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EVALUATION OF BROOME COUNTY'S COMMUNITY REINVESTMENT PROGRAMS

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SUMMARY

In the mid-1990s, New York State enacted the Community Reinvestment Act, which authorized the State Office of Mental Health to distribute new sources of appropriations to each county in the State on an annual basis. In its first five years in existence, the Community Reinvestment (CR) initiative resulted in allocations of almost $116 million in new funds to the counties to initiate new, or expand existing, local community-based mental health services for adults and children with serious mental health and emotional disturbances. Many of these people have histories of having received inpatient mental health treatment, and the CR funds were designed in part to help reduce the incidence and related costs of such treatment.

Despite the importance of the Community Reinvestment initiative and the significance of the State's financial investment, until a year ago neither the State nor any counties had undertaken an evaluation of what difference CR has made. At the impetus of the Broome County Mental Health Commissioner and Legislature, and the State Office of Mental Health, CGR (the Center for Governmental Research) assessed the impact of the first seven years of CR funding in Broome County—the first such evaluation in the State.

Community Reinvestment funds have had a major impact in expanding the mental health service system in Broome County. CR has helped build the capacity of the service system, and has helped fund a number of new services, and expand existing needed services, that would not otherwise have been possible. Since 1995, 24 separate mental health programs (most new, some expanded) have been funded

through CR. CR funds, in conjunction in some cases with other funding sources, have added about $2 million in needed services to the community on an annual basis. The cumulative impact of the new and expanded resources totals well over $8 million over the past seven years. More specifically:

- CR funds have helped Broome County build and strengthen an infrastructure of a continuum of needed services for the mentally ill.
- CR has created the opportunity to fund and develop a variety of needed services, many of which, because they were "non-traditional," would not otherwise have been funded. As such, it enabled the County to take some risks with new, previously untested programs to meet community needs.
- It has given powerful support to the consumer movement, and in many ways enabled its empowerment.
- The largest proportion of the funded programs involves case management services, helping to fill a large gap in services for both children and adults. The vast majority of the programs serve the adult (22-64) population, with relatively small proportions serving children and youth and the geriatric population. Service gaps remain among those populations.

In general, programs seem to have met the objectives they established when they were created, and several report data suggesting that they have been effective in reducing the extent of unnecessary hospital and other institutional care and treatment, with resulting cost savings. But much more rigorous tracking and monitoring of cases is needed before such conclusions can be stated with confidence. Moreover, in general, more outcome/ impact types of indicators need to be developed and tracked across service providers in the future in order for definitive conclusions to be offered about the overall impact of CR on improving the quality of life and related outcomes of those served by the CR programs.

Based on the study's findings, new processes have been recommended to assess community needs, develop funding priorities, evaluate program impact, and reallocate funding where appropriate in the future. The County Mental Health Commissioner is already in the process of moving to implement the core recommendations; and the study's methodology, findings and recommendations are believed to have implications for the State OMH and other counties throughout the state.

Contributing Staff

Significant portions of the field research, data analyses, and report writing for this project were done by James Fatula and Kimberly Hood.

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I. INTRODUCTION

In this report, we examine the historical dimensions of Community Reinvestment (CR) mental health funding in Broome County, such as: What is Community Reinvestment? What was it intended to do? What was funded? How were programs selected for funding? How were they monitored? And, what has been the overall impact of CR? While we address each of these questions, this report is less about the past and more about the future in the sense of what Broome County (and the mental health service providers) can and should be doing to address community needs for services, respond to those needs appropriately, and adequately account for what happens as a result of that service provision.

Our goal in this report, then, is not so much to revisit or "second guess" either the planning and selection process for CR-funded programs at the time they were first funded, or how they have been monitored or evaluated over time. The fact is that there was a priority and selection process at the County level for CR programs. All of the funded programs were reviewed and approved at both the County and State levels. Nor is our report about recommending which agencies/programs should continue to be funded, and which ones, if any, should not.

Instead, if there is a general theme to our report, it is about "Accountability" and how to *ensure accountability for the future.* Public dollars and resources have been made available to accomplish certain public goals. Have they been used as intended? What difference have they made? Have they been and are they being used as effectively and as efficiently as they can be? How is this known? What needs to be done to ensure this kind of accountability in the future?

Accountability has typically referred to *fiscal* accountability: Were funds spent as intended? We are suggesting that "accountability" be broadened to also include *programmatic*, and indeed *system* accountability, i.e., the overall community impact these CR-funded programs have had and are likely to have in the future.

In this report, we analyze what has happened to date under CR in Broome County, with the primary goal of documenting what has or has not happened over the past several years, and of learning from these experiences and using them to draw implications and help shape recommendations for the future.

Project Methodology

In conducting this study, we reviewed:

- The original State legislation authorizing Community Reinvestment;
- Other State documents, and annual guidelines published by the State Office of Mental Health;
- Various Broome County documents, including the Broome County Mental Health Department Annual Reports and the Broome County Adopted Budgets;
- Original applications for CR funding from the agencies;
- Consolidated Fiscal Reports for each funded agency;
- Other material supplied by the agencies/programs, such as Annual Reports.

We also conducted interviews with:

- Art Johnson, Broome County Commissioner of Mental Health, and his staff;
- Other Broome County officials (Tom Hoke, Deputy County Executive; Chip Houser, Broome County Department of Social Services Commissioner; Jane Sweet, County Legislator and past Chair of the Health Services Committee);
- Community Services Board members;
- Mental Health Subcommittee and individual members;
- Management Council and individual members;
- Recipient/consumer leadership;

- Leadership staff of the Syracuse Field Office of the State Office of Mental Health, and a representative of the OMH Central Office;
- Conference of Local Mental Hygiene Directors Executive Director Gary Weiskopf, and Steve Dungan, Monroe County Director of Mental Health and former Chair of the Conference;
- Agency executives and staff for each CR-funded program.

We also conducted six separate focus groups with recipients of mental health services, including CR programs. Overall, more than 50 consumers participated in these focus groups.

In addition to preparing this overall report, based on our findings from these various sources, we also prepared detailed summaries of findings for each individual CR-funded program, along with our observations about the strengths and areas of improvement for each. In those separate program summaries, we suggested actions for each program's consideration and self-improvement. These summaries are not included in this overall report, but rather were shared only with their respective agencies and the County Mental Health Commissioner.

Background

What is the Community Reinvestment Act?

Chapter 723 of the Laws of 1993 (and reauthorized by Chapter 358 of the Laws of 1998 extending Community Reinvestment through September 30, 2001) enacted the Community Reinvestment Act (Article 41-55 of the Mental Hygiene Law), which authorized the State Office of Mental Health to distribute annual appropriations to the counties. These allocations were to be based on the projected savings resulting from the reduction of State-operated inpatient care for adults ages 22-64. Special monies were also made available for persons with mental illness who are also homeless and persons with co-occurring psychiatric and addictive disorders (MICA).

Community Reinvestment funding was intended to "convert" or "reinvest" savings from closing or downsizing State psychiatric

centers into improved community services for the seriously mentally ill.

Who were the intended target populations?

The CR authorizing legislation designated the provision of community mental health reinvestment services to *persons with serious mental illness, including children and adolescents with serious emotional disturbances, and for the expansion of community mental health services for homeless mentally ill persons and persons who are mentally ill and in need of substance abuse services.*

Since total community reinvestment funds were tied to meeting certain adult inpatient census targets for the State psychiatric centers, it was important to develop a system of care directed to persons currently in State inpatient care and in need of community placement, and to those at risk of State hospitalization.

A variety of community mental health services could be funded. "Community mental health reinvestment services" were spelled out by the State Office of Mental Health to mean the following mental health services for persons with serious mental illness, defined as adults or children in crisis, adults diagnosed with severe and persistent mental illness, and children and adolescents diagnosed with serious emotional disturbances:

- emergency and crisis services;
- outpatient services;
- community support services, including residential services, other than inpatient;
- case management services;
- psychiatric rehabilitation;
- client advocacy;
- supported work;
- consumer self-help;

- family support;
- vocational training;
- other services for children and adolescents with serious emotional disturbances;
- services for special populations, including homeless mentally ill persons, persons who are mentally ill and in need of substance abuse services, persons with frequent hospitalizations, and persons who have a history of noncompliance with necessary mental health treatment programs, as approved by the commissioner;
- technical assistance and/or training to multi-cultural groups to develop culturally appropriate service programs;
- consumer empowerment and advocacy training;
- other, new or innovative programs, which are not presently available, as approved by the commissioner; and
- LGU (Local Governmental Unit) Administration, including quality assurance, monitoring, and evaluation.

Note that the CR legislation targets the "seriously mentally ill" (SMI), which includes the "seriously and persistently mentally ill" (SPMI). In the rest of this report, we use the term "seriously mentally ill" in the same way as described here by the State Office of Mental Health.

There were restrictions on the use of reinvestment funds. Generally, CR funds could <u>not</u> be used:

- "For any annualization of [non-CR-funded] community mental health or residential services initiated or committed in any prior year.
- For the development of housing or other services authorized, developed or operated as part of the New York/New York agreement on or before the effective date of the reinvestment legislation.

- To fund any cost of living adjustment for any program (COLA), except that funds may be used to support costs attributable to a cost of living adjustment enacted in the same fiscal year as the new service development or expansion.

- To fund capital projects."

How were funds allocated to the counties?

Eighty-five percent of CR funds were allocated to the counties for community mental health services; the remaining 15 percent of funds were for the enhancement of State psychiatric center inpatient staffing ratios.

The Legislature devised the following formula for allocating CR funds: Of the 85 percent, 50 percent of the funds were allocated to the counties based on prevalence rates of persons with serious mental illness, including children with serious emotional disturbances; 25 percent of the allocation was based on "equity" to ensure that no county would receive less than $75,000 annually from CR; 5 percent was allocated to those areas where there was a closure or consolidation of a State-operated psychiatric hospital; and the rest of the money was allocated through a "Performance Pool."

There was a "maintenance of effort" requirement. CRA funds could not be used in a manner which "supplants or replaces" other funds supporting the same community mental health services.

A Local Government Assurance Form (signed by the Chair of the Mental Health Subcommittee; Chair, Community Services Board; and County Director of Mental Health) was required. The Mental Health Subcommittee was required to certify that it had the opportunity to participate in the development of the revised Reinvestment plan and/or one-time use request.

How much funding has been made available through Community Reinvestment?

At the State level, based on Statewide CRA data—"Five Year Summary of Reinvestment 1994-95 through 1999"—the annual allocations for Community Reinvestment were:

1994-95: $32.813 million,

1995-96: $22.862 million,

1996-97: $18.700 million,

1997-98: $20.570 million,

1998-99: $20.910 million,

for a total of $115.855 million additional funding made available through Community Reinvestment for its first five years of funding. Another $20.4 million was allocated for state inpatient staffing enhancements, and an additional $30 million was made available for the Homeless/MICA population.

For the same first five years of CR, *Broome County* was allocated these amounts:

1995: $514,160,

1996: $154,380,

1997: $166,245,

1998: $190,795,

1999: $514,010,

for a total of $1,539,590 of additional new funding made available through Community Reinvestment for its first five years.

More detail on CR funding, including data for more recent years, is provided in Chapter II of the report.

II. Analysis and Findings

In this chapter, we discuss our *overall* findings concerning Community Reinvestment in Broome County. The findings and conclusions reflect how the CR process has been implemented in the County, and how well it has worked overall, with its strengths and limitations. The findings also reflect the combined impact of the separate decisions made over the years about CR. Obviously it is not possible to talk about the impact of CR and the difference it has made in the community without referencing the individual programs and services that have been funded through the process. However, since the focus of this chapter is on the *composite, overall impact of the CR initiative*, we do not include detailed assessments of the impact of each individual program.

Indeed, by agreement at the beginning of this project with the Broome County Mental Health Commissioner and the individual agencies and programs that have received CR funding over the years, the more detailed individual program evaluations/ assessments were shared only with the individual programs and the Commissioner through separate individualized memoranda. The intent of those memos is to provide CGR's objective assessments of the impacts, strengths and areas in need of improvement for each program. They are intended primarily as communications designed for the individual programs and the Commissioner to use in working together to make any needed adjustments in current operations in order to prepare for the future.

Data Limitations/ Focus on the Future

Our findings are based as much as possible on objective, empirical data analyses. To a reasonable extent that was possible. However, *one of the central findings of this report is that in many cases, key data were missing or incomplete, and in other cases, important information has never been collected at all, because the programs have never been asked for it or required to maintain it in the past.*

Thus our findings and conclusions are based on our observations and analyses derived after numerous discussions with people familiar with all aspects of the CR system, its programs and its processes, supplemented by the most objective analysis possible of

the partial data available to us. This chapter represents the findings and conclusions which resulted from our synthesis of all the information—measurable or not—available to us. Even with the limitations of the data available through the mental health system, we believe the findings are credible, objective, and accurate reflections of the reality in Broome County at this point. Implementation of the recommendations made in the concluding chapter of the report will enable even more empirical findings and conclusions to be possible in the future, as needed reporting procedures and outcome measures, not now consistently in place, are put into operation.

CGR's findings about what happened in the past have their primary value in helping suggest what needs to be done in the future.

We emphasize again that the purpose of these findings is not to "second guess" the processes and procedures in place now or in previous years. Rather, our findings about what happened in the past have their primary value in helping suggest what needs to be done in the future. We recognize that the County and the Mental Health leadership and providers responded to CR opportunities under the circumstances and requirements in place at the time, and the providers submitted proposals and reported on their programs based on those fairly minimal requirements.

In our evaluation, it would not be fair to hold any of the participants in the process to a set of standards that might make sense under different circumstances in the future, but which were not in place at the time. *But it is fair to use these findings to suggest what was not in place, and what should be considered for the mental health system of the future.* Accordingly, based on these findings, we do recommend a number of changes in the final chapter to improve how the County and its mental health providers should conduct their business in the future, for both CR-funded and other mental health programs and services.

We begin the analysis section by summarizing a variety of perspectives about the Community Reinvestment process, as obtained in numerous interviews over the past several months with key stakeholders in, and knowledgeable about, the mental health system in Broome County. We decided to present these perspectives up front because they help to frame many of the issues that are discussed in more detail throughout the report. It is useful to keep these overview perspectives in mind in reviewing

the subsequent analyses provided in the remainder of this chapter, and they also begin to suggest issues and solutions addressed in detailed recommendations in the report's concluding chapter. In a few cases, the data presented following the stakeholder perspectives suggest different interpretations of issues raised by the stakeholders, but in most cases, the data tend to confirm their shared perspectives. As the subsequent data are discussed, we refer back to these summary perspectives where appropriate.

Stakeholder Perspectives on the CR Process in Broome County

As CGR staff met with key staff from the agencies and programs funded by Community Reinvestment; with key administrative and legislative officials of County government; and in group meetings with the Community Services Board, Mental Health Subcommittee, Management Council, and consumers/recipients, we asked about their expectations and perspectives concerning CR and how it had been implemented in Broome County. The following composite comments represent an accurate reflection of the views we heard expressed. Although different people emphasized different issues, there was clear consensus around most issues, and very little basic disagreement on any of the major themes that surfaced in the discussions.

What follows is a summary of *stakeholder comments, in their words*, organized by broad theme areas.

Perceived Value of CR

- Community reinvestment was long overdue, as it should have happened at the beginning of deinstitutionalization, but it's better later than never. Can be much more creative at the local level in allocating funds to meet needs than without the initiative.

- CR was a great idea, even if too little too late. Unfortunately, with CR came the end of the requirements for counties to do community plans, thereby undercutting one of the ways to assure that decisions about CR funding would be made based on community priorities and demonstrated needs. It was almost as if the state wanted to say, "You wanted this, fine, now let's see you implement it and make local decisions without any guidelines from us, or without requirements for you to have a plan in the future." So counties got uneven effects of implementation, depending on whims of commissioners in some cases, and

rubber stamping of proposals in some areas, to careful needs assessments in other areas, despite the lack of a mandated process.

Perceived Impact of CR

- Generally think CR has been used to meet some level of defined needs, though not necessarily of previously-institutionalized people.

- Think it's OK that we haven't always used CR funds for SPMI recipients, since CR dollars were not historically channeled for otherwise reimbursable programs. Therefore have tended to shy away from clinical Medicaid-type programs that might be otherwise reimbursed. So I think it's OK to have used more of the CR funds for such things as outreach and identification types of services, as long as their objectives are clear and we knew what we were doing, and could hold the programs accountable.

- CR impact: CR has been a welcome resource as a way for the community to respond to some unmet needs and service voids. For example, it's enabled us to expand the community's case manager resources, which was a major need 10 years ago. We're still playing catchup, but we're much closer to what the community needs than we were before CR.

- It allowed us to try some things that we hadn't been able to do before. For example, CCSI (Coordinated Children's Services Initiative) funding has been leveraged in such a way that we're beginning as a system to change how we work with families. The FLEX team probably would not be in place without CR, and that allows staff to go into institutions in ways we couldn't before. We've been able to package resources in some new ways, such as flexible funding, wraparound services, etc. As a community we're working with seniors in ways we weren't able to before. In general, we've been able to tailor resources to needs more effectively.

- CR has enabled us to set up new programs that would not otherwise exist, though it's also enabled us to expand some

existing programs that can now reach more people as a result.

- As a result of CR, we're able to be doing more to break down the barriers to children's MH services, through such approaches as CCSI, ICM (Intensive Case Management), etc. We're doing more work with families in a holistic manner; but there are still lots of gaps in services to children.

- My sense is that all of the funded CR programs have come out of some identified gaps in services. I think they're all making a difference and filling community needs. The process for making that determination may not always have been the best, but I don't think a lot of bad decisions were made along the way.

- Think most programs have pretty much remained consistent with their initial objectives and approaches.

Stakeholder Involvement

- There are concerns about the planning process and who's involved in it at this point. Needs to be broad input, but in recent times has tended to involve too few people, and decisions haven't necessarily been made in the best interests of the overall community. More and more agencies are seeking new sources of funds, as old funding sources dry up, so means that in some cases agencies perhaps not best equipped to carry out needed services are being considered. They may not have the best experience or skills to be selected, but this is the danger in the apparent desire at times to "spread the wealth around," rather than selecting who's best to provide a service. That may have some advantages as a policy, rather than having all services concentrated with too few providers, but it should be a more democratically-derived decision, rather than being made with too little involvement of key stakeholders.

- All providers should always be at the table as needs are assessed and decisions made about future funding. In the past, there was such broad involvement, as we made

decisions about planning, needs assessments, and funding allocations.

- All stakeholders should be included in key decisions about establishing community needs, determining what should be funded, how allocation decisions get made or even shifted in the future. Stakeholders should include the County, non-profit and other service providers, recipients, parents. The role of the Management Council could be reactivated, with perhaps some additions, to reactivate the old planning function.

- Concerns about the conflicts between the local psychiatric center, local hospitals and the community. The first two are in survival modes, so need to be cautious about their roles in the process, but they need to be key participants in the process, and the County needs to include them, but also be strong enough not to be overly influenced by their needs. Any decisions about the future of such institutions need to be made with community input.

- Management Council and the MH Subcommittee could be the final decision-makers in setting priorities and determining needs and resources to be devoted to those needs, as long as we include careful input throughout the process from all stakeholders.

Planning and Needs Assessment

- Need careful planning and needs assessment process, and the assurance that what comes out of that process will help shape future allocation of resources. Process needs to include meetings with key stakeholders, public forums, surveys of service recipients and caregivers, collection of various data about the community and its changing needs and characteristics. Need a mechanism in place with the resources to be responsible for pulling together such information and sharing it in an objective manner with Management Council, MH Subcommittee, etc. to stimulate discussion.

- County, thru the Management Council and the MH Subcommittee, should periodically reassess needs in the community, and see how funding stacks up against those

needs. This can happen locally, and needs to be reestablished if we are to make wise decisions in the future.

- Timeframes have been a problem in the past, with not enough time between release of the CR RFPs and the deadline date, not allowing sufficient time to put together the best response. On the other hand, it's true that we should be better prepared in the future, and not just wait til the RFP comes out to develop an assessment of community needs and priorities. We should have an ongoing planning process in place and operational at all times. Even if there were no RFP forcing us to think about the future, we need to have a planning process in place on a routine basis, which includes careful assessment of county needs and available resources.

- The role in needs assessment and planning of existing groups such as the Management Council should be supplemented by additional input from the criminal and juvenile justice systems, since more and more of the people we need to be serving are related to those systems.

Priority Determination and Program Selection

- There is a lot of competition for existing and limited resources. Need good process, and strong leadership, to bridge those gaps and competing needs and interests. Thinks it's possible to do, however, as long as the process is perceived as fair, objective, and comprehensive, and that all legitimate "players" have input into the process. Have to rebuild the levels of trust that have been compromised over the years of different commissioners and different processes.

- Children's and Youth Services Council has demonstrated that it can do what is being discussed here, in terms of being at the table and helping to set community priorities, but at the same time being able to put aside individual interests and make common interest decisions for the good of the full community. A common planning process that all have agreed to seems to work effectively.

- Need to have procedures in place to set priorities for the community. Too often we just fund projects without

relating them to assessments of needs and establishment of overall priorities. If the issues are defined clearly and the priorities set, the allocation of funds should be easier to do, and the question of who should do what will become clearer. We can help make those decisions for the good of the community, without being overly influenced by our agency objectives. As long as we and other key stakeholders have input into the establishment of the priorities, it's less important that they be involved in the actual funding decisions, and maybe that's the logical distinction between our roles at various stages of the process. The Mental Health Subcommittee or the Community Services Board could perhaps make final decisions with input and questions from providers or Management Council, but without our being involved in the final allocation decisions.

Evaluation Process/ Performance Outcome Measurement

- Beyond a more effective needs assessment, priority setting and allocations process, it's also important that a careful mechanism be in place to evaluate the impact of what we're doing. Not just a matter of collecting a lot of data, but of making sense of it, and putting the data in context and determining what it means, and what are the implications for individual programs and the overall mental health delivery system. We need to focus more on outcomes and on rewarding those programs that help stabilize people and keep them out of institutions to the extent possible. We have to go well beyond determining what services we provide to whom, and ask more and more the question of "so what are the outcomes as a result."

- State needs to mandate need for outcome requirements and provide guidance in how to set them up at county level. Not just measures, but how to use and interpret them; not just set up data collection requirements, but help counties interpret the data and understand how data can be helpful to them in management and monitoring and fund allocation contexts. State should spearhead overall evaluation of how resources have been allocated and what impact they've had, and how to reallocate if needed. This

current County evaluation is a good start in that process, that should be replicated in other counties around the state.

Reassessment of Existing CR Funding

- We think that it's important to have process in place to reassess what has been funded in the past and to consider reallocating resources if a needs assessment shows that needs and priorities have changed. Needs to be done on an objective basis. Needs to be a better planning and needs assessment process in place for this to happen. We particularly like the idea of having a transition period whereby existing programs have a chance to take corrective actions if needed, and/or to look at ways they could productively shift funding from lower priority to higher priority services, and thereby better meet community needs, but without necessarily losing agency funding if they're able to adjust.

- Locally, most decisions are OK, but we never set up a clear process for making the decisions, and especially we never revisited them in the future to see if we should reassess how moneys were allocated, and whether any shifts should occur in light of changing needs. For example, at no time did the Management Council come together to discuss what's now in place with CR funds to assess what exists and whether that's a good reflection of responding to current community needs.

- We should be reassessing funding in the past vs. current and changing needs to see if any reallocation of resources should occur. But this needs to be done in an open process with all stakeholders involved.

- We need to assess existing funding arrangements and see if needs have changed, which might necessitate shifts in how funds are allocated over some orderly transition period. We need a careful process to make such decisions and be willing to say, times and circumstances and needs may change, and we may need to adjust funding and resource allocations accordingly at times. Probably not a lot would change, but we need to be open to the possibility to be responsible to the community.

- It's time to rethink what's been funded and see if any reallocation decisions may be needed in light of changing community needs.

- We need to be willing to go through the process of reallocating resources if need is justified. The provider community should be a legitimate part of this process, if they are empowered and taken seriously; it's better than ignoring us and having too many decisions made in effect unilaterally. Need to be broad-based decisions that factor in legitimate needs and interests and perspectives of providers, as well as obtaining recipient perspectives. Should be based on needs assessment and on criteria clearly set and followed and applied consistently and fairly.

Recipient Issues

- CR has been used in part to address recipient issues, since they'd been instrumental in the political process of getting CR passed. This has been a good thing overall. However, the "travesty" was that we expected programs to be peer run, but gave them no resources to enable it to happen effectively. For example, we set up peer-run programs, but not always with the requisite skills; we held them accountable and added stress to these programs and their key officials, and expected them to meet the state's reporting requirements, but we never set up any process to help develop needed skills, or to help them in such things as board member selection. No assistance was provided in helping them understand the need to have board members with good financial and personnel skills, and we never worked with most of them to help them understand that this wasn't about imposing anything on them, but was about helping them to succeed; that all boards, regardless of whether recipient run or not, need such skills. We should have set some criteria/guidelines for board membership that mandated key skills but still left recipients in control. Instead, we never gave them the opportunity to succeed, and then held them accountable if they failed. Not fair.

Perceived Service Gaps/Unmet Needs

- Gaps in services: kids services in general, and lacking in comprehensiveness, with particular gaps in housing and

other supportive services. Need to "professionalize" child psychiatry, which is where we were years ago with adult services. We need more inpatient MH services for children, since now often have to send kids to Syracuse, Rochester or Buffalo areas, as there is nothing locally. There are few other forms of intensive services for kids in the area either. This issue needs to be faced as a planning issue, and then focus our resources on how we can best address it. Ideally we don't want to pit adults against children's services, but we do need to carefully figure out what's working and consider shifting resources if we can to unmet needs.

- Both services to older adults and children's services need increased attention in the mental health community in the future.

- Greatest unmet needs in county are for services for children and adolescents, especially outpatient, and including better and more frequent programs integrating MH services within schools. Deliver services to kids and their families where they can be reached. Very difficult for community this size to get and keep child psychiatrists, which are needed.

- Need long-term solutions to children's mental health services. Youth services are at the low end of the totem pole at this point.

- In particular, we need to be putting more emphasis on prevention, but it's tough as we kept getting pulled back to deal with today's crises, such as the need to address needs surfacing in the juvenile justice system.

- There is a need to have a single entry system in place for children as well as adults, and probably in the long run for all adults, and not just case management.

- Schools provide a new resource for us to work with and develop partnerships with as a way of reaching more people. They seem open to making more use of strengths-based assets approaches to problems. We need to find more ways to collaborate with schools.

- The resource balance is skewed between the State and various non-profit service providers, as we have State shared staff positions working with our staff, being paid much more per year to do similar functions. In general, the infrequency of COLAs and raises in general for non-profit staff—along with uncertainties concerning the State budget—have made it very difficult for non-profits to keep pace with the public sector. This hurts us, as we tend to do a lot of training of staff who then move on to higher paying jobs. It's very tough for us to keep the best people as a result.

In the remainder of this chapter, we move now beyond the stakeholder comments to a broader discussion of other CGR findings about the CR process and its effects in Broome County.

Degree of Local Flexibility and Control

As discussed in the Background section in Chapter I, Community Reinvestment was intended to make possible a number of mental health services from which local communities could select various options. While restrictions were placed on some of the funding made available to counties, for the most part counties were given considerable latitude and flexibility in how they allocated their available CR funds.

CR, for the most part, allowed counties considerable latitude and flexibility in how they allocated available funds.

We heard a number of complaints that the State was too prescriptive in its guidelines for CR funding, and that it did not adequately take into account local community needs. *We find little or no basis for these complaints.* To the contrary, it is apparent that *counties had wide latitude in what they pursued CR funding for*, and there seemed to be little questioning of county CR funding priorities and proposals in the State review of applications.

We did find that *tight timelines* imposed by the State for producing annual CR proposals did at times have adverse effects on the quality and comprehensiveness of the proposals submitted, especially in the absence of a baseline needs assessment for Broome County. Providers noted that "we ended up throwing things together" and that it was often impossible to collaborate with other agencies with such quick turnaround times. On the other hand, to be fair, it was not the State's fault that no planning or needs assessment process was in place in recent years in Broome. There could have been, but wasn't, at least not

consistently. Had there been, the effects of the difficulties imposed by the admittedly tight timelines that were imposed some years could have been minimized.

Allocation of Local CR Funds

As indicated in Table 1, beginning with seven proposals funded in the first year of CR funding (1994-95 State fiscal year), a total of 36 separate CR proposals have been funded since the program began. Twelve of these proposals represent additional/expanded funding for previously-funded programs, meaning that a total of *24 separate mental health programs in the county have received funding through the CR initiative.*

State Fiscal Year	# CR Proposals Funded	New CR Funding	Total Annual CR Funds	Cumulative CR Funding
1995	7	$514,160	$514,160	$514,160
1996	4	$154,380	$668,540	$1,182,700
1997	3	$166,245	$834,785	$2,017,485
1998	5	$190,795	$1,025,580	$3,043,065
1999	12	$514,010	$1,527,281	$4,570,346
2000	4	$163,845	$1,601,020	$6,171,366
2001	1	$66,000	$1,711,165	$7,882,531

*Table does not include funding for CGR evaluation.

The CR program was set up such that each year's funds awarded to a county are virtually guaranteed for subsequent years of funding. Therefore, each year's new funds get added to previous years of funds, so that the annual impact of CR on the mental health system of the County keeps expanding. Thus, in 2001, the annual value of the CR investment in Broome County has grown from the initial year's investment of just over half a million dollars to *more than $1.7 million of CR-funded services in 2001 that did not exist prior to 1994-95.* Moreover, the cumulative value of all the CR funds invested in the county since the initiative began totals approximately $7.9 million. Clearly, *CR funding has had a significant and growing impact on the availability of mental health services throughout the county.* (A more detailed list of the programs—along with their agencies, the year of initial funding, and the annual CR amount when initially funded—is included in the appendix.)

In 2001, Broome County received more than $1.7 million in CR funding.

Table 2 on the next page indicates that the 24 funded programs are distributed across nine separate agencies, most of which are in

the non-profit sector. Eight of the programs are operated by Catholic Charities. Four are run by the Mental Health Association, and three each by the Recipient Affairs Office (RAO) and by the Broome County Mental Health Department (BCMH).

Agency	Initial CR Funding	Community Reinvestment Program	Program Type
BPC	1998	Trauma Self-Help	Outreach
BCMH	1995	MICA-Homeless	MICA Case Management
BCMH	1995	LGU Administration *	LGU Administration
BCMH	1999	Forensic Program	Case Management
CC	1995	Aging Out Intensive Case Management	Case Management
CC	1995	Adult Flex Team	Case Management
CC	1997	Crisis Sitters	Crisis Support/Intervention
CC	1997	Single Entry	Service Coordination
CC	1998	CCSI	Service Coordination
CC	1999	Home Based Crisis Intervention	Crisis Support/Intervention
CC	1999	Supportive Case Management	Case Management
CC	2000	MICA Intensive Residential Treatment	MICA Case Management
F&C	1998	Family Support Center	School-based Initiative
F&C	2001	In-home Mental Health Mgmt Program	Case Management
FRS/BPC	1999	MICA Network	MICA Case Management
Lourdes	2000	Case Management- Child/SED	Case Management
MHA	1995	Multicultural Initiative	Advocacy
MHA	1996	BEAR	School-based Initiative
MHA	1998	Rural BEAR Program	School-based Initiative
MHA	1999	SHIP (Self Help Independence Project)	Advocacy
RAO	1997	Peer Advocacy	Advocacy
RAO	1999	Bridger	Advocacy
RAO	1999	Parent Partners/CCSI	Advocacy
UHS	1995	HOME Geriatric Outreach	Outreach

*Does not include LGU (Local Governmental Unit) funds for CGR evaluation.

Growth of Case Management Programs

Although the program categories are not as clearly defined as we would have liked, there are more programs defined as case management programs than any other type (nine), and at least one or two of the others (e.g., CCSI, Single Entry) could also be considered to have case management characteristics. *At least one additional newly-funded case management program has been added to the list of funded programs virtually every one of the seven program years.* Programs which have been funded only in more recent years include the four advocacy programs (three of which were funded for the first time in 1999).

Another indication of the dominance of case management programs is shown in Table 3 below. Case management programs, including MICA case management, account for 47% of the CR funding available to programs in 2001. When two service coordination programs—CCSI and Single Entry (both of which focus heavily on case management services and coordination)—are added in, *case management services account for 55% of all CR funds in 2001.* As noted in the stakeholder comments earlier, *clearly one of the things that CR funds have made possible is to gradually expand the numbers and types of case management programs for both young people and adults.*

Funding By Program Type		
Program Type	**2001 Funding Amount**	**% of Total Funding**
Advocacy	$313,422	18.3%
Case Management	$735,549	43.0%
Crisis Support/Intervention	$71,853	4.2%
LGU*	$33,434	2.0%
MICA Case Management	$70,209	4.1%
Outreach	$220,060	12.9%
School-based Initiative	$129,965	7.6%
Service Coordination	$136,674	8.0%
Total	*$1,711,165*	*100.0%*

*Does not include CGR evaluation

As indicated in the table, Advocacy has recently grown into the second largest type of program funded by Community Reinvestment dollars, growing in recent years to 18% of the total CR annual investment in 2001 (with a series of programs offered by RAO and the Mental Health Association). Outreach services account for another 13% of the total funds.

What has not been funded for the most part were "services" aimed at "LGU [Local Governmental Unit] Administration, including quality assurance, monitoring, and evaluation." This is quite understandable, since clearly the priority was on putting in place programs to address a wide variety of unmet service needs. In another respect, however, it is unfortunate—though certainly not unusual anywhere in the State—that there was no insistence on using some of the CR funds to evaluate on an ongoing basis what was working well and what was not. On the other hand, to the credit of Broome County and the Mental Health Commissioner, CR funds were sought and approved to undertake this evaluation effort, which will hopefully result in an ongoing process for assessing community needs, setting priorities, and evaluating programs in the future against defined outcomes and measures of program impact (see recommendations in the next chapter).

Predominance of Adult Services

As shown in Table 4 on the next page, the vast majority of programs funded through Community Reinvestment to date have offered services to adults between the ages of 22 and 64. As suggested by the stakeholder comments related to service gaps, *a relatively small proportion of the funding has gone to services for children and youth (18%). Even less (about 8%) is targeted to the geriatric population.* This latter figure should be viewed in the context of the fact that Broome's 65+ population is 16.4% of the total county population—well above the statewide geriatric proportion of 12.9%, and one of the highest concentrations of older citizens of any county in the state. Note that the new In-home Mental Health Management Program, starting in 2001, while targeted to the larger adult population with particular defined needs, is aimed heavily at the geriatric population. If that program were included in the geriatric target population, the geriatric proportion of CR funds would grow to 12%.

The largest proportion (about 72%) of CR funds is allocated to programs serving the adult population.

Funding By Age of Target Population		
Target Population	2001 Funding Amount	% of Total Funding
Children/Youth	$307,092	17.9%
Adults	$1,229,632	71.9%
Geriatric	$141,007	8.2%
N/A - LGU*	$33,434	2.0%
Total	*$1,711,165*	*98.0%*

*Does not include CGR evaluation

New vs. Expanded Programs

Of the 24 programs which have received CR funding, six had previously existed in some form, and the CR funds enabled the programs to add additional staff or to otherwise expand services. The six include: additional staffing in the County's MICA Homeless program, expanded staffing in the County's Forensic program, institutionalization and expansion of the CCSI pilot project, expansion of the Catholic Charities congregate MICA residential program, expansion of a Lourdes children's case management program, and additional resources for the County's LGU Administrative operations. *About 75% of the funded programs had not previously existed, and they would not in all likelihood exist today were it not for at least partial, if not 100% CR funding.*

Once programs have received their initial CR funds, for either startup or expansion, they are eligible, if they can justify the need, to apply for additional continuation/expansion funds through the regular CR proposal process. Seven of the funded efforts appear to have been able to obtain supplemental funding in one or more future funding year cycles to further enhance their efforts: the UHS/HOME program, the FLEX Team, Rural BEAR, Multi-Cultural Initiative, the Forensic Outreach program, the RAO Peer Advocacy program, and the LGU (see table in the appendix).

Additional Value of CR Funds

In addition to determining the mental health programs made possible by CR funding, we attempted to determine the extent to which CR dollars leveraged, or were combined with additional sources of funds to expand their value. Unfortunately, the data maintained by the financial system, via the Consolidated Fiscal Report (CFR) forms, and the information supplied by program

staff were not always consistent, and in some cases alternative funding sources were not included at all in the CFR data, so that data on supplementary funding sources should be viewed with great caution. Nonetheless, some overall observations are possible.

At least 14 of the 24 programs appear to have been funded solely through CR. These 14 programs (58% of the total) clearly owe their existence solely to the presence of CR funds. In an additional three programs, services funded through other sources were well under way prior to CR funding, and new positions or resources were added through 100% CR funds, not matched by other funding sources.

In six additional programs, various forms of collaborative funding were clearly in place to enable the new or expanded programming to occur. In three of these, CR funds were matched in various ways with funds available through the Sheriff's office, DSS, and the Youth Bureau, respectively. In the other three, Medicaid reimbursement was available to supplement the CR funds to enable a new program to be established or an existing one to expand. (For one program, it was impossible from existing information to determine whether any joint funding of the program was involved or not.)

CR funds, combined with other sources of matching funding, now add about $2 million worth of mental health services to Broome County annually.

Although the financial data concerning the value of the matches for CR funding are inconsistent and incomplete at best, it appears as if close to $250,000 in non-CR sources of funds are being used in combination with CR resources in the jointly-funded programs noted above. When these funds are added to the more than $1.7 million in strictly CR money in the system on an annual basis, it is fair to conclude that *CR funds, combined with other sources of matching funding, are now adding a total of about $2 million worth of new or expanded mental health services to the Broome County community on an annual basis. The value of those combined resources, CR plus matched funds, totals well over $8 million cumulatively over the past seven years.*

County officials may wish in future years to examine the extent to which some of the programs now funded through 100% CR funds might be able to find partial match funding through other foundation or public sources of funds. For example, for certain target groups, changes in eligibility criteria which have been occurring over time may make it possible to

consider matches from such sources of funding as DSS preventive services block grant, TANF block grant, and other sources of primarily state and federal funds that may enable some CR funds to be freed up and extended to other programs and/or target populations in the future.

Effectiveness of the Allocations Process

For the most part, it appears that Broome County and local service providers responded on an ad hoc basis to the annual CR funding process. This should not be surprising, given the circumstances.

Prior to 1995, counties were required to prepare an Annual Mental Health Plan. This mandated annual planning process at the county level ceased with the introduction of the CR funding process. The expectation was that the annual "planning" for CR programs would replace the County's Annual Mental Health Plan. At least in Broome County, however, there was little evidence, especially in later years, that a substantive annual planning and needs assessment process formed the basis for each year's CR funding requests, a conclusion noted by stakeholders in an earlier section of this chapter.

Contributing to this situation was the fact that there was no stable leadership in the Mental Health Commissioner's office during that time period, with turnover in that office occurring practically annually between 1995 and 1999.

The authorizing legislation for CR emphasized the targeting of the 22-64 age group vis a vis reduced utilization of state inpatient care. At the same time, there were apparently a number of unmet needs within Broome County for a variety of populations, including children and the elderly. As one stakeholder said, "At the beginning of the CR process, we needed everything." Although there was no updated systematic needs assessment in place, there were plenty of ideas and pent up needs for new or expanded programs for community-based services for the mentally ill.

During the first reinvestment years, the Management Council, composed of the agency directors, collectively decided (at the Commissioner's request) upon CR funding priorities—a kind of "gentleman's agreement." Given fairly tight turnaround times for the proposals, and the variety of unmet needs, this turned out to be a fairly efficient way to decide on annual funding priorities. For

the most part, it was reactive, and there was the perception that, in part at least, the process could be used to not only meet existing long-unmet needs, but could also provide an opportunity to use the resources to "divvy up the pie" and "spread the wealth around."

The Broome County Mental Health Commissioner revised the selection process in 1999 to eliminate the dominant role of the Management Council in reviewing and recommending proposals—based on the assumption that people with vested interests were too involved in making the funding decisions and that, even though the process seemed to work fairly, the process at least gave the appearance of not being fair or equitable. As noted earlier in the chapter, many of the service providers have not been pleased with this decision, and many now feel "disenfranchised" as a result. They argue for an expanded role in the process in the future, more like what it was initially, at least to the extent of being more integrally involved in defining needs and establishing overall funding priorities. For further discussion of this issue, see the Recommendations chapter to follow.

Formal Monitoring of Programs

For the most part, there has been no formal monitoring of the impact of CR funded programs—actually, no more or no less than the monitoring of any other mental health funded programs in Broome County. Agencies are required to submit "annual reports" to the LGU for inclusion in the LGU's Annual Report. These annual reports continue to be submitted to the Mental Health Department in an abbreviated form. Monthly units of service were reported on LS3 forms (Service Report for Outpatient Programs). But beyond that, we found no evidence of any systematic programmatic oversight.

Historically, CR-funded programs have been subject to no formal monitoring.

Counties typically are tightly constrained with regard to having the staff to do anything more than what is strictly required by State requirements. Claiming of course is a high priority, so it tends to take precedence at any given time. Given the amount of money that flows through the County Mental Health Department, it seems justifiable and prudent to have the staffing resources necessary to ensure that monies that flow through this office to providers are spent as intended.

Lots of "information" is required to be reported by funded agencies: CFRs (Consolidated Fiscal Reports), CBRs (Consolidated Budget Reports), LS3s (Service Reports for Outpatient Programs), etc. But there remains the question of how much is it useful for monitoring and performance measurement? Even with all the reports that are required to be filed with the County, it is difficult to make budgeted-to-actual expenditure comparisons, and to account for actual service provision. And of course the larger questions of whether the intended impacts are being made are left unaddressed.

That is, the review process currently in place only monitors the actual spending of dollars for approved purposes. The process has not to date been able to incorporate any programmatic review of how well each program has done what it said it would do with regard to meeting its stated objectives, reaching intended target groups, meeting measurable performance objectives, and having a positive impact on those the program serves.

One final note on the CR process: CR funding appears to have ended up being a kind of "entitlement," whereby a program, once selected for CR funding, has continued to be renewed annually for that funding no matter what—i.e., regardless of performance, regardless of new community needs that may have been identified; etc. In large part, such continuation funding has occurred both for political reasons, but also because there has been no process in place to do anything else.

Changes in Contract Monitoring Process

Since 1999, the Commissioner has introduced a number of improved contracting and monitoring requirements, including simplifying the reporting process. County contract monitoring went from 42 individual program contracts to 11 overall agency contracts in 2001 (including programs other than just CR-funded services). Furthermore, new additional requirements were spelled out for agencies to meet in order to have a contract with the County.

Nonetheless, these changes, while headed in the right direction, still do not focus adequately on the need for strengthened outcome measures of program impact; nor do they address the central question of the need for an ongoing process for assessing needs, determining priorities, and establishing an evaluation and

monitoring process that holds programs accountable for performance against stated performance objectives and outcomes consistent with those needs and priorities. County officials have begun to discuss ways of putting such a process in place, and the next chapter outlines specific recommendations for addressing this issue.

Target Population and Numbers Served

Getting a clear handle on specifically what target populations are served by each program, and the extent to which the target populations actually served conform to initial Community Reinvestment stated goals—and the program's initial statements in their applications—is one of the important focuses of this study. As in several other cases, however, the ability to be as definitive as we would like is compromised by the quality, consistency and completeness of the data as required in the past by the County and State, and therefore maintained by each program.

As noted earlier in the report, the primary focus of the CR legislation was on providing a range of mental health services for people defined as having serious mental illness (SMI), including children and adolescents diagnosed with serious emotional disturbances (SED). It seems clear from earlier discussions in the report that the CR goal of helping to create a more comprehensive, diverse service system has, to a great extent, happened in Broome County. What is less clear is how well those services have reached the highest priority SMI and SED populations. Few programs have in place the data to answer such a question with any degree of confidence.

It is unclear how well CR-funded services have reached the highest need SMI and SED populations.

Clinical and Case Management Services

However, based on the data that are available, and on our discussions with program staff, it seems reasonable to conclude that the more traditional clinical and case management types of programs, and those focused on MICA populations, have generally been serving the populations they initially agreed to serve, who are for the most part the SMI and SED populations. In few cases do the data enable us to say with complete assurance that specific proportions of those served meet the criteria, but in those programs which fall into the "actually served the target population" category, the information available to us suggests that the programs can be generally viewed to be serving consistently the types of people whom they said they would serve.

School-Based, Outreach and Advocacy Services

Where it is less possible to say with reasonable confidence that SMI and SED target populations are being reached consistently are in the school-based, outreach and recipient/advocacy types of programs. In such programs, there is often little or no formal diagnosis done, and/or the people being referred for services are not necessarily those with the most serious mental illnesses. In many cases, the issue may be one of behavioral problems that cause concerns in a school setting, or difficulties accessing services in the community (as with seniors), and the services provided may be quite consistent with such needs and "presenting problems." But the "problems" may not always rise to the level of meeting the definitions of SED or SMI. And, even if they do, the data maintained by these programs—and the data required for reporting by the County and State—often have not recorded such information in a manner which enables such data to be reported consistently.

This should not be considered a negative reflection on the programs, since they have not historically been asked to provide such information. And, furthermore, the programs were approved by County and State officials for funding to provide more outreach and referral and advocacy types of services. The program selection process said, in effect, "these are types of services we want to have in place within the county," and, as some of the stakeholders said, "it's fine that not all of the County's funded programs have specifically targeted the highest risk people, because there are other legitimate needs of people at lower levels of risk that should be addressed within an overall mental health system." If that conclusion changes, and there becomes a desire to focus more exclusively in the future on SMI and SED individuals, that should be a conscious decision that results from a comprehensive needs assessment and priority setting process, such as recommended in the next chapter.

In the future, programs must consistently track outcomes appropriate to the services being provided.

And, whatever that decision is, it will be important for all programs, whether dealing with SMI, SED or other types of individuals with other needs, to more consistently track what happens to whomever they are working with in terms of outcomes appropriate to the services being provided, as also described in more detail in the recommendations which follow.

Numbers Served

Again, subject to data considerations as addressed above, it is generally possible to conclude that *most of the programs for which we have appropriate data appear to be serving numbers of people consistent with the numbers they expected to serve, as indicated in their initial proposals.* Ideally, for the future, it should be expected that programs would periodically update their expectations of numbers to be served, in light of changing needs or other circumstances, and those changes should be reviewed and approved through the type of process outlined in the next chapter. However, in the meantime, since such expectations have not been required up to this point, it is most fair and realistic to ask how programs are doing in serving the numbers they promised to serve at the time their initial proposal was formally reviewed.

In addressing numbers served, the issues regarding data affect the different types of programs in similar ways to those discussed under the target population discussion. That is, for the most part, expectations concerning numbers to be served, and data demonstrating numbers actually served, are more likely to be spelled out consistently by the case management/MICA types of programs, and are less likely to be available in ways that make appropriate comparisons possible for school-based, advocacy and outreach types of programs. Thus it is hard to state with assurance how many people are served, and how those numbers compare with initial expectations, for most of the programs in the latter categories, except in the case of the HOME program, where the numbers are maintained consistently and can be easily compared over time. For most of the other programs in these categories, the data are too inconsistent, and are not always reported on an annual basis, to enable such comparisons to be made. Issues related to the collection and monitoring of such information are discussed in more detail in the individual program summaries shared with the individual programs, and in the systemwide recommendations in the next chapter.

For those programs which had been in operation long enough to have relevant data and where the appropriate data existed, only two of the programs had fallen short of meeting their expectations, and in both cases the declines had to do at least in part with cases becoming more complex over time and taking more staff time to work through the problems, and/or cases in

which there was less turnover and longer stays in the program, thus necessitating fewer new cases being opened. In one if not both of those programs, actions are in the process of being taken to enable the program to increase their numbers of cases, without compromising the quality of the services they provide. Related issues are discussed in more detail in the separate management summaries CGR has prepared for each of the individual programs, along with targeted recommendations for program-specific changes.

Program Impact

The more important question than just the number of persons served in the programs has to do with more of the "so what" question. That is, so what happens as a result of people being served by the program? Are their lives stabilized or improved in some measurable way? Are they less likely to be institutionalized as a result of involvement with the program? The answer to such questions for the Broome programs overall is mixed and mostly uncertain, though it seems clear that on balance the CR-funded programs, individually and collectively, have had a substantial impact on the mental health system in Broome County. The extent and nature of that impact is subject to individual interpretation. Our analyses focus on a number of different dimensions of the impact or outcome question, but all are designed to answer in one way or another the question of what difference has Community Reinvestment made in Broome County? Answers to that question are addressed in various ways below.

Capacity Building

CR funds have had a major impact on expanding the capacity of the mental health system in Broome County.

Perhaps the most unequivocal conclusion related to the impact of CR is its role in *expanding the capacity* of the mental health service system in the county. As discussed above, *there is no question that CR provided the flexibility and the opportunity to fund a variety of programs, both new ones and expansion of existing programs—programs that otherwise would not have been funded.* For example:

- As noted above, CR has helped to significantly expand the number of case management and service coordination programs in the county.
- New programs have been developed to address the needs of children and families in more holistic ways, even though significant gaps in services to children and youth remain.

- CR has helped expand a range of "non-traditional" non-clinical programs. These include a mixture of school-based programs that help expand preventive services into the school setting, where it may be possible to reach people with emotional and behavioral problems who would not otherwise have been reached. Other programs operated by agencies such as the Mental Health Association have provided advocacy and support services for people with various issues concerning living and coping skills that would not otherwise be in place. Overall, a new array of services has been made available, and an expanded infrastructure of services has been developed.

- An array of advocacy services has been established on behalf of mental health recipients, and opportunities are now provided for consumer voices to have a more direct forum and "place at the table" around mental health issues. Jobs within the mental health system are also provided for individuals who are in recovery, although issues remain concerning how to make best use of those jobs, and how traditional service providers fully integrate and accept the value of the work performed by people in those positions. As one observer put it, "Community Reinvestment made possible the consumer movement." In that respect, CR has indeed had a significant impact.

- In-home services have been expanded to help make mental health services more accessible to isolated adults in the community, and particularly to isolated elderly people.

Meeting Program Objectives

One key question in assessing what impact CR funding has had concerns the extent to which providers/programs actually do what they said they would do in their proposals; that is, to what extent did they accomplish the goals and objectives they set for themselves?

Proposals for CR funding varied considerably in how clear they were in stating their objectives. Several of the proposals approved for funding were vague in what their objectives were (if they were included at all). As discussed above, some of the non-traditional programs, as important as their creation and expansion may have been to the system, have been among the programs least likely to

be clear in expressing measurable objectives against which they can be held accountable. As a result, it is difficult in some cases to determine the impact that was expected at the time some of the proposals were initially developed. However, in most cases, the goals were reasonably clear in writing, and/or were clear in discussions with program staff.

Clarity of program objectives has varied considerably from proposal to proposal and from year to year.

Even where initial goals and objectives were clearly stated, for the most part agencies/programs have not been required to report (either quarterly or annually) on how they were doing with regard to achieving their objectives. Thus there is not a clear data-driven record in most cases documenting how well objectives were met. However, despite these very real concerns, review of the data that do exist and discussions with program staff and various stakeholders suggest that many of the objectives programs began with have indeed been met, or are in the process of being accomplished.

Most of the more traditional types of programs appear to have done what they said they would do. The larger question is whether those goals were as clearly stated as they should have been, and whether they best reflected needs in the community at the time, but insofar as they met the primary test of "passing muster" in the selection process in place at the time, those goals became one of the key standards against which those programs should be held accountable. Even though for the most part their continued annual funding has not been dependent on a careful review of whether their goals have been met, our assessment suggests that *in most cases, the programs have been faithful to what they promised to do.*

In most cases the programs continue to do what they said they would initially do, without significant changes in the goals over time. In one primary exception, a program changed its approach recently to shift focus from a primarily adult to primarily children's focus. This is probably justified under the circumstances, and given the expressed needs for more services for children and youth, the shift seems understandable. However, it illustrates the need for a process against which programs should have to defend any major shifts in focus in order to continue to justify CR funding—so that any changes can be reviewed and deemed by

others outside the program to be consistent with community needs. In order to continue to receive these funds, it is reasonable to require programs to justify major changes in programs, rather than making unilateral adjustments that may or may not be consistent with changing needs facing the community.

Impact on Institutional and Hospital Placements

In particular, since CR funding was tied to a reduction in the inpatient census in the state psychiatric centers, it is reasonable to ask what effect the programs have had in reducing or preventing hospitalization and/or institutionalization, and what effect they have had in reducing re-placements and/or in reducing lengths of stay while in an institutional setting. To what extent did CR funding result in (or at least be associated with) a reduction in hospitalizations, including Binghamton Psychiatric Center use? Were programs/services selected for CR funding with that in mind?

Nominally, an important goal for the use of Community Reinvestment funding was to target the seriously mentally ill—particularly those most at risk of institutionalization. As shown earlier, many of the programs have targeted this population. And many cited the goal of reducing the amount of care or time spent in an institutional setting, although few specifically stated a goal of helping to reduce the census at BPC. Indeed, *we could find no systematic evidence that programs were selected or were primarily intended to address a reduction in census in the state psychiatric centers.* Most programs (with the possible exception of programs like the FLEX team) were only incidentally connected to a reduction in census at BPC.

Because of the fact that most of the reduction in BPC's census had occurred before the bulk of CR-funded programs were in place, it seems to us to be unlikely that any major further impact on the reduction of the census would have occurred as a direct result of CR funding, but it is not possible to make any definitive statements to that effect. What we can say is that between 1990 and the end of fiscal year 1994—prior to the implementation of CR programs—the BPC census had been reduced by 236, a 45% reduction from 522 to 286. Between the end of 1994 and 2000, an additional smaller decline had occurred, a 40% reduction in the census of 114, from 286 to 172. It is not impossible that CR had

some role in that further reduction, but it seems unlikely that any effect would have been significant.

Moreover, during the same years, the comparable overall State census declines had been by 42% and 51%, respectively, suggesting that *if CR did have any effect in the census reduction, it is likely to have been greater statewide than it was in Broome.* It should also be noted that any declines in the BPC census that could be attributable to the effects of CR could have been offset, in whole or in part, by concomitant increases in the use of local acute care hospitalization and related services by non-psychiatric care providers. Currently-available data did not enable us to make such comparisons at a systemwide level. The ability to monitor not only psychiatric center but also hospital diversion should be a key component of any ongoing evaluation process in the future (see recommendations in the next chapter).

Most of the data that programs use to monitor impact of their programs on reduction of hospital and other institutional placements are not currently as rigorously collected or compared with other groups, pre-and post-time periods, or other reasonable bases for comparisons as one would hope. Thus the evidence that is collected does not represent definitive answers as to the question of whether CR has helped reduce the use of institutional care and placement. However, *the data that are available do consistently strongly suggest that many of the programs have had some impact on reducing institutional care and placements—and some go further in documenting substantial cost savings* of as much as several hundred thousand dollars in the case of the County's forensic program, and more than $2.5 million annually as a result of the CCSI program efforts.

CR programs appear to have helped reduce institutional placements, though better data are needed in the future.

At least a dozen programs consider such reductions to be part of the means by which they should be judged, and the data presented by at least eight of those programs support the notion that CR services contribute to reduced use of hospital and other types of inpatient care or placement. (Appropriate data were not available for the other programs). For definitive statements to be made in support of such a conclusion, however, tracking of cases would need to be done on a more rigorous basis, a task that should be possible to undertake if a planning and evaluation unit were to be

activated by the County in the future, as recommended in the next chapter.

Quality of Life/ Consumer Input

The majority of the programs funded through CR currently do not routinely seek systematic input from program recipients about their perceptions of program operations and how well the program has helped them address their mental illness or behavioral problem. In most of the programs, few recipients get consistently asked about what difference they believe the programs have made in improving their situations or in helping stabilize or improve their quality of life. As noted at the end of this chapter, consumers and service recipients have a wealth of ideas about programs and how they work well, and how they can be improved, but in most cases they are not asked routinely to share those comments in ways that could be used to assess program impact or to help management improve program operations. Even more rarely are *caregivers* asked how the program may have impacted on the quality of their lives.

The ability to obtain not just traditional customer satisfaction survey information from program participants, but also perceptions of how the program has affected the person's stability, ability to cope with various problems, and quality of life is a key component of assessing the impact of the program. Incorporation of recipient and caregiver input on a routine basis in the future is an important aspect of any program evaluation component, as discussed in more detail in the recommendations in the next chapter.

Involvement of Peers/Recipients in Programs

Beyond just assessing more effectively and more regularly the input of program recipients as part of comprehensive assessments of the impact of program services, it is also important to assess the extent to which recipients play active roles in operating and/or governing the programs in which they are involved. One of the goals of Community Reinvestment as it has evolved has been to expand recipient-run programs and the extent to which recipients play substantive policymaking and paid staff roles in mental health programs.

The role of recipients in the mental health system has certainly been enhanced in Broome County as a result of an active Recipient Affairs Office, which currently receives more than $225,000 in annual CR funds to advocate for changes in the mental health system, to hire people

recovering from mental illness as part-time staff and resources to various mental health programs, and to hire parent partners to assist in programs such as CCSI. The RAO is acknowledged by most of those knowledgeable about mental health issues in the county to have become an effective voice for change within the mental health system.

Beyond the efforts of RAO and CCSI, *relatively few of the CR-funded programs have made formal efforts to hire recipients on staff.* Based on our interviews with staff of the various programs, only four other programs—Single Entry, the Trauma Self-Help Program, Adult Flex Team, and Supportive Case Management—proposed to hire recipients in their proposals and have actually followed through on those commitments. Other agencies have hired peers in some of their programs over the years, but the programs have not been peer run.

Peer run/peer administered programs are a particular example of what could be funded and happen through CR. It seems clear that without CR funding, such programs would probably not exist. At the same time, it is also clear—in retrospect—that goals and expectations for peer run/administered programs were not well defined, and to a great extent are still evolving. As noted earlier, some believe that opportunities for improved operations of recipient-run programs have been lost because there was no effort locally or at the State level to advise and provide assistance to help RAO-type programs build a successful management and board infrastructure to enable them to succeed, rather than "sitting back in effect and letting them struggle before intervening."

Peer run/administered programs are a work in progress. Their goals are often vague, and it is difficult to determine, except anecdotally, what difference they are making and are trying to make. There is indeed considerable anecdotal evidence that suggests the value of the programs in providing employment opportunities for those recovering from mental illness and in providing supports for mental health professionals in reaching some of those receiving treatment within the system. But *those concerned with assessing the impact of CR or other sources of funds on the system need to give careful attention in the future to the development of more*

effective measures of the difference recipient-run programs can make in the system and in the lives of those such programs affect.

Fiscal Issues/ Administrative Costs

Table 5 on the next page combines a series of data about most of the CR-funded programs. Some of the information such as numbers served in 2000 was derived from data supplied by the programs to CGR, but most of the information was abstracted from the CFR forms for 2000. The data are presented mainly to illustrate the difficulties in using such information without appropriate caution, as they can easily lead to comparisons of "apples and oranges," with misleading conclusions resulting if the casual reviewer is not careful. *Units of service and costs per unit of service can be especially troubling, as units of service are frequently defined very differently, certainly across different types of services, and sometimes even within similar service types—thus making genuine comparisons practically impossible.* Also, numbers of people served per month can be inflated by numbers in training sessions, for example, in one program, and yet compared directly to numbers receiving intensive case management in another program.

To illustrate the difficulty in using such numbers without putting them in context, the HOME Geriatric Outreach program had by far the highest gross cost *per unit of service* in 2000 of all the listed programs, yet if its costs are compared to the relatively high number of people it served last year, its average costs *per person* served are much *lower* than in several of the other programs. Our examination of CFR data suggests that there are many anomalies within the data, as well as many questionable data elements that do not appear to be consistent with other information known about the program (e.g., some of the data on numbers of persons served per month). *At the very least, data should be compared only after equating for similar types of services and with comparable definitions of units of service.* (For more discussion of this issue, see the recommendations chapter which follows.)

Program	# served by program in 2000	Comments on # served	Total Adj. Expenses (2000 CFR)	Net Deficit Funding (2000 CFR)	Total Persons Served/Month (2000 CFR)	Total Units of Service (2000CFR)	Gross Cost/Unit of Service (2000 CFR)	TOTAL FTEs (1999 CFR)	Agency admin. as % tot. adj. exp.(2000)
MICA Network	46		$209,299	$205,276	0	7,004	29.88	4.11	0
Forensic Case Mgmt	509	new admits	$20,574	$20,574	9	1,298	15.85	0.00	4.25
Forensic Outreach			$43,817	$22,804	68	1,050	41.73	0.77	4.24
Crisis Sitters*	65	60 youth/5 adults	$20,249	$20,249	25	1,433	14.30	0.69	10
Flex Team	63		$416,863	$415,780	19	9,555	43.63	7.39	9.4
CCSI	238	children (107 fam)	$106,816	$45,449	0	3,481	30.69	2.41	9.5
Single Entry	177	placed (380 screened)	$91,014	$91,014	0	exempt from reporting	NA	2.98	9.43
Lourdes Case Mgmt	0	not operational	$39,950	$39,950	10	280	142.68	-	0
Aging Out	14		$52,631	$11,565	0	592	88.90	1.56	8.7
Supportive Case Mgmt	75		$173,110	$55,267	na	1,633	106.01	2.29	9.5
Congregate Care	0	not operational	$4,517	$0	0	0	0.00	-	0
Bridger		data not avail.	$28,000	$28,000	25	1,434	19.53	0.13	10.89
Peer Advocacy		data not avail.	$76,192	$76,192	92	3,478	21.91	0.96	10.59
Parent Partner/CCSI		data not avail.	$25,699	$35,699	83	2,014	17.73	0.04	12.71
Home Based Crisis Int.	40	youth (26 fam.)	$42,200	$42,200	26	1,894	22.80	0.00	9.5
Family Support Center	48		$48,744	$48,744	0	1,456	33.48	0.90	9.91
HOME Geriatric Outreach	251		$145,861	$138,923	0	866	168.43	1.83	10.91
BEAR	120		$37,628	$37,268	120	1,547	24.32	0.77	16.13
Rural BEAR	44		$65,467	$50,956	44	2,012	32.54	1.01	16.68
Multicultural Initiative	75		$53,217	$52,868	75	2,925	18.19	1.25	18.29
SHIP	80	undup. estimate	$41,652	$41,352	160	1,716	24.27	0.94	15.84
TOTAL			$1,743,500	$1,480,130	756	51,305		30	

*1999 CFR data (2000 unavailable or data missing)

No CFR for BPC programs (incl. Prgm with FRS)

No data for F&C In-home program begun in 2001

LGU Admin. is not included

Moreover, for any such comparisons to be particularly useful for evaluation and resource allocation purposes, such data ultimately need to be interpreted in the context of outcome data showing the impact of different programs. For example, a program with high costs per unit of service or per person served may well be worth funding if it can demonstrate that it reduces costly hospital days in treatment by a substantial amount, thereby reducing overall system costs significantly. Such a program may ultimately prove more cost beneficial than a program with somewhat lower costs per case or per unit of service, but which has little or no impact on reducing systems costs or on improving lives of its participants. The point is that for the types of data shown in the table, their value is somewhat limited without also knowing what happens as a result of people being in certain programs.

Administrative Costs

In enacting CR funding, the Legislature was concerned about funding excessive administrative costs. Note that there is a statutory provision in the CR legislation whereby the Legislature authorized the State Commissioner of Mental Health to promulgate regulations "setting limits on the total or component forms of administrative expenses projected or actual, that may be approved in connection with providers of community mental health reinvestment services,"... "to ensure that funds made available under this section are insofar as possible used for the provision of community mental health reinvestment services...." (MHL 41.55 (e)(2).

Table 6 (on the next page) shows the range of reported agency administrative costs by program over the past several years, as a proportion of total adjusted expenses for each program. There are obviously some anomalies, such as one year in which RAO administrative costs were abnormally high, but these appear to have returned to a more normal range in 2000. Over the past several years, the agency administrative cost proportion appears to have ranged between roughly 8% and 12% in most programs, with some considerably lower and others substantially higher. It is probably reasonable to raise questions about any program whose administrative costs are much higher than that range for more than a year or two. However, *more careful attention is needed to developing common definitions of what is included under administrative costs,*

before making definitive judgments about what is or is not an appropriate proportion for any program.

Agency	Community Reinvestment Program	Initial CR Funding	Agency Admin. as % of Total Adjusted Expenses					
			1995	1996	1997	1998	1999	2000
BPC	Trauma Self Help	1998				na	na	na
BCMH	MICA-Homeless	1995	na	na	Na	3.3%	5.3%	0.0%
BCMH	Forensic Program	1999					5.5%	4.2%
CC	Aging Out ICM	1995	7.6%	12.5%	8.0%	8.0%	10.0%	8.7%
CC	Adult Flex Team	1995	9.0%	8.0%	8.1%	8.1%	10.0%	9.4%
CC	Crisis Sitters	1997			7.7%	8.0%	10.0%	11.7%
CC	Single Entry	1997					10.0%	9.4%
CC	CCSI	1998				8.0%	10.0%	9.5%
CC	Home Based Crisis Intervention	1999					0.0%	9.5%
CC	Supportive Case Management	1999					10.4%	9.5%
CC	MICA Intensive Residential Treatment	2000						0.0%
F&C	Family Support Center	1998				7.4%	4.9%	9.9%
F&C	In-home Mental Health Mgmt	2001						
FRS/BPC	MICA Network	1999					na	na
Lourdes	Case Management- Child/SED	2000						0.0%
MHA	Multicultural Initiative	1995	na	na	12.3%	19.6%	12.4%	18.3%
MHA	BEAR	1996		na		14.5%	12.4%	16.1%
MHA	Rural BEAR	1998				14.5%	13.4%	16.7%
MHA	SHIP (Self Help Independence Project)	1999					12.2%	15.8%
RAO	Peer Advocacy	1997					32.2%	10.6%
RAO	Bridger	1999					58.0%	10.9%
RAO	Parent Partners/CCSI	1999					58.0%	12.7%
UHS	HOME Geriatric Outreach	1995	na	na	Na	10.9%	10.9%	10.9%

Source: Consolidated Fiscal Reports

Beyond looking at such data, CGR has also examined opportunities for administrative efficiencies and collaborative possibilities to strengthen agencies' core administrative functions and where possible to reduce core administrative costs and help redirect some of those costs to direct service. For example, there may be opportunities for efficiencies between programs involved in providing outreach and related mental health services to seniors, and between programs involved in providing services within schools. Those issues are addressed in some detail as opportunities

within appropriate individual program summaries provided directly to the agencies.

Identified Service Gaps

In the early part of this chapter, stakeholder views were noted concerning their perceptions of service gaps. Additional observations concerning gaps and unmet service needs surfaced during our discussions with program staff, in focus group discussions with consumers, and in our analyses of available data. This brief summary of possible service gaps is summarized here, without comment. CGR is not in a position to independently verify the accuracy or level of priority that should be assigned to each of the possible gaps noted. However, we suggest that this list of perceived gaps, along with the list noted earlier from the stakeholder interviews, should be among the inputs considered as part of the needs assessment process recommended in the next chapter. The possible service gaps are presented below in no particular order:

- Outpatient services to SED children and adolescents.
- Aftercare services following placement and inpatient care, to help facilitate timely and successful return to the person's home, to help minimize the risk of return to the facility.
- Single entry system for young people in case management, similar to the adult single entry system.
- Expand the single entry system for adults beyond just case management.
- Respite care for parents of troubled children and adolescents (though this is now beginning to be addressed through the shift in focus of the Crisis Sitters program). Some added the notion that it's not just that more respite care is needed, but also that it's needed for longer with fewer time restrictions.
- Expand FLEX.
- Programs targeted to older youth 16-21.

- Mental health services for those in the juvenile justice system.
- More mental health outreach services located in the schools.
- A children's inpatient unit within the county, to avoid so many placements out of the area.
- Expanded geriatric outreach services, not only to individuals living at home, but within adult homes as well, potentially including expansion of the new medications management program, which may not be able to serve enough people to meet the need.
- Need better integration of mental health services with other systems of care and services, such as through the Integrated County Planning (ICP) process.
- Possibility that more Adult Protective Services cases should be covered under CR.
- May need more expansion of services in rural areas.
- More accommodations for women and children in half way houses and group facilities.
- Need for training in better communication between mental health staff and peer/recipient staff, to enable the latter to be better used within the system.
- Single point of entry to help reintegrate young people returning to community from hospitals and institutions scattered around the state. Perhaps need such a single point of entry in general for youth.

Focus Group Findings

CGR conducted five focus groups with a variety of consumers served by the mental health programs operating in Broome County. The primary objective of the focus groups was to explore consumers' perceptions and opinions of mental health services provided in the county, and in particular, to explore ways in which

ongoing consumer feedback could be obtained in the future for program improvement.

The groups were moderated by CGR staff using a semi-structured focus group protocol (included in the appendix). In developing the protocol CGR sought feedback from the Mental Health Commissioner, mental health providers, and consumers.

Catholic Charities, The Mental Health Association, and Broome Recipient Affairs Office provided recruitment assistance to CGR. Participation in the focus groups was open to any recipient of mental health services in Broome County, though recruitment targeted individuals currently served by Community Reinvestment funded programs. In particular, one group targeted parents of children served by mental health programs and one group targeted peer providers. Overall, more than 50 consumers participated in the five focus groups that lasted approximately an hour and a half each.

What follows is a summary of comments made by participants, in their words. We have simply summarized these comments and have not attempted to verify their accuracy.

Participant Needs at Entry into System

The focus groups opened with a discussion of participant needs at the time they began receiving mental health services and whether or not those needs had been met by the program or service provider. Participants reported a wide range of needs, including the following:

I was looking for help for a suicidal child.

Moral support, someone to talk to rather than hold it all inside. (parent of SED child)

I needed to be stabilized and to control symptoms. (MICA individual)

To feel needed and to feel useful again.

Help getting an apartment.

Drug and alcohol recovery.

I didn't understand my illness. I needed to understand more about my diagnosis and I needed a psychiatrist.

I needed the support of co-workers and employees. I wanted to grow and perform in the mental health industry. (Peer staff)

Working with peers I don't have to hide my illness. I feel free to talk with peers and that helps me help myself, so I can then try to help others. (Peer staff)

Depression. I needed someone to talk to.

I needed to get out more and socialize with other people. (SHIP participant)

My ten year old granddaughter was seeing a psychiatrist at Lourdes. When the children's unit there closed, they suggested I contact the BEAR Program.

The school referred me to BEAR when my daughter was having problems. I don't have health insurance. The social worker who comes out to my house once a week to see my daughter is pro bono.

[My] most pronounced need was that for self-expression and self-enhancement.

My son had been having various problems at home and in school. He was full of anger and starting to show signs of violence.

I needed [a representative payee program] and I needed positive experiences.

Unmet Needs

While many of the needs identified by participants had been/ were being met, the following represent some of the unmet needs that they also identified:

There is a need for inpatient hospitalization for kids, especially younger kids, but [there is a] lack of bed availability locally. (Parent)

If/when providers find a bed for a child it's four or five hours away.

CPEP is supposed to have three extended observation beds for children, but nobody at CPEP knows about them.

ICM services [for my child] have been helpful, though they were not available immediately following [my child's] release from the hospital.

There are no [residential program] accommodations for women with children. I couldn't get the care I needed and keep my kids.

You can't live in a group home when you have kids. I went from having a lot of support to not having any.

Mothers tend not to follow-through in getting help for their own mental health issues because there are no services or residences that will accommodate mothers and their children.

This is an all or nothing system. To be seen by a private psychiatrist you have to leave the [public] system.

Clients needing emergency crisis help—[their] needs are not met by CPEP. Clients are turned away and told [CPEP] has no beds.

I couldn't talk to my psychiatrist.

It took too long to get the service in place; it took about half the school year. (Parent)

My diagnosis needed to be updated. I was being given medications that didn't help.

We need more for girls. There are no RTF's for girls in the area; the closest is Utica.

Recommended Changes

Based upon their experiences described in Section I, participants were then asked what changes they would make at the *program or agency level*, and what changes they would make at the *system level*.

More respite services with structured activities for children; eliminate time limits on respite services.

Need for preventive care for high-risk children.

Better triage/ability to prioritize when placing a person on a waiting list; link person with other support services while on waiting list.

Need for more ICM slots for children as well as child care for older (teenage) children.

Take away some of the time limits on programs and services. Time limits don't work with mental health.

Need more children's programming for when school is not in session.

Sometimes programs are understaffed.

We need more transportation and easier transportation. There may be a greater need for van service.

Doctors just see you for a couple of minutes and try to get you out the door. I would tell doctors to spend more time with patients.

I would like to see more day programs for people in assisted living.

Bring in more well-educated therapists and therapists with more modern thinking. Many of the psychiatrists practice therapy that is paternalistic and condescending.

I would like to see—at the administration and staffing-level—some training in communicating with peer staff. Staff feel like they have control over peers; traditional staff need sensitivity training. Most people try, but many don't have a good grasp of what it means to be a peer.

DSS and Social Security need training on how to deal with peers and persons with mental illness. They say "I'll get back to you," and they never do.

Program and agency protocol needs to be evaluated on a micro-management level. I understand that the system has more cases than it can handle, and I believe the answer to expanding services is through experience and empowerment of positions for peers.

Re-establish a county-run day treatment program.

Hire more therapists, as their caseloads are ridiculously large. Hire more peers to "pick up the slack."

How to Obtain Feedback

Participants were then asked: 1) whether or not in the past, as consumers, they had been asked to provide feedback about the mental health services they'd used; 2) if so, whether this experience was satisfactory; and 3) if *they* were service providers asking for recipient feedback, what would they ask?

Consumers who had been asked to provide feedback were most often asked to complete a written "satisfaction survey." A complaint heard from participants across the various groups was

not ever knowing the results of such surveys and not knowing how, or if, the information was ever even used by the provider.

What Feedback to Request

The following are participant responses to the question "If you were seeking feedback from recipients of mental health services, what questions would you ask?"

What were your needs and were they met?

Did we feel we had other needs that the program could help with? Sometimes you start out with one thing identified as the problem, and then others come up later on. The problem you're working on right now may not be the root problem. To better understand what's going on, a provider may need to have more information on the child and the family [need for more communication with providers, better sharing of information to provide broader context for provider].

You should ask whether or not a parent is kept informed about what's going on with the child in counseling. I understand there are confidentiality issues and the provider may not be able to tell me what they discussed, but in the past I didn't even know if my child was getting better or worse.

What can we do?

Were your needs met?

Ask a parent "Were you were informed of your child's progress?"

Are you comfortable in the program?

Do you feel the program is serving you well?

What are some changes you'd like to see in the program, if any?

"How has this program aided your recovery from a mental illness?" A question like this would get me thinking about the program and what it has done for me.

What/How do you expect this program to assist your recovery?

What did you like about this program?

What did you dislike about this program?

What suggestions do you have for future SHIP meetings/mini-courses/conferences?

Do the programs fill a need that is not being filled by other agencies and programs?

Do the programs work in rebuilding lives?

I'd ask "how you liked the program?" "Did you have a good time?"

Did it help you? Did it have an effect on your recovery?

What would you like to see added to mini workshops?

How well does the staff perform its duties?

I'd ask about the physical upkeep of the building. A clean and healthy environment is very important.

How well [are] the services run?

I'd ask about the interactions between staff and clients, and interactions between clients and clients. The latter is important if a program is trying to help people be able to live in the community.

The question is not what you ask, but what you do with the results.

I would ask if my help was useful and if they had suggestions for how I could empower them to build the work that I do to cater to their needs.

What do you need?

What can we do for you?

Do you think you are receiving the services you need?

When we say we will do something for you do we carry through?

"What can I do to help you?" Ask this at the beginning of a program, then in the middle of the program ask "How are we doing?"

"What services that we do not offer would you like to see us offer?" When a person starts a program providers make assumptions about what the person needs. These may not always be the correct assumptions.

"How can we help you?" You don't always realize that agencies have what you need.

Are your needs being met?

One of the most important things is to feel that my family has been treated with respect and dignity. Ask parents this.

Are there any other services we can offer?

How to Ask for Feedback

Participants were asked, "How should you be asked for feedback?" and responded with the following:

Meetings like this.

Just ask us [for feedback]! There are many boards and committees that we don't/can't attend because of the stigma attached to mental illness.

I prefer to be asked face-to-face because I'll tell you what I'm thinking.

Ask us! We are human beings!

Face to face. Over the phone can feel like a telephone survey. This is a personal matter and should be done in person and with some feeling.

Have a group of recipients gather and ask about needs, continue to do this every few weeks. Use mailings, radio announcements, and pass information on to friends and self-help programs.

Send out surveys; informal meetings like this one.

I welcome being asked to provide feedback. I prefer to have my concerns or feedback be confidential. But group brainstorming is also a helpful way to get feedback and [is] often enjoyable.

MICA ICM recently began generating a list that we use to call recipients and ask about their needs. We heard a lot about transportation needs, so we got a van.

Don't like phone interviews, they are impersonal and they always call at the wrong time.

I like getting a written questionnaire with a stamped return envelope, but I know you typically get low response rates with a mail survey.

Face-to-face interviews are the best.

Personal groups/individual interview.

One participant said she would prefer a group meeting, held face-to-face with a provider so provider has a better understanding of where the parent is coming from.

Another parent liked the idea of first filling out a survey, then bringing people together in a group setting to discuss the survey/explore some issues in greater depth.

Another parent's experience with phone surveys has been that you don't really get into the issues, sometimes you and/or the interviewer just want to get through the survey.

Another parent doesn't like to use a lot of negatives around her son, so it's hard to provide feedback over the phone if her son is present. But, she also said with a written survey, her responses will depend on whether she had a good day or a bad day.

Each child has individual needs, so if you've got more than one child receiving services, you may need to respond for each child.

How to Use Feedback

The final discussion topic was: "How should feedback be used?" Overall, participants seemed eager and willing to provide feedback, though several also offered some cautions about how feedback could potentially be used.

I hope the results are used to push concrete changes.

It should be taken seriously and implemented.

People who care about the people in the program should make decisions.

Feedback should go to the higher-ups at OMH in order to expand opportunities to create consumer-run initiatives.

I have concerns about negative feedback. If it's negative, instead of trying to fix the problem, they may decide to drop the funding.

"Is this information going to be used against me?" could be a personal concern.

My major concern is that so many mental health programs have been cut that I don't dare say anything bad about an [existing] program The first thing Art Johnson did was to cut Broome's Continuing Day Treatment.

Take it as all positive feedback and continue the program so we all feel alive and worth something.

I believe that this feedback should be used to encourage continuation of these programs or services.

It should be used to better the programs if possible. Negative feedback doesn't mean great changes have to be made, just adjustments.

How much feedback does a provider really want, and how honest do you want us to be in providing feedback? When we give feedback we want it to be heard for what it is and taken seriously.

[Feedback] should be used to better and empower consumers; it should not be used as a "show" of figures for quarterly and year-end reports just to make the grade with the government.

How are you going to use the feedback? Is the feedback [going to] have a negative impact on my life?

Nobody knows a child like a parent does, so providers should value information from parents more than they currently do.

Something needs to be done before it is too late; before kids kill themselves or end up in jail.

People are not always aware of services that are out there. Need better advertising of services, maybe a parent newsletter.

Question about providing feedback is "are they really going to hear us?"

Feedback should go to the Commissioner—he has the big picture, so if feedback goes to him, he's in a position to make changes.

Information can be used to better MH services. We [parents participating in the focus group] have a lot more information; we probably all have a lot more to say and could probably stay for hours.

Focus Group Summary

Consumers across the five focus groups consistently indicated a strong desire and willingness to be part of the feedback process.

Consumers are particularly interested in providing substantive feedback that will assist agencies and providers in determining how well their programs are meeting consumer needs. Of concern to many consumers was the lack of follow-up or information sharing back to the consumers in the past when feedback was collected. In the future, it will be *important for agencies or providers to "close the loop" with consumers by sharing the results or findings of surveys/ interviews/focus groups and also what the agency or provider intends to do as a result of that information.*

When providers ask for consumer feedback in the future, they should not be asking only the simple satisfaction-type questions which typically *do not* get at the impact a program has had on a person's life. Using an instrument that contains both qualitative and quantitative questions would likely provide a more robust understanding of program effects than quantitative questions alone. Consumers also realized the value of providing feedback in a group setting and having the opportunity for discussion with providers rather than a one-way flow of information from consumers to providers that surveys and structured interviews would entail. Most participants saw a mix of written surveys (note: most consumers objected to the idea of phone surveying) and some sort of focus group opportunity for discussion around the written surveys with the providers or with objective outsiders as the ideal means to obtain honest and useful consumer feedback.

Summary of Findings about CR

Community Reinvestment funds have had a major impact in expanding the mental health service system in Broome County. It has helped build the capacity of the service system, and has helped fund a number of services, and expand existing needed services, that would not otherwise have been possible. CR funds, in conjunction in some cases with other funding sources, have helped add about $2 million in services to the community on an annual basis. The largest proportion of the funded programs involved case management services, and the vast majority of the programs serve the adult (22-64) population, with relatively small proportions serving children and youth and the geriatric population.

In general, programs seem to have met the objectives they established when they were created, and several report data suggesting that they have been effective in reducing the extent of

unnecessary hospital and other institutional care and treatment, with resulting cost savings, but much more rigorous tracking and monitoring of cases is needed before such conclusions can be stated with confidence. Moreover, in general, more outcome/ impact types of indicators need to be developed and tracked across service providers in the future in order for definitive conclusions to be offered about the overall impact of CR on improving the quality of life and related outcomes of those served by the CR programs.

It could be argued that from the initial CR proposals, through annual reporting, or the relative lack thereof—*it appears in retrospect that for the State, Broome County and the providers, CR funding was viewed as being as much about putting in place a variety of needed programs, as about making an impact on the target populations, or evaluating whether intended impacts were actually being made.* Even at the State level, there appears to have been a deliberate effort to allow local flexibility intended for Community Reinvestment, and the emphasis seemed to be on expanding the service base for the mental health system. Indeed, the "Five Year Summary of New and Expanded Programs Funded Through Reinvestment, 1994-1995 through 1998-1999" report issued by the State Office of Mental Health in October, 1999, provides an inventory of programs funded, but says almost nothing about the impact of Community Reinvestment on State psychiatric center census.

Such a primary focus on service enhancement, if that indeed was the intent, is not without merit. However, *at this time it is appropriate to begin to put in place a system which can provide on an ongoing basis the ability to monitor the impact of programs in the future, to enable the community to be assured that funds are being allocated in the most cost effective manner.* Such a proposed system is outlined in the next chapter.

III. Discussion and Recommendations

Introduction

Our efforts focused on the Community Reinvestment funded programs in Broome County, from 1995 - 2000: what were they intended to do; and did they accomplish what they were intended to do. Nevertheless, *our recommendations have applicability beyond only CR-funded programs.* Our recommendations address the tools and approaches needed to exercise the broader accountability functions and responsibilities of the Mental Health Department, so they can be used by the Department for needs assessment and priority-setting, for monitoring and oversight for *all* of its mental health programs, and in fact for all of the programs under its purview. Indeed, our recommendations can be used more generally by other County government departments with regard to exercising the County's accountability responsibilities in planning for and contracting for services.

County Roles

We begin by discussing what are the roles and responsibilities of the Broome County Mental Health Department—the Local Government Unit (LGU)—and how it can exercise these roles. We are focusing on the mental health dimension of its responsibilities, recognizing that it also has responsibilities in developmental disabilities and alcohol and substance abuse.

The Department's roles/functions/responsibilities include:

- Planning, needs assessment and priority-setting for the community mental health system;
- Accountability and monitoring for the overall mental health system, and for the programs and services that it contracts for, through Consolidated Fiscal Reporting and other means;
- Systems advocate: within the County government, and vis a vis the State;

- Supporting the Community Services Board, the Mental Health Subcommittee and the other two subcommittees;
- Liaison to all contract agencies and responsibility for day to day administrative relations;
- Liaison to regional and central state offices (OMH, OMRDD, and OASAS) and responsibility for day to day administrative relations;
- Processing state claims;
- Partnership—with providers, with consumers, etc.;
- Direct provider of service.

The LGU stands as the focal point of public accountability, in the way it exercises its responsibilities.

The exercise of these roles and responsibilities becomes complicated when the County is itself a provider of services. Often, counties—particularly smaller, more rural ones—have little or no choice when it comes to who will be the provider of services. By necessity, the county takes on the role of direct provider of needed services in these counties because there are few or no private providers. But in counties like Broome, choices can be made between having the county directly provide a service, and contracting for these services with private providers. When it is the county that makes these choices, then it is imperative that the county have a stated rationale for the circumstances or criteria under which it will become or continue to be the direct provider of services. *In this case, when Broome County wears several such "hats," it is imperative that there be both the reality and the perception of objectivity on the part of the County in how it exercises its roles. In any event, the programs that the County runs should be subject to the same performance and monitoring oversight that non-County providers must adhere to.*

The Importance of Accountability

A constant theme throughout our specific recommendations is that of **accountability and performance**: at the County level—in the ways in which it exercises its roles and responsibilities for the overall community mental health system—and at the provider/program level.

System accountability begins with defining community goals for the mental health system in Broome County.

System accountability begins with defining community goals for the mental health system in Broome County: What are you trying to achieve for the mental health system and for those with mental health needs in Broome County? What do you want to accomplish? This overarching set of goals is intended to guide the County and the providers in the planning, needs assessment and priority-setting processes. Without such a statement of goals, it would be difficult to determine whether progress is being made, and whether there is any impact to the service delivery system.

What should the mental health system look like? The literature suggests that the following features should characterize the mental health system:

- Comprehensive;
- Coordinated;
- Ethnically and culturally responsive;
- Consumer oriented; peer/recipient involvement;
- Local and accessible;
- Acceptable;
- Flexible;
- Efficient;
- Effective;
- Focused on strengths;
- Oriented towards meeting special needs;
- Accountable;
- Evaluated.

(Huntley et al., 1990; Reynolds and Thornicroft, 1999)

The *goals* should be related to *population-based* measures of mental health for the community. Note that the *goals* for the mental health

system are not the same issue as, What mix of services should be provided? The service mix is a *means* to the goal, not the goal itself. These systemwide goals then serve as the basis and framework for what is expected from individual program objectives and outcomes.

Planning, Needs Assessment and Priority-Setting

System accountability starts with a planning/needs assessment and priority-setting process. Effective planning is a "management tool designed to help organizations cope with uncertainty" (Benveniste, 1989, p. 17). It is about defining goals, and assessing alternatives to accomplish those goals.

System accountability starts with a planning/needs assessment and priority-setting process.

"Needs assessment" is a "systematic set of procedures undertaken for the purpose of setting priorities and making decisions about program or organizational improvement and allocation of resources. The priorities are based on identified needs" (Witkin and Altschuld, 1995, p.4). "A need is generally considered to be a discrepancy or gap between 'what is,' or the present state of affairs in regard to the group or situation of interest, and 'what should be,' or a desired state of affairs" (Witkin and Altschuld, 1995, p.4).

There are a variety of stakeholders in the mental health system, including: the public as taxpayers, and as potential users of the mental health system; recipients of mental health services, and family members of recipients; the various providers of services; and other governmental agencies whose clients are also served by the mental health system.

The various stakeholders need to be able to perceive that the planning/needs assessment/priority-setting process is legitimate and objective, and that it has genuinely heard their concerns and issues. If the process does not do that, stakeholders are likely to feel less connection to and ownership of the subsequent priority-setting and provider/program selection and contracting process.

Recommendation

We recommend that the County Mental Health Department should take the lead in conducting periodic needs assessments, compiling and making available data on communitywide mental health population, supply, and utilization measures. It should solicit feedback from key stakeholders on what they identify as needs and gaps in services. It should summarize that feedback, present it to

various community groups, and have the Mental Health Subcommittee make recommendations to the Commissioner regarding overall priority areas for funding, both on a longer-term basis, and shorter-term (one year).

Successful planning/needs assessment/priority-setting involves both *content* (issues, areas of concern based on data and other forms of input) and *process* (how is that data and feedback used to determine priorities). We next discuss how the County should go about the content of planning and the process of planning/needs assessment.

Content of Needs Assessment

Time and again, we heard that "planning" was done in a *reactive* mode for the CR process. Planning reactively would appear to be an oxymoron. An objective community needs assessment enables the County (and the other stakeholders) to have a framework through which it can plan and establish its priorities, and allocate resources accordingly. Absent a reliable and current needs assessment, there is little objective basis for establishing priorities and allocating resources.

An objective community needs assessment enables the County (and the other stakeholders) to have a framework through which it can plan and establish its priorities, and allocate resources accordingly.

While there are a variety of ways to conduct a needs assessment, **we suggest the following approach for the future, for all mental health programs and services, and not just those programs affected by Community Reinvestment funding**:

1) The County should decide on the various areas that it wants feedback on from the stakeholders for planning and priority setting. We offer the following areas as the basis for planning/needs assessment and priority-setting by the County for mental health services:

- What populations, by age groups, are to be served by the mental health system: e.g., adults, children and adolescents, older adults; what is known about these populations and their use of and need/demand for services.
- Are there "special needs" populations (e.g., homeless persons; MICA; dual diagnosed, such as MH/DD; older adolescents; "hard to serve;" etc.); what is known about their use of and need/demand for services.

- what is the appropriate continuum and mix of services to meet the needs of each of these populations, such as:

  - inpatient;
  - outpatient;
  - residential;
  - supportive;
  - preventive.

- What are the "overlapping" needs of other systems: e.g., health, social services, criminal justice/probation, juvenile justice, education? How can services be integrated across systems to best address those needs?

- Are there waiting lists for needed services?

2) As part of the planning process, data are needed. Baseline data for various measures of mental health and functional status for the population should be made available to the stakeholders (to the extent that the data exist). A *starting* point for these community measures should be various *communitywide* measures of *supply* and *utilization*. These measures can provide important benchmarks. The idea is for the County to have a systems perspective on mental health issues within which to judge priority areas. Such supply and utilization measures might include:

The idea is for the County to have a systems perspective on mental health issues within which to judge priority areas.

- Adult psychiatric hospital beds per 1,000 population.

- Child/adolescent psychiatric hospital beds per 1,000 population.

- ICMs per 1,000 adult, and child/adolescent population.

- Age-adjusted inpatient psychiatric admission rates (for Article 28 hospitals and for the state psychiatric center);

- Age-adjusted psychiatric inpatient hospital days per 1,000 population.

- Age-adjusted per capita spending on mental health services, total, and by inpatient and outpatient costs.

Cross-county comparisons would be very helpful here, and we recommend that the State provide assistance in making this information available to the counties.

Additional data on inventories of existing programs and who they serve would also be helpful as part of the needs assessment process. Some of the data collected on individual programs for this project would be a good point of departure for that effort.

Recommendation

This "data collection" for the planning/needs assessment could in fact be contracted out, in whole or in part. The County could ask the local University or a consultant to put together, to collect, the "content" of this plan. **However, instead we recommend that the Mental Health Department itself take the lead in putting together the baseline community data on these measures.** But simply collecting the data, however indispensable this is, will not in itself determine what the priorities should be. That requires a *process* that is responsive to the various stakeholders.

Process for Needs Assessment

Data tell us where there are needs, and gaps in services. A process is needed to determine which needs and gaps should be identified as priority areas for action, and where resources should be allocated to address those priorities.

Priority setting is based on data, but in fact it is a "political" process: That is, what is a priority for one stakeholder may not be so for another. So, a legitimizing process for establishing priorities is needed.

This "legitimizing process" must involve all of the system stakeholders: the public; recipients of services, and their family members; providers; other governmental agencies. No planning, needs assessment and priority setting can be successful without the active involvement of the stakeholders.

Management Council and Mental Health Subcommittee

In the past, particularly during the initial years of CR, the Management Council served as the primary vehicle for needs assessment and priority-setting. (The Management Council should contain all mental health provider agencies in the county and is

currently made up of members representing the following providers and agencies: Binghamton Psychiatric Center; Binghamton University, Psychology Department; Broome County Department of Social Services; Broome County Mental Health Department; Broome Recipient Affairs Office; Catholic Charities; Children's Home of Wyoming Conference RTF, Inc; Children's Home of Wyoming Conference; Family and Children's Society; Lourdes Hospital; Mental Health Association; and the OMH Central New York Field Office. It is unclear whether Fairview Recovery Services or United Health Services are official members, but as service providers within the mental health system, and as agencies housing CR-funded programs, it seems to CGR that they should be if they are not already.)

For a number of reasons, the Management Council no longer plays the central role it once played. Some providers have complained that they no longer have the role they once had (primarily through the Management Council) in planning and priority-setting. They have argued for a more pre-eminent role again for the Management Council in this process. Clearly, the Management Council brings to the table a unique expertise that needs to be recognized and incorporated into the process. And indeed, *there would be great value in having the Management Council play a more formal role again in working together as a group. We believe that the Management Council needs to play a key role in the future in the needs assessment and priority-setting process for all mental health services.*

Management Council needs to play a key role in the needs assessment and priority setting process.

But that being said, *there are also other important stakeholders in this process, and the process needs to be perceived to be responsive to all of them.* We heard consumers argue that money should be set aside exclusively for peer programs, not in competition with other providers. Just as priority-setting should include, but not be driven solely by providers, similarly the priority-setting should include, but not be driven solely by consumer/recipient concerns. All stakeholders need to be part of the priority-setting process, and the process needs to recognize the concerns of the various stakeholders.

There are the additional and complicating issues of the local psychiatric center—how it is involved in the planning process by the County, and how its services, and service mix, are part (or

not) of the County planning and needs assessment process. This parallel system ("community-based" and psychiatric center-based) is longstanding, and there continue to be significant challenges in sorting out the relationship and coordination between them. One example of this ambiguity is the membership of the Mental Health Subcommittee. Representatives of Binghamton Psychiatric Center "attend" the Mental Health Subcommittee meetings, but are not "voting" members. While we did not examine the governance and planning structure of BPC, we assume that planning and service decisions for it are made essentially through the "State" system, and with little or no "local" input.

So there is a dilemma here. It is hard to justify a "community planning" process which does not include a major provider of services such as the psychiatric center—a provider of services which can have a major impact on the use of community based services, e.g., in terms of the volume and kinds of discharges it is responsible for. Yet, the decision to provide certain services can apparently be made by the State psychiatric centers without the involvement of the local mental health planning process. We do not have an answer to this dilemma; we can only point it out. Ideally, however, the Psychiatric Center should be an active participant in any needs assessment process undertaken by the County.

Recommendation

We suggest a process for the Mental Health Department to obtain systematic and comprehensive feedback from all of the key stakeholders, without having any particular stakeholder dominate. We recommend that the *process* for this system accountability for community mental health services, needs assessment, and priority-setting occur through the Mental Health Subcommittee of the Community Services Board.

We recognize that the Management Council served as this vehicle in the past and that there can be limitations to locating the accountability for needs assessment and priority-setting within the Mental Health Subcommittee. We recognize, for example, that the Mental Health Subcommittee often lacks the expertise that the Management Council brings to bear. Nevertheless, on balance, we

believe that the Mental Health Subcommittee provides the best vehicle for *public* accountability for *all* the stakeholders. Its membership, while somewhat vague as to who is an official voting member and who simply attends for informational purposes, is made up of providers and consumers. Although CGR is uncertain about the specific "official and unofficial" membership roles of each, the following appear to be members of, or at least invited as guests to, the Mental Health Subcommittee meetings:

...on balance we believe the Mental Health Subcommittee provides the best vehicle for public accountability for all the stakeholders.

- Broome County Department of Social Services
- Broome County Mental Health Department
- Broome County Probation
- Broome Recipient Affairs Office
- Consumers
- Consumer Advocate
- Lourdes Hospital and United Health Services
- Parent of SED Child
- Representatives of mental health providers

Recommendation

We recommend that the Mental Health Department formally clarify the criteria for Mental Health Subcommittee membership, voting and non-voting roles, rotating membership of providers, and how members resolve potential conflicts of interest. Membership is governed by State regulations, but within those guidelines, we recommend that membership include representation from not only mental health providers and consumers, but also from other service systems such as schools, social services, and the juvenile justice system.

There has been confusion among many of the stakeholders with whom we met during the study concerning the roles and responsibilities of people and organizations represented on the Mental Health Subcommittee, and concerning potential conflicts of interest, and what providers can play what roles in the meetings. This is a good opportunity to address these issues, in the context of the broadened role being recommended for the Subcommittee. Attention is already being given to the conflict of interest issue, so this is a good foundation upon which to develop a larger discussion of related issues.

Recommendation

In light of the broader responsibilities being recommended for the Mental Health Subcommittee, we recommend additional training and orientation concerning future roles and responsibilities of Subcommittee members. Our recommendations are consistent with the prescribed roles of the Mental Health Subcommittee, but given the more visible and more explicit roles we recommend for planning, needs assessment and priority-setting, we suggest that the development of a training/ orientation session and/or written materials would be appropriate and helpful, both for current and potential future members of the Subcommittee.

Recommendation

We recommend that the County Mental Health Department solicit and obtain systematic and comprehensive feedback from all of the stakeholders regarding priorities. (The County would have previously made available the data on community supply and utilization measures.) This feedback can be obtained in a variety of ways: meetings, public forums, written materials, etc.

Recommendation

We note that while needs assessment focuses on *population* needs, this process does allow providers to make the case for *agency* needs which can then be factored into the needs assessment and priority-setting processes. **We recommend that the Management Council meet formally to develop its collective view of County needs and priorities, and formally present that information to the County.**

This feedback would be sent to the Mental Health Department for summarizing. The summaries would then be given to the Mental Health Subcommittee for its review and for making recommendations about priorities.

Priority Setting Process

Recommendation

Although the Commissioner/LGU could legally establish the priorities unilaterally, **we recommend that the Mental Health Subcommittee serve as the forum for formally reviewing and recommending specific priorities to the Commissioner**. The Mental Health Subcommittee will at least review these materials, and it may also ask for opportunities to hear directly from various stakeholders as it makes recommendations on priorities. We

envision that the Subcommittee will produce a formal set of recommended priorities to the Commissioner.

Selecting and Contracting with Providers

Priorities are a function of *system* needs, including but not limited to provider needs. Priorities can change over time, and the system needs the opportunity to re-allocate resources to new or emerging priorities. This has not been the case with CR, where it seems that "once-funded, always-funded" has been the rule of thumb. We are proposing a change in this "entitlement" mentality, recognizing that it will affect providers and their programs.

Recommendation

We recommend that agencies/programs be funded for a three-year time horizon expectation (subject of course to annual contracting renewal, based on performance and availability of funds). At the end of the three-year period, the agency/program would be subject to a new RFP process, wherein it may be renewed for funding (because its services are still consistent with community priorities), or it may be determined to be no longer a priority area for funding. In the latter case, the agency would still have the opportunity to apply for funding for a different program offering services consistent with changing and newly-established priorities.

The priorities established by the Mental Health Commissioner—based on the recommendations of the Mental Health Subcommittee—should involve long-term and shorter-term (annual) priorities that are consistent with the long-term priorities. Proposals to address these priorities can then be submitted annually to the Mental Health Subcommittee for review and recommendation to the Commissioner. If approved, the funding should be for three years, consistent with the above recommendation.

Updating Needs Assessment, Establishing New Priorities

While the overall goals of the system should not change that much over time, it is quite likely that *annual* priorities can and will change, although not dramatically. The current mechanisms for funding services encourage an "entitlement" mentality whereby "once funded, always funded." While it is prudent for a system of services to have stability and continuity, nevertheless, it is important for the County, for the service system, to be able to direct, and re-direct resources to currently identified priorities. Thus limited annual updates of the priority-setting process may be

needed, to assure that funding decisions about new opportunities that may surface during a given year are placed in priority context.

If in fact service or target priorities do change over time (because of the needs assessment), it is important for the County to be able to re-direct resources from less important to more important areas.

Recommendation

We suggest that the County consider a timeframe of three years for its contracts with individual programs and agencies, with an annual renewal of the contract. This will give the County and the providers the opportunity to re-assess priorities, but not in a disruptive way.

Criteria for Selecting/Re-selecting Programs

Article 41.55 of the Mental Hygiene Law, which authorized Community Reinvestment funding, requires that

Prior to entering into contracts for the provision of services pursuant to....this section, the office of mental health and any local government unit receiving such funds shall consider the following:

(1) *the service needs of persons with serious mental illness, including children and adolescents with serious emotional disturbances, in the geographical area in which the community mental health reinvestment program operates;*

(2) *the capacity of the program to meet identified service needs and specified performance standards related to access, admission, referral, and service coordination and delivery;*

(3) *the extent to which such services authorized by the contract will be integrated with other available services in the area to more effectively maintain persons with serious mental illness in the community, including children and adolescents with serious emotional disturbances;*

(4) *the availability of resources for such services;*

(5) *the extent to which community mental health reinvestment services authorized by the contract are consistent and integrated with the plan prepared and approved pursuant to section 41.16 and other applicable provisions of this article;*

(6) the extent to which such contracts conform with the minimum contractual requirements as established by the commissioner of mental health; and

(7) the reliability and capability of the provider, including its expertise, prior experience, financial responsibility, record of adherence to law, record of providing quality of care and services, and ability to deliver appropriate services in a cost-effective and efficient manner to persons with serious mental illness, including children and adolescents with serious emotional disturbances, homeless mentally ill persons, persons who are mentally ill and in need of substance abuse services, and, where appropriate, hard-to-serve populations.

Recommendation

In light of the legislative criteria, **we recommend the following criteria for the County to use in selecting programs/providers for funding. These criteria can be point weighted or scored if the County prefers a more quantitative decision tool.**

- Consistency with the system goals and with the community needs assessment;
- Measurable program objectives;
- Target population (documented high need, high risk; unmet need, etc., again consistent with the needs assessment), and expected numbers to be served;
- Formal collaboration with other providers, where appropriate;
- Evidence of linkages with other organizations, supports, etc.;
- Budget (including, e..g., administrative costs and unit costs;
- Evidence of community support ("letters of support"—although usually it is pro forma to obtain letters of support);
- Demonstrated evidence of organizational capability to implement the program;

- Evaluation plan for the program, including statements of outcome measures to be used to assess program impact;
- Recipient involvement;
- Evidence of recipient input concerning the perceived impact of the program;
- Evidence of cultural competence and diversity for the program.

By insisting on measurable objectives and outcomes for all funded programs, we want to be clear that it should not result in a system of perverse incentives, whereby providers would be deterred from choosing to serve the "hard to serve" populations, because it is more difficult to achieve "results" with them. On the contrary, the selection process should be directed to whichever populations are determined by the needs assessment and priority-setting process, with the understanding that there need not be "earth-shaking" results with these populations—but measurable outcomes, nevertheless.

...the selection process should be directed to whichever populations are determined by the needs assessment and priority-setting process...

Nor do we propose to encourage a selection system that is biased in favor of "tried and true" programs rather than new and potentially innovative ones. We see no reason why there should be a bias for or against expanding existing programs. What is primarily at stake is what program, new or expanded, will produce the outcomes that are desired. We do suggest, however, that new and innovative programs bear a particular obligation to evaluate their results. That does not mean that new and innovative programs must always be "successful." It does mean that lessons must be learned from every new program. By the same token, it is important that existing programs be included in ongoing evaluation efforts as well, and that lessons also be learned and applied from their experiences.

Suggestions for Measurable Objectives

Here are some *suggestions* for measurable objectives and outcome measures for various priority target populations that would presumably be consistent with the communitywide goals and how they are instrumental to these goals and priorities. The list is not exhaustive by any means, but is intended to serve as a starting

point for determining measures that are instrumental to the larger system goals.

Potential measurable objectives and outcome measures for programs for adults:

- ❖ reduction in, diversion from psychiatric inpatient admissions;
- ❖ reduction in ER/crisis visits;
- ❖ reduction in time in treatments;
- ❖ reduction of Adult Protective referrals;
- ❖ measures of housing stability;
- ❖ reduced homelessness;
- ❖ increased periods of sobriety or abstinence in using drugs or alcohol.;
- ❖ reduced levels of incarceration;
- ❖ discharge to lower level of care;
- ❖ greater level of independence;
- ❖ employment placement;
- ❖ reduction of repeat episodes/admissions to system/ program.

Potential measurable objectives/outcomes for programs for children/adolescents (including but not limited to school based programs):

- ❖ reduced out of home placements/foster care, etc.;
- ❖ increased reunification with family;
- ❖ reduced LOS in placements;
- ❖ reduction in, diversion from psychiatric inpatient admissions;

- reduction in days in treatment;
- reduced repeat placements/recidivism;
- reductions in Family Court petitions;
- reductions in PINS or JD petitions;
- reductions in Probation;
- completion of GED;
- reduced crisis episodes with MH programs or ER settings;
- reduced crisis residence admissions;
- improvement in various school measures such as attendance, reduced suspensions or other behavioral referrals, improved grades/test performance, etc.;
- reduction in various risk-taking behaviors (e.g., smoking, drinking, substance abuse).

Potential measurable objectives/outcomes for programs for older adults:

- reduced rates of hospitalization or other institutionalization (e.g, nursing homes);
- reduced lengths of stay in such facilities;
- reduced use of emergency room care;
- reduced repeat placements/recidivism;
- improved medication compliance;
- provision of appropriate levels of care, compared with defined needs at entry to system;
- increased stabilization in community;
- increased levels of functional independence as measured by Activities of Daily Living (ADLs).

We reiterate one final issue noted above regarding the recommendations for selection of programs for funding by the Mental Health Subcommittee. Given the composition of the Subcommittee, there will inevitably be "conflicts of interest" when Subcommittee members vote on recommended programs. The Subcommittee should articulate its policy regarding conflicts of interest. That may mean, for example, that Subcommittee members whose proposals are under consideration abstain from the discussion, and/or on the vote on their proposals.

Contract Monitoring

Finally, the County Mental Health Department needs to exercise its accountability through a contract monitoring process.

Recommendation

We recommend that the Mental Health Department establish a process for the quarterly and annual monitoring of contracts.

Providers under contract with the County should report quarterly and annually program information in three areas: financial information; programmatic information; and recipient feedback.

Recommendation

Most financial and programmatic information now required to be reported by agencies under contract is in the form of "inputs" or "outputs"—e.g., number of people served, units of service, amounts expended, etc. Less frequent historically has been a requirement to report on outcomes, or the impact the program is having on those it serves. We have found it particularly difficult to decipher the comparative value of reporting "units of service" which is so commonplace. It is not at all clear how simply reporting units of service serves a useful purpose, when the term can refer to so many different definitions. **We recommend that if units of service are reported, the programs provide an accompanying explanation of what that volume of units of service tells about the program and what it is trying to accomplish. Beyond that, the proposed planning/needs assessment/evaluation unit (see below) should focus attention on working with programs to come up with common definitions of units of services for comparable types of programs.**

We note, by way of example, that the Monroe County Office of Mental Health, through Coordinated Care Services Inc., requires

each of its agencies under contract to submit annual information in the following areas:

- Service Description
- Target Population
- Expected Outcomes
- Performance/Quality Assurance information in a variety of areas, specific to each program.

Recommendation

We recommend that agencies report annually on these areas to the Mental Health Department.

Importance of Outcome Measures

Practically all agencies support the notion of outcomes as the basis for measuring effectiveness. But there is great variability among the agencies in their ability to both identify and measure outcomes. We recognize that some agencies, often smaller ones, are not equipped to engage in these activities at this time; and there is a cost to doing this. Larger agencies are more likely to have the capacity to conduct and implement evaluation activities. We raise this question, because would such a process end up favoring larger agencies over smaller ones in the selection?

On the other hand, it is clear that all funders, whether government or private, are moving in the direction of requiring outcome performance and measurement. As a result, we do not view our recommendation here as one that involves responding to *county-imposed* requirements, but rather one that involves meeting *agency-mission* requirements. All public and nonprofit organizations today must be prepared to address the differences they are making. There is the additional benefit that agencies will be better equipped to pursue additional funding if they have this capability.

Recommendation

To address this need, we recommend that the County provide technical assistance to agencies to help them undertake and improve on their statement of, and ability to track, outcome measures for their programs.

Regular Recipient Feedback

Recommendation

We also recommend that agencies obtain systematic feedback from recipients, and report on that annually to the Department.

A number of programs already obtain feedback from recipients. There is no reason not to build on these current feedback mechanisms. Overall, we believe it is advisable to have a variety of sources of feedback from recipients, not just one source.

Overall, we believe it is advisable to have a variety of sources of feedback from recipients, not just one source.

How often should recipients be asked for feedback? We suggest at least annually. Which recipients should be asked—a sample, or everyone? It would be appropriate to ask a random sample of recipients for their views on the services they receive. *It will be important not to limit feedback to a certain segment of the recipient population.*

Questions asked can be both quantitative and qualitative. **Quantitative** questions will involve a scale: for example, on a scale of 1 to 5, where "1" means "Very much disagree," and "5" means "Very much agree," how would you rate the following items:

- I was treated with dignity by program staff.
- My needs were met.
- This program has helped me in my recovery.
- The therapist involves me in the treatment plan.
- Overall, I am satisfied with the services I received.

Such questions need to be adapted to the particular program. The questions we propose here are more suitable for "clinical" and case management programs. Other kinds of questions would need to be asked for outreach and advocacy programs. Questions for them might include:

- I was satisfied with the service I received.
- My access to needed services was improved through using this program.
- I was treated professionally by the program staff.
- This program fills a need.

Qualitative surveys are also helpful, where open-ended questions are asked. This can be accomplished through the use of occasional focus groups or even simple written questionnaires. (We note that a number of recipients who participated in the focus groups found the focus group approach very useful for them to provide feedback.) Following are some examples of the types of questions that might be included in such a qualitative survey approach.

- Are there other ways that the program could be helping you? If so, how?
- Are there ways that this program could better serve you? If so, how?
- What are some of the changes you would like to see in this program, if any?
- How has the program aided in your recovery from mental illness?

We also emphasize that recipients very much want to know what happens to the feedback they give. So **it is important for programs and agencies—and the County—to have ways to let recipients know how their feedback is actually being used.**

Use of Information by Department

How will the financial, programmatic, and recipient feedback information reported to the Department be used?

This information is intended for program accountability:

- To report on progress in achieving stated objectives;
- To guide program/quality improvement;
- For a corrective plan of action;
- In the worst case, for ending the provider contract.

Recommendation

We recommend the County Mental Health Department require from each currently funded mental health program (Community Reinvestment as well as other mental health funded programs) an updated description of:

- Brief program description;
- Measurable program objectives and outcomes;
- Target population;
- Certain volume measures (as appropriate)—such as units of service, number of persons served;
- Any substantive changes in program objectives, target population, and/or performance measures. (Such changes should require approval by the County.)

Recommended Contract Monitoring Process

How could the County exercise its accountability responsibilities, including monitoring and oversight, with regard to providers under contract with the Department?

Basically, the Broome County Mental Health Department has two options for exercising its accountability responsibilities with regard to providers under contract with the Department:

1) an "in-house" staff unit option whereby the Mental Health Department hires two or more staff (employees) for these contract management and needs assessment/priority-setting/evaluation purposes; or

2) the Department could contract out the functions to a third party.

Since "form follows function," we summarize the various activities and functions that we have recommended that the Mental Health Department be engaged in for its overall accountability activities:

- Planning, needs assessment and priority-setting activities: gathering baseline data and disseminating the data;
- Annual updates to the needs assessment and priority-setting processes;
- Technical assistance for the providers;
- Contract management: devising and updating contracts with the providers:

- Collecting and analyzing quarterly and annual financial data from the providers;

- Programmatic oversight including program site visits, recipient feedback, and monitoring performance against objectives and outcome measures.

Generally speaking, the primary advantage for the "in-house" option is that it presumably allows greater control by the Commissioner over the resource. The primary disadvantage is that the "in house" option will be subject to County budgeting "vagaries." County positions are subject to the overall annual County budgeting processes, which means that at any given time, "non-essential" County positions may be a target for budget cuts. It may also be harder for "in house" staff to be perceived as being as objective and "neutral" as necessary when evaluating County-operated programs.

Whichever approach is taken, what is most important is *that the Mental Health Commissioner have direct control over the hiring of the appropriate people with the right expertise for this unit, even if the unit is provided by an outside agency on a contractual basis, and that he have ongoing oversight responsibility for these staff; that the staff be physically located in the Commissioner's office; and that the Commissioner have the necessary flexibility to carry out the functions listed above.*

We note again that the County's monitoring and oversight role can be affected by whether it is itself a direct provider of service.

Recommendation

We recommend that all mental health programs funded through the Department of Mental Health be subject to the same reporting and monitoring provisions.

Oversight of Contracts in Other Departments

Finally, can this kind of staff function in the Mental Health Department also provide the opportunity for shared oversight activities with other County departments that involve similar kinds of contract management, such as the Department of Social Services and the Youth Bureau? While we have argued for a set of functions (and expertise) beyond contract monitoring and oversight for the Mental Health Department, **there is no inherent reason why this "unit" could not also provide contract**

monitoring more broadly for other County departments, perhaps through a memorandum of understanding.

Provider/Program

Our recommendations for the overall system, and for providers and for individual programs, are included in the above section. We have also sent more detailed confidential memos to each CR-funded program regarding our appraisal of its strengths and where it needs improvement.

We add these overall observations for the providers. It is becoming increasingly apparent that organizations, particularly nonprofit human services/mental health organizations, themselves need to be engaged in their own organizational planning, including defining their mission and understanding what business they are in. The competition for resources is increasing, and too often it seems that agencies "chase after the dollars" first and foremost rather than pursuing their defined mission as their primary focus.

In a related matter, we heard a number of complaints from agencies about the relatively short turnaround time imposed by the State in requiring proposals to be submitted for consideration and review for possible CR funding. As undesirable as this is, nevertheless, it is a fact of life that funders often impose fairly unrealistic turnaround times for the submission of proposals. As a result, agencies need to be prepared with their ideas and to be internally equipped to be able to deal with such short turnaround times. That strongly suggests the need for regular and systematic agency planning, including agency strategic planning—which can then be instrumental as part of the community needs assessment.

State

While we are not making any specific recommendations regarding the State, we do make some observations. *We understand and applaud the fact that the State is increasing its efforts for accountability and evaluation of programs.* These efforts are important and need to be supported, particularly if they are directed to the overall mental health service system, and not just Community Reinvestment programs.

And as we mentioned above in our recommendations, it would be very helpful if the State were to take the lead in spearheading the

collecting and disseminating of *cross-county* comparisons on various measures of supply and utilization, including standardized historical and current data for both state psychiatric center utilization (census, admissions, discharges, by age group, and county of origin), by PC and overall for the State, as well as for non-State psychiatric supply and utilization measures. *Ideally, the State would also place significant emphasis on the development and comparison of outcome, as well as primarily input, measures.*

Concluding Observations

Community Reinvestment has been successful in a number of ways.

- It has given a great deal of latitude to the counties to fund a variety of services, and it has helped Broome County build an infrastructure of a continuum of needed services for the mentally ill.
- It has created the opportunity to fund and develop a variety of needed services, many of which, because they were "non-traditional," would not otherwise have been funded.
- It has given powerful support to the consumer movement, and in many ways enabled its empowerment.
- It has allowed communities to take some risks with new, previously untested programs to meet community needs.

There are a number of ways that the Community Reinvestment system could be improved upon:

- While the seriously mentally ill, children and adolescents with serious emotional disturbances, homeless, and MICA populations were generally the ones served by Community Reinvestment programs, that has not always been the case.
- In retrospect, the CR funding process has until recently turned out to be a lost opportunity to evaluate the impacts of giving counties greater control over determining what their priorities are, and what kinds of impacts they are making as a result.

- Overall, accountability has not been as strong as it could be and needed to be: at the system level, and at the provider/program level. The report addresses a number of ways in which the accountability can be strengthened, through needs assessment, priority selection, selection of programs for funding, contract monitoring, and ongoing evaluation.

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APPENDIX 1: COMMUNITY REINVESTMENT PROGRAMS

YEAR FUNDED	AGENCY	PROGRAM	ANNUAL FUNDING
2000	BCMH	Case Management- Forensic Adult	$40,190
1999	BCMH	Forensic Outreach	$24,711
1995	BCMH	LGU Administration	$12,940
1999	BCMH	LGU Administration	$20,000
1995	BCMH	MICA-Homeless	$50,000
1998	Binghamton Psychiatric Center	Trauma Self Help	$53,174
1995	Catholic Charities	Aging Out ICM	$25,300
1998	Catholic Charities	CCSI	$38,469
1997	Catholic Charities	Crisis Sitters	$29,060
1995	Catholic Charities	Adult Flex Team	$190,000
1995	Catholic Charities	Adult Flex Team	$73,807
1996	Catholic Charities	Adult Flex Team	$44,032
1996	Catholic Charities	Adult Flex Team	$45,766
1998	Catholic Charities	Adult Flex Team	$9,633
1998	Catholic Charities	Adult Flex Team	$38,141
2000	Catholic Charities	Adult Flex Team	$73,734
1999	Catholic Charities	Home Based Crisis Intervention	$41,731
1997	Catholic Charities	Single Entry	$96,185
1999	Catholic Charities	Supportive Case Management	$61,272
1999	Catholic Charities	Supportive Case Management	$18,000
2000	Catholic Charities	Treatment/Congregate	n/a
2001	Family and Children's Society	In-home Mental Health Mgmt Program	$66,000
1998	Family and Children's Society	Family Support Centers	$42,000
1999	FRS/BPC	MICA Network	$9,200
2000	Lourdes	Case Management- Child/SED	$39,950
1999	Mental Health Association	Self Help Independence Project	$30,000
1996	Mental Health Association	BEAR Program	$36,500
1995	Mental Health Association	Multicultural Initiative	$46,500
1996	Mental Health Association	Multicultural Initiative	$4,772
1998	Mental Health Association	Rural BEAR	$33,043
1999	Mental Health Association	Rural BEAR	$16,500
1999	Recipient Affair's Office	Bridger	$28,000
1999	Recipient Affair's Office	Parent Partners/CCSI	$35,699
1997	Recipient Affair's Office	Peer Advocacy	$41,000
1999	Recipient Affair's Office	Peer Advocacy	$87,626
1998	Recipient Affair's Office	Peer Advocacy, Consumer Advisory Board	$11,800
1999	Recipient Affair's Office	Peer Advocacy/Peer Education	$23,392
1995	United Health Services	HOME Geriatric Outreach	$115,613
1996	United Health Services	HOME Geriatric Outreach	$23,310

APPENDIX 2: FOCUS GROUP GUIDE

Please do not put your name on this packet. This packet is intended to serve only as a guide to the issues we will be discussing in the group. It also offers you an opportunity to provide written responses to any questions we raise during the discussion. ***Thank you for your participation in this focus group!***

SECTION I:

1. Think about your most recent experience with the mental health system: What were your needs at the time you began receiving services?

2. How well have these needs been met by the program or service provider? Please explain.

SECTION II:

1a. Based on the experiences you described in Section I, from your point of view, what changes if any, should be made at the program or agency level? (How would you adjust program services to better meet your needs?)

b. Are there things that work well now that you'd like to see expanded or replicated?

2a. What changes if any should be made at the system level? If you were in charge (you're the Commissioner of Mental Health), what kind of changes would you make at the system level?

b. What types of new programs or services are needed in the future?

SECTION III:

1a. Think about your overall past experience with the mental health system and the specific mental health services you have received. Have you ever been asked for feedback about the mental health services you've used? ____Yes ____No

If YES, please explain: What were you asked about? Who asked? How?

b. In general, were you satisfied or unsatisfied with this experience? What was satisfactory or unsatisfactory about it?

2. If you were a service provider asking for feedback from recipients of services you provided, what would you ask?

SECTION IV:

1. When programs and providers ask for recipient feedback in the future in order to identify changes that may be needed in existing services, seek to improve their services, and/or plan for new mental health services, what's the best way to get input from you and your fellow service recipients?

2. How should your feedback be used? How should it not be used? Do you have any concerns about being asked to provide feedback on the services you receive?

ADDITIONAL COMMENTS: