

2015

Local Services Plan

For Mental Hygiene Services



Albany County

Department of Mental Health

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2015 Mental Hygiene Local Services Plan Albany County Dept. of Mental Health

2015 Local Services Plan Forms

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County Needs Assessment Survey

Albany County Dept. of Mental Health (70520)

Consult the LSP Guidelines for additional guidance on completing this form.

The current OASAS treatment need methodology was implemented in 2003 and has undergone periodic adjustments over the past decade. Considering the evolution of the substance use disorder treatment system during that time and the dramatic changes underway today, the entire methodology is now under review. As OASAS considers the development of a new methodology for estimating specific treatment service needs at the county, region and state levels, counties are being asked to complete this survey to inform the state about: 1) how local service needs are determined, 2) how accessible services are or should be, 3) the extent to which local treatment needs are being met and where service gaps may exist, and 4) existing barriers to accessing treatment. All questions regarding this survey should be directed to Jean Audet at 518-485-2410 or at Jean.Audet@oasas.ny.gov

1. Resources for Identifying Service Needs: How important is each of the following resources in identifying substance use disorder problems and service needs in your county?

Needs Assessment Resources	Very Important	Somewhat Important	Not Very Important	Resource Not Used
1. Public forums or hearings		X		
2. Focus groups on specific topics		X		
3. Advisory group/task force/coalition reports	X			
4. CSB/sub-committee/provider meetings	X			
5. Population surveys		X		
6. Patient satisfaction/perception of care surveys	X			
7. Provider surveys	X			
8. Provider waiting lists		X		
9. OASAS client data/LGU Inquiry Reports	X			
10. OASAS treatment need methodology	X			
11. Medicaid data		X		
12. Other secondary data (e.g., census, health stats)		X		
13. Other (Specify): CLMHD data dashboard	X			

2. Service Areas: From a service planning perspective, indicate whether each service listed below should be considered primarily a county or regional resource (i.e. should the service be available in every county or should it be accessible within a multi-county service area?) If you indicate that the service should be a regional resource, identify the counties that you believe fall within your county's service area for that particular service.

Service	County Resource	Regional Resource	Counties in Service Area
1. Medically Managed Detoxification	X		
2. Medically Supervised Withdrawal Inpatient	X		
3. Medically Supervised Withdrawal Outpatient	X		
4. Medically Monitored Withdrawal	X		
5. Inpatient Rehabilitation Treatment		X	Renns, Schen, Saratoga, Columbia/Greene
6. Outpatient Treatment (non-opioid)	X		
7. Opioid Treatment	X		
8. Intensive Residential Treatment		X	same as above
9. Community Residential Treatment	X		
10. Supportive Living Facility	X		
11. Primary Prevention	X		
12. Prevention Counseling	X		
13. Housing	X		
14. Recovery Supports	X		

3. Assessment of Service Capacity within County or Region: For each service listed below, indicate whether there is sufficient or insufficient capacity available within your county or region to meet the needs of the residents of your county. (NOTE: If you indicated above that the service should be considered a regional resource, assess available capacity for that service on a regional level.) If you indicate that the capacity within your county is insufficient, indicate whether filling the service gap represents a high, moderate, or low priority. (NOTE: When determining priority level, assess each service relative to all other services.)

Service	Sufficient Capacity	Insufficient or Unavailable		
		High Priority	Moderate Priority	Low Priority
1. Medically Managed Detoxification	X			
2. Medically Supervised Withdrawal Inpatient	X			
3. Medically Supervised Withdrawal Outpatient		X		
4. Medically Monitored Withdrawal		X		
5. Inpatient Rehabilitation Treatment	X			
6. Outpatient Treatment (non-opioid)	X			
7. Opioid Treatment		X		
8. Intensive Residential Treatment	X			
9. Community Residential Treatment		X		
10. Supportive Living Facility				X
11. Primary Prevention		X		
12. Prevention Counseling		X		
13. Housing		X		
14. Recovery Supports		X		

4. Access to Services by Population Group: For each population group listed below, indicate the extent to which you believe it has access to needed services. If you indicate that access is insufficient, indicate whether filling the service gap for that population is a high, moderate, or low priority, and identify the services that are lacking for that population within your county or region. (NOTE: When determining priority level, assess each service relative to all other services.)

Population Group	Sufficient Access	Insufficient Access			Services that are Lacking
		High Priority	Moderate Priority	Low Priority	
1. General Population Opioid and other Medication assisted treatment options; IP and OP withdrawal options for opiates		X			Opioid and other medication assisted treatment options; IP and OP withdrawal options for opiates
2. Men same as above and Perm supportive housing		X			Same as above and Perm supportive housing
3. Women Perm supportive housing; specialized OP treatment		X			Perm supportive housing; specialized OP treatment
4. Women with Children Perm supportive housing		X			Perm supportive housing
5. Adolescents (under age 18) More intensive OP services, IP specialized treatment tracks		X			More intensive OP services; IP specialized Treatment tracks
6. Young Adults (age 18 to 24) Perm supportive housing		X			Perm supportive housing
7. Seniors (60+) more intensive levels for seniors			X		More intensive levels for seniors
8. Persons with Co-occurring Disorders Care that is fully integrated			X		Care that is more fully integrated
9. Veterans Outreach		X			Outreach
10. LGBT "cultural competency" in services		X			Cultural Competency in services
11. Other (specify): Family Services		X			Specialized services for families impacted by addiction
12. Other (specify): Recovery Supports		X			Recovery Community Supports

5. Barriers to Accessing Treatment: How significant would you say each of the following barriers to treatment are for the residents in your county?

Barriers to Treatment	Significant Barrier	Moderate Barrier	Minor Barrier	Not a Barrier
1. Not enough service capacity in county		X		
2. Appropriate services not available in county			X	
3. Waiting time to get admitted to treatment	X			
4. Individuals not being referred to treatment		X		
5. Insufficient case management/care coordination	X			
6. Lack of insurance coverage	X			
7. Insurance/managed care restrictions	X			
8. Restrictive government regulations/policies	X			
9. Insufficient childcare services		X		
10. Insufficient transportation services		X		
11. Insufficient culturally competent clinical staff		X		
12. Stigma, cultural/language barriers		X		
13. Other (specify): insufficient knowledge to navigate treatment system		X		

The following question pertains to the OMH State psychiatric inpatient transformation and Regional Centers of Excellence. All questions regarding this question should be directed to Jeremy Darman at 518-474-4403 or at Jeremy.Darman@omh.ny.gov

6. Local needs to support State psychiatric inpatient transformation and Regional Centers of Excellence: What types of services and/or supports does your locality need to assist in reducing avoidable admissions and reduce length of stay in inpatient psychiatric facilities (Article 28, 31, and State-operated)?

Crisis Residence-Adult Waiver Services for Children Respite Services for Children.

Mental Hygiene Priority Outcomes Form

Albany County Dept. of Mental Health (70520)

Plan Year: 2015

Priority Outcome 1: Maximize and or develop safe and affordable housing opportunities across the Mental Hygiene System (Mental Health, Chemical Dependency and Developmental Disabilities) to address unmet need across the age continuum.

OASAS; OMH; OPWDD

Priority Rank: 2

OASAS Priority Focus Area: Service Capacity Expansion; Sub-Focus Area: Housing.

OMH Priority Focus Area: Service Capacity Expansion/Add New Service

OPWDD Priority Focus Area: Housing; Sub-Focus Area: Supported Housing.

Rationale: For many years, planning stakeholders in Albany County have identified the need for safe, affordable housing and the importance of developing and/or redesigning a comprehensive continuum of housing and residential opportunities for individuals across the three disability areas. OMH, OASAS and OPWDD, continue to offer counties and providers opportunities to develop new housing options and/or to redesign current housing to support emerging needs (i.e. individuals leaving psychiatric hospitals, DD facilities; individuals completing residential treatment; those needing housing following 24/7 residential housing). While some strategies were achieved in 2012, 2013, and 2014, Albany County's plan and subsequent strategies will continue to reflect how housing opportunities, for individuals across the mental hygiene system, can be expanded and/or redesigned to be less restrictive, support recovery, and foster independence in the community in which they reside.

Strategy 1.1: OPWDD

Reallocate existing resources to add, or develop new resources whenever possible, to increase the number of opportunities for individuals with Developmental Disabilities requesting Out-of-Home Residential placements within the next 3 years.

Metric 1.1:

- Encourage the development of up to 32 Individual Residential Alternative Supervised and/or Supportive Housing opportunities for individuals ages 9-21 years to address unmet needs;
- Encourage the development of 132 residential opportunities for individuals ages 18-64 years;
- Convene two (2) DD stakeholder planning meetings to explore the development of a fuller spectrum of residential support options for individuals with DD to fill the gap between 24/7 residential support and complete independence.

Strategy 1.2: OASAS

Develop Permanent Supportive housing units for “high need- high risk” individuals leaving and/or completing Chemical Dependency treatment.

2014 Update: MRT Permanent Supportive housing is now available, through an RFP. Two OASAS providers have submitted a joint application proposing 20 Permanent Supportive Apartments for Women.

Metric 1.2:

Add 10 Supportive housing units over the next 3 years.

Strategy 1.3: OASAS

Establish a Supportive Housing Program for Youth-in-transition (18-25 years) who require housing and support following their completion of intensive residential CD treatment.

Metric 1.3:

- Add 10 supportive housing units over next 3 years.

Strategy 1.4 OASAS

Work with community of providers to develop permanent supportive housing for men and women that is safe, affordable and is operated utilizing recovery oriented system of care concepts.

Strategy 1.5: OMH

Reconfigure existing MH community residence resources to develop a single site, residential program for youth –in –transition (ages 18-25 years).

Metric 1.5:

- Establish a residence with 6-8 beds/units over the next 3 years.

Strategy 1.6: OMH

Fully Implement a Mental Health “adult home-like” program for seniors and other individuals in need of this service.

2014 Progress: This strategy has been achieved. 10 beds are operational and at 100% capacity.

Strategy 1.7: OMH

Fully Implement a MH community residence/SRO facility.

Metric 1.7:

- A residence with up to 50 beds will become operational over the next 3 years.

Strategy 1.8: OMH

Explore enhancement of transitional youth housing to include wrap-around mental health services.

Strategy 1.9: OMH

Add Supportive Housing beds for patients (high need/high use of services) expected to be treated and or monitored by the Capital Region Health Home.

2014 Update: This strategy has been achieved. 10 Supportive housing beds became operational in 2013-2014.

Strategy 1.10 OMH (New)

Establish additional MRT beds with “enhanced services” for individuals discharged from institutional settings. RFP to be released in 2014 and provider selected for project. Number of beds needed: to be determined.

Priority Outcome 2: Albany County will maintain current services and enhance/increase treatment access/capacity where gaps have been identified across the Mental Hygiene System (Mental Health, Chemical Dependency and Developmental Disabilities).

OASAS; OMH; OPWDD

Priority Rank: 4

OASAS Priority Focus Area: Service Capacity Expansion; Sub-Focus Areas: Opioid Treatment; Community Residential Treatment; Other (specify): RRSY; Outpatient Services to rural parts of Albany County.

OMH Priority Focus Area: Service Capacity Expansion/Add New Service

OPWDD Priority Focus Area: Relationship Development and Community Supports; Sub-Focus Areas: Family Support Services; Community Habilitation; Clinical Workforce.

Rationale: During these fiscally challenging times, it has become more and more challenging to continue to provide the range of behavioral health services to those most in need; however, Albany County is committed to being responsive to our residents with disabilities. While service capacity has remained somewhat stagnant, and in some instances has been reduced or eliminated, demand for services continues to exceed existing capacity in most all domains of local behavioral health services. As in past years, we continue to collaborate and plan with individuals with disabilities and their families, the Albany County Community Services Board and it’s three Subcommittees, and our community partners to identify and provide the full range of supports and services to those most in need. The following strategies highlight either already planned capacity increases as well as those areas of need that the planning stakeholders have identified as a critical need. Finally, consistent with the mission of the state agencies, Albany County has identified strategies that explore ways to enhance

community based services and supports as well as developing peer/recovery models that support recovery and wellness in the community.

2013 Update-While Strategy 2.2 reflects our strategies and metrics to increase and enhance access to treatment for Opiates in Albany County, Priority 7 reflects the use/misuse of prescription opiates, the increase in illicit use and addiction in our community as well as the high incidence of opiate overdose as an “emerging behavioral health issue” requiring additional community based interventions.

2014 Update: In 2012 and 2013, the idea of new funding/new opportunities for new and enhanced services seemed unlikely. This year NYS is realizing MRT savings and the value and importance that Behavioral Health treatment. The issue of opiate addiction and the “opiate epidemic” are now being identified as a “public health issue” and is receiving significant attention at the national, state and local levels. As the result, new bills are being proposed that could potentially provide new funding opportunities for prevention, treatment and recovery services. In addition, as our system moves to a managed care model, MRT savings are realized and systems and services transform under the new health care models, opportunities for behavioral Health providers to partner and participate in initiatives like DSRIP, health homes and residential redesign, are becoming increasingly more available. Albany County will continue to encourage any provider participation that can result in enhanced/increased treatment access/capacity where gaps have been identified across the Mental Hygiene System.

Strategy 2.1: OPWDD

Enhance Developmental Disability (DD) community based services/supports for persons with DD and their families.

Metric 2.1:

- Convene two (2) Developmental Disability stakeholder planning meetings to assess the local need for the development and or expansion of habilitative (respite, supported employment, recreational, etc.) clinical and behavioral supports for persons with Developmental Disabilities.

Strategy 2.2: OASAS

Increase and enhance access, capacity and treatment options for individuals addicted to Opiates over the next 3 years.

2014 Update: The LGU collaborated with Albany County Department of Health, hospital and community stakeholders to develop the 2014-2017 Prevention Agenda and identified prevention agenda focus areas and goals related to the *Promote Mental Health and Prevent Substance Abuse Focus Area*. This strategy aligns with the goal developed as a part of the 2014-2017 Community Health Improvement Plan (CHIP- see attached). Where possible, the LGU will align planning efforts, strategies and tactics to address this issue.

In addition to the CHIP, significant progress was made in 2013- 2014 to increase access and treatment resources for those addicted to Opiates. Metrics have been updated and adjusted accordingly.

Metric 2.2:

- Establish a new 822.5 service (MMTP) within the next 3 years;
- Review and approve 1-2 new MMTP treatment service applications.
2014 Update: AC has met with one provider who will be submitting an 822.5 application in 2014.
- Add 100-400 new MMTP opportunities (slots);
- Encourage 822.4 OPC providers to replicate the co-location model, i.e. Establish 822.4 OPC satellites within a physical health care provider setting that utilize addiction medicine (Suboxone and/or Vivitrol); Encourage the development of ancillary outpatient withdrawal services; 1-2 822.4 OPC providers will add this service over the next 2 years;
- Five (5) CD Providers will become “Vivitrol Ready” in 2013-2014.
2014 Update: 3 CD providers became Vivitrol ready in 2013-2014; in 2014-2015 these 3 CD providers will fully implement the use of Vivitrol, for appropriate patients, within the treatment milieu.
- Increase the number of individuals referred to non-substance abuse treatment services and low-threshold services (such as syringe exchange, treatment readiness, and harm reduction counseling) by substance abuse treatment providers by 25%.

Strategy 2.3: OASAS

Increase OASAS Certified Community Residential (Re-integration) services for men and women in Albany County.

2014 Update: While there are plans underway for two providers to add Community Residential beds in Albany County, the OASAS Residential Redesign Initiative will require the LGU, in collaboration with local Residential providers, to assess the need for the “re-integration” phase of treatment for all populations needing such service.

Metric 2.3:

- Work with providers and OASAS as well as other stakeholders, to determine service need for the “re-integration” phase of treatment.

Strategy 2.4: OASAS

Increase the number of OASAS Certified Residential Rehabilitation Services for Youth ages 12-21 years.

2014 Update: This strategy and related metric will be accomplished by September 2014.

Metric 2.4:

- Add 20 OASAS Certified Residential Rehabilitation Beds for Youth over the next 3 years.

Strategy 2.5: OMH

Increase Mental Health Outpatient Clinic treatment capacity across the age continuum.

2014 Update: Mental Health Outpatient Clinic services continues to be a need in Albany County. Services for youth, particularly those aging out of the children’s mental health system and entering the adult mental health system, continues to be a focus of this strategy. In 2013, the Albany County Dept. of Children Youth and Families convened a children’s mental health provider network meeting to review the needs of the community, how referrals are being handled, and if there is any wait list and capacity at the local Outpatient Clinic level.

Metric 2.5:

- Add up to 40 new treatment opportunities (slots) at ACDMH’s Children’s Clinic.
2014 Update: This metric was achieved and exceeded target.
- Review 1-2 PAR applications and further determine need and capacity for youth needing mental health treatment.
2014 Update: Achieved. Two PAR’s were reviewed and approved.
- Fully implement newly approved OMH Outpatient Clinic for adolescents.
2014 Update: Two clinics opened; one closed within 6 months and the second has opened and is building capacity.
- Encourage the development of new Mental Health OPC’s for adults in Albany County; review and approve 1-2 new PAR applications over the next 3 years.
2014 Update: Two PAR’s have been reviewed and approved.
- Fully implement newly proposed Outpatient Clinic (100 slot capacity).
2014 Update: New OMH clinic has opened and is building capacity.

Strategy 2.6: OMH

Build upon existing peer support services that address the needs of individuals who may not benefit from PRO’s and /or need additional supports in the community.

2014 Update: Peer services in this area continues to be a need. However, this year, 2 peer-based services are providing increased meaningful activities during the day.

Strategy 2.7 OMH/OASAS (New)

Develop services in rural parts of Albany County to address emerging needs (e.g. Hill towns; Ravena/Coeymans).

The Department of Children Youth and Families in conjunction with Bern Knox Westerlo school district and several providers (St. Catherine’s and Berkshire Farms) have developed outreach and clinical prevention services to meet the needs of children and youth in this community while simultaneously continuing to assess the on-going needs of the community including assessing the need for mental health clinic services. Ravena continues to be an area of identified need for a structured program / afterschool programming for youth. The need for mental health and addiction services for adults in these communities has been a long standing need requiring further assessment.

Metric 2.7:

- Meet with community leaders and perform quantitative/qualitative needs assessment.

Priority Outcome 3: Enhance the quality of screening, treatment and care to persons across the Mental Hygiene System (Mental Health, Chemical Dependency and Developmental Disabilities)

OASAS; OMH; OPWDD

Priority Rank: Unranked

*OASAS Priority Focus Area: Service Improvement/Enhancement; Sub-Focus Areas: Implement/Expand Best/Promising Practices; Implement/Expand Recovery Supports; Train Workforce.
OMH Priority Focus Area: Service Improvement/Enhancement*

Rationale: Workforce development, cross-systems collaboration and cross-system training provides opportunities for skill development, employment retention and positive systemic changes that can enhance treatment and improve outcomes to individuals served across multiples systems of care. As the behavioral health field faces significant changes and transformation in the years ahead, the need to collaborate and work together is more critical than ever before. The following strategies, identified by planning stakeholders, target some specific trainings/cross-system training initiatives to be delivered during this planning cycle.

Strategy 3.1: OASAS, OMH

Increase the number of clinical staff who has been trained in integrated treatment for co-occurring Mental Health and Chemical Dependency Disorders.

2014 Update: A percentage of staff have been trained and this training is ongoing.

Metric 3.1:

- The number of CD and MH clinical staff trained through the Focus on Integrated Treatment (FIT) modules will increase by 20% a year over the next 3 years.
- Encourage staff in MH and CD programs to obtain the integrated MH/Addiction Treatment training certificate (completing 31 FIT treatment modules); Identify and recognize staff who obtain this certificate.

Strategy 3.2: OASAS, OMH

Encourage System-wide training in trauma informed care e.g. ACES Training.

Metric: 3.2:

- Continue to take advantage of community trainings (e.g. U Albany School of Social Welfare and OASAS trainings)
- Explore Jail Mental Health training opportunities.

Strategy 3.3: OASAS, OMH

Encourage the use of Screening, Brief Intervention and Referral to Treatment (SBIRT).

2014 Update: SBIRT training, was delivered to local law enforcement this year (Albany Police Dept. and the Albany County Sheriff's department). In addition, this strategy is addressed in the 2014-2017 CHIP, with the plan to train health professionals in SBIRT techniques.

Strategy 3.4: OMH

Mental Health Case Managers will receive specialized, evidence-based training, including the treatment of COD, to enhance their expertise to deliver care coordination services through the Health Home model.

2014 Update: Training has occurred and is ongoing.

Metric 3.4:

- ACDMH will collaborate with the Health Home lead agency and other impacted community providers to re-tool and re-train 100% of Albany County OMH case managers over the next 3 years.

Strategy 3.5 OMH (New)

ACDMH in collaboration with the Albany County Sheriff, Albany County Department of Probation, Albany County Executive and NYS OMH, DCJS, DOCCS will develop and implement enhanced Jail Mental Health practices to include the use of screening tools, evidence-based treatment and community re-integration practices.

Priority Outcome 4: Enhance Crisis Services across the Mental Hygiene System (Mental Health, Chemical Dependency and Developmental Disabilities)

OASAS; OMH; OPWDD

Priority Rank: 3

OASAS Priority Focus Area: Service Improvement/Enhancement; Sub-Focus Areas: Implement/Expand Best/Promising Practices; Implement/Expand Recovery Supports; Train Workforce.

OMH Priority Focus Area: Service Improvement/Enhancement

OPWDD Priority Focus Area: Health; Sub-Focus Area: Crisis Intervention.

Rationale: For many years, and reflected in past plans, Albany County stakeholders have recognized the central importance of a crisis system that is responsive to the increasing prevalence of co-occurring behavioral health conditions (i.e. mental health and chemical dependency; mental health and Developmental Disabilities). In previous years, significant gains and enhancements were made to the children's crisis system (e.g. Capital Region Child and Adolescent Mobile Team, designed to respond to children and adolescents in crisis across the disability areas). In 2012, there was renewed focus on adults due to systemic changes in the crisis service system. ACDMH's CART/Mobile Crisis Team was re-configured and the Chemical Dependence Crisis Center was

defunded, resulting in its closure. Planning stakeholders continue to identify the need to more effectively address and respond to the increased prevalence of behavioral health crises as well as addressing current gaps resulting from the loss of crisis services in the county. The following strategies reflect how we intend to address this priority over the next 3 years.

2014 Update: For the OASAS crisis service system in particular, this year, new potential treatment models are emerging under the Residential Re-design Initiative. Planning for these services, i.e. Stabilization Services will be an important role and focus for the LGU to ensure that these services are offered in Albany County.

NY START (Systematic, Therapeutic, Assessment, Respite and Treatment), a new initiative at OPWDD to address the need for available community-based crisis prevention and intervention services for individuals with intellectual/developmental disabilities (I/DD) and co-occurring mental health (MH) and behavioral health needs is an evidence-informed mental health system for crisis prevention and intervention for I/DD individuals. START program will help individuals with these complex service needs obtain adequate treatment options when they need them most in the least restrictive setting possible. START outcomes include: The reduction in inpatient and emergency services use; for traditional MH providers to become more willing to serve individuals with I/DD; for cross systems planning to become a core service element; and START has been shown to be cost effective. Two additional strategies were added this year to reflect these system changes.

Strategy 4.1: OASAS, OMH, OPWDD

Improve coordination and collaboration among law enforcement and crisis/emergency services; improve linkages to appropriate treatment services from crisis/emergency services.

Metric 4.1:

- Train 20-25 Albany Police Department Community officers in Crisis Intervention Training (CIT) annually;
- Explore providing CIT training to additional law enforcement including corrections;
Continue to encourage Law Enforcement and E.R. personnel to collaborate on the Opiate Overdose Prevention Initiative (see Priority 7).

Strategy 4.2: OASAS, OMH

Develop an innovative/alternative peer recovery support model that compliments existing crisis services.

Metric 4.2:

- Inventory all existing peer and recovery coach resources in Albany County including hospital diversion opportunities.
- Encourage local hospitals and ERs/EDs/detox units to add and/or broaden the roles of peers and recovery coaches in their facilities;
- Explore innovative peer/recovery support models elsewhere across the State;
- Explore training opportunities for enhancing existing, and developing new, peer and recovery resources locally;

- Explore grant opportunities for training, innovative initiatives and partnerships.

Strategy 4.3: OMH

Encourage the development of a Mental Health Crisis Residence for adults of all ages.

2014 Update: Three (3) proposals have been submitted to NYS OMH and are under review.

Metric: 4.3:

- ACDMH will continue to meet with CDPC, leaders in peer support and other community stakeholders.

Strategy 4.4: OMH

Improve coordination between Emergency Rooms/ Departments and CDPC Crisis Unit.

Metric 4.4:

ACDMH will convene a meeting/workgroup of local hospital ER/ED representatives, including OMH representatives to develop improved model of coordinated crisis care.

Strategy 4.5: OMH

Cultivate an array of respite across the age continuum to complement existing crisis services.

2014 Update: Achieved: An RFP was issued and awarded. An array of respite services, including respite services for SED children and individual mentoring services that offer monthly family engagement gatherings are now available.

Strategy 4.6 OASAS (New)

Albany County Residential Providers will work with the LGU to ensure that the Crisis/Stabilization phase of treatment, per the OASAS Residential Re-design initiative, is added to existing residential services in a sufficient capacity to meet the needs of Albany County Residents in need of this service.

Strategy 4.7 OPWDD (New)

Collaborate with the Capital District DDRO to implement **START** (Systemic, Therapeutic, Assessment, Respite and Treatment) services and integrate those services with other community crisis service providers in Albany County.

Priority Outcome 5: Peer Services, Advocacy Councils and Recovery Coaches will be more fully integrated into a continuum of mental hygiene services in order to better promote wellness and recovery.

OASAS; OMH; OPWDD

Priority Rank: Unranked

OASAS Priority Focus Area: Service Coordination/Integration; Sub-Focus Areas: Coordinate Care with Recovery Support Services; Coordinate Care with Other Service Systems; Integrate Care with Recovery; Support Services; Integrate Care with Other Service Systems; Other (specify): Recovery to Practice Training
OMH Priority Focus Area: Workforce Development

OPWDD Priority Focus Area: Relationship Development and Community Supports; Sub-Focus Areas: Family Support Services; Other (specify): Advocacy/peers

Rationale: Peer, family/individual and recovery supports are all themes that can be found as core values across all three of NYS's Mental Hygiene Strategic Plans. According to SAMSHA, recovery support is "partnering with people in recovery from mental health and substance use disorders to guide the behavioral health system and promote individual, program and system level approaches that foster health and resilience; increase permanent housing, employment, education and other necessary supports; and reduce barriers to social isolation". For people with developmental disabilities, person-centered care, personal choice, increased family and individual supports as well as meaningful relationships are all values and services highlighted in OPWDD's People First Waiver. These support services will be delivered based on the unique identified needs of each individual, regardless of their setting, resulting in better personal outcomes. ACDMH recognizes the value of these "natural supports" to people served in our system and will assume a leadership role in planning and supporting for greater integration of these services across the mental hygiene system (see Priority 4- Peers and crisis services).

2014 Update: Last year's 2013 Recovery Oriented System of Care (ROSC) provider survey revealed a CD provider system that is in the very early stages of integrating the ROSC concepts. Most providers identified the need for more information and education regarding the elements of a Recovery Oriented System of Care. In order to successfully integrate peers/recovery coaches into the continuum of care in Albany County, ROSC trainings will be encouraged and supported. A new strategy will address this need.

With regards to the integration of peers in addiction programs, some progress has been made. This year, The Addictions Care Center of Albany was awarded a Recovery to Practice Mini-Grant to develop and implement an innovative peer services model. They have established a Recovery Coach Academy; trained 20 alumni/staff to become certified peer advocates in phase one, and in phase two, recovery coaches will be integrated into the later stage of outpatient treatment services and will provide recovery supports at discharge and beyond.

Recovery Coach training is also being provided as a part of the same grant, to alumni/staff of the three Albany County Drug Court programs. There are plans underway to integrate Recovery Coaches/Peers into the Drug court model. Integrating peer support services across the behavioral health continuum remains a priority for Albany County.

Finally, this year, Mental Health funds have been re-allocated to two peer run agencies to work in collaboration with local health homes to provide peer support to health home recipient's previously known as ICM recipients.

Strategy 5.1: OASAS, OMH, OPWDD

Engage leaders in the local peer community in a focused planning efforts to detail available resources, identify evidence-based practices, explore regional collaboration opportunities and continue to build local partnerships with peer and recovery advocacy organizations (e.g. Friends of Recovery New York; Young People in Recovery etc.)

Strategy 5.2 OASAS (New)

The LGU will encourage and support Recovery to Practice trainings for all CD providers in Albany County to increase awareness, acceptance, and adoption of recovery-based practices in the delivery of addiction-related services.

Providers will be encouraged to utilize professional associations that have received Recovery to Practice Initiative awards (e.g. NAADAC: has developed a national recovery-oriented training curriculum that is intended to educate addiction professionals about a recovery-oriented model of care; educate addiction professionals about addiction recovery (and their specific role in promoting it); and teaches competencies needed to integrate addiction recovery concepts into practice.

Priority Outcome 6: Develop and/or enhance access to treatment services for special populations across the Mental Hygiene system.

OASAS; OMH

Priority Rank: Unranked

OASAS Priority Focus Area: Service Capacity Expansion; Sub-Focus Area: Services for a Target Population (specify population):

OMH Priority Focus Area: Service Improvement/Enhancement

Rationale: Albany County has and continues to recognize the unique needs of special populations across disability areas. Historically, the development of CD and MH treatment services for special populations has been encouraged resulting in the development and implementation of specialized CD treatment services for seniors, women, women with children, as well as enhanced crisis services for children and adolescents who are experiencing severe mental hygiene related crises.

Planning stakeholders continue to identify youth-in-transition, and Veterans as those populations also needing specialized Mental Health/Chemical Dependency services. Our systems do not allow for easy or successful transitions for youth who are aging out of the adolescent MH or CD treatment systems. Many Veterans from past wars as well as those returning from more recent conflicts often struggle with addiction,

mental health disorders and at times homelessness. In addition to these special populations, many planning stakeholders as well as the general community are becoming increasingly concerned about the potential rise in problem and compulsive gambling that may result from a Las Vegas type Casino being located in the Capital Region.

2014 Progress: Strategy 6.2 was achieved this year. Camino Nuevo, a new OASAS 822.4 Outpatient Clinic, became operational in March of 2014. This clinic, operated by PROMESA, is a specialized clinic for Hispanics and Latinos. The program is building their census.

Strategy 6.1: OASAS

Continue to develop and build local partnerships with veteran/military groups (e.g. Army National Guard) to assess and be responsive to behavioral health needs. The LGU and CD Providers as well as other stakeholders will continue to assess if additional specialty services are needed for veterans in Albany County. CD providers will develop a referral relationship with the NY Army National Guard Substance Abuse Program. The Substance Abuse Coordinator for the Army National Guard has been invited and will attend the monthly CD Provider/Planning meeting hosted by ACDMH.

Strategy 6.2: OMH

Develop “Re-entry” process for youth being discharged from OCFS facilities that identifies appropriate timeframes for linking and establishing Mental Health Services in the Community.

2014 Update: Monthly meetings are occurring with a number of stakeholders and progress is being made with pre-discharge service planning for youth. These meetings have increased communication, planning and overall knowledge of clinical needs, diagnosis and medication of youth being released. A barrier regarding discharge timeline regarding those youth that might need to be released immediately due to court orders, sentencing expired, etc. is still a concern for preplanning.

Metric 6.2:

- ACDMH’s Youth-in-Transition Task Force will continue to meet monthly with OCFS and OMH stakeholders.

Strategy 6.3: OMH

Continue to develop partnerships with local providers of behavioral health who serve seniors.

Strategy 6.4 OASAS (New)

The LGU, treatment and community stakeholders will monitor the need for additional problem gambling prevention and treatment services in Albany County.

Priority Outcome 7: Develop Community-wide interventions that include education, prevention and treatment efforts to address emerging behavioral health conditions.

OASAS; OMH; OPWDD

Priority Rank: 5

OASAS Priority Focus Area: Service Improvement/Enhancement; Sub-Focus Areas: Implement/Expand Best/Promising Practices; Train Workforce.

OMH Priority Focus Area: Service Improvement/Enhancement

OPWDD Priority Focus Area: Infrastructure; Sub-Focus Areas: Communications; Other (specify): Planning

Rationale: Several “emerging” behavioral health conditions as well as circumstances that impact youth and adults receiving and/ or in need of behavioral health services, continue to be concerns in our community requiring strategies at the local level. Opioid Overdoses and the increased use/ misuse of prescription opiates and the increase in the incidence of Heroin addiction have been on the rise for several years. The CDC reports that drug overdose deaths increased for the 11th consecutive year in 2010. In 60% of the drug overdose deaths, pharmaceutical drugs were involved. Opioid analgesics, such as oxycodone, hydrocodone as well as other opioid pain medications were involved in 3 of every 4 pharmaceutical overdose deaths, confirming the predominant role opioid analgesics play in drug overdose deaths. This year we consulted with our county coroner for the first time to obtain data regarding accidental overdoses and suicides where poly pharmaceuticals were involved. According to the data, in 2012, there were 27 deaths in Albany County where drugs were involved; 16 deaths were determined to be “Accidental Poly-pharmaceutical Overdoses” and 11 were determined to be “Suicides”. The preliminary data indicates that “drugs involved in these cases” included: multiple types of pharmaceutical opiate analgesics, heroin, methadone, benzodiazepines/other sedative hypnotics, cocaine and Ketamine. We are currently working with the county coroner to “drill down” the data in these cases. While the number of deaths related to opiates and other drugs is alarming, the treatment admissions to our Albany County CD programs where heroin and other opiate analgesics were the primary drug reported at admission has been increasing at epidemic rates in the last decade. In 2003, 5.6% of the CD treatment program admissions in Albany County reported heroin and other opiates as the primary drug at admission.

For patients in treatment in our Albany County CD programs as of April 2013, 35.6 %, or a reported heroin and other opiate analgesics as their primary drug at admission (a 700% increase since 2003; see attached report). Alcohol remains the primary substance of abuse reported at admission, with heroin and other opiates now second. More specifically, we are seeing a rise to in prescription drug misuse/abuse in our youth. In our county’s residential adolescent program, over 50% of the youth ages 12-21 reported opiates as their primary, secondary or tertiary drug at admission.

Marijuana remains the primary drug at admission at 80% and 70% reported alcohol as their primary secondary substance at admission. Underage drinking and drug use/abuse remains a focus for our prevention providers and local law enforcement. The 2010 Youth Risk Behavior Survey for Albany County revealed that 47% of H.S.

seniors drank alcohol in the past 30 days; 25% reported binge drinking in the last 2 weeks; 12% of the seniors had abused prescription pain medications and 13% of all youths in grades 7-12 reported smoking marijuana in the past 30 days. According to the Department of Health and Human Services, about 10% of 12 year olds say they have tried alcohol, but by age 15, that number jumps to 50%. Almost half of the cigarettes smoked in the United States are smoked by people with serious mental illness and substance use disorders. People in these groups are dying earlier than the general population, often as a result of tobacco use. There is no doubt that reducing and quitting smoking results in tremendous improvements in overall health. Mental health providers can and should provide these services to people who need it.

Preventing Suicide, reducing stigma and training staff to address the issue of suicide in our community continues to be an area where local actions are required. Finally, this year we witnessed the devastating effect that natural disasters can have on our service delivery systems. The State and counties have been charged with developing emergency management and disaster response plans in the event behavioral health services are impacted by natural disasters or traumatic events. Local planning is occurring consistent with these initiatives. The following strategies reflect how we intend to address these issues. Any progress made thus far is reported as a 2014 strategy “update”.

Strategy 7.1: OASAS

Explore the development of a local task force and or other strategies to address prescription opiate misuse/abuse, the increased incidence of illicit opiate use/addiction and high rates of death as the result of opiates overdoses.

2014 Update: Albany County Dept. of Mental Health participates on the CHIP Behavioral Health Task Force, which was developed to implement the 2013-2017 NYS Prevention Agenda’s Community Health Improvement Plan. The submitted and approved plan includes the goal and respective “tactics” to reduce the use/abuse of opiates (illicit and legal). In addition, County government is developing a Task Force to address this issue in Albany County.

Strategy 7.2: OASAS

Collaborate with the Albany County Health Department, Catholic Charities Overdose Prevention Program, AMCH, the Regional Underage Drinking and Drug Use Prevention Coalition, local CD providers, law enforcement and medical personnel to increase the number of individuals trained in Opioid Overdose Prevention to reduce/reverse opioid overdoses in Albany County.

2014 Update/Progress: With the recent attention to this issue and countless community deaths as the result of opiate overdose, opiate overdose trainings delivered last year has far exceeded metric expectations. The county will continue to support all overdose prevention efforts within the community and will collaborate with the Albany County Health Department to host Overdose Prevention trainings to the community 6-12 times annually.

In early 2014, CD Providers and local law enforcement partnered with the School of Pharmacy and hosted a community forum on Heroin and prescription opiates. The forum included education, overdose prevention training and resources for the community. There are plans to hold a follow-up forum to educate the community about available resources (prevention and treatment) to address Opioid dependence. These efforts will continue and be supported by ACDMH.

Strategy 7.3: OASAS

Reduce underage drinking, illicit drug use and medication misuse/abuse among youth in Albany County.

2014 Update/Progress: The Regional Underage Drinking and Drug Use Prevention Coalition continue to meet regularly to plan and deliver evidence based environmental strategies. New partnerships are developing to educate the community about underage drinking/illicit drug use (i.e. Beacon of Hope/Choices 301) and these partnerships should continue to be encouraged. Two Town Hall meetings/community forums were facilitated in Albany County and plans are underway to host town hall meetings in 2015. Finally, the Addiction Care Center, on behalf of the Underage Drinking Coalition applied for a Drug Free Schools grant and if funded, will provide resources to increase prevention efforts in Albany County. This year a new Youth Development Survey is being conducted in Albany County. The LGU will work with OASAS and contracted Prevention providers to assess the survey results and plan accordingly.

Strategy 7.4: OASAS, OMH, OPWDD

Improve Emergency Preparedness and Disaster Mental Health Planning across the Mental Hygiene System.

2014 Update: Metrics related to this strategy have been achieved.

Metric 7.4:

- In collaboration with the OASAS, OMH and OPWDD the LGU will require all providers to develop emergency management plans by 12/13. Providers with residential programs will need to include the NYS Evacuation of Facilities in Disasters System (NYS e-FINDS) emergency patient tracking system in their plan by the 2013 Hurricane season;
2014 Update: All contracted providers are now required per the contract, to have emergency management plans.
- **ACDMH** will work with the County's Emergency Management Unit to identify and train a designated team of county Disaster Mental Health responders that could be called on to assist the public following a disaster or traumatic event- by 12/13.
2014 Update: ACDMH now has a Disaster Mental Health Team. All members completed training in early 2014.

Strategy 7.5: OMH

The LGU will collaborate with Albany County Dept. of Health, OMH and Mental Health providers to explore and implement evidence based interventions to reduce tobacco use in persons with Mental Illness.

2014 Update: ACDMH has started to integrate tobacco free programming in their mental health clinic which includes, assessment, treatment interventions including the smoking cessation program, to reduce tobacco use in persons with mental illness. Additionally, ACDMH is leading the Tobacco Free initiative in partnership with other mental health providers in the Capital District. Several MH clinics in the Capital District have pledged to become tobacco-free.

Metric 7.5

- All new patients at the ACDMH Clinic will be assessed for tobacco use and where indicated, will be linked to a clinical intervention.
- In 2014/2015 the Department of Mental Health inclusive of the children's clinic and providers will focus attention on prevention measure for adolescents discouraging smoking and resources to assist youth and their parents to quit smoking.

Strategy 7.6: OASAS, OMH

The LGU will work in collaboration with OMH and the Suicide Prevention Center of NY to advance local actions to reduce suicide attempts and suicide (across the age continuum) in Albany County and promote the recovery of persons affected by suicide.

2014 Progress/Update: The SPEC committee continues to meet on a regular basis. Additionally, Children's Mental Health staff has connected with all local school districts to be a resource for information and materials regarding suicide prevention, warning signs and school response. Children's mental health staff has responded to schools that have concerns and/or a student (s) with suicidal incident. Children's mental health has worked with OMH to provide community, providers and schools with the ASIST training. Finally, Albany County has submitted a Suicide Prevention mini-grant application to develop suicide prevention "App" for mobile devices.

Metric 7.6:

- Convene 1-2 joint MH/CD Planning meetings to explore expanding the role of the Suicide Prevention and Education Committee (SPEC) to provide community education, encourage training for all behavioral health providers and to consider developing an Albany County post-vention response team.

Strategy 7.7 OASAS (New)

Albany County Providers will partner with local government to host a follow up community forum on Heroin and Opioid Abuse in late 2014 or early 2015. The goal of the forum will be to provide an overview of the community resources; i.e. prevention and treatment available in Albany County.

Priority Outcome 8: Establish a county-level “System of Care” Developmental Disabilities Provider and Planning Committee.

OPWDD

Priority Rank: Unranked

OPWDD Priority Focus Area: Infrastructure; Sub-Focus Areas: Communications; Other (specify): Planning

Rationale: While system transformation is occurring across all of the behavioral health disability areas, the Developmental Disabilities (DD) system of care is undergoing significant reform initiatives (i.e. People First Waiver/ 1115 Wavier), designed to improve OPWDD’s delivery of services to meet the needs of persons with developmental disabilities.

This system reform will impact all individuals served by DD system of care, which is by far the largest, and most expensive of the three behavioral health service delivery systems in Albany County. According to the 2012 County Demographic Profile (County Planning System, OPWDD County Data), there are over 2700 persons with Developmental Disabilities, receiving DD services, that reside in Albany County. While the County is responsible for the local planning of DD services for these individuals, ACDMH and the DD Subcommittee agree that a more formal forum for ongoing dialogue with OPWDD/DDSO, and the community providers, will allow for greater collaboration, improved service delivery and a more unified and comprehensive planning process. ACDMH and the DD Subcommittee are committed to assuming a leadership role to promote public understanding in these times of change, and to facilitate interagency collaboration to meet the needs of people with DD.

Strategy 8.1: OPWDD

Engage DD Providers, consumers/families, and OPWDD/DDSO staff in collaboration with ACDMH and the DD Subcommittee in an expanded local planning process to 1) detail the full continuum of existing DD services, across all ages in Albany County; 2) document existing capacity of the services offered and track enrollment rates provided by OPWDD’s county data; 3) assess for unmet service/support needs within Albany County for the DD population based on this data, 4) prepare the community for systemic changes (i.e., *DISCOs, 1115 Waiver, START, The Front Door, etc.) by being informed and proactive in our approach to these changes.

Metric 8.1:

- Convene 4 planning meetings annually;
- Produce an Albany County Developmental Disabilities “Service Needs Profile” by utilizing available county data;
- The DD Subcommittee in collaboration with ACDMH and the OPWDD/DDRO will host 1-2 Town Hall community meetings annually for people with DD, their families, DD providers and all interested stakeholders.
- Maximize collaboration and training opportunities with the local DDRO.

Priority Outcome 9: To prepare behavioral healthcare providers and the community, across all disability areas, for systemic changes that result from Health Care Reform and Medicaid Redesign-New 6/14

OASAS; OMH; OPWDD

Priority Rank: 1

OASAS Priority Focus: Service System Planning/Management; Sub-focus Area(s): Improve System Management/Oversight, Collaborate with BHO/Health Home/Others on Care Management/Oversight

OMH Priority Focus: Service System Planning/Management.

OPWDD Priority Focus: Putting People First; Sub-focus Area(s): Managed Care Transition

Rationale: In 2015, New York State will be a full Managed Care system for all behavioral health services (i.e. Mental Health, Chemical Dependency and Developmental Disabilities). There is concern on the part of the providers, families and consumers on the potential impact on access to services as well as service delivery. Providers will be required to show value in the services that they provide, while demonstrating quality patient care. This performance based model will require providers to track and assess different types of data, review and carefully monitor performance outcomes and patient satisfaction. The Albany County LGU has a local role in maintaining a service delivery system that is accessible and responsive to all consumers and as the result will collaborate on all initiatives that impact local service delivery (i.e. Health Homes, DISCO's, DSRIP, ACO's/MCO's, Residential Re-design, etc.). In addition, the LGU will play an active role in providing ongoing communication, information and support to the provider community as system changes are implemented.

Strategy 9.1 OMH/OASAS/OPWDD

- ACDMH will provide ongoing updates and information on strategies to assist local providers in readiness to change to a fully managed care environment. This will include ongoing in-services/meetings specifically targeted towards managed care readiness and implementation.

Strategy 9.2 OMH/OASAS/OPWDD

- Encourage providers to seek collaborative opportunities to reduce fixed costs and maximize resources that ensure that behavioral health services in Albany County are accessible and responsive to local need.

Strategy 9.3 OMH/OASAS/OPWDD

- ACDMH will actively engage in dialogue with providers, Health Homes, Managed Care Organizations, DISCO's and the State agencies to participate in the planning and implementation of a fully managed behavioral health benefit for Albany County consumers. Through this involvement and participation, ACDMH will demonstrate the value of a locally driven system of care by easing the transitions and assisting our local provider networks to quickly and proactively adapt to changing requirements.

2015 Multiple Disabilities Considerations Form

Albany County Dept. of Mental Health (70520)
Certified: Debra Rhoades (5/20/14)

Consult the LSP Guidelines for additional guidance on completing this form.
LGU: Albany County Dept. of Mental Health (70520)

The term "multiple disabilities" means, in this context, persons who have at least two of the following disabling conditions: a developmental disability, a mental illness, or an addiction. In order to effectively meet the needs of these individuals, several aspects should be addressed in a comprehensive plan for services. Accordingly:

1. Is there a component of the local governmental unit which is responsible for identifying persons with multiple disabilities?

- ✓ Yes
- No

If yes, briefly describe the mechanism used to identify such persons:

The identification of multi-disabled persons, as well as the timely referral and linkage to appropriate services when necessary, remains one of the department's highest priorities. Every component of the local government unit recognizes the importance of assessing for multiple disabilities and the value of coordinated care. The department has a well-established "single point of access" for MH housing, MH case management, and MH clinical services where identification, assessment and referral of multi-disabled individuals takes place. The SPOA allows for a triage system in which the highest priority, highest need individuals are given priority consideration.

In addition, the Central Management Unit (CMU) performs Chemical Dependence assessments and makes referrals for CD treatment as well as screens for other disabilities and makes necessary referrals when indicated.

Albany County Department of Mental Health (ACDMH) also facilitates cross-system; interdepartmental forums for adults and adolescents where "high risk/high need" individuals, most of whom have multiple disabilities, are identified and community interventions are developed.

ACDMH routinely works with providers, state representatives, consumers, and family members, to respond to the needs of individuals in Albany County with multiple disabilities.

ACDMH operates a Mobile Crisis Team (MCT) where crisis workers are available to respond to crisis situations in the community.

ACDMH continues to work with the Albany Police Department to deliver training in the Crisis Intervention Team (CIT) model. In addition, this year, a local CD provider will train Albany Police Officers in SBIRT (Screening Brief Intervention Referral to Treatment) to enhance local law enforcements efforts to identify behavioral health conditions in the community and to appropriately link those individuals to services.

2. Is there a component of the local governmental unit which is responsible for planning of services for persons with multiple disabilities?

- ✓ Yes
- No

If yes, briefly describe the mechanism used in the planning process:

The Albany County Department of Mental Health's Quality Assurance Unit is responsible for planning for services for people with multiple disabilities. Albany County's Planning process continues to evolve and remains consistent with the State's integrated local services plan introduced in 2009. This process allows for multiple cross system planning platforms as well as many opportunities to discuss and resolve cases. One planning initiative, now in its fourth year, is the Albany County Co-occurring Disorders (COD) initiative. Consistent with the State direction, Albany County continues to work to transform its Mental Health and Chemical Dependency system to become "Co-occurring Capable". The ACDMH's QA unit has planned and provided trainings in the area of COD, facilitates annual planning forums regarding COD services and routinely works with providers, state representatives, consumers and families, to better respond to the needs of individuals with co-occurring mental health and substance use disorders. Finally, ACDMH worked closely with the Center for Excellence and Integrated Care (CEIC) to have most of our local OP programs evaluated for COD capability establishing a baseline and recommendations for improvement. Currently, follow up and re-evaluation of progress towards COD capability is planned across our MH and SA programs.

3. Are there mechanisms at the local or county level, either formal or informal in nature, for resolving disputes concerning provider responsibility for serving persons with multiple disabilities?

- ✓ Yes
- No

If yes, describe the process (es), either formal or informal, for resolving disputes at the local or county level and/or at other levels of organization for those persons affected by multiple disabilities:

A county-wide grievance procedure is in place for providers and consumers of MH services. ACDMH continues to operate a department-wide grievance procedure for consumers receiving Mental Health and/or Chemical Dependence services. The department provides an Ombudsman service for its internal services to receive and investigate complaints, reports, findings and helps to achieve equitable settlements.

Lastly, the LGU works whenever possible to facilitate the resolution of disputes informally. With increased opportunity for cross system discussions, there is more willingness and increased opportunity to work with local and state representatives to determine the most appropriate treatment setting for individuals with multiple disabilities.

2015 Community Service Board Roster

Albany County Dept. of Mental Health (70520)

Consult the LSP Guidelines for additional guidance on completing this form.

Note: There must be 15 board members (counties under 100,000 population may opt for a 9-member board). Indicate if member is a licensed physician or certified psychologist. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the particular community interest being represented. Members shall serve four-year staggered terms.

Chairperson

Name E. Nancy Wiley
Physician No
Psychologist No
Represents Mental Health Chair/Family
Term Expires 12/31/2015
eMail: None

Member

Name Allen C. Israel, Ph.D.
Physician No
Psychologist Yes
Represents Mental Health/Public Representative
Term Expires 12/31/2014
eMail aisrael@albany.edu

Member

Name William Barnette, LMSW
Physician No
Psychologist No
Represents Developmental Disabilities/Public Representative
Term Expires 12/31/2016
eMail wbarnet1@nycap.rr.com

Member

Name Bonita Marie Sanchez, LCSW
Physician No
Psychologist No
Represents Developmental Disabilities Chair
Term Expires 12/31/2014
eMail sanchez@albany.edu;
bms@nycap.rr.com

Member

Name Lewis Krupka, MA,
CASAC, NYCGTC
Physician No
Psychologist No
Represents Alcohol and Substance Abuse Chair
Term Expires 12/31/2014
eMail gamblenomore@talktherapy.com

Member

Name Eleanor Billmyer (Emeritus)
Physician No
Psychologist No
Represents Mental Health/Public Representative
Term Expires 12/31/2017
eMail

Member

Name Doris Bedell
Physician No
Psychologist No
Represents Mental Health
Term Expires 12/31/2014
eMail

Member

Name Margaret Capozzola
Physician No
Psychologist Yes
Represents Developmental Disabilities
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eMail jrmac10@hotmail.com

Member
Name Henrietta Messier (Emeritus)
Physician No
Psychologist No
Represents Developmental Disabilities/Family
Term Expires 12/31/2010
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Member
Name William B. Barr, LCSW, CASAC
Physician No
Psychologist No
Represents Public Representative
Term Expires 12/31/2014
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Member
Name Robert J. Pagelow
Physician Yes
Psychologist No
Represents Community
Term Expires
eMail

Member
Name Dennis Morrissey
Physician No
Psychologist No
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Member
Name William Serafin, LCSW
Physician No
Psychologist No
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Term Expires 12/31/2016
eMail bserafin6@nycap.rr.com

2015 ASA Subcommittee Membership Form

Albany County Dept. of Mental Health (70520)

Consult the LSP Guidelines for additional guidance on completing this form.

Note: The subcommittee shall have no more than nine members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.

Chairperson

Name Lewis Krupka, MA, CASAC,
NYCGTC
Represents Public Representative
eMail gamblenomore@talktherapy.com
Is CSB Member Yes

Member

Name Marsha Nadell Penrose, LMSW
Represents Provider- The Next Step, Inc.
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Is CSB Member No

Member

Name Barry D. Walston, LMSW
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Is CSB Member Yes

Member

Name Alan Kott
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Is CSB Member No

Member

Name Kimberly Aichner, LCSW
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Is CSB Member No

Member

Name Jennifer Vitkus
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Is CSB Member No

Member

Name Michelle Heroux, RN
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eMail MichelleRN0504@gmail.com
Is CSB Member No

2015 Mental Health Subcommittee Membership Form

Albany County Dept. of Mental Health (70520)

Consult the LSP Guidelines for additional guidance on completing this form.

Note: The subcommittee shall have no more than eleven members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.

Co-chairperson

Name E. Nancy Wiley

Represents Family

eMail

Is CSB Member Yes

Co-chairperson

Name William J. Serafin, LCSW

Represents Public Representative

eMail bserafin6@nycap.rr.com

Is CSB Member Yes

Member

Name Allen C. Israel, Ph.D.

Represents Psychologist/Public Representative

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Is CSB Member Yes

Member

Name Sally Jo Smith

Represents Consumer

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Is CSB Member No

Member

Name James Stone,MSW, LCSW

Represents Public Representative

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Is CSB Member No

Member

Name Mame Lyttle

Represents Family

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Is CSB Member No

Member

Name Joan Ruecker

Represents Children/Parent Advocate

eMail

Is CSB Member No

Member

Name Rick Johnson

Represents Provider

eMail

Is CSB Member No

2015 Developmental Disabilities Subcommittee Membership Form

Albany County Dept. of Mental Health (70520)

Consult the LSP Guidelines for additional guidance on completing this form.

Note: The subcommittee shall have no more than nine members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.

Chairperson

Name Bonita Marie Sanchez, LCSW
Represents Public Representative
eMail sanchez@albany.edu;
bms@nycap.rr.com
Is CSB Member Yes

Member

Name Frederick Erlich
Represents Provider-Living Resources
eMail elicf@livingresources.org
Is CSB Member No

Member

Name William Barnette, LMSW
Represents Public Representative
eMail bbarnet1@nycap.rr.com
Is CSB Member Yes

Member

Name Henrietta Messier (inactive)
Represents Public Representative
eMail emessier@nycap.rr.com
Is CSB Member Yes

Member

Name Fern Pivar
Represents Family
eMail pondview@nycap.rr.com
Is CSB Member No

2015 Mental Hygiene Local Planning Assurance

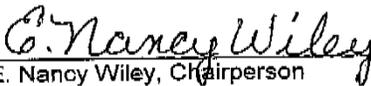
Albany County Dept. of Mental Health (70520)

Consult the LSP Guidelines for additional guidance on completing this form.

Pursuant to Article 41 of the Mental Hygiene Law, we assure and certify that:

Representatives of facilities of the offices of the department; directors of district developmental services offices; directors of hospital-based mental health services; directors of community mental health centers, voluntary agencies; persons and families who receive services and advocates; other providers of services have been formally invited to participate in, and provide information for, the local planning process relative to the development of the Local Services Plan; The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities have provided advice to the Director of Community Services and have participated in the development of the Local Services Plan. The full Board and the Subcommittees have had an opportunity to review and comment on the contents of the plan and have received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16(c); The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities meet regularly during the year, and the Board has established bylaws for its operation, has defined the number of officers and members that will comprise a quorum, and has membership which is broadly representative of the age, sex, race, and other ethnic characteristics of the area served. The Board has established procedures to ensure that all meetings are conducted in accordance with the Open Meetings Law, which requires that meetings of public bodies be open to the general public, that advance public notice of meetings be given, and that minutes be taken of all meetings and be available to the public.

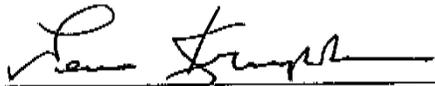
OASAS, OMH and OPWDD accept the certified 2015 Local Services Planning Assurance form in the Online County Planning System as the official LGU assurance that the above conditions have been met for the 2015 Local Services planning process.



E. Nancy Wiley, Chairperson
Community Services Board; Co-Chair,
Mental Health Subcommittee



William Serafin, LCSW; Co-Chairperson
Mental Health Subcommittee



Lewis Krupka, MA, CASAC, NYCGTC;
Chairperson Alcohol and Substance Abuse
Subcommittee



Bonita Marie Sanchez, LCSW; Chairperson
Developmental Disabilities Subcommittee

Appendix A

Community Health Improvement Plan 2014-2017

Mental Health Community Health Improvement Plan 2014-2017

Goal 1: Reduce opiate abuse, both illicit and prescribed, in Albany and Rensselaer counties.

Objective: Increase capacity optimization and efficiency of treatment for opiate abuse, as well as knowledge of best practices in prevention and treatment of opiate abuse.

Outcome Measure: By 2017, reverse the trend of increasing ED visits due to opiate abuse.

Strategy 1: Educate the public about the risks of opiate abuse.

Tactics:

1. Students will have an opiate abuse module added to their existing substance abuse school-based programs or health classes. By December 2017, high schools in 6 school districts in Albany and Rensselaer Counties will have added an opiate abuse module to their existing substance abuse school-based programs or health classes.
2. Partners will promote Take Back Drug initiatives in their facilities and community settings, raising awareness of opiate abuse and encouraging people to dispose of their old prescription drugs from their medicine cabinets properly. By December 2017, 75% of partner organizations will promote disposal programs for old prescription drugs.
3. Advertise Drug Hotlines to increase enforcement, with over 40 signs posted and local newspaper coverage. By December 2017, 25% increase in utilization of Drug Hotlines.

Organizational Partners:

1. Rensselaer County Department of Mental Health, Albany County Stop DWI, Capital Region BOCES, Capital Region school districts & all task force partners available for classroom speaking requests.
2. All task force partners.
3. Rensselaer County Department of Mental Health, Capital Region Underage Drinking and Drug Use Prevention Coalition, Rensselaer County Stop DWI Program, Rensselaer County Sheriff

Strategy 2: Increase PCP knowledge of resources and best practices for opiate use and addiction.

Tactics:

1. Develop and distribute a decision tree for providers with referral options, resource documents, and patient educational material for use in response to the I-STOP program. By December 2017, 75% of contacted providers report using decision tree.
 - a. This can include written materials, online education, and in-person sessions for CME.
 - b. Develop a brochure of the signs of prescriptive opiate abuse and the location and phone numbers of Suboxone, methadone, and detox providers.
 - c. Use OASAS resources and CME classes.
 - d. Streamline coordination and case management support to PCPs for relapsing patients.

2. Train over 200 health professionals annually in motivational interviewing and SBIRT techniques. By December 2017, 200 health professionals annually trained in motivational interviewing and SBIRT techniques.
3. Discuss prescribing patterns with eligible health care providers, including dental providers who are high-volume opioid prescribers. By December 2017, 50% decrease in opioid prescriptions written in Albany and Rensselaer Counties.
 - a. Offer treatment recommendations for members who are receiving routine opiate prescriptions through telephonic or web-based consultation services.

Organizational Partners:

1. CDPHP, St. Peter's Health Partners, Albany Medical Center, primary care and specialty practices, Catholic Charities, Albany County Department of Mental Health, Rensselaer County Department of Mental Health, NYSDOH
2. Albany Medical Center, CDPHP, St. Peter's Health Partners, primary care and specialty practices, Catholic Charities, Albany County Department of Mental Health, Sage College, SUNY Albany, OASAS, Whitney M. Young, Jr. Health Services
3. CDPHP, Fidelis, MVP, Empire Blue Cross Blue Shield, United Healthcare

Strategy 3: Promote cross-system collaboration to optimize utilization and capacity of addiction services.

Tactics:

1. Form a task force to facilitate knowledge of opiate abuse resources and implementation of the Community Health Improvement Plan. By December 2017, 75% of active partners participating in quarterly meetings.
 - a. Provide educational information to CDPHP and Fidelis regarding available opiate abuse treatment resources.
 - b. Encourage the development of ancillary outpatient withdrawal services through task force identification of the location, lead organization and resources needed.
 - c. Identify high areas of need for doctors with X licenses; develop outreach materials clarifying the benefits of licensure and recruit doctors for licensure.
2. Increase the number of individuals referred to non-substance abuse treatment services and low-threshold services (such as syringe exchange, treatment readiness, and harm reduction counseling) by primary care and substance abuse treatment providers by 25%. By December 2017, 25% increase in number of individuals or participating in non-substance abuse treatment services and low-threshold services.
3. Increase colocation of behavioral health professionals and case managers in primary care offices by 3 practices a year. By December 2017, 3 practices annually will have increased number of behavioral health professionals and/or case managers in primary care offices.
4. Increase the number of doctors trained and licensed to prescribe medications treating opiate addictions. By December 2017, increase the number of doctors trained and licensed to prescribe medications treating opiate addictions by 24.
 - a. Increase the number of doctors trained and licensed to prescribe Suboxone by 3 doctors per year. By December 2017, 3 doctors per year trained and licensed to prescribe Suboxone.
 - b. Increase the number of doctors who prescribe Vivitrol by 3 doctors per year. By December 2017, 3 doctors per year trained and licensed to prescribe Vivitrol.

5. Tailor a training curriculum to review opiate addiction resources, including an overdose prevention kit to be given to patients at discharge. By December 2017, training curriculum is updated and delivered to 100 people annually.
 - a. Train 100 individuals annually in the NYS Opioid Overdose Prevention Program. By December 2017, 100 individuals annually trained in NYS Opioid Overdose Prevention Program.
 - b. Pursue legislation to make Naloxone/Narcan have standing status so that it is available over the counter to readily treat an opiate overdose event.

Organizational Partners:

1. CDPHP, Catholic Charities, Albany County Department of Mental Health, Rensselaer County Department of Mental Health, Albany Medical Center, St. Peter's Health Partners, Whitney M. Young, Jr. Health Services, Rensselaer County Department of Mental Health, Addictions Care Center of Albany, Inc.
2. Catholic Charities, Whitney M. Young, Jr. Health Services, Albany Medical Center, St. Peter's Health Partners
3. CDPHP, Whitney M. Young, Jr. Health Services, , St. Peter's Health Partners– SPARCS
4. St. Peter's Health Partners, CDPHP, Whitney M. Young, Jr. Health Services, primary care providers
5. AIDS Council, Whitney M. Young, Jr. Health Services, Catholic Charities, St. Peter's Health Partners, Albany Medical Center, Albany County Department of Health, Albany County Department of Mental Health

Goal 2: Reduce tobacco use in people with mental health needs.

Objective: Two mental health clinics in the counties of Albany and Rensselaer will become tobacco free grounds facilities by January 1, 2017.

Outcome Indicators: Number of facilities with tobacco free grounds.

Strategy: Support and promote smoking cessation among staff and consumers of mental health facilities by establishing tobacco free grounds policies.

Tactics:

1. Recruit and train staff from multiple mental health facilities on the need, benefits, tools and supports available to reduce smoking on campus.
 - o Tobacco Free Coalition to provide guidance, signage, policy development, etc.
 - o Cessation Center will train staff on how to help consumers quit, how to help those who choose to smoke to adjust to the new policy, how to cope with push back, and how to help staff who want to quit smoking.

By December 2017, 2 mental health clinics in Albany and Rensselaer Counties have implemented tobacco free policies or initiatives.

Organizational Partners:

Capital District Tobacco-Free Coalition, Center for Smoking Cessation at Seton Health, Rensselaer County Department of Health, Rensselaer County Department of Mental Health, Albany County Department of Health, Albany County Department of Mental Health.

Provider Survey's
(Surveys available on request)