



**NYS Conference of Local Mental Hygiene Directors, Inc.  
Technical Assistance Project**

## **2008 Plan for New York Mental Health Services**

### **County and City Priorities**

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## **2008 Plan for New York Mental Health Services County and City Priorities**

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## I. Executive Summary - NYS County Mental Health Planning Priorities

During the spring of 2007, the 57 County and New York City membership of the NYS Conference of Local Mental Hygiene Directors, Inc. (CLMHD) embarked on the next phase of a multi-year Mental Health Services Planning Initiative. This year features the development of a partnership between the State Office of Mental Health (SOMH), OASAS, and the CLMHD, who agreed to develop, as a pilot planning project, a new web-based planning tool that allowed counties to review, revise, drop, and resubmit mental health planning priorities for 2008. The new tool resides and is accessed via the OASAS CPS (County Planning System) as a new, but separate, section of the CPS. Many of the features of the CPS structure and formats were utilized in the new 2008 Mental Health Planning Priorities tool, which was used to collect all of the information found in this report. A more detailed description of the background and the steps involved in the process to revitalize county- and city-level mental health services planning, including the new partnerships formed this year, are outlined in this report. **In addition, a joint planning work group comprised of the CLMHD, county planning staff and representatives from the three State mental hygiene agencies is meeting to review and recommend common planning themes and processes relating to county plans and the State 5.07 plans.**

For 2008, counties had the option of submitting as many as nine or as few as three priorities. They were able to separate priorities for Adult and Children's services as well as priorities that relate to Systems Issues. Further, in addition to describing their priorities in narrative format, counties were asked to categorize their priorities using a drop-down list of categories that were developed to better summarize local county input and better describe common themes and needs. Counties were asked to indicate which of the priorities submitted represent their Top Three. This report is based on analysis and tabulation of the CLMHD membership's Top Three priorities to provide a statewide view of these data. Highlights of the process and the results of analyses contained in this report are below.

- **100% County Participation in a Refined Planning Priorities Process**
  - Consistent with the previous year, it is noteworthy that **100% of the counties completed and submitted plans this year.**
  - There were a total of **45 possible Summary Category options** in an attempt to best capture local input.
  
- **Most Frequently Cited Priorities for 2008:**
  - **The Residential Services category** (which includes priorities specifying an increased need for housing or any level of residential services) **was the most frequently cited priority (18%)** across all counties. Over one-half (51%) of the counties that reported Adult service priorities indicated that Residential Services are a top priority.
  - **Cross-Systems Coordination/Service Integration** (which includes priorities that emphasize the importance of coordinating and/or integrating services for people with a combination of mental health, MR/DD,

substance abuse, i.e., "dual diagnosis", and/or medical issues) **represented the second most highly ranked (12%)** of all county priorities.

- **General Children's Services and Funding issues ranked next highest, with each category accounting for 8% of the total responses.**

General Children's Services include priorities describing any non-specific needs for increased/enhanced children's services; Funding issues include priorities that specify the maintenance of existing funding or the need for additional funding streams. Further, **general children's services and preventive services** are a focus for counties that reported at least one child service priority (cited by 30% and 16%, respectively).

- **New York City's top priorities were Funding issues as well as planning and implementation issues** (which include priorities specifying needs for future planning or implementing change).

➤ **Priorities based on NYS Population:**

- **Funding accounted for the highest percent** of the NYS population with **55%** represented.
- **Planning and Implementation (45%)** was the second highest.
- The third highest was **Residential services with 43%**.
- **Cross-Systems Coordination/Services Integration** accounted for **25%** of the population.

➤ **Comparison Between 2007 and 2008 Planning Priorities:**

- While **Residential Services and Cross-Systems Coordination** appeared among the top four priorities from last year's planning process, this year they **emerged at the top of the list**.
- Children's Services, which received the most Top 3 rankings of any priority last year, dropped to tie Funding as the third-highest collective rankings from counties.

➤ **Document to be Shared with SOMH and Other Stakeholders to Raise Awareness of County Needs and Inform the Budgeting Process**

- This report will be shared with SOMH as a mechanism for informing the 5.07 planning and budgeting process for 2008.
- The document will also be shared with other stakeholders in an effort to raise awareness of and advocate for the needs and priorities for improving mental health services at the county and city level.
- Finally, working closely with SOMH and with input from the CLMHD, efforts will be made to fine-tune this planning process as needed.

➤ **Collaboration Among the Three State Mental Hygiene Organizations Continues**

- The CLMHD Planning Committee members continue to facilitate discussions between members of the State Mental Hygiene organizations and county planning staff to review and recommend common processes

related to county planning. The hope and expectation are that such a collaborative effort will result in more integrated planning processes and the tools to support them.

## II. Acknowledgements

The membership of the CLMHD has to be recognized for its incredible response to the Planning Initiative and for 100% participation in both the prior survey of county mental health services priorities and in the current submission of Plan Summaries and Priorities for 2008. The very high level of participation is indicative of the importance of local planning. The efforts of Community Services Boards, consumers, families, providers, other stakeholders, and county planning staff must also be recognized for the vital roles they all play in helping to formulate local plans.

NYSOMH Commissioner Michael Hogan must be recognized for his support of planning in general, and more specifically, for his support of the CLMHD Planning Initiative and generous contribution of significant staff assistance to the effort. The strong spirit of collaboration between the Conference and OMH Staff has revitalized joint planning efforts. Individual contributions throughout the process included those of Keith Simons, Deputy Commissioner, Sheila Donahue, Director of Data Analysis and Performance Measurement, Catherine Matt, Research Scientist, Betty Pease, Director of Strategic Plan Development and Kevin Conley, Mental Health Specialist IV.

Anne Wilder, Dr. Thomas Jewell, Rodney Corry and Deborah Hodgeman of Coordinated Care Services, Inc. (CCSI), were also helpful in assisting SOMH staff with development of the County Planning Data section of the web site and in organizing, categorizing and analyzing the data from the plan summaries.

The Planning Subcommittee is indebted to both Keith Simons of SOMH and Jean Audet of OASAS and their staffs, for their support in making this unprecedented collaborative planning effort possible.

Lastly, we wish to express our gratitude to Jim Tansey, OASAS Chief of Data Processing Services, and one of the main architects of the OASAS CPS, who was integral to this process and worked closely with the committee, our planning consultants and CCSI in developing the new 2008 Mental Health Planning Priorities tool.

### III. Background

#### 1. New York State/County Planning History

During the latter 1990s and early 2000s, the traditional New York State and Local Planning process defined in Section 5.07 of the Mental Hygiene Law had significantly atrophied. Comprehensive State 5.07 plans were not being produced. While a number of individual counties continued a local planning process and produced county plans, a robust locally-based planning process to inform the SOMH 5.07 plans was not functioning at an appropriate level. During the period of Reinvestment funding in the latter 1990s and early 2000s, counties were producing extensive Reinvestment Plans and submitting the plans to SOMH. However, these were mainly spending plans rather than fully formed plans. During this period SOMH did publish an annual planning document, but it was not the traditional significant annual plan of prior years, which is integral to the intent of Section 5.07. Equally significant as the absence of the fully formed plans was the demise of a vigorous planning process that provided for participation of consumers, other stakeholders in the mental health community, and most importantly, the local communities pursuant to a county planning process managed by county mental health agencies and Directors of Community Service (DCS).

The Conference of Local Mental Hygiene Directors, among other groups and advocates, was very active in advocating for reestablishing the planning process and observing the full implementation of Section 5.07 of the MHL. Conference leadership testified at numerous legislative and other hearings and consistently communicated to SOMH and other appropriate organizations its position regarding reestablishing the mental health planning process in New York State.

#### 2. CLMHD Planning Initiative—2004 to Present

In 2004, the CLMHD decided to formally undertake an initiative to strengthen the county planning process. Central to this initiative was the development of a planning process that would result in fully formed county plans that would inform a reestablished statewide 5.07 plan. This initiative was extremely timely because in early 2004, SOMH Commissioner Carpinello made planning a major priority and SOMH produced the first substantial 5.07 Plan in many years. Thus began an extremely productive partnership in which the CLMHD and SOMH have cooperated to refine and professionalize the planning process, which has resulted in this report as well as other interim products that have ensured appropriate county input into the SOMH 5.07 Plan.

Year One (2004): During the first year of the initiative, the CLMHD established a Mental Health Planning Subcommittee under the leadership of Dr. Michael O’Leary, Director of Community Services of Columbia County and a CLMHD Officer. The Conference designated planning as a Technical Assistance project and developed and implemented a survey of county mental health services priorities. The survey was completed by every county, was analyzed by CLMHD, and the results of the survey were included by SOMH in its updated 5.07 Plan. An early version of the Planning Template (an effort to

standardize local input) was developed and preliminary work was undertaken to assure that the county planning staff would have access to data necessary for a rigorous planning process. Regular meetings were held with SOMH staff and have continued throughout this three-year project.

Year Two (2005): During the second year of the initiative, the Planning Template was finalized after considerable review and input from the CLMHD membership and SOMH. This accomplishment was particularly significant as it provided a comprehensive and consistent format for counties to use to guide the planning process and develop their annual plans.

The other major accomplishment was the expansion of the SOMH website to facilitate access to data needed to support the planning process. In a model of cooperation, the CLMHD and SOMH identified, with input from the members, data needed to support local planning. SOMH maintains a number of comprehensive data sources, and generates many routine and specialized reports. However, county users are often not aware of these resources, or may lack the technical staff to access the various NYS OMH data marts. To address these issues, SOMH enhanced their Bridges Website to include a County Planning Reports Menu, which consolidated key reports and data resources and organized this information in a manner consistent with the Planning Template. CCSI assisted with this component of the planning project and helped to identify appropriate reports and define a process for user-friendly access.

Finally, various survey instruments that had been developed by Michael O'Leary to guide the Columbia County planning process were made available to all the counties for use in gathering input from local stakeholders.

Year Three (2006): During the third year of the initiative, the full county planning process was implemented as proposed and the planning process returned to its intended and appropriate role in mental health services. A detailed timetable was developed in cooperation with SOMH so that the results of the county plans were fed into the 5.07 Plan issued by SOMH in the first quarter of 2007. There was an unprecedented response to this revitalized mental health planning exercise with 100% of counties participating. The Planning Template used by all counties included a priorities section in which counties identified the three most important mental health priorities and associated target populations and narrative detail, and articulated the county's planning goals for the coming year. Pursuant to the cooperative agreement developed with SOMH, the priorities section was submitted by the counties to the CLMHD, and the Conference summarized the results and submitted them to SOMH for inclusion in the 5.07 Plan. The full county Plans were submitted directly to SOMH and a feedback process was developed to inform the counties, CLMHD and SOMH regarding the priorities and issues described in the plans.

Response to this initiative was tremendous and priorities were submitted by each of the 57 counties and New York City. At the spring 2006 biannual meeting, the preliminary results of the priorities were reviewed in the Technical Assistance presentation. In

addition, CCSI and SOMH presented refinements and updates to the TA products, primarily the County Planning Reports Menu upgrades. The members also reviewed the strengths and problem areas of the planning process and the supporting tools. In particular, counties expressed an interest in having a web-based tool to support planning data collection and analysis.

Year Four (2007): During the fourth year, the focus of the planning exercise shifted to reviewing and updating the priorities submitted the previous year, and resubmitting for 2008. At the Fall 2006 TAP meeting and throughout the process, the Planning Subcommittee received many fine suggestions for improvements to the process including automating planning priority submissions in a manner similar to the OASAS web-based planning tool. The committee worked collaboratively with SOMH and OASAS planning staff toward that effort. As a result, all parties agreed to develop, as a pilot planning project, a new web-based planning tool that allowed counties to review, revise, and resubmit mental health planning priorities for 2008. The new tool resides and is accessed via the OASAS CPS (County Planning System) as a new but separate section of the CPS. Many of the features of the CPS structure and formats were utilized in the new 2008 Mental Health Planning Priorities tool, offering the opportunity for rapid development and significant economies of scale. The Planning Subcommittee anticipated that County Directors and planning staff would find the 2008 Mental Health Planning Priorities exercise much less labor-intensive while allowing for greater flexibility. Anecdotal feedback confirmed that this was indeed the case.

In the exercise for 2008, counties had the option of submitting as many as nine or as few as three priorities. They were able to separate priorities for Adult and Children's services as well as priorities that relate to Systems Issues. Further, in addition to describing their priorities in narrative format, counties were asked to categorize their priorities using a drop-down list of summary categories that were developed based on the previous year's responses. Counties were again asked to indicate which of the priorities submitted represent their Top Three. Consistent with the previous year, it is noteworthy that 100% of the counties completed and submitted plans this year.

#### **IV. Methodology**

##### **1. Plan Template, Summary & Priorities**

As mentioned above, the focus of this most recent planning exercise shifted to reviewing, adding, dropping and updating the priorities submitted the previous year and resubmitting them as the priorities for 2008. In an effort to develop greater consistency of operational definitions, counties were asked to follow a three-step process to self-categorize their responses. First, counties were instructed to review, add, drop and update their priorities using a narrative format. Second, counties had the option of submitting up to three separate priorities each for Adult and Children's services as well as priorities that relate to Systems Issues—a total of nine possible priorities. Specifically, counties were asked to specify in which of the three domains (i.e., child, adult, system) each priority belonged. Third, within each of the domain areas counties

were also asked to self-select, via drop-down lists, which summary category best captured the main focus or theme of the priority.

Consistent with last year, counties were again asked to indicate which of the priorities submitted represent their three most significant, or “Top Three.” These Top Three planning priorities, identified by each county, were utilized in developing this report. It is intended that summarized results of the plans will be the focus of discussions and negotiations with SOMH regarding state and county priorities, and that results will be fed into the 5.07 Plan to be issued by SOMH in the last quarter of 2007.

## 2. Analysis Methodology

Each local priority submission was reviewed carefully by the project team. While the local priorities were quite specific and reflected the unique needs of the community, counties self-classified their individual responses into 32 possible summary category options (i.e., 12 options for Child services, 12 options for Adult services, and 8 options for System Issues). In addition to reviewing the narrative responses, the category options and format were also reviewed by members of CCSI’s Evaluation and Services Research team with clinical and programmatic expertise, as well as an appreciation for local system management. A decision was made to expand the summary category options and reclassify the responses, as needed, to better summarize the local input and to develop a better understanding of common themes and needs. More specifically, additional categories such as “Prevention” and “Forensic/Court-based” were added within the major domain areas, and several of the summary categories originally found only in the Child and Adult system domains were added to the System Issues domain. This resulted in a total of 45 possible summary category options into which each narrative response could be placed.

One trained rater then reviewed the classifications made by the counties, confirming the accuracy of each existing classification or reclassifying the priorities based on the expanded summary categories. Next, a second trained rater independently reviewed every narrative response and the accompanying classification determination made by the first rater, and indicated his agreement or disagreement. It is noteworthy that the two raters agreed on 94% of the categorizations, and subsequently collaborated to resolve the relatively small number of discrepancies. The results from this report are based on the final categorizations determined by CCSI’s Evaluation and Services Research team members.

To assist the reader in better understanding the summary categories and what they represent, the following chart provides definitions of the major Summary Priority Categories, and under which domain each of the summary categories may fall:

**2008 Plan for New York Mental Health Services: County and City Priorities**

<b>Summary Category</b>	<b>Description/Definition</b>	<b>Possible Domains (A=Adult, C=Child/Youth, S=System)</b>
Access issues (not related to specific service/program capacity)	Any county needs specifying access issues (i.e., barriers and challenges) related to the inability of recipients to access services, including issues that are NOT related to specific service/program capacity. Example of items that would be coded into this category include: references to transportation problems, lack of child care, conflicting schedules, etc.	A, C, S*
Adult services (general or other)	Any general, non-specific needs for increased/enhanced adult services.	A
Case Management/Care Coordination	County priorities that focus specifically on increased availability of case management and/or care coordination services.	A, C, S*
Children's services (general or other)	Any general, non-specific needs for increased/enhanced children's services.	C
Clinic services	Any county needs specifying limited capacity of existing clinic services.	A, C, S*
Crisis services	County needs that focus on increased availability of any type of crisis service, including crisis beds, emergency services, and suicide prevention.	A, C, S*
Cross-Systems Coordination/Services Integration	County priorities that emphasize the importance of coordinating and/or integrating services for people with a combination of mental health, MR/DD, substance abuse (i.e., "dual diagnosis") and/or medical issues.	S
Forensic/Court-based*	County needs that specified a link with the criminal justice system or additional court-based services	A*
Funding	County priorities that specify the maintenance of existing funding or the need for additional funding streams.	S
Geriatric services	Any needs for increased/enhanced services specifically for older adults.	A
Information systems	County needs that focus on information management, data collection/analysis, IT resources/limitations, etc.	S
Inpatient services	Any county needs specifying limited capacity of existing inpatient services.	A, C, S*
Other workforce issues	County priorities that focus on recruitment, retention and/or professional development of local mental health providers (excluding psychiatrists).	A, C, S
Peer Services/Peer Involvement*	County priorities that emphasized peer input and advocacy.	A*, S*
Person-centered/ Recovery-oriented	Priorities that emphasized person-centered planning or recovery-oriented services (e.g., PROS; Care Coordination process).	A
Physical plant/space	County needs related to physical space, program environment, etc.	S
Planning and Implementation	County needs related to future planning or implementing change.	S

Prevention*	County priorities that specified preventive services (suicide and general mental health), early intervention and/or school-based services.	A*, C*, S*
Psychiatrist availability	Priorities that specify a need for recruitment of, or access to, psychiatrists.	A, C, S*
Residential services	Priorities specifying an increased need for housing or any level of residential services.	A, C, S*
System monitoring	County needs related to quality improvement, program evaluation, and/or performance management.	S
Transitional services	Any needs for increased/enhanced transitional services for older adolescents.	C
Wrap-around and/or family-centered approach	Priorities expressing a need for a more family-driven treatment process, such as wrap-around or a Child & Family Team (CFT) process.	C
Other (specify): _____	Any county priorities that do not fit into another category (please specify how you would summarize this priority).	A, C, S

\* New category or this category option was added to the “System Issues” domain

Note that while the summary categories are useful in describing the most frequently identified needs and priorities, the underlying descriptive detail is also helpful in understanding issues at the local level. Thus, both levels of data were maintained and are referenced in the subsequent sections of this report. Once categorized, responses were analyzed by other county attributes such as region and county type (rural, urban, etc.) to determine the extent to which stronger commonalities or differences were evident both within and across the various subgroups.

In reviewing the data described in the sections that follow, it is important to take into consideration the following points:

- While the planning template asked counties to identify and describe up to nine priorities, this report is based primarily on summary analyses of their “Top Three” priorities. However, details about additional priorities were retained in the database.
- The planning template provided a consistent structure for local feedback and self-classification of priorities, but was fairly open-ended in terms of the extent of detail provided for each priority. In reviewing the results, it is clear that there was a fair degree of variance in county approach. In some cases, priorities were described in a great amount of detail, which helped facilitate categorization. In other cases, only a priority title was provided.

## V. Results. Top 3 County Mental Health Priorities for 2008 Overall (Across Domains)

The sections that follow highlight key findings from the analysis of the data provided in the summary sections of the individual county plans. Composite views of the Top Three planning priorities are presented on a statewide and regional basis—by county population, by county type, and by targeted service populations. These are further broken down by region and by county type to examine similarities and differences from those perspectives.

*“The ongoing struggle of housing, hospital, crisis and treatment issues faced by individuals affected by developmental, behavioral and mental health disorders needs to be improved.”*

### 1. Statewide and Regional Planning Priorities<sup>1</sup>

Summary Priority Type	Central	Hudson River	Long Island	NYC	Western	Total
Access issues	6.7%	2.2%	0.0%	0.0%	7.0%	5.3%
Adult services (general or other)	1.7%	0.0%	0.0%	0.0%	0.0%	0.6%
Case Management/Care Coordination	3.3%	8.9%	16.7%	0.0%	5.3%	5.8%
<b>Children’s services (general or other)</b>	<b>8.3%</b>	<b>8.9%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>7.0%</b>	<b>7.6%</b>
Clinic services	3.3%	4.4%	16.7%	0.0%	3.5%	4.1%
Crisis services	6.7%	8.9%	0.0%	0.0%	3.5%	5.8%
<b>Cross-Systems Coordination/ Services Integration</b>	<b>10.0%</b>	<b>13.3%</b>	<b>16.7%</b>	<b>0.0%</b>	<b>14.0%</b>	<b>12.3%</b>
Forensic/Court-based	1.7%	0.0%	0.0%	0.0%	0.0%	0.6%
<b>Funding</b>	<b>8.3%</b>	<b>6.7%</b>	<b>16.7%</b>	<b>66.7%</b>	<b>3.5%</b>	<b>7.6%</b>
Geriatric services	1.7%	2.2%	0.0%	0.0%	0.0%	1.2%
Inpatient services	5.0%	4.4%	0.0%	0.0%	1.8%	3.5%
Other	6.7%	0.0%	0.0%	0.0%	5.3%	4.1%
Other workforce issues	1.7%	0.0%	0.0%	0.0%	0.0%	0.6%
Peer services (Peer involvement)	1.7%	0.0%	0.0%	0.0%	5.3%	2.3%
Person-centered/Recovery- oriented	1.7%	4.4%	0.0%	0.0%	8.8%	4.7%
Planning and Implementation	6.7%	2.2%	0.0%	33.3%	3.5%	4.7%
Preventive services	0.0%	2.2%	0.0%	0.0%	12.3%	4.7%
Psychiatric availability	5.0%	2.2%	0.0%	0.0%	1.8%	2.9%
<b>Residential services</b>	<b>15.0%</b>	<b>28.9%</b>	<b>33.3%</b>	<b>0.0%</b>	<b>12.3%</b>	<b>18.1%</b>
Transitional services	0.0%	0.0%	0.0%	0.0%	3.5%	1.2%
Workforce issues	5.0%	0.0%	0.0%	0.0%	0.0%	1.8%
Wrap-around and/or family-centered approach	0.0%	0.0%	0.0%	0.0%	1.8%	0.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

<sup>1</sup> Regions as defined by the New York State Office of Mental Health: **Hudson River:** Albany, Columbia, Dutchess, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, Westchester. **Western:** Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates. **Central:** Broome, Cayuga, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, St. Lawrence. **Long Island:** Nassau, Suffolk. **NYC:** Bronx, Kings, New York, Queens, Richmond.

On a regional and statewide basis, it is clear that two summary priority categories stand out as being ranked in the Top Three: **Residential Services and Cross-Systems Coordination/Service Integration both received significantly more responses than all other categories.**

- Residential services was the most frequently cited priority (18%) across all counties, although NYC was the one region that did not list Residential services among the Top 3 priorities.
- The highest rankings for Residential services were in the Long Island (33%) and Hudson River (29%) regions.
- At 12% overall, Cross-Systems Coordination/Service Integration represented the second most highly ranked priority. With the exception of NYC, the range across regions was fairly consistent (10% - 17%).
- Children’s Services and Funding issues ranked next highest, with each category accounting for 8% of the total responses.
- New York City’s top priorities were funding issues as well as planning and implementation issues.
- In the Western Region, most of the counties participating in the WNY Care Coordination project listed efforts to continue expansion of person-centered planning as their top priority. Several counties in the Western region also indicated that Preventive services are among the top priorities.
- The priorities expressed by counties in the Central and Hudson River regions exhibited the highest degree of variability.

*“The County currently has close to 500 individuals who have been identified as being ready for levels of housing in the community, but are on a generally long waiting list.”*

*“The County is in a unique position to provide services to individuals with mental illness and chemical dependency since the two clinical programs are under the same umbrella. However, regulatory issues within OMH and/or OASAS often prohibit the proper or timely delivery of services.”*

## 2. Priority by County Population

The table below provides a representation of the priorities in terms of the population represented in the counties (including New York City) in which those priorities had been identified.

Summary Priority Type	Total NYS population represented	% of NYS population represented
Funding	10,618,617.00	55.23%
Planning and Implementation	8,598,700.00	44.72%
Residential services	8,324,876.00	43.30%
Cross-Systems Coordination/Services Integration	4,744,960.00	24.68%
Case Management/Care Coordination	3,454,495.00	17.97%
Person-centered/Recovery-oriented	2,522,791.00	13.12%
Clinic services	2,053,079.00	10.68%
Children's services (general or other)	2,030,367.00	10.56%
Access issues	1,391,643.00	7.24%
Wrap-around and/or family-centered approach	936,318.00	4.87%
Inpatient services	901,526.00	4.69%
Crisis services	808,750.00	4.21%
Psychiatric availability	745,111.00	3.88%
Preventive services	610,621.00	3.18%
Other	590,611.00	3.07%
Transitional services	282,879.00	1.47%
Peer services (Peer involvement)	265,937.00	1.38%
Workforce issues	201,216.00	1.05%
Forensic/Court-based	63,858.00	0.33%
Geriatric services	54,422.00	0.28%
Other workforce issues	49,283.00	0.26%
Adult services (general or other)	5,227.00	0.03%

When local priorities are examined from the NYS population perspective, there are some significant differences as compared to the regional view of these data. Most notably, presumably due in large part to the large population size of the NYC area, priorities related to Funding (55% of the population represented), and Planning and Implementation (45%) received substantially higher rankings. However, another noticeably high ranking was Residential priorities, which represented the third-highest population ranking (with 43% of the population represented), followed by issues related to Cross-Systems Coordination/Services Integration (25%) and Case Management/Care Coordination (18%).

***“We now have several important programs that were planned and developed locally that no longer have sufficient funding to cover operating costs. This situation creates the possibility that the services considered important by the County will eventually need to be closed.”***

### 3. Priority by County Population Size<sup>2</sup>

To continue to better understand county priorities in terms of the county population size, below we provide a detailed view and ranking of the summary priority categories listed for each population.

Summary Priority Type	Large	Mid	Small	NYC	Total
Access issues	6.7%	2.7%	7.7%	0.0%	5.3%
Adult services (general or other)	0.0%	0.0%	1.3%	0.0%	0.6%
Case Management/Care Coordination	<b>13.3%</b>	9.3%	1.3%	0.0%	5.8%
Children's services (general or other)	6.7%	5.3%	<b>10.3%</b>	0.0%	7.6%
Clinic services	6.7%	4.0%	3.8%	0.0%	4.1%
Crisis services	0.0%	6.7%	6.4%	0.0%	5.8%
Cross-Systems Coordination/Services Integration	<b>13.3%</b>	<b>16.0%</b>	<b>9.0%</b>	0.0%	12.3%
Forensic/Court-based	0.0%	0.0%	1.3%	0.0%	0.6%
Funding	6.7%	5.3%	7.7%	<b>66.7%</b>	7.6%
Geriatric services	0.0%	0.0%	2.6%	0.0%	1.2%
Inpatient services	0.0%	5.3%	2.6%	0.0%	3.5%
Other	0.0%	5.3%	3.8%	0.0%	4.1%
Other workforce issues	0.0%	0.0%	1.3%	0.0%	0.6%
Peer services (Peer involvement)	0.0%	2.7%	2.6%	0.0%	2.3%
Person-centered/Recovery-oriented	<b>13.3%</b>	4.0%	3.8%	0.0%	4.7%
Planning and Implementation	0.0%	2.7%	6.4%	<b>33.3%</b>	4.7%
Preventive services	0.0%	2.7%	7.7%	0.0%	4.7%
Psychiatric availability	0.0%	4.0%	2.6%	0.0%	2.9%
Residential services	<b>26.7%</b>	<b>21.3%</b>	<b>14.1%</b>	0.0%	18.1%
Transitional services	0.0%	1.3%	1.3%	0.0%	1.2%
Workforce issues	0.0%	1.3%	2.6%	0.0%	1.8%
Wrap-around and/or family-centered approach	6.7%	0.0%	0.0%	0.0%	0.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

<sup>2</sup> County Population Size classifications are based on county data from the Population Estimates Program, Population Division, U.S. Census Bureau, 2000, and are as follows:

**Small:** Total population of less than 75,000 people

**Mid:** Total population of 75,000-500,000 people

**Large:** Total population of greater than 500,000 people

**NYC:** Total combined population for counties of New York, Bronx, Kings, Queens and Richmond.

#### 4. Priority by County Type<sup>3</sup>

To assist in understanding county priorities in terms of size and proximity to urban areas, we examined priorities by county “type.” Counties were grouped by type using a modified version of the classification developed by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) to present county data as part of their PRISMS (Prevention Risk Indicator Services Monitoring System) Risk Profiles report series.

Summary Priority Type	NYC	Rural	Suburban Upstate	Suburban Downstate	Upstate Urban	Total
Access issues	0.0%	7.6%	0.0%	8.3%	0.0%	5.3%
Adult services (general or other)	0.0%	1.0%	0.0%	0.0%	0.0%	0.6%
Case Management/Care Coordination	0.0%	4.8%	4.2%	16.7%	7.4%	5.8%
Children’s services (general or other)	0.0%	9.5%	0.0%	8.3%	7.4%	7.6%
Clinic services	0.0%	2.9%	12.5%	8.3%	0.0%	4.1%
Crisis services	0.0%	5.7%	12.5%	0.0%	3.7%	5.8%
Cross-Systems Coordination/ Services Integration	0.0%	11.4%	12.5%	16.7%	14.8%	12.3%
Forensic/Court-based	0.0%	1.0%	0.0%	0.0%	0.0%	0.6%
Funding	66.7%	5.7%	8.3%	8.3%	7.4%	7.6%
Geriatric services	0.0%	1.9%	0.0%	0.0%	0.0%	1.2%
Inpatient services	0.0%	2.9%	8.3%	0.0%	3.7%	3.5%
Other	0.0%	3.8%	4.2%	0.0%	7.4%	4.1%
Other workforce issues	0.0%	1.0%	0.0%	0.0%	0.0%	0.6%
Peer services (Peer involvement)	0.0%	3.8%	0.0%	0.0%	0.0%	2.3%
Person-centered/Recovery-oriented	0.0%	3.8%	4.2%	0.0%	11.1%	4.7%
Planning and Implementation	33.3%	6.7%	0.0%	0.0%	0.0%	4.7%
Preventive services	0.0%	6.7%	0.0%	0.0%	3.7%	4.7%
Psychiatric availability	0.0%	2.9%	4.2%	0.0%	3.7%	2.9%
Residential services	0.0%	13.3%	29.2%	33.3%	22.2%	18.1%
Transitional services	0.0%	1.0%	0.0%	0.0%	3.7%	1.2%
Workforce issues	0.0%	2.9%	0.0%	0.0%	0.0%	1.8%
Wrap-around and/or family-centered approach	0.0%	0.0%	0.0%	0.0%	3.7%	0.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Consistent with the overall regional results, Residential services and Cross-Systems Coordination/Service Integration were the most frequently cited priorities across all county types except for NYC. Beyond these top two ranked priorities, however, some

<sup>3</sup> County Type classifications are as follows:

**Rural:** Allegany, Cayuga, Chenango, Cattaraugus, Chautauqua, Chemung, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Orleans, Oswego, Otsego, St. Lawrence, Schoharie, Schuyler, Seneca, Steuben, Tioga, Warren, Washington, Wayne, Wyoming, Yates

**Suburban:** Dutchess, Ontario, Orange, Putnam, Saratoga, Sullivan, Tompkins, Ulster

**Upstate Urban:** Albany, Broome, Erie, Monroe, Niagara, Oneida, Onondaga, Rensselaer, Schenectady

**Suburban Downstate:** Nassau, Rockland, Suffolk, Westchester

**NYC:** Bronx, Kings, New York, Queens, Richmond

differences emerged based on this view of the data. After considering Residential services and Cross-Systems Coordination, *Suburban Upstate* top priorities are evenly split among Clinic services and Crisis services (each cited by 13% of counties). The *Rural* counties priority breakdown is Children’s services (10%) and Access issues (8%). After Residential services and Cross-Systems Coordination, *Upstate Urban* counties are focused on Person-Centered/Recovery-oriented services (11%), while *Downstate Suburban* counties are focused on Case Management/Care Coordination (17%).

**“There was a crisis service in our county that was defunded and closed two years ago... there continues to be a significant gap in [crisis] coverage.”**

5. Priority by Domain or Targeted Service Population

For each priority listed in the planning summary, counties were asked to specify which domain or target population was the focus of the priority. Below is a detailed view of county priorities from this perspective.

Summary Priority Type	Adult	Child/Youth	System	Total
Access issues	0.0%	2.3%	<b>9.8%</b>	5.3%
Adult services (general or other)	2.2%	0.0%	0.0%	0.6%
Case Management/Care Coordination	6.7%	<b>9.1%</b>	3.7%	5.8%
Children’s services (general or other)	0.0%	<b>29.5%</b>	0.0%	7.6%
Clinic services	4.4%	6.8%	2.4%	4.1%
Crisis services	4.4%	<b>9.1%</b>	4.9%	5.8%
Cross-Systems Coordination/Services Integration	0.0%	0.0%	<b>25.6%</b>	12.3%
Forensic/Court-based	2.2%	0.0%	0.0%	0.6%
Funding	0.0%	0.0%	<b>15.9%</b>	7.6%
Geriatric services	4.4%	0.0%	0.0%	1.2%
Inpatient services	2.2%	<b>9.1%</b>	1.2%	3.5%
Other	4.4%	2.3%	4.9%	4.1%
Other workforce issues	0.0%	2.3%	0.0%	0.6%
Peer services (Peer involvement)	2.2%	0.0%	3.7%	2.3%
Person-centered/Recovery-oriented	<b>15.6%</b>	0.0%	1.2%	4.7%
Planning and Implementation	0.0%	0.0%	<b>9.8%</b>	4.7%
Preventive services	0.0%	<b>15.9%</b>	1.2%	4.7%
Psychiatric availability	0.0%	6.8%	2.4%	2.9%
Residential services	<b>51.1%</b>	0.0%	<b>9.8%</b>	18.1%
Transitional services	0.0%	4.5%	0.0%	1.2%
Workforce issues	0.0%	0.0%	3.7%	1.8%
Wrap-around and/or family-centered approach	0.0%	2.3%	0.0%	0.6%
Grand Total	100.0%	100.0%	100.0%	100.0%

The view of summary priority categories by Targeted Service Population indicates that counties that included priorities serving the *adult* population within their Top Three priorities ranked Residential services most frequently (51%) followed by Person-Centered/Recovery-Oriented services. Counties that included priorities serving exclusively *children and youth* most frequently ranked Children’s services (general), followed by Preventive services, Case Management, Crisis services and Inpatient services. Counties that indicated priorities within the Top Three for *Systems issues* most frequently ranked Cross-Systems Coordination and Funding issues, followed by Access, Planning and Implementation issues and Residential services.

***“The objective of this initiative [establishing a Children’s Satellite Clinic and hiring another child psychiatrist] is to increase the sheer volume of children’s mental health services available and to focus on promotion of public mental health. The desired results include decreased wait time for access and the creation of a proactive rather than a reactive svstem.”***

6. Targeted Service Population by Region

Summary Priority Category	Central	Hudson River	Long Island	NYC	Western	Total
Adult	25.0%	35.6%	33.3%	0.0%	21.1%	26.3%
Child/Youth	21.7%	26.7%	16.7%	0.0%	31.6%	25.7%
System	53.3%	37.8%	50.0%	100.0%	47.4%	48.0%
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

7. Targeted Service Population by County Type

Summary Priority Category	New York City	Rural	Suburban	Suburban Downstate	Upstate Urban	Total
Adult	0.0%	25.7%	29.2%	25.0%	29.6%	26.3%
Child/Youth	0.0%	27.6%	25.0%	16.7%	25.9%	25.7%
System	100.0%	46.7%	45.8%	58.3%	44.4%	48.0%
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**VI. Results. Detailed Views of the Most Frequently Cited Priority Categories for 2008**

In an attempt to better understand and capture counties’ responses and the specific nature of the narrative descriptions, below please find detailed views of the four most frequently cited priority categories: Residential, Cross-Systems Coordination, Children’s Services and Funding.

Residential Priorities – Detailed View

The table below contains detailed examples residential priorities noted by counties across the state. Specific needs range from general community needs for affordable housing to very specific programmatic and population-based needs (e.g., geriatric, transitional, SRO, supervised apartments, etc.).

Detailed View of Residential Priorities
24-hour supervised apartment programs
Single Room Occupancy (SRO) with or without specialized services (e.g., geriatric)
Community-based housing options for adults
Enhancement of residential services for the target population
Ensure the availability and accessibility of a full continuum of safe and affordable housing for all adults with serious mental illness.
Expand residential options—child and adult
Housing: Community Residences; Child & Adult; Transitional; Emergency; Rehabilitative
Safe, affordable housing with supports for individuals with SPMI
Specialized housing

**Cross-System Priorities – Detailed View**

Many counties noted a need for enhanced cross-systems services and coordination. As noted in the list below, these needs often referred to increased collaboration between mental health, OMRDD and/or OASAS services. A number of counties also mentioned integration of physical and mental health services.

***“Government regulations require that people with co-occurring disorders have their treatment compartmentalized... This modality to care is inefficient; it undermines the holistic approach to service delivery.”***

Detailed View of Cross-System Priorities
Effective treatment options/best practices for individuals facing mental illness and chemical abuse (MICA)
Coexisting/Co-Occurring Disorders
Consultation and Evaluation
Coordination of services for high needs people
Cross-Systems coordination or integration (OMH/OASAS/OMRDD) for adult and children
Cross-system housing opportunities
Dual recovery initiative
Dually Diagnosed Mental Health and MRDD
Forensic mental health services
Improve coordination and programming between OMH, OASAS and OMRDD services for Children and Adults
Improved coordination and programming between OMH and OMRDD.
Integrated/Improved services for Dual Disorders
Integration of Physical and Behavioral Health Care
Medical co-morbidity/needs
Multi-Disability cooperation
Reconfiguration of adult Crisis services
Service consolidation/Development of rural models
Single Point of Service for Dual Diagnosed Individuals
The development of a Regional Dispute Resolution Committee

Children’s Services Priorities – Detailed View

County needs for children’s services that do not fit into another priority category (e.g., clinic services, case management, etc.) often mentioned a general expansion of services for children and families. However, some specific service needs were also noted, including trauma services, respite, and vocational supports.

Detailed View of Children’s Services Priorities
Additional Home and Community Based Services (HCBS) slots
C&Y system of care
Children/Adolescent Needs Identification and Clinical Treatment
Children’s Services—General (new or increased capacity for existing)
Community services (non-residential)
Development of an array of in-county programs to support children and adolescents at risk of out of home placement.
Enhance community supports for children and families
Ensure the availability and accessibility of a full continuum of treatment, vocational rehabilitation and support services for all Rockland children and adolescents with serious emotional disturbance.
Family support services
Increased respite opportunities
Link at risk children facing serious emotional disturbance (SED) and out-of-home placement with appropriate services.
Trauma Informed care for children and families

Funding Issues – Detailed View

Funding issues, both general and specific, were identified as priorities by many counties. Examples of fiscal issues raised include Medicaid reimbursement, reinvestment funding, deficit funding and rising operating costs. Additional details can be found in the table below.

***“The Medicaid Neutrality cap limits new funding to expand a mental health system that has historically and systemically been under-funded.”***

Detailed View of Funding Priorities
Comprehensive Outpatient Payment System (COPS) funding
Elimination of Medicaid Neutrality Cap
Finance issues
Funding/Medicaid Shift/Over-reliance on Medicaid
Funding maintenance; keeping up with operating costs
Funding must keep up with cost of operations
Increase deficit funding
Increase rates for NY/NY I and Reinvestment-funded Housing
Outpatient program funding
Rate change
Regulations
State resources are required to meet the needs of an aging infrastructure.

## VII. Results. Top 3 County Priorities for 2008 (By Domain)

The tables that follow contain results from the analysis of the data provided in the summary sections of the individual county plans analyzed by each of the three domain areas – Child services, Adult services, and System Issues. Composite views of the Top Three planning priorities are presented on a statewide and regional basis, and by county type, to allow the reader to closely examine similarities and differences from those perspectives.

### 1. Child and Youth Mental Health Services: Top Three Priorities

#### Child and Youth: Statewide and Regional Planning Priorities

Summary Priority Type	Central	Hudson River	Long Island	NYC	Western	Total
Access issues	0.0%	0.0%	0.0%	0.0%	5.6%	2.3%
Case Management/Care Coordination	0.0%	8.3%	<b>100.0%</b>	0.0%	11.1%	9.1%
Children's services (general or other)	<b>38.5%</b>	<b>33.3%</b>	0.0%	0.0%	<b>22.2%</b>	29.5%
Clinic services	7.7%	<b>16.7%</b>	0.0%	0.0%	0.0%	6.8%
Crisis services	7.7%	<b>16.7%</b>	0.0%	0.0%	5.6%	9.1%
Inpatient services	<b>23.1%</b>	8.3%	0.0%	0.0%	0.0%	9.1%
Other	7.7%	0.0%	0.0%	0.0%	0.0%	2.3%
Other workforce issues	7.7%	0.0%	0.0%	0.0%	0.0%	2.3%
Preventive services	0.0%	8.3%	0.0%	0.0%	<b>33.3%</b>	15.9%
Psychiatric availability	7.7%	8.3%	0.0%	0.0%	5.6%	6.8%
Transitional services	0.0%	0.0%	0.0%	0.0%	11.1%	4.5%
Wrap-around and/or family-centered approach	0.0%	0.0%	0.0%	0.0%	5.6%	2.3%
Total	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%

#### Child and Youth: Planning Priority by County Type

Summary Priority Type	NYC	Rural	Suburban	Suburban Downstate	Upstate Urban	Total
Access issues	0.0%	3.4%	0.0%	0.0%	0.0%	2.3%
Case Management/Care Coordination	0.0%	6.9%	16.7%	<b>50.0%</b>	0.0%	9.1%
Children's services (general or other)	0.0%	<b>34.5%</b>	0.0%	<b>50.0%</b>	<b>28.6%</b>	29.5%
Clinic services	0.0%	3.4%	<b>33.3%</b>	0.0%	0.0%	6.8%
Crisis services	0.0%	6.9%	16.7%	0.0%	14.3%	9.1%
Inpatient services	0.0%	10.3%	16.7%	0.0%	0.0%	9.1%
Other	0.0%	0.0%	0.0%	0.0%	14.3%	2.3%
Other workforce issues	0.0%	3.4%	0.0%	0.0%	0.0%	2.3%
Preventive services	0.0%	<b>20.7%</b>	0.0%	0.0%	14.3%	15.9%
Psychiatric availability	0.0%	6.9%	16.7%	0.0%	0.0%	6.8%
Transitional services	0.0%	3.4%	0.0%	0.0%	14.3%	4.5%
Wrap-around and/or family-centered approach	0.0%	0.0%	0.0%	0.0%	14.3%	2.3%
Total	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%

### 2. Adult Mental Health Services: Top Three Priorities

**Adult: Statewide and Regional Planning Priorities**

Summary Priority Type	Central	Hudson River	Long Island	NYC	Western	Total
Adult services (general or other)	6.7%	0.0%	0.0%	0.0%	0.0%	2.2%
Case Management/Care Coordination	6.7%	6.3%	0.0%	0.0%	8.3%	6.7%
Clinic services	0.0%	0.0%	<b>50.0%</b>	0.0%	8.3%	4.4%
Crisis services	6.7%	6.3%	0.0%	0.0%	0.0%	4.4%
Forensic/Court-based	6.7%	0.0%	0.0%	0.0%	0.0%	2.2%
Geriatric services	6.7%	6.3%	0.0%	0.0%	0.0%	4.4%
Inpatient services	0.0%	6.3%	0.0%	0.0%	0.0%	2.2%
Other	6.7%	0.0%	0.0%	0.0%	8.3%	4.4%
Peer services (Peer involvement)	6.7%	0.0%	0.0%	0.0%	0.0%	2.2%
Person-centered/Recovery-oriented	6.7%	6.3%	0.0%	0.0%	<b>41.7%</b>	15.6%
Residential services	<b>46.7%</b>	<b>68.8%</b>	<b>50.0%</b>	0.0%	<b>33.3%</b>	51.1%
Total	100.0%	100.0%	100.0%	<b>0.0%</b>	100.0%	100.0%

**Adult: Planning Priority by County Type**

Summary Priority Type	NYC	Rural	Suburban	Suburban Downstate	Upstate Urban	Total
Adult services (general or other)	0.0%	3.7%	0.0%	0.0%	0.0%	2.2%
Case Management/Care Coordination	0.0%	7.4%	0.0%	0.0%	12.5%	6.7%
Clinic services	0.0%	3.7%	0.0%	<b>33.3%</b>	0.0%	4.4%
Crisis services	0.0%	7.4%	0.0%	0.0%	0.0%	4.4%
Forensic/Court-based	0.0%	3.7%	0.0%	0.0%	0.0%	2.2%
Geriatric services	0.0%	7.4%	0.0%	0.0%	0.0%	4.4%
Inpatient services	0.0%	0.0%	14.3%	0.0%	0.0%	2.2%
Other	0.0%	7.4%	0.0%	0.0%	0.0%	4.4%
Peer services (Peer involvement)	0.0%	3.7%	0.0%	0.0%	0.0%	2.2%
Person-centered/Recovery-oriented	0.0%	14.8%	0.0%	0.0%	<b>37.5%</b>	15.6%
Residential services	0.0%	<b>40.7%</b>	<b>85.7%</b>	<b>66.7%</b>	<b>50.0%</b>	51.1%
Total	<b>0.0%</b>	100.0%	100.0%	100.0%	100.0%	100.0%

3. General Mental Health System Issues: Top 3 Priorities

**System Issues: Statewide and Regional Planning Priorities**

Summary Priority Type	Central	Hudson River	Long Island	NYC	Western	Total
Access issues	12.5%	5.9%	0.0%	0.0%	11.1%	9.8%
Case Management/Care Coordination	3.1%	11.8%	0.0%	0.0%	0.0%	3.7%
Clinic services	3.1%	0.0%	0.0%	0.0%	3.7%	2.4%
Crisis services	6.3%	5.9%	0.0%	0.0%	3.7%	4.9%
Cross-Systems Coordination/ Services Integration	18.8%	35.3%	33.3%	0.0%	29.6%	25.6%
Funding	15.6%	17.6%	33.3%	66.7%	7.4%	15.9%
Inpatient services	0.0%	0.0%	0.0%	0.0%	3.7%	1.2%
Other	6.3%	0.0%	0.0%	0.0%	7.4%	4.9%
Peer services (Peer involvement)	0.0%	0.0%	0.0%	0.0%	11.1%	3.7%
Person-centered/Recovery- oriented	0.0%	5.9%	0.0%	0.0%	0.0%	1.2%
Planning and Implementation	12.5%	5.9%	0.0%	33.3%	7.4%	9.8%
Preventive services	0.0%	0.0%	0.0%	0.0%	3.7%	1.2%
Psychiatric availability	6.3%	0.0%	0.0%	0.0%	0.0%	2.4%
Residential services	6.3%	11.8%	33.3%	0.0%	11.1%	9.8%
Workforce issues	9.4%	0.0%	0.0%	0.0%	0.0%	3.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**System Issues: Planning Priority by County Type**

Summary Priority Type	NYC	Rural	Suburban	Suburban Downstate	Upstate Urban	Total
Access issues	0.0%	14.3%	0.0%	14.3%	0.0%	9.8%
Case Management/Care Coordination	0.0%	2.0%	0.0%	14.3%	8.3%	3.7%
Clinic services	0.0%	2.0%	9.1%	0.0%	0.0%	2.4%
Crisis services	0.0%	4.1%	18.2%	0.0%	0.0%	4.9%
Cross-Systems Coordination/ Services Integration	0.0%	24.5%	27.3%	28.6%	33.3%	25.6%
Funding	66.7%	12.2%	18.2%	14.3%	16.7%	15.9%
Inpatient services	0.0%	0.0%	0.0%	0.0%	8.3%	1.2%
Other	0.0%	4.1%	9.1%	0.0%	8.3%	4.9%
Peer services (Peer involvement)	0.0%	6.1%	0.0%	0.0%	0.0%	3.7%
Person-centered/Recovery- oriented	0.0%	0.0%	9.1%	0.0%	0.0%	1.2%
Planning and Implementation	33.3%	14.3%	0.0%	0.0%	0.0%	9.8%
Preventive services	0.0%	2.0%	0.0%	0.0%	0.0%	1.2%
Psychiatric availability	0.0%	2.0%	0.0%	0.0%	8.3%	2.4%
Residential services	0.0%	6.1%	9.1%	28.6%	16.7%	9.8%
Workforce issues	0.0%	6.1%	0.0%	0.0%	0.0%	3.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**VIII. Comparison with Previous Year's Planning Priorities**

We believe that it is important to “step back” and examine how county planning priorities may remain consistent from year to year, or the extent to which these priorities may change over time. We therefore took a close look at how the rankings and priority summaries for 2008 compare to the results from last year’s analysis of county priorities. The section below highlights key findings regarding the similarities and differences between the 2007 and 2008 county planning priorities presented on a statewide, county population and regional basis. It is important to note that an exact comparison of the two years’ priorities is difficult because the summary categories were different for each of the years. Specifically, for 2007 there were only 14 possible categories, while for 2008 there were 45 possible categories. Nevertheless, we may be able to glean useful information from a side-by-side comparison of the planning priorities.

***“The continuum of housing options must include a comprehensive range of licensed congregate residential settings, supervised and supportive apartments and supported living options, with placement into such options based upon consumer choice.”***

1. Statewide Comparison View

**Statewide Planning Priorities – Overall**

<b>2008 Priorities (current year)</b>	<b>2007 Priorities (last year)</b>
1. Residential services (18%)	1. Children’s services (19%)
2. Cross-Systems Coordination (12%)	2. Residential (17%)
3. Children’s services (8%)	3. Access and Availability (9%)
3. Funding (8%)	4. Cross-Systems Coordination (8%)

As can be seen above, it is noteworthy that while Residential services and Cross-Systems Coordination appeared among the top four priorities from last year’s planning process, this year they emerged at the top of the list. Additionally, Children’s services, which received the most Top Three rankings of any priority last year, dropped to tie Funding as the third highest collective rankings from counties.

2. County Population Comparison View

**Planning Priority by County Population**

<b>2008 Priorities – Total % NYS Population Represented (current year)</b>	<b>2007 Priorities – Total % NYS Population Represented (last year)</b>
1. Funding (55%)	1. Funding (53%)
2. Planning and Implementation (45%)	2. Administrative issues (49%)
3. Residential services (43%)	3. Residential services (43%)
4. Cross-Systems Coordination (25%)	4. Access and Availability (23%)

In terms of the planning priorities as seen through the lens of total NYS population represented, the picture is very similar when comparing the 2007 and 2008 plans. Specifically, Funding, Planning and Implementation issues (which may also be

considered administrative issues and were likely classified as such in 2007), and Residential issues represent the Top Three priorities in both years. However, Cross-Systems Coordination was the single priority type to emerge as a significant and “new” top priority this year.

### 3. Regional Comparison View

Below please find detailed comparisons of the top priorities by NYS region for the current year (2008) as compared to last year (2007).

#### Central Region – Planning Priorities

2008 Priorities (current year)	2007 Priorities (last year)
1. Residential services (15%)	1. Residential (17%)
2. Cross-Systems Coordination (10%)	2. Children’s services (15%)
3. Children’s services (8%)	3. Access and Availability (10%)
3. Funding (8%)	4. Workforce issues (8%)

#### Hudson River Region – Planning Priorities

2008 Priorities (current year)	2007 Priorities (last year)
1. Residential services (29%)	1. Residential (29%)
2. Cross-Systems Coordination (13%)	2. Children’s services (16%)
3. Case Mgmt./Care Coord. (9%)	3. Cross-Systems Coordination (11%)
3. Children’s services (9%)	3. Crisis services (11%)
3. Crisis services (9%)	

#### Long Island Region – Planning Priorities

2008 Priorities (current year)	2007 Priorities (last year)
1. Residential services (33%)	1. Residential (33%)
2. Case Mgmt./Care Coord. (17%)	2. Access and Availability (17%)
2. Clinic services (17%)	2. Case Management (17%)
2. Cross-Systems Coordination (17%)	2. Funding (17%)
2. Funding (17%)	

#### NYC – Planning Priorities

2008 Priorities (current year)	2007 Priorities (last year)
1. Funding (67%)	1. Administrative issues (67%)
2. Planning and Implementation (33%)	2. Funding (33%)

**Western Region – Planning Priorities**

<b>2008 Priorities (current year)</b>	<b>2007 Priorities (last year)</b>
1. Cross-Systems Coordination (14%)	1. Children’s services (28%)
2. Preventive services (12%)	2. Cross-Systems Coordination (12%)
2. Residential services (12%)	3. Access and Availability (9%)
4. Person Ctr/Recovery-Oriented (9%)	3. Person Ctr/Recovery-Oriented (9%)

**IX. Discussion and Future Directions**

All of the counties and the City provided information on up to nine planning priorities and initiatives for their local mental health services systems. Participants were also asked to indicate their Top Three priorities, and these data were categorized and analyzed to provide several statewide views to help us better understand the collective and individual priorities throughout New York State.

The results of the process yielded a wide and rich variety of detailed planning priorities and initiatives indicative of the diversity of counties and the specific needs of their residents. However, collectively two planning priorities stand out significantly, indicating a broad consensus among counties regarding the highest levels of need and attention. These include priorities focused on Residential Services and Cross-Systems Coordination, which received significantly higher rankings as compared to the other priorities. It is noteworthy that while Residential services and Cross-Systems Coordination appeared among the top four priorities from last year’s planning process, this year they emerged at the top of the list. Additionally, Children’s services and Funding also received high collective rankings from counties.

***“Local data indicate that the County lacks the sufficient capacity to provide children’s mental health services in a timely manner. Families would benefit greatly from the availability of an immediate supportive response when a child has developed behaviors and symptoms of a mental illness.”***

County- and city-level planning processes themselves are informed directly through significant input and participation of local consumers, families, providers and numerous other local stakeholders. These collective plans provide a view of mental health service needs and priorities closer to those who utilize and benefit from those services. Collectively, the county and city plans serve to better articulate overall mental health services planning priorities for the combined 57 counties and the City of New York. The primary function of the aggregated plans and priorities is to better inform the SOMH 5.07 planning and budgeting processes as well as to inform other state-level policy makers and funders about needs and priorities from the local perspective.

This detailed report on county and city planning priorities for mental health services will be shared with the NYS Office of Mental Health as a significant input to the 5.07 planning and budgeting process for 2008. Additionally, the document will be shared

with other stakeholders and policymakers in an effort to raise awareness of and advocate for the needs and priorities for improving mental health services at the county and city level. Complete comprehensive county mental health services plans providing significantly more detail, as well as county and city level goals, objectives, planning priorities and initiatives beyond those selected by counties as being the Top Three will also be submitted by each county SOMH. Those plans will become the focus of individual county and city discussions in negotiations regarding implementing the planning priorities and initiatives outlined within them.

Finally, the CLMHD Planning Committee members are actively participating in and facilitating discussions between members of the State Mental Hygiene organizations and county planning staff to review and recommend common processes related to county planning. The hope and expectation is that such a collaborative effort will result in more integrated planning processes and the tools needed to support them. Furthermore, there are additional possibilities to build upon the lessons learned from this project and enhance future collaboration among the CLMHD and the three State Mental Hygiene organizations. For instance, it may be possible to move in the direction of a unified website to complete all three county plans, including a warehouse of data and/or resources from all three agencies to use in designing local plans. Such a unified tool may also promote the identification of top service areas that cross over the populations served, which may further strengthen planning and program development efforts for the people served across in New York State.