

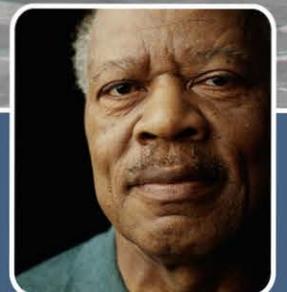


# Statewide Comprehensive Plan

2013-2017



New York State Office of  
Alcoholism and Substance Abuse Services



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## **Chapter 1: Background and Context**

### **Background**

OASAS oversees one of the largest addictions service systems in the country that includes a full array of services to address prevention, treatment, and recovery. Treatment services were provided to approximately 245,000 individuals in 2012 through outpatient, crisis, inpatient, residential and opioid treatment services. The prevention system reached over 400,000 individuals through direct service provision.

While the OASAS system of care continues to provide quality, individualized services, the agency recognizes the transformational changes that are occurring in the health care system. With the implementation of the Affordable Care Act, Medicaid Redesign, and the integration of behavioral health into the larger health care system, OASAS is working with its state and local partners to implement a more coordinated system of care that addresses the behavioral and physical health care needs of individuals with substance use disorders. OASAS is collaborating with the Office of Mental Health (OMH), Department of Health (DOH), New York City Department of Health and Mental Hygiene, and the Conference of Local Mental Hygiene Directors (CLMHD) to integrate services through initiatives like Health Homes, Behavioral Health Organizations (BHOs), and the behavioral health services carve-in to Medicaid managed care.

### **Behavioral Health Services Advisory Council**

A significant development in the integration of care for individuals with co-occurring substance use and mental health disorders was the formation of the Behavioral Health Services Advisory Council (BHSAC). Changes to Mental Hygiene Law in 2012 established the Council, which replaced the former OASAS Advisory Council on Alcoholism and Substance Abuse and the OMH Mental Health Services Advisory Council. The BHSAC will advise the two state agencies on matters relating to the provision of behavioral health services. The OASAS and OMH commissioners are non-voting members of the BHSAC. The Chair of the CLMHD serves on the Council. The Governor designated a chair and the 28 members of the BHSAC who were approved by the Senate in 2013. OASAS and OMH staff conducted an orientation for BHSAC members on October 1, 2013 and the Council conducted its first meeting on October 2, 2013.

### **OASAS-OMH Joint Public Hearing**

On August 27, 2013, OASAS and OMH held the second annual joint public hearing on their statewide comprehensive plans. The hearing was conducted by videoconference among eight locations: Albany, Buffalo, Long Island, Manhattan, Ogdensburg, Staten Island, Syracuse, and Rochester. OASAS Commissioner Arlene González-Sánchez and OMH Acting Commissioner John Tauriello gathered input for consideration in the development of their respective plans and ongoing initiatives to deliver more integrated care that meets the unique needs of those with co-occurring substance use and mental health disorders.

A total of 240 representatives from local government, advocacy organizations, providers, family members, and recipients of services attended the hearing with 29 individuals presenting testimony. Among the topics discussed were: Health Homes, regional planning, implementation of Behavioral Health Organization (BHO) Phase 2, recovery supports, opioid treatment expansion, peer recovery support, and supportive housing. Individuals also had the opportunity to submit comments in writing on the public hearing comment cards and by e-mail. As a result of the hearing, OASAS is identifying opportunities to incorporate stakeholder thoughts and feedback into ongoing planning and service integration initiatives.

## **Behavioral Health Organizations**

In January 2011, Governor Cuomo established the Medicaid Redesign Team (MRT) and charged it with finding ways to reduce costs, and increase quality and efficiency in the Medicaid program. One of the MRT's recommendations was to move all Medicaid beneficiaries, including people with substance use disorders and mental illness who were previously exempted from managed care requirements, into a managed care behavioral health model. This move would bring fee-for-service payment to an end, and through managed care reduce Medicaid costs and improve outcomes for patients in both systems of care. The MRT recommended a transition period for bringing these two populations into managed care as Medicaid managed care organizations have limited experience working with these populations. The OASAS and OMH commissioners contracted jointly with BHOs to help prepare the fields of substance use disorder services and mental health for the transition from a fee-for-service environment to care management. Implementation was planned as a two-phase transition to take place over a three-year period.

### **BHO Phase I**

Beginning in January 2012, the state contracted with five BHOs to monitor inpatient behavioral health services for Medicaid-enrolled individuals whose inpatient behavioral health services were not covered by a Medicaid Managed Care plan and who also were not enrolled in Medicare. The Phase I BHOs were responsible for working with providers to learn how to improve care in anticipation of a managed care environment. This involved: collecting and submitting data to help OASAS and OMH learn how to improve care; identifying improvements in relation to inpatient discharge planning, ambulatory engagement/continuity of care and utilizing Medicaid data to inform treatment and care planning; and developing and testing metrics for monitoring behavioral health system performance.

Quantitative and qualitative methods were employed to assess performance and progress during Phase I and included analyzing Medicaid information on a regular basis, discussing the results with BHOs and providers, and using both to inform further decision making. The state refined the role of the BHOs in 2012 to better understand what new approaches and evidence-based practices are needed to: facilitate transitions from inpatient care to the community; sustain engagement in community-based care; and address co-morbid medical problems and co-occurring substance use and mental health disorders.

In addition, the state narrowed the focus of the BHOs to fee-for-service populations with "complex needs" that met an incident threshold based on a *qualifying number of days* since a

service admission where previously the number of days since admission was not included in the criteria. The criteria for individuals engaged in substance use disorder treatment were revised as follows:

- Individuals (all ages) admitted to a substance use disorder (SUD) inpatient unit (Part 816 detoxification or Part 818 rehabilitation) who had a previous SUD admission within the *past 90 days*;
- High need Inpatient Detoxification individuals (admissions with 3 or more inpatient detoxification admissions *in the prior 12 months*).

Moving forward BHOs will take a more active role in consulting with inpatient providers for complex admissions or long stay cases; assist providers with facilitating single point of access and other care coordination; arrange or assign peer support; increase outreach and follow-up with outpatient providers and fee-for-service individuals following an inpatient episode of care; work with providers to identify and engage individuals with multiple detoxification episodes who leave the inpatient unit before care coordination efforts are initiated; and assist OASAS and OMH in identifying gaps in care and develop system support processes that improve efficiency and care coordination referrals and follow-up.

## **BHO Phase II**

In October 2012, the Medicaid Redesign Team (MRT) and the MRT Behavioral Health Subcommittee put forward a number of recommendations to support the careful and responsible transformation of the current fee-for-service system to Medicaid Managed Care for Medicaid enrolled individuals with Substance Use Disorder (SUD) and Mental Health (MH) treatment needs. These recommendations informed the design and development of BHO Phase II. One of the main goals of Phase II is for the state to establish contracts with specialty managed care plans to address the needs of individuals whose benefits have been ‘carved out’ of managed care plans. There were a number of specific recommendations that pertained to finance and contracting with plans, as well as those that addressed eligibility, performance metrics and evaluation, peer services, and the interface with Health Homes implementation. A few overarching concepts from the work group’s recommendations include:

- Establish risk-bearing managed care approaches/entities - either as special needs plans (SNPs), provider-based Integrated Delivery Systems (IDSs), or BHOs.
- Invest or reinvest in community-based systems of care in order to create the strong, well-functioning system of care necessary to meet the needs of individuals no longer utilizing inpatient care. Such investments are needed in care coordination, affordable housing, health information exchanges, and other non-clinical services and supports.
- Risk-bearing managed care approaches should bear responsibility to pay for inpatient care at OMH Psychiatric Centers and to coordinate discharge planning from these facilities, and other inpatient settings.
- Advance the core principle that managed care approaches for people with behavioral health care needs should assist enrollees in recovery and in functioning in meaningful life roles.

- Develop outcome measurements and standards to review performance that are meaningful, easy to measure, validated and readily available, and easy to use – for both adult and children’s behavioral health services.

To address the recommendations, OASAS and OMH conducted a great deal of research on how BHOs and SNPs have been implemented in other states, State Plan Amendment (SPA)/waiver requirements that must be addressed to achieve program design goals, model payment approaches, and the financial impact of the redesign initiative. As a result, in May 2013 the design for managed behavioral health was presented to, and endorsed by the MRT. The design includes the following provisions and key requirements:

- Behavioral health will be managed by special needs Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs;
- Mainstream managed care plans may operate services directly only if they meet rigorous standards or partner with a BHO that meets those standards;
- Design will enhance the array and quality of services available in all plans;
- All plans must meet rigorous standards for managing behavioral health benefits;
- All plans must qualify to manage currently carved out behavioral health services and populations;
- Plans may apply to be a HARP with expanded benefits;
- Individual plans of care and care coordination must be person-centered and be accountable for both in-plan benefits and non-plan services;
- Plans must interface with social service systems to address homelessness, criminal justice and employment related issues for their members;
- Plans must interface with Local Governmental Units (LGUs);
- Plans must interface with State psychiatric centers to coordinate care for members.

HARPs are described as a “distinctly qualified, specialized and integrated managed care product for individuals with significant behavioral health needs.” Individuals must meet HARP eligibility criteria to enroll in the program. Initial eligibility will be based on historical use of services while future eligibility will be based on a functional/clinical assessment and historical utilization. Finally, HARP premiums will include all Medicaid State Plan services. This includes physical health, behavioral health, pharmacy, long-term care and health homes. HARPs will also manage the new 1115 waiver benefits which are akin to the home and community based 1915(i) waiver services that are not currently covered by Medicaid. These waivers address services in support of participant-directed services, crisis, support services, empowerment services, service coordination and rehabilitation. Access to these services will be based on a functional needs assessment.

To evaluate the behavioral health redesign, the state will build on current metrics to measure quality and outcomes for the substance use disorder and mental health services and create enhanced performance standards for managed care organizations and HARPs. The measures will address behavioral health in primary care and the newly managed substance use disorder and mental health services. There will be additional HARP measures that focus on the coordination of care between behavioral health and primary care. Given new metrics will require data beyond

the claims and encounter data currently available through eMedNY, these measures may be phased in to allow time to build the necessary infrastructure to collect and analyze the data to support these measures.

The plan qualification process also needs to be finalized before the state takes final steps to implement Phase II. There has been constructive, critical feedback from stakeholders regarding details related to program features, baseline data, and rate development activities that is requiring additional time and consideration as the state develops the managed behavioral health services package. On December 5, 2013, OMH, OASAS, and DOH released a Request for Information (RFI) regarding “New York’s Request for Qualifications (RFQ) for Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plan.” The RFI solicited input concerning New York State’s draft proposal to manage Medicaid substance use and mental health benefits. Stakeholder feedback will help inform any revisions to the final RFQ as well as guide New York State in the provision of Plan and Provider readiness assistance. The RFQ will qualify Plans to manage services on their own or in partnership with a BHO. It will establish the qualification parameters for HARPs for individuals with higher levels of SUD and MH treatment and support needs.

The new implementation dates for the final steps in the behavioral health transformation are:

- January 1, 2015: Implementation BH Adults in NYC (HARP and Non HARP)
- July 1, 2015: Implementation BH Adults in Rest of State (HARP and Non HARP)
- January 1, 2016: Implementation BH Children Statewide

The additional time allotted with the revised implementation dates will allow the state to:

1. Provide Medicaid Managed Care Plans and Behavioral Health Providers more time to prepare;
2. Continue to obtain feedback from stakeholders and better leverage community based services in the design;
3. Develop key performance measures for the new behavioral health services environment;
4. Obtain needed federal approval for new services and design; and,
5. Allow DOH, OASAS, and OMH to continue working on reasonable and efficient plan and service payment rates with the state’s actuary.

## **Health Homes**

New York State is authorized under the federal Patient Protection and Affordable Care Act (ACA) to develop and provide Health Home services for Medicaid recipients with chronic illness. Health Home services support the provision of coordinated, comprehensive medical and behavioral health care to patients with chronic conditions through care coordination and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes use of health information technology (HIT), and avoids unnecessary care. Health Home services include:

- Comprehensive care management;
- Health promotion;
- Transitional care, including appropriate follow-up from inpatient to other settings;
- Patient and family support;
- Referral to community and social support services;
- Use of health information technology to link services.

An individual is eligible for Health Home enrollment if he or she is currently on Medicaid and has: (1) two chronic conditions; (2) one chronic condition and is at risk for a second chronic condition; or (3) one serious persistent mental health condition.

Comprehensive care management calls for all of an individual's caregivers to communicate with one another to comprehensively address the patient's needs. A care manager is responsible for overseeing and managing this process and assuring the patient has access to all the services necessary to improve health, reduce emergency room visits, and avoid hospitalization. Patient health information is shared among providers to address all needs fully and ensure there is no duplication of services. Health Home services are provided through a network of organizations – providers, health plans, and community-based organizations who work cooperatively to provide care. As of September 2013, there were 32,661 Medicaid recipients in active care management in a Health Home and another 21,146 engaged in outreach activities with a Health Home provider.

To evaluate the impact and effectiveness of the Health Home implementation the state developed the Health Home Care Management Assessment Reporting Tool (HH-CMART), which collects standardized care management data for members assigned to Health Homes. The data will provide DOH with information about care management services to evaluate the volume and type of interventions and the impact care management services have on outcomes for people receiving these services. The data requirements include submission of specified data about care management services provided to members in Health Homes.

Statewide quality measures were developed to address five goal areas of treatment. Substance use disorders are included in the goal to “improve outcomes for persons with substance use and/or mental health disorders.” The actual measure addresses follow-up care after a hospitalization for detoxification for alcohol or chemical dependence. For this measure, the state will rely on Medicaid claims data to determine the percentage of discharges for specified alcohol and chemical dependence conditions that are followed up with visits to chemical dependence treatment and other qualified providers within 7 days and within 30 days of detoxification in addition to those who have ongoing visits within 90 days of the discharge.

OASAS continues to work with DOH and OMH on the management and oversight of Health Homes and provider networks across the state. Additional monitoring and evaluation tools are being developed within a larger evaluation plan that includes an external entity, the National Center on Addiction and Substance Abuse (CASA) at Columbia University, conducting in-depth analyses of outcomes for individuals with a substance use disorder engaged in Health Homes.

## Problem Gambling Prevention and Treatment

OASAS supports statewide prevention and treatment services that target problem gambling. Outpatient treatment for problem gambling is provided in 20 community-based programs while the state-operated St. Lawrence Addiction Treatment Center (ATC) provides inpatient treatment. OASAS partners with the New York Council on Problem Gambling (NYCPG) to integrate problem gambling awareness into its prevention system and to develop public awareness campaigns.

Problem Gambling Prevention Integration training began in fall 2013 and approximately 60 percent of OASAS-funded prevention providers have been trained. The remaining providers will be trained by February 2014. After completing the training, prevention providers will deliver problem gambling awareness presentations in their communities. All prevention providers must complete three presentations by June 30, 2014, which will result in approximately 550 presentations statewide. The presentations will continue during the following year.

Prevention providers are participating in the Parent Project, which is a public education and awareness effort directed toward parents of school-aged youth. The Project's message is that gambling is not a safe activity for youth. To date, 367 parents have attended awareness events conducted by prevention providers. A media campaign that included radio ads and interviews, television and movie trailer Public Service Announcements (PSAs), newsletter articles, print ads, parent brochures, social media, billboards, and information flyers reached an estimated 1.1 million people statewide.

The Know the Odds public awareness campaign reached an estimated 7.8 million people this year. The campaign used the web, radio, television, videos, e-books, blogs, PSAs, billboards, and Facebook to increase awareness regarding the consequences of problem gambling. Materials were made available for use at the local level via the web at <http://knowtheodds.org>.

As part of the contract with OASAS, NYCPG worked with the New York State Gaming Commission to conduct over 500 compliance reviews during spring and summer 2013. These compliance reviews included checking for proper identification when vendors sold gambling products and for required signage regarding age requirements to participate in gambling activities. The Commission and NYCPG are implementing an education plan to increase awareness of the gambling laws and the responsibility of vendors not to sell lottery tickets to minors or allow them to place bets.

OASAS collaborated with the Commission and NYCPG in forming the Responsible Play Partnership to promote problem gambling prevention and treatment through New York State-licensed entities such as retail outlets, racinos, and off-track betting facilities. The Partnership's efforts include: the Underage Compliance Education Tour and Awareness of Underage Sales Issues; developing a comprehensive self-exclusion policy, and ensuring proper signage and resources at gaming facilities. The Underage Compliance Education Tour and Awareness campaign uses signage with the "*Under 18? / It's the Law! / We check ID!*" slogan and direct mailings to retailers to reinforce laws restricting the sale of gambling products to minors. OASAS is also developing a self-exclusion resource guide targeted to individuals who may self-

identify as having a gambling problem and are interested in information about treatment from the OASAS HOPEline. The agency has also partnered with the Commission to promote the annual Holiday Campaign, which includes a scrolling message on lottery terminals to give lottery products responsibly and discourage underage use of such products.

OASAS is piloting three new problem gambling prevention projects: “Teen Intervene” to address potential problem gambling among youth, “Stacked Deck: A Program to Prevent Problem Gambling,” and three targeted public awareness campaigns in New York City.

Teen Intervene is an evidence-based screening and brief intervention program used to identify potentially problematic substance use behavior among youth. The program is used by many OASAS prevention providers. Teen Intervene has been adapted to assess youth for gambling problems and provide an educational intervention to prevent escalated gambling before it becomes an addiction. It also provides referrals to treatment as needed. Four providers at ten sites implemented the program during the 2013-2014 school year. If the pilot is successful, Teen Intervene will be integrated into the array of services offered by OASAS prevention providers throughout the state.

The New York City Department of Education is implementing “Stacked Deck: A Program to Prevent Problem Gambling.” It purchased the six-lesson curriculum for grades 9 – 12 and trained Substance Abuse Prevention Intervention Services (SAPIS) staff to implement the curriculum during the 2013-14 school year.

OASAS is also funding three new problem gambling public awareness campaigns in New York City targeted to specific communities and ethnic groups: Hispanic (Bronx), Jewish (Brooklyn), and Asian (Manhattan).

## OASAS Outcomes Dashboard

In March 2013, OASAS issued the sixth annual OASAS Outcomes Dashboard. The five core destinations provide the framework for the 12 key metrics, and 42 sub-metrics used to measure progress by OASAS staff and the field. The Dashboard is available on the agency's website at: <http://www.oasas.ny.gov/pio/oasas.cfm#strategy>. OASAS will report on *2013 Outcomes Dashboard* results in its *2014 Interim Report on the Statewide Comprehensive Plan*.

## Planning for Local Mental Hygiene Services

The local services planning process for mental hygiene services is a collaborative effort among the three state Department of Mental Hygiene agencies - OASAS, OMH, and the Office for People With Developmental Disabilities (OPWDD). 2013 marked the sixth consecutive year that OASAS, OMH, and OPWDD issued joint local plan guidelines reflecting an integrated planning approach. This has resulted in more person-centered planning at the local level that focuses on the needs of individuals with multiple disabilities. The online County Planning System (CPS) enables counties and providers to complete and submit required local planning forms to the state electronically. Rather than completing separate local services plans for each state mental hygiene agency, LGUs submit a single integrated plan to all three agencies through CPS. Integrated planning fosters collaboration among the systems that serve people with multiple disabilities.

## Mental Hygiene Planning Committee

The Mental Hygiene Planning Committee includes representatives from the three state mental hygiene agencies, CLMHD, and several LGUs. It meets regularly to guide the local planning process and develop resources to support the work of county planners. The committee focuses on meeting the needs and requirements of the state agencies and provides guidance to LGUs in conducting an efficient and data informed planning process. A primary objective of the planning committee is to guide and support an integrated person-centered local planning process that facilitates system-wide improvements in the quality of services and supports to individuals, families, and communities.

The committee's cross-system approach allows it to focus its efforts on addressing the needs of the whole person, particularly coordinating behavioral health care with primary health care and improving access to recovery support services. In response to significant reforms facing the behavioral health care system, the committee is working to ensure that the important role of the LGUs in the provision and oversight of local behavioral health services for their populations is maintained. It is a priority of the committee that LGUs provide timely and informed input into state policy decision-making regarding these reforms and to continue to manage their local service systems to achieve cost-effective care and better patient outcomes. The committee has

two workgroups that are committed to improving the ability of local mental hygiene agencies to conduct effective planning that is focused on the rapidly changing behavioral health care environment.

The **Data Needs Workgroup** identifies county data needs and develops resources that result in a more data informed and outcomes-focused planning process. Over the past year, the Data Needs Workgroup collaborated with OASAS to revise a number of client data inquiry reports that provide county planners with extensive information on the characteristics of the chemical dependence treatment population. Among the improvements made to these reports were the ability to generate aggregate county-level reports by service type, the ability to access data from non-contracted programs within the county and on county residents treated outside the county, and the ability to export data into more usable formats, like Excel.

Another successful workgroup effort was facilitating county access to the OMH Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), and establishing a PSYCKES users group. The first meeting of the group was attended by 37 county planners and included a presentation by OMH staff on the available health promotion indicators and utilization data, the system's querying function and graphing capabilities, and examples of ways to use the system to support local planning.

The **Community of Practice for Local Planners (CPLP)** promotes best planning practices and techniques for assessing local needs, defines outcomes and strategies, and identifies and utilizes available data resources. The CPLP conducts webinars and coordinates with the Data Needs Workgroup to include webinars on the new data resources that are developed for county planners. As a community of practice, this group is chaired by a county planner and includes representatives from county and state agencies.

Over the past year, the CPLP convened a live training session that covered a practical application of the OASAS Client Inquiry Reports, a review of DOH's Prevention Quality Indicators (PQI), and a practical application of spreadsheet tools for analysis and presentation of data. In addition, two webinars were conducted, including a presentation on resources available on the OMH County Profiles Portal and the BHO Portal, and a presentation on the OASAS Client Inquiry Reports, and recent changes made to the OASAS online County Planning System (CPS). The CPLP also conducts periodic surveys to ensure that training topics are selected based on the needs and interests of county planners.

## **Local Services Plan Guidelines**

The ***Local Services Plan Guidelines for Mental Hygiene Services*** are developed annually in compliance with State Mental Hygiene Law. These guidelines are developed collaboratively by OASAS, OMH, and OPWDD with guidance from the Mental Hygiene Planning Committee. The guidelines provide LGUs and OASAS service providers with updated information on statewide planning initiatives and priorities, as well as guidance on the development of the local services plan.

The key component of the local services plan is the priority outcomes and strategies, which address the problems and needs identified through the LGU's ongoing planning and needs assessment efforts. Those priorities also provide OASAS, OMH, and OPWDD with important local input into each agency's statewide planning process. Priorities related to the OASAS service system are summarized in Chapter III of this document.

In addition to requiring local priorities, the guidelines ask LGUs to respond to questions that help to inform statewide decision-making on a number of important policy questions. For example, in the aftermath of two recent weather disasters, it was apparent that there was a need for improved coordination and communication among multiple levels of government and service providers. In response to that experience, LGUs were surveyed this year on their emergency preparedness and response efforts so that OASAS and OMH could determine where improvements can be made. OASAS providers were also surveyed on their emergency management efforts. Information from these surveys will help OASAS to better assess emergency preparedness and response at the local level so that improvements can be made.

This year, LGUs were also asked to describe the collaborative efforts with their local health department (LHD) regarding DOH's Prevention Agenda, which includes a priority focus on *improving mental health and preventing substance abuse*. OASAS and OMH participated in the development of this priority area and related plan guidance and endorsed the LGU/LHD collaboration. While engaging other local agencies and stakeholders is an important part of an LGU's planning process, collaboration with the LHD on this effort is particularly important, given that mental health and substance abuse were identified by LHDs across the state as among the five most important priority areas to address in their Community Health Improvement Plan.

## Chapter II: System Overview

### National Outcome Measures (NOMs)

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed National Outcome Measures (NOMs) in collaboration with states to demonstrate and improve the effectiveness of the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the corresponding Center for Mental Health Services (CMHS) Block Grant, as well as discretionary grant programs. The SAPT Block Grant provides approximately \$108 million annually to prevention, treatment, and recovery services in New York.

The ten NOMs domains cut across mental health, substance use treatment, and substance use prevention services:

1. Reduced Morbidity (e.g., abstinence);
2. Increased Employment and Education;
3. Decreased Criminal Justice Involvement;
4. Stability in Housing;
5. Social Connectedness;
6. Access and Capacity;
7. Retention in Care;
8. Perception of Care;
9. Cost Effectiveness;
10. Use of Evidence-Based Practices.

**Table 2.1** shows outcomes for the entire certified treatment system (excluding crisis services for which NOMs have not been developed) and **Table 2.2** shows net improvement over four years.

**Table 2.1 National Outcome Measures (NOMs) for Non-crisis Chemical Dependence Treatment Services\* Based on Persons Discharged in Calendar Year 2012 \*\*\***

National Outcome Measure	At Admission	At Discharge	Net** Improvement
Abstinence in Past 30 Days			
From Alcohol	62.9%	86.5%	23.6%
From Other Drugs	45.4%	74.8%	29.4%
From Alcohol and Other Drugs	30.5%	68.9%	38.4%
Employed or Enrolled in School	27.3%	33.7%	6.4%
Stable Living Situation#	87.5%	90.1%	2.6%
Not Arrested in Past 6 months	75.0%	87.8%	12.8%
Social Connectedness	26.7%	40.3%	13.6%

- \* These figures include non-crisis outpatient, inpatient rehabilitation, residential and opioid treatment services.
- \*\* Net improvement is simply the percentage point difference between the admission and discharge measures.
- \*\*\* Total discharges with valid data (the denominator) vary by measure: 196,304 for abstinence measures; 196,479 for employment/enrollment; 196,417 for living situation; 204,638 for arrest; and, 193,887 for social connectedness.
- # Stable living situation includes congregate care residences, but excludes homeless shelters and unsheltered situations.

**Table 2.2 Four-Year Trends of National Outcome Measures (NOMs) for Non-crisis Chemical Dependence Treatment Services\* Showing Net Improvement for Persons Discharged for Calendar Years 2009 - 2012 \*\*\***

National Outcome Measure	Net** Improvement 2009	Net** Improvement 2010	Net** Improvement 2011	Net** Improvement 2012
Abstinence in Past 30 Days				
From Alcohol	24.4%	23.6%	23.6%	23.6%
From Other Drugs	28.0%	28.1%	28.4%	29.4%
From Alcohol and Other Drugs	37.5%	37.2%	37.7%	38.4%
Employed or Enrolled in School	5.5%	6.3%	6.4%	6.4%
Stable Living Situation#	2.2%	2.5%	2.6%	2.6%
Not Arrested in Past 6 months	13.0%	13.9%	13.3%	12.8%
Social Connectedness^	11.3%	13.8%	14.2%	13.6%

- \* These figures include non-crisis outpatient, inpatient rehabilitation, residential and opioid treatment services.
- \*\* Net improvement is simply the percentage point difference between the admission and discharge measures.
- \*\*\* Total discharges with valid data (the denominator) varies by measure: 196,304 for abstinence measures; 196,479 for employment/enrollment; 196,417 for living situation; 204,638 for arrest; and, 193,887 for social connectedness.
- # Stable living situation includes congregate care residences, but excludes homeless shelters and unsheltered situations.
- ^ Social Connectedness refers to attendance at self-help programs.

## System Facts: Prevention

### Prevention Activity and Results Information System (PARIS)

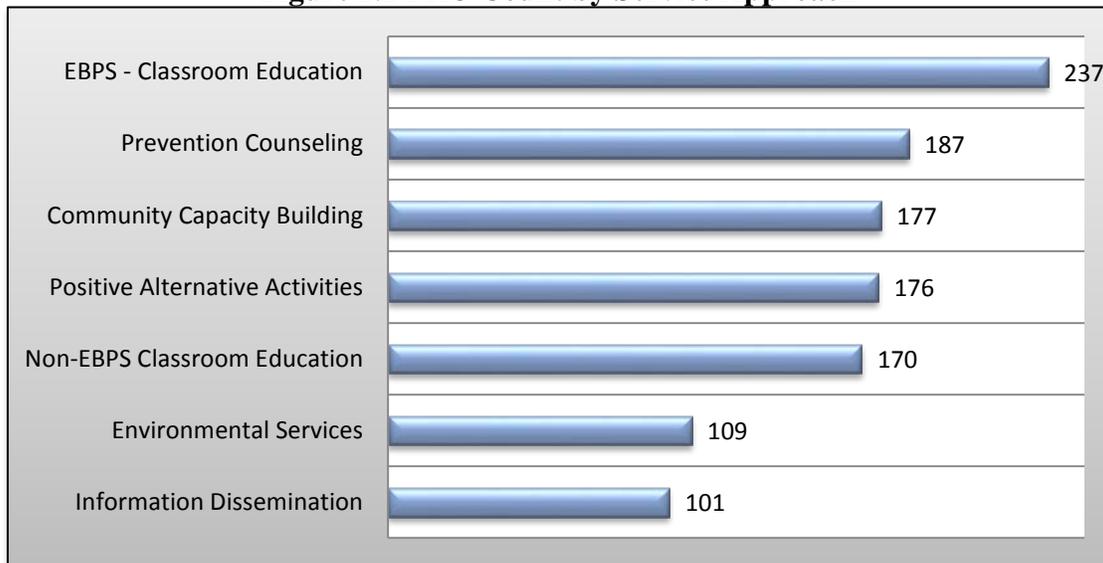
PARIS is a web-based information system that supports the annual planning and approval process, service delivery data reporting, and performance measurement of OASAS-funded prevention providers. The annual workplan approval process - with review by county and OASAS Field Office managers - produces activity data collection templates for the planned services used by providers to report monthly service delivery. PARIS is used to collect data on all funded prevention providers' service activities.

A distinguishing feature of PARIS is the integration of the planning and activity reporting functions. Each provider is required to conduct an assessment of community needs, describe the populations affected by risk and protective factors for substance abuse, and then select service approaches for targeted groups of individuals or communities. The OASAS state and county review and approval process supports the coordination of prevention activities in each county and New York City.

### Prevention Activity Data for 2012

**Figure 2.1** illustrates how many of the 385 Prevention Programs provided each of the seven types of prevention services in 2012.

**Figure 2.1 PRU Count by Service Approach**



Note: EBPS – Classroom Education is Evidence-Based Programs/Strategies – Classroom Education and Non-EBPS Classroom Education is Non-Evidenced-Based Programs/Strategies – Classroom Education.

Information on the number of direct and indirect service activities conducted during 2012 is in **Table 2.3**.

**Table 2.3 2012 Activity Count by Service Approach**

<b>Service Approach</b>		
<b>Direct Services</b>	<b>n</b>	<b>%</b>
EBP – Education	118,370	48%
Non-EBP – Education	39,424	16%
Positive Alternatives	32,296	13%
Prevention Counseling	58,441	24%
<b>Total</b>	<b>248,531</b>	<b>100%</b>
<b>Indirect Services</b>		
Environmental Strategies	73,145	93%
Information / Awareness	5,664	7%
<b>Total</b>	<b>78,809</b>	<b>100%</b>
<b>Grand Total (Direct + Indirect)</b>	<b>327,340</b>	

Note: Positive alternatives in this table include all positive alternative services regardless of the Service Approach.

**Table 2.4** includes information on the number of individuals that participated in each of the four types of direct service provision.

**Table 2.4 Participant Count by Service Approach for Direct Services, 2012**

<b>Service Approach</b>	<b>N</b>	<b>%</b>
EBP Education	267,011	64%
Non-EBP Education	74,768	18%
Positive Alternatives	35,882	9%
Prevention Counseling	36,433	9%
<b>Total</b>	<b>414,094</b>	<b>100%</b>

Note: Positive alternative participants include only positive alternative counts recorded as a continuing activity

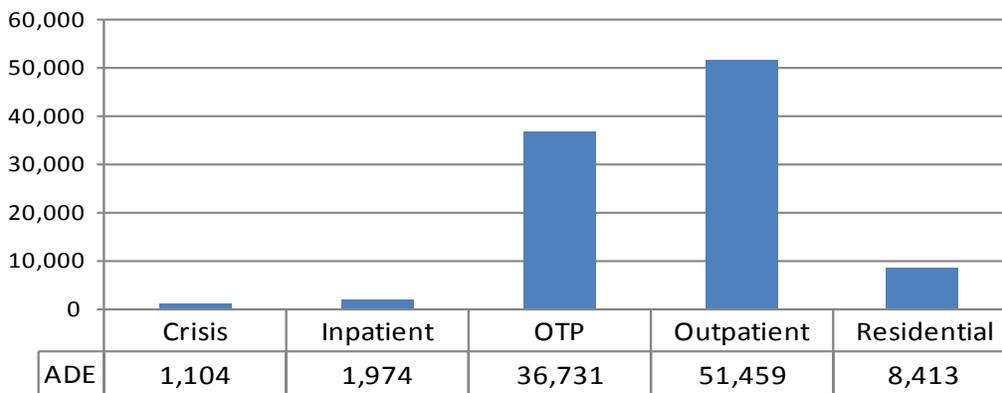
## System Facts: Treatment

### System Summary

- In 2012, there were approximately 294,000 admissions to OASAS-certified chemical dependence (CD) treatment programs. Almost half of those admissions were to outpatient programs (46%), followed by crisis (30%), inpatient (13%), residential (7%), and opioid treatment programs (OTPs) (4%), formerly known as methadone programs. There are fewer OTP admissions because clients have longer lengths of stay in this service type.
- Average daily enrollment was nearly 100,000 mostly in outpatient programs (52%) and OTPs (37%) (**Figure 2.2**).

**Figure 2.2 Average Daily Enrollment by Program Category, CY2012**

□



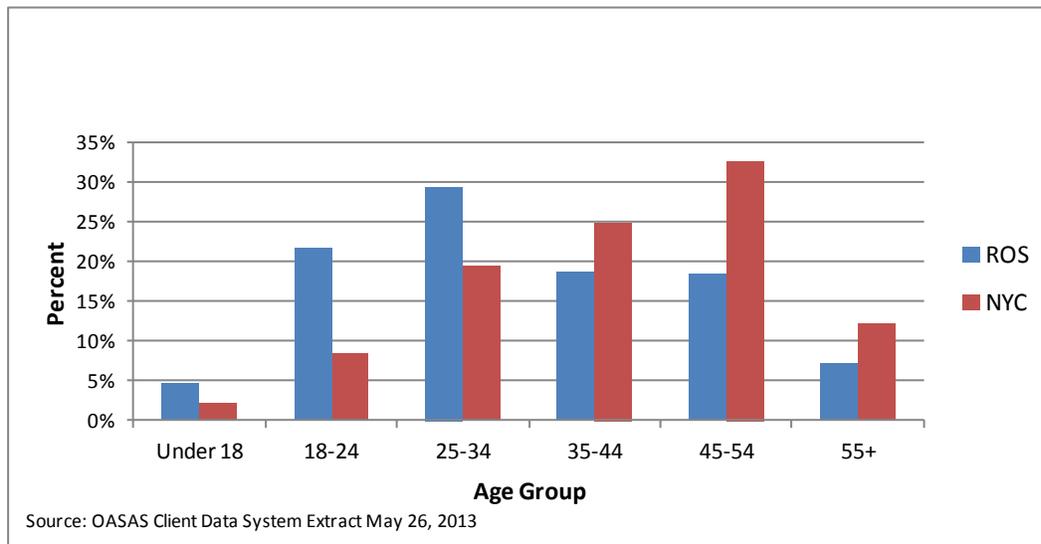
Source: OASAS Client Data System Extract - May 26, 2013

### Client Characteristics

- Seventy-four percent were male.
- One-quarter of admissions were ages 45-54, followed by 25-34 (25%), 35-44 (22%), 18-24 (16%), 55 and over (9%), and under 18 (3%).
- Alcohol was the most common primary substance (42%), followed by heroin and other opioids (29%), marijuana (16%), cocaine/crack (10%), and other (3%).
- Two-thirds (66%) of admissions reported two or more problem substances.

- Twenty-one percent reported a prescription<sup>1</sup> drug as a primary, secondary, or tertiary substance. 45-54 year olds were most likely to report a prescription drug as a problem substance in NYC while 25-34 years olds were most likely to report a prescription drug as a problem substance in the rest of the state (**Figure 2.3**).

**Figure 2.3 Percent of 2012 Admissions with a Primary, Secondary or Tertiary Prescription Drug Used by Age Group (New York City vs. Rest of State)**



- Over one-third (38%) of admissions reported a primary, secondary, or tertiary opioid.
- Forty-seven percent were White non-Hispanic, 30 percent Black non-Hispanic, 20 percent Hispanic, and 3 percent other non-Hispanic.
- Thirty-nine percent of admissions were high school graduates, 33 percent had less than a high school education, and 28 percent had more than a high school diploma.
- Twenty-two percent were employed.
- Fifty-two percent of non-crisis admissions were identified as having a co-existing psychiatric disorder or had ever been treated for a mental illness.
- Thirty-four percent of crisis admissions and 8 percent of non-crisis admissions were homeless.
- Three percent reported being a veteran.
- The most common referral source was self (35%), followed by criminal justice (21%), other CD programs (15%), health care/social services (12%), other/unknown (13%), and CD prevention/intervention (4%).
- Fifty-one percent of non-crisis admissions had criminal justice involvement.

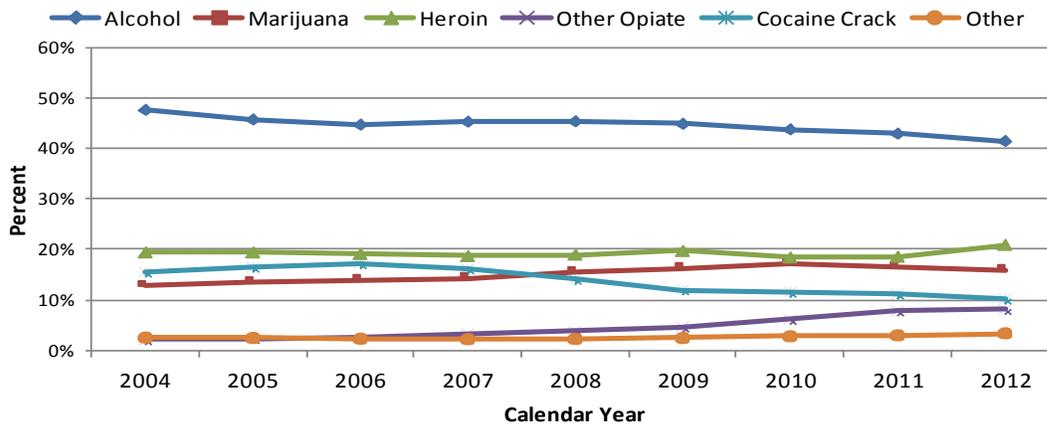
<sup>1</sup> Prescription drugs include the following listed on the admission and discharge forms: Buprenorphine, Non-Rx Methadone, OxyContin, other opiate/synthetic, Alprazolam (Xanax), Barbiturate, Benzodiazepine (Klonopin), Catapres (Clonidine), other sedative/hypnotic, Elavil, other tranquilizer, other stimulant, Ephedrine, Ketamine, Rohypnol and Viagra.

- Eleven percent reported living with children.
- Seventy-three percent reported using tobacco at admission.
- Half of all discharges paid with Medicaid (50%), followed by other/unknown (14%), private insurance (12%), none (12%), self (6%), Congregate Care (4%), and Medicare (2%).
- Thirty-two percent of outpatient, 69 percent of inpatient, and 35 percent of residential discharges completed treatment.
- Median length of stay for those who completed treatment was 182 days for outpatient, 23 days for inpatient, and 174 days for residential.

### Notable Trends

- The percentage of outpatient admissions increased from 43 percent to 46 percent, while the percentage of crisis admissions decreased from 32 percent to 30 percent between 2004 and 2012.
- From 2004 to 2012, the percentage of admissions who reported alcohol as their primary substance decreased from 48 percent to 42 percent, while other opiates increased from 2 percent to 8 percent (**Figure 2.4**).

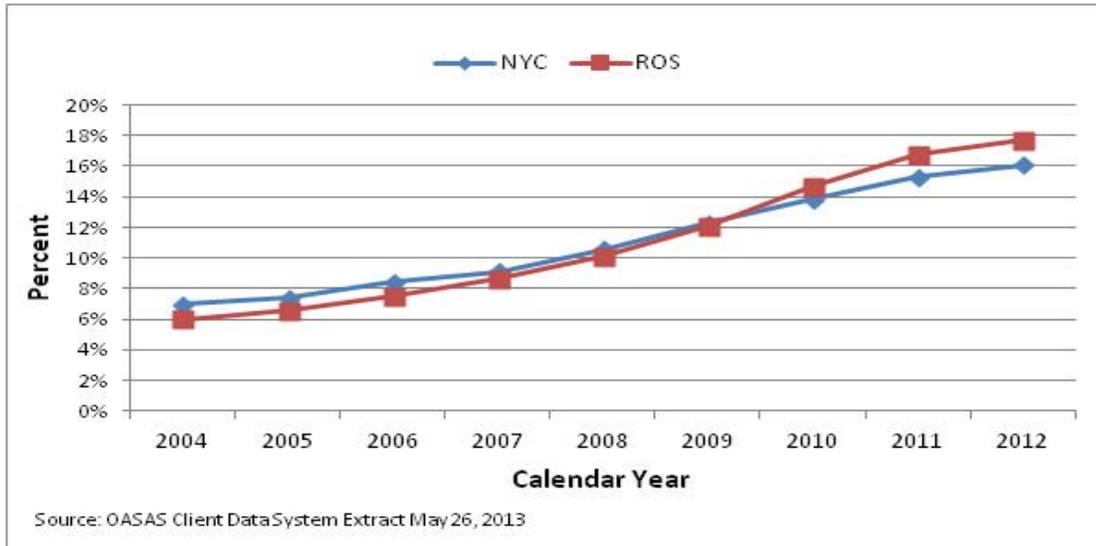
**Figure 2.4 Trend for Primary Substance at Admission (Calendar Year 2004 – 2012)**



Source: OASAS Client Data System Extract May 26, 2013

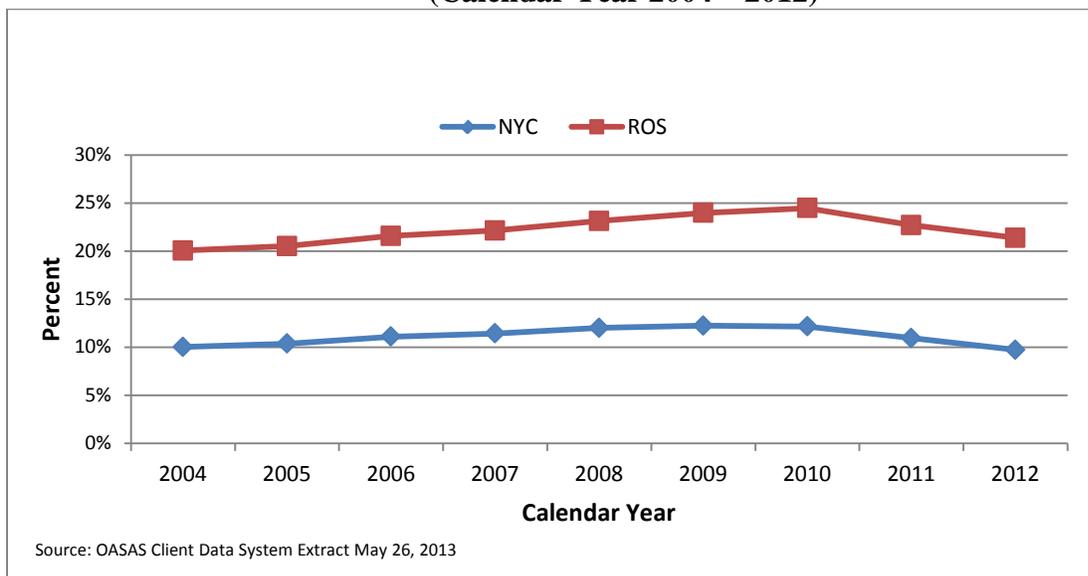
- As shown in **Figure 2.5**, from 2004 to 2012, the percentage of admissions that had a primary, secondary, or tertiary prescription drug increased from 7 percent to 16 percent for New York City (NYC) residents and 6 percent to 18 percent for rest of state (ROS) residents.

**Figure 2.5 Trend for Admissions with Primary, Secondary or Tertiary Prescription Drug Use (Calendar Year 2004 – 2012)**



- The admissions trend for individuals in the chemical dependence treatment system who are also involved with the criminal justice system is shown in **Figure 2.6**. The figure shows a comparison of admissions with criminal justice involvement in New York City compared with the rest of the state. Both groups show a slight decline over the past few years.

**Figure 2.6 Trend for Admissions with Criminal Justice Involvement (Calendar Year 2004 – 2012)**



## **Chapter III: County Planning**

New York State Mental Hygiene Law requires that OASAS, OMH, and OPWDD guide and facilitate an annual local services planning process. Each county and the City of New York is required to conduct a broad-based planning process to identify the mental hygiene service needs in the community and develop a local services plan to address them. In addition to describing their own local priorities and strategies, these plans also inform each state agency's statewide comprehensive planning process.

Since 2008, OASAS, OMH, and OPWDD have collaborated to coordinate a single unified local services planning process to help ensure that local mental hygiene services are planned for in a more comprehensive and integrated manner. The statewide Mental Hygiene Planning Committee guides the local planning process. The committee includes planning staff from the three state agencies, the CLMHD, and representatives from several LGUs. The committee is co-chaired by a state agency representative and a county representative and meets throughout the year to guide and support local planning. Additional information about the work of the committee is provided in Chapter I of this document.

This chapter contains a summary of the 2014 local services plans, which were submitted to the state in early summer 2013. Specifically, this summary includes the local priorities associated with OASAS and responses to selected planning surveys completed by LGUs and OASAS treatment and prevention providers. In addition, this chapter summarizes LGU activity and priorities associated with the DOH's Prevention Agenda 2013-2017. LGUs were encouraged to collaborate with local health departments to reduce duplicative efforts by addressing mutual priorities related to promoting mental health and preventing substance abuse in a more efficient and effective manner.

### **County Priority Outcomes**

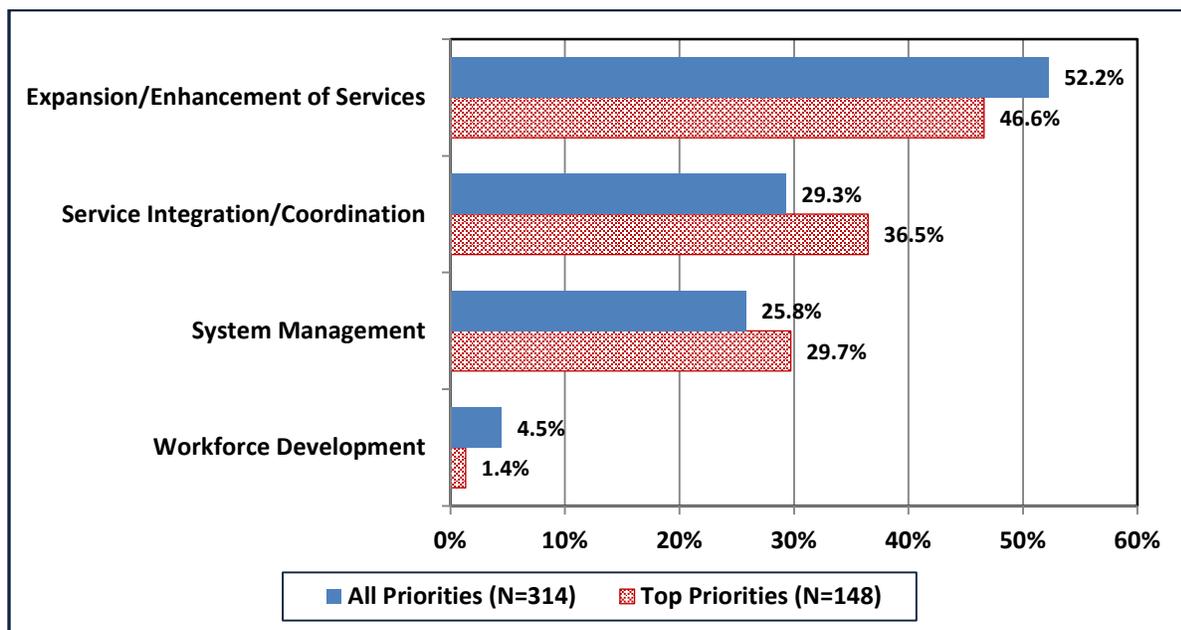
County planning continues to focus on the needs of individuals with multiple disabilities who may need services from more than one system and on the significant reforms that are affecting the delivery of services to individuals suffering from mental illness, substance use disorders, or developmental disabilities. The need to focus planning and system management efforts in this way resulted in 63 percent of county priorities submitted in the current planning cycle that were associated with multiple mental hygiene disabilities, while 49 percent were associated with all three disabilities. Priorities that address cross-system collaboration, service integration, and care coordination continue to increase each year, as do priorities that address the common needs of individuals served by each disability system, such as housing, transportation, employment, advocacy, and other support services.

This year, county plans included a total of 439 priority outcomes, up slightly from last year, but still down significantly from the first several years of integrated planning. With greater attention focused on systemic changes brought about by health care reform and Medicaid redesign, counties developed more targeted priorities in their plans.

The 2014 local services plans included a total of 314 priorities related to OASAS. The following summary analysis is based on those priorities, of which 39 (12%) were associated with OASAS, while 64 (20%) were associated with both OASAS and OMH, and 213 (67%) were priorities relating to all three agencies. One priority was associated with both OASAS and OPWDD.

As **Figure 3.1** shows, all 314 priorities were associated with one or more of four broad topic areas, with 35 (11%) falling under multiple topic areas. Like last year, counties were also asked to designate their “top three” priorities overall. While counties were not required to include priorities from each disability as a top three, 85 percent of those that were designated a top priority were associated with multiple disabilities.

**Figure 3.1: 2014 County Priority Outcomes by Category (N=314)**



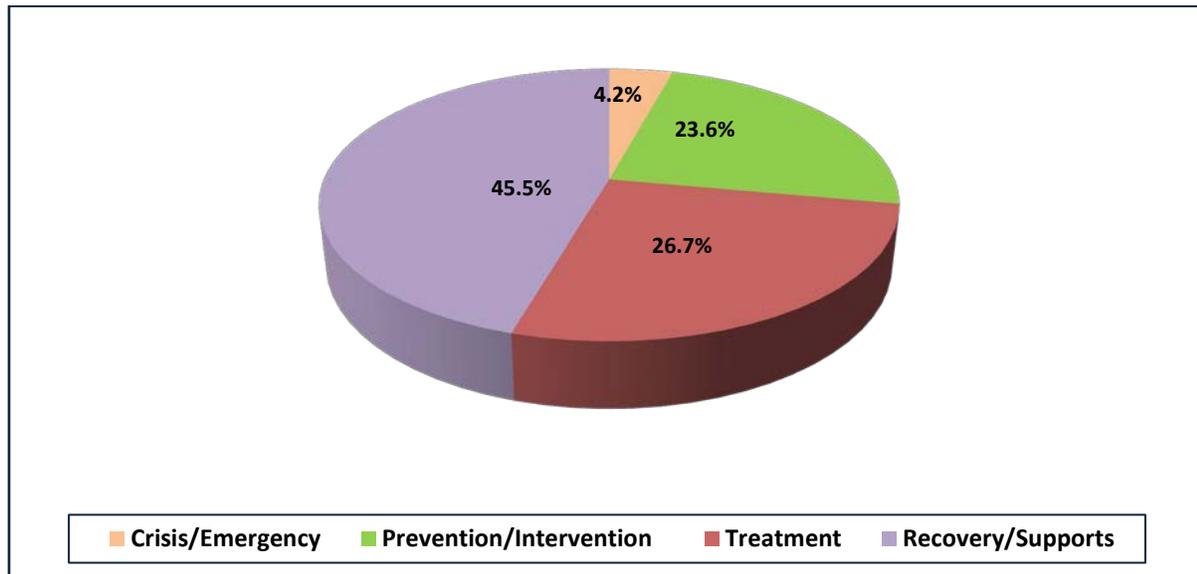
The largest priority category included those related to expanding or enhancing prevention, treatment, and recovery services in the community. These priorities represented 52 percent of the total and about 47 percent of those designated as a top priority. Priorities related to service integration and coordination represented about 29 percent of all priorities, but about 37 percent of top priorities. Fifty-nine percent of all priorities in this category were designated as a top priority. Priorities related to system management represented about 26 percent of the total, but about 30 percent of top priorities. Fifty-four percent of all priorities in this category were designated as a top priority. Finally, five percent of all priorities related to the addiction workforce.

**Expansion/Enhancement of Services (N=165)**

The largest grouping of county priorities was classified as expanding or enhancing existing program services. As in previous years, a number of these priorities were very broad, covering multiple service categories. In almost all of those situations, a review of the associated strategies

allowed each priority to be categorized as primarily prevention, treatment, or recovery. As **Figure 3.2** shows, nearly half of all priorities in this category were for recovery support services (46%). While there were fewer priorities related to treatment services, those priorities had the highest percentage that were designated top priorities (52%), compared to recovery support (41%), prevention services (37%), and crisis services (27%).

**Figure 3.2: 2014 County Priorities Related to Service Enhancement (N=165)**



### **Prevention Services:**

There were 39 county priorities focused on expanding or enhancing prevention services. The area most frequently addressed continues to be suicide prevention. While several of the suicide prevention priorities and strategies identified OMH as the associated disability agency, most also identified OASAS. Other prevention priorities focused on underage drinking, non-medical use of prescription pain relievers, problem gambling, public education, and tobacco use. Specific strategies for addressing prevention priorities included implementing evidence-based practices and environmental strategies, and collaborating with other organizations and coalitions in a more effective and comprehensive manner. Most prevention-related priorities included in this year's plans are being pursued in collaboration with local health departments as part of DOH's Prevention Agenda 2013-2017. These priorities are addressed in more detail in the Prevention Agenda section of this chapter.

### **Treatment and Crisis Services:**

There were 44 county priorities focused on expanding or enhancing treatment services. Priorities primarily focused on establishing or expanding treatment capacity (13), implementing evidence-based practices (7), and expanding access to treatment services for specific populations, including: adolescents (6), seniors (4), veterans (3), and persons with co-occurring disabilities (3). A few priorities addressed the need to provide training to clinical staff to help ensure more culturally and linguistically competent services or improved services to persons with co-

occurring disabilities. Those priorities are included below under workforce development priorities.

There were seven priorities that focused primarily on crisis services. They all addressed either the need for detoxification services as an alternative to hospital emergency departments, establishing short-term or mobile crisis services, or improving treatment engagement among those receiving crisis services.

### **Recovery Support Services**

There were 75 county priorities focused on recovery services. This category includes all the strategies intended to provide support to persons in recovery, including housing, transportation, vocational and educational services, and peer support.

**Housing** – Safe and affordable housing continues to be the single greatest need identified across the state in all three disabilities, and represents over half of all recovery support priorities. Forty-three counties identified housing as a priority for the chemical dependence service system, with 22 counties designating it as a top priority. This was also the top priority shared across the three mental hygiene systems. Most housing priorities identified the need for it to be safe, affordable, and supportive of recovery. These priorities included improving access to both transitional and permanent supportive housing options.

**Vocational and Transportation Services** – Fifteen priorities focused on providing vocational or transportation services to persons in recovery. Ten counties identified the need to enhance vocational opportunities by expanding competitive employment options in the community and providing more training. Five rural counties in the North Country and in the western part of the state included priorities addressing the lack of public transportation and the need to develop a countywide transportation plan to get people to services and employment.

**Other Supports** – In addition to support services in housing, 20 counties included priorities to increase recovery supports in the community. About half focused on a general increase in access to community-based supports for persons in recovery, while the other half focused specifically on developing peer recovery supports, including training recovery coaches. One priority focused on providing recovery case management.

### **Service Integration/Coordination (N=92)**

Priorities related to the integration or coordination of services represented about 29 percent of all priorities included in this year's plans and about 37 percent of those categorized as a "top three" priority. Fifteen priorities focused in a very general way on coordinating or integrating physical and behavioral health care, either by co-locating services or coordinating care between the different service systems. Another 11 priorities focused on integrating or coordinating mental health and substance abuse treatment services. Most of these priorities addressed the need to train clinical staff on providing treatment to persons with co-occurring disorders, while there was one priority to co-locate mental health and substance use disorder treatment services.

Twelve priorities focused on working with the regional BHOs and Health Homes on care coordination. Two priorities specifically addressed the need to access and use BHO data so that the county can provide better oversight of the services provided to its residents.

Eleven priorities addressed collaborating with the criminal justice system. These included strategies to provide services to persons involved in the criminal justice system, either inside the jail or in the community, training staff in the courts and jails on mental illness and substance use disorders, working with the jails on re-entry into the community and into treatment, and providing treatment as an alternative to incarceration.

There were an additional 16 priorities focused on collaborating with other systems and stakeholders to address a particular problem or need, such as suicide prevention or the abuse of prescription drugs. Five priorities addressed the need to coordinate care among all the agencies that provide care to children and their families. There were four priorities to expand the use of Screening, Brief Intervention and Referral to Treatment (SBIRT) in the medical and behavioral health community.

### **System Management (N=81)**

System management covers all priorities that relate to planning, outcomes management, contract management, and similar activities that pertain to the county's oversight of the mental hygiene service system. They represented about 21 percent of all priorities, but like those related to service integration and coordination; a significant majority of them (54%) were categorized as a "top three" priority. Most system management priorities were in the following three areas.

### **Planning and Needs Assessment**

There were 35 priorities that primarily focused on the planning and needs assessment responsibilities of the counties. Thirteen priorities addressed the need to expand participation in the county's planning process, including establishing ad hoc committees, advisory boards, and task forces to address major problems in the community, such as suicide, prescription drug abuse, and housing. Thirteen priorities focused more generally on data informed planning and needs assessment or conducting a more strategic planning process.

### **Performance Management**

There were 18 priorities specifically focused on system performance management. These priorities identified data-driven strategies to monitor utilization patterns and Medicaid spending to achieve cost savings and system improvements. Other priorities included developing or improving the county emergency response plan for mental hygiene services (5) and implementing electronic medical records (3).

## **Transitioning Health Homes and Managed Care**

Twenty priorities focused on working with BHOs and Health Homes to ensure that the network meets the behavioral health needs of county residents. Some priorities addressed working with providers to optimize the service system's adaptation to the new health care environment and to support the transition from Medicaid fee-for-service to managed care. Other priorities focused on LGU participation in the development of a regional Health Home and on BHO and Health Home advisory committees.

## **Workforce Development (N=14)**

There were 14 priorities in this year's plans that focused on workforce development. Four priorities from upstate rural counties addressed the general need to develop a plan for recruiting and retaining qualified professionals in a part of the state where it is problematic. Several priorities addressed the general need for training, while a few addressed specific needs, such as hiring and training culturally and linguistically competent professionals, providing more training on serving persons with multiple disabilities, including training on evidence-based practices for treating persons with co-occurring disorders, and training on the Focus on Integrated Treatment (FIT) training modules. One priority focused on training first responders on mental illness and another addressed training on medication management.

## **Prevention Agenda 2013-2017**

In December 2012, DOH distributed guidelines describing the essential elements of a local health department (LHD) Community Health Assessment and Community Health Improvement Plan, as well as the requirements for Hospital Community Service Plans. The guidelines reflect DOH's Prevention Agenda 2013-2017, which was developed in conjunction with the agency's new health improvement plan. The Prevention Agenda 2013-2017 is the blueprint for local action to improve the health of all New Yorkers in five priority areas. LHDs and hospitals are being encouraged to collaborate with each other and other community partners on the development of the Community Health Improvement Plans. DOH believes that collaboration on a community health assessment and community health improvement plan will reduce duplication of services in a more efficient and effective manner. Each LHD is required to address at least two of the five priority areas.

One of the five priority areas covered under the Prevention Agenda is **“Promote Mental Health and Prevent Substance Abuse.”** OASAS and OMH staff participated in developing the guidelines for this priority area, which were endorsed by both agencies. The 2014 Local Services Plan Guidelines for Mental Hygiene Services strongly encouraged LGUs to proactively reach out to their LHDs to collaborate on this priority area and report on that collaboration and related priorities in their own plans. OASAS also asked LGUs to identify relevant priorities for the LHDs to consider including in their plans.

The guidance provided to the LHDs for the Promote Mental Health and Prevent Substance Abuse priority identified three primary focus areas and seven goals (**Table 3.1**). Under the goals were 17 specific and measurable objectives.

**Table 3.1: Prevention Agenda 2013-2017 Focus Areas and Goals Related to the Promote Mental Health and Prevent Substance Abuse Priority Area**

<p><b>Focus Area 1:</b> Promote Mental, Emotional and Behavioral Well-Being in Communities.  <b>Goal 1.1:</b> Promote mental, emotional and behavioral (MEB) well-being in communities.</p>
<p><b>Focus Area 2:</b> Prevent Substance Abuse and other Mental Emotional Behavioral Disorders.  <b>Goal 2.1:</b> Prevent underage drinking, non-medical use of prescription pain reliever drugs by youth, and excessive alcohol consumption by adults.  <b>Goal 2.2:</b> Prevent and reduce occurrence of mental, emotional and behavioral disorders among youth and adults.  <b>Goal 2.3:</b> Prevent suicides among youth and adults.  <b>Goal 2.4:</b> Reduce tobacco use among adults who report poor mental health.</p>
<p><b>Focus Area 3:</b> Strengthen Infrastructure across Systems.  <b>Goal 3.1:</b> Support collaboration among leaders, professionals and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery.  <b>Goal 3.2:</b> Strengthen infrastructure for MEB health promotion and MEB disorder prevention.</p>

### **Collaboration with Local Health Departments**

Most LGUs collaborate with LHDs in their ongoing local planning process. Some LGUs reported sitting on health planning boards or committees with LHD staff, and several counties reported collaborative planning activity with other stakeholders, including local health care providers, coalitions, rural health networks, school districts, housing agencies, and other service agencies. In this year’s plan, LGUs were asked to describe the collaborative efforts specifically related to the Prevention Agenda. Because mental hygiene local services plans were due in June and the Health Improvement Plan would not be due until later in the year, some counties reported having preliminary discussions regarding the Prevention Agenda. Other counties reported various stages of collaboration ranging from meetings to coordinated implementation of programming to address specific objectives. Of the 56 LGUs that responded to the question, 52 (93%) reported active collaboration with their LHD around setting prevention priorities.

### **LGU Priorities Related to the Prevention Agenda 2013-2017**

A review of LGU priorities submitted with the 2014 local services plans showed considerable alignment with the goals of the Prevention Agenda. Because many county mental hygiene agencies have included plans to address one or more of the problem areas covered by the Prevention Agenda in previous plans, it is not clear how many priorities were developed in collaboration with their LHD or were going to be part of their plan anyway. What is clear is that there is a significant level of collaboration being reported, which suggests that most of these priorities will be addressed in partnership with the LHD and other community stakeholders. Thirty-seven LGUs (65%) included one or more priorities that are in alignment with the Prevention Agenda. Many priorities and strategies overlap multiple goals within the Prevention

Agenda. While a full assessment of mutual priorities cannot be made until the LHDs submit their Community Health Improvement Plans, the following is a summary overview of the mental hygiene priorities that align with the goals of the Prevention Agenda.

***Focus Area 1: Promote Mental, Emotional and Behavioral Well-Being in Communities.***

Fourteen counties (25% of the total) included a priority or strategies that were in alignment with this focus area. Most involved increasing the number of prevention programs that utilize evidence-based practices or screening tools. Several counties reported focusing their efforts on a specific population or topic, including suicide prevention (2), tobacco use reduction (1), opiate addiction (1), and underage drinking (1).

***Focus Area 2: Prevent Substance Abuse and other Mental Emotional Behavioral Disorders***

Thirty-two counties (56%) included a priority or strategies that were in alignment with this focus area. Suicide prevention was identified as a priority in 28 plans. Several plans identified multiple and integrated strategies to address suicide prevention, which included the following:

- Provide community education and awareness about suicide prevention, including utilizing multimedia approaches (16).
- Provide a cross-system approach to reducing suicides and suicide attempts through service coordination and establishing or maintaining a countywide suicide prevention coalition or task force (15).
- Provide training on recognizing at risk behaviors and appropriate response to suicides and suicide attempts, including OASAS providers, first responders, clergy, schools, and other organizations (8).
- Implement evidence-based suicide prevention screening and risk assessment in schools and the community (5).
- Promote recovery of persons affected by suicide; establish a suicide support group (3).
- Other strategies included working with the coroner for reliable data on suicides, targeting suicide prevention efforts to certain populations (youth, adult males, and veterans), and working to get insurance companies to pay for suicide assessment.

There were 14 counties (25%) that included strategies related to preventing underage drinking (10), non-medical use of prescription pain relievers by youth (9), and excessive alcohol consumption by adults (1). Most strategies involved collaborating with other organizations, including state agencies, the local health department, prevention coalitions, and underage drinking task forces. Other strategies included implementing evidence-based prevention programs, changing community norms about underage drinking and drug use, educating parents and promoting supervision, and enforcing underage drinking laws to reduce sales to minors. Several counties noted that it has become a top priority to address the increased use of non-prescription pain relievers among young people and the alarming number of overdose deaths occurring recently.

Five counties (9%) included strategies to reduce the use of tobacco, generally focused on collaborative efforts with the local health department to explore implementation of evidence-based programs and other tobacco use prevention initiatives. One county noted that a prevention program would be conducting tobacco retail outlet compliance checks in an effort to reduce sales to minors.

Two counties (4%) included strategies to prevent and reduce occurrence of mental, emotional, and behavioral disorders among youth and adults, specifically providing early detection of mental illness and connecting to mental health services.

### ***Focus Area 3: Strengthen Infrastructure Across Systems.***

Twenty-two counties (39%) included a priority or strategies that were in alignment with this focus area. Most of these priorities and strategies overlapped with those described above, particularly with respect to collaboration with other stakeholders and providing cross-system training and other technical assistance to providers and other organizations in the community. Several counties reported that their needs assessment and planning efforts are focused on identifying and quantifying problems and needs related to the goals of the Prevention Agenda.

As noted earlier, after the local Health Improvement Plans are completed and submitted to DOH, another look will be given to how the priorities in those plans align with those in the mental hygiene local services plans. Whether or not the plans have mutual priorities, LGUs will be encouraged to continue collaborating with LHDs in their ongoing planning efforts and to continue to pursue priorities and strategies that engage multiple stakeholders to address the physical and behavioral health needs of the community.

## **2013 Recovery Oriented Systems of Care (ROSC) Survey**

Over the past several years, the addiction treatment field has undergone profound changes and started to move from an acute care model to a long-term chronic care recovery model. SAMHSA defines recovery as a “*process of change in which an individual, family member, or family moves from impairment to an enduring and holistic focus on self awareness, understanding of others, and an improved quality of life.*” It further defines a Recovery Oriented System of Care (ROSC) as a “*coordinated network of community-based services and supports that is person-centered and builds on the strength and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.*”

OASAS recognizes and supports the emerging consensus that a substance use disorder is a chronic condition requiring treatment and supports and has employed strategies such as Recovery Community Centers, training of peer support specialists and recovery coaches, supportive housing, and the development of a web-based perception of care system. The agency also established a Recovery Implementation Team (RIT) in 2008 to inform the transition to a ROSC.

OASAS conducted a survey during the 2014 local services planning process to assess the readiness of the treatment system to participate in the transformation to a ROSC and to identify the supports that are needed to achieve that transformation. The survey was completed by 968 programs, 98.7 percent of the total surveyed.

One way to assess the efforts of treatment providers to become part of a recovery oriented system of care is to look at the activities related to identifying and implementing components of a ROSC within their own programs. For example, when asked if the program was a member of a local or regional ROSC task force or workgroup, 24 percent of programs reported that they were members.

### **The Use of Quality of Life Assessment Tools**

Quality of life assessment tools have been used in treatment planning and outcome assessment in primary care and mental health services for many years. More recently, the addiction treatment field began using these tools to address the needs of the whole person rather than just the substance use disorder. Programs were asked if they had implemented and currently use a standardized quality of life assessment tool with their participants. Statewide, 12 percent reported having a standardized tool.

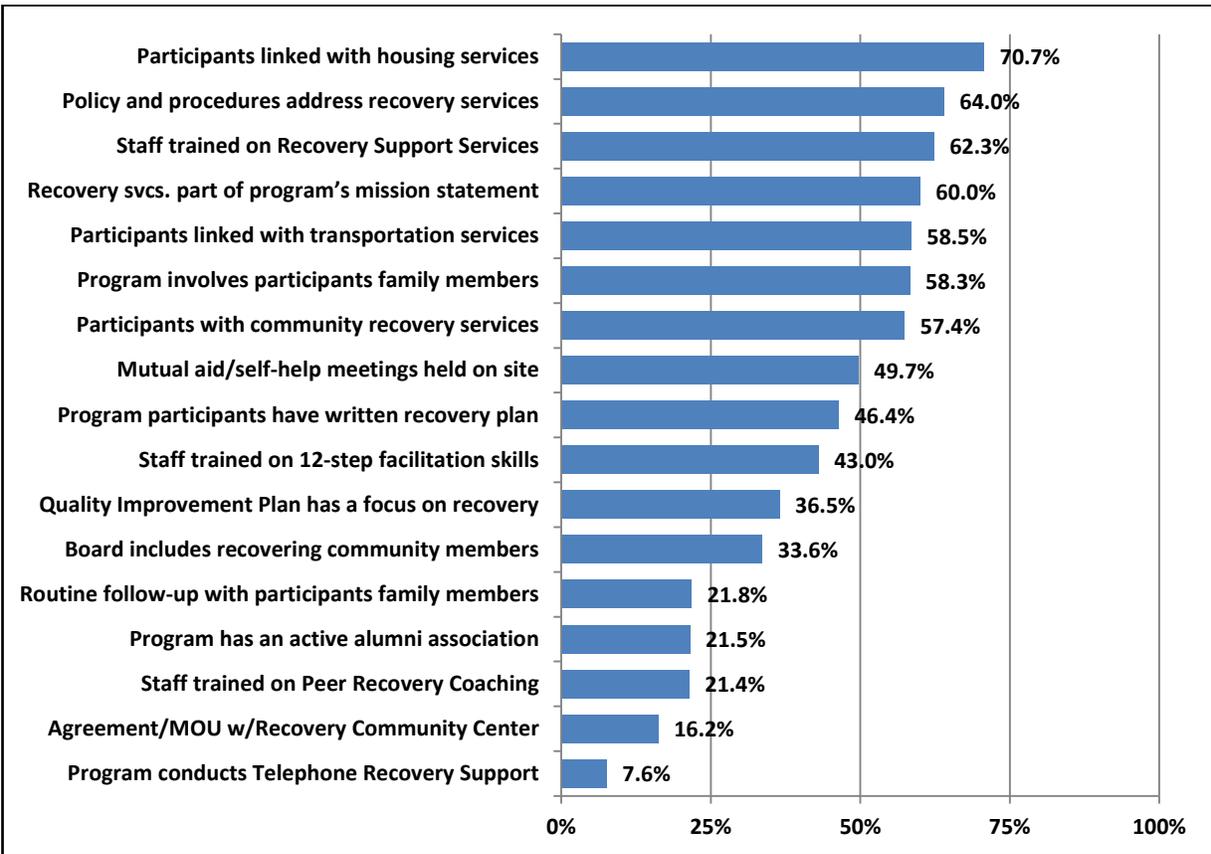
Of those programs that reported using a standardized tool, 87 percent indicated that all program participants received a quality of life assessment. When those programs were asked about when the quality of life assessment was administered, 94 percent reported administering it at intake and 46 percent at discharge. Nearly half of respondents reported administering the assessment after three or six months in treatment, and six percent reported administering it after discharge. Of those reporting that they administered the assessment at intake, 57 percent reported administering it at a later time as well.

Among the assessment tools most frequently identified by programs were the bio-psychosocial assessment (15), an agency developed assessment tool (11), the Daily Living Activities Survey (DLA-20) (8), the Global Assessment of Functioning Survey (GAF) (5), and the Patient Health Questionnaire (PHQ-9) (5). A variety of other assessment tools were also reported, including the World Health Organization Quality of Life (WHOQOL), the Addiction Severity Index (ASI), and in-house patient surveys.

### **Components of a ROSC**

The survey asked programs to indicate which of 17 different components of a ROSC they currently had in place. As **Figure 3.3** shows, the ROSC component most commonly used is linking program participants to housing services, reported by 71 percent of all programs. There was minimal variation for different types of services, and it was the only ROSC component that was among the top three reported in every region of the state.

**Figure 3.3: ROSC Components Currently in Place**



Several other ROSC components were reported in place by a majority of programs, although some significant variations were noted among regions of the state or service types. For example, linking participants to transportation services was reported most frequently in the Finger Lakes region (82%) and least frequently on Long Island (40%). Another significant variation was noted in the percentage of programs that reported providing treatment and recovery services with family members ranged from 45 percent in the Finger Lakes region to 76 percent in the Mid-Hudson region.

### **Obtaining Program Participant Feedback**

Nearly all programs (95%) reported that they had implemented and sustained a process to routinely obtain participant feedback on program services. Of those, 96 percent reported using a client satisfaction survey, 16 percent participant focus groups, 11 percent a perception of care survey, and 7 percent some other means. (Note: this survey was completed at a time when the OASAS web-based Perception of Care Survey was just being implemented. Therefore, the percentage of programs using the perception of care survey is expected to be much higher than what was reported when this survey was completed. OASAS launched its web-based Perception of Care survey system on May 3, 2013 enabling access by all treatment and recovery service providers.)

Approximately half (45%) of all programs that collected participant feedback reported that they provided participants with a summary of that feedback. Most programs (95%) reported having a process to act upon the participant feedback collected. The Finger Lakes region (51%) and opioid treatment programs (57%) had the highest percentage that reported having a process to act upon participant feedback.

Finally, programs were asked about their interest in assessing how well recovery policies and practices are currently integrated into their services or their readiness to move toward the integration of recovery policies and practices. Statewide, 42 percent indicated an interest. When asked what additional supports they would like from OASAS in order to move towards a more Recovery Oriented System of Care, nearly 400 programs responded. The types of support identified included the following:

- Training, technical assistance, education regarding elements of a ROSC:
  - Unspecified training and technical assistance (160);
  - Clarity of OASAS policy/regulations/guidelines/standards regarding ROSC (53);
  - Specified training: recovery coaching (25); evidence-based practices (1);
  - Assistance conducting planning/needs assessment (21);
  - Access to standardized assessment tools (13); data/information (4).
- Assistance in developing or accessing recovery supports and services:
  - Additional funding (43);
  - Additional staffing for peer coaches/mentors (16);
  - Locating local recovery support services (18);
  - Developing a Recovery Community Center (5).

The information obtained through this survey will help OASAS to better assess the readiness of the treatment system to participate in the transformation to a ROSC. In addition, OASAS will continue to explore ways to support providers' capacity to measure its effectiveness in integrating recovery principles, policies, and practices into their services.