

2012 Planning Activities Report Form (Part A: Needs Assessment)

Erie County Dept. of Mental Health (70290)

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

I. Assessment of Mental Hygiene Problems - Provide a brief geographic and demographic description of the service area. Based on all the planning and needs assessment activities conducted over the past year, define the nature and extent of mental hygiene problems in the county. Include only the results of qualitative and quantitative activities in this section and describe those activities in more detail in Item #3 below. Describe how specific resources available on the CPS County Data Page were used in your needs assessment. Resources you may find particularly helpful include: OMH County Mental Health Profiles (Community Characteristics), OASAS Service Need Profiles, and OASAS Chemical Dependence Treatment Profiles.

Erie County is a large diverse county comprised of rural, suburban, urban, and island areas. Its western line is Lake Erie and the Niagara River shoreline. It covers approximately 1,044 square miles and borders two Native American reservations. It is at the western end of New York State. The 2009 population estimate from the U. S. Census Bureau indicates that total population for Erie County is 909,247, with a relatively equal split between males and females.

Erie's largest city is Buffalo with a total population of approximately 270,240. Buffalo, with Lake Erie and the Niagara River on its western boundary, is otherwise surrounded by several large first and second ring "suburban" cities and towns, and numerous towns and villages beyond, including much agricultural land.

According to 2009 estimates of the U.S. Census bureau, the largest of the communities surrounding Buffalo are the Town of Amherst at approximately 115,535 and, Cheektowaga at approximately 87,496. Four more each have a population of approximately 40,000 to 80,000. The local economy is varied and includes manufacturing, services, small business, government, farming and, several colleges and universities. Government and public schools are among the larger employers, given 54 cities, towns and villages and, 30 school districts. The county's ethnic and racial mix is diverse, with a non-English-speaking populace included.

The median household income of Erie County is approximately \$48,427 with close to 14% of the individuals living below the poverty line. According to national statistics, Buffalo is one of the poorest communities of its size in the United States.

Erie County, New York

People QuickFacts

	Erie County	New York
Population, 2009 estimate	909,247	19,541,451
Population, percent change, April 1, 2000 to July 1, 2009	-4.3%	3.0%
Population estimates base (April 1) 2000	950,265	18,976,811
Persons under 5 years old, percent, 2009	5.4%	6.3%
Persons under 18 years old, percent, 2009	21.5%	22.6%
Persons 65 years old and over, percent, 2009	15.8%	13.4%
Female persons, percent, 2009	51.8%	51.4%
White persons, percent, 2009 (a)	82.6%	73.4%
Black persons, percent, 2009 (a)	13.5%	17.2%
American Indian and Alaska Native persons, percent, 2009 (a)	0.7%	0.6%
Asian persons, percent, 2009 (a)	1.9%	7.1%
Native Hawaiian and Other Pacific Islander, percent, 2009 (a)	Z	0.1%
Persons reporting two or more races, percent, 2009	1.2%	1.6%
Persons of Hispanic or Latino origin, percent, 2009 (b)	4.0%	16.8%
White persons not Hispanic, percent, 2009	79.3%	59.9%
Living in same house in 1995 and 2000, pct 5 yrs old & over	62.9%	61.8%
Foreign born persons, percent, 2000	4.5%	20.4%
Language other than English spoken at home, pct age 5+, 2000	9.0%	28.0%
High school graduates, percent of persons age 25+, 2000	82.9%	79.1%
Bachelor's degree or higher, pct of persons age 25+, 2000	24.5%	27.4%
Persons with a disability, age 5+, 2000	168,549	3,606,141
Mean travel time to work (minutes), workers age 16+, 2000	21.3	31.1
Housing units, 2009	423,872	8,017,881
Homeownership rate, 2000	65.3%	53.0%
Housing units in multi-unit structures, percent, 2000	40.0%	50.6%
Median value of owner-occupied housing units, 2000	\$90,800	\$148,701
Households, 2000	380,873	7,056,861
Persons per household, 2000	2.41	2.6

Median household income, 2008	\$48,427	\$55,98
Per capita money income, 1999	\$20,357	\$23,38
Persons below poverty level, percent, 2008	13.5%	13.7%
Business QuickFacts	Erie County	New York
Private nonfarm establishments, 2008	22,619	518,632
Private nonfarm employment, 2008	409,334	7,617,164
Private nonfarm employment, percent change 2000-2008	-0.8%	3.6%
Nonemployer establishments, 2008	42,444	1,513,17
Total number of firms, 2002	57,556	1,707,16
Black-owned firms, percent, 2002	4.0%	7.6%
American Indian and Alaska Native owned firms, percent, 2002	0.4%	0.7%
Asian-owned firms, percent, 2002	2.2%	8.5%
Native Hawaiian and Other Pacific Islander owned firms, percent, 2002	F	0.2%
Hispanic-owned firms, percent, 2002	1.4%	9.6%
Women-owned firms, percent, 2002	27.1%	29.6%
Manufacturers shipments, 2002 (\$1000)	13,494,429	147,317,46
Wholesale trade sales, 2002 (\$1000)	D	343,663,04
Retail sales, 2002 (\$1000)	9,838,147	178,067,53
Retail sales per capita, 2002	\$10,448	\$9,29
Accommodation and foodservices sales, 2002 (\$1000)	1,213,115	27,835,95
Building permits, 2009	973	18,34
Federal spending, 2008	7,968,228	174,070,949
Geography QuickFacts	Erie County	New York
Land area, 2000 (square miles)	1,044.21	47,213.7
Persons per square mile, 2000	910.2	401.
FIPS Code	029	3
Metropolitan or Micropolitan Statistical Area	Buffalo-Niagara Falls, NY Metro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.

(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information

F: Fewer than 100 firms

FN: Footnote on this item for this area in place of data

NA: Not available

S: Suppressed; does not meet publication standards

X: Not applicable

Z: Value greater than zero but less than half unit of measure shown

Overview

The Behavioral Health System in New York State and specifically in Erie County is in a period of rapid change due to environmental factors such as Medicaid Reform, Health Care Reform and budget constraints. In Erie, we are focused on preparing for a Managed Care environment through data driven management, fidelity to practice, utilization management, practice to outcome models, quality improvement and improved performance accountability. Our goal is to be able to provide the right service to the right person at the right time for the right length of time. The examples below illustrate our approach to using quantitative and qualitative tools to identify problems and areas of focus in the planning/system management cycle.

The purpose of the Adult SPOA (Single Point of Access and Accountability) is to ensure right service/right person/right time/right length of time for high need, high risk individuals. However, when we looked at 2008 Medicaid Adjudicated fee for service claims, only 25% of the highest cost individuals were enrolled in Care Coordination for Care Coordination. This alerted us to a problem, and we have since begun a SPOA reform process.

We have indications that our use of residential beds is different from state wide use. In Erie County the percentage of individuals with a length of stay over 2 years in congregate treatment is 39% and apartment treatment is 56% while the state wide numbers are 31% and 42% respectively. This difference points out the need for further examination, and an opportunity to use existing beds more effectively.

Our review of the PQI (Potentially Preventable Hospitalization) data demonstrates that there are opportunities to save cost and improve care with better coordination of services, specifically integration of health and behavioral health. Individuals with a current alcohol/substance abuse disorder, major mental health diagnosis, co-occurring alcohol/substance abuse disorder or other mental health disorder make up the following percentages of preventable hospitalizations by physical condition:

- diabetes- 31%
- circulatory condition - 27%
- respiratory - 38%
- Acute conditions such as infection - 40%

The PQI data is for all payors. Medicaid fee for service for Erie County mental health consumers in 2010 as of February 2011 is broken out as follows:

- OMH licensed services - 31%
- Non-OMH behavioral health services - 28 % (includes psychotropics)
- Non-behavioral health services - 41%

The PQI data and the Medicaid fee for service data both indicate that non-behavioral health issues are important for the individuals whom we serve, particularly in a managed care environment.

Prevalence of Chemical Dependence Problems

According to the most March, 2011, prevalence statistics supplied by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) as applied to 2009 population estimates the prevalence of substance abuse (all substances including alcohol) for Erie County residents ages 12 and above is estimated to be 100,502 or, 12.8% of the population.

OASAS estimates total treatment demand, the number of individuals with chemical dependence problems who would engage in treatment services, at approximately 29,104 individuals. According to treatment statistics, Erie County is meeting roughly 67% of the overall treatment capacity needed. This compares to statewide capacity being 72% of the state wide need.

A closer look at these statistics shows there is approximately 7,296 adolescents (age 12-17) who are dependent on non-opiates, an estimated 25% (1,824) of whom would accept treatment. Of this estimated demand, according to the OASAS Service Need Profile, roughly 47% of this demand is being met. Programs serving adolescents continue to report seeing continuing growth in the abuse of prescription drugs by youth, particularly pain killers such as Oxycontin and Vicodin. Heroin use continues to be a small but notable problem in the late teen to early adult age group although anecdotal reports indicate that the number is growing.

Alcohol abuse and alcoholism continues to be largest chemical dependence problem. Adult prevalence of alcohol only problems is present in an estimated 9.8% of the total population while prevalence of all other drugs or other drugs in combination with alcohol is present in an estimated 2.6% of the population in Erie County.

According to a recent survey completed by Roswell Park Cancer Institute, 83% of Erie County 9th graders get their alcohol from home or someone they know (as opposed to a purchase) and, that alcohol use is three times more prevalent than illicit drug use.

Beyond the OASAS provided prevalence estimates and treatment statistics, the following are various reported and anecdotal observations regarding chemical dependency in Erie County:

Methamphetamine

It appears that there has been little or no change in methamphetamine abuse in Erie County since last year's plan. This information is repeated here.

Nationally and, in other areas of New York, particularly in New York City, dramatically increasing prevalence in the abuse of methamphetamines and its associated serious ramifications have been widely reported in recent years. Because this has drawn sharp attention to itself it is necessary to briefly report on Erie County's experience with methamphetamine use.

According to local treatment providers methamphetamine continues to be minimally present here. DEA sources report that methamphetamine trafficking and abuse in New York State is a less serious problem when compared to heroin, cocaine, crack, and MDMA. According to treatment agency reports, the few individuals who have participated in Erie County treatment programs for methamphetamine are transplants from other states.

Heroin

As reported in the 2010 Plan, of greater concern to local law enforcement is a continuing influx of relatively cheap, high quality heroin. Methadone providers reported over the past few years a trend of decreasing age in those seeking care. Recent reports indicate that this trend seems to have leveled-off with many being around 30 and, with there being a handful currently in methadone treatment at age 18. However, as noted above, adolescent treatment providers, the County Health Department and, local law enforcement are seeing a small but increasing problem of adolescent heroin use.

DEA Pharmaceutical Threat Assessment

This is assessment, presented in the 2010 Plan, is thought to be largely of continuing relevance and is therefore included in this 2012 Plan.

In the fall of 2008 the local DEA office conducted a survey of various treatment providers, hospitals and, law enforcement regarding availability and unprescribed use of pharmaceutical drugs in Western and Central New York. While far from a scientific survey, its results are reproduced here for the interesting picture it presents regarding the growing abuse of prescription drugs:

Pharmaceutical Threat Assessment 2008

1. Which diverted controlled pharmaceuticals in your division are of greatest concern?

· Oxycodone (Oxycontin, Percocet), hydrocodone (Vicodin, Lortab), fentanyl (Duregesic patches and lollipops), benzodiazepines (Xanax, Klonopin), and methadone. A commonly diverted non-controlled substance is carisoprodol (Soma).

2. What controlled pharmaceuticals are most abused and by what demographic group?

- Hydrocodone and Oxycodone are the most frequently abused pharmaceuticals.
- These pharmaceuticals are being abused primarily by Caucasian and Hispanic males and females ranging in age from teens through the forties.
- Age of abusers is trending lower throughout Western New York.
- Soma (non-controlled substance) is popular primarily among the African-American population.

3. What are the average street prices of the diverted controlled pharmaceuticals in your division that are of greatest concern?

- Hydrocodone ranges from \$2-\$8 per tablet.
- Oxycodone averages about \$1 per milligram for smaller doses. One source quoted a street price of \$50 for an 80 milligram tablet.

- Percocet ranges from \$3-\$4 per dose.
 - Valium and Xanax have been reported as low as \$.25 - \$.50 per tablet.
 - Prices were obtained from local law enforcement sources as well as area treatment centers for chemical dependency.
4. Which areas in your division are most affected by the abuse of diverted controlled pharmaceuticals?
- Urban and rural areas of Western New York are affected equally.
5. Are there any unique characteristics within your division that impact the threat?
- The area of responsibility for the Buffalo RO includes the international border with Canada as well as the border with Pennsylvania while also being within close proximity to major drug trafficking and distribution centers such as New York City and Philadelphia.
 - These unique characteristics can have a direct affect on the supply and price of diverted controlled pharmaceuticals in the area.
6. How many fatal overdoses can be attributed to abuse of controlled pharmaceuticals in your division for each year from FY 2003 to present?
- This information is difficult to obtain due to confidentiality issues and the fact that most abusers of controlled pharmaceuticals are poly-drug abusers making it difficult to attribute overdose deaths directly to a controlled pharmaceutical.
 - One local drug treatment center reported the July 2008 death of a 43 year old female from the abuse of fentanyl patches.
 - Another local treatment center reported two fentanyl overdoses in Hamburg, NY within the last six months but had no further details available.
 - The Cattaraugus County Sheriff's Department reported that there have been "four or five" fatal overdoses in the Southern Tier region since 2003. At least one of these overdoses involved the injection of a mixture of Oxycontin and fentanyl.
7. Have drug treatment programs in your division observed an increase or decrease of abuse of controlled pharmaceutical substances from FY 2003 to present?
- All contacted drug treatment programs reported an increase in abuse of controlled pharmaceuticals since 2003. Some centers are reporting waiting lists of abusers seeking admittance to their programs.

Diversion Methods

1. How are controlled pharmaceuticals diverted and distributed in your division?

- Internet ordering.
- Fraudulent prescriptions and call-in prescriptions.
- Thefts from residences, hospitals, doctor's offices and pharmacies.
- Doctor shopping.

2. How and to what extent are mail and parcel carriers unwittingly being used in the diversion of controlled pharmaceuticals in your division?

- The only known use of mail and parcel carriers in diversion of pharmaceuticals are those delivering pills purchased from online pharmacies.

3. How and to what extent is the Internet used for diversion of controlled pharmaceuticals in your division?

- The Internet is widely used by abusers purchasing controlled substance from online pharmacies without a legitimate medical need.
- Drug traffickers are also using the Internet to facilitate the sale of diverted controlled pharmaceuticals via email and other forms of electronic communication.

4. Has the availability of Internet diversion of controlled pharmaceuticals changed in your division from FY 2003 to the present?

- Internet diversion of controlled pharmaceuticals has increased since 2003.

PROBLEM AND PATHOLOGICAL GAMBLING IN ERIE COUNTY

(This assessment is repeated from the prior year's Plan.)

The Erie County Department of Mental Health requested an analysis of local compulsive gambling needs in Erie County from the OASAS certified gambling recovery program Jewish Family Service of Buffalo and Erie County. The program has a long tenure of providing gambling recovery services in Erie County and is widely viewed as a local expert on this issue. It has a long history of tracking and assessing the compulsive gambling issues in Erie County. In addition, the OASAS Household and School surveys were utilized. (1, 2)

The 2008 US Census Bureau Population estimate for Erie County is 909,845, of which 710,589 adults are over the age of 18. Utilizing the OASAS prevalence estimate of 4.9% of adult population from the OASAS 2006 Household Survey, it is estimated that the number of adults in Erie County with problem gambling is estimated to be 34,819. (2) According to the National Council on Problem Gambling:

Problem gambling is gambling behavior which causes disruptions in any major area of life: psychological, physical, social or vocational. National Council on Problem Gambling. Web page: www.ncpgambling.org, July 2007.

In addition, according to the OASAS 2006 School Survey of adolescents approximately 10 percent of NY State students in grade 7-12 have experienced problem gambling in the past year and my need gambling treatment services. An additional 10 percent of NY State students may be at risk of developing problem gambling. (1)

Studies have found that as gambling opportunities increase, the rate of gambling problems increase. In the case of casinos, having a casino

within 50 miles doubles the prevalence rate, (3). Gambling opportunities have increased significantly in Erie County, with seven gambling venues within a 50 mile radius (including the two, easily assessable, in Canada).

References:

1. Rainone, G. and Gallati, R.J. (2007) Gambling Behaviors and Problem Gambling Among Adolescents in New York State: Initial Findings from the 2006 OASAS School Survey. NYS Office of Alcoholism and Substance Abuse Services.
2. Rainone, G., Marel, R., and Gargon, N. (2007) Gambling Behaviors and Problem Gambling Among Adults in New York State: Initial Findings from the 2006 OASAS Household Survey. NYS Office of Alcoholism and Substance Abuse Services.
3. National Opinion Research Center at the University of Chicago, et al. (1999) Gambling Impact and Behavior Study: Final Report to the National Gambling Impact Study Commission. <http://www.norc.uchicago.edu/new/gamb-fin.htm>
4. New York State Office of Alcoholism and Substance Abuse Services 2009 Local Services Plan - Erie County Dept. of Mental Health (70290) and pathology. Journal of Gambling Studies. 20(4), 405-423.
5. Report to the New York Council on Problem Gambling. (1996) Gambling and Problem Gambling in New York: A Ten-Year Replication study, 1986-1996. <http://www.nyproblemgambling.org/pubs.shtml#adult>

CPS resources used:

NYS and County Quick Facts

PQI data

OMH County Mental Health Profiles - Medicaid Paid

OMH County Mental Health Profiles - Residential Program (note that SROs are missing from this report)

OASAS Service Need Profile - March, 2011

2. Analysis of Service Needs and Gaps - Based on the needs assessment results reported in Item #1 above, describe and quantify the mental hygiene prevention and treatment service needs of the population, including recovery support services and 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 and quantify the gaps between services needed and services provided. Describe existing barriers to accessing needed services. Use this section to identify target populations and specialized service needs. Use this section to describe changes in the current configuration of the local service system that you believe would better meet the needs of individuals and families in your county, and identify any capital improvement needs within the local mental hygiene service system. This item provides the basis for developing priority outcomes and related strategies designed to achieve those outcomes. Resources you may find particularly helpful in completing this item include: OMH County Mental Health Profiles (Service Use Snapshot), OASAS Service Need Profiles, and OASAS Summary of County Profiles, OPWDD County Profiles, and OPWDD Special Population Enrollments.

PREVENTION SERVICES

Cost effective programs and activities for the prevention of chemical dependency and problem gambling is a priority category of service for Erie County. Recognizing the limited resources currently available for prevention, recurring intensive evidence based prevention services are to be targeted primarily to those individuals and communities at highest risk for chemical dependency and problem gambling. Environmental strategies are being employed to support existing other prevention efforts in targeted communities and settings and, to bring prevention messages to all residents of the County, to the greatest extent possible.

Since 1994 the Department has articulated approaches to targeting services based on documented risks for addictions. As described in the Local Services Plans of the past several years, it has made available to its provider system a database of relevant archival risk indicators (Risk Indicator Database – RIDB) with associated “risk maps” of the county. The RIDB has provided the additional benefit of readily accessible archival data for meeting one OASAS Prevention Activity and Results Information System (PARIS) needs assessment requirement. The Department has sponsored provider training for conducting Key Informant Interviews and, Focus Groups, to further aid in their meeting of PARIS needs assessment requirements.

Contracted prevention providers are required to provide their services primarily to those communities and/or specifically identified populations shown as at highest risk.

The Department’s long-standing working relationship with the Buffalo State College, Center for Health and Social Research (CHSR) has continued for prevention needs assessment and, performance measurement. In November of 2007, the Department initiated with all prevention providers a series of participative meetings for updating the County’s prevention needs assessment and long term, comprehensive prevention plan.

This prevention plan, developed in partnership with Dr. William Wiczorek, Director of the CHSR and, with both substance abuse and mental health prevention providers under contract with the Department, was finalized in March, 2009. The collaborative implementation work for this plan was initiated in April, 2009.

The following is the Executive Summary from Erie County’s prevention plan:

The Buffalo State Center for Health and Social Research (CHSR) was designated by the Erie County Department of Mental Health (ECDMH) to implement a collaborative process to develop a multi-year, comprehensive prevention plan. The development of the plan was a deliberately methodical approach that was collaboratively inclusive of chemical dependency and mental illness prevention agencies in Erie County, CHSR, ECDMH, and the Western Field Office of

the New York State Office of Alcoholism and Substance Abuse Services (OASAS). The planning process required more than a year of interactive meetings to identify the goals and guiding principles on which to implement prevention programming and to ensure the continuing evolution of a vibrant, evidence-based prevention system responsive to the public health needs of Erie County.

The comprehensive prevention plan is divided into separate sections that include the planning process, system goals, prevention implementation, system impact assessment, system coordination, system development, and career enrichment. Also included are two appendices that identify the participants in the development of the plan and supporting data and documents used in the planning process.

Section 2 of the plan describes the process of developing the plan. The process was driven by collaborative meetings to identify the values of the prevention system, identify challenges to the system and their potential solutions, interpret and discuss data on prevention needs and gaps in prevention services, to develop prevention priorities and guiding principles, and to provide feedback and guidance for each section of the plan and for the entire final written plan.

Section 3 of the plan presents the mission of the entire prevention system; all subsequent sections of the plan are explicitly related to the overall mission. The mission statement includes goals in three areas: system goals, target populations, and prevention resources. There are two system goals; the first focuses on the desired public health impact of the prevention system (e.g., to delay alcohol, tobacco, and drug use and the onset of unhealthy behaviors, to prevent substance use disorders and mental illness, to promote and maintain a healthy population), whereas the second focuses on providing a continuum of prevention services (i.e., universal, selective, and indicated). The target population goals are to provide prevention coverage to the entire population of Erie County and to implement targeted (selective, indicated) programs for higher-risk populations. The goals pertaining to prevention resources are to ensure sustained investment in professional development for individuals and agencies in the prevention field, and to invest in cost-effective programs while recognizing that higher-risk populations require commensurately greater resources.

Sections 4 and 5 present the guiding principles for implementing prevention programs and services in Erie County. Section 4 focuses on the overall provision of prevention services by identifying ECDMH as providing oversight for services and coordination with OASAS, while using the principles to guide the operation and evolution of the prevention system. Individual agencies are responsible for using the guidelines to develop yearly prevention work plans. The guiding principles are the concepts that drive decisions regarding the nature of the prevention programming in Erie County, including where and to whom services are targeted, the type of program and its evidence base, and data utilization for needs assessment and program quality assurance. One of the basic principles is to provide prevention services to the entire population, while also providing more intensive services to those populations at highest risk. A key principle is to increase the utilization of evidence-based practices across a spectrum of prevention modalities that are responsive to the full array of risk and protective factors. Another main principle is to drive program decisions and the continual improvement of the prevention system through the utilization of various data sources, such as archival indicators (e.g., Risk Indicator Data Base), program evaluation, and other data sources (e.g. surveys, key informants, focus groups, prevention gaps analysis).

Section 5 identifies the guiding principles for implementing an environmental prevention and community education strategy for Erie County. The early stage of environmental prevention in Erie County and the nature of environmental prevention approaches (i.e., based on changing social norms, enforcement of current laws/regulations, and improving/developing policies to discourage unhealthy behaviors, all of which are based on collaborations) require a large amount of coordination. An environmental planning committee will oversee the implementation of coordinated environmental prevention and community education services. The guiding principles for environmental prevention include identifying all environmental and community education programs, coordinating these programs across agencies to enhance impact, identifying specific goals that are aligned with specific SAMHSA national outcome measures (NOM). Each agency with substantial environmental and community education programming will develop a written plan that specifies how their approaches are aligned with the plan.

Section 6 focuses on the plan for implementing a coordinated approach to measuring the impact of the prevention system. The basic principles of this plan are to utilize a consultant agency's expertise, in collaboration with ECMH and prevention providers, to develop a yearly dash-board style report of measures that align with the SAMHSA national outcome measures. The main purpose of the impact and outcome assessment system is to provide information on whether the prevention system as an entire entity is having discernable effects on the health and well being of Erie County, especially persons under age 21. The County is divided into six subareas to facilitate the analysis of trends for key outcomes. Survey data on CD-specific measures will be used to supplement the archival data, as will comparisons to other similar counties in New York State to identify whether Erie County and the subcounty areas are showing improving, declining, or stable trends.

Section 7 identifies the procedures for improving coordination and collaboration across the prevention system. A coordinating committee consisting of decision-making representative of the prevention providers and others identified by ECDMH will implement this portion of the comprehensive plan. A key principle for enhancing coordination is the development of a central information repository that facilitates the sharing of descriptive information on each prevention agency, its programs, and capabilities. Other collaboration principles include regular networking sessions, coordination of media utilization, and specific coordination on such issues as strategies to enhance school-district access and the sharing of staff and the co-location of services. Collaborative opportunities will be assessed on a yearly

basis to identify the number and quality of collaborations, as well as to identify ways to improve collaborative coordination.

Section 8 presents the guiding principles required to support system development. The system development goals will be implemented by a work group which may be a subset of the coordinating committee for section 7. This work group will identify the yearly priorities pertaining to system development. The key goals for the system development focus on three issues: resources, marketing, and outreach. The guiding principles are to maintain and enhance resources for prevention, to implement marketing of the prevention system to increase recognition and funding, and to enhance community outreach, especially efforts to eliminate the stigma associated with mental health and chemical dependency.

Section 9 focuses on issues associated with mental health/chemical dependency career enrichment. A career enrichment workgroup will coordinate the activities assorted with this section of the comprehensive plan. The membership of this workgroup will be jointly determined by ECDMH and prevention providers. The goal of this aspect of the plan is to support the overall mission of the prevention system by ensuring that a well-trained and experienced staff of prevention professionals is in place to deliver prevention services. The guiding principles are to focus on identifying career path opportunities, support for training, recognition of those in the field, and creating recognition of the opportunities in the field for those students and others that are currently students in higher education. Career enrichment activities will focus on making prevention a career of choice, identifying resources to support professional development, to strengthen career-track infrastructure, and to coordinate with OASAS and other training opportunities.

Please see the full plan at: http://www.erie.gov/health/mentalhealth/chemical_dependency.asp

Please note that while implementation of this prevention plan has increased the number and quality of collaborative environmental strategies, we do not have yet updated data to discern whether there are any significant changes in need as a result. We do believe that previously identified gaps in prevention services remain largely consistent with the findings published in the Prevention Plan due to there have been no additional funding for these services and, there remains many communities with the County that receive little or no targeted prevention due to resource limitations. It should be noted, however, that CHSR is conducting a representative sampling survey of the County to begin to get better data.

CD TREATMENT SERVICES

Crisis Services

Erie County's crisis system for managing the acute effects of addiction including intoxication and withdrawal is generally of high quality, with low rates of complications and with rates of engagement in further treatment above the state average. Despite changes in patterns of drug use (e.g. the explosion of prescription drug dependence and an increasing presence of heroin use among individuals under the age of twenty-one) and in treatment methods and despite regulatory restructuring of 28 local community-based detoxification beds, the system capacity and configuration has not changed significantly in many years. Further, there are significant opportunities for cost reduction while maintaining quality.

Primary problem areas that could present opportunities for improving access, quality of care and cost effectiveness include:

Detoxification service providers report that significant numbers of people who need only services for acute intoxication are brought to emergency rooms instead of to treatment programs.

One detoxification provider estimated that roughly fifty percent (50%) of opiate dependent patients currently being served in medically managed detoxification programs could be more cost effectively managed by medication assisted treatment in less costly non-hospital based medically supervised or outpatient treatment.

Providers report that many patients stay beyond needed length of stay while awaiting linkage to stable housing or residential treatment.

Systems of reimbursement discourage use of lower levels of care by not covering them.

To maintain a high level of quality and to improve efficiency, several systems changes are needed. These changes will require coordination of state, county, and provider resources.

As referenced in recent previous Local Services Plans, in 2008 the Department convened a workgroup to examine these issues and to develop associated recommendations. The work of this group produced a report with recommendations that has been separately submitted to OASAS. Moreover, the workgroup has voluntarily continued to meet to begin implementation of those recommendations requiring little or no new funding and, to develop a detailed plan of implementation for those recommendations requiring new resources and/or OASAS participation.

OASAS service needs estimates indicate that additional capacity is needed for Crisis Services. However, local wisdom is that the current capacity is sufficient, especially when utilization is taken into account.

Outpatient Services

Adult Outpatient Treatment

The OASAS Service Need Profile methodology as adjusted by the Sub-county plan indicates that about 64% of the adult outpatient treatment need is being met. A closer look at Erie's outpatient sub-county planning tool reflects a picture that some areas of the county have little or no needed outpatient capacity and yet others have sufficient or even excessive capacity. For example, it suggests that the City of Buffalo has more outpatient treatment capacity than necessary, meeting 135% of the need while it appears that sub-county Planning Areas along the southern and eastern boundaries of the County, numbers 5 and 6 are meeting 0% and 6.8%, respectively. Meeting the need in such grossly underserved areas should be an overarching priority consideration in regard to further development of this level of care.

Planning Area #'s 5 and 6 have a significant rural quality characterized by little or no public transportation. Alternatives such as tele-counseling might be considered if the level of potential service demand in these areas would be insufficient to support the cost of locating clinics there.

While this sub-county methodology is far from being scientifically accurate, it does provide a more focused starting point in considering local need within specific geographic areas within the County. It therefore will allow Erie County to consider outpatient services deployment more appropriately than in the past.

Methadone Treatment

OASAS Service Need Profile of March, 2011, indicates that currently approved and operating capacity of 980 slots is meeting 56.8% of local need.

Methadone providers continue to report that they are not able to admit all those seeking service due to being consistently at capacity.

The CAO-DART program has been approved to expand its capacity by 100 slots. It is anticipated that these additional slots will become available in early June, 2011.

The DART program has agreed with the detoxification providers to experiment with establishing both a rapid admission track for individuals referred from detoxification and, possibly a methadone-to-abstinence track for appropriate individuals referred from detoxification once the anticipated new capacity is established.

Inpatient Rehabilitation

OASAS considers this level of care to be a Regional rather than strictly County, resource. The Service Need Profile of March, 2011, indicates that currently approved and operating Inpatient Rehabilitation capacity of 221 beds is meeting 113.3 % of the calculated need for this level of care in the Western Region.

The Erie County Medical Center Corporation has given notice that has reduced its inpatient rehabilitation capacity by 15 beds as May 1, 2011. This reduces the OASAS calculated need being met to 105.6%.

Residential Services

The OASAS Service Need Profile data reflects a Regional unmet need of 695 Intensive Residential beds and, an Erie County unmet need of 184 Community Residence beds. While Erie County does not presently have sufficient data to confirm the accuracy of these figures, it does concur that significant expansion of these levels of residential care is needed.

However, what has not been thoroughly examined on the local level nor, to the best of our knowledge, at the State level is what would the effect on need and utilization be if the system was re-designed to meet the needs of those currently accessing those services with intensive and targeted community based services and supports.

For instance, intensive community based care coordination services which would provide non traditional care coordination, life skill development specific to individual needs, available crisis supports that go beyond traditional business hours/days, family intervention and supports, etc. may decrease the need for residential services on two planes. The first being, if those services were offered as part of an aggressive discharge planning process that focused on effective transition to the community by providing such intensive community services and supports shortly after the point of admission into community residence and especially intensive residential services it is believed that LOS could be shortened without negatively impacting upon and hopefully improving outcomes.

It is acknowledged that existing services currently clearly provide discharge and transition planning. However, they do so without the resources available to them that are discussed here. In addition, if such services were provided to

individuals who met certain criteria predictive of further penetration into more intensive residential services prior to the need for such services rising to that level, we may be able to prevent placements in residential care when with these additional supports the individual would be able to maintain sobriety in the community.

Therefore, more of the existing bed space might be made available by a decrease in utilization by decreasing LOS of many of those that are admitted and preventing admissions to residential services for those whom with the proper supports would be able to maintain there sobriety without utilizing such high levels of care. This is not to say that these efforts would eliminate the need for any additional residential services but it may create greater access while providing community based care.

Expanded housing resources remains a high need in Erie County. As referenced in the detoxification report described earlier, crisis or emergency housing capacity is virtually non-existent. This type of housing resource would likely go a long way toward improving engagement with the recovery system during a crisis involving an individual's need to separate from his/her current living situation. It can also relieve some of the demand pressure on and expense of inpatient services that are sought and provided in part due to this need for crisis housing. In this case, were the crisis or emergency housing available, treatment services in these instances might appropriately and more cost-effectively be provided in a non-hospital based or even outpatient setting

Problem Gambling

Prevalence and Needs estimates are not currently available from NYS OASAS within the County Service Need Profile it updates a few times per year. The following information is from the prior year's Plan.

Utilization of gambling recovery services in Erie County's single NYS OASAS certified gambling recovery program, reflects the decline in available resources. This is evidenced by the decline in Intake calls (request for services). The number of unique persons serviced in the program declined approximately 10.8% in 2008 and 14.5% in 2009. In 2008, with the addition of a minority staff member, African American admissions rose to 11.4%. However, in 2009 with the reduction of the minority staff member and the reduction in education and outreach funds from the prior year, African American admissions fell to 5.6%. Hispanic admissions fell to 2.4% in 2008 and declined to 1.4% in 2009.

Barriers to accessing treatment service and the continuing decline in 2008 and 2009 unique persons served are accounted for by several continuing factors:

§ Reductions in Direct Care Staff from 2.83 in 2007 to 1.0 in 2010.

§ Reduction and elimination of problem gambling outreach/education services to adults and organizations in 2008, both in the minority and non minority communities in Erie County as a component of State funded services in the treatment program. Local problem gambling prevention services continue to be limited to a few schools. Outreach services to adults and community organizations in Erie County are non-existent. Outreach services to adult minority communities are also non-existent.

§ Reduction and elimination of public awareness advertising campaigns. The strategically placed Billboards of 2007 were eliminated in 2008. Advertising on public transportation buses was eliminated in April 2009 due to erosion of available funding.

It is clear the demand for treatment of problem gambling is negatively affected by the stigma associated with admitting and seeking assistance. The demand for treatment is also negatively affected by the ability to engage both the minority and non minority Communities in Erie County. The implementation of expanded public awareness and education campaigns might stimulate growth in the number of problem gamblers seeking treatment.

§ Erie County's recommendations for chemical dependency prevention, consistent with those articulated by OASAS are:

§ To use evidence-based programs that yield proven, measurable results;

§ To increase public awareness of alcohol, drug and gambling problems; and,

§ To provide communities and residents with the knowledge and skills necessary to develop and/or maintain attitudes and behaviors so they can be safe and healthy.

CD POPULATIONS OF NOTE

Chemical Dependency and Criminal Justice

According to the February 2010 County Reentry Task Force Report provided by the NYS Division of Criminal Justice Services as of the end of January 2010, Erie County had 1258 active parolees. Of these, 32.9% were employed at some level and 689 were lodged in a housing program. The needs of these individuals are frequently diverse and touch multiple life areas including but not limited to alcohol and substance abuse, mental health, appropriate housing, social skills, and employment.

In an effort to better respond to the needs and issues presented by the returning parole population, NYS has developed County and State level Reentry Task Forces. The Erie County Reentry Task Force (ECRTF) was formed in

response to a NYS Division of Criminal Justice (NYS DCJS) grant awarded to the Erie County Department of Mental Health. This Taskforce comprised on state, county and local service providers has a threefold focus:

- 1) To provide coordinated services to high risk offenders, including housing, employment, education, family support, mental health/substance abuse services and physical health and other transitional needs. The Taskforce will coordinate with other state criminal justices agencies as well as other human service providers to develop a well defined plan for transitioning former offenders back into the community.
- 2) To assess the current system of offender transition in Erie County and implement strategies to promote successful reentry.
- 3) To assist in developing the community's capacity through means such as public education, establishing mentoring programs, and inclusion of former offenders in volunteer services as a means of reparation.

A review of system-wide gaps and barriers indicated a need for a subcommittee structure to be included in the Taskforce that can identify and obtain community solutions for issues facing the parolee upon return to the community.

The Taskforce provides oversight to two reentry initiatives in Erie County:

The Erie Reentry Unit - Located at Orleans Correctional Facility is a 60 bed unit that provides pre-release services to high risk individuals returning to the county. This 90 day program includes linkage with Reentry Care Coordination services that will work with former offenders for 9 -12 months post release. Care Coordination provides assessment, service planning, transitional planning, wrap services, linkage, referral for criminogenic/stabilization needs, and an ongoing working relationship with NYS Parole to better serve the offender once he returns to the community.

County Taskforce Model - Reentry Care Coordination works hand-in-hand with NYS Parole to screen and serve high risk/high need offenders who are return to Erie County from prisons across New York State. Reentry Care Coordination includes assessment, transitional planning, linkage and follow up with service providers, and ongoing consultation.

In 2010, The Taskforce identified some critical system wide needs that are causing barriers for successful transitioning of parolees. Planning for 2011 includes goals that are specific to the population and the community serving criminal justice:

- A) Education, many local universities are requiring a (1) year waiting before enrolling in college courses. The Taskforce would like to work with individual academic institutions to review each case individually and facilitate a quicker college enrollment.
- B) Faith-based or peer mentoring is an evidence-based practice that can assist in the successful transition to community. The Taskforce has developed a pro social mentoring model that can assist parolees in meeting life challenges upon release. This model will work parallel with parole and service providers to offer a seamless menu of services that can better serve the target population
- C) Reentry issues need a louder voice in the Erie County community. State, County and local providers will partner together to provide multi-media events to the community with a specific emphasis on criminal justice/chemical dependency. The Taskforce will use local television, radio, and community events to promote an understanding of the relationship between reentry and community.

The current reentry system in centered on prison releases from NYS institutions. Erie County wants to expand this system to reach out to the local jail and federal system to work together with the Taskforce in an effort to expand services. The County Jail will focus on integrated treatment approaches that address health, mental health and chemical dependency that can assist local system releases. This approach is designed to include an actuarial assessment process, pre and post release care coordination services, linkage and referral to community services, employment services and a data program that will focus on follow up and outcomes. In addition to reentry services, the County Jail will develop (4) beds that are designed to serve individuals who are in the need of clinical & support services for substance abuse.

The preceding information on this population was repeated from the prior year's Plan. While it remains valid, the State's current fiscal challenges have resulted in the elimination of OASAS funding for "re-entry" services within Erie County. Accordingly, the need for these services will be increased as these supports and associated case management capacity is significantly reduced.

Adolescents

OASAS estimates that outpatient services for adolescents are meeting 47.3% of Erie County need. The actual number is probably notably lower since the Lake Shore adolescent outpatient program has closed its doors.

One local agency provides Residential Rehabilitation Services for Youth (RRSY). While utilization has historically been less than 90% the agency has recently been making strides in improving utilization. While OASAS does not provide a need methodology for this level of care, the Department of Mental Health suggests that the need is significantly greater than the utilization reflects. The Department continues to receive anecdotal reports from sources such as Family Court judges and, the County's Department of Social Services that many youth thought to need this level of care are unable

to access. The Department and the OASAS Field Office are working with the local provider of RRSY to identify and rectify to greatest extent possible the barriers to access.

Experience and research informs us that significant percentages of the children and youth targeted for services within the children and youth system of care are affected by either their own chemical abuse/addiction, or that of their primary caregivers. For example, consistent with the national literature, it is estimated that approximately 65% of the youth in non secure detention in Erie County have a history of regular habitual use of alcohol and other substances including, but not necessarily limited to marijuana, heroin, cocaine and Rx drug abuse.

Therefore, as part of the ongoing efforts begun in October, 2004 to address the needs of children and youth (age 5-17) experiencing complex serious mental health challenges in a more comprehensive manner the Erie County Children's System of Care "Wraparound Model" the Department continues to explore means of more effectively identifying youth in systems outside of chemical dependence who have issues of alcohol and other substance abuse. This model is a nationally known evidence based practice for providing services to youth and families most at risk of out of home/school/community placement based on their mental health needs.

The Department continues to work with the court system, juvenile justice system, residential and other providers how to better identify and provide access to youth with primary substance abuse issues which may go under identified primarily because the system of "entry". One critical effort is expected to examine current process and other barriers which if improved upon would allow youth in secure and non secure detention or in a Residential Treatment Center (RTC) swifter access to appropriate chemical dependency care such as residential chemical dependency services for youth.

As we look at the number of youth placed in the most restrictive levels of care by the Family Court, a majority were placed due to continued abuse of drugs and/or alcohol. These youth do not participate in CD treatment while they are in restrictive placement. Moreover, it is estimated that eighty percent (80%) to ninety percent (90%) of all youth placed by the Family Court are youth of color and, these youth are under-represented in the treatment programs serving youth. There is much more work left to be done to address this issue.

Another cohort that has been identified within the mental health Children's System of Care and within Family Court is those youth who have just begun to experiment with alcohol/drug use and, those who are at very high risk for imminent experimentation. These youth do not yet have a diagnosable dependence and therefore are ineligible for chemical dependence treatment services. It is seen as critical that these very high risk youth be prioritized for engagement in an intensive, Indicated Prevention intervention such as Reconnecting Youth or, Prevention Counseling. The Department continues to explore how existing Prevention resources can be re-targeted and/or reconfigured to service this population.

For those families impacted by alcohol and other substances, incorporating effective and evidence based treatment, intervention, and prevention services are critical components of the overall system of care. Presently under development with some families is in home engagement and supports if deemed necessary to achieve family involvement in those cases where such involvement has been otherwise limited or non-existent.

These cross system collaborations and integrative services will continue to be explored to more broadly include the chemical dependency service system of treatment and prevention providers within the children and youth system of care reform. Efforts to more accurately identify and engage youth in chemical dependency treatment services, while necessary, may create strain on existing capacity levels.

Included in the 2009 Local Services Plan and deemed of continuing relevance: The Alcohol and Substance Abuse Subcommittee of the Community Services Board conducted a focus group of youth who were currently enrolled in a Residential Chemical Dependency Facility for Youth. Consumer demographics of those participating were as follows:

- × Gender: Male – 8, Female – 4
- × Race/Ethnicity: Caucasian – 9, Hispanic – 1, African-American – 1, East Asian – 1

It should be noted that while asked to provide their responses to their experiences with the chemical dependency treatment services in Erie County, the participants focused almost all of their responses on their experience with their present facility. This was found to be the case for most of the focus groups held of the last couple of years. A summary of the consumer responses to questions follow:

1) What do you like best about the services that you have received through Erie County chemical dependency programs? Is there any specific part of Erie County chemical dependency programs that you like best? (Such as: a particular group, type of counseling, etc.)

They noted that treatment was individualized and that they are able to choose their counselors. They emphasized that nothing in treatment is forced and they feel less resistant as a result. They had high praise for the counselors, noting that they are not judgmental, are connected and "really care". They appreciated the activities available to them, both therapeutic and field trips. They felt the facility is a very safe environment and they can be open and honest as a result.

2) What do you like least about the services that you have received through Erie County chemical dependency

programs?

With regard to the program they were presently attending, the participants noted great ambivalence about some of the rules (not unusual for any inpatient or residential program). They noted that some of the rules make them feel they are being treated like little children (e.g. 15 minute checks). They felt the 10:00 PM bedtime was very unrealistic for adolescents, given the tendency to be awake later. They note that staff can interpret the rules differently and that some do not follow up on concerns that are expressed. They also noted "invasion of privacy" issues, e.g. staff reading outgoing mail, reading journals when they are left open. Minor complaints were about not having access to caffeinated drinks or sugar for hot drinks. However, the participants had many negative remarks about the outpatient treatment they had received. They felt the counselors did not pay close enough attention, especially to drug testing. One participant noted not having been drug tested at all during six months of treatment. The content of outpatient group sessions too often consisted of "war stories" and they thereby learned more efficient ways to cheat drug tests in the groups.

3) Are program hours convenient for you?

Yes=7, No=4

These responses addressed outpatient treatment. The negative responses noted transportation issues, having appointments scheduled at the convenience of the counselor (especially when they were more frequent), and being unable to get a job due to the scheduled appointments.

4) When I first requested services for Alcohol/Substance use, I feel that I received services in a timely manner:

Strongly Agree=4 Agree=1 Neutral=1 Disagree=1 Strongly Disagree=4

One participant waited 12 months for treatment, two others were on a waiting list for a couple of months, and one spent three months in jail awaiting treatment.

5) How well does Erie County chemical dependency programs do at coordinating with other programs/services that you are involved in? For example, mental health programs, probation officers, physicians, vocational training.

In regard to their current provider, the participants felt that the linkages were quite good, especially to vocational and educational programs. The link between the local CountyHospital and their current provider was also praised. However, it was disturbing to hear two participants report that outpatient programs provided false positive information to courts concerning their progress. The false information included results on drug tests that were never conducted. In keeping with the purpose of the focus group this information was not corroborated. There were negative feelings expressed about the time and opportunity wasted in those programs.

6) Is it important to you to have your families/significant others involved?

There were mixed reviews about the importance of family involvement. Families are expected to participate even when they are "fine" and not the source of difficulty. (We did not address whether the sessions were helpful to the family members even in these cases). It was noted that some suggestions to families are "stupid" and overly cautious (e.g. recommending no cell phone access after discharge).

7) To what extent have programs attempted to engage your families & significant others in your treatment?

Very much so = All respondents gave this response concerning their current provider. One noted that residents can pick their individual counselors, but not the family counselors. That respondent does not have the same level of trust with the family counselor.

They would also like increased access to parents, since they currently can only speak to them on the telephone for 5 minutes three times weekly while with their current provider.

8) To what extent have the CD services that you have received been presented in a manner that is respectful and understanding of your culture?

The issue was addressed by only one respondent, who noted a failure to allow culturally appropriate grooming materials.

9) Is there anything else that we are missing that you would like the leaders directing substance abuse services in Erie County to know?

The issue of atheism/agnosticism in treatment needs greater attention in reference to the Twelve Step programs.

The Erie County Department of Mental Health remains committed to the chemical dependency treatment needs of adolescents as a critical priority. However, shrinking resources due to the State's ongoing fiscal crisis is a significant impediment to improving access to greatly needed adolescent treatment and prevention services and supports.

Veterans

The Buffalo Veterans Treatment Court held its first session in January, 2008. It was the first court that specialized and adapted to meet the specific needs of veterans. As of October, 2008, it was the only known Veterans Treatment Court in the United States. The mission driving this Court is to successfully rehabilitate offending veterans by diverting them from the traditional criminal justice system and, providing them with the tools they need in order to lead a productive and law-abiding lifestyle.

To facilitate the veteran's progress in treatment, the prosecutor and defense counsel shed their traditional adversarial courtroom relationship and work together as a team. Once a veteran is accepted into the treatment court program, the team's focus is on the veteran's recovery and law-abiding behavior, not on the merits of the pending case.

This Court is now the "training court" for all new Veterans Courts in the United States. The National Association of Drug Courts in Washington D.C. has designated Buffalo's Court as its "Mentor Court."

Presently, the Court has one hundred fifty (150) participants. Since its inception only five (5) individuals have dropped out of the program. Typically it takes approximately one-and-one-half (1.5) years to complete the program. If successful, criminal charges are dropped or reduced. All graduates of the program are gainfully employed or are actively attending school.

CD SPECIALIZED SERVICES AND AREAS OF SPECIAL FOCUS

Overarching Issues for Consideration

Cutting across many if not all specific system development areas, there are several issues or considerations that are or will be significantly impacting on the chemical dependency field. Some of these are areas presently are under development while yet others are being discussed without ready solutions. All have critical implications for the development of the chemical dependency and problem gambling services. Briefly, these include:

- Integration of chemical dependency treatment services with primary healthcare – relates to reduction of stigma, more effective, holistic, person centered services and, improving access and cost-effectiveness. It is expected, however, that this is beginning to be addressed through Medicaid reform in NYS, particularly in regard to the anticipated adoption of "health homes."
- Workforce development – while not generally a new concern, it is one that has not yet been adequately addressed and which will bear considerably on availability, access and cost-effectiveness. Recently developments indicate that in the foreseeable future certified programs will require licensed professionals to address issues of integrated treatment;
- Utilization management and ongoing quality improvement – also critical to cost effectiveness and service quality in an environment of shrinking resources and growing accountability;
- Mandated, fully capitated Medicaid managed care for all clinical services is expected and will likely be a significant challenge for both insurers and providers as Medicaid reform is implemented in NYS. -

Evidence Based Practices

Service providers, treatment and prevention alike, have endeavored to utilize evidence based practices as a primary means for improving service efficacy. Despite successes, successful implementation of these has been hampered by a lack of resources sufficient to achieving the requisite full organizational commitment. Staff training and requisite practicum, integration with supervision, development of fidelity and impact assessment systems and, opportunity costs are key factors. Erie County recommends that additional resources must be brought to bear to this issue so critical to effectiveness, efficiency and, accountability.

Given the likely growing criticality of data showing effectiveness and, the likelihood that additional resources will not be forthcoming in foreseeable future, difficult resource reallocation decisions might be necessary to provide resources essential to further the implementation of evidence based practices and associated data accountability systems.

Case Management

As was stated in prior years' Plans, a relative lack of case management services remains as a service gap in the chemical dependency treatment services continuum of care. While there have some targeted case management services developed in the state and local system over the past several years, this resource remains scarce. Providers consistently cite the lack of case management services as a barrier to engagement, abstinence, treatment completion, and efforts to enhance recovery of chemically dependent consumers. Erie County providers when asked, "What services are needed or difficult to access for individuals who are unserved or underserved?" in a 2005 provider survey, cited case management as the second most frequently cited need (behind transportation) and with the highest weighted average response. Although we have not update the survey since that time, anecdotal reports at various provider meetings and informal discussions suggest that this remains as an important missing component of the milieu of available services.

Based on a review of the current needs of the multiple recidivist/multiple needs consumers that resulted from the work group of Chemical Dependency Steering Committee of the same name as well as the responses received from Chemical Dependency Provider Survey question, "What resource challenges or barriers to recovery do you face in providing your consumers with the best services possible?", "time to teach daily life skills" received the third highest weighted response out of thirteen. This appears to be directly linked to case management and rehabilitation services.

Such skills from anger management, socialization, appropriate budgeting, system navigation, work force management are all directly or indirectly related to recovery. Those with the most chronic, severe and debilitating chemical dependency diagnosis are frequently most in need of such skill development yet there are few resources that are presently well integrated into the chemical dependency treatment system which are readily available to focus treatment efforts on such fundamental skills.

Assessment of Recovery Support Services has not been otherwise explicitly and directly addressed. Consistent with the previous two paragraphs, there is a long-standing, general "sense" that recovery support is inadequate, because it is typically not billable nor usually funded.

Families of Chemically Dependent

The CD system must work with the local Department of Social Services to address issues of the number of infants removed from their home and community due to safety concerns. Disproportionality is a concern as minority infants remain in care/custody much longer than majority children. We need to define the needs of these families and implement evidence-based intervention strategies that address the issues.

Integration with Healthcare

The system must begin to shift focus to monitor individual treatment outcomes as they relate to overall health and, community functioning, especially as mental disability systems become more integrated with primary healthcare. Many stakeholders report that the un- or under-insured with co-morbid physical maladies or impairments coupled with a CD diagnosis incur large public sector expenses. The system must evolve and demonstrate an effective set of interventions in not only controlling but in reducing overall healthcare costs/expenditures. Successful treatment is expected to lead to better self-management of overall health and the individual's affect on relationships and community.

MENTAL HEALTH Service Needs and Gaps

Adult Single Point of Access & Accountability (SPOA) reform

Based on the data presented in question #1 above, Erie County identified the following service needs and gaps for adults

- Rapid access to care coordination for high need, high risk individuals
- Integration of behavioural and physical health care needs
- Rapid access to psychiatry/medication management for high need/high risk individual

In order to address these service gaps, we need to better utilize the Care Coordination and Housing capacity that is available. Our first step was a Six Sigma project using DMAIC tools to reduce the variation in length of stay of individuals in Care Coordination, and as a result, reduce the average length of stay in order to serve the emerging high need, high risk population. In the initial stages of this project, we realized that there is a large variation in length of stay for individuals in Intensive Case Management, Supportive Case Management and Blended Case Management programs but the length of stay for individuals in Assertive Community Treatment programs does not have much variation i.e. the length of stay is long for most enrolled individuals.

During the project, we reviewed the case records of individuals with the longest lengths of stay in ICM, SCM and BCM programs. The average length of stay for these 28 individuals was 5.23 years. The most frequently cited problems at admission for these individuals was inability to maintain stable housing, and frequent arrests. At the time of review, individuals were generally linked to treatment, housing. Most were also linked to community supports, natural supports and medical care but the linkages were less clearly displayed in the charts. Six of the individuals who we thought were open were, in fact, closed.

As a result of our initial work:

- The reduction in variation in length of stay was reduced by a statistically significant level, from 538 days to 432 days
- The reduction in mean length of stay was reduced but not by a statistically significant level yet, from 451 days to 413 days

This points to the following necessary initial measure that are necessary to manage lengths of stay/access to these programs:

- clear Utilization Management guidelines, procedures and practices

- accurate and timely rosters and real time reports from the rosters
- improved management information system.

We have also begun the next steps in our SPOA reform:

- Identifying individuals who are high risk and high need as evidenced by high Medicaid utilization, and working with Care Coordination programs to engage and enroll them;
- Developing management information system that will support critical functions including Utilization Management and
- Working with Dr. Dan Herman on the applicability and hopefully implementation of the Critical Time Intervention model for Intensive Case Management, Supportive Case Management and Blended Case Management.

It should be noted that Critical Time Intervention (CTI) is a nine-month case management intervention designed to enhance continuity of support for persons with severe mental illness during periods of transition. Such periods may include the months following discharge from hospitals, jails and other institutions, the transition from homelessness to housing, or the transition between different levels of treatment and support.

CTI is an evidence-based model that has been tested in several rigorously designed trials. It is listed in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).

Disproportional Minority Representation/Share

Disproportionate Minority Representation at the most restrictive levels of care continues to be a barrier to service, and the lack of OMH data broken out by race/ethnicity limits our ability to address this issue in an actionable way, and monitor our progress. However, we are using local data when possible. An example is our Children's System of Care where we have identified specific disparities such as residential placement at discharge. The data is below for residential placements used for children/youth discharged from the Wraparound in 2010

	African American	White
Residential Treatment Center	14% (n=17)	7% (n=17)
Psychiatric Inpatient	4% (n=5)	11% (n=29)

As a result, we have established a Quality Improvement work group to address risk factors and practice improvements, and are monitoring the data in order to reduce disparities.

Integration of Physical and Behavioral Health

In response to the physical health service gaps described in question #1 above, we identified high users of physical and behavioral health services as a target population. The following are critical issues that need to be addressed as a regional behavioral health organization is implemented. For these high need individuals, critical issues are

- identification/triage
- engagement
- array of services
- fidelity to practice
- utilization management
- performance outcomes and
- system-wide quality improvement

MENTAL HEALTH SERVICE NEEDS AND GAPS CONTINUED: CHILDRENS SYSTEM OF CARE

As we continue to examine the trends within the Children System of Care it has been identified that there are gaps in the need and service flexibility for alcohol and substance abuse services for youth. Nearly half of the 155 youth placement into Residential Treatment Centers in 2010 has unmet alcohol and substance abuse needs. Theses youth can be defined as high need/high risk. They are challenging to engage into traditional substance abuse services. Their failure to engage is a primary factor of being placed into out of home.

Another gap with the Children's System of Care is child psychiatry. There are a limited number of child psychiatrists within our community. The limited community resource has resulted in the challenge to deliver the optimal timely engagement necessary to achieve community level stabilization. This has also resulted in increased out of home care.

Respite has also been a challenge in our community. It is an ongoing struggle to sustain respite services for families. The identified barrier is that both the youth and child must agree to the respite. In many incidents respite is necessary for a "time out" amongst family members. However the system has found it a challenge to have both youth and child agree to respite during a time of conflict and crisis. The underutilization of the services makes is fiscally challenging for an agency to sustain the service.

The Children's System of Care that is funded through Medicaid as well as blended dollars has proven to be highly successful in having youth remain in their home community where it is developmentally appropriate to meet their needs in a family friendly, strength-based manner. Through a variety of community service contracts that are targeted to meet the needs of families we have been successful in reducing the number youth in out of home care. The length of time a youth remains in out of the home has also been reduced. We have been able to build a system of care that meets the needs of a large service-needing population in a more individualized fashion through identifying emerging trends of youth being placed on out of home care. Based on the identified unmet needs of youth, best practice services within the community are initiated.

With the adherence to utilization management and quality improvement practices, we have been able to sustain quality service delivery that focuses on prescribed matrix and benchmarks. These matrix and benchmarks have demonstrated successful interventions that support stabilization of a youth within their home. Moving toward informed decision making and reducing variability of practice among practitioners has produced a consist delivery of services for families within our community. This has resulted in a decrease of deeper system penetration for youth within our community.

The ability to have strong community partnerships within and outside of county government has brought a stronger focus on single point access of services for youth at risk of out of home care. Our community has built a strong vendor network system which allows for individualized service planning to meet the unmet needs and risk of families.

2c. What current elements of your local Medicaid program or system of care do you find have truly worked to control costs and enhance quality, and that you feel should be preserved or expanded?

3. Effective Assessment Techniques and Practices Utilized - One of the objectives of the Community of Practice for Local Planners (CPLP) is to identify effective or innovative planning and needs assessment practices being used in the local planning process that could be shared with other county planners across the state to improve planning efforts. This may also include innovative process change activities that have resulted in a more efficient use of time and resources employed in the planning process. This section contains a list of common needs assessment techniques that could be used to assess the mental hygiene problems and service needs in the population. Indicate each technique or practice that was utilized in your county's planning process and provide a brief description of how it was used, who participated, and the results achieved.

- a) Community Forum
- b) Focus Groups
- c) Advisory Groups/Task Forces/Coalitions
- d) Key Informant Interviews
- e) Population Surveys
- f) Provider Surveys
- g) Patient Satisfaction Surveys
- h) Analysis of Secondary Data
- i) Other (specify):

3a. Community Forum:

As part of the Local Service Planning Discovery Process, the Erie County Department of Mental Health in partnership with the OPWDD Subcommittee scheduled a meeting and invited all local MR/DD agencies to discuss and identify issues, concerns, problems or service gaps that exist within the local community.

In preparation for the meeting a description of the Discovery Process and the Local Service Plan existing priorities and outcomes were forwarded.

The following agency representatives were invited:

Barb Lamoreaux	BLamoreaux@claddaghcomm.or
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The discussion was facilitated by Susan Barlow, Executive Director of Parent Network of WNY who has worked on Local Service Planning with the Department in the past and is also a parent representative. The process included the review of the existing priority outcomes and the areas of concerns that continue to exist and newly identified areas. While housing and coordinated health care, by consensus, were identified as the top priorities the areas representatives agreed that it was necessary to keep the existing priorities and add the additions of work force development.

The attachment CommunityForumIdentifiedPriorities2011.doc includes the forum notes and additional priorities by state and local committees. The issues and recommendations will be integrated into the existing priority outcomes. A schedule of meetings will be forwarded to local stakeholders to work on each identified priority throughout 2011-12.

3c. Advisory Groups/Task Forces/Coalitions:

Advisory groups/task forces/coalitions

- Community Services Board
- Mental Health Subcommittee
- CD Subcommittee
- OPWDD Subcommittee
- NY Care Coordination Program - various committees
- Adult Single Point of Entry Six Sigma Team
- Adult Mental Health Leadership Group
- Family Voices Network Management Team
- Children's Executive Directors/ Commissioner
- Children - Tier II
- Erie County Comm. Coordinating Council on Children and Families
- Children's Safety Net for Youth
- Family Services Team Management Group
- Reentry Task Force
- Homeless Alliance of Western New York
- Housing Improvement Team
- Erie County SPOA for Housing Executive Committee
- Licensed Housing and Support Services Oversight Committee
- Care Coordination SPOA County/Agency Case Conference
- Px20: Department contracted Prevention Providers group

3h. Analysis of Secondary Data:

Our use of secondary data has proved helpful in our preparations for 1) moving to a managed behavioral care environment 2) physical/behavioral health integration and 3) implementation of behavioral health homes. Our local approach has been on fidelity to practice and performance outcomes.

Examples of data that we are using:

- Medicaid fee for service data to identify high cost users and to evaluate our system performance
- Office of Children and Family Services residential treatment data to evaluate the efficacy of our Children's System of Care in reducing residential treatment costs
- CareManager data to evaluate fidelity to practice in the Children's System of Care, implement quality improvement efforts, evaluate system performance, evaluate agency performance and achievement of contract outcomes
- Agencies' report of NYCCP Periodic Reports in Housing and Care Coordination to evaluate system performance, evaluate agency performance and achievement of contract outcomes

A Risk Indicator Database (RIDB) comprised of various archival chemical dependency risk indicators has been made available online and periodically updated for assisting chemical dependency and other prevention providers in conducting needs assessment for targeting services to highest risk communities and populations in Erie County.

An analysis of prevention gaps and barriers has been conducted on behalf of the Department by the Center for Health and Social Research at

Buffalo State College. It is periodically reviewed and updated to further refine the targeting of chemical dependency and other prevention services to highest risk communities and populations within Erie County.

3i. Other:

Request for Proposal Process

Erie County has implemented an RFP process with the following critical goals:

- Achieving timely implementation of services
- Ensuring organizational capacity to manage service capacity and other contract metrics
- ensure fidelity to evidence based/emerging/effective practices
- demonstrate ability to achieve valued outcomes with targeted sub-populations

In this challenging environment, the Department has been using, and will continue to use, the RFP process to reallocate current resources to address high priority emerging need and to resolve deficiencies in practice to outcome contract performance.

Six Sigma DMAIC (Define, Measure, Analyze, Improve and Control)

Erie County has used six sigma processes and tools to define the scope of problems through development of control plans that institutionalize improvement plans. Tools include:

- project charters
- stakeholder analysis
- development of primary and secondary process metrics
- data collection plans
- various statistical analyses in order to target improvements and evaluate their efficacy
- various process flow tools
- cause and effect analysis
- failure modes and effects analysis
- payoff matrix
- capability analysis
- control plans

Attachments
<ul style="list-style-type: none">• CommunityForumIdentifiedPriorities2011.doc.docx - CommunityForumIdentifiedPriorities-OPWDD