2009
Local Services Plan
For Mental Hygiene Services

Nassau Cty Dept of MH, CD Dev Dis Svcs
September 24, 2008

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Consult the LSP Guidelines for additional guidance on completing this exercise.
1. Assessment of Chemical Dependence and Problem Gambling (OASAS) - Provide an assessment of the nature and extent of the chemical dependence and problem gambling in the county. Describe the results of qualitative activities, including the use of consumers, providers, task forces, workgroups, committees, public forums, key informant interviews, and other stakeholder groups. Describe the quantitative assessment activities, including data resources used, surveys conducted, etc. Include a geographic and demographic description of the service area. **Note: Please address prevention needs assessment separately in the next question.**

Description of Service Area

Nassau County together with Suffolk County makes up the region of Long Island. A suburb of New York City, Nassau County has a population estimated at 1,306,533 for 2007 (US Census Bureau) with a population density of 4,655 persons per square mile compared to the similar counties average of 2,811.5 (2005 OASAS PRISMS Risk Profile). It is the most densely populated county outside New York City in the downstate region. Between 2000 and 2007, the U. S. Census Bureau population estimates show a slight decrease in population of 28,011 persons as more people move out of the county.

Nassau is a well-established suburb that is slowly undergoing changes—the population is aging (the percent of the population aged 65 or older doubled from 6% in 1950 to 15% in 2006), undeveloped land has become scarce, affordable housing needs have increased, and employment is centered around a more locally oriented economy which means a shift from higher-paying jobs to lower-paying ones. The largest number of the population is employed in health care and social assistance sectors, followed by retail trade. Unemployment, however, is relatively low at 4.3% for the first three months of 2008 compared to the State's unemployment rate of 5.2%.

The demographics of Nassau County residents are changing and becoming more diverse as more immigrants arrive from Latin America and Asia. Because many immigrants tend to locate in certain areas, needs within communities are gradually changing. There has been an increase in the need for Spanish-speaking personnel in many segments of the health and social services areas.

Nature and Extent of Chemical Dependence and Compulsive Gambling Problems in the County

The OASAS March 2008 Service Need Profile estimated the number of county residents with chemical dependence problems at 103,020 or 9.1% of the county's general population aged 12 and over. Of the total number in need, 85,554 (83%) are adults aged 18 and over and 11,477 (11%) are adolescents 12 to 17 years of age with alcohol and/or non-opiate drug abuse. Individuals aged 16+ using opiates are estimated at 5,889 (6%).

The table below shows the Prevalence of Chemical Dependence Problems for Nassau and counties that are similar:

County	Prevalence	% of Population
Nassau	103,020	9.1%
Suffolk	118,028	9.6%
Putnam	8,125	9.5%
Rockland	23,174	9.6%
Westchester	74,770	9.4%

Nassau County as a whole presents a fairly stable profile on indices in the OASAS 2005 PRISMS report compared to NY State and similar counties average values. Nassau County's Risk indicators rates were lower than the NYS Average (excluding New York City) and the Similar Counties Average on Violent Crime Arrests, Homicides, Property Crime Arrests, Adult DWI Arrests, Adult Drug Arrests, and other arrests. Similarly, on all Poverty/Economic indices, Alcohol Accessibility, Adult Probation, Family Dysfunction, and

School Conduct, Nassau County was well below the NYS Average and below or equal to the Similar Counties Average.

For Youth Violent Crime Arrests, Nassau County was slightly above the NYS Average (35.9 versus 35.0) but below the similar counties average of 38.8. The rate per 10,000 of adults age 21 and older who were in treatment at some time during the year due to drugs other than alcohol was greater than the NYS Average (36.6 vs 33.9) but lower than the Similar Counties Average of 40.8. This was also true for the number of youth (aged 12-20) who were in treatment at some time during the year with drugs other than alcohol, (rated per 10,000 youth age 12-20). The Nassau County rate was 45.2 while the NY State Average was 42.4 and the Similar Counties average was 37.8.

Treatment and Prevention programs completing the Community Epidemiology Survey for the 2008 Local Services Plan indicated that Alcohol (availability to minors), Marijuana/Hashish, Smoked Tobacco, Cocaine, and Crack were the most highly available substances in their communities followed by Heroin, and prescription pain relieving drugs such as OxyContin, Vicodin, and Percocet. Trends that were noted by the programs included usage at an earlier age, more extensive use of prescription drugs, increased use of alcohol and marijuana at an earlier age, more use of heroin, and an increase in clients with co-occurring disorders.

The Nassau County Police Department indicated that more youths are abusing recreational drugs as indicated by sale and possession arrests which have increased recently. The Nassau Narcotics and Vice Squad expressed concern that there has been a rise in heroin use and because the heroin is purer, users can snort and smoke it rather than inject it intravenously. They are working with school officials to educate teachers and parents to look for signs of abuse in students.

In 2007 there were 9,236 non-crisis admissions to treatment programs in Nassau County of which 90% were Nassau County residents. More than half of the admissions reported some type of involvement with the Criminal Justice System. Clients who were ever hospitalized for mental illness increased from 2% in 2000 to 11.7% in 2007. Clients in the 19-25 age group increased from 16% in 2000 to 22% in 2007.

There were 2,500 admissions to crisis programs in Nassau County in 2007. While there were only 6.7% admissions to non-crisis programs with a primary substance of heroin, 27% of the crisis admissions indicated heroin as the primary substance, with 11.7% indicating Crack as the primary substance vs. only 5.5% of those admitted to non-crisis programs.

More than half of the non-crisis admitted clients indicated they had smoked tobacco in the week prior to admission. In the 2008 Tobacco Survey for treatment and prevention programs in Nassau County, 30% of the prevention and 22% of the treatment programs responded that they had fully implemented the OASAS tobacco-free policies & procedures; 4% of prevention and 13% of treatment programs indicated they had partially implemented the tobacco-free policies & procedures. Twenty-nine percent of the programs have not yet implemented these policies (7% prevention; 22% treatment).

Problem Gambling

No formal assessment has been made of compulsive gambling problems in Nassau County. A review of the Gambling Survey responses for Treatment Providers in Nassau County indicated that 54% screen for a compulsive gambling problem whereas 46% do not. The number of individuals who screened positive for

compulsive gambling over the past 12 months was relatively small (under 60). Ninety-one percent of the treatment programs and 89% of the prevention programs responded that they did not have any clinical staff members that had completed the 60-hour Compulsive Gambling Core Curriculum Training.

Two agencies are now providing gambling services to residents of Nassau County. Community Counseling Services of West Nassau was funded to provide gambling treatment services and COPAY, Inc. is providing gambling prevention services.

2008 Planning Priorities Survey

Analysis of the 2008 Planning Priorities Survey completed by Nassau County providers (80% completed at time of analysis) indicated the following five "High" priority issues in rank order from highest to lowest in each of the three categories below:

Priority Populations: 1) Adolescents 2) Criminal Justice Clients 3) Persons with a Co-occurring mental illness 4) Uninsured/Underinsured clients and 5) Women with Children.

Prevention, Treatment and Recovery Priorities: 1) Relapse prevention and 1) Underage drinking (tied scores), 2) Education services, 3) Implementing model programs/best practices, 4) Parenting training, and 5) Linkages with the recovery community.

Administrative priorities: 1) Collaboration with Court System, 2) Program Accountability, 3) Collaboration with other human service systems, 4) Staff training and credentialing, and 5) Staff salary and benefits.

When asked to identify the top three highest priority issues, programs in Nassau County selected Staff Recruitment and Retention as the #1 priority issue followed by Staff Salary and Benefits and Program Accountability. Recruitment and retention are difficult if salaries are not competitive and retirement and medical benefits do not increase. In particular, programs are concerned about the ability to hire and retain staff with CASAC credentials and how quality of services may be affected by staff turnover.

Programs recognize that accountability is essential but continue to be concerned about meeting mandated requirements and retaining or increasing their ability to provide high quality levels of care.

Quantitative data used by Nassau County include the County Resource Book (2007), PRISMS (2005), CRISP (2007), and OASAS Client Data System.

Qualitative data are collected informally through participation in meetings, task forces, and various committee activities. The department participates in meetings with other county Health and Human Services department (Youth Board, Probation, Social Services, Senior Citizens, Veterans, and Physically Challenged). The department also participates in other county coalitions such as The Long Island Association for AIDS Care and with other stakeholders, such as the Nassau Alliance for Addiction Services and HEVN (Help End

Violence Now).

2. Prevention Needs Assessment (OASAS) - Please describe the county's prevention needs assessment efforts, including the resources utilized and needs determined. Describe the role of prevention providers and other stakeholders in those efforts.

On an individual basis the Department has identified and coordinated funding for school districts to conduct formal needs assessment surveys. Department staff has researched and provided archival and model program resources to our funded prevention network to assist in the implementation of research-based services. The Department is also creating resource tables containing county-wide data and where possible by district and/or community.

Programs completing (in 2007) the Community Epidemiology Survey for the 2008 Local Services Plan indicated that alcohol availability to minors, marijuana/hashish, smoked tobacco, cocaine and crack were the most highly available substances within the communities followed by heroin and perscription pain medications such as OxyContin, Vicodin and Percocet. Trends noted included usage at an earlier age, more extensive use of perscription drugs, increased use of alcohol and marijuana at an earlier age, more use of heroin and an increase in clients with co-occurring disorders.

An informal survey conducted in 2008 identified alcohol, marijuana and perscription drugs as the primary substances of use/abuse. Trends identified were the same as those noted in the Epidemiology survey. Other trends identified included MICA at an earlier age, substance use as a result of gang involvement or exposure to gang influences.

Gambling has not been identified as a significant trend in school-based prevention. Internet Poker, Poker, dice (c-lo), lottery and sports betting have been identified as the types of gambling activities adolescents are engaging in.

Within the PARIS system, we have provided technical assistance, information and relevant archival data that programs used to evaluate their needs. We have encouraged collaboration between the school district and the local community-based agency concerning programming based upon these needs assessments. The Department meets with prevention providers approximately every six weeks to both impart and garner relevant information concerning programmatic issues. These meetings include ongoing training and education.

3. Analysis of Service Needs and Gaps (OASAS) - Describe and quantify the chemical dependence and problem gambling prevention and treatment service needs of the population. Describe the capacity and resources available to meet the identified needs, including those services that are accessed outside of the county and outside the OASAS funded and certified system. Describe and quantify the gaps between services needed and services provided. Describe existing barriers to accessing needed services. Use this section to identify target populations and specialized service needs. If the county believes that local service needs are different from those estimated by the OASAS treatment need methodology, include the alternative county estimates and explain the basis for those estimates.

Based on the OASAS Service Need Profile – March 2008 for Nassau County, the prevalence of the substance abuse problem is estimated at 103,020 or 9.1% of the population of individuals aged 12 and over for *all substances* . For alcohol and non-opiate drug use for adults aged 18 and over, the prevalence of *alcohol only* is estimated at 64,090, for *drug use only* at 7,092, and for *both alcohol and drug* use at 14,472. The chemical dependence prevalence for youth aged 12-17 is estimated at 11,477 or 10% of the population aged 12-17. The prevalence of opiate use for those aged 16 and over is estimated at 5,889 or .6% of the population aged 16 and over.

The treatment demand for individuals aged 12 and over for all substances is estimated at 30,462 or 29.6% of the prevalence. The treatment demand allocations for alcohol and non-opiate drugs, youth and opiate use are presented in the table below.

Prevalence and Treatment Demand for Chemical Dependence Problems

	Alcohol and Non-Opiate Drugs Adults Aged 18+	Youth Aged 12-17

	Aged 12+ All Substances	Alcohol Only	Drug Only	Alcohol and Drug	Aged 12-17 Chemical Dependence	Aged 16+ Opiates
Population1	1,126,734	1,011,966	1,011,966	1,011,966	114,768	1,050,185
Prevalence of Problem2	103,020	64,090	7,092	14,472	11,477	5,889
Percent of Population	9.1%	6.3%	0.7%	1.4%	10.0%	0.6%
Treatment Demand	30,462	16,023	2,837	5,789	2,869	2,945
Percent of Prevalence	29.6%	25.0%	40.0%	40.0%	25.0%	50.0%
Percent of Population	2.7%	1.6%	0.3%	0.6%	2.5%	0.3%

Source: 1 U.S. Census Bureau (OASAS adjusted); 2 County-level prevalence rates from the 1998 NYS School Survey, 1994 NYS Adult Household Survey, 1998 NYS Heroin Study; applied to 2005 population

OASAS has further identified the following service need profile by treatment service category:

Chemical Dependence Service Need Profile

Service Category	Capacity Needed	Current Capacity3	Unmet Need	Percent Of Need Met
Crisis Services :				
Medically Managed Detoxification	30	28	2	93.3%
Medically Supervised Withdrawal (Inpatient)	29	0	29	0.0%
Medically Supervised Withdrawal (Outpatient)	59	0	59	0.0%
Medically Monitored Withdrawal	74	30	44	40.5%
Outpatient Services :				
Services to Adolescents (12-17)4,5	56,885	37,299	19,586	65.6%
Services to Adults (18+)4,5	365,023	293,650	71,373	80.4%
Methadone Treatment:	2,398	950	1,448	60.4%
Inpatient Rehabilitation 6,7: Region	365	315	50	86.3%
County	N/A	30	N/A	N/A
Residential Services :				
Intensive Residential 6 Region	1,277	344	933	26.9%
County	N/A	0	N/A	N/A
Community Residence 8 Multi-County	N/A	N/A	N/A	N/A
County	299	42	257	14.0%
Residential CDY Region	202	0	202	0.0%
County	N/A	0	N/A	N/A

Source: 3OASAS Certified Capacities (adjusted) as of March 3,2008. Note: Capacity is measured in beds for all inpatient and residential services, slots for medically supervised withdrawal outpatient and methadone services, and visits provided for outpatient services. 4Primary outpatient visits reported for the 12-month period from October 2006 through September 2007 (pas-48 and cds extracts 3/3/08). 5Need adjusted. 6Regional resource. 7Capacity adjusted. 8Need estimates are at the county level, except where there is an approved Multi-County Collaborative Agreement.

The data in the above table affords the opportunity to see what services are available within the county, within the region, and where gaps exist in services for Nassau County residents. For example, Community Residences at the County level meet only 14% of the need for this service category and there are no multi-county collaborative agreements. Statewide the need for community residences is met at 37.6%. Within Suffolk County, only 32.8% of the need is being met. Individuals needing this type of service need to seek treatment in other counties, and overall the percent of need met is very low.

Both Intensive Residential and Residential CDY Services are viewed as regional resources. Only 26.9% of the Intensive Residential need is met through Suffolk County's 344 beds.

Statewide 64.7% of the need is met. No Residential CDY beds are available within either Nassau or Suffolk counties. The statewide percent of need met is fairly low at only 36.0%.

In addition to the gaps identified above, other unmet treatment service needs identified through Direct Services Administrative Committee conferences include: the need for additional rehabilitation beds for the chemically dependent persons who are uninsured, need for additional beds for clients with co-occurring disorders, the need for increased services overall for clients with co-occurring disorders, the need for regulation of sober homes (the demand is great making regulation a primary concern), the need to revise counselor /caseload requirements for MMTP's (lower the ratio from 50 to one to 25 to one) and the need for additional funding for specialty treatment services for CD/ MMTP clients who are in need of trauma services.

In addition, the Chemical Dependence Service Need Profile Table 2 from OASAS listed the current capacity of Methadone Treatment in Nassau County as 250. This capacity is incorrect as it failed to include the 650 department slots. The two methadone program reporting units were assigned new provider and pru numbers as of February 22, 2008 and have a capacity of 650 slots. The recalculation of the unmet need results in 1,498 slots and a percent of need met of 62% rather than 10.4%.

An informal survey of prevention providers identified the following needs: professionals who specialize in and programs that focus on adolescent dual diagnosis; parenting at the elementary school aged level; staffing and networking at alternative high schools; greater awareness programs for perscription drug use/abuse as well as gambling addiction (also development of positive alternatives within local neighborhoods); resources at outpatient clinics for free services to low or non-income families.

This same survey identified the following gaps: long term adolescent residential centers on Long Island; culturally competent public service groups (beyond just being bi-lingual) that would have greater impact for outreach and services within the communities; unavailable mental health services due to long waiting lists; services for children who do not attend school regulary.

Identified barriers: parents are not mandated to receive education concerning addiction issues, poor parenting and attitudes sabotage efforts; immigration status issues

4. Service System Design (OASAS) - Considering the assessment of local chemical dependence and gambling problems in your county, the OASAS core continuum of services and program development hierarchy, the OASAS service need methodology, existing gaps in services, and any unique or changing local conditions, describe changes in the current configuration of the local service system that you believe would better meet the needs of individuals, families and communities in your county.

There are a number of changes to the local services system that were initiated in 2008 and will continue to take priority through 2010. These changes focus on improving the sysytem so that it will better meet the needs of the individuals and families in Nassau County. Among these changes are the establishment of a model program for delivery of treatment to persons with Co-occurring Disorders (COD), mental illness and chemical dependency. The integrated model delivers evidenced based practices to persons with COD and attempts to not only improve outcomes for persons with COD and their families, but will simplify processes, diminish administrative complexities and encourage sytem wide change which will support the development of additional COD evidenced based services. In addition to the COD model, the county will be working with local providers to establish a similar model program to address COD specific to treating adolescents. The need for additional adolescent services (including in-patient beds) is identified in state service need methodology and remains a priority for this county. The initiation of the integrated adolescent treatment model is planned for late 2008. Workforce training will also be a system wide priority for this planning cycle. To support the state local planning priorities namely, integration of mental health and chemical dependency treatment services, gambling treatment program expansions, tobacco free policy and programming, and other wellness issues, the department will develop and expand it's workplace training efforts to ensure that all staff throughout the system have access to up-to-date information and treatment practices that are evidence based. Adressessing unmet housing needs continues to be a focus of this department as part of the county behavioral health system and will continue to be a priority iof the current system. Efforts will be initiated that will support the OASAS 2008 Planning Supplement -100 Beds for Long Island plan and local providers will be encouraged and supported tand respond to this request for applications (RFA).

Other current changes to our local system include the development of funded Transitional Case Management (TCM) services. TCM will be provided to persons with chemical dependency who are high risk for HIV with the focus on engaging heroin and other substance users who have been identified as "hard to engage". Efforts will target individuals who have COD's such as, chemical dependency, mental illness, HIV/AIDs and suffer from gambling addiction. TCM services are funded through the New York State AIDS Institute. These services could be enhanced by OASAS funded providers by delivering off-site services in approved locations for persons unable or unwilling to access on-site services. Such locations could include community health centers, senior housing and socialization centers, veteran service centers, homeless shelters, etc.

In addition, we continue to see the benefit to be gained by the funding of case management services within the OASAS certified and funded provider network. While OASAS has seemingly eased the stringent focus on unit of service production it remains a reality that when clinical time is diverted into accessing other needed services and entitlements and coordinating client use, it detracts from the time available for training, clinical service delivery, supervision and other activities required to deliver gold standard services. Having a funded case management component would free clinical staff from these activities.

Also, we have long believed that the delivery of services lasting longer than 1 hour should be reported to OASAS as more than 1 unit of service. It is only by doing this that we get a true understanding of the productivity of the clinical staff. Several Nassau providers have

continued to provide intensive 1/2 day services despite being able to report only 1 unit of service for the clients who attend those programs. This results in a distortion in their calculated gross cost per unit of service and often penalizes those very programs that are providing quality interventions to clients in need of extended service time.

5. Capital Improvement Plan (OASAS) - Identify the need for capital improvements within the local service system. Include a list off active capital projects for which a **Schedule C - OASAS Capital Project Funding Request Form** has been completed and submitted to OASAS.

The Nassau County Department of Mental Health, Chemical Dependency and Developmental Disabilities Services supports the following capital projects:

Freeport PRIDE- Building acquisition and rennovation

Long Beach Medical Center FACTS and MMTP- Construction and rennovation of existing space

Mercy Medical Center Recovery House- Relocation and rennovation

Roosevelt Educational Alcoholism Counseling Treatment Center (REACT)- Building acquisition and rennovation

TEMPO GROUP, Inc.- Purchase of existing leased space

Youth Environmental Services (YES)- Construction of second floor to current site.

6. Discovery Process Documentation (OMRDD) - Identify the constituent groups consulted as part of the local discovery and priority setting process (e.g., individuals with developmental disabilities, families, advocacy groups, providers of services, DDSO, other community organizations, etc.)

The constituent groups consulted as part of the local discovery and priority setting process included: Individuals with developmental disabilities, family members, advocacy groups, providers of service and the DDSO.

7. Methods of Discovery (OMRDD) - Identify the methods of discovery utilized to determine the issues, concerns, needs and priorities for local planning (e.g., surveys, forums, key informant interviews, focus groups, analysis of available data, etc.). Summary information obtained from these discovery methods should be included.
The methods of discovery utilized during the planning process included surveys and community focus groups as well as analysis of available data. The findings of this process determined five high priority topic areas for our region which included: Special Populations (Dually diagnosed persons with mental illness and developmental disabilities, Medically fragile individuals and Persons on the Autistic Spectrum), Residential Services, Quality Staffing, Individualized Services and Family Support Services

Special Populations:
The findings indicated that a need exists for the development of inpatient services for dually diagnosed individuals with mental illness and developmental disabilities that have eroded over the past two decades. A need also exists for continued development of respite services accessible for parents and families of school-aged children with Autism and/or with serious behavioral challenges. Increased opportunities for community support services for higher functioning children and adolescents, particularly persons with Aspergers Syndrome was also noted as it was for medically frail individuals, both children and older persons.

Residential:
In the area of residential services the findings indicated a need for increased opportunities for persons residing with aging parents who are no longer able to provide community supports for their children with developmental disabilities or mental retardation. This priority need was also evident with persons who present with behavioral challenges that require more intensive community support as well as for medically fragile persons with developmental disabilities

Stable Direct Care Work Force:
The need to improve the availability of a stable, well-trained workforce was also identified as a priority issue as a result of the focus groups and surveys conducted. In order to improve consumer outcomes and satisfaction with services a stable workforce is essential. Wages and benefits for direct support workers have historically been consistently low when compared to other occupations. COLAs do not adequately address the base salary level. Also the disparity between the salaries and benefits offered to State employees and those of individuals employed in the non-profit sector, where the overwhelming amount of turnover and job abandonment occur must be addressed. The lack of a true career ladder in the field of developmental disabilities is another disincentive. Until such time that the fundamental disincentives to work in this field are addressed the constant turnover of direct care personnel will continue.

Individualized Services/Person Centered Supports:
Greater choice and input regarding individualized services by consumers, with a focus upon community inclusion was another priority topic identified as a result of the discovery process. The findings indicated that consumers and families desire a planning process that places the consumer or family squarely in the center, basing services and supports on their personal capacities, need and interests. As part of this, many individuals expressed the need for typical supports, activities and services in the community to be more accommodating, accessible and available to adults with developmental disabilities. Within the Person Centered Planning framework, individual and families will be encouraged to exercise more input over the identification, individualization and design of their personalized system of supports and services to make these more responsive to their personal needs and preferences, many of which will involve natural community supports of their choosing.
Families with younger children and adolescents with developmental disabilities expressed that their children do not have equal access to after school activities that are enjoyed by neuro-typical children. Many families questioned the role of home school districts to provide after school activities rather than having to rely upon OMRDD-funded activities whether through inclusion or parallel programs.

Family Support Services:
According to the results of the focus groups and surveys conducted as part of the planning process, families often experience difficulties in obtaining specific information about the nature and location of family support services. There appear to be subsets of individuals, each with different informational needs. Parents of infants and young children who are recently identified as having mental retardation or developmental disabilities as well as parents of school aged children in need of after/before school respite recreational and social activities in the community are groups identified who could benefit from improved information dissemination.
For adults with developmental disabilities the need for increased opportunities for socialization was paramount. Following their transition from the educational system into the adult services system many individuals with developmental disabilities lose their naturally occurring social networks and friendships. Although some indicated that trips into the community to restaurants, shops or movies with a direct support staff member is helpful, more opportunities are needed for adults to form a social nexus of their own

8. Assessment of Existing Supports and Services (OMRDD, optional) - This optional section should address the base resources of the county's developmental disabilities service system and the base of generic supports and services available within the county. Information may be summarized in a table or in narrative format. Data to assist in the formulation of this assessment is available under "County Data".

2009 Mental Hygiene Priority Outcomes Form
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Plan Year: 2009
Certified: Patricia Fulton (5/30/08)

Consult the LSP Guidelines for additional guidance on completing this exercise.
2009 Local Services Plan Guidelines Glossary

2009 Priority Outcomes

Priority Outcome 1
The availability of evidence based treatment services for persons with multiple disabilities.
Agencies: OASAS; OMH; OMRDD;
Service Categories: Treatment / Clinical Services;
Focus: Increased Availability of and Access to Services; Abstinence from Substances/Decreased Symptomatology; Increased Retention and Engagement in Treatment/Reduced Utilization of Psychiatric Beds; Use of Evidence-Based Practices/Best Practices/Promising Practices;
Impacted Populations: All Ages; Male; Female; Addiction; Mental Illness; Mental Retardation / Developmental Disability; No special population targeted;

Both anecdotal and quantitative data support the reality that persons often enter chemical dependency treatment, mental health treatment while simultaneously suffering from the ill effects of a co-occurring CD, MH diagnosis or with the cheallenge of a MR or developmental disabilty. Similarly, it is not uncommon to find persons in MR/DD services who also have a MH or CD diagnosis. To adequately address the needs of these clients with multiple needs it is necessary that staff be adequately trained and that resources be adequate to support a range of services to allow for concurrent treatment through the application of best practice models. In this way outcomes will be improved.

Strategy 1.1 In Progress
Agencies: OASAS; OMH; OMRDD;
Target Complete Year: 2009
Participants: State certified and funded providers; Advocacy Organizations; OASAS Field Office; OMH Field Office; OMRDD DDSO;

Continued integration and operational understanding among the CD, MH and MR/DD staff of a recently merged county department. This includes developing forums for staff exchange of information to facilitate cross training, for leadership meetings across areas to further educate on treatment philosophies, protocols, regulations and barriers to integrated treatment, and for merged program visits and reviews for programs reporting service provisions to those with multiple disabilities.

Strategy 1.2 In Progress
Agencies: OASAS; OMH;
Target Complete Year: 2010
Participants: State certified and funded providers; OASAS Field Office;

Continued training and improved capacity for the development of best practice treatment approaches including the integration of Motivational Interviewing as a standard of care in at least 50 % of all funded CD outpatient programs.

Strategy 1.3 In Progress
Agencies: OASAS; OMH; OMRDD;
Target Complete Year: 2009
Participants: State certified and funded providers; Advocacy Organizations; OASAS Field Office; OMH Field Office; OMRDD DDSO;

Continue to provide operational oversight and outcome evaluation to the county funded co-occurring demontration program operated by Peninsula Counseling. The experieinces and resulting operational analysis and data will be used to inform other providers of the most effective and efficient program design and clinical interventions.

Priority Outcome 2
Improve the availability of a stable, well-trained work force to improve consumer outcomes and satisfaction with services
Agencies: OASAS; OMH; OMRDD;
Service Categories: Treatment / Clinical Services;
Focus: Health and Wellness; Increased Availability of and Access to Services; Use of Evidence-Based Practices/Best Practices/Promising Practices; Quality Management/Performance Measurement/Consumer Satisfaction; Workforce Development;
Impacted Populations: All Ages; Male; Female; Addiction; Mental Illness; Mental Retardation / Developmental Disability; All Races / Ethnicities; No special population targeted;

Individuals with disabilities deserve competent and consistent care from people who care about them, but also from people who enjoy and take pride in their work. It means that as we enhance the types of services we offer, we must also work to improve the job of the direct support worker, making it one of high standards and desirable, rewarding work.

Strategy 2.1 In Progress
Agencies: OASAS; OMH; OMRDD;
Target Complete Year: 2010
Participants:

Agencies that employ direct support workers should use a mix of techniques, such as realistic job previews and job shadowing, to identiify those workers who value developing positive, interested and caring relationships with the people they serve.

Agencies that employ direct support workers should undertake a comprehensive review of their employee training regimen and enhance direct support skills training by incorporating elements of values-based competencies.

Agencies that employ direct support workers should make employee training for all levels of staff ongoing and establish a schedule and procedures for regularly assessing the effectiveness of their training programs.

Strategy 2.2 In Progress
Agencies: OASAS; OMH; OMRDD;
Target Complete Year: 2010
Participants: State certified and funded providers; OASAS Field Office; OMH Field Office;

In addition to the mandatory training requirements, the County will continue to support and encourage program staff to access workshops and seminars which provide skill development in best practice methodologies. By supporting professional growth and development treatment effectiveness is enhanced and job satisfaction is improved.

Priority Outcome 3
Greater choice and input regarding individualized services by consumers, with a focus upon community inclusion.
Agency: OMRDD;
Service Categories: Recovery / Community Support Services;
Focus: Increase in Retained Employment / Meaningful Activity / Education; Health and Wellness; Increased Social Connectedness/Community Inclusion; Self Direction/Independence/Economic Self-Sufficiency; Transportation/Community Supports; Increased Availability of and Access to Services; Use of Evidence-Based Practices/Best Practices/Promising Practices;
Impacted Populations: All Ages; Male; Female; Mental Retardation / Developmental Disability; All Races / Ethnicities; No special population targeted;

Consumers and families desire a planning process that places the consumer or family squarely in the center, basing services and supports on their personal capacities, need and interests. As part of this, many individuals expressed the need for typical supports, activities and services in the community to be more accommodating, accessible and available to children and adolescents with developmental disabilities, through home school districts rather than having to rely upon OMRDD-funded activities that are not necessarily integrated. Many families expressed that children and adolescents with developmental disabilities do not have equal access to after school activiities that are enjoyed by neuro-typical children such as clubs (i.e.photography, chess, school paper), sports (i.e., track, baseball...) and activities (school plays, art and music), whether inclusion or parallel programs.

Within the Person Centered Planning framework individuals with developmental disabilities and families will be encouraged to exercise more input over the identification, individualization and design of their personalized system of supports and services to make these more responsive to their personal needs and preferences, many of which will involve natural community supports of their choosing.

Strategy 3.1 In Progress
Agencies:
Target Complete Year: 2008
Participants:

To advocate for greater opportunities for interpersonal contribution in the community, through working, volunteering and joining clubs and civic organizations that are not disability -related or provider-agency driven/organized. For example: persons interested in physical fitness to be enrolled in the gym or fitness program of their choice (i.e., Gold's Gym or Jenny Craig or Weight Watchers).

Exploration of a volunteer driver and scheduler initiative across all agencies that will enable consumers and families to pool their transportation resources and agency resources.

Exploration of the use of alternative transportation providers to the existing publicly-funded transportation system (i.e., county buses, SCAT and ABLE-RIDE) such as taxi companies, using a negotiated voucher system to enable consumers opportunities to travel to community activities, such as attending a movie on a Saturday night, when public transportation is minimal.

Encouraging higher-functioning consumers to manage their own plan of services through self-determination and increased levels of self-advocacy to allow for greater independence in decision making and more fiscal control.

Increased use of ISS and/or Consolidated Support Services funding by families and consumers.

Priority Outcome 4
To assure safe, stable, supportive housing which promotes recovery, facilitates rehabilitation and maximizes potential for independent living.
Agencies: OASAS; OMH; OMRDD;
Service Categories: Recovery / Community Support Services;
Focus: Increased Access and Stability in Housing; Increased Social Connectedness/Community Inclusion;
Impacted Populations: All Ages; Male; Female; Addiction; Mental Illness; Mental Retardation / Developmental Disability; All Races / Ethnicities; No special population targeted;

In the absence of appropriate transitional and permanent housing, the return to full familial functioning and social standing is delayed and ones complete recovery is never achieved for those with CD and/or MH disabilities. Housing is equally important for persons with MR/DD as it serves as the foundation for ones achievement of their life goals.

Unfortunately, there are substantial shortages of residential options for our clients and at times one is forced to dwell in an enviromnment that undermines their sense of well being. In Nassau County the housing dilemma is complicated by the suburban attitude of Not in My Backyard." Increasingly there are fewer areas that are not in someone's backyard which makes citing of residential and housing resources a difficult undertaking.

This situation has also been difficult to resolve because the funding levels received from state government are barely sufficient to cover the

cost of living on Long Island.

Strategy 4.1 In Progress
Agency: OASAS;
Target Complete Year: 2009
Participants: Private Sector/ Business Community ; State certified and funded providers; OASAS Field Office;

Support the development of a housing initiative resultiing from the OASAS 100 bed planning supplement

Strategy 4.2 In Progress
Agencies: OASAS; OMH; OMRDD;
Target Complete Year: 2010
Participants: State certified and funded providers; Other local participants - sober home operators;

Establish ongoing communications with the operators of sober homes within Nassau County

Strategy 4.3 In Progress
Agencies: OASAS; OMH; OMRDD;
Target Complete Year: 2011
Participants: Private Sector/ Business Community ; Advocacy Organizations; Other federal or state participants - HUD;

Participate in dialogue with OASAS/OMH/OMRDD regional staff and others to identify and pursue the establishment of permanent housing options within Nassau County

Strategy 4.4 In Progress
Agency: OMH;
Target Complete Year: 2009
Participants: State certified and funded providers; Consumers; Families/Friends; OMH Field Office;

It is our recommendation that OMH adopt a funding methodology for supported housing beds that is commensurate with the cost of living in Nassau County. If this is done it would allow for the establishment of new beds in a timely manner and it would enable providers to not limit their search for apartments to the lower socio-economic areas of the county.

Strategy 4.5 In Progress
Agencies: OASAS; OMH; OMRDD;
Target Complete Year: 2009
Participants: State certified and funded providers; Consumers; Families/Friends; OASAS Field Office; OMH Field Office; OMRDD DDSO;

Many of the clients living in community beds have complex, difficult to manage conditions, such as MICA, MIMR or forensic backgrounds. Because of this, supported housing providers would benefit from receiving additional funds to be used to provide skill enhancement services for clients whose community tenure is jeopardized.

Strategy 4.6 In Progress
Agencies: OASAS; OMH; OMRDD;
Target Complete Year: 2011
Participants: State certified and funded providers; Consumers; Families/Friends; OMH Field Office;

There is a need for people who cannot live in shared housing and require more support than offered in scatter site apartments. Therefore, we recommend that additional beds be clustered in such a way that 24 hour staff can be on premises in a separate apartment.

Priority Outcome 5
Restructuring of the Outpatient Reimbursement Methods
Agencies: OASAS; OMH;
Service Categories: Treatment / Clinical Services; Recovery / Community Support Services;
Focus: Health and Wellness; Increased Availability of and Access to Services; Cost Effectiveness (Average Cost); Cross System Collaboration/Service Integration;
Impacted Populations: All Ages; Male; Mental Illness; All Races / Ethnicities; No special population targeted;

Funding methodologies are overly dependent upon Medicaid, and that income source is insufficient to cover the cost of delivering care. Managed care rates are extremely inadequate and revenue generation is limited by COPS thresholds. Another concern is that the majority of clients served are "high need", and, therefore, require a great deal of indirect care, for which the agency does not receive any reimbursement.

Strategy 5.1 In Progress
Agencies: OASAS; OMH;
Target Complete Year: 2011
Participants: Other Community Based Agencies; Consumers; Families/Friends; OASAS Field Office; OMH Field Office; OMRDD DDSO;

One approach to alleviating this problem would be to blend the resources from the multiple systems that serve the same consumer. This should minimize the current duplications of effort and allow for the deployment of resources in a more coordinated and effective manner. Furthermore, 100% initiatives should be established that are not restricted by Medicaid requirements and are instead governed by best practice standards and the expectation the the recipients of care will achieve outcomes that are measurable and consumer driven.

2009 County Addiction Funding Priorities Form
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: Patricia Fulton (5/27/08)

Decertify

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

County Funding Priorities

Funding Priority 1
Funding Priority Description:

Competitive salary and benefit structure

Determination of Need:

high staff turnover

Applicable Service Categories: Outpatient Treatment;
Priority Focus: Talent Management/Workforce Recruitment & Retention;
Will pursuit of this funding priority include a request for capital funding? No

Funding Priority 2
Funding Priority Description:

Expanded treatment capacity to address the needs of persons with co-occurring disorders. This includes funding for system-wide and program specific training and consultation in evidence based treatment, and program development as well as staffing additions and access to case management

Determination of Need:

Need is based on recognition of a significant percentage of persons in CD treatment who also have a MH disorder, and the desire for a research based standard of treatment for persons with COD.

Applicable Service Categories: Outpatient Treatment;
Priority Focus: Improved Access to/Availability of Services; Implementation of Evidenced-Based Practices; Expansion of Existing Service Capacity; Cross Systems Collaboration/Service Integration;
Will pursuit of this funding priority include a request for capital funding? No

Funding Priority 3
Funding Priority Description:

The establishment of residential treatment capacity for adolescents

Within the Nassau /

Determination of Need:

The Long Island Region currently has no adolescent residential beds while both school-based prevention and treatment providers continue to report the initiation of drug abuse at younger ages. The Nassau County Police recently reported an increase in heroin use among the adolescent population. Outpatient providers with a high percentage of clients under 18 are routinely forced to refer adolescents either out of state or upstate to access adolecent beds.

Applicable Service Categories: Residential Treatment;
Priority Focus: Improved Access to/Availability of Services; Implementation of Evidenced-Based Practices; Expansion of Existing Service Capacity; Establishment of Services Targeted to Special Populations;
Will pursuit of this funding priority include a request for capital funding? Yes

2009 Multiple Disabilities Considerations Form
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: Patricia Fulton (5/29/08)

Consult the LSP Guidelines for additional guidance on completing this exercise.
LGU: Nassau Cty Dept of MH, CD Dev Dis 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:

Several departments within the NAssau County Government structure sharte responsibility for identifying multi-disabled persons. The Department of Mental Health, Chemical Dependency and Developmental Disabilities Services has units such as Case Management, EAP, Court Services, and Treatment Intake and Placement which are all staffed by persons with credentials and experience to recognize, identify and intervene with clients with mutiple health and social service needs. Other departments within the Health & Human Services Vertical, such as Social Services, Veteran's Services, Senior Citizens, Youth Board, conduct outreach to identify those with unmet needs and also utilize the expertise within MH/CD to assess and address unmet mental health and chemical dependency treatment needs.

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:

Within the couunty government structure all departments within the Health and Human Services sector are under the direction and leadership of one Deputy County Executive. This facilitates and provides accoutablility to assure that comprehensive services are accessible to county residents. In addition, the LGU has weekly Commissioner meetings which is attended by each department in the Health and Human Services vertical.

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:

The LGU has established monthly "Case of the Week" forums. Within this context a case with multiple needs is presented and through collaborative efforts interventions are discussed and determined across department lines which assure the most comoprehensive and thorough solutions for the individual and/or family.

2009 ASA Subcommittee Membership Form
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: Christine Hunter (5/30/08)

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

Member	
Name	list is established but is waiting approval from County Legislature
Represents	Process has been delayed by administrative restructuring to join NCDDAA with Mental Health
Address	,
eMail	

Member	
Name	David Weingarten
Represents	Parent Advocate for DD
Address	64 Thompson Ave Oceanside, NY 11572
eMail	weing224@aol.com

Member	
Name	Richard Dina
Represents	Community Rep
Address	79 Maryland Ave Freeport, NY 11520
eMail	rdina@familyandchildrens.org

Member	
Name	Barbara Roth
Represents	Parent Advocate Mentall Illness
Address	2 Burling Lane Old Bethpage, NY 11804
eMail	

Member	
Name	Pamela Visconti
Represents	Consumer
Address	280 Commonwealth St Franklin Square, NY 11010
eMail	

Member	
Name	Steven greenfield
Represents	Community Rep
Address	2336 Harison Ave Baldwin, NY 11510
eMail	

Member	
Name	Wendell Knight
Represents	Provider, Exec Dir MTI Inc
Address	590 Flatbush Ave. Brooklyn, NY 11225
eMail	

Member	
Name	Susan Berger
Represents	Family Advocate
Address	32 Harmony Drive Massapequa Park, NY 11762
eMail	

Member	
Name	Billy Martin
Represents	Provider, REACT
Address	21 Oakdale drive Westbury, NY 11590
eMail	

Member	
Name	Maria Elisa Cuadro-Fernandez
Represents	Provider, Exec Dir. COPAY
Address	28 Ringler Drive East Northport, NY 11731
eMail	mecfcopay@aol.com

Member	
Name	Gladys Serrano
Represents	Provider, Exec Dir. Hispanic Counseling Center
Address	344 Fulton Ave. Hempstead, NY 11550
eMail	Hispaniccc@aol.com

Does this Sub-committee have a workgroup dedicated to compulsive gambling?

- ○ Yes
- ◉ No

2009 Developmental Disabilities Subcommittee Membership Form
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: Patricia Fulton (5/30/08)

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

Member	
Name	There is 1 integrated Community Services Board for the combined MH, CD, MR/DDS. The membership list is established but is waiting approval from the County legislature.
Address	,
eMail	

Member	
Name	David Weingarten
Represents	DD Parent Advocate
Address	64 Thompson Ave. Oceanside, NY 11572
eMail	weing224@aol.com

Member	
Name	Richard Dina
Represents	Community Rep
Address	79 Maryland Ave Freeport, NY 11520
eMail	

Member	
Name	Barbara Roth
Represents	MH Parent Advocate
Address	2 Burling La Old Bethpage, NY 11804
eMail	

Member	
Name	Pamela Visconti
Represents	Consumer
Address	280 Commonwealth St Franklin Square, NY 11010
eMail	

Member	
Name	Steven Greenfield
Represents	Community Rep
Address	2336 Harrison Ave Baldwin, NY 11510
eMail	

Member	
Name	Wendell Knight
Represents	Provider
Address	590 Flatbush Ave Brooklyn, NY 11225
eMail	

Member	
Name	Susan Berger
Represents	Family Advocate
Address	32 Harmony Dr Massapequa Park, NY 11762
eMail	

Member	
Name	Billy Martin
Represents	Provider
Address	21 Oakdale Dr Westbury, NY 11590
eMail	

Member	
Name	Maria Cuadra-Fernandez
Represents	Provider
Address	28 Ringler Dr East Northport, NY 11731
eMail	mecfcopay@aol.com

Member	
Name	Gladys Serrano
Represents	Provider
Address	344 Fulton Ave Hempstead, NY 11550
eMail	hispaniccc@aol.com

2009 Mental Hygiene Local Planning Assurance
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: Christine Hunter (5/30/08)

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

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 OMRDD accept the certified 2009 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 2009 local services planning process.