

Local Government Unit (LGU) and Children's Single Point of Access (C-SPOA)

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Today's Agenda

- Why an LGU?
- Brief history of why the LGU was created
- LGU role and function in the Mental Hygiene System
- Children's Single Point of Access (C-SPOA)
- C-SPOA referral process
- NYC specific processes
- Case examples: Monroe & Rensselaer Counties
- Contact your C-SPOA Coordinator

Terms for Today – Article 41 Mental Hygiene Law

- Local Governmental Unit (LGU) - the unit of local government given authority in accordance with this chapter by local government (Counties & NYC) to provide local services.
- Board - a Community Services Board (CSB) for services to the mentally ill, intellectually and developmentally disabled, those suffering from substance use disorder.
(Every LGU has a CSB)

Terms for Today – Article 41 Mental Hygiene Law

- “Director” - the **Director of Community Services**, who is the Chief Executive Officer of a Local Governmental Unit, by whatever title known. (County Mental Health Commissioner, LGU, DCS)
- “Local Services Plan” - **the plan of local services (MH/SUD/DD)** which is submitted by LGU and approved by the (state) commissioner pursuant to MHL §41.18. **The CSB approves the local plan**
- “Comprehensive Statewide Plan - The 5.07 Plan” – **the plan of state services** which OMH/OASAS/OPWDD issue separately. **The Local Services Plans inform the State 5.07 Plans**

Where to Find Comprehensive Statewide 5.07 Plan

Comprehensive Statewide Plans for OMH, OASAS and OPWDD can be located on the CLMHD website.

The screenshot shows the website for the NYS Conference of Local Mental Hygiene Directors, Inc. The header includes the organization's logo and a search bar. The navigation menu contains links for Home, About Us, State Budget, Legislation & Regulations, Regional Planning Consortia, Hot Topics / Priority Issues, DCS/LGU Resources (highlighted in red), and Contact Local Mental Hygiene Dept. The main content area is titled "DCS/LGU RESOURCES" and features a section for "Statewide 5.07 Plans: OMH, OASAS, OPWDD". Below this, there are links to the NYS Office of Mental Health (OMH) Statewide Comprehensive Plan - 2016 - 2020, the NYS Office of Alcohol and Substance Abuse Services Plan - 2015 - 2019, and the NYS Office of People with Developmental Disabilities Plan - 2012 - 2016. A link to an August 2013 5.07 Hearing is also present. A left sidebar contains a list of navigation options, including Overview, Children and Families, Developmental Disabilities, NYSDOH Prevention Agenda 2013-2018, LGU Role in Managed Care/CLMHD, Mental Hygiene Planning (with a sub-link for Statewide 5.07 Plans: OMH, OASAS, OPWDD), Local Services Planning Process and Guidelines, CLMHD Portal & Dialogues, CLMHD Regional Map, State Agency Acronym Lists, and CONTACT US.

http://www.clmhd.org/dcs_resources/Statewide-507-Plans-OMH-OASAS-OPWDD_11_68_sb.htm

Article 41: Responsibility of the LGU

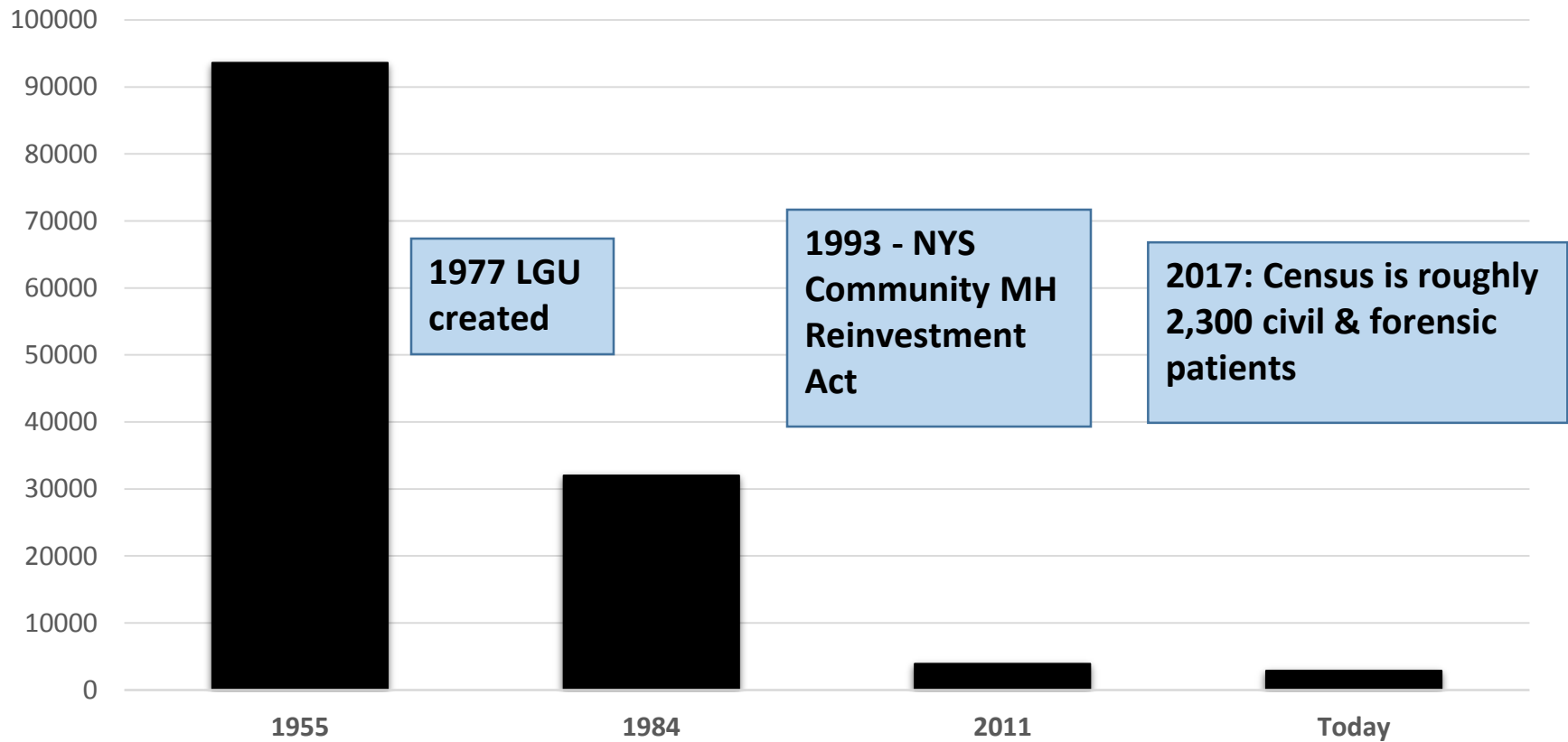
- The LGUs have a **statutory responsibility** under NYS Mental Hygiene Law to oversee and manage the local mental hygiene system and develop, implement and plan for services and supports for **adults and children with mental illness, substance use disorder and developmental disabilities.**
- The 3 disabilities intersect at the county level.
- LGU is required to Plan for the needs of the entire population - **not solely the Medicaid population.**

60 years of History in 5 minutes

- This overview uses the evolution of the adult mental health system from institutional care to community care to provide the context for why a local authority (LGU) was necessary and why the LGU has the statutory authority and responsibility for local services
- **Adult & Children's SPOA are embedded in the authority of the LGU**

From Institutional to Care in the Community

State Psychiatric Center Inpatient Census



Then and Now

- In 1955 New York's Inpatient Psychiatric Hospital population peaked at 93,600 across 27 institutions
- Today New York's Inpatient Psychiatric Hospital census is roughly 2,300 adults and children (civil and forensic) across 19 institutions

The Environment at the Time

- **July 3, 1946** - President Truman signed the **National Mental Health Act**, which included a significant amount of funding for psychiatric education and research
- **1949** - National Institute of Mental Health (**NIMH**) created.
- **1954** - **The New York State Community Mental Health Services Act was passed**. The act encouraged localities to establish community-based mental health programs and to apply for state reimbursement of up to 50% of the cost of these programs.
- Costs are borne by the State and Counties

First Wave of Deinstitutionalization

- **1963** - President Kennedy proposed and signed The Community Mental Health Act
- National Institutional census – 500,000 people
- Avg. LOS for someone with schizophrenia was 11 years
- Intended to shift resources away from large institutions into Community Mental Health Centers
- People could receive treatment at a CMHC while working and living at home
- Provided Federal grants to States to establish CMHCs

The Results Nationally

- Only 50% of the expected 1,500 Community Mental Health Centers were built
- None were fully funded
- The Act didn't provide enough funding to operate CMH Centers on a long-term basis.
- When Federal grants ended— responsibility for cost fell back to the states and localities.
- States closed expensive state hospitals without spending the money on community-based care

The Failure of Deinstitutionalization

Late 1960's – 1970's

The problems associated with the policy of mass discharges (deinstitutionalization) from state hospitals became increasingly evident.

- Lack of continuity of care
- Failure to meet the needs of the seriously mentally ill

National Problem – Local Solution

- New York State recognized that the **complex needs** of individuals with serious mental illness **could not be effectively addressed from Washington or from Albany.**
- The state needed to create a local entity which had both:
 - **The responsibility for the local planning and oversight of the services across the disabilities, and;**
 - **The statutory authority and funding necessary to implement the Local Services Plan for local mental hygiene services across all systems.**
- **1977** – NYS established Art. 41 MHL (Local Services) & created the LGU for this purpose.

Purpose of Art. 41 & LGU Responsibilities

Article 41 is designed to create a process that governs a **joint effort between state and local governments** with regard to the **planning for and the financing** of mental hygiene services in New York.

- LGU has the powers necessary and proper for the effective performance of its functions and duties.
- **Identify and plan for** the provision of care coordination, emergency services, and other needed services for high need persons.

Powers & Duties of LGUs (§41.13)

- Review services and local facilities for the mentally disabled (the 3 disabilities – MH, SUD, and DD).
- Direct and administer the development of a local comprehensive plan. The Local Services Plan, which is approved by the Community Services Board.
- Submit the Local Services Plan annually to the department for its approval and subsequent state aid, a report of long range goals and specific intermediate range goals.

Local & State Partnership for Access to Services

LGUs are required under Art. 41 MHL to:

- Develop in the community preventive, rehabilitative and treatment services offering continuity of care.
- Improve and expand existing community programs for individuals with SMI, SED, SUD and DD.
- Plan for the integration of community and state services.

LGUs develop and oversee comprehensive, integrated and cost-effective systems of care locally while working in partnership with the NYS Mental Hygiene agencies (OMH/OASAS/OPWDD)

Goals of the Local Services Plan

Seek to assure that under the goals and plans required pursuant to this subdivision:

- All population groups are adequately covered
- Sufficient services are available for all the mentally disabled within its purview,
- That there is coordination and cooperation among local providers of services,
- That the local program is integrated and coordinated with the provision of community support services, and
- That there is continuity of care among all providers of services.

Where to Find Your County's Local Services Plan



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Albany County

Stephen Giordano, Ph.D.

[Local Services Plan](#)
[2016 Local Services Plan](#)
[2017 Local Services Plan](#)
[2017 County Profile](#)

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Choose a County ▼

http://www.clmhd.org/contact_local_mental_hygiene_departments

LGU Linkages with Other Community Systems

In order to carry out its responsibilities under Art. 41, the LGU has to be embedded in the community.

- The people we serve *never* need 1 service. Their needs are complex and cross over into other community systems, services providers, and programs.
- The LGU has linkages and relationships across every system in their county. **This is why the SPOA is embedded in the LGU.**
- C-SPOA knows the moving parts of the children's system and navigates the services available to the youth and the family.

LGU: Linkages & Relationships with the Community



Clinical Need Drives Priority Access

- **Assisted Outpatient Treatment (AOT)** – Court Ordered Outpatient MH treatment.
 - LGU oversees the AOT program (Petitions the court, develops treatment plan, oversees implementation)
- **ACT Services** - Limited number of ACT slots available for the highest need individuals (regardless of payer).
 - The LGU oversees the front door, the waiting list and the back door for ACT services. AOT's are prioritized
- **Children's HCBS Waiver** – Limited number of Waiver slots for the highest-need youth.
 - C-SPOA oversees the waiver slots for SED youth

CHILDRENS SINGLE POINT OF ACCESS (C-SPOA)

Children and Youth Single Point of Access (C-SPOA)

- In 1991 a study of the NY children's mental health system indicated that while NY had a comprehensive array of services for youth with SED and their families, there was not necessarily good coordination with and prioritization of these services.
- As a result, the Single Point Of Access (SPOA) was developed as part of the Governor's New Initiative 2000-2001.
- The C-SPOAs were created in 2001 to link and provide timely access to intensive OMH services and supports based on the identified service needs of a Serious Emotional Disturbance (SED) youth and their family.

Children and Youth Single Point of Access (C-SPOA)

- Each County/Local Government Unit across NYS has an established C-SPOA to serve as a way to help support, prioritize and effectively assure access to children's mental health services.
- The majority of C-SPOAs involve the parent/guardian as well as the youth in the C-SPOA meetings to assure that the treatment plan is family-driven and youth-guided approach.
- C-SPOAs ensure **ACCOUNTABILITY** across the board. This includes LGU responsibility to: ensure appropriate access, prioritize based on need, ensure accountability between systems and providers, ensure providers accept referrals from the C-SPOA and be held to standards, practices and values and accountability to broader systems to be informed about the C-SPOA and to utilize this streamlined process.

Children and Youth Single Point of Access (C-SPOA)

- C-SPOAs maintain ongoing contact and have established linkages with a variety of systems in order to obtain initial and ongoing input to best serve the youth/family:
 - Primary Care Providers
 - Substance Abuse Providers
 - Foster Care
 - Juvenile Justice System
 - Family/Peer Supports
 - Community Based Organizations
 - Local Department of Social Services (LDSS)
 - Mental Health Providers
 - School Systems
 - Prevention Services
 - Family Court System

The C-SPOA Referral Process

- The youth/family or provider need only contact the local C-SPOA office, please refer to the below CLMHD link to find C-SPOA contact information:

[http://www.clmhd.org/contact local mental hygiene departments/](http://www.clmhd.org/contact_local_mental_hygiene_departments/)

- The youth/family or provider completes the referral form, obtains signed consents and provides all required supporting documentation (i.e. psychological, psychiatric, medical assessments, IEP plans, etc.) to C-SPOA.

The C-SPOA Referral Process

- Once the C-SPOA receives the referral form with all supporting documentation, the C-SPOA schedules a multi-disciplinary team meeting including the youth/guardian to:
 - Determine the Level of service need
 - Identify needed treatment services/supports
 - Facilitate all treatment referrals
- The C-SPOAs meet regularly (and often) for continued assessment of the Plan of Care, continued connections and linkage to additional “non-SPOA” services to meet the youth/family needs (i.e. additional County services, non-traditional community services and traditional mental health services).

The C-SPOA Referral Process

- CLMHD is currently working with the C-SPOA Coordinators to identify best practices and opportunities for statewide standardization.
- Most C-SPOAs in the State will accept the OMH NYS Universal referral form for the 1915 (c) HCBS and other high end services in the Mental Health system. The C-SPOAs may request further information from the referral source.
- The C-SPOA OMH NYS Universal referral form can be located at the link below:

https://www.omh.ny.gov/omhweb/guidance/hcbs/forms/universal_referral_form.pdf

C-SPOAs Primary Functions

- The C-SPOAs are utilized as a resource for youths and families while they await for services to begin or are in a transition of care.
- C-SPOAs are considered to be the “safety net” to address immediate needs and are able to respond quickly and attain rapid access to services to meet urgent needs.
- C-SPOAs have standardized measures to conduct eligibility screens for Level of Care determination for the 1915(c) OMH Waiver services until the transition to Health Home/Medicaid Managed Care.

C-SPOAs Primary Functions

- Refer youth for the highest level service areas (i.e. RTFs, Community Residence). C-SPOAs have established relationships with the Pre Admission Certification Committee (PACC) and provide the required documentation for a RTF referral.
- Coordinate referrals and service provision for Non-Medicaid youths and families, providing a continuum of care when an individual may fluctuate between being Medicaid eligible and non-Medicaid eligible.
- C-SPOAs will initiate and develop wraparound planning for youth/families with complex needs that one service program and/or system would not be able to meet.

C-SPOAs Primary Functions

- C-SPOAs have knowledge of unique services in their respective counties (supported by State Aid and County Tax Levy) and provide linkage to them as needed.
- C-SPOAs are available to Health Homes and Care Management Agencies for consultation to assist any provider in identifying and linking the youth/family to needed services/supports.
- LGU/C-SPOAs provides systems of care training (i.e. trauma informed care, safety, cultural competence, wraparound service provision, etc.)

NYC Children's Single Point of Access

NYC C-SPOA

- NYC C-SPOA processes approximately 2500 referrals yearly and over 40,000 since 2002.

Once NYC C-SPOA receives a complete referral:

- Comprehensive assessments are conducted for all referred youth using the Child and Adolescent Needs and Strengths (CANS).
- Level of care determinations are made within 5 business days.
- Within the 5 day review period, NYC C-SPOA Specialists make concentrated efforts to consult with the referral source, treatment providers, and parent/caregivers.
- The NYC C-SPOA Specialist engages the parent/caregiver by using the “parent questionnaire” which is designed to help and guide with identification of the the youth’s strengths and capabilities while also identifying areas of parent/caregiver concerns.

NYC Children's Single Point of Access

NYC C-SPOA

- All caregivers are offered the option of being referred to the C-SPOA Parent Advocate.
- The C-SPOA Parent Advocate is a full time staff member available to assist families with linkages to appropriate community supports.
- NYC C-SPOA works collaboratively with the referral sources and community partners throughout NYC- these relationships are reinforced through the C-SPOA's participation in borough specific community forums and monthly provider meetings.
- NYC C-SPOA refers to the following services: Home and Community Based Services Waiver; Community Residence, Non-Medicaid Care Coordination, and Health Home Care Management. It also collaborates with the PACC on children referred for a Residential Treatment Facility.

Monroe County Case Example

DEMOGRAPHIC DATA:

- 16 year old male with Medicaid
- Diagnosis of Oppositional Defiant Disorder, Cannabis related Disorder, history of ADHD and Adjustment Disorder. Additional diagnosis of Epilepsy with Grand Mal and Non epileptic seizures.

PRESENTING BEHAVIORS:

- History of Robbery
- Extensive property destruction
- Self-reported Gang involvement
- Refusal to take prescribed medication
- Tantrums and Emotional Outbursts
- Refusal to meet with treatment providers
- Homicidal threats
- Weapons possession
- Assault and Assault with a knife towards family members
- Poor school attendance (1x weekly)
- Frequent Cannabis use, history of using codeine cough syrup and possible K2 exposure

Monroe County Case Example

CONCERNING SYMPTOMS/AREAS OF NEED:

- History of psychiatric illness in his family
- Victim of ongoing physical abuse
- Suffered head trauma during an attack in late 2015
- Suffered a seizure in early 2016 where he fell and was knocked unconscious.
- Paranoia directed at Mother, inmates and community members
- Frequently stares off and appears unresponsive
- Poor understanding of timelines of events
- Frequent confusion leads to feeling “tricked”

Monroe County Case Example

HISTORICAL PROVIDERS:

- Pediatric Neurology (client stopped attending)
- Chemical Dependency Residential (client was discharged hastily with concerns of safety and recommended psychological evaluation be completed in an outpatient setting)
- Outpatient Chemical Dependency Treatment
- City School District
- County Probation
- County Mental Health Court and Transition Management

What Did The SPOA Do?

SPOA PLANNING & INTERVENTION:

- Informed Mental Health court team and Transition Manager about variety of services available through Child and Youth System of Care.
- Engaged youth (in person) at the jail to assess his state, and gain his consent to communicate with family and providers. Also met with mother at home to engage and partner with in planning.
- Partnered with a counselor who visits the jail (pro-bono) to talk to 16 and 17 year olds separately. This created a path for this client to share concerns about his medication and treatment.
- Facilitated the jail psychiatrist in completing a very brief Psychiatric evaluation.
- Assessed need and gathered documentation for referral to appropriate care coordination.

What Did The SPOA Do?

SPOA PLANNING & INTERVENTION:

- Connection with On Track NY (formerly First Episode Psychosis) to determine eligibility; continued to negotiate barriers within this process on behalf of youth.
 - barriers included first being told a clinical note indicating possibility of psychosis would need to be provided.
 - Once provided, SPOA was then told that the history of head trauma and drug use made youth ineligible. After this was resolved, was then told that a referral was never received.
- Facilitated discharge from Jail to a family member's house with the following supports in place and secured unanimous agreement with plan:
 - HCBS Waiver (Would have been HHSC if no slot available immediately)
 - Outpatient Therapy and Psychiatry through local clinic
 - An intake appointment with Strong Pediatric Neurology
 - Continued involvement with Monroe County Probation
 - Further involvement with MC Mental Health Court
 - Medical Motors will support Grandmother to transport to appointments
 - Return to school with IEP support

What Did The SPOA Do?

ONGOING SPOA PLANNING & INVOLVEMENT:

- Facilitated an expedited intake with community-based psychiatry provider.
- Continued communication with providers about their ability to assess him for psychosis.
- Collaboration with Waiver ICC entity to ensure strength-based planning.
- Close monitoring to ensure level of care remains appropriate.
- Maintains continuity of care, oversight and planning as youth was incarcerated two more times and his living situation destabilized which leads to periodic loss of services/supports.
- **Weekly consultation with Socio-Legal Team, ensuring Medicaid does not lapse and the LGU provided funding (wraparound dollars) to maintain Waiver ICC when services were in jeopardy due to length of incarcerations and fluctuating Medicaid eligibility status.**

What Did The SPOA Do?

ONGOING SPOA PLANNING & INVOLVEMENT:

- CPS case opened when he was physically abused by his father (Jan. 19th). A large team meeting convened to clarify planning that included SPOA, CPS, DHS, On-Track NY, Outpatient Therapist, Monroe Co. probation officer, Waiver ICC, and his mother by phone. The youth was incarcerated at this time. The following plan was made:
 - Waiver ICC would have the mother sign consents to have him evaluated by On Track NY.
 - Jail MH staff used information identified through SPOA involvement in their summary to inform a secondary psychiatric evaluation.
 - Need for RTF assessed.
 - SPOA approval of Waiver's involvement past the 30 days of incarceration if it was needed and appropriate to do so.
 - Jail MH staff and Judge Elliot will request a direct admission to Strong Memorial Psychiatric Inpatient Unit.

Monroe County Case Example

CURRENT STATUS:

- He was admitted to a psychiatric inpatient unit.
- Planned collaboration with CPS, Probation and Waiver regarding needs at discharge from the psychiatric inpatient unit.
- RTF referral was completed, ongoing system level exploration of appropriate intervention for his needs.
- Youth has been currently placed by the court system into a secure OCFS facility.
- Upon release from the OCFS facility, the Adult and Children's SPOA will collaborate around the transition and planning needs for the youth.

Rensselaer County Example

DEMOGRAPHIC DATA:

- 16 year old Female with Medicaid
- C-SPOA received a call from a new Health Home Care Manager regarding this child
- Child was previously referred to C-SPOA by the Persons In Need Of Supervision (PINS) diversion worker.
- Child is currently receiving Detention Diversion Services

PRESENTING BEHAVIORS:

- Running away
- 2 Psychiatric Hospitalizations within the last 12 months
- Texting/Sexting with older men
- History of suicidal ideation
- Loss of interest in activities
- Concerns of potential substance use
- Concerns of possible trafficking

What Did The SPOA Do?

SPOA PLANNING & INTERVENTION:

- The HHCM obtained consent from the parent to contact the C-SPOA and seek advice on services/supports needed for the child/family.
- The C-SPOA provided referral information to the HHCM for the local Human Trafficking program “Safe Harbor”.
- C-SPOA discussed the higher levels of service on the Care Management Continuum, including: HCBS Waiver, Community Residence and RTF with the HHCM, providing information they could share with the child/family.
- Based on the needs identified and the increased amount of contact this child was requiring, the HHCM was encouraged to apply for HCBS Waiver services.
- The C-SPOA assisted the HHCM with obtaining in-patient and out-patient records to accompany the C-SPOA application.

What Did The SPOA Do?

SPOA PLANNING & INTERVENTION:

- A C-SPOA application, with all required signed consents and HIPAA releases, was received.
- The C-SPOA consulted with the clinical providers, gathered additional information/documentation, completed and scored the CANS to determine HCBS Waiver eligibility.
- C-SPOA scheduled a meeting with the child/family, the multi-disciplinary care team and standing members of the SPOA Committee:
 - LDSS
 - Probation
 - Family Peer Support Services
 - Children's Outpatient Mental Health Clinic

What Did The SPOA Do?

SPOA PLANNING & INTERVENTION:

- The Level of Care determination was made for the 1915 (c) HCBS Waiver Services.
- There was a current waitlist for HCBS Waiver services so the C-SPOA assured the family that both the HHCM and the C-SPOA would operate as a “safety net” for the child/family until Waiver services could begin.
- C-SPOA offered access to a crisis respite bed as needed, discussed access to the Child and Adolescent Mobile Crisis Team and the HHCM discussed their agency’s on-call policy. The group also discussed scenarios which would require a 911 call.
- C-SPOA agreed to be “on-call” for the HHCM for further consultation and the HHCM agreed to continue with the child/family until a HCBS Wavier slot became available.

Contact Information and Resources

- The Conference of Local Mental Hygiene Directors (CLMDH) Website:

<http://www.clmhd.org/>

- Who We Are and What We Do information sheet:

http://www.clmhd.org/about_us/

- How to contact your county C-SPOA Coordinator

http://www.clmhd.org/contact_local_mental_hygiene_departments/

Where to find this Webinar and the OMH Webinar presented on July 19, 2017:

http://www.clmhd.org/dcs_resources/Children-and-Families_189_pg.htm

- OMH contact for LGU/SPOA and OMH TCM Legacy/Care Coordination

Michelle Wagner: Michelle.Wagner@omh.ny.gov

- OMH HCBS Waiver Team: DCFS@omh.ny.gov