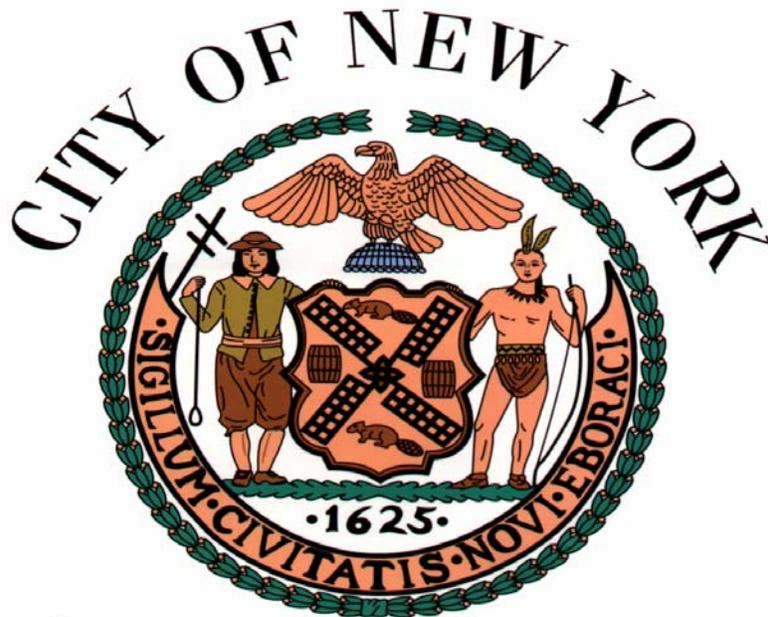


**NEW YORK CITY  
DEPARTMENT OF HEALTH  
AND MENTAL HYGIENE**



**LOCAL GOVERNMENTAL PLAN  
CHEMICAL DEPENDENCY SERVICES**

**2007**

**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**



## ***Overview from the Executive Deputy Commissioner***

*I am pleased to present the 2007 New York City Local Government Plan for Chemical Dependency (CD) Services. This Plan is the culmination of a collaborative planning process with local stakeholders and State partners, and reflects continued progress in implementing a comprehensive local planning process for CD services in New York City.*

*This year's Plan again includes estimates of unmet need derived from the Office of Alcoholism and Substance Abuse Services' (OASAS) Need Methodology, including analyses of Citywide and borough-based service capacity and unmet need. Throughout the year we have continued to collaborate with OASAS around using this methodology for estimating community-level service needs in New York City. This year's Plan describes our initial efforts to derive community-level estimates -- so relevant in a culturally diverse, densely populated city such as New York.*

*Both ongoing and new initiatives of the Division of Mental Hygiene (DMH) of the Department of Health and Mental Hygiene are described in this year's Plan. They include updates on our efforts to: promote buprenorphine to treat opioid addiction and naloxone to prevent opioid overdose deaths; reduce alcohol morbidity and mortality using an evidence-based brief intervention, SBIRT; and launch the City's Managed Addiction Treatment Services program (MATS). A new topic this year is housing; DMH's housing development activities for individuals who are homeless or at risk of becoming so now include supportive housing development for individuals with chemical dependency disorders.*

*Quality improvement continues to be a priority for DMH. Data from the first year of participation of the City's chemical dependency programs in Quality IMPACT, DMH's quality improvement initiative, is reported, with its emphasis on: the treatment of co-occurring chemical dependency and mental health disorders; identifying and addressing cultural factors during treatment; increasing admissions of underserved groups; and assessing consumer perceptions of care.*

*We appreciate OASAS' leadership in areas of great importance to New York City -- addressing with MATS the disproportionate and ineffective use of Medicaid by chemical dependency high utilizers; repurposing funding for clinically unnecessary detoxification and emergency services to expand community-based, lower level withdrawal and treatment services; and supporting local planning through the creation of a statewide needs assessment methodology. We continue to seek expanded data-sharing to better understand who we are and are not serving, and with what outcomes.*

*We thank our State and local planning partners, and hope this Plan is instrumental in supporting continued progress among government, consumers, families, providers and other advocates in advancing the development of New York City's CD services system.*



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Members of the following NYC provider stakeholder groups:

The Association of New York City Addiction Programs  
Alcoholism and Substance Abuse Providers of New York State  
The Committee of Methadone Program Administrators  
The Therapeutic Communities Association  
Participants of the consumer meeting

*The New York City Community Services Board*

Kenneth Popler, PhD, MBA, Chair  
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*The New York City Federation for Mental Health, Mental Retardation and Alcoholism Services*

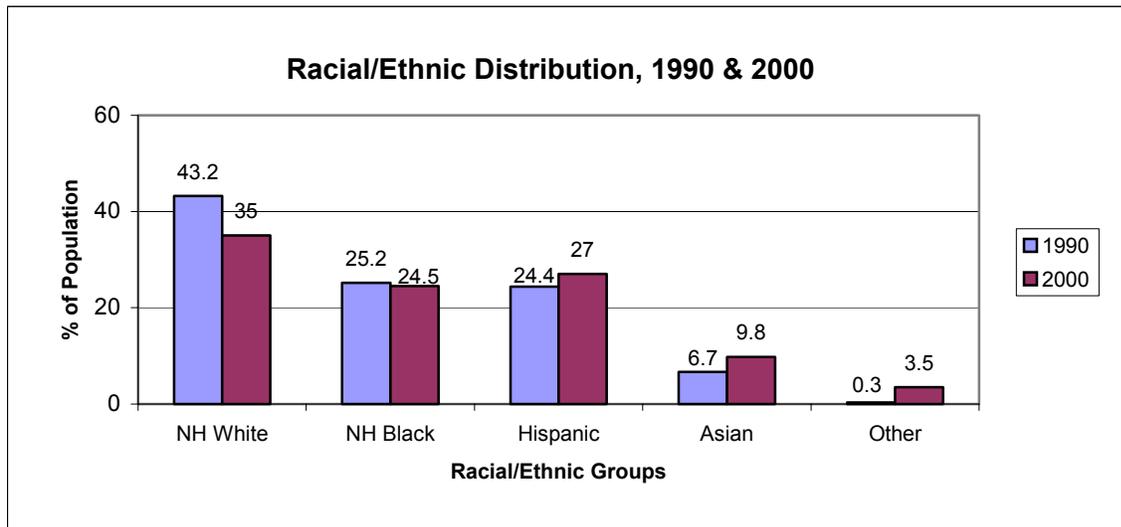
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## **I. NEW YORK CITY DEMOGRAPHICS**

According to the latest census figures, NYC's population grew by more than 9% between 1990 and 2000. The City's population is now for the first time over 8 million. The Department of City Planning estimates that by 2004, the City grew another 2% for a total population of 8,168,000. 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 NYC residents are now foreign-born and only about a quarter of these individuals are proficient in English.

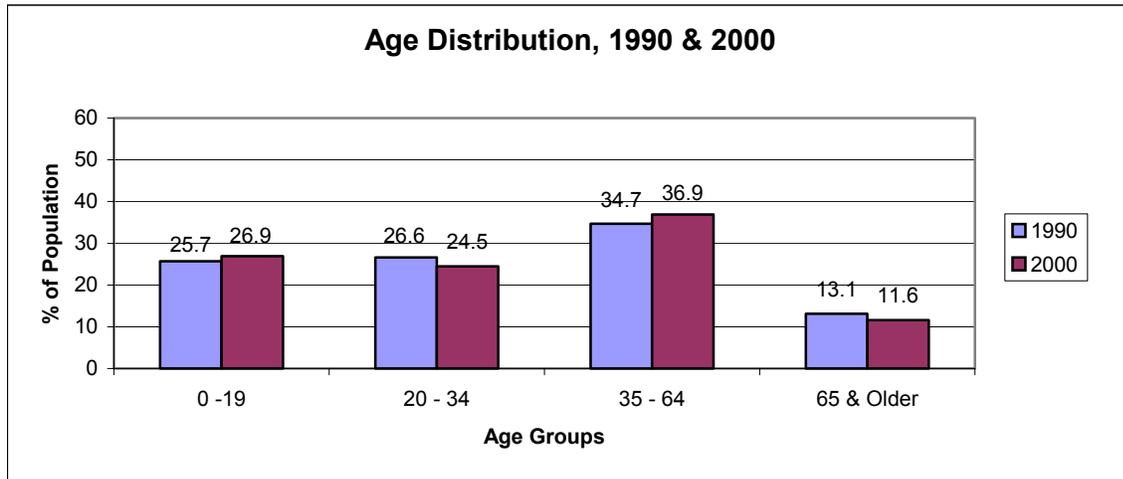
NYC is the largest and most racially and ethnically diverse city in New York State. Thirty-five percent of City residents are Non-Hispanic White, 24.5% are Non-Hispanic Black, 27% are Hispanic, 9.8% are Asian and 3.5% are Other (predominantly Non-Hispanic of mixed race). As indicated in the chart below, 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.



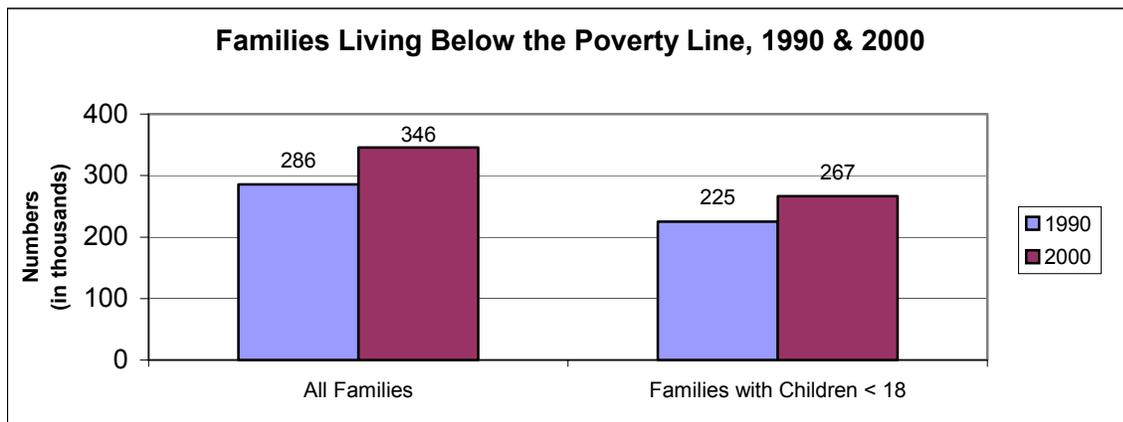
The City's minority populations originate from many different countries. For example, the five largest Asian populations come from China, India, Korea, the Philippines and Pakistan; and, the five largest Hispanic populations emigrated from Puerto Rico, the Dominican Republic, Mexico, Ecuador and Colombia.

Queens is the City's most diverse borough. Over one-third of NYC's foreign-born reside in Queens and over 120 languages are spoken in that borough alone. However, each of NYC's boroughs is 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 years old and younger, and adults 35-64 years old increased slightly, while the proportion of younger adults 20-34 years old and seniors 65 years and older decreased slightly. Perhaps the most interesting change occurred in the population 85 years 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 NYC residents 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.



## **Homeless Individuals**

This year's Plan includes a description of new DMH initiatives that address the needs of homeless individuals, including outreach activities and supportive housing development. Below is demographic information for this population, as well as data regarding their chemical dependency treatment needs.

In 2005, the number of homeless persons sleeping in the NYC shelter system on any single night was estimated to be about 32,000: approximately 8,000 single adults; 11,600 adult family members; and 12,500 children. However, several thousand more are known to sleep on NYC streets and in the subways and parks. The 2006 NYC Homeless Street Survey estimates that the number of unsheltered homeless is over 3,800, down about 13% from last year. The survey found that 41% of the unsheltered homeless are in Manhattan, 13% in both Brooklyn and in the Bronx, 8% in Queens, 5% in Staten Island and 19% in the subways.

A recent study of family homelessness in NYC (2005)<sup>1</sup> found that 44% of adult families (i.e., families without children) and 14% of families with children reported that someone in their family had a history of drinking or drug use prior to entering the shelter system. Almost 75% of these adult families and less than half of these families with children had received some treatment. Fifty-seven percent of all the families who indicated that substance abuse was a problem also indicated that the abuse contributed at least somewhat toward their homelessness.

A collaborative NYC Department of Homeless Services (DHS)/OASAS study found that of the 30,736 DHS single adult clients who received shelter services in NYC during Fiscal Year 2004<sup>2</sup> (FY 2004), about 12,000 (39%) received chemical dependency treatment services during that same time period.

Another NYC study, a collaboration between the NYC Department of Health and Mental Hygiene (DOHMH) and DHS, found that from 2001 to 2003 drug and alcohol use were the most frequent causes of hospitalizations among homeless adults. Drugs accounted for 14,865 hospitalizations and alcohol for 11,589; that is, 31% and 24% of all hospitalizations in this population, respectively. This study also found that together, drugs and alcohol accounted for 178 deaths, or almost 20% of all deaths, of adults in single shelters. Drugs accounted for 16.7% and alcohol 3%.

## **II. LOCAL SERVICE SYSTEM ASSESSMENT**

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

The 2005 NYC DOHMH Community Health Survey (CHS), a telephone survey of 10,000 adult New Yorkers (ages 18+), collected data on the 30-day prevalence of two types of problem

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<sup>1</sup> Smith, N., Flores, Z.D., Lin, J., & Markovic, J., "Understanding Family Homelessness: An In-Depth Study of Families' Experiences Before and After Shelter, Section III: Struggling to Make Ends Meet, Pre-Shelter Experiences of Homeless Families in New York City", (The Vera Institute of Justice, September 2005).

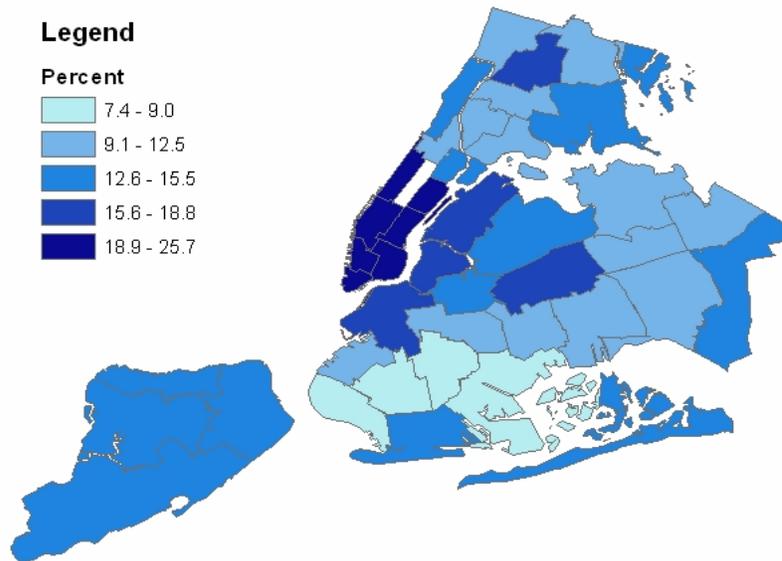
<sup>2</sup> The New York City Fiscal Year runs from July 1 through June 30.

drinking: binge drinking and heavy drinking.<sup>3</sup> It found that about 15.5% of adult New Yorkers are binge drinkers and 4.7% are heavy drinkers. Adults 21 to 24 years old reported the highest rates of problem drinking. Analyses of survey data from 2002 through 2005 found that 28.3% in this age group are binge drinkers and 8.7% are heavy drinkers. Rates of problem drinking were also found to be relatively high for 18 to 20 year olds, for whom drinking is illegal, with 18.1% identified as binge drinkers and 5.4% as heavy drinkers.

High rates of problem drinking were also found by the 2004 NYC Health and Nutrition Evaluation Survey (CHANES)<sup>4</sup> of 2,000 adult New Yorkers (ages 20+). The survey found that the one-year prevalence rates of binge drinking and heavy drinking were 24.7% and 7.1%, respectively.

Binge drinking by adults occurs most frequently in the following neighborhoods: Manhattan, below 96<sup>th</sup> Street; Brooklyn, in Park Slope, the Heights, Greenpoint and Downtown; and Queens, in Long Island City and Astoria.<sup>5</sup>

### Prevalence of Binge Drinking by Neighborhood, NYC 2005



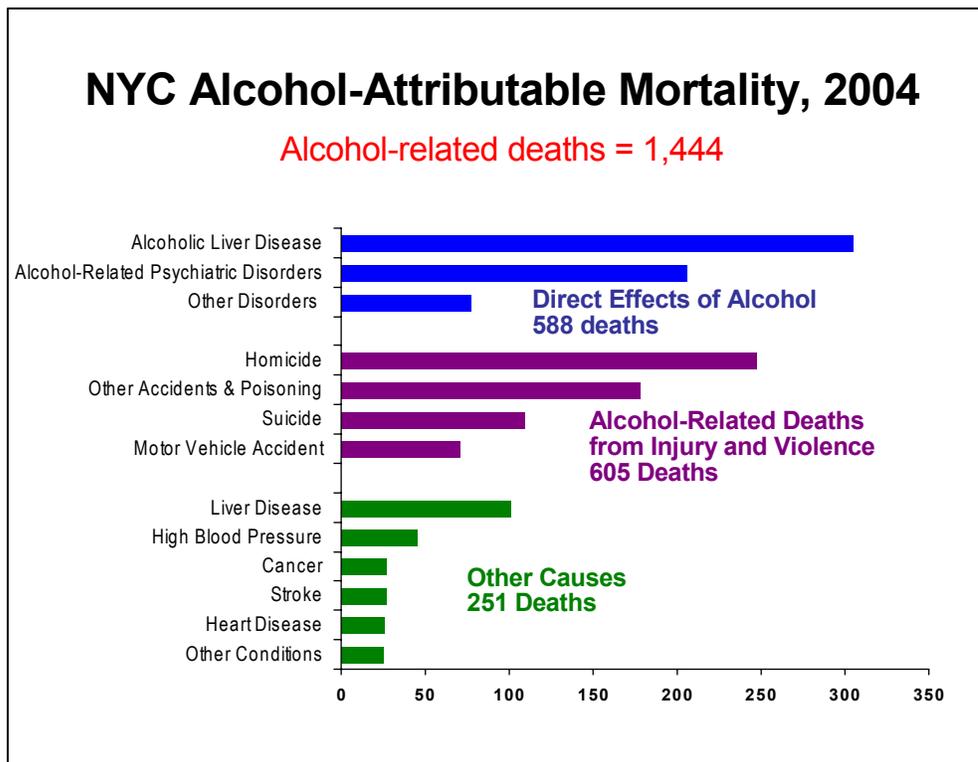
<sup>3</sup> Binge drinking is defined as 5 or more drinks on at least one occasion in the month prior to the survey. Heavy drinking is defined as 30 drinks and 60 drinks for women and men, respectively, in the month.

<sup>4</sup> The sample size of the CHANES survey was too small to allow for breakouts by age or neighborhood.

<sup>5</sup> The 2005 Community Health Survey, NYC DOHMH.

Binge drinking declined in recent years, according to the Youth Risk Behavior Survey (YRBS)<sup>6</sup>, a biennial survey of NYC’s high school students. The prevalence in 2005 was 13.6%, down from 17.9% in 2001. The percentage of students reporting that they are current drinkers has also dropped somewhat, from 41.8% in 2001 to 35.5% in 2005. In 2005, Staten Island had the highest prevalence of current drinkers (46%) compared with Manhattan (40%), the Bronx (35%), Brooklyn (34%) and Queens (31%).

Excessive drinking takes its toll in both illness and death. About 435 of every 100,000 New Yorkers, or about 35,000 individuals, are hospitalized each year for alcohol-related illnesses.<sup>7</sup> And, DOHMH estimates that in 2004 more than 1,400 deaths were due to alcohol-related conditions.



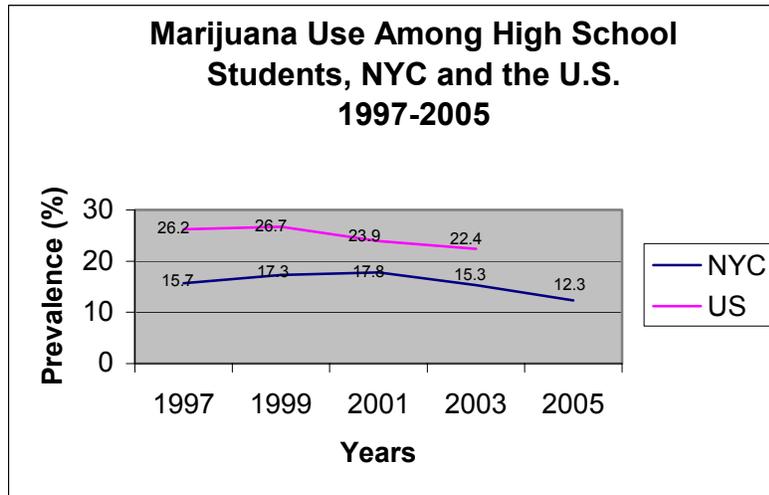
### Prevalence of Substance Use Problems in New York City

The 2004 CHANES found that 4.5% of New Yorkers used illicit drugs in the year prior to the survey.<sup>8</sup> Younger adults ages 20 to 29 reported the highest rate of use, 7.5%. The prevalence of the use of crystal methamphetamine, a drug of increasing concern in the City as elsewhere in the country, is currently about 0.4%, according to the 2005 CHS.

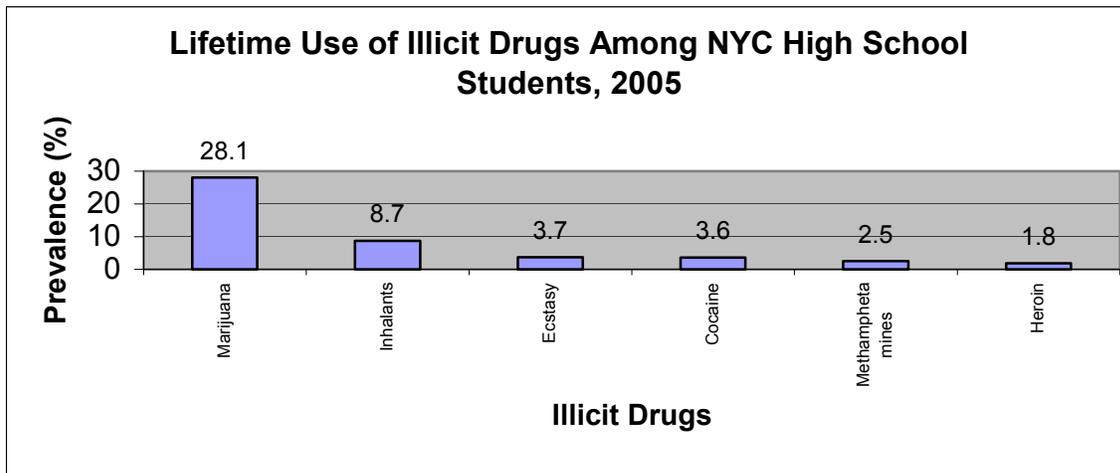
<sup>6</sup> The Youth Risk Behavior Survey is a national survey from the Centers for Disease Control that DOHMH administers in NYC.

<sup>7</sup> The New York State Department of Health’s Statewide Planning and Research Cooperative System (SPARCS) database (2002-2003).

<sup>8</sup> The CHANES included questions about the use of specific illicit drugs, but the numbers of respondents who reported use was too small to estimate prevalence with any confidence.



Marijuana use among high school students has declined significantly, from 17.8% in 2001 to 12.3% in 2005.<sup>9</sup> Although national rates have declined as well, they are still much higher than NYC rates. However, lifetime use of heroin seems to have increased over the past few years, from 1% and 0.9% in 1999 and 2001, respectively, to 1.6% in 2003 to 1.8% in 2005.<sup>10</sup>



Recent hospital discharge data<sup>11</sup> indicate that annually about 595 of every 100,000 New York City residents, about 48,000 individuals, have drug-related hospitalizations. The DOHMH Office of Vital Statistics (2004) estimates that annually about 10 of every 100,000, or about 800 individuals, die from drug causes. Most deaths are caused by heroin and cocaine.

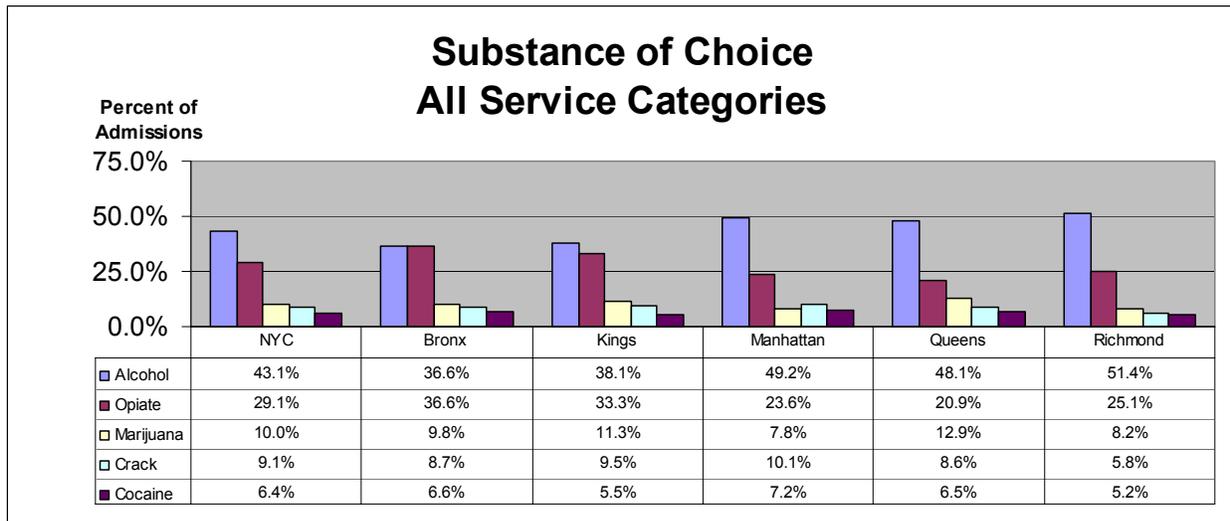
<sup>9</sup> Youth Risk Behavior Survey (2005).

<sup>10</sup> The most recent OASAS School Survey, conducted in 2002, reported similar rates as the 2003 NYC Youth Risk Behavior Survey.

<sup>11</sup> The New York State Department of Health's Statewide Planning and Research Cooperative System (SPARCS) database (2002- 2003).

## Service Use and Estimates of Unmet Service Need in New York City

Knowing the frequency of alcohol and substance use does not directly tell us the level of services needed. For instance, problem drinking is many times more prevalent than opiate use, but problem drinking is associated with 43% of admissions to chemical dependency services and opiate use 29%. The graph below depicts current service utilization. Alcohol, heroin and other opiates are clearly the primary choice of substance for those individuals admitted to chemical dependency services across all five boroughs. Marijuana, cocaine and crack account for relatively fewer admissions. We do not know what this would look like if all of those needing and willing to accept treatment for alcohol and substance abuse were being served, as this graph does not account for unmet service need.



To assist local governments in estimating unmet service need, OASAS provides county-level (borough) estimates of unmet service need generated by their Need Methodology. We commend OASAS for developing this valuable planning tool, which uses population-based surveys, focus groups and historical utilization patterns to estimate prevalence, service demand, and needed capacity at the borough level. The estimates derived from this methodology allow counties to compare current service capacity with estimated needed capacity, and determine areas of unmet need at the borough level.

In the 2006 Local Government Plan, DMH presented data from the OASAS Need Methodology to reflect unmet service need in NYC, noting that we were in the beginning stages of determining how to best utilize this tool in NYC. We are currently reviewing some of the assumptions and data used:

- The use of historical utilization rates to estimate the breakout of need between service types may be biased by the current service system and the way individuals are utilizing it.
- There is no certified capacity for outpatient services. Thus OASAS uses historical utilization as a measure of capacity. This may not provide accurate estimates of current/projected capacity needed for planning purposes.

- OASAS makes annual updates to the Methodology which can result in substantial decreases or increases in estimates of need, making it difficult to plan for new services.
- The Need Methodology includes a “migration” adjustment for outpatient services to shift need from the outer boroughs (Bronx, Brooklyn, Queens and Staten Island) into Manhattan, based on historical utilization patterns; that is, the tendency of individuals from outer boroughs to go to Manhattan for services. It is currently not known how much of this “migration” to Manhattan reflects consumer preference, versus the greater availability of services in Manhattan and the relative lack of services in the outer boroughs.

We believe the Methodology includes the elements needed to provide useful borough-level data for service planning, and intend to apply it in its current form while continuing to work with OASAS to improve its accuracy in estimating service need.

What follows is a presentation of updated Citywide and borough-level estimates of unmet service need as derived by the OASAS Need Methodology, and a discussion of our efforts to disaggregate this borough-level data to derive community-level estimates of unmet service need.

### Citywide and Borough-Level Estimates of Unmet Need

Overall, these data show significant unmet need when current service capacity is compared to the estimated service capacity that is needed across most of the service categories. These data also show an uneven distribution of service among the five boroughs for many service categories, with a high concentration of services in Manhattan overall and a low concentration in Queens.

The following table shows the updated 2007 service need data for NYC.

	2007		
	Need <sup>12</sup>	Capacity	Need Met <sup>13</sup>
Medically Managed Detox	225	600	267%
Medically Supervised Withdrawal - Inpatient	239	155	65%
Medically Supervised Withdrawal - Outpatient	632	153	24%
Medically Monitored Withdrawal	539	172	32%
Outpatient Adolescents	326,490	110,276	34%
Outpatient Adults	2,579,973	2,173,815	84%
Methadone Treatment	63,031	37,014	59%
Inpatient Rehabilitation	641	514	80%
Intensive Residential	5,286	5,169	98%
Community Residence	2,589	457	18%
Residential Chemical Dependency for Youth	208	0	0%

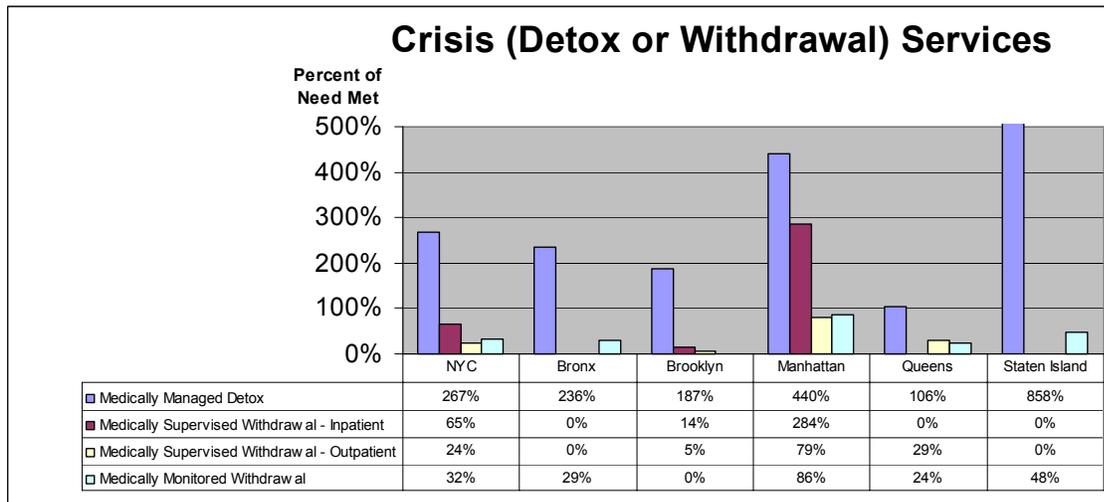
<sup>12</sup> Need/Capacity is measured in beds for all inpatient and residential services, slots for medically supervised withdrawal-outpatient and methadone services and visits provided for outpatient services.

<sup>13</sup> Percent of ‘need met’ is the ratio of current service capacity to the estimated service capacity that is needed.

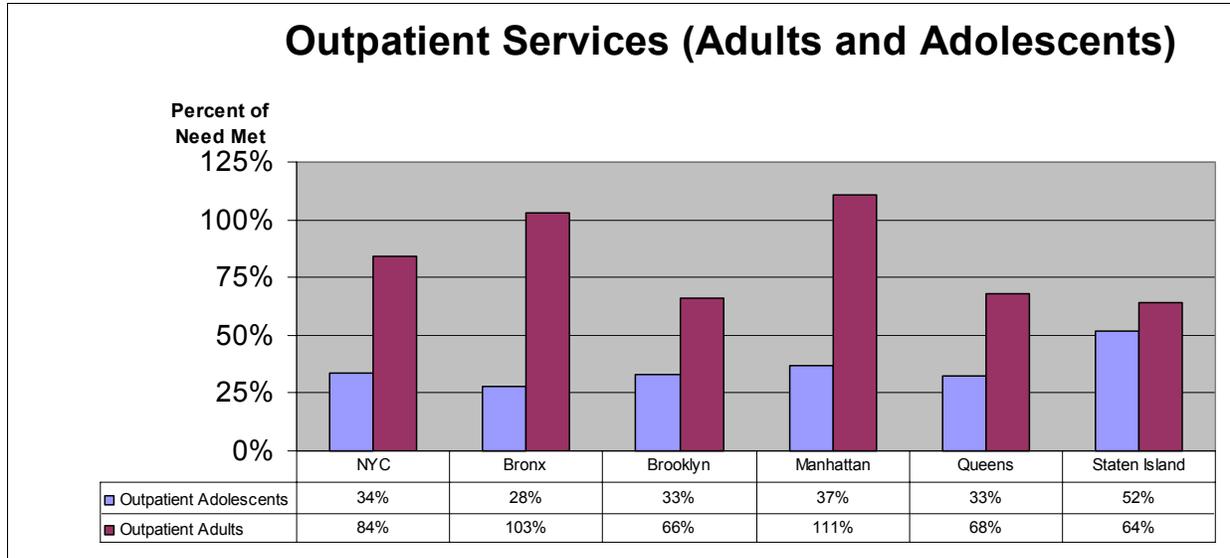
Other Citywide highlights are as follows:

- While medically managed detox is over-capacity in all five boroughs, medically supervised and medically monitored withdrawal services are considerably under-capacity in all boroughs except Manhattan.
- Outpatient services for adolescents are significantly under-capacity in all five boroughs.
- Inpatient rehabilitation and intensive residential services are in need of better distribution throughout the boroughs.
- All boroughs are in need of adult community residence services, and even more acute is the need for residential chemical dependency services for youth.

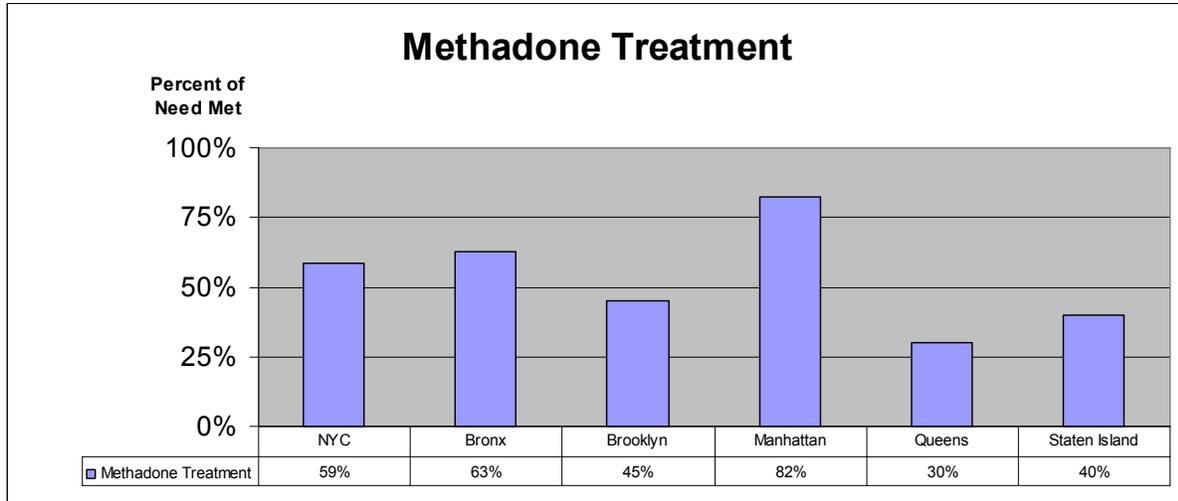
Updated borough-level data from OASAS are displayed below via charts that show the percent of service need met, indicating where there is inadequate capacity, or unmet need (ratio of current service capacity to estimated needed service capacity below 100%), and where there is over-capacity (ratio above 100%).



Citywide, especially in Manhattan and Staten Island, medically managed (hospital inpatient) detox services are well over-capacity. To ensure more flexible, cost-effective and less restrictive service options, more capacity is needed in the medically supervised and monitored categories. Stakeholders also noted that there is a need for a more comprehensive range of detox/withdrawal service options, especially community-based crisis and detox beds.

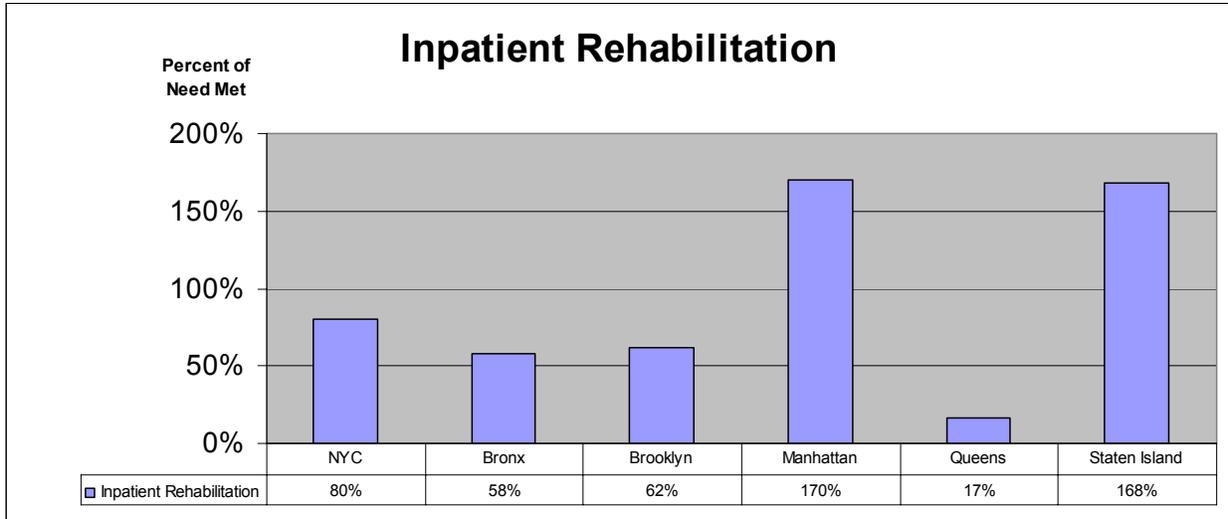


The above chart incorporates the “migration” adjustment for outpatient services to reflect the tendency of individuals from outer boroughs to “migrate” to Manhattan for services. Even with this “migration” adjustment, it appears that adult outpatient services are at or are slightly over-capacity in Manhattan and the Bronx, with respective rates of 110.6% and 103.3%. All boroughs remain significantly under-capacity for adolescent outpatient services, a need that was identified by stakeholders.<sup>14</sup>

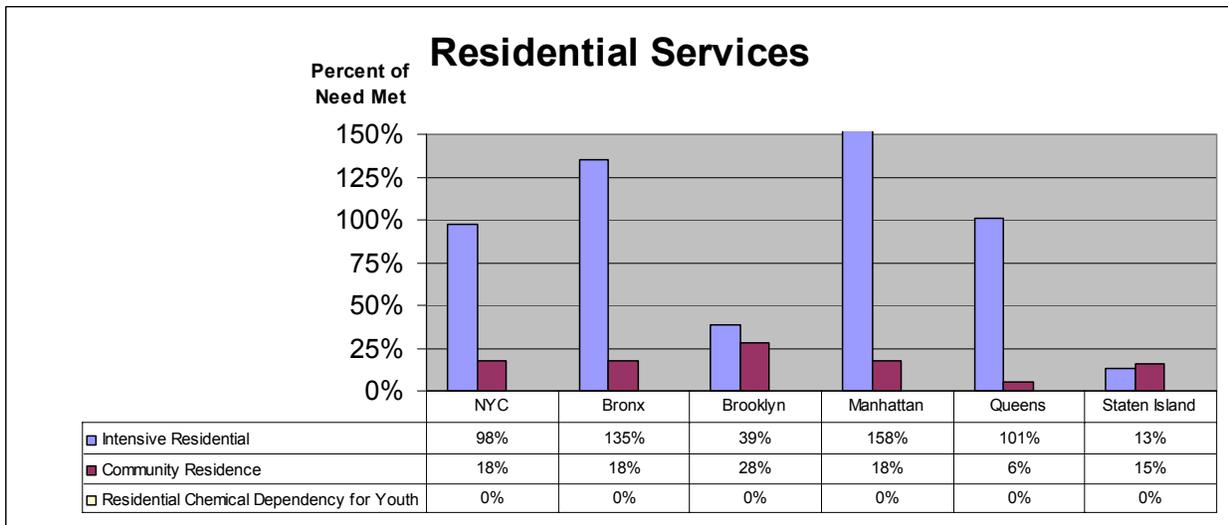


Methadone treatment services are under-capacity in all five boroughs, with Queens most in need and Manhattan least in need of increased capacity.

<sup>14</sup> Without the “migration” adjustment, need for adult outpatient services is being met at a rate of 139% in Manhattan and only 94% in the Bronx, and all boroughs remain significantly under-capacity for adolescent outpatient services.



Inpatient rehabilitation services are significantly under-capacity Citywide and are very unevenly distributed throughout the boroughs.



Intensive residential services are in need of better distribution throughout the boroughs. All boroughs are in need of adult community residence services, and even more acute is the need for residential chemical dependency services for youth.

### Community-Level Estimates of Unmet Need

The preceding borough-level estimates of unmet need generated by the OASAS Need Methodology offer DMH guidance in its local review of certification applications for new and expanded chemical dependency services. However, because of the City's population density and diversity, and the variation in need and service demand throughout the City, DMH is interested in estimating service need within smaller geographic areas. Disaggregation of borough-level data down to the community level will allow us to better identify saturated and underserved areas

within each borough, and subsequently work to improve the distribution of services throughout the City.

During this past year, DMH began the process of using OASAS' borough-level data to develop community-level estimates of need. We embarked on this work as a collaborative effort with stakeholders, who can assist us to better understand consumers' service location preferences and their use of the public transportation system to access services – key factors in this level of analysis. The basic methodology we are utilizing for this needs assessment work involves disaggregating OASAS' borough-level need data using poverty as a social indicator of need. A more detailed explanation of our initial methodology, along with an example of maps and estimates we can generate to evaluate need at the community-level are included in the Appendix, on page 40.

Refining this methodology will be a multi-year process that involves resolving issues and concerns such as:

- Determining the allocation of local vs. non-local need and capacity (e.g., some individuals prefer to access services close to work as opposed to close to home).
- Identifying and adjusting for capacity targeted at special populations (e.g., some programs only serve individuals mandated by the courts).
- Developing a capacity measure for outpatient services that is more useful for planning than the current historical measure provided by OASAS.

Moving forward, we will continue to seek the advice of stakeholders as we work to address these issues. In summary, we believe the Methodology is a useful tool and will provide enhanced insight into community-level service need.

### **Stakeholder Input**

The input of NYC stakeholders is a key feature of the local planning process. The New York City Charter identifies the Federation for Mental Health, Mental Retardation and Alcoholism Services as the stakeholder group that advises DMH in its mission to ensure access to high quality services to improve the lives of New Yorkers with mental hygiene disorders and disabilities. The current Federation structure includes five borough Chemical Dependency Councils comprised of consumers, family members, provider agencies and advocates. Ideally, these Councils would participate in the local planning process by developing a prioritized list of service needs and planning issues at the borough level, which could then be filtered up through the Federation's structure and presented to DMH as a comprehensive, Citywide list of annual planning needs.

This past year DMH and the Federation engaged a consultant to develop and implement a reorganization plan with the goal of revitalizing and strengthening the Federation's advisory and planning role. Increasing participation by chemical dependency stakeholders is a critical goal of this reorganization, which will require at least a year to implement.

In order to ensure adequate and diverse stakeholder input for the 2007 Plan, DMH met with the Federation Borough Councils and four other stakeholder organizations representing different

sectors of the chemical dependency community: the Association of New York City Addiction Programs (ANYCAP), Alcoholism and Substance Abuse Providers of New York State (ASAP), the Committee of Methadone Program Administrators (COMPA) and the Therapeutic Communities Association (TCA). In addition, DMH expanded efforts to elicit stakeholder input this year by reaching out to a critical group, chemical dependency consumers. Those who participated in these meetings were asked 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 improve the system; and priority issues that need government attention.

Seven general themes emerged from these meetings. Most echoed issues identified last year, with the exception of one major theme that emerged during the consumer meeting – service programming concerns – where consumers provided suggestions about how services could more fully meet their needs. Below is a non-prioritized summary of the issues that were raised by stakeholders.

#### Access to Services for Specific Populations

Stakeholders reported that certain populations in NYC experience particular difficulty accessing services, and that culturally competent services with culturally and linguistically competent staff need to be more widely available. Special populations identified as needing greater access to services include: the un- or under-insured; Asian Americans; individuals with co-occurring medical needs; seniors; individuals involved in the criminal justice system; and women, especially those who are pregnant and/or have children. Two specific populations identified as having significant unmet needs are:

- Adolescents – Programs need to develop services that address the unique needs of adolescents, who often use different drugs than adults (e.g., marijuana vs. heroin), and have different services needs (e.g., education vs. employment). Additionally, residential providers identified requirements for congregate care reimbursement as a barrier for adolescents to access treatment.
- Co-occurring Chemical Dependency and Mental Illness – Stakeholders consistently noted that individuals with co-occurring chemical dependency and mental illness do not receive the full range of services they need, and that mental health practitioners need to become more knowledgeable about chemical dependency and chemical dependency services. For example, many are not aware that chemical dependency programs are drug-free but not medicine-free, and allow consumers to take their required psychiatric medications while in a chemical dependency program.

#### Prevention

Stakeholders expressed a need for additional prevention services, especially community-based prevention services targeted at high-risk populations, including adolescents and children of substance abusers. Also recommended were prevention services that engage families and community members, not just schools, and focus on helping to keep adolescents out of jail for drug-related offenses.

### Housing

A critical unmet need mentioned by the majority of stakeholders was housing. In fact, consumers noted it as the most important issue, commenting that stability at home is a critical first step toward enabling an individual to focus on recovery. Stakeholders noted a need for housing opportunities that offer more flexibility around sobriety and relapse, as well as provide the various levels of support needed to meet an individual at his/her stage of recovery. A model cited as effective in meeting this need is the Housing First approach, which can include intensive case management, including an Assertive Community Treatment (ACT) team. It was also noted that more sober homes are needed, as long as they are better regulated and adequately reimbursed for services rendered.

### Service Coordination

Several stakeholders commented on the need for better service coordination and a continuum of care, noting that consumers often fall through the cracks or are sent to inappropriate levels of care. It was suggested that linkages between chemical dependency providers and other services be improved, to allow faster access to needed medical, mental health, and emergency services. Stakeholders also commented that an expansion of community-based detoxification services, along with a reimbursement structure that fully supports this level of care, would greatly improve the continuum of care and provide many consumers with treatment options that meet their needs. Finally, it was noted that a Citywide central intake process would provide a better way to triage individuals to ensure they are sent to the appropriate level of care.

### Workforce Issues

Stakeholders expressed concerns about workforce issues, noting that there is a shortage of well-trained, bilingual staff. Smaller programs commented that they experience great difficulty competing with hospitals in terms of salaries and benefits, and this is an obstacle to attracting and retaining qualified staff. Consumers expressed concerns that direct service staff do not receive adequate supervision.

### Funding/Regulatory Issues

Providers continued to express concern and frustration with various funding and regulatory barriers to providing services. Of greatest concern is reimbursement structures that do not allow for full reimbursement of services provided, thereby creating a disincentive to provide certain services. Many stakeholders also commented that “presumptive eligibility” and emergency Medicaid coverage would greatly improve access to services for consumers who do not yet have Medicaid when they present for services. As for regulatory barriers, stakeholders expressed frustration that truly integrated treatment for individuals with co-occurring chemical dependency and mental illness is not supported by the current regulatory framework.

### Service Programming Issues

Consumers noted a need for more constructive and meaningful programming, with a focus on vocational preparation and skills such as resume writing and computer training. They also noted a need for more life-skills training and education to assist with re-entry into the community. Finally, consumers expressed a desire for more person-centered treatment, with increased information about their diagnoses, treatment and rights while in treatment, as well as an approach to treatment that is more individualized, rather than the common “one size fits all” approach.

Several of these issues noted by stakeholders are currently being addressed by DMH initiatives. These areas of alignment include: i) collaboration with State partners to implement the New York/New York III agreement (NY/NY III) which will provide over 3,000 units of housing for individuals with chemical dependency disorders and their families; ii) implementation of the Managed Addiction Treatment Services (MATS) program, which aims to improve service coordination and linkages for individuals who are not appropriately engaged in services and continue to cycle through inpatient detoxification services; iii) promotion of SBIRT, a brief intervention to prevent and minimize problem drinking and drug abuse; and iv) efforts to improve cultural competency within the chemical dependency services system and obtain data on consumer perceptions of care through DMH's quality improvement initiative, Quality IMPACT. These and other DMH initiatives are described in the following section.

### **III. LOCAL GOVERNMENT INITIATIVES**<sup>15</sup>

This section of the plan describes both ongoing and new initiatives aimed at improving access to and quality of chemical dependency services for residents of NYC. Ongoing initiatives are listed first, in the same order as in last year's Plan, followed by new initiatives.

#### **Reducing Opioid Abuse and Overdose Deaths**

Launched in March 2004, Take Care New York (TCNY) is DOHMH's 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. To address this priority, DMH continues to focus on reducing the number of people who use heroin and other opioids by promoting the use of buprenorphine (BPN), and reducing the number of people who die from heroin and other opioid overdoses by promoting the use of naloxone.

Opioid dependence is a significant public health problem in NYC. One fifth of the heroin users in the United States, an estimated 200,000 people<sup>16</sup> reside in NYC.<sup>17</sup> Most of the City's injection drug users use heroin on a daily basis, whereas about 50,000 are occasional users who may ingest the drug in other ways such as inhalation.<sup>18</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. Of NYC's heroin users, approximately

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<sup>15</sup> For more information about DOHMH and the initiatives detailed here, you can access the Department's website at: <http://www.nyc.gov/html/doh/html/home/home.shtml>

<sup>16</sup> Johnson, B., Rosenblum, A. and Kleber, H., "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," (White paper, New York City Department of Health and Mental Hygiene, 2003).

<sup>17</sup> Sederer, L.I. and Kolodny, A., "Office-Based Buprenorphine Offers a Second Chance," *Psychiatric Services* 55 (July 2004):743.

<sup>18</sup> Johnson, B., Rosenblum, A. and Kleber, H., "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," (White paper, New York City Department of Health and Mental Hygiene, 2003).

34,000, or less than 20%, are currently enrolled in methadone maintenance.<sup>19</sup> Untreated heroin addiction is associated with high rates of mortality, poly-drug use, crime, HIV/AIDS, hepatitis, increased health care costs, family violence and disruption, and other negative impacts upon our communities. Each year, approximately 700 New Yorkers (approximately two people each day) die from overdoses involving the use of opioids.<sup>20</sup>

BPN and naloxone present opportunities for effective interventions to address opioid addiction and overdose deaths. Below is a discussion of DMH's activities to promote the use of BPN to treat opioid addiction, followed by a description of efforts to promote naloxone for preventing opioid overdose deaths.

### **Promoting Buprenorphine**

Treating people for opioid addiction has been shown to be effective in helping them return to work and live productive lives. In 2002, the U.S. Food and Drug Administration approved BPN for the treatment of opioid dependence, allowing certified physicians to prescribe BPN to treat heroin and other forms of opioid dependence in their private offices and in clinics, as well as in traditional drug treatment programs. Compared with methadone, BPN has a lower risk for abuse and dependence, fewer side effects and drug-drug interactions, is safe and has a longer duration of action. Studies of early use show promise for BPN as an effective treatment option. For instance, a study by the Substance Abuse Mental Health Services Administration (SAMHSA) showed that most prescribing physicians perceived BPN to be effective, particularly for longer treatment periods, with minimal adverse effects. Additionally, the vast majority of consumers were satisfied with BPN treatment, with 97% saying they would recommend it to friends who also used opioids. After 6 months of BPN treatment, 81% reported abstinence from all drugs (except BPN) during the past 30 days.<sup>21</sup>

#### ***2006 Accomplishments:***

- To date, DMH has sponsored eight physician training sessions, resulting in 460 physicians trained. Currently, there are approximately 600 physicians certified to prescribe BPN in New York City, a 30% increase compared to last year.
- DMH awarded funding (\$500,000 in total) to 11 hospital-based outpatient substance abuse treatment programs, to support the cost of training and certifying physicians to prescribe BPN. With the assistance of DMH's "BPN Outreach Team," each facility reached its patient-load goal, resulting in a total of 194 new patients treated with BPN.
- DMH developed and distributed a brochure entitled, "Buprenorphine: Basic Information for Heroin Users"<sup>22</sup> to 150 health facilities and needle exchange programs for distribution to

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<sup>19</sup> OASAS 2004 County Data Profile for New York City (April 2004). Bureau of Addiction Planning and Grants Development, NYS Office of Alcoholism and Substance Abuse Services, page 1.

<sup>20</sup> Kolodny, A., McVeigh, K., and Galea, S., "A Neighborhood Analysis of Opiate Overdose Mortality in New York City and Potential Interventions," (Discussion Document, New York City Department of Health and Mental Hygiene, August 2003).

<sup>21</sup> American Society of Addiction Medicine, "SAMHSA/CSAT Evaluation of the Buprenorphine Waiver Program, Expanding Treatment of Opioid Dependence: Initial Physician and Patient Experiences with the Adoption of Buprenorphine," [http://www.buprenorphine.samhsa.gov/ASAM\\_06\\_Final\\_Results.pdf](http://www.buprenorphine.samhsa.gov/ASAM_06_Final_Results.pdf) (accessed May 5, 2006).

<sup>22</sup> New York City Department of Health and Mental Hygiene, "Buprenorphine: Basic Information for Heroin Users," <http://www.nyc.gov/html/doh/downloads/pdf/basas/basas-buprenorphine-brochure.pdf>.

heroin users. The brochure is for the education of current users about BPN and how it can assist them in becoming drug-free.

- DMH and OASAS sent a joint letter to all certified outpatient clinics urging them to provide medication-assisted treatment for opioid and alcohol dependence, including BPN.
- Legislation to correct The Federal Drug Addiction Treatment Act's 2000 (DATA) 30-patient BPN limit for group practices was passed in 2006.
- In 2006, OASAS reduced the BPN prescriber registration application from 8 pages to 2 pages and simplified the documentation requirements. DMH also successfully worked with OASAS to eliminate the redundant physician registration requirement.

### ***2007 Goals:***

#### **GOAL: Increase the number of New Yorkers receiving treatment for opioid addiction**

##### **Objective 1:** Expand capacity for buprenorphine treatment

Action Step: Increase the number of non-physicians trained to support physicians who use buprenorphine to treat opioid addiction

In 2007 DMH will focus on training auxiliary staff to support physicians for two main reasons: i) the American Psychiatric Association, along with other organizations, will conduct BPN physician trainings for a nominal fee in 2007; ii) the management and coordination of patients taking BPN is demanding to clinical staff such that non-physicians require training to assist in carrying out this work.

Training efforts for auxiliary health personnel focus on: referral to an induction provider; facilitation of the coordination between counselors, doctors, psychiatrists, family members and the consumer; and ensuring that consumers keep follow-up treatment appointments. The training includes information on BPN treatment guidelines and how to work effectively with substance abusing consumers. As of the writing of this Plan, two trainings for nurses, counselors and pharmacists have taken place, for a total of 120 auxiliary health staff trained. During 2007, DMH plans to hold five additional trainings.

DMH is also providing in-kind support to the American Society for Addiction Medicine's (ASAM) 'Physician Clinical Support' mentoring program. This program has developed a national network of physician mentors who have expertise in BPN treatment and clinical education. The aim is to provide mentoring support to newly certified doctors as they begin to prescribe BPN.

##### **Objective 2:** Integrate buprenorphine into the primary care setting

Action Step: Develop and pilot the "Clinical Integration and Best Practices Project"

DMH is planning to collaborate with the NYC Health and Hospitals Corporation (HHC) to develop a written protocol for integrating BPN in primary care and specialty care settings such as

HIV/AIDS clinics, and to test the feasibility of this approach. If successful, these facilities will provide training on this practice to others.

### **Promoting Naloxone**

Naloxone can be an effective means of preventing deaths by heroin overdose. Death from heroin overdose is rarely instantaneous (it occurs over a 1 to 3 hour period)<sup>23</sup> and the majority of overdoses occur in the presence of others.<sup>24</sup> Moreover, at the moment when overdose may be occurring, many injection partners do not call emergency personnel for fear of legal system involvement. Recovery from opioid overdose treated with naloxone is nearly universal and carries a minimal risk of serious adverse side effects.<sup>25</sup> For these reasons, there is an opportunity to educate injection drug users on how to use naloxone to prevent fatal heroin overdoses. Education in the use of naloxone is critical as it is possible for individuals to revert back into overdose once the first dose of naloxone wears off.

#### ***2006 Accomplishments:***

- DMH collaborated with the Harm Reduction Coalition (HRC), an agency that works to reduce drug-related harm by promoting harm reduction activities, to develop and implement the “Opioid Overdose Prevention Initiative,” which was designed to reduce the number of overdose-related fatalities. During City FY 2006, HRC provided training to syringe exchange programs (SEPs), conducting 4 training sessions per week and distributing 1,200 kits containing naloxone and information about its use. In addition, HRC provided technical assistance on overdose prevention to 25 different drug treatment programs, including SEPs and community-based organizations.
- 800 naloxone prescriptions were written in 2006, and there were 87 documented overdose reversals involving naloxone.
- In April 2006, the NY State Legislature passed the Opioid Overdose Prevention Law (NYS Public Health Law 3309), which permits the NYS Department of Health to approve opioid overdose prevention programs that choose to register with the State as official programs. This will assist DMH in efforts to expand training activities and increase distribution of naloxone.

#### ***2007 Goals:***

**GOAL: Reduce heroin-related overdose fatalities by 29% by 2008 – from 11.3 per 100,000 to 8 per 100,000**

**Objective 1:** Collaborate with syringe exchange programs and other agencies to increase awareness, skills and knowledge regarding opioid overdose prevention

Action Step: Fund training activities regarding overdose prevention

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<sup>23</sup> Sporer K., “Strategies for preventing heroin overdose.” *British Medical Journal* 326: (February 2003); 442-444.

<sup>24</sup> Darke S., Ross J., and Hall W. “Overdose among heroin users in Sydney, Australia. II. Responses to overdose,” *Addiction* 91: (1996); 413-417.

<sup>25</sup> Sporer K., “Strategies for preventing heroin overdose.” *British Medical Journal* 326: (February 2003); 442-444.

In 2007 DMH will fund HRC to provide naloxone training to 1,200 individuals. The training will teach how to provide naloxone in an overdose situation, how to provide rescue breathing, how to obtain prescriptions and will also provide prevention kits. Staff at approximately 12 programs, including homeless shelters, post-incarceration programs, methadone clinics, housing programs and programs funded to do harm reduction/recovery readiness under the Ryan White Care Act, will be targeted. It is projected that this training will prevent 112 fatal overdoses during the next fiscal year. Additionally, HRC will provide training and technical assistance to a minimum of three agencies so they can in turn train staff within their own agencies.

**Objective 2:** Improve data collection and analysis regarding opioid overdoses to inform ongoing intervention initiatives

In order to develop and implement effective overdose prevention strategies, it is imperative to have a fuller understanding of the target population, overdose patterns and risk factors for heroin overdose.

Action Step: Develop a demographic profile of heroin overdose decedents and a comprehensive opioid overdose death surveillance system

In collaboration with DOHMH's Offices of Vital Statistics, Epidemiology and the Medical Examiner, DMH will utilize opioid mortality data to better target this initiative. We will review 2005 death certificate data to develop a demographic profile of decedents, and identify associated risk factors for opioid overdose death. Moving forward, we will monitor opioid overdose mortality and associated risk factors through ongoing surveillance.

### **Reducing Alcohol-Related Morbidity and Mortality**

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 U.S.<sup>26</sup>
- 18.2 million Americans ages 12 or older met the criteria for alcohol dependence or abuse during 2006.<sup>27</sup>
- 92,663 deaths in the U.S. in 2001 were related to alcohol.<sup>28</sup>
- 24.7% of NYC residents are binge drinkers and 7.1% are heavy drinkers.<sup>29</sup>
- 35,000 hospitalizations each year in NYC are related to alcohol abuse.<sup>30</sup>

As part of the TCNY health policy agenda, DMH continues to focus on reducing alcohol-related morbidity and mortality by promoting the use of SBIRT (screening, brief intervention and

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<sup>26</sup> Mokdad A., Marks J., Stroup D., and Gerberding J., "Actual Cause of Death in the United States," *Journal of the American Medical Association* 291: (2004); 1238-1245.

<sup>27</sup> Substance Abuse and Mental Health Services (SAMSHA), "National Survey of Drug Use and Health (NSDUH)" (2005).

<sup>28</sup> Centers for Disease Control and Prevention, "Behavioral Risk Factor Surveillance System Survey Data BRFSS," (Atlanta, GA: Department of Health and Human Services (US), CDC 2002). Available online at: <http://apps.nccd.cdc.gov/brfss/index.asp>.

<sup>29</sup> "The 2004 NYC Health and Nutrition Evaluation Survey (CHANES)" (NYC Department of Health and Mental Hygiene, 2004). Available online at <http://www.nyc.gov/html/doh/html/hanes/hanes.shtml>.

<sup>30</sup> The New York State Department of Health's Statewide Planning and Research Cooperative System (SPARCS) database (2002-2003).

referral to treatment), an evidence-based practice designed to train physicians to address problem-drinking behavior during visits to emergency rooms and other medical settings. SBIRT has been shown to be effective in reducing risky drinking, increasing abstinence from alcohol and reducing substance-related health and social consequences among alcohol and drug abusing persons who appear for care in emergency departments. DMH's efforts to promote SBIRT are targeted at individuals who have moderate to high-risk drinking habits, but whose drinking has not yet passed the threshold to qualify for dependence.

### ***2006 Accomplishments:***

- During FY 2005 and FY 2006, DMH provided funding for SBIRT training for emergency department staff at five HHC hospitals: Bellevue, Elmhurst, Lincoln, Jacobi and Kings County. Over 300 emergency department staff were trained to utilize SBIRT. In addition, all hospitals have hired a peer-educator to promote and oversee the use of SBIRT.
- In November 2005, an issue of the DOHMH City Health Information (CHI) publication on the use of brief intervention in physicians' offices was published and distributed to over 50,000 physicians, nurses and other providers, including every licensed physician in New York City, to educate them about this intervention and promote its use. The publication, titled "Brief Intervention for Alcohol Problems," can be found at:  
<http://www.nyc.gov/html/doh/downloads/pdf/chi/chi24-8.pdf>.

### ***2007 Goals:***

#### **GOAL: Reduce alcohol-related morbidity and mortality**

**Objective:** Promote the use of SBIRT to improve screening, treatment and referral of problem drinking and alcohol abuse/dependence

Action Step 1: Provide funding to hospitals to expand capacity to implement SBIRT

The five HHC sites that received SBIRT funds from DMH in FY 2005 and FY 2006 will receive additional funds in FY 2007. These funds will allow the specialty chemical dependency programs at each facility to train their staff regarding SBIRT so that they can collaborate with the emergency department staff in implementing SBIRT and tracking the number of screenings and referrals.

Action Step 2: Collaborate with OASAS to expand the use of SBIRT

DMH and OASAS submitted an \$8.9 million 4-year grant proposal to SAMHSA seeking funding to expand SBIRT in NYC. If funded, this expansion would include hospital emergency departments, homeless shelters, sexually transmitted disease clinics and Federally Qualified Health Clinics (FQHCs). Efforts would be targeted at people who have moderate to high-risk drinking, but whose drinking has not passed the threshold to qualify for dependence.

Action Step 3: Provide education and information about problem drinking and SBIRT in various health settings

In 2007, DMH will develop and implement a public health detailing campaign regarding problem drinking and SBIRT, which will involve DMH staff delivering brief, targeted messages to doctors, physicians' assistants, nurse practitioners, nurses and administrators at their practice sites. Detailing efforts will be targeted at the Department's three District Public Health Office (DPHO) areas – neighborhoods identified as high-need, which include the South Bronx, East and Central Harlem, and North and Central Brooklyn. Specific focus will be on problem drinking, brief intervention strategies and underage drinking.

In addition, DMH seeks to launch a public education campaign on problem drinking and expand SBIRT training capacity in NYC through a series of train-the-trainer sessions. This increased capacity will facilitate training of other City agency staff and direct care staff including those in sexually transmitted disease clinics and DHS shelters. These activities are pending receipt of grant awards and allocation of additional resources.

### **Promoting a Culture of Quality**

#### **Quality IMPACT: Overall Implementation**

Quality IMPACT (Improving Mental Hygiene and Communities Together) is a multi-year quality improvement (QI) initiative that aims to incrementally move the New York City mental hygiene service system toward more effective services, better client outcomes and the integration of evidence-based and innovative practices. Quality IMPACT has two components: continuous quality improvement (CQI) activities, where participating programs implement CQI projects that target specific service improvements; and consumer perceptions of care surveys, where data on consumer assessment of satisfaction and other relevant domains are collected and used as program-level outcome measures and for system-wide service evaluation and planning.

The CQI component of Quality IMPACT is designed to increase programs' capacity to engage in rigorous CQI activities and to spearhead the improvement of key service outcomes for consumers. Its principles include broad stakeholder involvement in project development, use of data-driven quality improvement methods, intensive provider education and support, implementation of evidence-based, promising and innovative practices and transparent reporting of results. Quality IMPACT currently focuses on treatment programs in the three mental hygiene disability areas. Details of FY 2006 CQI activities relating to chemical dependency services and plans for FY 2007 are described beginning on page 24 of the Plan.

The collection and analysis of consumer perceptions of care data in the mental hygiene disability areas on an annual basis is a cornerstone of Quality IMPACT. Consumer satisfaction with services is widely recognized as an important component of outcome performance; consumers who are satisfied with services tend to follow their treatment/recovery/service plans and remain engaged in services. In Quality IMPACT, stakeholder workgroups in conjunction with DMH staff select and adapt the surveys for use in NYC. Priority is given to widely used survey tools that allow for the comparison of data across NYC programs and with other cities and states. DMH analyzes the survey data and communicates findings to the participating programs through individualized reports, and to the public through the DOHMH website. The details of the FY

2006 chemical dependency survey, and plans for FY 2007 and FY 2008 are described beginning on page 27 of the Plan.

**2006 Accomplishments:**

Since it was begun in 2004 (FY 2005), Quality IMPACT has been incrementally expanded each year as additional program categories have been phased in.

<b>Growth of Quality IMPACT FY 2005 – FY 2007</b>				
<b>Fiscal Year</b>	<b>MH Programs<sup>31</sup></b>	<b>MRDD Programs<sup>32</sup></b>	<b>CD Programs<sup>33</sup></b>	<b>Total Participating Programs</b>
FY 2005	39	28	0	67
FY 2006	74	36	37	147
FY 2007	162	28	27	217

Our longer-term goal is for most of the City’s mental hygiene programs to incorporate CQI activities and consumer perceptions of care surveys into their standard program operating practices.

**2007 Goals:**

**GOAL: Promote and facilitate a culture of quality within the mental hygiene service system**

**Objective 1:** Develop an infrastructure within DMH to promote, support and monitor quality improvement activities

Action Step 1: Support the capacity of mental hygiene programs to conduct quality improvement by providing training, technical assistance, data analysis and other needed supports

DMH has developed a structure to guide programs through the CQI process. All participating providers receive training and assistance in establishing CQI in their programs, including: initial staff training on team development and the CQI model, a timeline for project selection, templates for project selection and data submission and ongoing technical assistance. Additionally, for their first two years of the initiative, programs are strongly encouraged to participate in DMH-sponsored priority projects. Priority projects engage groups of programs in improving services in specified areas that stakeholders have identified as systemic problems. In addition to the above-mentioned supports, priority projects provide structured workbooks which offer step-by-step guides to project planning and implementation, electronic data collection tools and data training, monthly group conference calls for each project group and three Interactive Project Group (IPG) meetings. Expert consultants and trainers assist DMH in staffing the conference calls and IPGs.

<sup>31</sup> Clinic and Continuing Day Treatment Programs.

<sup>32</sup> Clinics, Work Readiness, Transitional Employment and Day Treatment Programs.

<sup>33</sup> Clinic Programs.

Based on input from stakeholders, advisory committees, and programs, DMH has determined that after two years of participation in a structured CQI project with intensive support, most programs have developed sufficient proficiency in CQI to continue their CQI activities with less support. Hence, programs entering their third year of participation in Quality IMPACT are expected to continue CQI activity each year on a more independent basis by doing an approved CQI project that is of their own choosing.<sup>34</sup> DMH staff review both submissions from providers describing proposed CQI projects, which are subject to DMH approval, and accompanying project data. These programs continue to receive training on CQI and technical support, but do not participate in monthly conference calls or IPGs.

Action Step 2: Build Quality IMPACT participation into DMH’s contractual requirements and oversight process

Consistent with its commitment to promote quality improvement throughout the City’s mental hygiene services system, DMH requires chemical dependency treatment providers receiving City funding to participate in Quality IMPACT. During program audits, review of the on-site implementation of the CQI project will be conducted. Providers needing additional assistance will be identified and technical assistance provided.

Action Step 3: Collaborate with City and State mental hygiene partners to advance a unified approach to quality improvement in NYC

DMH actively collaborates with State partners and other organizations within the mental hygiene community to promote an integrated approach with consistent standards for implementing quality improvement within NYC. Such integration is key to limiting provider burden, enhancing the dissemination of improvements and collecting useful system-wide data.

DMH collaborated with OASAS throughout the development and implementation of the co-occurring disorders project, which promotes screening, assessment and coordinated treatment for consumers with co-occurring mental health disorders in chemical dependency clinics. The project utilizes the tool recommended by OASAS (the Modified Mini Screen: MMS) to screen for anxiety, mood and psychotic disorders. OASAS provided training in implementing the screen and granted Workscope<sup>35</sup> credit to chemical dependency programs participating in this Quality IMPACT project.

Last year, OMH developed a quality improvement initiative which implemented a Medicaid rate increase for participating community-based (Article 31) clinics. DMH worked with OMH to obtain agreement that Quality IMPACT participation by New York City clinics would meet OMH QI requirements. DMH has also been collaborating with the Urban Institute for Behavioral Health (UIBH). As UIBH develops quality improvement projects, DMH has offered its model and materials for use in UIBH projects, and has accepted participation in UIBH QI projects as satisfaction of Quality IMPACT requirements.

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<sup>34</sup> Programs with well established CQI capacity and a desire to work independently can move to this independent phase prior to completing two years of participation.

<sup>35</sup> The Workscope Objective Attainment System is a requirement for OASAS funded programs that is designed to establish and monitor progress toward meeting program performance objectives.

**Objective 2:** Continue to develop and support CQI projects focused on improving quality of care in the mental hygiene system

Action Step 1: Continue to support providers engaging in CQI projects through Quality IMPACT

In FY 2007, 14 chemical dependency clinics and 25 mental health clinics will be participating in co-occurring disorders priority projects. Two chemical dependency programs and 13 mental health programs will be implementing their projects for the first time; the others will be continuing on with their FY 2006 projects and expanding their scope.

Three of the programs that participated in the cultural competency project in FY 2006 are continuing this project in FY 2007 and have plans for expanding its scope.

One chemical dependency provider has chosen to implement an independent CQI project for FY 2007, improving show-rates for psychiatric evaluation appointments in chemical dependency clinics.

Action Step 2: Develop new priority CQI projects to meet emerging needs

For FY 2007, a new priority project, “The Welcoming Clinic: Improving Access through Client-Centered Services,” was developed for mental health and chemical dependency adult treatment programs. This area for improvement was identified by numerous Quality IMPACT providers, who in FY 2006 implemented independent CQI projects on aspects of consumer engagement and retention. This project will offer interactive group support, targeted staff education and standardized data collection. Seven chemical dependency providers, along with 41 mental health providers, will participate.

Recognizing that a mental hygiene service system that values consumer self-determination, choice and empowerment is a top priority at the federal, state and local levels, this priority project aims to assist mental hygiene service providers in finding new ways to enhance consumer engagement in services. Throughout the project year, providers will design and implement interventions that focus on key issues of access and treatment efficiency. For example, providers can develop more convenient and flexible scheduling practices, work to increase planned discharge rates, or develop interventions to maximize rapid access to treatment (e.g., reduce the time or numbers of consumers on waiting lists, decrease the time between intake and first appointment). Programs will track their quality improvement successes by collecting data on show-rates for both initial and ongoing visits. These data are perceived by many treatment programs to be useful indicators of consumer engagement and retention. Programs will also collect data on discharges due to consumer non-attendance.

### **Improving Treatment of Co-occurring Chemical Dependency and Mental Health Disorders**

In FY 2005, a group of 22 mental health treatment programs began implementation of a Quality IMPACT CQI project designed to screen all newly evaluated adult consumers using the Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD). Consumers who screened

positive were further assessed for a chemical dependency disorder. Those who were diagnosed were treated either on-site or referred off-site for chemical dependency treatment services, and their progress was monitored in their mental health treatment plan. In FY 2006, 13 of the original 22 programs continued with this project for a second year with an expanded scope, and a new group of 18 mental health programs started this project.

Also, in FY 2006, 23 chemical dependency programs began a similar project to identify and provide treatment for clients with co-occurring disorders. These 23 programs used the Modified Mini Screen (MMS), which has been validated in chemical dependency settings to help identify and refer for mental health assessments those clients who may have a mood, anxiety or psychotic disorder. Those diagnosed were likewise provided mental health treatment on-site or referred off-site for mental health treatment services, and their progress was monitored in their chemical dependency treatment plan.

**2006 Accomplishments:**

- The chart below presents selected findings from the mental health and chemical dependency programs that participated in the co-occurring disorders projects.

<b>Selected Findings from Co-occurring Disorders Priority Projects</b>					
Groups of Programs (Number of Programs in each Group)	New Clients Who Were Screened* (Number Screened)	Screened Clients Determined to Need Assessment	Timely Assessments Occurred (Within 30 Days)	Assessments Indicating Co-occurring Treatment Need	Treatment Goals Documented in Initial Treatment Plan
Mental Health FY 2005 (22) & FY 2006 (13)	87% (2,257) 95% (1,541)	23% 22%	94% 95%	NA 93%	85% 98%
Mental Health FY 2006 (18)	94% (1,349)	20%	98%	94%	93%
Chemical Dependency FY 2006 (23)	81% (1,580)	30%	73%	79%	96%
All Programs/All Years	88% (6,727)	24%	88%	88%	93%

\*The screenings in mental health clinics were done at intake; the screenings in chemical dependency clinics were done at or soon after admission. Therefore, the denominators were all new intakes or all new admissions for mental health and chemical dependency programs, respectively.

- Based on the experiences of participating programs, it is clear that implementing a standardized screen for co-occurring disorders – which is an accepted best-practice – followed by assessment when indicated, is feasible and effective in both chemical dependency and mental health treatment programs.

- In collaboration with the Mental Health Association of NYC (MHA) and through Mentally Ill and Chemically Addicted (MICA) training funding provided by OMH, DMH was able to offer educational programs for both chemical dependency and mental health treatment providers in the co-occurring disorders projects. Trainings included: motivational interviewing, including supervision of this technique; dual recovery therapy, which was targeted at chemical dependency clinicians and clinical supervisors; and assessment and treatment planning.

**2007 Goals:**

**GOAL: Improve access to and quality of treatment services for individuals with co-occurring mental hygiene disorders**

**Objective:** Improve screening, assessment, and treatment planning for co-occurring mental health and substance use disorders in adults receiving treatment for either disorder

Action Step: Develop and implement a series of CQI priority projects that promote screening, assessment and coordinated treatment for consumers with co-occurring mental health and substance use disorders in both mental health and chemical dependency outpatient treatment programs

In FY 2007, 14 chemical dependency clinics and 25 mental health clinics are participating in co-occurring disorders priority projects. Two chemical dependency programs and 13 mental health programs will be implementing their projects for the first time; the others will be continuing on with their FY 2006 projects and expanding their scope. Problems of retention and engagement of clients with co-occurring disorders will receive particular attention in FY 2007 as will problems with timely assessments, which thus far have proved more difficult for chemical dependency programs than for mental health programs.

**Improving Cultural Competence**

The Quality IMPACT CQI project to improve cultural competence was designed to help providers better meet the treatment needs of NYC's increasingly diverse adult consumer population. Participating providers screen for cultural factors using the City-wide Cultural Assessment (CCA), a tool developed by DMH with input from NYC mental hygiene stakeholders. Programs also target a particular underserved cultural group for increased admissions, based on the demographics of their consumer population compared to that of their service area. During FY 2006, 4 chemical dependency clinics participated in this project (along with 9 mental health outpatient treatment programs).

**2006 Accomplishments:**

- 463 of the 508 adult chemical dependency clients (91%) who had an initial assessment were screened using the CCA; 58% were found to have cultural factors important in the development of treatment plans.
- Target group admissions increased over baseline (23%).

## ***2007 Goals:***

### **GOAL: Improve cultural competence in chemical dependency treatment programs**

**Objective:** Increase program admissions of adults from underserved cultural groups, and improve the cultural competence of assessment and treatment of all adults

Action Step: Develop and implement a series of CQI priority projects that promote culturally competent assessment and treatment and increase access for underserved populations

Three of the chemical dependency programs that participated in FY 2006 are continuing this project in FY 2007 and have plans for expanding its scope.

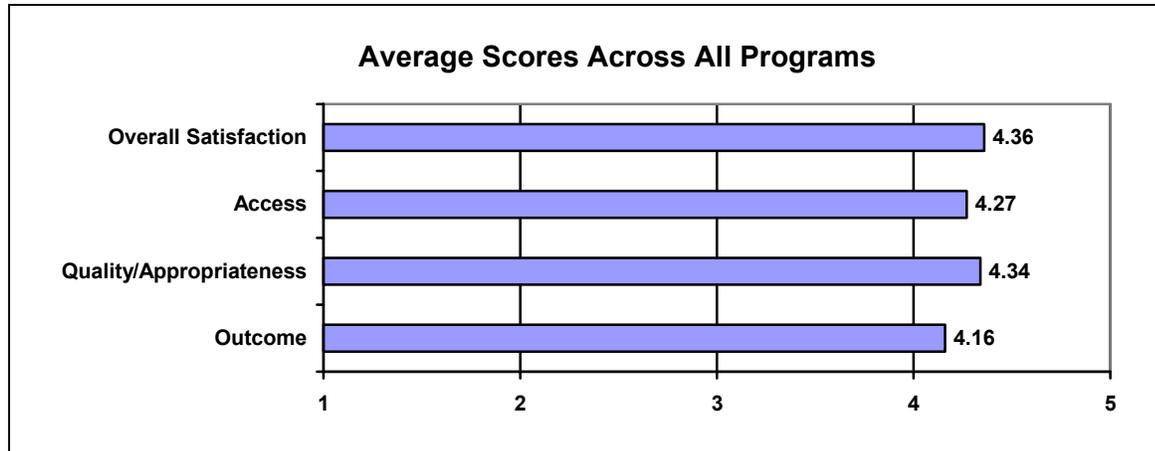
### **Surveying Consumers on Perceptions of Care**

In FY 2006, chemical dependency clinics participating in Quality IMPACT implemented a modified version of the Mental Health Statistics Improvement Program (MHSIP) - Adult Consumer Survey, a nationally recognized survey instrument that was developed for use in the public mental health system and is now widely used by state and local governments. DMH worked with the chemical dependency stakeholder community to modify the original survey to be more relevant to chemical dependency programs.

The primary purposes of consumer surveys is to give clients a voice in improving the quality of their services and to identify service areas for improvement. The survey measured consumer perceptions of care in the areas of general satisfaction, access, quality/appropriateness and outcomes. It was self-administered, anonymous and confidential.

### ***2006 Accomplishments:***

- 1,161 consumers participated in the survey. Those consumers represented 53% of all consumers seen at the 24 participating programs during the two-week survey administration period.
- Survey results suggest that the majority of consumers have positive feelings about the services that they receive. However, consumers in many of the chemical dependency clinics indicated that staff could be more sensitive to their cultural and ethnic background.



Note: Consumers, who responded to 29 survey items, had the option of 5 responses:  
 5 = Strongly Agree, 4 = Agree, 3 = I am Neutral, 2 = Disagree, and 1 = Strongly Disagree.  
**A response of 5 indicates the most positive perceptions.**

**2007 Goals:**

**GOAL: Give mental hygiene consumers a voice in improving the quality of the services they receive through consumer perceptions of care surveys**

**Objective:** Incorporate consumer perceptions of care into services evaluation and planning

Action Step: Conduct a consumer perceptions of care survey for clients in chemical dependency programs

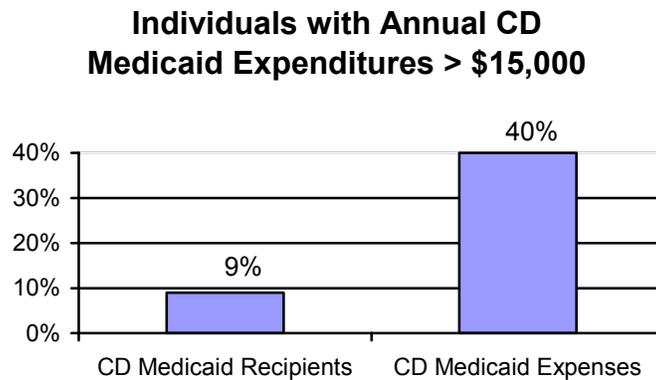
During the fall of 2006, participating programs will receive individualized reports of their survey findings. Each report will present the program’s performance ratings and, for comparative purposes, the average performance ratings across all programs. Providers will be encouraged to share their reports with staff and use the information to target areas for improvement. Beginning in FY 2007, results of individual programs will be made public; programs will be identified by name and their results reported on the DMH Quality IMPACT website and sent to participating chemical dependency programs.

Looking ahead, DMH intends to conduct perceptions of care surveys annually. By conducting annual surveys, participating programs will be able to monitor any improvements they make in response to consumer concerns. In addition, DMH will be able to aggregate the data to evaluate system performance.

**Improving Treatment for High-Utilizers of Medicaid-Funded Services**

New York State Medicaid expenditure data reveal that a relatively small number of individuals account for a disproportionate amount of Medicaid expenditures for chemical dependency

treatment services. As indicated below, a small proportion of Medicaid recipients, 9%, account for a disproportionate amount of Medicaid expenditures in CD services, 40%.<sup>36</sup>



The majority of these high utilizers of Medicaid-funded chemical dependency services live in NYC; 3,073 individuals in NYC used in excess of \$30,000 in Medicaid chemical dependency services. These individuals comprise 91% of the State’s total Medicaid chemical dependency costs for those with over \$30,000 in costs for State FY 2002-03. These are individuals who are not being effectively engaged in the chemical dependency treatment system, and are likely to have co-occurring medical and psychiatric disorders, as well as significant problems in other domains, including legal, child welfare, domestic violence, employment and housing.

In Spring 2005, OASAS released a Planning Supplement to elicit applications from counties and NYC to address this problem via an intensive case management (ICM) program to be called Managed Addiction Treatment Services (MATS). Studies throughout the last 15 years have shown that individuals receiving ICM services have had fewer and shorter psychiatric hospitalizations,<sup>37</sup> were less likely to become homeless, received better health care, were more likely to receive Federal disability benefits (SSI/SSDI), and had lower Medicaid costs.<sup>38</sup> MATS will initially provide ICM services to high Medicaid users on public assistance.

**2006 Accomplishments:**

- DMH, in conjunction with the NYC Human Resources Administration (HRA), was awarded a three-year award of \$21,000,000.
- Vendor negotiations are underway, with services to begin Fall 2006.

<sup>36</sup> “OASAS 2005 Planning Supplement II: Managed Addiction Treatment Services (MATS),” (Office of Alcoholism and Substance Abuse Services, 2005).

<sup>37</sup> Okin RL, Boccillari A, Azocar F. et al, “The Effects of Clinical Case Management on Hospital Service Use Among Emergency Department Frequent Users,” *American Journal of Emergency Medicine*, Vol. 18, No. 5, (Sept 2000).

<sup>38</sup> Walters LJ, Ackerman L, and Allen S., “Medical Chemical Dependency Patients in a Commercial Health Plan: Do High Medicaid Costs Come Down Over Time?” *Journal of Behavioral Health Services and Research*, 32(3), (2005): 253-263.

## **2007 Goals:**

### **GOAL: Improve access to and engagement in treatment and related services for high-utilizers of Medicaid-funded chemical dependency services**

**Objective:** Establish a NYC 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

#### Action Step 1: Implement Year 1 of the NYC MATS Program

During Year 1 (FY 2007) the NYC MATS Program will provide ICM services to 736 Medicaid recipients who are high-utilizers of addiction treatment services (i.e., individuals who have used in excess of \$30,000 in Medicaid funding for substance abuse treatment services in State FY 2002-03). DMH, with HRA and OASAS, will identify eligible individuals and voluntarily engage them to stabilize their treatment and social services. In addition, MATS will provide eligible participants with needed housing services, including homeless diversion services, supportive housing (NY/NY and DHS) and emergency, transitional and permanent housing for people with HIV/AIDS.

#### Action Step 2: Monitor Year 1 activities and prepare for Years 2 and 3 of the NYC MATS Program

DMH will monitor the implementation and quality of the MATS program. This will include establishing performance-based measures to hold providers accountable and incentivize them to achieve program goals. Additionally, DMH will assist in provider trainings on Contingency Management, Motivational Interviewing, and Intensive/Strengths-Based Case Management Techniques.

Services in Years 2 and 3 of the MATS program will be competitively solicited via an RFP process.

### **Increasing Access to Chemical Dependency Treatment for Individuals with Mental Retardation and/or Developmental Disabilities (MR/DD)**

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>39</sup> With a one-year prevalence rate, based on national studies, estimated at 11.5%<sup>40</sup>, we estimate there are 5,520 adults with DD (1,380 with MR only) in NYC who need chemical dependency treatment.

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<sup>39</sup> Wunsch-Hitzig, R., Engstrom, M., Lee R., King, C. and McVeigh, K., "Prevalence and Cost Estimates of Psychiatric and Substance Use Disorders and Mental Retardation and Developmental Disabilities in NYC," (NYC Department of Health and Mental Hygiene, Division of Mental Hygiene, Bureau of Planning, Evaluation, and Quality Improvement, 2003).

<sup>40</sup> Wunsch-Hitzig, R., Engstrom, M., Lee R., King, C. and McVeigh, K., "Prevalence and Cost Estimates of Psychiatric and Substance Use Disorders and Mental Retardation and Developmental Disabilities in NYC," (NYC Department of Health and Mental Hygiene, Division of Mental Hygiene, Bureau of Planning, Evaluation, and Quality Improvement, 2003). Note that the estimated prevalence rate of 11.5% refers to individuals ages 18-54.

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.

A workgroup comprised of DMH staff and members of the Federation's<sup>41</sup> MR/DD Borough Councils was established in Fall 2004 to improve access to inpatient substance abuse and alcohol treatment programs for consumers with MR/DD and a chemical dependency disorder.

### ***2006 Accomplishments:***

- The workgroup identified the Alcohol Treatment Centers (ATCs) operated by OASAS as a resource for meeting the inpatient chemical dependency needs of consumers with MR/DD. The ATCs, one per borough, offer 28-day inpatient treatment for alcohol and substance abuse disorders. ATCs will now begin to admit and track referrals.

### ***2007 Goals:***

#### **GOAL: Increase access to chemical dependency treatment services for adults with mental retardation and/or developmental disabilities**

**Objective:** Provide MR/DD service providers, consumers and their families with a referral list of inpatient chemical dependency providers that have committed to providing tailored treatment to consumers with MR/DD

**Action Step:** Explore additional chemical dependency providers, both inpatient and outpatient

### **Increasing the Availability of Supportive Housing**

Safe and reliable housing is a top priority for DMH, as it is a critical step toward recovery. Supportive housing empowers tenants, fosters their independence, and is a cost-effective solution to homelessness. While it is difficult to accurately estimate the unmet need for housing for individuals with chemical dependency disorders, the need far exceeds supply, and an unacceptably large number of individuals with chemical dependency disorders are homeless or unstably housed.

In 2004, Mayor Bloomberg announced a plan to end chronic homelessness in New York City, *Uniting for Solutions Beyond Shelter*, which included a commitment by the City to develop

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<sup>41</sup> The Federation for Mental Health, Mental Retardation and Alcoholism Services is an advisory body to DMH. It is comprised of mental hygiene service consumers, family members, provider agencies and advocates.

12,000 new units of supportive housing over the next ten years. While 3,000 units were already in the City's development pipeline, in November 2005 Governor Pataki and Mayor Bloomberg entered into a third New York/New York agreement (NY/NY III) that will create 9,000 units of supportive housing in NYC for homeless populations that have special housing needs. It will create nearly twice as many units as the first two NY/NY agreements combined, and the City and State will invest close to \$1 billion in capital funding and over \$150 million annually for services and operating expenses.

Unlike the previous two NY/NY agreements, which provided housing solely for single adults with serious and persistent mental illness who had some history of homelessness, NY/NY III will also provide supportive housing for individuals with substance abuse disorders. Two specific populations are targeted: homeless single adults with a substance abuse diagnosis, and chronically homeless families in which the head of household suffers from a substance abuse disorder and/or mental illness. More specifically, this initiative will fund:

- 750 units (250 congregate, 500 scattered site)<sup>42</sup> for homeless single adults who have completed a course of treatment for a substance abuse disorder, are at risk of street homelessness or sheltered homelessness, and who need transitional supportive housing to sustain sobriety and achieve independent living.
- 750 units (250 congregate, 500 scattered site) for chronically homeless single adults who have a substance abuse disorder that is a primary barrier to independent living, and who also have a disabling clinical condition (i.e., a medical or mental health condition that further impairs their ability to live independently).
- 750 congregate units for chronically homeless families, or families at serious risk of becoming chronically homeless, in which the head of household suffers from a substance abuse disorder, a disabling medical condition or HIV/AIDS.
- 1,000 units (600 congregate, 400 scattered site) for chronically homeless single adults living with HIV/AIDS who suffer from a co-occurring serious and persistent mental illness, substance abuse disorder or both (i.e., MICA).

The remaining 5,750 units of the NY/NY III housing allocation will be developed for various populations, including adults and families affected by a mental illness or other disabling medical condition and are at risk of becoming homeless, and youth aging out of foster care.

### ***2007 Goals:***

**GOAL: Increase the availability of supportive housing opportunities for individuals and families with chemical dependency disorders**

**Objective:** Begin developing the City's share of 9,000 units of supportive housing for NYC under the *NY/NY III Supportive Housing agreement*

**Action Step:** Contract with providers to develop NY/NY III housing units

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<sup>42</sup> DMH funds the services and operating costs for congregate supportive housing buildings, which offer consumers on-site services. DMH also funds scattered site apartments, where individuals are housed in apartments spread out across the City, and services are provided by visiting social service staff. Both models are permanent and unlicensed.

During the past year DMH’s Housing Office collaborated with an interagency workgroup to develop new housing models to meet the needs of those populations targeted for NY/NY III housing opportunities. Focus groups were held with chemical dependency providers and consumers to guide the development of the models.

DMH will issue two RFPs, one for congregate housing and the other for scattered site housing, in October 2006. Nine-thousand units will be developed over the next ten years, according to the following schedule:

<b>Fiscal Year<sup>43</sup></b>	<b>Units</b>
2007	1,320
2008	1,680
2009	950
2010-12	2,568
2013-16	2,482

**Improving Homeless Outreach Services**

Many of the approximately 3,800 homeless adults currently living on the streets in NYC suffer from a serious and persistent mental illness and/or chemical dependency. Typically intolerant of homeless shelters, some of these individuals remain on the streets for years. The challenge facing DMH is to make transitional housing, permanent supportive housing and other long-term residential settings accessible to chronically street homeless individuals. Historically, the mission of street outreach has been to render emergency assistance to homeless clients in the form of food, treatment or transportation to shelters. DMH, in partnership with DHS, now seeks to shift the focus to attaining long-term housing for chronically street homeless individuals in order to promote their recovery and reintegration into meaningful community life.

Currently, DMH contracts for outreach services require providers to meet a very high number of “contacts” (face to face encounters) per month. DMH believes that this focus on numerous contacts rather than on housing placement is a barrier to getting people off of the streets. DMH and DHS, along with a group of not-for-profit, private, federal, state and consumer stakeholders, are reconfiguring homeless outreach services Citywide to achieve the goal of more housing placements for the chronic street homeless population. Specific assistance to individual clients will take the form of, among other things: helping clients complete application forms; escorting clients to medical and mental health services and other appointments; and preparing clients for housing interviews using motivational interviewing techniques. Outreach providers will be expected to collect data, conduct street counts of homeless individuals in their catchment areas and track clients, and share such information with other involved agencies in order to better integrate homeless services in the provider’s community.

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<sup>43</sup> NYC Fiscal year runs from July 1 to June 30; e.g., FY 2007 is July 1, 2006 – June 30, 2007.

### ***2007 Goals:***

**GOAL: Reduce chronic street homelessness by improving housing opportunities and access to long-term substance abuse treatment options for the street homeless population**

**Objective:** Implement new street outreach service model with a focus on placement of homeless individuals directly into housing or other long-term chemical dependency residential settings

Action Step: Revise outreach contracts so all outreach providers follow the new housing placement-centered model in FY 2008

In 2006, five DMH-funded outreach providers began implementing the new placement-centered outreach model. Despite the new outreach approach, placement in housing is slow due to limited housing and residential treatment.

Beginning July 2007, the Department will fund City homeless outreach services in accordance with the new housing placement-centered model. Consistent with the emphasis on housing placement, providers' performance will be measured based on the following milestone indicators: 1) completion of the components required by the supportive housing referral application form (HRA 2000); 2) completion of applications for housing, entitlements and any other needed services; 3) client enrollment in substance abuse treatment and/or mental health services; and 4) client placement in transitional housing, permanent supportive housing or other long-term residential setting.

### **Increasing Community-based Withdrawal (Detoxification) Services**

There is a long-standing and costly problem of residents of homeless shelters repeatedly accessing inpatient hospital detox services, but not engaging in follow-up treatment services. DMH, OASAS and the Department of Homeless Services are collaborating on an initiative to address this need.

### ***2007 Goals:***

**GOAL: Increase community-based withdrawal (detoxification) services**

**Objective:** Improve access to community-based withdrawal (detoxification) services that are tied more closely to treatment services

Action Step: Establish a Shelter-Based Detoxification Demonstration Project that provides shelter residents with greater access to chemical dependency treatment by strengthening linkages between detoxification and treatment

On-site detoxification services will be provided in three City shelters: the Third Street Men's Shelter in Manhattan, a specialized shelter operated by Project Renewal that currently provides a range of OASAS-licensed services; the Atlantic Avenue Shelter, an assessment shelter for men

in Brooklyn operated by the Salvation Army; and the Franklin Avenue Shelter, an assessment shelter for women in Brooklyn operated by DHS. All three shelters operate medically supervised withdrawal services. OASAS, DHS and DMH will jointly oversee these three shelter programs and monitor outcomes for placement into and retention in long-term treatment.

### **Other DMH Activities**

Two chemical dependency-related initiatives that are not included as goals for 2007 are briefly described:

- Last year's Plan described a goal to expand treatment capacity for compulsive gambling. The NY State Psychiatric Institute was awarded a grant for a Gambling Disorders Clinic Program, which will target individuals of Hispanic descent who reside in Washington Heights and the Bronx. There remains a need for additional treatment capacity for compulsive gambling in NYC.
- DMH is continuing efforts described in last year's Plan to limit the spread of crystal methamphetamine among high-risk groups in NYC. Three main areas of focus are: i) conduct ongoing surveillance to gather information on trends in crystal meth use; ii) coordinate and support a prevention and education campaign through the Crystal Meth Task Force; and iii) promote outreach to and the availability of evidence-based treatment for those addicted to crystal meth.

**COUNTY PLANNING ASSURANCES**

**Assurance A  
The 2007 Local Services Planning Process for  
Alcoholism and Substance Abuse Services**

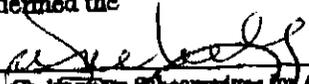
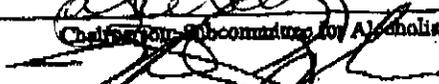
LGU: NYC

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.

8/18/06  JANE VELEZ  
 Date: 8-17-06  Kenneth Popler  
 Date: 14 August 2006  Gerald J. Accurso  
 Date: \_\_\_\_\_  Commissioner/Director

**Assurance B**  
**Full and Equal Participation of Newly Established**  
**Not-for-Profit Community-Based Organizations**  
**2007 Local Services Plan**

LGU: NYC

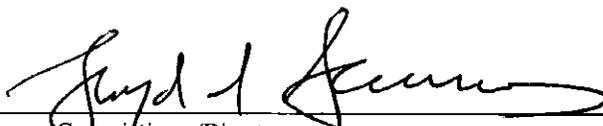
New York State and its local municipalities provide health and human services primarily through arrangements with not-for-profit organizations. As the ethnic composition of New York has changed, newly established organizations have sought funding to serve these new populations. In many cases, these emerging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

14 August 2006  
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

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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**

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## APPENDIX: Community-Level Estimates of Unmet Need

The basic methodology DMH is utilizing for our needs assessment work involves disaggregating OASAS' borough-level need data at the census block level, using poverty as a social indicator of need. Using poverty as an indicator of need for services is widely accepted in the social sciences field. In fact, a recent study to determine effective social indicators of public health disparities showed that the most appropriate indicator of inequalities in health was poverty at the census tract level.<sup>44</sup> More importantly, because we are planning for the publicly-funded services system, using poverty improves our ability to address the needs of those most likely to utilize public mental hygiene services.

General steps in the methodology are as follows:

- Disaggregate and display borough-level need data at the census block level.
  - Using the distribution of adults in poverty at the census block level for each borough
  - Using the distribution of adult population at the census block level for each borough (to provide a comparison to the poverty-based distribution)
- Display program capacity at the program site level.
- Display other pertinent community features (i.e., subways, bus lines, geographic barriers, zoning).
- Draw boundary lines around geographic areas of interest and apply an equation that takes travel patterns and service preferences into account, in order to determine the difference between service need and service capacity.
- Use the above information, along with community-specific information from stakeholders, to determine where capacity adjustments are needed and feasible.

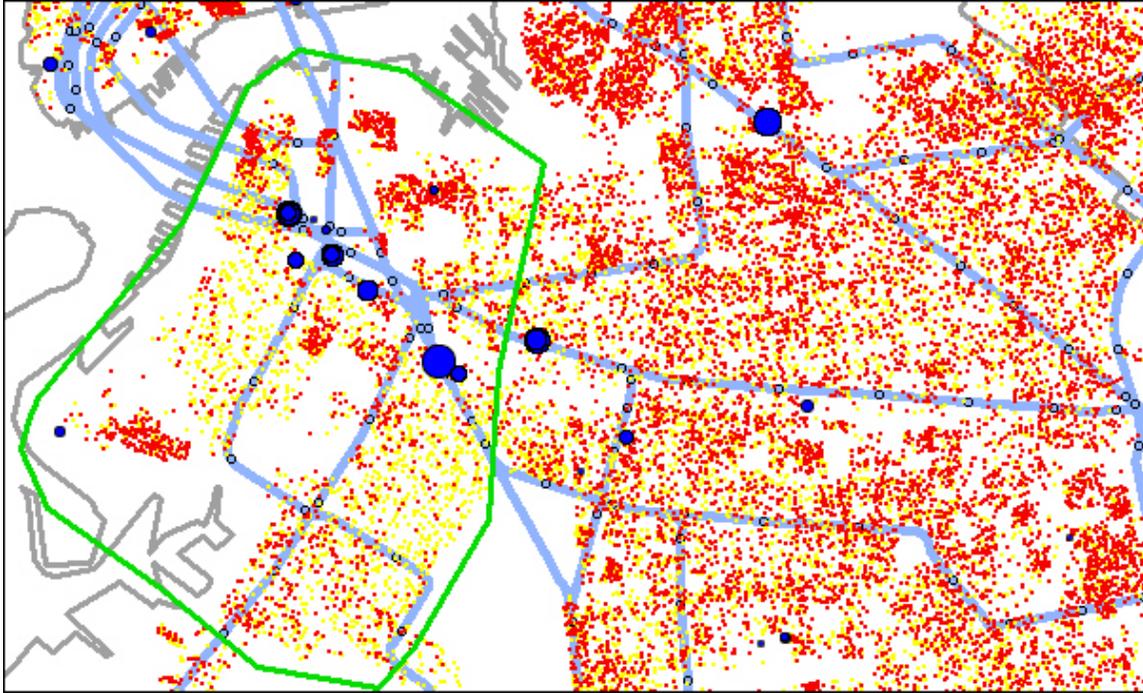
### Demonstration of Methodology

To demonstrate the application of this methodology in this year's Plan, we have chosen to map adult outpatient services in an area of Brooklyn that ranges from Red Hook to Bushwick. Adult outpatient services were chosen because the need is large enough that it is economically feasible to attempt to distribute capacity throughout the communities in order to ensure services are available where they are most needed and wanted. In addition, most consumers utilize outpatient services on a frequent basis, so access barriers will serve as a significant hindrance to receiving services. This particular area of Brooklyn was chosen because the methodology shows part of the area with significant capacity and another part of the area with significant need but minimal capacity.

Below is a map of the selected area of Brooklyn, displaying adult outpatient service need (1 dot = 25 visits) distributed by both adult poverty (red dots) and adult population (yellow dots), OASAS' outpatient capacity (blue circles in graduated sizes according to capacity level), as well as the MTA subway system.

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<sup>44</sup> Harvard University, "Geocoding and Monitoring US Socioeconomic Inequalities in Health: An introduction to using area-based socioeconomic measures," <http://www.hsph.harvard.edu/thegeocodingproject/webpage/monograph/execsummary.htm>.



Following is a hypothetical example of how this methodology can be used in a quantitative way:

In this case, the targeted area (outlined in green) has a service need of 51,393 visits. Although we do not know what percentage of need will be serviced outside of the area due to consumer preference, for the sake of demonstrating this methodology, we will hypothetically assume this number is 10%. That leaves a need of 46,254 visits for the community. Capacity in the targeted area totals 144,290 visits. Since this is a major transportation hub, we will hypothetically assume that 40% of that capacity services individuals who live outside this area. That leaves 86,574 visits to meet the community's need. This allows us to see that this community is estimated to have almost twice as much capacity as need. The map suggests that a similar analysis of the highly populated area on the right side of this map will reveal significant under-capacity of outpatient services.

This example illustrates that developing accurate assumptions about individual preference are essential to the use of this methodology to estimate local capacity vs. need. This will be a focus of our ongoing collaboration with NYC stakeholders and OASAS.