2020
Local Services Plan
For Mental Hygiene Services

Schenectady Co Office of Comm Services
September 6, 2019
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## Attachments

- Schenectady County Plan 2019.pdf
1. Overall Needs Assessment by Population (Required)

Please explain why or how the overall needs have changed and the results from those changes.

The question below asks for an overall assessment of unmet needs; however certain individual unmet needs may diverge from overall needs. Please use the text boxes below to describe which (if any) specific needs have improved, worsened, or stayed the same.

a) Indicate how the level of unmet mental health service needs, overall, has changed over the past year:  
- Improved  
- Stayed the Same  
- Worsened

Please describe any unmet mental health service needs that have improved:

The wait list for clinical services at Ellis Medicine's Adult Outpatient clinic decreased from 299 in 2017 to 130 in 2018 due to the hiring of 2 prescribers. Two newly built or renovated clinics opened: The Ellis Medicine Mental Health Clinic and the Schenectady Community Support Center (CDPC) The new facilities enhanced the environment for those requiring services for mental health conditions. Both clinics improved safety and security. The new structures also improved the environment in the Hamilton Hill area that is replete with poor housing, poverty, crime and drug abuse. Inpatient populations for adults and adolescents decreased slightly.

Please describe any unmet mental health service needs that have stayed the same:

The ACT team in 2017 was at capacity serving 28 individuals. The same is true for 2018. The need for more services and housing stayed the same.

Please describe any unmet mental health service needs that have worsened:

The wait lists for clinical services remained high. At the Ellis Medicine Adolescent Outpatient Clinic there were 45-75 persons on the wait list. At the Ellis Medicine Adult Outpatient Clinic the wait list was 130. There were 2 open positions. One for a Psychiatrist and one for a Social Worker. While at the CDPC satellite clinic there was no wait lists but due to the loss of positions caseloads were significantly higher. There is no plan to replace these positions. The ACT program was at capacity for the entire year. While there were no wait lists for the PROS program it remains under capacity. There were wait lists for virtually all housing programs throughout 2018. The need for mental health services in the community continues to rise due to poverty, unemployment, crime and trauma.

b) Indicate how the level of unmet substance use disorder (SUD) needs, overall, has changed over the past year:  
- Improved  
- Stayed the Same  
- Worsened

Please describe any unmet SUD service needs that have improved:

New Choices Recovery Center also made ready to open a new facility at the end of 2018. The newly renovated building is located in the relatively same area as the Ellis Medicine and Schenectady Community Support Center contributing to better access to treatment and a greater capacity to meet the needs of the community. Many other community initiatives were in process such as the Community and School based Prevention Service. The county also established a partnership with the Office of Community Services and Public Health in order to track the opioid crisis in the community. OCS also established the Substance Use Prevention Coalition. Catholic Charities has integrated a mobile needle exchange program that also distributes Narcan to those who come to the van and also operates a 'health hub' that persons can call 24/7 and receive immediate assistance. Catholic Charities is also providing Narcan training throughout the county. All county departments have Narcan on site as do most community providers. Also in 2018 the Schenectady Police Department began planning for the 'Schenectady Cares for You' initiative. When implemented this program will invite persons in need of assistance to come to the police station for immediate help. Toward the end of 2018 as well the county applied for a significant grant to establish Medicated Assisted treatment in the county jail.

Please describe any unmet SUD service needs that have stayed the same:

Recovery Housing residences through New Choices continued to have some openings throughout 2018 as in 2017. The New Choices Recovery Center had no wait lists, nor did the St. Peter's Addiction Center or the Conifer Park outpatient clinic.

Please describe any unmet SUD service needs that have worsened:

Immediate access to inpatient treatment is a significant problem. Often persons have to wait in order to be admitted for days until a bed is available. This is most often an impediment to treatment as many persons cannot abstain from using due to the nature of addiction. Relapse is a common consequence of having to wait for any period of time.

c) Indicate how the level of unmet needs of the developmentally disabled population, overall, has changed in the past year:  
- Improved  
- Stayed the Same  
- Worsened

Please describe any unmet developmentally disability service needs that have improved:

Most recently OPWDD has provided data to counties in order to be more transparent regarding the numbers of people and services in each county. This gives counties the opportunity to advocate for needed services with the IDD population.

Please describe any unmet developmentally disability service needs that have stayed the same:

According to the most recent data provided from 2016-2017 most services have seen an increase in the numbers of persons that are served in the community. However, housing supports have remained much the same but this number does not reflect the rate of need.

Please describe any unmet developmentally disability service needs that have worsened:

The numbers of persons served in the community is on the increase. The service that has increased significantly is day habilitation. The numbers served for vocational and workshop opportunities has dramatically decreased due to the closing of beds and workshop settings in the community. Employment numbers are much the same. Numbers of persons with dual diagnosis (IDD, mental health and very often substance abuse) are gradually rising.
The need for psychiatric services is increasing as the number of persons with co-occurring disorders is on the rise. There is a dearth of psychiatrists across the state and nation. Telepsychiatry is still in its infancy and does not address issues specific to the IDD population due to a lack of training. Many times clinics operated under OMH are having to treat persons with IDD and mental health issues for those with limited capacity or who have problematic behaviors exhibited due to IDD. OPWDD needs to make a concerted effort to obtain and retain psychiatrists that are trained in this specialty or advocate to allow MD’s trained in this field to be licensed to provide psychiatric services as well.

The second section of the form includes; goals based on local need; goals based on state initiatives and goals based in other areas. The form allows counties to identify forward looking, change-oriented goals that respond to and are based on local needs and are consistent with the goals of the state mental hygiene agencies. County needs and goals also inform the statewide comprehensive planning efforts of the three state agencies and help to shape policy, programming, and funding decisions. For county needs assessments, goals and objectives to be most effective, they need to be clear, focused and achievable. The following instructions promote a convention for developing and writing effective goal statements and actionable objectives based on needs, state or regional initiatives or other relevant areas.

2. Goals Based On Local Needs

<table>
<thead>
<tr>
<th>Issue Category</th>
<th>Applicable State Agenc(ies)</th>
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<tbody>
<tr>
<td>a) Housing</td>
<td>OASAS OMH OPWDD</td>
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<td>b) Transportation</td>
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<td>c) Crisis Services</td>
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<td>d) Workforce Recruitment and Retention (service system)</td>
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<td>e) Employment/ Job Opportunities (clients)</td>
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<td>f) Prevention</td>
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<td>g) Inpatient Treatment Services</td>
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<td>h) Recovery and Support Services</td>
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<td>i) Reducing Stigma</td>
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<td>j) SUD Outpatient Services</td>
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<td>k) SUD Residential Treatment Services</td>
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<td>m) Coordination/Integration with Other Systems for SUD clients</td>
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<td>n) Mental Health Clinic</td>
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<td>o) Other Mental Health Outpatient Services (non-clinic)</td>
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<td>r) Developmental Disability Children Services</td>
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<td>s) Developmental Disability Student/Transition Services</td>
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<td>x) Developmental Disability Front Door</td>
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<td>z) Other Need 1(Specify in Background Information)</td>
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<td>aa) Other Need 2 (Specify in Background Information) (NEW)</td>
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<tr>
<td>ab) Problem Gambling (NEW)</td>
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<tr>
<td>ac) Adverse Childhood Experiences (ACES) (NEW)</td>
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(After a need issue category is selected, related follow-up questions will display below the table)

2a. Housing - Background Information

The need for safe and affordable housing in Schenectady is at a critical level. Rents are incrementally on the rise due to the nearby Rivers Casino. Housing programs for the mental health system have a difficult time locating apartments in safe neighborhoods. While recently there is one low income apartment building constructed (the Joseph Allen Apartments) the waiting list is months long. Most construction that is occurring now are for luxury apartments and thus not affordable for fixed or low income people. Housing for those with mental health illness is at a serious level. Mohawk Opportunities in 2018 had a waiting list for supported apartments is at 87; a 60% increase over 2017. For RSS the wait list in 2018 was at 59. Adult SPOA applications numbered 378 in 2018, an over 100% increase over 2017. Referrals from the state correctional system are also on the rise as are those on AOT orders. In 2017 there were 26 persons with an AOT designation. That number rose to 33 in 2018.
Do you have a Goal related to addressing this need?  Yes  No

**Goal Statement**- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Office of Community Services will seek more funding opportunities for additional housing units.

**Objective Statement**

Objective 1: OCS will advocate for an increase in funding from OMH, particularly since persons are being discharged from state psychiatric facilities, prisons and the jail.

- Applicable State Agency: (check all that apply): OASAS OMH OPWDD

Objective 2: OCS in collaboration with community providers will investigate all possibilities for grants for additional funding opportunities

- Applicable State Agency: (check all that apply): OASAS OMH OPWDD

**Change Over Past 12 Months (Optional)**

See Executive Summary

2b. Transportation - Background Information

Transportation is cited across the region as an impediment to accessing services. There are many rural communities that do not have the benefit of public transportation and most services are located in the city of Schenectady. The Capital District Transportation Authority has set routes that do not include the outlying areas. Therefore, persons in need of services have to use Medicaid Transportation which is often difficult to arrange, or they have to rely on taxies and uber services that cost a good deal of money.

Do you have a Goal related to addressing this need?  Yes  No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

This is a regional issue and is best addressed with the RPC

**Change Over Past 12 Months (Optional)**

2c. Crisis Services - Background Information

This issue has not been chosen as a priority at the time of this report, however this issue is being looked at and addressed on a regional basis with capital district counties.

Do you have a Goal related to addressing this need?  Yes  No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

**Change Over Past 12 Months (Optional)**

2d. Workforce Recruitment and Retention (service system) - Background Information

Workforce turnover has been much the same. Residential services most often see the highest rate of turnover in residences for those with mental illness and especially for those with IDD. Data is not available to show these numbers.

Do you have a Goal related to addressing this need?  Yes  No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

**Change Over Past 12 Months (Optional)**

2e. Employment/ Job Opportunities (clients) - Background Information

The city of Schenectady has a high rate of unemployment. Industry such as GE have left the community and most often establish out of state locations. Thus there is a lack of job opportunities, especially for those with a high school education or less or for persons with disabilities. Most new businesses are restaurants, luxury apartments, hotels and stores within the area of the casino. There are few grocery stores in the City of Schenectady.

Do you have a Goal related to addressing this need?  Yes  No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

**Change Over Past 12 Months (Optional)**

2g. Inpatient Treatment Services - Background Information

The major issue here is the lack of immediate access to inpatient rehabilitation for substance abuse. Anecdotally this is a problem across the state and remains a high priority. Persons who need to wait often for days in order to be admitted have a difficult time abstaining from using without immediate help. The resolution for this issue lies in the hands of private providers and/or state funding in order to increase bed capacity.
Do you have a Goal related to addressing this need?  
Yes ☐  No ☐

**Goal Statement** - Is this Goal a priority goal (Maximum 5 Objectives per goal)?  
Yes ☐  No ☐

Substance Abuse Prevention is a significant issue in the community, especially with regard to the opioid epidemic. Much like other counties this concern is of primary importance to all.

**Objective Statement**

Objective 1: The Office of Community Services in collaboration with Public Health and community agencies will continue ongoing monitoring of the use of substances in the population with a focus on opioid use and treatment.

Applicable State Agency: (check all that apply):  ☑ OASAS  ☑ OMH  ☑ OPWDD

Objective 2: The Substance Abuse Prevention Coalition will continue to provide educational opportunities to the community on various prevention activities, strategies and resources

Applicable State Agency: (check all that apply):  ☑ OASAS  ☑ OMH  ☑ OPWDD

Objective 3: The Office of Community Services will distribute any and all grant and funding opportunities to community providers and advocate for increased inpatient beds for those seeking immediate help

Applicable State Agency: (check all that apply):  ☑ OASAS  ☑ OMH  ☑ OPWDD

**Change Over Past 12 Months (Optional)**

2i. Reducing Stigma - Background Information

The stigma surrounding most disabilities, but especially with those with mental illness and/or substance abuse issues. Many persons do not seek treatment for fear of being labeled. This is a main reason that men in particular do not ask for help due to gender socialization.

Do you have a Goal related to addressing this need?  
Yes ☐  No ☐

**Goal Statement** - Is this Goal a priority goal (Maximum 5 Objectives per goal)?  
Yes ☐  No ☐

The Office of Community Services in collaboration with the community of providers will continue efforts to reduce the perceptions of 'blaming the victims' for having a disability, especially with regard to mental illness and substance abuse.

**Objective Statement**

Objective 1: Reducing stigma is a main objective of the Schenectady Suicide Prevention Coalition. A work group to address this problem is being initiated.

Applicable State Agency: (check all that apply):  ☑ OASAS  ☑ OMH  ☑ OPWDD

Objective 2: The Office of Community Services sponsors a Mental Health Awareness event during the month of May

Applicable State Agency: (check all that apply):  ☑ OASAS  ☑ OMH  ☑ OPWDD

Objective 3: The Office of Community Services will collaborate with other providers to have an annual recovery day celebration.

Applicable State Agency: (check all that apply):  ☑ OASAS  ☑ OMH  ☑ OPWDD

**Change Over Past 12 Months (Optional)**

2m. Coordination/Integration with Other Systems for SUD clients - Background Information

Integrating mental health services with SUDS services has been a challenge and there continues to be state policy barriers to integrated services.

Do you have a Goal related to addressing this need?  
Yes ☐  No ☐

**Goal Statement** - Is this Goal a priority goal (Maximum 5 Objectives per goal)?  
Yes ☐  No ☐

The dual recovery task force is comprised of community providers that work in collaboration to address this issue. Integrating treatment is a best practice that is difficult to achieve.

**Objective Statement**

Objective 1: The task force will provide education regarding best practices pertaining to dual diagnosis treatment to community providers

Applicable State Agency: (check all that apply):  ☑ OASAS  ☑ OMH  ☑ OPWDD

Objective 2: Create more options for dual diagnosis treatment within community provider agencies

Applicable State Agency: (check all that apply):  ☑ OASAS  ☑ OMH  ☑ OPWDD

**Change Over Past 12 Months (Optional)**

2n. Mental Health Clinic - Background Information
The need for clinical services for those with mental illnesses is increasing throughout the county, but particularly in the city of Schenectady where social determinants of health contribute to increased stress, depression and traumatic experiences. In rural communities the lack of public transportation limits access to most services. The wait list for the Ellis Medicine Mental Health Clinic, the primary provider of services was at 130 in 2018, a significant decrease from 299 in 2017. This is due to the hiring of a new prescriber. However, the intake process itself can last from 4-6 weeks until a person is able to see a psychiatrist or prescriber. Hometown Health, a federally qualified health center offers mental health services but only after being admitted to a primary care provider. This often takes 4-6 weeks to obtain an appointment. Persons in private practices are most often closed to taking new patients or do not take certain insurances.

Do you have a Goal related to addressing this need? 🟢 Yes 🟡 No

Goal Statement - Is this Goal a priority goal (Maximum 5 Objectives per goal)? 🟢 Yes 🟡 No

The Office of Community Services will seek grant and other opportunities to expand service capacity within Schenectady County.

Objective Statement

Objective 1: The Office of Community Services will seek grant and other funding opportunities and partner with community agencies when opportunities exist for service expansion in order to increase clinical services for those experiencing mental illness.

  Applicable State Agency: (check all that apply): □ OASAS □ OMH □ OPWDD

Objective 2: The Office of Community Services will provide support and advocacy for new initiatives in the community.

  Applicable State Agency: (check all that apply): □ OASAS □ OMH □ OPWDD

Change Over Past 12 Months (Optional)

2o. Other Mental Health Outpatient Services (non-clinic) - Background Information

Bethesda House of Schenectady is a non-profit agency that serves the homeless, those with mental illness, and substance abuse. They are in the process of becoming a provider of care coordination through the Health Home. This organization continues to embrace those who cannot engage in traditional treatment settings.

Do you have a Goal related to addressing this need? 🟢 Yes 🟡 No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

Change Over Past 12 Months (Optional)

2q. Developmental Disability Clinical Services - Background Information

As stated in the Executive Summary there is a critical need for more treatment providers and prescribers for the dually diagnosed (IDD, mental illness, substance use) There is a dearth of psychiatrists in the state and country, especially those who are trained in serving the IDD population. Primary Care MD’s are not licensed to provide psychiatric services. OPWDD needs to advocate and sponsor legislation for a change in this policy.

Do you have a Goal related to addressing this need? 🟢 Yes 🟡 No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

Change Over Past 12 Months (Optional)

2ab. Problem Gambling (NEW) - Background Information

With the establishment of the Rivers Casino in Schenectady there is a recognized need to assist those with gambling addictions. New Choices Recovery Center was awarded funding by the NYS OASAS in 2019 to help address Problem Gambling.

Do you have a Goal related to addressing this need? 🟢 Yes 🟡 No

Goal Statement - Is this Goal a priority goal (Maximum 5 Objectives per goal)? 🟢 Yes 🟡 No

Increase problem Gambling education and treatment options.

Objective Statement

Objective 1: Pursue funding opportunity for treatment expansion for problem gambling

  Applicable State Agency: (check all that apply): □ OASAS □ OMH □ OPWDD

Objective 2: Provide Community Education regarding Problem Gambling.

  Applicable State Agency: (check all that apply): □ OASAS □ OMH □ OPWDD

Change Over Past 12 Months (Optional)

2ac. Adverse Childhood Experiences (ACEs) (NEW) - Background Information
It is well known that Adverse Childhood Experiences impact the wellness of a person throughout their life. Their is a dose response relationship to the ACES questionnaire and each box that is checked increases the risk of having multiple health problems including chronic diseases, addictions, legal problems and interpersonal difficulties.

Do you have a Goal related to addressing this need?  

- Yes  
- No

**Goal Statement**

Is this Goal a priority goal (Maximum 5 Objectives per goal)?

- Yes  
- No

The Office of Community Services will continue its efforts to assist providers of all medical care through trainings in the community with a goal of impacting improvement in health outcomes.

**Objective Statement**

Objective 1: The Office of Community Services has contracted with the Parsons Sidney Albert Institute for the past 3 years to provide trauma informed trainings throughout the community. This initiative will continue for the foreseeable future.

Applicable State Agency: (check all that apply):  
- [ ] OASAS  
- [x] OMH  
- [ ] OPWDD

Objective 2: The Office of Community Services will also provide trauma informed trainings in county offices and in the community as requested.

Applicable State Agency: (check all that apply):  
- [ ] OASAS  
- [x] OMH  
- [ ] OPWDD

Objective 3: The Office of Community Services will continue to support all efforts to increase awareness about adverse childhood experiences in school systems, juvenile justice settings and seek all opportunities to continue this endeavor.

Applicable State Agency: (check all that apply):  
- [ ] OASAS  
- [x] OMH  
- [ ] OPWDD

**Change Over Past 12 Months (Optional)**
The following survey is intended to promote alignment with the NYS Prevention Agenda for 2019-2024 as part of local services plan development.

All inquiries regarding this survey should be directed to oasasplanning@oasas.ny.gov.

**Background**

The New York State Prevention Agenda for 2019-2024 aims to make New York State the Healthiest State in the Nation for People of All Ages. The Prevention Agenda's overarching strategy is to implement public health approaches that improve the health and well-being of entire populations and eliminate health inequities. This strategy includes an emphasis on social determinants of health - the social, cultural and environmental factors that influence health status, and are root causes of poor health and adverse outcomes. An agenda that focuses on social determinants necessitates cross-cutting policy development and support for local implementation.

As part of the Prevention Agenda, counties are required to submit Community Health Assessment and Community Health Improvement Plans to the Department of Health. LGUs responsible for mental hygiene services have often been active partners in the development and implementation of these plans that align with the statewide prevention agenda. The 2019-2024 Prevention Agenda includes goals and interventions specific to behavioral health, and overall health and well-being. Within the Prevention Agenda, available here, please review the Healthy Women, Infants, and Children Action Plan (pgs. 97-153) and the Promote Well-Being and Prevent Mental and Substance Use Disorders Action Plan (pgs. 154-171).

To reach the statewide prevention goals, future local service planning should include implementation of identified or other evidence-based interventions. Localities will need to create or identify metrics and data collection methods to determine impact. In some cases, data or metrics may not exist. Therefore, data collection will need to occur at the county/provider levels. These activities will require the support of all stakeholders.

**Questions**

1. Has your LGU developed a plan that aligns with the Statewide Prevention Agenda?
   - [ ] No
   - [ ] Yes, please explain:
     Broadly speaking the LGU has a plan the aligns with the Statewide Prevention Agenda. We are active participants with our Public Health Department in their planning and are represented on the Schenectady County Healthy Communities Coalition. This group and/or subset workgroups meet on a regular basis to address the many health concerns of our community. The membership include many not-for-profit agencies, Public Health, Ellis Medicine and many others. We have a number of coalitions and groups devoted to initiatives that fully support certain aspects of the Prevention agenda including a Suicide Prevention Coalition, Heroin/Opiate Coalition, Substance Abuse Prevention Coalition, Trauma Workgroup and focus areas which will be noted below.

2. Each of the eight goals in the "Promote Well-Being" focus area and "Prevent Mental and Substance Use Disorders" focus area, have an associated intervention. Please select which of the following interventions you have begun or will begin implementing:

**Focus Area 1: Promote Well-Being**

**Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan**

- [ ] 1.1 a) Build community wealth
- [ ] 1.1 b) Support housing improvement, affordability and stability through approaches such as housing improvement, community land trusts and using a "whole person" approach in medical care
- [ ] 1.1 c) Create and sustain inclusive, healthy public spaces
- [ ] 1.1 d) Integrate social and emotional approaches across the lifespan and establish support programs that establish caring and trusting relationships with older people. Examples include the Village Model, Intergenerational Community, Integrating social emotional learning in schools, Community Schools, parenting education.
- [ ] 1.1 e) Enable resilience for people living with chronic illness by increasing protective factors such as independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety.
- [ ] 1.1 f) Implement evidence-based home visiting programs
- [ ] 1.1 g) Other

**Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages**

- [ ] 1.2 a) Implement Mental Health First Aid
- [ ] 1.2 b) Implement policy and program interventions that promote inclusion, integration and competence
- [ ] 1.2 c) Use thoughtful messaging on mental illness and substance use
- [ ] 1.2 d) Other

**Focus Area 2: Mental and Substance Use Disorders Prevention**

**Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults**

- [ ] 2.1 a) Implement environmental approaches, including reducing alcohol access, implementing responsible beverage services, reducing risk of drinking and driving, and underage alcohol access
- [ ] 2.1 b) Implement/Expand School-Based Prevention and School-Based Prevention Services
1. Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) using electronic screening and brief interventions (e-SBI) with electronic devices (e.g., computers, telephones, or mobile devices) to facilitate delivery of key elements of traditional SBI.
2. Integrate trauma-informed approaches into prevention programs by training staff, developing protocols and engaging in cross-system collaboration.
3. Engage in sub-state or regional partnerships in implementing actions related to the New York State Prevention Agenda (e.g., Local Health Coalitions).

### Goal 2.2 Prevent opioid overdose deaths

- Increase availability of access and linkages to medication-assisted treatment (MAT) including Buprenorphine.
- Increase availability of access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers.
- Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations.
- Build support systems to care for opioid users or those at risk of an overdose.
- Establish additional permanent safe disposal sites for prescription drugs and organized take-back days.
- Integrate trauma informed approaches in training staff and implementing program and policy.

### Goal 2.3 Prevent and address adverse childhood experiences (ACEs)

- Address Adverse Childhood Experiences and other types of trauma in the primary care setting.
- Grow resilient communities through education, engagement, activation/mobilization and celebration.
- Implement evidence-based home visiting programs.

### Goal 2.4 Reduce the prevalence of major depressive disorders

- Strengthen resources for families and caregivers.
- Implement an evidence-based cognitive behavioral approach such as Peter Lewinsohn's Coping with Depression course, Gregory Clarke's Cognitive-Behavioral Prevention Intervention.
- Implement the Combined Parent-Child Cognitive-Behavioral Therapy (CPC_CBT).

### Goal 2.5 Prevent suicides

- Strengthen economic supports: strengthen household financial security, and policies that stabilize housing.
- Strengthen access and delivery of suicide care "Zero Suicide (a commitment to comprehensive suicide safer care in health and behavioral health care systems)."
- Create protective environments: reduce access to lethal means among persons at risk of suicide; integrate trauma informed approaches; reduce excessive alcohol use.
- Promote connectedness, coping and problem-solving skills: social emotional learning, parenting and family relationship programs, peer norm program.

### Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population

- Implement a multilevel intervention model that focuses at the individual, health systems, community and policy-levels. This model describes a comprehensive framework that may be useful for designing, implementing and evaluating interventions and programs to reduce excess mortality in persons with SMD.
- Implement integrated treatment including concurrent therapy for mental illness and nicotine addiction.
- Support and strengthen licensing requirement to include improved screening and treatment of tobacco dependence by mental health providers.

Please describe your efforts implementing the interventions selected above (if any). Also, if you selected an "other" category from any set of interventions above, please describe it here:

Through a OCFS grant and in partnership with Parsons Sydney Albert Research Institute Trauma Informed Care trainings have been delivered to over 500 participants per year for the past 4 years educate and inform the community and workforce about ACEs, trauma and resiliency. The Schenectady Healthy Communities has a work group that focuses on trauma informed care and has recently worked with a number of agencies to implement a trauma informed organizational assessment. Recently this Coalition chose to Promote Well-Being as its priority area for the 2019-2024 agenda. This priority area includes mental health, substance use and nicotine addiction. The county also has a suicide prevention coalition which has provided education on means restriction and is actively pursuing multiple strategies to reduce suicide risk in the community. Additionally, there is a Substance Abuse Prevention Coalition and Funded Prevention Team which actively works to reduce substance abuse through multiple mechanisms. There also exists a Heroin/Opiate Task Force which has increased MAT access in the community, partnered with agencies around the COTI project, added a CERPA to the Ellis Hospital ER, developed in reach capacity for peers and case managers to to the county jail, provided narcan training as well as a number of other strategies to deal with the Opiate crisis. In youth suicide prevention the county facilitates a "high Risk" committee which partners with multiple youth serving agencies and school districts to monitor and create linkages for youth who have risk factors for suicide.

3. Have you engaged any local or regional partners in implementing actions related to the New York State Prevention Agenda (e.g., Local Health Department, hospital or hospital system, substance use disorder prevention coalition)?
We have partnered with the County Health Department, have a Suicide prevention Coalition, Substance Abuse Prevention Coalition and Heroin/Opiate Coalition all with broad community involvement.

4. As data and metrics related to the Prevention Agenda's behavioral health interventions may not exist, has your LGU considered how to track progress of implementation?

- No
- Yes, please explain:
  There are some areas in which we are in preliminary stages of looking at data collection and progress tracking related to the prevention agenda, though we closely monitor opiate overdose deaths and other data related to the opiate crisis and have a great deal of data related to substance abuse as well as a few other areas.

5. Has your LGU identified statewide policies that assist or impede implementation of Prevention Agenda interventions?

- No
- Yes, please explain:
  The LGU has been actively involved at looking at statewide policies, such as tobacco free efforts etc.

6. Is your LGU planning for Prevention Agenda alignment by Article 31 and 32 clinics via implementation of evidence-based practices? If so, please describe, and include relevant details on any LGU support of data protocols that would assist clinics in determining outcomes.

- No
- Yes, please explain:
  We have supported SBIRT implementation and other evidence based practices in our article 31 clinic.

7. Are the Prevention Agenda's cross-cutting goals and priorities (e.g., environmental concerns, chronic illness reduction) addressed in your health department's Community Health Assessment and Community Health Improvement Plan? If so, how will your LGU support these cross-cutting goals and priorities?

- No
- Yes, please explain:
  The Healthy Communities Coalition has identified behavioral health issues as a priority area and the LGU is actively involved with this working group. In Schenectady County the LGU and Health Department work closely together on a number of issues and have a history of supporting each other on goals and objectives.

8. DSRIP funding has advanced many projects related to the overall improvement of behavioral health and well-being. Of these projects supported by DSRIP, are there local prevention opportunities that your LGU could build upon and sustain?

- No
- Yes, please explain:

9. Aside from Prevention Agenda activities, please identify any of the following social determinants of mental health that you are addressing in your community:

- Un/Underemployment and Job Insecurity
- Food Insecurity
- Adverse Features of the Built Environment
- Housing Instability or Poor Housing Quality
- Discrimination/Social Exclusion
- Poor Education
- Poverty/Income Inequality
- Adverse Early Life Experiences
- Poor Access to Transportation
- Other

Please describe your efforts in addressing the selections above:
We are working with public health on food insecurity and with the department of social services on housing instability. We have two programs designed to move individuals and families from homelessness to quality apartments to address housing instability.

10. In your county, do you or your partners offer training related to strengthening resilience, trauma-informed or trauma-sensitive approaches?

- No
- Yes

If yes, please list:

- Title of training(s):
  As stated above we have had ongoing trauma informed care trainings for a range of audiences for the past four years which have served over 500 individuals per year. The target audiences have ranged from professional agency staff to probation, child protective services, youth serving agencies as well as community members in addition to training mental health and substance abuse staff.

- Target audience for training:
  How many hours:
  Estimate number trained in one year: over 500
11. New to the 2019-2024 cycle of the Prevention Agenda is the incorporation of a Health-Across-all-Policies approach, initiated by New York State in 2017, which calls on all State agencies to identify and strengthen the ways that their policies and programs can have a positive impact on health. As part of this effort, New York State was designated as the first Age-Friendly State in the nation by the American Association of Retired Persons (AARP).

Does your LGU have policies and procedures in place to support the positive environmental, economic, and social factors that influence the health and well-being of all residents, especially older adults?

- [ ] No
  - [ ] Yes, please provide examples:
    We are in the process of developing policies in this area.
There is a collaborative team of directors/managers along with an LGU representative that meets once a month to review DYSRIP performance.

b) Please explain:

a) Increase community awareness about this program. By 2020 they expect to be able to provide these services independent of the DSRIP funding.

b) Please explain:

a) Projects through billing Medicaid for eligible services. For example, the Living Room is newly established. With that it is taking some time to

2. Has your LGU planned for PPS project sustainability beyond March 31, 2020?

a) Yes ○ No

b) Please explain:

A number of community providers have been awarded funding for DSRIP projects. -Mohawk Opportunities has hired an intensive case manager who works with high risk individuals who are discharged from Ellis Hospital's inpatient unit. She works with them for 30 days to ensure that they get to their follow up appointments. -RSS, in collaboration with the Ellis Medicine Outpatient Clinic in establishing the Living Room project, a best practice diversion from hospitalization. Ellis Medicine is establishing and integration of Primary Care in the outpatient clinic and putting mental health into primary care. In addition they have initiated the PHQ-9, SBIRT and health screens for all clinic

1. Have the PPS supported your LGU and community? For example, support for efforts such as: addressing gaps in services, promoting evidence based and best practices, and facilitating clinical integration.

a) Yes ○ No

b) Please provide more information:

A number of community providers have been awarded funding for DSRIP projects. -Mohawk Opportunities has hired an intensive case manager who works with high risk individuals who are discharged from Ellis Hospital's inpatient unit. She works with them for 30 days to ensure that they get to their follow up appointments. -RSS, in collaboration with the Ellis Medicine Outpatient Clinic in establishing the Living Room project, a best practice diversion from hospitalization. Ellis Medicine is establishing and integration of Primary Care in the outpatient clinic and putting mental health into primary care. In addition they have initiated the PHQ-9, SBIRT and health screens for all clinic

2. Has your LGU planned for PPS project sustainability beyond March 31, 2020?

a) Yes ○ No

b) Please explain:

The Schenectady County LGU is not a provider of services. However agencies in the PPS collaborate on ways to continue sustaining these projects through billing Medicaid for eligible services. For example, the Living Room is newly established. With that it is taking some time to increase community awareness about this program. By 2020 they expect to be able to provide these services independent of the DSRIP funding.

3. Are there any behavioral health providers in your county in VBP arrangements?

a) Yes ○ No

b) Please explain (if "yes" include steps providers have taken to execute contracts):

There is a collaborative team of directors/managers along with an LGU representative that meets once a month to review DYSRIP performance
measures. The members are from Ellis Medicine, RSS, Mohawk and Bethesda House. The Health Home also has a representative at the table.

4. Is the LGU aware of the ways in which managed care organizations and mental health providers plan to leverage VBP resources to implement evidence and best practices like, but not limited to, Collaborative Care Model (CCM), Dual Diagnosis Integration, or Self-Help and Peer Support Services?
   a) Yes ☐ No ☐
   b) Please explain:
   The LGU is aware that the MCO's are working on billing practices for a variety of services. There is a Peer Support program at Ellis Medicine. Catholic Charities and Conifer Park have also introduced CERPAs into the community and are also imbedded in the ED. Ellis Medicine's has a Dual Diagnosis Coordinator for the clinic and PROS program and offer groups and individual work for clients. Likewise New Choices Recovery Center is able to provide clinical services and groups for dually diagnosed individuals who do not require anti-psychotic medications.

5. Is the LGU aware of the development of In-Lieu of proposals?
   a) Yes ☐ No ☐
   b) Please explain:

6. Can your LGU support the BHCC planning process?
   a) Yes ☐ No ☐
   b) Please explain:
   Providers are working collaboratively to improve guidelines for case management services through education. The Regional CLMHD supports the BHCC planning process and are represented on the board of the local group.

7. Does your county have access to data and IT systems that will support further transformation to VBP and outcomes management?
   a) Yes ☐ No ☐
   b) Please explain:
   We have access to PSYKES, the comprehensive CLMHD Behavioral Health Portal, MAPP, Schenectady County DYSRIP measures etc.
<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
<th>Represents</th>
<th>Term Expires</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathryn Martin</td>
<td>Physician, Psychologist</td>
<td>Public Agency</td>
<td>12/2020</td>
<td><a href="mailto:kmartin832@gmail.com">kmartin832@gmail.com</a></td>
</tr>
<tr>
<td>Cynthia Sood</td>
<td>Physician, Psychologist</td>
<td>NAMI/Family Member</td>
<td>12/2023</td>
<td>Cynthia Sood</td>
</tr>
<tr>
<td>Paul Stephens</td>
<td>Physician, Psychologist</td>
<td>Family Member</td>
<td>12/2020</td>
<td><a href="mailto:paulanns@netzero.com">paulanns@netzero.com</a></td>
</tr>
<tr>
<td>Patrick Carrese</td>
<td>Physician, Psychologist</td>
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<td>12/2020</td>
<td><a href="mailto:pcarrese@sphcs.org">pcarrese@sphcs.org</a></td>
</tr>
<tr>
<td>Robert Corliss</td>
<td>Physician, Psychologist</td>
<td>NAMI</td>
<td>12/2020</td>
<td><a href="mailto:robertcorliss3@gmail.com">robertcorliss3@gmail.com</a></td>
</tr>
<tr>
<td>Richard Garnett</td>
<td>Physician, Psychologist</td>
<td>Family Member</td>
<td>12/2020</td>
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</tr>
<tr>
<td>Al Tompkins</td>
<td>Physician, Psychologist</td>
<td>Haven Family Center</td>
<td>12/2020</td>
<td><a href="mailto:havenfc@gmail.com">havenfc@gmail.com</a></td>
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<tr>
<td>Christine Parsons</td>
<td>Physician, Psychologist</td>
<td>Bridges Out of Poverty</td>
<td>12/2020</td>
<td>unavailable</td>
</tr>
<tr>
<td>Robert Winchester</td>
<td>Physician, Psychologist</td>
<td>Town of Niskayuna</td>
<td>12/2020</td>
<td><a href="mailto:trustinbob@aol.com">trustinbob@aol.com</a></td>
</tr>
<tr>
<td>Betty Barlyn</td>
<td>Physician, Psychologist</td>
<td>Community Member</td>
<td>12/2020</td>
<td>unavailable</td>
</tr>
<tr>
<td>Joseph Mancini</td>
<td>Physician, Psychologist</td>
<td>Community Member</td>
<td>12/2020</td>
<td><a href="mailto:jmanc221@gmail.com">jmanc221@gmail.com</a></td>
</tr>
<tr>
<td>Name: Dona Fragnoli</td>
<td>Physician</td>
<td>Represents: Community Member</td>
<td>Term Expires: 12/2023</td>
<td>Email Address: unavailable</td>
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<tr>
<td>Laura Velez</td>
<td>Physician</td>
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<td>Term Expires: 12/2023</td>
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<tr>
<td>Tele Rabbi</td>
<td>Physician</td>
<td>Represents: Peers</td>
<td>Term Expires: 12/2023</td>
<td>Email Address: <a href="mailto:tkrabbi95@gmail.com">tkrabbi95@gmail.com</a></td>
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<tr>
<td>Vacant</td>
<td>Physician</td>
<td>Represents:</td>
<td>Term Expires:</td>
<td>Email Address:</td>
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Indicate the number of mental health CSB members who are or were consumers of mental health services: 1

Indicate the number of mental health CSB members who are parents or relatives of persons with mental illness: 4
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<thead>
<tr>
<th>Name</th>
<th>CSB Member</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Kathryn Martin</td>
<td>Yes</td>
<td>Public Agency</td>
<td><a href="mailto:kmartin832@gmail.com">kmartin832@gmail.com</a></td>
</tr>
<tr>
<td>Joanne Egnaczyk</td>
<td>Yes</td>
<td>Conifer Park</td>
<td><a href="mailto:jegnaczyc@libertymgr.com">jegnaczyc@libertymgr.com</a></td>
</tr>
<tr>
<td>Laura Combs</td>
<td>No</td>
<td>New Choices Recovery Center</td>
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</tr>
<tr>
<td>Patrick Carrese</td>
<td>Yes</td>
<td>At. Peter's Addiction Center</td>
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<td>James Wolff</td>
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<tr>
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<td>Ellis Hospital</td>
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</tr>
<tr>
<td>S? Lang?</td>
<td>No</td>
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<tr>
<td>Stephanie Lao</td>
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<td>Catholic Charities</td>
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<tr>
<td>Megan McClearn</td>
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</tr>
</tbody>
</table>

Note: The subcommittee shall have no more than nine members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.
## Mental Health Subcommittee Roster

**Schenectady Co Office of Comm Services (70440)**

Certified: Margaret Coker (6/13/19)

### Note:

- The subcommittee shall have no more than eleven members. Three subcommittee members must be members of the board; those members should be identified here.

New York State Mental Hygiene Law requires that "each subcommittee for mental health shall include at least two members who are or were consumers of mental health services, and at least two members who are parents or relatives of persons with mental illness."

Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.

<table>
<thead>
<tr>
<th>Name</th>
<th>CSB Member</th>
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<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joseph Mancini</td>
<td>Yes</td>
<td>Community Member</td>
<td><a href="mailto:jmanc225@gmail.com">jmanc225@gmail.com</a></td>
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<tr>
<td>Jodi Kovach</td>
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<tr>
<td>Dave Rossetti</td>
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<tr>
<td>Kimberly Hostig</td>
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</tr>
<tr>
<td>Christopher Burky</td>
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<tr>
<td>Robert Corliss</td>
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</tr>
<tr>
<td>Cynthia Seacord</td>
<td>Yes</td>
<td>NAMI</td>
<td><a href="mailto:cwseacord@hotmail.com">cwseacord@hotmail.com</a></td>
</tr>
<tr>
<td>Justin Reimenschneider</td>
<td>Yes</td>
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<tr>
<td>Kimarie Sheppard</td>
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<tr>
<td>Mary May</td>
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<td>Elishia Marocco</td>
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</tr>
</tbody>
</table>

Indicate the number of mental health subcommittee members who are or were consumers of mental health services: 2

Indicate the number of mental health subcommittee members who are parents or relatives of persons with mental illness: 2
### Developmental Disabilities Subcommittee Roster

Schenectady Co Office of Comm Services (70440)
Certified: Margaret Coker (6/13/19)

**Note:**

Note: The subcommittee shall have no more than nine members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.

<table>
<thead>
<tr>
<th>Name</th>
<th>CSB Member:</th>
<th>Represents:</th>
<th>Email Address</th>
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</thead>
<tbody>
<tr>
<td>Paul Stephens</td>
<td>Yes No</td>
<td>Family Member</td>
<td><a href="mailto:paulanns@netzero.com">paulanns@netzero.com</a></td>
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<td>Kirk Lewis</td>
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<tr>
<td>Joseph Morelli</td>
<td>Yes No</td>
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<td>Robert VanZetta</td>
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<tr>
<td>Al Tompkins</td>
<td>Yes No</td>
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<td><a href="mailto:havenfc@gmail.com">havenfc@gmail.com</a></td>
</tr>
<tr>
<td>Jacqueline Abbaticchio</td>
<td>Yes No</td>
<td>OPWDD</td>
<td><a href="mailto:jaqueline.abbaticchio@opwdd.ny.gov">jaqueline.abbaticchio@opwdd.ny.gov</a></td>
</tr>
</tbody>
</table>
Pursuant to Article 41 of the Mental Hygiene Law, we assure and certify that:

Representatives of facilities of the offices of the department; directors of district developmental services offices; directors of hospital-based mental health services; directors of community mental health centers, voluntary agencies; persons and families who receive services and advocates; other providers of services have been formally invited to participate in, and provide information for, the local planning process relative to the development of the Local Services Plan;

The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities have provided advice to the Director of Community Services and have participated in the development of the Local Services Plan. The full Board and the Subcommittees have had an opportunity to review and comment on the contents of the plan and have received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16(c);

The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities meet regularly during the year, and the Board has established bylaws for its operation, has defined the number of officers and members that will comprise a quorum, and has membership which is broadly representative of the age, sex, race, and other ethnic characteristics of the area served. The Board has established procedures to ensure that all meetings are conducted in accordance with the Open Meetings Law, which requires that meetings of public bodies be open to the general public, that advance public notice of meetings be given, and that minutes be taken of all meetings and be available to the public.

OASAS, OMH and OPWDD accept the certified 2020 Local Services Planning Assurance form in the Online County Planning System as the official LGU assurance that the above conditions have been met for the 2020 Local Services planning process.
2018 Needs Assessment Report
Schenectady Co Office of Comm Services (70440)
Certified: Margaret Coker (6/23/17)
Consult the LSP Guidelines for additional guidance on completing this exercise.

PART A: Local Needs Assessment

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

The last analysis of data in 2016 gathered during planning activities associated with multiple system transformation projects an estimated 19% of Schenectady County residents were diagnosed with a mental illness, 4% with serious mental illness. While Schenectady County’s facilitated health insurance enrollment and other linkage to services initiatives has resulted in 90% of residents having health insurance coverage, the rate of Emergency Department visits and hospitalizations secondary to mental illness is higher than that of the rest of the state. In 2015 there were 2,685 crisis evaluations done. In 2016 there were 5,275; an increase of over 100%. In identified high risk neighborhood; predominately inner city neighborhoods impacted by poverty, gang violence, food insecurities, housing insecurities, family and community trauma, substance abuse including heroin addiction, and underground economies, mental health crisis visits were up to 5x higher for this population. High risk neighborhoods were also 2 to 6x’s higher in hospitalization and Emergency Department rates for self-inflicted injury compared to the rest of state. Schenectady County is ranked in the 3rd risk quartile for suicide mortality and 4th risk quartile for self-inflicted injury hospitalizations. Schenectady County falls in the 4th quartile for both adult obesity and no leisure time activities. With regard to substance use related indices, Schenectady County was shown to have a significantly higher rate of newborn drug related hospitalizations and overall higher substance use related hospitalizations with high risk neighborhoods demonstrating 5 to 11x more substance use related Emergency Department visits and 2 to 4x higher hospitalization rates. Specific to Opiate related trends, data shows a drop in opiate related admissions, however, use of the Emergency Department is steadily overtaking hospitalization rates. Estimates indicate approximately 4,000 residents 12 y/a and older identified as having a substance use disorder with 2,700 residents identified as needing but not receiving treatment.

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

The capacity of existing resources available to meet identified needs, including services accessed outside the funded and certified systems, is comprised of licensed clinical provider agencies, community service agencies, and local government agencies working collaboratively to provide a broad range of services. Ellis Medicine, a 438 bed community teaching hospital serves as the
county’s one acute care hospital. The county is also served by a single federally qualified health center, Hometown Health Center, and a specialty hospital, Sunnyview Rehabilitation Hospital, a member of an Albany based system.

Ellis Medicine operates 3 campuses, provides teaching residencies in Family Medicine and General Dentistry, and includes a skilled nursing facility, women’s health center, and an emergent care facility, which provides urgent care services. Ellis Medicine also provides the only local adult and adolescent inpatient psychiatric unit and crisis service. In addition to hospital based care, Ellis Medicine operates an adult outpatient mental health services, a child/adolescent outpatient mental health clinic, a PROS program, case Management program, and a Peer Services Program. Ellis Medicine also operates a number of primary and specialty care medical practices.

- Ellis Medicine’s Psychiatric Inpatient unit has a capacity of 36 and had 1,111 admissions in 2015. In 2016 there were 1,253 admissions. Crisis Services provided 2,685 crisis evaluations in 2015. In 2016, 5,275 crisis evaluations were conducted, an increase of over 100%.
- The adult outpatient clinic served 1,657 individuals in 2014. That number increased to 1,892 in 2015. In 2016 the number of clients served was somewhat less due to the loss of 3 Psychiatrists. The PROS program served 284 clients in 2015 and 253 clients in 2016.
- In 2015, the Intensive Case Management program served 156 clients and generated 1,300 client visits. That number increased to 1,887 visits in 2016.
- Ellis Medicine’s Peer Service program provided 1,499 units of service in the Ellis Emergency Department and Crisis Services Department, co-facilitated 566 groups on the inpatient unit, and facilitated or co-facilitated 44 groups within Schenectady County. In 2016 peers provided 1,184 units of service.

The New York State Capital District Psychiatric Center provides inpatient psychiatric care to patients whose symptoms have not stabilized with brief or short term care in a community hospital. Schenectady County has a 24 bed allocation. The rate of occupancy in the 24 beds has decreased by approximately 50% due to the closing of beds in the facility.

The Schenectady Community Support Center, an outpatient satellite clinic operated by the Capital District Psychiatric Center, served 432 individuals in 2015 and 335 in 2016. This decrease can be attributed to the loss of prescribers in that period of time. Assertive Community Treatment Services (ACT) is operated by Mohawk Opportunities Inc., and provides community based psychiatric, mental health, and intensive case management services to individuals with significant persistently chronic mental health disorders who are not able to engage in standard outpatient care modalities. Schenectady County’s ACT team has a capacity of 48 and maintains full utilization.

The Child and Adolescent system is also experiencing a significant shortage of services. The IFEP program (In-Home Respite) has 15 families on the waiting list. 3 spots are funded for SPOA. For recreational respite there are 37 children on the waitlist. Currently 12 spots are funded for SPOA, but only 7 are receiving services at this time. Waiver services have 21 children on the wait list with 24 spots funded. Most of the SPOA referrals do end up getting case
management services if they have Medicaid. Right now there about 10 non-Medicaid families who receive case management services which are for the most part, paid for by the county. There is also a dearth of services for young people who have substance abuse issues. Conifer Park no longer has an adolescent unit and outpatient services for youth cannot meet the need.

Hometown Health Center offers comprehensive mental health care, providing psychiatric counseling, and support services to children over the age of 5 and adults. The program is designed to be a bridge service helping clients access care quickly until a longer term plan is coordinated. Hometown Health also expedites prescriptions for individuals released from the county jail as individuals are released with only a 7 day supply of medications. Appointment for primary care services are also priorities for individuals in re-entry to the community.

New Choices Recovery Center provides community based residential, rehabilitation, and outpatient services for individuals in recovery from substance use disorders and co-occurring disorders. The 4 community residence programs have a total capacity of 75, with a 21 bed capacity for female clients and a 54 bed capacity for male clients. The day rehabilitation program admitted 329 individuals. Data for 2016 is not available. In 2015 the outpatient clinics admitted 718 individuals into treatment in 2015. In 2016 admission 1062, a 67% increase.

Conifer Park provides a 225 bed residential treatment program that offers Medically Supervised Withdrawal with a 34 bed capacity, Inpatient Rehabilitation with a 171 bed capacity, and Residential Rehabilitation with a 20 bed capacity. Conifer Park also operates an outpatient treatment center located in Schenectady. St. Peter’s Addiction Recovery Clinic, located in Rotterdam, provides outpatient recover services to 347 clients in 2015. The trend is much the same as New Choices.

Housing support services within Schenectady County include OMH supported and certified residential and housing programs coordinated and accessed through the SPOA program, HUD and grant funded housing programs and case management, advocacy, and resource supports for individuals who are chronically homeless, displaced, and have been affected by mental, emotional, or behavioral health problems, and Medicaid Redesign Team housing programs for individuals coping with significant chronic mental health problems. Schenectady County is served by 5 Community Residence programs specifically allocated for individuals with significant mental illness. The community residences are commonly at capacity.

Mohawk Opportunities, Inc. operates a 12 bed crisis residence which provides short term support and housing to individuals with a severe and persistent mental illness. Individuals referred to the program have experienced a crisis that has disrupted their stability in the community or are in the process of transitioning back to the community.

The Capital District Psychiatric Center residence has a capacity of 13 beds and provides community based housing for individuals transitioning from long-term and intermediate hospitalizations; OMH Certified and Supported Housing Programs, Transitional Supported Housing, Crisis Housing, Family Care Homes, and Continuum of Care. Supported Housing Programs are operated by various agencies within the community. Each program serves a specific demographic based on eligibility and need.
OMH Certified and Supported Housing Programs offer affordable housing and community-based supports to individuals with a severe and persistent mental illness. Mohawk Opportunities, Inc. operates a Certified Apartment Program which serves 40 individuals. Standard OMH Supported Housing Programs within the county are operated by Mohawk Opportunities and Rehabilitation Support Services.

Supported Housing programs allow individuals with mental health issues and their families to live independently. Mohawk Opportunities Standard Supported Housing has a capacity of 43 with an average waitlist of 45-50 individuals. Mohawk Opportunities also operates the Young Adult Apartment Program, a subcomponent of the supported housing program. This program has a capacity of 5.

Rehabilitation Support Services Supported Housing has a capacity of 59. The average waitlist is 40-45 individuals. RSS operates 3 respite beds and 3 beds are dedicated to the forensic population. In addition to standard supported housing beds, both RSS and Mohawk Opportunities also have allocated targeted beds for: High Needs for individuals who have been served by OMH licensed residential programs; Priority Long Term beds for individuals transitioning from long-term stays at the Capital District Psychiatric Center for individuals transitioning into the community from correctional facilities, and Medicaid Redesign Team beds for individuals being served by the county’s Health Home. Additional housing resources within the community serving individuals who are impacted by mental health challenges, substance use difficulties, and homelessness include:

- New Choices Recovery Center Shelter Plus Care Program
- New Choices Recovery Center Medicaid Redesign Team Housing Program
- Community Action Program Permanent Housing Program
- Schenectady County Community Action Program Shelter Plus Care Program
- Schenectady Community Action Program Solutions in Supported Housing Program
- Schenectady Community Action Program Sojourn House
- Mohawk Opportunities Continuum of Care Services Supported Housing Program
- Bethesda House Beacon Residential Program Bethesda House Lighthouse Program
- YMCA’s Men’s Housing Program
- YWCA’s Rosa’s House Program
- City Mission of Schenectady’s Transitional Housing Apartment Program Emergency
- In 2017 the DePaul apartment program will open 25 beds in support of the mental health population who are able to transition to independent living.

Shelter and Crisis Housing supports in Schenectady County include:

- City Mission of Schenectady’s 35-bed Women and Children’s Shelter City Mission
- Schenectady’s 76-bed Men’s Shelter Schenectady County
- Department of Social Services Emergency
- Housing Bethesda House
- Veteran’s Emergency Bed Program
Access to care coordination services is managed through Schenectady County’s Health Home, Care Central for Medicaid or Medicaid eligible individuals who are experiencing a significant mental health condition and/or 2 chronic medical conditions. Individuals who are involved with Assisted Outpatient Treatment Services are linked to ACT services or Ellis Medicine Intensive Case Management services via Schenectady County’s Office of Community Services. Mohawk Opportunities Inc. Transitional Services Program provides short term support and quick access to needed psychotropic medication for individuals with a history of mental illness who have recently been released from jail or prison or discharged from the hospital.

Through a grant provided by the New York State Office of Mental Health, our Transitional Manager works closely with release/discharge coordinators from local and state correctional facilities and hospitals to identify individuals who will be in need of mental health services upon their return to the community. The Transitional Manager is then able to help link these individuals to needed services in the community and provide them with a Medication Grant Card that will enable them to obtain needed medications while they await Medicaid eligibility determination or obtain third party health insurance.

Bethesda House and the Schenectady Community Action Program also provide case management services including: crisis case management, advocacy support, financial management, budgeting supports, linkage to health care services, and rapid rehousing and advocacy support for individuals at risk for homelessness. These services also seek to serve persons who have a difficulty engaging with traditional mental health services.

Schenectady County Crisis response resources include regional adult mobile crisis service and a child and adolescent mobile crisis, both operated by Northern Rivers Family Services. Parson’s launched an Adult Mobile Crisis program in 2015 to support adults in crisis in Rensselaer, Schenectady, Saratoga, Warren and Washington Counties. In 2015 the criteria for services was restricted to working with higher risk individuals who have recently been discharged from NYS psychiatric facilities, forensic mental health clients recently released from NYS correctional facilities, and individuals currently receiving Assisted Outpatient Treatment. In 2016 services expanded to the SMI population in general.

Alternative Living Group Inc. (ALG) is a not-for-profit organization that provides a wide range of services to individuals with intellectual and developmental disabilities. The Individuals Support Services Program includes independent living skills, training and supports to persons in their own homes. In addition, individuals in this program also receive a monthly rental subsidy which is based upon their income. The program currently has a capacity of 16.

The Medicaid Service Coordination Program provides linkage, advocacy and other supports to individuals residing in both community and residential settings. The program has a capacity of 225 and is unable to meet the needs of the community. The residential program has a variety of residential opportunities that are provided in the community. The programs are designed to encourage independence. In general, housing, supervision, skills training, transportation and recreational activities are provided. Respite Services, as needed, are available 24 hours a day, 7 days a week. This program has a capacity of 55 and is currently beyond the maximum level. Many persons in need are waitlisted. The Community Habilitation Program offers one to one
rehabilitative and support services to people in community-based settings. This program has a capacity of 49 and is currently beyond capacity.

Schenectady ARC operates several day habilitation programs which introduce participants to a wide array of fun, safe and enriching person-centered activities necessary for community-based living and employment. ARC also provides a wide array of services to support families of individuals with intellectual and developmental disabilities who reside at home. Medicaid Service Coordination provides assistance and advocacy to individuals and their families in identifying and accessing programs and activities necessary to achieve life goals. Schenectady ARC provides afterschool services to students with intellectual and developmental disabilities who reside in the Scotia-Glenville Central School District. Schenectady ARC’s residential programs provide varying levels of structure and support to help individuals with developmental disabilities ages 18 years and older to successfully live in the community.

Living Resources employment program provides employment services to individuals with disabilities. The Employment Services Program Staff help individuals explore what kinds of jobs they might like to do, find a job that matches their interests and abilities, learn the various job tasks, and maintain employment. Services are available to individuals who have been diagnosed with either a developmental disability or a brain injury. Residential services provide support to individuals living in a variety of group or individual settings. Staff support varies from 24/7 to as little as 2 hours per week based on the individual’s needs and abilities. Living Resources residential services operates ten residential programs with a capacity of fifty. The Service Coordination Department monitors all services received by any individual. The Service Coordinator ensure that the services meet the consumer’s needs or advocates to amend to replace services that enhance individuality, integration and independence.

Schenectady County is a community supported by committed programs with a strong collaborative cross systems network of service providers are poised to respond to existing gaps, barriers, and complex service challenges. Schenectady County may technically be geographically the second smallest county in Upstate New York. It serves a population of approximately 155,000 residents. Within the community there are several high risk/high need neighborhood areas, denoted by zip code, struggling with high unemployment, persistent poverty, housing and food insecurity issues, high rates of imposed violence and self-inflicted injury. The City of Schenectady has a significant number of residents in living in poverty, over 41.9% impacting children. Approximately 1/3 of the population receives Medicaid benefits. This high percentage contributes to the exacerbation of identified risks and places additional stress on existing resources.

The last community needs assessment in 2016 reported that between 2009 and 2013 Schenectady County had the highest percentage of low-income household, 22.5% as well as the lowest percentage of high income households, 22.4% compared to the surrounding Capital District Region. In addition, the City of Schenectady experienced a sharp rise in unemployment across 2009-2014, with a comparatively shallower recovery than the overall county. In relation to violent crime, reports in 2013 recorded 17 violent crimes per 1,000 residents within the City of Schenectady. It can be said that the situation is much the same and worsening.
Research demonstrates lower socio-economic status contributes to higher risk for mental illness. Some studies have indicated correlations between higher unemployment, poverty, and a lack of safe affordable housing accounts for more than 1/2 of community differences in psychiatric hospitalization rates. This is proven to be true given the number of visits to the crisis unit at Ellis Hospital increased by over 100% between 2015 and 2016.

The CDC reported that lower socio-economic status shapes exposure to psychosocial, environmental, environmental and biomedical risk factors that directly and indirectly affect mental health. The 2016 needs assessment reported that several neighborhoods in Schenectady County within the City of Schenectady have been identified as high risk and have shown indices of higher mental health admissions and higher rates for self-inflicted injuries. Schenectady is also ranked in the 3rd risk quartile for suicide mortality and 4th risk quartile for self-injury hospitalizations.

As the County of Community Services identified during planning activities for 2017 many of the service gaps and areas of need within the community are indicative of constellations of circumstances related to poverty, violence, trauma, and socio-economic insecurities. Individuals who engage in self-harming behaviors, or who engage in behaviors threatening to others have a difficult time maintaining housing and outpatient treatment engagement.

Many services are not accessible or available for those who cannot afford to pay out of pocket expenses or who are not covered by commercial insurance. Many find themselves on waitlists for supported housing, outpatient mental health care, or medication assisted treatment due to maximized resources, included limited number of prescribing practitioners. For others, the focus and energy expended on trying to meet basic needs supersedes the motivation to meet mental health and physical health care needs. For some, the established patterns noted are to not follow through with outpatient services and utilization Emergency Department services when the need breaches a threshold that is not necessarily a standard Emergency Department circumstance.

Other’s in the community struggle with access to services based on specific sets of social, emotional, and cognitive learning disabilities that undermine independent living functional abilities, but their unique needs do not fit well with current community residence supports available. For many fitting into the eligibility criteria and having demonstrable documentation to support eligible for services can cause delays in linkage that undermine follow through. This is a particular concern for providers who offer outreach to individuals who are homeless or have a short window of opportunity in which to access care.

As providers and recipients of OPWDD services adjust to changes in the system’s structure there has been noted concerns regarding increases in waitlists for respite services, funds for transportation, and an inability to accommodate the need for day respite spots. There is also a stated increase in reports of domestic violence and concerns regarding the capacity to manage behavioral problems both in terms of limited number of beds available in the S.T.A.R.T program, a significantly reduced number of psychiatrists’ currently providing services, and the need for additional clinical staff to manage the behavioral issues in a community based setting.
2018 Needs Assessment Report

PART A: Local Needs Assessment

1. Assessment of Mental Hygiene and Associated Issues

The last analysis of data in 2016 gathered during planning activities associated with multiple system transformation projects an estimated 19% of Schenectady County residents were diagnosed with a mental illness, 4% with a serious mental illness. While Schenectady County’s facilitated health insurance enrollment and other linkage to service initiatives has resulted in 90% of residents having health insurance coverage, the rate of Emergency Department visits and hospitalizations secondary to mental illness is generally higher than that of the rest of the state. In 2016 there were 5,275 crisis evaluations done. In 2017 there were approximately 4,915, 360 less or a 6.8% decrease. This small decrease may be attributed to having more peer and/or mobile crisis presence in the ED which has helped divert some of the ER visits. In identified high risk neighborhoods, predominantly inner city neighborhoods impacted by poverty, gang violence, food insecurities, housing insecurities, family and community trauma, substance abuse including heroin and fentanyl, and underground economics the rate of mental health crisis visits were up to 5xs higher for this population. High risk neighborhoods were also 2 to 6x’s higher in hospitalization and Emergency Department rates for self-inflicted injury compared to the rest of the state. Schenectady County is ranked in the 3rd risk quartile for suicide mortality and the 4th risk quartile for self-inflicted injury hospitalizations. With regard to substance use related indices, Schenectady County was shown to have a significantly higher rate of newborn drug related hospitalizations and overall higher substance use related hospitalizations with high risk neighborhoods demonstrating 5 to 11x’s more substance related emergency department visits and 2 to 4x higher hospitalizations rates. Specific to Opiate related trends, data shows a drop in Opiate related admissions, however, use of the Emergency Department is steadily overtaking hospitalization rates. Estimates indicate that approximately 4,000 residents 12 years of age and older identified as having a substance use disorder with 2,700 residents identified as needing but not receiving treatment.

Schenectady County is a community supported by committed programs with a strong collaborative cross systems network of service providers are poised to respond to existing gaps and barriers and complex service challenges. Schenectady County may technically be geographically the second smallest county in Upstate New York. It serves a population of 155,000 residents. With the community there are several high risk/high needs neighborhood
areas denoted by zip code, struggling with high unemployment, persistent poverty, housing and food insecurity issues, high rates of imposed violence and self-inflicted injury. There are many residents living in poverty, over 41% impacting children. Approximately one third of the population receives Medicaid benefits. This high percentage contributes to the exacerbation of identified risks and places additional stress on existing resources.

The last community needs assessment in 2016 reported that between 2009 and 2013 Schenectady County had the highest percentage of low income households, 22.4% as well as the lowest percentage of high income households, 22.4% compared to the surrounding Capital District Region. In addition, the City of Schenectady experienced a sharp rise in unemployment across 2009-2014, with comparatively shallower recovery than the overall county. In Schenectady County in 2016 there were 3,038 index crimes (murder, rape, robbery etc.) per 100,000 compared to the state average of 1,904 index crimes. While the rate is dropping some, most of this activity occurs within the city. Drug trafficking and gang violence are high contributors to this number.

The CDC reported that lower socio-economic-status shapes exposure to psychosocial, environmental and environmental-biomedical risk factors that directly or indirectly affect mental health. The 2016 needs assessment reported that several neighborhoods in Schenectady County and the City of Schenectady have been identified as high risk and have shown indices of higher mental health admissions and higher rates for self-injuries and hospitalizations.

As the County Office of Community Services identified during 2018 planning activities many services are not accessible or available to those who cannot afford to pay out of pocket expenses or who are not covered by commercial insurance. Many find themselves on wait lists for supported housing, community residences, outpatient mental health care or medication assisted treatment due to maximized resources, including fewer prescribing practitioners. For others, the focus and energy expended on trying to meet basic needs supersedes the motivation for mental health treatment and physical health care needs. For some, the established patterns noted are to not follow through with outpatient services and thus visits to Emergency Department services increase for issues that do not necessarily meet standard Emergency Department circumstances.

Others in the community struggle with access to services based on specific sets of social, emotional, and cognitive learning disabilities, but their unique needs do not fit well with current community residence supports available. For many, fitting into the eligibility criteria having demonstrable documentation to support eligibility can cause delays in linkage that undermine follow through. This is a particular concern for providers that offer outreach to individuals who are homeless or have a short window of opportunity in which to access care.
As providers and recipients of OPWDD services adjust to changes in the system’s structure there has been noted concerns regarding increases in waitlists for overnight respite services, day respite services and funds for transportation. There is also a stated need for more certified apartments and more services for parents who are trying to manage the behavioral problems both in terms of limited available beds and a dearth of psychiatrists. There is also a need for additional clinical staff to manage the behavioral issues in the community. Hiring and maintaining staff continues to be a significant issue. Many potential staff persons will state that they can earn more money at McDonald’s than in working as staff in a residential setting where behavioral issues are often challenging and at times, dangerous.

Analysis of Service Needs and Gaps

BEHAVIORAL HEALTH SERVICES FOR ADULTS

The capacity of existing resources available to meet identified needs, including services accessed outside the funded and certified systems, is comprised of licensed clinical provider agencies, community service agencies, and local government agencies working collaboratively to provide a broad array of services. Ellis Hospital, a 438 bed community teaching hospital serves as the county’s one acute care hospital. The county is also served by a single federally qualified health center, Hometown Health Center, and a specialty hospital, Sunnyview Rehabilitation Hospital, a member of an Albany based system.

Ellis Medicine operates 3 campuses, provides teaching residencies in Family Medicine and General Dentistry and includes a skilled nursing facility, women’s health center, and an emergent care facility which provides urgent care services. Ellis Medicine also provides the only local adult and adolescent inpatient psychiatric unit and crisis service. In addition to hospital based care, Ellis Medicine operates an adult outpatient mental health service, a child/adolescent outpatient mental health clinic, a PROS program and a Peer Services program. Ellis Medicine also operates a number of primary and specialty care medical practices.

- Ellis Medicine’s Psychiatric Inpatient Unit for adults has a capacity of 36 and had 1,253 admissions in 2016 and 1,354 admissions in 2017. Crisis services provided 5,275 evaluations in 2016 and approximately 4,915 evaluations done in 2017.
- At the adult outpatient clinic there were 18,484 visits in 2016. This number reflects the loss of two Psychiatrists. The wait list was 127. In 2017 there were over 24,673 visits. The wait list was 299 but over the course of the year 2 Psychiatrists had been hired.
- The PROS program served 253 clients in 2016 and in 2017 served 224. The decrease in numbers served in 2017 is accountable to the loss of prescribers in that period of time.
• In 2017 the Intensive Case Management program served 130 clients and generated 1228 units of service client visits.

• Ellis Medicine’s Peer Service program provided 1,267 units of service in the Emergency Department in 2017. They also co-facilitated 580 groups on the inpatient unit and facilitated or co-facilitated 126 groups in the community.

The New York State Capital District Center provides inpatient psychiatric care to patients whose symptoms have not stabilized with brief or short term in a community hospital. Schenectady County has a 24 bed allocation with an average census of 22 in 2017.

The CDPC Schenectady Community Support Center provides services to adults with a serious mental illness. In 2016 there were 36 admissions and 71 discharges. The number of screenings was 44. There were 3 part time prescribers and 1 full time prescriber. There were a total of 8 clinicians. In 2016, 335 persons were served. The number of admissions in 2017 was 101, with 53 discharges and 131 screenings. This rather significant increase in admissions could be attributed to the addition of another full time prescriber and the need to accept people who were on the wait list for the Ellis Medicine Mental Health Clinic. However, the number of clinicians decreased to 6. Two vacancies are yet to be filled by CDPC.

Assisted Community Treatment Services (ACT) is operated by Mohawk Opportunities, Inc. and provides community based psychiatric mental health services and intensive case management services to an SMI population who are not able to engage in traditional outpatient care modalities. In 2016 the capacity was for 28 individuals and maintained full capacity throughout the year. The same can be said for 2017 maintaining full utilization.

BEHAVIORAL HEALTH SERVICES FOR YOUTH

Ellis Hospital has the only adolescent inpatient program in the area other than Four Winds which is a for-profit psychiatric hospital in Saratoga. At Ellis hospital a NYS certified school program is conducted on site. Ellis has a capacity of unit bed capacity of 16 beds. There were 571 admissions in 2017 and 566 discharges. The average length of stay was 7.41 days.

The Ellis Adolescent Outpatient Clinic served an average of 528 individuals with 381 visits per month. The program serves youth between the ages of 4.5 and 18. Services include psychiatric evaluations, medication management, individual, group, and family therapies. There are currently 1.4 prescribers and 2.9 clinicians on staff.

The Behavioral Health Center (BHC) serves adults, children and families. In 2016 BHC admitted 450 persons and discharged 834. The average length of stay was 15.14 months. In 2017 519 were admitted and 609 were discharged. The average length of stay was 33.6 months.

A significant issue facing the children’s clinical services and family services is the frequency of staff turnover in some agencies thus disrupting an opportunity for a long term therapeutic
relationship. Children as well as families experience frustration when having to begin work with a new person too often. In general this issue faces many agencies in the community. Since the unbundling of waiver services this has been particularly true as these services have not been readily available for Waiver families. There is some improvement occurring since Northern Rivers is contracting out the service supports for individual care coordinators who provide skill building, recreational respite, crisis response, intensive home services and family support services.

The IFEP program continues to have 3 spots designated for those identified through SPOA. The wait list in 2017 was generally 7-10 families. Additional slots would be beneficial in serving the intensive needs of our youth. IFEP is the most in-home family program that we have access to through SPOA at this time.

The Recreational Respite program gained spots in 2017. The wait list is currently 18 while 17 are receiving services. This is an improvement since in 2016 there were 37 children on the wait list.

A wait list exists for clinical services at both Behavioral Health outpatient services and the Ellis Child and Adolescent clinic.

Regarding waiver services the wait list decreased from 21 in 2016 and now stands at 8. The program has the capacity to serve 24.

All Schenectady County youth who are eligible and receiving Medicaid are being linked with Care Management services through the three identified Health Homes serving Schenectady County. These services have helped our families gain access to services earlier and divert many from reaching crisis type situations.

PRIMARY CARE AND BEHAVIORAL HEALTH

Hometown Health Center, a federally qualified health center, offers comprehensive primary care services along with mental health care to children over the age of 5 and adults. The mental health component is designed to be a bridge service, helping clients access to care quickly until a longer term plan is coordinated. Hometown Health has also started to provide counseling services within the Schenectady City schools. In mid-year 2017 a new Medical Director was hired. As a result persons being released from the jail need to accept a primary care physician at Hometown Health in order to be prescribed psychotropic medications. Because persons who are being released from jail still only receive a one week supply or script for psychiatric meds many individuals ‘fall through the cracks’ due to the long wait to see a prescriber at the Ellis Mental Health Clinic in particular.

SERVICE GAPS WITHIN THE CORRECTIONAL SYSTEM

Along these lines, efforts to gain more services within and without the jail have experienced roadblocks to progress. In addition to the medication issue there is a great need for transitional
case managers for inmates being released into the community. Without assistance many of those being released into the community are unable to connect with needed services. Most if not all case management agencies cannot provide services within the jail because the agencies cannot get reimbursed for these services. The need to engage with a case manager prior to release is an essential component in reducing recidivism and or hospitalization especially for those with serious mental illnesses or co-occurring disorders.

SUBSTANCE ABUSE SERVICES

New Choices Recovery Center provides community based residential, rehabilitation and outpatient services for individuals in recovery from substance use and co-occurring disorders. The combined outpatient programs conducted 1182 screenings and admitted 1062. In 2017 the number decreased slightly to 1,151 screenings and 953 admissions. In general, the New Choices 3 residential programs for men had an occupancy rate of 85% while the single women’s residence rate was 90%. In 2017 the occupancy rate for men increased to 91%. The women’s residence remained the same. There has been a stated need for more residential services for woman.

Schenectady County like most counties in the state is facing an increase in Opioid addictions. The county is taking on numerous initiatives to stem the tide of substance use and addiction and in particular, the Opioid crisis.

Beginning in 2017 the Dual Recovery Task Force was re-established. The membership includes many agencies and peers working collaboratively to address the concerns faced by the community at large. The purpose of this group is to identify needs and barriers within the system in order to meet the needs of those with co-occurring disorders. A Recovery Celebration Day was held in the fall of 2017. It was a successful and well attended event for the community.

Also in 2017 New Choices Recovery Center gained funding for a Substance Abuse Prevention Program. This program is building the capacity to enhance prevention efforts so that they are integrated throughout all systems in Schenectady County. The program empowers youth to engage in prevention efforts, delivers numerous evidenced based curriculums and programs to educate the public on substance abuse with and for all age groups and utilizes multi-media to increase public awareness.

Finally, the Office of Community Services and the Public Health Department are working collaboratively in addressing the Opioid crisis in the county. Collecting accurate data on the number of overdoses in the county has been difficult to achieve as oftentimes the cause of death is listed as cardiac arrest or other causes. In addition, the Substance Abuse Coalition was restarted toward the end of 2017. Within the county jail the prospect of administering Vivitrol for heroin addiction is being explored. Significant initiatives are in process with the Schenectady
Police Department. There is strong support for bringing in new criminal justice models to Schenectady including LEAD and a Schenectady version of the Chatham Cares 4 U. COTI is already present in Schenectady.

Rehabilitation Support Services (RSS) has a scattered site apartment program dedicated to dually diagnosed (MH and SA) individuals. There are 12 beds in this program and the rate of occupancy is consistently 100% with an on-going list of 15-20 persons waiting for admission. The need for more beds for this population is great.

HOUSING

Mohawk Opportunities has 5 Community Residences that in 2016 were virtually at capacity with a total of 9 persons on the waiting list. In 2017 this number decreased to 4 persons on the list. The county Adult SPOA Coordinator has diligently created more movement in the system. However the 8 Priority Long-Term Stay beds remained vacant in both 2016 and 2017 due to the restricted nature of assigning these beds. The supported housing programs remain overwhelmed with long wait lists. In 2016 Mohawk Opportunities there were 52 individuals on the list. In 2017 the wait list increased to 60 Individuals waiting for a bed. Likewise, in 2016 RSS had a wait list of 25 but in 2017 the wait list increased to 45. These numbers underscore the need for more supported housing in Schenectady. The CDPC Union Street residence also has a 100% occupancy rate most of the time.

In addition, the Schenectady YMCA operates a 25 bed transitional housing program, an 8 bed dual diagnosis unit and a 15 bed supported housing program. Similar to other housing programs the YMCA is at capacity no less than 95% of the time.

The need for more supported housing beds is great. In general the need for affordable safe housing in Schenectady continues to rise. On a more positive note the Joseph Allen apartments opened in the fall of 2017. Sponsored by DePaul House and SCAP this 50 bed apartment building has 25 units for persons with mental health diagnoses and 25 units for the low income population. However, these beds were filled rapidly and are now at capacity.

Other housing programs not under the office of OCS in Schenectady include:

- The Community Action Permanent Housing Program
- Schenectady County Community Action Program-Shelter Plus Care
- Schenectady Community Action Program Solutions in Supported Housing
- Schenectady Community Action Program-sojourn House for Women
- Bethesda House Beacon Residential Program-Lighthouse
- The YMCA
- The YWCA-Rosa House
The City Mission Transitional Apartment program

Shelter and Crisis housing is available at:
• the City Mission’s 35 bed Women and Children’s Shelter
• Schenectady’s city Mission’s 76 bed men’s shelter
• DSS emergency housing
• Bethesda House
• Veteran’s Emergency bed program

CASE MANAGEMENT

Access to care coordination services is managed through Schenectady County’s Health Home, Care Central for Medicaid or Medicaid eligible individuals who are experiencing a significant mental health condition and/or 2 chronic medical conditions. Individuals who are involved with Assisted Outpatient Treatment services are linked to the ACT team or Ellis Medicine’s ICM services via Schenectady County’s Office of Community Services Adult SPOA Coordinator.

Mohawk Opportunities, Inc. Transitional Services Program provides short term support and quick access to needed psychotropic medications through the OMH Medicaid Grant Program for those who have a history of mental illness and who have recently been released from jail, prison or discharged from the hospital. These individuals are provided with a Medication Grant Card until Medicaid eligibility is determined or obtain third party health insurance.

Bethesda House continues to increase its ability to serve the homeless, many of whom are experiencing mental illnesses as well. The Schenectady Community Action program along with Bethesda House case management services include: crisis case management, advocacy support, financial management, budgeting supports, linkage to health care services, and rapid re-housing for individuals at risk for homelessness. These services also seek to serve persons who have difficulty in engaging with traditional mental health services.

CRISIS SERVICES

Crisis services for Schenectady County include:

• The Adult Mobile Crisis Team (Regional)
• The Children’s Mobile Crisis Team (Regional)
• Ellis Medicine’s Crisis Hotline and Emergency Services
• Samaritan’s Crisis Hotline (Family and Children’s Services of the Capital Region)
• DSS—After Hours Emergency Housing
• Paramedic/Ambulance Services
• Equinox Domestic Violence hotline

In addition state-wide hotlines are:
• 9-1-1
• The Combat Heroin hotline
• Substance Abuse hotline
• Child Abuse hotline
• Unplanned pregnancy hotline
• Suicide Prevention hotline
• Trevor Lifeline
• Lifeline for Vets

VOC-ED

The Ellis Medicine PROS program provides vocational services through education and support for seeking and gaining employment or educational opportunities in the community. Likewise, Northeast Career Planning that has a contract with OCS provides similar opportunities specifically to those with mental health disorders. In addition, New Directions is a supported employment program that assists individuals in choosing, obtaining and maintaining competitive employment. A wide variety of job types are chosen by individuals including clerk positions, and jobs in maintenance, customer service and warehousing. H.E.L.P. is a crew model supported work program that holds numerous state, city and private contracts for commercial cleaning and landscape maintenance. The program is operated by RSS employees and individuals with mental illness. This program has the capacity to serve 20 individuals.

DEVELOPMENTAL DISABILITIES

Alternative Living Group, Inc. is a not-for-profit organization that provides a wide range of services to individuals with intellectual and developmental disabilities. The Individuals Support Service Program includes independent living skills, training, and supports to people in their own homes. In addition, individuals in this program also receive a monthly rental subsidy which is based on income. The program currently has a capacity of 27.

The ALG Medicaid Service Coordination Program provides linkages, advocacy and supports to individuals living in community and residential settings. The program has a capacity of 260 and is challenged to meet the needs of the community. The residential program has a variety of residential opportunities that are provided in the community. The programs are designed to encourage independence. In general, housing, supervision, skill training, transportation and recreational activities are provided. In 2017 ALG will be opening 2 supervised double occupancy apartment. Respite services, as needed, are available 24/7. This program has the capacity of 55 and is currently beyond the maximum level with many persons in need on the wait list. Likewise, the Community Rehabilitation Program offers one to one rehabilitative and support services to people in community based settings. This program has a capacity of 87 and is currently serving 65 families.
Schenectady ARC is in its 64th year of operations. It has several day rehabilitation programs which introduce participants to a wide array of fun, safe and enriching person-centered activities necessary for community-based living and employment. The residential program offers housing at varying levels of structure and support. There are 21 group homes in the service area. Medicaid Service Coordination provides assistance and advocacy to individuals and their families in identifying and accessing programs and activities necessary to achieve life goals. The agency also offers Service Navigation which assists individuals in satisfying eligibility and funding requirements. It has several rehabilitation services, family support services and a mental health clinic licensed by OPWDD. Schenectady ARC provides after school services to students with intellectual and developmental disabilities who reside in the Scotia-Glenville School District. ARC’s residential programs provide varying levels of structure and support to help individuals 18 years and older to successfully live in the community.

Living Resources primary location provides day habilitation and access to nursing, clinical and support services to individuals with developmental and acquired brain injuries. It provides deaf and interpreter services to the Capital Region’s deaf community. Through OPWDD funding it provides employment services through the Pathways to Employment program. The employment services program helps individuals with disabilities explore what kind of jobs that they might like to do and seek a job that matches their interests and abilities. Living Resources operates 66 residential programs with a capacity of 283. Staff support varies from 24/7 to as little as two hours based on need. The Service Coordination Department monitors all services received by individuals.

Region-wide OPWDD has lost many Psychiatrists over the past two years in particular. The Center for Disability Services has no prescribers for psychotropic medications needed by those with mental illness. Additionally, the need for housing and respite services is great as persons continue to be released from state facilities back to their county of origin.

OTHER RESOURCES FOR THE DEVELOPMENTALLY DISABLED

- The Center for Disability Services is the primary provider of comprehensive medical services in the region. It also includes many specialized services including respite services, both adult and children services, family services, vocational programs and opportunities for employment. There are also camping experiences offered through the center.
- Family and Child Services of Schenectady, Inc.
- Wildwood Programs, Inc.
- Catholic Charities

Catholic Charities is seeking sites in Schenectady for two supported double occupancy apartments for individuals with MH and ID diagnoses. These individuals will have additional support from the HARP program. OPWDD continues to screen and make admissions for those in
emergency need. NY START is actively involved in establishing resources in Schenectady County and residents will soon have access to this program. Staffing issues at most agencies are improving due to a 2% COLA in January of 2018 and is due to increase an additional 3% later in the year. The greatest identified needs in the county are for certified housing and respite services.
SCHENECTADY COUNTY PLAN 2019-2020

EXECUTIVE SUMMARY

In the last report data from a 2016 community assessment it was indicated that Schenectady County faces many challenges. In 2018 it remains a county in great need. The population of the county is 155,565. The median income is $62,514 which is the second lowest in the 4 county-region (Albany, Rensselaer, Saratoga and Schenectady). According to the US Census Bureau (data from 2017 to July of 2018), despite being the smallest of the 4 counties the poverty rate is the highest in the region at 12.9%. 39,000 people were receiving Medicaid in 2018 which is 25% of the county’s population. Though difficult to track an exact number, many persons who receive social services are from out of the county, primarily from NYC per the Department of Social Services. The median income is slightly more than Albany County at $62,154. Home values are also the lowest in the region at $164,400. Rensselaer is at $183,400; Albany at $214,400 and Saratoga at $243,600.

Affordable housing is on the decrease in Schenectady County. Much of this has to do with the incremental rise in rents due to the nearby Rivers Casino. While recently there has been some development in high risk neighborhoods, i.e. the Joseph Allen Apartments, this apartment building is filled to capacity and has a long wait list. There are many apartment buildings under construction. All of them are noted to be luxury apartments and thus are not affordable for those in need. The final report to HUD for the period of September 1, 2017- August 31st, 2018 indicated that there were 605 referrals for homeless families and singles. By the end of the funding year there were still 293 homeless persons. The numbers housed was 164 for singles and 148 for families.
Housing specifically meant for those with mental illness have significant wait lists. Within the city of Schenectady several neighborhoods are considered at high risk. The crime index rate overall remained high from 2017 to September of 2018 at 2,965 per 100,000, somewhat lower than 2016 but still higher than the 4 county region and NYS in general. For NYS the rate is 1,987.5 per 100,000. (DCJS 2017- July 2018). However, According to the chief of police, data-driven policing is helping them to focus resources around the city thus contributing to the lowering the crime rate.

In the most recent data submitted to DOH Schenectady County continues to have one of the lowest health rankings for New York State ranking 53 out of a possible 62. This is significantly lower than the identified 4 county region: Saratoga at #4, Albany at # 22 and Rensselaer at #30. The Schenectady Healthy Community Coalition’s most recent data is reflected in data from 2016. The next census of 2019-2024 will hopefully show improvements in the overall health of the county. Included in the Prevention Agenda are several community coalitions that collaborate in order to address salient concerns: The Opioid Task Force, the Substance Abuse Coalition, the Suicide Prevention Coalition, and the Schenectady Healthy Community Coalition among others.

Homelessness is also prevalent in the community. On a more positive note the number of suicides in the county continues to decrease. In 2016 there were 22 persons who died by suicide. In 2017 that number decreased to 15, and the number of deaths by suicide in 2018 was 11. Much of this effort has been due to the collaborative efforts of the community at the Children at Risk Committee and the Adults at Risk Committee where persons who are at high risk are monitored closely. The Office of Community Services facilitates these committees.
Analysis of Service Needs and Gaps

BEHAVIORAL HEALTH SERVICES FOR ADULTS

Generally the existing clinical services for mental health remain overly saturated though some progress was made in 2018. The need for services continues to increase. The Crisis Unit at Ellis Hospital had 4,915 evaluations in 2017 which decreased to 4,456 in 2018. Much of this decrease can be attributed to the increase of Peer Services across the board. Ellis Medicine also has an adult inpatient unit with a 36 bed capacity. The unit saw fewer admissions in 2018 at 1,296, a decrease of 58 admits. The Adolescent Unit had 464 admissions down from 517 in 2017.

The wait lists for clinical services in 2018 at the Ellis Medicine Outpatient Clinic decreased from a high of 299 in 2017 to 130 in 2018. This was due to the hiring of another psychiatrist. The number of visits in 2017 was 24,673 and increased to 27,673 in 2018. The Care Coordination program has seen a dramatic increase in the need for services. In 2017 the total number of units of service was 1,228, but in 2018 rose to 2,438, a 100% increase. This is due to the increase need for services for HH+ clients. The PROS program admitted 91 persons in 2018 and remains under capacity. The ACT team in 2017 and 2018 remained at 100% capacity. The Schenectady Community Support Center (CDPC) admitted 101 persons in 2017 which decreased to 69 in 2018. Positions that were vacated in 2018 are not scheduled to be filled by OMH. The Northern Rivers Behavioral Health Services (BHC) had a wait list of 130 in 2017 which increased to 140 in 2018. This clinic serves adults, children and families. BHC generally has fairly consistent turnover which disrupts treatment for those persons who are treatment. Persons who are referred
from the inpatient unit and who have private insurances have a great deal of difficulty finding providers with openings for new patients.

A major change in Schenectady was the construction of 3 new facilities for behavioral health services in mid to late 2018. The Ellis Medicine Outpatient Clinic, the Schenectady Community Support Center and New Choices Recovery Center all relocated to newly built or renovated buildings. These much needed clinical services are now located in the Hamilton Hill neighborhood and enhances the environment in this part of the city. The new locations are also located within a ½ mile of each other and are on the same bus line, making access easier for those in need of services.

Bethesda House of Schenectady is a non-profit charitable organization that has provided mental health services for those who cannot engage in traditional clinic treatment. Many of the persons they serve are homeless and are reluctant to go elsewhere. There is a team of social workers and case managers that assist their clients. In 2018 two social workers were added to the mental health component. Plans were also in the making for increasing services, including transportation for 2019.

BEHAVIORAL HEALTH SERVICES FOR YOUTH

The Ellis Medicine Adolescent Clinic had an average wait list of 57. Admissions to the inpatient unit decreased from 528 in 2017 to 464 in 2018. The Adolescent Unit has the capacity of 16 beds. When these beds are at capacity often youth have to wait in the crisis unit, sometimes for days, until another bed can be found in the region. The Four Winds Hospital, a for-profit facility located in nearby Saratoga County has children and adolescent residential treatment and this hospital as well is generally at capacity.
Children’s SPOA services in 2017 recorded a wait list for waiver services at 8. For IFEP the wait list included 7-10 families, and for recreational respite the wait list was at 18. The year of 2018 saw similar data and the wait list was slightly decreased for these services.

Behavioral Health Clinic/Northern Rivers serves primarily children and families. In 2018 adult clinical services were made available. The wait list for appointments was at 130 in 2017 and then increased to 140 in 2018.

PRIMARY CARE AND BEHAVIORAL HEALTH

Hometown Health Center, a federally qualified health center, offers comprehensive care services along with mental health care for adults. The mental health component is designed to be a bridge service helping clients access care quickly until a longer term plan is coordinated. Many referrals for the mental health service come from the Schenectady County jail or the state prison system depending on the mental health diagnosis. Persons who wish to access this service need to be assigned to a primary care provider prior to receiving the mental health service.

SUBSTANCE USE SERVICES

New Choices Recovery Center provides community based residential, rehabilitation and outpatient services for individuals in recovery from substance use and co-occurring disorders. The combined outpatient programs admitted 1,183 persons in 2017. In 2018 there were 1,418 admissions, a 20% increase. In tracking the treatment percentage of primary substances the 2018 numbers indicate that 32% were treated for alcohol, 24% for heroin plus 5% for other opiates equaling 29%, 23% for marijuana, and 7% for crack/cocaine.

Under the auspices of New Choices there are 3 residences for men which in 2018 had 88.7% occupancy. The residence for women was occupied 90% of the time. In addition the ‘Shelter
Plus’ Care Program has a capacity for 59 units and has an occupancy rate of 100%. The Medicaid Re-Design Team utilization rate was 105% in 2018. New Choices has also implemented the Community and School Based Prevention Service. This program has successfully expanded services and delivers evidenced based prevention services. Included in the programming are ‘Too Good for Drugs’, Life Skills, Active Parenting and the PAX Good Behavior Game. In 2018 the Prevention Team had numerous community events promoting substance use awareness and education.

St. Peter’s Addiction Recovery Center (SPARC) outpatient clinic had no waiting list in 2018 and was able to meet with persons within 5 days of first contact. Conifer Park, a for-profit agency has an inpatient rehabilitation program and an outpatient clinic.

The Office of Community Services in partnership with Public Health work collaboratively to address the opioid crisis in the community. In 2017 New Choices and Public Health tracked the number of persons admitted for opioid treatment in certified programs in the county. The number of persons in treatment at that time and who were admitted for all opioids (incl. heroin) was 1,022. In the first two quarters of 2018 that number was 474. Anecdotally the trend is on a par with the previous year. Narcan was administered by EMS 237 times in 2017. In the first 3 quarters of 2018 Narcan was administered by EMS 128 times.

Dealing with the heroin/opiate crisis is a priority for the Schenectady County Office of Community Services and several initiatives were initiated in 2018 to address the opioid crisis in Schenectady County. Mass distribution of flyers and brochures educating the public about a toll free 24/7 helpline for individuals or family members dealing with addictions in partnership with Catholic Charities occurred. In addition a social media campaign using material from the CDC Rx Awareness campaign was initiated. Planning with the Schenectady City Police Department was initiated to develop a police response to
individuals with opiate addictions. Additionally, a partnership with Ellis Hospital and Capital Care was
developed to train additional physicians in the use of suboxone (a total of 40 additional physicians were
trained). In collaboration with the Schenectady Department of Health monthly Narcan Trainings were
held for county employees, community agencies and interested citizens. Through an application for
DSRIP funding the overall capacity for CERPAs was increased by 6 in the substance abuse provider
system and planning was started for placing a peer in the Ellis emergency department to assist with
individuals with opiate and other substance abuse disorders. Planning was also initiated with Ellis hospital
with goal of developing the capacity for the ER to prescribe and write scripts for suboxone. The Office of
Community Services also broadly distributed information to the community educating the public about
the two Prescription Drug Take Back Days held in 2018 which included 25,000 pamphlets distributed at
local pharmacies. In partnership with local physicians a campaign was also developed to distribute
information on safe prescribing guidelines for opiates to Schenectady Doctors.

SERVICE GAPS WITHIN THE CORRECTIONAL SYSTEM

Individuals being released from the county jail are only given a 1 week script or meds of
psychotropic medications. Many individuals ‘fall through the cracks’ due to the long wait to see
a psychiatrist at the Ellis Mental Health Clinic. They more often than not end up waiting for 2
months until that time.

The Medicaid Grant Case Manager position at the jail was vacant towards the end of last year. In
addition 2 social workers also left leaving those in need of mental health services. Though one
position was filled as part-time, the nursing staff in the medical unit had to assume extra duties.
Case management services continued to be at a premium as those case managers serving the
mental health population in the community could not provide services in the jail due to a lack of
billable revenue. Plans for increasing services were in the making towards the end of the year and a major grant from OASAS was awarded to institute substance abuse treatment in the jail. The total number of incarcerated individuals according to Medicaid records in 2018 was 1,264. 179 of these inmates had a mental illness, 204 have a substance use disorder, and 189 had dual diagnoses. The county continues to be challenged by SPOA referrals from the state correctional facilities for housing within the mental health system.

HOUSING FOR MENTAL HEALTH

The certified housing programs in Schenectady are completely filled most all of the time. Each program has waiting lists. Mohawk Opportunities Community Residential programs have a wait list of 5, the CAP apartments 4, and the Supported Housing programs have a list of 87. In 2017 that number was 60. This reflects an increase of over 60%. The wait list for RSS SH is 59, slightly less than in 2017. Both Mohawk Opportunities and RSS have open staff positions that they are struggling to fill. RSS has 12 open positions and Mohawk has 9. Most of these openings are in the residential programs. Staff recruitment is worsening, having much to do with low salaries that do not correlate with the responsibilities of the jobs. The Union St. Residence (CDPC) is virtually occupied 100% of the time. As previously stated the OMH long stay beds have several openings but due to the restrictions for usage they are difficult to fill. Persons who are discharged from CDPC are generally unable to live independently. This can be said for the daisy chain transition from the CDPC CR as well. There were 378 SPOA referrals in 2018, increasing from 2017 when 131 referrals were made. This reflects an increase of over 100%. The housing situation for those with mental illness is at a critical level. Those with AOT designations numbered 26 in 2017 which increased to 33 in 2018. Most programs not under the auspices of OCS also have waiting lists. The Joseph Allen apartments also have dedicated apartments for
persons with mental illness. The YMCA has dedicated apartments funded through OMH are at 100% capacity. There are long waiting lists for these units as well.

CASE MANAGEMENT

Capital Region Health Connections is the Health Home operated under St. Peter’s hospital. Case management referrals are down-streamed to providers in Schenectady County, namely Mohawk Opportunities, RSS and Ellis ICM program. Currently at Mohawk there are 5 care managers, 1 of whom is dedicated to HH+. RSS has 6 care managers, 3 who are assigned to the River St. Co-occurring disorders apartment program, and 3 to supported housing. With the inception of the Health Homes under DOH a major burden is placed on care coordinators who have inherited inordinate documentation requirements for intake and evaluations that often take 2-4 hours to complete. This reality essentially limits the amount of actual face time they might have with their clients, especially when caseloads increase as they often do.

CRISIS SERVICES

Other than the Ellis Medicine ED/Crisis Unit the region also shares an adult mobile crisis team. When called they will make immediate phone contact with the person requesting assistance to assess the situation. They then dispatch the team to the individual who is requesting the service or by family who are likewise requesting a visit. The response time is between 1-2 hours for a home or community based visit. In 2017 the mobile crisis team saw 216 individuals in the community. The number of visits in 2018 increased to 346. A 25% increase. Other crisis services include the Children’s Mobile Crisis Unit, the Ellis crisis hotline, DSS after-hours emergency housing, and the Equinox domestic violence hotline.

DEVELOPMENTAL DISABILITIES
Recently OPWDD released data reports for all counties in the state. In Schenectady County the number of persons in the community remained relatively stable from 2017-2018 for residential housing and respite services. Day habilitation and community habilitation services increased somewhat likely due to de-institutionalization but does not reflect a critical need. There are a variety of agencies in the county that serve persons with IDD but most services are shared regionally. Anecdotally there is a high rate of turnover in residential programs. The primary area of concern is for those persons with dual diagnosis, i.e. IDD and Mental Health. Many of these persons are also using substances. There is a dearth of psychiatric services for this population and most psychiatrists specialized in treating mental health are not adept at treating persons with IDD. Even though the number of those with co-occurring disorders increased from 512 in 2017 to 527 in 2018, which is not a significant change, though any increase is problematic to due to psychiatric shortages. This is a major deficit facing most counties since overall there is a shortage of psychiatrists nation-wide and those with IDD are often not able to be treated in traditional settings.