

# Local Planning and Priority Setting

Local mental health services planning is very challenging in the face of external pressures, scarce resources, and a changing system of care. Communities are targeting resources toward the most effective practices and care, enabling recovery and resiliency for their many residents. Together, community services boards, mental health advocacy organizations, professional mental health and other service providers, including peers, people engaged in services, family members, policy makers and planners are working to address their unique cultures and community characteristics to meet local mental health needs effectively. Robust planning processes are central to well-developed systems of care that support individuals in living, learning, working and participating fully in their communities. Such processes nurture bottom-up change and improvements in the quality of care.

The Office of Mental Health's (OMH) goal is to continue support for integrated planning across the mental health, health, developmental disabilities and substance abuse areas. Drawing upon input from New York's diverse communities, the partnerships between the State Psychiatric Centers and the localities they serve are vital to meeting the goal. Also important is OMH's participation in the Interagency Mental Hygiene Planning Committee with its partner, the Conference of Local Mental Hygiene Directors (CLMHD).

## Strengthened collaborations between adult State Psychiatric Centers and localities

In January 2009, Commissioner Hogan initiated a series of planning meetings between adult Psychiatric Centers, including forensic facilities, and the localities they serve. The meetings focused on Psychiatric Center outpatient services transformation in conjunction with local planning. Recognizing that most localities plan well for children's services, OMH challenged its adult Psychiatric Centers, in collabo-

ration with localities, to apply the same planning and systems-of-care principles to adult and forensic services.

OMH's five Field Offices continue to facilitate the process toward one that continually gives priority to community need. In conjunction with the Office of Planning, Field Office Directors assist Psychiatric Centers and localities in resource, utilization, needs, and capacity options. The process is also enhanced through the Mental Hygiene Planning Committee resources via the online County Planning System (CPS), where counties specify their annual local priorities.

During this year's annual planning cycle, counties reported voluntarily in the CPS on progress being made under the Psychiatric Center—local partnerships. Specifically, within the context of clinic restructuring, they described what outcomes had been achieved through collaboration over the last year and major goals for this coming year. About one-third of the counties responded, indicating a continuum from strong, well-established working relationships to newly established or renewed partnerships.

Examples of well-established working relationships include Chemung County, where the Elmira Psychiatric Center is well connected to the community, very active in community-based planning with the Community Services Board, and relies upon well-established mechanisms for triaging cases and working with the Elmira City School District; and Onondaga County, which enjoys an ongoing partnership with Hutchings Psychiatric Center. The County and Psychiatric Center work together on person-centered planning and other key initiatives, including the County's Clinic Access Project (described in Chapter 3).

Newly formed relationships are represented by the work under way between Rensselaer County and the Capital District Psychiatric Center to help persons who have had long inpatient stays to resettle successfully in their communities; and in Cattaraugus County, where the Psychiatric Center and County are improving discharge planning for individuals who will be transitioning out of the hospital by using targeted strategies such as improved physician-to-physician communication. Also, Monroe County and the Rochester Psychiatric Center have collaborated on a new outpatient

## Having faith: Supporting a personal journey of recovery

To be of use and to feel productive . . .

For many of us, we think of our jobs. But what if finding or keeping that job was a challenge? What if your mental health became a barrier to employment?

For Astha, a 29-year-old woman of South Asian heritage, numerous relapses and hospitalizations for debilitating anxiety disrupted many areas of her life, including completing her educational goal and finding that long hoped-for job.

Although she had completed a bachelor's degree, Astha experienced an overwhelming sense of anxiety that led to a self-imposed isolation and fear of being "labeled." It was these symptoms that brought her to the Synergy Center at Clubhouse of Suffolk in the early 2000s. She asked for help in dealing with her mental health issues and, when ready, help in finding and keeping the job she desired.

At the Synergy Center, which in May 2007 became a licensed PROS program, Astha found services grounded in the belief that meaningful employment—a salaried job or volunteer position that provides a sense of satisfaction—is often essential for personal fulfillment and good mental health. She found skilled, respectful, and passionate staff trained in evidence-based practices. She found people who desired to help her manage her symptoms and work on her own goals. Astha learned what "meaningful work" meant to her, and she recognized that her greatest strength was writing. With staff, she mapped out a plan and specific activities to help her reach her goals.

As Astha worked closely with an employment specialist, she determined that her top priorities were to earn an advanced college degree and gain full-time employment in her chosen field of education. Stigma and family cultural expectations, along with the related anxiety, were challenges that needed to be addressed. Staff worked through these challenges with her and with this support, she came to realize her own unique strengths and skills. Drawing upon them, she addressed barriers to pursuing a job and enrolled in a graduate study program with pride and confidence.

The year after she secured a position as a teacher's assistant, Astha was accepted into a graduate studies program in education. Despite ongoing feelings of anxiety, she maintained her job until she suffered a relapse and was hospitalized for a month. While she did lose her job, she did begin medication during the hospitalization that helped her manage the symptoms of anxiety. Following



her discharge, she started her graduate classes and was able to secure another teacher assistant position.

Recovery from a diagnosed mental illness is a journey, sometimes with unexpected detours, as Astha recounts: "After graduating with my master's degree, I had a relapse and had to go back to the hospital for a month. I contacted Clubhouse and began receiving services at Synergy Center again. I attended classes on yoga and meditation skills, medication management, and constructed a relapse prevention plan with my vocational rehabilitation counselor."

"We worked on my personal recovery and job search, and after about five months after my relapse, I found a full-time position as a clerk/research assistant at a local university. I worked for about a year and had another relapse. This time, I took the advice of my vocational counselor to disclose my health situation to my employer. When I felt better, I returned to the *same* workplace. . . something I didn't think was possible after disclosure. The staff at Synergy Center ensured me that my disclosure would be treated with privacy by my employer and that going back to the same workplace was not going to be a problem. Sure enough, I have been back at work for over a year."

Astha's journey reminds us that good mental health, like all areas of health, must be attended to and nurtured. Our journeys differ, but the process is one that we each define. For Astha, she now has the skills to do her job while managing her health and she is doing both well.

To learn more about the PROS program and employment support offered at Synergy Center, Clubhouse of Suffolk, contact Lisa Koop at [Lisa.Koop@clubhouseofsuffolk.org](mailto:Lisa.Koop@clubhouseofsuffolk.org) or visit the website at <http://www.clubhouseofsuffolk.org/index.cfm>.

clinic (Steve Schwarzkopf Community Mental Health Center) on the grounds of the Psychiatric Center, using the mo-

bile community-based model to meet the needs of high-need individuals.

## Sharing growth and success: The power of “having been there and done that”

By Steven Duke, LCSW-R, CPRP

In 1995, a small group of innovative and creative people seized the opportunity to obtain funding from the New York City (NYC) Department of Mental Hygiene (DOMH) to start up a peer-run agency based on the belief that individuals who have shared similar experiences can serve as role models for success while helping themselves and their peers through self-help, mutual support, peer support, education and advocacy.

The idea was welcomed and funded by DOMH and the seeds for cultivating the grassroots program of Baltic Street AEH (Advocacy, Employment, Housing) were sown. A core group of motivated, talented and dedicated peers in Brooklyn signed up to provide peers in NYC with personalized, quality services that would help them sustain themselves in their communities with dignity and self-respect. They desired a place they could be a part of, a place where helping others and giving back would become a part of their healing process. This ability to give back and see other people accomplish their dreams with support from us has always been and will always continue to be the catalyst of passion and inspiration that motivates our staff every day of their lives.

Since 1996, Baltic Street AEH has grown from a group of five peers serving 400 people a year to 100 peers serving 5,000 peers a year. Baltic Street is now one of the largest peer-run organizations in the country and boasts having 13 programs in four of the five NYC boroughs. The agency has shown remarkable success in providing advocacy, employment, housing, and wellness services based on best practice models of recovery and self-help.

Of great pride is that one of the original peers, Isaac Brown, has returned as the Chief Executive Officer, and another original peer, Janice Jones, is currently the Chief Operations Officer. Both are dedicated to assuring that the agency remains true to its original mission and values—improving the quality of life for people living with mental illness through recovery-oriented services and helping recipients obtain jobs, housing, social supports, education, vocational training, entitlements, and other life-enhancing services. All services are delivered through partnerships between clients and our staff of professional peers who can safely say that they have “been there and done that.” They help empower clients to attain their recovery goals.

The concept of peer-to-peer service delivery is the backbone of our agency. It is essential that the individual is always an equal partner involved in planning and carrying out their own goals for recovery. People are urged to “define, discover, and take credit for finding meaning and purpose in their daily lives,” while living in



Baltic Street's Issac Brown & Janice Jones

their own communities. Our services help clients improve their physical and emotional well-being, create opportunities for developing friendships and relationships, find stable and affordable living conditions and engage in productive activity through hobbies and positive work experiences, including competitive employment, and more.

By facilitating the process of recovery, we naturally decrease, and at times totally remove the stigma and alienation related to mental health labels. This process of helping people reconstruct their lives not only requires planning, but also requires action as well. Our staff is continually trained to be competent human services workers and develop partnerships based on principles of shared decision making. Through their relationships with peer service providers, many of our clients have been able to make their dreams a reality by getting step-by-step assistance to set goals and develop skills that bring their ambitions to life. Our doors are always open and our clients can remain active in our programs as long as they want to and feel it necessary to achieve and maintain their goals. All of our services are geared toward helping people balance their lives in the real world.

With confidence, we can say that we have repeatedly been able to make remarkable differences in the lives of many individuals. There are many stories of accomplishments that people never thought would be possible such as leaving a hospital, finding a home, finding a job, finding friends, increasing their financial status, improving their health, and achieving other identified goals that lead toward recovery and satisfying lives.

We are very proud of who we are and what we do. We hope that we can continue to be there to help people to improve their overall quality of life in the community by providing them with a caring support system that is available to them at all times.

To learn more about Baltic Street AEH, visit its website at <http://www.balticstreet.org/index.htm> or contact Steven Duke at [sduke@balticstreet.org](mailto:sduke@balticstreet.org)



## New county planning data resources

Based on feedback from localities, the Office of Planning formed a workgroup early this year with members of the Office of Performance Management and Evaluation and the Information Technology Office to provide online data resources for localities and Psychiatric Centers. The workgroup recently completed a series of reports, giving each locality a snapshot of key indicators to aid planning.

Called the “County Mental Health Profiles,” data on the page will be available publicly via the OMH website in October. The page offers a consolidated, high-level view or “dashboard” of key county community characteristics, mental health services, expenditures, and outcomes. It is the focal point of the 2010 Office of Planning initiative to make data more accessible to county planners, thus allowing planners to identify mental health service gaps and disparities and plan improved service delivery.

The reports provide quick, at-a-glance views of county mental health data, and offer comparative statewide statistics. They are presented in nine domains:

### Community Characteristics

This report presents key demographic and vital statistics of a county’s overall population and the population of mental health consumers. Data for the mental health population are presented by the county of the provider.

### Service Use Snapshot

This report compares counts and percentages of adult consumers and children who received public mental health emergency, inpatient, outpatient, residential and support services during the 2009 Patient Characteristics Survey week (October 26 to November 1, 2009). Data are displayed for the selected county of the provider and for New York State (NYS). Rates are based on the calculation of individuals served divided by total county population times 10,000. County population values are displayed under Community Characteristics.

### Adult Medicaid Expenditures Summary

This report displays summary information of the selected county and NYS annual Medicaid expenditures for mental health services provided to adults who were Medicaid eligible on the date of service within the 2008 Local Fiscal Year (Calendar Year 2008 for all counties except NYC; July 1, 2007-June 30, 2008 for NYC counties).

### Average Daily Inpatient Census

This is a display of average daily inpatient census for the selected county of residence as reported by licensed Article 28 (inpatient unit of general hospital), Article 31 (private psychiatric hospital) and State psychiatric facilities for adults (18 years and older). Inpatient census rates per 10,000 adults are also shown. Rates are based on the calculation of daily census divided by total adult county population times 10,000. County population values are displayed under Community Characteristics. Statewide figures are provided for comparison purposes.

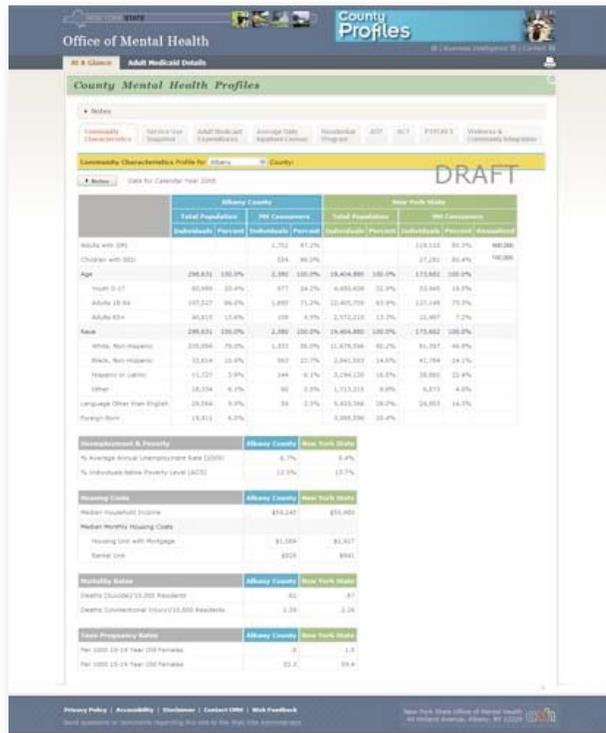
### Residential Program

The adult residential program data provide selected program benchmarks and performance measures, by county and statewide, for adult residential program types: congregate treatment, apartment treatment, congregate and apartment support, and supportive housing. Two tables show the number of county and statewide beds in each program type

and eight key performance measures from the Adult Housing data mart. Also shown are county and statewide residential bed rates, per 10,000 adult populations, for each of the program types. Bed rate calculations are based on the number of adults in the total county and state populations, using the 2008 population estimates shown in the Community Characteristics data domain.

### Assisted Outpatient Treatment

The Assisted Outpatient Treatment program was created in response to Kendra’s Law, which establishes a procedure for obtaining



court orders for certain individuals with mental illness and a history of hospitalizations or violence who participate in community-based services appropriate to their needs. This report displays selected up-to-date statistical data relative to program operation, recipient outcomes and demographic characteristics.

### **Assertive Community Treatment**

Assertive Community Treatment is an evidence-based practice model designed to provide treatment, rehabilitation and support services to individuals who are diagnosed with serious mental illness and whose needs have not been well met by more traditional mental health services. This report displays selected, up-to-date statistical data on county program operations, recipient outcomes and demographic characteristics.

### **Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)**

Initially developed for use in State psychiatric facilities, where it supported significant improvement in medication practices, PSYCKES is an award-winning portfolio of web-based tools designed to improve the quality and efficiency of psychotropic prescribing practices in NYS. Psychotropic polypharmacy is a particular concern due to potential side effects such as weight gain, diabetes, and metabolic syndrome, as well as increased risks of drug interactions. This report displays PSYCKES youth polypharmacy, adult polypharmacy, and cardiometabolic indicators for the selected county and NYS for Calendar Year 2009.

### **Wellness and Community Integration**

The 2007 and 2009 Patient Characteristics Surveys include questions on chronic medical conditions, special education services for children, parental custody of minors, living situation and employment in a community setting. This report displays measures deemed relevant to client wellness and community integration for a selected county and NYS. The site also provides competitive employment data by county of residence.

The report is organized with a tab at the top of each page representing a different section or domain of information. When a user clicks on the tab of interest, he or she will see a summary report and, in many instances, a corresponding chart to aid understanding. Most of the sections also have a “Related Reports” button that links the user to other websites containing additional information. And, next to this button is an indication of the time frame for data being displayed (e.g., Data represents Calendar Year 2008).

The original home page for this site, called “Adult Medicaid Details,” has been moved to a separate menu item, located at the top of the page. The Adult Medicaid Details report, first introduced in December 2009, contains summary information about mental health service utilization funded through Medicaid for Local Fiscal Years 2007 and 2008. Program totals are based on date of service and data are refreshed on a monthly basis. Each report summary displays counts of individuals, service units, and Medicaid expenditures by program type. The reports also include program expenditure rates service rates. Data may be displayed regionally and by the provider county within regions.

## **Integrated mental hygiene county planning**

OMH continues a strong partnership with its sister mental hygiene agencies and localities through the Mental Hygiene Planning Committee— a collaboration between CLMHD and the three mental hygiene agencies. The Mental Hygiene Planning Committee is a part of the Inter-Office Coordinating Council (IOCC), which represents OASAS, OPWDD and OMH. The role of the IOCC, among other duties, is to ensure comprehensive planning, implementation, and evaluation of State policy for the prevention, care, treatment and rehabilitation of mental illness, developmental disabilities and addictions. The Council also strives for the elimination of gaps in services to individuals with more than one disability.

An important product of the collaboration is to incorporate county priorities into planning at the State level, helping to align State priorities to those of the counties. For the purpose of analysis, OMH examined the top two mental health priorities for each county. A summary of findings follows. In addition, the Committee queried counties this year on planning related to cultural competence, clinic restructuring and Personalized Recovery-Oriented Services (PROS).

### **Mental Health Priorities**

Fifty-eight of 62 counties submitted and certified their priorities in the CPS as part of the annual planning cycle. Counties declared varying numbers of priorities, but for the purpose of this analysis, the top two for each county were examined through the lens of mental health to understand more fully general areas of emphasis across counties. The analysis included mapping of priorities by region to the strategic framework.<sup>1</sup>

### OMH and OPWDD: Building collaborative approaches to advance integrated care

Many of us are aware of the challenges that exist when two bureaucracies attempt to join forces to solve common problems. For OMH and the Office of Persons with Developmental Disabilities (OPWDD), the challenge has been to provide appropriate services for people recovering from mental illness who also have developmental disabilities.

Each agency defines who will be served and outlines specific criteria to follow in accepting individuals for services funded along these guidelines. In a bureaucracy, this approach makes perfect sense on paper. Unfortunately, however, significant numbers of people around the State could benefit from services from both organizations. Frustrating to service providers, families, bureaucrats, and others, such individuals may not meet eligibility standards set by the OPWDD, but may have IQ scores that make it difficult for them to benefit from traditional forms of cognitive therapy provided by the OMH system.

Since the late 1970s, these persons have been labeled the “multi-disabled” or “dually diagnosed,” terms that reflect the time when the NYS Department of Mental Hygiene was in operation and mental health and developmental disabilities were in the same agency (along with substance abuse and alcoholism services). Not surprising, when the Department split, people served did not divide clearly by agency jurisdiction. Although memoranda of understanding were written to guide the provision of primary care, the two agencies have struggled to find ways to serve these individuals.

Some persons end up in local hospital emergency rooms or hospital inpatient units until suitable placements can be made.

In 2007, an important event occurred when the People First listening forums brought together Commissioners from OMH, OPWDD, Office of Alcohol and Substance Abuse Services (OASAS) and the Department of Health to listen to stakeholders describe challenges in trying to obtain services from the various systems. Agency leaders heard the message: Find a better way. The listening forums, then, set the stage for OMH and OPWDD to think about people as people with needs rather than as people as “disabilities.”

As a result, the OMH Field Offices and OPWDD Developmental Disabilities Service Organizations (DDSO) developed teams to identify and solve problems for people whose needs crossed the two systems. OMH Psychiatric Centers and Developmental Centers also encouraged collaborative projects. Relationships in some areas grew out of solving problems for people, one at a time. A statewide training initiative, “Navigating the Two Systems,” was developed to facilitate staff understanding and shared problem solving between the two systems. While Medicaid and financing rules have proven to be difficult to bend, several new, cost-effective strategies have resulted in people receiving improved access to care.

Here is how one community has created a pocket of innovation. The Capital District Psychiatric Center (CDPC) Director Lewis

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The analysis takes into account the 116 top two priorities that counties indicated were of chief concern for the delivery of mental health services and supports. The majority of the priorities relate solely to mental health (56.9%); the others are shared with one of the other two mental hygiene areas or among all three. Mental health/developmental disabilities priorities account for 17.2%. The percentage of priorities is split equally between the mental health/substance abuse and

all three areas, each with 12.9%. While the distribution reflects much attention to priorities that relate to mental health services alone, it also points to a continuing emphasis within mental health to cross-systems, comprehensive, integrated person-centered services and supports necessary for individual and family health and well-being.

#### Mental Health Focus of Top-Two County Priorities by OMH Regions

Region	MH	MH/DD	MH/SA	MH/DD/SA	YET TO RESPOND	Total
Central	20	7	4	7	2	40
Hudson River	17	6	5	2	2	32
Long Island	2	1	0	1	0	4
New York City	10	0	0	0	0	10
Western	17	6	6	5	4	38
<b>Total</b>	<b>66</b>	<b>20</b>	<b>15</b>	<b>15</b>	<b>8</b>	<b>124</b>

Campbell and recently retired Capital District DDSO Director David Slingerlands put their heads together to find solutions. Community services and program operations staff from the two agencies meet bi-monthly. Once they identify people who are ready for discharge from CDPC, but who would be better served in the OPWDD system, staff members work closely to blend resources and bring about appropriate placement. Since 2008, 10 persons discharged from CDPC are now living in community settings operated by OPWDD and another seven are close to placement. These are persons who had lived or have been living at CDPC for up to 20 years.

From Mr. Slingerland's perspective, what makes the collaboration work is trust. CDPC promised it would support persons after discharge and it is doing this, for instance, by providing on-site community staff support, temporary financing for day programming, and return to the hospital if needed. From Mr. Campbell's perspective, whatever helps people to make positive change and transition is well worth the investment of resources. Some examples of cross-systems program initiatives that have developed out of this fruitful partnership include:

- ◆ **Family Care Discharge Project:** First in the State to do so, CDPC and the DDSO arranged to have a long-term resident of CDPC eligible for OPWDD services to be placed in an OPWDD licensed family care home. Before placement, the CDPC resident visited with the family care provider, enjoyed weekend passes to the home, and completed a week-long pass. CDPC covered the cost of visits to the family care provider, the resident attended an OPWDD dayhab program, and CDPC supported her on-site transition to the day program. While staff was confident of successful placement, the resident was

placed on convalescent care status for one month prior to discharge as a good faith effort to facilitate her return to the hospital if the placement did not work out.

- ◆ **Child and Adolescent Mobile Crisis Team (CAMT):** In 2007, CDPC entered into a partnership with Parsons Child and Family Center, Rensselaer County, Albany County, Schenectady County and the OPWDD to fund a mobile crisis team that would serve children and families in crisis throughout the three counties. While CDPC contributes four staff, OPWDD and the counties contribute funds. As noted in Chapter 4, since its inception, the team has made a significant difference to the communities it serves.
- ◆ **Shared Respite Resources:** The DDSO has agreed to make available to CAMT its Respite House for 24–48 hour respite for children and youth in crisis and in need of safety/crisis stabilization. This much-needed community service should result in reduced hospitalization, while providing safe crisis care.
- ◆ **Shared Program Space:** The DDSO and CDPC have agreed that CDPC satellite clinic staff will share space at the DDSO within the Glens Falls Medicaid Service Coordinator offices. Shared space will allow staff from both agencies to exchange information, provide consultations for adults and children, and increase understanding of agency eligibility requirements and services. CDPC clinic staff includes psychiatrists, psychologists and social workers who will be available for interagency trainings and consults.

In an era of declining resources, ingenuity is the star that guides.

## Priorities in Relation to Strategic Framework

The strategic framework brings structure to the values and principles guiding recovery-oriented, person-centered, family-driven and youth-guided services and supports. They include:

### 1. People First

Respect individuality by demonstrating hope and positive expectations, a belief in recovery, and regard for diversity.

### 2. Person-Centered Decision Making

Provide supports and treatment based on self-defined needs, while enhancing personal strengths.

### 3. Basic Needs Are Met

Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.

### 4. Relationships

Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.

### 5. Living a Healthy Life

Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.

### 6. Mental Health Treatment and Supports

Foster access to treatment and supports that enable people to lead satisfying lives in their communities.

### 7. Self-Help, Peer Support, Empowerment

Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.

### 8. Mental Health System of Care, Workforce and Accountability

Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.

Across the State, priorities fall largely into Domain 6, with 50 of the top 116 top two priorities relating to Mental Health Treatment and Supports (43.1%). Domains 5 and 8 are the

### Regional Priorities by Framework Domain

Region	1 People First	2 Person-Centered Decision Making	3 Basic Needs are Met	4 Relation- ships	5 Living a Healthy Life	6 MH Treat- ment & Supports	7 Self-Help, Peer Sup- port, Em- powerment	8 MH System of Care, Workforce & Accounta- bility	9 Other	Yet to Respond	Total
Central	0	1	5	0	5	18	0	8	1	2	40
Hudson River	1	0	8	1	3	9	3	4	1	2	32
Long Island	0	0	2	0	0	1	0	1	0	0	4
New York City	0	0	0	0	0	10	0	0	0	0	10
Western	1	1	8	1	3	12	1	7	0	4	38
<b>Total</b>	<b>2</b>	<b>2</b>	<b>23</b>	<b>2</b>	<b>11</b>	<b>50</b>	<b>4</b>	<b>20</b>	<b>2</b>	<b>8</b>	<b>124</b>

next two areas of chief concern among counties, with 23 (19.8%) relating to Basic Needs and 20 (17.2%) to the System of Care, Workforce and Accountability issues.

Overall, the data appear to indicate an ongoing commitment to ensure quality mental health treatment and supports, help people meet basic needs that promote productive community living, and make sure the workforce and system of care bolster quality, integrated care. They also point to efforts under way across the State and localities to prepare for ambulatory and clinic restructuring; to continue strengthening the quality of care through standards of care, evidence-based practices, and a commitment to the principles of recovery and resiliency; and to examine effective and efficient ways to help people improve the quality of their lives in stressed fiscal times.

### Regional Priorities

#### Central New York Region

Among the priorities under Domain 6, most focus on improving access to an array of integrated services that meet the needs of persons with co-occurring and dual disorders and those at risk for hospitalization or contact with the criminal justice system. Counties often call for better collaboration, recognizing the importance of integrated care across the systems of care.

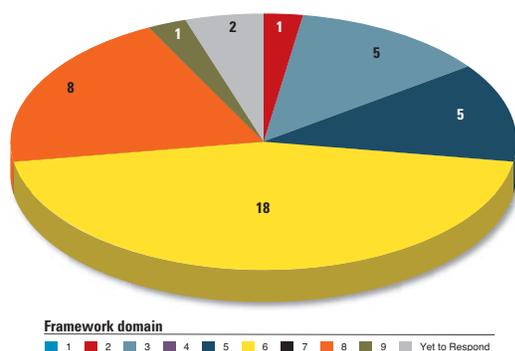
With respect to improving workforce and accountability, counties indicate a number of strategies to strengthen their systems of care to meet the needs of elderly adults, particularly those with co-occurring disorders, better educate parents and professional staff about dual mental health and developmental disability disorders, promote the value of the recovery orientation to care, and enhance care for children and youth.

Of interest is that counties show nearly equal interest between Domain 5, where safe, affordable housing is most often cited as a priority, and Domain 3, where living a healthy life is highly valued. For the latter priorities, counties point to the need for accessible community respite, peer respite and crisis services not only for promoting good health, but also for providing a continuum of services that allows people to maintain health and well-being in their communities.

#### Hudson River Region

In the Hudson River Region, counties identified priorities mainly in Domains 3 and 6. Under Basic Needs, the eight priorities all dealt with safe, affordable housing. A number of

Central Region priorities by framework domain (n=40)



## STEL leading the way and filling the housing gap—innovatively

Responding to the lack of suitable housing stock and limited funding from OMH, the Southern Tier Environments for Living (STEL) has worked tirelessly since the mid-2000s to develop and put in place alternate funding techniques to accomplish an important goal: safe and affordable housing for persons with mental health conditions.

STEL looked to the U.S. Department of Housing and Urban Development, NYS Office for Temporary and Disability Assistance, NYS Division of Housing and Community Renewal, Low Income Tax Credits and private banks to fund a 16-apartment unit in Olean. Out of its efforts came a huge success. STEL developed an integrated apartment facility, with one-half certified treatment apartments and one-half generic affordable housing. STEL also shared with OMH its financing technique, which leveraged dollars and saved on the State's capital investment.

A major additional benefit turned out to be the socialization experience that evolved naturally for residents of the treatment apartments who interacted daily with occupants from the affordable housing apartments.

The experience in Olean led STEL to utilize this funding technique and apartment distribution system in future developments. It proved so successful that OMH asked STEL to partner with other State mental health agencies and to “show them the way.” STEL has also developed a second important function in the mental health field. It has gathered together a Housing Development Consulting Services team, which uses its unique knowledge and expertise to work with other agencies in planning, financing and constructing special needs housing.

Following the Olean financial formula, work was completed on a mixed-use 37-unit apartment project in Dunkirk in 2006. Typically, there is a 50-family waiting list. It took less than two weeks to achieve qualified full occupancy. Also that year STEL took over the operation of an 18-unit apartment building in South Dayton and re-structured it into 21 mixed-use apartments in the next year.

In 2007 two projects were developed using similar cooperative planning, financing and oversight formulas. A 25-unit single-room occupancy project was built in Buffalo and a 24-unit adult home project was completed in Chautauqua County. Both used tax credits as a major source of funding. In 2008 the STEL Housing Development Team collaborated in helping construct the Ridgeview Special Needs Apartments in Rochester; it contains 64 studio apartments for persons with mental illness and is the first-ever project to utilize tax-ex-



empt bonds to finance OMH housing. Also that year STEL participated in the Ithaca Special Needs Apartments project of 38 single-room occupancy units funded by Low Income Housing Tax Credits and a market rate loan from Community Preservation Corporation.

Established in 1980 in Dunkirk, STEL is a nonprofit corporation that operates using the Psychiatric Rehabilitation Model adopted from Boston University. STEL enables people with psychiatric disabilities to obtain the skills necessary to live, learn and work in environments of their choice. In addition to addressing housing needs, STEL provides its own support services, partners with area treatment agencies, and fosters the abilities of residents to transition to various levels of independence.

STEL is the primary provider of a broad spectrum of residential options in a four-county area that includes all of Allegany, Cattaraugus, and Chautauqua counties and parts of Erie County. Because of the rural nature of this service area, housing stock to match various stages of recovery is often not available. And, as noted, STEL has risen to the challenge by taking on the role of conversion and construction of various levels of appropriate housing.

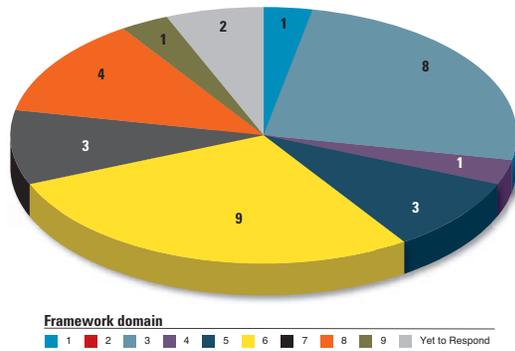
This rural character of STEL's service area has also encouraged the agency to take the lead in establishing services once not available to their clients. It has, for example, established the only area diversion program serving as support for young people with mental health problems who have been incarcerated. It also has played a leading role in helping to establish a Mental Health Court and later a Drug Court and has followed this up with full participation in these functions.

Currently, the agency manages seven larger congregate facilities, single-room occupancy units, supported housing, a treatment apartment program and affordable housing units. Together it has 360 units of housing, many newly designed and constructed specifically for their purpose. Present capacity serves 154 persons with psychiatric disabilities in housing licensed by OMH and 207 individuals through non-licensed housing. With an occupancy rate averaging 95%, STEL's annual budget for residential services is approximately \$7 million, 93% of which goes to direct client care.

Apart from its strong housing program, STEL also offers services through Workforce, a supported employment program; Compeer Chautauqua, a friendship/mentoring program; and the Cattaraugus Case Management program.

To learn more about housing programs or other services offered by STEL, contact Tom Whitney at [whitneyt@stel.org](mailto:whitneyt@stel.org) or visit the STEL website at <http://www.stel.org/>.

Hudson River Region priorities by framework domain (n=32)



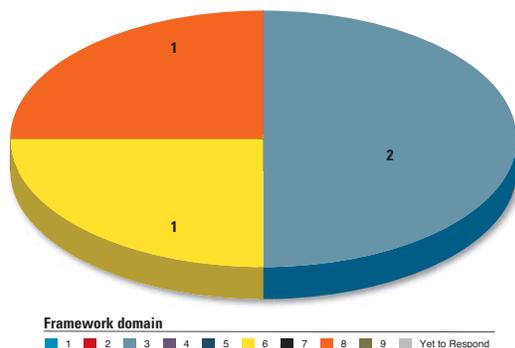
counties cite the importance of providing safe, affordable housing opportunities, particularly for people with special needs (e.g., dual diagnosis, youth in transition, sober housing).

Counties affirm the priority of integrated, coordinated, and collaborative treatment and supports that are responsive to the complex needs of individuals with mental hygiene and other disabilities. The nine priorities under Domain 6 focus on older adults, people with co-occurring substance abuse and mental illness, children and families, and persons with serious mental illness and criminal justice contact. Priorities also address the need for healthy living, self-help and peer support services, and work toward stronger local systems of care as the transition to clinic restructuring occurs.

### Long Island Region

On Long Island, two priorities deal with Domain 3, one with Domain 6, and one with Domain 8. Each county endeavors to address housing shortages for individuals and families having mental illness, developmental disabilities and substance abuse. They note the particularly challenging circumstances they encounter in trying to address critical basic needs (e.g., very high housing and living costs, matching available housing to specific needs, finding housing for people who traditionally are difficult to place).

Long Island Region priorities by framework domain (n=4)



### Local solutions and innovation: Watching out for our veterans and their families

*By John Javis, Director of Special Projects, Mental Health Association of Nassau County*

You might be surprised to know that among the approximate 1,000,000 veterans in NYS nearly 20% (174,000) live on Long Island. In fact, Long Island is second only to San Diego in the percentage of veterans among its citizens. Even though Long Island is not home to a major military installation, it has provided heavy representation in the armed services, especially after 9/11.

In 2007, the Veterans Health Alliance of Long Island, a project of the Mental Health Association of Nassau County, formed with the help of a passionate group of individuals who were military veterans or family members of veterans with post-traumatic stress disorder (PTSD), or who knew a veteran who completed suicide. One of the benefits of the Alliance has been its encouragement of longtime leaders of Long Island's mental health community to talk openly about veterans' experiences. Today, the Alliance comprises representatives from state and county government, the Veterans Administration, veterans' organizations, mental health and substance abuse providers, universities, businesses and individual veterans. Its mission is to promote the health and well-being of Long Island veterans and their families through advocacy and a broad array of services.

The Alliance's reach and strength in supporting veterans is evident by "Luis's" experience. After joining the Marines following the 9/11 World Trade Center attacks, Luis was seriously injured during the "Battle of Fallujah," when the vehicle in which he was riding was hit by a suicide car bomber. Luis suffered a wound that earned him a Purple Heart, and he also sustained a traumatic brain injury from the blast. After a brief transition period, he was discharged home to Long Island. He was not educated, however, about the signs and symptoms of PTSD, or about the availability of veterans' benefits and services.

Once home, his family and friends noticed that he was different. He seemed distant and angry. When he drove his car he sometimes envisioned that the car behind him contained an explosive device. Realizing that he was having difficulties, Luis reached out to the student counseling center where he was taking college courses. Center staff educated him about PTSD, let him know about a non-profit agency on Long Island that specialized in the care of returning veterans, and linked him to free counseling services with the agency.

*Continues on next page*

Luis's journey brought him to the Veterans Health Alliance of Long Island, where he met a number of Vietnam veterans who shared with him their stories of transition decades earlier. Luis then began to work as a peer veteran outreach worker for the Mental Health Association of Nassau County. In that role he helped enhance social services provider training sessions by sharing the story of his experience with PTSD and recovery. He also courageously went on local television and disclosed the story of his recovery. He attended Veteran Stand Down



events and encouraged his fellow veterans to seek services. (The Stand Down concept took hold during the Vietnam War to provide a safe retreat for units returning from combat operations. Today, Stand Down events provide an array of services, from food and shelter to access to numerous medical, legal, employment, benefits and social services.) Luis recently completed his education, is in a fulfilling relationship, and is now embarking upon a successful civilian career.

If you have read the recent Rand Corporation Study, *The Invisible Wounds of War*, you would be inclined to think that the odds have been in Luis's favor. The study estimates that 31% of service members returning from Iraq and Afghanistan have either PTSD or traumatic brain injury. Only about 50% of those service members have sought help for their conditions, and, of those seeking help, about one-half receive "minimally adequate care." The Veterans Health Alliance is helping to make a difference. It does this daily by reaching out to veterans in need; participating actively in Veteran Stand Down Events and National Guard Yellow Ribbon Events (which provide information, services, referrals and proactive outreach programs to Service members of the National Guard and Reserves and their families through all phases of the deployment cycle); and helping to engage with veterans who are homeless.

Good training is crucial to the Alliance's success. Training efforts are spearheaded by the OMH Long Island Field Office and focus

on improving providers' understanding of the military culture and how to treat combat-related PTSD. It also helps members of the public and others not involved in clinical care to recognize the early signs of emotional distress and equip them with information and resources they can offer the veteran. To date, the training, which is a partnership between clinical experts and combat veterans, has been provided to more than 2000 mental health and substance abuse clinicians, other social service providers, members of law enforcement, veterans and family

members. They have received education on PTSD, substance abuse, suicide prevention, and traumatic brain injury. The training is often done as a partnership between clinical experts and combat veterans.

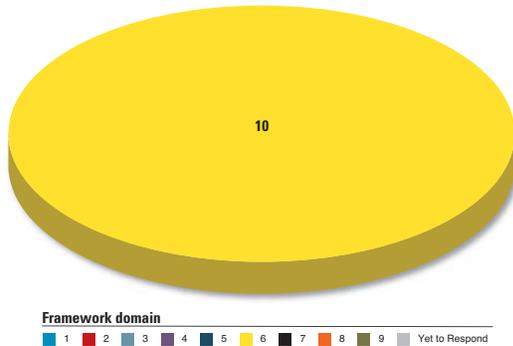
The principles and values underlying the Alliance's work are taking root in other communities. Recently, in collaboration with the NYS Health Foundation and Mental Health Association of NYC, the Alliance helped to found a sister organization, the Veterans Mental Health Coalition of New York City. Plans are also under way to reach out around the State and encourage development of similar alliances.

The key to the Veterans Health Alliance is that it is truly a collaborative effort among so many individuals and groups. In fact, supporters of the Alliance are so passionate that every summer a group of them parachutes out of "perfectly good airplanes" as a fundraising event! Now, that's ardent support, wouldn't you say?

To learn more about the Veterans Health Alliance of Long Island, go to its website at <http://www.mhanc.org/?PageID=789> or contact John Javis at [jjavis@mhanc.org](mailto:jjavis@mhanc.org). You may also learn about the Veterans Health Coalition of New York City by going to <http://www.mhaofnyc.org/advocacy/veterans-mental-health-coalition.aspx>

Suffolk County is also giving priority to developing PROS so that they become a wide-scale method of treatment and recovery while increasing the county’s capacity for clinic treatment services. In Nassau County, much attention focuses on integrating the substance abuse, mental health and developmental departments into one. The merger presents opportunities to facilitate cross training, develop leadership that fosters the integration of treatment philosophies, proto-

**New York City Region priorities by framework domain (n=10)**



cols, regulations and barriers to treatment, and comprehensive service provisions to those with multiple disabilities.

**New York City Region**

New York City has declared two priorities that fall into Domain 6, covering each of the City’s five counties. (The priorities were given the weight of two for each county, totaling to 10.)

The first priority deals with facilitating access to the services and supports that will enable people to reach their full potential and lead personally meaningful lives through housing, employment, and educational opportunities.

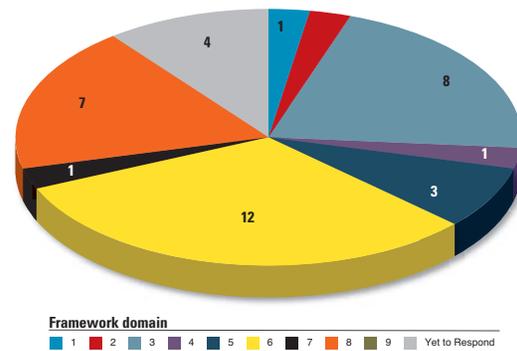
The second priority includes striving to have children from birth to five years of age reach their optimum developmental potential through assessment and early mental health intervention, when indicated. The priority aligns with the goals of The Children’s Plan to promote the social and emotional growth and development of New York’s children.

**Western New York Region**

Priorities for Western New York cluster mainly around Domains 3, 6 and 8, and focus on Basic Needs, Treatment and Supports, and the System of Care, Workforce and Accountability.

Priorities addressing basic needs include residential housing for children as well as housing for persons with co-occurring mental health/developmental disabilities and substance abuse/mental health disorders. Provision of sup-

**Western Region priorities by framework domain (n=38)**



ported employment is crucial for one county, while another is centering its attention on helping transition-age youth meet basic needs for housing, education, employment and community living. Others are addressing issues unique to rural counties such as transportation to health appointments, classes, work and recreation.

Mental health treatment priorities tend to concentrate on the specific needs of populations served by mental health and other providers. The priorities call for strengths-based, person-centered care coordination and integrated services across systems of care for high-need, high-risk populations (e.g., dual disorders, multiple disabilities, criminal justice contact) and for strengthened System of Care efforts on behalf of children with serious emotional and behavioral challenges and their families.

System, Workforce and Accountability priorities vary, with three counties noting the need to expand psychiatry services through recruitment of child psychiatrists and/or use of tele-psychiatry. Another county indicates that it will be assessing the level of services needed for children and families, while another will be examining how it can increase access to children’s services. Staff development is another theme to emerge, with one county focusing on use of screening tools to improve care across disability areas and another looking at how it can improve provider education for providers serving people with co-occurring mental health and substance abuse disorders.

**Surveys of Cultural Competence, Clinic Restructuring, and PROS**

As noted in Chapter 2, a report of findings from the cultural competence survey is presented in Appendix I. While the data from the clinic restructuring and PROS surveys are still being analyzed, preliminary data from the clinic restructuring survey were shared with the Division of Adult Services to be used for training and education sessions prior to the implementation of restructuring on October 1. Once the data analysis has been completed, the findings will be

presented to local planners and agency staff and made available in the CPS.

### Chapter 5 endnote

- 1 Regions as defined by OMH: *Hudson River*: Albany, Columbia, Dutchess, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, Westchester. *Western*: Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates. *Central*: Broome, Cayuga, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, St. Lawrence. *Long Island*: Nassau, Suffolk. *NYC*: Bronx, Kings, New York, Queens, Richmond.

