Alan G. Hevesi
COMPTROLLER

OFFICE OF THE
NEW YORK STATE COMPTROLLER

DIVISION OF STATE SERVICES

OFFICE OF MENTAL HEALTH

CHILDREN'S MENTAL HEALTH SINGLE POINT OF ACCESS

Report 2004-S-83

AUDIT OBJECTIVES

Our objectives were to determine whether the Office of Mental Health has: (1) ensured local governments have established Single Points of Access for high need children and families and (2) provided sufficient technical assistance to enable Single Points of Access to be successful in preventing out-of-home placements and in developing appropriate strategies to manage high need children in their home communities.

AUDIT RESULTS - SUMMARY

We determined the Office of Mental Health (Office) has taken steps to implement the Single Point of Access process. Single Points of Access have been established in 58 of 62 counties statewide. However, Single Points of Access have not been established in four of the five New York City boroughs. The process was initially implemented in 2001 and as of April 2005 these remaining Single Points of Access will not be implemented for one to two years. The Office has provided some technical assistance to counties on the Single Point of Access process, most notably during initial implementation. However, Office officials stated "strict monitoring against mandated rules is not required" and as a result the Office does not enforce minimum requirements. In addition, the Office uses reports that are inconsistently completed and inaccurate to determine the types of technical assistance needed by counties. Specific issues include the following.

Single Points of Access have not been established in four of five boroughs in New York City. Although the implementation in these boroughs has begun, it will take one to two years for completion. Continued oversight is needed by the Office to ensure Single Points of Access are set up in an appropriate and timely manner. [Page 4]

The Office requires counties to use an evidence-based screening instrument in their assessment of children. The Office uses the instrument to ensure children are assessed on the same criteria and have an equal opportunity to access high-end (most intense) services. The Office needs to do more to ensure the successful use of these instruments statewide. [Pages 4-5]

Not all children are receiving services in a timely manner. Children are placed on wait lists until their prescribed services become available. While on wait lists, many children receive interim services; which are not as intensive as the prescribed services. [Pages 5-6]

We found counties have different levels of participation in Single Point of Access meetings where placement decisions are made. More consistent representation of families, community agencies and service providers in the process is necessary to help ensure the most appropriate placement decisions are made. [Page 6]

Continued focus is needed on Field Office site visits to ensure timely and comprehensive oversight of local Single Points of Access. In addition, reports used to monitor the process are often inaccurate and completed inconsistently by county and Field Office officials. [Pages 7-10]

Our report contains three recommendations to improve the Single Point of Access process. Office officials generally agreed with our recommendations and indicated actions either already taken or planned to implement them.

This report dated April 6, 2006, is available on our website at: http://www.osc.state.ny.us. Add or update your mailing list address by contacting us at: (518) 474-3271 or
Office of the State Comptroller
Division of State Services
State Audit Bureau
110 State Street, 11th Floor
Albany, NY 12236

BACKGROUND

Single Point of Access is an initiative that began in the 2000-01 fiscal year under the Governor's New Initiatives for Mental Health. The Single Point of Access process is overseen by the Office's Division of Children and Family Services (Division). The Office serves the needs of approximately 140,000 children and adolescents statewide each year, of which about 6,000 have been served through Single Point of Access.

The purpose of the Single Point of Access process is to identify children who are at high risk of placement in out-of-home settings and to use community-based services to manage these children in their communities. The Office is committed to moving toward a system that promotes coordination between institutional and community-based systems and has asked each local government to implement a Single Point of Access process for children and families. Single Point of Access serves as an entry point for all high-risk and high-need children and serves to coordinate mental health services at the county level. Counties work with children and their families to maintain stability in their home communities and avoid inpatient hospitalization.

Typically a child who goes through the Single Point of Access process has a history of mental health issues, is a danger to themselves or others, abuses drugs and/or alcohol, and/or has been subject to or witnessed abuse. As a result, this child would be at high risk of placement outside of their home. A child is generally referred to the process within the county they live by one or more different sources including their school, mental health provider, parent or police. An assessment of the child is completed to determine whether or not they are eligible for the process. This assessment includes reviewing mental health and other evaluations and speaking with the family, referral sources and any other relevant parties. The Division requires the use of an evidence-based screening instrument to document this assessment process and to ensure consistency and uniformity.

In many counties a family advocate would also contact the family during this time to explain the Single Point of Access process and provide assistance. The child's case would then be brought to a Single Point of Access meeting for placement decisions. At this meeting, various community agencies and providers could be represented including: mental health, probation, social services, juvenile justice, Office of Mental Retardation and Developmental Disabilities, local school districts, mental health service providers, and family members. The services available vary by county, but they typically include services of varying intensities including case management (a specially trained mental health expert works with the child and family), home and community-based waiver (the child remains at home even though they qualify for out-of-home placement and it includes a variety of services tailored to the child's needs) and residential treatment facility placements (placements outside the home).

Division senior management stated Single Point of Access is a "process not a program" and it is not their role to enforce Single Point

of Access requirements because there is no legislative mandate. Rather Single Point of Access was created as part of the Governor's New Initiatives for Mental Health. Despite this, senior management did create New Initiative Guidelines which "require local governments to develop methods to identify, screen, assess, plan for and monitor high risk children and families." Senior management did not set a timeframe for the implementation of these New Initiative Guidelines and according to officials, "strict monitoring against mandated rules is not required." Officials further stated that, "Rather than monitoring, the Division provides counties with technical assistance."

The Office has five Field Offices that oversee the county function: Central New York, Hudson River, Long Island, New York City, and Western New York. Together, these Field Offices oversee 62 counties throughout the State. At the inception of this initiative, approximately $2.7 million was allocated for Children's Single Point of Access and distributed to counties in various amounts. For the 2004-05 fiscal year, approximately $1.7 million was distributed.

AUDIT FINDINGS AND RECOMMENDATIONS

Establishment of Single Points of Access in the Counties

During the 2000-01 fiscal year, the New Initiative Guidelines required each local government to establish a Single Point of Access for high need children and families. Currently, Single Points of Access have been established in 58 Counties. However, four of the five New York City boroughs have not implemented a Single Point of Access.

In November 2002, the Bronx Single Point of Access was developed as a pilot process. According to New York City Field Office officials, the City is currently in the process of implementing the Single Point of Access process in the other boroughs. A final draft of the request for proposal was expected to be completed in February 2005, but the completion was pushed back until April 2005. It is expected to take one to two years for implementation. As a result, there is increased potential for high-risk/high-need children to not be identified and therefore, go without needed services. The Division could not provide the number of children who received Single Point of Access type mental health services in Manhattan, Brooklyn, Queens and Staten Island in 2004. However, since a large percentage of the State's population resides in these areas, a significant number of children have been affected. Children that do not have access to the process may regress and eventually require out-of-home placement.

Recommendation

1. The Division should work with New York City officials to implement a Single Point of Access which meets the requirements set in the Office's New Initiative Guidelines in the remaining four boroughs.

Technical Assistance

We determined the Office has taken steps to implement the Single Point of Access process. The Office is responsible for overseeing county progress in implementing the process and for ensuring that each county's process functions as well as possible. To assist the counties, the Office has provided some technical assistance on the Single Point of Access process including regional and statewide meetings, and regular contact through phone calls and emails. We found that while the counties have made progress,

there is more that should be done. Most shortcomings are due to the Office's position that "strict monitoring against mandated rules is not required" and as a result the Office has not enforced compliance with minimum standards issued in the New Initiative Guidelines. In addition, the Office has not established specific criteria for participation by agencies, providers and family. Further, they have not established minimum requirements for documenting the process and for the required frequency and form of Field Office monitoring and site visits. In addition, the Office uses reports that are inconsistently completed and inaccurate to determine the types of technical assistance needed by counties. Accurate data is critical if the Office is to make proper decisions. Areas needing improvement are as follows:

Screening Instruments

The Office requires an evidence-based screening instrument be used to assess potential children for the process. Using the instrument provides consistency in decision-making and documenting results. We found 58 (38.4 percent) files we tested did not have an evidence-based screening instrument. These instruments are not currently used in two of the seven counties we visited (Erie and Westchester), accounting for 43 of the 58 missing instruments we identified. We also found five instances (5.4 percent) in which instruments were left incomplete, 37 instances (39.8 percent) in which they were not dated and three instances (5.4 percent) in which they were not completed in a timely manner. In surveys issued by the Office in January 2004, 11 additional counties indicated that they either do not use or do not have an evidence-based screening instrument and three others indicated they would be implementing an instrument.

Process Completion Time

In addition, we found that children accepted into the process are not receiving services in a timely manner. Each county we visited uses a 30-day guideline for completing the Single Point of Access process. During our file review we found the process was not completed in a timely manner for 33 children (18.9 percent). Process completion for these 33 children ranged from 35 to 111 days. In addition, we found 15 children (19.5 percent) did not receive assigned services in a timely manner, ranging from 31 to 162 days to access those services.

Wait Lists

We found 27 children (21.1 percent) were officially placed on wait lists. While on the wait list, many children received interim services (lower intensity services). In Erie County, each of the 15 children in our sample accepted into Single Point of Access was placed on a wait list prior to receiving services. During the time these children spent on the wait list they were often referred to the same services they were already receiving or had received when they entered the process and were possibly provided with a parenting communication or similar class. More appropriate interim services were not provided while the child waited for the recommended service to become available. For example, one child in our sample was referred to and accepted intensive case management plus services. This child spent 134 days on the wait list before being placed into these services. While the child waited to be placed into the intensive case management plus services, the recommendations received from the Single Point of Access were to continue the child's current services with its current doctor, the same services the child was receiving when referral to the Process was deemed necessary. Additional

recommendations received included a needed improvement in the child's coping skills and needed improvement in communication between mother and child. While both of these services address a need of the child neither is an adequate substitute for intensive case management plus. In contrast, in Onondaga County we identified a child who was referred to a residential treatment facility, but was placed on a wait list until an opening was available. This child was receiving home and community-based waiver services until they could be placed in a residential treatment facility. These waiver services are the highest level of interim care that could have been provided by the county until a residential treatment facility bed became available. Also in Erie County, we identified one child who while on a wait list, was placed into a psychiatric hospital. Erie County officials could not provide the date the child entered the hospital, the date the child was released, or the reason the child was hospitalized. We question why these items could not be identified since the child was on Erie County Single Point of Access's wait list at the time of hospitalization.

Participating Agencies

Single Point of Access meetings should have consistent representation from various community agencies and family members to best serve the interest and proper placement of each child. We found each county has different levels of agency and provider participation. Some counties we visited, such as Albany and Essex, have a regular panel of agencies and providers that attend Single Point of Access meetings while others, such as Erie, have agencies and providers that attend only when requested. The Bronx has regular meetings with service providers in which some children are discussed. Service providers are organizations that provide children with the mental health treatment they are assigned to receive by the Process. However, other City agencies, such as NYC Administration for Children's Services, NYC Juvenile Justice and NYC Office of Mental Retardation and Developmental Disabilities are not included in these meetings. A wide range of participants at Single Point of Access meetings results in an increased level of input to make the best possible service placement decisions for the child. The Division's senior management has not developed minimum requirements for agency, service provider or family participation. Without the input of other agencies, service providers and parents, Single Point of Access's intended purpose of making the best placement decision using all resources within the community to keep the child in their home is not best assured.

The files of 42 children (29.6 percent) either had no documentation showing meetings regarding their placement occurred or documentation including meeting participants could not be provided. Two counties in particular, Westchester and Onondaga, do not maintain documentation, including participation levels, for any meetings.

Documentation

We found inadequate and missing documentation for many other items throughout the Single Point of Access process. During our file reviews we found documentation was inconsistent and/or missing for items such as: the date the referral was received, and evidence the child began receiving services. We identified 6 instances (3.4 percent) in which there was no date the referral was received, and 42 instances (36.2 percent) in which documentation of placement in services could not be provided. There are currently no policies, procedures or expectations regarding documentation. Without adequate documentation, the potential exists for excessive delays in

placement decisions, for making improper placement decisions or for a child not receiving assigned services.

Monitoring and Assessments

The Division's senior management has taken a "hands off" approach to administration of the Single Point of Access process. They have not developed standardized procedures for the counties or Field Offices regarding the implementation of Single Point of Access. Instead, they have issued minimal guidelines and allowed each county to interpret these guidelines as they see fit in their implementation of Single Point of Access. This has resulted in significant variations in the process from county to county. Standardized procedures or defined expectations regarding the frequency or content of Field Office site visits to counties have also not been developed. In addition, there is no formal review by the Office to ensure Field Office officials are conducting site visits and providing the most appropriate technical assistance to the counties.

The Division created and distributed surveys to counties statewide on January 14, 2004 to assess implementation and identify areas needing improvement within the Single Point of Access process. These surveys were not mandatory; however, 45 of 62 counties completed and returned them. The Division used the surveys to gather information on how each county had implemented Single Point of Access and areas where the counties would like more guidance and information. According to Division officials, some of the information and technical assistance requested on the survey responses was provided to the counties during the statewide meeting held on October 27, 2004. The meeting included various workshops on topics such as using the Child and Adolescent Integrated Reporting System, completion of the Child and Adolescent Needs and Strengths (an evidence based instrument), Dually Diagnosed Youth, and Engaging Families in the Single Point of Access process. The meeting also provided an opportunity for county and Field Office officials to network with each other and share ideas.

While we acknowledge not every issue raised on the surveys could be addressed at the statewide meeting, there were issues that should have been addressed on an individual basis with counties. For example, on the survey received from Erie County, officials stated one of the biggest needs or challenges for their county was wait lists. During our visit to the county we found this continues to be a pervasive problem, as every child in our sample accepted into the process was placed on a wait list. In addition, 17 other counties cited wait lists, slot availability, or lack of resources as a problem in their survey. This includes Monroe County, which cited wait lists of approximately one year for their intensive case management and home and community-based waiver programs. These are issues that should be specifically addressed by Division senior management.

In addition, we found 20 counties cited problems getting other service providers, agencies and/or schools involved in the process. This was also a major complaint of Oneida County during our visit, specifically relating to the Office of Mental Retardation and Developmental Disabilities. According to Oneida County officials, the majority of their problems are with children diagnosed with both mental health and developmental disabilities. These children are generally placed in one type of service or the other, and cannot access both types of services. This issue was addressed at the statewide meeting. However, in situations involving organizations/agencies that are a problem at

numerous counties statewide or in situations such as the one raised by Oneida County, the Division should consider addressing the issue at the Central Office or senior management level.

We found other instances in which Division senior management has not required the counties to correct deficiencies reported in their survey responses; for example, parent satisfaction surveys. The New Initiative Guidelines require counties to implement a parent satisfaction survey. These surveys are to be completed by parents after the completion of the process to measure their level of satisfaction with Single Point of Access. Twenty-three counties reported not using satisfaction surveys. Seven others stated they were in the process of implementing them including Erie County. However, during our visit to Erie County in January 2005, no survey had been implemented.

Field Offices

Each Field Office is responsible for overseeing and monitoring the counties within their catchment area. Site visits should be an integral part of this process. However, site visits to counties are completed sporadically, do not include file review, and are not documented. Currently, the Office has not developed any standardized procedures regarding the frequency or content of Field Office site visits to counties. We found the frequency varied from quarterly to annually among the Field Offices. Further, officials at each Field Office stated that file reviews, to ensure proper placement of children and proper maintenance of documentation, are not part of site visits. Instead, Officials stated they attend a County Single Point of Access meeting and meet with the County Single Point of Access Coordinator to discuss any issues. None of the Field Offices document site visits except for the Hudson River Field Office and then only when extreme deficiencies are found.

Field Office officials also stated they have regular contact with the counties within their catchment area through phone and email and each holds regional meetings with their counties on a regular basis. These meetings are an opportunity to provide training and guidance to counties and for county and Field Office officials to network with each other and share ideas. We found the frequency of these meetings varied from two to four meetings a year. According to Field Office officials, Division representatives also attend these meetings.

Semi-annual Operations Reports

Semiannual Operations Reports are additional tools used for monitoring counties and assessing the implementation of Single Point of Access. Central Office officials stated that Field Offices are responsible for gathering information and completing the Operations Reports. These reports are used to "assess how well Counties are implementing the New Initiative Guidelines and areas where technical assistance is needed." The reports include eight basic elements each county Single Point of Access should have and five advanced elements the counties should work on to develop over time. The report also documents which community agencies participate in the process. Basic elements include items such as whether there is a structure in place to implement and maintain the process, whether referrals are being processed, and whether a system is in place to prioritize referrals. Advanced elements include items such as performance measures and making quality improvements based on performance measures.

During our visits to field and county offices, we observed differences in the method of

completion of Operations Reports, depending on which Field Office is completing the report. For example, the Western New York Field Office sends a questionnaire out to the counties for completion and return, while the New York City Field Office fills the Operations Report out with Bronx personnel.

We found discrepancies between information in the Operations Report and the basic and advanced elements the counties actually have implemented. We tested the implementation of each of the 13 elements. Our review found 23 instances in which a county had not implemented a basic or advanced element. In addition, we found 15 instances in which the Operations Report stated a county had implemented an element, when in fact this element had not been implemented. We also found one instance in which a county had implemented an element, but this did not appear on the Operations Report.

We found inconsistencies in how county and Field Office officials determine whether a county has fulfilled an element and whether or not a community agency is considered participating in the process. For example, one of the advanced elements reported on the Operations Reports is achieving a working relationship with other community children's agencies. The report also documents whether or not the county has established these relationships with specific agencies including probation, local schools, social services, mental health service providers and the Office of Mental Retardation and Developmental Disabilities. During our review, a Western New York Field Office official stated some counties consider an agency as participating only if they attend all Single Point of Access meetings while other counties consider them as participating if they attend only some meetings. Both counties would be documented as having achieved this advanced element, although the levels of participation at meetings varied greatly between the counties. Both counties would also document all of these agencies as participating; however, this difference cannot be seen in reviewing the Operations Report.

There are also variations among counties in their understanding of the Operations Report and the basic and advanced elements. According to Division senior management, these reports "were designed as informational tools which counties complete to focus their efforts and which the Office collects as indicators of county accomplishments and potential need for technical assistance." However, three counties we visited, Westchester, Essex, and Oneida, were not familiar with the Operations Report or the elements, and Erie County was only vaguely familiar. Westchester County officials were surprised to find they were documented as having all elements, both basic and advanced, implemented. The remaining counties we visited, Albany, Onondaga, and Bronx, were familiar with both the Operations Report and elements. We question how effective these reports can be as an informational tool or for identifying the need for technical assistance if some counties are not familiar with them or the required elements.

Overall, Field Office officials have not done enough to ensure Operations Reports are accurate. As a result, there is less assurance the information is accurate and can be used to properly identify improvement opportunities within a county. For instance, when we compared information in survey responses received by the Division in February 2004 to Operations Reports for December 2003 and June 2004, we identified discrepancies regarding participating agencies. We identified discrepancies as instances in which the Operations Reports for both December 2003 and June 2004 showed an agency as participating but the February 2004 survey, in

between the two operation reports, showed they did not (and vise versa). We also identified as a discrepancy when the survey showed an agency only participated sometimes. In comparing the surveys to the Operations Reports we found discrepancies for 36 of the 45 counties that responded, totaling 203 instances in which agencies recognized as participating did not match. We did not count as a discrepancy any case where the survey matched one Operations Report and not the other, as this could result from an agency beginning or ending their participation during the time period.

Quarterly Reports

The Division also uses Quarterly reports as indicators of county accomplishments and the potential need for technical assistance. These reports track the total number of applications received by each county, the total number of children meeting the priority population definition, the source of referrals to the county, and the services children are referred to. The reports are completed by counties and then forwarded to the appropriate Field Office. After review by the Field Office they are forwarded to the Division.

Quarterly Reports are not checked for accuracy. According to Division senior management, these reports "were designed as informational tools which counties complete to focus their efforts and which the Office collects as indicators of county accomplishments and potential need for technical assistance." During our visits to the Field Offices, we found officials review these reports for completeness and mathematical accuracy. However, officials do not ensure accuracy of the information contained in the reports before forwarding them to the Division. For example, a New York City Field Office official stated she makes the assumption that the numbers are correct, but she does check for reasonableness.

Training on the completion of Quarterly Reports is not adequate. Erie County's Single Point of Access Coordinator indicated to us that at a regional meeting the counties discussed how to accurately capture some information contained in the Quarterly Report. Different people had different definitions of the various categories within the Quarterly Report. For example, if a child comes through the process as a referral from residential treatment facility for a lower level of service, the report does not include residential treatment facility as a choice for a referral source and, therefore, county officials do not know where to classify that referral. Without accurate information, the reports cannot be used effectively to identify trends or improvement opportunities within a county.

Recommendation

2. The Division should take a more proactive role in the implementation of the Single Point of Access process and ensure counties are meeting minimum standards.

   Areas needing improvement include the following:

   - Using screening instruments,
   - Completing the Process and assignment of services timely,
   - Providing proper levels of interim services to children while on wait lists,
   - Obtaining consistent representation from participating agencies,
   - Obtaining adequate, complete and accurate documentation, and
   - Developing procedures for the frequency and content of field office site visits.

Best Practices

During our site visits to the counties and regions, we identified best practices in Oneida County and the Bronx. Division officials agreed with our assessment of these practices and have provided some information on them to other counties. The Division should further encourage the implementation of these practices statewide.

We found Oneida County officials have taken a proactive approach in the Single Point of Access process by developing a partnership with school districts in the county. The purpose of this partnership is to identify children in the schools that need Single Point of Access so services can be provided at the first signs of a problem, instead of waiting for the child to be identified when they do something more severe and require intensive services. Each school district has a designated District Liaison for Single Point of Access. This person is responsible for completing the evidence based screening instrument for all children referred from their district. Oneida County has provided evidence based assessment training to all District Liaisons. In addition, the county has provided a Single Point of Access manual, which includes an outline and protocol for the process and a detailed explanation of the services available. Quarterly meetings are held with the District Liaisons to update them on any changes or developments in the process. We believe this proactive approach should be replicated across the State as a method of identifying high risk/high need children before they regress to the point of needing intensive services.

In late 2003, Bronx officials developed a tracking form for each child that enters services through the process. Providers complete the form, document their initial contacts with the child and their family and return them to county officials. We believe the completion of this form helps to ensure each child referred through the process makes a connection with the service to which they have been assigned and no child fails to receive services. This form should be duplicated in counties statewide.

Recommendation

3. The Division should further encourage the implementation of best practices statewide.

AUDIT SCOPE AND METHODOLOGY

We did our audit according to generally accepted government auditing standards. We audited the Office of Mental Health's oversight of the Single Point of Access process for the period of January 1, 2003 through July 1, 2005. To accomplish our objectives, we reviewed applicable guidelines and interviewed Office, field, and county officials. We visited 7 of 62 counties: Albany, Bronx, Erie, Essex, Oneida, Onondaga, and Westchester. We also visited four of five Field Offices: Central New York, Hudson River, New York City, and Western New York. These locations were selected based on geographic location and counties that had potentially been more and less successful at implementing the Single Point of Access process. At each county we reviewed a random sample of 25 children's files. Our file review focused on timeliness of the process, timeliness and documentation of service placement, the use of evidence based screening instruments, the appropriateness of a child's acceptance to the process and their placement. We also looked at whether each county had implemented each element required by the Office's New Initiative Guidelines. In addition, we reviewed the Office's Operations Reports, Quarterly

Reports, and surveys completed by the counties in 2004.

In each of the areas of our file review, the actual population reviewed varied for reasons such as the child had not yet reached that point in the process, the child moved, or the family declined services. Consequently, percentages will vary within the same paragraphs. To find the population for any stated percentage simply divide the number identified by the percentage.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of who have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

AUTHORITY

The audit was performed according to the State Comptroller's authority under Article V, Section 1, of the State Constitution; and Article II, Section 8, of the State Finance Law.

REPORTING REQUIREMENTS

We provided a draft copy of this report to Office officials for their review and comment. Office officials generally agreed with our recommendations and indicated actions either already taken or planned to implement them. A complete copy of the Office's response is included as Appendix A. Appendix B contains State Comptroller's Comments which address the matters of disagreement contained in the Office's response.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

CONTRIBUTORS TO THE REPORT

Major contributors to this report include William Challice, David R. Hancox, Sheila Emminger, Todd Seeberger, Andrea Inman, Vicki Wilkins, Alicia Bialy, Jennifer Mitchell, Dan Towle, Chi Hwan Shin, Nicole Van Hoesen, Kimberly Bott, and Paul Bachman.

APPENDIX A - AUDITEE RESPONSE

New York State
Office of Mental Health
Sharon E. Carpinello, RN, Ph.D.
Commissioner

44 Holland Avenue
Albany, New York 12229
Barbara L. Cohn
Executive Deputy Commissioner

February 22, 2006

William Challice
Audit Director
State Audit Bureau, 21st Floor
Office of the State Comptroller
123 William Street
New York, NY 10038

Dear Mr. Challice:

The Office of Mental Health has reviewed the draft audit report entitled, Children's Mental Health Single Point of Access (2004-S-83). Our comments to your findings and to the three recommendations contained in the report are enclosed.

The Office of Mental Health appreciates the Office of the State Comptroller's efforts to recommend improvements in our operations.

Many thanks for your continued help and cooperation.

Sincerely yours,

Barbara L. Cohn
Executive Deputy Commissioner

Enclosure

OFFICE OF MENTAL HEALTH
RESPONSE TO THE OFFICE OF THE STATE COMPTROLLER
DRAFT AUDIT REPORT 2004-S-83
CHILDREN'S MENTAL HEALTH SINGLE POINT OF ACCESS

Overall OMH Comments

Since its inception, the SPOA process has served approximately 25,600 children statewide and has been consistently cited for its ability to produce positive results at keeping children at home and in the community, in the most integrated setting possible. It is described as a potential model at the local level to address the needs of children who are placed out-of-state, in order to bring them home and back to their community as quickly as possible (Interagency Out-of-State Residential Placement Work Group report, 2005). Moreover, through the SPOA process, counties have reported a reduction in out-of-home placement.

The Office of Mental Health is pleased that OSC acknowledged the Single Point of Access process for children has been established in 58 of 62 counties statewide. This has been accomplished despite the fact that there is no statutory authority requiring the establishment of SPOAs, and that OMH does not have specific authority to require counties to establish SPOAs. After OSC's audit work was completed, and as long planned, an RFP was issued to implement the SPOA process in the remaining four boroughs of New York City. The RFP was issued after a successful SPOA process had been established and proven effective in the Bronx and, as described later in this response, SPOA implementation is currently planned on a citywide basis beginning in April 2006.

As described on the following pages, OMH is in general agreement with OSC's three recommendations and has taken actions consistent with those recommendations. However, we also noted in the draft report that the auditors' comments indicate that they view the SPOA process as a mandated program for the counties. As explained in our response to OSC's preliminary findings, SPOA is not a mandated program; rather, it is a process. SPOA guidelines were issued to assist counties in the development of that process, while allowing the focus of control to remain with the counties so that they could shape the process within their existing infrastructures. As such, OMH staff work in partnership with the counties, providing guidance and technical assistance on this important state-county initiative.

* Comment 1

Across the state, counties and children's service system stakeholders (e.g., mental health, DSS, family court, probation, schools, and families) have reported that the SPOA process has been an asset to the system of care for multiple reasons, for example:

- there is a reduction in time from referral to receipt of services;
- there is an increase in the proportion of high-needs children receiving priority services;

* See State Comptroller's Comment, page 19

- there are improvements in service access, appropriateness and outcomes;
- because of the emphasis on interagency and collaborative stakeholders in the SPOA process, there is a better gauge on all high-risk children in the county, resulting in earlier intervention to prevent future high-risk behaviors;
- there is better planning and assurance that children and families are comprehensively served and that their needs are met;
- there is increased and more cooperative planning prior to a child leaving placement, as well as prior to a child going into placement; and
- children who were initially referred for out-of-home placement have been successfully maintained at home and in their community with a comprehensive plan of care.

OMH Response to OSC Recommendations

OSC Recommendation No. 1 - The Division (OMH Division of Children and Families) should work with New York City officials to implement a Single Point of Access which meets the requirements set in the Office's New Initiatives Guidelines in the remaining four boroughs.

OMH Response to OSC Recommendation No. 1:

The SPOA process is operational in all upstate and Long Island counties, and in the borough of the Bronx. New York City officials chose to implement the SPOA process in two stages. It was first initiated in the Bronx, where it was found to work effectively within the system of care that exists in that locality. Data demonstrates that it was not only effective, but as noted in the OSC audit report, the Bronx SPOA process yielded some best practices through the SPOA tracking process.

Based on its successful implementation in the Bronx, NYC is currently finalizing a citywide contract for SPOA. An RFP was issued in Fall 2005 and a NYC SPOA coordinator has been named, which will be followed by full implementation of the SPOA process beginning in April 2006. OMH representatives will continue to work with NYC officials on the implementation and oversight of SPOA.

The Bronx SPOA is to be commended for the tracking process as noted in the OSC audit report. Providers complete a tracking form for SPOA, document their initial contacts with the child and their family, and return the form to county officials. It is clear that this tracking process helps to ensure each child referred through the process makes a connection with the service to which they have been referred and all children receive services. The form has been distributed to SPOAs and counties statewide as a best practice effort and is now being utilized by many counties.

OSC Recommendation No. 2 - The Division should take a more proactive role in the implementation of the Single Point of Access process and ensure that counties are meeting minimum standards.

OMH Response to OSC Recommendation No. 2:

Given the research which documents the effectiveness of community-based services and systems, the New Initiatives Guidelines targeted certain resources to accomplish several objectives. The resources were used to: expand community services, deliver care directly to families and children in natural and the most integrated settings, and to organize and implement community-based care management strategies for families with children at risk of alternative placements. As part of this strategy, locally-based systems were enhanced to increase accountability, best practices, and coordination for high-risk children. SPOA was implemented as a new process. As it was untested, OMH did not mandate its implementation. As a result, the SPOA process was issued as a set of guidelines for local governments to develop methods to identify, screen, assess, plan for, and monitor high-risk children and families. The SPOA process is designed to build upon other inter-system initiatives within each county.

* Comment 1

The manner in which the guidelines were implemented was designed to complement the county infrastructure. There were no specific timeframes nor was it expected that there would be strict monitoring of SPOA processes. Rather than strict monitoring (as is often done for programs or initiatives with significant and complete funding attached), SPOA processes and coordination are addressed in several ways. OMH provides counties with technical assistance through meetings and visits to observe the SPOA process in individual counties, regional meetings with SPOA coordinators, as well as statewide meetings. In addition, the SPOA coordinators in each county are surveyed annually to gather data on the process, to ascertain best practices and to identify trends and issues that arise.

The SPOA process specifies tasks to be implemented to complement the county infrastructure. It is a locally-based and driven initiative consistent with systems of care principles and practices. To mandate a set of rules and regulations regarding the SPOA process could jeopardize the local planning process and infrastructure that works for each county. It would also impose accountability and reporting that is not necessary for a local initiative which is not based upon generation of funding or revenue. In fact, the counties were asked to implement the SPOA process primarily using existing resources, with minimal additional funding (some counties received as little as $20,000 to implement the SPOA process for children and adults).

OMH oversight of the SPOA process is addressed in several ways. Field Office staff conduct regional meetings two to three times per year, and also routinely visit SPOAs in their catchment areas. Where areas of concern are identified by Field Office staff, and where these cannot be resolved at the local or regional level, Central Office representatives make field visits. Central Office staff also regularly attend the SPOA regional meetings and make visits to SPOA sites across the state. In New York City,

* See State Comptroller's Comment, page 19

oversight meetings are held with representatives of OMH's New York City Field Office, the Mental Health Association of New York City and the NYC Department of Health and Mental Hygiene. On Long Island, Field Office staff participate as regular members of the SPOA processes in both counties.

In addition, data is collected at the state level on SPOA processes in each county through regular reporting. Quarterly reports are collected from counties, as to numbers of referrals, referral sources and other important data elements. Counties report semi-annually on implementation of SPOA guidelines. As noted earlier, the Children's SPOA process is also surveyed annually and more recent audit results are being aggregated currently.

Important and significant technical assistance topics and best practices identified via the survey are shared through regional and statewide meetings, and will also be incorporated in a newsletter regarding the SPOA process. Recently, OMH convened a SPOA work group to re-examine data that are being collected on quarterly reports to determine what elements are essential to report, and to enhance the current data collection process. The work group has met several times to discuss and make recommendations as to effective and important data elements to be reported. The survey and data workgroup are geared to assist us in continuing to improve the structure and process of SPOA, to ensure that children can be served in their homes with their family.

The use of screening instruments that are evidence-based and that yield important data on outcomes and systems strengths and gaps continue to be utilized. Instruments like the Child and Adolescent Needs and Strengths survey, and the Child and Adolescent Functional Assessment Scale are also being implemented within other children's initiatives such as Residential Treatment Facilities, and the Home and Community Based Services Waiver, to increase outcomes reporting and data. These instruments help to ensure that children are provided with proper levels of interim services while awaiting the service to which they were referred, and will assist in tracking the progress of children.

OSC Recommendation No. 3 - The Division should further encourage the implementation of best practices statewide.

OMH Response to OSC Recommendation No. 3:

Encouraging best practices is done in several ways. Best practices are shared through regional and statewide meetings, and a new newsletter will describe effective practices and provide recommendations for improvement statewide. The newsletter will kick off with the recommendations set forth in this audit report, among other topics.

Visits to individual counties both by Field Office and Central Office staff will continue, in an effort to share best practices and identify any issues or needs which should be addressed. Central Office representatives are currently promoting more widespread use of satisfaction surveys to monitor outcomes for families; increased collaboration at the

SPOA process table by all child-serving systems, families and youth; and the use of evidence-based instruments to measure outcomes and yield effective data to enhance planning on a local, regional and state level.

It should be noted that such visits now include state staff from other child-serving agencies such as OCFS, who are exploring SPOA as an effective process to plan comprehensively and prioritize services for children with child welfare needs. In addition, SPOA is cited in the Interagency Out-of-State Residential Placement Work Group report to the Governor as an effective practice to address not just the needs of children with serious emotional disturbance, but to meet the needs of children with multi-systems issues at the local level. There is a subcommittee on Model Processes whose focus is to "Strengthen local and regional service coordination and streamline placement processes and access to community based services, which include or complement existing infrastructures (e.g., SPOA...)", (Interagency Out-of-State Residential Placement Work Group report to the Governor, p. 5).

Contact continues with counties statewide through sharing of best practices, regional meetings and individual visits by both OMH Central Office and Field Office representatives. Those counties who were visited by OSC during the SPOA audit have since been visited or contacted by OMH staff to ascertain how they have improved their SPOA process. Counties visited by OSC have reported changes to improve their system of care to make the SPOA process more effective and comprehensive, and this work effort has been shared in a SPOA statewide survey currently being aggregated by OMH. For example, Oneida County (cited for effective practices in school involvement to identify children earlier who are high risk/high need) notes that they are now doing work in the area of documentation of program enrollments and modification of their tracking systems. They are also reviewing quality improvement in the areas of assessment, treatment and access to services for children across systems, as are many other counties.

APPENDIX B - STATE COMPTROLLER'S COMMENT ON AUDITEE RESPONSE

1. While Office officials did not mandate implementation of Single Point of Access, the Office did, prior to receiving funding, require each county to sign an agreement stating that it would adhere to the New Initiative Guidelines. These guidelines set forth the acceptable minimum standards for identifying, screening, assessing, planning for, and monitoring high-risk children and families. Our audit determined the Office has not enforced county compliance with the Guidelines. The Office needs to take a more proactive role in implementing and monitoring the Single Point of Access process to ensure the counties are meeting the acceptable minimum standards set forth in the Guidelines. Some areas we identified needing improvement include: monitoring counties to verify they are using an evidence-based screening instrument; completing the Single Point of Access process and assigning services timely; providing proper levels of interim services to children on wait lists; and using a parent satisfaction survey.