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# **CHILDREN IN BROOME COUNTY WITH CO-OCCURRING MENTAL HEALTH AND DEVELOPMENTAL DISABILITY CONDITIONS**

## **SUMMARY OF STRATEGIC PLANNING SESSION TO ESTABLISH COMMUNITY PRIORITIES AND IMPLEMENTATION ACTION PLAN**

Prepared for:  
**Broome County Children's Mental Health Task Force**

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## INTRODUCTION AND CONTEXT

The Broome County Children’s Mental Health Task Force is a coalition of local agencies and individuals concerned about the lack of adequate services for children and adolescents with mental health conditions who also have or are considered likely to have developmental disabilities. The Task Force requested CGR (Center for Governmental Research Inc.) to conduct a needs assessment in 2005 to determine the numbers of such children and the extent of gaps in services for this population.

Previous studies and considerable anecdotal information have suggested that numerous children and adolescents in Broome County have co-occurring mental health and developmental disability conditions. In particular, in a July 2002 “Visioning Project” report for the Broome County Mental Health Department, CGR concluded that “There are many cross-systems children with mental health issues not being adequately addressed (their own or, in many cases, their family’s).” More specifically, the report noted that “some estimate that perhaps a couple hundred MRDD children and adolescents need crisis care and support during a year, but don’t receive mental health services.” Moreover, that report added that many family-related problems caused by the stresses often don’t get addressed.<sup>1</sup> However, beyond those broad estimates, no one at that time had reliable data on the true magnitude of the numbers of co-occurring MH/MRDD children and families affected, or the gaps in services for this population.

The Mental Health Task Force concluded that the key first step in improving services for this population was to obtain better empirical estimates of the numbers of children with co-occurring conditions. In order to move the issue forward, the Task Force requested CGR to quantify the numbers of affected youth and any service gaps more precisely than anyone had been able to do previously. Following extensive analyses of survey and other data, CGR concluded, in its report issued in November 2005,<sup>2</sup> that there were about 500 children in Broome County with co-occurring mental health and developmental disability conditions who had been identified and were receiving some services from MH and DD service providers in the county during 2004 and early 2005. Of those, an estimated 300 children had at least some unmet service needs due to service gaps and difficulty accessing needed services in one or both of the MH and DD service systems. Major perceived service gaps were also identified.

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<sup>1</sup> See CGR, *Broome County Visioning Project for Children and Adolescents: An Assessment of What Exists and Service Gaps*, July 2002. See especially pp. 82-84.

<sup>2</sup> See CGR, *Children in Broome County with Co-Occurring Mental Health and Developmental Disability Conditions: Numbers and Service Gaps*, November 2005.

In addition to documenting the numbers of young people in the county with co-occurring conditions and unmet service needs, the CGR report made 15 recommendations for state and local consideration and action. Two of those focused on the need for the establishment of a strategic action planning process to review the report and its recommendations, and to develop a process and action plans in response to the report:

- ❖ An action planning process should be convened by the Broome County Mental Health Commissioner, including representatives from the County Children’s Mental Health Task Force and high level officials from the county’s MH and MRDD service providers and advocacy groups, to develop specific short-term and longer-term action and implementation plans in response to the report.
- ❖ The next step in the process should include making arrangements as soon as possible for a strategic planning “visioning day” with key stakeholders to prioritize and expand on these recommendations, establish goals and action plans, and determine subsequent actions and timelines.

Accordingly, Arthur Johnson, the County’s Mental Health Commissioner, and Maria Dibble, Executive Director of the Southern Tier Independence Center and Chair of the Children’s Mental Health Task Force, jointly convened a “Strategic Planning Session for Children with Co-Occurring Mental Health and Developmental Disability Conditions.” That session took place on Friday, February 3, 2006. It was scheduled from 10am to 4 pm.

According to the letter of invitation, invited to the strategic planning session were the chief executive officers and key “administrative staff from all the agencies in Broome County that serve children with either mental health or developmental disabilities or both.” The focus of the session was “to review the list of recommendations and barriers identified in the CGR report We will then prioritize short term and long term strategies to improve our community’s response to these children and their families.”

This brief report summarizes the discussions that took place at the February 3 strategic planning session, the outcomes of those discussions, and the next steps that have been agreed upon. As such, this report should be viewed as a companion document to supplement the initial November 2005 CGR report. The proposed priorities and action plan summarized in this document move the CGR report and recommendations into the critical action/implementation phase of this ongoing project, lay out an agenda for change and improvement of services for an underserved subset of children and adolescents in Broome County, and provide a benchmark and reference point against which the community should judge the progress over time toward implementation of the recommendations, priorities and plan for the future.

## **AGENDA AND ATTENDANCE : FEBRUARY 3, 2006 STRATEGIC PLANNING SESSION**

### **Agenda**

The order of the initial agenda was as follows:

Welcome and Introductions

Project Overview: Summary of Process, Findings and Recommendations

Clarification and Overview of Recommendations

Process for Determining Priorities

Lunch

Selection of Short-Term and Long-Term Priorities

Discussion of Priorities and Establishing Work Groups

Wrap-up and Next Steps

### **Attendance**

Those in attendance were:

Carol Aronowitz, Managing Director, Children's Home of Wyoming Conference

Tonya Brown, Children and Youth Services Division Director, Catholic Charities

Stephanie Campbell, Deputy Director, Broome Developmental Disabilities Service Office (DDSO)

Lizanne Clifford, Director of Children and Family Services, Mental Health Association of the Southern Tier; Parent

Terry Cole, Dual Recovery Coordinator, Broome County Mental Health Department

Thomas Creagh, DDPS IV, Broome DDSO

Linda Daly, Nurse Manager, CPEP, Binghamton General Hospital

Maria Dibble, Executive Director, Southern Tier Independence Center

Casey Epe, Executive Director, Mental Health Association of the Southern Tier

Nicki French, Director of Support Services, Mental Health Association of the Southern Tier; Parent

Bette Gifford, Youth Services Director, Lourdes

Fran Hall, Residential Services Division Director, Catholic Charities

Arthur Johnson, Broome County Commissioner of Mental Health and Social Services

Stephen Lisman, Director Psychological Clinic, Psychology Department, Binghamton University

Patricia Macumber, Director of Adult and Family Services, Broome County Department of Social Services

Patricia McDonnell, Director, Broome DDSO

Karry Mullins, Co-Director of Special Services, Binghamton School District

JoAnne Novicky, MSC Supervisor, Southern Tier Independence Center

Robert Russell, Psychologist, Broome County Mental Health Department

Renee Spear, Executive Director, Community Options, Inc.

Mary Jo Thorn, Executive Director, Broome-Tioga ARC  
Sue Tiffany, Administrator, Broome-Tioga BOCES  
Casey Truillo, CCSI Coordinator, Catholic Charities; Parent  
Cynthia Voce, Psychologist, Handicapped Children's Association  
Renee West, Family Services Supervisor, Broome County Probation Department  
Cathy Williams, Executive Director, Family and Children's Society  
Brenda Zeoli, Mental Health Program Coordinator, Broome County Mental Health Department

Donald Pryor, Director of Human Services Analysis, CGR – group facilitator

## **Project Overview**

Don Pryor presented an overview of the project, including the process, major findings and conclusions, and recommendations. A copy of the PowerPoint presentation is presented in the Appendix.

## **Discussion of Findings**

Before discussing the specific recommendations, there was a brief discussion by the group of the perceived reasons why the estimated 300 children and adolescents with co-occurring MH and DD conditions were not receiving adequate services. The group suggested a number of reasons and concerns, including:

- Insufficient access to services;
- Insufficient awareness of services, and who is eligible for them, by both professional service providers and parents;
- Often in the MH system, if a developmental disability is suspected, the process stops, with no comprehensive evaluation, so actual service needs are often not explored beyond that;
- MRDD system typically doesn't provide emergency crisis services;
- Lack of adequate diagnoses/assessment of needs within both service systems;
- MH service providers often assume the MRDD system is all-encompassing and provides full range of services, which is often not the case;
- Funding barriers.

The bottom line consensus was summarized as follows: the precipitating factor behind the study, which was basically confirmed by the findings, was that significant numbers of children and adolescents in both service systems have needs that are not being met, in large part due to various funding, access and eligibility issues, combined with lack of adequate assessments/ diagnoses of needs. There needs to be more effective collaboration and working together between providers in the two systems. Some improvements have been noted over time, but there is still a long way to go.

## PROCESSING OF CGR'S INITIAL RECOMMENDATIONS

### Summary of Initial Recommendations

CGR presented 15 recommendations in its November 2005 report. Two of those, as noted above, focused on the need for a process to review and prioritize the recommendations, and to establish an action/implementation planning process. Those recommendations helped shape the February 3 strategic planning session summarized in this report. Beyond those two recommendations, the 13 remaining recommendations are summarized below, and are spelled out in more detail in the November 2005 report:

1. Disseminate report statewide and hold follow-up meetings with NYS officials (e.g., State and regional officials in OMH and OMRDD, NYS Conference of Local Mental Hygiene Directors).
2. Have provider agencies identify by name all children and adolescents with suspected co-occurring Mental Health/Developmental Disability conditions and unmet service needs.
3. Establish a consistent assessment process using licensed trained professionals to conduct comprehensive diagnoses/needs assessments of those youth identified with possible co-occurring MH/DD conditions.
4. Expand capacity in the County for conducting psychological assessments of youth with suspected co-occurring MH/DD conditions as potential alternative to some psychiatric assessments – to help determine diagnoses, strengths/weaknesses, treatment goals, service eligibility determinations.
5. Access services for children with co-occurring conditions through a single point of entry, using either (a) revision of existing SPOA, (b) creation of new review and service access process, and/or (c) building on existing Coordinated Children's Services Initiative (CCSI) processes.
6. Ensure MRDD representatives become active participants in the SPOA and/or CCSI single point of entry processes to address cross-systems perspectives and service-eligibility issues.
7. Establish a database and management system to track characteristics, diagnoses, needs and services of children with co-occurring conditions, and to monitor progress and outcomes across systems over time.
8. Improve communications to service providers and parents concerning what services are available for children with co-occurring MH/DD conditions, and the criteria for determining who is eligible.

9. Establish Task Force(s) to address one or more of the following perceived needs and service gaps for children with co-occurring MH/DD conditions:
  - (a) child/adolescent psychiatric and psychological evaluations and testing;
  - (b) counseling services for children and parents;
  - (c) emergency and ongoing respite care for children and families;
  - (d) crisis intervention (such as MRDD expert at CPEP);
  - (e) medication management;
  - (f) any other needs or service gaps?
10. Explore and develop expanded linkages between MH and MRDD service providers and school special education programs (e.g., through SPOA or related processes) to improve information sharing and the appropriate, efficient and cost-effective provision of services.
11. Expand cross-training of staff in both MH and MRDD systems, and develop staff with cross-specialty skills to assess needs and serve children with co-occurring conditions, and assist their families.
12. Develop cross-agency, cross-systems recruiting approaches, funding packages and potential shared-staff options to share costs and increase the odds of being able to recruit needed specialists to Broome County.
13. Develop a pilot project to address service needs of children with co-occurring MH/DD conditions (and their parents), and seek NYS cross-systems funding to help underwrite the pilot project costs.

## **Discussion and Grouping of Recommendations**

In the ensuing discussion, some clarifications and new information were offered, and several recommendations were considered to be closely related and therefore were grouped together before any priority voting occurred. These clarifications and groupings are summarized below:

**Recommendation 1:** Art Johnson made it clear that this recommended dissemination of the report, with follow-up discussions, will happen, regardless of what level of priority it is assigned by the group, as this is central to getting any changes made at the state level.

**Recommendations 2 and 7 Combined:** These were considered by the group to be clearly related, and in planning for the future should be considered together. It was also noted that the MRDD has a good case-specific Management Information System in place, through the DDSO,

which could become a building block for the development of a cross-systems database for tracking children with co-occurring conditions. Also, some individual agencies in both the MH and DD service systems have existing MIS databases in place, often used for billing purposes, which could potentially add diagnoses and outcomes to existing demographic data. It was also noted that it may be possible to integrate selected school district data with MH and DD service provider information. *So action on these recommendations would not need to start from scratch.* The need was also noted to make sure any dates related to aging out of specific systems and eligibility for specific services should be clearly noted in any future data tracking system.

**Recommendations 3 and 4 Combined:** As with 2 and 7, these were considered by the group to be clearly related and need to be considered together in developing implementation plans. The need to link assessment and treatment was also noted, so that assessments aren't made without a follow-up treatment context. Moreover, it may be necessary in some cases, especially within the MRDD system, to link initial assessments with a commitment to subsequent treatment in order to ensure funding to cover the assessments, which might not otherwise be covered if they are done in isolation. The potential of combining MH and DD staff to do evaluations/assessments was also mentioned, in part to ensure that the child's needs are assessed holistically.

**Recommendations 5 and 6 Combined:** The recommendations both relate to strengthening single points of entry and access to services for those with co-occurring conditions, so it makes sense that the recommendations be combined for implementation purposes.

**Recommendations 8, 10 and 11 Combined:** These recommendations were seen by the group to have common threads related to improved communications and information-sharing, combined with improved training and use of staff resources. The point was made during the discussion that the Children and Youth Services Council could be helpful in addressing these issues (and perhaps some of the other recommendations as well).

**Recommendations 9 and 12 Combined (especially 9a and 12):** The group viewed all the service gap recommendations included in #9 as interrelated, and felt that they should be addressed as a whole by a work group charged with developing an action plan for that recommendation. But they agreed that #9a is especially critical, given the historical problems in the community related to the gap in psychiatric and psychological services for children and adolescents in the county. Because of the difficulty in attracting psychiatrists to the community, the group concluded that Recommendation 12, focusing on pooling resources to attract talented, often high-priced specialists to the county, should be integrated with the recommendation to close service gaps. There was also a perspective advanced that the ability to attract the best professionals to Broome may be less related to an ability to pay sufficient salaries than to other issues such as whether the community offers a "sexy" enough population to make it interesting to attract the best professional people, and whether there are enough opportunities for career path growth in the area. Some members of the group also expressed the belief that

recent access to psychiatric services, at least on a partial basis, may have helped to reduce, to some extent at least, the perceived historical crisis in terms of access to psychiatric services.

**Recommendation 13:** This proposed pilot project remained a stand-alone recommendation which the group liked in concept, though it had difficulty determining how it should be accomplished, and in what sequence. The key question which the group was not at this point able to resolve was how to frame a pilot project: whether it should be framed after addressing some or all of the other recommendations, so the pilot project could be based on the action plans that result from addressing those recommendations, OR whether a pilot project could be framed up front to help design and frame the planning and implementation of the other recommendations, e.g., to seek funding support to help put a pilot project plan together. In other words, does the pilot project get framed in such a way that it helps create and shape the vision of what is to come, or does it follow as a clear proposal that can only be developed after implementation plans for other recommendations have been conceptualized? The question was also raised as to whether a pilot project can be effectively designed without the active presence in the design stages of a psychiatrist.

Others raised the need to link Recommendations 1 and 13, at least in conceptual terms. That is, *even if the pilot project design (Recommendation 13) is to come later, initial discussions with regional and state officials (Recommendation 1) should at least begin to plant the seeds of the possibility of funding for a pilot project, and to begin to seek approval for the core concept, and perhaps to discuss how state officials can be at the table to help in the design of an appropriate and effective pilot project.* One off-line suggestion also involved the possibility of bringing a representative from the Western Region Joint Planning Group, which had dealt with issues of children with co-occurring conditions in the western region of the state a couple years ago, to meet with this group at some point. Linda Kurtz, who was a key person in this process, was suggested as a possible point person to contact. Her office is in Rochester.

Thus at the end of the process of reviewing and grouping the recommendations, a total of 7 key recommendations remained for group consideration.

## PRIORITIZING OF RECOMMENDATIONS

### The Process

The initial process was intended to give each agency represented in the group a limited number of priority votes which could be assigned to one or more of the sets of recommendations, to determine those recommendations that were of the highest priority for action, and to determine those recommendations that needed immediate attention vs. longer-term action.

But before any priority determinations were made, the group decided by consensus that it did not want to engage in a process that risked eliminating any of the recommendations, or by implication demoting any recommendations in a way that would lessen their likelihood of being addressed in the future. *Thus the group made the initial determination that all of the remaining 7 regrouped recommendations should remain under active consideration, and that the group therefore wanted to pursue active implementation of all 7.*

With that premise in mind, and based on issues discussed in the review and groupings of the initial recommendations, the group proceeded to vote on the ordering and sequencing of the recommendations. The group decided to rank order the 7 sets of recommendations, with 1 representing the most important for immediate action, and 7 the least. Each agency in attendance ranked the recommendations from 1 to 7, so that each recommendation received one vote (anywhere from a 1 to a 7) from each agency. If an agency had more than one person in attendance (as several did), the representatives from that agency caucused and decided together how their agency's votes were to be allocated. Those in attendance represented 18 specific agencies, so 18 sets of votes were cast.

### Recommendations in Priority Order

Based on the voting, the following priority order was established (smallest number of votes represents the higher priority):

#### **Priority 1/44 votes: Combination of Initial Recommendations 8, 10 and 11**

8. Improve communications to service providers and parents concerning what services are available for children with co-occurring MH/DD conditions, and the criteria for determining who is eligible.

10. Explore and develop expanded linkages between MH and MRDD service providers and school special education programs (e.g., through SPOA or related processes) to improve information sharing and the appropriate, efficient and cost-effective provision of services.

11. Expand cross-training of staff in both MH and MRDD systems, and develop staff with cross-specialty skills to assess needs and serve children with co-occurring conditions, and assist their families.

**Priority 2/53 Votes: Combination of Initial Recommendations 9 and 12**

9. Establish Task Force(s) to address one or more of the following perceived needs and service gaps for children with co-occurring MH/DD conditions:

- (a) child/adolescent psychiatric and psychological evaluations and testing;
- (b) counseling services for children and parents;
- (c) emergency and ongoing respite care for children and families;
- (d) crisis intervention (such as MRDD expert at CPEP);
- (e) medication management;
- (f) any other needs or service gaps?

12. Develop cross-agency, cross-systems recruiting approaches, funding packages and potential shared-staff options to share costs and increase the odds of being able to recruit needed specialists to Broome County.

**Priority 3/59 Votes: Combination of Initial Recommendations 3 and 4**

3. Establish a consistent assessment process using licensed trained professionals to conduct comprehensive diagnoses/needs assessments of those youth identified with possible co-occurring MH/DD conditions.

4. Expand capacity in the County for conducting psychological assessments of youth with suspected co-occurring MH/DD conditions as potential alternative to some psychiatric assessments – to help determine diagnoses, strengths/weaknesses, treatment goals, service eligibility determinations.

**Priority 4/62 Votes: Combination of Initial Recommendations 5 and 6**

5. Access services for children with co-occurring conditions through a single point of entry, using either (a) revision of existing SPOA, (b) creation of new review and service access process, and/or (c) building on existing CCSI processes.

6. Ensure MRDD representatives become active participants in the SPOA and/or CCSI single point of entry processes to address cross-systems perspectives and service-eligibility issues.

**Priority 5/69 Votes: Initial Recommendation 1**

1. Disseminate report statewide and hold follow-up meetings with NYS officials (e.g., State and regional officials in OMH and OMRDD, NYS Conference of Local Mental Hygiene Directors).

### **Priority 6/75 Votes: Combination of Initial Recommendations 2 and 7**

2. Have provider agencies identify by name all children and adolescents with suspected co-occurring Mental Health/Developmental Disability conditions and unmet service needs.
7. Establish a database and management system to track characteristics, diagnoses, needs and services of children with co-occurring conditions, and to monitor progress and outcomes across systems over time.

### **Priority 7/115 Votes: Initial Recommendation 13**

13. Develop a pilot project to address service needs of children with co-occurring MH/DD conditions (and their parents), and seek NYS cross-systems funding to help underwrite the pilot project costs.

## **Conclusions**

**Priority 1:** The group in its composite wisdom voted its preference for initial action on improving communications, expanding linkages and sharing of information across systems, providers and parents, and on expanding cross-training and skills of staff across MH and DD systems.

**Priority 2:** As its second priority, it focused on addressing the service gaps identified by the study. Actually, this recommendation received 5 #1 (top-priority) rankings (tied for the most of any recommendations), but it also received more lower rankings than did the top-ranked combination of recommendations.

**Priorities 3 and 4:** Perhaps not surprisingly, just behind the service-gap recommendations were the recommendations to establish an improved assessment process, followed in turn by the recommendations to strengthen the single point of entry/access to services process.

**Priority 5:** Although it received a tie for the most #1 (top-priority) rankings with 5, the recommendation to disseminate the report widely at the state and regional level was only the fifth-highest priority overall, as a number of lower-priority rankings offset its high number of top-priority votes. Several voters apparently decided not to rank this as highly, given the declaration at the beginning of the discussion that this would be acted on by the Commissioner as an important priority regardless of the vote.

**Priority 6:** The determination of the specific names of children and adolescents with co-occurring conditions and unmet service needs, along with the establishment of an information system to track their characteristics, diagnoses and progress in the future, received mixed support, with about equal numbers of votes across the board from 1 to 7.

**Priority 7:** Finally, the recommendation to establish a pilot project received the vast majority of the lowest-priority votes, even though the group voiced approval of the basic concept.

Apparently voters ultimately decided that more work was needed on the other recommendations before tacking the creation of a pilot project.

## DECISIONS AND NEXT STEPS

After considerable discussion, the full group agreed upon the following decisions and next steps:

- ❖ The group in attendance will continue to meet, and views itself as the key decision-making/oversight group in terms of determining priorities, action plans and timetables for implementing the recommendations. Ultimate practical decisions about what gets funded will be made at the Commissioner, DDSO and state levels, but this group is viewed as having considerable influence on those decisions, because of the fact that it represents the key agencies involved in serving and funding services to children with co-occurring conditions, and that high-level decision-makers from each agency are either part of the group, or are officially represented within the group. It was recognized that special efforts are needed to have the group include in future meetings high-level representation from the Greater Binghamton Health Center (invited but not able to be present on February 3) and from the State Office of Mental Health.
- ❖ The group in attendance acknowledged the crucial role of the Children's Mental Health Task Force in providing the leadership needed to get the initial study undertaken and in helping formulate the initial recommendations. This February 3 meeting would not have occurred without the efforts and leadership of the Task Force. As such, the Task Force and its individual members will continue to be informed of progress in implementing the recommendations; any of its participants will be invited to join the February 3/implementation oversight group in its subsequent meetings; and any of the Mental Health Task Force members will be invited to join any work groups subsequently established to develop action plans for implementing the recommendations. Many of the Task Force members were also invited to the February 3 planning session, so are already on the group that will continue to meet, and any who were not specifically invited have their agencies represented on the ongoing oversight group.
- ❖ This summary of the February 3 meeting will be circulated to all members of the February 3 group in attendance, as well as the few who were invited but unable to attend. The summary will also be circulated to all members of the Children's Mental Health Task Force.
- ❖ Individual work groups will eventually be established under the leadership/oversight of the full February 3/oversight group to develop action/implementation plans for each of the 7 recommendations. Initially, however, the focus will be on the 1<sup>st</sup>-priority recommendation (the summary of initial recommendations 8, 10 and 11). The group decided that the determination of the action/work plan for this top priority set of recommendations will be developed by a committee of the whole, i.e., the entire group acting together. Subsequent work groups will be made up of smaller subsets of members of the larger group, supplemented as needed and appropriate by additional members of the Children's Mental Health Task Force and perhaps other individuals who could bring useful expertise to the deliberations of each group. OMH and OMRDD agency providers, policymakers and perspectives should be represented on each of the work groups. These work groups would report back to the full oversight group.

- ❖ The full group will be co-chaired by Arthur Johnson and Maria Dibble, who will continue to play the effective roles they played during the CGR study co-chairing the Children’s Mental Health Task Force study process.
- ❖ Since the full oversight/February 3 group will be modeling the process for developing action/implementation plans, as it determines what needs to happen to implement the top-priority set of recommendations, it will need to develop a set of guiding principles to guide its work and the work of the subsequent implementation work groups. It will also need to address a number of “Questions/Issues to Address” by each work group. At least some of those questions/issues are summarized in the section below.
- ❖ It was agreed that each of the work groups needs to be encouraged to not be limited by existing policies, practices or funding approaches, and to think “outside the box” to challenge both state and local agencies and service providers to consider new ways of operating in the future.
- ❖ **The next meeting of this full oversight group will be on Friday, March 3 from 9 to 11 a.m. The meeting is tentatively scheduled to be held at the STIC offices.**
- ❖ In advance of the March 3 meeting, this summary will be circulated, as described above. Each participant in the oversight group is encouraged to in turn circulate the summary to key staff in their organizations, including those who have been involved in the Children’s Mental Health Task Force, to solicit reactions to the priority recommendations; determine their views as to potential roadblocks to implementing the recommendations and ways to get around them; get their thoughts as to what may have been tried before and either failed or met with success; and get their suggestions as to what might be implemented going forward around each set of recommendations. Such feedback should be brought back to the group on March 3.
- ❖ At the March 3 meeting, in addition to beginning to address specific issues related to implementing initial Recommendations 8, 10 and 11 (together making up Priority Recommendation 1), the full group should make time to listen to relevant feedback obtained from various organizations concerning the overall recommendations, and in particular be aware of opportunities to build on work that may already have been done or be in process related to any combination of the recommendations. In addition, it should set a realistic timeline for completion of its action/implementation plan for the Priority 1 Recommendation (suggestion: within 3 to 6 months from now); establish a timeline for creation of the next two or three work groups (suggestion: to be established by no later than the beginning of May); consider establishing co-chairs for each of those groups at the March 3 meeting; and discuss the process of implementing the recommendation to disseminate and discuss the CGR report with state and regional officials and the Conference of Local Mental Hygiene Directors. *A preliminary proposed agenda for that March 3 meeting is presented in a subsequent section below.*
- ❖ The issue of dissemination and discussion of the implications of the report need not wait for further action by the oversight group, or for the creation of a formal work group, to develop an implementation plan for that recommendation, including at least beginning to plant the seeds of the idea to create—and involve the state in the development of—a pilot project for Broome County, with larger statewide implications. The Commissioner is empowered to bring together

as soon as possible a small group to develop a plan of action and to report on that plan to the full group on March 3, or if that is not possible, by no later than the next subsequent meeting of the full group. It can begin to implement the dissemination action plan without waiting for the approval of the full group.

## **Questions/Issues to be Addressed by Each Implementation Work Group**

The full Oversight Group, dealing with issues related to implementation of the Priority 1 set of recommendations, and ultimately other work groups responsible for developing action/implementation plans for the other recommendations, will need to address a number of specific questions and issues as they develop their plans. Among the key questions/issues for each group to consider are the following:

- Who needs to be represented on each work group? Who will be the co-chairs of each group? Who will be the champions/advocates in pushing the implementation plan once it is completed?
- What is needed to accomplish each recommendation? What needs to happen to make the recommendation possible? Does the recommendation need to be modified in any way?
- What are the goals and objectives? How will accomplishment of the recommendation and the related goals be measured? How will we measure success?
- What is the realistic timeline for implementation?
- What are the likely costs, staffing and other resource needs? Who are the responsible parties, i.e., who needs to do what, when?
- What are the barriers/roadblocks that need to be addressed, and what is the plan for overcoming them?
- Who will be the recorder of actions taken and decisions made by the work group? Who will report back to the full Oversight group?
- Other key questions/issues?

## **Preliminary Proposed Agenda for March 3 Meeting of Oversight Group**

Suggestions for at least the core agenda for the March 3 follow-up meeting of the Co-Occurring Conditions Oversight Group:

- ❖ Reflections on February 3 meeting, including any questions/clarifications of this summary of the meeting.
- ❖ Discussion of any feedback from participants and their staff to the priority recommendations and selected actions that may currently be underway or in planning that could be built on by implementation work groups.
- ❖ Suggestions for next work groups to be started, dates for their start, and identification of co-chairs for each group.
- ❖ Discuss recommended process for dissemination of report and discussion with appropriate state and regional officials (if group has met to formulate recommended process before the March 3 meeting).
- ❖ Establishment of timeline for completion of the action/implementation plan for Priority 1 Recommendation.
- ❖ Development of Guiding Principles to guide work groups.
- ❖ Review, modification and approval of proposed “Questions/Issues to be Addressed by Each Work Group” list (see above).
- ❖ Beginning of development of Priority 1 action plan.
- ❖ Assignments as needed for tasks to be undertaken before next meeting.
- ❖ Determination of next meeting of group.
- ❖ Other business?

## **APPENDIX: SUMMARY OF POWERPOINT PRESENTATION 2/3/06**

## Children in Broome County with Co-Occurring Mental Health and Developmental Disability Conditions

### Setting Priorities

Prepared for:  
Broome County Strategic Planning Session  
February 3, 2006

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## CGR's Charge

- ❖ Conduct a needs assessment to determine the numbers of children birth - 21 with co-occurring Mental Health and Developmental Disability conditions, and the extent of gaps in service for this population

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## Methodology

CGR's study methodology was developed in consultation with the Children's Mental Health Task Force

- ❖ Most data gathered via a series of surveys
  - Supplemented by analyses of various existing databases

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## Research Components

- ❖ Five targeted surveys provided most of the data

Type of Survey	Surveys Distributed	Surveys Completed
Providers	59	58
Svc. Coordinators	32	31
CSE Chairpersons	12	12
CPSE Chairpersons	12	12
Parents	na	20

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## Additional Analyses

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- ❖ **Special analysis by CCSI**
  - Medicaid recipients 21 and under with dual MH/MRDD diagnoses
- ❖ **Special analysis by Broome DDSO**
  - All children receiving services in the MRDD service system during the summer of 2005

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## Additional Analyses (Data)

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- ❖ **Obtained from:**
  - All 12 school districts in Broome County
  - NYS Education Department
    - Indicating the numbers of children classified in each district with various special educational needs
- ❖ **Selected data from the Broome County SPOA**

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## Additional Resources

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- ❖ **Literature/Internet survey of best practices in place throughout the country**
- ❖ **Review of national research re: estimated proportions of children in the larger population with MH/emotional disorders and DD conditions**

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## Survey Limitations/ Cautions/Value

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- ❖ **Based on perceptions and best judgments of survey respondents**
  - Estimates not always based on thorough professional assessments
  - In some cases, data are more suggestive than providing definitive answers
- ❖ **But surveys can be useful in providing data**
  - Where no other reliable sources exist
  - Useful in pointing to potential issues where further exploration is needed (and better data)

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## Survey Strengths

- ❖ Similarities and consistencies in the findings lend strength to the validity and value of survey data
- ❖ Both MH/MRDD providers and school-based special education officials conclude:
  - Very similar estimates of the numbers of children with co-occurring MH and DD conditions with unmet service needs

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## Service Providers

- ❖ **For Broome County children and adolescents:**
  - 41 Mental Health (MH) programs
  - 17 Mental Retardation/Developmental Disability (MRDD) programs
- ❖ **MH providers**
  - 29 of the 41 MH programs (71%) provide services to DD children
  - Only 4 MH service providers indicated that their programs specifically exclude serving children with developmental disabilities

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## Service Providers

- ❖ **MRDD Providers**
  - None of the MRDD providers specifically exclude serving children who have mental health needs
  - Fewer than half (7) indicated that they actually provide MH services to children 0 - 21

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## Children with Co-Occurring MH/DD Conditions – Spring '05

- Service providers at that time were serving:
  - > 1,600 Broome County children with MH needs (including > 1,000 with an SED)
  - nearly 800 children with a DD
- Of these:
  - About 500 children with co-occurring MH and DD conditions
  - Roughly 20% of those were receiving services paid for by Medicaid

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### Children with Co-Occurring MH/DD Conditions and Unmet Service Needs - Served at Any Point During 2004

	Estimated # living in Broome County
# with a DD served in 2004	885
# with a DD who had unmet MH service needs	122
# with MH needs served in 2004	2962
# with MH needs who had unmet DD service needs	151
# on wait list with both DD & MH conditions	41

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### Children with Co-Occurring MH/DD Conditions and Unmet Service Needs – Provider Data

- ❖ Approximately 300 county children with co-occurring MH and DD conditions reportedly had service needs which could not be met by MH and MRDD providers during 2004 and early 2005

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### Children with Co-Occurring MH/DD Conditions and Unmet Service Needs – School Data

- ❖ Students identified in schools with unmet service needs

	Total
Total estimated # of school & pre-school children with both DD and MH conditions	780
Of those with co-occurring conditions, # with unmet needs due to service gaps	310
Of those with co-occurring conditions, # in need of educational programs that would better meet emotional/educational needs	125

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### Summary: Children with Co-Occurring MH/DD Conditions and Unmet Service Needs

- ❖ The data from service providers and schools are consistent:
  - Both independently suggest that approximately 300 county children with co-occurring conditions have unmet needs due to service gaps and/or difficulty accessing services
  - Can't be sure same children; total could be somewhat >300; used conservative estimate

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## Children with Co-Occurring MH and DD Conditions

Categories of Children	Numbers of Broome County Children Birth-21 in Each Category	
Estimated Children with Co-Occurring Conditions with Unmet Service Needs	300	
Estimated Children with Co-Occurring Conditions	500 (School estimates = 780)	
Estimated Children with MH and DD Needs Served by MH/MRDD Programs in 2004	2,962 MH	885 DD
Estimated Ranges of Children with MH and DD Conditions in County Population (at any given time, based on various national estimates)	Between 3,606 and 13,466 MH	Between 1,390 and 10,390 DD Census: 4,085 (ages 5-20) Schools: about 5,400 <sup>1</sup> 7 special needs children

## The Challenge

- ❖ **A relatively small proportion of children in the county have co-occurring conditions with unmet service needs**
  - However, they represent a significant challenge to the MH and MRDD service systems to meet those unmet needs

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## Perceived Highest Priority Unmet Service Needs

Among children and adolescents with co-occurring MH and DD conditions:

- ❖ Child and adolescent psychiatric evaluations
- ❖ Counseling for children and family members
- ❖ Emergency and ongoing respite care
- ❖ Crisis intervention
- ❖ Medication management

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## Top Perceived Unmet Need

- ❖ **Child and adolescent psychiatric evaluations**
  - 65% or more of all 5 surveyed groups listed this among the Highest Priority unmet needs

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## Major Barriers (to providing needed services)

- ❖ Poor coordination between agencies and between the MH and MRDD service systems
- ❖ Insufficient availability of psychiatric services
- ❖ Problems with Medicaid or insurance coverage
- ❖ Lack of sufficient providers and access to needed services

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## Issues

Too often, simply because of their specific conditions, children with co-occurring MH/DD conditions:

- ❖ Do not receive services they need
- ❖ Get bounced between systems
- ❖ “Fall through the cracks”
- ❖ Are placed in higher levels of care than is appropriate

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## Overall Conclusions

- ❖ **Broome County is Not Unique**
  - Broome and counties throughout NYS have difficulties addressing the needs of children and adolescents with co-occurring MH and DD conditions
- ❖ **The Difference**
  - Broome County has begun to address the issue by beginning to define the problem and the scope of the needs

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## Overall Conclusions

- ❖ Comprehensive, full-scale solutions, including adequate funding, will require actions by the State at the OMH and OMRDD levels, as well as local actions
- ❖ What needs to happen locally is why we're here today

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### Recommendation # 1

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Report should be forwarded to:

- ❖ Commissioners and key State and regional officials in NYS OMH and OMRDD
- ❖ NYS Conference of Local Mental Hygiene Directors
- ❖ Broome County officials, service providers and advocates

Schedule follow-up meetings with NYS officials

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### Recommendation # 2

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- ❖ Identify through agencies the roughly 300 children and adolescents with co-occurring MH/DD conditions with unmet needs
- ❖ Currently no central register of these individuals, and no way to define their needs, evaluate, or diagnose them on a consistent professional basis. Should be.

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### Recommendation # 3

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Establish a consistent assessment process based on:

- ❖ Licensed trained professionals (e.g., psychologists, MSWs) conducting comprehensive diagnoses and needs assessments of youth identified by service providers as likely to have co-occurring MH/DD conditions
- ❖ Establish service and treatment needs<sup>§7</sup>

### Recommendation # 4

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- Expand the capacity for conducting psychological assessments as alternative to psychiatric assessments
- ❖ Psychological testing helps determine diagnoses, strengths/weaknesses, and treatment goals
  - ❖ Necessary for eligibility determinations; may preclude need for psychiatric assessments
- May be able to supplement their efforts with appropriate clinical trainees at SUNY Binghamton to help in the diagnostic process

### **Recommendation # 5**

Once a diagnosis process is in place, access services for children with co-occurring conditions through a single point of entry, either:

- Making revisions in the existing County SPOA; or
- Creating a new but similar process to expedite the review and service access process; and/or
- Building on the existing processes involved with the county's Coordinated Children's Services Initiative (CCSI)

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### **Recommendation # 6**

❖ **MRDD representatives should be explicitly invited to and expected to become active participants in the SPOA and/or CCSI processes**

- Ensure that broad cross-systems perspectives are represented
- Explicitly address eligibility for services across systems

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### **Recommendation # 7**

**Establish an effective database and management system to:**

- Record characteristics, diagnoses and service needs of children with co-occurring conditions
- Track services they are receiving
- Monitor their progress and outcomes across service systems over time

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### **Recommendation # 8**

❖ **"Demystify" services for parents and service providers**

- Provide better understanding of what services are available for children with various MH/DD characteristics
- Define eligibility criteria more precisely
- Publicize available services and criteria more effectively, through service guides, Internet, etc.

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### **Recommendation # 9**

Establish Task Forces to determine response to the following needs and service gaps:

- ❖ Child and adolescent psychiatric and psychological evaluations and testing, especially comprehensive professional psychological diagnoses and assessments
- ❖ Counseling services for children and parents
- ❖ Emergency and ongoing respite care for children and families
- ❖ Crisis intervention (e.g., MRDD expert at CPEP)
- ❖ Medication management
- ❖ Any other needs or service gaps?

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### **Recommendation # 10**

**Linkages should be explored between community-based service providers and school district special education programs:**

- ❖ Representation on SPOA or related processes for accessing services
- ❖ Cross-referrals and shared information between school, MH and MRDD systems
- ❖ Ensure that service/treatment needs are met appropriately, efficiently, cost-effectively

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### **Recommendation # 11**

- ❖ **More cross-training is needed of program staff in both MH and MRDD systems**
- ❖ **Need to develop staff with cross-specialty skills who can assess needs and serve children with co-occurring conditions, and their families**

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### **Recommendation # 12**

**Explore ways to:**

- ❖ Put together cross-agency, cross-systems recruiting packages to help share the costs of bringing needed specialists to Broome County
- ❖ Combine funding packages and sharing staff time across agencies to create options for attracting high-caliber professionals to the area

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## Recommendation # 13

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Establish pilot project. Approach the State for:

- ❖ Cross-systems funding to establish a pilot project in the County, cutting across funding barriers and focusing on holistic approaches to children and families

New York State should be a willing contributor to Broome's efforts, as those efforts could become a model for other areas across the state

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## Next Steps

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### ❖ Today's strategic planning session with key stakeholders

- to prioritize recommendations
- establish short- and long-term goals and action plans
- determine next steps and timelines

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## When You Leave Today

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- ❖ Have established top priorities and timelines for action
- ❖ Identify who will work on top priorities
- ❖ Outline process for reporting progress
  - Timeline
  - Actions and resources needed
  - How success will be measured

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