Mental Hygiene Goals and Objectives Form
Albany County Dept. of Mental Health (70520)
Certified: Jeffrey Ray (12/21/20)

Mental Hygiene Law, § 41.16 "Local planning; state and local responsibilities" states that "each local governmental unit shall: establish long range goals and objectives consistent with statewide goals and objectives." The Goals and Objectives Form allows LGUs to state their long-term goals and shorter-term objectives based on the local needs identified through the planning process and with respect to the State goals and objectives of each Mental Hygiene agency.

The information input in the 2020 Goals and Objectives Form is brought forward into the 2021 Form. LGUs can use the 2020 information as starting point for the 2021 Plan but should ensure that each section contains relevant, up-to-date responses.

Please indicate below if the overall needs of each disability population got better or worse or stayed about the same over the past year. Completion of these questions is required for submission of the form.

New To assist LGUs in the assessment of local substance use disorder (SUD) needs, OASAS Planning has developed a county-level, core-dataset of SUD public health data indicators. These reports are based on the recommendations of the Council of State and Territorial Epidemiologists and the regularly updated county-level datasets available in New York State. Each indicator compares county-level population-based rates to statewide rates. Reports for all counties are available in the County Planning System Under **Resources -> OASAS Data Resources -> Substance Use Disorder Key Indicators**

1. Overall Needs Assessment by Population (Required)

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

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

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

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

Transportation, Mental Health Care Coordination, Crisis Services issues have in general stayed the same, but there are some improvements within sub-areas of these issue categories that are worth noting:

- Transportation: with the implementation of "Circulation," a pilot transportation program that assists Medicaid eligible individuals. With "Circulation", short-term non-medical transportation opportunities to address social determinants of health needs (e.g., Department of Social Services, education, food assistance, etc.); this is a co-sponsored program between two local DSRIP PPS agencies (Better Health for Northeaster New York (BHNNY) and Alliance for Better Health) in partnership with Lyft. This service is available partnering agencies through the Albany County (and neighboring) communities. There are limitations to this benefit, however, as it only services a specific population of individuals; and it is a DSRIP pilot program, without clear information about ongoing services at this time.

- Mental Health Care Coordination: a) there are additional care management agencies (CMA) serving Albany County individuals through the Capital Region Health Connections (CRHC) CMA network and b) the implementation of BHNNY Cares, another DSRIP pilot program that provides transitional care management support services to Medicaid eligible individuals has been valuable to the Albany County service system; again this poses similar limitations as noted above about Circulation.

- Crisis Services: Albany County is gaining two new crisis services, The Albany Living Room and the Northern Rivers Behavioral Health Center crisis beds; more details about these are reflected under Crisis Services goal.

More details about what has improved/stayed the same/worsened is reflected throughout this plan

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

Housing, Transportation, Crisis Services, Employment/Job Opportunities, Prevention, Recovery and Support Service, Reducing Stigma, Other Outpatient Mental Health Services, Other Need 1: System Coordination/Integration, as well as newly identified issue categories of Adverse Childhood Experiences, and Other 2: System Transformation, have overall stayed the same, in that the balance of strengths/challenges have stayed the same. There are some specific sub-areas of these issues that have also concurrently improved and/or worsened as reflected accordingly in this section.

More details about what has improved/stayed the same/worsened is reflected throughout this plan

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

While the issues of Crisis Services, Workforce Recruitment/Retention, Inpatient Treatment Services, MH Clinic Services and Other Outpatient Mental Health Services have in general stayed the same, there are some sub-areas within these categories that have notably worsened:

- Crisis services: has worsened as it relates to the ability to manage high need/high utilizers/co-occurring individuals; it is not without effort from the crisis service system; however, the level of need is outweighing the available resources, time and expertise needed.

- Workforce Recruitment/Retention: issues continue to worsen; loss of staffing and expertise is not getting replaced in a reasonable amount of time, or at all; this compounds access and service provision throughout the service system. Shortage of psychiatry is one of the biggest issues across all three disability areas, but especially in the Mental Health system.

- Inpatient Treatment services: the closing of psychiatric inpatient beds and shorter inpatient stays are leaving more individuals in the community who are unstable or marginally stable; this is becoming a worsening challenge for the community-based service system.

- Mental Health Clinic: service system is currently experiencing severe/significant capacity issues across the age spectrum, most notably due to workforce recruitment/retention issues, but also due an increase in the number and acuity of individuals seeking services and less access to inpatient beds.

- Other Outpatient Mental Health Services: overall this area of unmet service needs has stayed the same, but requests for AOT and ACT are increasing, without an increase in resources for these programs, therefore it is emerging as area of issue.

More details about what has improved/stayed the same/worsened is reflected throughout this plan

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

Please describe any unmet **SUD** service needs that have **improved**:

Despite evidence of continued incidents of overdoses, the capacity to meet this service need has actually improved in that access to SUD/Opiate Use Disorder (OUD) treatment continues to be adequate; the access to Medicated Assisted Treatment (MAT) services is expanding throughout the system. Though there is always room for continued expansion, all levels of care have shown a greater use and acceptance of MAT. The area of Crisis Services has also improved as the Capital Region Open Access Engagement Program (CR-OAEP) is in full operation and the Ambulatory/Ancillary detox services have been up and running. With the CR-OAEP in community 24/7 services the ability to rapidly respond, engage, and connect individuals to treatment when they are in crisis demonstrates improvement. CR-OAEP has engaged 262 individuals as of June 2019, all within 3 hours of contact. *More details about what has improved/stayed the same/worsened is reflected throughout this plan*

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

The level of unmet **substance use disorder (SUD)** needs areas that have generally stayed the same include:

Housing, Transportation, Crisis Services, Workforce Recruitment/Retention, Employment/Job Opportunities, Prevention, Recovery and Support Service, SUD Residential Treatment Services, as well as newly identified issue categories of Problem Gambling and Adverse Childhood Experiences have overall stayed the same. The balance of strengths/challenges have stayed the same but there are some specific sub-areas of these issues that have also concurrently improved and/or worsened as reflected accordingly in this section.

- Transportation: there are proposals in the works for increased access and expansion of service across Albany County, with a focus on rural areas. SOR grants will open possibilities of mobile response, tele-practice, and physical transportation to treatment programs or a hub site. Awaiting award response keeps this area of service as the same.
- SUD Outpatient Treatment services stayed the same, but one outpatient treatment provider, specialized in SUD and Traumatic Brain Injury (TBI) (Belvedere) closed. This is not expected to have a huge impact on capacity.
- Gambling is a new category addressed independently in this plan.
- Workforce Recruitment/Retention continues to be a significant issue across all disciplines.

More details about what has improved/stayed the same/worsened is reflected throughout this plan

Please describe any unmet **SUD** service needs that have **worsened**:

An area that has worsened, in context, is the coordination/integration with other systems. The OASAS, OMH, OPWDD systems have operated vertically for many years resulting in a less responsive ability to address complex multi-disciplinary cases. The different systems are slowly adapting to coordinated treatment and staffing patterns that allow for integrated services, however, there remains some areas of issue. For example, although Mental Health Clinic category is not a direct SUD service, capacity issues related to Mental Health Clinic access are affecting those with co-occurring MH/SUD and/or MH/DD diagnoses. This is compounded by the shortage of psychiatry available within the SUD system, a continued high-level unmet SUD workforce recruitment/retention issue. In addition, there is a recognized need for integrated Residential Treatment for individuals with high SUD/high MH needs.

Lastly, the number of providers who accept Non-English speaking/Immigrants/Refugees has remained the same and is minimal, but the request from this population continues to grow, leaving a worsened "gap."

More details about what has improved/stayed the same/worsened is reflected throughout this plan

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

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

There are no identified areas of improvement; the areas of DD Student Transition Services, DD Self-Directed Services, and DD Front Door continue to go well and therefore are not identified as high level of unmet needs.

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

Areas of Housing, Transportation, Crisis Services, Workforce Recruitment/Retention, DD Clinical, DD Children, DD Respite Service, DD Family Support, Autism Services, DD Service Coordination and Other Need 1: System Coordination/Integration, as well as newly identified areas of Inpatient Treatment Services, Prevention, Reducing Stigma, and Other Need 2: System Transformation have stayed the same. *More details about what has improved/stayed the same/worsened is reflected throughout this plan*

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

Some areas within the DD service system that have worsened include:

- DD Respite/Crisis services: there is a gap as it relates to how quickly DD individuals are able to rapidly access housing, housing respite and/or clinical services needs during/after a crisis situation; specifics are discussed in the Crisis Services and Respite Services section of this local services plan.

- Employment/Job opportunities--- for clients is a growing issue; employment/job coach programs are finding it difficult to recruit/retain employment/job coaching staff to meet the needs of consumers. Furthermore, employment providers are reporting a decrease in available employment opportunities for behavioral health/disabled consumers

- Mental Health Clinic: although not a direct OPWDD service, capacity issues related to Mental Health Clinic access issues are also influencing access for those with co-occurring MH/SUD and/or MH/DD diagnoses. This is compounded by the shortage of psychiatry available within the OPWDD system, which remains a high-level unmet workforce recruitment/retention issue.

More details about what has improved/stayed the same/worsened is reflected throughout this plan

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

2. Goals Based On Local Needs

Please select any of the categories below for which there is a **high level of unmet need** for LGU and the individuals it serves. (Some needs listed are specific to one or two agencies; and therefore only those agencies can be chosen). When considering the level of need, compare each issue category against all others rather than looking at each issue category in isolation.

- **For each need identified you will have the opportunity to outline related goals and objectives, or to discuss the need more generally if there are no related goals or objectives.**
- **You will be limited to one goal for each need category but will have the option for multiple objectives.** For those categories that apply to multiple disability areas/state agencies, please indicate, in the objective description, each service population/agency for which this unmet need applies. (At least one need category must be selected).

Issue Category		Applicable State Agenc(ies)		
		OASAS	OMH	OPWDD
a)	Housing	☑	☑	☑
b)	Transportation	☑	☑	☑
c)	Crisis Services	☑	☑	☑
d)	Workforce Recruitment and Retention (service system)	☑	☑	☑
e)	Employment/ Job Opportunities (clients)	☑	☑	☑
f)	Prevention	☑	☑	☑
g)	Inpatient Treatment Services	☐	☑	☐
h)	Recovery and Support Services	☑	☑	☐
i)	Reducing Stigma	☑	☑	☑
j)	SUD Outpatient Services	☐	☐	☐
k)	SUD Residential Treatment Services	☑	☑	☐
l)	Heroin and Opioid Programs and Services	☑	☐	☐
m)	Coordination/Integration with Other Systems for SUD clients	☑	☐	☐
n)	Mental Health Clinic	☑	☑	☑
o)	Other Mental Health Outpatient Services (non-clinic)	☐	☑	☐
p)	Mental Health Care Coordination	☐	☑	☐
q)	Developmental Disability Clinical Services			☑
r)	Developmental Disability Children Services			☑
s)	Developmental Disability Student/Transition Services			☐
t)	Developmental Disability Respite Services			☑
u)	Developmental Disability Family Supports			☑
v)	Developmental Disability Self-Directed Services			☐
w)	Autism Services			☑
x)	Developmental Disability Front Door			☐
y)	Developmental Disability Care Coordination			☑
z)	Other Need 1(Specify in Background Information)	☑	☑	☑
aa)	Other Need 2 (Specify in Background Information)	☑	☑	☑
ab)	Problem Gambling	☑	☑	☑
ac)	Adverse Childhood Experiences (ACEs)	☑	☑	☑

(After a need issue category is selected, related follow-up questions will display below the table)

2a. Housing - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Housing remains a priority need in Albany County; planning stakeholders continue to identify a need for safe, affordable housing and the importance of developing and/or redesigning a comprehensive continuum of housing and residential opportunities for individuals across the three disability areas. OMH, OASAS and OPWDD continue to offer counties and providers opportunities to develop new housing options and/or to redesign current housing to support emerging needs (i.e. individuals leaving psychiatric hospitals, DD facilities; individuals completing residential treatment; those leaving prison, and those needing step down housing following 24/7 residential housing). There also has been an ongoing consideration about how viable and appropriate the current housing options are and working to keep them available. Albany County's Local Services Plan (LSP) and identified goals/objectives will continue to reflect how housing opportunities for individuals across the mental hygiene system can be expanded and/or redesigned to be less restrictive, support recovery, and foster independence in the community in which they reside. There does continue to be some challenges/ high level unmet housing needs within Albany County, as well as some positive gains in the system, both which are reflected below.

Housing challenges/high level unmet needs

- There is an increasing need for Integrated Residential Treatment programs for individuals with co-occurring serious mental illness and severe SUD diagnoses- *further discussed under SUD Residential Treatment Programs goal.*
- There is a need for more specialized housing opportunities for individuals who have complicated medical issues, especially Senior individuals, across all three disability areas. The level of need outweighs current existing options, especially for those with co-occurring medical and MH, DD and/or SUD diagnoses.
  - At times, this issue has resulted in longer medical hospital stays; either because of homelessness or an individual's available housing options are not appropriate for the medical/handicap needs. There are several forums that are looking more deeply at this issue including the Albany County Coalition on Homelessness (ACCH) and the Capital Region Planning Consortium (RPC)
- Access to specialized aging/complex medical needs facilities (e.g. nursing homes, assisted living etc.) for behavioral health consumers remains limited due to capacity issues (general shortage of staffing/facilities) and/or because the varying facilities' limitations in being able to manage the behavioral health population.
- There continues to be a high number of Assisted Outpatient Treatment (AOT) orders among both the general community, as well as individuals released from prison, psychiatric facilities and transfers from other Counties with an AOT Order already in place. At times, these individuals' AOT Orders include a need for prioritized housing. These placements sometimes occur ahead of other individuals who may have already been waiting for a placement, but whose priority level falls below those with an AOT.
- There remains a high need for community-based housing placements for adult individuals with histories of high-risk behaviors (e.g., violence, sex offense, arson, and forensic histories). It is noted there are some program proposals and possible funding opportunities related to housing programs for prison re-entry, sex offenders with mental illness, parenting youth and aging out youth; these are much needed in the Albany County community.
- Local agency did not get residential programming renewed for pregnant/parenting youth program; this was a major loss to the community.
- There is a shortage of transitional living facilities/programs for individuals returning to the community from incarceration; this is regardless of whether they are involved with parole/probation or not. Past programs that existed have since closed. There have been new programs (see below), but the Albany County community could benefit from more "forensic" beds.
- The local state operated psychiatric hospital, Capital District Psychiatric Center (CDPC), continues to transition individuals with long stay admissions out of the hospital, as well as from CDPC state operated community residences; some of these individuals' County of origin is not Albany and at times they have been housed before Albany County residents who are also on wait lists, usually because of the nature of their priority level (i.e. AOT, OMH forensic level, etc.).
- Housing for children, youth, and youth in transition remains a need in Albany County; especially for those with high-level needs and/or challenging behavior histories, such as youth with current or past history of violence, sex offenses, and/or forensic contact; children presenting with a need for residential therapeutic care; and children/youth with co-occurring cross system disability needs.
- Equinox's independent living program while still active, is at risk of closing due to funding losses; efforts to remain open via alternative funding sources are being explored.
- There remains a need for generic supported housing resources to help individuals seeking independent housing, but do not have the financial support to successfully obtain it.
- There is a shortage of general affordable housing, handicap accessible housing, and single level accessible housing in the Albany County community, especially for the Senior population.
- There is an increasing awareness of the housing and service needs of individuals who are victims of human sex trafficking. Efforts towards community awareness continue. There is a specialized case manager for this population at the St. Anne's Youth shelter and a Coordinator in Albany County
- For adults, Shelter Plus Care (S+C) remains available, but there is not enough capacity to meet the needs.
- Adolescents and young adults with SUDs who are unable to go "home" still have little to no recovery oriented supported housing.
- There is essentially no housing for families in recovery.
- Barriers to supported housing for adults with co-occurring MH/SUDs remains limited due to treatment/medication and abstinence requirements.
- Housing that fully supports addiction recovery remains a high need in the Albany County community; the HUD definition of homelessness eliminates eligibility for individuals graduating from long term treatment programs.
- There continues to be a high rate of homelessness amongst the behavioral health population within Albany County; this is evidenced by the quantity and types of referrals being made to the various housing programs in this community (such as the mental health and homeless Single Point of Access' (SPOA)) as well as the known frequency to which shelters and street outreach programs are used. There has also been a noted increase in the number of untreated/under-treated mentally ill individuals in the homeless system; this is impacting shelters ability to manage the population, although they do try.
- There remains a need for housing options for individuals with high functioning autism.
- Within OPWDD there continues to be difficulty accessing and a high demand for residential support services for DD individuals who have complex and/or dually diagnosed needs; there are no long-term residential treatment programs for children.
- There is a significant need for rapid access crisis respite housing services for OPWDD enrolled individuals (short term, interim, supportive housing opportunities while awaiting permanent housing opportunities)

- There is an increasing need for housing programs for individuals with co-occurring mental illness and I/DD; especially those with high risk/challenging behaviors.
- With OASAS 820 regulations for residential redesign transition, programs are beginning to adjust their services to cover stabilization, rehabilitation, and/or reintegration. This will impact the housing services system as some housing resources are lost and some are gained; it is too early to tell what the level of impact will be. This is an area to watch for the upcoming year to better adjust ratios to needs.

Housing progress/positive gains

- Albany County LGU continues to operate a Housing SPOA with a dedicated Coordinator; the Housing SPOA coordinates the OMH housing process, referrals, provider contracts, placements and prioritizations; participates in the Coordinated Entry SPOA; and acts as a resource for all housing needs throughout the behavioral health service system. Within the last year, Albany County LGU oversaw and monitored approximately 807 OMH housing opportunities, which is expanding to 847 over the next year.
- Albany County gained 40 OMH housing beds through a new housing provider, DePaul Community Services via Empire State Supportive Housing Initiative (ESSHI) funding. An affiliated housing company, Home Leasing, also brought additional affordable housing units to the community that are not OMH specific, but are available for behavioral health consumers should they apply and qualify. More ESSHI opportunities potentially anticipated.
- It is noted there are some program proposals and possible funding opportunities related to additional housing for prison re-entry, sex offenders with mental illness, parenting youth, child welfare family supportive housing and aging out youth; these are much needed in the Albany County community. For example, St Catherine's Center for Children will have a mixed use, mixed size, multiple units apartment program in late 2019 targeting homeless individuals, child welfare families (12 apartment units) and aging out foster out youth (8 single units). There are multiple other housing programs in various stages of implementation coming to the Albany County service system.
- Albany County continues to have a Coordinated Entry- Homeless SPOA with a universal coordinated application/placement process; as a result, homeless individuals and (many with mental hygiene disabilities) have successfully been placed in permanent housing.
    - The Albany Coordinated Entry (CE) System in 2018 received a total of 372 referrals for Permanent Supportive Housing and Rapid Re-Housing assistance. Of those referrals, 232 were for homeless single adults (62%) and 140 were for homeless families (38%). The majority of households were living in homeless shelters at time of submission (including seasonal Code Blue shelters); however many households were temporarily residing in hospitals, in-patient treatment facilities, or places not meant for human habitation such as on the streets or in abandoned buildings.
    - 87% of all single adult CE referrals were approved for housing, and of those 132 households were successfully placed into Permanent Supportive Housing (PSH), Rapid Re-Housing (RRH), private housing, and/or other positive housing types such as reconnecting permanently with family and friends. 72% of all family CE referrals were approved for housing, and of those 61 households were successfully placed into positive housing types including PSH, RRH, and/or reconnected with friends and family.
- The Rehabilitative Support Services (RSS) Capital District Stabilization and Support (CDSS) crisis respite program continues to offer supportive services to individuals in need; this 3 bed program is offered regardless of insurance and often works with community providers to work towards long term stabilization goals of individuals. In 2018, CDSS had 54 admissions.
- Albany County continues to have two forensic beds available for eligible adult MH individuals that is monitored through the OMH Housing SPOA; six additional forensic beds (for re-entry/justice involved individuals with a disabling condition that are HUD defined homeless) were opened in September 2018 through Homeless and Traveler's Aid Society (HATAS) and are monitored through the CE.
- The Lionheart Residence (managed by a local OPWDD provider) remains available to eligible individuals
- The Equinox, Inc.'s Holt House, which serves individuals with MH and DD diagnoses has maintained consistent utilization.
- The CDPC state operated Transitional Living Community Residence (New Scotland Residence -aka- NSR) continues to accept individuals from state prisons and forensic psychiatric units
- Interfaith Partnership for the Homeless continues to operate the *Sister Mavis Jewell Medical Respite* program which is specialized shelter services for homeless individuals who have significant (qualifying) medical issues and needs
- St Catherine's Center for Children continues to support the housing needs of high need adult individuals through the Project Connect and Project Host programs,. Some notable stats for these programs include:
    - In 2017, Project Connect outreached to 34 and housed 33 individuals; numbers increased in 2018 to 66 individuals outreached and 53 housed. As of June 2018, St Catherine's Connect housed 84 individuals in 3 years. 45 remain housed at 6-month interview and 91% at 12 months. This SAMSHA grand funded project ends in Sept. 2019, but there are hopes to replace funding and continue it
    - In 2017 Project HOST had 56 individuals outreached and 54 housed; in 2018, 39 individuals remained permanently housed. This program remains funded and will continue to serve high utilizers of emergency services.
    - In February 2019 St Catherine's created an Outreach Central Intake and were providing outreach to 96 individuals.
    - Project Connect and HOST use the "Critical Time Intervention" evidenced based practice model, developed to specifically transition individuals from hospitals. jails, homelessness to community.
- The CDPC-Mobile Integration Team and the RSS -Transitional Support Team programs continue to assist individuals who have histories of long stay and/or chronic psychiatric hospitalizations to locate stable community housing and

supportive services to remain out of the hospital.

- HATAS continues to operate the Capital Region Furniture Bank in partnership with several other community partners; currently in its 3rd year, the furniture bank has had 196 deliveries to date. It services individuals emerging from homeless shelters and domestic violence situations, as well as household's affected by local disasters (such as fires and floods).
- St. Anne's Institute's crisis/homeless youth shelter that opened in September 2018 in Albany continues to serve youth ages 13-17 years old and now has 8 beds; these beds a regularly close to capacity. This is a valuable and needed service.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Maximize and/or develop safe and affordable housing opportunities to address unmet needs across the mental hygiene system and age continuum.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Explore resources and funding to expand or enhance existing housing programs, including community residences, single room occupancy facilities, and shelter plus care.
　　Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: Explore funding options for additional generic supported beds to help individuals seeking independent housing, but do not have the financial support to successfully obtain it.
　　Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 3: Explore and expand opportunities for safe and supportive housing programs for adults/youth/families in SUD recovery.
　　Applicable State Agency: (check all that apply): ☑ OASAS ☐ OMH ☐ OPWDD

Objective 4: Continue to reallocate existing resources or develop new resources whenever possible, to increase the number of opportunities for individuals with DD requesting Out-of-Home Residential placements and further support the larger transitional goals related to Developmental Center closures.
　　Applicable State Agency: (check all that apply): ☐ OASAS ☐ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- There have been numerous changes reflected in narrative above. In general, serious challenges remain despite positive gains.

2b. Transportation - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

For individuals to access the services they need, they must be able to either go to the service provider directly or find services that can come to them. In home services have become severely limited, especially for the behavioral health population. As a result, individuals must travel to their provider. Transportation issues could cause individuals to appear "noncompliant;" especially when they are having to navigate multiple services in different locations. Within Albany County there continues to be several challenges related to transportation, which in turn then impact access to care.

Identified challenges related to transportation are as follows:

- There are continued limitations and inconsistencies with Medicaid Transportation (i.e. Medicab) services. Examples of issues that individuals have are:
    - the timeliness of pick up and return trips (it can often be a several hour process for one appointment);
    - access with short notice (the 3 day advance notice requirement limits access to urgent care services and/or a sooner appointment becoming unexpectedly available);
    - poor reliability of transportation in inclement weather;
    - providers have reported that there have been safety and ethical issues with some Medicaid Transportation providers (e.g. paying individuals to exclusively use them, reports of illicit substances being given to individuals during transports etc.);
    - issues of Medicaid Transportation providers being investigated/charged for fraudulent activity, including a few in the Capital Region area;
    - many times, clinicians/practitioners are having to spend time on the phone arranging/addressing Medicab service issues, which takes away from direct patient care.
- There are no known medical transportation services/payment assistance for those privately insured.
- There are no medical transportation services for individuals with Medicare; they can only receive half fare rate on the local bus transportation system. Recently, the local bus company made changes to their rates/processes. This has made it more difficult for individuals eligible for half fare rate (e.g. fare increase, where/how bus fares are purchased/redeemed, no more "day passes," half fare rate pick up location is less accessible); individuals can no longer just "show their Medicare card" as they used to be able to do.
- Historically there was little to no transportation support for non-medical service needs (recreation, respite, seeking employment etc.). Implementation of Health and Recovery Plans-Home and Community Based Services (HARP-HCBS) and the local DSRIP PPSs "Circulation" program (further discussed below under transportation strengths) has helped for the Medicaid population; however the Medicare only and privately insured individuals do not benefit from these programs and therefore there remains a gap.
- Although Medicab is available, many DD individuals are unable to maintain themselves independently in the Medicab and Medicab providers are inconsistent with whether they allow others to ride with the individual during the medical transport (i.e. family members).
- The issue of limited access to care in outlying areas (Hilltowns, Ravena, etc.), is further exacerbated by transportation limitations. Transportation to/from services from the County's rural and underserved areas communities remains a high need. In some areas, there is not even a public bus route.
- Although the option of the Specialized Transit Available by Request (STAR) bus remains available to those with disabilities, it has limitations and not everyone qualifies (e.g. individuals must live within certain distances of a public bus stop).
- Many Health Homes/Care Coordination providers often do not provide transportation services to individuals, or only do so for a limited basis; especially (and understandably) when the individual has a history of high-risk behaviors. Often time's transportation support is what individuals need to move forward in their recovery.
- Because parents are required to be with children/youth during Medicab usage, children end up having to stay home from school in order to attend medical appointments, as the Medicab will not pick up the parent without the children or go with parent to get the child from the school. This disrupts their educational progress.

Identified strengths related to transportation include:

- Children's MH providers continue offer services to rural and more outlying areas areas; for example, there are children's MH satellite clinics co-located in pediatric offices and schools (further discussed under *Mental Health Clinics).*
- HARP-HCBS services include transportation to activities that support an individual's stability, for those that qualify
- Two local DSRIP PPS agencies (BHNNY and Alliance for Better Health) in partnership with Lyft implemented a pilot transportation program (i.e. "Circulation") that assists eligible Medicaid recipients with short-term non-medical transportation opportunities to address social determinants of health needs (e.g., Department of Social Services, education, food assistance, etc.). This service is available partnering agencies through the Albany County community.
- Some in-community SUD services are now reimbursable if provided by Article 32 providers; this may ease some of the difficulty individuals have with getting to a provider for an assessment. This does not alleviate issues related to regular access to treatment.
- As of July 2017, transportation for DD individuals receiving respite is at times reimbursable, which has had some positive impact on the service system
- Albany County has submitted proposals for access and expansion in rural areas for providing, engaging, and connecting individuals to Substance Use services. These proposals include tele-practice and a vehicle for transportation or in-community services.

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

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

There are no specific goals/objectives related to transportation. Albany County will continue to advocate and coordinate with existing transportation providers, maintain awareness, support the implementation of and explore new transportation opportunities, should any arise. In addition, Albany County will continue to explore opportunities to expand services in underserved areas. New innovative services, such as tele-medicine, may also help with this issue.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- Rural Access/Expansion is pending (based on OASAS funding being awarded)
- Pilot "Circulation" transportation program

2c. Crisis Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Crisis services can range anywhere from community based mobile crisis teams, interventions by emergency personnel (police/fire/ambulance), local emergency rooms (ER), and respite support. It is important to have crisis services available to individuals across the age and disability spectrum to help in times of acuity. Albany County is fortunate to continue to have multiple crisis support services available.

High-level unmet crisis services needs include:

- The community has identified the need for a behavioral health stand-alone crisis stabilization unit where individuals could go and receive withdrawal services, psychiatric stabilization, and recovery supports. Development of this continues to be explored with the Albany County LGU, local community partners, state agencies and a local Delivery System Reform Incentive Payment- Performing Provider System (DSRIP-PPS).
- The OPWDD's NY Systemic, Therapeutic, Assessment, Resources, and Treatment (NYSTART) Resource Center has not opened yet (although progress is being made).
- Crisis Stabilization services for individuals with SUDs remains a need in Albany County. The Albany County LGU continues to work with providers to identify and address unmet crisis service's needs. There have been positive gains in the past few years within the service system such the Ambulatory/Ancillary Detox programs, expansion of Catholic Charities Bridge Clinic MAT's prescribing, and the Capital Region Open Access Engagement Program (CR-OAEP) (as reflected throughout this plan).
- The Albany County treatment community continues to have several individuals who have complicated high needs and are high utilizers of emergency/law enforcement/hospital/human services resources (in some cases, as often as over a dozen times per day). Albany County LGU continues to chair the Patient Service Coordinating Committee (PSCC) to assist and intervene with these individuals; currently there are 26 active cases. The number of "new" referrals received each year to the PSCC has been steadily increasing over the years with 19 in 2017, 21 in 2018, and as of June 2019, there have been 16 new referrals; there are additional new ones expected for July. There continues to be challenges with getting some of the individuals the services they need due to several barriers (e.g., limited resources, "burned bridges," poor engagement etc.)
- A local hospital, Albany Medical Center, opened a new children's dedicated emergency room, however it does not manage behavioral health emergencies, despite there being a need for this. Capital District Psychiatric Center (CDPC) continues to note an increase in the number of children coming to their Crisis Intervention Unit (CIU).
- Considering the presenting need to divert children from unnecessary use the ERs and CIU, there are discussions amongst community providers to explore possible interventions/programs in this area; an example idea is a children and family Living Room model.
- CDPC Crisis Unit has anecdotally reported that in the last year a) there has been an increase in "new people" being seen for crisis support (e.g. never seen before-newly presenting with MH issues) and b) an increase in people presenting with "new" psychotic symptoms.
- There continues to be a tri-county crisis respite service offered in partnership by ACDCYF, Rensselaer County Mental Health and Schenectady County Mental Health. It is reported that there has been a rapid increase of requests and usage of this service. This is further exasperated by less foster families doing respite services and foster homes in

general closing. In addition, long distances between those needing respite and where the respite placements are, posing additional challenges.

- Albany County's Mobile Crisis services plan was approved by OMH/OASAS; efforts are being made towards implementing billing processes; there is concern, however, that rates/volume will not be enough for independent sustainability of a full program.
- There is a significant need for crisis respite housing services and crisis care management for OPWDD enrolled individuals. This especially true for individuals who are chronically homeless and/or poorly engaged with their care manager or other service providers that could help facilitate stability. The amount of resources it takes to intervene with these individuals is significant and there are growing safety concerns. Local OPWDD providers and State representatives have been involved in assisting with these cases, but there lacks a process to rapidly respond to these individual's crisis needs to work towards stabilization. Much of these individual's crisis response needs are falling to other systems of care (hospitals, police, MH programs, local DSS etc.), which adds additional strain to these systems (additional details under *DD Respite Services*).

Strengths of the Albany County Crisis support service system reflected below:

- Albany County continues to offer two (2) Crisis Intervention Team (CIT) trainings each year to local law enforcement agencies. To date (since September 2012) over 250 law enforcement officers have graduated from this training. This training covers multiple topics related to the larger behavioral service system across all three disability areas. Efforts are being made to explore opportunities for expansion of this initiative, for example to include dispatchers and other first responders.
- In 2018 the Albany County Department of Mental Health's (ACDMH) Mobile Crisis Team (MCT) provided crisis triage support and intervention services to 1286 youth and adults; 53% of these individuals were diverted from further assessment at the local MH crisis unit (CDPC-CIU); the ACDMH MCT continues to be available 24/7/365 and offers enhanced follow up services.
- Northern Rivers Mobile Crisis (formerly named Capital Region Child and Adolescent Mobile Team) provided crisis triage support and intervention services to 613 youth in Albany County in 2018; 75% were diverted from higher levels of care. In addition, this program was enhanced with changes made to the referral process; referents/families no longer call a gatekeeper, but rather calls the program directly (during business hours) and speaks with a clinician for assistance and triage.
- NYSTART continued to provide support to individuals with co-occurring DD and MH conditions. Currently there are 17 in Albany County (out of 87 for the Capital Region). NYSTART continues to offer services 24/7 and remains in high demand. NYSTART has increased their involvement in meetings related to Albany County LGU/service system initiatives. The Resource Center has not been opened yet, but there is an identified location and renovations have been done; the date for when it is to open is unknown at this time. Albany County LGU, along with other local Albany County crisis providers, remains active on the Advisory Council.
- The CDPC CIU and local hospital ERs continue to provide 24/7/365 psychiatric emergency room services to the community; CDPC is now also a designated MHL 9.39 hospital.
- Several local MH clinics offer psychiatric emergency crisis support to the community; ACDMH Integrated Clinic provides this service via their Same Day Access (further discussed below under MH Clinics); in 2018 over 1000 individuals were screened via Same Day Access, which would include an emergency assessment should the individual present with the need.
- The Albany County Department for Children, Youth, and Families (ACDCYF), Children's MH clinic also offers crisis support services to the community via their same day access service (called Open Access on Mondays and Wednesdays); more information is provided under MH Clinic Services below.
- The Rehabilitative Support Services (RSS) Capital District Stabilization and Support (CDSS) program continues to offer supportive services to individuals in need; this 3 bed program is offered regardless of insurance and often works with community providers to work towards long term stabilization goals of individuals. In 2018 CDSS had 54 admissions.
- There continues to be a tri-county crisis respite service offered in partnership by ACDCYF, Rensselaer County Mental Health and Schenectady County Mental Health.
- Albany County continues to have ongoing collaborative relationships with local ERs and law enforcement, who participate in interdisciplinary committees, initiatives, cross system case coordination, and trainings toward the larger goal of strengthening crisis support.
- St. Peter's Addiction Recovery Center (SPARC) continues to offer its detox services to include Ambulatory and Ancillary Detox during weekdays, evenings and weekends.
- Albany County LGU and other local crisis providers continue to participate in the DSRIP- PPS- BHNNY's Behavioral Health Committee which regularly reviews BHNNY behavioral health initiatives, including crisis support services.
- Albany County continues to offer free monthly Narcan trainings to the community through a partnership between the ACDMH and the Albany County Department of Health (ACDOH)
- Catholic Charities continues the Project Safe Point Health Hub service, which includes 24 hour Peer Recovery Advocates who will try to engage individuals who may be experiencing a related SUD crisis, especially those at risk of opiate overdose; this may include responding to local emergency rooms and other community sites when warranted.
- The Albany County Opiate Task Force continues to meet and explore avenues for combating the opioid crisis.
- The Albany County Suicide Prevention and Education Committee (SPEC) continued to strengthen the infrastructure of suicide prevention and interventions services throughout Albany County via development of public information,

- education resources and enhancement of additional practices; Albany County continues to have a Suicide Task Force comprised of local community leaders across multiple disciplines.
- Transition to Managed Care has allowed for a full range of services to be eligible for reimbursement, including crisis support services. Albany County's Mobile Crisis services plan was approved by OMH/OASAS and efforts are being made towards implementing billing processes; however, as noted above there is concern that rates/volume will not be enough for independent sustainability of a full program.
- Albany County LGU, with partners Addiction Care Center of Albany (ACCA) and Catholic Charities received an OASAS RFA award to implement an open access center Albany County and 7 other surrounding counties. The outcome was that in October 2018 the Capital Region Open Access and Engagement Program (CR-OAEP) officially launched. This program is available to engage individuals in the community and institutional settings who present with SUD needs and assist with rapid assessments, "warm hand off" service linkages, and when appropriate, starting MAT. This service will be available to individuals 24/7 whether they are in a crisis or not. This service is available across eight counties in the Capital District Region. The program has connected with 262 individuals as of 6/2019, covering 8 counties in the region.
- RSS, through partnership and funding with the Albany Medical Center PPS BHNNY, started the Capital District Crisis Diversion (CDCD) program in Jan 2018, which provides short-term engagement and transitional case management services to individuals who are psychiatrically "cleared" by CIU and/or MCT, but need assistance with service linkages. In 2018 60 individuals were served.
- St. Anne's Institute's crisis/homeless youth shelter that opened in September 2018 in Albany continues to serve youth ages 13-17 years old and now has 8 beds; these beds a regularly close to capacity. This is a valuable and needed service.
- In Summer 2019, Albany County will gain the Rehabilitation Support Services program "The Living Room;" this program is designed to be a comfortable, homelike space for guests who are experiencing a mental health crisis to work on reducing their symptoms to maintain their safety in the community. It is intended to be an alternative to the Emergency Room or Crisis Center and will be staffed by a trained team of individuals who will provide short term Crisis Intervention services and intensive support. The Living Room. Participants must be able to maintain their safety and the safety of others while visiting the Living Room, to include not meeting hospitalization criteria, be actively suicidal or homicidal, and not under the influence of substances. The Living Room will be available weekday from 11am-7pm.
- Northern Rivers Behavioral Health Center is opening 5 crisis beds in the near future, which will include crisis stabilization services for children/youth with a focus of diverting emergency room use; it will include an integrated model of care (medical, behavioral health etc.). The existing Northern Rivers Mobile Crisis Team (that serves children in Albany County) will also be moving to the new Center in the foreseeable future.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Maintain and enhance crisis services across the Mental Hygiene System (Mental Health, Substance Use Disorder, and Developmental Disabilities)

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: ACDMH will continue to offer twice annual CIT trainings to local law enforcement agencies and explore options for further expansion.
      Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: The Albany County LGU will continue to explore the development of an innovative crisis stabilization program in Albany County, as well as new crisis stabilization/withdrawal services, and crisis residential opportunities across the age spectrum. Also, opportunities to enhance existing crisis stabilization support services with local community partners, state agencies and the local DSRIP-PPSs. Fully implement new programs including The Living Room and Northern River behavioral Health Center's crisis beds.
      Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 3: Continue to offer CR-OAEP services and expand outreach, engagement and linkage services to the SUD population. This includes potential increase of services to the rural, suburban and urban communities if the additional OASAS SOR grants are awarded.

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

Objective 4: Continue to work towards improving coordination between Emergency Rooms/Departments and CDPC CIU. In addition, having expanded to 24/7 hours and offering enhanced follow up services, the ACDMH MCT will explore ways to increase crisis contacts and responsiveness to the community in order to help support diversion from unnecessary emergency room/crisis unit/hospital contacts.

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

Objective 5: Continue with the Albany County SPEC, Suicide Task Force and suicide prevention/intervention/education efforts.

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

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- The number of CIT graduates (since the trainings inception) increased to 263
- St. Anne's youth shelter increasing from 4 beds to 8
- Gaining the RSS Albany Living Room
- Northern Rivers/Parsons Child and Family Center's 5 crisis beds.
- Transition to Managed Care has allowed for a full range of services to be eligible for reimbursement, including crisis support services

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

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Workforce recruitment and retention remains one of the highest-level unmet needs within Albany County across the mental hygiene service system. There remains a need for more providers across multiple disciplines (e.g. psychologists, therapists, CASAC's, psychiatrist, nurse practitioners, direct care and respite workers, primary care and dental); however, the demand for medical professionals is particularly high. The challenges in this area have begun to overwhelm and cause issues in other areas of service; for example: a) lack of psychiatry causes clinics to have limited capacity; b) shortage in respite staff leads to increased usage of crisis services; c) shortage of job coaches limits consumers' access to employment opportunities.

There is also an increasing need for providers who are able and willing to work with some of the more challenging population of individuals who are presenting with co-occurring, multi system, high need, high risk issues (such as individuals with multiple acute medical/MH/SUD/DD diagnoses, forensic histories, and sex offenders, for example). However, low salaries, both in general and in comparison, to the increased difficulty of the work, leads to limitations in recruitment, high turnover and a limited workforce. Reimbursement rates have not been adequate to offer competitive salaries. In turn, lack of adequate workforce limits service capacity and at times can cause a delay in service access. Salaries/benefits across the service system are not always competitive enough to retain staff; especially when considering the level of challenges that come with the work. The work is getting more difficult while salaries remain low; the existing workforce is dealing with burnout and low morale.

Another recognized need (and potential solution) around work force recruitment/retention is for existing providers to receive training to enhance their skills and abilities to work with the growing population of high need individuals; for example, training around how to work with those with a criminogenic history or co-occurring diagnoses. It is noted, however that staff development and training also require resources, funds and time away from service provision (i.e. reimbursable hours), so these efforts can be slow moving at times. The practice of tele-medicine also continues to be explored throughout the service system to help rectify staffing shortages; the feasibility and/or availability of tele-medicine, however, is not yet fully known; there are Albany County providers exploring this.

Children's providers are noting an increase in workforce issues because of the "unbundling" of waiver services; reimbursement rates for each independent program are low and therefore a deterrent to recruitment and retention; this will be further monitored to see if/how much of an issue it will be.

An issue that continues to influence workforce recruitment and retention issues across all three disability areas is the impact of the Justice Center. While providers are in agreement with the Justice Center's overall mission, there have been some instances of what is believed to be extraneous hardship to services providers. The "fear" of Justice Center interventions have caused some professionals to avoid joining the field of behavioral health care; and in some anecdotal cases, existing professionals are choosing to leave the field. In addition, the length of time for background checks on prospective hires is inconsistent, quick for some agencies and lengthy for others; for the latter they have lost these professionals to other opportunities because clearance took so long to come back. Lastly, when there is a Justice Center investigation, the identified staff either have to stop working with the agency and/or in their profession, sometimes with and sometimes without pay; and/or they are given other job duties depending on the agency and the circumstances. These situations can be a personal hardship for the professional and a challenge for agencies to maintain services and programming in; most agencies do not have the resources or funds to hire temporary staff throughout the investigation.

Another emerging issue is that children's providers anticipate needing to increase staffing, including psychologists who can do forensic assessments, because of Raise the Age implementation. Preparation will need to be made to have service capacity for youth who will need service linkage. There has been a noted increase in the need for respite and independent living programs.

Highlighted workforce shortages within each disability area for Albany County are as follows:

- Mental Health: Psychiatric prescribers (MD/nurse practitioners), Physicians, Physician Assistants, Nurses, Diagnostic/Assessment specialists, psychologists, peer specialists, Health Home Care Managers, Licensed Clinical Social Workers, and job coach/employment workers; supervision oversight requirements for Nurse Practitioners/Physician Assistances adds additional challenges; the service system would benefit from changes to these guidelines.
- Developmental Disability: Psychiatric prescribers, Diagnostic/Assessment specialists, Direct care/respite workers (for both self-direction and agency-based providers), and dental providers
- Substance Use Disorder and Gambling: Psychiatric prescribers, medical specialists in addiction medicine, peer/recovery support specialists and CASACs; also, any providers of outpatient SUD services for those with Medicare insurance only (there are very few).
- Multiple Disabled persons: there are shortages across all professional disciplines of providers who have the capacity and skill/knowledge base to treat those with co-occurring disabilities, but especially for those with MH and/or SUD issues combined with DD.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Address workforce and retention challenges across all three disability areas in order to minimize capacity limitations and obstacles to accessing care. Advocate for and facilitate opportunities for cross system training and collaboration in order to increase the knowledge and skill base of the existing workforce.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Albany County behavioral health providers will continue to recruit and hire providers/staff who are qualified and have the skills needed to provide the services offered.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: Encourage behavioral health providers to seek collaborative opportunities to reduce fixed costs and maximize resources that ensure that behavioral health services in Albany County are accessible and responsive to local need. This includes Albany County LGU continuing to develop an awareness of any emerging integrated license primary care/behavioral health agencies and engage them in order to facilitate these providers being an active part of the larger service system.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 3: Albany County LGU will advocate for and promote cross system training opportunities including those offered by OPWDD's NY Systemic, Therapeutic, Assessment, Resources, and Treatment (NYSTART) and the Center for Practice Innovations (CPI). This includes offering a specialized training on therapeutic approaches that MH and SUD providers can

use when treating I/DD consumers.

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

Objective 4: Albany County and ACDMH intends to sponsor 10 scholarships for Certified Recovery Peer Advocate (CRPA) to engage individuals in attaining certification and employment in the substance use field; planning and implementation is progress.

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

Objective 5: Albany County LGU and the behavioral health provider system will continue to work with local educational institutions (colleges, trades programs, school districts/BOCES) to share information about job opportunities, accept interns, and recruit graduates for employment; for example recently the local State Psychiatric Hospital and Albany County LGU shared information with the Capital Region BOCES about openings/recruitment for the OMH Mental Health Therapy Aide (MHTA) position; a paraprofessional NYS State retirement job. In addition, a local community college offers a Community Health Worker certificate program which local providers can/do take interns from and can recruit future employees.

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

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- The shortage of psychiatric prescribers is becoming critical and is impacting Mental Health Clinic capacity, as well as causing an increase in the need for co-treatment models of care- *further discussed under Mental Health Clinic goal.*

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

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

The ability for behavioral health consumers to be able to access gainful employment as part of the recovery process is important. Often finding employment and sustaining employment can be challenging due to reasons such as lack of education/credentials, lack of skill/training, legal history, forensic history, and/or disabilities that impact functioning, skills and abilities. Previously discussed transportation challenges further make it hard for consumers to pursue employment/job opportunities. Through initiatives and programs related to enhancing consumers' access to employment/job opportunities such as PROS, job coaching, Health and Recovery Plans-Home and Community Based Services (HARP-HCBS), ACCESS-VR, and local Department of Social Services employment programs, individuals will have greater opportunities to seek employment as part of their recovery. The issue of employment/job opportunities for clients is growing. In particular, as it relates to a) employment/job coach programs are finding it difficult to recruit/retain employment/job coaching staff to meet the needs of consumers, b) employment providers are reporting a decrease in available entry-level job opportunities for behavioral health/disabled consumers (for example, with the onset of more self-checkout technology), and c) providers are reporting challenges finding employment opportunities for the forensic re-entry population and those coming out of treatment programs.

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

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):
Albany County LGU will work with local providers and support progress/efforts as it relates to enhancing access to vocational/employment programs, as well as continue to monitor and participate in the implementation of HARP-HCBS and Residential Redesign, with the goal of providing opportunities for consumers to gain employability skills and jobs as part of their recovery.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- None noted, but this issue category is becoming a growing concern.

2f. Prevention - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Mental Health: Ideal prevention/intervention strategies remains strongly linked to recognizing risk factors, identifying service needs and starting interventions as early as possible. Starting interventions sooner rather than later could potentially prevent a full-on mental illness and/or limit the acuity of the illness. Recognizing the potential need for MH services often comes first from those closest to individuals, i.e. key people in their life like parents, family, friends, school personnel and primary doctors/medical professionals. This is accomplished through community education and support for professionals, stakeholders, family/friends and the community in general.

In addition, the Albany County Department for Children Youth and Family (ACDCYF) and Albany County Department of Health (ACDOH) continues to offer the Single Point of Entry (SPOE) community referral line (started in 2015) where women of child bearing age and families of children birth to five years old can seek support and referral assistance to an array of community-based services, including behavioral health care; in 2018, over 1400 referrals were sent to a variety of services levels/programs. ACDCYF also continues to have Prevention services via multiple agencies available to families with risk for out of home placement (for various reasons); all of these providers offer clinical services, as well as early intervention. Also, the Parsons OnTrack NY program (started in late 2015) in the Capital Region provides early intervention services and treatment to youth and adults who are newly experiencing symptoms of psychosis.

In addition, legislation went into effect in 2018 mandating inclusion of mental health education in the public-school system curriculum, starting as young as kindergarten; implementation is in its early stages.

Substance Use Disorder: Prevention services in Albany County are limited to OASAS funded providers. The three current prevention providers serve 13 public school districts and communities throughout Albany County, but are not able to provide services in all of the schools that have requested their services. In the last few years, Albany County prevention providers have been getting new requests and demands from suburban schools to provide community education/forums etc. in the wake of the opiate/heroin epidemic that is now affecting those communities. Additionally, the Albany County prevention providers have reported that it is difficult to access young adults, ages 17-25 with prevention/early intervention strategies. Access to SUD prevention services for youth age 21 and under remains a high need. Expanding prevention services by increasing funding for prevention and community education, as well as clearly identifying a Prevention Council could address the increased need for prevention education across the age spectrum. Of note, "vaping" among youth is a growing area of issue; Albany County LGU and OASAS prevention programs recognize the seriousness of these issues and will continue to develop strategies to address this gateway to smoking and other drugs of abuse.

Suicide Prevention and Education: Reducing stigma and training staff to address the issue of suicide in the Albany County community remains a priority within Albany County. The larger general community, as well as service providers within the mental hygiene system, continue to have access to multiple suicide prevention and awareness initiative, trainings and events such as SAFE TALK, ASSIST, CONNECT and "Out of the Darkness." Albany County state licensed agencies also continue to have access to the Center for Practice Innovations (CPI) training programs, one of which is specific to suicide. Albany County LGU is working with local providers and stakeholders to explore and implement standardized evidence-based screening tools for suicide prevention across the system of care. In addition, along with continuing to maintain and strengthen crisis supports within the community, Albany County continues to offer the Help, Options, Prevention, Education (HOPE) suicide prevention mobile app, which has been active since 2014. The Albany County Suicide Prevention and Education Committee (SPEC) and Albany County Suicide Task Force remain active in addressing suicide issues within Albany will continue explore system wide suicide prevention efforts.

Developmental Disability: Although in some cases a developmental disability cannot necessarily be "prevented," it is recognized that early detection and interventions can at times decrease the severity of a disability, prevent or limit secondary consequences/disabilities and improve the quality of life for the affected individual. There are a number of early detection/intervention services offered within the Albany County including the aforementioned ACDCYF/ACDOH SPOE community referral line, assessments and evaluations for speech, occupational, and physical therapy, early intervention services, prevention services, as well as education to the community in schools. In addition, ACDOH offers several community-based programs related to prevention of disabilities in children/youth such as asthma/lead exposure prevention and promotion of maternal/child health; ACDMH partners with these programs when appropriate.

Gambling: See newly identified *Problem Gambling* goal

Cross Systems: Prevention, early identification and appropriate interventions for individuals with co-occurring behavioral health issues remains a recognized area of need. Individuals with behavioral health challenges frequently encounter emergency services and law enforcement personnel while presenting with an "emotional disturbance." In an effort to improve care to those individuals and to improve safety in the community there continues to be cross system collaboration within the Albany County service system to help educate and improve how interventions with those with mental illness or emotional disturbances occur within the emergency services system. Albany County LGU continues to implement the Sequential Intercept Model (SIM) approach to identifying individuals with behavioral health issues who interact with the criminal justice and crisis/emergency services system and improve interventions. The goal of this continued initiative is to reduce unnecessary incarcerations/hospitalizations, prevent further penetration into the forensic system (when appropriate), facilitate linkages to services when warranted, and improve how individuals with behavioral health needs interface with these systems. Furthermore, Albany County LGU continues to provide trainings to local law enforcement agencies and other collateral providers to support the importance of early detection, appropriate responses and intervention/service linkages. Since September 2012, over 250 officers from local law enforcement agencies have been training in Crisis Intervention Team (CIT). Lastly, Albany County continues to operate the PSCC, which is a multi-disciplinary, cross system planning meeting that works to assist individuals who have high needs and/or are high utilizers of emergency services in order to attempt to decrease dependence and use of emergency services and help improve their quality of life in the community. In addition, youth in transition referrals can be facilitated via the PSCC as well.

Social Determinants of Health: There is also an emerging recognition of the impact that social determinants of health have on the overall wellbeing and development of youth/adults, most notably in areas where poor access to addressing basic needs (food, shelter, safety etc.) has led to behavioral health disabilities. There are several existing and evolving programs within Albany County with intent to address this issue. This is further discussed in the *New York State Prevention Agenda Survey.*

There has also been an increased recognized need to educate vulnerable individuals (consumers of behavioral health services, seniors etc.) to prevent them from becoming victims of scams/fraud; there have been initiatives in the community towards this, especially for Seniors.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Continue and enhance existing behavioral health prevention and education programs/initiatives in Albany County; explore opportunities to expand programs and services.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: The Albany County LGU will explore increasing OASAS Prevention funding in Albany County to meet the community and school prevention demands. Re-allocation of existing funding will be considered as well. The Albany County LGU will also monitor and promote the need for increased prevention and treatment services for problem gambling.
    Applicable State Agency: (check all that apply): ☑ OASAS ☐ OMH ☐ OPWDD

Objective 2: ACDMH will continue to offer twice annual CIT trainings to local law enforcement agencies and explore opportunities for further expansion.
    Applicable State Agency: (check all that apply): ☑ OASAS ☐ OMH ☐ OPWDD

Objective 3: Albany County's #betheoneto suicide prevention campaign has been launched, along with the development and dissemination of community resources.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 4: Albany County LGU will continue to work in collaboration with OMH, Albany County SPEC, the Albany County Suicide Task Force, and the Suicide Prevention Center of NY to advance local actions to reduce suicide and suicide attempts (across the age continuum) in Albany County. Also, promote the recovery of persons affected by suicide; this includes the exploration and implementation of standardized evidence-based screening tools for suicide prevention across the system of care.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 5: Albany County LGU will host a SIM forum to review progress made with the SIM initiative practices and set goals for future progress.

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

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- The number of CIT graduates (since the training's inception) increased to 263

2g. Inpatient Treatment Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Albany County continues to experience a shortage of adult and children inpatient services. Furthermore, admission practices for inpatient hospitalization is shifting, with fewer individuals admitted, or individuals being admitted for shorter stays. While it is recognized that inpatient admissions are costly, there continues to be some individuals who present with a need for inpatient level of care for stabilization and safety, as well as to allow time to facilitate service linkages that will support long-term stability. The push to reduce state operated intermediate to long-term psychiatric beds has occurred at a faster rate than the outpatient services system can handle; as a result, there are simply not enough beds for those who need them. Acute care hospital units are reporting it is cumbersome to refer to the local State psychiatric hospital due to the lengthy application process, long wait for determination, and frequent denials. As a result, increasing numbers of individuals are in the community who are either chronically unstable or marginally stable. Many are not following through with service linkage (being offered) due to either volitional refusal or them being too impaired to follow through. Many are homeless or under-housed, have co-occurring issues, have limited support network, and limited economic resources. These individuals are ending up in the shelter system, emergency rooms and/or having contact with the police and/or being incarcerated. Community based providers have limitations with serving those who are chronically unstable with acute care interventions.

In addition, there continues to be challenges related to discharge planning for individuals who are inpatient and/or in crisis units/ERs, especially those who have special and/or challenging circumstances (i.e. sex offenders, history of aggression/violence, co-morbid medical/behavioral health issues, chronic homelessness etc.). Furthermore, the local state operated hospital, Capital District Psychiatric Center (CDPC), has been working to get individuals who have had long stay admissions out of the hospital; some of these individuals' County of origin is not Albany; however, they are discharged to the Albany County community with local services (i.e. clinical, care management, housing etc.) for a variety of reasons. This puts additional strain on already limited service resources. The increase in the availability of acute care beds in Albany at CDPC over the last 1+ year has given some help to the system, but there are capacity issues with the community-based services that the acute care inpatient units are referring to (housing, care management clinic treatment).

Identification of this inpatient treatment services area is primarily a MH/OMH issues, it should be noted that those with co-occurring DD and SUD are also impacted; when individuals have these additional disabilities it compound the issue of access to MH inpatient and discharge planning, compounding the challenges reflected above.

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

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

Any goals/objectives that are related to addressing high-level unmet needs for MH inpatient treatment services are synonymous with the existing goals/objectives reflected throughout this plan (for example addressing issues related to housing, transportation, treatment access etc.). It is noted, some initiatives within Albany County serve as a forum to help address some of the challenges related to discharge planning from inpatient hospitalization. For example, Program Services Coordinating Committee (PSCC) cross systems case conferences, Provider/Planning meetings, and the Albany County Coalition on Homelessness (ACCH); specifically ACCH continues to address the role homelessness and housing needs plays in discharge planning from hospitals, incarcerations and youth placements as aligned with the local HUD strategic plan to prevent, reduce and combat homelessness. In addition, the Capital Region RPC is beginning to look at the issue of homelessness-hospital stays impact; in June 2019 the RPC hosted a forum on the issue.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- Expansion of identified need

2h. Recovery and Support Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Peer Support Services: There continues to be a need for Peer Support, Recovery Coaches, and Parent Partner services. Albany County LGU continues to build relationships with peer and recovery support services such as a Capital Area Peer Services, Mental Health Empowerment Project and the New York State National Alliance on Mental Illness (NAMI) for individuals with MH; peer specialist certification trainings continue to be available. Within the SUD system, Albany County LGU continues to collaborate with Friends of Recovery-New York and Second Chance Opportunities to increase recovery supports in the Albany County community. There are now two Recovery Community Center's (RCC); this is a positive gain to the service system. These services can build upon the therapeutic process started in treatment as well as provide initial or ongoing recovery support for adults, youths, and families. The Albany County LGU continues to support local recovery organizations' interest in developing RCOs and RCCs. Finally, Certified Peer Recovery Advocates (CRPA's) can work in OASAS 822 Outpatient Clinics and these services are billable. In partnership with OASAS State representatives and OASAS Outpatient clinics, there is intent for CRPA's to be a more available service. Albany County LGU will continue to work with OASAS and local providers to implement these services across the Albany County outpatient network. Catholic Charities' Project Safe Point Health Hub continues to provide Peer Recovery Advocates 24 hours a day who try to engage individuals who may be experiencing a related SUD crisis, especially those at risk of opiate overdose; this includes responding to local emergency rooms and other community sites when warranted. To further compliment, peers have a prominent role in the CR-OAEP through in-community contact and engagement with individuals via a partnership with Catholic Charities and ACCA's Family Navigator Program (further discussed throughout this plan).

Family Support: Within the Albany County SUD system, Addiction and Recovery Family support includes 12-Step programs like Alanon and Naranon, Family Navigators, ACCA's Addiction education and Support group, and resources from the regional organization, North East Community Action Partnership (NECAP). As previously referenced, the CR-OAEP utilizes Family Navigators for in-community services and engagement to those in recovery and their families. It is expected that any new Recovery Organizations/Centers will need a family component. Albany County LGU will work with any new RCO's/RCC's to ensure this need continues to be addressed in our county. The OPWDD system also continues to have a strong peer and family support network. Two local agencies, Capital District Psychiatric Center (CDPC) and Equinox, Inc. also provide family support services for the adult MH population. The children and youth system had parent partner services, however the previous contract ended; it remains a recognized need.. There will be new Child and Family Treatment Services (CFTS) service going into effect in July 2019 for parent support services, however the reimbursement rate is low so service capacity and if/how much benefit it will be to the community is unclear at this time.

In general, as peer support services have become or will become billable/reimbursable services, providers will need to learn to navigate and appropriately manage these processes. In addition, some SUD peer services are not billable at this time as they are not connected to an Article 32 clinic; determining how to sustain these valuable programs is another area of need.

Health Home Care Management (HHCM): Albany County continues to have a Health Home Care Management network via the lead Health Home, Capital Region Health Connection, which includes ten downstream care management organizations. HHCM is a resource to individuals who have chronic medical, MH and/or SUD diagnoses. There continues to be a demand for case management services for non-Medicaid/non-health home eligible individuals, but staffing challenges makes it difficult for placement of these individuals, resulting in wait lists. There have been recent challenges related to Medicaid based HHCM access due to staffing shortages, increased referrals of individuals with high needs/high risk history, expansion of Health Home + criteria and an increase in AOT cases. Capital Region Health Connections Health Home agencies have also had to navigate multiple concurrent changes related to regulations, direct billing, new electronic health record, and an intensive training schedule, which has had its challenges.

Health and Recovery Plans (HARP)/Home and Community Based Services (HCBS): HARP/HCBS implementation continues for those that qualify; enrollment remains low.

Children/Youth Recovery Resources: As the HCBS waiver services have changed and are implemented in the children's system, Albany County LGU, ACDCYF and providers continue to monitor the transition. There continues to be challenges as it relates Children's Health Homes, especially for children who have dual eligibility with the DD system. Children's providers

are noting increased challenges due to the "unbundling" of waiver services; there is concern that reimbursement rates may pose issues of sustainability and workforce issues.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Albany County LGU recognizes the value of individuals "lived" experiences, lending credible voices to the systems planning and service delivery. Albany County LGU will continue to work with local partners to strengthen the infrastructure of recovery and support services in order to maintain, enhance or develop new service opportunities. This will include a) Peer Services, Advocacy Councils, Recovery Coaches and Family Support programs being more fully integrated into a continuum of mental hygiene services in order to better promote wellness and recovery; and b) continuing to participate in the implementation of adult and children's HHCM.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Engage leaders in the local peer community in focused planning efforts to detail available resources, identify evidence-based practices, explore regional collaboration opportunities and continue to build local partnerships with peer and recovery advocacy organizations
　　　Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: Continue to provide peer support groups at Albany County Department of Probation and intends to offer peer groups at the Albany County Jail through the ACDMH's Jail Mental Health Unit
　　　Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 3: Albany County and ACDMH intends to sponsor 10 scholarships for Certified Recovery Peer Advocate (CRPA) to engage individuals in attaining certification and employment in the substance use field; planning and implementation is progress.
　　　Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 4: Continue Integrated Planning meetings to allow local providers from all three disability systems to meet and collaborate with each other throughout the year.
　　　Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 5: Continue to encourage growth of integrating peer support services into the service system. If/when needed, assist with learning about/navigation of peer support services billing processes for OASAS system.
　　　Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- Second Chance Opportunities with OASAS support opened Albany Counties second Recovery Community Center, which will service individuals in stable recovery. This extends the continuum of care past formal treatment and assists individuals to continue their recovery journeys.

2i. Reducing Stigma - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)

- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Stigma is an issue that is unfortunately experienced by many individuals who have behavioral health issues across all three disability areas; often individuals experience barriers to opportunities and resources when their behavioral health issues are known, for example educational and/or job opportunities. Furthermore, sometimes individuals don't seek the services they need because of the stigma that exist in society. There continues to be ongoing efforts within the services system to not only attempt to prevent MH and/or SUD/gambling issues before they start and help reduce issues and symptoms when issues already exist, but to also prevent and address stigma.

In addition, another major focus of Suicide Prevention includes reducing stigma about suicide, mental illness and other behavioral health issues so that individuals will be able and willing to seek the help they need. This includes community and professional education on using less stigmatizing verbiage when referencing a behavioral health condition and suicide. Providing trainings to staff, the community, and the consumers themselves how to address the issue of suicide in the Albany County community remains a priority. There continues to be access to multiple suicide prevention and awareness initiative, trainings and events such as SAFE TALK, ASSIST, CONNECT, "Out of the Darkness" and "Lights of Hope." Albany County state licensed agencies also continue to have access to the Center for Practice Innovations (CPI) training programs, one of which is specific to suicide.

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

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

See related goals/objectives as referenced above under the Prevention and other initiatives reflected throughout this LSP. The Albany County SPEC and the Albany County Suicide Task Force remains active in addressing suicide issues within the community. ACDCYF is regularly tabling at community events and at school districts towards efforts of reducing stigma. Albany County Department of Mental Health, in collaboration with the Albany County Executive's office, hosted a panel discussion *Overcoming Stigma, Bigotry and Discrimination in Mental Health* in recognition of Mental Health Awareness month in 2018 and intends to host additional forums in the future. The Albany County Equity Agenda remains an ongoing initiative; it is intended that the needs of those with behavioral health disabilities and addressing stigma around these issues will be included. Family support and education services, whether provider based, or through partnering agencies like National Alliance on Mental Illness (NAMI). Lastly, the legislation requiring schools to offer mental health curriculum to students across the age spectrum can help with prevention, early detection/intervention, and reducing stigma.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- Implementation of mental health curriculum into NYS school districts has begun

2k. SUD Residential Treatment Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Albany County treatment providers are in the early stages of converting to new OASAS 820 stabilization, rehabilitation, re-integration regulations. Currently two programs (Homer Perkins, Addictions Care Center of Albany) have officially converted to re-integration and stabilization/rehabilitation and a number of other programs await sanctioning from OASAS. As stated earlier, it is early in this process and no hard data is available to assess how this conversion will influence the treatment system. Albany County LGU will continue to monitor community reactions to OASAS program site locations.

There continues to be SUD Residential Treatment Service for youth however, there is only one all-male facility, lowering capacity for female adolescent beds.

Another emerging issue recognized in the service system is the need for an Integrated Residential Treatment Program that can service individuals with high SUD and high MH needs in a safe, therapeutic, treatment-based setting for moderate to extended periods of time (e.g. 6/9/12 months). There are individuals, for example that have a diagnosis of schizophrenia, but

also have a severe Alcohol or Opiate Use Disorder. These individuals' ability to stabilize and be safe in the community has been challenging as their co-occurring disorders compound each other. Programs that are lower levels of care (i.e. half way houses, community residences, IOPs, OASAS 822 and 820 levels of care etc.) in both the OMH and OASAS service system are limited in their abilities to manage these individuals. Many times the staff lack knowledge, skills and comfort in the areas that are opposite their specialty; this is applicable across of levels of care, but most challenging in more intensive and residential treatment settings (for both OMH and OASAS).

Efforts to address these issues include cross training, co- treatment models, and collaboration. This supports many individuals, but there are others, whose severity rises to a level of needing more. These more severe individuals are cycling through the emergency rooms, crisis centers, jails/courts, and psychiatric hospitalizations.

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

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

There is no goal/objective at this time for this area of need. Albany County LGU will continue to assess this issue as well as explore opportunities to address it, but ultimately an integrated residential based treatment program is what is needed.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- Emerging area of issue.

2I. Heroin and Opioid Programs and Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

The opiate/heroin epidemic is a public health crisis and continues to take a toll on the Albany County community. The treatment community is being challenged to treat the problem of opiate/heroin addiction like never before. The cost to individuals, families, and the community is immense and efforts to combat this remain a high priority. Through education, offering of treatment opportunities and several preventative initiatives, the Albany County provider system continues to address this issue. The crisis has created a more open and responsive treatment system. Rather than discharging individuals for return to use the treatment community has become more responsive to the engagement process meeting clients "where they are at" and serving SUD as the chronic disease it is. Children/youth opiate/heroin use is a concerning issue; local probation officers are reporting positive drug screen of youth on their caseloads. Additionally, the opiate/substance use of adults has led to child welfare issues.

Albany County is fortunate to have a growing number of providers who offer Medication Assisted Treatment (MAT), however despite significant improvement, not all do. Per the Client Data System (as of May 31, 2019), out of 2723 individuals in substance use disorder (SUD) treatment, 78% of those with an opioid diagnosis receive MAT across the Albany County treatment services system. When considering different levels of care, use of MAT is Opioid Treatment Program (OTP) (100%), Residential Services (51%), community residence/supportive living services (76%), Outpatient Programs (all levels) 69% and Inpatient Rehabilitation nearly 100%. Those who do offer MAT are close to or at full capacity, per the federal regulations. For those that do not, barriers include lack of medical expertise/providers, concerns of risk/liability and "abstinence bias. "The percent of individuals on MAT has remained fairly stable and access to prescribers appears to be growing. Through discussions with emergency rooms and expansion of Catholic Charities Project Safe Point Bridge Clinic abilities to prescribe to more individuals and Albany County Correctional Facility now administering various medications for MAT, demonstrates an encouraging trend.

The use of NARCAN by EMT's, Police and trained personnel has demonstrated the lifesaving importance. Statistics from 2017-2018 (NYS Opioid Annual Report 2018) show opioid OD's continue to climb and the use of NARCAN parallels that. Albany County LGU continues to encourage and support training and use of NARCAN, including a co-sponsored monthly Narcan training available to the general community and treatment providers; as well as use of the "Over Dose Map" (ODMAP) as a tool to track in near real time numbers of OD's, NARCAN administration, and OD deaths. The ODMAP is a multi-agency partnership initiative.

As discussed in the Crisis Services section of this Local Service Plan, Albany County is fortunate to have: a) an increase in the opportunity for withdrawal services. St. Peter's Addiction Recovery Center (SPARC) expanded its detox services to Ambulatory and Ancillary Detox. This provides services during week days, evenings and weekends; b) Catholic Charities continuing to offer the Project Safe Point Health Hub service, which includes 24 hour Peer Recovery support, and c) the launch of the Capital Region Open Access Engagement Program (CR-OAEP), which offers 24/hour support for engagement, assessment treatment linkage, and when appropriate, initiation of MAT.

It is a recognized that the diagnosis of Opioid Use Disorders (OUD) and the need for appropriate interventions, like MAT, is not isolated to just substance use disorder treatment settings. Recent guidelines released by the NYS Office of Mental Health (OMH) speaks to the necessity of appropriate screening, identification, and management of OUD needs in Article 31 mental health and integrated treatment settings, including the use of MAT. Albany County LGU will work with local Article 31 and integrated clinics to explore how appropriate screenings and treatment is being provided. In addition, CLMHD was instrumental in securing funding from the NYS Senate Task Force on Heroin and Opioid Addiction for jail-based services; these funds allowed for enhancement of the innovative services, providing all levels of MAT at Albany County Correctional Facility (ACCF).

The immense benefits of MAT are regularly discussed and advocated for amongst and with providers and these efforts will continue. It is a hope that barriers, in time and with education and advocacy, result in the maximized use of MAT across the SUD service system, as well as mental health and integrated treatment settings.

Albany County intends to develop a Mobile Response Team (MRT) to perform OD survivor outreach follow up. Staffed by CASACs and CRPAs, this team will compliment outreach, engagement, and treatment services throughout Albany County.

Albany County Department of Mental Health (ACDMH) continues to partner with Albany County Department of Health (DOH) on several initiatives related to addressing the opiate/heroin epidemic, including:

- The Albany County Opiate Task Force, co-chaired by the Albany County Director of Community Services and the Albany County Health Commissioner remains active; this Task Force is comprised of public health, behavioral health, and law enforcement leaders.
- Monthly Opiate Overdose Prevention (Narcan) trainings are offered to human services providers and the general community.
- An Opioid Data Dashboard and ODMAP are tools used to help track and map out opioid overdoses in close to real time.
- Working with local Emergency Room physicians to increase the use of MAT in hospitals.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Albany County LGU will coordinate efforts in collaboration with the Albany County Executive's office; ACDOH; behavioral health treatment, prevention and harm reduction providers; law enforcement; the community; schools; and the medical community, to continue addressing the heroin/opioid epidemic that plagues the Albany County community through the enhancement of services available.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Continue to offer and promote education and awareness of the Heroine and Opiate crisis. Support opportunities to prevent and intervene, including: Disseminating the CDC Opiate Prescribing Guideline; Encourage local prescribers to attend existing educational events; continue to disseminate information on new law/regulations; participate in community events; continue to maintain awareness of and disseminate information on Drug Take Back events, Project Orange and other safe drug disposal options.
     Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Objective 2: Albany County LGU will continue to work with treatment providers to maximize the use of MAT in the substance use, mental health, and integrated treatment settings. By encouraging and supporting an increase in the number of providers utilizing state recommended screening instruments to assess for OUD, increased use of MAT and a coordinated referral/linkage process for co-treatment when necessary; this includes using the CR-OAEP to assist in this process.

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

Objective 3: The Albany County Executive, ACDMH, ACDOH, Catholic Charities Overdose Prevention Program, Albany Medical Center Hospital, the Regional Underage Drinking and Drug Use Prevention Coalition, local SUD providers, law enforcement and medical personnel will work collaboratively to increase the number of individuals trained in Opioid Overdose Prevention (NARCAN) to reduce/reverse opioid overdoses in Albany County. Albany County LGU will continue to disseminate additional harm reduction strategies/resources (needle exchange) to the community. This includes continuing to offer monthly Overdose Prevention/Narcan trainings via a partnership with ACDMH and ACDOH.

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

Objective 4: Albany County LGU will continue to collect, assess and monitor the number of fatal and non-fatal opiate overdoses in Albany County in collaboration with the County Coroner; continue to collect data reports from Peer Advocate(s) in ED's; and continue to partner with ACDOH on the development of the Opioid Data Dashboard and use of ODMap.

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

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- With OASAS 820 Residential Redesign, some providers have stabilization beds to use for initiating MAT.

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

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

See below, "Other;" specifically the goal/objectives related to System Coordination/Integration for information related to *Coordination/Integration with Other Systems for SUD clients*

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

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):
See below, "Other;" specifically the goal/objectives related to System Coordination/Integration for information related to *Coordination/Integration with Other Systems for SUD clients*

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

N/A

2n. Mental Health Clinic - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

There continues to be several OMH-licensed MH clinic programs within Albany County that service adults and children. There are continued issues, however, that cause high level unmet needs in the system.

High level unmet needs/challenges for mental health clinics include:

- MH clinic capacity issues in Albany County have become significant for adults and children/youth. Capacity has been limited, but demand has been high. At least one adult clinic in Albany County has been unable to accept any new patients due a psychiatrist retiring soon and them needing to lower their census. Other adult clinics have had to limit access due to staffing shortages. Of those adult clinics who are accepting, many have become overwhelmed with the volume of referral/service requests, especially those from hospitals/ERs/crisis units (which have a priority status). Staffing shortages include social workers and psychiatric prescribers.
- Staffing shortages are also affecting the children's MH clinic system access (e.g. staffing issues with psychiatry and social workers); some children's MH clinics have had to maintain a wait list. The demand is higher than the capacity.
- Psychiatry shortages in the addiction and developmental disability field has led these providers to seek MH services for their consumers from mental health clinics, adding additional strain to a strained service system. For example, one of the major MH/psychiatry providers of the DD system is no longer accepting new patients due to loss of a psychiatrist for an unforeseeable amount of time.
- Private mental health providers have become less accessible to the service system; those individuals that were typically accepted via referrals from the OMH Clinic system are no longer being accepted. Barriers include reference that they "don't accept Managed Medicaid," and/or they do not feel equipped to handle "high need" individuals. At least one major private provider has been closing its offices over the last few months, with the final office closing in Sept 2019; OMH clinics have begun getting calls trying to find new services for some of these displaced individuals. This adds additional strain on an already strained system.
- MH clinics continue to have difficulty managing the increase of individuals with "special needs," such as those with co-occurring complicated medical conditions, histories of high-risk safety and threatening behaviors, non-English speaking/Immigrant/Refugee individuals and those with forensic histories (including sex offenders). This has become a significant area of issue for MH Clinics in Albany County.
- MH clinics in Albany County have also had increasing issues with managing individuals who frequently no show to treatment; this includes individuals with poor engagement/follow through and those that leave treatment through discharge or choice. Sometimes these individuals decompensate in the community, have ER/police/hospital contact and are re-referred back to the treatment community; there are a number of individuals who do this cycle repeatedly. One anecdotal example was an individual who missed 20+ appointments in one year (only attending 6). MH Clinics do not have the staffing/resources to manage the amount of outreach it takes to track and engage these individuals.
  - In these cases, referrals are being made to ACT and/or AOT, when appropriate. However, this results in further strain on the ACT program (with a current wait list of over a dozen individuals), and the AOT system (which has noted increases in referrals/active cases, but with no additional resources to help manage it). Additional supportive programs are also available but have their own limits (as reflected below).
- The longstanding issue of limitations to access to behavioral health services in the outlying communities (i.e. Hilltowns, Ravena etc.) remains. There is consideration/ anticipation that there may be more service options available to individuals who live in the outlying areas as health care reform and integration of primary/behavioral care initiatives continue.
- The local state operated psychiatric hospital, Capital District Psychiatric Center (CDPC) has been working to get individuals who have had long stay admissions out of the hospital; some of these individuals' County of origin is not Albany, however they are discharged to the Albany County community with local services (i.e. clinical, care management, housing etc.) for a variety of reasons. This puts additional strain on already limited service resources.
- NE Career Planning was approved to be a PROS with clinic but has not been able to find psychiatric staff to do so.
- There is a growing need for diagnostic/assessment specialists who can offer diagnostic testing to children, youth and adults
- There is an increasing request for MH clinic and care management services for non-English speaking/Immigrant/Refugee individuals across the age spectrum, however resources to adequately service this populations are limited (see below under "Other" for more details).
- To better meet the needs of individuals and comply with recent NYS Office of Mental Health guidelines, Mental Health and Integrated Clinics will need to begin exploring and implementing enhanced substance abuse screening, referral and interventions practices, especially as it relates to Opioid Use Disorders (OUD) and the use of Medication Assisted Treatment (MAT).
- The local service system, including children and adult mental health clinics, will need to begin preparing for the changes and impact that will result from Raise the Age; it is anticipated there will be a significant increase in youth/young adults presenting with service needs when considering the number of youth that are currently being arrested.
- There continues to be limited mental health clinic resources for Seniors; although all adult mental health clinics will and do serve this population, there remains gaps, especially for those with co-occurring, high need, complicated medical issues.

Positive gains with MH clinics include:

- ACDMH continues to offer an Adult Integrated Clinic, which provides services to individuals with MH and/or SUD needs. In 2018, the Integrated Clinic started Same Day Access at which individuals who wish to seek mental health treatment services with the clinic can just come in during business hours; if clinically appropriate, individuals could start their intake process immediately that same day. This has resulted in cutting the time to first provider visit by more than 50%, as well as cut no show rates. In 2018, 1040 individuals were served via for Same Day Access service requests.

- The Albany County Department for Children, Youth and Families (DCYF) Children's Mental Health Clinic implemented a same day access referral/intake process; called Open Access, parents/youth can self-present to seek services Monday and Wednesday mornings. In 2018, 133 children/youth were serviced through Open Access. To date in 2019, 103 children/youth have been served.
- ACDMH Integrated Clinic continues to move forward with initiatives related to developing evidenced based protocols and practices to ensure the viability of clinical services moving forward as a Vital Access Provider (VAP).
- The Counseling Center at LaSalle remains an Integrated Clinic.
- Camino Nuevo, an OASAS certified program, became an Integrated Clinic (OASAS Host)
- Parson's OnTrack NY continues to offer treatment services to individuals 16-21 who are experiencing their first onset of psychosis
- Parson's Behavioral Health Center continues to transition towards being able to treat adults up to age 64; they anticipate a psychiatric prescriber for their adults to start in July 2019.
- Albany County LGU continues to engage non-OMH licensed clinical/private providers (behavioral health and medical) in order to expand the service network available to consumers, to include integrated services.
- There continues to be expansion of children's mental health services via satellite clinics in local school districts and to underserved/rural areas via satellite clinics in schools and co-located MH treatment in pediatric offices. Specifically, Parsons Behavioral Health Center offers services to a Middle School in Cohoes 5x a week; Albany County DCYF has clinicians in a pediatric office in Cohoes 1x a week and Berne Knox Westerlo School 1x a week. Additional expansions include Guilderland, North Colonie, Ravena/Coeymans/Selkirk and Albany City School Districts.
- Albany County LGU continues to operate a Clinical Single Point of Access (SPOA) with a dedicated Coordinator
- ACDCYF continues to operate a Children's SPOA with a dedicated Coordinator as it relates to navigation and management of children's mental health services.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Albany County will maintain, enhance and increase mental health clinic and access/capacity where gaps have been identified.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Albany County mental health providers will explore opportunities to enhance mental health clinic capacity through intensive outpatient programming and continuing to explore innovative Value Based Payment (VBP) programming with local MCO partners.
Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: Albany County LGU will develop an awareness of any emerging integrated licensed clinics (OMH, OASAS and/or DO) which individuals can be referred, especially in underserved areas.
Applicable State Agency: (check all that apply): ☐ OASAS ☑ OMH ☐ OPWDD

Objective 3: Albany County LGU will continue to participate with the Albany County Long Term Care Coordinating Council (LTCC), the annual aging summit and to encourage providers across the system to consider when seeking new staff to hire individuals with experience in serving seniors along with experience in MH and SUD.
Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 4: Increase and enhance outpatient treatment capacity across the age continuum and disciplines; this includes exploring the development of services to rural/underserved areas of Albany County to address emerging needs (e.g. Hill towns; Ravena/Coeymans; Cohoes, etc.). This also includes maintaining awareness of and preparing for potential increase in need because of Raise the Age implementation.
Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 5: Albany County LGU will advocate for an increase in the number of providers who will service non-English speaking/Immigrant/Refugee individuals; this will include working with both public and private behavioral health providers to begin to participate in and/or enhance their capacity for translation services

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

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- Significant capacity challenges in MH clinics is becoming critical
- Private clinics closing
- State licensed programs no longer taking new patients
- Expansion of children MH services into additional school districts

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

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

PROS: Albany County continues to have three (3) PROS programs, two with clinical services included (Equinox Inc. and Rehabilitative Support Services (RSS)) and one (Northeast Career Planning) without clinical services. It should be noted that Northeast Career Planning has indicated intent to add a clinical component once they secure psychiatric staff, but they have been unable to hire one to date. This continues to be a major source of treatment support to the Albany County community. There is little to no PROS access, however, for individuals who only have private insurance or straight Medicare insurance, despite consumers request and interest for PROS services.

ACT: Albany County continues to have one ACT team, however the demand for this service remains high and the requests exceed capacity. There is currently a wait list of over a dozen individuals. Albany County would benefit from an expansion of this service. It is often the recommendation to refer to ACT and/or AOT for individuals who are high need, high utilizers, difficult to engage with high no show rates. The service system currently does not have the capacity to absorb these individuals into ACT/AOT and it is not always the appropriate recommendation.

Assisted Outpatient Treatment (AOT): Albany County LGU continues to manage AOT services. It can be a beneficial service to those who present with the need, helping individuals gain/maintain stability and be safe. There are challenges, however, as this is an unfunded mandated program that is in high demand. There has been an increase in the number of Assisted Outpatient Treatment (AOT) referrals/Orders. In addition, the already extensive investigation process has been even lengthier and requires a lot of invested staff time, because of how long it takes for hospitals/facilities to forward requested records; it can sometimes take 2-3 months (and repeated requests) to get them. The two local 9.39 hospitals included. In addition, it is often the recommendation to refer to ACT and/or AOT for individuals who are high need, high utilizers, difficult to engage with high no show rates. The service system currently does not have the capacity to absorb these individuals into ACT/AOT and it is not always the appropriate recommendation. Furthermore, the high volume of AOT cases in Albany County puts additional strain on the already challenged MH Care Coordination system, as there are only two care coordination agencies within Albany County that can serve AOT individuals.

Albany County does not have any Intensive Outpatient Programs (IOP) currently, although there is the opportunity for mental health providers to explore offering this service. There is also no partial hospitalization program locally; the closest one is at least one hour away in another County (although Albany County residences have utilized this service). Albany County would also benefit from a "social club" type program, something that is between clinical day treatment/PROS and a MH clinic.

The Capital District Psychiatric Center-Mobile Integration Team and the RSS -Transitional Support Team continue to assist individuals who have histories of long stay and/or chronic psychiatric hospitalizations to locate stable community housing and supportive services to remain out of the hospital. These programs have limited capacity, are voluntary and have specific criteria; they are not widely accessible to general community providers.

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

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

Albany County LGU and local behavioral health providers will continue to maintain existing MH outpatient services' programs, as well as explore opportunities for enhancement whenever possible.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- Increase challanges to speciality care coordination service systems such as ACT, AOT Care Coordination, and Health Homes.

2p. Mental Health Care Coordination - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Care coordination services in Albany County continue to be provided via Health Home Care Management, Non-Medicaid Care Management, Community Transitions Team Aging Out Adolescents (CTT-AOA) and Assertive Community Treatment (ACT) services. Currently, there continues to be availability for all of these services, but the demand continues to rise and there is a strain on care management services. Albany County Care Management providers continue to be active with the Capital Region Health Connections Steering Committee (the Albany/Rensselaer/Schenectady County lead health home), which manages all Health Home referrals. Albany County also continues to operate a Case Management Single Point of Access (SPOA) with a dedicated Coordinator that manages all "specialty" case management referrals (i.e. CTT-AOA, ACT, non-Medicaid care management, Assisted Outpatient Treatment (AOT) and OMH Prison releases). It is also notable that implementation of Children's Health Homes continues to have its challenges to navigate, especially as it relates to the overlap with OPWDD care management services. Furthermore, Albany County Department for Children Youth and Family (DCYF) operates a Children's SPOA with a dedicated Coordinator as it relates to navigation and management of children's mental health services.

There have been some positive gains within the care management network in Albany County. Notably, the lead Health Home Capital Region Health Connections (CRHC) gained several new agencies into their network when they merged with the Schenectady County care management network; many of these "new" care management agencies do work with Albany County individuals. There are also new care management agencies joining CRHC in the near future. There was also expansion of Health Home Plus qualifying criteria, opening the door for more individuals to receive intensive services when needed. In addition, diagnostic criteria for MH Care Coordination now includes DD diagnoses (as long as it is co-occurring with another qualifying medical, MH or SUD diagnosis).

The high-level unmet needs/challenges as it relates to Care Coordination services (regardless of whether it's Health Homes or Specialty Case Management) in Albany County include:

- Shortage of care managers that have the skill, credentials, and/or capacity to work with special needs populations, such as sex offenders; Health Home Plus individuals (e.g. AOT/OMH Prison releases/state psychiatric facility long term stay releases, homeless); those with history of high risk safety behaviors; and those who cannot/do not consistently maintain their Medicaid.
- MH Care Coordination system continues to work through the process and challenges related to Health and Recovery Plans- Home and Community Based Services (HARP-HCBS) services; enrollment rates remain low.
- Many Health Homes/Care Coordination providers often do not provide transportation services to individuals, or only do so on a limited basis; especially (and understandably), when there is a history of high-risk behaviors; transportation support is a common need to help individuals forward in their recovery.
- The request for non-Medicaid care management remains high, however workforce shortages have influenced capacity for this service; currently there is a wait list. The previously noted high volume of AOT cases in Albany County impacts access to non-Medicaid care management because the only two care coordination agencies that can serve AOT individuals are also the only two agencies that can serve non-Medicaid care management agencies. Both of these agencies' capacity has been filled by AOT cases, making it difficult to take non-Medicaid cases.
- The local state operated hospital, Capital District Psychiatric Center (CDPC) has been working to get individuals who have had long stay admissions out of the hospital; some of these individuals' County of origin is not Albany, however they are discharged to the Albany County community with local (i.e. clinical, care management, housing etc.) for a variety of reasons. This puts additional strain on already limited service resources.
- There is an increasing request for MH clinic and care management services for non-English speaking/Immigrant/Refugee individuals. Resources to service this population adequately are limited.
- There can sometimes be a delay in care management linkage from time of referral to actual service provision; there are a variety of reasons this occurs (for example, workforce challenges, insurance issues, individuals not having a

phone and/or being homeless, lapsed Medicaid, people not paying spend-downs); delayed access to care management services can at times negatively impact an individual's stability.

- There is a limitation in access to rapid/short term/interim case management services. The period between referral to linkage for many care management services can be lengthy at times, despite individuals need for help quickly, which can impact stability, well-being and crisis situations. There was a positive gain with the implementation of the Albany Medical Center DSRIP Better Health for Northeaster New York (BHNNY) CARES program however this program only services a specific population of individuals and therefore other individuals continue to go underserved.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Continue to support and maintain an awareness of and participate in the implementation of existing mental health care coordination services for both children and adults; advocate/facilitate for enhancements whenever possible.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Albany County LGU will continue to participate in the Capital Region Health Connections Steering Committee
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Objective 2: Albany County LGU will continue to participate in and maintain awareness of the implementation of HARP/HCBS services and intends to partner with New York Association Psychiatric Rehabilitation Services (NYAPRS) in the coming year to host informational forums with the goal of increasing enrollment.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Objective 3: Health Home Care Managers will receive specialized, evidence-based training, as identified via the lead health home's Staff and Training Development subcommittee, of which Albany County LGU and many providers participate
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Objective 4: Continuing to maintain awareness of and when warranted participate in the implementation of children's Health Home Care Management.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Objective 5: Albany County LGU will continue to lead the Case Management SPOA and ACDCYF will continue to operate the Children's SPOA.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- CRHC merging with Schenectady County care management network
- BHNNY CARES services

2q. Developmental Disability Clinical Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Throughout Albany County there are number of clinical providers who serve the DD population, however, there continues to be unmet needs for psychiatry, diagnostic/assessment specialist, OT, PT (especially those that take Medicaid), and dental with sedation; there is also a growing need for nurses to support DD individuals with more complex medical needs. As it relates to behavioral health (psychiatric) providers, there are limited prescribers for both children and adults throughout the system, including DD. Cross systems trainings can assist with building the skill base of providers who do not traditionally serve the DD system to be able to begin doing so.

Additional challenges include:

- DD individuals with co-occurring MH and/or SUD issues,
- DD individuals who are "aging out" from children/youth services to adult services with cross system issues (forensic, MH/SUD etc.); there are limited resources available to support the multitude of unique needs these individuals present with,
- Adult individuals who are presenting with DD symptoms/history, however are not enrolled in OPWDD (*further discussed in Other Need 1: System Coordination/Integration*
- Challenges with serving immigrant/refugee individuals who present with developmental disabilities, but may not have documentation before age 21, as well as other challenges associated with serving this population (*further discussed in Other Need 1: System Coordination/Integration)*

As the OPWDD system continues to transition through Care Coordinating Organizations (CCO) implementation there may be more opportunities for treatment services access. Although CCO implementation began a year ago, we are still waiting to determine its impact on the system. There have been some concerns/issues around this transition (as further discussed in the *DD Care Coordination section*).

A positive gain to the DD service system is the opening of the Baker Victory program in Western, NY, which services children/youth/families who present with co-occurring I/DD and MH/behavioral issues for stabilization. This is a new program, so the full gain is not yet known, but it does offer a needed service in the system. There are questions/concerns with how discharge planning will go from this facility, as it relates to OPWDD waiver access process, but these concerns are being monitored with intent to work through any issues that may arise.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Albany County LGU will continue to work with local behavioral health providers and OPWDD to maintain current DD services and better equip providers to service individuals with DD issues and/or co-occurring DD/MH/SUD issues. In addition, work towards enhancing service opportunities whenever possible; continuing cross system case coordination; and explore/promote/advocate for training opportunities to help enrich the knowledge and skill base of providers across all 3 disability systems.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Encourage/facilitate providers to offer and participate in cross training opportunities, including those which are offered by OPWDD's NY Systemic, Therapeutic, Assessment, Resources, and Treatment (NYSTART); explore facilitating a targeted training to providers (especially MH and SUD providers) around working with dually diagnosed I/DD individuals.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: Continue to support and facilitate cross system coordination on specific cases, if/when they arise.
    Applicable State Agency: (check all that apply): ☐ OASAS ☑ OMH ☑ OPWDD

Objective 3: Continue to maintain awareness of any integrated service providers within DOH, MH, DD and/or SUD systems (through state licensure and/or DSRIP).
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 4: Facilitate Integrated Planning meetings to allow local providers from all 3 disability systems to meet and collaborate with each other throughout the year.

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

Objective 5: Maintain awareness of the progress in CCO implementation and the impact it has on access to DD Clinical services across the age spectrum.

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

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- Gaining Baker Victory as a new program/resource

2r. Developmental Disability Children Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Throughout Albany County, there are wealth of providers who offer DD children services. Example services include medical care, behavioral health, self-direction, family support, service coordination, respite, vocational/employment, educational, and home and community-based services. There is, however, continue to be high-level unmet needs. As referenced above, there are workforce issues, as well as a shortage of clinical providers for psychiatry, diagnostic/assessment specialist, occupational therapy, physical therapy, and dental with sedation; two additional high-level unmet needs are highlighted below in more detail:

- There is a lack of specialists who can provide diagnostic, functional, and/or behavioral assessments needed to determine the level of service need and/or eligibility; especially for autism (as further discussed below). Furthermore, most insurances do not cover the necessary testing; as a result, the diagnostic process can be very costly for families and/or there is a long wait for specialists who do the appropriate testing. While schools do provide evaluations when appropriate through the special education process, school-based testing does not always lead to a formal diagnosis nor does school-based testing do some of the most pertinent testing that is needed for most services. Previously referenced workforce issues further influence this. There is a need for more Diagnostic/Assessment specialists especially who will accept Medicaid insurance.

- There is a significant lack of residential services for children with DD diagnoses. It is being reported that families are having to "choose" between children's MH services or DD services because although the child may present with eligibility for DD services, they are finding the limitations or lack of capacity for some DD services unmanageable; especially respite and residential services. However, by them choosing MH services instead families may be left without some of the DD services that would be beneficial to them.

As the OPWDD system continues to transition through Care Coordinating Organizations (CCO) implementation there may be more opportunities for treatment services access. Although CCO implementation began a year ago, we are still waiting to determine its impact on the system. There have been some concerns/issues around this transition (as further discussed in the *DD Care Coordination section*).

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

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

The goal/objectives for DD Children Services align with the DD Clinical Services, noted above.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

Same as DD Clinical Services above

2t. Developmental Disability Respite Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

As previously mentioned, there are limited respite providers and a limited workforce of respite workers for community-based respite within the DD system. This has been a strain on the service system and often time's families must wait for services. Furthermore, there has been an overlap of respite services into family support services infrastructure. This adds strain to resources in both areas.

An emerging issue related to respite services includes crisis respite and response for individuals in the community who present with instability and have frequent ER/crisis center/police/DSS/shelter contacts. There is a significant need for crisis respite housing services and crisis care management for OPWDD enrolled individuals. This especially true for individuals who are chronically homeless and/or poorly engaged with their care manager or other service providers that could help facilitate stability. In Albany County, there are several individuals of high need, little or no engagement with providers, and are high users of emergency services. The amount of resources it takes to intervene with these individuals is significant and there are growing safety concerns. Local OPWDD providers and State representatives have been involved in assisting with these cases, but there lacks a process to rapidly respond to these individual's crisis needs to work towards stabilization. CCO care managers are not always available to respond to ERs the same day the individual is in the ER. Housing referrals are being made, the process is lengthy and not responsive to immediate housing needs; local DSS shelters are not adequately equipped to support these individuals' specialized needs (although they do try); respite housing opportunities are limited and only available to those already in a housing placement and/or part of NY START. Much of these individual's crisis response needs are falling to other systems of care (hospitals, police, MH programs, local DSS etc.), which adds additional strain to these systems

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

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

Albany County LGU will continue to work with local OPWDD providers and the OPWDD Regional State offce as needed to maintain the current respite services structure, work towards enhancing service opportunities whenever possible and support implementation of system changes as it relates to respites services. LGU will facilitate opportunities for local DD providers to meet and collaborate with each other throughout the year.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- None; this remains a high level unmet need

2u. Developmental Disability Family Supports - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

As discussed above, the limitations related to workforce issues and shortage of respite providers has led to strains on the DD Family Support services. Families must wait for services because of limited capacity. Furthermore, the limitations of the DD respite services are overlapping with the family support services infrastructure, as both service systems and are often pulling from the same resources.

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

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

Albany County LGU will work with local OPWDD providers and the OPWDD state agency as needed to maintain the current family support services structure, work towards enhancing service opportunities whenever possible and support implementation of system changes as it relates to family support services. LGU will facilitate opportunities for local DD providers to meet and collaborate with each other throughout the year.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- None; this remains a high level unmet need

2w. Autism Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

In Albany County, there is a lack of specialists who can provide diagnostic, functional/behavioral assessments that are necessary to determining level of service need and/or eligibility for those that are presenting with a potential need for autism services. Furthermore, most insurances do not cover the necessary testing; as a result, the diagnostic process can be very costly for families and/or there is a long wait for specialists who do the appropriate testing. While schools do provide evaluations when appropriate through the special education process, school-based testing does not lead to a formal diagnosis nor does school-based testing do the most pertinent testing that is needed for most services. Previously referenced workforce issues further impact this issue. There is a need for more Diagnostic/Assessment specialists, especially who will accept Medicaid insurance. It should be noted, one local provider, Center for Disability Services, did have an existing provider in their network offer new openings for autism assessments in the last few months.

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

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

There is no specific goal/objective for this high-level unmet need at this time. LGU and local providers will continue to advocate and assist with system navigation, as well as explore additional diagnostic and service opportunities whenever possible.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- Center for Disability Services was able to offer additional opportunities for autism assessment.

2y. Developmental Disability Care Coordination - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

In July 2018, the OPWDD system transitioned from Medicaid Service Coordination to Health Home Care Management via a model of Care Coordination Organizations (CCO). There are now six new entities, (CCOs) offering care management services to OPWDD enrolled individual. Implementation of CCOs affected both how DD individuals received their care management services, but also DD services providers. This change influenced workforce issues, organizational structure for agencies that were Medicaid Service Coordination providers, referral processes and service access, and how care coordination will occur. Albany County LGU has maintained an awareness of implementation progress.

Notable challenges recognized in the Albany County system include:

- The transition to the CCO model included changes on how to refer to the OPWDD system for eligibility. Those wishing to seek OPWDD services now refer first to a CCO, and then the CCO manages their application/eligibility process. There have been challenges with this as it relates to timeliness of the process, assisting individuals with how to choose a CCO and assisting individuals with pressing DD service needs. In addition, once an individual is deemed OPWDD appropriate, it appears that formal CCO enrollment can only occur certain times of the month, delaying the start of both CCO and other DD services.
- There has been some concern about what happens when a CCO begins to realize someone likely will not become OPWDD eligible during early stages of the eligibility process. It is known this will result in CCO services ending, but it is not clear yet how transitions to alternative services will occur and/or will those alternative services be sufficient.
- Once an individual is determined newly eligible for OPWDD services, via the CCO process, s/he are enrolled into formal CCO care management services. The CCO then works on additional level of care assessments and development of care plans for the individual. If the individual/family is not readily available or has poor follow through and engagement, this causes a delay in the individual access to services.
- Local OPWDD providers have expressed there are discrepancies and issues with communication about CCO care plans (i.e. dates of Life Plans/addendums/staff action plans) and provider treatment plans. There were examples noted of process/procedural incongruities; for example, the different CCO agencies have different plan formats and/or dates are not matching. These issues are causing unintended compliance concerns, duplication of work, inconsistent documentation. Local OPWDD State Representatives are aware of these concerns and are working to address them.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Albany County LGU will continue to work with local OPWDD providers, OPWDD State offices, and other local behavioral health providers to support successful implementation of CCOs.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Maintain awareness of the progress in CCO implementation and the impact it has on access to DD Clinical services across the age spectrum
    Applicable State Agency: (check all that apply): ☐ OASAS ☐ OMH ☑ OPWDD

Objective 2: Facilitate DD and Integrated Provider/Planning meetings to allow local providers from all 3 disability systems to meet and collaborate with each other throughout the year. Invite CCO representatives to provider/planning meetings.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 3: Facilitate opportunities for non-OPWDD human service/behavioral health providers to have an understanding and awareness of CCO's, especially as it relates to cross system treatment linkages.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- CCO implementation continues

2z. Other Need (Specify in Background Information) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

System Coordination/Integration

The health care system continues to steadily move towards integration between all three mental hygiene disabilities, as well as with other systems such as health/medical, forensics, seniors, children and youth, veterans, and individuals who are Non-English speaking/Immigrant/Refugee. As more individuals are presenting with co-occurring issues, Albany County providers have found it challenging to meet the "special" and sometimes high-level needs of these individuals, especially when considered along with already the existing issues of workforce/retention, service capacity and limitations of resources. There continues to be difficulties referring and bridging individuals across the varying systems of care.

Highlighted areas of presenting issues are reflected below:

- *Human Trafficking-* There is an increasing awareness of the housing and service needs of individuals who are victims of human sex trafficking. Efforts towards community awareness continue including community trainings. Partnerships with law enforcement exist. There is a specialized case manager for this population at the St. Anne's Youth shelter and a Coordinator in Albany County.

- *Non-English speaking/Immigrant/Refugee System:* Albany County remains a resettlement community for immigrants and refugee's via programs in the Capital Region (for example, US Committee for Refugees Immigrants Albany (USCRI)); as a result, there has been a steady population of non-English speaking individuals and/or those who have special cultural assimilation needs. The number of individuals who are "re-settling" in the Albany County area has been steady over the last few years; according to the USCRI-Albany, historically there office assists and facilitates the resettlement needs of over 400 individuals each year and believe there is capacity for more if needed. Over the last 5+ years, there have been a growing number of individuals in this population who are requesting behavioral health services.

There are several considerations when providing services to these individuals, regardless of their language proficiency. However, language proficiency and access to translation services can be one of the biggest barriers to treatment. Translation services are costly (with little to no reimbursement); translation services have been particularly challenging when a non-English speaking individual needs services like housing, care management and/or group treatment services. Children's services programs are reporting an increase need and usage of face-to-face translation services, as opposed to phone line translation, as services typically involve whole families; this can be more costly then phone translation services.

Another challenge is the lack of documentation about this population's behavioral health/health history, which is usually needed to determine diagnoses, especially when trying to determent eligibility for OPWDD services; typically, little to no information is available due to the nature of the individuals' emigration (often they are coming from under-developed and/or war-torn countries).

In addition, there is an emerging issue around these individuals who have legal issues/needs and/or whether they are documented or not; for example, if they are undocumented or having legal issues they may not have the insurance coverage to help them with access to treatment services.

Many of the above referenced challenges apply to any individual with limited English proficiency, regardless of what their immigration status has been.

There has also been a growing issue of stigma as it relates to being an immigrant or refugee; this is regardless of whether someone has a chronic medical and/or behavioral health issue. This issue of stigma has resulted in some individuals not seeking the help they need.

- *Forensic System*: There continues to be several individuals with criminogenic/forensic histories being referred for behavioral health services; many with high-level services needs and/or histories of high-risk behaviors (violence, sex offense, acute substance use treatment needs, and co-occurring health/behavioral health issues). This has caused increased concern and issue for providers' ability to safely maintain these individuals while providing services (both in the community and in office settings). This has also resulted in an increase of Assisted Outpatient Treatment (AOT) referrals/Orders. These individuals need clinical, medical, care coordination and housing services. Providers are sometimes lack the knowledge/skills and resources to address the unique needs of these individuals.

Furthermore, the local service system for children and adults will need to begin preparing for the changes and impact that will result from Raise the Age; as anticipated there has been an increase in youth/young adults presenting with service's needs based on current trends of youth arrests and courts seeking alternatives to incarceration/placement. There is also a noted increase in the need for respite services and independent living programs. Probation officers will continue to facilitate more needs assessments on youth and facilitate linkages when warranted; there continues to be progress made in the development of formal assessment tools practices for probation officers that will be implemented in the near future. Its possible children's providers will need to increase staffing, including psychologists who can do forensic assessments. In addition, there has been a noted increase in court ordered mental health evaluations from local city/town courts throughout Albany County on individuals under the age of 18; Albany County LGU has worked in partnership with Albany County Department of Children, Youth and Families to address this, but it further speaks to the increased volume of forensic service needs for the children/youth population.

There remain issues with OMH prison discharge planning process; established protocols for how OMH Prison Pre-Release Coordinators are supposed to be make these referrals to community providers are not consistently followed. Some individuals continue be provided with a program name, address and phone number and are advised to "walk in" or call independently upon release to the community, with no formal referral being initiated. This leaves the provider with little to no information, nor adequate time to facilitate appropriate coordination of care (for example, medication needs, including injections); or referrals are being made direct to agencies as opposed to the existing Forensic SPOA Coordinator, which also poses its own set of challenges and breakdown of the referral process if not done correctly.

- *Youth in Transition System:* There is a continued need to provide the support and services to aging out/youth in transition. Often there are challenges related to limited resources, translating youth/SED diagnoses to adult/SMI diagnoses, housing placements and youth coming out of forensic detention placements (especially when Albany is not their original county of origin, but they are being referred for Albany services in their transition). Also, as noted above, is the impact Raise the Age will have on this issue. Equinox has a Youth Outreach Program that offers a variety of valuable services for this population.

- *Sex Offenders*: There have always been challenges with finding services for this population. As already reflected throughout this plan, individuals with sex offense histories (whether with formal sex offender "levels" or not) present with higher levels of need. There are very limited options for services whether it be housing, clinical treatment, care management etc.; especially if they concurrently present with other issues like severe MH/SUD/DD diagnoses, high risk behaviors, high risk for re-offending, offenses against children etc. In addition, there are very little sex offense treatment programs that accept insurance; having to pay out of pocket for voluntary or mandated sex offender treatment can be a burden. All this, in addition to the stigma that is typically associated with sex offenders, cause additional difficulties across the service system for these individuals.

- *Medical:* This is a growing issue. Behavioral health clinics, care coordinators and housing programs are finding it difficult to maintain individuals who need the behavioral health services, but their medical conditions make it difficult for them to participate in traditional treatment/services; especially when the medical issues have them in/out of the hospital or not having adequate community services for the medical needs.

- *Non-OPWDD enrolled Developmental Disability*: There remains a steady number of adult individuals presenting with DD symptoms/history who are not enrolled in OPWDD services. Either these individuals' level of acuity and impairment does not qualify them for OPWDD services, or they never applied/enrolled before the age of 21 for some reasons and the documentation/information needed to reflect potential eligibility is unavailable/inaccessible. The non-OPWDD service system is limited in the number of providers who have the skill base and/or capacity to support these individuals. There were positive gains in that MH Care Coordination diagnostic criteria now includes DD diagnoses (as long as it is co-occurring with another qualifying diagnosis); this assists with some individuals, but not all.

- *Seniors:* As the population is aging and living longer there is an increasing need of behavioral health services for seniors/older adults (those 65+) across the services system, most with co-occurring medical issues. Services are needed to support individuals with aging while at home but remaining safe and having a meaningful life. Services are also needed to support those who care about and for Seniors. There is a lack of recreational opportunities for Seniors, especially those with challenging medical and/or behavioral health issues. Recent data on suicides within Albany revealed that suicides for this age group are on the rise. There has been a focus among senior service agencies to work with individuals to prevent scams/fraud. In addition, there has been an increase recognition of the need to educate adults/seniors on the risks and ways to prevent minimize the associated acuity and risks of Alzheimer's. A positive gain in the service system is the continuation of services for Seniors with SUD issues through Senior Hope.

- *Veterans*: Albany County continues to be the home of many military veterans; individuals who served in past wars or those returning from more recent conflicts. These Veterans often struggle with addiction, MH disorders and at times homelessness.

Albany County LGU, along with community providers, participates in several initiatives related to helping to address the presenting needs reflected above, including:

- Participation in the Albany Refugee Roundtable and collaborating with USCRI when needed.

- Participation in the Albany County Long Term Coordinating Council (LTCC) and the Albany County NY Connects/No Wrong Door (NWD) implementation committees.
- Albany County LGU continues to implement the Sequential Intercept Model (SIM). An approach to identifying individuals with behavioral health issues who interact with the criminal justice and crisis/emergency services system to improve interventions. The goal of this continued initiative is to reduce unnecessary incarcerations/hospitalizations, prevent further penetration into the forensic system (when appropriate) , facilitate linkages to services when warranted, and improve how individuals with behavioral health needs interface with these systems.
- There are three Integrated Clinics in Albany County: ACDMH Adult Integrated Mental Health Clinic, the Counseling Center at LaSalle, and Camino Nuevo. Albany County LGU plans to maintain an awareness of any emerging integrated license primary care/behavioral health agencies to help further explore service options in this area. Albany County LGU also continues to advocate and try to engage private providers and medical practices to further support cross system collaboration with integration of services.
- Albany County LGU and providers continue to explore opportunities to expand services for Seniors. It is noted there is a special program for Senior Refugees/Immigrants.
- Albany County continues to have a Community Mental Health and Criminal Justice Unit (CMHCJU) operating the Forensic SPOA that includes facilitating community re-integration and services for OMH prison releases (36 in 2018). In addition, DCJS funded Re-entry Forensic to facilitate community re-integration and services for qualifying individuals (non OMH) prison releases (304 intakes in 2018) and the Albany City court-based Jail Diversion Program (average of 84 active cases in 2018). AOT services (37 referrals with an average of 70+ active cases each month in 2018), and co-facilitated peer support groups in partnership with Albany County Probation Department (with 6 served in 2018; this number is lower than usual because only one session was offered in 2018 due to staffing changes at probation). In addition, there were 192 court ordered evaluations completed in 2018 (including competency exams) by ACDMH staff (across various programs).
- Albany County LGU continues to work with local partners to develop the framework for a Mental Health court.
- Albany County continues to participate in Juvenile, Family, County, and Regional Drug Courts, the Albany City Police's Gun Involved Violence Elimination (GIVE) and Law Enforcement Assisted Diversion (LEAD) initiatives.
- Albany County continues to operate the PSCC, which is a multi-disciplinary, cross system planning committee that works to assist individuals who have high needs and/or are high utilizers of emergency services to decrease dependence and use of emergency services and help improve their quality of life in the community. In addition, youth in transition referrals can be facilitated via the PSCC as well.
- ACDMH continues to collaborate with the Albany VA and other community providers to be attentive to the distinct needs of veterans and their families.
- Albany County remains involved with the State Epidemiological Workgroup (SEW).
- Albany County state licensed agencies also continue to have access to the Center for Practice Innovations (CPI) training programs, many of which address cross systems treatment issues.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Albany County LGU in partnership with local providers will enhance and further develop an integrated system of services that will address the needs of all behavioral health consumers across the age spectrum and all three disabilities, independent of any additional "special needs" the individuals may have.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Build upon Albany County LGU's commitment to train all employees in trauma informed care (e.g. Adverse Childhood Experiences (ACE) training); Screening, Brief Intervention and Referral to Treatment (SBIRT), Human Trafficking, and integrated treatment practices and encourage community providers to do so as well.
Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: Albany County LGU will continue to work with local partners to develop the framework for a Mental Health court.
Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 3: Albany County LGU and local providers will continue to participate in relevant initiatives that support strengthening cross system collaboration and partnerships. This in turn enhances the services available to consumers. This includes (but is not limited to) the following: GIVE, LEAD, NY Connects, Long Term Care Coordinating Council (LTCC),

Refugee Roundtable, OPWDD Regional Directors Meetings, OPWDD's NY Systemic, Therapeutic, Assessment, Resources, and Treatment (NYSTART) Advisory Council, Veteran's services, Albany County Department for Children Youth and Family (DCYF) initiatives, Women & Infants, Linking Lifetime Opportunities for Wellness (WILLOW), and Youth in Transition coordination

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

Objective 4: ACDMH will continue to maintain an Integrated treatment license and will support/ encourage other providers to seek an integrated license.

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

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- There have been numerous changes reflected in narrative above. In general, serious challenges remain despite positive gains.

2aa. Other Need 2 (Specify in Background Information) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

System Transformation

All three disability areas across the age spectrum are in the midst of system transformation with OMH, OASAS, OPWDD and Children's Systems transition to managed care, regulation changes (e.g. OASAS Residential Redesign, Children's system HCBS waiver changes/unbundling, integration of services, BHCCs, Value Based Payment and DSRIP ending. Albany County LGU and local providers continue to work through these processes as best as possible. There is an experience of initiative fatigue amongst providers. There is also concern of sustainability of temporary funding from state/federal grants, DSRIP etc., especially as providers are finding reimbursable rates are not providing the revenue needed to sustain programs.

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

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

The main goal/objectives at this time is for Albany County LGU and providers to remain aware of and involved in all relevant initiatives and continue towards system transitions.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- Newly added/identified issue category

2ab. Problem Gambling - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

There remains an ongoing need to maintain and enhance gambling prevention and intervention services. There is increased awareness and concern with the lack of credentialed gambling treatment staff and gambling specific treatment providers. There is a need to develop training that is more effective, coordinate with other behavioral health providers, and identifying/referring individuals to appropriate problem gambling treatment programs.

As with other disorders, Problem Gambling negatively effects individuals, families, and communities. Over the years attempts to address problem gambling have, though well intended, been far short of the need. Data from OASAS CDS shows that a high percentage of screenings are performed but that a very low percentage screen positive. This indicates improvement in assessment/screening is warranted. The use of screening tools and well-designed treatment approaches have been less then what is needed. With the identification as a separate goal there now comes a way to focus resources on effectively identifying, referring and/or treating this disorder. There remains a high need to identify and connect individuals to services.

Albany County has a (new) Northeast Region Problem Gambling Resource Center and a stand-alone treatment clinic (Center for Problem Gambling).With these resources Albany County is in a positive position to capitalize on these resources to better serve our community.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Albany County LGU will encourage and support treatment providers (across the behavioral health service system) to implement/expand use of best practice problem gambling screening tools and to make referrals to specialized gambling treatment services for individuals screening positive for problem gambling.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Facilitate/encourage training on best practice gambling screening and referral/intervention practices across all three disability (OASAS, OMH and OPWDD) areas. This includes continuing to collect data on frequency of gambling screenings.
　　Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: Identify and support treatment providers in prevention training of individuals at risk.
　　Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 3: Maintain awareness of the growing service system now that OASAS providers can offer treatment and accept individuals who have problem gambling "only" diagnosis.
　　Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 4: Maintain awareness of progress on pending implementation of the specialized gambling LOCATDR.
　　Applicable State Agency: (check all that apply): ☑ OASAS ☐ OMH ☐ OPWDD

Objective 5: Explore how peer/recovery services can be expanded to the gambling service community.
　　Applicable State Agency: (check all that apply): ☑ OASAS ☐ OMH ☐ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- The new Northeast Region Problem Gambling Resource Center

2ac. Adverse Childhood Experiences (ACEs) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Adverse Childhood Experiences (ACE) can have a lasting impact on individuals of all ages- behaviorally, medically, socially and developmentally, regardless of additional MH/SUD/DD issues. Recognizing risks early on with children/families and implementing interventions as early as possible is key. For adults, identifying past history of exposure and implementing appropriate interventions is also key. Prevention services and all relevant treatment services, as outlined throughout this local services plan, are the best approach to addressing ACE issue. Also, recognizing that there may be adverse experiences that individual may have and be impacted by that are in addition to those originally identified in the original published ACE assessment is important. Overall, trauma informed and sensitive services, for any adverse experience, is the best practice providers should be striving for and is the standard Albany County LGU holds for the provider system.

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

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

There are no identified goals/objectives for this area of need at this time. The strengths/gaps/challenges and goals/objectives reflected throughout this plan will have an equal impact on addressing ACEs as it does on any other issue area. Throughout the Albany County service system providers are aware of and are actively addressing ACE through assessment, evaluation, training of staff, interventions and services. Albany County LGU will continue to maintain an awareness of encourage expansion of training opportunities and expansion of best practices as it relates to screening and treatment of ACE.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

- Newly added/identified issue category

COMPLETE

Tuesday, November 10, 2020 4:26:39 PM

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Q1

Contact Information

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Q2

LGU:

Albany County Dept. of Mental Health

Q3

a.   Indicate how your local mental hygiene service system (i.e., mental health, substance use disorder and problem gambling, and developmental disability populations), overall, has been affected by the COVID-19 pandemic: Please specifically note, Any cross-system issues that affect more than one population; Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

COVID related issues that have impacted more than one population include:

• Housing- Across all Systems, the ability to transition between housing programs has been significantly limited and the ability to discharge/evict from housing programs has stopped. This effects consumers' ability to transition between levels of care, posing a challenge for programs to have to maintain consumers who are presenting with various challenging behaviors/issues at the inappropriate level of care. In addition, there are fiscal consequences to agency-based housing programs and for private landlords when individuals are not paying their rent and/or they cause costly damage.

In addition, housing programs with group living models maintained these levels of service while addressing the varying safety and health risks that came as a result of COVID; such as consumers interactions with each other, staff, and others in the community; preventing/minimizing family/friend visits to the home; educating consumers about COVID and the new lifestyle practices (masks, social distancing etc.); navigating the health risks of staff coming in/out of the home including risks to themselves and the risks they bring to the home from their own lives; navigating some consumers altered access to clinical services (using telehealth, no day programming etc.); and helping consumers still have meaningful experiences in their life despite the challenges of COVID.

Some individuals came to the area from downstate and elsewhere in NY to avoid COVID "hot spots." This led to increased population of homeless/transient individuals- who then presented with need for shelter, housing, and/or services.

Lastly, proposed State agency funding withholds impacted agency-based housing programs significantly, including causing access issues/shortages and exacerbates work force challenges.

• Workforce- Due to COVID there have been staffing challenges as it relates to maintaining minimal staffing patterns while also maintaining regulatory standards of spacing/# of people in a room etc. In addition, staff who are caregivers to children who were out of school/childcare or who have alternative school models (i.e. virtual) has posed additional challenges on both the staff and the agencies. Lastly there are issues with staffing and maintaining staff patterns while navigating those who test positive for COVID, have pending test results, need quarantine, present with concerning symptoms, have family members who are ill or might be ill, and/or exposed in their personal lives or work. Some agencies have had to lay off or furlough their staff. In addition, there were issues at times related to staff having the limited ability/technology to work remotely. COVID exacerbated pre-existing workforce issues in the services system.

• Fiscal viability- COVID has impacted the fiscal viability of providers across the service system due withholds and/or loss of revenue and/or government-based funding. In addition there has been increased expenses related to a) facility/building changes being made to meet COVID safety requirements, b) technology needs (e.g., purchasing equipment and web-platform services like zoom, doxy, etc.) and c) the purchasing of Personal Protective Equipment and related cleaning items. Some programs had to close or lessen the availability of their services, such as the loss of psychiatric hospital beds. The increase in expenses, continued demand for services (and in some cases an increase) combined with the fiscal issues/limited funding at the State and Federal level further add to fiscal concerns.

• Crisis Services- Across the service system, crisis service providers have had to manage the continued steady stream of request for crisis services (and in some cases an increase in presenting need) while also managing appropriate precautions related to COVID. This includes serving individuals that are known to be COVID+ and/or presenting with high risk COVID exposure behaviors, and/or finding/securing higher levels of care for individuals who present in need while also being COVID+ and/or high risk (i.e. a psychiatric ER seeking an inpatient hospital bed). The RSS CDSS program had lessened their bed availability from 3 beds to 1 as a result of COVID, however they recently increased to 2 beds. Both ACDMH Mobile Crisis Team and the Northern Rivers Mobile Crisis team (the latter serving children only in Albany County) remained active during the COVID shutdown and throughout the pandemic; they primarily

latter serving children only in Albany County) remained active during the COVID shutdown and throughout the pandemic, they primarily provided telephonic crisis support when clinically appropriate, but did provide in person support when necessary.

Albany County (as a whole) implemented a COVID MH support line that was available to the community from 8am - 8pm throughout the pandemic (including present day), which was managed by ACDMH and staffed primarily by Mobile Crisis Team members, as well as other ACDMH Emergency/Disaster MH Team member and some partner agencies.

• Employment- As a result of the COVID shut down many businesses/employers either shut down, altered, or minimize how they have provided services; this impacted the overall workforce in communities in many ways (e.g., lay-offs, hours cut, navigating working while concerned with health risks, navigating working while children were out of school/child care etc.). Many individuals in society, including Mental Hygiene consumers, had to navigate these challenges.

• Prevention- During the peak of the COVID shutdown and ongoing throughout the pandemic there is an increased need for the awareness of suicide risk and suicide prevention efforts across all disability areas. Due to the reality and nature of this pandemic there is increased isolation, life stressors, economic struggles etc. and decreased access to moral support (due to social distancing, school shutdown etc.) and access to resources. Albany County provider system has maintained suicide prevention efforts throughout (for example, a dedicated COVID support line for Albany County residents)

• Inpatient - Across the service system inpatient service providers have had to manage the continued steady stream of request for psychiatric and SUD inpatient treatment services (and in some cases an increase in presenting need) while also managing appropriate precautions related to COVID. This includes serving individuals that are known to be COVID+ and/or presenting with high-risk COVID exposure behaviors, and discharge planning for individuals who are COVID+ and/or high risk for COVID exposure. In addition, due to workforce and fiscal challenges, multiple hospitals in the Capital Region area lessened their psychiatric inpatient bed census; across this region, there have been close to 40 psychiatric beds lost. This shortage exacerbates an already existing issue of not having enough inpatient beds. SUD Inpatient remain available in terms of capacity; however these programs also have to navigate the mentioned issues of COVID health and safety needs.

• Care Coordination- due to the nature and reality of COVID, necessary safety precautions, and regulatory mandates, Care Coordination services was less in person and more telehealth focused during the peak of the COVID shutdown. The suddenness of this transition posed challenges for consumers and staff, especially when considering not all consumers have phones or internet capability to do telehealth practice. In addition, care coordination needs increased due to COVID related issues. To date, all care coordination programs for health homes and CCO (for children and adults) are doing a hybrid approach to services (some in person and some via telehealth).

• Other Need: Refugees and Immigrants- individuals who are refugees/immigrants and/or have limited English proficiency experienced additional challenges with navigating the mental hygiene service system throughout COVID – for example, implementing translation services in conjunction with telehealth services was successfully offered by providers, but not all refugees and immigrants had the technology or knowledge on how to do this; some individuals from this population experienced heightened fear/anxiety from the pandemic as they had already dealt with similar experiences from their country of origin (re-traumatization)

• Community provider indicated that there has been a disproportionate of those residing in under-served areas, many of which are Black/African American, that have been most notably impacted by COVID-19.

• Across all disability areas, consumers having access to technology and/or enough data/minutes to engage in telehealth services was an additional challenge many had to navigate.

Q4

b.   Indicate how your mental health service needs, overall, have been affected by the COVID-19 pandemic:Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

• Housing- See #1A above.

• Crisis Services – See #1A above.

• Workforce Recruitment and Retention (service system) – See #1A above.

• Employment/ Job Opportunities (clients) – See #1A above.

• Prevention – See #1A above. Also, prior to COVID, school districts had already begin the process of implementing mental health/social emotional learning prevention services and programming into their curriculum; as a result of schools being shut down, and now having varying levels of limitations, progress on these prevention efforts have been impacted. In addition, limited ability to interact in person and assess mental status/needs/issues for individuals of all ages hinders the ability to prevent onset or worsening of potential mental health issues.

• Inpatient Treatment Services- See #1A above.

• Recovery and Support Services – Peer support services remained available to individuals via telehealth practice during the COVID shutdown period. More recently, the Capital Area Peer Services Drop In Center has become available for in person services with some additional safety practices implemented and lowered maximum capacity to allow for appropriate spacing.

• Mental Health Clinics – MH clinics in Albany County (for adults and children) remained opened and continued to service patients throughout this COVID pandemic while navigating the varying challenges, including the aforementioned issues of workforce recruitment/retention, addressing/preventing health risks to staff and consumers, cost of and shortage of access to PPEs and cleaning supplies etc. All Clinics transitioned to offering telehealth services, while also continuing to provide in-person services for those who were psychiatrically high risk, had specific needs (e.g. injections), and/or who did not have adequate personal technology (like telephones or computers) to engage in telehealth services. School based clinics transitioned to telehealth services for families as well. Some clinics have indicated improved no show rates since transition to telehealth, but also noted as the community began to "open back up" the no show rate began to re-increase. There was no shortage of referrals/requests for services, and some clinics reported an increase in requests. One satellite-based clinic for children did permanently close during the COVID shutdown period, but all families were provided with comparable alternative treatment options.

• Other Mental Health Outpatient Services (non-clinic)- As a result of the COVID pandemic, all the Albany County PROS programs initially suspended in-person classes and clinical appointments; individuals with specific specialty need (high risk, injections etc.) did continue to receive in person clinical services. Clinical services (i.e. psychiatric) transitioned to telehealth, and eventually telehealth classes began to be offered. Many consumers expressed "liking" classes via telehealth. However, some had difficulty with having enough minutes/data to attend extended telehealth appointments (i.e. multiple groups). To date, all PROS program has transitioned to a hybrid approach of offering both in-person and telehealth programming.

• Mental Health Care Coordination- See #1A above. In person care coordination services, in conjunction with a hybrid of approach of telehealth, did continue for MH Care Coordination services when clinically necessary. For example, the Albany County ACT Team continued to see individuals in person for medication, crisis and urgent clinical needs.

• Other Need - see #1A above.

Q5

c.   Indicate how your substance use disorder (SUD) and problem gambling needs, overall, have been affected by the COVID-19 pandemic:Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

• Housing - see #1A and below SUD Residential Treatment Services

• Transportation – Transportation services from residential programming continued as necessary but were kept minimal and involved maintaining appropriate COVID healthy/safe practices. In nonresidential programming, clients continued to rely on transportation resources in the community (MAS, public transportation etc.) which had its related strengths/barriers. In many cases, clients had access to telehealth services, which minimized the need for transportation.

• Crisis Services – See #1A above. SUD Crisis services continued to be available. Many transitioned to being offered via telehealth during the peak of the COVID shutdown, for the health and safety of all. All programs are now offering a hybrid approach of in person and/or telehealth services, with appropriate COVID precautions in place when necessary. In addition, with there being less in person assessments (when clinically appropriate) the triage process was more refined to allow more direct referrals being made from the point of phone/telehealth assessment (as opposed to having an in person/in community assessment in between).

• Workforce Recruitment and Retention (service system) – See #1A above.

• Employment/ Job Opportunities (clients) - See #1C Reducing Stigma below.

• Prevention – See #1A above. Also, SUD prevention programs adjusted in order to continue providing services. School based programs were impacted when schools closed and are now exploring alternative modes of providing the service as schools are opening including creating a web-based delivery system.

• Inpatient Treatment Services – See #1A above

• Recovery and Support Services - This area was impacted in that personal, one on one, connections is ingrained in recovery and support services. Due to safety, recovery focused group events and support meetings were shifted to virtual settings. This added to possible isolation of individuals and increased risk of relapse. Due to churches and community buildings closing- access to self-help groups (NA, AA etc) were limited to online services only until buildings/programs re-opened. There was a wealth of online self-help groups available, but not everyone had the means to access.

• Reducing Stigma- Stigma has always been an issue, whether it is public perception, or one substance user being perceived as worse than another. COVID further exacerbated stigma for this population, as there was the added worry of a contagious illness. Individuals in contained environments, residential setting and/or correctional settings were impacted that much more due to the limited ability to socially distance and limited space for isolation and PPE limits/shortages, increasing possible exposure.

• SUD Outpatient Services Outpatient services were dramatically impacted in that the system shifted to tele-practice service, and providers had to institute additional safety protocols for individuals needing face-to-face services. This shift was a drastic change in traditional services, affecting both clients and staff. The system adapted, however, with evidence of improved attendance in some cases. In addition, the ability to obtain regular UDS testing was impacted by COVID (it occurred less) which comes with a whole other host of concerns related to monitoring whether it be for court, probation, or just tracking abstinence levels for recovery.

• SUD Residential Treatment Services – Similar to what's referenced under Housing #1A, programs were negatively impacted due to the added policies/procedures/practices/expenses related to COVID safety precautions. Programs had to adapt to the need of isolating individuals who tested positive for COVID 19 and they had to submit daily reports on this status. See also Workforce issues referenced above, as SUD Residential Treatment Programs were impacted in this area as well. Residential providers indicated a decrease in referrals from legal sources due to court systems having some sort level of shutdown as well. There was a closure of an adolescent residential treatment facility, which was then redesigned to an 820 adult program. While it is noted that this closure is not

directly related to COVID, it was still a service loss in the midst of the pandemic.

• Heroin and Opioid Programs and Services – These programs remained open and available, just as other programs, however there was a need for them to remain available for in person services at a more frequent level due to daily dosing of methadone. This was adjusted to some degree with OASAS implementing multi-dose distribution for some of the population, although there continues to be a demand/access for daily dosing and access to a medical consultation. There was also an overall spike in opioid overdoses reported in some areas resulting in an increased need for interventions, while also navigating the limitations due to health/safety risks.

• Coordination/Integration with Other Systems for SUD clients- See #1A above for areas of overlap. The COVID pandemic made integration efforts between the three disabilities more challenging at times due to an increase in limitation of resources.

• Other Need – see #1A above

• Problem Gambling- Similar to all SUD services, Problem gambling was impacted in that there was a transition to tele-health services and virtual support meetings. In addition, the casinos/gambling establishments closed during the peak of the pandemic- which in some ways has it pros (i.e. individuals aren't able to access the gambling), but the downside would include people being at risk of experiencing withdrawal or having to find alternative modes of addressing their disorder. In addition, individuals lost access to the interventions that are displayed and available at the gambling establishments (e.g. phone #s, PSAs etc.). Also, during the lockdown, their gambling behaviors may have gone more unnoticed. Gambling family support programming reported decrease in attendance due to the impact of the COVID pandemic.

Q6

d.   Indicate how the needs of the developmentally disabled population, overall, have been affected by the COVID-19 pandemic:Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

• Housing/Developmental Disability Residential Services – See #1A above. Loss of day programming and altered family visitation to group homes were notable areas of issue for the DD system.

• Crisis Services – See #1A above. NYSTART continued to provide services to consumers and providers throughout the COVID pandemic via telehealth.

• Workforce Recruitment and Retention (service system) – See #1A above.

• Employment/ Job Opportunities (clients) – See #1A above

• Prevention – Due to school/childcare center shut downs and alterations of how school is provided (e.g. virtually), the ability to observe potential presenting issues in children (i.e. early identification) is impacted, as is the ability to implement early intervention/prevention practices. Access to evaluations/testing opportunities were also impacted by the COVID pandemic.

• Inpatient Treatment Services – same as above under #1A. In addition, previously existing challenges related to inpatient treatment services for the DD population remain and are exacerbated by the challenges of COVID (i.e. little to no availability of inpatient programs that specialize in the DD population and presenting needs, complications in discharge planning etc.)

• Developmental Disability Clinical/Children Services/Autism Services- Services continued as best as they could, however many transitioned to telehealth services as a result of the pandemic. Services that were provided in schools/childcare settings were impacted when schools/childcare settings shut down and until telehealth services could be implemented. Some children/adults lost the structure of day programming. Medical appointments were also impacted (postponed and/or altered in how they were provided). And as previously mentioned, access to evaluations/testing opportunities were also impacted.

• Developmental Disability Service Coordination- See #1A above.

• Other Need - See #1A above.

Q7

a. Mental Health providers

* Suicide Prevention/Intervention services in the midst of COVID-19; COVID agitates risk factors. Need a 3 digit help hotline sooner rather than later.

* Need for training around increased violence offenses and victimization and building coping skills among youth and young adults; while this is not COVID specific, there has been an unprecedented increase of violence within communities, including in NY/Capital Region concurrently with COVID

* Effective provision of telepractice services.

* Avoiding provider burnout in pandemic times

* Building resilience

Q8

b.   SUD and problem gambling service providers:

* Effective provision of telepractice services.

Q9

c.   Developmental disability service providers:

* Effective provision of telepractice services.

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Q10

a.   Since March 1, 2020, how would you describe DEMAND for mental health services in each of the following program categories?

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	**Increased**
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	**Increased**
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	**Increased**
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	**Increased**
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	**Increased**

Q11

If you would like to add any detail about your responses above, please do so in the space below:

* Inpatient: There appears to be an increase in demand for Inpatient treatment services, however its not clear if this is due to an increase in individuals presenting with acute needs or if the decrease in available inpatient beds is making it seem like there is more demand up against decreased capacity

* Residential: Providers are report no increase than usual in demand for OMH residential services, however lack of movement in/out of housing opportunities (due to COVID) and funding changes have impacted access, which makes the steady demand more challenging. Some individuals came to the area from downstate and elsewhere in NY to avoid COVID "hot spots." This led to increased population of homeless/transient individuals- who then presented with need for shelter, housing, and/or services.

* Emergency and Support: There has been an increase in the demand for both of these categories. Family support program indicated increase in request for this service.

Q12

b.   Since March 1, 2020, how would you describe ACCESS to mental health services in each of the following program categories?

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)   **Decreased**

OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)   **Decreased**

RESIDENTIAL (Support, Treatment, Unlicensed Housing)   **Decreased**

EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)   **Decreased**

SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)   **Decreased**

Q13

If you would like to add any detail about your responses above, please do so in the space below:

There is a reported decrease in access to services in all areas throughout the pandemic. In some areas (notably inpatient) the access is due to capacity issues (i.e. the Region has lost about 40 psychiatric inpatient beds). In the other areas the decrease in access is more related to access to in-person services; limitations with being able to provider services at an in person level has impacted availability and access. Overall, however, services are still in place and available to the community.

Q14

a.   Since March 1, 2020, what number of mental health program sites in your county closed or limited operations due to COVID-19, apart from transition to telehealth?

9

Q15

If you would like to add any detail about your responses above, please do so in the space below:

• All 3 PROS programs temporarily suspended groups/classes until telehealth groups/classes could be arranged (which did eventually occur). All are now offering a hybrid of in person and/or telehealth groups/classes.

• Across this region, there have been close to 40 psychiatric beds lost.

• CDSS is usually a 3 bed program but moved to only 1 bed at the peak of the pandemic and is now back up to 2; there is intent to eventually move back to 3 beds.

• RSS Living Room recently closed. It is noted this was primarily due to loss of a DSRIP funding source and not due to the pandemic, however it is still the loss of a valuable resource.

• BHNNY Cares program recently ended; they stopped taking referrals in Fall 2020 and will stop serving individuals by the end of the year. It is noted this was primarily due to loss of a DSRIP funding source and not due to the pandemic, however it is still the loss of a valuable resource.

• 1 peer drop-in center (CAPS) remains open but has limited their maximum capacity due to the pandemic.

• One satellite-based clinic for children did permanently close during the COVID shutdown period, but all families were provided with comparable alternative treatment options. It was noted this was already in process pre-COVID pandemic but was finalized during and as a result of it.

Q16

b.   What number of mental health program sites in your county remain closed or are offering limited services now, apart from transition to telehealth?

5

Q17

If you would like to add any detail about your responses above, please do so in the space below:

• One clinic must remain at primarily telehealth services (aside from injections, those with clinical need etc.) until construction is complete to allow for more appropriate social distancing needed due to COVID. Construction/renovations are needed to allow for appropriate spacing practices between staff and consumers.

• Across this region, there have been close to 40 psychiatric beds lost.

• CDSS is usually a 3 bed program but moved to only 1 bed at the peak of the pandemic and is now back up to 2; there is hope/intent to eventually move back to 3 beds.

• BHNNY Cares program recently ended; they stopped taking referrals in Fall 2020 and will stop serving individuals by the end of the year. It is noted this was primarily due to loss of a DSRIP funding source and not due to the pandemic, however it is still the loss of a valuable resource.

• 1 peer drop-in center (CAPS) remains open but has limited their maximum capacity due to the pandemic.

Q18

c. If your county operates services, did you maintain any
level of in-person mental health treatment

Yes

Q19

If you would like to add any detail about your responses above, please do so in the space below:

ACDMH continued to offer in person mental health treatment services across all programs to those with presenting clinical need
(crisis, injections etc.) and/or those who did not have adequate technology to engage in telehealth.

Q20

d.   As a result of COVID-19, are any mental health
programs in your county closing operations permanently?
If yes, list program name(s) and type(s).

No

Q21

If you would like to add any detail about your responses
above, please do so in the space below:

Respondent skipped this question

Q22

e.   Did any mental health programs in your county close
due to workforce issues (e.g. staff infections,
recruitment/retention issues)?

No

Q23

If you would like to add any detail about your responses
above, please do so in the space below:

Respondent skipped this question

Q24

a.   Apart from telehealth, during COVID-19, did your county or mental health providers within your county develop any innovative services or methods of program delivery that may be continued post-COVID? If yes, please describe.

Yes (please describe):
Albany County (as a whole) implemented a COVID MH support line that was available to the community from 8am - 8pm throughout the pandemic (including present day), which was managed by ACDMH and staffed primarily by Mobile Crisis Team members, as well as other ACDMH Emergency/Disaster MH Team member and some partner agencies. ACDMH explored alternative options for Substance Use/UDS screenings considering the challenges posed by COVID and is currently transitioning to a new vendor that offers both UDS and saliva testing options, as well as opportunities (when implemented) to remote saliva based drug testing. Alliance for Better Health provided mental health providers with access to Zoom services to help support and facilitate telehealth implementation. A provider indicated that via telehealth services they were able to match like youth across the region who may not have otherwise been able to work together in the same group, as well as able to pair caregivers at different phases in the continuum of care.

Q25

b.   During COVID-19, did any mental health providers within your county form any partnerships with other providers that may be continued post-COVID? If yes, please describe.

No

Q26

a.   During COVID-19, how many mental health providers within your county implemented existing continuity of operations plans?

6

Q27

If you would like to add any detail about your responses above, please do so in the space below:

6 MH providers (ACDMH, RSS, Equinox, AMC, Northern Rivers/Parsons, and CDPC)

Q28

b.   During COVID-19, how many mental health providers within your county did not implement existing continuity of operations plans?

0

Q29

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q30

c.   During COVID-19, did your county LGU or Office of Emergency Management (OEM) assist any mental health providers in the development or revision of continuity of operations plans?

None

Q31

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q32

During COVID-19, what OMH guidance documents were beneficial to your disaster management process?

Program-level Guidance,

Telemental Health Guidance,

Infection Control Guidance,

Fiscal and Contract Guidance,

FAQs

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Q33

1. Please indicate any needs for or issues with SUD and problem gambling prevention, treatment, and recovery providers acquiring Personal Protective Equipment (PPE), face masks, cleaning or disinfectant supplies, or similar materials related to the COVID-19 pandemic:

In the initial stages of the COVID 19 all programs were short on any PPE. Slowly the response to garner supplies was initiated by the programs, often on their own. Programs rallied and shared wherever and whenever they could. Eventually the state response kicked in and eased the stress to some degree. There are some reports, currently, that programs are having some difficulties with continuing to keep enough supplies on hand.

Q34

a.   How has COVID-19 affected the delivery of and demand for SUD and problem gambling prevention services in your county?

Prevention programs were effected like others in that the switch to tele-practice caused an initial disruption of delivery. School based prevention programs had a dramatic initial stop, as schools closed and coordinated access to virtual classrooms took time to establish. With the new school year, new innovative approaches are being explored.

Q35

b.   How has COVID-19 affected the delivery of and demand for SUD and problem gambling recovery services in your county?

All programs had to shift to tele-practice thus reducing personal contact. There was a slight decrease in services provided initially as everyone adjusted the "new normal". There has been positive progress with telehealth, as this has helped improve attendance at sessions. Individuals were able to be in sessions from their homes and not have transportation issues or childcare issues, etc.

Q36

c.   How has COVID-19 affected the delivery of and demand for problem gambling treatment services in your county?

Problem gambling services were effected essentially the same as substance use programs. Tele-practice was implemented, and services were able to continue. As with all the programs, the initial impact was quite significant but leveled out as everyone adapted to the "new" processes.

Q37

d.   Since March 1, 2020, how would you describe DEMAND for SUD Treatment services in each of the following program categories?

INPATIENT	**No Change**
OUTPATIENT	**No Change**
OTP	**No Change**
RESIDENTIAL	**No Change**
CRISIS	**No Change**

Q38

If you would like to add any detail about your responses above, please do so in the space below:

It must be noted that there was no overwhelming change in the SUD demand; some providers noticed some decrease and/or increase, but no definitive patterns/outcomes. It would appear a future picture may show individuals in need (demand) of services increased. People initially may not have reached out, but over time will move to access services in greater numbers.

Q39

e.   Since March 1, 2020, how would you describe ACCESS to SUD Treatment services in each of the following program categories?

INPATIENT	**No Change**
OUTPATIENT	**No Change**
OTP	**No Change**
RESIDENTIAL	**No Change**
CRISIS	**No Change**

Q40

If you would like to add any detail about your responses above, please do so in the space below:

Access to services, though initially interrupted, became accessible with minimal impact. Once programs and individuals became accustom to the tele-practice model, accessing services seemed to flow relatively smoothly.

Q41

a. Apart from telehealth, during COVID-19, did your county or SUD and problem gambling service providers within your county develop any innovative services or methods of program delivery that may be continued post-COVID? If yes, please describe.

Yes (please describe):
One provider indicated adding additional evening groups as a result of COVID-19. Increase access to online "self-help" support groups SUD adolescents able to interact with peers regardless of whether they were community based or residentially placed due to the platform of telehealth services

Q42

b. During COVID-19, did SUD and problem gambling service providers within your county form any partnerships with other providers that may be continued post-COVID? If yes, please describe.

No

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Q43

1. Has your county conducted analysis on the impact of COVID related to IDD services/OPWDD service system? If yes, please explain.

Yes (please explain):
Albany County LGU put out a survey monkey, as well as hosted a provider/planning meetings, which all OPWDD providers who service Albany County had the opportunity to participate in (along with other providers throughout the service system and other disability areas).

Q44

2. What are the greatest challenges your county will be facing over the next 12 months related to IDD services?

• Providing continuity of care despite fiscal challenges,
• The continued risks and uncertainties of the COVID pandemic (health and safety wise)
• Continuing to transition towards telehealth care practices- not all agencies and/or consumers have the necessary technology for this; especially consumers who don't always have a consistently working phone, computer, device, or internet.
• Navigating the challenges related to providing in person services- which is a huge part of IDD services (respite, community habilitation, day programming etc.). Providers indicated OT/PT/Speech is a challenge to provide via telehealth (i.e. not designed for it). Care Coordinators have decreased ability to accompany consumers to appointments for support (like medical etc.)
• If distancing and other restrictions continue, this continues to place challenges with visits of family/friends to residential programs.
• The challenges of balancing a consumer's "individual rights" to make choices for themselves, and yet keep the consumer and the community safe when there are COVID risks.
• Challenges for Care Coordinators to find services for individuals as various types of services remain limited and/or difficult to access.
• Challenges reflected under #1A above

Q45

3. Is there data that would be helpful for OPWDD to provide to better information the local planning process? Please list by order of priority/importance.

Census of programs (how many available openings are there in a particular program in a particular time).

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Q46

Please use the optional space below to describe anything else related to the effects of COVID-19 on Mental Hygiene service delivery that you were not able to address in the previous questions:

Developmental Disabilities:
* identified strengths/innovative practice: Creation of a closed private Facebook group for people to connect and participate in virtual events together