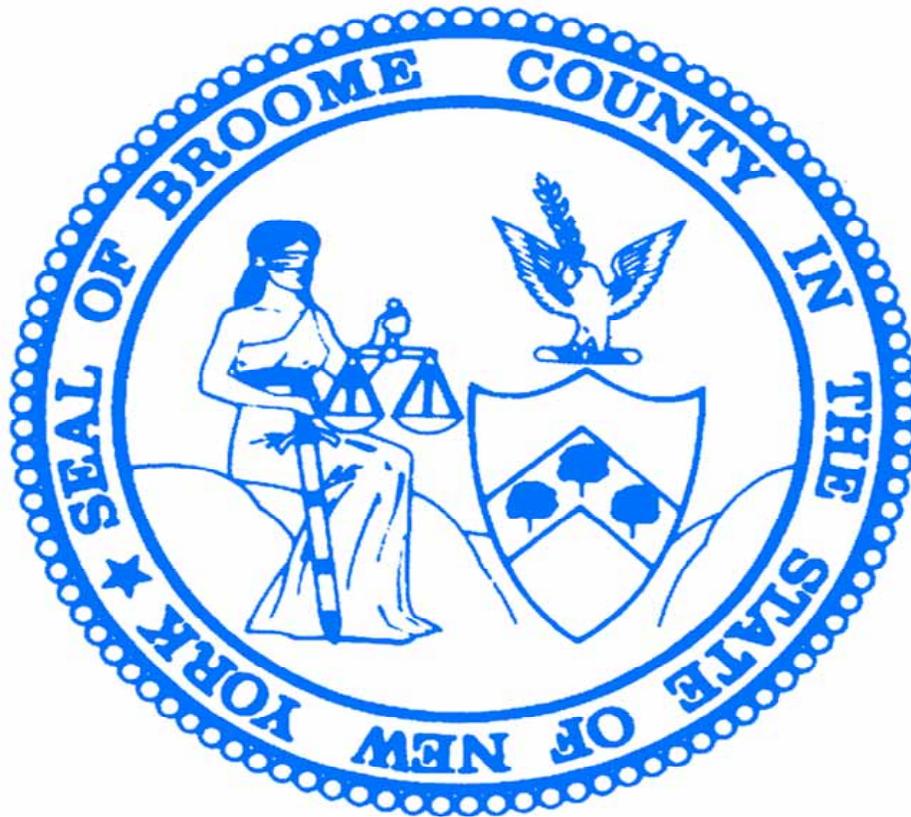


Broome County Department of Mental Health



2006 – 2008

Submitted May 2006

THREE YEAR COMPREHENSIVE PLAN FOR MENTAL HEALTH

Arthur R. Johnson, LMSW
Commissioner

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Mission Statement

It is the mission of the Broome County Mental Health Department to plan, organize and oversee a comprehensive continuum of care for consumers of public mental hygiene services in Broome County. This continuum of care will provide for the health and safety of Broome County citizens.

Vision

Planning: The Broome County Mental Health Department will engage in a participatory planning process to develop mental hygiene services in Broome County. The planning process will include government officials, providers, community representatives, and recipients or their families.

Accountability: The Department will assure that State and/or Local oversight mechanisms are in place to assure that services are delivered in a responsible, efficient manner.

Coordination: The Department will assure that all mental hygiene service providers in Broome County will coordinate and collaborate for the delivery of services that are responsive to the needs of recipients, including culturally diverse populations.

County Operations: The Department's primary role is to facilitate and oversee the continuum of care for consumers of mental hygiene services in Broome County. The Department will only provide direct services as the provider of last resort.

I. County Government Assurances:

We certify that the Plan for Mental Health Services, which includes information on programs and services, has been submitted to the Community Services Board, and that the Mental Health Subcommittee of the Board has been authorized to evaluate the Plan for its consistency with the needs of persons with serious mental illness including children and adolescents with serious emotional disturbances.

Date: __/__/__ (x) _____
Chairperson, Mental Health Subcommittee

Date: __/__/__ (x) _____
Chairperson, Community Services Board

Date: __/__/__ (x) _____
Director/Commissioner

II. Executive Summary

Broome County Profile

Broome County is located in South Central New York State. Tioga, Chenango, Delaware and Cortland Counties, and the State of Pennsylvania border it. The total land area for Broome County is 706 square miles. The County has a central urban/suburban core comprised of Binghamton, Johnson City, Endicott, and Vestal, surrounded by rural villages and towns. According to the 2000 Census, about 70% of our population is considered urban, with the remaining 30% described as rural.

According to Census 2000 data, the total population of Broome County is approximately 200,536, with a population density of 283 people per square mile. Census data reveals that 91.3% of the population is Caucasian, 3.3% African-American, 2.8% Asian, 2% Hispanic and .8% other. The County has served as a Refugee Resettlement site for over 3000 Asian, Middle Eastern, African, and Eastern European refugees since 1988.

Broome County also has an elderly population that is higher than the State and National averages. According to the 2000 Census, persons aged 60 and older represent 20.7% of Broome County's population, and 40.3% of Broome seniors are age 75 and older. In addition, the age 85 and older population is our fastest growing population (Aging Futures Findings Report, 2003).

Census data also shows that 12.8% of the population has an income below the poverty level, compared to the statewide rate of 14.6%. The median income is \$35,347, which is below the state median income of \$41,994; 15.9% of Broome's children live in poverty.

Nearly all of the jobs, services, health care and educational facilities are located in the central urban/suburban area. Once a thriving Manufacturing and Defense Industry community, the last recession hit Broome County particularly hard. An estimated 12,000 well paying manufacturing and industrial jobs were lost in the past decade.

Broome County has two Article 28 hospitals, Our Lady of Lourdes and United Health Services. The NYS OMRDD operated Broome Developmental Center, and the NYS OMH operated Greater Binghamton Health Center (formerly the Binghamton Psychiatric Center); both operated within the County. The county enjoys two colleges, Binghamton University, and Broome Community College. There are also seven nursing homes within the County. In addition, there are a number of private, voluntary not for profit agencies in the County providing services under government contract for various services.

Adult Profile

As mentioned previously, Broome County has a higher number of aged persons in the population than the statewide average. Broome has 20.7% of the population age 60 and over vs. 16.9% statewide. Our county ranks 6th in the state for the proportion of elderly. 40% of our Seniors are age 75+. The fastest growing population group is those age 85 and up. For those persons age 60 and over, 6.8% live in poverty, and 11.3% are near poor (125% of poverty).

Mental health concerns are also significant for our older community members. In 2003, there were 245 referrals to the HOME team; diagnoses included depression (33.9%), dementia (43.8%), anxiety (14.7%), depression and dementia (9.3%), and depression and anxiety (3.9%).

Youth Profile

Broome County Youth Population by Age and Sex for Year 2000

AGE GROUP	FEMALE	MALE	TOTAL
0 – 4	5,524	5,747	11,271
5 – 9	6,363	6,598	12,961
10 – 14	6,752	7,244	13,996
15 – 17	3,835	4,032	7,867
18 – 19	3,917	3,722	7,639
20 – 21	3,733	3,654	7,387
TOTALS	30,124	30,997	61,121

SOURCE: U.S. Census 2000

Youth and Poverty

The percent of children ages 0-17 living in poverty is 15.9%. Children continue to experience poverty at an alarming rate. Reliance on free or reduced school lunch is another indication of poverty and the Broome County average = 40.2%.

Area Hospitals Serving the Mentally Ill

United Health Services Hospitals (UHS) operates an in-patient psychiatric unit that has three units: Memorial 5 (M5), Krembs 5 (K5), and Krembs 3 (K3).

- M5 is a 17-bed locked unit for severely mentally ill patients who may be imminently dangerous to themselves or others. M5 has a fully enclosed nurses’ station, a smoking area, and an observation room for dangerous patients in need of constant observation.
- K5 is a 17-bed specialty unit for patients who have significant medical problems. Many geropsychiatric patients are served on this unit. This unit also has an ECT unit that provides approximately 2500 treatments annually.
- K3 is a 22-bed unit that is appropriate for patients who have been successfully stabilized. Although K3 is designed to accommodate less severe patients, it also has an observation room to hold dangerous individuals. Many of the patients here are engaging in psychotherapy groups, and may be awaiting discharge.
- UHS also operates a Comprehensive Psychiatric Emergency Program (CPEP). CPEP is a mental health crisis service, but in 1998, it also admitted 36% of its clients seen to inpatient hospitals.
 - CPEP has 4 extended observation beds that are used to observe people in crisis for no more than 72-hour stays.
 - CPEP also provides mobile outreach services to people in the community in need of intervention or assessment.

The Greater Binghamton Health Center (GBHC) provides in-patient and comprehensive outpatient services for individuals who are seriously mentally ill. GBHC has six in-patient units: an admissions unit, an intensive treatment unit, a geriatric infirmary, a geropsychiatric unit, and two extended treatment service units.

- Psychotherapy and other treatment groups are conducted in a treatment mall. Within the treatment mall concept, patients come to one central location for the group, rather than having groups in each unit.
- GBHC maintains a twenty-bed community placement unit for transitional living.
- GBHC maintains a six-bed adult situational crisis program for people who are experiencing a non-psychiatric emergency, but may be facing housing or financial difficulties.

A GBHC official reports their current cost per person, per day to be \$333.00, all-inclusive. The staffing is fixed, as opposed to proportional to their number of current patients, so they do not incur any additional costs from maintaining empty beds.

III. Strategic Priorities

Broome County Mental Health has identified three priorities that are intended to strengthen the existing service system. The three priorities are listed below.

Strategic Priority #1

1a. Title: Funding must keep up with cost of operations. This includes net deficit, COPS, Medicaid and DSH.

1b. Type: All Program Areas

1c. Target Population: Adults and Children

1d. Estimated Cost: Not Available

1e. Narrative – Need/Priority #1: Broome County has experienced a series of funding cuts over the last decade that have had a significant impact on the system. An example of these cuts include: Shared Staff, ARMS, and State Aid Reductions. Over the same 10 year period, many programs experienced increased costs associated with fringe benefits, utility and rent increases, increased transportation cost, etc. At the same time, program revenues have been held flat or have had one time only increases. The overall effect has been that funding and revenue have not kept up with the cost of living. This translates into further program cuts as agencies are forced to live within their budgets.

1f. Strategies & Time Frames #1: Over the next six months, we will cost out the impact of this problem. Develop a strategy for advocacy with state and elected officials and legislators to determine the cost and impact of service operation. Engage in political process to identify funding increases and service impact.

Strategic Priority #2

2a. Title: Recruitment and Retention of Board Certified Psychiatrists/Nurse Practitioners in Psychiatry

2b. Type: Treatment

2c. Target Population: Adults and Children

2d. Estimated Cost: Not Available

2e. Narrative – Need/Priority #2: All Broome County providers who employ psychiatrists have been challenged to recruit and retain psychiatrists. The average age of Broome County Psychiatrists is probably over 60 years of age. We have had two long term psychiatrists die within the last two years. In years past, Greater Binghamton Health Center would recruit and employ psychiatrists that would also work in Community-based programs part-time. In recent years, Greater Binghamton Health Center has been hiring Limited Permit psychiatrists who cannot work outside of a hospital setting. We also think that salaries for psychiatrists are not sufficient to recruit. All providers are using Psychiatrist Nurse Practitioners; however, they still need to be supervised by a Psychiatrist.

2f. Strategies & Time Frames #2: Management Council will work on a joint project to determine how many psychiatrists are required to make the public mental health system function adequately. We will also evaluate salary and fringe benefit packages so we can be more competitive in recruiting psychiatrists.

Need to advocate for changes in federal legislation that prohibit limited permit and J-one physicians from working in community health care. Develop recommendations so that doctors are not the only ones at the top of the treatment plan. Need to identify legislative barriers that exacerbate this problem and change to allow nurse practitioners to be able to sign-off on treatment plans.

Partner with UHS or GBHC as part of a residency program for one of the state schools where psychiatry degrees are offered. Need state elected officials support to institute this change.

Strategic Priority #3

3a. Title: Improve coordination and programming between OMH, OASAS, and OMRDD Services for Children and Adults including Forensic, Geriatric and Veterans.

3b. Type: System Enhancement/Care Coordination

3c. Target Population: Multi-Disabled

3d. Estimated Cost: Not Available

3e. Narrative – Need/Priority #3: In Children and Adult services, there is a need to collaborate more between systems (OMH, OASAS, OMRDD) in order to provide a full range of services addressing all consumer needs.

3f. Strategies & Time Frames #3: This priority will be addressed at various staff, management and provider meetings over the next year. Cross-system collaboration for Children services between OMH and OMRDD is already being addressed per a recent OMH/OMRDD research study done by the Center for Governmental Research (CGR) in

late 2005. Cross system between OMH and OASAS is being addressed through the County's Dual Recovery Project.

There are multiple agencies that are developing strategies to coordinate and improve services for OMH/OMRDD clients. The three priorities are:

- Improve access to diagnostic assessments
- Improve competency of staff by trainings
- Identify barriers on a continuing basis

IV. Addressing the Needs/Gaps Identified

The first priority addresses the need for funding to be maintained at the Consumer Price Index for all OMH programs. While this is necessary to retain/recruit a qualified workforce; it is more important to keep the program viable and serve mental health consumers. The second priority feeds into the first one in that funding must be kept current to retain and recruit a qualified workforce but it adds the urgent need to specifically retain and recruit Board Certified Psychiatrists/Nurse Practitioners in Psychiatry. This need is not only a County one but a National issue.

The cross-system collaboration discussion between OMH and OMRDD for Children Services began in 2005 which kicked off a study conducted by CGR. This study identified recommendations and the OMH/OMRDD Task Force continue to meet and discuss strategies to address system changes that will be implemented in the near future.

Broome County is moving toward inclusion of OMRDD providers in the Coordinated Children's Services Initiative to improve Cross-System collaboration between OMH, OMRDD, DSS and Probation.

Many agencies are looking at ways to enhance service and programs for children with mental illness and developmental disabilities.

It is important to receive a commitment from the Office of Mental Health with funding and direction/assistance to address all three priorities and successfully support Broome County in achieving resolutions to these important issues.

V. Planning for Mental Health Services

Broome County's Planning Process

The Broome County Mental Health Department (also called the LGU) works collaboratively with a number of groups on an ongoing basis to establish needs, goals, and objectives for the mental health system of care in the County. The Mental Health Subcommittee meets on a monthly basis. The Subcommittee includes membership from the criminal justice system, consumers, and families, as well as the communities at large. Subcommittee meetings are public meetings and the meeting schedule is posted on the County's website. The Management Council also meets on a monthly basis and consists of the administrators from all of the mental health service providers in the County. The

Broome County Mental Health Commissioner is also a member of the Broome County Integrated County Planning team which also meets monthly.

Over the last seven years, the Mental Health Department has engaged in a number of initiatives that were targeted at evaluating the needs and performance of various parts of the mental health system of care. Three projects were conducted by the Center for Governmental Research (CGR). Six were completed in conjunction with Binghamton University's Graduate School of Psychology. Several were conducted by Coordinated Care Services, Inc.

The Mental Health Department engaged the Center for Governmental Research (CGR) to conduct three comprehensive studies in Broome County. All three initiatives included a broad group of stakeholders including service recipients and families. The following is a list of these projects:

- The Evaluation of Broome County's Community Reinvestment Programs, 2001;
- The Broome County Visioning Project for Children and Adolescents, An Assessment of What Exists and Service Gaps, 2002;
- Children in Broome County with Co-Occurring Mental Health and Developmental Disability Conditions, Numbers and Service Gaps, 2005.

Every year the Mental Health Commissioner employs a doctoral candidate from Binghamton University to analyze and research different parts of the mental health system. The following is a list of the projects that have been completed over the last six years:

- Psychiatric Inpatient Utilization for Adults in Broome County, 2000
- Adult Mental Health Case Management & Residential Utilization, 2000
- Psychiatric Inpatient Utilization for Children, 2001
- Community Mental Health Services for the Elderly in Broome County, 2003
- Residential Mental Health Services for Adults, 2004
- The researcher also participated in the Children's Visioning Project with CGR in 2002, and the Children's MH/MR Project with CGR in 2005.

Coordinated Care Services, Inc. (CCSI) has been conducting Medicaid claims analysis on the County's Behavioral Health population beginning in 1998 through 2004. This data is used to assist the County in understanding the performance of Medicaid funded programming in the County. In 2004, CCSI also conducted an analysis of the performance of Broome County's Mental Health Case Management Services. The purpose of this project was to provide the County with information regarding the effectiveness of the current complement of case management services in targeting and serving individuals with significant mental health needs.

Integrated County Planning

The Broome County Integrated County Planning team has been successfully operating since 1998. Our mission is to establish and maintain an integrated, interagency planning

process that will effectively guide us in allocating and managing our human service resources.

The Broome County Integrated County Planning team continues to meet twice a month and consists of Department Heads and Administrators from the Broome County Human Services Departments including the Departments of Social Services, Youth Bureau, Health, Probation, Mental Health, Office for Aging, Office of Employment and Training, as well as the County Executive's Office, the County Information and Technology (IT) Department, the United Way, Binghamton City School, BOCES, and the Community Foundation for South Central NY. In addition to these bi-weekly meetings, ICP has held annual retreats for ICP members to focus on current status and future planning efforts.

Broome County's vision continues to be investing our resources to build strong families and communities.

Our view of effective integrated planning is centered on the following Guiding Principles:

- I. Coordination, collaboration, and communication with the broader community maximize our ability to respond to the needs of our residents.
- II. A comprehensive needs assessment process should drive human service funding decisions. Our programs and services should build on the strengths of individuals and of our community.
- III. A multidisciplinary approach to planning provides the best opportunity to meet the needs of the community.
- IV. Consumer input is critical to the planning process.
- V. Planning will address all areas of human development and family life (i.e., economic security, physical and emotional health, education, citizenship, and community).
- VI. Funded programs and services will have empirical support and will be measured against outcomes.
- VII. Technology enables and supports our efforts.

Broome County Mental Health Forum

On May 15, 2006 Broome County Mental Health Department hosted their first Mental Health Forum that was open to the public. Approximately 60 people attended the forum which was held from 1-3pm at the Lourdes Youth Services/Oral Health Facility at 219 Front Street in Binghamton, NY. The four topics that we discussed were: Adults including Seniors, Children, Families and Peer Services. For each of the four topics, we focused on soliciting input from the attendees on the Strengths, Weaknesses and Recommendations for Improvement. The event was covered by two local TV stations. Because of the recent announced closure of the Catholic Charities Continuing Day Treatment program, the discussion was somewhat dominated by the participants from CDT. A full report will be completed in the near future on this event.

VI. Participation in Planning

Families, Mental Health Providers, providers of other services, and others are involved in the planning process for the Broome County’s system of care for persons with mental illness.

Constituent Groups:	Planning Activities			
	Surveys	Public Hearings	Committees	Other
Consumers	Peer Survey, Consumer Focus Groups	MH Subcommittee, Community Services Board are public meetings that are posted on the Web	Community Services Board, Mental Health Subcommittee, Consumer Advisory Board	Consumers are members of MH Subcommittee and Consumer Advisory Board
Families	Parent Surveys	Mental Health Public Forum scheduled on May 15, 2006	Children’s SPOA, CCSI, MH/MR Task Force, KYDS Coalition	MH/MRDD Task Force Study & Report
General Public		Child and Family Community Forum held at the BC Library	C&Y Services Council	
Youth	Youth Survey, KYDS Coalition	Mental Health Public Forum scheduled on May 15, 2006	The Free Radicals Youth Group, KYDS Coalition	Children’s Visioning Project, 2002
Agencies/Providers	Broome County Mental Health Dept. and all agencies that contract with the Department	Mental Health Public Forum scheduled on May 15, 2006	Children’s SPOA Advisory & Member Committee, MH/MR Task Force, Children & Youth Services Council, Management Council, Integrated County Planning Committee, CCSI	CCSI Strategic Planning Session
Others: Identify	Dual Recovery Surveys (3)		Dual Disorder Core Group, Treatment	

			Workgroup, Education/Training Workgroup, Interagency Collaboration Workgroup, Screening/Assessment Workgroup, Housing Workgroup, Review Committee, Consumers are members of the Dual Recovery Project	
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The following is a list of all Mental Health member agencies of Management Council in Broome County:

1. Catholic Charities
2. Greater Binghamton Health Center
3. Children’s Home of the Wyoming Conference
4. Mental Health Association
5. United Health Services Hospital
6. Lourdes Hospital
7. Family & Children’s Society
8. Broome County Mental Health Dept
9. Renaissance Plaza
10. Veteran’s Service Center
11. Community Options

BC Community Services Board Members

Barbara Brozovic, Chair
 Nicki French, Vice Chair
 Lee Colvill
 James Mannion
 Robert Russell
 Barbara Newman
 Thomas Hull
 James Smith
 Jacqueline Shrader
 Kristen Ericksen
 Michael Lurie
 Mark Giroux

BC Mental Health Subcommittee Members

Jeffery Davis, Chair
 Barbara Brozovic
 Barbara Newman
 Lee Colvill
 Patricia Macumber
 David Nemec
 Robert Russell
 Deborah Totten
 Kevin Tobin
 William Parsons
 Ruth Ferrari

VII. Overview – Broome County’s System of Care for Adults and Children with Mental Illness

Important to effective services planning and monitoring is the ability to estimate the level of unmet need and to monitor progress toward addressing these needs. Ideally, this should be accomplished by assembling data that describe the prevalence of mental illness within the larger Broome County population, the capacity within the current array of service providers, and the number of individuals receiving services. The sections that follow describe the County’s population along these parameters. However, there are some challenges in assembling some of the information required. These limitations, detailed below, need to be taken into consideration in using these data to guide planning efforts.

1. Population/ Estimated Prevalence

Table 1. 2000 County population: 200,536

2000 Broome County Population Statistics	
Age Groups	Number
Under 5 years old	11,271
5-14 years old	26,957
15-19 years old	15,506
20-44 years old	68,305
45-59 years old	36,955
60-84 years old	36,966
85 & over	4,576

Prevalence

There have been some studies done at the national level to estimate the prevalence of Serious Mental Illness among adults as well as Serious Emotional Disturbance among children¹. The New York State Office of Mental Health has used these national rates to construct county-specific prevalence estimates. However, no studies have been conducted to determine the extent to which prevalence rates may vary from county to county. As such, we do not yet know the degree of confidence with which these estimates can be applied to our community and thus are not relying on these data to assist us in assessing unmet need within Broome County. Instead, we are using data assembled through several special studies (described elsewhere in this document), as well as feedback from providers, consumers, and other stakeholders to help us identify areas of unmet need.

¹ Estimates for Adults with Serious Mental Illness are derived from the CMHS, Federal Register, Vol 64, No. 121: 33890-33897. Estimates for Children with Serious Emotional Disturbance are derived from the CMHS, Federal Register, Vol. 63, no. 137: 38661-38665

2. Mental Health Subpopulations:

Persons Served

Like most other counties across New York State, Broome County does not have a single source of information to describe the unique number of individuals served across the entire mental health system. While information on the number of persons served is available for individual programs and providers it does not provide us with the ability to create an unduplicated count of clients served across the system for specific subgroups of interest (e.g., adults with SPMI). For planning purposes, both program-specific and community-wide data are needed.

To supplement the data collected at the program level, Broome County has a long history of using Medicaid claims data to carry out analyses to help inform services planning and evaluation efforts. This data set is comprised of New York State MMIS Adjudicated Claims records, provided to the County through a Data Exchange Application (DEA) with the New York State Department of Health, Office of Medicaid Management. The Medicaid claims files received from NYS DOH include information about claims paid for *fee-for-service* activity, along with capitation payments to managed care plans including the mental health pre-paid plan.²

We have used this dataset to compute the estimated number of persons served across the mental health system within the subgroups identified in Table 2 below. However, it is important to note that this represents services provided to the Medicaid subset of the County's population only, and therefore understates the total number of individuals served by the Broome County mental health system.

Table 2: Number of Broome County residents served across Mental Health programs Medicaid Fee-for-Service - 2002 - 2004*³

Population	2002	2003	2004
Total # of Mental Health service recipients	2,581	2,621	2,688
Adults with SPMI	367	376	357
Adults with MH Disorders	1,981	2,025	2,093
Children With SED	58	66	65
Children with MH Disorders	600	596	595
Multiple Dx MH/CD*	501	524	393
MH/DD	84	101	108

**figures may be underrepresented for 2004*

² The MMIS claims data *does not* include the following:

- Utilization detail for recipients enrolled in Medicaid managed care plans. This information is captured on an “encounter” basis in the NYS DOH Managed Care Encounter Data (MEDS) System. While much of the utilization is not captured for this Medicaid managed care subset of the population, a number of specific mental health services, such as Continuing Day Treatment and Clinic COPS visits are carved out, and as such, are included in the dataset constructed for this analysis.
- Overburden payments to counties for clients meeting applicable disability and utilization criteria. Overburden payments and activity are summarized in the NYS Medicaid Administrative Reporting Series (MARS) provided to counties on a monthly basis.
- State-operated Inpatient psychiatric services for adults.

³ Data on individuals served based on Adjudicated Medicaid claims data for calendar year 2004. SPMI and SED are calculated using an algorithm based on diagnosis and service thresholds. For additional detail, please see Appendix One.

Estimates for the number of adults with Severe and Persistent Mental Illness and children with Serious Emotional Disturbance have been calculated using an algorithm based on diagnosis and service utilization thresholds. While limited to the Medicaid fee-for-service population, these figures provide a sense for the size of the population served by the county’s mental health system and the distribution among some of the specific subgroups important to our planning efforts.

Broome County has 715 dual eligible (Medicare/Medicaid) Severe and Persistent Mentally Ill (SPMI) individuals per 2005 NYS Department of Health data.

In addition to the Medicaid data, we utilized the NYS OMH Patient Characteristics survey data⁴ to provide us with information about two other subgroups of interest: veterans and older individuals. The tables below describe demographics of clients served during the 2003 PCS survey week that fell into these categories.

**Table 3: 2003 Patient Characteristics Survey Data
Percentage of Veterans Served by Selected Program Types**

Program Type	Veteran Status ⁵				
	Yes	No	Unknown	% Veteran	Total
Case Management		82	1	0%	83
Clinic Treatment - Mental Health	5	843	30	1%	878
Inpatient Psychiatric Unit		86	36	0%	122
Intensive Case Management	1	109		1%	110
Supported Housing	4	135		3%	139
Supportive Case Management (SCM)		58		0%	58
Treatment/Apartment		36		0%	36
Treatment/Congregate		40		0%	40
Total	10	1,389	67	1%	1,466

⁴ Managed by the NYS OMH, the Patient Characteristics Survey ("PCS") collects demographic, clinical, and service-related information for each person who receives a mental health service during a specified one-week period. With the exception of private practice clinicians and U.S. Veterans Administration programs, all state- and locally-operated programs are required to complete the survey. The PCS is conducted biennially and receives data from over 4000 programs about approximately 170,000 people. The data in this plan are based on the 2003 PCS (10/27/03 – 11/02/03).

⁵ NYS OMH Patient Characteristics Survey Data Mart – CY 2003

**Table 4: 2003 Patient Characteristics Survey Data
Percentage of Individuals 65+ Served by Program Type**

Program Type	Age Group		
	Under 65	65+	% 65+
Advocacy Services	27	0	0%
Assertive Community Treatment (ACT)	49	2	4%
Assisted Competitive Employment	8	0	0%
Case Management	72	11	13%
Clinic Treatment - Mental Health	847	31	4%
Continuing Day Treatment	43	0	0%
Crisis Residence	5	0	0%
Day Treatment	35	0	0%
Drop In Centers	47	0	0%
Emergency Unit Clinic Treatment	73	4	5%
Family Care	38	18	32%
General Hospital	47	16	25%
Home & Community Based Waiver (HCBS Waiver)	13	0	0%
Inpatient Psychiatric Unit	102	20	16%
Intensive Case Management	108	2	2%
Intensive Psychiatric Rehabilitation (IPRT)	7	0	0%
MICA Network	18	0	0%
Ongoing Integrated Supported Employment Services	116	5	4%
Outreach	17	0	0%
Prepaid Mental Health Plan (PMHP)	78	24	24%
Psychosocial Club	165	10	6%
Respite Care, Free Standing	10	0	0%
Special Demo/Other	1	0	0%
Support/Congregate	8	0	0%
Supported Housing	134	5	4%
Supportive Case Management (SCM)	57	1	2%
Treatment/Apartment	35	1	3%
Treatment/Congregate	40	0	0%
Grand Total	2,200	150	6%

It is important to note that data based on the PCS represent a one-week snapshot of the characteristics of individuals receiving services within the County's mental health system. Because the accuracy of the data is dependent on the completeness of the data collection processes followed during the survey week, as well as any anomalies during that time period, caution should be used in generalizing these data to the broader population.

Adult Services:

Provider:	Programs																		Other		
	Clinic	Continuing Day Tx	In-Patient	Psych Emergency	HOME	ACT	ICM	SCM	Other Case Mgmt	Psycho Social Club	MICA Weekend Drop In	Drop In	Outreach	Advocacy	Supported Empl.	3 Group Homes (40)	Apartment Treatment (48)	Supported Housing (CC:108, GBHC:20)	Jail/Forensic	In-Home Mental Health Mgmt	
2004 Statistics																					
Broome County Mental Health	1519																				
Catholic Charities Mental Health Services		73				65	129	183	48	173		99	172	194	28	107	71	177			
United Health Services **	450		1265	3807	185																
Broome County Forensics																				1548	
Greater Binghamton Health Center		465	276						195				12					31			
Mental Health Association*									57		362			128							
Broome County DSS Adult Protective Services									400												
Community Options																18					
Veterans Administration***	600																				
Family & Children's Society																					20
Total Estimated Capacity:	2569	538	1541	3807	185	65	129	183	700	173	362	99	184	322	28	125	71	208	1548	20	

*Note 1: 2004 data for Drop-In and Advocacy is from Broome Recipient Affairs Office.

**Note 2: data is from April 2005 for the Clinic.

***Note 3: data is a point-in-time for 2006

VIII. Integrated and Coordinated Services for Adults

Single Point of Entry Program

Catholic Charities Single Entry Program (SPOE) matches SPMI clients with mental health case management and residential services deemed most appropriate to their needs through a single application (referral packet).

The professionals that comprise the Single Entry Committee carefully consider requests for Case Management and Residential Services. If services are not assigned, the committee will recommend other community resources that will best meet the individuals' needs. The Single Entry Committee member agencies include: Addiction Center of Broome County, Greater Binghamton Health Center, GBHC Community Treatment and Rehabilitation Center, Binghamton YMCA, Broome County Mental Health Department, Broome County MICA Program, Broome County Department of Social Services, Catholic Charities of Broome County, Mental Health Association Project Uplift, United Health Services, Fairview Recovery Services, Inc., Addiction Crisis Center, Addiction Case Management, Residential Services.

Levels of Case Management options from least to most intensive are:

- Community Support Services Case Management (CSS)
- Supportive Case Management (SCM)
- Intensive Case Management (ICM)
- Assertive Community Treatment (ACT Team)

Levels of Residential options are from least to most intensive are:

- Supported Housing (Independent Apartment Program)
- Certified Apartment Program
- Supervised Community Residence
- The Community has one large and two small Adult homes.

Forensic Services

Effective January 1, 2006 responsibility for all Mental Health treatment of inmates at the Broome County Correctional facility was transferred from the Broome County Mental Health Department to a private company, Corrections Medical Care Inc. (CMC). These services are defined in a contract between the Broome County Sheriff's Department and CMC and have been approved by the New York State Commission of Corrections.

The Broome County Mental Health Department continues to operate an outpatient Forensic Unit that provides court-ordered mental health evaluations that are the department's responsibility as defined in Mental Hygiene Law. The Forensic Unit also assists mentally ill inmates to link to community services upon their discharge from correctional facilities.

Homeless Services

Broome County offers a full continuum of Homeless Services. This continuum includes:

- Emergency Shelter (90 beds)
- Transitional Housing (224 beds)
- Permanent Supported Housing (118 beds)

Mentally ill individuals, as well as individuals with dual disorders (MICA), represent significant number of homeless services recipients in Broome County.

The City of Binghamton in its 5-year strategic plan for chronic homeless individuals has identified the following 4 priorities:

- Maintaining and expanding community-based case management and treatment programs to formerly homeless and those at-risk of homelessness due to chemical dependency and/or mental illness
- Increase the number of permanent supportive housing beds throughout Broome County
- Strengthen the process to document persons housed under very temporary/unstable conditions
- Support existing housing/service programs with demonstrated experience in assisting homeless individuals to obtain permanent and stable housing

There are a small number of chronic homeless individuals who are mentally ill substance abusers who over utilize shelter programs and are difficult to engage in treatment services in any meaningful way.

The Mental Health Department believes that a permanent housing model like HUD's Housing First Model for these chronically homeless individuals should be considered for development in the county.

Officials from the Mental Health Department, Department of Social Services and non-profit agencies have visited a program like this in Albany County. The Department is interested in developing a program like this on a smaller scale.

Recipient Employment and Retention Initiatives

The Vocational Initiatives Program (VIP) is a vocational case management service designed to assist recipients of mental health services to obtain and maintain competitive employment. Emphasis is placed on helping individuals recognize their strengths, interests, and needs, and on development of an individualized job search plan. On-going personal support is offered throughout the job search and job retention process.

The available services include:

- Focus on care planning with ongoing one-on-one assistance in obtaining and maintaining competitive employment
- Guidance in identifying vocational strengths, interests, and aptitudes
- Assistance with resume development, filling out applications and learning positive interviewing skills

- Information provided on accessing job leads and networking
- Bi-Monthly Vocational Support Group providing an opportunity for individuals in the job search process to share experiences, job leads and suggestions with each other
- Referral to, and collaboration with, other support services
- Emphasis on development of skills and supports needed to achieve vocational goals and long term self-sufficiency
- Provision of information and strategies for addressing mental health needs with respect to employment
- Training in “soft skills” and job-keeping skills designed to help individuals work through issues and conflicts on the job
- Time unlimited support

Employment, Retention, and Advancement Program

The ERA Program provides comprehensive vocational case management and case coordination services including but not limited to:

- Linkage with Mental Health and other needed services such as VESID, Supported Employment, Department of Labor, Broome Employment Center, Catholic Charities, Southern Tier Independence Center, Families First, BOCES, Legal Aide, BC Transit and Subsidized Day Care.
- Individualized vocational counseling throughout each phase of job search. This includes on-going vocational assessment, identification of interest, needs and goals related to employment, vocational service plan development, training in job seeking skills including how to write a cover letter and a resume, interview preparation, development of a job search plan, and counseling in reference to job keeping skills.
- Job search assistance with time-unlimited support.
- Information regarding the labor market and work environments/climates.
- On-going support and guidance to address obstacles as they arise – subsequently promoting job retention and advancement.
- Benefits counseling and advisement.
- Continuous collaboration with service providers involved in each participant’s case. ERA staff has developed solid relationships with community providers and maintains close contact with relevant providers to promote successful vocational outcomes for each program participant. The Vocational Case Manager is co-located with the TANF vocational staff at the Broome Employment Center to facilitate ongoing collaboration and services coordination.

IX. Mental Health Services for Older Adults

Broome County's Elderly Population

In May 2003 Broome County Mental Health Department conducted a Mental Health Needs Assessment of Broome County's Elderly Population in conjunction with Binghamton University.

Broome County has a large percentage of elderly individuals (16.3% are over 65, 2000 Census), their needs are not fully met. Several organizations, such as Office for Aging, do their best to refer individuals to the limited services available, while organizations like Action for Older Persons do their best to make the available resources known to consumers.

Geriatric Services

Based on past surveys and comments of stakeholders, it can be concluded that the mental health needs of the elderly population are not being fully met. There is a greater need for community based programs than there are services. Although outpatient agencies do provide services to the elderly, few of the agencies surveyed provide services specifically for the elderly. In addition, because of various problems such as transportation issues, physical problems, and cost, many elderly individuals are unable to travel to the outpatient programs to receive services. Most stakeholders are also quick to note that the problems with mental health services for the elderly extend beyond those individuals who are seriously and persistently mentally ill. The majority of elderly individuals, whether SPMI or not, have mental health needs (primarily around treatment for depression), and these needs generally go unaccounted for.

A strong need exists for at-home services, such as United Health Services' HOME program, which appears severely understaffed, considering the demand for such resources. However, many at-home services are specifically for medical conditions, and any counseling that may occur is short term, and those receiving such services must have a medical problem severe enough to warrant the at-home treatment. Besides being more cost effective than long-term and emergency treatment, allowing individuals to remain at home while receiving treatment improves the individual's quality of life (Bernstein & Hensley, 1993).

Several directions can be taken for the future allocation of resources. First, many stakeholders cite difficulties in providing mental health services due to a lack of transportation. This includes not being able to provide individuals in rural areas with assistance because of their distance from any mental health service.

Problems with medications are another frequently cited problem, including the high cost of medications, having many medications prescribed to an individual, incorrect usage of the medication, infrequent monitoring of medication effectiveness, and a lack of doctor control over medication interaction.

Above all, however, there exists a need for more community-based mental health organizations, especially those providing in-home services. Community-based mental health care proves beneficial to both the individual and the community in personal and economic ways, while providing services in the individual's home allows those who would not be able to travel to participate in the services. A review of the agencies in Broome County reveals that few agencies exist that provide in-home mental health care to the elderly. Future resources should be allocated to founding and developing such organizations and programs.

By focusing resources on developing community-based programs and making these and existing programs more accessible to those desiring services, including individuals whose mental health needs are not severe enough to earn them the label of seriously and persistently mentally ill, substantial gains can be made in providing mental health services to those elderly individuals in need of them.

Aging Futures

The Aging Futures Partnership is made up of many local organizations, planners, and consumers who work to identify and then address needs of our significant elder population. The partnership has been active since 1989. In 2004, the Aging Futures Partnership was selected as one of 8 national communities funded through a grant from the Robert Wood Johnson Foundation via the Community Partnerships for Older Adults Program.

The partnership conducted a needs assessment and developed a strategic plan. Priorities for 2004-2007 were established and are outlined below. Most are managed through a workgroup dedicated to the initiative.

1. Understanding and Using Services
2. Managing Chronic Disease; Hypertension and Depression
3. Supporting Caregivers
4. Promoting Social Connections

Suicide Prevention

The Mental Health Department has participated in an initiative that was implemented by the Broome County Office for Aging, The Aging Futures Project. This planning project was awarded a grant from the Robert Wood Johnson Foundation to conduct a comprehensive plan for the aging in Broome County. There is a significant percentage (up to 20%) of the elderly that experience symptoms of depression. Depression is clearly linked to suicide in the elderly. We are exploring methods and programs targeted at the elderly to reduce depression and prevent suicide.

Single Point of Entry for Adults

The Single Point of Entry efficiently matches individuals diagnosed with a serious and persistent mental illness (SPMI) with the mental health case management and residential services deemed most appropriate to meet their needs. The 2004 data shows that 11 adults over 65 years of age were served. In 2005, that number rose to 15 adults over 65 years old that were served with case management or residential services.

Helping through Outreach and Mental Health for the Elderly

The HOME program provides direct services such as consultation with a mental health professional, in-home mental and medical health assessment and/or short-term counseling and referrals to other services. The program offers services to any Broome County resident age 60 or older who requires and can benefit from in-home mental health care. In 2004, the HOME team served 180 individuals and 42 were Veterans. The 2005 data shows an increase in clients served to 202 and 45 of those were Veterans.

In-Home Mental Health Management

The In-Home Mental Health Management program promotes the independence of persons who need help with life skills and have a diagnosis of mental illness. They reduce self-neglect, unwarranted crisis center visits, and re-hospitalizations by offering help in managing psychotropic medications and assistance with life skills. For 2004/2005, HOME served 31 clients total, 11 of those clients were over 70 years of age.

X. Broome County's Veterans Services

Outpatient Veterans Clinic

The Outpatient Veterans Clinic, operated by the Veteran's Administration on the grounds of the Greater Binghamton Health Center, provides physical/mental health care to veterans (men/women) with 2+ years of active duty service and honorable discharge after 1980. Approximately 596 Adult clients are currently receiving mental health services at the clinic. There are about 90% of the clients served at the Clinic that are considered severe and persistent mentally ill (SPMI). The clinic offers groups in PTSD, Mental Health and Smoking Cessation. The clinic does not treat sex offenders. Four of the biggest challenges are recruitment of new psychiatrists, serving the needs of the elderly, understaffed in nurse practitioners and implementing best practices.

Veteran's Service Center

The Veteran's Service Center, a non-profit agency, offers a variety of services to assist veterans and their families whose lives have been impacted by Post-Traumatic Stress Disorder (PTSD).

The director of the VSC received the Jefferson Award for her work with veterans. There were 95 other recipients nationwide but Binghamton's was the only community program honored for serving veterans. The center has served 17 new clients in 2005.

The center has a Work Study program with Binghamton University. Three students participated and successfully completed the program. The center also works with several community organizations and local churches in combining ministry with helping families readjust from deployment.

XI. Networking for Adult Services

Provider Networks

Management Council consists of the Executive Directors of all mental health providers in Broome County (see list on page 14). The Council meets monthly.

The Professional Advisory Group (PAG) consists of the Alcohol and Substance Abuse providers in Broome County. The Group advises the Alcohol and Substance Abuse (A/SA) Subcommittee. The Group meets monthly.

Local Consumer Networks

New York Association of Psychiatric Rehabilitation Services (NYAPRS) – Broome County Consumers are members
National Alliance on Mental Illness (NAMI) of Broome County
Broome County Consumer Advisory Board

Broome County has a number of Private Practitioners listed in the yellow pages as shown below.

<u>Number</u>	<u>Private Practitioner</u>
42	Counselors
31	Social Workers
5	Psychiatrists
42	Psychologists

Children’s Services:

Provider:	Programs										Other								
2004 Statistics	Clinic	Day Treatment	FFT	In-Patient	ICM	SCM	Home Community Based Waiver	Aging Out Case Management**	Family Support	School Based Services	Residential Tx Facility	Community Res	CCSI	CCSI-F	MHJJ	SPOA	MICA	Re-Entry Program	Psych. Emergency
Broome County Mental Health Clinic	459																		
Children’s Home of Wyoming Conference		21							128		9								
Catholic Charities Children & Youth Services*			124		100	29	77	100				15	121			175	33	47	
Mental Health Association										181				39					
Family & Children’s Society										66									
Lourdes Hospital															89				
Greater Binghamton Health Center	537	25																	
United Health Services**+				108															871
Total Estimated Capacity:	996	46	124	108	100	29	77	100	128	247	9	15	121	39	89	175	33	47	871

*Note 1: Aging Out and ICM Case Management total 100 cases served combined.

**Note 2: data is from 2005

+Note 3: data is from 2005 for Total Adolescent Psych. Admits

XII. Integrated and Coordinated Services for Children

Single Point of Accountability

The SPOA program improves access to services, provides continuity of care for mental health services, reduces out of home placements, and increases family participation in planning for mentally ill youth.

Catholic Charities Single Point of Accountability (SPOA) includes professionals who represent human service agencies such as: Broome County Department of Social Services, Lourdes Mental Health Juvenile Justice, Mental Health Association, Greater Binghamton Health Center, BOCES, Harbour Program, Children's Home of Wyoming Conference, Catholic Charities Children & Youth Services, Family & Children's Society, Broome County Mental Health Department, Coordinated Children's Service Initiative (CCSI).

Integrated County Planning (ICP) includes all of the County's Human Service Department Heads plus other funders, as well as school superintendents, and meet twice a month for cross system collaboration focusing on children and families.

Coordinated Children Services Initiative (CCSI) Tier I and Tier II meet monthly.

XIII. Networking for Children Services

Provider Networks

Management Council consists of the Executive Directors of all mental health providers in Broome County. The Council meets monthly.

The Professional Advisory Group (PAG) consists of the Alcohol and Substance Abuse providers in Broome County. The Group advises the Alcohol and Substance Abuse (A/SA) Subcommittee. The Group meets monthly.

Children's SPOA – Provides access and coordination of services for the highest-need SED children to reduce out-of-home placements. SPOA Committee meets weekly.

Local Family Networks

CCSI/Children's Home of Wyoming Conference Family Support Groups, NAMI

Provider and Family Networks

Coordinated Children Services Initiative (CCSI), Coordinated Children Services Initiative Families and Others Collaborating for Understanding and Success (CCSI FOCUS) and the Children's Home of Wyoming Conference teamed up to serve families and children. Children and parents have dinner together then are separated to participate in the activities. CCSI FOCUS works with the family of a child who exhibits significant difficulties in the school and/or home settings (at-risk behaviors). This child may be at risk of PINS Diversion/PINS or Juvenile Delinquent status but is not at risk of immediate out of home placement. The child must be involved with two or more service providers; such as schools, physicians, counselors, DSS, Probation, Catholic Charities, and other human service agencies. CCSI creates an integrated system of care that responds

promptly to the needs of children at high risk of out-of-home care, their families and community. The program is child centered, family focused, strength based, culturally competent and flexible enough to meet the unique needs of children and their families.

The Children's SPOA encourages parents to participate in the coordination of services for their child at the Provider meeting. The Children's SPOA employs two part-time Family Advocates to assist the family in gaining, understanding and collaborating mental health services.

XIV. Identified Service Needs for Children and Adults in Broome County

2006 Broome County's Identified Service Gaps/Needs for Adults & Children Adult Outpatient/Inpatient Mental Health

- Recruitment and retention of board certified psychiatrists
 - Current population is aging
 - Potential/hired candidates have had performance issues
- Uncompensated Care
 - Medicaid/Medicare/COPS/DSH funding does not cover all for uncompensated care costs
- Rise in potential dangerous situations with violent clients
- Inpatient treatment for Dual Disorders located in Broome County
- Social Work staff routinely serve clients with lengthy case management needs
 - Only billable if client is present
- Recruitment of registered nurses for hospitals
- Gap in services for dually diagnosed adults (those discharged from CPEP and inpatient in need of assessment and referral to MICA programs)
- Increasing caseloads for mental health providers and no new positions (psychiatry, psychology, nursing, social, case work)
- Limited case management slots for Adults
- Transportation needs for Adults
- Improved coordination between OMH, OASAS and OMRDD services

Geriatric Mental Health

- Recent studies suggest that 20% of Broome County's elderly population suffer from some degree of depression
- Aging population with limited mental health services (in home and in facilities)
- Managing chronic disease
- Remaining socially connected

Case Management

- State deficit funding has not kept up with high cost of living expenses for the MICA ICM Program resulting in staff and capacity reduction
- Shared Case Management Staff for three positions have been held up 10 months in 2004, 8½ months in 2005, and 2½ months in 2006 causing 12 clients from each position not to be served
- Retaining well trained mental health case managers
 - Issues of safety and compensation

- The need of bilingual case managers
- Provision of rep-payee services impacting the placement of individuals with case management - See below as of February 2006

Program	Current Rep-Payee #
CC CSS	14
CC SCM	51
CC ICM	38
CC ACT	33
GBHC CM	15
Project Uplift	4
Broome Co MICA ICM	7
DSS	403
TOTAL	565

- Rep-payee services also impact the ability to transition within the mental health case management continuum
- Housing for the elderly chronically mentally ill
 - Family Care is full
 - Services provided generally are complicated by failing physical health as much as mental health difficulties
- Working with the dually diagnosed clients

Residential

- Wait List for Supported Housing at end of year
 - More people able to live independently with ICM or ACT Team
 - 10 additional beds will significantly reduce year end wait list, which begins on or about October 15th each year
- Dual Diagnosis individuals require more intensive support in Community Residence
 - Need MICA Program staffing level in at least one of the CR's
 - 65% of individuals in certified housing have a dual diagnosis
- Addition of Registered Nurse FTE to Residential Model
 - Approximately 30% of people present with diabetes, heart disease, Hepatitis B or C, HIV Virus and high blood pressure among the serious health related issues
 - Staff supervise dispensing of medications with no nursing oversight
- Certified Residential Fiscal Model unchanged for 20 years providing for minimal staffing. Residential programs need an annual automatic rate increase.
 - People now present with complicated multiple mental and physical health problem areas such as substance abuse, forensic involvement and substantial histories of violence

Dual Disorders

- Case management capacity for MICA clients approaching critical condition
 - Large increase in MICA clients being seen in both mental health and substance abuse systems and referred to Single Entry

- Increased awareness and discussion regarding individuals with co-occurring disorder issues
- Lack of experienced and trained professionals to treat clients with an integrated model of care for co-occurring disorders
- Develop integrated services for co-occurring disorders among children i.e. mental health, substance abuse, developmental disabilities
 - Significant number of children with issues regarding mental health/developmental disabilities also have substance abuse involvement in self and/or family
- Develop local inpatient unit for MICA clients
 - Dollars for inpatient MICA treatment currently leaving the County
 - Care coordination for clients receiving inpatient treatment out of County is inadequate
- Better coordination and collaboration with the criminal justice system; both adult and children's services
 - Increasing number of clients receiving mental health services who also have co-occurring substance abuse issues also are involved with the CJS
- Substance abuse agencies represented at children's SPOA
 - High percentage of children have substance abuse involvement in self and/or family
- Appropriate level of care for housing
 - Increasing number of safety issues prevent and/or hinder clients ability to access existing housing services
 - Increasingly high needs of clients including high level of supervision prevent and/or hinder clients ability to access existing housing services
 - Clients use and abuse of substances prevent and/or hinder clients ability to access existing housing services
 - Mentally Retarded Developmentally Delayed clients who are also mentally ill

Mental Health Prevention

- Lack of funding for suicide prevention and the primary prevention of all Mental Health disorders

Veterans Mental Health

- Private practitioners in the community have little experience in the military and lack of awareness of combat trauma
- Post Traumatic Stress Disorder (PTSD) training is not widely available among local agency case managers
- Department of Labor, Veterans Service Division personnel need training to identify early PTSD symptomology

Children's Mental Health

- Local Inpatient Hospital unit for SED children
- Need more Home & Community Based Waiver slots
 - Medicaid stops after child is discharged
 - Skill Building services for children who are not in the Waiver
- Broome County does not have an OMH Licensed Community Residence for girls

- Female SCM Staff
- Mentoring
- More Respite hours
- Local treatment options for children with eating disorders
- Treatment/training for children who cut or injure themselves
- More Board Certified Child Psychiatrists or Psychiatric Nurse Practitioners to help in assessment and medication management
- Case Management slots are operating at full capacity
- Transportation needs for children
- Need for Big Brother and Big Sister openings

XV. Performance Management for Children and Adult Programs

In the report entitled, “Evaluation of Broome County’s Community Reinvestment Programs”, authored by The Center for Governmental Research (CGR) in August 2001 it was recommended that the Mental Health Department establish a process for the monitoring of contracts. In addition, CGR recommended that the County provide technical assistance to agencies to help them undertake and improve on their statement of, and ability to track, outcome measures for their programs.

In January 2002, the Coordinated Care Services Inc. (CCSI) Performance Management Analyst began employment under contract with Broome County Mental Health reporting directly to the Commissioner of Mental Health. Provider agencies submit quarterly report statistics and outcome measures four times per year. Site visits to agencies are done four times per year and evaluations are done yearly which create the Annual Community Report Card. In addition, many activities have been provided in order to bring Cultural Competency to agencies. Cultural Competency training sessions, workshops and personal assistance aided the providers in implementing cultural initiatives into their organization.

In the Annual Report, data is pulled from each program to report their progress. The data reflects annual persons served for each contract agency’s program. A program narrative is also included to provide overview information about the service.

The Annual Community Report Card reflects the program’s annual financial and program performance. This report card rates the programs based on information gathered throughout the year. The provider’s receive their program ratings and have follow-up recommendations if deemed necessary. The site visits and quarterly reports are used as part of the whole report card process. Financial information is reported by the Fiscal Administrator regarding the whole agency, not just on a program level. Performance measures are tied to quarterly reports and county claims. The Fiscal Administrator and Performance Management team work closely to evaluate the agency’s performance on an annual basis.

XVI. Cultural and Linguistic Competence

Cultural Competence

The October 2004 Cultural Competency Planning Seminar consisted of six half-day sessions with the Cultural Diversity Professionals from Coordinated Care Services, Inc. (the Cultural Diversity Director and a Consultant) and assistance from the Broome County Mental Health CCSI Performance Management Staff.

This seminar was the first step in preparing for a culturally competent plan for each agency. At the seminar, the facilitators reviewed with each agency where improvements were needed with respect to cultural competency within the agencies according to an assessment that was conducted at an earlier date. Furthermore, break-out sessions were conducted where each organization was assigned a facilitator who would lead the group through the planning process. Several procedures followed the October seminar that were key in reaching the ultimate objective of having a sound cultural competency plan for every agency. First, individual technical assistance was given to eight agencies. This assistance allowed the CCSI staff to clarify any questions that the agencies had regarding their cultural competency plans. Following these sessions, the agencies were given a submission deadline for their cultural competency drafts. These drafts would then be presented to all of the agencies involved in this project at the May 2005 Cultural Competency Knowledge-Sharing Seminar.

The May 2005 Cultural Competency Knowledge-Sharing Seminars consisted of three half-day group meetings with the Cultural Diversity Professionals from CCSI and assistance from the Broome County Mental Health CCSI Performance Management Staff.

Each agency presented their plans to the group, discussing any challenges, successes, issues, and concerns. Feedback was then generated from the facilitators and the other group participants. There was constructive criticism by the group toward all of the plans, which was deemed important and helpful. Furthermore, group members were able to gather ideas about how to improve their plans by reviewing the plans of the other agencies present.

In addition to reviewing the cultural competency plans, there were particular topics discussed by those present regarding cultural competency. Interpreter services was an important topic, because there are barriers to obtaining those services for some agencies because of the cost and being unaware of where to find such services.

Group members mentioned that there is a need for consistent cultural competency training, and being able to obtain the training inexpensively. This suggests that there is need for future seminars sponsored by the county to address cultural changes in the community and how those changes affect the cultural competency plans of the agencies.

The October 2004 Cultural Competency Planning Seminar was successful in introducing to every agency the importance of Cultural Competence and being able to integrate Cultural Competence into the inter-workings of every agency. By utilizing the

assessment conducted in 2003, it was feasible to determine what the strengths and weaknesses were for each agency. This assessment provided the Cultural Diversity professionals with a starting point that helped them focus on where the greatest Cultural Competency needs were for each agency.

The individual technical assistance that was provided gave participating agencies personalized attention that enabled them to get specific questions answered by the Cultural Diversity professionals. It also enabled the agencies to finalize their Cultural Competency Drafts that were to be submitted to the BCMHD and then presented at the May 2005 seminar.

The May 2005 Cultural Competency Knowledge-Sharing Seminar was a useful collaboration for every agency present. Organizations were able to share ideas and offer different points of view on how they currently handle Cultural Competency matters. For example, one agency utilized a Language Identification Card at intake. This card would be presented to a client, and the client could point to the language that he or she spoke. Also, key Cultural Competency issues were discussed specifically regarding interpreter services, trainings, and the objectives of the Local Multicultural Advisory Committee (LMAC).

XVII. Peer Services for Recovery

Peer Advocacy

This service serves Adults who are Serious and Persistently Mentally Ill (SPMI) and is intended to focus on self-help and empowerment for both peer staff and advocacy recipients. The Mental Health Association (MHA) links the recipient to mental health services, peer groups and providers. Services include providing support, linkage to other services, improving communication between the mentally ill, mental health professionals and the general public. Peer Advocacy as well as the services listed below are located at the Mental Health Association of the Southern Tier, Inc.

Peer Educators

The Peer Educators program provides informational presentations to recipients throughout the community as requested. These presentations include topics such as advocacy, self-help and empowerment, Voter Registration and more.

Peer Counselor

The Peer Counselor program provides peer support and self-help services. The recipients are sought through individuals utilizing the MICA/ICM Peer meeting, from the BEACON Drop-In Center or through referrals.

Self-Help Independence Project

This program offers a continuum of programming and self-help services designed to provide opportunities for consumers who wish to become active participants in their own self-directed recovery.

XVIII. Consumer Satisfaction

The 2006 Broome County Mental Health Department CCSI Performance Management Staff conducted a “Peer Survey” during March 8-16, 2006 to assess the satisfaction of adults using mental health services in this area. A total of 89 individuals, at four different locations, took part in the survey. The majority of individuals participating in the survey indicated they were satisfied with the mental health services in this area. Additionally, the majority of individuals participating in the survey provided a favorable overall rating for the mental health services in this area.

Exactly, 89 percent of the respondents provided a positive (either “excellent” or “good”) overall rating to the mental health services in this area. Additionally, 98 percent of the respondents indicated (by selecting “fair”, “good”, or “excellent”) they were satisfied with the mental health services in this area. Furthermore, individuals were approximately 77 percent likely to respond positively (“yes”) to questions related to both services and results.

The greatest deviation from the other responses was for the question of “I was encouraged to use consumer run programs”. This question produced the most negative responses, with 16 percent of individuals selecting “no”. The question “my symptoms are not bothering me as much” had the most neutral responses, with 25 percent of individuals selecting “maybe”.

Therefore, it can be generalized that the overwhelming majority of individuals participating in the survey were at least satisfied with the mental health services provided in this area. The individuals were most satisfied with the quality of the staff. Individuals were least satisfied with the encouragement of consumer run programs; although, a majority was still satisfied.

In addition, all Broome County Mental Health Contract Agencies perform a client satisfaction survey at a year minimum; most of the providers obtain the satisfaction survey upon a program discharge. The survey results are summarized and reported on the quarterly site visit forms and/or the quarterly report received from the Providers.

The 2006 Mental Health Association of the Southern Tier conducted a Consumer Focus Group Findings Document on March 20, 2006 to look at the current Mental Health system that provides consumers their services. A total of 33 individuals attended the 6 break out groups that emphasized a different aspect of our mental health community.

The 6 groups were:

1. Crisis Services
2. Access to Services/Medication
3. Cultural Competency
4. Family/Children Services
5. Community Programs/Collaboration
6. Inpatient/Outpatient Services

The break out groups participated in a 20-minute discussion of the 6 topics. The participants then rated three areas they thought were most critical to address.

XIX. Performance and Outcome Data Studies

Broome County Case Management Services Report, October 2004

In the summer of 2004, CCSI conducted an evaluation of the adult mental health case management service system in Broome County. This evaluation was requested by Arthur R. Johnson, LMSW, Commissioner, in order to assess performance and identify opportunities for improvement with this important community resource.

The mental health case management services system in Broome County has evolved since the New York State OMH New Initiative in 2001, which provided new funding to expand service capacity and to strengthen the County's infrastructure to manage those resources. The purpose of this report is to provide Broome County leadership with information regarding the effectiveness of the current complement of case management services (and the supporting systems) in targeting and serving individuals with significant mental health needs.

Broome County offers the following mix of Case Management services to area residents:

Program Name	Service Providers	Capacity (slots)	Managed under SPOE?
Assertive Community Treatment (ACT)	Catholic Charities	68	Yes
CSS Case Management	Uplift-MHA	55	Yes
	Catholic Charities	30	Yes
Intensive Case Management (ICM)	Catholic Charities	84	Yes
Supportive Case Management (SCM)	Catholic Charities	120	Yes
State Operated Case Management	GBHC (BPC)	160	Yes
Assisted Outpatient Treatment ICM (AOT)	Catholic Charities	12	No
MICA ICM	BCMH	35	Yes
Addiction Case Management	Fairview	100 annually	No*
DSS Case Management	DSS	Variable	No*
MICA Net	Fairview	15-20	No

*Will accept cases, but SPOE is not the only referral.

An assessment of this system was conducted using techniques which included: site visits, interviews with key personnel, medical record and documents review, and various Medicaid claims-based data analyses. The assessment yielded a number of findings which identify both strengths of the system and opportunities for improvement. The key findings and recommendations are outlined below.

- The Single Point of Entry process is working well, but additional emphasis on MICA services and additional training may strengthen the system.
- Assessing opportunities for increased linkages between CPEP and Case Management Service Providers may help ensure the system is reaching those in need.
- Efforts to implement more standard Utilization Review Processes should continue to ensure appropriate allocation of existing case management slots.
- Capacity constraints related to Representative Payee Services are straining case management capacity – the County should consider other options for meeting this service need.
- Review of Utilization Data point to differences in cost and utilization patterns following enrollment in case management services depending on level of care.

Residential Services for Mentally Ill Adults in Broome County, February 2005

An Assessment of What Exists and Service Gaps

This study assessed residential services for mentally ill adults in Broome County. Information gathered included a detailed listing of residential services currently available including utilization data and patterns of referral among county agencies. The purpose of this study is to determine if the level of residential services is matched to community needs. A specific issue to be examined was why the Catholic Charities Certified Apartment program is underutilized.

Agency	Program	Capacity	% Mentally Ill
Catholic Charities	Madison House Community Residence	14 beds	100%
Catholic Charities	Damon Hall Community Residence	14 beds	100%
Catholic Charities	Bridgeway Community Residence	12 beds	100%
Catholic Charities	Certified Apartment Program	48 beds	100%
Catholic Charities	Supported Housing	108 units	100%
Greater Binghamton Health Center	Transitional Living Unit	21 beds	100%
Greater Binghamton Health Center	Family care homes	13 homes 65 beds	100%
Fairview Recovery Services	Addictions Crisis Center	18 beds	40-50%
Fairview Recovery Services	Fairview Community Residence	24 beds	40-50%
Fairview Recovery Services	Merrick Community Residence	12 beds	40-50%
Fairview Recovery Services	Supportive Living	40 beds	40-50%
YMCA	Housing Program	87 beds	~25%
YWCA	Emergency Housing	10 beds + up to 8 children	~33%
Renaissance Plaza		316 beds	30-40%
Volunteers of America	Men's Shelter	30 beds	~15%

The Certified Apartment program was underutilized and had been for at least 5 years. The primary reason for this is that people prefer to live in their own apartment. While the Certified Apartment program had openings, there were individuals on the waiting list for the Supported Housing program, which puts residents in their own apartment. Other issues that may contribute to the seeming lack of interest in the Certified Apartment program is that individuals must have a roommate that significant others are not able to live with them, and that attendance in treatment programs is highly recommended. In addition, services provided in the Certified Apartment program may overlap with existing case management.

Broome County supported Catholic Charities eliminating 6 Certified Apartment beds and converting those 6 slots to non-certified apartment beds. Our attempt to get the Office of Mental Health (OMH) to give Broome County more Supported Housing beds in lieu of the Certified Apartments was unsuccessful.

In November 2005, Catholic Charities eliminated 6 certified apartment beds due to low occupancy for 2 years. At the same time, Catholic Charities had continued to request to OMH for additional supported beds and did receive 6 beds which was unrelated to the relinquishing of the 6 certified beds.

In summary, the key findings from the Residential Service research are listed below:

- Funding from the New York State (NYS) Office of Mental Health (OMH) has not kept up with the increased cost of operating residential programs.
- Catholic Charities certified residential programs all received the highest level of certification possible from the NYS OMH in 2003 – three year certification.
- Satisfaction of Catholic Charities residents is high across all housing programs.
- Percentage of Residents that are Mentally Ill
 - Catholic Charities and Greater Binghamton Health Center – 100%
 - Fairview Recovery Services – 40-50%
 - YMCA, YWCA & Renaissance Plaza – 25-40%
 - Volunteers of America – 15-25%
- In the last four quarters, the Occupancy rate for the Catholic Charities Certified Apartment Program was 76%. It was between 83-86% from 1999-2003.
- 17 (6%) of the 274 referrals to Catholic Charities Housing in the last four quarters were denied.
- The median length of stay for the Catholic Charities Certified Apartment Program is less than half the New York State average.
- Broome is one of few counties with a lower percentage of Community Residence beds than of Certified Apartment beds. Most other counties have a higher percentage of Community Residence beds, which provide a referral base for their Certified Apartments.
- The “Stepdown” model is not an accurate description of how residents move through Catholic Charities Residential Services.
- Housing for high risk clients is an issue in Broome County.
- Renaissance Plaza had the lowest occupancy rate of all agencies surveyed, 57% in the last four quarters.

- The Section 8 Housing program in the Town of Union has 400 person waitlist.

Dual Recovery Project

The objective of the Dual Recovery Project is to coordinate, improve, and enhance treatment and ancillary services for individuals with co-occurring mental health and substance abuse disorders, especially those with the most serious and persistent mental illness and substance abuse problems. New York State OMH and OASAS jointly sponsor this initiative and are committed to working at a State level to address system barriers. The Dual Recovery Coordinator acts as a liaison and advocate for the community at the State level and has organized community mental health and substance abuse agencies as well as DSS, housing and consumer groups into six active workgroups and an oversight advisory group that work together to accomplish the project objectives. These groups meet regularly and the following are some of the accomplishments to date: Case Review Committee met to resolve client referral and services barriers; the Dual Recovery Project sponsored 18 free trainings and offered 35 CASAC credit hours to a wide range of participants on various topics concerning co-occurring disorders; the Dual Recovery Project conducted a survey of providers working with the project which has assisted us in the coordination of care for individuals with co-occurring disorders; the Project designed, printed and distributed over 3000 copies of “Consumer Pocket Guide to Services in Broome County” which has been positively received by both consumers and providers; we designed and completed a field testing of evidence based screening instruments working with three mental health and substance abuse agencies and utilized this work to guide the project; we applied for and were selected for the OMH Connect Initiative.

The workgroup planned, developed and has begun presenting a series of cross trainings on adult addictions, mental illness, the New York Model, and psychopharmacology.

The following information reflects the Dual Recovery Project Participation in Planning:

Surveys:

1. March 2004 – Laura Cramer, MA, BU psychology intern, produced a report, “The System of Care for Dually Diagnosed Individuals: Broome County, New York”. Laura surveyed MH, D&A, DSS – 33 agencies across the system involved in the DR Project. The survey asked about issues related to care for individuals with co-occurring disorders:
 - Referral and treatment priorities for both inpatient and outpatient treatment
 - Priorities for improvement in the treatment system for individuals with co-occurring disorders
 - Input on effective treatment programming for individuals with co-occurring disorders
2. May 2004 – Laura Cramer, MA, under the supervision of Rob Russell, EdD, finalized a report, “A Pilot Study of Dual Diagnosis Screening Tools in Broome County: The RAFFT and the modified MINI”
 - This study was the result of a pilot study with 3 participating agencies: BCMHC, ACBC, and UHSH- New Horizons.

- Results indicated that the modified MINI was viewed as beneficial in screening for co-occurring disorders, and the RAFFT was viewed as having no real benefit.
3. April 2004 – Terry Cole surveyed all OMH and OASAS licensed treatment providers in Broome County as to their understanding and adherence to ASAM’s Patient Placement Criteria 2-R Dual Diagnosis Capable and Dual Diagnosis Enhanced standards of care. Results from these surveys have been shared and utilized within the Dual Recovery Project and individual agencies to enhance agencies’ standards of care for individuals with co-occurring disorders.

Committees:

Core Group, Treatment Workgroup, Education/Training Workgroup, Interagency Collaboration Workgroup, Screening/Assessment Workgroup, Housing Workgroup, Review Committee, Consumers are members of the Dual Recovery Project.

The Dual Recovery Project holds an annual retreat for planning purposes as well as convenes the Core Group as needed throughout the year to review and oversee special projects or community issues.

Broome County Visioning Project for Children and Adolescents, July 2002

An Assessment of What Exists and Service Gaps

Past studies in Broome County have suggested that there are gaps in mental health services for children and adolescents in the county and that, at least in part as a result, growing numbers of children and adolescents in recent years have been referred to hospitals for inpatient psychiatric treatment. This study built on those earlier efforts to provide a comprehensive, objective assessment of the mental health services currently in place in the county, and those who have been served by those mental health programs.

A wide variety of services and programs currently serve children and adolescents in Broome County. Many programs are well-regarded, and many are operating at or close to full capacity. The county is also unique among counties of its size in having a Comprehensive Psychiatric Emergency Program (CPEP) available to respond to the crisis needs of its Serious Emotionally Disturbed (SED) youth.

Key building blocks of a strong future mental health system for children and adolescents are in place, but some had been too small to meet the perceived needs, while others were not operating at full capacity, despite the perceived needs for expanded services. Finding ways to better match resources with needs is part of the challenge facing the community as a blueprint for a new system continues to develop.

As a result of the Children’s Visioning Project in 2002, Broome County has accomplished the following:

- Inpatient Unit for Children and Adolescents at Greater Binghamton Health Center (GBHC) opening the Spring of 2006
- Developed Children and Youth Re-Entry Coordinator position (full-time)

- Significantly increased resources for CCSI including the development of CCSI FOCUS
- Expanded 1 FTE staff to Lourdes Youth Services Mental Health Juvenile Justice (MHJJ) program
- Created Children’s SPOA, funded it, and added 2 Family Advocates
- Funded a comprehensive study of Children’s needs with Mental Health and Mental Retardation disabilities through the Mental Health task force, study authored by CGR
- Developed the KYDS Coalition and recently added Suicide Prevention to its mission
- Developed the Functional Family Therapy (FFT) program
- Increased the number of Mental Health Nurse Practitioners working in the County
- Expanded the Children’s Flex Team (HCBW) by 4 slots

Continuum of Care for Mental Health Services for Children & Adolescents in Broome County, 5/30/02

Component	Current Service Array / Capacity	Comments/ Additions
Preventive/ Outreach	Information and Referral <ul style="list-style-type: none"> • Mental Health Association 	
	Primary Prevention	
	Education <ul style="list-style-type: none"> • Mobile Mental Health Team (BPC) • Mental Health Players 	
Clinic/Outpatient Counseling	Counseling Services (Including School-based) / 538 <ul style="list-style-type: none"> • Family & Children’s Society* • Gateway* • Adolescent Preventive Services* • The Corner for Youth & Family Services* • BEAR, Rural BEAR* • Therapeutic After School Program* • Student Assistance Program 	

	<p>Office or Outpatient Clinic / 700</p> <ul style="list-style-type: none"> • SOMH Clinic* • BCMH Clinic* • UHS Child Treatment Services* • School-based Health Centers 	
	<p>Private Practitioners</p>	
<p>Youth & Family Supports/ Services</p>	<p>Family Support Services / 18</p> <ul style="list-style-type: none"> • CCSI* • Children’s Home • CFT • Corner (Lourdes) • Family Ties (UHS) 	
	<p>Youth Support Services (e.g., mentoring, peer support)</p> <ul style="list-style-type: none"> • Catholic Charities Mentoring • Urban League • Binghamton Schools • Boy Scouts/ Girl Scouts • Challenger Baseball • Youth Sports • YMCA and YWCA • Saturday SUNY Programs 	
	<p>Respite Care Services / 42</p> <ul style="list-style-type: none"> • Catholic Charities* • Children’s Home • Urban League 	
	<p>Wraparound Model/Funds</p> <ul style="list-style-type: none"> • Intensive Case Management • CCSI • CFT • Adolescent Preventive Services • Youth Advocate Program 	
<p>Intensive Services</p>	<p>Intensive Case Management / 166</p> <ul style="list-style-type: none"> • Catholic Charities ICM* • Flex Team* • Mental Health/Juvenile Justice* • Youth Advocate Program 	
	<p>Home-based Treatment Services / 32</p> <ul style="list-style-type: none"> • MICA Intensive In Home Services* • Families First* 	
	<p>Day Treatment / 34</p> <ul style="list-style-type: none"> • SOMH* • Children’s Home of Wyoming Conference* 	
	<p>Partial Hospitalization / 0</p>	
<p>Emergency/ Crisis</p>	<p>Emergency/Crisis Services</p> <ul style="list-style-type: none"> • CPEP • Mobile Mental Health Team (UHS) 	

	Crisis Residence / 6 <ul style="list-style-type: none"> • Adolescent Crisis Residence* 	
Residential	Therapeutic Group Home or Community Residence/ 145 <ul style="list-style-type: none"> • Adolescent Girls' Group Home* • Boys of Courage* • Teen Transitional Living* • Ardsley House* • Boys' Group Home* • Close to Home* • Diagnostic Center* • Haskins* • CCSI Respite Per Diem • Harbor Home • Berkshire Farms Specialized Foster Care • Adolescent Crisis Residence/Respite 	
	Residential Treatment Facility / 51 <ul style="list-style-type: none"> • Children's Home of Wyoming Conference* 	
Inpatient	Hospital Treatment <ul style="list-style-type: none"> • Inpatient services for children & adolescents provided out-of-county 	

* Programs included in the capacity estimate. All capacity data obtained from CGR's provider survey administered in December 2001.

Children in Broome County with Co-Occurring Mental Health and Developmental Disability Conditions, November 2005

Numbers and Service Gaps

The Broome County Children's Mental Health Task Force is a coalition of local agencies and individuals concerned about the lack of adequate mental health services for children and adolescents with mental health needs who also have or are considered likely to have developmental disabilities. The Task Force requested Center for Governmental Research Inc. (CGR) to conduct a needs assessment to determine the numbers of such children with co-occurring mental health (MH) and developmental disability (DD) conditions and extent of gap in services for this population. A few of the highlighted findings, conclusions, implications and a list of the final recommendations are:

- Based on imprecise national estimates, there may be between about 3,600 and as many as about 13,500 children and adolescents in Broome County with some level of mental health needs/emotional disturbances, and between about 1,400 and as many as 10,400 with development disability.
- During 2004, almost 3,000 children with mental health needs and almost 900 with development disabilities were reportedly served by the county's Mental Health and Mental Retardation/Development Disability (MRDD) community-based service providers.

- Of those children and adolescents, about 500 county children with co-occurring MH and DD conditions have reportedly been identified and are currently being served by the MH and MRDD service providers in the county.
- Of those, approximately 300 county children with co-occurring MH and DD conditions reportedly had service needs which could not be met by MH and MRDD providers during 2004 and early 2005.
- More than a dozen recommendations to both State and local officials conclude the report. They focus on ways to build bridges between the MH and MRDD service systems; strengthen psychological testing to more effectively diagnose and assess service needs of youth thought to have co-occurring mental health and developmental disability conditions.

Priorities	Recommendations
Priority 1	Improving communications, expanding linkages and sharing of information across systems, providers and parents, and on expanding cross-training and skills of staff across MH and DD systems.
Priority 2	Focus on addressing the service gaps identified by the study.
Priority 3	To establish an improved assessment process.
Priority 4	To strengthen the single point of entry/access to services process.
Priority 5	To disseminate the report widely at the state and regional level.
Priority 6	The determination of the specific names of children and adolescents with co-occurring conditions and unmet service needs, along with the establishment of an information system to track their characteristics, diagnoses and progress in the future.
Priority 7	To establish a pilot project.

XX. Quality of Care

Broome County Mental Health Clinic Quality Improvement Plan

The Broome County Mental Health Department clinic for adults and children provide comprehensive outpatient mental health services, including individual therapy, group therapy for a variety of special topics and medication education and management. The Adult Clinic provides services to approximately 1100 recipients while the Child & Adolescent Clinic provides services to approximately 250 children and their families.

It is the mission of Broome County Mental Health Department (BCMHD) Local Governing Unit (LGU) to plan, organize, and oversee a comprehensive continuum of care for consumers of public mental hygiene services in Broome County.

The mission of BCMHD is to develop and provide the highest quality services possible, within the limits of the resources available, to individuals within Broome County who are in need of services for mental illness. BCMHD strives to ensure that the services provided reflect the current community need.

BCMHD cooperates with other service providers at the local and state level to develop community preventive, rehabilitative, and treatment services offering a continuum of care to improve and expand existing services and to plan for the integration and coordination of services. In the planning process, the total community need is taken into consideration to develop a full range of services. Individual needs and circumstances are also taken into consideration to ensure adequate access to services for those individuals who otherwise would not have access to such services.

The Quality Improvement Plan serves as a foundation of the commitment of this clinic to continuously improve the quality of the treatment and services it provides. Quality services are services that are provided in a safe, effective, recipient-centered, timely, equitable, and recovery-oriented fashion. BCMHD is committed to the ongoing improvement of the quality of care its consumers receive, as evidenced by the outcomes of that care.

XXI. Best Practices/Evidence Based Treatment Programs for Adults

Assertive Community Treatment (ACT) is a mobile team-based approach which delivers comprehensive and flexible treatment, support and rehabilitation services to individuals with severe mental illness; it provides these services in recipient's natural environment, rather than in an office setting. ACT supports recovery through a highly individualized approach that provides recipients with the tools to obtain and maintain housing, employment, relationships and relief from symptoms and medication side effects. It was implemented nationally in the 1980s, and it serves individuals with the most serious symptoms of mental illness whose needs have not been well met by more traditional service delivery approaches. ACT is recognized as a fundamental mental health service by professional and government organizations:

- It is one of the interventions that is documented to be effective by the National Institute of Mental Health's Schizophrenia Patient Outcomes Research Team (PORT) study;
- The Surgeon General's report endorses ACT as an essential treatment for severe mental illness;
- The National Alliance for the Mentally Ill made ACT a top priority in the United States;
- The Centers for Medicare and Medicaid Services has authorized ACT as a Medicaid-reimbursable treatment; and
- SAMHSA has indicated that accessibility to ACT treatment is one of the three best practice measures of the quality of state's mental health system.

The Single Entry Process (SPOE) has been identified as the streamlining of assessment, referral, and case management for community residents in need of mental health services. The process will expedite coordination between a series of agencies offering a full menu of services. Appropriate linkages within the patient's identified/individualized continuum of care shall be provided, absent of duplication/over utilization of services and effort. Communication shall be enhanced to continue linkages with hospitalized individuals to ensure smooth transitioning upon discharge. Specific population needs shall be the focus upon which to develop or enhance additional services, i.e., MICA, Forensic population, cultural and ethnically diverse groups, etc. The SPOE Team is comprised of one (1) full-time SPOE Coordinator and one (1) full-time case manager/clerk.

The process will develop and maintain service delivery standard by which to ensure top quality care delivery, meeting both the expectations of the consumer and the providers. The target population is seriously and persistently mentally ill adults, specifically, individuals with repeat hospitalizations who have not been successfully linked to community based services.

Family Psycho Education

Catholic Charities was one of 19 agencies chosen out of 53 who applied for participation in this project. The official project began in January of 2004 and ended in July 2005. It was offered through a partnership between the NYS Office of Mental Health and the Family Institute for Education, Practice and Research at the University of Rochester Medical Center.

This grant provided a network of consultants to provide intensive staff training, organizational consultation and clinical supervision in the McFarlane model of family psycho-education. This is considered a model of "best practice" in mental health services.

The process was to identify 5-8 consumers who shared a common diagnosis (i.e. schizophrenia) and may possibly have family/loved ones who would be willing and interested in participating in regular problem solving groups. The goal is to establish a group of 12-15 individuals, 5-8 consumers and family/friends who meet twice monthly for 9-18 months.

In February of 2005, we decided to include the other staff from additional programs (besides ACT) who were also trained. This increased the pool of resources from 68 consumers on the ACT Team to approximately 240 consumers between ACT, CDT and Four Seasons. The new staff quickly identified additional individuals who may fit well into this type of group setting. We identified eight individuals along with their families to participate in a multifamily group. Four of these were from CDT, three from Four Seasons and one from ACT. Several joining sessions were conducted and our family education workshop was held in August 2005. The first multifamily problem solving group was held in September 2005. These groups have continued to meet twice monthly.

Because of the overall positive exposure, we plan in the future to incorporate more multifamily groups and family services into our mental health programs. The Family Institute plans to continue arranging quarterly project coordinator meetings to provide

more long term support and resources to the agencies who participated in this project. A Catholic Charities representative will continue to attend these when scheduled.

XXII. Best Practices/Evidence Based Treatment Programs for Children

Functional Family Therapy (FFT) is designed to offer home-based family therapy services to families with at-risk children ages 11-18. The program follows three phases of the Functional Therapy model, which is an outcome-driven prevention/intervention model for youth who have demonstrated the entire range of maladaptive, acting out behavior and related syndromes. In phase one, the program will engage and motivate youth and their families by decreasing the intense negativity, blaming and hopelessness. In phase two, the program will reduce and eliminate the problem behaviors and accompanying family relational patterns through individualized behavior change interventions. In the final phase, the program will generalize changes across problem situations by increasing the family's capacity to utilize community resources and engage in relapse prevention. Program interventions will range from 8 – 12 one-hour sessions for mild and up to 30 for severe cases.

FFT is multisystemic and multilevel as an intervention in that it focuses on the treatment system, family and individual functioning and the therapist as major components. An additional component is included (a Case Manager) in Broome County's FFT program that will provide intensive case management services to the families. The Case Manager will be engaged throughout the entire Phase System to assist families with community resources/support services as needed.

FFT works first to develop family member's inner strengths and sense of being able to improve their situations – even if modestly at first. These characteristics provide the family with a platform for change and future functioning that extends beyond the direct support of the therapist and other social systems. In the long run, the FFT philosophy leads to greater self-sufficiency, fewer total treatment needs and considerably lower costs.

The Broome County Children's Single Point of Accountability (SPOA) was developed as a county-wide process utilizing a team model for the purpose of managing referrals to specified services in an efficient manner. It is designed to improve access to service while monitoring and coordinating utilization of these services through a single point. SPOA does not provide clinical or other mental health services beyond evaluation for appropriate level of service determination. SPOA gives equal consideration for all children and providers of children's services within Broome County. The SPOA Team is comprised of one (1) full-time SPOA Coordinator and one (1) full-time Family Advocate.

The Home and Community Based Waiver (HCBW) or Children's Flex Team serves seriously emotionally disturbed (SED) children/adolescents with complex mental health needs with global assessment of functioning scale (GAF) of 50 or lower. The child must be at imminent risk of psychiatric placement. The services provided are individualized, strength-based services utilizing the wraparound resources. Services provided by the Individual Care Coordinator include coordinating Waiver Services and all Medicaid billable services to assure for cost effective service delivery, coordination of clinical

pathways for the child/family team, assessment of strengths and need, advocacy, linking, monitoring, accessing flex dollars to community support development, and family/child team development. There is access to services including Skill Builder (Intensive In-Home), Respite (hourly and daily), family support and crisis response. Twenty-four hour direct crisis intervention is provided.

In the 2006-2007 Executive Budget Recommendations, the NYS Office of Mental Health reported that the HCBW program has proven effective in enabling children at risk for institutional placement to remain at home and in school while receiving needed services.

Broome County Youth Prevention Partnership is Keeping Youth Drug-free and Safe (KYDS Coalition)

The Broome County Youth Prevention Partnership is Keeping Youth Drug-free and Safe (KYDS Coalition) is a board of community agencies, organizations and school districts initially brought together in August 2000 to oversee the State Incentive Cooperative Agreement (SICA) Project in order to ensure the development of science based substance abuse prevention programs in Broome County. The KYDS Coalition is currently funded by a federal grant, Drug Free Communities Support Program Grant through the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant will be maintained by the KYDS Coalition through 2008. The KYDS Coalition utilizes the Communities That Care Model to guide prevention strategies in the community. The KYDS Coalition goals are to strengthen and expand the capacity for systemic change by increasing community involvement and continuing to gather and use information regarding youth substance use to create change in the factors that have been demonstrated by research to influence alcohol and other drug use among youth. Since inception the KYDS Coalition has increased membership and now includes the school districts of Union-Endicott, Maine-Endwell, Johnson City, Chenango Forks, Broome-Tioga BOCES, Susquehanna Valley, Children's Home of Wyoming Conference, Vestal, and Whitney Point. A number of these schools are implementing science-based prevention programs Life Skills Training, Reconnecting Youth, All Stars, and Families and Schools Together on behalf of the KYDS Coalition. The KYDS Coalition recently received an Underage Prevention Block Grant from NYS OASAS (Office of Alcoholism and Substance Abuse Services) to utilize the strategy of media advocacy to reduce underage drinking. The KYDS Coalition has partnered with WBNG for this grant. The KYDS Coalition continues to gather data and update the multifaceted needs assessment of the community and is working on many prevention strategies such as server trainings and compliance checks, poster/essay contests, community awareness initiatives, School Mapping Project, etc. The KYDS Coalition is continuing to put prevention strategies in place in the community to reduce youth substance use and antisocial behaviors.

In 2005 the Mental Health Department initiated activities to address adolescent suicide. In 2006 the KYDS Coalition adopted suicide prevention as one of its objectives. All school districts involved with the KYDS Coalition enthusiastically support this initiative. The KYDS Coalition plans to utilize the NYS Office of Mental Health SPEAK Awareness Kit in the community, train staff and Executive Board Members on suicide prevention and work with the school districts to put plans in place to address suicide prevention. Many of the school districts are currently implementing the Reconnecting Youth science-based prevention program, a program that addresses depression and

suicide. The KYDS Coalition is continuing to expand this program into other districts and will also seek additional science-based programs to address this issue as well as other antisocial behaviors.

The Mental Health Department has begun discussion with representatives from local colleges to address the issue of suicide among college students.

XXIII. Workforce Issues:

- Significant challenge recruiting and retaining Psychiatrists.
- Cross training for Mental Health Chemical Dependency and MRDD Staff.
- Flat funding and increased program expenses have caused agencies to convert professional staff positions to paraprofessionals and convert full-time positions to part-time positions without benefits.
- Many Residential programs have bare bones staff coverage to comply with regulations.

XXIV. Budget – County-Wide

A. Intermediate – Represents a high level view of the county’s projected total budget for mental health services and the county’s fiscal request to OMH for the coming year. The Budget would include both ongoing service costs and separately, the cost of any new, expanded or reconfigured services for the coming fiscal year, if any. Detail may vary depending on the size and impact of the proposed initiatives.

Total Revenue and Expenses for 2004:

Category	Medicaid	Medicare	3 rd Party	Deficit	Misc. Rev	Subsidy	Total Revenue	Total Expenses
Case Mgmt	794,004	0	0	725,763	72,836	884,325	2,476,928	2,476,928
Comm. Support	1,147,614	0	82,985	1,692,340	339,037	1,493,928	4,755,904	4,755,904
Emergency	997,986	495,766	1,314,787	0	(549,768)	2,050,208	4,308,979	4,308,979
Inpatient	2,147,397	5,163,982	3,933,882	0	84,577	26,398,221	37,728,059	37,728,059
Outpatient	3,835,337	381,886	521,153	115,712	56,720	6,226,081	11,136,889	11,136,889
Other	0	0	0	373,830	200,000	326,236	900,066	900,066
Residential	1,294,558	0	0	136,792	554,852	2,380,645	4,366,847	4,366,847
Grand Total	10,216,896	6,041,634	5,852,807	3,044,437	758,254	39,759,644	65,673,672	65,673,672

Source: 2004 CFR

Appendix A – OMH Strategic Plan Framework

New York State

George E. Pataki, Governor

Office of Mental Health

Sharon E. Carpinello, RN, PhD

Commissioner

Barbara L. Cohn

Executive Deputy Commissioner

Keith Simons

Deputy Commissioner and Chief Planning Officer

Mission, Vision & Values

Mission

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

Vision

The New York State Office of Mental Health envisions a future when everyone with a mental illness will recover, when all mental illnesses can be prevented or cured, when everyone with a mental illness at any stage of life has access to effective treatment and supports essential for living, working, learning, and participating fully in the community.

Values

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

OMH is achieving its mission and vision by focusing on accountability, best practices, coordination of care, and attention to disparities elimination and cultural competence to plan and manage performance in its day-to-day operations. Known as the "ABCD's of mental health care," they are:

Accountability for Results, whereby a clearly defined entity or individual is responsible for the effectiveness of services delivered. Services are designed and delivered to achieve specific outcomes, which are measured by performance indicators.

Best Practices, whereby service design and delivery are based on the best research and evidence available and best practice guidelines are incorporated into treatment practices. Adherence to these guidelines is measured as part of the accountability process.

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

Disparities Elimination and Cultural Competence, whereby all service components are held accountable to address disparities in access to and participation in services, differences are managed skillfully, cultural knowledge is absorbed organizationally, language assistance services are provided routinely, and service modifications are made to take into account the diversity of individuals, families and communities.

To effectively meet agency responsibilities, OMH organizes day-to-day operations into four lines of business:

1. **Regulation, Certification, and Oversight of New York’s Public Mental Health System**
2. **Direct Provision of State-Operated Inpatient and Outpatient Mental Health Services**
3. **Mental Health Research to Advance Prevention, Treatment, and Recovery**
4. **Promotion of Mental Health through Public Education**

NYS Office of Mental Health - Strategic Plan								
Aims:								
<ul style="list-style-type: none"> • To promote the achievement of person-centered recovery goals for children, families and adults • To promote wellness and resiliency for individuals and communities • To promote cultural and linguistic competence as an integral part of all mental health services • To promote community integration and acceptance through the reduction of stigma 								
S U P P O R T I N G	Outcomes		Mental Health Services			System Management		
	Public Mental Health Promotion	Positive Outcomes for Children, Families and Adults	Research to Practice	Continuous Quality Improvement	Access to Services	Service System Capacity	Accountability for Results	Care Coordination
	Goal 1 Improve the public health outcomes, wellness, and	Goal 2 Improve outcomes for children with serious	Goal 3 Reduce the burden of illness through	Goal 4 Improve the quality of mental health	Goal 5 Increase access to appropriate and effective	Goal 6 Improve the capacity of State and Local	Goal 7 Increase State and Local accountability for	Goal 8 Increase the delivery of a coordinated array of

O A L S	resiliency of all New Yorkers through an effective public and provider education function.	emotional disturbance and adults with serious mental illness through the use of proven, effective treatments.	strengthened ties with the scientific and consumer communities engaged in basic, clinical and services rendered.	services currently available to all children with serious emotional disturbance and all adults with serious mental illness.	services, with an emphasis on access for vulnerable and/or underserved populations.	governments to achieve agency goals.	improvements in access to services, quality and appropriateness of services, and cost of services.	medical, self-help, social, supportive, and rehabilitative services designed around the needs and desires of the individual.
O B J E C T I V E S	<p>1.1 Increase public awareness of the prevalence of suicide and of risk and preventive factors.</p> <p>1.2 Maintain the capacity to rapidly and effectively provide mental health support in response to natural and human-caused disasters.</p> <p>1.3 Improve public understanding of the causes, effects and treatment of emotional disturbance in children and mental illness in adults.</p> <p>1.4 Promote the detection, early intervention, and treatment of the psychological aspects of</p>	<p>2.1 Increase the use of mental health services that have the strongest demonstrated evidence base.</p> <p>2.2 Increase consumer and family input and participation in the treatment planning process.</p> <p>2.3 Promote services with the potential to help individuals achieve success and satisfaction in living, learning, work, and social environments.</p>	<p>3.1 Improve the base of knowledge about the causes and treatments of mental illness.</p> <p>3.2 Promote the development of new treatments based on the best available scientific knowledge.</p> <p>3.3 Develop and improve culturally and linguistically competent models of evidence-based services and their delivery.</p> <p>3.4 Reduce the length of time it takes to disseminate research findings to key stakeholder audiences.</p> <p>3.5 Improve</p>	<p>4.1 Improve service quality through fidelity to the principles of informed choice, recovery-focused and person-centered care.</p> <p>4.2 Increase the quality of services through the incorporation of evidence-based practices in routine care.</p> <p>4.3 Minimize the risk and occurrence of adverse consequences resulting from harm, neglect or suboptimal care or treatment.</p> <p>4.4 Ensure that the State and counties have the tools and resources necessary to measure and monitor the</p>	<p>5.1 Improve access to appropriate and effective services for children with serious emotional disturbance and their families.</p> <p>5.2 Improve access to appropriate and effective services for children with serious emotional disturbance and developmental challenges.</p> <p>5.3 Improve access to appropriate and effective services for children with depression.</p> <p>5.4 Improve access to appropriate and effective services for individuals involved in the criminal justice system.</p>	<p>6.1 Promote the capability of State and Local service systems to provide appropriate and effective services.</p> <p>6.2 Improve retention and recruitment to ensure a qualified workforce.</p> <p>6.3 Improve system capacity for delivery of culturally and linguistically competent services.</p> <p>6.4 Improve system capacity for the delivery of services identified by individuals with mental illness and their families as effective in meeting their recovery goals.</p>	<p>7.1 Improve the State and Local mental health planning and oversight process to promote accountability.</p> <p>7.2 Improve oversight of medication practices for both children and adults.</p> <p>7.3 Improve the service provider certification and licensing process.</p> <p>7.4 Improve the State and Local mental health planning capacity to identify and address disparities in access to and quality of mental health services based on culture, age and gender.</p>	<p>8.1 Develop collaborative approaches with other State level child-serving agencies to assure integrated, accessible, effective treatment services that assist children with serious emotional disturbance to remain at home, in school and in their communities.</p> <p>8.2 Improve the coordination of services for individuals who require intensive levels of care coordination, including children served by CCSI and adults served by the SPOA system, ACT teams, and the AOT program.</p>

<p>eating disorders.</p> <p>1.5 Promote screening, early intervention and prevention strategies, particularly with primary care physicians, other health care providers, and community providers important to consumers.</p>		<p>the degree to which researchers provide technical assistance (both continuing education and consultation) to service providers and policy makers.</p> <p>3.6 Improve the degree to which the agency and stakeholders can assess the magnitude of social cost and burden in order to prioritize resource allocation.</p>	<p>quality of care.</p> <p>4.5 Increase the State's and counties' capability to improve performance based outcomes measurement.</p> <p>4.6 Maintain adequate resources to ensure that high-quality services are able to be provided.</p>	<p>5.5 Improve access to appropriate and effective services for young adults.</p> <p>5.6 Improve access to appropriate and effective services for older adults.</p> <p>5.7 Improve access to appropriate and effective services for people with mental illness who reside in adult homes.</p> <p>5.8 Improve access to appropriate and effective services for individuals with co-occurring mental health and substance abuse service needs.</p> <p>5.9 Improve access to safe and affordable housing for individuals with serious emotional disturbance and serious mental illness.</p>	<p>6.5 Improve system capacity for employee skills development and competency.</p> <p>6.6 Develop and refine system capacity to assess and monitor cost-effectiveness.</p>		<p>8.3 Improve mental and physical care coordination for people with multiple inpatient admissions and with little connection to appropriate outpatient services.</p>
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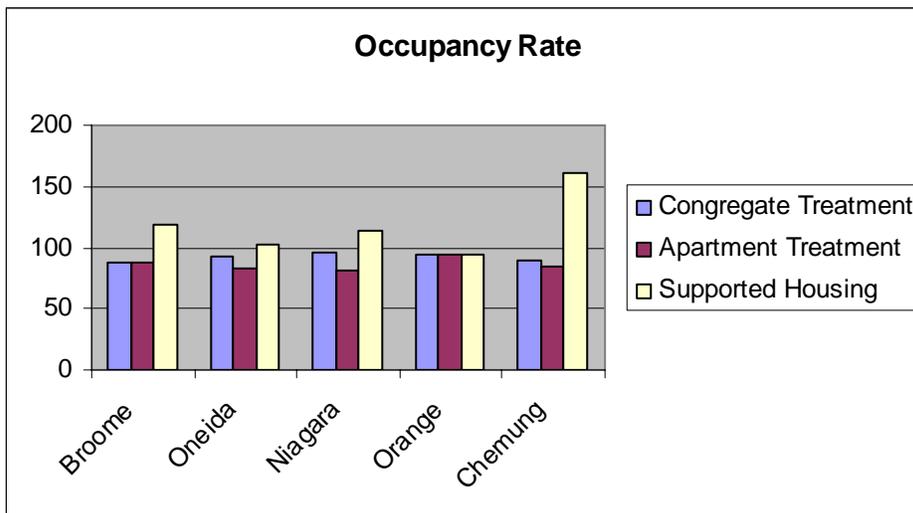
Appendix B – Broome County Residential Summary Report

**Broome County Residential Summary
October 1, 2004 – September 30, 2005**

Number of Beds, 10/1/2004-9/30/2005					
Program Type	Broome	Oneida	Niagara	Orange	Chemung
Congregate Treatment	40	86	22	94	14
Apartment Treatment	42	41	62	52	36
Supported Housing	108	107	91	116	81

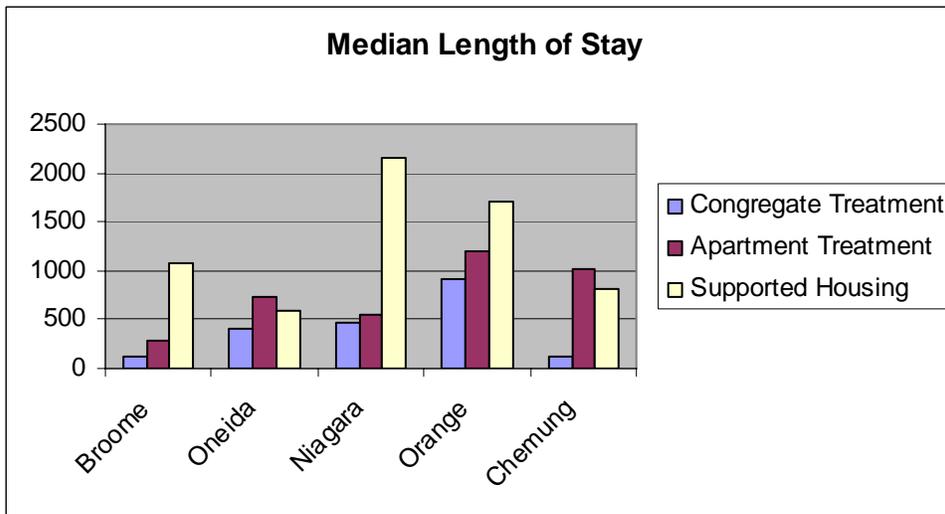
The number of beds for the Apartment level in Broome County decreased from 48 to 42. Also, the number of beds for Supported Housing in Niagara County increased from 75 to 91.

Occupancy Rate, 10/1/2004-9/30/2005					
Program Type	Broome	Oneida	Niagara	Orange	Chemung
Congregate Treatment	87.7	93	96.5	95.1	90
Apartment Treatment	88.5	83.7	82	94.6	84.4
Supported Housing	118.9	102.7	114.1	93.6	161.6



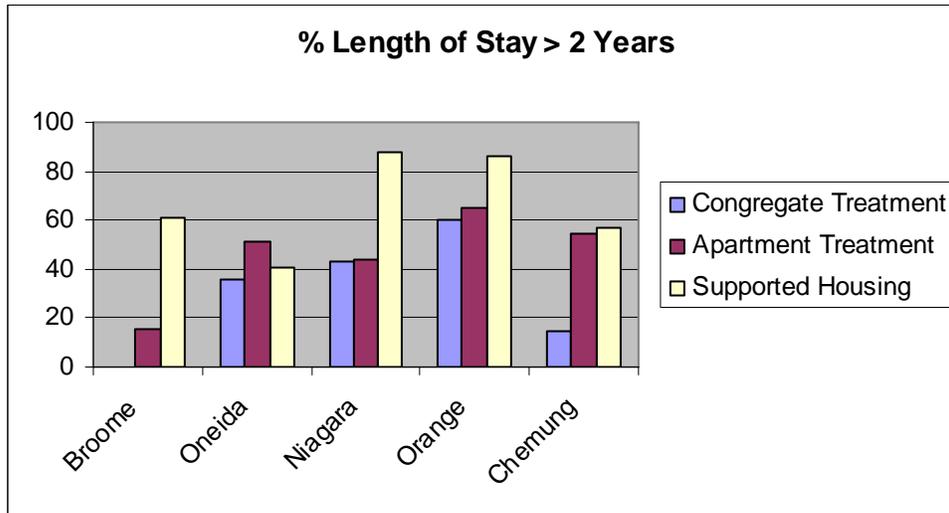
The Occupancy Rate for Broome County is slightly below average for Congregate Treatment and slightly above average for Apartment Treatment and Supported Housing. *(It is important to note that there are a limited number of beds involved in this comparison. Also, the number of beds were reduced for Apartment Treatment from 48 to 42 in Broome County.)*

Median Length of Stay, 10/1/2004-9/30/2005					
Program Type	Broome	Oneida	Niagara	Orange	Chemung
Congregate Treatment	120	408	467	922	131
Apartment Treatment	289	731	549	1200	1017
Supported Housing	1085	593	2161	1703	811



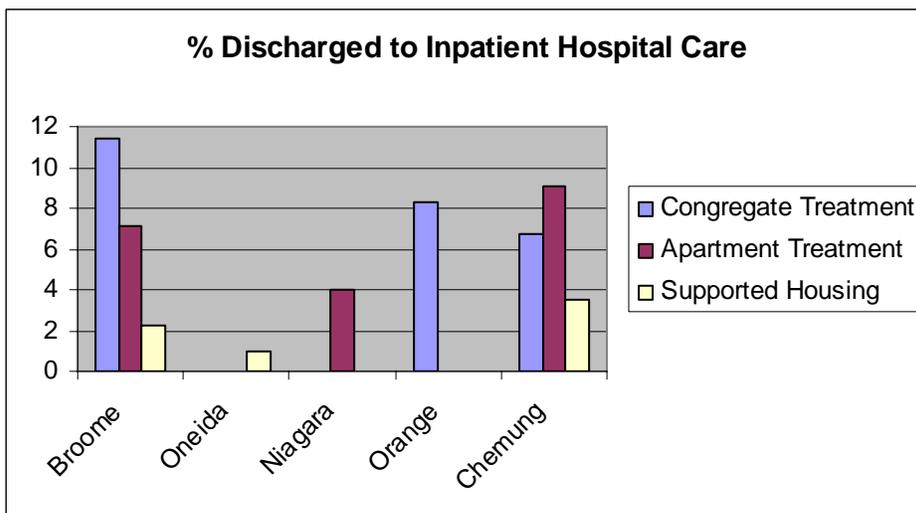
Broome County is below average for all levels of residential care. Broome is also the lowest for Congregate Treatment and Apartment Treatment, and third lowest for Supported Housing. Supported Housing is designed to be a longer term treatment level, and therefore will have a longer median length of stay.

Percent Length of Stay Greater than 2 Years, 10/1/2004-9/30/2005					
Program Type	Broome	Oneida	Niagara	Orange	Chemung
Congregate Treatment	0	35.8	42.9	60.2	14.3
Apartment Treatment	15.8	51.5	44.2	65.3	54.8
Supported Housing	60.6	40.7	88.1	86.2	57



Broome is the lowest for the Congregate level and the Apartment level. Broome is below average for the Supported Housing level. Supported Housing is designed to be a longer term treatment level and often exceeds two years.

Percent Discharged to Inpatient Hospital Care, 10/1/2004-9/30/2005					
Program Type	Broome	Oneida	Niagara	Orange	Chemung
Congregate Treatment	11.4	0	0	8.3	6.7
Apartment Treatment	7.1	0	4	0	9.1
Supported Housing	2.2	1	0	0	3.5



The “% Discharged to Inpatient Hospital Care” is often used to illustrate the ability of residential services to maintain clients in the community. Broome had the highest

percentage discharged to inpatient hospital care at the Congregate level. Broome was also above average for the percent discharged to inpatient hospital care at the Apartment level and at the Supported Housing level.

Admission and Discharge Data

Number of Admissions, 10/1/2004-9/30/2005					
Program Type	Broome	Oneida	Niagara	Orange	Chemung
Congregate Treatment	67	53	14	26	17
Apartment Treatment	33	5	28	13	11
Supported Housing	50	197	9	8	61

Number of Discharges, 10/1/2004-12/30/2005					
Program Type	Broome	Oneida	Niagara	Orange	Chemung
Congregate Treatment	70	54	13	24	15
Apartment Treatment	28	9	25	13	11
Supported Housing	45	201	12	11	57

Appendix C – 2006 Broome County Peer Survey Summary Report

2006 Peer Survey Summary of Results

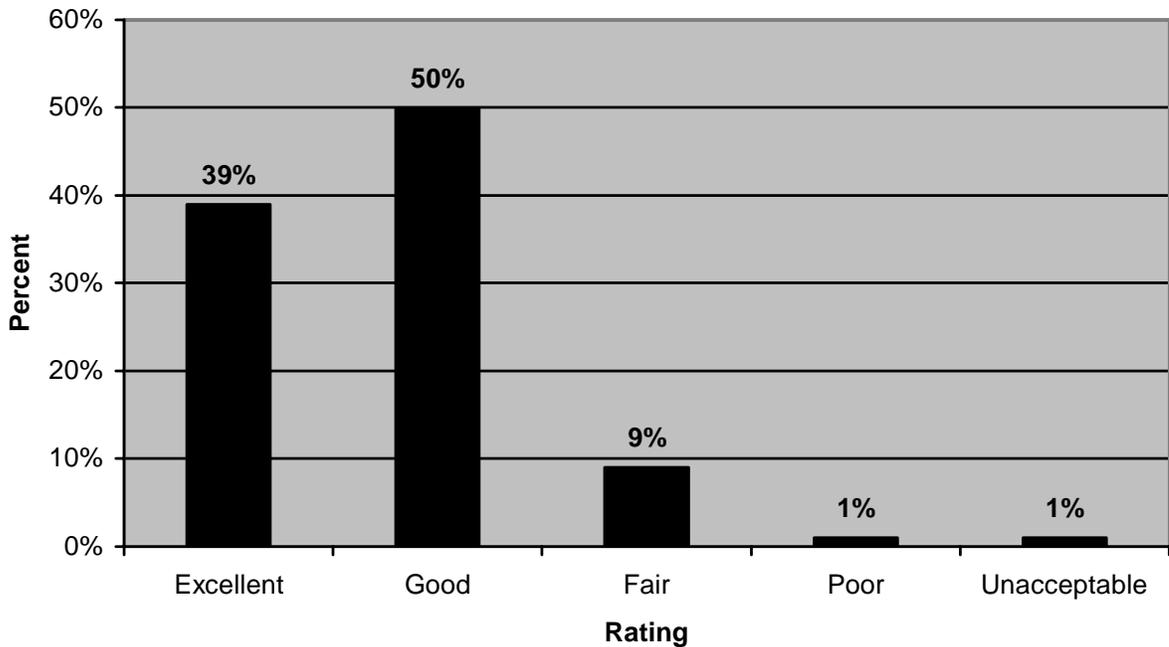
From March 8 to March 16, 2006, the Coordinated Care Services Inc. (CCSI) Performance Management Staff for Broome County Mental Health conducted a series of “peer surveys”. The purpose of the survey was to determine consumer satisfaction with the programs and providers in the area regarding their mental health service experience.

A total of 89 individuals, at four different locations, took part in the survey. The majority of individuals participating in the survey indicated they were satisfied with the mental health services in this area.

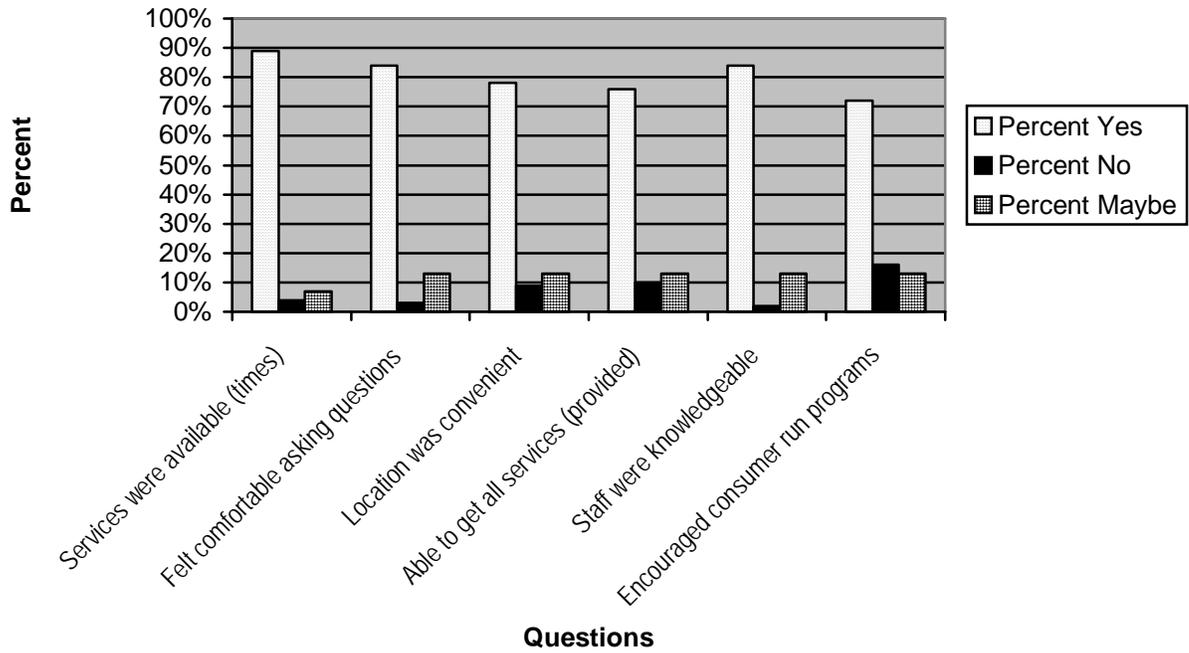
The results of the report, including additional comments and suggestions, were provided to the Broome County Commissioner of Mental Health. The table and chart below provide a summary of the survey responses.

Location	Date	Time	Responses
Broome County Mental Health Clinic Groups	3/8, 3/13 & 3/16	3-4pm, 12-1pm	12
Catholic Charities – Four Seasons Club	Monday, March 13	9:30-10:30 am	53
MHA - Beacon Drop-In Center	Friday, March 10	4:30-5:30pm	12
GBHC – Community Treatment and Rehabilitation Center	Thursday, March 9	10am-11am	12
		Total	89

OVERALL MENTAL HEALTH SERVICE RATING



MENTAL HEALTH SERVICE DELIVERY



RESULTS OF DIRECT SERVICES

