2009 Mental Hygiene Planning Activities Report
Oswego County Mental Health Division (70320)

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

Description of Service Area

Oswego County is located on the southeast shores of Lake Ontario and encompasses an area of 953 square miles with two major population centers in the cities of Fulton and Oswego. The County is a predominately rural county of an estimated 123,373 people. According to Us Census Bureau and the 2005 American Community Survey Data Profile, 97% of the population is identified as white, 25% of the population is under the age of 18. The median household income is $42,731 with 13% of families and 18% of individuals are living below poverty level, which is above the national average. Oswego County has struggled with an elevated unemployment rate for several decades. As of April 2007, the rate of unemployment was 5.1% according to the NYS DOL ; remaining higher than NYS or National averages. A significant number of individuals seeking chemical dependency services lack a HS diploma or GED and most often are not engaged in gainful employment.

Clients physically access services in a variety of manners. Clients may receive Medicaid transportation, walk, drive (though many have lost the license to drive), have someone drive them, and/or use buses if residing within the city limits. However, there are still pockets of the county that struggle to receive services due to their location. There are also those Oswego County residents who choose to access services in Onondaga County because travel in that direction is easier for them. Due to size and rural nature of Oswego County, transportation has traditionally and remains, an issue for this county. Physical access to service locations is a barrier. Transportation to services is a concern stated by all consumer and provider groups. Oswego County residents are spread across a large rural area. Access to public and even Medicaid transportation is limited. This contributes to frequent no-shows and limited opportunities to participate in supportive services and community activities.

Qualitative Needs Assessment Activities

2007 Provider Priorities Survey on CPS

Priorities identified by providers include the need for additional preventive and supportive services, emergency housing, housing for women in recovery, case management, coordination of services for criminal justice clients, staff training and credentialing, increased reimbursement and funding to promote staff retention.

2007 Local Stakeholder & Provider Surveys of Capacity, Service Gaps, & Priority Needs

Service Areas where a need for development or expansion was identified include emergency housing (this is a need for the entire county, not just this special population); psychiatric emergency room; overnight crisis bed/hospital diversion; chemical dependency detoxification program; intensive treatment programs directed at young people; residence for women in recovery; county-wide hotline; increased availability of 1:1 counseling;

non-traditional or holistic treatment approaches; family counseling; therapeutic counseling for treatment of co-occurring disorders; support groups for adolescents; Spanish speaking providers, and the need for expansion of all prevention related services, especially in the schools.

Additional issues identified include abused, neglected and abandoned young people turning to substance usage as a way of dealing with their experiences; and insufficient funding for vital preventive services not eligible for 3rd party reimbursement.

Staff training or Community Education Needs identified include training on intervention methods for lay staff in the field; QHP training with CASAC/CPP approved hours; local OASAS approved CASAC training opportunities; collaboration with clergy; community education and engagement to increase awareness of substance use and physical/psychiatric impacts of use; staff training for those required under revised CS Part 822 Regulations; and difficulty recruiting and retaining qualified staff for QHP's due to low salary levels.

CSB ASA Subcommittee

The subcommittee meets monthly and discusses new challenges, changes, trends, etc that are occurring. The members share suggestions, strategies, and experiences to support providers in improving utilization, access, and service delivery.

Quantitative Needs Assessment Activities

Data sources utilized to quantify service needs include the OASAS 2007 County Resource Book, OASAS 2007 County Service Need Profile, 2007 OASAS Community Response Indicators for Improving Services System Performance (CRISP), 2005 Prevention Risk Indicator Services Monitoring System (PRISMS) for Alcohol and Substance Abuse for Oswego County, and 2007 Local Survey of OASAS Providers regarding Capacity and Service Gaps.

Assessment of the Nature and Extent of Chemical Dependence Problem in the County

According to the March 2008 OASAS Service Need Profile for Oswego County, the estimated prevalence, number of county residents with chemical dependency service needs is 10,285, approximately 9.7% of the general population age 12 and over. Of the total number estimated in need, 8,955 (87%) are adults and 1,162 (11.3%) are adolescents (ages 12-17) with alcohol and/or non-opiate drug use. 168 residents, 0.2% of population age 16 and over, are using opiate drugs.

(comparison to other rural counties of similar size)

County	2006 Est. Population (age 12 and over)	Percentage of County Residents with Chemical Dependence Service Needs
Oswego	105,764	9.7%
Jefferson	95,797	10.4 %
St. Lawrence	96,947	11.8%
Chautauqua	117,103	9.4 %
Statewide (including NYC)	16,378,922	10.7 %

OASAS Prevention Risk Indicator Services Monitoring System for Alcohol and Substance Abuse (PRISMS) 2005 Risk Profile indicates Oswego County is above the NYS average (excluding NYC) in the following areas:

- Unemployment
- Single-headed households in poverty
- Adult DWI arrests
- Youth DWI arrests
- Adults in treatment for alcohol
- Youth in treatment for alcohol
- Children in foster care
- Teenage pregnancy
- On-Premise Alcohol vendors
- Off-Premise Beer & Wine Cooler vendors
- High school drop outs (equal to state average, but higher than similar counties)

Oswego County residents account for 1086 admissions across chemical dependency services within NYS in 2006. 66.5% of these admissions were with services provided within Oswego County.

OASAS Client Data Systems (CDS) data indicates recent increases for Oswego County residents in utilization for the following services or categories:

- Persons with co-occurring disorders accessing outpatient services
- Persons with co-occurring disorders accessing residential services
- Children of Alcoholics or Substance Abusers accessing services (across all services)
- Marijuana/Hashish as primary substance at admission
- Having NO source of income at admission
- Crisis admissions for age group 25-34
- Inpatient admissions for age groups 25-34 and 45-54

- Outpatient admissions for age groups 25-34
- Residential admissions for age groups 18-24 and 25-34
- Methadone treatment admissions

Individuals with co-occurring (either Mental Illness or MRDD) and Chemical Dependency disorders are in need of services. As the table below indicates, the more significant number lies within the MICA (Mentally Ill Chemically Addicted) population. The following table represents percentages of the total admissions in NYS from Oswego County residents of individuals with a co-occurring disorder.

2006	Inpatient Services	Residential Services	Outpatient Services	Methadone Services
MR/DD	1%	1%	3%	10%
Mental Illness	31%	47%*	25%	40%

*A survey of local Mental Health providers done in 2006 returned findings that adults with co-occurring mental health and substance abuse service needs are frequently enrolled in community mental health services. The following table represents the percentage of total number served by local community mental health programs in 2005 that also had a chemical dependency diagnosis.

Community Residence	Supportive Apartments	CDT	ICM Case Management	ACT Team
40%	48%	18%	22%	41%

Assessment of the Nature and Extent of Compulsive Gambling Problem in the County

The extent of the compulsive gambling problem in Oswego County is not known. This is an area the County plans to assess over the next three years.

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

Assessment of Prevention Needs

Oswego county youth and families are struggling and continue to be at risk for substance abuse. Prevention services that are available are proving to be successful and schools and stakeholders are requesting additional services. A high number of out of home placements is one symptom of inadequate attention to prevention and community education. The increases in Children of Alcoholics or Substance Abusers accessing services, Crisis admissions for age group 25-34, Inpatient admissions for age groups 25-34, Outpatient admissions for age groups 25-34, and Residential admissions for age groups 18-24 and 25-34 further indicate that prevention services directed at youth and community in Oswego County are insufficient to positively impact the County as a whole.

The 2006 OASAS gambling Survey reports that among adults who had gambled in the past year, the average age at which they first made a wager or bet money was 23 years old. The same was true for adults who had gambled on a weekly basis in the past year. However,

among those adults who had experienced problem gambling in the past year, the average age of first gambling experience was 19 years old. Ap proximately 10 percent of students in grades 7-12 have experienced problem gambling in the past year and may need treatment services. An additional 10 percent of students may be at risk of developing problem gambling. Oswego County is home to a State University, SUNY Oswego, which enrolls more than 8,000 students, 6,600 of them full-time undergraduates. About 3,850 students live on campus. 25% (or roughly 30,000) of the Oswego County population is under 18 years of age, of which 9.5% (or roughly 11,000) are age 12-17. Another 12.5 % (or roughly 15,000) are age 18 -24. Given the demographics, there is opportunity to have a great impact on decreasing problem gambling and addictions within Oswego County. To do so, additional prevention and education efforts are needed.

DSS, Probation, Mental Health and Addiction Providers Collaboration

The objective of this collaboration is to identify strategies to address Youth Drug & Alcohol use in effort to positively effect family unity, improving family wellness, functioning and quality of life so that families stay together and avoid the need for placement outside the family home. One part of this effort is to identify common drug and alcohol factors contributing to placements and suggestions for services, programs, best practices to address these risk factors. A sample review of JD/PINS cases, who were place out of the home, idenitifed a common factor to be drug and alcohol use or abuse on the part of the child and/or the parent(s).

Community education and engagement are necessary to sustain prevention efforts beyond targeted youth. Contributing risk factors and the extent of chemical dependence problem and gambling issues needs to be communicated openly to the public to increase awareness of the issue.

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

Treatment Service Needs

The table below depicts estimated Treatment service needs versus local capacity as provided by OASAS.

Service Category	Capacity Needed	Current Capacity	Unmet Need	Pct. of Need Met
Crisis Services: Medically Managed Detoxification	3	0	3	0.0%
Medically Supervised Withdrawal (inpatient)	3	0	3	0.0%
Medically Supervised Withdrawal (outpatient)	5	0	5	0.0%
Medically Monitored Withdrawal	7	0	7	0.0%
Outpatient Services: in units of service Services to Adolescents (12-17)	5,610	1,692	3,918	30.2%
Services to Adults (18+)	32,191	17,891	14,300	55.6%
Methadone Treatment:	69	0	69	0.0%
Community Residence Beds:	28	16	12	57.1%

Source: [3] OASAS Certified capacities (adjusted) as of March 3, 2008. Note: Capacity is measured in beds for all inpatient and residential services, slots for medically supervised withdrawal outpatient and methadone services, and visits provided for outpatient services. [4] Primary outpatient visits reported for the 12-month period from October 2006 through September 2007 (pas-48 and cds extracts 3/3/08).

Capacity & Resources Available to meet Treatment Needs

Oswego County has three OASAS licensed outpatient treatment providers with a total capacity to serve an estimated 422 persons. Within the three outpatient programs, there are services available for adults, adolescents, families and couples, those with co-occurring disorders, single gender groups, acupuncture detoxification, an Intensive Outpatient Program operating five days per week, and a specialized program for individuals with MRDD and co-occurring substance abuse issues. Local data indicates 1493 individuals received treatment services in 2006. The wait time between initial request for service and first appointment ranges from one to 3 weeks.
Crisis, Inpatient, and Methadone Treatment services are not available in county. For those services not available in county, there is a strong network or referral locations utilized by local providers, primarily in Onondaga and Jefferson Counties. Transportation is a significant obstacle to accessing these services.

Gaps in Treatment Services

Within the continuum of treatment services, residents needing crisis services, detoxification, inpatient, long and short-term rehab, or intensive residential service must all go out of county. Referrals are made out of county when necessary as need in this county is low and does not support such services being provided locally. Treatment services for individuals with co-occurring mental health and substance abuse services are limited. One provider is working to expand this component to their treatment program by adding a psychiatric nurse practitioner to perform evaluations and prescribe and monitor medications for this client population. Currently no services are being provided to inmates. This is an area that should remain a priority as funding becomes available. In prior years, outpatient clinic staff provided psychosocial education at Oswego County Correctional Facility as part of a State Education grant. No funding is currently available. The local mental health plan includes efforts to address or enhance available crisis services such as emergency evaluations, hotline, crisis bed for respite or admission diversion.

Barriers to providing additional Treatment Services

- Inadequate reimbursement rates to allow for expansion of programs
- Fiscal instability resulting from inadequate reimbursement rates and deficit funding models, as well as variations in funding from County, United Way, and other funding sources largely contribute to the limitations of program development and expansion.
- Multiple requirements on treatment staff (including non-treatment related services such as case management) decreases time available for direct treatment service delivery. These activities are not reported or reimbursed. Clinicians are performing this case managemetn function which is having an impact on availability of time for actual delivery of clinical service. This is also impacting staff retention as clinical staff are

having to perform other than clinical roles and still needed to meet thresholds for units of service.

- Funding available for staff training to meet the needs of individuals with co-occurring MI and CD disordersInadequate reimbursement rates to allow for expansion of programs

- Regulatory restrictions on location of service delivery

Barriers to accessing Treatment services include

- Lack of insurance, inability to self-pay
- Stigma
- Service Hours
- Transportation

Prevention Service Needs

- Additional school based prevention programs
- Family engagement and connections to schools and community
- Parent and Community education and awareness of risks
- Structured wellness and recreation activities
- Youth support groups
- Drop-In Center for adolescents
- Prevention efforts targeting Gambling

Capacity & Resources available to meet Prevention Service Needs

Two of the treatment providers also provide prevention services. These services include:

- FAST (Families and Schools Together)
- Project Success
- Reconnecting Youth
- Project Alert

There are currently no gambling prevention services available in Oswego County. Prevention services have limited capacity and consequently are not availableto the community as a whole.

Gaps in Prevention Services

Local funding was cut in the several years ago, which greatly impacted the ability to provide sufficient Prevention services. Local providers have needed to pursue alternative funding sources to be able to provide needed services and those sources are also limited or are now being reduced or eliminated as well. Related planning and committee discussions across multiple systems continually identify the ongoing need for additional prevention services.

Barriers to Accessing/Providing needed Prevention Services

Funding is truly the only barrier to providing additional Prevention services. Providers are willing and able to deliver additional services with adequate financial support.

Recovery Support Service Needs

- Residential programs for women, women with children
- Additional Residential beds for youth
- Coordination of Services with criminal justice
- Collaboration with existing community drop in centers and after school programs to offer adolescent support groups and educational opportunities
- Case Management Services for Adolescents and Adults
- Transitional and Supported Employment Services

Capacity & Resources Available to meet the identified Recovery Service Needs

Oswego County has one OASAS certified residential provider (16 Community Residence beds and 12 Supportive Apartment beds). These beds are available for adult males only. There are no available beds currently available for women or women with children. A group home for youth, ages 16-18, is available with a bed capacity of 10.

Other Recovery services include programs that benefit youth at risk. These programs include OASAS youth case management included within the PATH and Options programs, Street Outreach Services (SOS), Rural After School Program (RASP), and Fulton Youth and Family (FYF) Case Management.

Support groups available within the County include Alcoholics Anonymous, Adult Children of Alcoholics, Al-Anon, Al-Ateen, Double Trouble in Recovery (MICA), Gamblers Anonymous, and Narcotics Anonymous.

One full time employee provides vocational Rehabilitation counseling. Supported or Transitional employment programs are not available for individuals in recovery from chemical dependency.

Gaps in Recovery Services

Service gaps include residential services for women and women with children. Currently a provider is pursuing this option and is struggling with local community resistance to development of this program. Youth in need of a group home have to wait three months or more for an available bed. Support group for adolescents, youth mentoring program, and dedicated services to support families and affected others do not exist, and community awareness/education services are limited by lack of available funding. Minimal Case management is available for youth with a waiting period of approximately three months. There are no dedicated case management services for adults with chemical dependency.

Barriers to providing needed Recovery Services

- Funding for Program Development and Expansion
- Community/neighborhood/Town support for residential program site development
- Absence of dedicated case management program model, reimbursement structure

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

Regulatory relief to allow for flexibility to provide treatment services outside of a certified site would allow providers the opportunity to bring the service to people and improve access; i.e. in schools, community centers, churches, mental health clinics, primary care facilities, etc.

Transitional & Supported Employment services as are available for mental health and MRDD eligible consumers to support recovery and efforts to obtain and sustain self-sufficiency.

Case Management activities need to be provided by other than treatment staff. A large amount of individual treatment time is spent performing case management activities. Offering case management, as a service separate but coordinated with treatment, would allow for increased availability of 1:1 counseling as previously mentioned to be a need. This service would increase coordination and follow through, promote recovery activities and ultimately lead to improved outcomes for individuals, families, providers, and communities.

Coordination with OMH SPOAs for access to MH case management for the MICA population.

OASAS approved QHP list need to include new licensing title of Licensed Mental Health Counselor so that providers can access this available resource.

The need exists for coordination of care between OMH, OASAS, and OMRDD systems. Regulatory constraints are prohibitive to an individual accessing the services of multiple systems. The needs of individuals with multiple disorders are unique and require staff to be cross-trained and the funding streams supporting the services to be flexible.

Funding or reimbursement is needed to cover gambling prevention and treatment costs, Peer recovery and support services.

Prevention programs that incorporate family involvement, similar to FAST.

Evening programming is needed for adolescents.

Parenting support groups for parents in recovery to strengthen families.

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

None at this time.

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

The following groups, individuals, and agencies were offered the opportunity to participate in the local planning process. There were varying levels of response or participation across the groups.

Consumers
Family Members
Self-Advocate Groups
CSB MRDD Subcommittee Members
Oswego County CSB
Local Voluntary Agency Staff
Local State Operated Facility Staff
School, CSE
Local College, SUNY Oswego
Local Mental Health Clinic
Dept of Social Services
Family Support Services Council

7. Methods of Discovery (OMRDD) - Identify the methods of discovery utilized to determine the issues, concerns, needs and priorities for local planning (e.g., surveys, forums, key informant interviews, focus groups, analysis of available data, etc.). Summary information obtained from these discovery methods should be included.

- Locally developed survey of known consumers, targeted 1/3 of MSC caseload
- Brief survey of CSB MRDD Subcommittee members including provider administrators, regarding priority needs
- Provider information gathering with program staff, consumers, and families, informal and formal varied by provider
- Review of local waitlist data
- Review of NYS OMRDD Data for Oswego County
- Review of NYS VESID Data on Students with Disabilities

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

Oswego County has many services available, but is lacking in either capacity or local access in several areas as listed below.

HOUSING

More beds overall are needed to address the local wait list. More diversity in types (levels of care) of housing options, i.e. beds for medically frail consumers, Supervised Apartments, Supported Apartments to facilitate transition to independent living. One-bedroom options in housing programs, and smaller settings with less housemates are also needed. Supervised and/or Supportive Housing with daycare service for consumers who are parents of minor

children have also been requested.

INFORMATION AND EDUCATION

Consumers and Family members are in need of additional information to be able to make informed choices and make full use of service options. Training related to Educational & Systems Advocacy, rights and responsibilities of families, schools, and providers, Future Planning (trusts, guardianships), are some of the areas of particular need. Improved access to information would benefit all stakeholders.

QUALITY OF LIFE, Activities & Skill Development

Day Habilitation, Recreation, Educational, and Volunteer opportunities need further development. Social Skills training, Independent Living Skills training, and Sibling Supports are identified as unmet or under met needs.

TRANSPORTATION

Although Oswego County has worked very hard to improve and coordinate transportation systems, this area remains an issue for the MRDD population. There is a need for greater flexibility in local eligibility restrictions for Medicaid transportation.Services are lacking in general for access to community services events. The current system presents as an obstacle for employment, and accessing recreation and respite services. Transportation Training is needed for consumers as well as for drivers regarding working with individuals with disabilities.

EMPLOYMENT

The development of more job opportunities is needed to be able to connect individual skills with meaningful work. Employers need additional information and education about vocational supports and other information related to the needs of consumers in the work place, assistance with accommodations, etc.

SPECIALIZED POPULATIONS

Populations with special needs identified in Oswego County include Transition-Aged youth. A specific concern is that this group needs to be better prepared for changes that will occur upon graduation when they enter the realm of adult services and choices. Individuals and families need to become aware of the changes and service options so that they can effectively participate in transition planning.

Individuals dually diagnosed with both MRDD and Mental Health disorders do not have access to appropriate services. There is a need for an increase in Medicaid providers trained in providing family and individual counseling to this population group. A child/family-centered approach is requested. There is a lack of services across the array available to effectively provide for children with difficult behaviors, i.e. respite, residential habilitation, residential). Oswego County also lacks the capacity to provide emergency mental health services for children & adolescents with behavioral difficulties separate from adults.

INDIVIDUALIZED SERVICES AND SUPPORTS

Several areas of need fall within this category. Additional access to In-Home Residential Habilitation, Self-Advocacy, Self-Determination opportunities and training, Education and Counseling for Pregnant/Parenting

consumers, Access to Behavioral Assessment / Development of Behavior Management Plans, Access to Assistive Technology and Environmental Modifications are all areas of need identified by the local information gathering process.

FAMILY SUPPORTS

Family members are increasingly willing to care for their loved ones at home. This contributes greatly to individual's quality of life and benefits the service system as well. An increase in support for families is needed to maintain and enhance this effort. A support network for parents of adult children needs to be developed. Families providing continuous care need support from Respite services. There is a local need more free-standing respite, especially in outlying areas, for drop in respite (few hours), for planned overnight and hourly respite, for emergency/crisis respite, and for in-home respite.

WORKFORCE

Local providers are experiencing an ongoing struggle with recruiting and maintaining quality staffing levels. Low salaries for difficult work contributes to employers finding it difficult to expand the local workforce fast enough to meet demand/needs, which leads to restricted access to programs and services for individuals. Increased training is needed for staff to develop effective skills and the knowledge base specific to this population.