Transformation Plan
2016-2017
End of Year Report
February 1, 2017
Table of Contents

I. Overview ................................................................................................................................... 1
II. Background ............................................................................................................................. 2
III. Reinvestment and Regional Planning Progress ................................................................. 3
    Western New York Reinvestment and Planning Progress ...................................................... 6
    Rochester Area Reinvestment and Planning Progress .......................................................... 7
    Finger Lakes and Southern Tier Reinvestment and Planning Progress .................................. 8
    Central New York Reinvestment and Planning Progress ....................................................... 9
    North Country Reinvestment and Planning Progress ........................................................... 9
    Hudson River Region Reinvestment and Planning Progress ............................................... 10
    New York City Reinvestment and Planning Progress ............................................................. 11
    Long Island Reinvestment and Planning Progress ................................................................. 13
    Statewide Initiatives: Forensics, Suicide Prevention, Skilled Nursing Facility Transitions, and Risk Monitoring .......................................................................................................................... 15
IV. Inpatient Utilization & Community Integration ............................................................... 17
    1) State PC inpatient census, utilization rates and average length of stay .......................... 17
    2) Acute psychiatric settings inpatient capacity and utilization rates ............................... 19
    3) Post-discharge follow-up emergency room and readmission rates ............................ 20
    4) Post-discharge engagement for individuals discharged from State PC inpatient settings 24
    5) State-operated psychiatric inpatient persons aging into long stay trends ................... 26
    6) Transition of State PC and acute psychiatric inpatient discharges to community-based settings: Supported Housing ................................................................. 27
    7) Utilization of community based supports: competitive employment and HCBS Waiver ... 28
    8) Impact measures related to homelessness ...................................................................... 31
    9) Criminal justice involvement of the NYS mental health population ............................. 33
V. The Transformation Plan Services Consumer Satisfaction Survey .................................. 35
APPENDIX A: Database/Terms Glossary ............................................................................. 38
APPENDIX B: Consumer Satisfaction Surveys .................................................................... 40
I. Overview

The New York State Office of Mental Health (OMH) has prepared this annual report to provide timely information on the progress of the agency’s Transformation Plan investments in community mental health services. This report describes the progress and effectiveness of investments in community mental health services in reducing the need for inpatient services and hospital lengths of stay, and the improvement of service effectiveness for children, adolescents and adults.

Under the leadership of Commissioner Ann Marie T. Sullivan, the agency has enhanced its efforts to provide improved community services to help children and adults recover from mental illness with their families, friends and loved ones in the communities where they live, rather than being separated from them in a State Psychiatric Center (PC).

As described in detail later in this report, OMH has made significant investments in every region of the State during the past two fiscal years to enhance community mental health services that are designed to reduce the need for unnecessary inpatient hospitalizations at State PCs. The investments were made with input from a broad set of community stakeholders and advisory bodies in every region of the State.

Since April 2014 OMH has committed approximately $100 million in new annualized investments to support the following services in all areas of the State, including:

- 1,105 additional supported apartments with appropriate wrap-around services to ensure individuals can be served safely in the community, and avoid potential future homelessness.
- 246 additional Home and Community Based Services Waiver slots which provide children and their families with respite services, skill building, crisis response, family support, intensive home support, and care coordination.
- Twelve State-operated Mobile Integration Teams (MIT) which provide an array of mobile services and supports for youth and adults, including on-site crisis assessment, skill building, family support, and respite. Five other existing State-operated community support services have also been converted to the MIT model. MITs serve hundreds of individuals each month, and are scaled and located to community need. To date, all MITs are operational and have provided critical supports to over 4,500 new individuals statewide.
- Four State-operated, child and adolescent crisis/respite houses.
- Expansion of State and voluntary-operated clinic programs, State-operated school-based clinic satellites, and extended clinic hours to provide services when they would be otherwise unavailable or inaccessible.
- Staffing support for three of the First Episode Psychosis programs being implemented statewide under the nationally recognized OnTrackNY initiative.
- Sixteen new and expanded crisis intervention programs, many with extended hour coverage, mobile capacity, and peer-support components in order to best meet the needs of individuals in times of crisis.
• Over a dozen new advocacy, outreach and bridger programs, to guide individuals through transitions from inpatient settings into integrated, clinically-supported community living, and link them to various community based supports.
• Ten new or expanded Assertive Community Treatment (ACT) teams, accounting for a capacity expansion of 572 slots.
• Forensic programs for both adult and juvenile offenders, developed to link individuals with mental health services, provide specialized assessments for probation and courts, and reduce future recidivism and hospitalization.
• Fourteen long stay teams to assist with the transition individuals with State PC or residential lengths of stay exceeding one year, into structured community settings. OMH has also developed more resources out of the State PCs to aid in the transition of PC long-stay inpatients requiring skilled nursing facility or managed long term care services in the community.

These community investments have continued to yield positive results. The average daily census in OMH civil PCs declined by 3.5 percent during calendar year 2016, while the respective State-operated community service expansion increased the number of people served by 94 percent when compared to the previous calendar year. These community investments are directly associated with and funded through reduced costs associated with lower inpatient census, and from individuals who no longer need to be placed in a hospital- allowing for the reduction of over 500 vacant inpatient beds across the system since 2014. Most importantly, hundreds of children and adults are now receiving quality and effective care in the community, and no longer have to be separated from their families and support networks by an inpatient stay.

II. Background

New York exceeds both the national average inpatient utilization rate at state-operated Psychiatric Centers, and per capita inpatient census levels at state-operated PCs in other urban states and all Mid-Atlantic States. New York’s extensive State PC inpatient capacity includes 24 facilities with nearly 3,500 budgeted beds. This situation has led to unreasonably high State-operated inpatient per capita costs, as more individuals with mental illness are supported successfully in the community, and the inpatient footprint has remained disproportionately large. For example, nearly half of OMH civil hospitals operate fewer than 100 beds, with an average budgeted capacity of only 55 beds.

The evidence of this imbalance is clear: while New York’s State-operated inpatient facilities serve approximately one percent of the total number of people accessing the public mental health system, they account for 20 percent of gross annual system expenditures. With the inclusion of other acute inpatient facilities (Article 28 or 31 psychiatric hospitals), inpatient psychiatric costs amount to approximately half of the total spending on public mental health services.

The OMH Transformation Plan aims to rebalance the agency’s institutional resources by further developing and enhancing community-based mental health services throughout New York State. By doing so the Plan will strengthen and broaden the public mental health system to enhance the
community safety net; allowing more individuals with mental illness to be supported with high quality, cost-effective services within home and community-based settings and avoid costly inpatient psychiatric stays. Beginning with the State Fiscal Year (SFY) 2014-15 State Budget and continuing through SFY 2016-17, the OMH Transformation Plan has “pre-invested” $81 million annualized into priority community services and supports, with the goals of reducing State and community-operated facilities’ inpatient psychiatric admissions and lengths of stay. An additional $19 million has been reinvested from Article 28 and 31 inpatient facilities to further support the OMH Transformation Plan.

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

The OMH Transformation Plan is consistent with these ongoing reforms in health care policy and financing. As the market for health care services becomes more consumer-directed, integrated and community-oriented, OMH must advance in step with the people we serve in order to be relevant and sustainable in the future. The OMH Transformation Plan will create the mental health system that New York needs in the 21st Century—a system focused on prevention, early identification and intervention, and evidence-based clinical services and recovery supports. Finally, the Plan’s rebalancing of the agency’s institutional resources to further develop and enhance community-based mental health services is also consistent with the Americans with Disabilities Act (ADA). The US Supreme Court’s 1999 Olmstead decision held that the ADA mandates that the State’s services, programs, and activities for people with disabilities must be administered in the most integrated setting appropriate to a person’s needs.

Section III of this report describes progress made in developing community based mental health services across New York State through regional planning and consultation among OMH field offices, facilities, and community stakeholders. Section IV presents OMH’s evaluation of the overall impact of such community services on the following domains: recipient outcome measures, quality of treatment, access to care, functioning level, and social outcomes. Finally, section V provides information on the experiences of individuals engaged in new community services, including satisfaction with these services and overall quality of life.

III. Reinvestment and Regional Planning Progress

With the passage of the SFY 2014-15 budget, planning for pre-investment funding began in all areas of the State: Western New York, the Rochester area, the Southern Tier/Finger Lakes region, the North Country, Central New York, the Hudson River region, New York City, and Long Island. Local government units, OMH Field Offices, and State PC directors have continued
working collaboratively to operationalize the goals of a broad set of community stakeholders who participated in regional advisory bodies initiated in the fall of 2013. The goals of the regional advisory bodies focused on the following resources: Supported Housing, Medicaid Home and Community Based Services (HCBS) Waiver, State-operated community enhancements, and Aid to Localities funding—in addition to overall systemic reforms required to most effectively use these resources. The three-year aggregate of annualized investments by State-operated facility service area are presented in Table 1.

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

Table 1 exhibits approximately $81 million in annualized Transformation Plan pre-investment funds that have been allocated to expanded local and State-operated community services. Services are operational in all areas of the State, with additional programs continuing to develop and phase into implementation throughout 2016 and 2017. When including additional Article 28 hospital reinvestment (also outlined in this report) the total allocation amounts to nearly $100 million annualized. OMH is committed to continuing its work with stakeholders to further develop community services intended to reduce inpatient hospitalizations and lengths of stay, and optimize community living for the adults, children, and families residing throughout New York State. The ensuing section outlines the progress of regional plans to date, including the services already funded and implemented across many areas of the State.
## Table 1. Transformation and Article 28/31 Reinvestment Summary - By Facility

<table>
<thead>
<tr>
<th>OMH Facility</th>
<th>Target Population</th>
<th>Prior Capacity</th>
<th>Expansion</th>
<th>Annualized Reinvestment</th>
<th>New Individuals Served</th>
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<td>12</td>
<td>$315,516</td>
<td>12</td>
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<tr>
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<td>90</td>
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<tr>
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<tr>
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<td>Children</td>
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<tr>
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<tr>
<td>Hutchings</td>
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<tr>
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<td></td>
<td>1,479</td>
<td>246</td>
<td>$5,611,652</td>
<td>230</td>
</tr>
</tbody>
</table>

| Greater Binghamton | Adults | 289   | 84    | $656,607 | 90 |
| Elmira            | Adults | 517   | 70    | $591,188 | 66 |
| St. Lawrence      | Adults | 306   | 53    | $407,543 | 63 |
| Sagamore          | Adults | 2,245 | 175   | $2,761,972| 124|
| Pilgrim           | Adults | 1,196 | 108   | $913,314 | 108|
| Western NY        | Adults | 552   | 113   | $592,309 | 136|
| Buffalo           | Adults | 8,776 | 234   | $4,551,482| 185|
| Rochester         | Adults | 1,841 | 134   | $1,734,717| 108|
| New York City     | Adults | 859   | 43    | $152,480 | 24 |
| Hutchings         | Adults | 837   | 28    | $216,468 | 15 |
| Subtotal          |        | 17,221| 1,105 | $12,938,080| 919|

| Greater Binghamton | Adults | $5,740,000 | 2,610 |
| Elmira             | Adults | $2,806,160 | 1,373 |
| St. Lawrence       | Adults | $4,480,000 | 884 |
| Sagamore           | Adults | $1,050,000 | 590 |
| Pilgrim            | Adults | $4,900,000 | 129 |
| Western NY         | Adults | $2,145,440 | 459 |
| Buffalo            | Adults | $2,240,000 | 57 |
| Rochester          | Adults | $1,090,000 | 14 |
| New York City      | Adults | $1,090,000 | 14 |
| Hutchings          | Adults | $21,070,000| 6,901|
| Subtotal           |        | $27,662,000| 12,805|

| Greater Binghamton | Adults | $1,815,000 | 1000 |
| Elmira             | Adults | $681,000   | 1429 |
| St. Lawrence       | Adults | $5,376,000 | 71 |
| Sagamore           | Adults | $2,555,000 | 2,555|
| Pilgrim            | Adults | $3,173,000 | 1036|
| Western NY         | Adults | $7,432,000 | 595 |
| Buffalo            | Adults | $5,460,000 | 3,723|
| Rochester          | Adults | $1,077,000 | 561 |
| New York City      | Adults | $27,562,000| 12,805|
| Capital District PC| Adults | $13,725,636| 20,859|
| Hutchings          | Adults | $2,500,000 | N/A |
| Subtotal           |        | $5,500,000 | N/A |
| Statewide          |        | $13,725,636| 20,859|

| Suicide Prevention, Forensics and Risk Monitoring | $2,500,000 | 1,634 |
| Residential Stipend Adjustment                    | $5,725,636 |
| SNF Transition Supports                           | $5,500,000 |
| Subtotal                                          | $18,892,411| 7,587|

| GRAND TOTAL                                       | $99,799,779| 28,446|

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1. Prior capacity refers to the program capacity at the end of State fiscal year 2013-14; before Transformation investments began.
Western New York Reinvestment and Planning Progress

OMH has made funding available for the counties served by Western New York Children's Psychiatric Center and the Buffalo Psychiatric Center in an annualized amount of $5.6 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS Waiver, State-operated community service expansion, and Aid to Localities. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through on-going consultation with community stakeholders, including the local governmental units (LGUs).

- 108 Supported Housing units.
- 24 Home and Community-based Services Waiver slots.
- A State-operated MIT for children and youth.
- A State-operated MIT for adults.
- State-operated children’s outpatient clinic expansion.
- An expanded State-operated Mobile Mental Health-Juvenile Justice Team
- Peer Respite Center Hospital Diversion Program. These peer-run respite centers provide recovery-based alternatives for adult consumers. The centers' services are designed to enhance engagement in community service supports, help maximize community tenure and avoid inpatient hospitalizations.
- Mobile Transitional Supports provide mobile clinical intervention and support with follow-up during the time when discharged individuals are transitioning to engagement in the community-based services and supports identified on their discharge plan. This program will provide mobile interventions during hours when community-based clinical services are largely unavailable, care management may not be immediately available, and crisis outreach is not appropriate.
- Crisis Intervention Team. This team provides clinical intervention and supports to successfully maintain each person in his/her home or community by providing the level of clinical care, community-based supports and supervision that are needed to maintain community tenure.
- Long Stay Team. This community integration team operated out of Erie County will help transition long stay individuals from Buffalo PC into community settings through collaborative discharge planning and linkages to community supports.

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

Medina Memorial Hospital:

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

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

Rochester Area Reinvestment and Planning Progress

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

- **113 Supported Housing units.**
- **A State-operated MIT for adults.**
- **A State-operated First Break Psychosis Team** under the OnTrackNY initiative.
- **State-operated adult outpatient clinic expansion.**
- **Community Support Teams for Individuals in Supported Housing.** These teams meet the complex needs of individuals who move directly into Supported Housing after discharge from Article 28 Hospitals and the Rochester Psychiatric Center. These individuals are assessed on an ongoing basis to determine their service needs. The level of supports available from the community support teams will match the level of identified needs.
- **Peer-Run Respite Diversion** provides an alternative to emergency room service or inpatient admission for individuals experiencing a psychiatric crisis. This program will provide a home-like environment with peer-directed mental health services and supports.
- **Adult Crisis Transitional Housing** provides short-term intensive supports following a psychiatric hospitalization. In addition, these units are available to individuals already in the community who are experiencing a behavioral health crisis, are at risk of being homeless, or may be at risk of a psychiatric inpatient admission. The units have enhanced staffing available to support the intensive support needs of this population.
- **Two Assertive Community Treatment (ACT) Teams:** ACT Teams are evidence-based programs that deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings rather than in hospital or clinic settings. These teams have been found to improve recipient outcomes with studies showing greater reductions in psychiatric hospitalization rates,
emergency room visits, and higher levels of housing stability after receiving ACT services.

- **Peer Bridger Program** to work with individuals transitioning from psychiatric inpatient units into Supported housing. Bridger staff offer shared experience and information with the individuals transitioning to the community, using a person-centered approach to best meet each person’s needs.

- **Enhanced Recovery Supports** to expand existing peer-operated programs in Wyoming County. These programs support the recovery goals of individuals in community-based settings by promoting consumer empowerment, education, skill development, peer support, advocacy, and community integration.

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

### Finger Lakes and Southern Tier Reinvestment and Planning Progress

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

- **154 Supported Housing units.**
- **24 Home and Community-based Services Waiver slots.**
- **Eight Children’s Crisis/Respite beds** on the grounds of Elmira PC.
- **A State-operated MIT for adults** operating out of hubs at Elmira PC and Greater Binghamton Health Center.
- **A State-operated First Episode Psychosis Team** under the OnTrackNY initiative.
- **Transportation** supports for individuals and families who must access crisis/respite beds.
- **Adult Crisis Transitional Housing** and the increased utilization of State-operated community residential services for crisis/respite.
- **Family and Peer Support** service expansion, including support for peer training and certification, and peer support services for adults utilizing State-operated crisis/respite services.
- **Forensic Staff Support.** Mental health clinical staff support to work with local law enforcement on the Broome County (Binghamton PD) Crisis Intervention Team forensic program to help prevent criminal justice involvement and subsequent hospitalization of individuals with serious mental illness.
- **Respite Services** to stabilize individuals in the community rather than utilize inpatient or long term out of home services.
- **Long Stay Team.** The expansion of a community support program operated out of Chemung County will help transition long stay individuals from Elmira PC into community settings through collaborative discharge planning and linkages to community supports.
Central New York Reinvestment and Planning Progress

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

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

North Country Reinvestment and Planning Progress

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

- 53 Supported Housing units.
- 12 Home and Community-based Services Waiver slots.
- Six Children’s Crisis/Respite beds on the grounds of St. Lawrence PC.
- A State-operated MIT for children and adults.
- A State-operated children’s outpatient clinic expansion.
- Outreach and Support Services in Clinton, Essex, Franklin and Lewis counties, connecting individuals to community-based services, offering quicker access to mental health services and supporting peer engagement in the recovery process.
- A Self-Help Program to connect adults to community mental health services, offer short-term emergency housing, and provide other incidental services to support recovery.
- Enhanced Crisis Outreach/Respite Programs. Capacity expansion, after hour services and an increase in support staff to enhance existing mobile crisis and crisis intervention programs in Essex, Franklin and St. Lawrence counties.
- Forensic Program expansion to support local jail discharge planning for individuals with serious mental illness and reduce recidivism among this population. Crisis Intervention Team training will also be administered to help prevent future criminal justice involvement and to promote successful community tenure maintenance.
Hudson River Region Reinvestment and Planning Progress

OMH has made funding available for the counties served by Capital District Psychiatric Center, Rockland Psychiatric Center and Rockland Children’s Psychiatric Center in an annualized amount of $8.7 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS waiver, State-operated community service expansion, and Aid to Localities funds. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through ongoing consultation with community stakeholders, including the LGUs.

- **177 Supported Housing units.**
- **12 Home and Community-based Services Waiver slots.**
- **A State-operated MIT for adults,** serving the Capital District PC service area.
- **A State-operated MIT for adults,** serving the Rockland PC service area.
- **A Self-Help Program** to offer short-term care and interventions in response to behavioral health crises that create an imminent risk for escalation without supports.
- **Outreach Programs** to assist in locating and securing housing of a service recipient’s choice and in accessing the supports necessary to live successfully in the community. Outreach programs are intended to engage children, adults, and families who are potentially in need of mental health services.
- **Advocacy and Support Services** to assist consumers in protecting and promoting their rights, resolving complaints and grievances, and accessing services and supports of their choice. A self-help component of the program provides rehabilitative and support activities based on the principle that people who share a common condition or experience can be of substantial assistance to each other. These programs include mutual support groups and networks, self-help organizations and/or specific educational, recreational and social opportunities.
- **Mobile Crisis Intervention** programs to provide the clinical intervention and support necessary to successfully maintain children in home or community-based settings and prevent inpatient hospitalizations.
- **An Assertive Community Treatment (ACT) Team.** ACT Teams are evidence-based programs that deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings rather than in hospital or clinic settings. These teams have been found to improve recipient outcomes with studies showing greater reductions in psychiatric hospitalization rates, emergency room visits, and higher levels of housing stability after receiving ACT services.
- **Adult Outreach Services** intended to engage and access individuals potentially in need of mental health services.
- **A Children’s Crisis Intervention/Mobile Mental Health Team** to provide the clinical interventions and supports necessary to successfully maintain children in home or community-based settings and prevent inpatient hospitalization.
- **Six Long Stay Teams.** These outreach teams will help long stay individuals from transition into community settings through collaborative discharge planning and linkages to community supports. Teams operated out of Albany and Schenectady Counties will work with long stays discharged from Capital District PC and teams operated out of Dutchess, Orange, Rockland and Westchester Counties will work with long stays discharged from Rockland PC.
In addition to these Transformation Plan services, OMH and the New York State Department of Health are funding the following services with $4.6 million in reinvestment funds associated with inpatient psychiatric reductions at the Stony Lodge Children’s Psychiatric Hospital and the intermediate care Hospital at Rye.

- **Respite Services** to stabilize individuals in the community rather than utilize hospital or long term, out of home services.
- **Home Based Crisis Intervention (HBCI) Services** to provide intensive in-home crisis services to children aged 5-17.
- **Mobile Crisis Intervention Services** to prevent or limit inpatient hospitalization or emergency room use for adults, adolescents and children experiencing acute symptoms. This service will operate late in the day and in the evenings.
- **18 Home and Community Based Services (HCBS) Waiver Slots** for intensive home based services to enable children to live and receive services in their homes and avoid inpatient hospitalizations.
- **Supported Housing and Community Support** to enable people to live independently and reduce the utilization of costlier Medicaid services. These funds support at least 10 additional supported housing units with community supports for targeted populations, including transitional youth (aging out) at risk of hospitalization.
- **Children and Youth Family Support** to provide core services of family/peer support, respite, advocacy and skill building, and educational opportunities. This is a cost-effective and evidence-based method of reducing the need for inpatient services.
- **Self-Help Program.** A peer-operated alternative to hospitalization that provides supports to individuals in crisis or emotional distress.

**New York City Reinvestment and Planning Progress**

OMH has made funding available for New York City in an annualized amount of $16 million. Pre-investment resources will support services in several programmatic areas including Supported Housing, HCBS waiver, State-operated community service expansion, and Aid to Localities funds. The geographic and programmatic specifications for the services funded in this region that are listed below were determined through ongoing consultation with community stakeholders, including the New York City Department of Health and Mental Hygiene.

- **294 Supported Housing units.**
- **63 Home and Community-based Services Waiver (HCBS) slots.**
- **Three State-operated MITs for adults and children across the City.**
- **Transitions in Care Teams** focused on State PC and acute care discharges. OMH is funding two types of transitions in care teams known as the Pathway Home (2) and Parachute teams (3), for a total of 5 teams, largely focused on assisting recipients in the transition from a State Psychiatric Center to a community setting. These teams will become a critical part of what is missing in the crisis management system in the City. Although largely focused on State PC discharges, these teams can also be used as a bridge service for individuals being discharged from an acute care hospital as a way to provide more intensive support while a recipient is being engaged in outpatient clinic and other services. Both teams are focused on recipient engagement through a multi-disciplinary mobile team consisting of Peer Specialists and nurses, social workers and part-time physician staff and have as their goal the collaboration with treatment and housing providers to facilitate timely, safe discharge to the community.
with ongoing support. Although run by different providers, the basic aim is similar — providing time-limited support in transitions in care to prevent future crises, and costly inpatient and psychiatric emergency services use. The team support is very patient-centered and depending on the recipient’s needs can extend from 3 months to year. An important part of the engagement is the use of recipient wrap-around dollars.

- **Long Stay Team.** The expansion of a transition in care teams operated by Pathway Home to help transition long stay individuals from New York City PCs into community settings through collaborative discharge planning and linkages to community supports.

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

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

**Holliswood Hospital:**

- **15 Home and Community Based Services (HCBS) Waiver Slots** for intensive home based services targeted at children who would otherwise require hospitalization or residential treatment.

- **Children’s Crisis Respite Beds** to offer short-term overnight respite of up to 21 days for relief from a current stressful living situation children aged 4-18. This funding increases bed capacity in Queens and Bronx Counties from 16 beds to 21 beds.

- **Rapid Access Mobile Crisis Teams** provide short-term crisis response and management for children and adolescents aged 0-17 in Brooklyn, Queens, Staten Island, and Manhattan. This funding adds a total of 6.5 new teams.

- **Family Advocates** to work with children and families accessing community hospital emergency departments and inpatient and outpatient units by advocating for their needs and assisting them in accessing and navigating services and supports in the community. Family advocates are family members with a child with emotional challenges who have experienced firsthand the services offered through the community mental health system.

- **Three Family Resource Centers** to strengthen secure attachment between parent and child relationships, and to promote healthy social-emotional development in children ages five and under from high risk families residing in the Bronx and Harlem.

- **High Fidelity Wraparound (HFW),** a youth-guided, family-driven planning process that allows youth and their family achieve treatment goals that they have identified and prioritized, with assistance from their natural supports and system providers, while the youth remains in his or her home and community setting.

- **Child Specialist Staff** to assess and divert children from inpatient admissions and develop linkages to Home Based Crisis Intervention and other intensive services.
Stony Lodge Hospital:

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

Mount Sinai Hospital:

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

Long Island Reinvestment and Planning Progress

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

- **178 Supported Housing units.**
- **54 Home and Community-based Services (HCBS) Waiver slots.**
- **Eight Children’s Crisis/Respite beds** on the grounds of Sagamore CPC.
- **A State-operated MIT for children and youth.**
- **A State-operated MIT for adults.**
- **A State-operated adult and children’s outpatient clinic expansion.**
- **Two Assertive Community Treatment (ACT) Team.** Two ACT Teams serving 48 and 68 individuals, respectively. ACT Teams are evidence-based programs that deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings rather than in hospital or clinic settings.
These teams have been found to improve recipient outcomes with studies showing greater reductions in psychiatric hospitalization rates, emergency room visits, and higher levels of housing stability after receiving ACT services.

- **Non-Medicaid Care Coordination for Children.** 72 Non-Medicaid Care Coordination slots aimed at linking children with serious emotional disturbances and their families to the mental health service system and coordinating these services to promote successful outcomes with continuity of care and service. While children with Medicaid may receive services from this program, it is open to all children and families meeting the criteria for service provision.

- **Child and Family Intensive Case Management.** 18 Child and Family Intensive Case Management slots will promote optimal health and wellness for children diagnosed with severe emotional disturbance. These case management services will help children and families with linkages to and coordination of essential mental health services and community resources, allowing the children served to live successfully in the community.

- **Mobile Residential Support Teams** to focus on transitioning adults living in supported housing apartments into community living. Once these individuals are living in the community, the Mobile Residential Support Teams will visit them in their homes to help ensure that their basic needs are being met.

- **A Hospital Alternative Respite Center** to provide a viable option to inpatient hospitalization for individuals experiencing psychiatric distress. In many cases, an individual with psychiatric challenges might not require inpatient psychiatric admission, but could benefit from a break from daily stressors in a non-hospital environment that supports recovery and allows for a renewed perspective and wellness plan. A respite setting will not only prevent avoidable emergency room and inpatient hospitalization usage, but also provide care in a less stigmatizing and low stress environment.

- **A Recovery Center** in Riverhead, NY to help individuals living with psychiatric diagnosis to live, work and fully participate in their communities. This center will focus on programs that will build on existing best practices in self-help, peer support, and mutual support.

- **Three Long Stay Teams.** These teams will help long stay individuals transition into community settings through collaborative discharge planning and linkages to community supports. Mobile crisis and mobile residential support teams operated out of Suffolk County, and an expanded crisis program in Nassau County will work with long stays from Pilgrim PC.

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

- **Mobile Residential Support Teams (6):** These teams assist with discharge and community residential support for high risk individuals (e.g., those with co-morbid medical conditions and dual diagnoses of mental illness and developmental disability).

- **Mobile Crisis Team Expansion.** Funding for additional staff and transportation enables existing mobile crisis team to increase its coverage hours to 10:00 a.m. to 11:00 p.m., seven days per week.
• A Family Advocate to work in the Emergency Room and child and adolescent inpatient units to provide support, crisis diversion, and service planning assistance.
• 6 Additional Home and Community-based Services (HCBS) Waiver slots.
• Satellite Clinic. Funding for a satellite clinic in Long Beach or for an agency interested in adding mental health services to an existing operation.
• Onsite Rehabilitation Services. Funding for three different programs to serve individuals who have not this been able to make use of existing treatment services. The services would provide specific skill building to allow individuals to transition into traditional PROS programs.
• Peer Counselor to provide outreach to high risk individuals. This peer will be able to work when needed with the Mobile Crisis Team, Hospital Diversion Program and other crisis settings.
• Clinic Treatment Expansion for three Nassau County clinics:
  o North Shore Child and Family Guidance Center will develop a bi-lingual open access children’s urgent and emergency services unit, and a short term intensive group therapy and parent psycho-educational support group;
  o Central Nassau Guidance and Counseling Services plans to develop an open access model of urgent psychiatric care focusing on stabilization to avoid emergency room and inpatient services; and
  o Catholic Charities will provide comprehensive walk-in services combined with consumer advocate outreach services.

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

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

Suicide Prevention

Funding has been allocated to the Statewide Suicide Prevention Center to develop and promote evidence based practices in suicide prevention and identification of individuals at risk of suicide attempts. These efforts will help drive the strategic direction of OMH’s newly created Suicide Prevention Office and its strategic planning efforts under the “Zero Suicide” initiative with the goal of zero suicides for individuals receiving health or behavioral health care.

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

Forensics

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

**Skilled Nursing Facility (SNF) Discharge Supports**

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

**Risk Monitoring and Engagement**

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

**Residential Stipend Adjustments**

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

- An increase in State Net Deficit funding for SRO beds to address funding gaps in the existing SRO models. For non-homeless SRO beds, this equates to an increase of $750 per unit annually Downstate and $675 per unit annually Upstate (approximately 5.5 percent on average above existing funding levels for these programs). For the NY/NY I and II homeless housing SRO beds, this equates to a $1,777 increase to increase the earlier models to the NY/NY III funding levels.
- A targeted Supported Housing stipend increase of $250 in New York City and select counties with the same magnitude of funding gaps relative to Fair Market Rent.
IV. Inpatient Utilization & Community Integration

1) State PC inpatient census, utilization rates and average length of stay
From April 2014 to December 2016, the average daily census in State psychiatric centers (State PCs) dropped for adult and child populations served while increased for forensic population served (Graph 1). During this period of time, admissions to civil PCs declined for all populations (Graph 2). It is important to note that the forensic share of census and admissions to civil PCs increased during this period.


Graph 2. State PC Inpatient Admissions: April 2014-December 2016
The discharge average length of stay (ALOS) in days in State PCs from April 2014 to December 2016 fluctuated for adults and was relatively stable for children (Graph 3). For adults, the spikes in ALOS are largely reflective of discharges of individuals with long lengths of stay (greater than one year). Graph 4 shows the ALOS for State inpatient census at the end of each month, which has declined for both adult and child populations since April 2014.


Source: MHARS, updated as of Jan 24, 2017

Percentage change from Apr 14 to Dec 16:
Adult: -8.6%    Child: -30.9%
2) Acute psychiatric settings inpatient capacity and utilization rates
From April 2014 to December 2016, acute psychiatric (Article 28 units or 31 psychiatric hospitals) inpatient capacity (licensed beds) remained stable for children while decreased for adults (Graph 5). From April 2014 to June 2016, acute hospitals experienced declines in psychiatric admissions for both adults and children (Graph 6). Please note that actual total acute admissions are higher than indicated, as the data available for these settings during this period only captures inpatient stays paid by Medicaid.


![Graph 5](image1.png)

Source: CONCERTS, updated as of Jan 20, 2017


![Graph 6](image2.png)

Source: MEDICAID, updated as of Jan 25, 2017

Percentage change from Apr 14 to Jun 16:
Adult: -1.7%    Child: -12.9%
3) Post-discharge follow-up emergency room and readmission rates

**Psychiatric emergency room rates post-discharge**
From July 2013 to May 2016, adults and children discharged from State PC settings utilized psychiatric emergency services (ER) at consistently lower rates in comparison to adults and children discharged from acute psychiatric settings (Graphs 7 and 8). For children discharged from either setting, 30-day emergency service utilization rates tended to be lower in comparison to adults (Graph 8). The rate decreased dramatically starting from August-October 2015 data point since Medicaid system has had difficulty with the timely updating of managed care encounter data due to system transitions beginning in the fall of 2015. Therefore, the Medicaid encounter data included in the rate calculations may not fully represent all managed care inpatient readmission or ER encounters during this reporting time period.

**Graph 7. Adult Psychiatric Emergency 30-Day Post-Discharge Rates: July 2013-May 2016**

Source: MHARS, MEDICAID, updated as of Jan 20, 2017

Source: MHARS, MEDICAID, updated as of Jan 20, 2017
Psychiatric readmission rates
Graph 9 presents 30-day psychiatric readmission rates for adults discharged from State PC settings in comparison to adults discharged from acute psychiatric settings from July 2013 to May 2016. During this time period, 30-day readmission rates of adults discharged from either State PC settings or acute psychiatric hospital settings remained stable. In addition, psychiatric readmission rates for adults discharged from State PC settings were consistently lower in comparison to the readmission rates among adults discharged from acute psychiatric settings.

Graph 9. Adult Psychiatric Readmission 30-Day Post-Discharge Rates: July 2013-May 2016

Source: MHARS, MEDICAID, updated as of Jan 20, 2017
Graph 10 presents 30-day psychiatric readmission rates for children discharged from State PC settings in comparison to children discharged from acute psychiatric settings from July 2013 to May 2016. During this time period, 30-day readmission rates of children discharged from State PC settings trended downward slightly in recent cohorts, but remained stable for those from acute psychiatric settings. In addition, psychiatric readmission rates for children discharged from State PC settings were consistently lower in comparison to the readmission rates among children discharged from acute psychiatric settings.


Source: MHARS, MEDICAID, updated as of Jan 20, 2017
4) Post-discharge engagement for individuals discharged from State PC inpatient settings

**Continuity of care**
Proper follow-up care is associated with lower rates of readmission, and with a greater likelihood that gains made during hospitalization are retained. From July 2013 to May 2016, the percentage of State PC discharges receiving outpatient visits for mental health treatment (including specialty mental health services and non-specialty services for mental health reasons) increased for both adults and children (Graph 11). The rate increased dramatically starting with the November 2015-January 2016 data point due to the addition of follow-up appointment tracking data for State inpatient discharges.

**Graph 11. State PC Inpatient Discharges 30-Day Continuity of Care Rates: July 2013-May 2016**

![Graph showing continuity of care rates](image-url)

Source: MHARS, MEDICAID, updated as of Jan 23, 2017
**Medication fills**
Non-adherence with medication is a major factor that influences acute psychiatric hospital readmission. From July 2013 to May 2016, the percentage of State PC discharges where one psychotropic medication prescription was filled within 30 days of discharge remained relatively stable for adults, and increased for children (Graph 12).

**Graph 12. State PC Inpatient Discharges 30-Day Psychotropic Medication Fill Rates: July 2013-May 2016**

Source: MHARS, MEDICAID, updated as of Jan 23, 2017
5) State-operated psychiatric inpatient persons aging into long stay trends

State PC long stay population
A “long stay” is defined as an inpatient length of stay (LOS) greater than one year for an adult and greater than 90 days for a child. Graphs 13 and 14 show that the percentage of the State PC inpatient census that became long stay between Quarter 1, 2014 and Quarter 4, 2016 remained stable for adults and declined for children.


Source: MHARS, updated as of Jan 24, 2017
Note: Long Stay is defined as: LOS > 1 year for Adult

Note: Long Stay is defined as: LOS>90 Days for Child
6) Transition of State PC and acute psychiatric inpatient discharges to community-based settings: Supported Housing

Graph 15 displays the percentages of admissions to Supported Housing from targeted populations between Quarter 1, 2014 and Quarter 4, 2016. During this time period, the proportion of admissions to Supported Housing from State PC inpatient discharges increased. In contrast, the proportion of admissions to Supported Housing from acute psychiatric inpatient discharges decreased. The spike during the second quarter of 2015 is likely due to the convergence of an infusion of additional housing resources, and reformed discharge processes between PCs and housing providers early in 2015; the subsequent drop still represents a general trend of increased admissions to Supported Housing from all inpatient target populations.

Graph 15. Supported Housing Admissions from Targeted Populations (State PC Overall, PC Long Stay, and Acute Psychiatric Inpatient): Quarter 1, 2014-Quarter 4, 2016

Source: CAIRS, updated as of Jan 26, 2017
7) Utilization of community based supports: competitive employment and HCBS Waiver

**Competitive employment among State-operated clinic outpatient enrollees**

Graph 16 displays the percentage of outpatient recipients at State-operated clinics who were competitively employed from Quarter 1, 2011 to Quarter 4, 2016. During this period of time, the percentage of outpatient clinic enrollees who were competitively employed increased. “Competitively employed” refers to full-time or part-time work in an integrated setting for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without a disability.


<table>
<thead>
<tr>
<th>Quarter</th>
<th>% Competitively Employed</th>
</tr>
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<tbody>
<tr>
<td>2014-Q1</td>
<td>14.3%</td>
</tr>
<tr>
<td>2014-Q4</td>
<td>15.6%</td>
</tr>
<tr>
<td>2015-Q1</td>
<td>15.4%</td>
</tr>
<tr>
<td>2015-Q4</td>
<td>15.6%</td>
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<tr>
<td>2016-Q1</td>
<td>15.3%</td>
</tr>
<tr>
<td>2016-Q4</td>
<td>16.2%</td>
</tr>
</tbody>
</table>

Source: MHARS, updated as of Jan 23, 2016

Percentage change from Q1, 2014 to Q4, 2016: 13.3%
**Competitive and integrated employment for individuals with serious mental illness (SMI) in the public mental health system**

Graph 17 displays the percentage of public mental health clients who were reported as having competitive and integrated employment in the 2013 and 2015 OMH Patient Characteristics Surveys (PCS). The PCS is a biennial survey of persons served in the public mental health system during the last week in October of the survey year. The percentage of public mental health SMI clients who had competitive and integrated employment increased nearly two percentage points from 2013 to 2015. “Competitive and integrated employment” as defined in the PCS includes full and part-time work that is community-based, competitive (i.e., open to the public, not reserved for clients), and occurs in a normal work environment.

**Graph 17. Competitive and Integrated Employment Rates for Individuals with SMI (2013 and 2015)**

- **Survey Year**: 2013 2015
- **% of SMI Clients Having Competitive and Integrated Employment**: 10.6% 12.5%
- **Percentage change from 2013 to 2015**: 17.9%

**Source**: Patient Characteristics Survey (PCS), updated as of October 2016

**Note**: Employment percentage is based on the one week count of SMI clients who were identified as having competitive & integrated employment.
Utilization of Medicaid Home and Community-based Services (HCBS) Waiver

Graph 18 presents 30/60/90 day Medicaid HCBS waiver program utilization rates for children discharged from State PC inpatient settings from January 2014 to December 2016. During this period, HCBS waiver utilization rates for children discharged from State PC settings increased. Further increases in HCBS waiver utilization are expected as OMH continues its work with localities and providers to identify and improve access for children and families in need.

Graph 18. HCBS Waiver Utilization Rates 30/60/90 Days Post State IP Discharge for Children: January 2014-December 2016

Source: CAIRS, MHARS, updated as of Jan 24, 2016

Percentage change from Jan 2014 to Dec 2016:
- 30-day: 10%
- 60-day: 38.3%
- 90-day: 5.6%
8) Impact measures related to homelessness

Homelessness is monitored on a biennial basis via the OMH Patient Characteristics Survey. Data are displayed below for the years 2013 (Graph 19.a) and 2015 (Graph 19.b). The statewide homelessness rate for both adults and children decreased over the period, with most of the rates specific to selected OMH specialty services also decreasing.

Graph 19.a Individuals in the Public Mental Health System: Rates of Homelessness by Program Type: 2013

Note: Percent homeless is based on the one week count of clients who were identified as being homeless in shelter or on street at any time during the previous six months.
* Includes both ACT (program code 0800) and Children and Youth Assertive Community Treatment (program code 4800).
Graph 19.b Individuals in the Public Mental Health System: Rates of Homelessness by Program Type: 2015

<table>
<thead>
<tr>
<th>Impact Measure</th>
<th>Adult Rate</th>
<th>Child Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>25.8%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Adult n=1,292</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child n=81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop-In Centers</td>
<td>21.4%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Adult n=1,219</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child n=70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPEP Crisis Outreach</td>
<td>22.1%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Adult n=140</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child n=27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT*</td>
<td>7.9%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Adult n=3,903</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child n=94</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Percent homeless is based on the one week count of clients who were identified as being homeless in shelter or on street at any time during the previous six months.
* Includes both ACT (program code 0800) and Children and Youth Assertive Community Treatment (program code 4800).
9) Criminal justice involvement of the NYS mental health population

**Overall criminal justice rates**

The arrest rate for the public mental health population\(^1\) is monitored by examining records of individuals found in both the public mental health system and in the NYS Division of Criminal Justice Services (DCJS) data for the period indicated. During the 2011 to 2015 period, the arrest rate for individuals served in the public mental health system with arrest records in the public domain (i.e., unsealed) remained steady, ranging from 4.2% to 4.4%. The conviction rate decreased from 3.8% in 2011 to 3.3% in 2014 for individuals served in the public mental health system with arrests records in the public domain (i.e., unsealed) (Graph 20). Note: 2015 data are not shown for conviction rates due to incomplete DCJS data for this year.

**Graph 20. Overall Arrest and Conviction Rates for NYS Mental Health Population: 2011-2015**

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\(^1\) See glossary for a description of population.
Arrest rates by mental health service status (new and continuing clients)²
During the 2011-2015 period, the rate of any arrest for clients new to the public mental health system decreased from 5.9% to 5.3%. For clients with continuing mental health service use, the rate of any arrest remained steady, ranging from 3.5% to 3.7%. Overall, the arrest rates for new clients were consistently higher than for the continuing clients across the analytic period (Graph 21).

Graph 21. Arrest Rates for NYS Mental Health Population by Mental Health Service Status: 2011-2015

Source: DCJS, MHARS, MEDICAID, updated as of Dec 5, 2016

² See glossary for description of Mental Health Service Status for CJ Involvement.
V. The Transformation Plan Services Consumer Satisfaction Survey

The Office of Mental Health assesses consumer satisfaction with Transformation Plan services by directly surveying adults, youth, and youths’ families about services received from targeted programs. The survey uses population-specific questions to collect participants’ experiences in the following domains: access to services, appropriateness of services (for adults only), cultural sensitivity, participation in services, outcomes of services, overall satisfaction with services, and quality of life. The 2016 survey was administered from September 19, 2016 through October 14, 2016.

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

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

Adult Assessment of Care

Demographics

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

Assessment of Care

Adult respondents reported positive overall satisfaction with program services. When asked to rate the services they received using a scale of 0 (worst) to 10 (best), 80% of respondents responded with an 8, 9 or 10.

Graph 22 displays the percent of adult consumers who rated services positively for the additional six domains. The majority of the positive response rates for these domains were above 80%, with the cultural sensitivity domain having the highest positive response rate of 91%. The quality of life domain had the lowest positive response rate at 66%, which is consistent with findings for this domain in prior years.

12% of adult respondents reported that culture-related issues (such as language, race, religion, ethnic background, or culture) made a difference in the kind of service they needed. Of these individuals, 88% reported that the services they received were responsive to those needs.
Youth and Family Assessments of Care

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

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

Assessment of Care
Both youth and family respondents reported positive overall satisfaction with program services. When asked to rate the services youth received using a scale of 0 (worst) to 10 (best), 82% of youth and 91% of family respondents responded with an 8, 9 or 10.

Graph 23 displays the percent of youth and family respondents who rated services positively for the additional five domains. For both populations the positive response rates for all domains were above 80%. For the youth respondents, the participation in services domain received the highest positive response rate at 94%. For the family respondents, the cultural sensitivity and participation in services domains both had the highest positive rating at 100%. The lowest positive response rates were the quality of life domain for youth (84%), and the outcomes of services for family (86%).
Graph 23. Youth and Family Member Assessment of Transformation Services: Percent Rating Positive* by Domain (Youth n=112; Family Members n=71)

% RATING POSITIVE

<table>
<thead>
<tr>
<th>Domain</th>
<th>Family</th>
<th>Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Sensitivity</td>
<td>100%</td>
<td>92%</td>
</tr>
<tr>
<td>Access to Services</td>
<td>96%</td>
<td>92%</td>
</tr>
<tr>
<td>Participation In Services</td>
<td>100%</td>
<td>94%</td>
</tr>
<tr>
<td>Outcomes of Services</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>87%</td>
<td>84%</td>
</tr>
</tbody>
</table>

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

*Percent Rating Positive = Average of (Agree + Slightly Agree) and/or (Usually + Always)/All Respondents
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## APPENDIX A: Database/Terms Glossary

<table>
<thead>
<tr>
<th><strong>MHARS</strong></th>
<th>Mental Health Automated Record System (MHARS) is an electronic clinical patient record system for New York State psychiatric center programs (inpatient, outpatient &amp; residential).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicaid</strong></td>
<td>Medicaid is a joint federal and state government health insurance program that helps people with low income and limited resources, and run by state governments. The Medicaid data include Fee For Service (FFS) claims submitted by providers for each covered service and managed care claims for medical services submitted by Managed Care Organizations.</td>
</tr>
<tr>
<td><strong>Acute Psychiatric Settings</strong></td>
<td>Article 28/31 psychiatric licensed beds in hospitals or units are referred to as acute psychiatric settings.</td>
</tr>
<tr>
<td><strong>CONCERTS</strong></td>
<td>Certificate of Need Certification (CONCERTS) application processes information gathered by the Bureau of Inspection and Certification (BIC) on local service providers that are licensed and/or funded by OMH. It captures provider information at the sponsor, agency, facility, program and site levels. Site-specific information includes program capacity, services, population served, and counties served.</td>
</tr>
<tr>
<td><strong>CAIRS</strong></td>
<td>Child and Adult Integrated Reporting System (CAIRS) application is a web-based information tracking system that facilitates the processing, managing and coordinating of on-going mental health services to children and adults. It integrates the reporting requirements of state and local level providers in consolidating their reporting needs as well as tracking statewide outcomes.</td>
</tr>
<tr>
<td><strong>PCS Survey</strong></td>
<td>The Patient Characteristics Survey (PCS) is conducted every two years, and collects demographic, clinical and social characteristics for each person who receives a public mental health service during a specified one-week period. The PCS receives data from approximately 5,000 mental health programs serving 178,000 people during the survey week. All programs licensed or funded by the OMH are required to complete the survey.</td>
</tr>
<tr>
<td><strong>Transformation Plan Services Consumer Satisfaction Survey</strong></td>
<td>OMH assessed consumer satisfaction with public mental health Transformation Plan services by directly surveying adults, youth, and their families in targeted programs and counties. The 2016 Transformation Plan Services Consumer Satisfaction Survey was administered from September 19, 2016 through October 14, 2016. Population-specific questionnaires were developed for each service population and included the following domains: access to services, appropriateness of services (for adults only), cultural sensitivity, participation in services, outcomes of services, overall satisfaction with services, and quality of life.</td>
</tr>
<tr>
<td><strong>Criminal Justice (CJ) Involvement</strong></td>
<td>NYS Department of Criminal Justice Services (DCJS) provided the criminal justice information, which included arrest and conviction information on individuals throughout NYS for the analytic period (calendar years 2011 through 2015). The following were excluded: 1) Individuals younger than 18 at age of arrest; 2) Sealed arrest records; 3) All infraction and violation records; 4) All violation of traffic law (VTL) records; and 5) Forensic-only state-operated facilities (since clients in these facilities receive services while serving a prison sentence, resulting in criminal justice rates of 100%).</td>
</tr>
<tr>
<td><strong>Mental Health Population for CJ Involvement</strong></td>
<td>The mental health population included those individuals who, during the analytic period, received any mental health service from either 1) NYS Medicaid, or 2) any NYS-operated psychiatric facility (inpatient or outpatient). Note that forensic-only state-operated facilities were excluded from the analysis since clients in these facilities...</td>
</tr>
</tbody>
</table>
receive services while serving a prison sentence (resulting in criminal justice rates of 100%).

<table>
<thead>
<tr>
<th>Arrest Rate for Mental Health Population</th>
<th>Arrest Rate is the percentage of individuals in the mental health population during the calendar year who had an arrest during the same calendar year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conviction Rate for Mental Health Population</td>
<td>Conviction Rate is the percentage of individuals in the mental health population during the calendar year who were convicted for an arrest that occurred during the same calendar year. Conviction rates are only reported through 2014 due to a high rate pending disposition information for 2015 (i.e., incomplete 2015 conviction data).</td>
</tr>
<tr>
<td>Mental Health Service Status for CJ Involvement</td>
<td>Mental Health Service Status separates individuals who received a mental health service during the current calendar year into either a “new” status, indicating that they did not receive a mental health service in the prior year, or a “continuing” status, indicating that they did receive a mental health service in the prior year.</td>
</tr>
</tbody>
</table>
APPENDIX B: Consumer Satisfaction Surveys

The Office of Mental Health (OMH) assesses consumer satisfaction with its Transformation Plan services by directly surveying adults, youth, and youth families about services received from targeted programs and counties. The survey uses population-specific questionnaires to collect participants’ experience in the following domains: access to services, appropriateness of services (for adults only), cultural sensitivity, participation in services, outcomes of services, overall satisfaction with services, and quality of life. The 2016 survey was administered from September 19, 2016 through October 14, 2016. Survey forms were distributed to consumers by program staff. Respondents’ completion of the survey was kept confidential and their responses were anonymous. The following are the adult, youth, and family surveys used to assess consumer satisfaction.
These questions ask about your experience receiving services from this program in the past three months. Please respond even if you had only one visit with this program. If the question is about something you have not experienced, shade the circle to indicate that this item is "not applicable" to you.

Please rate your level of agreement or disagreement with each of the following statements by shading the circle that best represents your opinion.

Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Not Applicable
---|---|---|---|---|---
1. The services I received were helpful.................................................................
2. The services I received will help me make positive changes...................................
3. Staff were sensitive to my cultural background (race, religion, language, etc)............
4. I will be better able to deal with crisis.................................................................
5. I have learned some skills that will help me maintain my wellness............................
6. The services made me aware of community supports available to me........................

Please rate how often these things occurred in your experience with this program by shading the circle that best represents your opinion.

Never | Sometimes | Usually | Always | Not Applicable
---|---|---|---|---
7. How often did staff treat you with respect and kindness?........................................
8. How often did you get services at days/times that were convenient to you?...................
9. How often did you get the services where you needed them?.....................................
10. How often did you get services that were appropriate to your situation?......................
11. How often did you get the services you needed as soon as you wanted?....................... 
12. How often did the people you went to for treatment listen carefully to you?...................
13. How often were you involved as much as you wanted in your treatment?.....................

Again, please rate your level of agreement or disagreement with each of the following statements by shading the circle that best represents your opinion.

Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Not Applicable
---|---|---|---|---|---
14. I have a safety plan that would work for me............................................................
15. My living situation is safe and feels like home to me................................................
16. I have access to reliable transportation.................................................................
17. On most days, I have something purposeful to do....................................................
18. I have friends outside the program I can turn to in times of need............................... 
19. I have an intimate and meaningful relationship with someone...................................

20. Does your language, race, religion, ethnic background or culture make any difference in the kind of service you need?
   ○ Yes  ○ No
   
20a. If YES, were the services you received responsive to those needs? ○ Yes ○ No
   
21. Using any number from 0 to 10, where 0 is the worst services and 10 the best service possible, what number would you use to rate the services you received from this program? (please circle your response)
   
   0 1 2 3 4 5 6 7 8 9 10

Please continue on the back

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NEW YORK STATE OF OPPORTUNITY: Office of Mental Health

Draft
In general, how would you rate:

22. your overall physical health? .................................................. Excellent Very good Good Fair Poor
23. your overall mental or emotional health? ................................. Excellent Very good Good Fair Poor
24. the quality of your life at the present time? .............................. Excellent Very good Good Fair Poor

Background Information
Please do not share your name. This confidential information will allow us to provide services that will meet the needs of consumers of these services. Please fill in the blank or shade the circles to indicate your answers.

25. What is your age?  ○ 18-24 ○ 25-34 ○ 35-44 ○ 45-54 ○ 55-64 ○ 65-74 ○ 75 +
26. What was your sex at birth (on your original birth certificate)?  ○ Female ○ Male ○ Other
27. What is your gender identity? ○ Female ○ Male ○ Other
28. How would you describe your sexual orientation?
   ○ Heterosexual or Straight ○ Homosexual, gay or lesbian ○ Bisexual ○ Other ○ Not sure ○ Prefer not to answer
29. Are you of Hispanic/Latino Origin?  ○ Yes, Hispanic or Latino ○ No, not Hispanic or Latino
30. What is your race? (select all that apply)
   ○ White (Caucasian) ○ American Indian/Alaskan Native ○ Asian
   ○ Black/African American ○ Native Hawaiian/Pacific Islander ○ Other
31. Where were you born?  ○ The United States ○ Outside of the United States, includes US territories (e.g., Puerto Rico, Guam)
32. How often do you receive services from this program? ○ Once ○ More than once
33. Have you been discharged from a State psychiatric hospital in the past year? ○ Yes ○ No
   33a. If YES, was your recent stay at the State psychiatric hospital longer than one year? ○ Yes ○ No
34. Did you work for pay in the last year? ○ Yes ○ No
35. How hard is it for you to pay for the very basics like food, housing, medical care and heating?
   ○ Very hard ○ Somewhat hard ○ Not hard at all
36. Who, if anyone, helped you complete this form? (Please select one)
   ○ Peer ○ Peer specialist/advocate ○ Staff member ○ Family/Friend ○ No one
37. Using any number from 0 to 10, where 0 is very easy and 10 is very difficult, what number would you use to rate how easy or difficult it was to complete this survey? (please circle your response)
   ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Thank you for taking this survey!
These questions ask about the services you received from this program in the past three months. Please respond even if you had only one visit with this program. If the question is about something you have not experienced, shade the circle to indicate that this item is “not applicable” to you.

Please rate your level of agreement or disagreement with each of the following statements by shading the circle that best represents your opinion.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I got services that were helpful to me.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2. The services I received will help me make positive changes in my life.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3. Staff were sensitive to my cultural background (race, religion, language, etc.).</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. My culture, beliefs and values were accepted</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Please rate how often these things occurred in your experience with this program by shading the circle that best represents your opinion.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. How often did staff treat you with respect and kindness?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>6. How often did you feel safe in the place(s) you received services?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>7. How often did you get the services you needed as soon as you wanted?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>8. How often did the people you went to for treatment listen carefully to you?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>9. How often were you involved as much as you wanted in your treatment?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Again, please rate your level of agreement or disagreement with each of the following statements by shading the circle that best represents your opinion.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. I have a safety plan that would work for me if I needed one</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>12. I received services that helped me feel better.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>13. I am more hopeful.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>14. I am aware of more community supports available to me [HARP]</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>15. I have gained new coping skills that are helpful.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>16. I have a better sense of my strengths.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>17. This service helped my family talk about our needs.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>18. I know what is going to happen after this service ends.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

19. Does your language, race, religion, ethnic background or culture make any difference in the kind of service you need?  
○ Yes  ○ No  

19a. If yes, were the services you received responsive to those needs?  
○ Yes  ○ No

20. Using any number from 0 to 10, where 0 is the worst services and 10 the best service possible, what number would you use to rate the services you received from this program?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>1</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>6</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>7</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>8</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>9</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>10</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

21. In general, how would you rate your overall physical health?  
○          ○  ○  ○  ○

22. In general, how would you rate your overall mental or emotional health?  
○          ○  ○  ○  ○

23. In general, how would you rate the quality of your life at the present time?  
○          ○  ○  ○  ○
Background Information
Please do not share your name. This confidential information will allow us to provide services that will meet the needs of consumers of these services. Please fill in the blank or shade the circles to indicate your answers.

24. What is your age? □ 9-11 years old □ 12-14 years old □ 15-18 years old □ 19-21 years old

25. What was your sex at birth (on your original birth certificate)? □ Female □ Male □ Other

26. What is your gender identity? □ Female □ Male □ Other

27. How would you describe your sexual orientation?
    □ Heterosexual or Straight □ Homosexual, gay or lesbian □ Bisexual □ Other □ Not sure □ Prefer not to answer

28. Are you of Hispanic/Latino Origin?
    □ Yes, Hispanic or Latino □ No, not Hispanic or Latino

29. What is your race? (Select all that apply)
    □ White □ American Indian/Alaska Native □ Asian
    □ Black/African American □ Native Hawaiian/Other Pacific Islander □ Other

30. How often have you received services from this program?
    □ Once □ More than once

31. Have you been discharged from a State psychiatric hospital in the past year? □ Yes □ No

    31a. If Yes, was your recent stay at the State psychiatric hospital longer than one year? □ Yes □ No

32. Where do you live?
    □ At Home (with parent/parents) □ At Home (with relatives – e.g., aunt, grandparent)
    □ Foster Home □ Residential Program □ Other ________________

33. Who, if anyone, helped you complete this form?
    □ Peer □ Peer Specialist/advocate □ Staff member □ Family/Friend □ No one

34. Using any number from 0 to 10, where 0 is very difficult and 10 is very easy, what number would you use to rate how difficult or easy it was to complete this survey?

    0 1 2 3 4 5 6 7 8 9 10
These questions ask about the services your child and family received from this program in the past three months. Please respond even if you had only one visit with this program. If the question is about something you or your child has not experienced, shade the circle to indicate that this item is “not applicable” to you.

Please rate your level of agreement or disagreement with each of the following statements by shading the circle that best represents your opinion.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The services my child and/or family received were helpful to us.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2. The services my child and/or family received will help my family make positive changes.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3. Staff supported my needs as a parent.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. I received services that addressed my immediate needs.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Please rate how often these things occurred in your experience with this program by shading the circle that best represents your opinion.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. How often did staff treat you with respect and kindness?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>6. How often did staff accept your culture, values and beliefs?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>7. How often did your child receive services in a timely manner?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>8. How often did staff show respect for what you had to say?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>9. How often did your child receive services where he/she needed them?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>10. How often were services available days/times your child needed them?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>11. How often were services available at locations convenient to you?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Again, please rate your level of agreement or disagreement with each of the following statements by shading the circle that best represents your opinion.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. My child and I have a safety plan that would work for us if we needed one</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>13. My child is better able to cope when faced with challenges</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>14. I am more hopeful for my child and family.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>15. I am aware of more community supports available to me and my child.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>16. I have gained new skills to better help myself and my child.</td>
<td>○</td>
<td>○</td>
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<td>17. I have a better sense of my family’s strengths.</td>
<td>○</td>
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<td>18. I feel less alone and isolated.</td>
<td>○</td>
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<td>19. I have a clear understanding of next steps.</td>
<td>○</td>
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20. Does your language, race, religion, ethnic background or culture make any difference in the kind of service you and your child need?  
○ Yes  ○ No    
20a. If yes, were the services you and your child received responsive to those needs?  ○ Yes  ○ No

21. Using any number from 0 to 10, where 0 is the worst services and 10 the best service possible, what number would you use to rate the services you received from this program?

<table>
<thead>
<tr>
<th>Number</th>
<th>0</th>
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</tbody>
</table>

22. In general, how would you rate your child’s overall physical health?  
○ Excellent  ○ Very good  ○ Good  ○ Fair  ○ Poor

23. In general, how would you rate your child’s overall mental or emotional health?  
○ Excellent  ○ Very good  ○ Good  ○ Fair  ○ Poor

24. In general, how would you rate the quality of your child’s life at the present time?  
○ Excellent  ○ Very good  ○ Good  ○ Fair  ○ Poor
Please tell us a little about your child (who is receiving services) and family:

25. Your child’s age?
   - □ 4 years old or under
   - □ 5-8 years old
   - □ 9-11 years old
   - □ 12-14 years old
   - □ 15-18 years old
   - □ 19-21 years old

26. What was your child’s sex at birth (on your child’s original birth certificate)? □ Female □ Male □ Other

27. What is your child’s gender identity? □ Female □ Male □ Other

28. How would you describe your child’s orientation?
   - □ Heterosexual or Straight
   - □ Homosexual, gay or lesbian
   - □ Bisexual
   - □ Other □ Not sure □ Prefer not to answer

28. Is your child of Hispanic/Latino Origin?
   - □ Yes, Hispanic or Latino
   - □ No, not Hispanic or Latino

29. What is your child’s race? (Select all that apply)
   - □ White
   - □ American Indian/Alaska Native
   - □ Asian
   - □ Black/African American
   - □ Native Hawaiian/Other Pacific Islander
   - □ Other

30. How often has your child received services from this program?
   - □ Once
   - □ More than once

31. Has your child been discharged from a State psychiatric hospital in the past year? □ Yes □ No

32a. If yes, was your child’s recent stay at the State psychiatric hospital longer than three months? □ Yes □ No

32. Where does your child live?
   - □ At Home (with parent/parents)
   - □ At Home (with relatives – e.g., aunt, grandparent)
   - □ Foster Home
   - □ Residential Program
   - □ Other ________________

33. Who, if anyone, helped you complete this form?
   - □ Peer
   - □ Peer Specialist/advocate
   - □ Staff member
   - □ Family/Friend
   - □ No one

34. Using any number from 0 to 10, where 0 is very difficult and 10 is very easy, what number would you use to rate how difficult or easy it was to complete this survey?
   - 0 1 2 3 4 5 6 7 8 9 10