

APPENDIX A: STAKEHOLDER INPUT

During May and June 2005, DMH held meetings with five groups of stakeholders to elicit input for the Chemical Dependency Services Local Government Plan: the Association of New York City Addiction Programs (ANYCAP), Alcoholism and Substance Abuse Providers (ASAP), the Committee of Methadone Program Administrators (COMPMA), the Therapeutic Communities Association (TCA) and the Federation for Mental Health, Mental Retardation, and Alcoholism Services. Participants were asked to comment on unmet needs they have encountered, obstacles that hinder effective service provision, changes that would help improve the system, and priority issues that need government attention. Comments and suggestions are organized below according to target population and/or service area. Note that there is some overlap between the different service issues discussed, and that the bullets in the “Comments” and “Suggested Actions” columns are not meant to be read across, as there is not a 1:1 correlation between comments and suggestions.

<u>Target Population / Service Area / Issue</u>	Comments	Suggested Actions
Special Populations – Mentally Ill and Chemically Addicted (MICA)	<ul style="list-style-type: none"> • There are not enough MICA services or properly trained staff (psychiatrists & social workers) to provide MICA services; at least 50% of CD clients are MICA • It is difficult to enroll clients in MICA programs because it requires a mental health (MH) treatment history, which many MICA clients do not have because they self-medicate • Certain CD treatment philosophies (e.g., drug-free) conflict with the needs of MICA clients, who may need medication for MH issues • Reimbursement rates do not fully compensate providers for treating MICA clients • Regulatory rules do not allow for truly integrated treatment • CD programs are concerned that MH programs are seen by government as the place to serve MICA clients; this would result in CD programs losing half their client base; CD providers believe they are capable of providing MICA services • Screening activities (like those promoted through Quality IMPACT) will not result in service improvements until more funding is put into the system and funding/regulatory barriers are addressed • Many methadone clients need MICA services 	<ul style="list-style-type: none"> • Provide funding to increase capacity and to appropriately train staff to meet MICA needs • Advocate for rate enhancements that adequately reimburse providers for full MICA services • Advocate for OASAS and OMH to develop creative mechanisms for joint funding to serve MICA clients • Advocate for changes to regulations so that true integrated treatment can be provided (dual licensure) • DMH should be helping the system develop and implement integrated treatment models; CD providers should be given the opportunity to take the lead • Consider using harm reduction models for MICA services

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Special Populations – Adolescents	<ul style="list-style-type: none"> • Existing approaches to treatment are not working well (e.g., marijuana & alcohol use is up among adolescents and traditional drug treatment models, which are typically aimed at heroin and cocaine, do not effectively address abuse of these substances) • Need a continuum of treatment services for adolescents, including prevention, crisis, residential and halfway houses • There is a lack of services for adolescents, especially residential, so many are being served inadequately in the juvenile justice system • A big barrier to treatment is the lack of collaboration with the juvenile justice and foster care systems; adolescents are encouraged by lawyers to deny CD issues in order to improve their case disposition, which results in a lack of treatment • Many congregate care facilities are closing down • Programs located out of the City encounter barriers with transporting kids to the City for their court cases • Some providers are seeing an increase in adolescents with co-occurring CD/MH 	<ul style="list-style-type: none"> • Implement best practices and EBPs for adolescent treatment services • Develop treatment programs in schools since it is a captive audience; include families in the treatment process • Promote (improved) collaboration between adolescent CD services and the juvenile justice and child welfare systems • Provide funding to increase residential services for adolescents • The City should try to draw down Medicaid funds for adolescent services
Special Pops: Other	<ul style="list-style-type: none"> • Elderly – growing need; often require different services than models are set up to provide (e.g., can't get into top bunks in residential programs); many do not speak English • Women (w/ kids) – growing need (especially in residential setting); not enough appropriate services available (e.g., hard to get residential treatment unless willing to be away from kids) • Uninsured/working poor – many programs can not afford to provide services to this population; non-profits often serve this population, and have to absorb the costs • Immigrants (undocumented) – difficult to get culturally/ linguistically competent services; often afraid to seek treatment if undocumented • Homeless – many homeless individuals with CD problems have cognitive impairments and require specialized services which many programs are not equipped to provide 	<ul style="list-style-type: none"> • Providers request that DMH begin thinking about initiatives to better meet the needs of these populations

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Special Pops: Other – Continued	<ul style="list-style-type: none"> • Forensic – there is a great deal of client overlap between the criminal justice and CD systems, but limited collaboration around service provision 	
Prevention	<ul style="list-style-type: none"> • There is a lack of prevention services, and existing services do not effectively target specific populations (e.g., not enough prevention counselors in schools for adolescents) • Existing prevention services do not adequately engage/educate families and the community • Existing prevention services do not utilize promising/evidence based practices 	<ul style="list-style-type: none"> • Funding for prevention services should be increased • High-risk adolescents (e.g., children of alcoholics) and elderly users of prescription drugs should be targeted for specific prevention services • Innovative/promising programs and EBPs should be used as models to improve existing services and to engage families and the community in services • With the merger, DMH should look more broadly at prevention; use the public health model and look outside the CD system – to primary health care, schools, etc. • Prevention services should also target individuals who access prescription drugs through the Internet
Housing	<ul style="list-style-type: none"> • There is a lack of housing opportunities for individuals in the different stages of recovery (Note: housing is distinct from residential treatment) • DHS eligibility rules are unnecessarily restrictive, forcing many individuals into the unstable environment of shelters 	<ul style="list-style-type: none"> • More halfway houses should be made available (e.g., no supportive living facilities in Manhattan) • More permanent housing should be made available • DMH should collaborate with DHS to change some of the restrictive eligibility rules • SROs should have services (e.g., relapse prevention groups); and there should be more sober SROs
Cultural Competency	<ul style="list-style-type: none"> • Due to a lack of services for those minimally proficient in English, many programs turn away clients • It is difficult for bilingual staff to become certified (some have certifications from other countries that are not recognized here); it is difficult to supervise bi-lingual staff • There are not enough services for Asians, Hispanic/Latinos and members of the Lesbian, Gay, Bisexual & Transgender community • Creating an awareness about cultural competency (through Quality IMPACT) is good, but no real change will happen until money is put into the system 	<ul style="list-style-type: none"> • DMH’s MH MSW scholarship program with Hunter should be replicated for CD • Provide funding to increase culturally competent services for the Asian, Hispanic/Latino and LGBT communities • Provide funding for cultural competency work including designing/re-designing program models, staff training, and staffing up programs with culturally competent staff

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Crisis / Detox Services	<ul style="list-style-type: none"> • There are not enough beds; notable areas/populations lacking services include Queens, Brooklyn and immigrants (citywide) • Need a range of service options, especially community-based detox; and detox needs to be tied more closely to treatment • Funding mechanisms make it difficult to develop community-based detox because many clients will not have Medicaid, and if they apply, approval process will be slow, so programs would need to absorb those costs 	<ul style="list-style-type: none"> • Advocate for Medicaid reimbursement rules that will reverse the disincentive for developing community-based detox services • The MATS initiative should be planned carefully so that it addresses concerns regarding crisis/detox services
Residential Services	<ul style="list-style-type: none"> • Residential services are one of the most neglected service areas, funding-wise (e.g., there has been no expansion of the therapeutic community system and no rate increases in the past 12 years) • Medicaid reimbursement/rate structures do not allow for full reimbursement of actual services provided (residential programs receive \$50 for a full day -- meals, bedding and treatment -- while outpatient programs receive \$77 for a 45-minute visit) • Managed care rules are a barrier to treatment (once enrolled in a residential program, clients are dis-enrolled from managed care and the programs must absorb the costs) 	<ul style="list-style-type: none"> • Funding should be provided to help increase rates and capacity so it meets the need • Advocate for fair rate structures and enhanced rates for comprehensive case management and/or wraparound services
Workforce Issues	<ul style="list-style-type: none"> • Providers are concerned about if/how the recent changes in social work licensure (two new professional licenses – LMSW & LCSW) will affect the system • Educational requirements for maintaining CASACs are excessive and costly so the number of CASACs is decreasing • Salaries are too low; providers have trouble attracting and retaining qualified staff • There is a lack of skilled staff able to work with cognitively impaired clients; many programs must use para-professional staff, which is not adequate 	<ul style="list-style-type: none"> • Funding should be provided for salary increases • DMH's MH MSW scholarship program with Hunter is a good model for CD
Interagency Collaboration	<ul style="list-style-type: none"> • CD discipline crosses many government agencies (social services, child welfare, criminal justice, etc) and coordination is difficult • Coordination with law enforcement is especially difficult and important, since many CD clients wind up in the criminal justice system first 	<ul style="list-style-type: none"> • Providers would ideally like one central local government agency (DMH) to be their first point of contact for all City-related concerns • OASAS and DMH should look into using the consolidated reporting form that was developed awhile ago for Suffolk County

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Interagency Collaboration – Continued	<ul style="list-style-type: none"> • Most providers are in contract with various City and State agencies, which all have different paperwork requirements, as well as auditing schedules and requirements; this puts a tremendous burden on staff, causing bureaucracy to get in the way of treatment 	<ul style="list-style-type: none"> • OASAS and DMH should coordinate auditing requirements and schedules
Methadone	<ul style="list-style-type: none"> • A major regulatory barrier in NYS (but not the rest of the country) is that the regulations do not allow for once a month pick-up; also, restrictive capacity limits result in waiting lists • Because regulations are so strict, treatment planning is driven by regulations, rather than clients' service needs • Methadone providers are dependent on Medicaid; government is telling providers to get clients employed, but once employed, clients lose Medicaid and can't access treatment • Methadone providers see methadone as the gold standard, because it is a successful method of treatment for many individuals, but they would like to participate in DMH's buprenorphine initiative so that they have the ability to offer another treatment option • Methadone treatment is underutilized in the criminal justice system 	<ul style="list-style-type: none"> • Advocate for NYS regulations to be updated to match revisions made to the Federal regulations, which are now more flexible
Funding / Regulatory Issues	<ul style="list-style-type: none"> • Reimbursement structures do not support actual cost of treatment so programs either turn away clients in need or absorb the costs; can be a disincentive to expanding or developing needed services (community-based detox was given as an example) • Funding for CD has been flat for years, despite increasing needs • CD programs, especially residential programs, must implement many unfunded mandates, which cause financial strain • Regulatory rules do not allow for truly integrated treatment (MICA) • Managed Care regulations create barriers for working people who need on-going recovery (only get approved for 10 outpatient sessions or 3-5 day rehab) 	<ul style="list-style-type: none"> • Advocate for changes to reimbursement structures and enhanced rates • Advocate for regulatory changes to allow for dual-licensure and truly integrated treatment • Provide funding to help increase capacity so it meets need, and to ease the burden of unfunded mandates
Aftercare Services	<ul style="list-style-type: none"> • Recovery is an ongoing process; treatment should not end after a predetermined number of days being sober • There need to be more aftercare services available to help people maintain recovery; AA and NA groups are not sufficient for all, some need more structured aftercare 	<ul style="list-style-type: none"> • Provide funding for aftercare services to ensure ongoing support and treatment for clients

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Vocational Services	<ul style="list-style-type: none"> • Employment is an important component of recovery and relapse prevention, but there are not enough vocational services available (especially for Hispanic/Latino communities) • Welfare-to-work rules are sometimes a hindrance to treatment/recovery; there needs to be improved collaboration with HRA 	<ul style="list-style-type: none"> • DMH should help increase the amount of vocational services available in the community, and should collaborate with HRA