INVENTORY OF
NYS OFFICE OF MENTAL HEALTH PROGRAMS

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A. ADULT SERVICES PROGRAM

A.1 Inpatient Services

PROGRAM

StOps Adult – **Inpatient Services**

LEGAL MANDATE/AUTHORITY

Mental Health Law (MHL) Sections 7.01, 7.11, 7.15, 7.17; Medicaid Federal Social Security Act (SSA) 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

OMH operates 16 adult civil Psychiatric Centers across the State. These facilities provide inpatient, outpatient, emergency, and community support services to support the mission of promoting the mental health of all New Yorkers with a particular focus on facilitating hope and recovery for persons with serious mental illness. Only inpatient services will be described in this section.

The utilization of beds in State-operated Psychiatric Centers has declined steadily since the mid-1950s. At the peak in 1955, there were more than 93,000 inpatients in State-operated hospitals. As of August 2008, there were 3,852 inpatients, a decrease of 96%. Over the last several years, the maximum inpatient capacity of the 16 adult hospitals has been stable at 4,030, with an occupancy rate of about 96%. Last year, there were 3,677 admissions and 3,711 discharges for the inpatient system.

The role of State-operated inpatient services has been to provide intermediate and long-term care for persons with serious mental illness. Among those served by the State Psychiatric Centers are court-adjudicated criminal defendants deemed incompetent to stand trial and ordered to psychiatric hospitals for treatment aimed at restoring each defendant's competence. Acute care, with some exceptions, is provided by Article 28 hospitals with licensed inpatient psychiatric units.

OMH has embraced a new vision for a transformed adult mental health system and of the role of its Psychiatric Centers in this system. The goal is to continue movement toward a community-oriented service delivery system with expanded, accessible and better-integrated clinic, housing, intensive treatment, and crisis care options. The State Psychiatric Centers beds will continue to serve as the ultimate safety net for New Yorkers with the most serious mental illness, and do so in a way that provides inpatient care with fewer beds.

Each of the Adult Psychiatric Centers has been asked to begin the process of transforming its current service configuration into one that is consistent with the new vision, and also one that is consonant with the mental health service needs of the diverse communities it serves.

Over the course of the year, the goal is to make changes in the operations of the Adult Psychiatric Centers that support the beginning of transformation, that adhere to the principles outlined above, and that address the following basic objectives:

- Lower the number of long-stay patients in each facility.
- Increase the number of annual admissions.
- Serve individuals with an overall higher acuity level.
- Plan for growth or change in program type to better meet community needs.
- Strengthen facility involvement in the community-based system of care.

ISSUES

Competency Restoration Costs

While the counties bear financial liability for competency restoration of felony-level defendants, OMH is responsible for covering the costs of treatment for less complex misdemeanants. Such an approach leads to the unintended consequence of providing an incentive to institutionalize persons who should be subject to community supervision.

Examining the Conversion of Inpatient Capacity to Step-Down Levels of Care

As noted previously, most State Psychiatric Center beds will continue to be needed for vulnerable persons suffering with the most serious mental illnesses. Yet, there is a portion of long-stay patients who require intensive care and supervision, but not hospital care. There may be an opportunity to serve these individuals in step-down levels of care, using an approach similar to the one used for persons in need of skilled post-hospitalization, rehabilitation services. One approach might include some modest conversion of inpatient capacity for persons with serious mental illness to settings in which they can receive supervised rehabilitative care before moving into community outpatient placements. An important benefit of such an approach would be to facilitate recovery by offering additional supports and preparation for transition to community living. An additional benefit would be to use professional nursing services in the most efficient and effective manner to meet the more intensive clinical needs of inpatients

Other factors affecting inpatient care and having a bearing on managing resources during an economic downturn include:

- Having a high demand for access to long-term inpatient beds in certain geographic areas, notably large urban areas
- Closing of Article 28 inpatient psychiatric units in several areas (e.g., Niagara Falls, Oneonta, Albany, Plattsburgh), placing pressure on State Psychiatric Centers to provide more acute care services
- Having insufficient discharge options for patients ready to return to the community, resulting in longer than necessary length of inpatient stays
- Having up to 30% of patients in some civil facilities with a forensic history, making discharge difficult
- Having difficulty in recruiting and retaining nurses, physicians and other mental health professionals in many areas of the State, contributing to overtime challenges
- Achieving goals to transform the inpatient system of care through administrative and budgetary support

POPULATION SERVED

Individuals with serious and persistent mental illness, and adults who are deemed dangerous to themselves or others

(Admissions are about two-thirds male, one-third female, and slightly more than one-half of all admissions are involuntary. The majority of persons admitted are indirect, having received acute care prior to transfer.)

PERFORMANCE MEASURES

- Number of persons served and characteristics: age, sex, race, ethnicity
- Number of admissions
- Median, mean length of stay for discharged clients
- Median, mean length of stay for residents at end of year by tenure (in facility for less than one year, in facility for one year or more)
- Trend in census, admissions, discharges
- Capacity
- Annual bed days
- Occupancy rates
- Atypical antipsychotic drug utilization
- Rate of incidents
- Restraint and seclusion rates and durations
- Cost of care
- Use and cost of overtime
- Results from surveys (e.g., the Joint Commission)

PROGRAM

ATL Adult – **Inpatient Psychiatric Unit of a General Hospital (Article 28)**
State Share Budgeted in DOH)

LEGAL AUTHORITY/MANDATE

MHL Sections 7.07, 7.09, 7.15; 14 New York Codes, Rules and Regulations (NYCRR), Part 580;
Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND:

This is a licensed, 24-hour inpatient psychiatric treatment program jointly licensed by OMH and the State Department of Health (DOH) and operated in medical hospitals. These facilities provide Medicaid-reimbursable full-time medical, psychiatric and social services and around-the-clock nursing services for individuals with mental illness. Article 28 units are used primarily for acute inpatient psychiatric care. Approximately 5,525 adult psychiatric inpatient unit beds serve 220,603 individuals served annually.

ISSUES

For many years there has been an over reliance on inpatient care in the State. New York's per-capita spending on psychiatric inpatient care is approximately four times the national average. Inpatient beds are not distributed equally across the State; the length of stay for inpatient care is higher than the national average; readmission rates are high; and there are poor transitions from inpatient to outpatient care. It is anticipated that hospital readmission rates and transitions to outpatient care will be addressed within the outpatient restructuring effort that is currently under way.

New York faces significant challenges and complexities regarding psychiatric inpatient care. Article 28 inpatient units provide most high-urgency and short-term psychiatric care, and face capacity and reimbursement problems. This has become evident, as noted above, by actual and threatened unit closures. OMH is striving to provide access to inpatient care while the productivity of OMH Psychiatric Centers is increased, care management is improved, and capacity is examined to identify selective replacement of inpatient care with less expensive community care. DOH and OMH will continue to work together to solve these problems.

POPULATION SERVED

Individuals who in need of acutely care for mental illness and in need of a safe environment to receive active treatment aimed at stabilizing symptoms and planning for ongoing symptom management.

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of admissions, capacity, occupancy, total bed days, average daily inpatient bed usage
- Median, mean length of stay for discharged clients
- Median, mean length of stay for residents at end of year by tenure (in facility for less than one year, in facility for one year or more)
- Number of discharges and 30- and 180-day readmission rates
- Operating certificate duration and capacity

PROGRAM

ATL Adult – **Article 31 Inpatient**

(State Share Budgeted in DOH)

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.09, 7.15; 14 NYCRR, Part 582; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

This is a licensed, 24-hour inpatient psychiatric treatment program licensed by the OMH as a freestanding psychiatric hospital. These facilities provide full-time medical, psychiatric and social services and around-the-clock nursing services for individuals with mental illness. Article 31 hospitals are considered an institution for mental diseases (IMD) and federal law does not allow Medicaid reimbursement for care provided to individuals in an IMD who are older than 21 years or younger than 65 years of age. There are nine Article 31 hospitals with a licensed capacity of 498 adult beds in the State.

ISSUES

For many years, there has been an over reliance on inpatient care in the State. New York's per-capita spending on psychiatric inpatient care is approximately four times the national average. Inpatient beds are not distributed equally across the State; the length of stay for inpatient care is higher than the national average; readmission rates are high; and there are poor transitions from inpatient to outpatient care. It is anticipated that hospital readmission rates and transitions to outpatient care will be addressed within the outpatient restructuring effort that is currently under way.

POPULATION SERVED

Individuals who in need of acute care for mental illness, and in need of a safe environment to receive active treatment aimed at stabilizing symptoms and planning for ongoing symptom management.

PERFORMANCE MEASURES

All persons regardless of insurance

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Operating certificate duration and capacity

Medicaid recipients only

- Number of admissions
- Capacity, occupancy, total bed days, average length of stay
- Average daily inpatient bed usage
- Median, mean length of stay for discharged clients
- Median, mean length of stay for residents at end of year by tenure (in facility for less than one year, in facility for one year or more)
- Number of discharges and 30- and 180-day readmission rates

A.2 Outpatient Services

PROGRAM

StOps Adult – **Continuing Day Treatment (CDT)**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.15, 7.17; 14 NYCRR, Parts 587, 588; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The CDT program provides active treatment designed to maintain or enhance current levels of functioning and skills, to maintain community living, and to foster the development of self-awareness and self-esteem. CDT provides assessment and treatment planning, discharge planning, medication therapy, medication education, case management, health screening and referral, rehabilitative readiness development, psychiatric rehabilitative readiness determination and referral and symptom management. The program may also provide supportive skills training, activity therapy, crisis intervention, and clinical support services.

ISSUES

While the CDT program is consistent with the agency core mission of assisting individuals to develop skills and supports needed for community tenure, it does not allow flexibility to prescribe a level of support that may be needed by some participants. Additionally, the model requires blocks of attendance. Currently, OMH is moving away from this model toward more recovery-oriented services provided under the Prepaid Mental Health Program (PMHP).

POPULATION SERVED

Adults with severe and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Reduction in hospitalizations
- Length of community tenure
- Outpatient admissions, census, and terminations
- Recipient ratings of quality of life, service quality, access to services, appropriateness of services, outcomes of services
- Certification tier, operating certificate duration and capacity

PROGRAM

ATL Adult – **Continuing Day Treatment (CDT)**
(State Share Partially Budgeted in DOH)

LEGAL AUTHORITY/MANDATE

MHL Section 41.47; 14 NYCRR, Parts 587, 588, 592; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

CDT programs provide active treatment and rehabilitation designed to maintain or enhance current levels of functioning and skills, to maintain community living and to foster development of self-awareness and self-esteem. CDT programs are day programs that were designed at a time when many individuals were re-entering the community after long-term inpatient stays. This program is premised on the belief that individuals need a place away from their living situations that provides an essential daytime alternative for many persons.

ISSUES

CDT programs are day programs that were designed at a time when many individuals were re-entering the community after long-term inpatient stays. While CDT programs provide treatment alternatives, the service represents a now outmoded model of care; the treatment model does not reflect current knowledge of the concepts of recovery and community integration. The capacity from CDT could be used much more effectively if deployed into the Personalized Recovery-Oriented Services (PROS) model, utilizing recovery-oriented and peer-operated services. Despite this concern, OMH is striving to maintain resources associated with the CDT program for conversion to new program models such as PROS. Incentives to encourage conversion to PROS are under consideration.

CDT programs are also being reviewed within the context of the larger ambulatory restructuring initiative that is in progress. Potential financing changes at the federal level could have a negative impact, including the interim final[1] Targeted Case Management (TCM) regulations; the Upper Payment Limit regulations; and the Center for Medicare and Medicaid Services (CMS) movement away from bundled rates.

POPULATION SERVED

Adults who have a mental illness and associated functional impairments

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Certification tier, operating certificate duration and capacity

[1] An "interim final" rule is one issued by the federal government without a notice of proposed rulemaking. While an interim final rule is often effective immediately, it does provide a "post-promulgation" opportunity for public comment. In instances where public comments persuade the federal government that changes are needed in the interim final rule, the government may revise and publish a final rule to reflect such changes.

PROGRAM

StOps Adult – **Clinic Treatment**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.15, 7.17; 14 NYCRR, Parts 587, 588; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

A clinic treatment program provides treatment designed to reduce symptoms, improve patient functioning, and provide ongoing support. Services include assessment and treatment planning, health screening and referral, discharge planning, verbal therapy, medication therapy, mediation education, symptom management, and psychiatric rehabilitative readiness determination. A clinic treatment program may also provide case management, crisis intervention, and clinical support services.

ISSUES

Clinic treatment is consistent with the agency mission to provide treatment in community-based settings. The program is developing into a more recovery-oriented, person-centered approach to treatment, in line with the recommendations of the New Freedom Commission on Mental Health. The clinic has been the primary site for the delivery of several PMHP services and this has allowed for a more holistic service delivery model.

POPULATION SERVED

Adults with severe and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Community tenure
- Reduction in hospitalizations
- Outpatient admissions, census, and terminations
- Employment rates
- Certification tier, operating certificate duration and capacity
- Recipient ratings of quality of life, service quality, access to services, appropriateness of services, outcomes of services

PROGRAM

ATL Adult – **Clinic Treatment**

(State Share Partially Budgeted in DOH)

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.09; 14 NYCRR, Parts, 587.7, 588, 592; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Clinic treatment programs provide treatment designed to reduce symptoms, improve functioning and ensure ongoing support. A clinic treatment program for adults provides assessment and treatment planning, health screening and referral, discharge planning, verbal therapy, medication therapy, medication education, symptom management, and psychiatric rehabilitation readiness determination. Clinic treatment may also include case management, crisis intervention, clinical support, and family treatment services.

Clinic services were one of the first community-based ambulatory treatment options developed under the community mental health center model of the 1970s. Clinic services can either be operated by general hospitals or freestanding diagnostic and treatment centers (Article 28 clinics), or by private entities, counties or OMH (Article 31 clinics). The clinic is the cornerstone of treatment and often the point from which individuals access rehabilitation and recovery services in their communities. There are approximately 441 licensed clinic programs. On average, 241,146 persons are served annually.

While the clinic program model has not been dramatically revised over time, changes to the reimbursement methodology over the years have created multiple layers of complexity, further complicated by the ongoing expansion of mandatory enrollment in Medicaid managed care. (Clinic services are included in the basic benefit package.)

ISSUES

Because clinic services are regarded as a key component of the public mental health system, a number of reform initiatives are in various stages of development or implementation. Currently, OMH has a major clinic restructuring project under way that will refine the scope of clinic services and develop a rational reimbursement system, including attention to uncompensated care. Another action intended to improve clinic services is the recent elimination of the Medicaid neutrality rule. It is anticipated that this action will help reduce the long waiting times for clinic treatment services and increase crisis services and after-hours care by encouraging greater access to services. The provision of increased services will also improve revenue flow to providers. It should be noted that federal financing pressures and pending regulations related to the TCM state plan option will affect the incidental case management provided within clinics, and the Upper Payment Limit regulations will impact the clinic rate-setting and payment structure.

Recent advances by OMH and the Office of Alcoholism and Substance Abuse Services (OASAS) in integrating services for more effective treatment of co-occurring disorders are further intended to improve treatment outcomes for persons served in clinics, while the recent distribution of the Standards of Care document (as part of the New York State/New York City Mental Health–Criminal Justice Panel Report) is expected to provide substantial aid to promote provider accountability.

POPULATION SERVED

Adults, age 18 and older who have a diagnosis of mental illness

(Most OMH-licensed clinics also serve children and adolescents.)

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Certification tier, operating certificate duration
- Prescribing practices

PROGRAM

StOps Adult – **Partial Hospitalization**

LEGAL MANDATE/AUTHORITY

MHL 7.07, 7.15; 14 NYCRR, Parts 587, 588; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

A partial hospitalization program aims to provide treatment to stabilize and ameliorate acute symptoms, serve as an alternative to inpatient hospitalization, and reduce the length of a hospital stay within a medically supervised program. The program provides assessment and treatment planning, health screening and referral, symptom management, medication therapy, medication education, verbal therapy, case management, psychiatric rehabilitative readiness determination and referral, crisis intervention, activity therapy, discharge planning, and clinical support services.

ISSUES

While this treatment model is not utilized statewide, it does meet the agency mission to provide community-based services for one site in the State. As the concept of recovery has evolved, partial hospitalization and similar services have the potential to be incorporated into the PMHP model for care delivery that is more holistic and consistent with the treatment needs of individuals receiving such services.

POPULATION SERVED

Adults who have severe and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Outpatient admissions, census, and terminations
- Avoidance of hospitalization
- Community tenure
- Recipient ratings of quality of life, service quality, access to services, appropriateness of services, outcomes of services
- Certification tier, operating certificate duration and capacity

PROGRAM

ATL Adult – **Partial Hospitalization**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.09, 31.04, 43.01; Social Services Law (SSL) Sections 364, 364-a;

14 NYCRR, Parts 587, 588, 592: Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Partial hospitalization programs, first created in 1991, are designed to provide treatment to stabilize and ameliorate acute symptoms, serve as an alternative to inpatient hospitalization, and reduce the length of a hospital stay within a medically supervised program. Partial hospitalization programs provide assessment and health screening, and treatment and discharge planning services. In addition, the program offers health referral, symptom management, medication therapy, medication education, verbal therapy, case management, psychiatric rehabilitation readiness determination and referral, crisis intervention, and clinical support services.

ISSUES

While partial hospitalization programs have been largely unchanged since their inception, they are being reviewed within the context of the larger ambulatory restructuring initiative that is currently in progress. Potential financing changes at the federal level that could negatively impact this program include the interim final TCM regulations, the Upper Payment Limit regulations, and movement away from bundled rates.

As stated above, the primary purpose of the partial hospitalization program is to provide short-term stabilization for individuals with acute symptoms, to avert hospitalization if possible and aid individuals in remaining in their homes and communities. Since this type of program is intended to be intensive and targeted, individual lengths of stay are expected to be of relatively short duration. To this end, it may be helpful to support recovery by examining incentives that help each person with serious mental illness to move from partial hospitalization back to other treatment modalities based in their communities.

POPULATION SERVED

Adults with serious acute care needs who can be served in outpatient settings

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Outpatient admissions, census, and terminations
- Avoidance of hospitalization
- Community tenure
- Recipient ratings of quality of life, service quality, access to services, appropriateness of services, outcomes of services
- Certification tier, operating certificate duration and capacity

PROGRAM

StOps Adult – **Intensive Psychiatric Rehabilitation Treatment (IPRT)**

LEGAL MANDATE/AUTHORITY

MHL 7.09, 7.15; 14 NYCRR, Parts 587, 588; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

IPRT is time limited, with active psychiatric rehabilitation designed to assist clients in forming and achieving mutually agreed-upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitative technologies to overcome functional disabilities; and to improve environmental supports. IPRT programs provide psychiatric rehabilitative readiness determination, goal setting, functional and resource assessment, service planning, skills and resource development, and discharge planning.

ISSUES

This program meets the agency mission of assisting individuals to lead quality lives in their communities. Participants continue to receive clinical treatment services. As the concept of recovery has evolved, many of the services provided by IPRT have the potential to be provided within the PMHP model to provide more holistic care.

POPULATION SERVED

Adults with severe and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Skill acquisition
- Goal attainment
- Outpatient admissions, census, and terminations
- Avoidance of hospitalization
- Community tenure
- Recipient ratings of quality of life, service quality, access to services, appropriateness of services, outcomes of services
- Certification tier, operating certificate duration and capacity

PROGRAM

ATL Adult – **Intensive Psychiatric Rehabilitation and Treatment (IPRT)**

LEGAL MANDATE/AUTHORITY

MHL 7.09, 7.15; 14 NYCRR 587, 588; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The program is intended to be time limited, with psychiatric rehabilitation designed to assist a patient in forming and achieving mutually agreed-upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies to overcome functional disabilities; and to improve environmental supports.

The IPRT program, which was originally implemented in 1991, is designed to ameliorate the negative impact of psychiatric illness on an individual's daily functioning, enabling them to attain or maintain desired life roles and settings. There have been virtually no changes to the program model since its inception. Currently, there are approximately 33 licensed IPRT programs, with a capacity to serve approximately 842 individuals.

ISSUES

As PROS models are being implemented in each county, IPRT programs are being targeted for conversion to PROS. A small number of IPRT programs have already converted to PROS and providing services, in great measure, within the Intensive Rehabilitation (IR) component of PROS. IPRT programs are also being reviewed within the context of the larger ambulatory restructuring initiative that is currently in progress.

POPULATION SERVED

Adults diagnosed with a serious mental illness and with a functional disability due to that diagnosis

(In limited instances, IPRT programs provide services to individuals 15 to 17 years of age.)

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Certification tier, operating certificate duration and capacity

PROGRAM

StOps Adult – **Prepaid Mental Health Plan (PMHP)**

LEGAL MANDATE/AUTHORITY

MHL 7.15, 7.17; SSL 36-a; Medicaid Federal SSA 1905(a), 1932

BRIEF DESCRIPTION/HISTORY/BACKGROUND

PMHP is a non-comprehensive Medicaid managed care plan for adults residing in or discharged from State-operated Psychiatric Centers and adults who receive Social Security Income (SSI)/Medicaid only services from State-operated outpatient programs. PMHP is considered a partial capitation program in that the benefit package consists primarily of outpatient services and inpatient coverage only after the 60th day. PMHP covers all outpatient mental health services, and inpatient services beginning on the 61st inpatient day. Individuals asked to participate in PMHP must be using OMH Medicaid services exclusively. OMH will permit Plan enrollees to choose a primary mental health provider in their geographic areas. Any enrollee who does not choose a primary provider is assigned to a provider by the Plan. Benefits available under PMHP fall into five broad categories: treatment, rehabilitation, crisis, support, and self-help/empowerment services. Service in any of these categories may be provided by peer-run organizations or by traditional programs, which may also include peers as staff. Services in the self-help and empowerment category are by definition peer run. The services are more rehabilitative in nature and provided under the direction of a physician. The number of individuals enrolled in PMHP is 8,339 and they are being served in 18 programs.

ISSUES

Consistent with directives from the New Freedom Commission on Mental Health, PMHP is directly related to the OMH mission of providing community-based, individualized treatment and allows for services to be provided based on individual needs and wants. PMHP allows for flexibility in type of and duration of services and is playing a central role in the facility transformation plans. As the concept of recovery has evolved, many of the services of more traditional models (e.g., CDT, IPRT, partial hospitalization) have the potential to be incorporated into the PMHP model and to deliver more holistic care that is consistent with the recovery-oriented needs and desires of people served by the program.

POPULATION SERVED

Adults with severe and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Enrollment
- Community tenure
- Employment rates
- Number of treatment and recovery services delivered
- Recipient ratings of access to, appropriateness of, and outcomes of services, quality of life

PROGRAM

ATL Adult – **Personalized Recovery-Oriented Services (PROS)**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.09(b), 31.04(a); 14 NYCRR, Part 512; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The PROS program is a comprehensive program that includes treatment, rehabilitation and support services. The implementation of PROS programs, which has been deliberately cautious, has involved the conversion of IPRTs, CDTs and selected categories of Community Support Programs (CSP). The first PROS license was issued in January 2006. To date, there are 14 licensed programs in four counties, serving approximately 3,000 individuals. Several other counties and providers are currently expressing an interest in conversion.

Comprehensive PROS with Clinical Treatment

PROS—with clinical treatment—is a comprehensive recovery-oriented program, with integrated services for individuals diagnosed with severe and persistent mental illness. Services include community rehabilitation and support, intensive rehabilitation, vocational support, and clinical treatment

Comprehensive PROS without Clinical Treatment

PROS—without clinical treatment—is a comprehensive recovery-oriented program, with integrated services for individuals diagnosed with severe and persistent mental illness. Services include community rehabilitation and support, intensive rehabilitation, and vocational support.

Limited License PROS

Limited license PROS is a comprehensive recovery-oriented program, with integrated services for individuals diagnosed with severe and persistent mental illness. Services include vocational support and intensive rehabilitation services.

PROS Rehabilitation and Support Subcontract Services

PROS rehabilitation and support subcontract services are those provided under a contract arrangement to a licensed PROS program. This permits PROS programs with the ability to purchase certain services that would be more effectively delivered by other providers.

ISSUES

The PROS program is funded under the Medicaid Rehabilitation Option. Proposed regulations previously issued by CMS are currently subject to a moratorium, which is in effect until April 2009. The PROS model generally comports well with the proposed regulations, but because individual PROS components are reimbursed via a monthly case payment, the program could be negatively impacted if the federal government eventually requires a different reimbursement methodology (e.g., an unbundled rate). Although the PROS program currently represents the most advanced program model for adults within New York's public mental health system, it is still considered an interim step to a person-centered, recovery-based model that provides

accountable, coordinated care. As such, it is being reviewed within the context of the larger ambulatory restructuring initiative that is currently in progress.

The PROS program was originally designed to be funded with Medicaid alone, but as implementation has progressed, the need for reimbursement of services that are not Medicaid-reimbursable (i.e., some employment services) and people who are not Medicaid-eligible has required the introduction of State aid.

For PROS programs that include clinical treatment, that component is reimbursed using an add-on payment. To the extent that rates for clinic programs are increased, the PROS clinical treatment add-on should be increased at a commensurate level to avoid a disincentive for providers' conversion.

POPULATION SERVED

Adults diagnosed with serious mental illness and with related functional disabilities

PERFORMANCE MEASURES

- Characteristics of individuals enrolled, including age, sex, language, race/ethnicity, education level, education activity, living situation (including homelessness), employment status, criminal justice status, number of arrests, number of hospitalizations, physical health issues, number of emergency and comprehensive psychiatric emergency program (CPEP) visits, substance abuse status, recipient assessment of unmet needs
- Number of programs developed and licensed
- Utilization of inpatient and outpatient services

PROGRAM

StOps Adult – **Assertive Community Treatment (ACT)**

LEGAL MANDATE/AUTHORITY

MHL Section 41.47; 14 NYCRR, Part 575; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

ACT teams provide mobile intensive treatment and support to people with psychiatric disabilities. The focus is on improving an individual's quality of life in the community and reducing the need for inpatient care through intense community-based treatment services by an interdisciplinary team of mental health professionals. Building on the successful components of the Intensive Case Management (ICM) program, the ACT program has low staff-to-outpatient ratios; 24-hour, seven-day per week availability; and flexible service dollars. Treatment is targeted toward individuals who have been not been successful in traditional forms of treatment.

ACT program service dollars support individual services aimed at meeting the basic needs of the recipients of ACT. These services may include emergency care, as well as job coaching, education, leisure-time services and others.

ISSUES

ACT is an evidence-based model of care that has case management embedded into it and meets the agency mission to provide individualized treatment and services in the community setting. Currently, ACT services are reimbursed under a monthly case payment method and are financed under the Medicaid Rehabilitation Option of Medicaid. The federal government, however, has indicated that case management services, even if not financed using the TCM option, may need to meet the interim final regulations for TCM as well as (in the case of ACT) the proposed Rehabilitation Option regulations, which are both under a moratorium until April 2009. Because the federal government has indicated that monthly case payment models may no longer be allowed, OMH may be required to redesign the payment model for ACT services.

POPULATION SERVED

Adults with severe and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation, education level, employment status, criminal justice status
- Number of individuals enrolled
- Employment rates
- Community tenure
- ACT Fidelity Scale
- Engagement in services
- Current treatment plan
- Adherence to medication

- Current medical problems
- Number of hospitalizations
- Number of emergency room visits
- Episodes of homelessness
- Number of arrests
- Number of incarcerations
- Social, interpersonal, family, self-care, and community living skills
- Behaviors dangerous to others and to self

PROGRAM

ATL Adult – **Assertive Community Treatment (ACT)**

LEGAL MANDATE/AUTHORITY

MHL Section 41.47; 14 NYCRR, Part 575; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

ACT teams provide intensive treatment and support to people with psychiatric disabilities. The focus is on improving an individual's quality of life in the community and reducing the need for inpatient care through the provision of intense, community-based treatment services using an interdisciplinary team of mental health professionals.

ACT program service dollars support individual services aimed at meeting the basic needs of the recipients of ACT. These services may include emergency care, as well as job coaching, education, leisure-time services and others.

ISSUES

ACT is an evidence-based practice mobile treatment service that includes skill-building, rehabilitation and case management services. As part of OMH's ambulatory restructuring project, consideration is being given to licensing other entities to provide mobile services similar to those provided under ACT.

Currently, ACT services are reimbursed under a monthly case payment method and are financed under the Medicaid Rehabilitation Option of Medicaid. The federal government, however, has indicated that case management services, even if not financed using the TCM option, may need to meet the interim final regulations for TCM as well as (in the case of ACT) the proposed Rehabilitation Option regulations, which are both under a moratorium until April 2009. Because the federal government has indicated that monthly case payment models may no longer be allowed, OMH may be required to redesign the payment model for ACT services.

POPULATION SERVED

Adults diagnosed with a severe mental illness and a functional impairment due to the diagnosis, whose needs have not been well met by traditional services.

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation, education level, employment status, criminal justice status
- Number of individuals enrolled
- Employment rates
- Community tenure
- ACT Fidelity Scale
- Engagement in services

- Current treatment plan
- Adherence to medication
- Current medical problems
- Number of hospitalizations
- Number of emergency room visits
- Episodes of homelessness
- Number of arrests
- Number of incarcerations
- Social, interpersonal, family, self-care, and community living skills
- Behaviors dangerous to others and to self

A.3 Residential Services

A.3.1 Residential: Family Care Services

PROGRAM

StOPs Adult – **Family Care**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.09, 31.03; 14 NYCRR Part 87

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The Family Care program provides a 24-hour supervised setting, necessary clinical services, and case management services to maximize linkages with community support services. The program serves persons who no longer require inpatient care, who cannot yet function in an independent living arrangement, and who have demonstrated a functional level appropriate for living in a natural family environment.

ISSUES

An increasing number of undocumented immigrants without SSI and Medicaid are being referred to the Family Care program. These individuals utilize a disproportional amount of Family Care resources because they are not deemed eligible for federal benefits.

Currently, OMH is exploring incentives to expand Family Care; it is OMH's lowest cost housing alternative.

POPULATION SERVED

Individuals who no longer require inpatient care but are unable to function in their own homes, large group settings, or other independent living arrangements

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of beds occupied and vacant
- Number of admissions by origin (e.g., OMH inpatient)
- Mean length of stay, median length of stay, and detail (e.g., greater than two years)
- Number of discharges, percent discharges with length of stay greater than two years, percent discharged in first 90 days, number of discharges by destination (e.g., inpatient), reasons for discharge

PROGRAM

ATL Adult – **Family Care**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.09, 31.03; 14 NYCRR, Part 87

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The Family Care program provides a 24-hour supervised setting, necessary clinical services, and case management services to maximize linkages with community support services. The program serves persons who no longer require inpatient care, who cannot yet function in an independent living arrangement, and who have demonstrated a functional level appropriate for living in a natural family environment.

ISSUES

An increasing number of undocumented immigrants without SSI and Medicaid are being referred to the Family Care program. These individuals utilize a disproportional amount of Family Care resources because they are not deemed eligible for federal benefits.

Currently, OMH is exploring incentives to expand Family Care; it is OMH's lowest cost housing alternative.

POPULATION SERVED

Individuals who no longer require inpatient care but are unable to function in their own homes, large group settings, or other independent living arrangements

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Capacity, number of beds occupied, number of beds vacant
- Number of admissions by origin (e.g., OMH inpatient)
- Mean length of stay, median length of stay, and detail (e.g., greater than two years)
- Number of discharges, percent discharges with length of stay greater than two years, percent discharged in first 90 days, number of discharges by destination (e.g., inpatient), reasons for discharge

A.3.2 Residential: Congregate and Residential Treatment and Support

PROGRAM

ATL Adult – **Congregate Treatment**

LEGAL MANDATE/AUTHORITY

MHL Sections 41.38, 41.44, 41.45; 14 NYCRR, Part 595; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Congregate Treatment programs are licensed transitional, rehabilitative residential programs that teach skills, offer support, and help residents to achieve the highest level of independence possible. These residences are single-site facilities, with private or shared bedrooms, for up to 48 individuals. Three meals a day are provided, as well as on-site rehabilitative services and 24-hour staff coverage. This level of housing is appropriate for individuals who need rehabilitative services in a non-hospital setting prior to placement in more permanent community-based housing. Presently, OMH funds and voluntary providers operate 4,648 Congregate Treatment units. The statewide average occupancy rate is 94%. All counties use a single-point-of-access (SPOA) process in matching available OMH housing to individuals with the highest needs.

Following the introduction of Congregate Treatment residences in the late 1970s, OMH developed a fiscal model in the early 1980s that included the ability to reimburse agencies for 100% of reasonable and actual property costs. While funding for Congregate Treatment and Apartment Treatment programs has not kept pace with inflation, the recent three-year model enhancement initiative (two years already implemented) is aimed at allowing housing providers to increase staff retention.

ISSUES

OMH has been undertaking a housing restructuring initiative in which the structures that govern the mental health housing assets in New York are being revisited. The ultimate goal is to ensure that individuals have access to permanent, integrated housing that is not bundled with support services. Expanding access to supported housing is therefore a key objective. While this can be achieved through the development of new resources, the restructuring of existing resources to this model is also being encouraged, particularly in the creation of mixed-use settings.

Although Congregate Treatment housing may provide a necessary setting for some individuals with special needs who require 24-hour staff availability (e.g., older adults, individuals dually diagnosed with mental illness and developmental disabilities), OMH is examining opportunities to convert Congregate Treatment programs to more flexible models that lead to permanent housing for individuals. For example, in instances where existing community residences are identified as in need of major renovations or relocation, OMH has initiated discussions with providers to consider conversion of the program to an Apartment Treatment or Supported Housing model.

The Congregate Treatment model was converted to Medicaid funding in the early 1990s using the federal Rehabilitation Option (for programs with 16 or fewer units). Proposed regulations related to funding previously issued by CMS are currently subject to a moratorium, which is in effect until April 2009. OMH's

model generally comports well with the proposed regulations, but because Congregate Treatment is reimbursed via a monthly case payment, the program could be negatively impacted if the federal government eventually requires a different reimbursement methodology (e.g., an unbundled rate).

POPULATION SERVED

Adults with a diagnosis of mental illness and an extended impairment in functioning

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of admissions, percent priority admissions from State Psychiatric Center, State-operated community residence, Article 28 inpatient unit, or the streets
- Capacity, number of beds occupied, number of beds vacant
- Mean length of stay, median length of stay, and detail (e.g., greater than two years)
- Number of discharges, percent discharges with a length of stay greater than two years, percent discharged in first 90 days, number of discharges by destination (e.g., inpatient), reasons for discharge
- Certification tier, operating certificate duration and capacity

PROGRAM

ATL Adult – **Congregate Support**

LEGAL MANDATE/AUTHORITY

MHL Sections 41.38, 41.44, 41.45; 14 NYCRR, Part 595; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Congregate Support programs are single-site residential programs that provide support designed to improve or maintain an individual's ability to live as independently as possible and eventually access generic housing. Interventions are provided in a manner consistent with the each resident's desire, tolerance and capacity to participate in services. Most individuals in these programs choose not to participate in treatment programs or have not previously benefited from them. Staff is on site 24 hours per day.

OMH has only seven programs in the Congregate Support category. These programs include four programs formerly licensed as Residential Care Center for Adults, a State-operated transitional residence, a State-operated community residence, and a 10-bed emergency housing program. OMH does not anticipate any significant increase in this program category. Presently, there are 509 Congregate Support units, with none in the pipeline. The statewide average occupancy rate is 96%.

ISSUES

Individuals diagnosed with mental illness need safe housing and supports to assist them in successfully moving toward recovery and making the transition from hospitals and other institutional settings to their communities. As such, congregate support is essential to the recovery of adults with severe and persistent mental illness and provides them with around-the-clock access to staff capable of meeting clients' multiple service needs.

POPULATION SERVED

Adults with severe and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of admissions, percent priority admissions from State Psychiatric Center, State-operated community residence, Article 28 inpatient unit, or the streets
- Capacity, number of beds occupied, number of beds vacant
- Mean length of stay, median length of stay, and detail (e.g., greater than two years)
- Number of discharges, percent discharges with a length of stay greater than two years, percent discharged in first 90 days, number of discharges by destination (e.g., inpatient), reasons for discharge
- Certification tier, operating certificate duration and capacity

PROGRAM

ATL Adult – **Community Residence/Single-Room Occupancy (CR-SRO)**

LEGAL MANDATE/AUTHORITY

MHL Sections 41.38, 41.44, 41.45; 14 NYCRR, Part 595; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

A CR-SRO provides service-enriched, licensed, extended-stay housing with on-site services for individuals who want private living units, but who have minimal self-maintenance and socialization skills. A CR-SRO is usually located in a discrete building and the living units are usually designed as studio apartments or as suites with single bedrooms around shared living spaces. The CR-SRO must maintain 24-hour front desk security and make services available (i.e., case management, life skills training, etc.). Participation in services is encouraged but not required. Individuals are encouraged to seek more independent housing, but there is no length-of-stay limit.

Each county has a SPOA process for housing that is intended to ensure that individuals with the greatest need are given priority access to the most appropriate available placements. Presently, OMH funds and voluntary providers operate 1,816 CR-SRO units. The statewide average occupancy rate is 90%. In addition, there is a pipeline to develop another 2,957 CR-SRO units.

ISSUES

Individuals diagnosed with mental illness need safe housing and supports to assist them in successfully moving toward recovery and making the transition from hospitals and other institutional settings in their communities. As such, congregate support is essential to the recovery of adults with severe and persistent mental illness and provides them with around-the-clock access to staff capable of meeting clients' multiple service needs. OMH is striving to use its resources in partnership with other State and local agencies to enable people with serious mental illness to have affordable, generic housing in the community.

Housing under development is targeted to people in priority groups, including individuals with long lengths of stay in State Psychiatric Centers and homeless persons. Much of the existing CR-SRO housing and of the CR-SRO housing in development is pursuant to the NY/NY III agreement between the New York City and State Offices of Mental Health. Moreover, OMH is encouraging providers to develop mixed-use, integrated housing, (rather than housing solely for a mental health population), utilizing low-income housing tax credits and other government capital resources.

POPULATION SERVED

Individuals diagnosed with serious and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of admissions, percent priority admissions from State Psychiatric Center, State-operated community residence, Article 28 inpatient unit, or the streets
- Capacity, number of beds occupied, number of beds vacant
- Mean length of stay, median length of stay, and detail (e.g., greater than two years)
- Number of discharges, percent discharges with a length of stay greater than two years, percent discharged in first 90 days, number of discharges by destination (e.g., inpatient), reasons for discharge
- Certification tier, operating certificate duration and capacity

PROGRAM

ATL Adult – **Apartment Treatment**

LEGAL MANDATE/AUTHORITY

MHL Sections 41.38, 41.44, 41.45; 14 NYCRR, Part 595; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Apartment Treatment programs provide a high level of support and skills training to individuals in apartment settings. This licensed program is designed to be transitional in nature, and the average length of stay is 18 months. Residents gain skills and independence, learn to use community programs and develop community support systems of friends and family. Apartment Treatment sites are usually scattered-site rental units located in the community.

Staff members work on-site with each resident, providing rehabilitative and supportive services designed to improve an individual's ability to live as independently as possible and eventually access more independent housing options. Assistance with daily living skills is emphasized to enable individuals to live independently with minimal supports. Presently, OMH funds and voluntary providers operate 4,117 Apartment Treatment units. The statewide average occupancy rate is 93%. In addition, there is a pipeline to develop another 38 Apartment Treatment units. All counties use the SPOA process in matching available OMH housing to individuals with the highest needs.

OMH has funded the Apartment Treatment housing model since the late 1970s. Once known as either intensive supportive or supportive apartments, both were combined into the broader Apartment Treatment category in 1984. The model has been largely unchanged since that time.

ISSUES

Individuals diagnosed with mental illness need safe housing and supports to assist them in successfully moving toward recovery and making the transition from hospitals and other institutional settings to their communities. As such, OMH Apartment Treatment provides people with multiple service needs with high levels of staff support, while residents also have the benefits of privacy and security of their own apartments.

Within existing resources, OMH is striving to reconfigure housing and supports to be responsive to individual and system needs; it is exploring various options for individuals to access supportive services as needed in a flexible manner without changing their housing settings. Apartment treatment gives individuals the most flexibility in receiving services without moving to new locations, better supporting recovery.

The Apartment Treatment model was converted to Medicaid funding in the early 1990s using the federal Rehabilitation Option. Proposed regulations previously issued by CMS are currently subject to a moratorium, which is in effect until April 2009. OMH's model generally comports well with the proposed regulations, but because Apartment Treatment is reimbursed via a monthly case payment, the program could be negatively impacted if the federal government requires a different reimbursement methodology (e.g., an unbundled rate).

POPULATION SERVED

Adults with a diagnosis of mental illness and an extended impairment in functioning

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of admissions, percent priority admissions from State Psychiatric Center, State-operated community residence, Article 28 inpatient unit, or the streets
- Capacity, number of beds occupied, number of beds vacant
- Mean length of stay, median length of stay, and detail (e.g., greater than two years)
- Number of discharges, percent discharges with a length of stay greater than two years, percent discharged in first 90 days, number of discharges by destination (e.g., inpatient), reasons for discharge
- Certification tier, operating certificate duration and capacity

A.3.3 Residential: State-Operated Community Residences and Residential Care Centers

PROGRAM

StOps Adult – **State-Operated Community Residence (SOCR)**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15; 14 NYCRR, Part 595; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

A SOCR is a residential program licensed by OMH and designed to provide a therapeutic living environment for residents with mental illness. The goal of this residential option is to enable persons with severe and persistent mental illness to develop skills necessary for successful reintegration into the community at a pace commensurate with their levels of functioning. The community residence program is both rehabilitative and transitional in nature and provides access to necessary treatment services. There are 531 OMH-operated SOCR beds.

ISSUES

State-operated programs provide housing for some of the most difficult-to-place individuals with serious mental illness. Residential services, which are in great demand, are essential to the mission of the agency to provide community treatment. The Supported Housing model, however, is more in keeping with the direction of the field and with what recipients say they want.

POPULATION SERVED

Persons with severe and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of admissions, percent priority admissions from State Psychiatric Center, State-operated community residence, Article 28 inpatient unit, or the streets
- Development of community living skills
- Capacity, number of beds occupied, number of beds vacant
- Mean length of stay, median length of stay, and detail (e.g., greater than two years)
- Number of discharges, percent discharges with a length of stay greater than two years, percent discharged in first 90 days, number of discharges by destination (e.g., inpatient), reasons for discharge
- Certification tier, operating certificate duration and capacity

PROGRAM

StOps Adult – **Residential Care Center for Adults (RCCA)**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15; 14 NYCRR, Part 595

BRIEF DESCRIPTION/HISTORY/BACKGROUND

An RCCA is a residential program of at least 50 beds licensed by OMH and designed to provide supervised long-term residential services for residents with chronic mental illness. The program provides on-site services such as assistance with activities of daily living, task and skill training, medication monitoring and administration, and case management. This program assists residents in accessing necessary treatment and rehabilitation services that enhance their ability to live in the community. OMH operates three RCCAs at the Buffalo, Pilgrim, and Rockland Psychiatric Centers, with a total of 367 beds.

ISSUES

Residential services are essential to the mission of the agency to provide community treatment, and residential placement opportunities are limited while demand is great. State-operated programs provide housing for some of the most difficult-to-place individuals with serious mental illness.

POPULATION SERVED

Persons with severe and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of admissions, percent priority admissions from State Psychiatric Center, State-operated community residence, Article 28 inpatient unit, or the streets
- Development of community living skills
- Capacity, number of beds occupied, number of beds vacant
- Mean length of stay, median length of stay, and detail (e.g., greater than two years)
- Number of discharges, percent discharges with a length of stay greater than two years, percent discharged in first 90 days, number of discharges by destination (e.g., inpatient), reasons for discharge
- Certification tier, operating certificate duration and capacity

A.3.4 Residential: Supported Housing Arrangements

PROGRAM

ATL Adult – **Supported/Single-Room Occupancy (SP-SRO)**

LEGAL MANDATE/AUTHORITY

MHL Sections 41.44, 41.45

BRIEF DESCRIPTION/HISTORY/BACKGROUND

An SP-SRO provides long-term or permanent housing in settings where residents can access the support services they require to live successfully in the community. There is no OMH certification or licensing process for SP-SROs, which are built in a manner consistent with local building codes. An SP-SRO can be located in a building existing solely as SP-SRO, or integrated into a building that serves other population groups. Front desk coverage is provided 24 hours per day. However, other 24-hour staffing is not required. While each SP-SRO must make services available to residents, individuals are encouraged but not required to participate. Individuals are also encouraged to seek more independent housing, but there is no length-of-stay limit. Each county has a SPOA process to ensure that individuals with the greatest need are given priority access to the most appropriate and available housing. Presently, OMH funds and voluntary providers operate 2,709 SP-SRO units. In addition, there is a pipeline to develop another 4,732 SP-SRO units.

ISSUES

Individuals diagnosed with mental illness need safe housing and supports to assist them in successfully moving toward recovery and making the transition from hospitals and other institutional settings to their communities. Within existing resources, OMH is striving to reconfigure housing and supports to be responsive to individual and system needs; it is exploring various options for individuals to access supportive services as needed in a flexible manner without changing their housing settings. An important goal is to integrate people with mental illness into their communities with affordable, generic housing,

Housing in development is targeted to people in priority groups including individuals with long lengths of stay in State Psychiatric Centers, and homeless persons. A great deal of the existing SP-SRO housing, and of the SP-SRO housing in development, is pursuant to the NY/NY III Agreement between the New York City and State Offices of Mental Health. Moreover, OMH is encouraging providers to develop mixed use, integrated housing, (rather than housing solely for a mental health population), utilizing innovative approaches (e.g., low income housing tax credits, funding from the State Division of Housing and Community Renewal [DHCR]).

POPULATION SERVED

Individuals diagnosed with serious and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of admissions, percent priority admissions from State Psychiatric Center, State-operated community residence, Article 28 inpatient unit, or the streets

- Capacity, number of beds occupied, number of beds vacant
- Mean length of stay, median length of stay, and detail (e.g., greater than two years)
- Number of discharges, percent discharges with a length of stay greater than two years, percent discharged in first 90 days, number of discharges by destination (e.g., inpatient), reasons for discharge
- Certification tier, operating certificate duration and capacity

PROGRAM

ATL Adult – **Supported Housing Rental Assistance**

LEGAL MANDATE/AUTHORITY

MHL Section 41

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Supported Housing became an OMH housing option in the late 1980s. It provided an alternative to licensed transitional housing, and also enabled individuals to live more independently in the community while they waited for Section 8 vouchers to become available. Recipients of supported housing may be able to live in the community with a minimum of staff intervention from the sponsoring provider. Others may need the provision of additional supports such as an ACT team or case management services. Many recipients are coping with co-occurring substance abuse disorders and at various stages of recovery. Presently, OMH funds and voluntary providers operate 12,268 supported housing units that currently have a 100% occupancy rate. In addition, there is a pipeline to develop an additional 3,323 supported housing units.

Supported Housing Rental Assistance

Rental assistance is provided to residents of supported housing programs through the means of a voluntary agency-administered rent stipend mechanism. Residents are expected to contribute 30% of their income toward the cost of rent and utilities in decent, moderately priced housing in the community. The difference between the residents' contributions and the actual cost of the housing is paid directly to the landlord on behalf of the program residents.

ISSUES

Individuals diagnosed with mental illness need safe housing and supports to assist them in successfully moving toward recovery and making the transition from hospitals and other institutional settings to housing in their communities. Within existing resources, OMH is striving to reconfigure housing and supports to be responsive to individual and system needs; it is exploring various options for individuals to access supportive services as needed in a flexible manner without changing their housing settings. An important goal is to integrate people with mental illness into their communities with affordable, generic housing,

Housing in development is targeted to people in priority groups, including individuals with long lengths of stay in State Psychiatric Centers, homeless persons, individuals on Assisted Outpatient Treatment (AOT) status, and people residing in adult homes. In transitioning individuals from inpatient settings to community housing, OMH considers supported housing as the most independent option.

POPULATION SERVED

Adults with severe mental illness, many of whom have co-occurring substance abuse and mental health issues

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of admissions, percent priority admissions from State Psychiatric Center, State-operated community residence, Article 28 inpatient unit, or the streets
- Capacity, number of beds occupied, number of beds vacant
- Mean length of stay, median length of stay, and detail (e.g., greater than two years)
- Number of discharges, percent discharges with a length of stay greater than two years, percent discharged in first 90 days, number of discharges by destination (e.g., inpatient), reasons for discharge
- Certification tier, operating certificate duration and capacity

PROGRAM

ATL Adult – **Supported Housing Community Services**

LEGAL MANDATE/AUTHORITY

MHL Section 41

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Supported Housing became an OMH housing option in the late 1980s. It provided an alternative to licensed transitional housing, and also enabled individuals to live more independently in the community while they waited for Section 8 vouchers to become available. Recipients of supported housing may be able to live in the community with a minimum of staff intervention from the sponsoring provider. Others may need the provision of additional supports such as an ACT team or case management services. Many recipients are coping with co-occurring substance abuse disorders and at various stages of recovery. Presently, OMH funds and voluntary providers operate 12,268 supported housing units that currently have a 100% occupancy rate. In addition, there is a pipeline to develop an additional 3,323 supported housing units.

Supported Housing Community Services

This includes all services provided to residents of supported housing programs by the supported housing agency, excluding rental assistance. The objective of the program is to assist individuals in locating and securing housing of their choice and in accessing the supports necessary to live successfully in the community. Services may include assistance with choosing housing, roommates, and furniture; providing financial assistance with purchasing apartment furnishings and with initial apartment/utility deposits; assistance with resolving roommate or landlord issues that may jeopardize the stability of the housing placement; and linking residents to a comprehensive community support system of case management, mental health and general health supports.

ISSUES

Individuals diagnosed with mental illness need safe housing and supports to assist them in successfully moving toward recovery and making the transition from hospitals and other institutional settings to their communities. Within existing resources, OMH is striving to reconfigure housing and supports to be responsive to individual and system needs; it is exploring various options for individuals to access supportive services as needed in a flexible manner without changing their housing settings. An important goal is to integrate people with mental illness into their communities with affordable, generic housing.

Housing in development is targeted to people in priority groups, including individuals with long lengths of stay in State Psychiatric Centers, homeless persons, individuals on Assisted Outpatient Treatment (AOT) status, and people residing in adult homes. In transitioning individuals from inpatient settings to community housing, OMH considers supported housing as the most independent option.

POPULATION SERVED

Adults with severe mental illness, many of whom have co-occurring substance abuse and mental health issues

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of admissions, percent priority admissions from State Psychiatric Center, State-operated community residence, Article 28 inpatient unit, or the streets
- Capacity, number of beds occupied, number of beds vacant
- Mean length of stay, median length of stay, and detail (e.g., greater than two years)
- Number of discharges, percent discharges with a length of stay greater than two years, percent discharged in first 90 days, number of discharges by destination (e.g., inpatient), reasons for discharge
- Certification tier, operating certificate duration and capacity

A.3.5 Residential: Transitional Residences

PROGRAM

StOps Adult – **Transitional Residences (TRs)**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.37, 7.37-a

BRIEF DESCRIPTION/HISTORY/BACKGROUND

A TR is a specialty State-operated community residence intended to provide short-term (average length of stay six months) residential care and treatment for inpatients who are assessed as clinically stable, but who require additional support and assistance before discharge to more independent community residences. The program is a key component within the residential care continuum allowing earlier discharge from more costly inpatient settings and providing enhanced discharge planning and assistance overcoming barriers to other community residences. Enriched staffing is maintained at the TR to provide continuous and intensive support and supervision. There are currently eight TRs with 344 beds operated on the property of the Adult Psychiatric Centers.

Individuals discharged from inpatient status who are appropriate for this level of housing alternative will reside in TRs designed to provide experiences that enable recipients to gain community living skills as well as to learn how to comply with provider residential requirements. The residential component includes 24-hour supervision, training focused on community living skills and participation in group and peer-run activities. Each resident has a treatment plan that is aimed at medication management and full participation in day programs. An individual admitted to a TR is required to complete a housing application for other residential alternatives.

ISSUES

TRs are an integral component of the State's facilities discharge planning and a critical resource to Adult Psychiatric Centers in meeting the vision of a transformed mental health system; TRs provide a discharge option for the difficult-to-place and/or long-stay inpatient who otherwise may not have an opportunity for placement. Individuals without funding entitlements who are placed in TRs may have few options of placement in other residential alternatives.

POPULATION SERVED

TRs serve high-risk individuals who may have had a forensic history or a history of violence; individuals with a history of poor treatment compliance and/or frequent re-hospitalizations and possibly meeting the criteria for AOT; persons accepted for and awaiting alternative placement and individuals who have been placed with another community living provider, but whose placement is delayed due to lack of entitlements for the person.

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of admissions, percent priority admissions from State Psychiatric Center, State-operated community residence, Article 28 inpatient unit, or the streets
- Capacity, number of beds occupied, number of beds vacant
- Mean length of stay, median length of stay, and detail (e.g., greater than two years)
- Number of discharges, percent discharges with a length of stay greater than two years, percent discharged in first 90 days, number of discharges by destination (e.g., inpatient), reasons for discharge
- Certification tier, operating certificate duration and capacity

A.4 Emergency Services

A.4.1 Emergency: Residential

PROGRAM

StOps Adult – **Crisis Residence**

LEGAL MANDATE/AUTHORITY

MHL Section 7.15l; 14 NYCRR, Parts 589, 594

BRIEF DESCRIPTION/HISTORY/BACKGROUND

This is a licensed residential, 24 hours/day, stabilization program, which provides services for acute symptom reduction and the restoration of a person's condition to pre-crisis level of functioning. These programs are time limited for persons until they achieve stabilization (generally up to 30 days). Crisis residences serve persons experiencing rapid or sudden deterioration of social and personal conditions and clinically at risk of hospitalization, but appropriate for treatment in this alternative setting.

ISSUES

The Crisis Residence program meets the agency mission to enable individuals with serious mental illness to remain in their communities through the provision of crisis services aimed at a high level of acuity and reduction in the need for hospitalization.

POPULATION SERVED

Adults with severe and persistent mental illness in crisis

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Avoidance of hospitalization
- Community tenure
- Operating certificate duration and capacity

PROGRAM

ATL Adult – **Crisis Residence**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.09; 14 NYCRR, Part 589

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The crisis residence program is a licensed residential, 24 hours/day, stabilization program, which provides services for acute symptom reduction and the restoration of an individual's condition to a pre-crisis level of functioning. These programs are time-limited for persons until they achieve stabilization (generally up to 30 days). Crisis residences serve persons experiencing rapid or sudden deterioration of social and personal conditions and clinically at risk of hospitalization, but appropriate for treatment in this alternative setting. Presently, there are six licensed crisis residence programs with 78 units.

ISSUES

Crisis Residence beds are a valuable temporary housing option for individuals diagnosed with mental illness as they offer an alternative to hospitalization. The individual's issues that are causing the crisis can be dealt with in a homelike setting instead of in a hospital, and he or she can then return to his or her own residence upon resolution of the crisis condition. This is beneficial in that it achieves the desired outcomes without using the most expensive hospital beds.

POPULATION SERVED

Adults with severe and persistent mental illness in crisis

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Licensed capacity
- Certification tier, operating certificate duration and capacity

PROGRAM

ATL Adult – **Crisis Respite Beds**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.0; 14 NYCRR, Part 589

BRIEF DESCRIPTION/HISTORY/BACKGROUND

This is a non-licensed residential program, or dedicated beds within a larger licensed program. Crisis respite beds provide a homelike environment with room, board and supervision in cases where individuals must be removed temporarily from their usual residence. Also, a number of Congregate Treatment and SRO programs have additional units available for crisis respite purposes. Although occupancy data are not available for these units, it is understood that they are very well utilized.

ISSUES

Crisis Respite beds are a valuable temporary housing option for individuals diagnosed with mental illness as they offer an alternative to hospitalization. The individual's issues that are causing the crisis can be dealt with in a homelike setting instead of in a hospital, and he or she can then return to his or her own residence. This is beneficial in that it achieves the desired outcomes without using the most expensive hospital beds.

POPULATION SERVED

Adults with severe and persistent mental illness in crisis

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Licensed capacity
- Certification tier, operating certificate duration and capacity

A.4.2 Emergency: Non-Residential

PROGRAM

ATL Adult – **Crisis Respite Services**

LEGAL MANDATE/AUTHORITY

14 NYCRR, Parts 587(c) (8); 14 NYCRR, Parts 588, 589, 590.4(a); Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The purpose of respite services is to provide relief to the primary care provider, allow situations to stabilize and prevent hospitalizations and/or longer term placements out of the home. Respite services are temporary services (not beds) provided by trained staff in the recipient's place of residence or other temporary housing arrangement. This service includes custodial care for a disabled person so that primary caregivers (family or legal guardian) may have temporary relief from care responsibilities. There are nine programs providing a maximum of 14 days of services per year per client.

ISSUES

There continues to be an increasing need for accessible community-based respite options for caregivers who provide ongoing care for their own family members diagnosed with mental illness. Approximately 66% of caregivers report physical and mental health problems as a result of associated caregiver burden; this often results in increased stress and family instability that is detrimental to the person with mental illness and family caregiver. Respite services provide direct services to recipients of services and provide caregivers will the ability to maintain ongoing care.

POPULATION SERVED

Adults with mental illness and their primary caregivers (e.g., a family member or legal guardian)

PERFORMANCE MEASURE

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation

PROGRAM

StOps Adult – **Crisis Services/Outreach**

LEGAL MANDATE/AUTHORITY

MHL Section 7.07

BRIEF DESCRIPTION/HISTORY/BACKGROUND

This program includes any activities in a non-patient setting, including a residence, to provide support for when a person's acute emotional distress requires immediate attention. The program covers expenses incurred directly for providing crisis services, including salaries, wages, professional fees, supplies, travel, and purchased and other direct expenses.

ISSUES

Crisis services are essential to the mission of providing treatment within the community and assisting persons to remain in their communities, and avoid hospitalization through support that addresses acute emotional distress. Crisis services aim to address the immediate issues by utilizing, to the extent possible, the natural supports in the individual's environment. These safety net services are an essential component of the system of care.

POPULATION SERVED

Adults with severe and persistent mental illness who are experiencing a crisis, persons with severe mental illness who are homeless

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Avoidance of hospitalization

PROGRAM

ATL Adult – **Crisis Intervention Services**

LEGAL MANDATE/AUTHORITY

14 NYCRR, Parts 587(c) (8); 14 NYCRR, Parts 588, 589, 590.4(a); Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Crisis intervention services are applicable to adults, children and adolescents. The services are intended to reduce acute symptoms and restore individuals to pre-crisis levels of functioning. Services may be provided in emergency rooms and residential settings. Services may also be provided by mobile treatment teams, generally at service recipients' residences or other natural settings (not at an inpatient or outpatient treatment setting). Services provided include screening, assessment, stabilization, triage, and/or referral to an appropriate program or programs. There are 27 programs.

ISSUES

While programs vary in their settings and approaches to delivering crisis services, all directly deliver crisis intervention services to individuals in need of them. Mobile crisis teams are able to deliver highly flexible services in natural settings and often divert hospital emergency visits or admissions.

POPULATION SERVED

Adults, adolescents, or children who may be experiencing acute psychiatric symptoms requiring immediate attention

PERFORMANCE MEASURE

Number of persons served by age, sex, race, ethnicity, diagnosis, living situation

A.4.3 Emergency: CPEP Services

PROGRAM

ATL Adult – **Comprehensive Psychiatric Emergency Programs (CPEPs)**
(State Share Partially Budgeted in DOH)

LEGAL MANDATE/AUTHORITY

MHL Sections 9.40, 41.50, 41.51; 14 NYCRR, Parts 590, 591, 596; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

CPEPs are designed to directly provide or ensure the provision of a full range of psychiatric emergency services, seven days a week, for a defined geographic area. Currently, 18 hospitals are licensed to operate 19 CPEPs statewide and provide emergency observation, evaluation, care, and treatment in accordance with the model. The four required components of service are:

1. Crisis Intervention services in the CPEP emergency room
2. Extended Observation Beds in the hospital
3. Crisis Outreach services in the community
4. Crisis Residence services in the community.

The most frequently reported discharge diagnoses of individuals who received CPEP services in 2007 were major mental illnesses such as schizophrenia, psychotic disorder, delusional disorder, and mood disorder (56%). The remaining 44% of discharge diagnoses were psychoactive substance abuse disorder (16%), personality disorder (5%), organic disorder (2%), or one of a number of other disorders (21%). Regarding age, 17% of the recipients served were less than 18 years; 34% were 18–34 years old; 44% were 35–64 years old; and 5% were 65 years old or older. Fifty-seven percent of the recipients were male and 43% female. There were 97,471 visits to CPEP emergency rooms throughout the State in the same year, with an overall monthly average of 8,123 visits.

CPEP Crisis Intervention

This licensed, hospital-based psychiatric emergency program establishes a primary entry point to the mental health system for individuals who may have a mental illness diagnosis. The program provides emergency observation, evaluation, and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits, which result in a CPEP admission and treatment plan, include a psychiatric diagnostic examination, psychosocial assessment and medication examination. Brief and full emergency visit services are Medicaid reimbursable.

CPEP Extended Observation Beds

Beds operated by the CPEP, which are usually located in or adjacent to the CPEP emergency room, are available 24 hours per day, seven days per week. Extended observation beds provide assessment and evaluation as well as a safe and comfortable environment for up to 72 hours for persons who, in the opinion of the examining physicians, require extensive evaluation, assessment, or stabilization of their acute psychiatric symptoms. Extended observation bed services are reimbursed at the inpatient psychiatric rate of the hospital where the CPEP is located. There were 10,241 admissions in 2007 to extended observation beds. This represents 10.5% of all visits to the CPEP emergency room.

CPEP Crisis Outreach

Crisis outreach is a mobile crisis intervention component of the CPEP. It offers crisis outreach and interim crisis service visits to individuals outside an emergency room setting, in the community in natural (e.g., homes), structured (e.g., residential programs), or controlled (e.g., instructional) environments. Crisis outreach service visits are emergency mental health services provided outside an emergency room that include clinical assessment and crisis intervention treatment. Interim crisis service visits are mental health services provided to individuals who are released from a CPEP for the purpose of facilitating the individual's community tenure while waiting for the first post-CPEP visit with a community-based mental health provider. CPEP crisis outreach and interim crisis service visits are Medicaid reimbursable. There were 22,246 crisis outreach services visits in 2007, with an overall monthly average of 1,854 visits, with an unduplicated number of 14,414 recipients.

CPEP Crisis Beds

CPEP crisis beds are a residential (24 hour/day) stabilization component, providing supportive services for acute symptom reduction and the restoration of an individual's condition to pre-crisis level of functioning. These programs are time limited (up to five days) for individuals until they achieve stabilization. Crisis beds serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting. CPEP crisis bed services are neither funded by OMH nor are they Medicaid-reimbursable; rather, they are purchased from the facility operating these beds.

ISSUES

Many CPEPs report loss of funds in operating the program. The issue, however, is complex and needs to be examined more closely to assess options that respond to the programmatic and fiscal concerns raised. There is considerable variation in how CPEPs implement mobile crisis outreach services. There may be opportunities to capitalize on disseminating best practices of hospitals that do this well, providing a variety of crisis services in the community that are Medicaid reimbursable on a fee-for-service basis.

Nearly all CPEPs report a steady increase in children presenting for services. As noted above, nearly two out of 10 persons served in CPEPs in 2007 were children. CPEPs that have dedicated space in which children and families can be served separately appear to serve this population better than those without such space. Options for assisting programs to respond to physical space concerns need to be explored.

POPULATION SERVED

Adults with severe and persistent mental illness and children with emotional disturbance in need of emergency psychiatric services

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- CPEP Extended Observation Beds: Total admissions, number of persons not admitted because a bed was not available, occupancy rate, time between presentation and emergency room departure for extended observation bed
- CPEP Crisis Beds: Total admissions, occupancy rate
- CPEP Crisis Outreach: Number of initial visits, number of interim visits, number of persons seen
- CPEP Crisis Intervention: Time between presentation and first contact with clinical staff; with physician; time between presentation and emergency room departure

A.5 Support Services

A.5.1 Support: Care Coordination/Case Management

PROGRAM

StOps Adult – **Care Coordination/Case Management Programs**

LEGAL MANDATE/AUTHORITY

MHL Section 41.47; 14 NYCRR, Parts 506, 575; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Intensive Case Management (ICM)

ICM services are operated under a fidelity structure defined in statute and a memorandum of understanding (MOU) between OMH and the State Department of Health (DOH).

Case Management

Case managements services are aimed at linking recipients to the service system and coordinating the various services to achieve a successful outcome. The objective of case management in a mental health system is continuity of care. Services provided may include linking, monitoring and case-specific advocacy.

Mental Health Care Monitoring Teams

In the wake of several highly publicized violent incidents involving individuals with mental illnesses, officials in the State and New York City convened a panel to examine these cases, consider opinions of experts and recommend actions to improve services and promote the safety of all New Yorkers. Among the recommendations was the establishment of special Care Monitoring Teams (CMTs) that will oversee both mental health services offered to high-needs individuals and the providers that offer high-intensity programs to improve both treatment and services. A database will be created to enable the CMTs to track care patterns so that interruptions in care or escalating need for services are better identified and addressed.

ISSUES

The federal government has issued interim final TCM regulations that are currently in moratorium until April 2009. These regulations require case management programs that are reimbursed via a monthly case payment to bill in 15-minute increments. If the final regulations are issued in their current form at the end of the moratorium, significant changes to the fiscal, documentation and program requirements of the current federal Comprehensive Medical Case Management (CCCM) services system will be necessary.

OMH is currently undergoing a review of its outpatient design and structure. The current case management system that is funded under the TCM Medicaid option may not be the configuration OMH utilizes in the future. If there is a structural change to the delivery of services currently provided by care coordination/case

management program, then alternative ways to fund this service will have to be designed, approved and implemented.

POPULATION SERVED

Individuals identified as high users of service, who have problems accessing care, are diagnosed with a serious mental illness, and whose mental illness interferes with the ability to function independently, appropriately and effectively

PERFORMANCE MEASURES

- Characteristics of the individual including age, sex, language, race/ethnicity, living situation, education level, employment status, criminal justice status
- Engagement in services
- Current treatment plan
- Number of case managers by type case management type (e.g., ICM) and auspice (e.g., State, local)
- Maximum consumer capacity
- Number of individuals under court order
- Length of stay in AOT
- Number of arrests and number of incarcerations
- Adherence to medication
- Current medical problems
- Number of hospitalizations
- Number of emergency room visits
- Episodes of homelessness
- Social, interpersonal and family skills
- Self-care and community living skills
- Behaviors dangerous to others and dangerous to self

PROGRAM

ATL Adult – **Case Management Programs**

LEGAL MANDATE/AUTHORITY

MHL Section 41.47; 14 NYCRR, Parts 506, 575; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Intensive Case Management (ICM)

The ICM program is targeted to persons with serious and persistent mental illness. The program is designed to increase community tenure by abating hospitalization through intensive interaction with the participants. Case workers assist recipients to develop and maintain viable living, working and social situations in their communities. The program is available 24 hours a day, seven days a week. Case workers have an average caseload of 12 clients.

ICM services are operated under a fidelity structure defined in statute and an MOU between OMH and DOH. The term "Services Dollars" refers to the direct costs of support provided by the county or agency for contracted management expenses.

Supportive Case Management (SCM)

SCM is a variant of the ICM program and is designed to provide services to individuals who require less support than provided under ICM. SCM services are based upon the rehabilitation-oriented case management approach aimed at helping persons with mental illness to develop and maintain viable living, working and social situations in their communities. Crisis intervention services are available 24-hours per day, seven days per week. Managers carry an average caseload of either 20 or 30 clients.

SCM services are operated under a fidelity structure defined in 18 NYCRR, Part 505, and an MOU between OMH and DOH.

Case Management

Case Management funds are used to coordinate services for individuals experiencing serious and persistent mental illness and ensure that their basic needs are met. Case managers play a major role in identifying, engaging in services, advocating for, and helping clients to find their way through complex health care and social services systems; they also provide on-site crisis intervention and skills teaching when other services are not available. These services, which include some specialized case management programs for the elderly, are an essential support for many individuals currently living in community settings.

Case management is aimed at linking the individuals to the service system and coordinating the various services necessary for successful outcomes. The objective of case management in a mental health system is continuity of care. Services provided may include linking, monitoring and case-specific advocacy.

Blended Case Management (BCM)

This program facilitates a team approach to case management services by combining the caseloads of multiple Intensive Case Managers and/or Supportive Case Managers.

Consumer Service Dollars (Non ICM/SCM/BCM/ACT)

Consumer Service Dollars (also known as "wraparound dollars") may be used for any service(s) that address a recipient's basic needs and assists him or her in living, working and/or socializing in the community. Examples of eligible expenses include food, security deposits, lodging, respite, clothing, payment of a utility bill to prevent shut-off, medical care, transportation, crisis specialist services, educational services, vocational services, leisure time activities, homemakers and escorts. Authorizations, internal controls and Consumer Service Dollar details are maintained by providers and subject to field audits and requirements that internal controls are in place to ensure that funds are used as specified.

ICM/SCM/BCM Emergency and Non-Emergency Service Dollars

Non-Emergency Service Dollars may be utilized in a manner consistent with a recipient's treatment plan. These dollars are designed to be flexible and responsible to current individual needs. These service dollars may be used to address either emergency needs or non-urgent needs. The emergency service dollars are intended to address immediate basic needs of the consumer such as transportation, medical/dental care, shelter/respite/hotel, food/meals, clothing, escort, etc. Service dollars may also be used for furnishings, utilities, tuition, job-related costs, job coaching, education, vocational services, leisure time services and others. This program does not include agency administration.

ISSUES

Approximately 25,500 adult slots are funded for ICM, SCM and BCM. The federal government has issued interim final TCM regulations that are currently in moratorium until April 2009. These regulations require case management programs reimbursed via a monthly case payment to bill in 15-minute increments. If the final regulations are issued in their current form at the end of the moratorium, significant changes to the fiscal, documentation and program requirements of the current case management services system will be necessary.

OMH is currently undergoing a review of its outpatient design and structure. The current case management system that is funded under the TCM Medicaid option may not be the configuration OMH utilizes in the future. If there is a structural change to the delivery of services currently provided by case management, alternative ways to fund this service will have to be designed, approved and implemented.

POPULATION SERVED

Individuals identified as high users of service, who have problems accessing care, are diagnosed with a serious mental illness, and whose mental illness interferes with the ability to function independently, appropriately and effectively. Individuals must meet one of the four following criteria:

PERFORMANCE MEASURES

- Characteristics of the individual including age, sex, language, race/ethnicity, living situation, education level, employment status, criminal justice status
- Engagement in services

- Current treatment plan
- Number of case managers by type case management type (e.g., ICM) and auspice (e.g., State, local)
- Maximum consumer capacity
- Number of individuals under court order
- Length of stay in AOT
- Number of arrests and number of incarcerations
- Adherence to medication
- Current medical problems
- Number of hospitalizations
- Number of emergency room visits
- Episodes of homelessness
- Social, interpersonal and family skills
- Self-care and community living skills
- Behaviors dangerous to others and dangerous to self

A.5.2 Support: Community Support Programs

PROGRAM

StOps Adult – **Community Support Programs (CSPs)**

LEGAL MANDATE/AUTHORITY

MHL Sections 41.18, 41.23, 41.47; 14 NYCRR, 575

BRIEF DESCRIPTION/HISTORY/BACKGROUND

CSPs provide a wide range of support services for individuals in community settings who have severe and persistent mental illness, including those individuals who are homeless.

On -Site Rehabilitation

This program provide program consisting of a planned combination of services provided for individuals residing in private proprietary homes for adults and SRO hotels that are designated as high priority by OMH. On-site rehabilitation services are provided by teams placed at the residential locations. The teams provide assessment and treatment services, verbal therapies, medication therapy, crisis services, case management services, special training, task and skill training and socialization activities.

Psychosocial Club

Psychosocial clubs provide a planned combination of vocational, social and other rehabilitative services and experiences that include but are not limited to prevocational day programs stressing the use of work units within the Club; transitional employment clubs with commerce and industry; evening and weekend programs stressing socialization, social support and social training; and cooperative apartment programs. Fully realized club programs operate seven days a week.

Advocacy/Support Services

Advocacy/support services are aimed at individual advocacy or systems advocacy or a combination of both. Such services include making available warm lines and hot lines, teaching daily living skills, providing representative payee services, and training in any aspect of mental health services. These services support adults and their families, as well as families of children and youth.

Persons utilizing these services consistently report high rates of satisfaction with the outcome. These services are cost-effective in promoting stability and recovery. Services provided in this category also support the goals of Public Law 102-321 and the inclusion of recipients and family members in the federal Block Grant planning process.

Mental Health Screenings

Screening assists to determine the need for services, identify major functional deficits and abilities of those in need of service, and establish service relationships between individuals and service providers.

Day Training

Day Training programs provide a planned combination of social, prevocational, vocational or educational services for persons with mental illness. Such programs are not eligible for participation in the medical assistance program in accordance with Part 579 of this title.

ISSUES

CSP programs assist the agency in meeting its core mission of providing community-based, therapeutic activities. The programs are consistent with the recommendations of the President's New Freedom Commission on Mental Health and are important in improving the quality of life.

As the concept of recovery has evolved, many of the services provided in CSP programs have the potential to be provided in the PMHP model, which is more recovery-oriented and better able to deliver more holistic care that is consistent with the needs and desires of persons accessing these services.

Programs and models that provide advocacy services, peer-oriented and family support services and the statewide organizations that support them are of high priority and essential to the agency mission. OMH is striving to invest in such approaches that are shown to be beneficial to persons with mental illness and children and youth with serious emotional disturbance.

POPULATION SERVED

Adults with severe and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Avoidance of hospitalizations
- Recipient satisfaction and quality of life
- Employment rates

PROGRAM

ATL Adult – **Community Support Programs (CSPs)**

LEGAL MANDATE/AUTHORITY

MHL Sections 41.18, 41.23, 41.47; 14 NYCRR, 575; MHL Sections 7.07, 7.15 (Geriatric Demos)

BRIEF DESCRIPTION/HISTORY/BACKGROUND AND ISSUES

Community Support Programs provide a wide range of support services for individuals in community settings who have severe and persistent mental illness, including individuals with mental illness who are homeless. These programs are funded by Community Support Services, Reinvestment and Local Assistance Regular. In addition to issues identified below for specific categories of CSP, all of these programs are being reviewed within the context of the larger ambulatory restructuring initiative that is currently in progress. Below are brief descriptions of the array of programs and, when relevant, issues these programs face.

On-site Rehabilitation

Description: The objective is to assist individuals disabled by mental illness who live in adult congregate care settings, and supervised or supported living arrangements to achieve their treatment and community living rehabilitation goals. Services include one or a combination of self-help and support interventions, community living, and academic and/or social leisure time rehabilitation training and support services.

Issues: This program is exceptionally segregated. Individuals receive supports and services within an IMD-labeled housing location.

Recreation

Description: This is a program of social, recreational, and leisure activities that are intellectually and interpersonally stimulating, but not necessarily part of a goal-based program plan.

Issues: These programs provide recreational activities that may not otherwise be available in the community.

Transportation

Description: The provision of transportation to and from facilities or resources specified in the client's individual treatment plan is s a necessary part of his or her services for mental disability.

Issues: Transportation is a significant issue throughout the State, but especially in rural and suburban locations. As OMH has added more programming into Medicaid-funded services, individuals served are able to participate more frequently in Medicaid-funded transportation programs. Remaining funds support transportation to non-Medicaid eligible services and/or individuals.

Outreach

Description: Outreach programs and services are intended to engage and/or assess individuals potentially in need of mental health services. Outreach programs and services are not crisis services. Examples of applicable services are socialization, recreation, light meals, and provision of information about mental health and social services as well as off-site, community-based assessment and screening services. These services can be provided at forensic sites, a home of a person who receives mental health services, and other residential settings, including homeless shelters, and the streets.

Issues: This service allows for activities to engage and assess individuals who may not yet be aware that mental health services are available and that they are eligible for such services.

Psychosocial Club

Description: The objective is to assist individuals disabled by mental illness to develop or reestablish a sense of self-esteem and group affiliation, and to promote their recovery from mental illness and their reintegration into a meaningful role in community life through the provision of two or more of the following: (1) self-help and empowerment interventions; (2) community living; (3) academic; (4) vocational and/or (5) social-leisure time rehabilitation, training and support services.

Issues: This program has been identified for conversion to the PROS model as PROS programs are implemented in each county. The psychosocial club services are primarily to be supported in the community rehabilitation and support component of PROS.

Advocacy/Support Services

Description: Advocacy/support services are aimed at individual advocacy or systems advocacy or a combination of both. Examples include making available warm lines and hot lines, teaching daily living skills, providing representative payee services, and training in any aspect of mental health services. The program serves adults and their families, as well as families of children and youth. Persons utilizing these services consistently report high rates of satisfaction with the outcome. These services are effective in the promotion of stability and recovery resulting in lower overall cost. Services provided in this category also support the goals of Public Law 102-321 and the inclusion of consumers and family members in the federal Block Grant planning process.

Issues: Programs and models that provide advocacy services, peer-oriented and family support services and the statewide organizations that support them are of high priority and essential to the agency mission. A portion of other services identified as "advocacy" may not as affordable during a State fiscal crisis.

Drop-in Center

Description: The objective of a Drop-in Center program is to identify and engage persons who may choose not to participate in more structured programs or who might not otherwise avail themselves of mental health services, and to provide services and supports in a manner that makes them acceptable to the individuals for whom they are intended. These programs are low demand, flexible, relatively unstructured, and responsive to individual need and circumstance.

Issues: The drop-in center program is unstructured and flexible, and it is hard to identify whether participants have a documented diagnosis of mental illness. Communities rely on these programs to provide a safe place for individuals to congregate and a setting in which individuals may socialize.

Transition Management Services

Description: Transition Management Services (discharge planning) programs provide support for improved community service linkages and timely filing of Medicaid applications for persons with serious and persistent mental illness being released from local correctional facilities.

Bridger Services

Description: Bridger services are targeted to serve individuals who are transferring from one level of mental health service to a less restrictive mental health service. The services provide supports to link service recipients to appropriate community services and to ease their transition. Specifically, the services support adult service recipients who are long-term stay patients in hospitals. Through the Bridger services, these individuals are assisted in transitioning to community placements. The net effect of these services is to support the Olmstead decision goals of serving individuals in the most integrated setting possible.

Self-Help Programs

Description: This 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 may take the form of mutual support groups and networks, or they may be more formal self-help organizations that offer specific educational, recreational, social or other program opportunities. These services are the most effective and least costly services provided in the system of care. They are offered seven days per week, 365 days per year and enhance the use of natural supports. The President's New Freedom Commission's report cites an emerging evidence base to support the effectiveness of peer support in promoting recovery. Currently, there more are more than 100 family group and 200 peer support programs in virtually every jurisdiction of the State. These programs have been given high satisfaction ratings by the individuals using them.

Multicultural Initiatives

Description: Funds support activities related to the development and operation of outreach interventions in underserved communities and to address disparities based upon culture, ethnicity, age, or gender. There is a focus on the cultural and linguistic competence of programs, management and staff. These activities span the entire service system continuum. The Surgeon General's *Report on Mental Health* points to a critical need for these types of activities among many of the growing demographic groups within our society.

Supported Education

Description: The objective of this program is to provide mental health and rehabilitation services to individuals with a serious mental illness, helping them to develop and achieve academic goals in natural and community-based educational settings.

Issues: This program has been identified for conversion to the PROS model as PROS programs are implemented in each county. The services provided by this component should complement the services of offices for students with disabilities and should not duplicate the services these programs can provide. These services are supported by the Intensive Rehabilitation component of PROS.

MICA Network

Description: The network defines a service area and target population and ensures that persons with mental illness and chemical abuse (MICA) have access to housing, treatment, peer support/self-help and alcohol/substance abuse services and case management. A MICA network includes, but is not limited to residential capacity, case management, psychosocial capacity, enhancement of treatment capacity, self-help, peer leadership/peer specialist/peer case management, linkages with drug and alcohol providers.

Issues: In the past, individuals with co-occurring disorders have had difficulty accessing services that would address both their psychiatric and substance abuse needs in one setting. The MICA network provides the opportunity for these needs to be met. An evaluation of the effectiveness of each of these programs has not taken place.

Geriatric Demo Gatekeeper

Description: The Gatekeeper Program is designed to identify at-risk older adults in the community who are not connected to the service delivery system. Gatekeepers are nontraditional referral sources who come into contact with older adults through their everyday work activities. They are specifically trained to look for signs and symptoms that may indicate that the older adult is in need of mental health assistance. The program increases public awareness of the needs of the older adults before a crisis occurs. Upon identification of an older adult in need, a gatekeeper calls upon trained staff to initiate an individual assessment and to provide a variety of in-home supportive services. The program is designed to keep at-risk seniors in their own homes, and prevent premature out-of-home placement.

Issues: This is the first of two types of Geriatric Mental Health Service Demonstration Program grants established in accordance with the Geriatric Mental Health Act of 2005, which took effect on April 1, 2006. In response to an OMH-issued request for proposals (RFP), three entities were awarded contracts for the Gatekeeper program in 2007.

Geriatric Demo Physical Health-Mental Health Integration

Description: The Physical Health-Mental Health Integration Program is designed to increase coordination and collaboration between and among physical health and mental health providers. The two integrated care models being used in this demonstration are the co-location of mental health specialists within primary care settings and improved collaboration between separate providers. Older adults benefit from the increased convenience and coordination of mental and medical disorders.

Issues: This is the second of two Geriatric Mental Health Service Demonstration Program grants established in accordance with the Geriatric Mental Health Act of 2005, which took effect on April 1, 2006. In response to an OMH-issued RFP, six applicants were awarded contracts for the Physical-Mental Health Integration program in 2007.

POPULATIONS SERVED

On-site Rehabilitation

Adults over the age of 18; there are 30 on-site rehabilitation programs funded in the State.

Recreation

There are both adult and child programs and 22 funded recreation programs in the State.

Transportation

There are 93 funded transportation programs in the State.

Outreach

There are 124 outreach programs funded in the State.

Psychosocial Club

There are 156 psychosocial club programs funded in the State.

Drop-in Center

There are 58 funded drop-in centers in the State.

Supported Education

There are 20 supported education programs funded in the State.

MICA Network

Individuals with co-occurring psychiatric and substance abuse disorders

Geriatric Demo Gatekeeper (1410) and Geriatric Demo Physical Health-Mental Health Integration

Adults 65 years of age and older whose independence, tenure, or survival in the community are in jeopardy because of behavioral health problems

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- For Geriatric Demos: Under development are also measures of the number of individuals screened, outcomes of screening (scores on screening tool, issues) and level of need identified during assessment (e.g., mental health, physical health, housing, substance abuse, financial, self-harm/suicide).

A.5.3 Support: Employment Services

PROGRAM

StOps Adult – **Employment Programs**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 41.39; 14 NYCRR, Part 25

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Sheltered Workshop/Satellite Workshop

This program provides a planned range of vocational assessment, training and sheltered work services and experiences. These include, but are not limited to, vocational assessment, prevocational training, vocational adjustment training, paid work experience (at graduated levels of difficulty), vocational counseling, open competitive placements, and permanent sheltered employment.

Client Worker Program

The Client Worker Program provides time-limited, part-time vocational exposure and experience. These experiences are located on the facility grounds. The level of support varies based on individual need and provided from daily to weekly. All 16 Adult Psychiatric facilities participate in employment programs.

ISSUES

Supported employment is a major focus of the agency mission, a key to recovery, and recommended by the President's New Freedom Commission on Mental Health. All State-operated facilities are moving toward supported employment with less or no reliance on sheltered work.

POPULATION SERVED

Adults with severe and persistent mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Employment rates, including competitive employment
- Hours worked
- Wages received

PROGRAM

ATL Adult – **Employment**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.09, 41.39; Education Law Section 1004-b; 14 NYCRR, Part 25

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Sheltered Workshop/Satellite Sheltered Workshop

The objective is to provide vocational assessment, training and paid work in a protective and non-integrated work environment for individuals diagnosed with mental illness.

Transitional Employment Placement

The objective is to strengthen an individual's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by a competitive- sector employer. These programs provide time-limited employment and on-the-job training in one or more integrated employment settings as an integral part of the individual's vocational rehabilitation growth.

Enclave in Industry

The objective is to provide vocational assessment, training and transitional or long-term paid work for individuals with severe disabilities in an integrated employment environment.

Assisted Competitive Employment

The objective is to assist individuals in choosing, finding and maintaining satisfying jobs in the competitive employment market at minimum wage or higher.

Affirmative Business/Industry

The objective is to provide vocational assessment, training, transitional or long-term paid employment, and support services for persons diagnosed with mental illness in a less restrictive/more integrated employment setting than sheltered workshops.

Work Program

The objective is to provide vocational assessment, training and transitional or long-term paid work in institutional or community job sites for individuals diagnosed with mental illness.

Ongoing Integrated Supported Employment Services

These funds are intended for ongoing job maintenance services including job coaching, employer consultation, and other relevant supports needed to assist an individual in maintaining a job placement.

ISSUES

For the purpose of understanding evolving program development, the reader is directed to Section A.2 for more details on employment-related Personalized Recovery Oriented Services (PROS) initiatives (i.e., Comprehensive PROS with Clinic, Comprehensive PROS without Clinic and Limited License PROS). As noted, in this section, PROS is a comprehensive recovery-oriented program, with integrated services for individuals diagnosed with severe and persistent mental illness.

With the exception of these PROS programs, the majority of the above programs are decades old, and largely unchanged during that time frame. Based on scientific evidence, OMH is now promoting the use of supported employment, a well-defined and widely recognized evidence-based practice that supports the recovery of individuals diagnosed with a mental illness. It is a service that promotes integration into individuals' natural environments, with income at a competitive market rate.

Underscoring a more intense emphasis on supported employment is the fact that, despite the realistic and appropriate desire of the vast majority of individuals living with a mental illness to be employed, few have attained that goal. Currently, only 15% of the working-age adults receiving services in the State public mental health system are employed. Thus, OMH is increasing the value of the needed services by targeting reductions in three programs—Sheltered Workshop/Satellite Sheltered Workshop, Enclave in Industry and Work Program—for conversion to recovery-oriented, integrated, competitive employment opportunities. The beneficial effects will include improving community integration, reducing the stigma associated with sheltered work settings, and enabling clients to work for competitive wages and raise their standard of living beyond the poverty level.

Data on the number of people served are not collected on the majority of the programs listed in this category, with the exception of Ongoing Rehabilitation and Support services. The Ongoing Rehabilitation and Support data are collected via the New York Integrated Supported Employment Report (NYISER). In 2007–2008 3,284 individuals were served.

Programs above marked with an asterisk (*) do not provide supports in fully integrated settings, which is consistent with OMH's current direction. It will be important to consider how to transition resources toward services that support integrated and competitive employment, and how we can support individuals who are interested in employment, but are not ready to participate in integrated and competitive employment.

With respect to the Affirmative Business and Industry program, the intent is to move toward funding the mental health supports required by individuals employed in these businesses. Many of the businesses under this program appear to have been ineffective in targeting funding to support work/training opportunities for individuals diagnosed with mental illness. Thus, the plan is to transition the mental health supports and funding from these programs into PROS programs as they are implemented in the counties. PROS programs assist individuals in obtaining and retaining integrated and competitive employment.

An issue specific to Ongoing Integrated Supported Employment program is that OMH does not control who participates. Rather, that decision is made by the Office of Vocational and Educational Services for Individuals with Disabilities (VESID), which provides the intensive phase of supported employment. OMH is

compelled by State law (Chapter 515) to provide the ongoing phase of supported employment to those individuals who have successfully completed the VESID-funded intensive phase.

As noted above, PROS programs are described separately. The PROS program does have a component specifically created to support individuals in integrated and competitive employment and who are working at least 15 hours in a week within a month. This component is intended to replace ongoing integrated supported employment in areas where PROS is implemented. The program also includes funding to provide employment supports that are not reimbursable by Medicaid.

As we move ahead, it will be important to consider how to stay on track with transitioning resources toward services that have been demonstrated by the science to support integrated and competitive employment effectively, and how we can support individuals who are interested in employment, but not ready to participate in integrated and competitive employment.

POPULATION SERVED

Adults diagnosed with mental illness

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Ongoing Integrated Supported Employment: Number of individuals served

B. CHILDREN AND FAMILY SERVICES PROGRAM

B.1 Inpatient Services

PROGRAM

StOps Kids – **State-Operated Inpatient Services**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.09, 9.39, 7.21, 29.29, 31.02, 31.04, 45.19; 14 NYCRR, Parts 580, 582;
Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Inpatient services are provided in hospitals that offer a full range of psychiatric and pediatric treatment, education, nursing, recreation, social work, psychology and other support services, child and family psychoeducation, and skill acquisition in an intensively supervised, structured setting. OMH has targeted a multiyear effort at community service expansion focused on keeping children at home with their families. The early signs of this reform effort have shown a 35,000-bed day reduction in the first half of the decade. In our State-operated facilities that provide intermediate and long-term care, concerted efforts have been made to focus treatment and return children home sooner, supporting their recovery and also making this resource available to more children in need.

Inpatient programs serve the most acute and clinically complex youngsters in the State, a trend that is likely to continue. Closures of general hospital inpatient psychiatric services (Article 28) for children due to financial losses resulted in OMH increasing its capacity in the absence of other willing providers.

Currently, there are six Children's Psychiatric Centers and eight inpatient Child and Adolescent units operating in adult Psychiatric Centers. These services provide a total inpatient capacity of 535 beds. State-operated inpatient services for children provide dual safety net roles depending on community needs. In the New York City and Long Island regions, OMH provides intermediate and long-term care while providing acute and intermediate care in Upstate New York. In large areas of the State, OMH provides the only access to inpatient care for children and their families.

ISSUES

OMH has implemented complex, multiyear reform efforts aimed at reducing the need for acute admissions. These efforts are predicated on a shift of resources to more responsively balance early identification and high needs children and families. While progress continues toward the shift from institutional to community-based care, OMH struggles to improve clinical capacity at State-operated Psychiatric Centers in light of growing physician shortages.

The shortage of child and adolescent psychiatrists is a major concern, and has become more acute during the first half of 2008. Several State facilities in the upstate area have been on the brink of having no child

psychiatrist on staff. In the first quarter of 2008, statewide admissions increased 8% (due to local hospital closures) and statewide discharges increased only 2%, with the net effect of raising the average daily census. Not coincidentally, increased admissions were concentrated in nine inpatient children's facilities that had adequate physician coverage, while the remaining facilities experienced an average 25% drop in admissions. OMH efforts to recruit and retain psychiatrists, while important, are not sufficient to satisfy workforce needs. Exploring the use of psychiatric nurse practitioners, physician assistants and trained pediatricians is of priority.

POPULATION SERVED

Children and adolescents ages 5–18 years of age with serious emotional disturbance

PERFORMANCE MEASURES

- Annual satisfaction as measured by youth and family satisfaction surveys
- Census, inpatient admissions by age, by referral source, length of stay
- First admissions, readmissions
- Discharges by length of stay, discharges by median length of stay
- Percent of restraint and seclusion
- Outpatient census, admission, discharges, screenings
- Clinic and day treatment outpatient fiscal

PROGRAM

ATL Kids – **Inpatient Psychiatric Unit of a General Hospital (Article 28)**
(State Share Budgeted in DOH)

LEGAL MANDATE/AUTHORITY

Public Health Law (PHL) Article 28; MHL Sections 7.09, 9.39, 7.21, 29.29, 31.02, 31.04, 45.19; 14 NYCRR, Parts 580, 582; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Inpatient services are provided in hospitals that offer a full range of psychiatric and pediatric treatment, education, nursing, recreation, social work, psychology and other support services, child and family psychoeducation, and skill acquisition in an intensively supervised, structured setting.

With the additional expansion of SPOA, community-based Waiver and Family Support, OMH anticipates a further reduction in the need for inpatient care for children. Nonetheless, the agency is cognizant that youngsters who in need of inpatient services may have additional clinical complexity, and therefore require a concomitant reinvestment of some funds into remaining inpatient services.

There are 460 children's inpatient psychiatric beds at 24 general hospitals. During peak seasonal periods, families and providers experience difficulty in accessing beds for children and adolescents with acute mental illness. Barriers to access are related to bed shortages and an increasing complexity of diagnosis, including but not limited to, increased cases of autism spectrum disorders and combined mental health and mental retardation co-occurring issues.

ISSUES

Psychiatric Units of general hospitals face several challenges, including child-specialized physician shortages, fiscal constraints, and human resources limits that hamper their ability to adequately serve the children and youth with serious emotional disturbance.

Despite the overall growth of inpatient beds within the State, there have been a number of closures or reductions in size of inpatient psychiatric units in recent years. Within the past year, two inpatient psychiatric units serving children have closed due to these issues. Most general hospitals involved in this downsizing have cited financial losses as the reason. In the future, OMH plans to work with DOH to develop an inpatient rate restructuring methodology.

POPULATION SERVED

Children and adolescents with a diagnosis of mental illness, in acute psychiatric distress, often a danger to themselves to others

PERFORMANCE MEASURES

- Number of children served by age, sex, race, ethnicity, diagnosis, living situation
- Capacity, number of admissions
- Median, mean length of stay for residents at end of year by tenure (in facility for less than one year, in facility for one year or more)
- Median, mean length of stay for discharged clients
- Number of discharges and 30- and 180-day readmission rates
- Operating certificate duration and capacity

PROGRAM

ATL Kids – **Article 31 Inpatient**
(State Share Budgeted in DOH)

LEGAL MANDATE/AUTHORITY

PHL Article 31; MH Sections 7.09, 9.39, 7.21, 29.29, 31.02, 31.04, 45.19; 14 NYCRR, Parts 580, 582; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Inpatient services are provided in hospitals that offer a full range of psychiatric and pediatric treatment, education, nursing, recreation, social work, psychology and other support services, child and family psychoeducation, and skill acquisition in an intensively supervised, structured setting.

With the additional expansion of SPOA, community-based Waiver and Family Support, OMH anticipates a further reduction in the need for inpatient care for children. Nonetheless, the agency is cognizant that youngsters in need of inpatient may have additional clinical complexity, and therefore require concomitant reinvestment of some funds into remaining inpatient services.

Currently, eight private psychiatric hospitals are licensed by OMH, providing a 455-bed capacity serving children and adolescents. During peak seasonal periods, families and providers experience difficulty in accessing beds for children and adolescents with acute mental illness. Barriers to access are related to bed shortages and an increasing complexity of diagnosis, including but not limited to, increased cases of autism spectrum disorders and combined mental health and mental retardation co-occurring issues.

ISSUES

Like psychiatric units of general hospitals, private hospitals face several challenges, including child-specialized physician shortages, fiscal constraints, and human resources limits that hamper their ability to adequately serve the children and youth with serious emotional disturbance.

Despite the overall growth of inpatient beds within the State, there have been a number of closures or reductions in size of inpatient psychiatric units in recent years. Within the past year, two inpatient psychiatric units serving children have closed due to these issues. Most hospitals involved in this downsizing have cited financial losses as the reason. In the future, OMH will work with DOH as it develops an inpatient rate restructuring methodology.

POPULATION SERVED

Children and adolescents with a diagnosis of mental illness, in acute psychiatric distress, often a danger to themselves to others

PERFORMANCE MEASURES

- Number of children served by age, sex, race, ethnicity, diagnosis, living situation
- Capacity, number of admissions
- Median, mean length of stay for residents at end of year by tenure (in facility for less than one year, in facility for one year or more)
- Median, mean length of stay for discharged clients
- Number of discharges and 30- and 180-day readmission rates
- Operating certificate duration and capacity

PROGRAM

ATL Kids – **Residential Treatment Facilities (RTFs)**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.09, 9.39, 7.21, 29.29, 31.02, 31.04 and 45.19; 14 NYCRR, Parts 580, 582

Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION

RTF's provide fully integrated, long-term inpatient mental health treatment services to children with serious emotional disturbance between the ages of 5 and 21. These services are provided in facilities licensed by OMH and accredited by the Joint Commission or the Council on Accreditation. RTFs serve youngsters with the most clinically complex needs in the State, a trend that is likely to continue. Currently, there are 19 State-licensed RTFs with 539 beds serving approximately 869 children and adolescents annually.

With the additional expansion of emerging systems of care approaches (e.g., SPOA, Waiver, Family Support with wraparound services), OMH anticipates a reduction in the need for RTF inpatient care for children. Nonetheless, the agency is cognizant that a capacity for inpatient services for youngsters that have additional clinical needs will need to be supported.

ISSUES

Established in the early 1980s, there have been significant changes in the RTF program, including movement from a residential to inpatient services model, reduction in length of stay from 24 to 15 months, reduction in the admission waiting lists from 200 to 75, and a 40-percent reduction in restraints. Currently the program offers 539 beds and operates at a 99.5% occupancy rate. A challenge for the future is geographic alignment of bed capacity with regional need. The Hudson River and New York City regions currently have the highest demand, while per-capita bed totals are higher in the Western and Central Regions.

Other issues facing inpatient services include challenges recruiting and retaining child psychiatrists and the use of psychotropic medications in children. Further, many of the RTFs are aging and need major capital investment for renovations or replacement of buildings. One important approach to examine as the transformation of care is under way is taking an identified portion of the current residential capacity and converting it to community resources for the purpose of helping to maintain children in their homes and communities and diverting future residential admissions.

POPULATION SERVED

Children and youth from the age of 5 to 22 who are identified with primary diagnoses of severe emotional disturbance and for whom there is evidence that lower intensity services would not be effective

(While OMH admission criteria include an intelligence quotient (IQ) equal to or greater than 51 based on a standardized IQ testing for the specialized mental retardation/mental health RTFs, equal to or greater than 70 for other RTFs, the agency routinely admits children below this level due to pressures to meet needs not able to be met in other systems of care.)

PERFORMANCE MEASURES

- Percent of children who get better during a treatment episode as indicated by functional impairment indicators
- Percent of children whose strengths were enhanced during a treatment episode as indicated by child strength indicators
- Percent of children whose family strengths have stabilized or were enhanced during a treatment episode as indicated by family strengths and needs indicators
- Percent of children who had needs met during a treatment episode as indicated by risk behavior indicators
- Percent of children who had needs met during a treatment episode as indicated by care intensity and organization indicators
- Satisfaction indicated yearly by youth and families
- Trends in RTF lengths of stay

B.2 Outpatient Services

PROGRAM

StOps Kids – **Clinic Services**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15; 14 NYCRR, 587, 588, 592; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Clinic treatment programs serve children with a diagnosis of emotional disturbance and provide treatment designed to reduce symptoms, improve patient functioning while maintaining children in their natural environments, support family integrity and functioning, and provide ongoing support to the children and their families during treatment. Clinic treatment programs for children provide assessment and treatment planning, verbal therapy, symptom management, health screening and referral, medication therapy, medication education, clinical support and discharge planning services. Services may also include case management and crisis intervention.

Outpatient clinics for children are operated by the Elmira, Greater Binghamton, Hutchings, Mohawk Valley, St. Lawrence, Capital District, and South Beach Psychiatric Centers and the Children's Psychiatric Centers of Western New York, Rockland, Bronx, Brooklyn, Queens and Sagamore.

ISSUES

The State-operated clinics typically serve a safety net role for children whose families are more indigent, uninsured or underinsured in comparison to their community-operated counterparts. Some children come to clinic as a step down from inpatient care while others are referred by child-serving agencies in the communities.

POPULATION SERVED

Children and adolescents ages 0 to 18, and their families, with some clinics serving more limited age ranges

PERFORMANCE MEASURES

- Number of children served by age, sex, race, ethnicity, diagnosis, living situation
- Certification tier, operating certificate duration
- Number of outpatients, admissions and terminations

PROGRAM

ATL Kids – **Clinic Services**

(State Share Partially Budgeted in DOH)

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15; 14 NYCRR, 587, 588, 592; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The State Community Mental Health Services Act was passed in 1954 and encouraged localities to establish community-based mental health programs and to apply for State reimbursement of up to 50% of the cost of these programs. The community Mental Health Movement soon followed, and clinic treatment replaced inpatient care as the centerpiece of the mental health system. In 2006, clinic treatment was significantly advanced through the *Achieving the Promise for New York's Children* initiative. Child and Family Clinic-Plus is the flagship of the children's clinic of the future. Clinic treatment programs serve children with a diagnosis of emotional disturbance and provide treatment to reduce symptoms, improve functioning while maintaining children in their natural environments, support family integrity and functioning, and provide ongoing support to the children/youth and families during treatment. Children's clinic treatment programs provide assessment and treatment planning, verbal therapy, symptom management, health screening and referral, medication therapy, medication education, clinical support, and discharge planning services. Services may also include case management and crisis intervention services.

ISSUES

Clinic treatment forms the basis of mental health treatment for children in New York State. Each year, more than 120,000 children are seen in mental health clinics. As the first line of defense for the mental health system, clinics hold the key to promoting wellness and preventing higher levels of care, and are perfectly positioned to collaborate with other child-serving agencies. Because clinic services are regarded as a key component of the public mental health system, a number of reform initiatives are in various stages of development or implementation. Currently, OMH has a major clinic restructuring project under way that will refine the scope of clinic services and develop a rational reimbursement system, including attention to uncompensated care. Another action intended to improve clinic services is the recent elimination of the Medicaid neutrality rule. It is anticipated that this action will help reduce the long waiting times for clinic treatment services and increase crisis services and after-hours care by encouraging greater access to services. The provision of increased services will also improve revenue flow to providers. It should be noted that federal financing pressures and pending regulations related to the TCM state plan option will affect the incidental case management provided within clinics, and the Upper Payment Limit regulations will impact the clinic rate-setting and payment structure.

POPULATION SERVED

Children and adolescents between ages 0 to 18 with emotional disturbance

PERFORMANCE MEASURES

- Number of children served by age, sex, race, ethnicity, diagnosis, living situation, educational attainment (at or above grade level), juvenile justice status
- Clinic treatment admissions and discharges
- Certification tier, operating certificate duration

PROGRAM

ATL Kids – **Clinic-Plus Clinic Treatment, Outreach and Screening**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15; 14 NYCRR, 587, 588, 592; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The State Community Mental Health Services Act was passed in 1954 and encouraged localities to establish community-based mental health programs and to apply for state reimbursement of up to 50% of the cost of these programs. The community Mental Health Movement soon followed, and clinic treatment replaced inpatient care as the centerpiece of the mental health system. In 2006, Clinic treatment was significantly advanced through the Achieving the Promise for New York's Children initiative. Child and Family Clinic-Plus is the flagship of the children's clinic of the future.

Children and Youth Clinic Treatment

Clinic treatment programs serve children with a diagnosis of emotional disturbance and provide treatment designed to reduce symptoms, improve functioning while maintaining children in their natural environments, support family integrity and functioning and provide ongoing support to the children/youth and their families during treatment. Clinic treatment programs for children provide assessment and treatment planning, verbal therapy, symptom management, health screening and referral, medication therapy, medication education, clinical support services and discharge planning. Services may also include case management and crisis intervention services.

Clinic-Plus, authorized by the 2006–2007 enacted budget, represents an enhancement of traditional clinic services such that the Clinic-Plus programs adopt a public health approach. The approach enables earlier identification of children with emotional disturbance as well as earlier intervention. Clinic-Plus offers an integrated package of family engagement, broad-based screening, comprehensive assessment, in-home treatment and evidence-based treatment. Children who screen positive have access to a comprehensive assessment that utilizes evidence-based tools and scales. Children who require treatment will have increased access to services as a result of an expansion of clinic services. Treatment consists of evidence-based approaches both in the clinic and in the home.

Child and Family Clinic-Plus Outreach and Screening Service

Outreach and screening services are conducted by designated Clinic-Plus clinic. This is a broad-based approach to identify children and adolescents with emotional disturbances and to intervene at the earliest possible opportunity. Screenings are conducted in community settings and only with the prior written consent of parents or guardians.

ISSUES

Clinic treatment forms the basis of mental health treatment for children in New York State. Each year, more than 120,000 children are seen in mental health clinics. Clinics are the first line of defense for the mental health system, hold the key to preventing higher levels of care, and are perfectly positioned to collaborate with other child-serving agencies; clinics are integral to the core mission of OMH.

Because clinic services are regarded as a key component of the public mental health system, a number of reform initiatives are in various stages of development or implementation. Currently, OMH has a major clinic restructuring project under way that will refine the scope of clinic services and develop a rational reimbursement system, including attention to uncompensated care. Another action intended to improve clinic services is the recent elimination of the Medicaid neutrality rule. It is anticipated that this action will help reduce the long waiting times for clinic treatment services and increase crisis services and after-hours care by encouraging greater access to services. The provision of increased services will also improve revenue flow to providers. It should be noted that federal financing pressures and pending regulations related to the TCM state plan option will affect the incidental case management provided within clinics, and the Upper Payment Limit regulations will impact the clinic rate-setting and payment structure.

Focused on accountability, best practices, and cultural competence, Clinic-Plus is essential to OMH's core mission. Clinic-Plus components directly address four goals of the OMH Strategic Plan: community-based screening, evidence-based treatment and family involvement, and clinic quality improvement participation, and clinic expansion. Collectively, these goals assist in promoting health and well-being, producing positive outcomes for children and families, providing continuous quality improvement, and expanding access to services. These components and the Clinic-Plus fiscal model, which includes incentives to providers, have begun to address the fiscal challenges faced by clinics as discussed above.

Originally, the fiscal model for Clinic-Plus provided Medicaid would cover the rate enhancement for in-home treatment and comprehensive assessment of children receiving Medicaid. Because the State Plan Amendment is pending federal review, State aid is covering these enhancements. Clinic-Plus is still in its implementation phase, with 66 provider agencies currently licensed, and 15 more to be licensed before the end of 2008. OMH has received many requests to expand Clinic-Plus. When fully operational, Clinic-Plus will have the annual capacity to screen up to 260,000 children, admit an additional 20,000 children, assess 70,000 children, and provide in-home treatment for 16,000 children.

POPULATION SERVED

Children and adolescents ages 0 to 18

PERFORMANCE MEASURES

- Number of children served by age, sex, race, ethnicity, diagnosis, living situation, educational attainment (at or above grade level), juvenile justice status
- Number of new collaborations with schools, preventive services agencies, primary care practices and early childhood programs
- Percent of screening target achieved and percent of assessment target achieved
- Percent of admissions target achieved and percent of children receiving in-home treatment target achieved
- Number of consent letters sent and signed
- Length of time between each component of Clinic-Plus services
- Number of children discharged with treatment successfully completed
- Percent of Article 31 Medicaid clinic services delivered on weekends and during the evening
- Medication management indicators

PROGRAM

StOps – **Evidence-Based Treatment Dissemination Center (EBP-DC)**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15

BRIEF DESCRIPTION/HISTORY/BACKGROUND

To address the disparity between scientifically proven research finding and clinical practice, states are beginning to incorporate evidence-based treatment (EBT) into state-level training and dissemination initiatives. In 2005, OMH began a broad EBT training and dissemination program. EBT-DC is an *Achieving the Promise Initiative,* which is a highly integrated series of initiatives that resulted from coordination in reform, policy and funding. The initiative is designed to improve the quality of clinical care for youth and families through statewide training, consultation and support in the use of EBTs. This initiative was driven by various scientific, family advocacy and community provider imperatives and directly responds to the many issues and challenges presented in the President's New Freedom Commission report. EBT-DC's ultimate goal is to "retool the workforce" in public mental health services for children.

The EBT-DC is a two-phase approach which consists of an intensive three-day training workshop taught by the national experts who developed the treatments followed by a full year of biweekly phone consultations conducted by an expert clinical consultation team based at Columbia University. These trainings are offered for two years. Between 2006 and 2007), the EBT-DC program focused on the dissemination of cognitive behavioral treatments (CBTs) for trauma and depression. A total of 780 clinicians have been trained in the above treatments. Presently, EBT-DC has begun is training for disruptive behavior disorders.

ISSUES

To date, nearly 400 clinicians have been trained in trauma and depression CBT and more than 400 clinicians and supervisors have registered for this year's trainings on disruptive behavior disorders (scheduled through November 2008), and a waiting list is active. Contracts have been established with national expert trainers and staff of clinical consultants. While participating agencies are largely outpatient clinic programs, day treatment and residential treatment clinical program staffs also participate. Most clinicians who have been participating in the trainings primarily have a social work professional background. Clinic-Plus has the potential to impact the lives of 40,000 children and families annually.

POPULATION SERVED

Clinicians and supervisors annually from State- and locally operated programs

PERFORMANCE MEASURES/PROGRAM EVALUATION AND RESEARCH

- Assessing the impact of the training on clinician knowledge and skills in the practice of the evidenced based treatment
- Determining the feasibility of the training and consultation process
- Identifying barriers to the large-scale dissemination of evidence-based practices

PROGRAM

StOps Kids – **Day Treatment**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15; 14 NYCRR, Parts 587, 588, 592; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Day treatment services for children and adolescents provide intensive services intended to maximize each child or adolescent's adjustment to academic settings. State-operated day treatment programs either facilitate transition out of the hospital or help to prevent hospitalization. Educational services are integrated within the program and coordinated through the local education agency. The day treatment program is characterized by a blend of mental health and education services provided in a fully integrated program, including special education in small classroom settings to emphasize individualized instruction, individual and group counseling, family services such as family counseling, crisis intervention, interpersonal skill development, task and skill development, case management and behavior modification. Children and adolescents receive psychiatric assessment, medication therapy and monitoring by an on-site psychiatrist. Children and adolescents usually come to day treatment services after being identified by their school district Committees on Special Education (CSE).

The introduction of Intensive Day Treatments (IDT), a program to quickly return children or adolescents to their home schools with staff support is the most significant change in State-operated day treatment programs. Intensive academic and mental health supports are combined with planned rapid reintroduction to the home school. All IDTs are State-operated and demonstrate marked improvement in both clinical and academic outcomes.

POPULATION SERVED

Children and adolescents with the diagnosis indicating a serious emotional disturbance, with either an extended impairment in functioning due to emotional disturbance or a current impairment in functioning with severe symptoms

PERFORMANCE MEASURES

- With limited data existing for measuring day treatment, new measures to be included in the current ambulatory restructuring project
- Satisfaction of youth and family as measured by the annual youth and family satisfaction surveys

PROGRAM

ATL Kids – **Day Treatment**

(State Share Partially Budgeted in DOH)

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15; NYCRR, Parts 587, 588, 592; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Day treatment services for children and adolescents provide intensive, non-residential services. Day treatment programs have been operated in collaboration with the State Education Department (SED) since the late 1970s. The program is characterized by a blend of mental health and special education services provided in a fully integrated program. Typically, these programs include special education in small classes with an emphasis on individualized instruction, individual and group counseling, family services such as family counseling, crisis intervention, interpersonal skill development, task and skill development, case management and behavior modification. Children and adolescents receive psychiatric assessment, medication therapy and monitoring by an on-site psychiatrist. Children and adolescents usually come to day treatment services after being identified by their school district CSEs. OMH currently licenses 40 programs serving approximately 2,413 children and adolescents.

ISSUES

Predicated on improving treatment quality and more integrated care, children's day treatment services are currently being reviewed by OMH and providers through the outpatient ambulatory restructuring project. Funding is currently based on bundled rates for full, half or brief day visits with family/guardian visits, home visits and crisis visits also reimbursed. Since Comprehensive Outpatient Programs (COPS) funding and bundling rates will no longer be permitted under new federal rules, changes in billing methods and mechanics are under consideration. An increasing number of providers report that current reimbursement rates are insufficient to meet expenses, and a number of individual programs, particularly in the downstate area, have closed in recent years.

POPULATION SERVED

Children and adolescents with a serious emotional disturbance, with either an extended impairment in functioning due to emotional disturbance or a current impairment in functioning with severe symptoms who also require a special education setting

PERFORMANCE MEASURES

- With limited data existing for measuring day treatment, new measures to be included in the current ambulatory restructuring project
- Satisfaction of youth and family as measured by the annual youth and family satisfaction surveys

B.3 Residential Services

PROGRAM

ATL Kids – **Family-Based Treatment (FBT)**

LEGAL MANDATE/AUTHORITY

MHL Sections 7, 31; 14 NYCRR, Parts 593 and 594; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The FBT program, which originated in 1989, provides care and treatment to children and adolescents with serious emotional disturbance who benefit from treatment in a smaller, more intensive family setting. Children needing rehabilitative services, as deemed by a physician, are placed in the home of professionally trained parents, who work collaboratively with youth and their families to address mental health related barriers and to support the development of individual goals. Professional parents are supported by other FBT staff, including a trainer, family specialists, a family counselor, cluster meetings and respite services. Children served successfully in FBT historically have been less than 12 years of age. This program serves as a bridge to the community for many youth leaving inpatient care or for those who are able to remain in the community, but require more intensive services than home-based interventions.

ISSUES

With the introduction of the Waiver, FBT programs have received significantly fewer referrals of younger children and have struggled to meet the typically more complex needs of older youth. Further, an increasing number of youth in FBT have limited family support to assist with treatment and discharge planning. Limited options also exist to assist youth in need of continuing intensive mental health services to move into the community or to adult services when they reach the age of 18.

The federal Office of Inspector General (OIG) is reviewing Community Residence Rehabilitation Services, including FBT programs in selected states, among them New York. The OIG audit will be forthcoming.

POPULATION SERVED

Children between the ages of 5 and 18 who require multi-agency intervention and involvement and who have been diagnosed with mental illness that interferes with social and educational functioning, family and/or peer relationships, and serious and persistent symptoms of cognitive, affective and personality disorders

PERFORMANCE MEASURES

- Percent of children who got better during a treatment episode as indicated by symptom indicators
- Percent of children who get better during a treatment episode as indicated by functional impairment indicators
- Percent of children whose strengths were enhanced during a treatment episode as indicated by child strength indicators
- Percent of children whose family strengths have stabilized or were enhanced during a treatment episode as indicated by family strengths and needs indicators

- Percent of children who had needs met during a treatment episode as indicated by risk behavior indicators
- Percent of children who had needs met during a treatment episode as indicated by care intensity and organization indicators
- Satisfaction indicated yearly by youth and families from youth and family satisfaction surveys

PROGRAM

ATL Kids – **Teaching Family Home**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.09, 7.15, 41.38; SSA 1905(a); Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The TFH program provides an individually tailored residential environment for children and adolescents with serious emotional disturbance. This program utilizes carefully selected and trained parents and child care staff who provide services, support and education for up to four youth within the TFH. The teaching parents are responsible for the social education of the children and the implementation of a service plan developed in conjunction with the family and clinical service provider. The focus is to provide the necessary supports and teaching to ensure that the youth will be able to live successfully in a family or independent community setting, to achieve success in school or vocational activities, and to live productively in the community. There are four programs in the State, with a capacity of 16 beds.

ISSUES

Developed in the 1980s, the TFH program has moved to an individualized structure based upon geographic and regional practices. These changes have challenged the fiscal feasibility of the program as exampled by 50% of the program sites struggling to recruit and retain teaching couples and to address budget shortfalls. The program in the Hudson River region is in the process of closing the last of three homes in Schenectady, Sullivan and Ulster counties. OMH is working with the Field Offices and the counties to ensure that the needs of their region are adequately met—either through the continuance of these types of programs or the transition to other types of residential services. Long Island has reported success in utilizing TFHs and they have been included in the recent RFP for children's residential beds.

POPULATION SERVED

Children between the ages of five and 18 who require multi-agency intervention and involvement and who have designated mental illness diagnosis; substantial problems in social functioning due to a serious emotional disturbance; serious problems in family relationships, peer-social interaction or school performance; and serious and persistent symptoms of cognitive, affective and personality disorders

PERFORMANCE MEASURES

- Percent of children who got better during a treatment episode as indicated by symptom indicators
- Percent of children who get better during a treatment episode as indicated by functional impairment
- Percent of children whose strengths were enhanced during a treatment episode as indicated by child strength indicators
- Percent of children whose family strengths have stabilized or were enhanced during a treatment episode as indicated by family strengths and needs indicators
- Percent of children who had needs met during a treatment episode as indicated by risk behaviors
- Percent of children who had needs met during a treatment episode as indicated by care intensity and organization indicators
- Satisfaction indicated yearly by youth and families from youth and family satisfaction surveys

PROGRAM

StOps Kids – **Community Residence**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15, 41.37; 14 NYCRR, Parts 593, 594; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

This program is affiliated with the children's State-operated Psychiatric Centers, staffed by State employees and provides an environment supportive of the clinical treatment plans of eight children and adolescents with serious emotional disturbance who are unable to live at home due to their treatment needs. The program focuses on helping youth and families to develop pro-social skills and to live successfully and productively in the community by progressing toward their goals relating to education, employment and other normative life roles. Emphasizing integration into the community, this program develops natural supports and collaborates with other providers. There are currently 16 beds in operation.

ISSUES

This program serves as a bridge to the community for many youth leaving inpatient care or for those who are able to remain in the community, but require more intensive options than the home-based interventions. These community residences provide a needed alternative to many children and adolescents who would otherwise be accessing hospitals and inpatient units without necessarily requiring that level of care.

POPULATION SERVED

Youth who have least 5 years of age but not older than 18 who require multi-agency intervention and involvement and who have a designated mental illness that results in problems with social and educational functioning, family and/or peer relationships, and serious and persistent symptoms of cognitive, affective and personality disorders

PERFORMANCE MEASURES

- Percent of children who got better during a treatment episode as indicated by symptom indicators
- Percent of children who get better during a treatment episode as indicated by functional impairment indicators
- Percent of children whose strengths were enhanced during a treatment episode as indicated by child strength indicators
- Percent of children whose family strengths have stabilized or were enhanced during a treatment episode as indicated by family strengths and needs indicators
- Percent of children who had needs met during a treatment episode as indicated by risk behavior indicators
- Percent of children who had needs met during a treatment episode as indicated by care intensity and organization indicators
- Satisfaction indicated yearly by youth and families from youth and family satisfaction surveys

PROGRAM

ATL Kids – **Community Residence**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15, 41.37, 41.38; 14 NYCRR, Parts 593, 594; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION

The Children's Community Residence Program, which started in 1990, provides a therapeutic environment for up to eight children and adolescents with serious emotional disturbance who are unable to live at home due to their treatment needs. The program helps youth and families develop pro-social skills and to live successfully and productively in their communities by working toward goals relating to education, employment and other normative life roles. Emphasizing integration in the community, this program develops natural supports and collaborates with other providers.

The program is in the process of expanding to accommodate community needs with several sites in development and others soon to be awarded via an RFP process. Currently, there are 304 community residence beds in operation by private nonprofit providers, with an additional 120 beds in various stages of development, and 76 beds currently being bid in an RFP process. Eight beds in NYC are still to be awarded via a future RFP.

ISSUES

For a number of years OMH has been working around a policy framework to keep kids at home, and in their schools and communities wherever possible. In this regard, it appears that a number of programmatic initiatives have begun to have broad systemic effect. A growing number of community residence providers report an increase in vacancy rates, as evidenced by a marked increase in requests for contingency funds; some sites remain undeveloped. It is anticipated that community residences will increasingly be targeted to serving older adolescents and assisting them in building independent living skills. Administrative problems relating to the transition between federal funding streams and SSI funding is resulting in denials of critical SSI funding. Additionally, as noted elsewhere, the federal OIG is reviewing Community Residence Rehabilitation Services in selected states, among them New York. The OIG audit will be forthcoming.

POPULATION SERVED

Children from age 5 to youth before age 18, who require multi-agency intervention and involvement and who have designated mental illness that results in problems with social and educational functioning, family and/or peer relationships, and serious and persistent symptoms of cognitive, affective and personality disorders.

PERFORMANCE MEASURES

- Percent of children who got better during a treatment episode as indicated by symptom indicators
- Percent of children who get better during a treatment episode as indicated by functional impairment indicators
- Percent of children whose strengths were enhanced during a treatment episode as indicated by child strength indicators

B.4 Emergency Services

PROGRAM

StOps Kids – **Crisis Residence**

LEGAL MANDATE/AUTHORITY

14 NYCRR, Parts 587, 593 and 594, 594.12

BRIEF DESCRIPTION/HISTORY/BACKGROUND

This program at the Greater Binghamton Health Center provides a short-term (1–21 day) crisis residential option for adolescents experiencing a crisis threatening their psychiatric stability. The program provides crisis supports to the youth, the family and/or to the service provider. The goals of the program are to stabilize the crisis situation; support the family's or service provider's efforts to maintain the adolescent in his or her current residence, and to decrease the inappropriate use of an inpatient facility or other out-of-home placements. The crisis residence, with a capacity of six beds, works with the family and/or service provider to develop strategies to avert future crisis situations.

ISSUES

While the programmatic intent of crisis respite and residences is closely aligned with the core mission of OMH to keep children with their families in their community, severe limitations in the current regulatory and funding model prohibit expansion.

POPULATION SERVED

Youth at least 5 years of age, but not older than 18, who have a mental illness diagnosis; substantial problems in social functioning due to a serious emotional disturbance within the past year; serious problems in family relationships, peer/social interaction or school performance, serious and persistent symptoms of cognitive, affective or personality disorders; and at risk of psychiatric hospitalization without the intervention of crisis residence services.

PERFORMANCE MEASURES

- Percent of children who got better during a treatment episode as indicated by symptom indicators
- Percent of children who get better during a treatment episode as indicated by functional impairment indicators
- Percent of children whose strengths were enhanced during a treatment episode as indicated by child strength indicators
- Percent of children whose family strengths have stabilized or were enhanced during a treatment episode as indicated by family strengths and needs indicators
- Percent of children who had needs met during a treatment episode as indicated by risk behavior indicators
- Percent of children who had needs met during a treatment episode as indicated by care intensity and organization indicators
- Satisfaction indicated yearly by youth and families from youth and family satisfaction surveys

PROGRAM

ATL Kids – **Home-Based Crisis Intervention**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15 14; NYCRR, Parts 507, 593, 594

BRIEF DESCRIPTION/HISTORY/BACKGROUND

HBCI is a clinically oriented program that provides in-home crisis services to families (natural, adoptive, or foster) where a child is at imminent risk of psychiatric hospitalization. Linked to emergency rooms, these programs provide intensive in-home intervention from four to six weeks with the goals of admission diversion, teaching problem-solving skills to the family, and linking the child and family with community-based resources and supports. A counselor is available seven days a week, 24 hours a day to work with the child and family. There are currently 20 HBCI programs with a statewide capacity of 162 slots.

ISSUES

HBCI is a highly cost-effective program. The intensity of services and family-driven, child-directed nature of the program produce excellent results for families (child remains at home) and for the mental health system in that higher levels of care are avoided. The program, however, is solely funded with State aid and as a result is available in limited areas and at a low capacity. Options for expansion through inclusion in billable services will be explored within the clinic and ambulatory restructuring projects.

POPULATION SERVED

Youth ages 5 to 17 who are living at home with their natural, foster, or adoptive families, and experiencing a psychiatric crisis that would require hospitalization without immediate intensive intervention.

(To participate, the child and his/her parents must be willing to receive in-home crisis services. Also served are children who may have had previous or ongoing contact with the juvenile justice system, the special education system, the foster care and/or the mental health system.)

PERFORMANCE MEASURES

- Percent of children who got better during a treatment episode as indicated by symptom indicators
- Percent of children who get better during a treatment episode as indicated by functional impairment
- Percent of children whose strengths were enhanced during a treatment episode as indicated by child strength indicators
- Percent of children whose family strengths have stabilized or were enhanced during a treatment episode as indicated by family strengths and needs indicators
- Percent of children who had needs met during a treatment episode as indicated by risk behavior indicators
- Percent of children who had needs met during a treatment episode as indicated by care intensity and organization indicators
- Satisfaction indicated yearly by youth and families from youth and family satisfaction surveys

PROGRAM

ATL Kids – **Comprehensive Psychiatric Emergency Program (CPEP): CPEP Crisis Intervention, Extended Observation Beds, Crisis Outreach, Crisis Residence (State Share Partially Budgeted in DOH)**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15, 9.40; 14 NYCRR, Parts 590, 593, 594; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

CPEP began shortly before 1990 to address the need for a more coordinated and comprehensive emergency service system. CPEPs provide appropriate responses at the point of psychiatric crisis in the emergency room to avoid unnecessary admissions and/or discharges. Each CPEP is responsible for providing four program components:

- Crisis intervention services in the CPEP emergency room: Triage and evaluation, including both medical and psychiatric evaluation, stabilization and referral to appropriate disposition
- Extended observation beds in the hospital: Extended observation, assessment and treatment for up to 72 hours
- Crisis outreach services: Initial crisis intervention and interim crisis services in the community
- Crisis residence: Temporary respite and support in the community

There are 19 programs serving adults, as well as children and adolescents. Two programs in New York City serve only children. The statewide capacity of short-term observation beds is 83.

ISSUES

While CPEPs provide assistance with the stabilization of urgent psychiatric crisis for children and families, the service is largely an adult model that is not configured to connect well with the larger children's system of care. This model is also relatively high cost in comparison with crisis diversion and HBCI.

POPULATION SERVED

Children (and adults) with a major mental illness or serious emotional disturbance, those diagnosed with psychoactive substance abuse, and those with dual diagnoses of substance abuse and mental illness

PERFORMANCE MEASURES

- Number of children served by age, sex, race, ethnicity, diagnosis, living situation
- CPEP Extended Observation Beds: Total admissions, number of persons not admitted because a bed was not available, occupancy rate, time between presentation and emergency room departure for extended observation bed
- CPEP Crisis Beds: Total admissions, occupancy rate
- CPEP Crisis Outreach: Number of initial visits, number of interim visits, number of persons seen
- CPEP Crisis Intervention: Time between presentation and first contact with clinical staff; with physician; time between presentation and emergency room departure

B.5 Support Services

B.5.1 Support: Care Coordination (Case Management/RTF Coordinators)

PROGRAM

ATL Kids – **Residential Treatment Facility Transition Coordinator**

LEGAL MANDATE/AUTHORITY

MHL Sections 31.26, 9.51; 14 NYCRR, Part 584; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

In 2001, OMH established Transition Coordinator positions within each RTF to ensure family engagement as well as timely, successful discharges of children and adolescents. Transition Coordinators maintain relatively small caseloads of approximately 12 clients in the RTF and three to four children in post-discharge follow-up. The Transition Coordinators provide direct support and connect the child and family with the resources in their home community. There are 45 Transition Coordinators serving 650–700 children and families yearly.

ISSUES

Transition Coordinators are a vehicle to keep children and families connected while the child receives treatment out of the home. Family support—at what can be a very stressful times—is essential for treatment success. Further, their ability to be in the field, connecting the child and family to resources in their communities has resulted in more effective and timely discharges from RTFs. As with all programs that are constructed under the case management rubric, pending federal regulations regarding TCM will need to be monitored for potential impact on this service.

POPULATION SERVED

Children with serious emotional disturbance and their families currently being served in RTFs or having been recently discharged from them

PERFORMANCE MEASURES

- Percent of children who got better during a treatment episode as indicated by symptoms
- Percent of children who get better during a treatment episode as indicated by functional impairment
- Percent of children whose strengths were enhanced during a treatment episode as indicated by child strength indicators
- Percent of children whose family strengths have stabilized or were enhanced during a treatment episode as indicated by family strengths and needs indicators
- Percent of children who had needs met during a treatment episode as indicated by risk behaviors
- Percent of children who had needs met during a treatment episode as indicated by care intensity and organization indicators
- Satisfaction indicated yearly by youth and families from youth and family satisfaction surveys

PROGRAM

StOps Kids – **Intensive Case Management**

LEGAL MANDATE/AUTHORITY

MHL 7.07, 7.17; 14 NYCRR, Part 506; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

ICM assists children and youth with serious emotional disturbance and their families residing in the community. Well-qualified and specially trained professionals assess and coordinate the supports and services necessary to help children and adolescents live successfully at home and in the communities. The Intensive Case Manager works with the child's family, and coordinates with teachers and other helping professionals. Services are based on the specific needs and desires of the child and his or her family and are made available for as long as necessary. Caseloads include 12 children and the expectation is that four contacts per month are made at a minimum.

ISSUES

Case management services have been highly effective in maintaining children with their families, in their homes and communities. There are considerable issues with the federal Medicaid regulations regarding TCM and in the underlying assumptions of Medicaid eligibility upon which the ICM/SCM programs have been built. In some areas of the State programs are unable to reach the percentage of Medicaid youngsters served. This is largely a result of Medicaid eligibility not being an effective proxy for serious mental illness in children as it often is in adults. The agency's ambulatory restructuring project will be reviewing and recommending changes in case management services for children.

POPULATION SERVED

Children who at a minimum have a history of psychiatric hospitalization within the last two years with existing risk of re-hospitalization, recent hospitalization of greater than 90 days in duration, history of crisis-related contacts with the mental health system, history of out-of-home placements due to psychiatric impairment, or history or treatment in mental health services that are deemed ineffective as demonstrated by the likelihood of impending admission to psychiatric inpatient treatment or a history of unplanned movement out of treatment

PERFORMANCE MEASURES

- Percent of children who got better during a treatment episode as indicated by symptom indicators
- Percent of children who get better during a treatment episode as indicated by functional impairment
- Percent of children whose strengths were enhanced during a treatment episode as indicated by child strength indicators
- Percent of children whose family strengths have stabilized or were enhanced during a treatment episode as indicated by family strengths and needs indicators
- Percent of children who had needs met during a treatment episode as indicated by risk behaviors
- Percent of children who had needs met during a treatment episode as indicated by care intensity and organization indicators
- Satisfaction indicated yearly by youth and families from youth and family satisfaction surveys

PROGRAM

ATL Kids – **Case Management Programs**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15; 14 NYCRR, Part 506; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

ICM

The ICM program assists children and youth with serious emotional disturbance and their families residing in the community. Well-qualified and specially trained professionals assess and coordinate the supports and services necessary to help children and adolescents live successfully at home and in the community. The Intensive Case Manager works with the child's family, and coordinates with teachers and other helping professionals. Services are based on the specific needs and desires of the child and his or her family and are made available for as long as necessary. Caseloads include 12 children and the expectation is that four contacts per month are made at a minimum. There are 217 Intensive Case Managers covering 2,608 slots. The term "Services Dollars" refers to the direct costs of support provided by the county or agency for contracted management expenses.

SCM

The SCM program provides ongoing support to children and is similar to ICM, but less intense. Supportive Case Managers are required to have two or more contacts with the child/family per month and have caseloads of 20 families at a time. There are 78 Supportive Case Managers and 1,560 slots.

Case Management

Case Management funds are used to coordinate services for children with serious emotional disturbance and to ensure that their basic needs are met. Case managers play a major role in identifying, engaging n services, advocating for, and helping children and families find their way through complex health care and social services systems, and doing on-site crisis intervention and skills teaching when other services are not available. These services are an essential support for many children and their families. Activities are aimed at linking the child and family to the service system and coordinating the various services to achieve successful outcomes. The objective of case management in a mental health system is continuity of care. Services provided may include linking, monitoring and case-specific advocacy.

BCM

BCM is a team approach to case management services by combining the caseloads of multiple Intensive Case Managers and/or Supportive Case Managers.

ISSUES

Case management services have been highly effective in maintaining children with their families, in their homes and communities. There are considerable issues with the federal Medicaid regulations regarding TCM and in the underlying assumptions of Medicaid eligibility upon which the ICM/SCM programs are built. In some areas of the State, programs are unable to reach the percentage of Medicaid youngsters served. This is largely a result of Medicaid eligibility not being an effective proxy for serious mental illness in children as it often is in adults. The agency's ambulatory restructuring project will be reviewing and recommending changes in case management services for children.

POPULATION SERVED

Children/youth at a minimum who have a history of psychiatric hospitalization within the last two years with existing risk of re-hospitalization, recent hospitalization of greater than 90 days in duration, history of crisis-related contacts with the mental health system, history of out-of-home placements due to psychiatric impairment, or history of treatment in mental health services that are deemed ineffective as demonstrated by the likelihood of impending admission to psychiatric inpatient treatment or a history of unplanned movement out of treatment.

PERFORMANCE MEASURES

- Percent of children who got better during a treatment episode as indicated by symptom indicators
- Percent of children who get better during a treatment episode as indicated by functional impairment
- Percent of children whose strengths were enhanced during a treatment episode as indicated by child strength indicators
- Percent of children whose family strengths have stabilized or were enhanced during a treatment episode as indicated by family strengths and needs indicators
- Percent of children who had needs met during a treatment episode as indicated by risk behavior s
- Percent of children who had needs met during a treatment episode as indicated by care intensity and organization indicators
- Satisfaction indicated yearly by youth and families from youth and family satisfaction surveys

PROGRAM

ATL Kids – **Children's Single Point of Access (SPOA)**

BRIEF DESCRIPTION/HISTORY/BACKGROUND

From 2000–2002, the Governor's New Initiatives expanded children's mental health to include the Home and Community-Based Services (HCBS) Waive, Family Support Services and Case Management. To ensure priority access to these services and to support children in their homes and communities whenever possible, OMH asked that each county and the City develop SPOA processes, whereby the needs of particular children are assessed, their families engaged, community resources explored, and service plans developed. When out-of-home placement is warranted, the SPOA serves as a linkage mechanism back to a child's community of origin, thus enabling a smooth transition and a shorter length of stay in residential placement, better supporting the child's recovery and utilizing mental health resources more effectively.

ISSUES

SPOA for children has been a highly effective initiative. Although the total number of referrals to SPOA has remained constant, aggregate data from 2005–2007 show an upward trend in youth served through community-based services. There has been an 11% decrease in OMH residential placements and a 13% in enrollment to OMH-licensed community-based services/supports through the SPOA. In 100% of the counties, including the City, each child-serving system makes referrals to SPOA. Data from the same period also show that, of the total referrals, 9% were from social services, 7% from probation/juvenile justice and 11% from the education systems.

Since 2004, OMH has worked to phase into SPOA access to its licensed residential programs for children and youth. With the exception of day treatment and clinic, all OMH-licensed community-based and residential services are now accessed through SPOA.

The SPOA has representation across system of care for children. Thus, if a child's needs cannot be met by one system, the SPOA serves as the connector from mental health to other systems of care (e.g., child welfare) to support a child and his or her family. In many communities without the infrastructure to support the Coordinated Children's Services Initiative (CCSI), the SPOA has taken on this function.

OMH and local governments continue to work on improved accountability and performance in their SPOA processes, with the goal of appropriately serving and supporting youth and families effectively and efficiently. To achieve this goal, OMH and each SPOA has embraced a set of core elements: implementation of an evidence-based assessment instrument for each child and family to aid decision making and family support, a mechanism for family involvement and support through the SPOA process, adoption of data elements that track the SPOA process for: timeliness, vacancies, and wait lists to ensure that youth with the highest needs receive supports and services, and collaboration and coordination with other child-serving systems.

POPULATION SERVED

Children and adolescents and their families served by the mental health system

PERFORMANCE MEASURES

- Percent of children who got better during a treatment episode as indicated by symptom indicators
- Percent of children who get better during a treatment episode as indicated by functional impairment
- Percent of children whose strengths were enhanced during a treatment episode as indicated by child strength indicators
- Percent of children whose family strengths have stabilized or were enhanced during a treatment episode as indicated by family strengths and needs indicators
- Percent of children who had needs met during a treatment episode as indicated by risk behaviors
- Percent of children who had needs met during a treatment episode as indicated by care intensity and organization indicators
- Satisfaction indicated yearly by youth and families from youth and family satisfaction surveys

B.5.2 Support: Community Support Programs

PROGRAM

ATL Kids – **School-Based Mental Health Programs**
(With or Without Clinic Treatment Program)

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15; 14 NYCRR, Part 587, 588, 592; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The School-Based Mental Health Initiative (SBMHI) began in 1995 and the School Support Program (SSP) in 2001. School-based mental health programs combine school-based satellite clinics with "school collaboration" services in high-need, low-performing schools (As part of the School under Registration Review [SURR] process by SED, SED places a number of low-performing schools on the SURR list based on State elementary assessments and pass rates and dropout rates for high schools; once placed on the SURR list, schools can be removed only if they meet targeted improvements mandated by the State.).

Clinic treatment and support services for children, parents and other collaterals (including teachers) are supplemented by supports to school staff to develop and implement service plans for students with intensive needs, by supports to at-risk children, and by psychoeducation and consultation services to faculty and parents. All projects include clinical and family support services.

- **SBMHI:** Initially, these projects were separate from licensed clinics. In a policy realignment initiative in 2008, all programs were required to license sites under their current clinic licenses and a new formula for State aid was developed that was tied to school enrollment, resulting in State aid reductions.
- **SSP:** SED committed to three-year matching funds for SSP projects throughout the State, which expired in 2004; DOH committed to three-year matching funds for SSP projects in New York City, which expired in 2004. In a policy realignment initiative in 2007, a new formula for State aid was developed that was tied to school enrollment, resulting in State aid reductions.

There are 32 school sites, and, at any given time, these programs serve approximately 1,200 children and adolescents via clinic treatment. There are also "whole school" benefits, as well as benefits to some children who receive brief, crisis intervention services. A 2004 study of SSP conducted by the Center for the Advancement of Children's Mental Health affiliated with Columbia University measured strengths and difficulties among children, youth and teachers and found significant positive outcomes among the groups.

ISSUES

The agency's future policy direction is to utilize licensed clinic treatment, Child and Family Clinic-Plus and Family Support to collaborate with schools rather than funding a standalone program. Further, many of the "non-treatment" services that are provided are more closely aligned with educational supports. Currently, OMH is consolidating the SBMHI and SSP into one "School Mental Health Program," which requires staff to

devote 70% of time to treatment services and which stipulates the types of "school collaboration" activities that may be supported with OMH State aid.

POPULATION SERVED

Children and adolescents

PERFORMANCE MEASURES

- Number of children served by age, sex, race, ethnicity, diagnosis, living situation, education level (at or above grade), juvenile justice status
- SSP: indicators of global functioning and strengths and difficulties for youth, parents, and teachers

PROGRAM

ATL Adult – **Family Support Services (Children & Family)**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Through targeted programs, Family Support, which was organized in the 1990s, assists and supports families in the care of their children with emotional challenges. The goal is to reduce family stress and to educate families regarding the child's illness and research-informed methods to support recovery. Core services include advocacy, education and skill building, respite, and peer support. Many families of children and youth with serious mental health issues have multiple stressors, including poverty, and are involved with more than one child-serving system.

Family support is a key tool in engaging families in services. Families may be wary of receiving services from providers or be concerned about their child being labeled or stigmatized. Therefore, effective engagement approaches require that the mental health system understand family concerns, take into consideration family cultural backgrounds, and take time to listen to family experiences with care.

Family members and young people with personal experience with emotional disturbance have a unique ability to engage with their peers. Understanding, acceptance and ability to communicate are unique to Family and Peer Support. There are 100 programs serving 17,000 families annually.

ISSUES

Family Support is the most requested service for expansion in children's mental health. Parent empowerment and the development of effective self-advocacy skills are crucial in this effort. The other family support services, including respite and peer support, continue to play an important role in ensuring that families are able to support their children in the least restrictive environment possible.

Youth Empowerment has been added as a key component of the statewide family support organization. Youth empowerment initiatives are being piloted in various localities throughout the State. In New York City, the family support infrastructure is undergoing a major reorganization by the Department of Health and Mental Hygiene, with input from State and local stakeholders, including OMH.

Family Support is a key strategy in the OMH vision for children's services to enable families to keep their children at home while receiving needed mental health services and avoiding expensive out-of-home care. Within OMH, a wide variety of programs and models are funded as "advocacy." Among these are peer and family support and the statewide organizations that support them. The programs are of high priority to the agency.

POPULATION SERVED

Families of children and adolescents between 0–21years with serious emotional and behavioral challenges as well as parents and caregivers with mental health issues

PERFORMANCE MEASURES

Studies of family support programs have demonstrated unequivocal improvements in outcomes, such as retention of children in mental health services, parental knowledge of mental health issues, parental self-efficacy related to securing needed services and supports, and improved family interactions. Additionally, many families have attested in focus groups and surveys, and most recently during the Children's Mental Health Plan public forums, that family support is one of the most valuable services in the mental health system. The use of family advocates has been key in engaging families in all program areas.

PROGRAM

ATL Kids – **Coordinated Children's Services Initiative (CCSI)**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15; SSL Section 483-c

BRIEF DESCRIPTION/HISTORY/BACKGROUND

CCSI began in the 1990s as a multi-agency approach to help counties create local structures to provide cross-systems services to children with serious emotional and behavioral disabilities who are at risk of residential placement. In 2002, CCSI was established within the Council on Children and Families by law and expanded to address the cross-system treatment needs of children with multiple diagnoses.

CCSI serves as a mechanism to make certain that children with multiple diagnoses receive the necessary services and supports that will allow them to remain in their homes, schools and communities. CCSI ensures the coordinated delivery of services through a three-tier interagency structure that addresses service barriers. As an interagency initiative, CCSI exists at a local community level (Tier I), County level (Tier II), and State level (Tier III).

ISSUES

The continuation of CCSI Tier III has been under review by a workgroup of Commissioners from the child-serving agencies in 2008. A reconfiguration of this program is expected in 2009.

POPULATION SERVED

Children and adolescents with serious emotional disturbance

PROGRAM

StOps Kids – **Mobile Mental Health Teams (MMHTs)**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15

BRIEF DESCRIPTION/HISTORY/BACKGROUND

MMHTs provide treatment services for youth in the custody of Office of Children and Family Services (OCFS) in its Division of Juvenile Justice and Opportunities for Youth (DJJOY). Children and adolescents incarcerated in a DJJOY facility presenting with behaviors suggesting psychiatric intervention may be required are treated by the MMHT. Services include assessment of mental health status, mental heath treatment and discharge planning, crisis intervention mental health counseling (individual, group, family), and case consultation with OCFS residential staff and other providers.

This initiative was piloted in the mid 1990s, with statewide implementation beginning in 1999. It is an early example of interagency collaboration to best serve the needs of youth involved in more than one State system.

ISSUES

Staffing is provided by OMH State-operated psychiatric centers. The availability of psychiatric treatment for children within OCFS facilities is beneficial to the child and has the added benefit of reducing State costs. Given the mental health needs of youngsters in the juvenile justice system, this is a service that could be expanded or enriched and would be in line with the federal Department of Justice's desire for greater mental health services availability.

OMH continues to work collaboratively with OCFS to provide consistency of care and high quality clinical services within juvenile justice settings. To this end the agencies continue to refine communication of policies and expectations amidst systemic OCFS staff retention issues.

POPULATION SERVED

Children and adolescents at OCFS facilities

PROGRAM

StOps Kids – **South Beach Psychiatric Center Family Court Evaluations**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The South Beach Psychiatric Center provides staff to the Staten Island Family Court to conduct psychiatric evaluations of families, children and adolescents who appear in the court primarily in custody cases. This diagnostic assessment program was established in the 1980s as a model of collaboration between the State mental health providers and the local justice system to provide mental health assessments to family court judges. OMH professionally licensed staff members also testify in family court proceedings and help facilitate supervised visitations to support and maintain family relationships.

At the onset, the program began with 20 full-time equivalents (FTEs); resources were reduced over time, however, driven by fiscal constraints, and the program currently operates with 7–8 FTEs. Further, to supplement and support the program, South Beach collaborates with St. Vincent's Medical Center, which provides two child psychiatry residents annually. The program serves approximately 300 families per year.

ISSUES

The OMH program model is highly valued by local family court judges, State, City and local politicians as an example of high quality mental health care and collaboration.

POPULATION SERVED

Families, children and adolescents appearing in the Staten Island Family Court who have some history or indication of mental illness

PERFORMANCE MEASURES

- Annual review of evaluations performed by the program's medical director
- Collaboration between OMH and the Medical Center in assessing, evaluating and analyzing the effectiveness of the program through the child resident studies, and meetings with the Staten Island Family Court Judge

PROGRAM

StOps Kids – **Rural Telepsychiatry**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15

BRIEF DESCRIPTION/HISTORY/BACKGROUND

In 2006–2007, *Achieving the Promise for New York's Children* increased the availability of children's mental health services, a part of which provided funding to implement a Child and Adolescent Telepsychiatry initiative. This provides psychiatric consultations to rural health care shortage areas. This pilot was developed to meet the growing psychiatric needs of children and adolescents living in rural areas without access to child psychiatric care and to address growing concerns regarding the use of psychotropic medications in children. Staffed under contract by board-certified child and adolescent psychiatrists from Columbia University, the program is currently active in 12 upstate counties, and two additional counties expect to participate soon.

Expansion to the rural health networks is imminent, and will include 21 upstate, rural counties in the initial rollout. After the initial implementation, OMH anticipates that all providers associated with rural health networks will be able to access the service.

ISSUES

There remains a well-documented critical shortage of behavioral healthcare professionals in rural New York counties, especially child and adolescent psychiatrists. Initial implementation of telepsychiatry occurred in 12 upstate, rural counties. The program is now expanding to add two additional counties, which will soon be receiving videoconferencing equipment. Further, the program is also expanding to include primary care providers linked to rural health networks, with a goal of reducing crisis and intervening earlier in a child's mental health trajectory. This expansion will be doctor-to-doctor consultation and will be primarily limited to phone conversations between the doctors focusing on child-specific issues. Linking the current OMH-funded children's clinic-based telepsychiatry initiative to select rural health networks will increase the number of children who can be accurately diagnosed and treated in a timely manner.

POPULATION SERVED

Children and adolescents ages 0–18

PERFORMANCE MEASURES

- Usage and number of children served among the participating county clinics

B.5.3 Support: Employment

PROGRAM

ATL Kids – **Innovative Vocational Programs**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15

BRIEF DESCRIPTION/HISTORY/BACKGROUND

This program provides vocational/career development services targeting highly individualized, community-based work experience. These services include vocational counseling, vocational assessment, work placement, analysis of work experience to determine effectiveness and future career planning, and family counseling. Six programs serve 220 students annually

ISSUES

The Innovative Vocational Programs reports a collective work placement rate of 39%, which is very impressive. While successful in its outcomes, the program is still in need of an ongoing source of funding.

POPULATION SERVED

Youth ages 14–18 with an identified diagnosis of mental illness

PERFORMANCE MEASURES

- Youth job placement (type and duration) with correlating demographic information

B.5.4 Support: Home and Community-Based Services (HCBS)

PROGRAM

ATL Kids – **Home and Community-Based Services (HCBS) Waiver**

Family Support, Crisis Response, Skill Building, Intensive In-Home Care, Respite Care, and Individualized Care Coordination

(This program description covers all areas of HCBS.)

LEGAL MANDATE/AUTHORITY

Chapter 170 of the Laws of 1994; Medicaid Federal SSA Section 1915(c)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The federal Health Care and Finance Administration approved New York's request to waive three statutory requirements of Section 1915(c) of the SSA on January 1, 1996. The Medicaid HCBS Waiver covers three statutory requirements: state-wideness, amount, duration and scope of services and parental deeming—allowing the child to be considered a family of one. The goal of the Waiver is to maintain children, who would otherwise require a hospital level of care, at home in the community by providing individualized care based upon a partnership with family members, and treatment and service providers. The six Waiver services are as follows:

1. **Family Support Services** are designed to enhance the health and growth of children and adults in the family unit to ultimately develop safe, stable, and supportive families who are connected to their communities. Family Support Services provide resources, including, but not limited to, education, training, advocacy and supports. Family Support also assists families by introducing and connecting them to activities in the community (e.g., educational, cultural, recreational) that foster family cohesion. Such activities must be consistent with the family's budget to assure the possibility of continuing the activities post-Waiver enrollment.
2. **Crisis Response** reinforces the agreed-upon safety plan that the child and family have developed and attempts to stabilize occurrences of crises with the child and family when they arise. These services may include assessment, consultation, linkage and immediate intervention wherever necessary, for example, in schools, at home and work. This service is available 24 hours a day, seven days a week.
3. **Skill-Building Services** focus on helping the child to be successful in the home, community and school by assisting him or her to acquire developmentally appropriate social and environmental skills. Skill-Building Services utilize an individualized, strengths-based approach in assisting the child in recognizing functional assets/strengths and those that need developing. Support is offered through a variety of activities in areas such as completing homework, solving problems, strengthening social and verbal skills, developing play skills and imagination, building organizational skills, fostering cooperation, strengthening peer relationships, managing public transportation, and more. Skill Building may also assist youth in developing skills for independent living and by facilitating access to, monitoring and supporting vocational training. Skill Building Services may be provided to the child's family to support the child's development and maintenance of skill sets.

4. **Intensive In-Home Services** provide intensive, ongoing interventions that are specified in the child's Waiver Service Plan and that support the child and family in implementing their Treatment Plan (from the clinical provider) and the Waiver Service Plan (established by the Waiver program). This service reinforces the desired behavioral or cognitive changes by assisting the child and family in everyday application of the clinical treatment plan strategies and resultant insights. Interventions may include psychoeducation, crisis de-escalation, support in working through safety plans, parent-child relationship building, parenting skills, feedback on emotional self-regulation in situational contexts, sibling relationship building, and development of healthy coping mechanisms, healthy choices, and self-esteem. These services may be provided in the home or in the community to an individual child and family in the Waiver program.
5. **Respite** provides a needed break for the family and the child to ease the stress at home and promote overall wellness for the child and family. Respite Services activities include providing supervision and recreational activities that match the child's developmental stage and/or transporting a child to school, an appointment or a program. Respite care may be provided on a planned or emergency basis, day or night, in the child's home or in the community by trained respite workers with one child or a group of children in the Waiver program.
6. **Individualized Care Coordination** provides the first and ongoing point of engagement for the child and family. It serves as the case management functions for the HCBS Waiver and oversees delivery of the remaining five services. It ensures ongoing partnership with the child and family in the Waiver program as well as continuing collaboration with treatment providers.

Data show that children with serious emotional disturbance are more apt to attain optimal development and wellness when supported in their home and community environments. The HCBS Waiver ensures that New York's children with serious emotional disturbance and their families have access to services and supports that lead to improved resiliency, and the achievement of age-specific developmental imperatives and a supportive home environment.

Significant changes in program since inception

The Waiver has been a cornerstone of OMH's efforts to provide intensive mental health services to troubled children and their families. A multiple-year development plan continues to advance with the Waiver now being available, albeit minimally in some areas in every county and New York City borough in the State.

Reflective of the systemic impact of HCBS, OCFS purchased Waiver capacity using preventive services funds in 2005 and again in 2006 for a total of 352 slots. (OCFS has now created and had approved a "look alike" Waiver to serve their population.) Other progress includes:

- Group rates are in the process of being approved for the first time for Respite, Skill Building and Family Support; numerous billing rules were revised or developed.
- Approval was granted by CMS to allow for a limited number of Crisis Response telephone calls to be billable.
- Periodic utilization of Child and Adolescent Needs and Strengths (CANS) assessment has become a requirement in service planning.
- Qualifying Intensive Care Coordinator experience was broadened to enhance recruitment.
- Competencies were developed for each Waiver service role.

- The Child and Adult Integrated Reporting System (CAIRS) data are in the process of being aggregated for outcome measures and the Waiver roster will soon become part of CAIRS.

A study of the effectiveness of a children's HCBS Waiver program in *Psychiatric Quarterly* published in 2007 indicated that the St. Luke's Waiver program in the City successfully maintained 8 out of 10 children in the community during an average period of 12 months, compared to 3 out of 10 children for a substantially shorter (three and one-half months) period. This program was noted for its efficacy and cost-effectiveness. There are currently statewide 1,506 Waiver slots (352 funded by OCFS Preventive Services and 1,154 OMH/CMS funded at 50%/50%). The Waiver is provided by 31 agencies and is available in every county except Oneida, which provides home and community based services via its Kids Oneida program.

ISSUES

Potential federal Medicaid regulations for TCM are expected to have significant impact on the Waiver (e.g., Intensive Care Coordinator role and the need to unbundle services). This and related issues are under review by the Ambulatory Care Restructuring Committee.

Among the programs and models that provide advocacy services, peer-oriented and family support services and support and the statewide organizations that support them are of high priority.

POPULATION SERVED

Children and adolescents with serious emotional disturbance between the ages of 5 and 17 years (prior to 18th birthday) who demonstrate complex health and mental health needs; are at imminent risk of admission to a hospital level of care or have a need for continued hospitalization; whose service and support needs cannot be met by just one agency/system; who are capable of being cared for in the home and/or community if services are provided; and have a viable and stable living environment with parents/guardians who are able and willing to participate in the HCBS Waiver and support their child in the home and community.

PERFORMANCE MEASURES

- Percent of children who got better during a treatment episode as indicated by symptom indicators
- Percent of children who get better during a treatment episode as indicated by functional impairment
- Percent of children whose strengths were enhanced during a treatment episode as indicated by child strength indicators
- Percent of children whose family strengths have stabilized or were enhanced during a treatment episode as indicated by family strengths and needs indicators
- Percent of children who had needs met during a treatment episode as indicated by risk behaviors
- Percent of children who had needs met during a treatment episode as indicated by care intensity and organization indicators
- Satisfaction indicated yearly by youth and families from youth and family satisfaction surveys
- Number of children receiving HCBS

PROGRAM

ATL Kids – **Kids Oneida**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.15; 14 NYCRR, Parts 587, 588, 592; Medicaid Federal SSA 1905(a)

BRIEF DESCRIPTION/BACKGROUND

Kids Oneida was initiated as a three-year demonstration project to provide integrated services and supports to children and adolescents with serious emotional, behavioral and mental health disturbances in Oneida County. The program provides case management via its service coordinators for a provider network that offers more than 50 traditional and non-traditional services to children and adolescents and their families. Under Kids Oneida, office-based services become only a small part of the services received and greater emphasis is placed on community-based services such as mentoring and supervision.

When Kids Oneida began, funding allowed for enrollment of a maximum of 120 children. Currently 125 slots serve 180 children and families per year. The Step-Down Program includes a Department of Social Services (DSS) contract for 30 funded slots. Children and youth maintain the same service coordinator and providers after disenrollment from the regular Kids Oneida program but at a reduced level.

Of the 341 children and families served in 2007, 40 children were placed in an institutional level of care; functional assessment scores tracked since 1998 continue to demonstrate a 30% improvement in youth mental health symptoms; days of care over a 24-month period were reduced approximately 6,320; and more than $6 million cost to Oneida County was avoided.

ISSUES

Kids Oneida has shown significant, positive outcomes for Oneida County and has become the county's version of the HCBS Waiver program. Kids Oneida has not proven to be strategy that can be widely implemented throughout the State. A strategy for maintaining the localized success of this program will need to be identified.

POPULATION SERVED

Children deemed by the Oneida County Family Court or DSS to be at imminent risk of out-of-home placement.

Compared to 15% of the general population in the Kaiser Permanente Study (1998), nearly two out of three children experienced a serious family history of mental health problems with a parent or guardian, more than 55% experienced a parent-caretaker with a serious substance abuse problem; more than one-third of youth experienced a parent-caretaker who was incarcerated; 76% of children experienced domestic violence; 71% of Kids Oneida enrollees experienced four or more adverse childhood experiences.

PERFORMANCE MEASURES

- Service utilization
- Functional assessment at baseline and every six months
- Satisfaction as measured by the annual family and youth satisfaction surveys

C. FORENSICS SERVICES PROGRAM

C.1 Inpatient Services

PROGRAM

StOps Forensic – **Inpatient Services**

LEGAL MANDATE/AUTHORITY

Criminal Procedure Law (CPL) Sections 330.20, 730; MHL Article 9; Correction Law Section 508; 14 NYCRR, Part 57

BRIEF DESCRIPTION/HISTORY/BACKGROUND

OMH has operated statutorily mandated secure inpatient forensic facilities for non-sentenced individuals since 1976. This consists of two freestanding maximum security centers, Mid-Hudson Forensic Psychiatric Center (FPC) and Kirby FPC; and two maximum security regional units, the Rochester Regional Forensic Unit and Northeast Regional Forensic Unit. Funding supports 506 inpatient beds at these facilities.

Kirby was opened in 1985 at a surplus building on the grounds of Manhattan Psychiatric Center (MPC) due to over census at Mid-Hudson FPC. While it was recognized then that the building would require rehabilitation to bring it into compliance with current building codes and privacy requirements of the Joint Commission, no major renovations have been undertaken.

Mid Hudson also has a unique physical plant. Unlike the newer freestanding facilities, Mid-Hudson has a series of buildings requiring patient escorts between them by staff, which has safety and staffing implications. Many of the buildings were constructed in the early 1900s when the Psychiatric Center opened as a reformatory for juveniles from New York City. While buildings have been updated over the course of the past several years, wards offer limited privacy and must accommodate 35–40 patients each.

ISSUES

Physical Plants

Both Kirby and Mid-Hudson have aging facilities.

Consolidation of Administration (for civil service purposes) at Kirby

Much of the administrative work at Kirby and Manhattan is consolidated within a single, unified staffing structure. However, Civil Service views the two facilities as having distinct personnel structures. Thus, simple staff promotions, for example, are classified as new hires and require additional scrutiny. There may be an opportunity to align Civil Service classifications and consolidated administrative staff into a single organizational structure.

Reducing overtime at Mid-Hudson

Overtime at Mid-Hudson is uniquely impacted by the need to provide 1:1 or 2:1 supervision of four-to-six highly aggressive patients. These patients have been with FPC for years and despite numerous consults and interventions, they remain volatile and assaultive. Reductions in use of restraints have contributed to the need for more intensive staffing.

POPULATION SERVED

The non-sentenced services provide secure inpatient services to persons committed to the Commissioner's custody pursuant to Criminal Procedures Law as well as persons transferred from adult civil Psychiatric Centers pursuant to 14 NYCRR, Part 57.

PERFORMANCE MEASURES

- Inpatient census, inpatient admissions and releases, length of stay, readmission rates, restraint and seclusion rates, elopement rate
- Prevalence of co-occurring psychiatric and substance disorders
- New-generation antipsychotic use, proportion of patients receiving new-generation antipsychotic medication that receive any antipsychotic agent

PROGRAM

StOps Forensic – **Inpatient – Department of Corrections (DOCS) Services**

LEGAL MANDATE/AUTHORITY

Correction Law Section 402

BRIEF DESCRIPTION/HISTORY/BACKGROUND

OMH assumed responsibility in 1976 for the commitment and treatment of mental illness in inmates. Central New York Psychiatric Center (CNYPC) operates a 209-bed inpatient Joint Commission-accredited hospital in Marcy, with an authorized staffing level of 462 FTE positions. The program provides services for a DOCS inmate population of approximately 65,000 inmates, with an average length of stay of 60 days.

ISSUES

With the PSA requirement of an additional 20-bed inpatient ward at CNYPC and the passage of SOMTA, all available inpatient capacity within CNYPC is encumbered. As a result, CNYPC lacks a swing ward in which to place inmates in the even of an emergency such as a flood or fire, necessitating the movement of individuals or affected wards to other locations.

POPULATION SERVED

Primarily inmates with schizophrenia and other psychotic disorders, major mood disorder, with or without personality disorder

PERFORMANCE MEASURES

- Inpatient census, inpatient admissions and releases, length of stay, readmission rates, restraint and seclusion rates, elopement rate
- Prevalence of co-occurring psychiatric and substance disorders
- New-generation antipsychotic use, proportion of patients receiving new-generation antipsychotic medication that receive any antipsychotic agent

C.2 Support Services

PROGRAM

StOps Forensic – **Onsite Services to DOCS**

LEGAL MANDATE/AUTHORITY

Correction Law Section 401

BRIEF DESCRIPTION/HISTORY/BACKGROUND

In 1976, OMH assumed responsibility for the treatment of inmates with mental illness in DOCS facilities. Outpatient services, which are provided in 55 DOCS facilities, include individual or group therapy, psychiatric services, the evaluation of inmates for DOCS programs, and evaluation of inmates for referral to the Division of Parole (DOP). The CNYPC "outpatient component" consists of a statewide network of mental health units located in DOCS correctional. There are 23 outpatient clinics with 14 full Satellite Units, providing a total of 196 crisis beds, 591 Intermediate Care program beds, 199 Transitional Intermediate Care beds, 108 Special Treatment Program beds and 102 Behavioral Health Unit beds and clinic services to approximately 8,500 inmate/patients of the DOCS inmate population.

ISSUES

The provision of mental health services to DOCS inmates in correctional facilities is part of the OMH core mission. Two-thirds of the caseload, however, is not for inmates with serious mental illness and would not be a priority population outside the confines of the correctional system. In challenging fiscal times, the opportunity exists for OMH to assume its safety net function by serving inmates diagnosed with serious mental illnesses such as schizophrenia and bipolar disorder. This approach would enable OMH, in collaboration with DOCS, ensure that inmates suffering from serious mental illness are given priority, closely monitored and served. In addition, there is an opportunity to attain greater services efficiency, effectiveness and quality by consolidating resources across the forensics system of care in DOCS. Of the outpatient caseload approximately 38% have a designated serious mental illness and 67% receive some type of psychiatric medication; the most common diagnostic classes are major mood disorder (25%), and schizophrenia and other psychotic disorders (19%).

PSA Requirements

Some of the major enhancements of the PSA include (1) providing inmates in SHUs with serious mental illness with two hours of out-of-cell therapeutic programming each business day; (2) screening all inmates at reception for mental health service provision; (3) and increasing the bed capacity, including 90 new Intermediate Care beds, 215 Transitional Intermediate Care beds, 90 new Special Treatment beds, a new 100-bed Residential Mental Health Unit; and a new 20-bed inpatient ward at CNYPC. In addition the agreement called for additional services and reviews of treatment for inmates/patients in SHUs (e.g., review of SHU sentences, SHU mental health assessments, SHU time cuts, expansion of SHU Case Management Committees). Most of these enhancements have been implemented, and the remaining enhancements are in the progress awaiting completion of construction and/or budget authorization to staff the programs. Consideration to defer the opening of the 20-bed inpatient ward at CNYPC until that service is needed may present a short-term fiscal savings in response to the budget crisis.

SHU Bill Requirements

In 2008 the SHU Bill was signed into law by the Governor. This legislation deals with diverting inmate/patients with mental illness to other programs, rather than being placed in SHU confinement. The legislation, which must be implemented no later than July 6, 2011, incorporates agreed-upon clauses of the PSA and adds additional requirements. Some of the new mandates include (1) broader and quicker mental health assessment/screening; (2) increased hours of out-of-cell therapy; (3) enhanced training for DOCS staff; and (4) construction of additional Residential Mental Health Units, Behavioral Health Units, and/or Intermediate Care programs. Most of these initiatives are in the planning stages.

When implemented, the SHU bill will require additional resources to achieve evaluations at Level III and IV sites[2] training, additional staff for assessments at Level I and II sites,[3] and additional Residential Mental Health Units.

Caseload Pressures

The CNYPC caseload has increased by more than 20% since 2000. More notably, since 2002, the Level I caseload has increased by 54% and Level 2 by 69%. Thus, the caseload is getting larger and cases are receiving higher service designations. OMH currently provides services in 55 correctional facilities. Resource constraints present the opportunity to examine ways to more effectively and efficiently deliver services to inmates with the greatest need.

Services provided by OMH in DOCS facilities have steadily increased over the last several years. The outpatient caseload reached to 8,567 inmates by the end of the 2007. During the 2007 calendar year, CNYPC outpatient programs provided services as follows:

- Inmates/patients served – 17,358, a 7% increase over the previous calendar year
- New caseload admissions – 9,178, a 13% increase over the previous calendar year
- Caseload discharges – with 7,974 patients terminated from the caseload
- Clinic contacts –160,668
- Reception center screenings – 10,044 inmates for possible admission to OMH caseload
- Inmates/patients housed in SHU decreased 7.9% compared to 2006
- Private SHU interviews offered increased 10%
- Private SHU interviews completed increased 13.8%

POPULATION SERVED

All DOCS inmates

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[2] Level III inmates are those who may need short-term medication therapy for disorders such as anxiety, moderate depression, or adjustment disorders or who suffer from a mental disorder that is currently in remission and can function in a facility with part-time mental health staff. Level IV inmates are those who may need mental health services (other than medication) for disorders such as mild depression, anxiety, adjustment disorder, or other life problems.

[3] Level I inmates have a major mental illness and (1) have not been stable for six months or more, (2) have prior psychiatric hospitalization, and/or (3) have a repetitive history of self-harm. Level II inmates are similar to Level I, but have at least six months of stabilization and are medication compliant.

PERFORMANCE MEASURES

- Census, number of admissions to Intermediate Care programs, percent of Intermediate Care program admissions receiving 20 hours of treatment, median length of stay in observation and dormitory bed
- Number of universal screenings
- Number of clinical contacts
- Number of patients treated in Residential Care Treatment Programs
- Percent of patients in SHU, number of cell-side contacts, number of private interviews, number of SHU time cuts
- Percent of patients on psychiatric medications, adverse drug events, number patients in special programs

PROGRAM

ATL Forensic – **Community Support Program (CSP)**

LEGAL MANDATE/AUTHORITY

General Municipal Law Section 209-q; Correction Law Sections 404, 500-b; MHL Section 9.60

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The forensic CSP facilitates collaboration and service coordination between mental health services and law enforcement/criminal justice programs in the community, provides training for criminal justice practitioners to improve services for persons with mental illness within the criminal justice system, identifies gaps in programming for persons with mental illness within the criminal justice system, and works with partners to develop effective responses.

There is no separate funding stream for CSP. Discrete projects initiated and carried out by community forensics (e.g., Project Caring, community training) are State funded. The only exception is for Wellness Self-Management, which is grant funded.

OMH CSP partners include the Unified Court System (UCS), DOCS, Commission on Corrections (COC), DOP, Division of Probation and Correctional Alternatives (DPCA), Division of Criminal Justice Services (DCJS), Conference of Local Mental Hygiene Directors (CLMHD), New York Association of Psychiatric Rehabilitation Services (NYAPRS) and the Center for Urban Community Services (CUCS). Many of the services, which are described below as falling under Community Education and Program Development, aid local and state law enforcement/criminal justice agencies in fulfilling their statutory and regulatory mandates to provide services to persons with mental illness.

Community Education

The role of forensics CSP is to provide training content, technical assistance, consultation, and coordination as indicated. Programs include:

- **Police Mental Health Training**: Enables police officers to identify and understand emotional disturbance; to utilize the MHL to make safe, effective assessments and intervene appropriately; and to document actions appropriately
- **Local Correctional Suicide Prevention Crisis Service Program:** Establishes linkages between corrections and mental health personnel within a correctional facility and has successfully reduced suicide incidence
- **Mental Health Resource Handbook:** Provides an overview of the State criminal justice; guidance for providing mental health services within the criminal justice system, and a primer on State laws relative to the delivery of mental health services to jail and lockup inmates
- **Crisis Intervention Officer Training:** DCJS training for local police and other criminal justice personnel, covering advanced knowledge of mental illness and techniques for safely and effectively responding to situations involving persons with emotional disturbances
- **Meeting the Behavioral Health Needs of Inmates:** Developed by OMH and COC to provide county jail mental health, corrections and medical personnel with information about inmates with mental illness and the special demands this population presents

- **Connect Parole Mental Health Training:** Designed by modifying Connect Program content (see "Connect" under Program Development) in response to a DOP request to provide mental health training for Parole staff
- **Men & Women Transitions Trainings:** Enhances mental health provider skills and receptivity toward serving this population and increases coordination between providers and Parole staff in safely managing this population in the community

Program Development

- **Parole Support and Treatment Program (PSTP):** This program serves up to 56 parolees with blended case management and supported housing services to facilitate community re-entry in a law-abiding manner, ensure access to appropriate services, and acquire long-term housing before parole expires. The forensics CSP role is to provide problem solving, monitoring and support to agency and Parole staff.
- **Community-Oriented Reentry Program (CORP):** During the last three months of sentence, inmates are provided "in reach" services from community providers to ease community transition. Many inmates are then released to Parole supervision with access to PSTP, which is a joint venture of OMH, DOCS, DOP and a consortium of community providers. The forensics CSP role is to oversee funding for the Entitlement Specialist and problem solve with agencies providing PSTP.
- **Project Caring Community:** This collaboration between OMH, DOCS, and DOP is aimed at women with mental illness returning from State prison to the New York City counties. The program contract is under review by the State Comptroller, with an expected start date of October 2008. There will be a caseload of 36 to 48 for community case management. The forensics CSP role will be to oversee all aspects of program development, procurement. It will coordinate and monitor all elements of in-reach and case management services.
- **Connect:** This staff development and technical assistance program in 17 counties is aimed at facilitating systems change and meeting the needs of those working with persons with serious mental illness and co-occurring substance use disorders on probation or in alternative to incarceration (ATI) programs. It represents collaboration between OMH, DPCA and NYAPRS. The forensics CSP role is development of content and implementation among local mental health and probation departments.
- **Wellness Self-Management in Correctional Facilities:** This collaboration between OMH, DOCS, DOP and CUCS is using grant funding to pilot test a Wellness Self-Management curriculum for inmates with serious mental illness in three prisons who are within six to nine months of release. The forensics CSP role is to collaborate on the proposal and coordinate the research and program components with partners.
- **New York City OMH ICM LINK Team:** This team provides ICM services for a caseload of between 36 to 48 inmates released from State correctional facilities to the City. As individual release dates draw near, OMH pre-release coordinators assign clients to ICM. Within three to six months, ICM secures long-term case management by identifying an alternative case management entity within the client's service delivery network. The forensics CSP role is to collaborate with LINK, CNYPC Pre-Release Services, and the City OMH Field Office and Re-Entry programs to problem solve and support their activities.
- **Mental Health Courts:** Currently 17 courts in the State are providing criminal defendants diagnosed with mental illness access to supervision and services, including close judicial supervision of medical treatment and vocational training.
- **Mental Health Court Connections:** This program supports jurisdictions in providing meaningful

county-wide responses to the problems posed by defendants with mental illness in the criminal justice system. The forensics CSP role is to provide content, training expertise, and technical assistance.

- **Medication Grant Program (MGP):** A component of Kendra's Law, the MGP provides funding to counties to cover the cost of medications and medication-related services for individuals who have left prison and are awaiting Medicaid determination eligibility. Enrollment for this program in 2007 was 1,989. The forensics CSP role is to provide MGP cards to persons with serious mental illness who are leaving prison.
- **Transition Management:** A component of Kendra's Law, transition management funding is provided to localities on a population-based formula for support of transition services from local correctional facilities into the community. The forensics CSP role is to provide MGP cards to persons with serious mental illness who are leaving prison.
- **Prison SSI Initiative:** Using federal funds, OMH and DCJS contract with CUCS to facilitate the development and enhancement of structures and procedures in prisons to better ensure SSI acceptance for inmates with mental illness who are preparing for community release. The forensics CSP role is to oversee CUCS implementation of the program.
- **Riker's Island Parole Violation Diversion Initiative for Person's with Serious Mental Illness:** This program provides expeditious identification of persons with serious mental illness in the Parole violation process at Riker's Island in the City and diverts them to appropriate community programs. The forensics CSP role is to identify eligible parole violators for diversion.
- **Entitlements Specialist:** Albion, Bedford Hills, and Sing Sing correctional facilities provide pre-release benefits assistance (e.g., SSI/SSD application, mental health housing, Medicaid) with the aim of ensuring that individuals receive benefits within the first full month following their release from prison. The forensics CSP role is to over see CUCS implementation of program.

ISSUES

Forensics CSP directly relates to this core mission of OMH by focusing on a particularly vulnerable group of individuals with serious mental illness—adults who have become involved in the criminal justice system. CSP programs and services assist communities in establishing mental health–criminal justice partnerships to divert individuals with mental illness from involvement in the criminal justice system to the appropriate services; to keep people from going farther into the criminal justice system once involved; and to support reentry transition planning to community-based services.

Forensics CSP helps to improve the quality of care received by persons with mental illness involved in the criminal justice system and reduce the need for incarceration. The incarceration of persons with serious mental illness often results in further deterioration of their mental health. The costs associated with the incarceration of persons with mental illness have increased in recent years in part due to enhanced service requirements from the settlements of lawsuits and the enactment of recent. There is, therefore, an opportunity to examine strategies closely for supporting recovery and reducing the incarceration of persons with serious mental illness.

The complexity of delivering community services to persons with mental illness is compounded when these persons become involved in the criminal justice system. Stigma and discrimination toward persons with mental illness is well known. The stigma and discrimination toward persons with mental illness with criminal justice involvement is much greater and, therefore, services generally available in communities are much more difficult to access. There is a tremendous lack of understanding and misunderstanding of the complex

relationship between mental illness, substance abuse, criminal behavior and violence. This is true for both the mental health and substance abuse providers as well as the criminal justice system personnel. Community education and program development are critical to transforming attitudes and perspectives of many, including providers and police officers, judges, district attorneys, defense attorney, local correctional facility staff, community members and more.

POPULATION SERVED

Individuals with serious and persistent mental illness, as with all CSPs, particularly persons with co-occurring mental illness and substance abuse disorder

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Avoidance of hospitalizations
- Recipient satisfaction and quality of life
- Employment rates
- Number of participants in law enforcement training

D. SEX OFFENDER MANAGEMENT AND TREATMENT (SOMTA)

D.1 Classification

PROGRAM

StOps Sex Offender – **Classification**

LEGAL MANDATE/AUTHORITY

MHL Article 10

BRIEF DESCRIPTION/HISTORY/BACKGROUND

SOMTA became effective April 2007 and requires a process for evaluating the mental condition of certain sex offenders scheduled to be released from the custody of "agencies with jurisdiction," to determine whether the individual is a "sex offender requiring civil management." A sex offender requiring civil management can be either (1) a dangerous sex offender requiring civil confinement (who would be confined to a secure treatment facility operated by OMH), or (2) a sex offender requiring strict and intensive supervision and treatment (supervised by a Parole Officer in the community). The statute assigns a number of duties and responsibilities to OMH relative to the identification, assessment and treatment of individuals found by the court to be in need of civil management.

MHL delineates the process for OMH's mandated review of individuals referred by an agency with jurisdiction for the purpose of evaluating whether such individuals are appropriate candidates for civil management. The OMH Records Assessment and Record Review Unit (RARR) meets this mandate through a multi-tiered assessment process. The first step involves a record review by the Multidisciplinary Review (MDR) team to ensure that the respondent is eligible for civil management. The team completes research-based, valid actuarial risk assessments to determine whether the case should be forwarded for review by a Case Review Team (CRT). The CRT conducts second step reviews and appoints psychiatric examiners to evaluate respondents and determine whether they suffer from a mental abnormality that predisposes them to sexually offend. Based on the CRT's assessment and findings of the examiners, the CRT has statutory authority to determine which respondents are referred to the Office of the Attorney General (OAG) for civil management petitioning.

ISSUES

Given the sensitive nature of the work, its importance to public safety, and OMH's commitment to the high priority the Classification Program requires, a quality assurance program is vital to ensure that work products, documents used in the court proceedings, and the statutorily required civil management determinations are accurate and adherent to best practices and national standards. Recruitment and retention of the staff necessary to ensure the integrity of the civil management process and the best outcomes (e.g., accurate risk prediction, community safety) is an ongoing challenge.

As a result of a recent Court of Appeals decision, DOCS has released a number of inmates subject to periods of post-release supervision (PRS) that were imposed by DOCS and not imposed by the court at the original

time of sentencing. Since this decision also pertains to inmates eligible for review pursuant to Article 10, the workload for the RARR has increased and had a profound impact on the RARR process, as these cases often require a quick one-to-two day turnaround. While these cases absorb a great deal of staff resources, there has been an impact on the ability for the review of cases already in the queue. Given the large number of cases affected by the court decision, these urgent referrals will remain a struggle.

In addition to completing psychiatric evaluations to determine the presence of a mental abnormality, the psychiatric examiners also conduct psychiatric examinations for persons who are in violation of their Strict and Intensive Supervision and Treatment (SIST) conditions and subject to being detained upon the direction of their SIST Parole Officer. When detained, a psychiatric examination must be conducted within five days. There has been a dramatic increase in the number of SIST violation exams from 2007 to 2008, leading to an unanticipated increase in workload for the psychiatric examiners. Psychiatric examiners are required to testify at probable cause hearings and trials. If judges and courts are unable to utilize videoconferencing technology for probable cause hearings, trials, and retention hearings (or receive the psychiatric examiners' reports without requiring travel to testify), travel costs will continue to increase. Additionally, CRT clinicians are increasingly subject to court subpoenas and required to testify in person. As it is difficult to predict when such testimony will be needed, the unscheduled absence of CRT members has a substantial impact on operational planning and the ability for timely case reviews.

POPULATION SERVED

Four agencies have the jurisdiction to refer cases to OMH for civil management consideration—DOCS, DOP, DOP, OMH, and the Office of Mental Retardation and Developmental Disabilities (OMRDD). A respondent can be referred to OMH for review if that individual has been convicted of a requisite sex offense and is scheduled for release by an agency with jurisdiction. The requisite sex offenses include felony sex offenses, sexually motivated felonies, certain prostitution/incest offenses, and attempts or conspiracy to commit any such offenses.

PERFORMANCE MEASURES

- Number of SIST investigations, SIST orders
- Number of SIST in community with parole term
- Number of SIST in community without parole term
- Number of SIST violations

D.2 Inpatient Services

PROGRAM

StOps Sex Offender – **Secure Treatment Facility – Sex Offender Treatment Programs Inpatient Services**

LEGAL MANDATE/AUTHORITY

MHL Article 10

BRIEF DESCRIPTION/HISTORY/BACKGROUND

SOMTA became effective April 2007 and requires a process for evaluating the mental condition of certain sex offenders who are scheduled to be released from the custody of "agencies with jurisdiction" to determine whether the individual is a "sex offender requiring civil management." A sex offender requiring civil management can be either (1) a dangerous sex offender requiring civil confinement (who would be confined to a secure treatment facility operated by OMH, or (2) a sex offender requiring strict and intensive supervision and treatment (supervised by a Parole Officer in the community). The statute assigns a number of duties and responsibilities to OMH relative to the identification, assessment, and treatment of individuals found by the court to be in need of civil management.

Under SOMTA, OMH is authorized to accept custody (and confine respondents in secure treatment facilities) for the purposes of providing care, treatment, and control, following a finding of probable cause. Secure treatment facilities are separate and distinct facilities from psychiatric hospitals and its patients must be kept separate from other persons in the care, custody, or control of the Commissioner. Each secure treatment facility at MPC (20-bed ward), CNYPC (5 wards currently operating with a total capacity of 125), and St. Lawrence Psychiatric Center, (SLPC; two wards currently operating with a capacity of 44) houses and treats its patients separate from the inpatient populations at the Psychiatric Centers, and the facilities are operated as separate and distinct entities from those hospitals.

Once a judge issues a probable cause or confinement order, respondents are admitted to one of the two sex offender treatment programs. A respondent admitted on a probable cause order remains in the secure treatment facility until the conclusion of his trial where the judge then issues a final decision for civil confinement, SIST, or release. With a confinement order, the patient is expected to fully engage in all aspects of a five-phase program, which incorporates elements of relapse prevention, cognitive behavioral therapy, recovery, and risk-needs-responsivity. There are three treatment tracks, depending upon clinical need—tracks for general treatment, high psychopathy, and serious and persistent mental illness/cognitive limitations. Per statute, the patient's continued confinement is reviewed annually, where upon the OMH psychiatric examiner seeks feedback from treatment staff, and assesses the patient's risk for recidivism and whether he continues to be a dangerous sex offender in need of confinement. The examiner then issues a formal report to the court for retention determination.

After a formal treatment progress and risk assessment and after a patient successfully completes the first four phases of treatment, the OMH Commissioner will submit a recommendation for discharge to the court and the OAG. It is anticipated that most, if not all, patients will be recommended for SIST prior to discharge.

ISSUES

A majority of patients in the secure treatment facilities are being held on probable cause orders and have not yet been civilly confined. As of July 30, 2008, 101 of 149 patients within the sex offender treatment programs were being held on probable cause orders awaiting trial. This is significant because patients with this legal status often do not participate in treatment in any meaningful way and are often disruptive to the treatment milieu. While the State is using high-cost alternatives to meet the requirements of the law, lower cost alternatives may be possible to sustain public safety. Specifically, these patients are occupying "treatment" beds until trial.

OMH is exploring less costly approaches to care with DOCS. One option may be to have OMH provide residential treatment program housed in on the grounds of a DOCS facility until a final confinement order is issued. Developing a DOCS-based secure treatment facility that is consistent with statutory provisions may generate additional savings by taking advantage of DOCS perimeter security and support functions and eliminating an urgent need for new construction. While OMH would still provide treatment in that setting, OMH staffing could be reduced and the need for new construction to meet the increasing capacity for individuals civilly confined could be delayed.

Another opportunity for restructuring may be present in OMH SOMTA ward staffing levels. Other states have lower patient-to-staff ratios than OMH for sex offender treatment programs. Reducing the current ratio to one more in line with existing OMH forensic inpatient programs may prove to be cost-effective, while maintaining safety and security within the SOMTA program.

Both CNYPC and SLPC face staffing shortages and difficulties in recruiting nurses, social workers, and secure care treatment aides (SCTAs). Part of the problem is the result a general national shortage of nursing and social work professionals in the field. Recruitment is also hindered by the fact that other private and public agencies offer higher salaries for professional positions.

Another factor impacting the program relates to court orders stipulating that OMH transfer patients to court for various legal proceedings. Existing transport protocols call for patients escorted outside the secure perimeter to be accompanied by two safety officers and one direct care staff member. There may be opportunities here to restructure security arrangements and staffing for transport to reduce costs.

POPULATION SERVED

Individuals served in OMH's secure treatment facilities referred under Article 10 for civil management

(Individuals are initially referred to OMH from an agency with jurisdiction for consideration of civil management (i.e., DOCS, DOP, OMH, OMRDD). Individuals are only referred to OMH for review if they have been convicted of a qualifying offense and scheduled for release from a qualified referring agency. The criteria for referral include requisite sex offenses, including felony sex offenses, sexually motivated felonies, certain prostitution/incest offenses, and attempts or conspiracy to commit any such offenses. Upon completion of the RARR process that results in a determination that the individual suffers from a mental abnormality which predisposes him to committing repeated sexual offenses, the case is referred to the OAG, which has the discretion whether to pursue the case in court. If the outcome of a court hearing is a finding of probable cause, the individual is referred to OMH for care, treatment, and control.

PERFORMANCE MEASURES

Performance measures under development will focus on general measures for inpatient populations (e.g., census, admissions and releases, and length of stay measurements, as well as incident and restraint and seclusion indicators). Length of stay data shed light on characteristics such as diagnosis, phase, and treatment track. Additional performance measures will include number of modules developed, number of hours of programming broken down by type (needs based, recreational, vocational, psychoeducational), and relapse/recidivism rates.

D.3 Outpatient Services

PROGRAM

StOps Sex Offender Outpatient Services – **Strict and Intensive Supervision and Treatment (SIST)**

LEGAL MANDATE/AUTHORITY

MHL Article 10

BRIEF DESCRIPTION/HISTORY/BACKGROUND/CURRENT

Under SOMTA, sex offenders who are adjudicated to be in need of civil management may be placed by the court in a secure treatment facility or in outpatient civil management under a regimen of SIST in the community. In addition, sex offenders released by the court from secure treatment upon a finding that they are no longer dangerous may be placed in SIST upon their transition back into the community. SIST is supported by State funds. However, providers are expected to bill third-party sources, such as patient's insurance, when possible, as well as the patient when has the financial means to pay. OMH is considered the payer of last resort.

The primary goal of SIST is to enhance community safety through the effective treatment and management of designated sex offenders in the community. When the court orders an individual to be released into the community under SIST, it orders a specific regimen of supervision and treatment. DOP has the responsibility to implement the supervision plan and assure compliance with the conditions of the court-ordered regimen of supervision and treatment. Sex offender treatment providers work closely with the assigned parole officers to successfully manage and treat individuals in the communities, as well as to implement the court-ordered treatment plans.

All treatment is based upon a cognitive-behavioral model, and includes a relapse prevention component. Important objectives of SIST are to protect the community from criminal sexual behaviors and to assist offenders in gaining control over criminal sexual behaviors, thinking, arousal and other life issues to aid safe reintegration into the community. Offenders often have mental health and/or substance abuse needs that must be addressed. These needs may be directly addressed by the treating agency or by referral to qualified mental health or substance abuse treatment providers.

OMH works collaboratively with the DOP and OAG, as well as treatment providers in State correctional facilities, forensic facilities and in the community, to develop plans for SIST. These efforts begin with contact from the OAG that a SIST disposition is being considered. The viability of a SIST disposition may be, and often is, explored prior to a case proceeding to jury trial. A preliminary review of the case for a possible SIST disposition is initiated by the OAG and involves OMH, DOP, and treatment staff from the referring agency. If the OAG determines that a SIST disposition may be appropriate, the respondent may agree to a finding of mental abnormality without a trial and the court may order a SIST investigation. A SIST investigation also may be ordered by the court subsequent to a trial verdict finding of mental abnormality.

When a SIST investigation is requested by the court, OMH works closely with the DOP, institutional and community treatment providers, and other pertinent parties to determine whether the sex offender can be

adequately managed in the community. The SIST team must find an appropriate residence for the individual, identify treatment providers, and propose a treatment and supervision plan. If the sex offender is a confined sex offender, the SIST team works closely with the institutional transitional service program to ensure continuity of treatment and well-planned reintegration back into the community. Signed releases of information from the individual are obtained for all designated service providers, and all issues relating to the delivery of, and payment for, treatment services are addressed. When the investigation is complete and the information and recommendation is returned to the court, the court may order an individual to be released into the community under a SIST order or, in the alternative, be placed in a secure treatment facility.

ISSUES

OMH and qualified sex offender treatment providers work closely with the assigned Parole officers in helping to successfully manage and treat the individual under the SIST conditions. SIST individuals require a team of professionals, and the supervision/treatment team who are communicating frequently and convening regularly to examine individual progress, make necessary revisions in the supervision/treatment plan, and instituting them in a timely manner.

- As the number of persons released to SIST increases, there will be a need to hire staff to monitor treatment adherence and these individuals' suitability for continued community placement. The Department of Civil Services has authorized AOT Compliance Specialists to serve this purpose.
- Dedicated funding is unavailable to assist offenders to secure and/or maintain housing and employment. In addition, transportation to and from treatment appointments is often difficult to secure, particularly in rural areas.
- Ongoing and advanced training is needed for current sex offender treatment providers to stay up to date regarding evidence-based practices in the field of sex offender assessment, treatment, supervision, and management of sex offenders.
- Service provision would be enhanced through a network of treatment providers organized to support the SIST program. Qualified treatment providers are particularly scarce in rural areas of the State.

POPULATION SERVED

Adult sex offenders ordered to a regimen of SIST under the provisions of SOMTA

PERFORMANCE MEASURES

Performance measures under development will focus on treatment and supervision compliance and recidivism. Additional performance measures are also being developed for providers and will include measures of efficacy of treatment, competency and knowledge base, training needs, and quality of collaboration with Parole.

E. RESEARCH PROGRAM

E.1 Research: State-Operated Inpatient Program

PROGRAM

StOps Research – **Inpatient Services**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.05, 7.15, 7.17; Public Health Law (PHL) Article 24-a

BRIEF DESCRIPTION/HISTORY/BACKGROUND

There are three inpatient units at the New York State Psychiatric Institute (NYSPI) and two inpatient units at the Nathan Kline Institute (NKI) for Psychiatric Research.

NYSPI Inpatient Units

The three inpatient units at NYSPI are 4 Center, 5 South, and 4 South. The primary mission of the first two units is research, while the primary mission of 4 South is to provide clinical care and treatment services. For this reason, 4 South is similar to the inpatient units in OMH Adult Psychiatric hospitals, and substantially different from the other two inpatient units at NYSPI.

- **4 Center Unit**

  Research conducted on this 12-bed unit is focused on studies of suicidal behavior, mood disorders, and eating disorders. Patients participate in research protocols and receive clinical care. An example of research conducted on 4 Center is a treatment intensity study of patients with anorexia nervosa where the usual NYSPI treatment, which includes a stay of several months, was compared with a managed care type treatment, including a short inpatient stay followed by a day treatment.

- **5 South Unit**

  Research pursued on this unit 24-bed unit is focused on psychotic disorders, substance abuse, and depression and depression-related disorders. Patients enrolled in research protocols on 5 South receive clinical treatment while participating in research. Some examples of research studies conducted on the 5 Center are neuroimaging (e.g., PET receptor research), electrophysiology studies, and research on social functioning and cognition, as they relate to biological measures in schizophrenia.

- **4 South Unit**

  This 22-bed unit provides a range of psychiatric services to patients who reside in the surrounding Washington Heights community. 4 South is part of a comprehensive service that includes two off-site ambulatory clinics at Inwood and Audubon.

The inpatient services at NYSPI also include occupational therapy and recreation therapy, clinical psychology, the division of clinical social work, and healthy outreach through psychoeducation.

NKI Inpatient Units

The two inpatient units at NKI are in the Clinical Research and Evaluation Facility (CREF), where researchers study treatment-refractory schizophrenia and novel therapeutic approaches, and aggression and violence in persons who suffer from mental illness. Each CREF inpatient unit has 12 beds. In one unit, research projects include the psychopharmacology, brain imaging, genetics, gene expression, and cognition of aggression and violence. In the other unit, researchers focus on improving the treatment of severe mental and neurological illnesses, using diverse approaches, including neuroimaging, electrophysiology, neurochemistry, analytic psychopharmacology, and advanced neurodiagnostics. In addition, clinical trials of new medications, and new approaches to the use of conventional medications, take place on the second CREF unit.

ISSUES

Staff is the principal issue facing the three (3) NYSPI inpatient units and the two (2) NKI inpatient units. The staffing on 4 Center, 5 South, and the two CREF units must be sufficient to execute the research protocols in which the patients are enrolled, and to provide high-quality clinical care and treatment to these patients. This complex research and treatment environment requires a relatively high staff-to-patient ratio.

POPULATION SERVED

NYSPI Inpatient Units

On 4 Center, patients with eating disorders comprise 37% of the population; with a mood disorder, 37%; and with substance use disorders, schizophrenia and other psychotic disorders, and anxiety disorders making up the remaining 26%. Of patients served, 66% are female; and 52% is between 18 to 34 years of age and 37% between 35 and 54. On 5 South, 58% of patients have substance use disorders; 35%, schizophrenia and other psychotic disorders; and 7%, anxiety and mood disorders. Of patients served, 71% male is male; 58% s between 35 and 54 years of age, and 36% between the ages of 18 and 34. On 4 South, 61% of patients suffer from schizophrenia and other psychotic disorders; 33% have mood disorders; and 6% have adjustment, anxiety disorders, impulse control, personality, and substance-use disorders.

NKI Inpatient Units

With few exceptions, persons served by these inpatient units have a primary diagnosis of schizophrenia or schizoaffective disorder. The population is overwhelmingly male, with no fewer than 83% male patients at any time. While patients range from 18 years of age and older, the majority is between the ages of 30 and 50.

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Number of admissions
- Capacity, occupancy rate
- Number of discharges, median and mean length of stay for discharged clients
- Median and mean length of stay for residents at end of year, by tenure (in facility for less than one year; in facility for one year or more)
- 30- and 180 day-readmission rates
- Average daily inpatient bed usage by county of residence (Bridges' County Planning Pages)

E.2 Research: State-Operated Outpatient Program

PROGRAM

StOps Research – **Outpatient Services**

LEGAL MANDATE/AUTHORITY

MHL Sections 5.05, 7.17; PHL Article 24-a

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Both NYSPI and NKI provide outpatient services. At NYSPI, these services consist of the Washington Heights Community Services Outpatient Clinic Treatment and Day Treatment Programs, and the NYSPI Children's Day Unit. NYSPI outpatient programs are primarily designed to provide clinical services to patients, while NKI outpatient programs are focused on the pursuit of research studies. In short, NYSPI outpatient programs are basically clinical in nature; NKI outpatient programs are basically research in nature.

The Washington Heights Community Services outpatient programs serve patients who are predominantly poor and Latino. To qualify for outpatient services, patients must be 16 years of age or older, and have a diagnosis of severe mental illness. The outpatient clinics are located in Inwood and Audubon. The average daily census for both clinics combined is approximately 1,000 individuals, and the combined total visits to the clinics exceed 45,000 per year. The Children's Day Unit has capacity for 12 children and adolescents who suffer from conduct disorders, anxiety, depression, and/or psychotic disorders. These children and adolescents participate in therapeutic trials with medication and psychotherapy. The Unit includes on-site schools for the children and adolescents who are receiving treatment. It also provides screening, assessment, and referral services. The NKI outpatient program conducts studies with children and adults with mental illness, as well as "control groups" of volunteers from the local community, who have not been diagnosed with mental illness.

ISSUES

The principal issue facing the NYSPI and NKI outpatient programs is continued OMH funding, particularly for outpatient clinical programs. The outpatient programs in Washington Heights and the geographic area surrounding NKI in Rockland County are key to providing mental health services to the citizens of these communities.

POPULATION SERVED

At NYSPI

The Day Treatment Programs and the outpatient clinics serve the Washington Heights community. Of the patients served, 55% female; 83% are 35 years of age or older; and 54% have schizophrenia and other psychotic disorders, while another 40% have mood disorders, and 6% have anxiety and personality disorder or substance-use disorder.

At NKI

The outpatient research program includes 26 different research protocols at NKI and the New York University School of Medicine. These studies include patients as young as six years of age and as old as 90. The pediatric and adult subjects have 36 different primary diagnoses. The outpatient study control group is 59% male, 78% Caucasian, 18% African American, 3% Asian, and 1% Native Hawaiian or Other Pacific Islander. Seventy-seven percent of the research group is male, 68% Caucasian and 32% African American.

In the population enrolled in the geriatric and memory clinical trials, gender representation is about equal; most subjects are Caucasian. Of those individuals who participate in clinical trials, 76% are diagnosed with late life major depression and 24% with probable Alzheimer's disease. The vast majority of these individuals are more than 60 years of age.

PERFORMANCE MEASURES

- Number of persons served by age, sex, race, ethnicity, diagnosis, living situation
- Reduction in hospitalizations
- Length of community tenure
- Outpatient admissions, census, and terminations
- Recipient ratings of quality of life, service quality, access to services, appropriateness of services, outcomes of services
- Certification tier, operating certificate duration and capacity

E.3 Research: State-Operated Research

PROGRAM

StOps Research – **Research**

LEGAL MANDATE/AUTHORITY

MHL Sections 5.05, 7.17; PHL Article 24-a

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Under MHL, NYSPI and NKI are charged with conducting research to improve the mental health of the State's citizens. The preponderance of basic, clinical, and applied research into mental illness conducted by OMH occurs at NYSPI and NKI. The two Institutes' research programs and divisions focus on different psychiatric disorders, but these emphases are complementary and, between the two Institutes, research occurs into every aspect of mental illness. The basic research, clinical research, and clinical work at NYSPI and NKI are conducted in close collaboration with major academic medical centers. NYSPI is affiliated with the Columbia University Department of Psychiatry, and NKI with the New York University Child Study Center. Each of these affiliations provides a framework in which research, clinical practice, and teaching flourish and enhance one another.

At NYSPI

Research involves basic and clinical science, including efforts to identify the genetic precursors to psychiatric illness, develop and test new pharmacological and psychotherapeutic treatments, identify childhood precursors of mental disorders, and understand brain function at the molecular level and how it is compromised in major mental diseases. Researchers conduct clinical trials to help elucidate the relative benefits of new medications in mental illness, including schizophrenia, depression, Alzheimer's disease, substance abuse, and autism. A variety of agencies, including the federal National Institutes of Health (NIH) fund this research. Of note is that NYSPI is in the forefront of efforts to develop and implement culturally competent integrated physical and mental health care for persons with serious mental illness. To pursue these efforts, the New York State Center of Excellence for Cultural Competence was established at the Institute, through an amendment to MHL.

NYSPI also plays a key role in promoting OMH's research-to-practice agenda, whereby cutting-edge scientific knowledge and expertise are rapidly made available to inform decision makers, planners, policy makers and clinicians. This is accomplished through consultation and dialogue between the research experts and program managers. One structure which has been created to facilitate large-scale dissemination of research-informed best practices is the Evidence-Based Practice and Training Center.

At NKI

Research includes basic, clinical, and services research studies focusing on the causes, diagnosis, treatment, prevention, and care of severe and long-term psychiatric disorders; clinically relevant, basic research on physiological and biochemical aspects of mental illness; and studies of the cost, quality, and effectiveness of services for patients receiving services from programs certified, operated, and/or funded by the State. NKI researchers are investigating how to facilitate recovery-based approaches to individuals with serious mental

illness. In a related effort, the NKI Center for Cultural Competence seeks to identify and develop evidence-based practices to improve culturally competent mental health service delivery across the State.

Research by NKI's scientists has resulted in significant accomplishments, including the introduction of pharmacologic treatment for depression and affective disorders; application of computers to psychiatry; and development of the first mental health information systems; creation of a now widely used laboratory assay technology to measure therapeutic blood levels; development of statistical design technologies and data analysis methodologies for clinical trials; and, identification of the optimal plasma level of haloperidol for the treatment of schizophrenia. At NKI research continues into brain functioning, now with the aid of new facilities, including the Center for Advanced Brain Imaging, with its powerful Magnetic Resonance Imaging (MRI) technology. A new inpatient clinical research and evaluation unit has been established and is dedicated to identifying new treatments for psychiatric patients who do not respond to currently available medications. The NKI Information Sciences Division offers a range of clinical study management systems and services designed and developed to meet the needs of the clinical research community.

ISSUES

The OMH Research Program at NKI and NYSPI is a highly leveraged combination of State, federal, and private and industry funding. Such financial support is predicated upon prior feasibility demonstration and strong pilot data. State funds are important in launching fundable grants and attracting federal, private, and industry support. Initiating and conducting such research rests in part on continued federal funding. Thus, a major issue facing the OMH Research Program is the erosion of federal NIH research funding over the past five years. NIH support is anticipated to be flat at least through the next federal budget cycle. This problem is exacerbated by the fact that funding of approved grant applications is frequently reduced—in some instances by 20% or more.

At NKI specifically, the most critical issues facing the Research Program include (1) challenges presented by having basic functions (e.g., plant and facilities, business office, human resources, security) substantially supported almost entirely by funds generated through grants; and (2) the need to stay positioned for federal and other research funding to support advanced brain imaging in the next three to five years through State funding for new and renovated magnets for MRI research.

At NYSPI specifically, the most important issues facing the Research Program include challenges that result from (1) having a portion of the Institute's State-funded positions allocated to research, because the Institute is also charged with providing clinical treatment and services to the surrounding community; to enable the Institute to continue to attract revenue from federal, private and industry resources, NYSPI is striving to have the number State-funded positions remain stable; (2) having the terms of many federal grants require that the NYSPI budget contain a certain level of State support, which is necessary for researchers to compete successfully for federal funding and not have research revenues decline; and (3) recognizing the value that mental health services research findings have for immediate application to the delivery of mental health services to the State's citizens.

POPULATION SERVED

Defined by the criteria established by the many research protocols in place and clinical treatment needs of individuals participating in research studies

(As note previously, these different populations range in age from pediatric to geriatric and cover a range of psychiatric disorders, including autism, eating disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, Tourette's disorder, social phobia, late-life dementia, and Alzheimer's disease.)

PERFORMANCE MEASURES

- Total dollars obtained through grants to support research studies at the Institutes
- Total number of articles published in peer-reviewed journals, as a measure of information dissemination
- Number of research and clinical consultations provided to OMH Executive staff, program managers, and clinicians by the experts, to bring the latest research findings to individual care and policy decisions

F. ADMINISTRATION AND FINANCE PROGRAM

F.1 State Administration and Finance

PROGRAM

StOps Research – **State Administration & Finance**

LEGAL MANDATE/AUTHORITY

MHL Sections 7.07, 7.09, 7.11

BRIEF DESCRIPTION/HISTORY/BACKGROUND

The mission of OMH is to promote the mental health of all New Yorkers with a particular focus on facilitating hope and recovery for adults with serious mental illness and children with serious emotional disturbances. The OMH Central Office is organized around the populations served by the mental health system—adults, children and their families, and those involved with the criminal justice system—to position the agency to successfully meet the diverse needs of recipients of mental health services across all groups, and to support the integration of State-operated and licensed inpatient and community-based services for each population.

- ***The Division of Adult Services*** oversees, funds and regulates an integrated system of mental health care that includes the State Adult Psychiatric Centers and a comprehensive, coordinated network of community service providers delivering a balanced array of medical, self-help, social, supportive and rehabilitative services.
- ***The Division of Children and Family Services*** oversees, funds and regulates an integrated system of mental health care that includes the State Children's Psychiatric Centers and a coordinated, effective, flexible array of clinically appropriate services which yield positive outcomes such as family support, emergency services, outpatient services, community residential services, and inpatient services.
- ***The Division of Forensic Services*** oversees, funds and regulates an integrated system of secure Forensic Psychiatric Centers, secure regional forensic units and an array of community-based training and technical assistance services that enable local governmental units (LGUs) to better serve this population. Additionally, the Division evaluates sex offenders upon the expiration of their criminal sentences to determine whether they require civil commitment or SIST, and provides confinement and treatment as appropriate.
- OMH's five ***Field Offices*** provide and coordinate, at a policy and administrative level, technical assistance and oversight to LGUs concerning local mental health program planning, development, implementation and evaluation. Staff in the Field Offices serve as resources to local governments and mental health providers and advocate for their needs; manage development and implementation of newly funded isnitiatives (e.g., housing, vocational services, case management); conduct licensing and certification activities; provide technical assistance and participate in OMH regulatory reform workgroups; collaborate on review and refinement of new

program models (e.g., case management); and share the goal of programs, services and funding methods that support a comprehensive, outcome-based mental health system.

- The ***Office of the Medical Director*** provides clinical direction and supervision to the Assistant Medical Directors in the OMH Divisions of Adult, Children and Families, and Forensic Services; provides advice and counsel concerning clinical and medical issues; and provides clinical supervision to the Clinical Directors of the OMH-operated Psychiatric Centers. Within the Office of the Medical Director, the ***Office of Quality Management*** monitors compliance with OMH and other State and federal standards of patient care and performs external review, clinical risk management, and clinical information management functions.
- The ***Office of Consumer Affairs*** facilitates input from service recipients into planning and policy development, and plays a critical role in maintaining and encouraging ongoing communication and dialogue with current and former recipients of mental health services. Additionally, the Office coordinates and leads efforts to ensure that mental health services provided to individuals and their families are culturally relevant and that service delivery systems effectively address treatment and service needs in a manner consistent with cultural, ethnic, linguistic and spiritual norms, beliefs, and values.

OMH's major program Divisions and Offices are supported by 11 administrative offices, bureaus and centers, including the Office of Counsel, Public Information, Intergovernmental Relations, Planning, Investigations, Audit, Financial Management, Information Technology, Evaluation Research, Evidence-based Services and Implementation Science Group, and Human Resources Management.

- The ***Office of Counsel*** provides legal advice and representation to OMH executive staff and to the administration of the Psychiatric Centers and other programs operated by the OMH. Additionally, the Office of Counsel develops OMH formal policy and regulations and monitors State and federal regulatory developments affecting OMH.
- The ***Office of Public Information*** represents the agency publicly and manages and executes responses to Freedom of Information Law (FOIL) requests.
- The ***Office of Intergovernmental Relations*** is the OMH point of contact for Legislators and legislative staff regarding constituent concerns, requests for information, and briefings. Moreover, it is responsible for meeting requirements related federal Block Grant activities and the Governor's Inter-Office Coordinating Council, and developing and responding to all federal requirements related the Block Grant.
- The ***Office of Planning*** is responsible for meeting all statutory requirements related to local and State planning under MHL. The Office works collaboratively with the Conference of Local Mental Hygiene Directors, the Interagency Planning Workgroup, and the Governor's Inter-Office Coordinating Council in facilitating integrated mental health, substance abuse, and mental retardation/developmental disability planning. The Office has programmatic responsibility for public education and health promotion efforts.
- ***Investigations*** conducts administrative and clinical investigations concerning issues of internal concern and sensitivity within OMH.
- The ***Bureau of Audit*** conducts audits and reviews of OMH facilities, Central Office operations, and local providers of mental health services.

- The ***Office of Financial Management*** administers OMH's budgeting functions for State-operated programs as well as State resources made available for community-based mental health services, including the development of annual budget requests and coordination and development of the Aid-to-Localities budget. The Office also develops and implements Medicaid and non-Medicaid reimbursement methodologies, analyzes financing strategies, establishes performance-based rate adjustment and provider-specific rates, and ensures that Central Office and all facilities receive the necessary business management services (e.g., payroll, vouchering, accounting) to support campus operations and patient activities.
- The ***Center for Information Technology*** maintains the agency computing and telecommunications infrastructure. All OMH-operated facilities statewide depend on OMH systems for patient care, financial and human resources management and communication. More than 2,500 locally operated mental health programs use OMH-operated systems for required financial, care coordination and outcomes reporting. Additionally, all county and City mental health authorities use OMH systems for planning and for oversight of their local systems, as often OMH systems are their only source of "hard data."
- The ***Center for Evaluation Research*** conducts program evaluations, which are the primary means for assessing the efficacy of key public mental health services. OMH-produced statistical information is essential for public mental health system planning as the State, local and federal government rely on reports and other publications produced by OMH evaluation research staff.
- The ***Evidence-based Services and Implementation Science Group*** is primarily responsible for the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)), an interactive, computerized decision support system that enables cost-conscious, guideline-driven, quality improvement in the State-operated hospitals.
- The ***Center for Human Resources Management (HRM)*** develops and implements personnel, employee relations, training, HRM information systems, and diversity policies and practices, criminal history information, and coordinates their consistent implementation throughout the agency.

ISSUES

Consonant with Governor Paterson's July 31, 2008, order to reduce State agency spending by 7%, OMH has initiated a comprehensive review of all categories of expense. A critical element in this effort is focusing on the management of the State workforce under the hard hiring freeze process. A significant challenge for OMH will be the preservation of core mission-related functions in an environment of funding reductions and declining staff levels.

F.2 Administration – Local Government Units (LGUs)

PROGRAM

ATL – Administration – **Local Government Units (LGUs)**

LEGAL MANDATE/AUTHORITY

MHL Article 41, 41.16, 41.18; MHL Sections 9.40, 15

BRIEF DESCRIPTION/HISTORY/BACKGROUND AND ISSUES

Administration and technical assistance is provided for all mental health agency programs as well as in areas such as clinical oversight, quality assurance and planning. Funding for such technical assistance is made available, as appropriate, within the individual program resources or by use of personnel funded under the State purposes portion of the budget. In addition, LGUs and other eligible providers of mental health services contact the appropriate OMH Field Office to arrange for technical assistance.

LGU (LGU) Administration – Includes Reinvestment and Medication Grant Program (MGP)

Description: This program category includes all local government costs related to administering mental hygiene services that are provided by a local government or by a voluntary agency pursuant to a contract with an LGU.

In 1999, New York State enacted legislation that provides AOT for certain individuals diagnosed with mental illness who, in view of their treatment history and present circumstances, are in need of community supervision. Commonly referred to as "Kendra's Law, this law authorizes grants to counties to provide medications to treat mental illness during the pendency of a medical assistance eligibility determination. In support of this medication grant program, funds have been authorized to ensure appropriate release planning and timely filing of Medicaid applications for individuals receiving mental health services in local jails, one of the priority populations to be served by the medication grant program.

Monitoring and Evaluation, Community Support Services (CSS)

Description: CSS funding provides for monitoring and evaluation activities associated with the program and fiscal management of the CSS program provided by a Core Service Agency and those costs incurred by the LGU for the administration of the CSS program in those counties that have opted to administer the combined CSS/620 funding streams. In the 1970s, OMH developed 100% deficit funding to assist counties with the rapid development of community-based services to address the needs of individuals who were returning to the community from State psychiatric facilities. CSS funding has been used to develop social clubs, transportation and various community support and employment support programs.

Issues: Many of the original CSS-funded programs were converted to CSP Medicaid add-on funding; others are being reviewed within the context of the larger ambulatory restructuring project.

Subcontract Service(s)

Description: All expenses incurred which are payments to subcontract provider agencies for program delivery; and all revenues received by a Core Service Agency on behalf of subcontracted provider agencies. This program does not include agency administration.

LGU Administration

Description: The LGU is defined in MHL. This program category includes all local government costs related to administering and planning for mental hygiene services that are provided by a local government or by a voluntary agency pursuant to a contract with an LGU. This program does not include agency administration.

Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training

This program provides individual and/or group treatment to alleviate the mental and emotional crises and their subsequent psychological and behavioral conditions resulting from major disaster or its aftermath. This is funded through FEMA.

Conference of Mental Hygiene Directors

Description: The New York State Conference of Local Mental Hygiene Directors is a statewide membership organization that was statutorily incorporated under MHL in 1976. The Conference comprises local mental hygiene directors and commissioners in all of the 57 counties and the City of New York. The conference advances State and local policies, practices, laws, regulation and funding for the purpose of ensuring comprehensive, integrated and cost-effective systems of care to meet the needs of those persons, and their families, affected by mental illness, developmental disability and/or chemical dependency. The Conference has statutory responsibility to comment upon proposed rules, regulations and policies involving local mental hygiene services plans and programs. The Conference is also represented, sometimes through statutory requirement, on a variety of statewide advisory councils, task forces and advocacy organizations, through which it provides advice and counsel for the planning and financing of community-based mental hygiene services. In the fall of 1997, the Conference implemented its Technical Assistance Project. The Project helps county directors collectively meet the challenges of a changed and changing system. The Project regularly issues publications, reports and tools for use by the counties. This program code category represents funds used by the Conference to provide technical assistance to counties.

Issues: Reliance on Medicaid funding is an ongoing concern for counties, as they have lost the flexibility of using State Aid to support local initiatives. Fiscal management of county-operated programs and the need for technical assistance has been a priority for the technical assistance projects directed by the Conference. Lastly, because many individuals come into contact with a variety of different government agencies (e.g., county social services, mental retardation/developmental disabilities, alcoholism and substance abuse, probation, parole) and receive care from as system that is fragmented, the Conference plays a central role in coordinating and facilitating cross-systems collaboration and system performance as they relate to the provision of integrated services for New York's citizens.

SPOA

Description: During the late 1990s, some recipients of services with high-level needs were unable to access housing and case management services. During fiscal year 2000–2001, OMH charged local governments with developing local strategies to prioritize their high-risk populations for the purpose of creating easy access to

the case management, ACT, and housing systems. The SPOA process connects eligible applicants with appropriate vacancies in these three systems through a process that identifies individuals most in need of services, manages service access, and tracks vacancies and utilization. The SPOA process helps LGUs achieve community-based mental health systems that are cohesive and well coordinated for individuals most in need of services. Currently, there are 66 SPOA Coordinators across the State. In 2007, 3,439 applications for services were received.

Issues: There may be conflicts among the priority populations for equal access to limited resources. For example, persons under AOT court order may be seen as the number one priority group, while others may feel that recipients who are leaving State Psychiatric Centers should have priority access. Limited resources and access to services are issues that impact the SPOA process. Implementation of federal TCM regulations could also have significant impact on the range of services that the SPOA process would manage.

POPULATION SERVED

LGU Administration and Medication Grant Program

Those served under the medication grant program are individuals who are leaving correctional facilities or psychiatric inpatient settings, have a diagnosed mental illness, and have pending Medicaid eligibility. The medication grant program insures that individuals can obtain their medications upon discharge and that the individuals are linked to community-based treatment, rehabilitation and supports.

Monitoring and Evaluation, CSS

The CSS population consists of those individuals who are living with a serious mental illness, have a history of institutionalization, are homeless, and/or are living in a shelter, RCCA, SRO or in adult home. They each have a functional disability due to mental illness in three of six areas of functioning (i.e., self-care, social functioning, activities of daily living, economic self-sufficiency, self-direction or ability to concentrate) and are in jeopardy of losing community tenure with the provision of community support services.

Single Point of Access (SPOA)

Adult SPOA priority populations include individuals with psychiatric disabilities who may be subject to AOT orders, who are leaving State Psychiatric Centers, or who have a history of homelessness.

F.3 Legislative Member Items

PROGRAM

StOps – **Legislative Member Items**

LEGAL MANDATE/AUTHORITY

Article III and VII (Section 4) of the State Constitution

BRIEF DESCRIPTION/HISTORY/BACKGROUND

OMH's Budget includes funding for Legislative Member Items to support two initiatives. For 2008-09, the Legislative Member Items included the following:

- 10 new Research Scientists at the Nathan Kline Institute (NKI) in Rockland County
- New laboratory equipment for NKI

PROGRAM

ATL – **Legislative Member Items**

LEGAL MANDATE/AUTHORITY

Article III and VII (Section 4) of the State Constitution

BRIEF DESCRIPTION/HISTORY/BACKGROUND

OMH's Budget includes funding for Legislative Member Items to support a variety of initiatives. For 2008-09, the Legislative Member Items included the following:

- Mental Health Association of Rockland County
- Mental Health Association of Orange County
- Relief Resources
- Hospital Audiences
- Farm Net
- Occupations, Inc.
- Ohel Children and Family Services
- NASW training related to mental health services for veterans
- Health Care Coverage for Direct Care Workers
- Children's Day Treatment
- North Country Children's Mental Health Programs

G. CAPITAL PROGRAM

PROGRAM

StOps – **State Capital Program**

LEGAL MANDATE/AUTHORITY

MHL 7.17; SSA 1905(a)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

OMH operates sixteen Adult Psychiatric Centers, six Children and Youth Psychiatric Centers, three Forensic Psychiatric Centers, two Research Facilities and one Cook Chill food production site. These facilities comprise more than 600 buildings encompassing 18,000,000 square feet of space located on more than 4,500 acres of grounds and infrastructure.

OMH inpatient facilities require certification by the Joint Commission to maintain federal reimbursement. The Joint Commission requires complete code compliant inpatient and program space or the implementation of interim life safety measures. OMH maintains a statewide MOU with the Joint Commission that includes plans for improvement for all life safety violations. Mandated standards include the 2000 National Fire Protection Association (FPA) Life Safety Code and Guidelines for Design and Construction of Health Care Facilities and the State Department Health Regulations.

- *Administration*

  Description: Personal services and non-personal services, including fringe benefits related to the administration of the capital programs for new and re-appropriated State-operated institutional capital projects. Administrative functions include campus planning, development of capital project scopes and estimates consistent with long-term plans, development and implementation of design standards, design review and approval, and project management through project completion.

  Issues: The State inpatient infrastructure must be maintained and preserved in accordance with all accreditation and health and safety standards to maintain federal reimbursement. Life safety and State building codes must be met. Adequate levels of project management staffing are required to assure compliance.

- *Accreditation*

  Description: Land acquisition, construction, reconstruction and improvements, including the preparation of designs, plans, specifications and estimates related to accreditation improvements to existing facilities and programs. OHM facilities are inspected by the Joint Commission and the federal CMS and as such require a constant state of readiness. Examples of projects that keep facilities in a state of readiness are the provision of emergency generators to meet power supply needs, improvements as required by the life safety code, therapeutic environment improvements, roof replacements, boiler and air conditioning replacements, door replacements and other security improvements. A statement of conditions is prepared and continuously updated for each inpatient building, identifying areas for improvement to be compliant. Project scopes are developed and implemented to ensure compliance.

Issues: The State inpatient infrastructure must be maintained and preserved in accordance with all accreditation and health and safety standards to maintain federal reimbursement. The Joint Commission enforces the life safety code through its inspection program.

- *Energy Conservation*

  Description: Construction, reconstruction and improvements, including the preparation of designs, plans, specifications and estimates for the primary purpose of reducing the consumption of energy resources. Included are energy and building management systems, weatherization and efficient lighting installations. OMH compliance with Executive Order 111 has resulted in annual energy cost avoidance of $50M, resulting from the 32% energy use reduction achieved to date. A new Executive Order is anticipated that will mandate an additional 15% reduction by 2015. The current mandate requires buildings undergoing major reconstruction to be at least 10% more energy efficient than what is required by the State's Energy Conservation Code. The order also requires that 20% of the overall energy requirements of buildings owned, leased or operated by State agencies be met through renewable technologies by 2010. Energy Conservation is mandated by the State Energy Conservation Code, Executive Order 111: Green and Clean State Buildings and Vehicles and Executive Order 4: State Green Procurement and Agency Sustainability Program.

  Issues: The evaluation of energy conservation measures involves a payback analysis to determine the value and justification for the initial investment. OMH pursues measures that provide a quick return on investment, and focuses first on operational and maintenance measures that save energy, and second on capital improvements that yield energy savings. New building construction to meet energy saving goals adds to the up-front capital costs, but saves substantially in the life cycle cost of building operations.

- *Environmental Protection*

  Description: Construction, reconstruction and improvements, including the preparation of designs, plans, specifications and estimates for the primary purpose of preservation, enhancement, restoration and improvement of the environment. Environmental issues such as indoor air quality, boiler and generator emissions, storm water protection, fuel spill prevention, hazardous waste handling and disposal, asbestos management, land preservation and reclamation, and other environmental health and safety concerns are dealt with quickly and aggressively. Through the Audit Agreement between OMH and the U.S. Environmental Protection Agency (EPA), and the annual State Environmental Audit, violations to environmental regulations are identified, with corrections required and implemented. The State Department of Environmental Conservation (DEC) regulations, EPA regulations and Audit Agreement requirements, and State Department of Labor enforcement of OSHA regulations help to govern environmental conservation and improvement activities.

  Issues: The State inpatient infrastructure must be maintained and preserved in accordance with all accreditation and health and safety standards to maintain federal reimbursement. Violations of environmental regulations must be corrected within 60 days for compliance with the EPA Agreement DEC-issued consent orders and stipulation agreements are periodically received and requirements met.

- *Health and Safety*

  Description: Construction, reconstruction and improvements, including the preparation of designs, plans, specifications and estimates for health and safety improvements to existing facilities and programs. This purpose includes projects which have as their primary purpose protection of life and reduction or elimination of risk of personal injury or harm to users of OMH facilities. Projects are completed to gain

and maintain compliance with the life safety code, health codes, OSHA standards, and safety-related provisions of other codes. Included are installations of fire protection systems, secure perimeter fencing, personal alarm systems, and emergency projects to protect the health and safety of clients, staff and visitors. Projects to correct health code violations, such as leaking sewer pipes, inadequate ventilation and potable water distribution deficiencies are common examples.

Issues: The State inpatient infrastructure must be maintained and preserved in accordance with all accreditation and health and safety standards to maintain federal reimbursement.

- *Minor Rehabilitation*

  Description: Minor alterations and improvements to various facilities. In many cases this type of renovation work can be accomplished by special project teams or facility staff under a special project assignment. Necessary work is completed in a cost-effective manner. Work is completed by this method for compliance with the Joint Commission and CMS requirements, other heath and safety improvements, building and infrastructure preservation, energy conservation and environmental protection and program improvements.

  Issues: The state inpatient infrastructure must be maintained and preserved in accordance with all accreditation and health and safety standards to maintain federal reimbursement. Minor rehabilitation projects enable the cost-effective, efficient completion of smaller capital projects that do not require as much architectural or engineering design or full contract documents.

- *Plan Preparation*

  Description: Preparation and review of plans, specifications estimates, services, construction management and supervision, inspection, studies, appraisals, surveys, testing and environmental impact statements for new and existing projects. OMH relies on the professional services of the Office of General Services Design and Construction Group and the Dormitory Authority State of New York for design and construction contract administration.

  Issues: The State inpatient infrastructure must be maintained and preserved in accordance with all accreditation and health and safety standards to maintain federal reimbursement. Professionally prepared capital project plans and specifications are necessary for project completion.

- *Preservation of Facilities*

  Description: Construction, reconstruction and improvements, including the preparation of designs, plans, specifications and estimates primarily intended to preserve assets and maintain continued operations. This includes the replacement of components of buildings and facility infrastructure such as roof replacements or rehabilitation, rehabilitation of existing support systems such as heating, ventilating, air conditioning, electrical, lighting and hot water, sealing and caulking of building exteriors, resurfacing roads and parking, and replacement of flooring.

  Issues: The State inpatient infrastructure must be maintained and preserved in accordance with all accreditation and health and safety standards to maintain federal reimbursement. Failure to preserve buildings and infrastructure causes accelerated deterioration and more costly corrective actions.

Program Improvement

Description: Construction, reconstruction and improvements, including the preparation of design, plans, specifications and estimates with the primary purpose to upgrade facilities, enhance programs in existing facilities or improve the health or comfort of clients and staff. Examples are the addition of space for patient education, treatment and recreation programs, reconfiguration of existing space to achieve efficiencies in the provision of services and the construction of new facilities to replace obsolete, inefficient and non code compliant facilities.

Issues: The State inpatient infrastructure must be maintained and preserved in accordance with all accreditation and health and safety standards to maintain federal reimbursement. In some cases, new facilities and improvements to existing space are required to meet this objective.

POPULATION SERVED

Those served by these capital programs are 4,936 adults with a serious mental illness, 413 children and youth with a serious and persistent emotional disturbance, 644 forensic clients and 154 sexual offender clients, as well as, numerous clients in community residences, RCCAs, transitional living units and crisis residences.

PERFORMANCE MEASURES

The most significant measure of the quality of care provided by psychiatric hospitals is the Joint Commission survey scores. These include a comprehensive assessment of therapeutic environment as well as clinical care. Continued compliance with Joint Commission and CMS requirements enables OMH to receive more than $750M annually in federal Medicaid and Medicare funding.

PROGRAM

ATL – **Local Capital**

LEGAL MANDATE/AUTHORITY

MHL Article 41

BRIEF DESCRIPTION/HISTORY/BACKGROUND

This program provides capital funding to develop new housing opportunities and to maintain existing housing for persons with serious mental illness. This program has existed since 1978 originally funded as a grant program. Since 1989, the majority of OMH local capital funding is supported by the sale of tax-exempt bonds. Annual bond repayment costs, as well as other approved debt from developing housing, are included in the OMH Aid-to-Localities Budget. Local Capital appropriations fall into four categories:

- *Administration*

  Description: Bonded funds that represent the cost of staff that work on OMH's local capital program. OMH collects a fee (a) for each project included in a bond sale, and (b) for each semi-annual bond repayment made. These fees currently support eight housing staff.

- *Minor Rehab*

  Description: Funding included in the capital projects budget that is utilized on projects deemed too small for bond financing, or for projects determined to be ineligible for OMH's bonding program. Most minor rehab funding is utilized on existing housing sites that need refurbishing.

- *New Facilities*

  Description: Funding for all new housing units (e.g., NY/NY III, 2007–2008 SRO units, 2005–2006 high service need units). These are all bonded appropriations.

- *Preservation*

  Description: Funding for refurbishment of existing housing sites. These projects meet the minimum bonding threshold ($200,000) and other bonding eligibility requirements.

ISSUES

OMH funds a housing system consisting of more than 30,000 units. More than 50% of these units are located in buildings owned by not-for-profit housing agencies. These buildings are often older homes, and the residents are very hard on these properties. OMH local capital funding for basic maintenance is needed for heating/plumbing systems, inefficient windows, roofs or worn-out bathrooms and kitchens. Funding for Preservation and Minor Rehab is already at the minimum levels needed to keep residences/homes safe and clean for residents with disabilities.

OMH's bonding program provides the funding necessary to support the OMH development of the bed pipeline. Over the years, OMH has entered into shared agreements and commitments with New York City to develop housing under the New York/New York Agreements for the homeless. In addition, the City has

matched OMH's capital funding in 2003–2004, 2005–2006, 2007–2008 and 2008–2009. Any reductions in OMH's bed pipeline will impact the City's commitment to match OMH bed development.

OMH has targeted a portion of its bed pipeline to house individuals who have resided in OMH inpatient units for more than one year. Individuals with limited income, who are able to control their mental illness symptoms or are in recovery from mental illness, and no longer require OMH institutional care or housing in congregate settings, cannot afford to live independently without a generic housing subsidy. Therefore, these individuals must either remain in OMH housing or else they would become homeless.

POPULATION SERVED

Adults with a serious mental illness and children with a serious emotional disturbance who have no other viable housing option and could benefit from OMH housing

(A portion of new housing resources is targeted toward providing housing for persons in OMH inpatient facilities who have long lengths of stay. Another significant portion of OMH's local capital resources are committed to the NY/NY III Agreement.)

PERFORMANCE MEASURES

- Occupancy rates, length of stay, percentage of priority admissions, and other key performance indicators

H. MISCELLANEOUS FUNDS

PROGRAM

StOps – **Miscellaneous Funds**

LEGAL MANDATE/AUTHORITY

Mental Hygiene Gifts and Donations: MHL Section 7.29, 13.29

OMH Grants and Bequests: MHL Section 7.29

Cook Chill Account: MHL Sections 7.07, 7.15

Research Recovery Account: MHL Sections 7.05, 7.07, 7.15

Internal Services Funds: MHL Sections 7.07, 7.15

Community Stores Account: MHL Sections 7.27 and 13.27

Sheltered Workshop Account: MHL Section 33.09

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Mental Hygiene Gifts and Donations

This is a special revenue fund, the purpose of which is to account for various gifts and donations to Mental Hygiene facilities for purposes designated by the donor. The revenue sources include gifts and donations. The funds may be used for miscellaneous purchases for the use or benefit of the patients.

Mental Health Grants and Bequests

This is a special revenue fund, the purpose of which is to account for various gifts and donations to Mental Hygiene facilities for purposes designated by the donor. The revenue sources include gifts and donations. The funds may be expended for the purposes designated in the particular gift, grant, or bequest.

Cook Chill Account

The Cook Chill program was created as a cost reduction and quality improvement program. Program benefits included the immediate reduction of 140 FTEs, stabilized food cost to OMH, the closure of facility storehouses and reduced space requirements for food preparation at facilities. This method of food preparation allows OMH higher quality food than otherwise available to patients. The program has become the cornerstone of emergency management and disaster needs.

Research Recovery Account

The Research Foundation for Mental Hygiene (RFMH) is a private not-for-profit organization incorporated to act on behalf of the State Department of Mental Hygiene in the furtherance of research, teaching and training in all areas of mental disabilities. Funding for RFMH is largely through federal government, foundation, and industry grants and contracts. Indirect cost reimbursement from these grants and contracts is a means through which the State can recoup some of its research investment costs.

Grant funds must be spent directly on the activities described and assigned to the grant in the application. However, federal rules allow the grantee to recover overhead expenses. A percentage of the indirect funds obtained from grants resides in the Research Recovery Account and can be used to offset the agency's operating costs. These funds are available to support central administration, research associates, equipment provided through external grants, travel, conference expenses, contractual services, grant writers to increase income from non-state sources, research scientists formerly supported by the general fund, and other research initiatives.

Internal Services Fund

The Internal Services Fund (Utica Print Shop), was established in 1844, to serve the printing needs of the Mental Hygiene Department. The Utica Print Shop was combined with the Central Office Design Center in the 1980's and the entire organization is now called Printing and Design Services. Today, the organization provides all publication and reproduction services to OMH, its Field Offices, psychiatric centers, numerous other State agencies and many county/local not-for-profit organizations.

Community Stores Account

This is an enterprise fund, the purpose of which is to account for community store operations in Mental Hygiene facilities. The revenue sources include sales of merchandise at the various community stores and canteens located in mental health facilities. The funds are expended for the operating expenses of the community store programs

Sheltered Workshop Account

This is an enterprise fund, the purpose of which is to account for sheltered workshop operations in Mental Hygiene facilities. The revenue sources include contract work performed for private businesses, and the sale of manufactured articles. The funds are expended for the operating expenses of the sheltered workshop programs

ISSUES

The Cook Chill program recently lost the Health and Hospitals Corporation (HHC) account to provide meals to City hospitals. This was a significant loss of revenue to the program, and efforts are under way to rebuild the customer base.

The Research Overhead Account relies on external grant support to maintain and replenish a core research infrastructure from which quality research and treatment innovations can emerge. The revenue available to this account has been declining as a result of a dwindling level of grants.

POPULATION SERVED

These funds support individuals served by OMH Psychiatric Centers. In addition, the Cook Chill Account also serves OCFS, the Office of Alcoholism and Substance Abuse Services, and OMRDD. The Internal Services Fund provides services to numerous other State agencies as well as several county and not-for-profit groups.

PROGRAM

ATL – **Medication Grant Program (MGP)**

LEGAL MANDATE/AUTHORITY

Article 15 (Kendra's Law)

BRIEF DESCRIPTION/HISTORY/BACKGROUND

In August of 1999, Kendra's Law was signed into law. In addition to the AOT aspect of the law, the legislation established a grant program administered by OMH that provides funding to localities for medications and certain other services to treat mental illness during the period that an individual's eligibility for medical assistance (Medicaid) is being determined. The MGP provides coverage for the cost of certain psychiatric medications and other services for those who are eligible for Medicaid and being discharged or released from hospitals, local jails, and prisons. The coverage bridges the gap between the time an individual is discharged or released into the community and the time when their Medicaid becomes active. It assists individuals to maintain themselves in the community by providing access to necessary medications and other services while awaiting activation of their Medicaid benefits.

To participate, counties must opt in and submit a plan outlining their intended use of MGP. Their submitted plan requires approval from the Commissioner of Mental Health. To date, 43 counties are participating. (This includes 38 counties statewide plus the five counties comprising New York City.)

ISSUES

None

POPULATION SERVED

Individuals who are eligible for Medicaid (for whom application has been completed and filed) and who are being discharged/released into the community from a hospital, local jail, or state prison are eligible for MGP

PERFORMANCE MEASURES

- Number of individuals enrolled in MGP based on discharge source
- Average time frames required to complete Medicaid eligibility determinations.
- Medicaid billing for reimbursement of costs attributed to individuals eventually determined to be eligible for medical assistance.

PROGRAM

ATL – **Special Revenue Federal Funding**

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Community Mental Health Services Block Grant

The Community Mental Health Services (CMHS) Block Grant is authorized by Part B of Title XIX of the Public Health Service Act (PHSA) and is the single largest federal contribution dedicated to improving mental health service systems across the country. Block grants are awarded to states to provide mental health services to people with mental disorders. Through the block grant, CMHS supports existing public services and encourages the development of creative and cost-effective systems of community-based care for people with serious mental disorders.

Shelter Plus Care (S + C) Program

S+C is funded by U.S. Department of Housing and Urban Development (HUD) under the McKinney Homeless Assistance Act. The purpose of S+C programs is to provide rental subsidy for homeless individuals or families, in which a member is handicapped, including those who have serious mental illness, physical handicaps or have substance abuse problems. Under S+C, HUD provides a multiyear grant for rental assistance. The grant is based upon the Fair Market Rent as determined by HUD for the geographic area and size of the unit. The S+C application must demonstrate a non-federal match of at least equal value to the rent in supportive services to be provided by non-S+C. These services may include new or existing services.

Permanent Housing for the Handicapped Homeless Program

The Permanent Housing for the Handicapped Homeless Program (PHP) is funded by HUD under the Stewart B. McKinney Homeless Assistance Act. It is intended to serve homeless individuals or families in which a member is handicapped, including those with a serious mental illness, physical disability, or substance abuse problem. Services funded by this program include site acquisition and rehabilitation (up to a maximum of $400,000 per project), property and other non-capital costs for a period of up to five years. PHP grants require a non-federal match for capital grants (50%) and a non-federal share for non-capital costs grants (25% in the first two years and 50% for subsequent years).

Projects for Assistance in Transition from Homelessness (PATH) Grant

Projects for homelessness and mental illness are funded by the PATH grant. These projects provide a variety of mental health services to persons who are suffering from serious mental illness, or are suffering from serious mental illness and substance abuse, and are homeless or at imminent risk of becoming homeless. Services include, but are not limited to, outreach, case management, alcohol and drug treatment services, housing services such as one-time rental payments, and minor renovations.

ISSUES

The CMHS block grant has a statutory maintenance of effort (MOE) provision. The MOE requires the State to maintain spending at certain levels to avoid a reduction in the State grant award. If the State falls below the MOE requirements, the CMHS block grant is reduced by an equal amount.

Since 2003, the CMHS Block Grant awarded to the State has been reduced by approximately $5M, equivalent to 17% of the funding attributed to federal reductions and changes in the allocation formula. The most recent cut in federal fiscal year 2008 reduced New York's Block Grant award by an additional $855K, or 3.3%, compared to the prior year.

POPULATION SERVED

Adult and children with mental illness

PROGRAM

StOps – **Special Revenue Federal Funding**

BRIEF DESCRIPTION/HISTORY/BACKGROUND

Community Mental Health Services Block Grant

The CMHS Block Grant is authorized by Part B of Title XIX of the PHSA and is the single largest federal contribution dedicated to improving mental health service systems across the country. Block grants are awarded to states to provide mental health services to people with mental disorders. Through the Block Grant, CMHS supports existing public services and encourages the development of creative and cost-effective systems of community-based care for people with serious mental disorders.

ISSUES

Up to 5% of funds may be used for administrative purposes.

POPULATION SERVED

Adult and children with mental illness

Attachment B

AGENCY PROGRAMS/ACTIVITIES: INVENTORY AND KEY DATA
OFFICE OF MENTAL HEALTH
(Dollars Reported in Thousands)

Relation to Core Mission (H/M/L)		3/31/09 FTE's (All Funds)	Slots/ Beds	2006-07 (Actuals) ATL	2006-07 (Actuals) State Ops	2006-07 Total	2007-08 (Projected) ATL	2007-08 (Actuals) State Ops	2007-08 Total	2008-09 (Projected) ATL	2008-09 (Projected) State Ops	2008-09 Total	2009-10 (Projected) ATL	2009-10 (Projected) State Ops	2009-10 Total	2008-09 Projected Total Expenses - All Providers	2008-09 Total Medicaid Revenue - All Providers
	A. ADULT SERVICES PROGRAM																
	A.1 Inpatient																
H/M	State Operated Inpatient	8,925 *	4,030	-	612,420	612,420	-	639,789	639,789	-	675,442	675,442	-	696,833	696,833		
H/M	Inpatient Psychiatric Unit of a General Hospital (State Share Budgeted in DOH)	-	5,241	-	-	-	-	-	-	-	-	-	-	-	-		
H/M	Article 31 Inpatient (State Share Budgeted in DOH)	-	498	-	-	-	-	-	-	-	-	-	-	-	-		
	Subtotal	**8,925**		**-**	**612,420**	**612,420**	**-**	**639,789**	**639,789**	**-**	**675,442**	**675,442**	**-**	**696,833**	**696,833**	**2,508,566**	**1,382,898**
	A.2 Outpatient																
M	Continuing Day Treatment (State Share Partially Budgeted in DOH)	40	-	14,440	6,554	20,994	13,970	5,706	19,676	14,417	6,034	20,451	14,922	6,423	21,345		
H	Clinic Treatment (State Share Partially Budgeted in DOH)	484	-	101,127	60,647	161,774	106,298	71,129	177,427	110,847	75,217	186,064	125,004	80,067	205,071		
H/M	Partial Hospitalization	13	-	1,065	2,043	3,108	983	2,049	3,032	1,015	2,167	3,182	1,051	2,307	3,358		
H/M	Intensive Psychiatric Rehabilitation Treatment	12	-	262	1,280	1,542	263	992	1,255	271	1,049	1,320	281	1,116	1,397		
H	Prepaid Mental Health Plan (PMHP)	315	-	-	43,419	43,419	-	37,027	37,027	-	39,155	39,155	-	41,680	41,680		
H	Personalized Recovery Oriented Services (PROS)	-	-	1,889	-	1,889	3,594	-	3,594	4,770	-	4,770	6,021	-	6,021		
H	Assertive Community Treatment (ACT)	98	5,044	24,667	7,998	32,665	22,762	8,857	31,619	23,778	9,367	33,145	25,007	9,970	34,977		
	Subtotal	**962**		**143,450**	**121,942**	**265,392**	**147,870**	**125,761**	**273,631**	**155,098**	**132,989**	**288,087**	**172,286**	**141,563**	**313,849**	**1,277,584**	**796,338**
	A.3 Residential																
H	Family Care	69	2,413	6,958	6,315	13,273	9,663	6,067	15,730	11,494	6,416	17,910	13,720	6,830	20,550		
H	Licensed Community Residence (Congregate Treatment/Support/SRO-CR/RCCA/SOCR)	473	11,517	146,819	38,978	185,797	159,042	42,133	201,175	173,232	44,555	217,787	196,176	47,427	243,603		
H	Unlicensed Supported Housing / Supported Single-Room Occupancy (SP-SRO)	-	14,977	163,476	-	163,476	184,135	-	184,135	186,069	-	186,069	221,982	-	221,982		
H	Transitional Residences	222	344	-	16,443	16,443	-	19,260	19,260	-	20,367	20,367	-	21,681	21,681		
	Subtotal	**764**		**317,253**	**61,736**	**378,989** 378,989	**352,840**	**67,461**	**420,301**	**370,795**	**71,338**	**442,133**	**431,878**	**75,937**	**507,815**	**632,998**	**169,527**
	A.4 Emergency																
H	Crisis Residence/ Crisis Respite beds	112	-	1,975	11,692	13,667	1,918	11,191	13,109	1,982	11,834	13,816	2,057	12,597	14,654		
H	Crisis Respite/Crisis Intervention	11	-	19,691	373	20,064	23,358	447	23,805	24,180	473	24,653	25,030	503	25,533		
H	Comprehensive Psychiatric Emergency Program (CPEP) (State Share Partially Budgeted in DOH)	-	-	2,794	-	2,794	2,887	-	2,887	2,759	-	2,759	4,487	-	4,487		
	Subtotal	**123**		**24,460**	**12,066**	**36,526**	**28,163**	**11,638**	**39,801**	**28,921**	**12,307**	**41,228**	**31,574**	**13,100**	**44,674**	**240,362**	**22,354**
	A.5 Support																
H	Care Coordination / Case Management	249	25,453	79,131	23,615	102,746	83,767	24,362	108,129	86,921	25,762	112,683	91,683	32,588	124,271		
H/M/L	Community Support Programs -- Peer Run and Family Support (High)	126	-	139,543	10,958	150,501	150,117	13,947	164,064	151,104	14,649	165,753	155,857	15,600	171,457		
H/M/L	Employment	117	-	32,522	14,131	46,653	39,221	13,357	52,578	39,104	14,125	53,229	40,694	15,036	55,730		
	Subtotal	**492**		**251,196**	**48,704**	**299,900**	**273,105**	**51,666**	**324,771**	**277,129**	**54,536**	**331,665**	**288,234**	**63,223**	**351,457**	**532,610**	**98,048**
	TOTAL ADULT SERVICES PROGRAM	**11,266**		**736,359**	**856,867**	**1,593,226**	**801,978**	**896,314**	**1,698,292**	**831,943**	**946,611**	**1,778,554**	**923,972**	**990,657**	**1,914,629**	**5,192,119**	**2,469,166**
	B. CHILDREN AND FAMILY SERVICES PROGRAM																
	B.1 Inpatient																
H	State Operated Inpatient	1,570 *	535	-	89,752	89,752	-	93,196	93,196	-	99,713	99,713	-	103,492	103,492		
H	Inpatient Psychiatric Unit of a General Hospital (State Share Budgeted in DOH)	-	460	-	-	-	-	-	-	-	-	-	-	-	-		
H	Article 31 Inpatient (State Share Budgeted in DOH)	-	455	-	-	-	-	-	-	-	-	-	-	-	-		
H/M	Residential Treatment Facility (RTF)	-	539	41,721	-	41,721	43,061	-	43,061	45,242	-	45,242	49,929	-	49,929		
	Subtotal	**1,570**		**41,721**	**89,752**	**131,473**	**43,061**	**93,196**	**136,257**	**45,242**	**99,713**	**144,955**	**49,929**	**103,492**	**153,421**	**556,968**	**421,783**

Attachment B

AGENCY PROGRAMS/ACTIVITIES: INVENTORY AND KEY DATA
OFFICE OF MENTAL HEALTH
(Dollars Reported in Thousands)

Relation to Core Mission (H/M/L)		3/31/09 FTE's (All Funds)	Slots/ Beds	2006-07 (Actuals) ATL	2006-07 (Actuals) State Ops	2006-07 Total	2007-08 (Projected) ATL	2007-08 (Actuals) State Ops	2007-08 Total	2008-09 (Projected) ATL	2008-09 (Projected) State Ops	2008-09 Total	2009-10 (Projected) ATL	2009-10 (Projected) State Ops	2009-10 Total	2008-09 Projected Total Expenses - All Providers	2008-09 Total Medicaid Revenue - All Providers
	B.2 Outpatient																
H	Clinic (State Share Partially Budgeted in DOH)	59	-	10,332	7,168	17,500	23,926	8,394	32,320	24,820	8,981	33,801	35,058	9,305	44,363		
H	Day Treatment (State Share Partially Budgeted in DOH)	248	-	8,039	25,343	33,382	7,286	25,682	32,968	7,598	27,624	35,222	7,973	28,694	36,667		
	Subtotal	**307**		**18,371**	**32,512**	**50,883**	**31,212**	**34,076**	**65,288**	**32,418**	**36,606**	**69,024**	**43,031**	**37,999**	**81,030**	**214,694**	**130,076**
	B.3 Residential																
H	Family Based Treatment	-	490	344	-	344	290	-	290	301	-	301	313	-	313		
H	Teaching Family Home	-	16	15	-	15	320	-	320	330	-	330	342	-	342		
H/M	Community Residence	22	304	8,656	1,555	10,211	14,255	2,006	16,261	16,423	2,157	18,580	19,226	2,241	21,467		
	Subtotal	**22**		**9,015**	**1,555**	**10,570**	**14,865**	**2,006**	**16,871**	**17,054**	**2,157**	**19,211**	**19,881**	**2,241**	**22,122**	**39,812**	**29,359**
	B.4 Emergency																
H	Crisis Residence/ Respite beds	10	6	-	442	442	-	548	548	-	643	643	-	695	695		
H	Home Based Crisis Intervention	-	-	8,943	-	8,943	9,590	-	9,590	9,903	-	9,903	10,259	-	10,259		
H	Comprehensive Psychiatric Emergency Program (CPEP) / Crisis Beds / Crisis Outreach (State Share Partially Budgeted in DOH)	-	-	187	-	187	190	-	190	476	-	476	943	-	943		
	Subtotal	**10**		**9,130**	**442**	**9,572**	**9,780**	**548**	**10,328**	**10,379**	**643**	**11,022**	**11,202**	**695**	**11,897**	**14,087**	**650**
	B.5 Support																
H	Care Coordination (Case Management / RTF coordinators)	52	4,825	8,181	3,425	11,606	8,490	3,933	12,423	8,900	4,306	13,206	9,400	4,511	13,911		
H/M/L	Community Support Programs -- Peer Run and Family Support (High)	33	-	20,579	5,970	26,549	21,002	4,770	25,772	21,686	5,578	27,264	22,460	5,834	28,294		
H	Employment	-	-	2,237	-	2,237	2,263	-	2,263	2,336	-	2,336	2,418	-	2,418		
H	Home and Community Based Services (HCBS)/Kids Oneida	-	-	22,783	-	22,783	28,093	-	28,093	29,522	-	29,522	31,286	-	31,286		
	Subtotal	**85**		**53,780**	**9,395**	**63,175**	**59,848**	**8,703**	**68,551**	**62,444**	**9,884**	**72,328**	**65,564**	**10,345**	**75,909**	**101,727**	**31,521**
	TOTAL CHILDREN AND FAMILY SERVICES PROGRAM	**1,994**		**132,017**	**133,655**	**265,672**	**158,766**	**138,528**	**297,294**	**167,537**	**149,002**	**316,539**	**189,607**	**154,771**	**344,378**	**927,288**	**613,389**
	C. FORENSICS SERVICES PROGRAM																
	C.1 Inpatient Services																
H	State Operated Inpatient	1,082	506	-	75,602	75,602	-	89,308	89,308	-	93,076	93,076	-	99,687	99,687		
H/M	State Operated Inpatient -- DOCS Services	431 *	209	-	25,645	25,645	-	30,294	30,294	-	31,572	31,572	-	33,814	33,814		
	Subtotal	**1,513**		**-**	**101,247**	**101,247**	**-**	**119,602**	**119,602**	**-**	**124,648**	**124,648**	**-**	**133,501**	**133,501**	**173,441**	**69,135**
	C.2 Support																
H/M	Onsite Services to DOCS	466	-	-	33,279	33,279	-	34,620	34,620	-	36,080	36,080	-	38,643	38,643		
H	Community Support Program	-	-	835	-	835	862	-	862	889	-	889	920	-	920		
	Subtotal	**466**		**835**	**33,279**	**34,114**	**862**	**34,620**	**35,482**	**889**	**36,080**	**36,969**	**920**	**38,643**	**39,563**	**51,773**	**-**
	TOTAL FORENSIC PROGRAM	**1,979**		**835**	**134,526**	**135,361**	**862**	**154,222**	**155,084**	**889**	**160,728**	**161,617**	**920**	**172,144**	**173,064**	**225,214**	**69,135**
	D. SEX OFFENDER PROGRAM																
H	**D.1 Classification**	59	-	-	1,066	1,066	-	2,132	2,132	-	4,275	4,275	-	4,750	4,750	-	-
M/L	**D.2 Inpatient Services**	594	169 **	-	12,229	12,229	-	23,197	23,197	-	28,776	28,776	-	52,351	52,351	64,000	-
H	**D.3 Outpatient**	-	-	-	-	-	-	10	10	-	250	250	-	500	500	-	-
	TOTAL SEX OFFENDER PROGRAM	**653**	**169**	**-**	**13,295**	**13,295**	**-**	**25,339**	**25,339**	**-**	**33,300**	**33,300**	**-**	**57,600**	**57,600**	**64,000**	**-**

AGENCY PROGRAMS/ACTIVITIES: INVENTORY AND KEY DATA
OFFICE OF MENTAL HEALTH
(Dollars Reported in Thousands)

Relation to Core Mission (H/M/L)		3/31/09 FTE's (All Funds)	Slots/ Beds	2006-07 (Actuals) ATL	2006-07 (Actuals) State Ops	2006-07 Total	2007-08 (Projected) ATL	2007-08 (Actuals) State Ops	2007-08 Total	2008-09 (Projected) ATL	2008-09 (Projected) State Ops	2008-09 Total	2009-10 (Projected) ATL	2009-10 (Projected) State Ops	2009-10 Total	2008-09 Projected Total Expenses - All Providers	2008-09 Total Medicaid Revenue - All Providers
	E. RESEARCH PROGRAM																
H	**E.1 Inpatient**																
	New York Psychiatric Institute (NYPI)	88		-	7,924	7,924	-	9,259	9,259	-	10,114	10,114	-	10,505	10,505		
	Nathan Kline Institute (NKI)		-														
	Subtotal	88		-	7,924	7,924	-	9,259	9,259	-	10,114	10,114	-	10,505	10,505		
H	**E.2 Outpatient**																
	New York Psychiatric Institute (NYPI)	10	-	-	605	605	-	668	668	-	729	729	-	758	758		
	Nathan Kline Institute (NKI)		-														
	Subtotal	10		-	605	605	-	668	668	-	729	729	-	758	758		
H	**E.3 Research**																
	New York Psychiatric Institute (NYPI)	302 *	-	-	25,587	25,587	-	27,779	27,779	-	29,291	29,291	-	30,815	30,815		
	Nathan Kline Institute (NKI)	107	-	-	10,775	10,775	-	11,908	11,908	-	12,555	12,555	-	13,209	13,209		
	Subtotal	409		-	36,362	36,362	-	39,687	39,687	-	41,846	41,846	-	44,024	44,024		
	TOTAL RESEARCH PROGRAM	507		-	44,891	44,891	-	49,614	49,614	-	52,689	52,689	-	55,287	55,287	94,753	-
	F. ADMINISTRATION AND FINANCE PROGRAM																
H/M/L	State Operations	686	-	-	70,404	70,404	-	72,162	72,162	-	75,612	75,612	-	78,539	78,539		
H/M/L	Community - Local Government Unit Administration	-	-	29,793	-	29,793	29,342	-	29,342	32,062	-	32,062	34,204	-	34,204		
M/L	Legislative Member Items			1,966		1,966	3,576		3,576	1,429	1,500	2,929	300	1,000	1,300		
	TOTAL ADMINISTRATION AND FINANCE PROGRAM	686		31,759	70,404	102,163	32,918	72,162	105,080	33,491	77,112	110,603	34,504	79,539	114,043	122,647	23,496
	General Funds and Special Revenue - Other Subtotal	17,085		900,970	1,253,638	2,154,608	994,524	1,336,179	2,330,703	1,033,860	1,419,442	2,453,302	1,149,003	1,509,998	2,659,001	6,626,021	3,175,186
	Fringe Benefits										511,591	511,591		561,050	561,050		
	General Funds and Special Revenue - Other TOTAL	17,085		900,970	1,253,638	2,154,608	994,524	1,336,179	2,330,703	1,033,860	1,931,033	2,964,893	1,149,003	2,071,048	3,220,051	6,626,021	3,175,186
	G. CAPITAL PROGRAM																
H/M/L	Administration	41	-	525	3,500	4,025	555	3,573	4,128	555	3,717	4,272	555	3,717	4,272		
H	Accreditation	-	-	-	40,563	40,563	-	52,320	52,320	-	56,164	56,164	-	66,436	66,436		
H	Energy Conservation	-	-	-	3,500	3,500	-	3,579	3,579	-	3,500	3,500	-	3,500	3,500		
H	Environmental Protection	-	-	-	5,000	5,000	-	4,769	4,769	-	4,000	4,000	-	4,000	4,000		
H	Health and Safety	-	-	-	40,563	40,563	-	52,320	52,320	-	56,164	56,164	-	66,436	66,436		
H/M/L	Minor Rehabilitation	-	-	5,300	3,000	8,300	4,100	3,051	7,151	6,000	3,000	9,000	6,000	3,000	9,000		
H/M/L	New Facilities	-	-	17,672	-	17,672	25,441	-	25,441	59,945	-	59,945	74,945	-	74,945		
H/M/L	Plan Preparation	-	-	-	12,000	12,000	-	16,751	16,751	-	14,000	14,000	-	14,000	14,000		
H/M/L	Preservation of Facilities	-	-	2,803	56,788	59,591	7,004	73,247	80,251	17,500	78,630	96,130	24,500	93,010	117,510		
H/M/L	Program Improvement	-	-	-	24,328	24,328	-	31,392	31,392	-	33,698	33,698	-	39,862	39,862		
	TOTAL CAPITAL PROGRAM	41		26,300	189,242	215,542	37,100	241,002	278,102	84,000	252,873	336,873	106,000	293,961	399,961		
	H. MISCELLANEOUS FUNDS																
H	State Miscellaneous Funds	30	-	-	8,883	8,883	-	8,507	8,507	-	8,515	8,515	-	8,515	8,515		
H	Local Miscellaneous Funds	-	-	3,797	-	3,797	3,881	-	3,881	3,966	-	3,966	4,054	-	4,054		
H	Special Revenue Federal (CMHS & HUD grants)	11	-	27,978	1,691	29,669	27,978	1,953	29,931	27,123	1,233	28,356	27,123	1,170	28,293		
	TOTAL FTE'S	17,167															

*Some Personal Service expenses associated with Administrative and Support FTE's included in this category have been distributed as indirect costs in other categories.
** Represents current operational beds
*** In 2006-07 & 2007-08 fringe was not budgeted in OMH's appropriation. For expense data column, fringe is distributed among program lines