

Public Mental Health System Highlights

As the Office of Mental Health (OMH) prepares for the introduction of national and State health care reform and the redesign of services, particularly for people who receive Medicaid, it focuses on the provision of efficient and effective behavioral health services and the preservation of the safety net for New York's most vulnerable citizens and families. Planning for the future builds on the underpinnings of good care:

- Early and ready access to appropriate treatment and supports
- Clinically and culturally competent care that considers individual needs
- Continuous, personalized and integrated physical and behavioral health and support services from trusted caregivers
- A focus on helping people to live, learn and work productively in their communities
- Services and supports that are consonant with the values of recovery and resiliency

As reforms are considered and planned, OMH remains committed to providing treatment and supports based on quality, scientific evidence, safety, fairness and accountability. The necessity for data-driven planning has never been greater.

This chapter provides a snapshot of the current public mental health system of care in New York State (NYS)—a view of where we are now. It also provides indications of why integrated behavioral and physical health care matters, and ends with a picture of data resources that inform ongoing planning and monitoring, with an eye toward the changing system of care.

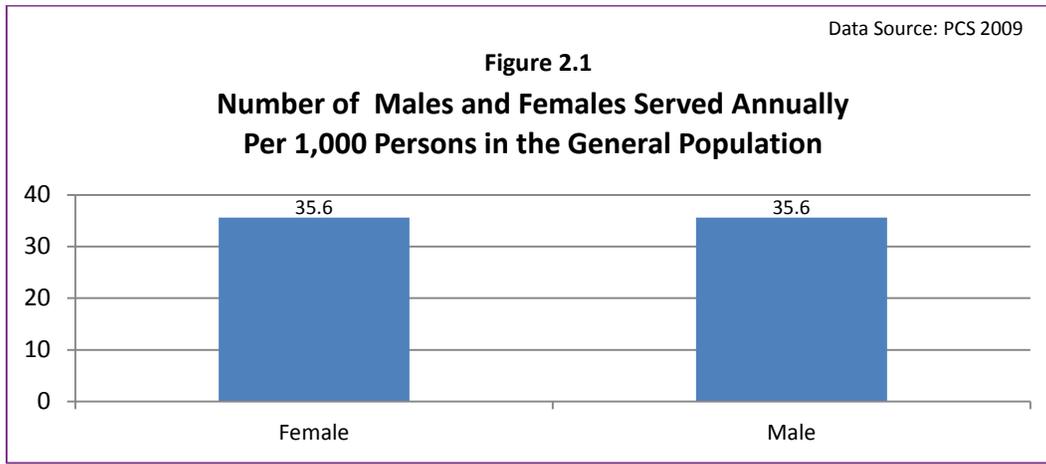
Snapshot of the State Public Mental Health System

Who is Served?

The Patient Characteristics Survey (PCS) captures the characteristics of children and adults served in the public mental health system. Conducted every other year, the one-week-long survey gathers clinical and demographic information for people who receive mental health services from programs operated, funded, or certified by OMH. The most recent survey includes 173,682 individuals served during a one-week period in October of 2009.

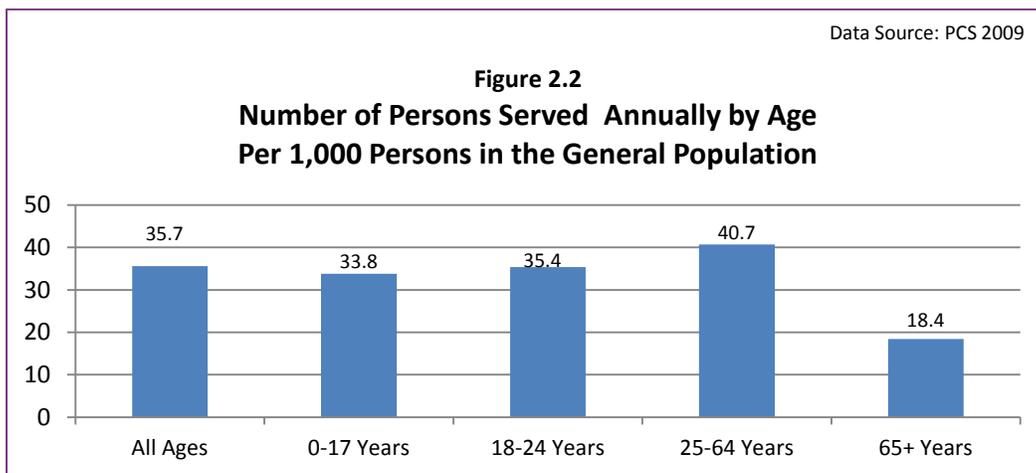
OMH estimates the number of people served annually in the public mental system from the PCS. Annual estimates were prepared using statistical capture-recapture methodology developed by researchers from the Nathan Kline Institute for Psychiatric Research.¹ Such estimates prove valuable for local- and State-level decision making and for directing the

development of policy in the areas of planning, services delivery, resource management, financing, evaluation and ongoing monitoring.

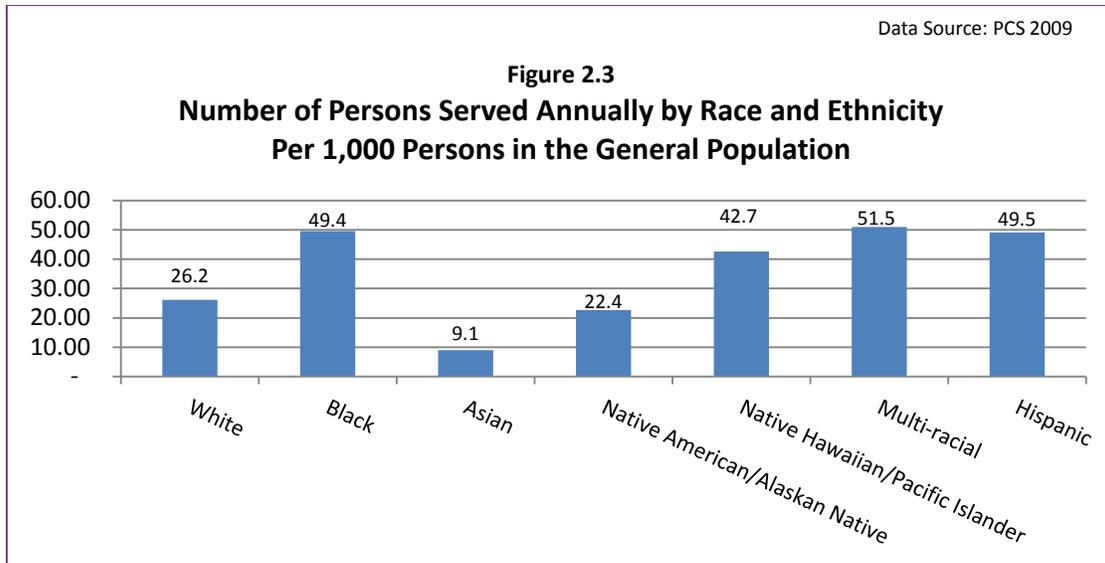


The NYS public mental health system provides services annually to an estimated 695,000 persons.^{2,3} Among them (see Figure 2.1), 35.6/1,000 males and an equal number of females in the general population receive mental health services.

Figure 2.2 illustrates that the highest annual rate of utilization is in the 25–64 year old age group. By comparison, the rate of utilization is lowest for older adults (65 years of age and above).



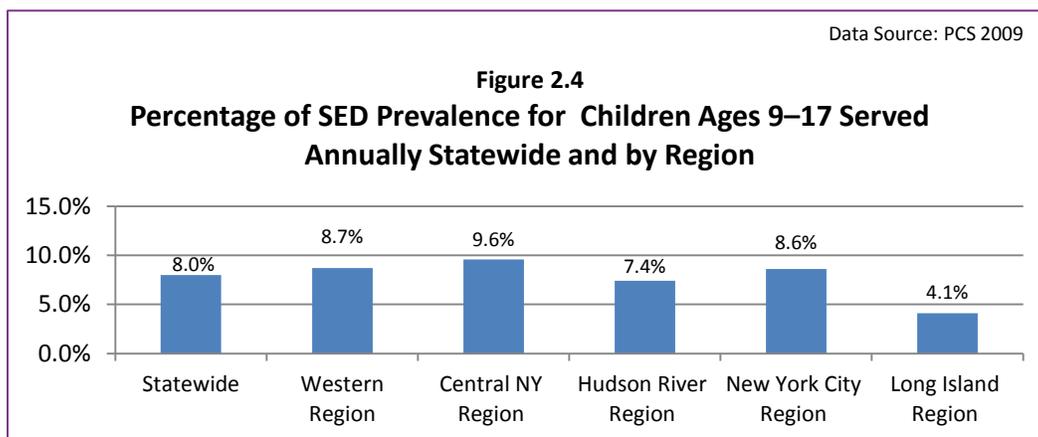
By race and ethnicity, as shown in Figure 2.3, the rates of services annually are highest among people who are Multi-racial, Black, Hispanic, and Native Hawaiian/Pacific Islander and lowest among people who are Asian. The rates for Black and Hispanic persons served are nearly the same, with annual rates of 49.4 and 49.5 respectively.



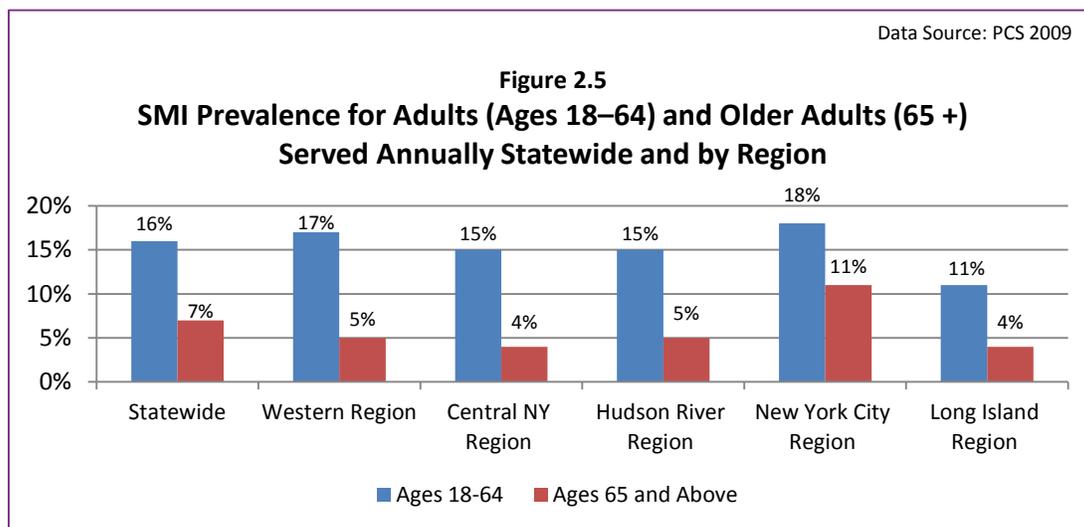
Disability Status and Diagnoses of People Served

Most children and adults served in the NYS public mental health system are engaged in services because of symptoms that impede their ability to function day to day. Serious mental illness (SMI) occurs in individuals diagnosed with mental illness and with significant impairments in functioning, while serious emotional disturbance (SED) in children is characterized by a diagnosable mental disorder and impairment that substantially limits functioning in school, family, or community activities.⁴

Figure 2.4 depicts that among children served annually, the serious emotional disturbance prevalence is about 8 percent, with the lowest percentage of serious emotional disturbance prevalence found in the Long Island Region.⁵ A prevalence rate for children between ages birth to 8 years of age has not been estimated.



For adults between 18 and 64 years of age and older adults age 65 and above, the percentage of serious mental illness prevalence is sometimes two to four times higher in adults than in the older adults. Also illustrated in Figure 2.5, the percentage of serious mental illness prevalence across regions for older adults is two times higher in New York City than in any of the other regions.



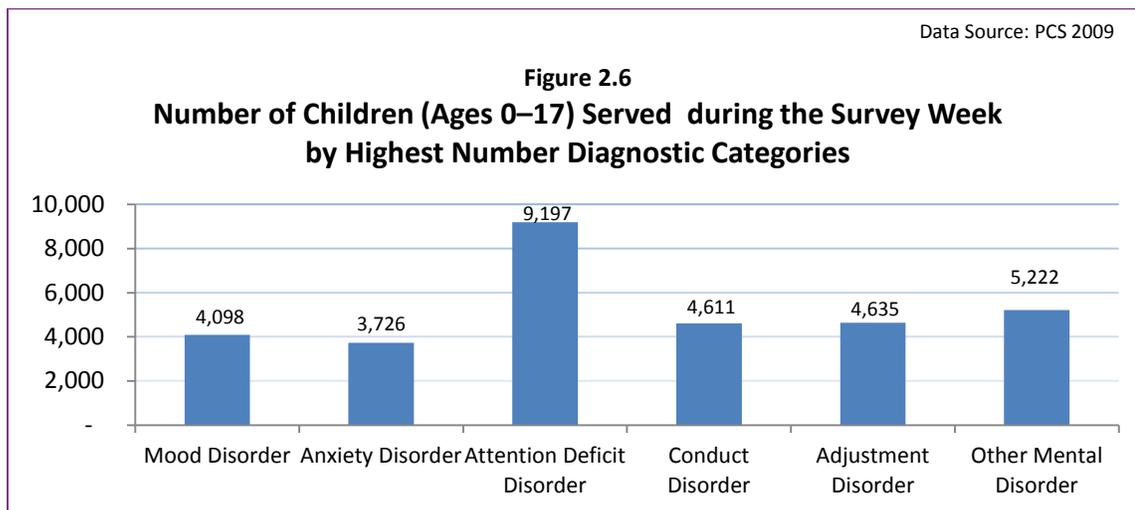
Across the United States only one-half of the individuals who are in need of mental health treatment actually receive the treatment. The societal results are readily apparent.⁶ The disabling effects of mental illness in adults can result in incarceration, homelessness, joblessness, chronic physical health problems, social isolation, and suicide. Half of all lifetime cases of mental disorders begin by age 14, with long delays, sometimes decades, between the first onset of symptoms and when people seek and receive treatment. The incapacitating effects are often serious and extended, leading to poor academic achievement, failure to complete high school, substance abuse, involvement with the juvenile and criminal justice systems, lack of vocational success, higher health care utilization costs, inability to live independently, and suicide.^{7,8,9,10}

Specific mental health diagnoses reported in 2009 for New Yorkers served in the public mental health system during the survey week are broken out by population for children 17 years and younger, young adults 18 to 24, adults 25 to 64 years, and older adults 65 years of age and older.

Children 17 Years and Under

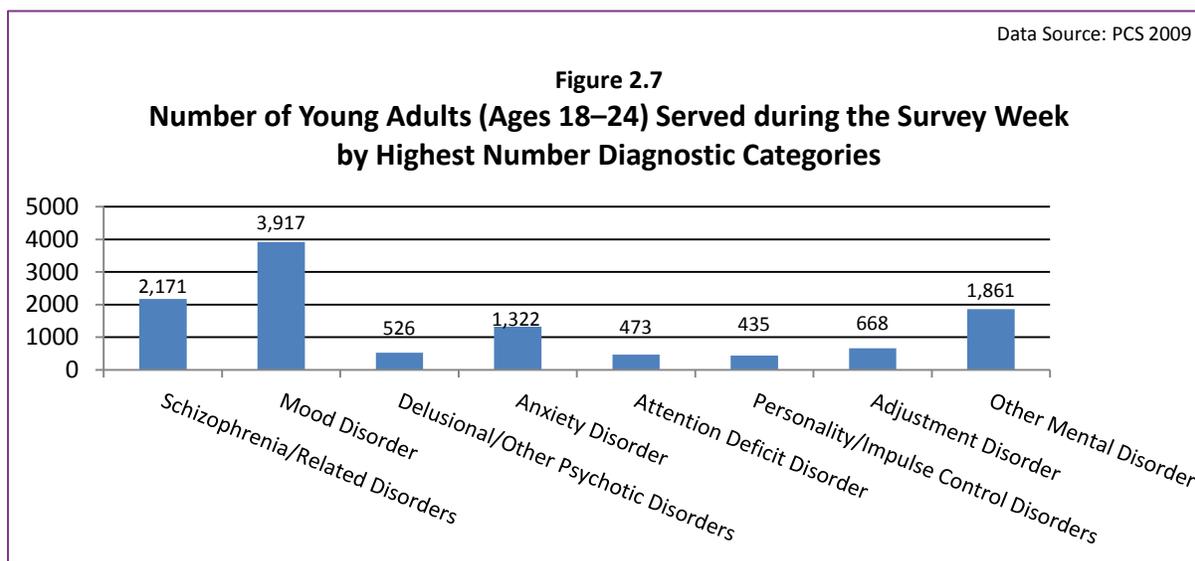
As illustrated in Figure 2.6, attention deficit disorder leads the diagnostic categories for children served during the one-week survey. The other diagnoses seen most often for children during that week are adjustment, conduct, mood (all types of depression and bipolar disorder) and anxiety disorders. “Other” mental disorder is defined by the survey as a mental health diagnosis that does not fit into any of the diagnostic categories identified for survey reporting; some examples of “other” diagnoses would be eating disorder, somatoform disorder or

dissociative disorder. About 5,200 children served during the survey week had other mental health diagnoses.



Young Adults between Ages 18–24

Figure 2.7 shows that mood disorders are highest in number among the diagnoses given to young adults during the survey week. Schizophrenia and related psychotic disorders, when combined with the delusional disorder diagnoses, accounts for the next highest number of young adults served during the survey week. Smaller numbers of young adults served were diagnosed with adjustment, personality/impulse control, and attention-deficit disorders.



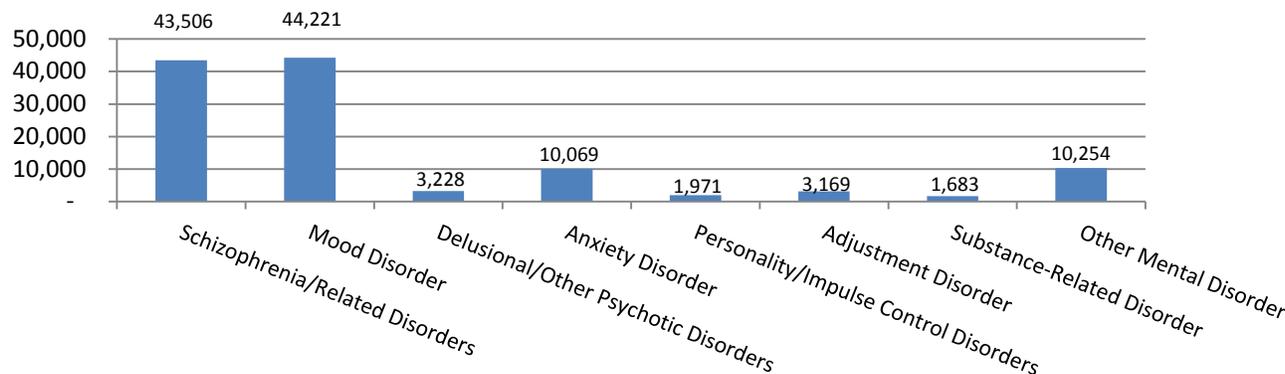
Adults between the Ages of 25 and 64

As illustrated in Figure 2.8, the two diagnoses with the highest numbers for adults served during the survey are schizophrenia and related disorders and mood disorders. When the number of delusional disorder diagnoses is combined with the schizophrenia and related

disorders number, then the combined diagnostic category edges in number slightly over mood disorder. The third most frequent diagnosis from the one-week survey for adults is anxiety disorder.

Data Source: PCS 2009

Figure 2.8
Number of Adults (Ages 25–64) Served during the Survey Week
by Highest Number Diagnostic Categories

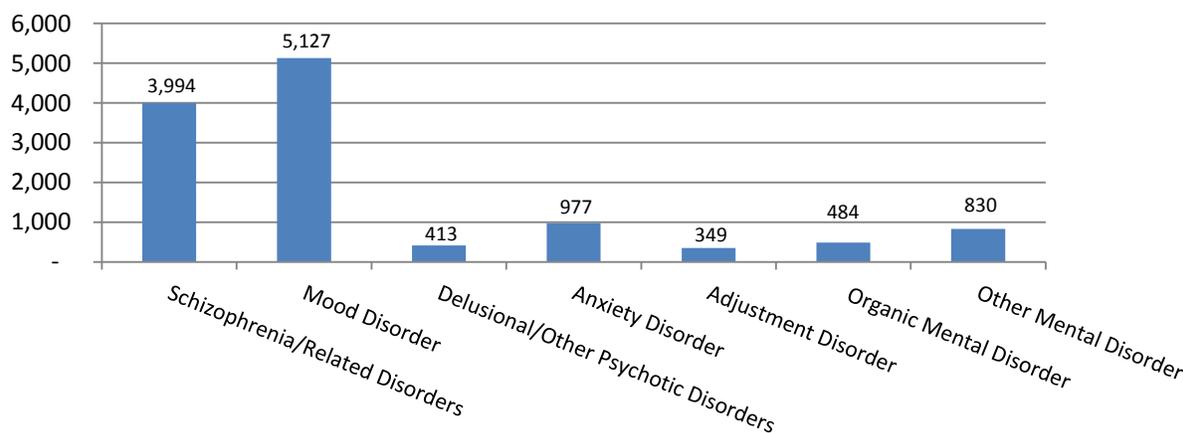


Older Adults 65 Years of Age and Above

Among older adults served during the survey week, the category of mood disorders is highest in number, followed closely by schizophrenia and related disorders (see Figure 2.9). As with the adult population, anxiety disorder is also third highest in number. One difference between the other populations and the older adults is the presence of organic mental health disorders, which is consistent with research findings that the risk of Alzheimer’s disease, vascular dementia and other dementias rises with age.¹¹

Data Source: PCS 2009

Figure 2.9
Number of Older Adults (Ages 65 +) Served during the Survey Week
by Highest Number Diagnostic Categories



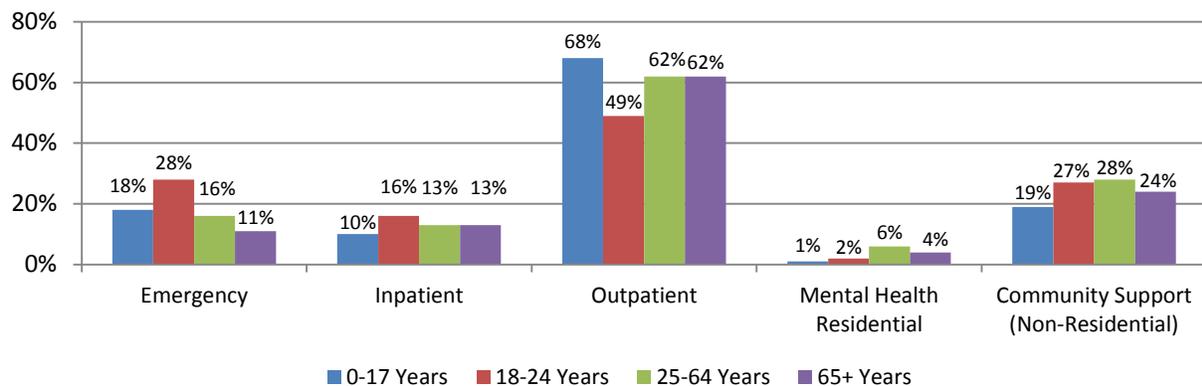
Where People Engage in Services

Public mental health services cluster in five major categories across the health care continuum: emergency, inpatient, outpatient, residential and community support. Both State and locally operated programs provide services in each of these categories and people may receive services from more than one category.

- Emergency services bring rapid psychiatric and/or medical stabilization for individuals and families, thereby supporting their safety and well-being. These programs include a range of mobile crisis counseling and residential services, as well as comprehensive psychiatric emergency programs.
- Inpatient services provide acute psychiatric stabilization, intensive treatment and rehabilitation within 24-hour controlled care environments. They are the programs of choice only when the required services and supports cannot be delivered in community settings.
- Outpatient treatment and rehabilitation services take place in ambulatory settings, including clinics, partial hospital programs, ACT, prepaid mental health plan (PMHP) and personalized recovery-oriented services (PROS).
- Residential services provide basic housing services that enable individuals to live in their community settings. Congregate treatment, apartment treatment, and supported housing are among residential services provided.
- Community support services assist individuals diagnosed with serious mental illness to live as independently as possible in the community, and help children with serious emotional disturbance to remain with their families. These programs provide case management, vocational/employment, self-help/peer, residential and other support services.

Figure 2.10 reveals that the highest proportions of persons in the public mental health system are served in outpatient programs, ranging from 49 percent for young adults to 68 percent for children receiving outpatient services. Of those served in non-residential community support programs, the range is from a low of 19 percent for children to 28 percent for adults between ages 25–64; in mental health residential programs, between 1 percent for children and 6 percent for adults (ages 25–64); in inpatient settings, from 10 percent for children to 16 percent for young adults; and in emergency programs, the highest proportion of persons served is young adults (28 percent). Totals for each age group across the five program categories exceed 100 percent because people attend more than one program during the course of the year.

Figure 2.10
Percentage of Persons Served Annually by Program and Age Categories



Other Characteristics of People Served

PCS data describe characteristics of people served in the public mental health system. Among them are data on basic needs, employment, and the appropriateness of grade levels for the ages of children.

Basic Needs

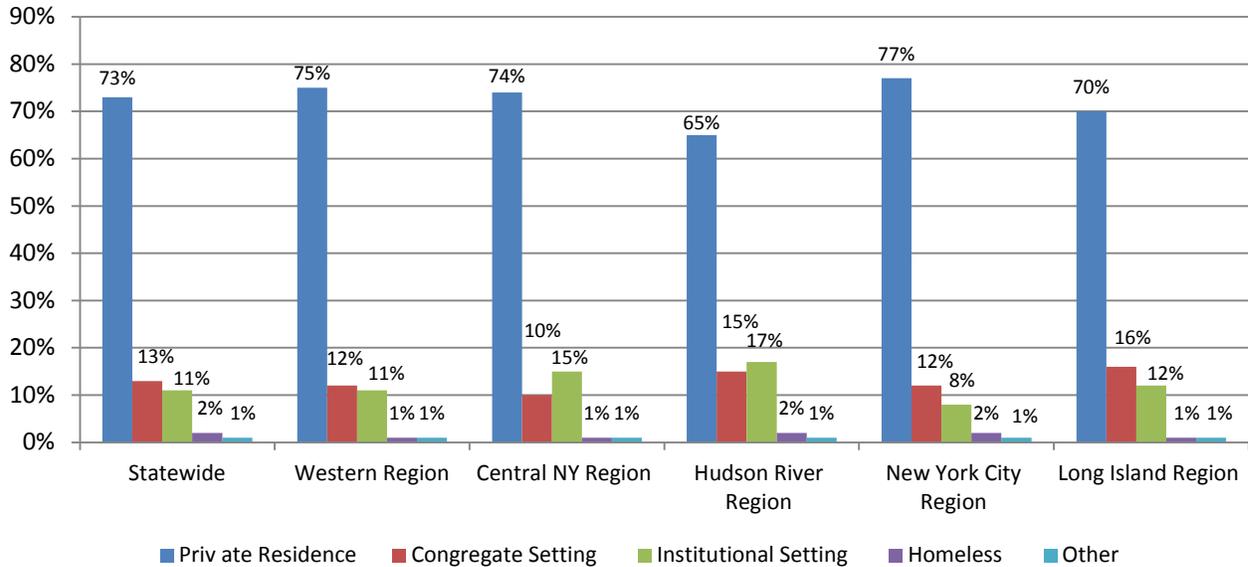
As Chris Koyanagi of the Bazelon Mental Health Center notes, good health is among a set of basic needs—secure and safe place to live, income for necessities, recreational and social opportunities, and a sense of purpose—required for community integration and recovery for people with serious mental illness.¹² As illustrated in Figure 2.11, the PCS offers a view of how people served in the public mental health system are faring in terms of basic needs.

Community integration and recovery for people with psychiatric disabilities, while unique for each individual, require that a set of basic needs be met. A safe, secure place to live, enough income for life's necessities, recreational opportunities, social contact and a sense of purpose are all part of recovery. High on the list, and affecting most of the other areas, is good health.

Chris Koyanagi
Will Health Reform Help People
with Serious Mental Illnesses?
Bazelon Center for Mental Health Law

At the top of the basic needs list is safe and secure housing. Figure 2.11 shows that nearly three-quarters of individuals served annually and across the five regions live in a private residential setting such as a home, apartment, rooming house or hotel room. While the level of homelessness among individuals served is at 1 percent across four of the regions, in the large urban NYC region and the Hudson River regions, the percentage is doubled to 2 percent each.

Figure 2.11
Percentage of Living Situations for All Ages Served Annually



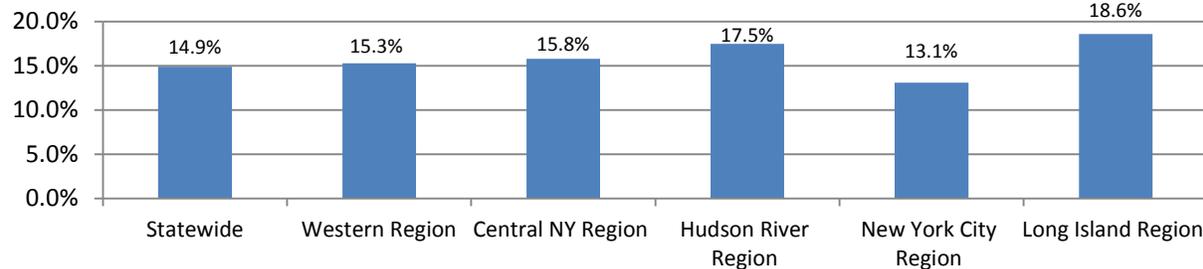
Employment Status

Most individuals who cope with serious mental illness want to work; some with the most serious conditions hold positions that require high levels of functioning.¹³ Work is essential to most of our lives, provides monetary compensation and reward, and offers benefits not measured by dollars alone, such as a social identity, social support, constructive use of time, community engagement, and personal satisfaction. A vital link to community living and active citizenship, work helps us in maintaining our overall health and in staying on the path toward recovery.

Despite this, people with serious mental illness experience significant barriers to work, many linked to prejudice, stigma, and discrimination. National survey data indicate an employment rate of 17 percent for working age adults with schizophrenia, paranoia or delusional disorder, compared to 33 percent for persons with other mental health disorders and 77 percent for the population not living with disabilities.¹⁴

In the State public mental health system, the rates of competitive, full- or part-time employment in community settings for adults (ages 18–64) served annually (Figure 2.12) range from 13.1 percent in NYC to 18.6 percent in the Long Island Region. The rates include individuals who receive supported employment services.

Figure 2.12
Percentage of Adults (Ages 18–64) Served Annually Who Are Employed in the Community Setting



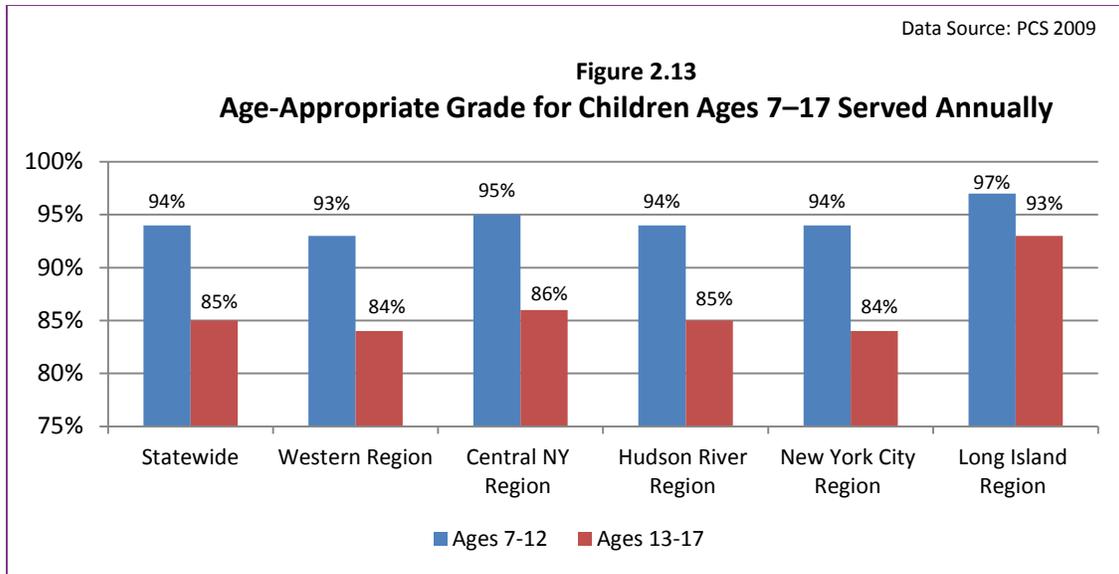
Helping people with serious mental illness find and keep work is a priority for OMH, with a focus over the last year on the development of a cross-agency comprehensive job matching/employment supports coordination and data system. The new system is designed to support competitive employment opportunities and outcomes for all New Yorkers with disabilities. A part of the “New York Makes Work Pay” federally funded grant initiative, which is administered by OMH, the system serves as a single point of access for each New Yorker seeking employment and employment supports, regardless of individual abilities and regardless of the state agency (e.g., children and family services, substance abuse, vocational rehabilitation) serving the individual.

Child Age-Appropriate Grade Levels

Directly connected to employability is educational attainment. A fundamental part of the American dream is the belief that educational achievement leads to future economic well-being. Data support this view and show that at most ages of the adult years, more education equates to higher earnings.¹⁵ Data also show that education pays off in terms of lower unemployment rates.¹⁶

Understanding that children and youth with mental health problems have lower educational achievement, greater involvement with the criminal justice system, and fewer stable and longer-term placements, OMH remains committed to monitoring and addressing how children do at home, in school, and in their communities. For children served in the State public mental health system, the PCS gathers data on the percentage of children from ages 7–17, for example, whose education level is age-appropriate. A child is considered in an age-appropriate grade when the difference between the child's age (in years) and current grade level is less than or equal to 6. For example, a child in the first grade should be 7 years old or less, to be age appropriate for that grade.

As Figure 2.13 shows, the age-appropriate grade for children from ages 7–12 is higher than for youth between ages 13–17. In the Long Island region, the gap between children and youth is narrower than for the other regions of the State.



Data Informing Improved Integration of Physical and Behavioral Healthcare

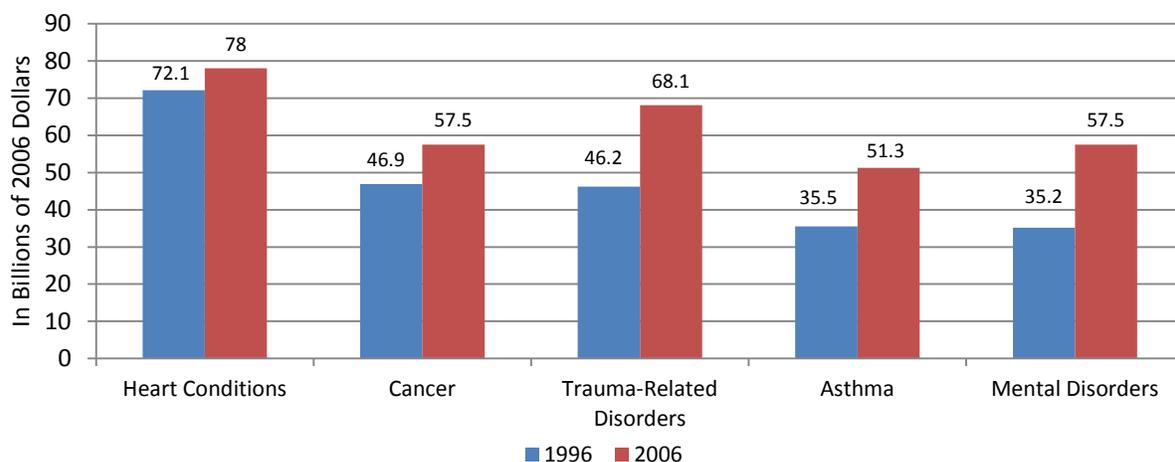
National and state health reforms concentrate to a large degree on improving the quality of healthcare by strengthening care coordination and the integration of physical and behavioral health care.

Neuropsychiatric disorders, including mental illnesses, rank first among illnesses in our nation that cause disability, surpassing cancer and cardiovascular disease.¹⁷ The cost of this disability is also staggering. In 2006, total direct expenditures for mental health services totaled \$57.5 billion, making them the third most costly medical condition in the United States, tied with cancer and behind heart conditions and trauma.¹⁸

Poor coordination generally leads to less effective and more costly care, and more importantly, can result in potential errors, misdiagnoses and expensive complications, as well as increased mortality and morbidity rates.

Complex Chronic Illness: An Essential Target in Health Cost Management
World at Work Journal, 3rd Quarter 2009

Figure 2.14
Expenditures for the Five Most Costly Conditions, 1996 and 2006



Data Source: Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality, Household Component of the Medical Expenditure Panel Survey, 1996 and 2006

These data become even more compelling when considered within the context of what we now know about the burden of chronic medical conditions:

- Nearly one-half of Americans have a chronic medical condition
- Health care spending for a person with a chronic condition, on average, is four times that for a person without a chronic condition
- About one in two people with a chronic condition have more than one chronic condition
- Average spending in yearly medical plans is 15 times more when a person has five or more chronic conditions.¹⁹

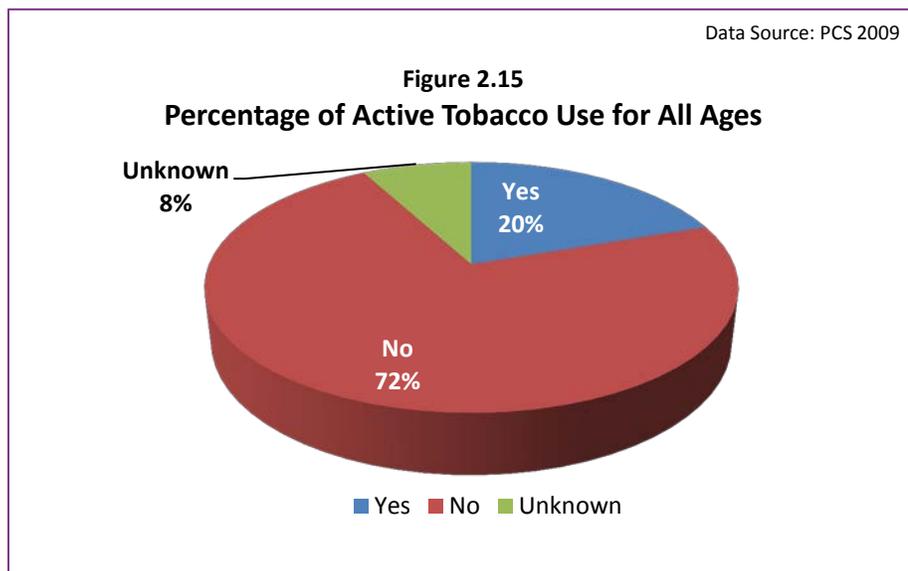
Ongoing PCS data collection is taking into account this knowledge and will continue to be of value in monitoring health care trends as OMH moves toward behavioral managed care arrangements. Two data points illuminate how PCS data are informing ongoing care aimed at reducing behaviors that contribute to poor health outcomes: the use of tobacco and the presence of chronic medical conditions.

Active Tobacco Use

Among people with serious mental illness, high rates of smoking are associated with increases in physical illness (e.g., coronary heart disease, peripheral vascular disease, chronic obstructive pulmonary disease) and mortality. People with serious mental illness, on average, die 25 years younger than the general population—largely from conditions caused or worsened by smoking, according to a 2006 report by NASMHPD.²⁰ People with psychiatric disorders consume nearly one-half (44.3 percent) of all cigarettes smoked in this country, causing them to be at greater risk for the adverse consequences of tobacco use.²¹

The 2009 PCS survey week is the first time that OMH is reporting on active tobacco use among all people served in the public mental health

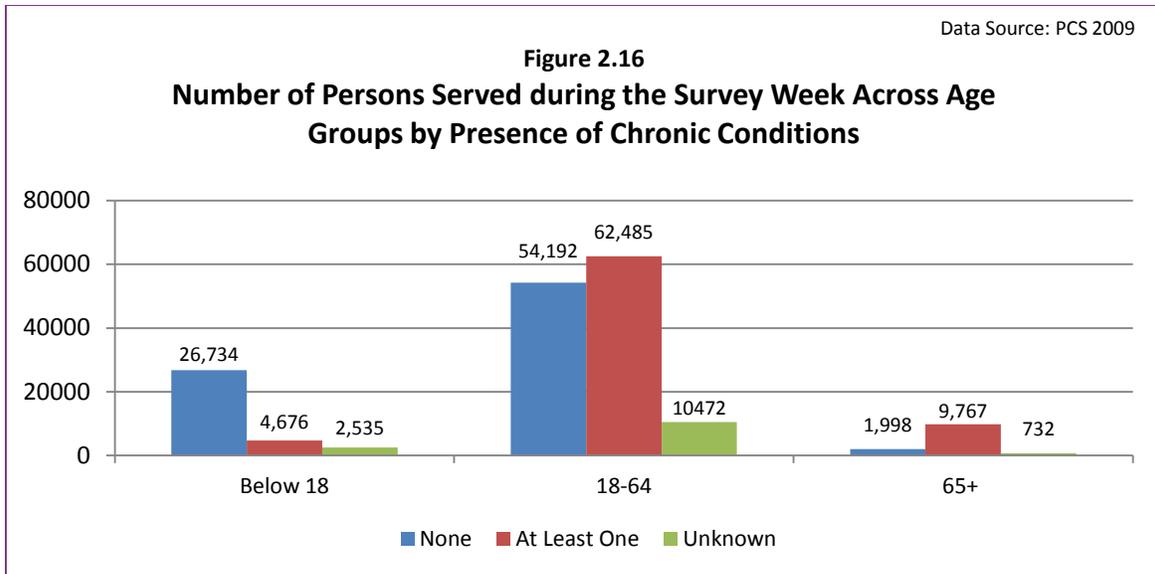
system. During the survey week in 2009, percentage of active tobacco use for all ages is 20 percent.



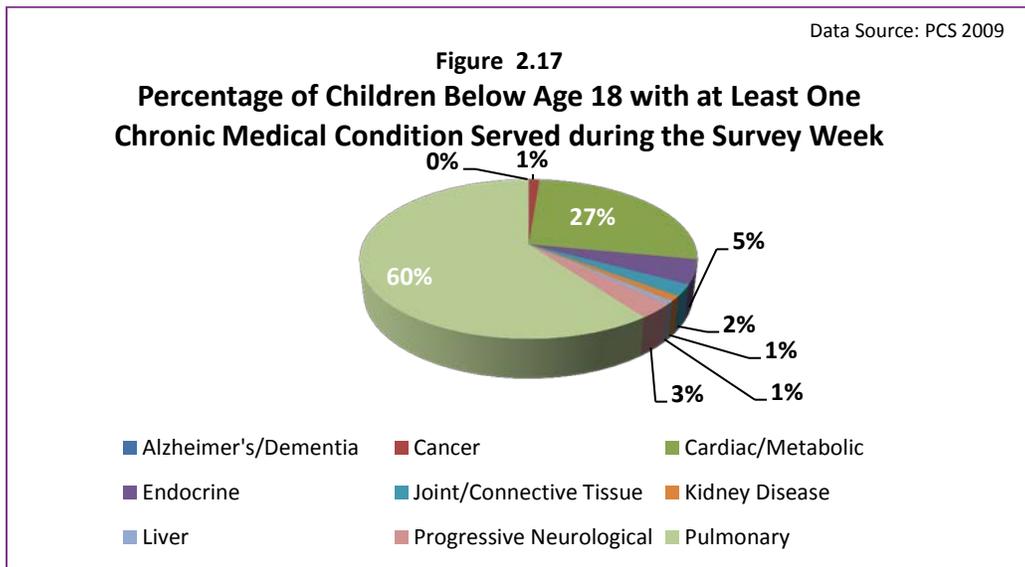
Chronic Medical Conditions

For the 2009 PCS Survey, another new question aims to identify the presence of chronic medical conditions experienced by people served during the survey week. The question asked about the existence of any chronic medical conditions, including cardiac and metabolic (e.g., high blood pressure, elevated cholesterol), pulmonary conditions (e.g., emphysema), tobacco use, Alzheimer’s disease or dementia, kidney disease, liver disease (e.g., hepatitis), endocrine disorders (e.g., thyroid disease), progressive neurological disorders (e.g., multiple sclerosis) traumatic brain injury, joint and connective tissue disease (e.g., arthritis, lupus), cancer. Also included among choices is “none of the above,” and “unknown.”

Of the 173,682 individuals served during the survey week, 44 percent had at least one chronic medical condition. As noted in Figure 2.16, the proportion varies by age group. Children and youth have the lowest rate, with just 14 percent having one or more chronic medical conditions compared to 49 percent for adults and 78 percent for older adults.

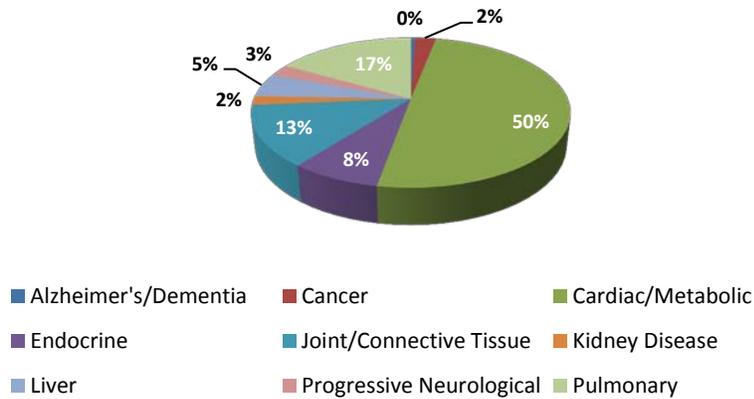


The percentages of people served with at least one chronic medical condition are displayed by condition and age group in Figures 2.17 to 2.19. For children and youth under 18 years of age, more than one-half have pulmonary illness (60 percent), followed by cardiac and metabolic illnesses (27 percent) and endocrine disorders (5 percent).



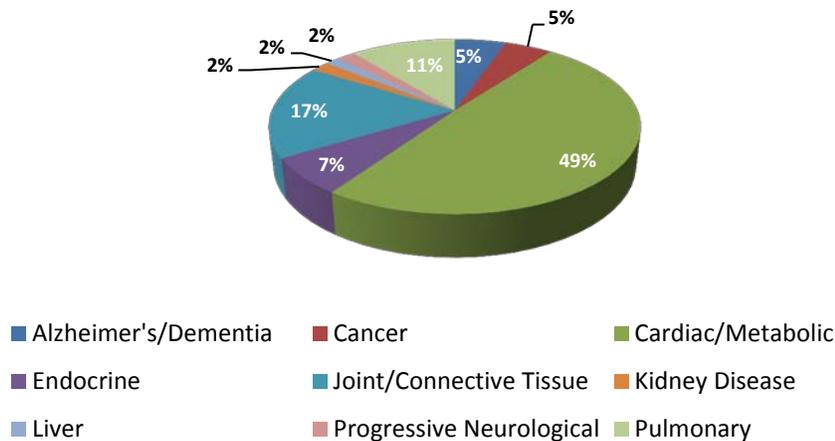
Among persons 18 years of age and older served during the survey week, one-half (50 percent) have cardiac and metabolic illnesses, followed by pulmonary illnesses (17 percent) and joint and connective tissue diseases (13 percent).

Figure 2.18
Percentage of Adults (Ages 18-64) Served during the Survey Week with at Least One Chronic Medical Condition



For older adults, the category of cardiac and metabolic disease is the highest, followed by joint and connective tissues and pulmonary disease. Alzheimer’s and dementias, seen most often in people more than 65 years of age, accounted for 5 percent of chronic conditions reported during the survey week.

Figure 2.19
Percentage of Older Adults (Ages 65+) Served during the Survey Week with at Least One Chronic Medical Condition



The large presence of co-morbidity amongst individuals served and the types of conditions seen most often in the age cohorts highlight the importance of managing mental health and physical health in a culturally competent manner to improve overall health and well-being.

Data such as these are key to future planning and meeting the needs of New York's most vulnerable citizens in efficient and effective ways and require OMH to sustain and improve data and information resources.

Strengthening the Planning Infrastructure

State–County Planning

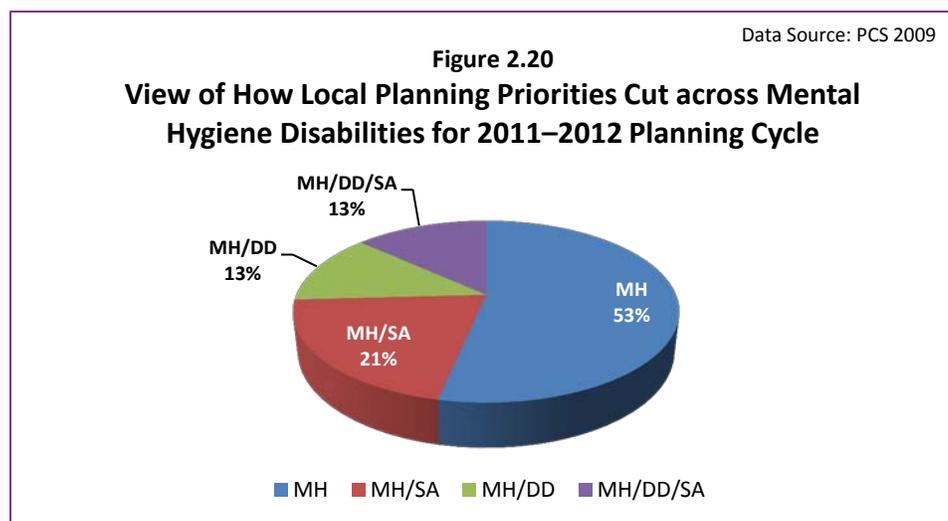
State Mental Hygiene Law requires that OMH as well as its sister agencies, the Office of Alcoholism and Substance Abuses Services (OASAS) and the Office for Persons With Developmental Disabilities (OPWDD), guide and facilitate local planning. It also requires each LGU to develop and annually submit to each mental hygiene agency a local services plan that establishes long-range goals and objectives consistent with statewide goals and objectives. In addition, statewide comprehensive plans are expected to reflect local priorities.

In 2007, the three mental hygiene agencies, in collaboration with the Conference of Local Mental Hygiene Directors (CLMHD), established the Mental Hygiene Planning Committee to strengthen planning efforts between the State and localities. Before the Committee formed, each agency conducted its own local planning process, followed its own timetable, and established its own planning requirements for the LGUs. At the county level, planning for each disability was often conducted independent of the other disabilities.

As a result of the Mental Hygiene Committee's work, counties today enjoy a more integrated mental hygiene local planning process. The Committee, which is formally a subcommittee of the Inter-Office Coordinating Council, instituted an annual planning calendar that aligns local services planning with State planning and budgeting processes. Annually, it creates and refines integrated cross-agency planning documentation. This documentation is stored in an online County Planning System (CPS) hosted by OASAS, with support from OMH and OPWDD. Many of the improvements to the local planning process, plan guidelines, and CPS result from county and service provider collaboration and input.

First developed and piloted by OASAS in 2004, the CPS was redesigned and implemented statewide the following year. CPS quickly became an innovative, state-of-the-art platform from which counties documented needs assessment and planning activities, completed required planning forms, and

submitted online their entire chemical dependency plans to OASAS. In 2007, OMH utilized CPS on a pilot basis for gathering mental health priorities and in 2008 fully integrated their local



planning requirements into CPS. OPWDD followed suit, making CPS a tool for comprehensive mental hygiene local services planning. Rather than submitting three separate plans, each county now submits a single integrated mental hygiene local services plan to all three State agencies at once.

An important achievement of the integrated planning process has been the ability to identify local planning priorities that cut across the three disability areas. Figure 2.20 highlights the breakdown of mental health and cross-disability priorities for the current planning cycle. As shown, 47 percent of priorities cut across two or more disability areas, up from 43 percent last year. This suggests that the integrated planning process and CPS continue to foster more coordinated and focused planning across multiple systems of care. (More findings from this year's local planning activities are presented in Chapter 5.)

State and Local Data-Informed Decision Making

In 2010, OMH introduced its County Mental Health Profiles portal online to facilitate local planning. The portal is the result of an ongoing collaboration between the OMH Offices of Information Technology, Performance Management/Evaluation and Planning with CLMHD and Mental Hygiene Planning Committee members. The portal aims to aid county planners in identifying mental health service gaps and disparities and in using the data provided to improve the quality of service delivery. The portal reports consolidate utilization, services need, and expenditure data from an array of OMH and non-OMH data systems. These reports present content in a standard format that enables planners to make comparison across agencies and between consumer cohorts. Sections of the portal include:

- ***Medication Utilization – Mental Health Services***
The reports on this page provide summary information on Medicaid mental health services utilization and expenditures for Local Fiscal Years, beginning in 2007 for adults and 2010 for children and updated yearly thereafter. Program totals are based on date of service. Because data are refreshed on a monthly basis, values in the same report may change over time. Prepaid Mental Health Plan (PMHP) data are included in these reports as recovery services (RS). Medicaid managed care capitation payment data, however, are not included. Expenditures include comprehensive outpatient program services (COPS) and community support program (CSP) add-on payments, where applicable.
- ***Medicaid Utilization – All Medicaid Services***
These statewide and County-level reports offer an OMH perspective of Medicaid service utilization and expenditures for mental health and other Medicaid services (e.g., alcohol and substance abuse, pharmacy, general health, long-term care) based on reimbursement claims paid by the Medicaid fee-for-service billing system to OMH-licensed providers for services delivered in a State Fiscal Year (SFY), i.e. from April 1, 2008 to March 31, 2009, labeled SFY 2009. A similar report is available from OASAS. In addition to aggregate data on mental health inpatient, outpatient and residential service utilization, the profile report aggregates data by the county of fiscal responsibility and by the county where services are provided.

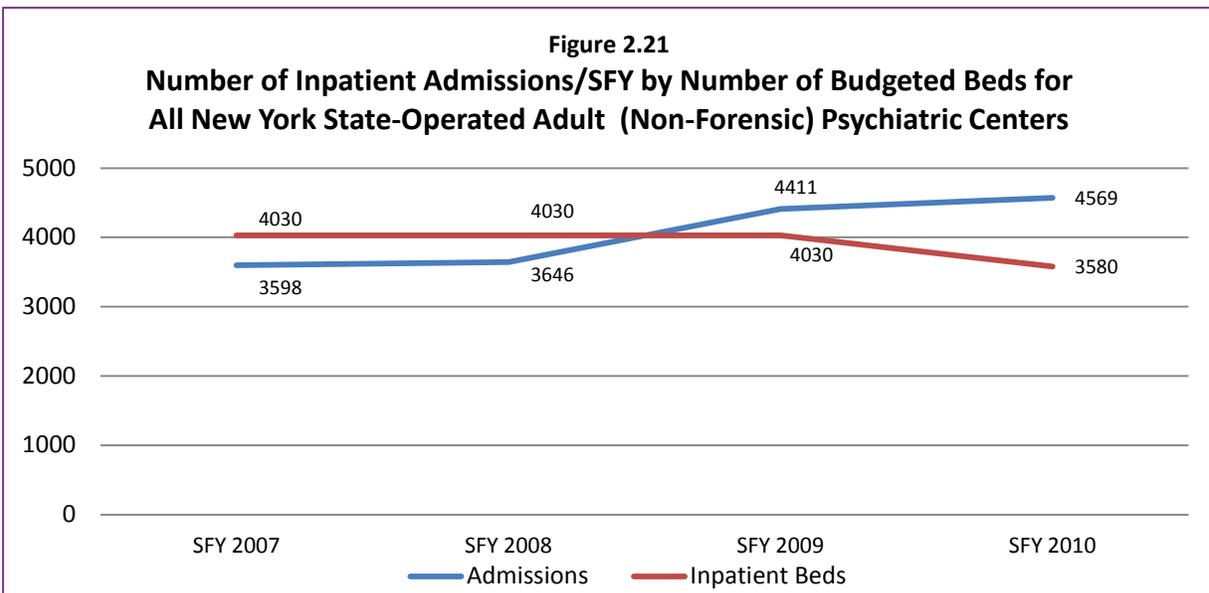
- **Dashboard**

The Dashboard includes summary reports focused on key County community characteristics, mental health services, expenditures, and outcomes. The reports provide quick, at-a-glance views and offer comparative statewide statistics in a number of relevant domains (e.g., community characteristics, service use, inpatient readmission rates, wellness and community integration). Each domain tab brings you to an individual report that displays summary data and, for most, a corresponding chart. The time frame for data is displayed.

- **Managed Care Reports**

With the changing health care system and movement to managed care arrangements, OMH has added its first report that specifies for each county managed care enrollment and penetration rates.

With ongoing data infrastructure development, OMH continues to monitor services across time, as well as provider outcomes to enable performance assessment and quality improvements in critical areas such as admissions and readmissions to inpatient psychiatric hospital care. Since 2008, for example, OMH has focused on improving efficiency and productivity within its adult psychiatric hospitals (not including forensic hospitals) by increasing access to acute inpatient care. During state fiscal year (SFY) 2009, OMH adult psychiatric hospitals admitted 4,411 individuals into 4,030 beds (Figure 2.21). The SFY 2009 admissions included 765 more admissions than the prior year and represent an increase of 19 percent in admissions per inpatient bed over SFY 2008.



The trend continued in SFY 2010 when 4,569 individuals were admitted into 3,580 beds. The SFY 2010 admissions included 158 more than in the prior year and represent an increase of 19 percent in admissions per inpatient bed over SFY 2009. Overall, between 2008 and 2010 the number of beds in OMH adult psychiatric hospitals has declined by 11 percent (N=450),

while the number of admissions per budgeted bed increased 38 percent. This gain in admissions occurred with no significant change in readmission rates (as illustrated in Figure 2.22), reflecting increased productivity and efficiency in hospital operations.

Discharge Year	Cumulative Readmission Rate by Days after Discharge						
	7 Days	14 Days	21 Days	30 Days	60 Days	90 Days	180 Days
SFY 07	3%	6%	8%	12%	18%	23%	31%
SFY 08	2%	6%	9%	11%	18%	22%	32%
SFY 09	3%	7%	10%	13%	20%	24%	35%
SFY 10	3%	6%	9%	12%	19%	23%	31%
SFY 07–10 Change	0%	0%	1%	0%	1%	0%	0%

The role of performance measurement, monitoring, and quality improvement initiatives remains crucial as the system of care moves toward the introduction of behavioral managed care (e.g., regional behavioral health organizations (BHOs) and, later, health homes) under the leadership of Governor Cuomo and the Medicaid Redesign Team.

During the first phase of preparing for managed care, BHOs will be charged with employing data to monitor psychiatric inpatient lengths of stay, reducing unnecessary inpatient hospital days and readmission rates; improving rates of engagement in outpatient treatment following discharge; better understanding clinical conditions of children diagnosed as having a serious emotional disturbance; and profiling provider performance. Data will play a central role in assessing the strength of discharge planning and successful community living after hospitalization.²²

Region	Admissions		Length of Stay			
	# of Persons	# of Admissions	Mean	Lower Quartile	Median	Upper Quartile
Western	3,480	4,922	11.4	4	7	13
Central	2,289	3,349	8.6	3	6	10
Hudson River	5,101	7,135	17.5	5	10	20
New York City	14,954	23,237	20.1	6	13	22
Long Island	3,328	4,870	22.5	7	12	23
Statewide	28,047	43,514	18.0	5	11	20

For the very small number of admissions that had not resulted in discharge by 6/30/2010, length of stay was computed as if discharge occurred on 6/30/2010. The number of persons admitted is an unduplicated count of persons admitted in calendar year 2009.

Figure 2.23 exemplifies baseline admission and length of stay data from the OMH Medicaid data warehouse, which has been made available to the regional BHOs and will serve as a basis for such analyses. As the data show, for calendar year 2000, there is a moderate degree of regional variation in admissions and lengths of stay for adults and children covered by Medicaid and admitted to non-OMH-operated hospitals during calendar year 2009.

The data underscore the importance by BHOs to account for those factors that explain regional and local variations and to foster the development of strategies tailored to the needs of people, particularly those with the most complex conditions, to support such persons in recovery and successful community living.

Data-Informed Decision Making

In an environment of fiscal stress and budget reductions, and where it is complex to sustain the financing, operation and maintenance of behavioral prevention, treatment and supports, OMH relies upon data to sustain the safety net of mental health treatment services for New York's most vulnerable citizens and to promote public safety and well-being.

It provides data resources additional to the ones already described in the chapter that are essential to the ongoing planning, delivery, monitoring and evaluation of care. Links to other data resources appear on the [Statistics and Reports](#) page of the OMH website. There you can find portals that offer information and statistical data on housing; ACT; assisted outpatient treatment (AOT); children, teen and family indicators; consumer assessment of care; and the balanced scorecard.

Over the last year, in particular, the balanced scorecard has helped to highlight progress toward achieving priorities. The scorecard uses up-to-date quantitative data to compare actual performance against specific measurable targets. Content areas include outcomes experienced by individuals served in the NYS public mental health system, results of public mental health efforts undertaken by OMH, and critical indicators of organizational performance.

An example of how the scorecard helps to reflect the quality of care is in the area of restraint and seclusion. As described in a previous Statewide Plan, the Positive Alternatives to Restraint and Seclusion (PARS) initiative, led by the OMH Office of Quality Management, occurred over three years with federal funding and focused on a set of core strategies for reducing the use of restraint and seclusion: commitment of leadership to organizational change; use of data to inform practice; workforce development; use of seclusion and restraint reduction tools; involvement of consumers in the planning development and implementation of programming; and post-event debriefing techniques.

While the formal initiative has ended, the work of reducing restraint and seclusion continues. The balanced scorecard helps to maintain attention to transforming the system of care to one that is free of coercion and violence and one where the goal is to reduce and eventually eliminate the use of restraint and seclusion in the State public mental health system. It provides quarterly reports of restraint and seclusion in adult, children's and forensic settings. OMH and stakeholders regularly monitor progress toward the goal of eliminating restraint and seclusion.

It is only through such efforts that we can obtain the best outcomes possible. As OMH continues to provide inpatient and residential services and moves toward implementing BHOs and behavioral health homes, its data resources will play a pivotal role in the comprehensive monitoring and management of the delivery of care and the operations of the behavioral system of care at the State and regional levels.

¹ OMH derives its estimates of the number of people served annually by the public mental health system from its PCS using a population-based approach based on the 2008 U.S. Census data. The PCS gathers information about the demographic and clinical characteristics of persons receiving mental health services in programs operated, funded, or certified by OMH during a one-week period. The one-week data are then used to estimate the total number of people served annually and their characteristics. OMH uses estimates rather than actual counts because the variety of administrative data systems does not allow a complete enumeration across all service sectors of the number of persons served.

² Using the methodology described in the first footnote, an estimated 695,162 persons (95 percent confidence interval of 629,712 to 773,559) were served in the public mental health system in 2009. .

³ Services provided in New York's public mental health system are those delivered by programs funded, certified or operated by OMH. They do not include mental health services provided by private practitioners or by programs operated by other State agencies.

⁴ Adults with serious mental illness are persons ages 18 or older who currently have, or at any time during the past year, have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-RE) and the diagnosable disorder must result in functional impairment that substantially interferes with or limits one or more major life activities. Children with serious emotional disturbance are persons ages 17 or younger who currently have, or at any time during the past year, have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV-TR and the diagnosable disorder must result in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

⁵ OMH regions are include **Western**: Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, and Yates; **Central**: Broome, Cayuga, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, and St. Lawrence; **Hudson River**: Albany, Columbia, Dutchess, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, and Westchester; **Long Island**: Nassau and Suffolk; and **New York City**: Bronx, Kings, New York, Queens, and Richmond.

⁶ Kessler RC, Berglund PA, Bruce ML, et al. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, 36, 987-1007.

⁷ U.S. Department of Health and Human Services. (1999). *Mental health: Report of the Surgeon General*. Rockville, MD: Author, Office of the Surgeon General.

⁸ U.S. Department of Health and Human Services. (2008, July 8). *Mental health 101*. Rockville, MD: Office of Minority Health. Available online at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=81> .

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- ¹¹ Mayo Clinic. (2011, April 16). *Dementia: Risk factors*. Available online at <http://www.mayoclinic.com/health/dementia/DS01131/DSECTION=risk-factors> .
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- ¹³ Mechanic D, Bilder S & McAlpine D. (2002). Employing persons with serious mental illness. *Health Affairs*, 21(5), 242-253.
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- ²⁰ National Association of State Mental Health Program Directors. (2007). *Tobacco-free living in psychiatric settings: A best-practices toolkit promoting wellness and recovery*. Alexandria, VA: Author. Available online at http://www.nasmhpd.org/general_files/publications/NASMHPD.toolkitfinalupdated90707.pdf .
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