2017
Local Services Plan
For Mental Hygiene Services

Rockland County Dept of Mental Health
August 16, 2016
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Mental Health Rockland County has many challenges related to the provision of certified and non-certified housing supports for individuals with serious mental illnesses. These challenges are varied but rest in the limited number of affordable housing opportunities and no shelter system. Rockland County continues to work effectively to help individuals in the (8) impacted adult homes to secure community based residential options. There has been extended efforts to help place individuals leaving long-term stay psychiatric hospitals, residential treatment facilities, and county jail / state prison system. Rockland County does not have secure, supportive step down residential sites/supports for persons who were receiving intensive, site based supports and who will continue to have complex needs in the community. The newly initiated OMH funded Outreach wrap around supports will provide assistance with the housing and services needs of long-term hospitalized individuals. There are no such supports for the other limited certificated and uncertificated residential opportunities for individuals with co-occurring mental health issues and IDD and/or substance use disorders. Another challenge is the limited number of supported housing subsides and other non-certificated housing options. The cost of rental housing is Rockland County is prohibitive to agency providers for both new subsides and for lease renewals. There is a Partial Hospital program in Rockland County. People needing a PHP travel across the river to adjacent counties or to the next state. There is a need for IOP/PHP level of care in Rockland County. Individuals discharged from inpatient settings are frequently needing a higher level of care than a PROS or clinic can provide. A higher level of care setting would also lessen the number of inpatient psychiatric admissions as well as shorten the length of hospital stay. There are a limited number of geriatricians in Rockland County including the provision of psychiatric services. As individuals across the mental hygiene systems of care move toward increasing community inclusion, the need for integration and collaboration between public and private entities is more salient than ever.

Integration between behavioral health and general health services is resulting in care management/coordination reaching beyond traditional providers to secure supports and services for people with disabilities. Care Coordination and sharing of resources is increasing between MH, DD and CD entities. The latest challenge is to incorporate entities from the health system at large. There are increases in diversion programs, reentry treatment and housing needs through the criminal justice system. There will be increasing demands for public transportation and para-transportation as individuals with disabilities rely less on agency based transportation. Family advocacy and peer workforce expansion are bringing additional entities into the system of care. Employment opportunities for individuals with serious mental illness would support their recovery and community tenure. Workforce recruitment and retention are increasingly significant issues for agencies and for individuals with disabilities. Salient issues are low salaries, debate to raise the minimum wage without additional funding from OMH, impact of overtime on agency budgets and Justice Center accountability concerns for staff. Rockland County is culturally diverse, with distinct populations such as Orthodox and Hassidic, Caribbean-American, and undocumented immigrants who have distinct treatment and service needs. There are very limited number of geriatricians in Rockland County to accommodate the overflow from the Emergency Departments. There have been many obstacles and regulations that have prevented this. There are a limited number of geriatricians in Rockland County including the provision of psychiatric services. As individuals across the mental hygiene systems of care move toward increasing community inclusion, the need for integration and collaboration between public and private entities is more salient than ever.
also limited in the County. As a result of the epidemic suboxone and vivitol are becoming longer term maintenance treatment similar to methadone, which will require additional recovery support services. There is also a need to utilize vivitrol injections in the Rockland County Jail prior to release to prevent relapse upon returning into community. Due to the Heroin/Opiate Epidemic large number of inmates come into the jail in withdrawal from opiates. Individuals in Crisis with co-occurring disorders to all age groups to hospital diversion behavioral health treatment opportunities like PHP. There are limited opportunities in the County for outpatient and inpatient treatment with clinical staff trained to treat serious and persistent co-occurring mental health and substance use issues. Additional recovery support services similar to case management will be necessary to prevent relapse. Due to the heroin/prescription drug epidemic there is also a demand for Recovery support services for parents and spouses who have family members suffering from an addiction which are usually accessed through prevention providers. Families are frightened by the possibility of overdose and need support and education. There is a need for Family Support Navigators and Recovery Coaches to assist families in accessing treatment services and insurance benefits. Rockland County needs a Recovery Community Center to provide recovery support services to families and individuals struggling with the chronic disease of addiction to find long-term sustained recovery. The biggest gap in addiction treatment is the lack of recovery support services following primary treatment. Also, Prevention Counseling can only provide services to those 21 years and under. It would be helpful to raise the age to 25 or all age groups to accommodate the need for services. Rockland County is culturally diverse with various populations such as Orthodox, Hasidic, Haitian and undocumented immigrants from South America. There is a high need for Creole and Spanish speaking Substance Abuse Services in the County. There is also a moderate need for Yiddish and Hebrew Substance Abuse Services. It is difficult to recruit counselors in the various substance agencies with these language skills. There needs to be an incentive to attract people who want to work in the field of chemical dependency. Many consumers only receive individual therapy at minimum when group would be the treatment of choice. Rockland County does not have a shelter system for homeless individuals, many who are impacted by substance use disorders. There are limited housing opportunities for individuals returning home from prison through Re-Entry. There continues to be a need for safe, sober housing to support individuals in the early stages of recovery from substance use disorder. There is only one facility in the County that provides a Community Residence Program for men and women and a small Supportive Living Program. Employment opportunities for the chemically dependent population are limited especially if there are previous felony convictions which can be an issue in recovery from substance use disorder. Child and Adolescent Population Rockland County is geographically unique in that it is a small county that is bordered by New Jersey to the south, the Hudson River to the east and a large, mountainous tract of parkland to the north. These natural and political boundaries together act to make accessing regional mental health resources more difficult than may be expected for a densely-populated suburb in the Metro-NY area. In addition to geographical obstacles to care, Rockland's small size precludes specialized, cost-intensive programs from being financially sustainable within the boundaries of the county. Access to in-county inpatient and intermediate levels of care are limited to Rockland Children's Psychiatric Center (RCPC) and its affiliated Intensive Day Treatment (IDT) program. RCPC has been able to accommodate more acute referrals but serves only adolescents and has had a significant reduction in its number of beds over the years. Families typically have to transport their children to inpatient units in Westchester County which can be problematic when the family does not have access to a car. Similarly, children who require intermediate levels of care (PHP, IOP) have to seek services outside of the county. Rockland residents often utilize the Hi-Focus program in New Jersey but Medicaid is not accepted at that program. Children who are referred to intermediate levels of care in Westchester County need to be transported daily which is difficult for working families and families without access to a car. Finding qualified child and adolescent mental health providers that accept insurance is also a challenge for Rockland's families. When these children require emergency evaluation they are typically referred to the local 9.39 hospital where services are not typically provided by mental health clinicians who specialize in children and adolescents.

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.

Please see attached: The County Executive's Community Behavioral Health Commission Report.

3. Assessment of Local Needs - For each category listed in this section, indicate the extent to which it is an area of need by checking the appropriate check box under "High", "Moderate", or "Low" for each population: Youth (Under 21) and Adults (21 and Over). When considering the level of need, compare each issue category against all others rather than looking at each issue category in isolation. For each issue that you identify as a "High" need, answer the follow-up question to provide additional detail.

<table>
<thead>
<tr>
<th>Issue Category</th>
<th>Youth (&lt; 21)</th>
<th>Adult (21+)</th>
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<tbody>
<tr>
<td>Substance Use Disorder Services:</td>
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<td></td>
</tr>
<tr>
<td>a) Prevention Services</td>
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<td>b) Crisis Services</td>
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<td>c) Inpatient Treatment Services</td>
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<td>d) Opioid Treatment Services</td>
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<td>e) Outpatient Treatment Services</td>
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<td>f) Residential Treatment Services</td>
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<td>g) Housing</td>
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<td>h) Transportation</td>
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<td>i) Other Recovery Support Services</td>
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<td>j) Workforce Recruitment and Retention</td>
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<td>k) Coordination/Integration with Other Systems</td>
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<td>l) Other (specify):</td>
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<td>n) Crisis Services</td>
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<td>o) Inpatient Treatment Services</td>
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<td>p) Clinic Treatment Services</td>
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<tr>
<td>q) Other Outpatient Services</td>
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<tr>
<td>r) Care Coordination</td>
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**Follow-up Questions to "Housing" (Question 3g)**

3g1. Briefly describe the issue and why it is a high need for the populations selected.

Rockland County has a high need for safe, sober housing to support individuals in recovery from substance use disorders. The heroin epidemic affects many adolescents and the need for opioid treatment has increased. There is a high demand for detox and withdrawal services since many individuals are being denied access to Inpatient Detox programs.

**Follow-up Questions to "Inpatient Treatment Services" (Question 3c)**

3c1. Briefly describe the issue and why it is a high need for the populations selected.

Rockland County needs to implement Ambulatory Detox and Outpatient Withdrawal service to meet the demand of overflow from hospital emergency departments when individuals do not meet admission criteria for inpatient detox or rehab. There are many obstacles and regulations that have prevented this service from operating effectively in the community.

**Follow-up Questions to "Opoid Treatment Services" (Question 3d)**

3d1. Briefly describe the issue and why it is a high need for the populations selected.

There is a high need for Opioid Treatment Services due to the Heroin/Opiate Epidemic that has become a public health crisis. There is a high demand for detox and withdrawal services since many individuals are being denied access to Inpatient Detox programs.

**Follow-up Questions to "Housing" (Question 3g)**

3g1. Briefly describe the issue and why it is a high need for the populations selected.

Rockland continues to have a high need for safe, sober housing to support individuals in recovery from substance use disorders. There is a need for additional Community Residence programs and Supported Housing programs.

**Follow-up Questions to "Recovery Support Services" (Question 3i)**
Follow-up Questions to "Workforce Recruitment and Retention" (Question 3j)

3j1. Briefly describe the issue and why it is a high need for the populations selected.
Rockland County has a high demand for Spanish speaking services and needs to recruit and retain bilingual Spanish-speaking staff including counselors, social workers and nurses in the substance use disorder treatment programs.

Follow-up Questions to "Inpatient Treatment Services" (Question 3o)

3o1. Briefly describe the issue and why it is a high need for the populations selected.
There is only one hospital available for adolescents in the county (RCPC) and no inpatient beds for children in the county. The number of adolescents beds at RCPC has decreased from 54 to 26.

Follow-up Questions to "Other Outpatient Services" (Question 3q)

3q1. Briefly describe the issue and why it is a high need for the populations selected.
There is a need for IOP/PHP level of care. Individuals are being discharged from inpatient settings with higher needs than a clinic or PROS level of care can meet. PHP/IOP level of treatment is also beneficial as an inpatient diversion level of care.

Follow-up Questions to "HCBS Waiver Services (Children)" (Question 3t)

3t1. Briefly describe the issue and why it is a high need for the populations selected.
There are 30 HCBS waiver slots in the county and there is usually a waiting list.

Follow-up Questions to "Housing" (Question 3v)

3v1. Briefly describe the issue and why it is a high need for the populations selected.
Supported Housing opportunities are being designed for individuals leaving State PC sites. There are less opportunities for people already living in the community. The cost of rental housing in Rockland County is prohibitive to agency providers for both new subsidies and for lease renewals.

Follow-up Questions to "Workforce Recruitment and Retention" (Question 3x)

3x1. Briefly describe the issue and why it is a high need for the populations selected.
Workforce recruitment and retention are increasingly significant issues for agencies and for individuals with disabilities. Salient issues are, low salaries, debate to raise the minimum wage without additional funding from OMH, impact of overtime on agency budgets, and accountability concerns from staff regarding the justice center.

Follow-up Questions to "Coordination/Integration with Other Systems" (Question 3y)

3y1. Briefly describe the issue and why it is a high need for the populations selected.
As individuals across the mental hygiene systems of care move toward increasing community inclusion, the need for integration and collaboration between public and private entities is more salient than ever. Integration between behavioral health and general health services is resulting in care management/coordination reaching beyond traditional providers to secure supports and services for people with disabilities. Care Coordination and sharing of resources is increasing between MH, DD and CD entities. The latest challenge is to incorporate entities from the community at large. There is an increasing need for cross systems collaboration with the criminal justice system due to the number and complexity of referrals. There will be increasing demands for public transportation and para-transportation as individuals with disabilities rely less on agency based transportation. Family advocacy and peer workforce expansion are bringing additional entities into the system of care.

Follow-up Questions to "Crisis Services" (Question 3aa)

3aa1. Briefly describe the issue and why it is a high need for the populations selected.
There is a significant need for emergency services and inpatient beds for children with IDD and co-occurring mental illness or behavioral challenges. There is only one hospital for adolescents in the County (RCPC) and there are no inpatient beds for children in the county. There is a need for a dedicated unit to address the specific needs of individuals with dual diagnosis. There is a significant need for emergency services and inpatient beds for adults with IDD and co-occurring mental illness or behavioral challenges. The only inpatient behavioral health facility in Rockland County is not able to fully address the needs of individuals with significant medical presentations. The existing resources are not designed to provide for the extended period of re-stabilization an individual with IDD requires. There are no long-term hospitalization sites for people with IDD and co-occurring mental illness. There is a need for a dedicated unit to address the specific needs of individuals with dual diagnosis.

Follow-up Questions to "Respite Services" (Question 3ff)

3ff1. Briefly describe the issue and why it is a high need for the populations selected.
There are limited planned respite opportunities for children with IDD issues. There is no crisis respite service. The NYSTART will not consider children for the future Resource Center. There are limited planned respite opportunities for adults with IDD issues. An individual in crisis utilizes an intensive level of OPWDD and agency staffing to arrange for crisis respite. NYSTART has not yet opened the limited amount of supports through the Resource Center.
Follow-up Questions to "Residential Services" (Question 3kk)

3kk1. Briefly describe the issue and why it is a high need for the populations selected.
Availability of affordable housing is a nationwide issue. There is a high need for person-centered, certified and non-certified residential opportunities for people living in the community, other than the special populations of residential school age outs or those leaving institutional settings. There are limited new certified residential development funds available. Voluntary providers are reporting difficulty supporting individuals with high behavioral and medical needs.

Follow-up Questions to "Transportation" (Question 3mm)

3mm1. Briefly describe the issue and why it is a high need for the populations selected.
Transportation costs to agencies for children is a significant portion of an agency budget. Barriers remain in transportation funding for children to attend after school/program respite services. Transportation costs to agencies for adults is a significant portion of an agency budget. In response to greater community inclusion for the people with disabilities, there is a need for public transportation to be more responsive to the medical and behavioral needs of the riding public.

Follow-up Questions to "Workforce Recruitment and Retention" (Question 3pp)

3pp1. Briefly describe the issue and why it is a high need for the populations selected.
Workforce recruitment and retention are increasingly significant issues for agencies and for individuals with disabilities. Supports and services are being authorized through OPWDD, yet individuals are not being served due to staffing shortages. Salient issues are the negative impact of rate rationalization, low salaries, debate to raise the minimum wage without additional funding from OPWDD, impact of overtime on agency budgets, accountability concerns from staff regarding the justice center and the need for core competencies.

Follow-up Questions to "Coordination/Integration with Other Systems" (Question 3qq)

3qq1. Briefly describe the issue and why it is a high need for the populations selected.
As individuals across the mental hygiene systems of care move toward increasing community inclusion, the need for integration and collaboration between public and private entities is more salient than ever. Integration between behavioral health and general health services is resulting in care management/coordination reaching beyond traditional providers to secure supports and services for people with disabilities. Public transit, the criminal justice system, employment and volunteer opportunities, senior services for those individuals choosing retirement from sheltered workshops are a few examples of the new venues for coordination and integration. There will be increasing demands for public transportation and para-transportation as individuals with disabilities rely less on agency based transportation.

Local needs generally do not change significantly from one year to the next. It often takes years of planning, policy change, and action to see real change. In an effort to assess what changes may be happening more rapidly across the state, indicate below if the overall needs of each disability population got better or worse or stayed about the same over the past year.

4. How have the overall needs of the mental health population changed in the past year?
  o a) Overall needs have stayed about the same.
  o b) Overall needs have improved.
  o c) Overall needs have worsened.
  o d) Overall needs have been a mix of improvement and worsening.
  o e) Not sure.

4d. If you would like to elaborate on why you believe the overall needs of the mental health population have been a mix of improvement and worsening over the past year, briefly describe here
Overall needs of the mental health population have improved due to the following: -Increased outpatient clinic capacity; -Capacity of Javonio Article 28 Health Center to provide targeted general health and behavioral health to the uninsured/underinsured accompanied by targeted care coordination through a grant received by the agency; -Development of 10 additional supported housing opportunities; -Increased family and peer advocacy opportunities; -Funding received by the LGU to develop a local Suicide Prevention Coalition. Overall needs of the mental health population have worsened due to the following factors: -Demand for housing opportunities exceeding available opportunities; -Lack of a PHP/IOP level of care; -Limited access to respite beds; -Lack of new supported housing subsidies for people residing in the community; -Need for housing and clinical treatment for discharges from Residential Treatment Facilities.

5. How have the overall needs of the substance use disorder population changed in the past year?
  o a) Overall needs have stayed about the same.
  o b) Overall needs have improved.
  o c) Overall needs have worsened.
  o d) Overall needs have been a mix of improvement and worsening.
  o e) Not sure.

5c. If you would like to elaborate on why you believe the overall needs of the substance use disorder population have worsened over the past year, briefly describe here
The overall needs of the substance use disorder population have worsened due to the Heroin/Opiate Epidemic and increased overdoses. Narcan use by emergency responders has increased the need and demand for services.

6. How have the overall needs of the developmentally disabled population changed in the past year?
  o a) Overall needs have stayed about the same.
  o b) Overall needs have improved.
  o c) Overall needs have worsened.
  o d) Overall needs have been a mix of improvement and worsening.
  o e) Not sure.

6d. If you would like to elaborate on why you believe the overall needs of the developmentally disabled population have been a mix of improvement and worsening
over the past year, briefly describe here

Overall needs of the developmentally disabled population has improved due to the following: Increased authorization of supports and services; -Launch of MCO, Partners in Health, for FIDA-IDD population; -New Alternatives to Incarceration program for people with IDD; -Removal of NYSTART waitlist; -Engagement in cross systems education by RCDMH and provider agencies to local nursing schools to reduce health care disparity.

In addition to working with local mental hygiene agencies, LGUs frequently work with other government and non-government agencies within the county and with other LGUs in their region to identify and address the major issues that have a cross-system or regional impact. The following questions ask about the nature and extent of those collaborative planning activities.

7. In the past year, has your agency been included in collaborative planning activities related to the Prevention Agenda 2013-2018 with your Local Health Department?
   a. Yes
   b. No

7a. Briefly describe those planning activities with your Local Health Department.

   Staff of the Department of Mental Health participate on the local Health Department "Public Health Priorities" committee.

8. In the past year, has your agency participated in collaborative planning activities with other local government agencies and non-government organizations?
   a. Yes
   b. No

8a. Briefly describe those planning activities with other local government agencies and non-government organizations.

   Collaborated with Rockland Paramedic Services to establish a mobile crisis team, the Behavioral Health Response Team. Collaborated with the DA's Office, BOCES, DSS and Probation to establish the Partnership for Safe Youth and submit a System of Care application to SAMHSA. Collaborated with North Rockland School District to establish a Department of Mental Health satellite mental health clinic with a Spanish speaking social worker at Fieldstone Middle School to enhance access to services. Collaborated with the Village of Haverstraw to establish a Department of Mental Health satellite mental health clinic with a Spanish speaking social worker at the Haverstraw Center to enhance access to services. Collaborated with Transportation Department on service mapping project. Increased membership on IDD and MH Workgroups. Participated in cross-systems training with DOCCS, local police, DSS. Participation of Health Department Public Health Priorities Committee. Participate on the Heroin Overdose Task Force. Under the direction of the RC District Attorney, this Task Force was developed to integrate substance treatment and prevention with law enforcement, mental health and schools/colleges. The Task Force does presentations to the community and also tracks overdoses and Narcan administration for statistical purposes. Participate on the Re-Entry Task Force. This Task Force operates under the direction of the RC District Attorney, which coordinates with NYS Parole and Community Supervision, as well as correctional facilities making referrals back to the community. Intersects with mental health, substance treatment and parole mandates for Safe Communities while offering support and reintegration for individuals returning into the community.

9. In the past year, has your agency participated in collaborative planning activities with other other LGUs in your region?
   a. Yes
   b. No

9a. List each activity and the LGU(s) involved in that collaboration and provide a brief (one or two sentence) description of the activity.

   NYSTART Advisory Council - DDRO Region 3 LGUs meet quarterly to review progress and needs within NYSTART and collaborate on linkage agreements. Monthly phone conferencing between Rockland, Westchester, Orange and Sullivan County LGUs and DDRO Region 3 Director and Deputy Director to discuss County and region specific needs.

9b. Did your collaborative planning activities with other LGUs in your region include identifying common needs that should be addressed at a regional level?
   a. Yes
   b. No

9c. Did the counties in your region reach a consensus on what the regional needs are?
   a. Yes
   b. No

9d. Briefly describe the consensus needs identified by the counties in your region

   Increased respite opportunities by NYSTART Resource Center for children and adults with IDD. Increased training to address mental health and behavioral health challenges of people with IDD issues. Regional psychiatric inpatient beds for children and adults with IDD issues. Regional step down unit for individuals with IDD and co-occurring mental illness who are not ready to return to residence but no longer require inpatient level of care.
The term "multiple disabilities" means, in this context, persons who have at least two of the following disabling conditions: a developmental disability, a mental illness, or an addiction. In order to effectively meet the needs of these individuals, several aspects should be addressed in a comprehensive plan for services. Accordingly:

1. Is there a component of the local governmental unit which is responsible for identifying persons with multiple disabilities?
   - Yes
   - No

   If yes, briefly describe the mechanism used to identify such persons:

   The Rockland County Department of Mental Health conducts assessment and evaluation for mental status, chemical dependence and developmental function for all individuals seeking treatment. Based on the findings, a treatment plan is developed and services are arranged to meet the individual's needs, or an appropriate referral is made.

2. Is there a component of the local governmental unit which is responsible for planning of services for persons with multiple disabilities?
   - Yes
   - No

   If yes, briefly describe the mechanism used in the planning process:

   The Rockland County Adult Mental Health Workgroup, Child and Adolescent Workgroup, Chemical Dependency Workgroup, DD Workgroup, MH Housing Subcommittee and Outpatient Providers Subcommittee are all used as a forum to identify needs and service gaps for all individuals, including those with multiple disabilities, and to plan for services to address the needs of persons with multiple disabilities.

3. Are there mechanisms at the local or county level, either formal or informal in nature, for resolving disputes concerning provider responsibility for serving persons with multiple disabilities?
   - Yes
   - No

   If yes, describe the process(es), either formal or informal, for resolving disputes at the local or county level and/or at other levels of organization for those persons affected by multiple disabilities:

   Disputes at the county level concerning provider responsibility for serving persons with multiple disabilities are addressed informally on a case by case basis. The Workgroups may also be used as a forum to discuss and resolve issues between providers concerning the provision of care. If a dispute cannot be resolved in this setting, the matter is referred to the Commissioner of Mental Health for further intervention. The Department of Mental Health also conducts Special Case Conferences, available to staff of the Department and to community providers. This provides a formal venue for review of difficult cases.

   Disputes within the Department of Mental Health concerning responsibility for serving persons with multiple disabilities may be resolved at the Clinical Rounds Committee where any clinician can bring a case forward for review.
Consult the LSP Guidelines for additional guidance on completing this form.

2017 Priority Outcomes. Please note that to enter information into the new items under each priority, you must click on the "Edit" link next to the appropriate Priority Outcome number.

Priority Outcome 1:

Expand the availability and accessibility of a full continuum of safe, adequate and affordable housing in the least restrictive setting for persons across the mental hygiene service system.

Progress Report: (optional)*new

Mental Health - Loeb House expanded the Crisis Respite Bed Capacity from one bed to two beds. Nine supported housing beds were added in 2015. RPC developed a Meet and Greet for area housing providers to interact with patients seeking community placement. RPC expanded the Model Apartment Program to help prepare individuals nearing discharge to practice the skills required in a non-institutional setting. Expanded the stakeholders attending Adult SPOA meeting to include RILC, MHA Peer Advocate, DOCCS and MH Outpatient Treatment providers as needed. Six agencies are working collaboratively to seek NYS funding for new Supportive Housing beds and supportive services in the County. These new beds are intended to serve individuals in RE-Entry, Veterans, victims of domestic violence and homeless youth. IDD - Several agencies began the conversion of ICF facilities to IRAs, thus enabling individuals to have increased opportunities for community inclusion. RCALD opened a two-person Supportive IRA for two individuals, thus providing for their preference of less staff oversight and support. ARC of Rockland provided residential opportunities to five individuals previously living with their families through facility renovation and internal residential moves. Substance Use Disorder - Open Arms, Inc. has undergone trainings provided by OASAS related to residential redesign and is currently utilizing the Locadr 3.0 system. Agency is currently in the process of determining which aspect of residential redesign is appropriate for serving their consumers. Open Arms, Inc. submitted an application for a capital project renovation at the 18 bed men's community residence which has been processed. Open Arms, Inc. received individuals from and referred individuals to OMH licensed housing in order to accommodate the residents with co-occurring substance use disorder and mental illness.

Priority Rank: 1

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative:*new

☒The Prevention Agenda 2013-2018
☒OMH Transformation Plan

Is this priority also a Regional Priority? *new Yes

Strategy 1.1

Expand the number of housing opportunities available to individuals with serious mental illness.

Applicable State Agency: OMH

Strategy 1.2

Implement OASAS Residential Redesign to help individuals in recovery establish and maintain abstinence.

Applicable State Agency: OASAS

Strategy 1.3

Renovate existing OASAS licensed 18 bed men's residence to improve safety and accessibility.

Applicable State Agency: OASAS

Strategy 1.4

Provide certified and non-certified housing opportunities for individuals with intellectual and developmental disabilities that reflect increased community integration and a home of the person's choice.

Applicable State Agency: OPWDD

Strategy 1.5

Complete ICF to IRA conversions for individuals with developmental disabilities in accordance with State planning.

Applicable State Agency: OPWDD

Strategy 1.6
Increase referrals from OASAS licensed housing to OMH licensed housing and accept referral from OMH licensed housing in order to accommodate residents with co-occurring substance use disorder and mental illness.

**Applicable State Agencies:** OASAS OMH

**Strategy 1.7**

Train staff and implement evidenced based practices in OASAS licensed housing.

**Applicable State Agency:** OASAS

**Priority Outcome 2:**

Prepare the mental hygiene system of care in Rockland County for Medicaid Redesign, DSIRIP Initiative and Managed Care through coordination and management of all service components.

**Progress Report:** *(optional)* *(new)*

Nyack Hospital was the recipient of a multi-million dollar award for its application to build a Medical Village that will include a continuum of substance abuse and mental health services. Jawonio began implementation of DSIRIP Project 2.1.i.iii - Health Home At-Risk Intervention Program for proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services at the Jawonio Health Center. St. Dominic’s Home is actively involved in three DSIRIP projects with Westchester Medical Center: • 2.a.i. - Create Integrated Delivery Systems that are focused on Evidence-Based Medicine/Population Health Management. • 2.d.i. - Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care. • 2.a.iii. - Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services. One of the major DSIRIP initiatives is the integration of behavioral health care and physical health care. Rockland County demonstrated this by awarding a contract to Rockland Paramedics Services to provide mobile crisis services. This was a unique endeavor in that the Mobile Crisis Team utilizes staff that have expertise and experience in providing care to individuals with both behavioral health issues and physical health issues who are in crisis. This allows the team to not only address behavioral health issues but to also assess and address the impact of physical health issues on those in crisis. As a result of the Department's involvement with the DSIRIP PPS, the need for services to become more accessible as well as culturally compatible with the community became apparent, resulting in the County established two off-site satellite mental health clinics staffed by a Spanish speaking social worker. The clinics are located in typically underserved areas, one of which is a middle school, thus providing easier access to culturally competent mental health treatment services. A total of 10 provider agencies in the County were designated by New York State as providers of a wide array of Home and Community Based Services to eligible individuals in Health and Recovery Plans or HARP eligible in HIV Special Needs Plans (SNPs). These services are designed to allow individuals to gain the skills to be fully integrated into the community. Some of the agencies will need to become established Medicaid providers. Many agencies in Rockland County have actively participated in planning with the three DSIRIP lead agencies in the County, are members of the various DSIRIP committees and have signed contracts as members of the Performing Provider Systems. The Rockland County Department of Mental Health hosted a county-wide meeting with the three DSRIP lead agencies, Montefiore, Refiush and Westchester Medical Center. The County and service providers attended numerous trainings and webinars on the implementation of Medicaid Managed Care for adults and children. ARC of Rockland successfully launched the Partner Health Plan managed care organization for adults with IDD with Medicaid and Medicare eligibility. RPC established a Managed Care Dept. to enhance enrollment.

**Priority Rank:** Unranked

**Applicable State Agencies:** OASAS OMH OPWDD

**Aligned State Initiative:** *(new)*

- Population Health Improvement Plan (PHIP)
- Medicaid Delivery System Reform Incentive Payment Program (DSRIP)
- Adult Medicaid Behavioral Health Managed Care Implementation
- Child Medicaid Behavioral Health Managed Care Implementation
- OMH Transformation Plan
- Fully Integrated Duals Advantage Program (FIDA)
- OPWDD People First Transformation

*Is this priority also a Regional Priority?* *(new)* Yes

**Strategy 2.1**

Train Care Coordinators to enhance competency to provide integrated care coordination for both medical and behavioral health needs for individuals with serious mental illness.

**Applicable State Agency:** OMH

**Strategy 2.2**

Attend DSIRIP PPS meetings and webinars offered by the three (3) lead DSIRIP PPS agencies and complete requested surveys in order to maintain ongoing contact and planning for DSIRIP Projects.

**Applicable State Agencies:** OASAS OMH

**Strategy 2.3**

Increase benefits management and support services for individuals with serious mental illness an/or substance use disorder.

**Applicable State Agencies:** OASAS OMH

**Strategy 2.4**

Provide managed care navigation assistance for individuals with serious emotional disturbance/serious mental illness and/or substance use disorder.

**Applicable State Agencies:** OASAS OMH
Collaborate with Nyack Hospital on the establishment of a Medical Village to address unmet needs in the community.  
Applicable State Agencies: OASAS OMH

Two mental health clinics will participate in Refuah's Medication Adherence project.  
Applicable State Agency: OMH

Fully implement DSRIP Project 2.1.iii - Health Home At-Risk Program for proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services at the Jawonio Health Center. 
Applicable State Agency: OMH

RILC is developing a resource guide for services and supports to be used by the DSRIP program through Refuah Community Health Collaborative.  
Applicable State Agencies: OASAS OMH

Expand the availability and accessibility of affordable, recovery oriented, person centered, age appropriate and evidence based treatment services across the continuum of care to all persons, including those with co-occurring disorders.

Mental Health - One of the major DSRIP initiatives is the integration of behavioral health care and physical health care. Rockland County demonstrated this by awarding a contract to Rockland Paramedic Services to provide mobile crisis services. This was a unique endeavor in that the Mobile Crisis Team utilizes staff that have expertise and experience in providing care to individuals with both behavioral health issues and physical health issues who are in crisis. This allows the team to not only address behavioral health issues but to also assess and address the impact of physical health issues on those in crisis. The County established two off-site satellite mental health clinics staffed by a Spanish speaking social worker. The clinics are located in typically underserved areas, one of which is a middle school, thus providing easier access to culturally competent mental health treatment services. VCS Inc. was awarded a Mental Health Clinic license by NYS OMH, thus expanding clinic capacity to meet the needs in the community and identified populations. The Orangeburg Service Center began a Cognitive Remediation program, an evidence-based, interactive computer program designed to increase the cognitive skills of adults. The RPC Turning Point program for individuals ages 18 -30 who are experiencing a first episode of psychosis was established. IDD - RCALD expanded the number of individuals participating in its Day Habilitation without walls opportunity. ARC of Rockland expanded the behavioral health psychiatric and psychological services in its Article 16 Clinic. ARC of Rockland partnered with Camp Venture to render Article 16 services at its Day Habilitation program. Substance Use Disorder - Lexington Center for Recovery implemented evidence based treatment for persons with substance use disorder as follows: CBT-DWI Curriculum; Integrating Dialectical Behavior Therapy with the Twelve Steps; Wellness Self-Management; SAMHSA Anger Management in all sites. Blaisdell ATC trained staff and implemented Motivational Interviewing that is utilized in daily clinical practice with all patients with substance use disorder. Samaritan Daytop Village implemented the following groups for persons with substance use disorders: Thinking for A Change; Domestic Violence; and Anger Management. Nyack Hospital began the provision of outpatient substance abuse services to the adolescent population and their families.

Priority Rank: Unranked
Applicable State Agencies: OASAS OMH OPWDD

The State Health Innovation Plan (SHIP)/State Innovation Models (SIM)
Population Health Improvement Plan (PHIP)
Medicaid Delivery System Reform Incentive Payment Program (DSRIP)
Adult Medicaid Behavioral Health Managed Care Implementation
Child Medicaid Behavioral Health Managed Care Implementation
OMH Transformation Plan
OPWDD People First Transformation

Is this priority also a Regional Priority? *new Yes

Train staff and implement the use of evidence based practices for treatment of individuals with serious mental illness in mental health clinic setting.  
Applicable State Agency: OMH

Implement ambulatory detox/outpatient withdrawal services for individuals addicted to opiates.  
Applicable State Agency: OASAS
Strategy 3.3
Implement SBIRT to expand and enhance screening for substance abuse in mental health clinic settings.
  Applicable State Agency: OASAS

Strategy 3.4
Increase the use of Vivitrol injections in substance use disorder outpatient programs for continuity of care upon discharge from inpatient programs.
  Applicable State Agency: OASAS

Strategy 3.5
Train staff and implement the use of evidence based practices in substance use disorder programs.
  Applicable State Agency: OASAS

Strategy 3.6
Expand the availability of evidenced-based day services, physical health and behavioral health treatment opportunities to individuals with intellectual and developmental disabilities.
  Applicable State Agency: OPWDD

Strategy 3.7
Provide mental health services to individuals with IDD barriers, most notably those with Autism Spectrum Disorder, in PROS setting.
  Applicable State Agencies: OMH OPWDD

Strategy 3.8
Improve community access for children, adolescents and adults who require emergency mental health evaluation through development of a Medical Village at Nyack Hospital.
  Applicable State Agency: OMH

Strategy 3.9
Improve care coordination with regional providers of child and adolescent PHP/IOP programs by participating in HealthlinkNY RHIO.
  Applicable State Agency: OMH

Strategy 3.10
Explore the provision of behavioral health diagnostic, treatment and ongoing support services for pre-school age children and their families.
  Applicable State Agency: OMH

Strategy 3.11
Assess need for PHP or IOP level of care for adults with serious mental illness and those with co-occurring substance use disorder.
  Applicable State Agencies: OASAS OMH

Strategy 3.12
Improve the enrollment period turnaround time for individuals with serious mental illness from inquiry to disposition in PROS program.
  Applicable State Agency: OMH

Strategy 3.13
Expand the Cognitive Remediation program for persons with serious mental illness at outpatient mental health clinic site.
  Applicable State Agency: OMH

Strategy 3.14
Expand the Turning Point program for young people experiencing their first episode of psychosis and relocate to off-campus site for greater community integration and access to public transportation.
  Applicable State Agency: OMH

Strategy 3.15
Assess need for PHP or IOP level of care for individuals with intellectual and developmental disabilities and co-occurring mental illness or behavioral challenges.
  Applicable State Agencies: OMH OPWDD
Strategy 3.16
Address need for psychiatric inpatient services specific to individuals with co-occurring intellectual/developmental disabilities and serious mental illness.

Applicable State Agencies: OMH OPWDD

Strategy 3.17
Expand one PROS program in the County to six days a week.

Applicable State Agency: OMH

Strategy 3.18
Initiate a group therapy milieu in outpatient mental health clinic that includes a co-occurring disorders group for those with co-occurring substance abuse.

Applicable State Agencies: OASAS OMH

Strategy 3.19
Expand upon primary medical services offered in Opiate Treatment Program site.

Applicable State Agency: OASAS

Strategy 3.20
Institute a summer school for all school districts for students with substance use disorder.

Applicable State Agency: OASAS

Strategy 3.21
Develop a new Day Rehabilitation program for persons with substance use disorder.

Applicable State Agency: OASAS

Strategy 3.22
Develop a more comprehensive adolescent outpatient substance abuse treatment program.

Applicable State Agency: OASAS

Strategy 3.23
Cross train CASACs, nurses and social workers in both OASAS and OMH licensed programs on working with persons with co-occurring serious mental illness and substance use disorders.

Applicable State Agencies: OASAS OMH

Priority Outcome 4:
Provide comprehensive recovery services and supports including peer advocacy, family peer support, recovery coaching, mutual aid groups and recovery activities to prevent relapse and promote wellness for persons with mental illness and/or substance use disorder.

Progress Report: (optional)
Mental Health - Nyack Hospital began hosting weekly groups for area mental health providers to educate patients on available community resources. Nyack Hospital psychiatric unit began a process to link peer advocates with patients upon discharge. NAMI Rockland conducted a number of educational programs promoting recovery awareness through monthly programs and the annual "Breaking the Silence" Public forum co-sponsored with the Mental Health Coalition of Rockland. In an effort to raise awareness in diverse communities, NAMI held a presentation at Reform Temple of Rockland County. NAMI Rockland held a first-time, county-wide, Mental Health Awareness Ribbon Campaign, kicking off mental health awareness month. Noteworthy events included a mental health awareness flag raising by County Executive Ed Day and a special program hosted by County Legislature Chair Alden Work and members of the County Legislature. In 2015 NAMI of Rockland launched the Family Peer Support Services (FPA), providing an array of formal and informal supports and services to parents and other caregivers of children or young adults from ages 3 to 23, who are experiencing social, emotional and/or behavioral challenges at home, school or in the community. FPA helps caregivers develop skills and access community supports to reduce family isolation, promote positive youth functioning and enhance wellness and successful community life. Caregivers learn strategies for self-care, stress management and crisis intervention strategies to prevent hospitalization and emergency room visits. NAMI Rockland has expanded all its family support groups, offering twice monthly evening groups and two daytime groups specifically for families of children and teens with serious emotional/behavioral issues. A third NAMI Basics class was also added. Jawonio PROS program incorporated a weekly AA meeting, chaired by peers. Six of Jawonio's PROS program peers are enrolled in the Peer Academy and awaiting certification as peer specialists. The Jawonio Front Porch, an entirely peer run social and recreational program, was established. MHA PROS program implemented a number of peer-led groups including music, art, WRAP recovery and a men's group. VCS began a mental health consumer review board to review grievances and patterns of treatment disparity. IDD - Jawonio has embraced a recovery model philosophy in provision of services and supports for people with intellectual and other developmental disabilities. Substance Use Disorder - Open Arms was an active participant in providing recovery awareness in the community by presentations in the Haverstraw Center and Nanuet Rotary Club and was also involved in "The Perfect Storm" presentation. RCADD trained 15 additional Recovery Coaches; orchestrated GRASP (Grief group for parents who have lost children to substance use disorders); established a new mutual aid group, Smart Recovery; developed recovery advocacy efforts and developed Friends of Recovery/Rockland; attended advocacy efforts in Albany and Washington DC; attended Science of Recovery Train the Trainer; attended Medication Assisted Recovery Train the Trainer; and trained Rockland recovery community in Recovery Messaging. Nyack Hospital hired a certified recovery coach for the inpatient substance abuse services and began the process of educating and certifying an additional inpatient counselor as a recovery coach.

Priority Rank: 4
Aligned State Initiative: *new

- The Prevention Agenda 2013-2018
- The State Health Innovation Plan (SHIP)/State Innovation Models (SIM)
- Population Health Improvement Plan (PHIP)
- Medicaid Delivery System Reform Incentive Payment Program (DSRIP)
- OMH Transformation Plan

Is this priority also a Regional Priority? *new Yes

Strategy 4.1

Increase the use of peer supports and recovery coaches to prevent relapse and promote wellness for persons with serious mental illness and/or substance use disorder.

Applicable State Agencies: OASAS OMH

Strategy 4.2

Promote recovery awareness in the community for individuals with serious mental illness and/or substance use disorder through presentations and community forums.

Applicable State Agencies: OASAS OMH

Strategy 4.3

Provide long term recovery services and supports for persons with serious mental illness and/or substance use disorder.

Applicable State Agencies: OASAS OMH

Strategy 4.4

Provide integrated physical wellness services and education for recipients of mental health and substance use disorder services.

Applicable State Agencies: OASAS OMH

Strategy 4.5

Reconfigure the array of Family Support Services for children with serious emotional disturbance to provide Family Peer Support Services with credentialed Family Peer Advocates in accordance with new OMH definition of this service.

Applicable State Agency: OMH

Strategy 4.6

Expand the provision of Family Peer Support Services to families of children with serious emotional disturbance to include families whose children are patients at Rockland Children's Center.

Applicable State Agency: OMH

Strategy 4.7

IDD agencies will begin to embrace the concept of recovery as part of person-centered planning.

Applicable State Agency: OPWDD

Strategy 4.8

Incorporate monthly NAMI speakers in substance use disorder inpatient setting for individuals with co-occurring disorders that focus on recovery, motivate patients to remain in treatment and destigmatize mental illness.

Applicable State Agencies: OASAS OMH

Strategy 4.9

Provide recovery coach trainings and recovery coach supervision training.

Applicable State Agency: OASAS

Strategy 4.10

Develop an engagement specialist position in outpatient setting to re-engage persons with substance use disorder who are at risk of being lost to contact.

Applicable State Agency: OASAS

Strategy 4.11

RILC is seeking additional funding to increase the credentialed education and employment services for individuals in the Re-Entry program, expanding services to
include individuals on probation and parole.

**Applicable State Agencies**: OASAS OMH

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**Strategy 4.12**

RILC is working with the Rockland County Re-Entry Task Force to develop a Re-Entry Advisory Board that is intended to encourage the establishment of peer supports.

**Applicable State Agencies**: OASAS OMH

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**Priority Outcome 5:**

Expand access to culturally and linguistically competent services and supports to ensure the ability to address the needs of, and more effectively treat, the increasingly diverse population in Rockland County.

**Progress Report**: (optional) *new

Mental Health - St. Dominic’s Home hired a bilingual service worker in their MH Community Residence program. Hatzolah EMS conducted a Cultural Competency training session for Rockland Paramedics, funded by DSRIP program. The County established two off-site satellite mental health clinics staffed by a Spanish speaking social worker. The clinics are located in typically underserved areas, one of which is a middle school, thus providing easier access to culturally competent mental health treatment services. NAMI Rockland employed a bi-lingual (English and Spanish) Family Peer Advocate. In addition to providing services to families of young children and young adults, this staff member provided assistance with the Helpline and translated educational materials, flyers, brochures, etc. MHA provided staff trainings on the Undoing Racism curriculum. VCS hired and trained bilingual clinical and volunteer counseling staff. VCS was active in the Access4All initiative to address health care coverage for undocumented residents. IDD - ARC of Rockland contracted an interpreting service to provide professional translation services while focusing it recruitment to reflect a culturally and linguistically diverse workforce. Substance Use Disorder - Lexington Center for Recovery hired a .5 FTE bilingual counselor in the Haverstraw SUD Clinic and hired 2 FTE Spanish-speaking clinical staff in Opiate Treatment Program. Blaisdell ATC hired a bilingual psychiatric nurse practitioner and a bilingual addiction counselor. Good Samaritan Hospital hired a FTE nurse who is fluent in Spanish to assist with bilingual patients and will be available to run groups and complete sessions and assessments in Spanish. CANDLE presented LGBTQ+ cultural competency trainings to the Rockland County Department of Mental Health, the Nyack Youth Collaborative and to staff at the Prevention Youth Drug Abuse meeting. Nyack Hospital trained staff in cultural sensitivity, particularly relative to the LGBT population. Nyack Hospital identified and developed a list of community resources that offer culturally and linguistically competent treatment services for individuals with serious mental illness and/or substance use disorder. RILC addressed the needs of the diverse population of Rockland by employing eleven (11) bilingual staff, speaking either Spanish or French-Creole, reflecting the needs of Rockland County.

**Priority Rank**: 3

**Applicable State Agencies**: OASAS OMH OPWDD

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**Aligned State Initiative**: *new

- The State Health Innovation Plan (SHIP)/State Innovation Models (SIM)
- Population Health Improvement Plan (PHIP)
- Medicaid Delivery System Reform Incentive Payment Program (DSRIP)
- OPWDD People First Transformation

**Is this priority also a Regional Priority?** *new Yes

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**Strategy 5.1**

Increase the number of culturally and linguistically competent staff to meet the needs of Rockland County’s diverse population across the mental hygiene service system.

**Applicable State Agencies**: OASAS OMH OPWDD

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**Strategy 5.2**

Train staff in OASAS programs on LGBTQ population to increase staff awareness and provide OASAS CPP, CPS and CASAC credits.

**Applicable State Agency**: OASAS

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**Strategy 5.3**

Conduct peer-led discussions within agency programs to assess how well agency is serving its diverse population of clients, such as LGBTQ, individuals of color, etc.

**Applicable State Agency**: OMH

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**Strategy 5.4**

Increase outreach to non-English speaking families and provide services in languages other than English.

**Applicable State Agency**: OMH

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**Strategy 5.5**

Explore means to increase community integration and access to healthcare and affordable transportation for deaf and hearing impaired individuals with serious mental illness.

**Applicable State Agency**: OMH
Strategy 5.6

Provide training to the Behavioral Health Response Team in interpretive technology to better serve deaf and hearing impaired individuals with serious mental illness.

Applicable State Agency: OMH

Priority Outcome 6:

Increase vocational/employment and educational opportunities for persons across the mental hygiene service system.

Progress Report: (optional) *new

Mental Health - RPC Recovery Center increased vocational rehabilitation counseling service hours, resulted in increased job placement in the community. Jawonio, Inc. utilized a 2015 Special Legislative Grant to provide employment supports and job coaching for 23 individuals with mental illness who are in danger of losing their employment or who are opting not to enroll in PROS program. MHA PROS has expanded its vocational supports by adding ACCES-VR services, increasing caseloads and enhancing community liaisons. IDD - Yedei Chessed developed a vocational training program within their Day Program opportunities. Jawonio, Inc. increased the Pathway to Employment and the Employment Internship programs. ARC of Rockland partnered with RILC to develop a number of work readiness classes able to accommodate eight individuals in an eight week academic cycle. ARC of Rockland and Camp Venture continued to reduce the daily census of their Workshop programs while focusing on person centered planning for other opportunities. ARC of Rockland opened a CAFE in its headquarters building, purchased the Strawtown Jewelry Store in New City and developed a cleaning business to provide community integrated competitive, part-time employment for individuals in the Sheltered Workshop. ARC of Rockland developed three person-centered, community based prevocational groups for individuals to participat in daily volunteer/internship experiences. Provided community-based, integrated pre-vocational opportunities and job placements for individuals with intellectual and developmental disabilities through Rockland County’s unique Alternative to Incarceration (IDDATI) program. Substance Use Disorder - Open Arms referred at least 80% of residents to ACCES-VR for vocational training and/or testing. Nyack Hospital Recovery Services increased the number of referrals to programs that provide various levels of vocational training. RILC increased vocational opportunities for individuals with substance use disorder released from Jail through coordination of Re-entry Task Force and ACCES-VR. This includes individuals completing the evidence-based Thinking for a Change curriculum.

Priority Rank: 2

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new

☑ OPWDD People First Transformation

Is this priority also a Regional Priority? *new Yes

Strategy 6.1

Develop additional supported competitive employment opportunities for individuals with serious mental illness through the Transitional Business program.

Applicable State Agency: OMH

Strategy 6.2

Increase vocational opportunities for individuals with substance use disorder released from Jail through coordination of Re-entry Task Force and ACCES-VR.

Applicable State Agency: OASAS

Strategy 6.3

Provide increased community-based, integrated employment opportunities for individuals with intellectual and developmental disabilities, while decreasing daily census enrollment in sheltered workshop programs.

Applicable State Agency: OPWDD

Strategy 6.4

Provide increased community-based, integrated pre-vocational opportunities, training and job placements for individuals with intellectual and developmental disabilities.

Applicable State Agency: OPWDD

Strategy 6.5

Develop connections with new employers and host opportunities for employers to engage with peers and staff to increase employment opportunities for individuals with serious mental illness and/or substance use disorder.

Applicable State Agencies: OASAS OMH

Strategy 6.6

Increase person-centered Day Habilitation opportunities for individuals with intellectual and developmental disabilities.

Applicable State Agency: OPWDD

Strategy 6.7

Increase the number of job developers and job coaches for individuals with intellectual and developmental disabilities.

Applicable State Agency: OPWDD
Strategy 6.8
Increase the capacity of vocational training program for individuals with intellectual and developmental disabilities and increase the network of community employers.
Applicable State Agency: OPWDD

Strategy 6.9
Increase collaboration between OASAS licensed housing agency and ACCES-VR for individuals with substance use disorder by reviewing cases quarterly to insure that appointment were kept and to follow up.
Applicable State Agency: OASAS

Strategy 6.10
Identify additional vocational/employment/educational resources and increase referrals to such resources for persons with serious mental illness and/or substance use disorder in order to enhance individual's ability to work and increase independence.
Applicable State Agencies: OASAS OMH

Strategy 6.11
RILC will be offering the program Ready Set Work as part of the Integrative Employment services and will have a certified Offender Workforce Development Specialist to provide the RSW.
Applicable State Agencies: OASAS OMH

Priority Outcome 7:
Expand access to support services including care coordination, community habilitation, habilitative services, family support, transportation, respite and recreation for persons across the mental hygiene service system.

Progress Report: (optional) *new
Mental Health - Nyack Hospital initiated a Family Support Group in the psychiatric inpatient unit. Jawonio Health Center secured a State Legislative Grant and hired imbedded care coordinator and outreach worker who assists individuals and families in accessing services across healthcare systems regardless of insurance coverage. IDD - Yedei Chesed developed a weekend Community Respite Partnership Program with a number of alternating host communities. RCALD restructured a Family Support Services respite program for individuals 18-28 years old to maximize census capacity. ARC of Rockland was able to provide increased community habilitation opportunities to twelve individuals, and respite services to two children and four adults. ARC of Rockland successfully launched the Partner Health Plan managed care organization for adults with Medicaid and Medicare eligibility. RILC expanded supportive services for children and adults with intellectual and developmental disabilities through the RILC Skill-Building Program for youth as well as through the RILC Re-Entry Program, in collaboration with IDDATI. RILC expanded utilization of public transportation and para-transportation opportunities for individuals with intellectual and developmental disabilities to access community based supports and services opportunities. Substance Use Disorder - MHA and Jawonio have partnered to provide enhanced training for the care management teams, including substance use recovery training. Lexington Center for Recovery increased family participation in the Day Rehab program for people with substance use disorders. CANDLE's Youth Pride Program coordinator held meetings with the gay-straight transgender alliances in three middle schools in Rockland County to inform them of CANDLE's LGBTQ+ support group. Nyack Hospital implemented a multi-family group for families of persons with substance use disorders. RILC has secured a grant from the NY Department of Transportation for two (2) accessible vehicles that will be used to provide transportation for people with disabilities as well as for outreach to underserved communities in Rockland County.

Priority Rank: 5
Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new
☑ Medicaid Delivery System Reform Incentive Payment Program (DSRIP)
☑ OPWDD People First Transformation

Is this priority also a Regional Priority? *new Yes

Strategy 7.1
Increase family involvement in substance use disorder and mental health treatment programs.
Applicable State Agencies: OASAS OMH

Strategy 7.2
Increase the number of community habilitation opportunities for individuals with intellectual and developmental disabilities.
Applicable State Agency: OPWDD

Strategy 7.3
Expand respite services for children and adults with intellectual and developmental disabilities.
Applicable State Agency: OPWDD

Strategy 7.4
Expand utilization of public transportation and para-transportation opportunities for individuals with intellectual and developmental disabilities to access community
Increase outreach, prevention and education to schools concerning mental health and substance use disorder issues.

**Applicable State Agencies:** OASAS OMH OPWDD

**Strategy 8.1**

Provide educational opportunities and forums for professionals.

**Applicable State Agencies:** OASAS OMH OPWDD

**Strategy 8.2**

Increase outreach, prevention and education to schools concerning mental health and substance use disorder issues.

**Applicable State Agencies:** OASAS OMH
Strategy 8.3

Expand substance use prevention counseling services.

Applicable State Agency: OASAS

Strategy 8.4

Local government and voluntary provider agencies will offer community educational opportunities for individuals with intellectual and developmental disabilities and their families in live and print formats.

Applicable State Agency: OPWDD

Strategy 8.5

The County will contact the new CAP-PC provider to determine if any PCPs are in need of re-engagement due to the change in provider to enhance awareness of and screening for pediatric issues in the primary care setting.

Applicable State Agency: OMH

Strategy 8.6

Offer community education to parents of children around mental health topics.

Applicable State Agency: OMH

Strategy 8.7

Provide educational opportunities and forums for the community at large.

Applicable State Agencies: OASAS OMH OPWDD

Strategy 8.8

The District Attorney's Heroin Overdose Task Force will conduct training for guidance counselors in all schools.

Applicable State Agency: OASAS

Strategy 8.9

Deliver evidence based prevention and recovery education that will include recovery messaging, advocacy training and recovery coach training. (RCADD)

Applicable State Agency: OASAS

Strategy 8.10

Advocate for enhanced collaboration between OASAS and State Education Department to ensure consistency of prevention education information at all grade levels by qualified prevention providers.

Applicable State Agency: OASAS

Strategy 8.11

Continue to educate emergency department staff, physicians and first responders, specific to individuals with intellectual/developmental disabilities who are in a psychiatric crisis or presenting with a substance abuse disorder, concerning appropriate assessment strategies and referral to ongoing care.

Applicable State Agencies: OASAS OMH OPWDD

Strategy 8.12

Conduct a county wide outreach initiative to educate school administrators and teachers in all levels of education in opioid addiction and the use of opioid overdose kits.

Applicable State Agency: OASAS

Strategy 8.13

Provide training to the Behavioral Health Response Team to serve individuals with intellectual and other developmental disabilities who have co-occurring mental illness or are experiencing behavioral challenges.

Applicable State Agencies: OMH OPWDD

Strategy 8.14

Advocate for enhanced collaboration between OASAS and State Education Department to ensure consistency of prevention education information at all grade levels by qualified prevention providers.

Applicable State Agency: OASAS
Strategy 8.15
The County will organize and host a Suicide Prevention Coalition Key Leader’s Stakeholder meeting and participate in training offered by the Suicide Prevention
Center of New York.
   Applicable State Agency: OMH

Strategy 8.16
RILC is developing a community resource guide through the Rockland County Voluntary Organizations Active in Disasters (VOAD).
   Applicable State Agencies: OASAS OMH OPWDD

Priority Outcome 9:
Enhance collaboration with the criminal justice system to provide services and supports for persons that are involved in the criminal justice system and those
returning to the community from prisons and jails.

Progress Report: (optional) *new
Mental Health - The Adult SPOA Committee engaged in cross system training with the Department of Corrections to enhance placement of individuals with serious
mental illness released from the State prison system into OMH licensed housing programs. RILC actively participates in the Rockland County Alternatives to
Incarceration Advisory Board and helped strategize how the criminal justice system may collaborate with federal agencies in order to increase funding for mental
health services to be provided within all levels of the criminal justice system.

Priority Rank: Unranked
   Applicable State Agencies: OASAS OMH OPWDD

   Aligned State Initiative: *new
   ✔ The Prevention Agenda 2013-2018
   ✔ Combat Heroin and Prescription Drug Abuse

   Is this priority also a Regional Priority? *new Not Sure

Strategy 9.1
Provide cross systems forensic training to the criminal justice system, OMH providers, OASAS providers and OPWDD providers to support the needs of individuals
with disabilities who encounter the criminal justice system.
   Applicable State Agencies: OASAS OMH OPWDD

Strategy 9.2
Train staff in substance use disorder inpatient program with education on criminal thinking and behaviors.
   Applicable State Agency: OASAS

Strategy 9.3
Increase outreach to NYS correctional facilities, parole and drug court to educate referrants on inpatient substance use disorder specialty track for criminal justice
patient population.
   Applicable State Agency: OASAS

Strategy 9.4
Continue to advocate for legislation and programs to divert individuals with serious mental illness, including those with co-occurring substance use disorder, from
jails and prisons and into treatment.
   Applicable State Agencies: OASAS OMH

Strategy 9.5
Work with Alternatives to Incarceration programs to provide a compliment of recovery focused clinical services to the program's service engagement track.
   Applicable State Agencies: OMH OPWDD

Strategy 9.6
RILC is partnering with Hudson Link to provide educational opportunities for individuals receiving Integrative Services and will be piloting Recharge in partnership
with Beyond the Bars.
   Applicable State Agencies: OASAS OMH

Strategy 9.7
RILC is seeking additional funding to increase the credentialed education and employment services for individuals in the Re-Entry program, expanding services to
include individuals on probation and parole.
   Applicable State Agencies: OASAS OMH
Formulate strategies to address challenges to workforce recruitment and retention that negatively impact access to services across the mental hygiene service system.

**Progress Report: (optional)**
RCALD met with Legislators to advocate for increased funding to voluntary providers to be able to provide increased wages to meet minimum wage increases and to provide salary increases to employees who currently earn above the minimum wage.

**Priority Rank:** Unranked

**Applicable State Agencies:** OASAS OMH OPWDD

**Aligned State Initiative:**
- The State Health Innovation Plan (SHIP)/State Innovation Models (SIM)
- Medicaid Delivery System Reform Incentive Payment Program (DSRIP)
- OPWDD People First Transformation

**Is this priority also a Regional Priority?** Yes

**Strategy 10.1**
IDD agencies and the individuals they serve will collectively review recruitment, retention, staff development, career paths, credentialing, etc. and develop a formal Recruitment and Retention plan that will train managers and a team of individuals served by the agencies to perform effective interviewing of candidates for Direct Support Professional positions.

**Applicable State Agency:** OPWDD

**Strategy 10.2**
Encourage more social workers and licensed mental health counselors to obtain CASAC certification to more effectively treat those with co-occurring serious mental illness and substance use disorder.

**Applicable State Agencies:** OASAS OMH
Consult the LSP Guidelines for additional guidance on completing this form.

Note: There must be 15 board members (counties under 100,000 population may opt for a 9-member board). Indicate if member is a licensed physician or certified psychologist. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the particular community interest being represented. Members shall serve four-year staggered terms.

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

The OMH Transformation Plan aims to rebalance the agency's institutional resources by further developing and enhancing community-based mental health services throughout New York State. By doing so the Plan will strengthen and broaden the public mental health system to enhance the community safety net; allowing more individuals with mental illness to be supported with high quality, cost-effective services within home and community-based settings and avoid costly inpatient psychiatric stays.

Beginning with the State fiscal year (SFY) 2014-15 State Budget and continuing through SFY 2015-16, the OMH Transformation Plan "pre-invested" $59 million annualized into priority community services and supports, with the goals of reducing State and community-operated facilities' inpatient psychiatric admissions and lengths of stay. In addition, $15 million has been reinvested from Article 28 and 31 inpatient facilities to further support the OMH Transformation Plan goals.

1. Did your LGU/County receive OMH Transformation Plan Reinvestment Resources (State and Locally funded) over the last year?
   - a) Yes
   - b) No
   - c) Don't know

   If "Yes":
   Please briefly describe any impacts the reinvestment resources have had since implementation, particularly as it relates to impacts in State or community inpatient utilization. If known, identify which types of services/programs have made such impacts.
   There have been two funding sources (Funding Code 142a and 1752) utilized for a Mobile Mental Health outreach team under Rockland Paramedic Services to provide emergency room and hospital diversion for individuals experiencing behavioral health crisis. Wellness checks for individuals served by the two area State Outpatient Mental Health Clinics are also utilized as a prevention tool. Monthly tracking reports indicate how many individuals have been previously served by State hospital adult and child psychiatric units. To date in 2016 an average of 29.4% the day tour crisis responses and 27.6% of the night tour crisis responses were to individuals discharged from State PC centers.

2. Please provide any other comments regarding Transformation Plan investments and planning.
   Rockland County has issued an RFP for a Mobile Integration. These funds will be used to provide Housing Outreach Services and a supported transition for individuals leaving long term State psychiatric hospitalization through intensive peer, licensed mental health professional and registered nursing supports. Monthly reporting will capture the frequency and value based quality of contacts for identified individuals prior to discharge and throughout the community reintegration process.
Consult the LSP Guidelines for additional guidance on completing this form.

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 2017 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 2017 Local Services planning process.
The County Executive’s
Community Behavioral Health
Commission Report

Rockland County, New York
June 2015
County Executive's Commission on Community Behavioral Health

Executive Committee

Hon. Edwin Day, Rockland County Executive
Hon. David Carlucci, NYS Senate
Dr. Mary Leahy, Good Samaritan Hospital
Michael Leitzes, Commissioner, Rockland County Department of Mental Health
Dr. Mary Jean Marsico, Superintendent, Rockland BOCES
Hon. John Murphy, R. C. Legislature
Chief Michael O'Shea, Piermont Police Department
Guillermo Rosa, Deputy County Executive
Susan Sherwood, Commissioner, Department of Social Services
Dr. Michael Rader, Nyack Hospital
Dr. Christopher Tavella, Rockland Psychiatric Center
Hon. Thomas Zugibe, Rockland County District Attorney

Action Team

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Michael D'Angelo, Rockland County Planning Dept.
Dr. Christine Ditrano, Rockland BOCES
Rena Finkelstein, NAMI Rockland
Joseph Guidice, Rockland County Sheriff's Office
Cheryl Hunter-Grant, Lower Hudson Valley Perinatal Network
Sheila Magee, Good Samaritan Hospital
Linda McMullan, Rockland County DSS
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Judy Rosenthal, District Attorney's Office
Evan Sullivan, NYS Senate
Christine Verrier-Iametti, Department of Mental Health

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Marion E. Breland, Village of Haverstraw, Community Services Board
Ronaldo L. Figueroa, Department of Social Services
Jo Ann Zucker, Rockland Behavioral Health Response Team
Acknowledgments

The County Executive's Commission on Community Behavioral Health gratefully acknowledges the following individuals and organizations who made this work possible:

Focus Groups

Alternatives to Incarceration Case Mgrs Focus Group
BOCES Adult Ed Focus Group
CEOs Focus Group
Chemical Dependency Workgroup
Child and Adolescent Workgroup
Community Services Board
DSS Caseworkers Focus Group
EMT Workers Focus Group
Family Resource Center Coordinators Focus Group
Haverstraw Collaborative
High School Principals Focus Group
R.C. Immigration Coalition
Intellectual/Developmental Disabilities Workgroup
Jawonio Consumers Focus group
Jawonio Parents meeting
Latino Health Collaborative
Law Enforcement Focus Group
Mental Health Coalition
Mental Health Workgroup
MHA of Rockland Parent and Teen Support Group
NAMI Rockland Family Group
Nyack Youth Collaborative
New York Westchester Rockland Advocacy Council
Open Arms Residents Focus Group
Open Arms Staff Focus Group
Probation Supervisors Focus Group
Public Health Priorities Workgroup
Rockland BOCES Family Fun Night group
Rockland Children's Action Network
Safe and Drug Free Schools Coalition
School Clinical Staff
School Superintendents Focus Group
Special Education Meeting at BOCES
Spring Valley Collaborative
Transitions Group
TRUST Group (LGBTQ Support)
Veteran's Focus group
Western Ramapo Collaborative

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Special Thanks to the Following:

循环经济 Rockland County Planning Department- for the use of space and support for planning purposes
循环经济 Michael D’Angelo- for going above and beyond in the creation of the Commission's needs assessment instruments and for invaluable guidance
循环经济 Hon. Thomas Zugibe and the Rockland County District Attorney's Office- for ongoing support of the initiative and for the work of the Action Team
循环经济 Honorable Harriet Cornell- for her work to provide resources to actualize this initiative
循环经济 Rockland BOCES and Veronica Shea- for support with focus group and Commission meetings
循环经济 Rockland County Department of Health- for assistance with the electronic survey instrument
循环经济 Rockland County Fire Training Center- for meeting space and technical assistance

A VERY Special Thanks to:

Rena Finkelstein- for the extensive research on the history of the behavioral healthcare system in Rockland, and for providing an excellent historical narrative.
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I. Introduction

“We look at people who are suffering from an illness or disability, and we call them by disparities terms. Society tolerates this, and we’ve got to change that.” Key Informant

Rockland County was, at one time, a model for the rest of New York State, and for the nation, in its behavioral health service delivery system. Tragically, changes over the past three decades have rendered our former rich system of care virtually unrecognizable, and largely dismantled. At the same time, challenges to Rockland’s youth, adults, elders and families have been increasing exponentially, with the need for services greater than ever before. These opposite trajectories have created a crisis for our County- one that demands compassionate, thoughtful leadership, and decisive action.

The behavioral health of our county’s residents is not strictly a private, personal or family matter— it is something that affects all of us, to the benefit or to the detriment of all. It is something that ripples through our shared social ecosystem, woven into the very fabric of our everyday lives, and impacts every institution and every sector of our communities. As the Rev. Dr. Martin Luther King, Jr. once wrote, “We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly.”

The past fifteen years have brought unprecedented challenges to our communities. As the new millennium arrived, no one could have imagined the events of September 11th. Within a few years, our nation was immersed simultaneously in several protracted wars and, within a few more years, the economy was rapidly tumbling in a downward spiral from which we are still slowly recovering. Many families lost their homes, many workers lost their jobs, and many college graduates found themselves drowning in debt. At the same time, the prison population in the United States kept growing to the point where our nation now had the highest rate of incarceration in the world, surpassing Russia, China and Iran.
Tremendous strain was being placed on communities. With this also came a widespread epidemic of chemical dependence to prescription drugs and myriad other substances, as well as a resurgence of heroin use. The internet introduced us to many new wonders, but also brought with it new hazards like identity theft, cyber-attacks on institutions and businesses, cyber-bullying among students, predatory use of social media and expanded human trafficking. Public opinion polls were telling us that public discourse had become increasingly rigid and difficult, and that our collective trust in institutions was faltering significantly. In the workplace and among neighborhoods, social tensions were rising.

While awareness was rapidly growing among parents and families about autism and other behavioral challenges for an alarmingly escalating number of children and youth, there still remained much to learn and understand about these conditions. Conversations about attention deficit disorders and hyperactivity became commonplace, as did familiarity with the drugs to medicate these conditions. Despite the widening attention to these issues, perspectives on causes and appropriate interventions were conflicting and confusing. Then, stunning the nation and severely deepening the fears and anxiety for families across our country, came the news of the violent attack on an elementary school in Newtown, Connecticut. To many, it felt like no place was safe-- that something sacred had been shattered with the loss of these innocents.

The stress on individuals and families has been persistent and intensifying since the advent of the new millennium. The need for behavioral health services and support has clearly not diminished over time. We have had great numbers of people, and even whole communities, dealing with tremendous losses, post-traumatic stress disorders, addictions, anxiety and depression. Many are tending to loved ones who suffer from illness or disabling conditions.

Yet, as our families and communities were immersed in these troubling circumstances, we saw continual reductions in services or added restriction of access, as this report will later elucidate. The entire landscape of once readily available prevention, intervention, treatment and recovery supports completely changed during this time.

Not all was lost. At the same time, it is worth noting that the past fifteen years have also borne some positive and hopeful achievements for our county. For well over a decade, there have been
four monthly roundtable discussions that are held throughout our county, commonly referred to as “collaboratives.” These roundtables serve to bring together human service providers, educators and government representatives in a spirit of community and shared learning. The simple routine of these collaboratives has enhanced our local agencies’ ability to communicate more productively, make stronger connections and fertile partnerships, and respond more effectively to changing community needs.

Similarly, this period has also seen the establishment of family resource centers located in schools throughout Rockland County. These have become a vital support to our families and a frontline of assistance in connecting with behavioral health services. As the demographic profile of Rockland County continued to diversify ethnically and linguistically, family resource centers served as a portal for newly arriving families to make key community connections, to access needed human services, and to transition less stressfully.

Other successes included the establishment of a well-recognized drug court that has helped hundreds of individuals turn their lives around, mitigate the damages of drug dependence, and find a chance of becoming contributing members of society. Our county has also made tremendous strides during this time in reducing the overall use of tobacco—a terribly addictive and destructive drug. Championed by the Rockland County Health Department and supported by groups and institutions in every sector, this particular outcome gives evidence to the power of collaboration in our county. Today, Rockland County is considered among the healthiest places in the state, as measured not only by smoking cessation but by numerous other indices of community health and well-being. In April of this year, it was announced that Rockland County ranked first in New York State for healthy living in 2015. The annual report issued by Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute recognized the county's coordinated efforts aimed at healthy eating and an active lifestyle that lead to a unified community commitment to better health.

This period has also seen an increasing awareness and commitment to reducing racism in our communities—a powerful stressor upon many residents. For many years, VCS, Inc. sponsored yearly sessions of the Undoing Racism Workshop with support from the Office of the County
Executive. Monthly gatherings and annual trainings have ensued throughout the years, and various organizations and local government agencies have undertaken independent efforts to address institutional racism that produces racial disparities in health outcomes, in child welfare, and in criminal justice.

Collectively, these achievements are not only significant strides made by our communities but, also, they are a testament to the readiness of our communities to embrace health, in all its meanings and manifestations, and support the re-design of a forward-looking and genuinely responsive behavioral health system for our county.

Communities can be resilient and can thrive largely when healing and wholeness are a shared value and a commonly held expectation. This is why it is more critical than ever for our communities to come together, foster ongoing dialogue, collectively assess the needs and existing resources, and marshal new energy and strategies to address these important challenges. It is with this value in mind that the County Executive's Commission on Community Behavioral Health was born.

II. The Purpose of the Commission

As part of his mission to improve the lives of all residents of Rockland County, including some of our most vulnerable citizens, County Executive Edwin J. Day formed the County Executive's Commission on Community Behavioral Health in August 2014. Pulling together some of the most dedicated, passionate and talented individuals with experience and expertise in the human services field in Rockland County, the Commission's primary task was to conduct a thorough, county-wide community assessment of behavioral health needs, including an analysis of the strengths and gaps. This assessment would assist in better meeting these needs in a comprehensive and culturally-sensitive fashion, both now and in the future. Based upon this assessment, the Commission was to help re-design the behavioral health service delivery system in Rockland County to maximize services to residents in a financially sustainable way.
A comprehensive behavioral health needs assessment for Rockland County would achieve the following:

- Rockland County residents and service providers would work together to identify the current services needs and to explore ways to deliver services to meet these needs.

- As a result, the County Executive's office would receive recommendations of the best possible “re-design” of county provided mental health services, as well as an overview of an optimal comprehensive re-design of the overall county-wide behavioral health system, including public and private partners, to insure a continuum of care for our residents.

- This thoughtful and thorough approach would enable the County to seek potential venues for generating resources now and in the future, including public and private funding, as a result of the data gathered.

This approach had numerous advantages and benefits. First, the development of a comprehensive behavioral health needs assessment could be undertaken quickly and effectively at no additional cost to the County. Second, a careful study of what is truly needed and what would work best in Rockland County would inform a well thought out re-design of the County's mental health department and behavioral health services. Third, this approach would require and sustain coordination and support from several County departments as well as from many outside organizations and individuals. Finally, and perhaps most importantly, by reaching out to the entire county as partners in the re-design of the service delivery system, the Commission would be fostering and strengthening county-wide investment and collaboration in the effort to address the county’s behavioral health needs.

At the end of the nine-month process, the Commission was to issue this report- the Rockland County Community Behavioral Health Needs Assessment-- providing a comprehensive profile of Rockland County’s behavioral health needs, resources and opportunities, with recommendations for specific actions steps. Rockland County's behavioral health system would
be re-designed based upon a thorough understanding of both our resident's needs, as well as the best and most sustainable practices to meet those needs.

"I think, if my voice could be heard, I would invite anyone with the power to make change to realize that we are saving money and preventing community problems by investing in behavioral health." Key Informant

There were three key activities that the Commission was charged with undertaking in order to achieve its goals- (1) gathering information, (2) identifying needs and resources, and (3) making recommendations to the County Executive's office about existing and needed county services and overall system re-design.

- Information gathering included a search of all of the currently available data on Rockland's behavioral health needs and related topics, as well as an overview of existing services and changing demographics. In addition, information was gathered through the development and utilization of instruments designed to get both a broad and deep perspective of the county's behavioral health needs. Focus groups were held with community groups and behavioral health agencies and coalitions, key informant interviews took place with stakeholders representing all community sectors for a more in-depth perspective, and surveys for the general public were made available on-line in multiple languages and in paper format.

- Based upon the information gathered in the assessment process, the Commission identified strengths and gaps in Rockland County's current behavioral health system, keying on unmet needs for our residents and new, significant or emerging trends. Particular attention was given to existing disparities in access to care. Based upon this, the Commission searched for and recommended best practices and promising approaches to behavioral health care, including existing and potential new collaborations among service providers and community organizations. Supportive resources began to be sought, including public and private funding opportunities, in order to address the needs that the Commission's work brings to light.
Finally, the Commission made recommendations in a number of areas, including needed services to particular communities or target groups, or in some cases service enhancements or changes in modalities, or strengthening the continuum of care. The Commission will make recommendations regarding resource development in the form of grant-writing and other funding sources, best practices and effective strategies, forging new partnerships both within and outside of government, and both the application of existing polices and the creation of new policies that will promote the overall health and welfare of Rockland County residents with behavioral health needs.

**Commission on Community Behavioral Health - Key Activities**

- **Gather Information**
  - Available Data
    - Current Services
    - Outcomes
    - Demographic
  - Facilitated Focus Groups
    - Key Informant Interviews
    - Service Providers
    - Persons/Families Served
    - Community Leaders
  - Surveys/Questionnaires
    - Other
    - NYS Reports
    - Studies, Articles

- **Identify**
  - Unmet Need
  - Gaps in Service
  - Existing Disparities
  - Significant Trends
  - Best Practices & Promising Approaches
  - Potential Collaborations
  - Supportive Resources

- **Recommend**
  - Services
  - Resource Development
  - Strategies & Practices
  - Partnerships
  - Policies
The Commission was structured in three primary parts: an Executive Committee, an Action Team, and Commission Coordinators.

The Executive Committee provided the authority, guidance, and in some cases, the resources necessary for the Commission's success:

- The Executive Committee met every 1-2 months to review the progress of the Commission in meeting its goals.
Members of the Executive Committee participated in task committees with Action Team members as needed.

The Executive Committee advised the Commission on issues of importance pertaining to the Behavioral Health Needs Assessment as well as to their respective areas of expertise.

The Executive Committee ensured that Commission has the resources necessary to complete its tasks, both monetary and in terms of personnel, and served to troubleshoot any emerging obstacles to the Commission's progress.

The Executive Committee also had a primary role in the prioritization of needs detailed in the report, as well as a primary role in the redesign of County behavioral health service delivery system.

The Executive Committee was to continually ensure that the Commission served the best interests of the community.

The Action Team was at the heart of the Commission's operations. It took on the nuts and bolts of the work, and its members' expertise was key to the Commission's success:

- The Action Team met as often as needed, both as a whole and/or in task committees. In the initial stages, the Action Team met as a group at least once a week.

- The Action Team was tasked with the design of the Behavioral Health Needs Assessment Report, as well as the County's Behavioral Health System re-design.

- The Action Team researched and prepared the tools necessary to gather data, including development of the instruments to be deployed, including the focus group protocols, key informant interview format, and survey questions. Review of current data, including school surveys and other reports, were part of the Action Team's mission.
• The Action Team was responsible to reach out to each community by sector to compile the data necessary for the needs assessment - to personally conduct the in-person interviews or to insure that they were completed and representative of the various sectors of the County so that a comprehensive picture was achieved.

• Part of its mission was the collection of archival data as needed to better inform its work, including data from the Rockland County Planning Department and school districts.

• Once the data was gathered, the Action Team carefully analyzed the data and synthesized findings into the Community Behavioral Health Needs Assessment report.

• The Action Team worked hand in hand with the Executive Committee to prioritize the county's behavioral health needs, and worked with Executive Committee in the redesign of County behavioral health service delivery system.

• As with the Executive Committee, the Action Team was responsible to ensure that the Commission serves the best interests of the community.

The Commission Coordinators were responsible for keeping the Commission stays on task, addressing and removing any barriers to the successful completion of its mission:

• The Coordinators oversaw the work of the Commission as a whole, managing the logistics, the needed documentation, and the process.

• The Coordinators attended both Executive Committee and Action Team meetings, and were responsible for keeping active communication within the Commission in the form of group facilitation, meeting minutes, and email correspondence.

• The Coordinators facilitated Commission tasks as described above, and troubleshooting any difficulties in completion of Commission tasks.
The Coordinators finalized in written form the Community Behavioral Health Needs Assessment and Prioritization/Behavioral Health System Redesign reports, and then helped to present the Commission’s findings to the public with and on behalf of the County Executive.

Like each person and component part of the Commission, the Coordinators were responsible to ensure that the Commission served the best interests of the community.

Working together, each component part supported the work of the other in completing the work of the County Executive’s Commission on Community Behavioral Health.

IV. Some Perspective- How Did We Get Here?

"Those who cannot remember the past are condemned to repeat it." George Santayana

As the foundation for the Commission's work, it was important to look back on Rockland's behavioral health history, to gain perspective on what we had, what we lost, and what we hope to build for the future. The following represents a review of the social and historical determinants that brought us to this point. For a more thorough history of the development of behavioral health services in Rockland County, please see Appendix A, page 89, "Historical Overview of the Behavioral Health System in Rockland County."

Rockland County was once recognized as a model behavioral health delivery system. How did we get where we are today?

The creation and subsequent dismantling of a system of behavioral health care did not happen overnight, and is not the result of random occurrences. A confluence of world and national events and social policy decisions, both locally and on a larger scale, brought us to where we are today, with more need for services than ever, and a system of care less adequate than ever to meet those needs. The thoughts and decisions that led us here must be looked at with scrupulous honesty if we are to craft and maintain an appropriate, lasting response for those Rocklanders
suffering from behavioral illnesses. This crisis was, in substantial measure, preventable- a fact which is both tragic on one hand, and hopeful on the other, if we use what we have learned from our mistakes to create a better system of care moving forward. In the words of Mahatma Gandhi, "The future depends on what we do today."

Social/Historical Factors

**Trauma**- The last five decades have been marked by a continuing series of traumatic events for the United States of America, including wars from Vietnam to the continuing armed conflicts in the Middle East and Asia. Thousands of lives have been lost or changed- not just those of the soldiers who protected and served the country, but also those of the families affected, and the culture as a whole.

“Bullet wounds are OK [to respond to]... 'invisible' wounds are not” Focus Group Participant

The shock and horror of September 11th shook the country to its core, and began a series of changes to our sense of safety and security in our everyday lives. With the increased fear created by this very real and shared traumatic event, policies were and still are being created that intruded and infringed upon our privacy and dignity, with these becoming ever more elusive concepts.

**Economic Recession**- Fear did not come only in the guise of war. The American economic system has been close to the brink of disaster, with the last decade bringing with it the "Great Recession"- high unemployment, less and less unskilled jobs available, the need for higher education greater than ever while college tuition costs are at an all-time high, unreachable for many families. Americans have increasingly lost faith in traditionally trusted institutions- the banking industry, educational system, and even the government itself. The gap between the rich and poor has significantly widened over time, resulting in the further disparity of access to needed services for lower and middle class Americans. These are conditions that foster fear, and have been conducive to an atmosphere in which those at the bottom of the economic strata are pitted against one another and blamed for the problems. Inevitably, this has also led to less support for social programs and human services initiatives, and created an attitude in the United States which is increasingly self-protective instead of concerned with the good of the whole. Conversely, the good of the whole may well be the best "self-protection" possible.
Population Explosion/Diversification- The population of the United States has almost doubled over the past fifty years, with the current population over 300 million people, and rising at an increasing rate. Not only are there more people in America, but also a more diverse population than before, especially over the past twenty years. With resources for human services more reduced than ever in the face of need that is greater than ever, there is resentment of those in need and an outrage about sharing these scant resources, especially with those from diverse backgrounds who may look, speak, or act differently than what the majority expects or is used to. Existing services, already reduced, must be stretched to accommodate multiple languages and cultures if they are to be effective. National ambivalence makes this much more difficult.

Ambivalence About the Role of Government- Based on the above, government funding has not only shrunk over time, but what remains has been shifted away from human services and social supports. Such was not always the case. With the advent of the Social Security Act of 1935 under Franklin Roosevelt, and moving on to more recent initiatives and reforms (Lyndon Johnson's Great Society programs, War on Poverty, Civil Rights Act, creation of Medicare and Medicaid), Americans once strongly believed that it was the role of government to provide a social safety net, holding each of us accountable for ourselves and one another while at the same time providing support for us in times of need. The passage of the Mental Retardation Facilities and Community Mental Health Centers Construction Act, an outgrowth of President Kennedy’s message, began a new era in Federal support for mental health services and is a prime example of governmental programs focused on behavioral health.

Today, Americans have strong, often opposing, ideas about what the role of government should be, with more and more responsibility being placed on the private sector to fill the gaps created by the reduction of government funding and services. There is a great divide in opinion about whether or not we are really responsible for the care of others, and what government should do or pay for. Even such recent developments as the Affordable Care Act, providing insurance coverage for many more Americans than ever before, are still highly controversial, with many feeling outraged at the government's interference in the healthcare of its citizens. Many Americans are not sure that they are, or should be, their brothers' and sisters' keepers. As
resources shrink and people become ever more afraid for themselves and their families, they are less likely to answer that question affirmatively.

In Rockland, the County's mental health services once employed hundreds of workers, and served thousands of residents. Today, the staff numbers less than fifty workers, and there is a substantially reduced number of clinic hours available to meet the needs of the public. The gaps created by this divestiture of direct service by the County have not been filled by community based agencies.

**Behavioral Health Policy Factors**

*Managed Care*- Beginning in the 1970's and coming into play as a significant factor in 1988, managed care has created a system that, in essence, provides a financial incentive for undertreating those in need of medical and/or behavioral health services. Billions of dollars per year paid by individuals to their insurance companies, dollars that once paid directly for services to meet their needs, have been diverted over time to large corporations, who deny healthcare benefits and reduce insurance costs while increasing their profit margin. There are four times the number of healthcare lobbyists as Congress members in the United States which exemplifies the leverage they control over policy and funding. These organizations are even involved with the Medicaid system with the advent of DSRIP (Delivery System Reform Incentive Payment) in New York State. The Mental Health Parity Act in 2008 at least set the stage for behavioral health services receiving the same substandard treatment as medical health, and no worse- but this is far from adequate, and has been the cause of the closure of countless behavioral health services in Rockland, including those the County once provided directly.

*“Relapse is so prevalent... there's a 'revolving door' at inpatient rehab,” Focus Group Participant*

As a result of managed care, providers are no longer able to concentrate on the high quality direct care of their patients. Instead, they are now forced to spend countless hours on billing and haggling with insurance companies in order to be paid for treatment that is needed and that they wish to provide. Waiting lists, denials of care based upon insurance, the closure of small practices and behavioral health programs, and greatly reduced services are the natural consequences.
Olmstead Decision- This United States Supreme Court decision of 1999 was based on principles respectful of human rights and protective of those in need- at least in theory. In essence, it protected the rights of individuals with disabilities to exist, in all aspects of their lives, in the least restrictive settings possible. The goal of the Olmstead decision was to eliminate large, segregated work, educational and living facilities in favor of total community integration and de-institutionalization in order to prevent discrimination based upon disabilities.

Noble as this goal is and was, the application of this decision in New York State poses potentially disastrous consequences for those in need, particularly the most vulnerable. By 2020, it is the expectation of New York State that all existing programming will be "transformed" to meet the requirements of this decision, with many current types of programs (sheltered workshops, large group settings) eliminated. This might be acceptable if the necessary infrastructure, programming and supports were in place within communities to accommodate the former consumers in these programs, but such is not the case statewide, including in Rockland County. The timeline will make it difficult, if not impossible, to create new systems of care in time to comply with this decision.

It is already true that our jails are too often taking the place of treatment facilities and support services that have been decimated over time. As it currently stands, it is likely that trend, and worse, will only continue unless something truly transformational is done, as the current system struggles to catch up to meet the needs appropriately. This is why decisive action must be taken immediately and sustained over time to prevent this tragedy.

De-centralization- Re-centralization, and Back Again- The past five decades have seen a system of care born and expanded, and then constricted and virtually destroyed. The initial years were a time of enlightenment and growth, with satellite centers for behavioral health services being created in multiple locations throughout Rockland County in order to better reach out to the community. These services were not only at a walking distance for most residents in need, but were also affordable to all, and services were available during evening and weekend hours in order to best meet our residents' needs.

Economic crisis, provoking increasing fear for survival and consequent ambivalence about responsibility to care for one another, was the impetus for decisions to close these satellite
programs and to re-consolidate services in a central location, with the theory that this would save money, while still providing services that residents could get to by bus or by car. In the end, such was not the case. Those in communities not close to the centralized locations, particularly those living in more economically deprived communities in Rockland, in fact did not attend these re-centralized services. This led to behavioral health crises in these communities as well as poor attendance at the remaining clinics, consequently reducing the number of staff, and the ability to serve, even more drastically.

Reactive vs. Proactive Responses to Emerging Concerns- Behavioral health services have too often been created and funded in a reactive manner, rather than proactively looking to address problems as a way to prevent and/or address crises. Moreover, there is almost a cyclical nature to these responses.

An example has been the leadership's response to addiction in New York State and in Rockland County. As national economic policies changed in the early 1980's to favor more support for business and less for social programs, federal and state funding for addiction services was beginning to decrease. However, in the mid-1980's, two crises occurred that changed this picture. One was the advent of the AIDS epidemic- the other was the explosion of crack/cocaine. Suddenly money was flowing again to deal with these issues- not as a planned approach, but as a reactive response. Interestingly enough, we are re-experiencing this trend over the past several years with Rockland's/New York's "Heroin Epidemic."

In order to create a safe, healthy community, and a lasting change for the better, a thoughtful, well-informed and well planned approach is necessary. This will build a firm foundation from which to respond appropriately and effectively if and when crises occur.

Conclusion

"A goal without a plan is just a wish." Antoine de Saint-Exupéry

If the road to perdition is paved with good intentions, then the pathway out and toward a better future for those in need of behavioral health services in Rockland County must be paved with something much more substantial. Our good intentions must be backed up and informed not only
by principles of fairness, kindness, and justice for all, but also by facts about what is truly needed, and a long-term plan to meet those needs.

“The fact is that we may not reduce the stigma at all until we take this issue seriously, give it the importance it is due, and put the needed resources in place to address the problems. People take it seriously when the leadership takes it seriously.” Key Informant

With this in mind, we present our plan for the transformation of behavioral healthcare in Rockland County.


*County Executive's Commission on Community Behavioral Health- Timeline*

The Commission undertook a nine-month process in four basic phases.

**PHASE ONE (Summer 2014):** The County Executive appointed and announced the formation of the Commission, representing a broad range of backgrounds/expertise, as well as experience
in community outreach, research, planning, and governmental operations. The Commission members participated in an orientation process and begin to meet regularly as planned.

**PHASE TWO (Summer-Fall 2014):** The Commission researched and designed several methods of collecting countywide behavioral health data. The Commission then proceeded to reach out to each diverse communities and sectors in the county, and conducted the needs assessment.

**PHASE THREE (Fall 2014-Winter 2014-15):** Working closely with the County Executive’s office, the Commission examined in detail the findings of the assessment, synthesized the information obtained, prioritized Rockland County's behavioral health needs and prepared a system re-design plan for countywide behavioral health, including fiscal viability and sustainability through grants and with county funding.

**PHASE FOUR (Winter- Spring 2015):** The County Executive’s office began the re-design of Rockland County’s behavioral health services and of the Department of Mental Health based upon the Commission's findings and recommendations. The report was to be presented to the public by mid-Spring. The recommendations would inform the County budget for fiscal year 2016, and become the basis for seeking federal, state and other grant funding to support needed services now and in the future.

**VI. Methods for the Needs Assessment**

"Ask the people who matter most... those who need and use services. Unfortunately, much is missed. The answers are not always in 'book knowledge' and credentials, because this is not always connected to people’s realities, real-life experiences and challenges."

*Focus Group Participant*

Beginning in August, 2014, the Commission's Action Team met on at least a weekly basis, spending most of its time during the first weeks developing and finalizing its quantitative and qualitative data collection instruments with the oversight and assistance of the Rockland County Planning Department. With the intention of delving both as broadly and as deeply as possible into Rockland County's behavioral health needs given the time frame allotted, the Action Team
saw the need to develop and deploy a variety of methods. The Action Team quickly adopted several different approaches to gather the information sought in this particular needs assessment process. These were a variety of sound, time-tested approaches commonly used in all kinds of research. They included (1) guided focus group discussions, (2) in-depth interviews with key informants, and (3) surveys and questionnaires. The Action Team would also conduct a review of any available archival data related to behavioral health in Rockland County. These approaches were selected because they were flexible, adaptable and usable within a limited timeframe. Collectively, they gave the Commission the most comprehensive profile within a relatively short time period.

**Focus Groups:** These are facilitated, time-limited discussions held in group settings. Often, they are done among naturally-occurring groups, in order to more effectively overcome the fears of having to speak up among strangers or explain everything in detail. The common language and shared perspectives (and other affinities among the group members) can move the process along more smoothly. A set of guiding questions are uniformly used from group to group.

**Rationale:** Focus groups can serve to elicit a wide variety of responses and themes. An individual’s thoughts are often stimulated and ideas are triggered by hearing another’s ideas, experiences or examples. It can be very rich and productive, and it can provide a lot of information in a short time span. Participants often help each other articulate an idea or recall a relevant story. Often participants can help identify an emerging theme or a connection to other community issues (historic or current).

**Implementation:** A focus group questionnaire consisting of ten questions was developed under the guidance of the Planning Department. Twenty-four focus groups were set up by Action Team members for the month of September to reach already-existing community groups and organizations, with the intention of reaching beyond this to the larger community. During this process, the Action Team met weekly to assess what groups or constituencies in Rockland County had not yet been reached, and the Executive Committee was convened in September to lend its assistance. As a result, in October, 16 additional focus groups were added in order to gain access to the harder-to-reach populations in Rockland County. In
all, a total of 40 focus groups were completed by the end of October, with an average of 20 participants per session.

**Key Informant**

**Interviews:** These are face-to-face interviews conducted with people representing different sectors and constituencies. (e.g., government, education, faith, business, human services, parent groups, youth groups, ethnic communities, persons in recovery, other affinity groups). They are usually done as one-on-one conversations with an interviewer taking notes. A uniform set of questions is used with each person interviewed and the person interviewed can choose to indicate if a particular question does not seem relevant to their constituency or to their experience.

**Rationale:** Key informant interviews can give a deeper and more detailed perspective into the needs, concerns, and experiences among a particular community or group. These interviews sometimes elicit information on specific incidents and episodes that illustrate problems encountered or positive outcomes experienced.

**Implementation:** In order to delve into the underlying issues and concerns of Rockland County regarding behavioral health, key informant interviews were used. Each participant was asked a series of 35 questions in an interview spanning at least 90 minutes, ranging from topics such as the strengths and gaps in services, to the role of government, to the individual's personal perspective and story. These rich, revealing interviews were especially helpful not only in adding humanity and depth to the information gathered, but also in engaging harder to reach populations and constituencies. The Action Team completed 28 key informant interviews by the end of its data collection period in early November.

**Surveys and Questionnaires:** These are very common research instruments. They are compilations of targeted questions. A survey is usually composed of close-ended questions with multiple answers from which an individual can choose. Surveys tend to be quick to administer and to complete; they often have sample responses to simply check off.
Questionnaires are similar but they can include open-ended questions and respondents are asked to elaborate or explain. Both kinds of instruments can be disseminated in written (hard-copy) format or in electronic format.

**Rationale:** Surveys and questionnaires are often used to gather the widest response and reach the broadest audience. Because they can be typically done in a few minutes (5-15 minutes respectively), it is easier to get a greater number of people to participate. However, they are usually limited in scope and need to be used in tandem with other approaches (as was being done in this case). For the purposes of this Commission’s needs assessment, a variety of targeted instruments were devised and made available in diverse formats.

**Implementation:** In order to reach the broadest population possible, three types of surveys were developed: (1) a resident survey, designed to be distributed to the general public, (2) a consumer survey, for those who use or have used behavioral health services in Rockland and their families, and (3) a provider survey. It is important to note that a number of questions on these surveys were aligned so that comparisons could be made between respondent types and the different perspectives of residents, consumers and providers could be analyzed. These surveys were distributed online through Survey Monkey and in paper format, and were also made available in Spanish. By the end of the data collection process in early November, nearly 1,400 Commission surveys were completed, collected and analyzed.

Some additional considerations regarding the data gathered are as follows:

- 1,375 surveys were completed in total from mid-September to early November 2014. Considering the County’s 2013 population estimate, the resident survey has a margin of error of ±3.52. In terms of the consumer survey, there is a margin of error of ±4.65 based upon available information about those in Rockland County with cognitive difficulties. This means that our survey results more than meet the criteria to be statistically significant in terms of reflecting the community in Rockland.
• In the consumer surveys, among those who self-identified as a consumer, over 2/3 identified as having a behavioral health problem themselves, while more than 1/3 identified as being a family member of someone with a problem.

• In terms of representing all of the community sectors outlined in our original proposal, all were represented, with the exception of media, which given the sensitivity of the subject matter was eliminated from the sample. The business community was only sampled by survey, with several of the County's largest employers agreeing to distribute surveys to their employees. Half of the focus groups and over 64% of the key informants were related to behavioral health agencies, but almost 1/3 of all focus groups were consumer-based, ¼ were school-based, and 1/5 were law-enforcement based participants.

• The surveys were generally representative of Rockland in terms of gender, race and ethnicity, and age group, with youth being under-represented and women outnumbering men by three to one on the resident survey, but not on the consumer survey.

• Each town in Rockland County was represented, with Clarkstown and Haverstraw being slightly over-represented, and Ramapo slightly under-represented.

• The following constituencies were represented by the focus groups:

<table>
<thead>
<tr>
<th>Constituency Represented - Focus Groups</th>
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<tbody>
<tr>
<td>Mental Health (MH) Providers</td>
</tr>
<tr>
<td>Children's Service Providers (community)</td>
</tr>
<tr>
<td>Community/Human Services (Haverstraw)</td>
</tr>
<tr>
<td>Intellectual/Developmental Disabilities (I-DD) Providers</td>
</tr>
<tr>
<td>Emergency Services Workers</td>
</tr>
<tr>
<td>Community/Human Services (Western Ramapo)</td>
</tr>
<tr>
<td>Healthcare Providers</td>
</tr>
<tr>
<td>Chemical Dependency (CD) Consumers (residential)</td>
</tr>
<tr>
<td>Chemical Dependency Treatment Provider (residential)</td>
</tr>
<tr>
<td>Mental Health Consumers (family)</td>
</tr>
<tr>
<td>Community Services/Government</td>
</tr>
<tr>
<td>Recipient Advisory Council- MH Consumers</td>
</tr>
<tr>
<td>CD Providers- Treatment and Prevention</td>
</tr>
<tr>
<td>Criminal Justice System</td>
</tr>
<tr>
<td>Consumers, Providers, Advocates for all Behavioral Health areas</td>
</tr>
<tr>
<td>Education/Community</td>
</tr>
<tr>
<td>Healthcare-Latino</td>
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</tbody>
</table>
These are some of the features of the population interviewed as key informants. In each case, the individual was selected because of a single, or in many cases a multiple, population representation, including those hard to reach in Rockland County.

<table>
<thead>
<tr>
<th>Population Represented - Key Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Under 21</td>
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<tr>
<td>Over 65</td>
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<tr>
<td>Chemical Dependency (CD) Consumer (Includes family)</td>
</tr>
<tr>
<td>CD Provider</td>
</tr>
<tr>
<td>Intellectual/Developmental Disability (I-DD) Consumer</td>
</tr>
<tr>
<td>I-DD Provider</td>
</tr>
<tr>
<td>Mental Health (MH) Consumer (Includes family)</td>
</tr>
<tr>
<td>MH Provider</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Latino</td>
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<tr>
<td>Haitian</td>
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<tr>
<td>Indigenous</td>
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<tr>
<td>Recent Immigrant</td>
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<tr>
<td>Informal Community Leader</td>
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<tr>
<td>LGBTQ Community</td>
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<tr>
<td>Faith Leader</td>
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<tr>
<td>Orthodox Jewish</td>
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<tr>
<td>Business</td>
</tr>
<tr>
<td>Elected Official</td>
</tr>
<tr>
<td>Media</td>
</tr>
<tr>
<td>Veteran</td>
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<tr>
<td>State Agency Rep</td>
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</table>
VII. Preliminary Findings

By November, 2014, the Action Team had begun to examine the data gathered, to synthesize the initial findings into significant groupings, and identify clearly emerging themes. Although a search for archival sources was not productive--largely because data collected at national, state and regional levels was not disaggregated in a manner that produces relevant information for directly addressing local need--the information derived from the other methods employed by the Commission was very useful. The preliminary data from surveys, focus groups and interviews captured community perceptions of gaps, barriers and needs, but also of strengths and opportunities. It also contained numerous recommendations and suggestions put forth by respondents for improving conditions for those with behavioral health needs in our county and for reshaping the current system of care.

It became immediately evident that this topic was widely deemed worthy of significant attention and that the needs assessment was seen as a welcome opportunity for dialogue. Asked if behavioral health was an important concern, Rockland County residents scored this an 8.5 out of 10, with 10 being a very large concern, and with no results being lower than a 4. Clearly, Rockland County residents considered this an important issue.

VIII. The Five (5) Core Themes

There are five (5) core themes that distinctly emerged from the review of the needs assessment data: Strengths, Awareness, Barriers, Gaps, and Role of Government. Each is listed below with a brief description, including data used to reach the finding, and recommendations from the community on how to address the issue.

Theme I: The Strengths of Behavioral Health Services in Rockland County

When asked about the ability of behavioral health services in Rockland County to meet consumer needs, more than two thirds of those surveyed reported that their needs were met after receiving behavioral health services in Rockland County. This does not take into account people
in need that do not access services because of barriers or gaps in the continuum of care. Consumers surveyed were given a menu of 37 different types of services representing developmental disabilities, chemical dependency/substance use disorders, and mental health, and running the gamut from treatment to prevention, from residential to short-term therapy. The following is a list of the six services utilized where residents expressed the highest degree of satisfaction with their treatment, the highest numbers being for private therapy, outpatient mental health services, and “personalized recovery oriented services,” or PROS.

<table>
<thead>
<tr>
<th>Behavioral Health Services and Programs with High Consumer Satisfaction</th>
<th>Participated Number</th>
<th>Highly Satisfied Number</th>
<th>Somewhat Satisfied Number</th>
<th>Not Meeting my Needs Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Care Management</td>
<td>180</td>
<td>100</td>
<td>56</td>
<td>24</td>
</tr>
<tr>
<td>Mental Health Clinic</td>
<td>182</td>
<td>104</td>
<td>55</td>
<td>23</td>
</tr>
<tr>
<td>PROS (Personalized Recovery Oriented Services)</td>
<td>121</td>
<td>75</td>
<td>30</td>
<td>16</td>
</tr>
<tr>
<td>Outpatient Mental Health Program</td>
<td>173</td>
<td>108</td>
<td>41</td>
<td>24</td>
</tr>
<tr>
<td>Private Psychiatrist or Therapist</td>
<td>177</td>
<td>111</td>
<td>40</td>
<td>26</td>
</tr>
<tr>
<td>Early Intervention Services (DD)</td>
<td>51</td>
<td>31</td>
<td>12</td>
<td>8</td>
</tr>
</tbody>
</table>

Among the significant relative strengths of behavioral health services in Rockland County, respondents cited:

- Location- services that are close to home
- Quality of staff and atmosphere; caring and respectful treatment; maintaining confidentiality and privacy
- Acceptance of insurance
- Flexibility- serving people of all ages, and

<table>
<thead>
<tr>
<th>Relative Strengths of Behavioral Health Services in Rockland</th>
<th>Resident Survey Number</th>
<th>Resident Survey Percent</th>
<th>Consumer Survey Number</th>
<th>Consumer Survey Percent</th>
<th>Provider Survey Number</th>
<th>Provider Survey Percent</th>
<th>Focus Group Number</th>
<th>Focus Group Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close to home</td>
<td>259</td>
<td>56.4%</td>
<td>190</td>
<td>56.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serve people of all ages</td>
<td>189</td>
<td>41.2%</td>
<td>143</td>
<td>42.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidential/ Private</td>
<td>175</td>
<td>38.1%</td>
<td>160</td>
<td>47.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff is skilled and knowledgeable</td>
<td>157</td>
<td>34.2%</td>
<td>182</td>
<td>54.5%</td>
<td>14</td>
<td>9.6%</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Connects people to other services needed</td>
<td>156</td>
<td>34.0%</td>
<td>154</td>
<td>46.1%</td>
<td>1</td>
<td>0.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caring, respectful atmosphere</td>
<td>153</td>
<td>33.3%</td>
<td>199</td>
<td>59.6%</td>
<td>5</td>
<td>3.4%</td>
<td>2</td>
<td>5.0%</td>
</tr>
<tr>
<td>Accept my insurance</td>
<td>147</td>
<td>32.0%</td>
<td>179</td>
<td>53.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Service collaboration. Professionals expressed that they did collaborate with one another, and both professionals and the public outlined the value of collaboration to insuring better services for those with behavioral health needs.

<table>
<thead>
<tr>
<th>Provider Survey Indicator</th>
<th>Number of Responses</th>
<th>Yes Number</th>
<th>Yes Percent</th>
<th>No Number</th>
<th>No Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you collaborate with other service providers?</td>
<td>162</td>
<td>151</td>
<td>93.2%</td>
<td>11</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

Many respondents urged that behavioral health needs be approached with greater intentionality and collaboration, and with more deliberate inclusion of consumer perspectives. Respondents also saw that there needed to be a closer connection among behavioral health services and the education and primary health care systems. Many emphasized the need to establish working partnerships with natural leaders in the immigrant communities. Respondents also urged enhanced funding for services that are working effectively.

**Theme II: Lack of Awareness of Behavioral Health Services in Rockland County**

The needs assessment revealed a marked lack of awareness of existing services in Rockland County, despite the clear indications that the public sees behavioral health as a pressing need. This limited awareness of behavioral health services in Rockland County applies to residents, consumers and providers alike, who expressed in high numbers that they either did not know where to access services, and/or that there was a lack of familiarity with different types of services.

<table>
<thead>
<tr>
<th>Barriers to Accessing Behavioral Health Care</th>
<th>Resident Survey</th>
<th>Consumer Survey</th>
<th>Provider Survey</th>
<th>Focus Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not know where to get services</td>
<td>212</td>
<td>66</td>
<td>N/A</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>42.9%</td>
<td>27.3%</td>
<td>N/A</td>
<td>30.0%</td>
</tr>
<tr>
<td>Unfamiliar with types of service</td>
<td>186</td>
<td>58</td>
<td>95</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>37.7%</td>
<td>24.0%</td>
<td>55.9%</td>
<td>17.5%</td>
</tr>
</tbody>
</table>
More than 40% of respondents did not know of a place to go for behavioral healthcare in Rockland County. When asked about specific types of services, this number was even higher, with approximately half of the residents surveyed not knowing where to go for help with a whole host of services representing all of the behavioral health areas. Preventive services seemed to be the least familiar to residents, with over 60% being unaware of any services that promoted good emotional health and development.

<table>
<thead>
<tr>
<th>Resident Survey Indicator</th>
<th>Number of Responses</th>
<th>Yes Number</th>
<th>Yes Percent</th>
<th>No Number</th>
<th>No Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you currently know of or have a place where you could go for behavioral health care service in Rockland County?</td>
<td>734</td>
<td>430</td>
<td>58.6%</td>
<td>304</td>
<td>41.4%</td>
</tr>
<tr>
<td>Do you know any community programs in Rockland County that help individuals and families under stress, experiencing trauma, suffering from losses or other emotional difficulties?</td>
<td>694</td>
<td>337</td>
<td>48.6%</td>
<td>357</td>
<td>51.4%</td>
</tr>
<tr>
<td>Do you know where someone can get help coping with learning problems or developmental disabilities in Rockland County?</td>
<td>687</td>
<td>359</td>
<td>52.3%</td>
<td>328</td>
<td>47.7%</td>
</tr>
<tr>
<td>Do you know where someone can get help for children or teens with emotional difficulties, learning problems, or addiction (their own or a family member’s) in Rockland County?</td>
<td>679</td>
<td>319</td>
<td>47.0%</td>
<td>360</td>
<td>53.0%</td>
</tr>
<tr>
<td>Do you know where in Rockland County someone can get help with a problem with alcohol, other drugs, or another addiction, such as gambling?</td>
<td>693</td>
<td>366</td>
<td>52.8%</td>
<td>327</td>
<td>47.2%</td>
</tr>
<tr>
<td>Are you aware of community programs in Rockland County that promote good emotional health and development?</td>
<td>685</td>
<td>273</td>
<td>39.9%</td>
<td>412</td>
<td>60.1%</td>
</tr>
</tbody>
</table>

The leadership was rated by our key informants as being somewhat more aware of behavioral health services, efforts and needs than residents, with an average score of 5.3 out of 10 as opposed to 4 for residents. However, the numbers for leadership were split, with 21.7% of leaders being seen as very aware, while the same number, 21.7% seen as having very little awareness. Far more residents (37.5% compared with 21.7%) were seen as being very aware of behavioral health needs than leaders, despite a lower average number.
There seemed to be little awareness of any evaluation of behavioral health efforts. Key informants were asked about evaluation efforts, and nearly 62% were unaware of any efforts, despite most believing that the quality of care and care coordination were of utmost importance.

Respondents suggested a range of strategies to address the lack of awareness.

Recommendations regarding the use of media included:

- Advertise with public service announcements
- Educate through media, social networks, movies
- Signs in and on buses and at bus stops
- Newsletters & flyers
- A handy listing of behavioral health resources in the county that could be available in the malls and other public places; needs to be readily accessible when people need it—an easy-to-use pocket guide, for example.

Some suggestions regarding approaches for outreach to the community included:

- Holding “Lunch and Learns” to educate the business community
- Making connections with local libraries
- Educating community faith leaders on behavioral health issues and resources
- Using local doctors’ offices to convey information on behavioral health

“Every child has to go to school. So, sending home information to parents could help as well. It could reduce the stigma and assist them to find services.” Survey Participant

Emphasis was given to the idea of a single point of information that was easily identifiable, accessible and more specialized in matters of behavioral health. The need for a centralized place where everyone could access information about services, such as a website or hotline was repeatedly cited. Many saw a need for a comprehensive directory of private and public services
available inside and outside of the county to county residents, categorized with specific information such as who is served and what kind of insurance is accepted.

Respondents commented on the need to establish a common language for behavioral health, and emphasized the need to educate elected officials on behavioral health issues and potential solutions. Some indicated that it is vital to make BH information part of school education, and to encourage local colleges to have sessions/forums regarding behavioral health issues.

**Theme III: Significant Barriers to Obtaining/Providing Behavioral Health Services in Rockland County**

Rockland County residents, providers and consumers all reported significant barriers to obtaining behavioral health services. *Lack of insurance or insurance not accepted* was listed as one of the top three barriers by all participants. *Lack of transportation* was a primary barrier in all but the resident responses. Residents cited price, lack of insurance or insurance not accepted, and not knowing where to go for services as the primary barriers. Consumers listed lack of transportation, lack of insurance or insurance not accepted, and price as the biggest obstacles. Providers overwhelmingly saw insurance issues as the primary barrier, with lack of transportation and lack of familiarity with type of service also ranking high. Focus group participants saw lack of transportation, insurance issues and language as the primary barriers to people with behavioral health needs receiving help.

“*It depends on the socioeconomic status-- the poor go to the Emergency Room while [people with] higher socioeconomic status go to specific programs.*” Key Informant

While the issue of stigma was not listed as a survey response choice for possible barriers, it was a big discussion point in both the focus group and key informant interviews, with 45% of focus groups listing *stigma as a primary barrier* to accessing care.
At the same time that the results indicated that Rockland community members rate behavioral health services an 8.5 out of 10 in terms of a priority, those same respondents do not believe that there is or will be nearly enough support for behavioral health services among their friends and neighbors, nor is there the perception of support from the leadership. Less than a quarter believe that the County’s leadership sees these issues as a major concern, and only slightly more than 18% believe that the community at large would strongly support increased services, even though those services are vitally needed.

Following is the complete list of barriers to accessing behavioral health care in Rockland County, by survey and focus group results:
Providers listed the obstacles that they encountered in attempting to provide care for community members with behavioral health needs. **Funding limitations and/or restrictions, and limited staffing resources topped their list**, with consumer non-adherence to treatment being third. This was a subject discussed in a number of key informant interviews and focus groups, where medication non-compliance, for example, came up as a repeated theme. However, funding limitations, primarily but not only connected to insurance coverage and payments, was the identified as a primary barrier.

<table>
<thead>
<tr>
<th>Barriers to Providing Behavioral Health Care</th>
<th>Provider Survey Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding limitations and/or restrictions</td>
<td>89</td>
<td>55.3%</td>
</tr>
<tr>
<td>Limited Staffing Resources</td>
<td>87</td>
<td>54.0%</td>
</tr>
<tr>
<td>Consumer non-adherence to treatment</td>
<td>73</td>
<td>45.3%</td>
</tr>
<tr>
<td>Proscribed parameters of services, regulations,</td>
<td>64</td>
<td>39.8%</td>
</tr>
<tr>
<td>limitations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refusal of Service</td>
<td>49</td>
<td>30.4%</td>
</tr>
<tr>
<td>Limited Space/ Equipment</td>
<td>40</td>
<td>24.8%</td>
</tr>
<tr>
<td>Consumer inability to afford prescription medications</td>
<td>29</td>
<td>18.0%</td>
</tr>
<tr>
<td>Other:</td>
<td>37</td>
<td>23.0%</td>
</tr>
<tr>
<td>Insurance Companies/Limitations</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lack of Awareness of the Provider/Service</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

When asked if certain segments of the population in Rockland County faced disproportionately high barriers in trying to obtain behavioral health services, it was clear that consumers, providers, and the general public all believed that this was the case, as seen below.
It was commonly perceived that **there exist many behavioral health policies in place that contribute to barriers**. All of the state agencies (NYSOASAS, NYSOMH, NYSOPWDD) have policies that limit, intentionally or unintentionally, access to care. Particularly with some of the new rulings-- such as the Olmstead decision, which was intended to foment greater “consumer independence”-- essential services currently in place are in jeopardy of being discontinued or greatly curtailed. Other NYS behavioral health policies limit access as well. One such example is the NYSOASAS prevention guidelines, limiting prevention counseling care to "children," defined as age 20 or under, while new brain research suggests that this age should be increased to at least 25 years of age. Particular barriers exist for those with co-occurring disorders, especially those classified under NYSOPWDD, who are then prevented from receiving services under NYSOMH. Three fourths of our key informants felt that policies existed that stood in the way of behavioral health service delivery to our community. One response captures this: “If you are NYSOPWDD eligible, you are not NYSOMH eligible. So people are only partially served….silos based on funding streams stand in the way. Skills needed in I-DD residential services are different than in MH residential services. Sometimes you need both.”

Respondents made various suggestions and recommendations for **improvements to address some of the barriers**. These include reference to the need for after-hours services, more service on demand and elimination of long waits. It was observed that there are a growing number of people who are underserved, including the working poor and undocumented persons residing in the county. Many stated that we need to remove the institutional barriers created by State and local policies through advocacy and government leadership.

> “Recovery after going to a behavioral health program is not always talked about. If the discussion in program is all about managing symptoms and only focused on what can go wrong, there is no hope.” Focus Group participant

Many respondents saw the question of **insurance coverage and funding** for needed services and ancillary supports as a central issue. The concerns aired included the need for affordable treatment, the dearth of therapists who accept insurances, Medicaid, or self-pay, the need for ancillary supports to help families (e.g. bus tickets, taxi fares, case management, mini-grants), and the need for sliding fee schedules that are truly affordable so more people can receive
services. Another common response was in reference to the issue of transportation. An example of this was the statement: “Make arrangements with bus companies to get consumers low-cost bus tickets. We did this before and it was a great success— it made a huge difference.”

One topic of discussion that emerged continually in discussions and interviews was the issue of stigma related to behavioral health disorders and treatment. Many highlighted how deeply this affects not only the individual or family in need, but historically affected the entire field of behavioral health. Some respondents commented about the need to drop “mental illness” in language, replace it with “mental health.” Others supported the approach of looking at this as “behavioral health” and doing away with some of the divisions among mental health, chemical dependency/substance use disorders and developmental disabilities.

Theme IV: Gaps in the Continuum of Care for Behavioral Health Services in Rockland County

“When services can’t be provided, the behavioral health problem doesn’t go away.” Key Informant

The needs assessment revealed that there are huge tears in the safety net of behavioral health services in Rockland County and that, for certain groups in particular, conditions have now reached dangerous if not disastrous proportions. The following is a list of the most often mentioned behavioral health issues or problems in Rockland County, as indicated by surveys, focus groups, and key informant interviews. These are listed alphabetically—not in order of importance.

<table>
<thead>
<tr>
<th>Most Significant Behavioral Health Issues/Problems Cited By Respondents in the Needs Assessment (in alphabetical order)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction</td>
</tr>
<tr>
<td>Aftercare</td>
</tr>
<tr>
<td>Autism/Asperger's</td>
</tr>
<tr>
<td>Case Management</td>
</tr>
<tr>
<td>Child Psychiatry</td>
</tr>
<tr>
<td>Children Services</td>
</tr>
<tr>
<td>Information and Referral</td>
</tr>
<tr>
<td>Inpatient Hospitalizations</td>
</tr>
<tr>
<td>Insurance</td>
</tr>
<tr>
<td>Length of Stay</td>
</tr>
<tr>
<td>Medication</td>
</tr>
<tr>
<td>Nyack Hospital</td>
</tr>
</tbody>
</table>
In addition to this list, 68.5% of residents believed that behavioral health services were limited or not available in Rockland County. In both the resident surveys and the focus groups, the community indicated that our residents are leaving Rockland to access services. Discussion in the focus groups indicated that individuals and families left for a variety of services that were unavailable in Rockland. Some mentioned frequently included child and geriatric mental health care, autism and Asperger's services, and psychiatric care for those with developmental disabilities.

More than 40% of residents believed that community members were leaving Rockland to access care. There were others who felt that the services they used in Rockland County did not adequately meet their needs.
The following is a list of the programs that those surveyed felt were not meeting their behavioral health needs. Some, such as mobile crisis service for developmental disabilities, had comparable high satisfaction and dissatisfaction rates. However, none of these services rated by the community had more than 42% of consumers feeling "highly satisfied" by their services, and more than 1/3 in all of these services did not think that the service met their needs.

<table>
<thead>
<tr>
<th>Behavioral Health Services and Programs</th>
<th>Participated</th>
<th>Highly Satisfied</th>
<th>Somewhat Satisfied</th>
<th>Not Meeting my Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Inpatient Hospitalization for Psychiatric Services</td>
<td>80</td>
<td>20.0%</td>
<td>30</td>
<td>37.5%</td>
</tr>
<tr>
<td>Mental Health Crisis Services (ER, other)</td>
<td>90</td>
<td>22.4%</td>
<td>36</td>
<td>40.0%</td>
</tr>
<tr>
<td>Mental Health Services for Children/Adolescents</td>
<td>61</td>
<td>15.2%</td>
<td>21</td>
<td>34.4%</td>
</tr>
<tr>
<td>Supportive Employment (DD)</td>
<td>53</td>
<td>13.2%</td>
<td>21</td>
<td>39.6%</td>
</tr>
<tr>
<td>Mobile Crisis Service (DD)</td>
<td>24</td>
<td>6.0%</td>
<td>10</td>
<td>41.7%</td>
</tr>
<tr>
<td>Substance Use Detox program</td>
<td>45</td>
<td>11.2%</td>
<td>16</td>
<td>35.6%</td>
</tr>
<tr>
<td>Methadone Maintenance</td>
<td>21</td>
<td>5.2%</td>
<td>4</td>
<td>19.0%</td>
</tr>
</tbody>
</table>

The following list represents those services that the needs assessment indicates are too limited or not currently available in Rockland based upon our findings. This list represents the topics that came up on a repeated basis in the focus groups, key informant interviews and all three surveys.
There were differences in consumer and provider ideas about what services were missing or limited that needed to be available. The following are the issues mentioned by consumers but not by providers:

Perhaps the widest range of recommendations from respondents came in reference to perceived gaps. Among these were such things as mobile mental health services that could go from community to community and respond to a range of needs, in-home behavioral health evaluations for people who cannot necessarily get out to a hospital or clinic, and a centralized, one-stop BH service center where behavioral health programs could be co-located and where triage could be conducted.
Some repeated the idea of an in-county partial hospitalization program for a given segment of people in need, while others emphasized the growing need for homeless services and housing. The notion of more closely integrating mental health and pediatrics was cited by several respondents—to have behavioral health providers embedded in pediatric sites for screening and referral, and to amplify cross-training opportunities. Some respondents expressed a concern over the lack of supportive services for parents with higher-functioning children with developmental needs, for college-aged youth who have "aged out" of services/schools—support for transitional-aged individuals, and for persons with autism—many of whom have to turn to neighboring counties for support unavailable in our own county. There was also the view that respite services for families dealing with behavioral health problems are needed, as well as more peer advocates and mentors for children and youth— it was felt that this should be built into all of the behavioral health programs. Yet others stated that we needed to be concerned that, as the aging population continues to grow, we will need inpatient facilities that are equally adept at handling dementia and geriatric psychiatric needs.

Investing in staff development was another topic among respondents. Some suggested recruitment of behavioral health providers who are culturally-attuned to our community— including para- professionals. It was also recommended that Mental Health First Aid training be given to every helping professional who can come in contact with people with behavioral health issues. Among behavioral health professionals, there was a perceived need for trauma-informed sensitivity training as a mandatory requirement.

"So many people present to a doctor’s office with a physical problem but it could be a behavioral health problem. It would help to have a questionnaire for healthcare providers and train the providers to administer this questionnaire to patients to treat them more effectively."

Survey Participant
Theme V: The Role of Government

While there may be a difference between the actual role of government, and the perception of community members as to what the role of government should be, our data clearly indicates that the community believes that *Rockland County government has a vital role to play* in keeping its people safe and in ensuring that their basic behavioral health needs are met. Part of the work for the Commission involves researching the County charter to clarify the legal responsibilities of our elected officials, and to become as knowledgeable as possible about the ever-changing state and local mandates affecting behavioral health. The Olmstead decision and all of its ramifications for some of our most vulnerable residents must be explored, as the behavioral health community comes to grips with Medicaid re-design and all of its implications.

The community believes that *Rockland County government is properly positioned* to more effectively address the behavioral health concerns of its residents. They see local municipalities as too small to have the more ample perspective needed or the resources to tackle their own behavioral health problems, and the state and federal government as too large to assess the community's needs or be motivated to meet them.

The results of the needs assessment conducted indicate that the community believes that the *County should provide behavioral health services, especially safety net services* and those services not covered (or not adequately covered) by insurance. However, it was indicated time and again, in both focus group and key informant interviews, that the County's financial picture
is a grave concern, and that therefore the County probably could not and should not provide all services as directly as it once did. That said, it was the clear expectation that the **County should insure that the full array of behavioral health services are available, accessible and affordable** for residents without significant impediments. The needs assessment reveals that the community views the County as responsible to insure that the fabric of the behavioral health safety net be repaired as quickly and completely as possible. Those who participated believed strongly that the County should be responsible for the health and welfare of its residents. They see the role of government as supporting, not necessarily directly providing, behavioral health services.

Those who were surveyed believed that the **County is responsible to insure that the services provided are meeting the needs** of the community. There were many mentions of the local Unified Services process, both for the good that it still does in the coordination of services, and
for what it is lacking in comparison with the past, where there was a more robust and inclusive process. This was seen as a primary role for the County moving forward—**to rebuild this support system and to work hand in hand with the community and the State licensing agencies** in supporting providers who serve the behavioral health needs of residents.

**Role of County Government in Providing/Overseeing Behavioral Health Services in Rockland**

**Support, Supervise & Coordinate Services**
- Ensure that Needed Services are Available
- Quality Assurance of Providers—Insure they are effective and efficient
- Oversight of Regulations
- Compliance Communication with Agencies
- Invest in Dashboards to Provide Real-Time Analytics
- Oversight of Continuum of Care
- Monitor Cost of Care
- Ensure equitable treatment for all
- Make Sure People Don’t Fall Through Cracks—Don’t Get Lost or Discouraged
- Oversight to Avoid Duplicating of Services
- Unified Services model that was in place previously is a good concept
- Give Mandate—Give permission to allow work to be done
- Better Transportation Services
- More Culturally Competent/Specific Services
- Ensure Services Available for Uninsured
- Ensure Services are Inclusive
- Identify Services and Gaps
- Staying in Touch with what Science Says—Newest Evolving Changes and Not Being Afraid to Implement Them

County government is seen as the place that should be **the hub of all information regarding behavioral health services** for its residents. Additionally, those who participated believed that the County should be **reaching out to those who have difficulty accessing services**, and in particular to **reach those who have been traditionally underserved**.

“Services have to be culturally-responsive to the needs of the population they serve and have a staff that is not just sensitive but multi-lingual and multi-cultural.”

*Focus Group Participant*
Among respondents, there was a widely held belief that it is the responsibility of the County to proactively seek resources to rebuild and maintain behavioral health services in Rockland County, including but not limited to municipal and grant funding through the formation of new partnerships and alliances. This includes helping to build the capacity of contract agencies and local grassroots organizations to better meet community needs.

Finally, it is believed that there is a strong role for advocacy on the part of Rockland County government. The needs assessment indicates that the community expects its leaders to know what the behavioral health needs are, and to use their power to advocate on the state and national levels to remove barriers and increase access to good quality care. Countless focus group and key informant participants praised Rockland County government for the forward-thinking nature of this needs assessment, and stated that this was the beginning of something important in terms
of taking behavioral health needs seriously. There is a strong expectation on the part of the participants that the results of the needs assessment will be used by County government to shape a better future for those affected by behavioral health issues in Rockland County.

Participants in the needs assessment process offered various recommendations regarding the role of local government. In particular, there was an emphasis on County government coordinating BH services through a single entity for oversight and accountability, advocating for the co-licensing of programs/facilities by NYS (OMH & OASAS) and for blended funding (MH/I-DD services), and revitalizing the County planning process, including the Community Services Board and its subcommittees.

County government was also seen in the roles of coordinating training for all BH service providers and in conducting or spearheading BH studies on a regular basis that could help move forward in strategically addressing community needs and attracting outside funding. Another important role was that of strengthening and supporting community-based organizations that provide BH services and other ancillary support for BH consumers and their families. It was also perceived that local government could be proactive in educating and alerting elected officials so that behavioral health was more valued and appropriately funded.
IX. Recommendations

After carefully reviewing all the information gathered, the Commission’s next task was to craft a set of recommendations that would, in essence, begin to re-design the behavioral health service delivery system in Rockland County and take into account a wide range of voices and perspectives. There was consensus among Commission members that recommendations needed to be articulated as actions to be taken, with an identified entity responsible for initiating or implementing the action. Whenever possible, additional specifications would include a timeframe, partners, and short-term measurable outcomes.

“Look at long term rather than short term needs-- a real fix rather than a band aid.”
Key Informant

The recommendations were organized to align with the themes that came out of the needs assessment. The Strengths section of the needs assessment corresponds with “Building Upon Strengths” in the recommendations, Awareness with “Increasing Awareness,” Barriers with “Removing the Barriers,” Gaps with “Closing the Gaps,” and Role of Government with “Reaffirming the Role of Government.”

Gaps constituted, by far, the largest section of the needs assessment, and as such, the recommendations have been divided into seven sections: Adult Mental Health, Chemical Dependency/Substance Use Disorders, Child and Adolescent Mental Health, Co-located Services, Criminal Justice Services, Crisis Services, and Intellectual-Developmental Disabilities.

There are several subcategories under each recommendation’s theme. These were taken in large part from the format of the Senate Finance Committee's Summary and Overview of Mental Health recommendations, published in February 2014. These categories include, for example, care provision and expansion, care integration, information access, role of government, service access, and education.

We have included a reference chart, (see Appendix E, pg 133) where all of the recommendations are listed by a code, page number, responsible parties and partners, implementation timeframe,
and availability of resources, making it easier to search through the recommendations in an efficient way. The key to the codes is at the bottom of the page, with S standing for the section on Building Upon Strengths, A for Increasing Awareness, and so on, as listed.

If you look through the reference chart and see a recommendation you want to learn about in more detail, one could do so; for example, let’s look at the recommendation dealing with waiting list times through referrals. Looking to the left, you would see the code for the recommendation—this case, BA-5, indicating the section on Barriers—Section B, Category A, Number 5. To the right of the recommendation, you would see the page number listed, and see that you could find the full recommendation on page 56 of the report.

<table>
<thead>
<tr>
<th>Code</th>
<th>Recommendation</th>
<th>Section</th>
<th>Category</th>
<th>Number</th>
<th>Reference</th>
<th>Responsible</th>
<th>Implementation Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-5</td>
<td>Awareness efforts directed to special populations</td>
<td>BCODH</td>
<td>BH providers incl. BCODH</td>
<td>1 to 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A-D1</td>
<td>Annual education sessions for all mental health professionals</td>
<td>County of Rockland, Legislature</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A-D2</td>
<td>Create a BH media campaign</td>
<td>BCODH</td>
<td>BH providers, other agencies included</td>
<td>1 to 5</td>
<td>1 to 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-A2</td>
<td>Access &amp; treat waiting lists</td>
<td>BCODH</td>
<td>BH providers, other BH agencies</td>
<td>1</td>
<td>2 to 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-A5</td>
<td>Serve homeless youth with BH issues</td>
<td>BCODH</td>
<td>BH providers incl. BCODH, Some BH agencies</td>
<td>1</td>
<td>2 to 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-A4</td>
<td>Develop a “problem” tool for BH professionals</td>
<td>Rockland</td>
<td>Rockland, BH agencies</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-A6</td>
<td>Link youth through referrals</td>
<td>BCODH</td>
<td>Some BH agencies</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-56</td>
<td>Adapts PROS to serve those unable to work 10+ hours a week</td>
<td>MH</td>
<td>MH, DD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-67</td>
<td>ACCESS/NO present services, troubleshoot issues</td>
<td>BCODH</td>
<td>BH Workgroups, ACCESS, State agencies</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-R1</td>
<td>Add resource assessment to annual planning process</td>
<td>BCODH</td>
<td>BH Workgroups, Subcommittees, CSB</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-S2</td>
<td>Build client engagement</td>
<td>BCODH</td>
<td>BH Workgroups, peer support, housing specialists</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-C1</td>
<td>Recruitment efforts—BH, special populations</td>
<td>BCODH</td>
<td>BH providers</td>
<td>3 to 5</td>
<td>3 to 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-C2</td>
<td>Analysis of BH agency staffing for core components</td>
<td>BCODH</td>
<td>BH providers incl. BCODH</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-C3</td>
<td>Reduce BH staff with mental, linguistic components</td>
<td>Rockland</td>
<td>Rockland</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-C4</td>
<td>Measure improvement ratio of staff to patients</td>
<td>BCODH</td>
<td>BH Workgroups, Subcommittees, CSB</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-C5</td>
<td>Expand use of peer professionals and recovery coaches</td>
<td>BCODH</td>
<td>BH Workgroups</td>
<td>1</td>
<td>3 to 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-D1</td>
<td>Work with State reps to address uninsured restrictions</td>
<td>BCODH</td>
<td>State and Federal representatives</td>
<td>2 to 5</td>
<td>3 to 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The chart can also be used as an easy reference guide to see who is responsible for implementing the recommendations. For example, if you were a member of the Community Services Board, you could search the sections on Primary Entities Responsible and on Other Partners, to find any Recommendation where the Community Services Board (CSB) is listed. You could then turn to the corresponding page to read the full recommendation pertaining to the Community Services Board.

Finally, the chart may be used for understanding what the next steps for implementation might be. Under the Implementation Timeframe category, any item scored as a “1” is something that the Commission ranked as being something to achieve within the first year, a “2” is something to be done within 2-3 years, and a rating of “3” would be done within 3-5 years.
Using the Implementation Timeframe category in conjunction with the category on “Resources Needed” is especially helpful. A ranking of “1” in this category means that the Commission assessed that the recommendation can be implemented with existing resources; “2” means minimal additional resources would be needed, and a “3” indicates that substantial additional resources are required to achieve the recommendation.

In a quick review of the chart, there are dozens of recommendations that the Commission has assessed can be achieved within the first year, with no additional resources but can make a tremendous difference in the lives of those we hope to serve, without adding an additional burden to the County tax base.

On the other hand, there are a number of recommendations that the Commission has deemed to be urgent, but will definitely require additional resources. Those are the recommendations with lower numbers in the Implementation Timeframe category, and higher numbers in the Resources Needed category. There are significant tears in Rockland County’s behavioral health safety net that must be repaired, and to do our job effectively and honor our commitment to our community, more resources will be necessary. It is for this reason that a Resource Development Committee of the Commission is so very important.
**Building upon Strengths** *(Recommendations Code S)*

A. Care Provision/ Expansion

1. Programs that were identified as highly satisfactory to consumer participants in the Needs Assessment should be further studied as to what factors made them effective and what can be teachable or translatable to other services to improve overall quality of care in Rockland. This could be addressed by entities such as the Community Services Board or the Rockland County Department of Mental Health.

B. Care Integration

1. RCDMH, through the local planning and oversight process, must ensure that all Rockland behavioral health agencies normalize collaboration with an intention to improve access and services for their consumers beyond their specific BH needs. This must include enhanced partnerships and a thorough knowledge of available services outside of the BH system. Agencies must monitor the effectiveness of these efforts through information collected from staff and consumers.

C. Workforce Development/ Expansion

1. A primary mission of RCDMH must be to ensure professional development opportunities to the county-wide behavioral health workforce, including Continuing Education Units. RCDMH will do this by disseminating best practice information, utilizing local expertise and providing training opportunities on evidence-based practices that are open to all BH agencies.

D. Role of the LGU/ Government Departments

1. RCDMH will establish a consistent method of measuring consumer satisfaction that is developed within the existing behavioral health Workgroups. This should include the development of a uniform survey instrument and process to be conducted throughout the course of service delivery under the oversight of RCDMH. As part of the annual contractual review, RCDMH will meet with programs to review and analyze results for the purpose of directing or
redirecting services to better meet consumer needs and improve program efficiency. These results will be presented to the Community Services Board by RCDMH as part of the annual programmatic and budgetary review.

2. County Departments will establish/ enhance their presence within existing local community networks and partnerships including, but not limited to, community collaboratives, community coalitions, consumer advocacy groups, etc. This can include County Departments such as Mental Health, Health, Community Development, Public Transportation and Planning, DSS, Youth Bureau, Probation, DA’s Office, County Executive’s Office. Departments should provide resources, convey relevant information and foster opportunities for collaboration. Departments must listen and respond to emerging community needs and integrate into the established planning processes.

3. County of Rockland (County Executive and County Legislature) will revitalize and re-empower the former Unified Services System in Rockland County, including the Community Services Board, Subcommittees and Work Groups. County of Rockland will utilize the county planning process and Community Services Board to effectively structure and maintain a comprehensive system of quality behavioral health services in Rockland.

E. Information Access

1. RCDMH will assess, through the contract process, that representatives of behavioral health agencies have established/ expanded their presence in existing local community networks and partnerships including, but not limited to, community collaboratives, community coalitions, consumer advocacy groups, etc. This will also apply to those programs receiving direct contracts through the County of Rockland to provide BH services.

F. Service Access

1. Behavioral health agencies in Rockland, including RCDMH, will look for opportunities to create/re-create services located within Rockland communities, including the establishment of satellites, co-located services, shared resources, to further develop resources to address BH needs.
2. Behavioral health agencies in Rockland, including RCDMH, will explore partnerships in underserved communities, including linkages to natural community leaders, to more effectively respond to the BH needs of these communities. Care must be given to engage the community to identify their natural leaders.
**Increasing Awareness** (Recommendations Code A)

A. Workforce Development/ Expansion

1. Create a position within County Government under RCDMH that serves the role of an education resource specialist/community liaison regarding behavioral health. This position should be responsible for developing a public awareness campaign about behavioral health, for collecting and disseminating BH resources (brochures, posters, newsletters, grants announcements, State and National campaign materials), and conducting outreach to the community.

B. Role of the LGU/ Government Departments

1. As a means of capturing what currently exists in Rockland County, develop a series of organizational charts depicting the entire Unified Behavioral Health Services System. These charts will reflect all of the levels of care and the providers serving Rockland County residents. These charts must be developed and updated annually by RCDMH, in collaboration with all possible BH providers.

2. As a contractual requirement, behavioral health agencies that receive contracts through the County of Rockland will be required to submit updated information annually. This one-page submission will, at a minimum, include contact information, description of services, insurance accepted and hours of operation. This information will be utilized by a single point of contact to keep information current regarding BH services in Rockland County. This must be upgraded as soon as possible to a digital system.

C. Information Access

1. County Executive will designate, within the County, a single point of contact where Rockland residents can access information about behavioral health services. This needs to include a phone line, separate and apart from a crisis hotline, that can both provide referral information as well as a direct link to BH crisis services when needed. Additionally, a publicly available website
containing this information should emanate from this single point of contact. InfoRock has an infrastructure in place, if additional resources are made available, that may meet this need.

2. An interagency collaboration between the single point of contact and RCDMH must explore ways to capture salient information in printable formats, i.e. a pocket guide for first responders, a two-sided card with behavioral health contact information to be handed to the public, a comprehensive desktop binder for human service and other professionals, a downloadable digital resource guide, etc. When applicable, these printable formats should include a glossary of BH terms, modalities and approaches. These must be reviewed and updated annually as necessary.

3. Behavioral health agencies in Rockland, including RCDMH, will explore partnerships in underserved communities, including linkages to natural community leaders, to increase awareness of BH services and resources available to these communities.

4. RCDMH will work with local behavioral health providers to ensure that awareness efforts are directed and relevant to the needs of special populations identified in the Needs Assessment e.g. LGBTQ, trauma survivors, underserved cultural/religious groups.

D. Education

1. An educational session, co-sponsored by the County Executive’s Office and the Rockland County Legislature, will be developed and presented annually to all local elected officials. The purpose of this forum will be to present a current overview of behavioral health services/emerging BH needs for Rockland’s residents. The presentation will be created with input from the entire Unified Behavioral Health Services System and should coincide with Mental Health Awareness Month that takes place in May.

2. RCDMH will spearhead a county-wide campaign regarding behavioral health that utilizes multiple strategies (public service announcements, media, social networks, digital media, movies, bus signs, newsletters, etc.) to promote existing programs and services and increase understanding of behavioral health issues. The education resource specialist/community liaison (see above) will coordinate the campaign. The campaign will include both general messages for
the public at large and targeted messages for those in need. This will be developed and implemented in collaboration with existing organizations and sectors, e.g. schools, faith communities, human service and BH agencies, business, law enforcement, healthcare providers, government, media, etc.
Removing the Barriers (Recommendations Code B)

A. Care Provision/ Expansion

1. RCDMH, through the annual contract process, will ensure that evening and weekend services for all levels of behavioral health care are made available throughout the county, including within County-run services.

2. RCDMH, through the annual contract process, will ensure that behavioral health service providers, including County-run services, expand their outpatient services to include assessment and treatment for walk-in consumers. There is a percentage of appointments that are not kept at out-patient treatment programs; these available hours could be utilized to respond to walk-in clientele. MSW interns could be used to supplement staffing.

3. RCDMH will meet with local home health providers to explore expansion of their services to include behavioral health interventions, either by the addition of staff or by contracts with existing providers. This will enable them to serve homebound consumers with BH illnesses. These BH services will include assessment and treatment.

4. The County of Rockland (County Executive and Legislature) will work with RCDMH to develop a “pro-bono pool” of licensed behavioral health professionals in Rockland County, to provide ongoing free BH service to residents in need on a rotating basis. Providers in this “pool” would be required to maintain and utilize their own malpractice insurance, and to name Rockland County as “other insured” to protect the County against liability for services rendered. The Rockland County Department of Law will develop a mechanism to provide tax credits and possibly other incentives to these professionals based upon their service.

5. RCDMH must work with State licensing agencies to require local behavioral health programs to refer to one another when possible, rather than to maintain a wait list that is longer than two weeks.

6. RCDMH will convene all providers who administer PROS to develop strategies to adapt this model to serve consumers who are engaged in competitive employment less than 10 hours a
week. This could include substitution of volunteer hours or internships to meet required employment thresholds.

7. RCDMH will arrange for Access VR to present an overview of their services and eligibility requirements to all of the behavioral health Workgroups. If eligibility barriers are identified, RCDMH will work with the appropriate State agencies to address these issues.

B. Care Integration

1. During the annual local planning process, RCDMH and behavioral health providers will not only review community behavioral health needs, but will also identify the types of resources required to meet those needs. The RCDMH will facilitate collaboration among the providers to identify available resources within the provider community and help arrange partnerships to fulfill these needs. These resources can include space, equipment and personnel for training and supervision.

2. An Olmstead Implementation Task Force will be established, through the existing Behavioral Health Workgroups, consisting of a broad base of service providers, real estate developers and housing specialists. The goals of this Task Force will be to develop viable models for non-segregated housing and to access funding opportunities in criminal justice and other systems, such as Community Development Financial Investment Fund (CDFI) and Home & Community Based Waiver Services (HCBS – OPWDD).

C. Workforce Development/ Expansion

1. Behavioral health service providers will recruit and hire professionals who specialize in the areas of child, adolescent, adult and geriatric treatment. An added focus will be to recruit and hire professionals with experience and competence in serving special populations identified in the Needs Assessment e.g. limited English proficient (LEP) persons, LGBTQ, veterans, trauma survivors and cultural/religious groups. RCDMH will review these efforts as part of the annual programmatic review and contract process.

2. Beginning in 2015, as part of the annual contract process, RCDMH will analyze the staffing patterns of behavioral health programs to ensure that staff is representative of and/or has the
core competencies necessary to serve the community, i.e.; linguistic and cultural proficiency. Specific attention must be given to serving the needs of special populations identified in the Needs Assessment e.g. LGBTQ, veterans, trauma survivors, underserved cultural/religious groups. Consumer satisfaction surveys developed and standardized by RCDMH (see Building Upon Strengths) will measure effectiveness.

3. As staff vacancies occur in behavioral health programs, RCDMH will work with the Rockland County Commission on Human Rights, Rockland County Personnel (for municipal programs) and/or local providers to recruit new staff with the core competencies necessary to serve the community, including the linguistic and cultural capabilities necessary to serve Rockland residents.

4. In order to ensure the retention of a diverse and competent behavioral health workforce, RCDMH will provide guidance to local BH agencies and make available sample instruments that agencies will use to assess employees’ respective experience of inclusion, equity and engagement in the workplace--especially as this relates to issues of race, gender, ethnicity, age, sexual orientation, religion and ability. Through the established workgroups, RCDMH will promote continued evaluation, dialogue, action, review of outcomes and shared learning.

5. Through the various behavioral health workgroups, the Rockland County LGU will connect the provider community to BH and other agencies that provide training of para-professionals/recovery coaches. The LGU will ensure that at least one presentation a year on the use of para-professionals/recovery coaches is conducted at each behavioral health workgroup. These trained non-professionals could be used in Rockland’s BH agencies to support those receiving/waiting to receive services, i.e.; waiting list groups, family support, advocacy services etc.

D. Role of the LGU/ Government Departments

1. The County of Rockland and State representatives will advocate on a state/federal level to remove barriers to behavioral health treatment arising from insurance restrictions. This would include convening a series of meetings with National Commission on Quality Assurance and Employee Benefit Director Associations to identify the limitations of private insurers, such as limits to coverage, length of stay, level of care, provider network restrictions and high co-
payment requirements, and will develop appropriate regulatory changes to respond to these barriers.

2. County of Rockland will advocate with State behavioral health licensing agencies to require establishing optimal hours of operation to best serve the community. BH Service Providers will reallocate their staffing resources to cover evening and weekend hours. Providers will inform the public of their expanded hours by alerting consumers, workgroups, community collaboratives, regulatory agencies, etc.

3. RCDMH will advocate with State behavioral health agencies to provide capital improvement dollars for the purpose of increasing physical accessibility at BH program sites in Rockland. If funding is not available and/or increased access is needed, RCDMH will work with State BH agencies to aid providers in developing temporary alternate locations that are more accessible to community residents, particularly those with limited physical mobility.

4. The County Executive and Rockland County Legislature will convene a hearing/series of hearings by the end of 2016 addressing the effect of the high cost of prescription medications on Rockland residents, particularly those with behavioral health needs. The County will invite all local, State and Federal representatives to participate and widely publicize these hearings for maximum community input. Based upon the result, the County will then advocate with these officials for legislative changes setting a cap on and/or reducing these costs.

5. The County of Rockland will investigate Orange County’s model with NYS Division of Housing and Community Renewal that provides tax set-asides and capital funding for behavioral health housing.

6. RCDMH will develop a baseline for analyzing the impact of both the implementation of the Olmstead transformational agenda and Medicaid managed care. This will serve to assess whether needs are being met by the current system or problems and costs are devolving down to local government.
E. Regulatory Changes

1. RCDMH, State and Federal agency heads will work with representatives from the provider and consumer community to assess and identify the barriers created by current regulatory guidelines. Once identified, the agencies will make changes to these regulations to reduce or eliminate these barriers.

2. The County of Rockland will explore the possibility of federal tax incentives for landlords who set aside a certain percentage of housing for people with disabilities, including those with behavioral health needs.

F. Service Access

1. RCDMH will develop a standardized percentage rate of every contracted provider’s budget to be used for service provision for the uninsured/under-insured behavioral health consumer. The County will hold the contracted providers accountable to ensure that they are meeting this rate at a minimum which results in providing services that were previously unavailable to the uninsured/under-insured. This will apply to County-operated programs as well. The standardization of the percentage rate ensures that all providers are treated equally.

2. The County of Rockland will provide half-price bus tickets to all treatment and prevention programs to ensure that consumers can avail themselves of the Rockland County bus system to get to and from their programs and other therapeutic activities.

3. The County of Rockland will propose and pass a local law requiring that all County-based behavioral health agencies that provide crisis services be required to provide these services to anyone living in Rockland who requires them, regardless of citizenship/immigration status.

4. The County of Rockland will work with State elected officials to advocate for legislative changes allowing for those who are deemed eligible for services under one State behavioral health agency (OPWDD, OASAS, OMH) to receive additional services from one or both of the other agencies, in the case of co/multiple-occurring disorders.
5. The County Executive will advocate that the county-based Housing Authorities include representation from the Behavioral Health community on their advisory boards in order to assist Housing Authorities in expanding their planning process and to take advantage of HUD, CDFI and other funding possibilities to better serve the behavioral health population.

6. The County of Rockland will explore existing county-owned properties for the feasibility of developing needed behavioral health housing resources, including a shelter for single individuals that could serve BH consumers.

G. Education

1. RCDMH will coordinate the development of a training program with treatment providers, consumer groups, local colleges and State agencies. This will include identifying training gaps and needs, identifying current State and national training curricula, and coordinating the development of training presentations and programs to meet these needs. Training areas will include current trends, best practices, evidence-based programs and issues of localized concern. Specific attention must be given to addressing the needs of special populations identified in the Needs Assessment e.g. LGBTQ, veterans, trauma survivors, underserved cultural/religious groups. These trainings will be open to all human service providers/consumers in Rockland.
Closing the Gaps - Adult Mental Health (Recommendations Code GA)

A. Care Provision/Expansion

1. The County of Rockland and RCDMH will advocate with NYSDOH to increase the number of in-patient psychiatric beds at Nyack Hospital, as well as increasing the number of psychiatric staff available to provide timely mental health assessments and psychiatric evaluations.

2. RCDMH will work with RPC to expand access to the enhanced clinical services provided at the Orangeburg Service Center for residents who require a level of care that does not warrant hospitalization but requires a higher level of care than an outpatient clinic provides.

3. RCDMH will advocate with NYSDOH to expand the current role of Care Coordinators to include some of the services previously provided by Case Managers, to better meet the needs of individuals. This would include more face-to-face time for accessing treatment and more wraparound services, such as being driven to appointments. Peer advocates can be used to assist Care Coordinators.

4. RCDMH will advocate with NYSOMH to expand the number of treatment slots available to the Assertive Community Treatment (ACT) Team, including serving more high-risk/treatment-resistant consumers as well as the homeless population afflicted by mental illness. Services must include more frequent contact with consumers than at present, including providing structured daily support services, and social/emotional skill building.

5. RCDMH, through the annual contract process and through the Unified Behavioral Health Services system, must ensure that local providers are utilizing evidence-based practices, including Cognitive Behavioral Therapy, Dialectic Behavioral Therapy, Functional Family Therapy and trauma-informed care.

6. RCDMH will advocate with NYSOMH to provide mental health services to homeless veterans and their families living in Rockland.
B. Care Integration

1. RCDMH will ensure that the Mobile Crisis Team, as well as both Nyack and Good Samaritan Hospital’s emergency rooms, provide a referral for a follow-up appointment to any person who is evaluated for behavioral health issues and is not in need of hospitalization. The Behavioral Health Evaluation & Referral Center will accept these referrals.

2. RCDMH will ensure that the Mobile Crisis Team, as well as both Nyack and Good Samaritan Hospital’s emergency rooms, will obtain releases to notify an individual’s current treatment provider if s/he has been evaluated for emergency behavioral health services.

3. RCDMH will work with local Emergency Departments to remove barriers in order to allow family/peer advocates in the ED. These advocates will help patients navigate the system and reduce trauma and anxiety. Examples of resources for peer and family advocates include NAMI, MHA, RILC and possibly college interns.

4. RCDMH, through the Assisted Outpatient Treatment (AOT) Coordinator, will work with Nyack Hospital’s inpatient physicians to increase referrals and collaboration with AOT, as appropriate, for patients with safety concerns and treatment resistance. This will reduce recidivism and improve safety for the individual and the community.

5. RCDMH will encourage all MH & CD agencies to apply for dual-licensure, when available, to address consumers with co-occurring disorders.

6. The County of Rockland will encourage NKI and its academic affiliates to explore offering affordable online or local onsite courses on psychopharmacology and behavioral health treatment, specifically geared to primary care doctors. NKI’s academic affiliates will offer CME/CEU credit as an incentive for physicians and mental health practitioners to participate.

C. Role of the LGU/Government Departments

1. RCDMH must clarify the role of Good Samaritan Hospital in providing psychiatric evaluations and medical clearances.

2. The County of Rockland and RCDMH will meet with local primary care practitioners to encourage integration of behavioral health and primary care, which could include behavioral health providers being embedded in primary care sites for screening and referral.
D. Regulatory Changes

1. The County of Rockland and the Rockland County Office of Veterans' Services will advocate on the federal level with the VA to expand local services to Rockland County, to include: addition of evening and weekend hours, assistance with medication compliance, employment, services for women veterans, sexual trauma services, marital/family therapy, outreach, and overall assistance with navigation of the VA system.

E. Information Access

1. RCDMH will develop a simple screening tool and release form for local physicians to determine their patients' need for and/or current involvement in behavioral health services, and to encourage care coordination. BH professionals will be encouraged to seek releases from patients to facilitate integration of care.

F. Service Access

1. RCDMH will ensure that Nyack Hospital will implement effective discharge planning that includes follow-up appointments, information about community resources and housing, with appropriate referrals for needed services.

2. RCDMH will ensure that Nyack Hospital will accept insurances necessary to serve all residents of Rockland County, including government employees and veterans.

3. RCDMH will facilitate the development of formal linkages among local and regional behavioral health providers to fill inpatient service gaps, e.g. eating disorders, stabilization, and other specializations.

G. Education

1. RCDMH, through the County’s Unified BH Services system, will ensure that all behavioral health agencies in Rockland, including hospital-based programs, will receive annual sensitivity training to help reduce the stigma of mental illness and learn how to foster partnerships between families and providers. Local organizations such as NAMI and Parents Helping Parents may help organize and/or provide this training in coordination with RCDMH.
2. RCDMH, through the County’s Unified Behavioral Health Services, will ensure that all BH agencies in Rockland, including hospital-based programs, will receive at least one training by the end of 2015, provided by a mental hygiene attorney, to better understand the rights of individuals with Severe Persistent Mental Illness (SPMI) and other BH issues. Training should be repeated annually and/or as needed based upon changes in the law.

3. RCDMH will work with the Rockland County Office of Veterans' Services to arrange for training for behavioral health providers on meeting the needs of veterans and their families. At least one training will be provided by the end of 2015.

4. RCDMH will ensure, through the workgroups, that specific training be delivered to MH providers related to serving the needs of special populations identified in the Needs Assessment e.g. LGBTQ, trauma survivors, underserved cultural/religious groups.
**Closing the Gaps- Chemical Dependency Treatment and Prevention Services/ Substance Use Disorders** (Recommendations Code GCD)

A. Care Provision/ Expansion

1. RCDMH will advocate with NYSOASAS to expand prevention counseling services to include those over 21 years of age. Prevention services must be made available in a variety of locations, including schools.

2. RCDMH will advocate with NYSOASAS to reestablish the Student Assistance program at the college and secondary school levels, with funding restored by OASAS, as well as by NYSED.

3. RCDMH, through the annual contract process and through the Unified Behavioral Health Services system, must ensure that CD providers are utilizing evidence-based practices, including Cognitive Behavioral Therapy, Motivational Interviewing, Screening, Brief Intervention and Referral to Treatment (SBIRT), Teen Intervene, etc.

4. RCDMH will advocate with NYSOASAS to provide chemical dependency treatment services to homeless veterans and their families living in Rockland.

5. RCDMH will work with NYSOASAS to encourage local treatment providers to expand their services to include ambulatory detoxification.

B. Care Integration

1. RCDMH will work with BOCES and school/community-based prevention providers to develop a drugged driving prevention training for student drivers.

2. RCDMH will encourage all MH & CD agencies to apply for dual-licensure, when available, to address consumers with co-occurring disorders.
C. Role of the LGU/ Government Departments

1. RCDMH will work with DSS, Office of Community Development, local NYSOASAS housing providers and/or other service providers to increase sober housing opportunities. NYSOASAS will make permanent supportive housing availability in Rockland a priority.

2. RCDMH must work with NYSOASAS to expand their oversight of existing programs to include reviewing records for people not admitted to detoxification to ensure that admission decisions are made based on evidence-based practice and not insurance considerations.

D. Regulatory Changes

1. RCDMH will advocate with NYSOASAS to have its Addiction Treatment Centers expand their admission criteria to include patients who meet the admission criteria but have been denied by their insurance company.

2. RCDMH will work with NYSOASAS to ensure that all medically assisted treatments (Methadone, Suboxone, Vivitrol, etc.) be available through the County's methadone program as well as at hospital-based programs and to ensure that staff providing these treatments have adequate ongoing training.

3. County of Rockland will advocate with NYSDMV for the addition of a segment specifically focused on the prevention of driving under the influence of alcohol and other drugs to the mandatory five-hour driver’s training course.

E. Service Access

1. RCDMH will ensure that Ambulatory Detoxification slots, to address heroin and other narcotic addictions, are expanded to include patients with multiple addictions, including cocaine and benzodiazepine.
2. CD providers in Rockland will explore partnerships in underserved communities, including linkages to natural community leaders, to more effectively respond to the CD needs of these communities. Care must be given to engage the community to identify their natural leaders.

F. Funding

1. RCDMH and the Office of Community Development will work with housing providers to explore state and federal funding opportunities through SAMHSA & NYSOASAS to serve special populations such as parents with children, veterans, LGBTQ, etc.

G. Education

1. School Superintendents will arrange for regular training regarding addiction prevention and treatment resources, including new trends, for key school personnel from qualified Rockland County CD providers.

2. RCDMH will ensure, through the workgroups, that specific training be delivered to CD providers related to serving the needs of special populations identified in the Needs Assessment e.g. LGBTQ, trauma survivors, underserved cultural/religious groups.
Closing the Gaps - Child and Adolescent Mental Health (Recommendations Code GCA)

A. Care Provision/Expansion

1. Nyack Hospital ED, Good Samaritan Hospital ED and RCPC will each designate a representative responsible for coordinating care among the agencies, to meet at least monthly.

2. Rockland BOCES will coordinate and provide access to needed educational services for children who are hospitalized, to provide continuity in their education.

3. RCDMH, RCPC, and Rockland BOCES will coordinate their resources in order to provide a crisis respite program for children and adolescents.

4. RCDMH must pursue increasing local outpatient services for children, working with RCPC to provide outpatient services, including expansion of the Nyack clinic.

5. NAMI and other behavioral health agencies will provide comprehensive community level supports for families, including skill building, crisis intervention, advocacy and navigation of system (NAMI Pilot project & NAMI Basic Course, Family Support Groups, RCDSS).

6. Rockland County District Attorney’s Office and Rockland County Probation Department will work with local NYSOASAS prevention providers to expand juvenile justice prevention programs, e.g. Project SHIFT and Youth Police Initiative.

7. RCDMH will coordinate with SPOA referral sources in order to actively increase parental involvement.

8. RCDMH will develop a consumer satisfaction survey for the Children's SPOA process, to be conducted at various points in the process, to ensure that there is adequate consumer participation in the process.

9. RCDMH and the Community Services Board will encourage RCPC to begin accepting direct admissions from 9am-5pm on weekdays, when medical clearance can be completed onsite because pediatricians are available and bloodwork can be completed.
B. Care Integration

1. RCDMH, RCPC and Nathan Kline Institute, together with the NYSOMH will collaborate to create a subscription Consultation Service for local pediatricians to consult on questions about medication and treatment of their young patients.

2. The County of Rockland will encourage NKI and its academic affiliates to explore offering affordable online or local onsite courses on psychopharmacology and behavioral health treatment, specifically geared to primary care doctors treating children. NKI's academic affiliates will offer CME/CEU credit as an incentive for physicians and mental health practitioners to participate.

3. Behavioral health agencies in Rockland, including RCDMH, will explore partnerships in underserved communities, including linkages to natural community leaders, to more effectively respond to the BH needs of children and families in these communities.

4. RCDMH will work with MHA and St. Dominic’s to facilitate a smooth transition of youth from WAIVER level services to other services, i.e. case management, including instituting a process of networking at each stage of the process to establish and maintain the communication necessary for coordinated care.

5. RCDMH will facilitate the inclusion of agencies such as Rockland Independent Living Center and NAMI in the Children's SPOA process, to provide support and education for parents throughout the process.

6. RCDMH will utilize the CCSI (Coordinated Children’s Service Initiative - Network) when a child is being transitioned between levels of care in case management.

7. RCDMH will encourage RCPC to designate a specific staff person to receive phone calls regarding the transfer of youth from EDs to ensure a seamless transition into the facility.

8. RCDMH will work with Nyack Hospital, Mobile crisis, BOCES, RCDSS and RCPC to develop a referral system to streamline the process of admission to RCPC, including a standardized referral form.
C. Role of the LGU/Government Departments

1. RCDMH will partner with MHA of Rockland to improve the CCSI/Network to better coordinate wrap-around services with school, home, treatment providers, and natural supports.

2. RCDMH will coordinate and/or combine workgroups to ensure services for children with dual and/or multiple diagnoses (CD, I-DD &MH). The individual workgroups meet with one another at least semi-annually.

3. RCDMH must work with NYSOMH, RCPC and BOCES to create a crisis unit that would provide brief respite for children/adolescents and families in crisis.

4. NYSOMH and RCDMH must ensure that referrals to RCPC are evaluated quickly and accepted admissions transferred as soon as possible.

5. The County of Rockland will support and study the effectiveness of new initiatives that are designed to better coordinate care (e.g. Multi-Agency Collaborative for Safe and Healthy Youth) through the exchange of information among agencies/government departments.

6. The County of Rockland and RCDMH will meet with local pediatric practitioners to encourage integration of behavioral health and pediatrics, which could include behavioral health providers being embedded in pediatric sites for screening and referral.

7. RCDMH will advocate with NYSOMH and local parties involved with Children's SPOA to establish a uniform standard of evaluation and placement of children into the next level of care, with increased transparency between agencies and a process more inclusive of parents.

8. RCDMH will work with NYSOMH and RCPC to allow RCPC to accept children into treatment regardless of their insurance, and prior to insurance authorization.

9. The County of Rockland will advocate with NYSOMH to increase psychiatric staffing at RCPC, allowing for admissions during evenings and weekends.
D. Regulatory Changes

1. RCDMH must work with NYSOMH to change current regulations prohibiting two or more children from the same family from accessing WAIVER services at the same level at the same time.

2. RCDMH must work with NYSOMH to remove barriers that currently complicate direct admissions to RCPC, including providing parents with written assurance that they will not be responsible for payment if there is a delay in obtaining prior authorization.

3. RCDMH must work with local elected officials and NYSOMH to lower the age of admission at RCPC to meet the needs of children ages 5-10.

E. Information Access

1. RCDMH will develop a simple screening tool and release form for local physicians, including pediatricians, to determine their patients’ need for and/or current involvement in behavioral health services, and to encourage care coordination. BH professionals will be encouraged to seek releases from patients to facilitate integration of care.

F. Service Access

1. RCDMH will review the mechanisms that the Children's SPOA process uses to involve and prepare parents to best meet the needs of their children, and convene a meeting with both parents and the participating agencies to address barriers related to accessibility and transparency.

2. RCDMH will work with school superintendents to link children and families to community resources and services to meet their behavioral health needs, and ensure that school staff members are fully knowledgeable about available BH resources.
3. School superintendents must develop procedures to ensure that children with disabilities have transition plans when they exit school including vocational assessment, vocational training and, if applicable, Access VR.

4. RCDMH will facilitate the development of formal linkages among local and regional behavioral health providers to fill child and adolescent inpatient service gaps, e.g. eating disorders, stabilization, and other specializations.

G. Education

1. School superintendents will arrange for periodic training for all school faculty and staff on behavioral health issues, such as signs and symptoms, early intervention, and treatment. Training agencies may include RCDMH, NAMI Parents & Teachers as Allies, and the NKI speakers program.
Closing the Gaps- Co-Located Services (Recommendations Code GCL)

A. Care Integration

1. RCDMH, potentially in partnership with RPC, will establish and staff a Behavioral Health Evaluation & Referral Center located in local hospital emergency rooms. The Center will assess services needed for those not in emergency situations and coordinate with care providers to make referrals. The Center should be open at a minimum 9AM to 9PM Monday- Friday and weekends as funding allows. During off hours, Mobile Crisis will provide assessment coverage and referrals to the Center.

B. Role of the LGU/ Government Departments

1. County of Rockland must be responsible to establish a computer interface between Rockland Mobile, the local ERs and the Behavioral Health Evaluation & Referral Center in order to schedule an immediate follow-up appointment for services.

C. Regulatory Changes

1. RCDMH must take the lead with NYS licensing agencies in expediting the co-location process and removing barriers.

D. Service Access

1. NAMI, MHA, RCADD and other organizations will ensure that trained, credentialed recovery coaches and peers will be located in and available through the local emergency rooms to help support those with behavioral health needs and their families, and connect them to services and community supports.

2. RCDMH must encourage service providers to look for opportunities to share space, staff and other resources in one community-based location. This will serve to better respond to individuals
and families with multiple needs, and must be incorporated annually into the local planning process.

3. Behavioral health agencies in Rockland, including RCDMH, will explore partnerships in underserved communities, including linkages to natural community leaders, to more effectively respond to the BH needs of these communities and to special populations. Care must be given to engage the community to identify their natural leaders.
Closing the Gaps- Criminal Justice Services (Recommendations Code GCJ)

A. Care Provision/ Expansion

1. County of Rockland (CE and Legislature) will create an Observation (inpatient Behavioral Health) Unit, in a segregated section within the Rockland County Jail (RCJ), staffed by the RCDMH and overseen by the Sheriff’s Office. The County of Rockland will utilize the previous architectural study of RCJ to expedite the process and to determine space and staffing needs.

2. RCDMH will designate a full-time social worker within the Rockland County Jail (RCJ), whose specific function will be to facilitate a smooth transition into the community through treatment referral plans for these inmates prior to their release.

3. Rockland County District Attorney’s Office and the Rockland County Dept. of Probation will work with local NYOSASAS prevention providers to expand criminal justice prevention program, i.e. Project SHIFT and Youth Police Initiative.

B. Care Integration

1. RCDMH will co-locate a social worker at the Rockland County Probation Department, in order to conduct assessments and assist probation officers with referrals for behavioral health services.

2. Criminal justice administrators and RCDMH will ensure that behavioral health programs and criminal justice community supervision staff communicate on a regular basis with each other to better serve criminal justice-involved consumers, with appropriate consents to share information in place. Treatment planning, discharge planning, results of urine drug screens, crisis intervention and case "problem-solving" must be coordinated.

C. Information Access

1. Law enforcement first responders must have a printed resource guide made available to them regarding behavioral health services in Rockland County, for reference in BH emergency
situations or BH calls. This resource guide will be developed by RCDMH through the County’s Behavioral Health Unified Services process. This could be developed as an addition to the annual Law Enforcement manual developed and printed by the Rockland County Police Chief’s Association. Electronic availability of the guide by pdf would be the best approach for easy access.

D. Service Access

1. The Rockland County Dept. of Transportation and Planning will collaborate with DSS, and other appropriate agencies, to provide discounted or free bus tickets to eligible participants in the various treatment court programs (Felony Drug Court, Family Treatment Court, Misdemeanor Drug Court, other Alternative to Incarceration programs). This will facilitate their compliance with the court’s requirements, e.g. inpatient or outpatient treatment, court appearances, and vocational services.

E. Education

1. The Rockland County Mental Health Alternatives To Incarceration (MHATI) Advisory Board will be responsible for arranging free training, as needed, to Rockland providers to improve their capacity to serve criminal justice-involved consumers. Training will take place at least annually, with CEUs available.

2. The Rockland County Police Academy will provide a basic curriculum on behavioral health interventions for all cadets, as well as in-service officer training on issues such as working with victims, perpetrators, and/or their significant others who have BH issues. The curriculum will be developed in conjunction with RCDMH, local BH agencies, peer groups and advocacy groups, or existing evidence-based training programs should be reviewed for applicability for this purpose.
Closing the Gaps - Crisis Services & Intervention (Recommendations Code GCR)

A. Care Provision/Expansion

1. Mobile crisis unit must have a widely publicized 24-hour hotline that serves as the central phone number for all behavioral health-related emergency calls. It must be staffed by a mental health professional or trained paraprofessional who can determine level of need and connect residents to appropriate services, including NYSTART and/or Jawonio mobile crisis units. The hotline must also provide telephonic de-escalation and crisis intervention and dispatching of mobile crisis team as indicated, or provide police letters, as appropriate. The unit will operate 24 hours a day and 7 days per week.

2. Mobile Crisis unit will provide referrals to the Behavioral Health Evaluation & Referral Center (see below) for those who don’t require emergency services.

3. RCDMH, potentially in partnership with RPC, will establish and staff a Behavioral Health Evaluation & Referral Center located in a designated local hospital emergency room to assess services needed for those not in emergency situations and coordinate with care providers to make referrals. The Behavioral Health Evaluation & Referral Center should be open at a minimum 9AM to 9PM Monday-Friday and weekends as funding allows.

B. Care Integration

1. A standard referral form will be given to the individual and forwarded to the receiving agency or Behavioral Health Evaluation & Referral Center to ensure follow up if Mobile Crisis team/Crisis Center determines that hospitalization is not necessary. The receiving agency must contact the individual within 24 hours if he or she fails to keep the appointment.

C. Role of the LGU/Government Departments

1. RCDMH must ensure that a standard referral form is created and utilized by Mobile Crisis and local ERs to ensure continuity of care.
D. Education

1. Mobile Crisis team will collaborate with Clarkstown PD for Crisis Intervention Training by the end of 2015.

2. Mobile Crisis team will expand Crisis Intervention Training across all police departments within the next three years.

3. RCDMH will ensure that appropriate ongoing education and specialized training is in place for the staff of ERs and Mobile Crisis team. Training must include knowledge of available resources and the needs of special populations identified in the Needs Assessment e.g. LGBTQ, trauma survivors, underserved cultural/religious groups. Sensitivity training will be offered in collaboration with key agencies such as NAMI (In Our Own Voice), MHA (peer advocates), RCADD and others. Training must take place on at least an annual basis.

4. The RCDMH Behavioral Health education resource specialist/community liaison will ensure that awareness regarding Mobile Crisis team and BH Evaluation & Referral Center services are provided to underserved communities, in collaboration with natural leaders in these communities.
Closing the Gaps- Intellectual-Developmental Disabilities (I-DD) Services
(Recommendations Code GID)

A. Care Provision/Expansion

1. Jawonio, ARC, Bikur Cholim, federally qualified Health Clinics (FQHC), and/or any clinic receiving State or Federal funding will develop the competency to provide services to I-DD consumers and families, to include psychiatric services i.e.: evaluation, screening, referral and follow-up, medication management, counseling, psychological services and follow-up care.

2. The above-mentioned providers must provide eligibility services onsite to allow I-DD children to receive OPWDD or early intervention services, e.g. psychiatric, psychological, psychosocial evaluations and adaptive behavior scales.

B. Care Integration

1. The County of Rockland, RCDMH and NYSOPWDD will work with both Nyack Hospital and Good Samaritan Hospital administrations to develop the capacity to treat individuals with I-DD in their emergency rooms as well as in their inpatient and outpatient services before the end of 2015.

C. Role of the LGU/Government Departments

1. The County of Rockland (County Executive and Legislature) must advocate with NYS elected officials to expand the NYSDOH "no wrong door" policy among NYSOASAS and NYSOMH licensed programs, developing the capacity to treat individuals with I-DD.

2. NYS elected officials and the County of Rockland must advocate with NYSOMH to require outpatient MH service providers in Rockland County, including RCDMH, to develop their capacity to provide psychiatric care and evaluative screenings for children and adults with I-DD, serving individuals across the lifespan.
3. The County of Rockland must advocate with NYS elected officials and NYSOMH to insist that RPC develops and RCPC expands their crisis respite beds to include Rockland adults and children who are not eligible for NYSOPWDD services but who still present with I-DD issues and who are on the autism spectrum.

4. RCDMH must work with NYSOPWDD to expand their adult and child crisis respite beds for those eligible to receive their services.

5. The County of Rockland will advocate with State elected officials and OPWDD to promote greater involvement by the Conference of Local Mental Hygiene Directors, Developmental Disability Committee in the OPWDD planning process regarding the Olmstead decision/OPWDD Transformation Agreement.

6. The County of Rockland will advocate with State elected officials to promote the direct and ongoing involvement of RCDMH and the Community Services Board in Medicaid re-design as it pertains to Rockland residents. Specifically, these local entities should be part of the vetting process for parties seeking to become a Developmental Disabilities Individual Support and Care Coordination Organization (DISCO) serving Rockland, and have ongoing input with these organizations once they are established in this capacity.

7. The County of Rockland will advocate with State elected officials to promote the direct and ongoing involvement of RCDMH and the Community Services Board in OPWDD decisions pertaining to Rockland residents being returned to the community from institutional settings to ensure that housing and needed services are available and in place, thus slowing the process based on consumer needs.

8. The County of Rockland will advocate with State elected officials and OPWDD to delay/slow the process of the closure of ICFs and sheltered workshops in Rockland County until and unless adequate community supports and employment opportunities are in place.

9. RCDMH will advocate with OPWDD and HUD to help people with I-DD find and retain independent residential opportunities in integrated settings in Rockland County, including enabling these individuals to utilize assistive technology to remain in their homes.
D. Service Access

1. By the end of 2015, an I-DD Single Point Of Access (SPOA) will be created through the RCDMH in collaboration with NYSOPWDD and the RCDOH early intervention services, as a referral resource for families of children with I-DD. The new I-DD SPOA could replicate the Orange County model, including an online SPOA application.

2. RCDMH will facilitate the development of formal linkages among local and regional BH providers to fill I-DD service gaps, e.g. socialization groups for autism spectrum disorder, and other specializations.

E. Education

1. RCDMH must provide at least annual training for their BH staff in I-DD. In addition, by the end of 2015, a RCDMH clinical supervisor must receive intensive training in delivering I-DD services, in order to oversee the work of the staff.

2. RCDMH must ensure that I-DD training is provided in every workgroup (e.g. CD, MH, C & A) at least annually if not more often, beginning in 2015.

3. RCDMH will work with NYSOPWDD to provide local training on serving I-DD consumers and families to all local MH and CD providers.

4. RCDMH will work with NYSOMH, NYSOPWDD and NYSOASAS to provide local cross-training opportunities for all Rockland County BH staff.

5. RCDMH, in partnership with the I-DD Workgroup, will reach out to the Rockland Business Association (RBA) to educate the business community about the needs of I-DD individuals, in order to create employment opportunities, mentorships, internships, work readiness opportunities etc. in the local community.

6. RCDMH, in partnership with the I-DD Workgroup, will develop and provide a series of community forums designed to educate Rockland residents about individuals with I-DD, to break
down barriers and dispel myths and stereotypes, promoting a more positive connection between these individuals and the community at large.

7. RCDMH, in partnership with the I-DD Workgroup, will develop and provide a training series designed to educate the criminal justice system (correctional facilities, police, first responders, the judiciary and court staff, etc) about individuals with I-DD, to break down barriers, dispel myths and stereotypes, and develop the skills necessary to respond to them appropriately, creating a more positive outcome for these individuals when coming into contact with the criminal justice system.
Reaffirming the Role of Government (Recommendations Code RG)

A. Care Provision/ Expansion

1. RCDMH will work with RPC and NYSOMH to look for creative ways the State can utilize the resources and facility of the Psychiatric Center to meet community behavioral health needs identified in this report.

B. Care Integration

1. The County of Rockland will designate a person/team, separate and apart from existing departments, to oversee and coordinate the implementation of the recommendations of the Commission on Behavioral Health. The person/team will ensure that, both inter-departmentally and among partner agencies, services are integrated, work in the most efficient manner to serve the community, and the goals of the Commission are effectively achieved.

2. Where appropriate and available, RCDMH will work with all MH & CD agencies to apply for dual-licensure, to more effectively address the needs of consumers with co-occurring disorders.

C. Role of the LGU/ Government Departments

1. Within the next two years, the County of Rockland will establish a unifying mission and vision for the structure and delivery of behavioral health in Rockland County, enforcing these principles as the operating framework for services and supports throughout Rockland County.

2. The County of Rockland must advocate with New York State behavioral health agencies and NYS government to ensure that safety net services are provided for residents in need of BH services. Most specifically, this includes services not covered by insurance but necessary to make sure that needs are met and that residents have equal access to care.

3. A primary mission of RCDMH must be to proactively seek resources. This would include, but not be limited to, governmental and private grant funding, the formation of
partnerships and alliances, the collection of information regarding the availability of resources from local agencies and communities and the ongoing analysis of behavioral health needs in the community.

4. RCDMH will provide support for and build capacity within local contract agencies and other potential partners to better meet community behavioral health needs.

5. RCDMH will explore and encourage partnerships in underserved communities, including linkages to natural community leaders, to more effectively respond to the behavioral health needs of these communities.

6. The County of Rockland will ensure that RCDMH reaches beyond traditional boundaries to meet local behavioral health needs and to access resources to meet these needs. RCDMH will work with the CSB to advise the County of Rockland on how to best affect policies at state and federal levels on behalf of the community. This requires a strong, vigorous and ongoing process that expands and then maintains community connections. The County of Rockland will advocate on the state and national levels to remove barriers and increase access to good quality care.

7. The County of Rockland and RCDMH will advocate on an ongoing basis with all three NYS behavioral health agencies and State and Federal elected officials to ensure that Medicaid re-design will reduce costs while also serving overall community BH needs, not just the needs of the most chronically and persistently ill.

8. The County of Rockland and RCDMH will advocate with NYSDOH to ensure that the specific needs of Rockland residents as detailed in this report will be addressed through the DSRIP/Medicaid re-design process, including possible modification of the current DSRIP recommendations to meet these needs.

9. The County of Rockland and RCDMH will advocate on an ongoing basis with all three NYS behavioral health agencies and State and Federal elected officials to ensure that decisions made regarding compliance with the Olmstead decision realistically take into account the best interests of consumers vis-à-vis adequate community resources in Rockland, i.e. housing, employment. This includes preserving existing services such as sheltered workshops and ICFs until viable alternatives exist.
10. The County Executive and the County Legislature will be responsible for developing an objective mechanism by which to evaluate and prioritize behavioral health services. This will serve to balance the financial and BH needs of Rockland County while making sure that BH needs are prioritized appropriately.

11. RCDMH leadership and County Legal Department will conduct a biannual review of the County Charter and local laws to assess whether they are aligned with and current with State and Federal rules and regulations related to behavioral health.

12. RCMDH, by the end of 2015, will meet with Mental Health Departments from other Mid-Hudson counties to review their behavioral health systems and share information regarding best practices and promising approaches.

13. The results of this needs assessment will be used by the County of Rockland to shape a better future for those affected by behavioral health issues in Rockland. The final report will be presented to local, State and Federal leadership. A quarterly review of progress made on recommendations from this report will be conducted by the County Executive’s Office. RCDMH will present an annual update to Rockland County government regarding progress made on the recommendations. The behavioral health needs assessment process will be repeated in five years.

D. Regulatory Changes

1. The County of Rockland will advocate for co-licensing among all behavioral health State Agencies, not just OMH and OASAS. In addition, the County of Rockland will advocate for the current co-licensing process, between OMH and OASAS, to be expedited.

2. The County of Rockland will advocate with NYS government to create legislation mandating that private insurers pay reimbursement rates equal to or better than Medicaid rates.

3. The County of Rockland will amend the County charter, changing the name of the Department of Mental Health to the Department of Behavioral Health, in recognition of the comprehensive, integrated and updated nature of the department's services and mission.
E.  Funding

1. The County of Rockland and RCDMH will advocate on an ongoing basis with all three NYS behavioral health agencies and State and Federal elected officials to achieve parity not only for consumers, but also for frontline BH workers in Rockland agencies, so that salaries become commensurate with the services delivered.

F.  Rebuilding the Unified Services System

1. Community Services Board will resume its former practice of meeting monthly and will establish a quarterly meeting, at a minimum, with the County Executive’s Office and RCDMH, to ensure that the County is prepared to respond to emerging behavioral health issues as they arise.

2. County of Rockland has to reestablish the preliminary approval process, both within Rockland and on the State level, which needs to be conducted prior to State approval of any programmatic changes in behavioral health.

3. County Executive will reaffirm the structure and restore the function of the Community Services Board to advise the County Executive, County Legislature and RCDMH, on a regular basis, regarding the community’s behavioral health needs and the assessment of new and existing programs, changes to existing programs and the impact of the closing of programs, including those that are provided by the RCDMH.

4. County of Rockland will utilize the existing Workgroup and Subcommittee process more fully, as per the County Charter, to assist the RCDMH in conducting the State-mandated comprehensive planning process.

5. County of Rockland will increase the opportunity for community input and public participation in the Unified Services process by scheduling Subcommittee meetings and Community Services Board meetings after traditional work hours.
X. Resource Development

One additional component that came about after the inception of this initiative was the Resource Development Committee. This committee was composed of both Action Team and Executive Committee members along with others with expertise in grant-writing and funding. Its purpose is threefold: to assess, connect and utilize existing resources that benefit behavioral health services, both monetary and otherwise, to develop new resources in the form of public and private funding, and finally to bring all of the County behavioral health services up to date and into alignment with DSRIP and other Medicaid redesign issues both to improve service delivery through greater collaboration, and to put the County services on a more solid financial footing into the future. The Resource Development Committee developed a template to collect information from a variety of places—human service agencies, municipalities, and even private businesses and organizations. Early in 2015, representatives of the Committee met with state representatives to advise them of the progress of this initiative, to get a better picture of what is ahead in terms of new directions and funding for behavioral health in the next few years, and to get support in securing needed resources for implementation of the recommendations.

XI. Looking Forward

The County Executive's Commission on Community Behavioral Health represents an important step towards a better future for our community. The Commission will have achieved its purpose when each and every person in our county has a voice in this process and access to the care they need— and when the behavioral health needs of our residents, including a full continuum of services such as preventive care, is seen as just as vital and just as natural as dealing with any other health concern. Together, we can transform our county into a better and safer place for all.
Appendices

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A. Historical Overview of the Behavioral Health System in Rockland County

Rockland County Behavioral Health: An Historical Perspective

A review of the historical background of the behavioral health system in Rockland County from the 1920s to 2015 indicates that the one constant in its development has been CHANGE – change in philosophies, change in treatments and programs, and change in funding depending on the economic times. The past decade has seen many major, rapid, and simultaneous changes, which are altering the face of mental health delivery throughout the state and in Rockland County. Availability of funding has been the driver for many system changes over the years. Hence, it is important to examine the Rockland County behavioral health system against the backdrop of the state and national legislation and systems.

Mental Illness: The Early Days

Care and treatment of individuals with mental illness in the late 1920’s was largely provided within the framework of institutionalization. During the economic boom prior to 1929, new state hospitals were proposed. In 1925, 43,600 people were reported being in State hospitals, at which time fiscal responsibility was transferred to the state. In 1926 the NY State Department of Mental Hygiene (now the NYS OMH) was created to visit and inspect State hospitals. The following year the Mental Hygiene Law expanded the Department’s responsibilities to include the administration, oversight and care of all mentally ill, developmentally delayed and epileptic individuals (Kathleen Keefe-Cooperman).

Rockland State Hospital (now Rockland Psychiatric Center) opened in 1931, as a result of an appropriation in 1925 for acquisition of lands in the NYC vicinity in order to improve care for the increasing number of mentally ill individuals. The goal was to contain costs by centralizing services and housing in a rural environment, which was believed to be curative. RSH was like a small town with an infirmary, dental area, x-ray facilities, social services and clinical offices. The catchment area included Rockland, Bronx, Manhattan and Richmond counties. Employees lived in one of 10 staff home on campus with additional homes for the superintendent and support staff in the general vicinity. A post office, employee barbershop, industrial shop, occupational center, tennis courts and a baseball field, community store and a recreational center that held four bowling alleys and two pool tables were added. Sports and physical activity were
encouraged. Weekly dances and movies were held and Broadway and radio stars came to perform for the patients. Higher functioning patients worked in manufacturing and farming, which were observed to have a positive therapeutic effect. By 1936, 119 buildings had been constructed. By 1940, RSH had almost 1,500 employees and 6,600 patients.

Initially, care was often custodial with no hope of cure and no truly effective treatments. The hospital managed symptoms and provided housing. Hospitalization extended for many months with the widely held belief that the institution “provided an environment removed from the difficult home setting or familial patterns of maladaptive interactions.” Many were institutionalized for years, evidencing significant cognitive deterioration.

1,634 individuals who died between 1928 and 1965 are buried in one of two cemeteries, located adjacent to the golf course at RPC. These individuals lie in graves marked only by a number, reflective of the stigma that was prevalent in the early days of RSH (and still exists today). A “new” cemetery on Blaisdell Road has 794 graves (Note: Figures from minutes of Cemetery Restoration Taskforce).

Patients not only included those with serious mental illness, but elderly patients with psychosis caused by syphilis, senility or arteriosclerosis. However, Dr. Blaisdell, who came on prior to the opening, was a dedicated and forward-thinking administrator who desired to be on the cutting edge of treatment advances. Orientation included a mental status exam with a detailed physical exam Annual physical exams were implemented “with the aim to improve overall physical health and to emphasize an individualized approach to treatment (integration of health and mental health).” Positive community relationships were encouraged including talks to organizations such as the PTA, service clubs. RSH was also a teaching hospital with an on-site School of Nursing. Higher functioning patients formed a Boy Scout troop. During his tenure Dr. Blaisdell tried all treatments known at the time. He also valued research and continually introduced new and then innovative treatments, such as insulin coma therapy, Metrazol Convulsive Therapy (1934) Electrotherapy (ECT).

Dr. Blaisdell was a pioneer in research and treatment of substance abuse. RSH was the first hospital to hold an Alcoholics Anonymous (AA) meeting in 1939 and patients were bused out to attend meetings in following years. He felt that alcoholics would be better served in a separate
specialized site staffed by psychiatrists trained to treat alcohol addiction. The treatment facility 
was opened some years later, and was named as a tribute to Dr. Blaisdell’s lifelong dedication to 
this problem.

The Depression created financial strains for the hospital . The population of RSH increased 
greatly throughout the financial crisis. Initial reports by Dr. Blaisdell focused on treatment 
advances and new buildings. However, as the first decade came to a close, cost cutting in 
maintenance and staff reduction were instituted, overcrowding became a problem and patient 
care was severely impaired. The capacity of the hospital, when completed, was 5,768. In 1940 
The Tenth Annual Report (1941) anticipated 7000 patients by year end with no additional service 
buildings or staff housing (Kathleen Keefe-Cooperman). RSH reached a top census of 9,500 in 
the 1960’s (Murphy, 1994).

(Information about the first decades of Rockland Psychiatric Center was obtained largely from a 
manuscript by Kathleen Keefe- Cooperman, Psy.D, for which she researched archival letters and 
reports by its first Superintendent, Dr. Russell Blaisdell and Board reports). In her conclusion, 
Dr. Keefe-Cooperman points out that RSH was not the snake pit as commonly portrayed by the 
media. Care was provided within the constructs of the day using the most up-to date treatment 
methods that have led to methods in use today. For example, the somatic approach to treatment 
developed in the bio medical model. “ RSH used treatments that might be perceived an unethical 
today, but were representative of a time when hope for a cure was rare. Financial instability is a 
constant over time. “However, AA, the child guidance movement and the therapeutic milieu 
approach were developed out of a need for successful and creative treatments that were cost 
effective.”

**Changes Over the Years/ RPC Today**

Over the years there have been many changes and improvements at RPC, transforming it into a 
modern, patient-centered hospital, and greatly reducing its census. The hospital’s strong 
connection with the nationally and internationally recognized Nathan Kline Institute for 
Psychiatric Research (NKI), located on the campus has encouraged development of innovative 
evidence based programs. Rockland Psychiatric Center also operates two wards (24 beds) at the
Clinical Research and Evaluation Facility (CREF) in partnership with NKI, which provides research scientists to conduct various studies.

An example of some recent changes is the development of the first treatment mall in the state system in 1993, providing “decentralized, specialized units to better serve people facing similar issues” (Bopp, 2010). In 1993 RPC absorbed Harlem Valley and started to accept people from Ulster, Dutchess and Putnam Counties. In 2006 Middletown Psychiatric Center was closed and its patients transferred to the Rockland site. RPC now includes patients from the seven counties in the Hudson River region that make up its catchment area. In the early 2000’s the inpatient census was about 500. The census dropped to 482 by 2010 and to 430 by 2013. Currently, the maximum census is 380, of which approximately 70 are from Rockland County. About 50% of the people in RPC today have some prior involvement with the criminal justice system, to varying degrees (Tavella, 2015).

There are currently three units for “forensic” patients, including one all male unit, half of which is for newly arrived patients and half for registered sex offenders. A new Intensive treatment unit (ITU), a pilot project for NYS, will take people who have completed their sentence but are not ready to be returned to the community. After 90 days these patients will be transferred to Bronx Psychiatric Center’s transitional residential center. The third unit is for patients charged with crimes but deemed not responsible for their actions due to mental illness (Report to the RPC Family Advisory Committee, April 23, 2015).

The original plans, announced in July of 2013, for Regional Centers of Excellence (RCEs) has been abandoned. However, OMH has steadily reduced its inpatient population from 43,803 in 1973 to 3,876 in 2012. As of July 1, 2013 the total number of non-forensic patients in NY State psychiatric hospitals was 2,980, 1328 of whom have stayed longer than one year. The goal by 2015 was to reduce this number by 10%.

Recent years have seen the development of outpatient programs at the Rockland campus, including the Orangeburg Clinic, the “Turning Point” for intervention in first diagnosis psychosis. The peer centered Recovery Center is focused on community living and vocational development skills. It also houses the Living Museum, a therapeutic art center. RPC has
specialized services for Deaf/Hard of Hearing Sign Language users. RPC also operates an outpatient service center in Nyack.

The Clara Taylor RCCA is a 136 bed Residential Care Center for Adults, which currently houses 94 people, and efforts are being made to gradually reduce occupancy. There are several residences for adults recovering from serious mental illness, mainly patients discharged from RPC’s inpatient units. The TPP (Transitional Placement Program), located in Bldg. 57, is a 27 bed residence for adults who have experienced long term institutionalism that addresses the re-acquisition of basic living skills.

**Mental Illness: Deinstitutionalization**

To understand some of the changes in mental health delivery in the nation and in Rockland County, it is necessary to refer to de-institutionalism, a government policy that moved mental health patients out of state run hospitals into federally-funded community mental health centers. It began in the 1960’s as a way to improve treatment of the mentally ill, while also cutting government budgets and it continues today. Three major societal changes and scientific developments occurred that led to de-institutionalism.

1) The development of various psychotropic drugs such as Thorazine (chlorpromazine) (1954) and, more recently, Clozapine (clozaril) (1990) which treated some of the symptoms of mental illness

2) Societal changes that occurred in attitudes about treatment of the mentally ill in lieu of locking them away

3) Federal funding (Medicare and Medicaid) could be applied to community mental health Centers and not to state mental hospitals

In 1963 President John F. Kennedy signed the Mental Retardation Facilities and **Community Mental Health Center Construction Act (CMHC)**. The National Institute of Mental Health (NIMH) created community based mental health facilities to provide prevention, early treatment, and ongoing care, with one per every 125,000 to 250,000 people. By 1977 there were only 650 community health centers nationwide serving 1.9 million patients. As states closed hospitals, the centers were overwhelmed with patients with serious and persistent mental illness (SPMI).
In 1965 Medicaid was passed but did not pay for patients in mental hospitals, so states moved patients into nursing homes and community hospitals to transfer the costs to the Federal government.

In 1980 President Jimmy Carter signed the Mental Health Systems Act to fund more direct care and rehabilitation, but the act was repealed by President Reagan the next year with the Omnibus Budget Reconciliation Act of 1981. Funding was shifted to the states through Block grants, which meant that community mental health centers were competing for funds with other needs like housing, food banks and economic development.

In 1985 Federal funding dropped to 11% of community mental health agency budgets. Between 1955 and 1994, roughly 487,000 patients were discharged from state hospitals, reducing the number from 558,000 to 72,000 patients nationwide. More than 750,000 individuals with SPMI are now living in the community. By 2010 there were 43,000 psychiatric beds available nationwide.

In 2004, studies of jails and prisons in the U.S. indicated that approximately 16% of inmates are seriously mentally ill (roughly 320,000 people).

In 2009 the “Great Recession” forced states to cut $4.35 billion in mental health spending over three years. (Amadeo, Deinstitutionalization: What It Is and How It Affects You Today)

**Children’s Services: The Early Days**

Frank F. Tallman, who joined Blaisdell at RSH, was a staunch advocate of the mental hygiene movement and the advancement of mental wellness. Child Guidance Demonstration Clinics were organized in the early 1920’s, modeled after Healy’s Juvenile Psychopathic Institute and the Institute of Juvenile Research (Levy, 1968). This field focused on proactive and strength based treatments for juvenile delinquents. The movement changed focus over time to a middle class and native born population that was felt to have a greater chance for successful treatment. The targeted population included children and adolescents who manifested behavioral, psychological and emotional issues. New York State institutions began providing outpatient child guidance services in the early 1920s with only 42 child guidance clinics throughout the country. Tallman advocated a team approach within the therapeutic milieu and working with and within the
community to develop a preventative approach to mental illness, which he applied to the Children’s Group at RSH. The RSH treatment team, which included psychiatrists, psychologist and social workers were from child guidance clinics in various parts of NYS, worked together with schools and judicial systems to arrange treatment. Tallman supported a preventive approach focusing on the normal child with the clinic used as a center for community outreach. Outpatient centers were placed in social agencies, health centers and schools. Partner organization included the Boy Scouts, Girl Scouts, and YMCA. RSH became the first site to have an on-site children’s unit consisting of six cottages linked to a central administration building, which officially opened in May of 1936.

The first psychologist started at RSH in 1936, and the hospital had the first specified job line for a psychologist in New York in 1941. Intelligence and psychological assessment was a key part of the admissions process. Psychologists’ roles also included providing play therapy, remedial reading and math help. Their increased roles help solidify their importance within the mental health field as a whole (Kathleen Keefe-Cooperman).

Rockland Children’s Psychiatric Center (RCPC) was an outgrowth of the Children’s Group at RSH. It was located on the RSH campus and operated as a separate outpatient facility for many years.

A new state of the art facility broke ground on August 8, 2006. The administration of RCPC, now called Rockland Children’s Center, was merged with that of RPC in 2015. One unit has been closed, reducing the current capacity to 37.

**Developmental Disability**

Institutionalization also marked the beginning of the development of services for people with developmental disability. In 1911 Letchworth Village, the “state institution for the segregation of the epileptic and feeble minded” opened and was lauded as a model facility and a major departure from the almshouse of the 19th century. Like RSH, it was a self-contained community in a rural setting located in Thiells. Letchworth ultimately became the largest facility in the nation for the mentally retarded, housing up to 5,500 children and adults. As late as 1958 the patients grew their own vegetables, tended cows, pigs and chickens, providing food for the entire Village. They also made toys and sold them at Christmas.
At its peak Letchworth consisted of over 130 buildings spread out over 2,000 acres of land. Reports of inadequate funding, overcrowding and improper and inhumane care surfaced. At first described as an ideal center for the mentally challenged and praised by the state, rumors arose about residents being found unclothed, unbathed and neglected, and horrific human experimentation. In 1921 an annual report describe three categories of “feeble-mindedness:” moron, imbecile, and idiot (un trainable). The various jobs assigned to male patients included loading thousands of tons of coal into storage facilities, building roads, and farming. That year, out of 506 people admitted, 317 were between the ages of 5 & 16, and 11 were under 5 years. Visitors observed that the children were malnourished and looked sick. Children were often used for experimental testing and were neglected. Many were able to learn, but were not given the chance because they were “different”. By 1921, the village was already overpopulated. There were nearly 1200 patients with patients living in small cramped dormitories with as many as 70 beds because the state would not complete construction of more buildings.

In the 1940s Irving Haberman did a series of photos which revealed to the public the overcrowded conditions and the dirty, unkempt patients. They showed naked residents huddled in sterile day rooms (Wikipedia, 2015).

By the 1950s there were 4,000 inhabitants. Many families abandoned their relatives there. Letchworth began putting higher functioning patients out into the community to live and work for local Rockland County families. Female patients often worked as maids or housekeepers. Social workers from the State Office of Mental Retardation and Developmental Disabilities visited the homes to ensure that requirements were being met and that residents were being well treated. Some patients fared better than others in their community family homes.

Letchworth was finally closed in 1996. Attitudes about the mentally retarded (now called developmentally disabled) were changing. Old methods of segregating patients and the disabled were changed to include them in society. Patients were moved to other facilities in the county.

Another facility, which served children who were orphans or socially disadvantaged, was a private charitable organization known as Five Points House of Industry. Founded in 1850, the organization took its name from the area it served, NY City’s Five Points District, considered to be the toughest and poorest neighborhood of its time. In 1911 one of its trustees, William
Church Osborn and his wife gave the agency a 286 acre farm in Pomona for a children’s home, then called Happy Valley, which was to become Woodycrest in 1972 and Greer-Woodycrest in 1977. The mission of the agency changed between 1977 and 1979 to caring for mentally disabled children (Murphy, 1994).

In the mid 1980’s, the care of mentally disabled was turned over to Crystal Run Village, an Orange County based agency run by Mark Lukens. In the late 1980s the land was sold to a golf course developer and the children were re-situated in other community residences including Camp Venture (Murphy, 1994).

**Developmental Disability: Development of Community Based Centers**

Jawonio started in 1947 as the Rockland County Center for the Physically Handicapped, a local chapter of the National Cerebral Palsy Association. Jawonio has continued to expand its programs and now provides services to more than 5,000 children and adults with physical and developmental disabilities. Jawonio has a Health Center providing a variety of medical clinic services, extensive employment and vocational services, and operates several businesses that employ its clients. The agency has expanded into behavioral health services and is one of the two providers in Rockland County of Personalized Recovery Oriented Services (PROS) for individuals with psychiatric or emotional conditions (www.jawonio.org).

The Association for Retarded Citizens (ARC) was the first agency to serve mentally retarded in a community setting. Founded in 1954 by a small group of parents, ARC today provides supports and services to more than 1,200 people with intellectual and other developmental disabilities. ARC runs evaluation and early intervention services; a preschool; recreational and educational programs; teen programs; residential services, a summer camp, day habilitation, senior programming, and family support services, as well as a medical facility providing primary care and therapeutic services (www.rocklandarc.org).

In 1969, under the leadership of Kathy Lukens, a group of mothers of the Exceptional Child PTA founded Camp Venture summer camp. Camp Venture grew exponentially during the 1980s, led by its founder Lukens, who also served as consultant to Governors Rockefeller, Wilson, Carey and Cuomo. In the 1960’s people with disabilities had few recognized rights under the law and
there were virtually no community based services available (http://www.campventure.org/index.php/?/campventure/about/history/).

An expose in 1971 by TV’s investigative reporter Geraldo Rivera of the conditions at Willowbrook on Staten Island sparked national interest in conditions for the mentally retarded and led to court-mandated reform. “Kathy [Lukens] gave voice to that interest in Rockland and indeed helped put Rockland at the leading edge of change in the public care of the retarded. She helped charter an entirely new life’s course for mentally retarded individuals, one that paralleled a nondisabled person’s life” (Murphy, 1994). “In 1973 Mrs. Lukens and the other founding families were joined by John Murphy, a young political leader” (http://www.campventure.org/index.php/?/campventure/about/history/).

Venture has expanded and adapted to include a variety of residences, a Day Habilitation program and a number of smaller community Day treatment sites. Seven of the older large residences were downsized to offer a more personal and individualized lifestyle. New programs include respite services. After school programs, Club Venture Saturday programs, Venture currently serves about 1,200 children and adults with developmental disabilities with a staff just under 600 and 30 program sites across Rockland County.

Services and residences for mentally retarded individuals received a boost from Hon. Eugene Levy (NYS Assemblyman 1969 to 1985, NYS Senator 1985-1990), helping Camp Venture obtain matching funds from the State Department. of Mental Hygiene. Levy was posthumously inducted into the Association for Retarded Children 50th Anniversary Hall of Fame for his support and involvement in causes related to people with disabilities. He helped obtain funding for residential and support services that formed the foundation for many of the residential and educational programs of the agencies serving the developmentally disabled (Wikipedia).

By 1994 there were 696 community beds for the developmentally disabled in Rockland County, run by various agencies and overseen by the OPWDD. Other agencies serving individuals with mental retardation also grew dramatically during the 1970’s and 1980s (Murphy, 1994).
Chemical Dependency/Substance Use Disorder Services

Dr. Russell E. Blaisdell was also a pioneer in the study and treatment of substance abuse, and Rockland State Hospital was the first hospital to hold an Alcoholics Anonymous (AA) meeting in 1939. Dr. Blaisdell felt that alcoholics would be better served in a separate specialized site staffed by psychiatrists trained to treat alcohol addiction. The alcoholism treatment center that opened some years later was named after him as a tribute to Dr. Blaisdell’s lifelong dedication to combating this disease.

In the mid 1970's, New York State created the Offices of Alcoholism and Alcohol Abuse, and the Narcotics Addiction Control Commission (later the Drug Abuse Control Commission, and finally the Division of Substance Abuse Services). Initially, there were very separate schools of thought and treatment philosophies about the best approaches to treat and prevent addiction by each agency. By the early 1990's however, practice and research clarified that alcohol, though legal for use among adults, was an addictive drug just as any other, and that treatment approaches such as abstinence, self-help, individual/group/family counseling and pharmacotherapy were, when applied correctly, effective in treating both. Prevention strategies from each discipline, such as information/education, environmental strategies, and school and community-based outreach were also found to be effective in reducing and preventing addiction across the board, including alcoholism. In 1993, New York State combined the two agencies into the Office of Alcoholism and Substance Abuse Services (OASAS).

Under the Rockland County Department of Mental Health, a continuum of services was established for alcoholism and other drug addictions, including a medical detoxification program, day rehabilitation, outpatient clinic services and methadone maintenance for opiate addiction. These County-operated programs, serving all residents in need regardless of the ability to pay, were forced by OASAS to be closed in the mid 2000's, due to the higher costs associated with operating a county-run program. However, this was done in a deliberate, planned fashion, where Rockland County issued a Request for Proposals (RFP), requiring any new provider of service to maintain the same standard of treating any resident in need regardless of
the ability to pay. Lexington Center for Recovery has been the largest, primary provider of these services ever since.

In the late 60's and early 1970s, community-based drug counseling centers were established in Haverstraw, Clarkstown, Nyack and Ramapo. These programs, initially designed to work with adolescents who were beginning to experiment with drugs, were originally staffed primarily by para-professionals and people in recovery from their own addictions. The programs developed into free/affordable clinics, with professional staff, treating adults and children alike, and providing community-based prevention services. These counseling centers were deficit-funded by New York State, with local governments (towns and villages) providing a portion of the funding as a match. They were proven to be not only effective, but cost-effective, with good results and increasing community support. Over time and as a result of the changes brought by managed care, OASAS determined that deficit-funded treatment would be phased out, and as a result, three of the four community-based counseling programs were closed. The one remaining, the Haverstraw Counseling Center, is still deficit-funded and supported by the Village of Haverstraw and local municipalities in North Rockland, but is only able to provide prevention services, not treatment.

Project Rainbow, begun in 1979 under the Rockland County Mental Health Association, became recognized as one of the pioneer programs in the nation for children from alcoholic/addicted families. The program served children as young as five years of age, helping them to cope with life in an addicted family. The most revolutionary aspect of this program was that it was the first of its kind to treat children affected by family addiction as the primary clients. Concepts still in use today, such as the notion of codependency, were born out of this ground-breaking work.

Rockland Council on Alcoholism (later RCADD) opened its center in 1985 in Nyack, providing information, education, brief counseling and referral for those affected by their own, or a loved one's, addiction. Hospital-based inpatient and outpatient services were created at Good Samaritan and Nyack Hospitals to accommodate Rockland residents in need of a continuum of chemical dependency/substance use disorder services which were locally accessible.
Rockland County has been in the forefront of working through the criminal justice system to foster treatment and prevent incarceration of those who have committed non-violent crimes as a result of their addiction. Rockland created its first Drug Court in 1998, and has since helped hundreds of people regain sober and productive lives. Today, Rockland has a host of Alternative to Incarceration programs, including Family Treatment Court, Mental Health Court, Drug Market Intervention, and the Re-Entry program.

Open Arms has been the sole Rockland County provider of housing and case management services for recovering men and women since 1985. The program provides both community residential services designed for those who are new in recovery, to a supportive living program geared to those who are developing employment skills or pursuing an education in order to become and remain sober and productive members of the community.

Today, treatment programs in Rockland County include not only those previously mentioned, but also Daytop/Samaritan, specializing in work with adolescents and families as well as adults, and the Mental Health Association, with programs for those with mental health issues which co-occur with a chemical dependency diagnosis. The treatment field has moved into the use of more evidence-based and humanistic approaches, such as cognitive behavioral therapy, motivational interviewing, and, more recently, trauma-informed care. While traditional methods such as self-help are still utilized widely, newer approaches, such as recovery coaching and alternative self-help programs like SMART Recovery are providing avenues to those affected by addiction.

The field of substance use prevention has been revolutionized over the past three decades, and has led the way for the rest of the chemical dependency/substance use disorder field in the use of evidence-based approaches to solving community problems or addressing addiction. Existing prevention programs in Rockland, such as the Haverstraw Center, CANDLE, and the Rockland Council on Alcoholism and other Drug Dependence (RCADD) all employ the use of data collection, school and community-based surveys and focus groups, and environmental strategies to address chemical dependency/substance use disorder issues on a macro as well as micro level.
The Rockland County Department of Mental Health

The origins of the RCDMH date back to 1950 when a group of volunteers, both lay and professional, combined to form the Rockland County Mental Health Association (MHA) and initiated a non-profit psychiatric clinic. Rockland County Community Mental Health Services (CMHS) were formed in 1955 under the leadership of psychiatrist Dr. Bert Pepper, to take advantage of the NYS Community Mental Health Services Act passed the year before. The MHA assisted local County government in developing the Rockland County Community Mental Health Board. Using a combination of County and State funds, the Board contracted with the MHA for services for many years. In 1958 a social rehabilitation program for former mental hospital patients was begun.

In 1967, taking advantage of the Federal Community Mental Health Construction Act (CMHC), application was made to the National Institute of Mental Health for a complex of buildings meant to be an integrated center for health, welfare, and mental health services. Buildings F, G, H, J, and K were opened in 1969. These became the Dr. Robert L. Yeager Health Center, named for the original director.

During the 1960’s a number of contract agencies each operated by a citizen-dominated board, provided components of the system of service. In 1974 the Community Mental Health Board authorized staff to assist in development of a Citizens Advisory Council. This group became the Rockland County Community Services Board.

Unified Services Legislation in New York carried forward a process begun with the 1954 New York State Community Mental Health Act, which placed authority for the development of community mental hygiene services in the hands of local government with a state-local process.

The New York unified services legislation of 1974 provided an opportunity to move from a dual system of care to a total integration of public mental hygiene services, not only local government and voluntary nonprofit agencies, but also the local outpatient components of state facilities. Administrative, fiscal and programmatic responsibilities would be unified under the community mental health department. The act was intended to encourage local alternatives to state hospital admission, using a complex funding formula.
The legislation provided “no exit” for counties who took the risk of adopting this program. Rockland was one of only five counties that opted for a unified services system, (Pepper).

Although the five pilot counties unanimously judged the system to be beneficial, within a year after taking office, a new Governor from a different political party placed a moratorium on further conversions of counties to the unified services system, leaving Rockland and the other four counties as permanent “pilot projects.”

The key features were joint and continuous state and local planning including mutual agreement of assessment of needs, the participation of voluntary agency providers of mental health, retardation and substance abuse services, consumers of service and providers of various health-related programs, such as social services and education.

During the 70’ and 80’s these services continued to grow and were recognized as a model for communities throughout the state. In 1986 the Charter form of County Government was established with its first County Executive, John Grant who appointed Bert Pepper as the first Commissioner of Mental Health.

The goal was to provide “comprehensive coordinated mental health services to community members from birth. Services focus on all age groups – infants, children, adolescents, adults and the geriatric group. Also important is provision of treatment for alcohol and substance abuse. There is no arbitrary separation between retardation and emotional disturbances for either children or adults; the broad range of services are made available without regard to diagnostic label” (From Historical Overview: Rockland County Department of Mental Health).

The enhanced reimbursement formula provided by Unified Services made possible the employment and retention of a large and highly qualified staff. By 1985 the Department of Mental Health employed 472 individuals and provided a comprehensive array of mental health and chemical dependency/substance use disorder services to approximately 6,700 consumers annually. Services included a psychiatric inpatient unit, Alcohol and Substance Abuse services including Detoxification and Methadone maintenance treatment, a Crisis Center, Acute Day Treatment, Adolescent treatment team, Child development center, two Community Support Centers located in Pomona and Garnerville, Case management services, Pomona Mental Health
clinic with satellites in Spring Valley, Orangetown, North Rockland and Nyack, Consultation
and Education services and Forensic Services.

Rockland’s Unified Services received a Significant Achievement Award from the American
Psychiatric Association (APA) in 1983 in recognition of its comprehensive service system and
shared the 1985 APA Gold Award for its contribution to treatment of young adult chronic
psychiatric patients (Rockland County Department of Mental Health 1985).

In 2010, the Unified Services law was repealed, but the planning process was continued and is
now known as the Local Services system.

Changes in the funding formulas and reductions of funding incentives provided to Unified
Services over a five year period have resulted in huge reductions in staff and direct services
provided by the RCDMH. Some programs were transferred to non-profit agencies and others
were eliminated altogether. Partial Hospitalization and the Crisis Center were among those
programs that were eliminated. Day Treatment Programs and sheltered workshops were
considered not in keeping with provisions of the Olmstead Act and new attitudes about recovery.
Some agencies applied for and received state grants to assist in the transition from sheltered
workshops to community alternatives. The Mental Health Association and Jawonio, which are
major providers of behavioral health programs in Rockland today, developed new Personalized
Recovery Programs (PROS).

RCDMH, with a highly reduced staff of 38, still continues responsibility for oversight and
coordination of all County Behavioral Health services, in cooperation with service providers
(local, state, and not-for-profit). RCDMH also provides Direct Services through Single Point of
Access (SPOA) for Adults and SPOA for Children and Adolescents and, Behavioral health
services in the jail, the Pomona Mental Health Clinic, and is responsible for coordinating and
monitoring Assisted Outpatient Treatment Services (AOT).

Nonprofit agencies are brought together in the planning process through a system of workgroups
and subcommittees with each workgroup representing a designated age and/or disability area.
Workgroup meetings provide opportunities to share information, deal with changing events and
have input into the planning process. The Rockland County Community Services Board (CSB)
also meets regularly with the goal of advising County government in initiating, developing and
coordinating state and local behavioral health services, stimulating community interest and
developing awareness of Federal, State and local resources (Rockland County Local Planning

The “Transformation of the Mental Health System” in New York State called for a number of
changes that will “drastically alter the future of mental health services and supports to improve
health outcomes, provide sustainable cost control and a more efficient administrative structure.”
(2011 Message from the Commissioner.) In 2011 Gov. Cuomo appointed a Medicaid Redesign
Team (MRT) to develop principles and recommendations for transitioning services into managed
care. The NYS Office of Mental Health (OMH) has been collaborating with the Department of
Health (DOH) and Office of Alcoholism and Substance Abuse Services (OASAS) to implement
managed care transition. The Transition was phased in over a three year period. In Phase I, five
regional Behavioral Health organizations (BHOs) were contracted to manage a review process
and identify improvements to end fee for service and prepare for expansion of implementation of
Health Homes. Phase 2 called for integration of physical and behavioral health care under
Qualified Mainstream Managed Care Plans and Health Recovery Plans (HARPs). The
implementation for this final phase is April 1, 2015 for adults in NYC (HARP and Qualified
Mainstream Managed Care Plans); October 1, 2015 for adults in the rest of the State; and
January 1, 2016 for children statewide.

The OMH Transformation Plan has called for the pre-investment of $25 million into priority
community services and supports, based on a one year reduction of 399 psychiatric inpatient
beds. In Rockland, pre-investment funds made possible Rockland’s new Mobile Crisis Team, a
Crisis Intervention Team pilot project in Clarkstown, and some other new programs at various
nonprofits.

Mental Health Residential Services

The first Community Residence (CR) in Rockland was established by Irving and Irene
Berkowitz in 1977 as a response to the lack of residential services in the community when their
son was discharged from RPC. It was intended to serve as a permanent home and support
system for individuals with serious and persistent mental illness. Incorporated as Rockland
Hospital Guild (RHG), it is known as CLUE (Community Link-Up Experience). RHG has grown
CLUE 1, 2, and 4 (for deaf people) provide various levels of support in a park-like setting located adjacent to Rockland Psychiatric Center. CLUE 3’s supported housing apartments are located at various sites in the community.

In 1979 the Mental Health Association of Rockland launched its residential services with the opening of the Bernstein House, which still successfully operates at the MHA satellite site in West Haverstraw. This residence was in response to the Community Residence system started by NYS OMH that year. In 1986, with the design of “The New Model”, OMH residences became more focused on treatment and community residences became transitional (2 to 5 year length of stay) instead of permanent. Around the same time, Jeanette Bernstein Intensive Supportive Apartments and Supportive Apartments were developed, intended to be transitional with an anticipated length of stay of about 2 years. In 1993 Supportive apartments morphed into what are now known as Treatment Apartments, with the same supportive services.

In 1982, a consortium of public officials, including John Murphy and Dr. Bert Pepper incorporated Loeb House. Its first 14 bed Community Residence, Davis House, opened in New City in 1986, followed by Monsignor James Cox 12 bed apartment program in 1987, which was later expanded to 30 beds, using community reinvestment funds. Today, Loeb House Inc. operates a large variety of residential services for adults with SPMI. These include Lukens House, established in 1988 and the only MICA residence in Rockland County, which always has a waiting list.

The other major operator of local residential programs is St. Dominic’s Home. Originally founded in 1878 by the Blauvelt Dominican Sisters as a home for immigrant children abandoned on the streets of NYC, this nonprofit agency now provides OMH residential services to Rockland County Residents. These include two 24-hour supervised Community Residences. (one of which is for individuals with dual diagnosis of MI and mild Developmental Disability), Treatment Apartments and Supported Housing.

In the early 90’s residential services became Medicaid billable. Providers started to bill for services that were previously direct OMH contracts, and residential placements became transitional. Program fees are paid by residents through whatever income source they have including SSI, SSD and private pay.
The only permanent housing today consists of 163 Supported Housing (SH) beds, divided among Loeb, St. Dominic’s, RHG and MHA, a program which OMH began throughout the state in 1992. Supported Housing is located at scattered sites with individual leases and landlords. Rent is subsidized by NYS OMH via the housing provider, which provides supportive services related to residency and rental stipend support. Counselors provide linkage to clinical support and are available via telephone. Providers must adhere to OMH guidelines and are monitored by Rockland County Department of Mental Health. SH beds are funded by different OMH funding streams depending on when the beds were developed. For example, 8 out of 54 of Loeb’s Supported Housing beds are funded by reinvestment. More recent supported apartments receive OMH Medicaid Redesign funding, and for the past three years SH beds have been tied to discharge from state hospitals, nursing homes or adult homes.

The original goal of supported housing was to help people establish their apartments, and then to apply for Section 8 Housing so that they could stay in place, utilizing community supports. As a result, residential opportunities for others would open up. However, Section 8 Housing was always difficult to obtain and is not available at all today. There has been no increase in funding for SH beds, which are greatly underfunded in terms of market value rents in Rockland. Thus, local providers are reluctant to develop new supported housing beds, as funding does not cover the rental costs. This program remains risky for both consumers and providers, as necessary community support resources are limited.

In summary, there is a total of 392 OMH beds in Rockland County. (Data from SPOA). These include 11 Community Residences with a total of 135 beds, providing 24-hour staffing and restorative services. Of these, 61 are specialty beds (41 designated for blind or deaf, 12 MICA and 8 Mental Illness and mild Developmental Disability). There are 94 Treatment Apartment beds, 41 of which are specialty beds. Treatment apartments have counselors available during the day and by telephone after hours, seven days a week.

There are also about 1,000 SPMI living in 8 Adult Homes, licensed by the NYS Department of Health. Joseph’s Home, Inc. operates a 20 bed boarding house (Conway House) and 26 affordable housing beds for people who are homeless and have a disability (mostly mental illness) as well as Homes for Heroes for homeless disabled vets, which was opened in 2014. There is one respite bed for SPMI operated by Loeb House in Spring Valley and a second
respite bed is being planned. There are also 11 family type homes with 2 to 4 beds each that provide room, board and limited supervision and are licensed under DOH. OMH has plans for 150 OMH licensed single room occupancy beds (SRO’s) for the entire Hudson Valley region, but not likely to be located in Rockland County. There are also some transitional residences provided at Rockland Psychiatric Center (See RCCA and TPP).

Housing providers point out that lack of operating COLAs has caused overall financial hardship in operating residential programs, one of the consequences being great turnover in staff. Rockland County has a general shortage of affordable housing, which impacts severely on vulnerable individuals with SPMI and other disabilities. The large increase of people with mental illnesses being sent to jails and prisons in New York State has also resulted in serious problems for supervised housing options for returning citizens.

(Thanks to Jennifer Clark, Coordinator of Planning, Mental Health Services Rockland County Dept. Mental Health, Tom Zimmerman, Executive Director of Loeb House, Inc. and Maggie Trainor, Director of Residential Services, Mental Health Association of Rockland County for their help and insights in collecting and interpreting the information about Mental Health Residential Services).

**Delivery System Reform Incentive Payment (DSRIP)**

On April 14, 2014 Governor Andrew Cuomo announced a “groundbreaking waiver” that will allow the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. The waiver amendment dollars will address critical issues throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP will involve collaborations of community health and behavioral services with a specific goal of achieving a 25% reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement All DSRIP funds will be based on performance linked to achievement of project milestones. The terms commit the state to comprehensive payment reform and continue New York’s efforts to
effectively manage its Medicaid program within the confines of the Medicaid Global Spending Cap (from DSRIP Overview).

Most of Rockland County behavioral health providers have enrolled in one or all of three regional DSRIP programs servicing Rockland County. The application process has been involved and time consuming. Project Plans submitted by the three networks have been assigned scores, but at this point in time there is much uncertainty about who will receive funding through DSRIP. Smaller non-profits that currently depend on reinvestment dollars in order to offer free services, and often do not have the capacity for the electronic requirements and Medicaid billing are concerned about their survival.

Even back in 1983 Dr. Bert Pepper and Hilary Ryglewicz expressed the importance of “a fiscal mechanism for fully integrating state and community programs.” “Without such support, any model for integrating state and community systems is doomed to only partial success, at best.” Those words hold true today. (Pepper, B & Ryglewicz H.)

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NYS Office of Mental Health Interim Report, July 1, 2014.
Michael F. Hogan, Ph.D., 2012 Statewide Comprehensive Plan Interim Report

In addition to the above sources, the following individuals provided invaluable help and insights in collecting and interpreting information for sections of this history

For Section on Unified Services of Rockland County

   - Bonnie Halley

For early history of Rockland State Hospital

   - Kathleen Keefe-Cooperman, Psy.D., L.I. University

For current information on Rockland Psychiatric Center

   - Christopher Tavella, Ph.D., Executive Director of RPC and various staff members

For Mental Health Residential Services

   - Jennifer Clark, LMSW, Coordinator of Planning, Mental Health Services Rockland County
   Department of Mental Health

   - Thomas Zimmerman, MPA, Chief Executive Officer, Loeb House, Inc.

   - Maggie Trainor, Director of Residential Services, Mental Health Association of Rockland County, Inc.
### B. Glossary of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ARC</td>
<td>Association for Retarded Citizens</td>
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<tr>
<td>BH</td>
<td>Behavioral Health</td>
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<tr>
<td>BOCES</td>
<td>Board of Cooperative Educational Services</td>
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<tr>
<td>CCSI</td>
<td>Coordinated Children’s Service Initiative - Network</td>
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<tr>
<td>CD</td>
<td>Chemical Dependency/Substance Use Disorder</td>
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<tr>
<td>CME/CEU</td>
<td>Professional educational credits for course completion</td>
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<td>Community Services Board</td>
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<td>DA</td>
<td>Rockland County District Attorney's Office</td>
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<td>DCJS</td>
<td>Division of Criminal Justice Services</td>
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<td>DOH, NYSDOH</td>
<td>New York State Department of Health</td>
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<tr>
<td>DSRIP</td>
<td>Delivery System Reform Incentive Payment</td>
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<td>DSS/RCDSS</td>
<td>Rockland County Department of Social Services</td>
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<td>ED</td>
<td>Hospital Emergency Department</td>
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<td>HUD</td>
<td>Housing and Urban Development</td>
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<td>ICF</td>
<td>Intermediate Care Facility</td>
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<td>I-DD</td>
<td>Intellectual-Developmental Disabilities</td>
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<td>LGBTQ</td>
<td>Lesbian/Gay/Bi-Sexual/Transgender/Queer or Questioning</td>
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<td>LGU</td>
<td>Local Governmental Unit</td>
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<td>MH</td>
<td>Mental Health</td>
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<td>MHA</td>
<td>Mental Health Association of Rockland</td>
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<td>MHATI</td>
<td>Mental Health Alternatives to Incarceration</td>
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<td>MSW</td>
<td>Master in Social Work</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>NAMI</td>
<td>National Association for the Mentally Ill</td>
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<td>NKI</td>
<td>Nathan Kline Institute</td>
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<td>New York State Department of Motor Vehicle</td>
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<td>New York State Education Department</td>
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<td>NYSOCFS</td>
<td>New York State Office of Children and Family Services</td>
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<tr>
<td>NYSTART</td>
<td>Mobile crisis for I-DD</td>
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<td>OASAS, NYSOASAS</td>
<td>New York State Office of Alcoholism and Substance Abuse Services</td>
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<td>OMH, NYSOMH</td>
<td>New York State Office of Mental Health</td>
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<td>OPWDD, NYSOPWDD</td>
<td>New York State Office for Persons With Developmental Disabilities</td>
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<td>RCADD</td>
<td>Rockland Council on Alcoholism and Other Drug Dependence</td>
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<td>RCDMH</td>
<td>Rockland County Department of Mental Health</td>
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<tr>
<td>RCJ</td>
<td>Rockland County Jail</td>
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<tr>
<td>RCPC</td>
<td>Rockland Children's Psychiatric Center</td>
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<tr>
<td>RILC</td>
<td>Rockland Independent Living Center</td>
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<tr>
<td>RPC</td>
<td>Rockland Psychiatric Center</td>
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<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Adminstration (federal department)</td>
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<tr>
<td>SPOA</td>
<td>Single Point of Access</td>
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<tr>
<td>VA</td>
<td>Veteran's Administration</td>
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C.

Needs Assessment Data Collection Instruments

Resident Survey
Resident Survey- Spanish
Consumer Survey
Provider Survey
Focus Group Questions
Key Informant Questions
Community Awareness Resident Survey

The following survey is intended to gather information to help improve the behavioral health service delivery system in Rockland County. Your thoughts, experiences and ideas will help inform County leaders on ways to better help our residents with behavioral health needs. By "behavioral health," we are referring to services for anyone affected by a developmental disability, mental illness, and/or a substance use disorder (their own or a family member’s).

Please answer the following questions. Your answers are strictly confidential! Thanks so much.

Please check all that apply to you (respondent):

- **GENDER:**  □ Female  □ Male  □ Other
- **RACE/ETHNICITY:**  □ White  □ Black  □ Asian  □ Native American  □ Hispanic/Latino  □ Other
- **AGE GROUP:**  □ Under 18  □ 18-24 years  □ 25 – 34 years  □ 35 – 44 years  □ 45 – 64 years  □ 65 years and older
- **RESIDENCE:**  □ Clarkstown  □ Haverstraw  □ Orangetown  □ Ramapo  □ Stony Point  □ ZIP CODE: __________

1. Do you currently know of or have a place where you could go for behavioral health care service in Rockland County?
   - □ YES  □ NO

2. Have any of the following prevented you or someone you know from receiving needed behavioral health care (Please check all that apply.)
   - □ Lack of transportation
   - □ Fear/distrust
   - □ Limited hours of operation
   - □ Long Wait list
   - □ Price/Cost
   - □ Lack of insurance or insurance not accepted
   - □ Limited physical mobility
   - □ anonymity/Confidentiality
   - □ Other (Please specify)

3a. Have you or someone you know ever received behavioral health care services in Rockland County?
   - □ YES  □ NO

3b. Were your/ their needs met?
   - □ YES  □ NO
4. What are some of the best things about behavioral health services in Rockland County? Please check all that apply.

- Close to home
- Serve people of all ages
- Affordable
- Connect people to other services needed
- Confidential/private
- Caring, respectful atmosphere
- Staff is skilled and knowledgeable
- Different approaches are used according to needs
- Staff speaks my language
- Handicapped-accessible facilities
- Staff understands my culture
- Able to get service immediately
- Staff is skilled and knowledgeable
- Convenient hours
- Accept my insurance
- Other (Please specify)

5. Do you or someone you know ever leave Rockland County to obtain behavioral health care services?

- YES
- NO

6. Do you know any community programs in Rockland County that help individuals and families under stress, experiencing trauma, suffering from losses, or other emotional difficulties?

- YES
- NO

7. Do you know where someone can get help coping with learning problems, or developmental disabilities in Rockland County?

- YES
- NO

8. Do you know where someone can get help for children or teens with emotional difficulties, learning problems, or addiction (their own or a family member's) in Rockland County?

- YES
- NO

9. Do you know where in Rockland County someone can get help with a problem with alcohol, other drugs, or another addiction, such as gambling?

- YES
- NO

10. Are you aware of community programs in Rockland County that promote good emotional health and development?

- YES
- NO

11. What do you think in general about the availability of behavioral health services in our county?

- Available in the area
- Limited in the area
- Not available in the area
12. Anything you would like to add? Please write below.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

PLEASE return survey to: or complete the survey online at:

www.surveymonkey.com/s/RCCAS

Rockland County Office of the County Executive
Attention: Community Relations
11 New Hempstead Road
New City, New York 10956

(845) 638-5856 (fax)

Thank you so much!
Encuesta Sobre Conocimiento entre Residentes Comunitarios

La siguiente encuesta tiene por objeto reunir información para ayudar a mejorar el sistema de servicios de salud conductual en el Condado de Rockland. Sus pensamientos, experiencias e ideas le ayudarán a informar a los líderes del Condado sobre mejores maneras de ayudar a nuestros residentes con necesidades de salud conductual. Por “salud conductual,” nos estamos refiriendo a los servicios para cualquier persona afectada por una discapacidad del desarrollo, enfermedad mental, y/o un trastorno por uso de sustancias (propio o de un familiar).

Por favor conteste las siguientes preguntas. Sus respuestas son estrictamente confidenciales!
Muchas gracias.

Por favor marque todas las que les correspondan (encuestado):

GÉNERO: □ Femenino □ Masculino □ Otro
RAZA/ETNICIDAD: □ Blanco □ Negro □ Asiático □ Nativo Americano □ Hispano/Latino □ Otro
GRUPO DE EDAD: □ Menores de 18 □ 18-24 años □ 25 – 34 años □ 35 – 44 años □ 45 – 64 años □ 65 años o más
RESIDENCIA: □ Clarkstown □ Haverstraw □ Orangetown □ Ramapo □ Stony Point CÓDIGO POSTAL: _______

1. ¿Actualmente sabe o tiene usted un lugar dónde usted puede ir para atención necesaria de salud conductual en el Condado de Rockland?
   □ Sí □ NO

2. ¿Ha alguno de los siguientes impedido que usted o alguien que usted conoce reciba la atención de salud conductual necesaria? (Por favor marque todas las que correspondan.)
   □ Falta de transporteación □ Idioma
   □ Miedo/desconfianza □ Fé/Religión
   □ Limitadas horas de operación □ Diferencias Culturales
   □ Larga lista de espera □ Ciudadanía/estado de Inmigración
   □ Precio/Costo □ No familiarizados con el tipo de servicios
   □ Falta de Seguro o Seguro no aceptados □ No saber donde obtener servicios
   □ Movilidad física limitada □ Necesidad de anonimato/Confidencialidad
   □ Otros (especificar)

3a. ¿Alguna vez ha recibido usted, o alguien que usted conoce, servicios de atención de salud conductual?
3b. ¿Se cumplieron sus necesidades?
   □ Sí          □ NO

4. ¿Cuáles son algunas de las mejores cosas acerca de los servicios de salud conductual en el Condado de Rockland?
   □ Cerca de la casa
   □ Económico
   □ Confidencial/privado
   □ Personal está capacitado y bien informado
   □ El personal habla mi idioma
   □ Personal comprende mi cultura
   □ Aceptan mi seguro
   □ Otro (Favor de especificar)
   □ Sirven a las personas de todas las edades
   □ Conecta a las personas a otros servicios necesarios
   □ Atentos, respetuoso ambiente
   □ Diferentes enfoques se utilizan de acuerdo a las necesidades
   □ Accesibles para personas discapacitadas
   □ Capaz de obtener el servicio de inmediato
   □ Horas convenientes

5. ¿Alguna vez ha dejado usted, o alguien que usted conoce, el Condado de Rockland para obtener servicios de salud conductual?
   □ Sí          □ NO

6. ¿Conoce usted programas comunitarios en el Condado de Rockland para ayudar personas y familias bajo estrés, experimentando trauma, el sufrimiento de pérdidas, u otras dificultades emocionales?
   □ Sí          □ NO

7. ¿Sabe dónde alguien puede obtener ayuda para hacer frente a los problemas de aprendizaje o discapacidades del desarrollo en el Condado de Rockland?
   □ Sí          □ NO

8. ¿Sabe dónde alguien puede obtener ayuda para los niños o adolescentes con dificultades emocionales, problemas de aprendizaje, o adicción (propia o de un familiar) en el Condado de Rockland?
   □ Sí          □ NO

9. ¿Sabe dónde en el Condado de Rockland alguien puede obtener ayuda con un problema con alcohol, otras drogas, u otra adicción, como los juegos/las apuestas?
   □ Sí          □ NO

10. ¿Está usted consciente de los programas comunitarios en el Condado de Rockland que promueven la buena salud y el desarrollo emocional?
    □ Sí          □ NO
11. ¿Qué le parece, en general, la disponibilidad de servicios de salud conductual en nuestro condado?
☐ Disponible en el área
☐ Limitado en el área
☐ No disponible en el área

12. ¿Algo que le gustaría añadir? Por favor escriba a continuación.
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

POR FAVOR devuelva la encuesta a:  O complete la encuesta en el siguiente sitio
Web:

Rockland County Office of the County Executive
Attention: Community Relations
11 New Hempstead Road
New City, New York 10956
(845) 638-5856 (fax)

Muchas gracias por su tiempo!
County Executive's Commission on Behavioral Health- Consumer Questionnaire

The following survey is intended to gather information to help improve the behavioral health service delivery system in Rockland County. Your thoughts, experiences and ideas will help inform County leaders on ways to better help our residents with behavioral health needs. By "behavioral health," we are referring to services for anyone affected by a developmental disability, mental illness, and/or a substance use disorder (their own or a family member's).

Please answer the following questions. Your answers are strictly confidential! Thanks so much.

Please check all categories below that apply to you:

- Individual living with mental illness/developmental disability/substance use disorder
- Family member
- Provider
- Other ________________

GENDER:  
- Female
- Male
- Other

RACE/ETHNICITY:  
- White
- Black
- Asian
- Native American
- Hispanic/Latino
- Other

AGE GROUP:  
- Under 18
- 18-24 years
- 25-34 years
- 35-44 years
- 45-64 years
- 65 years and older

RESIDENCE:  
- Clarkstown
- Haverstraw
- Orangetown
- Ramapo
- Stony Point
- ZIP CODE: __________

1. Have you or a loved one participated in any of the following services or programs in the past three months? Please review the list below, and rate your satisfaction with how these services have met or are meeting your needs or those of your family member:  
* (DD) refers to Developmental Disability services

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<th>Service</th>
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<th>Somewhat satisfied</th>
<th>Not meeting my needs</th>
<th>Don't know</th>
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<td>Mental Health Care Management</td>
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<td>Mental Health Clinic</td>
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<td>PROS (Personalized Recovery Oriented Services)</td>
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<td>Outpatient Mental Health Program</td>
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<td>Private Psychiatrist or therapist</td>
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<td>Inpatient Hospitalization for Psychiatric Services</td>
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<td>List of Services (cont.)</td>
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<td>Somewhat satisfied</td>
<td>Not meeting my needs</td>
<td>Don’t know</td>
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<td>Option 2</td>
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<td>Substance Use Detox program</td>
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<td>Methadone Maintenance</td>
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<td>Intensive Day Treatment for Substance Use</td>
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<td>Outpatient Substance Use Treatment</td>
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<tr>
<td>Substance Use Prevention Services</td>
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<td>Addiction-related Self-help</td>
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<tr>
<td>Other (Please indicate type of services)</td>
<td></td>
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</tr>
</tbody>
</table>

2. Have any of the following prevented you or your family member from receiving the care you need or that someone close to you needs? Please check all that apply.

- [ ] Lack of transportation
- [ ] Limited hours of operation
- [ ] Fear/distrust
- [ ] Long Wait list
- [ ] Price/Cost
- [ ] Lack of Insurance or insurance not accepted
- [ ] Limited physical mobility
- [ ] Other (Please specify)

- [ ] Language
- [ ] Faith/Religion
- [ ] Cultural differences
- [ ] Citizenship/Immigration status
- [ ] Unfamiliar with types of service
- [ ] Do not know where to get services
- [ ] Need for anonymity/Confidentiality

3. What are some of the best things about behavioral health services in Rockland County? Please check all that apply.
☐ Close to home
☐ Affordabe
☐ Confidential/private
☐ Staff speaks my language according to needs
☐ Staff understands my culture
☐ Accept my insurance
☐ Serve people of all ages
☐ Other (Please specify)

☐ Connects people to other services
☐ Caring, respectful atmosphere
☐ Staff is skilled and knowledgeable
☐ Different approaches are used
☐ Able to get service immediately
☐ Handicapped-accessible facilities

4. Please list any behavioral health services that you believe would be helpful to you or your family member that are not currently available in Rockland County or you believe are too limited.

____________________________________________________________________________________

____________________________________________________________________________________

5. Please add any comments, specific suggestions, etc. (including the identification of gaps or problems in current services that need improvement).

____________________________________________________________________________________

____________________________________________________________________________________

Or complete the survey online at: www.surveymonkey.com/s/RBHConsumer Thank you so much for you time!
Community Behavioral Health Assessment – Provider Questionnaire

The following survey is intended to gather information to help improve the behavioral health service delivery system in Rockland County. Your thoughts, experiences and ideas will help inform County leaders on ways to better help our residents with behavioral health needs. By "behavioral health," we are referring to services for anyone affected by a developmental disability, mental illness, and/or a substance use disorder (their own or a family member’s).

Please answer the following questions. Your answers are strictly confidential! Thanks so much.

Agency:  □ Community-based Human Service/Rockland  □ Community-based Human Service/Other
         □ Health Care  □ Government  □ Education  □ Private  □ Other

Role:  □ Behavioral Health Professional  □ Health Care Professional  □ Administrator
       □ Other Human Service Professional  □ Other ______________________

What are the five most significant behavioral health problems/issues facing the consumers served in Rockland County?

1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________
4. ____________________________________________________________
5. ____________________________________________________________

Do you collaborate with other service providers? Please explain: __________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

What do you think are the strengths of the behavioral health system in our county?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

What are the most significant barriers that consumers face in accessing behavioral health care from you?

□ Lack of transportation  □ Faith/Religion
□ Limited hours of operation  □ Citizenship/Immigration status
□ Price/cost  □ Lack of familiarity with types of services
What are the most significant barriers impacting your ability to provide care to your consumers?

- Limited staffing resources
- Consumer inability to afford prescription medications to treatment
- Proscribed parameters of services, regulations, limitations
- Funding limitations and/or restrictions
- Other (specify)

Are there any important behavioral health services that are unavailable to the people you serve? Please explain:

What are the top 3 behavioral health priorities of agencies in Rockland County?

1. 
2. 
3. 

Please return survey to: Rockland County Office of the Executive Attention: Community Relations 11 New Hempstead Road New City, New York 10956 (845) 638-5856 (fax)

or complete the survey online at: www.surveymonkey.com/s/RCCBHAP

Thank you so much!
Guiding Questions for Focus Groups

1. In your community, organization or group what are the most important concerns and issues regarding behavioral health?

2. In your community, organization or group, what are the current priorities that need to be addressed?

3. What are the strengths of the Behavioral Health Services System in Rockland County?

4. In the Behavioral Health Services System in Rockland County, what areas need improvement?

5. In the Behavioral Health Services System in Rockland County, what are the barriers to obtaining behavioral health care?

6. Are people leaving Rockland County to obtain behavioral health services? If yes, what is the reason and where do they go?

7. What are your suggestions to improve efforts to meet the behavioral health needs of people in Rockland County?

8. What are the best ways to raise the awareness of Behavioral Health Services in Rockland County?

9. Are there others who should be interviewed to learn more about these issues and concerns?

10. Any other thoughts or comments?
The County Executive's Commission on Community Behavioral Health was appointed by County Executive Ed Day in August 2014 as a way to learn about and therefore better meet the behavioral health needs of Rockland County residents. To that end, the Commission's purpose is to conduct a County-wide community behavioral health needs assessment. Based upon the results of this needs assessment, the County will re-design the county-wide behavioral health service delivery system to improve and maximize services to our residents.

In order to gain both a broad and deep picture of Rockland's behavioral health needs, the assessment involves the use of surveys, small group meetings, and one on one interviews with key members of the community. To that end, you have been selected to be interviewed by the Commission because of your standing in the community and your knowledge of the needs of its residents. Your input is vitally important.

The following questions pertain to your ideas about behavioral health in Rockland County. Please be aware that when we speak about behavioral health, we are including needs and services for those with developmental disabilities, mental health problems/mental illness, and/or alcohol and other drug abuse treatment and/or prevention-related issues. The questions are geared to ask your opinion as to the specific issues present in Rockland, your knowledge of what services are already available, and your suggestions as to what would be needed.

Your answers to all questions will be strictly confidential. Your thoughts and ideas about behavioral health in Rockland will be compiled and used to develop a comprehensive plan for the County. Your assistance is greatly appreciated.

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Intro Questions:

Tell us about yourself/your organization-

- Mission? How long here?
- Services provided or issue you work on (if any)?
- How do you define your organization/community/service area? Who do you represent?
- Do you or your organization address the needs of people with behavioral health needs in Rockland County?

1. Using a scale from one to ten, how much of a concern is behavioral health to the community, with one being not at all and ten being a very large concern?

2. Who would someone with a behavioral health problem turn to for help?
3. What efforts are available in your community to address issues of behavioral health?
   a. What are the services available in your community? Whom do they serve?
   b. Are there specific populations not being served at all?
      i. What do you think is preventing these folks from being served?
      ii. Are some served well? Please describe.
      iii. Is there anyone who is receiving services but shouldn't be, or should be seen somewhere else?
   c. Are there special needs not being met? (co-occurring disorders, corrections/parole, dual needs such as DD and CD, homeless, racial/ethnic/age/cultural barriers)
   d. What do you consider to be the biggest unmet need related to behavioral health in Rockland County?

4. Using a scale from one to ten, how aware are people in the community of these efforts/services, with one being no awareness and ten being very aware?

5. How long have these efforts been going on in your community and how are they viewed by the community?

6. What is it like to receive behavioral health services in Rockland?
   a. Where do people go first for mental health care? Crisis services? Outpatient services? Case management?
   b. What about people who are new to the system/county?
   c. What about those with no health insurance?
   d. What about those with other barriers? (accessibility, language, etc)
   e. Are there qualified agency, individual practitioner providers of behavioral health services in Rockland county? Do you know how to find them?

7. Using a scale from one to ten, how aware are leaders, groups or committees in the community of behavioral health needs and services in Rockland County, with one being no awareness and ten being very aware?

8. What are the strengths of these efforts?
   a. Are there services that should be preserved or expanded?
   b. Are there policies that help to insure that adequate services are available?
   c. Are the services high quality?
   d. Is there enough oversight to insure good services?

9. What are the weaknesses of these efforts?
   a. What services are missing or inadequately available?
   b. Are there services that should be curtailed or are not useful?
   c. What ideas might you have to make the system better?
10. What are the primary obstacles or barriers to behavioral health in your community?
   a. Are there policies that impede service delivery?
   b. Are the rates being paid to providers adequate to insure good services? Too high? Too low?
   c. Other obstacles?

11. Would people support increased behavioral health services in your community? If yes, using a scale from one to ten, how much support would they give, with one being not at all and ten being a lot?
   a. If you were to rank the top three behavioral health priorities in Rockland County, what would they be?
   b. Do you believe that your neighbors/colleagues/peers would agree with these priorities? Why or why not?

12. Does the community at large have any say as to what is needed in terms of behavioral health services, and how things are working?
   a. Is there enough public input into service delivery decisions? (public forums, customer satisfaction surveys, outreach)
   b. Are behavioral health leaders seeking and accepting of feedback?
   c. Are some groups/communities excluded or given limited opportunities?

13. What is the community’s attitude about supporting behavioral health efforts with people, money, time and space?

14. Are there segments of the community in which you think behavioral health efforts do not apply, for example, due to age, religion, ethnicity, gender or socioeconomic status?

15. Who provides the resources for behavioral health services and how long do they last?
   a. What do you see as the role of Rockland County government in providing/overseeing behavioral health services for Rockland residents?
   b. Are there enough qualified service providers and agencies/individual practitioners in Rockland?
      i. Which do you consider to be adequate/excellent, and which aren't?
      ii. What are some of the factors that you think affect recruitment of qualified behavioral health practitioners?
      iii. What are the barriers to recruitment and retention of qualified professionals?
      iv. Are the training and information needs of providers being met? Do you know of any best practices or promising approaches to suggest?
16. Is there a need to expand behavioral health services? Why or why not?

17. Are there plans to expand or develop other behavioral health efforts? If yes, can you tell me more about the plans?

18. Is there ever a time when or circumstance in which a member of your community might think that behavioral health issues are overlooked or ignored due to age, religion, ethnicity, gender or socioeconomic status?

19. What in your opinion are the formal or informal leadership positions in your community? Prompt: people whose opinion is respected and who may be contacted informally when issues arise.

   a. Are there people or groups we should be talking with about the needs in your area? Who are they and how do we contact them?

20. Using a scale from one to ten, how much of a concern is behavioral health to the leadership, with one being not at all and ten being very large concern? Can you tell me why you’ve chosen that number?

21. Are the leaders involved in behavioral health efforts in your community? How much are they involved?

22. Would the leadership support additional efforts? Please explain.

   a. What do you see as the role of Rockland County government in providing/overseeing behavioral health services for Rockland residents?

23. Are you aware of any proposals or action plans that have been written to address the behavioral health issues in your community?

   a. Who is working on these behavioral health issues locally?
   b. Who is working on these behavioral health issues in the state and nationally?
   c. What do you see as the political and economic landscape of people with behavioral health issues in the next five years?

24. What types of formal policies (rules and regulations) related to behavioral health are in place in your community? Do you believe that they are adequate?

25. Are there informal practices that are in place in your community? If yes, what are they?

   a. Who are the informal leaders in your community who can help people with behavioral health issues?

26. Are the people in your community aware of these policies?
27. How are these policies viewed by the community?

28. In your community, what type of information is available about behavioral health?

29. Is local data on behavioral health issues available in your community?

30. How do people obtain this information in your community?

31. Do you know if there is any evaluation of the efforts? If yes, using a scale from one to ten, how sophisticated is the evaluation effort, with one being not at all and ten being very sophisticated.

32. Are the evaluation results being used to make changes in the programs, activities or policies or to start new ones?

33. Based on the answers you’ve provided so far, can you tell what the overall feeling of the community is regarding behavioral health?

34. What ideas do you have for changes that could make Rockland County's behavioral health system better?

35. Is there anything else that you consider to be important to know about behavioral health in the county that we did not get to today?
# D. County Executive’s Commission on Community Behavioral Health - Recommendations

<table>
<thead>
<tr>
<th>Item</th>
<th>Recommendation</th>
<th>Page</th>
<th>BH Sector</th>
<th>Primary Entity(ies) Responsible</th>
<th>Other Partners</th>
<th>Implementation Timeframe</th>
<th>Resources Needed</th>
<th>Status</th>
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<tr>
<td>S-A1</td>
<td>Programs identified as highly satisfactory</td>
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<td>CSB</td>
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<tr>
<td>S-B1</td>
<td>Normalize collaboration, measure effectiveness</td>
<td>50</td>
<td>All</td>
<td>RCDMH, BH Workgroups</td>
<td>Community coalitions, other agencies</td>
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<tr>
<td>S-C1</td>
<td>Training with CEUs for BH program staff, others</td>
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<td>All</td>
<td>RCDMH</td>
<td>BH providers, other agencies/coalitions</td>
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<tr>
<td>S-D1</td>
<td>Uniform Consumer Satisfaction survey</td>
<td>50</td>
<td>All</td>
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<td>CSB, BH Workgroups</td>
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<tr>
<td>S-D2</td>
<td>County depts, represented in community coalitions</td>
<td>51</td>
<td>All</td>
<td>County of Rockland</td>
<td>All County Depts.</td>
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<td>S-D3</td>
<td>Rebuild/empower the Unified BH Services system</td>
<td>51</td>
<td>All</td>
<td>County of Rockland</td>
<td>RCDMH, CSB, Subcommittees, Workgroups</td>
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<tr>
<td>S-E1</td>
<td>Measure BH agency involvement in community</td>
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<td>BH providers</td>
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<td>S-F1</td>
<td>Establish satellites, co-located sites in community</td>
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<td>All</td>
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<td>BH providers (incl.RCDMH), State BH agencies</td>
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<td>2 to 3</td>
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<tr>
<td>S-F2</td>
<td>Establish partnerships in underserved communities</td>
<td>52</td>
<td>All</td>
<td>RCDMH</td>
<td>BH providers (incl.RCDMH)</td>
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<tr>
<td>A-A1</td>
<td>Education/community resource specialist position</td>
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<td>RCDMH</td>
<td>1</td>
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<tr>
<td>A-B1</td>
<td>Organizational charts- Unified Services BH system</td>
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<td>CSB, BH Workgroups</td>
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<tr>
<td>A-B2</td>
<td>Update all BH provider information annually</td>
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<td>BH providers</td>
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<tr>
<td>A-C1</td>
<td>Create a single point of contact for BH info</td>
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<td>RCDMH</td>
<td>RCDSS</td>
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<tr>
<td>A-C2</td>
<td>Capture info in printable and digital format</td>
<td>53</td>
<td>All</td>
<td>RCDMH</td>
<td>BH providers, other agencies/coalitions</td>
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<tr>
<td>A-C3</td>
<td>Explore partnerships in underserved communities</td>
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<td>BH providers (incl. RCDMH)</td>
<td>Community coalitions, other agencies</td>
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**Codes:**
- **S=** Building Upon Strengths,
- **A=** Increasing Awareness,
- **B=** Removing the Barriers,
- **GA=** Closing the Gaps - Adult MH,
- **GCD=** Closing the Gaps - Chemical Dependency,
- **GCA=** Closing the Gaps - Child and Adolescent,
- **GCL=** Closing the Gaps - Co-located Services,
- **GCI=** Closing the Gaps - Criminal Justice,
- **GCR=** Closing the Gaps - Crisis Services,
- **GID=** Closing the Gaps - I/DD Services,
- **RG=** Reaffirming the Role of Government

**Timeframe:**
- 1= can accomplish within first year,
- 2= can accomplish within 2-3 years,
- 3= can accomplish within 3-5 years

**Resources Needed:**
- 1=Can accomplish with current resources,
- 2= Needs minimal additional resources to accomplish,
- 3= Needs substantial resources to accomplish
<table>
<thead>
<tr>
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<th>Description</th>
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<th>Timeframe</th>
<th>Level</th>
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<tr>
<td>A-C4</td>
<td>Awareness efforts directed to special populations</td>
<td>All RCDMH</td>
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<tr>
<td>A-D1</td>
<td>Annual education session for all elected officials</td>
<td>RCDMH, CSB, Workgroups</td>
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<tr>
<td>A-D2</td>
<td>Create a BH media campaign</td>
<td>RCDMH</td>
<td>1 to 2</td>
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<td>B-A1</td>
<td>Expand BH services to evenings/weekends</td>
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<td>2</td>
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<tr>
<td>B-A2</td>
<td>Assess and treat walk-in consumers</td>
<td>All RCDMH</td>
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<td>2</td>
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<tr>
<td>B-A3</td>
<td>Serve homebound consumers with BH issues</td>
<td>All RCDMH</td>
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<td>B-A4</td>
<td>Develop a ‘pro-bono’ pool of BH professionals</td>
<td>All RCDMH</td>
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<td>B-A5</td>
<td>Limit wait lists through referrals</td>
<td>All RCDMH</td>
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<tr>
<td>B-A6</td>
<td>Adapt PROS to serve those unable to work 10+ hours a week</td>
<td>MH/UI-DD RCDMH</td>
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<tr>
<td>B-A7</td>
<td>ACCES-VR to present services, troubleshoot gaps</td>
<td>All RCDMH</td>
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<tr>
<td>B-B1</td>
<td>Add resource assessment to annual planning process</td>
<td>All RCDMH</td>
<td>1</td>
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<tr>
<td>B-B2</td>
<td>Create Olmstead Implementation Taskforce</td>
<td>RCDMH</td>
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<tr>
<td>B-C1</td>
<td>Recruitment of specialists- BH, special populations</td>
<td>RCDMH</td>
<td>2 to 3</td>
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<tr>
<td>B-C2</td>
<td>Analysis of BH agency staffing for core competencies</td>
<td>RCDMH</td>
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<tr>
<td>B-C3</td>
<td>Recruit BH staff with cultural, linguistic competence</td>
<td>County of Rockland</td>
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<tr>
<td>B-C4</td>
<td>Measure employees' sense of equity in workplace</td>
<td>RCDMH</td>
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<tr>
<td>B-C5</td>
<td>Expand use of para-professionals and recovery coaches</td>
<td>RCDMH</td>
<td>1</td>
<td>1 to 2</td>
</tr>
<tr>
<td>B-D1</td>
<td>Work with State reps to address insurance restrictions</td>
<td>County of Rockland</td>
<td>2 to 3</td>
<td>2 to 3</td>
</tr>
</tbody>
</table>

**Codes:**
- **Items:** S=Building Upon Strengths, A= Increasing Awareness, B= Removing the Barriers, GA= Closing the Gaps- Adult MH, GCD= Closing the Gaps- Chemical Dependency, GCA= Closing the Gaps- Child and Adolescent, GCL= Closing the Gaps- Co-located Services, GCR= Closing the Gaps- Criminal Justice, GCR= Closing the Gaps- Crisis Services, GID= Closing the Gaps- I-DD Services, RG= Reaffirming the Role of Government
- **Timeframe:** 1= can accomplish within first year, 2= can accomplish within 2-3 years, 3= can accomplish within 3-5 years
- **Resources Needed:** 1=Can accomplish with current resources, 2= Needs minimal additional resources to accomplish, 3= Needs substantial resources to accomplish
| B-D2  | BH agencies to be required to operate within optimal hours | 59 | All | County of Rockland | State BH agencies | 2 | 2 |
| B-D3  | Increase physical accessibility of BH program sites | 59 | All | RCDMH | State BH agencies | 2 | 3 |
| B-D4  | Convene hearings on the high cost of prescription medications | 59 | All | County of Rockland | State and Federal reps, State BH agencies | 1 to 2 | 1 |
| B-D5  | Investigate Orange County model of incentives for BH housing | 59 | All | County of Rockland | RCDMH | 1 | 2 |
| B-D6  | Develop Rockland baseline for Olmstead-related costs | 59 | All | County of Rockland | Legislature, RCDMH, BH providers | 1 | 1 |
| B-E1  | Work to reduce barriers due to regulatory guidelines | 60 | All | RCDMH | BH providers and consumers, State BH agencies | 2 | 1 |
| B-E2  | Tax incentives to landlords who set aside housing for BH pop. | 60 | All | County of Rockland | RCDMH, State elected officials | 2 | 2 |
| B-F1  | Develop a standardized percentage rate for un/under-insured | 60 | All | RCDMH | BH providers (incl. RCDMH) | 3 | 2 to 3 |
| B-F2  | Half-price bus tickets for needy BH consumers | 60 | All | County of Rockland | County Dept. of Transportation and Planning | 1 to 2 | 2 |
| B-F3  | Crisis service to be provided regardless of immigration status | 60 | All | County of Rockland | BH providers and consumers, State BH agencies | 2 | 2 to 3 |
| B-F4  | Services to a consumer from different licensed BH agencies | 60 | All | County of Rockland | State elected officials, State BH agencies | 2 | 2 |
| B-F5  | Integrate BH community into Housing Authority advisory bdls | 61 | All | County of Rockland | BH consumers, providers, local housing authorities | 1 | 1 |
| B-F6  | Explore conversion of county-owned properties to BH housing | 61 | All | County of Rockland | RCDMH, State agencies, BH providers | 2 | 2 to 3 |
| B-G1  | Training on best practice/special pops for BH providers | 61 | All | RCDMH | BH consumers/providers, colleges, State BH agcy | 1 | 2 |
| GA-A1 | Increase inpatient psych beds at Nyack Hospital | 62 | MH | County of Rockland | RCDMH, Nyack Hospital, NYSDOH | 1 to 2 | 2 to 3 |
| GA-A2 | Create an enhanced outpatient program at RPC | 62 | MH | RCDMH | RPC, NYSOMH, CSB | 2 | 2 to 3 |
| GA-A3 | Expand role of Care Coordinators | 62 | MH | RCDMH | NYSOMH, MH Workgroup, CSB | 1 to 2 | 2 |
| GA-A4 | Expand slots for the ACT Team for homeless/high risk | 62 | MH | RCDMH | MHA, NYSOMH | 1 to 2 | 2 to 3 |
| GA-A5 | Local practitioners using evidence-based practice | 62 | MH | RCDMH | BH Workgroups, Subcommittees, CSB | 1 | 1 to 2 |

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| GA-A6 | Mental Health services onsite for homeless vets and families | 62 | MH | RCDMH | NYSOMH, local MH providers, vet's housing agcy | 2 | 2 |
| GA-B1 | Mobile Crisis Team & ED's provide follow-up appointments | 63 | MH | RCDMH | Rockland Mobile, Nyack Hosp, Good Sam | 1 | 1 |
| GA-B2 | Mobile Crisis Team & ED's obtain releases for BH provider | 63 | MH | RCDMH | Rockland Mobile, Nyack Hosp, Good Sam | 1 | 1 |
| GA-B3 | Family/peer advocates to offer support in the ED | 63 | MH | RCDMH | Nyack Hosp, Good Sam | 1 | 1 |
| GA-B4 | Improved coordination between ED's and AOT | 63 | MH | RCDMH | Nyack Hosp, Good Sam, AOT Coordinator | 1 | 1 |
| GA-B5 | OASAS/OMH-licensed agencies apply for dual licensure | 63 | MH | RCDMH | BH providers and consumers, State BH agencies | 2 | 2 to 3 |
| GA-B6 | NKI to offer online/onsite BH courses for CEUs | 63 | MH | RCDMH | Nathan Kline Institute, State BH agencies | 2 | 2 |
| GA-C1 | Clarify the role of Good Sam in psych eval, medical clearance | 63 | MH | RCDMH | Good Sam, NYSOMH, NYSDOH | 1 | 1 |
| GA-C2 | Encourage integration of primary and behavioral health | 63 | MH | RCDMH | Primary care providers, BH providers | 2 | 2 to 3 |
| GA-D1 | Expand local veterans' BH services | 64 | MH | RCDMH | Rockland County Office of Veteran's Services | 2 | 2 to 3 |
| GA-E1 | Development of BH screening tool for primary care docs | 64 | MH | RCDMH | Primary care providers, BH providers | 1 | 1 |
| GA-F1 | Nyack Hosp, provide comprehensive referrals at discharge | 64 | MH | RCDMH | Nyack Hospital | 1 | 1 |
| GA-F2 | Nyack Hosp, accept more local insurances, incl. veterans | 64 | MH | RCDMH | Nyack Hospital | 1 | 1 |
| GA-F3 | Establishment of linkages to fill inpatient service gaps | 64 | MH | RCDMH | Local and regional BH providers | 1 | 1 |
| GA-G1 | Sensitivity training for all BH providers on work with families | 64 | MH | RCDMH | MH providers and consumers, Workgroups | 1 | 1 |
| GA-G2 | Training for BH providers on patient rights | 63 | MH | RCDMH | MH providers and consumers, Workgroups | 1 | 1 to 2 |
| GA-G3 | Training for BH providers on meeting needs of veterans | 63 | MH | RCDMH and RC Office of Veteran's Serv. | MH providers and consumers, Workgroups | 1 | 1 |
| GA-G4 | Training for MH providers on special populations | 63 | MH | RCDMH | MH providers and consumers, Workgroups | 1 | 1 |
| GCD-A1 | Expand prevention counseling to over 21 population | 66 | CD | RCDMH | NYSOASAS, CD prevention providers | 1 | 2 |

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Resources Needed</th>
<th>Timeframe</th>
<th>Additional Notes</th>
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<tbody>
<tr>
<td>GCD-A2</td>
<td>Re-establish Student Assistance Program- college, secondary</td>
<td>66 CD</td>
<td>RCDMH</td>
<td>NYSOASAS, State Ed, RCC, local high schools</td>
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<tr>
<td>GCD-A3</td>
<td>CD providers will use evidence-based treatment/prevention</td>
<td>66 CD</td>
<td>RCDMH</td>
<td>CD providers, NYSOASAS</td>
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<tr>
<td>GCD-A4</td>
<td>CD treatment onsite to homeless vets and families</td>
<td>66 CD</td>
<td>RCDMH</td>
<td>NYSOASAS, CD providers, Vet's housing agcy</td>
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<tr>
<td>GCD-A5</td>
<td>Add ambulatory detox to outpatient treatment programs</td>
<td>66 CD</td>
<td>RCDMH</td>
<td>NYSOASAS, CD treatment providers</td>
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<tr>
<td>GCD-B1</td>
<td>Develop a drugged driving prevention program for youth</td>
<td>66 CD</td>
<td>RCDMH</td>
<td>BOCES, CD prevention providers</td>
</tr>
<tr>
<td>GCD-B2</td>
<td>OASAS/OMH-licensed agencies apply for dual licensure</td>
<td>66 CD</td>
<td>RCDMH</td>
<td>BH providers and consumers, State BH agencies</td>
</tr>
<tr>
<td>GCD-C1</td>
<td>Permanent supportive housing for CD population</td>
<td>67 CD</td>
<td>RCDMH and NYSOASAS</td>
<td>RC Comm. Dev., OASAS housing providers</td>
</tr>
<tr>
<td>GCD-C2</td>
<td>Review records for those not admitted to detox</td>
<td>67 CD</td>
<td>RCDMH and NYSOASAS</td>
<td>Nyack Hosp, Good Sam</td>
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<tr>
<td>GCD-D1</td>
<td>Expand admission criteria to State-operated ATCs</td>
<td>67 CD</td>
<td>RCDMH and NYSOASAS</td>
<td>CD Workgroup, CB</td>
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<tr>
<td>GCD-D2</td>
<td>All medically-assisted treatments at methadone clinic, hosp,</td>
<td>67 CD</td>
<td>RCDMH and NYSOASAS</td>
<td>Lexington Center, Nyack Hosp, Good Sam</td>
</tr>
<tr>
<td>GCD-D3</td>
<td>Add drugged driving curriculum to NYS driver's course</td>
<td>67 CD</td>
<td>County of Rockland</td>
<td>NYSDMV, NYSOASAS, State elected officials</td>
</tr>
<tr>
<td>GCD-E1</td>
<td>Open ambulatory detox slots to poly-addicted</td>
<td>67 CD</td>
<td>RCDMH</td>
<td>Nyack Hospital, NYSOASAS, CD providers</td>
</tr>
<tr>
<td>GCD-E2</td>
<td>Explore partnerships in underserved communities</td>
<td>68 CD</td>
<td>CD providers</td>
<td>Community coalitions, other agencies</td>
</tr>
<tr>
<td>GCD-F1</td>
<td>Expand CD housing to special populations</td>
<td>68 CD</td>
<td>RCDMH and NYSOASAS</td>
<td>CD housing providers, Office of Comm. Devel.</td>
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<tr>
<td>GCD-G1</td>
<td>Training on CD issues for school staff</td>
<td>68 CD</td>
<td>RCDMH and BOCES</td>
<td>School superintendents, CD providers</td>
</tr>
<tr>
<td>GCD-G2</td>
<td>Training for all CD providers on serving special populations</td>
<td>68 CD</td>
<td>RCDMH</td>
<td>CD providers and consumers, Workgroups</td>
</tr>
<tr>
<td>GCA-A1</td>
<td>RCPC and hospitals will coordinate care</td>
<td>69 MH</td>
<td>RCDMH</td>
<td>RCPC, Nyack, Good Sam</td>
</tr>
<tr>
<td>GCA-A2</td>
<td>BOCES will provide educational services in hospital</td>
<td>69 MH</td>
<td>BOCES</td>
<td>RCPC</td>
</tr>
<tr>
<td>GCA-A3</td>
<td>Crisis respite for children and adolescents at RCPC</td>
<td>69 MH</td>
<td>RCDMH</td>
<td>RCPC, BOCES</td>
</tr>
</tbody>
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| GCA-A1 | Increased outpatient slots for children, adolescents | MH | RCDMH | RCPC, NKI | 2 | 2 |
| GCA-A2 | Provide community-level support for families | MH | RCDMH | NAMI, BH agencies, RCDSS | 1 | 1 to 2 |
| GCA-A3 | Increase juvenile justice prevention programs | All | Rockland County DA and Probation | RCDMH, Prevention providers, NYSOCFS/DCJS | 1 | 2 to 3 |
| GCA-A7 | Coordinate with SPOA referral sources, involve parents | MH | RCDMH | St. Dominc’s, MHA, MH providers | 1 | 1 |
| GCA-A8 | Consumer satisfaction survey for Children's SPOA | MH | RCDMH | SPOA participating agencies | 1 | 1 |
| GCA-A9 | RCPC will accept direct admissions during weekday hours | MH | RCDMH | RCPC, CSB | 1 | 1 |
| GCA-B1 | Create subscription BH consultation service for pediatricians | MH | RCDMH | RCPC, NKI | 2 | 2 |
| GCA-B2 | Online/onsite BH courses for pediatricians | MH | RCDMH | NKI | 2 | 2 |
| GCA-B3 | Explore partnerships in underserved communities | MH | Child MH providers | Community coalitions, other agencies | 1 | 1 |
| GCA-B4 | Facilitate smooth transition from WAIVER services | MH | RCDMH | St. Dominc’s, MHA, MH providers | 1 | 1 |
| GCA-B5 | Include more support for parents in Children's SPOA | MH | RCDMH | NAMI, Rockland Independent Living Ctr. | 1 | 1 |
| GCA-B6 | Utilization of CCSI in transitions | MH | RCDMH | SPOA participating agencies | 1 | 1 |
| GCA-B7 | RCPC dedicated staff member for referrals | MH | RCDMH | RCPC | 1 | 1 to 2 |
| GCA-B8 | Streamline referral system to RCPC | MH | RCDMH | RCPC, Nyack, Good Sam | 1 | 1 |
| GCA-C1 | Improve CCSI/Network | MH | RCDMH | MHA | 1 | 1 |
| GCA-C2 | Combine workgroups at least quarterly | All | RCDMH | All workgroups | 1 | 1 |
| GCA-C3 | Create short-term crisis unit at RCPC | MH | RCDMH | RCPC, NYSOMH | 2 | 2 to 3 |
| GCA-C4 | Expedite admissions to RCPC for Rockland youth | MH | RCDMH | RCPC | 1 | 1 |
| GCA-C5 | Study promising approaches in shared service and info | All | RCDMH | RCDSS, DA, Probation, BOCES | 1 | 1 |

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| GCA-C6 | Encourage integration of pediatric and behavioral health | 71 | All | RCDMH | Primary care providers, BH providers | 2 | 2 |
| GCA-C7 | Uniform standard, increase parent involvement in SPOA | 71 | MH | RCDMH | RCPC, NYSOMH, MH Workgroup | 1 | 1 |
| GCA-C8 | Children accepted into RCPC with no insurance authorization | 71 | MH | RCDMH | NYSOMH, MH Workgroups, CSB | 2 | 2 |
| GCA-C9 | Increase psychiatric staff at RCPC, evening/weekends | 71 | MH | RCDMH | NYCH, NYSOMH | 2 | 3 |
| GCA-D1 | Change regulations prohibiting WAIVER services | 72 | MH | RCDMH | NYSOMH | 2 | 3 |
| GCA-D2 | Remove barriers to direct admission to RCPC | 72 | MH | RCDMH | NYSOMH | 2 | 1 to 2 |
| GCA-D3 | Lower age of admission to RCPC | 72 | MH | RCDMH | RCPC, NYSOMH | 2 | 3 |
| GCA-E1 | Development of BH screening tool for pediatricians | 72 | All | RCDMH | Pediatric providers, BH providers | 1 | 1 |
| GCA-F1 | Assess ways to improve parental involvement in SPOA | 72 | MH | RCDMH | MH providers and consumers, Workgroups | 1 | 1 |
| GCA-F2 | Link school personnel to BH community resources | 72 | All | RCDMH | School superintendents, BH providers | 1 | 1 |
| GCA-F3 | Schools must ensure transition plans for students | 73 | All | School Superintendents | ACCESS/VR | 1 | 1 |
| GCA-F4 | Establishment of linkages to fill inpatient service gaps | 73 | MH | RCDMH | Local and regional BH providers | 1 | 1 |
| GCA-G1 | Periodic training for school faculty and staff on BH issues | 73 | All | School Superintendents | RCDMH, BH workgroups, NAMI | 1 | 1 to 2 |
| GCL-A1 | Establishment of a BH Evaluation and Referral Center | 74 | All | RCDMH | RCPC, Nyack Hosp, Good Sam | 1 | 2 to 3 |
| GCL-B1 | Establishment of computer interface for referrals | 74 | All | RCDMH | BH Excl Ctr, Rockland Mobile, hospitals | 1 | 2 to 3 |
| GCL-C1 | Expedite the co-location process and remove barriers | 74 | All | RCDMH | NYS BH Licensing agencies, Workgroups, Depts | 2 | 2 to 3 |
| GCL-D1 | Train and locate recovery coaches and peer advocates at EDs | 74 | All | NAMI, MHA, RCADD | BH Workgroups, Nyack Hosp, Good Sam | 2 | 2 |
| GCL-D2 | Encourage service providers to share space, resources | 74 | All | RCDMH | BH providers, other agencies/coalitions | 2 | 1 to 2 |
| GCL-D3 | Explore partnerships in underserved communities | 75 | All | RCDMH | Community coalitions, other agencies | 1 | 1 |

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<tr>
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<th>Description</th>
<th>All</th>
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<th>RC Sheriff’s Office, NYS BH agencies, RCDMH</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>GCJ-A1</td>
<td>Create an observation unit in Rockland County Jail</td>
<td>76</td>
<td>All</td>
<td>RCDMH</td>
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<tr>
<td>GCJ-A2</td>
<td>Social Worker in Rockland County Jail to facilitate referrals</td>
<td>76</td>
<td>All</td>
<td>RCDMH</td>
<td>1</td>
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<tr>
<td>GCJ-A3</td>
<td>Expand criminal justice prevention programs</td>
<td>76</td>
<td>All</td>
<td>RCDMH, Haverstraw Center, RCADD</td>
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<tr>
<td>GCJ-B1</td>
<td>Co-locate a social worker at the Probation Dept.</td>
<td>76</td>
<td>All</td>
<td>Probation Dept, BH providers</td>
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<tr>
<td>GCJ-B2</td>
<td>Criminal justice and BH staff improve communication</td>
<td>76</td>
<td>All</td>
<td>RCDMH, Criminal Justice Administrators</td>
<td>1</td>
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<tr>
<td>GCJ-C1</td>
<td>Printed information guide for law enforcement, first responders</td>
<td>76</td>
<td>All</td>
<td>County of Rockland, RCDMH, Workgroups</td>
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<tr>
<td>GCJ-D1</td>
<td>Discounted bus tickets for needy participants in BH courts</td>
<td>77</td>
<td>MH, CD</td>
<td>County of Rockland, County Dept. of Transportation and Planning</td>
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<tr>
<td>GCJ-E1</td>
<td>Improve capacity of BH providers to serve court participants</td>
<td>77</td>
<td>All</td>
<td>MHATI Advisory Board, BH providers, other agencies, Workgroups</td>
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<tr>
<td>GCJ-E2</td>
<td>Provide basic BH curriculum for police academy cadets</td>
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<td>All</td>
<td>RCDMH</td>
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<tr>
<td>GCR-A1</td>
<td>24-hour Mobile Crisis hotline, triage, referral</td>
<td>78</td>
<td>All</td>
<td>Rockland Mobile and RCDMH, BH Evaluation and Referral Center</td>
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<td>GCR-A2</td>
<td>Mobile Crisis referrals to BH Evaluation and Referral Center</td>
<td>78</td>
<td>All</td>
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<tr>
<td>GCR-A3</td>
<td>Establishment of a BH Evaluation and Referral Center</td>
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<td>All</td>
<td>RCDMH</td>
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<tr>
<td>GCR-B1</td>
<td>Standard referral form used to facilitate follow-up</td>
<td>78</td>
<td>All</td>
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<td>GCR-C1</td>
<td>Standard referral form developed</td>
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<tr>
<td>GCR-D1</td>
<td>Mobile Crisis to train Clarkstown PD</td>
<td>79</td>
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<td>GCR-D2</td>
<td>Mobile Crisis to train other police depts.</td>
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<td>Special population training for mobile crisis team</td>
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<tr>
<td>GCR-D4</td>
<td>Awareness of Mobile Crisis to underserved communities</td>
<td>79</td>
<td>All</td>
<td>RCDMH Community Resource Specialist</td>
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<td>GID-A1</td>
<td>Clinics receiving federal funding will provide I-DD services</td>
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<td>I-DD</td>
<td>County of Rockland, RCDMH, BH State licensing agencies</td>
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</tbody>
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<td>Clinics receiving federal funding will provide I-DD screenings</td>
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<tr>
<td>B1</td>
<td>Hospitals will develop capacity to treat I-DD in their ED's</td>
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<td>1 to 2</td>
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<td>C1</td>
<td>County must advocate to uphold 'no wrong door policy'</td>
<td>2</td>
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<td>Outpatient MH providers will develop capacity to treat I-DD</td>
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<tr>
<td>C3</td>
<td>RCPC and RPC develop capacity to treat I-DD consumers</td>
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<td>C4</td>
<td>NYSOPWDD will expand adult and child crisis respite beds</td>
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<tr>
<td>C5</td>
<td>Greater local input in NYSOPWDD planning re Olnmscal</td>
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<tr>
<td>C6</td>
<td>Local input for vetting process for DISCO providers</td>
<td>1</td>
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<tr>
<td>C7</td>
<td>Insurance of supports for individuals returned to community</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>C8</td>
<td>Delay closures of ICFs and Sheltered Workshops</td>
<td>1</td>
<td>1</td>
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<tr>
<td>C9</td>
<td>Individuals with I-DD finding/retaining independent living</td>
<td>2</td>
<td>2 to 3</td>
<td></td>
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<tr>
<td>D1</td>
<td>Form an I-DD SPOA</td>
<td>1</td>
<td>1</td>
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</tr>
<tr>
<td>D2</td>
<td>Establishment of linkages to fill inpatient service gaps</td>
<td>1</td>
<td>1</td>
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<tr>
<td>E1</td>
<td>Annual training for County BH staff, supervisors in I-DD</td>
<td>1 to 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E2</td>
<td>Annual training in I-DD issues for all workgroups</td>
<td>1 to 2</td>
<td></td>
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<tr>
<td>E3</td>
<td>Training MH and CD staff to serve I-DD consumers, families</td>
<td>1 to 2</td>
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<td></td>
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<tr>
<td>E4</td>
<td>Cross-training for all Rockland BH staff</td>
<td>1 to 2</td>
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<td></td>
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<tr>
<td>E5</td>
<td>Training for Rockland business community in I-DD</td>
<td>1 to 2</td>
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</tbody>
</table>

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- A= Increasing Awareness
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- GA= Closing the Gaps- Adult MH
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- RG= Reaffirming the Role of Government

**Timeframe:**
- 1= can accomplish within first year
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- 3= can accomplish within 3-5 years

**Resources Needed:**
- 1=Can accomplish with current resources
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<table>
<thead>
<tr>
<th>Codes:</th>
<th>Items:</th>
<th>Timeframe:</th>
<th>Resources Needed:</th>
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<tbody>
<tr>
<td>GID-E6</td>
<td>Community forums to educate residents about I-DD</td>
<td>82</td>
<td>I-DD</td>
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<tr>
<td>GID-E7</td>
<td>Training series for criminal justice/first responders re I-DD</td>
<td>83</td>
<td>I-DD</td>
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<tr>
<td>RG-A1</td>
<td>Expanded Utilization of Rockland Psychiatric Center</td>
<td>84</td>
<td>MH</td>
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<tr>
<td>RG-B1</td>
<td>Creation of a position/team to oversee human services</td>
<td>84</td>
<td>All</td>
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<tr>
<td>RG-B2</td>
<td>Promotion of dual licensure for BH agencies</td>
<td>84</td>
<td>MH, CD</td>
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<tr>
<td>RG-C1</td>
<td>Unifying vision and mission for BH in Rockland</td>
<td>84</td>
<td>All</td>
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<tr>
<td>RG-C2</td>
<td>Provision of safety net BH services</td>
<td>84</td>
<td>All</td>
</tr>
<tr>
<td>RG-C3</td>
<td>Proactively seek BH resources</td>
<td>84</td>
<td>All</td>
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<tr>
<td>RG-C4</td>
<td>Build capacity within local communities to meet BH needs</td>
<td>83</td>
<td>All</td>
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<tr>
<td>RG-C5</td>
<td>Explore partnerships in underserved communities</td>
<td>85</td>
<td>All</td>
</tr>
<tr>
<td>RG-C6</td>
<td>RCDMH and CSB work in partnership to advocate, advise</td>
<td>85</td>
<td>All</td>
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<tr>
<td>RG-C7</td>
<td>Advocacy re Medicaid re-design to better serve residents</td>
<td>83</td>
<td>All</td>
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<tr>
<td>RG-C8</td>
<td>Advocacy re DSRIP to include Commission recommend.</td>
<td>85</td>
<td>All</td>
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<tr>
<td>RG-C9</td>
<td>Advocacy re Olmstead to ensure community supports exist</td>
<td>83</td>
<td>All</td>
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<tr>
<td>RG-C10</td>
<td>Develop evaluation of local BH services for funding</td>
<td>86</td>
<td>All</td>
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<tr>
<td>RG-C11</td>
<td>Bi-annual review of County Charter to update re State/Feds</td>
<td>86</td>
<td>All</td>
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<tr>
<td>RG-C12</td>
<td>Review and comparison of other local county BH systems</td>
<td>86</td>
<td>All</td>
</tr>
<tr>
<td>RG-C13</td>
<td>Results of Commission used, evaluated quarterly, repeated</td>
<td>86</td>
<td>All</td>
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<tr>
<td>RG-D1</td>
<td>Advocacy for co-licensing of all BH programs</td>
<td>86</td>
<td>All</td>
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</tbody>
</table>

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<th>Item</th>
<th>Description</th>
<th>Timeframe</th>
<th>Resources Needed</th>
<th>Code(s)</th>
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<tr>
<td>RG-D2</td>
<td>Mandate private insurance equal to Medicaid/Medicare</td>
<td>1</td>
<td>2</td>
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<tr>
<td>RG-D3</td>
<td>Change DMH name to Department of Behavioral Health</td>
<td>1</td>
<td>1</td>
<td>A</td>
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<tr>
<td>RG-E1</td>
<td>Advocacy for parity for BH frontline workers</td>
<td>2 to 3</td>
<td>1</td>
<td>A, B, C</td>
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<tr>
<td>RG-F1</td>
<td>CSB to meet monthly, and quarterly with CE</td>
<td>1</td>
<td>1</td>
<td>A</td>
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<tr>
<td>RG-F2</td>
<td>Re-establish CSB preliminary approval process w NYS</td>
<td>1</td>
<td>1</td>
<td>A</td>
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<tr>
<td>RG-F3</td>
<td>Reaffirm structure and restore function of CSB</td>
<td>1</td>
<td>1</td>
<td>A</td>
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<tr>
<td>RG-F4</td>
<td>Utilize Unified Services BH system more fully in planning</td>
<td>1</td>
<td>1</td>
<td>A</td>
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<tr>
<td>RG-F5</td>
<td>Schedule CSB meetings for maximum public participation</td>
<td>1</td>
<td>1</td>
<td>A</td>
</tr>
</tbody>
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Priority Outcome 2 – Prepare the mental hygiene system of care in Rockland County for Medicaid Redesign, DSRIP Initiative and Managed Care through coordination and management of all service components.

Progress Report (continued)

Lexington Center for Recovery implemented the Patient Activation Measure “PAM” in all substance use disorder program sites and with all clients.

CANDLE was designated as the DSRIP partner regarding prevention of tobacco use among youth and will be distributing to schools and community agencies throughout Rockland posters that discourage the growing practice of “vaping.”

St. Dominic’s Home organized an ongoing meeting of designated Adult HCBS providers to collaborate and coordinate the delivery of services.

RILC was selected as a lead agency by Refuah Community Health Collaborative to identify 1000 unduplicated individuals annually for Medicaid navigation.

Priority Outcome 3 - Expand the availability and accessibility of affordable, recovery oriented, person centered, age appropriate and evidence based treatment services across the continuum of care to all persons, including those with co-occurring disorders.

Progress Report (continued)

The Department of Mental Health has imbedded System of Care principles in its co-located satellite clinic within a local middle.

On behalf of the Multi-Agency Collaborative for Safe and Healthy Youth, the Department of Mental Health submitted a System of Care grant application to SAMHSA.

In coordination with the Multi-Agency Collaborative for Safe and Healthy Youth and the Partnership for Safe Youth, submitted a System of Care grant application for at risk children and adolescents with serious emotional disturbance to SAMHSA for $1,000,000 per year over a four (4) year period.

The Department of Mental Health co-located a social worker at the Multi-Agency Collaborative for Safe and Healthy Youth, a program that incorporates staff from
BOCES, Probation, DMH, DSS and the District Attorney’s Office who collaborate and meet with children and families, often court-referred, to identify strengths and develop a comprehensive plan of care.

RCDMH worked closely with Nyack and Good Samaritan Hospitals to reduce barriers to admission to Inpatient Rehab, Inpatient Detox and Ambulatory Detox programs.

RCDMH coordinated with OASAS and Lexington Center for Recovery to expand methadone services to meet the increase in drug addiction in the County.

RCDMH converted the North Central Rockland District (Pomona) Clinic from an Article 28 to an Article 31 as a result of the change in status of Summit Park Hospital.

**Priority Outcome 8** - Provide prevention, education and outreach across the mental hygiene system concerning mental health, intellectual/developmental disability and substance use disorder issues and services.

**Progress Report** (continued)

The C-SSRS is included in each RCDMH Clinic assessment to enhance assessment and prevention of suicide. Clinicians have been trained in its use and it has been incorporated into the EMR.

Providers in Rockland continue to access CAP-PC (Child and Adolescent Psychiatry for Primary Care), thus enhancing awareness of and screening for pediatric mental health issues in the primary care setting, although there has been a change in providers. CAP_PC is a free consultation service that links PCPs with child psychiatry.

RCDMH coordinated with Refuah and Rockland Parmamedic Services to have a billboard placed on Rt. 59 in Spring Valley in multiple languages alerting the community to contact the Behavioral Health Response Team in the event of a crisis.

RCDMH assisted in the development and coordination of Crisis Intervention Training (CIT) in conjunction with DCJS and OMH, which resulted in the training of 15 officers from Clarkstown and two from the Sheriff’s Department. Developed a resource card that is being tested by the Clarkstown PD and Sheriff and will ultimately be rolled out to all PDs in the County.

In collaboration with OMH, the Department of Mental Health is in the process of developing a Disaster Mental Health Team to respond in times of emergency/disaster situations.
RCDMH issued an RFP for $210,000 to develop a Mobile Integration Team to provide services to support individuals discharged to residential services from RPC in order to maintain these individuals in the community.

RCDMH participated in Drug Take Back Day with both the Clarkstown and Haverstraw Police Departments which resulted in the collection of over eight (8) large containers of unwanted pharmaceuticals.

In collaboration with the Mental Health Association, RCDMH obtained funding from OMH to work with community agencies on development of a Suicide Prevention Coalition for the community.

RCDMH continued our initiative to expand relationships with colleges in the County by providing in-service training on behavioral health issues, including substance abuse, among college students as well as providing in-service training on Turning Point, a program for first break schizophrenia that is often found in that age cohort.

RCDMH held a Child and Adolescent Conference on May 5 on Dialectical Behavioral Therapy. Approximately 130 members of the community were trained in this important treatment modality.

The Department of Mental Health increased community awareness of the Behavioral Health Response Team by participating in radio shows and supplying written materials across agency meetings and community forums.

The Department of Mental Health and Department of Social Services-Protective Services for Adults held a joint presentation to the Adult Abuse Training Institute in Albany, NY on a Cross Systems Approach to Supports and Services.

The County DMH increased the network of stakeholders participating in the Mental Health Workgroup by inviting peers/peer advocates, Department of Corrections and the Rockland County Geriatric Mental Health Alliance to become regular participants.

The County DMH provided a number of educational opportunities for Family Type Home providers to learn about supporting a person with mental health issues.

The County DMH provided a roundtable format for local police and DSS to discuss the responsibilities for providers and residents of Family Type Homes with the goal to reduce the number of calls to the local police by home owners and the residents.
The County DMH conducted a series of presentations to local providers of MH and SUD services regarding OMH Certified Residential Opportunities, Care Management, ACT Services and the SPOA process.

A County DMH staff member participated as a panel member of a Rockland County Legislative Forum on uncertified housing development for people with disabilities.

The County DMH presented to Dominican College Nursing Students on the health care disparities for people with intellectual and other developmental disabilities.

The County DMH participated in an inter-county phone conference discussion on OPWDD related issues and concerns.

The County DMH continued and expanded upon efforts with RILC and Fire Training Center regarding disaster preparedness for people with disabilities.

As a member of the transition consortium RILC provided trainings and presentations to participating agencies to inform other providers within the mental hygiene system concerning services provided.

RILC developed a Handbook of Programs and Services detailing prevention, education, and outreach services provided by RILC.