

2017 Needs Assessment Report
Erie County Dept. of Mental Health (70290)
Certified: John Grieco (5/26/16)

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

Attachments

- Summary of Survey Responses NAN (1).pptx - Integrating Primary and Behavioral Health Care Survey
- Figure 1.docx - Figure 1 from Needs Assessment Question #1

PART A: Local Needs Assessment

1. Assessment of Mental Hygiene and Associated Issues - In this section, describe the nature and extent of mental hygiene disabilities and related issues. Use this section to identify any unique conditions or circumstances in the county that impact these issues. You have the option to attach documentation, as appropriate.

A summary of selected data indicating the extent of which behavioral health concerns exist and the impact of such on individual and the community can be found in the data below. Selected 2013 Erie County Prevalence Data (most recent available): 12-17 18-25 26+ Total Alcohol or Dependence or Abuse 2,459 16,468 36,072 54,999 Drug Dependence or Abuse 2,362 9,772 12,830 24,964 Alcohol or Drug Dependence or Abuse 3,917 21,550 43,943 69,410 At Least One Major Depressive Episode 4,945 9,139 38,365 52,449 Any Mental Illness * 20,983 116,086 137,069 Serious Thoughts of Suicide * 7,547 18,965 26,512 Serious Mental Illness * 4,101 23,304 27,405 * not collected source - National Survey on Drug use and Health <https://nsduhweb.rti.org/> Not unlike National and Statewide trends, Erie County continues to experience an opioid epidemic. The opioid use crisis, has resulted in increasing occurrences of overdoses and deaths. According to the Erie County Department of Health, data received from the Erie County Medical Examiner's office indicated that in 2015, the number of fatal opioid overdoses doubled from 127 in 2014 to 256 in 2015. As of this writing in mid May 2016, Erie County is experiencing approximately 10 fatal opioid overdoses per week or a projection of over 500 fatal opioid overdoses for calendar year 2016. This would represent another year over year doubling of opioid related fatalities. In addition, after years of consistent increases the number of Erie County residents who sought treatment with Opioid as a primary substance exceeded that of those seeking treatment with alcohol as the primary substance for the first time in 2015. Data is from the NYS Office of Alcoholism and Substance Abuse Services (NYS OASAS) Inquiry Reports and is illustrated in Figure 1. Please refer to other sections of this plan for related information. See Figure 1. Which is attached. Figure 1: % of Admissions by represented Opiate as primary substance of Erie County Residents of those active as of December 31st of each respective year. As Statewide, regional and local reform initiatives place a value on integrated and comprehensive care for those with multiple chronic conditions Erie, not unlike other jurisdictions continues to see opportunities in reaching those admitted to inpatient psychiatric care with multiple chronic conditions. The relatively large numbers of those presenting with multiple chronic conditions is illustrated in the following data, Behavioral Health Inpatient Admissions in Erie County (2012 most recent data) o 86% of individuals admitted to a hospital with a behavioral health diagnosis (mental illness or substance abuse) also have one or more chronic health conditions o 55% of individuals admitted to a hospital with a behavioral health diagnosis (mental illness or substance abuse) also have three or more chronic health conditions A summary of the number of Unique individuals receiving Emergency Department Treat and Release services in Erie County under managed care (if enrolled) or Fee for Services for each of the years from 2010-2014: Emergency Department Treat and Release: 2010-2014 2010 2011 2012 2013 2014 Age 00 to 05 3,313 3,235 3,639 2,876 2,520 6 to 11 2,285 2,456 2,947 2,560 2,485 12 to 17 2,884 2,991 3,812 3,399 3,086 18 to 44 17,849 18,721 23,136 20,844 21,240 45 to 64 7,052 7,731 10,520 9,726 10,072 65+ 1,071 1,369 2,147 2,111 2,046 Total 34,454 36,503 46,201 41,516 41,449 Race American Indian 268 316 387 337 330 Asian or Pacific Islander 455 489 681 699 778 Black 13,872 14,654 18,174 16,053 15,708 Hispanic 3,571 3,833 5,212 4,587 4,444 Multiple Races 1,071 1,111 1,388 1,227 1,229 Unknown 177 174 221 190 558 White 14,782 15,631 19,792 18,075 18,070 Total 34,196 36,208 45,855 41,168 41,117 Gender Female 20,256 21,270 27,471 24,488 24,519 Male 14,033 15,034 18,533 16,820 16,817 Total 34,289 36,304 46,004 41,308 41,336 Among the observations are expected decreases in inpatient utilization, but the trend through 2014 is not yet clear. While there has been a 10.2 % decrease in 2014 as compared to 2012, 2012 represented a 34% increase from 2010 and despite the 10.2 % reduction from 2012-2014, 2014 still represents a 20% increase as compared to 2010. Behavioral Health reform efforts would be expected to curtail the use of emergency rooms and will warrant monitoring and perhaps appropriate intervention if data for more recent years where the impact of behavioral health reform would be expected do not alter this pattern of emergency room utilization. Estimated Economic Costs of Excessive Alcohol Use in Erie County: In 2014 the CDC reported that in 2006 excessive alcohol use in the U.S. cost \$223.5 billion. 72% of this total was due to lost workplace productivity, and 11% to health care costs. Using the 2010 Census populations for Erie County (919,040) and the U.S. (308,745,538), the estimated annual economic cost to Erie County is \$663,802,047. Lost work productivity accounts for \$477,937,474, and health care costs for \$73,018,225 of this total. Source: <http://www.cdc.gov/features/alcoholconsumption/> Estimated Economic Costs of Illicit Drug Use in Erie County: In 2011 the U.S. Dept. of Justice National Drug Intelligence Center reported that in 2007 illicit drug use in the U.S. cost at least \$193 billion. 62% of this total was due to productivity related loss, and 6% due to health care related costs. Using the 2010 Census populations for Erie County (919,040) and the U.S. (308,745,538), the estimated annual economic cost to Erie County is \$574,789,853. Productivity related loss accounts for \$356,369,709, and healthcare related costs for \$34,487,391 of this total. Source: <http://www.justice.gov/archive/ndic/pubs44/44731/44731p.pdf> Combined Estimated Costs: The combined estimated annual costs of alcohol and substance abuse are: Productivity: \$834,307,183 Healthcare: \$107,505,616 Productivity and healthcare combined: \$941,812,799 Non productivity/healthcare related costs: \$296,779,101 Total: \$1,238,591,000 The above Cost estimate information provided to Erie County Department of Mental Health by the Institute for Community Health Promotion, Center for Health & Social Research, SUNY Buffalo State, Buffalo, NY Therefore, while Erie County (like other communities) face challenges, we in Erie County are fortunate to have Executive Leadership that not only recognizes the importance of human services and the role that mental, emotional and physical health play in the strength of a community, but also places importance in putting in place an action plan to help improve upon such concerns. The initiatives contained in the document can be categorized in four broad sections: • Employment and Financial Security; • Strong Families, Strong Schools, Strong Children; • Lifelong Health; and • Help Where and When it is Needed What follows are the introductory pages from County Executive Mark Poloncarz Administration's Initiatives for a Stronger Community which was released in March 2015: "Erie County is a diverse community, rich with assets and overflowing with resurgence. Evidence of this revitalization is everywhere with advanced manufacturing at the former sites of Bethlehem and Republic Steel, the construction of HARBORCENTER, the all-season activity at Canalside Buffalo, exploding growth at the Buffalo Niagara Medical Campus, and a vibrant arts and cultural sector. This resurgence has made a difference in the lives of Erie County residents. It has created jobs, earnings are on the rise, and the number of people living in poverty is dropping. 1 Consider the following statistics which highlight the turnaround that Erie County is beginning to see: 1Sources: CA30 Regional Economic Profiles; Bureau of Economic Analysis. Updated November 20, 2014 and 1 year estimates from American Community Survey 2011 and 2013. 2 Source: 1 year estimates from American Community Survey 2011 and 2013. • Median household income in Erie County is \$51,245—7.8

percent higher than in 2011. • Family households are doing even better, with a median income of \$66,071 compared to \$61,939 just two years earlier. • The gender gap in wages has narrowed. The difference in median full time wages between men and women fell from 26.2 percent in 2011 to 19.7 percent in 2013. • The percent of children under the age of 5 that are living in poverty has dropped from 32.8 percent to 23.8 percent. While the rebirth our community has seen is unprecedented in our lifetimes, without question, Erie County could be stronger. Many tough issues continue to plague our community including persistent economic disparity, high rates of chronic disease and high risk health behaviors, limited access to healthy food, and less than satisfactory educational outcomes. In several of these areas, progress is being made but more must be done. Here is a particularly compelling statistic: In 2011, 55.8 percent of unmarried mothers, heading up their own household, with children under 5 had incomes at or below the poverty level. That percentage had dropped to 48.1 percent in 2013.³ Although this is a marked improvement, it certainly remains unacceptably high, and points to a continued need to help women in a variety of ways from finding good jobs and negotiating fair wages, to helping to ensure there are adequate childcare options available throughout our community. This is not an isolated instance. Although indicators show that the County as a whole is better off than it was a few short years ago, some of Erie County's residents are not reaping the benefit of this upswing to the same extent as others. For example, older adults on relatively fixed retirement incomes are, understandably, not benefitting from a greater supply of jobs in the local economy. Moreover, poor health outcomes also continue to be more likely here than in other counties in New York State. The following statistics point to specific areas where Erie County could be stronger: • The percent of older adults living in poverty has inched up in recent years, from 8.5 percent in 2011 to 9.3 percent in 2013. ⁴ • Residents of Erie County report more “physically unhealthy days” than their counterparts across New York State—3.9 in the past 30 days, compared to 3.5. ⁵ • Six percent of Erie County residents report having limited access to healthy food compared to two percent in NYS. ⁶ • Sixteen percent of Erie County residents report having severe housing problems.⁷ ³ Source: 1 year estimates from American Community Survey 2011 and 2013. ⁴ Older adults age 65 and older. Source: 1 year estimates from American Community Survey 2011 and 2013. ⁵ Source: County Health Rankings and Roadmaps, 2014 ⁶ Source: County Health Rankings and Roadmaps, 2014. Percent of population that is low income and does not live close to a grocery store. ⁷ Source: County Health Rankings and Roadmaps, 2014. Includes overcrowding, high housing costs, and/or lack of kitchen or plumbing ⁸ See “America’s Most Economically Segregated Cities” by Richard Florida. February 23, 2015 <http://www.citylab.com/work/2015/02/americas-most-economically-segregated-cities/385709/> Interestingly, regions that are experiencing economic resurgence, especially those that include growth in high-tech and knowledge-based industries, actually run the risk of creating even greater economic disparity than may have existed prior to the resurgence.⁸ We cannot let this incredible “New Buffalo”—this “New Erie County”—benefits just a select few. All boats can rise with the tide. GUIDING PRINCIPLES Initiatives for a Stronger Community is the Poloncarz Administration’s health and human services action plan for Erie County government based on the idea that it is unacceptable for a newly revitalized Western New York to leave behind significant portions of our community when we can effect positive change in their lives. As such, the plan outlines specific measures that Erie County government will undertake to improve the quality of life for residents in need. Initiatives for a Stronger Community is grounded in compassion and premised on two fundamental principles: 1. County government represents everyone: Erie County government does not just represent the taxpayers—it represents everyone— from our youngest child, to our oldest adult, to our newest immigrant, and our most vulnerable resident, regardless of race, national origin, age, sex, sexual orientation, religious affiliation, or socio-economic status. We as a community have a duty to ensure all of our residents are given the same chance – as level a playing field as possible – to advance themselves; and 2. Government is an essential partner, and where appropriate, it can and should lead: For too long we have been told government cannot be a solution to a problem because government is the problem. The Poloncarz Administration rejects that premise because strong, organized, and above all effective government, working in partnership with the private, non-profit, philanthropic, religious, and academic sectors, can be part of the solution to the problems that ail us. And, in many instances, not only is government an essential partner, but also an essential leader. When the other sectors cannot or will not step up to solve tough issues, government must not back away from its duty to represent everyone and provide leadership. Throughout the plan, one will find initiatives that reflect these key values. They are inclusive, work to address needs and create opportunities, embrace both leadership and partnership, and support the ongoing efforts of others to build a stronger community.” The entire report can be found at: <http://www2.erie.gov/sites/www2.erie.gov/files/uploads/pdfs/Initiatives%20for%20a%20Strong%20Community.pdf>

2. Analysis of Service Needs and Gaps - In this section, describe and quantify (where possible) the prevention, treatment and recovery support service needs of each disability population, including other individualized person-centered supports and services. Describe the capacity of existing resources available to meet the identified needs, including those services that are accessed outside of the county and outside the funded and certified service system. Describe the gaps between services needed and services provided. Describe existing barriers to accessing needed services. Identify specific underserved populations or populations that require specialized services. You have the option to attach documentation, as appropriate.

The Erie County Department of Mental Health conducts an extensive needs analysis for Prevention, Mental Health and Chemical Dependency Services. Much of this material was referenced and/or attached to the 2016 Local Services Plan. The planning documents are utilized, among other uses, to determine various gaps in services plan for the location of prevention and Mental Health or Chemical Dependency treatment services. Maps are produced illustrating various levels of risk and service availability by zip code within the County, including the City of Buffalo. These are updated periodically and where last updated in 2015. The information and data are consolidated and labeled as the “Erie County Risk Indicator Data Base”. This is completed for the Erie County Department of Mental Health (ECDMH) with input from the ECDMH and the Prevention Community by the Center for Health and Social Research. These planning documents can be accessed on the web at http://www4.buffalostate.edu/centers/chsr/ridb/risk_indicators.asp?intro=1. In addition the following specific issues were selected for inclusion in the 2017 Local Services Planning Document Stigma: One of the overarching concerns across all disability types and services includes the impact of stigma on care and those with a behavioral health diagnosis. Stigma can impact those in the community with a behavioral health diagnosis in several ways. These may include, but are certainly not limited to: A reluctance to reach out to discuss one’s concerns or to seek services; negative impact upon social activities and acceptance by family members or one’s social network, an environment that is not supportive of hope and recovery, more limited employment and economic opportunities; and discrimination. Corrigan, Druss and Perlick in an August 1, 2014 article published in The Association for Psychological Science titled “The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care” report that “in 2011, only 59.6% of individuals with a mental illness — including such conditions as anxiety, depression, schizophrenia, and bipolar disorder — reported receiving treatment.” Stigma itself creates personal, cultural and environmental barriers to treatment and related support services. As a result, the Erie County Department of Mental Health (ECDMH) has been meeting in a collaborative partnership to plan for and implement a community wide Anti-Stigma campaign that will be designed to provide a consistent message for an ongoing period. This committed group of stakeholders includes provider agencies, a local foundation, other stakeholders and expert consultants. Initial planning steps include research, the development of a strategic plan, and seeking funding resources. High Deductible plans: Many employers are moving to High Deductible Health Plans to save expenses. However these plans de-incentivize people from accessing Behavioral Health benefits. Many of these family’s utilize these plans to save money. However, they also discourage out of pocket spending on non-essential services. These plans contradict the intent of Federal Parity. Out of Pocket spending reached \$329.8 billion, or 10.9% of the total \$3 trillion in health spending in 2014. This trend is only increasing. The cost of carving out, Behavioral Health Outpatient Services from these high deductible plans would be nominal. We would encourage the State Department of Health to advocate with the Department of Financial Services and Federal Government to amend the Federal Parity Act to exclude this benefit from the high deductible plans. Pending changes at the federal level, a sourced community solution included providing emergency and temporary supplemental funding for individuals who have health insurance but cannot afford the high co-pays and deductibles required for them to access outpatient and residential care. Housing: Through the provision of State

resources Erie County continues to receive additional Supported Housing beds. The recent additions have been targeted to facilitating the transition of individual transitioning from State Psychiatric Centers or Correctional institutions. These resources are designed to maximize the chances of successful community tenure. Data recently provided by the Buffalo Psychiatric Center indicated that: For those receiving Inpatient Services: • 80 inpatients have a length of stay of 12 months or longer (49% of census). • 40 inpatients are under the age of 65 and do not have a legal status of CPL 330.20 and have a length of stay of 12 months or greater (24% of census). • 23 inpatients have a legal status of CPL 330.20 (15% of census). • 19 inpatients are appropriate for an assisted living or nursing home level of care (12% of census). For those in Residential Services: • 96 residents have a length of stay of 12 months or longer (53% of census). • 9 residents have a legal status of CPL 330.20 (5% of census). • 19 residents are appropriate for an assisted living or nursing home level of care (10% of census). Within Erie County and surrounding counties, Buffalo Psychiatric Center serves several individuals who can benefit from targeted in-reach services to enhance and sustain integration into the community. Services will be provided to support and teach those who may have significant medical comorbidities, limited independent living and social skills, complex cognitive impairments, criminal justice histories, and significant substance use disorders. Therefore the State's funding of such beds to include supports leading for those with histories of long term care in developing skills that assist them in succeeding in the community (cooking, shopping, cleaning, etc.) are most appropriate, welcomed and serve a critical need for individuals to successfully make and sustain the transition to community living. However, due the expectation of permanency and related stipend, supported housing offers little direct incentive for providers to collaborate with the recipient to further increase independence. This permanency combined with the relative lack of movement from Single Room Occupancy living situations frequently leads to a lack of open slots for those in need. Not only access but access to the right level of housing at the right time. Therefore, Erie County continues to advocate for the emergence of other best and/or promising practice of housing, if even on a pilot basis. As discussed, in subsequent plans Critical Time Intervention provides and offers one such model. This evidence based practice supports all of the States philosophy of consumer choice, empowerment, and recovery. In doing, CTI facilitates decreases in lengths of stay while providing positive consumer outcomes. Shorter lengths of stay, increased community tenure, with other positive consumer outcomes are congruent with the triple aim of health care reform. Additionally, housing providers in Erie County are reporting an increasingly aged and infirm population that is in need of assisted living or even skill nursing facilities. However, such facilities will most often not accept consumers into their facility due to payment issues. This leaves the housing provider to continue to provide care for these individuals, which in addition to the obvious care challenges to services not ideally set up to provide for such chronic medical conditions, it also creates further issues with the ability to access higher level housing services. Also, due to many apartment conversions that have been occurring in Buffalo rents have been increasing. This results in an increase in the length of time for housing searches and decreases the supply of affordable and appropriate locations from which to choose. An increase in the bed rate for supported housing providers would help with apartment searches and choice of living environment. For recipients of developmental disability related residential services, the current Residential Opportunity process has changed and imposed some unintended consequences for individuals in need of/desiring certified placements. The evaluative process has caused a growing concern that the new practice has and will continue to delay the filling of certified housing vacancies. Due to the screening and required reporting from providers to OPWDD individuals are waiting longer for placement. Couple with the Certified Placement process the expansive Residential Request List (RRL) has compelled Region 1 OPWDD to facilitate a heightened review process of current residential facilities which include environmental components of the residence, neighborhoods (community integration), leases and agreements to promote independence and individual choice i.e. is the environment too regimented for personal choice. In NYS there are 11,000 individuals on the RRL of which approximately 1,100 live in Erie County. Individuals on the list are categorized as follows: Priority 1 individuals who are homeless/are in imminent danger; Priority 2 individuals could soon be homeless or in imminent danger of such i.e., elderly parents are not able to care for appropriately and Priority 3 are individuals who are interested in changing their living environment within the next year or so. The challenge of managing the RRL is the volume of people who are in need/desire housing assistance. Local discussions include recommendations to OPWDD to also include Housing Planning for the future. Erie County will continue to support Region 1 efforts to allocate new money for individuals living at home and prioritizing placements through the utilization of the Residential Request List. Criminal Procedure Law CPL 730.40, Competency Restoration: The trends over the past 4 years have shown an increase in not only persons with mental illness being incarcerated for crimes; but an increase in costs to restore their capacity to proceed. Typically, cases that reach this level have been serious felony charges that involve a violent act. Charges have ranged from homicide, assaults, and sexual offenses to destruction of property. In one circumstance, a person entered the jail being charged with petit larceny, however after being caught with contraband (a concealed box cutter); he was then charged with a felony. While in many cases, the person was linked with treatment in the community, others have no known treatment histories, refuse medications while incarcerated and have been deemed as incompetent by the court. They are then sent off to a secure state psychiatric forensic unit for restoration. Once in the state hospital care, lengths of stay are long and very costly. It is the responsibility of the Forensic Mental Health Service to have exerted due diligence. These efforts include placement on the jail mental health treatment unit (Residential Treatment Unit), psychiatric medications, frequent contact with a clinician and prescriber and if needed, inpatient care at ECMC Sheriff's lock up. These interventions are successful locally and have resulted in stabilization of many patients. For those few individuals with serious charges and an unstable mental state, court ordered costs have increased. Challenges we face with the criminal justice system include a judicial system that is often uninformed regarding mental health issues and driven by hired experts opinions brought into a case by the defense attorney. When individuals deemed as incapacitated are designated to state forensic hospitals, their cases are delayed and stays are long. An April 2016 review indicates that in one case the individual has been committed for almost 24 months and in other for 22 months prior to being released. Further review indicates that, three individuals were first committed in November 2011, May 2013 and January 2015 respectively. At the time of the April 2015 data pull; these three individuals remained committed to the state psychiatric forensic unit. Costs continue to accrue. As illustrated in the table below, this then results in increased costs to the county and has been increasing substantially in recent years. Year Expense to County # of individuals 2016 \$1,093,440 (annualized amount estimate based on invoices received thru Q1 2016 Q1) N/A 2015 \$749,100 8 2011-2014 Average \$446,576 N/A 2014 \$610,651 7 2013 \$338,672 3 2012 \$523,821 4 2011 \$313,159 3 Cost related to CPL 730.40 to Erie County is 67.7% greater in 2015 than the average cost for the period from 2011-2014. The cost for 2016 is projected to be \$1,093,440 or 144% greater than the average cost from 2011-2014. However, despite these costs to the County, regular feedback from the hospital is not provided and must be obtained by the county staff. Currently, the Conference of Local Mental Hygiene Directors is proposing legislation for financial relief of the local government unit after the first 3 months of hospitalization and regular report backs to the home county by the state forensic hospitals. The state is also proposing that local jail mental health programs pilot restoration programs. While this may be an opportunity, there are no additional resources available, nor the ability to do treatment over objection in the jail setting. Appropriate resources are required. Also, a recommendation to increase awareness and education of mental health issues is to provide Mental Health First Aid training to the judiciary and attorneys, including the District Attorney's office and defense attorneys. Locally, the ECDMH will continue to expand opportunities for diversion and support care management services in our treatment courts. Erie County will also continue to maximize treatment and provide comprehensive discharge planning for persons we serve in our correctional settings. However, Local diversionary and coordination efforts, while offering further opportunity to avoid competency restoration costs, are limited if the State relief is not forthcoming. Substance Use: In addition to the prevalence and other related statistics cited earlier under question #1 of the Local Needs Assessment of this document, use patterns as reported by providers are particularly clear among Heroin, and other Opiates, and Tranquilizers/Sedatives. While cited earlier, the number of Opiate related deaths in Erie County bare repeating. According to the Erie County Department of Health, data received from the Erie County Medical Examiner's office indicated that in 2015, the number of fatal opioid overdoses doubled from 127 in 2014 to 256 in 2015. As of this writing in mid May 2016, Erie County is experiencing approximately 10 fatal opioid overdoses per week or a projection of over 500 fatal opioid overdoses for calendar year 2016. This would represent another year over year doubling of opioid related fatalities. Given these numbers it is not unexpected that, as part of the Local Planning process, a NYS Office of Alcoholism and Substance Abuse Services survey asking providers to respond to a Drug Use Trends Survey almost every respondent views Heroin as a serious problem and with an increase in usage over the past 12 months. Specifically, as of March 30, 2016 with 91.3% of providers reporting, 97.6% of respondents responded that Heroin is a serious problem within the community, 82.9% see Other Synthetic Opiates, and 61.9% believe that Tranquilizers/Other Sedatives are a serious problem in the community. In addition, at

97.7%, 79.1% and 54.8% respectively each of these substances are viewed by the provider community as having an increase in usage in the past twelve months. A limited sample of related recommendations that have been generated from local discussions to address substance abuse issues in general and the opioid epidemic more specifically include but are not limited to the following:

- o Pilot of judicially mandated treatment that is modeled after Assisted Outpatient Treatment model, but adapted to substance abusing individuals who through their substance abusing behaviors are at high risk of causing substantial and serious harm themselves, others, and/or the community. A tool of this variety has been frequently voiced by family members of substance abusing individuals;
- o Initiate a requirement that all drug courts allow the use of medication assisted treatment when indicated by the professional clinical team;
- o I-Stop Prescription Monitoring Program should be modified to allow for the inclusion of prescriptions that originate from an Emergency Room and those that are prescribed for less than 7 days. If possible Emergency Room presentations for overdoses should be viewable. In addition, physicians have been asked that the information be “pushed” to them versus the multiple step process of today so it is more readily viewable;
- o Provision of direct support for family members who accompany the individual to the emergency room, even if the substance abusing individual is not ready to consent to treatment, the family member may be willing and would benefit from the support and skills that could be provided.
- o Increased access and availability of medication assisted treatment. This is discussed elsewhere in this section. Action however, is being taken to help address the epidemic. Several related resources and initiatives are underway or in the planning stages;
- As a result of the explosion in Heroin and other Opioid abuse and deaths Erie County has formed an Opiate Epidemic Task Force. Although planning efforts had been undertaken prior to this the formal Task Force held its initial meeting on February 1, 2016. The Opiate Epidemic Task Force mission is “to provide a framework for organizations and individuals from across the opiate overdose continuum to collaborate, develop and share best practices and provide timely sharing of information.” The task force consists of seven (7) workgroups each charged with a different, though often complimentary task. Workgroups have met and in their task/goals are being further developed. However, the workgroups and a very brief synopsis of each task are as follows:
- o Rapid Evaluation Appropriate Placement (REAP): Provide support and immediate linkage to treatment for those appearing at a participating law enforcement agencies office;
- o Families and Consumers/Support and Advocacy: To strengthen and support the segments of the Erie County Opiate Epidemic Task Force to deliver improved services to those addicted by strengthening the community response, to attain our common goal of eliminating addiction, illness and death from opiate use, to advocate for our loved ones while eradicating this public health crisis from our community and our homes.
- o Community Education: Coordinate efforts to educate public;
- o Provider Education and Policy Reform: Increase number of physicians willing and able to prescribe Suboxone, increase provider community support for these physicians, and training in prescribing for acute pain;
- o Hospitals/ER Release of Information Project: Facilitate Linkage to treatment;
- o Naloxone Access: Community access to training in the administration of Narcan to those who have overdosed;
- o Treatment Providers: Ensure community needs are met related to substance use disorders including prevention, treatment and after care to assist individuals and families in recovery.
- In addition, there are now Federal and Statewide Taskforces underway that have begun to address some of these issues. These Taskforces have made and will likely make additional recommendations to help address this national crisis. Therefore, while there are many efforts underway and progress is being made on several fronts, one such specific effort pertains to the limited availability of providers able to prescribe buprenorphine in the community. Federal limits on the number of patients any one physician can provide buprenorphine to and physician uncertainty has limited access to this important medication assisted treatment. Recent federal efforts may help to alleviate this concern. Locally, the Erie County Department of Health is collaborating with the University of Buffalo Medical School to provide training and increase the number of physicians willing to apply to become an administrator of buprenorphine. At the same time, the local treatment community has been approached and is providing its support to provide these physicians with treatment as a resource for patients under their care. Still, the lack of timely access to buprenorphine is underscored by a recent survey of provider agencies indicated that most outpatient clinic locations offer buprenorphine, but most often there is an approximate 2 week or more delay in receiving this medication. Therefore, it is hoped that expanding the list of available private physicians who able to offer buprenorphine will increase access and timeliness. In addition, Federal efforts, if implemented, to increase the patient limit above the present restriction of 100 for qualified physicians who prescribe buprenorphine would greatly improve access to this medication and thereby, also positively impact upon decreasing the number of those who seek this in the street. At the State, given the epidemic proportions, it is suggested that NYS OASAS collaborate with the Department of Health to apply for an emergency waiver to allow mid-level practitioners to prescribe buprenorphine. Mid-level health care providers, such as Nurse Practitioners and Physician Assistants being allowed to prescribe Buprenorphine would also help to improve access to this treatment tool.
- It should also be mentioned that the four Methadone Maintenance Treatment facilities in Erie and Niagara County with utilization rates for 2015 ranging from 96-100% are at or near current capacity. Several providers are exploring increasing capacity.
- As part of the response to this epidemic the Erie County Department of Health has been and continues to be a leader, among others, in providing regularly scheduled free training to first responders and other citizens in the administration of Naloxone (Narcan).
- Furthermore, the Erie County Department of Mental Health (ECDMH) has recognized the need for a singular number for those experiencing a substance use related crisis or assistance need and this goal has been among the ECDMH’s priority outcome goals for the past two years. This year we are able to report that through the leadership of Erie County Executive Mark Poloncarz, his administration, and the support of the Erie County Legislature funding through Erie County has been secured to implement this service. It is anticipated that this singular contact number will not only offer referral and support, but assessment services to the REAP initiative previously mentioned.
- It has been long recognized that family support/advocacy and peer support are difficult to locate and access outside of the 12 step programs. Recognizing the importance NYS OASAS has provided funding to Erie County for both services and these are expected to be implemented in the second quarter of 2016. Although welcomed, family support/advocacy and peer support/advocacy remain limited within the formal provider system.
- Finally, another new initiative to support individuals at risk of or in recovery is a Youth Club House. The Youth Club House, recently funded by NYS OASAS will offer young adults a safe environment and pro-social activities. It is anticipated that this too will be implemented in the second quarter of 2016.

Intermediate levels of Care –Addiction: Currently there are no Chemical Dependency Intensive Outpatient programs and limited transitional supports in Erie County. Given the occupancy rates in residential treatment in our area frequently in excess of 95 % there is a need for these programs. High risk, high need clients returning from Inpatient settings cannot access residential treatment programs due to the limited beds and high occupancy rate. Transitional housing, or a “3/4 House”, if you will, is also a gap in the present continuum. Here individuals would have a higher level of supervision and support than present supportive living facilities can offer. The lack of such transitional levels of care creates a gap in service and jeopardizes the success in aftercare as well as increasing the likelihood of overdose. Offering such levels of care as a clinical transition would improve outcomes and care and protect the “investment” made in treatment up to that point. State and Federal leadership to encourage and provide the financial incentives to providers to initiate this program would fill in a necessary gap in care. The above is also true for Adolescent care in Erie County. Adolescents completing Residential or Inpatient care have no transitional levels of care. They return to the same neighborhoods, and schools. They are exposed to many of the same influences that were instrumental in their addiction. The Investment of millions in high cost inpatient and residential services without the back end support for those in need would lead to better outcomes for a significant segment of the population if offered such transitional supports. While residential redesign will help to address this issue to some extent, it is suggested that providing additional funding to support intensive outpatient and build transitional and supported recovery housing would help address this gap. Evaluation could help determine who best to target these services, at what point, and where they could be most effective. Admission to detox is often an immediate desire for individuals withdrawing from opiates. Often however, admission is not medically necessary. This however, does not mitigate the withdrawal symptoms being experienced by the individual and regardless of motives, presents an opportunity for treatment engagement. When not admitted to detox where these symptoms can be medically mitigated, the individual often returns to a cycle of use. Having an option for individuals to reside in a safe, comforting environment where these symptoms can be ameliorated and engagement to longer term counseling can occur is an alternative that is not presently available. Similar models exist for recipients of mental health services who may not require an emergency department and/or psychiatric inpatient admission. One example of such may be known to the community as the Living Room model. Here individuals reside for a brief stay of approximately 5 days, to “gather” themselves with the support of professional and peer staff and medications as indicated. Engagement to the service provider is also made. Such a model, though most likely of a longer duration, can be adapted to the needs of the substance abusing individual at a much lower cost than repeated emergency department

presentations, and a greater opportunity for further engagement with a peer and treatment provider, than presenting at detox without an admission or plan to address the profound symptoms of withdrawal. Such services should and must include efforts and resources to engage the individual in longer term treatment services that are appropriate to the individual's needs. Moreover, a strong family component should be included. Current Medically Monitored services and residential redesign may offer an avenue, but it must be adequately funded. Direct linkage from Detox and perhaps transport to such a service from Detox would, it appear, be critical. Integrated Primary Care: The integration of behavioral health services and primary medical care are key components of health care reform efforts across the Nation and State. By some estimates those in the public mental health system die as much as 25 years earlier than the general population. It is not uncommon for those with a behavioral health diagnosis to have no primary care doctor. At one large local behavioral health provider which locations across a diverse geographic and economic area, self-report data collected from their recipients indicated that when viewing each location separately the median average percentage of consumers reporting no or unknown primary care physician across their clinic locations was 52%. Although, this represents only one sample it is not without surprise. Still, this provider and others are beginning to regularly track such data and data collection combined with focused Quality Improvement efforts are often the first step towards improving the percentage of those with a primary care physician. While increased collaboration continues to occur, true integration will require further regulatory reform, training, and an ongoing investment in human and financial capital. Still, there is progress being made in Erie County. Providers are increasingly co-locating behavioral health services with primary care physicians, collecting several related metrics pertaining to BMI, selection of a primary care physician and other meaningful use measures are becoming more common. The Delivery System Reform Incentive Payment (DSRIP) Program projects also are pursuing the enhancement of primary and behavioral health care. In addition, if NYS is selected by the Federal Government as a pilot several local providers have applied for and are well positioned to be selected as Certified Community Behavioral Health Clinics (CCBHC). Although, steps remain to determine implementation in NYS and locally, if selected and the pilot demonstrates the expected value, CCBHC hold great promise as a sustainable avenue to not only integrate aspects of behavioral health care, but also with primary medical care. So while the future holds promise for integrated care, the Erie County Department of Mental Health (ECDMH) conducted a survey of the behavioral health provider community in Erie County to gain a baseline understanding of the present state of integrated/collaborative care in Erie County. The survey was conducted in November of 2015 and the full results can be viewed as an attachment to this plan. However, a summary of the survey responses follows. Sixteen (16) providers responded and ten (10) of those indicated that they had at least one site co-located with a primary medical care provider. Moreover, all but two (2) had at least two (2) co-located locations. However, 70% of the co-located sites offered OMH Services, 13% offered OMH/OASAS services while 17% offered OASAS services. Most promising is the fact that ten (10) providers or 62.5% plan on opening additional co-located locations in the next twelve months, and only one (1) provide had plans to close such a location in the next twelve months. Still, despite these trends barriers remain to co-location and integrated services. Specific response can be found on the attached survey but some of these in the broadest sense include: Coordination and collaboration challenges, coordination challenges within the co-located facility, Present state of EMR issues disrupt the ability to truly integrate, Regulatory barriers and challenges, resource challenges (fiscal, human, and technical). Consumer Input: In an effort to hear the voices of those who receive and affected by the many reforms occurring in the system the Erie County Department of Mental Health held a consumer forum in April of 2016. This forum was designed to solicit and hear their concerns/suggestions. There were 45 participants in the forum (some of whom were staff of this peer agency), which was energized by information and feedback from all parties. The discussion focused on: Behavioral Health Reform, Health Homes, Employment and the Peer Certification process. What follows is a general summary of that discussion. Behavioral Health Reform The discussion began with the consumers experience with Behavioral Health reform and access to care. The participants had not had extensive experience with these reforms. They are mildly aware of the Health Homes and the HARP projects. As for access they discussed transportation as a concern. The group reflected on access issues as well in the discussion. They discussed their entrance into the Behavioral Health treatment system. Many entered care through services coordinators, DSS as well as from their PCP. Some accessed these services through self-referral, release from incarceration and hospitalization. The next topic was barriers to accessing services. A quarter of the participants stated services were not easy to access. In further discussions they mentioned a number of barriers. These included financial issues, including payment and insurance approval. Many providers do not take Medicaid and this limits access. They mentioned lack of funding and network limitations as a barrier. Knowledge of the system and this complexity were also discussed. The group was frustrated by the limited access to substance abuse beds as well as limited peer support. However, the group was favorable to peer services. The discussion moved to fixing the system. Increasing knowledge of patient rights and the service system was detailed as helpful. More choices of available care and increased access was mentioned. Improved transportation and provider accountability were discussed. A specific concern was related, removing clinic restrictions on having to see the clinic therapist if they see the clinic Psychiatrist. Services should be allowed to be accessed by all residents, not just those in the Mental Health system. Health Homes Discussion then moved to Health Homes. The group initially discussed the definition of Health Homes. There was some confusion for the participants. There were various perceptions voiced, including residential programs, Nursing Homes, and Managed Care. The majority of the group was aware of Health Homes and the consensus was that the Health Homes linked and coordinated services. The consumers were aware of the names of the local Health Homes, and a number participated in this program. The participants felt positively about the care management, transportation, linkages and coordination of care the Health Homes provide. Frustrations voiced included some Health Homes are not contracted with Managed Care. There was consensus that the Health Homes and Managed Care did not communicate well with each other. The consumers were also frustrated that in order to participate in Health Homes one must have Medicaid. An additional question was asked about waiver services and the benefits of this. A number of the group participants were aware of the waiver and the services included. Employment In these discussions the consumers felt that employment services would assist them in a job, career, and being independent. These services would lead to skill improvement, self-sufficiency and improved quality of life. They felt that these Employment services should also focus on assisting with placements, interviews, applications but most importantly actual employment. Consumers felt additional Job Coaches would be helpful. The group members were asked if they felt that vocational opportunities were encouraged by providers. The majority of the responders felt they were. A few believed that service providers were not supportive or ambivalent. Some believed the programs needed to be enhanced as they were too basic to better meet the needs of the consumers. Many of the participants felt that these opportunities needed to be expanded beyond minimum wage jobs in the more traditional placements such as fast food or cleaning. Some felt it was wrong and not helpful to terminate the vocational training when they completed treatment at that agency. The inclusion of a job at the end of the training would be helpful, as well as financial incentives for participating. Peer Certification The discussion moved to peer certification. Participants felt positively about peer services being certified and many in attendance were aware of the certification process. They were aware of the role of the Peer Advocates and their duties. The group was able to describe Counseling, advocacy, linkages, information sharing, skill building, system navigation and referral as some of the peer services peers could provide. Peers mentioned their advantage in this position was perspective in having lived this process. This allowed them greater insight, empathy and experience in this position. After this a discussion occurred as to the steps involved in becoming a certified peer advocate and the upcoming opportunities with these positions. Community based diversionary services for those with Developmental Disabilities: The local CPEP in collaboration with the Erie County Department of Mental Health has identified a need for community based care for the developmental disability population. Access to Psychiatry through Intermediate Care (APIC) has been identified as the model of care. APIC is a mobile service that provides psychiatric interventions and case management for children, adolescents, and young adults with developmental or intellectual disabilities. APIC does not replace current care but assists, augments, and coordinates treatment to help create a sustainable plan for families, providers, and natural supports. APIC is designed to divert from emergency department or hospital visits because of inadequate intermediate care in the community. Since the inception of APIC services in December 2014, 183 referrals have been received; of those, some level of treatment was provided to 157 individuals and their families. However, up to mid-2016 these services were available primarily to those under 26 years of age. The Erie County Department of Mental Health is supporting the expansion of services provided through a local agency to include those individuals ages 26 and older. It is expected APIC will reduce the risk of unnecessary arrests, assist in the transition from incarceration into the community, create a chronic care model for individuals whose mental health needs can only be met by in-home interventions and partner with new and/or existing mobile medical providers to create an integrated care model for individuals who are at risk medically/psychiatrically and cannot receive traditional office based interventions based on their disability. Crisis prevention services for

individuals with developmental disabilities and coexisting mental health or behavioral health concerns: Western Finger Lakes (WFL) START is a crisis prevention program that serves individuals with developmental disabilities and coexisting mental health or behavioral health concerns. Individuals must be 6 years of age or above with a suspected developmental disability which would qualify for OPWDD eligibility. The WFL START program serves 17 counties across Western New York and the Finger Lakes which began accepting referrals in August 2014. In the first year of program development 100 referrals were anticipated but over 250 referrals for individuals and teams in need of additional supports were received. Services emphasize a positive psychology approach to provide systemic engagement therefore supporting not only the identified individual but also the system surrounding him/her. As many referrals are dually diagnosed, WFL START may assist in identifying appropriate supports across (OPWDD and OMH) service systems and promote most efficient linkages and appropriate use of existing services i.e. CPEP, Medical ER. A key component of the program is to work with the individual and their team to develop a crisis prevention and intervention plan which can be utilized as a supplemental tool across settings. In addition 24 hour crisis support is available to offer regular telephonic or in person support to those teams. In the second year of the program, implementation of therapeutic In Home Supports were included, extending teaching and training on existing crisis plans as well as offer opportunity for systems to enhance required skillsets like coping or social skills. The availability of therapeutic programming will be further developed upon the opening of a Resource Center which will offer planned and emergency admissions for individuals enrolled in the program. Consistent with moderate/high need areas identified for Erie County youth and adults and based on the success of the program, requests for WFL START assistance have currently exceeded available resources. At maximum capacity, WFL START has served approximately 200 individuals with many more referrals being made. In contrast to other national START programs, WFL START referrals have reflected a high percentage, above 50%, of children under the age of 21 in need of supplemental supports. Approximately half of WFL START referrals reflect teams that are seeking traditional services, which might assist in supporting individuals residing within family residences, such as community habilitation and respite. In order to address the enhanced volume, WFL START has begun a focus on developing community capacity by trialing a support group and planning trainings to local service provision agencies. Region 1 OPWDD representatives frequently provide updates to the Erie County Department of Mental Health (ECDMH) OPWDD Subcommittee which includes their efforts to find additional resource to support WFL START expansion. When requested, ECDMH will assist Region 1 OPWDD and WFL START in program development discussions.

3. Assessment of Local Needs - For each category listed in this section, indicate the extent to which it is an area of need by checking the appropriate check box under "High", "Moderate", or "Low" for each population: Youth (Under 21) and Adults (21 and Over). When considering the level of need, compare each issue category against all others rather than looking at each issue category in isolation. For each issue that you identify as a "High" need, answer the follow-up question to provide additional detail.

Issue Category	Youth (< 21)			Adult (21+)		
	High	Moderate	Low	High	Moderate	Low
Substance Use Disorder Services:						
a) Prevention Services	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
b) Crisis Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
c) Inpatient Treatment Services	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
d) Opioid Treatment Services	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
e) Outpatient Treatment Services	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
f) Residential Treatment Services	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
g) Housing.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
h) Transportation.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
i) Other Recovery Support Services	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
j) Workforce Recruitment and Retention	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
k) Coordination/Integration with Other Systems	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
l) Other (specify): Coordinated Discharge Planning	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Mental Health Services:						
m) Prevention	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
n) Crisis Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
o) Inpatient Treatment Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
p) Clinic Treatment Services	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
q) Other Outpatient Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
r) Care Coordination	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
s) HARP HCBS Services (Adult)				<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
t) HCBS Waiver Services (Children)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>			
u) Other Recovery and Support Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

v) Housing	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
w) Transportation	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
x) Workforce Recruitment and Retention	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
y) Coordination/Integration with Other Systems	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
z) Other (specify): Coordinated Discharge Planning	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Developmental Disability Services:						
aa) Crisis Services	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
bb) Clinical Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
cc) Children Services	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>			
dd) Adult Services				<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
ee) Student/Transition Services	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
ff) Respite Services	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
gg) Family Supports	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
hh) Self-Directed Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
ii) Autism Services	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
jj) Person Centered Planning	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
kk) Residential Services	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
ll) Front Door	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
mm) Transportation	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
nn) Service Coordination	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
oo) Employment	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
pp) Workforce Recruitment and Retention.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
qq) Coordination/Integration with Other Systems.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
rr) Other (specify): Day Programs	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Follow-up Questions to "Opioid Treatment Services" (Question 3d)

3d1. Briefly describe the issue and why it is a high need for the populations selected.

Please refer to other sections of this plan that discusses and quantifies the concern. However, increased and more timely access to medication assisted treatment, follow along and continuous care models, single referral line, care for post detox and inpatient and/or residential treatment, related peer and family support, and for those not admitted to detox but suffering from withdrawal a form of a brief residential respite to afford stabilization, symptom management and opportunities for treatment/peer engagement are all among the gaps.

Follow-up Questions to "Outpatient Treatment Services" (Question 3e)

3e1. Briefly describe the issue and why it is a high need for the populations selected.

Speaking largely to greater access and more timely access to medication assisted treatment. Specifically, Suboxone. This is a critical tool required to assist those fighting opioid addiction. Delays of even a couple of weeks in accessing this can often lead to disruptions in treatment attendance and a return to street drug use. This is critical for successful transitions from detox and inpatient care, for those seeking outpatient treatment, as well as for those making a transition from the local correctional facility when using opiates prior to incarceration. There is also a growing concern, that the numbers in the workforce will not be sufficient to meet the demands. Increasing demand due to the opioid epidemic combined with competition for other human service workers due to the expansion of care management services and Home and Community Based Services creates concern about the ability to create enough capacity.

Follow-up Questions to "Residential Treatment Services" (Question 3f)

3f1. Briefly describe the issue and why it is a high need for the populations selected.

Intensive residential services are frequently at capacity. One such regional resource recently reported wait lists that are typically in excess of 40 people.

Follow-up Questions to "Housing" (Question 3g)

3g1. Briefly describe the issue and why it is a high need for the populations selected.

It is difficult for adolescents to leave an inpatient setting and return directly to their home environment. Most of their environments are not conducive to recovery which makes it difficult to focus on their recovery. This results in relapse and on going addictive behaviors. Eventually this leads to increased high risk use and behaviors

Follow-up Questions to "Coordination/Integration with Other Systems" (Question 3k)

3k1. Briefly describe the issue and why it is a high need for the populations selected.

While additional resources continue to be welcomed it is only through the true coordination and collaboration of all such services which recipients of these services "touch" that truly effective and efficient outcomes can be maximized and achieved. Somewhat ironically, and while welcomed, the addition of additional resources and providers increases the challenge of communication, coordination, and integrated care. This is especially salient for complex cases where multiple systems and service providers are involved and in cases where youth receiving services have families which are also receiving care for concerns that affect and impact family stability and childhood/adolescent development. Effective and wide spread use of EHR is one tool to address this concern.

Follow-up Questions to "Clinic Treatment Services" (Question 3p)

3p1. Briefly describe the issue and why it is a high need for the populations selected.

Clinic services can occur on an outpatient basis and allow for a menu of services to be offered. Services such as integrated care (Substance Abuse, Peer Support, Physical Health Screenings, and job readiness skills). Clinics can be a hub for many individuals to receive many services in one setting.

Follow-up Questions to "Housing" (Question 3v)

3v1. Briefly describe the issue and why it is a high need for the populations selected.

One is an issue of access and therefore, Housing services and supports are welcomed and appreciated. The other pertains to proactively facilitating the emergence and development of independent living skills. The move to resources which actively assist individuals in developing community living skills are very welcomed. Suggest a continuing move towards newer beds that are resourced to provide for empowerment, recipient choice, foster independence, and community living skills including employment. Explore best practice models. The shorter Lengths of stay and greater skill development that these have the potential to foster will lead to enhanced consumer outcomes, fewer hospitalizations while increasing capacity.

Follow-up Questions to "Coordination/Integration with Other Systems" (Question 3y)

3y1. Briefly describe the issue and why it is a high need for the populations selected.

Please refer to the response to 3K1.

Follow-up Questions to "Respite Services" (Question 3ff)

3ff1. Briefly describe the issue and why it is a high need for the populations selected.

Respite and Family Support services are essentially one in the same or very closely aligned in that respite services are a high percentage of what is needed by families. The Transformation Panel recommendations for Supporting Families are consistent with local needs for in and out of home support services.

Follow-up Questions to "Family Supports" (Question 3gg)

3gg1. Briefly describe the issue and why it is a high need for the populations selected.

The OPWDD system along with other systems that support people with disabilities is complex. Families and individuals often get lost in the system especially if they are aging in from the school environment. Navigating supports currently in place, let alone services outlined in the transformation agenda are overwhelming. Family Support services provide guidance and education to families so they can better understand the processes for accessing services along with ways to help manage supports. In addition, FSS strongly supports families whose children with disabilities have behavioral issues with accessing various tools, developing strategies and supports. Finally, with self-directed services becoming more of the model of service delivery it is imperative the families learn the programmatic and fiscal options and realities.

Follow-up Questions to "Residential Services" (Question 3kk)

3kk1. Briefly describe the issue and why it is a high need for the populations selected.

The current Residential Opportunity process has changed and imposed some unintended consequences for individuals in need of /desiring certified placements. The evaluative process has caused a growing concern that the new practice has and will continue to delay the filling of certified housing vacancies. Due to the screening and required reporting from providers to OPWDD individuals are waiting longer for placement. Couple with the Certified Placement process the expansive Residential Request List (RRL) has compelled Region 1 OPWDD to facilitate a heightened review process of current residential facilities which include environmental components of the residence, neighborhoods (community integration), leases and agreements to promote independence and individual choice i.e. is the environment too regimented for personal choice. In NYS there are 11,000 individuals on the RRL of which approximately 1100 live in Erie County. Individuals on the list are categorized as follows: Priority 1 individuals who are homeless/are in imminent danger; Priority 2 individuals could soon be homeless or in imminent danger of such i.e., elderly parents are not able to care for appropriately and Priority 3 are individuals who are interested in changing their living environment within

the next year or so. The challenge of managing the RRL is the volume of people who are in need/desire housing assistance. Local discussions include recommendations to OPWDD to also include Housing Planning for the future. Erie County will continue to support Region 1 efforts to allocate new money for individuals living at home and prioritizing placements through the utilization of the Residential Request List.

Local needs generally do not change significantly from one year to the next. It often takes years of planning, policy change, and action to see real change. In an effort to assess what changes may be happening more rapidly across the state, indicate below if the overall needs of each disability population got better or worse or stayed about the same over the past year.

4. How have the overall needs of the mental health population changed in the past year?

- a) Overall needs have stayed about the same.
- b) Overall needs have improved.
- c) Overall needs have worsened.
- d) Overall needs have been a mix of improvement and worsening.
- e) Not sure.

4d. If you would like to elaborate on why you believe the overall needs of the mental health population have been a mix of improvement and worsening over the past year, briefly describe here

There are indications that suicide rates have increased nationally. An article published on April 22, 2016 in the NY Times, cited a study by the National Center for Health Statistics stating that, "The suicide rate for middle-aged women, ages 45 to 64, jumped by 63 percent over the period of the study (2014), while it rose by 43 percent for men in that age range, the sharpest increase for males of any age. The overall suicide rate rose by 24 percent from 1999 to 2014, according to the National Center for Health Statistics, which released the study on Friday. The article continues to state, "The increases were so widespread that they lifted the nation's suicide rate to 13 per 100,000 people, the highest since 1986. The rate rose by 2 percent a year starting in 2006, double the annual rise in the earlier period of the study." Although the comparative time frame is condensed for Erie County, Mortality statistics show similar increases for New York State as well as for Erie County. For instance, the latest period as reported by the Erie County Department of Health, in 2014 and 2015 the Erie County suicide mortality rate is 12.4 and 10.5 respectively. This compares with the suicide mortality rate for Erie County, as reported on the NYS Department of Health website, ranging from the mid to high 7/100,000 in the years from 2004-2006. Additional resources have been helpful to address community integration, Hospital and Emergency Department diversion efforts and goals. However, additional resources does not necessarily lead to better coordination. Consumers would benefit from enhanced coordination and integration of the additional resources and services. Suggest careful data driven review of impact of some of the high caseloads and mix of health home care management.

5. How have the overall needs of the substance use disorder population changed in the past year?

- a) Overall needs have stayed about the same.
- b) Overall needs have improved.
- c) Overall needs have worsened.
- d) Overall needs have been a mix of improvement and worsening.
- e) Not sure.

5c. If you would like to elaborate on why you believe the overall needs of the substance use disorder population have worsened over the past year, briefly describe here

Continued increase in the number of Fatal Opioid Overdoses. Please see other areas w/n this Plan submission.

6. How have the overall needs of the developmentally disabled population changed in the past year?

- a) Overall needs have stayed about the same.
- b) Overall needs have improved.
- c) Overall needs have worsened.
- d) Overall needs have been a mix of improvement and worsening.
- e) Not sure.

6d. If you would like to elaborate on why you believe the overall needs of the developmentally disabled population have been a mix of improvement and worsening over the past year, briefly describe here

Upon review of the Assessment of Local Needs by the OPWDD Subcommittee the areas rated high are due to the changes in service delivery as a result of the OPWDD Transformation agenda. With a focus on community integration the needs of individuals and families has changed/increased. Each of the high need areas identified are also impacted by workforce recruitment and retention and transportation needs. High staff turnover rates inhibits consistent and quality care. As service delivery changes there is question/concern about how future authorization of services will align with individual/family needs and will there be resources available.

In addition to working with local mental hygiene agencies, LGUs frequently work with other government and non-government agencies within the county and with other LGUs in their region to identify and address the major issues that have a cross-system or regional impact. The following questions ask about the nature and extent of those collaborative planning activities.

7. In the past year, has your agency been included in collaborative planning activities related to the Prevention Agenda 2013-2018 with your Local Health Department?

- a. Yes
- b. No

7a. Briefly describe those planning activities with your Local Health Department.

Most notably, a great deal of collaborative work pertaining to the Opioid Epidemic has occurred.

8. In the past year, has your agency participated in collaborative planning activities with other local government agencies and non-government organizations?

- a. Yes
 b. No

8a. Briefly describe those planning activities with other local government agencies and non-government organizations.

Erie County Department of Mental Health is continually involved in collaborative planning activities with several other County Departments and other community stakeholders. A brief summary includes but is not necessarily limited to the following: • Regular participation in various planning groups attended by other County and State Stakeholders and sponsored by the Conference of Local Mental Hygiene Directors • Departments of Social Services and Probation pertaining to a broad array of children’s services and behavioral health reform; • Family Court pertaining to community integration services and supports for youth; • Health Homes, provider agencies, NYS OMH and NY Success to plan and prepare for the transition in services for children; • Department of Health, academia, insurers, the provider community, law enforcement, family members and peers to address Substance use and the Opioid epidemic in particular; • Academia and prevention provider agencies monthly as it pertains to the planning for and provision of Mental Illness and, Alcohol and Substance Abuse prevention; • Erie County Sheriff’s Office, the Department of Health, University Psychiatric Practice, and Community Connections of NY to address Inmate services; • Erie County Senior Services and provider agencies to address service coordination for seniors; • Erie County Medical Center Corporation and other stakeholders to plan for enhanced discharge planning, services for those with a developmental disabilities and co-occurring mental health concerns; • Broad array of government, grass roots and traditional provider agencies for prisoner reentry services; • Regular meetings with other County LGUs in our region pertaining to aspects of behavioral health reform; • Various organizations to review and plan for required management information systems that will assist in program services planning and oversight; • Obtain guidance and recommendations from the Community Services Board and its Subcommittees • Erie County Suicide Prevention Coalition was created with the support of a Garrett Lee Federal grant and Erie county Mental Health funds. The Coalition consists of a cross discipline group from County Government (Health and Mental Health); various school districts; local colleges and community non-profits. The focus has been on evidence –based trainings for clinical and non-clinical staff who encounter youth and young adults. • Currently in the implementation phase with the OMH to improve functions in the local jail system as it pertains to individuals with a Mental Illness. Specifically, the planning group is exploring the development of a System of Evidence-Based Practices for Persons with Mental Illness in Jail will bring \$100K in funding for the next two years that will support efforts to reform the entire process in local jail from initial booking to d/c planning and community integration. (NYS OMH, Erie County Departments of Mental Health, Probation and Health, as well as the Erie County Sheriff’s Office; • Planning is occurring amongst provider agencies, the Erie County Department of Mental Health, Erie County Office of the Disabled, The Tower Foundation, and others to implement a consistent and ongoing anti-stigma campaign.

9. In the past year, has your agency participated in collaborative planning activities with other other LGUs in your region?

- a. Yes
 b. No

9a. List each activity and the LGU(s) involved in that collaboration and provide a brief (one or two sentence) description of the activity.

• Regular participation in various planning groups attended by other County and State Stakeholders and sponsored by the Conference of Local Mental Hygiene Directors (Multiple Counties throughout the State); • Regional Meeting of Local DCS’s and representatives pertaining to Behavioral Health Reform Initiatives and more recently to discuss the implementation of the Regional Planning Consortium (Niagara, Genesee, Orleans, Chautauqua, Cattaraugus, Wyoming); • Planning for the transition of individuals from the State Psychiatric Center to the Community (Niagara, Chautauqua); • Participate with the NY Care Coordination program to plan for, among other issues, individualized person centered, recovery focused services, timely access to care. Participating counties include those representing the Western, Central and Finger Lakes regions; • Implementation related to Forensic Mental Health Services (Monroe)

9b. Did your collaborative planning activities with other LGUs in your region include identifying common needs that should be addressed at a regional level?

- a. Yes
 b. No

9c. Did the counties in your region reach a consensus on what the regional needs are?

- a. Yes
 b. No

9d. Briefly describe the consensus needs identified by the counties in your region

While no formal process or agreement is in place discussions have tended to focus on recent reinvestment initiatives, diversion services, and among counties that are behavioral health service providers (which Erie is not), planning for those services in a managed care environment. More

recently, discussions have also included preparations for the implementation of Regional Planning Consortiums. It is expected that there will be greater clarity and focus in the coming months.