2011 Mental Hygiene Planning Activities Report
Sullivan Co Dept of Community Services (70170)

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

1. Assessment of Chemical Dependence and Problem Gambling (OASAS)

Provide an assessment of the nature and extent of chemical dependence and problem gambling in the county. Describe the results of qualitative activities, including the use of consumers, providers, task forces, workgroups, committees, public forums, key informant interviews, and other stakeholder groups. Describe the quantitative assessment activities, including data resources used, surveys conducted, etc. Include a geographic and demographic description of the service area.

Sullivan County, in comparison to other counties classified as a Rural Social Area, rates well above average in the following community indicators: alcohol and drug use and abuse; access to alcohol and drugs and consequences of use/abuse; economic deprivation; neighborhood instability; violence and gang involement; family dysfunction; psychological dysfunction; and risk factors for children and youth. The 2005 Prevention Risk Indicator Services Monitoring System (PRISMS) report continues to find Sullivan County's youth to be at significantly high risk of developing alcohol/drug problems. The Office of Alcoholism and Substance Abuse Services (OASAS) County resource data continually reports a high prevalence rate for adult residents as well. The geographic service area considered for this plan is Sullivan County. Sullivan County is an economically depressed rural county, the size of the state of Rhode Island. We are 100 miles northwest of New York City, with no urban population area and its major employers are government and the healthcare industry. According to the US Census Bureau 16.4% of our residents live below the poverty level. We have culturally diverse population of 76,189, of which 9.5% are African-Americans, 11.9% are Hispanic/Latino, 1.10% is oriental or Native American, and 86.9% are white. There are significant Ukrainian, Russian, Czechoslovakian and Korean Communities. The population of Sullivan County quadruples from June to September with the influx of summer second home residents. This influx includes a substantial Hassidic population. Sulliv
Sullivan County uses several tools to assess the need for chemical dependency services. Specific resources from OASAS include the County Resource Book (2007), PRISMS (2005), and Community Response Indicators for Improving Service System Performance (CRISP) (2007) data. Data is also incorporated from Kids Count, the Sullivan County Communities that Care (CTC) 2009 Surveys, and the Inter County Planning (ICP) Committee. Meetings were held with the directors, supervisors, and/or managers of the various treatment and prevention programs, guidance counselors, and other public officials in the county. Each person provided information on their perspective of needs in the county.

2. Analysis of Service Needs and Gaps (OASAS)

Describe and quantify the chemical dependence and problem gambling prevention and treatment service needs of the population. Describe the capacity and resources available to meet the identified needs, including those services that are accessed outside of the county and outside the OASAS funded and certified 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. If the county believes that local service needs are different from those estimated by the OASAS treatment need methodology, include the alternative county estimates and explain the basis for those estimates. 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.

Sullivan County has seen steady yearly increases in dual diagnosed clients over the past sixteen years. We continue to see an increase in “Quadrant III and IV” clients. There has been a steady increase in clients with borderline personality disorders, depression, anxiety disorders and Post Traumatic Stress Disorder (PTSD). Safe sober housing continues to be a need for this population. Many live in adult homes where alcohol or drug use by others places them at a higher risk for relapse. Relapse on drugs/alcohol usually leads to mental decomposition and need for hospitalization. There is a lack of inpatient treatment programs that treat specific problems that require special attention. These clients present with higher substance abuse relapse rates.

Space restrictions limit the services offered at the Sullivan County Jail and group treatment and sober support meetings cannot be afforded to inmates. Individual sessions cannot be conducted in reasonable privacy. Our local law enforcement agencies predict a proportionate increase in arrests and incarcerations once a casino opens in our County, including a rise in drug and alcohol related incidents.

Transportation is a major barrier to treatment, especially for adolescents. Development of satellite programs and student assistance programs in the school districts will provide increased access to youth for prevention, intervention, and referral to other services.

Additional barriers to treatment include child care issues and the inability to pay for services. Sullivan County has a large uninsured/underinsured population which impacts on the fiscal health of our providers.

There is also an absence of housing options, especially for the dually diagnosed and other special

populations. There is need for supportive transitional housing for the homeless and newly recovered. Discreet services for women are not available along the entire continuum of care.

While Sullivan County and our providers are preparing to deal with gambling prevention and treatment efforts based on the projected development of additional casinos in our county, we have developed prevention and treatment interventions since the RACINO opened approximately four (4) years ago. Consideration will be given to the fact that gambling addiction has a rapid impact on family members as well, due to the rapid escalation of financial problems. Adolescents are also very susceptible to developing gambling problems. A side effect of gambling may be predicted rise in arrests, incarcerations, and alcohol and drug related incidents that will influence our criminal justice and substance abuse services. The Recovery Center has a Credentialed Gambling Counseling Supervisor and other trained staff. They currently have a gambling treatment and prevention program.

Sullivan County is home to five long-term residential programs, two DAYTOP facilities (adult male), New Hope Manor (women, adolescent females, pregnant women, and women with children under 2yrs of age, VERITAS Therapeutic Community, and Dynamite Youth Center (adolescents). The majority of clients at these facilities are from outside Sullivan County.

The Council on Alcoholism and Drug Abuse of Sullivan County (the Recovery Center) provides a Medically Supervised Withdrawal Unit, a Medically Monitored Withdrawal Unit, Suboxone detox, an Outpatient Clinic, a Halfway House, and an Outpatient Rehabilitation, including Dual focus program and Adolescent Day treatment. The Recovery Center also operates a seventeen (17) bed Supported Living Facility and a twenty-eight (28) Shelter plus Care apartments.

Catskill Regional Medical Center provides Alcohol Acute Care and Suboxone detoxification services.

The Sullivan County Department of Community Services has an Alcohol and Substance Abuse Service (ADAS) Clinic, Mental Health Clinic, Case Management Unit, Continuing Day treatment (CDT) program with a Dual Recovery Track. Chemical dependency treatment is provided at Sullivan County Jail by Sullivan County Alcohol and Drug Abuse Services. Fewer than thirty (30) Sullivan County residents are enrolled in a Methadone maintenance program and receive their treatment in Orange and Ulster Counties.

Our County facilities work closely with the Division of Family Services (DFS) to address housing and other ancillary needs. We also work closely with Rehabilitation Support Services (RSS) They maintain a MICA Community Residence and supported living apartments. Mental Health Services are available at Catskill Regional Medical Center (Formerly Community General Hospital), the Department of Community Services Mental Health Clinic and Continuing Day Treatment Program, and The Rockland Psychiatric Center (RCP) Clinic.

The Recovery Center and New Hope Manor have psychiatrist and vocational services available to their clients.

Sullivan County Alcohol and Drug Abuse Services and the Recovery Center provide evaluations, monitoring and referrals for the Sullivan County Family Treatment Court, the Sullivan County Juvenile Family Treatment Court, and the Sullivan County Drug Court. All chemical dependency providers in the county are participating in the provision of services for all courts.

Our treatment providers present some degree of prevention services through presentations in the community and schools. The DARE program is a presence in all school districts in the County. Prevention is also provided by Footings Inc.Club Rec program, Boys & Girls Club, and the YMCA Gym. There is one OASAS funded prevention programs in Sullivan County located at the Recovery Center in Monticello, NY.

3. Capital Improvement Plan (OASAS)

Identify the need for capital improvements within the local addiction service system. Include a list of active capital projects for which a **Schedule C - OASAS Capital Project Funding Request Form** has been completed and submitted to OASAS.

The Recovery Center applied for Capitol Project funding to make some needed repairs and upgrades to their current structures.

New Hope Manor applied for Capitol Project Funding to make upgrades to their existing structure; add on administrative offices and group rooms; remove the old school house; and relocate the parking area. the completion for the project is slated for late summer of 2010.

4. Discovery Process Documentation (OMRDD)

Identify the constituent groups consulted as part of the local discovery and priority setting process (e.g., individuals with developmental disabilities, families, advocacy groups, providers of services, DDSO, other community organizations, etc.)

Information was gathered from the Mental Retardation/Developmental Disabilities (MR/DD) Sub and Planning Committee members,Inter County Planning (ICP) Committee, Individuals with disabilities, parents, family members, self advocacy groups and providers' school personnel, hospital employees, criminal justice system, Department of Social Services and Public Health.

5. Methods of Discovery (OMRDD)

Identify the methods of discovery utilized to determine the issues, concerns, needs and priorities for local planning (e.g., surveys, forums, key informant interviews, focus groups, analysis of available data, etc.) Summary information obtained from these discovery methods should be included.

An open community forum was held May 2010. The responses provided were carefully reviewed through a gaps and analysis process. The issues that were evident are as follows:

Establishment of a Mobile Mental Health Team for children and adolescents, Enhancement of services for children and adolescents aging out, maintaining and enhancement of prevention and outreach services for the community, and additional respite beds for adults and children.

For the future, the following unmet needs will continue to be discussed and will drive development:

- Enhanced hospital care and crisis respite services (medical and psychiatric) for individuals with mental retardation who have co-occurring disorders and/or behavioral challenges. Attraction of clinicians who are well versed with the dually diagnosed population to Sullivan County.

- Community Residence for youngsters up until age Twenty-one (21), who have challenging behaviors. Many of these youngsters are currently in out-of-County or out-of State placements. Close coordination with Division of Family Services and the school systems is required in the development of such a residence.

- Additional respite beds for adults and children with mental retardation/developmental disabilities.

- Single Point of Entry (SPOE) Task Force.

- Additional recreation activities targeted towards all children with mental retardation.

- Additional integrated recreational activities for adults with mental retardation.

- Additional full day recreation respite for children during the summer months.

- Appropriate services for all MR/DD individuals involved with the Criminal Justice System (ie: sex offenders, misdemeanor assaults, petty larceny, etc.)

- Brochures and training sessions for parents, teachers and generic providers explaining the access to MR/DD services in Sullivan County.

- Non-waiver case management.
- Bi-lingual Service Providers.
- Referrals to Special Education Training and Resource Center (SETRC).
- Housing (NIMBY).

Another long standing issue in the community is the response of the medical community to the special needs of consumers with MR/DD. Initiated by the Director of Community Services, a forum for the providers' of medical/psychiatric staff to discuss any issues concerning the Catskill Regional Medical Center's care of this population to meet regularly. An outcome to this initiative is the MR/DD providers provide monthly training/meetings for the hospital staff regarding the special needs population. While this population accounts for five percent of admissions to the mental health unit, the hospital has recognized that MR/DD consumers with dual diagnosis and/or behavioral issues may not be aptly served on the unit. We need to make services available to the hospital, from OMRDD or its agencies, to help develop and/or train hospital staff in the development of skills to better accommodate consumers who need behavioral interventions and to handle disruptive behaviors in consumers who need medical interventions. The unit will also be staffed to better diagnose consumers who may be exhibiting signs of organic involvement, as the population ages. The need of aging consumers is offering unique challenges to providers of existing IRA's and ICF's. Agencies are coping with the challenge of providing increased medical and personal care. Agencies have proposed increased staffing to accommodate 24/7 nursing care and increased behavioral supports for consumers.

The needs for appropriately trained and experienced staff impact all areas of the service delivery system. Residential providers have worked closely with Sullivan County Community College to develop direct support and professional curriculum. The program was not well attended as initially anticipated and closed. Most of the direct care staff holds second jobs, due to economic necessity, and finding time to attend classes was difficult. There is a shortage of affordable housing, both for direct care professionals and professional staff. The Sullivan County Planning Department has been working with providers to encourage private developers to meet this need.

6. Assessment of Existing Supports and Services (OMRDD, optional)

This optional section should address the base resources of the county's developmental disabilities service system and the base of generic supports and services available within the county. Information may be summarized in a table or in narrative format. Data to assist in the formulation of this assessment is available under "County Data".

Currently, the County hosts 760 OMRDD certified beds. The Center for Discovery has the largest concentration of children's SED beds; and SARC has one of its residences certified for children. The total annual operating budget of the four residential providers is approximately $145 million. The County is served by one not for profit hospital, Catskill Regional Medical Center, that has a satellite in Callicoon. The hospital is a designated 9.39 receiving hospital for the County, and has a mental health unit that is staffed for 16 beds. The County of Sullivan has four PPHA's (Private Priority Homes for Adults) with a census of 246 beds. Seventy-six percent of the residents have mental health needs, and approximately twenty percent have a diagnosis of Mental Retardation. The majority receive either clinic or day treatment services. This concentrated mental health population puts a higher demand on the hospital than the prevalence data for this area would suggest. Furthermore, the high number of OMRDD beds increases the need for inpatient mental health needs for individuals who are dual diagnosed or have behavioral issues. The County and its providers have previously cited the need for an additional behavioral facility like Fortune Road.

Four years ago, under the auspices of the local government unit, the County's school districts partnered with the provider community to form a task force to identify and resolve issues relating to service provision for children with menta retardation/developmental disabilities. The long term goal of this group is to ensure that appropriate services for children and families in the community are provided. This group seeks to do so through increased awareness and collaboration; ultimately to prevent out of county/state placements. Improved communication and team building have become a major outcome of this task force. The staff of Early Intervention and pre-school providers have joined this endeavor and there continues to be discussion on how to impart hope to the families of children with developmental disabilities who are newly identified. A brochure on Medicaid Service Coordination was developed with the goal of

ensuring that every professional and eligible family becomes knowledgeable of this service. Staffs from the DDSO and the County will continue to provide in-service training to the schools on the eligibility process. There has been a measurable increase in families requesting Medicaid Service Coordination. Increased awareness and collaboration reduced the number of MR/DD children who are referred to the Family Court. The group has further identified the need for residential opportunities, including respite for children and adolescents here in the community and our residential providers are willing to develop programs to meet the need. Families remain reluctant to give permission for such placements. The Task Force strongly supports the need for residential opportunities where families do not have to give up custody.

7. Paterson Drug Law Reforms (OASAS, optional)

The 2009 reforms to the Rockefeller Drug Laws eliminated certain mandatory prison sentences by giving judges discretion to divert non-violent individuals with substance abuse histories to a variety of alternative sentences, including Judicial Diversion programs modeled after Drug Courts. These reforms were expected to significantly increase access to treatment for many offenders. In this section please address each of the following:

a. How has the implementation of the Paterson Drug Law Reform affected the demand for treatment services in your county or the need to re-prioritize patient access to treatment?
b. How does the service system in your county address the criminogenic needs of individuals within the treatment system? (Criminogenic needs are defined by anti-social cognition; anti-social personality and temperament; anti-social associates; troubled family factors; difficulties in work or school settings; use of leisure time and recreational activities; presence of substance abuse.)
c. What additional challenges to addressing the service needs of the criminal justice involved individuals within your county have been created as a result of Drug Law Reform? (This may include: gaps in treatment; need for case management services; lack of residential programs or housing; collaboration with criminal justice entities and treatment court)

Has had minimal to no impact on our area

8. Personal Recovery Oriented Services (OMH, optional)

PROS support adults with serious mental illness to improve functioning, increase employment, attain higher levels of education, secure preferred housing, and aid recovery through integrated treatment, support and rehabilitation options. Please provide your county's perspective on PROS by answering the following questions:

a. If your county has PROS programs in place, briefly describe for your colleagues in other counties the successes and challenges you have encountered with PROS implementation, monitoring, and evaluation.
b. If providers in your county are considering conversion to PROS or already have PROS in place, please comment briefly on the following:
    - In keeping with the intent of the PROS program, have you or providers identified populations for whom PROS is not appropriate and/or individuals who are not eligible for PROS? If so, how are you and providers working with these populations to avoid having gaps in services develop?
    - If you are an existing PROS provider, what services are difficult to have provided?
    - If you are considering a PROS program, what new services required under PROS are you not fully able to provide?
    - Has the county developed a plan that promotes synergy across providers and builds upon the recognition that PROS programs operate within a broader system of care (e.g., not introducing new services when existing capacity or expertise exists)? How will the introduction of PROS impact the service needs of individuals not in PROS and what steps will be taken to ensure a continuum of care to meet the individual needs of persons and families served by your local system of care?
c. Are there additional data, training, or other supports that the Field Office could provide to aid providers' implementation of or planning and conversion to PROS? (Be sure to contact your Field Office with your requests so they can be addressed in a timely manner.)

N/A

9. Mental Health Clinic Restructuring (OMH, optional)

Clinic restructuring creates a more rational basis for financing clinic services and providing incentives for quality care and improved outcomes by promoting care premised on the principles of person first, engagement, recovery and resiliency. In this section please address each of the following:

a. How will the county promote change in the way services are delivered by providers within this new restructured model? What would be required to make providers financially viable and able to meet the recovery needs of the people serve in the community (e.g., new service models)?
b. What strategies will providers use to address areas such as outreach and engagement, use of peer and family staff, after-hours/weekend services coverage, crisis diversion, and in-home service delivery?
c. What outcomes have been achieved through the State psychiatric center and county collaboration over the last year and what major goal will you be working on this year to ensure that the services offered by the psychiatric center provide added value, help fill service gaps, and complement the array of services already provided locally?
d. Has the county developed a plan that promotes synergy across all mental health providers and builds upon the recognition that clinics operate within a broader system of care (e.g., not introducing new services when existing capacity or expertise exists)? What steps are being taken to ensure a continuum of care that meets the individual needs of persons and families served by the local system of care?
e. Are there additional data, training, or other supports that the Field Office could provide to aid implementation of clinic restructuring? (Be sure to contact your Field Office with your requests so they can be addressed in a timely manner.)

A. Our County Clinic (Sullivan County Community Services Mental Health Clinic) will be impacted by the Clinic Restructuring Model - Sullivan County is a rural area with limited transportation and the Clinic Restructuring model will aide many of our clients from having to attend varying appointments on different days; clinics will be able to coordinate services to better fit the needs of our clients. The methodology and focus of Clinic Restructuring is good.

This new model of service also promotes concerns, which are as follows:

- we will be adding additional services with no additional staff to provide the service,
- no clear qualifications regarding who can provide some of the services,
- concern over the status of case management services,
- additional documentation required for tracer model,
- changes that will be required for scheduling practices, updating our soft ware and training staff to meet the need,
- and the fiscal challenges with titrating into APG's.

B. Sullivan County Community Services MHC Clinic will be utilizing outreach and engagement, collateral visits, individual and group sessions, doctor and nurse visits, and all other services currently and previously provided. At this time our county utilizes Mobile Mental Health Crisis Response team for after hours and weekend coverage - however this services is only provided to individuals eighteen (18) and above at this time. During normal business hours Community Services MHC provides crisis assessments and diversions.

C. The County has been collaborating with the State regarding our initiative to add a Mobil Mental Health Crisis Response component for children. The only request being made is allowing designated staff to attend the training provided by the State Psychiatric Center, the matter is being discussed.

D. Due to the fiscal climate our County we have been working with Direct Care Physicians, our local hospital, and the Monticello Mental Health Clinic to address gaps in services and provide needed coverage to individuals when able, allowing us to provide a continuum of care to individuals in our community. Consistent collaboration and communication is becoming the norm. Attendance to discharge planning meetings, frequent phone and email communications have aided in this process.

E. Our County's concerns have been noted above and provided to our Regional Field Representative. Additional information and clarification regarding these concerns would be helpful.

10. Balancing the OMRDD Services Portfolio (OMRDD, optional)

A balanced services portfolio would offer individuals and family members access to a diverse array of service options, with an emphasis on expanding the availability of individualized supports and services, and maintaining traditional opportunities. In this section please address each of the following:

a. What information do you need to effectively support this service direction? (e.g. service utilization patterns, etc.)
b. What strategies are you using/considering for engaging families related to this new emphasis? (For families who have experienced the "old" system, and those new to the system)
c. How are Counties working with service providers to address this direction?

A. At this time we are aware that there are approximately one hundred eighty (180) vacancies in the Hudson Valley Region, five (5) within our County, justification on actual vacancies and locations would be needed. According to the New York State Cares Waitlist there are twenty-six (26) inividuals on the list,

nineteen (19) of which are looking for 24 hour care, and the remianing seven (7) are looking for part time/supervised apartments. This information is only reflect of individuals who have sought out Service Coordination and does not excompass individuals seeking services bwho are unclear or confused as to where to obtain assistance.

B. Although our area is very scenic and relaxing many families are concerned regarding the travel time for visits and the lack of recreational services in the area. Our county and the Hudson Valley DDSO District is considering utilization of a webpage that would provide a listing of vacancies with written details and pictures to inform individuals of home, amenities, and the area. We are also looking to educate individuals seeking services on the new methodology of practice and our ability to accommodate their needs within those confines.

C. Hudson Valley Providers from Sullivan County, Rockland County, and Orange County are collaborating on the development of a prioritized waiting list method to mange district vacancies.

11. Cultural and Linguistic Competence (OASAS, OMH, OMRDD)

Cultural and linguistic competence reflects at all levels of the system of care regard for the importance of culture, attention to the elimination of disparities, and the importance of adaptations to meet culturally unique needs.

a. Does your county have a cultural competence plan in place for meeting needs of individuals and families in any of three mental hygiene areas (CD/DD/MH)? If so, please specify for which area you have a plan.
b. Does your county currently use tools to assess the cultural and linguistic competence of county-run and other provider organizations? If so, please identify the tools and briefly describe the areas assessed.
c. Does the county analyze data by race and ethnicity to reveal disparities in services provision? If yes, please indicate the areas you are examining (e.g., access to services, utilization patterns) and specify performance measures and benchmarks being used to reduce disparities.
d. What data would better enable your county to identify disparities among providers and across the system of care?
e. In which areas would it be helpful for providers to have cultural competence training? Please provide your thoughts on the content and method of delivery of such training.

N/A