

**NEW YORK CITY
DEPARTMENT OF HEALTH
AND MENTAL HYGIENE**



**LOCAL GOVERNMENTAL PLAN
MENTAL RETARDATION AND
DEVELOPMENTAL DISABILITIES SERVICES**

2005-2007

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TABLE OF CONTENTS

| | <u>Page</u> |
|--|-------------|
| I. Introduction..... | 1 |
| II. Service Priorities for State FY 2006..... | 1 |
| Residential Services..... | 2 |
| Adult Day Services..... | 4 |
| Family and Individual Support Services..... | 7 |
| III. Local Government Initiatives..... | 9 |
| Collaboration with the Federation Borough Councils to Address Service Gaps... | 9 |
| Increase Psychiatric Inpatient Capacity and Acute Psychiatric Care Alternatives for Individuals with MR/DD..... | 10 |
| Increase Access to Alcohol and Substance Abuse Treatment for Adults with MR/DD..... | 11 |
| Improve Transition from the Department of Education to the Adult MR/DD Services..... | 13 |
| Continuous Quality Improvement Initiative: Quality IMPACT..... | 15 |
| Improving Identification of Mental Health Problems in Children..... | 16 |
| Independent Continuous Quality Improvement Projects..... | 17 |
| The Consumer Perceptions of Care Survey for MR/DD Work Programs..... | 17 |
| Unmet Service Needs of New York City Foster Care Children..... | 19 |
| IV. Comments on New York City Options for People Through Services (OPTS)..... | 20 |
| V. Listing of Key Participants..... | 21 |
| VI. Assurances..... | 29 |

I. INTRODUCTION

This year's Mental Retardation and Developmental Disabilities (MR/DD) Local Government Plan represents incremental movement towards a planning framework that is data-driven and includes quality as a key component. Data on service need are included in this year's Service Priorities, and limited data on prevalence, system capacity and utilization are included elsewhere in the Plan. For the first time, the Plan includes outcomes and data for the first year of Quality IMPACT, the quality improvement initiative of the Division of Mental Hygiene of the Department of Health and Mental Hygiene (DMH). The Plan also reflects a strengthened partnership between DMH and the City's MR/DD community, as it reports on the progress of three workgroups, established by DMH and Federation¹ Borough Councils to work together to address local service system issues.

This year's planning process was inclusive and collaborative. Following a kick-off meeting in late spring, borough-based planning meetings were held in the five boroughs. Participants included Federation Borough Council family and provider members, Consumer Council members, Developmental Disabilities Services Offices (DDSO's) and DMH. Through a review of available data on unmet need, participants agreed on service priorities to guide funding allocations for the upcoming year. The progress of the workgroups focusing on the local service system issues was reviewed at the meetings, and in some boroughs, service priorities in support of the workgroup goals were adopted. Data from Quality IMPACT were also presented and discussed. Finally, input was elicited on the Options for People Through Services (OPTS) initiative, and these comments are summarized in the Plan.

DMH is committed to continuing the work begun this year and described herein: to improve and expand upon the use of data in local planning; to continue to focus on quality and quality improvement; and to co-lead and support initiatives aimed at addressing local service system issues. Next year's Plan will report on our continued progress in these areas.

II. SERVICE PRIORITIES FOR STATE FY 2006

Service priorities identified for NYC are listed below for each of the three major service categories: residential services, adult day services, and family and individual support services. Within each service category, priorities are listed by borough and by the specific service need in order of priority. Following each priority, in italics, is the number of individuals to be served during Fiscal Year 2006, and where available, the number of individuals on a waitlist for this service (*# to be served / # on waitlist*).

The process for accessing data on service need and determining the number of opportunities needed differed by borough. Numbers were generated through a combination of DataPack information, DDSO and Borough Council data, and anecdotal information about existing service needs in the community. The process for determining waitlist numbers differed even more by borough, and by service category. For residential services, most waitlist numbers came from the NYS Creating Alternatives in Residential Environments and Services (CARES) list; some

¹ The Federation for Mental Health, Mental Retardation and Alcoholism Services is an advisory body to DMH comprised of mental hygiene service consumers, family members, provider agencies and advocates.

boroughs listed that number as the waitlist for the overall service category, while others distributed that number among the various service priorities. For adult day services and family and individual support services, waitlist numbers were typically developed using anecdotal information and DDSO and Borough Council data; not all boroughs were able to determine waitlist numbers for these service categories. Where no waitlist numbers are available, there is only one number listed after the priority, and that is the number of individuals to be served. Additionally, some service priorities do not include data on the number to be served, because the priority addresses a system-wide barrier or needed system improvement, rather than specific service opportunities for individuals.

Residential Services

Residential opportunities are needed for individuals with developmental disabilities (DD) who reside at home and are currently on the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) waitlist for entering a housing program. Most needed are small community residences (which now, predominantly, take the form of Individualized Residential Alternatives, or IRAs) with varying levels of care and support services based on the needs of the individuals living therein, and innovative residential programs for consumers whose needs are not adequately met by existing programs. Note that residential service priorities that do not include data on the number to be served address urgent and/or emergency situations where the number of service opportunities needed cannot be known in advance.

In addition to the prioritized service needs listed below, Borough Council members expressed concern about and frustration with the process for developing new residential opportunities in all five boroughs of NYC. Specific concerns included the complex and lengthy approval process, an inadequate capital threshold, extremely high rents, and the saturation of the current housing market. All five boroughs noted these barriers to residential development as a major concern, and some included specific priorities relating to the process of residential development.

Bronx

1. Individuals who have been identified and are on the DDSO Wait List, who may be dually diagnosed, with challenging behaviors such as hyperactivity, aggression, assault, self-abuse and elopement and/or who may have been rejected for placement. *(65/65)*
2. Individuals of all ages who require a barrier-free facility, and may require enhanced nursing support. These individuals may be residing in existing residential or nursing facilities, or living in the community without adequate housing supports. *(60/60)*
3. Individuals of all ages who need 24-hour nursing care and may require enhanced nursing support. *(16/16)*
4. Adolescents who may have challenging behavior and whose family structure does not allow them to be maintained at home. *(10/10)*
5. Aging individuals who require barrier-free senior housing that is equipped to provide progressive medical support. New opportunities are needed for individuals in need of residential placement, as well as individuals whose current residential placement does not meet their needs. *(25/150)*

Brooklyn

The following priorities highlight the needs of specific populations from a total of 633 waitlisted individuals in Brooklyn:

1. Individuals with an acute mental health care need who require time-limited residences that provide intensive psychiatric/therapeutic services. (40)
2. Children diagnosed with autism. (24)
3. Aging adults with medical needs and/or ambulation difficulties. (50)
4. Parents with DD and their dependent children. (20)
5. Dually diagnosed individuals, specifically those with MR/DD who also have chronic mental health care needs. (40)
6. Individuals with a chemical dependence disorder who are in need of long-term residential chemical dependence treatment and services. (10)

Manhattan

1. Because of the tremendous obstacles to residential development in Manhattan:
 - The capital threshold must be increased
 - The approval process must be greatly expedited
 - Consideration must be given to placing Manhattan consumers in other boroughs
2. Residential services for individuals in emergency situations.
3. Residential services for individuals with urgent needs.
4. Residential services for DD individuals with non-urgent needs, with priority to: (355/355)
 - Difficult-to-place adults with severely challenging behaviors, including high-functioning adults with psychiatric diagnosis and/or substance abuse
 - Physically impaired, medically fragile, multiply-impaired and/or non-ambulatory adults
 - Adults with autism, traumatic brain injury (TBI), epilepsy, and low-incidence disabilities
 - Adults who are non-ambulatory but high functioning
 - Adults who are not medically fragile, but have intensive medical needs, including non-ambulatory persons
 - Adults who are comparatively independent and need supported-apartment type IRAs
 - Families with parents who have developmental disabilities
 - Residential services that would serve as alternatives to skilled nursing facilities (SNFs) for people needing 24-hour medical care—for those currently in need and for those already in SNFs who desire to return to OMRDD settings
 - Residential services for individuals who are aging or medically frail
5. In-patient beds and crisis residences for individuals dually diagnosed with MR/DD and mental illness (MR/DD-MI). (2-3)
6. Detoxification services for DD individuals who have a chemical dependence disorder. (20)

Queens

The following priorities highlight the needs of specific populations from a total of 622 waitlisted individuals in Queens:

1. New York State CARES IRA development for the following groups:

- Consumers whose caretakers are at risk of being unable to provide ongoing care (222)
 - Consumers who are aging (23)
 - Consumers who are medically frail (12)
 - Consumers with dual diagnoses (358)
 - Individuals with DD who are parents with children (could be supportive apartments) (7)
2. Dually diagnosed/behaviorally challenged DD individuals not living in an appropriate certified setting. (10)
 3. Time-limited residential opportunities for:
 - Individuals with DD and mental health issues who need crisis intervention services (8)
 - Individuals with DD and alcohol and/or other substance abuse problems who require chemical dependence treatment and/or rehabilitation services (5)

Staten Island

1. A simplified and expedited process for the development of new residential opportunities for individuals with special needs.
2. Residential opportunities for: (150/339)
 - Adults with MR/DD and a co-occurring disorder (mental illness, chemical dependence)
 - Older adults with increasing need for skilled nursing services
 - IRA residents in need of a placement that accommodates hospice services
 - Individuals not previously on a waitlist but in need of immediate placement
 - IRA residents in need of residential placements that house fewer than five people
 - Adolescents with autism and/or dual diagnosis
3. Time-limited residential programs for individuals who require therapeutic interventions for alcohol and/or chemical dependence, and/or who require acute psychiatric mental health care. (6/40)
4. Environmental modifications to residential settings to accommodate the changing needs of aging consumers. (25/75)
5. Transportation services for residential consumers that facilitate community involvement and inclusion and ensure safe travel.
6. Certificate training program for direct support professionals who work in residential settings.

Adult Day Services

Day services opportunities, using all available service models, are needed for Department of Education (DOE) graduates who are developmentally disabled and other adults with DD.

Bronx

1. Individuals aged 55 and older who are medically deemed unable to participate in a standard six-hour day habilitation program. (30/30)
2. Individuals with severe to profound mental retardation (MR) with challenging behaviors, in need of an intensive program in a small therapeutic setting with appropriately trained staff; especially for recent DOE graduates, individuals previously rejected from other programs, and individuals dually diagnosed with MR/DD-MI. (20/20)
3. Individuals with mild to moderate MR with challenging behaviors, in need of an intensive program in a small therapeutic setting with appropriately trained staff; especially for recent

DOE graduates, individuals previously rejected from other programs, and individuals dually diagnosed with MR/DD-MI. (35/35)

4. Individuals, DOE graduates in particular, who are non-ambulatory/multiply handicapped and medically frail. (10/25)
5. Individuals with autism who may have challenging behaviors and who require programs using inclusion models. (25/25)
6. Individuals who are blind and/or significantly visually impaired. (10/10)
7. Individuals with physical/medical disabilities that impede transition to employment, or individuals who have been in sheltered workshops for many years and are fearful of entering the work world. Programs need to provide day training and supported employment, and are especially needed for recent DOE graduates and individuals with autism. (30/40)

Brooklyn

1. All day service models for DOE graduates who are developmentally disabled. (200/200)
2. Individuals not enrolled in any program (who may have been rejected/discharged from programs or have never been in a program). (35/35)
3. Individuals exhibiting challenging behaviors. (40/100)
4. Paid work experience along a continuum of work programs that provide travel training and transportation (Pay should be commensurate with the Department of Labor minimum wage guidelines). (40/40)
5. Individuals who are wheelchair-dependent. (25/25)
6. Individuals who are medically frail or in need of medical support. (10/10)
7. Aging adults. (50/50)

Additional Priorities:

- Although not a traditional form of day programming, day hospitalization options are needed for individuals dually diagnosed with MR/DD and mental health disorders.
- Consumers in vocational training need enhanced support to transition to supported work.
- Consumers who are not Medicaid-waiver eligible need day services.

Manhattan

1. Day habilitation services for individuals aging out of DOE as well as for individuals of all ages who are currently unserved. Services should be designed to serve a mix of adults with DD, which must include individuals with any one (or more) of the following conditions: non-ambulation, behavioral challenges, dual diagnosis with a significant psychiatric component, autism, multiple impairments, TBI, epilepsy, and low-incidence disabilities. Individuals may be served in either newly developed day habilitation programs or in backfills in existing adult day programs. (55/259)
2. Innovative and person-centered adult day program initiatives for consumers whose needs cannot be met in traditional day program models—such as aging adults as well as others who need additional supports for inclusionary experiences, including college experiences. (20/50)
3. Supported employment and transitional employment opportunities for currently unserved adults, especially those with more severe DD who require intensive staffing and transportation assistance or travel training. (30/361)
4. Funding to compensate consumers for work activities in day habilitation. (71/71)

5. Work readiness/prevocational service opportunities for individuals with DD transitioning out of DOE, individuals who may have additional physical, medical, or psychiatric disabilities which impede transition to employment, and individuals currently in Sheltered Workshops for many years who are apprehensive about entering the world of work. (60)
6. Supported employment and transitional employment service opportunities for individuals with DD who do not meet OMRDD eligibility criteria. (40)
7. Expedite transition from school to adult day services, to begin at least 3 years before graduation, through:
 - Collaborative partnerships between DOE and voluntary agencies to enhance the transition process into adult day services
 - Education and information to parents in public and private specialized schools
 - Resources dedicated by DOE to the positions of transition linkage coordinators and borough transition coordinator, and to provide training for the coordinators
8. Day hospitalization/specialized out-patient services for MR/DD-MI dually diagnosed individuals. (2-3)

Additional Priorities:

- Funding for new and existing day habilitation services should be adequate to meet the needs of those who require intensive staffing and enhanced capital costs for specialized settings. Funding should be flexible to adapt to consumers' changing needs. The funding approval process should be expedited.
- The goal of adult day services should be the inclusion of adults with DD with their non-disabled peers. Sufficient funding must be provided to make inclusion possible.
- Out-of-borough residential placements should be accompanied by funding for appropriate adult day opportunities.
- Additional service components are needed to fill any service gaps for individuals currently enrolled in adult day services (e.g., speech therapy, additional days of supported employment, help finding employment, pre-travel training, travel training).
- Rehabilitation engineering services are needed to make physical adaptations to work tools and work sites in order to meet the needs of adults with DD.

Queens

1. Day service programs, with transportation, in integrated settings for DOE graduates (various developmental disabilities) who are non-ambulatory. (12)
2. Day service programs for consumers with severe, challenging behaviors, including individuals with autism spectrum disorders and others. (100)
3. Blended day programs for consumers who work fewer than five days a week and need structured activities for the alternate days. (10)
4. Day service programs, with transportation, for geriatric and medically frail consumers. (25)
5. Day service programs for persons without day programs. (25)
6. Time-limited, intensive day hospitalization or similar programs for dually diagnosed individuals with intensive psychiatric service needs. (8)

Additional Priority:

- Day services for DOE graduates who may present with a disability but do not meet OMRDD eligibility requirements for services.

Staten Island

1. Day service opportunities for individuals with DD who have intensive medical and/or functional needs. *(15/15)*
2. Day service opportunities for adults with DD who are not in any day programs and who are not new graduates from DOE. *(10/10)*
3. Day service opportunities for individuals who are being transferred from other counties of the State and/or from other states. *(10/10)*
4. Day services for individuals with DD and challenging behaviors, who require specialized programming, staffing and training. *(12/12)*
5. Day services for seniors that meet the changing needs of aging consumers. *(25/25)*

Family and Individual Support Services

Family and individual support services are needed for many individuals with DD who reside with their caregivers in their own homes. Opportunities should be developed as follows:

Bronx

1. Respite services, with transportation, for children ages 5 to 21, and/or adults who are mentally retarded and medically frail, in order of priority: *(100/200)*
 - After-school respite/recreation programs
 - Summer and school holiday respite
 - Weekend respite (one day, two days or weekend away)
 - Planned free-standing respite
 - Non-camp vacations
2. Respite services, with transportation, for children ages 5 to 21, and/or adults with MR/DD who are autistic, in order of priority: *(125/200)*
 - Summer and school holiday respite
 - After-school respite
 - Weekend respite (one day, two days or weekend away)
 - Planned free-standing respite
 - Non-camp vacations
3. Respite services, with transportation, for children ages 5 to 21, and/or adults with MR/DD who are dually diagnosed with a mental health disorder, in order of priority: *(100/200)*
 - Weekend respite (one day, two days or weekend away)
 - After-school respite/recreation programs
 - Summer and school holiday respite
 - Planned free-standing respite
4. Respite services, with transportation, for children ages 5-21, and/or adults with MR/DD who are blind, in order of priority: *(25/75)*
 - After-school respite
 - Summer and school holiday respite
 - Weekend respite (one day, two days or weekend away)
 - Planned free-standing respite
5. Sports programs, with supports, for children and adults with MR/DD of all ages. *(50/100)*
6. Vacation with staffing for children and adults with MR/DD of all ages. *(25/50)*

7. Transportation network for all family support programs that addresses the inadequacies of existing transportation services. *(50/150)*

Brooklyn

1. In-home residential habilitation. *(40/545)*
2. Respite services, with transportation, for the following time periods: *(65/703)*
 - School holidays
 - After-school
 - Weekends
 - Overnight (in and out of home)
3. Enhanced funds for transportation to include recreational programs and non-medical/clinical needs. *(200/534)*
4. Professional services for psychological assessments for children to determine eligibility for OMRDD services. *(20/50)*
5. Reimbursement funds to families for goods and services. *(1,000/1,250)*
6. Service coordination for individuals who do not have Medicaid. *(50/336)*
7. Summer day camps for children who may or may not be multiply-disabled. *(35/155)*
8. Crisis intervention that includes an in-home behavior management component. *(40/144)*

Manhattan

1. Addition of one-on-one staff support to existing recreation programs in order to include new, unserved people with intensive needs of all kinds. The one-on-one staff could also provide support on public transportation, Access-a-Ride, taxi, etc. *(10/33)*
2. Free psychological evaluations for people who do not have Medicaid. *(100)*
3. After-school recreation opportunities, with transportation, for children ages 5-21, including non-ambulatory and behaviorally challenged children. *(60/222)*
4. Parent and sibling support group. *(40)*
5. Expansion of existing OMRDD-funded programs that have waiting lists. *(20)*
6. Creative projects for a documented need (e.g., diaper co-op; training for parents with DD; parent support groups by age, stage, or disability). *(25)*
7. New and/or expanded emergency respite sites and/or individual providers (similar to the family care model), especially for those with severe challenging behaviors. *(15/35)*
8. Housing advocacy services and/or procurement of environmental modifications, to help families with a disabled member to obtain affordable, accessible housing. *(50/500)*

Additional Priorities:

- Individuals living independently who are not funded in a residence need access to reimbursement monies for expenses not otherwise covered.
- Access to parenting, behavior management, and skills training for foster care parents with children with DD.

Queens

1. Crisis and overnight respite (in-home and out-of home) for consumers with challenging behaviors. *(85)*

2. Year-round, 5-day per week after-school respite and recreation programs, with transportation, for children ages 3-21. *(166)*
3. Funding for evaluations for individuals who do not have Medicaid. *(130)*
4. In-home respite for individuals of all ages.
5. In-home residential habilitation. *(34)*
6. Family reimbursement for goods and services (e.g. transportation). *(74)*
7. Transportation for existing family support programs without transportation (e.g. drop-off respite).

Staten Island

1. A comprehensive response system for crisis management and crisis prevention for individuals of all ages with DD and a mental health disorder who are living at home. Services should include psychiatric services and skilled clinical support. *(50/200)*
2. Emergency respite services for individuals of all ages whose families are in an emergency situation. *(50)*
3. In-home respite for individuals of all ages. *(70/300)*
4. Recreation and summer day camp opportunities, with transportation, for individuals of the following age groups: 14-21, 21 and over, 7-13 and 3-6. Activities should be both indoor and outdoor and be provided on both weekdays and weekends. *(100/500)*
5. Parent training and education on issues such as behavior management, sexuality, transition services, and personal care. *(100/150)*
6. One-on-one staff support and transportation services for individuals in existing recreational and summer camp programs. *(5/15)*
7. Funding for necessary evaluations (e.g., psychological and psychosocial) to determine eligibility for OMRDD services for individuals without Medicaid. *(100/400)*
8. In-home residential habilitation for individuals of all ages. *(50/384)*

III. LOCAL GOVERNMENT INITIATIVES

Collaboration with the Federation Borough Councils to Address Service Gaps

DMH meets regularly with the Federation's MR/DD Borough Council Chairs to discuss concerns and critical issues they face as family members, consumers and providers of MR/DD services. This year DMH asked the Council Chairs to identify three priority concerns where local government could have substantial impact. Consensus was quickly reached and the following priority concerns were identified:

- Increase psychiatric inpatient capacity and acute psychiatric care alternatives for adult and child/adolescent populations with MR/DD who are suffering from an acute mental illness
- Increase access to alcohol and substance abuse treatment for adults with MR/DD
- Improve the transition of MR/DD consumers who are aging out of the public school system into the adult services system at ages 18-21

Workgroups comprised of Federation Borough Council members and DMH staff were established in the late fall of 2004 to develop recommendations and actions to take in each of these areas. The following sections describe their progress to-date.

Increase Psychiatric Inpatient Capacity and Acute Psychiatric Care Alternatives for Individuals with MR/DD

This workgroup is focusing on increasing access to psychiatric services for adults who are dually diagnosed with MR/DD and mental illness (MR/DD-MI), and is looking toward developing the same opportunities for children/adolescents. It set out to explore best-practice service models and develop recommendations for creative service planning strategies that are both programmatically and financially effective in addressing the needs of this population.

There is limited information available to assess the need for acute psychiatric services for those with MR/DD-MI. Utilization data from a New York State Department of Health study in 1997 indicated that between 2-3% of people admitted to acute psychiatric units in NYC had a diagnosis of MR, representing about 1,000 admissions annually.² Additionally, data extracted from the New York State Department of Health's Statewide Planning and Research Cooperative System (SPARCS) database indicated that there were 2,076 admissions in 1998 with MH/MRDD and/or SA/MRDD diagnoses in all NYC Hospitals.³ What these data do not describe is those who were in need, but unable to access inpatient psychiatric services.

While the issue of mental illness in individuals with MR/DD has been recognized since the 1950's, the development of mental health treatment services for individuals with MR/DD-MI has lagged behind those developed for the general population. In the 1980's OMRDD developed specialty clinics (under Article 16) to address the medical and mental health issues of the MR/DD-MI population, but these clinics provide only outpatient services. This leaves acute care services to the hospitals, which are typically not equipped to effectively manage the specialized needs of the MR/DD population. Currently, there are only two acute inpatient units available to NYC residents that specialize in treating individuals with MR/DD-MI. One is at St. Mary Immaculate Hospital in Queens, which allocates half of its 21-bed inpatient unit to treat this population. These beds are typically filled to capacity, with an average length of stay of 21 days. The other option is St. Vincent's Hospital in Westchester, which has a 26-bed unit for specialized psychiatric inpatient services. Since 2004, this unit has served approximately 173 individuals with MR/DD-MI.

Through its research, the workgroup has identified two major barriers to providing appropriate psychiatric care to individuals with MR/DD. One, specific programming and higher staffing levels are needed to provide the higher level of care required by this population. Two, individuals with MR/DD-MI sometimes present special dispositional issues, which result in longer lengths of stay. They may be unable to return to their families from the hospital, or are sometimes unable to return to their community residences. Because reimbursement rates drop significantly for patients who are stabilized but awaiting community placement, this creates a financial disincentive for hospitals to serve these people, and ties up acute care beds that are needed by others.

² Lahrer, S., Greene, E., Browning, C., & Lesser, M. (1999). Do Individuals with Dual Diagnosis Admitted to Acute Psychiatric Hospitals Require More Service and Stay Longer? *Dual Diagnosis and Acute Psychiatric Hospitalization*, 1-8.

³ People with a dual diagnosis of DD and mental health disorder and/or substance abuse disorder were treated on an acute care psychiatric unit according to the SPARCS data and differential data was not available.

The workgroup has developed and is pursuing the following recommendations:

- Create/expand specialized acute services for the MR/DD-MI population citywide to create a continuum of acute psychiatric care, ideally in each borough. This continuum would include three types of services, which would facilitate transition from one level of care to the next:
 - Specialized hospital inpatient services.
 - Community-based crisis residences that admit acutely ill patients, as well as those “stepping down” from inpatient care.
 - Day hospital – the workgroup is considering a day hospitalization model demonstrated to be effective by McLean Hospital in Massachusetts. It is a highly structured day program that follows a combined behavioral and medical model and includes comprehensive cognitive and behavior therapeutic programming.

The workgroup plans to develop staffing and budget models for these three program types

- Estimate the number of treatment openings needed throughout NYC in order to assess current service needs and trends for more focused service planning. This will be accomplished through an analysis of in-patient data extracted from the SPARCS database from 1999 to 2004.
- Develop and provide cross-training for both mental health and MR/DD providers in the identification and referral of individuals with MR/DD-MI.

In support of these recommendations, MR/DD Borough Councils have included service priorities in this year’s Plan that relate to these recommendations.

Increase Access to Alcohol and Substance Abuse Treatment for Adults with MR/DD

Investigators have mixed views on the prevalence of chemical dependence (CD) among adults with cognitive disabilities (specifically MR), some noting that the rate of CD might be lower than in the general population and others suggesting that it may be the same.⁴ DMH estimates that approximately 119,000 non-institutionalized New Yorkers have MR or DD with impairment, or both, of which 48,000 (12,000 MR only) are age 18+.⁵ With the national prevalence rate for adults with CD being 6-8%⁶ and the one-year prevalence rate in NYC for 2000 estimated at 11.5%⁷, there could be as many as 5,520 adults with DD (1,380 with MR only) who need CD treatment in NYC.

⁴ Longo, M.D., Lance, P. (1997). Alcohol Abuse in Individuals with Developmental Disabilities. *The Habilitative Mental Healthcare Newsletter, Mental Health Aspects of Developmental Disabilities*, 16(4), 61-64; National Institute on Alcohol Abuse and Alcoholism: Social Work Education for the Prevention and Treatment of Alcohol Use Disorders. (October 2004) Module 101: Disabilities and Alcohol Use Disorders.

<http://www.niaaa.nih.gov/publications/Social/Module101Disabilities/Module101.html>

⁵ Wunsch-Hitzig, R., Engstrom, M., Lee R., King, C. & McVeigh, K. (2003). *Prevalence and Cost Estimates of Psychiatric and Substance Use Disorders and Mental Retardation and Developmental Disabilities in NYC*. New York: New York City Department of Health and Mental Hygiene, Division of Mental Hygiene, Bureau of Planning, Evaluation, and Quality Improvement.

⁶ Burgard, J., Donohue, B., Azrin, N. & Teichner, G. (Sept 2000). Prevalence and Treatment of Substance Abuse in the Mentally Retarded Population: An Empirical Review. *Journal of Psychoactive Drugs*, 32(3), 293-298.

⁷ Wunsch-Hitzig, R., Engstrom, M., Lee R., King, C. & McVeigh, K. (2003). *Prevalence and Cost Estimates of Psychiatric and Substance Use Disorders and Mental Retardation and Developmental Disabilities in NYC*. New York: New York City

MR/DD Borough Council provider Co-chairs reported that their agencies frequently encounter individuals with MR/DD in need of specialized CD treatment services. To help quantify the need for CD services in the MR/DD community, two MR/DD service provider members of this workgroup, the Association for the Help of Retarded Children (AHRC) and the Young Adult Institute (YAI), gathered program data for the workgroup. AHRC currently provides the only outpatient program dedicated to individuals who are MR/DD and need sobriety services. They serve 150 consumers with MR annually through their sobriety services. However, a cohort of these individuals does not benefit from outpatient treatment and requires residential treatment. YAI's and AHRC's records indicate that up to 23 identified individuals with MR/DD needed and were not receiving residential detoxification services in 2004. These numbers, even for just two providers, are low, as consumers who could benefit from residential treatment sometimes end up in the inpatient hospital setting, the forensic justice system or inappropriately placed in other programs because of a lack of appropriate services. Yet they substantiate that there is unmet need for residential detoxification, a need that is no doubt significantly larger citywide.

Chemical dependence treatment options in NYC geared towards individuals with co-occurring MR/DD and CD (MR/DD-CD) are extremely limited. An appropriate service array should include outpatient treatment, inpatient detoxification, 28-day rehabilitation, 6-month residential and 18+ month residential programs, which vary in intensiveness and service configuration based on the needs and abilities of the consumer. Currently, there is one long-term (18+ month) residential treatment program, located in Poughkeepsie, NY, that routinely accepts men from NYC who have co-occurring MR/DD-CD needs. There are no NYC-based residential detoxification programs (28-day or 6-month) for this population, and although inpatient detoxification services (5-7 days) can be accessed at local hospitals, they are typically not equipped to work effectively with individuals with MR/DD.

There are many barriers to the treatment of individuals with MR/DD in traditional alcohol and substance abuse settings, or even in MICA programs, whose programs are focused on individuals dually diagnosed with mental illness and chemical addiction. Factors impacting treatment that require special programs include characteristics of individuals with MR/DD -- expressive and receptive language deficits, inability to comprehend abstractions, low frustration tolerance, deficits in making sound judgments, and multiple-diagnoses (it is estimated that between 40-70% of individuals with MR/DD have a psychiatric diagnosis⁸) --; lack of training for CD professionals on the unique needs of people with MR/DD; and the inability of MR/DD service providers to identify substance abuse and make appropriate referrals.

As it is difficult to develop new treatment capacity, the workgroup decided to focus on improving the competence of select existing CD providers in order to provide treatment for individuals with MR/DD-CD. The specific goals are to:

- Recruit a limited number of CD treatment providers to effectively serve individuals with MR/DD, provide training for them, and develop and distribute a preferred referral list of these providers in each borough.

Department of Health and Mental Hygiene, Division of Mental Hygiene, Bureau of Planning, Evaluation, and Quality Improvement.

⁸ Phillips, M. G. (2004). An Outpatient Treatment Program for People with Mental Retardation and Substance Abuse Problems. *The NADD Bulletin*, 7(1).

- Train MR/DD providers in the identification of CD problems, and in following through on finding appropriate placements for consumers who need treatment.

The workgroup is focusing first on engaging CD providers who currently serve individuals with CD who are also mentally ill, since they already work with a dually diagnosed population. The workgroup intends to provide training to enable these CD providers to address the specialized needs of consumers with MR/DD. The training sessions will include information about the most effective therapies for individuals with MR/DD-CD, such as the need for higher intensity services like smaller group settings, one-on-one individual coaching and slower paced, more concrete therapy, as well as modified cognitive-behavioral models, which research suggests can be effective with the co-occurring MR/DD-CD population.⁹ Ideally, these training sessions will provide OASAS Certified Alcohol and Substance Abuse Counselors (CASAC) with credits toward renewing their certification.

Over the next several months, the workgroup plans to: follow-up with three providers who have expressed interest in providing long-term residential treatment to the MR/DD-CD population; reach out to try to recruit additional CD providers for 28-day rehabilitation services; schedule site visits so interested CD providers can see how AHRC's program serves this dually diagnosed population; implement training sessions for both CD and MR/DD providers; and develop and distribute the list of preferred referral sources. In addition to these efforts to improve the ability of existing CD treatment services to address the needs of the MR/DD-CD population, MR/DD Borough Councils have included service priorities in this year's Local Plan that seek to increase treatment capacity for individuals with co-occurring MR/DD-CD.

Improve Transition from the Department of Education to Adult MR/DD Services

Parents and providers alike have expressed concerns about the process of transitioning young adults, ages 18-21, from the Department of Education (DOE) to the adult MR/DD service system. Transition services, as stipulated in the Federal Individuals with Disabilities Education Act (IDEA), are a coordinated set of activities for a student with a disability, designed to promote movement from school to post-school activities, including but not limited to post-secondary education, vocational training, integrated employment, independent living or community participation.¹⁰ The IDEA requires that beginning at age 14, and updated annually, each student's Individualized Education Program (IEP) includes a statement of the transition service needs of the student.¹¹ Success in the development and implementation of an effective transition plan requires well-coordinated collaboration between DOE, the student, parents, teachers, and service providers. According to parents and providers, DOE is providing the basic transition services in accordance with its legal mandate, but these services are far from adequate in addressing students' and families' needs.

The workgroup on transition planning has as its members: parent advocates, voluntary non-profit providers, representatives from DMH, the Federation Borough Councils, OMRDD, DOE, and

⁹ Burgard, J., Donohue, B., Azrin, N. & Teichner, G. (Sept 2000). Prevalence and Treatment of Substance Abuse in the Mentally Retarded Population: An Empirical Review. *Journal of Psychoactive Drugs*, 32(3), 293-298.

¹⁰ 20 U.S.C. § 1401(30); 34 C.F.R. 300.29

¹¹ It should be noted that the IDEA is currently under review; one item being considered is changing the starting age for transition planning from 14 to 16.

Vocational and Education Services for Individuals with Disabilities (VESID). It was convened to develop a problem statement and potential solutions to be shared with DOE for consideration. To estimate the scope of the issue, the group gathered what data are currently available. The total public school register for 2004-2005 is 1,075,338; 158,193 of these students are receiving special education services (includes all disabilities).¹² The majority of special education students who meet the criteria for MR/DD, are served in District 75 schools, the DOE district dedicated to serving children with severe disabilities. Data regarding 2005 projected needs of District 75, which serves 22,603 students in need of special education services, estimate that 392 individuals want to transition to OMRDD-funded adult day services, and that an additional 185 will transition to VESID for Supported Employment and Vocational Training (note that some of these latter students may not be eligible for OMRDD services). Projections for 2006 indicate 444 transitioning to OMRDD-funded and 213 to VESID-funded services. Data were unavailable for those children transitioning out of special education services in regular or alternate high schools. Each of these students should also be receiving or already have received transition planning services to ensure that all on-going service needs are met in an adequate and timely fashion.

The workgroup identified several barriers to effective transition planning. Many parents do not understand the importance of getting involved early on in the process to ensure that their children receive needed services after leaving school, because DOE is responsible for these students until they reach transition age. Yet early participation by all parties, especially parents and teachers, is critical to the process. Another set of difficulties relates to evaluations. The evaluations conducted by DOE lack certain components that OMRDD requires for determining service eligibility, including IQ scores, psychological or psychosocial evaluations, and proof of the existence of MR/DD and age of onset. To obtain these required components, students are often sent to clinics or private practitioners, where families must pay expensive fees. Additionally, there are often long waiting periods, which cause some students to have to stay at home for extended lengths of time after graduation. Another problem is inadequacy of the various data tracking mechanisms related to transition services. They are neither well coordinated nor comprehensive enough to meet the needs of those doing transition planning. Finally, there is insufficient transition planning and limited availability of post-school services for those individuals who need and use special education services, but do not qualify for OMRDD-funded services.

To address these issues, the workgroup has developed the following preliminary recommendations:

- Improve parent, student and teacher education/involvement in the transition process:
 - Increase outreach to parents in the form of career/transition fairs, Parent Teacher Association (PTA) presentations, and user-friendly handbooks and resource guides, including an on-line resource guide.
 - Involve parents earlier in the process so that transition planning happens in a timely fashion and so parents take on the more active role necessary to ensure adequate service provision from OMRDD.
 - Increase the number of DOE Transition Coordinators to assist in the process and ensure that sufficient funds are allocated to transition activities.

¹² Department of Education Website <http://www.nycenet.edu/offices/stats/default.htm>

- Educate DOE staff about the MR/DD service system so they can effectively contribute to transition planning.
- Improve the evaluation process:
 - Encourage families, through various outreach methods like PTA presentations and resource guides, to apply for a Medicaid Service Coordinator early in the process so they have an advocate to assist with evaluations and transition planning.
 - Involve MR/DD service providers in the process by inviting them to outreach activities and annual IEP meetings; it is in the interest of providers with vacancies to assist DOE in completing evaluations and ensuring that their referral process is user-friendly.
 - Encourage DOE to consider revising its evaluation process so it meets OMRDD's requirements for eligibility determinations.
 - Urge DOE to implement uniform requirements for tracking and storing data regarding evaluations.
- Develop a comprehensive data tracking system. Workgroup members recommend a data tracking system that can track the following information:
 - Students who need services.
 - Students who transition into adult services.
 - Retention/outcomes of individuals placed in adult services.
 - Students who drop out of the system or are not able to access services.
- Additional Recommendations:
 - Develop more appropriate services (i.e., housing, recreation, education and support) and employment opportunities for students who are leaving the DOE system, especially those who do not qualify for OMRDD-funded services.
 - Revise the IEP forms used by transition teams to be more meaningful, practical and less abstract, so they can better facilitate the transition process.
 - Develop a citywide transition committee, which includes the agencies providing services for transitioning students (DOE, DOHMH, OMRDD, VESID, Department of Labor, and voluntary service providers). This committee will help develop and coordinate effective transitioning to appropriate adult services.

Over the next several months the workgroup plans to further develop these preliminary recommendations; once finalized, they will be presented to the Department of Education for consideration.

Continuous Quality Improvement Initiative: Quality IMPACT

In 2004, DMH launched a multi-year quality improvement initiative called Quality IMPACT (Improving Mental Hygiene and Communities Together). The initiative, which includes the broad participation of stakeholders, introduces and supports within individual programs a data-driven, continuous quality improvement (CQI) process that will incrementally move the mental hygiene system toward more effective services, better outcomes, and the integration of evidence-based and innovative practices.

DMH, in consultation with national experts and the NYC MR/DD community -- consumers, families, providers and advocates -- developed three MR/DD CQI activities for FY05. One was a priority project designed for MR/DD clinics to improve the identification of mental health problems in children. Another was an option of an independent project, also intended to improve an aspect of service delivery identified by the clinic. Throughout the year, DMH guided and supported all of the various clinic projects. DMH also implemented a consumer perceptions of care survey in two types of MR/DD work programs: transitional employment and work readiness.

Improving Identification of Mental Health Problems in Children

The aim of this project was to better identify and refer for treatment MR/DD children who have co-morbid mental health problems. The project was designed to screen all newly evaluated children (ages 4-18) in MR/DD clinic settings for likely mental health problems and to refer those children who screen positive for further evaluation and treatment, if necessary. The screening tool used in this project was the 35-item Pediatric Symptom Checklist (PSC), which has been validated and widely used in a general pediatric population. Parents/caregivers completed the screen and discussed their responses with clinical staff.

Seven MR/DD clinics participated in this CQI project. Over the nine-month course of this project, 1,192 of the 1,423 newly evaluated children (83%) were screened using the PSC and about half of those screened (56%) were referred for further evaluation. Feedback from participating programs and families suggest that the screen:

- Was an effective tool in helping to identify mental health problems in children.
- Provided a comfortable means for clinicians to engage parents/caregivers in discussing their children's possible mental health needs.
- Enriched the mental health assessment process by engaging parents/caregivers early in the intake process.
- Helped clinics in providing more effective services by targeting their clinical resources to those children most in need.
- Was readily incorporated into the intake process.

Prior to the start of this CQI project, anecdotal data suggested that obtaining needed psychiatric evaluations for MR/DD children was no easy task. The project confirmed this concern. The project required that follow-up calls to check on the status of mental health assessments be made within 75 days after making a referral. Almost all (95%) these calls were made. However, even after 75 days, only about half (52%) of the evaluations had been completed. (The experiences of clinics varied significantly, from 39% of evaluations completed to 100% completed.) Yet, the importance of these evaluations was also made clear from the project data: of those children who had completed evaluations, the majority (82%) was deemed to need mental health services.

The difficulty experienced by clinics in obtaining evaluations, and the high rate of mental health service need among those who were evaluated, points to a systemic problem that merits attention. DMH needs to better understand the obstacles to obtaining completed evaluations, and to examine the strategies utilized by those clinics that had greater success in accessing

evaluations for referred children. DMH is committed to continuing to work with clinics, problem-solve around the obstacles and share effective strategies with all clinic providers.

Based on their experiences this past year, all 7 participating programs decided to incorporate this screening and referral project into their regular operations in a manner that meets theirs and their clients' specific needs. During FY06 these clinics will be implementing independent projects that are designed to address other quality improvement opportunities. Five clinics intend to improve access to services and retention rates. One clinic will work on improving the identification of chemical dependence issues in its consumer population. And, another clinic will work on improving treatment outcomes by engaging with other agencies in better coordination of care. DMH intends to continue to guide and support these programs in their new projects.

Independent CQI Projects

During FY05, three MR/DD clinics chose to design their own CQI projects. DMH worked with each of these clinics to meet their project goals.

One clinic instituted a screening process to improve the identification and care of adult consumers with Alzheimer's disease or dementia. As a result of this project, the clinic is developing a day program specifically aimed at meeting the needs of this special population.

Another clinic designed a project to improve consumer care by encouraging medical providers to respond more frequently and promptly to requests for information. Not only is this clinic continuing to reach out to medical providers, but it has begun to integrate the medical information that is being provided more effectively into treatment planning.

The third clinic worked toward improving the psychiatric referral rate of those adult consumers who were identified as having a mental illness, particularly a mood or anxiety disorder. In response to their finding that clinical staff needed to be better educated about the treatment needs of this special population, the clinic has increased staff training.

The first two clinics are continuing on with their projects, and expanding their scope for FY06. The third clinic intends to work on a new independent project that is designed to improve the no-show rates of children and their families at appointments for psychological assessments.

The Consumer Perceptions of Care Survey for MR/DD Work Programs

The primary purpose of this survey was to give MR/DD consumers a voice in improving the quality of the services that they receive and to identify service areas that may benefit from further attention.

DMH developed the survey through an iterative process that included in-depth reviews of the survey literature, pilot testing of different versions of the survey and significant feedback from MR/DD stakeholders. The final FY05 version of the survey focused on four areas of interest: quality and appropriateness of services, consumer reported outcomes, training satisfaction and job satisfaction (in transitional employment programs only).

In the fall of 2004, Division staff conducted face-to-face interviews with consumers at their program sites. Spanish-speaking interviewers were available as needed, as were advocates who were there to help consumers feel more comfortable with the interview process. Sixteen work readiness and two transitional employment programs participated in the survey. In all, Division staff conducted 305 consumer interviews, which represented 78% percent of the 392 consumers enrolled in the participating programs during the interview period.

Participating programs have received individualized reports of their survey findings. Each report presented the program’s own performance ratings and, for comparative purposes, the average performance ratings across all programs (presented in chart below). Providers were encouraged to share their reports with staff and use the information to target areas for improvement.

Survey results suggest that the majority of consumers have positive feelings about the services that they receive. They:

- Express satisfaction with the quality and appropriateness of services.
- Believe that because of the services they receive they can do more things on their own.
- Express satisfaction with the quality and amount of training offered to them.

However, consumers also voiced a need for some improvement in the scope of choices offered to them, in relating what they learn in training to their needs on the job, and in reaching their goals.

Summary Results of MR/DD Consumer Perceptions of Care Survey

| | Average Scores Across All Programs | Average Rates of “Yes” Responses Across All Programs |
|---|---------------------------------------|--|
| <u>Quality/Appropriateness of Services</u> | | |
| 1. Is the staff here nice to you? | 2.96 | 96.3% |
| 2. Does the staff like to hear what you think? | 2.85 | 87.6% |
| 3. Does the staff here let you decide things for yourself? | 2.74 | 81.8% |
| 4. If you have a problem, does someone here at this program help you fix it? | 2.90 | 93.7% |
| 5. Do you feel safe when you are at your program? | 2.93 | 94.3% |
| <u>Consumer Reported Outcomes</u> | | |
| 1. Have you reached your goals at this program? | 2.09 | 33.1% |
| 2. Since coming to this program can you do more things on your own? | 2.79 | 85.9% |
| 3. Have you learned any new things at this program that will help you with working? | 2.49 | 68.4% |
| <u>Training Satisfaction</u> | | |
| 1. Do you get to choose what kind of training you do at your program? | 2.06 | 48.2% |
| 2. Do you like being in this training? | 2.80 | 85.2% |
| 3. Are you happy with how much training you are getting now? | 2.80 | 86.0% |
| 4. Do you like this program? | 2.87 | 91.4% |

Notes:

1. One of the eighteen programs yielded unusable surveys and, therefore, its 10 consumers are not included in the findings.
2. Two measures of consumer perceptions are presented: the average response score across programs (response options were yes=3, sometimes =2 and no = 1); and, the average rate (expressed as a percentage) of “yes” responses across programs. Higher scores and rates indicate more positive perceptions of care.
3. In keeping with DMH policy not to make public the data of individual clinics during the first year of the survey, the average program responses on the job satisfaction questions, which included consumers from only two transitional employment programs, are not presented above. The job satisfaction questions, which were similar to the training satisfaction questions, also showed that lack of choice was a concern of many consumers.

DMH is in the process of further refining the FY05 version of the consumer survey. Modifications, which will be included in the FY06 survey, will reflect changes suggested by this past year's survey participants. DMH is also working on changes to its survey implementation plan that should improve even further its already high response rate of 78%.

In FY06, DMH intends to expand the survey to include day training and day treatment programs. Workgroups of providers, consumers, families and advocates have already begun working with DMH staff to create a new consumer survey that pays particular attention to the unique communication needs of these consumers, some of whom are nonverbal. Because families/caregivers play a significant role in caring for these consumers, the workgroups are developing a separate survey for families/caregivers.

Looking ahead, DMH intends to conduct perceptions of care surveys annually. Therefore, not only will participating programs be able to monitor the improvements they make in response to consumer concerns, but in addition, DMH will be able to use the data from these annual surveys to inform its planning and evaluation activities.

Unmet Service Needs of NYC Foster Care Children

One of the Division of Mental Hygiene's ongoing key priorities will be to continue to engage in inter-agency planning and collaboration with the New York City Administration for Children's Services (ACS) regarding the unmet needs of children with mental retardation, a developmental disability, or both, who are in the City's foster care system. We have met with ACS during the past year and offered assistance to them on their survey of 53 foster care agencies operating in New York City in January 2005. The goal of the survey was to identify children eligible for OMRDD services, but not yet on the waiting list for residential placement. The number of children in foster care at the time of the survey was 18,826. Although not all agencies responded to the survey, those who did identified over 200 children who have mental retardation or developmental disabilities and were not receiving OMRDD services, nor were on a waiting list for placement. The foster care agencies noted 50 children were reported to have mental retardation, 25 were developmentally disabled and 49 had both mental retardation and developmental disabilities.

ACS has reported that at the time of this plan 94 children in New York City foster care are awaiting placement in OMRDD facilities. An additional 56 children are at various stages in the OMRDD application process.

Over the coming year, we plan to continue to work with ACS to identify unmet need for non-residential services (i.e., day and family support services). We also plan to assist ACS in their efforts in the early identification of MR/DD children entering the foster care system by creating training guidelines for foster care agency staff and ACS nursing staff who perform pre-placement medical screenings to identify children with mental retardation and developmental disabilities.

This work will also entail implementing the requirements of the Federal Child Abuse Prevention Act (CAPTA), which requires that infants and toddlers "involved in substantiated child abuse or neglect" are screened for eligibility for Early Intervention Services under Article 25 of the Public Health Law.

Foster children are currently deemed ineligible for an array of specialized services available through the MR/DD Home and Community-Based Services Waiver program which enables children to stay in home settings and avoid residential placement. Given the importance of providing services for all children in the least restrictive setting possible, we also call for OMRDD to make Home and Community-Based Waiver Services and Family Support Services available to the children with MR/DD in foster care and their caregivers.

IV. COMMENTS ON NYC OPTIONS FOR PEOPLE THROUGH SERVICES

The Options for People Through Services (OPTS) initiative, which is being implemented throughout NY State by OMRDD, utilizes an organized service delivery approach and a flexible funding methodology to promote increased choice and individualization of services for persons with MR/DD. In NYC, implementation of OPTS is still in its preliminary stages; to-date only one City proposal, in Staten Island, has been approved. Nonetheless, comments from NYC MR/DD stakeholders regarding OPTS are included in the Plan because it is a required section. OPTS was discussed at each of the MR/DD borough planning meetings and the comments are summarized below.

Overall, stakeholders are hopeful about the innovative service opportunities that this new funding mechanism will make possible. They look forward to the approval of more NYC proposals. Features of OPTS that are perceived as most promising by NYC stakeholders include the focus on consumer choice and individualized planning, the strong family involvement, and the flexibility afforded to providers in utilizing new service models and creative programming to address unmet need. Stakeholders' interest in seeing OPTS promote innovative service development in NYC was evident in the discussions, which often led to creative brainstorming about possible OPTS proposals. Similarly, OPTS was often mentioned as a way to meet some of the service needs discussed during the priority setting portions of these local planning meetings.

A few concerns were noted, mostly related to process. Stakeholders expressed frustration with the extensiveness of the application process, particularly the lengthy review and approval process. One specific issue frequently mentioned is the difficulty of accomplishing the consumer verification requirement, especially given the typically long time period between program development and when verification must happen. NYC stakeholders hope to see an expedited process so that many more individuals and families will be able to receive improved services through OPTS.

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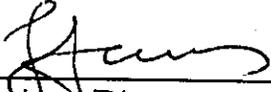
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VI. ASSURANCES

01 Assurance

Pursuant to Article 41 of the Mental Hygiene Law, and as Director of the Local Government Unit, I hereby assure and certify that directors of district developmental services offices, directors of community mental health centers, voluntary agencies, other providers of services, and consumers and consumer groups have been formally invited to participate in, and provide information for, the local planning process relative to the development of the 2005 Local Services Plan.

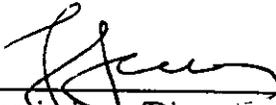
7/27/05
Date


Commissioner/Director
Local Government Unit

02 Assurance

Pursuant to Article 41 of the Mental Hygiene Law, I hereby assure and certify that the Community Services Board has provided advice to the Director of Community Services and has participated in the development of the 2005 Local Government Plan. Additionally, I assure and certify that the full Board has had an opportunity to review and comment on the contents of the plan and has received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed with procedures outlined in the Mental Hygiene Law 41.16(c).

7/15/05
Date


Commissioner/Director
Local Government Unit

04 Assurance

Pursuant to Article 41 of the Mental Hygiene Law, I, as Chairperson of the Subcommittee for Mental Retardation and Developmental Disabilities, assure and certify that the Subcommittee for Mental Retardation and Developmental Disabilities has provided advice and input to the Community Services Board and to the Director of Community Services relative to the development of the 2005 Local Services Plan as such relates to the field of services for those individuals represented by this subcommittee.

Additionally, I assure and certify that the Subcommittee has had an opportunity to review and comment on the contents of the plan and has received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16(c).

July 22, 2005

Date

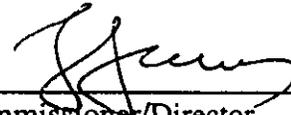
DR. Jim Norwalk
Chairperson
Subcommittee for MR/DD

05 Assurance

I assure and certify acknowledgement and compliance with the following: The information made available for the development of the Local Government Plan and its constructs includes confidential information concerning individuals served or proposed to be served by OMRDD or approved providers. Confidentiality is required by Mental Hygiene Law Section 33.13. The law prohibits one from making any further disclosure of confidential information unless disclosure is made pursuant to the provisions of Section 33.13.

7/15/05

Date



Commissioner/Director
Local Government Unit

06 Assurance

On behalf of the Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities, I, as director of the DDSO assure and certify that the development process and content of the 2005 Local Government Plan for _____ are in compliance with the requirements of Article 41 of the Mental Hygiene Law, and that they indicate that reasonable and appropriate efforts are being made to extend or improve local mental retardation and developmental disabilities services in accordance with Statewide priorities and goals.

Date

DDSO Director for:

_____ DDSO