

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



**LOCAL GOVERNMENTAL PLAN  
CHEMICAL DEPENDENCY SERVICES**

**2006**

**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**



**Bureau of Planning, Evaluation and Quality Improvement**

Jane D. Plapinger, MPH  
*Assistant Commissioner*

Rachel Amols, MPA  
*Planning Analyst Supervisor*

Angela Christofides, MSW  
*Planning Analyst*

Ken Mort  
*Research Scientist*

Robin Wunsch-Hitzig, PhD  
*Research Scientist II*

**Specials thanks to:**

Members of the following NYC provider stakeholder groups: the Association of New York City Addiction Programs, Alcoholism and Substance Abuse Providers, the Committee of Methadone Program Administrators, the Therapeutic Communities Association, and the Federation for Mental Health, Mental Retardation, and Alcoholism Services

Kenneth Popler, PhD, MBA, Chair  
*New York City Community Services Board*

Jane F. Velez, Chair  
*New York City Community Services Board Subcommittee for Alcoholism and Substance Abuse*

Alan J. Mathis, MS, Chair  
*Federation for Mental Health, Mental Retardation and Alcoholism Services*

Andrew Kolodny, MD  
*Medical Director, Special Projects*  
*Department of Health and Mental Hygiene, Division of Mental Hygiene*

And other colleagues at the Department who contributed to this Plan

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## **I. INTRODUCTION**

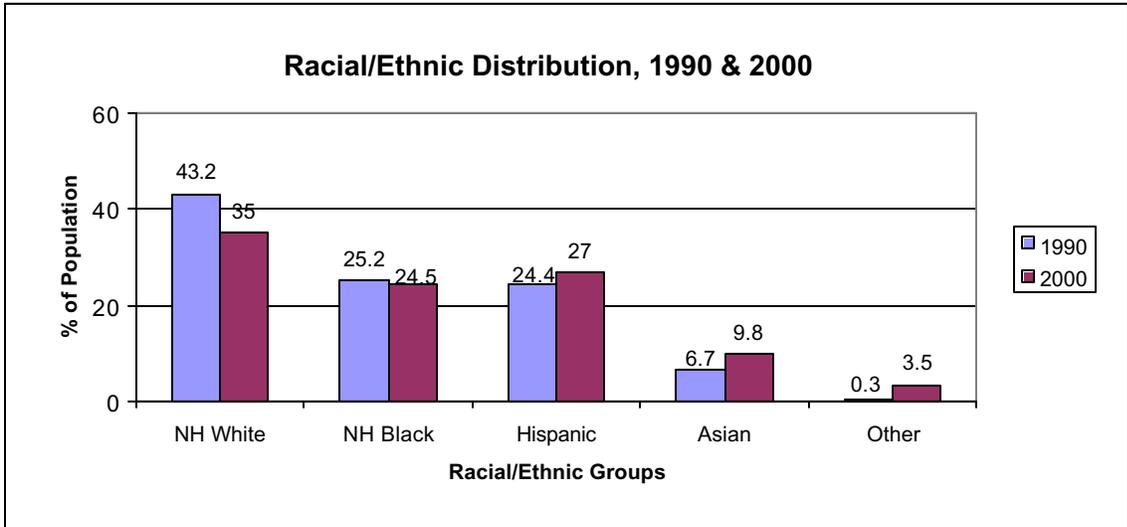
This year's Chemical Dependency Local Government Plan demonstrates incremental movement towards the implementation of a planning framework that is data-driven and includes quality as a key component. General prevalence data on alcohol and drug use in New York City (NYC), along with specific prevalence data relating to local priority initiatives, are presented. The Local Services System Assessment section has been strengthened this year by the inclusion of estimates of unmet need derived from OASAS' Need Methodology. The Division of Mental Hygiene's (DMH) quality improvement initiative, Quality IMPACT, is described, and data from the first year of activity are presented and discussed. Finally, stakeholder participation in the planning process was strengthened through meeting with key stakeholder groups to elicit their input regarding unmet need and priority concerns. Their input is summarized in the Plan and detailed in the appendix.

This year's Plan includes basic demographic information about NYC, the largest and most diverse city in the state. Local priority initiatives are outlined in the Plan using *goal* and *objective* statements, which will assist DMH with tracking the progress of targeted efforts to improve the City's chemical dependency service system. Finally, this year's Plan describes several new local priority initiatives: a brief intervention for problem drinking; pursuit of a strategy to reduce heroin overdose deaths; a project to improve access to chemical dependency services for individuals who are mentally retarded and/or developmentally disabled; and activities in response to OASAS Planning Supplements.

## **II. NEW YORK CITY DEMOGRAPHICS**

According to the latest census figures, New York City's population grew by more than nine percent between 1990 and 2000. The City's population is now for the first time over 8 million. Immigration played a crucial role in the City's growth with nearly 1.2 million new immigrants coming to reside in the City during the 1990s. Thirty-six percent of New York City residents are now foreign born and only about a quarter of them are proficient in English.

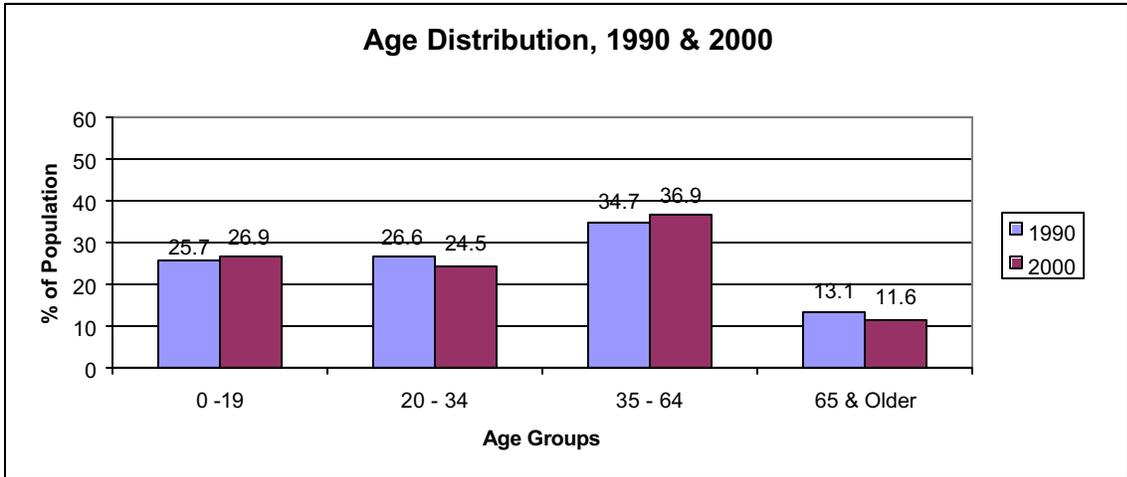
New York City is the largest and most racially and ethnically diverse city in New York State and the nation. Thirty-five percent of City residents are Non-Hispanic White, 24.5% are Non-Hispanic Black, 27% are Hispanic, 9.8% are Asian and 3.5% are Other (predominantly Non-Hispanic of mixed race). As indicated in the chart below, the proportions of Hispanics, Asians and Other increased during the 1990s while the proportions of Non-Hispanic Whites and Non-Hispanic Blacks decreased, the former most significantly.



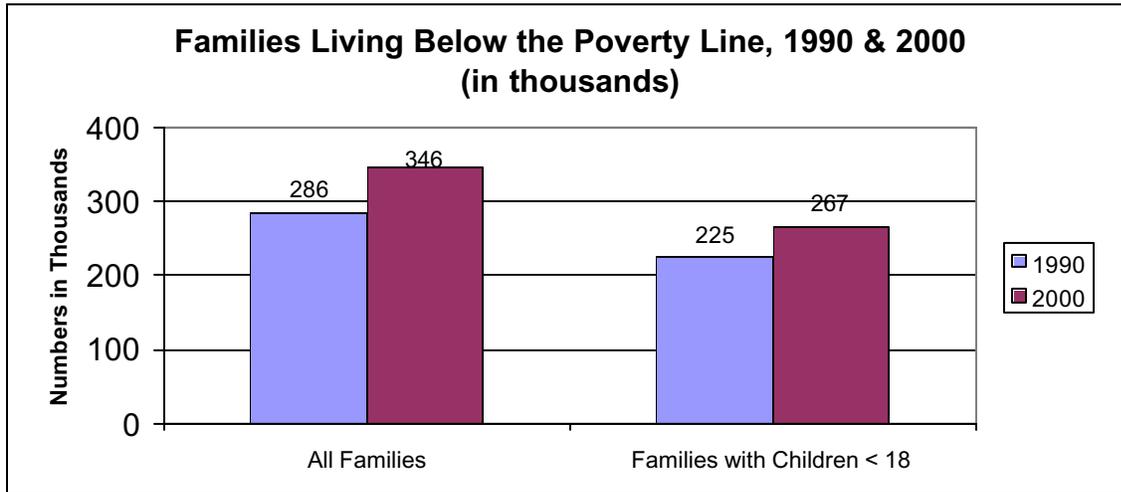
The City's minority populations originate from many different countries. For example, the five largest Asian populations come from China, India, Korea, the Philippines and Pakistan; and, the five largest Hispanic populations emigrated from Puerto Rico, the Dominican Republic, Mexico, Ecuador and Colombia.

Queens is the City's most diverse borough. Over one third of New York City's foreign born reside in Queens and over 120 languages are spoken in that borough alone. However, all five of New York City's boroughs are home to a heterogeneous population. Only in Staten Island does one group, Non-Hispanic Whites, make up a large majority. But even in Staten Island, almost 30% of the population is minority.

The overall age distribution in the City has changed little between 1990 and 2000. The proportion of youth 19 and younger and adults 35-64 increased slightly while the proportion of younger adults 20-34 years old and seniors 65 and older decreased slightly. Perhaps the most interesting change occurred in the population 85 and older. Although they are still a very small proportion of the population their numbers grew almost 19%.



Between 1990 and 2000 the number of New Yorkers living below the poverty line increased from about 1.4 to about 1.7 million, or from 19.3% to 21.3%, respectively. The numbers increased in all of the boroughs and across all major age groups. As indicated below, both in 1990 and 2000, the majority, or about three quarters, of families living in poverty included children under the age of 18.



### **III. LOCAL SERVICE SYSTEM ASSESSMENT**

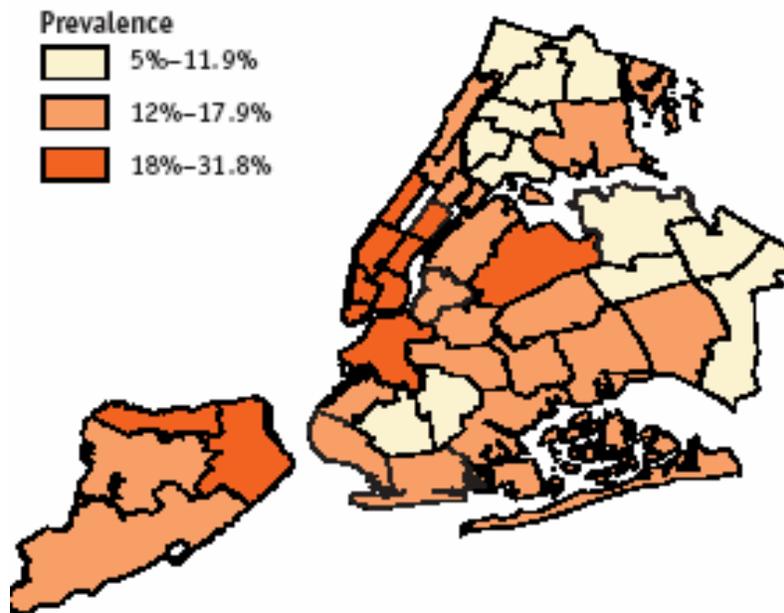
#### **Prevalence of Alcohol Problems in New York City**

OASAS estimates that about 500,000, or about 8%, of adult New Yorkers (ages 18+) have a drinking problem. A recent NYC Department of Health and Mental Hygiene (DOHMH) Community Health Survey<sup>1</sup> (CHS) found that about 15% of adult New Yorkers (ages 20+) drink to excess; that is, they are either heavy drinkers (consuming more than 60 drinks a month for men or more than 30 a month for women) or binge drinkers (consuming at least 5 drinks on any one occasion). About 2% are heavy drinkers; 11% are binge drinkers; and an additional 3% are both.

The CHS found that excessive drinking occurs most frequently in the following neighborhoods: below 96<sup>th</sup> Street in Manhattan; Jackson Heights, Elmhurst and Maspeth in Queens; Fort Greene, Park Slope and the Heights in Brooklyn; and in northern Staten Island.

<sup>1</sup> McVeigh, K.H., Kerker, B., Karpati, A., Lowe, C., Mostashari, F. & Sederer, L.I. (2004). Drinking in New York City. *NYC Vital Signs*, 3(3).

### Excessive Drinking by Residence, New York City, 2003



Another recent DOHMH study, the Youth Risk Behavior Survey (YRBS) conducted in 2003, found that about 16% of NYC high school students binge drink and that among males in the 12<sup>th</sup> grade that figure is as high as 25%. These figures have been fairly stable over the past several years. The most recent New York State Office of Alcoholism and Substance Abuse Services (OASAS) school survey for which data are available (1998) reports similar findings, stating that about 14% of 7<sup>th</sup> through 12<sup>th</sup> graders are “heavier” drinkers (consuming at least 2-4 drinks in a week). Although these figures have been fairly stable over the past several years, NYC provider stakeholders reported observing recent increases in alcohol use among the adolescents they are encountering.

Excessive drinking takes its toll in both illness and death. The most recent data from the New York State Department of Health’s Statewide Planning and Research Cooperative System (SPARCS) database (2001) indicate that about 322 of every 100,000 New Yorkers, or about 25,000 individuals, are hospitalized each year for alcohol-related illnesses. And, DOHMH estimates that in recent years more than 1,500 deaths have been due to alcohol related conditions.<sup>2</sup> These figures, too, have been relatively stable over the past several years.

#### **Prevalence of Substance Use Problems in New York City**

OASAS estimates that about 140,300, or about 2.2%, of adult New York City residents (ages 18+) have a problem with non-opiate drug use, and another 151,900, or 2.4% (ages 16+), have a problem with opiates. A recent white paper commissioned by DMH in 2003 puts the estimate of opiate use at approximately 200,000: 150,000 with near daily use and an additional 50,000 with

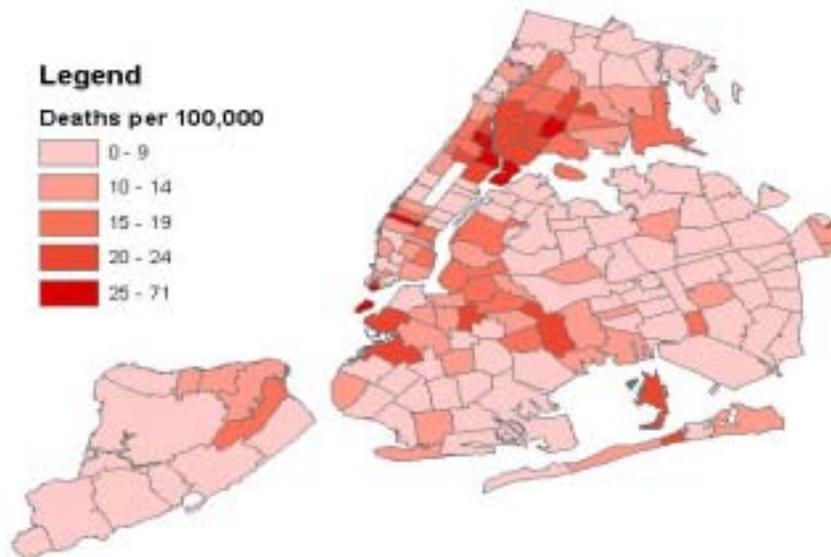
<sup>2</sup> McVeigh, K.H., Kerker, B., Karpati, A., Lowe, C., Mostashari, F. & Sederer, L.I. (2004). Drinking in New York City. *NYC Vital Signs*, 3(3).

occasional use.<sup>3</sup> Provider stakeholders indicated that heroin use is a significant problem in NYC. Local data estimating adult drug use in NYC will soon be available from both the 2004 and 2005 Community Health Surveys and the 2004 NYC Health and Nutrition Examination Survey.

The 2003 YRBS found that among high school students 15% use marijuana. That figure, which is lower than the national average of 24%, has remained stable over the past several years, although stakeholders reported recent observed increases in marijuana use among the adolescents they encounter. The study also found that fewer than 5% of students report current use of other drugs, among them the so-called “hard” drugs: cocaine, 4%; heroin, 2%; ecstasy, 5%; inhalants, 3%; and, methamphetamines, 2%. Although reports of current use have remained relatively low over the past several years, the reported rate of lifetime use of heroin has increased slightly from 1% and 0.9% in 1999 and 2001, respectively, to 1.6% in 2003. The 1998 OASAS school survey reported similar rates of marijuana and other drug use.

Each year about 900 New Yorkers die from drug overdoses, primarily from heroin and cocaine. That figure also has remained relatively stable over the past few years. Drug deaths are most frequent in the following neighborhoods: East Harlem, Central Harlem, Chelsea/Clinton and Union Square/Lower East Side in Manhattan; Hunts Point/Mott Haven, High Bridge /Morrisania, Croton/Tremont, and Pelham/Throgs Neck in the Bronx; and Sunset Park, Williamsburg/ Bushwick, East New York and Bedford Stuyvesant in Brooklyn. The following detailed map shows the geographic distribution by zip code of drug deaths across the City.

### Mean Annual Drug Deaths per 100,000 Population, 2000 - 2002



<sup>3</sup> 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.

## **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 five groups are: the Association of New York City Addiction Programs (ANYCAP), Alcoholism and Substance Abuse Providers (ASAP), the Committee of Methadone Program Administrators (COMPA), the Therapeutic Communities Association (TCA) and the Federation for Mental Health, Mental Retardation, and Alcoholism Services. A discussion tool developed for these meetings prompted participants to comment on the current chemical dependency service delivery system in NYC in terms of: 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.

While a range of concerns were discussed at these meetings, several issues were repeatedly noted:

- A lack of appropriate services for individuals with co-occurring chemical dependency and mental illness; adolescents; and the elderly
- A need for more prevention services, especially those targeted at high-risk populations like children of alcoholics, and those that engage families, the community and schools
- A lack of housing opportunities, including halfway houses and permanent housing
- Difficulties recruiting and retaining qualified staff
- A lack of coordination among the various agencies and systems that interact with the chemical dependency system, including DMH, OASAS, and the criminal justice, social services and child welfare systems
- Low reimbursement rates that do not meet the full costs of service provision and regulatory barriers that hinder treatment

Appendix A presents a detailed summary of stakeholder comments.

## **Estimates of Unmet Service Need in New York City**

DMH used the OASAS Need Methodology to generate estimates of unmet service need in NYC. The OASAS Need Methodology quantifies prevalence, service demand, needed capacity and current capacity to identify unmet need at the county/borough level. OASAS used population-based surveys to develop prevalence rates, focus groups to estimate service demand rates, and historical utilization patterns to estimate needed capacity within the different service categories. The resulting data derived from this methodology allow counties to compare current service capacity with estimated needed capacity to determine areas of unmet need.

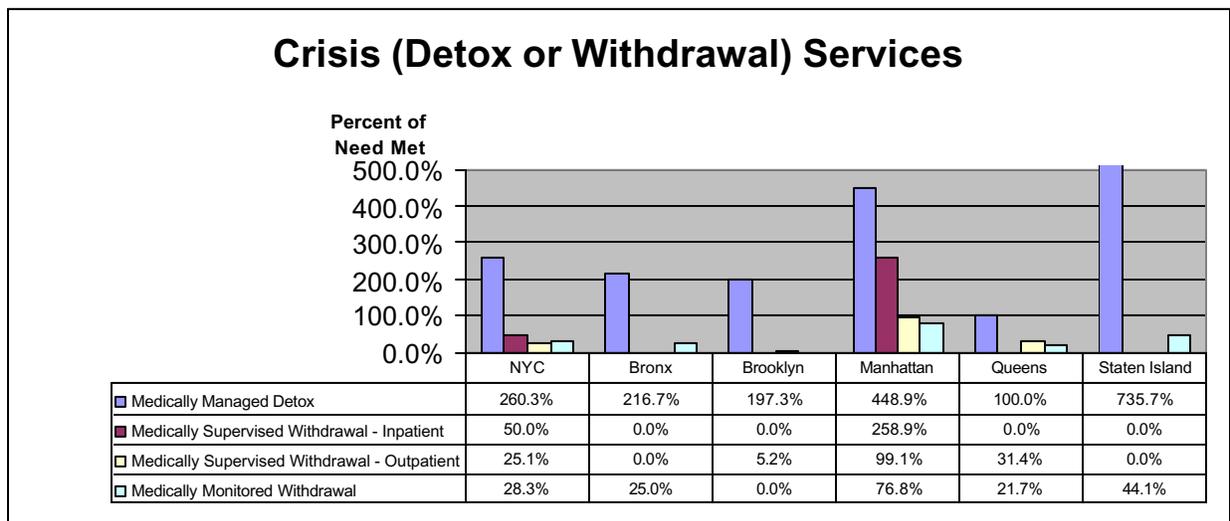
As this is DMH's first experience using this methodology, we are just beginning to assess whether it yields accurate projections of NYC service needs. NYC is a unique area of the state, with a much larger and more diverse population than other counties, a large and complex network of services, and a unique geographic landscape and public transportation system. In particular, the use of historical utilization rates to estimate treatment demand requires further assessment, as it is not clear whether this method accurately depicts how the optimal, preferred local service system should be configured, or rather merely depicts how people utilize the existing system, which may not be fully meeting their needs. DMH will collaborate with

OASAS over the course of the next year to further develop this methodology for application in NYC.

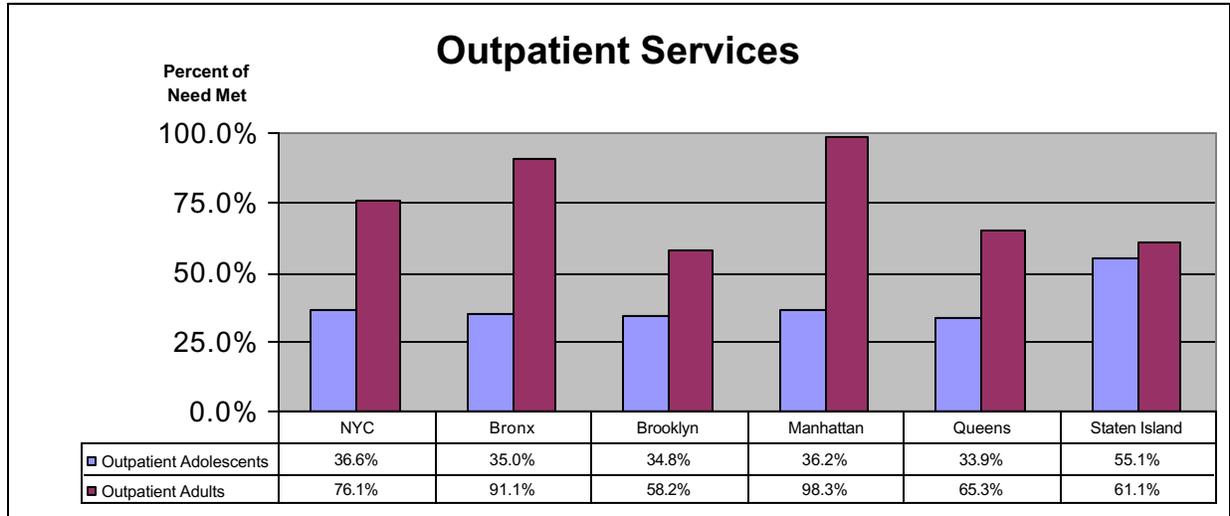
For this year’s plan, we are using the Need Methodology, as developed by OASAS, to estimate unmet service need by borough.

**Percent of Service Need Met**

The following charts and tables depict the percent of need met in the different service types. Percent of need met is defined as the ratio of current service capacity to estimated needed service capacity. The charts and tables indicate where there is inadequate capacity, or unmet need, and where there is over-capacity.

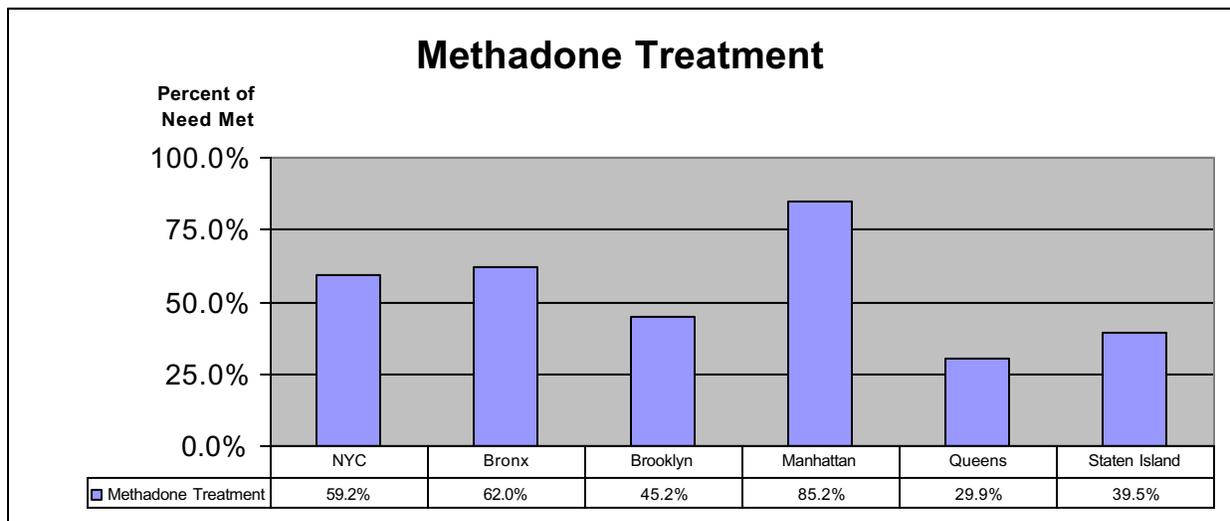


Citywide, especially in Manhattan and Staten Island, medically managed (hospital inpatient) detox services are well over-capacity (available service opportunities are greater than the need/demand for services). Medically supervised and medically monitored withdrawal services are significantly under-capacity throughout the five boroughs. Stakeholders advocated a shift in capacity from medically managed detox services to these other service types, noting that a range of service options are needed, especially community-based crisis and detox beds.

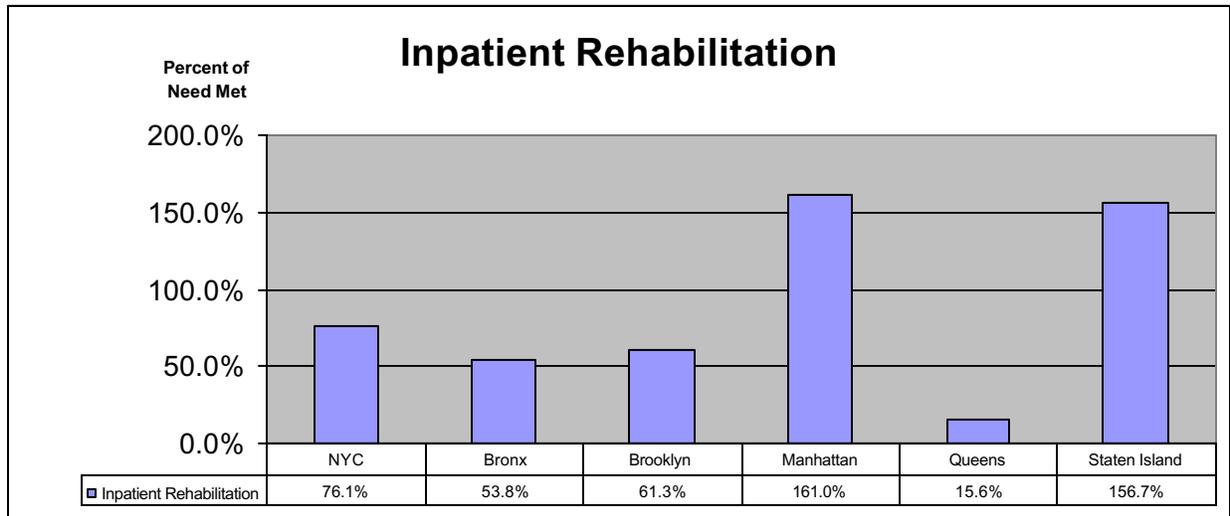


OASAS' Need Methodology included a "migration" adjustment this year to shift need from the outer boroughs (Bronx, Brooklyn, Queens and Staten Island) into Manhattan, based on historical utilization patterns. This was done to reflect the tendency of individuals from outer boroughs to "migrate" to Manhattan for services. With the "migration" adjustment, it appears that adult outpatient services are close to capacity in Manhattan and the Bronx, and under-capacity in the other boroughs. It is currently not known whether this "migration" to Manhattan reflects client preference or the greater availability of services in Manhattan and the relative lack of services in the outer boroughs. Without this adjustment, adult inpatient services percent of need met would be 127% in Manhattan (showing over-capacity) and 78% in the Bronx (showing under-capacity).

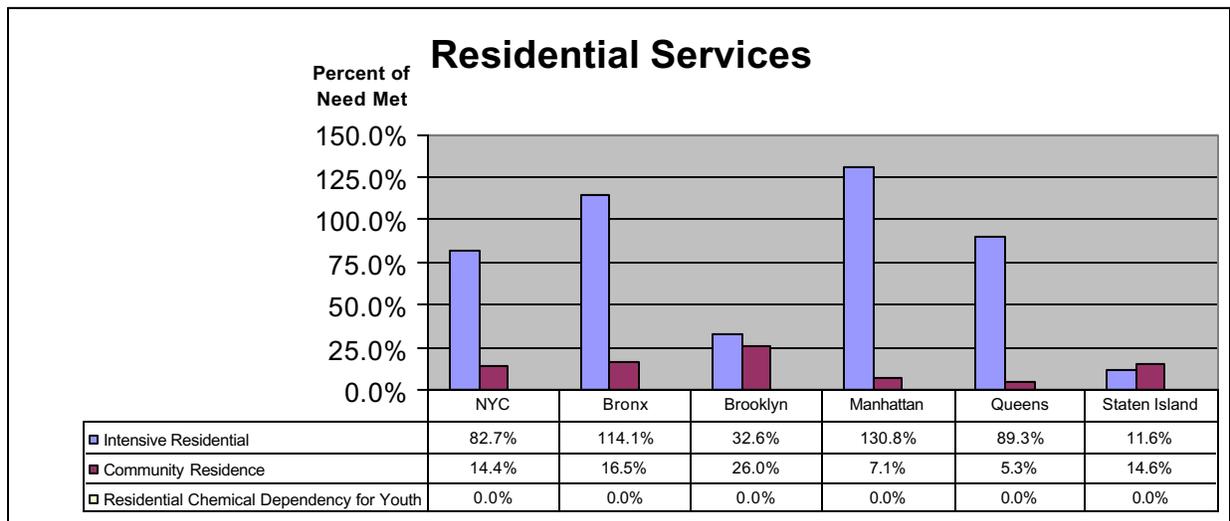
With or without the "migration" adjustment, all boroughs remain significantly under-capacity for adolescent outpatient services. This is consistent with stakeholders' concerns that there is an overall lack of service capacity for adolescents.



Methadone treatment services are under-capacity in all five boroughs, with Queens most in need and Manhattan least in need of increased capacity. These data are in line with stakeholders' comments that there are waiting lists for methadone treatment in NYC.



Citywide, inpatient rehabilitation is meeting need at a rate of 76%. However, the percent of need met is lowest in Queens, Bronx and Brooklyn.

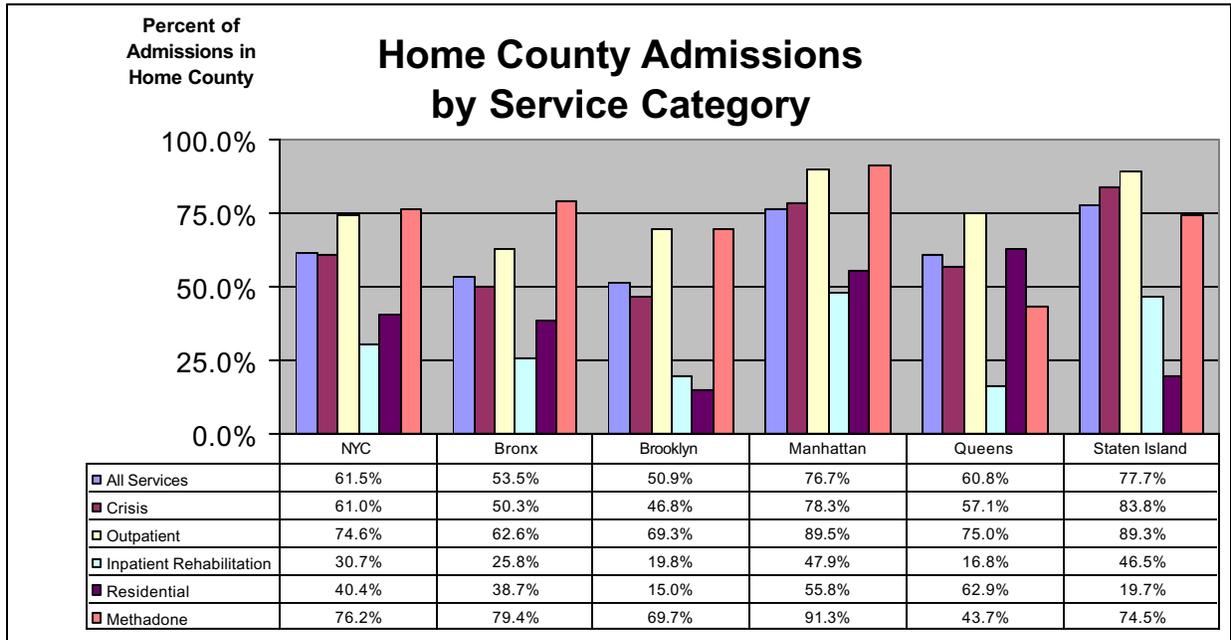


Citywide, intensive residential services are under-capacity at a rate of 82.7%. At the borough level, however, Staten Island and Brooklyn are in much greater need of capacity increases than the other boroughs.

Citywide, community residences are well under-capacity at a rate of 14.4%, and all five boroughs need increases in capacity. Stakeholders' cited a lack of residential services, noting in particular that there has been no expansion of the therapeutic community system in the past twelve years.

There is currently no capacity in NYC for residential chemical dependency for youth; according to NYC stakeholders, residential services are one of the many service areas that need to be expanded for adolescents.

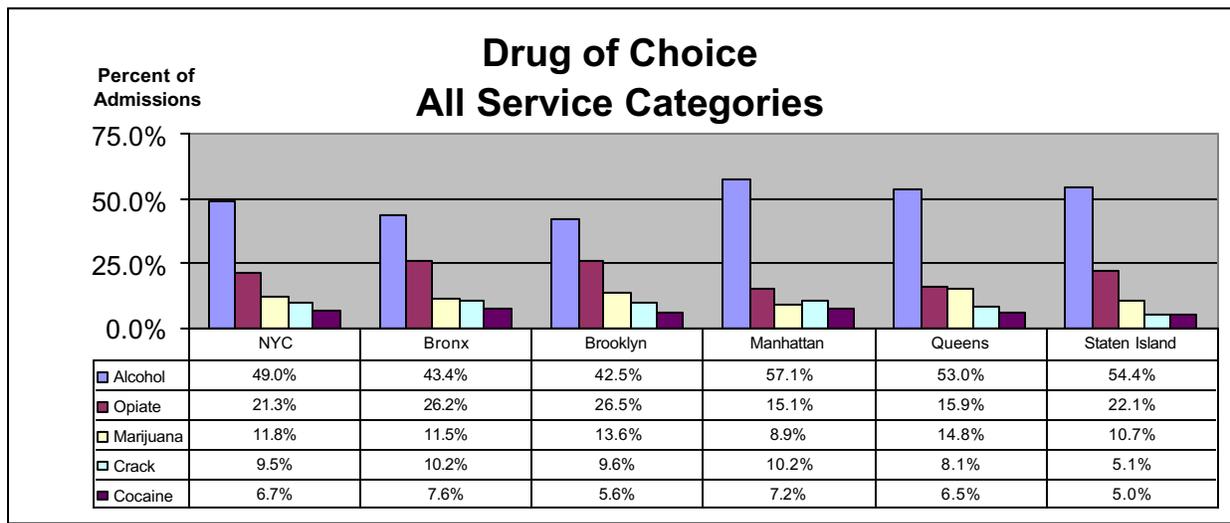
### Home County Admissions



The issue of where services should be located to meet individual needs and preferences for service location is complicated in NYC. Factors to consider include transportation, availability of services, convenience, and confidentiality. The information shown here, which comes from OASAS admissions data, shows how clients are currently accessing the system in relation to their home borough (e.g., 53% of all service admissions for Bronx residents were in services located in the Bronx).

In general, it appears that the higher the percent of need met in the borough, the higher the home county admission rate; however, sometimes this observation is not true. Additionally, it is noteworthy that even when service capacity is greater than the need, there is still a migration out of borough for services. For instance, although Manhattan is well over-capacity in the area of crisis services, more than 20% of Manhattan residents in need of crisis services leave the borough for treatment. DMH needs to better understand these data, drawing on other information sources (i.e., focus groups, stakeholder feedback, surveys) in order to determine how to distribute service capacity in accordance with clients' service preferences.

## Primary Drug of Choice



Alcohol, followed by opiates, is clearly the primary drug of choice for the majority of admissions for chemical dependency services across all five boroughs. However, rates of alcohol admissions in the Bronx and Brooklyn are approximately ten percentage points lower than the other boroughs; conversely, opiate admissions in the Bronx and Brooklyn are approximately ten percentage points higher than the other boroughs.

\* \* \*

The preceding estimates of unmet need generated by the OASAS Need Methodology will undergo further scrutiny in the months ahead, both by DMH and by CD stakeholders who have not yet had a chance to review these estimates. DMH will seek to validate and refine this methodology for its use in NYC. In the meantime, where the data show significant disparities between current service capacity and needed capacity for particular service types, the estimates offer guidance to DMH in its local review of certification applications for new and expanded chemical dependency services.

## **IV. COUNTY THREE-YEAR GOALS AND OBJECTIVES STATUS REPORT**

### **Treatment Goals**

#### **GOAL 1: Increase the number of New Yorkers receiving treatment for opioid addiction through the use of Buprenorphine (BPN) ('05/'06)**

Launched in March 2004, Take Care New York (TCNY) is an ambitious health policy agenda that provides a framework for improving the health of New Yorkers in ten key areas. The policy, which sets measurable goals for achieving better health, focuses on leading causes of illness and death for which proven methods of effective interventions exist. One of the TCNY

priorities directly targets substance use: Live Free of Dependence on Alcohol and Drugs. Goals 1-3 are part of the TCNY initiative.

Opioid dependence is a significant public health problem in NYC. One fifth of the heroin users in the United States reside in NYC.<sup>4</sup> Each year, approximately 700 New Yorkers die from overdoses involving the use of opioids. (That is approximately two people dying from opioid overdoses each day.)<sup>5</sup> Of NYC's estimated 200,000 heroin users<sup>6</sup>, approximately 34,000 are currently enrolled in methadone maintenance.<sup>7</sup> Additionally, DMH believes that the number of New Yorkers abusing non-heroin opioids (e.g., narcotic pain relievers such as OxyContin, Vicodin, Percodan), exceeds the number using heroin. Most of the City's injection drug users use 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 negative impacts upon our communities.

**Objective 1:** Expand capacity for BPN treatment ('05/'06)

Action Step 1: Increase the number of physicians trained to prescribe BPN ('05/'06)

DMH sponsored two physician certification training events during Fiscal Year (FY) 2005, and is planning four more for FY 2006. For FY 2005, DOHMH set a goal of 347 new physicians certified by SAMHSA to provide BPN treatment. Our data show that 460 NYC physicians have received their buprenorphine certification, 34% higher than the goal for FY 2005.

Action Step 2: Increase the number of programs offering BPN treatment ('05/'06)

DMH awarded start-up funding to 11 hospitals with outpatient substance abuse treatment programs (8 HHC and 3 voluntary hospitals). This funding supports the cost of training and certifying physicians so they can prescribe BPN, as well as the costs associated with implementing a BPN treatment program.

DMH is collaborating with OASAS to encourage NYC residential treatment providers to offer BPN treatment, and is co-authoring a letter that will be sent to all certified outpatient clinics (822s) urging them to take advantage of new medications to treat addiction, including BPN.

**Objective 2:** Increase the number of referrals for BPN treatment ('05/'06)

Action Step 1: Conduct outreach in the community to market BPN ('05/'06)

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<sup>4</sup> Sederer, L.I. & Kolodny, A. (July 2004). Office-Based Buprenorphine Offers a Second Chance. *Psychiatric Services*, 55(7) 743.

<sup>5</sup> Kolodny, A., McVeigh, K., Galea, S. (August 2003). *A Neighborhood Analysis of Opiate Overdose Mortality in New York City and Potential Interventions: A Discussion Document* (on file with the New York City Department of Health and Mental Hygiene).

<sup>6</sup> 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.

<sup>7</sup> 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.

DMH is pursuing several strategies to increase BPN referrals. BPN outreach teams (comprised of DMH staff) are currently conducting outreach at NYC medical centers to market BPN treatment in an effort to increase referrals. The BPN outreach teams aim to increase provider, consumer, and family awareness that this new treatment option for opioid addiction is available in their communities.

In addition, a listing of all outpatient chemical dependency programs (822s) in NYC that are offering BPN treatment, along with informational brochures, posters and other materials, are being distributed to a variety of potential referral sources including the NYC Human Resources Administration, chemical dependency treatment programs, syringe exchange programs, primary care providers, faith-based organizations and other community groups.

DMH has also made BPN treatment available to inmates at Rikers Island, in an initial and limited manner.

**Objective 3:** Advocate for the removal of regulatory barriers to BPN treatment in NYC ('05/'06)

Action Step 1: Lobby at the State and Federal level for needed changes ('05/'06)

The Federal Drug Addiction Treatment Act 2000 (DATA) placed a 30-patient limit for individual physicians and group practices on the number of patients they can treat with BPN. The 30-patient limit applies to many medical centers that meet the Federal definition of a group practice, thus creating a significant obstacle to facilitating greater access to BPN treatment. Corrective legislation was recently signed into law. DMH will now work closely with group practices at HHC and voluntary hospitals and in community settings to capitalize on this legislative accomplishment.

DMH has been advocating for elimination of the New York State buprenorphine prescriber registration process. New York is one of only two states in the country that has instituted a buprenorphine registration for physicians, which is in addition to the federal registration requirement. OASAS recently reduced the prescriber registration application from 8 pages to 2 pages and simplified the documentation requirements. DMH is in discussion with OASAS about additional actions to improve the provider registration process.

**GOAL 2: Reduce heroin overdose deaths ('06)**

The NYC Mayor's Management Report (MMR) tracks and reports drug overdose deaths in NYC. Between the years of 1998-2004, the number of drug overdose deaths fluctuated between 843 and 960. It is estimated that approximately 80% of drug overdose deaths involve opiates.

**Objective 1:** Collaborate with syringe exchange programs to provide overdose prevention education ('06)

Action Step 1: Fund training activities regarding overdose prevention ('06)

DMH is providing funding to the Harm Reduction Coalition to work with syringe exchange programs to teach heroin users how to reduce their risk of overdose and how to respond appropriately when they witness an overdose. Some of these training programs are also providing intravenous drug users (IDUs) with naloxone and instructions on how to administer it effectively. Recovery from opiate overdose treated with naloxone is nearly universal and carries a minimal risk of serious adverse side effects.<sup>8</sup>

### **GOAL 3: Reduce alcohol-related morbidity and mortality ('06)**

Excessive drinking is a public health problem at both the national and local level.

- Alcohol abuse is the third leading preventable cause of death in the US
- 14 million Americans are subject to alcohol-related diseases and injuries each year
- 107,000 deaths each year in the US are alcohol-related
- 15% of New Yorkers drink excessively
- 25,000 hospitalizations each year in NYC are related to alcohol abuse

**Objective 1:** Promote the use of an evidence-based brief intervention (SBIRT) to improve screening and treatment of alcohol abuse in emergency department settings ('06)

DMH's initiative to reduce alcohol-related morbidity and mortality focuses on training emergency room staff to screen individuals for problem-drinking behavior during health-related visits. Once an individual is identified as being at risk for alcohol-related problems, staff provide a brief intervention, and those identified as having more serious alcohol problems are referred to an appropriate treatment program.<sup>9</sup> This approach, known as SBIRT (screening, brief intervention and referral to treatment), has been shown to be effective in reducing risky drinking, increasing abstinence from alcohol and reducing substance-related health and social consequences among high-risk/alcohol dependent persons who appear for care in emergency departments.

Action Step 1: Provide funding to hospital emergency departments for training and implementation of SBIRT ('06)

DMH provided funding for SBIRT training for emergency department staff at five HHC hospitals: Bellevue, Elmhurst, Lincoln, Jacobi and Kings County. Each hospital had 40 to 80 emergency department staff attend the trainings, including nurses, physicians, residents, physicians assistants, social workers, and addiction treatment staff. Trained staff are responsible for teaching the model to their emergency department colleagues, and for establishing a means by which each hospital will financially sustain this intervention after the initial start-up period. Implementation efforts will include the use of a peer educator to spearhead the SBIRT intervention in the emergency rooms.

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<sup>8</sup> Sporer, K. (February 2003). Strategies for preventing heroin overdose. *BMJ* (326), 442-444.

<sup>9</sup> Helping Patients with Alcohol Problems: A Health Practitioner's Guide, US Department of Health and Human Service, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism (Publication No. 04-3769, revised February 2004).

**Objective 2:** Educate New York City's primary care physicians about brief intervention for alcohol problems ('06)

Action Step 1: Develop and disseminate a City Health Information (CHI) publication followed by a detailing initiative in 2006 ('06)

An issue of City Health Information (CHI) on the use of brief intervention in physicians' offices is scheduled for publication later this year. This DOHMH-published pamphlet will be distributed to tens of thousands of physicians, nurses and other providers, including every licensed physician in New York City.

**GOAL 4: Promote quality improvement activities within the chemical dependency service system ('05/'06)**

In FY 2005, the Division of Mental Hygiene launched a multi-year quality improvement initiative called Quality IMPACT (Improving Mental Hygiene and Communities Together). The initiative, which includes the broad participation of stakeholders, assists individual programs in implementing a data-driven, continuous quality improvement (CQI) process and in collecting and using consumer perceptions of care data for service planning and evaluation. Quality IMPACT is being introduced gradually into the mental hygiene community. In FY 2006, the initiative is being expanded to include 32 chemical dependency outpatient clinics among the 152 participating programs.

**Objective 1:** Introduce continuous quality improvement (CQI) as a method for improving services and outcomes, and incorporating evidence-based, best and innovative practices in the service system ('05/'06)

Action Step 1: Train and assist treatment providers to implement a CQI project focused on improving key aspects of care ('05/'06)

In FY 2006, 32 chemical dependency clinics will participate in one of the following CQI projects:

- Improving Cultural Competence in Chemical Dependency Outpatient Clinics
- Improving Screening and Monitoring of Mental Health Needs of Adults in Chemical Dependency Outpatient Clinics
- An Independent Project (to be determined by the provider and approved by DMH)

**Objective 2:** Incorporate consumer perceptions of care into services evaluation and planning ('05/'06)

Action Step 1: Develop and conduct a consumer perceptions of care survey for clients in chemical dependency programs ('05/'06)

Chemical dependency clinics participating in Quality IMPACT will be expected to participate in a consumer perceptions of care survey. The purpose of this survey is to give clients a voice in improving the quality of the services that they receive and to identify service areas that may benefit from further attention. DMH, with input from the chemical dependency stakeholder community, has decided to implement a modified version of the Mental Health Statistics Improvement Program (MHSIP) Adult Client Survey, which measures client perceptions of care related to general satisfaction, access, quality/appropriateness, and outcomes. The survey will be self-administered, anonymous and confidential. Surveys will be analyzed by DMH. Program-level and citywide data will be made available to participating programs and citywide data will be posted on DMH's website.

**GOAL 5: Improve cultural competence in chemical dependency clinics ('05/'06)**

**Objective 1:** Increase program admissions of adults from cultural groups that are considered to be underserved, and improve the cultural competence of assessment and treatment of all adults ('05/'06)

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a program to enable that program to work effectively with a diverse population. A cultural group can be defined, for example, on the basis of age, gender and gender identity, race, ethnicity, country of origin, language, sexual orientation or disability.

Action Step 1: Develop and implement a CQI priority project focused on cultural competence ('05/'06)

This project is designed to help providers better meet the treatment needs of NYC's increasingly diverse adult client population. A total of 7 chemical dependency providers will participate in this project during FY 2006.

**GOAL 6: Improve access to and quality of treatment services for individuals with chemical dependency and a co-occurring mental hygiene disorder<sup>10</sup> ('05/'06)**

**Objective 1:** Improve the screening and treatment planning for co-occurring chemical dependency and mental health disorders in adults receiving treatment for either disorder ('05/'06)

Action Step 1: Develop and implement a CQI priority project working with providers to screen and plan treatment for chemical dependency needs for consumers in mental health treatment programs ('05/'06)

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<sup>10</sup> While integrated treatment for individuals with co-occurring mental health and chemical dependency disorders has an established evidence base, DMH determined not to adopt it yet as a Quality IMPACT goal. DMH will move toward integrated treatment as a Quality IMPACT goal at the pace that the regulatory and reimbursement environment supports. The current projects will add to the data available to inform our advocacy efforts.

In FY 2005, 22 mental health treatment programs participated in this project, which was designed to screen all newly evaluated adult clients using the Simple Screening Instrument for Alcohol and other Drugs (SSI-AOD).<sup>11</sup> Clients who screened positive were further assessed for a chemical dependency disorder. Those who were diagnosed with a chemical dependency disorder were treated either on-site or referred off-site for chemical dependency services. In either case, their progress was monitored in the mental health treatment plan.

Over the nine-month course of this project, 2,257 (87%) of the 2,607 newly evaluated adults were screened using the SSI-AOD and about a quarter of them (23%) screened positive and were further assessed. Of those clients who were assessed, diagnosed with a chemical dependency disorder and still in treatment at the time that their initial treatment plan was written (within 30 days after admission), the majority (83%) was known to be in treatment for their chemical dependency disorder. It is likely that the actual percentage of those receiving chemical dependency services was even higher.

Feedback from participating providers suggests that for the majority of the programs the screen: was readily incorporated into the initial evaluation process; was a useful tool in helping to identify unmet need; and provided an opportunity for clinicians to engage clients in discussing possible chemical dependency problems. Provider feedback also indicated that participation in this project significantly improved the capacity of mental health treatment programs to identify clients with co-occurring chemical dependency disorders. Having attended trainings, which were offered by DMH on screening, assessment and treatment of dually diagnosed clients, the staff at participating programs became much more receptive to providing treatment in their mental health settings to consumers with co-occurring disorders, and more skilled at doing so.

Thirteen of the 22 participating programs are continuing with this project and expanding its scope for FY 2006.

Action Step 2: Develop and implement a CQI priority project working with providers to screen and monitor mental health needs for clients in chemical dependency outpatient clinics ('05/'06)

SAMHSA estimates that 50-70 percent of patients in chemical dependency treatment programs have a co-occurring mental illness. The 25 providers who participate in this project will use the Modified MINI Screen that has been validated in chemical dependency settings to help identify and refer for a mental health assessment those clients who may have a mood, anxiety or psychotic disorder. Once clients are assessed, providers will provide appropriate services or make mental health referrals as needed.

Action Step 3: Offer professional development trainings for mental health and chemical dependency providers to increase their knowledge and skill level in detecting and treating individuals with co-occurring chemical dependency and mental health disorders ('06)

In collaboration with the Mental Health Association of New York City (MHA), DMH utilized MICA Training funds from the NYS Office of Mental Health to provide a range of training activities during FY 2005. Specific trainings provided included:

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<sup>11</sup> Screening tool developed by SAMHSA.

- Trainings for Quality IMPACT participating providers on evidence-based practices, including Screening, Assessment and Treatment Planning, the Integrated Dual Disorder Treatment (IDDT) model, and Motivational Interviewing (MI). Trainees were offered follow-up consultation and supervision around specific cases to insure that skills obtained in didactic presentations were applied in clinical settings.
- Trainings to assist doctors in becoming certified to prescribe Buprenorphine as a treatment for opioid addiction, with a focus on psychiatric co-morbidity.
- Presentations regarding best practices for older adults with co-occurring disorders, focusing on integration of health, mental health and substance abuse in primary care; substance abuse and misuse in elders; and suicide prevention in older adults.
- Symposium to introduce participants to the Comprehensive, Continuous, Integrated Systems of Care model for treating dual diagnosis patients.

**Objective 2:** Increase access to chemical dependency treatment services for adults with mental retardation and/or developmental disabilities (MR/DD) ('06)

Investigators have mixed views on the prevalence of chemical dependency among adults with cognitive disabilities (specifically MR), some noting that the rate of chemical dependency might be lower than in the general population and others suggesting that it might be the same.<sup>12</sup> DMH estimates that approximately 119,000 non-institutionalized New Yorkers have MR or DD with impairment, or both, of which 48,000 (12,000 MR only) are age 18 years or older.<sup>13</sup> With the national prevalence rate for adults with chemical dependency being 6-8%<sup>14</sup> and the one-year prevalence rate in NYC for 2000 estimated at 11.5%<sup>15</sup>, there could be as many as 5,520 adults with DD (1,380 with MR only) who need chemical dependency treatment in NYC.

Chemical dependency treatment options in NYC geared towards individuals with co-occurring MR/DD and chemical dependency (MR/DD-CD) are extremely limited. Currently, there is one long-term residential treatment program, located in Poughkeepsie, NY, that routinely accepts men from NYC who have co-occurring MR/DD-CD needs. There are no NYC-based residential detoxification programs for this population, and although inpatient detoxification services can be accessed at local hospitals, they are typically not skilled to work effectively with individuals with MR/DD. Hospital staff and chemical dependency professionals are not familiar with the unique needs of these individuals, including expressive and receptive language deficits, inability to comprehend abstractions, low frustration tolerance, and deficits in making sound judgments.

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<sup>12</sup> Longo, M.D. & Lance P. (1997). Alcohol Abuse in Individuals with Developmental Disabilities. *The Habilitative Mental Healthcare Newsletter, Mental Health Aspects of Developmental Disabilities*, 16(4), 61-64; National Institute on Alcohol Abuse and Alcoholism: Social Work Education for the Prevention and Treatment of Alcohol Use Disorders. (October 2004) Module 101: Disabilities and Alcohol Use Disorders.

<http://www.niaaa.nih.gov/publications/Social/Module101Disabilities/Module101.html>

<sup>13</sup> Wunsch-Hitzig, R., Engstrom, M., Lee R., King, C. & McVeigh, K. (2003). *Prevalence and Cost Estimates of Psychiatric and Substance Use Disorders and Mental Retardation and Developmental Disabilities in NYC*. New York: New York City Department of Health and Mental Hygiene, Division of Mental Hygiene, Bureau of Planning, Evaluation, and Quality Improvement.

<sup>14</sup> Burgard, J., Donohue, B., Azrin, N. & Teichner, G. (Sept 2000). Prevalence and Treatment of Substance Abuse in the Mentally Retarded Population: An Empirical Review. *Journal of Psychoactive Drugs*, 32(3), 293-298.

<sup>15</sup> Wunsch-Hitzig, R., Engstrom, M., Lee R., King, C. & McVeigh, K. (2003). *Prevalence and Cost Estimates of Psychiatric and Substance Use Disorders and Mental Retardation and Developmental Disabilities in NYC*. New York: New York City Department of Health and Mental Hygiene, Division of Mental Hygiene, Bureau of Planning, Evaluation, and Quality Improvement.

A workgroup comprised of Federation Borough Council members and DMH staff was established in fall 2004 to address the issue of access to chemical dependency treatment for individuals with MR/DD.

Action Step 1: Recruit and train chemical dependency providers to effectively treat individuals with co-occurring MR/DD-CD, and train MR/DD providers to identify and refer for treatment individuals with co-occurring MR/DD-CD ('06)

The workgroup is focusing on engaging chemical dependency providers who currently serve another population with co-occurring disorders, individuals with chemical dependency who are also mentally ill. The workgroup plans to provide training to enable these providers to address the specialized needs of consumers with MR/DD. A goal of these training sessions is to provide OASAS Certified Alcohol and Substance Abuse Counselors (CASAC) with credits toward renewing their certification. The workgroup also plans to implement training sessions for MR/DD providers so they are better able to identify and address consumers' chemical dependency needs.

**GOAL 7: Improve access to and engagement in needed treatment and related services for high-utilizers of Medicaid-funded chemical dependency services ('06)**

According to New York State Medicaid expenditure data for State Fiscal Year (SFY) 2002-03, recipients with over \$15,000 in total Medicaid expenditures for chemical dependency treatment services represented only 9% of the OASAS Medicaid recipient population but accounted for over 40% of the total chemical dependency Medicaid expenditures for the population.<sup>16</sup> NYC has a high proportion of the State's high utilizers of Medicaid-funded Alcohol and Other Drug (AOD) services; 3,073 individuals who used in excess of \$30,000 in Medicaid AOD services comprise 91% of the State's total Medicaid AOD costs for those with over \$30,000 in costs for SFY 2002-03. These are individuals who are not being effectively engaged in the chemical dependency treatment system. OASAS released a Planning Supplement in spring 2005 to elicit applications from counties and NYC to address this problem.

**Objective 1:** Establish a Managed Addiction Treatment Services (MATS) program that will employ an intensive case management model to coordinate the provision of needed services, improve participant outcomes, and reduce Medicaid expenditures ('06)

Action Step 1: Develop a proposal to respond to the OASAS 2005 Planning Supplement II: Managed Addiction Treatment Services (MATS) ('06)

DMH has developed and submitted a proposal, in conjunction with the Human Resources Administration (HRA), to implement a MATS program in NYC. This intensive case management program will target Medicaid recipients who are high-end users of addiction treatment services (i.e., have used in excess of \$30,000 in Medicaid for substance abuse treatment services in SFY 2002-03). It is expected that these individuals will have a high

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<sup>16</sup> OASAS 2005 Planning Supplement II: Managed Addiction Treatment Services (MATS).

prevalence of co-occurring medical and psychiatric disorders, as well as significant problems in other domains including legal, child welfare, domestic violence, employment and housing. A key feature of the proposed NYC MATS program is to make every effort to provide eligible participants with needed housing services, including homeless diversion services, NY/NY Supportive Housing, emergency, transitional and permanent housing for people with HIV/AIDS, and Department of Homeless Services supportive housing. During the first two years MATS will focus on individuals receiving public assistance and Medicaid; during the third year MATS may also serve individuals receiving Medicaid only.

As of the writing of this Plan, DMH is awaiting a formal response from OASAS for its MATS proposal.

### **GOAL 8: Increase access to treatment for compulsive gambling in NYC ('06)**

Approximately 3% of American adults who gamble can be classified as compulsive gamblers, and an estimated 30% of people receiving treatment for chemical dependency also have a co-occurring diagnosis of compulsive gambling.<sup>17</sup> Yet according to the National Epidemiological Survey of Alcohol and Related Conditions<sup>18</sup> only 10-15% of compulsive gamblers will seek treatment. Epidemiological studies suggest that non-whites are more at risk for compulsive gambling.<sup>19</sup> One study suggests that Hispanics have a 23% higher risk for compulsive gambling than non-Hispanic Whites.<sup>20</sup> A study of casino revenues in major Las Vegas hotel-casinos indicated that Asian players comprise 17% of table revenue and 80% of the revenue for high stakes games like baccarat.<sup>21</sup> Women, seniors and adolescents are also at high risk for compulsive gambling. In the NYC area, there are a growing number and range of gambling opportunities which contribute to this rising rate of compulsive gambling.

#### **Objective 1: Expand treatment capacity for compulsive gambling in NYC ('06)**

Action Step 1: Collaborate with OASAS to direct available State funding to NYC providers interested in developing or expanding compulsive gambling treatment programs ('06)

Currently, there is only one certified program for compulsive gambling in NYC. The expansion of this very limited capacity would be an incremental step toward the needed significant expansion. In response to the OASAS 2005 Planning Supplement I: Compulsive Gambling Prevention and Treatment Initiative, four NYC providers submitted proposals to create or expand treatment capacity for compulsive gambling. Due to the overwhelming need for treatment services for compulsive gambling in NYC, DMH recommended that OASAS fund all four programs. Each proposal targeted a specific population with high rates of compulsive gambling

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<sup>17</sup> OASAS 2005 Planning Supplement I: Compulsive Gambling Prevention and Treatment Initiative.

<sup>18</sup> Blanco, C., Hasin, D.S., Petry, N.M., Stinson, F. & Grant, B.F. *Problem and pathological gambling: National prevalence estimates and gender correlates*. Submitted for publication.

<sup>19</sup> Volberg, R.A. (1999). *National Research Council, Pathological gambling: A critical review*. Washington DC: National Academy Press.

<sup>20</sup> Volberg, R.A. (1994). The prevalence and demographics of pathological gamblers: Implications for public health. *Am Journal of Public Health (84)*, 237-241.

<sup>21</sup> Levin, C. (1996). Cultural bull's eye. *International Gaming and Wagering Business*, 17(10), 166-167.

and significant unmet treatment need, including: individuals of Hispanic descent who reside in the Washington Heights area and in the Bronx; Chinese and other Asians in the City; African-American, Hispanic-American, Asian-American and Eastern European groups in Queens and Brooklyn; and the Brooklyn Sephardic, Orthodox and Hasidic communities.

## **Prevention Goals**

### **GOAL 1: Limit the spread of crystal meth use among high-risk groups in NYC ('05/'06)**

Crystal methamphetamine, often referred to as “crystal meth,” is a highly addictive drug associated with unsafe sexual practices, particularly among men who have sex with men (MSM), which may result in increased transmission of HIV, STDs and hepatitis A and B. While the crystal meth problem in NYC currently appears to be less extensive than in some other parts of the country, DOHMH does not know its full extent. Preliminary data from the 2004 Community Health Survey supports a focus on the MSM community. Of nearly 10,000 New Yorkers surveyed, fewer than 1% reported using crystal meth in the last year. However, reported use among MSM is much higher, at approximately 4%; DOHMH believes that this self-reported data is likely to underestimate actual use. According to the National HIV Behavioral Surveillance System, which conducted HIV testing in five US cities including NYC, 14% of the MSM’s tested had used methamphetamine in the 12 months preceding the test. Moreover, 3% used the drug once a week or more.<sup>22</sup>

**Objective 1:** Develop a formal mechanism to evaluate and address crystal meth concerns in NYC ('05/'06)

Action Step 1: Convene and support an ongoing Crystal Meth Task Force to provide local leadership and coordination of a prevention campaign among key stakeholders ('05/'06)

To guide this Department-wide initiative, DOHMH formed a Crystal Meth Task Force in 2004, which includes staff from various DOHMH bureaus, the NYC Police Department, OASAS, and more recently, the State Health Department’s AIDS Institute. The Task Force’s goals are to raise awareness, increase access to care, broaden outreach for people who use or are addicted to crystal meth, and coordinate care across the City. It meets regularly to review and assess implementation of its action plan, and to ensure coordination of efforts.

**Objective 2:** Prevent crystal meth use in high-risk populations ('05/'06)

Action Step 1: Develop and maintain an on-going crystal meth prevention education campaign ('05/'06)

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<sup>22</sup> This data is from the National HIV Behavioral Surveillance System’s Five Cities study, 2004-2005, and was reported in a presentation made by Grant Colfax, co-director, HIV/AIDS Biostatistics, Epidemiology and Intervention Branch, San Francisco Department of Public Health, at the 2005 National HIV Prevention Conference this June in Atlanta. The title of the presentation is: Crystal Methamphetamine: Its Evolving Influence on HIV-related Risk and the link to his discussion is: [http://www.kaisernetwork.org/health\\_cast/uploaded\\_files/Colfax\\_Monday.pdf](http://www.kaisernetwork.org/health_cast/uploaded_files/Colfax_Monday.pdf) (see page 6).

The Crystal Meth Task Force developed a multi-faceted prevention education campaign aimed at preventing crystal meth use among people who are at risk but have not yet started to use crystal meth. Key aspects of this campaign include collaborating with providers, City, State and Federal agencies and entities (e.g., the HIV Prevention Planning Group and the HIV Health and Human Services Planning Council) to improve the dissemination of information about crystal meth; partnering with the State Health Department to conduct outreach to sex clubs, bathhouses, circuit parties and internet dating sites; and funding prevention programs (discussed below).

Action Step 2: Fund crystal meth prevention programs ('05/'06)

During FY 2004 and FY 2005, DOHMH awarded funding for prevention services to four NYC providers: The Lesbian and Gay Community Services Center, Callen-Lourde Community Health Center, Gay Men's Health Crisis, and Latino Commission on AIDS (which only received FY 2005 funding). Specifically, these providers were contracted to develop social marketing campaigns designed to prevent individuals from using crystal meth. The four agencies have developed and implemented primary prevention campaigns targeting MSM from different ethnic groups, neighborhoods, and age groups.

Action Step 3: Fund treatment programs to enhance their ability to conduct community outreach and treat crystal meth addiction using Evidence Based Practices (EBPs) ('05/'06)

During FY 2005, DOHMH funded three substance abuse treatment programs: the Addiction Institute, Greenwich House and St. Vincent's Hospital's outpatient chemical dependency clinic. They were asked to incorporate into their existing programs a variety of evidence-based treatment approaches for dependence on crystal meth, including: the Matrix Institute Model, which focuses on concrete lifestyle modification, training in relapse prevention, education about dependencies, and family involvement; contingency management, which utilizes voucher-based incentives (e.g. movie passes) to provide tangible rewards for negative urine toxicology results; and gay-affirmative treatment groups in which high-risk sexual behavior associated with crystal meth use can be freely discussed among peers. The treatment programs are now incorporating these approaches and techniques, and have begun marketing them to reach individuals in need.

**V. COUNTY PLANNING ASSURANCES**

**Assurance A  
The 2006 Local Services Planning Process for  
Alcoholism and Substance Abuse Services**

LGU: NYC

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 other 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.

Date 8/16/05 [Signature]  
Chairperson, Subcommittee for Alcoholism or Alcoholism and Substance Abuse

Date 8/17/05 [Signature]  
Chairperson, Community Services Board

Date 22 August 2005 [Signature]  
Commissioner/Director

**Assurance B**  
**Full and Equal Participation of Newly Established**  
**Not-for-Profit Community-based Organizations**  
**2006 Local Services Plan**

LGU: NYC

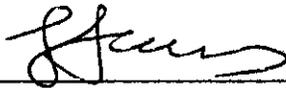
New York State and its local municipalities provide health and human services primarily through arrangements with not-for-profit organizations. As the ethnic composition of New York has changed, newly established organizations have sought funding to serve these new populations. In many cases, these emerging community-based organizations, (CBOs), including faith-based organizations, 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), including faith-based organizations, 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.

22 August 2005



Date

Commissioner/Director

**Assurance C: Multi-disabled Considerations**

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 the Bureau of Program Services, is responsible for planning services for multi-disabled persons. DMH has adopted a planning framework that is population-based, data-driven and epidemiologically informed, and driven by measurable quality indicators. Individuals with co-occurring chemical dependency and mental health disorders are one of several special populations DMH takes into consideration when doing service planning.

Additionally, the Dual Recovery Coordinator (DRC), jointly funded by OASAS and OMH, coordinates the various activities that deal with co-occurring chemical dependency and mental illness and participates in planning services for multi-disabled persons. The DRC plays an active role in DMH's Quality IMPACT projects that address screening and treatment of individuals with co-occurring chemical dependency and mental illness, attends various community meetings related to co-occurring disorders, and acts as a liaison and coordinator around the various DMH initiatives that involve co-occurring chemical dependency and mental illness.

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 Division's Bureau of Community Liaison and Training, along with its Office of Consumer Affairs, assists in resolving disputes presented by providers and consumers. Finally, the Citywide Oversight Committee of the NYS Coordinated Children's Service Initiative is another mechanism to assist providers. It provides a dialogue between key child serving agencies, families and representatives of Borough-Based Councils for the purpose of enhancing the system of care; any issues that cannot be resolved at the borough level are forwarded to the Citywide Oversight Committee for discussion and action.

## **Assurance D: Membership of ASA Subcommittee**

Ms. Jane F. Velez, Chairperson  
Palladia, Inc.  
10 Astor Place, 7<sup>th</sup> Floor  
New York, NY 10003  
Tel: # (212) 979-8800  
Fax: # (212) 979-0100  
Email: Jane.Velez@PalladiaInc.org

Mr. Gerald Heaney, MPA, CASAC  
Samaritan Village, Inc.  
34 Azalea Court  
Staten Island, NY 10309  
Tel: # (718) 277-6317 X105  
Fax: # (718) 277-6463  
Email: Jhean@Samvill.org

Ms. Carmen Rivera, Vice Chair  
VIP Community Services  
1513 St. Lawrence Avenue  
Bronx, NY 10460  
Tel: # (718) 792-7341  
Email: Crivera@scholastic.com

Mr. Neil Sheehan  
The Outreach Project  
103 Noble Street  
Brooklyn, NY 11222  
Tel: # (718) 849-9233  
Fax: # (718) 849-1093  
Email: NeilSheehan@opiny.org

Barbara E. Warren, Psy. D.  
Lesbian, Gay, Bisexual & Transgender  
Community Center  
208 West 13<sup>th</sup> Street  
New York, NY 10011  
Tel: # (212) 620-7310  
Fax: # (212) 924-2657  
Mobile: (917)971-0689  
Email: BarbaraW@gaycenter.org

Mr. James T. Curran  
John Jay College of Criminal Justice  
899 Tenth Avenue  
New York, NY 10019  
Tel: # (212) 237-8658  
Email: Jcurran@faculty.jjay.cuny.edu

Ketty H. Rey, MSW, JD.PhD.  
President, International Alliance for Health and  
Social Development, Inc.  
ANYCAP Chair  
520 Beach 43<sup>rd</sup> Street  
Edgemere, NY 11691  
Tel: # (718) 471-0981  
Fax: # (718) 471-2369  
Email: Ketty.Rey2@Verizon.net

Brian F. Sands, M.D.  
North Brooklyn Health Network  
760 Broadway  
Brooklyn, NY 11206-5317  
Tel: # (718) 963-8829  
Fax: # (718) 963-5976  
Email: [Brian.Sands@woodhullhc.nychhc.org](mailto:Brian.Sands@woodhullhc.nychhc.org)