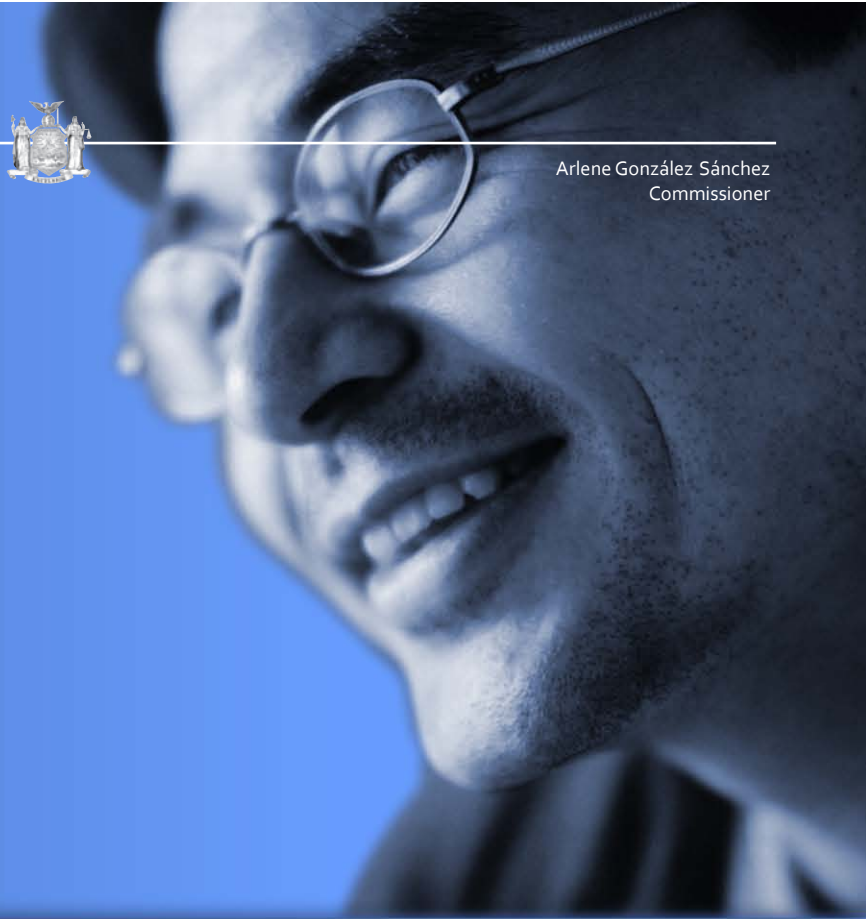Andrew M. Cuomo
Governor

Arlene González Sánchez
Commissioner

New York State Office of Alcoholism and Substance Abuse Services

Statewide Comprehensive Plan

2011-2015

OASAS
Improving Lives.

October 1, 2011

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Chapter I: Background and Context

OASAS Mission

To improve the lives of all New Yorkers by leading a premier system of addiction services through prevention, treatment, and recovery.

Background

The Office of Alcoholism and Substance Abuse Services (OASAS) estimates that 11 percent, or 1.8 million, state residents age 12 and older (including 160,000 adolescents ages 12-17) experience a substance use disorder (substance dependence or abuse) annually. These figures do not fully depict the widespread impact of addiction in New York because of the millions of other individuals whose lives are also affected: children, spouses, and extended families. The cost to society is compounded by the consequences of addiction, which impact public safety, health, welfare, and education throughout the state.

As overseer of one of the nation's largest addiction service systems, OASAS provides a full continuum of services to a large and diverse population of approximately 260,000 unique individuals each year. OASAS certified and funded providers deliver prevention, treatment, and recovery services. Treatment services are provided in inpatient, outpatient, and residential settings. New York State's service continuum also includes school- and community-based prevention services as well as intervention, support, crisis, and recovery services.

OASAS, counties, and providers collect and analyze a great deal of information, which informs all aspects of service delivery. These data support policy development, planning, funding decisions, and performance monitoring. As OASAS enhances the use of outcomes management and encourages providers to adopt evidence-based programs and practices to achieve the best possible results, the use of data becomes even more critical to providing quality services.

OASAS is required by Mental Hygiene Law to produce a *Statewide Comprehensive Plan* every October 1 and an *Interim Report on the Plan* on February 15. Developed in accordance with Section 5.07 of Mental Hygiene Law, the *Statewide Comprehensive Plan 2011-2015* informs counties, providers, people in recovery, their families, other state agencies, the federal government, and other interested parties about major priorities and future directions. Although planning documents are produced and released on regular cycles, as set by Mental Hygiene Law, OASAS views planning as a year-round process that informs policy development, budgeting, and the development and delivery of services at the state, local, and provider levels. Our collaborative planning efforts with counties, providers, state, and federal agencies will guide future efforts and have the flexibility to respond to changing conditions. OASAS seeks feedback on the use and usefulness of the *Statewide Comprehensive Plan*. To provide feedback on the Plan, please e-mail 5YearPlan@oasas.ny.gov.

Medicaid Redesign

A key aspect of Governor Andrew Cuomo's agenda is to increase the quality and efficiency of the Medicaid program while reducing costs. To accomplish these objectives, the Governor created a Medicaid Redesign Team (MRT), comprising key stakeholders. OASAS Commissioner Arlene González-Sánchez served on the MRT, which provided recommendations to the Governor for improving the quality of the state's Medicaid system and reducing costs and inefficiencies. Many recommendations from the MRT were adopted into law. Among these were behavioral health provisions that are critical to the addictions field. These provisions will help ensure that the behavioral health population receives the highest quality of care. They demonstrate Governor Cuomo's commitment to maintaining the quality of services, while achieving greater efficiencies and increased cost effectiveness.

An important Medicaid Redesign provision for the addictions system is the requirement to transition Medicaid services from a carved-out fee for service system to one that will be fully managed. OASAS and the Office of Mental Health (OMH) are implementing this transition by contracting with Behavioral Health Organizations (BHOs). Major highlights of this initiative include:

- OASAS and OMH as the state's behavioral health agencies will be the lead agencies in implementing the BHO model.

- The BHOs will assist with managing the services that are currently carved out of mandatory Medicaid managed care. Phase I BHOs are assisting with fee-for-service medically managed/supervised detoxification and inpatient rehabilitation only. Phase II BHOs will support management of fee-for-service outpatient and opioid treatment.

- The BHOs will not be responsible for developing provider networks as all certified OASAS providers will be part of the BHO network.

- During this transition period, behavioral health services will continue to be reimbursed on a fee-for-service basis.

- OASAS will also take advantage of the federal Health Homes opportunity, which is completely connected to the BHO transition period.

- The BHO legislation specifically requires OASAS and OMH to consult with Local Governmental Units (LGUs). This gives LGUs a more formal role in the development process.

On June 24, 2011, OASAS and OMH jointly issued a Request for Proposal (RFP) to announce that they were accepting applications for five regional BHOs to provide Medicaid fee-for-service administrative and management services for the purposes of conducting concurrent review of inpatient behavioral health services and coordinating the provision of behavioral health services. Implementation of the BHOs is being divided into two phases. Phase I of the BHOs is the first

step in improving the coordination of behavioral health services and reducing system fragmentation. Phase I BHOs will be tasked with:

- Monitoring behavioral health inpatient length of stay;
- Reducing unnecessary behavioral health inpatient hospital days;
- Reducing behavioral health inpatient readmission rates;
- Improving rates of engagement in outpatient treatment post discharge;
- Better understanding of the clinical conditions of children diagnosed as having a Serious Emotional Disturbance;
- Profiling provider performance.

The addictions system is moving to a fully managed system of integrated care and care coordination that has proven to be effective in putting addicted individuals on the path to recovery. It is essential to better coordinate care within the addictions service system and with the mental health system. An area of particular concern is with patients who access treatment through hospital-based inpatient detoxification programs. Improved care coordination will enable us to better serve this population by ensuring their access and participation in the next appropriate level of care, helping them to secure other needed supports such as housing, and coordinating services for other health and mental health needs.

OASAS recognizes that a significant number of people served by addiction treatment programs have co-occurring mental health issues. Poorly integrated substance use and mental health treatment can lead to relapse, psychiatric emergencies, and overuse of emergency rooms and hospitalization. Care coordination is a key to successfully providing people with integrated, effective, and cost efficient co-occurring services.

As BHOs and Health Homes are implemented, OASAS will work with counties, providers, and other stakeholders to redesign in a way that improves access to quality care. LGUs are in a unique position to influence and to assist providers to improve and begin to focus on models for achieving integrated care through developing multi-disciplinary teams that can manage multiple chronic illnesses and to develop partnerships across service systems.

OASAS will use the BHO transition period to develop better care coordination standards as a regular part of the addictions service system. The agency will collaborate with counties, providers, and advocates to develop a coordinated, comprehensive, and integrated system of care.

OASAS implemented Ambulatory Patient Groups (APGs) in July 2011. Implementing APGs for behavioral health services is a key component of New York State's overall effort to reform Medicaid reimbursement and rationalize service delivery. Clinically, for the addictions field, the implementation of APGs is an integral part of the move toward one outpatient system of care. APGs support a range of medically necessary clinic services for patients to promote recovery from chemical dependence. The APG methodology supports integrated substance use, mental health, and physical health services through a common ambulatory Medicaid payment structure. The BHO model of better coordinating fee for service outpatient care will allow OASAS to implement and evaluate the impact of APGs.

Two of the new services in OASAS, OMH, and the Office for People With Developmental Disabilities (OPWDD) include medication management and complex care coordination. These services will allow programs to provide medication-supported recovery and better coordinate care between disabilities. Programs will be able to choose the right service for the patient and be reimbursed based on the intensity of the resource to deliver that service. OASAS, OMH, and OPWDD, along with the Department of Health (DOH), worked closely to ensure the maximum amount of consistency between settings while allowing for enough flexibility in the categories and codes to preserve what is unique to each.

Planning Principles and Purposes

OASAS uses the following principles to guide its planning efforts:

- Planning is an ongoing process that informs policy development, budgeting, and the delivery of services;
- Planning produces documents and reports that are useful and used by stakeholders and customers;
- Planning focuses on desired system and individual outcomes;
- Planning has "buy in" from all key customers including OASAS leaders and staff, other state agencies, counties, providers, patients/participants, individuals in recovery, and other stakeholders;
- Planning engages stakeholders in meaningful ways at all levels: federal, state, county, and community.

Usefulness

An overarching principle of the planning process OASAS undertakes and the documents it produces is that stakeholders find these useful and apply them in their work. One of the agency's objectives is for counties, providers, and other stakeholders to use planning to enhance their particular efforts to monitor and improve performance. OASAS uses the statewide planning process to monitor and publicize progress on the agency Dashboard. Customers benefit from the increased transparency related to the functioning of OASAS and the service delivery system.

The Statewide Comprehensive Plan is designed to:

- Inform stakeholders of OASAS directions and destinations;
- Enable counties and providers to develop initiatives and programs that are aligned with OASAS directions and destinations;
- Inspire innovation and change at all levels of the addiction service system;
- Encourage collaboration with other service systems;
- Facilitate program and policy changes and improvements.

Comprehensiveness/Meaningfulness

OASAS continues to more closely align local planning, statewide planning, and outcomes management. 2011 was the fourth year that OASAS, OMH, and OPWDD engaged in a fully

integrated mental hygiene local services planning process. This approach has provided a consistent and efficient foundation for developing solutions to local priority issues and a timetable that better aligns with statewide planning and budgeting timelines.

The sustained commitment by the three agencies to integrated planning supports a human services system that puts the needs of individuals at the forefront. This person-centered philosophy serves as the underpinning for high-quality, individualized services for New Yorkers and their families. It is the cornerstone to improved outcomes for individuals with multiple needs by addressing the way supports and services are delivered across systems.

Releasing the *2012 Local Services Plan Guidelines for Mental Hygiene Services* http://www.oasas.state.ny.us/hps/state/documents/2012LSPGuidelines.pdf on March 1, 2011 provided OASAS the opportunity to use information submitted in the county plans to develop the *Statewide Comprehensive Plan 2011-2015*.

Public Input

A considerable amount of public input assisted OASAS in shaping this Plan including:

- Information that counties and providers submitted through the local planning process;
- Feedback from the New York State Advisory Council on Alcoholism and Substance Abuse Services;
- Testimony from counties, providers, and constituency and stakeholder groups during the three public hearings conducted by Commissioner González-Sánchez;
- Comments submitted by e-mail to 5yearplan@oasas.ny.gov;
- Responses to the evaluation surveys for the *Statewide Comprehensive Plan 2010-2014* and *2011 Interim Report*.

Readers of the Plan can submit comments using the survey located at: https://www.surveymonkey.com/s/OASASPlan2011-15Survey or by e-mail to 5yearplan@oasas.ny.gov.

Public Hearings

Commissioner González-Sánchez held three public hearings to offer people in recovery, counties, providers, and constituency and stakeholder groups the opportunity to provide input on the *OASAS 2011 Outcomes Dashboard* as well as areas that were not included. The Dashboard is part of the Commissioner's commitment to integrate outcomes management into the agency and the field. It identifies OASAS' system-wide priorities, including how progress will be measured, and is the foundation for this Statewide Comprehensive Plan.

The public hearings were held in Albany on September 8, Buffalo on September 15, and New York City on September 19, 2011. **OASAS will consider testimony presented during the hearings along with information submitted by LGUs and providers in their Local Services Plans as it develops the 2012 Dashboard, which will be released in February 2012.**

A total of 147 representatives from local governments, providers, and people in recovery attended the hearings with 23 individuals presenting testimony. Four other stakeholders who were unable to attend a hearing submitted testimony by e-mail. Those presenting testimony represented all components of the service continuum and reflected a broad diversity of perspectives.

Collaboration

Inter-Office Coordinating Council

The Inter-Office Coordinating Council (IOCC) is a statutorily created body under Section 5.05(b) of Mental Hygiene Law. The IOCC was created as a result of the breakup of the Department of Mental Hygiene (DMH) into three separate offices in the 1970s. The IOCC, which had long been dormant, was reinvigorated in 2007 when the OMH, OPWDD, and OASAS commissioners began meeting regularly. The IOCC aims to eliminate barriers to accessing care and to improve coordination of services for people with disabilities, particularly with respect to those issues that involve multiple agencies.

In 2007, the IOCC commissioners added DOH, Office of Children and Family Services (OCFS), State Education Department (SED), and the Developmental Disabilities Planning Council (DDPC) as ad hoc members. Representatives of these agencies attend all IOCC meetings and fully participate in the policy deliberations.

The IOCC meets quarterly. Agenda and meeting minutes can be found at: http://www.oasas.state.ny.us/pio/collaborate/IOCC. As required by Chapter 294 of the Laws of 2007, the IOCC submits an annual report on its activities to the Governor and Legislature. The 2010 annual report is available at: http://www.oasas.state.ny.us/pio/collaborate/IOCC/documents/IOCCAnnualReport2010.pdf. The next annual report is due December 31, 2011.

IOCC's Mental Hygiene Planning Committee

The Mental Hygiene Planning Committee was formed in 2007 to explore opportunities for integrated mental hygiene services planning and became a standing committee of the IOCC in 2008. It is responsible for coordinating the integrated local planning process of the three mental hygiene agencies and each LGU. To ensure that the planning process meets the needs of each state agency and is relevant to each county, membership of the committee includes OASAS, OMH, and OPWDD planning staff; the Conference of Local Mental Hygiene Directors (CLMHD); and several county mental hygiene agencies. The committee meets monthly and focuses its efforts on further integrating the local planning process and developing and refining web-based planning tools and data resources that support and facilitate local planning and needs assessment efforts. 2011 marked the fourth year of a fully integrated mental hygiene local planning process. As a result, local priorities reported in the plans have continued to reflect an expanded cross-systems focus. Forty-eight percent of all county priority outcomes included in

the 2012 plans included a multiple-disability focus, compared with 38 percent in the first year of integrated planning.

The Community of Practice for Local Planners (CPLP) is a subcommittee of the IOCC's Mental Hygiene Planning Committee. This county-led group of local Mental Hygiene planners is organized around common interests, activities, and needs. OASAS, OMH, and OPWDD support the CPLP by providing data resources for planning and by having a section in the online County Planning System (CPS) http://cps.oasas.state.ny.us dedicated to CPLP activities. The CPLP gives counties access to data tools and supports so that they can collaborate in developing local services plans. By participating in the CPLP, counties are able to provide OASAS with addiction prevention, treatment, and recovery plans that better reflect local priorities and needs. This enhances OASAS' ability to develop statewide strategies and services that address local concerns.

The County Data Needs Subcommittee was formed in 2009 to provide broader county input on recommendations for developing and enhancing those data resources. This subcommittee is chaired by a county planner and has active participation from several other county planners and planning staff from each state mental hygiene agency. During 2011, one of the primary objectives of the subcommittee has been to expand county access to OASAS program utilization data used in planning and managing their local service system. The subcommittee continues to work with OASAS and OMH to make Medicaid data available to counties in the most usable and accessible format.

Outcomes Management

OASAS recognizes how critically important addiction services are to individuals, families, and communities. One of OASAS' overarching goals is to ensure that New York has the nation's premier and most fiscally responsible system for prevention, treatment, and recovery. The *OASAS 2011 Outcomes Dashboard* (See Chapter II) defines where OASAS and the service system are headed by clarifying what success will look like for the addiction field. The Dashboard is especially important in OASAS' statewide planning activities because it identifies specific steps the agency will take to achieve the desired outcomes. The *2011 Interim Report on the Statewide Comprehensive Plan* http://www.oasas.ny.gov/pio/commissioner/5yrplan.cfm reported on the results of the *OASAS 2010 Dashboard*.

Program scorecards are a centerpiece of OASAS outcomes management efforts. During 2010, OASAS released scorecards for all chemical dependence treatment programs. The scorecards provide a one-page summary of performance for treatment programs and will eventually be available for all programs. The scorecards measure access, quality, outcomes, efficiency, and compliance. In November 2011, OASAS will post updated scorecards for nearly 1,000 treatment programs on its website. LGUs, providers, and members of the public are able to search for a chemical dependence treatment program and review data about program performance, patient outcomes, and other useful descriptive information about the program and the people it serves. The scorecards are also a key part of OASAS' Gold Standard Initiative designed to support and facilitate exemplary performance by service providers and high-quality outcomes for patients and participants.

Based on annual surveys of providers, progress has been made on a key OASAS metric: "Outcome Management is actively used across the addiction system by a critical mass of OASAS and Field leaders." A summary of the results of the 2011 Outcomes Management Survey is included in Chapter IV of this Plan.

In addition, 86 percent of the metrics included in the OASAS 2010 Outcomes Dashboard were achieved or partially achieved. Chapter II of this Plan has the 2011 Dashboard metrics.

OASAS continues to join together with approximately 25 other state agencies to participate in a state level Outcomes Management Community of Practice. The meetings occur quarterly and continue to draw a large number of participants from a wide range of state agencies.

Regional Communities of Practice for Outcomes Management

In addition to implementing outcomes management within the agency, OASAS continues to encourage its use by the field through regional Communities of Practice. Communities of Practice are formed by people who engage in regular interaction over a shared topic of interest. Participants learn and develop skills around a topic either through explicit learning objectives or as a secondary effect of sharing experiences, tools and resources, providing peer support, or problem solving around an issue. The benefits of participating in a Community of Practice include:

- Access to shared resources;
- Insight from others who are trying to do the same or similar things;
- An established support network as agencies try new approaches to improving performance and individual outcomes.

The success of a Community of Practice lies in participants' interest, commitment, and willingness to try new approaches. OASAS offers the following resources and opportunities to the regional Communities of Practice for Outcomes Management:

- Regular interaction with other participants, including county administrators, treatment providers, and other service providers working with individuals in the addiction treatment system;
- Exposure to other practitioners engaged in performance improvement and tracking patient outcomes;
- Information about different tools and mechanisms for collecting data;
- Support and technical assistance.

In exchange for this support, OASAS asks that Community of Practice participants:

- Agree to regular, consistent attendance from management level staff;
- Be willing to share their experiences with performance management;
- Be open to new ideas;
- Provide honest feedback on the usefulness of Community of Practice sessions.

Typically, the Communities of Practice meet quarterly with participants volunteering to host the meetings at their respective program site. Providers and county administrators are included in these sessions. The two active regional Outcomes Management Communities of Practice, located in the Mid-Hudson Valley and on Long Island, focus on prevention and treatment outcomes respectively. A third Community of Practice is in the planning stages, also in the Mid-Hudson Valley, but intended for treatment providers specifically. Locations for additional regional Communities of Practice are forthcoming based on the strong interest expressed in the 2011 Outcomes Management survey administered through CPS. Fifty-four percent of the programs that responded to the survey indicated interest in becoming part of a regional Outcomes Management Community of Practice.

Lean Government

In an effort to increase efficiency, OASAS has been applying a "Lean Government" strategy. Lean is a collection of principles and methods that focus on the identification and elimination of non-value added activity involved in producing a product or delivering a service to customers. Where outcomes management encourages the use of data to monitor and improve outcomes, Lean offers a way of thinking that allows for change and adaptation to increase efficiency, better use resources, and continuously improve processes.

In May 2010, OASAS worked with pro bono consultants from the Center for Economic Growth (CEG) in Albany to conduct the first Lean project with the procurement process as the focus. *The Procurement Process for New Initiatives – Procurement Guidelines* were developed as a result of the Lean exercise. OASAS implemented and tested the guidelines for the Enforcing Underage Drinking Laws (EUDL) procurement during summer 2011. An analysis of the EUDL pilot found increases in efficiency from 30 to 50 percent depending on the measure used. Additionally, staff found the Lean approach helpful in articulating all key process steps, and identifying decision points early in the process, which eliminated potential problems later. The agency will complete two additional Lean exercises this year. The first will be with the Office of Human Resources to improve the vacancy control process and the second in the prevention area aimed at improving oversight and monitoring.

Block Grant

The Substance Abuse Prevention and Treatment (SAPT) Block Grant provides approximately $114.8 million annually to prevention, treatment, and recovery services in New York State. Over the past year, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has focused its efforts on planning for health care reform implementation, mapping out strategic initiatives to move the field forward, and revising the Block Grant application to assist in meeting upcoming demands facing the field. SAMHSA believes that behavioral health care is essential to the nation's health and must achieve the same goals as other health care systems, including: coordination with primary care, prevention, quality, and accountability. The "science to service" lag and a lack of adequate and consistent person level data have resulted in questions from stakeholders and policy makers, including Congress and the Office of Management and Budget (OMB) regarding the Block Grant's effectiveness.

Future of the Block Grant

Given that many individuals whose services are funded (in whole or partially) by the SAPT Block Grant will likely be covered in the future by Medicaid or private insurance, SAMHSA announced a new approach for the Block Grant. States will use the Block Grant program for prevention, recovery supports, and other services that will supplement services covered by Medicaid, Medicare, and private insurance. In light of these changes, SAMHSA proposes that Block Grant funds be directed toward four purposes:

- To fund priority treatment and support services for individuals without insurance or who cycle in and out of health insurance coverage;
- To fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance offered through the exchanges and that demonstrate success in improving outcomes and/or supporting recovery;
- To fund universal, selective, and targeted prevention activities and services;
- To collect performance and outcome data to determine the ongoing effectiveness of behavioral health prevention, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis.

Health Care Reform

The Mental Health Parity and Addictions Equity Act (MHPAEA) significantly enhanced access to behavioral health services for millions of Americans. The Patient Protection and Affordable Care Act will also enhance access to the prevention, treatment, and recovery support services for persons with or at risk of mental and substance use disorders. These laws will improve the nation's ability to close service gaps that have existed for decades for far too many individuals and their families. In 2009, more than 39 percent of individuals with serious mental illnesses or serious emotional disturbances and 60 percent of individuals with substance use disorders were poor and uninsured. Despite these changes, not everyone will have access to the full range of support services necessary to achieve and maintain recovery.

In addition, between 2012 and 2015, 32 million individuals who are uninsured will have the opportunity to enroll in Medicaid or private health insurance. This expansion of health insurance coverage will have a significant impact on how states use their limited resources. One population of particular note in 2014 will be the newly-insured. Many of these individuals will be covered by Medicaid or private insurance in FY 2014, and this will present new opportunities for behavioral health systems to expand access and capacity. In addition, states should identify who will not be covered after FY 2014, as well as whose coverage is insufficient and how federal funds will be used to support these individuals who may need treatment and supports.

OASAS and OMH are implementing provisions of the Patient Protection and Affordable Care Act to enhance access to prevention and treatment support services for persons with or at risk of mental and substance use disorders. This work to identify and address gaps in services will continue for several years. OASAS is focusing on health care reform and services redesign efforts, working with providers and other state agencies to: define benefits; innovate, protect, and

reform the funding structures that support the services system; develop viable Health/Medical Home models that include OASAS-certified providers; develop electronic health record and health information technology systems; and assist providers in marketing to the health insurance exchanges, insurance, and managed care organizations. A revised configuration and array of funding and service delivery approaches will be implemented and tested over the next several years.

SAMHSA's Strategic Initiatives

In addition to health reform, SAMHSA has established eight Strategic Initiatives to improve the delivery and financing of prevention, treatment, and recovery support services to advance and protect the nation's health. These initiatives will focus SAMHSA's work on improving lives and capitalizing on emerging opportunities. The areas and goals that comprise the strategic initiatives include:

1. **Prevention of Substance Abuse and Mental Illness**. Creating communities where individuals, families, schools, faith-based organizations and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This initiative will focus especially on the nation's high risk youth, youth in Tribal communities, and among military families.

2. **Trauma and Justice**. Reducing the pervasive, harmful and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved or at risk of involvement in the criminal and juvenile justice systems.

3. **Military Families**. Supporting America's service men and women – Active Duty, National Guard, Reserve, and Veterans – together with their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are successful.

4. **Recovery Support**. Partnering with people in recovery from mental and substance use disorders to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce barriers to social inclusion.

5. **Health Reform**. Broadening health coverage to increase access to appropriate high quality care, and to reduce disparities that currently exist between the availability of services for substance abuse, mental disorders, and other conditions such as HIV/AIDS.

6. **Health Information Technology**. Ensuring the behavioral health system, including states, community providers, peer and prevention specialists, fully participates with the general healthcare delivery system in the adoption of Health Information Technology (HIT) and interoperable Electronic Health Records (EHR).

7. **Data, Outcomes, and Quality**. Realizing an integrated data strategy that informs policy and measures program impact leading to improved quality of services and outcomes for individuals, families, and communities.

8. **Public Awareness and Support**. Increasing understanding of mental and substance use disorders to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

Chapter II: Dashboard

OASAS 2011 Outcomes Dashboard

2011 marks the fourth year OASAS has issued a system-wide *Outcomes Dashboard* - a tool designed to focus staff across the agency and the prevention, treatment, and recovery system on the most important success indicators associated with mission achievement. This document is our system-wide plan as it specifies our five core "destinations" and how progress will be measured through 12 key metrics. This year, there are five *Commissioner's Priorities* - new areas of focus Commissioner Arlene González-Sánchez has identified. Also included this year are system-wide initiatives for improving key client level performance measures.

Core Destinations

The five destinations that organize the OASAS strategic map reflect a comprehensive look at system performance including *Mission Outcomes* - our primary purpose; *Provider Engagement* - the evidence that our key customers and partners are highly committed to our joint success and involved in our journey; *Leadership* - our commitment to initiate change and demonstrate to others our success; *Talent Management* - the essential role staff play at all levels; and *Financial Support* - our responsibility to be good stewards of the public's trust.

- **Mission Outcomes** - To establish an effective, science-based system, which integrates prevention, treatment, and recovery.

- **Provider Engagement** - To develop a "Gold Standard" system of service provision.

- **Leadership** - To be the state resource on addiction and lead the nation in the field of chemical dependence and problem gambling prevention, treatment and recovery.

- **Talent Management** - To become a "Profession of Choice" for attracting, selecting and developing system-wide talent.

- **Financial Support** - To ensure a system with strong return on taxpayer investment and stewardship of resources.

The 12 metrics included in the 2011 Dashboard reflect the agency's priorities for the year while meeting the three M criteria of meaningful, measurable, and manageable. Each metric on the 2011 OASAS Dashboard is intended to be:

- Meaningful - generally accepted by those most familiar with the metric and connected to the agency mission;
- Measureable - valid, reliable, and associated with a readily available, regularly updated data source;
- Manageable - able to be affected through agency efforts and vertically integrated at the system, county, provider, and program levels.

OASAS marks progress towards accomplishing each of the 12 metrics through a series of milestones. The milestones are short-term goals that OASAS can achieve towards the metric by the end of 2011. There are 39 milestones associated with the 12 metrics. **OASAS will report on 2011 Outcomes Dashboard results in the** *2012 Interim Report on the Statewide Comprehensive Plan*.

Mission Outcomes

Commissioner's Priority **Metric 1: Strengthen addiction services through a comprehensive, integrated, culturally competent system that focuses on individual needs and accessibility. (Hanson)**

1.1: Improve system-wide treatment outcomes in two of the National Outcomes Measures as well as in two NYS Scorecard Domains, which are most closely associated with positive patient outcomes. (Hanson/Brandau)

1.2: The 12 OASAS-run Addiction Treatment Centers will increase one-week retention rates from 84.6% to 87.6% and maintain the overall occupancy rate at 90% for the 10,000 patients served this year. (Hanson)

1.3: Improve services to individuals in treatment by achieving the following results:

- Expand by 50 the number of Opioid Treatment Program (OTP) slots. (Greenfield)
- Increase the number of Opioid Overdose reversals in NYS from 320 to 420. (Kipnis)
- 50% of the 32 Pregnant and Parenting Women's programs will complete an assessment of cultural competence in delivering gender specific care to women. (Morris-Groves)
- Compile baseline data regarding number of individuals with tuberculosis, HIV, Hepatitis A, Hepatitis B, Hepatitis C and other communicable diseases. (Kipnis)
- Improve services to veterans by conducting knowledge enhancement and skill building training for 500 treatment provider staff. (Noonan)
- Compile an inventory of universal screening and assessment instruments for adolescents and their families and make it available on the OASAS website. (Morris-Groves)

Commissioner's Priority **Metric 2: Successfully implement a new evidence-based Drinking Driver Program and enhanced DWI screening and assessment, which will reduce DWI recidivists based on the total number of drivers with a DWI conviction. (Kent)**

2.1: Training on the Prime for Life curriculum will be provided to 480 DDP providers and 90% will report they are prepared to implement the curriculum. (Fesko)

2.2: 90% of 1500 providers will be trained on the standards for screening and assessment of impaired drivers and 75% will attest adherence to the clinical guidelines through the IDS system. (Fesko)

2.3: Create a baseline rate for recidivism of offenders who complete the DDP and for offenders who complete treatment. (Flaherty)

Metric 3: Reduce rates of past 30-day substance use and reduce levels of substance abuse risk factors including: perception of risk, perception of parental disapproval, and percent of youth exposed to prevention messages in New York State. (DiChristopher)

3.1: Increase from 53 to 62, the counties that are implementing evidence-based prevention practices with 35% or more of their county-wide prevention effort. (Brady)

3.2: Develop a baseline of culturally competent evidence-based practices in the prevention provider community. (Brady)

3.3: The 11 funded Strategic Prevention Framework State Incentive Grant communities, which are supported by a $10.6 million federal grant that requires cultural competence in each step, will administer an OASAS-approved survey, complete their needs assessment report, and have their data driven, culturally competent strategic plan approved by the Evidence Based Review Panel. (Brady)

Metric 4: Recovery: Increase the number of persons successfully managing their addiction within a culturally competent, recovery-oriented system of care. (DiChristopher)

4.1: The $13 million federally supported 4-year Access to Recovery grant will achieve its enrollment target of 1,500 people by the end of 2011. (McNeil)

4.2: The system's housing portfolio for people in recovery across the state will be increased from 1,365 to 1,460 apartment units. These increases will also expand the number of communities with available housing for this population from 23 to 24. (Panepinto)

Provider Engagement

Commissioner's Priority **Metric 5: Implement increased program oversight and strengthen provider accountability to ensure culturally competent, quality services. (Monson)**

5.1: Implement an enhanced program-monitoring system that will result in (30) focused reviews of at-risk programs, which will identify deficiencies requiring corrective action and implementation. (Lachanski)

5.2: Provide technical assistance to the estimated 70 programs annually receiving a 6-month (non-compliance) or one-year (minimal compliance) conditional operating certificate. At least 80% of programs receiving technical assistance will demonstrate improvement. (Lachanski)

5.3: In conjunction with the Department of Corrections and Community Supervision, OASAS will certify 5 additional DOCCS addiction services programs adding to the 5 certified in 2010. (Hanson)

5.4: Implement an integrated early warning system for prevention programs reporting under the PARIS system to reduce reporting delinquencies. (Walker)

Metric 6: Increase Provider engagement in the Gold Standard Initiative. (Monson)

6.1: Increase the number of providers implementing at least one Gold Standard element from 35% to 50% as evidenced by survey results received from the Gold Standard Initiative website. (Paloski)

6.2: Based on an annual survey of providers, OASAS will increase from 2010 baselines the percentage of non-crisis programs (which total 677) adopting targeted evidence-based practices (EBPs) as follows (Brandau):

- Screening for Co-occurring Disorders (2010 Baseline 67%, Target 70.4%).
- Motivational Interviewing (Baseline 67%, Target 70.4%).
- Cognitive Behavioral Therapy (Baseline 60%, Target 63%).
- Medication Supported Recovery/Buprenorphine (Baseline 37%, Target 38.85%).
- Process Improvement. (Baseline 32%, Target 34%).

6.3: The first prevention scorecard will be released using PARIS data with support and approval from the Gold Standard Outcomes Management Advisory Committee. (Walker)

6.4: The OASAS Integrated Quality System (IQS) will achieve the following implementation milestones by the end of the year: (Paloski/Lachanski)

- Conduct Statewide Regional forums.
- Complete data integrity review and issue 4-year operating certificates.
- Finalize 5-year operating certificate application process.

6.5: Reduce the number of programs with recurring management plans from 31% to 29% and from 22% to 20% for repeat categories. (Rabinowitz/Murphy)

Leadership

Commissioner's Priority **Metric 7: Utilize outcome management concepts that focus on performance measures and hold both OASAS and its providers accountable. (Phillips)**

7.1: Increase the number of programs and OASAS managers that use performance data to improve results over 2008 baselines. Programs (77% to 80% treatment) OASAS Managers (38% to 40%). (Burke/Hogan)

7.2: Build upon being the first New York State Agency to implement a Lean thinking process improvement approach by fully implementing the procurement and human resources projects and by launching at least two additional Lean projects that eliminate waste and improve customer outcomes. (Burke)

Metric 8: Educate and partner with the community, government agencies and elected officials to advance the agency mission by increasing public awareness through positive media coverage and proactive communication strategies. (Zuber-Wilson/Rondó)

8.1: Support a statewide Recovery consumer movement by adding 100 new stories to the 307 collected since 2009 through the "Your Story Matters" campaign at www.iamrecovery.com. (Rondó)

8.2: Issue at least 24 press releases highlighting agency initiatives, campaigns and activities. Respond to press inquiries within two days and effectively communicate OASAS' perspective on policy issues affecting the addictions field. Continue to inform communities, government agencies, and legislators via weekly web postings and weekly OASAS mailing and e-mail distributions. (Rondó/Zuber-Wilson)

Talent Management

Commissioner's Priority **Metric 9: Increase cross-systems training to support integrated, culturally competent behavioral health services. (Monson)**

9.1: Increase the number of OASAS programs (63 to 80) that enroll staff and provide access to the on-line Focus on Integrated Treatment (FIT) modules, which are designed to help programs implement integrated treatment for co-occurring disorders, and establish the number of successfully completed modules for 2011. (Rosenberry)

9.2: Increase by 25% the average integrated service provider capability score on the Dual Diagnosis Capability in Addiction Treatment (DDCAT) following completion of targeted training efforts. (Rosenberry)

Metric 10: Increase full knowledge, expertise and retention of a high-performing, diverse staff throughout the field. (Caggiano-Siino)

10.1: Expand provider skills through training in the following areas. All training outcomes will be at or above 80% satisfaction and 30% implementation rates: (Hanson)

- Increase from 150 to 300 the number of provider staff from the addictions system and other service systems receiving fetal alcohol spectrum disorder training.
- Increase from 16 to 25 providers receiving overdose prevention training.
- Increase from 0 to 100 the number of individuals completing SBIRT training in both OASAS and non-OASAS settings.
- Provide Wellness Self-Management Plus training to 15 OASAS providers, reaching 100 clients.

10.2: Increase the number of addiction professionals across the state as follows: (Rosenberry)

- Certified Alcohol and Substance Abuse Counselors (CASACs) by 5% (7,594 to 7,974).
- CASAC Trainees by 10% (4,681 to 5,149)
- Certified Addictions Registered Nurses (CARNs) by 5% (54 to 57).
- American Board of Addiction Medicine (ABAM) Certified Physicians by 5%.
- Psychologists with Addiction Proficiency Certification by 5%.
- Credentialed Addiction Professionals in the Corrections system by 5% (135 to 142).
- Increase the pass rate for the CASAC credentialing exam from 57.3% to 60%.

10.3: Increase by five the number of providers that apply for Best Places to Work recognition during 2011. (Caggiano-Siino)

10.4: At least 50% of 125 providers participating in the Best Practices human resources initiative will implement at least one Best Places to Work dimension. (Caggiano-Siino)

Metric 11: Improve OASAS leadership capabilities as follows: (Wilson)

11.1: Eighty-five percent of OASAS managers will discuss performance expectations with staff and encourage their professional development. (Wilson)

11.2: Managers will ensure that 100% of performance programs for OASAS supervisors include a standard supervision performance task/measure for timeliness and quality of task completion. (Wilson)

11.3: Increase satisfaction and implementation of supervisory learning principles. A training participation rate by supervisors and managers of 90% is expected with an 80% satisfaction rate as measured by a survey of training participants. (Wilson)

11.4: Seventy percent of OASAS managers will participate in cultural competency training with an eighty percent satisfaction rate based on evaluations. (Wilson)

Metric 12: Increase or stabilize funding resources while ensuring strong return on taxpayer investment. (Lawler)

12.1: Successfully convert to a new Statewide Financial System (SFS) by meeting all implementation dates. (Lawler)

12.2: Successfully implement the revised Substance Abuse Prevention and Treatment Block Grant in the context of Health Care Reform, Medicaid Redesign and SAGE Commission recommendations. (Zuber-Wilson)

12.3: Implement Ambulatory Patient Groups (APGs) reimbursement methodology in all OASAS freestanding programs. (Lawler)

12.4: Successfully implement the 2011 Medicaid reform team recommendations including issuance of behavioral health organization solicitation according to agreed upon interagency plans. (Kent)

12.5: The annual NYS Retailer Violation Rate for underage tobacco sales, which is required by the federal Synar Amendment for states to receive federal Block Grant Funds, will continue to be less than the weighted national average which was 9.3% in 2009. (Phillips)

Chapter III: System Overview

National Outcome Measures (NOMs)

SAMHSA developed NOMs in collaboration with states to demonstrate and improve the effectiveness of the SAPT Block Grant and the corresponding Center for Mental Health Services (CMHS) Block Grant, as well as discretionary grant programs. The SAPT Block Grant provides approximately $114.8 million annually to prevention, treatment, and recovery services in New York.

The ten NOMs domains cut across mental health, substance use treatment, and substance abuse prevention services:

1. Reduced Morbidity (e.g., abstinence);
2. Increased Employment and Education;
3. Decreased Criminal Justice Involvement;
4. Stability in Housing;
5. Social Connectedness;
6. Access and Capacity;
7. Retention in Care;
8. Perception of Care;

9. Cost Effectiveness;
10. Use of Evidence-Based Practices.

These domains are intended to represent "meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and live, work, learn, and participate fully in their communities."

For treatment services, many of the NOMs use before-and-after measures, specifically, changes in status from admission to discharge. While this may not be a strong design from a research perspective (e.g., no control group), it is an excellent design for managing outcomes and improving performance. In order to implement this measurement design, SAMHSA required states to enhance reporting of client admission and discharge data to the federal Treatment Episode Data Set (TEDS). OASAS began implementing new data items based on NOMs requirements in 2006 and will continue as necessary to augment its Client Data System (CDS). At the same time, OASAS continues to participate in SAMHSA's Technical Consultation Groups (TCGs) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) Performance Management Work Group. OASAS' purpose is to minimize the reporting burden on service providers while assuring that the NOMs measures developed are useful for performance management at the federal, state, county, and provider levels.

Table 3.1 presents statewide outcomes for chemical dependence treatment in four of the ten domains. In the table, "Net Improvement" is the percentage point difference between the before and after rates; SAMHSA refers to this as "absolute" change. While NOMs reported to SAMHSA are limited to outcomes for funded programs and exclude methadone treatment services, the statistics reported here include all non-crisis treatment services regardless of funding. The NOMs in **Table 3.1** represent outcomes for the entire certified treatment system (excluding crisis services for which NOMs have not been developed).

Table 3.1 National Outcome Measures (NOMs) for Non-crisis Chemical Dependence Treatment Services* Based on Persons Discharged in Calendar Year 2010 ***			
National Outcome Measure	At Admission	At Discharge	Net** Improvement
Abstinence in Past 30 Days			
From Alcohol	62.3%	85.9%	23.6%
From Other Drugs	46.2%	74.3%	28.1%
From Alcohol and Other Drugs	31.5%	68.8%	37.2%
Employed or Enrolled in School	28.0%	34.3%	6.3%
Stable Living Situation#	88.4%	90.9%	2.5%
Not Arrested in Past 6 months	74.1%	88.1%	13.9%

   * These figures include non-crisis outpatient services, inpatient rehabilitation, residential and methadone services

  ** Net improvement is simply the percentage point difference between the admission and discharge measures.

 ***Total discharges with valid data (the denominator) varies by measure: 215,172 for abstinence measures, 207,201 for employment/enrollment, 207,140 for living situation, and 215,455 for arrest.

  #Stable living situation includes congregate care residences, but excludes homeless shelters and unsheltered situations.

- Abstinence is measured as frequency of use in the past 30 days (i.e., zero frequency). SAMHSA measures abstinence separately for alcohol and other drugs while OASAS includes abstinence from alcohol and other drugs combined.
  - o *Alcohol and Other Drugs* – Among persons discharged in 2010 from non-crisis treatment services, 32 percent had used neither alcohol nor drugs in the 30 days prior to admission while 69 percent had used neither alcohol nor drugs in the 30 days prior to discharge. Thus abstinence from alcohol and drugs increased by 37 percentage points, meaning that 80,000 more persons were alcohol and drug abstinent at discharge than at admission.
  - o *Alcohol* – Among persons discharged in 2010 from non-crisis treatment services, 62 percent had not used alcohol in the 30 days prior to admission while 86 percent were not using alcohol in the 30 days prior to discharge. Abstinence from alcohol increased by 24 percentage points, meaning that 51,000 more persons were alcohol abstinent at discharge than at admission.
  - o *Other Drugs* – Forty-six percent of persons discharged had not used other drugs in the 30 days prior to admission while 74 percent were not using other drugs in the 30 days prior to discharge. Abstinence from other drugs increased 28 percentage points, meaning that 60,000 more persons were abstinent from other drugs at discharge than at admission.

- Employment and Education – Among persons discharged in 2010 from non-crisis treatment services, 28 percent had been employed or enrolled in school at admission while 34 percent were employed or enrolled at discharge. This increase of six

percentage points means that 13,000 more persons were employed or enrolled at discharge than at admission.

- Stability in Housing – Among persons discharged in 2010 from non-crisis treatment services, 88 percent had been in a stable housing situation at admission while 91 percent were in a stable housing situation at discharge. This increase of three percentage points in stable housing situation means that 5,000 fewer persons were homeless at discharge than at admission.

- Criminal Justice Involvement – Among persons discharged in 2010 from non-crisis treatment services, 74 percent had not been arrested in the six months prior to admission while 88 percent had not been arrested in the six months prior to discharge. This increase of 14 percentage points means that 30,000 fewer persons were arrested in the six months prior to discharge than had been arrested prior to admission.

Regarding the adoption of evidence-based practices, SAMHSA's plan is to use its annual National Survey of Substance Abuse Treatment Services (N-SSATS) to ask about practices implemented. No NOMs data on EBPs have been published to date. However, OASAS has conducted biennial surveys of treatment programs through CPS.

Access/capacity and retention indicators need further testing. SAMHSA may in the future require states to conduct annual client perception of care surveys. Cost-effectiveness measures are still under development. OASAS is awaiting clarification from SAMHSA regarding the impact of Block Grant changes and health care reform on existing NOMs and those under development.

For prevention NOMs, the first five domains are population-based and epidemiological in nature. Data for these indicators are taken from surveys or collected from administrative sources. Indicators are presented in OASAS' annual State and Regional Epidemiological Profile. Data for access/capacity, retention and use of evidence-based practices is collected in PARIS. Cost-effectiveness measures are under development.

Moving forward, OASAS will continue to analyze and review NOMs and other performance indicators at the state and regional levels to identify trends and develop policies and programs for improving the health and well-being of New Yorkers as well as supporting the recovery of individuals who have experienced substance use disorders. OASAS will continue to enlist counties in performance improvement efforts. In collaboration with CLMHD, OASAS developed comprehensive county profiles, which include NOMs and other outcomes measures for both prevention and treatment services.

As New York's systems evolve and improve, NOMs are being integrated as appropriate. In most cases, improved performance on scorecard indicators and on Integrated Program Monitoring and Evaluation System (IPMES) indicators translate directly into improvement on NOMs indicators. OASAS will not superimpose a new performance monitoring system on top of scorecards and IPMES, but rather will continue to integrate NOMS and these systems over time.

Needs Assessment

OASAS has developed systems for measuring the nature and extent of the use of alcohol and other substances as well as gambling problems, developing and targeting programming to populations in need, and evaluating the outcomes of services. These systems include epidemiology and needs assessment, state and local planning, outcomes measurement, and performance evaluation.

OASAS is required to assess the need for both prevention and treatment services as stipulated in Mental Hygiene Law (MHL 19.09). In addition, the SAPT Block Grant and the Center for Substance Abuse Prevention's (CSAP's) Strategic Prevention Framework State Incentive Grant (SPF SIG) require OASAS to address epidemiology and needs assessment. Needs assessment informs prevention, treatment, and recovery policy making, planning, and program development at the state and local levels and ensures that OASAS is in compliance with the mandate stipulated by MHL 19.09 and federal grant requirements.

Assessing the nature and extent of substance use and its related consequences within various communities and population groups is accomplished through a program of surveys, indicator systems and ethnographic and qualitative studies. Three basic methodologies are used: (1) epidemiological surveys of household, school, and special populations conducted by OASAS as well as other state and federal agencies; (2) ethnographic studies, special investigations, and other qualitative methods; and (3) statistical indicators representing both substance use and related consequences. OASAS collects original data and intelligence and uses information collected by the federal government and other state, county, and municipal agencies.

In addition to state level efforts, OASAS conducts a comprehensive annual local services planning process through which 57 counties and the City of New York are required to assess local chemical dependence problems and service needs and develop long range goals and intermediate range objectives to address those needs. Local planning and needs assessment is required by Mental Hygiene Law to be comprehensive and participatory, involving consumers, providers, other agencies and interested stakeholders. Local needs assessments are updated on an annual basis and reported to OASAS in county Local Services Plans.

State Epidemiological Outcomes Workgroup (SEOW)

The State Epidemiology Outcomes Workgroup (SEOW) assists OASAS in its needs assessment efforts. In 2006, OASAS received funding from CSAP to establish an epidemiological workgroup to integrate data about the nature and distribution of substance use and related consequences into ongoing assessment, planning, and monitoring decisions at the state and community levels. In 2009, the SEOW was integrated into the broader SPF SIG funded by CSAP. The SEOW promotes data-driven decision making in the substance abuse prevention system by bringing systematic analysis to guide effective and efficient use of prevention resources.

The primary mission of the SEOW is to improve needs assessment, planning, implementation, and monitoring efforts through the application of systematic, analytical thinking about the causes

and consequences of substance use. This is carried out by collecting, analyzing, interpreting, and applying state and community level epidemiological data. The SEOW consists of representatives of state agencies, local government, prevention service providers and other concerned parties. The SEOW project and its Workgroup promote:

- Better integration of data analysis, planning and policy development at the state and local levels;
- Improved communication and data sharing among state and local agencies;
- Increased collaboration in addressing substance abuse problems across various systems at the state and local levels;
- Enhanced capacity for data-driven planning and decision making at the state, local, and provider levels.

Data-driven decision making necessitates the development of state monitoring systems for substance abuse. Such systems can help inform assessment ("*What do substance use and related consequences look like in the State?")*, planning *("What are the current priorities that emerge after needs assessment?"),* and monitoring/evaluation activities *("How are we doing in our efforts to address these issues*?") to enhance substance abuse prevention and treatment services. CSAP has defined a series of data-driven activities to be undertaken by the SEOW, to assist New York State in developing an effective monitoring system by:

- Developing a key set of indicators to describe the magnitude and distribution of substance related consequences and consumption patterns across New York State;
- Collecting, analyzing, interpreting, and communicating these data through the development of Epidemiological Profiles;
- Establishing prevention priorities for New York State resources based on data analyzed and interpreted through the profiling process;
- Allocating resources to populations based on the established priorities;
- Developing a systematic, ongoing system of monitoring statewide substance related consumption patterns and consequences and tracking OASAS' progress in addressing prevention priorities, detecting trends, and using data to redirect resources if needed.

OASAS-funded prevention programs complete an annual work plan, which includes a community-level needs assessment. Community prevention development passes through a county-level review and approval process where county governments are responsible for developing local plans, including prevention services for substance abuse and underage drinking. Integrating the SEOW into OASAS' state and local planning processes, allows the SEOW to assist in guiding inclusive, data-driven, and results-focused prevention planning for communities and the state.

The SEOW supports the Strategic Prevention Framework (SPF) for New York State, consistent with the framework described by CSAP. The first step in the SPF process is the assessment of population needs and prevention resources, including development of baseline data against which progress and outcomes can be measured.

State and Regional Epidemiological Profile

OASAS annually produces a State and Regional Epidemiological Profile of Substance Use-Related Problems as part of its epidemiological and needs assessment efforts. The Epidemiological Profile documents trends in risk and protective factors, substance use consumption patterns, and the resulting negative consequences of alcohol and other substance abuse. By measuring the nature and extent of substance use within various communities and population groups through population-based surveys and archival indicator systems, the Profile assists in assessing the need for prevention and treatment services. The Profile monitors trends in substance use and the negative consequences of abuse and includes the NOMs for prevention services as specified by SAMHSA. The following are highlights from the Profile.

Risk and Protective Factors

The Epidemiological Profile includes results of the *2008 Youth Development Survey (YDS)*, which substantially increased OASAS' knowledge of risk and protective factors at the state and local levels. Prevention research has demonstrated that lowering risk factors and increasing protective factors that drive substance abuse prevalence in communities leads to reductions in substance abuse. OASAS supports a strategic planning process that includes a local needs assessment and the selection and implementation of appropriate prevention services to address the risk and protective factors to prevent or reduce substance abuse in individuals, families, and communities.

The 2008 YDS of 7th-12th grade students measured 21 risk factors that increase the probability of youth substance use and other problem behaviors. These risk factors operate within individual, peer, family, school, and community domains. New York State students reported elevated levels of risk for only 3 of the 21 risk factors (compared to a seven state normative average): *Community Disorganization*, *Parental Attitudes Towards Problem Behavior,* and *Having Friends That Engage in Problem Behavior*. *Community Disorganization* was the most elevated risk factor reported in the YDS, with 56 percent of 7th-12th grade students residing in communities whose conditions place them at higher risk for substance use. New York State students also experience elevated risk for two other risk factors: *Parental Attitudes Towards Problem Behavior* (49 percent) and *Having Friends That Engage in Problem Behavior* (47 percent). The YDS found that 7th-12th grade students experience lower than average risk on more than half of the risk factors (12 of 21), including those risk factors most closely related to drug use. New York State students reported levels of risk about equal to the average for the remaining six risk factors.

The YDS also measured 11 protective factors that reduce problem behaviors by promoting stronger attachment and bonding to family, school and the community. New York State students reported lower rates than average on 7 of the 11 protective factors, leaving them more vulnerable to substance abuse. *Community Rewards for Prosocial Involvement* was the least prevalent protective factor, with only 38 percent of students reporting that neighbors notice, encourage, and are proud of them when they do well. All the Family Domain protective factors were significantly lower than the seven state normative rates, with *Family Attachment* being the lowest; only 46 percent of 7th-12th graders experienced high levels of *Family Attachment*. *The*

Level of Prosocial Involvement, at 44 percent was also lower than the normative average. New York State students reported levels of protection significantly above the average rate for 3 of the 11 protective factors. The strongest protective factor was *School Opportunities for Prosocial Involvement*.

The Epidemiological Profile also monitors NOMs for Substance Abuse Prevention. CSAP identified specific outcome measures that will be required of SAPT Block Grant and discretionary grant recipients. These NOMs include the following domains: Abstinence from Alcohol and Other Drugs, Employment/Education, Crime and Criminal Justice, Access/Service Capacity, Retention, Social Support/Social Connectedness, Cost-Effectiveness, and Use of Evidence-Based Practices. These NOMs relate to youth ages 12 to 17 and to adults 18 and older. Outcome trend data for all of the state level NOMs are necessary to identify need and monitor global effectiveness at the population level in order to inform federal resource allocation decisions.

The Epidemiological Profile measures several Prevention NOMS that are risk and protective factors, including perception of risk from alcohol, cigarettes, marijuana, and age of first use of various substances. Perceived risk of harm from using alcohol, marijuana, and tobacco, especially heavy use is a deterrent to using these substances, especially among youth. Research demonstrates that respondents who believe great risk of harm results from using these substances were significantly less likely to use than those who thought there was little risk of harm.

New York State estimates from the *National Survey on Drug Use and Health (NSDUH)* for 2007-08 indicate that only 41 percent of adolescents perceive great risk from *binge drinking once or twice a week* while less than one-third of young adults (ages 18-25) perceive great risk. Almost one-half of older adults (age 26 and older) perceive great risk from binge drinking once or twice a week. There was little change in the perception of great risk regarding binge drinking from 2002-03 to 2007-08.

The 2007-08 NSDUH reported that only 30 percent of adolescents perceive great risk from smoking marijuana once a month while less than one-quarter of young adults (ages 18-25) perceive great risk. Less than 40 percent of older adults (age 26 and older) perceive great risk from smoking marijuana once a month. From 2005-06 to 2007-08, there was a slight *decrease* in the perception of great risk regarding smoking marijuana among adolescents and older adults (age 26 and older), but not among young adults.

Less than three-quarters of adolescents and three-quarters of young adults (ages 18-25) perceive great risk from smoking one or more packs of cigarettes a day, while four-in-five older adults (age 26 and older) perceive great risk from smoking one or more packs of cigarettes a day, according to the 2007-08 NSDUH. The perception of great risk regarding smoking cigarettes has increased from 2002-03 to 2007-08 in all three age groups.

The Epidemiological Profile, which monitors the age of first use of various substances, has found a decrease in proportion of students who used a substance before age 15. Based on the OASAS School Survey, between 1998 and 2006, the proportion of students in high school grades (9 through 12) who smoked cigarettes before age 15 decreased by over 40 percent while the
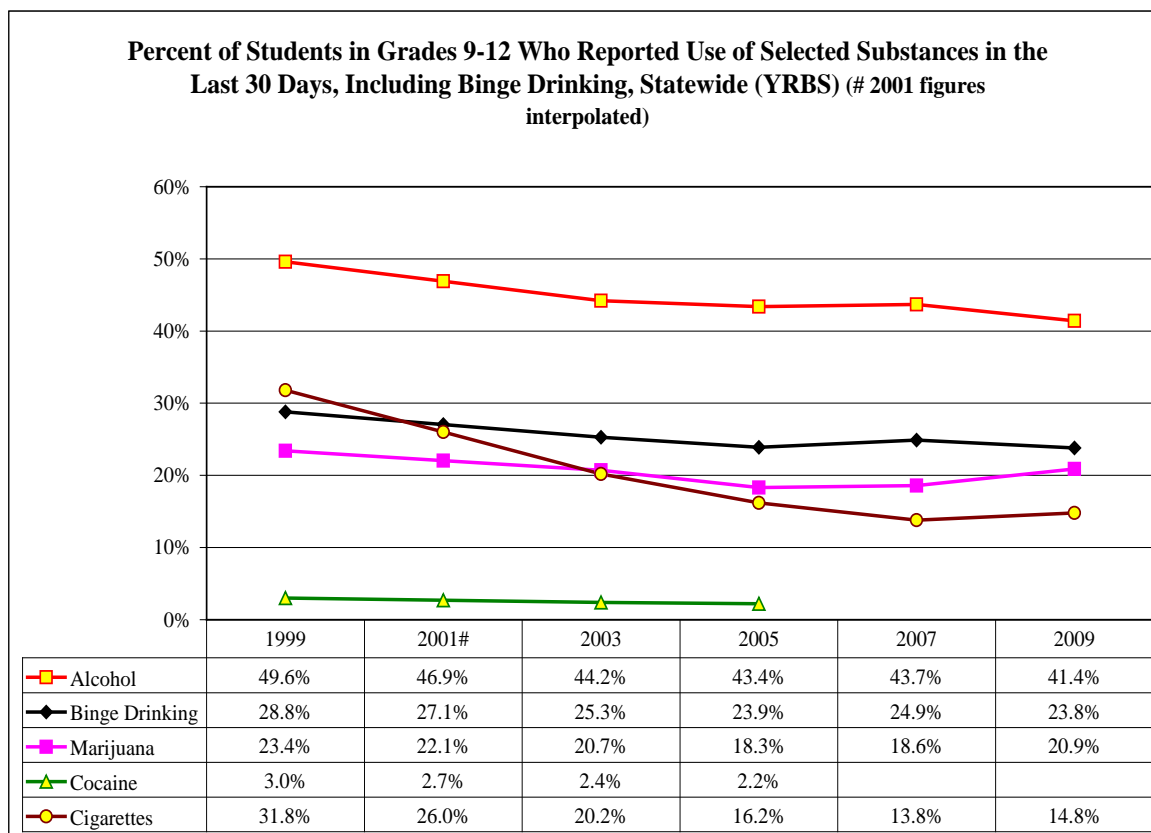
proportion who used marijuana before age 15 decreased by one-quarter and the proportion who used alcohol before age 15 decreased by about 9 percent. The most recent statistics (2006) indicate that 59 percent of students in grades 9-12 used alcohol before age 15 while 28 percent used cigarettes and 24 percent used marijuana before age 15.

Consumption Patterns and Substance Use Behavior

The Epidemiological Profile monitors consumption patterns consistent with the Prevention NOMS specified in the Reduced Morbidity domain by measuring the nature and extent of substance use within various communities and population groups. The Prevention NOMs include the consumption of alcohol, cigarettes, other tobacco products, marijuana, and use of other drugs other than marijuana in the general population, among adolescents 12-17, and adults 18 and older.

According to the *2009 Youth Risk Behavior Survey (YRBS)*, one-in-four (24 percent) of New York State high school students (grades 9-12) engaged in binge drinking in the last 30 days. The current binge drinking rate declined 14 percent between 1999 and 2009 (from 29 percent to 24 percent). One-in-five (21 percent) of high school students used marijuana in the last 30 days. The rate of current marijuana use declined about 10 percent between 1999 and 2009 (from 23 percent to 21 percent). The 2009 statistic suggests that marijuana use may be increasing but is not definitive. One-in-seven (15 percent) of high school students smoked cigarettes in the last 30 days. The rate of current cigarette use declined by more than one-half between 1999 and 2009 (from 32 percent to 15 percent). According to the 2005 YRBS, about two percent of high school students used cocaine or crack in the last 30 days.

Figure 3.1

Percent of Students in Grades 9-12 Who Reported Use of Selected Substances in the Last 30 Days, Including Binge Drinking, Statewide (YRBS) (# 2001 figures interpolated)

	1999	2001#	2003	2005	2007	2009
Alcohol	49.6%	46.9%	44.2%	43.4%	43.7%	41.4%
Binge Drinking	28.8%	27.1%	25.3%	23.9%	24.9%	23.8%
Marijuana	23.4%	22.1%	20.7%	18.3%	18.6%	20.9%
Cocaine	3.0%	2.7%	2.4%	2.2%		
Cigarettes	31.8%	26.0%	20.2%	16.2%	13.8%	14.8%

Note

(#): Figures are not available for 2001; estimates based on linear interpolation are charted in order to assure the correct slope for the trend lines. ***Data Source:*** **Youth Risk Behavior Survey, 1999-2009.**
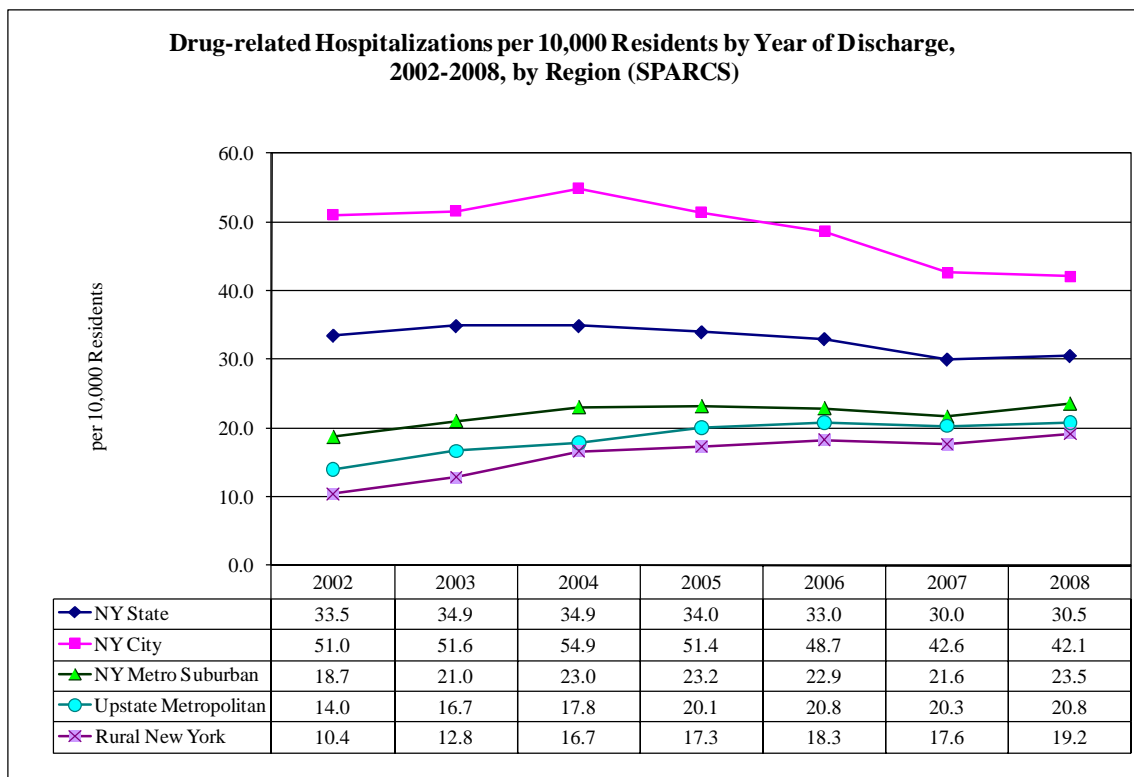
Consistent data for adults in New York is generally limited to periods from 2002 on and these data do not show a definitive trend in substance use, with the exception of tobacco. Substance use among young adults (aged 18-25) is substantially higher than for older adults (age 26 and older). The most recent data (2007-08) from the NSDUH indicate that almost half of young adults engaged in binge drinking in the past month while less than one-quarter of older adults did so. One-in-five young adults used marijuana in the past month compared to one-in-twenty older adults. Eight percent of young adults used illicit drugs other than marijuana in the past month compared to three percent of older adults. Past month rates of cigarette smoking among all age groups has declined during the 2002-03 to 2007-08 time period. Young adults experienced the most pronounced decline in current smoking rates, from 40 percent (2002-03) to 33 percent (2007-08). Analysis based on New York's four epidemiological regions indicates that, on average, New York City adults are less likely to engage in binge drinking in the past month than adults in other regions. Residents of the Upstate Metropolitan and Rural New York regions are more likely to have smoked cigarettes in the past month compared to residents of New York City or the New York Metropolitan Suburban region. No significant difference was found among epidemiological regions in the rate of adults using marijuana or "illicit drugs other than marijuana" in the past month.

Negative Consequences

The consequences of substance abuse affect millions of New York State residents annually. The individual, societal and economic costs include lost earnings and productivity, increased health care spending, alcohol and other drug related automobile crashes and other accidents, and increased need for law enforcement, corrections, and social services.

New York State hospitals recorded 58,882 drug-related hospitalizations in 2008, a rate of 31 per 10,000 residents, and an increase from the 57,790 drug-related hospitalizations in 2007. From 1999 to 2004 the rate of drug-related hospitalizations increased about 17 percent, from 29.7 to 34.9 per 10,000 residents. The statewide drug-related hospitalization rate declined from 2005 until 2007. The increase to 31 per 10,000 residents in 2008 is below the 2004 rate of 34.9, however. The New York Metro Suburban (23.5) and Rural New York (19.2) regions are responsible for most of the statewide rate increase. The 2008 drug-related hospitalization rate for New York City residents (42.1) is more than twice the rate in other regions of the state (19.2 – 23.5).

Figure 3.2

Drug-related Hospitalizations per 10,000 Residents by Year of Discharge, 2002-2008, by Region (SPARCS)

	2002	2003	2004	2005	2006	2007	2008
NY State	33.5	34.9	34.9	34.0	33.0	30.0	30.5
NY City	51.0	51.6	54.9	51.4	48.7	42.6	42.1
NY Metro Suburban	18.7	21.0	23.0	23.2	22.9	21.6	23.5
Upstate Metropolitan	14.0	16.7	17.8	20.1	20.8	20.3	20.8
Rural New York	10.4	12.8	16.7	17.3	18.3	17.6	19.2

Data Source: NYS Community Health Data Set, 2007. NYS Department of Health, SPARCS (Statewide Planning and Research Cooperative System) data as of February 2009. *http://www.health.state.ny.us/statistics/chac/hospital/drug.htm*

In New York State, 7,267 persons were injured or killed in alcohol-related motor vehicle accidents in 2008, a rate of 3.8 per 10,000 residents. From 2001 to 2008, the rate of alcohol-related motor vehicle injuries and fatalities decreased by more than 20 percent statewide. Among residents of Rural New York, the rate of injury or death in alcohol-related motor vehicle

accidents (7.2) is almost twice the statewide rate, while the rate for New York City residents (1.8) is less than half the statewide rate.

Figure 3.3

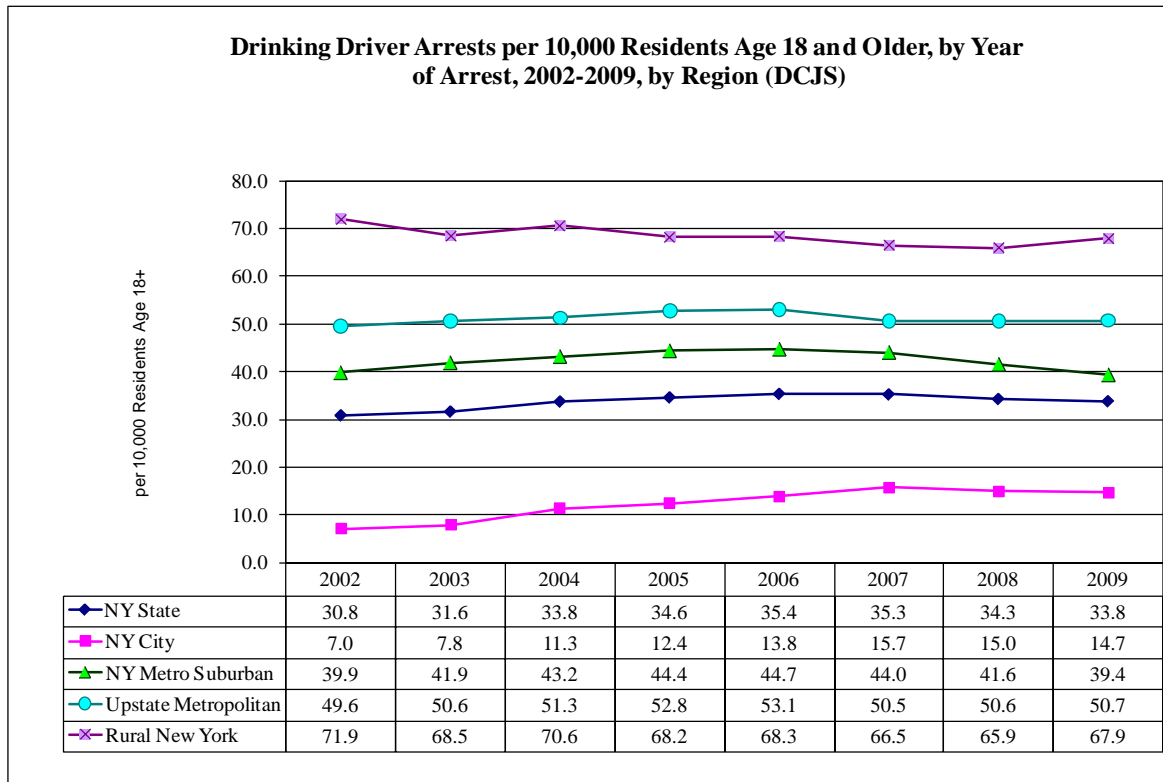**Alcohol-related Motor Vehicle Injuries and Fatalities per 10,000 Residents by Year of Accident, 2002-2008, by Region (DMV)**

	2002	2003	2004	2005	2006	2007	2008
NY State	4.9	4.3	4.4	4.2	4.0	3.9	3.8
NY City	2.0	1.8	1.7	1.9	1.9	1.8	1.8
NY Metro Suburban	6.3	5.5	5.9	5.5	4.9	4.8	4.9
Upstate Metropolitan	6.6	6.3	6.1	5.7	5.6	5.6	5.0
Rural New York	9.8	7.8	8.4	8.4	7.7	7.2	7.2
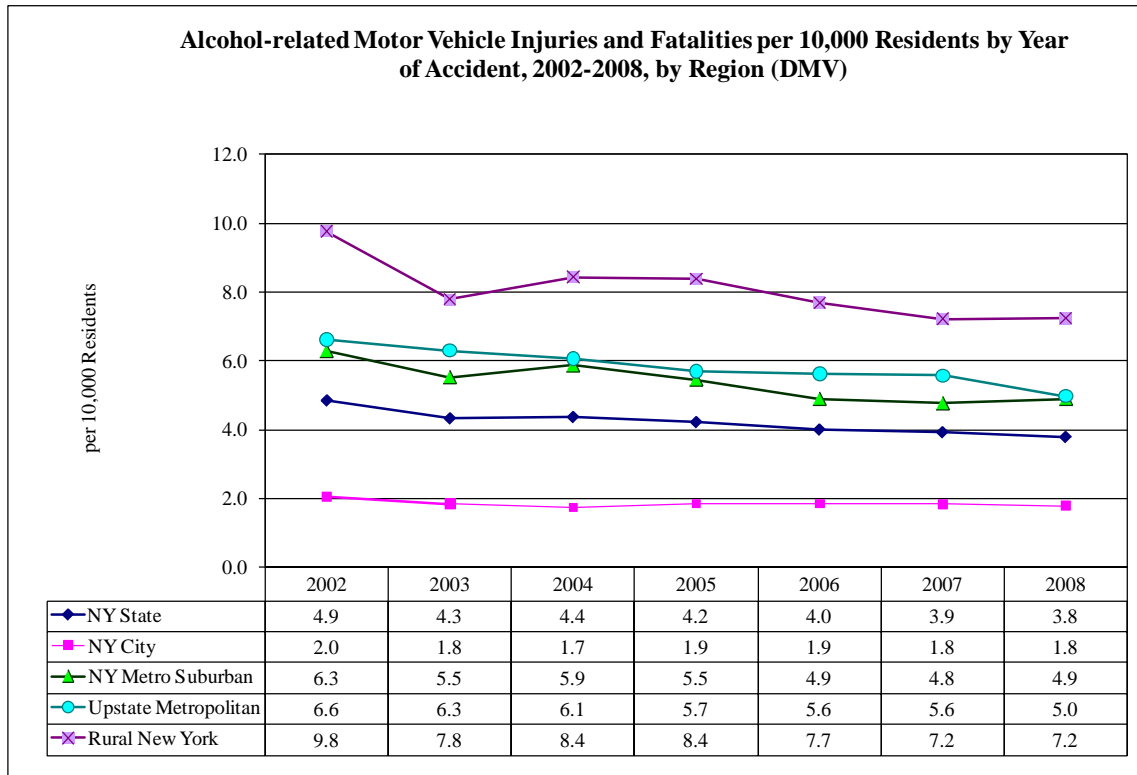
Data Source: NYS Department of Motor Vehicles, NYS Alcohol-Related Accident Data 2002-2007, provided by the NYS DOH, June 2009 (numerator). http://www.health.state.ny.us/statistics/chac/general/mvalcohol.htm

In 2009, law enforcement officials made 51,016 drinking driver arrests in New York State. Statewide, DWI arrest rates increased from 2002, reaching a high of 35.4 DWI arrests per 10,000 adult residents in 2006, but have declined slightly to 33.8 in 2009. The New York City drinking driver arrest rate more than doubled since 2002, reaching 15.7 in 2007, but then declined slightly to 14.7 in 2009.   Even with this dramatic increase, the New York City arrest rate is less than half the statewide rate, however.   The Rural New York drinking driver arrest rate has declined slightly since 2002, but it is still more than double the statewide rate, at 67.9 DWI arrests per 10,000 adult residents in 2009.
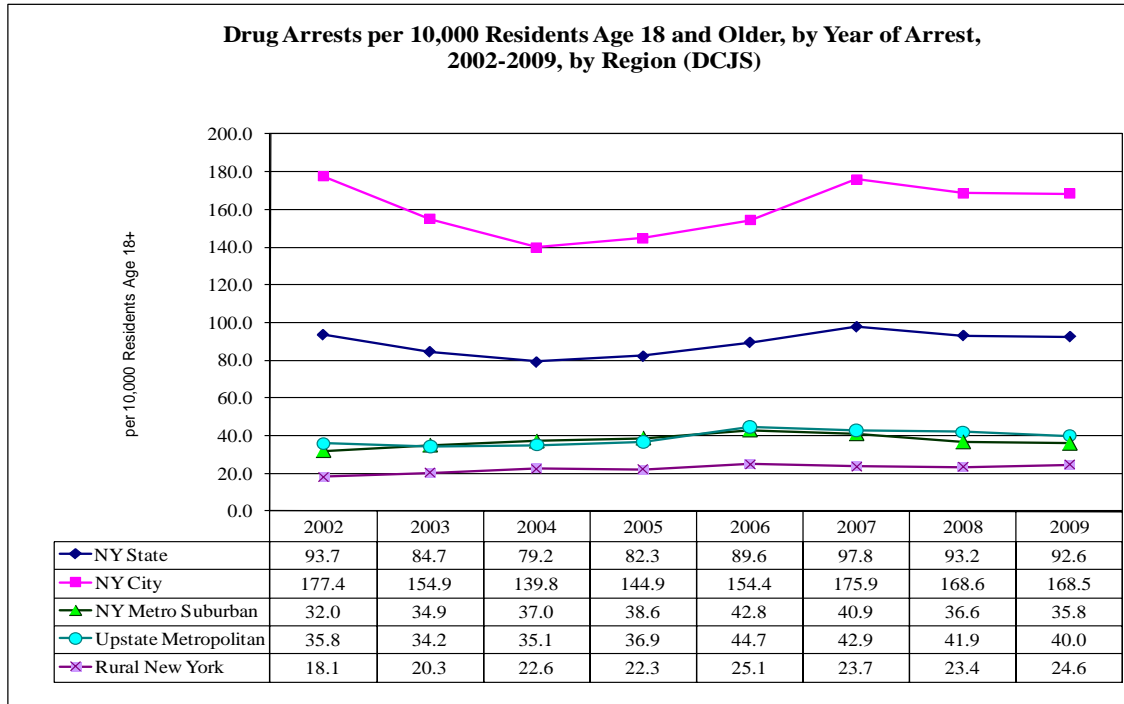
Figure 3.4

Drinking Driver Arrests per 10,000 Residents Age 18 and Older, by Year of Arrest, 2002-2009, by Region (DCJS)

	2002	2003	2004	2005	2006	2007	2008	2009
NY State	30.8	31.6	33.8	34.6	35.4	35.3	34.3	33.8
NY City	7.0	7.8	11.3	12.4	13.8	15.7	15.0	14.7
NY Metro Suburban	39.9	41.9	43.2	44.4	44.7	44.0	41.6	39.4
Upstate Metropolitan	49.6	50.6	51.3	52.8	53.1	50.5	50.6	50.7
Rural New York	71.9	68.5	70.6	68.2	68.3	66.5	65.9	67.9

Data Source: New York State Division of Criminal Justice Services, Computerized Criminal History system as of 01/2010 (numerator). Population estimates from the U.S. Bureau of the Census (denominator).
http://criminaljustice.state.ny.us/crimnet/ojsa/arrests/index.htm

The *2006 OASAS School Survey* indicated that one-in-six high school students age 16 and older drove under the influence of alcohol or another drug in the past year. New York City students ages 16 and older were half as likely as students in the rest of the state to have driven under the influence of alcohol or other drugs in the past year (11 percent vs. 22 percent). The *2006 OASAS Household Survey* indicates that one-in-eight young adults (ages 18-25) drove a vehicle after drinking or using drugs in the past year.

Figure 3.5

Drug Arrests per 10,000 Residents Age 18 and Older, by Year of Arrest, 2002-2009, by Region (DCJS)

	2002	2003	2004	2005	2006	2007	2008	2009
NY State	93.7	84.7	79.2	82.3	89.6	97.8	93.2	92.6
NY City	177.4	154.9	139.8	144.9	154.4	175.9	168.6	168.5
NY Metro Suburban	32.0	34.9	37.0	38.6	42.8	40.9	36.6	35.8
Upstate Metropolitan	35.8	34.2	35.1	36.9	44.7	42.9	41.9	40.0
Rural New York	18.1	20.3	22.6	22.3	25.1	23.7	23.4	24.6

Data Source: New York State Division of Criminal Justice Services, Computerized Criminal History system as of 01/2010 (numerator). Population estimates from the U.S. Bureau of the Census (denominator). http://criminaljustice.state.ny.us/crimnet/ojsa/arrests/index.htm

In 2009, there were 140,599 adult arrests for drug offenses in New York State, a rate of 92.6 arrests per 10,000 adult residents. Although the statewide arrest rate has fluctuated during the 2002-2009 time period, the current drug arrest rate is nearly identical to the 2002 figure of 93.7. The 2009 New York City drug arrest rate of 168.5 is slightly lower than the 2002 figure of 177.9, the highest drug arrest rate during the 2002-2009 time period. Drug arrests in New York City reached their lowest rate of 139.8 arrests per 10,000 residents in 2004. The rest of New York State portrays a different trend, with drug arrests increasing from 2002 until 2006, and then decreasing slightly from 2006 to 2009. Drug arrest rates are still higher in 2009 than in 2002 for all of the regions outside New York City. In 2009, the New York Metro Suburban region reported a drug arrest rate of 35.8, per 10,000 residents, while the Upstate Metro Region experienced an arrest rate of 40.0, with Rural New York reporting 24.6 drug arrests per 10,000 residents.

The *2006 OASAS School Survey* indicated that one-in-twenty students in grades 7-12 physically assaulted someone due to the influence of alcohol or drugs in the past year while a similar number got into trouble with the police due to alcohol or drug use. These rates did not vary significantly between New York City and the rest of the state. The *2006 OASAS School Survey* indicated that one-in-five students in grades 7-12 attended class while intoxicated on alcohol, marijuana or other drugs in the last six months and one-in-twenty-five students got into trouble with his or her teachers because of drinking or drug use in the past year. There is no significant

difference between New York City and the rest of the state in the percent of students attending class while intoxicated or getting into trouble with teachers due to drinking or drug use.

System Facts: Prevention

Prevention Activity and Results Information System (PARIS)

PARIS is a web-based information system that collects, organizes, and maintains data on activity planning and service delivery for OASAS-funded prevention providers. There is an annual prevention work plan development and approval process with review at the county and OASAS Field Office levels. Activity data collection templates for the planned services are automatically generated from the approved workplan. PARIS includes modules for activity planning, activity data collection, reporting, system administration, and user support.

A distinguishing feature of PARIS is the emphasis on the workplan process. Each provider is required to conduct an assessment of community needs, describe the population affected by those concerns, and then select service approaches for a targeted group of at-risk individuals. The OASAS and county review and approval process encourages the coordination of prevention activities.

PARIS captures direct service activities reported to OASAS by funded prevention providers. In summer 2011, OASAS added a Coalition Module to PARIS to incorporate information from providers of indirect prevention services such as those delivered by the regional Prevention Resource Centers (PRCs) and by 11 federally funded SPF SIG local community coalitions. As this module is enhanced and refined it will be made available to all prevention-related coalitions in the state.

Providers deliver Prevention Services through several Service Approach categories

1. Classroom Education Evidence-Based (EB) Programs ("Model" Programs):

   These are primarily school-based classroom education programs, which have been extensively researched and shown to reduce youth substance use. These programs use multi-session curricula to increase family and youth understanding of the consequences of substance use, improve drug use and other problem behavior attitudes, and teach drug refusal and other social skills. Examples are:

   - LifeSkills Training
   - Project SUCCESS
   - Project ALERT
   - Reconnecting Youth.

2. Classroom Education Non Evidence-Based (Non-EB) Programs (or "Non-Model" Programs):

These programs are similar to classroom education evidence-based programs described above, but have been modified or locally developed and have not been rigorously evaluated for effectiveness in meeting the OASAS Prevention goals and objectives.

3. Prevention Counseling:

This service is for individuals who are considered at highest risk and may require referral to more intensive services. Components of prevention counseling include assessment and referral, individual counseling, group counseling, and family counseling. "Counseling assessment" data in PARIS is a count of the total number of individuals assessed for alcoholism and substance use risk factors while "counseling session activities" is a summation of the total number of individual, group, and family counseling sessions conducted by a program in a given time period.

4. Positive Alternative Activities:

These programs consist of pro-social, constructive, and healthy activities that provide opportunities for positive social bonding, which has been shown by research to buffer the attraction to alcohol, tobacco, and other drugs and decrease the use of these substances. Examples are fitness-sports, arts, and cultural-multicultural activities that help to develop a healthy lifestyle.

5. Information Dissemination:

Information dissemination programs are prevention services directed at providing information to the general and specific populations about the issues of substance use or abuse and problem gambling. They are provided at community meetings and events or through media technologies such as newsletters, print media, video, radio, television, or the internet.

6. Community Capacity Building:

These services aim to enhance the ability to more effectively provide and integrate substance abuse and problem gambling prevention services within the community. Examples of these activities include training, technical assistance for schools and social providers, law enforcement, or other groups.

7. Environmental Strategies:

Environmental strategies are sets of evidence-based prevention activities that are implemented to: 1. improve or develop regulations and policies regarding alcohol/substance use and gambling; 2. increase compliance with regulations and policies to reduce the availability of alcohol, tobacco, other substances, and underage gambling;

and 3. change community norms regarding alcohol/substance abuse and problem gambling. Examples include alcohol outlet/retail lottery sales compliance checks, advertising restrictions, and social norms marketing.
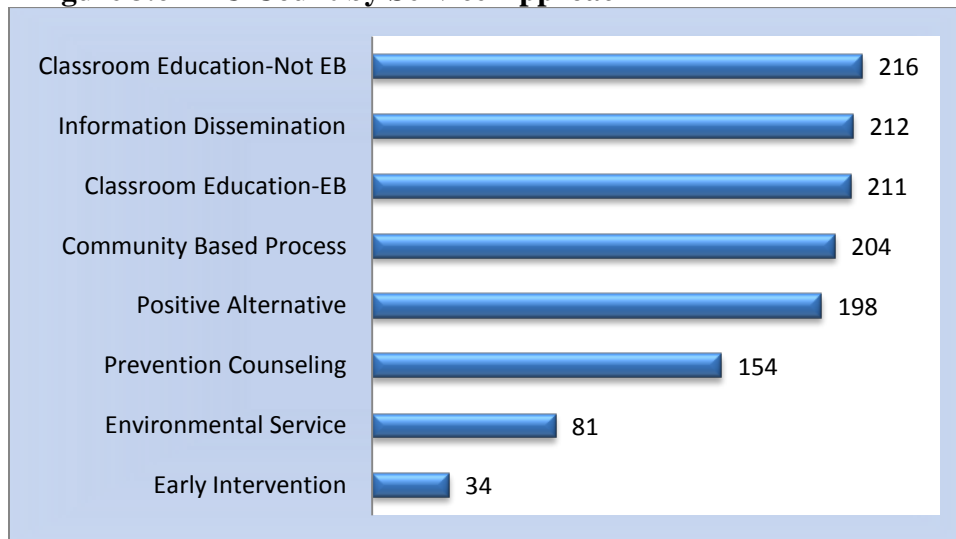
8. Early Intervention Strategies:

Early Interventions are services designed to address specific individual risk factors and substance use initiation behaviors that put a person at high risk for developing substance abuse problems. Early Intervention can be effective for Institute of Medicine (IOM) Indicated populations; *i.e.*, those individuals who have demonstrated early involvement with substance use and have specific individual risk factors that put them at high risk for developing substance abuse. Early Intervention services may include screening and referral to treatment services, but are not a substitute for treatment services. Examples of early interventions include the evidence-based program Teen Intervene and the New York State Alcohol Awareness Programs (AAPs).

Prevention Activity Data for 2010

Provider/PRU Count

- OASAS prevention providers deliver addiction prevention services mainly to youths and young adults through designated entities called Program Reporting Units (PRUs). Individual programs may provide multiple services in a county.

- A total of 282 PRUs delivered prevention services in 2010 with the highest number (216) delivering classroom education Non-EB services and the least (34) delivering Early Intervention services. (**Figure 3.6**)

Figure 3.6 PRU Count by Service Approach

Service Approach	Count
Classroom Education-Not EB	216
Information Dissemination	212
Classroom Education-EB	211
Community Based Process	204
Positive Alternative	198
Prevention Counseling	154
Environmental Service	81
Early Intervention	34

Table 3.2 Service Approach Percentages

Service Approach	PRU Count	
	n	%
Classroom Education - Not EB	216	77%
Information Dissemination	212	75%
Classroom Education – EB	211	75%
Community-Based Process	204	72%
Positive Alternative	198	70%
Prevention Counseling	154	55%
Environmental Service	81	29%
Early Intervention	34	12%
Total Number of PRUs	**282**	

EB = Evidence-Based.
Percentages do not add up to 100% because individual PRUs deliver multiple programs.

Participant Count:

- Substance Abuse prevention activities are broadly classified in two major categories: Direct (or Individual-based) services and Indirect (or Population-based) services. A total of 477,185 participants received direct prevention services during the 2010 activity year (**Table 3.3**).

- Even though Classroom Education non-EB services were done by the largest number of PRUs, the percentage of participants for Classroom Education EB services was the highest (49%) while Community-Based Process and Early Intervention strategies was the lowest (less than 1%; **Table 3.3**).

Table 3.3

Participant Count by Service Approach for Individual Based Services, 2010

Service Approach	Participant Count for Individual-Based Services	
	N	%
Classroom Education – EB	235,489	49.3%
Classroom Education - Not EB	146,975	30.8%
Community-Based Process	2,025	0.4%
Early Intervention	1,355	0.3%
Positive Alternative	48,750	10.2%
Prevention Counseling	42,591	8.9%
Total	**477,185**	**100%**

Activity Count:

- There were a total of 362,593 sessions, events, and activities delivered in 2010. Of these, 84% (304,318) were Individual-based and 16% (58,275) Population-based (**Table 3.4**).

- Almost half of the total number of Individual-based activities delivered was Classroom Education EB (44%), followed by Prevention Counseling (35%).

Table 3.4 Activity Count by Service Approach, 2010

Service Approach	Total Activity/Event Count	
Individual-Based	**N**	**%**
Classroom Education - EB	92,428	30%
Classroom Education - Not EB	72,656	24%
Community-Based Process	25,372	8%
Early Intervention	866	0%
Positive Alternative	37,777	12%
Prevention Counseling	75,219	25%
Total	**304,318**	**100%**
Population-Based		
Environmental Service*	40,197	69%
Information Dissemination	18,078	31%
Total	**58,275**	**100%**
Grand Total	**362,593**	

*Media Advocacy counts are excluded because of the complexity in delineating precise geographic boundaries and accurately estimating population exposure counts.

- Two types of prevention service approaches are generally considered "evidence-based" for OASAS' purposes. These are Classroom Education EB and Environmental Activities (**Table 3.4**).
- Providers are encouraged to provide evidence-based activities and in 2010, 25.5 percent of the total output was evidence-based, up from 14 percent in 2009.
- Over half (56 %) of the total number of classroom education sessions were evidence-based, compared to 50 percent in 2009.
- The percentage of environmental strategies also increased (from 13% in 2009) to 28.7 percent in 2010.

Table 3.5 Prevention Activity Performance Measures, 2010

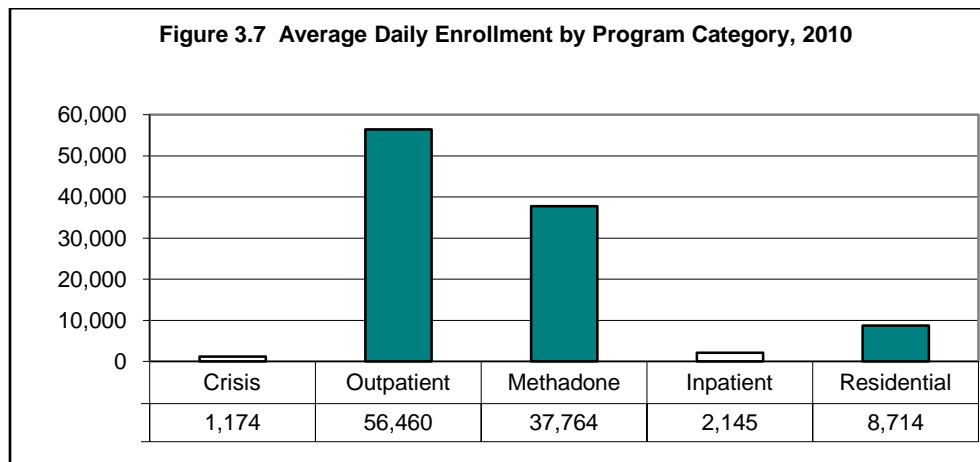| Activities	Percent
% Total Output that is Classroom Education (EB)	25.5%
*n-Classroom Education - EB (92,428)	
*d-Total Output (362,593)	
% Classroom Education sessions that are evidence-based	56.0%
n-Classroom Education - EB (92,428)	
d-Classroom Education: EB + Not EB (165,084)	

PRUs	Percent
% Programs delivering Classroom Education (EB)	74.8%
n-Classroom Education - EB (211)	
d-Total PRUs (282)	
% Programs delivering Environmental Strategies (EB)	28.7%
n-Environmental Service (81)	
d-Total PRUs (282)	

*n=Numerator, d=Denominator

System Facts: Treatment

System Summary

- In 2010, there were 309,667 admissions to OASAS certified chemical dependence treatment programs. Almost half of those admissions were to outpatient programs (47%), followed by crisis (30%), inpatient (13%), residential (7%), and methadone (4%).
- Average daily enrollment was 106,257 mostly in outpatient programs (53%), followed by methadone programs (14%) (**Figure 3.7**).

Figure 3.7 Average Daily Enrollment by Program Category, 2010

Crisis	Outpatient	Methadone	Inpatient	Residential
1,174	56,460	37,764	2,145	8,714

- 261,825 unique individuals received treatment in New York State during 2010.
- As shown in **Table 3.6**, there are just over 1,000 OASAS-certified chemical dependence treatment programs. Half (50%) of those programs are outpatient programs.

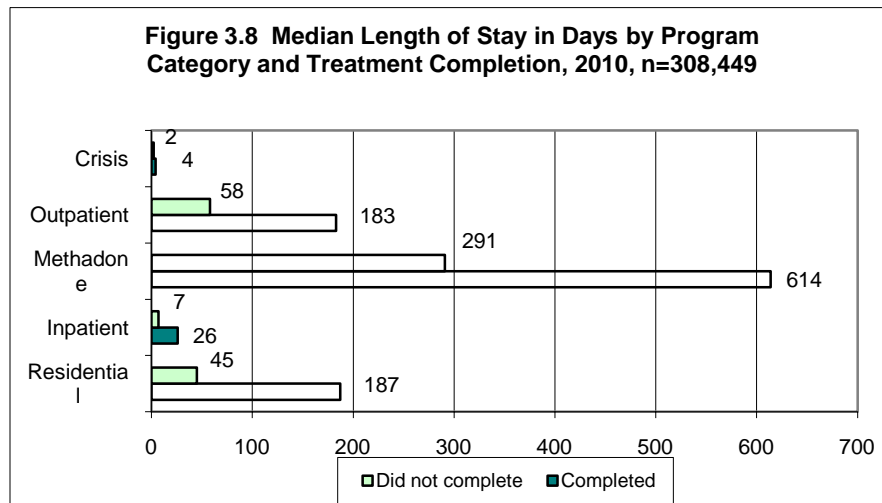**Table 3.6 Program Count by Region and Program Category**

	Crisis	Inpatient	Methadone	Outpatient	Residential	Total
Central	6	7	1	37	30	81
Finger Lakes	6	7	4	42	30	89
Long Island	7	7	8	83	13	118
Mid-Hudson	16	15	10	74	33	148
New York City	34	12	90	191	72	399
Northeastern	5	7	3	49	32	96
Western	5	8	4	49	22	88
Total	79	63	120	525	232	1,019
Program Category %	8%	6%	11%	50%	22%	

Client Characteristics

- Seventy-five percent were male.
- One-quarter of admissions were ages 45-54, followed by 35-44 (24%), 25-34 (23%), 18-24 (16%), 55 and over (8%), and under 18 (4%).
- Alcohol was the most common primary substance (44%), followed by heroin and other opioids (25%), marijuana (17%), and cocaine/crack (12%).
- Almost two-thirds (65%) of admissions had two or more problem substances.
- Seventeen percent reported a prescription drug as a primary, secondary, or tertiary substance.
- One-third (33%) reported a primary, secondary, or tertiary opioid.
- Forty-five percent were White non-Hispanic, 32 percent Black non-Hispanic, 20 percent Hispanic, and 3 percent other non-Hispanic.
- Thirty-nine percent of admissions were high school graduates, 36 percent had less than a high school education, and 25 percent had more than high school.
- Twenty-three percent were employed, 19 percent were unemployed, and 58 percent were not in the labor force.
- Forty-three percent were identified as having a co-existing psychiatric disorder or had ever been treated for a mental illness at admission.

- Eighteen percent were homeless.
- Three percent reported being a veteran.
- The most common referral source was self (33%), followed by criminal justice (23%), other chemical dependence programs (14%), health care/social services (12%), and chemical dependence prevention/intervention (4%).
- Fifty-three percent of non-crisis admissions had criminal justice involvement.
- Seventeen percent reported living with children.
- Sixty-one percent reported using tobacco at admission.
- Over half of discharges paid with Medicaid (56%), followed by none (13%), self (9%), private insurance (12%), DSS Congregate Care (5%), and other (5%).
- Thirty-nine percent completed treatment. Median length of stay by treatment completion and program category is shown in **Figure 3.8**.

Figure 3.8 Median Length of Stay in Days by Program Category and Treatment Completion, 2010, n=308,449

Crisis: 2, 4
Outpatient: 58, 183
Methadone: 291, 614
Inpatient: 7, 26
Residential: 45, 187

□ Did not complete   ■ Completed

Notable Trends

- The percentage of outpatient admissions has increased from 41 percent to 47 percent, while the percentage of crisis admissions has decreased from 33 percent to 30 percent between 2001 and 2010.
- From 2001 to 2010, the percentage who reported marijuana as their primary substance increased from 11 percent to 17 percent while alcohol decreased from 53 percent to 44 percent (**Figure 3.9**).

Figure 3.9 Trend for Primary Substance at Admission, 2001-2010
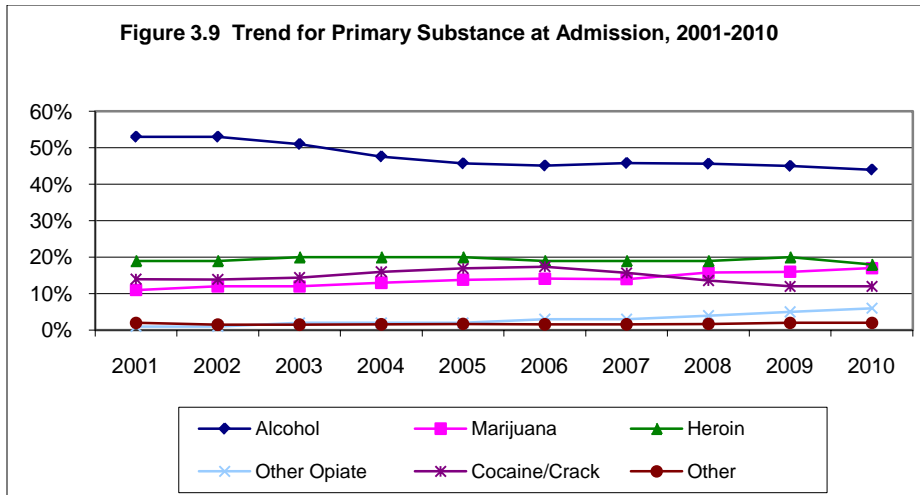
- Admissions in the 18-24, 45-54, and 55+ age groups increased between 2001 and 2010, while admissions in the under 18 and 35-44 age groups decreased (**Figure 3.10**).

Figure 3.10 Age Group Trend - All Services 2001-2010
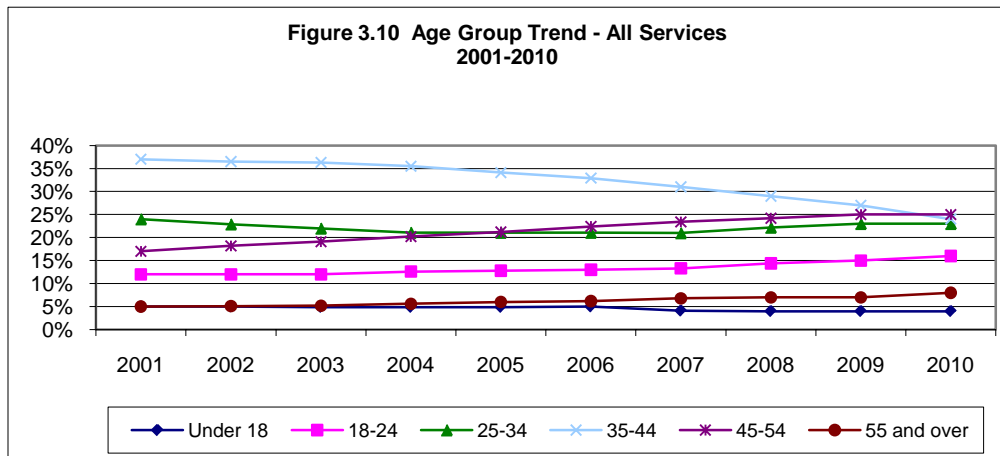
Geographic Comparisons

When comparing those who live in New York City to those who live in the rest of the state (ROS), those who live in New York City were:

- More likely to be male (80% vs. 70%);
- More likely to be over age 35 (69% vs. 47%);
- More likely to be non-Hispanic Black (45% vs. 20%) or Hispanic (32% vs. 10%);
- More likely to be admitted to a crisis program (40% vs. 21%) and less likely to be admitted to an outpatient program (36% vs. 56%);
- Less likely to have completed high school (56% vs. 71%);
- More likely to be homeless (26% vs. 10%);
- More likely to have a primary substance of heroin (22% vs. 15%) and less likely to have a primary other opiate (2% vs. 10%);
- Less likely to have a primary, secondary, or tertiary prescription drug (11% vs. 22%);

- Less likely to have a co-occurring mental health disorder (36% vs. 47%);
- Less likely to have criminal justice involvement (43% vs. 60%);
- More likely to pay with Medicaid (65% vs. 47%);
- Less likely to complete treatment in residential (33% vs. 45%), outpatient (28% vs. 34%), and inpatient (64% vs. 69%) programs.

Recovery

Few studies exist that attempt to estimate the number of individuals in recovery from addictive disorders. NSDUH provides estimates of the number of Americans 12 or older in need of treatment for alcohol or illicit drug problems in the past year as well as those who received treatment, but does not provide information about recovery status.

The *2001-02 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)* sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) provides a basis for a national estimate of the number of persons in recovery from alcohol dependence. The epidemiological literature based on NESARC has defined "persons in recovery" from alcohol dependence as persons who: have had an alcohol dependence condition in their lifetime based on having met at least three of the seven Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) criteria in the same year; have not met any of the DSM-IV criteria for dependence in the past year; and have not met any of the DSM-IV criteria for alcohol abuse in the past year. Based on this definition, persons in recovery may have engaged in high-risk drinking (such as binge drinking) or low-risk drinking in the past year. Thus, abstinence is not a requirement for being in recovery—only being non-symptomatic in terms of the DSM-IV diagnostic criteria. Less than half of the persons in recovery were abstinent in the past year.

The published literature based on NESARC does not directly provide an estimate of the number in recovery. However, careful analysis of this literature indicates that five to six percent of the adult population is "in recovery" from alcohol dependence, which constitutes 11 to 13 million Americans. These rates applied to New York would mean that 754,000 to 905,000 adult New Yorkers are in recovery from alcohol dependence. About two percent of the adult population, five million Americans, are in recovery and have been abstinent in the past year. This rate applied to New York would mean that 302,000 adult New Yorkers are in recovery and have been abstinent in the past year.

OASAS obtained a copy of the NESARC data set and is conducting a secondary analysis to determine the extent to which recovery estimates can be made for substances other than alcohol and whether more accurate figures for New York can be developed through synthetic estimation methods. The objective is to produce analyses of DSM-based estimates of recovery from Substance Use Disorders that will parallel the more global recovery estimates that the Partnership for a Drug Free America obtained from the OASAS-funded preparatory studies that were conducted for the Multistate Recovery Survey.

Multistate Recovery Survey

OASAS is sponsoring development of a Multistate Recovery Survey through The Partnership for a Drug Free America. The aims of this survey are to: capture the experiences and needs of individuals in recovery; characterize the diversity of recovery paths and experiences; and identify barriers to recovery, resources valuable in initiating and maintaining recovery, and service needs as recovery unfolds. Forty-six Single State Agencies (SSAs) have indicated a desire to participate in the Multistate Recovery Survey.

This survey will principally use a web-based questionnaire supplemented by other methods, such as, telephone surveying. Respondents will be solicited through community-based media. In addition, population parameters (e.g., the demographic characteristics of persons in recovery) will be estimated by supplementing the survey with data from items embedded in large scale randomized surveys.

OASAS has supported development of the survey instrument through contracting with the Partnership to implement a series of preparatory studies including focus groups and individual interviews with persons in recovery and obtaining national estimates of the size of population in recovery (based on self-identification) through the use of a brief household survey. To date, The Partnership has provided OASAS with reports of findings from these studies as well as a revised grant proposal package and will continue to seek federal and private foundation sponsors to support the research. If funded, the Multistate Recovery Survey will provide each participating state with information about persons in recovery in its state. This will enable the SSA to develop strategies for transforming to a recovery-oriented system of care (ROSC) based on the needs of its recovering population and the resources available in its communities.

Chapter IV: County Planning

New York State Mental Hygiene Law requires all counties and the City of New York to develop and annually submit a local services plan to each state agency. OASAS, OMH, and OPWDD are each required to "guide and facilitate the process of local planning." For the past four years, the three state agencies have worked collaboratively to ensure that local mental hygiene services are planned in a unified and fully integrated manner.

The ongoing collaboration among OASAS, OMH, OPWDD, and CLMHD through the Mental Hygiene Planning Committee resulted in local plan submissions this year that reflected a greater focus on cross-system planning than ever before. This shift in planning focus is evident in the number of county priorities that now address some level of cross-systems collaboration, service integration, or care coordination.

This chapter has summary analyses of OASAS-specific information contained in the 2012 local services plans, including county priority outcomes and a number of county and provider planning surveys that were conducted to provide OASAS with information in support of a variety of ongoing initiatives.

County Priority Outcomes

The *2012 Local Services Plan Guidelines for Mental Hygiene Services* provided counties with an opportunity to develop priority outcomes and associated strategies in a consistent manner across the three mental hygiene disabilities. The guidelines enabled counties to identify and address cross-systems issues in a more comprehensive and person-centered manner by allowing for the development of priorities and strategies for each separate disability planning area as well as those areas that affect multiple systems.

This year, county plans included a total of 587 priority outcomes, which was down six percent from the previous year and 18 percent from the first year of integrated planning. The reduction in the number of priorities is primarily due to the continued consolidation of priorities that are common to multiple disability areas. In a time of fewer resources, more counties are reducing the number of priorities from their plans so they can focus on a smaller more realistic set of targeted outcomes. This year, counties included a total of 1,375 separate strategies associated with these priority outcomes.

Table 4.1 shows the trend in county priorities by disability area over the four years of integrated planning. In the most recently completed planning cycle, 48 percent of all county priorities involved more than one mental hygiene disability, including 32 percent that crossed all three disability areas. Over the four-year period, the number of single disability priority outcomes dropped by 32 percent while priorities involving two disabilities dropped by 17 percent. Only the number of priorities involving all three disabilities has gone up, increasing by 19 percent in the four-year period. A review of the priorities suggests that the counties are focusing their planning efforts more directly on those outcomes that most affect persons with co-occurring disorders who may need services from multiple systems, or persons within each system that may need similar services (e.g., housing, transportation, employment, etc.).

Table 4.1: County Priority Outcomes by Disability Area (2009-2012)

Disability Combination	2009	2010	2011	2012	Change
OASAS Only	121	111	87	71	-41.3%
OMH Only	118	116	100	90	-23.7%
OPWDD Only	208	167	154	144	-30.8%
OASAS/OMH	67	57	62	65	-3.0%
OASAS/OPWDD	0	0	0	1	---
OMH/OPWDD	45	45	42	27	-40.0%
OASAS/OMH/OPWDD	159	170	182	189	18.9%
Total	718	666	627	587	-18.3%

OASAS-Related County Priorities

Table 4.2 shows the distribution of county priority outcomes by five major categories. Because many of the priorities fall under multiple categories, the percentages do not add up to 100 percent. For example, a priority to expand outpatient treatment services for adolescents would be listed under "Expansion of Treatment Services" and "Services Targeting Adolescents." To provide relative weight across multiple priorities, counties were asked to identify their top two priority outcomes by disability. The final column in the table shows the percentage distribution of all priorities identified as a "top two" in the county plans.

Table 4.2: 2012 County Priority Outcomes by Category (N=326)

Priority Outcome Category	Percent of Total (N=326)	Top Two Priority (N=106)
Expansion/Enhancement of Services	**60.4%**	**63.2%**
• Treatment/Crisis Services	18.4%	19.8%
• Prevention Services	16.0%	15.1%
• Recovery Support Services	25.8%	29.2%
Services Targeting Special Populations	**23.9%**	**32.1%**
• Co-Occurring Disorders	13.8%	22.6%
• Adolescents/Youth in Transition	8.3%	9.4%
• All Other Populations	5.2%	2.8%
Cross-System Collaboration/Service Integration	**23.6%**	**31.1%**
Planning/System Management/Financing	**16.0%**	**17.0%**
Workforce Development	**8.9%**	**2.8%**

NOTE: This table reflects an analysis of priority outcomes completed by 55 of 57 LGUs.

Expansion/Enhancement of Services

The largest number of county priorities could be classified as expanding or enhancing existing services and, to a lesser extent, developing new services to address an unmet need. As **Table 4.2** shows, 60 percent of all priorities and 63 percent of all "top two" priorities fall into this category. This category was further subdivided into treatment and crisis services, prevention services, and recovery support services.

Priorities related to **treatment and crisis services** primarily focused on expanding access to existing services by making systemic reforms, implementing evidence-based practices, and targeting services to specific populations. While priorities varied considerably and many priorities addressed a general enhancement of treatment services, the following represent the most frequently mentioned priorities:

- Expand services to special populations (13); including adolescents (8), persons with co-occurring disorders (7);

- Reconfigure/reform/expand the crisis services system to provide greater access (10);
- Develop/expand/enhance outpatient treatment services (9);
- Implement evidence-based treatment practices and/or medication supported treatment options in existing services (8);
- Develop new gambling treatment services (6);
- Provide/expand services to opiate-dependent individuals, including expanding access to buprenorphine (5).

Priorities related to **prevention services** primarily focused on a general expansion or enhancement of prevention and education services in the community, collaborating with community partners to better coordinate and target prevention services in high need areas, and addressing particular problems in the community. Most prevention-related priorities can be categorized as follows:

- Focus prevention efforts on particular problems or substances (13); including suicide (4), underage drinking (4), FASD (2), prescription drugs (1), nicotine (1), and opiates (1);
- Implement evidence-based models and best practices in existing prevention services (9);
- Develop or expand access to gambling prevention services (8).

Priorities related to **recovery support services** focused on a number of specific and interrelated issues, such as housing, transportation, vocational and educational services, peer support, wellness, etc. However, a significant number of recovery-related priorities simply addressed the need for non-specific "recovery supports" or "recovery-oriented person-centered services." Most recovery support priorities can be categorized as follows:

- Housing (36) – Safe and affordable housing continues to be one of the most pressing needs and top priorities identified in the county plans. In particular, transitional housing with individualized supports for those leaving treatment was noted by many counties as necessary to support recovery and to achieve independence within the community. One county noted that it was piloting a "person-centered screening tool designed to match individuals to desired housing settings." Some counties identified specific populations in need of supported housing, including persons with co-occurring disabilities, women with children, and formerly incarcerated individuals. It is important to note that 45 percent of all housing-related priorities were identified as a "top two" priority, the highest percentage of any priority category.

- Vocational Services (23) – Many individuals leave treatment unprepared to enter the workforce, lacking sufficient education and employment skills to obtain and keep a job. Several counties identified priorities that address the need to provide more vocational services, such as vocational assessments and skill building. Other priorities included integrating vocational services into treatment and establishing stronger linkages between treatment providers and vocational service providers. One county recommended that OASAS training resources be used to support treatment staff efforts to provide vocational training services.

- Transportation (14) – The lack of available transportation was identified by several counties as one of the greatest barriers to accessing needed services, including health care, education, and employment. The lack of public transportation in remote rural counties continues to be a problem. County priorities focused on finding available, cost-effective alternatives to public transportation, such as establishing peer-run transportation programs and supporting coordinated transportation programs across service systems and between providers.

- Other Supports (22) – Other recovery supports identified include: wellness/recovery care management (6), peer/family support (6), educational services (5), and case management (3). Two counties included a priority to establish a recovery center.

Services Targeting Special Populations

All priorities in this category were associated with priorities in other categories, primarily expansion/enhancement of services (48%) or cross-system collaboration/service integration (55%). Consistent with the increasing focus of county priorities on addressing problems across systems, 58 percent of all priorities identifying target populations identified persons with a co-occurring disability, while 35 percent identified adolescents or youth in transition, and 22 percent identified other populations. The following is a summary of the kinds of priorities associated with each target population.

- Persons with Co-Occurring Disabilities – While persons with co-occurring disabilities were specifically referenced in about 14 percent of all county priorities, they were associated with nearly 23 percent of all "top two" priorities. This demonstrates the importance counties place on serving this population. Roughly half of all priorities associated with this population involved improved cross-system collaboration, mostly within the mental hygiene system of care, but also with other systems such as criminal and juvenile justice and health care. Providing care coordination, care management, or case management services were specifically identified by seven counties. Thirteen counties had priorities associated with providing integrated services, including implementing evidence-based practices and models of care for the co-occurring population. Six counties identified the need for regulatory, programmatic, policy, or funding reforms at the state level to remove barriers to providing integrated mental hygiene services. Additional priorities included providing earlier identification and engagement in treatment, improved access to support services, and increased cross-training of clinicians in each treatment system.

- Adolescents/Youth in Transition – While several priorities focused on a general expansion of services targeted to adolescents, nearly half specifically addressed the needs of adolescents with co-occurring disabilities or youth in transition. The primary focus of priorities associated with adolescents with co-occurring disabilities included increasing cross-system collaboration and expanding specialized treatment services (including trauma) and supports. Seven counties specifically identified youth in transition (generally aged 16 to 24) as a priority population, with efforts focused on providing developmentally appropriate services and better coordination between the youth and adult

service systems. One county noted that providing a seamless transition from adolescent services to adult services will help to avoid a possible transition to the social services or criminal justice system.

- Other Populations – A small number of priorities identified additional populations that services need to be targeted to, primarily through collaboration with other systems or by providing specialized services that address their unique circumstances. These populations included elderly (4), criminal justice involved (4), trauma involved (2), and women with children, veterans, persons with physical health conditions, and the uninsured (1 each).

Cross-System Collaboration/Service Integration

The number of county priorities related to cross-system collaboration or service integration increased once again this year, representing 24 percent of all priorities submitted in the plans and 31 percent of the "top two" priorities. Most priorities involved working to better coordinate services within the behavioral health system and across other systems in which behavioral health clients may be involved. An increased number of priorities this year focused on service integration, while a few priorities addressed actions that need to be taken at the state level in order for collaboration or integration to occur.

- Cross-System Collaboration – While most priorities involved greater collaboration between behavioral health agencies, many county priorities focused on broader collaboration with other systems, including local health departments, criminal and juvenile justice systems, social services agencies, and schools. Seven priorities specifically included providing care coordination or case management services to persons with co-occurring disabilities. Four priorities included establishing or expanding Single Point of Access (SPOA) programs.

- Service Integration – The topics most frequently covered by these priorities included providing dual diagnosed capable services (6), providing access to evidence-based practices or innovative service models for the dual diagnosed population (4), and improved assessments and referrals of individuals who may need services from multiple systems (4).

- State Agency Reforms – Eight separate priorities focused on advocating for state agency reforms that would make it easier to develop and provide innovative programming for the co-occurring population. These included funding and rate setting changes; allowing for dual certification of services; and easing regulations, eligibility criteria, and programming requirements that are seen as barriers to service integration.

Planning/System Management/Financing

Approximately 16 percent of all priorities in this year's plans addressed planning and needs assessment, system performance management, or funding issues. This is twice the percentage reported in the category last year, suggesting an increased effort by counties to ensure that shrinking resources are allocated in the most efficient and cost-effective manner. Several

priorities addressed targeted needs assessment efforts and development of quality indicators for measuring system performance. While a small number of priorities addressed the need to maintain funding levels or find alternative funding sources, more counties are trying to assess the impact of major reforms, such as health care reform, Regional Behavioral Health Organizations, and Ambulatory Patient Groups.

Workforce Development

Nine percent of all priorities involved workforce development issues, yet they represented only three percent of the "top two" priorities. There were a slightly higher percentage of workforce-related priorities included in this year's plans compared to last year, yet this was the only major priority category that was less represented among top priorities than among all priorities.

As in previous plans, most workforce-related priorities addressed the need to recruit and retain qualified direct care staff, particularly in rural counties where the talent pool is much smaller. Other priorities focused on the need for cross-training of chemical dependence and mental health clinical staffs, raising the cultural and linguistic competency level of clinicians, and providing more staff training on evidence-based practices, and service models that address the needs of persons with co-occurring disabilities.

Outcomes Management Survey

OASAS remains strongly committed to the use of outcomes management by the agency and the field. The *OASAS 2011 Outcomes Dashboard,* which includes five new priorities identified by Commissioner González-Sánchez, demonstrates this commitment. One of these priorities is to "Utilize outcome management concepts that focus on performance measures and hold both OASAS and its providers accountable." With that goal in mind, OASAS continues to encourage the use of outcomes management through a three pronged strategy that includes modeling its use by OASAS managers, engaging the field to better understand local approaches, and reaching out to other New York State agencies and states to share best practices.

In terms of the use of outcomes management internally, the Division of Outcome Management and System information established these metrics:

> *Commissioner's Priority Metric #7: Outcome Management is actively used across the addiction system by a critical mass of OASAS and Field leaders and managers.*
>
> a) *Increase the percentage of local government units and providers that report setting targets and measuring progress over time.*
> b) *Increase the percentage of local government units and providers that report reviewing outcomes at least quarterly.*
> c) *Increase the percentage of local government units and providers that report using data to monitor performance.*
> d) *Maintain the number of Outcome Management Communities of practice (CoP) in which OASAS either serves as a facilitator or is a participating member.*

To track progress in achieving this outcome in the field, the Outcomes Management Survey was administered to counties and providers again this year as part of the local planning process. This is the third year the Outcomes Management Survey was administered to counties and providers, although this year some modifications were made to the data collection instrument. Survey questions were refined to distinguish between established outcomes management programs and the less formal use of performance measures. Questions were added to elicit more specific information about data sources, data management, and data dissemination. Although these changes limit the number of comparisons that can be made to the previous years' data, these refinements provide more meaningful data moving forward. The data analysis method was also refined this year to separate responses by provider type (treatment versus prevention) as OASAS is at a different point with each in identifying outcomes and using data to measure performance.

The following table summarizes the results of the survey against the 2011 metrics:

Table 4.2: 2011 Outcomes Management Survey Results

	Baseline	Target	Result
1. Outcome Management is actively used across the addiction system by a critical mass of OASAS and Field leaders and managers.			
a. Increase the percentage of local government units and providers that report setting targets and measuring progress over time.	40% (LGU) 60% (Providers)	45% (LGU) 70% (Providers)	57% (LGU) 88%(Prevention) 82%(Treatment)
b. Increase the percentage of local government units and providers that report reviewing outcomes at least quarterly.	53%(LGU) 70% (Providers)	55% (LGU) 80% (Providers)	46% (LGU) 66%(Prevention) 71%(Treatment)
c. Increase the percentage of local government units and providers that report using data to monitor performance.	42% (LGU) 61% (Providers)	45% (LGU) 70% (Providers)	54% (LGU) 83%(Prevention) 80%(Treatment)
2. Maintain the number of Outcome Management Communities of practice (CoP) in which OASAS either serves as a facilitator or is a participating member.	4	4	4

A slight majority of the counties that completed the 2012 Outcomes Management Survey reported active engagement in performance measurement and the use of data. Fifty-seven

percent (32 of 58) reported the use of performance targets and described the county agency as having an active outcomes management program in place. Of those, 91 percent have been using outcomes management for three or more years. While there are those counties well-versed in the use of outcomes management, there remains a significant number of counties (43% or 26) not yet using outcomes management.

OASAS encourages counties to work collaboratively on outcomes management so that those not using this approach to program or contract management could benefit from those with experience. An Outcomes Management Community of Practice (CoP) would provide this opportunity; that is to share experience using performance measures to track outcomes and learn from others' experience in using this approach to program management. More than half (64%) of the counties surveyed said yes to participating in an Outcomes Management CoP.

When asked how often the county reviewed progress toward performance targets, 81 percent of the counties that use performance measures indicated reviewing targets at least quarterly. Such frequent monitoring suggests the regular use of data is well-integrated into the county agency operations, which is very positive. The types of data the counties use includes: IPMES (72%); program scorecards (63%); and, other sources (75%). The majority of the other sources of data were county-specific performance contracts, county generated data, or program reports developed by the county. Counties also cited the County Profile available in CPS as another data source they use.

Survey questions also addressed how counties use performance information and disseminate data. Annual reporting was the single most common method for sharing written summary information about the performance of contracted programs. Almost all counties use the performance information for planning and making decisions regarding program services at 94 percent and 91 percent, respectively. Budgeting is the third area in which performance information is used to support decision making. In terms of with whom counties discuss performance, program administrators (90%) and the Community Services Board (81%) were the most frequently cited.

More than half of counties using performance management (56%) report discussing performance information with OASAS. This, taken in conjunction with the number of counties that report not using performance measures or outcomes management, means that OASAS has an opportunity to further engage counties in the use of data to track outcomes. Overall, three-quarters of counties are not engaging in data driven communication with OASAS. Clearly, engaging counties in how to increase the use of performance measurement is an important next step for OASAS.

There were similar results for provider survey responses. A majority of prevention and treatment providers report using outcomes management to track performance. Sixty percent of prevention providers and 49 percent of treatment providers indicate they discuss performance information with OASAS. These findings provide OASAS with the opportunity to be more proactive in discussing and using performance data with providers. A high percentage of both provider groups report using performance measures (prevention 66% of 209 respondents and treatment 82% of 397), which, therefore, leaves a relatively small number of providers not engaged in

using data to track performance. A smaller portion of providers have yet to engage in the use of outcomes management and more providers are actively using data, but not necessarily in dialogue with OASAS.

For those providers who are using performance measurement, the analysis revealed similar results to that discussed for the county-based survey. A majority of the providers using performance measurement assess progress on a regular (at least quarterly) basis (prevention 74% and treatment 86%). In reviewing this information on a regular and frequent basis, providers are demonstrating the use of data as part of an information feedback loop. This is exactly the type of behavior demonstrated by organizations that practice an outcomes management approach to decision making.

The type of data used by treatment versus prevention providers varies with prevention relying more heavily on data sources like the Youth Development Survey, school records, proprietary databases, and pre-and post testing. Client surveys are a significant source of information for both treatment and prevention providers. **Table 4.3** illustrates the use of data sources by the two provider groups.

Table 4.3 Data Sources used by Prevention and Treatment Providers

Data Source	Prevention	Treatment
Scorecard	16%	48%
IPMES	23%	69%
Focus Groups	26%	8%
Client Surveys	50%	59%
Other Data Source	46%	26%

Treatment and prevention providers discuss performance measures and progress with the same main target groups, as well as share the same primary method for disseminating this information. Providers report discussing performance outcomes with programs administrators and staff most often at 77 percent and 84 percent for prevention and 91 percent and 89 percent for treatment. The extent to which providers share this information with OASAS was discussed previously and, again, is an area where OASAS can foster greater communication and use of the data. Annual reporting is the most common mechanism used by both groups to share performance information. Seventy-three percent of prevention providers and 85 percent of treatment providers who use performance measures share the results in an annual report format. Planning, developing program services, and staff supervision are the key areas of program management where providers make use of performance information.

Clinical Supervision and Qualifications Survey

In 2011, OASAS surveyed the treatment provider community to obtain a clearer understanding of the composition of that segment of the workforce providing clinical supervision as well as how they divide their time between administrative tasks and staff supervision. This information is critical as OASAS and its service delivery system prepare for the substantial transition that will occur with national health care reform, introduction of scopes of practice, sunset of the Social Work Licensure exemption, and the push for better integrated substance abuse and mental

health services. As stated in *TIP 52 – Clinical Supervision and Professional Development of the Substance Abuse Counselor*, "clinical supervision enhances the quality of client care; improves efficiency of counselors in direct and indirect services; increases worker satisfaction, professionalization, and retention; and ensures that services provided to the public uphold legal mandates and ethical standards of the profession."

In addition to getting a better understanding of who provides clinical supervision and how they do it, the survey data provides a solid baseline for talent management leaders to analyze as they develop strategies for enhancing clinical supervision skills and competencies. The results of the survey are grouped into three general areas: (1) composition of the clinical supervision workforce; (2) clinical supervision practices; and (3) recipients of clinical supervision.

Composition of the Clinical Supervision Workforce

With a survey response rate of 97 percent, the data provides a nearly complete picture of clinical supervision in New York's addiction treatment system. However, there is evidence to suggest that some entries may have been incomplete because that data was not necessarily submitted for all clinical supervisors on staff. Nevertheless, OASAS is confident that the high response rate is sufficient to give a reasonably accurate snapshot of how clinical supervision is being provided and received.

Based on the responses, the OASAS treatment provider community currently employs a total of 1,164 clinical supervisors, 85 percent (989) of whom are full-time and 15 percent (175) who are part-time. Of the total population of clinical supervisors, survey respondents indicated that 90 percent (1,058) were Qualified Health Professionals (QHPs) versus ten percent (106) who were not. **Figure 4.1** shows the breakdown of clinical supervisor QHP designations, from most common to least.

Figure 4.1: Distribution of QHP Clinical Supervisors (N=1,058)
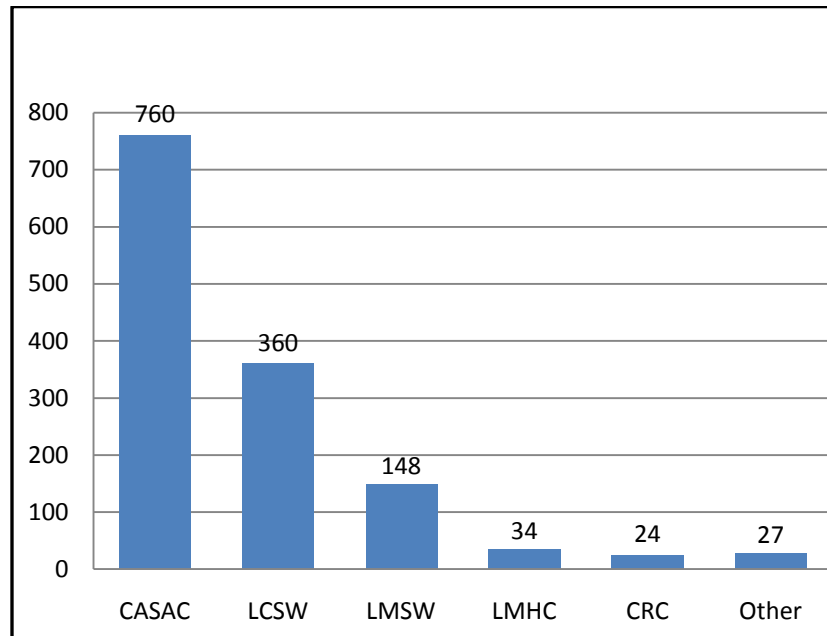
Survey results showed some notable trends:

- More than half (54 percent) of the clinical supervisors who have a CASAC also have another professional license or designation.
- More than 26 percent of clinical supervisors with a CASAC also are Licensed Clinical Social Workers (LCSWs) or Licensed Master Social Workers (LMSWs).
- Forty-six percent of clinical supervisors are CASACs with no other professional license or designation.
- Twenty-six clinical supervisors who currently lack QHP status are expected to become QHPs by July 1, 2013, the day the Social Work licensure exemption sunsets.

Several observations may be made based on these statistics. Clinical supervisors in New York are largely dominated by CASACs, LCSWs, and LMSWs. This bodes well considering that CASACs are permanently exempt from the restrictions that will be placed on non-licensed personnel in the OASAS system in 2013 and LCSWs and LMSWs have defined scopes of practice that will allow them to continue functioning as clinical staff. (Note: LMSWs cannot supervise LCSWs.) It also provides reasonable assurances that the vast majority of practitioners functioning as supervisors have met a high standard of competency either through licensure or the OASAS credentialing process. Finally, it underscores the need to work with that segment of the clinical supervisor population (106 supervisors) who do not have QHP status to help them achieve it and solidify their standing as gatekeepers for the profession.

Clinical Supervision Practices

A second area that the Clinical Supervision survey attempted to capture was how clinical supervisors divide their day, in terms of activities ranging from administrative duties to managing their own caseload, as shown in **Figure 4.2**. Not surprisingly, on average, 47 percent of a clinical supervisor's time is devoted to administrative duties. This is consistent with feedback that has surfaced from clinical supervisors who say they are "drowning in paperwork." Face-to-face supervision – largely recognized as the cornerstone of professional skill development – is regrettably limited to 16 percent (less than one day in a five-day work week) of a clinical supervisor's time. On the positive side, it was noted that 98.2 percent of all supervisors engage in face-to-face supervision. This is reassuring, especially considering that individual supervision is acknowledged as the most labor intensive and time-consuming method of supervision.

Figure 4.2: Allocation of Time Devoted to Clinical Supervisor Activities
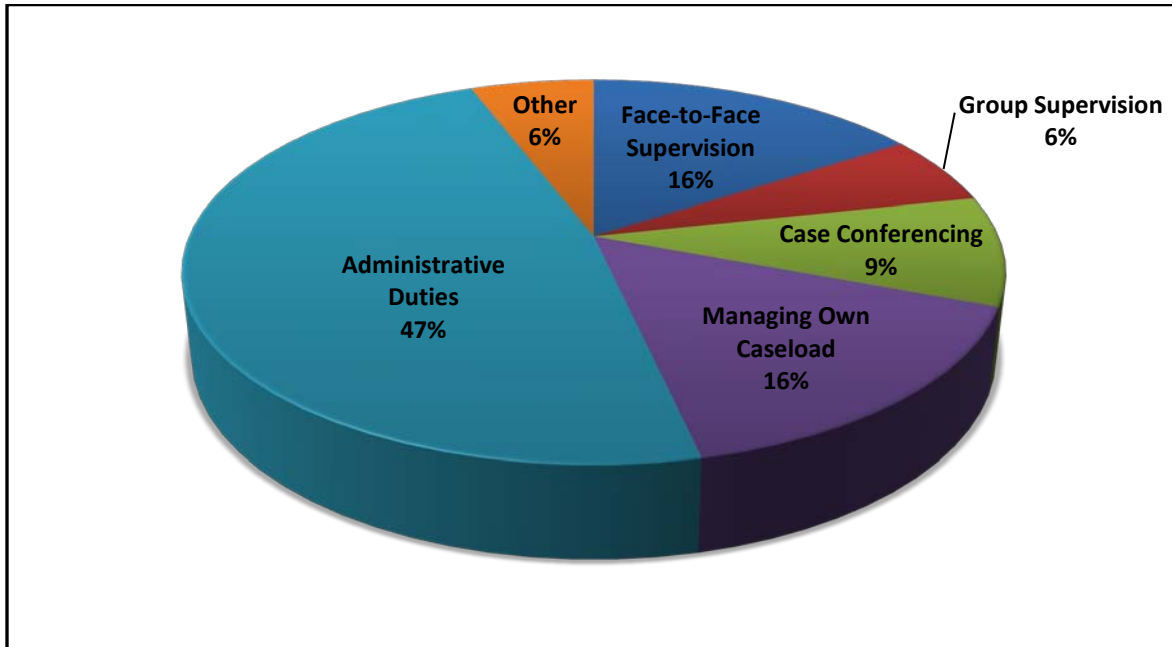
The survey also shed light on clinical supervisors who, in addition to their clinical supervision responsibilities, manage their own caseload. An estimated 47 percent of clinical supervisors (554) carry their own patient caseload, which limits the time available for supervisory tasks. This is often a function of program size or staff turnover, but time dedicated to this activity (16 percent overall) clearly impacts the overall effectiveness of clinical supervisors as teachers, mentors, coaches, and role models.

Among the central principles of clinical supervision, TIP 52 identifies implementation of evidence-based practices (EBPs) as a critical role for supervisors. Supervisors are uniquely positioned to determine which EBPs are relevant in their organization and how they can be successfully integrated into ongoing programmatic activities. In the Clinical Supervision survey, respondents were asked to identify specific EBPs that clinical supervisors had implemented in their agencies. Motivational interviewing, cognitive behavioral therapy, and motivational enhancement therapy were the three most common EBPs reported. Seventy percent (821) of all clinical supervisors were reported to have supervised the implementation of EBPs in their agencies. This suggests that a sizeable proportion of clinical supervisors have not yet engaged in this kind of activity. Whatever the reason, this points to a need to better train clinical supervisors in their role as teachers in helping counselors develop new clinical skills and knowledge about the application of EBPs.

Recipients of Clinical Supervision

The third area of focus was on those direct care staff who receive clinical supervision. The survey captured two types of information in this area: (1) how many direct care staff are supervised by clinical supervisors; and (2) what are the qualifications of the supervisors

compared to licenses/credentials held by their supervisees. Overall, full-time clinical supervisors (989) were reported to supervise an average of 5.6 direct care staff.

Figure 4.3: Number of Direct Care Staff Supervised by Clinical Supervisors
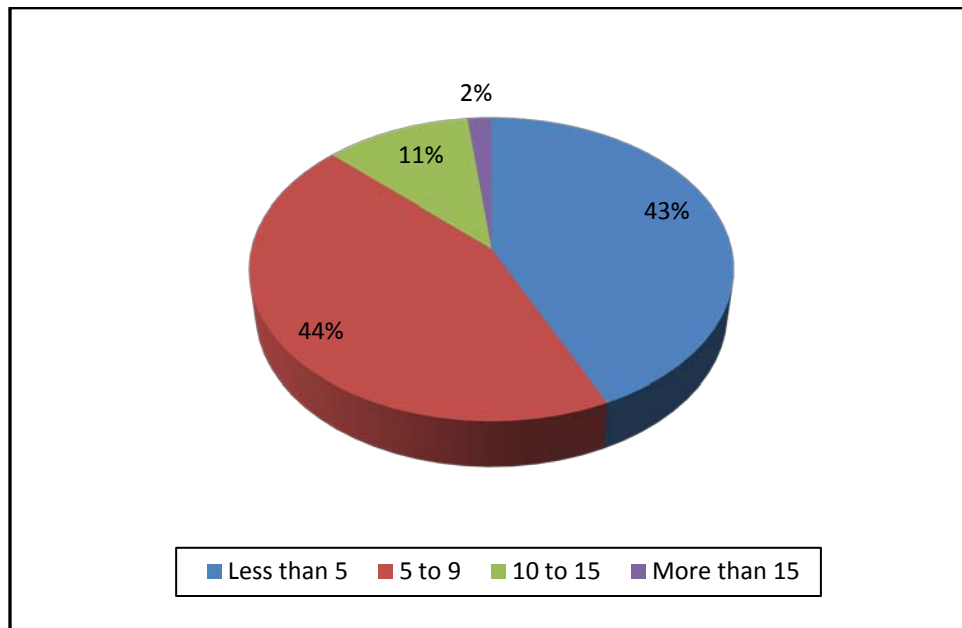
Two key observations may be made relative to the number of direct care staff supervised. First, the statewide average of 5.6 supervisees per supervisor is, in most agencies, a reasonable and manageable number of staff to oversee in the context of supporting the professional development of those being supervised. TIP 52 emphasizes the importance of the relationship between the clinical supervisor and supervisee as critical to a positive learning alliance. However, as the number supervised increases, the potential for effective clinical supervision diminishes, especially considering the limited opportunity for face-to-face supervision. Given our second observation that more than 13 percent of clinical supervisors supervise ten or more direct care staff, a substantial number of clinical supervisors continues to be challenged in their ability to provide quality supervision.

In our last analysis, OASAS sought to identify the number of unlicensed clinical supervisors who may be supervising licensed professionals in New York. The extent of this supervisory relationship will be important as the addictions treatment system prepares for the sunset of the Social Work licensure exemption. The survey determined that 11 percent (130) of clinical supervisors are unlicensed CASACs who supervise licensed social workers. This relationship may be challenged with the sunset of the exemption given that CASACs, by statute, are not considered qualified supervisors of social workers. Likewise, the survey found that 12 percent (145) of clinical supervisors are LMSWs who supervise the delivery of clinical services. Like CASACs, LMSWs are also at risk of being displaced, given the limitations of their scope of practice with respect to supervising clinical social work. Combining these two groupings of clinical supervisors, up to 25 percent (275) of clinical supervisors are at risk of displacement in 2013, unless action is taken to mitigate the potential impact.

Domestic Violence Assessment and Referral Survey

OASAS is a member of the State Office for the Prevention of Domestic Violence's (OPDV's) Domestic Violence Advisory Council. As part of its participation on this Council, OASAS added questions to its client discharge report on whether or not a client was ever a victim or perpetrator of domestic violence. In 2010, 11.3 percent of patients discharged from non-crisis chemical dependence treatment programs reported being victims of domestic violence and 5.2 percent reported being perpetrators.

OASAS conducted a survey of treatment programs during spring 2011 to determine the extent to which programs are assessing and referring individuals to the domestic violence provider system when appropriate. The results will provide OASAS and OPDV with additional information to better meet the needs of individuals affected by both substance use disorders and domestic violence.

A total of 1,022 treatment programs were surveyed, with 990 (96.9%) responding. Ninety-four percent reported that they screened their incoming clients for whether or not they were domestic violence victims. Since most OASAS programs do not provide treatment for domestic violence, referrals must be made to a domestic violence program. Ninety-one percent of those programs that screen also reported referring people to appropriate services, mostly to domestic violence programs, coalitions, or mental health programs.

Eighty percent of programs responding to the survey reported screening clients for whether or not they had a history as a domestic violence perpetrator. Seventy-seven percent of those programs reported making referrals to appropriate services. Most programs referred to a spousal abuse group, anger management therapy, or mental health services.

Discussion and Implications

The relationship between substance use disorders and domestic violence complicates treating individuals affected by both. If both problems are not addressed, the effectiveness of interventions for each could be seriously compromised. The vast majority of treatment programs report screening clients for a history of domestic violence. While more programs reported screening and referring victims of domestic violence than reported screening and referring perpetrators of domestic violence, more information is needed to assess the reasons for and implications of this difference.

While the incidence of a client's self-reported domestic violence history appears to be under-reported in the discharge data, the number of programs reporting that they screen clients does not seem to account for this disparity. Therefore, more information is needed regarding the types of screens used and the efficacy with which they are implemented. This could help to determine if there is a need for different protocols regarding the use of screening tools such as when, where, and how the screening occurs during the course of treatment. A comparison between self-reported information and a review of client records could also help to assess the validity of self-reporting a history of domestic violence. The survey results will also be shared with OPDV's

Domestic Violence Advisory Council to obtain additional guidance related to identifying and referring clients with a history of domestic violence and improving recovery outcomes.

Older Adult Services Survey

OASAS conducted a survey of treatment programs during spring 2011 to help the agency develop a plan targeting age-sensitive services to older adults (defined here as aged 60 and over). The survey sought to identify treatment approaches used with this population so that OASAS can assist programs in adapting protocols and enhancing clinical skills that will improve the availability and accessibility of services tailored to the needs of older adults. Additionally, OASAS seeks to engage addiction treatment programs in multi-faceted community service networks that will improve the availability and quality of services provided to older adults.

A total of 1,007 treatment programs were surveyed, with 976 (97%) responding. Programs that provide services exclusively to adolescents were not included in the survey. Of the programs responding to the survey, 81 percent reported that older adults represented less than ten percent of their treatment population (72% in NYC; 86% in the rest of the state), while only about six percent reported that they constituted at least 20 percent of their patients (10% in NYC; 3% in the rest of the state).

Older adults are referred to treatment from a variety of sources. Seventy-three percent of responding programs indicated that they received older adults through self-referral. That was followed by the criminal justice system (64%), the health care system (58%), a family member (55%), a Drinking Driver Program (39%), and a senior center (8%). The most striking regional differences were in programs receiving referrals from the criminal justice system (NYC: 51%; ROS: 72%) and a Drinking Driver Program (NYC: 19%; ROS: 51%). Among "Other" referral sources not specifically listed were local Departments of Social Services, mental health programs, adult protective services, providers of homeless and various residential services, employers, and veterans services programs. Only 16 percent of programs reported receiving referrals from a senior center. While senior centers may not typically refer individuals to treatment, they do provide information and assistance to caregivers and professionals that provide services to older adults.

Twenty percent of treatment programs also reported having formal service agreements with community-based service providers to improve the accessibility and coordination of addiction services for older adults. That percentage is higher in New York City (27%) than in the rest of the state (15%). **Table 4.4** shows the top seven community-based service entities that programs reported coordinating services with for older adults. While programs across the state reported the most service agreements with mental health services, crisis services, and hospitals, there are some regional differences when it comes to other types of organizations. Most notably, New York City programs are much more likely to have formal agreements with visiting nurses (54% to 8%) and pharmacies (39% to 13%), while programs in the rest of the state are much more likely to have formal agreements with housing services (40% to 20%).

Table 4.4: Formal Coordination of Services for Older Adults within the Community

Community-based Service Entity	Statewide N=188	New York City N=96	Rest of State N=92
Mental Health Services	70.7%	71.9%	69.6%
Crisis/Detoxification Services	59.0%	64.6%	53.3%
Hospitals	58.0%	60.4%	55.4%
Adult Protective Services	37.8%	41.7%	33.7%
Visiting Nurses	31.4%	54.2%	7.6%
Housing Services	29.8%	19.8%	40.2%
Pharmacies	26.1%	38.5%	13.0%

When asked if any of five specific screening and assessment tools developed for older adults were utilized by their program, only 31 percent indicated that any of them were used. The tool most frequently used was the CAGE Questionnaire, reported by 28 percent of survey respondents. That was followed by the Michigan Alcohol Screening Test - Geriatric Version (MAST-G) used by 11 percent and the Alcohol Use Disorders Identification Test (AUDIT) used by ten percent of programs. Only about three percent indicated that their program used the Instrumental Activities of Daily Living Scale (IADL) or the Geriatric Depression Scale (GDS).

Eight percent of treatment programs reported providing discrete specialized services targeted to older adults. That percentage is slightly higher in New York City (13%) compared to the rest of the state (5%). Of those programs that do provide discrete services, 57 percent reported that they had at least one staff member who completed training courses in gerontology. Programs were asked to indicate the types of discrete services they provided to older adults. At least 90 percent indicated that their program delivered individual counseling (96%), group-based approaches (94%), and cognitive behavioral approaches (90%). Other services included outreach to other organizations (73%), marital/family therapy (72%), and nicotine replacement therapy (65%). Only seven programs (9%) indicated that they provided reminiscent therapy which uses prompts, such as photos, music, or familiar items from the past to encourage the patient to talk about earlier memories. Reminiscent therapy is generally offered to people in their later years who have mood or memory problems or need help dealing with the difficulties that come with aging.

In addition to the service approaches listed above, programs that reported providing discrete services to older adults were asked if they utilized specific tools in delivering those services. Blackboards and flipcharts were used by 38 percent of programs, followed by simultaneous visual and audible presentation of material (32%), and enlarged print (25%). Ten percent of programs use peer supports such as recovery coaches to work with older adults.

The key focus of the OASAS Older Adult Initiative is to engage addictions providers with community organizations that are already involved in providing services to older adults. OASAS will use the findings of this survey to update its existing plan and enhance programming for the growing older adult population. The agency will assist programs and professionals in adapting standardized protocols and enhancing skills that will improve the availability and accessibility of quality services tailored to the needs of older adults.

Veterans/Military Services Survey

In spring 2011, OASAS conducted a survey of treatment programs to assess the extent to which addiction services are provided to veterans and active military service members, identify possible gaps in available services, and identify ways to improve the quality and effectiveness of services to veterans and their families. The survey also sought to determine how addiction services are provided as well as any specific therapeutic models being utilized. For the purposes of this survey, a veteran was defined as any individual who had previously served or is presently serving in the armed forces of the United States.

A total of 1,007 treatment programs were surveyed, with 976 (97%) responding. Of those programs responding to the survey, 72 percent indicated that they had provided treatment to veterans during the previous 12 months. However, only three percent reported that they operated a veterans specific track or group separately from programs for non-veterans. Half of those veterans groups were conducted within residential treatment programs.

Approximately half of the programs that reported providing treatment to veterans also indicated that they collaborated with outside veterans organizations in the delivery of those services, primarily the United States Department of Veterans Affairs (VA) (29%) and county-level veterans agencies (21%). Another nine percent indicated that they collaborated with the New York State Division of Veterans' Affairs (DVA). Twenty-two percent reported they had veterans on staff that provide treatment services to fellow veterans. When asked to indicate which of two topic areas would be most beneficial in meeting their program's staff training and development needs with respect to veteran's services, 71 percent identified Skill Building Training (i.e., use of specific evidence-based practices). Thirty percent indicated that Competency Level Training (e.g., working with co-occurring disorders, engaging the family, nicotine addiction, gambling, etc.) would be most beneficial.

Programs were asked if they utilized any of several different treatment approaches with veterans. The three approaches most frequently utilized included Motivational Interviewing (84%), Relapse Prevention Therapy (82%), and Cognitive Behavioral Therapy (75%). Twenty-five percent of programs reported utilizing Trauma-informed Care, while 22 percent reported utilizing Motivational Enhancement Therapy.

In addition to providing various treatment approaches to veterans, 43 percent of programs provide vocational services, 27 percent provide services to family members, and seven percent offered veterans-oriented recovery services.

The experiences of these providers will be helpful in identifying particularly effective treatment approaches, therapies and evidence-based practices which OASAS may share with the field in the form of guidance documents. In addition, the survey data as well as any anecdotal information will form the basis for skill-building training programs. More importantly, this information will enable OASAS to initiate work on planning, developing, and refining a programmatic service model responsive to the needs and characteristics of veterans.