New York. While the goals of this paper are to summarize the content of the four dialogues and to draw out of them recommendations and implications for future directions, it is important to provide a brief context for this effort.

The *Winds of Change* Initiative

At a Best Practices Conference that took place in Brooklyn, New York, in June 2001, OMH introduced its multifaceted *Winds of Change* Initiative, a campaign whose goal was to create an environment of quality through the introduction of evidence-based practices (EBPs) into routine mental health settings. The campaign included media presentations and educational materials designed to acquaint various audiences with the science base underlying the practices known to be effective for children and adults. Recognizing the challenge inherent in implementation of any new vision, *Winds of Change* included three phases: consensus building, enacting and sustaining. The four dialogues among OMH senior administrators, experts and stakeholders, including consumers and family members, constituted part of the consensus building stage.

Each dialogue included about 35 individuals. Each group watched a videotape of an hour-long presentation that Donald Berwick, M.D., President and CEO of the Institute for Healthcare Improvement, had given on December 11, 2001. In the video Berwick, who was a member of the Committee on Quality of Health Care in America, interprets and applies the findings and recommendations of its report, *Crossing the Quality Chasm*. Thus, each dialogue group began its work with a common grounding in a vision and a set of principles summarized by Berwick's title, *Every Single One*. That title points to the obligation of the provider, and ultimately of the larger service system, to recognize, know, treat and follow every individual person whom they are responsible for serving. It also suggests the need to provide every individual with access to the service system.

Berwick presents the ten "rules" that *Crossing the Quality Chasm* admonishes purchasers, providers, clinicians and patients to follow.[12] Because they were central to the dialogues, it is worth listing them:

1. Care should be based on continuous healing relationships: patients should receive care whenever they need it and in many forms, not just face-to-face visits;
2. The system of care should be standardized, but have the capacity for customization based on patient needs and values;
3. The patient is the source of control: the health system should be able to accommodate differences in patient preferences;
4. There should be shared knowledge and the free flow of information between clinicians and patients;
5. Decision making should be based on evidence;
6. Safety should be a priority of the system;
7. There should be transparency in the system: patients and their families should receive information that allows them to make informed decisions about where they receive care and what treatment they receive;
8. The health system should anticipate patient needs;
9. The health system should not waste resources or patient time; and
10. Clinicians and institutions should actively cooperate to exchange information and coordinate care.

It is important to note here that since each dialogue lasted for one to one and one-half days, and had dozens of participants, this document will not attempt to summarize the full range of the discussions that took place. Nor will it, for lack of space, enumerate all the valuable insights and illustrations participants offered. The paper will select highlights from each dialogue, try to sew together some of the threads of the discussions, and focus on promising ideas that might help improve the quality of the system. Although the groups were not asked to achieve consensus, in some cases there was apparent agreement among the participants. Nonetheless, while there were innumerable provocative questions raised, relatively few were answered.

The Dialogues

New York State's Office of Mental Health sponsored the four dialogues as a way of bringing outside experts together with the system's senior administrators, advocates and providers. Since the goal of the dialogues was for the assembled stakeholders to offer advice to OMH on its current initiatives, particularly *Winds of Change*, the four dialogues examined dissemination of evidence based practices in different components of the system. The first focused on the integration into the community of individuals with mental health conditions; the second concen-

trated on creating work opportunities for those individuals; the third examined issues related to children and families; and the fourth discussed cultural differences and cultural competence in mental health treatment.

Dialogue One

The first dialogue took place on June 3, 2002, on the topic, "Dissemination of Evidence-Based Practices, Community Integration: Every Single One." The group addressed integration into the community of individuals with mental health conditions, framing its discussion by referring to several of the new "rules" proposed in *Crossing the Quality Chasm* and listed above. Specifically, the conversation focused on the expectations that care is based on continuous healing relationships; that care is customized based on patient needs and values; and that the patient is the source of control. Frequent reference was made to other rules as well.

Cultivating "champions"
It may be useful, in the short run, for the state to seek out and develop individuals or sites that have a "felt need" and therefore are prepared to make the changes necessary for the adoption of EBPs and the new rules. These "champions" should, perhaps, receive additional funding, consultation and supervision on the new practices, the goal being for these individuals to help the new practices become more widespread and have a broader impact. Dialogue participants pointed out that there are a number of quandaries associated with this approach: on the one hand, without extra support, clinicians usually will lack the time to learn enough about EBPs to put them into action; on the other hand, the state's message will ultimately be that use of EBPs is not something "extra" or "special," but rather is the new (and universally required) way of doing business. Finally, it is important that providers not hear any implication that they are not working or trying hard enough. Many, especially direct care staff, are paid little and stretched thin, and provider agencies cannot be expected to transform themselves without adequate resources. Thus the fundamental challenge is how to find ways to incentivize and thereby spread the desired practices in order to achieve the system's new goals.

"True North": Should policy provide "directions" or a "map"?
A key concept that was discussed in Dialogue One at some length, both explicitly and implicitly, was whether policy makers should be giving providers *directions* or merely a *road map*, that is, how detailed should the state be in its prescriptions and requirements? Berwick points often to the concept of "every single one" as "true north," meaning that it is the unfailing *direction* toward which every effort must point. (In mental health, to reiterate the New Freedom Commission's point, "true north" is services that are consumer and family centered, and that facilitate recovery.) Several in the dialogue group discussed the extent to which local service providers should be regulated and how detailed the regulations should be. It was suggested that expectations of change can and should be embedded in policies and regulations promulgated by the state agency, and indeed, that this is already being done in some cases. The challenge, of course, is to develop oversight methods that can reliably determine whether providers are in fact moving in the right direction, toward "true North."

We do not have EBPs for treating all clients
In the spirit of "every single one," consideration must also be given to the clients in any clinic who are not seriously mentally ill, and/or for who there are no appropriate EBPs. Until we have a broader base of evidence, we will have to supplement EBPs with promising practices.

Implications of consumer control in relation to EBPs
The concept of consumer control also contains within it certain contradictions. For example, what control do consumers actually have over their own treatment if a clinic uses EBPs to treat specific diagnoses or behaviors? What "choice" do people have from among the limited number of EBPs currently available? Also, if the universe of programs includes some that are consumer-run, are those held to the same standards as other programs are?

As EBPs are promulgated more widely clinicians will find that the same treatments work differently for different individuals. Satisfaction, functionality and symptoms do not necessarily vary together, in the same direction, at the same time. One guiding principle is that when a decision needs to be made as to which of the three dimensions should receive priority for a particular consumer, it is that consumer, rather than the provider, who should decide. Provider organizations, that is, must understand that services are offered to meet the needs of consumers, not to meet the needs of clinicians. They must never forget that "true north" is consumer centered services that focus on recovery and hope.

Developing a provider culture that values data and is transparent
The culture of provider agencies needs to support the use of data in decision-making; lacking this attitude, organizations will not "learn" or adapt to new requirements and realities. The goal of transparency probably also requires an organization that values the use of data, because in such an organization consumers are more likely to be given information that will help them choose the course of treatment that will best help them realize their goals. On the other hand, there may be a conflict between the value of transparency and the recovery goal of encouraging hopefulness, since consumers may find it discouraging to learn in detail what providers think, or what the evidence suggests, about their situations.

Training issues
Academic institutions need to be training professionals and paraprofessionals to work under the new rules, in a changed culture. Public agencies can help move state universities in this direction.

Partners in Care
Participants in this dialogue discussed at some length the Partners in Care (PIC) demonstration project,[13] a trial conducted from 1995 to 2000 in 46 primary care clinics within six managed care plans in five states. Designed to improve the quality of care for depression in such practices, PIC evaluated two quality-improvement (QI) programs that were based on previous suc-

cessful collaborative care interventions, and that cost about the same amount to implement. The two programs shared many common materials, but had different supplemental resources. One program directed resources toward supporting medication treatment, the other toward supporting psychotherapy. Both programs encouraged providers to consider patient treatment preferences in choosing a treatment plan. The quality-improvement programs significantly increased the rates of counseling and appropriate use of antidepressant medication. In addition, more of the patients in the quality-improvement programs remained in the workforce after one year than did their counterparts who were receiving care as usual.

One of the study's investigators participated in the dialogue and commented on its relevance to change in the New York system. He suggested, for example, developing a training protocol and a resource library that would help people adapt practices to local needs. At the same time, he recommended against micromanaging the process, noting that it is the local practitioners, who are on the scene, who know what the needs are.

Resources for evaluation of new policies and processes
Finally, the participants in this dialogue noted the importance of setting aside resources for evaluation of adaptations to the system, so that policies as well as practices can be based on evidence.

Dialogue Two

The focus of the second dialogue, which took place on July 12, 2002, was "Community Integration: Creating Successful and Satisfying Work Opportunities for 'Every Single One.'" Following are some of the highlights of the discussion, in which there was substantial agreement expressed about several issues:

Recovery is not linear and consumers are not a homogeneous group
A number of participants expressed the critical notion that recovery is a process, rather than an end state; this concept has significant ramifications for program planning and development, among which is the fact that people receiving psychiatric services are by no means a homogeneous group. This recognition increases the challenge of addressing "every single one."

Integration into the mainstream is a primary element of recovery
Most consumers of mental health services want to engage in meaningful activity that integrates them into the mainstream of the society. Numerous dialogue participants reinforced the notion that if the system is focused on recovery, and the expectation is that everyone can recover, then help with employment must be a central component of services. Yet, if the system is to serve "every single one," it must recognize that employment is not an appropriate goal for every client at every moment; for example, some individuals with serious mental illness are parents, and their caretaking role offers meaningful and productive activity.

Is work an intervention or an outcome?
For all of us as citizens of our society, work may be both the means to an end (for example, having money, transportation, housing, a way of connecting with others) and an end in itself. Similarly, for consumers in the mental health system, employment may be seen as an intervention, or as an outcome, or both.

Supported employment as an EBP
Randomized clinical trials have shown that supported employment is the most effective intervention available to help people reach their work goals. Consumers also need help to keep their jobs once they are in them. Elements of supported employment (such as job coaches) may create an artificial environment, but that is not inherently problematic; our society has many artificial environments, such as colleges and nursing homes. What we need, however, are effective ways for people to transition from one environment to another.

Meaningful choices
Consumers are constantly making choices; the challenge for providers is to keep helping each consumer reevaluate his or her options. At the macro level, the wide variety of available programs may seem to offer choice. The extent of choice may be more apparent than real, however, because each consumer is likely to develop a relationship with one provider, and that provider probably offers a relatively narrow range of programs. Making a decision to find a new provider may be like facing a divorce, as one of the participants noted. It is important to remember, though, as another observed, that underneath choice lies the fundamental value of hope.

Lack of knowledge about work
About 60 percent of people experience the initial onset of mental illness when they are between 17 and 22 years old and have therefore never really experienced work. Thus, they may not have a meaningful idea of what the world of work is like, even as they say that they want to participate in it. To achieve greater success, supported employment and training programs may need to assess and supplement consumers' previous experience.

Taking risks and facing fears
To enter the work force requires that people take risks and face fears. About 30 percent of consumers have never been in a competitive work environment, and the other 70 percent may have had dramatic, even humiliating, failures in work related environments. In addition, the vast majority of mental health consumers say they do not want to disclose their illness in the workplace. Services therefore may need to help people understand the risks they face and cope with their fears.

Train and place or place and train
One participant noted that some years ago, in the field of supported employment, there was a "battle" between so-called "train and place" programs and those that "place and train." The latter programs help people find jobs and then provide them with the training they need to meet the requirements of those jobs. In "train and place" programs, the reverse is true: clients receive training first, and then are helped to find employment. Medicaid reimburses only for "train and place," and other insurance will not pay for either type. Providers need to know how to develop and define their programs to meet Medicaid's requirements.

Cognitive assessment
As one participant observed, studies of people receiving psychiatric rehabilitation services show that their clinical symptoms do not play a significant role in their ability to benefit from those services, or in their ability to live independently and work. However some individuals, especially those with schizophrenia, experience cognitive impairments which may necessitate assistance in the form of cognitive skills training or cognitive rehabilitation. There was a difference of opinion among the group concerning the value of assessing cognitive deficits when consumers enter employment programs. On the one hand, some argue that before an individual is placed in a job a thorough assessment should be done to determine any cognitive deficits, while others suggest that the individual should be presented with a job description and asked what tasks required by the position might cause problems. Still others, however, were concerned that this approach might become part of the "hunt for pathology," the return to a focus on deficits rather than strengths.

Staff
Participants raised a number of concerns about staff, both professional and paraprofessional. One noted that social workers leave their training wanting to do "intra-psychic exploration types of things," but are immediately confronted with the requirement that they engage in EBPs, which creates a "disconnect." In addition, requiring that experienced staff change what they have been doing for many years implies that they have been doing something wrong, which raises their levels of fear. Case managers, who would theoretically be responsible in many instances for presenting clients with their options or choices, lack the training to carry out that responsibility. Perhaps, one participant suggested, we need to develop, teach and promulgate "evidence based process," defining and modeling activities such as engaging in a relationship, teaching specific skills, coaching and "inspiring."

Responsibilities of the mental health system
Several participants in this dialogue expressed concerns about the public image of the mental health system and its responsibilities to the larger society, the taxpayer, and its consumers. Since every state's mental health authority constitutes one of its largest budget items, it is essential that its efforts and its image are, as one said, "congruent with society's values." Encouraging consumers to engage in paid work is congruent with those values, while encouraging them to "do whatever they want to do" (e.g., spend time in clubhouses or reading in the public library, as other speakers had noted as options) is not.

Setting targets
In response to one administrator's proposal that OMH consider establishing a target requiring an increase in the level of employment, another participant warned that the clear message such a target sends also brings unintended outcomes. For example, if an employment target is set, without the inclusion of other types of productive activity such as parenting, then the individuals for whom employment is impossible, many of whom may already be ignored by the system, will be ignored even more. Another speaker noted that while it is easy to write a regulation requiring that a certain proportion of clients need to be place, it is very hard to write regulations defining how to talk to and engage clients.

Dialogue Three

Dialogue Three took place on October 7, 2002. Its focus was "Every Single Child." Highlights of the discussion included the following.

Using Evidence Based Practices
While the evidence base is stronger for adults than for children, there is considerable support for certain treatment models, including functional family therapy, multi-systemic therapy and therapeutic foster care. Research is being done on integrated implementation of these models. The group debated at some length whether it is more important for clinicians to achieve fidelity in implementing EBPs, or whether they should be encouraged to be flexible in their implementation. Fidelity is especially important if one wants to measure outcomes, but it may be impossible to achieve with some populations or in some settings, and it may also be very expensive. One important question is whether it may be possible to identify the key techniques or competencies involved in certain EBPs and train clinicians to use those, while allowing for family choice and clinician flexibility.

Providers and families do not share common expectations
Several participants noted that parents often do not know their child's diagnosis, or what to expect from treatment. What families want, and what they experience, may differ significantly from what clinicians think they are providing. Since a recent study has shown that 80 percent of children drop out of clinic treatment before providers think they are ready for discharge, clients are, as one participant observed, voting with their feet. In the words of another, "if I, as a consumer, come with needs that you don't hear and you give me something I didn't ask for and I don't get it delivered very well, it is no surprise that I don't engage and come back." Others suggested that even when providers do know what families want, it may be impossible to give it to them (for example, a family may want longer term respite care than the system allows). Finally, one participant asked how we know what children themselves want. Transparency and symmetry of information between families and providers might help providers deliver the services consumers want.

Engaging families and children in care is crucial, and challenging
It is impossible to know whether our interventions are effective if families stop coming; in the words of one participant, "if the engagement doesn't happen, it doesn't even matter if you have the right treatments." But often assessment alone may take weeks, with the family being required to go from place to place, and throughout this period no one tells the parent what is happening. Furthermore, the system may not yet have to capacity to create the range of choices families need, or to communicate those choices to them. We don't know enough about customizing care, or about implementation of the many components of care, such as supervision, referral or triage.

Alliance and resistance
One issue that makes care for children very different from care for adults is the level of resistance clinicians often encounter in children. As one participant said, adults rarely try to "fool the therapist," but adolescents commonly do. In addition, developing a clinical alliance is more complicated with children, because the therapist needs to ally with the child and with the family at the same time.

Providers can only be as flexible as their reimbursement
The payment system must be aligned with performance expectations. As the IOM notes, we need to move beyond a focus on visits. Providers can only offer flexible, customized care if there is a way for them to receive appropriate compensation.

Several clinicians participating in the dialogue pointed out that it is impossible to treat a child in a family where the adults are mentally ill, if you don't treat the adults as well. And treatment will work best if the same team treats the entire family. But that may be difficult to do in the face of systemic constraints and funding restrictions. Not the least of these is that if the child is the identified client, it may be infeasible to open cases for numerous other family members.

Furthermore, although not all interventions need to be implemented by the clinician in the clinic, reimbursement may be unavailable or inadequate for care that is offered in other forms and modalities. Providers might be happy to make home visits, communicate via e-mail, talk to clients on the telephone, and seek out other innovative techniques beyond encounters if they are paid for them. Participant notes that we need to reimburse for outcomes and develop a "market" for services that is not mediated by third parties. This requires giving consumers and families a choice in the services they purchase.

Using a public health model
Several participants pointed to the value of a public health model of care, where the focus is on the community, rather than the individual, as the unit of interest. In the public health model, an effort is made to identify a disorder in its earliest stage, and to intervene at that point. We do not do that in mental health. In fact, mental health clinics are often unknown to their communities, and vice versa.

But it is important for mental health providers to know and understand the communities in which they operate. They should communicate with the leaders of those communities, making known the services that they have to offer, and clarifying what those services can and cannot achieve. They also must identify the other resources their communities can offer families and seek to coordinate their own resources with them. This step is of special importance for children and families.

Should we "triage" children, or focus on certain ones?
Although we often use the word triage, it is unlikely ever to be a care model for children because it entails deliberately ignoring certain individuals when there is no known way to treat them. On the other hand, in situations where children have needs that exceed the capacity of the traditional mental health system, devoting extensive mental health services to them may simply be wasting resources. For example, as one participant asked, "What is wrap-around going to do when you are going from shelter to shelter, or your mother is having sex with her boyfriend in front of you?" Many problems children face reflect large social issues that are beyond the capacity of the mental health system to address.

One participant described as "frequent flyers" those children who are being served by multiple systems and who may lack functioning families. They are the ones who are most likely to be found ultimately in the adult mental health and prison systems. Some of these children, however, have enough resilience to become competent adults. Sometimes, as one participant said, "we think kids [got] better when really they just grew up."

Educating and empowering consumers
One of the roles of the mental health system should be to educate and empower families, helping them to take better care of their children. What matters most is how children are able to function in the real world. Participants suggested that the mental health system should become "transparent" with regard to expectations for children, especially those with the most difficult problems. In addition, consumer directed purchasing approaches should be considered.

Providers should be measuring outcomes, but which ones and for whom?
As one administrator noted, at its most basic level the key question is, "What is the public getting from [our] $4.8 billion industry?" Ideally, we should be able to measure outcomes on a continuous basis, so that we know how the system is performing. But the taxpayer, the government funder, the foundation, the school, the police, the child and the family do not all want the same outcome. All families don't even look forward to the same outcomes.

In general, providers devote far more resources to their financial systems, and to "getting paid," than to measuring outcomes. Changed payer expectations could have an impact on this situation. System performance and clinical outcomes should be measured, and those measures should be reviewed, refined and used to improve quality. This process is at the heart of Berwick's message.

Can we build resilience?
The group engaged in an extensive discussion of child, family and community resilience, especially within New York City, and how the mental health system might be able to enhance it. Clinicians in the group suggested that poverty saps resilience, and that trauma compromises the ability to be connected to others. One administrator asked explicitly whether we could think of building resilience as an intervention. But a researcher expressed concern that during the course of the discussion innumerable interventions, ranging from art groups to music groups to Little League had been described as building resilience. While the mental health system's unique contributions to this picture may not be readily apparent, our children's "system of care" initiatives as well as other efforts are clearly focused on community integration.

Working to change the system
Administrators expressed the need to work both from the bottom up and from the top down in the effort to change the system so that it comes closer to meeting the needs of all stakeholders. Change can only be realized by modifying the culture and the structure of the system, and by offering appropriate incentives. Both "the carrot" (in the form of new funding) and "the stick" (in the form of revised licensing requirements and regulations) must be used. Rather than being imposed on an organization, change must be integrated into it. Patience is essential.

Dialogue Four

Dialogue Four, which took place on December 16, 2002, focused on cultural issues in mental health treatment. There was considerable agreement among participants on a number of issues. Below are some of the highlights of the discussion.

Crossing the Cultural Chasms
Participants agreed that, although the Institute of Medicine monograph makes little mention of culture, race or class differences, they are extremely important. Indeed, they are perhaps more so in mental than in physical health because of the centrality of "relationships" in mental health interventions. One participant asked whether adhering to the rules the IOM proposed would mean that the culture issues would "take care of themselves," while another asked, in a similar vein, whether good clinical practice is "the same as cultural competency." But implicitly others answered these questions by saying that we don't know enough about the needs and values of minority populations, and that, therefore, the concept of EBPs is "overrated" for those groups. Yet another noted, however, that we don't have tailored care "even for white people in mental health." Rather, care is program-based, and "you fit into a program or you don't get care."

The group also discussed the issue of whether specific minority groups should be targeted for special attention. On the one hand, the principle of "every single one" would seem to suggest that such targeting is not desirable; rather, the goal should be to leave no one underserved. However, the principles of quality improvement highlight the importance of identifying and tracking practice patterns in need of change; these should include patterns of service to specific racial and ethnic groups.

The state mental health authority might develop a cultural sensitivity campaign that cuts across several agencies, and that also is aimed at service staff. In addition, it might disseminate information and serve as a clearinghouse for materials in specific areas, such as EBPs and cultural sensitivity.

Access to care and availability of services
While the notion of access to care assumes that there are quality services that are actually available, this may not always be the case. Furthermore, consumers and family members may not want access to just any provider; rather they may want information about provider quality and cultural competence, and this may be difficult to find. First impressions are very important in the effort to maximize access to care. Such factors as who answers the phone and what they say, and the attitude and body language of staff who greet clients when they come for care, will have a significant impact on those individuals' decisions about whether to return. It was noted that the typical family and child make just one visit to a child outpatient mental health service, emphasizing that assuring entry into the system is only the beginning of the process.

Training law enforcement personnel, clergy and others in the community to screen for depression and encourage those who need care to seek it might increase access, especially in minority neighborhoods. Similarly, efforts should be made to disseminate information in the community about serious emotional disturbances in children. The information might be distributed through different channels in different neighborhoods, determined by how residents of those areas are most likely to receive it. For example, messages might be inserted in church bulletins, literature made available in beauty and barbershops, and public service announcements as well as the Web might be used. OMH might provide the message and training tools, and encourage a dialogue between mental health providers and those who distribute materials and/or become engaged in community screening.

A key point made in this dialogue was the importance of insuring access for all who need services, because those who don't come in for care will eventually be seen in other systems, whether medical, social service or criminal justice. An illustration of this problem was presented from the children's system: among children in the inpatient and residential treatment systems in New York, a large proportion came into contact with the mental health system through emergency rooms, not through the newer, more innovative mental health programs that have been developed in the community.

Each organization must be able to serve the whole person
In the words of one participant, "If an agency just narrowly looks at . . the mental health, the illness that is being presented or the symptoms, and doesn't look at the whole person, [that agency] is going to fail." There needs to be an infrastructure in place so that when a client comes in with a medical problem, or without a place to live, the provider can respond other than by saying (as another participant put it), "I really understand, but let's talk about some of your childhood problems." While a mental health clinician will probably not receive reimbursement for time spent seeking care for a client who needs services elsewhere, a case manager might be available to engage in this effort, enabling the clinician to be responsive to a wider range of need.

Barriers to seeking and receiving treatment
Several individuals noted the cultural variation in definitions and interpretations of mental illness. African American communities, for example, may not recognize mental illness, instead defining it as, in the words of one participant, "the work of the devil, they had a hex on them, the outcome of cocaine use or they are just not quite right, that is just the way they are." Furthermore, as another dialogue participant pointed out, the complexity of

the service system may discourage some clients. They may be puzzled and irritated by the need to have therapy with one person, receive medication from another, have case management appointments with a third and then also go to day treatment or see an ACT team. They do not want to have to tell their stories repeatedly, and develop relationships with so many people. They would much prefer to see the one person with whom they feel most comfortable, rather than wasting their time going to four different places at four different times.

Peer education, that is, involving consumers in helping their peers to understand the system, might break down some of these barriers. Family education might serve a similar purpose.

Evidence based practices and practice based evidence
Several individuals noted that EBPs, specific toolkit practices, often exclude more people than they include; that is, they have been tested on and validated for individuals with specific characteristics, and most people are ineligible because they do not share all of those characteristics. But in communities all over the country there are clinicians developing and using "practice based evidence." That is, they have learned through trial and error what works with the population they serve, i.e., their evidence is based on practice. It is important for them to share their knowledge with others who may be serving similar populations.

Change can be difficult
Any state agency, even one with extensive resources, has most of those resources committed to ongoing programs, most of which have been in operation for many years. Moving funds out of those programs is politically very difficult. Sometimes evidence and evidence-based practices can provide an objective basis for shifting money into newer programs.

Common Themes

While each dialogue was devoted to its own subject within the general topic area of disseminating evidence-based practices, they not surprisingly shared a number of common themes. This section will pull those ideas together, leading to a final section which draws conclusions as to how state mental health authorities (MHAs) might achieve desired change in their systems.

Customization and Evidence Based Practices

As a key focal point for Berwick, and the title of the videotape that all dialogue participants viewed at the initiation of their discussions, it is hardly surprising that the theme of "every single one" surfaced early and often in each group. In the ten "rules" presented by *Crossing the Quality Chasm*, "every single one" comes close to the meaning of Rule 2: "Customization based on patient needs and values." At least one group noted: "If we can do it (customization) with cars, why can't we do it with mental health services?" While everyone agreed with the notion, the various groups did raise some intriguing policy dilemmas associated with customization and the implementation of EBPs.

EBPs are exclusive
There is conflict inherent in trying to realize both EBPs and the value of "every single one," primarily because to some extent EBPs are exclusive rather than inclusive. That is, EBPs are available only for certain, well defined conditions, and they employ techniques that are appropriate only in specific situations. Therefore, concentrating on using EBPs will, by definition, exclude many clients. One obvious way to resolve this tension is to develop new EBPs, but that is not an option open to individual providers, or even necessarily to one state MHA. Furthermore, it is unlikely that an EBP will be developed to cover every condition and every population. Clearly, however, implementation of EBPs must constitute one component of any state's full array of practices.

Can consumers control their treatment when they are receiving EBPs?
Another tension concerns the relationship between use of EBPs and consumer or family control. If clinicians are trained to employ specific practices in clearly defined situations, what choice do consumers have over their treatment, or families over the treatment of their children? One apparent response to this dilemma, as discussed in Dialogue One, is to recognize that clients' satisfaction, functionality and symptoms will not all improve simultaneously and to the same extent. When choices need to be made as to which of these domains will receive priority in determining a course of action, the vision of the IOM and the President's New Freedom Commission would suggest that the client or family should decide.

Fidelity versus flexibility in implementation
A third dilemma related to implementation of EBPs in light of the "every single one" standard, raised in Dialogue Three, has to do with the opposing notions of fidelity and flexibility. On the one hand, EBPs are, by definition, practices that have documented success when implemented according to specific protocols – that is, when carried out in specified ways by certain types of providers who have received required training, with certain types of clients who have specific diagnoses. A particular clinic, however, may not have enough staff with training to serve the number of clients in their care (perhaps because of turnover), or a client's circumstances may change to make him or her technically ineligible for participation in the protocol. State policies and provider practices may need to maintain flexibility when EBPs are implemented system-wide.

Practice based evidence
Participants in Dialogue Four proposed one potential response to this dilemma, which they called "practice based evidence." Clinicians are constantly learning in their practices, and many are collecting evidence of what works best for their clients; thus, they accumulate evidence that is based on their individual work. Finding ways for these professionals, who may not work in environments that encourage publishing or speaking at conferences, to share their insights could lead to significant improvements in care for some populations. Furthermore, data documenting existing practices are essential to development of successful quality improvement activities that can lead to better standards of practice.

The need for "evidence based process"
Implicitly or explicitly several of the dialogues touched on the need for development and promulgation of "evidence based processes," that is, clear descriptions of activities such as engaging in relationships with clients and families, teaching clients specific skills, coaching clients and their families and finding ways to inspire clients to achieve the most they are capable of. These are not skills that are necessarily taught in school or in field placements; nor are they defined clearly in every EBP. Some staff, however, show special capability at one or more of these skills, and it might be valuable to document and disseminate their practices.

Transparency

In addition to customization of care, another rule in the IOM's list is "the need for transparency," meaning that,

> the health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments.[14]

Although the legislation was not raised in any of the dialogues, some aspects of transparency are covered by HIPAA, the Health Insurance Portability and Accountability Act, which took effect in April 2003. HIPAA attempts not only to assure the privacy of health records; it also gives individuals further control over, and better access to, those records.

Access to information about providers
As the IOM rule suggests, in addition to transparency in medical recordkeeping, the system needs to offer each consumer better ways of making informed decisions about her actual source of care. Currently, there is so little information available to the public about the quality or substance of services offered by various providers that the consumer must often choose blindly. Yet once a consumer has chosen, or at least entered care in, a particular provider agency, her choice is immediately circumscribed to that which is offered by that system. If that provider does not offer, for example, a supported employment program geared to her needs, she may never learn that a provider a mile away does offer such a program.

Sustaining hope in the face of transparency
One dilemma raised by several of the dialogue groups in relation to transparency, which every provider must recognize and deal with in the face of HIPAA's requirements, has to do with sustaining hopefulness in the face of discouraging diagnostic and treatment information that is potentially contained in the record. In light of both the new IOM and HIPAA rules, as well as the statement of the President's New Freedom Commission that, "the system is not oriented to the single most important goal of the people it serves – the hope of recovery," it is clear that providers need to find ways of maintaining notes and records that will both document services and assist the consumers and families who are in their care through the recovery process.

The Provider System

Discussion of providers figured prominently in every Dialogue group, for the obvious reason that they ultimately bear responsibility for implementing any vision of a new healthcare system.

Staff training
Inevitably, staff training is a key issue in implementation of EBPs. Training experienced staff to work in new ways is a challenge, as is telling freshly minted clinicians that they will not be doing the kind of work for which they may have been trained. Implicit in this issue is the need for OMH and other state MHAs to work with state training institutions to assure that they are producing the kinds of professionals the system needs, and that they also offer continuing education programs to help working professionals update their skills. MHAs might also find it useful to work with state professional licensing authorities, ensuring that license renewal requires appropriate training for all types of mental health staff.

Reimbursement needs to be flexible
As numerous dialogue participants said, providers can only do what the system will pay them for. The IOM, in its first rule, suggests that flexibility is a highly desired commodity when it says that,

> Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means . . .[15]

It is hard to disagree with this concept, but its realization represents a considerable challenge when the system as it is currently organized is based on reimbursement for specific procedure codes, nearly all of which require face-to-face visits. Similarly, maintaining around-the-clock availability will require that many systems restructure and refinance their services.

The need to treat families, not just children
The need for flexibility in provision of services is particularly clear in the case of children. Serving children and adolescents without simultaneously caring for their families is futile. Yet the current reimbursement system in New York and in most states does not automatically allow for such treatment.

Measuring Outcomes

In every dialogue the subject of outcomes arose, usually repeatedly and in various contexts. Interestingly, although the importance of evaluating outcomes is implicit in many of the IOM's new rules, no one rule explicitly points to how, when or whether outcomes should be measured. For example, rule 5 refers to evidence-based decision making, and says that,

> Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.[16]

Rule 6, "Safety as a system property," also implies a need to know the outcomes of care.

The President's New Freedom Commission similarly offers as its Goal 5, Excellent Mental Health Care Is Delivered and Research Is Accelerated. The Commission goes on to say,

> Every time any American – whether a child or an adult, a member of a majority or a minority, from an urban or rural area – comes into contact with the mental health system, he or she will receive excellent care that is consistent with our scientific understanding of what works.

As with the IOM's rules, achievement of this goal requires that good data be available to guide treatment decisions.

Unfortunately, however, in the field of mental health, there are as yet no generally agreed upon standards, methods or instruments for measuring outcomes of treatment. The nature of the condition is difficult to measure and research has shown that there is often no relation between satisfaction and outcomes. A wide range of competing instruments and measurement systems are currently in use, often in minimal or limited ways. There has been considerable recent progress in the last year or so on a national level in developing performance measures that begin to address the critical clinical process issues, such as initiation of treatment, engagement and retention. While these are clearly not clinical outcome measures, they do use administrative data to measure aspects of the relationship between consumers and clinicians that may advance the debate. Achieving consensus in this area should hold a high priority for the field, because it apparently will need to precede realization of other valued goals. Ultimately, for instance, everyone agreed that data on performance and outcomes needs to be an explicit part of mental health purchasing decisions by states and consumers.

Building Resilience

While only one dialogue group focused on the topic of resilience, it was sufficiently important to that group that it seems worthy of mention here. The President's New Freedom Commission offers the following definition,

> Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses - and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits . . . Closely-knit communities and neighborhoods are also resilient, providing supports for their members.

Although its conversation took place before the Commission's report was issued, the participants in Dialogue 3 said essentially the same things. In the face of poverty and trauma, then, what can the mental health system do to foster resilience? One response to this question would seem to be that services can and should be better integrated into the larger community. However, our mental health systems should also participate in and provide leadership for explicit efforts to increase the resilience and social capital[17] of communities. This includes efforts to increase "connectedness" in communities, developing a safety net of social supports, using non-traditional providers and focusing on collaboration at the micro-system level of services.

Mental Health in the Context of the Larger Community

The mental health system occupies a prominent position in the budget of virtually every state. It is therefore especially incumbent on mental health agencies to be certain that they know, and in turn are known by, their local communities.

Recovery entails integration into the mainstream
Providers need access to resources in their communities, at the same time that they should be making their own resources available to those communities, in order to maximize opportunities for recovery among their clients.

Applying a public health model
In a public health model the measurement and planning unit is the community, rather than the individual consumer. The mental health system, in contrast, has historically been organized to treat individuals who are ill. Reaching into the community to prevent that illness in the first place would be far preferable, but is probably largely beyond the scope of the mental health system to achieve. However, any preventive programs a MHA or a mental health provider can implement in at-risk communities will move the system in a preferred direction.

Finding the underserved
There is now an understanding shared among medical, mental health, corrections and other professionals that individuals who need but do not receive mental health services are likely to appear in other service sectors, and will probably cost society more in the long run. Thus, the goal of ensuring access to care for all who need it is perhaps less controversial now than it might have been in an earlier generation.

Improving the System

In several of the dialogues participants noted the challenge inherent in trying to move a large system in new directions. Several dilemmas were discussed:

Cultivating 'champions' by providing extra resources
A state agency can exert considerable leverage by seeking out individuals or organizations that are willing and able to begin using EBPs, and providing them with additional funding and consultation to help them do so. The challenge for states that seek to have EBPs become the routine way of doing business, however, is to find a way of engaging all providers in using them, through dissemination, mentoring, changing financial incentives and ultimately, perhaps, new regulations.

Encouraging a culture that values and uses data
The MHA can set an example by using data itself, thereby developing 'evidence based policies.' It can also require providers to set aside funds for evaluation, so that they are contributing to improvement in the system.

Anticipating unintended consequences
Requiring providers to meet specific targets, while often a necessary and useful step, may also have unintended consequences. OMH acknowledges this risk, and strives to minimize it, for example in its structuring of such initiatives as the Performance-Based Contracting Demonstration Program. This program uses incremental funding, which is weighted so that smaller payments at the beginning make service

delivery viable, while larger payments at later stages of employment provide the incentive to help consumers retain employment. In addition, it offers a two-tiered payment structure that reimburses at a higher rate services to those with more barriers to employment, in an effort to eliminate creaming.[18]

Conclusion

These final sections of the paper will frame a series of recommendations within a paradigm offered by Donald Berwick. In "A User's Manual for the IOM's 'Quality Chasm' Report,"[19] Berwick details four levels at which the healthcare system must be redesigned:

A. Patients' experiences;

B. The "microsystems" that provide care;

C. The organizations that house and support the Microsystems; and

D. The larger environment.

Berwick describes this model as hierarchical, because "it asserts that the quality of actions at Levels B, C and D ought to be defined as the effects of those actions at Level A, and in no other way."[20] A state MHA has the ability to influence all four of these levels, and participants at all four should always be oriented toward "true North."

A. Patients' Experiences: Maintaining the Focus on the Consumer
The patient level is the one at which changes at all the other levels are directly experienced. Moreover, this is the level that ultimately matters most. As the Quality Chasm report says,

> All health care organizations, professional groups, and private and public purchasers should adopt as their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States.[21]

In other words, every component of the healthcare system should focus its effort in the direction of "true north," which is keeping people healthy. As much as possible, elements of the system that do not contribute to that goal should be modified.

B. Microsystems of Care
Microsystems are the work units that provide the care the patient actually experiences. According to Berwick, a microsystem, whose definition he takes from work by Brian Quinn[22], is "a small team of people combined with their local information system, a client population and a defined set of work processes."[23] Berwick and the IOM suggest three principles for redesigning the microsystem: care should be "knowledge-based, patient-centered, and systems-minded."[24] All of these principles relate directly to issues raised in the dialogues.

Knowledge-based care. The best information available should always guide the delivery of care. Thus, when an existing EBP is appropriate to a given client, it should be used. When there is no suitable EBP, every effort should be made to seek out and offer treatment that has some basis in science, rather than offering treatment based on tradition or on the personal preference of the clinician. The system should constantly encourage providers to add to the base of knowledge by sharing findings. OMH's focus on incorporating EBPs into standard care throughout the child and adult systems is an example of attempting to improve the microsystems of care.

Patient-centered care. Each patient should be in control of his or her own care. Microsystems should offer choice to each individual to the extent possible. Care, while fitting within a standard framework based on knowledge, should be customized to the client. Although consumer and family involvement and empowerment have been primary values in the mental health system for the last decade and more, much work remains to achieve them.

Systems-minded care. This is a kind of care that "assumes responsibility for coordination, integration, and efficiency across traditional boundaries of organization, discipline, and role," according to Berwick. He goes on to suggest that this type of care is "especially relevant to patients with chronic illnesses," among whom individuals with mental illness would clearly be counted. Thus, breaking down barriers among systems can help make care as efficient, timely and effective as possible. The delivery of "systems-minded" care represents a particular challenge in the context of a structure that is as large and complex as that in New York State, where multiple state and county agencies may share responsibility for care.

C. Healthcare Organizations
Healthcare organizations, to support the efforts of their microsystems, need to achieve improvement in six areas[25]:

- Identifying best practices and assuring their use;
- Using information technology to support decision making;
- Focus on developing human resources;
- Creation of more effective teams and teamwork;
- Coordination of care among services and settings; and
- Measurement of performance and outcomes.

Most of these reflect themes that were discussed in one or more of the dialogues. All of them suggest directions in which mental health provider organization should be trying to move.

D. Healthcare Environment
The environment in which healthcare organizations function includes the surrounding policies, laws and regulations, accreditation requirements, financing systems and professional education programs, as well as countless other components. Each of these domains presents barriers and "toxicities," as Berwick calls them, many of which were discussed at length in the dialogues. The *Quality Chasm* report suggests that the systems of payment, professional education and regulation require immediate change, and that high level and system-wide dialogues should determine other needed changes.

In a system as large and diverse as New York's, the opportunities and challenges are significant. Thinking about system change in light of Berwick's paradigm

can help structure and evaluate the most appropriate next steps.

Recommendations

New York's OMH and mental health authorities across the country have an extraordinary opportunity over the next several years to achieve the transformation envisioned by the President's New Freedom Commission, the IOM's *Crossing the Quality Chasm* report and the *Report of the Surgeon General*. The effort involved in this process will require new leadership styles at every level of the system. What is needed is leadership that is collaborative, visionary, data-focused and impassioned. Berwick's presentation of two physicians, Dr. "Olderway" in the Blue Hat and Dr. "Newerway" in the Yellow Hat, illustrates the different styles starkly and humorously. The reality is never so easy.

The Significance of the Dialogue Groups

New York's Dialogue Groups represented one significant step forward in the process of developing a consensus around Evidence Based Practices and Quality Improvement in our mental health systems. The groups assembled many of the brightest minds in the field, from New York and across the country, to discuss and debate the various issues associated with transforming systems by orienting them toward "true North." This type of effort represents a key step in the implementation process: building consensus. The other steps in the change process, enacting and sustaining, have been underway and should be expanded.

Related National Efforts

The discussion and debate will soon be joined by the Substance Abuse and Mental Health Services Administration, where a blueprint is being developed to implement the New Freedom Commission's recommendations. In addition, the Institute of Medicine, in collaboration with the American College of Mental Health Administration, is implementing a new initiative to transpose the *Crossing the Quality Chasm* findings and recommendations to behavioral health. These efforts to offer guidance and outline action steps are necessary but not sufficient to achieve the goals of transforming the system.

The Importance of Leadership

Leadership is critical to beginning the process. Leaders must identify strategies and tactics appropriate for each level of the system, and must inform officials of the barriers that need to be torn down and the new incentives that need to be created in order to achieve a system-wide transformation. In a county-based system like New York's, where the various government agencies have interwoven financial responsibilities, this is quite challenging.

One approach is to start with a small cadre of leaders at different levels of the system who volunteer to develop initiatives that will implement some of the recommendations from the Dialogue Groups. Statewide leaders should guide and support these efforts, perhaps providing incentives for participation. Once results of the demonstration projects are disseminated, new projects can be identified. The initial leadership group can serve as mentors, role models and peer supports to their colleagues throughout the state.

Targeting Specific Issues

Among the areas that these teams might consider targeting for implementation are the following:

- Consumer directed services;
- Special integration projects, such as expanded Home and Community Based Services, for targeted groups of consumers;
- Some of the new disease management approaches being implemented across the country; and
- Efforts to integrate mental health care with primary care.

Another possibility might be to develop collaborative quality improvement efforts, at local and regional levels, that would make intensive use of data. These groups might focus on areas such as the following:

- Reducing disparities or
- Implementing outcome management projects in support of evidence based services.

All of these options are consistent with the recommendations of the New Freedom Commission and the IOM. More importantly, however, they advance the state of the art in local administration and delivery of high quality services; that is, they are oriented in the direction of "true North."

End Notes

1 See, for example, S.E. Carpinello, L. Rosenberg, J.L. Stone, M.Schwager, and C.J. Felton. "New York State's Campaign to Implement Evidence-Based Practices for People with Serious Mental Disorders," *Psychiatric Services*, 2002:53(2); and K. Hoagwood, B.J. Burns, L. Kiser, H. Ringeisen, S.K. Schoenwald. "Evidence-Based Practice in Child and Adolescent Mental Health Services.," *Psychiatric Services*, 2001: 52(9), 1179-1189. Other references are included in the list below.

2 *Mental Health: A Report of the Surgeon General* (1999), at: http://www.surgeongeneral.gov/library/mentalhealth/home.html

3 Institute of Medicine, Committee on Quality of Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: National Academy Press, 2001.

4 New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*, DHHS Pub. No. SMA03-3832. Rockville, MD: 2003.

5 *Crossing the Quality Chasm*, p. 1.

6 *Ibid.*

7 *Crossing the Quality Chasm*, p. 6

8 *Achieving the Promise*, pp. 3-4.

9 *Achieving the Promise*, p. 1

10 *Ibid.*, p. 5.

11 *Achieving the Promise*, Executive Summary

12 *Crossing the Quality Chasm*, pp. 8-9.

13 This description is adapted from http://www.rand.org/health/pic.products/overview.html

14 *Crossing the Quality Chasm*, p. 62.

15 *Ibid.*, p. 61.

16 *Ibid.*, p. 62.

17 Putnam, Robert D. Making Democracy Work. Princeton, NJ: Princeton University Press, 1993.

18 See http://www.omh.state.ny.us/omhweb/ebp/implementing.htm

19 *Health Affairs*, 21:3, May/June 2002, pp. 80-90. Henceforth referred to as Berwick.

20 *Ibid.*, p. 83.

21 *Crossing the Quality Chasm*, p. 39.

22 J.B. Quinn, *Intelligent Enterprise: A Knowledge and Service Based Paradigm for Industry* (New York: Free Press, 1992); and E.C. Nelson and P.B. Batalden, "Knowledge for Improvement: Improving Quality in the Micro-Units of Care," in *Providing Quality Care*, ed. D. Nash (Gaithersburg, MD: Aspen Publishers, 1999).

23 Berwick, p. 84..

24 *Ibid.*, pp. 84-85.

25 *Ibid.*, pp. 86-87.

Bibliography

Berwick, D. "A User's Manual for the IOM's 'Quality Chasm' Report," *Health Affairs*, 21:3, May/June 2002, pp. 80-90.

Burns, BJ, Hoagwood, K. (Eds), (2002), *Community treatment for youth:* Evidence-based interventions for youth with severe emotional and emotional disorders. Oxford: Oxford University Press.

Burns, BJ & Hoagwood, K (in press). "Evidence-based practices for child and adolescent mental health." *Psychiatric Clinics of North America*.

Carpinello, S.E., Rosenberg, L., Stone, J.L., Schwager, M., and Felton, C.J. (2002). "New York State's Campaign to Implement Evidence-Based Practices for People with Serious Mental Disorders." *Psychiatric Services*, 53(2).

Chavez, N., Hyman, S., Arons, B. (1999), Mental Health: *A Report of the Surgeon General*, at: *http://www.surgeongeneral.gov/library/mentalhealth/home.html .*

Finnerty M. Altmansberger R. Bopp J. Carpinello S. Docherty JP. Fisher W. Jensen P. Krishnan P. Mittleman M. Olfson M. Tricarico J. White T. Felton C. (2002). "Using state administrative and pharmacy data bases to develop a clinical decision support tool for schizophrenia guidelines." *Schizophrenia Bulletin.* 28(1):85-94.

Fisher, C, Hoagwood, K., Boyce, C., Duster, T., Frank, DA., Grisso, T., Levine RJ., Macklin, R., Spencer, MB., Takanishi, R., Trimble, JE, Zayas, LH (2002). "Research ethics for mental health science involving ethnic minority children and youth." *American Psychologist*, 57(12), 1024-1040

Hermann RC. Finnerty M. Provost S. Palmer RH. Chan J. Lagodmos G. Teller T. Myrhol BJ (2002). "Process measures for the assessment and improvement of quality of care for schizophrenia." *Schizophrenia Bulletin.* 28(1):95-104.

Hoagwood, K. (2002). "Making the translation from research to its application." *Clinical Psychology:* Science and Practice, 9(2), 210-213.

Hoagwood K. (2003). "School Psychology: A public health perspective: Reply to Comments." *Journal of School Psychology*, 41(1), 91-96.

Hoagwood, K (2003). "The policy context for child and adolescent mental health services: Implications for systems reform and basic science development." *Annals of the New York Academy of Sciences* 1008: 1-9

Hoagwood, K. (in press). "System barriers, policy contexts, and research directions on evidence-based practices for adolescents." In *Treatments That Work for Adolescents.* The Annenberg Foundation Series. Oxford University Press

Hoagwood, K., Burns, B.J., Kiser, L., Ringeisen, H., Schoenwald, S.K. (2001). "Evidence-Based Practice in Child and Adolescent Mental Health Services." *Psychiatric Services*, 52(9), 1179-1189.

Hoagwood K & Johnson J (2003). "School Psychology: A public health perspective. I. From evidence-based practices to evidence-based policies." *Journal of School Psychology*, 41(1), 3-21.

Institute of Medicine, Committee on Quality of Health Care in America (2001), *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, D.C.: National Academy Press.

Nelson, E.C., Batalden P.B. (1999) "Knowledge for Improvement: Improving Quality in the Micro-Units of Care," *Providing Quality Care*, Gaithersburg, MD: Aspen Publishers.

New Freedom Commission on Mental Health (2003), *Achieving the Promise: Transforming Mental Health Care in America.* Final Report, DHHS Publication No. SMA-03-3832. Rockville, MD.

New York State Office of Mental Health Web site: http://www.omh.state.ny.us/omhweb/ebp/implementing.htm.

Partners in Care Web site: http://www.rand.org/health/pic.products/overview.html.

Pappadopulos, E., Macintyre, II J.C., Crismon, M.L., Findling, R.L., Malone, R.P., Derivan, A., Schooler, N., Sikich, L., Greenhill, L., Schur, S.B., Felton, C.J., Kranzler, H., Rube, D.M., Sverd, J., Finnerty, M., Ketner, S., Siennick, S.E., Jensen, P.S. (2003) "Treatment recommendations for the use of antipsychotics for aggressive youth (TRAAY). Part II". *Journal of the American Academy of Child & Adolescent Psychiatry.* 42(2):145-61.

Quinn, J.B. (1992), *Intelligent Enterprise: A Knowledge and Service Based Paradigm for Industry*, New York: Free Press.

Schoenwald, S & Hoagwood, K. (2001). "Effectiveness, transportability, and dissemination of interventions: What matters when?" *Psychiatric Services*, 52(9), 1090-1097.

Strein W, Hoagwood K, Cohn A. (2003). "School psychology: A public health perspective. I. Prevention, populations, and systems change". *Journal of School Psychology*, 41(1), 23-38

New York State Office of Mental Health

Sharon E. Carpinello, RN, Ph.D.
Acting Commissioner

44 Holland Avenue
Albany, New York 12229

August 13, 2003

Dear [insert County Mental Health Director/Commissioner]

The New York State Office of Mental Health (OMH) and the New York State Conference of Local Mental Hygiene Directors (The Conference) have begun a collaborative effort to strengthen and improve the mental health planning process. We expect this effort to be a multi-phased, long-term effort that will build on the strengths of the current process and add increased emphasis in priority areas identified by OMH, the Conference and the Mental Health Services Council.

OMH and the Conference will be co-hosting a series of "round table" forums beginning this fall to advance discussions begun on the planning process. Ultimately, our goal is to have this redefined planning process become a catalyst to pull communities together in a multi-year, population based planning effort which reflects county priorities as well as Statewide needs. The attached draft document, "County/City and State Planning Workgroup Planning Principles and Implementation Requirements," which was developed by the Conference, provides the beginning of a blueprint to shape our ongoing discussions and the eventual content of the forums.

As this long-term effort is beginning, OMH is also initiating the development of this year's *Statewide Comprehensive Plan For Mental Health Services.* The counties and New York City are invited and encouraged to participate by providing county/city input to the Statewide planning process. Earlier this year the Mental Health Services Council (MHSC) held a hearing in New York City that provided insight on county/city needs and on ways to strengthen the planning process. One result of that hearing has been a statement of goals and objectives for the mental health system that is intended to guide counties in the development of their mental health plans. The MHSC statement of Statewide goals and objectives, and a summary of the testimony received at the hearing, are attached.

OMH is required to complete the statewide plan for 2003-08 by October 1, 2003. For this year, OMH is requesting that counties provide a copy of their local plan, if available, by August 31, 2003. We recognize that some counties may still be preparing their plans by that date. Still, we would welcome any information you think relevant, and encourage you to send it to John Flaherty, NYSOMH, 44 Holland Avenue, Albany, N.Y., 12229, so it may be considered.

Sincerely,

Sharon E. Carpinello, RN, Ph.D.
Acting Commissioner
NYS Office of Mental Health

David S. Brownell, ACSW
Chair
NYS Conference of Local Mental Hygiene Directors

Attachments

CC: Gary Weiskopf
OMH Cabinet
OMH Field of Directors
John Flaherty

County/City and State Planning Workgroup Planning Principles and Implementation Requirements

The New York State Office of Mental Health (OMH) and the Conference of Local Mental Hygiene Directors (CLMHD) are continuing discussions regarding the comprehensive planning process as envisioned in Section 5.07 of Mental Hygiene Law. This on-going collaboration seeks to develop a protocol or implementation process that defines the respective roles of both OMH and the counties. Two priority areas of attention include: 1) Principles that will guide this intergovernmental planning process; and 2) Planning implementation requirements.

The following is offered as a first draft for discussion purposes:

Elements to be Included in Planning:

A planning process should address the following elements:

- System (and subpopulation) Capacity
- System (and subpopulation) Utilization
- Quality of Services: Appropriateness of Care, Perceptions of Care, Outcomes (results)
- Prevalence (need)

Principles for Planning:

1. Effective statewide and county/city based mental health planning requires the consistent compilation and availability of current data on resources, needs, financing and program cost effectiveness;
2. It is critical that recipients and family members participate in statewide and county/city based planning;
3. County/city based annual mental health plans and recommendations need to be referenced and reflected in state five-year and annual plans, and related to resource allocation decisions;
4. Statewide plans should include the role and future of state operated programs and county/city plans should integrate state operated services with community based programs;
5. A chapter of statewide plans should be devoted to services and issues related to multiply disabled clients;
6. Services for and needs of all major subpopulations of mentally ill adults and children should be clearly addressed in statewide plans. This presentation should also focus on issues differentially affecting clients, programs and systems of care in rural suburban and urban areas of the state;
7. Formal and informal linkages with other key service sectors should be discussed in statewide plans, including other mental hygiene agencies, the educational system, residential settings not under the OMH jurisdiction and the correctional system;
8. Planning will use a population-based approach to identifying needs. A main purpose of planning is to determine the relationship between need and resource allocations, and point government in the direction of achieving greater alignment. The planning foundation offered above could direct resource allocation;
9. The State should provide psychiatric center bed utilization projections as part of the plan for state-operated programs. A similar comment applies for outpatient services. By so doing, planning would be better separated from budget.

Planning Implementation Requirements

As noted in workgroup discussions, Section 5.07 of MHL describes a procedure for the establishment of statewide goals and objectives and requires development of statewide comprehensive plans for services for the mentally disabled. The guidelines presented in this documents are designed to give county/city government a set of realistic expectations for information that will be used in the development of a statewide comprehensive plan. As articulated in section 5.07 of MHL: "Each local government shall direct and administer a local comprehensive planning process for its geographic area, consistent with established state goals and objectives. All providers of services and department facilities hall participate in and provide information for this planning process."

To the extent that such information is available (and if not available counties will establish a process), counties will:

1. Describe needs of the mentally ill in their community, including subpopulations. Describe the array of services, including collaborations with a variety of service providers currently operating in the county.
2. Describe long range, and intermediate goals and objectives in relation to services to this population;
3. List priorities and when possible estimated costs;
4. Report on the participation of consumers into the planning process;
5. Report on the participation of all providers of services;
6. Submit this plan to the OMH in compliance with a timeline that will allow incorporation of county/city plans in the statewide plan.

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MENTAL HEALTH SERVICES COUNCIL

44 Holland Avenue, Albany, New York 12229

Barry B. Perlman, M.D.
Chairperson

July 21, 2003

Sharon E. Carpinello, R.N., Ph.D.
Acting Commissioner, NYS Office of Mental Health
44 Holland Avenue
Albany, New York 12229

Dear Commissioner Carpinello:

As you know, the Mental Health Services Council held a hearing on June 13, 2003 in New York City to garner public input about issues, goals and objectives for OMH statewide planning. The Council members who participated in the hearing all said that this hearing was very worthwhile part of the information gathering process.

I have attached for reference, a summary of the testimony presented. The members present at the hearing felt that the testimony was very revealing and informed our recommendations to OMH. Below you will find several suggestions which Council would like to highlight as particularly important. These are not prioritized.

Effective statewide and local mental health planning requires the consistent compilation and availability of current data on resources, needs ands financing.

County/city annual mental health plans and their recommendations needs to be referenced and taken into consideration in state agency five year and annual statewide plan and in related resource allocation decisions.

Statewide plans should include an analysis of the role and future of state operated psychiatric centers, forensic psychiatric programs and research institutes collectively and with reference to each facility. Suggestions included a task force charged with developing and implementing an assessment tool to collect data and prepare a report on the need for state operated inpatient beds for adults and children.

Services for major sub-populations of mentally ill adults (e.g., prisoner mental health services) and children should be explicated in statewide plans, also this presentation should focus on issues generated by location (i.e., rural suburban and urban). Service

Sharon Carpinello, R.N., Ph.D.
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gaps should be identified. Special attention should be directed at small sub-populations (e.g., young adults with mental illness who are also homeless) for whom targeted service design historically has been lacking.

Global review of other agencies' budgeting with respect to their impact on OMH budgeting plans. Also other linkages both formal and informal, collaborations and joint initiatives with other key service sectors should be discussed and reviewed in statewide plan. This would include but not be limited to the educational, health, residential and correctional systems.

The services provided by Article 28 general hospitals should be included in planning processes, likewise OMH should have a formal linkage (i.e.,liaison) to this service sector.

Service design should be culturally competent. Consumer and family input is invaluable to service design. The critical role of employment in recovery must be recognized. Employment must be highlighted and real meaningful work opportunities developed.

The Mental Health Services Council appreciates this opportunity to assist the Office of Mental Health in the development of attainable goals and objective for statewide planning. As always, we look forward to working with you.

Sincerely,

Barry B. Perlman, M.D.
Chairman

Summary of Testimony at June 13, 2003 Mental Health Services Council Public Hearing on Planning

NOTE: Comments are grouped by topic and sources of comments are identified. Comments are quotes and paraphrasing of quotes.

Goals and Objectives

Proposed Goals and Objectives:

- Effective statewide and local mental health planning requires the consistent compilation and availability of current data on resources, needs, and financing. (NYS Conference of Local Mental Hygiene Directors, CLMHD)
- Recipients and family members should participate and provide input in statewide and county mental health sector planning, and should rate the quality of their individual programs with aggregate ratings made available to planning bodies. (CLMHD)
- County/city annual mental health plans and their recommendations need to be referenced and taken into consideration in State agency five-year and annual statewide plans, and in related resource allocation decisions. (CLMHD)
- Statewide plans should include analysis of the role and future of State-operated Psychiatric Centers, forensic psychiatric programs, and research institutes both collectively and with a reference in the plan to each individual facility. County/city plans should endeavor to rationalize and help integrate state-operated services and other community-based programs serving the local area. (CLMHD)
- A chapter of statewide plans should be devoted to services and issues related to multiply disabled clients. (CLMHD)
- Services for and needs of all major subpopulations of mentally ill adults and children should be explicated in statewide plans, even if they are variable prioritized in terms of major initiatives or new program creation. This presentation should also focus on issues differentially affecting clients, programs, and systems of care in rural, suburban and urban areas of the State. (CLMHD)
- Formal and informal linkages, and collaborations and joint initiatives with other key services sectors should be discussed in statewide plans, including the other mental hygiene agencies, the educational system, the public health system, residential settings not under OMH jurisdiction and the correctional system. (CLMHD)
- State and local governments should work together to increase the supply of a continuum of housing options and associated supportive services, to reduce homelessness among those with mental illness, and to improve the care of individuals with mental illness who live in shelters. (NYC Dept. of Health and Mental Hygiene, NYCDOHMH)
- There should be planning on mental health disaster preparedness to give priority to this new core responsibility of the public mental health system. (NYCDOHMH)
- OMH should plan, develop and evaluate integrated models of mental health, substance abuse, and primary care service delivery similar to the Disaster Service Centers used in the followup to Sept. 11. (NYC Health and Hospitals Corp., NYCHHC)
- There is a need for a comprehensive suicide prevention strategy in NYS. (National Alliance for the Mentally Ill – NYS, NAMI)
- Programs such as assertive community treatment, intensive rehabilitation, and intensive case management are extremely useful in treating individuals with serious mental illness. More of these programs are needed. (NAMI)
- Cutting costs can no longer be a matter of simply cutting State Psychiatric Center beds and staff, but must be one of making the system more effective and efficient while preserving the care that still remains. Careful planning is needed with the participation of stakeholders to find solutions that are best for the populations served by the psychiatric centers — intermediate and long term care populations, forensic populations, and sex offenders. (NAMI)
- There is a need to add 3,000 community residential beds yearly and housing placements should be permanent. (NAMI)
- Major changes to the mental health system should be done in the context of a planning process that involves all stakeholders. (NAMI; Public Employees Federation, PEF; Mental Health Association in NYS, Inc., MHA)
- A comprehensive system of mental health services and supports has five major components:
  1. It is built on the recognition of a right to live in the community
  2. It is built on the recognition that a broad range of services and supports are needed
  3. A comprehensive community mental health system must serve multiple populations
  4. A comprehensive community mental health system in NYS includes multiple providers
  5. A comprehensive Statewide plan requires coordination of services and supports. (MHA of NYC)

Planning Process

- Components of a robust public mental health planning process include: data based needs assessments;

evaluation data; a focus on quality and quality improvement; significant provider, consumer, and family stakeholder input; a population-based/epidemiological perspective; a focus on prevention and early detection and treatment; and, the identification of opportunities to impact mental health through health venues (and vice versa). (NYCDOHMH)

- A separate planning process which incorporates the above components along with collaboration from other agencies in involved in caring for children and families should be instituted. (Children's Mental Health Action Network, CMHAN)

- Components of a Five-year plan are: existing services; those currently being served; the need for services not being met in the current system; those that will need services in the future; and, a plan for developing resources to serve unmet need. (The Coalition of Voluntary Mental Health Agencies, Inc., Coalition)

- For many years, OMH prepared a "chart book" of mental health financial and service statistics for statewide use. Unfortunately, over the past few years, this chart book has only been sporadically produced and the last editions — now several years old — have not been comprehensive. Similarly, the Patient Characteristics Survey (PCS) is the only available comprehensive review of patient activity, and has not always received the attention and priority that is appropriate for a fundamental planning tool. It would be extremely helpful if the chart book and PCS were continuously updated. Other information that should be available includes residential information and waiting list information for treatment programs, case management services, vocational programs and specialized residential placement. (CLMHD, Coalition)

- There is a discrepancy between the level of Medicaid-related data available to counties and the level of data available for services and units paid through different funding sources. (CLMHD)

- OMH plans should devote at least a chapter which reports on individual local priority recommendations; quantifies how local priority recommendations compare regionally and statewide, and informs the reader to what extent such local priority recommendations are or are not funded. (NYCDOHMH)

- The Conference would like the Inter-Office Coordination Council (IOCC) to author an annual comprehensive plan to which all local DMH offices would contribute relevant information. (CLMHD)

- The IOCC should be reconvened and function as described in Sec 5.05 (a)(b) of MHL. (Mental Health Project, Urban Justice Center, UJC)

- The participation of family members and consumers in the creation of 5.07 plans should be increased. (UJC, PEF)

- Local plans with input from consumers and family members should be used to create the 5.07 plan. (UJC)

- OMH should publicize the work of the MH Services Council to encourage input in goal setting by this group. (UJC)

- Suggested planning cycle time frames are:
  - Distribute a planning proposal for public comment in July.
  - Conduct hearings in all five regions by the Commissioner and/or senior staff of OMH. Adequate notice of the hearings should be given.
  - Complete a revised plan in November. (Schuyler Center for Analysis and Advocacy, SCAA; CMHAN)

- OMH should identify residents of adult homes as one of the target populations whose needs should be addressed in annual plans developed by local Community Service Boards (CSB). Local CSBs should solicit input from adult home residents, operators, and service providers when developing local plans; and, local CSBs in communities where adult homes in which 25% or more of the population has a psychiatric disability are located should include both residents and adult home providers. (SCAA)

- A taskforce of stakeholders should be convened to develop and implement an assessment tool, collect data, and prepare a report on the need for State psychiatric inpatient beds for adults and children. There continue to be long waiting periods for admission to these beds due to a lack of availability. No further beds should be closed until this study is completed. (NYS Psychiatric Association, NYSPA)

- OMH should support a strong local planning process, especially the work of Community Service Boards and MH Subcommittees with consumers and family members on them. (NAMI)

- 5.07 Plans from the past included regional plans which could lead to an aggregation of needs and priorities for the State plan. Also, previous 5.07s included definitions of SPMI and SED and these practices should be reinstituted. (NAMI)

Other Issues

- The longstanding cap on increases in Medicaid spending for mental health services has artificially limited system growth and hence, service use, making utilization data an even less reliable proxy for need. (NYCDOHMH)

- OMH should further enhance the opportunity for public participation in the planning process through the creation of regional child mental health planning advisory committees and a statewide child mental health planning advisory committee. (CMHAN)

- There are major gaps in both the capacity and infrastructure (funding) of housing services. (Coalition; NAMI; Advocate, A; Covenant House New York; Community Access; MHA; OHEL Children's Home and Family Services, OHEL)

- OMH should increase its efforts to improve cultural competency in the mental health system through training, resources for translation of psychoeducational and other materials, and provide resources for the recruitment of specialized culturally competent clinicians. (NYCHHC, PEF)
- OMH should provide resources to promote the use of physician extenders such as psychiatric physician assistants, peer counselors, and peer case managers. (NYCHHC)
- OMH should make use of work that was done in planning SNPs to fund demonstration projects targeted to a high-user population in a capitation model that spreads the financial risk fairly across the providers and various State and city governmental entities. (NYCHHC)
- OMH should advocate for a policy in the Executive Budget planning process for a global review of other state agencies' budget proposals to determine the impact on OMH programs and services and individuals with mental illness. (NYSPA)
- OMH should support exclusion of psychiatric medications from any Medicaid pharmacy management plan that would establish limited access to certain listed drugs. (NYSPA)
- OMH should support electroconvulsive therapy (ECT) as a valuable and necessary tool and oppose special restrictions on access to ECT. (NYSPA)
- OMH should designate a liaison to Article 28 facilities. Also, OMH should issue the Inpatient Utilization Review Manual jointly drafted by OMH, DOH, and representatives of Article 28's and providers.
- OMH should identify discriminatory health insurance coverage for MH treatment as a major impediment to access to care and a major source of additional cost to the State. (NYSPA)
- Individuals with mental illness leaving the State psychiatric system and the State and local correctional system should be deemed eligible for Medicaid to assure continuity of care and ongoing access to medication. (NYSPA)
- The State plan should include support for continued State funding of research in mental illness. NKI and NYSPI are two excellent research institutions. (NYSPA, NAMI)
- There is a need for additional case management for residents of adult homes. (NAMI)
- There is a need for additional psychiatric inpatient beds for inmates of State prisons. (The Correctional Association of New York, CANY; Community Access)
- Prisoners with mental illness are inappropriately placed in Special Housing Units. Additional mental health treatment and housing options in the prisons are needed. (CANY, UJC)
- OMH should increase capacity of Intermediate Care Programs in the prisons. (UJC)
- OMH should offer a continuum of treatment options in each of the varying levels of prison facilities. (UJC, A)
- OMH should use the Brad H. settlement as a model to assure provision of services to those leaving State prisons. (UJC)
- There is a need for additional training for police in handling psychiatric emergencies. (NAMI, UJC, A)
- There is a need for additional community-based housing for released prisoners with mental illness. (UJC)
- OMH should educate NYC Human Resources and Office of Temporary Disability to the needs and limitations of individuals with mental illness and how their policies and procedures are discriminatory to this population. (UJC)
- OMH should create a Bureau of Young Adult services within the OMH adult system. This Bureau would take the initiative in developing funding streams, coordinating housing, programming, training and research, and partnering with the private sector. (Covenant House)
- OMH should have a public education campaign focused on improving employment opportunities for individuals with serious mental illness. (OHEL)

Summary of Hearings on the 2002–2006 5.07 Plan

OMH held two public hearings on the recently released "Statewide Comprehensive Plan for Mental Health Services: 2002–2006." The first was held on December 19, 2002 at the Rochester Psychiatric Center and the second hearing was held on December 20, 2002 at OMH's New York City Field Office. Summarized below are the written and oral testimony provided at those hearings.

Highlights

- The most prevalent comment was the short notice for preparing testimony. Although the Plan and Hearing Notice were posted on the OMH Web site, hard copy was not received by many until only a few days before the hearings were held. That criticism led to a broader comment about lack of local involvement prior to the production of the Plan.
- Most everyone was in support of the goals and values expressed in the Plan. Several said it was long on vision. But a second, pervasive criticism was that the Plan was not consistent with requirements of the statute, and did not translate the broad picture into a specific service configuration supported by needs analysis and other supporting data. It was felt the Plan was "more like a report and a public relations piece, than a real analysis and plan."
- From a programmatic perspective, housing was the most often cited need. While many noted that progress had been made, they felt so much more needed to be done and that the Plan was lacking in specificity.
- The NYCDOHMH testimony was generally laudatory of the collaborations with OMH, and descriptive of several of the initiatives they were taking to strengthen their planning process, and laid out several areas where they anticipated contributing to the goals of the OMH 5.07 Plan (eg. adult home assessment, housing).
- NYC Health and Hospitals Corporation felt OMH has provided strong leadership in several interagency collaborations (AOT, Project Liberty) and felt that better collaboration in planning, development and coordination of services was needed between OMH and OMRDD. A similar theme was echoed with collaboration with the Department of Heath and OASAS regarding development of integrated models of mental health care, substance abuse and primary care service delivery. The Corporation also felt expansion of NIMRS should be a priority, and supported elimination of the Medicaid neutrality requirement. The Corporation felt the Plan should have discussed the issue of the Prospective Payment System being developed by the Centers for Medicare and Medicaid Services that is scheduled to be implemented in January, 2004. The need for OMH support in local workforce development was mentioned, as were perceived gaps in the adult community services, and childrens and family services' sections.
- NAMI was supportive of the ABC's, expansion of ACT, implementing family psycho education, Project Liberty, and the collaboration with OASAS on ways to address the multiple needs of people with co-occurring disorders. NAMI was most critical of housing, stating that despite the availability of 28,500 new units "state assisted housing is being provided to only 12.6% of individuals with serious mental illness, continuing a crisis of now epic proportions." NAMI also feels that "New York has now gone below the minimum number of beds needed to serve those who need intermediate and long-term psychiatric care." Mention was made of forensic services, with NAMI feeling that the Plan doesn't reflect the kind of resources and residential treatment programs for the dually diagnosed that are needed. NAMI also asked: "What funding will replace reinvestment funding to expand local services?"
- The Coalition of Voluntary Mental Health Providers testimony focused on the planning process itself (wishing it were more bottom up and based on data), and the implications of various initiatives on their provider agencies. There was also a call for passage of a new reinvestment bill.
- The Juvenile Rights Division of the Legal Aid Society felt the Plan is "seriously deficient in the area of children's and adolescent's mental health." That conclusion was based on the assertion that OMH "has apparently not assessed or even estimated the future mental health needs of the children in New York State." Lack of planning for RTFs was also mentioned, claiming that since the program was created in the 1980's there have been long waiting lists. And once children progress to the point where they no longer need the intensive care of an RTF, the Plan "fails to ensure that a comprehensive continuum will exist anytime in the foreseeable future. Moreover, there is criticism that the Plan lacks specifics on how much program capacity will be developed over the next five years.
- Several Project Liberty Peer Support Specialists spoke in support of using peer specialists in the provision of crisis counseling and other mental health services.

MHPAC–Mental Health Planning Advisory Council

September 12, 2003

Acting Commissioner Sharon E. Carpinello, RN, Ph.D.
New York State Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Dear Commissioner Carpinello:

As in previous years, the Mental Health Planning Advisory Council met twice to review New York State's Mental Health Block Grant Application for 2004 provided by OMH. This letter was prepared from input of our members and our Subcommittee on Children and Families.

Two years have now passed since the horrible September 11 attacks. We wish to start by reiterating our thanks from last year to OMH, Governor Pataki, the Federal Emergency Management Administration (FEMA) and the Center For Mental Health Services (CMHS) for Project Liberty which so successfully addressed the mental health needs of the people in our state affected by the attacks.

The Council's input on the Block Grant Application is given below. Paragraphs dealing with the Adult Plan are identified by (A), the Children's Plan, by (C) and those relating to both, by (A&C). MHPAC has singled out the issues in the paragraphs below for special attention because we believe that they are global in character, require a great deal of attention, and are most critical to the well being and recovery of the population OMH serves.

Priority Issues:

(A&C) New York is unique in the breadth and depth of the cultural diversity of its population and resources. We are aware of OMH's effort to assure culturally relevant and sensitive access to mental health services for both adults and children. All services should continue to be adapted to meet the cultural needs of the population served.

(A) Consistent with the Council's belief in the principle of recovery, OMH should continue to emphasize a broad continuum of vocational services including integrated employment, and the removal of barriers and disincentives to employment. Employment should include both part-time and full-time work and a full array of support services. It must be commensurate with the individual's education, qualifications and needs. No one should be forced into it.

(A) Council members express their concern over the ramifications of Medicaid funding of psychiatric rehabilitation services, Personal Recovery Oriented Services (PROS) and will continue to monitor developments in this area.

(A) Lack of sufficient housing of adequate quality and affordability continues to be a persistent and grave problem in New York State for people suffering from serious mental illness (SMI). OMH should develop a model housing agreement with the state housing agency which can then be passed on to localities to use. Support services are also needed for people living in Section 8 housing. The availability of community-based housing alternatives needs increasing; OMH should investigate successful models of housing alternatives and support services in NYS with the idea of expanding such services; it should also consider convening a task force to study the issues around community-based housing and related support services.

(A) We are encouraged by the recent involvement of OMH with other NYS agencies in improving the situation of residents in adult homes. However, the situation in many adult homes is an ongoing concern and MHPAC would like to encourage OMH to continue this work at the highest level of priority.

(A&C) Successful treatment of adults and children with dual diagnosis of either substance abuse and mental illness or developmental disability and mental illness continues to be a great challenge for providers. The Council encourages OMH and its researchers to develop best practices for treating patients with dual diagnosis.

(A&C) Extremely low pay for direct care workers in the mental health industry is a very serious problem. It leads to unacceptable employee turnover, poorly trained staff and, ultimately, inferior care. There is a great need for competitive salaries and better training. We would like to see OMH become a leader in working to overcome this problem.

(A&C) Too many adults with SMI populate jails and prisons and too many adolescents with serious emotional disturbances (SED) come in contact with the justice system. MHPAC believes that OMH, as part of its best practices approach, should develop and implement guidelines for preventive measures to ensure that individuals at risk are better identified and served in a more timely and appropriate manner by the mental health system.

(C) There is a serious shortage of child psychiatrists. Additionally, pediatricians should be trained to recognize children with mental illness and SED and make appropriate referrals

We would like to encourage OMH to spearhead the development of a plan, possibly in conjunction with the federal government, to ameliorate this situation in NYS.

Other Issues:

(A&C) We encourage OMH to investigate broadening its evidence-based practice efforts to incorporate individuals' total environment and health. It has been shown that mental illness often goes hand-in-hand with other health problems or other problems. For example, loneliness and old age result in higher rate of suicide.

(A) We are pleased that the state has received a Statewide Coalitions to Promote Community-Based Care Grant and has formed a Coalition to Promote Community-Based Care for NYS. MHPAC supports the state's consideration of the needs of individuals who are at risk of unnecessary institutionalization and remains concerned about those at risk of becoming institutionalized because of lack of housing or related services.

(A) MHPAC remains concerned about the slow progress of developing a data collection and reporting system. The Council is pleased that OMH received a data infrastructure grant to support its efforts in this area and looks forward to periodic updates as the project progresses. We hope to see the MHSIP Consumer Satisfaction Report Card as part of this effort and encourage NYS to work with CMHS guided by HIPAA principles.

(A&C) OMH should continue to seek methods to provide nontraditional and flexible models of treatment and funding streams. This should apply to adults as well as children and families. OMH should continue assisting families to maintain children at home and in the community. Crisis services for adults suffering from mental illness and children with SED and their families should be strengthened.

(A&C) In addressing the needs of children, families and adults, OMH must continue efforts at early identification and prevention, particularly through schools, colleges, the medical community, and social services. Links with schools, school-based services and collaborative programs with child protective and family foster care services must be maintained and strengthened. Identification, prevention and timely treatment should be encouraged to assist both adults and children, at the earliest possible moment, to improve their chances for recovery and a meaningful life in the community. This intervention should be focused on the individual and family and include access to a full range of services.

(C) The Council believes that OMH's initiative, Single Point of Accessability (SPOA) can be an effective model for identifying youngsters with the highest needs and assuring access to services for them. Since counties with close collaboration between SPOA and Coordinated Children's Service Initiative (CCSI) have had success in implementing this initiative, we encourage OMH to continue supporting these collaborations at the local level.

(C) The Council commends OMH for its efforts to address transitional services for adolescents aging out of the children's mental health system and encourages OMH to expand these efforts. MHPAC believes that there is a need for an increase in transitional beds, supportive services and vocational/educational opportunities for these adolescents. All programs and services should be attentive to each individual's needs.

(C) While the Council acknowledges the growth in the Home and Community-Based Services (HCBS) waiver program, we encourage OMH to find mechanisms to increase the size of the program to cover more children.

(A&C) Additional gaps in service have been identified by the Council, in addition to those listed in the Application. They include: need for better planning, availability of early identification/prevention protocols, suicide prevention services and services for seniors and other specialized populations, and better access to dental care.

The Council appreciates the opportunity to review the State's Mental Health Block Grant Application and trusts that our comments and recommendations will aid OMH in carrying out its plans and programs. As always, we welcome the opportunity to meet with you throughout the year to discuss the Application, Implementation and related issues.

As required, the Mental Health Planning Advisory Council also reviewed the 2003 Implementation Report and believes that it reflects the progress that has been made.

Yours truly,

Isaac D. Rubin, Ph.D, Chairperson

cc: Ms. LouEllen Rice

Multicultural Advisory Committee

Authorization:

The Multicultural Advisory Committee was created administratively by the Commissioner of Mental Health in the late 1980s.

Purpose:

The Multicultural Advisory Committee advises the Commissioner of Mental Health on policy, programs, and activities regarding service provision to individuals from diverse ethnic and cultural backgrounds who are diagnosed with mental illness. The Committee makes recommendations to improve understanding of the clinical needs of this population and to assist with the design and development of culturally appropriate treatment and support strategies.

Members:

Members appointed to the MAC by the Commissioner represent diverse cultural communities. Members are also appointed with consideration for representation from all regions of the state, mental health discipline and training, demonstrated leadership, experience in research, manpower development and training, and service delivery.

Name	Location
Cessie Alfonso, ACSW, R-LCSW,	Albany, NY
Jyoti R. Barot, Ph.D.	Amityville, NY
Joan D. Barrett	Binghamton, NY
Celia Brown	New York, NY
Cathy Cave	Albany, NY
Nolly Climes, MAC Co-Chair	Middletown, NY
Casemiro Epe, Jr.	Binghamton, NY
Ali Gheith, M.S.	New York, NY
Ulysses Harrell, M.S.W., MAC Co-Chair	Buffalo, NY
Gregory Hicks	Brooklyn, NY
Anthony Hunter	New York, NY
Sabrina Johnson	White Plains, NY
Kandee Kennedy	New York, NY
Wendell Knight, MAC Co-Chair	Hempstead, NY
Gail P. Lyons	Nedrow, NY
Jacqueline Melecio, M.S.W.	Albany, NY
John M. Morihisa, M.D.	Albany, NY
D.D. O'Neill	Staten Island, NY
Minerva Torres Orta, MSW	Newburg, NY
Lenora Reid-Rose, MAC Chairperson	Rochester, NY
Denila Rosa, Ph.D.	Fairlawn, NJ
Warren Skye, Jr.	Batavia, NY
Joseph Suarez, Ph.D.	Jackson Heights, NY
DeMecia Wooten-Irizarry	New York, NY

As of December 2003

Recipient Advisory Committee

Authorization:

The Recipient Advisory Committee was created administratively by the Commissioner of Mental Health in the early 1990s.

Purpose:

The Recipient Advisory Committee (RAC) was established in 1993 to provide the Office of Mental Health with a formal mechanism for gathering information on the perspectives and concerns of people who receive or have received mental health services. The RAC is an advisory committee to the Commissioner that assists the Bureau of Recipient Affairs to obtain broad, grassroots input into how to foster activities that promote recovery, growth and autonomy in environments that are respectful of the rights and dignity of the individual.

Members:

To be a member, an individual must have demonstrated grassroots ties to the region in which they work or reside. Members commit to bringing input from their respective regions to the Commissioner and the Recipient Affairs Bureau and also bringing back to their region information learned from the Commissioner and the Bureau of Recipient Affairs.

Name	Location
Benjamin Allen	Richmond Hill, NY
John Allen	Albany, NY
Peter Ashenden	Albany, NY
Ron Bassman	Albany, NY
Celia Brown	New York, NY
Isaac Brown	Brooklyn, NY
Cathy Cave	Albany, NY
Amy Colesante (Shanty)	Albany, NY
Doug Drew	West Brentwood, NY
Bill Gamble	Middletown, NY
Carole Hayes-Collier	Syracuse, NY
Ellen Healion	Central Islip, NY
Kathy Lynch	Buffalo, NY
Susan Orens	Albany, NY
Victor Pagano	Albany, NY
Brian Phillips	Rochester, NY
Larry Roberts	Ithaca, NY
Harvey Rosenthal	Albany, NY
Jody Silver	New York, NY
Jody Szczech	Rochester, NY
Toni Turner, Chairman	Auburn, NY

As of December 2003

Mental Health Services Council

Authorization

The Mental Health Services Council is authorized by Section 7.05 of New York State Mental Hygiene Law

Purpose

Under Section 7.05, "the Council may consider any matter relating to the improvement of mental health services in the State and shall advise the Commissioner on any such matter..." There are three committees which are required by statute: Regulation (for the review and approval or disapproval of OMH proposed regulations), Prior Review Committee (for the review and approval or disapproval of PARs, a.k.a. CON's), and the Planning Committee (which is charged with identifying attainable goals and objectives for the OMH statewide comprehensive planning process).

Members

The Commissioner is an ex officio member, as is the Chairman of the Conference of Local Mental Hygiene Directors. There are 24 members, appointed through the Governor's Office. They are required to meet at least quarterly and more often if necessary. While each committee meets in person quarterly, some committees hold conference calls to move business during "off" months. MHSC also held a hearing, its first, on planning during 2003.

Name	Location
David S. Brownell, ACSW	Syracuse, NY
Pinny Cooke	Rochester, NY
Steven J. Friedman	Yorktown Heights, NY
Eve Hazel, Ph.D.	New York, NY
Jerry Klein	Monsey, NY
Thomas O. MacGilvray	Hauppauge, NY
Leslie Major, M.D.	Binghamton, NY
Peter V. McGinn, Ph.D.	Binghamton, NY
John Morihisa, M.D.	Albany, NY
Gail Nayowith	New York, NY
John Victor Oldfield	Syracuse, NY
Barry B. Perlman, M.D., Chairman,	Yonkers, NY
Edgar R. Scudder, CSWR,	Herkimer, NY
Louis B. Tehan, Jr.	Utica, NY

As of December 2003

Mental Health Planning Advisory Council

Authorization:

P.L. 99-660; currently Section 1914 of Part B, Title XIX of the Public Health Services Act.

Purpose:

The Mental Health Planning Advisory Council (MHPAC) was formed in 1988 as a result of the federal statute creating the Mental Health Block Grant, which required states to establish planning councils in order to be eligible to receive federal block grant funding. The role of MHPAC is to advise, review, monitor and evaluate all aspects of the development and implementation of OMH's Block Grant Plan.

Members:

The authorizing legislation stipulates that the membership include state agency representatives, public and private entities concerned with mental health services, adults who are or have received mental health services, and family members of such adults or children with emotional disturbances. There are currently 28 members from a myriad of stakeholder groups who meet 4 times a year.

Name	Location
Douglass Bailey	Albany, NY
Jack Cadalso, CSW	Schenectady, NY
Angela Cerio	Staten Island, NY
Lorraine Chesin, ACSW	Delmar, NY
Anthony D'Amore	Lancaster, NY
George Ebert	Sterling, NY
Ruth Fennelly	Wynantskill, NY
Patricia Fitzmaurice	Albany, NY
Alfred Fusco,	Syracuse, NY
Judith B. Gallo	Rensselaer, NY
Joseph A. Glazer, J.D.	Albany, NY
Ulysses Harrell, M.S.W.	Buffalo, NY
Carole Hayes Collier	Syracuse, NY
Lisa Irizarry	Albany, NY
Jerome Klein	Monsey, NY
Sylvia Lask	Bronx, NY
Melissa Levow	New York, NY
John M. Morihisa, M.D.	Albany, NY
Richard Nussbaum	Albany, NY
Paige Pierce Macdonald	Albany, NY
Jane Plapinger	New York, NY
Eric Redlener, Ph.D.	New Rochelle, NY
Isaac D. Rubin, Ph.D., Chairperson	Wappingers Fall, NY
L. Mark Russakoff, M.D.	Sleepy Hollow, NY
Muriel Shepherd	New Paltz, NY
Susan B. Somers	Rensselaer, NY
John Wiechec	Albany, NY
McKenzie Willis	Albany, NY

As of December 2003

Commissioner's Committee for Families

Authority:

The Commissioner's Committee for Families was created administratively by the Commissioner of Mental Health in the late 1990s.

Purpose:

The Commissioner's Committee for Families is comprised of 21 community-oriented and diverse mental health advocates from across the state.

These individuals advise the Commissioner on mental health policy and planning and work closely with OMH staff to assure coordinated, effective and timely public mental health services. The Commissioner established this Committee in l998.

Members:

The members of the Commissioner's Committee for Families are chosen by the Commissioner of Mental Health

Name	Location
Peter Campanelli	New York, NY
Martin Cirincione	Albany, NY
Patricia Dinardo	Shortsville, NY
Reverend Robert Eskridge	Corning, NY
Joseph Fodero, Ed.D.	Oneonta, NY
Michael Friedman	White Plains, NY
Neil Futterman	Monsey, NY
Sherry Grenz	Delmar, NY
David Hymowitz, C.S.W.	Hempstead, NY
Celeste Johns, M.D.	Cooperstown, NY
Trudy Kornfein	Niskayuna, NY
Margaret LeGrande	New York, NY
Irene Levine, Ph.D.	Orangeburg, NY
Jorge Petit, M.D.	New York, NY
Davis Pollack, D.D.S.	Bay Shore, NY
Aviva Rice	New York, NY
Barbara Roth	Old Bethpage, NY
David Seay, J.D.	Albany, NY
Michael Silverberg	New York, NY
Ellen Tollefsen	Hampton Bays, NY
Casey Truillo	Binghamton, NY

As of December 2003

New York State Suicide Prevention Council

The NYS Suicide Prevention Council was formed following a 1998 national conference organized by the Suicide Prevention Advocacy Network (SPAN/USA). The goal of the Council is to promote suicide awareness and development of a statewide suicide prevention plan for New York.
SPAN/USA is a national organization started by the Weyrauch family in Georgia, following the death of their 34 year old daughter to suicide. It has attracted researchers, suicidologists, survivors and interested parties and actively collaborated with the Surgeon General in his 1999 Call to Action to Prevent Suicide and the National Strategy for Suicide Prevention announced in 2001. The National Strategy is a massive effort, spanning several Federal agencies (including SAMHSA), state governments, non-profit organizations, communities, and others. One of its primary goals is for each state to develop and implement its own statewide prevention plan. About 30 states have done so.

The New York State Suicide Prevention Council is the de facto state affiliate of SPAN. Like SPAN, the NYS Suicide Prevention Council is a public/private partnership of New Yorkers. Like SPAN/USA, the Council has been "a catalyst, a conscience, and a prod to action." Council members are drawn from leading research organizations, the U.S. Public Health Service (Region 2), local providers, such as the Samaritans, suicide survivors and families, the New York City Department of Health and Mental Hygiene, and, since 2002, the New York State Office of Mental Health with the assistance of the New York State Department of Health.

Mary Jean Coleman
Executive Director, Samaritans Suicide Prevention Center, Albany
President, Samaritans USA; Member, National Suicide Prevention Council
P.O. Box 5228,
Albany, New York 12205

Robert L. Davidson
Deputy Regional Health Administrator, Region II
U.S. Public Health Service
26 Federal Plaza, Room 3835
New York, New York 10278

Connie Dunne
Nassau County Department of Senior Citizen Affairs
32 Pearsall Avenue, Apt. 1H
Glen Cove, New York 11542

Laurie Flynn
Roisin O'Mara
The Carmel Hill Center
Division of Child & Adolescent Psychiatry
Columbia University
Teen Screen Program
1775 Broadway, Suite 715
New York, New York 10019

Madelyn Gould, Ph.D., M.P.H.
Professor of Psychiatry and Public Health
Division of Child Psychiatry
Columbia University &
Research Scientist, NYSPI
1051 Riverside Drive, Unit 72
New York, New York 10032

Jack Herrmann, M.S. Ed., NCC
Project Coordinator
Univ. of Rochester Center for Study and Prevention of Suicide
300 Crittenden Boulevard
Rochester, New York 14642

Kerry L. Knox, Ph.D.
Assistant Professor
Dept. of Psychiatry & Community and Preventive Medicine
Univ. of Rochester Medical Center
601 Elmwood Avenue, Box 644
Rochester, New York 14642

J. John Mann, MD
Chief of Neuroscience, NYSPI &
Professor of Psychiatry and Radiology
Columbia University College of Physicians & Surgeons
Box 42, New PI 2917C
1051 Riverside Drive
New York, New York 10032

Dempsey Rice, MA
Daughter One Productions, Inc.
335 Court Street, #161
Brooklyn, New York 11231

Marta Riser, MA
Acting Director, Bureau of Child & Adolescent Health
New York State Department of Health
Corning Tower, Room 208
Empire State Plaza
Albany, New York 12237

Dimitra Risueno, Ph.D.
Assistant Commissioner
New York City Dept. Of Health and Mental Hygiene
Suite 610, 16 Court Street
Brooklyn, New York 11241

Alan Ross
Executive Director,
Samaritans of New York, Inc.
Member, National Suicide Prevention Council
P.O. Box 1259
Madison Square Station
New York, New York 10159

David Shaffer, MD
Director of Child Psychiatry, NYSPI
& Professor of Psychiatry
Columbia University
College of Physicians & Surgeons
Box 78, Annex 221
1051 Riverside Drive
New York, New York 10032

Gary Spielmann, MA, MS
Director of Project Management
New York State
Office of Mental Health
44 Holland Avenue
Albany, New York 12229

Kurt Weyrauch, MBA
Director, SPAN USA
(Suicide Prevention Advocacy Network)
30 East 9th St., 3M
New York, New York 10003

Membership as of December 18, 2003

Association of Boards of Visitors of New York State Facilities for the Mentally Disabled

November 14, 2003

Sharon E. Carpinello, RN, Ph.D.
Acting Commissioner
Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Dear Ms. Carpinello:

On behalf of the Association of Boards of Visitors of New York State, thank you for delegating Al Holmes to represent the Office of Mental Health at our Annual Conference, October 25, 2003 in Buffalo, New York. He was both informative and amiable, as always.

Our next Executive Board meeting is in conjunction with our Legislative Brunch in Albany, February 28 to March 2, 2004 at which time we anticipate meeting with you on Monday, March 1 at the Marriott and on Tuesday, March 2 at the LOB.

We will be having a "Planning Session" for 2004 of the Association Officers at the Albany Marriott on December 5-6, 2003. We extend an invitation to you to meet with us informally at your convenience on Saturday, December 6, 2003 between 9:00 a.m. and 4:00 p.m. or join us for lunch at noon. We look forward to meeting you prior to our March 2004 Legislative meeting to get acquainted and discuss a few important issues.

Sincerely,

Patricia Okoniewski

Patricia M. Okoniewski
President, ABOV NYS

TIOGA COUNTY
DEPARTMENT OF MENTAL HEALTH

Washington-Gladden Building
1277 Taylor Road, Owego, NY 13827
www.tiogacountyny.com

Paul LeBlanc, ACSW, CSW
Director of Community Services

Ruth Shenk, MSW, CSW
Clinical Director
Children and Specialized Services

Diane Schaumberg, MSW, CSW
Clinical Director
Adult Services

Owego - (607) 687-4000
Waverly - (607) 565-9594/2800
Administration - (607) 687-0200

Owego Fax - (607) 687-0248
Waverly Fax - (607) 565-7194

November 7, 2003

Sharon E. Carpinello, RN, Ph.D.
Acting Commissioner
NYS Office of Mental Health
44 Holland Avenue
Albany, New York 12229

Re: Regional 5.07 Plan

Dear Sharon,

Enclosed with this letter, please find a submission from the 10-County Finger Lakes Counties for the 5.07 Plan.

This document details areas of concern and common need for our 10 upstate rural counties.

We feel strongly about the critical importance of local level planning and offer this document as our effort to organize this collectively and collaboratively across the 10 Counties.

We ask that the needs and issues of our region be considered as part of the overall OMH 5.07 Plan.

Please let me know if I can offer any further information about our submission.

Thank you.

Sincerely,

Paul LeBlanc, ACSW, CSW
Director of Community Services, Tioga County
Coordinator, 10 County Finger Lakes Region

PL:ch
Enclosure

• Alcohol & Drug Services • Mental Health Services • Continuing Day Treatment • Childrens Services • Administration

Conference of Local Mental Hygiene Directors Regional Mental Health Plan- November 2003

Fingerlake Counties (Allegany, Chemung, Ontario, Tioga, Tompkins, Schuyler, Seneca, Steuben, Wayne, Yates)

Regional Planning Principles

This plan is being developed by 10 Finger Lakes Counties in recognition of the following:

1. Planning for local services and local systems is best accomplished at the local level.
2. Coordination, cooperation and collaboration across the 10 County region maximizes options and enhances efficiency for each participating County.
3. Multi-county planning and multi-county service development reduces the limitations of geography, population density and other critical mass limitations forced by the counties in the region.
4. Needs and issues, which are common in multiple counties, are communicated more strongly in a joint fashion.
5. Needs and issues, which crosscut multiple counties, are likely to achieve a higher priority for resolution.

Regional Planning Issues

Services Enhancements

Children's Services – Child Psychiatry in particular is a high priority need. This is not unique to the Finger Lakes region, in fact, it is a significant deficit across much of the state. A regional solution that is supported by the respective State agencies will most likely yield practical and responsive results for the counties. The Finger Lakes Counties request support in exploring various options which may include partnering with State facilities and/or other providers in recruitment and hiring, development of regionally based fellowships, the development and implementation of telemedicine capacity and the ability to utilize Nurse Practitioners or similar staff to provide local services in collaboration/consultation with a centrally located Child Psychiatrist.

Recognition and acknowledgement is needed on both the state and the local level that significant effort and financial resources will be required to develop an effective level of service. Cost will include such items as the current high market salary requirements, the recruitment process, the development and support of fellowship opportunities, the infrastructure to implement a telemedicine initiative across 10 counties and the ongoing resources need for continuing education.

Other children's services needs **include community residence, respite services and day treatment.** Also needed is a **transitional/prevention layer of services to** prevent RTF and inpatient admissions and to facilitate quicker admissions and shorter lengths of stay. RTF lengths of stay are too long and limit access forcing less optimal interventions for many children. Maintain current capacity and facilitate step down services/preventive services to keep shortest length of stay possible for Inpatient Psychiatric Beds for Children.

Continued support is needed for the **Finger Lakes multi-county ACT team** and expansion of the team to respond to an increase in need within the counties.

Maintain current **adult inpatient psychiatric bed** availability.

Forensic Services – Those counties that have jail/forensic services rely on unstable and fragile funding mechanisms to support these services. Most jails have a high percentage of mentally ill inmates. A more stable funding source is needed. Reimbursement for mental health and addictions services provided in jails would be appropriate in assuring the engagement and follow up needed to assure after release participation in treatment efforts.

Transportation – Geographic barriers create difficulties in accessing services. Medicaid reimbursement is limited to one service per day, when available. Enhancement of access to services through improved transportation options is needed across the region.

System Enhancements

Facilitate and support the increase of **self-help, consumer-operated and natural community-based supports.** Research clearly demonstrates the effectiveness of these options.

Geriatric Services – Despite aging populations within the counties, few, if any, geriatric services exist. Due to needs and dynamics related to this age group such as multiple physical issues, multiple medication issues, physical barriers to accessing services, and generational negative perceptions of stigma and reaching out for assistance. Home-based services are needed to overcome the multiple barriers to the provision of effective services. Aging individuals are unable or unlikely to access services in their current form.

Fiscal support is needed for **Children & Youth CCSI model,** which is a very effective paradigm. CCSI has been found to be very effective in moving local service systems to a family centered/family partnership service model with accompanying beneficial improvement in the effectiveness of service interventions and the development/enhancement of natural support systems.

Develop Support and Incentives for **Multi-County Initiatives** – Most

Finger Lakes Counties depend on multi-county initiatives to address their limitations due to insufficient critical mass of need to support a full program.

Develop an **incentive-based funding** which funds success and improvement rather than narrowly defined programs and services. Experiments with such funding in such places as El Paso County Colorado have yielded very positive and cost effective results.

Administrative Enhancements

Cap County share for **Medicaid**. This largest threat to local services is the uncontrolled expansion of county cost for new or enhanced mandated Medicaid services. As these costs rise, the county funds otherwise available to support services are diverted to cover state mandated costs. This further reduces funding available for locally responsive services.

The **conversion to Medicaid/Federal COPS reimbursement of reinvestment funds** related to the PROS initiative and, most recently, the conversion to Medicaid of non-PROS reinvestment funds assigned to Clinic, CDT programs and contract services creates an additional burden on counties and providers. Cash flow becomes problematic and this change creates an exaggerated dependence on units of service that are subject to unpredictable fluctuations. A dedicated reinvestment fund is needed to insure availability of these funds to the counties to meet their specific and ongoing needs related to de-institutionalization. The conversion to Medicaid/COPS of these funds prevents the counties from reappropriating these funds to adapt to locally changing needs and reduces the flexibility of what was originally intended to be a locally flexible funding and appropriation process.

Develop, facilitate and coordinate services and service responsiveness for the **dually (MH/SA, MH/MR, SA/MR) diagnosed or triple diagnosed (MH/SA/MR).** Develop residential options for the multiply diagnosed, both adult and child.

Streamline and improve the **communication and responsiveness of state agencies.** Currently counties are forced to divert significant resources to accommodate difference timelines and requirements imposed by the Mental Hygiene State agencies. An example is the new CFRS. Three different state agencies will utilize this form in three different manners requiring adaptation by every county. Budget and plan related submissions, as well as funding processes, vary by state agency and require further diversion of resources to understand and respond to the divergent requests. Alignment by the Mental Hygiene State agencies in function, timing, communication and requirements related to common fiscal reporting is needed as soon as possible. Collaboration by the three state agencies would enable consistency and ease of reporting and access for assistance by the counties. Collocating field/regional offices to improve interagency communication, save on overhead costs and simplify communication for counties is needed.

Assistance is needed in addressing the serious problems resulting from the continual large increases in **liability coverage costs.** Services are placed in jeopardy due to the exponential inflation of these costs.

On behalf of the Finger Lakes Counties Mental Hygiene Directors:

Robert W. Anderson, PhD
Director of Community Services
Allegany and Steuben Counties

Pamela Larnard, CASAC
Director of Community Services
Yates County

Rick Hoyt, PhD
Director of Community Services
Wayne County

George Roets, RN, MS
Director of Community Services
Schuyler County

Anthony Deluca, ACSW
Director of Community Services
Tompkins County

David Heckel, CSW
Director of Community Services
Seneca County

Brian Hart, CSW
Director of Community Services
Chemung County

William Swingly, CSW
Director of Community Services
Ontario County

Paul LeBlanc, ACSW, CSW
Director of Community Services
Tioga County
Coordinator Finger Lakes Counties

Contributing to "Olmstead" Planning

In June of 1997, the U.S. Supreme Court held in Olmstead vs. L.C. that persons with mental disabilities have a right under the Americans with Disabilities Act to receive services in an integrated community setting when appropriate. OMH is involved in two planning efforts designed to assess the implications of the Olmstead decision in New York that are summarized in this Appendix.

Most Integrated Setting Coordinating Council

Authorization:

The Most Integrated Setting Coordinating Council was established through the passage of Chapter 551 of the Laws of 2002 and became effective December 16, 2002.

Purpose:

The Most Integrated Setting Coordinating Council oversees the development and implementation of a statewide plan for providing services to individuals of all ages with disabilities in the most integrated setting.

Membership:

Under the legislation, leadership of the Council rotates among the Commissioners of Mental Health, Health, OMRDD, and the director of the Office for the Aging. Other members of the Council include the Commissioners of the Office for Children and Families Services, Transportation, Office of Alcohol and substance Abuse Services, State Education, and the Division of Housing and Community Renewal. Also, representatives from the Office of the Advocate for Persons with Disabilities, the Commission on Quality of Care for the Mentally Disabled, three consumers of services for individuals with disabilities, three individuals with expertise in the field of community services for people of all ages with disabilities, and finally three individuals with expertise in or recipients of services available to senior citizens with disabilities. Meetings are at the call of the Chairman.

The Coalition to Promote Community-Based Care

Authorization:

In FY 2000, the federal Center for Mental Health Services (CMHS) awarded the Office of Mental Health a three year Grant for $20,000 per year to establish and facilitate the work of a Coalition to Promote Community-Based Care. The grant has been reauthorized for an additional three years, commencing October 1, 2003.

Purpose:

Guidelines for the grant state "the Center for Mental Health Services is committed to assisting States to expand resources and opportunities for people with serious mental illnesses and children with severe emotional disturbances to live in their home communities. This includes facilitating necessary partnerships among service delivery systems and stakeholders." CMHS awarded the funding to assist State mental health agencies in developing service linkages across all consumer-serving systems at the state and local levels in order to expand community-based supports.

Members:

According to the federal guidelines for the grant, "membership should include multiple stakeholder groups, including significant consumer and family representation, as well as representation from relevant state agencies and state level advocacy groups." The Coalition meets at irregular intervals.

Isaac Brown
Brooklyn Peer Advocacy Project
Brooklyn, NY

Jack Cadalso, CSW
Director
Schenectady County
Community Services
Schenectady, NY

Robert Eskridge
NAMI of Chemung & Steuben
Counties of New York
Corning, NY

Ulysses Harrell, M.S.W.
Social Worker 1 - Inpatient Services
Buffalo Psychiatric Center
Buffalo, NY

Carole Hayes Collier
Syracuse, NY

Irene Levine, Ph.D.
Nathan Kline Institute for
Psychological Research
Orangeburg, NY

Phillip J. Malebranche
New York, NY

Jacqueline Melecio, MSW
NASW - NYS Chapter
Albany, NY

Lenora Reid-Rose
Rochester, NY

Isaac D. Rubin, Ph.D.
NAMI-NYS Board Member
Wappingers Falls, NY

Informational Resources

OMH makes available an extensive array of information and data to aid local planning efforts through the Internet. This Appendix summarizes:

- The 2001 OMH *Progress Report* on New York State's Public Mental Health System, which contains information and data on the progress made in enhancing community-based services and improving the quality of mental health care;
- Features of the OMH Web site specifically designed to aid local planners; and
- The rapidly expanding capabilities of OMH's Data Warehouse.

2001 OMH Progress Report on New York's Public Mental Health System

The 2001 OMH *Progress Report* was a valuable companion document to the *2002–2006 Statewide Comprehensive Plan for Mental Health Services.* It provides depth and context to understanding the mental health system and the efforts being made to continuously improve that system.

OMH will not publish a separate Progress Report this year. The 2003–2007 Statewide Comprehensive Plan for Mental Health Services will be an integrated planning document which contains information previously provided in the Progress Report including an update on the Enhanced Community Services Program, progress on improving the quality of mental health care, and various reference and resource materials.

Copies of the *2001 Progress Report* may be obtained by writing to:

OMH Progress Report
NYS Office of Mental Health
44 Holland Avenue
Albany, NY 12229

The *2001 Progress Report* is also available on the OMH web site at:

http://www.omh.state.ny.us/omhweb/progressreport/index.htm

NYS Office of Mental Health Web Site

By supporting its Web site (http://www.omh.state.ny.us), OMH recognizes the great potential for disseminating information to the general public, mental health service providers, people with concerns regarding psychiatric disabilities, researchers, clinicians and to OMH employees. The OMH Web site averages over 6,000 unique visitors weekly.

The OMH Web site is organized into "areas of interest." The site has been structured according to user needs and also contains a search function and site map to assist visitors. Spanish language versions are available for many of the OMH web pages. The site can be used as a consolidated source of information on mental health services, programs and regulations. The site contains a description of the OMH mission and vision, as well as extensive information on the Evidence-Based Practices initiative, which seeks to improve the ABCs of mental health care, which include accountability for results, best practices, and coordination of services and programs throughout the mental health system in New York State.

The site contains information on OMH Initiatives such as Kendra's Law and Violence Prevention. Numerous OMH publications are available for download, including the OMH Quarterly, the Statewide Plan for Comprehensive Mental Health Services and Crisis Counseling for Children and Families in Disasters. The OMH Chartbook of Mental Health Information and Patient Characteristics Survey make comprehensive statistical information available to the public. Other areas of interest include a section on HIPAA, Forensic Mental Health and the Ticket to Work. Employment openings at OMH facilities and Central Office are also posted along with general information on employment at OMH.

Through the OMH Internet site, we hope that we can share information with anyone who has an interest in mental health. The site continues to evolve based on the OMH pledge to promote and enact positive changes for the current system of care to reflect a continued commitment to ensuring the highest quality and most effective mental health services possible.

OMH Enterprise Data Warehouse Components Available to Local Mental Health Departments

The OMH Enterprise Data Warehouse is a repository of data from a wide variety of sources that are strategically important to the agency. The data warehouse organizes and integrates these data to facilitate rapid ad-hoc analysis and reporting. Over the several years of its development, the OMH enterprise data warehouse has become a cornerstone of the agency's increasing capacities for data-driven performance-based management.

Over the past two years, OMH has opened up much of the enterprise data warehouse for use by authorized staff at local mental authorities around the state. This unprecedented data sharing and decision-support initiative is designed to provide local mental health administrators with access to relevant and timely information about quality and efficacy of mental health programs. This initiative consists of several key components:

OMH Data Warehouse Infrastructure

Basic Structure

The OMH Data Warehouse is comprised of three basic layers: the data integration layer, the data mart layer, and the data presentation layer.

- The **data integration layer** stores all data extracted from the various operational systems that feed the Data Warehouse. Data content includes but is not limited to: service encounters, financial information, and recipient and provider characteristics.

- The **data mart layer** is where project-specific views of the data integration layer content are deployed. Data marts are constructed to meet the unique information needs of various audiences/departments.
- The **data presentation layer** contains the tools-reports, graphs, Web pages, and other more sophisticated ad-hoc query and analytic tools-through which end-users interact with the Data Warehouse contents and turn data into information.

Data Marts

There are four data marts available to local mental health authorities at this time:

- **MedFisA–** The Medicaid Fiscal Aggregate data mart contains summary information about Medicaid claims and payments for mental health services beginning January 1995. This data mart is updated on a quarterly basis.
- **PCS–** The Patient Characteristics data mart contains demographic, clinical and service data as reported on the biannual Patient Characteristics Survey of 1999. Currently, data from the 1999 and 2001 PCS are available.
- **Medicaid Info–** This data mart will become a key source of information for planning and evaluation of performance and will ultimately replace the Medicaid Fiscal Aggregate data mart. This data mart provides detail level information about services, clinical, demographic, and fiscal factors while preserving individual level confidentiality (as required and defined by the Health Information Portability and Accountability Act).
- **Project Liberty–** This data mart provides information about mental health services provided to individuals experiencing trauma as a result of the September 11 terrorist attacks. It is available to counties participating in the Project Liberty grant.

Query Tool

OMH has installed Oracle Discoverer as the software product for accessing information from the data marts. This tool provides a familiar windows-based, spreadsheet-like format that makes it easy for users to tailor their requests for information without having to learn a syntactically complex query language.

Web Portal

Local mental health authorities can access the OMH Data Warehouse via the Internet through a secure Web portal, called Bridges, that contains links to all data presentation layer tools and data marts relevant to a specific user. This portal also contains links to announcements, technical assistance, and e-mail for feedback. Access to sections of the Bridges portal that contain sensitive data is restricted via a token authentication device.

State and Local Partnership

OMH has been working closely with the Conference of Local Mental Hygiene Directors (CLMHD) and individual counties to create an information sharing environment that is relevant and responsive to county needs.

- Pilot Counties
  Six counties (Erie, Monroe, Onondaga, Suffolk, Westchester, Wyoming) and New York City are participating in a pilot test of data warehouse accessibility and usefulness. Lessons learned from evaluation of this pilot are being incorporated into warehouse improvements.
- SHARE workgroup
  The SHARE workgroup consists of staff from OMH, CLMHD, and Coordinated Care Services, Inc. (CCSI) of Monroe County. The group is jointly responsible for disseminating information about warehouse features and availability for local mental health authorities, providing training and assistance with use of Oracle Discoverer, providing mechanisms for receiving and evaluating feedback, encouraging county collaboration, and recommending warehouse improvements.

Utilization of Inpatient Beds

Capacity data is aggregated for New York City to match bed usage data where New York City county-level data is unavailable for all inpatient categories. Inpatient capacity uses total 2003 licensed or approved information by State Psychiatric Center, general hospital unit, and private hospitals. For inpatient capacity in Tables 1 and 3 in Appendix 5, State Psychiatric Center beds are allocated to the counties in the catchment area based on the county of residence of current inpatients, and all Article 28, Article 31, and Residential Treatment Facility beds are allocated to the county the hospital or facility is located in. Data sources for all inpatient capacity graphs and tables are the OMH Bureau of Certification and Inspection licensed bed capacity as of September 2003, Department of Mental Hygiene Information System (DMHIS) State psychiatric census data for April 1, 2003, and the 2000 U.S. Census data.

Utilization of adult and child inpatient psychiatric hospital beds is presented in Appendix 5 by examining total inpatient average daily census in 2001. This county-level information is displayed by auspice (Article 28 hospital inpatient beds, Article 31 hospital inpatient beds, Residential Treatment Facilities (RTF), and State Psychiatric Center beds) and population. For inpatient average daily census in Tables 2 and 4 in Appendix 5, State Psychiatric Center census is allocated to the county of residence of inpatients. Unlike the capacity data, all Article 28, Article 31, and Residential Treatment Facility census are assigned to the county of residence of clients. State Psychiatric Center census data for 2001 is obtained from DMHIS. Article 28 census data is obtained for persons with primary psychiatric diagnoses from New York State Department of Health (DOH) 2001 SPARCS data. Article 31 and RTF census data are obtained from Medicaid Management Information System (MMIS) data. Since Article 31 and RTF files do not include all patients with psychiatric diagnoses, estimated aggregate census is an underestimate of its true value. Census data is based on the 2000 U.S. Census.

NYS Counties by Region

Region	Counties	
Central	Broome	Jefferson
	Cayuga	Lewis
	Chenango	Madison
	Clinton	Montgomery
	Cortland	Oneida
	Delaware	Onondaga
	Essex	Oswego
	Franklin	Otsego
	Fulton	St. Lawrence
	Hamilton	Tioga
	Herkimer	Tompkins

Region	Counties	
Hudson River	Albany	Saratoga
	Columbia	Schenectady
	Dutchess	Schoharie
	Greene	Sullivan
	Orange	Ulster
	Putnam	Warren
	Rensselaer	Washington
	Rockland	Westchester
New York City	Bronx	Queens
	Kings	Richmond
	New York	

Region	Counties	
Long Island	Nassau	
	Suffolk	
Western	Allegany	Niagara
	Cattaraugus	Ontario
	Chautauqua	Orleans
	Chemung	Schuyler
	Erie	Seneca
	Genesee	Steuben
	Livingston	Wayne
	Monroe	Wyoming
		Yates

Table 1
2003 Adult Inpatient Capacity by County*

County	2000 Adult Population (> or = 18)**	Licensed Article 28 Capacity	Article 28/ 100,000	Licensed Article 31 Capacity	Article 31/ 100,000	2003 PC Census from County***	State Inpatient/ 100/000	Total Inpatient	Total Inpatient/ 100,000
Albany	228,088	53	23.2	0	0.0	93	40.8	146	64.0
Allegany	37,733	0	0.0	0	0.0	1	2.7	1	2.7
Bronx	935,278	379	40.5	0	0.0	396	42.3	775	82.9
Broome	154,441	69	44.7	0	0.0	103	66.7	172	111.4
Cattaraugus	61,992	14	22.6	0	0.0	5	8.1	19	30.6
Cayuga	61,400	14	22.8	0	0.0	8	13.0	22	35.8
Chautauqua	105,519	50	47.4	0	0.0	14	13.3	64	60.7
Chemung	68,860	25	36.3	0	0.0	32	46.5	57	82.8
Chenango	37,940	0	0.0	0	0.0	8	21.1	8	21.1
Clinton	61,546	22	35.7	0	0.0	8	13.0	30	48.7
Columbia	47,910	18	37.6	0	0.0	11	23.0	29	60.5
Cortland	37,093	15	40.4	0	0.0	1	2.7	16	43.1
Delaware	36,971	0	0.0	0	0.0	6	16.2	6	16.2
Dutchess	209,882	46	21.9	0	0.0	53	25.3	99	47.2
Erie	719,715	223	31.0	68	9.4	183	25.4	474	65.9
Essex	29,993	0	0.0	0	0.0	2	6.7	2	6.7
Franklin	39,489	12	30.4	0	0.0	7	17.7	19	48.1
Fulton	41,385	0	0.0	0	0.0	3	7.2	3	7.2
Genesee	44,640	0	0.0	0	0.0	4	9.0	4	9.0
Greene	37,103	0	0.0	0	0.0	3	8.1	3	8.1
Hamilton	4,320	0	0.0	0	0.0	1	23.1	1	23.1
Herkimer	48,735	0	0.0	0	0.0	2	4.1	2	4.1
Jefferson	82,164	25	30.4	0	0.0	17	20.7	42	51.1
Kings	1,802,827	841	46.6	0	0.0	613	34.0	1,454	80.7
Lewis	19,450	0	0.0	0	0.0	3	15.4	3	15.4
Livingston	49,265	0	0.0	0	0.0	5	10.1	5	10.1
Madison	52,134	0	0.0	0	0.0	1	1.9	1	1.9
Monroe	547,087	136	24.9	0	0.0	149	27.2	285	52.1
Montgomery	37,544	22	58.6	0	0.0	6	16.0	28	74.6
Nassau	1,005,465	291	28.9	0	0.0	239	23.8	530	52.7
New York	1,279,279	1,047	81.8	150	11.7	628	49.1	1,825	142.7
Niagara	165,609	66	39.9	0	0.0	36	21.7	102	61.6
Oneida	179,225	61	34.0	0	0.0	69	38.5	130	72.5
Onondaga	340,255	80	23.5	43	12.6	97	28.5	220	64.7
Ontario	74,749	18	24.1	0	0.0	12	16.1	30	40.1
Orange	242,211	82	33.9	0	0.0	72	29.7	154	63.6
Orleans	32,612	0	0.0	0	0.0	4	12.3	4	12.3
Oswego	89,629	32	35.7	0	0.0	7	7.8	39	43.5
Otsego	47,701	36	75.5	0	0.0	5	10.5	41	86.0
Putnam	70,371	20	28.4	0	0.0	8	11.4	28	39.8
Queens	1,720,155	509	29.6	50	2.9	512	29.8	1,071	62.3
Rensselaer	115,566	63	54.5	0	0.0	14	12.1	77	66.6
Richmond	330,470	119	36.0	0	0.0	75	22.7	194	58.7
Rockland	206,467	62	30.0	0	0.0	93	45.0	155	75.1
Saratoga	150,387	16	10.6	40	26.6	6	4.0	62	41.2
Schenectady	110,893	36	32.5	0	0.0	19	17.1	55	49.6
Schoharie	24,013	0	0.0	0	0.0	3	12.5	3	12.5
Schuyler	14,351	0	0.0	0	0.0	2	13.9	2	13.9
Seneca	25,069	0	0.0	0	0.0	2	8.0	2	8.0
St. Lawrence	85,710	28	32.7	0	0.0	30	35.0	58	67.7
Steuben	73,027	26	35.6	0	0.0	17	23.3	43	58.9
Suffolk	1,049,288	203	19.3	330	31.4	347	33.1	880	83.9
Sullivan	55,514	18	32.4	0	0.0	23	41.4	41	73.9
Tioga	37,777	0	0.0	0	0.0	12	31.8	12	31.8
Tompkins	78,205	26	33.2	0	0.0	18	23.0	44	56.3
Ulster	135,978	37	27.2	0	0.0	30	22.1	67	49.3
Warren	48,111	32	66.5	0	0.0	7	14.5	39	81.1
Washington	46,014	0	0.0	0	0.0	5	10.9	5	10.9
Wayne	68,050	16	23.5	0	0.0	10	14.7	26	38.2
Westchester	692,662	514	74.2	87	12.6	108	15.6	709	102.4
Wyoming	32,980	12	36.4	0	0.0	4	12.1	16	48.5
Yates	18,053	12	66.5	0	0.0	5	27.7	17	94.2
Grand Total	**14,286,350**	**5,426**	**38.0**	**768**	**5.4**	**4,257**	**29.8**	**10,451**	**73.2**

* Unless otherwise specified, data is from 9/3/03 Concerts System

** Source: U.S. Census Bureau

*** Source: DMHIS

Table 2
2001 Adult Average Daily Bed Usage

County	2000 Adult Population (> or = 18)	Article 28	Article 31	State PC	Total Inpatient	Rate/100,000 Population
Albany	228,088	51.3	0.7	90.7	142.6	62.5
Allegany	37,733	4.5	0.0	4.1	8.6	22.7
Broome	154,441	37.7	0.1	100.9	138.7	89.8
Cattaraugus	61,992	9.6	0.1	8.2	17.9	28.9
Cayuga	61,400	11.1	0.3	11.9	23.3	37.9
Chautauqua	105,519	18.0	0.3	28.6	46.9	44.4
Chemung	68,860	17.6	0.1	29.1	46.7	67.9
Chenango	37,940	5.8	0.0	7.2	13.0	34.3
Clinton	61,546	9.6	0.0	21.6	31.2	50.8
Columbia	47,910	10.7	0.0	15.7	26.4	55.2
Cortland	37,093	5.7	0.0	2.1	7.8	21.1
Delaware	36,971	4.1	0.0	10.4	14.6	39.4
Dutchess	209,882	45.1	0.5	75.5	121.0	57.7
Erie	719,715	156.7	1.4	196.4	354.4	49.2
Essex	29,993	3.8	0.0	2.8	6.6	21.9
Franklin	39,489	4.9	0.0	7.4	12.3	31.0
Fulton	41,385	5.3	0.1	5.9	11.3	27.4
Genesee	44,640	5.4	0.2	2.6	8.2	18.4
Greene	37,103	5.6	0.1	6.3	11.9	32.1
Hamilton	4,320	0.2	0.0	1.4	1.6	38.2
Herkimer	48,735	6.9	0.0	6.5	13.4	27.5
Jefferson	82,164	12.5	0.3	14.0	26.8	32.6
Lewis	19,450	2.7	0.0	5.2	8.0	40.9
Livingston	49,265	3.7	0.1	6.0	9.7	19.7
Madison	52,134	3.9	0.4	3.0	7.3	14.1
Monroe	547,087	103.6	0.0	160.4	263.9	48.2
Montgomery	37,544	6.9	0.0	6.6	13.5	36.1
Nassau	1,005,465	181.6	3.9	295.1	480.5	47.8
Niagara	165,609	25.6	0.7	41.3	67.6	40.8
Oneida	179,225	34.7	0.1	80.3	115.1	64.2
Onondaga	340,255	48.0	0.7	115.9	164.6	48.4
Ontario	74,749	8.3	0.0	17.4	25.6	34.3
Orange	242,211	42.4	0.6	103.3	146.3	60.4
Orleans	32,612	2.3	0.1	4.8	7.2	22.0
Oswego	89,629	16.7	0.0	4.0	20.7	23.1
Otsego	47,701	6.9	0.0	8.2	15.1	31.6
Putnam	70,371	15.2	0.0	8.1	23.3	33.2
Rensselaer	115,566	25.6	0.0	16.7	42.3	36.6
Rockland	206,467	51.7	0.5	98.7	150.9	73.1
Saratoga	150,387	15.3	0.5	17.0	32.8	21.8
Schenectady	110,893	26.3	0.4	27.0	53.8	48.5
Schoharie	24,013	3.8	0.0	3.5	7.3	30.3
Schuyler	14,351	1.5	0.0	2.4	3.9	27.2
Seneca	25,069	2.4	0.0	5.4	7.8	31.1
St. Lawrence	85,710	19.9	0.0	34.8	54.7	63.8
Steuben	73,027	10.6	0.0	12.9	23.5	32.2
Suffolk	1,049,288	155.4	11.0	399.6	566.0	53.9
Sullivan	55,514	13.6	0.1	28.3	41.9	75.5
Tioga	37,777	3.7	0.0	12.5	16.2	42.8
Tompkins	78,205	9.7	0.0	14.9	24.6	31.4
Ulster	135,978	31.2	0.6	41.6	73.3	53.9
Warren	48,111	10.4	0.2	9.2	19.8	41.2
Washington	46,014	7.2	0.0	5.2	12.4	27.0
Wayne	68,050	8.4	0.0	6.5	14.8	21.8
Westchester	692,662	193.4	1.9	134.0	329.3	47.5
Wyoming	32,980	3.5	0.0	5.7	9.2	27.8
Yates	18,053	2.2	0.0	5.1	7.2	40.0
New York City*	6,068,009	2126.4	57.2	2126.0	4309.6	71.0
Grand Total	**14,286,350**	**3656.3**	**83.1**	**4515.6**	**8255.1**	**57.8**

* NYC could not be broken out into individual counties

Data Sources:
Article 31 is based on Medicaid eligible residents
State PC Census: DMHIS
Article 28: SPARCS
Population: 2000 US Census

Data does not include 18 year adults in RTF's.

Table 3
2003 Children's and Youth Inpatient Capacity by County*

County	2000 Population <18**	Licensed Article 28 Capacity	Article 28/ 100,000	Licensed RTF Capacity	RTF/ 100,000	Licensed Article 31 Capacity	Article 31/ 100,000	2002 PC Census from County***	State PC/ 100/000	Total Inpatient	Inpatient/ 100,000
Albany	71,257	0	0.0	20	28.1	0	0	3	4.2	23	32.3
Allegany	13,391	0	0.0	0	0.0	0	0.0	3	22.4	3	22.4
Bronx	416,757	25	6.0	32	7.7	0	0.0	49	11.8	106	25.4
Broome	49,664	0	0.0	0	0.0	0	0.0	5	10.1	5	10.1
Cattaraugus	23,338	0	0.0	0	0.0	0	0.0	3	12.9	3	12.9
Cayuga	21,656	0	0.0	42	193.9	0	0.0	2	9.2	44	203.2
Chautauqua	36,792	10	27.2	0	0.0	0	0.0	2	5.4	12	32.6
Chemung	23,249	0	0.0	0	0.0	0	0.0	7	30.1	7	30.1
Chenango	14,166	0	0.0	18	127.1	0	0.0	0	0.0	18	127.1
Clinton	19,843	12	60.5	0	0.0	0	0.0	1	5.0	13	65.5
Columbia	15,886	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Cortland	12,669	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Delaware	11,838	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Dutchess	73,935	13	17.6	20	27.1	0	0.0	10	13.5	43	58.2
Erie	243,470	16	6.6	59	24.2	20	8.2	18	7.4	113	46.4
Essex	9,264	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Franklin	12,255	0	0.0	0	0.0	0	0.0	2	16.3	2	16.3
Fulton	14,324	0	0.0	0	0.0	0	0.0	2	14.0	2	14.0
Genesee	16,413	0	0.0	0	0.0	0	0.0	3	18.3	3	18.3
Greene	11,822	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Hamilton	1,139	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Herkimer	16,537	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Jefferson	31,204	0	0.0	0	0.0	0	0.0	5	115.4	5	16.0
Kings	693,324	46	6.6	0	0.0	0	0.0	36	0.0	82	11.8
Lewis	7,900	0	0.0	0	0.0	0	0.0	0	25.3	0	0.0
Livingston	16,543	0	0.0	0	0.0	0	0.0	2	0.0	2	12.1
Madison	18,987	0	0.0	0	0.0	0	0.0	0	47.4	0	0.0
Monroe	198,343	25	12.6	74	37.3	0	0.0	9	1.0	108	54.5
Montgomery	12,730	0	0.0	0	0.0	0	0.0	2	117.8	2	15.7
Nassau	343,302	35	10.2	14	4.1	0	0.0	15	5.8	64	18.6
New York	272,585	87	31.9	32	11.7	0	0.0	20	1.1	139	51.0
Niagara	57,438	12	20.9	0	0.0	0	0.0	3	13.9	15	26.1
Oneida	59,541	0	0.0	18	30.2	0	0.0	8	16.8	26	43.7
Onondaga	124,418	0	0.0	0	0.0	64	51.4	10	0.8	74	59.5
Ontario	26,699	0	0.0	0	0.0	0	0.0	1	41.2	1	3.7
Orange	103,520	0	0.0	0	0.0	0	0.0	11	0.0	11	10.6
Orleans	12,179	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Oswego	34,746	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Otsego	15,465	12	77.6	0	0.0	0	0.0	1	6.5	13	84.1
Putnam	26,267	0	0.0	14	53.3	0	0.0	1	3.8	15	57.1
Queens	535,228	47	8.8	61	11.4	50	9.3	51	9.5	209	39.0
Rensselaer	39,271	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Richmond	118,628	5	4.2	0	0.0	0	0.0	7	5.9	12	10.1
Rockland	83,905	0	0.0	0	0.0	0	0.0	10	11.9	10	11.9
Saratoga	52,415	0	0.0	0	0.0	48	91.6	0	0.0	48	91.6
Schenectady	37,054	16	43.2	0	0.0	0	0.0	2	5.4	18	48.6
Schoharie	8,284	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Schuyler	5,175	0	0.0	0	0.0	0	0.0	1	19.3	1	19.3
Seneca	8,645	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
St. Lawrence	28,696	0	0.0	0	0.0	0	0.0	5	17.4	5	17.4
Steuben	26,914	12	44.6	0	0.0	0	0.0	5	18.6	17	63.2
Suffolk	385,698	10	2.6	14	3.6	0	0.0	42	10.9	66	17.1
Sullivan	19,253	0	0.0	0	0.0	0	0.0	4	20.8	4	20.8
Tioga	14,635	0	0.0	0	0.0	0	0.0	2	13.7	2	13.7
Tompkins	21,855	6	27.5	0	0.0	0	0.0	3	13.7	9	41.2
Ulster	43,956	0	0.0	0	0.0	0	0.0	4	9.1	4	9.1
Warren	15,966	0	0.0	0	0.0	0	0.0	1	6.3	1	6.3
Washington	15,827	0	0.0	0	0.0	0	0.0	2	12.6	2	12.6
Wayne	26,875	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Westchester	239,433	84	35.1	121	50.5	198	82.7	8	3.3	411	171.7
Wyoming	11,011	0	0.0	0	0.0	0	0.0	2	18.2	2	18.2
Yates	7,008	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Grand Total	**4,930,588**	**473**	**9.6**	**539**	**10.9**	**380**	**7.7**	**383**	**7.8**	**1,775**	**36.0**

* Unless otherwise specified, data is from 9/3/03 Concerts System

** Source: U.S. Census Bureau

*** Source: DMHIS

Table 4
2001 Children and Youth Average Daily Bed Usage

County	2000 Population <18	Article 28	Article 31	RTF	State PC	Total Inpatient	Rate/100/000 Population
Albany	71,257	3.0	4.1	5.6	1.9	14.6	20.5
Allegany	13,391	1.6	0.5	1.8	1.1	5.0	37.2
Broome	49,664	2.6	3.5	3.9	3.1	13.1	26.3
Cattaraugus	23,338	1.6	0.0	1.8	3.3	6.8	29.0
Cayuga	21,656	1.1	0.9	0.9	0.5	3.4	15.5
Chautauqua	36,792	5.1	0.4	4.0	4.0	13.4	36.4
Chemung	23,249	1.9	2.8	2.2	4.2	11.1	47.7
Chenango	14,166	0.6	0.9	0.4	0.3	2.2	15.3
Clinton	19,843	2.5	1.9	4.1	1.4	9.9	50.1
Columbia	15,886	0.2	2.3	0.0	0.0	2.6	16.2
Cortland	12,669	0.3	1.1	0.4	1.7	3.5	27.7
Delaware	11,838	1.1	1.0	0.5	0.6	3.1	26.4
Dutchess	73,935	5.7	7.0	2.6	2.8	18.1	24.4
Erie	243,470	15.0	2.5	10.3	16.9	44.7	18.4
Essex	9,264	0.4	0.5	0.0	0.7	1.7	17.9
Franklin	12,255	0.8	0.4	0.6	1.3	3.1	25.4
Fulton	14,324	0.7	3.3	0.5	1.6	6.0	42.2
Genesee	16,413	0.3	0.1	0.0	1.0	1.4	8.5
Greene	11,822	0.1	1.3	0.0	0.3	1.7	14.7
Hamilton	1,139	0.0	0.3	0.0	0.0	0.3	25.0
Herkimer	16,537	0.2	1.2	1.0	1.3	3.7	22.4
Jefferson	31,204	0.6	4.1	5.0	5.6	15.3	49.0
Lewis	7,900	0.1	0.1	0.0	1.1	1.3	16.9
Livingston	16,543	1.4	0.3	3.4	0.9	6.0	36.3
Madison	18,987	0.1	2.1	0.0	0.5	2.7	14.4
Monroe	198,343	11.2	0.8	15.6	9.5	37.2	18.7
Montgomery	12,730	0.5	1.6	1.2	1.7	4.9	38.6
Nassau	343,302	19.2	10.2	2.6	13.6	45.5	13.3
Niagara	57,438	3.7	0.6	4.2	5.2	13.7	23.8
Oneida	59,541	0.5	4.5	3.7	5.8	14.5	24.3
Onondaga	124,418	1.0	9.0	8.7	9.0	27.7	22.3
Ontario	26,699	1.3	0.3	1.6	1.6	4.8	18.0
Orange	103,520	2.8	10.0	2.3	7.4	22.5	21.7
Orleans	12,179	0.7	0.2	0.0	0.3	1.1	9.1
Oswego	34,746	0.6	1.9	1.1	0.9	4.5	12.9
Otsego	15,465	2.8	1.8	1.7	1.0	7.2	46.7
Putnam	26,267	1.6	1.5	0.7	0.5	4.2	16.1
Rensselaer	39,271	1.3	2.7	0.5	1.2	5.8	14.8
Rockland	83,905	4.2	3.7	0.9	10.1	18.9	22.5
Saratoga	52,415	1.5	2.8	2.7	0.8	7.8	14.9
Schenectady	37,054	4.1	4.2	2.6	1.7	12.7	34.3
Schoharie	8,284	1.0	0.6	0.0	0.4	2.1	25.1
Schuyler	5,175	0.2	0.1	1.0	0.7	2.0	37.9
Seneca	8,645	0.7	0.5	0.0	2.6	3.7	42.9
St. Lawrence	28,696	0.5	2.0	1.0	9.2	12.7	44.3
Steuben	26,914	1.9	1.1	3.8	1.9	8.7	32.4
Suffolk	385,698	13.9	17.5	15.0	39.7	86.1	22.3
Sullivan	19,253	0.7	5.0	0.0	4.8	10.5	54.6
Tioga	14,635	0.7	0.4	1.1	0.5	2.6	18.1
Tompkins	21,855	0.6	1.3	1.5	4.3	7.7	35.2
Ulster	43,956	2.7	11.3	3.0	2.1	19.1	43.5
Warren	15,966	0.5	3.1	0.7	1.0	5.3	33.1
Washington	15,827	0.5	0.9	0.0	1.4	2.9	18.2
Wayne	26,875	1.7	0.8	0.9	2.1	5.5	20.4
Westchester	239,433	36.5	9.4	11.2	7.5	64.6	27.0
Wyoming	11,011	0.2	0.0	0.5	2.0	2.7	24.9
Yates	7,008	0.3	0.1	0.0	0.3	0.8	10.8
New York City*	2,036,522	192.9	175.8	121.2	161.0	650.8	32.0
Grand Total	**4,930,588**	**359.5**	**328.4**	**260.0**	**367.6**	**1315.6**	**26.7**

* NYC could not be broken into individual counties.

Data Sources:
Article 31 and RTF Census are based on Medicaid eligible residents
State PC Census: DMHIS
Article 28: SPARCS
Population: 2000 US Census

Table 5 State Adult PC'c Census, Catchment Areas and General Hospital Capacity*

Facility	Counties in Facility Catchment Area	2000 General Population 18+ for Catchment Area	12/4/03 Inpatient Census	3/31/04 Budgeted PC Census	Article 28 Capacity	General Hospitals in Catchment Area
Binghamton PC	Broome, Chenango, Delaware, Otsego, Tioga, Tompkins	393,035	153	140	131	United Health/Binghamton General (69), A O Fox Memorial Hospital (16), Mary Imogene Bassett Hosptial (20), Cayuga Medical Center (26)
Bronx PC	Bronx	935,278	354	340	330	Bronx-Lebanon (73), Jacobi (HHC) (125), Lincoln (HHC) (30), Montefiore Med Ctr (22), North Central Bronx (47), Our Lady of Mercy (33)
Buffalo PC	Cattaraugus, Chautauqua, Erie, Niagara	1,052,835	234	240	353	Olean Gen Hosp (14), Lake Shore Health Care Ctr (20), WCA of Jamestown (30), Erie Co Med Ctr (116), Kaleida Health (107), Niagara Falls Mem Med Ctr (66)
Capital District PC	Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	808,085	145	165	218	Albany Medical Center (53) Columbia Memorial Hospital (18) Saratoga Hospital (16), Ellis Hospital (36) Samaritan Hosptial (63) Glens Falls Hospital (32)
Creedmoor PC	Queens	1,720,155	433	420	492	Elmhurst Hosp (117), Jamaica Hosp (50), Long Island Jewish Med Ctr (223), Queens Hosp (HHC) (35), St. John's Episcopal Hosp (43), St. Vincent's CMC Jamaica (24)
Elmira PC	Allegany, Chemung, Schuyler, Seneca, Steuben, Yates	237,093	81	75	63	St. Josephs Hospital (25), St. James Mercy Hospital (26), Soldiers and Sailors Memorial Hospital (12)
Hudson River PC	Dutchess, Putnam, Ulster	416,231	128	131	103	St. Francis Hospital (46), Putnam Hospital Center (20), Benedictine Hospital (37)
Hutchings PC	Cayuga, Cortland, Madison, Onondaga, Oswego	580,811	95	105	141	Auburn Memorial Hospital (14), Cortland Memorial Hospital (15), St. Josephs Hospital Health Center (30), Community General Hospital-Syracuse (26), Oswego Hospital/Krakau Mental Health (32), SUNY Health Science Center (24)
Kingsboro PC	Serves Kings CD 8,9,14,17,18 and south portion of 5	605,096	286	290	396	Brookdale Hosp Med Ctr (52), Interfaith Med Ctr (120), Kingsbrook Jewish Med Ctr (30), Kings County Hosp Ctr (HHC) (216), University Hosp (SUNY) (34)
Manhattan PC*	limited to transfers from criminal justice system, the forensic system, and to	1,066,919	340	340	849 xfer to Rockland	In most cases, Article 28 & 31 hospitals in catchment area transfer patients in need of intermediate care in a state PC to Rockland PC or South Beach
Middletown PC	Orange, Sullivan	297,725	112	109	100	Mercy Community Hospital (20), Cornwall Hospital (22), Arden Hill Hospital (40) New Catskill Regional Medical Center (18)
Mohawk Valley PC	Fulton, Hamilton, Herkimer, Montgomery, Oneida	311,209	130	115	83	St. Marys CMHC (22), St. Lukes Memorial Hospital Center (26), St. Elizabeth Medical Center (24), Rome Memorial Hosptial (11)
Pilgrim PC	Nassau, Suffolk	2,054,753	701	685	492	Brookhaven Mem Hosp (20), Eastern Long Island Hosp (18), Franklin Hosp Med Ctr (21), Island Med Ctr @ Hempstead (33), Huntington Hosp (21), Long Beach Med Ctr (24), John T. Mather Mem Hosp (20), Mercy Med Ctr (39), Nassau University Med Ctr (85), North Shore University Hosp (26) North Shore @ Glen Cove (18) North Shore @ Syosset (20), S. Nassau Communities Hosp(30), Southside Hosp (45), St. Catherine's (42), SUNY Stony Brook (30)
Rochester PC	Genesee, Livingston, Monroe, Ontario, Orleans, Wayne, Wyoming	849,383	176	177	222	Park Ridge Hosp (40), Rochester Gen Hosp (30), St. Mary's (40), Univ. of Rochester/Strong Mem Hosp (66), Clifton Springs Hosp (18), Newark-Wayne Comm Hosp (16), Wyoming Co Comm Hosp (12)
Rockland PC	Rockland, Westchester Also serves the northern portion of New York County	899,129	410	397	639	NY Presbyterian Hosp-Westchester Div (235), Mt. Vernon Hosp (22), NY United Hosp Med Ctr (28), Northern Westchester Hosp Ctr (15), Phelps Memorial Hosp Ctr (19), St. Joseph's Med Ctr (29), St. Vincent's CMC- Westchester (90), Lenox Hill Hosp (27), Mt. Sinai Med Ctr (80), NY Presbyterian Hosp (127), North General Hosp (42), Bellevue Hosp Ctr (309), Harlem Hosp Ctr (66), Metropolitan Hosp Ctr (110), NYU Hosp Ctr (22), St. Clare's Hosp (12), St. Luke's Roosevelt Hosp Ctr (97), Westchester Med Ctr (66), White Plains Hosp Ctr (30), Good Samaritan (19), Summit Park Hosp-Rockland Co (43)
St. Lawrence PC	Clinton, Essex, Franklin, Jefferson, Lewis, St. Lawrence	318,352	70	65	87	Champlain Valley Physicians Hospital (22), Samaritan Medical Center (25) Hepburn Medical Center (28), Adirondack Medical Center (12)
South Beach PC	Richmond + Kings CD 1,2,3,4,5 (northern portion), 6,7,10,11,12,13,15 & southern portion of New York County below 42nd st.)	1,740,538	319	315	714	Coney Island Hosp (60), Long Island College (39), Lutheran Med Ctr (35), Maimonides (70), NY Methodist Hosp (50), Woodhull Med & MH Ctr (135), Beth Israel Med Ctr (92), Cabrini Med Ctr (30), St. Vincent's CMC-Manhattan (84), St. Vincent's CMC Staten Island (55), Staten Island University Hosp (64)
Washington Heights (adult unit at PI)	Northern Manhattan (Washington Heights/Inwood)		22	21		
Totals		14,286,627	4,189	4,130	5,410	

* an estimated 17% of Manhattan's total resident population below 42nd Street are sent to Article 28 Hospitals in the South Beach Catchment Area (excluding Bellevue)

Table 6

Children & Youth State Psychiatric Inpatient and General Hospital Psychiatric Census by State Facility Catchment Area

Facility	Counties in Facility Catchment Area	2000 General Population < 18 for Catchment Area	3/31/04 Budgeted Census	12/04/03 Census	Licensed Article 28 Beds	General Hospitals in Catchment Area	RTF Beds
Bronx CPC	Bronx	397,372	78	70	25	Bronx-Lebanon Hospital Center (25)	32
Brooklyn CPC	Kings	662,499	48	33	51	Kings County Hosptial Center (46), St. Vincent's Catholic Medical Center (5)	0
Queens CPC	Queens	509,224	84	69	59	Long Island Jewish Medical Center (15), Elmhurst Hospital Center (26), Flushing Hospital (18)	93
Rockland CPC	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	566,104	54	43	170	St. Francis Hosp (8); NY Presbyterian-Westchester Div (44); Westchester Med Ctr (35); St. Vincent's Hosp-Westchester Div (13); Mt. Sinai Med Ctr (23); Metropolitan Hosp Ctr (17); Bellevue Hosp Ctr (30)	155
Sagamore CPC	Nassau, Suffolk	699,160	69	64	30	Nassau University Med Ctr (10); John T. Mather Mem Hosp (10); SUNY Stony Brook University Hosp (10)	28
Western NY CPC	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming (Monroe, Livingston–ages 12 & under)	665,382	76	34	58	WCA of Jamestown (10); Erie Co Med Ctr (16); Niagara Falls Mem Med Ctr (12); BryLin Hosp (20)	59
Binghamton PC	Broome, Chenango, Delaware, Otsego, Tio	116,918	No inpt	0	12	A.O. Fox (12)	0
Elmira PC	Chemung, Ontario, Schuyler, Seneca, Steuben, Tioga (inpt), Tompkins (inpt), Wayne, Yates	163,474	18	19	18	St. James Mercy (12); Cayuga Medical Center (6)	0
Hutchings PC	Broome (inpt) , Cayuga, Cortland, Madison, Onondaga, Oswego	246,300	16	11	0		42
Mohawk Valley PC	Albany (inpt), Chenango (inpt), Columbia (inpt), Delaware (inpt), Fulton, Greene (inpt), Hamilton, Herkimer. Montgomery, Oneida, Otsego (inpt), Rensselaer (inpt), Saratoga (inpt), Schenectady (inpt), Schoharie (inpt), Warren (inpt), Washington (inpt)	982,321	35	26	16	Ellis Hosp (16)	56
Rochester PC	Monroe, Livingston (ages 13-18 only)	92,319	12	11	25	University of Rochester/Strong Memorial (25)	74*
St. Lawrence PC	Clinton, Essex, Franklin, Jefferson, Lewis, St. Lawrence	102,140	28	19	12	Champlain Valley Physicians Hospital (12)	0
South Beach PC	Richmond	113,258	10	7	21	St. Vincent's-Staten Island (5); St. Vincent's-Manhattan (16)	0
Total		5,316,471	528	406	497		539

*Children's Beds in Monroe County are spilit between <13 (Western CNY) and >=13 (Rochester PC)

Table 7

Adult Inpatient Services Overview by State PC

				INPATIENT												OUTPATIENT		
Facility	Counties in Facility Catchment Area	2000 General Population 18+ for Catchment Area	Quarterly Admission Cohort LOS (days)**	12/4/03 Inpatient Census	3/31/04 Budgeted PC Census	Census/ 10,000 pop	State Inpt Annual Admissions	Article 28 Capacity	Article 31 Capacity	Licensed Congregate Beds (State) 6/30/03	Licensed Congregate (Voluntary) # Beds 6/30/03	Licensed Apartments (Voluntary) # Beds 6/30/03	Supported Housing (Voluntary) # Beds 6/30/03	Family Care	Total Capacity	CY 2002 State Outpt Enrollees	State Outpt Annual Admissions	Non-State Outpatient
Binghamton PC	Broome, Chenango, Delaware, Otsego, Tioga (inpt), Tompkins (inpt)	393,035	125	153	140	3.89	149	131	0	0	68	64	168	99	683	482	148	21 programs: clinic, day treatment, intensive psych rehab, partial hospitalization
Bronx PC	Bronx	935,278	102	354	340	3.78	411	330	49	96	521	289	966	70	2,675	870	640	63 programs: clinic, continuing day treatment, day treatment, intensive psych rehab, partial hospitalization, 2 CPEPS
Buffalo PC	Cattaraugus, Chautauqua, Erie, Niagara	1,052,835	137	234	240	2.22	166	353	68	163	483	365	789	195	2,650	1,356	812	127 programs: clinic, day treatment, intensive psych rehab, CPEP, partial hospitalization
Capital District PC	Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	808,085	103	145	165	1.79	147	215	40	24	332	370	431	79	1,636	881	214	32 programs: clinic, day treatment, intensive rehab, partial hospitalization
Creedmoor PC	Queens	1,720,155	102	433	420	2.52	522	492	50	72	455	385	800	108	2,795	1,748	442	83 programs: clinic, continuing day treatment, day treatment, intensive psych rehab., partial hospitalization, 1 CPEP
Elmira PC	Allegany, Chemung, Schuyler, Seneca, Steuben, Yates	237,093	77	81	75	3.42	170	63	0	24	113	118	315	227	941	293	177	19 programs: clinic, day treatment, intensive psychiatric rehabilitation, partial hospitalization programs
Hudson River PC	Dutchess, Putnam, Ulster	416,231	81	128	131	3.08	91	103	0	88	109	89	300	103	920	594	492	61 programs: clinic, day & continuing day treatment, intensive psych rehab., partial hospitalization programs
Hutchings PC	Cayuga, Cortland, Madison, Onondaga, Oswego	580,811	56	95	105	1.64	217	141	43	19	177	155	441	37	1,108	1,190	246	68 programs: clinic, continuing day and day treatment, intensive psychiatric rehabilitation, 1 CPEP
Kingsboro PC	Serves Kings CD 8,9,14,17,18 and south portion of 5	605,096	193	286	290	4.73	351	396	0	48	763	390	1,283	125	3,291	701	292	109 programs: clinic, continuing day and day treatment, intensive psychiatric rehabilitation, partial hospitalization programs, 1 CPEP
Manhattan PC*	New York (intermediate admissions are limited to transfers from criminal justice system, the forensic system, and to readmissions within 30 days of discharge)	1,066,919	348	340	340	3.19	112	849 xfer to Rockland	0	48	973	634	1,332	2	4,178	473	222	127 programs: clinic, day treatment, intensive psychiatric rehabilitation, partial hospitalization programs
Middletown PC	Orange, Sullivan	297,725	90	112	109	3.76	141	100	0	12	106	80	139	188	737	582	268	42 programs: clinic, day treatment, intensive psychiatric rehabilitation, partial hospitalization programs

Table 7 continued

Adult Inpatient Services Overview by State PC

				INPATIENT												OUTPATIENT		
Facility	Counties in Facility Catchment Area	2000 General Population 18+ for Catchment Area	Quarterly Admission Cohort LOS (days)**	12/4/03 Inpatient Census	3/31/04 Budgeted PC Census	Census/ 10,000 pop	State Inpt Annual Admissions	Article 28 Capacity	Article 31 Capacity	Licensed Congregate Beds (State) 6/30/03	Licensed Congregate (Voluntary) # Beds 6/30/03	Licensed Apartments (Voluntary) # Beds 6/30/03	Supported Housing (Voluntary) # Beds 6/30/03	Family Care	Total Capacity	CY 2002 State Outpt Enrollees	State Outpt Annual Admissions	Non-State Outpatient
Mohawk Valley PC	Fulton, Hamilton, Herkimer, Montgomery, Oneida	311,209	83	130	115	4.18	104	83	0	24	166	92	182	56	733	943	377	36 programs; clinic, continuing day and day treatment, intensive psychiatric rehabilitation programs
Pilgrim PC	Nassau, Suffolk	2,054,753	181	701	685	3.41	259	492	146	289	659	395	1,348	467	4,497	2,171	434	79 programs: clinic, continuing day and day treatment, intensive psychiatric rehabilitation, partial hospitalization programs, 1 CPEP
Rochester PC	Genesee, Livingston, Monroe, Ontario, Orleans, Wayne, Wyoming	849,383	109	176	177	2.07	232	222	0	24	452	181	529	260	1,844	713	590	76 programs: clinic, continuing day and day treatment, intensive psychiatric rehabilitation, partial hospitalization programs
Rockland PC	Rockland, Westchester Also serves northern portion of New York County	899,129	87	410	397	4.56	654	639	222	163	289	285	757	36	2,801	1,767	480	108 programs: clinic, continuing day and the day treatment, intensive psychiatric rehabilitation, partial hospitalization programs, 3 CPEPs, 163 adult RCCA and CR beds
St. Lawrence PC	Clinton, Essex, Franklin, Jefferson, Lewis, St. Lawrence	318,352	58	70	65	2.20	120	87	0	22	87	76	184	117	643	1,043	456	23 programs: clinic, continuing day and day treatment, intensive psychiatric rehabilitation program, CR: 22 beds
South Beach PC	Richmond + Kings CD 1,2,3,4,5 (northern portion), 6,7,10,11,12,13,15 & southern portion of New York County below 42nd St.)	1,740,538	99	319	315	1.83	633	714	0	0	154	70	228	35	1,520	3,645	715	Over 200 programs: clinic, continuing day and day treatment, intensive psychiatric rehabilitation, partial hospitalization programs, 1 CPEP
Washington Heights (adult unit at PI)	Northern Manhattan (Washington Heights/Inwood)	—	25	22	21	—	261	—	—	—	—	—	—	—	22	5,462	1,431	
Totals	—	**14,286,627**	**114**	**4,189**	**4,130**	**2.93**	**4,740**	**5,410**	**618**	**1,116**	**5,907**	**4,038**	**10,192**	**2,204**	**33,674**	**24,914**	**8,436**	

* an estimated 17% of Manhattan's total resident population below 42nd Street are sent to Article 28 Hospitals in the South Beach Catchment Area (excluding Bellevue)

** period ending December 2002 except for Binghamton, Bronx, Buffalo, CDPC, Kingsboro and Pilgrim (Sept 2002) and Manhattan (March 2002)

Table 8

Inpatients Under Care – Number and Rate per 100,000 Civilian Population by Age and Type of Inpatient Psychiatric Care Program: United States, 1997 and New York, 2003

Inpatient Psychiatric Care Program

a. Number Under Care

	GENERAL			PRIVATE			STATE			TOTAL		
	18+	<18	All ages	18+	<18	All ages	18+	<18	All ages	18 +	<18	All ages
NYS– 2003*	5,426	473	5,899	768	380	1,148	4,730	528	5,258	10,924	1,381	12,305
US– 1997	26,623	2,328	28,951	11,490	5,966	17,456	51,362	2,653	54,015	89,475	10,947	100,422

b. Rate per 100,000 Civilian Population**

	GENERAL			PRIVATE			STATE			TOTAL		
	18+	<18	All ages	18+	<18	All ages	18+	<18	All ages	18 +	<18	All ages
NYS– 2003	38.0	9.6	30.7	5.4	7.7	6.0	33.1	10.7	27.4	76.5	28.0	64.0
US– 1997	13.6	3.3	10.9	5.9	8.6	6.6	26.2	3.8	20.3	45.6	15.7	37.8

Source: Mental Health U.S. and NYS OMH Concerts Data system.

* New York State Bed Capacity as of Aug 2003. Actual census estimates are unavailable for all programs in 2003.

** U.S. Bureau of the Census population estimates for 2000 are used as denominators for rate computations.

Table 9

Article 28 and State PC Averaging Daily Census and Inpatient Days by Region and Year

(Includes Adult, Children and Forensic)

Article 28 Average Daily Inpatient Census by Region by Year

Year	Central	Hudson River	Long Island	NYC	Western	Unknown/NA	Grand Total
1995	308	720	432	2,380	584	103	4,527
1996	310	711	422	2,394	569	101	4,506
1997	301	650	411	2,346	517	95	4,320
1998	271	655	428	2,235	483	97	4,168
1999	261	647	407	2,268	488	112	4,184
2000	270	652	386	2,306	473	116	4,204
2001	269	615	370	2,319	443	102	4,118

State Psychiatric Center Average Daily Inpatient Census by Region by Year

Year	Central	Hudson River	Long Island	New York City	Western	NA/Unk	Grand Total
1995*	900	1,222	1,272	4,013	1,051	1,093	9,550
1996*	794	1,078	1,122	3,540	927	964	8,423
1997*	700	950	989	3,121	817	850	7,426
1998*	638	866	901	2,844	745	774	6,768
1999	611	783	858	2,672	646	697	6,266
2000	569	772	794	2,475	622	688	5,919
2001	510	725	748	2,287	613	673	5,557
2002	499	686	717	2,243	622	639	5,407
2003**	291	396	398	1,343	365	328	3,121

Article 28 Inpatient Bed Days by Region by Year

Year	Central	Hudson River	Long Island	NYC	Western	Unknown/NA	Grand Total
1995	112,312	262,951	157,690	868,768	213,115	37,479	1,652,315
1996	113,306	259,378	153,866	873,695	207,740	36,826	1,644,811
1997	109,911	237,391	150,009	856,129	188,562	34,759	1,576,761
1998	98,898	238,945	156,155	815,748	176,349	35,281	1,521,376
1999	95,365	236,329	148,711	827,826	178,060	40,947	1,527,238
2000	98,569	238,096	141,025	841,739	172,470	42,387	1,534,286
2001	98,076	224,554	135,042	846,531	161,585	37,313	1,503,101

State Psychiatric Center Inpatient Bed Days by Region by Year

Year	Central	Hudson River	Long Island	New York City	Western	NA/Unk	Grand Total
1995*	328,389	445,927	464,162	1,464,831	383,654	398,787	3,485,750
1996*	289,636	393,303	409,386	1,291,966	338,379	351,726	3,074,395
1997*	255,353	346,749	360,928	1,139,041	298,326	310,093	2,710,490
1998*	232,726	316,025	328,947	1,038,113	271,892	282,617	2,470,320
1999	223,093	285,817	313,098	975,261	235,665	254,279	2,287,213
2000	207,818	281,602	289,824	903,252	226,928	251,138	2,160,562
2001	186,288	264,466	273,031	834,753	223,863	245,814	2,028,215
2002	182,276	250,521	261,697	818,614	227,142	233,254	1,973,504
2003**	106,080	144,700	145,312	490,288	133,048	119,881	1,139,309

* Estimated

** 2003 data not yet complete

Data Sources: SPARCS and DMHIS

Table 10

30 Day Readmission Rates for Medicaid Recipients to Inpatient Settings

(State, General and Private Hospital)

		Year of DIscharge				
Region	**County**	**1997**	**1998**	**1999**	**2000**	**2001**
Western	Allegany	13.9%	15.1%	6.8%	13.8%	16.6%
	Cattaraugus	15.8%	9.7%	11.9%	12.7%	10.2%
	Chautauqua	10.5%	10.6%	12.8%	11.4%	10.9%
	Chemung	11.8%	10.6%	10.6%	15.3%	16.1%
	Erie	15.7%	16.0%	16.1%	15.4%	13.9%
	Genesee	18.6%	21.1%	8.7%	10.7%	18.9%
	Livingston	15.2%	12.7%	9.1%	17.1%	11.2%
	Monroe	17.0%	16.7%	18.2%	17.0%	15.1%
	Niagara	16.7%	16.0%	18.4%	21.1%	23.1%
	Ontario	16.6%	19.3%	22.5%	16.6%	14.9%
	Orleans	11.1%	22.8%	10.7%	16.0%	13.0%
	Schuyler	15.7%	12.5%	16.4%	16.4%	21.2%
	Seneca	17.6%	14.8%	14.9%	6.0%	25.4%
	Steuben	11.8%	15.5%	16.1%	15.7%	13.4%
	Tompkins	22.1%	17.0%	14.8%	17.1%	17.5%
	Wayne	11.2%	10.5%	25.5%	18.1%	10.6%
	Wyoming	16.8%	22.5%	24.0%	17.6%	15.7%
	Yates	17.0%	14.8%	6.3%	19.6%	19.1%
Western Total		15.7%	15.5%	16.1%	16.2%	15.5%
Central	Broome	13.8%	11.6%	11.0%	10.7%	10.8%
	Cayuga	20.8%	20.6%	19.0%	15.7%	21.2%
	Chenango	11.4%	11.2%	12.7%	9.4%	12.4%
	Clinton	10.5%	10.3%	13.1%	14.0%	10.9%
	Cortland	21.1%	16.9%	23.4%	20.7%	16.6%
	Delaware	12.3%	6.0%	11.5%	11.5%	10.7%
	Essex	14.8%	18.8%	3.7%	17.1%	8.6%
	Franklin	18.0%	10.8%	8.9%	9.3%	8.3%
	Fulton	15.9%	16.2%	17.9%	15.0%	15.3%
	Hamilton	0.0%	0.0%	0.0%	16.7%	9.1%
	Herkimer	9.0%	5.7%	11.5%	18.9%	17.2%
	Jefferson	18.0%	16.4%	21.5%	17.3%	12.5%
	Lewis	23.5%	16.3%	14.3%	13.6%	20.0%
	Madison	13.3%	22.6%	16.0%	17.5%	8.2%
	Montgomery	13.3%	11.7%	9.8%	13.6%	10.9%
	Oneida	12.9%	14.4%	14.2%	13.9%	12.3%
	Onondaga	16.1%	17.1%	17.0%	16.3%	17.4%
	Oswego	29.5%	26.0%	28.9%	24.5%	26.1%
	Otsego	8.1%	16.7%	11.6%	12.9%	13.4%
	Saint Lawrence	15.4%	18.5%	15.9%	17.7%	16.1%
	Tioga	9.2%	17.8%	7.1%	11.9%	14.0%
Central Total		16.5%	16.1%	16.3%	15.5%	15.0%
Hudson River	Albany	16.0%	17.2%	16.5%	18.4%	20.6%
	Columbia	12.4%	9.0%	21.2%	18.2%	11.3%
	Dutchess	14.6%	13.5%	15.0%	15.1%	13.9%
	Greene	5.6%	9.0%	15.7%	17.2%	15.8%
	Orange	13.2%	13.8%	14.0%	14.5%	14.5%
	Putnam	21.1%	27.3%	19.3%	13.8%	7.9%
	Rensselaer	14.6%	15.0%	21.5%	20.0%	24.8%
	Rockland	15.7%	15.9%	15.3%	19.5%	21.8%
	Saratoga	15.3%	16.6%	19.4%	19.9%	19.9%
	Schenectady	15.8%	14.0%	14.8%	17.6%	15.9%
	Schoharie	6.0%	11.5%	16.0%	16.1%	16.5%
	Sullivan	10.5%	19.6%	11.9%	12.3%	16.4%
	Ulster	11.1%	13.6%	14.3%	11.3%	12.8%
	Warren	12.7%	26.4%	23.6%	22.3%	24.8%
	Washington	25.8%	18.9%	16.5%	15.3%	15.0%
	Westchester	20.2%	19.0%	17.8%	19.9%	17.9%
Hudson River Total		16.4%	16.9%	16.7%	17.5%	17.8%
New York City		18.8%	19.6%	18.4%	18.4%	19.1%
New York City Total		18.8%	19.6%	18.4%	18.4%	19.1%
Long Island	Nassau	15.9%	16.0%	16.4%	17.7%	16.9%
	Suffolk	16.6%	18.4%	16.1%	17.5%	17.6%
Long Island Total		16.3%	17.3%	16.3%	17.6%	17.2%
Grand Total		**17.6%**	**18.2%**	**17.5%**	**17.7%**	**18.0%**

Table 11

180 Day Readmission Rates for Medicaid Recipients to Inpatient Settings

(State, General and Private Hospital)

		Year of DIscharge				
Region	**County**	**1997**	**1998**	**1999**	**2000**	**2001**
Western	Allegany	46.7%	31.6%	33.3%	36.3%	43.7%
	Cattaraugus	35.9%	30.2%	31.3%	31.2%	24.9%
	Chautauqua	29.7%	28.0%	28.5%	31.1%	27.5%
	Chemung	28.2%	26.5%	32.2%	35.8%	38.1%
	Erie	38.5%	38.6%	39.5%	37.8%	37.3%
	Genesee	34.9%	44.0%	41.3%	38.1%	36.8%
	Livingston	33.3%	38.0%	27.3%	41.0%	33.7%
	Monroe	38.5%	38.7%	40.1%	36.9%	36.9%
	Niagara	41.3%	41.7%	44.5%	45.9%	45.6%
	Ontario	40.0%	44.2%	44.5%	34.4%	38.8%
	Orleans	22.2%	32.9%	25.0%	38.0%	28.6%
	Schuyler	35.3%	33.3%	43.6%	32.7%	50.0%
	Seneca	38.2%	33.3%	29.8%	24.0%	38.0%
	Steuben	26.8%	31.0%	37.7%	37.3%	33.8%
	Tompkins	43.6%	39.3%	38.1%	45.4%	39.0%
	Wayne	25.6%	28.1%	41.5%	40.3%	34.4%
	Wyoming	44.2%	48.8%	45.0%	38.2%	32.9%
	Yates	25.5%	29.5%	25.0%	32.6%	40.4%
Western Total		37.4%	37.0%	38.7%	38.1%	37.4%
Central	Broome	37.9%	32.9%	33.6%	32.7%	29.9%
	Cayuga	46.2%	44.0%	44.0%	43.5%	48.6%
	Chenango	39.0%	28.0%	26.2%	28.2%	26.8%
	Clinton	26.2%	26.2%	31.4%	30.1%	31.0%
	Cortland	47.4%	41.9%	47.7%	39.0%	37.1%
	Delaware	32.9%	32.1%	25.0%	28.1%	29.1%
	Essex	33.3%	37.7%	24.1%	31.4%	31.4%
	Franklin	36.1%	37.7%	27.7%	30.6%	30.3%
	Fulton	47.3%	40.2%	46.6%	38.6%	39.3%
	Hamilton	0.0%	0.0%	0.0%	33.3%	27.3%
	Herkimer	21.0%	24.1%	33.3%	33.0%	36.2%
	Jefferson	46.9%	42.1%	44.7%	39.1%	33.3%
	Lewis	35.3%	32.6%	40.8%	22.0%	32.7%
	Madison	37.3%	35.7%	28.0%	38.6%	26.2%
	Montgomery	32.8%	36.2%	31.4%	35.6%	37.1%
	Oneida	34.2%	38.6%	37.7%	36.6%	34.9%
	Onondaga	38.1%	40.7%	39.3%	35.5%	37.1%
	Oswego	59.5%	53.1%	55.3%	54.5%	59.5%
	Otsego	35.0%	40.0%	31.6%	31.5%	32.5%
	Saint Lawrence	36.0%	38.1%	35.2%	39.0%	34.9%
	Tioga	29.9%	41.6%	30.0%	36.9%	31.8%
Central Total		40.1%	39.1%	38.7%	37.0%	36.9%
Hudson River	Albany	38.5%	38.7%	41.2%	39.4%	43.5%
	Columbia	26.5%	29.0%	43.2%	38.0%	35.7%
	Dutchess	35.7%	32.9%	33.8%	35.3%	35.8%
	Greene	20.8%	26.9%	37.3%	44.1%	27.4%
	Orange	35.1%	37.0%	34.4%	35.3%	37.1%
	Putnam	50.0%	50.3%	44.8%	37.7%	27.2%
	Rensselaer	38.0%	38.1%	43.2%	47.1%	53.0%
	Rockland	39.2%	35.8%	36.9%	42.6%	43.9%
	Saratoga	39.6%	44.2%	48.0%	48.8%	45.3%
	Schenectady	39.4%	39.2%	36.1%	37.4%	40.4%
	Schoharie	29.9%	27.9%	30.9%	40.2%	37.1%
	Sullivan	36.4%	40.3%	34.1%	36.6%	35.5%
	Ulster	28.8%	34.6%	30.8%	31.5%	31.0%
	Warren	38.6%	49.8%	48.1%	42.9%	44.8%
	Washington	44.4%	37.7%	33.5%	43.2%	40.6%
	Westchester	45.1%	43.3%	41.8%	44.2%	41.2%
Hudson River Total		39.6%	39.7%	39.1%	40.5%	40.5%
New York City		40.4%	41.4%	40.1%	40.3%	40.6%
New York City Total		40.4%	41.4%	40.1%	40.3%	40.6%
Long Island	Nassau	37.7%	38.9%	38.1%	40.7%	39.2%
	Suffolk	39.9%	42.0%	38.1%	39.7%	38.0%
Long Island Total		38.9%	40.6%	38.1%	40.2%	38.6%
Grand Total		**39.7%**	**40.3%**	**39.5%**	**39.8%**	**39.8%**

Table 12

Rates of Readmission to Inpatient Psychiatric Units Among Mental Health Recipients Who Discharged During Calendar Year 2001 in Medicaid Claim Data

Provider County	Provider Name	# of Dicharge	Readmitted within 30 Days Number	Readmitted within 30 Days Percent	Readmitted within 180 Days Number	Readmitted within 180 Days Percent
STATEWIDE		**66659**	**12187**	**18.3%**	**26572**	**39.9%**
General Hospital		**60985**	**11135**	**18.3%**	**24453**	**40.1%**
Private Hospital		**3571**	**516**	**14.4%**	**1287**	**36.0%**
State PC		**1683**	**351**	**20.9%**	**592**	**35.2%**
RTF		**420**	**185**	**44.0%**	**240**	**57.1%**
Central Region		**5272**	**846**	**16.0%**	**1963**	**37.2%**
General Hospital		**4434**	**709**	**16.0%**	**1683**	**38.0%**
Broome	UNITED HEALTH SERV HOSP INC	625	67	10.7%	192	30.7%
Cayuga	AUBURN MEMORIAL HOSPITAL	222	51	23.0%	112	50.5%
Clinton	CHAMPLAIN VALLEY PHYSICIANS H	297	26	8.8%	84	28.3%
Cortland	CORTLAND MEMORIAL HOSP IN	143	24	16.8%	57	39.9%
Franklin	ADIRONDACK MEDICAL CENTER	16	2	12.5%	4	25.0%
Jefferson	SAMARITAN MEDICAL CENTER	320	45	14.1%	104	32.5%
Montgomery	ST MARYS HOSP AMSTERDAM	368	64	17.4%	141	38.3%
Oneida	ST ELIZABETH HOSPITAL UTICA	314	42	13.4%	108	34.4%
Oneida	ST LUKES MEMORIAL HOSPITAL CN	278	39	14.0%	107	38.5%
Onondaga	ST JOSEPHS HOSPITAL HEALTH CE	356	54	15.2%	135	37.9%
Onondaga	UNIVERSITY HSP SUNY HLTH SC	251	49	19.5%	99	39.4%
Oswego	OSWEGO HOSPITAL	473	127	26.8%	286	60.5%
Otsego	AURELIA OSBORN FOX MEM HOSP	227	30	13.2%	61	26.9%
Otsego	MARY IMOGENE BASSETT HOSPITAL	188	35	18.6%	74	39.4%
Saint Lawrence	HEPBURN MEDICAL CENTER	356	54	15.2%	119	33.4%
Private Hospital		**276**	**40**	**14.5%**	**91**	**33.0%**
Onondaga	FOUR WINDS SYRACUSE	276	40	14.5%	91	33.0%
State Psychiatric Center		**499**	**77**	**15.4%**	**161**	**32.3%**
Broome	BINGHAMTON PC	30	15	50.0%	18	60.0%
Oneida	MOHAWK VALLEY PC	238	30	12.6%	69	29.0%
Onondaga	HUTCHINGS PC	91	8	8.8%	23	25.3%
Saint Lawrence	ST LAWRENCE PC	140	24	17.1%	51	36.4%
RTF		**63**	**20**	**31.7%**	**28**	**44.4%**
Cayuga	RTF HILLSIDE CHILD CTR FNGR L	32	11	34.4%	14	43.8%
Chenango	RTF CHILDRENS HOME RTF INC	8	0	0.0%	4	50.0%
Oneida	RTF HS OF THE GOOD SHEPHERD	23	9	39.1%	10	43.5%
Hudson River Region		**12708**	**2341**	**18.4%**	**5236**	**41.2%**
General Hospital		**10736**	**2053**	**19.1%**	**4547**	**42.4%**
Albany	ALBANY MEDICAL CTR HOSPITAL	504	93	18.5%	195	38.7%
Columbia	COLUMBIA MEMORIAL HOSPITAL	164	28	17.1%	61	37.2%
Dutchess	ST FRANCIS HOSPITAL	598	80	13.4%	193	32.3%
Orange	ARDEN HILL HOSP	338	40	11.8%	108	32.0%
Orange	CORNWALL HOSPITAL	225	31	13.8%	82	36.4%
Orange	MERCY COMMUNITY HOSPITAL	246	48	19.5%	108	43.9%
Putnam	PUTNAM HOSPITAL CENTER	144	17	11.8%	53	36.8%

Provider County	Provider Name	# of Dicharge	Readmitted within 30 Days Number	Readmitted within 30 Days Percent	Readmitted within 180 Days Number	Readmitted within 180 Days Percent
Rensselaer	SAMARITAN HOSPITAL TROY	700	183	26.1%	388	55.4%
Rockland	GOOD SAMARITAN HSP SUFFERN	126	26	20.6%	52	41.3%
Rockland	SUMMIT PARK HOSPITAL ROCKLAND	597	120	20.1%	278	46.6%
Saratoga	SARATOGA HOSPITAL	373	68	18.2%	159	42.6%
Schenectady	ELLIS HOSPITAL	741	118	15.9%	307	41.4%
Sullivan	COMMUNITY GEN SULL/HARRIS	279	57	20.4%	114	40.9%
Ulster	BENEDICTINE HOSPITAL	486	71	14.6%	167	34.4%
Warren	GLENS FALLS HOSPITAL	467	105	22.5%	213	45.6%
Westchester	MOUNT VERNON HOSPITAL	363	68	18.7%	139	38.3%
Westchester	NORTHERN WESTCHESTER HOSPITAL	54	6	11.1%	18	33.3%
Westchester	NY HOSPITAL	1480	301	20.3%	629	42.5%
Westchester	PHELPS MEMORIAL HSP ASSOC	142	34	23.9%	65	45.8%
Westchester	ST JOSEPHS HOSP	395	76	19.2%	185	46.8%
Westchester	ST VINCENTS HSP MED CTR NY	816	175	21.4%	385	47.2%
Westchester	UNITED HOSPTIAL MED CENTER	461	126	27.3%	247	53.6%
Westchester	WESTCHESTER COUNTY MED CTR	866	146	16.9%	324	37.4%
Westchester	WHITE PLAINS HOSPITAL CENTER	171	36	21.1%	77	45.0%
Private Hospital		**1618**	**196**	**12.1%**	**536**	**33.1%**
Saratoga	FOUR WINDS SARATOGA	468	61	13.0%	166	35.5%
Westchester	FOUR WINDS HOSPITAL	707	68	9.6%	195	27.6%
Westchester	RYE PSYCHIATRIC HOSPITAL CTR	67	12	17.9%	26	38.8%
Westchester	STONY LODGE HOSPITAL INC	376	55	14.6%	149	39.6%
State Psychiatric Center		**238**	**44**	**18.5%**	**88**	**37.0%**
Albany	CAPITAL DISTRICT PC	12	3	25.0%	6	50.0%
Dutchess	HUDSON RIVER PC	16	6	37.5%	11	68.8%
Orange	MIDDLETOWN PC	22	8	36.4%	14	63.6%
Rockland	ROCKLAND PC	46	14	30.4%	20	43.5%
Rockland	ROCKLAND CHILDRENS PC	142	13	9.2%	37	26.1%
RTF		**116**	**48**	**41.4%**	**65**	**56.0%**
Albany	RTF PARSONS CHILD & FAMILY CT	29	20	69.0%	22	75.9%
Dutchess	RTF ASTOR HOME FOR CHILDREN	7	2	28.6%	4	57.1%
Putnam	RTF GREEN CHIMNEYS CHILD SVCS	5	2	40.0%	3	60.0%
Westchester	RTF CHILDRENS VILLAGE	9	4	44.4%	5	55.6%
Westchester	RTF JEWISH BOARD GOLDSMITH CT	32	13	40.6%	17	53.1%
Westchester	RTF JEWISH BOARD LINDEN HILL	34	7	20.6%	14	41.2%
Long Island Region		**6630**	**1143**	**17.2%**	**2569**	**38.7%**
General Hospital		**5816**	**948**	**16.3%**	**2229**	**38.3%**
Nassau	NASSAU UNIVERSITY MEDICAL CENTER	1050	165	15.7%	397	37.8%
Nassau	FRANKLIN HOSPITAL MEDICAL CTR	236	48	20.3%	98	41.5%
Nassau	LONG BEACH MEDICAL CENTER	391	62	15.9%	168	43.0%
Nassau	LONG ISLAND JEWISH MED CTR	1094	175	16.0%	395	36.1%
Nassau	MERCY MEDICAL CENTER	297	46	15.5%	112	37.7%
Nassau	NORTH SHORE UNIV GLEN COVE	139	16	11.5%	50	36.0%
Nassau	NORTH SHORE UNIVERSITY HSP	210	40	19.0%	88	41.9%
Nassau	SOUTH NASSAU COMMUNITIES HSP	322	64	19.9%	150	46.6%
Suffolk	ST CATHERINE OF SIENA MED CTR	308	39	12.7%	120	39.0%
Suffolk	BROOKHAVEN MEMORIAL HOSPITAL	256	38	14.8%	93	36.3%

Provider County	Provider Name	# of Dicharge	Readmitted within 30 Days Number	Readmitted within 30 Days Percent	Readmitted within 180 Days Number	Readmitted within 180 Days Percent
Suffolk	EASTERN LONG ISLAND HOSPITAL	164	20	12.2%	54	32.9%
Suffolk	HUNTINGTON HOSPTIAL	148	22	14.9%	46	31.1%
Suffolk	JOHN T MATHER MEM HOSP	264	44	16.7%	105	39.8%
Suffolk	SOUTHSIDE HOSPITAL	615	123	20.0%	262	42.6%
Suffolk	UNIVERSITY HOSPITAL	322	46	14.3%	91	28.3%
Private Hospital		**530**	**86**	**16.2%**	**210**	**39.6%**
Suffolk	BRUNSWICK HALL	267	40	15.0%	98	36.7%
Suffolk	SOUTH OAKS HOSPITAL	263	46	17.5%	112	42.6%
State Psychiatric Center		**267**	**105**	**39.3%**	**123**	**46.1%**
Suffolk	PILGRIM PC	148	102	68.9%	106	71.6%
Suffolk	SAGAMORE CHILDRENS PC	119	3	2.5%	17	14.3%
RTF		**17**	**4**	**23.5%**	**7**	**41.2%**
Nassau	RTF MADONNA HGTS SERV COTTAGE	7	3	42.9%	4	57.1%
Nassau	RTF ST MARYS CHLD FAM SVCS IN	6	0	0.0%	2	33.3%
Suffolk	RTF MADONNA HGTS SERV COTTAGE	4	1	25.0%	1	25.0%
New York City		**34136**	**6611**	**19.4%**	**13836**	**40.5%**
General Hospital		**32516**	**6244**	**19.2%**	**13170**	**40.5%**
Bronx	BRONX LEBANON HOSPITAL CENTER	1966	490	24.9%	968	49.2%
Bronx	JACOBI MEDICAL CENTER	1080	164	15.2%	384	35.6%
Bronx	LINCOLN MEDICAL/MENTAL HLTH	382	47	12.3%	127	33.2%
Bronx	MONTEFIORE MEDICAL CENTER	388	57	14.7%	124	32.0%
Bronx	NORTH CENTRAL BRONX	589	111	18.8%	223	37.9%
Bronx	OUR LADY OF MERCY MED CT	425	90	21.2%	195	45.9%
Bronx	ST BARNABAS HOSPITAL	1130	288	25.5%	548	48.5%
Kings	BROOKDALE HSP MED CTR	728	149	20.5%	287	39.4%
Kings	CONEY ISLAND HOSPITAL	622	85	13.7%	200	32.2%
Kings	INTERFAITH MEDICAL CENTER	1596	456	28.6%	872	54.6%
Kings	KINGS COUNTY HOSPITAL CENTER	1767	294	16.6%	609	34.5%
Kings	KINGSBROOK JEWISH MED CENTER	221	26	11.8%	76	34.4%
Kings	LONG ISLAND COLLEGE HSP	544	116	21.3%	238	43.8%
Kings	LUTHERAN MEDICAL CENTER	387	62	16.0%	146	37.7%
Kings	MAIMONIDES MEDICAL CENTER	773	120	15.5%	283	36.6%
Kings	NEW YORK METHODIST HOSP	362	46	12.7%	133	36.7%
Kings	UNIVERSITY HOSP OF BROOKLYN	241	40	16.6%	94	39.0%
Kings	WOODHULL MED & MNTL HLTH CTR	1725	310	18.0%	724	42.0%
New York	BELLEVUE HOSPITAL CENTER	2320	378	16.3%	842	36.3%
New York	BETH ISRAEL MED CTR	920	204	22.2%	411	44.7%
New York	CABRINI MEDICAL CTR	406	100	24.6%	191	47.0%
New York	HARLEM HOSPITAL CENTER	776	175	22.6%	359	46.3%
New York	LENOX HILL HOSPITAL	227	41	18.1%	81	35.7%
New York	METROPOLITAN HOSPITAL CENTER	1360	347	25.5%	631	46.4%
New York	MOUNT SINAI HOSPITAL	1283	254	19.8%	535	41.7%
New York	NORTH GENERAL HOSPITAL	579	133	23.0%	284	49.1%
New York	NY HOSPITAL	398	62	15.6%	130	32.7%
New York	NY UNIVERSITY MEDICAL CENTER	60	7	11.7%	23	38.3%
New York	PRESBYTERIAN HSP CITY OF NY	1377	311	22.6%	560	40.7%
New York	ST CLARES HSP HLTH CTR	336	75	22.3%	151	44.9%

Provider County	Provider Name	# of Dicharge	Readmitted within 30 Days Number	Readmitted within 30 Days Percent	Readmitted within 180 Days Number	Readmitted within 180 Days Percent
New York	ST LUKES ROOSEVELT HSP CTR	1081	187	17.3%	393	36.4%
New York	ST VINCENTS HSP MED CTR NY	1200	254	21.2%	510	42.5%
Queens	CITY HOSPITAL CTR AT ELMHURST	1477	208	14.1%	436	29.5%
Queens	EPISCOPAL HEALTH SERVICES	670	103	15.4%	293	43.7%
Queens	FLUSHING HOSPITAL & MED CENT	155	13	8.4%	49	31.6%
Queens	JAMAICA HOSPITAL MED CTR	784	86	11.0%	231	29.5%
Queens	NEW YORK HOSP MED CTR QUEENS	11	0	0.0%	0	0.0%
Queens	QUEENS HOSPITAL	613	74	12.1%	199	32.5%
Richmond	BAYLEY SETON HOSPITAL	495	76	15.4%	178	36.0%
Richmond	ST VINCENTS MED CTR RICHMOND	518	94	18.1%	214	41.3%
Richmond	STATEN ISLAND UNIV HOSP	544	111	20.4%	238	43.8%
Private Hospital		**1010**	**182**	**18.0%**	**404**	**40.0%**
New York	GRACIE SQUARE GENERAL HOSP	442	69	15.6%	166	37.6%
Queens	HOLLISWOOD HOSP ADOL DTP	568	113	19.9%	238	41.9%
State Psychiatric Center		**470**	**88**	**18.7%**	**153**	**32.6%**
Bronx	BRONX PC	51	25	49.0%	33	64.7%
Bronx	BRONX CHILDRENS PC	92	17	18.5%	31	33.7%
Kings	Brooklyn Children's Psychiatric Center	44	7	15.9%	15	34.1%
Kings	KINGSBORO PC	37	11	29.7%	13	35.1%
New York	MANHATTAN MEYER PC	9	5	55.6%	5	55.6%
New York	NEW YORK PC	23	2	8.7%	5	21.7%
Queens	CREEDMOOR PC	32	10	31.3%	12	37.5%
Queens	QUEENS CHILDRENS PC	115	10	8.7%	29	25.2%
Richmond	SOUTH BEACH PC	67	1	1.5%	10	14.9%
RTF		**140**	**97**	**69.3%**	**109**	**77.9%**
Bronx	RTF JEWISH BOARD ITTLESON CTR	16	3	18.8%	9	56.3%
New York	RTF AUGUST AICHHORN CENTER	13	4	30.8%	4	30.8%
Queens	RTF OTTILIE HOME FOR CHILDREN	111	90	81.1%	96	86.5%
Western Region		**7913**	**1246**	**15.7%**	**2968**	**37.5%**
General Hospital		**7483**	**1181**	**15.8%**	**2824**	**37.7%**
Cattaraugus	OLEAN GENERAL HOSP MAIN	201	18	9.0%	50	24.9%
Chautauqua	LAKE SHORE HOSPITAL	197	22	11.2%	61	31.0%
Chautauqua	WOMANS CHRISTIAN ASSOCIATION	325	40	12.3%	100	30.8%
Chemung	ST JOSEPHS HOSPITAL ELMIRA	400	67	16.8%	153	38.3%
Erie	BUFFALO GENERAL HOSP	1116	179	16.0%	473	42.4%
Erie	ERIE COUNTY MEDICAL CTR	1156	139	12.0%	367	31.7%
Monroe	GENESEE HOSPITAL ROCHESTER	93	16	17.2%	40	43.0%
Monroe	PARK RIDGE HOSPITAL	450	70	15.6%	159	35.3%
Monroe	ROCHESTER GENERAL HOSPITAL	288	41	14.2%	104	36.1%
Monroe	STRONG MEMORIAL HOSPITAL	739	101	13.7%	259	35.0%
Niagara	NIAGARA FALLS MEM MED CTR	1119	253	22.6%	497	44.4%
Ontario	CLIFTON SPRINGS HSP CLINIC	249	56	22.5%	107	43.0%
Steuben	ST JAMES MERCY HOSPITAL	543	89	16.4%	218	40.1%
Tompkins	CAYUGA MEDICAL CTR/ITHACA	207	30	14.5%	76	36.7%
Wayne	NEWARK-WAYNE COM HSP INC	136	19	14.0%	53	39.0%
Wyoming	WYOMING COMMUNITY HOSP CO	136	25	18.4%	55	40.4%
Yates	SOLDIERS AND SAILORS MEM HSP	128	16	12.5%	52	40.6%

Provider County	Provider Name	# of Dicharge	Readmitted within 30 Days Number	Readmitted within 30 Days Percent	Readmitted within 180 Days Number	Readmitted within 180 Days Percent
Private Hospital		**137**	**12**	**8.8%**	**46**	**33.6%**
Erie	BRY-LIN HOSPITAL	137	12	8.8%	46	33.6%
State Psychiatric Center		**209**	**37**	**17.7%**	**67**	**32.1%**
Chemung	ELMIRA PC	85	16	18.8%	35	41.2%
Erie	BUFFALO PC	25	11	44.0%	12	48.0%
Erie	WESTERN NY CHILDRENS PC	40	5	12.5%	8	20.0%
Monroe	ROCHESTER PC	59	5	8.5%	12	20.3%
RTF		**84**	**16**	**19.0%**	**31**	**36.9%**
Erie	RTF BAKER HALL	25	0	0.0%	6	24.0%
Erie	RTF CONNERS	19	8	42.1%	11	57.9%
Monroe	RTF CRESTWOOD CHILDRENS CTR	8	0	0.0%	2	25.0%
Monroe	RTF HILLSIDE CHILDRENS CENTER	23	7	30.4%	10	43.5%
Monroe	RTF ST JOSEPHS VILLA-ROCH	9	1	11.1%	2	22.2%

Table 13
CMHS Indicators, Priority and Data Sources

Domain	Num	Measure	CMHS Priority	Yr OMH Will Be Able to Report Measure	Data Sources										
					PCS	CAIRS	MHSS/PAC	NIMRS	NYISERS	Meds Solutions	DMHIS	Medicaid	SPARCS	CFR	CONCERTS
Access	A1	Penetration/Utilization rates (by age, sex, race,SMI/SED)	Initial & Developmental	2003	Y										
	A2	Consumer perception of access	Initial	2004			Y								
	A3d	Average time to first service	Longer-Range	NA											
	A4d	Denial of care	Longer-Range	NA											
	A5d	rural access	Developmental	2003											Y
Quality / Appropriateness	Q1	Consumer participation in treatment planning (Adults)	Initial	2003		Y	Y				Y				
	Q2	Consumers linked to primary health services	Longer-Range	NA		Y					Y	Y			
	Q3	Contact within 7, 30 days following hospital discharge	Longer-Range	NA							Y	Y			
	Q4	Consumer perception of Quality/Appropriateness	Initial	2004			Y								
	Q5	(EBP) adults receiving assertive community treatment "ACT"	Developmental	2004	Y	Y						Y			
	Q6	(EBP) adults in supported employment	Developmental	2004?	Y	Y			Y						
	Q7	(EBP) adults in supported housing	Developmental	2003	Y	Y									
	Q8	(EBP) adults receiving new generation "atypical" medications	Developmental	2004						Y		Y			
	Q9	(EBP) Children living in family-like setting for children and	Developmental	2003	Y	Y									
	Q10	Family Involvement in treatment for Children/Adolescents	Developmental	2004			Y								
	Q11	Readmissions within 30, 180 days	Developmental	2003								Y	Y		
	Q12	Seclusion	Longer-Range	na				Y							
	Q13	Restraint	Longer-Range	na				Y							
	Q14	Medication errors	Longer-Range	na						Y					
	Q15d	Follow-up after emergency services	Longer-Range	na											
	Q16d	Family involvement in treatment (Adults)	Developmental	2003			Y								
	Q17d	Screening for TB, HIV, etc	Longer-Range	na											
Outcome	O1	Consumer perception of Outcomes	Initial	2003			Y								
	O2	School Improvement (Children)	Developmental	?											
	O3	Employment (adults)	Initial	2003	Y				Y						
	O4	Functioning	Developmental	NA	Y	Y					Y				
	O5	Symptom relief	Developmental	NA							Y				
	O6	Consumer injuries	Longer-Range	NA				Y							
	O7	Elopement	Longer-Range	NA							Y				

Table 13 continued

CMHS Indicators, Priority and Data Sources

Domain	Num	Measure	CMHS Priority	Yr OMH Will Be Able to Report Measure	Data Sources										
					PCS	CAIRS	MHSS/PAC	NIMRS	NYISERS	Meds Solutions	DMHIS	Medicaid	SPARCS	CFR	CONCERTS
Outcome	O8	Out of home placements	Developmental	2003	Y										
	O9	Health status: mortality	Longer-Range	NA				Y					Y		
	O10	Recovery/Hope/Personhood (surrogate measures)	Longer-Range	NA											
	O11	Reduced substance abuse impairment	Longer-Range	NA		Y									
Outcome	O12	Living situation	Developmental	2003	Y										
	O13	Criminal Justice	Developmental	2003	Y										
	O14d	Recovery/Personhood/Hope	Longer-Range	NA											
	O15d	Abnormal Involuntary Movements (AIMS)	Longer-Range	NA											
Structure/ Plan Management	S1	Consumer/Family member involvement in policy development,	Longer-Range	NA											
	S2	Proportion of expenditures on administration	Initial	2002										Y	
	S3	Per member per month/average resources spent for MH	Initial	2002										Y	
	S4d	Stakeholder satisfaction	Longer-Range	NA											
	S5d	Cultural competence	Developmental	2004											
Early Intervention/ Prevention	P1d	Substance abuse screening	Longer-Range	NA											Y
	P2d	Use of self-help/self-management	Longer-Range	NA											
	P3d	Identification of high risk populations	Longer-Range	NA											
	P4d	Psycho-educational programs	Longer-Range	NA											
Denominators		All persons served in public mental health system	Initial	2003											
		Persons with SMI, SED in public mental health system	Developmental	2003	Y										
		Census by age, sex, race, ethnicity group	Initial	NA											

Overview of State Mental Health Expenditures

Summary of All Expenditures Within the Public Mental Health System Licensed and/or Funded by OMH

State Auspice	State auspice is defined as all programs operated by OMH including all funding sources (public and private). Expenses were obtained from the OMH facility Medicare/Medicaid cost reports.
Local Auspice	Local auspice includes all local mental health programs licensed and/or funded by OMH, including all funding sources.
General Hospitals	Expenses were generally obtained from the Institutional Cost Report (ICR). For those hospital programs that do not report on the ICR, expense data were obtained from the Consolidated Claims Report (CCR).
Article 31 Freestanding Providers	Expenses were obtained from the annual reconciliation of the Consolidated Fiscal Report (CFR) and the CCR.
Private Psychiatric Hospitals	Expenses were obtained from the ICR.
Residential Treatment Facilities	Expenses were obtained from the CFR except for Medicaid reimbursement amounts for education services which were obtained from the actual Medicaid claims payments.

Programs

Emergency Services	Emergency Programs include CPEPs and crisis programs.
Inpatient Services	Inpatient includes State-operated inpatient, general hospital inpatient, private psychiatric hospital, and residential treatment facilities.
Outpatient Services	Outpatient includes all licensed outpatient programs.
Community Support Program (CSP) (Residential)	CSP Residential included all OMH licensed and/or funded housing.
Community Support Program (Nonresidential)	CSP nonresidential includes all community support programs.

Table 1
Summary of State Mental Health Expenditures*

	DOLLAR AMOUNTS IN MILLIONS							
	ACTUAL						PROJECTED	
	1995	1996	1997	1998	1999	2000	2001	2002
STATE AUSPICE								
Emergency	$16	$17	$17	$19	$21	$24	$23	$24
Inpatient	1,159	1,084	1,077	1,037	1,052	1,132	1,133	1,139
Outpatient	170	161	161	157	164	177	—	—
CSP Non-Res.	94	94	109	107	113	127	—	—
CSP Residential	75	78	76	73	73	86	399	410
Subtotal	**$1,514**	**$1,434**	**$1,440**	**$1,393**	**$1,423**	**$1,546**	**$1,555**	**$1,573**
Percent Total Budget	**35.86%**	**33.93%**	**33.58%**	**32.18%**	**32.07%**	**32.77%**	**32.88%**	**32.56%**
LOCAL AUSPICE								
Emergency	$122	$146	$160	$162	$146	$159	$191	$200
Inpatient	1,249	1,272	1,265	1,286	1,289	1,359	1,382	1,409
Outpatient	773	802	820	849	890	892	—	—
CSP Non-Res.	282	281	301	324	353	410	—	—
CSP Residential	282	291	302	316	337	352	1,602	1,649
Subtotal	**$2,708**	**$2,792**	**$2,848**	**$2,936**	**$3,015**	**$3,172**	**$3,175**	**$3,258**
Percent Total Budget	**64.14%**	**66.07%**	**66.42%**	**67.82%**	**67.93%**	**67.23%**	**67.12%**	**67.44%**
TOTAL								
Emergency	$138	$163	$177	$181	$167	$183	$214	$224
Inpatient	2,408	2,356	2,342	2,323	2,341	2,491	2,515	2,548
Outpatient	943	963	981	1,006	1,054	1,069	—	—
CSP Non-Res.	376	375	410	431	466	537	—	—
CSP Residential	357	369	378	389	410	438	2,001	2,059
Total	**$4,222**	**$4,226**	**$4,288**	**$4,329**	**$4,438**	**$4,718**	**$4,730**	**$4,831**
	100.00%	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

* The dollar amounts reported in Table 1 include both New York State appropriations and appropriations from Medicare, Medicaid, and other third party payors.

Interagency Adult Home Initiative

- NYS Department of Health
- NYS Office of Mental Health
- NYS Commission on Quality of Care for the Mentally Disabled
- NYS Office for the Aging

Health and Safety

Creation and continuation of activities by State regulatory and monitoring agencies to maximize the health and safety of adult home residents. For example:

- interagency joint inspection teams;
- priority investigative teams;
- streamlined enforcement;
- fines;
- additional surveyors hired;
- training of surveyors;
- QIPP review (Quality Incentive Payment Program);
- resident council requirement;
- public release of adult home surveys;
- death reporting;
- strengthened regulations; and
- the Governor's adult home program bill.

Key features:

- Closed several impacted adult homes;
- Utilized priority investigative teams;
- Continued joint inspections;
- Continued monitoring of death reports;
- Continued educational development of surveyors at training academy;
- Computerized survey data allowing for live data collection and action.

Implementation features:

- Ongoing.

Appropriateness of Care/ Medical Necessity

Health and Mental Health Assessments

Assessment of residents for the purpose of gathering baseline information on their current health and mental health status, the current array of programs and providers, and an indication of residents' functional status and community living skills.

Key features:

- Development of an assessment tool that measures health status, mental health status, individual quality of life, services, functioning skills and cognition;
- Assessments will be done by licensed nurses and social workers under physician supervision.

Implementation features:

- Hired nurse assessors to complete resident assessments;
- Completed over 2,200 resident assessments in 15 impacted adult homes;
- Developed referral process for health/mental health needs of residents;
- Shared assessments with on-site mental health case managers;
- 2,500 residents will be assessed by the end of January 2004.

Case Management/ Peer Support

Creation of an independent case management function to ensure that residents are informed of community treatment, rehabilitation, vocational, housing and support options. Case managers will also be responsible for conducting assessments as appropriate, assisting residents in making informed choices regarding their various options, as well as assisting residents in accessing selected services.

Peers are intended to promote and support residents' recovery. They will assist residents in understanding their living and treatment choices, coordinating such efforts with the case managers. Peers will help residents to advocate for themselves and to utilize peer-run supports.

Key features:

- Target NYC/Long Island homes with significant problems;
- Engage residents in case management and peer services;
- Establish staff to resident ratio 1.5:30;
- Incorporate DOH assessment data;
- Provide bridge to self-help groups, community activities and education through peer support.

Implementation features:

- Released New York City RFP August 2003;
- Selected sites include Brooklyn Manor, Riverdale Manor and Anna Erika;
- Selected providers October 2003;
- Begin services January 2004;
- Release Long Island RFP October 2003;
- Selected provider January 2004;

- Begin services in Long Island adult homes February 2004;
- Supplement case management services on Long Island to support residents in homes that are closing;
- Include two New York City sites with State-operated services September 2003;
- Coordinate additional peer support resources October 2003.

Quality of Care

Medication Administration/ Management

Assure resident health and safety in adult care facilities by clarifying current regulatory authority for medication assistance.

Key features:

- Improve current regulatory oversite in assuring safe medication assistance to residents in adult care facilities;
- Reduce potential for medication errors;
- Develop demonstration project with colleges of nursing and pharmacies which will include collaborative approaches to assure resident health and safety.

Implementation features:

- Identify those homes that have medication management issues;
- Identified pharmaceutical and nursing schools who are interested in participating in a demonstration project;
- Develop curriculum for adult home staff on medication management;
- Implementation anticipated Spring 2004.

Wellness Self-Management Demonstration

Establishment of a demonstration program to provide targeted resident training to improve wellness self-management skills (i.e., psycho-education, social skills training, cognitive behavioral training, and coping skills training).

Key features:

- Target NYC/Long Island homes with significant problems;
- Manage stress and symptoms in order to prevent relapse and achieve personal goals;
- Develop staff and peer core competencies in wellness self-management;
- Provide on-site training, consultation and supervision utilizing resource materials including Illness Management Recovery Toolkit.

Implementation features:

- Began July 2003 (Queens Adult Care).
- Begin December 2003 (Riverdale Manor, Brooklyn Manor and Anna Erika)

Quality of Life

Social and Recreational Services

Development of enrichment activities, both within adult homes and in the community. Providers of such services are encouraged to hire peers.

Key features:

- Target NYC/Long Island homes with significant problems;
- Create opportunities for resident participation in educational, entertainment and enrichment activities in the community;
- Coordination with case management and peer program to facilitate resident participation.

Implementation features:

- Began September 2003 (Queens Adult Care);
- Began September 2003 (Riverdale Manor, Brooklyn Manor and Anna Erika)
- Initiated 20 social/performance events with 1,200 individuals participating between September and December 2003;
- Initiated trips to five community events with 120 individuals participating between September and December 2003.

Vocational and Educational Services

Development of vocational and educational activities both within the adult home and in the community

Key features:

- Create opportunities for resident participation in vocational and educational activities;
- Develop regional training forums in adult homes and in the community.

Implementation features:

- Initiated first ever job fair at an Adult Home (Queens Adult Care) in October 2003;
- Follow-up fair planned for Bronx in Winter 2004.

Advocacy

Residents will be supported in their ability to advocate for themselves, as well as their ability to access legal services and an ombudsman program.

Key features:

- Continuation of CIAD and CQC/SOFA ombudsman projects;
- Expansion of adult home advocacy projects.

Implementation features:

- Ongoing.

Housing

- Assist residents in homes that are closing;
- Explore housing options;
- Create interagency housing task force;
- Cap size of new homes at 120 beds (Regulation under development).

Key features:

- Increase access to 31,000 community residential beds (60% increase since 1995) including the development of 2,600 new community residential beds (proposed budget).

Implementation features:

- Support resident housing options;
- Utilize county's single point of access process;
- Initiated interagency housing task force;
- Created subgroup of interagency housing task force to review options for adult homes that are closing.

Public Awareness

Key features:

- Created centralized hotline;
- Provide information cards to residents;
- Distribute letters to the field regarding winter/heat advisory surveys;
- Conducted adult home Town Meetings;
- Provided information to residents on QUIP funding;
- Met with advocates and other stakeholders.

Implementation features:

- Ongoing;
- Continue to review resources to enhance quality of resident life.

Medicaid Buy-in Toolkit Draft

Welcome

Welcome to the Medicaid Buy-in Toolkit. Enclosed in this toolkit you will find everything needed in order to apply for the Medicaid Buy-in Program for Working People with Disabilities.

The Medicaid Buy-in for Working People with Disabilities is a new program that started on July 1st, 2003 that allows working New Yorkers with disabilities to earn more income and accrue more resources without the risk of losing their Medicaid coverage.

This is designed to help you decide whether or not you would like to apply for the Medicaid Buy-in, know whether or not you are eligible, and assist you in completing some important steps of the application process. If you complete the steps in this toolkit, your application will be complete before you step foot in a Department of Social Services office, and you will be knowledgeable about the Medicaid Buy-in Program for Working People with Disabilities and the process of applying for it.

The steps and information enclosed in this toolkit were steps used by people who applied and successfully obtained Medicaid Buy-in Program for Working People with Disabilities benefits. These steps include:

1) **Frequently Asked Questions:** Learn about the Program
2) **Determining Your Eligibility:** See if you are eligible
3) **Resources:** What they are, and how they affect you
4) **Self-Interview:** Find out if the program is right for you
5) **The Application:** Fill out the application
6) **Navigating the Department of Social Services:** Tips to guide you through this process
7) **Documenting your Actions:** Forms that will help you to document your actions and conversations while applying for the Medicaid Buy-in.
8) **BPAOs (Benefits Planning, Assistance, and Outreach)**
9) **Additional Resources**
10) **Self Employment:** Can it Really Work for Me?

Section 1: Learn about the Program

Frequently Asked Questions

On July 1st of 2003, New York State launched the new Medicaid Buy-in Program for Working People with Disabilities. This is a groundbreaking program that allows working New Yorkers with Disabilities to work without fear of losing their essential medical coverage through Medicaid.

What this means for thousands of New Yorkers with disabilities is independence, recovery, and support in achieving goals. Previously, people with disabilities could only work a limited number of hours, gaining a limited income, and then their essential Medicaid coverage would be cut along with their Supplemental Security Income. The New York State Medicaid Buy-in allows people with disabilities to earn up to 46,170 dollars, and still keep that coverage.

Why is the Medicaid Buy-in for Working People with Disabilities important?
Only 30% of people with disabilities are employed. Only 15% of people with psychiatric disabilities are employed. According to a national survey, the #1 reason that people with disabilities gave for not working was fear of losing their essential medical benefits.

This program allows people to keep their benefits in order to meet their medical needs in order to continue working. Medicaid coverage is more comprehensive than most other programs including private health insurance. Medicaid covers the medical costs of prescriptions, long term care, and ongoing medical supplies. Some private health insurance companies do not cover all of these costs, and Medicare doesn't either.

Why is it called the Medicaid Buy-in?
If your net available income is below 150% of the Federal Poverty Level (FPL), you will not have to pay anything to get Medicaid through the Buy-in program. If your net available income is between 150% and 250% of the Federal Poverty Level, you will have to pay 3% of your earned income, and 7.5% of your unearned income as a premium to obtain your Medicaid through the Buy-in. The term "Buy-in" is used because you are buying in (paying a premium) to the Medicaid program.

What is considered work?
Work is anything that you are doing that you earn money from. This can be full time or part time. You can even be self-employed! Under the basic group of the Medicaid Buy-in, there are no requirements on how many hours you work, or how much you are being paid. Under the medically improved group, you must work a minimum of 40 hours per month earning at least minimum wage.

What is the difference between the Basic Group and the Medically Improved Group?
In both groups, you must be considered to have a disability, be between 16 and 64, working, and meet the citizenship and residency requirements. In the Medically Improved Group, you would have lost eligibility under the Basic Group due to "medical improvement". In the Medically Improved Group, you must be working a minimum of 40 hours per month at minimum wage.

How much money do I have to make in order to apply?
There is no limit on how much money you make if you are in the "Basic Group". This means that you can earn as little as $1, and qualify for the Medicaid Buy-in.

Can I get Medicaid through the Medicaid Buy-in Program for Working People with Disabilities if I am on Social Security Disability Income(SSDI)?
If you are working, and meet all of the other eligibility guidelines, then yes, you can get the Medicaid Buy-in for Working People with Disabilities.

How come 250% of the Federal Poverty Level is approximately 23,000 dollars, yet I can earn up to 46,170 dollars?
When you apply for the Medicaid Buy-in program, your income is put through a budgeting methodology used by the Social Security Administration. In that test, there are deductions from both your earned and unearned income (see example). During this process, much more of your earned income is deducted in order to attain your net available income, while very little is deducted from your unearned income. This allows people to work more, and still keep their benefits.

If all of your income comes from earned income, you can earn up to 46,170 dollars gross. If most of your income is unearned, then you would only be able to make 23,000 dollars per year to qualify.

Will I have to pay co-pays and deductibles?
All of the standard co-pays and deductibles apply with the Medicaid Buy-in Program for Working People with Disabilities.

Is this the same as the Medicare Buy-in Program?
No. The Medicaid Buy-in Program for Working People with Disabilities is a program that launched July 1st of 2003.

What application can I use to apply for the Medicaid Buy-in Program for Working People with Disabilities?
The standard Medicaid application is being used to apply for the Buy-in. This is a green and white 16 page application. It is recommended that you write "MBI-WPD" on the top right hand corner of the application to help route your application.

Is there follow-up I need to do after handing in my application to a specific worker at social services?
After 10 days, contact that specific worker and make sure your application has been sent up to Albany.

Are there any services available to help me decide if I would like to apply for the Medicaid Buy-in Program for Working People with Disabilities?
Your local BPAO (Benefits Planning Assistance and Outreach) can provide you with information about the Medicaid Buy-in, and help you decide if you should apply for the Buy-in. A list of local BPAOs is enclosed in this toolkit.

How do I go about getting the Medicaid Buy-in?
You can apply for the Medicaid Buy-in Program for Working People with Disabilities at your Local Department of Social Services. This toolkit will help you in the process of applying for the Medicaid Buy-in Program for Working People with Disabilities.

What if I am working and have not been on any benefits for some time?
It is not a requirement that you be on any kind of assistance or receive any kind of benefits in order to qualify for the Medicaid Buy-in. You may still be eligible for the Medicaid Buy-in if you meet all of the eligibility guidelines.

What if I am working, have a disability, and have never received SSI or SSDI?
You can still qualify for the Medicaid Buy-in if you are determined disabled and you meet all the other eligibility requirements.

How much can I have in resources?
You can have countable resources up to 10,000 dollars. This does NOT include your home or vehicle. Your Local Department of Social Services can tell you what other resources are exempt.

What if I am already attaining Medicaid through spend down?
If you are on the spend down program and working, you should talk with your Social Services caseworker about the Medicaid Buy-in program. In most cases, you will save money by enrolling in the Medicaid Buy-in program.

If you apply for the Medicaid Buy-in, you should keep paying your spend down while you are waiting for the Medicaid Buy-in, and you will be reimbursed for the time you are waiting for the Medicaid Buy-in, once you are approved.

How long does the process take?
You should receive your notification within 60 days.

Are my children or other family members covered by the Medicaid Buy-in?
No. The Medicaid Buy-in for Working People with Disabilities is only for individuals or couples who both have disabilities. There are other programs that can cover children offered by the Department of Social Services.

Section 2: See if you are eligible

Part A: Self Interview

1 Am I working? ❑ Yes ❑ No

2. Have you been determined to be disabled by the Social Security Administration's guidelines? ❑ Yes ❑ No

if no, you will be reviewed by the State Disability Review team, please see details on this in Section

3. Are you a Citizen, a National, a Native American, or do you have legal status as an immigrant in the United States? ❑ Yes ❑ No

   if yes, continue on to #4

4. Are you a resident of New York State? ❑ Yes ❑ No

5. Are you between the ages of 16 and 64 ❑ Yes ❑ No

If you answered yes to all of the above questions, you may be eligible for the Medicaid Buy-in for Working People with Disabilities.

Part B: The Income Test

Your Earned Income:

Earned income is anything that you worked for. This would include any earnings from self-employment, or from an employer.

1. Total earned income last month: _____

2. -65 dollars standard income disregard = _____

3. x .50 = _____

Your Unearned Income:

Unearned income is any income that you receive that you have not worked for. This includes any bank interest, annuity payments, lottery winnings, or any other income that you are receiving that is not connected to work activity.

4. Total unearned income last month: _____

5. -20 dollar standard income disregard: = _____

Add lines 3 and 5 = _____

The last number is your net available income.

If that figure is under 1871.00, you meet the income eligibility requirements for the Medicaid Buy-in Program for Working People with Disabilities.

If that figure is over 1871.00, please refer to Section for information on meeting the income eligibility through other incentives available.

Section 3: What they are, and how they affect me

Resources

Under the Medicaid Buy-in Program for Working People with Disabilities, you will be able to keep more resources than ever before. **Countable Resources** are counted, their value determined, and then added up. With the new Medicaid Buy-in for Working People with Disabilities, you can keep up to 10,000 dollars in countable resources. Countable Resources include stocks, bonds, and vacation homes.

Exempt resources are **not counted.** These Exempt Resources include:

- Your Homestead
- Your Vehicle
- PASS Plans
- Term Life Insurance Policies
- Whole Life Insurance Policies with a face value of 1500 dollars or less

There are other resources that are not counted. It is best to check with your local Department of Social Services to see which resources are exempt.

Section 4: Tips to guide you through the process

Navigating the Department of Social Services System

When applying for the Medicaid Buy-in Program for Working People with Disabilities, you will eventually need to go in to your Local Department of Social Services to hand in your application.

This can be a very confusing and frustrating process that sometimes leads you in circles. If you are eligible and interested in the Medicaid Buy-in based on what you completed in this toolkit, you should be persistent in your efforts to sign up for the Medicaid Buy-in. Here are some tips to successfully get through this process:

Know your facts about the Medicaid Buy-in. This toolkit will help you with knowing all you need to know about the Medicaid Buy-in. Learn all you can about the Medicaid Buy-in, and you will go in with a knowledge base you can rely on.

Be Determined to get enrolled in the Medicaid Buy-in Program for Working People with Disabilities. If you don't get what you need from one person, ask to speak to a supervisor. If you don't get what you need from the supervisor, ask to speak to their supervisor. Be persistent until you get what you need and rightfully deserve.

Know Who Can Support You if you do run into problems. There is a list of local BPAOs enclosed with this toolkit, and you can seek out their assistance. BPAOs are contracted with the Social Security Administration to provide benefits counseling, planning, assistance and outreach free of charge. If you already have assistance with your benefits, seek out who you are most comfortable with.

Bring Documentation of your eligibility for the Medicaid Buy-in Program, as well as all of your other required documentation. Bringing the "Income Test" part of this toolkit can help, as well. Bringing the Department of Health flyer enclosed in this toolkit can help you as well.

Document Your Actions associated with DSS. Make sure you take names of everyone you speak with, or meet with, and make sure that you write down any problems you are experiencing along with the dates and times. Using the "Encounter Form" enclosed in this toolkit will help you to document your experiences.

Follow-up with the Local Department of Social Services you applied with. Make sure that have submitted your application, and that you are in the system. Follow-up is recommended 10 days after you submit your application.

Phone Conversation Form

When talking with someone involved with your application process for the Medicaid Buy-in, it is important to document everything: Including phone calls. If you experience any kind of problem applying for the Medicaid Buy-in, it is essential to have proper documentation of all of the actions you have taken. This form allows you space to document all of the phone conversations you have with people involved with your application process. Bring this form if you go anywhere to report problems you have been having.

Date: _____ Time :_____ Person I spoke with: _____

Describe your conversation:

_____

_____

_____

_____

Were you satisfied with your conversation? ❑ Yes ❑ No

Were there any follow-up actions taken?

_____

_____

Date: _____ Time :_____ Person I spoke with: _____

Describe your conversation:

_____

_____

_____

_____

Were you satisfied with your conversation? ❑ Yes ❑ No

Were there any follow-up actions taken?

_____

_____

Date: _____ Time :_____ Person I spoke with: _____

Describe your conversation:

_____

_____

_____

_____

Were you satisfied with your conversation? ❑ Yes ❑ No

Were there any follow-up actions taken?

_____

_____

Date: _____ Time :_____ Person I spoke with: _____

Describe your conversation:

_____

_____

_____

_____

Were you satisfied with your conversation? ❑ Yes ❑ No

Were there any follow-up actions taken?

_____

_____

Date: _____ Time :_____ Person I spoke with: _____

Describe your conversation:

_____

_____

_____

_____

Were you satisfied with your conversation? ❑ Yes ❑ No

Were there any follow-up actions taken?

_____

_____

Encounter Form

This form will help you if you encounter any problems while trying to apply for the Medicaid Buy-in. This helps you to ask the right questions, write down the right information, and bring it to a person who can help you with the problem. To speak with a Benefits Counselor, see the "BPAO" listing enclosed.

Date: _____ Time: _____

Name of Department of Social Services Caseworker: _____

Number of visits made to Department of Social Services: _____

Problem Experienced:

❑ I was told I am not eligible when my toolkit says I am.

❑ I was told about a program other than the Medicaid Buy-in.

❑ I was told there is no Medicaid Buy-in Program.

❑ I was told because I am working I do not qualify.

❑ I was told I am not eligible because I have too many resources, when my toolkit says I am.

Other: _____

Describe what you experienced at the Department of Social Services:

_____

_____

_____

_____

_____

Describe actions you took to help solve the problem:

_____

_____

_____

_____

_____

Your Name, Address, and Phone Number:

_____

_____

_____

_____

_____

Project Liberty Service Delivery

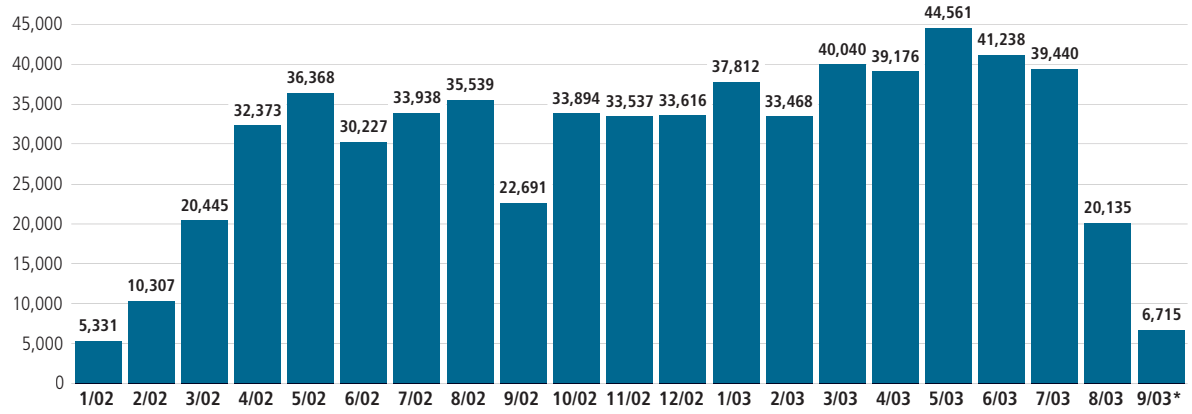
Service Volume for Project Liberty

Service Type	Region	Number of Sessions	Number of Individuals Served*
Individual or Family Counseling	Surrounding Ten-County Region	25,159	13,763
	New York City	583,144	436,308
Total		608,303	450,071
Group Counseling	Surrounding Ten-County Region	3,018	12,798
	New York City	31,329	80,361
Total		34,347	93,159
Group Public Education	Surrounding Ten-County Region	5,069	170,878
	New York City	19,619	339,771
Total		24,688	510,649
Grand Total		**667,338**	**1,053,879**

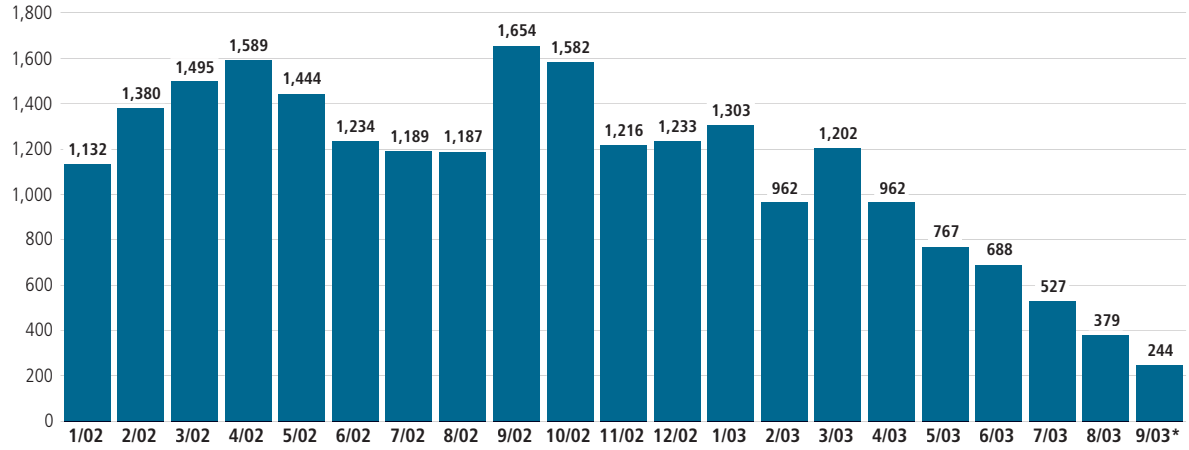
* The count of individuals is estimated by totaling the number of persons receiving first time Individual or Family Counseling, the number of persons receiving Group Counseling, where log forms for ongoing groups were excluded, and total number of persons attending Group Publiuc Education sessions. Some duplication is possible due to people attending multiple presenetations or receiving both individual and group counseling.

Data does not reflect the 26,596 sessions delivered in schools by the New York City Department of Education Project Liberty Program between January 1, 2003 and August 31, 2003.

Graph 1
Project Liberty Sessions Administered in New York City by Month



Graph 2
Project Liberty Sessions Administered in Ten-County Region by Month

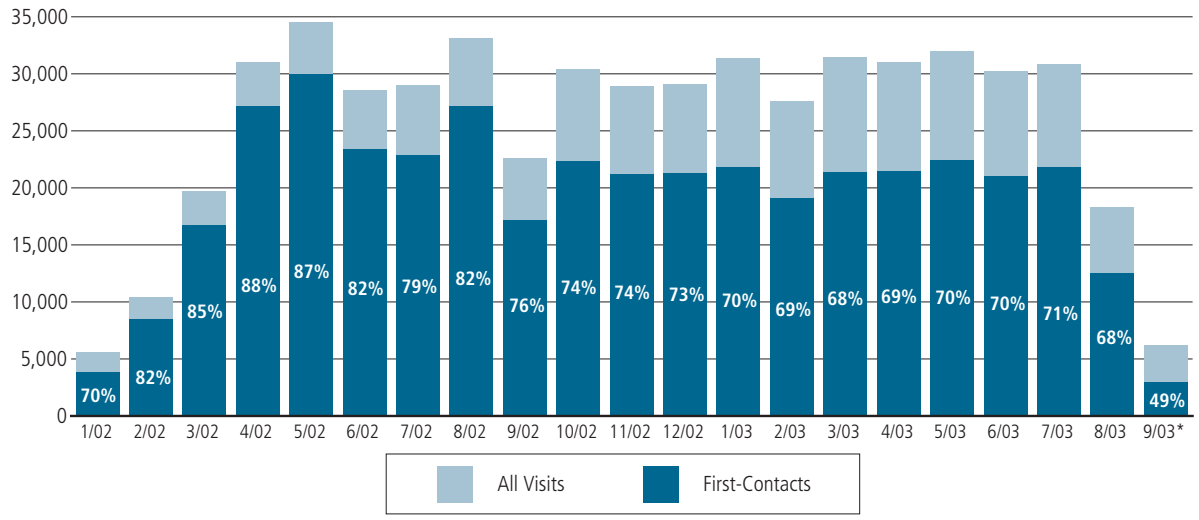


Overall New York City Based sites account for 95% of all Project Liberty Session.

* Data for September 2003 is not complete.

Graph 3

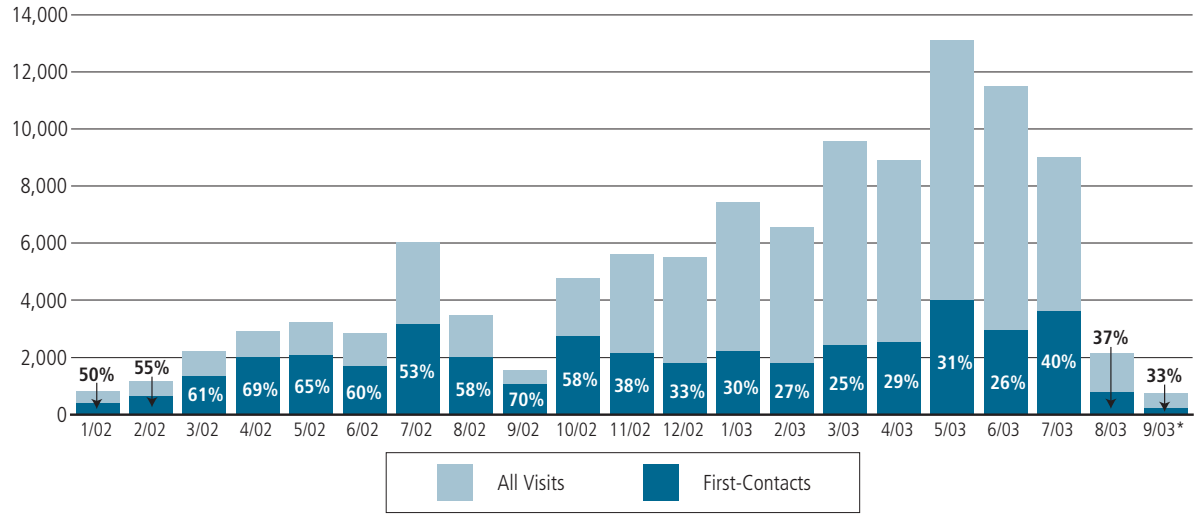
Proportion of Initial Visits to Total Visits for Adult Project Liberty Recipients per Month



Crisis counseling continues to reach new people in need of service. Overall for adults, approximately 77% of Individual & Family Counseling services were given to new program entrants.

Graph 4

Proportion of Initial Visits to Total Visits for Children & Youth Project Liberty Recipients per Month



Children & Youth are more likely to receive multiple counseling sessions than adults.

* Data for September 2003 is not complete.

Service to Children and Adolescents in New York City

In New York City approximately 70,000 children (under the age of 18) have received a face-to-face service from a Project Liberty counselor. This represents about 9% of all persons served.

For those children receiving either individual or family counseling, 3% percent of those sessions were with pre-school children, 43% with children age 6–11, and 54% with those 12–17.

Females were slightly more likely to be served (52% of the total) compared to males (48%).

Race/Ethnicity of the children/youth served:	
White	17%
Hispanic	41%
Black	34%
Asian/ PacificIslander	5%
Other	3%

Languages individual sessions provided in:	
English	91%
Spanish	6%
Chinese	1%
Other	2%

A school was the most likely place for the individual/family counseling to occur.

Location	**Percent of Individual/Family Counseling Sessions Held**
School	67%
Home	4%
Community Center	4%
Other community locations	16%
Provider Site	8%

7% percent of children and youth receiving individual counseling were referred for professional mental health treatment. This is slightly lower than the 10% rate for adults.

22% of public education presentations included children and participants whose concerns relate to schoolchildren such as parents, teachers, and school administrative staff.

Innovative Suicide Prevention Programs and Mental Health Interventions for Self-Harming Behaviors*

There are several examples worthy of note that provide important information regarding elements of potential suicide prevention efforts. Table 1 illustrates the elements of different intervention approaches.

Universal– Means Control:

When suicidal acts are impulsive or ideas are fleeting, limited access to the means of suicide may be especially powerful. Such an understanding has underpinned the recent UK effort to limit access to lethal doses of paracetamol (acetaminophen or Tylenol in the United States) and salicylates by changing the sizes of packages (24 doses in blister packs, giving a smaller number of hard to open pills). Initial reports suggest a marked drop in deaths and in the need for liver transplants, given the extreme hepatotoxicity of paracetamol.[12] The ingestion of available pills in the medicine cabinet is a common occurrence for individuals with less-than-lethal intent or ambivalent motivation, but the availability in the United States of this highly potent liver toxin in bottles of 100 or more suggests one approach to modestly reducing mortality and morbidity.

Selective/Indicted– Project Link, Rochester, New York:

Funded by grants from the NYS Office of Mental Health, the Monroe County Office of Mental Health, and the Robert Wood Johnson Foundation, Lamberti and colleagues of the University of Rochester Department of Psychiatry developed a community coalition with three ethnically oriented agencies and two other care providers to work the Monroe County Office of Mental Health, the local criminal justice systems, and the courts to proactively treat chemically dependent seriously mentally ill persons as they were being released from jail, discharged from inpatient psychiatric care, or individuals identified by providers or the courts to be at heightened risk for repeated incarceration. The program involves intensively focused community case management, careful evaluation of medical and psychiatric problems, and alternative supervised housing, all run by a team of culturally attuned, "street wise" clinicians and case workers who actively partner with probation and court-based personnel.

For the 46 participants enrolled during the first year, with an average of 278 days in the program, the average number of days in jail per month (comparing in-program versus year-before data) dropped from 9.1 per month to 2.1 and the average number of days in hospital declined from 8.3 to .3. At the time of enrollment, 39/41 were unemployed, 40/41 were unmarried, and 29/41 had less than a high school education. For the 41, the mean yearly days in jail dropped (year-before to year-after comparison) from 108 to 46, and the average number of days hospitalized decreased from 116 to 7.4. All of these were significant changes.

During the study period there were no assaults, suicide attempts, or other reportable incidents. Preliminary cost estimates showed that for the initial 46 participants, the monthly jail costs dropped from nearly $31,000 to $7,235 ($672 to $157 per consumer), and monthly hospitalization costs decreased from nearly $198,000 to just over $42,000 ($4302 to $918 each). Moreover, there was a high level of consumer satisfaction. The overall annual operating budget for Project Link during its first year was $681,063, which clearly was far less than the nearly $2.2 million in savings gleaned from reducing jail and hospital services.

Project Link shows the potential of combined provider-community action. It serves as a model of preventative morbidity reduction in a group of very difficult to treat individuals who have some of the highest rates of suicide.

Integrated and Multi-layered– US Air Force (USAF) Program:

Like the US Air Force program, it proved to be a broadly-based violence reduction intervention, in addition to demonstrably improving the lives of a very difficult-to-reach patient population. This population does not readily seek care through traditional service providers, including community mental health centers.

Following an alarming increase in suicide rates during the early to mid-1990s, top leadership mandated that suicide prevention had to become a USAF community-wide responsibility. Under the urgent impetus of its then Vice-Chief of Staff and its Surgeon General, the USAF promulgated service-wide a suicide prevention program during 1996-97 that was built through a broadly-based collaborative process that drew together and has since coordinated a comprehensive array of community and personnel-oriented agencies (e.g., health, mental health, and public health; police, criminal investigation, and legal services; family advocacy; child and youth; personnel).

A significant and sustained drop in suicide rates was observed following community-wide dissemination of the program. Key components of the program were the ongoing commitment from leadership; consistent, regular, and repeated education and communication regarding suicide prevention, including confronting and addressing possible stigma for seeking assistance for emotional and family problems (including mental health treatment); improved and sustained collaboration among community prevention agencies; and the identification and training of "everyday" gatekeepers. In addition to reducing suicides, there were significant changes in a variety of outcomes that share common risk factors with suicide,

*Prepared by Eric D. Caine, M.D. and Kerry L. Knox, Ph.D., Center for the Study and Prevention of Suicide, Universtiy of Rochester

including decreased rates of accidental death and homicide, violent offenses, and severe and moderate cases of family violence, suggesting that the USAF suicide prevention program had an overall impact on reducing the mean risk of violence in the population. There was also increased use of outpatient mental health services, with decreased inpatient admissions for psychiatric reasons.

The USAF is one of the few — if only — naturalistic experiments in which an entire community has been the recipient of such a comprehensive effort to change behavior. As such, the process at work in the USAF can serve as a model of community culture change.

The USAF experience underscored the absolute need for committed, sustained, urgent leadership working in tandem with innovation from those who actually carry out the work. The service's success reflected this interaction; neither "top-down" nor "bottom-up" action would have been sufficient alone. By taking a public health community model as the guide, the USAF program recognized that suicide has multiple factors and antecedents contributing to its final outcome and prevention must deal with people's need before they become acutely symptomatic. Thus, although not expected, the program had the effect of reducing other serious outcomes to a similar degree of magnitude as the reduction in suicide rates.

The personnel of the USAF are screened at multiple levels before entry into active duty status; in particular, they are better educated and they are randomly screened for drug use and have a low rate of illicit drug use as well. Beyond the hierarchical nature of the service, which facilitates implementation of the program, there is an unusually well-knit community, with informal supportive networks, clearly defined gatekeepers, and a diverse array of social support services. And of particular import, there are no fiscal barriers to seeking treatment of medical, mental health, and chemical dependency problems once they have been identified.

General Lessons from Recent Innovations for Application to Future Suicide Prevention Efforts

- Sustained, focused leadership conveying urgency is essential.
- There must be an energetic top-down process, marshalling political will that is integrated with creative, locally knowledgeable implementation — this has a dynamic interactive up-down-up quality.

Table 1
The Language of Mental Health Prevention Applied to Preventing Suicide and Attempted Suicide

Intervention Terminology	Approach	Target	Objectives	Examples of possible future prevention efforts
Universal Prevention Interventions ("Distal" Prevention Efforts)	Population	Implement sweeping, broadly directed initiatives in entire populations, not based upon individual risk. Develop programs that reach asymptomatic individuals.	Prevent disease through reducing risk and enhancing protective or mitigating factors across broad groups of people.	1. Enhance school and community programs to reduce alcohol and substance abuse in youth and young adults. 2. Develop effective violence reduction programs among men, ages 25-55 years. 3. Remove insurance barriers for access to mental health and substance abuse treatment.
Selective Prevention Interventions	High Risk	Identify individuals or subgroups bearing a significantly higher-than-average risk of developing mental disorders or adverse outcomes.	Prevent disease through addressing population-specific characteristics that place individuals at higher-than-average risk	1. Provide counseling and health services for homeless individuals and families. 2. Promote church-based and community programs to contact isolated elders. 3. Provide therapeutic support to victims of domestic violence.
Indicated Preventive Interventions ("Proximal" Prevention Efforts)	High Risk	Identify high-risk individuals with detectable symptoms. Future: Include asymptomatic individuals bearing defined risk markers.	Treat individuals with precursor/ prodromal signs and symptoms to prevent emergence of full-blown disorder.	1. Increase screening and treatment for depressed elders in primary care settings. 2. Vigorously treat elders with chronic pain syndromes. 3. Enhance lithium maintenance for persons with recurrent bipolar disorder. 4. Future: Prescribe pharmacological therapies for individuals bearing biomarkers for psychiatric disorders associated with suicide/suicidal behaviors.

- must be recognition of a "common risk" (akin to a "common enemy") for suicide, attempted suicide, and other significant community problems (e.g., drug use, violent crime, domestic disputes and violence) that draw attention, resources, energy, and commitment. Without a banding together, these efforts will be diminished in their potential to effectively alleviate any one of an array of very desirable outcomes.
- Authority must be shared with clearly defined (and accepted) responsibility and accountability at each level of action.
- Suicide prevention is founded on a multilayered public health approach that addresses key population risk and protective factors, and the specific needs of high-risk groups and individuals.
- Funding mechanisms must be restructured in a collaborative fashion to assure support of services designed to meet the needs of patients and families (e.g., patient/client-centered funding).
- Access to care must be assured. Even minimal barriers are least well met by the most vulnerable. Thus, treatment is assertive and community based, with an emphasis on continuity of care and interagency communication.
- Each level of governmental and nongovernmental action has an important role. Overall they must be integrated effectively, in a sustained and consistent fashion, if one truly seeks to establish a lasting impact, both across the breath of the nation and in the daily lives of specific individuals.

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List of Acronyms

The following list spells out some of the acronyms used most frequently in New York State's public mental health system and referenced in this publication.

(A) Advocate

ACF Adult Care Facility

ACLS Advanced Cardiac Life Support

ACT Assertive Community Treatment

AMI Alliance for the Mentally Ill

AOT Assisted Outpatient Treatment

APA American Psychiatric Association

ARF Association of Rehabilitation Facilities

BH Boarding Home

BMHC Brooklyn Mental Health Council

BOV Board of Visitors

BSMHB Baltic Street Mental Health Board

CAC Certified Alcoholism Counselor

CANS-MH Child and Adolescent Needs and Strengths – Mental Health Instrument

CANY The Correctional Association of New York

CCSI Coordinated Children's Service Initiative

CET Crisis (or Community) Evaluation Team

CFR Consolidated Fiscal Reporting

CITER Center for Information Technology and Evaluation Research

CLMHD NYS Conference of Local Mental Hygiene Directors

CM Case Management (or Manager)

CMAT Children's Mobile Assessment Team

CME Continuing Medical Education

CMHAN Children's Mental Health Action Network

CON Certificate of Need

Coalition The Coalition of Voluntary Mental Health Agencies, Inc.

Covenant Covenant House of New York

CPEOM Center for Performance Evaluation and Outcomes Management

CPEP Comprehensive Psychiatric Emergency Program

CQC NYS Commission on Quality of Care (of the Mentally Disabled)

CR Community Residence

CSS Community Support Services (or System)

C&Y Children and Youth

DASNY Dormitory Authority of the State of New York

DCJS NYS Division of Criminal Justice Services

DDSO Developmental Disabilities Service Office

DOB NYS Division of Budget

DOH NYS Department of Health

DOL NYS Department of Labor

DPC Discharge Planning Committee

DPCA NYS Division of Probation and Correctional Alternatives

EMS Emergency Medical Service

ESDC Empire State Development Corporation

FOIL Freedom of Information Law

FTE Full Time Equivalent (staffing)

HCBS Home and Community Based Services

HCFA Health Care Financing Administration

ICM Intensive Case Manager (or Management)

ICR Individual Case Review

IOC Inspection of Care

ISP Individual Service Plan

JCAHO Joint Commission on Accreditation of Healthcare Organizations

LAN Local Area Network

LGU Local Government Unit (county government)

MAR Medication Automated Record

MedSAP Medication Self-Administration Program

MHA Mental Health Association in NYS, Inc. or **MHA** Mental Health Assoc. of Rockland County

MHARS™ ℠ Mental Health Automated Record System™ ℠

MICA Mental Illness/Chemical Abuse

NAMI National Alliance for the Mentally Ill – NYS

NASMHPD National Association of State Mental Health Program Directors

NIMH National Institute of Mental Health

NIMRS™ ℠ New Incident Management Reporting System™ ℠

NYCDOHMH NYC Dept. of Health and Mental Hygiene

NYCHHC NYC Health and Hospitals Corp.

NYSCRR New York State Codes, Rules and Regulations

NYSNA NYS Nurses Association

NYSPA NYS Psychiatric Association

OASAS NYS Office of Alcoholism and Substance Abuse Services

OCFS NYS Office of Children's and Family Services

OGS NYS Office of General Services

OHEL OHEL Children's Home and Family Services

OMH NYS Office of Mental Health

OMRDD NYS Office of Mental Retardation and Developmental Disabilities

ORYX Not an acronym, but refers to the JCAHO required performance measurement system

(P) Practitioner

PAR Prior Approval Review, or Position Analysis Report (staffing)

PC Patient Council, or Psychiatric Center, or Personal Computer

PCS Patient Characteristic Study

PEF Public Employees Federation

PMHP Prepaid Mental Health Plan

PNA Personal Needs Allowance

PSC Personal Service Coordinator

PRO Patient Resource Office

PT Primary Therapist, or Physical Therapy (or Therapist)

QI Quality Improvement

(R) Recipient

RCCA Residential Care Center for Adults

RFP Request for Proposal

RPC Residential Program Counselor

RTF Residential Treatment Facility, or Request to Fill

SAMHSA Substance Abuse and Mental Health Services Administration

SCAA Schuyler Center for Analysis and Advocacy

SCM Supportive Case Manager (or Management)

SCOC NYS Commission of Correction

SED Seriously Emotionally Disturbed

SEFA State Employees Federated Appeal

SI Special Investigator (or Investigation)

SOCR State Operated Community Residence

SPMI Seriously Persistently Mentally Ill

SPOA Single Point of Accountability

SPOE Single Point of Entry

SRO Single Room Occupancy

TEP Transitional Employment Placement (or Program)

UCR Uniform Case Record

UJC Urban Justice Center, Mental Health Project

URC Uniform Reporting Code

VESID Vocational Educational Services for Individuals with Disabilities