



NY START
Systemic, Therapeutic, Assessment, Resources & Treatment

NY START Tri-Borough
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What is START?

NY START is a linkage model to promote a system of care in the provision of community services, natural supports and mental health treatment to people with intellectual and developmental disability who present with complex behavioral and mental health needs (IDD/ MH). The goal of the START program is to mitigate crisis, build relationships and supports across service systems to help people remain in their homes and communities, and enhance the ability and capacity of the community to support them.



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Who is Eligible for START?

NY START services are available to people who are at least 6 years of age and who have a developmental disability and co-occurring mental illness or complex behavioral health need.

An [OPWDD eligibility](#) determination is required in order to receive the full array of NY START services"


How Do I Make a Referral?
You can call the NY START referral line at 212-273-6300 or email us at nystart@yai.org.

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START Model Outcomes


- Reduce emergency intervention services
- Increase the utilization of community service providers
- Improve the support system and the individual overall quality of life
- Strengthen systems linkages that bring enrichment, increase resources and builds the capacity.
- A growing local, regional, statewide, and national learning community dedicated to evidence-based practices in mental health and IDD.

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START Components

- Consultation, assessment, and service evaluation;
- Comprehensive biopsychosocial evaluation
- Positive psychology, person-centered, and strength-based approaches.
- Employs data driven, evidence-informed practices and outcome measures;
- Technical support to maintain program integrity and fidelity to the START model;
- Clinical education trainings and online training forums;
- Family support and education;
- Focus on understanding problems in the context of the system of support.


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VIA Character Strengths

- **Wisdom and Knowledge:** [creativity](#), [curiosity](#), [judgment](#), [love of learning](#), [perspective](#)
- **Courage:** [bravery](#), [perseverance](#), [honesty](#), [zeal](#)
- **Humanity:** [love](#), [kindness](#), [social intelligence](#)
- **Justice:** [teamwork](#), [fairness](#), [leadership](#)
- **Temperance:** [forgiveness](#), [humility](#), [prudence](#), [self-regulation](#)
- **Transcendence:** [appreciation of beauty](#) and [excellence](#), [gratitude](#), [hope](#), [humor](#), [spirituality](#)^[2]

<https://www.viacharacter.org/www>

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Positive Psychology

Is the scientific study of the strengths that enable individuals and communities to thrive. It is the belief that people want to lead meaningful and fulfilling lives, to cultivate what is best within themselves, and to enhance their experiences of love, work, and play.

"You go into flow when your highest strengths are deployed to meet the highest challenges that come your way."


-Martin Seligman

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Community Trainings


- Understanding someone diagnosed with ID/ASD and Complex Behavioral Health Needs
- De-escalating techniques for people diagnosed with ID
- Using positive psychological techniques with people diagnosed with Fetal Alcohol Syndrome
- Assessment of Irritability and Challenging Behaviors for people diagnosed with ASD
- Trauma During Childhood
- Genetic Syndromes Associated with ID
- From Stability to Flourishing – Practical Strategies for Promoting Mental Wellness

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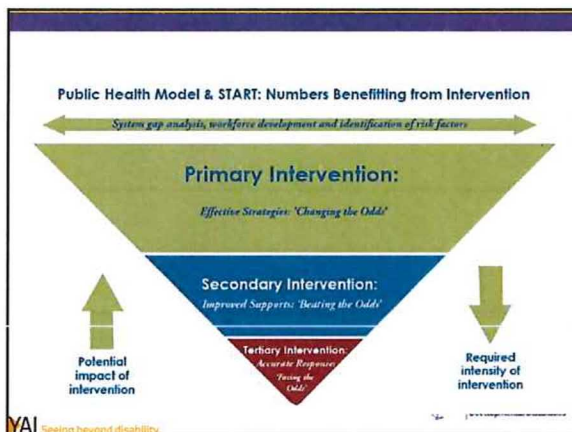
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The 3 A's

- **Access to Care and supports:** Care must be inclusive, timely and community-based. We provide a systemic approach to link systems and improve access to all services including those of our affiliates and partners.
- **Appropriateness of Care:** Appropriateness of care is reflected in the ability of service providers to meet the specific needs of an individual. This requires linkages to a number of services and service providers, as individual service needs range and change over time. It also requires expertise to serve the population.
- **Accountability:** The third essential element for effective service provision is accountability. There must be specified outcomes measures to care. Service systems must be accountable to everyone involved in the provision of care and this includes funding sources. Outcome measures must be clearly defined, and review of data must be frequent and ongoing. The service delivery system must be accountable first and foremost to the persons receiving care. Outcome measures should account for whether or not an individual's service/treatment plan is effective over time. Service recipient satisfaction with ~~measures~~ **an important** outcome measure as well.

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Tertiary WHO Approach

- Primary: Capacity building; communication and collaboration, improved quality services and quality of life; accountability; Professional Learning Community/Training; Access to experts in the field; Linkages
- Secondary: Expertise, access to appropriate care, cross systems communication; crisis prevention; accountability; CETS, START Plans, SIRS, Systemic analysis
- Tertiary: Integrated into the overall system, working with inpatient units, mobile crisis teams, emergency rooms; crisis evaluation, prevention, intervention, and stabilization; 24 hour access to care providers for assistance within 2 hours; discharge planning meetings within 24 hours with START Coordinators linked with in-home services; inpatient and START Resource Centers

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Service Coordinator Vs. START Coordinator

SERVICE COORDINATOR	START COORDINATOR
<ul style="list-style-type: none"> • Assessment of individual needs • Gather/ record information • Service Plan development • Implementation of ISP • Monitoring ISP, health and safety • Linkage of natural support • Referral to services • Follow-up to support informed choice • Advocacy for the individual • Documentation and record keeping 	<ul style="list-style-type: none"> • Crisis Assessment • Assessment of system needs • Gathering historical information • Development of Cross System Crisis Plan (CSCP) • Training system on CSCP and modifying as needed • Linkages with community partners • Comprehensive Service Evaluations • Discharge planning from acute settings • Training and consultation to community partners • Documentation and data collection

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Developing Capacity and Partnership

Formal affiliation/linkage agreements are a key to the START program. These agreements link the START program with mental health and medical providers, inpatient mental health units, developmental disabilities providers, residential providers, vocational and day services providers, state agencies, dentists, neurologists, experts in the field, etc.


Crisis Support Continuum Development: START develops relationships with community partners in order to bridge service gaps and improve service outcomes. This includes development of affiliation agreements and collaboration with Mobile Crisis Management and First Responders for increased diversion, collaboration with hospitals regarding admittance discharge planning and transition, as well as Crisis Plan Development and Emergency Respite.

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Basic Demographics as of 02/2018


		Children	Adults
	<i>n</i>	75	138
AGE	Average	14.5	31.0
	Range	7 to 17	18 to 65
GENDER	Female	20%	40%
	Male	80%	60%
RACE	White/Caucasian	16%	30%
	African American	33%	37%
	Asian	16%	5%
	Hispanic/Latino	20%	12%
	Other	11%	12%
	Unknown/Missing	4%	4%
ETHNICITY	Hispanic	43%	38%
	Non-Hispanic	57%	62%

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Emergency Dept. Visits Data



		Prior to Enrollment	During START	Difference
CHILDREN (n=75)	Visited ER %	36%	9%	-27%
	Mean No. of Visits (Range)	2.2 (1 to 7)	1.4 (1 to 3)	-0.8
ADULT (n=138)	Visited ER %	56%	13%	-43%
	Mean No. of Admissions (Range)	5.4 (1 to 40)	3.9 (1 to 15)	-1.5

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Psychiatric Hospitalization Data

		Prior to Enrollment	During START	Difference
CHILDREN (n=75)				
	Admitted %	32%	7%	- 25%
	Mean No. of Admissions (Range)	1.8 (1 to 3)	1.0 (1)	- 0.8
	Average Length of Stay	-	10 days	
ADULT (n=138)				
	Admitted %	41%	7%	- 34%
	Mean No. of Admissions (Range)	2.2 (1 to 20)	1.4 (1 to 4)	- 0.8
	Average Length of Stay	-	1 day	



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The START Therapeutic Resource Center and In Home Supports

4 Bedroom Home
2 Planned Beds
2 Crisis Beds




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- ### Principle approaches to care at the Resource Center
- "Guests"
 - Focus on positive psychology, and character strengths from the time of admission and throughout the stay
 - Sensory reduction room for people diagnosis with autism and other sensory stimulation.
 - All activities can be conducted in home
 - Trauma informed approach
 - Communication and collaboration with host home and providers
 - Data collection and assessment
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Service at the Resource Center

Guest services include:

- **Planned site-based**
 - Planned therapeutic beds at START are intended to serve people who have not been able to use respite in more traditional settings due to ongoing mental health or behavioral issues.
 - Families and others participating in the program must be approved as eligible for these services, but once approved, they schedule visits as needed (and when available).
 - The goals of planned respite include: provide a break from the daily life experiences of both the caregiver and guest, monitor the effects of treatment, coping skills training, crisis prevention, positive experiences to look forward to, training to providers and caregivers, and increased recreational opportunities for individuals who often lack the ability to access these supports in the community.
 - Length of stay 3-5 days.



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Service at the Resource Center

Guest services include:


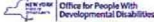
- **Emergency site-based**
 - These beds operated by START are designated for emergency therapeutic purposes
 - Emergency therapeutic is designed to provide out-of-home housing and services for people who, for a short period of time (max 30 days), cannot be managed at home or their residential program.
 - The goals of emergency therapeutic include: clinical assessment, hospital diversion, stabilization, reunification with home and community settings, training to caregivers and providers, collaborative contacts/consultation with treatment teams, step down from mental health inpatient services, positive social experiences, behavioral support and planning, assessment and refinement of treatment approaches, coping skills development and enhancement, diagnostic clarification, and family support and education.

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**Therapeutic In-Home Supports
(Crisis)**

- In-home supports are designed to assess and stabilize an individual in his or her natural setting. This service is part of the mobile crisis capacity of START, and the START Coordinator determines the need for supports.
- Works closely with START Coordinator and Clinical Director to define immediate goals and objectives
- Does not replace existing support system enhances utilizing qualified and trained personnel who will be part of the local mobile crisis network which is made up of START Coordinators and on-call clinicians who will provide assistance and support as needed.
- Up to 72 hours per intervention period.

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Therapeutic In-Home Supports (Planned)


- Aims to identify strengths and vulnerabilities of the system
- Trains on the effectiveness of communication tools, sensory stimulation and developing therapeutic structure in the setting.
- Works with individual/ system to promote growth and overall well-being
- Offers therapeutic resources, strategies and skills that promote enhance quality of life
- Supports to implement CSCPIP
- Transitional support after inpatient hospitalization or Resource Center stay
- In-home supports team will be located throughout the Tri-Borough to provide timely support.
- Provision of supports will depend on the person's goals and need for service.

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Q & A

What are your thoughts and questions?





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Resources and Additional Information

Additional Information on the Center for START Services and NY START can be found on the OPWDD website at the following link:

<http://www.opwdd.ny.gov/ny-start/home>

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