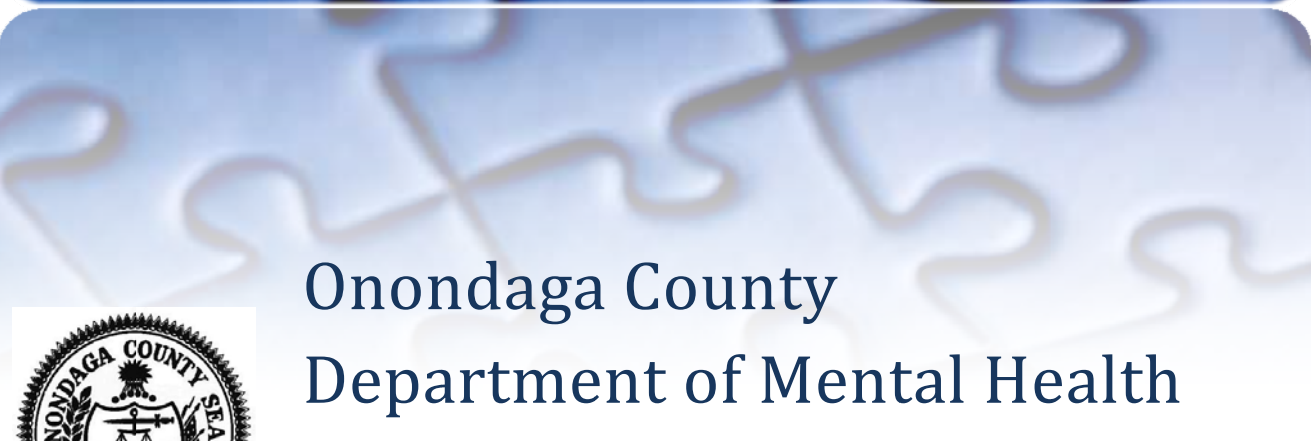
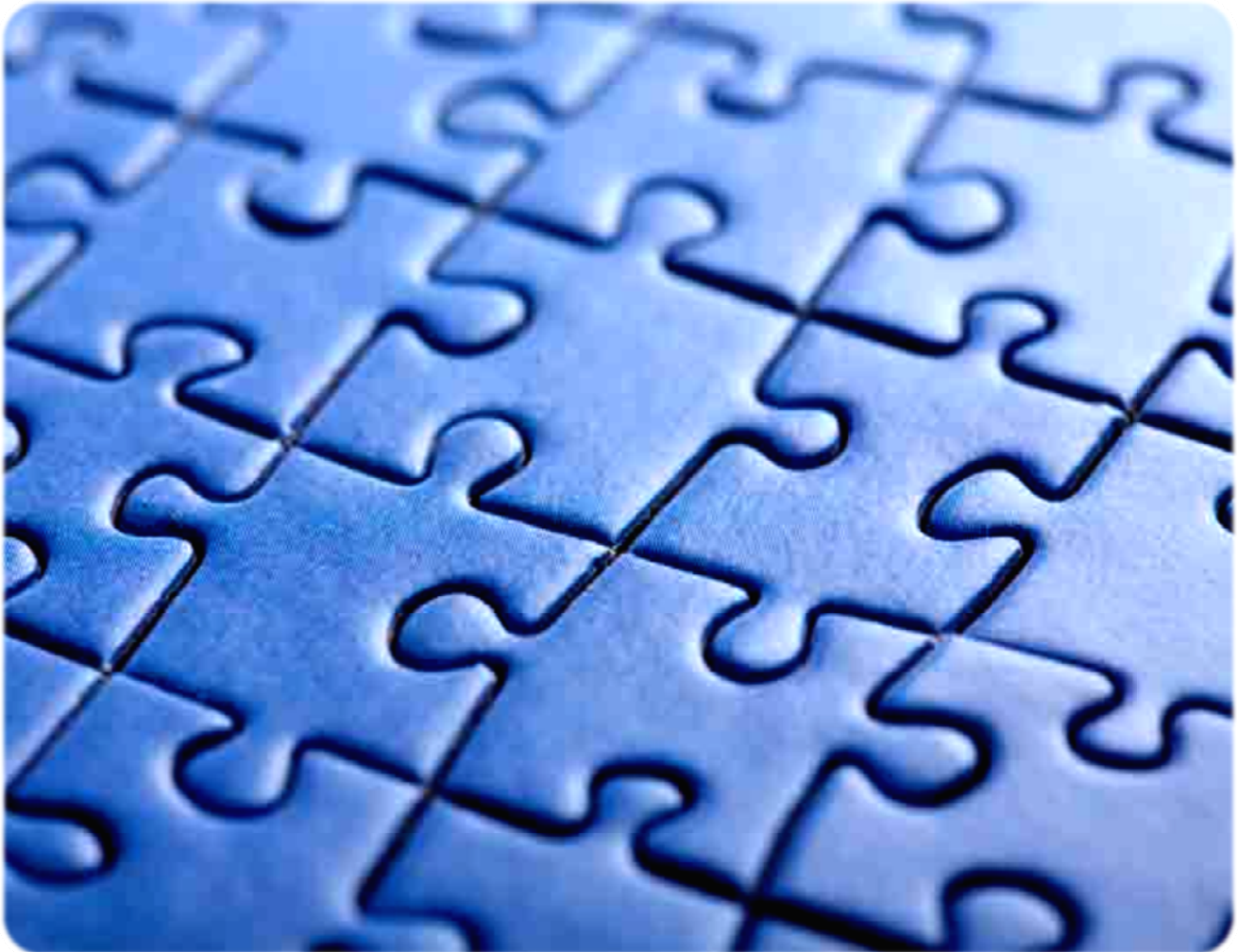


2011 ANNUAL REPORT



Onondaga County Department of Mental Health

Joanne M. Mahoney, County Executive
Robert C. Long, MPA, Commissioner

ONONDAGA COUNTY
DEPARTMENT OF MENTAL HEALTH
2011 ANNUAL REPORT

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1 Introduction

1.1 Legal Responsibility

Article 41 of the NYS Mental Hygiene Law provides that county mental health departments shall “seek to insure... all population groups are adequately covered, sufficient services are available for all the mentally disabled within its purview, (and) that there is coordination and cooperation among local providers of services...”

The Department’s primary role is facilitating and overseeing the provision of services, with a smaller role in providing services directly where the services are ‘public goods’, in that there is a need in our community that private provider’s are unable or unwilling to fulfill. In our primary role, we:

- establish the behavioral health mission to be accomplished in Onondaga County;
- set public policy to support that mission;
- establish performance standards and outcome measures;
- devise funding resources and mechanisms to support the mission; and
- evaluate performance.

This puts the Department in a leadership position that promotes and guides innovation and flexibility, and at the same time focuses on efficiency and effectiveness.

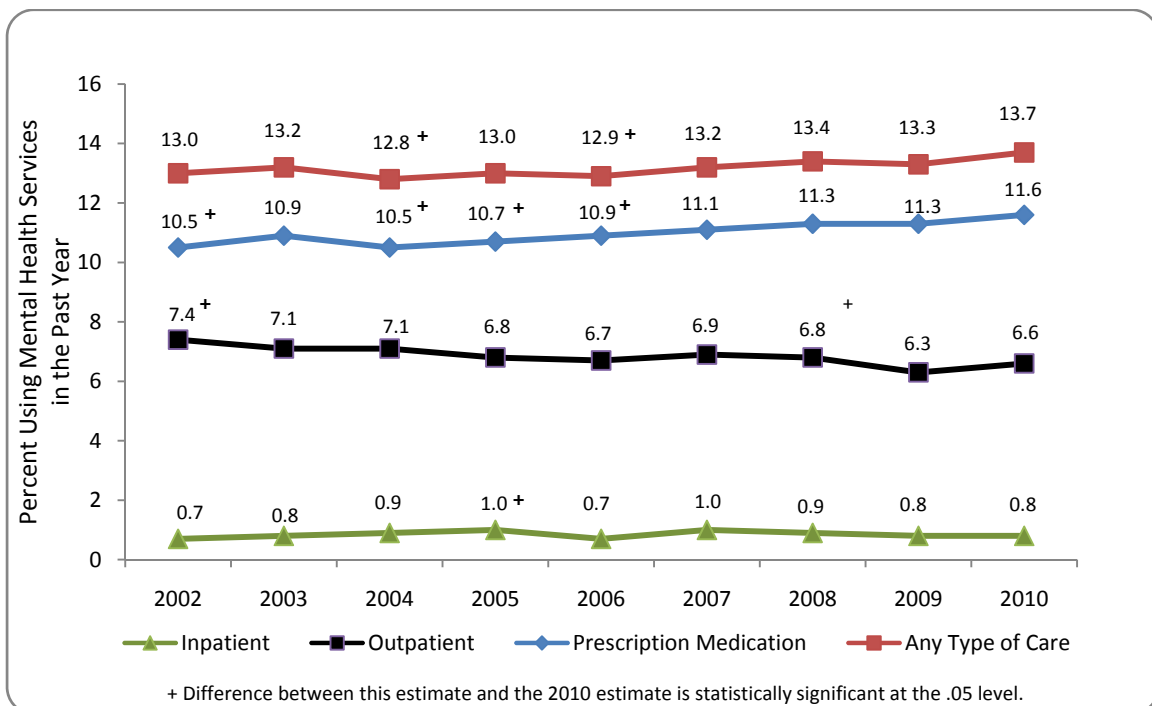


Figure 1-1 Past year Mental Health Service Use among Adults Aged 18 or older; by Type of Care¹

1.2 Mission Statement

Mental health means living a meaningful and productive life – having a life worth living – as defined by a person’s interests, goals, hopes, and dreams. The Department advances the mental health of County residents by monitoring and continuously improving the system of behavioral healthcare services in Onondaga County, and by collaborating with others to help reduce or ameliorate factors that contribute to behavioral health disorders (e.g. trauma, stress, and poor physical health).

These prevention, treatment, and rehabilitation services lessen the personal and community impact of mental illness, chemical dependency, and developmental disorders on children, adolescents, and adults by promoting recovery from serious illness.

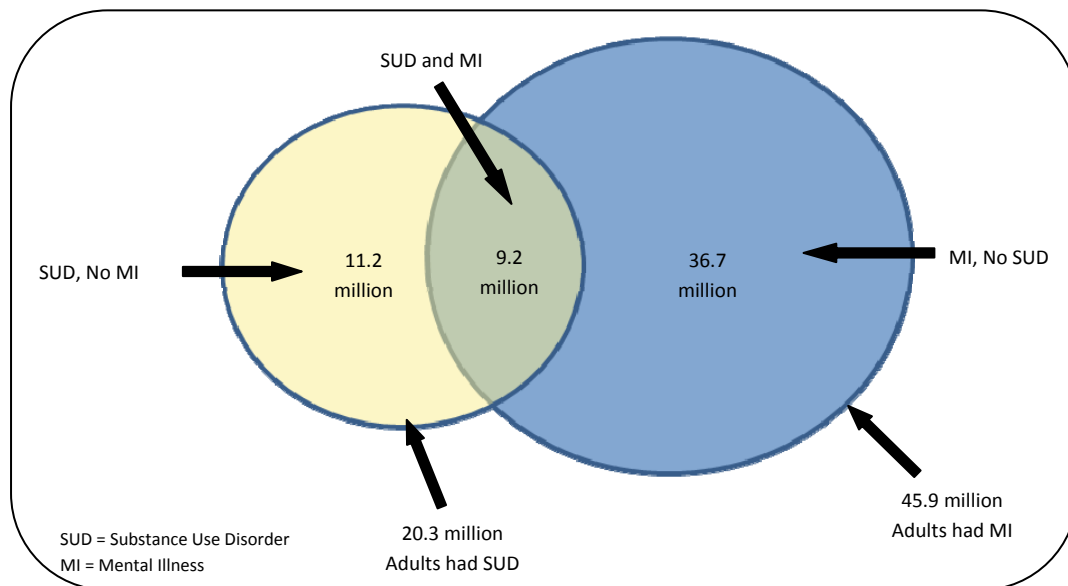


Figure 1-2 Past Year Substance Dependence or Abuse and Mental Illness among Adults Aged 18 or Olderⁱⁱ

Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potentialⁱⁱⁱ.

The following are the Principles of Recovery:

- person-driven;
- occurs via many pathways;
- is holistic;
- is supported by peers;
- is supported through relationships;

- is culturally-based and influenced;
- is supported by addressing trauma;
- involves individual, family, and community strengths and responsibility;
- is based on respect; and
- emerges from hope.

In fulfilling its mission, the Department:

- Initiates and supports coordination, cooperation and collaboration between service recipients, families, service providers, City, County, State, and Federal authorities.
- Sponsors and promotes education and training to advance the use of state of the art, evidence based practices.
- Assesses and plans for the behavioral healthcare needs of County residents.
- Develops appropriate service capacity and access to services through selected funding of behavioral healthcare services and oversees program performance and outcomes.
- Promotes public understanding of behavioral health disabilities to reduce stigma.
- Promotes meaningful and productive community involvement for those with these disabilities.

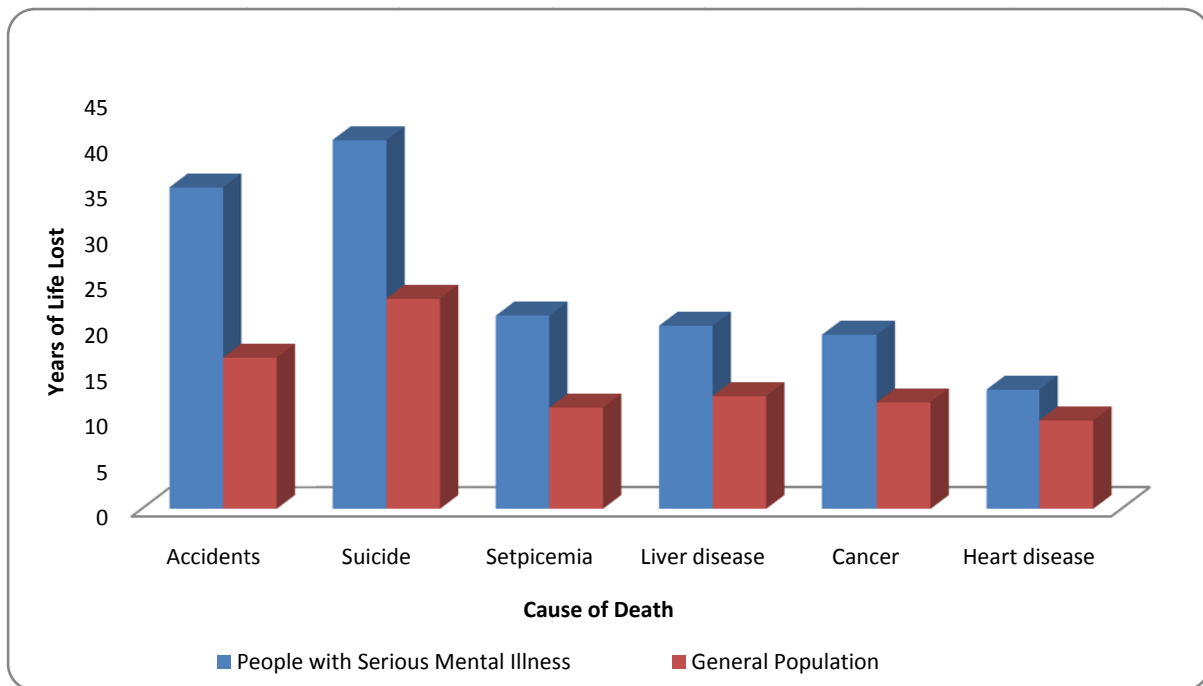


Figure 1-3 Years of Potential Life Lost & Cause of Death^{iv}

1.3 Department of Mental Health Organizational Structure

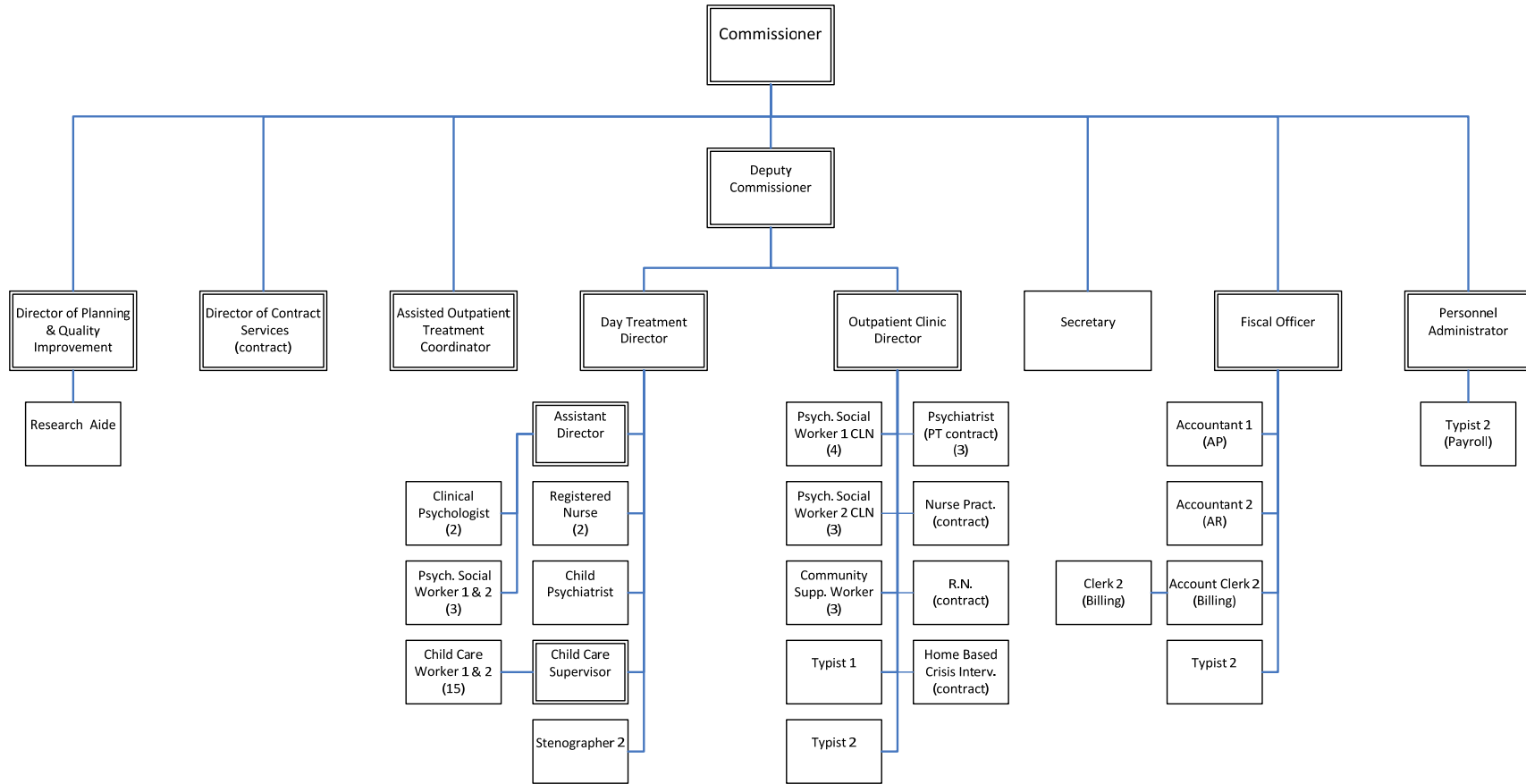


Figure 1-4 Department of Mental Health Organizational Structure

1.4 Department of Mental Health Functional Structure

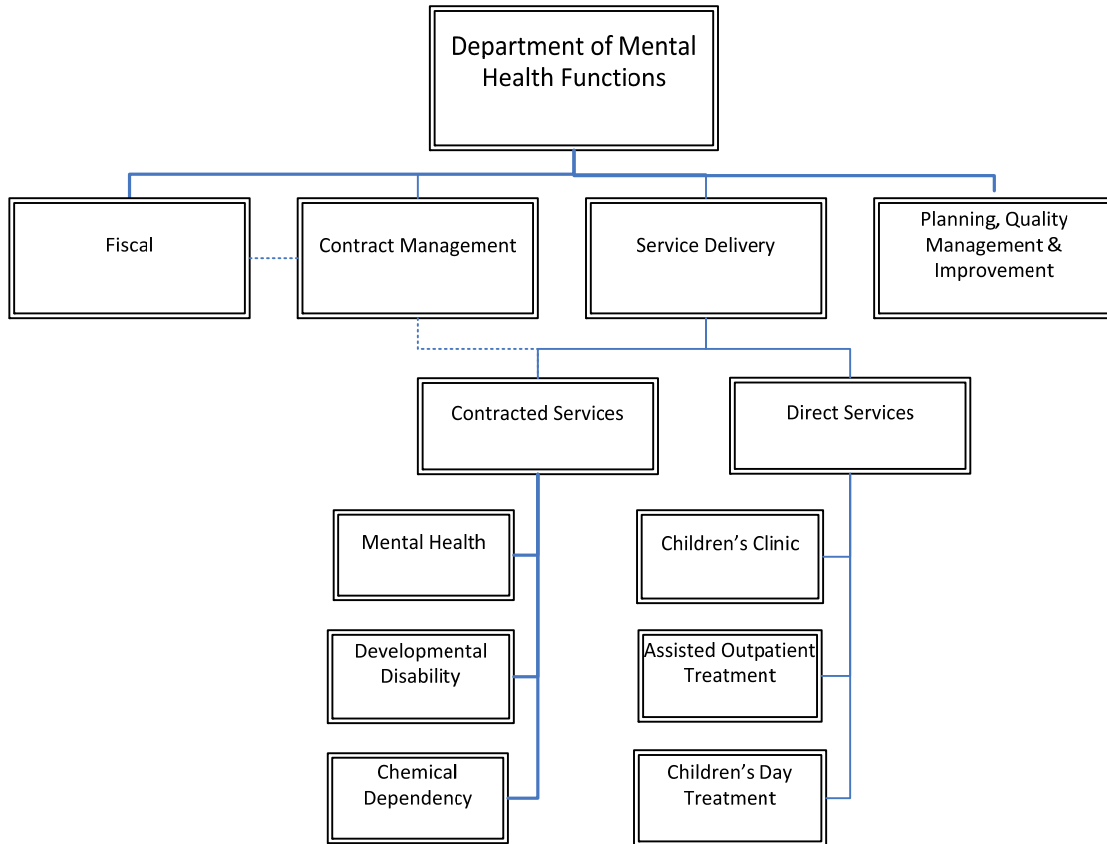


Figure 1-5 Department of Mental Health Functional Structure

2 Service Delivery

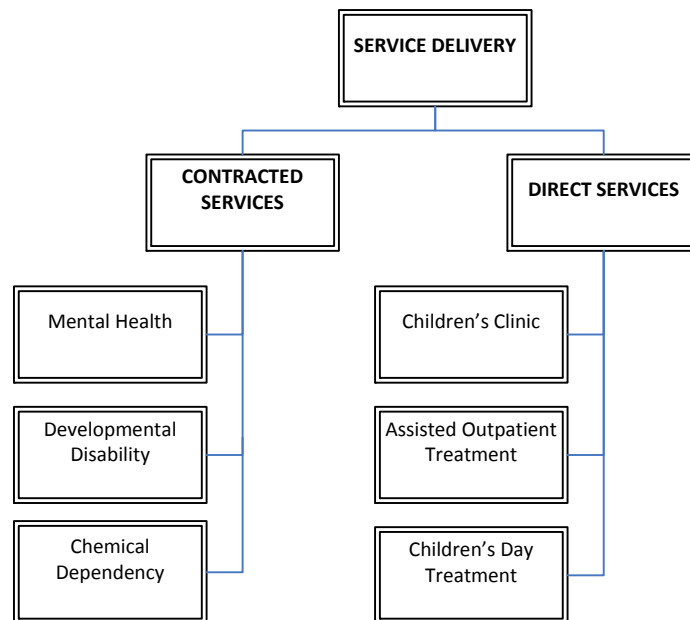


Figure 2-1 Department of Mental Health Service Delivery Structure

2.1 Contracted Services

Contracted services are funded and supervised by the Onondaga County Department of Mental Health. In 2011, the Department contracted with 25 providers, as listed in Table 2-1.

Table 2-1 Contracted Services Provider Summary

Agency (Provider)	Services		
	Mental Health	Developmental Disability	Chemical Dependency
820 River Street			X
ARC of Onondaga		X	
ARISE Child & Family Services	X		
Catholic Charities	X		
Central New York Services, Inc.	X		
CONTACT Community Services, Inc.	X		X
Coordinated Care Services, Inc.	X		
Crouse Health Hospital, Inc.			X
ENABLE		X	
Exceptional Family Resources		X	
Hillside Children's Center	X		
Liberty Resources	X		
NAMI-Promise	X		
OCAA Prevention Network			X
OCM BOCES			X
Onondaga Case Management	X		X
Rescue Mission	X		
Salvation Army	X		
Southwest Community Center			X
St. Joseph's Hospital	X		
SUNY Health Science Center	X		
Syracuse Community Health Center			X
Syracuse Behavioral Healthcare, Inc.			X
Transitional Living Services	X	X	
YWCA	X		

Contract Management

Contract Management includes fiscal and programmatic oversight of 98 programs provided by 25 not-for-profit agencies. These programs include a wide range of services for individuals with a mental illness, chemical dependency, and/or developmental disability.

Fiscal monitoring of programs is accomplished utilizing both web-based fiscal systems and numerous formulated spreadsheets that align and clarify federal, state, and county funding allocations.

Programmatic oversight includes program reviews, technical assistance, and data analysis. The ultimate goal is to ensure that the highest quality of service possible is being provided to the citizens of Onondaga County.

Service Summary

Continuing development of on-line data collection has greatly improved the accuracy and timeliness of data.

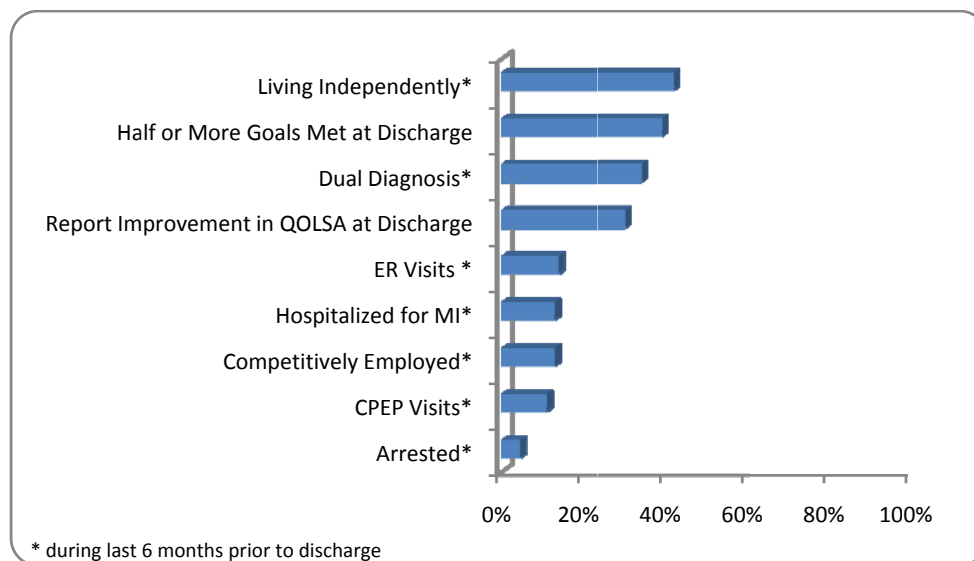


Figure 2-2 Contracted Services: People Served in 2011

Accomplishments

At the close of 2011, 37 programs reported into the Performance and Contract Management System (PCMS).

2012 Goals

Implementation will continue on the usage of PCMS. It is anticipated that by year end, 100% of all contracted programs will be reporting using this system.

By midyear, contract agencies will be able to use the system to generate their own ad-hoc reports based upon data submitted. Development will continue on community standards to rate agency performance.

2.1.1 Mental Health Services

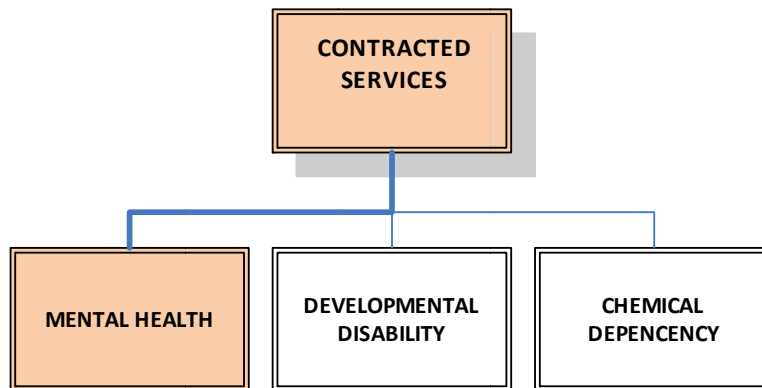


Figure 2-3 Contracted Services: Mental Health

One in 5 Americans has a mental illness including 90,000 people in Onondaga County. Mental illness is the leading illness-related cause of disability, a major cause of suicide, and contributes to school failure, poor overall health, incarceration, and homelessness, as illustrated in Figure 2-4.^v

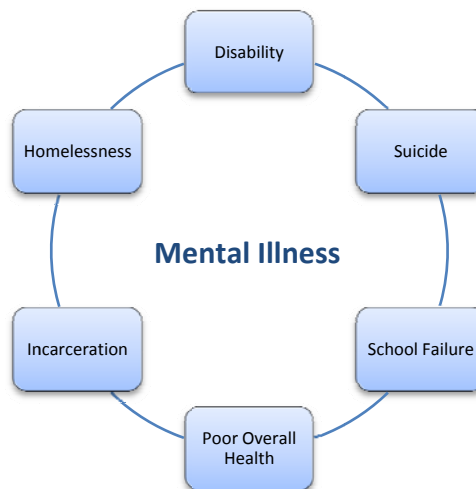


Figure 2-4 Leading Issues Caused by Mental Illness

Mental illnesses are medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others, and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life.

Mental illnesses can affect persons of any age, race, religion, or income. Mental illnesses are not the result of personal weakness, lack of character, or poor upbringing. Mental illnesses are treatable. Most people diagnosed with a serious mental illness can experience relief from their symptoms by actively participating in an individual treatment plan.^{vi}

Table 2-2 below summarizes Mental Health services contracted by the Department of Mental Health. Many of these agencies provide other services as well.

Table 2-2 Mental Health Services Overview

Agency	Service Description
ARISE Child & Family Services	Provides a school-based mental health team and services under the Clinic-Plus initiative.
Catholic Charities	Provides Therapeutic Nursery Services.
Central New York Services, Inc.	Provides Housing, Continuing Day Treatment, and Vocational Services.
CONTACT Community Services, Inc.	Provides Crisis Services for Adults and Children, Community and School based Prevention services for adults and children, Information, Referral, and Advocacy Services, a Family Run Support Group, and Community companion services.
Coordinated Care Services, Inc.	Provides consultation in the implementation of best practices and coordination of care for residents with a high need for mental health services.
Hillside Children’s Center	Provides Customized Services to assist agencies in serving high needs mental health clients.
Liberty Resources	Provides mental health services on an outpatient basis.
NAMI - Promise	Provides Information, Referral, Advocacy, and Self-Help Services.
Onondaga Case Management	Provides Case Management, Advocacy Services for youth and their families, a Children & Youth Coordinator, Vocational Coordinator, Housing Coordinator, Youth Emergency Services, Children’s Mobil Crisis Team, Assertive Community Treatment Team, Peer Mentoring Services, and the Coordinated Children’s Service Initiative.
Rescue Mission	Provides Drop in Center and Outreach Services for individuals with a mental illness.
Salvation Army	Provides Housing, Outreach, and Advocacy Services.
St. Joseph’s Hospital	Provides Employment/Vocational services.
SUNY Health Science Center	Provides a Child Psychiatry Community Consultation Program and a Child and Families Program Specialist.
Transitional Living Services	Provides Employment, Self-help, Transportation, Housing, Drop-in, Advocacy, Screening, and Supported Education services.
YWCA	Provides Case Management services for Women with a mental illness.

2.1.2 Developmental Disability Services

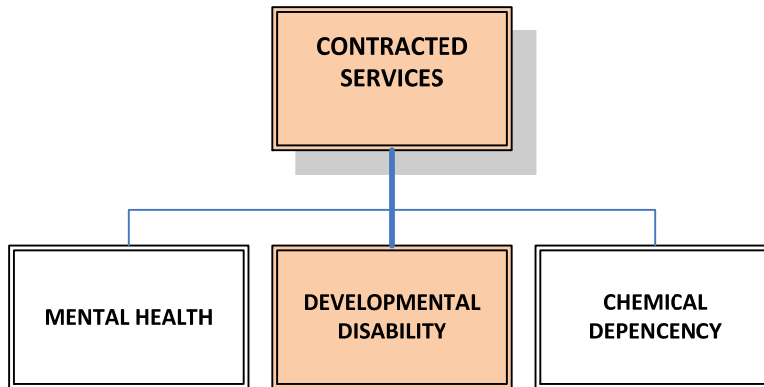


Figure 2-5 Contracted Services: Developmental Disability

Approximately 200,000 people in New York are thought to have a developmental disability, including over 5,000 people in Onondaga County.

People with a developmental disability show delays in learning, a slower pace of learning, and difficulty in applying learning. Developmental disabilities can result from a variety of factors, among them premature birth, genetic abnormalities, malnutrition, exposure to toxic agents, and social deprivation.

Developmental disabilities are a variety of conditions that become apparent during childhood and cause mental or physical limitation. These conditions include autism, cerebral palsy, epilepsy, mental retardation, and other neurological impairments. Developmental disabilities have a variety of causes, which can occur before, during or after birth.^{vii}

Table 2-3 below summarizes Developmental Disability services contracted by the Department of Mental Health. Many of those agencies provide other services as well.

Table 2-3 Developmental Disability Services Overview

Agency	Service Description
ARC of Onondaga	Provides Sheltered Work, Supported Employment, and community-based employment services.
ENABLE	Provides diagnostic, clinical, and assistive technology services.
Exceptional Family Resources	Provides Information, Referral, and Respite services to families and individuals.
Transitional Living Services	Provides service coordination, Habilitation, Vocational, and Housing services to families and individuals.

2.1.3 Chemical Dependency Services

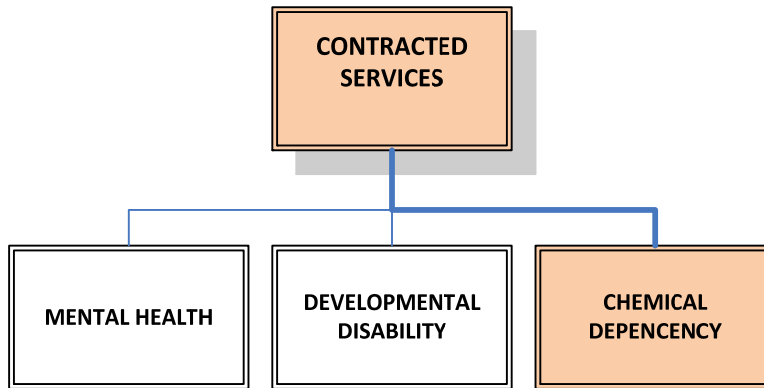


Figure 2-6 Contracted Services: Chemical Dependency

2.5 million New Yorkers – one out of every seven – are dealing with an alcohol, drug or gambling problem, including over 60,000 people in Onondaga County.

The term Chemical Dependency refers to a primary illness or disease which is characterized by addiction to a mood-altering chemical. Chemical dependency includes both drug addiction and alcoholism. A chemically dependent person is unable to stop drinking or taking a particular mood-altering chemical despite serious health, economic, vocational, legal, spiritual, and social consequences. It is a disease that does not see age, sex, race, religion, or economic status. It is progressive and chronic and if left untreated can be fatal.^{viii}

Table 2-4 below summarizes Chemical Dependency services contracted by the Department of Mental Health. Many of those agencies provide other services as well.

Table 2-4 Chemical Dependency Services Overview

Agency	Service Description
820 River Street	Provides intensive residential services.
CONTACT Community Services, Inc.	Provides Prevention Partners for Youth Development, Student Assistance Program and other Prevention services.
Crouse Health Hospital, Inc.	Provides Detoxification, Inpatient, Outpatient, and a variety of Vocational services.
OCAA Prevention Network	Provides Prevention, Education, and Referral services to individuals and agencies.
OCM BOCES	Provides prevention, education, referral, and counseling services to students in 17 school districts in Onondaga County.
Onondaga Case Management	Provides a Dual Recovery Coordinator position.
Southwest Community Center	Provides Prevention and Educational services.
Syracuse Behavioral Healthcare, Inc.	Provides Crisis, Inpatient, Outpatient, and Case Management services.

2.2 Direct Services

Direct services are services that are provided directly by Onondaga County Department of Mental Health to consumers.

2.2.1 Children's Clinic

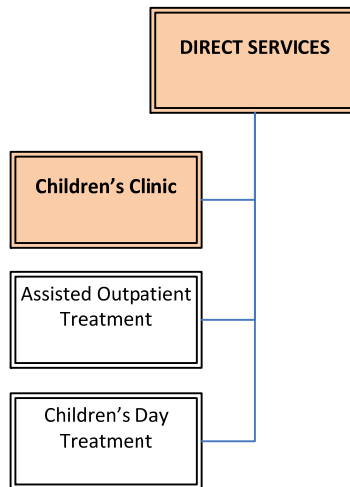


Figure 2-7 Direct Services: Children's Clinic

Program Overview

The Onondaga County Outpatient Mental Health Clinic exists to provide family-friendly, clinically effective outpatient mental health services to children and youth who face significant mental health challenges, often complicated by multiple environmental, generational and interpersonal stressors. Services are available to any child or youth under age 18 residing in Onondaga County who meet the criteria for one or more DSM IV mental health diagnoses.

As part of our mission, the clinic functions as a “safety net” for the community. For example: we are the only clinic that accepts United Behavioral Health (UBH) insurance, including Child Health Plus, we also receive the majority of our referrals from other community providers in a large part due to the fact that we admit clients regardless of ability to pay. Providing needed outpatient clinical services for the uninsured and underinsured in our community reduces costly hospital and emergency room visits for those that are not able to access other outpatient services.

The clinic also serves very complex individuals that often have multiple diagnosis, multiple medications, and family or relationship challenges. Community providers often struggle meeting the needs of these individuals and find it necessary to discharge them after missing several appointments. We do not discharge anyone after an arbitrary number of missed or cancelled appointments.

The Children’s Clinic is also the only community clinic that routinely accepts referrals for children under the age of five. This can be intensive and time consuming since much of the work involves educating the parent or guardian on how best to parent a very young child with mental illness. A major benefit to the community is that by starting treatment at a very young age there is often an increase in the chance of long term recovery as the child ages.

The Director and clinic staff participated in the work of the **Project Concern Team**, a group composed of fire, police, child welfare, educational and legal representatives, who seek to understand, track and prevent fire setting behavior in our community. The Director worked with the team to develop community educational materials and primary prevention strategies.

In addition, clinic staff provided:

- assessments for children and youth who had been involved in fire setting activities;
- interventions specifically designed to reduce the risk of further fire-setting activity; and
- expedited referrals for further treatment as needed.

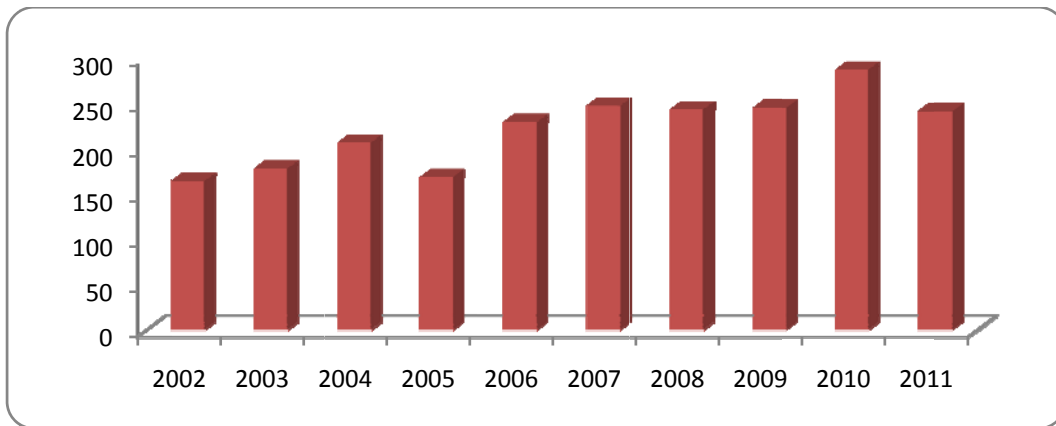


Figure 2-8 Children's Clinic: Referrals by Year 2002 - 2011

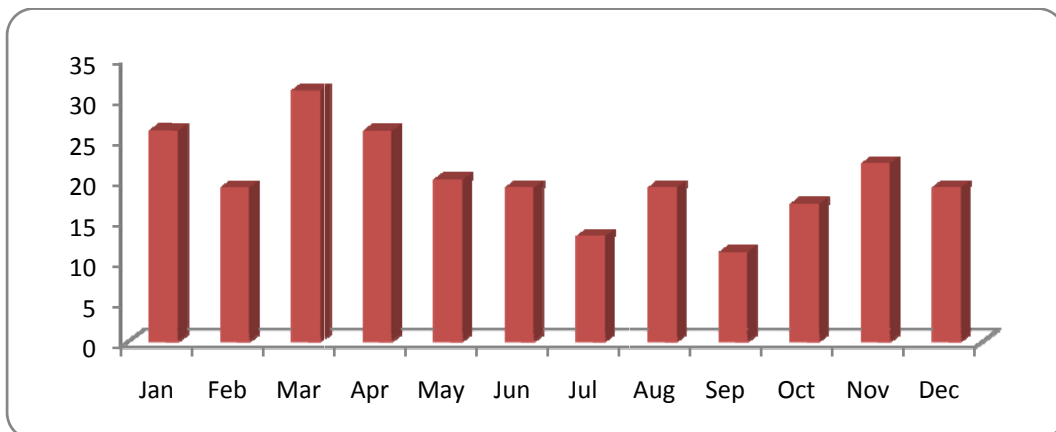


Figure 2-9 Children's Clinic: 2011 Referrals by Month

2.2.1.1 Family Support Services

Family Support Services (FSS) are designed to assist families in defining and accessing resources that will allow their children to become competent, fulfilled adults.

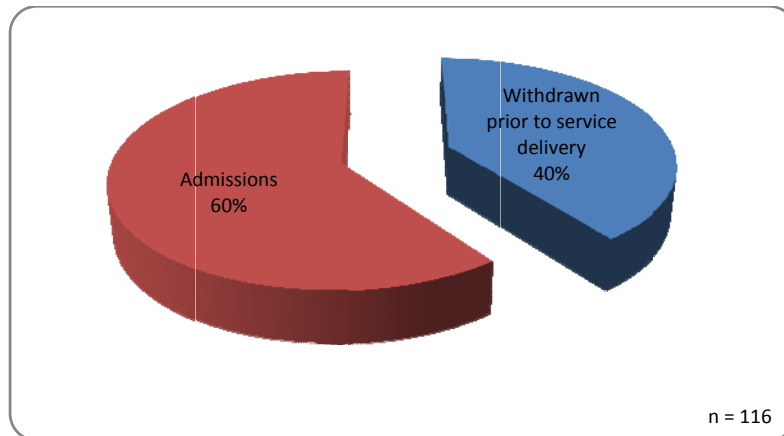


Figure 2-10 2011 Referrals: Family Support Services

FSS services are grounded in two fundamental beliefs:

1. Most parents (or other adults providing parenting to children and youth whose biological parents are unavailable) are doing the best they can.
2. Most caregivers want to ensure that their children have everything they need to grow up to become confident, contributing members of their community.

Family Support Service providers are “peer parents” who have the personal and professional experience to work alongside caregivers to:

- Facilitate understanding of their children’s complex physical, social and emotional needs.
- Work with families to develop a plan that identifies services and supports that will allow parents to meet their children’s needs.
- Encourage adults who are often challenged by their own mental, physical and developmental concerns, to remain focused and motivated as they pursue the resources they have identified as important to their family’s well being.
- Assist caregivers in accessing natural, community supports that will allow them to nurture their children in their own homes with minimal “professional intervention”.
- When professional interventions are required, assist caregivers in negotiating the complex system of care that exists to provided the services their children need.

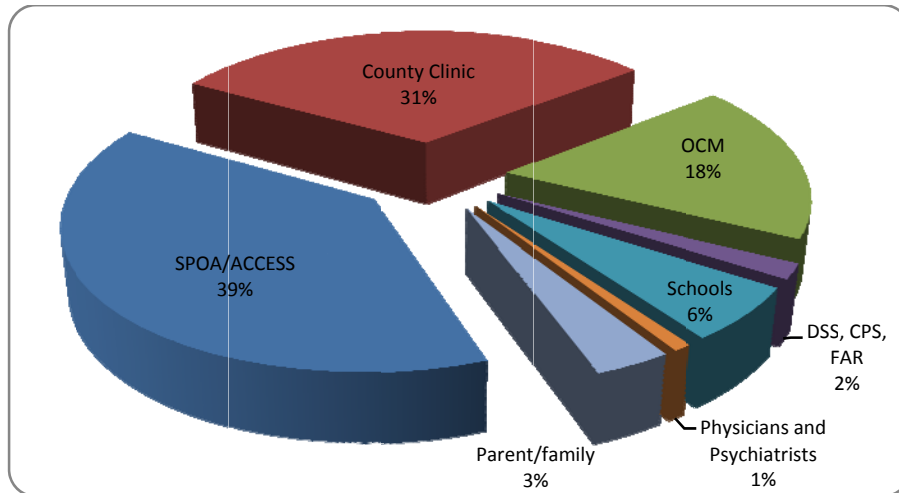


Figure 2-11 2011 Referral Source: Family Support Services

Table 2-5 2011 Family Support Service Requests

Service Type	Requests
Educational Advocacy	36
Parenting Skills	32
Household Organization	22
Access to Mental Health Services	22
Housing and Transportation	15
Access to OPWDD Services	14
Financial/SSI Needs	13
Court/DSS Related Concerns	10
Daycare/After School Programs	10
Linkage to Other Services	3
Other (translator, mentoring, etc.)	3
Total Requests	180

Service Summary

The Clinic Intake process is designed to be responsive to all callers who are requesting information or services for a child with emotional and/or behavioral issues. The process is intended to be flexible and family friendly; as well as reflecting a commitment to understanding the needs of each caller, many of whom have had difficulty accessing services or is unfamiliar with the service delivery system in this county.

The Intake worker responds to all requests for service on the same day that the call is received. Workers complete a referral for each child and/or also provide information about other appropriate community services and programs. When clinic services are needed, a risk assessment is done to identify any safety concerns, assess level of risk and prioritize intakes based on that level of risk.

The Clinic’s protocol of immediate risk assessment was implemented in April of 2011 and has allowed clinicians to respond quickly to high risk consumers. Over the course of the past year a significant wait list for “regular” referrals developed; due in part to these new modifications in clinic protocol. Based on information obtained through the Clinic’s risk assessment tool, requests are prioritized into one of three groups:

1. **Emergency referrals** - This category includes children and youth assessed as high risk without imminent danger. Callers describe children and youth who are actively considering harm to themselves or others and have a history of violence or self injury or a credible plan for future action. Children expressing fire setting intentions are also included in this high risk category. If adult caregivers are confident that their child/youth can be safely maintained at home until an intake appointment can be arranged, these families are offered an appointment within five days of risk assessment. Referrals from CPEP and inpatient units are also offered an intake appointment within five days of the call for services, even if the risk assessment indicates a moderate or low level of risk.
2. **Priority referrals** – This category includes children and youth assessed as moderate risk. In these cases, the adult caregivers indicate that although their child/youth has expressed some intent to harm themselves or others the caregiver is confident that the child/youth will not act on these thoughts in the near future. These cases are assigned as soon as possible with a goal of offering an intake appointment within 30 days.
3. **Regular referrals** - This category includes children and youth who present with significant mental health needs but whose adult caregiver does not indicate significant risk of harm to self or others. Very young children who express suicidal or homicidal ideation are often included in this category because they usually lack the means to carry out their plan and can be monitored effectively at home and in school or daycare settings to ensure safety.

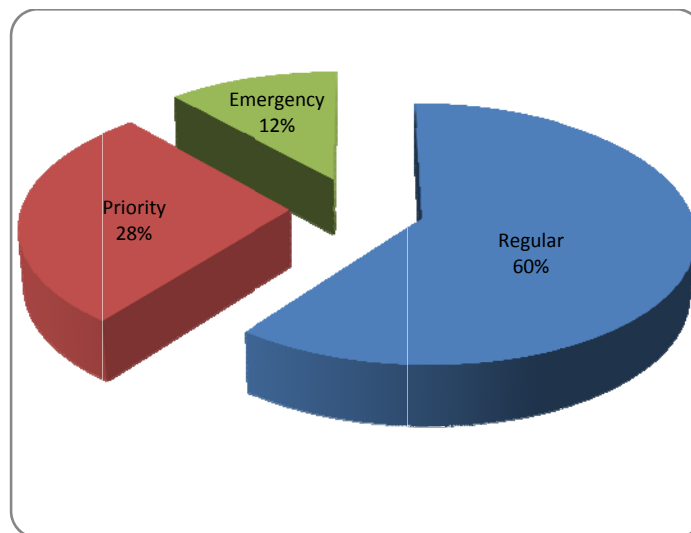


Figure 2-12 Children's Clinic: 2011 Referrals by Type

Of 283 requests received, 85% resulted in completed referrals for clinic treatment, 13% were withdrawn prior to completion of the referral process and 2% were immediately referred to emergency room services because of imminent danger.

In addition to responding to requests for service, the Intake worker also responded to sixty-nine general inquiry calls. Forty-four of these calls were made by adult caregivers seeking services that could not be provided by the County Clinic either because the need would best be met by another type of provider or because the recipient did not live in Onondaga County. In these cases, the Intake worker assessed the caller's needs and facilitated contact with appropriate agencies that could meet those needs. In addition, twenty-five calls were from professionals serving children and youth in variety of capacities. In these cases, the intake worker responded to requests for information about clinic services and/or the broader system of mental health care for children and youth.

The "typical" child referred was a seven year old boy who lived in a single parent household and was referred in the early spring by a service provider due to aggressive behaviors.

There was a significant increase in 2011 in the number of young children referred and a corresponding decrease in the number of older teens referred. Children age six and under accounted for 26% of referrals in 2011, an increase from 2010 when this age group accounted for 17% of total referrals. In 2011, the 16 to 18 year old age group represented only 8% of referrals, a decrease from 17% of referrals in 2010.

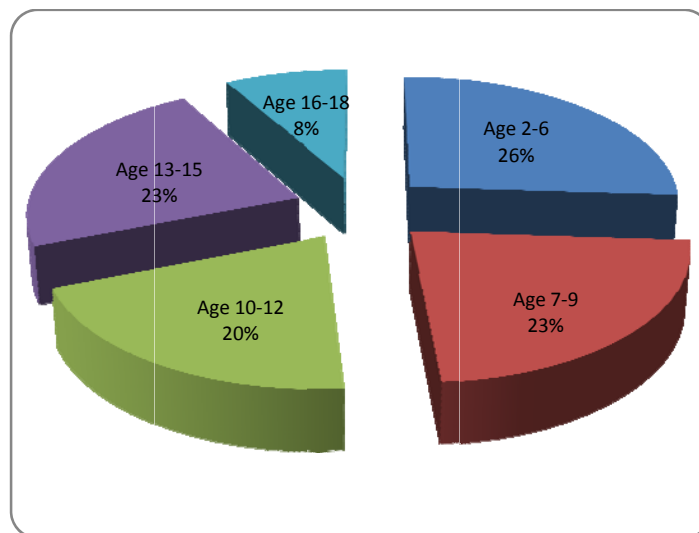


Figure 2-13 Children's Clinic: 2011 Referrals by Age

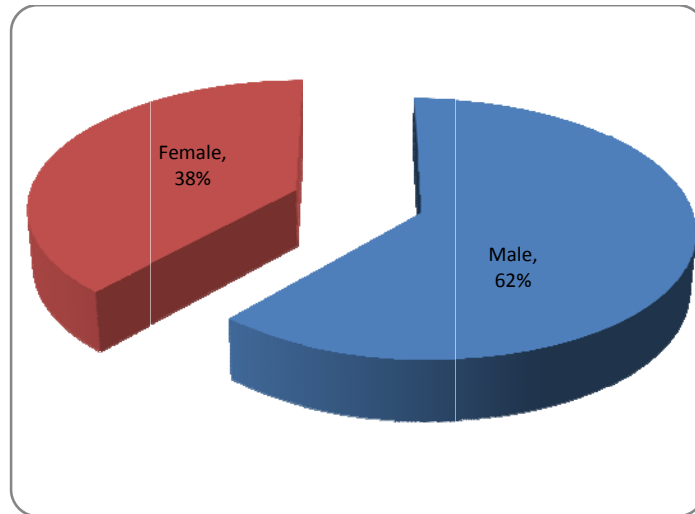


Figure 2-14 Children's Clinic: 2011 Referrals by Gender

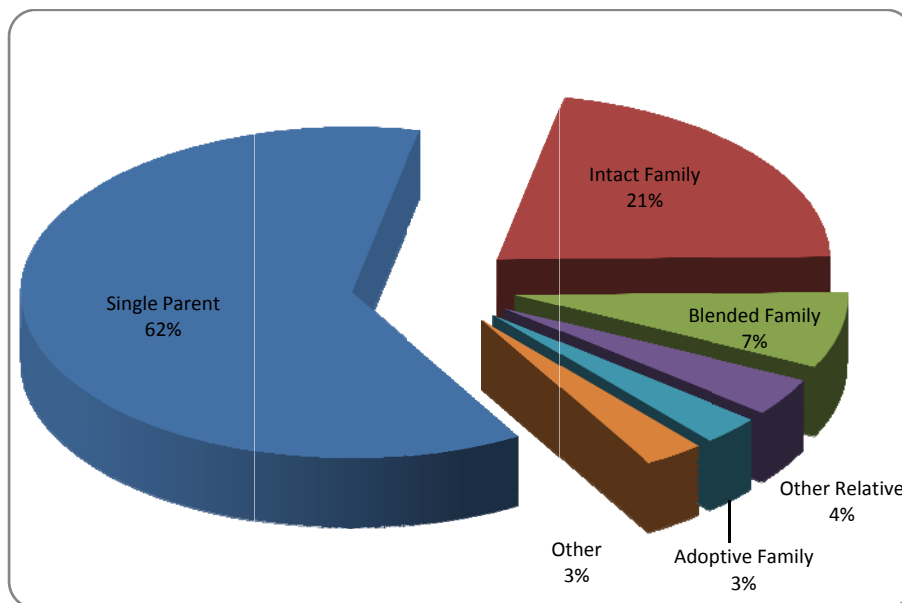


Figure 2-15 Children's Clinic: 2011 Referrals by Family Type

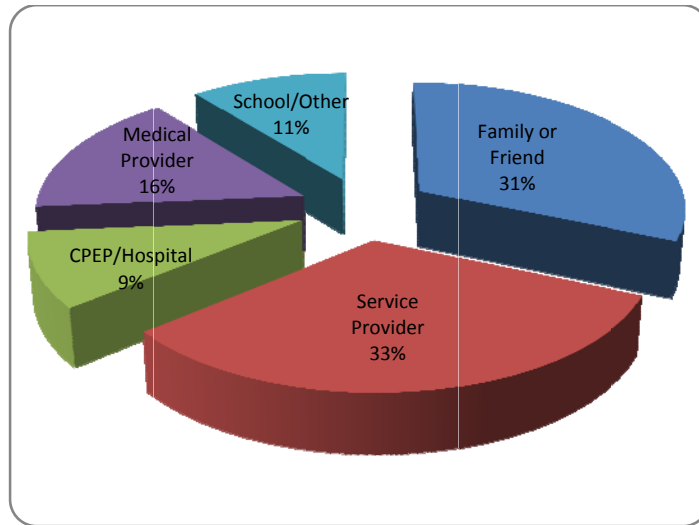


Figure 2-16 Children's Clinic: 2011 Referrals by Referral Sources

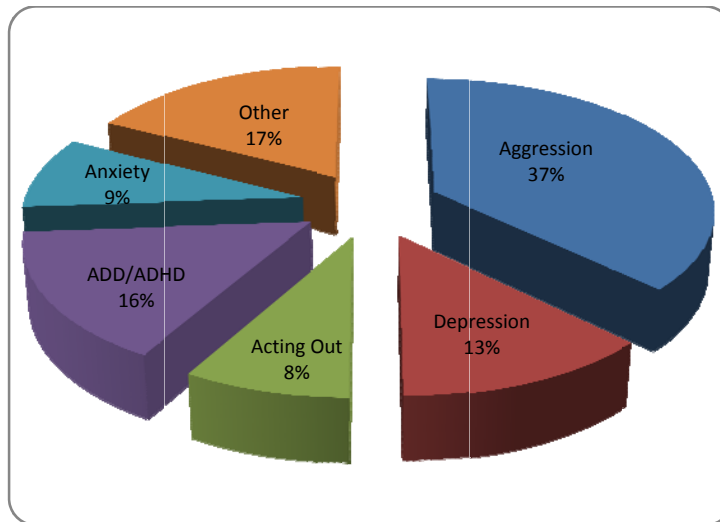


Figure 2-17 Children's Clinic: 2011 Referrals by Presenting Problem

One striking statistic that is not included above is the number of consumers who engaged in treatment after the initial intake appointment. Approximately 50% of consumers nationally, requesting outpatient mental health services attend only one or two sessions. In 2011, 80% of consumers presenting for treatment at the County Clinic continued treatment after their initial one or two sessions. This statistic underscores the value of having an experienced, empathic workforce that includes clinicians and support staff who warmly welcome families, quickly stabilize families in crisis and then move to change focused treatment that is relevant to the daily needs of recipients.

Changes and Challenges

In 2010, the Office of Mental Health published thirty-one new standards of care and revised their licensing renewal process to hold Clinics accountable to these new standards. The new standards required major changes in not only how therapy and medication services are to be delivered but also in how service delivery and the services themselves are conceptualized. Most of the staff has made the shift with courage and enthusiasm. We are now working on phase two of implementation, experimenting with how best to present these more complex service options to recipients and their caregivers so that they can make fully informed decisions about the design of their family's treatment plan.

In 2011, another area of focus has been gaining an understanding of the financial and operational changes that will be necessary to support the "big ideas" contained in the OMH restructuring plan. This has proven to be challenging on many levels. For example, APG billing was slated for gradual implementation using a complex formula to re-set old rates and phase in new ones. The County Clinic Director meets regularly with Directors of other clinics serving our community and despite a strong collaborative effort, Directors continue to express a high level of concern that the current lack of financial clarity and stability may lead to serious disruptions in the delivery of outpatient mental health services to children and youth in our community. The County Commissioner is aware of these concerns and is addressing them at the state level. As clarity emerges on a state and national level, the ability to strategize at a local level should improve.

In addition to changes in the rates of reimbursement, there have been sweeping changes in the payer mix as well. Prior to November 1, 2011 the majority of the Clinic's most acute recipients (those who met the criteria for a designation of 'seriously emotionally disturbed') were enrolled in Medicaid Fee For Service (FFS); a relatively simple and flexible insurance plan. Within a one month period, all of these recipients lost their Medicaid FFS coverage and were enrolled in one of four Medicaid Managed Care plans. Each company has a unique benefit plan, payment process and medication formulary. In some cases, the companies themselves had very little time to develop their new Medicaid plans resulting in a great deal of confusion at all levels in the process. To date, consumers, providers and even payers continue to seek clarity about exactly what each plan will pay for and how to access payments for all of the services included in the OMH restructuring plan.

The differences in medication formularies have been particularly problematic for the clinic's most vulnerable children. Many of the newer, longer lasting medications are not on the insurer's list of preferred drugs because they are more expensive. From a payer's perspective, it makes sense to require a prescriber to use a less expensive medication that requires multiple doses per day before approving a more expensive, longer lasting medication. For many of the families we work with, however, tracking and dosing multiple medications across multiple households at various times of the day is nearly impossible. Children living in poverty are often moving to and from multiple informal, care-giving settings (main residence, school, relatives or other parent's home, neighbor's house, etc.) throughout the day. Informal, flexible supervision involving multiple adults is the norm not the exception for these families. Yet, caregivers are expected to collaborate and coordinate to ensure that a thirty-day supply of

medication is managed appropriately and consistently across all settings; with the children, unfortunately, paying the price when this cannot be done.

Most Medicaid Managed Care companies will not authorize the use of a more expensive medication until a child has “failed” on trials of at least two less expensive medications. This may make sense for responsible adults living relatively stable lives but for children this can mean months of poor school performance and/or school suspensions, ejection from after school programs and extreme stress at home before a medication can be tried that could dramatically improve the child’s ability to focus and manage impulsivity or aggression across all settings.

The implications for the Clinic fall into two main areas, clinical and financial. Clinically, because it may take several months to link a child with the right medication, children and caregivers must manage longer periods of acute care before reaching a stable state, at which point the work of long-term change can begin. It can be difficult to maintain high levels of hope and motivation for children and families going through this experimentation period. Financially, because the approval process for obtaining a medication that is not on the Managed Care Company’s “preferred drug” list is extremely time consuming and requires the involvement of a medical provider who can explain why a particular drug is being requested for a particular child; it is expensive. The Clinic’s RN has become an expert in this process but obtaining prior authorizations is consuming work hours that were originally intended to provide support for prescribers so that they could deliver medical services as quickly and efficiently as possible.

On a positive note, Clinic re-structuring has provided an opportunity to bill for some of the services the Family Support team already provides. Specifically, if a family is having difficulty accessing outpatient mental health services or attending with the frequency necessary to achieve meaningful change, a Family Support worker can meet with the family in their own home to help. Family Support workers are skilled problem solvers and can work with families to identify many creative ways to overcome barriers keeping the child from engaging in successful treatment.

Research studies indicate that currently only 20 to 25 percent of children and youth who need mental healthcare are able to access it. Locally, access to clinic services accounts for 12% of referral requests to the FSS team, a percentage that undoubtedly grow as clinics and consumers become more aware of the role FSS can play in helping families engage in the treatment they need. In preparation for this change, FSS staff have completed the training required to become Licensed Family Support Workers and submitted their license applications just before year-end. All three members of the team meet the current licensing requirements and will be able to deliver reimbursable services as soon as that opportunity becomes available.

Over the past year in response to increased demand for psychiatry and medication services coupled with the high cost and relative scarcity of local psychiatrists, the Clinic implemented a new model for the delivery of medical services. The model focused on increasing hours for the Clinic Nurse, so that she could provide additional support to prescribers, allowing them to be more productive. In addition, some

high cost psychiatry hours were replaced with lower cost Nurse Practitioner hours, allowing the clinic to deliver more medical services without substantially increasing the cost of providing those services.

During 2011, the Psychiatric Nurse Practitioner served on the medical team; delivering psychiatric assessments and medication services under the supervision of one of the Clinic Psychiatrists. Because of high acuity and the complexity of medication needs for many of our recipients, the model was implemented slowly and carefully. Even with this cautious approach, the Clinic was able to deliver 25% more units of medical service and the Nurse Practitioner was able to deliver 35% of those units at a lower cost per unit. The model will be expanded in 2012, when the Nurse Practitioner is budgeted to deliver almost 60% of all medical services. The RN will also continue to play a key role as medication formularies, increased enrollment in managed care programs and caps on services complicate the delivery of medication services in 2012.

The Clinic also continued to participate in the OMH quality improvement initiative, designed to reduce the number of children and youth receiving three or more psychiatric medications simultaneously. The Clinic lost ground in terms of this indicator, ending 2011 with seventeen children on three or more psychiatric medications compared with fourteen children in 2010. Despite this increase, the current percentage of children on three or more medications (19%) is comparable with percentages reported by other clinics in the region. In 2012, the initiative will continue with a goal of bringing this Clinic's percentage back down to 15% or less; well below the regional average.

In addition, in 2011, the Clinic began work on managing a new quality indicator related to cardio metabolic risk. Children in this group are those at risk for metabolic disorders including heart disease, obesity and diabetes and are on psychotropic medications that may increase that risk over time. The goal of the quality initiative is to change medications whenever possible to replace those that could contribute to heightened risk with equally effective medications that present fewer risks. In the first year of this quality initiative, three of the five children who met the criteria for cardio metabolic risk and were taking the medications that could contribute to that risk were tried on an alternate medication regime with lower risk for cardio metabolic disorders. Two of those children were, however, returned to the higher risk medications following hospitalizations. We will continue to track both indicators and consider adding a third in 2012.

With the exception of medical staff, the Clinic and FSS teams experienced much needed stability in staffing throughout 2011. One new therapist was added at the Clinic, filling a part-time position that had been vacant for several months. Two psychiatrists left the Clinic in 2011 and were replaced in January of 2012. There were no changes to staff in the Family Support Services group. Concerted efforts were made throughout the year to unify the team around a common mission, vision and set of values, guidelines and processes that inform our efforts to meet the needs of the children and youth we serve. This effort will continue throughout 2012.

Table 2-6 Children’s Clinic Services Overview

Service Type	Service Description
Initial Mental Health Assessment	This is the ‘getting to know’ you part of treatment. We will learn about the concerns that brought you to our clinic, suggest ways in which change might happen and see if we can reach an agreement about what would work best for you and your child or teen.
Individual or Family Psychotherapy	Psychotherapy involves meeting face to face with your therapist to try to create changes that research and experience tell us are often helpful to families in your situation. Meetings may involve just your child or teen, you or other family members, other providers or any combination of these people. Meetings usually take place here at the clinic but can happen in your home, at your child’s school or in some other location when necessary.
Group Psychotherapy	Group psychotherapy is very helpful when children or teens need to learn how to have healthy relationships. When kids have developed unhealthy relationship patterns, learning new patterns in a group that is run by a skilled therapist can lead to big changes. Group psychotherapy can also be very helpful to parents or other caregivers who are trying to work on similar concerns. A skilled therapist can help adults share their experiences with each other, learn new skills and practice those skills with each other before trying them out at home. Groups also provide encouragement when the going gets tough and a group is a great place to celebrate each new success as change occurs!
Complex Care Management	Some families make the most progress when they have a team of people working with the family. In these situations, your therapist can help you get the most out of this ‘team’ experience. For example, a child with a developmental delays and a mental health concern might make the most progress when their team includes the therapist, a psychiatrist, a case manager, teachers and/or a school counselor all working together to achieve common goals. Your therapist can help you decide who you would like to have on your team, how to find these team members and how to work together effectively to support your child or teen as he or she works on making changes.
Emergency Services	Sometimes frightening or dangerous things happen between appointments. If this happens during regular business hours, caregivers or teens can call the clinic (435-7707) and ask to speak to their therapist. If their therapist is in an appointment, he or she will call back as soon as that appointment is over. If your therapist is not working on the day you call, another therapist will work with you to come up with a plan to deal with the crisis. After hours, adults and teens can call Contact (315-251-0600) when they are in crisis. The person answering the phone at Contact will try to resolve the crisis. If this does not work, the Contact staff person can pass the call on to a clinic therapist who will help you come up with a plan to deal with the situation. PLEASE USE THIS PROCESS ONLY FOR CRISIS or EMERGENCY CARE. For all other types of calls, call 435-7707 during regular business hours.
Outreach and Engagement	If a family is having difficulty getting set up for services at the Clinic or can’t get to the clinic often enough to benefit from treatment, a Family Support Services worker can meet with the family in their own home to help. Family Support workers are skilled “problem-solvers” and can come with many creative ways to overcome barriers to successful treatment at our Clinic.

Service Type	Service Description
Psychiatric Assessment and Medication Management	If medication is likely to be helpful in changing the patterns that are causing concern, your therapist can set up an appointment with one of our medical staff. Our Doctor or Nurse Practitioner will do his or her own assessment and, if appropriate, suggest medication that might help. The doctor will need to meet with your child or teen regularly in order to keep track of how he or she is responding to their medication and to make any changes needed in the prescriptions you receive. We do not provide “medication only” services at this clinic so if you need medication after you have achieved your treatment goals we will work with you to transfer medication services to your primary care physician or pediatrician.
Health monitoring	Whenever a young person is receiving medication here, we keep track of a set of “health indicators” including height, weight, blood pressure, etc. These indicators can alert us to important changes before they can become problems for the young person involved.

Accomplishments

2011 can be characterized as a year marked by sweeping changes in how outpatient mental health clinics will function at all levels of service delivery. In an effort to effectively implement these changes, Clinic and FSS staff, aided by many other Department of Mental Health management and support staff, has been able to accomplish the following tasks:

- In 2011, clinic staff delivered 6,248 units of service, an increase of 13% over units delivered during the prior year.
- Completion of the design of the Accumedic Electronic Medical Record and preparation for launch in January of 2012.
- Careful management of therapy, psychiatry and family support resources to allow for significant growth in the number of services delivered and the number of families served without a commensurate increase in staffing or operating costs.
- Completion of the redesign of the intake process, allowing for immediate risk assessment and rapid triage and crisis intervention thus ensuring that high risk families quickly receive the stabilizing care they need.
- Successful negotiation between the Commissioner of Mental Health and Hutchings management to regain use of the West wing of the building currently occupied by the Clinic. This additional space will provide ample room for the delivery of effective treatment for at least the next five years.
- Training and implementation of new evidence-based practices for the treatment of oppositional defiant disorders and attachment disorders in young children and in the use of motivational interviewing, an evidence-based practice designed to motivate and engage families in a more vigorous change process.
- Contributions by the Director to a variety of larger system of care initiatives. Specifically, the Director served on the **Child Death Review Committee**, a multidisciplinary team that investigates accidental deaths of children and youth in Onondaga County with a goal of identifying systemic changes that can reduce the likelihood of additional children dying under similar circumstances. In 2011, the Committee focused on unsafe sleep environments as a significant cause of infant and child mortality. A “safe sleep” campaign targeted at the general

public was designed and executed in 2011 and a conference for medical professionals is being planned for 2012. The conference will focus on partnering with medical professionals to change the behavior of parents of infants and young children so that every child in Onondaga County goes to sleep in a safe sleep environment.

- The Director also served as Co-chair of the **OnCare Crisis and Emergency Care** work group, composed of parents, recipients, service providers and others charged with reviewing the current mechanisms for the delivery of emergency and crisis services to children and youth and with making recommendations regarding possible improvements that might strengthen and unify this already robust service delivery system. A set of recommendations was delivered to the governing body and presented to the larger community in September of 2011 resulting in implementation of some recommendations before the end of the year with others slated for implementation in 2012.
- The Director participated in the monthly **Clinic Directors Meeting**, to share information and collaborate on how best to manage the challenges facing clinics operating under the new OMH guidelines and payment structure.
- The Director also served as a resource to the newly developed **ACCESS** team, a group operating under the management of OnCare staff and charged with integrating staff from DSS, the probation department and Onondaga Case Management into a cohesive team that could respond effectively to calls from parents attempting to access the full range of services offered to children and youth experiencing mental health challenges in Onondaga County.

2012 Goals

In 2012, our focus will be on refining and redefining basic service delivery processes to ensure maximum consumer satisfaction, service effectiveness and fiscal viability. Specifically,

- The Clinic will continue with revenue enhancing and cost cutting measures that include: transition to an Electronic Medical Record (EMR) to increase efficiencies, increasing hours for the Nurse Practitioner to reduce more costly Psychiatry time, use of grant funding for much needed equipment and physical space upgrades, and increased productivity standards for therapists.
- The planned launch of the EMR will assist therapists in tracking and completing complex documentation requirements and will allow supervisors to closely monitor individual performance, identify and resolve specific problems and hold staff accountable to full compliance as soon as the EMR has been launched and clinicians are fully trained in its' use.
- The Director will review and modify as needed all key processes to take maximum advantage of our new EMR capabilities. One goal will be to reduce the amount of time spent on paperwork and clerical tasks while increasing the time spent working with families in the design and delivery of services that will best meet their needs.
- By the end of 2012 Clinic and FSS staff will achieve verifiable compliance with all OMH standards of care and documentation requirements for all service lines at all times with an error rate of less than 5%.
- Working with the Director of Personnel and staff, the Director will update performance standards for Clinic and FSS team members so that the new standards reflect and support OMH regulations and recommendations regarding best practices for achieving the delivery of fiscally viable, clinically effective services. The team will also update the performance review process to

add value for the employee and for the County as specific staff development plans are designed and implemented for each employee engaged in the delivery of Clinic or FSS services.

- Working with the Deputy Commissioner and the Director of Finance, the Clinic Director will utilize OMH financial assessment tools to quantify the financial contributions of each service line and of each staff member providing services with the goal of addressing areas of financial vulnerability and developing specific strategies to improve financial outcomes across all service lines over the next three years.
- The Clinic Director will work with the Director of Day Treatment Services and the Deputy Commissioner to develop a five year plan for the use of the recently re-acquired West wing portion of the building.
- The Director will work with staff to research and access training in evidence based treatment and practice management skills. Trainings will be followed by rapid cycle testing and implementation of any skills and strategies that are proven to enhance clinical care and fiscal viability. Skill use will be monitored for a minimum of six months to ensure that new skills are then used routinely in treatment planning and service delivery.
- The Director will work with medical and clinical staff to develop methods to support adult caregivers in implementing complex medication regimens. In addition, the team will develop a strategy to move as rapidly as possible through various medication trials to arrive at the best medication for a particular child as quickly as possible.
- The Director will continue to seek opportunities to contribute to system wide initiatives that have the potential to improve the social and emotional well being of all children and youth living in Onondaga County.

2.2.2 Assisted Outpatient Treatment (AOT)

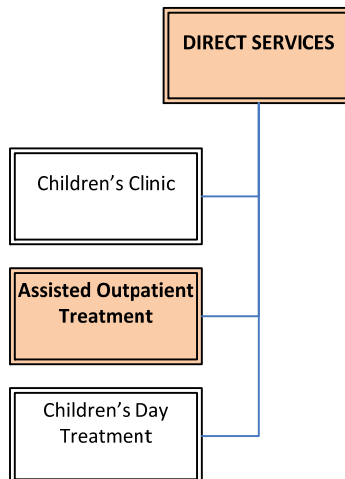


Figure 2-18 Direct Services: Assisted Outpatient Treatment

Program Overview

In 1999 New York State enacted legislation that provides for assisted outpatient treatment for those people with a psychiatric disability that, in view of their treatment history and present circumstances are unlikely to survive safely in the community without supervision. The law is commonly referred to as “Kendra’s Law” and is set forth in §9.60 of the Mental Hygiene Law (MHL). It was named after Kendra Webdale, a young woman who died in January 1999 after being pushed in front of a New York City subway by a person who was living in the community at the time, but was not receiving treatment for his psychiatric disability. The original legislation was in effect for five years and has since been extended twice. The current law is now scheduled to expire in June 2015.

Although Kendra’s Law establishes a procedure for obtaining court orders for individuals who meet the criteria, the emphasis is on providing enhanced services on a voluntary basis rather than to pursue formal court action mandating an approved service plan. If a court order needs to be obtained, the prescribed treatment is set forth in a written treatment plan prepared by a physician who has examined the individual. This is followed by a court hearing during which all the evidence, including testimony from the physician and, if desired, from the person alleged to need treatment, is presented to the Court. If the Court determines that the individual meets the criteria for Assisted Outpatient Treatment (AOT), an order is issued to the Director of Community Services (DCS) who oversees the mental health program of a locality. The court orders will require the director to provide or arrange for those services described in the written treatment plan that the Court finds necessary. The initial order is effective for six months and can be extended for successive periods of up to one year. The legislation also establishes a procedure for evaluation in cases where the individual fails to comply with the ordered treatment and may pose a risk of harm to self and others.

Onondaga County Department of Mental Health has a designated AOT Coordinator who supervises and coordinates the AOT program administration for Onondaga County. This includes acceptance of referrals, assessment and investigation, community planning, provision of enhanced services, formal psychiatric examinations, monitoring and coordination of services, and petitions to and representation in court.

Service Summary

There were thirty-one referrals to the Assisted Outpatient Treatment program in 2011. Of these referrals, all resulted in formal investigations. Twelve court orders were initiated as a result of the investigations and eleven petitions were granted. Four of these orders were extensions of previously granted orders. Thirteen voluntary enhanced service plans were developed, thereby diverting the need for court orders.

Accomplishments

- There was an increase in the number of voluntary enhanced service plans during 2011.
- AOT pick-up requests to CPEP were reduced from six to two from the prior year.
- Presentations at CPEP for those on formal AOT orders were reduced from ten in 2010 to four in 2011.
- New hospitalizations for those on formal AOT orders were reduced from seven in 2010 to four in 2011.

2012 Goals

- Hire a new AOT Coordinator to replace the retiring coordinator.
- Develop and implement an agreement with Oswego County for the transfer of AOT referrals and court orders.

2.2.3 Children's Day Treatment

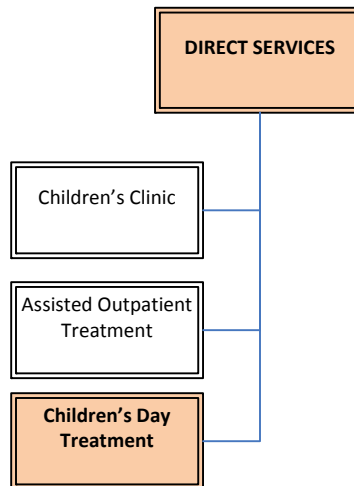


Figure 2-19 Direct Services: Children's Day Treatment

Program Overview

The Day Treatment Program for Children provides comprehensive mental health services to severely emotionally disturbed children throughout Onondaga County. The children range in age from five to thirteen. These children generally have a complex history that may include trauma, being involved in multiple community services, CPEP presentation, and in-patient hospitalizations. More often than not, these children have not been successful in any of the option programs offered within their home school district.

The Day Treatment program is the only licensed program in Onondaga County. Also, due to a long standing agreement with Hutchings Psychiatric Center (HPC), all office and program space is provided at no cost to the County. This includes use of the HPC Gym, Pool, and Play areas.

Service Summary

All referrals for day treatment evaluation and possible placement are received from the directors of special education and reviewed by the Centralized Committee for Day Treatment, a collaborative work group representing all of the certified day treatment programs in the area, SPOA, and other community based providers. Each child receives a three-day evaluation to determine admission to the program.

Evaluations were completed on eighteen children during 2011 with sixteen of those children admitted to the program. A total of nineteen children were discharged from day treatment during the prior year; thirteen of which were able to transition to a lower level of care/programming.

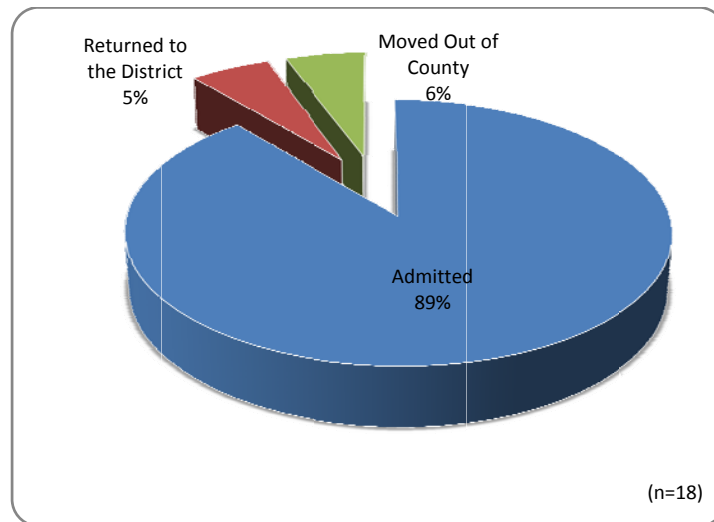


Figure 2-20 Children's Day Treatment: 2011 Referrals

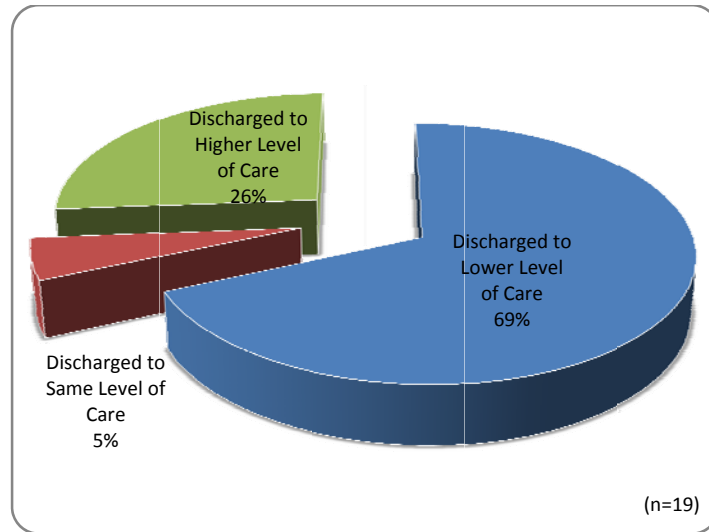


Figure 2-21 Children's Day Treatment: 2011 Discharges

Changes and Challenges

The Day Treatment Program for Children is operating with a full staff at this time. A major emphasis has been on helping the children identify their resources to help with their own regulation. The staff remains very involved in entering into a co-regulation phase with the children when they are feeling vulnerable and out of control. Many times, this state of regulation takes place in a one-on-one relationship. In addition, there are many more crisis situations that require a high level of skill for intervention.

During 2011, there was an increase in the number of children who needed in-patient hospitalizations. Also, over the past year there have been more females referred to day treatment for evaluation and placement. A new math curriculum was implemented in September 2011, as well as literacy intervention for every child who is not on grade level for reading.

Accomplishments

The day treatment program had a site visit (for license re-certification) completed in February 2011. The findings were very positive and a two year operating certificate was granted.

With the program goal of having a non-coercive treatment environment, the challenge of having pertinent training for staff is critical. The program collaborated with OCM BOCES in October 2011, for an all staff training that focused on trauma informed care, the development of de-briefing strategies, and the impact of trauma on neuro-biological development of the brain. In addition, there have been two other staff trainings during the past year that were developed by the day treatment staff.

The program still serves as a placement for the psychiatric fellows from Upstate Hospital. The “window of tolerance” and “individual care plans” are two tools that have been implemented for all children in the day treatment program. Efforts are continually made to include parents in as many activities and meetings as possible.

2012 Goals

- In collaboration with OCM BOCES and the Syracuse City School District, work to develop an older age group within the current program. This new group will:
 - better meet the needs of individuals that are unable to cope with school;
 - reduce the Day Treatment waiting list;
 - provide both education and coping skills;
 - avoid suspensions and expulsions; and,
 - increase the graduation rate.
 If successful, this pilot program may be expanded using additional space in 2013.
- Continue to attend/provide intensive staff training.
- Consider the development of a “pre-screening” process to front-end some referrals.
- Coordinate with the school districts on potential referrals for evaluation.

3 Planning, Quality Management and Improvement

3.1 Department of Mental Health 2011 Work Plan Priorities

Table 3-1 Department's 2011 Work Plan Priorities

No.	Goal	Outcome
1	Improve access to care for children, youth, & families through support of all OnCare activities, and through enhancements to Home and Community Based Services Waiver, Intensive Case Management, and Children and Youth SPOA.	Section 3.1.1
2	Enhance functioning/ performance of school aged children through partnership with Say Yes to Education and Promise Zone.	Section 3.1.2
3	Address needs of transition age youth (ages 16-25) through enhancement to residential, respite, and other services (E.g. employment).	Section 3.1.3
4	Increase service access and prevent crisis/hospitalization through the expansion of existing services, and through the implementation of new service models: <ul style="list-style-type: none"> • System wide implementation of Dialectical Behavioral Therapy • System level support for Clinic Restructuring implementation • Expansion of clinic resources • Implementation of PROS • Enhancement of mobile outreach services 	Section 3.1.4
5	Enhance peer and other natural supports for recipients by developing peer supports in a range of service settings.	Section 3.1.5

6	Continue the promotion of person centered recovery oriented reform of service delivery and financing through participation in NYCCP.	Section 3.1.6
7	Enhance data informed decision making for planning, contracting, and service implementation via further developments of data management systems.	Section 3.1.7
8	Address the physical health needs of the recipient populations by developing the health monitoring capabilities of providers.	Section 3.1.8
9	Foster quality improvement efforts of providers of developmental disability services through a learning collaborative model in order to address current resource challenges.	Section 3.1.9

2011 saw dramatic changes regarding reimbursement for behavioral health services, and the emergence of managed care models designed to contain ever increasing Medicaid costs. As data analysis has resulted in an increased awareness of the chronic health conditions suffered by many with behavioral health conditions, these efforts to reform the fiscal models driving services have prioritized more integrated approaches that address the full range of an individual’s healthcare needs. The local implication of these federal and state reforms resulted in much of the efforts related to 2011 priorities (particularly items 4,6,7,8 & 9 above) being adjusted to accommodate these system changes.

3.1.1 Support of OnCare

The Department is committed to achieving its goal of a fully transformed and seamless service system for children and youth with serious emotional and behavioral issues and their families that is strength-based, individualized, trauma informed, family-driven, youth-guided and culturally and linguistically competent. Therefore, it fully supports OnCare including the efforts of all OnCare work groups. In addition, the Department supported the implementation of the redesign of the Children and Youth SPOA to the Access to Services Team. This team is a true single point of access for high-end services offered through Mental Health, Child Welfare, and Probation.

The Department is dedicated to helping families support their children in reaching their goals. Working with the families to identify and develop a plan around a child’s talents and interests, that includes the families natural supports is essential to any child’s success. It empowers the family to be the driver and architect of their child’s plan for success. The department partnered with OnCare and the organizations that provide care coordination through Home and Community Based Waiver Services and Intensive Case Management to enhance the staff’s capability to develop and implement plans that are strengths based and include meaningful roles for natural supports.

3.1.2 Say Yes to Education and Promise Zone Initiative

The Syracuse Promise Zone is a partnership between the Department of Mental Health, Syracuse City School District, Say Yes To Education, OnCare and other community organizations. The mission is to

reduce suspensions, keep students in class and ready to learn, and match student's emotional/behavioral needs with effective targeted interventions.

In 2011, we expanded the number of schools with outpatient mental health clinic satellites from thirteen to nineteen. In addition, this partnership supported the Syracuse City School District in specifying and implementing policies, procedures, and trainings around best practices. These were designed to strengthen student support teams as well as develop collaboration between both schools and community based organizations serving the schools.

In 2012, we will work to expand additional satellites in the schools, create more effective interventions, establish tools to help monitor the progress of students and improve crisis response for students and staff in the Syracuse City School District.

3.1.3 Address Needs of Transition Age Youth

Youth entering adulthood who experience serious emotional or behavioral difficulties face complex challenges and expectations of adult life. In order to support these youth in meeting their goals, the adult and child serving systems must come together to individualize support in a developmentally appropriate manner. In 2011, the Department built collaborations with agencies serving both youth and young adults to better serve this population through the establishment of a housing option for transition age youth, the implementation of strategic response team process and implementation of an evidence based practice for adolescent substance use service with Central New York Services, Inc..

3.1.4 Increase Service Access and Prevent Crisis/Hospitalization

2011 saw OCDMH successfully support the expansion of outpatient mental health services through the opening of a new mental health clinic and through the development of applications for the opening of two PROS (Personalized Recovery Oriented Services) programs in 2012. Additional clinic expansions are also under way in school based settings and in two additional adult treatment settings. A range of supports were also offered to existing mental health clinics during 2011 as they successfully made the transition to new regulations.

OCDMH continues to promote a range of evidence based practices. The 2011 plan to develop Dialectical Behavioral Therapy (DBT) services in Onondaga County was hindered by some of the dramatic regulatory and fiscal changes that impacted clinical services. As a result, efforts to implement DBT were postponed and will be addressed in 2012. Given this context of continued systems change, efforts will be made to adjust planning related to DBT and other evidence based practices.

3.1.5 Peer Supports

During 2011, OCDMH partnered with a group of community peer stakeholders and representatives from providers who offered peer supports to develop a plan for a peer recovery center. This partnership resulted in a proposal that was submitted to and approved by the NYS Office of Mental Health (OMH).

During the early part of 2012, OCDMH will work with community stakeholders to select a partner agency to help develop this Recovery Center; which will eventually become an independent peer-run not-for-profit organization. This Recovery Center will serve multiple functions; all of which will promote successful integration into the community and achievement of personal life goals.

3.1.6 New York Care Coordination Program (NYCCP)

During 2011, the State Office of Mental Health and Office of Alcoholism and Substance Abuse Services selected NYCCP as the Regional Behavioral Health Organization (RBHO) for the nineteen counties in western New York. In late 2011 and into 2012, the NYCCP has developed a Health Care Innovation Grant application to the Centers for Medicaid and Medicare Services to promote peer support and peer employment, and is developing the ability to serve as a Health Home for upstate New York counties.

3.1.7 Data Management Systems

During 2011, utilization of the Department's online data collection system (PCMS) grew amongst contracted agencies. This allowed OCDMH to develop a Community Performance Level (CPL) for all Clinic, Case Management, and Residential contract programs. The CPL was based on data collected over the prior year and will allow the department to compare 2012 data to that baseline in the shift to a more data driven assessment of contract agency performance.

3.1.8 Physical Health Needs

The planned approaches to address the physical health needs of behavioral health recipients during 2011 were strongly trumped by the state level agenda regarding healthcare reform and Medicaid cost containment. The emergence of even more data regarding the poor health outcomes and ever increasing costs for preventable conditions has resulted in a strong focus on co-occurring physical and behavioral health conditions.

OCDMH is working to coordinate with state level initiatives, including Regional Behavioral Health Organizations (RBHOs), Health Homes, and Regional Health Information Organizations (RHIOs). Rather than engaging in local pilot efforts to address health conditions of those with co-occurring behavioral health conditions, 2011 saw OCDMH partnering with state agencies and through NYCCP to promote the effective development of the new health systems infrastructures. These efforts will continue into 2012, including participation in a federal CMS grant application designed to address the behavioral and physical health needs of Medicaid recipients through the use of peer wellness coaches and web-based technologies for monitoring health goals.

3.1.9 Developmental Disability Services

Significant changes at the state agency overseeing developmental disability services (Office for People with Developmental Disabilities (OPWDD)) have created strong impacts on local providers. As a result, OCDMH chose to postpone some of the change efforts planned for 2011 in order to support providers in the management of this period of rapid systems change.

2012 will likely see a resumption of some of these efforts to pull together the Developmental Disabilities provider community in order to explore process improvement and other quality improvement approaches that may help to ensure their successful transitions into the new healthcare environment.

3.2 Child Mental Health Initiative System of Care

OnCare, the Onondaga County System of Care federal grant through Substance Abuse and Mental Health Services Administration (SAMHSA), continues to build cross-system collaboration on behalf of children and youth with serious emotional and behavioral challenges.

Accomplishments

- Continued development of a community-based governance structure. Bringing together parents, youth, human service agencies, government, education and informal community supports to develop strategies to expand access to services and improve outcomes.
- Implementation of a single access point for intensive services (including residential services), which is staffed jointly by staff from mental health, child welfare, juvenile justice, and OnCare; including three family support partners. Families can now access services and supports from all three service systems through an integrated assessment and planning process.
- Distribution of \$1.4 million dollars for targeted service expansion projects. These include: respite, skill-building, innovative clinical services, educational advocacy, adolescent substance abuse treatment, and intensive supports for children in residential care and their families.

- Implementation of an integrated management information system that enables the County to track service utilization and outcomes at a child, agency and system level.

As a result, the County expects to contain the overall cost of services while ensuring better outcomes for children and their families.

3.3 Dual Recovery Coordinator (DRC) Activities

The primary function of the Dual Recovery Coordinator (DRC) is to serve as a “change agent” by being involved in activities to develop and implement integrated and coordinated approaches and services for treating Co-Occurring Disorders (COD) for mental health and substance abuse issues.

Training

Table 3-2 below lists the workforce development training and technical support that the Dual Recovery Coordinator has facilitated, coordinated and/or provided in 2011.

Table 3-2 Dual Recovery Coordinator Training Summary

2011 Trainings	Training and Presenter Information	# Hours	# of Trainee Slots
2/1,8,15/11 3/1,8/11	Recovery Coaching Academy: Joe Scripa, Janette Chavan	30	85
2/28/11	Recovery Management: “Lunch & Learn” Dan Kelley, Tracy Carmody, Joe Scripa	1.5	18
2/15/11	NCBI Diversity Training: Bridget Owens	6	15
3/21/11	Recovery Management: “Lunch & Learn” Joe Scripa, Dan Kelley, Tracy Carmody	1.5	18
3/14,15,16/11	NCBI Leadership Train the Trainer Seminar: Steve Jarose and Linda Hall	18	72
3/31/11	Cultural Breakfast: w/Paul Shenandoah (Native American Issues)	1.5	19
4/12/11	NCBI Diversity Training: Bridget Owens	6	10
4/25/11	Recovery Management: Lunch & Learn w/Jennifer Woods (CNY-DRP)	1.5	18
5/2/11	Peer Development: Focus Group Carole Hayes Collier, Joe Scripa	2	12
5/24/11	Recovery Management: Lunch & Learn Sherry Fuller, Donna Cruz (CNYS- housing)	1.5	24
6/9/11	Cultural Breakfast: Agnes Kariuki (Refugees)	1.5	24
6/9/11	Peer Development: Focus Group w/ Carole Hayes & Joe Scripa	2	8
7/19/11	Recovery Management: Lunch & Learn w/ Mary Jo	1.5	20

	Prioretta- Halpern (Farnham)		
7/21/11	Peer Development: Focus Group w/ Carole Hayes Collier & Joe Scripa	2	10
8/29/11	Drugged Driving Presentation: w/Syracuse Police Department	1.5	24
9/21/11	NCBI Diversity Training: Bridget Owens & Kevin Ruane	6	12
9/13,20,27/11 10/11,18/11	Recovery Coaching Academy: w/ Joe Scripa & Janette Chavan	30	75
10/25/11	Drug Impaired Training Intervention Process (DITEP): Robert Boris	6	43
10/25/11 11/1,8/11	Motivational Interviewing: Cheryl Martin & Rick Wellman	18	56
11/15/11	NCBI Diversity training: Bridget Owens, Kevin Ruane, & Tashia Thomas	6	37
11/17/11	"Cultural Breakfast: Human Rights, Immigrant, & Refugee Issues" Rebecca Fluentes & Julie Norman	1.5	19
12/13/11	Dual Recovery Core Curriculum: Dan Kelley	2	10
	Total	147.5	629

Projects

The DRC participated in projects that included:

- Hutchings Psychiatric Center Outpatient Clinic Co-occurring Disorder Initiative;
- Onondaga Case Management Services (OCMS) Substance Abuse Screening Initiative;
- Onondaga County Co-occurring Screening Survey Initiative;
- OCMS Cultural/Linguistic Competency Policy Assessment (CLCPA);
- OnCare System of Care: Cultural/Linguistic Competency (CLC) Workgroup;
- Brownell Center Co-occurring Disorder Initiative; and,
- OCMS Recovery Coach Pilot.

Provider Workgroups

The DRC participated in a number of workgroups and forums this past year. These workgroups are used to consult and collaborate on many common goals related to service delivery coordination, engagement, assessment, access, referral, intake, treatment, capacity, community support, and placement issues impacting those with co-occurring disorders. Forums are listed here to include meetings that primarily provide service related updates from the community and inform participants regarding emerging issues and trends in the field:

- Onondaga County Department of Mental Health's (OCDMH) Mental Health /Chemical Dependency Provider's Consortium
- Peer Mentor Advisory Committee at OCMS
- Dual Diagnosis Competence (DDC) Committee at OCMS

- Cultural Competence Committee at OCMS
- Friends of Recovery – Central New York
- Central New York Services Incident Review Committee
- Recovery Coaching Learning Community Committee
- Peer Leadership Committee
- PATH Steering Committee
- OCDMH/OCMS Coordinator’s Workgroup
- OnCare System of Care: Cultural/Linguistic Competency Committee
- OnCare Stakeholder’s Forum
- CEIC “Capacity Building Forum”
- SPOA/Residential Providers Committee
- OMH Recovery Center Proposal Committee
- NCBI Affiliate Steering Group

3.4 Department of Mental Health 2012 Work Plan Priorities

Table 3-3 Department's 2012 Work Plan Priorities

No.	Goal	Plan
1	Promote recovery through increased access to outpatient services.	Section 3.4.1
2	Improve opportunities and outcomes for transition age youth (16-25) through the use of Strategic Response Team (SRT) meetings & resource coordination with OnCare.	Section 3.4.2
3	Enhance the system of care for families and youth by promoting strength based service planning in care coordination programs for youth & coordinate resources with OnCare.	Section 3.4.3
4	Ensure adequate access to services for people with developmental disabilities.	Section 3.4.4
5	Assess supports for people with co-occurring substance use and mental health conditions.	Section 3.4.5
6	Enhance supports for school age children through school based service expansions.	Section 3.4.6
7	Enhance peer supports for mental health recipients.	Section 3.4.7
8	Implement data driven decision making by enhancing the use of data in contract management and provider projects.	Section 3.4.8
9	Support the implementation of the Regional Behavioral Health Organization (RBHO) and Health Homes.	Section 3.4.9

3.4.1 Promote Recovery

OCDMH will be working with mental health and chemical dependency providers to open new outpatient services (clinic and PROS) and to insure the utilization of evidence based practices in new and existing services.

3.4.2 Improve Opportunities and Outcomes for Transition Age Youth (16-25)

OCDMH will conduct a number of Strategic Response Team (SRT) sessions. As well as, promote this model of community wide coordination to address the needs of transition age youth with complex service needs that challenge the existing service system resources.

3.4.3 Enhance the System of Care for Families and Youth

OCDMH will work with providers to promote a focus on strengths and natural supports that will foster goal attainment and reduce lengths of stay.

3.4.4 Ensure Adequate Access to Services for People with Developmental Disabilities

By implementing process improvements that enhance service efficiencies in conjunction with the roll out of the OPWDD People First Waiver, OCDMH will use a learning collaborative model to work with providers of developmental disability services as they make changes to services in response to state level system changes.

3.4.5 Assess Supports for People with Co-occurring Substance Use and Mental Health Conditions

OCDMH will complete an analysis of survey results regarding provider screening for co-occurring substance use and mental health conditions, and will subsequently develop targeted screening enhancement projects.

3.4.6 Enhance Supports for School Age Children

OCDMH will partner with Syracuse City School District, Say Yes to Education, OnCare, & Community Based Organizations to expand services and enhance student performance.

3.4.7 Enhance Peer Supports for Mental Health Recipients

OCDMH will engage stakeholders in planning for peer support expansion, and community education regarding the value of peer supports.

3.4.8 Implement Data Driven Decision Making

OCDMH will use online data reporting into the Performance and Contract Management System (PCMS) to implement work plans for contracted agencies and a range of quality improvement projects.

3.4.9 Support the Implementation of the Regional Behavioral Health Organization (RBHO) and Health Homes

OCDMH will actively participate in a range of RBHO and Health Home advisory and oversight committees in order to promote person centered and inclusive implementation during this time of rapid healthcare reform

4 Fiscal Overview

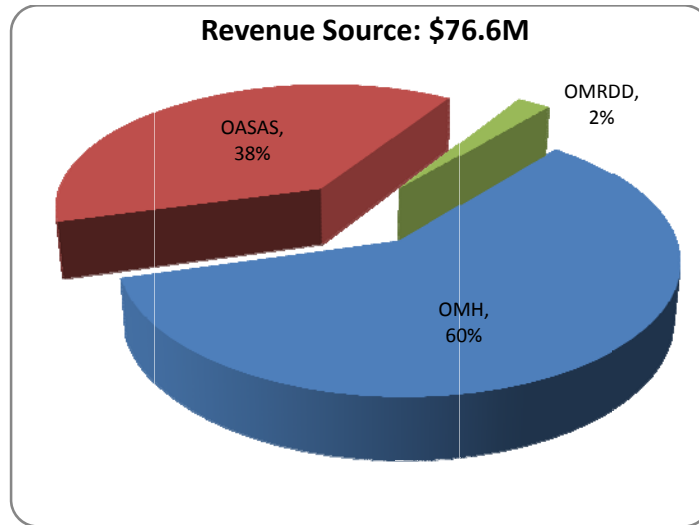


Figure 4-1 OCDMH Gross Program Costs

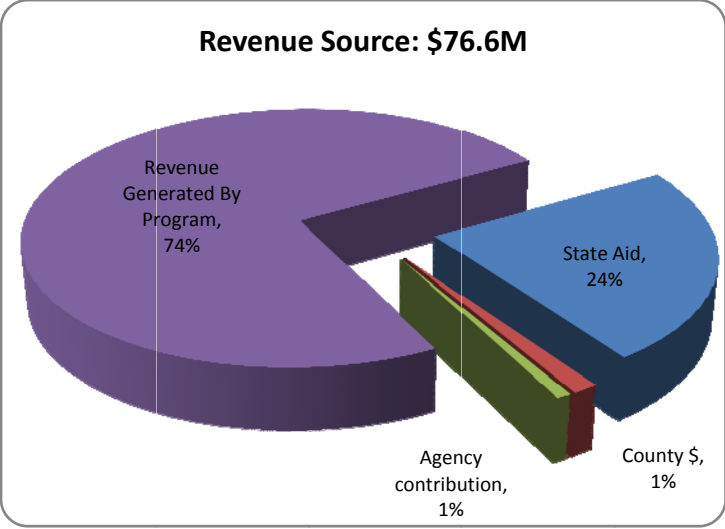


Figure 4-2 OCDMH Revenue Sources

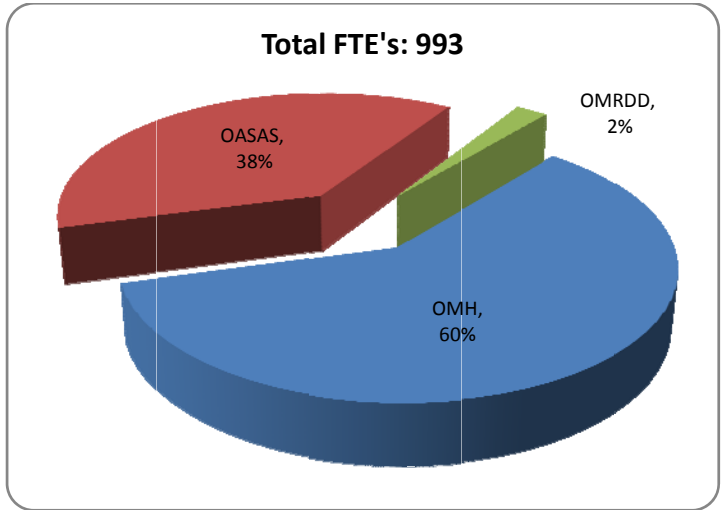


Figure 4-3 Total FTEs

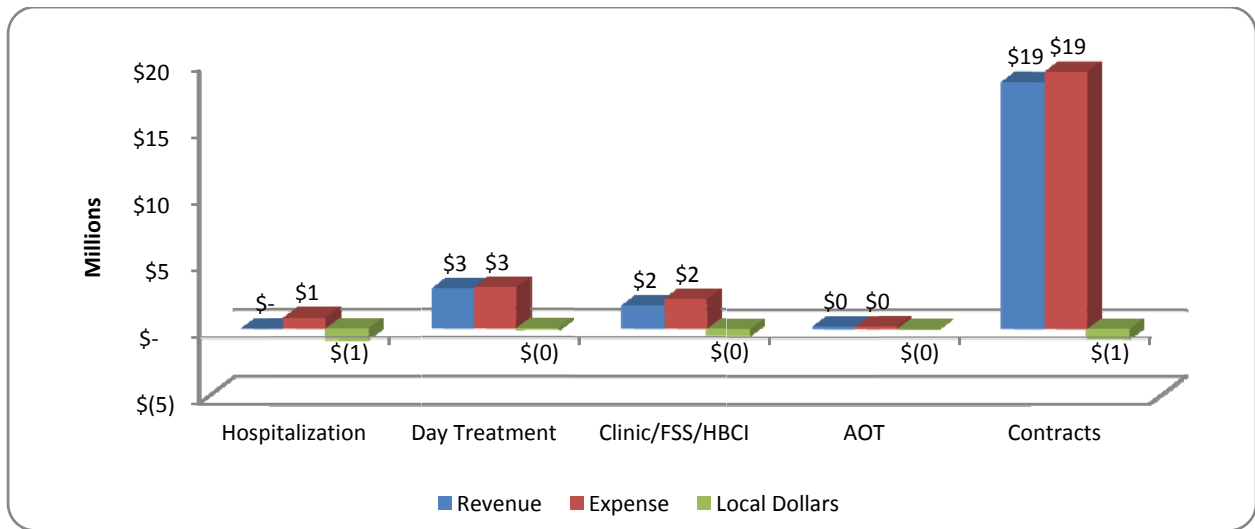


Figure 4-4 Fiscal Overview by Service Type

Day Treatment – Children’s Day Treatment
FSS – Family Support Services
HBCI – Home Based Crisis Intervention
AOT – Assisted Outpatient Treatment

4.1 Budget Changes Summary

The 2011-2012 budget adopted by the State in April included a flat budget and no State Aid cost of living adjustment (COLA). The State required an across the board reduction of 1.1% to most undisbursed general fund and state special revenue aid to localities appropriations (including Medicaid and State Aid). These provisions were enacted to address financial plan deficiencies related to reductions to the enhanced Federal Medical Assistance Percentage (FMAP) authorized by Congress.

The Office of People with Developmental Disabilities (OPWDD) implemented a savings initiative for 2011 that will be annualized in 2012 resulting in a \$173,543 cut.

The Office of Alcoholism and Substance Abuse (OASAS) implemented cuts to both the Gambling Prevention and ADAPEP programs in the amount of \$67,591 to be annualized in 2012 resulting in a \$135,182 cut.

5 Appendices

5.1 Appendix A: Onondaga County Legislature and Community Services Board 2011

COUNTY EXECUTIVE

- Joanne M. Mahoney, County Executive
- William Fisher, Deputy County Executive
- Ann Rooney, Deputy County Executive for Human Services
- Matthew Millea, Deputy County Executive for Physical Services
- Travis Glazier, Director of Intergovernmental Relations

COMMUNITY SERVICES BOARD

- Timothy J. Bobo, Chair
- Ben de la Garza Bassett
- Mary Beth Frey
- Aggie Glavin Parker
- Peggy Harper
- Kaymarie Kavanagh
- Daniel Kelley
- Joy King
- Sarah Merrick
- Diane O'Brien
- Stephen Russell
- Karen Virginia
- Sara Wall-Bollinger

DEVELOPMENTAL DISABILITIES SUB-COMMITTEE

- Peggy Harper, Co-Chair
- Patti Herrmann, Co-Chair
- Aggie Glavin Parker
- Kaymarie Kavanagh
- Steve Russell
- Sharon Sullivan
- Prudence York

COUNTY LEGISLATURE HEALTH COMMITTEE

- Robert Warner, Chair
- Sam Laguzza, Vice Chair
- William Meyer
- Kevin Holmquist
- Linda Ervin

5.2 Appendix B: Department of Mental Health Senior Staff 2011

- Robert C. Long, MPA, Commissioner
- Barry L. Beck, LMSW, Deputy Commissioner
- Katie Backus, Director of Contract Services
- Mathew Roosa, ACSW, LCSW-R, Director of Planning and Quality Improvement
- Patti Seitz, Personnel Administrator
- Sandra Miller-Martens, Fiscal Officer

5.3 Appendix C: References

ⁱ http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm#Fig2-1

ⁱⁱ http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm#Fig2-1

ⁱⁱⁱ Definition of recovery from SAMHSA

^{iv} An Examination of Premature Mortality among Decedents with Serious Mental Illness and Those in the General Population, Piatt, Munetz & Ritter: 2010.

^v New York State Office of Alcoholism & Substance Abuse Services, 2007 Agency Overview p.15

^{vi} http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm

^{vii} http://www.omr.state.ny.us/hp_faqs.jsp#q8

^{viii} http://draonline.org/chemical_dependency.html