FINAL REPORT OF THE YOUTH MENTAL HEALTH TASK FORCE

In 2015, U.S. Congressman John Katko and New York Assemblyman Bill Magnarelli formed a task force to identify the largest gaps in youth behavioral and mental health services in Central New York, and to provide recommendations.

"To service the needs of patients, youth mental health services must be expanded to include more community based resources. A major factor in providing these vital services is for private insurance companies to step up and meet this challenge, as well as provide coverage for youth in our State run facilities."

— Assemblyman Magnarelli

"The economic costs of mental illness will be more than cancer, diabetes, and respiratory ailments put together."

— Thomas Insel, MD
Director National Institute of Mental Health

"We have a responsibility as a community and as a nation to respond to the growing public health threat posed by mental illness among our youth."

- Congressman John Katko (NY-24)

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Introduction

BACKGROUND

The Youth Mental Health Task Force was created in April 2015 by Congressman John Katko (NY-24) and Assemblyman William B. Magnarelli (AD 129) following a proposal to examine New York's mental health system and the Hutchings Psychiatric Center.

The mission of the task force was: *to identify the largest gaps in youth behavioral and mental health services in Central New York, and to provide recommendations to better integrate behavioral and mental health care delivery using multiple settings and providers*.

The Richard H. Hutchings Psychiatric Center is one of the largest mental health providers in Upstate New York. The Center is a comprehensive, community-based system that provides services to moderately and severely mentally ill individuals and their families. Located near Syracuse University and the SUNY Upstate Medical University, Hutchings is under the auspices of the New York State Office of Mental Health and is uniquely positioned to provide both inpatient and outpatient services for children and adults. The Center has served Cayuga, Cortland, Madison, Onondaga, and Oswego counties since 1972.[1]

In the last two decades, there have been several proposals to consolidate or altogether end certain services offered by the Hutchings Center. Most recently, in 2013, the state Office of Mental Health announced plans to close the Hutchings Children and Adolescent Inpatient Service Units in Syracuse as part of a larger reconfiguration of the New York State mental health system. Closure of the only inpatient psychiatric center for youth in the region would have exacerbated the already existing shortage of inpatient beds for mentally ill children. It was estimated that nearly 1,000 patients would be affected, with many of them having to be transported to other parts of the state, making uninterrupted care more difficult.[2]

In Central New York, many families with private insurance face additional barriers to mental health services due to a hospital's lack of contracts with major insurance carriers, and as a result, private insurance companies will usually not pay for treatment at the facility. In 2004, the Four Winds Hospital in Syracuse with 64 youth beds closed.[3] This forced families to send children in need of inpatient care to facilities as far away as Buffalo and Saratoga. This distance and travel placed a burden on already stressed families.

Though the Hutchings Children and Adolescent Inpatient Services Program was not eliminated, the proposal spurred further examination and conversation of the availability and quality of

[1] "Hutchings Psychiatric Center". *State of New York, Office of Mental Health.* N.p., 2016 https://www.omh.ny.gov/omhweb/facilities/hupc/

[2] New York State Office of Mental Health. (2013). *OMH Regional Centers of Excellence: A Progressive Behavioral Health System*. Kristin M Woodlock, RN, MPA.

[3] "Closing Hutchings children's unit bad for kids, families, doctor training program, critics say", Syracuse.com, July, 14, 2013.

behavioral and mental health services throughout the State. Following the proposal, members of the hospital community, several not-for-profit organizations and numerous constituents met with their local elected officials to discuss the status of the behavioral and mental health system in Upstate New York. Ultimately, these conversations spurred the creation of the Youth Mental Health Task Force, which is comprised of individuals dedicated to improving youth mental health services throughout Upstate New York.

Executive Members of the Youth Mental Health Task Force include:

- John Katko, *Congressman of New York's 24th District, U.S. House of Representatives*
- William B. Magnarelli, *Assembly District 129, New York State Assembly*
- Tania S. Anderson, *CEO, ARISE Child & Family Service*
- Jeanette S. Angeloro, *Director of Outpatient Behavioral Health Services, St. Joseph's Hospital Health Center*
- George Blakeslee, *Previous Chief of Child Services at Hutchings Psychiatric Center and current Director of Regional Development in the Department of Psychiatry, SUNY Upstate Medical University*
- Ray Bizzari, *Director of Community Services, Cayuga County*
- Mark Cattalani, M.D., *Executive Director, Hutchings Psychiatric Center*
- Mantosh Dewan, M.D., *Interim Dean, College of Medicine, and Distinguished Service Professor of Psychiatry, SUNY Upstate Medical University*
- Wanda Fremont, M.D., *Medical Director of Child and Adolescent Psychiatry Clinic, Professor of Psychiatry and Behavioral Science, and Family Medicine, SUNY Upstate Medical University*
- Robert Gregory, M.D., *Former Chair, Department of Psychiatry and current Professor of Psychiatry and Behavioral Sciences, SUNY Upstate Medical University*
- Sheila LeGacy, *Director of Support and Family Education, AccessCNY*
- Ann Rooney, *Deputy County Executive for Human Services, Onondaga County Department of Children and Family Services*
- Jennifer Marsh, *Social Worker, Upstate Golisano Children's Hospital*
- Linda McAleer, RN, *Director of Nursing, Pediatrics, Upstate Golisano Children's Hospital*
- Mary Jane O'Connor, *Advocate*
- Karen Winters Schwartz, *President, National Alliance on Mental Illness Syracuse*
- Glady Smith, *New York State Office of Mental Health*
- Monika Taylor, *Director of Behavioral Health, Crouse Hospital*
- Mark Thayer, *Director of Community Services, Cortland County*
- Linda J. Veit, *Office of the President, Director of Community Relations, SUNY Upstate Medical University*
- Gina Atkins, *Associate Administrator for Behavioral Services Division, Oswego Health*

- Sherie Ramsgard, *MSN, Psychiatric Nurse Practitioner*

EXECUTIVE SUMMARY

From studies published between 1980 and 1993 to studies published between 1993 and 2002, the number of observations of children and adolescents presenting symptoms of mental illness has nearly quadrupled.[4] Mental illness not only causes distress in the affected youth, but also disrupts the family, interferes with school functioning, leads to risky behaviors, and increases risk of death by suicide. Suicide is now the tenth leading cause of death in the United States,[5] and the second leading cause of death among fifteen to thirty-four year olds.[6] At the turn of the new millennium, approximately three million youths were at-risk for suicide, but only 36 percent of those at-risk youth received mental health treatment.[7]

In New York State, specifically Upstate New York, the rate of suicide has far outpaced the national trend. According to the New York State Health Department, Cayuga County, Oswego County, Onondaga County, and Wayne County have a suicide rate that surpasses the statewide and national average.[8] Cayuga County's suicide mortality rate from 2008-2011 was 11.1 per 100,000 people, Oswego County's suicide mortality rate from 2008-2011 was 16.5 per 100,000 people, Onondaga County's suicide mortality rate from 2008-2011 was 10.7 per 100,000 people, and Wayne County's suicide mortality rate from 2008-2011 was 10.0 per 100,000 people.[9]

Early detection and diagnosis of mental illness is possible, but often missed. The first onset of mental disorders usually occurs in childhood or adolescence. Half of adults with mental health disorders had their first onset by 14 years of age and three-fourths were diagnosed by the age of twenty-four.[10] However, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 60 percent of children and adolescents with mental health problems of any kind do not receive mental health services.[11] SAMHSA estimates similar treatment

[4] Costello EJ, Egger H, Angold A. "10-Year Research Update Review: The Epidemiology Of Child And Adolescent Psychiatric Disorders: I. Methods And Public Health Burden. - Pubmed – NCBI". Ncbi.nlm.nih.gov. N.p., 2016

[5] American Journal of Psychiatry and U.S. Surgeon General's Report, 1999.

[6] Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2013, 2011) National Center for Injury Prevention and Control, CDC (producer). Available from http://www.cdc.gov/injury/wisqars/index.html.

[7] Substance Abuse and Mental Health Services Administration. (2011). *Identifying Mental Health and Substance Use Problems of Children and Adolescents: A Guide for Child-Serving Organizations* (HHS Publication No. SMA 12-4670). Rockville, MD.

[8] Curtin SC, Warner M, Hedegaard H. Increase in suicide in the United States, 1999–2014. NCHS data brief, no 241. Hyattsville, MD: National Center for Health Statistics. 2016.

[9] NYS Department of Health - Vital Statistics, NYS County Health Assessment Indicators, http://www.health.state.ny.us/statistics/chac/chai/; US Data Source: Centers for Disease Control, National Vital Statistics Reports, Volume 60, Number 04 Deaths: Preliminary Data for 2010, http://www.cdc.gov/nchs/fastats/deaths.htm

[10] Kessler RC., Amminger GP., Aguilar-Gaxiola S., Alonso J., Lee S., Ustun TB. Age of onset of mental disorders: a review of recent literature. *Curr Opin Psychiatry.* 2007;20:359–364.

[11] Substance Abuse and Mental Health Services Administration. (2011). *Identifying Mental Health and Substance Use Problems of Children and Adolescents: A Guide for Child-Serving Organizations* (HHS Publication No. SMA 12-4670). Rockville, MD: Author.

statistics for U.S. adults, reporting that only 59 percent of adults in the U.S. with a mental illness received mental health services in the past year.[12]

Sadly, despite the obvious magnitude and urgency of these insufficiencies, development of a comprehensive, coordinated approach to meeting mental health needs in the U.S., particularly the needs of children and adolescents, remains elusive. Numerous barriers prevent youth and their families from obtaining needed services, including the stigma associated with mental illness, a shortage of mental health professionals, insufficient coverage of mental health services by private health insurance companies, and complex and fragmented service delivery systems.

In the past several years, there has been an increasing number of office visits by children and adolescents seeking mental health care,[13] with the number of office visits for mental health care rising faster for youth than for adults.[14] According to the Health Resources and Services Administration (HRSA), however, there is a shortage of mental health care providers – the need for mental health care providers is only 47.74 percent met in the United States. In New York State, that percentage is only 44.12.[15] This shortage results in a majority of individuals with mental illness receiving mental health treatment from their primary care provider. There is clearly a need to both incentivize physicians to become mental health care providers and also to ensure more effective collaboration between primary care and mental health care providers.[16]

Efforts to enhance mental health services for youth must address every piece of the mental health system – from pediatric and adult practices to community mental health agencies, as well as private and public mental health providers. Additionally, the issue of adequately funding youth mental health services must be addressed. The federal and state government must provide additional funding to cover treatment and support services. Private health insurance companies must also provide adequate coverage for treatment.

Though the challenge of transforming the entire mental health system for youth still remains, last year, Congress passed the largest comprehensive mental health reform bill in 50 years. The bill, "Helping Families in Mental Health Crisis Act," supports services that invest in prevention, early identification and intervention, integrated behavioral health services, with recovery as the

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[12] Substance Abuse and Mental Health Services Administration, *Results from the 2014 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration. (2015). http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf

[13] Olfson, M., Blanco, C., Wang, S., Laje, G. And Correll, C. "National Trends in The Mental Health Care of Children, Adolescents, And Adults By Office-Based Physicians". *JAMA Psychiatry* 71.1 (2014): 81-90

[14] "NAMI: National Alliance On Mental Illness". N.p., 2016 http://www.nami.org/Learn-More/Treatment/Psychosocial-Treatments

[15] Bureau of Clinician Recruitment and Service, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, HRSA Data Warehouse: Designated Health Professional Shortage Areas Statistics, as of September 9, 2016.

[16] *Primary Care Providers' Role in Mental Health.* Washington, D.C. The Bazelon Center for Mental Health Law. http://naapimha.org/wordpress/media/Primary-Care-Providers%E2%80%99-Role-in-Mental-Health.pdf

ultimate goal. While the passage of this bill lays the foundation for comprehensive mental health reform in the United States, much remains to be done. The Youth Mental Health Task Force produced this report to provide valuable insights into the current state of child and adolescent mental health in Central New York as well as provide preliminary steps to improve mental health programs and services for youth in this region.

Authors:

- John Katko, *Congressman of New York's 24th District, U.S. House of Representatives*
- William B. Magnarelli, *Assembly District 129, New York State Assembly*
- Tania S. Anderson, *CEO, ARISE Child & Family Service*
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- Mantosh Dewan, M.D., *Interim Dean, College of Medicine, and Distinguished Service Professor of Psychiatry, SUNY Upstate Medical University*
- Wanda Fremont, M.D., *Medical Director of Child and Adolescent Psychiatry Clinic, Professor of Psychiatry and Behavioral Science, and Family Medicine, SUNY Upstate Medical University*
- Robert Gregory, M.D., *Former Chair, Department of Psychiatry and current Professor of Psychiatry and Behavioral Sciences, SUNY Upstate Medical University*
- Sheila LeGacy, *Director of Support and Family Education, AccessCNY*
- Ann Rooney, *Deputy County Executive for Human Services, Onondaga County Department of Children and Family Services*
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- Linda J. Veit, *Office of the President, Director of Community Relations, SUNY Upstate Medical University*
- Gina Atkins, *Associate Administrator for Behavioral Services Division, Oswego Health*
- Sherie Ramsgard, *MSN, Psychiatric Nurse Practitioner*

Contributors:

- Mark Cattalani, M.D., *Executive Director, Hutchings Psychiatric Center*
- Linda McAleer, RN, *Director of Nursing, Pediatrics, Upstate Golisano Children's Hospital*

Section I: Recommendation to Improve Data on the Prevalence of Mental Illness

UNRELIABLE DATA

Statistics vary greatly among the three surveys that provide national prevalence estimates of mental illness and are funded, in whole or in part, by the U.S. Department of Health and Human Services.

The National Comorbidity Survey Replication (NCS-R) and the National Comorbidity Survey Replication Adolescent Supplement (NCS-A) are funded primarily by the National Institute of Mental Health (NIMH) within the National Institutes of Health (NIH) of the Department of Health and Human Services (HHS). These surveys identify specific mental illnesses but are more than a decade old. It is important to note that the samples of more than 9,000 adults used to conduct the NCS-R and 10,000 adolescents (aged thirteen to seventeen) used to conduct the NCS-A did not include the homeless, individuals in institutions, or non-English Speakers. NCS-R data estimates of adults exhibiting symptoms that could be identified as a mental illness range from 26.2 percent to 32.4 percent. NCS-A data estimates the national prevalence of mental illness to be between 40.3 percent and 42.6 percent of adolescents.[17]

The National Survey on Drug Use and Health (NSDUH) is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) within HHS. Though NSDUH has the benefit of being conducted annually, it focuses primarily on the use of illegal drugs and alcohol; it does not identify specific mental illnesses and does not produce prevalence estimates for children or adolescents. The NSDUH is conducted in both English and Spanish but does not include active duty military personnel, homeless persons who do not live in a shelter, or individuals in institutions. According to the 2014 NSDUH, the prevalence of mental illness is estimated at 18.1 percent of adults when substance abuse disorders are excluded. That estimate is significantly lower than the NCS-R estimate of 24.8 percent when substance abuse disorders are excluded.[18]

[17] Erin Bagalman, Angela Napili, *Prevalence of Mental Illness in the United States: Data Sources and Estimates* (CRS Report No. R43047) (Washington, DC: Congressional Research Service, 2016), 4-6, http://www.crs.gov/reports/pdf/R43047.
[18] Erin Bagalman, Angela Napili, *Prevalence of Mental Illness in the United States: Data Sources and Estimates* (CRS Report No. R43047) (Washington, DC: Congressional Research Service, 2016), 6-7, http://www.crs.gov/reports/pdf/R43047.

Recommendation 1 – Maintain Longitudinal Data on Mental Illness

Longitudinal data tracks the same sample at different points in time, allowing changes within the sample to be measured over time. Longitudinal data also enables the timing of various events to be recorded and the duration of those events to be measured.

Comprehensive longitudinal databases exist for illnesses such as cancer and provide extensive information that has proven valuable to researchers, stakeholders, and policymakers seeking to serve these patients. Psychosis registries were used to compile longitudinal data and track mental illness in certain states in the 1950s through the 1970s – these databases are still used today in other countries such as Denmark, Sweden, and Finland. However, psychosis registries present significant confidentiality concerns for individuals, making it unlikely and impractical to revive their use in the United States.[19]

More accurate and more useful statistics on mental illness can be maintained without registries. Though federal investment in surveys measuring illnesses has expanded, the investment in surveys themselves has not been matched by investment in survey methods research.[20] Modifying survey methods to gain longitudinal data could help researchers to develop algorithms that estimate the frequency and intensity of mental illnesses likely to require crisis intervention or hospitalization. At the very least, more streamlined survey methods would provide better data that is necessary to inform the location and availability of mental health services.

With regard to youth, enhanced tools for recognizing and treating mental illness should be supported in schools. The use of standardized, culturally competent measurements of mental health in schools could provide more comprehensive data of mental illness among youth.

It is particularly important to implement routine screening for mental disorders in primary care settings and system-wide outcomes assessments in the mental health clinics and practices in Central New York.[21] It is only by regular monitoring through the implementation of objective and quantifiable outcome measures that one can assess whether the current treatment is effective, or whether an alternative treatment is indicated.

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[19] Teich, Judith. "Better Data for Better Mental Health Services." *Issues in Science and Technology* 32, no. 2 (Winter 2016).

[20] E.J. Sondik and E.L. Hunter, "National Data Experts on Access Measures," Health Affairs 17, no. 1 (1998): 189–190.

[21] MeschanJ, Kelleher KJ, Laraque D for the American Academy of Pediatrics Task Force on Mental Health. Enhancing Pediatric Mental health Care: Strategies for Preparing a Primary Care Practice. Pediatrics; 125, Supplement 3, June 2010; 887-1108.

Section II: Recommendations to Improve Administration of Mental Health Services

SYSTEM FRAGMENTATION

The health care system is generally not user-friendly for those in need of behavioral and mental health services. The lack of integration across systems used to treat substance abuse and mental illness is well-documented and often cited by patients and family members or caregivers. There is also fragmentation of care as adolescents transition from pediatric to adult-based services.

In New York State and across the country, fragmentation between the mental and physical health delivery and payment systems regularly prevents patients with mental illness from accessing coordinated care. For instance, though primary care physicians now provide mental health services to a majority of individuals receiving treatment, they are unable to receive payment for mental health services. Although additional billing codes are being made available for primary care, such as 96110 for mental health and developmental screening, these codes are not accepted by all payers. Additionally, federal reimbursement for children and young adults receiving inpatient care in institutions of mental disease is limited to inpatient psychiatric services. Medical services such as screenings and diagnostics are not reimbursed and must be administered elsewhere. The maze of restrictions surrounding delivery and payments makes it difficult for families to access care and difficult for patients to achieve continuity of treatment. These challenges are the result of a lack of adequate insurance coverage, and inadequate funding for mental health services by the state and federal governments.

Recommendation 2 – Increase Access to Assertive Community Treatment

Assertive Community Treatment (ACT) is a treatment model that provides "multidisciplinary, flexible treatment and support to individuals with mental illness twenty-four hours per day and seven days per week."[22] Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, ACT provides highly individualized service directly to patients. Under this treatment model, a team of providers supports the patient in every aspect of life that could affect mental health including medication, therapy, social support, employment, and housing.

ACT has proven useful for individuals who have transferred out of an inpatient setting but still benefit from comprehensive care while living independently.[23] It has been shown to be more

[22] "NAMI: National Alliance On Mental Illness Physchosocial Treatments". Nami.org. N.p. 2016 http://www.nami.org/Learn-More/Treatment/Psychosocial-Treatments

[23] Santos, Alberto B. Soreff, Stephen Michael (Ed). (1996). Handbook for the treatment of the seriously mentally ill, (pp. 411-431). Ashland, OH, US: Hogrefe & Huber Publishers, xv, 540 pp.

effective than traditional treatment for people diagnosed with mental illnesses such as schizophrenia and schizoaffective disorder.[24]

An effective community-based response for individuals at risk of experiencing mental health crises decreases utilization of acute services such as hospital emergency departments, lessens the need for law enforcement responses, lowers incarceration rates for individuals with mental illness, and increases the rate at which individuals are connected with outpatient mental health services.[25] In a study by the American Journal of Orthopsychiatry, only 18 percent of ACT clients were hospitalized the first year compared to 89 percent of the non-ACT treatment group. For those ACT clients that were re-hospitalized, stays were significantly shorter than stays of the non-ACT group.[26]

Despite the documented success of ACT, only a fraction of those with the greatest needs have access to this uniquely effective program. Only six states (DE, ID, MI, RI, TX, WI) currently have statewide ACT programs. Nineteen states have at least one or more ACT pilot programs in their state. In Upstate New York, Onondaga County and Oswego County have implemented assertive community treatment programs.[27] New York State should continue to support the ongoing efforts to expand the use of ACT.

Recommendation 3 – Create a Continuum of Care

Different individuals require different levels of care. Individuals with greater severity of illness who are in acute crisis need more intensive treatment to recover and live well. Some require more comprehensive support systems, such as community residence or school-based programs; whereas other individuals may require only a time-limited focused outpatient intervention. The Central New York region has inadequate capacity at all levels of care, but is particularly lacking in intermediate care levels, such as intensive outpatient treatment programs and partial hospitalization programs, as well as transitional programs to assist individuals recently discharged from the hospital, which is the time of highest risk of relapse and completed suicide. Syracuse is the only city in New York State (including Albany, Binghamton, Utica, Rochester, and Buffalo) that does not have a partial hospitalization program. New York State needs to encourage hospitals and community-based providers to develop and/or expand continuum of care for children's behavioral health services, such as partial hospitalization, in order to reduce unnecessary psychiatric hospitalizations and allow children to receive appropriate levels of care in their own communities.

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[24] "NAMI: National Alliance On Mental Illness Physchosocial Treatments". Nami.org. N.p. 2016 http://www.nami.org/Learn-More/Treatment/Psychosocial-Treatments

[25] Bond, G., Drake, R., Mueser, K. and Latimer, E. "Assertive Community Treatment For People With Severe Mental Illness". *Disease Management and Health Outcomes* 9.3 (2012): 141-159. http://link.springer.com/article/10.2165/00115677-200109030-00003

[26] Essock SM, Frisman LK, Kontos NJ. "Cost-Effectiveness of Assertive Community Treatment Teams." *American Journal of Orthopsychiatry* 68(1998):179–190

[27] *Mental Health Programs in New York State.* State of New York, Office of Mental Health, 2016 http://bi.omh.ny.gov/bridges/directory?region=&prog_selection=09

Recommendation 4 – Close Gaps in Patient Hand-off Process

The "hand-off" process in New York State of a patient from one provider to another is fragmented and should be strengthened to lower readmission and improve continuity of care. For example, there is currently no system in place to ensure notification of the regular psychiatrist of a youth or adult who is admitted to a hospital for a mental illness outside of the psychiatrist's regular hours. The same problem pertains to notifying schools of a student's hospitalization outside of school hours.

The New York State Office of Mental Health recommends a "warm hand-off" as a recommendation for reducing behavioral health admissions. Office of Mental Health suggests, "whenever possible, face-to-face meeting with receiving outpatient provider (clinician, case/care manager and/or peer) during inpatient stay or immediately upon discharge. Ideally, the outpatient provider participates in a discharge planning meeting with, client, caregiver, inpatient team, and has an individual meeting with client."[28]

When physicians and clinicians responsible for continuous care are not notified of emergency hospitalization or crisis intervention, they are unable to modify treatment or adjust diagnosis, if needed. Adopting a clear process and procedure to achieve the Office of Mental Health's "warm hand-off" recommendation will close gaps in the mental health care system and improve patient care during periods of crises.

Section III: Recommendations to Increase Access to Effective Services and Supports

PRIMARY AND MENTAL HEALTH CARE

Navigating complex health and social service delivery systems to identify available mental health resources can be a challenging and time consuming task. Adding to the already complex nature of accessing mental health care is a shortage of mental health professionals. The shortage is most significant in rural areas and for mental health professionals who serve children and adolescents. The following recommendations include mental health services that can be improved and expanded in New York State to increase access to mental health services for youth.

Recommendation 5 – Expand Use of Telepsychiatry

Telepsychiatry is a promising new tool which has been shown to increase the availability of quality psychiatric care through the use of television/video and other communications equipment. Telepsychiatry is designed to support all stakeholders involved in a patient's

[28] *Reducing Behavioral Health Readmissions: Strategies And Lessons Learned.* State of New York, Office of Mental Health, 2016 https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/rbhr.pdf

treatment, facilitating collaboration between the patient, family, clinician, psychiatrist, and community supports.[29]

Using telepsychiatry, patients can be diagnosed, evaluated, treated, and educated about their mental health.[30] Given the shortage of mental health providers, especially in rural areas that are not within close proximity of a wide array of mental health resources, telepsychiatry is an important means of assuring access to quality psychiatric care. However, as telepsychiatry is expanded in Central New York, the connectivity barrier that many rural communities face must be addressed, as communities must have sufficient telecommunications capabilities in order to utilize telepsychiatry services.

Recommendation 6 – Open Access to Psychiatric Services

Even as insurance coverage of mental health services has improved, individuals seeking mental health care have continued to experience obstacles to receiving care due to the administration of mental health facilities. There is a lack of doctors, nurses, and support staff at facilities. Additionally, the United States faces an acute lack of child psychiatrists.[31] This leads to difficulty scheduling appointments, restricted hours, and the need for referrals or prior evaluation that limit access to preventative or on-going treatment.

Research by the National Council for Behavioral Health shows the longer a person waits between seeking health care and actually receiving care, the more likely the individual is to not show for a scheduled appointment and to abandon the resources. Improved provider staffing enabling open access to mental health care – including open patient scheduling, same day appointments and extended hours for clinics with psychiatric services – will ensure that individuals get help when they need it. Multiple studies show this translates to improved follow through and adherence to treatment by patients.[32] In addition to better care for patients, open access also increases the capacity of providers and lowers overhead costs.[33]

Recommendation 7 – Incentives to Fix Mental Health Workforce Shortages

Mental health care is provided by individuals trained in a variety of disciplines. The Health Resources and Services Administration (HRSA) define "core mental health professionals" as

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[29] Deslich, S., Stec, B., Tomblin, S., & Coustasse, A. (2013). Telepsychiatry in the 21st Century: Transforming Health care with Technology. Perspectives in Health Information Management / AHIMA, American Health Information Management Association, 10(Summer), 1f.

[30] Kuo G. M., Ma J. D., Lee K. C., Bourne P. E. "Telemedicine, Genomics and Personalized Medicine: Synergies and Challenges."

[31] Liz Brown, Sally Zhang and Jon Schuppe, "Decades Into Crisis, Kids Still Suffer From Shortage of Psychiatrists." *NBC News*, June 8, 2016, http://www.nbcnews.com/news/us-news/decades-crisis-kids-still-suffer-shortage-psychiatrists-n581276.

[32] Kopach, R., DeLaurentis, PC., Lawley, M., Muthuraman, K,. Ozsen,L. Rardin, R,. Wan, H,. Intrevado, P,. Qu, X,. Willis, D. "Effects Of Clinical Characteristics On Successful Open Access Scheduling." *Health Care Management Science* 2007 June; 10(2):111-24 http://www.ncbi.nlm.nih.gov/pubmed/17608053

[33] Lloyd, David and Lloyd, Scott. "Help Now: Changing For Behavioral Health care Access". *National Council Magazine.* 2014. p. 46-48 http://www.thenationalcouncil.org/?api&do=attachment&name=many-faces-integration&index=0&type=magazine-issues&inline#page=46

clinical social workers, clinical psychologists, marriage and family therapists, psychiatrists, and advanced practice psychiatric nurses.[34]

HRSA uses the number of health professionals in a given area relative to the population of that area to designate Health Professional Shortage Areas (HPSA). For mental health, the population to provider ratio must be at least 30,000 to 1 (20,000 to 1 if there are unusually high needs in the community) to avoid an HPSA designation. In New York State, 154 mental health care HPSAs have been identified and an additional 116 practitioners would be needed to remove these designations. [35]

The current number of pediatric medical subspecialists, including pediatric surgical specialists, is inadequate to meet the growing health needs of American children. According to a 2012 Children's Hospital Association survey, the average wait time to see a developmental pediatric specialist is 14.5 weeks, 8.9 weeks for a neurologist, and 7.5 weeks to see a child and adolescent psychiatrist.[36] Immediate steps must be taken to expand the child and adolescent psychiatry workforce, otherwise the mental health needs of American youth will continue to not be met.

In Congress, legislation has been introduced to modify the National Health Service Corps to allow pediatric subspecialists working in underserved areas to participate in the Corps.[37] Currently, pediatric subspecialists are not eligible for the National Health Service Corps, a program that provides scholarships and student loan repayment for primary care providers in the medical, dental, and behavioral health fields who agree to practice in areas of the country that have health professional shortages.[38] Enabling pediatric subspecialists to participate in the National Health Service Corps will encourage young physicians to pursue the pediatric subspecialties that are most desperately needed and begin to close the gap for mental health treatment in underserved areas.

Recommendation 8 – Improve Mental Health Education for Primary Care Providers and the Public

In addition to workforce shortages, inadequate and varying training for primary care providers and the public – who are often the first point of contact for a patient seeking mental health care and are now providing more than half of mental health services – are contributing to the

[34]Elayne Heisler, Erin Bagalman, *The Mental Health Workforce: A Primer* (CRS Report No. R43255) (Washington, DC: Congressional Research Service, 2015), https://fas.org/sgp/crs/misc/R43255.pdf

[35] Bureau of Clinician Recruitment and Service, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, HRSA Data Warehouse: Designated Health Professional Shortage Areas Statistics, as of September 9, 2016.

[36] Children's Hospital Association. (2012, August 1). *Pediatric Specialist Physician Shortages Affect Access to Care* [Fact sheet]. Retrieved September 15, 2016, https://www.childrenshospitals.org/issues-and-advocacy/graduate-medical-education/fact-sheets/2012/pediatric-specialist-physician-shortages-affect-access-to-care

[37] Ensuring Children's Access to Specialty Care Act of 2015, H.R. 1859, 114th Cong. (2016).

[38] "National Health Service Corps Site Reference Guide". U.S. Department of Health and Human Services Health Resources and Services Administration. http://nhsc.hrsa.gov/downloads/sitereference.pdf

insufficiencies in mental health care.[39] Barriers primary care providers and the public face to providing mental health services include:[40]

- Insufficient knowledge needed to identify the signs and symptoms of mental illness
- Lack of comfort, training, and expertise to address mental health needs
- Lack of time to meet the "physical" health needs, let alone mental health needs, of patients
- Insufficient or no payment for mental health services as a result of poor insurance coverage and a lack of government support
- Inadequate referral resources and insufficient referral feedback/shared decision-making between primary care clinicians and mental health clinicians

As a result, tragic consequences of untreated mental health disorders occur daily. To raise awareness and increase public education on mental illness, Congress has introduced legislation that will amend the Public Health Service Act to provide grants to initiate and sustain mental health first aid training to emergency first responders, law enforcement personnel, primary care personnel, human resources professionals, teachers, students, and parents.[41] In addition, New York State through the Office of Mental Health supports statewide efforts to educate primary care providers through Project Teach and the CAP-PC program.[42] By expanding these programs to primary care providers and everyday Americans, those facing mental illness will have greater access to the mental health resources they need.

Recommendation 9 – Greater Awareness of and Access to 2-1-1 Information and Referral Call Centers

Health and Human Services Information and Referral telephone call centers are staffed by trained specialists who are able to directly connect callers to a variety of health and social services, including mental health services, twenty-four hours per day, seven days a week. The 2-1-1 centers have multilingual capabilities and can be accessed free of charge by dialing 2-1-1. They are funded through local and state sources, including non-profit organizations, foundations, businesses, and state and local governments. Currently, 2-1-1 centers exist or are being

[39] Bishop, T., Ramsay, P., Casalino, L., Bao, Y., Pincus, H. and Shortell, S. "Care Management Processes Used Less Often For Depression Than For Other Chronic Conditions in US Primary Care Practices". *Health Affairs* 35.3 (2016) 394-400 http://content.healthaffairs.org/content/35/3/394.abstract

[40] *Strategies For System Change in Children's Mental Health: A Chapter Action Kit.* American Academy of Pediatrics, 2007. p. 1-1 https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/finalcak.pdf

[41] Mental Health First Aid Act of 2015, H.R. 1877, 114th Cong. (2016).

[42] Laraque D. The New York Project TEACH (CAP-PC and CAPES Programs): Origins and Successes. Gen Hosp Psychiatry (2014)

developed in several states but, with the exception of Connecticut, Hawaii, and Minnesota, statewide access to the centers is not available.[43]

In New York State, 2-1-1 service is currently offered by six regional call centers and two supporting partner sites.[44] Where service exists, efforts should be made to increase awareness of the 2-1-1 centers. Where service is not yet accessible, impediments to service should be examined and eliminated. Central New York should strive to have 2-1-1 service available in the six county region served by Hutchings Psychiatric Center. Financial resources must be found to make this a reality.

Recommendation 10 – Increase Inpatient Psychiatric Services As-Needed

Over the past several decades, there has been a reduction in institution-based treatment resources and inpatient psychiatric services. Though this movement was never intentional, it has created a major void in mental health treatment.

In Central New York the reduction of private sector beds has created an acute shortage. Specifically, families that are covered by private health insurance saw their options for treatment dwindle. In 2004, the last private pay facility for children in Central New York (Four Winds) closed. This left Hutchings as the only inpatient unit in the region. However, Hutchings lacks contracts with major insurance carriers, and as a result, private insurance companies will usually not pay for treatment at the facility. This forces families to send children to facilities as far away as Buffalo and Saratoga where their insurance is accepted. In 2016, 240 children and adolescents in need of psychiatric hospitalization came to Upstate. Of these, almost half (111 kids) had to be sent out of Onondaga County to find an available bed.[45] Moreover, children and adolescents are often held for many days in CPEP, emergency departments, or the pediatric floors of Upstate Golisano Children's Hospital while waiting for a psychiatric bed to become available somewhere in the State.

The shift away from institutions and inpatient services was made without sufficient development of comprehensive community-based systems of care. Access to good outpatient treatment is necessary to minimize the use of inpatient services. As the number of dedicated psychiatric hospital beds has decreased, many communities report serious shortages of desperately needed inpatient psychiatric capacity. In turn, the shortage in psychiatric beds has resulted in longer wait lists for inpatient psychiatric services and overcrowding in public psychiatric facilities. Inpatient

[43] *Strategies For System Change in Children's Mental Health: A Chapter Action Kit.* American Academy of Pediatrics, 2007. p. 3-1 https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/finalcak.pdf

[44] "2-1-1 Service in New York State". N.p 2016 http://www.nysomce.org/new_york_211_service.htm

[45] (McAleer, Upstate Medical University, Director of Nursing, Pediatric Services)

psychiatric services should be increased, as needed, while newer outpatient models are being scaled.[46]

Locally, steps are being taken to address the acute shortage of inpatient beds. Upstate Golisano Children's Hospital, an extension of University Hospital, has completed initial design of an eight bed child and adolescent acute care behavioral health inpatient unit and is in the process of coordinating this initiative through the required regulatory agencies for approval and funding.

Since the Task Force's creation, it has been working with both the NYS Office of Mental Health and Excellus, the largest health insurer in the region, to facilitate an agreement by which Excellus will cover services at Hutchings. To this date, negotiations continue between OMH and Excellus on this solution. Assemblyman Magnarelli will introduce legislation that will require private insurance carriers in New York to cover inpatient treatment for children at OMH run hospitals. In addition, Upstate is exploring ways to support the efforts of Hutchings Psychiatric Center to meet the need for local access to acute inpatient psychiatric care.

Research shows that when the right services are delivered, close to home and families are involved, the outcomes are significantly better. Inpatient psychiatric services provide those services and allow families to raise children with emotional health and resilience. We should continue to promote inpatient psychiatric services throughout New York State.

EFFECTIVE CRISIS MANAGEMENT AND TREATMENT

Mental health crises are often difficult to predict and can occur even when all of the necessary crisis prevention treatment and procedures have been applied. When crises occur, families often have a difficult time knowing how to respond. Mental health resources dedicated to crisis treatments should be more readily available for use by families in crisis.

Recommendation 11 – Replicate Effective Mobile Crisis Response Treatment Model

Mobile crisis teams include mental health professionals trained to relieve first responders at the call site. The professionals are able to effectively evaluate and frequently stabilize the individual in crisis, then refer to community-based services for follow-up treatment. This limits time spent by police officers, EMTs and other emergency responders, on mental health crises.

When properly implemented, mobile crisis response has been found to produce lower hospitalization rates than response by emergency responders. Mobile Crisis response is both less costly than, and also as effective as, psychiatric hospitalization.[47] (See Appendix 1: The Neighborhood Center Mobile Crisis Proposal).

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[46] Salinsky, Elieen and Christopher Loftis, PhD. *Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?*. National Health Policy Forum, August 2007. http://www.nhpf.org/library/issue-briefs/IB823_InpatientPsych_08-01-07.pdf

[47] Currier, Glenn W., Susan G. Fisher, and Eric D. Caine. "Mobile Crisis Team Intervention to Enhance Linkage of Discharged Suicidal Emergency Department Patients to Outpatient Psychiatric Services: A Randomized Controlled

The Central New York Directors' Planning Group has proposed expansion of Mobile Crisis services as a way to fill in gaps in the continuum of care and reduce hospitalizations in the Central New York region. The Central New York Directors' Planning group is a working group represented by Hutchings Psychiatric Center and Directors of Community Services for the six counties served by Hutchings (Onondaga, Madison, Cayuga, Oswego, Oneida and Cortland). They are represented on the Task Force and have provided needed expertise in this model of care. Statistics have shown this model to be successful in other regions of New York State.

Recommendation 12 – Increase Access to Crisis Residence Programs

Hospitals are investing in crisis residence outpatient care as another way to steer patients away from the emergency room. Crisis residential programs reduce unnecessary stays in psychiatric hospitals, reduce the number and expense of emergency room visits, and provide a supervised residential setting for individuals exhibiting acute distress and requiring stabilization. Crisis residence programs are not designed to provide long-term care, rather the goal is to stabilize the situation quickly so the patient is able to return home. This increases the ability to maintain the patient's connection to his or her family, friends, and community.

The crisis residence provides comprehensive assessment, respite, and planning services that can be provided in the community and are not duplicated in the residence. Crisis residences are connected with local psychiatric emergency rooms and acute inpatient programs so that the patient and family can easily be linked up with community resources and supports following discharge.[48]

In Central New York, the Hutchings Psychiatric Center is the only local hospital with children's crisis residence capacity. As a result, many children in need of acute care either end up in a hospital emergency department or travel great distances to private hospitals with specialized care.[49] The absence of crisis diversion programs highlights the gap in the current mental health care system. Expanding a comprehensive system of care that will offer a breadth of crisis care service options focused on stabilizing and sustaining young people in the least restrictive settings, will drastically improve the health, safety, and well-being of the child.

Recommendation 13 – Increase Availability of Planned and Emergency Respite Services

Planned and Emergency Respite Services are an important resource for the families and caregivers of children and adolescents who live at home and have serious mental health needs. These programs exist to give a break to those who can be stressed by living with or caring for a family member with difficult-to-manage needs. Respite care creates a safe environment for the

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Trial." *Academic emergency medicine: official journal of the Society for Academic Emergency Medicine* 17.1 (2010): 36-43. PMC http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2859616/

[48] "Information For Children, Teens And Their Families Community Support Services". *State of New York, Office of Mental Health.* N.p., 2016 https://www.omh.ny.gov/omhweb/childservice/community_support.html

[49] New York State, Office of Mental Health. (2016, February 1). *Transformation Plan 2015-2016 End of Year Report*. https://www.omh.ny.gov/omhweb/transformation/docs/monthly-report-2015.pdf.

individual with special needs and can be provided in a family's home or licensed facility in the community.[50]

The New York State Caregiving and Respite Coalition (NYSCRC) is currently working to develop a comprehensive respite program staffed by hundreds of volunteer respite providers across New York State. Greater availability to respite services will improve the mental health of caregivers, helping them to better manage the physical and emotional stress that accompanies the responsibility of caring for an individual with special needs.[51]

Recommendation 14 – Strengthen Home Based Crisis Intervention

Home Based Crisis Intervention (HBCI) is aimed at youth aged five to seventeen who live at home and are at imminent risk of psychiatric hospitalization. HBCI programs are linked to emergency rooms and make a counselor available twenty-four hours per day, seven days a week, to provide rigorous in-home intervention for four to six weeks. The goal of these programs is to avoid inpatient admission and connect the patient and family with community-based resources.[52]

Recommendation 15 – Increase Availability of Specialized Evidence-Based Outpatient Treatment Programs

In addition to guiding and helping high risk individuals and their families through crisis management and outreach, referral to effective treatment is required. For many individuals, non-specific counseling and general psychiatric management are insufficient to break the tragic downward cycle of repeated hospitalizations and relapse. Effective treatment is needed to help individuals move towards recovery and to lead functional and fulfilling lives. Evidence-based treatments listed on SAMHSA's National Registry of Evidence-Based Programs and Practices, such as specialized psychotherapies, certain community and school-based programs, and treatments based in primary care settings, have been shown to be much more effective for most mental disorders and substance use disorders than the non-specific treatments that are typically offered. However, few of these evidence-based treatments are available in the Central New York area and access is limited in the programs offering them. Individuals need access to the most effective treatments and at the appropriate intensity and duration.

In order to rectify this situation, more specialty programs should be created and funded to treat vulnerable individuals having high risk conditions, such as autism, early psychosis, eating disorders, and/or suicidal thoughts and behaviors. Educational programs for evidence-based treatments should be made readily available to local mental health providers, and clinics should be encouraged to implement them, along with regular outcome assessments and quality control measures.

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[50] "ARCH National Respite Network". http://archrespite.org/
[51] "NYSCRC: New York State Caregiving & Respite Coalition". http://www.nyscrc.org/
[52] "Information for Children, Teens and Their Families Community Support Services". New York State, Office of Mental Health https://www.omh.ny.gov/omhweb/childservice/community_support.html

Recommendation 16 – Increase Number of Community Residences

Community Residences

Community residences provide a supervised environment for six to eight children or adolescents, between the ages of five and eighteen. The residences are nurturing environments that enhance daily living and generally include education to assist within the development of problem solving skills, as well as a behavior management system.

Necessary clinical supports are mostly accessed through community-based services outside of the residence. Community residences must work closely with other local mental health services such as inpatient psychiatric care, residential treatment facilities, and outpatient clinics.

Community residences are an important resource for providing a residential option for seriously emotionally disturbed children and youth who would otherwise likely be unnecessarily placed in more restrictive levels of care. Community residences are appropriate for youth who are diagnostically the same as youth placed in an inpatient or residential treatment facility yet are more independent and able to function in a community-based, supervised living environment. These are children who, with supervision, are able to participate in community, school, social, and recreational activities.[53]

EARLY DIAGNOSIS AND TREATMENT

Stigma and lack of recognition of mental health needs remain a barrier to people seeking help and treatment, not just for themselves but also for their children. Despite how common it is, mental illness continues to be met with widespread stigma: in hospitals, workplaces, and schools; in rural and urban communities; even among close friends and families.

Recommendation 17 – Earlier Identification of Behavioral and Mental Health Problems

There is inadequate identification of behavioral and mental health issues early in development – preschool, childhood, adolescence. Research shows, not only are behavioral and mental health problems detectable at an early age, in many cases they can be prevented.[54]

Mental health greatly affects classroom learning and social interactions, both of which are critical to the success and development of students. Children and youth in preschool and elementary school with mental health problems are more likely to struggle in school, be absent, or be suspended or expelled than are children with other disabilities.

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[53]"Information for Children, Teens and Their Families Community Support Services". New York State, Office of Mental Health https://www.omh.ny.gov/omhweb/childservice/community_support.html

[54] Hawkins, J. D., J. M. Jenson, R. Catalano, M. W. Fraser, G. J. Botvin, V. Shapiro, C. H. Brown, W. Beardslee, D. Brent, L. K. Leslie, M. J. Rotheram-Borus, P. Shea, A. Shih, E. Anthony, K. P. Haggerty, K. Bender, D. Gorman-Smith, E. Casey, and S. Stone. 2015. Unleashing the Power of Prevention. Discussion Paper, Institute of Medicine and National Research Council, Washington, DC. https://nam.edu/perspectives-2015-unleashing-the-power-of-prevention/

Unfortunately, behavioral and mental health problems are often mistaken for basic behavioral issues. Parents or guardians of children suffering from behavioral or mental health problems report frequent trouble in getting schools to recognize the relationship between their child's mental health disorder and the difficulty he or she is having in school. Local Education Authorities (LEAs) in New York require additional resources to furnish effective behavioral health interventions for students at risk and mental health services in school settings. [55]

In Congress, the Mental Health in Schools Act has been introduced to provide funding for public schools across the country to partner with local mental health professionals to establish on-site mental health care services for students. If enacted, the bill would establish a two hundred million dollar competitive grant program to local school districts across the country to provide on-site mental health services and programs for students (K-12).[56] The number of children affected by mental health issues is great, and the cost of counseling is comparatively low. If we can invest in our youth we will be able to avoid many of the tragic outcomes that can emerge with mental illness as children age such as suicide, crime, and a lifetime of missed opportunities.

Recommendation 18 – Reduce Stigmatization through Education and Leadership

Psychoeducation

Psychoeducation teaches individuals about their mental illness and how their treatment will work. When used most effectively, psychoeducation will also include education for family and friends in order to help them learn about coping strategies, problem-solving skills, and how to recognize the signs of relapse. In addition to other family-focused resources such as Planned and Emergency Respite Services, psychoeducation can be effective in easing tensions at home, which is important to both the individual suffering and their family.[57]

Promote Awareness and Education on Mental Health and Youth Substance Use Disorders

Awareness and education on mental health and substance use disorders should be promoted at all levels. A high proportion of youths with mental health or substance use problems have co-occurring problems, and each condition can contribute to developing the other.[58] Efforts and programs should be created to raise awareness, eliminate stigma and provide programs that support and address mental illness and substance use disorders in the community.

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[55] Mayor's Task Force on Behavioral Health and The Criminal Justice System of New York: Action Plan. Office of the Mayor of New York City 2014. https://www1.nyc.gov/assets/criminaljustice/downloads/pdfs/annual-report-complete.pdf

[56] Mental Health in Schools Act of 2015, H.R. 1211, 114th Cong. (2016).

[57] "NAMI: National Alliance On Mental Illness". N.p., 2016 http://www.nami.org/Learn-More/Treatment/Psychosocial-Treatments

[58] Greenbaum, P., Foster-Johnson, L., & Petrila, A. (1996). Co-occurring addictive and mental disorders among adolescents: Prevalence research and future directions. American Journal of Orthopsychiatry, 66(1).

Recovery High Schools

Nationally, Recovery High Schools have emerged as a continuing care resource for students recovering from a substance use disorder. The most common school model of Recovery High Schools is that of a program or affiliated school, embedded organizationally and physically with another school or set of alternative school programs.[59] Recovery High Schools meet state requirements for awarding high school diplomas while allowing students to learn in a substance-free and supportive environment. Recovery High Schools work closely with the teen and his or her family. A Recovery High School in Central New York would meet an unfilled need in our community.

On September 30, 2016, Governor Andrew Cuomo signed a law mandating that mental health education to be taught in NYS schools by July, 2018. This is a significant step, and the Task Force will help insure that this education is of the highest quality, providing specific recommendations such as NAMI Breaking the Silence.

Section IV: Conclusion

The Youth Mental Health Taskforce going forward will work with Congressman Katko and Assemblyman Magnarelli to advocate for the following:

1. Implementation of the foregoing recommendations discussed in this report.

2. Elected officials and community leaders are supporting efforts to enable Excellus patients to access inpatient services, such as access to Hutchings.

3. Actively support SUNY Upstate in its efforts to add an acute children and adolescent mental health unit.

4. Advocate for state and federal funding legislation that will ensure children and adolescents have access to mental health services.

[59] PhD, D. Paul Moberg PhD & Andrew J. Finch. "Recovery High Schools: A Descriptive Study of School Programs and Students." Journal of Groups in Addiction & Recovery (Oct 2008): Pages 128-161.

Appendix 1:

The Neighborhood Center Mobile Crisis Proposal

Prepared by the Central New York Directors' Planning Group, Inc.

Purpose

Unnecessary emergency room use and hospitalizations add millions to the skyrocketing costs of medical care. As the lead agency in Oneida and Herkimer Counties for the provision of emergency mental health services and a local suicide prevention resource, The Neighborhood Center's Mobile Crisis Assessment Team (MCAT), is experienced in dealing with high risk individuals and assessing suicidal risk. The Neighborhood Center, Inc. is proposing to provide comprehensive MCAT services to the residents of Chenango, Delaware, Otsego and Schoharie counties.

Needs Statement

All four counties are predominately rural with a decline in population, lower percentage of adults with a Bachelor's degree or higher (32.8% NYS), median household incomes below the state average and with high rates of indicated cases of child abuse/maltreatment. Schoharie County is the only county near a metropolitan area; however, the unemployment rate is the highest of all four counties and higher than the rest of New York State (6.6%). Stressors such as these seriously impact the health and wellness of the residents of the communities.

Pertinent County Demographics:

Indicator	Chenango	Delaware	Otsego	Schoharie
Population 2010 (April 1) estimates base*	50,479	47,989	62,253	32,749
Population, % change 4/1/10 to 7/1/12*	-1.1%	-1.5%	-0.9%	-2.0%
BA/BS or higher % of persons 25+ 2008-2012*	16.8%	18.8%	26.5%	19.9%
Median household income 2008-2012*	$44,127	$43,004	$46,358	$51,896
White alone, percent 2012*	97%	95.7%	94.9%	96.3%
Child Abuse/Maltreatment Indicated 0-17; 2011 rate/1,000 children**	33.3	28.1	16.6	21.9
Unemployment Rate Dec. 2013***	6.2%	6.7%	6.0%	7.3%
Civilian non-institutionalized population Uninsured Percentage Estimate	11.5%	10.2%	8.1%	8.2%
Land area in square miles, 2010 **Persons per square mile***	893.55 56.5	1,442.44 33.3	1,001.70 62.2	621.82 52.7
Metropolitan or Micropolitan Statistical Area*	None	None	Oneonta-Micro	Albany-Schenectady-Troy Metro

*Quick Facts-US Census Bureau **American Community Survey-US Census Bureau ***NYS Department of Labor

Individuals experiencing situational crises or those with emergent mental health needs may contemplate suicide. Suicide is a serious public health challenge with negative impact on the individual, family, and community as a whole. Individuals with existing mental health and or substance abuse issues are at increased suicidal risk.

According to the Substance Abuse and Mental Health Services Administration report, *Mental Health United States 2010*, an estimated 4.8% or 11 million people have some type of mental illness; 34,000 Americans committed suicide linked to mental illness; more than one quarter of adults with mental illness also had a substance abuse problem.

The charts below note suicide mortality rates and self-inflicted hospitalization rates for all four counties in addition to New York State as well as the cost to these four counties through Medicaid dollars. The need for comprehensive and mobile crisis response for the four counties is evident.