2011
Local Services Plan
For Mental Hygiene Services

Nassau Cty Dept of MH, CD Dev Dis Svcs
October 29, 2010

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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 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.

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 of over 1.3 million people with a population density of 4,650 persons per square mile. It is the most densely populated county outside New York City in the downstate region. According to the U. S. Census Bureau, population estimates show a slight increase of 1.7% from 2000 to 2009.

Nassau is a well-established suburb that is slowly undergoing changes—the population is aging (the percent of the population aged 65 or older more than doubled from 6% in 1950 to 15% in 2009), 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. In March 2010 the preliminary unemployment rate for Nassau County was 6.9%, up from 4.7% in 2008.

Demographic data from the US Census Bureau indicated that in 2008, White persons comprised 80.1% of the county's population. Black persons made up 11.3%, up from 10% in 2000. Asian persons numbered 7% of the population in 2009 compared to 4.7% in 2000. Persons of Hispanic or Latino origin made up nearly 13% of the population compared to 10% in 2000. White persons that are not Hispanic, comprised 68.5% of the county's population compared to 74% in 2000. These demographics of Nassau County residents indicate a greater diversity as more immigrants arrive from Latin America and Asia. Because many immigrants tend to locate in certain areas, needs within communities are gradually changing as well.

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

The OASAS March 2010 Service Need Profile estimated the number of county residents with chemical dependence problems at 156,953 or 13.5% of the county's population aged 12 and over. This rate is similar to other counties that comprise the NYC Metro Suburbs planning areas (Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Ulster, Westchester counties). Based on January – December 2008 client data from the Nassau County Chemical Dependence Profile, the total number of unique clients served in the county was 14,983. A total of 15,329 unique county residents were served anywhere in NY State. The average daily enrollment across all program categories was 5,651 clients with the greatest number being served in outpatient programs. The number of estimated service dollars spent per person in the county for Chemical Dependence Treatment Services was $4,159 compared to $6,487 statewide, a difference of $2,328 (OASAS Summary of the County Profile).

The OASAS Chemical Dependence Treatment Profile for Nassau County (5/13/2009) based on 2008 calendar year Admissions and Discharges indicated the following client characteristics across all treatment program categories:

- 71.6% were Males; 28.4% were Females
- 7% of clients were 17 years of age or less; 21.7% were 18-24; 23% were 25-34; 22.6% were 35-44; 19.5% were 45-54; and 6.2% were 55 and older.
- 65.5% were White; 18.3% were Black; 13.2% were Hispanic; and 3% were Other
- White clients comprised the highest percents of clients in the following services: Crisis Services (71.4%), Inpatient (76.9%), and MMTP (78%) services; Blacks utilized Residential Services (32.8%) more than other services; Hispanics tended to utilize Outpatient Services to a greater degree.
- 36.7% of the clients were employed Full or Part Time.
- 75.1% were high school graduates across all program categories
- 41.7% were involved with Criminal Justice across all program types with 52.8% in Non-Crisis Programs and 3.5% in Crisis programs.
- The percent of clients with co-occurring mental health problem was 31.8% for non-crisis programs.
- 46.3% indicated alcohol as the primary substance of abuse across all program types; 14.7% Marijuana; 20.5% Opioids (38% in Crisis programs); 12.7% Crack/Cocaine and 2.3% Other substances.
- 23.1% had Medicaid as the principal payment source at time of discharge; 24.5% had private insurance; 24.5% were Self-Pay; and 18.7% had none.

Treatment and Prevention programs continue to note that many substances are highly available in their communities and usage is occurring at an earlier age as reported in the 2008 Community epidemiology Survey. In addition, a more extensive use of prescription pain relieving drugs such as OxyContin, Vicodin, and Percocet, and more use of heroin was noted.

In 2008 the Nassau County Police Department indicated that more youths are abusing recreational drugs as indicated by sale and possession arrests. The Nassau Narcotics and Vice Squad expressed concern that they were seeing a rise in heroin use, particularly because it has been cheaper to obtain than other opiates and the purity of the drug has increased. They began to work intensely with school officials to educate teachers and parents to look for signs of abuse in students.

The Nassau County Medical Examiner reports the number of drug and alcohol related deaths every year. In 2000 the number was 75 and has gradually increased every year since then. In 2008 the total number of deaths was 169 that were directly related to drugs and/or alcohol. The number of deaths attributed to Heroin was 46 in 2008 with the greatest number of deaths (17) occurring in the 21-30 age group. In 2008 there were 47 deaths attributable to Cocaine with the greatest number occurring in the 41-50 age group.
Treatment data from the OASAS Client Data System indicates that heroin admissions across all types of services had increased. In 2004 there were 1,621 heroin admissions where heroin was listed as either the primary, secondary, or tertiary substance of abuse and represented 14% of the total admissions in Nassau County programs. In 2009, there were 2,709 admissions or 21% of the total admissions.

Heroin admissions to non-crisis services increased gradually from 2004 through 2009. In 2004 heroin admissions represented 9% of the total admissions. By 2009 heroin admissions represented 12% of the total admissions.
Heroin admissions to crisis services have been greater. In 2004, any heroin admissions made up 35% of the total admissions whereas in 2009, 47% of the crisis admissions included heroin as either a primary, secondary, or tertiary substance of abuse.

Heroin admissions where heroin is the primary substance of abuse increased across certain age groups. Prior to 2008, the 26-45 year olds represented the largest percentage of heroin admissions (55% in 2004) and decreased to 42% in 2009. In contrast, heroin admissions for the 19-25 year olds have been increasing. In 2004 the 19-25 year olds represented 29.6% of primary heroin admissions to Crisis Services. In 2009, this group made up 48% of the admissions and the largest represented age group in both 2008 and 2009.

This department is a member of the county's Heroin Prevention Task Force along with over 100 other members representing treatment, prevention, schools, parent organizations, law enforcement and other government agencies and consumers to decrease the presence and use of heroin and other opiates in Nassau County. Special events and education efforts for parents and students have already been conducted and will continue to reach as large and varied an audience as possible.

In 2008 4,241 Nassau County students participated in the OASAS 2008 Youth Development Survey. The survey identified four risk factors for Nassau County students: Peer Rewards for Antisocial Behavior, Parental Attitudes Favorable to Antisocial Behavior, High Community Disorganization, and Family Conflict. Peer rewards for antisocial behavior for the combined 7th – 12th grades was 52.1%, compared to the NY State value of 43.1% and the 7-state norm of 45%. This risk factor indicates that young people who receive rewards for their antisocial behavior are at higher risk for engaging further in antisocial behavior and substance abuse. Seventy percent of Nassau County students in the 11th-12th grades are at risk for this factor compared to 55.2% of NY State students in the same grades. Parental attitudes that are tolerant of antisocial behavior exacerbate the problem since children are then more likely to become drug abusers during adolescence. Nassau County students scored above the NY state levels at the 9th-12th grade levels. Sixty-four percent of 11-th graders indicated parental attitudes favorable to antisocial behavior compared to 54.3% in NY State and the 7-state norm of 45%. Similarly, High Community Disorganization was indicated by 62.5% of 11th-12th graders compared to 58.2% of NY state students and the 45% 7-state norm. Family Conflict was reported more frequently in the 9th-12th grades and 7th-8th grades compared to the older 11-12th grade students.

Protective factors that help to mitigate the risk factors by decreasing their negative effects indicated that Nassau County students had many more Opportunities for Prosocial Involvement (75.1%) compared to 59.1% of NY State across the 7th-12th grades and that there were many School Opportunities for Prosocial Involvement as indicated by 86.5% of the surveyed students. Of concern is the lack of Community Rewards for Prosocial Involvement which fell below the 7-state norm for 9th-12th graders and highlights the need for neighborhood residents to notice and participate in encouraging good behavior from students.

The survey also allows for an assessment of what substances are frequently used and how often. Alcohol was still the most frequently reported substance to the question, on how many occasions students used alcohol in their lifetime, with the percentages increasing with grade levels. While only 18.8% of 7th graders had used alcohol, 54.4% of 9th graders and 85% of 12th graders reported having used alcohol in their lifetime. More than half of Nassau county 11th graders and 12th graders reported drinking alcohol in the past 30 days compared to 43.1% of the nationally surveyed seniors in the Monitoring the Future Survey.

Binge drinking (having five or more drinks in a row within the past two weeks) was engaged in by 36.8% of 11th-12th grade students compared to 28.2% in NY State. Since many 11th and 12th graders are already driving, this presents an additional danger not only to themselves but to others. In 2008, there were 4,269 DWI arrests in Nassau County with 154 in the 16-18 age group, 343 in the 19-20 age group, 841 in the 21-24 age group, and 814 in the 25-29 age group (Nassau County Traffic Safety Board). Thus half of the total DWI arrests were for individuals below 30 years of age.

Questions regarding the use of other substances indicated that 46% of 11th graders had used marijuana; nearly 16% of 12th graders

reported using prescription pain killers. Also, more than half of the 12th graders reported having used some type of illicit drug in their lifetime.

Gambling

Results from the OASAS 2006 School Survey had indicated that 72% of students in grades 7-12 engaged in at least one gambling activity in the past year; 34% gambled in the past month while 12% gambled four or more times in the past month. Based on OASAS' findings they found that about 10 percent of students in grades 7-12 had experienced problem gambling in the past year and may need treatment services while an additional 10 percent of students may be at risk of developing problem gambling. For those students experiencing problem gambling, gambling for money involved most frequently playing cards, followed by playing pool, basketball or other skill games. Findings from the 2006 School Survey also indicated that for students in grades 7-12 who are in need of chemical dependency treatment, 28% also experienced problem gambling in the past year and an additional 17% may be at risk of developing problem gambling.

The 2008 Youth Development Survey indicated that for the combined grades 7 – 12 in Nassau County, 57.4% of the surveyed students gambled in the past year compared to 47.5% in NY State. For each grade level, more Nassau County students gambled than other students in NY State. Sixty-three percent of the 11th-12th grade students gambled compared to 50.8% of other state students.

The OASAS 2006 Household Survey looked at gambling behaviors and problem gambling among adults in New York State. Findings from this survey indicated that about five percent of adults experienced problem gambling in the past year and may be in need of treatment services. Of the nearly five percent of adults who experienced problem gambling in the past year, about 28% also experienced a substance use disorder in the past year. For those adults experiencing a substance use disorder in the past year, about 13% also experienced problem gambling.

The addition of a question to the OASAS admission form as of April 2009 provides information about how many admitted clients were screened for a gambling problem. A review of admissions to non-crisis programs in Nassau County from April 1, 2009 through March 31, 2010 showed that there were 127 (or approximately 2%) of the clients who screened positively for a gambling problem out of the 6,636 clients that were screened.

2. 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. Use this section to describe changes in the current configuration of the local service system that you believe would better meet the needs of individuals and families in your county.

The OASAS March 2010 Service Need Profile for Nassau County (see below) estimated the number of county residents with chemical dependence problems at 156,953 or 13.5% of the county's population aged 12 and over. Of the total number in need, 115,328 are adults aged 18 and over with alcohol only dependency problems, 24,204 are adults aged 18 and over with alcohol and non-opiate drug problems. Youth aged 12-17 with alcohol and/or non-opiate drug abuse are estimated at 11,532 or 10% of the population and that percentage is used through all the counties in NY State to estimate adolescent chemical dependence prevalence. The prevalence of opiate users aged 16 and over is estimated to number 5,889 or 0.5% of the population aged 16 and over (1,085,668).

Service Need Profile – March 2010 Nassau County
Prevalence and Treatment Demand for Chemical Dependence Problems

		Alcohol/Non-Opiate Drugs Adults Aged 18+		Youth Aged 12-17	
	Aged 12+ All Substances	Alcohol Only	Alcohol and Drug	Chemical Dependence	Aged 16+ Opiates
Population1	1,160,928	1,045,604	1,045,604	115,324	1,085,668
Prevalence of Problem2	156,953	115,328	24,204	11,532	5,889
Percent of Population	13.5%	11.0%	2.3%	10.0%	0.5%
Treatment Demand	44,342	28,832	9,682	2,883	2,945
Percent of Prevalence	28.3%	25.0%	40.0%	25.0%	50.0%
Percent of Population	3.8%	2.8%	0.9%	2.5%	0.3%

Source: 1 U.S. Census Bureau,2007 (CDC adjusted); 2 County-level prevalence rates from the 2006 NYS School Survey, 2006 NYS Adult Household Survey, 1998 NYS Heroin Study; applied to 2007 population.

Of the total 156,953 individuals estimated to have chemical dependence problems, OASAS estimates that 28.3% or 44,342 would seek treatment in Nassau County if treatment was accessible. Thus, nearly three out of every ten persons with a chemical dependence problem would seek treatment in a given year.

Between October 1st, 2008 and September 30th, 2009, there were 14,803 Nassau County residents that were admitted to treatment anywhere in NY State. Thus, only one-third of the estimated number of people that would seek treatment was admitted to treatment. A total of 10,812 Nassau County residents were admitted to programs in Nassau County, and an additional 3,991 individuals were treated in programs out of the county. The table below shows the number of admissions for each type of service.

Nassau Residents Admitted to CD Treatment Oct. 1, 2008 – Sept. 30, 2009

Service Type	In County		Out of County		Total Admissions - N
	N	%	N	%	
Crisis	2,107	64%	1,160	36%	3,267
Outpatient	8,077	92%	658	8%	8,735
Methadone	181	57%	137	43%	318
Inpatient	376	21%	1,449	79%	1,825
Residential	71	11%	587	89%	658
All Services	10,812	73%	3,991	27%	14,803

Source: NYS OASAS Data Warehouse, extract 2/22/2010

Across all services, Nassau's admission rate to programs in the county was 73%. The number of county residents admitted to Inpatient and Residential treatment services is very low primarily because of the low number of beds available in the county.

Additional detail is provided by OASAS in 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		46	28	18	60.9%
Medically Supervised Withdrawal (Inpatient)		45	0	45	0.0%
Medically Supervised Withdrawal (Outpatient)		90	0	90	0.0%
Medically Monitored Withdrawal		102	30	72	29.4%
Outpatient Services:					
Services to Adolescents (12-17)4,5		57,200	34,434	24,583	57.0%
Services to Adults (18+)4,5		574,898	307,426	267,472	53.5%
Methadone Treatment:		2,280	900	1,380	39.5%
Inpatient Rehabilitation6,7:	Region	449	315	134	70.2%
	County	N/A	30	N/A	N/A
Residential Services:					
Intensive Residential6	Region	1,685	331	1,354	19.6%
	County	N/A	0	N/A	N/A
Community Residence8	Multi-County	N/A	N/A	N/A	N/A
	County	393	42	351	10.7%
Residential CDY6	Region	79	0	79	0.0%
	County	N/A	0	N/A	N/A

Source: 3 OASAS Certified Capacities (adjusted) as of March 5, 2010. 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. 4 Primary outpatient visits reported for the 12-month period from October 2008 through September 2009 (pas-48 and cds extracts 3/14/10). 5 Need adjusted. 6 Regional resource. 7 Capacity adjusted. 8 Need estimates are at the county level, except where there is an approved Multi-County Collaborative Agreement.

For Inpatient treatment, the availability of beds is viewed as a regional resource so it is expected that residents would need to access services outside of the county and 79% of the inpatient admissions were out of the county. The estimated needed capacity for inpatient beds is 449 of which 315 are available in the region, leaving an unmet need of 134 beds. Thus 70% of the need for inpatient beds is being met. Statewide, 96.0% of the need is met for inpatient beds.

Residential Services were accessed out of Nassau County by 89% of county residents. The county has 42 community residence beds with an identified capacity need of 393 beds, leaving the county in need of 351 beds or an unmet need of 90%. In Suffolk County, only 22.6% of the need is met for this type of service and statewide 37.9% of the need is being met.

Residential Chemical Dependency for Youth services are not being met at all either in the county or on a regional basis. The needed capacity of 79 beds for the region currently has no beds for this service type and an unmet need of 100%. Statewide the need is met at 85.9% so most youth would utilize this type of service by going out of the Long Island region

Methadone treatment services also indicate a percent of need met at only 39.5%. Statewide the percent of need met is slightly higher at 54.2%.

Crisis services in Nassau County consist of medically managed detoxification and medically monitored withdrawal services. No medically supervised withdrawal (inpatient or outpatient) services are available in the county. The percent of need met for medically managed detoxification is 75.7% but only 34.9% for medically monitored withdrawal services. Medically managed detoxification treatment in Suffolk County is met at only 18.2%. In 2009, 60% of the primary heroin admissions to the Nassau University Medical Center were residents of Suffolk County.

Outpatient services based on visits for adolescents shows 57% percent of need met which is considerably better than Suffolk County (44.2% of need met) and New York State at 45.7% of need met. Outpatient services to adults (18+) for Nassau County meets 53.5% of need which is lower than Suffolk County (58.7%) and the statewide 72.4% of need met

In addition to the gaps identified above, other unmet treatment service needs identified within the department include: the need for additional rehabilitation beds for CD persons who are uninsured, need for additional beds for MICA clients with co-occurring psychiatric conditions, the need for increased MICA services overall, 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.

Another area of need that has been identified involves case management services for adolescents and young adults. While research indicates that treatment goals are better met the longer a client stays in treatment, it is often difficult to engage these clients in treatment. Reliance on detoxification services is not a solution and clients need to be assisted so that they can enter longer term treatment to become productive members of society. Too many clients are discharged from detoxification services and refuse further referrals into appropriate levels of care.

3. Capital Improvement Plan (OASAS)

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

The following Schedule C forms were submitted to OASAS in 2008 for consideration by OASAS: YES for the enlargement of provider owned facility; North Shore University Hospital at Glen Cove for a construction project to co-locate the 3 certified OASAS outpatient services; Rockville Centre Confide for the purchase of a facility; COPAY for the purchase of an existing leased space; TEMPO for the purchase of an existing leased space. In addition the Schedule C submitted in 2008 by REACT for purchase and renovation of existing leased space is currently being developed as a capital project. Following a feasibility study the request submitted by Friends of Bridge is to be withdrawn.

The Department gives priority to the requests from TEMPO, and COPAY; followed by Rockville Centre Confide and North Shore University Hospital @ Glen Cove.

4. Discovery Process Documentation (OPWDD)

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, service providers and the DDSO

5. Methods of Discovery (OPWDD)

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 during the planning process included surveys, forums, key informant interviews, as well as analysis of available data. The findings of this process determined several high priority topic areas for our County which included: (Dually diagnosed persons with mental illness and developmental disabilities, medically frail aging people 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 improved access to inpatient beds and services for individuals dually diagnosed with mental and developmental disabilities as these services have eroded over the past two decades.

A need also exists for continued development of services and programs accessible for children and adults with Autism and/or serious behavioral challenges. The findings indicate the need for continued development of respite services accessible to parents and families of school-aged children on the autism spectrum, particularly those with challenging behaviors. Increased opportunities for community support services for children and adolescents with Autism and/or serious behavioral challenges who are more capable, particularly persons with Aspergers Syndrome was also noted.

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 disabilites or mental retardat ion. This priority need was also evident with persons who present with behavioral challenges that require more intensive community support as well as for medically frail persons with developmental disabilities.

Stable 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 discovery process. 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 evelopmental disabilities is another disincentive. Opportunities for direct support workers that will allow them to climb a ladder to management, or alternatively, to be rewarded for advancing skills and qualifications while remaining in direct support must be considered. Until such time that the fundamental disincentives to work in this field are addressed the constant turnover of direct care personnel will continue.

Individualize 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, needs and interests. As part of this, many individuals expressed the need for typical supports, activities and services in the community to be more accomodating, accessible and available to adults with developmental disabilites. Within the Person Centered Planning framework, individuals 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.

6. Assessment of Existing Supports and Services (OPWDD, 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".

7. Paterson Drug Law Reforms (OASAS, optional)

The 2009 reforms to the Rockefeller Drug Laws eliminated certain mandatory prison sentences by giving judges discretion to divert non-violent individuals with substance abuse histories to a variety of alternative sentences, including Judicial Diversion programs modeled after Drug Courts. These reforms were expected to significantly increase access to treatment for many offenders. In this section please address each of the following:

a. How has the implementation of the Paterson Drug Law Reform affected the demand for treatment services in your county or the need to re-prioritize patient access to treatment?
b. How does the service system in your county address the criminogenic needs of individuals within the treatment system? (Criminogenic needs are defined by anti-social cognition; anti-social personality and temperament; anti-social associates; troubled family factors; difficulties in work or school settings; use of leisure time and recreational activities; presence of substance abuse.)
c. What additional challenges to addressing the service needs of the criminal justice involved individuals within your county have been created as a result of Drug Law Reform? (This may include: gaps in treatment; need for case management services; lack of residential programs or housing; collaboration with criminal justice entities and treatment court)

A felony drug court was established in Nassau County in October 2009 to address the diversion into treatment for those individuals targeted through the Paterson Drug LAw Reforms. OASAS issued a Planning Supplement to address the additional assessment and treatment needs to be generated by referrals from those diversions and estimated that within Nassau County an additional 52 persons would enter treatment. In reality the number of perons diverted into treatment through April 2010 has been more than 200. As a consequence to address the need for increased case management, the county is being required to move staff from district drug court into felony court. This will leave a void in the district court effort to screen, refer and monitor DWI offenders.

8. Personal Recovery Oriented Services (OMH, optional)

PROS support adults with serious mental illness to improve functioning, increase employment, attain higher levels of education, secure preferred housing, and aid recovery through integrated treatment, support and rehabilitation options. Please provide your county's perspective on PROS by answering the following questions:

a. If your county has PROS programs in place, briefly describe for your colleagues in other counties the successes and challenges you have encountered with PROS implementation, monitoring, and evaluation.
b. If providers in your county are considering conversion to PROS or already have PROS in place, please comment briefly on the following:
    - In keeping with the intent of the PROS program, have you or providers identified populations for whom PROS is not appropriate and/or individuals who are not eligible for PROS? If so, how are you and providers working with these populations to avoid having gaps in services develop?
    - If you are an existing PROS provider, what services are difficult to have provided?
    - If you are considering a PROS program, what new services required under PROS are you not fully able to provide?
    - Has the county developed a plan that promotes synergy across providers and builds upon the recognition that PROS programs operate within a broader system of care (e.g., not introducing new services when existing capacity or expertise exists)? How will the introduction of PROS impact the service needs of individuals not in PROS and what steps will be taken to ensure a continuum of care to meet the individual needs of persons and families served by your local system of care?
c. Are there additional data, training, or other supports that the Field Office could provide to aid providers' implementation of or planning and conversion to PROS? (Be sure to contact your Field Office with your requests so they can be addressed in a timely manner.)

Nassau County has initiated the implementation of PROS with the opening of three PROS programs in January 2010. Two additional PROS programs opened in February 2010 and we are antincipating the opening of one more PROS program within the next three or four months.

Even at this early stage our providers are aware and have indicated that PROS will create additional gaps in services, particularly for the geriatric and homebound individuals with a major mental illness. Limited transportation options for these populations, particularly those who have Medicare, but not Medicaid further complicates the situation. Nassau County in meeting with the Coalition of Mental Health Agencies within the county to address this situation and explore alternatives to address these gaps.

Although our programs in the initial stages, Nassau County has encouraged all of our PROS programs to work within the broader system of care. Each of the programs is actively working with VESID. In addition all of our programs also work with case management, ACT, AOT and are participating in the Ticket to Work Training.

All of the PROS programs in Nassau County participates in the monthly statewide conference call with OMH, and in the monthly Nassau County conference call with OMH to discuss issues and concerns, as well as to explore solutions. In addition, The Nassau County Department of Mental Health , Chemical Dependency and Developmental Disabilities services schedules quarterly meetings with the PROS providers to share successes, issues and to explore collaborative efforts.

9. Mental Health Clinic Restructuring (OMH, optional)

Clinic restructuring creates a more rational basis for financing clinic services and providing incentives for quality care and improved outcomes by promoting care premised on the principles of person first, engagement, recovery and resiliency. In this section please address each of the following:

a. How will the county promote change in the way services are delivered by providers within this new restructured model? What would be required to make providers financially viable and able to meet the recovery needs of the people serve in the community (e.g., new service models)?
b. What strategies will providers use to address areas such as outreach and engagement, use of peer and family staff, after-hours/weekend services coverage, crisis diversion, and in-home service delivery?
c. What outcomes have been achieved through the State psychiatric center and county collaboration over the last year and what major goal will you be working on this year to ensure that the services offered by the psychiatric center provide added value, help fill service gaps, and complement the array of services already provided locally?
d. Has the county developed a plan that promotes synergy across all mental health providers and builds upon the recognition that clinics operate within a broader system of care (e.g., not introducing new services when existing capacity or expertise exists)? What steps are being taken to ensure a continuum of care that meets the individual needs of persons and families served by the local system of care?
e. Are there additional data, training, or other supports that the Field Office could provide to aid implementation of clinic restructuring? (Be sure to contact your Field Office with your requests so they can be addressed in a timely manner.)

The Nassau County Depratment of Mental Health, Chemical Dependency and Developmental Disabilities Services is actively participating with the varous stakeholders to discuss issues of fiscal viability and meeting the needs of consumers currrently served who have managed care or other insurance. It should be noted that Nassau County has a low Medicaid base as compared to other regions in the state. Therefore, many of our mental health agencies have a high COPS rate. With the repeal of COPS, The Coalition of Mental Health Providers in the downstate area projects a decrease in revenue of 36% in the Long Island region at the 4 year completion of the Clinc Restructuring implementation. Through the establishment of bi-monthly meeting with providers and other stakeholder meetings, we hope to develop recommendations to address these issues and ensure the continued viability of services to individuals with serious and persistent mental illness irrespective of their benefits and/or insurance.

Due to the shortage of staff at Pilgrim Psychiatric Center, which is a bi-county facility there have be minimal services provided of added value or an attempt ot fill gaps or complement the array of services provided locally. While the opening of the transitional housing unit within the facility has allowed for the discharge of additional clinets from Pilgrim Psychiatric Facility, this further burdens other community resources.

10. Balancing the OPWDD Services Portfolio (OPWDD, optional)

A balanced services portfolio would offer individuals and family members access to a diverse array of service options, with an emphasis on expanding the availability of individualized supports and services, and maintaining traditional opportunities. In this section please address each of the following:

a. What information do you need to effectively support this service direction? (e.g. service utilization patterns, etc.)
b. What strategies are you using/considering for engaging families related to this new emphasis? (For families who have experienced the "old" system, and those new to the system)
c. How are Counties working with service providers to address this direction?

11. Cultural and Linguistic Competence (OASAS, OMH, OPWDD)

Cultural and linguistic competence reflects at all levels of the system of care regard for the importance of culture, attention to the elimination of disparities, and the importance of adaptations to meet culturally unique needs.

a. Does your county have a cultural competence plan in place for meeting needs of individuals and families in any of three mental hygiene areas (CD/DD/MH)? If so, please specify for which area you have a plan.
b. Does your county currently use tools to assess the cultural and linguistic competence of county-run and other provider organizations? If so, please identify the tools and briefly describe the areas assessed.
c. Does the county analyze data by race and ethnicity to reveal disparities in services provision? If yes, please indicate the areas you are examining (e.g., access to services, utilization patterns) and specify performance measures and benchmarks being used to reduce disparities.
d. What data would better enable your county to identify disparities among providers and across the system of care?
e. In which areas would it be helpful for providers to have cultural competence training? Please provide your thoughts on the content and method of delivery of such training.

Nassau County has a cultural comptence plan in place which is reflected in the language used in contracts signed with CD, DD and MH Providers. Language used in these contracts strongly encourage delivery of services by staff that reflect the ethnic and cultural diversity of the community served. The County in collaboration with the Mental Health Association offers annual trainings to Community Based Providers that focus on cultural and linguistic competence issues. The Nassau County Family Support System of Care grant initiative is being utilized to enhance cultural competence in support of the goal to reduce mental health disparities and lead a transformation of the mental health system as we know it. A Professional Feedback tool has been developed through the NC-FSS to assess cultural and linguistic competence in multiple domains consisting of physical environments, materials and resources, communication styles, values and attitudes and trainings. The development of this tool seeks to obtain useful information about beliefs, attitudes and values that will shape and guide the level of information delivered in a comprehensive training format. The County maintains data base of information that capture the breakdown of services received by ethnicity. This information is utilized as a barometer to identify and monitor disparites within our system of care in Nassau County. Provider organizations are strongly encouraged to distribute materials in the native languages within the communities they serve.

2011 Mental Hygiene Priority Outcomes Form
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Plan Year: 2011
Certified: James Dolan (6/2/10)

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

2011 Priority Outcomes

Priority Outcome 1 In Progress
The availability of evidence based treatment services for persons with multiple disabilities.

Both anecdotal and quantitative data support the reality that persons often enter chemical dependency treatment, or mental health treatment while simultaneously suffering from the ill effects of a co-occurring CD, MH diagnosis, or with the challenge 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 are 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.

During 2009 The Center for Excellence in Integrated Care identified and reviewed 2 cohort groups of programs to assess their ability to provide services to clients with co-occurring MH and SA diagnosis. All CD programs reviewed to date were found to be Dual Diagnosis Capable and all were provided with concrete suggestions and directions for moving towards enhancing their ability to address the needs of clients with COD.

Agencies: OASAS; OMH; OPWDD;
This outcome has been selected as a top two priority for OASAS.
This outcome has been selected as a top two priority for OMH.
This outcome has been selected as a top two priority for OPWDD.
Target Complete Year: 2011

Strategy 1.1 In Progress

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.

2010 Progress: The mental health, chemical dependency and MRDD staff routinely and regularly participate in meetings to share and exchange program information, to discuss common issues and to plan for maximization of system resources. Many of the barriers to fuller collaboration and cooperation among the systems could also be viewed as assets to that process if there were true integration of the behavioral health systems. For instance, the mechanisms and support for housing and case management within the MH system would benefit clients receiving chemical dependency services; and the support and mechanism for vocational development services within the CD system would be of benefit to those in the MH and MRDD systems. Likewise, the data collection efforts, resulting IPMES reports and outcome measurement is well developed in the OASAS system but absent from the MH system. Integrating these support and administrative systems would result in a more apprpriately responsive system of care for the client population.

Agencies: OASAS; OMH; OPWDD;
Target Complete Year: 2010
Is this an innovative practice that you would like to share with others?: No
Focus: Cross System Collaboration; Mental Hygiene Workforce Development;

Strategy 1.2 In Progress

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.

2010 Progress: Through the Reclaiming Future Initiative additional provider staff received training in motivational interviewing and other EBT approaches. Although most funded programs now have at least 1 or more tstaff trained in these methods, they find it difficult to train all staff due to the time requirements and the shortage of replacement personnel. So while the EBP is not yet the standard of care, it is practiced with greater freguency in a greater number of programs. We will continue to monitor progress made through 2010 in training and integrating MI as a standard of care.

Agencies: OASAS; OMH;
Target Complete Year: 2010
Is this an innovative practice that you would like to share with others?: No
Focus: Service Engagement;

Strategy 1.3 Dropped

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

Agencies: OASAS; OMH; OPWDD;
Target Complete Year: 2010
Is this an innovative practice that you would like to share with others?: No
Focus: Cross System Collaboration;

Strategy 1.4 Accomplished

Support for a proposed outpatient Mental Health Clinic (Article 31) application by a licensed MRDD Outpatient Clinical Service provider (Article 16). The Clinic will specialize in providing Mental Health services to individuals with a secondary diagnosis of epilepsy and/or cognitive limitations (i.e., Borderline intellectual functioning).

2010 Progress: On April 1, 2010 an OMRDD licensed program began operating an OMH livensed clinic for clients with a dual disorder.

Agencies: OMH; OPWDD;
Target Complete Year: 2010
Is this an innovative practice that you would like to share with others?: No
Focus: Health & Wellness;

Priority Outcome 2 In Progress
Improve the availability of a stable, well-trained work force to improve consumer outcomes and satisfaction with services

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. Improving training regimens and enhancing direct support skills training by incorporating elements of values-based competencies are needed as are other methods to stabilize our workforce. We must also address comprehensive strategies to expand our applicant pool to improve the stability of our workforce.

Agencies: OASAS; OMH; OPWDD;
Target Complete Year: 2012

Strategy 2.1 In Progress

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.

2010 Progress: The importance of skilled and motivated staff, especially direct support staff in delivering quality service continues to be a priority issue. Our provider agencies report investing considerable resources in staff training and development and have developed training standards according to best practice competencies. Training protocols include initial orientation to the agency's mission goal and services and supervisory oversight and training of direct care workers performance of their specific job responsibilities. Employees hired or promoted into supervisory positions are also expected to attend Supervisory Management Training courses. Also, data bases are being employed to track attendance and completion of training courses and monitor as to when staff are due for retraining. Other specific methods utilized by the LIDDSO to combine skills based training programs with comprehensive self assessment practices include: The development of a 3-day on-the-job training program for new Direct Care staff to give them first-hand, early out-of-the-classroom experience in working with our individuals.Attendee evaluations of our LI DDSO training sessions to obtain feedback to improve class trainings. Participants are also asked to assist in the development of other topics that would be help them with their jobs. A varied menu of short computer classes has also been developed by our LI DDSO. The topics are often conceived "on the fly" by special request of the Users participating in the training. Hands on computer training assists in the development of enhanced network and system skills which support all aspects of our work. The LI DDSO has also been a proud participant in the SUNY Stony Brook School of Social Work's "Extraordianry Caregiver Recognition Program", as well as the "Caregiver Fatigue Program" wherin select employees participate in educational presentations, group discussion and are awarded certificates of recognition for their outstanding work as direct care professionals.

Agencies: OASAS; OMH; OPWDD;
Target Complete Year: 2010
Is this an innovative practice that you would like to share with others?: No
Focus: Mental Hygiene Workforce Development;

Strategy 2.2 In Progress

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.

2010 Progress: The number of training opportunities available through the Mental Health Association with funding from the Department has been expanded to include topic relevant to CD treatment and prevention providers and is offered at little or no cost.

Agencies: OASAS; OMH; OPWDD;
Target Complete Year: 2010
Is this an innovative practice that you would like to share with others?: No
Focus: Mental Hygiene Workforce Development;

Strategy 2.3 In Progress

Agencies that employ direct support workers should continue to press with their elected officials, advocacy groups, professional associations and the media to obtain a living wage for persons working with individuals with developmental disabilities, particularly so given the costs of living in the Long Island region.

Addressing 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 occur should be considered.

2010 Progress: Our agencies continue to be committed to advocating at various public forums for a fair and equitable living wage for direct care staff who are vital to assuring that quality services continue to be provided.

Agency: OPWDD;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Mental Hygiene Workforce Development;

Strategy 2.4 In Progress

Development of a comprehensive and targeted advertising campaign to recruit direct support personnedl from a wider geographical area using a wide variety of media: billboards, television, radio, print and web-based recruiting.

Agency: OPWDD;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Mental Hygiene Workforce Development;

Priority Outcome 3 In Progress
Greater choice and input regarding individualized services by consumers, with a focus upon community inclusion.

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, needs 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 activities 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.

Agency: OPWDD;
Target Complete Year: 2011

Strategy 3.1 In Progress

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.

2010 Progress: In Nassau County our agencies have engaged in activities that enhance self-determination recognizing our consumers and their families as an important part of the planning process. Several of our agencies are Compass certified requiring a management plan and self survey process which is consumer centered and involves all stakeholders including consumers and their families. Within the Person Centered Planning framework a greater number of our residents with developmental disabilities and their families have exercised input over the design of their personalized system of supports and services, many of which have involved natural community supports of their choosing. In furthering our progress towards full community participation in all activiites, Nassau County has also engaged in the Portal initiative which has facilitated the self determination process. This service model can hopefully be expanded over time to include additional residents in our region. As people with all levels of disabilities attempt to live inclusive and contributory lives in the community, transportation continues to be an ever increasingly vital service that many cannot addess. Inadequate transportation continues to be the over-riding issue identified as an obstacle preventing people with disabilites from maximizing their potential for full communtiy inclusion.

Agency: OPWDD;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Self-Direction; Transportation;

Priority Outcome 4 In Progress
To assure safe, stable, supportive housing which promotes recovery, facilitates rehabilitation and maximizes potential for independent living.

In the absence of appropriate transitional and permanent housing, the return to full familial functioning and social standing is delayed and

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 achievement of their life goals.

Unfortunately, there are substantial shortages of residential options for our clients and at times clients are forced to dwell in an environment 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.

New York State has been developing only the least supervised housing and this housing is slotted for individuals with a major mental illness, who are being discharged from long long erm facilities. It is evident that a higher level of care is needed. Our system is therefore clogged with minimal movement due to the low number of supervised housing slots, which are the ones most needed and in demand.

Agencies: OASAS; OMH; OPWDD;
This outcome has been selected as a top two priority for OMH.
This outcome has been selected as a top two priority for OPWDD.
Target Complete Year: 2010

Strategy 4.1 In Progress

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

2010 Progress: There continues to be movement toward the Center for Rapid Recovery application. A site has been identified in Freeport but will require a zoning variance before the funding is made available for purchase. In addition the proposal has been altered from a female to a male community residence.

Agency: OASAS;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Housing;

Strategy 4.2 In Progress

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

2010 Progress: We are in the process of developing a 50 bed CRSRO facility. The planning and developing stage has begun. The time line for implementation and completion is still in question.

Agencies: OASAS; OMH; OPWDD;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Housing;

Strategy 4.3 In Progress

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 <u>not</u> limit their search for apartments to the lower socio-economic areas of the county.

2010 Progress: This issue remains a priority concern given the fact that a high percentage of the supported housing beds are in neighborhoods that are considered undesirable.

Agency: OMH;
Target Complete Year: 2010
Is this an innovative practice that you would like to share with others?: No
Focus: Housing;

Strategy 4.4 In Progress

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.

2010 Progress: Many of our clients who are severely symptomatic, require additional skill enhancement services for extended periods of time. Nassau County, using wrap around funds through reinvestment funds, has been providing individual plans for such services. Currently, there is no traditional funding stream that will provide for housing supports of this nature.

Agencies: OASAS; OMH; OPWDD;
Target Complete Year: 2010
Is this an innovative practice that you would like to share with others?: No
Focus: Housing;

Strategy 4.5 In Progress

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.

2010 Progress: This remains a priority concern and it is our recommendation that OMH offer housing of this sort to accomodate the client who would not tolerate or benefit from a group living situation, and needs more supervision than what is available in supported housing.

Agencies: OASAS; OMH; OPWDD;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Housing;

Strategy 4.6 In Progress

Persons with Austims-Spectrum Disorders and those with behavioral challenges represent a significant proportion of the persons served by OMRDD and constitute a population of major concern. Because of the needs of the consumers with behavioral challenges, agencies are required to provide more intensive levels of supervision and support. The staffing of these residences has become increasingly more difficult due in part to the nature of the clients served; and, difficulties in attracting and retaining qualified direct-care personnel, particularly so when the individuals span multiple service delivery systems.

On the local level, meetings need to be held between the heads of the Nassau and Suffolk LGUs, the LIDDSO and the Regional offices of OMH and OASES to focus upon the re-development and coordination of residential services with appropriate clinical supports. It would also appear to be appropriate to involve the local Department of Social Services.

Agency: OPWDD;
Target Complete Year: 2011
Is this an innovative practice that you would like to share with others?: No
Focus: Housing; Cross System Collaboration;

Priority Outcome 5 In Progress
To provide prevention, intervention and treatment responses to the increased abuse of heroin and other opiates by adolescents and young adults.

According to the Nassau County District Attorney's Office the number of annual heroin overdose deaths has risen from 24 in 2004 to 46 in 2008. During that same time peroid the number of overdose deaths from other opiates has gone from 28 to 97. Heroin arrests have increased from 171 in 2007 to 386 in 2009. In 2008 there were 168 arrests for illegal possession of prescription medications. That number increased to 673 in 2009.

Within the county's CD treatment system admissions to non-crisis services (outpatient, residential, inpatient rehabilitation) of persons indicating heroin as the primary, secondary or tertiary substance of abuse increased from 9% of the total to 12% between 2004 and 2009. During the same time period admissions to crisis services (detoxification and medically monitored withdrawal services) of those with primary, secondary or tertiary heroin increased from 35% to 47%. Within crisis services the percentage of admissions for persons ages 19 - 25 whose primary substance of abuse is heroin has increased from about 30% in 2004 to 48% in 2009.

A response to these statistics utilizing the approaches grounded in prevention, intervention and treatment will help to avoid the continued loss and destruction to young lives.

Agencies: OASAS; OMH;
This outcome has been selected as a top two priority for OASAS.
Target Complete Year: 2012

Strategy 5.1 In Progress

Establish and prticipate in a Community of Solution to form a consensus direction/strategy to address the issue of heroin abuse among the adolescent and young adult population in Nassau and across Long Island

Agencies:
Target Complete Year: 2010
Is this an innovative practice that you would like to share with others?: No
Focus: Quality Management; Cross System Collaboration;

Strategy 5.2 In Progress

Engage in efforts to increase EBP prevention throughout the county to assure that young people, schools, parents and communities are exposed to consistent messages and approaches to reduce risk and increase protective factors against any substance use/abuse and other destructive behaviors.

Agencies:
Target Complete Year: 2010
Is this an innovative practice that you would like to share with others?: No
Focus: Health & Wellness; Service Engagement;

2011 Multiple Disabilities Considerations Form
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: James Dolan (5/28/10)

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:

The Department of Mental Health, Chemical Dependency and Developmental Disabilities Services has units such as Case Management, EAP, and Court Services which are all staffed by persons with credentials and experience to recognize, identify and intervene with clients with mutiple health and social service needs. The department's single point of access for case managment, Assertive Community Treatment, intensive in-home services for children, and adult mental health housing are entry points for levels of care that address the needs of individuals with a primary mental health diagnosis, a large percent of those served also have a co-occuring drug/alcohol disorder. We also operate a Methadone Maintenance Treatment Program with a caseload of almost 600 clients, 100 of whom are prescribed psychotropic medications. In addition, we recently received approval from OMH to establish the first clinic in NYS that is licensed to served the mentally ill and developmentally disabled population.

Other county departments, such as Social Services, Veteran's Services, Senior Citizens, Youth Board, also utilize the expertise within the department to access and address the unmet mental health, chemical dependency and developmental disability needs fo their clientele.

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:

Under the direction of the commissioner, with input from a range of stakeholders that includes state agencies, providers, family members, consumers, criminal justice, and DSS, we continue to modify and develop services that address the needs of those we serve. As part of that process the assurance of access to evidenced based practices for those with multiple disabilities is a priority concern.

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 have an effectively functioning "Auspice Committee' that is comprised of representatives from the department, OMH, and OMRDD. The purpose of this committee is dispute resolution and the provision of joint service planning for mutiply disabled consumers. We also recently estabilised a "Difficult to Serve" committe that is comprised of executive directors of community based agencies. This group will develop recommendations for serving individuals who are high risk for hopitalization, homelessness, or criminal justice involvement. A high percentage of the cases to be addressed by that committee are likely to have co-occurring disorders.

2011 Community Service Board Roster
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: Anna Halatyn (7/30/10)

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

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	Arnold Gould
Physician	No
Psychologist	No
Represents	Family
Term Expires	
eMail	

Member	
Name	Constantine Ioannou
Physician	Yes
Psychologist	No
Represents	Nassau University Medical Center
Term Expires	
eMail	

Member	
Name	Carlos Tejara
Physician	Yes
Psychologist	No
Represents	FEGS - Clinic
Term Expires	
eMail	

Member	
Name	Mary Fasano
Physician	No
Psychologist	No
Represents	Family
Term Expires	
eMail	

Member	
Name	Debora Harris
Physician	No
Psychologist	No
Represents	Elija Foundation
Term Expires	
eMail	

Member	
Name	Thomas Hopkins
Physician	No
Psychologist	No
Represents	Epilepsy Foundation of America
Term Expires	
eMail	

Member	
Name	Nicole Dibra
Physician	No
Psychologist	No
Represents	Elija Foundation
Term Expires	
eMail	

Member	
Name	Chris Petrosino
Physician	No
Psychologist	No
Represents	Family
Term Expires	
eMail	

Member	
Name	Meryl Jackelow
Physician	No
Psychologist	No
Represents	Consumer
Term Expires	
eMail	

Member	
Name	David Weingarten
Physician	No
Psychologist	No
Represents	Family
Term Expires	
eMail	

Member	
Name	Barbara Roth
Physician	No
Psychologist	No
Represents	Family
Term Expires	
eMail	

Member	
Name	Susan Burger
Physician	No
Psychologist	No
Represents	Family
Term Expires	
eMail	

Member	
Name	Anthony Cummings
Physician	No
Psychologist	No
Represents	Consumer
Term Expires	
eMail	

Member	
Name	Patricia Hincken
Physician	No
Psychologist	No
Represents	Long Beach Medical Center
Term Expires	
eMail	

Member	
Name	Mary Lou Jones
Physician	No
Psychologist	No
Represents	South Shore Child Guidance Center
Term Expires	
eMail	

2011 ASA Subcommittee Membership Form
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: Anna Halatyn (7/30/10)

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

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	Patricia Hincken
Represents	Long Beach Medical Center
eMail	
Is CSB Member	Yes

Member	
Name	Anthony Cummings
Represents	Consumer
eMail	
Is CSB Member	Yes

Member	
Name	Constantine Ioannou
Represents	Nassau University Medical Center
eMail	
Is CSB Member	Yes

Member	
Name	list is established but is waiting approval from County Legislature
eMail	
Is CSB Member	No

Member	
Name	Barbara Roth
Represents	Parent Advocate Mentall Illness
eMail	
Is CSB Member	No

Member	
Name	Susan Burger
Represents	Family Advocate
eMail	
Is CSB Member	No

Member	
Name	Maria Elisa Cuadro-Fernandez
Represents	Provider, Exec Dir. COPAY
eMail	mecfcopay@aol.com
Is CSB Member	No

Member	
Name	Gladys Serrano
Represents	Provider, Exec Dir. Hispanic Counseling Center
eMail	Hispaniccc@aol.com
Is CSB Member	No

2011 Mental Health Subcommittee Membership Form
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: Anna Halatyn (7/30/10)

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

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	Arnold Gould
Represents	Family
eMail	
Is CSB Member	Yes

Member	
Name	Carlos Tejara
Represents	FEGS - Clinic
eMail	
Is CSB Member	Yes

Member	
Name	Constantine Ioannou
Represents	Nassau University Medical Center
eMail	
Is CSB Member	Yes

Member	
Name	There is one integrated community Services Board for the combined MH, CD, MR/DDS. The membership list is established but is waiting approval from the County legislature.
eMail	
Is CSB Member	No

Member	
Name	Barbara Roth
Represents	MH Parent Advocate
eMail	
Is CSB Member	Yes

Member	
Name	Susan Burger
Represents	Family Advocate
eMail	
Is CSB Member	No

Member	
Name	Maria Cuadra-Fernandez
Represents	Provider
eMail	mecfcopay@aol.com
Is CSB Member	No

Member	
Name	Gladys Serrano
Represents	Provider
eMail	hispaniccc@aol.com
Is CSB Member	No

2011 Developmental Disabilities Subcommittee Membership Form
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: James Dolan (6/2/10)

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

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	David Weingarten
Represents	DD Parent Advocate
eMail	weing224@aol.com
Is CSB Member	Yes

Member	
Name	Susan Berger
Represents	Family Advocate
eMail	
Is CSB Member	No

Member	
Name	Gladys Serrano
Represents	Provider
eMail	hispaniccc@aol.com
Is CSB Member	No

Member	
Name	Thomas Hopkins
Represents	Epilepsy Foundation of America
eMail	
Is CSB Member	Yes

Member	
Name	Meryl Jackelow
Represents	Consumer
eMail	
Is CSB Member	Yes

Member	
Name	Debora Harris
Represents	Elija Foundation
eMail	
Is CSB Member	Yes

Member	
Name	Nicole Dibra
Represents	Elija Foundation
eMail	
Is CSB Member	Yes

Member	
Name	Mary Fasano
Represents	Family
eMail	
Is CSB Member	Yes

Member	
Name	Chris Petrosino
Represents	Family
eMail	
Is CSB Member	Yes

Member	
Name	There is one integrated Community Services Board for the combined MH, CD, MR/DDS. The membership list is established but is waiting approval from the County legislature.
eMail	
Is CSB Member	No

2011 Mental Hygiene Local Planning Assurance
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: James Dolan (6/2/10)

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 OPWDD accept the certified 2011 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 2011 local services planning process.

2011 County Outcomes Management Survey
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: Patricia Fulton (5/10/10)

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

OASAS is adopting an outcomes management (also referred to as performance management) approach throughout the agency and promoting the adoption of this model throughout the field. Outcomes management uses outcome thinking to guide all management functions to improve client-level results and the return on investment. It is often described as a business-based or logic model designed to integrate organization-wide management and financial variables with performance metrics. This model or approach allows management to systematically measure progress towards predetermined outcomes. The benefits of proceeding this way include:

- Increased clarity throughout the organization as to what success looks like, what has been accomplished, and what still needs to be done;
- Puts meaning to the mission;
- Assists in aligning resources with desired outcomes; and
- Promotes learning, innovation, and builds staff enthusiasm.

In this survey, we are asking you to share your County's experiences with outcomes management , specifically if you are currently engaged in outcomes management in a planned way and if you are currently implementing any performance measures in your county.

All questions regarding this survey should be directed to Ms. Constance Burke at 518-485-0501 or constanceburke@oasas.state.ny.us.

1. How long has your County been involved with outcomes or performance management?

- (•) At least five years
- ( ) At least 3 years, but less than five years
- ( ) At least 1 year, but less than three years
- ( ) Less than one year
- ( ) Not involved or just starting

2. To what degree does your County systematically use data to monitor outcomes/performance?

- ( ) Very High
- (•) High
- ( ) Medium
- ( ) Low
- ( ) Very Low
- ( ) Not at all

3. To what degree does your County set outcomes/performance targets and measure progress over time in meeting those targets?

- ( ) Very High
- (•) High
- ( ) Medium
- ( ) Low
- ( ) Very Low
- ( ) Not at all

4. How often do you meet to review progress on outcomes?

- ( ) At least Monthly
- (•) Quarterly
- ( ) Semi-annually
- ( ) Annually
- ( ) Less than Annually

5. How do you use the information from your outcomes measurement? (check all that apply)

- [x] Planning
- [x] Policy Development
- [x] Budget Development
- [x] Staff Performance Appraisals
- [ ] Board Presentations

☐ Other (Please specify): N/A

6. What technology solutions are you using to collect outcome data?
Please describe

Excel Spreadsheets and Access databases.

7. What resources would you find useful to support your agency's outcomes/performance management efforts? (Check all that apply)

☑ Training of Administrators/ Managers
☐ Training of line staff
☐ Peer Assistance
☐ Software to track data
☐ Other resources (Please describe): N/A

8. Does your agency maintain a dashboard, report card, or scorecard that summarizes performance?

◉ Yes
○ No

9. Has your County engaged in a "Communities of Solution" discussion with providers and/or other governments?

◉ Yes
○ No

10. Have you used any of the following Communities of Solution resources to inform your planning or decision-making (check all that apply)?

☑ Summary County Profile
☐ Statewide Maps
☐ 100 Walkthroughs in 100 Days Toolkit

11. Over the next year do you plan to initiate a Community of Solution?

○ Yes
◉ No

2011 County Tobacco Survey
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: Anna Halatyn (5/5/10)

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

On July 24, 2008 OASAS implemented the Tobacco Free Part 856 Services regulation requiring all OASAS certified and/or funded programs to implement a policy to prohibit the use of tobacco products in facilities, grounds and in vehicles owned or operated by OASAS certified and/or funded prevention, treatment and recovery providers and to integrate tobacco into the context of treating all other addictions. The regulation applies to patients, staff, volunteers and visitors.

This survey is designed to provide OASAS with information as to the perceived effect of this regulation on the delivery of services provided by OASAS certified and/or funded facilities.

All questions regarding the survey should be directed to Mr. Edward Tesiny at (518) 485-7189 or EdTesiny@oasas.state.ny.us.

1. As the LGU, have you received feedback from providers as a result of the tobacco regulation?

- (●) Yes
- ( ) No

1b. What areas do your providers believe were affected and how?

	Positive	Negative	No Effect	Don't know
Admissions to the Program	( )	( )	(●)	( )
Retention in the Program	( )	(●)	( )	( )
Provision of Treatment Services	( )	( )	(●)	( )
Patient Outcomes	( )	( )	( )	(●)

1c. Have you reviewed the IPMES/Workscope or other performance or transaction data to determine if it supports the responses in #1b?

- (●) Yes
- ( ) No

2. Have you obtained copies of the tobacco-free policies of programs in your county?

- ( ) Yes
- (●) No

3. Have you offered any training or technical assistance to providers in implementing the tobacco free regulations?

- (●) Yes
- ( ) No

4. Do you have a tobacco free policy for other programs under your jurisdiction?

- ( ) Yes
- (●) No

Health Coordinator Designation (Part I)
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: Anna Halatyn (5/10/10)

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

Any questions related to this survey should be directed to Shonna Clinton by phone at 518-485-2410, or by e-mail at ShonnaClinton@oasas.state.ny.us.

1. How is the Health Coordinator function carried out within this agency? (check all that apply) *NOTE: Additional questions related to the Health Coordinator function are also being asked at the program level for selected treatment services.*

- [x] a) Paid Agency Staff
- [ ] b) Contracted Staff
- [ ] c) In-kind Staff, meaning volunteer staff or staff from other organizations
- [ ] d) This service is not provided to patients of this agency

If answer to Question #1 was "a", answer the following:

2. What is the average annual salary of staff responsible for carrying out the Health Coordinator function in this agency? (format: $XX,XXX)

65,000-120,00.00

3. What is the fringe benefit rate paid to the staff that are responsible for carrying out the Health Coordinator function in this agency? (format: XX.X%)

44%

- [ ] Does not apply to this staff

2011 Provider Outcomes Management Survey
Nassau Cty Dept of MH, CD Dev Dis Svcs (40150)
Certified: Anna Halatyn (5/11/10)
Approved: jayne greene (5/11/10)

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

OASAS is adopting an outcomes management (also referred to as performance management) approach throughout the agency and promoting the adoption of this model throughout the field. Outcomes management uses outcome thinking to guide all management functions to improve client-level results and the return on investment. It is often described as a business-based or logic model designed to integrate organization-wide management and financial variables with performance metrics. This model or approach allows management to systematically measure progress towards predetermined outcomes. The benefits of proceeding this way include:

- Increased clarity throughout the organization as to what success looks like, what has been accomplished, and what still needs to be done;
- Puts meaning to the mission;
- Assists in aligning resources with desired outcomes; and
- Promotes learning, innovation, and builds staff enthusiasm.

In this survey, we are asking you to share your agency's experiences with outcomes management , specifically if you are currently engaged in outcomes management in a planned way and if you are currently implementing any performance measures in your organization.

All questions regarding this survey should be directed to Ms. Constance Burke at 518-485-0501 or constanceburke@oasas.state.ny.us.

1. How long has your agency been involved with outcomes or performance management?

- (•) At least five years
- ( ) At least 3 years, but less than five years
- ( ) At least 1 year, but less than three years
- ( ) Less than one year
- ( ) Not involved or just starting

2. To what degree does your agency systematically use data to monitor outcomes/performance?

- ( ) Very High
- (•) High
- ( ) Medium
- ( ) Low
- ( ) Very Low
- ( ) Not at all

3. To what degree does your agency set outcomes/performance targets and measure progress over time in meeting those targets?

- ( ) Very High
- (•) High
- ( ) Medium
- ( ) Low
- ( ) Very Low
- ( ) Not at all

4. How often do you meet to review progress on outcomes?

- ( ) At least Monthly
- (•) Quarterly
- ( ) Semi-annually
- ( ) Annually
- ( ) Less than Annually

5. How do you use the information from your outcomes measurement? (check all that apply)

- [x] Planning
- [x] Policy Development
- [ ] Budget Development
- [x] Staff Performance Appraisals

☐ Board Presentations
☐ Other (Please specify): N/A

6. What technology solutions are you using to collect outcome data?
Please describe

AMS system..Clinical dosing and tracking system

7. What resources would you find useful to support your agency's outcomes/performance management efforts? (Check all that apply)

☑ Training of Administrators/ Managers
☑ Training of line staff
☑ Peer Assistance
☑ Software to track data
☐ Other resources (Please describe): N/A

8. Does your agency maintain a dashboard, report card, or scorecard that summarizes performance?

◉ Yes
○ No

9. Has your agency engaged in a "Communities of Solution" discussion with your County and/or other human service agencies?

○ Yes
◉ No

10. Have you used any of the following Communities of Solution resources to inform your planning or decision-making (check all that apply)?

☐ Summary County Profile
☐ Statewide Maps
☐ 100 Walkthroughs in 100 Days Toolkit

Health Coordinator Designation (Part II)
Nassau Cty Dept of MH Methadone Clinic (52128)
Certified: Anna Halatyn (5/11/10)
Approved: jayne greene (5/11/10)

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

Any questions related to this survey should be directed to Shonna Clinton by phone at 518-485-2410, or by e-mail at ShonnaClinton@oasas.state.ny.us.

1. What is the primary way that the Health Coordinator service is provided to patients in this program? (check one only)

- (●) a) Paid Agency Staff
- ( ) b) Contracted Staff
- ( ) c) In-kind Staff, meaning volunteer staff or staff from other organizations
- ( ) d) This service is not provided to patients of this agency (skip to end)

2. Is the Health Coordinator service provided on-site or off-site of this program?

- (●) a) On-site
- ( ) b) Off-site

If answer to Question #1 was "a", answer the following:
3. What is the total number of staff hours per week dedicated to carrying out the Health Coordinator function in this program? (format: XX.X)

Hours per week: 1 hour

2011 Talent Management Survey
Nassau Cty Dept of MH Methadone Clinic (52128)
Certified: Anna Halatyn (5/13/10)
Approved: jayne greene (5/11/10)

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

All questions regarding the survey should be directed to Doug Rosenberry at (518) 485-2033 or DougRosenberry@oasas.state.ny.

For the context to this survey, please review the discussion on talent management on pages 27 and 28 of the 2011 Plan Guidelines.

1. Does this program plan to apply to become a Best Place to Work in 2010 or 2011?

- ○ Yes
- ◉ No
- ○ Don't Know; need to learn more about it

2. Does this program plan to nominate one or more individuals to be recognized on Addictions Professionals Day in 2010 or 2011?

- ○ Yes
- ◉ No
- ○ Don't Know; need to learn more about it

3. Does this program plan to use the on-line Addiction Career Resource Center in 2010 or 2011?

- ○ Yes
- ◉ No
- ○ Don't Know; need to learn more about it

4. Has this program accessed resources from the local Department of Labor One Stop Center?

- ○ Yes
- ◉ No

5. Have program staff participated in one or more Learning Thursdays sponsored by OASAS?

- ○ Yes
- ◉ No

6. Indicate the number of clinical staff within your program who:

2	Hold a professional license, CASAC or CASAC Trainee
	Do not hold a professional license, CASAC or CASAC Trainee

7. How many staff within this program provide clinical supervision?
0

8. Of the clinical supervisors identified in question 7 above, how many hold the following? (Note: the sum of a through d must equal the total number of clinical supervisors identified in question 7)

	a) LCSW (with or without a CASAC or CASAC trainee)
	b) LMSW (with or without a CASAC or CASAC trainee)
	c) CASAC/CASAC Trainee only (without a LCSW or LMSW)
2	d) All Others (including those with no license)

2011 Tobacco Use Survey
Nassau Cty Dept of MH Methadone Clinic (52128)
Certified: Anna Halatyn (5/13/10)
Approved: jayne greene (5/11/10)

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

On July 24, 2008 OASAS implemented the Tobacco Free Part 856 Services regulation requiring all OASAS certified and or funded programs to implement a policy to prohibit the use of tobacco products in facilities, grounds and in vehicles owned or operated by OASAS certified and/or funded prevention, treatment and recovery providers and to integrate tobacco into the context of treating all other addictions. The regulation applies to patients, staff, volunteers and visitors.

This survey is designed to provide OASAS with information as to the perceived effect of this regulation on the delivery of services provided by OASAS certified and/or funded facilities. All questions regarding the survey should be directed to Mr. Edward Tesiny at (518) 485-7189 or EdTesiny@oasas.state.ny.us.

1. Does this program require all patients to stop smoking tobacco on program grounds at admission?

- ○ Yes
- ◉ No

2. What has been the continuing impact of the smoking regulations on the following?

	Positive	Negative	No Effect	Don't know
Admissions to the Program	○	○	◉	○
Retention in the Program	○	○	◉	○
Provision of Treatment Services	○	○	◉	○
Patient Outcomes	○	○	◉	○

3. Has this program reviewed the IPMES/Workscope or other performance or transaction data to determine if it supports the responses in #2?

- ◉ Yes
- ○ No

4. Did any of the following staff in your program take advantage of the tobacco training that was provided by the University of Albany Professional Development Program Regional Consortiums?

	Yes	No	Don't know
Executive Director	○	◉	○
Clinical Director	○	◉	○
Counseling Staff	○	◉	○
Other Direct Care Staff	○	◉	○
Support Staff	○	◉	○

5. Has the tobacco regulation resulted in staff turnover of this program's staff who smoke?

- ○ Yes
- ◉ No

6. Have patients, staff, visitors, or family brought tobacco or tobacco related items into this program since the implementation of the tobacco policy?

	Yes	No	Don't know
Patients	○	◉	○
Staff	○	◉	○
Visitors	○	◉	○
Family	○	◉	○

7. Has this program experienced any of the following circumstances as a result of the implementation of the tobacco regulation?

	Yes	No	Don't know
Increase in fire alarms	○	◉	○

Damage by fire/burning cigarettes	○	◉	○
Blocked plumbing	○	◉	○
Negative community feedback	○	◉	○

8. Approximately what percentage of this program's smoking patients have violated the non-smoking policy?
0 %

8a. How has the percentage of smoking policy violations changed since the implementation of the OASAS smoking regulation in August 2008?

- ○ Increased
- ◉ Remained the same
- ○ Decreased
- ○ Don't know

9. Does this program inform patients of its no smoking policy when they seek admission to treatment?

- ◉ Yes
- ○ No

9a. Have any patients refused admission because of this policy?

- ○ Yes
- ◉ No
- ○ Don't know

10. Is the use of tobacco addressed in the patients' treatment plan?

- ○ Yes
- ◉ No

11. Does this program offer group counseling sessions focused on smoking cessation?

- ◉ Yes
- ○ No

11a. How frequently are the smoking cessation group counseling sessions held?

- ○ Weekly
- ○ Bi-weekly
- ○ Monthly
- ◉ As needed

12. Do you believe the tobacco regulation has been beneficial to the health of this program's patients?

- ◉ Yes
- ○ No

13. How has the use of Nicotine Replacement Therapies (NRT) by this program's patients who smoke changed since the implementation of the smoking regulation in August 2008?

- ◉ Increased
- ○ Remained the same
- ○ Decreased
- ○ Don't know

2011 Evidence-Based and Best Practice Interventions Survey
Nassau Cty Dept of MH Methadone Clinic (52128)
Certified: Anna Halatyn (5/13/10)
Approved: jayne greene (5/11/10)

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

Specific questions related to the completion of this survey should be directed to Susan Brandau at 518-457-6129 or by email at SusanBrandau@oasas.state.ny.us.

1. For each of the practices or approaches below, please indicate the stage of implementation within this program. If this program has not yet considered implementation of a particular practice, you must indicate "Not Applicable". Sections III, IV and VI are specific to practices for persons with co-occurring psychiatric conditions. These are person-centered approaches for improving access to treatment that have been demonstrated to be effective for this population. Click on blue underlined words or phrases to "link to" the definitions.

	Implementation Stage					
	Exploration	**Installation**	**Implementation**	**Innovation**	**Sustainability**	**Not Applicable**
I. Screening and Assessment:						
A. Screening for Co-Occurring Disorders	○	○	○	○	○	◉
B. Assessment for Co-Occurring Disorders	○	○	○	○	○	◉
C. Other (Specify):	○	○	○	○	○	◉
II. Clinical Practices and Interventions:						
D. Motivational Interviewing (MI)	○	○	○	○	○	◉
E. Cognitive-Behavioral Therapy (CBT)	○	○	○	○	○	◉
F. Contingency Management (CM)	○	○	○	○	○	◉
G. Behavioral Couples Therapy (BCT)	○	○	○	○	○	◉
H. Brief Intervention Therapy	○	○	○	○	○	◉
I. Twelve-Step Facilitation (TSF)	○	○	○	○	○	◉
J. Anger Management	○	○	○	○	○	◉
K. Relapse Prevention	○	○	○	○	○	◉
L. Other (Specify):	○	○	○	○	◉	○
III. Clinical Practices and Interventions specific to treating patients with Co-occurring Disorders:						
M. Motivational Interviewing (MI)	○	○	○	○	○	◉
N. Cognitive-Behavioral Therapy (CBT)	○	○	○	○	○	◉
O. Contingency Management (CM)	○	○	○	○	○	◉
P. Behavioral Couples Therapy (BCT)	○	○	○	○	○	◉
Q. Mutual Self-Help Groups	○	○	○	○	○	◉
R. Other (Specify):	○	○	○	○	○	◉
IV. Achieving Integrated Care / Services for treating patients with Co-occurring disorders:						
S. Achieving Integrated Care / Services for treating patients with Co-occurring disorders	○	○	○	○	○	◉
V. Medication Assisted Therapy (Pharmacotherapy):						
T. Buprenorphine (Subutex and Suboxone)	○	○	○	○	○	◉
U. Methadone	○	○	○	○	◉	○
V. Naltrexone	○	○	○	○	○	◉
W. Acamprosate (Campral ®)	○	○	○	○	○	◉
X. Nicotine Replacement Therapies	○	○	○	○	◉	○
Y. Disulfiram/Antabuse	○	○	○	○	○	◉
Z. Other (Specify):	○	○	○	○	○	○
VI. Psychotropic Medication for treating patients with Co-occurring disorders:						
AA. Psychotropic Medication for treating patients with Co-occurring disorders	○	○	○	○	◉	○
VII. Process Improvement Administrative Practices :						
BB. NIATx	○	○	○	○	○	◉

CC. Other (Specify): ○ ○ ○ ○ ○ ◉

Follow-up Questions to "Medication Assisted Therapies" (Questions V - T through Z)

11a. Are at least half of this program's clinical staff trained in Medication Assisted Therapy?

◉ Yes

○ No

11b. For each patient, is the appropriateness for Medication Assisted Therapy incorporated into the assessment process and assessment instrument?

◉ Yes

○ No

11c. Are there ongoing mechanisms to monitor medication response and potential side-effects?

◉ Yes

○ No

11f. Follow-up to question V-U: Does this program's attending physician have a license to prescribe Methadone?

◉ Yes

○ No

Follow-up Questions to "Psychotropic Medications / (COD)" (Question VI - AA)

12a. Does this program have documented policies and procedures to evaluate and monitor patients' need for psychotropic medications?

◉ Yes

○ No

12b. For each patient, is the need for psychotropic medication routinely determined as part of the comprehensive assessment?

◉ Yes

○ No

12c. Is at least half the program's clinical staff cross-trained on psychotropic medications and their interaction with substance use and addictive medications (e.g. benzodiazepines)?

◉ Yes

○ No

12d. Are there Quality Assurance systems in place to monitor the use of psychotropic medications?

◉ Yes

○ No

12e. Is there a person on staff who is licensed or certified (e.g. psychiatrist) to prescribe psychotropic medications?

◉ Yes

○ No

Health Coordinator Designation (Part II)
Nassau Cty Dept of MH, CD Dev Dis Svcs (52127)
Certified: Anna Halatyn (5/11/10)
Approved: jayne greene (5/11/10)

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

Any questions related to this survey should be directed to Shonna Clinton by phone at 518-485-2410, or by e-mail at ShonnaClinton@oasas.state.ny.us.

1. What is the primary way that the Health Coordinator service is provided to patients in this program? (check one only)

- (●) a) Paid Agency Staff
- ( ) b) Contracted Staff
- ( ) c) In-kind Staff, meaning volunteer staff or staff from other organizations
- ( ) d) This service is not provided to patients of this agency (skip to end)

2. Is the Health Coordinator service provided on-site or off-site of this program?

- (●) a) On-site
- ( ) b) Off-site

If answer to Question #1 was "a", answer the following:
3. What is the total number of staff hours per week dedicated to carrying out the Health Coordinator function in this program? (format: XX.X)

Hours per week: 35.0

2011 Talent Management Survey
Nassau Cty Dept of MH, CD Dev Dis Svcs (52127)
Certified: Anna Halatyn (5/13/10)
Approved: jayne greene (5/11/10)

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

All questions regarding the survey should be directed to Doug Rosenberry at (518) 485-2033 or DougRosenberry@oasas.state.ny.

For the context to this survey, please review the discussion on talent management on pages 27 and 28 of the 2011 Plan Guidelines.

1. Does this program plan to apply to become a Best Place to Work in 2010 or 2011?

- ○ Yes
- ○ No
- ◉ Don't Know; need to learn more about it

2. Does this program plan to nominate one or more individuals to be recognized on Addictions Professionals Day in 2010 or 2011?

- ○ Yes
- ○ No
- ◉ Don't Know; need to learn more about it

3. Does this program plan to use the on-line Addiction Career Resource Center in 2010 or 2011?

- ○ Yes
- ○ No
- ◉ Don't Know; need to learn more about it

4. Has this program accessed resources from the local Department of Labor One Stop Center?

- ○ Yes
- ◉ No

5. Have program staff participated in one or more Learning Thursdays sponsored by OASAS?

- ◉ Yes
- ○ No

5a. Did staff find the training to be a valuable staff development resource?

- ◉ Yes
- ○ No

5b. How could the Learning Thursdays program be improved to better meet your program's staff training needs?
If the offerings were offered additional days in the week

6. Indicate the number of clinical staff within your program who:

12	Hold a professional license, CASAC or CASAC Trainee
1	Do not hold a professional license, CASAC or CASAC Trainee

7. How many staff within this program provide clinical supervision?
6

8. Of the clinical supervisors identified in question 7 above, how many hold the following? (Note: the sum of a through d must equal the total number of clinical supervisors identified in question 7)

5	a) LCSW (with or without a CASAC or CASAC trainee)
1	b) LMSW (with or without a CASAC or CASAC trainee)
	c) CASAC/CASAC Trainee only (without a LCSW or LMSW)
	d) All Others (including those with no license)

2011 Tobacco Use Survey
Nassau Cty Dept of MH, CD Dev Dis Svcs (52127)
Certified: Anna Halatyn (5/13/10)
Approved: jayne greene (5/11/10)

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

On July 24, 2008 OASAS implemented the Tobacco Free Part 856 Services regulation requiring all OASAS certified and or funded programs to implement a policy to prohibit the use of tobacco products in facilities, grounds and in vehicles owned or operated by OASAS certified and/or funded prevention, treatment and recovery providers and to integrate tobacco into the context of treating all other addictions. The regulation applies to patients, staff, volunteers and visitors.

This survey is designed to provide OASAS with information as to the perceived effect of this regulation on the delivery of services provided by OASAS certified and/or funded facilities. All questions regarding the survey should be directed to Mr. Edward Tesiny at (518) 485-7189 or EdTesiny@oasas.state.ny.us.

1. Does this program require all patients to stop smoking tobacco on program grounds at admission?

- ○ Yes
- ◉ No

2. What has been the continuing impact of the smoking regulations on the following?

	Positive	Negative	No Effect	Don't know
Admissions to the Program	◉	○	○	○
Retention in the Program	○	○	◉	○
Provision of Treatment Services	◉	○	○	○
Patient Outcomes	◉	○	○	○

3. Has this program reviewed the IPMES/Workscope or other performance or transaction data to determine if it supports the responses in #2?

- ○ Yes
- ◉ No

4. Did any of the following staff in your program take advantage of the tobacco training that was provided by the University of Albany Professional Development Program Regional Consortiums?

	Yes	No	Don't know
Executive Director	○	◉	○
Clinical Director	○	◉	○
Counseling Staff	○	◉	○
Other Direct Care Staff	○	◉	○
Support Staff	○	◉	○

5. Has the tobacco regulation resulted in staff turnover of this program's staff who smoke?

- ○ Yes
- ◉ No

6. Have patients, staff, visitors, or family brought tobacco or tobacco related items into this program since the implementation of the tobacco policy?

	Yes	No	Don't know
Patients	○	◉	○
Staff	○	◉	○
Visitors	○	◉	○
Family	○	◉	○

7. Has this program experienced any of the following circumstances as a result of the implementation of the tobacco regulation?

	Yes	No	Don't know
Increase in fire alarms	○	◉	○

Damage by fire/burning cigarettes	○	◉	○
Blocked plumbing	○	◉	○
Negative community feedback	○	◉	○

8. Approximately what percentage of this program's smoking patients have violated the non-smoking policy?
5 %

8a. How has the percentage of smoking policy violations changed since the implementation of the OASAS smoking regulation in August 2008?

○ Increased
◉ Remained the same
○ Decreased
○ Don't know

9. Does this program inform patients of its no smoking policy when they seek admission to treatment?

◉ Yes
○ No

9a. Have any patients refused admission because of this policy?

○ Yes
◉ No
○ Don't know

10. Is the use of tobacco addressed in the patients' treatment plan?

◉ Yes
○ No

11. Does this program offer group counseling sessions focused on smoking cessation?

◉ Yes
○ No

11a. How frequently are the smoking cessation group counseling sessions held?

○ Weekly
○ Bi-weekly
○ Monthly
◉ As needed

12. Do you believe the tobacco regulation has been beneficial to the health of this program's patients?

◉ Yes
○ No

13. How has the use of Nicotine Replacement Therapies (NRT) by this program's patients who smoke changed since the implementation of the smoking regulation in August 2008?

◉ Increased
○ Remained the same
○ Decreased
○ Don't know

2011 Evidence-Based and Best Practice Interventions Survey
Nassau Cty Dept of MH, CD Dev Dis Svcs (52127)
Certified: Anna Halatyn (5/13/10)
Approved: jayne greene (5/11/10)

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

Specific questions related to the completion of this survey should be directed to Susan Brandau at 518-457-6129 or by email at SusanBrandau@oasas.state.ny.us.

1. For each of the practices or approaches below, please indicate the stage of implementation within this program. If this program has not yet considered implementation of a particular practice, you must indicate "Not Applicable". Sections III, IV and VI are specific to practices for persons with co-occurring psychiatric conditions. These are person-centered approaches for improving access to treatment that have been demonstrated to be effective for this population. Click on blue underlined words or phrases to "link to" the definitions.

	Implementation Stage					
	Exploration	**Installation**	**Implementation**	**Innovation**	**Sustainability**	**Not Applicable**
I. Screening and Assessment:						
A. Screening for Co-Occurring Disorders	○	○	○	○	◉	○
B. Assessment for Co-Occurring Disorders	○	○	○	○	◉	○
C. Other (Specify):	○	○	○	○	○	○
II. Clinical Practices and Interventions:						
D. Motivational Interviewing (MI)	○	○	○	○	○	◉
E. Cognitive-Behavioral Therapy (CBT)	○	○	○	◉	○	○
F. Contingency Management (CM)	○	○	○	○	○	◉
G. Behavioral Couples Therapy (BCT)	○	○	○	○	○	◉
H. Brief Intervention Therapy	○	○	○	○	○	◉
I. Twelve-Step Facilitation (TSF)	○	○	○	○	○	◉
J. Anger Management	○	○	○	○	○	◉
K. Relapse Prevention	○	○	○	○	◉	○
L. Other (Specify):	○	○	○	○	○	◉
III. Clinical Practices and Interventions specific to treating patients with Co-occurring Disorders:						
M. Motivational Interviewing (MI)	○	○	○	○	○	◉
N. Cognitive-Behavioral Therapy (CBT)	○	○	○	◉	○	○
O. Contingency Management (CM)	○	○	○	○	○	◉
P. Behavioral Couples Therapy (BCT)	○	○	○	○	○	◉
Q. Mutual Self-Help Groups	○	○	○	○	○	◉
R. Other (Specify):	○	○	○	○	○	◉
IV. Achieving Integrated Care / Services for treating patients with Co-occurring disorders:						
S. Achieving Integrated Care / Services for treating patients with Co-occurring disorders	○	○	○	◉	○	○
V. Medication Assisted Therapy (Pharmacotherapy):						
T. Buprenorphine (Subutex and Suboxone)	○	○	◉	○	○	○
U. Methadone	○	○	○	○	◉	○
V. Naltrexone	○	○	○	○	○	◉
W. Acamprosate (Campral ®)	○	○	○	○	◉	○
X. Nicotine Replacement Therapies	○	○	◉	○	○	○
Y. Disulfiram/Antabuse	○	○	○	○	◉	○
Z. Other (Specify):	○	○	○	○	○	○
VI. Psychotropic Medication for treating patients with Co-occurring disorders:						
AA. Psychotropic Medication for treating patients with Co-occurring disorders	○	○	○	○	◉	○
VII. Process Improvement Administrative Practices :						
BB. NIATx	○	○	○	○	○	◉

CC. Other (Specify): PDAC ○ ○ ○ ○ ◉ ○

Follow-up Questions to "Screening for Co-Occurring Disorders" (Question I - A)

2a. Does this program have a documented implementation plan?

○ Yes

◉ No

2b. Does this program have written policy and procedures related to the implementation of this EBP?

○ Yes

◉ No

2c. Has this program received staff training by an OASAS-approved education and training provider on this assessment process or screening instrument?

○ Yes

◉ No

2d. Are positive screen findings incorporated into the treatment plans?

◉ Yes

○ No

2e. Does this program have documented service agreements (e.g., a Memorandum of Understanding, contract, etc.) with Mental Health service providers?

○ Yes

◉ No

Follow-up Questions to "Assessment for Co-Occurring Disorders / (COD)" (Question I - B)

3a. Is there a distinct section in the assessment tool that identifies the presence of a mental health condition?

◉ Yes

○ No

3b. Does a formal mental health assessment, if necessary, typically occur for each patient?

◉ Yes

○ No

3c. Is there a licensed or certified health professional on staff that can conduct the mental health assessment?

◉ Yes

○ No

3d. Does the mental health assessment typically lead to the formulation and recording of a mental health diagnosis in the clinical record?

◉ Yes

○ No

3e. Are changes in mental health status routinely documented in the clinical record during the course of treatment?

◉ Yes

○ No

3f. Is the interaction of the patient's mental health condition with his or her substance use documented in the assessment?

◉ Yes

○ No

3g. Does this program provide feedback to staff for the purpose of improving the proficiency of their skills used in assessing patients who have a co-occurring mental health condition?

◉ Yes

○ No

3h. Are there Quality Assurance systems in place to monitor the Assessment of Mental Health Conditions?

○ Yes

◉ No

Follow-up Questions to "Cognitive-Behavioral Therapy" (Question II - E)

5a. Does this program have a documented implementation plan for Cognitive-Behavioral Therapy?

○ Yes

◉ No

5b. Has staff from this program received training on Cognitive-Behavioral Therapy?

◉ Yes
○ No

5c. Has this program revised its assessment and treatment plan instruments to reflect the integration of Cognitive-Behavioral Therapy?

○ Yes
◉ No

5d. Does this program provide periodic observation of staff utilizing Cognitive-Behavioral Therapy?

○ Yes
◉ No

Follow-up Questions to "Cognitive Behavioral Therapy / (COD)" (Question III - N)

7a. Does this program utilize cognitive-behavioral therapy to treat a variety of mental health problems including for example, distortions in thinking or psychiatric symptoms, mood, anxiety, depression, personality, or psychotic disorders?

◉ Yes
○ No

7b. Does this program have a documented implementation plan for cognitive-behavioral therapy that is to be applied with patients who have a co-occurring mental health condition?

○ Yes
◉ No

7c. Has staff from this program received training on the application of cognitive-behavioral therapy with patients who have a co-occurring mental health condition?

◉ Yes
○ No

7d. Do the assessment and treatment plan sections of COD patients' clinical record reflect the use of cognitive-behavioral therapy?

◉ Yes
○ No

7e. Does this program provide feedback to staff to improve their skills in providing cognitive-behavioral therapy to patients who have a co-occurring mental health condition?

◉ Yes
○ No

7f. Are there opportunities to document patient feedback about this treatment approach in the clinical record?

○ Yes
◉ No

7g. Are there Quality Assurance systems in place to monitor the use of cognitive behavioral therapy?

○ Yes
◉ No

Follow-up Questions to "Achieving Integrated Care / Services / (COD)" (Question IV - S)

10a. Does the agency join together with an external consortium to create a program that will serve the population of patients with both conditions?

○ Yes
◉ No

10b. Do treatment staff use a program model (e.g., Relapse Prevention or Assertive Community Treatment) that integrates care?

◉ Yes
○ No

10c. Do treatment staff coordinate a variety of substance use and mental health efforts in an individual treatment plan and deliver care that integrates the needed services?

◉ Yes
○ No

10d. Do treatment staff consult with mental health specialists and integrate that consultation into the care provided?

◉ Yes
○ No

10e. Do two or more treatment staff work together to provide substance abuse and mental health services to the same patient?

◉ Yes
○ No

10f. Do treatment staff deliver a variety of substance abuse and mental health services to the same individual?

◉ Yes
○ No

Follow-up Questions to "Medication Assisted Therapies" (Questions V - T through Z)

11a. Are at least half of this program's clinical staff trained in Medication Assisted Therapy?

(•) Yes

( ) No

11b. For each patient, is the appropriateness for Medication Assisted Therapy incorporated into the assessment process and assessment instrument?

(•) Yes

( ) No

11c. Are there ongoing mechanisms to monitor medication response and potential side-effects?

(•) Yes

( ) No

11d. Follow-up to question V-T: Does this program's attending physician have a license to prescribe Buprenorphine?

(•) Yes

( ) No

11f. Follow-up to question V-U: Does this program's attending physician have a license to prescribe Methadone?

(•) Yes

( ) No

Follow-up Questions to "Psychotropic Medications / (COD)" (Question VI - AA)

12a. Does this program have documented policies and procedures to evaluate and monitor patients' need for psychotropic medications?

( ) Yes

(•) No

12b. For each patient, is the need for psychotropic medication routinely determined as part of the comprehensive assessment?

(•) Yes

( ) No

12c. Is at least half the program's clinical staff cross-trained on psychotropic medications and their interaction with substance use and addictive medications (e.g. benzodiazepines)?

(•) Yes

( ) No

12d. Are there Quality Assurance systems in place to monitor the use of psychotropic medications?

(•) Yes

( ) No

12e. Is there a person on staff who is licensed or certified (e.g. psychiatrist) to prescribe psychotropic medications?

(•) Yes

( ) No