

**NEW YORK CITY
DEPARTMENT OF HEALTH
AND MENTAL HYGIENE**



**LOCAL GOVERNMENT PLAN
ALCOHOLISM AND SUBSTANCE ABUSE SERVICES**

2005

**Michael R. Bloomberg
Mayor**

**Thomas R. Frieden, M.D., M.P.H.
Commissioner
Department of Health & Mental Hygiene**

**Lloyd I. Sederer, M.D.
Executive Deputy Commissioner
Division of Mental Hygiene**



TABLE OF CONTENTS

	<u>Page</u>
I. Introduction	1
II. Needs Assessment Activity	2
Prevalence and Cost Estimates Report.....	2
New York City Surveys.....	3
III. Local Government Initiatives	6
Promotion of Buprenorphine Treatment for Opioid Dependence.....	6
Live Free of Alcohol and Drugs: Take Care New York Initiative.....	7
Prevention of Crystal Methamphetamine Use.....	9
Quality IMPACT: DMH’s Quality Improvement Initiative.....	11
IV. Planning Priority Survey	14
Description and Response Rate.....	14
Summary of Key Findings.....	14
Top Three Priority Issues.....	15
V. Collaboration Between NYC DOHMH and NYS OASAS on Local Government Initiatives	16
VI. Plan Assurances	17
Assurance A: The 2005 Local Services Planning Process for Alcoholism and Substance Abuse Services.....	18
Assurance B: Full and Equal Participation of Newly Established Not-for-Profit Community-Based Organizations.....	21
Assurance C: Multi-Disabled Considerations.....	22
Assurance D: Membership of the Subcommittee for Alcoholism and Substance Abuse Services.....	25

I. INTRODUCTION

This year's Chemical Dependence Local Government Plan reflects an emphasis in the Division of Mental Hygiene's (DMH's) approach to mental hygiene planning towards a public health orientation. This shift reflects both the 2002 merger between the Department of Health and the Department of Mental Health, Mental Retardation and Alcoholism Services, and the experience of coordinating the public mental health response in the aftermath of September 11th. The public health approach to planning that we have adopted is population-based, data-driven, epidemiologically informed, and driven by measurable quality indicators.

More specifically, DMH has reformulated its planning framework to feature four key elements:

- ⌘ **Prevalence** data to estimate the number of New Yorkers who have chemical dependence disorders.
- ⌘ **Capacity** data to determine the existing resources available to meet service need. These data can be deconstructed into service type, geographical distribution, cultural competence and other factors.
- ⌘ **Utilization** data to determine who is actually being served, their characteristics and, equally important, by deduction, an approximation of people in need of services who have not accessed the service delivery system.
- ⌘ **Quality** data to determine the appropriateness of care, consumer perceptions of care, and outcomes relevant for people with chemical dependence.

This planning framework expands our purview from a more narrow focus on managing the existing chemical dependence service system to a broader population-based approach that is directed to the chemical dependence prevention and treatment needs of New York City's entire population. It further expands our focus from one that has been categorical and quantitative (e.g., how much do we need of different categories of service) to introduce three dimensions of quality: How appropriate are the services consumers are receiving? What are the perceptions of care among service recipients? And, what are the outcomes? Finally, one of our key planning goals is to obtain (de-identified) consumer-level data that will provide us with information about how many unique individuals we serve, what their diagnoses are, what services they are receiving, and if those services are effective.

In accordance with this new planning framework, this year's plan summarizes new data relating to these four key planning elements, and describes our efforts to engage in activities that will yield additional data in these areas. This year's plan also describes several locally determined priority initiatives aimed at improving the lives of New York City residents with chemical dependence. These priority initiatives focus on prevention, treatment, quality improvement, and a broad-based agency-wide policy initiative that includes an intervention that targets chemical dependence. This year's plan additionally presents data regarding an Office of Alcoholism and Substance Abuse Services (OASAS)-defined planning initiative, a provider survey (the Priority Survey). We anticipate this shift in our planning focus will better enable the Division of Mental

Hygiene to strategically address the needs of individuals with chemical dependence in New York City, and to provide new opportunities to collaborate with OASAS in these endeavors.

II. NEEDS ASSESSMENT ACTIVITY

Needs assessment is a core planning activity. It involves quantifying the needs of New Yorkers who have alcohol and substance abuse disorders, and estimating service need against the capacity of the service system. With our enhanced planning framework and its emphasis on quality, we plan to expand our needs assessment activities to incorporate a focus on quality. Our recently launched quality improvement initiative (described on page 10) is designed to help us assess service quality through surveying consumer perceptions of care, and improving cultural competence and detection of co-occurring mental illness, which will be incorporated into our needs assessments.

We also have engaged in several initiatives that help us better define and measure the alcohol and substance use disordered population in New York City. A description of these efforts follows.

Prevalence and Cost Estimates Report

To lay a foundation for a population-based approach to planning, DMH published a report entitled Prevalence and Cost Estimates of Psychiatric and Substance Use Disorders and Mental Retardation and Developmental Disabilities in New York City. The purpose of this 2003 report was to gather, in one document, estimates of the number of New York City residents with mental hygiene disorders and the associated costs.

When DMH began researching the data for this report, few population-based studies of the prevalence of mental hygiene disorders had been conducted in New York City. The Department of Health and Mental Hygiene (DOHMH) had only recently begun to collect local prevalence data through its first annual Community Health Survey (described in the next section). To develop the Prevalence and Cost Estimates Report, we reviewed national prevalence data (and the limited available local data) to derive "best estimates" for New York City based on large national studies. These approximations were applied to New York City's population figures from the 2000 Census. The report estimates that the number of individuals with substance abuse disorders includes 19,000 children ages 9-17; 511,000 adults ages 18-54; and 45,000 adults ages 55 and older, for a total of an estimated 575,000 New Yorkers with substance use disorders. Likewise, 166,000 individuals, ages 15-54, are estimated to have co-occurring psychiatric and substance use disorders.¹

While these and other prevalence estimates provide a broad picture of the extent of alcohol and substance use disorders, there are limitations to using national rates. Nationally-derived rates do not take into account the City's large and culturally diverse population and its unique socio-

¹ Wunsch-Hitzig R, Engstrom M, Lee R, King C, McVeigh K. *Prevalence and Cost Estimates of Psychiatric and Substance Use Disorders and Mental Retardation and Developmental Disabilities in NY*. New York: New York City Department of Health and Mental Hygiene, Division of Mental Hygiene, Bureau of Planning, Evaluation and Quality Improvement, 2003.

demographic characteristics, some of which are associated with higher rates of alcohol and substance abuse disorders and higher costs, such as poverty, homelessness and immigration. These disparities make it critical to obtain neighborhood-level data, which enable us to target resources and interventions to communities most at risk. We will be able to conduct neighborhood and population-based planning due to a number of survey activities that DOHMH has undertaken. Examples follow.

New York City Surveys

Community Health Survey

The Community Health Survey (CHS) is an annual population-based telephone survey conducted by DOHMH. Based on the Centers for Disease Control and Prevention’s (CDC’s) Behavioral Risk Factor Surveillance System, the CHS is a randomized survey with a large enough sample size (10,000) to generate neighborhood-specific estimates of the prevalence of a number of health and mental hygiene related disorders for 34 neighborhoods in New York City.

Questions on problem drinking were asked in 2002-2004. In 2002 the CHS survey found that among New York City adults 18 years and older, 15 percent drink excessively: about 2 percent of New Yorkers are heavy drinkers², about 11 percent binge drink³, and about 3 percent do both.⁴ Excessive drinking is responsible for over 1,500 deaths among New Yorkers each year from alcohol-related psychiatric disorders, diseases of the liver, heart and pancreas, cancer, homicide, injuries, motor vehicle accidents, suicide and other causes.⁵

Demographic findings about excessive drinking in the City are displayed in the table below and on the next page:

**Demographics of New York City Residents
Who Engage in Excessive Alcohol Consumption, 2003**

Population	Percentage
All New Yorkers	15.3
Men	20.4
Women	10.7
Ages 18-24	22.5
Ages 25-44	19.8
Ages 45-64	11.0
65 and Older	6.3

² Heavy drinking is defined as consuming an average of more than two drinks per day for men and more than one drink per day for women.

³ Binge drinking is defined as consuming five or more drinks in one sitting, at least once in the past 30 days.

⁴ *The State of New York City’s Health: NYC Vital Signs*. New York: NYC Department of Health and Mental Hygiene, August 2003:2(8).

⁵ Wunsch-Hitzig R, Engstrom M, Lee R, King C, McVeigh K. *Prevalence and Cost Estimates of Psychiatric and Substance Use Disorders and Mental Retardation and Developmental Disabilities in NY*. New York: New York City Department of Health and Mental Hygiene, Division of Mental Hygiene, Bureau of Planning, Evaluation and Quality Improvement, 2003, page 11.

**Demographics of New York City Residents
Who Engage in Excessive Alcohol Consumption, 2003**

Population	Percentage
White, non-Hispanic	21.1
Hispanic	14.8
Black, non-Hispanic	11.0
Asian	8.8
Never married	18.8
Married/Partnered	12.9
Divorced/Separated/Widowed	12.4
More than \$50,000	22.0
\$25,000 to \$50,000	16.7
Less than \$25,000	12.2
Employed	18.1
Unemployed	14.2
Out of Workforce	8.4

According to the results of the CHS identified in the above two tables, men, people between the ages of 18 and 24, white-non-Hispanics, and people who have never been married have the highest rates of excessive alcohol consumption. In addition, people who are employed and whose incomes are above \$50,000 also have higher rates of excessive drinking than people who are unemployed or who earn less.

The CHS data, coupled with other local data sources, will provide us with more specific information that can identify disparities among New York City demographic groups and neighborhoods so that we can discern where the need for chemical dependence services is highest. For example, the Statewide Planning and Research Cooperative System (SPARCS) hospital discharge dataset and New York City Vital Records show that despite the higher prevalence of excessive drinking among whites (21%), blacks (11%) and Hispanics (15%) are much more likely to be hospitalized or die as a result of excessive drinking. Hospitalizations due to alcohol and drug use have been higher in poorer neighborhoods than in more affluent neighborhoods for the last ten years. People who live in New York City's poorest neighborhoods are 4.2 times more likely to be hospitalized for drug use than those who live in the wealthiest areas, a rate that has not changed much over time.⁶ Excessive drinking occurs most frequently among persons who live in Manhattan below 96th Street, Downtown Brooklyn/Brooklyn Heights/Park Slope and Western Queens.

⁶ Karpati A, Kerker B, Mostashari F, Singh T, Hajat A, Thorpe L, Bassett M, Henning K, Frieden T. *Health Disparities in New York City*. New York: New York City Department of Health and Mental Hygiene, 2004, page 11.

NYC Health and Nutrition Examination Survey (HANES)

This summer DOHMH is undertaking the first-ever community-level HANES in the United States. Conducted over four months beginning in June 2004, NYC HANES is modeled on the National Health and Nutrition Examination Survey (NHANES), a population-based survey designed to collect information on the health and nutrition of the U.S. household population. For 50 years NHANES has provided information on the amount, distribution and effects of illness and disability in the United States. No other locality or state in the country has dedicated resources to conduct a local HANES study.

Moreover, NYC HANES will be the first survey to employ actual medical examinations to measure health and mental hygiene conditions among NYC residents. NHANES has been used to influence policy and improve the health of the U.S. population in many ways. We anticipate that NYC HANES will serve the same purpose for New York City, as it will provide baseline estimates on the actual prevalence of a wide range of health and mental hygiene disorders.

Specifically, the NYC HANES will survey 2,000 randomly selected New York City residents representative of the New York City adult (20 years and older) population. As opposed to the CHS, a self-report survey, each NYC HANES participant will receive a physical exam by a physician (which includes a number of laboratory tests), and an in-person at-home interview to detect drug use, depression and anxiety; the latter factors that can influence drug and alcohol use.

DOHMH will be assessing generalized anxiety and major depression in the home interview. We will use the Composite International Diagnostic Interview (CIDI), which was developed by the World Health Organization. The CIDI is a comprehensive, standardized instrument for the assessment of mental disorders according to the definitions and criteria of the International Classification of Diseases (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). It is intended for use in epidemiological and cross-cultural studies as well as for clinical and research purposes.

While the study will not directly test for drug use, the Audio Computer Assisted Personal Self Interview (ACASI) will be used to assess the extent of drug use. The ACASI has been used by NHANES and has been found to be valid. Using the ACASI, the interviewer will ask participants questions about their use of street drugs as well as prescription drugs during the past 12 months. The drugs queried about in the survey include heroin, cocaine, marijuana, LSD, stimulants and depressants; club drugs such as MDMA (Ecstasy), GHB, Rohypnol, ketamine, and methamphetamine; and prescription drugs such as anti-anxiety drugs, tranquilizers, sedatives and OxyContin. Questions about the use of alcohol are included in the physical exam and will be asked by the physicians and medical personnel involved in that portion of the study. NYC HANES will also look at patterns of use over a 12-month period and will employ criteria⁷ used by the CDC for identifying excessive alcohol use.

Taken together, the CHS, other NYC-based data sources and the NYC HANES will expand DMH's planning purview beyond the existing service system to incorporate individuals who do

⁷ "Heavy drinking" is defined as consuming an average of more than two drinks per day for men and more than one drink per day for women. "Binge drinking" is defined as consuming five or more drinks in one sitting, at least once in the past 30 days.

not present for services but who have conditions that warrant intervention. Such needs assessment activities can inform targeted prevention and treatment strategies that can be effectively planned and developed by local government, such as Take Care New York (discussed in the next section). Furthermore, we are eager to use our epidemiological data in conjunction with OASAS' Interim Chemical Dependence Needs Methodology so that we can better estimate need against capacity and consumer utilization of services.

III. LOCAL GOVERNMENT INITIATIVES

Promotion of Buprenorphine Treatment for Opioid Dependence

DMH has designated the promotion of buprenorphine as its primary treatment priority.⁸ Approved in October 2002 by the U.S. Food and Drug Administration for the treatment of opioid dependence, buprenorphine can be used to treat dependence on opioid-based prescription drugs, such as OxyContin, Percodan and other pain medications, as well as illicit drugs like heroin.

An important characteristic of buprenorphine is that it can be prescribed in the office of an approved physician and that prescriptions can be filled at local pharmacies. In contrast to the current model of methadone maintenance treatment, buprenorphine treatment offers a more flexible and anonymous setting for people who need treatment, some of whom have resisted taking methadone due to the stigma of visiting a clinic. It is hoped that buprenorphine will appeal to heroin and other opioid users who have declined to participate in, or who have been unsuccessful with, methadone or other types of treatment for opioid dependence.

Opioid dependence is a significant public health concern in New York City. One fifth of the heroin users in the United States reside in New York City.⁹ Each year, approximately 700 New Yorkers die from overdoses involving the use of opioids.¹⁰ Of New York City's estimated 200,000 heroin users¹¹, less than 40,000 are currently enrolled in methadone maintenance.¹² Most of the City's injection drug users consume heroin on a daily basis. Untreated heroin addiction is associated with high rates of mortality, poly-drug use, crime, HIV/AIDS and hepatitis, increased health care costs, family violence and disruption and other profound impacts upon our communities.

As of June 2004, 139 New York City-based physicians were approved to prescribe buprenorphine to treat heroin and other forms of opioid dependence. An estimated 640 patients

⁸ Johnson, B, Rosenblum, A. and Kleber, H (2003). *White Paper, A New Opportunity to Expand Treatment for Heroin Users in New York City: Public Policy Challenges for Bringing Buprenorphine into Drug Treatment and General Medical Practice*. Department of Health and Mental Hygiene: New York, NY.

⁹ Sederer LI, Kolodny A, Office-Based Buprenorphine Offers a Second Chance. *Psychiatric Services*. July 2004;55(7) 743.

¹⁰ Kolodny AJ, McVeigh T, Galea S. *A Neighborhood Analysis of Opiate Overdose Mortality in New York City and Potential Interventions: A Discussion Document*, August 2003 (on file with the New York City Department of Health and Mental Hygiene).

¹¹ Johnson, B., Rosenblum, A., & Kleber, H. (2003). *White Paper, A New Opportunity to Expand Treatment for Heroin Users in New York City: Public Policy Challenges for Bringing Buprenorphine into Drug Treatment and general Medical Practice*. Department of Health and Mental Hygiene: New York, NY, page 8.

¹² OASAS 2004 County Data Profile for New York City: April 2004, Bureau of Addiction Planning and Grants Development, New York State Office of Alcoholism and Substance Abuse Services, page 1.

in New York City are currently being treated with buprenorphine. DMH's long-range goal is to increase the number of New Yorkers who receive treatment for opioid addiction from 40,000 to 100,000 by the end of this decade.

To accomplish these goals, we are taking the following action steps during the next three years:

- ⌘ Promote the use of buprenorphine by physicians as a viable approach to the treatment of opioid addiction.
- ⌘ Train physicians to prescribe buprenorphine.
- ⌘ Implement buprenorphine treatment in DOHMH-funded HIV/AIDS service programs.
- ⌘ Implement buprenorphine treatment in Health and Hospitals Corporation medically supervised outpatient drug-free programs.
- ⌘ Collaborate with OASAS to bring buprenorphine treatment to the City correctional system.
- ⌘ Promote buprenorphine use directly with opioid users, through educating them, their families, and local community stakeholders such as clergy and community leaders.
- ⌘ Encourage the development of buprenorphine treatment programs in other settings such as therapeutic communities, detoxification programs, drug treatment programs, as well as harm reduction and syringe exchange programs.

Live Free of Alcohol and Drugs: Take Care New York Initiative

The Take Care New York (TCNY) campaign is a comprehensive health initiative focused on ten key health and mental hygiene interventions that address the City's leading preventable causes of illness and death. It is a multi-year initiative launched in 2004 whose success will be measured against targets to be achieved by 2008. The ten interventions were selected based on several criteria: the targeted problems significantly contribute to the City's public health burden, due to both their prevalence and their morbidity and mortality rates; the existence of proven, available treatments/solutions; and the ability of local government to act. TCNY is seeking the participation of City agencies, public-private partnerships, health care providers, the business community and individuals. DOHMH predicts that if all of these sectors of the City take up the challenge of TCNY, thousands of lives will be saved, and many more illnesses will be prevented.¹³

One of the ten areas targeted for intervention focuses on substance use: Live Free of Dependence on Alcohol and Drugs. While most New Yorkers have healthy drinking habits or do not drink at all, excessive drinking is a public health problem.

¹³ *City Health Information* 2004:23(3) 11-18.

During 2004, the Department will develop baseline targets for improved screening and treatment of alcohol abuse in primary care settings, which is one of the goals of this initiative. Another goal is to reduce the death rate from drug-induced causes from 11.3 per 100,000 persons to 8 per 100,000 by 2008.

To achieve a reduction in substance use, a key question is: How can individual New Yorkers, health and mental hygiene providers, community organizations, advocacy groups, and government agencies reduce the number of individuals who abuse alcohol and drugs? The following action steps have been developed for this initiative:

- €# Promoting alcohol abuse screening and brief counseling in primary care settings. Specifically, DOHMH is promoting the use of the CAGE¹⁴ by physicians. The CAGE is an internationally recognized, evidence supported assessment instrument for identifying alcoholics. Physicians will be encouraged to speak openly with patients about problem drinking and drug use, provide brief counseling, offer strategies to reduce drinking and provide follow-up, ongoing support, and referrals for treatment.
- €# Promoting new treatments for substance abuse, such as buprenorphine for opioid addiction (see previous section for more details).
- €# Advocating for chemical dependency/substance abuse treatment parity in public and private health insurance coverage, both for chemically addicted individuals and for individuals with both psychiatric and substance use disorders.
- €# Promoting the expansion of syringe exchange programs (SEPs) and other harm reduction interventions in high-need areas, both to prevent the spread of HIV and hepatitis C, and to encourage individuals into treatment for chemical dependency and HIV. Despite the need, there are currently no SEPs in Staten Island and Queens. DOHMH is assisting community-based providers in these boroughs to apply for necessary community board approval as well as providing data to inform their waiver applications. In addition, DOHMH is committed to providing financial resources to get these new programs off the ground. DOHMH will also focus on expanding harm reduction programs such as the Expanded Syringe Access Program (ESAP), which provides clean syringes for purchase without prescription at drug stores.
- €# Providing educational information to the public about recognizing alcohol and drug abuse problems and obtaining treatment.

As previously mentioned, there are 10 action areas in the TCNY campaign. Success in several other areas will directly help in the reduction of alcohol and drug use. For instance, 39.8 percent of the 1,202 people who died between January 1, 2004 and September 30, 2004 due to HIV/AIDS diagnoses, had a history of injection drug use.¹⁵ One of the goals of the HIV intervention is to substantially reduce behaviors that put people at risk for HIV infection. Alcohol and drug abuse are among the risk factors for HIV, so successful interventions

¹⁴ Adapted from: Ewing JA. Detecting Alcoholism: The CAGE Questionnaire. *JAMA*. 1984;252: 1905-1907.

¹⁵ NYC DOHMH HIV Epidemiology Program 3rd Quarter Report July 2004:2(4) 1-4.

addressing the spread of HIV should assist in reducing alcohol and drug use rates. Studies also indicate that depression often co-occurs with medical conditions, psychiatric disorders, and alcohol and substance abuse.¹⁶ Improved outcomes in these and other TCNY target areas (having a regular health care provider, being tobacco-free, being heart healthy, cancer screening, getting immunized, maintaining safe and healthy homes, and having a healthy baby) should also help to decrease alcohol and drug use.

Prevention of Crystal Methamphetamine Use

DMH's primary prevention priority for chemical dependence aims to decrease the number of individuals who use crystal methamphetamine, thus preventing a burgeoning public health crisis from escalating. Our goal is two-fold: to prevent crystal methamphetamine use, and improve access to treatment for those already using the drug thereby preventing the consequences of abuse of this drug, which include greater risk for HIV/AIDS and hepatitis C.

Crystal methamphetamine, or "crystal meth" as it is commonly called, is a highly addictive stimulant drug. It increases production of central nervous system dopamine thereby producing increased energy, short-term euphoria, and feelings of increased strength, improved confidence and invulnerability. There is only limited quantitative data on the use of crystal meth in New York City. Data from DOHMH's Poison Control Center and our surveillance of hospital emergency department visits suggest that crystal meth use is not yet widespread in the general population in New York City, as it is elsewhere in the U.S. For example, in 2002 crystal meth was the leading cause of admission to substance abuse treatment centers in California, and it was implicated in 18 percent of the drug-related deaths in San Francisco, where the crystal meth problem is a decade old.¹⁷

As crystal meth use appears to not yet be widespread in New York City, a targeted prevention strategy that can significantly impact its spread is timely. This and the serious public health consequences of more widespread use of crystal meth are the key reasons for designating the prevention of crystal meth use as one of DMH's highest priorities.

We are particularly concerned about the use of crystal meth in the gay and bisexual community, because use of the drug is associated with high-risk sexual behavior, which increases the risk of transmission of HIV and hepatitis C. There are additional risks for HIV-positive individuals who use crystal meth. It is well documented that substance-abusing individuals with HIV have a host of problems, including hazardous drug interactions and difficulty complying with HIV treatment regimens. Drug-resistant variants of HIV develop rapidly in response to irregular use of antiretroviral drugs. New York City has the largest HIV/AIDS epidemic in the nation, with more than 81,000 people living with HIV or AIDS. Therefore, the implications of crystal meth use for HIV transmission rates and its impact on those already HIV-positive are of great concern.

DMH's prevention strategy includes the following components:

¹⁶ This information has been excerpted from material developed by the National Institute for Mental Health.

¹⁷ New York Blade Online, *Tina Takes Center Stage - Again*, June 25, 2004, comment by Dr. Samuel Mitchell of the San Francisco Department of Health, based on a study his office conducted between November 2002 and March 2003. <http://www.newyorkblade.com/2004/6-25/news/localnews/tina.cfm>

- €# Convening a Crystal Meth Task Force to provide leadership and coordination of a prevention campaign. DMH is participating in a coordinated prevention effort facilitated by DOHMH's Bureau of HIV/AIDS to develop a citywide, multi-pronged prevention strategy. We are actively involved in the Crystal Meth Task Force along with other stakeholders including DOHMH Office of Gay and Lesbian Health, the Office of AIDS Policy Coordination and the Sexually Transmitted Diseases Control Bureau as well as other City agencies such as the Police Department.
- €# Strengthening data collection and information gathering through inclusion of questions about Crystal Meth use in the Community Health Survey. To increase our knowledge of the extent of the problem and track the effect of prevention efforts, the Community Health Survey, described in Section II, will include questions on crystal meth use in this year's survey. This will provide an estimate of the extent of use of the drug within 34 neighborhoods across New York City, and assist us in targeting our prevention efforts in communities with the greatest need. In addition, we are exploring other methods to monitor the use of crystal meth, allowing us to concentrate prevention activities where risk is greatest.
- €# Developing and implementing a multi-pronged public education campaign targeting at-risk populations and health care providers. Crystal meth education has been added to the "Healthy Men's Night Out" program, a prevention education activity that targets men who have sex with men (MSM's) where they congregate. Health educators from this program provide information on sexually transmitted diseases and recommend referrals for testing and health and mental hygiene care in a non-technical, peer-oriented manner. In addition, DOHMH is conducting educational conferences, workshops and programs targeted to health care providers, physicians, hospitals, community organizations and the leadership of the NYC HIV Prevention Planning Group, a group of consumers, providers and public officials who plan and prioritize HIV-prevention services and funding.
- €# Targeted treatment expansion using City Council appropriation. Crystal meth treatment services have been unable to keep pace with this rapidly emerging problem. DOHMH was awarded \$670,000 from the New York City Council for the development and implementation of a crystal meth prevention, treatment, and education initiative. A substantial portion of this funding will be allocated for treatment services. Specifically, this funding will permit chemical dependency treatment programs to increase their capacity to treat crystal meth abuse and/or institute new evidence-based treatment innovations.
- €# Applying for funding to further expand evidence-based treatment. In addition to our focus on prevention, we intend to promote the development of appropriate treatment services. There is an absence of evidence-based program models for individuals who become addicted to, or dependent on, crystal meth. We want to ensure that these individuals receive quality care. As a result, we are pursuing federal funding through the Substance Abuse and Mental Health Services Administration's Targeted Capacity Expansion grant to help us develop treatment models for crystal meth. With this funding,

we aim to develop a structured treatment model that can be replicated and that will enhance New York City's ability to provide treatment services to individuals who are addicted to crystal meth.

Quality IMPACT: DMH's Quality Improvement Initiative

Quality IMPACT: Improving Mental Hygiene Programs & Communities Together, is DMH's division-wide top priority initiative. It is aimed at increasing the quality of mental hygiene services throughout the NYC mental hygiene community. The mission of Quality IMPACT is to implement a data-driven process that supports continuous quality improvement in mental hygiene programs and that encourages groups of programs to focus on targeted improvement areas. The CQI process will eventually move the system toward more effective treatment and other services, better outcomes, and continuous integration of evidence-based and innovative practices.

Eight principles were established to guide all Quality IMPACT activities:

- ⌘ Continuous Quality Improvement processes are used to make improvements in services and outcomes.*
- ⌘ Consumers, families, providers and advocates as well as all Division of Mental Hygiene staff are involved in the quality improvement process at all levels.*
- ⌘ Communication is open and clear among all stakeholders.*
- ⌘ Incentives are used to promote quality mental hygiene services.*
- ⌘ Quality indicators and measures are compatible with state, federal and private performance measurement systems to maximize coordination and minimize burden.*
- ⌘ Quality indicators are useful, meaningful and manageable for all stakeholders.*
- ⌘ Evidence-based practices, clinical consensus guidelines, opportunities for innovation, and locally developed, promising practices are encouraged.*
- ⌘ Performance data are transparent and publicly available.*

DMH, with broad stakeholder input and consultation from national and local experts, has determined three system-wide priority areas for quality improvement: the identification and assessment of co-occurring disorders, cultural competence and consumer perceptions of care.

Co-Occurring Disorders

An estimated 20 percent of the seriously and persistently mentally ill consumers who receive

mental health services in NYC also have a substance use disorder.¹⁸ In addition, 1.5 percent of New York City youth ages 9-17 who are in mental health treatment also have a substance use disorder.¹⁹ According to OASAS 2002 admissions data, 15 percent of all New York City consumers admitted to chemical dependence treatment also have a mental illness.²⁰

The CQI projects addressing co-occurring disorders are planned as multi-year efforts. During the first and current year (FY '05), a structured CQI project is being implemented in 23 mental health clinics and continuing day treatment programs. The goal is to help clinicians improve the identification of substance abuse problems in consumers of ambulatory mental health treatment services. Additionally, it will direct clinicians within a mental health setting to better address substance abuse with consumers as an integral part of the treatment planning process.

Next year, the Quality IMPACT initiative will expand to implement an analogous project with alcohol and substance abuse treatment programs to increase the identification and assessment of psychiatric disorders in consumers of chemical dependence treatment programs. These projects, taken together, are intended to enable clinicians to better identify and address co-occurring disorders as an integral part of treatment planning, regardless of the setting. A Chemical Dependence stakeholder workgroup will be established to select tools, establish indicators and identify target rates for this project.

DMH recognizes that current research evidence supports the integrated treatment of co-occurring disorders as the best practice, yet there are systemic barriers to implementing integrated treatment in the current service system. The CQI co-occurring disorders project intends to incrementally move the system towards integrated treatment, by starting with the promotion of better identification and treatment planning for consumers entering any door of the mental hygiene system. We plan to utilize (MICA) training funding available to New York City to enhance provider competence in these two areas.

Cultural Competence

New York City is the largest and most racially/ethnically diverse city in New York State and in the country. According to the year 2000 Census, 35 percent of the city's population is white, 27 percent is of Hispanic origin, 25 percent is African American, and almost 10 percent is of Asian origin. These numbers however, obscure the true diversity of the people who live in the City. For example, the five largest Asian groups in the city are Chinese, Asian Indian, Korean, Filipino, and Pakistani and the five largest groups of Hispanic origin are Puerto Rican, Dominican, Mexican, Ecuadorian, and Colombian. Moreover, NYC comprises people who identify with races/ethnicities from all over the world. It is estimated, for example, that in Queens alone over 120 languages are spoken.

Providing culturally competent mental hygiene services is both an imperative and a challenge,

¹⁸ New York State Office of Mental Health Patient Characteristics Survey, 2001.

¹⁹ Wunsch-Hitzig R, Engstrom M, Lee R, King C, McVeigh K. *Prevalence and Cost Estimates of Psychiatric and Substance Use Disorders and Mental Retardation and Developmental Disabilities in NY*. New York: New York City Department of Health and Mental Hygiene, Division of Mental Hygiene, Bureau of Planning, Evaluation and Quality Improvement, 2003, page 12.

²⁰ OASAS 2004 County Data Profile for New York City, April 2004, Bureau of Addiction Planning and Grants Development, New York State Office of Alcoholism and Substance Abuse Services, page 4.

given the diversity of New York City's population. The goal of this project is to improve cultural competence among the City's mental hygiene providers.

We define cultural competence as follows:

- # Understanding the role that culture plays in defining and recognizing mental hygiene problems, accessing care, and adhering to treatment recommendations.*
- # Using culturally relevant outreach strategies to address barriers to accessing services.*
- # Developing effective treatment services that are compatible with the consumer's culture and linguistic needs.*

For the purposes of this project, cultural groups are defined on the basis of such characteristics as age, gender identity, race, ethnicity, country of origin, language, sexual orientation, and/or disability. The objectives of this project are to increase the admission of adults of an identified cultural group to programs where they are under represented or underserved, and to improve the assessment and treatment of all adults by identifying important cultural factors during the initial assessment that should be considered in the treatment planning process. Participating providers will choose a cultural group to target, and utilize a brief cultural assessment instrument, the City-Wide Cultural Assessment (CCA), which has been developed by a stakeholder work group sponsored by DMH. When cultural factors are identified through this assessment, recommendations for integrating these factors into treatment are incorporated into the consumer's initial treatment plan. In FY05 we are implementing this project in 15 adult mental health clinics and continuing day treatment programs. We are planning to implement this project among chemical dependence treatment providers in City FY06 (starting July '05).

Consumer Perceptions of Care

Consumer Perceptions of Care is a key element of quality that we are committed to addressing. It has been demonstrated that consumer satisfaction with services is critical to motivating consumers to engage and participate in treatment, and that consumer feedback can guide planning efforts to improve delivery of services. We are currently exploring the implementation of a Consumer Perceptions of Care survey in chemical dependence treatment programs in FY06. We plan to convene a stakeholder work group to select a tool and develop an implementation methodology. The survey will enable us to hear directly from consumers in a way that allows us to analyze responses across programs, develop system baselines, and plan systemic improvements. This year we are implementing Consumer Perceptions of Care surveys in mental retardation/developmental disabilities (MR/DD) employment programs and mental health treatment programs. The consumer survey we use addresses four domains: appropriateness and quality of services, service outcomes, consumer satisfaction, and consumer rights. We plan to build on the experience we gain this year through the administration of these surveys to guide us in planning for the upcoming survey of consumers with chemical dependence.

We anticipate Quality IMPACT will influence the chemical dependence service system on several levels. First, we expect programs to become proficient in continuous quality

improvement as a method for assessing how they are doing in key aspects of service delivery and in improving their services. Second, aggregate data analyses by DMH will enable us to identify local “best practices,” and establish benchmarks for desired service outcomes. We intend to ensure that public dollars are optimally spent, by incorporating benchmarks and outcomes into performance-based contracting, and using the data to identify exemplary programs. Furthermore, the process of working closely with providers as they implement interventions to improve services will yield important information about system-level obstacles to providing optimal services. Those obstacles the Division will not be able to address directly will become part of DMH’s advocacy agenda for improving services for New York City residents with chemical dependence.

IV. PLANNING PRIORITY SURVEY

Description and Response Rate

OASAS asked all OASAS-funded and -certified prevention and treatment programs to complete the 2005 Planning Priority Survey. The objective of this program-level mail survey was to identify priorities among prevention and treatment providers, and to obtain their input on potential strategies to address these issues. OASAS sent surveys to 120 prevention providers and 164 treatment providers in New York City with a request that they forward copies of the survey to their 493 treatment program sites.

The response rate was 17 percent, with 116 out of 493 programs responding. As we have minimal data on non-responding prevention and treatment programs, we are unable to assess the extent to which responding programs are representative of the universe of programs surveyed and whether the findings are generalizable to the 493 chemical dependency programs in New York City.

Summary of Key Findings

Using a five-point scale ranging from low (1 point) to high (5 points), respondents were asked to rate the “relative importance” of 26 issues that impact their “program, consumer, or the chemical dependence service system in general.” Many participants did not answer all of the questions; therefore, the response totals were different for each of the 26 Issue Categories. Moreover, since the question asked respondents to consider these three different aspects of the service delivery system, we cannot know which areas specific responses address.

Below are the top three Issue Categories based on the percentage of programs rating the issue as a “4” or “5”.

Table 1

Issue Category	Percent Rating the Issue 4 or 5
Housing	77%
Co-Occurring Disorders	76%
Vocational Rehabilitation	71%

Top Three Priority Issues

The second part of the survey asked participants to identify their top three priority issues from the 26 categories, to explain briefly why the issues are critical and to explain how they can be addressed by the county and OASAS. Table 2 shows the top three priority issues selected:

Table 2

Priority Issue	Number of Respondents (N=116)
Co-occurring Disorders	51
Housing	47
Adolescents	27

Housing and co-occurring disorders emerged as the two issues of greatest concern. Adolescent issues were ranked third, but were identified as priority by many fewer respondents.

Summary of Comments on the Top Three Priority Issues

Priority 1: Co-occurring Disorders: Providers are experiencing an increased number of adults and adolescents presenting with both chemical dependence and mental health disorders. Many programs estimate that the majority of their consumer population has co-occurring disorders with severe and persistent psychiatric conditions. Providers identified the following barriers to providing adequate treatment for individuals with co-occurring disorders: limited access to psychiatric staff or staff with special training; a lack of special programs to address the needs of consumers with co-occurring disorders; inadequate integrated models of treatment within the system; and a lack of community resources for referrals.

The results of the Planning Priority Survey are aligned with DMH's priority focus on the assessment and treatment of individuals with co-occurring disorders. Through DMH'S newly launched QI initiative, participation in the State's Dual Recovery Initiative and our related MICA training activities, we hope to effect a major improvement in the treatment of consumers with co-occurring disorders.

Priority 2: Housing: Providers perceive housing as a major component in recovery from chemical dependence disorders. Barriers to accessing affordable housing are stressors and may trigger relapses for consumers who have completed treatment. Providers experience great difficulty finding affordable housing for consumers who: are graduating from treatment programs; have co-occurring disorders; are in need of on-site mental health supportive services; or are mothers with children, and need more spacious residences and child-care.

Providers offered a few suggestions for resolving the housing problem. They recommended increasing funding to hire additional staff to focus more closely on the housing needs of consumers and increasing funding for Halfway Houses, Supportive Housing and Section 8 Housing.

At DMH, the creation of housing opportunities for persons with mental illness, chemical

dependence and MR/DD is a priority. While we currently fund a number of supported housing programs (both scattered-site and single room occupancy housing) that serve consumers with co-occurring mental health and chemical dependence disorders, the unmet need for such housing is significant.

Priority 3: Adolescents: Providers state that youth ages 12-19 are most at risk of experimenting with alcohol and/or other chemicals that can lead to dependence. Particularly at risk for chemical dependence are youth who have immigrated from other countries and may not be familiar with existing preventive and treatment programs; youth who are exposed to drug dealing and alcohol/drugs in their neighborhoods and schools; and teenagers who lack adequate supervision, runaway from home or are homeless. Providers believe there is a significant unmet need for prevention programs that target adolescents. Additionally, providers note a need for appropriate housing options for youth who are homeless.

V. COLLABORATION BETWEEN NYC DOHMH AND NYS OASAS ON LOCAL GOVERNMENT INITIATIVES

OASAS' emphasis on a needs assessment methodology complements our data-driven planning focus and revised planning framework. We anticipate a great deal of data exchange with OASAS, and we are actively engaged in discussion with OASAS to strengthen communication and data sharing. Data from the Community Health Survey and the NYC HANES studies will be shared with OASAS, while OASAS' provider database and service utilization data will enhance local planning in New York City. These opportunities to work together will enhance our mutual effort to more accurately identify the service needs of consumers with chemical dependence needs in New York City.

DOHMH is participating in the pilot for the Community Indicators for Service System Improvement (CISSI) project that OASAS has undertaken to identify areas for improvement across New York State. Of particular interest to DMH are those indicators concerning co-occurring disorders, as this is a major focus of our quality improvement activities.

DMH has identified a system-wide planning need to know: how many unique individuals access services, what their diagnoses are, what services they are getting and with what outcomes. DMH has designed a twelve-item minimum consumer-level data set with de-identified data that we would like to collect on all consumers in our chemical dependence programs. Collecting consumer-level data will support planning for individuals whose treatment needs cross multiple disability areas and services. We plan to access available consumer-level data from OASAS where possible.

Another area for collaboration between DOHMH and OASAS is in the development of "best practices," "innovative practices," and other resources to meet the needs of consumers with co-occurring disorders. As we expand our focus on co-occurring disorders through our quality improvement initiative over the next several years, we will be encouraging New York City providers to incorporate best practices into their service delivery, and at the same time, expect

that providers participating in this initiative will develop innovative practices worthy of further attention.

VI. PLAN ASSURANCES – See attached.

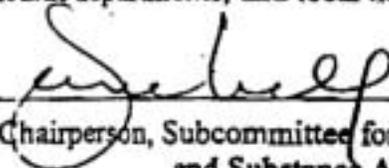
Assurance A
The 2005 Local Services Planning Process for
Alcoholism and Substance Abuse Services

LGU: New York City

Pursuant to Article 41 of the Mental Hygiene Law, we assure and certify that:

- Representatives of facilities of the offices of the department; directors of district developmental services offices; directors of hospital-based mental health services; directors of community mental health centers, voluntary agencies, consumers, and consumer groups; and other providers of services have been formally invited to participate in, and provide information for, the local planning process relative to the development of the Local Services Plan;
- The Community Services Board and the Subcommittee for Alcoholism or Alcoholism and Substance Abuse has provided advice to the Director of Community Services and has participated in the development of the Local Services Plan. Additionally, we assure and certify that the full Board and the Subcommittee have had an opportunity to review and comment on the contents of the plan and have received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16(c);
- The Community Services Board and the Subcommittee for Alcoholism or Alcoholism and Substance Abuse meets regularly during the year, and the Board has established bylaws for its operation, has defined the number of officers and members that will comprise a quorum, and has membership which is broadly representative of the age, sex, race, and ethnic characteristics of the area served. Additionally, I assure and certify that the Board has established procedures to ensure that all meetings are conducted in accordance with the Open Meetings Law, which requires that meetings of public bodies be open to the general public, that advance public notice of meetings be given, and that minutes be taken of all meetings and be available to the public.
- We also assure and certify that the local governmental unit has submitted a copy of this plan to the Health Systems Agency, where applicable according to 10 NYCRR Part 82 Section 82-1.6 (b) (7) which requires coordination of health system agencies activities with other appropriate general or special purpose regional health and human services planning or administrative agencies including area agencies on aging, local and regional alcohol abuse, drug abuse, and mental health planning agencies, social services agencies, county public health departments, and local health officers.

9/7/04
Date


Chairperson, Subcommittee for Alcoholism or Alcoholism
and Substance Abuse

Jane Velez

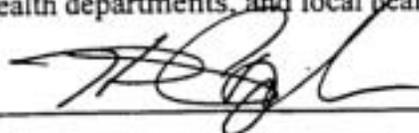
Assurance A
The 2005 Local Services Planning Process for
Alcoholism and Substance Abuse Services

LGU: New York City

Pursuant to Article 41 of the Mental Hygiene Law, we assure and certify that:

- Representatives of facilities of the offices of the department; directors of district developmental services offices; directors of hospital-based mental health services; directors of community mental health centers, voluntary agencies, consumers, and consumer groups; and other providers of services have been formally invited to participate in, and provide information for, the local planning process relative to the development of the Local Services Plan;
- The Community Services Board and the Subcommittee for Alcoholism or Alcoholism and Substance Abuse has provided advice to the Director of Community Services and has participated in the development of the Local Services Plan. Additionally, we assure and certify that the full Board and the Subcommittee have had an opportunity to review and comment on the contents of the plan and have received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16(c);
- The Community Services Board and the Subcommittee for Alcoholism or Alcoholism and Substance Abuse meets regularly during the year, and the Board has established bylaws for its operation, has defined the number of officers and members that will comprise a quorum, and has membership which is broadly representative of the age, sex, race, and ethnic characteristics of the area served. Additionally, I assure and certify that the Board has established procedures to ensure that all meetings are conducted in accordance with the Open Meetings Law, which requires that meetings of public bodies be open to the general public, that advance public notice of meetings be given, and that minutes be taken of all meetings and be available to the public.
- We also assure and certify that the local governmental unit has submitted a copy of this plan to the Health Systems Agency, where applicable according to 10 NYCRR Part 82 Section 82-1.6 (b) (7) which requires coordination of health system agencies activities with other appropriate general or special purpose regional health and human services planning or administrative agencies including area agencies on aging, local and regional alcohol abuse, drug abuse, and mental health planning agencies, social services agencies, county public health departments, and local health officers.

9/2/04



Kenneth Popler

Date

Chairperson, Community Services Board

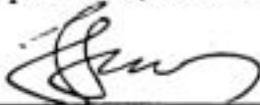
Assurance A
The 2005 Local Services Planning Process for
Alcoholism and Substance Abuse Services

LGU: New York City

Pursuant to Article 41 of the Mental Hygiene Law, we assure and certify that:

- Representatives of facilities of the offices of the department; directors of district developmental services offices; directors of hospital-based mental health services; directors of community mental health centers, voluntary agencies, consumers, and consumer groups; and other providers of services have been formally invited to participate in, and provide information for, the local planning process relative to the development of the Local Services Plan;
- The Community Services Board and the Subcommittee for Alcoholism or Alcoholism and Substance Abuse has provided advice to the Director of Community Services and has participated in the development of the Local Services Plan. Additionally, we assure and certify that the full Board and the Subcommittee have had an opportunity to review and comment on the contents of the plan and have received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16(c);
- The Community Services Board and the Subcommittee for Alcoholism or Alcoholism and Substance Abuse meets regularly during the year, and the Board has established bylaws for its operation, has defined the number of officers and members that will comprise a quorum, and has membership which is broadly representative of the age, sex, race, and ethnic characteristics of the area served. Additionally, I assure and certify that the Board has established procedures to ensure that all meetings are conducted in accordance with the Open Meetings Law, which requires that meetings of public bodies be open to the general public, that advance public notice of meetings be given, and that minutes be taken of all meetings and be available to the public.
- We also assure and certify that the local governmental unit has submitted a copy of this plan to the Health Systems Agency, where applicable according to 10 NYCRR Part 82 Section 82-1.6 (b) (7) which requires coordination of health system agencies activities with other appropriate general or special purpose regional health and human services planning or administrative agencies including area agencies on aging, local and regional alcohol abuse, drug abuse, and mental health planning agencies, social services agencies, county public health departments, and local health officers.

1/10/04
Date



Commissioner/Director

Dr. Lloyd J. Seider

Assurance B
Full and Equal Participation of Newly Established
Not-for-Profit Community-based Organizations
2005 Local Services Plan

LGU: New York City

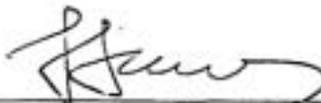
New York State and its local municipalities provide health and human services primarily through arrangements with not-for-profit organizations. As the ethnic composition of New York has changed, newly established organizations have sought funding to serve these new populations. In many cases, these emerging community-based organizations (CBOs) have little or no experience in identifying funding streams, developing proposals which meet the goals of the funding source, and successfully approaching State and local government agencies for funding.

It is the responsibility of State agencies to expand the potential provider network and to simplify the process by which service providers develop program proposals and funding requests, thereby ensuring that all organizations have an equal opportunity to compete for available funds.

As part of the local services planning and budgeting process for alcoholism and substance abuse services, it is the obligation of the local governmental unit and the local designated agency to take necessary steps to include these newly established organizations in all opportunities to fully participate in the competitive process that is open to all service providers, including any and all forms of technical assistance.

Therefore, pursuant to Executive Chamber Policy Memorandum No. 93-12, I assure that efforts have been undertaken to reach out to new and emerging not-for-profit community-based organizations (CBOs), to solicit their participation in the local planning and budgeting process, and to provide technical assistance to such organizations to insure their full and equal access to program development and funding opportunities.

9/10/04
Date


Commissioner/Director

Dr. Lloyd J. Sederer

Assurance C
Multi-Disabled Considerations
2005 Local Services Plan

LGU: New York City

The term "multi-disabled" means, in this context, individuals who have at least two of the following disabling conditions: a developmental disability, a mental illness, or alcoholism/substance abuse. In order to effectively meet the needs of these individuals, several aspects should be addressed in a comprehensive plan for services. Accordingly:

1. Is there a component of the local governmental unit responsible for identifying multi-disabled persons?

Yes No

If yes, briefly describe the mechanism used to identify such persons:

N/A _____

2. Is there a component of the local governmental unit responsible for planning of services for multi-disabled persons?

Yes No

If yes, briefly describe the mechanism used in the planning process:

The Bureau of Planning, Evaluation and Quality Improvement in conjunction with Adult and Child and Adolescent Program Service Offices are responsible for planning services for multi-disabled persons. Integrated treatment is the premier evidence-based practice for individuals with co-occurring disorders. A major planning goal of the Division of Mental Hygiene is to move all of New York City's mental hygiene providers towards providing integrated treatment. We are leading initiatives to promote integrated treatment and are working with other organizations that share our commitment to this goal.

Since 2000, the Department has participated in an initiative to promote integrated treatment for individuals with co-occurring mental health and substance abuse disorders, sponsored by OASAS and the State Office of Mental Health. This participation has enabled us to employ a full-time Dual Recovery Coordinator (DRC).

More recently, we have developed a quality improvement initiative, "Quality IMPACT: Improving Mental Hygiene Programs & Communities Together." The goal of this project is to move the mental hygiene system toward implementing evidence-based and innovative practices, providing effective integrated treatment, and achieving better outcomes.

During the first and current year (FY '05), implementation of Quality IMPACT is focused on piloting a screening tool to increase the identification and assessment of co-occurring alcohol

and substance use disorders in consumers served by mental health treatment programs. Next year, the Quality IMPACT initiative will implement an analogous project with chemical dependence treatment programs to increase the identification and assessment of psychiatric disorders. These projects are intended to enable clinicians to better address co-occurring disorders as an integral part of treatment planning. To that end, DMH has dedicated funding to provide training to those programs participating in the Quality IMPACT project. These trainings will focus on improving clinicians' screening, assessment, and treatment planning skills.

As part of the Quality IMPACT initiative, we are committed to collecting individual de-identified data that will enhance our understanding and planning for individuals whose treatment needs span more than one disability area. DMH is actively engaged in planning the most effective strategy to implement this project with OASAS and our other State mental hygiene partners.

To further support programs in providing integrated treatment, we have worked with the Mental Health Association of New York City to develop the MICA Training Institute, for which the State Office of Mental Health has provided funding. The Institute has conducted trainings focused on developing a highly skilled cadre of specialists who can more appropriately assess and treat the complex needs of individuals with dual psychiatric and substance abuse disorders. Both direct service and supervisory staff from DMH-funded agencies have participated in the trainings.

Thus far, in 2004, the MICA Training Institute has implemented three trainings: Screening and Assessment, Motivational Interviewing, and Psychopharmacology. In addition, the three primary participating agencies in the MICA Training Institute recently formed the MICA Partnership. The MICA Partnership's goal is to increase provider and other stakeholder representation in the advancement of integrated treatment at a citywide level.

The Department also serves on the NYS Dual Diagnosis Advisory Group. This group is overseeing a project of the New York State Developmental Disabilities Planning Council that is providing cross-disability training through three Centers of Excellence for Dual Diagnosis. Two of the centers are in the New York City region, and Department staffs are actively involved in the Centers' efforts. The Centers have offered in-person and video conference training sessions to providers and are in the process of preparing a resource directory.

During the past decade, DMH has utilized Community Mental Health Reinvestment funding to create and expand services to address the needs of people with both chemical dependence and mental health disorders. Reinvestment provided almost \$17 million for 91 programs throughout New York City to address the needs of individuals with dual disorders. These programs provide a range of services: outreach, housing, case management, including services for children and adolescents.

The Department looks forward to continuing its collaborative relationship with the State as well as with consumers, families of consumers, advocates, and providers to increase the capacity of New York City's mental hygiene system to appropriately assess and address the needs of those with more than one mental hygiene disorder.

3. Are there mechanisms at the local or county level, either formal or informal in nature, for resolving disputes concerning provider responsibility for serving multi-disabled persons?

Yes No

If yes, describe the process(es), either formal or informal, for resolving disputes at the local or county level and/or at other levels of organization for those persons affected by alcoholism and other disabling conditions:

The Federation's Citywide Committee for People With Co-Existing Disabilities is charged with addressing issues related to cross-system needs. When necessary, the Committee assists providers in arranging appropriate care for individuals with multiple disabilities. In addition, the disability-specific offices in the Department's Bureau of Community Liaison and Training assists in resolving disputes presented by providers and consumers. The Citywide Oversight Committee of the NYS Coordinated Children's Service Initiative is another mechanism to assist providers in resolving disputes about care for children and adolescents with multiple disabilities. In New York City, borough-based committees representing different child-serving systems (e.g., foster care, juvenile justice, education, mental hygiene) discuss problems with finding appropriate services for dually or multiply disabled children and resolving problems on a case-by-case basis.

Assurance D
Membership of the Subcommittee for
Alcoholism and Substance Abuse Services
2005 Local Services Plan

LGU: New York City

Name: Jane Velez, President and Chief Executive Officer*
Represents: Palladia, Inc.
Address: 10 Astor Place, 7th Floor
New York, New York 10003
* Chair of the Alcohol and Substance Abuse Subcommittee

Name: David Gibson, CSW
Represents: KidsPeace, National Centers of New York.
Address: 4900-McGrane Road
Romulus, New York 14541

Name: James T. Curran, Dean of Special Programs
Represents: John Jay College of Criminal Justice
Address: 899 Tenth Avenue
New York, New York 10019

Name: Gerald Heaney, Social Service Program Director
Represents: Samaritan Village
Address: 34 Azalea Court
Staten Island, New York 10309

Name: Ketty Rey, PhD., President
Represents: International Alliance for Health and Social Development
Address: 520 Beach 43rd Street
Edgemere, New York 11691

Name: Carmen Rivera, Vice Chair
Represents: VIP Community Services

Address: 1513 St. Lawrence Avenue
Bronx, New York 10460

Name: **Brian F. Sands, M.D.**, Director, Division of Chemical Dependency

Represents: North Brooklyn Health Network

Address: 760 Broadway
Brooklyn, New York 11206

Name: **Neil Sheehan**, Executive Vice President

Represents: The Outreach Project

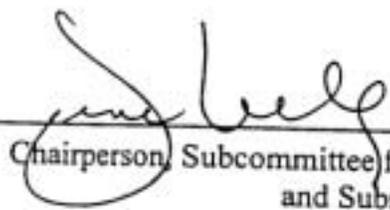
Address: 103 Noble Street
Brooklyn, New York 11222

Name: **Barbara Warren, Psy. D.**, Director of Organizational Development

Represents: The Lesbian, Gay, Bisexual, and Transgender Community Center

Address: 148 Bank Street, Apt. 5B
New York, New York 10014

9/7/04
Date


Chairperson, Subcommittee for Alcoholism or Alcoholism
and Substance Abuse

Jane Yekz