2016
Local Services Plan
For Mental Hygiene Services

Nassau Co Office of MH CD &DD Svcs OTP
July 14, 2015

Table of Contents

2016 Needs Assessment Report
Nassau Co Office of MH, CD and DD Svcs (40150)
Certified: James Dolan (6/30/15)

Consult the LSP Guidelines for additional guidance on completing this exercise.
PART A: Local Needs Assessment

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

Nassau County, a suburb of New York City, has a population of 1,339,532 as of the April 1, 2010 population census. It is the most densely populated county outside New York City in the downstate region. It is a mature suburb that is slowly undergoing changes – the population is aging, and it's becoming more diverse with many more immigrants of Hispanic and Asian origins. Transportation and housing continue to be major issues that affect all county residents, but especially those with special needs due to behavioral health and/or developmental disabilities. In order to assess the nature and extent of mental hygiene disabilities and related issues, we rely on information from many sources: national and state population surveys, local provider surveys, patient satisfaction surveys, advisory groups, task forces, community forums, and analysis of secondary data. The National Survey on Drug Use and Health (NSDUH) provides yearly data on the percentage of individuals with behavioral health problems in the United States, as well as on the percentage of individuals receiving treatment or counseling for behavioral health problems. The results of this survey are highlighted below: Nation-wide for individuals aged 12 or older Illicit Drug use in the 30 days before survey interview (current use) • 9.4% of the population aged 12 or older or an estimated 24.6 million Americans were current illicit drug users • Marijuana was the most commonly used illicit drug (7.5% or 19.8 million current users aged 12 or older • 2.5% or 6.5 million nonmedical users of prescription-type drug of which 1.7% or 4.5 million were users of prescription pain relievers • 0.6% or 1.5 million current cocaine users • 0.5% or 1.3 million users of hallucinogens • 0.2% or 496,000 were current inhalant users • 0.1% or 289,000 current heroin users aged 12 or older Illicit Drug use in the year prior to being surveyed • 2.6% of individuals aged 12 or older (an estimated 6.9 million individuals) in 2013 were dependent on or abused illicit drug within the year prior to being surveyed (This percentage has not changed significantly since 2009.) • Young adults aged 18-25 had the highest percentage (7.4%) of illicit drug dependence or abuse compared to 3.5% for 12-17 year olds; 3.1% for 26-44 year olds; 1.1% for those 45-64 year olds and 0.4% for 65 or older adults. • Illicit drug dependence or abuse was more prevalent among males (3.4%) than among females (1.9%) Alcohol Use • 6.6% of persons aged 12 or older (an estimated 17.3 million individuals) in 2013 were dependent on or abused alcohol within the year prior to being surveyed • The percentage of alcohol dependence or abuse decreased from 7.5% in 2009 to 6.6% in 2013. The decrease was found for adolescents aged 12-17 and young adults aged 18-25 but not for those in older age groups • 56.4% of adults aged 18 or older were current users of alcohol; 24.6% were binge alcohol users (drinking five or more drinks on the same occasion on at least 1 day in the past 30 days Nation-wide for Adolescents aged 12-17 • 8.8% of adolescents aged 12-17 (an estimated 2.2 million adolescents) reported using illicit drugs within the month prior to being surveyed • The percentage of adolescents using illicit drugs decreased from 10.1% in 2009 to 8.8% in 2013 • Marijuana and nonmedical use of psychotherapeutics were the most commonly used illicit drugs by adolescents in 2013 • Marijuana use in the month prior to the surveys increased from 2008 to 2011, then decreased in 2012 and 2013 • Past-year nonmedical pain reliever use among adolescents showed a decrease since 2011 • The percentage of binge drinking among adolescents decreased from 2008 to 2013 (8.9% in 2008; 6.2% in 2013) • Nearly 1 in 10 adolescents (9.7%) used alcohol for the first time in the past year. • First use of Psychotherapeutics (nonmedical use) decreased from 3.5% in 2009 to 2.4% in 2013 • First time Marijuana use in past year decreased from 5.5% in 2009 to 4.8% in 2013 • First time cigarette use decreased from 5.2% to 3.7% in 2013 • Percentage of adolescents who did not perceive a great risk from monthly use of marijuana increased from 69.7% in 2009 to 75.8% in 2013 • Percentage of adolescents who did not perceive a great risk from smoking marijuana once or twice a week increased from 51.0% to 60.5% • Percentage of adolescents who did not perceive great risk from smoking one or more packs of cigarettes per day increased the least from 34.5% in 2009 to 35.7% in 2013 Substance Use Disorder Individuals with alcohol or illicit drug dependence or abuse are defined as having an SUD or Substance Use Disorder. NSDUH estimates these numbers based on question of dependence on or abuse of alcohol or illicit drugs in the past year. • In 2013, 8.2% or 21.6 million individuals aged 12 or older had an SUD in the past year • 5.2% or 1.3 million adolescents aged 12 to 17 had an SUD • 8.5% or 20.3 million adults aged 18 or older had a past year substance use disorder Mental Health among adults aged 18 or older • 4.2% of adults (an estimated 10.0 million individuals) reported having serious mental illness within the year prior to being surveyed. This was a slight increase from 3.7% in 2009 • Adults aged 65 or older had the lowest percentage of SMI among adult age groups and the 26-44 age group had the highest percentage of SMI among adult age groups. • Females had a higher percentage of serious mental illness than males. • 3.9% of adults (about 9.3 million individuals) reported having serious thoughts of suicide within the year prior to being surveyed. This percentage did not change significantly from 2009 to 2013. • The 19-25 age group had the highest percentage of past-year serious thoughts of suicide among adults aged 18 or older. Mental Health among Adolescents aged 12-17 • 10.7% of adolescents (an estimated 2.6 million adolescents) in 2013 had at least one major depressive episode (MDE) within the year prior to being surveyed • The percentage among females (16.2%) was about 3 times higher than among males (5.3%) • The percentage of MDE increased from 11.7% in 2009 among females to 16.2% in 2013 with no significant change for male adolescents. Co-occurring Substance Use Disorders and Mental Health Issues • 1.4% of adolescents aged 12 to 17 nation-wide had both a substance use disorder and a major depressive episode in the past year • 3.2% of all adults aged 18 or older (7.7 million adults) had both a substance use disorder and any mental illness in the past year. • 1% of all adults aged 18 or older (2.3 million adults) had co-occurring SUD and a serious mental illness. Substance Use Treatment • NSDUH estimated that 22.7 million individuals (8.6%) aged 12 or older in 2013 needed treatment for an illicit drug or alcohol use problem • Of the 22.7 million individuals who needed treatment, an estimated 2.5 million received treatment at a specialty facility for an illicit drug or alcohol problem • Therefore, 20.2 million individuals, who needed treatment for an illicit drug or alcohol use problem, did not receive treatment at a specialty facility in the past year. • An estimated 4.5% or 908,000 reported that they perceived a need for treatment for their SUD problem • Of the 908,000 who felt they needed treatment but did not receive treatment at a specialty facility, 34.8% made an effort to get treatment while 65.2% reported making no effort to get treatment. • The most common reasons for those who needed but did not receive treatment, felt a need for treatment, and made an effort to receive treatment, were (1) no health coverage/could not afford cost (37.3%), (2) not ready to stop using (24.5%), (3) did not know where to go for treatment (9.0%), (4) had health coverage but it did not cover treatment or the cost (8.2%), and (5) no transportation or inconvenient hours (8.0%). Mental Health Treatment • Asked about receiving treatment for past year major depressive episode, 38.1% or 977,000 of the 2.6 million adolescents reported receiving treatment for depression. • Adolescents who had past year major depressive episode with severe impairment in carrying out responsibilities, 45.0% (832,000) received treatment. • Of the 34.6 million adults aged 18 or older, 14.6% received mental health treatment during the past year. We've used the results of this survey to estimate the prevalence of illicit drug use, alcohol use, and substance use disorder (SUD) in Nassau County. The data provide information for those aged 12 or older regarding illicit drug or alcohol use and also for adolescents aged 12 to 17. The adolescent data helps us to understand prevention efforts and their efficacy in preventing problems that may become life-long issues with costs that involve the quality of life for individuals, their families, schools, employers, and the communities in which they reside and interact. Attachment 1 provides an extrapolation of NSDUH data to the Nassau County population for years 2011 and 2012. Data are provided for the 12-17 Adolescent age groups, the 18-25 year olds and for those 26 and older. The 18-25 year olds tended to have the highest percentages of alcohol dependence or abuse and illicit drug dependence or abuse. It is estimated that 66,207 county residents have alcohol dependence or abuse; 29,024 have drug dependence or abuse; and 85,217 have alcohol or drug dependence. Those needing but not receiving alcohol treatment are estimated at 65,681, and those needing but not receiving drug treatment are estimated at 26,388. The estimated number of those having any mental illness numbered 185,153. These prevalence estimates indicate that there are many clients in need of treatment who are not accessing treatment. Mental Health disorders account for four of the top 10 causes of disability, and many individuals with serious mental illness die, on the average, at age 53, at least 25 earlier than the average citizen. In 2013, the OMH Patient Characteristic Survey provided a snapshot of mental health clients in treatment during a one-week period. Data indicated that in Nassau County there were 5,981 clients in treatment programs. Based on the prevalence estimates for Nassau County, there are many more individuals who would benefit from treatment, but are not seeking treatment. Research shows that people with alcohol problems on the average wait 20 years before seeking treatment. More county residents with these problems need to be educated to the benefits of treatment and outreach efforts need to be increased in all settings. The trends in Nassau County indicated a high abuse rate for heroin for the 18-25 year olds and the information helped to concentrate efforts to deal with the epidemic since 2008 through Narcan trainings in many communities that continue to reach thousands of individuals in an attempt to prevent overdoses, and to increase the awareness of the dangers in non-medical use of prescription drugs. The NSDUH (2013) reported that a majority of US adolescents did not perceive great risk from using marijuana monthly or weekly or having five or more drinks once or twice a week indicated that efforts need to be increased in the education of pre-adolescents to these dangers to prevent abuse as they get older. Co-occurring mental health problems and substance use disorders are often encountered together and housing needs for these individuals present greater difficulties in a climate where housing is difficult for all those with disabilities.

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

The treatment trends in Nassau County from 2009 through 2014 for chemical dependency programs are provided in Attachment 2. The data are provided by year and primary substance of abuse at admission for the different program categories. Overall, the number of admissions across all program types decreased by 24% in 2014 compared to 2009. The number of treatment programs decreased and several programs merged. An analysis of the number of county residents that were treated in county programs indicated that 88% were treated in county programs in 2010 whereas only 76% were treated in county programs in 2014. Nassau County only has 30 CD inpatient beds and 42 CD community residence beds. These services must be sought out of county by clients needing these modalities. Other barriers to needed services are addressed below in question 3 under the specific issues.

3. Assessment of Local Issues Impacting Youth and Adults - For each issue listed in this section, indicate the extent to which it is an area of need at the local (county) level for each disability population listed on the right. For each issue that you identify as either a "High" or "Moderate" need, answer the follow-up questions to provide additional detail.

	Youth (Under 21 years)			Adults (Over 21 years)		
Issue Category	**CD**	**MH**	**DD**	**CD**	**MH**	**DD**
a) Access to Prevention Services	**High Need**	**High Need**	**Low Need**	**High Need**	**Moderate Need**	**Low Need**
b) Access to Crisis Services	**Moderate Need**	**Moderate Need**	**Moderate Need**	**High Need**	**High Need**	**Moderate Need**
c) Access to Treatment Services	**High Need**	**High Need**	**Moderate Need**	**Moderate Need**	**High Need**	**Moderate Need**
d) Access to Supported Housing	**High Need**	**High Need**	**High Need**	**High Need**	**High Need**	**High Need**
e) Access to Transportation	**High Need**	**High Need**	**High Need**	**High Need**	**High Need**	**High Need**
f) Access to Home/Community-based Services	**Moderate Need**	**Moderate Need**	**Moderate Need**	**High Need**	**Moderate Need**	**High Need**
g) Access to Other Support Services	**High Need**	**High Need**	**High Need**	**High Need**	**High Need**	**High Need**
h) Workforce Recruitment and Retention	**High Need**	**High Need**	**Moderate Need**	**High Need**	**High Need**	**High Need**
i) Coordination/Integration with Other Systems	**High Need**	**High Need**	**High Need**	**High Need**	**High Need**	**High Need**
j) Other (specify):	**0**	**0**	**0**	**0**	**0**	**0**
k) Other (specify):	**0**	**0**	**0**	**0**	**0**	**0**

Follow-up Questions to "Access to Prevention Services" (Question 3a)

4a1. Briefly describe the issue and why it is a moderate or high need at the county level. If this involves high need populations or special circumstances, clarify those here

School-based prevention funding has decreased and many programs have been eliminated. Evidence-based curricula have become more difficult to implement due to conflicts with common core. Programs are not budgeted to absorb the costs associated with some of these curricula. Recent data from the 2014 National Youth Tobacco Survey co-conducted by the Centers for Disease Control and Prevention and the Food and Drug Administration indicated that while the percentage of students reporting current use of cigarettes decreased from 15.8% to 9.2%, the use among high school students of hookah and e-cigarettes have increased dramatically. The 18-25 year olds represent a special population, not just an extension of adolescence. These young adults need targeted prevention strategies more in line with their needs. Mental Health does not carve out youth prevention services. Early identification of emotional distress in children living in homes with mental illness and/or substance abuse has not been fully addressed. Overall gaps include the following: 1. Recognizing specialized prevention counseling for the 20-25 year old 2. Appropriate referral resources for the 13-18 year old adolescent 3. Services for non-English speaking populations

4a2. Identify strategies that could potentially be pursued to address this local issue.

Strategies that could be applied to address the above gaps include: 1. Engaging young adults through social media and assist local colleges with educational and awareness events 2. Continue prevention awareness programs to reduce stigma associated with mental illness and substance abuse. 3. Pursuit of additional funding for evidence-based interventions and strategies 4. Multi-cultural and multi-lingual programs that can provide outreach and educational resources. 5. Comprehensive prevention efforts need to focus on all tobacco products including hookahs and e-cigarettes.

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

4b1. Briefly describe the issue and why it is a moderate or high need at the county level. If this involves high need populations or special circumstances, clarify those here

Access to Crisis Services Chemical Dependency Crisis services for adolescents and young adults closer to home would be beneficial for this population in order to involve the families in their treatment. Many have to utilize services not only out of the county but also out of the state. This does not provide an easy transition back to their former living environments and often causes the problems to reoccur. A moderate need was identified for Crisis Services for developmentally disabled adults. Our Office receives requests for assistance from DD providers and NUMC's Emergency Department regarding adults who have co-occurring disorders (developmental disability and mental health) and present to NUMC's Emergency Department in crisis. Typically, NUMC's Emergency Dept. reports that the client is not in need of acute care/inpatient psychiatric treatment and the DD referring agency (or parent) refuses to take the individual back. The remedy is typically a "stalemate" and the individual remains in the ED until the DD system finds a respite bed. The individual may stay in the ED for several days or several weeks. While we have recently expanded the capacity of our mobile crisis team we would like to increase the size of this team further, as we wish to accompany the police, as much as possible, on calls they receive that have a behavioral health precipitant. The intent is to avoid unnecessary arrests, and referral to treatment when appropriate. Furthermore, the plan is for the team to conduct more "well visits" for people who are not using the traditional behavioral health system.

4b2. Identify strategies that could potentially be pursued to address this local issue.

1. Increased availability locally for treating adolescents in need of crisis services whether for inpatient and/or residential services. 2. Increase the availability of crisis respite beds for all disabilities to prevent use of emergency departments and inpatient hospitalizations wherever possible. 3. To further increase our mobile crisis response capacity.

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

4c1. Briefly describe the issue and why it is a moderate or high need at the county level. If this involves high need populations or special circumstances, clarify those here

CD: Over 3,252 individuals were turned away from the one Medically Managed Withdrawal and Stabilization program in Nassau County during the first nine months of 2013. Of those who sought detoxification services, only 26% were admitted. In addition, nearly half of the clients admitted to the program are Suffolk County residents. MH: There is very limited walk-in capacity for individuals seeking immediate treatment. In addition, changes in funding have resulted in decreased number of mental health clinics, contributing to waiting lists, and in some clinics a four week wait to be seen by a psychiatrist. DD: A moderate need was identified for DD services. The Office is represented on the bi-county Auspice committee which reviews "auspice" individuals who have co-occurring disorders (developmental disability and mental health). There is an increase of these cases, and they are typically denied treatment in both systems. The DD system may report that the individual is "too psych" and the mental health systems may report that the individual's IQ is "too low" and "lacks self-preservation". there are only two agencies in Nassau that treat individuals with these co-occurring disorders.

4c2. Identify strategies that could potentially be pursued to address this local issue.

CD: Several Outpatient treatment programs applied to provide Ancillary Withdrawal Services targeted at individuals undergoing mild or moderate withdrawal symptoms. These clients do not need the more intensive medically managed withdrawal services, and it would alleviate the burden on the hospital. Having withdrawal services in an outpatient setting also allows for better treatment engagement. MH: 1. Increase the walk-in capability at several sites across Nassau County to assist clients in immediate need that do not necessarily need an emergency room, but would benefit from speaking with someone to help them determine the type of help that is needed. 2. The hours of the mobile crisis team have been increased in Nassau County for adults and children; however, 24/7 covereage is not yet available and services need further expansion. 3. North Shore Child & Family Guidance and Central Nassau Guidance received funds to provide urgent care psychiatric evaluations for walk-in clients adolescent clients.

Follow-up Questions to "Access to Supported Housing" (Question 3d)

4d1. Briefly describe the issue and why it is a moderate or high need at the county level. If this involves high need populations or special circumstances, clarify those here

CD: Some progress has been made to obtain supported housing beds for clients with substance abuse disorders that are not sober houses. However, a greater number of safe, supervised housing for clients with substance abuse disorders and/or co-occurring disorders are still greatly needed. MH: There are over 500 individuals with a serious mental illness who are on the SPA waiting list for housing. Many of these individuals, due to historical patterns of development of mental health resources, are discharged from community inpatient psychiatric units, or are homeless in the community, and, therefore, are not eligible for many of the current supported housing beds. Housing agencies report empty Target A beds because of difficulty in filling them. DD: Subsequent to the Olmstead Act, OPWDD has a narrow interpretation of the results of the act regarding least restrictive housing. It appears that there is a belief that all developmentally disabled individuals can reside, with proper supports, in the community. This is a myth, and even if it were not mythology, there are not enough beds in the community for the population. As the developmentally disabled population increases, and their life expectancy increases, this deficiency in the system will continue.

4d2. Identify strategies that could potentially be pursued to address this local issue.

1. More safe housing units are needed with more support staff working in them for all disabilities. 2. Staff need to be better trained to deal with the clients who have not only behavioral problems, but many also have chronic physical ailments.

Follow-up Questions to "Access to Transportation" (Question 3e)

4e1. Briefly describe the issue and why it is a moderate or high need at the county level. If this involves high need populations or special circumstances, clarify those here

Historically, individuals in the DD system were in residential care, day habilitation, or sheltered workshops, and transportation was provided for these individuals. It appears to be the belief of the DD system that all individuals diagnosed with a developmental disability can be gainfully employed. However, this is not achievable for all individuals. Individuals who may be employable need transportation to and from work. There is a lack of travel training and the paratransit AbleRide System, as good as it is, is not able to meet the needs of this growing population.

4e2. Identify strategies that could potentially be pursued to address this local issue.

1. Increase travel training for clients. 2. Make more local and state legislators and other community organizations aware of the transportation issue in the county to enable more funding and generate ideas on how to overcome this issue.

Follow-up Questions to "Access to Home/Community-based Services" (Question 3f)

4f1. Briefly describe the issue and why it is a moderate or high need at the county level. If this involves high need populations or special circumstances, clarify those here

One of the current issues with HCBS access has to do with meeting the BIP requirement of a conflict-free structure. The assessment and assignment of children for waiver services is currently accomplished through a committee that CMS has determine is not conflict-free. As waiver services are very necessary to assist children so that they remain in their homes, another process needed to be proposed to maintain conflict-free determinations.

4f2. Identify strategies that could potentially be pursued to address this local issue.

A proposal was submitted to OMH last week for conflict-free determinations using the CANs-NY assessment by the LGU/SPOA Coordinator. This proposed structure would expand the LGU/SPOA's role and resolve the conflict-free issue. The LGU has many years of experience with the SPOA process and this is a logical extension of its role.

Follow-up Questions to "Access to Other Support Services" (Question 3g)

4g1. Briefly describe the issue and why it is a moderate or high need at the county level. If this involves high need populations or special circumstances, clarify those here

CD: There is a need for non Medicaid case management and services to retain clients in treatment and to assist them in transitioning from one level of care to another. Bridgers or even peer support services would be very beneficial to assist these clients.

4g2. Identify strategies that could potentially be pursued to address this local issue.

Case management services should be available to all clients until they are stabilized in their treatment. Assistance can then be provided by peers in all aspects of their disabilities. Nassau County is implementing a pre-PROS program for clients coming out of psychiatric and community inpatient units. This pilot program known as SOAR (Specialized Opportunities to Achieve Recovery) will target those who are not ready and/or unwilling to participate in PROS. They need structure during the day and access to socialization. They need to build skill development to get ready for PROS programming. Five programs will be implemented with the goal of targeting about 40 individuals at a given time in order to reduce hospitalization and facilitate skills for PROS readiness.

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

4h1. Briefly describe the issue and why it is a moderate or high need at the county level. If this involves high need populations or special circumstances, clarify those here

Workforce Recruitment and Retention is a serious issue across all three disabilities for clients of all ages. For adults in the various treatment modalities staff turnover can cause significant problems in gaining client's trust and helping them to maintain motivation. With the greater numbers of clients with co-occurring disabilities, staff need to be prepared to recognize and deal with the issues and pass them on. More experienced staff are needed to cope with multiple issues. Many staff are aging out of the system and will be retiring. The client population is also living longer and their aging presents new problems and greater health difficulties.

4h2. Identify strategies that could potentially be pursued to address this local issue.

1. Provide cross discipline training whenever possible to educate staff to recognize multiple issues and be able to cope with them. 2. Staff in supportive roles need to be better educated and trained to deal with difficult clients. More experienced staff tend to move on and less experienced staff are retained.

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

4i1. Briefly describe the issue and why it is a moderate or high need at the county level. If this involves high need populations or special circumstances, clarify those here

MH/SUD: High Need. Estimates range from 50-90% of clients having a co-occurring mental illness and alcohol and/or substance abuse issues. Clearly, there is a great need for integration of physical health services with behavioral health services in order to decrease ED visits and hospital admissions. DD = High Need. The Office is represented on the bi-county Auspice Committee which reviews individuals who have co-occurring developmental disabilities and mental health issues. Although there have been great strides in the integration of co-occurring care for individuals with mental health disorders and substance use disorders, neither OMH nor OPWDD has taken a leadership role in the coordination and integration of care for individuals with mental health disorders and developmental disabilities. All efforts to manage this population have been default efforts by agencies that happen to have such clients under their care.

4i2. Identify strategies that could potentially be pursued to address this local issue.

Support the movement of all behavioral health providers toward the delivery of integrated care and the provision of a single license that will oversee this service.

5. Please indicate how <u>useful</u> each of the following data resources is for your planning, needs assessment, and system management work.

Data Resource	Very Useful	Somewhat Useful	Not Very Useful	Never Used
a) CLMHD Data Dashboard	○	◉	○	○
b) OASAS Client Data Inquiry Reports	◉	○	○	○
c) OMH County Mental Health Profiles	◉	○	○	○
d) OMH PSYCKES Medicaid Portal	◉	○	○	○
e) BHO Performance Metrics Portal (on OMH Website)	○	○	◉	○
f) New York Employment Services System (NYESS)	○	○	○	◉
g) DSRIP Dashboard (on DOH Website)	○	◉	○	○
h) Health Data NY (DOH Health Data Portal)	○	◉	○	○
i) Open NY (New York's Open Data Portal)	○	○	○	◉

6. In addition to the data resources listed in #5 above, identify other data resources that you found helpful in your planning and needs assessment work and why they were helpful.

SAMHSA; NIDA; CDC

PART B: Regional Needs Assessment

The 2016 Local Services Plan Guidelines describe planning regions of the Public Health and Health Planning Council (PHHPC) that the Population Health

Improvement Program (PHIP) and Regional Planning Consortiums (RPC's) will operate in. Unless otherwise indicated, responses to these questions should be made based on the PHHPC planning regions.

7. Collaborative Planning Activities - Counties are strongly encouraged to work with other counties in their region to identify the major issues that have a regional impact. In this section, describe the planning and needs assessment activities that your agency participated in during the past year with other counties within your PHHPC region. Identify the other counties that were involved in the collaborative planning activities.

The LGU Community Services Director participates on the state-wide Conference of Local Mental Hygiene Directors which address issues that cross county lines and are pertinent to many counties in the state. Program liaisons confer and meet with their field office representatives to discuss programs and other issues. County structures are often insular in nature and deal specifically with issues that affect their county since that is where they can have greater impact and funding. The separate governmental structures often does not lend itself to the integration of bi-county operations. Issues that impact on regions are often addressed by special task forces or forums, but enactment of solutions are often still only within a county. Nassau County, along with provider agencies and mental health field office, has embarked on the implementation of a regional program that involves a bi-county forensic ACT Team serving a total of 68 clients from Nassau and Western Suffolk. Nassau County LGU is the Single Point of Access (SPOA) for referrals and assignments to team. However, referrals can be submitted on either Nassau County SPOA forms or Suffolk County forms. This plan was developed, submitted and approved by NYS OMH. The Suicide Prevention Coalition of Long Island consists of members from both Nassau County and Suffolk County addresses education and awareness around suicide issues. Data that are submitted to OASAS can only be extracted for one's own county. Data from neighboring counties are not available even if we have program sites in those counties. Staffing is an issue in this county, and priority has to be given to issues that impact the LGU and Nassau County first. At times prevention providers contact county staff to discuss correspondence they received from OASAS, but LGU has no awareness of its existence. In Nassau County the providers and LGU staff have always had a close relationship. When information doesn't reach LGU staff, it impacts our mandated responsibilities and relationships. There may be issues listed in question 8 that impact on the Long Island Region, but to address them individually would lead to only the viewpoint of Nassau county.

8. Assessment of Regional Issues Impacting Youth and Adults - For each issue listed in this section, indicate the extent to which it is an area of need at the regional level for each disability population listed on the right. For each issue that you identify as either a "High" or "Moderate" need, answer the follow-up questions to provide additional detail.

	Youth			Adults		
Issue Category	**CD**	**MH**	**DD**	**CD**	**MH**	**DD**
a) Access to Prevention Services	**0**	**0**	**0**	**0**	**0**	**0**
b) Access to Crisis Services	**0**	**0**	**0**	**0**	**0**	**0**
c) Access to Treatment Services	**0**	**0**	**0**	**0**	**0**	**0**
d) Access to Supported Housing	**0**	**0**	**0**	**0**	**0**	**0**
e) Access to Transportation	**0**	**0**	**0**	**0**	**0**	**0**
f) Access to Home/Community-based Services	**0**	**0**	**0**	**0**	**0**	**0**
g) Access to Other Support Services	**0**	**0**	**0**	**0**	**0**	**0**
h) Workforce Recruitment and Retention	**0**	**0**	**0**	**0**	**0**	**0**
i) Coordination/Integration with Other Systems	**0**	**0**	**0**	**0**	**0**	**0**
j) Other (specify):	**0**	**0**	**0**	**0**	**0**	**0**
k) Other (specify):	**0**	**0**	**0**	**0**	**0**	**0**

10. In addition to collaborating with other counties in your PHHPC region, has your agency collaborated with counties outside your PHHPC region on any planning and needs assessment activities in the past year?

(●) a. Yes

( ) b. No

If "Yes", identify the counties that you collaborated with and briefly describe the collaborative activity.

Collaboration with Suffolk County was described above in question 7. Through the Delivery System Reform Incentive Payment (DSRIP) program, Nassau County is participating with representatives that cover providers in Queens County as well as Nassau County.

Warm Line and Mobile Crisis Capacity Survey
Nassau Co Office of MH, CD and DD Svcs (40150)
Certified: James Dolan (6/22/15)

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

The questions below were developed out of OMH regional planning discussions in which areas of need were identified across the State. Existing data do not provide a clear picture of current capacity for the two program areas referenced below. Therefore LGUs are being asked to provide some basic information. All questions related to this survey should be directed to Jeremy Darman at Jeremy.Darman@omh.ny.gov or at (518) 474-4403.

1. Does your county have access to a local or regional mental health warm line ?

- (●) a) Yes
- ( ) b) No

2. What is the phone number for the mental health warm line?

516-227-TALK(8255)
3. What are the days and hours of operation of the mental health warm line?

24 hours per day, 7 days per week.
4. Is the warm line operated/staffed by peers (current and/or former recipients of mental health services)

- ( ) a) Yes
- (●) b) No
- ( ) b) Don't Know

5.Additional Comments?

We contract for a peer run warm line with the Nassau County Mental Health Association.

6. Does your county have access to a mobile crisis intervention program or mobile crisis team?

- (●) a) Yes
- ( ) b) No

7. What is the phone number for the mobile crisis intervention program/team?

516-227-TALK(8255)
8. What is the name of the operator/provider of the mobile crisis intervention program/team??

The team is staffed with personnel from Pilgrim Psychiatric Center and the South Shore Child Guidance Center. It functions as an integrated team serving adults and children. It is know as the Nassau County Mobile Crisis Team.
9. What are the days and hours of operation of the mobile crisis intervention program/team??

10AM to 11PM, seven days per week.
10. Additional Comments?

Mental Hygiene Priority Outcomes Form
Nassau Co Office of MH, CD and DD Svcs (40150)
Plan Year: 2016
Certified: James Dolan (6/22/15)

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

2016 Priority Outcomes

Priority Outcome 1:

Provide increased and rapid access to behavioral health services.

Priority Rank: 1

Applicable State Agencies:
OASAS Priority Focus: Service Coordination/Integration. **Sub-focus Area(s):** Coordinate Care with MH, DD, and/or Primary Health Services
OMH Priority Focus: Service Coordination/Integration.
OPWDD Priority Focus: Infrastructure. **Sub-focus Area(s):** Cross-system Collaboration

Strategy 1.1

Implement and expand walk-in services, including medication management and psychiatric evaluation time at all community-based mental health contract agencies.

Metric: At least three clinics will have walk-in capacity during all hours of operation.
State Agency:
OMH

Strategy 1.2

Expand the availability of Respiradol Consta, Inveiga, and Abilify injectables at Mental Health clinics.

Metric: A majority of community-based mental health contract agencies will provide Respiradol Consta.
State Agency:
OMH

Strategy 1.3

Toxicology testing will be available at mental health clinics.

Metric: A majority of mental health clinics will provide toxicology testing.
State Agency:
OMH

Strategy 1.4

Development of a PROS Readiness Track in order to serve clients who are unable to be currently served in the traditional PROS model, with a focus on individuals with co-occurring disorders, including significant developmental disabilities. The program would provide support and advocacy, pre-vocational and organizational skills, information and assistance in support of the client's direction, utilization of community resources, and peer supports.

Metric: PROS programs in Nassau County have procured money to implement a PROS Readiness Track by October 2015. The programs will establish a baseline of hospitalization and ER usage.
State Agency:
OMH

Strategy 1.5

All outpatient behavioral health agencies with two licenses will apply for the integrated licensure when the application becomes available.

Metric: A count of the number of agencies with an integrated licensure after applications are submitted.
State Agencies:
OASAS
OMH

Strategy 1.6

Increased provision of primary medical services in behavioral health clinics after availability of integrated licenses.

Metric: All clinics granted an integrated license will provide primary medical services.
State Agencies:
OASAS
OMH

Strategy 1.7

Support the development of a peer-run, three bed diversion house to decrease preventable hospitalizations and emergency room visits.
State Agency:
OMH

Strategy 1.8

1.8 Support the delivery of non-Medicaid Case Management and Outreach services for individuals with substance use disorders.
State Agency:
OASAS

Priority Outcome 2:

Provide Ancillary Withdrawal Management programs for persons in mild to moderate or persistent withdrawal in outpatient treatment settings for long-term recovery and prevention of relapse.

Priority Rank: 2

Applicable State Agencies:
OASAS Priority Focus: Service Capacity Expansion. **Sub-focus Area(s):** Services for a Target Population (specify population):

Strategy 2.1

The LGU issued an RFI in the spring of 2014 to determine how many providers would be interested in operating an Ancillary Withdrawal Management Program and to determine what financial assistance would be required for implementation. Initial responses indicated that several programs would like to add this service to their program with varying start-up times.

Metric: Monitor the number of clients served and provide a forum for programs to share any problems that they encounter.
State Agency:
OASAS

Strategy 2.2

One of the requirements for Ancillary Withdrawal Management Services to benefit clients is that they have a stable environment including housing and a support system. To help fulfill this requirement, Mary Haven Center of Hope, a medically monitored withdrawal program, has proposed to set aside two - five beds for clients who are homeless and are participating in outpatient detox services.

Metric: Monitor the use of the beds by clients in an Ancillary Withdrawal Management Program.
State Agency:
OASAS

Priority Outcome 3:

Expand the scope and services of the Assessment and Referral Center, co-located with the local Department of Social Services for individuals with behavioral and/or physical health care needs.

Priority Rank: 3

Applicable State Agencies:
OASAS Priority Focus: Service Coordination/Integration. **Sub-focus Area(s):** Coordinate Care with MH, DD, and/or Primary Health Services
OMH Priority Focus: Service Coordination/Integration.

Strategy 3.1

Continue the partnership with the lead Health Homes in Nassau County, whereby ARC provides outreach, and engages clients who are assigned to respective Health Homes by NYS DOH. ARC will continue to make a 'warm' hand off of the identified client to the appropriate Health Home.

Metric: Document the number of clients provided with a warm hand off to a Health Home on a monthly basis.

The metric has been achieved and will continue. ARC provided a "warm hand-off" to 388 Health Home eligible individuals between January 2014 through September 2014.
State Agencies:
OASAS
OMH

Strategy 3.2

ARC will be seeking a mental health clinic license to provide short-term, interim clinical services as needed. From January 2014 through September 2014, a total of 267 non-Health Home clients were served with an average monthly census of 30.
State Agency:
OMH

Priority Outcome 4:

Continue to expand the role of SPOA to all clients in need of care coordination, those with a serious mental illness and individuals with two or more chronic medical conditions including substance abuse.

Priority Rank: 4

Applicable State Agency:
OMH Priority Focus: Service Coordination/Integration.

Strategy 4.1

SPOA will continue to assess, review, and assign clients to the appropriate health home for care coordination.

Metric: Monthly metrics were developed to capture the SPOA activities. SPOA had over 1,336 incoming referrals in 2014, an increase of 16% over 2013.
State Agency:
OMH

Priority Outcome 5:

Support the development of safe, stable housing which promotes recovery, facilitates rehabilitation and maximizes the potential for independent living.

Priority Rank: 5

Applicable State Agencies:
OASAS Priority Focus: Service Capacity Expansion. **Sub-focus Area(s):** Housing
OMH Priority Focus: Service Improvement/Enhancement.
OPWDD Priority Focus: Housing. **Sub-focus Area(s):** Group Homes , Supported Housing , Rental Subsidies , Respite , Institutional Transition

Strategy 5.1

This Office will contine to work toward implementation of the SPA for all individuals with behavioral issues. This will simplify and expedite the housing process.

Metric: The Office will work with the state offices entities through the SPA to assure access and appropriate operation of this initiative
State Agencies:
OASAS
OMH

Strategy 5.2

Develop a mobile residential support team to provide enhanced services, including medication support and monitoring and peer support to individuals in supported housing.

Metric: This Office is working with OMH and the housing providers to implement six Mobile Residential Support Teams during the calendar year. An RFI was sent out to the largest supported housing providers, and those agencies awarded teams will be notified by the third week in May.
State Agency:
OMH

Priority Outcome 6:

Improve access to a more comprehensive transportation system to allow people with disabilities to live successfully in the community

Priority Rank: *Unranked*

Applicable State Agencies:
OPWDD Priority Focus: Infrastructure. **Sub-focus Area(s):** Transportation

Strategy 6.1

The LGU submitted a grant proposal seeking funds to provide improved and expanded transportation services for adults with developmental disabilities in Nassau County and was awarded a $357,000.00 grant from the Federal Transportation Administration/New York State Department of Transportation. Our Office will partner with Rides Unlimited, Inc., to implement a transportation program for clients of Family Residences and Essential Enterprises (FREE) and The Rehabilitation Institute (TRI). Consistent with the grant application, the task of convening a Stakeholder Transportation Advisory Committee, consisting of representatives from Rides Unlimited of Nassau & Suffolk, NYS Office for People With Developmental Disabilities, intellectual/developmental disability provider agencies, representatives from the target population, family, and advocacy groups was achieved.

Metric: Produce quarterly reports identifying grant outcomes including customer satisfaction surveys and a report outlining the recommendations of the Stakeholder Transportation Advisory Committee.

Convene quarterly meetings of the Stakeholders Transportation Advisory Committee.

Produce a Directory of Transportation Services for individuals in Nassau County with intellectual/developmental disabilities (one tri-fold and one directory).
State Agency:
OPWDD

Priority Outcome 7:

Expand care coordination services in the Mental Health Court

Priority Rank: *Unranked*

Applicable State Agency:
OMH Priority Focus: Service Capacity Expansion/Add New Service.

Strategy 7.1

Strategy 7.1 of adding one additional case manager has been achieved. Focus will now be on moving clients who have completed Phase 2 into health Home Care Coordination in order to allow for increased census.

Metric: Expansion of the d current maximum mental health court participants from 30 to 45 has been achieved. The monthly census at the mental health court has

increased to 45 and monitoring of the expansion of the census will continue with the aim of increasing from 45 to 50.
State Agency:
OMH

Strategy 7.2

This Office will work with the judiciary, the DA's office,legal aide and the private defense bar toward the development of a Behavioral Health Court, promoting integration of services of the current specialty courts in order to address the documented needs of individuals in these specialty courts, the majority of whom have co-occcurring disorders.

Metric: Provide uniform strategies for all individuals in the specialty courts.
State Agency:
OMH

Priority Outcome 8:

Continuation and expansion of the Behavioral Awareness Campaign

Priority Rank: *Unranked*

Applicable State Agencies:
OASAS Priority Focus: Service Improvement/Enhancement . **Sub-focus Area(s):** Train Workforce , Improve Outreach to a Target Population (specify population):
OMH Priority Focus: Outreach/Education.

Strategy 8.1

Professional staff will provide community trainings on topics to increase awareness and understanding of mental health and chemical dependency issues.

Metric: Produce quarterly reports regarding the number and type of trainings and outreach efforts consistent with the goals of the Behavioral Awareness campaign. Monthly reports indicated the following: 64 educational presentations, fairs, forums, NARCAN trainings and conferences were provided to the county at large in 2013. In 2014, the number increased to 84. Campaign also developed a webpage, brochures, banner and signs to further outreach efforts and promote events. This is an ongoing effort.
State Agencies:
OASAS
OMH

Strategy 8.2

Through the Behavioral Health Awareness Campaign, foster access to care through the provision of education and training to providers as well as other child support systems, such as pediatricians, educators, and caregivers.

Metric: Quarterly reports will be generated that will delineate the audience, number and type of training and outreach consistent with the goals of the Behavioral Health Awareness Campaign.
State Agencies:
OASAS
OMH

Priority Outcome 9:

The Office of Mental Health, Chemical Dependency and Developmental Disabilities will utilize all opportunities to participate in START Services for individuals with mental health disorders who also have intellectual/develomental disabilities.

Priority Rank: *Unranked*

Applicable State Agencies:
OMH Priority Focus: Service Improvement/Enhancement.
OPWDD Priority Focus: Infrastructure. **Sub-focus Area(s):** Cross-system Collaboration

Strategy 9.1

The LGU will collaborate with the START Services implementation organizations - The University of New Hampshire Center for START Services Institute on Disability, and the New York State Office for People With Developmental Disabilities.

Metric: The LGU will attend and participate in implementation and planning meetings and retain records of same.
State Agencies:
OMH
OPWDD

Priority Outcome 10:

Nassau County will begin to enroll children/youth in Health Home in 2015.

Priority Rank: *Unranked*

Applicable State Agencies:
OASAS Priority Focus: Service Coordination/Integration. **Sub-focus Area(s):** Coordinate Care with MH, DD, and/or Primary Health Services
OMH Priority Focus: Service Coordination/Integration.

Strategy 10.1

Currently Nassau County has a Single Point of Access (SPOA) structure for children/youth's intensive in-home services. This current process streamlines and facilitates access to care. The Children's Health Home will be under this current (SPOA) structure to continue facilitating access and provide administrative oversight.

Metric: SPOA, under Nassau County Office of Mental Health, will provide administrative oversight and assign children/youth on the DOH assignment list to the appropriate level of care coordination. Metrics similar to those developed for adult SPOA will be maintained monthly.
State Agency:
OMH

Priority Outcome 11:

Improve discharge planning in the Nassau County Correctional Facility for individuals with a diagnosed mental illness and/or co-occurring disorder.

Priority Rank: *Unranked*

Applicable State Agency:
OMH Priority Focus: Service Coordination/Integration.

Strategy 11.1

An LCSW staff member of the Nassau County Office of Mental Health, Chemical Dependency and Developmental Disabilities Services will collaborate with ARMOR Correctional. The staff member will provide medication grant cards, resource information, complete medication grant and SPOA care coordination forms. Staff member will work with ARMOR Correctional, a for profit, providing all medical and mental health services in the jail.

Metric: Reports will be generated numerating the services provided to identified clients in need. This has been achieved. Since October 2014 through March 2015, the Office staff person collaborated with ARMOR on 133 clients.
State Agency:
OMH

Strategy 11.2

Obtain a daily census from the Nassau County Correctional Facility to compare with database information of clients known to the mental health system.

Metric: Metrics will be maintained of the number of clients identified through the census.
State Agency:
OMH

Priority Outcome 12:

To expand Mobile Crisis Services

Priority Rank: *Unranked*

Applicable State Agency:
OMH Priority Focus: Service Capacity Expansion/Add New Service.

Strategy 12.1

To expand hours of operation and availability of services.

Metric: As the integration takes place, hours will be expanded to 10:00 am - 11:00 pm, 365 days a year.
State Agency:
OMH

2016 Multiple Disabilities Considerations Form
Nassau Co Office of MH, CD and DD Svcs (40150)
Certified: James Dolan (6/22/15)

Consult the LSP Guidelines for additional guidance on completing this form.
LGU: Nassau Co Office of MH, CD and DD Svcs (40150)

The term "multiple disabilities" means, in this context, persons who have at least two of the following disabling conditions: a developmental disability, a mental illness, or an addiction. In order to effectively meet the needs of these individuals, several aspects should be addressed in a comprehensive plan for services. Accordingly:

1. Is there a component of the local governmental unit which is responsible for identifying persons with multiple disabilities?

◉ Yes
○ No

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

- Individuals with co-occuring mental health, chemical dependency and/or physical health care issues, are identified through the SPOA process and assigned to targeted case managment or Health Home care coordination.

- The program liaison unit within the LGU has played an active role in increasing the capacity of OASAS and OMH licensed clinics to effectively serve those with mental health and chemical dependency disorders.

- We are active members of the Auspice Committe, in partnership with OMH and OPWDD, in the role of developing coordinated care plans for those who are diagnosed with mental health and developmental disability concerns.

2. Is there a component of the local governmental unit which is responsible for planning of services for persons with multiple disabilities?

◉ Yes
○ No

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

The planning process for each disability group no longer happens in silos. All planning for MH, CD or DD services incorporates the fact that a high percentage of all clients served have a co-occurring disorder.

3. Are there mechanisms at the local or county level, either formal or informal in nature, for resolving disputes concerning provider responsibility for serving persons with multiple disabilities?

◉ Yes
○ No

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

- We are active members of the Auspice Committe, in partnership with OMH and OPWDD, in the role of developing coordinated care plans for those who are diagnosed with mental health and developmental disability concerns.

2016 Community Service Board Roster
Nassau Co Office of MH, CD and DD Svcs (40150)
Certified: James Dolan (6/22/15)

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

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

Chairperson	
Name	Barbara Roth
Physician	No
Psychologist	No
Represents	Family
Term Expires	1/1/2017
eMail	elbsat@aol.com

Member	
Name	Nicole Sugrue
Physician	No
Psychologist	No
Represents	Elija Foundation
Term Expires	1/1/2017
eMail	nicolesugrue@gmail.com

Member	
Name	Meryl Jackelow
Physician	No
Psychologist	No
Represents	Consumer
Term Expires	1/1/2017
eMail	cpjack@optonline.net

Member	
Name	David Weingarten
Physician	No
Psychologist	No
Represents	Family
Term Expires	1/1/2017
eMail	davidw@latcp.org

Member	
Name	Robert Budd
Physician	No
Psychologist	No
Represents	Family Residences & Essential Enterprises
Term Expires	1/1/2017
eMail	rbudd@familyres.org

Member	
Name	Susan Burger
Physician	No
Psychologist	No
Represents	Family
Term Expires	1/1/2017
eMail	Sburger@lift4kids.org

Member	
Name	Janet Susin
Physician	No
Psychologist	No
Represents	NAMI
Term Expires	1/1/2017
eMail	jasusin@optonline.net

Member	
Name	Nicole Giambalvo
Physician	No
Psychologist	No
Represents	Youth Advocate
Term Expires	1/1/2017
eMail	nicolegiambalvo@gmail.com

Member	
Name	Andrew Malekoff
Physician	No
Psychologist	No
Represents	North Shore Child& Family Guidance
Term Expires	1/1/2017
eMail	amalekoff@northshorechildguidance.org

Member	
Name	Ann Pinto
Physician	No
Psychologist	No
Represents	Advocate
Term Expires	1/1/2017
eMail	ruby73157@aol.com

Member	
Name	Jeff McQueen
Physician	No
Psychologist	No
Represents	Consumer
Term Expires	1/1/2017
eMail	jmcqueen@mhanc.org

Member	
Name	Lisa Jacobson
Physician	No
Psychologist	No
Represents	Nassau University Medical Center
Term Expires	1/1/2017
eMail	ljacobso@numc.edu

Member	
Name	Rajvee Vora
Physician	Yes

Member	
Name	Amy Ejaz
Physician	Yes

Psychologist	No
Represents	Nassau University Medical Center
Term Expires	1/1/2015
eMail	rvora@numc.edu

Psychologist	No
Represents	Central Nassau Guidance
Term Expires	1/1/2017
eMail	aejaz@central nassau.org

Member	
Name	Mary Fasano
Physician	No
Psychologist	No
Represents	Family
Term Expires	1/1/2017
eMail	maryf371@aol.com

2016 ASA Subcommittee Membership Form
Nassau Co Office of MH, CD and DD Svcs (40150)
Certified: James Dolan (6/22/15)

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

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

Chairperson	
Name	Bruce Goldman
Represents	Provider
eMail	bgoldman1@lij.edu
Is CSB Member	No

Member	
Name	Ann Pinto
Represents	Consumer
eMail	ruby73157@aol.com
Is CSB Member	Yes

Member	
Name	Andrew Malekoff
Represents	Provider
eMail	amalekoff@northshorechildguid.org
Is CSB Member	Yes

Member	
Name	Anthony Cummings
Represents	Consumer
eMail	anthonycummings8@yahoo.com
Is CSB Member	Yes

Member	
Name	Rajvee Vora
Represents	Nassau University Medical Center
eMail	rvora@numc.edu
Is CSB Member	Yes

Member	
Name	Nicole Giambalvo
Represents	Youth Advocate
eMail	nicolegiambalvo@gmail.com
Is CSB Member	Yes

Member	
Name	Jamie Bogenshutz
Represents	YES Community Counseling
eMail	yesccc@vdot.net
Is CSB Member	No

Member	
Name	Barbara Rakusin
Represents	Provider
eMail	brakusin@yfcaoysterbay.org
Is CSB Member	No

Member	
Name	Scott Maidat
Represents	Southeast Nassau Guidance Center
eMail	smaidat@sngcounseling.org
Is CSB Member	No

2016 Mental Health Subcommittee Membership Form
Nassau Co Office of MH, CD and DD Svcs (40150)
Certified: James Dolan (6/22/15)

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

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

Chairperson	
Name	Janet Susin
Represents	NAMI
eMail	jasusin@optonline.net
Is CSB Member	Yes

Member	
Name	Adam Berkowitz
Represents	Consumer
eMail	aberkowitz@mhanc.org
Is CSB Member	No

Member	
Name	Jeff McQueen
Represents	Consumers
eMail	jmcqueen@mhanc.org
Is CSB Member	No

Member	
Name	Mary Ellen Conrad
Represents	Maryhaven Center of Hope
eMail	maryellen.conrad@chsli.org
Is CSB Member	No

Member	
Name	Rajvee Vora
Represents	Nassau University Medical Center
eMail	rvora@numc.edu
Is CSB Member	Yes

Member	
Name	Nancy Manigat
Represents	Central Nassau Guidance Center
eMail	nmanigat@centralnassau.org
Is CSB Member	No

Member	
Name	Barbara Roth
Represents	MH Parent Advocate
eMail	elbsat@aol.com
Is CSB Member	Yes

Member	
Name	Patricia Devery
Represents	OMH
eMail	Patricia.Devery@omh.ny.gov
Is CSB Member	No

Member	
Name	Dr. Reddy
Represents	South Nassau Communities Hospital
eMail	sreddy@snch.org
Is CSB Member	No

Member	
Name	Marge Vezer
Represents	South Shore Assoc. for Independent Living
eMail	mvezer@sail-inc.org
Is CSB Member	No

2016 Developmental Disabilities Subcommittee Membership Form
Nassau Co Office of MH, CD and DD Svcs (40150)
Certified: James Dolan (6/22/15)

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

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

Chairperson	
Name	Mary Fasano
Represents	Parent Advocate
eMail	mjf371@aol.com
Is CSB Member	Yes

Member	
Name	Michael Smith
Represents	Provider
eMail	msmith@acds.org
Is CSB Member	No

Member	
Name	Colleen Crispino
Represents	Provider
eMail	ccrispino@acld.org
Is CSB Member	No

Member	
Name	Robert Goldsmith
Represents	Provider
eMail	goldsmithr@acld.or
Is CSB Member	No

Member	
Name	Robert Budd
Represents	Provider
eMail	rbudd@familyres.org
Is CSB Member	No

Member	
Name	Robert McGuire
Represents	Provider
eMail	RMCGUIRE@UCP.ORG
Is CSB Member	No

Member	
Name	Nicole Sugrue
Represents	Provider
eMail	nicolesugrue@gmail.com
Is CSB Member	Yes

Member	
Name	Thomas Hopkins
Represents	Provider
eMail	thopkins@epli.org
Is CSB Member	Yes

Member	
Name	Meryl Jackelow
Represents	Consumer
eMail	cpjack@optonline
Is CSB Member	Yes

2016 Mental Hygiene Local Planning Assurance
Nassau Co Office of MH, CD and DD Svcs (40150)
Certified: James Dolan (6/30/15)

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

Pursuant to Article 41 of the Mental Hygiene Law, we assure and certify that:

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

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

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

OASAS, OMH and OPWDD accept the certified 2016 Local Services Planning Assurance form in the Online County Planning System as the official LGU assurance that the above conditions have been met for the 2016 Local Services planning process.