The seal of Broome County, New York, is a circular emblem. It features a central figure of a woman, likely representing Justice or Liberty, holding a scale and a sword. Above her is an eagle with wings spread, perched on a globe. The outer ring of the seal contains the text "SEAL OF BROOME COUNTY IN THE STATE OF NEW YORK" in a circular arrangement, with a star on the left side.

**ADULT OUTPATIENT MENTAL HEALTH  
CLINICS IN BROOME COUNTY**  
**An Evaluation of Utilization  
and Service Gaps**

**By**  
**Oliver Fassler, MA**  
Broome County Mental Health Department  
State University of New York at Binghamton

Broome County Mental Health Department  
One Hawley Street  
Binghamton, NY 13901

**Arthur R. Johnson, LMSW**  
**Commissioner**

# **ADULT OUTPATIENT MENTAL HEALTH CLINICS IN BROOME COUNTY**

## **An Evaluation of Utilization and Service Gaps**

### **Summary**

In this study we surveyed agencies licensed by the Office of Mental Health (OMH) to provide adult outpatient mental health treatment. Broadly, we assessed program utilization, staffing characteristics, aspects of clients receiving services, and current challenges to providing outpatient mental health treatment.

We developed a survey to be completed by personnel representing each of the five agencies. The survey contained questions about utilization, services provided, staff composition, characteristics of individuals receiving services, and challenges to providing services. In addition, the researcher met with agency representatives and community leaders for a semi-structured interview in order to clarify and elaborate on information from the survey, as well as to gather information that may not have been addressed in the survey.

### *Summary of Results*

- ❖ The agencies surveyed appear to be operating at capacity and would have a difficult time handling a large influx of clients. There are no indications that there will be a large increase in people seeking services in the future, but this possibility should be monitored.
  - ❖ Catholic Charities decided it will close its Continuing Day Treatment (CDT) program in the near future. Most of these clients will be referred to Broome County Mental Health Department (BCMHD) Adult Clinic.
  - ❖ Recruitment of psychiatrists is a very high priority at this time. Most of the psychiatrists employed by the agencies surveyed are over 60 years of age.
  - ❖ A large majority of clients at the BCMHD Adult Clinic are receiving psychiatric care and this agency is most at risk to shortages in psychiatrists.
-

- ❖ Twenty five percent of clients across all agencies are veterans. The majority are receiving services at the Binghamton Veterans Affairs (VA) outpatient clinic, which is greatly understaffed.
- ❖ Across the five agencies there are very few psychologists employed. Hiring more psychologists should be considered.
- ❖ There is a need for clinicians who speak Spanish and know American Sign Language. These individuals may be left out of services because of the cultural and/or language barriers.
- ❖ Long waiting times for non-hospital referrals appears to be a problem. This could be particularly problematic for clients in a significant amount of distress. Agencies may wish to implement a triage procedure where level of distress is considered.
- ❖ There appears to be the greatest need for more services for individuals with eating disorders and sex offenders.
- ❖ MICA clients appear to offer great challenges because of the difficulties in determining and prioritizing which disorder to treat.
- ❖ Coordinating services to individuals with comorbid mental illness and mental retardation is also a challenge. These adults have difficulty securing mental health services through OMH agencies. Although many Office of Mental Retardation and Developmental Disabilities (OMRDD) agencies offer mental health services, it is unclear whether these individuals are having their needs met. This state of affairs suggests a gap in services.
- ❖ Most agency representatives did not view the implementation of best practices as a significant concern; however, none of the agencies have a formalized system to help implement best practices. Greater emphasis on these guidelines seems important if agencies are to provide cost-effective services which are also effective therapeutically.

This report has limitations. Many of the items asked the respondent to make estimations or offer subjective opinions. The perspectives we included in our study, even collectively, may not be an accurate appraisal of the amount or types of services which exist.

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The following agency representatives assisted in completing the surveys and taking the time to meet with the author: Abigail Mack, Bob Millen, Lorraine Mangini, Ed Rivera, Glenn Gardener, and Pat Pomeroy. We would not have been able to complete this project without their help, and we are very grateful for their thoughtful and insightful responses to the questions. We would also like to thank Casey Eppe, Executive Director of the Mental Health Association, for taking the time to meet with the author and to offer his thoughts and opinions about mental health services in our community.

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## **Introduction**

### **Goal**

In this study we surveyed OMH licensed agencies providing outpatient mental health treatment to adults in Broome County. Broadly, we assessed program utilization, staffing characteristics, aspects of clients receiving services, and current challenges to providing outpatient mental health treatment. In addition, we were interested in identifying underserved groups. In sum, we hoped this information would improve management decision making, shape the services offered, and make these services more responsive to clients' needs. We did not assess the quality of the services provided by the agencies surveyed as this was beyond the scope of the current investigation and is often best conducted internally.

### **Background**

The Local Government Unit, under the Mental Health Commissioner Arthur R. Johnson, directly oversees county operated agencies for mental health and substance abuse services. There are a number of contract agencies under BCMHD, which are also within the scope of the commissioner. Although these agencies rely on the BCMHD for financial assistance, the commissioner does not directly oversee their operation. As a consequence of this broad oversight it is important that the commissioner continually evaluate mental health services in Broome County. In the ongoing attempt to evaluate mental health programs, the current study was designed to assess OMH-licensed adult outpatient clinics for the mentally ill.

There are three OMH-licensed agencies in the community providing adult outpatient treatment that are classified as clinics: BCMHD-Adult Clinic, UHS Mental Health Outpatient Clinic, and the Community Treatment and Rehabilitation Center (CTRC). The Catholic Charities CDT program is an OMH-licensed facility. It is, however, not classified as an outpatient clinic, but rather a continuing day treatment program. We included this program because it is an OMH-licensed facility providing outpatient treatment to adults. In addition, we also surveyed the Veteran's Affairs Outpatient Clinic, which is not an OMH-licensed facility. The VA clinic is a federally funded program. We included this clinic because they provide outpatient mental health treatment to a significant number of veterans and we wanted to learn more about services to this population.

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It is important to note that there is a broad range of mental health treatment options available other than the agencies listed above. For instance, one may choose to receive outpatient treatment from a professional in private practice, such as a psychologist, social worker, or psychotherapist. These professionals represent an additional resource for individuals in Broome County. Table 1 provides the number of psychiatrists, psychologists, social workers, and counselors listed in the 2006-2007 telephone book. It is important to note that many of these individuals have a part-time private practice. Also, we do not know the number of people who are receiving mental health treatment from these professionals. Gathering this information, however, is beyond the scope of this investigation.

**Table 1: Number of professionals in private practice**

<b>Profession</b>	<b>Total</b>
Psychiatrists	5
Psychologists	35
Social Workers	29
Counselors	40
Psychotherapists	2

There are also numerous other agencies/programs which provide mental health services including Binghamton University's Psychological Clinic, Catholic Social Services of Broome County, several programs run by the Mental Health Association (e.g. BEAR and Rural BEAR programs), Family and Children's Society, Samaritan Counseling Center, United Health Services Mental Health Crisis Center, the SOS Shelter, and several programs run by Catholic Charities (e.g. Adult Flex Team and Single Entry Case Management).

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## Method

### *Surveys of Community Mental Health Clinics*

All five agencies providing adult outpatient mental health services were surveyed for information about utilization, services provided, staff composition, characteristics of individuals receiving services, and challenges to providing quality services. The survey was developed by consultation with a number of individuals who are knowledgeable about outpatient mental health services. The reader is referred to Appendix A for the survey instrument used. The surveys were sent on 1/12/06 and completed by agency representatives from each of the five agencies. In addition, basic information about each of the agencies was acquired through sources available to the public, such as the internet and brochures.

### *Interviews with Community Leaders and Agency Representatives*

This researcher met with agency representatives and community leaders who are knowledgeable about mental health needs in Broome County to conduct a semi-structured interview. The set of questions varied somewhat for each person interviewed. An example of these questions is provided in Appendix B. The goal of the interviews was to clarify and elaborate information provided in the written survey. The second goal was to gather information that may not have been addressed in the written survey.

### *Limitations*

Although we consider our methodology adequate and sound in answering our research questions, it is important to note the limitations of our approach. The first limitation of our approach is that many of the items on the survey asked the respondent to make estimations and offer subjective opinions. Second, the interviews administered also have a built in bias toward the organizational perspective of those surveyed, which may not be the same as the individuals receiving those services. Third, we did not acquire information about all agencies providing mental health services, but a subset of these agencies. The perspectives we included in our study, even collectively, may not be representative of the entire community or constitute an accurate appraisal of the amount or types of services which exist. Finally, many of the data we collected have likely fluctuated since we collected them.

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## Results

In the first section we provide basic information about each agency including types of services provided, policies and procedures. The second section is comprised of an analysis of trends across all agencies, as well as perceived needs and challenges.

### Description of Surveyed Agencies

#### *Broome County Mental Health Department- Adult Clinic*

Beyond its regulatory role as the local governmental unit, the Broome County Mental Health Department is licensed to operate mental health programs, including the Adult Clinic.

The BCMHD Adult Clinic provides services Broome County residents who are experiencing mental health difficulties, and who have a psychiatric disorder as defined by the DSM-IV. Services are not provided to individuals whose primary problems include alcohol/drug disorders, development disabilities, organic brain syndrome, and social conditions (V-codes). Admissions are determined based on clinic capacity and whether services offered at the clinic match the client's needs. Individuals referred from inpatient or emergency settings are provided an initial assessment within five business days. Persons with serious and persistent mental illness are given priority access. A decision to admit occurs within the first three visits.

**The BCMHD Adult Clinic is the largest provider of outpatient services for mentally ill adults in Broome County.**

The BCMHD Adult Clinic is the largest provider of outpatient services for mentally ill adults in Broome County. The Clinic is staffed by an interdisciplinary team (i.e. psychiatrists, social workers, and a psychologist) that provides treatment for a wide range of mental health difficulties to individuals who are 18 years of age or older. The Clinic provides comprehensive outpatient services including individual therapy, various types of group therapies, and medication management. They offer approximately 12 groups including Medication and Health Management, Men's MICA- Relapse Prevention, Women's Issues Discussion Group, and Pregnant and Parenting Young Children Support Group. In recent years, they have seen an increase in clients with more severe mental illness.

#### *United Health Services: Mental Health Outpatient Clinic*

The United Health Services, Inc. (UHS) is a community-based not-for-profit health care system operated for the public benefit. United Health Services operates several mental health programs, including

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their outpatient program. For adults with disorders related to substance abuse they have an inpatient facility (New Horizon's Detoxification Unit) and an outpatient program (New Horizon's Outpatient programs). UHS provides mental health services to mentally ill adults in crisis at their Crisis Center, and inpatient services at Binghamton General Hospital's Psychiatric Inpatient Services unit. In addition they provide outpatient mental health treatment at their Mental Health Outpatient Clinic. The Mental Health Outpatient Clinic provides psychiatric assessment, individual, group, and couple psychotherapy, psychological testing, neuropsychological testing, medication management, a specialized mental health HIV program, and specialized groups. Group therapy has been increasingly emphasized in recent years and this modality is highly valued. They currently offer approximately ten groups. There are two groups for individuals with anxiety disorders and one group for depressive disorders. Both of these groups implement a Cognitive-Behavioral Treatment approach. They also have a group that implements Dialectical-Behavior Therapy for clients with Axis II disorders.

To be admitted one must be 18 years or older and be diagnosed with a mental illness. Individuals are excluded if their primary diagnosis is alcohol/substance abuse, developmental disabilities, V-codes, or organic brain syndromes.

#### *Binghamton Veterans Affairs Outpatient Clinic*

The mission of the Veterans Affairs Outpatient Clinic is to provide physical and mental health care for all veterans. The VA Outpatient Clinic serves veterans living in Broome, Chenango, Delaware counties, as well as residents of northern Pennsylvania. The majority (approximately 85-90%) of their clients reside in Broome County. Mental health services are provided by a behavioral health care team comprised of social workers, psychiatrists, a psychiatric nurse, and visiting counselors from the Syracuse VA Medical Center. Services include medication management, individual and group psychotherapy for veterans experiencing personal and emotional problems, including drug and alcohol problems. The VA outpatient clinic has been in operation for nine years and the number of clients has been steadily increasing. A large percentage of clients have trauma-related difficulties. The clinic is well-rounded and the staff have strong clinical and diagnostic skills. To receive services at the VA clinic a client must be eligible for VA benefits and have a diagnosis of a mental illness. Veterans with mental health problems are evaluated by the VA to determine the extent to which their difficulties are

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service related. The VA clinic accepts all veterans but higher priority is given to veterans with problems that are determined to be service related, unless the individual is in crisis.

In addition to individual psychotherapy, they also provide group therapy. The VA clinic has three different PTSD groups, a MICA group, and a smoking cessation group.

### *Community Treatment and Rehabilitation Center*

CTRC is operated by the New York State OMH through the Greater Binghamton Health Center (GBHC; formerly known as the Binghamton Psychiatric Center). The GBHC is an OMH operated facility that provides comprehensive outpatient and inpatient services for individuals who are seriously mentally ill. CTRC is the central location for the GBHC's outpatient services. The program offers a variety of treatment, support and rehabilitation services to individuals with severe and persistent psychiatric illness. Services include assessment, treatment and discharge planning, health screening and referral, verbal therapy, medication therapy, medication education, and symptom management. They offer approximately 11 groups including Wellness, MICA, Mind Over Mood, and Arts and Crafts. Their primary referral source is GBHC, but they also receive referrals from a number of other agencies including article 28 hospitals, and self-referrals.

To receive treatment a client must be over 18 years old and have a primary diagnosis of a mental illness as defined by the DSM-IV other than alcohol and drug disorders, developmental disabilities or organic brain syndromes.

### *Catholic Charities: Continuing Day Treatment*

Catholic Charities of Broome County, a not for profit agency, was established in 1937 as an area office of the Roman Catholic Diocese of Syracuse, New York, Inc.. Catholic Charities provides a wide range of human services to persons of all ages residing in Broome County. Services include several mental health programs, including outpatient and residential services for children and adults. In the current study we surveyed their CDT program.

Catholic Charities CDT is a supportive, group-oriented treatment program designed to assist adults diagnosed with serious and persistent mental illness and emphasizes psychiatric rehabilitation.

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The admission to Catholic Charities CDT occurs within the first three visits. Denial of admission may occur if they are currently engaging in aggressive behavior, or are currently abusing alcohol and/or illegal drugs. Exceptions can be made and are decided on a case by case basis. Approximately two-thirds of clients referred to Catholic Charities CDT do not start the program. This is, of course, due to a number of factors including client drop out.

Clients are expected to be actively involved in programming, which is a minimum of 15 hours per week. The programming heavily emphasizes group therapy and is intended to provide an intensive level of care that resembles inpatient care. Catholic Charities CDT offers a wide variety of group therapies in the following categories: Activity Therapy (e.g. Arts & Crafts), Symptom Management (e.g. Anger Management), Supportive Skills (e.g. Benefits), Verbal Therapy (e.g. Intensive Group Therapy), and Medication Education & Therapy (e.g. Medication Education). Catholic Charities CDT has seen an increase in the percentage of MICA clients attending programming. Also, the clients are primarily middle age.

**Catholic Charities decided it will close its CDT program in the near future.**

It is important to note that after we collected this data, Catholic Charities decided it will close its CDT program in the near future. Changes in client characteristics apparently resulted in lower attendance rates, and consequently insufficient billable hours to sustain the program. Their clients will be referred to other agencies in the community.

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## Results Across Agencies

### *Client Utilization*

Table 2 lists the number of adults (18 and over) currently receiving services at each of the clinics.

**Table 2: Number of clients at each agency**

<b>Agency</b>	<b># of clients</b>
BCMHD	1170
UHS	550
VA	507*
CTRC	385
CDT	45
<b>Total</b>	<b>2657</b>

As the table indicates, BCMHD has the greatest number of clients and has nearly twice the number of clients as the next largest clinic.

Billable units of service are an important indicator in determining client utilization of resources. A billable unit of service is defined as any contact with a service provider that a third party (e.g. Medicaid or private insurance) will reimburse. The amount of reimbursement received for each unit of service varies depending on the type of service provided. It is also important to note that because the VA clinic is federally funded, it tracks the number of “encounters,” which are similar to billable units of service. CTRC was not able to provide us with information on billable units of service because their data management system did not allow for retrieval of this information.

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\* There are a total of 596 clients at the VA clinic, but not all are residents of Broome County. It was estimated that approximately 85 to 90% of the clients are residents of Broome County. We used 85% to calculate the number of Broome County residents at the VA clinic because it provides a more conservative estimate.

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Figure 1 provides the billable units of service for each of the four agencies for the last three years.

**Figure 1**

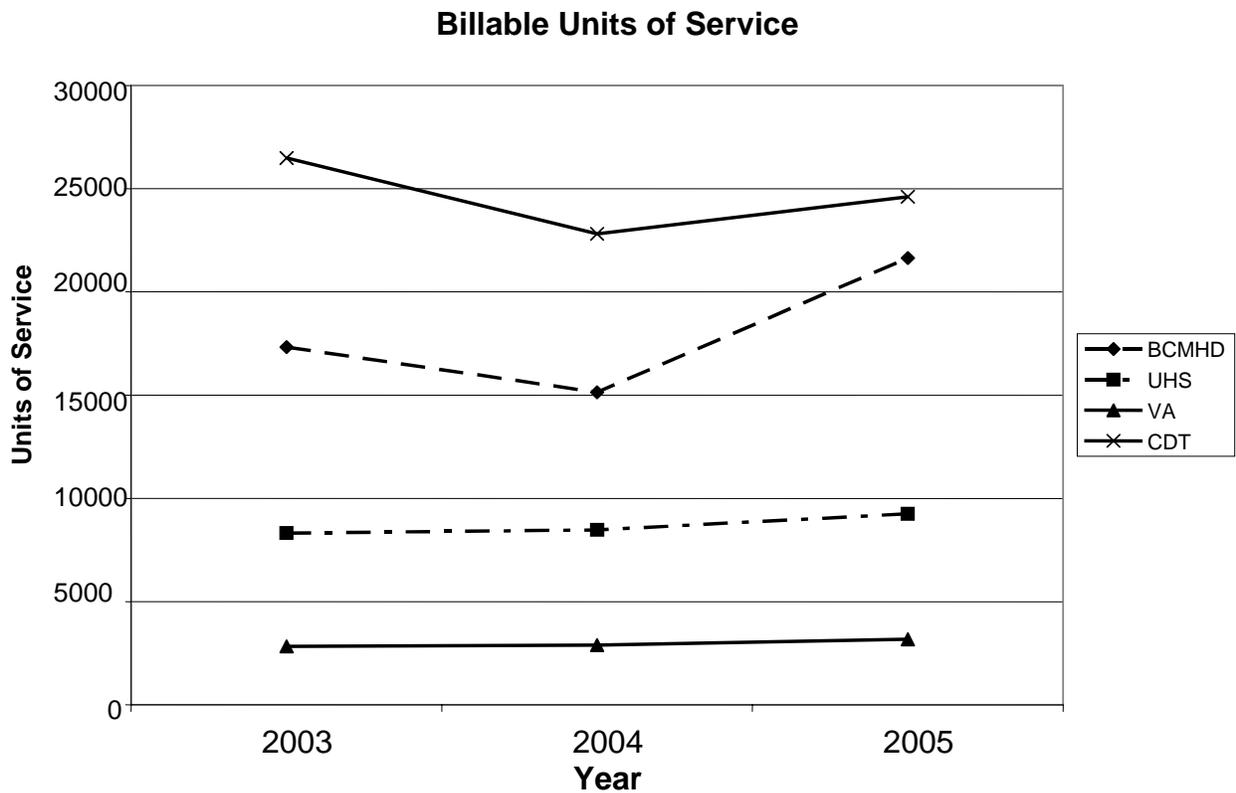
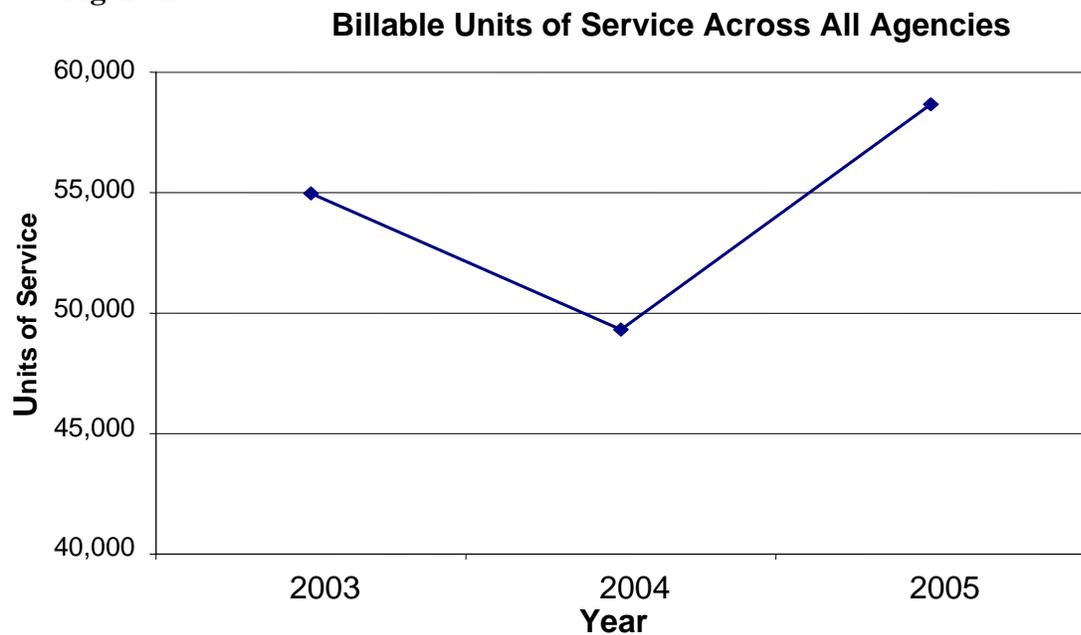


Figure 2 graphs the total billable units of service across agencies.

**Figure 2**



It is also important to note that BCMHD had a smaller number of billable units of service for 2004 because they experienced a shortage of psychiatrists and were accepting a smaller number of clients for medication management. In 2005, as the clinic's psychiatric staff increased, they were able to accept more clients for medication management and consequently their admissions increased. This may explain the overall dip in billable units of service across all agencies shown in Figure 2 in 2004. The graph also indicates that across agencies 2005 had the highest number of billable units of service. With the exception of Catholic Charities CDT, the number of billable units of service appears to be trending upward.

Each client's average billable units of service per year provide an approximate indication of the intensity of utilization. There is likely, however, to be considerable variability in how much each client utilizes services. Some clients may receive treatment occasionally whereas some may come more often. This is likely the case with all the agencies surveyed except Catholic Charities CDT. Because it is a continuing day treatment program, clients are expected to attend minimally 15 hours per week of programming. Not surprisingly each client at Catholic Charities CDT accounts for a high number of units of service. The averages for the other three clinics indicate that the average client is not utilizing services very frequently. Table 3 provides the average billable units of service per client for all agencies except CTRC because this information was not provided.

**Table 3: Yearly Average Billable Units of Service Per Client**

Agency	Average
BCMHD	14.8
UHS	16.8
VA	5.3
CDT	546.9

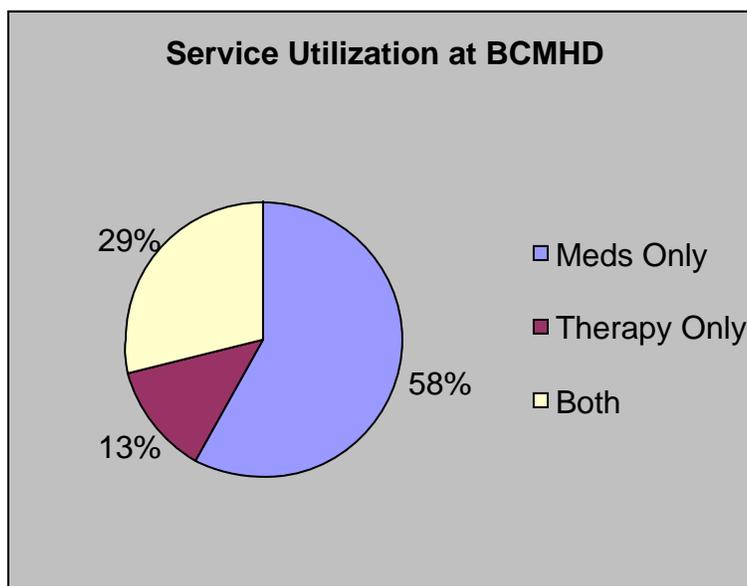
We also surveyed the percentage of clients at each clinic who are utilizing pharmacological treatment only, group/individual psychotherapy only, the percentage utilizing both, and the percentage who participate in psychosocial/life skills programming. One hundred percent of clients at CTRC and Catholic Charities CDT receive both pharmacological and group/individual psychotherapy. In addition, these were the only agencies surveyed that provide psychosocial/life skills programming. All of the clients at Catholic Charities CDT

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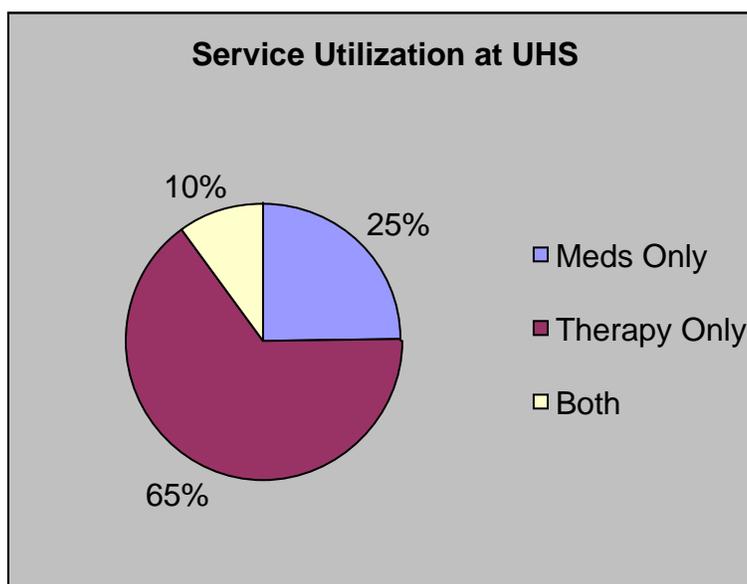
participate in this type of programming, and 40% of clients at CTRC.

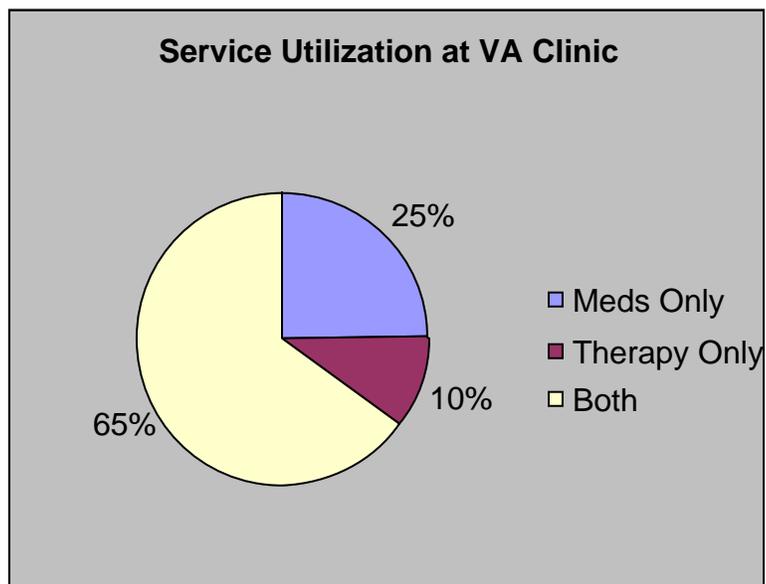
Figures 3, 4, and 5 provide this information for BCMHD, UHS, and the VA. Psychosocial/life skills programming is not included because these agencies do not provide this service. Figures 3 and 4 indicate that BCMHD and UHS differ greatly in terms of what type of services most clients are utilizing.

**Figure 3**



**Figure 4**



**Figure 5**

*Waiting Time and Likelihood of Acceptance*

Table 4 provides the estimated length of time from the client's initial contact with the agency until they receive treatment services. The waiting time does not include contacts with clients that were part of the assessment phase. The average waiting time varied much more for clients who were not referred from inpatient psychiatric care.

**Table 4: Waiting times for hospital and non-hospital referrals**

Agency	Non-hospital Referral	Hospital Referral
BCMHD	60 days maximum	Within 5 days
UHS	30-90 days	10 days
VA	Less than 30 days	Same day
CTRC	Varies	Within 5 days
CDT	10 business days	5 working days

Table 5 ranks the results of the survey question that asked agency representatives to determine on a Likert scale\* the likelihood that a client with the specified characteristics would be accepted for treatment. On the average, sex offenders were least likely to be accepted for treatment, followed by clients diagnosed with mental retardation.

**Table 5: Likelihood of acceptance by client characteristic**

Characteristic	BCMHD	UHS	VA	CDT	Avg.
Sex Offenders	1	2	NA	2	1.7
Mental retardation	2.5	1	NA	2	1.8
Referral from prison/jail	2.5	4	3	4	3.4
Recent substance abuse	2	4	4	4	3.5
History of substance abuse	4	4	4	4	4
SPMI	4	4	4	4	4

\*Four-point Likert scale (1=very unlikely; 4=very likely)

### *Staff Characteristics*

Table 6 provides the number of Full Time Equivalent (FTE) staff providing treatment services and their level of education. The majority of clinicians have master's degrees. As mentioned these numbers reflect the number of staff at the time the surveys were completed. There have been changes to these numbers, which is discussed later.

**Table 6: Number of FTE staff and staff level of education**

	BCMHD	UHS	VA	CTRC	CDT	Total
Psychiatrist	4	2	1	2	.2	9.2
Psychologist	.5	0	0	0	0	.5
Masters*	7.5	11	2	3	3	26.5
NP**	3.5	0	0	1	0	4.5
Bachelor	1	1	1	2	3	8
Associates	0	1	0	0	0	1
High School	0	0	1	0	1	2
<b>Total</b>	16.5	15	5	10	7.2	51.7

\*These individuals most commonly have a Masters in Social Work. BCMHD has one Ph.D. social worker.

\*\*NP=Nurse Practitioner

There is considerable variability across agencies in the client to staff ratio. The VA has the highest ratio. Table 7 provides this information.

**Table 7: Staff to client ratio at each agency**

Agency	Clients	Staff	Ratio
BCMHD	1170	16.5	71:1
UHS	550	15	37:1
VA	596	5	119:1
CTRC	385	10	39:1
CDT	45	7.2	6:1

We also determined the number of clinicians at each agency that were classified as peer counselors. Only two of the agencies surveyed utilize peer counselors: CTRC and Catholic Charities CDT. Both agencies have one peer counselor.

In addition to the concern that there are not enough psychiatrists in this county, there was a concern that the psychiatrists currently in practice may be nearing or past retirement age. If that is the case, there may be an even greater need to recruit psychiatrists. To assess this we attempted to determine the ages of the psychiatrists employed at the agencies surveyed. CTRC did not provide this information. The two psychiatrists at UHS are “in there forties.” The psychiatrist at Catholic Charities CDT is “Over 60.” At the VA the psychiatrist recently died and was approximately 70 years old. At the BCMHD the average age of the 10 psychiatrists (FTE=4) is 64 and the ages ranged from 56 to 73.

**Many psychiatrists are nearing or past retirement age.**

#### *Client Characteristics and Challenges to Providing Services*

Table 8 provides estimates of the percentage of clients who meet NYS-OMH criteria for severe and persistent mental illness (SPMI) and the percentage of veterans. Across all agencies approximately 61% are SPMI and 25% are veterans.

**Table 8: Percentage of clients who are SPMI and veterans**

Agency	% SPMI	% Veterans
BCMHD	41	0
UHS	42.5	15
VA	90	100
CTRC	96	5
CDT	100	1

**There appears to be a need for more Spanish speaking clinicians.**

We asked agency representatives to rank the languages that are posing the greatest demand. Three agencies responded to this item and all three agencies ranked Spanish as the language posing the greatest demand. Furthermore, all three agencies ranked American sign language second. We also asked agency representatives to list the languages that their clinicians speak. The VA did not respond to either question because individuals volunteering for the military are required to speak English. Only one agency (BCMHD) employs a clinician who speaks Spanish, and none have a clinician who knows American Sign Language.

There was variability across agencies regarding the percentage of clients paying for services via Medicaid, Medicare, Medicaid and Medicare, private insurance, or self-pay. Private insurance includes health insurance coverage, as well as health maintenance organizations. At the VA clinic services are paid through the VA medical benefits program for a large majority of clients (90%). Ten percent pay through private insurance. CTRC did not provide this information. Figure 5, 6, and 7 provide this information for BCMHD, UHS, and Catholic Charities CDT.

**Figure 6**

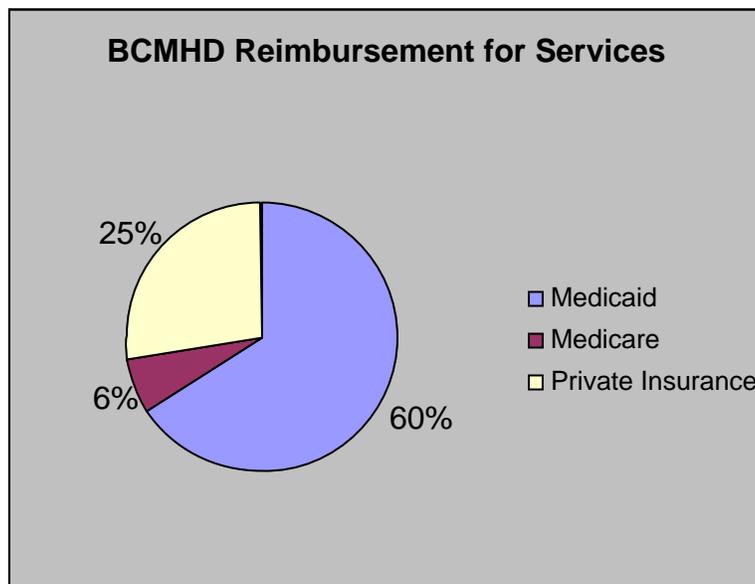


Figure 7

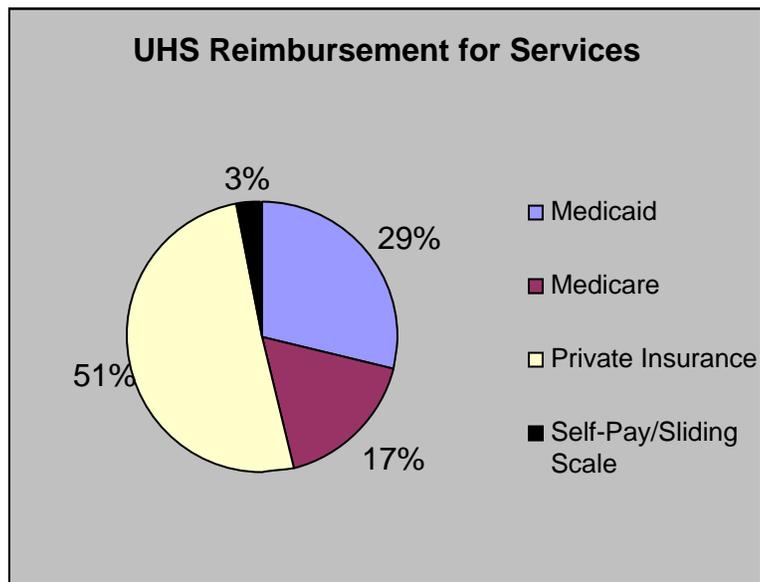
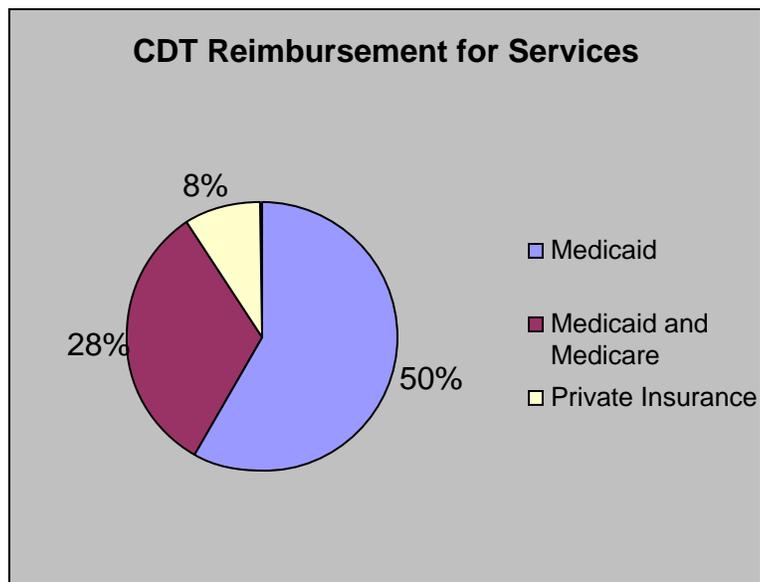


Figure 8



**Recruiting new psychiatrists was rated as the greatest challenge.**

We presented agency representatives with a list of possible challenges to providing quality outpatient treatment. Using a Likert scale\*, they rated how great a challenge each item was. Table 9 provides their responses rank-ordered. Recruitment of psychiatrists, treatment of sex offenders, and coordinating services to clients with mental retardation were rated as the most challenging on average.

**Table 9: Challenges to outpatient clinics**

<b>Agency</b>	<b>BCMHD</b>	<b>UHS</b>	<b>VA</b>	<b>CTRC</b>	<b>CDT</b>	<b>Avg.</b>
Recruitment of new psychiatrists	4	4	4	4	4	4
Treatment of sex offenders	4	2	NA	3.5	4	3.4
Coordinating services to clients with MR	4	4	NA	4	1	3.3
Coordinating services to MICA clients	3	1	2	3.5	2	2.3
Serving needs of clients outside triple cities	3	1	1	2	4	2.2
Understaffed	3	2	3	2	1	2.2
Inter-agency cooperation	1	2	2	2	3	2
Serving needs of the elderly	3	1	3	2	1	2
Serving needs of Multi-cultural clients	2	2	1	2	2	1.8
Implementing best practices	2	2	3	1	1	1.8

\*Four-point Likert scale (1=very unlikely; 4=very likely)

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## Discussion

### *Client Utilization*

**Approximately 61% of the clients meet criteria for SPMI.**

Of the clinics surveyed, a total of 2,657 adults were receiving mental health services, which constitutes approximately 1.7% of the adult population in Broome County.<sup>†</sup> The majority of the clients at these agencies appear to be presenting with rather severe psychopathology as approximately 61% of the clients meet criteria for SPMI. BCMHD has the largest clientele with nearly double the number of clients as the next largest clinic. Catholic Charities CDT had a much smaller clientele than the other agencies. It is important to note that Catholic Charities CDT differed from the other agencies in many respects, which reflects differences between day treatment programs and mental health clinics. Because of this fundamental difference, we will compare and contrast the other agencies more often. In addition, the recent decision to close this program also makes comparisons less relevant.

We enquired about the number of billable units of service provided over the past three years. With the exception of Catholic Charities CDT, all agencies had the highest number of billable units of service in 2005. This may represent a trend towards growing utilization of services, or other factors may account for this finding. Interviews with agency representatives suggested that utilization is increasing and that the community as a whole would have a difficult time handling a significant increase in demand. BCMHD, for example, is operating at capacity and would not be able to handle a large influx of clients. The agency representative at UHS reported that their numbers of clients have been increasing and that they are attempting to increase their capacity. Three years ago they had approximately 300 clients and now they have approximately 550. UHS is implementing more group psychotherapy, in part, to provide treatment to a greater number of people.

**The average client is not utilizing services very frequently.**

Another indicator that the four clinics (excluding Catholic Charities CDT) are operating at maximum capacity is the client's average billable units of service per year. This number provides a rough indication of the frequency of utilization. For the BCMHD, UHS, and the VA clinic, the average billable units of service per client ranged from 5 to 17 per year. This suggests that the average client is not utilizing services very frequently. This may be because

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<sup>†</sup> This percentage was calculated using 2000 census numbers for individuals over 18 years of age.

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the agencies are unable to provide more services, or that the clients are not interested in more frequent utilization, such as weekly psychotherapy. Also this number is, at least in part, due to the percentage of clients who are receiving medication management. People receiving this type of treatment often have less frequent contact with their provider. The VA clinic had the lowest average billable units of service per year because they are currently understaffed.

These findings do not necessarily indicate that there is a need in our area for more services, but may be an indication that the agencies are operating efficiently. In addition, there is little indication that there is likely to be a large increase in individuals seeking services in the near future. It may be important to follow this trend in coming years to monitor this possibility.

There appeared to be a moderate amount of variability in the types of services that BCMHD, UHS, and the VA are offering to the great percentage of their clients. The majority of clients at BCMHD (58%) are receiving pharmacological treatment only, at UHS 65% are receiving psychotherapy only, and at the VA most clients are receiving both types of treatment. At BCMHD 29% of clients are receiving both pharmacological treatment and psychotherapy which implies that 87% of their clients receive pharmacological services. The percentage of clients receiving pharmacological treatment at UHS was much less (approximately 35%). This suggests that there is a great difference between the two agencies in this regard. This also indicates that BCMHD is more vulnerable to shortages in psychiatrists, which we discuss further below. If BCMHD could increase the percentage of clients who receive therapy only, this agency would not be as vulnerable to this threat. Although BCMHD and UHS differ greatly in the types of treatment the majority of their clients are receiving, they have very similar percentages of SPMI clients, 41% and 42.5% respectively.

**BCMHD and UHS differ greatly in the types of treatment the majority of their clients are receiving.**

### *Staff Characteristics*

Staff composition also differed across agencies. BCMHD has the greatest number of staff providing psychiatric services and UHS has the most social workers. This further reflects the differences in the types of services these clinics offer. UHS had a lower client to staff ratio than BCMHD, which also supports this notion.

The VA, CTRC, and Catholic Charities CDT have a particularly high percentage of clients who are classified as SPMI (range 90-

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100%). It is therefore not surprising that CTRC and Catholic Charities CDT have fairly low staff to client ratios, 32:1 and 6:1 respectively. The VA, however, has a much higher ratio (119:1). They reported that they are understaffed and are unable to meet with clients as often as they would like, particularly clients suffering acute trauma.

**Twenty five percent of the clients across all the agencies are veterans.**

Twenty five percent of the clients across all the agencies are veterans. This number is slightly higher than one would expect because 14% of the adult population in Broome County are veterans (2000 Census). The vast majority of veterans are receiving services at the VA clinic. There does appear to be a need at this time for greater number of staff at the VA clinic. It is important to note that the VA clinic will soon be adding a full time nurse practitioner and social worker in addition to their current staff, which will help greatly in responding to the demand; however, the high percentage of SPMI clients and veterans suffering the effects of acute trauma suggest there still continues to be a need for more staff at this clinic. As reported above, 90% of clients at the VA clinic are SPMI. This number is quite high and may be an overestimate given that an individual must be functioning relatively well to serve in the military.

**The majority of psychiatrists are over 60 years of age.**

As Table 7 indicates, there was strong agreement among agency representatives that recruitment of psychiatrists is a great challenge. During the interviews many representatives mentioned this as a problem our area faces. Hiring nurse practitioners will help the problem, but there is still a need to recruit psychiatrists to our county. The ages of psychiatrists further suggests that recruiting these doctors should be a high priority at this time. The majority of psychiatrists are over 60 years of age. BCMHD and the VA clinic appear to be quite vulnerable to this need because 87% and 90% of their clients are receiving psychiatric care respectively. Because a majority of their clients are dependent on BCMHD for this type of care, it suggests that shortages in qualified psychiatric staff would greatly undermine their ability to provide sufficient services to these clients. In addition, the VA is equally as vulnerable to this threat.

There are recent indications that the threats posed by the need for more psychiatrists is coming to fruition. At the time of the writing of this report there have been changes in the number of FTEs employed at both the BCMHD and the VA. There are currently 2.8 FTE psychiatrists at the BCMHD and they have a capacity of 3.9 FTE psychiatrists. This indicates that they are 28% below capacity for FTE psychiatrists. The FTE psychiatrist at the VA recently

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**There are approximately 2177 clients receiving medication management, or 183 clients per FTE provider.<sup>‡</sup>**

passed away and a psychiatrist is employed part-time (.40 FTE) to fill in until the new psychiatrist begins in June.<sup>‡</sup> We are not aware of any changes in the number of psychiatrists at the other agencies. These changes suggest there are 7.4 FTE psychiatrists and 4.5 FTE nurse practitioners at the five agencies for a total of 11.9. There are approximately 2177 clients receiving medication management, or 183 clients per FTE provider<sup>§</sup>. The high percentage of clients receiving medication management and the importance of the need to recruit psychiatrists appears to reflect an emphasis on the medical model in treating mental illness and a decreased emphasis on the psychological and social factors in mental illness.

The majority of clinicians at the agencies have a Master's degree. At the time the surveys were completed there were a total of only .5 doctoral level FTE psychologist employed across the five agencies.<sup>\*\*</sup> Given the total number of clients seen at these agencies, this is a very small number. It would be beneficial for agencies to hire more psychologists because of their specialized knowledge and skill in assessment and treatment. They can also be instrumental in the development of best practice methods within an agency.

There also appears to be a need for clinicians who speak Spanish. Across the five agencies, there is only one clinician who speaks Spanish. One agency representative reported that individuals with different cultural backgrounds are most likely to be left out of services, particularly Spanish-speaking individuals. This representative also thought that the problem went beyond language barriers and that there is often a cultural divide between western mental health and their cultural values. An additional concern is the lack of clinicians who know American Sign Language.

**Clients can wait as long as 90 days before receiving treatment services.**

Agencies being understaffed may contribute to the potential problem of long waiting times for non-hospital referrals. These clients can wait as long as 90 days before receiving treatment services. One agency representative expressed concern that clients' symptoms may worsen during the long waiting time, which may result in the need for a more intense level of care (e.g. hospitalization). One solution to this may be to develop a triage process in which clients' level of distress is considered and clients in high levels of distress are prioritized. BCMHD, for example does endeavor to triage individuals seeking admission to the clinic. It is unclear, however, whether these individuals or individuals in

<sup>‡</sup> These numbers not reflected in Table 5.

<sup>§</sup> FTE provider includes psychiatrists and nurse practitioners.

<sup>\*\*</sup> BCMHD has a .4 FTE Masters level psychologist trainee.

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significant distress have shorter waiting times. Another possibility is to contact clients on the waiting list occasionally to enquire about their status and to determine if their level of distress has increased.

### *Client Characteristics and Challenges to Providing Services*

Although not assessed on our survey, many agency representatives were in agreement that there is a need in our community for programs to treat eating disorders. Two agency representatives stated that clients with eating disorders have no place to go. UHS, however, refers people to the Johnson City Family Care Center. They do not, however, employ anyone with specialized training in treatment of eating disorders, but do employ a nutritionist. One agency representative expressed a need for an inpatient facility for individuals with eating disorders. The nearest inpatient facility appears to be in New York City, which likely makes it more difficult for these individuals to receive inpatient care. Individuals with eating disorders may be required to seek outpatient care from a professional in private practice and it is unclear that these individuals have adequate resources in the community for this to be a viable option. It will be important in the future to establish how best to meet this need.

Only one agency surveyed, UHS, has targeted treatment programs for sex offenders. These individuals were the least likely to be accepted for treatment at the agencies surveyed. Many of the agencies will accept them only if their main needs are not treatment for such behaviors. There was strong agreement among agency representatives that there is a need for more programs to treat sex offenders. Family and Children's Society appears to be the main program for sex offenders. It is unclear if they are able to provide treatment to all sex offenders in the community and this may be an important question for further research. Three agencies expressed concerns that admitting sex offender would put their program or other clients (e.g. children) in jeopardy and are therefore leery of people with these difficulties. Beyond sex offenders, providing services to clients referred from jail or prison does not appear to be a problem at this time.

**There was strong agreement among agency representatives that there is a need for more programs to treat sex offenders.**

There was concern among some agency representatives that MICA clients may not be receiving sufficient services. One agency representative stated that the problem is mainly in the referral process from inpatient to outpatient care. Patients are not assessed adequately prior to discharge to determine if specialized substance abuse treatment is more appropriate. Another agency

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representative stated that there is a need in the community for an inpatient facility for MICA clients and that the nearest facility is in Bradford, PA. In sum, it does appear that there are difficulties in the assessment and referral process in determining the most appropriate type of care for MICA clients. This also affects the admission and treatment process because there is often confusion regarding the most appropriate type of service. These problems likely reflect the inherent difficulties in treating people with comorbid disorders and are not specific to this community. This difficulty may be further complicated by having two systems for mental illness (OMH) and substance abuse (Office of Alcoholism and Substance Abuse Services; OASAS).

Clients with a comorbid diagnosis of mental retardation were less likely to be accepted for treatment at BCMHD, UHS, and Catholic Charities CDT. This question was not relevant to the VA because individuals with mental retardation would be unable to serve in the military. CTRC did not provide this information. As Table 7 indicates, three agencies stated that coordinating services to clients also diagnosed with mental retardation is a great challenge. This information suggests that mentally retarded adults have difficulty securing mental health services through OMH agencies. For instance, it is known that many of them present at the Comprehensive Psychiatric Emergency Program (CPEP) in crisis and yet there is often nowhere to refer these individuals for treatment. Although OMRDD agencies often offer some mental health treatment, it is unclear whether their mental health needs are being adequately met. This state of affairs suggests a gap in services.

**Mentally retarded adults have difficulty securing mental health services through OMH agencies.**

Based on survey responses, there was strong agreement that implementing best practices is not currently a challenge. Based on the interviews with agency representatives, however, there appeared to be little agreement on what is meant by best practices and no agency has a formalized process to help ensure that the best practice is being applied. One agency reported that they would like to employ more best practices, but that they do not have the staff necessary to see patients often enough. Also, one person expressed the difficulty of selecting a preferred treatment for people who do not fit neatly into diagnostic categories and that implementing best practices often “rubs clinicians the wrong way.” Although it does not appear to be a high priority for agency representatives at this time, it may be beneficial for agencies to begin adopting a more formalized system to put best practice guidelines into practice, particularly given the indications that utilization is increasing and the high percentage of SPMI clients. One agency representative

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proposed that we attempt to improve the quality of services by adhering more closely to best practice guidelines instead of increasing the amount of services available. Following such guidelines has the potential to increase the efficiency and quality of services. For instance, some agencies appear to be changing the types of services offered by providing more group psychotherapy which can allow an agency to provide more services without necessarily sacrificing quality. Agencies could also consider placing a greater emphasis on short-term therapies that are empirically supported. Having best practice training in group therapy and short-term therapies seems important if agencies are to provide cost-effective services which are also effective therapeutically.

### *Summary of Results*

- ❖ The agencies surveyed appear to be operating at capacity and that they would have a difficult time handling a large influx of clients. There are no indications that there will be a large increase in people seeking services at this time, but this possibility should be monitored.
  - ❖ Catholic Charities decided it will close its CDT program in the near future. Most of these clients will be referred to BCMHD.
  - ❖ Recruitment of psychiatrists is a very high priority at this time. Most of the psychiatrists employed by the agencies surveyed are over 60 years of age.
  - ❖ A large majority of clients at BCMHD are receiving psychiatric care and this agency is most at risk to shortages in psychiatrists.
  - ❖ Twenty five percent of clients across all agencies are veterans. The majority are receiving services at the VA clinic, which is greatly understaffed.
  - ❖ Across the five agencies there are very few psychologists employed. Hiring more psychologists should be considered.
  - ❖ There is a need for clinicians who speak Spanish and know American Sign Language. These individuals may be left out of services because of the cultural and/or language barriers.
  - ❖ Long waiting times for non-hospital referrals appears to be problem. This could be particularly problematic for clients in a significant amount of distress. Agencies may wish to implement a triage procedure where level of distress is considered.
  - ❖ There appears to be the greatest need for more services for individuals with eating disorders, and sex offenders.
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- ❖ MICA clients appear to offer great challenges because of the difficulties in determining and prioritizing which disorder to treat.
  - ❖ Coordinating services to individuals with comorbid mental illness and mental retardation is also a challenge. These adults have difficulty securing mental health services through OMH agencies. Although many OMRDD agencies offer mental health services, it is unclear whether these individuals are having their met. This state of affairs suggests a gap in services.
  - ❖ Most agency representatives did not view the implementation of best practices as a significant concern; however, none of the agencies have a formalized system to help implement best practices. Greater emphasis on these guidelines seems important if agencies are to provide cost-effective services which are also effective therapeutically.
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**Appendix A: Outpatient Mental Health Treatment Questionnaire**

**Broome County Community Mental Health  
Evaluation Project  
Outpatient Mental Health Treatment Questionnaire**

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Name of Agency:

Contact Person:

Date:

**Researcher:** Oliver Fassler, MA  
Administrative Intern  
Broome County Mental Health Clinic  
Telephone: 778-1120  
FAX: 778-1164

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***Basic Agency Information:***

1. How many adults (18 and over) are currently receiving services at your clinic?
  2. Please provide the billable units of service your program provided for the time periods listed.
    - a. January 1, 2005-December 31, 2005 \_\_\_\_\_
    - b. January 1, 2004-December 31, 2004 \_\_\_\_\_
    - c. January 1, 2003- December 31, 2003 \_\_\_\_\_
  3. On average, how long does it take from client's initial contact until they receive treatment services (e.g. counseling, medication management). This does not include evaluation.
    - a. Non-hospital referrals \_\_\_\_\_
    - b. Hospital referrals \_\_\_\_\_
  4. To help us better understand your clientele, please attach a copy of your admission criteria/policy.
  5. Please list the groups that are currently being offered.
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6. Using the following scale please estimate the likelihood that a client referred to your agency with the following characteristics would be accepted for treatment:

1	2	3	4
Very Unlikely			Very Likely
Diagnosis of mental retardation			_____
Sex Offenders			_____
Referral from prison/jail			_____
History of substance dependence with recent usage			_____
History of substance dependence in remission			_____
Severe and Persistent Mental Illness (SPMI) <sup>††</sup>			_____

7. Please list the disciplines represented (e.g. psychiatrist, psychologist, social worker, nurse) and the number of Full Time Equivalent (FTE) employees in each discipline.

8. Please indicate the education level of staff who provide treatment services. In the space provided please provide the number of FTE employees for each education level.

Doctoral level	_____
Masters degree	_____
Bachelors degree	_____
Associates Degree	_____
High School Diploma	_____
No High school diploma	_____

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<sup>††</sup> Severe and persistent mental illness (SPMI) is defined by OMH as an individual over 18 years of age who has a DSM-IV diagnosis other than alcohol and drug disorders, organic brain syndromes, developmental disabilities, or social conditions. In addition one of the following criteria must be met: enrollment in SSI or SSD due to mental illness, **OR** extended impairment in functioning due to mental illness, **OR** demonstrated ongoing reliance on psychiatric treatment, rehabilitation and supports.

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9. Does your agency employ peer counselors? If so how many FTE employees are peer counselors?

10. In order to help us determine future psychiatric needs in our community, please provide the ages of the psychiatrists employed at your agency. Please provide ages only and no identifying information.

11. Are any of your clinicians bilingual? If so, what languages do they speak? Please provide the number of clinicians that speak each language listed.

***Client Characteristics:***

12. Please estimate the percentage of clients in your program who meet New York State OMH criteria for severe and persistent mental illness (SPMI). Please use the definition provided on the footnote of the preceding page.

13. Please estimate the percentage of clients accepted into your program who are veterans.

14. Please provide the percentage of clients who come to your clinic for:

Pharmacological treatment only	_____
Individual/Group therapies only	_____
Both of the above categories	_____
Psychosocial/Life skills programming	_____

15. Offering services to individuals who do not speak English poses certain challenges. From the list below please rank a maximum of four languages that are posing the greatest demand for your agency.

_____ Laotian	_____ Somali
_____ Vietnamese	_____ Sudanese
_____ Chinese/Mandarin	_____ Kurdish
_____ Spanish	_____ American Sign Language
_____ Serbo-Croatian	_____ Other: _____

16. If you offer a sliding fee scale, what is the lowest amount on your scale?

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17. For the following categories, please estimate the percentage of clients that have:

Medicaid only	_____
Medicaid and Medicare	_____
Medicare only	_____
Private Insurance	_____
Self-pay/Sliding Scale	_____

18. Below is a list of possible challenges to providing quality outpatient mental health services. Using the following scale, rate how great a challenge you consider each item from the list.

1	2	3	4
Not a challenge			Great Challenge
_____			Recruitment of new psychiatrists
_____			Understaffed. Which discipline(s)? _____
_____			Inter-agency cooperation
_____			Coordinating services to clients also diagnosed with mental retardation
_____			Coordinating services to MICA clients
_____			Serving the needs of elderly clients
_____			Serving needs of clients from culturally diverse backgrounds
_____			Serving needs of clients from areas in Broome county outside of the triple cities
_____			Treatment of sex offenders
_____			Implementing best practices
_____			Other _____
_____			Other _____

19. Please provide any additional comments or insights that you consider important in providing outpatient mental health services to adults in this community.

**Appendix B: Sample of Interview Questions**

Name of Agency:

Name of Contact:

Date of Interview:

1. What are some of the challenges your agency faces in providing outpatient mental health services?
  2. What are some of the strengths of your agency in providing outpatient treatment?
  3. Who gets most consistently left out of services?
  4. Which groups in need of mental health services get the least help?
  5. Which groups get most mental health services?
  6. What are your thoughts regarding peer counseling? What do the peer counselor's do? Do they run groups? What type of supervision and training do they get? What are some of the difficulties/advantages of peer counseling?
  7. What are the challenges to group therapy?
  8. Of the groups that you mention, how often are they being offered? Are they still being offered?
  9. What are the challenges regarding treatment of sex offenders?
  10. Where do you get information on best practices? How are they being implemented?
  11. Other thoughts or comments that are important?
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