Report on Behavioral Health Focus Groups

Prepared for
Center for Regional Healthcare Innovation
Westchester Medical Center

By
Markowitz Consulting

November 6, 2014
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Introduction
This qualitative research was designed to obtain input from staff and peers of partner provider organizations for the development of DSRIP project plans on:

- The integration of behavioral health (BH) services, including mental health (MH) and substance use (SU) services, with primary care (PC) services.
- Community-based BH crisis stabilization services.

The groups focused on services for adults, while recognizing that children, teens and people with developmental disabilities have similar needs.

Participants used varying terms for adults needing or using BH services, but this report employs “clients” for consistency.

Because this research is qualitative in nature, the findings are not projectable and should be used for directional guidance only.
Focus Group Question Areas

• Perceptions of the current use and integration of BH and PC services: what is working and not working for providers and clients, and why

• Suggestions about how to better integrate BH and PC services, including feedback on collaborative models for integration of BH and PC services

• Perceptions of the current use of ERs by BH clients: what is working and not working for providers and clients, and why

• Suggestions about how to help BH clients obtain care other than in ERs, including feedback on components of a comprehensive crisis stabilization system
Focus Group Design Overview

Six focus groups
- Four groups with providers
- Two groups with peers

Participants
- 39 providers from 24 organizations
- 14 peers from 6 organizations
- From 7 counties: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester

Dates
- October 7 – 9, 2014

Locations
- Poughkeepsie, NY
- Newburgh, NY
## Focus Group Participant Qualifications

<table>
<thead>
<tr>
<th>Providers</th>
<th>Peers</th>
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<tbody>
<tr>
<td>• Provide direct services at least 50% of the time in an ambulatory or community setting</td>
<td>• Provide direct services</td>
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<tr>
<td>• Have “lived experience” which informs their work with clients</td>
<td>• Have “lived experience” which informs their work with clients</td>
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<tr>
<td><strong>A mix in each group:</strong></td>
<td><strong>A mix in each group:</strong></td>
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<tr>
<td>• From MH, SU and PC organizations</td>
<td>• From MH, SU, PC, and peer organizations</td>
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<tr>
<td>• Including:</td>
<td>• Including:</td>
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<tr>
<td>o MH and SU clinicians (therapists, social workers and counselors), care/case managers and coordinators, and outreach staff, including in mobile vans</td>
<td>o Client, family and diversion advocates, recovery specialists, companions, care and housing coordinators</td>
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<tr>
<td>o PC physicians, nurse practitioners, social workers, and case managers</td>
<td>o A training coordinator, a wellness services director, an operations support manager, and a peer diversion and forensic connection specialist</td>
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</table>
Focus Group Recruitment Process

Source
- Behavioral Health Workgroup Master List

Outreach
- Contacted 33 organizations by phone and email*
- Asked each to identify 3 to 6 potential candidates**

Screening & Confirmation
- All candidates contacted by phone and/or email
- Qualified participants contacted at least 3 times

* 4 organizations disqualified because provided only residential or inpatient services
** PC providers generally unavailable to participate
**Overview of Key Themes that Emerged from the Research**

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Client Engagement &amp; Activation</td>
<td>• Relationships between providers and clients</td>
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<tr>
<td>Communications &amp; Transition Management</td>
<td>• Shared treatment plans and other information</td>
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<td></td>
<td>• “Ruthless follow-up”</td>
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<tr>
<td>Access to Expanded Services</td>
<td>• Workforce, service hours and resources</td>
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<tr>
<td>Beyond Healthcare in the Community</td>
<td>• Integrated community resources</td>
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<td></td>
<td>• Community outreach and education</td>
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<tr>
<td>Building on Successes</td>
<td>• Replicable effective local programs</td>
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</tbody>
</table>
Participant Input on Integration of Behavioral Health and Primary Care Services
How would you describe the integration of BH and PC services in your community?

To me it looks like the person’s a pinball. The [client] goes from here to there all over the place, and has a very difficult time just focusing in on, “Where do I get all this care?” -- Peer, Recovery Center Program Manager
Providers and peers described:

• Marginalized BH clients
• Disempowered, disenfranchised BH clients who may not understand purpose for PC referrals
• Shortage of resources in both BH and PC services
• Providers in silos (BH vs. PC; providers vs. peers)
• Increasing caseloads
• Poor communication among providers
• Non-responsive providers, sometimes lacking BH training
• Tension over medical model vs. recovery model
• Long waits to see psychiatrists, driving BH clients to PCPs and ERs for medications.
Providers and Peers Speak

Many providers are not comfortable – they need to be trained to be more comfortable with SA and MH people. -- Provider

We can’t find psychiatrists willing to help our population -- drug addicted, seriously mentally ill. -- Provider, MH/SA Program Supervisor

Clinics are overwhelmed. We can’t do the follow-up so the care managers obsessively spend time following up with clinicians to keep informed. -- Provider

No one goes to a doctor and says they are in substance abuse treatment. They are afraid that doctors will treat them differently. -- Provider, SA Counselor

Primary care doctors don’t know what we do. They are not aware of what is out there regarding health homes. -- Provider, Health Home Care Manager

The doctors are not talking with each other. -- Peer
Health Homes not yet meeting their promise

• Some providers and peers were optimistic about the Health Home model, especially when medical records become more accessible across sites.

• Peers generally raised concerns about Health Homes:
  o Over-emphasis on increasing the enrollment numbers
  o Unrealistic caseloads for care managers
  o Ineffective relationships with clients based on short telephone contacts.
Providers and Peers Speak

Moving toward Health Homes – this may be a remedy to problems.
-- Peer, Recovery Specialist

[This will be] a great system when we have access to all medical records.
-- Provider, Health Home Care Manager

They have doubled and tripled the caseloads. What is the expectation of clients after hearing about the Health Home? No one has time to do the job. I feel person-centered is out the window.
-- Peer, Assistant Care Manager

Health Homes need to be a home, but it is not a home at all.
-- Peer, Trainer

In Health Homes, people just get counted if they make a phone call. I am concerned that this is the new fast way. You need to have a connection with someone to really do this work.
-- Peer, Crisis Response Coordinator
Community and Cultural Challenges for BH Clients

Providers and peers described:

- Lack and cost of transportation
- Unstable housing and homelessness
- Scarcity of BH services and resources
- Changing and inadequate insurance
- Lack of BH understanding among police and throughout the criminal justice system
- Fear and stigma surrounding BH clients
- Biases in various ethnic communities and age cohorts.
How do you go to treatment when you are living in a shelter, with no support?
-- Provider, Mental Health and Substance Abuse Therapist

[Clients] have no stable address and are struggling to survive. Seeing a doctor is far down the list.
-- Provider, Housing Counselor

We’re working with an Asian family and his big thing is, “Please, if my parents find out, it’s the end of me.”
-- Peer

We need to involve law enforcement. It is not us and them; they are part of the continuum.
-- Peer

People are fearful if they see someone talking to themselves on the street. They run away rather than offer to help.
-- Provider
Participant Reactions to Collaborative Care Models
Three Approaches to Collaborative Care

**Coordinated**
- BH and PC are coordinated through information exchange, but delivered in different locations

**Co-located**
- BH and PC are provided in the same location by the same or different agencies, with more informal information exchange possible

**Integrated**
- BH and PC are provided in one treatment plan in separate or same location
• Most providers and peers believed that a single, integrated treatment plan would help solve communication challenges and facilitate better coordination of care, including:
  o Fewer delays and errors, and better follow-up
  o Reduction in “doctor-shopping” by clients.
• Some peers and providers were concerned that this approach would limit clients’ choices of providers.
• Peers emphasized that clients be actively involved in creating shared treatment plans to insure success.
Providers and Peers Speak

This allows for more interdisciplinary dialogue. The system is in place even if someone is less receptive.
-- Provider, Mobile Team Social Worker

If everyone understands and works that way and communicates, there is less confusion; everybody is on board.
-- Peer, Assistant Care Manager

If only the providers sign on, we will only have their agenda. We need the client-centered approach. Otherwise, the plan will tank.
-- Provider, MH Social Worker
Co-located Care model elicited mixed reactions

There was a range of reactions to the co-located care model:

- One location would be more convenient for clients.
- Single location would facilitate sharing information and reduce delays.
  - “Informal information exchange” was appealing but may present HIPAA issues.
  - Ideal would be having PCP at MH clinic.
- Co-location would limit clients’ choices to providers at same location.
- Some clients prefer to keep providers separate because of BH stigma.
- It would be challenging to coordinate multiple agencies at the same location.
Providers and Peers Speak

One location is best – no transportation problems.
--- Peer

I like the ability to share information and collaborate informally in the moment. You would avoid unnecessary ER visits right there – solve a problem before it becomes a crisis.
--- Provider

If an in-house psychiatrist was in the same building as an outpatient service, they would be familiar with that person. It would be easier for them and for us.
--- Provider, MH/SA Therapist

People want more choice of providers. If it’s in the same location, they don’t have a choice.
--- Peer, Assistant Care Coordinator
Coordinated Care model was liked least

• Providers and peers felt this model described the current dysfunctional system.
• Providers and peers felt this model is overwhelming for clients to cope with.
• Some peers felt this model offered clients more choice of providers and more control over sharing BH information with PC providers.
Providers and Peers Speak

I see the same obstacles we have in the current system.
  -- Peer

Things fall through the cracks and clients feel insignificant and unimportant.
  -- Provider, MH/SU Counselor

This is time-intensive – faxing, calling – really ridiculous. It’s like the system we have now.
  -- Provider, Mobile Van Clinician
Participant Suggestions for Integrating BH and PC Services
Establish respectful interpersonal connections between clients and providers

• Providers and peers emphasized the importance of:
  o Establishing supportive relationships built on continuity and trust to overcome fear and stigma.
  o Educating and supporting clients to know and exercise their rights as healthcare consumers, especially regarding choice of providers and other options.
• Clients’ desire for discretion regarding sharing diagnoses and medications with providers was noted, as was the tension between providers needing this information.
• Peers were recognized as having unique skills in this area.
Involve clients in developing shared treatment plans that include recovery goals

• Providers and peers wanted to see increased use of patient-centered treatment plans that include:
  o Clients’ responsibilities for their role in the treatment plan
  o Clarity about the role of each provider
  o Opportunities to engage family, partners and other key support people.

• Peers and some providers suggested including recovery, life and wellness goals, with peers recommending Wellness Recovery Action Plans (WRAP).

• Some providers and peers noted that co-locating services might inhibit clients’ choice of providers.
Share information and plans throughout multidisciplinary teams

• Sharing information was seen as key to facilitating the integration BH and PC care, whether co-located or not.
  o All providers would benefit from being informed and in agreement with the plan.
  o Multidisciplinary teams would benefit from training specifically focused on working across medical silos to better coordinate BH and PC services.

• Incorporating peers into treatment teams across the BH spectrum was suggested to increase mutual understanding and respect between providers and peers.
Provide transition management at every stage of treatment and recovery

• Providers and peers stressed that BH clients are vulnerable during any time of change, especially:
  o Inpatient to outpatient and vice versa
  o BH provider to PC provider and vice versa
  o When referred to other providers
  o During stages of crisis.
• Providers and peers thought transitions need to be better managed, requiring additional outreach, support and care management to ensure successful outcomes.
• Focusing on transitions was seen as providing opportunities for enhanced collaboration between providers and peers.
Improve access to expanded PC, BH and non-medical services

Providers and peers accentuated the need for more PC and BH providers, tools and other supportive services, including:

- More PCPs and more psychiatrists
- A single, integrated screening process
- Improved management of and access to medications
- Viable options to the ER, especially after office hours
- More mobile BH units
- More respite beds and available for longer than 48 hours
- Housing assistance
- Transportation assistance.
Reduce fear and stigma through community outreach and education

- Providers and peers stressed the need to change community attitudes toward BH clients to:
  - Reduce fear and stigmatization
  - Educate about alternatives to calling an ambulance or using the ER.
- Reaching out to families, community groups, clergy, police, and criminal justice system staff was suggested.
- Targeted outreach to specific communities where the stigmatization and fear are greatest was emphasized.
Learn from what is working, including local “small successes”

Focus group participants mentioned:

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<td>Westchester Jewish Community Services</td>
<td>Warm line with licensed BH clinicians on call</td>
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<td>Hudson River Healthcare</td>
<td>Referrals to MH resources</td>
</tr>
<tr>
<td>Welcome Orange</td>
<td>Warm hand-offs to providers</td>
</tr>
<tr>
<td>MHA Ulster</td>
<td>Programs with police and RN students to reduce fear and stigma about BH</td>
</tr>
<tr>
<td>State Healthcare Navigator</td>
<td>Mobile access to Medicaid coverage</td>
</tr>
<tr>
<td>PEOPLe, Inc.</td>
<td>Peer-run MH advocacy and service organization</td>
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Participant Input on Crisis Stabilization Services
What are the things that trigger a crisis that sends someone to the ER?

To someone who has mental illness and a medical issue and no housing and all of these other things, and they’re running out of meds, it is a crisis every day. That’s how they experience life.

-- Provider, Mobile Team Social Worker
Use of ER ingrained in BH culture

Providers and peers described use of ER as:
• Learned behavior in some families and communities
• Access to needed medications after-hours, on short notice
• Warm, safe place to stay if suddenly homeless
• Place care cannot be refused, often at low or no cost to clients
• Immediate gratification, without waiting for an appointment or Medicaid card
  o BH clients may not have stable PCP relationships
  o PCPs may refer BH clients to the ER to avoid risk
• Only 24/7 option in some communities
• Place clients taken by police.
Providers and Peers Speak

They go to the ER because they have lost housing. They can have a place to eat and stay.  
-- Provider

There is a sense of urgency. They can’t handle feeling powerless and hopeless.  
-- Peer

It’s difficult to get an appointment at an OPD clinic so if they lost their meds and the primary care provider does not feel comfortable prescribing meds, they go to the ER.  
-- Provider, Helpline Staff

Clients are left on their own so the patient ends up in the ER not able to access a primary care doctor.  
-- Provider, Social Worker

They all go to the ER. It’s what their friends and families do. -- Provider

They need three hots and a cot and to sleep for a couple days.  
-- Peer

The undocumented have to use the ER for primary care or they go untreated.  
-- Provider, Care Manager
ERs often not appropriate for BH crises

Providers and peers noted:

• Ambulance and ER experience can increase agitation.
• Appropriately trained BH staff may not be available.
• ER staff sometimes dismisses or ignores physical problems.
  o Assume every problem is psychiatric
  o Suspect SU clients of “med-seeking”
• MH and SU clients may be isolated or ignored in ERs during after-hours and weekends.
• ER treatment is short-term with no guarantee of follow-up after discharge.
Providers and Peers Speak

There should not even be an ambulance. Some people get more hyped up in there.
-- MH Peer Advocate

They look at your history and see ex-addict or whatever and immediately forget about the medical condition and start treating you for mental health or substance addiction.
-- Peer

The ED can handle a hysterical person on a medical issue. Why not be able to deal with a mental health person in the ED?
-- Peer, Assistant Care Manager

[The ER] puts them in a separate room, stripped of their clothing and identity.
-- Peer, Hospital Diversion and Forensic Connection Specialist

The smaller community hospitals can’t afford to have a psychiatrist in the hospital 24/7. The psychiatrist is on-call, so we have to call in the doctor or wait until they call us and consult over the phone.
-- Provider
Participant Reactions to Crisis Stabilization System Components
Crisis Stabilization System: Components of a Comprehensive Response

- A 24/7 Regional Triage/Assessment Center
- Mobile Multidisciplinary BH Teams
- Crisis Respite Services*
- Mobile Peer Recovery Network
- Outreach and education of providers and consumers
- Urgent Care After-Hours Service

* Must include up to 48 hour crisis beds
Positive response to the idea of an integrated crisis stabilization system

• Providers and peers saw promise in a suite of options and services to meet individual clients’ needs -- an improvement over the current patchwork of agencies and services.

• Providers tended to see some value in each of the crisis stabilization system components.

• Providers questioned whether there could be sufficient staffing for this entire integrated system.

• Peers also saw value in the components, but tended to be less positive toward the 24/7 Triage and Assessment Center, and more positive about Crisis Respite Services and Outreach & Education.

• Peers, believing they are marginalized, thought there could be a larger role for peers in every component of a crisis stabilization system.
Providers and Peers Speak

Great! If it were all there, it would work well. There’s a more holistic feel rather than a fragmented approach.
-- Provider, Information and Referral Specialist

I love it! Can we start today?
-- Provider

If the mobile peer network were integrated into the mobile crisis team, that would encourage recovery.
-- Provider, MH Social Worker

Peers have more credibility than a therapist, especially in crisis, because they can say “I’ve been there.” The element of having peers is so powerful.
-- Provider, MH Social Worker

If you had all the others, you could delete the triage center or it would be needed much less.
-- Peer, Client and Family Advocate

It’s hard for people who are not peers working with people who are peers. I see peers in all these approaches.
-- Peer, Recovery Specialist
Reactions to 24/7 Regional Triage and Assessment Center

• Providers and peers thought that each assessment center ideally would be:
  o Focused on assuring that each client receives care appropriate to their needs
  o Co-located with an ER
  o Serving as a “Welcome Center” and referral resource.

• Some peers and providers felt that assessment centers should be community-based bricks and mortar facilities, so staff can see and evaluate clients.

• Phone assessment systems and hot-lines were seen as inadequate, and the mid-Hudson region too large to be served by one centralized phone bank.
Questions about Urgent Care After-Hours Service

• There were questions about the concept of an Urgent Care After-Hours Service:
  o How would this differ from the 24/7 Triage and Assessment Center?
  o Would both PC and BH services be provided?
  o What types of providers would be available?
Providers and Peers Speak

Will the after-hours urgent center turn into a hot bed of activity? Will this become an alternative to the ED?  
-- Peer

People chronically call the helpline. It’s better to have face-to-face contact.  
-- Provider

Ideally you have one [triage center] in each county with a care manager, a doctor and a social worker.  
-- Provider, MH/SU Intensive Case Manager

They’re afraid to call a helpline because they are scared that someone will show up and take them to a hospital.  
-- Provider, MH/SU Therapist
Participant Suggestions for Crisis Stabilization Services
Increase use of peers in expanded roles

• Providers and peers agreed that:
  o Peers excel at building trust with clients and teaching coping skills.
  o Peers have great potential to assist in helping prevent unnecessary ER visits, as well as preventing crises from developing.

• Suggested expanded roles for peers included:
  o Recovery Coaches
  o Patient Advocates and Companions
  o Mobile Recovery Teams
  o Triage/Assessment Facilitators.
Providers and peers suggested several ways to improve crisis stabilization resources:

• Combine Mobile Multidisciplinary Teams with Peer Recovery Network to use mobile resources more efficiently and eliminate provider/peer silos

• Integrate 24/7 Triage with Urgent Care and/or Crisis Respite Services to facilitate referrals and hand-offs among providers

• Extend Crisis Respite Services beyond 48 hours

• Provide better supportive housing options for BH clients – to reduce crises as well as promote stabilization after crises.
• Providers and peers were frustrated with the lack of alternatives to the ER for BH clients in crisis.
  o Often the need is simply for a safe place for a client to stay for a few days/nights, and an empathic counselor/peer to help the client de-escalate.

• Suggested potential alternatives included:
  o Partial hospitalization
  o Hospital diversion programs
  o Temporary housing
  o After-hours urgent care with BH staff
  o Mobile multidisciplinary teams, including peers.
Ensure access to alternatives to the ER

- Recognizing the shortage of qualified BH, MH and SU providers, suggestions for ensuring access included:
  - Sharing providers
  - Using remote technology to aid in assessments (e.g., Skype)
  - Engaging additional peers, care managers, social workers, patient advocates, and care navigators.
- Providers and peers also suggested posting assessment and triage teams during off-hours at existing facilities that are currently closed nights and weekends.
Conduct community outreach and education

• Providers and peers thought that often the ER was not the appropriate place for care.
  o They recognize that clients, family, police, and others in the community use the ER in desperation.

• Providers and peers suggested that education is needed to inform the larger community, including police, schools and clergy, about:
  o Alternatives to the ER in a BH, MH or SU crisis
  o How to access these alternatives.
Learn from what is working, including local “small successes”

Focus group participants mentioned:

<table>
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<tr>
<th>Organization</th>
<th>Services</th>
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<tbody>
<tr>
<td>Rose House</td>
<td>Respite, hospital diversion, transitional housing, partial hospitalization, other alternatives to ER</td>
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<tr>
<td>Alliance House</td>
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<tr>
<td>Hudson House</td>
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<tr>
<td>Bon Secours</td>
<td>• Efficient flow of BH clients from ER to detox &amp; inpatient</td>
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<td></td>
<td>• Range of BH services</td>
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<tr>
<td>Greater Hudson Valley</td>
<td>Care coordinator in ER evenings to coordinate follow-up, referrals, transportation</td>
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<tr>
<td>Family Health Center</td>
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<tr>
<td>Occupations</td>
<td>On call for MH assessments at St Luke’s ER</td>
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Actionable Recommendations
### Overview of Actionable Recommendations

<table>
<thead>
<tr>
<th>Area</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>Client Engagement &amp; Activation</td>
<td>• Build and retain relationships</td>
</tr>
</tbody>
</table>
| Communications & Transition Management | • Share treatment plans and other information  
                                    | • Provide "ruthless follow-up"                                                  |
| Access to Expanded Services   | • Increase workforce, service hours and resources                                |
| Beyond Healthcare in the Community | • Develop integrated community resources  
                                    | • Conduct community outreach and education                                      |
| Building on Successes         | • Explore replicability of effective local programs                             |
Client engagement and activation: *Build and retain relationships*

- Improve the ratio of care managers to BH clients
- Assign highest-risk BH clients to care managers with lower caseloads
- Pair peers with Health Home care managers
- Bring PCPs into BH settings to establish relationships in safe places
- Expand role of peers across the continuum of care, including in community-based crisis stabilization services
Communications:
Develop systems for sharing treatment plans and other information

• Develop systems for sharing treatment plans, EHRs and other information, with clients’ approval, across provider sites and including community-based crisis stabilization services

• Move towards person-centered shared treatment plans that include client input, and might also:
  o Engage families, partners, key support people in developing plans
  o Include recovery goals, life goals building on clients’ strengths, and wellness goals, using Wellness Recovery Action Plans (WRAP)

• Develop strategies, including education and training, to break through the traditional siloes of MH, SU and PC
  o Provide multi-disciplinary team training, including BH trauma-informed methods, whether or not services are co-located
Transition Management: Provide “ruthless follow-up”

- Focus on transitions:
  - From inpatient to intensive outpatient treatment services
  - From intensive outpatient treatment to less intensive services
  - From crisis intervention to follow-up care
- Provide “warm hand-offs” to support BH clients’ transitions
- Establish follow-up procedures to check whether clients fill prescriptions and show up for appointments
- Involve peers, including companion peers, during transitions among levels of care and providers
Access to Expanded Services: 
*Increase workforce, service hours, resources*

- Increase number of available PCPs and psychiatrists
- Increase number of care managers to reduce caseloads
- Increase number of peers in all sites, including mobile units
- Include navigators in ERs and mobile units
- Deliver on same-day appointments
- Expand hours and days of services to include evenings and weekends
- Increase crisis respite beds and lengths of stay beyond 48 hours
- Provide 24/7 mobile units in each county to become alternatives to calling police, using ambulance services and going to ERs
Beyond Healthcare in the Community: Develop integrated community resources, outreach and education

• Advocate for the development of more supportive housing
• Expand transportation for BH clients to access services
• Conduct outreach and education to clergy and other influential community leaders
• Work with police, prisons and others in the criminal justice system to:
  o Identify BH needs earlier and address them appropriately
  o Connect incarcerated people with community-based BH services prior to release
• Develop public service messages to reduce fear and stigma about BH, as well as inform the larger community about how to access the range of services for BH crises
Building on Successes: 
*Explore replication of “small successes”*

Consider programs mentioned in the focus groups:

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<td>State Healthcare Navigator</td>
<td>Mobile access to Medicaid coverage</td>
</tr>
<tr>
<td>PEOPLe, Inc.</td>
<td>Peer-run MH advocacy and service organization</td>
</tr>
</tbody>
</table>
Building on Successes, continued:  
*Explore replication of “small successes”*

Consider programs mentioned in the focus groups:

<table>
<thead>
<tr>
<th>Program</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rose House</td>
<td>Respite, hospital diversion, transitional housing, partial hospitalization, other alternatives to ER</td>
</tr>
<tr>
<td>Alliance House</td>
<td></td>
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<tr>
<td>Hudson House</td>
<td></td>
</tr>
<tr>
<td>Bon Secours</td>
<td>• Efficient flow of BH clients from ER to detox and inpatient</td>
</tr>
<tr>
<td></td>
<td>• Range of BH services</td>
</tr>
<tr>
<td>Greater Hudson Valley Family Health Center</td>
<td>Care coordinator in ER evenings to coordinate follow-up, referrals, transportation</td>
</tr>
<tr>
<td>Occupations</td>
<td>On call for MH assessments at St Luke’s ER</td>
</tr>
</tbody>
</table>
Appendix
Focus Group Participant Organizations

Alcohol and Drug Abuse Council
Catholic Charities Community Services of Orange County
Dutchess County of Mental Hygiene
Greater Hudson Valley Family Health Center
Guidance Center
Health Alliance
Human Development Services of Westchester
Hudson River Health Care
Institute for Family Health
Lexington Center
Mental Health Association of Dutchess
Mental Health Association of Orange County
Mental Health Association of Rockland
Mental Health Association of Ulster
Mental Health Association of Westchester
MHAmerica of Dutchess
Mid-Hudson Recovery Center
My Independent Living Occupations
Open Door Family Medical Center
PEOPLe, Inc.
Rehabilitation Support Services
Rockland Psychiatric Center
Westchester Jewish Community Services