2021 Mental Hygiene Executive Summary
Livingston County Community Services

To say that planning for the future needs of behavioral health services during a pandemic is a challenge is, of course, an understatement. Stress levels are high as we all try to navigate the impact of funding withholds, regulatory waivers and the re imagining of the behavioral health service delivery system.

In addition to managing the ongoing challenges posed by COVID-19, two major focus areas of need have been illuminated. The first being the need for additional affordable housing units and housing options that encompasses supportive services to the chronically “hard to serve” population. The second is the need for sustainable comprehensive crisis services.

Fortunately, on a local level, although small in number, the dedication, resourcefulness and resiliency of the agencies and providers in Livingston County is vast and can be counted on to pull together to meet the most pressing needs of the community. On a state level, we urge our state partners to provide permanent regulatory relief and to reinstate the 20 % withhold to funding so the essential work of the localities can continue.

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Page 1

Q1

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Q2

LGU:

Livingston County Community Services

Q3

a. Indicate how your local mental hygiene service system (i.e., mental health, substance use disorder and problem gambling, and developmental disability populations), overall, has been affected by the COVID-19 pandemic: Please specifically note, Any cross-system issues that affect more than one population; Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

The overall impact of COVID 19 on our mental hygiene service system has been to stretch the very fabric of the system in an unprecedented test of its endurance. Fortunately, the fabric held together and highlighted the areas of historic strength while illuminating transformational opportunities to meet the demands of the future. Areas of strength have long included creativity, collaboration between agencies and systems, and the ingrained value of caring for your neighbor.

The areas of challenge, most notably lack of comprehensive crisis services and lack of affordable housing, became even more pronounced. Transportation, which has been a top priority of every county plan for at least the last decade, is becoming surpassed by the need to increase broadband access, which has never been considered a top priority.

Livingston County is a fairly homogenous community in terms of race and ethnicity with 95 % of the population identifying as Caucasian. A subset of that population, families who have experienced generational rural poverty, are disproportionately involved in our local mental hygiene service system. As they also tend to have less access to technology and wifi, remote sessions using an audio / video platform was challenging. Latinos, the next most populous group, appear to be negatively impacted by the rapid transition to telemental health services. Language barriers that often exist were exacerbated by the challenge of enabling 3 way calling or video connections.

As far as the impact of service disruption based on the age of recipients, children under the age of 12 and adults over the age of 55 had significantly more issues adapting to telemental health options. Children had difficulty maintaining attention and providers had difficulty practicing play and other age appropriate therapeutic modalities remotely. Older adults were less likely to feel comfortable using smart devices and less willing to learn how to use new technologies.

Q4

b. Indicate how your mental health service needs, overall, have been affected by the COVID-19 pandemic:Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

Discussions that have been ongoing over the last 2 years regarding how to add telemental health to our service delivery system turned into warp speed action with transition to telemental health being achieved quickly thanks in no small part to the regulatory relief provided by the COVID waivers. The most notable positive outcome associated with the use of telemental health was the increased “show” rates of clients who indicated that the removal of the major barriers to attendance of transportation, commute/wait time and co pay as the primary reasons.
Although while some clientele (and staff) extoled the virtues of remote sessions, some did not. Challenges with technology, broadband issues, and lack of in person connection were most often cited as reason for dissatisfaction. Age played a major role, as noted previously, as did degree of illness. People who had more complex or co occurring issues were less satisfied with the use of telemental health.
Another important difference between adult and youth services is the referral source. Often teachers, school counselors, and other trusted adults are the first to become aware of, and bring attention to, mental health needs. With the need to isolate and the universal strain families have been put under as a result of COVID, children’s mental health needs are more likely to go unnoticed. Data over the last 6 months has shown a decrease in CSPOA referrals, Mobile Mental Health Team referrals and outpatient clinic intakes. However, it is also noteworthy that when youth have sought treatment, the severity of their issues tended to be extreme.
The lesson learned in Livingston County is that choice is good. Allowing clients and providers the flexibility to provide services in the manner that best fits each individual’s needs, whenever possible, is important. Imagine the impact on show rates of giving our clients the option to attend their appointment using telemental health in inclement weather.

Q5

c. Indicate how your substance use disorder (SUD) and problem gambling needs, overall, have been affected by the COVID-19 pandemic:Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

The data shared by SUD providers indicate more negative impact on the treatment delivery system and fewer “silver linings” as compared to some of the other service systems. According to outpatient SUD providers, individual therapy sessions translated better to tele models than did group based therapy, which makes sense given that the learning curve to provide proficient tele group services is much steeper. Overall, outpatient SUD providers indicated that connectivity issues, concerns about confidentiality and lack of privacy/interference from household members impacted the sessions. As a result, most treatment was converted to be provided on an individual basis so clients that respond well to group process and accountability lost that aspect that has been so integral to the recovery process. Regarding use of tele services overall, outpatient SUD providers indicated that connectivity issues and client concerns about confidentiality and lack of privacy/interference from household members negatively impacted sessions. In addition to treatment implications, the budget models of SUD providers are based on a combination of group and individual sessions which have led to budget deficits and staff furloughs.

Across the SUD system, referrals have decreased as a result of the paused court system and overall lack of in person contact between referral sources and clients, has resulted in fewer evaluations and less admissions which translates to fewer individuals entering care. At the same time, increased CPS removals due to SUD issues and increased overdoses clearly indicate treatment needs still exist.

SUD providers have also struggled with such a dramatic change to method and mode to outpatient service delivery, and the increased safety risks of providing treatment in the inpatient and residential settings. With very few tox screens being done, the legitimacy of treatment outcomes are being questioned within, and outside of, the treatment setting.

Regarding Prevention Programs, overall the Prevention Department was able to adjust to virtual delivery working primarily with parents and the community through prevention campaigns and virtual activities. Unfortunately, multi-session programs with youth were not able to continue due to schools
being in crisis mode so individual and small group virtual meetings with a focus on students utilizing social emotional learning skill building and prevention youth group meetings were held virtually.

Various platforms were embraced to spread the prevention message including the start of a youth empowerment Instagram page, creating a Google Classroom with weekly updated resources related to substance use prevention, trauma informed practices and social emotional learning. A Facebook group for Livingston County parents was started as a way to support families. Collaboration with local restaurants, to distribute family support and education materials in take out orders, was done.

Similarly to treatment services, it has been noted that although there is an abundance of anecdotal information around the social and emotional needs of youth and families, the demand for actual programming has decreased, with even virtual attendance not getting the audience participation that was expected. Interestingly, the demand for prevention resources and materials by schools and families for independent use has increased.

Q6

d. Indicate how the needs of the developmentally disabled population, overall, have been affected by the COVID-19 pandemic:Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

The Arc of Livingston Wyoming is our only provider of development disability services. As expected, the need for isolation was particularly challenging for clients, especially for those in residential settings who were not able to have in person family contact. The temporary halting of day programs and most in person services led to increased loneliness for all clientele. Staff who were not furloughed had the extra burden of carrying the workload, often in reimagined ways, knowing that their furloughed counterparts were likely making more money staying home due to decades - long wage disparities in the OPWDD system. The halting of admissions has made the notoriously long and arduous entrance into the Developmental Disability system even longer.
However, out of the situation have come innovations and some pleasant lessons learned. Cross training staff to fill gaps has actually increased morale as it has resulted in a shared understanding of duties which allowed staff to become less singularly focused on their assigned tasks to instead see themselves as a more integral part of the entire treatment team process. Clients have also reported an improved experience from interacting with staff in “new” roles in different ways. Providing Day Habilitation Programming within the residential sites is a perfect example of how the local DD system has temporarily transformed itself with a positive outcome. Another achievement worth noting is that there have been no positive COVID cases, in the county, from any of The Arc residential settings.
An innovation that has come out of COVID necessity and has been so successful that it is likely going to continue post COVID is the use of the Relias system to provide necessary staff training and curriculum online.
Exploration of a collaboration between area colleges needing placements for student teachers and The Arc is also a creative endeavor that is being considered.
There have been no specific racial, ethnic or age related issues noted.

Q7

a. Mental Health providers

None noted.

Q8

b. SUD and problem gambling service providers:

None noted.

Q9

c. Developmental disability service providers:

None noted.

Page 2

Q10

a. Since March 1, 2020, how would you describe DEMAND for mental health services in each of the following program categories?

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	**Increased**
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	**Increased**
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	**Increased**
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	**Increased**
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	**No Change**

Q11

If you would like to add any detail about your responses above, please do so in the space below:

At the start of the pandemic, the demand for services decreased as people seemed to be avoiding all contact as much as possible to focus on the immediate needs associated with the pandemic. In the last 2 months, as the stress of COVID has gone from acute to chronic, service demands have definitely increased.

Q12

b. Since March 1, 2020, how would you describe ACCESS to mental health services in each of the following program categories?

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	**Decreased**
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	**No Change**
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	**Decreased**
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	**Decreased**
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	**No Change**

Q13

If you would like to add any detail about your responses above, please do so in the space below:

Inpatient beds were scarce before the pandemic, so the current situation is quite significant. There has been an increase in complaints regarding inappropriate discharges and there is concern that lack of capacity in higher levels of care is the reason.
Until recently, our mobile crisis staff have been remote, and in some cases redeployed, so in person crisis assessments could not be done.
The list for Adult SPOA Housing has doubled, with an increase in those referred also being homeless.

Q14

a. Since March 1, 2020, what number of mental health program sites in your county closed or limited operations due to COVID-19, apart from transition to telehealth?

0

Q15

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q16

b. What number of mental health program sites in your county remain closed or are offering limited services now, apart from transition to telehealth?

0

Q17

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q18

c. If your county operates services, did you maintain any level of in-person mental health treatment

Yes

Q19

If you would like to add any detail about your responses above, please do so in the space below:

In person treatment was provided on an as needed basis.

Q20

d. As a result of COVID-19, are any mental health programs in your county closing operations permanently? If yes, list program name(s) and type(s).

No

Q21

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q22

e. Did any mental health programs in your county close due to workforce issues (e.g. staff infections, recruitment/retention issues)?

No

Q23

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q24

a. Apart from telehealth, during COVID-19, did your county or mental health providers within your county develop any innovative services or methods of program delivery that may be continued post-COVID? If yes, please describe.

No

Q25

b. During COVID-19, did any mental health providers within your county form any partnerships with other providers that may be continued post-COVID? If yes, please describe.

No

Q26

a. During COVID-19, how many mental health providers within your county implemented existing continuity of operations plans?

2

Q27

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q28

b. During COVID-19, how many mental health providers within your county did not implement existing continuity of operations plans?

0

Q29

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q30

c. During COVID-19, did your county LGU or Office of Emergency Management (OEM) assist any mental health providers in the development or revision of continuity of operations plans?

None

Q31

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q32

During COVID-19, what OMH guidance documents were beneficial to your disaster management process?

Telemental Health Guidance,

Fiscal and Contract Guidance

Page 3

Q33

1. Please indicate any needs for or issues with SUD and problem gambling prevention, treatment, and recovery providers acquiring Personal Protective Equipment (PPE), face masks, cleaning or disinfectant supplies, or similar materials related to the COVID-19 pandemic:

Cleaning and disinfectant supplies are in short supply and often sold out in stores and through online outlets.

Q34

a. How has COVID-19 affected the delivery of and demand for SUD and problem gambling prevention services in your county?

Prevention Services adapted fairly well to the transition to virtual platforms. Google Classroom was used to provide weekly updated resources related to substance use prevention, trauma informed practices and social emotional learning. Instagram was used to start a youth empowerment page, and FB was used to launch a parent support group.
Regarding the demand for prevention, attendance at virtual group discussions and learning events has been lower than expected. Conversely, the demand for prevention resources and materials by schools and families to use on their own has increased.

Q35

b. How has COVID-19 affected the delivery of and demand for SUD and problem gambling recovery services in your county?

The delivery of peer services have become largely telephonic. Because the overall referral and evaluation rates are down, the demand for recovery services are down also.

Q36

c. How has COVID-19 affected the delivery of and demand for problem gambling treatment services in your county?

There is little data on problem gambling which has historically allowed it to be an undiagnosed and underserved population. so it is currently unknown what impact COVID has had.

Q37

d. Since March 1, 2020, how would you describe DEMAND for SUD Treatment services in each of the following program categories?

INPATIENT	**Decreased**
OUTPATIENT	**Decreased**
OTP	**Decreased**
RESIDENTIAL	**Decreased**
CRISIS	**Decreased**

Q38

If you would like to add any detail about your responses above, please do so in the space below:

The closure / pause of referral agencies, ability to do in
person services, difficulty with some telehealth services
along with criminal justice reform, and some OASAS regulations, client participation and engagement in treatment has decreased.

Q39

e. Since March 1, 2020, how would you describe ACCESS to SUD Treatment services in each of the following program categories?

INPATIENT	**No Change**
OUTPATIENT	**No Change**
OTP	**No Change**
RESIDENTIAL	**No Change**
CRISIS	**No Change**

Q40

Respondent skipped this question

If you would like to add any detail about your responses above, please do so in the space below:

Q41

a. Apart from telehealth, during COVID-19, did your county or SUD and problem gambling service providers within your county develop any innovative services or methods of program delivery that may be continued post-COVID? If yes, please describe.

No

Q42

b. During COVID-19, did SUD and problem gambling service providers within your county form any partnerships with other providers that may be continued post-COVID? If yes, please describe.

No

Page 4

Q43

1. Has your county conducted analysis on the impact of COVID related to IDD services/OPWDD service system? If yes, please explain.

Yes (please explain):
Although a formal analysis has not been done by the county, The Arc of Livingston Wyoming County is considering a merger with another Arc primarily to maintain financial sustainability.

Q44

2. What are the greatest challenges your county will be facing over the next 12 months related to IDD services?

How to best re open services safely, financial sustainability and adequate workforce.

Q45

3. Is there data that would be helpful for OPWDD to provide to better information the local planning process? Please list by order of priority/importance.

1. Who is currently on the waitlist for any IDD service, name of service, length of time on waitlist.
2. List of rejected referrals with rejection reason.

Page 5

Q46

Please use the optional space below to describe anything else related to the effects of COVID-19 on Mental Hygiene service delivery that you were not able to address in the previous questions:

As we all know, the mental hygiene service delivery system has been over burdened for years. The psychic and financial trauma that COVID has caused will be long lasting and while some good has certainly come out of the creativity, ingenuity and collaboration that has occurred, it could all be lost if organizations and providers cannot sustain funding withholds and mixed messaging from oversight agencies.