The County Executive's Community Behavioral Health Commission Report

Rockland County, New York

June 2015

County Executive's Commission on Community Behavioral Health

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Acknowledgments

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

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

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Special Thanks to the Following:

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

A VERY Special Thanks to:

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

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I. Introduction

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

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

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

The past fifteen years have brought unprecedented challenges to our communities. As the new millennium arrived, no one could have imagined the events of September 11th. Within a few years, our nation was immersed simultaneously in several protracted wars and, within a few more years, the economy was rapidly tumbling in a downward spiral from which we are still slowly recovering. Many families lost their homes, many workers lost their jobs, and many college graduates found themselves drowning in debt. At the same time, the prison population in the United States kept growing to the point where our nation now had the highest rate of incarceration in the world, surpassing Russia, China and Iran.

Tremendous strain was being placed on communities. With this also came a widespread epidemic of chemical dependence to prescription drugs and myriad other substances, as well as a resurgence of heroin use. The internet introduced us to many new wonders, but also brought with it new hazards like identity theft, cyber-attacks on institutions and businesses, cyber-bullying among students, predatory use of social media and expanded human trafficking. Public opinion polls were telling us that public discourse had become increasingly rigid and difficult, and that our collective trust in institutions was faltering significantly. In the workplace and among neighborhoods, social tensions were rising.

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

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

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

Not all was lost. At the same time, it is worth noting that the past fifteen years have also borne some positive and hopeful achievements for our county. For well over a decade, there have been

four monthly roundtable discussions that are held throughout our county, commonly referred to as "collaboratives." These roundtables serve to bring together human service providers, educators and government representatives in a spirit of community and shared learning. The simple routine of these collaboratives has enhanced our local agencies' ability to communicate more productively, make stronger connections and fertile partnerships, and respond more effectively to changing community needs.

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

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

This period has also seen an increasing awareness and commitment to reducing racism in our communities— a powerful stressor upon many residents. For many years, VCS, Inc. sponsored yearly sessions of the Undoing Racism Workshop with support from the Office of the County

Executive. Monthly gatherings and annual trainings have ensued throughout the years, and various organizations and local government agencies have undertaken independent efforts to address institutional racism that produces racial disparities in health outcomes, in child welfare and in criminal justice.

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

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

II. The Purpose of the Commission

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

A comprehensive behavioral health needs assessment for Rockland County would achieve the following:

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

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

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

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

At the end of the nine-month process, the Commission was to issue this report- the Rockland County Community Behavioral Health Needs Assessment-- providing a comprehensive profile of Rockland County's behavioral health needs, resources and opportunities, with recommendations for specific actions steps**.** Rockland County's behavioral health system would

be re-designed based upon a thorough understanding of both our resident's needs, as well as the best and most sustainable practices to meet those needs.

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

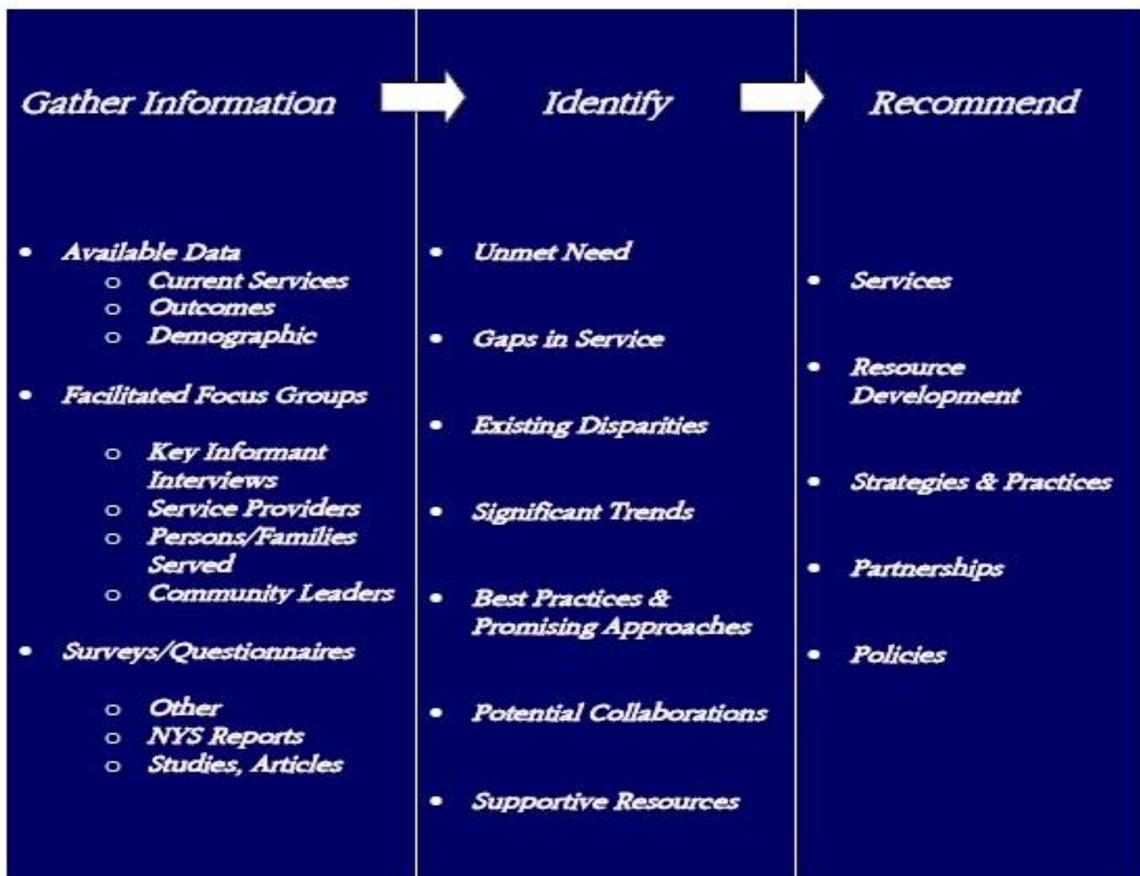
There were three key activities that the Commission was charged with undertaking in order to achieve its goals- (1) gathering information, (2) identifying needs and resources, and (3) making recommendations to the County Executive's office about existing and needed county services and overall system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

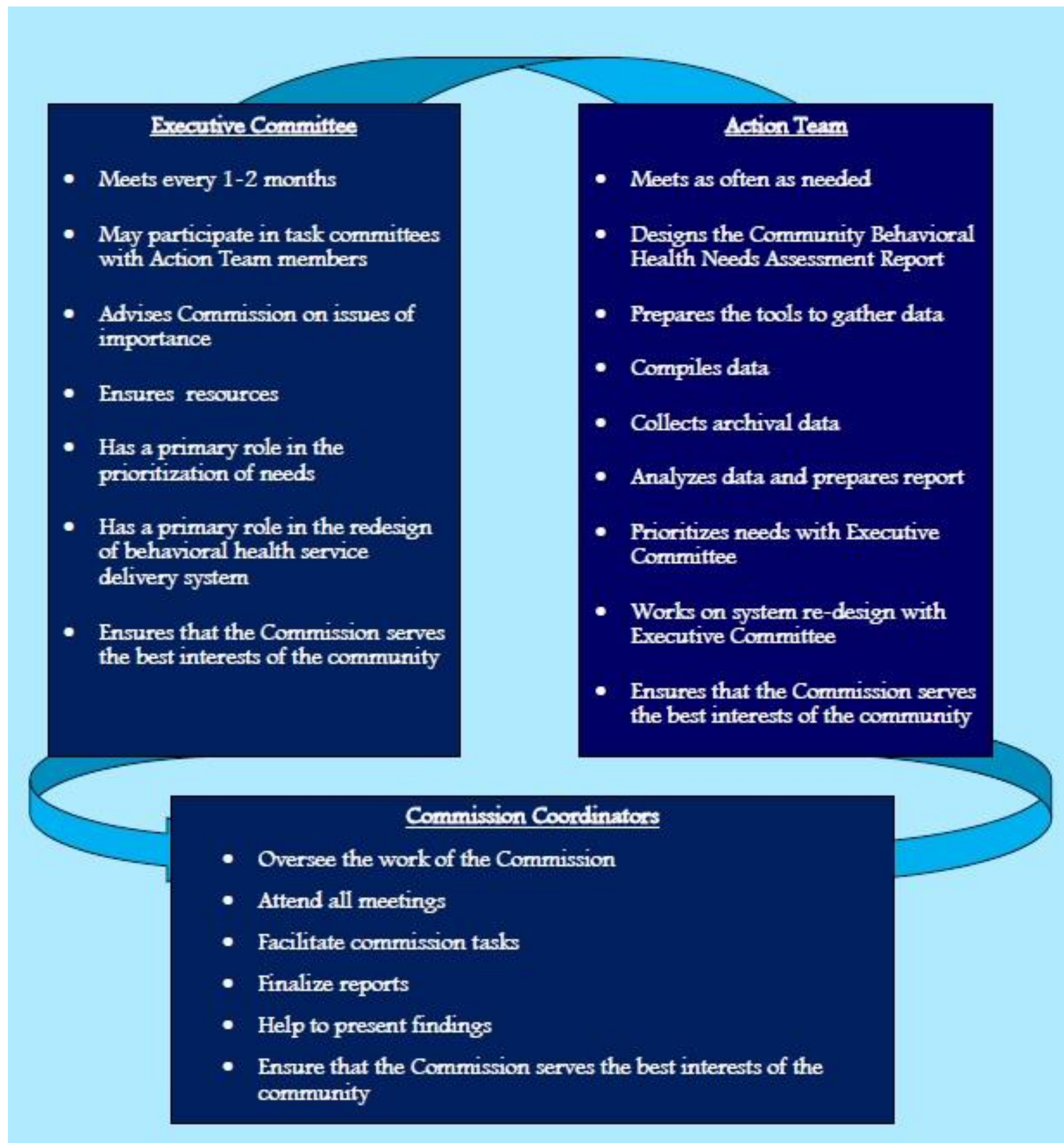
- Information gathering included a search of all of the currently available data on Rockland's behavioral health needs and related topics, as well as an overview of existing services and changing demographics. In addition, information was gathered through the development and utilization of instruments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

- Based upon the information gathered in the assessment process, the Commission identified strengths and gaps in Rockland County's current behavioral health system, keying on unmet needs for our residents and new, significant or emerging trends. Particular attention was given to existing disparities in access to care. Based upon this, the Commission searched for and recommended best practices and promising approaches to behavioral health care, including existing and potential new collaborations among service providers and community organizations. Supportive resources began to be sought, including public and private funding opportunities, in order to address the needs that the Commission's work brings to light.

- Finally, the Commission made recommendations in a number of areas, including needed services to particular communities or target groups, or in some cases service enhancements or changes in modalities, or strengthening the continuum of care. The Commission will make recommendations regarding resource development in the form of grant-writing and other funding sources, best practices and effective strategies, forging new partnerships both within and outside of government, and both the application of existing polices and the creation of new policies that will promote the overall health and welfare of Rockland County residents with behavioral health needs.

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





The Commission was structured in three primary parts: an Executive Committee, an Action Team, and Commission Coordinators.

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

- The Executive Committee met every 1-2 months to review the progress of the Commission in meeting its goals.

- Members of the Executive Committee participated in task committees with Action Team members as needed.

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

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

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

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

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

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

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

- The Action Team researched and prepared the tools necessary to gather data, including development of the instruments to be deployed, including the focus group protocols, key informant interview format, and survey questions. Review of current data, including school surveys and other reports, were part of the Action Team's mission.

- The Action Team was responsible to reach out to each community by sector to compile the data necessary for the needs assessment- to personally conduct the in-person interviews or to insure that they were completed and representative of the various sectors of the County so that a comprehensive picture was achieved.

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

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

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

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

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

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

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

- The Coordinators facilitated Commission tasks as described above, and troubleshot any difficulties in completion of Commission tasks.

- The Coordinators finalized in written form the Community Behavioral Health Needs Assessment and Prioritization/ Behavioral Health System Redesign reports, and then helped to present the Commission's findings to the public with and on behalf of the County Executive.

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

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

IV. Some Perspective- How Did We Get Here?

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

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

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

The creation and subsequent dismantling of a system of behavioral health care did not happen overnight, and is not the result of random occurrences. A confluence of world and national events and social policy decisions, both locally and on a larger scale, brought us to where we are today, with more need for services than ever, and a system of care less adequate than ever to meet those needs. The thoughts and decisions that led us here must be looked at with scrupulous honesty if we are to craft and maintain an appropriate, lasting response for those Rocklanders

suffering from behavioral illnesses. This crisis was, in substantial measure, preventable- a fact which is both tragic on one hand, and hopeful on the other, if we use what we have learned from our mistakes to create a better system of care moving forward. In the words of Mahatma Gandhi, "The future depends on what we do today."

Social/Historical Factors

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

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

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

Economic Recession- Fear did not come only in the guise of war. The American economic system has been close to the brink of disaster, with the last decade bringing with it the "Great Recession"- high unemployment, less and less unskilled jobs available, the need for higher education greater than ever while college tuition costs are at an all-time high, unreachable for many families. Americans have increasingly lost faith in traditionally trusted institutions- the banking industry, educational system, and even the government itself. The gap between the rich and poor has significantly widened over time, resulting in the further disparity of access to needed services for lower and middle class Americans. These are conditions that foster fear, and have been conducive to an atmosphere in which those at the bottom of the economic strata are pitted against one another and blamed for the problems. Inevitably, this has also led to less support for social programs and human services initiatives, and created an attitude in the United States which is increasingly self-protective instead of concerned with the good of the whole. Conversely, the good of the whole may well be the best "self-protection" possible.

Population Explosion/Diversification- The population of the United States has almost doubled over the past fifty years, with the current population over 300 million people, and rising at an increasing rate. Not only are there more people in America, but also a more diverse population than before, especially over the past twenty years. With resources for human services more reduced than ever in the face of need that is greater than ever, there is resentment of those in need and an outrage about sharing these scant resources, especially with those from diverse backgrounds who may look, speak, or act differently than what the majority expects or is used to. Existing services, already reduced, must be stretched to accommodate multiple languages and cultures if they are to be effective. National ambivalence makes this much more difficult.

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

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

resources shrink and people become ever more afraid for themselves and their families, they are less likely to answer that question affirmatively.

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

Behavioral Health Policy Factors

Managed Care- Beginning in the 1970's and coming into play as a significant factor in1988, managed care has created a system that, in essence, provides a financial incentive for under-treating those in need of medical and/or behavioral health services. Billions of dollars per year paid by individuals to their insurance companies, dollars that once paid directly for services to meet their needs, have been diverted over time to large corporations, who deny healthcare benefits and reduce insurance costs while increasing their profit margin. There are four times the number of healthcare lobbyists as Congress members in the United States which exemplifies the leverage they control over policy and funding. These organizations are even involved with the Medicaid system with the advent of DSRIP (Delivery System Reform Incentive Payment) in New York State. The Mental Health Parity Act in 2008 at least set the stage for behavioral health services receiving the same substandard treatment as medical health, and no worse- but this is far from adequate, and has been the cause of the closure of countless behavioral health services in Rockland, including those the County once provided directly.

"Relapse is so prevalent… there's a 'revolving door' at inpatient rehab." Focus Group Participant

As a result of managed care, providers are no longer able to concentrate on the high quality direct care of their patients. Instead, they are now forced to spend countless hours on billing and haggling with insurance companies in order to be paid for treatment that is needed and that they wish to provide. Waiting lists, denials of care based upon insurance, the closure of small practices and behavioral health programs, and greatly reduced services are the natural consequences.

Olmstead Decision- This United States Supreme Court decision of 1999 was based on principles respectful of human rights and protective of those in need- at least in theory. In essence, it protected the rights of individuals with disabilities to exist, in all aspects of their lives, in the least restrictive settings possible. The goal of the Olmstead decision was to eliminate large, segregated work, educational and living facilities in favor of total community integration and de-institutionalization in order to prevent discrimination based upon disabilities.

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

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

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

Economic crisis, provoking increasing fear for survival and consequent ambivalence about responsibility to care for one another, was the impetus for decisions to close these satellite

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

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

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

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

Conclusion

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

If the road to perdition is paved with good intentions, then the pathway out and toward a better future for those in need of behavioral health services in Rockland County must be paved with something much more substantial. Our good intentions must be backed up and informed not only

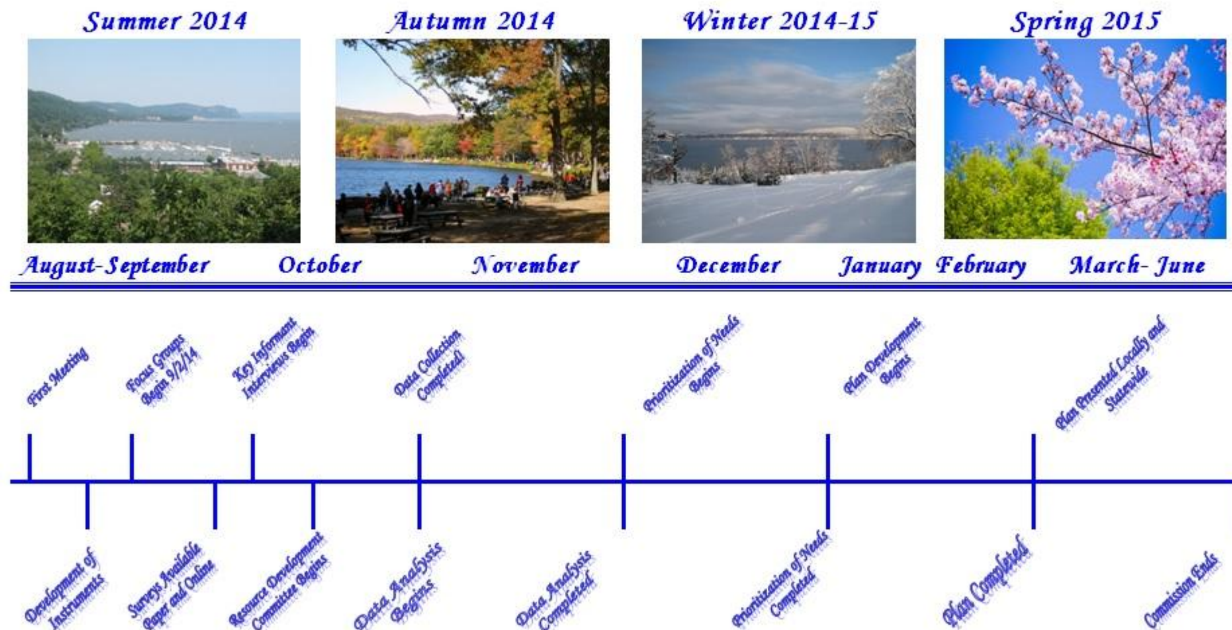
by principles of fairness, kindness, and justice for all, but also by facts about what is truly needed, and a long-term plan to meet those needs.

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

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

V. The Commission's Process (August 2014-May/June 2015)

County Executive's Commission on
Community Behavioral Health- Timeline



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

PHASE ONE (Summer 2014): The County Executive appointed and announced the formation of the Commission, representing a broad range of backgrounds/expertise, as well as experience

in community outreach, research, planning, and governmental operations.   The Commission members participated in an orientation process and begin to meet regularly as planned.

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

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

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

VI. Methods for the Needs Assessment

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

Beginning in August, 2014, the Commission's Action Team met on at least a weekly basis, spending most of its time during the first weeks developing and finalizing its quantitative and qualitative data collection instruments with the oversight and assistance of the Rockland County Planning Department. With the intention of delving both as broadly and as deeply as possible into Rockland County's behavioral health needs given the time frame allotted, the Action Team

saw the need to develop and deploy a variety of methods. The Action Team quickly adopted several different approaches to gather the information sought in this particular needs assessment process. These were a variety of sound, time-tested approaches commonly used in all kinds of research. They included (1) guided focus group discussions, (2) in-depth interviews with key informants, and (3) surveys and questionnaires. The Action Team would also conduct a review of any available archival data related to behavioral health in Rockland County. These approaches were selected because they were flexible, adaptable and usable within a limited timeframe. Collectively, they gave the Commission the most comprehensive profile within a relatively short time period.

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

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

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

all, a total of 40 focus groups were completed by the end of October, with an average of 20 participants per session.

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

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

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

Surveys and Questionnaires: These are very common research instruments. They are compilations of targeted questions. A survey is usually composed of close-ended questions with multiple answers from which an individual can choose. Surveys tend to be quick to administer and to complete; they often have sample responses to simply check off.

Questionnaires are similar but they can include open-ended questions and respondents are asked to elaborate or explain. Both kinds of instruments can be disseminated in written (hard-copy) format or in electronic format.

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

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

Some additional considerations regarding the data gathered are as follows:

- 1,375 surveys were completed in total from mid-September to early November 2014. Considering the County's 2013 population estimate, the resident survey has a margin of error of ±3.52. In terms of the consumer survey, there is a margin of error of ±4.65 based upon available information about those in Rockland County with cognitive difficulties. This means that our survey results more than meet the criteria to be statistically significant in terms of reflecting the community in Rockland.

- In the consumer surveys, among those who self-identified as a consumer, over 2/3 identified as having a behavioral health problem themselves, while more than 1/3 identified as being a family member of someone with a problem.

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

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

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

- The following constituencies were represented by the focus groups:

Constituency Represented- Focus Groups
Mental Health (MH) Providers
Children's Service Providers (community)
Community/Human Services (Haverstraw)
Intellectual/Developmental Disabilities (I-DD) Providers
Emergency Services Workers
Community/Human Services (Western Ramapo)
Healthcare Providers
Chemical Dependency (CD) Consumers (residential)
Chemical Dependency Treatment Provider (residential)
Mental Health Consumers (family)
Community Services/Government
Recipient Advisory Council- MH Consumers
CD Providers- Treatment and Prevention
Criminal Justice System
Consumers, Providers, Advocates for all Behavioral Health areas
Education/Community
Healthcare-Latino

Law Enforcement
Mental Health Advocacy Group
Education
Immigrant Rights/Human Services Organizations
Law Enforcement/ Treatment (CD and MH)
Teen and Parent Consumer/Family
Substance Abuse Prevention/Education
Community/Human Services (Spring Valley)
Consumer/ Family of Elementary School-Aged youth
Education/ Consumer
Youth/Young Adult- Education
Children/Teen Services Providers
MH Consumers
School Administration
School Social Workers and Guidance Staff
Transition Coordinators from Teen to Adult services
LGBTQ
School/ Special Services Directors
Behavioral Health CEOs
I-DD Consumers
Community/Human Services (Nyack)
Veterans

- These are some of the features of the population interviewed as key informants. In each case, the individual was selected because of a single, or in many cases a multiple, population representation, including those hard to reach in Rockland County.

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

VII. Preliminary Findings

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

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

VIII. The Five (5) Core Themes

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

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

When asked about the ability of behavioral health services in Rockland County to meet consumer needs, more than two thirds of those surveyed reported that their needs were met after receiving behavioral health services in Rockland County. This does not take into account people

in need that do not access services because of barriers or gaps in the continuum of care. Consumers surveyed were given a menu of 37 different types of services representing developmental disabilities, chemical dependency/substance use disorders, and mental health, and running the gamut from treatment to prevention, from residential to short-term therapy. The following is a list of the six services utilized where residents expressed the highest degree of satisfaction with their treatment, the highest numbers being for private therapy, outpatient mental health services, and "personalized recovery oriented services," or PROS.

Behavioral Health Services and Programs with High Consumer Satisfaction	Participated		Highly Satisfied		Somewhat Satisfied		Not Meeting my Needs	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Mental Health Care Management	180	44.9%	100	55.6%	56	31.1%	24	13.3%
Mental Health Clinic	182	45.4%	104	57.1%	55	30.2%	23	12.6%
PROS (Personalized Recovery Oriented Services)	121	30.2%	75	62.0%	30	24.8%	16	13.2%
Outpatient Mental Health Program	173	43.1%	108	62.4%	41	23.7%	24	13.9%
Private Psychiatrist or Therapist	177	44.1%	111	62.7%	40	22.6%	26	14.7%
Early Intervention Services (DD)	51	12.7%	31	60.8%	12	23.5%	8	15.7%

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

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

Relative Strengths of Behavioral Health Services in Rockland	Resident Survey		Consumer Survey		Provider Survey		Focus Group	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Close to home	259	56.4%	190	56.9%				
Serve people of all ages	189	41.2%	143	42.8%				
Confidential/ Private	175	38.1%	160	47.9%				
Staff is skilled and knowledgeable	157	34.2%	182	54.5%	14	9.6%	1	2.5%
Connects people to other services needed	156	34.0%	154	46.1%	1	0.7%		
Caring, respectful atmosphere	153	33.3%	199	59.6%	5	3.4%	2	5.0%
Accept my insurance	147	32.0%	179	53.6%				

- Service collaboration. Professionals expressed that they did collaborate with one another, and both professionals and the public outlined the value of collaboration to insuring better services for those with behavioral health needs.

Provider Survey Indicator	Number of Responses	Yes		No	
		Number	Percent	Number	Percent
Do you collaborate with other service providers?	162	151	93.2%	11	6.8%

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

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

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

Barriers to Accessing Behavioral Health Care	Resident Survey		Consumer Survey		Provider Survey		Focus Group	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Do not know where to get services	212	42.9%	66	27.3%	N/A	N/A	12	30.0%
Unfamiliar with types of service	186	37.7%	58	24.0%	95	55.9%	7	17.5%

More than 40% of respondents did not know of a place to go for behavioral healthcare in Rockland County. When asked about specific types of services, this number was even higher, with approximately half of the residents surveyed not knowing where to go for help with a whole host of services representing all of the behavioral health areas. Preventive services seemed to be the least familiar to residents, with ***over 60% being unaware of any services that promoted good emotional health and development.***

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

The leadership was rated by our key informants as being somewhat more aware of behavioral health services, efforts and needs than residents, with an average score of 5.3 out of 10 as opposed to 4 for residents. However, ***the numbers for leadership were split, with 21.7% of leaders being seen as very aware, while the same number, 21.7% seen as having very little awareness.*** Far more residents (37.5% compared with 21.7%) were seen as being very aware of behavioral health needs than leaders, despite a lower average number.

Key Informant Indicator	Number of Responses	Scores Over 7		Scores 4 to 7		Scores Under 4		Average Score
		Number	Percent	Number	Percent	Number	Percent	
How aware are people in the community of behavioral health needs, efforts and services? (1= No awareness; 10= Very aware)	24	9	37.5%	14	58.3%	1	4.2%	4.0
How aware are leaders, groups or committees in the community of behavioral health needs, efforts and services? (1= No awareness; 10= Very aware)	23	5	21.7%	13	56.5%	5	21.7%	5.3

There seemed to be little awareness of any evaluation of behavioral health efforts. Key ***informants were asked about evaluation efforts, and nearly 62% were unaware of any efforts***, despite most believing that the quality of care and care coordination were of utmost importance.

Key Informant Indicator	Number of Responses	Yes		No		Don't Know	
		Number	Percent	Number	Percent	Number	Percent
Do you know if there is any evaluation of the efforts?	21	8	38.1%	2	9.5%	11	52.4%

Respondents suggested a range of strategies to address the lack of awareness. Recommendations regarding the use of media included:

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

Some suggestions regarding approaches for outreach to the community included:

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

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

Emphasis was given to the idea of a ***single point of information*** that was easily identifiable, accessible and more specialized in matters of behavioral health. The need for a centralized place where everyone could access information about services, such as a website or hotline was repeatedly cited. Many saw a need for a comprehensive directory of private and public services

available inside and outside of the county to county residents, categorized with specific information such as who is served and what kind of insurance is accepted.

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

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

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

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

While the issue of stigma was not listed as a survey response choice for possible barriers, it was a big discussion point in both the focus group and key informant interviews, with 45% of focus groups listing ***stigma as a primary barrier*** to accessing care.

Most Significant Barriers to Accessing Behavioral Health Care	Resident Survey		Consumer Survey		Provider Survey		Focus Group	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Price/ Cost	253	51.2%	85	35.1%	84	49.4%	16	40.0%
Lack of Insurance or insurance not accepted	252	51.0%	89	36.8%	112	65.9%	22	55.0%
Do not know where to get services	212	42.9%	66	27.3%	N/A	N/A	12	30.0%
Lack of transportation	189	38.3%	92	38.0%	97	57.1%	23	57.5%
Unfamiliar with types of service	186	37.7%	58	24.0%	95	55.9%	7	17.5%
Fear/ Distrust	158	32.0%	50	20.7%	57	33.5%	1	2.5%
Limited Hours of Operation	121	24.5%	42	17.4%	65	38.2%	3	7.5%
Language	112	22.7%	21	8.7%	54	31.8%	20	50.0%
Stigma							18	45.0%

At the same time that the results indicated that Rockland community members rate behavioral health services an 8.5 out of 10 in terms of a priority, those same ***respondents do not believe that there is or will be nearly enough support for behavioral health services among their friends and neighbors***, nor is there the perception of support from the leadership. Less than a quarter believe that the County's leadership sees these issues as a major concern, and ***only slightly more than 18% believe that the community at large would strongly support increased services, even though those services are vitally needed.***

Key Informant Indicator	Number of Responses	Scores Over 7		Scores 4 to 7		Scores Under 4		Average Score
		Number	Percent	Number	Percent	Number	Percent	
How much of a concern is behavioral health to the community? (1= Not at all; 10= Very large concern)	28	23	82.1%	5	17.9%	0	0.0%	8.5
How much of a concern is behavioral health to the leadership? (1= Not at all; 10= Very large concern)	21	5	23.8%	13	61.9%	3	14.3%	6.2
Would people support increased behavioral health services in your community? (1= Not at all; 10= A lot)	22	4	18.2%	8	36.4%	10	45.5%	7.0

Following is the complete list of barriers to accessing behavioral health care in Rockland County, by survey and focus group results:

Barriers to Accessing Behavioral Health Care	Resident Survey		Consumer Survey		Provider Survey		Focus Group	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Price/ Cost	253	51.2%	85	35.1%	84	49.4%	16	40.0%
Lack of Insurance or insurance not accepted	252	51.0%	89	36.8%	112	65.9%	22	55.0%
Do not know where to get services	212	42.9%	66	27.3%	N/A	N/A	12	30.0%
Lack of transportation	189	38.3%	92	38.0%	97	57.1%	23	57.5%

Unfamiliar with types of service	186	37.7%	58	24.0%	95	55.9%	7	17.5%
Fear/ Distrust	158	32.0%	50	20.7%	57	33.5%	1	2.5%
Limited Hours of Operation	121	24.5%	42	17.4%	65	38.2%	3	7.5%
Language	112	22.7%	21	8.7%	54	31.8%	20	50.0%
Stigma							18	45.0%

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

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

When asked if certain segments of the population in Rockland County faced disproportionately high barriers in trying to obtain behavioral health services, it was clear that consumers, providers, and the general public all believed that this was the case, as seen below.

Segments of the Community that Disproportionately Face Barriers/ Might Think That Behavioral Health Issues are Overlooked Due to Age, Religion, Ethnicity, Gender or Socioeconomic Status
Age- Seniors
Socioeconomic Status
Yes- All of the Above
Non-English Speakers
Uninsured
I-DD and those with DD and MH are excluded
SPOA- Clients do not feel comfortable
Orthodox Jewish- cultural differences
Low Income
Insular Communities

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

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

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

Many respondents saw the question ***of insurance coverage and funding*** for needed services and ancillary supports as a central issue. The concerns aired included the need for affordable treatment, the dearth of therapists who accept insurances, Medicaid, or self-pay, the need for ancillary supports to help families (e.g. bus tickets, taxi fares, case management, mini-grants), and the need for sliding fee schedules that are truly affordable so more people can receive

services. Another common response was in reference to the issue of ***transportation.*** An example of this was the statement: “Make arrangements with bus companies to get consumers low-cost bus tickets. We did this before and it was a great success– it made a huge difference."

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

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

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

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

Most Significant Behavioral Health Issues/ Problems Cited By Respondents in the Needs Assessment (in alphabetical order)	
Addiction	Information and Referral
Aftercare	Inpatient Hospitalizations
Autism/ Asperger's	Insurance
Case Management	Length of Stay
Child Psychiatry	Medication
Children Services	Nyack Hospital

Community Residence	Partial Hospitalization Program
Community-Based Services	Provider Availability
Co-Occurring Disorders	Re-entry Services
Coordination	Regulatory Restrictions
Crisis Services	Respite
Cultural/ Language Needs	Lack of Services
Day Treatment Program	Special Populations
Family Therapy	Staff Training
Funding	Transitional Services
Home Care	Transportation
Hours of Operation	Trauma Informed Care
Housing	Vocational Services

In addition to this list, ***68.5% of residents believed that behavioral health services were limited or not available in Rockland County***. In both the resident surveys and the focus groups, the community indicated that ***our residents are leaving Rockland to access services***. Discussion in the focus groups indicated that individuals and families left for a variety of services that were unavailable in Rockland. Some mentioned frequently included child and geriatric mental health care, autism and Asperger's services, and psychiatric care for those with developmental disabilities.

Resident Survey Indicator	Number of Responses	Available in the Area		Limited in the Area		Not Available in the Area	
		Number	Percent	Number	Percent	Number	Percent
What do you think in general about the availability of behavioral health services in Rockland County	599	189	31.6%	328	54.8%	82	13.7%

More than 40% of residents believed that community members were leaving Rockland to access care. There were others who felt that the services they used in Rockland County did not adequately meet their needs.

Resident Survey Indicator	Number of Responses	Yes		No	
		Number	Percent	Number	Percent
Do you or someone you know ever leave Rockland County to obtain behavioral health care services?	692	280	40.5%	412	59.5%

The following is a list of the programs that those surveyed felt were not meeting their behavioral health needs. Some, such as mobile crisis service for developmental disabilities, had comparable high satisfaction and dissatisfaction rates. However, none of these services rated by the community had more than 42% of consumers feeling "highly satisfied" by their services, and more than 1/3 in all of these services did not think that the service met their needs.

Behavioral Health Services and Programs	Participated		Highly Satisfied		Somewhat Satisfied		Not Meeting my Needs	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Inpatient Hospitalization for Psychiatric Services	80	20.0%	30	37.5%	21	26.3%	29	36.3%
Mental Health Crisis Services (ER, other)	90	22.4%	36	40.0%	24	26.7%	30	33.3%
Mental Health Services for Children/Adolescents	61	15.2%	21	34.4%	18	29.5%	22	36.1%
Supportive Employment (DD)	53	13.2%	21	39.6%	10	18.9%	22	41.5%
Mobile Crisis Service (DD)	24	6.0%	10	41.7%	4	16.7%	10	41.7%
Substance Use Detox program	45	11.2%	16	35.6%	10	22.2%	19	42.2%
Methadone Maintenance	21	5.2%	4	19.0%	3	14.3%	14	66.7%

The following list represents those services that the needs assessment indicates are too limited or nor currently available in Rockland based upon our findings. This list represents the topics that came up on a repeated basis in the focus groups, key informant interviews and all three surveys.

Services that are Not Currently Available or Too Limited
ACT Services
Addiction/ Inpatient & Outpatient Substance Abuse Treatment/ Halfway Houses/ Step Down Programs for People Coming Out of Inpatient Rehab/ Transitional Programs for People with Substance Use Disorders
After-school Programs
Anger Management
Assessment Center
Autism/ Asperger's/ Special Education for Autism
Child Psychiatry
Community Habilitation
Community-Based Services
Consumer Advocate
Co-Occurring Disorders- DD, MH & CD (Youth & Adult)
Court-Involved Youth and Adult Behavioral Health Services
Crisis Services
Cultural/ Language Needs
Day Treatment Programs
Developmental Disabilities Crisis Services
Developmental Disabilities Psychiatry
Disengaged Youth Services (14 to 24 Years Old)
Early Childhood & Parent Services
Eating Disorders

Family Therapy
Geriatric Behavioral Health Specialists
Holistic Alternatives
Housing
Information and Referral Services
Inpatient Hospitalizations (Child/ Adolescent & Adult)
LGBTQ Behavioral Health Services
Medication Management
Men's Shelter
Mental Health Clinic
Mental Health Support Groups
OPWDD Services
Partial Hospitalization Program/ with Transportation
Personal Care Aides
Preventive Education Services
Preventive Services
Provider Training
Psychiatric & Geriatric Dementia Services
Re-Entry Services
Respite
Social Skills Training
Telephone Hotline
Transition from Treatment to Community
Transportation
Trauma Informed Care
Veterans Behavioral Health Services
Vocational Training

There were differences in consumer and provider ideas about what services were missing or limited that needed to be available. The following are the issues mentioned by consumers but not by providers:

Services that are Not Currently Available or Too Limited Identified by Consumers and Not Identified by Providers
Autism/ Asperger's/ Special Education for Autism
Consumer Advocate
Information and Referral Services
Mental Health Support Groups
Preventive Education Services
Social Skills Training
Transition from Treatment to Community
Vocational Training

Perhaps the widest range of recommendations from respondents came in reference to perceived gaps. Among these were such things as mobile mental health services that could go from community to community and respond to a range of needs, in-home behavioral health evaluations for people who cannot necessarily get out to a hospital or clinic, and a centralized, one-stop BH service center where behavioral health programs could be co-located and where triage could be conducted.

"[There is a] lack of understanding of what people need. It should be a partnership, not professionals always making choices for them." Key Informant

Some repeated the idea of an in-county partial hospitalization program for a given segment of people in need, while others emphasized the growing need for homeless services and housing.

The notion of more closely integrating mental health and pediatrics was cited by several respondents—to have behavioral health providers embedded in pediatric sites for screening and referral, and to amplify cross-training opportunities. Some respondents expressed a concern over the lack of supportive services for parents with higher-functioning children with developmental needs, for college-aged youth who have "aged out" of services/schools-- support for transitional-aged individuals, and for persons with autism-- many of whom have to turn to neighboring counties for support unavailable in our own county. There was also the view that respite services for families dealing with behavioral health problems are needed, as well as more peer advocates and mentors for children and youth-- it was felt that this should be built into all of the behavioral health programs. Yet others stated that we needed to be concerned that, as the aging population continues to grow, we will need inpatient facilities that are equally adept at handling dementia and geriatric psychiatric needs.

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

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

Theme V: The Role of Government

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

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

The results of the needs assessment conducted indicate that the community believes that the ***County should provide behavioral health services, especially safety net services*** and those services not covered (or not adequately covered) by insurance. However, it was indicated time and again, in both focus group and key informant interviews, that the County's financial picture

is a grave concern, and that therefore the County probably could not and should not provide all services as directly as it once did. That said, it was the clear expectation that the ***County should insure that the full array of behavioral health services are available, accessible and affordable*** for residents without significant impediments. The needs assessment reveals that the community views the County as responsible to insure that the fabric of the behavioral health safety net be repaired as quickly and completely as possible. Those who participated believed strongly that the County should be responsible for the health and welfare of its residents. They see the role of government as supporting, not necessarily directly providing, behavioral health services.

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

Provide Services

- Provide Services that are not Otherwise Provided- e.g. Clinics
- Provide a system that allows for services outside the managed care system encompassing broader services
- Supervision of Sex Offenders
- Services for Undocumented
- Contract Out All Services
- Ensure a Core System of Services is in Place
- More wraparound services- comprehensive treatment
- Expand services to return to a campus style system of care
- Crisis Assessment in All Languages
- More Programs for Veterans- those returning and suffering from PTSD
- More Affordable Housing for Underpaid Workforce
- Should Fill the Gaps- Responsible When No One Else Can Help
- Mandated Services through Sheriff's Department
- Facilitate the Establishment of a Special Housing Unit in the Correctional Facility
- Clinic and Crisis Management especially for Medicaid Population
- Should Provide Vocational Training to Clients- Access VR will pay for Vocational Training- Provide Housing for 2 to 3 Years
- Not Capable of Providing All Services

Those who were surveyed believed that the ***County is responsible to insure that the services provided are meeting the needs*** of the community. There were many mentions of the local Unified Services process, both for the good that it still does in the coordination of services, and

for what it is lacking in comparison with the past, where there was a more robust and inclusive process. This was seen as a primary role for the County moving forward— ***to rebuild this support system and to work hand in hand with the community and the State licensing agencies*** in supporting providers who serve the behavioral health needs of residents.

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

Support, Supervise & Coordinate Services

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

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

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

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

Outreach & Communication

- Make Sure Public is Informed
- Leadership in Publicizing Available Services
- Compliance Communication with Agencies about Changes in Regulations- Clearinghouse of Regulation Changes
- Apply for Grants with Agencies
- Advocate Needs
- Educate Residents

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

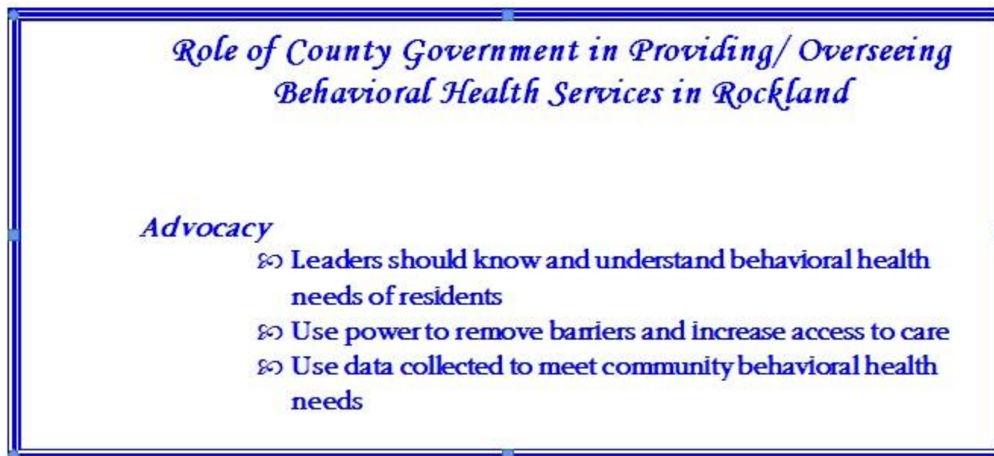
Role of County Government in Providing/ Overseeing Behavioral Health Services in Rockland

Resources and Funding

- Appropriation of Funds
- Commitment to Fund Services
- Need to Assist Non-for-Profits to Retain Financial Stability
- Not Capable of Funding All Efforts

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

of taking behavioral health needs seriously. There is a strong expectation on the part of the participants that the results of the needs assessment will be used by County government to shape a better future for those affected by behavioral health issues in Rockland County.



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

> *"Do away with some of the divisions among mental health, chemical dependency and developmental disabilities. People are suffering… and that's what matters." Survey Participant*

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

IX. Recommendations

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

> *"Look at long term rather than short term needs-- a real fix rather than a band aid."*
> *Key Informant*

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

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

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

We have included a reference chart, (see Appendix E, pg 133) where all of the recommendations are listed by a code, page number, responsible parties and partners, implementation timeframe,

and availability of resources, making it easier to search through the recommendations in an efficient way. The key to the codes is at the bottom of the page, with S standing for the section on Building Upon Strengths, A for Increasing Awareness, and so on, as listed.

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

A-C4	Awareness efforts directed to special populations	54	All	RCDMH	BH providers (incl. RCDMH)	1 to 2	1	
A-D1	Annual education session for all elected officials	54	All	County of Rockland &Legislature	RCDMH, CSB, Subcommittees, Workgroups	1	1	
A-D2	Create a BH media campaign	54	All	RCDMH	BH providers, other agencies/coalitions	1 to 2	1 to 2	
B-A1	Expand BH services to evenings/weekends	56	All	RCDMH	BH providers (incl.RCDMH), State BH agencies	1	2 to 3	
B-A2	Assess and treat walk-in consumers	56	All	RCDMH	BH providers (incl.RCDMH), State BH agencies	1	2 to 3	
B-A3	Serve homebound consumers with BH issues	56	All	RCDMH	Home healthcare providers	2	2 to 3	
B-A4	Develop a "pro-bono" pool of BH professionals	56	All	County of Rockland	RCDMH, Law Dept.	2	2	
B-A5	Limit wait lists through referrals	56	All	RCDMH	State BH agencies	1	1	
B-A6	Adapt PROS to serve those unable to work 10+ hours a week	56	MH/I-DD	RCDMH	RCDMH, PROS administrators	2	1 to 2	
B-A7	ACCES-VR to present services, troubleshoot gaps	57	All	RCDMH	BH Workgroups, ACCES-VR, State agencies	1	1	
B-B1	Add resource assessment to annual planning process	57	All	RCDMH	BH Workgroups, Subcommittees, CSB	1	1	
B-B2	Create Olmstead Implementation Taskforce	57	MH, I-DD	RCDMH	BH Workgroups, real estate developers, housing specialists	1	1	
B-C1	Recruitment of specialists- BH, special populations	57	All	RCDMH	BH providers	2 to 3	2 to 3	
B-C2	Analysis of BH agency staffing for core competencies	57	All	RCMDH	BH providers (incl. RCDMH)	2	1	
B-C3	Recruit BH staff with cultural, linguistic competence	58	All	County of Rockland	RC Commission on Human Rights, Personnel	2	1	
B-C4	Measure employees' sense of equity in workplace	58	All	RCDMH	BH Workgroups, Subcommittees, CSB	1	1	
B-C5	Expand use of para-professionals and recovery coaches	58	All	RCDMH	BH Workgroups	1	1 to 2	
B-D1	Work with State reps to address insurance restrictions	58	All	County of Rockland	State and Federal representatives	2 to 3	2 to 3	

Codes:
Items: S=Building Upon Strengths, A= Increasing Awareness, B= Removing the Barriers, GA= Closing the Gaps- Adult MH, GCD- Closing the Gaps- Chemical Dependency, GCA= Closing the Gaps- Child and Adolescent, GCL= Closing the Gaps- Co-located Services, GCJ= Closing the Gaps- Criminal Justice, GCR= Closing the Gaps- Crisis Services, GID- Closing the Gaps- I-DD Services, RG= Reaffirming the Role of Government

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

Resources Needed: 1=Can accomplish with current resources, 2= Needs minimal additional resources to accomplish, 3= Needs substantial resources to accomplish

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

Finally, the chart may be used for understanding what the next steps for implementation might be. Under the Implementation Timeframe category, any item scored as a "1" is something that the Commission ranked as being something to achieve within the first year, a "2" is something to be done within 2-3 years, and a rating of "3" would be done within 3-5 years.

Using the Implementation Timeframe category in conjunction with the category on "Resources Needed" is especially helpful. A ranking of "1" in this category means that the Commission assessed that the recommendation can be implemented with existing resources; "2" means minimal additional resources would be needed, and a "3" indicates that substantial additional resources are required to achieve the recommendation.

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

D. County Executive's Commission on Community Behavioral Health- Recommendations

Item	Recommendation	Page	BH Sector	Primary Entity(ies) Responsible	Other Partners	Implementation Timeframe	Resources Needed	Status
S-A1	Programs identified as highly satisfactory	50	All	RCDMH	CSB	1	1	
S-B1	Normalize collaboration, measure effectiveness	50	All	RCDMH, BH Workgroups	Community coalitions, other agencies	1	1	
S-C1	Training with CEUs for BH program staff, others	50	All	RCDMH	BH providers, other agencies/coalitions	1	1	
S- D1	Uniform Consumer Satisfaction survey	50	All	RCDMH	CSB, BH Workgroups	1	1	
S-D2	County depts. represented in community coalitions	51	All	County of Rockland	All County Depts.	1	1	
S-D3	Rebuild/empower the Unified BH Services system	51	All	County of Rockland	RCDMH, CSB, Subcommittees, Workgroups	1	1	
S-E1	Measure BH agency involvement in community	51	All	RCDMH	BH providers	1	1	
S-F1	Establish satellites, co-located sites in community	51	All	RCDMH	BH providers (incl.RCDMH), State BH agencies	2	2 to 3	
S-F2	Establish partnerships in underserved communities	52	All	RCDMH	BH providers (incl.RCDMH)	1	1 to 2	
A-A1	Education/community resource specialist position	53	All	County of Rockland	RCDMH	1	2	
A-B1	Organizational charts- Unified Services BH system	53	All	RCDMH	CSB, BH Workgroups	1	1	
A-B2	Update all BH provider information annually	53	All	RCDMH	BH providers	1	1	
A-C1	Create a single point of contact for BH info	53	All	RCDMH	RCDSS	1 to 2	2 to 3	
A-C2	Capture info in printable and digital format	54	All	RCDMH	BH providers, other agencies/coalitions	1 to 2	2	
A-C3	Explore partnerships in underserved communities	54	All	BH providers (incl. RCDMH)	Community coalitions, other agencies	1	1	

Codes:
Items: S=Building Upon Strengths, A=Increasing Awareness, B=Removing the Barriers, GA=Closing the Gaps- Adult MH, GCD- Closing the Gaps- Chemical Dependency, GCA=Closing the Gaps- Child and Adolescent, GCL=Closing the Gaps- Co-located Services, GCJ=Closing the Gaps- Criminal Justice, GCR=Closing the Gaps- Crisis Services, GID- Closing the Gaps- I-DD Services, RG=Reaffirming the Role of Government

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

Resources Needed: 1=Can accomplish with current resources, 2=Needs minimal additional resources to accomplish, 3=Needs substantial resources to accomplish

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

Building upon Strengths (Recommendations Code S)

A. Care Provision/ Expansion

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

B. Care Integration

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

C. Workforce Development/ Expansion

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

D. Role of the LGU/ Government Departments

1. RCDMH will establish a consistent method of measuring consumer satisfaction that is developed within the existing behavioral health Workgroups. This should include the development of a uniform survey instrument and process to be conducted throughout the course of service delivery under the oversight of RCDMH. As part of the annual contractual review, RCDMH will meet with programs to review and analyze results for the purpose of directing or

redirecting services to better meet consumer needs and improve program efficiency. These results will be presented to the Community Services Board by RCDMH as part of the annual programmatic and budgetary review.

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

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

E. Information Access

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

F. Service Access

1. Behavioral health agencies in Rockland, including RCDMH, will look for opportunities to create/ re-create services located within Rockland communities, including the establishment of satellites, co-located services, shared resources, to further develop resources to address BH needs.

2. Behavioral health agencies in Rockland, including RCDMH, will explore partnerships in underserved communities, including linkages to natural community leaders, to more effectively respond to the BH needs of these communities. Care must be given to engage the community to identify their natural leaders.

Increasing Awareness (Recommendations Code A)

A. Workforce Development/ Expansion

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

B. Role of the LGU/ Government Departments

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

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

C. Information Access

1. County Executive will designate, within the County, a single point of contact where Rockland residents can access information about behavioral health services. This needs to include a phone line, separate and apart from a crisis hotline, that can both provide referral information as well as a direct link to BH crisis services when needed. Additionally, a publicly available website

containing this information should emanate from this single point of contact. InfoRock has an infrastructure in place, if additional resources are made available, that may meet this need.

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

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

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

D. Education

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

2. RCDMH will spearhead a county-wide campaign regarding behavioral health that utilizes multiple strategies (public service announcements, media, social networks, digital media, movies, bus signs, newsletters, etc.) to promote existing programs and services and increase understanding of behavioral health issues. The education resource specialist/ community liaison (see above) will coordinate the campaign. The campaign will include both general messages for

the public at large and targeted messages for those in need. This will be developed and implemented in collaboration with existing organizations and sectors, e.g. schools, faith communities, human service and BH agencies, business, law enforcement, healthcare providers, government, media, etc.

Removing the Barriers (Recommendations Code B)

A. Care Provision/ Expansion

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

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

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

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

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

6. RCDMH will convene all providers who administer PROS to develop strategies to adapt this model to serve consumers who are engaged in competitive employment less than 10 hours a

week. This could include substitution of volunteer hours or internships to meet required employment thresholds.

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

B. Care Integration

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

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

C. Workforce Development/ Expansion

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

2. Beginning in 2015, as part of the annual contract process, RCDMH will analyze the staffing patterns of behavioral health programs to ensure that staff is representative of and/or has the

core competencies necessary to serve the community, i.e.; linguistic and cultural proficiency. Specific attention must be given to serving the needs of special populations identified in the Needs Assessment e.g. LGBTQ, veterans, trauma survivors, underserved cultural/ religious groups. Consumer satisfaction surveys developed and standardized by RCDMH (see Building Upon Strengths) will measure effectiveness.

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

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

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

D. Role of the LGU/ Government Departments

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

payment requirements, and will develop appropriate regulatory changes to respond to these barriers.

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

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

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

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

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

E. Regulatory Changes

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

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

F. Service Access

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

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

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

4. The County of Rockland will work with State elected officials to advocate for legislative changes allowing for those who are deemed eligible for services under one State behavioral health agency (OPWDD, OASAS, OMH) to receive additional services from one or both of the other agencies, in the case of co/multiple-occurring disorders.

5. The County Executive will advocate that the county-based Housing Authorities include representation from the Behavioral Health community on their advisory boards in order to assist Housing Authorities in expanding their planning process and to take advantage of HUD, CDFI and other funding possibilities to better serve the behavioral health population.

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

G. Education

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

Closing the Gaps- Adult Mental Health (Recommendations Code GA)

A. Care Provision/Expansion

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

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

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

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

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

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

B. Care Integration

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

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

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

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

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

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

C. Role of the LGU/Government Departments

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

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

D. Regulatory Changes

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

E. Information Access

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

F. Service Access

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

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

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

G. Education

1. RCDMH, through the County's Unified BH Services system, will ensure that all behavioral health agencies in Rockland, including hospital-based programs, will receive annual sensitivity training to help reduce the stigma of mental illness and learn how to foster partnerships between families and providers. Local organizations such as NAMI and Parents Helping Parents may help organize and/or provide this training in coordination with RCDMH.

2. RCDMH, through the County's Unified Behavioral Health Services, will ensure that all BH agencies in Rockland, including hospital-based programs, will receive at least one training by the end of 2015, provided by a mental hygiene attorney, to better understand the rights of individuals with Severe Persistent Mental Illness (SPMI) and other BH issues. Training should be repeated annually and/or as needed based upon changes in the law.

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

4. RCDMH will ensure, through the workgroups, that specific training be delivered to MH providers related to serving the needs of special populations identified in the Needs Assessment e.g. LGBTQ, trauma survivors, underserved cultural/ religious groups.

Closing the Gaps- Chemical Dependency Treatment and Prevention Services/ Substance Use Disorders (Recommendations Code GCD)

A. Care Provision/ Expansion

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

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

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

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

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

B. Care Integration

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

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

C. Role of the LGU/ Government Departments

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

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

D. Regulatory Changes

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

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

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

E. Service Access

1. RCDMH will ensure that Ambulatory Detoxification slots, to address heroin and other narcotic addictions, are expanded to include patients with multiple addictions, including cocaine and benzodiazepine.

2. CD providers in Rockland will explore partnerships in underserved communities, including linkages to natural community leaders, to more effectively respond to the CD needs of these communities. Care must be given to engage the community to identify their natural leaders.

F. Funding

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

G. Education

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

2. RCDMH will ensure, through the workgroups, that specific training be delivered to CD providers related to serving the needs of special populations identified in the Needs Assessment e.g. LGBTQ, trauma survivors, underserved cultural/ religious groups.

Closing the Gaps- Child and Adolescent Mental Health (Recommendations Code GCA)

A. Care Provision/Expansion

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

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

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

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

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

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

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

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

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

B. Care Integration

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

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

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

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

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

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

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

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

C. Role of the LGU/Government Departments

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

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

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

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

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

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

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

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

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

D. Regulatory Changes

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

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

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

E. Information Access

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

F. Service Access

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

2. RCDMH will work with school superintendents to link children and families to community resources and services to meet their behavioral health needs, and ensure that school staff members are fully knowledgeable about available BH resources.

3. School superintendents must develop procedures to ensure that children with disabilities have transition plans when they exit school including vocational assessment, vocational training and, if applicable, Access VR.

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

G. Education

1. School superintendents will arrange for periodic training for all school faculty and staff on behavioral health issues, such as signs and symptoms, early intervention, and treatment. Training agencies may include RCDMH, NAMI *Parents & Teachers as Allies,* and the NKI speakers program.

Closing the Gaps- Co-Located Services (Recommendations Code GCL)

A. Care Integration

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

B. Role of the LGU/ Government Departments

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

C. Regulatory Changes

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

D. Service Access

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

2. RCDMH must encourage service providers to look for opportunities to share space, staff and other resources in one community-based location. This will serve to better respond to individuals

and families with multiple needs, and must be incorporated annually into the local planning process.

3. Behavioral health agencies in Rockland, including RCDMH, will explore partnerships in underserved communities, including linkages to natural community leaders, to more effectively respond to the BH needs of these communities and to special populations. Care must be given to engage the community to identify their natural leaders.

Closing the Gaps- Criminal Justice Services (Recommendations Code GCJ)

A. Care Provision/ Expansion

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

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

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

B. Care Integration

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

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

C. Information Access

1. Law enforcement first responders must have a printed resource guide made available to them regarding behavioral health services in Rockland County, for reference in BH emergency

situations or BH calls. This resource guide will be developed by RCDMH through the County's Behavioral Health Unified Services process. This could be developed as an addition to the annual Law Enforcement manual developed and printed by the Rockland County Police Chief's Association. Electronic availability of the guide by pdf would be the best approach for easy access.

D. Service Access

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

E. Education

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

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

Closing the Gaps- Crisis Services & Intervention (Recommendations Code GCR)

A. Care Provision/Expansion

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

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

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

B. Care Integration

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

C. Role of the LGU/Government Departments

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

D. Education

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

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

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

4. The RCDMH Behavioral Health education resource specialist/ community liaison will ensure that awareness regarding Mobile Crisis team and BH Evaluation & Referral Center services are provided to underserved communities, in collaboration with natural leaders in these communities.

Closing the Gaps- Intellectual-Developmental Disabilities (I-DD) Services

(Recommendations Code GID)

A. Care Provision/Expansion

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

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

B. Care Integration

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

C. Role of the LGU/Government Departments

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

2. NYS elected officials and the County of Rockland must advocate with NYSOMH to require outpatient MH service providers in Rockland County, including RCDMH, to develop their capacity to provide psychiatric care and evaluative screenings for children and adults with I-DD, serving individuals across the lifespan.

3. The County of Rockland must advocate with NYS elected officials and NYSOMH to insist that RPC develops and RCPC expands their crisis respite beds to include Rockland adults and children who are not eligible for NYSOPWDD services but who still present with I-DD issues and who are on the autism spectrum.

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

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

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

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

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

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

D. Service Access

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

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

E. Education

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

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

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

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

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

6. RCDMH, in partnership with the I-DD Workgroup, will develop and provide a series of community forums designed to educate Rockland residents about individuals with I-DD, to break

down barriers and dispel myths and stereotypes, promoting a more positive connection between these individuals and the community at large.

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

Reaffirming the Role of Government (Recommendations Code RG)

A. Care Provision/ Expansion

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

B. Care Integration

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

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

C. Role of the LGU/ Government Departments

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

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

3. A primary mission of RCDMH must be to proactively seek resources. This would include, but not be limited to, governmental and private grant funding, the formation of

partnerships and alliances, the collection of information regarding the availability of resources from local agencies and communities and the ongoing analysis of behavioral health needs in the community.

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

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

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

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

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

9. The County of Rockland and RCDMH will advocate on an ongoing basis with all three NYS behavioral health agencies and State and Federal elected officials to ensure that decisions made regarding compliance with the Olmstead decision realistically take into account the best interests of consumers vis-á-vis adequate community resources in Rockland, i.e. housing, employment. This includes preserving existing services such as sheltered workshops and ICFs until viable alternatives exist.

10. The County Executive and the County Legislature will be responsible for developing an objective mechanism by which to evaluate and prioritize behavioral health services. This will serve to balance the financial and BH needs of Rockland County while making sure that BH needs are prioritized appropriately.

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

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

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

D. Regulatory Changes

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

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

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

E. Funding

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

F. Rebuilding the Unified Services System

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

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

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

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

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

X. Resource Development

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

XI. Looking Forward

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

XII.

Appendices

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

<u>Rockland County Behavioral Health: An Historical Perspective</u>

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

<u>Mental Illness: The Early Days</u>

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

Rockland State Hospital (now Rockland Psychiatric Center) opened in 1931, as a result of an appropriation in 1925 for acquisition of lands in the NYC vicinity in order to improve care for the increasing number of mentally ill individuals. The goal was to contain costs by centralizing services and housing in a rural environment, which was believed to be curative. RSH was like a small town with an infirmary, dental area, x-ray facilities, social services and clinical offices. The catchment area included Rockland, Bronx, Manhattan and Richmond counties. Employees lived in one of 10 staff home on campus with additional homes for the superintendent and support staff in the general vicinity. A post office, employee barbershop, industrial shop, occupational center, tennis courts and a baseball field, community store and a recreational center that held four bowling alleys and two pool tables were added. Sports and physical activity were

encouraged. Weekly dances and movies were held and Broadway and radio stars came to perform for the patients. Higher functioning patients worked in manufacturing and farming, which were observed to have a positive therapeutic effect. By 1936, 119 buildings had been constructed. By 1940, RSH had almost 1,500 employees and 6,600 patients.

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

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

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

Dr. Blaisdell was a pioneer in research and treatment of substance abuse. RSH was the first hospital to hold an Alcoholics Anonymous (AA) meeting in 1939 and patients were bused out to attend meetings in following years. He felt that alcoholics would be better served in a separate

specialized site staffed by psychiatrists trained to treat alcohol addiction. The treatment facility was opened some years later, and was named as a tribute to Dr. Blaisdell's lifelong dedication to this problem.

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

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

<u>Changes Over the Years/ RPC Today</u>

Over the years there have been many changes and improvements at RPC, transforming it into a modern, patient-centered hospital, and greatly reducing its census. The hospital's strong connection with the nationally and internationally recognized Nathan Kline Institute for Psychiatric Research (NKI), located on the campus has encouraged development of innovative evidence based programs. Rockland Psychiatric Center also operates two wards (24 beds) at the

Clinical Research and Evaluation Facility (CREF) in partnership with NKI, which provides research scientists to conduct various studies.

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

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

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

Recent years have seen the development of outpatient programs at the Rockland campus, including the Orangeburg Clinic, the "Turning Point" for intervention in first diagnosis psychosis. The peer centered Recovery Center is focused on community living and vocational development skills. It also houses the Living Museum, a therapeutic art center. RPC has

specialized services for Deaf/Hard of Hearing Sign Language users. RPC also operates an outpatient service center in Nyack.

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

Mental Illness: Deinstitutionalization

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

1) The development of various psychotropic drugs such as Thorazine (chlorpromazine) (1954) and, more recently, Clozapine (clozaril) (1990) which treated some of the symptoms of mental illness
2) Societal changes that occurred in attitudes about treatment of the mentally ill in lieu of locking them away
3) Federal funding (Medicare and Medicaid) could be applied to community mental health Centers and not to state mental hospitals

In 1963 President John F. Kennedy signed the Mental Retardation Facilities and **Community Mental Health Center Construction Act (CMHC)**. The National Institute of Mental Health (NIMH) created community based mental health facilities to provide prevention, early treatment, and ongoing care, with one per every 125,000 to 250,000 people. By 1977 there were only 650 community health centers nationwide serving 1.9 million patients. As states closed hospitals, the centers were overwhelmed with patients with serious and persistent mental illness (SPMI).

In 1965 Medicaid was passed but did not pay for patients in mental hospitals, so states moved patients into nursing homes and community hospitals to transfer the costs to the Federal government.

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

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

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

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

Children's Services: The Early Days

Frank F. Tallman, who joined Blaisdell at RSH, was a staunch advocate of the mental hygiene movement and the advancement of mental wellness. Child Guidance Demonstration Clinics were organized in the early 1920's, modeled after Healy's Juvenile Psychopathic Institute and the Institute of Juvenile Research (Levy, 1968). This field focused on proactive and strength based treatments for juvenile delinquents. The movement changed focus over time to a middle class and native born population that was felt to have a greater chance for successful treatment. The targeted population included children and adolescents who manifested behavioral, psychological and emotional issues. New York State institutions began providing outpatient child guidance services in the early 1920s with only 42 child guidance clinics throughout the country. Tallman advocated a team approach within the therapeutic milieu and working with and within the

community to develop a preventative approach to mental illness, which he applied to the Children's Group at RSH. The RSH treatment team, which included psychiatrists, psychologist and social workers were from child guidance clinics in various parts of NYS, worked together with schools and judicial systems to arrange treatment. Tallman supported a preventive approach focusing on the normal child with the clinic used as a center for community outreach. Outpatient centers were placed in social agencies, health centers and schools. Partner organization included the Boy Scouts, Girl Scouts, and YMCA. RSH became the first site to have an on-site children's unit consisting of six cottages linked to a central administration building, which officially opened in May of 1936.

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

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

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

Developmental Disability

Institutionalization also marked the beginning of the development of services for people with developmental disability. In 1911 Letchworth Village, the "state institution for the segregation of the epileptic and feeble minded" opened and was lauded as a model facility and a major departure from the almshouse of the 19th century. Like RSH, it was a self-contained community in a rural setting located in Thiells. Letchworth ultimately became the largest facility in the nation for the mentally retarded, housing up to 5,500 children and adults. As late as 1958 the patients grew their own vegetables, tended cows, pigs and chickens, providing food for the entire Village. They also made toys and sold them at Christmas.

At its peak Letchworth consisted of over 130 buildings spread out over 2,000 acres of land. Reports of inadequate funding, overcrowding and improper and inhumane care surfaced. At first described as an ideal center for the mentally challenged and praised by the state, rumors arose about residents being found unclothed, unbathed and neglected, and horrific human experimentation. In 1921 an annual report describe three categories of “feeble-mindedness:" moron, imbecile, and idiot (untrainable). The various jobs assigned to male patients included loading thousands of tons of coal into storage facilities, building roads, and farming. That year, out of 506 people admitted, 317 were between the ages of 5 & 16, and 11 were under 5 years. Visitors observed that the children were malnourished and looked sick. Children were often used for experimental testing and were neglected. Many were able to learn, but were not given the chance because they were “different”. By 1921, the village was already overpopulated. There were nearly 1200 patients with patients living in small cramped dormitories with as many as 70 beds because the state would not complete construction of more buildings.

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

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

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

Another facility, which served children who were orphans or socially disadvantaged, was a private charitable organization known as Five Points House of Industry. Founded in 1850, the organization took its name from the area it served, NY City’s Five Points District, considered to be the toughest and poorest neighborhood of its time. In 1911 one of its trustees, William

Church Osborn and his wife gave the agency a 286 acre farm in Pomona for a children's home, then called Happy Valley, which was to become Woodycrest in 1972 and Greer-Woodycrest in 1977. The mission of the agency changed between 1977 and 1979 to caring for mentally disabled children (Murphy, 1994).

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

Developmental Disability: Development of Community Based Centers

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

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

In 1969, under the leadership of Kathy Lukens, a group of mothers of the Exceptional Child PTA founded Camp Venture summer camp. Camp Venture grew exponentially during the 1980s, led by its founder Lukens, who also served as consultant to Governors Rockefeller, Wilson, Carey and Cuomo. In the 1960's people with disabilities had few recognized rights under the law and

there were virtually no community based services available (http://www.campventure.org/index.php?/campventure/about/history/).

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

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

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

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

Chemical Dependency/Substance Use Disorder Services

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

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

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

the ability to pay. Lexington Center for Recovery has been the largest, primary provider of these services ever since.

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

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

Rockland Council on Alcoholism (later RCADD) opened its center in 1985 in Nyack, providing information, education, brief counseling and referral for those affected by their own, or a loved one's, addiction. Hospital-based inpatient and outpatient services were created at Good Samaritan and Nyack Hospitals to accommodate Rockland residents in need of a continuum of chemical dependency/substance use disorder services which were locally accessible.

Rockland County has been in the forefront of working through the criminal justice system to foster treatment and prevent incarceration of those who have committed non-violent crimes as a result of their addiction. Rockland created its first Drug Court in 1998, and has since helped hundreds of people regain sober and productive lives. Today, Rockland has a host of Alternative to Incarceration programs, including Family Treatment Court, Mental Health Court, Drug Market Intervention, and the Re-Entry program.

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

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

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

The Rockland County Department of Mental Health

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

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

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

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

The New York unified services legislation of 1974 provided an opportunity to move from a dual system of care to a total integration of public mental hygiene services, not only local government and voluntary nonprofit agencies, but also the local outpatient components of state facilities. Administrative, fiscal and programmatic responsibilities would be unified under the community mental health department. The act was intended to encourage local alternatives to state hospital admission, using a complex funding formula.

The legislation provided “no exit” for counties who took the risk of adopting this program. Rockland was one of only five counties that opted for a unified services system, (Pepper).

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

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

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

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

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

clinic with satellites in Spring Valley, Orangetown, North Rockland and Nyack, Consultation and Education services and Forensic Services.

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

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

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

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

Nonprofit agencies are brought together in the planning process through a system of workgroups and subcommittees with each workgroup representing a designated age and/or disability area. Workgroup meetings provide opportunities to share information, deal with changing events and have input into the planning process. The Rockland County Community Services Board (CSB) also meets regularly with the goal of advising County government in initiating, developing and

coordinating state and local behavioral health services, stimulating community interest and developing awareness of Federal, State and local resources (Rockland County Local Planning Process-2015).

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

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

Mental Health Residential Services

The first Community Residence (CR) in Rockland was established by Irving and Irene Berkowitz in 1977 as a response to the lack of residential services in the community when their son was discharged from RPC. It was intended to serve as a **permanent** home and support system for individuals with serious and persistent mental illness. Incorporated as Rockland Hospital Guild (RHG), it is known as CLUE (Community Link-Up Experience). RHG has grown

considerably since then. CLUE 1, 2, and 4 (for deaf people) provide various levels of support in a park-like setting located adjacent to Rockland Psychiatric Center. CLUE 3's supported housing apartments are located at various sites in the community.

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

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

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

In the early 90's residential services became Medicaid billable. Providers started to bill for services that were previously direct OMH contracts, and residential placements became transitional. Program fees are paid by residents through whatever income source they have including SSI, SSD and private pay.

The only permanent housing today consists of 163 Supported Housing (SH) beds, divided among Loeb, St. Dominic's, RHG and MHA, a program which OMH began throughout the state in 1992. Supported Housing is located at scattered sites with individual leases and landlords. Rent is subsidized by NYS OMH via the housing provider, which provides supportive services related to residency and rental stipend support. Counselors provide linkage to clinical support and are available via telephone. Providers must adhere to OMH guidelines and are monitored by Rockland County Department of Mental Health. SH beds are funded by different OMH funding streams depending on when the beds were developed. For example, 8 out of 54 of Loeb's Supported Housing beds are funded by reinvestment. More recent supported apartments receive OMH Medicaid Redesign funding, and for the past three years SH beds have been tied to discharge from state hospitals, nursing homes or adult homes.

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

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

There are also about 1,000 SPMI living in 8 Adult Homes, licensed by the NYS Department of Health. Joseph's Home, Inc. operates a 20 bed boarding house (Conway House) and 26 affordable housing beds for people who are homeless and have a disability (mostly mental illness) as well as Homes for Heroes for homeless disabled vets, which was opened in 2014. There is **one respite bed** for SPMI operated by Loeb House in Spring Valley and a second

respite bed is being planned. There are also 11 family type homes with 2 to 4 beds each that provide room, board and limited supervision and are licensed under DOH. OMH has plans for 150 OMH licensed single room occupancy beds (SRO's) for the entire Hudson Valley region, but not likely to be located in Rockland County. There are also some transitional residences provided at Rockland Psychiatric Center (See RCCA and TPP).

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

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

Delivery System Reform Incentive Payment (DSRIP)

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

effectively manage its Medicaid program within the confines of the Medicaid Global Spending Cap (from DSRIP Overview).

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

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

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

For Section on Unified Services of Rockland County

- Bonnie Halley

For early history of Rockland State Hospital

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

For current information on Rockland Psychiatric Center

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

For Mental Health Residential Services

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

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

- Maggie Trainor, Director of Residential Services, Mental Health Association of Rockland County, Inc.

B. Glossary of Abbreviations

ARC	Association for Retarded Citizens
BH	Behavioral Health
BOCES	Board of Cooperative Educational Services
CCSI	Coordinated Children's Service Initiative - Network
CD	Chemical Dependency/Substance Use Disorder
CME/CEU	Professional educational credits for course completion
CSB	Community Services Board
DA	Rockland County District Attorney's Office
DCJS	Division of Criminal Justice Services
DOH, NYSDOH	New York State Department of Health
DSRIP	Delivery System Reform Incentive Payment
DSS/RCDSS	Rockland County Department of Social Services
ED	Hospital Emergency Department
HUD	Housing and Urban Development
ICF	Intermediate Care Facility
I-DD	Intellectual-Developmental Disabilities
LGBTQ	Lesbian/Gay/Bi-Sexual/Transgender/Queer or Questioning
LGU	Local Governmental Unit
MH	Mental Health
MHA	Mental Health Association of Rockland
MHATI	Mental Health Alternatives to Incarceration
MSW	Master in Social Work

NAMI	National Association for the Mentally Ill
NKI	Nathan Kline Institute
NYSDMV	New York State Department of Motor Vehicle
NYSED	New York State Education Department
NYSOCFS	New York State Office of Children and Family Services
NYSTART	Mobile crisis for I-DD
OASAS, NYSOASAS	New York State Office of Alcoholism and Substance Abuse Services
OMH, NYSOMH	New York State Office of Mental Health
OPWDD, NYSOPWDD	New York State Office for Persons With Developmental Disabilities
RCADD	Rockland Council on Alcoholism and Other Drug Dependence
RCDMH	Rockland County Department of Mental Health
RCJ	Rockland County Jail
RCPC	Rockland Children's Psychiatric Center
RILC	Rockland Independent Living Center
RPC	Rockland Psychiatric Center
SAMHSA	Substance Abuse and Mental Health Services Administration (federal department)
SPOA	Single Point of Access
VA	Veteran's Administration

C.

Needs Assessment Data Collection Instruments

Resident Survey

Resident Survey- Spanish

Consumer Survey

Provider Survey

Focus Group Questions

Key Informant Questions

Community Awareness Resident Survey

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

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

Please check all that apply to you (respondent):

GENDER: ☐ Female ☐ Male ☐ Other

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

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

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

1. Do you currently know of or have a place where you could go for behavioral health care service in Rockland County?

☐ YES ☐ NO

2. Have any of the following prevented you or someone you know from receiving needed behavioral health care (Please check all that apply.)

- ❑ Lack of transportation
- ❑ Fear/distrust
- ❑ Limited hours of operation
- ❑ Long Wait list
- ❑ Price/Cost
- ❑ Lack of Insurance or insurance not accepted
- ❑ Limited physical mobility
- ❑ Language
- ❑ Faith/Religion
- ❑ Cultural Differences
- ❑ Citizenship/Immigration status
- ❑ Unfamiliar with types of service
- ❑ Do not know where to get services
- ❑ Need for anonymity/Confidentiality
- ❑ Other (Please specify)

____

3a. Have you or someone you know ever received behavioral health care services in Rockland County?

☐ YES ☐ NO

3b. Were your/ their needs met?

☐ YES ☐ NO

4. What are some of the best things about behavioral health services in Rockland County? Please check all that apply.

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

____

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

☐ **YES** ☐ **NO**

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

☐ **YES** ☐ **NO**

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

☐ **YES** ☐ **NO**

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

☐ **YES** ☐ **NO**

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

☐ **YES** ☐ **NO**

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

☐ **YES** ☐ **NO**

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

☐ Available in the area ☐ Limited in the area ☐ Not available in the area

12. Anything you would like to add? Please write below.

____
____
____
____

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

www.surveymonkey.com/s/RCCAS

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

(845) 638-5856 (fax)

Thank you so much!

Encuesta Sobre Conocimiento entre Residentes Comunitarios

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

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

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

GÉNERO: ☐ Femenino ☐ Masculino ☐ Otro

RAZA/ETNICIDAD: ☐ Blanco ☐ Negro ☐ Asiático ☐ Nativo Americano ☐ Hispano/Latino ☐ Otro

GRUPO DE EDAD: ☐ Menores de 18 ☐ 18-24 años ☐ 25 – 34 años ☐ 35 – 44 años ☐ 45 – 64 años ☐ 65 años o más

RESIDENCIA: ☐ Clarkstown ☐ Haverstraw ☐ Orangetown ☐ Ramapo ☐ Stony Point **CÓDIGO POSTAL: _______**

1. ¿Actualmente sabe o tiene usted un lugar dónde usted puede ir para atención necesaria de salud conductual en el Condado de Rockland?

☐ SÍ ☐ NO

2. ¿Ha alguno de los siguientes impedido que usted o alguien que usted conoce reciba la atención de salud conductual necesaria? (Por favor marque todas las que correspondan.)

- ❑ Falta de transportación
- ❑ Miedo/desconfianza
- ❑ Limitadas horas de operación
- ❑ Larga lista de espera
- ❑ Precio/Costo
- ❑ Falta de Seguro o Seguro no aceptados
- ❑ Movilidad física limitada
- ❑ Otros (especificar) ____
- ❑ Idioma
- ❑ Fé/Religión
- ❑ Diferencias Culturales
- ❑ Ciudadanía/estado de Inmigración
- ❑ No familiarizados con el tipo de servicios
- ❑ No saber donde obtener servicios
- ❑ Necesidad de anonimato/Confidencialidad

3a. ¿Alguna vez ha recibido usted, o alguien que usted conoce, servicios de atención de salud conductual?

☐ SÍ ☐ NO

3b. ¿Se cumplieron sus necesidades?

☐ SÍ ☐ NO

4. ¿Cuales son algunas de las mejores cosas acerca de los servicios de salud conductual en el Condado de Rockland?

❑ Cerca de la casa
❑ Sirven a las personas de todas las edades
❑ Económico
❑ Conecta a las personas a otros servicios necesarios
❑ Confidencial/privado
❑ Atentos, respetuoso ambiente
❑ Personal está capacitado y bien informado
❑ Diferentes enfoques se utilizan de acuerdo a las necesidades
❑ El personal habla mi idioma
❑ Accesibles para personas discapacitadas
❑ Personal comprende mi cultura
❑ Capaz de obtener el servicio de inmediato
❑ Aceptan mi seguro
❑ Horas convenientes
❑ Otro (Favor de especificar)

____

5. ¿Alguna vez ha dejado usted, o alguien que usted conoce, el Condado de Rockland para obtener servicios de salud conductual?

☐ SÍ ☐ NO

6. ¿Conoce usted programas comunitarios en el Condado de Rockland para ayudar personas y familias bajo estrés, experimentando trauma, el sufrimiento de pérdidas, u otras dificultades emocionales?

☐ SÍ ☐ NO

7. ¿Sabe dónde alguien puede obtener ayuda para hacer frente a los problemas de aprendizaje o discapacidades del desarollo en el Condado de Rockland?

☐ SÍ ☐ NO

8. ¿Sabe dónde alguien puede obtener ayuda para los niños o adolescentes con dificultades emocionales, problemas de aprendizaje, o adicción (propia o de un familiar) en el Condado de Rockland?

☐ SÍ ☐ NO

9. ¿Sabe dónde en el Condado de Rockland alguien puede obtener ayuda con un problema con alcohol, otras drogas, u otra adicción, como los juegos/las apuestas?

☐ SÍ ☐ NO

10. ¿Está usted consciente de los programas comunitarios en el Condado de Rockland que promueven la buena salud y el desarollo emocional?

☐ SÍ ☐ NO

11. ¿Que le parece, en general, la disponibilidad de servicios de salud conductual en nuestro condado?

☐ Disponible en el area ☐ Limitado en el area ☐ No disponible en el area

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

____

____

____

____

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

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

(845) 638-5856 (fax)

Muchas gracias por su tiempo!

County Executive's Commission on Behavioral Health- Consumer Questionnaire

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

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

Please check all categories below that apply to you:

☐ Individual living with mental illness/developmental disability/substance use disorder

☐ Family member ☐ Provider ☐ Other ________________________

GENDER: ☐ Female ☐ Male ☐ Other

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

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

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

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

	Not Applicable	Highly satisfied	Somewhat satisfied	Not meeting my needs	Don't know
Mental Health Care Management					
Mental Health Clinic					
PROS (Personalized Recovery Oriented Services)					
Outpatient Mental Health Program					
Private Psychiatrist or therapist					
Inpatient Hospitalization for Psychiatric Services					

Mental Health Crisis Services (ER, other)					
Mental Health Family Support and/or Education					
List of Services (cont.)	Not Applicable	Highly satisfied	Somewhat satisfied	Not meeting my needs	Don't know
Mental Health Peer Operated Services					
Residential Mental Health Program					
ACT Team (Assertive Community Treatment)					
Mental Health Services in Jail					
Mental Health Services for Children/Adolescents					
Mental Health Supportive Employment					
Mental Health Drop-In/Social Club					
Care Management (DD)					
Family Support and/or Education (DD)					
Residential Program (Assisted Living, Group Home, Supported Apartment) (DD)					
In-Home Residential Habilitation (DD)					
Early Intervention Services (DD)					
Services for Children/Adolescents (DD)					
Supported Educational Services (DD)					
Vocational Education (DD)					
Supportive Employment (DD)					
Drop-In/Social Club (DD)					
Day Treatment (DD)					

Psychosocial Services (DD)					
Mobile Crisis Service (DD)					
Inpatient Substance Use/ Addiction Program					
Long Term Residential Substance Use Treatment					
Substance Use Halfway House or Supportive Living					
Substance Use Detox program					
Methadone Maintenance					
Intensive Day Treatment for Substance Use					
Outpatient Substance Use Treatment					
Substance Use Prevention Services					
Addiction-related Self-help					
Other (Please indicate type of services)					

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

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

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

____

3. What are some of the best things about behavioral health services in Rockland County? Please check all that apply.

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

____

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

____

____

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

____

____

Or complete the survey online at: www.surveymonkey.com/s/RBHConsumer Thank you so much for you time!

Community Behavioral Health Assessment – Provider Questionnaire

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

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

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

Role: ☐ Behavioral Health Professional ☐ Health Care Professional ☐Administrator ☐ Other Human Service Professional ☐ Other ____________________

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

1. ____
2. ____
3. ____
4. ____
5. ____

Do you collaborate with other service providers? Please explain:____

____

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

____
____

____

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

☐ Lack of transportation
☐ Limited hours of operation
☐ Price/cost
☐ Faith/Religion
☐ Citizenship/Immigration status
☐ Lack of familiarity with types of services

☐ Limited or No health insurance coverage
☐ Language
☐ Cultural differences
☐ Other (specify)
☐ Fear/distrust
☐ Limited physical mobility

____

What are the most significant barriers impacting your ability to provide care to your consumers?

☐ Limited staffing resources
☐ Consumer inability to afford prescription medications
☐ Limited space/equipment
☐ Consumer non-adherence to treatment
☐ Proscribed parameters of services, regulations, limitations
☐ Refusal of Service
☐ Funding limitations and/or restrictions
☐ Other (specify)

____

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

____
____
____
____

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

1. ____
2. ____
3. ____

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

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

(845) 638-5856 (fax)

Thank you so much!

County Executive’s Commission on Community Behavioral Health

Guiding Questions for Focus Groups

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

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

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

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

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

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

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

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

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

10. Any other thoughts or comments?

County Executive's Commission on Community Behavioral Health

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

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

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

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

Intro Questions:

Tell us about yourself/your organization-

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

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

2. Who would someone with a behavioral health problem turn to for help?

3. What efforts are available in your community to address issues of behavioral health?

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

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

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

6. What is it like to receive behavioral health services in Rockland?

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

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

8. What are the strengths of these efforts?

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

9. What are the weaknesses of these efforts?

a. What services are missing or inadequately available?
b. Are there services that should be curtailed or are not useful?
c. What ideas might you have to make the system better?

10. What are the primary obstacles or barriers to behavioral health in your community?

  a. Are there policies that impede service delivery?
  b. Are the rates being paid to providers adequate to insure good services? Too high? Too low?
  c. Other obstacles?

11. Would people support increased behavioral health services in your community? If yes, using a scale from one to ten, how much support would they give, with one being not at all and ten being a lot?

  a. If you were to rank the top three behavioral health priorities in Rockland County, what would they be?
  b. Do you believe that your neighbors/colleagues/peers would agree with these priorities? Why or why not?

12. Does the community at large have any say as to what is needed in terms of behavioral health services, and how things are working?

  a. Is there enough public input into service delivery decisions? (public forums, customer satisfaction surveys, outreach)
  b. Are behavioral health leaders seeking and accepting of feedback?
  c. Are some groups/communities excluded or given limited opportunities?

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

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

15. Who provides the resources for behavioral health services and how long do they last?

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

16. Is there a need to expand behavioral health services? Why or why not?

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

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

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

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

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

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

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

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

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

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

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

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

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

26. Are the people in your community aware of these policies?

27. How are these policies viewed by the community?

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

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

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

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

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

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

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

35. Is there anything else that you consider to be important to know about behavioral health in the county that we did not get to today?

D. County Executive's Commission on Community Behavioral Health- Recommendations

Item	Recommendation	Page	BH Sector	Primary Entity(ies) Responsible	Other Partners	Implementation Timeframe	Resources Needed	Status
S-A1	Programs identified as highly satisfactory	50	All	RCDMH	CSB	1	1	
S-B1	Normalize collaboration, measure effectiveness	50	All	RCDMH, BH Workgroups	Community coalitions, other agencies	1	1	
S-C1	Training with CEUs for BH program staff, others	50	All	RCDMH	BH providers, other agencies/coalitions	1	1	
S- D1	Uniform Consumer Satisfaction survey	50	All	RCDMH	CSB, BH Workgroups	1	1	
S-D2	County depts. represented in community coalitions	51	All	County of Rockland	All County Depts.	1	1	
S-D3	Rebuild/empower the Unified BH Services system	51	All	County of Rockland	RCDMH, CSB, Subcommittees, Workgroups	1	1	
S-E1	Measure BH agency involvement in community	51	All	RCDMH	BH providers	1	1	
S-F1	Establish satellites, co-located sites in community	51	All	RCDMH	BH providers (incl.RCDMH), State BH agencies	2	2 to 3	
S-F2	Establish partnerships in underserved communities	52	All	RCDMH	BH providers (incl.RCDMH)	1	1 to 2	
A-A1	Education/community resource specialist position	53	All	County of Rockland	RCDMH	1	2	
A-B1	Organizational charts- Unified Services BH system	53	All	RCDMH	CSB, BH Workgroups	1	1	
A-B2	Update all BH provider information annually	53	All	RCDMH	BH providers	1	1	
A-C1	Create a single point of contact for BH info	53	All	RCDMH	RCDSS	1 to 2	2 to 3	
A-C2	Capture info in printable and digital format	54	All	RCDMH	BH providers, other agencies/coalitions	1 to 2	2	
A-C3	Explore partnerships in underserved communities	54	All	BH providers (incl. RCDMH)	Community coalitions, other agencies	1	1	

Codes:

Items: S=Building Upon Strengths, A= Increasing Awareness, B= Removing the Barriers, GA= Closing the Gaps- Adult MH, GCD- Closing the Gaps- Chemical Dependency, GCA= Closing the Gaps- Child and Adolescent, GCL= Closing the Gaps- Co-located Services, GCJ= Closing the Gaps- Criminal Justice, GCR= Closing the Gaps- Crisis Services, GID- Closing the Gaps- I-DD Services, RG= Reaffirming the Role of Government

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

Resources Needed: 1=Can accomplish with current resources, 2= Needs minimal additional resources to accomplish, 3= Needs substantial resources to accomplish

A-C4	Awareness efforts directed to special populations	54	All	RCDMH	BH providers (incl. RCDMH)	1 to 2	1	
A-D1	Annual education session for all elected officials	54	All	County of Rockland &Legislature	RCDMH, CSB, Subcommittees, Workgroups	1	1	
A-D2	Create a BH media campaign	54	All	RCDMH	BH providers, other agencies/coalitions	1 to 2	1 to 2	
B-A1	Expand BH services to evenings/weekends	56	All	RCDMH	BH providers (incl.RCDMH), State BH agencies	1	2 to 3	
B-A2	Assess and treat walk-in consumers	56	All	RCDMH	BH providers (incl.RCDMH), State BH agencies	1	2 to 3	
B-A3	Serve homebound consumers with BH issues	56	All	RCDMH	Home healthcare providers	2	2 to 3	
B-A4	Develop a "pro-bono" pool of BH professionals	56	All	County of Rockland	RCDMH, Law Dept.	2	2	
B-A5	Limit wait lists through referrals	56	All	RCDMH	State BH agencies	1	1	
B-A6	Adapt PROS to serve those unable to work 10+ hours a week	56	MH/I-DD	RCDMH	RCDMH, PROS administrators	2	1 to 2	
B-A7	ACCES-VR to present services, troubleshoot gaps	57	All	RCDMH	BH Workgroups, ACCES-VR, State agencies	1	1	
B-B1	Add resource assessment to annual planning process	57	All	RCDMH	BH Workgroups, Subcommittees, CSB	1	1	
B-B2	Create Olmstead Implementation Taskforce	57	MH, I-DD	RCDMH	BH Workgroups, real estate developers, housing specialists	1	1	
B-C1	Recruitment of specialists- BH, special populations	57	All	RCDMH	BH providers	2 to 3	2 to 3	
B-C2	Analysis of BH agency staffing for core competencies	57	All	RCMDH	BH providers (incl. RCDMH)	2	1	
B-C3	Recruit BH staff with cultural, linguistic competence	58	All	County of Rockland	RC Commission on Human Rights, Personnel	2	1	
B-C4	Measure employees' sense of equity in workplace	58	All	RCDMH	BH Workgroups, Subcommittees, CSB	1	1	
B-C5	Expand use of para-professionals and recovery coaches	58	All	RCDMH	BH Workgroups	1	1 to 2	
B-D1	Work with State reps to address insurance restrictions	58	All	County of Rockland	State and Federal representatives	2 to 3	2 to 3	

Codes:

<u>Items</u>: S=Building Upon Strengths, A= Increasing Awareness, B= Removing the Barriers, GA= Closing the Gaps- Adult MH, GCD- Closing the Gaps- Chemical Dependency, GCA= Closing the Gaps- Child and Adolescent, GCL= Closing the Gaps- Co-located Services, GCJ= Closing the Gaps- Criminal Justice, GCR= Closing the Gaps- Crisis Services, GID- Closing the Gaps- I-DD Services, RG= Reaffirming the Role of Government

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<u>Resources Needed</u>: 1=Can accomplish with current resources, 2= Needs minimal additional resources to accomplish, 3= Needs substantial resources to accomplish

B-D2	BH agencies to be required to operate within optimal hours	59	All	County of Rockland	State BH agencies	2	2	
B-D3	Increase physical accessibility of BH program sites	59	All	RCDMH	State BH agencies	2	3	
B-D4	Convene hearings on the high cost of prescription medication	59	All	County of Rockland	State and Federal reps, State BH agencies	1 to 2	1	
B-D5	Investigate Orange County model of incentives for BH housing	59	All	County of Rockland	RCDMH	1	2	
B-D6	Develop Rockland baseline for Olmstead-related costs	59	All	County of Rockland	Legislature, RCDMH, BH providers	1	1	
B-E1	Work to reduce barriers due to regulatory guidelines	60	All	RCDMH	BH providers and consumers, State BH agencies	2	1	
B-E2	Tax incentives to landlords who set aside housing for BH pop.	60	All	County of Rockland	RCDMH, State elected officials	2	2	
B-F1	Develop a standardized percentage rate for un/under-insured	60	All	RCDMH	BH providers (incl.RCDMH)	3	2 to 3	
B-F2	Half-price bus tickets for needy BH consumers	60	All	County of Rockland	County Dept. of Transportation and Planning	1 to 2	2	
B-F3	Crisis service to be provided regardless of immigration status	60	All	County of Rockland		2	2 to 3	
B-F4	Services to a consumer from different licensed BH agencies	60	All	County of Rockland	State elected officials, State BH agencies	2	2	
B-F5	Integrate BH community into Housing Authority advisory bds	61	All	County of Rockland	BH consumers, providers, local housing authorities	1	1	
B-F6	Explore conversion of county-owned properties to BH housing	61	All	County of Rockland	RCDMH, State agencies, BH providers	2	2 to 3	
B-G1	Training on best practice/special pops for BH providers	61	All	RCMDH	BH consumers/providers, colleges, State BH agcy	1	2	
GA-A1	Increase inpatient psych beds at Nyack Hospital	62	MH	County of Rockland	RCDMH, Nyack Hospital, NYSDOH	1 to 2	2 to 3	
GA-A2	Create an enhanced outpatient program at RPC	62	MH	RCDMH	RPC, NYSOMH, CSB	2	2 to 3	
GA-A3	Expand role of Care Coordinators	62	MH	RCDMH	NYSOMH, MH Workgroup, CSB	1 to2	2	
GA-A4	Expand slots for the ACT Team for homeless/high risk	62	MH	RCDMH	MHA, NYSOMH	1 to 2	2 to 3	
GA-A5	Local practitioners using evidence-based practice	62	MH	RCDMH	BH Workgroups, Subcommittees, CSB	1	1 to 2	

Codes:

Items: S=Building Upon Strengths, A= Increasing Awareness, B= Removing the Barriers, GA= Closing the Gaps- Adult MH, GCD- Closing the Gaps- Chemical Dependency, GCA= Closing the Gaps- Child and Adolescent, GCL= Closing the Gaps- Co-located Services, GCJ= Closing the Gaps- Criminal Justice, GCR= Closing the Gaps- Crisis Services, GID- Closing the Gaps- I-DD Services, RG= Reaffirming the Role of Government

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GA-A6	Mental Health services onsite for homeless vets and families	62	MH	RCDMH	NYSOMH, local MH providers, vet's housing agcy	2	2	
GA-B1	Mobile Crisis Team & ED's provide follow-up appointments	63	MH	RCDMH	Rockland Mobile, Nyack Hosp, Good Sam	1	1	
GA-B2	Mobile Crisis Team & ED's obtain releases for BH provider	63	MH	RCDMH	Rockland Mobile, Nyack Hosp, Good Sam	1	1	
GA-B3	Family/peer advocates to offer support in the ED	63	MH	RCDMH	Nyack Hosp, Good Sam	1	1	
GA-B4	Improved coordination between ED's and AOT	63	MH	RCDMH	Nyack Hosp, Good Sam, AOT Coordinator	1	1	
GA-B5	OASAS/OMH-licensed agencies apply for dual licensure	63	MH	RCDMH	BH providers and consumers, State BH agencies	2	2 to 3	
GA-B6	NKI to offer online/onsite BH courses for CEUs	63	MH	RCMDH	Nathan Kline Institute, State BH agencies	2	2	
GA-C1	Clarify the role of Good Sam in psych eval, medical clearance	63	MH	RCDMH	Good Sam, NYSOMH, NYSDOH	1	1	
GA-C2	Encourage integration of primary and behavioral health	63	MH	RCDMH	Primary care providers, BH providers	2	2 to 3	
GA-D1	Expand local veterans' BH services	64	MH	RCDMH	Rockland County Office of Veteran's Services	2	2 to 3	
GA-E1	Development of BH screening tool for primary care docs	64	MH	RCDMH	Primary care providers, BH providers	1	1	
GA-F1	Nyack Hosp. provide comprehensive referrals at discharge	64	MH	RCDMH	Nyack Hospital	1	1	
GA-F2	Nyack Hosp. accept more local insurances, incl. veteran's	64	MH	RCDMH	Nyack Hospital	1	1	
GA-F3	Establishment of linkages to fill inpatient service gaps	64	MH	RCDMH	Local and regional BH providers	1	1	
GA-G1	Sensitivity training for all BH providers on work with families	64	MH	RCDMH	MH providers and consumers, Workgroups	1	1	
GA-G2	Training for BH providers on patient rights	65	MH	RCDMH	MH providers and consumers, Workgroups	1	1 to 2	
GA-G3	Training for BH providers on meeting needs of veterans	65	MH	RCDMH and RC Office of Veteran's Serv.	MH providers and consumers, Workgroups	1	1	
GA-G4	Training for MH providers on special populations	65	MH	RCDMH	MH providers and consumers, Workgroups	1	1	
GCD-A1	Expand prevention counseling to over 21 population	66	CD	RCDMH	NYSOASAS, CD prevention providers	1	2	

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GCD-A2	Re-establish Student Assistance Program- college, secondary	66	CD	RCDMH	NYSOASAS, State Ed, RCC, local high schools	2	2 to 3	
GCD-A3	CD providers will use evidence-based treatment/prevention	66	CD	RCDMH	CD providers, NYSOASAS	1	1 to 2	
GCD-A4	CD treatment onsite to homeless vets and families	66	CD	RCDMH	NYSOASAS, CD providers, Vet's housing agcy	2	2	
GCD-A5	Add ambulatory detox to outpatient treatment programs	66	CD	RCDMH	NYSOASAS, CD treatment providers	1	1 to 2	
GCD-B1	Develop a drugged driving prevention program for youth	66	CD	RCDMH	BOCES, CD prevention providers	2	1 to 2	
GCD-B2	OASAS/OMH-licensed agencies apply for dual licensure	66	CD	RCDMH	BH providers and consumers, State BH agencies	2	2 to 3	
GCD-C1	Permanent supportive housing for CD population	67	CD	RCDMH and NYSOASAS	RC Comm. Dev., OASAS housing providers	2	2 to 3	
GCD-C2	Review records for those not admitted to detox	67	CD	RCDMH and NYSOASAS	Nyack Hosp, Good Sam	1	1	
GCD-D1	Expand admission criteria to State-operated ATCs	67	CD	RCMDH and NYSOASAS	CD Workgroup, CSB	1	2	
GCD-D2	All medically-assisted treatments at methadone clinic, hosp.	67	CD	RCDMH and NYSOASAS	Lexington Center, Nyack Hosp, Good Sam	2	2 to 3	
GCD-D3	Add drugged driving curriculum to NYS driver's course	67	CD	County of Rockland	NYSDMV, NYSOASAS, State elected officials	3	2 to 3	
GCD-E1	Open ambulatory detox slots to poly-addicted	67	CD	RCDMH	Nyack Hospital, NYSOASAS, CD providers	1	1	
GCD-E2	Explore partnerships in underserved communities	68	CD	CD providers	Community coalitions, other agencies	1	1	
GCD-F1	Expand CD housing to special populations	68	CD	RCDMH and NYSOASAS	CD housing providers, Office of Comm. Devel.	2	3	
GCD-G1	Training on CD issues for school staff	68	CD	RCDMH and BOCES	School superintendents, CD providers	1	1	
GCD-G2	Training for all CD providers on serving special populations	68	CD	RCDMH	CD providers and consumers, Workgroups	1	1	
GCA-A1	RCPC and hospitals will coordinate care	69	MH	RCDMH	RCPC, Nyack, Good Sam	1	1	
GCA-A2	BOCES will provide educational services in hospital	69	MH	BOCES	RCPC	1	1	
GCA-A3	Crisis respite for children and adolescents at RCPC	69	MH	RCDMH	RCPC, BOCES	2	2	

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GCA-A4	Increased outpatient slots for children, adolescents	69	MH	RCDMH	RCPC, NKI	2	2	
GCA-A5	Provide community-level support for families	69	MH	RCDMH	NAMI, BH agencies, RCDSS	1	1 to 2	
GCA-A6	Increase juvenile justice prevention programs	69	All	Rockland County DA and Probation	RCDMH, Prevention providers, NYSOCFS/DCJS	1	2 to 3	
GCA-A7	Coordinate with SPOA referral sources, involve parents	69	MH	RCDMH	St. Dominic's, MHA, MH providers	1	1	
GCA-A8	Consumer satisfaction survey for Children's SPOA	69	MH	RCDMH	SPOA participating agencies	1	1	
GCA-A9	RCPC will accept direct admissions during weekday hours	69	MH	RCDMH	RCPC, CSB	1	1	
GCA-B1	Create subscription BH consultation service for pediatricians	70	MH	RCDMH	RCPC, NKI	2	2	
GCA-B2	Online/onsite BH courses for pediatricians	70	MH	RCDMH	NKI	2	2	
GCA-B3	Explore partnerships in underserved communities	70	MH	Child MH providers	Community coalitions, other agencies	1	1	
GCA-B4	Facilitate smooth transition from WAIVER services	70	MH	RCDMH	St. Dominic's, MHA, MH providers	1	1	
GCA-B5	Include more support for parents in Children's SPOA	70	MH	RCDMH	NAMI, Rockland Independent Living Ctr.	1	1	
GCA-B6	Utilization of CCSI in transitions	70	MH	RCDMH	SPOA participating agencies	1	1	
GCA-B7	RCPC dedicated staff member for referrals	70	MH	RCDMH	RCPC	1	1 to 2	
GCA-B8	Streamline referral system to RCPC	70	MH	RCDMH	RCPC, Nyack, Good Sam	1	1	
GCA-C1	Improve CCSI/Network	71	MH	RCDMH	MHA	1	1	
GCA-C2	Combine workgroups at least quarterly	71	All	RCDMH	All workgroups	1	1	
GCA-C3	Create short-term crisis unit at RCPC	71	MH	RCDMH	RCPC, NYSOMH	2	2 to 3	
GCA-C4	Expedite admissions to RCPC for Rockland youth	71	MH	RCDMH	RCPC	1	1	
GCA-C5	Study promising approaches in shared service and info	71	All	RCDMH	RCDSS, DA, Probation, BOCES	1	1	

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

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GCJ-A1	Create an observation unit in Rockland County Jail	76	All	County of Rockland	RC Sheriff's Office, NYS BH agencies, RCDMH	2	2 to 3	
GCJ-A2	Social Worker in Rockland County Jail to facilitate referrals	76	All	RCDMH	RC Sheriff's Office	1	2	
GCJ-A3	Expand criminal justice prevention programs	76	All	RC District Attorney's Office & Probation	RCDMH, Haverstraw Center, RCADD	1	2 to 3	
GCJ-B1	Co-locate a social worker at the Probation Dept.	76	All	RCDMH	Probation Dept, BH providers	1	1 to 2	
GCJ-B2	Criminal justice and BH staff improve communication	76	All	RCDMH, Criminal Justice Administrators	BH and CJ staff	1	1	
GCJ-C1	Printed information guide for law enforcem. first responders	76	All	RCDMH	County of Rockland, RCDMH, Workgroups	2	2	
GCJ-D1	Discounted bus tickets for needy participants in BH courts	77	MH, CD	County of Rockland	County Dept. of Transportation and Planning	1 to 2	2	
GCJ-E1	Improve capacity of BH providers to serve court participants	77	All	MHATI Advisory Board	BH providers, other agencies, Workgroups	2	1 to 2	
GCJ-E2	Provide basic BH curriculum for police academy cadets	77	All	RCDMH	Police Academy, BH providers, consumers	2	1 to 2	
GCR-A1	24-hour Mobile Crisis hotline, triage, referral	78	All	Rockland Mobile and RCDMH	BH Evaluation and Referral Center	1	1	
GCR-A2	Mobile Crisis referrals to BH Evaluation and Referral Center	78	All	Rockland Mobile and RCDMH	BH Evaluation and Referral Center	1	1	
GCR-A3	Establishment of a BH Evaluation and Referral Center	78	All	RCDMH	RPC, Nyack Hosp, Good Sam	1	2 to 3	
GCR-B1	Standard referral form used to facilitate follow-up	78	All	RCDMH, BH Evaluation and Referral Ctr	Rockland Mobile, Nyack Hosp, Good Sam	1	1	
GCR-C1	Standard referral form developed	78	All	RCDMH, BH Evaluation and Referral Ctr	Rockland Mobile, Nyack Hosp, Good Sam	1	1	
GCR-D1	Mobile Crisis to train Clarkstown PD	79	All	Rockland Mobile and RCDMH	Clarkstown PD	!	1	
GCR-D2	Mobile Crisis to train other police depts.	79	All	Rockland Mobile and RCDMH	Rockland County Police Depts.	2	1	
GCR-D3	Special population training for mobile crisis team	79	All	RCDMH	Rockland Mobile, BH providers, consumers	1	1	
GCR-D4	Awareness of Mobile Crisis to underserved communities	79	All	RCDMH	RCDMH Community Resource Specialist	1 to 2	1 to 2	
GID-A1	Clinics receiving federal funding will provide I-DD services	80	I-DD	County of Rockland	RCDMH, BH State licensing agencies	2	2 to 3	

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GID-A2	Clinics receiving federal funding will provide I-DD screenings	80	I-DD	County of Rockland	RCDMH, BH State licensing agencies	2	2 to 3	
GID-B1	Hospitals will develop capacity to treat I-DD in their ED's	80	I-DD	County of Rockland	RCDMH, BH State licensing agencies, hospitals	2	1 to 2	
GID-C1	County must advocate to uphold "no wrong door policy"	80	I-DD	County of Rockland	State BH licensing agencies, CSB, Workgroups	2	2 to 3	
GID-C2	Outpatient MH providers will develop capacity to treat I-DD	80	I-DD, MH	County of Rockland	NYS elected officials, NYSOMH, NYSOPWDD	1 to 2	2	
GID-C3	RCPC and RPC develop capacity to treat I-DD consumers	81	I-DD, MH	County of Rockland	NYS elected officials, NYSOMH, NYSOPWDD	1 to 2	2 to 3	
GID-C4	NYSOPWDD will expand adult and child crisis respite beds	81	I-DD	County of Rockland	NYS elected officials, RCDMH, NYSOPWDD	1 to 2	2 to 3	
GID-C5	Greater local input in NYSOPWDD planning re Olmstead	81	I-DD	County of Rockland	NYS elected officials, RCDMH, NYSOPWDD	1	1	
GID-C6	Local input for vetting process for DISCO providers	81	I-DD	County of Rockland	RCDMH, CSB, Subcommittees, Workgroups	1	1	
GID-C7	Insurance of supports for individuals returned to community	81	I-DD	County of Rockland	RCDMH, CSB, Subcommittees, Workgroups	1	1	
GID-C8	Delay closures of ICFs and Sheltered Workshops	81	I-DD	County of Rockland	NYS elected officials, RCDMH, NYSOPWDD	1	1	
GID-C9	Individuals with I-DD finding/retaining independent living	81	I-DD	RCDMH	NYSOPWDD, HUD	2	2 to 3	
GID-D1	Form an I-DD SPOA	82	I-DD	RCDMH	RCDOH, NYSOPWDD	1	1	
GID-D2	Establishment of linkages to fill inpatient service gaps	82	I-DD	RCDMH	Local and regional BH providers	1	1	
GID-E1	Annual training for County BH staff, supervisors in I-DD	82	All	RCDMH	I-DD providers and consumers, NYSOPWDD	1	1 to 2	
GID-E2	Annual training in I-DD issues for all workgroups	82	All	RCDMH	BH Workgroups, I-DD providers, consumers	1	1 to 2	
GID-E3	Training MH and CD staff to serve I-DD consumers, families	82	All	RCDMH	NYSOPWDD, I-DD Workgroup	1	1 to 2	
GID-E4	Cross-training for all Rockland BH staff	82	All	RCDMH	NYS BH Licensing agencies, Workgroups, Depts	1 to 2	1 to 2	
GID-E5	Training for Rockland business community in I-DD	82	I-DD	RCDMH	Rockland Business Association, I-DD Workgroup	1 to 2	1	

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GID-E6	Community forums to educate residents about I-DD	82	I-DD	RCDMH	I-DD Workgroup	1 to 2	1 to 2	
GID-E7	Training series for criminal justice/first responders re I-DD	83	I-DD	RCDMH	I-DD providers and consumers, I-DD Workgroup	1 to 2	1 to 2	
RG-A1	Expanded Utilization of Rockland Psychiatric Center	84	MH	RCDMH	RPC, NYSOMH, CSB	1	2 to 3	
RG-B1	Creation of a position/team to oversee human services	84	All	County of Rockland &Legislature	All County Depts, CSB, Workgroups, Subcomm.	1	2	
RG-B2	Promotion of dual licensure for BH agencies	84	MH, CD	RCDMH	BH providers, NYSOMH, NYSOASAS	1 to 2	1 to 2	
RG-C1	Unifying vision and mission for BH in Rockland	84	All	County of Rockland &Legislature	Human Services person/team, RCDMH, CSB	1 to 2	1	
RG-C2	Provision of safety net BH services	84	All	County of Rockland &Legislature	RCDMH, local BH providers	1 to 2	2 to 3	
RG-C3	Proactively seek BH resources	84	All	County of Rockland & RCDMH	State and Federal elected officials, Workgroups	1	1 to 2	
RG-C4	Build capacity within local communities to meet BH needs	85	All	RCDMH	BH providers,Community coalitions/agencies	1 to 2	2	
RG-C5	Explore partnerships in underserved communities	85	All	RCDMH	Community coalitions, other agencies	1	1	
RG-C6	RCDMH and CSB work in partnership to advocate, advise	85	All	RCDMH and CSB	County of Rockland, State BH licensing agencies	1	1	
RG-C7	Advocacy re Medicaid re-design to better serve residents	85	All	County of Rockland and RCDMH	NYS BH Licensing agencies, Workgroups, Depts	1	1	
RG-C8	Advocacy re DSRIP to include Commission recommend.	85	All	County of Rockland and RCDMH	BH Workgroups, NYSDOH, BH licensing agcys	1	1	
RG-C9	Advocacy re Olmstead to ensure community supports exist	85	All	County of Rockland and RCDMH	State and Federal elected officials, CSB	1	1	
RG-C10	Develop evaluation of local BH services for funding	86	All	County of Rockland & Legislature	RCDMH, CSB, Subcommittees, Workgroups	1	1	
RG-C11	Bi-annual review of County Charter to update re State/Feds	86	All	County of Rockland	RCDMH, Law Dept.	1	1	
RG-C12	Review and comparison of other local county BH systems	86	All	RCDMH	Orange, Westchester, other DMH	1	1	
RG-C13	Results of Commission used, evaluated quarterly, repeated	86	All	County of Rockland & Legislature	RCDMH, CSB, Subcommittees, Workgroups	1	1	
RG-D1	Advocacy for co-licensing of all BH programs	86	All	County of Rockland and RCDMH	NYS BH Licensing agencies, Workgroups, Depts	2	2 to 3	

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RG-D2	Mandate private insurance equal to Medicaid/Medicare	86	All	County of Rockland	NYS Licensing agencies, NYS elected officials	2	1	
RG-D3	Change DMH name to Department of Behavioral Health	86	All	County of Rockland & Legislature	Department of Law	1	1	
RG-E1	Advocacy for parity for BH frontline workers	87	All	County of Rockland and RCDMH	State and Federal elected officials, Licensing agcys	1	2 to 3	
RG-F1	CSB to meet monthly, and quarterly with CE	87	All	CSB and County of Rockland	RCDMH, Workgroups, Subcommittees	1	1	
RG-F2	Re-Establish CSB preliminary approval process w NYS	87	All	County of Rockland & Legislature	NYS Licensing agencies, NYS elected officials	1	1	
RG-F3	Reaffirm structure and restore function of CSB	87	All	County of Rockland & Legislature	RCDMH, Workgroups, Subcommittees	1	1	
RG-F4	Utilize Unified Services BH system more fully in planning	87	All	County of Rockland & Legislature	CSB, Workgroups, Subcommittees, RCDMH	1	1	
RG-F5	Schedule CSB meetings for maximum public participation	87	All	CSB and County of Rockland	RCDMH, Subcommittees	1	1	

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