

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



**LOCAL GOVERNMENTAL PLAN
CHEMICAL DEPENDENCY SERVICES**

2008

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EXECUTIVE SUMMARY

The 2008 Local Government Plan for Chemical Dependency (CD) Services represents the latest in several years of advances in planning for the New York City CD service system. It reflects the Department of Health and Mental Hygiene's (DOHMH) progress in collaborating with local stakeholders to identify service priorities, while continuing to partner with the State to implement more comprehensive, data-driven methods for assessing community service needs.

Prevalence of Alcohol and Substance Use Problems

Estimates derived from DOHMH's recent surveys indicate that approximately 16% of adults, and at least 14% of high school students, are problem drinkers. Problem drinking is most common among men, Caucasians, residents of Manhattan, and adults between the ages of 21 and 39 years. The impact of such drinking can be severe: in 2005, 1,450 New Yorkers died prematurely of alcohol-related causes.

The prevalence of substance use, as measured by these same surveys, is inversely correlated with age. Among all New York City adults, the prevalence is 4.5%, but among those ages 20 to 29, the prevalence is 7.5%. The rate for high school youth is even higher: 12% reported using marijuana in the past 30 days. Opioid use is of particular concern: each year, approximately 700 New Yorkers die from opioid-related overdoses.

Capacity, Utilization, and Need for CD Treatment Services

DOHMH relies on two tools provided by OASAS for assessing service capacity, utilization and need: data on local service use, and estimates of local service need. These suggest that only one-third of New Yorkers ages 12 and over with a CD disorder will seek treatment. Treatment demand also varies by type of substance used, with opioid users being most likely to seek treatment and alcohol users the least likely.

The OASAS needs assessment methodology has consistently demonstrated that, for most types of treatment services, New York City's service capacity is insufficient to meet the estimated need, particularly in the outer boroughs. This is particularly true of outpatient adolescent services and outpatient medically supervised withdrawal, the latter of which is virtually unavailable outside of Manhattan.

Stakeholder Priorities

The Federation for Mental Health, Mental Retardation and Alcoholism Services is an advisory body to DOHMH, and provides input into the annual planning process. The Federation identified several priority needs for FY 2008. Three of these addressed system-level issues:

1. Sensitivity to lesbian, gay, bisexual and transgender clients;
2. Awareness of traumatic brain injury; and
3. Protocols for response to DUI and DWI offenses.

Another five priorities addressed the need for particular services:

1. Housing;
2. Integrated CD and mental health treatment services;
3. Services targeted to youth, pregnant and parenting women, and seniors;

4. Well-qualified, bilingual staff; and
5. Community-based treatment for returning veterans.

Local Government Initiatives: Service System Improvements

A critical role of local government is to assist the community in addressing system and policy issues. At the State level, DOHMH has focused its recent efforts on legislation to reduce unnecessary use of inpatient detoxification services, and reinvest savings in community-based CD services. Locally, DOHMH has introduced initiatives that focus on system-wide quality improvement, as well as the use of effective interventions for particular CD disorders.

Opioids

A key DOHMH priority is addressing the prevalence and impact of opioid abuse. In FY 2008, DOHMH will expand its efforts in this area, continuing its work with buprenorphine treatment while also focusing attention on methadone treatment, and the use of naloxone to minimize the impact of overdose.

Screening and Intervention for Alcohol and Substance Use

Another DOHMH initiative focuses on identifying, and intervening with, users of any type of drugs or alcohol. Screening, Brief Intervention, and Referral to Treatment is an evidence-based practice that emphasizes prevention in general medical and community settings; DOHMH is currently implementing it in emergency departments, primary care clinics, and Department of Homeless Services facilities. Expansion to additional sites will be explored in FY 2008.

Quality Improvement

To date, DOHMH's quality improvement initiative, Quality IMPACT, has developed projects to address three aspects of CD services: identification and treatment of co-occurring disorders; cultural competence; and access and engagement of adults in treatment. These projects have increased screening for co-occurring disorders and cultural factors within participating programs, and identified promising practices such as the use of reminder phone calls to increase client attendance for appointments. In FY 2008, 31 CD programs will participate in Quality IMPACT.

Local Government Initiatives: Services for Specific Populations

Particular populations continue to be underserved by the City's chemical dependency system. However these populations are defined, they all share a need for focused interventions and greater resources. New York City is collaborating with the State to address many of these issues, such as the need for housing, and for enhanced coordination between detoxification and community-based treatment services.

Housing for the Homeless

There remains a critical shortage of housing for homeless people with CD disorders in New York City. The City and State are now partnering in the New York/New York III Agreement to develop supportive housing for this population. Supportive housing is a cost-effective model that combines permanent, affordable housing with health and social services. The Agreement will create 2,250 units of housing for homeless people with CD disorders by 2016; 886 of those will be open by the end of FY 2008.

Access to Detoxification Services and Treatment for High Utilizers of Medicaid-Funded Services

A relatively small number of people generate a disproportionate share of Medicaid expenditures for CD treatment. Among these people are many homeless shelter residents, who may not be connected with services after detoxification. To address this, OASAS has funded a one-year demonstration project that provides medically supervised outpatient detoxification to shelter residents, then connects them with further services. This project opened in spring 2007 and will expand to a second site in FY 2008.

OASAS is also looking at the situation of intensive users of Medicaid-funded CD services who are on public assistance. It has developed a model of intensive case management for this population, Managed Addiction Treatment Services, which was implemented in New York City in spring 2007. It served 300 clients in its first four months of operations and is expected to serve 730 people in its first 12 months.

Access to CD and Mental Health Services for People Affected by the September 11, 2001 Attack on the World Trade Center

Thousands of New Yorkers are estimated to continue to suffer from a range of conditions associated with the 2001 attack on the World Trade Center. In November 2006, DOHMH received funding to administer a five-year benefit program to address the remaining need for assistance in recovery from the WTC disaster. The Program will serve all New York City residents who are experiencing mental health or CD problems as a result of the WTC terrorist attack. The Program will pay for outpatient mental health and CD services, and provide financial assistance for medications prescribed during treatment. In addition, the Program will provide funding to Bellevue Hospital to support mental health care services to this population.

Access to CD Treatment for People with Mental Retardation/Developmental Disabilities

Treatment options for people with CD disorders and MR/DD are extremely limited. To expand those options, a workgroup of DOHMH staff and members of the Federation for Mental Health, Mental Retardation and Alcoholism Services was formed in Fall 2004. As a result of the group's efforts, a pilot program has been established within an inpatient OASAS-operated Addiction Treatment Center. The workgroup continues to monitor the pilot.

Conclusion

In the past year, DOHMH has intensified its work with the chemical dependency service system and the policy and regulatory issues that influence it. This has included the creation of a dedicated Bureau of Chemical Dependency Services and the introduction of multiple new initiatives, as well as the development of a legislative agenda to direct more resources toward services in the community. DOHMH will continue and further expand these efforts in FY 2008.

I. NEW YORK CITY DEMOGRAPHICS

In the size and diversity of its population, New York City is unique not only in the State but in the country. The City's population has grown steadily since 1990, reaching 8.2 million in 2005 and accounting for 40% of all New York State residents. It is expected to grow to as many as 9.5 million people by 2030.¹

Immigration has played a crucial role in this growth: Nearly 1.2 million immigrants arrived in the City during the 1990s; 36% of City residents are foreign-born, and more than half of these may not be proficient in English.² Immigration is also a key contributor to the racial and ethnic diversity of New York City. The proportion of the City that is white has declined steadily in the last decade, to 35%. In contrast, there has been steady growth in the percentage of residents who are Hispanic (currently 27% of the City's population) or Asian (10%), or who identify as "other" or mixed race (4%). The proportion of City residents who are black has remained relatively constant (25%).²

SOCIOECONOMIC INDICATORS

The most recent data from the U.S. Census Bureau indicate that the percentage of New Yorkers living in poverty grew 21% from 1990 to 2005. Approximately one-fifth of New Yorkers, nearly 1.5 million people, were living below the national poverty line in 2005, including 27% of youth under the age of 18.³

The most recent data available indicate that, while the City's unemployment rate decreased from 8.3% in FY 2003 to 7.0% in FY 2004,⁴ significant numbers of New Yorkers continued to seek assistance in meeting basic needs. In FY 2004, the New York City Department of Homeless Services housed an average of 9,347 families and 8,445 single adults each day. 437,453 families and individuals, nearly 5% of the City's total population, received public assistance; nearly twice as many received food stamps; and 2.5 million people were enrolled in Medicaid.⁵

¹ NYC Department of City Planning. (2006). *New York City Population Projections by Age/Sex and Borough*. Available at http://www.nyc.gov/html/dcp/pdf/census/projections_briefing_booklet.pdf (accessed July 17, 2007).

² NYC Department of City Planning. (2006). *Total Population by Mutually Exclusive Race and Hispanic Origin*. Available at <http://www.nyc.gov/html/dcp/pdf/census/pl3a.pdf> (accessed July 17, 2007).

³ U.S. Census Bureau. (2005). *2005 American Community Survey, New York City, New York: Poverty status in the last 12 months*. Available at http://home2.nyc.gov/html/dcp/pdf/census/acs_poverty_person.pdf (accessed July 24, 2007).

⁴ NYC Department of City Planning. (2004). *2004 Annual Report on Social Indicators: Summary: Economy and Unemployment*. Available at http://home2.nyc.gov/html/dcp/html/pub/socind04_eco.shtml (accessed July 24, 2007).

II. ASSESSMENT OF LOCAL PREVALENCE, SERVICE CAPACITY AND UNMET NEED

There is no more critical tool in planning and providing treatment services than an understanding of the local population and local resources. Such an understanding should be informed by both quantitative analysis of epidemiological and service data, and qualitative input from community stakeholders. The Department of Health and Mental Hygiene (DOHMH) is fortunate to have access to multiple sources of such information, including Citywide survey data provided by its Division of Epidemiology, data on service need and use provided by the New York State Office of Alcohol and Substance Abuse Services (OASAS), and additional input from its stakeholder advisory group, the New York City Federation for Mental Health, Mental Retardation and Alcoholism Services. This chapter describes quantitative indicators of the prevalence of chemical dependency disorders, and the need for treatment services; the following chapter presents the recommendations of Federation members for improvements to both individual services and the service system.

A note on language: For the purposes of this Plan, “substance use” refers to the use of illicit drugs, excluding the use of alcohol; “chemical dependency” encompasses drug and/or alcohol use.

Full information for all data discussed in this chapter is presented in Appendices A-D; an explanation of the OASAS needs assessment methodology and definitions of chemical dependency service types are presented in Appendices E and F.

PREVALENCE OF ALCOHOL PROBLEMS IN NEW YORK CITY

There are many ways to define “problem” drinking, and previous Local Government Plans distinguished between binge drinking and heavy drinking.⁵ These are different phenomena, but they pose many of the same health and treatment issues, and are addressed by the same community of service providers. Thus, for the purposes of assessing the City’s service need and allocation of resources, we have chosen this year to consider problem drinking as a single phenomenon.⁶

Two primary sources of information about drinking behaviors in New York City are the DOHMH 2005 Community Health Survey (CHS), an annual telephone survey of City residents ages 18 and older; and the 2005 Youth Risk Behavioral Survey, a biannual survey of young people in the ninth through twelfth grades. These indicate that approximately 16% of adult New Yorkers are problem drinkers, including 12% of adults living with children under the age of 18. Thirty-six percent of young people in New York City report having used any alcohol in the 30 days prior to the survey; 14% of City youth meet the criteria for binge drinking.

⁵ Binge drinking is defined as consumption of 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. Problem drinking is any binge drinking and/or heavy drinking.

⁶ The exceptions are the discussions of adolescent drinking taken from the 2005 Youth Risk Behavioral Survey. The Survey asks only about binge drinking, which it defines as drinking at least five drinks on at least one occasion in the last month.

Demographics Associated with Problem Drinking

Rates of problem drinking rise and decline across the life cycle. Twenty-four percent of people between the ages of 21 and 39 are problem drinkers; the prevalence is 8-10% lower for younger adults ages 18 to 20 and for older adults ages 40 to 59. Only 6% of people over age 60 report problem drinking.

Men are significantly more likely to be problem drinkers than are women (24% versus 9%); among racial groups, Caucasians are most likely to be problem drinkers (21%) and Asians and Pacific Islanders least likely (9%). Across the boroughs, problem drinking among adults is most common in Manhattan, where the prevalence is 25%; the prevalence in other boroughs ranges from 12% to 15%. In contrast, rates of drinking and binge drinking among youth are highest in Staten Island. Forty-six percent of Staten Island youth reported having at least one drink in the 30 days prior to the survey, versus 35% of youth Citywide; and one-quarter of Staten Island youth reported binge drinking, versus 14% of youth Citywide.

Demographics Associated with Problem Drinking			
Demographic Group	% of Group with Problem Drinking	Demographic Group	% of Group with Problem Drinking
AGE		RACE	
18-20 years	16%	Caucasian	21%
21-39 years	24%	African American	12%
40-59 years	14%	Hispanic	16%
60+ years	6%	Asian/Pacific Islander	9%
		Other	17%
GENDER		BOROUGH	
Male	24%	Bronx	14%
Female	9%	Brooklyn	12%
		Manhattan	25%
		Queens	15%
		Staten Island	15%

Source: NYC DOHMH Community Health Survey, 2005

Health Conditions Associated with Problem Drinking Among Adults

Thirty percent of problem drinkers have a co-occurring mental health disorder, compared to 16% of the general population. Problem drinking is also associated with lifestyle-related conditions that may jeopardize physical health, such as being overweight (56% of people with problem drinking) and smoking⁷ (33%).

The direct and indirect effects of problem drinking are severe: The DOHMH Office of Vital Statistics reports that problem drinking contributed to the deaths of 1,450 New Yorkers in 2005. Thirty-nine percent of these deaths were directly attributable to alcohol; another 43% were

⁷ Respondents were classified as smokers if they answered the question “Do you now smoke cigarettes every day, some days, or not at all?” with “every day” or “some days.”

caused by alcohol-related injuries and violence; and 18% were due to physical conditions such as cancer and heart disease, which are exacerbated by excessive alcohol use.

The health care system expends significant resources on treating people with problem drinking. In 2005, there were approximately 29,000 admissions to New York City hospitals of people with alcohol-related illnesses, and just over 42,000 admissions for alcohol detoxification or rehabilitation.⁸ Rates of hospitalization are higher in poorer neighborhoods than in wealthier neighborhoods, although that disparity has been declining in the last decade.⁹

PREVALENCE OF SUBSTANCE USE PROBLEMS IN NEW YORK CITY

One source of information about local trends in substance use is DOHMH's New York City Health and Nutrition Examination Survey (NYC HANES). The survey was last conducted in 2004, and included in-person health interviews and physical exams with 1,999 adult New York City residents.

NYC HANES data indicate that the prevalence of substance use among New Yorkers ages 20 and over is 4.5%. Prevalence is inversely correlated with age, with adults ages 20 to 29 having the highest prevalence, 7.5%. Prevalence among adolescents is even higher: The Youth Risk Behavior Survey reports that 12% of youth had used marijuana in the 30 days prior to the survey, and 28% have used it at least once in their lives. As with alcohol use, drug use is more common among youth living in Staten Island than among youth in other boroughs.

While the prevalence of crystal methamphetamine use has grown significantly in other parts of the country in recent years, it continues to be relatively uncommon in New York City, where the prevalence is only 0.4%. The experience of the City's treatment providers suggest that use is concentrated in particular populations, primarily among men who have sex with men.¹⁰

The prevalence of opioid abuse in New York City, particularly heroin abuse, is significantly higher than in the rest of the State and much of the country. Twenty-eight percent of people admitted to chemical dependency treatment services in New York City report that opioids are their drug of choice. Heroin addiction in particular is associated with high rates of mortality, but other opioids pose significant dangers as well. Each year, approximately 700 New Yorkers die from overdoses involving the use of opioids.¹¹

Substance use is more likely to result in hospitalization than is alcohol abuse. In 2005, just over 35,000 admissions to New York City hospitals were for illnesses related to substance use; another 38,000 admissions were for substance use detoxification or rehabilitation. Again, the hospitalization rate for substance use is several times higher for people from poorer neighborhoods than for those from wealthier neighborhoods.⁹

⁸ NYS Department of Health's Statewide Planning and Research Cooperative System database (2005).

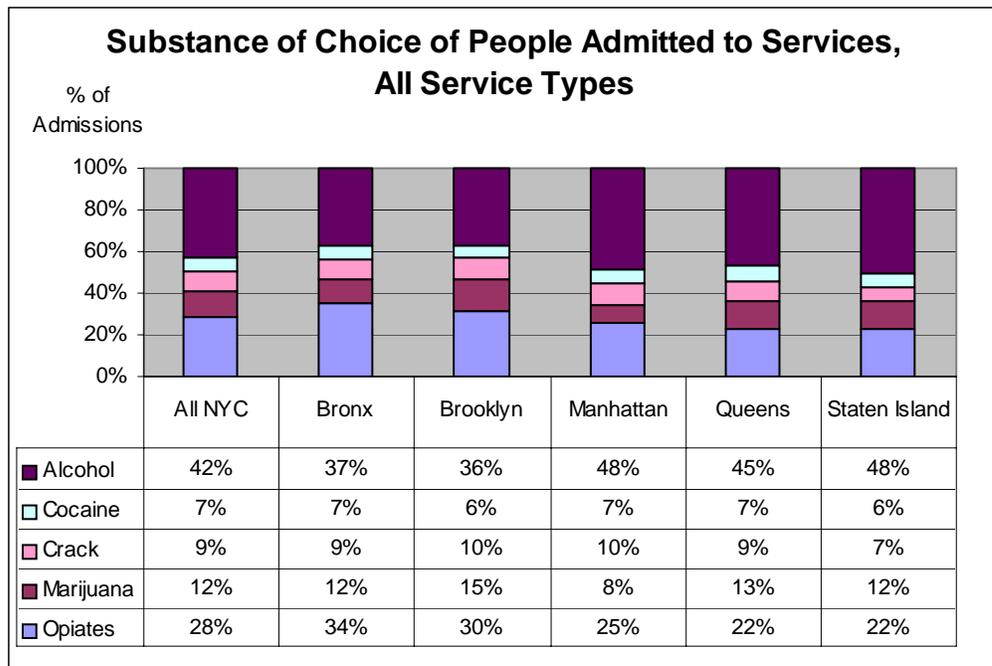
⁹ Karpati, A., et al. (2004). *Health Disparities in New York City*. New York: NYC DOHMH.

¹⁰ For information on DOHMH initiatives related to crystal methamphetamine, see Section IV. "Decreasing Use of Crystal Methamphetamine."

¹¹ Kolodny, A., McVeigh, K. & Galea, S. (2003). *A Neighborhood Analysis of Opiate Overdose Mortality in New York City and Potential Interventions*. Discussion document, NYC Department of Health and Mental Hygiene.

PREVALENCE OF CHEMICAL DEPENDENCY DISORDERS BY BOROUGH

OASAS data indicate that, among people admitted to treatment for chemical dependency, patterns in choice of drugs and alcohol have remained consistent over the last several years. As the chart below illustrates, there are substantial differences between boroughs, with the Bronx and Brooklyn in particular reporting lower levels of alcohol use. However, it is important to remember that these trends may not reflect the true community prevalence. For instance, while the Citywide prevalence of problem drinking is more than twice that of substance use, problem drinking accounts for less than half of admissions to chemical dependency treatment.¹²



Source: OASAS 2007

PREVALENCE OF CHEMICAL DEPENDENCY DISORDERS IN THE LESBIAN, GAY, BISEXUAL AND TRANSGENDER COMMUNITY

The Plan provides an opportunity to examine the prevalence of chemical dependency disorders and need for services among particular populations. The focus this year is on the lesbian, gay, bisexual and transgender (LGBT) community, which was prioritized as an underserved, high-need population by stakeholders, as discussed in the next chapter.

The 2006 CHS indicates that the proportion of New Yorkers who are lesbian, gay or bisexual^{13,14} is 4.2%, consistent with national estimates. This would suggest that the size of the City’s LGBT population may be nearly 345,000 people.

¹² Note that the chart refers to unique admissions, not unique individuals; one person may have multiple admissions.

¹³ CHS respondents were characterized as LGBT if they gave any answer but “heterosexual” to the question “Now I’ll read a list of terms people sometimes use to describe themselves – heterosexual or straight; homosexual, gay or lesbian; and bisexual. As I read the list again, please stop me when I get to the term that best describes how you think of yourself.”

The LGBT population is particularly likely to suffer from chemical dependency disorders. Data from the 2006 CHS indicate that 23% of people who are lesbian, gay or bisexual are problem drinkers (at least 79,000 New Yorkers), as opposed to 17% of heterosexuals. The national literature also suggests that lesbians and gay men are more likely than heterosexuals to use drugs,¹⁵ particularly during adolescents' period of "coming out."¹⁶

Not only are lesbians and gay men more likely to use drugs than are heterosexuals, they use different drugs – they are more likely to use psychedelic drugs, stimulants and “party drugs” such as ketamine.¹² As discussed in the previous section, the experience of treatment providers in the City suggests that men who have sex with men are also particularly likely to use crystal methamphetamine.

These differences in the experience of people who are LGBT suggest that treatment providers may need to adapt their outreach and treatment strategies to meet the characteristics and needs of this community. Those needs encompass not only treatment for particular types and patterns of alcohol and substance use, but also cultural sensitivity to the unique concerns of people who are LGBT, including safety and stigmatization within treatment programs. Yet there are few New York City programs that target this population. As noted by stakeholders in the next chapter, the City's service system continues to face challenges in serving the LGBT community.

SERVICE USE AND ESTIMATES OF UNMET SERVICE NEED IN NEW YORK CITY

Understanding local prevalence of disorders, service need and service use is critical to effective service system planning. However, prevalence alone cannot predict service need or use, because not everyone with a chemical dependency disorder seeks or receives treatment. Currently, our understanding of why and how many New York City substance users do or do not seek services is limited by practical factors, including a lack of data, and the difficulty of surveying those substance users that are not involved in the treatment system.

To assist local governments in better understanding their population, service system and service needs, OASAS provides two tools: data on local service use, and quantitative estimates of local service needs. The latter are based on a methodology which integrates data and qualitative information from a variety of sources to generate prototypical patterns of service need and use. (See Appendix E for further detail on the OASAS needs assessment methodology.)

Use of Treatment Services

OASAS data suggest that 33% of New Yorkers ages 12 and over with a chemical dependency disorder will seek treatment. This rate is lower when only youth ages 12 to 17 are considered;

¹⁴ While people who are lesbian, gay, bisexual and transgender are often grouped together for research and policy purposes, most research does not adequately address the transgender population. While this section refers to “the LGBT population” as a homogenous group, the data presented are not necessarily descriptive of people who are transgender.

¹⁵ Substance Abuse and Mental Health Services Administration (SAMHSA). (2001). *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals*. Rockland, MD: Author.

¹⁶ Rosario, M., Hunter, J. & Gwadz, M. (1997). Exploration of substance use among lesbian, gay and bisexual youth: Prevalence and correlates. *Journal of Adolescent Research* 12(4):454.

only 25% of this group will seek treatment. Among adults ages 18 and over, service demand varies with type of substance used: 40% of adults who use non-opiate drugs (with or without alcohol) will seek treatment, a rate nearly twice as high as that for adults who use only alcohol (25%). In addition, the type of treatment service used varies with substance of choice. In particular, adults who use alcohol make up the majority of those in crisis and inpatient rehabilitation services, but are particularly unlikely to use residential services.

Treatment Service Capacity and Unmet Need

The OASAS needs assessment methodology has consistently demonstrated that, for most types of treatment services, New York City's service capacity is insufficient to meet the estimated need, particularly in the outer boroughs. (Please see Appendix F for definitions of treatment service types.) As the table below demonstrates, the principal exceptions are medically managed detoxification, the availability of which surpasses the need, and intensive residential services, which nearly meet the need. All other service types fall short of the estimated need. This is particularly true of outpatient adolescent services and outpatient medically supervised withdrawal, the latter of which is virtually unavailable outside of Manhattan. Other service categories are also unevenly distributed across the boroughs, with Manhattan consistently meeting the greatest share of residents' treatment needs, Queens and the Bronx the least.

Chemical Dependency Service Need, Capacity, and Need Met								
Service Type	New York City			Bx	Bk	M	Q	SI
	Need	Current Capacity ¹	Need Met					
Crisis Services								
Medically Managed Detoxification	225	600	267%	242%	195%	414%	104%	858%
Medically Supervised Withdrawal (Inpatient)	238	155	65%	0%	15%	264%	0%	0%
Medically Supervised Withdrawal (Outpatient)	627	110	18%	0%	0%	71%	0%	0%
Medically Monitored Withdrawal	507	172	34%	31%	0%	89%	26%	52%
Inpatient Rehabilitation^{2,3}	665	514	77%					
Residential Services								
Intensive Residential ²	4,806	4,492	94%					
Community Residential ⁴	2,492	809	33%					
Residential CDY ²	211	0	0%					
Outpatient Services								
For Adolescents (12-17) ^{5,6}	329,045	100,051	30%	35%	27%	30%	25%	43%
For Adults (18+) ^{5,6}	2,567,733	1,988,459	77%	105%	65%	99%	54%	62%
Methadone Treatment	62,270	36,687	59%	64%	46%	81%	31%	41%

Notes:

¹ OASAS-certified capacities (adjusted) as of March 2007. 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.

² Regional resource.

³ Capacity adjusted.

⁴ Need estimates are at the county level, except where there is an approved Multi-County Collaborative Agreement.

⁵ Primary outpatient visits reported for the 12-month period Oct. 2005-Sept. 2006 (pas-48 and CDS extracts 3/11/07).

⁶ Need adjusted.

PROBLEM GAMBLING IN NEW YORK CITY

Gambling is a significant problem in New York City, yet its prevalence is poorly understood, and local treatment capacity is limited. The Statewide prevalence of problem gambling is 4%;¹⁷ however, this number may be higher in New York City. The Statewide Helpline of the New York Council on Problem Gambling reports that the majority of callers are located in downstate urban areas.¹⁸

There are several resources for treatment of problem gambling in New York City. However, while the size of the population with gambling problems is not known, practitioners suspect that the need for treatment may continue to exceed capacity, and that there may be a need for more services targeting specific geographic areas and ethnic groups.¹⁹

SUMMARY

Chemical dependency disorders affect many New York City residents: 16% of adult New Yorkers report problem drinking, and 4.5% report substance use. High rates of substance use among young people, though lower than the national average, are nonetheless of particular concern.

Chemical dependency takes a heavy toll on New Yorkers' health and mortality: It is the fourth most common cause of premature death for people ages 19 to 64; and it is a significant contributor to the third leading cause of premature death, HIV, which is often contracted from intravenous drug use.²⁰ Rates of death due to substance use are particularly high among African Americans; in 2005, that rate was 1.33 per 10,000 people, versus 1.05 for Hispanics and 0.80 for Caucasians.

Estimates of service use derived from the OASAS methodology indicate that the majority of New Yorkers who suffered from chemical dependency disorders in the last year did not seek treatment during the year. This suggests that service providers might consider a renewed focus on outreach to, and engagement of, active substance users. Such efforts might target adolescent substance users and adult users of alcohol, who are particularly unlikely to seek or receive services.

The capacity of the New York City treatment service system appears substantial, particularly for adult outpatient services. Yet with the notable exception of medically managed detoxification, available services fall far short of service need. Outpatient services for adolescents ages 12 to 17 years are particularly scarce, which may contribute to the lower likelihood of this group to engage in treatment.

¹⁷ Volberg, R.A. (1996). *Gambling and Problem Gambling in New York: A 10-year Replication Survey, 1986 to 1996*. Report to the New York Council on Problem Gambling.

¹⁸ New York State Psychiatric Institute. (2007). *Gambling Disorders Clinic: Free Treatment for Problem Gambling*. Available at www.columbiagamblingdisordersclinic.org (accessed July 12, 2007).

¹⁹ Padavan, F. (2004). *All Gambling All the Time: Turning the Empire State into the Gambling State*. Report to the New York State Legislature.

²⁰ New York City DOHMH Bureau of Vital Statistics, 2005.

The variation across the boroughs in percentage of need met raises questions about the current distribution of resources. Manhattan has considerably more services than do the other boroughs, and thus meets a greater proportion of its residents' service needs. Manhattan also provides services to a significant number of residents of other boroughs, suggesting that service demand within the borough may exceed the demand of borough residents. Certainly, Manhattan is not the only borough to serve residents of other boroughs, but it may be particularly likely to do so. We cannot say with certainty why this is; we do not know if people travel outside of their own borough for services by choice, or if they do so because of inadequate services in their own borough. We hope to explore this and other questions in greater depth in FY 2008.

III. STAKEHOLDER PRIORITIES

The Federation for Mental Health, Mental Retardation and Alcoholism Services is an advisory body to DOHMH, providing a forum for consumers, families and service providers to share their concerns about mental hygiene services in New York City. A critical role of the Federation is to assist DOHMH in identifying and prioritizing the City's mental hygiene service needs during the annual planning process.

The Federation was restructured in FY 2007, and now encompasses three levels. There are a total of 15 Borough Councils, one in each borough for each of chemical dependency, mental health and mental retardation/developmental disabilities; three Citywide Committees, one for each disability area; and one Citywide Interdisciplinary Committee. In addition, there are cross-disability Citywide Committees for each of three special populations: children, seniors, and people who are LGBT.

In FY 2007, the Federation introduced a new process for compiling a prioritized list of needs for each disability area. Each Borough Council generated a list of eight priorities, which were then taken to the Citywide Committee for that disability and further prioritized and refined. Many of these priorities echoed themes from the previous year, such as integrated services for people with co-occurring chemical dependency and mental health disorders; housing; vocational services; and difficulties attracting and retaining qualified staff. However, this year's priorities placed a greater emphasis on the need for attention to special populations, including seniors, youth, pregnant and parenting mothers, and lesbian, gay, bisexual and transgender individuals. What follows is a description of the priorities identified by the Citywide Chemical Dependency Committee, and a review of areas of overlap between those priorities and current DOHMH initiatives.

SYSTEM PRIORITIES

1) Provider Sensitivity to Lesbian, Gay, Bisexual and Transgender Clients

Advocates and providers report that many people who are LGBT are unlikely to engage or remain in treatment programs that do not provide services specific to this population. Many programs are reported to be insensitive to the concerns and needs of LGBT clients. To increase providers' awareness of, and sensitivity to, LGBT issues, stakeholders recommended a two-tiered approach. First, increase technical assistance, education and practice guidelines on these issues to providers. Then reinforce and monitor these with audit requirements specifying that programs have written policies and guidelines for dealing with LGBT clients.

2) Awareness of Traumatic Brain Injury

There is increasing evidence that a significant proportion of people with chemical dependency disorders have a history of traumatic brain injury (TBI). Not only does TBI pose challenges for chemical dependency treatment in itself, but it may also be associated with co-occurring mental health disorders. Stakeholders recommended that providers be educated about the relationship of

TBI and chemical dependency, and suggested that DOHMH address TBI assessment and referral in its Quality IMPACT initiative.²¹

3) Protocols for Response to DUI and DWI Offenses

Stakeholders noted that there appears to be no standard protocol for responding to people who have committed drinking-related offenses. In particular, the New York Police Department and the Department of Motor Vehicles have different guidelines for mandated treatment. This can result in inconsistency across cases, with significant variation in the amount and nature of treatment that people receive. Stakeholders suggested that there be a single protocol for the City and State, which should include coordination of assessment and treatment with multiple agencies.

SERVICE PRIORITIES

1) Housing

Stakeholders in all boroughs reported that there remains a shortage of appropriate housing for people recovering from chemical dependency. Concerns were expressed that clients are released from inpatient and residential treatment programs only to find themselves homeless. Other clients were reported to remain in transitional housing for long periods of time while they wait for affordable, permanent housing to become available.

Stakeholders also noted a need for a wider variety of types of housing, including more intensive service models, and transitional housing, which assists people in moving from shelters and other facilities to independent living in the community. They stressed the magnitude of the demand for affordable permanent housing, and recommended that housing be designated for the highest-need populations, such as homeless families and people with co-occurring disorders.

2) Integrated Chemical Dependency and Mental Health Treatment Services

Stakeholders reported that services for people with co-occurring disorders remain inadequate, with few or no programs targeted to this population. Divisions between the mental health and chemical dependency service systems, including a lack of communication between providers and conflicts in treatment philosophies (e.g., differing opinions regarding harm reduction²²), impede programs' ability to provide integrated care for both disorders, as do State regulations.

In order to advance the quality of treatment for this population, stakeholders recommended that staffing in both chemical dependency and mental health treatment programs be enhanced to better serve clients with co-occurring disorders in a variety of rehabilitative, residential and outpatient settings. Enhancement might include cross-training of staff in mental health and chemical dependency issues, screening for co-occurring disorders, and increasing communication between mental hygiene and chemical dependency treatment providers. The need for chemical dependency treatment programs to address the full range of mental health

²¹ For more on the Quality IMPACT initiative, see Chapter IV. "Improving the Quality of New York City's Chemical Dependency Treatment System."

²² "Harm reduction" refers to a philosophy that, for those people who continue to engage in harmful behaviors (e.g., drug use), services should seek to minimize the potential harm rather than insist on complete cessation.

disorders, from mild impairment to serious and persistent mental illness, was also emphasized. And it was recommended that treatment providers work together to reduce the additional burdens on clients with co-occurring disorders, such as the number of visits to multiple providers. Finally, stakeholders suggested that more Assertive Community Treatment (ACT) teams would help to support clients with co-occurring disorders in the community.

3) Services for Special Populations

Stakeholders expressed concern about the lack of services for several populations:

- *Young Adults (ages 13-21)*: Large numbers of young people are involved in the criminal justice system, often because of problems related to chemical dependency; yet there are few treatment and vocational programs for this group when they are released. As a result, young people may receive no treatment, or may be placed inappropriately in adult treatment programs. Stakeholders recommended the creation of vocational assessment services and job training, placement and retention services for young adults ages 13 to 21 with a history of drug and alcohol abuse. Such programs would also be used to divert young people from the criminal justice system and incarceration whenever possible.
- *Pregnant and Parenting Women*: Stakeholders expressed frustration with the current lack of services for pregnant and parenting women. Of particular concern are residential programs that limit the number and ages of children that women can bring with them to the program; some do not allow children at all. As a result, women may refuse or drop out of treatment. In the community, outpatient services rarely provide childcare, which also can discourage women from using services.

Stakeholders also noted that treatment programs fail to address other issues and needs that are specific to pregnant and parenting women, and asserted that treatment and services of every type should be developed for this population.

- *Seniors*: As the City's population ages, the limitations of the chemical dependency service system to accommodate the needs of the elderly are becoming more evident. Stakeholders noted that outreach services need to work more closely with existing senior services in order to effectively engage this population. They also encouraged the development of senior-specific chemical dependency programs, in which seniors may be more successful than in mixed-age groups. Finally, stakeholders reported a need to train staff to engage and work with aging members of the LGBT community.

4) Well-Qualified Bilingual Staff

Difficulty in recruiting and retaining qualified staff has been a consistent theme in recent Plans. In discussions this year, stakeholders put a renewed emphasis on the need for bilingual, culturally competent staff, particularly staff who can provide care in languages other than English or Spanish. Stakeholders emphasized a need to develop methods of recruiting and training speakers of languages that are currently under-represented in the service field.

5) Community-Based Treatment for Returning Veterans

Many veterans develop chemical dependency disorders in connection with their traumatic experiences in service and the challenges of reintegration into the community. As more veterans return home in the next few years, the number that will seek treatment for chemical dependency is likely to grow. For a variety of reasons, many of these veterans will seek treatment not from

Veterans Affairs (the VA), but from community treatment providers. Yet stakeholders reported that most of these programs are unprepared to work with this population, which has high rates of traumatic brain injury, post-traumatic stress disorder, and other mental health disorders, as well as additional issues unique to the military experience. It was recommended that a spectrum of community-based treatment programs be developed for veterans. The needs of female veterans are of particular concern, and in need of even more specialized attention.

ALIGNMENT OF STAKEHOLDER PRIORITIES AND DOHMH INITIATIVES

Several DOHMH initiatives address the concerns described here. The New York/New York III City-State partnership will create 2,250 units of supportive housing for people with chemical dependency disorders by 2016.²³ Since FY 2005, the Quality IMPACT initiative has supported 116 chemical dependency and mental health programs to improve their screening, referral, and treatment coordination for clients for co-occurring disorders. Building on this initiative, DOHMH will begin in FY 2008 to require all mental health and chemical dependency treatment programs to screen incoming clients for co-occurring disorders, and a new audit standard has been introduced to monitor compliance.

²³ For more information on the NY/NY III initiative, see Chapter V. “Increasing Housing for the Homeless.”

IV. LOCAL GOVERNMENT INITIATIVES: SERVICE SYSTEM IMPROVEMENTS

A critical role of local government is to assist the community in addressing system and policy issues that impact need and service provision. At the State level, DOHMH has focused its recent policy efforts on legislation to reduce unnecessary use of inpatient detoxification services, and reinvest savings in community-based chemical dependency services. Locally, DOHMH has introduced a number of initiatives that address trends in demographics, service quality, regulatory constraints, and other critical issues that cannot be resolved by individual providers. Many of these efforts focus on particular chemical dependency disorders for which effective interventions are available but under-utilized; others advance system-wide quality improvement.

REDUCING OPIOID ABUSE AND OVERDOSE DEATHS

As discussed in Chapter II, opioid abuse is a significant and far-reaching problem in New York City. Recognizing this, DOHMH has included it as a priority in its Take Care New York health policy agenda. In FY 2008, DOHMH will expand its efforts to address this issue and reduce the prevalence and impact of opioid abuse in New York City. This campaign will address not only buprenorphine and methadone treatment of opioid dependence, but also the use of naloxone to minimize the impact of overdose.

Buprenorphine

Buprenorphine was approved by the Food and Drug Administration in 2002 as an effective treatment for opioid addiction. With few side effects and a low risk of abuse or dependence, buprenorphine can be dispensed as a monthly prescription by primary care physicians. This not only decreases the frequency with which clients must return for treatment, but also reduces the stigma that clients might experience in visiting a chemical dependency treatment clinic.

2007 Accomplishments

- In FY 2007, DOHMH sponsored multiple trainings and roundtables regarding the implementation of buprenorphine in a primary care setting. Audiences included physicians, other clinicians, and staff and clients at needle exchange programs and a homeless shelter.
- The Harm Reduction Coalition, a City-funded organization that promotes harm reduction²² policies and practices, provided continuing medical education regarding buprenorphine to several hundred physicians and medical staff, and mentoring to seven physicians introducing buprenorphine into their practice.
- 940 New York City physicians were approved to prescribe buprenorphine. An average of 1,263 prescriptions were filled each month in New York City, an increase of 28% over the previous year.
- Three HHC hospital-based outpatient chemical dependency and internal medicine programs began providing induction and maintenance²⁴ in October 2006: Bellevue, North Central

²⁴ “Induction” refers to the first stage of buprenorphine therapy; clients in the early stages of withdrawal from opioids are medically monitored as they receive their first dose. “Maintenance” refers to the period when clients, having been induced, are

Bronx Healthcare Network, and Coney Island. St. Luke's-Roosevelt Hospital is expected to begin inductions in summer 2007.

2008 Goals

Goal: Increase the number of New Yorkers receiving buprenorphine treatment for opioid addiction.

Objective 1: Expand system capacity for buprenorphine treatment.

Action Step: Increase the number of non-physicians trained to support physicians who prescribe buprenorphine.

In FY 2008, DOHMH will begin training non-physicians who provide support to patients in buprenorphine-assisted treatment. These groups have not previously been targeted in buprenorphine implementation efforts, but have proven to be an integral part of successful buprenorphine treatment. As a result, the number of medical staff other than physicians who are trained to provide support to clients is expected to increase the number of clients that can be treated within a single practice. Trainings may be tailored to different groups working in primary care settings: Mid-level medical providers (e.g., nurse practitioners, physicians' assistants) who can provide on-going clinical support to clients; and mental health clinicians who provide support to clients during the process of recovering from chemical dependency.

Objective 2: Integrate buprenorphine into the primary care setting.

Action Step 1: Convene expert practitioners to identify best practices in buprenorphine treatment, and develop and disseminate a protocol for primary care providers.

DOHMH and HHC are finalizing a protocol for integrating buprenorphine into primary care and specialty care settings. It will be completed and disseminated to HHC hospitals and primary care providers by the end of calendar year 2007.

Action Step 2: Fund four community health centers or Federally-qualified health centers, at approximately \$100,000 each, to support comprehensive buprenorphine induction, stabilization, and maintenance in community-based primary care settings.

Action Step 3: Explore the possibility of increasing Medicaid billing options for buprenorphine inductions.

One challenge to buprenorphine induction is inadequate funding. In FY 2008, DOHMH will explore potential policy amendments at the Federal level that would allow providers to bill Medicaid for inductions. In the interim, DOHMH will work with community-based providers to pilot a system which ties payments to the number of buprenorphine inductions performed.

stabilized and taking a regular dose of buprenorphine. The length of the maintenance period varies by individual and may continue indefinitely.

Objective 3: Improve and expand consumers' understanding of buprenorphine, and awareness of treatment availability.

Action Step: Establish services to provide information in the community to potential buprenorphine patients.

DOHMH will engage, train, and supervise buprenorphine users to provide information about buprenorphine to other opioid users. This information will include an explanation of the buprenorphine induction process and description of treatment, and will be presented in an unthreatening, non-stigmatizing environment.

Methadone

Methadone has been known for decades as a safe, evidence-based treatment for opioid addiction, yet it is used by only 20% of heroin addicts in the U.S.²⁵ In New York City, many methadone clinics report that they are operating below capacity. In FY 2008, DOHMH will collaborate with OASAS and community agencies to ensure that those who would benefit from methadone treatment receive it.

2008 Goals

Goal: Increase use of methadone treatment among New Yorkers who would benefit from such treatment.

Objective 1: Advocate for the alignment of State regulations with Federal program requirements.

Action Step 1: Review Federal regulations to determine minimum program requirements for methadone clinic operations.

State regulations for methadone clinic operations are currently more stringent than Federal regulations, particularly in regard to clients' abstinence and behavior. These constraints may contribute to the difficulties New York City clinics are experiencing in engaging and retaining clients in treatment. DOHMH and DOHMH staff will review existing Federal regulations to verify the minimum regulatory requirements for service components and program attendance in methadone clinics.

Action Step 2: Advocate alignment of State and Federal program requirements.

Having identified the inconsistencies between State and Federal methadone regulations, DOHMH and DOHMH staff will develop and promote amendments to the State's minimum requirements.

²⁵ Mathias, R. (1997). NIH Panel Calls for Expanded Methadone Treatment for Heroin Addiction. *NIDA Notes*, 12(6).

Objective 2: Increase use of available methadone-assisted treatment.

Action Step: Identify causes for under-utilization of methadone clinics.

In FY 2008, DOHMH will assess the number and capacity of New York City's methadone providers, an evaluation which may include analysis and collaboration with these providers and OASAS. DOHMH and partners may also conduct community assessments to explore the perspectives of potential patients, and to identify barriers to, and facilitators of, treatment participation. Based on the community assessment and analysis of current under-utilization, DOHMH will work with OASAS, practitioners and others to develop a plan to expand utilization.

Naloxone

Naloxone can be an effective means of preventing death by heroin overdose, one that can be administered by people without medical training. Thus, distributing naloxone and educating substance users about the effects and administration of naloxone is critical to the effort to prevent fatal opioid overdoses.

The DOHMH Bureau of HIV Prevention and Control (BHIV) first introduced the naloxone initiative in FY 2005, in the harm reduction programs that it funded for HIV prevention. DOHMH became involved in FY 2006, when legislation authorized the establishment of opioid overdose prevention programs, expanding interest in naloxone within the substance abuse treatment system. In FY 2008 DOHMH will take full ownership of the initiative, which focuses on training syringe exchange and drug treatment programs in the use of naloxone.

2007 Accomplishments

- 87 overdose reversals achieved by the use of naloxone were voluntarily reported.
- The Harm Reduction Coalition trained more than 1,500 clients at New York City syringe exchange programs, and staff at treatment and housing programs. The Harm Reduction Coalition also partnered with BHIV to train medical providers and health educators working at the Department of Homeless Services or in correctional settings.
- BHIV began discussions with HHC regarding the possible introduction of overdose prevention programs into HHC hospital departments such as internal medicine and substance use services.

2008 Goals

Goal: Reduce heroin-related overdose fatalities by 29% – from 11.3 per 100,000 in 2005 to 8.0 per 100,000 in 2008.

Objective 1: Introduce opioid overdose prevention programs in community-based settings.

Action Step 1: Train clients and staff at harm reduction programs to use naloxone.

In FY 2008, DOHMH will fund the Harm Reduction Coalition to dispense naloxone to 15 harm reduction programs, and to provide the programs with training in its use.

Objective 2: Expand naloxone availability in New York City public agencies.

Action Step 1: Implement an overdose response and reversal protocol, including naloxone administration, in all Department of Homeless Services (DHS) programs and facilities.

DOHMH is collaborating with DHS to finalize and implement an overdose response and reversal protocol in all DHS outreach programs and shelter facilities. This will include distribution of DOHMH-funded overdose prevention kits and naloxone, and training for DHS staff in their use.

Action Step 2: Implement overdose prevention programs in detoxification units and methadone programs at all HHC facilities.

As with DHS, DOHMH is partnering with HHC to implement an opioid overdose program in all HHC detoxification units and methadone programs. DOHMH will provide overdose prevention kits and naloxone, and train staff in their use.

Action Step 3: Work with the DOHMH Office of Correctional Health Services (CHS) to provide education in overdose prevention and naloxone use to people who are being released from jail and are at risk of overdose.

DOHMH and CHS are exploring opportunities for overdose prevention and reversal education within correctional settings. Based on their findings, they will then introduce and evaluate an educational program. They will also look for opportunities to prescribe and dispense naloxone to people who are at risk of overdose after they leave jail.

Action Step 4: Develop and disseminate overdose prevention training videos.

In order to help sustain new overdose prevention programs, DOHMH will develop training videos for use by the agencies it has trained. The videos will be distributed to providers who are conducting opioid overdose prevention training and prescribing and dispensing naloxone. Providers may include health care, housing, and community-based human services providers.

Objective 3: Strengthen ongoing intervention initiatives with a better understanding of the population affected and trends in use, morbidity and mortality.

Action Step 1: Expand and improve upon existing surveillance systems for tracking overdose morbidity and mortality at the DOHMH Division of Epidemiology.

DOHMH and the Division of Epidemiology will review existing systems for tracking vital statistics and other data to identify possible areas for improvement. This information will allow DOHMH both to better understand characteristics and patterns of overdose in New York City, and to monitor progress toward its goal of a 29% reduction in mortality by the end of calendar year 2008.

Action Step 2: Develop an updated profile of overdose deaths using the most recent vital statistics data on mortalities.

An existing profile created with 2003 data will be updated with more recent data in FY 2008. This profile will be used to identify populations at high risk of overdose, and to target interventions accordingly.

DECREASING USE OF CRYSTAL METHAMPHETAMINE

The use of crystal methamphetamine has increased significantly in the U.S. in recent years. This trend is of great concern not only because of the impact of the drug itself, but also because its use is associated with elevated rates of sexually transmitted disease. Thus, while the prevalence of use in New York City is only 0.4%,²⁶ the City is taking steps to address crystal methamphetamine as a serious public health concern.

2007 Accomplishments

- DOHMH collaborated with the City Council to coordinate activities across agencies that provide preventive education regarding crystal methamphetamine. The result has been a unique cross-agency strategy, centered on an ad campaign developed by Gay Men's Health Crisis. The campaign identifies agencies funded by DOHMH and the City Council in FY 2007 as prevention and treatment resources.
- DOHMH and the City Council expanded prevention and education outreach to reach men who have sex with men in targeted areas of New York City. Five agencies were contracted to conduct 48 outreach sessions each by the end of FY 2007. This outreach was directed at high-need areas in the Bronx, Brooklyn, Manhattan and Queens, as well as at party venues Citywide for men who have sex with men.
- Two Manhattan agencies were funded to provide an evidence-based treatment intervention for crystal methamphetamine abuse. The experience of these agencies underscores the higher incidence of crystal methamphetamine use among men who have sex with men, and the importance of targeting this population in outreach and treatment efforts: The agency which targets this population had treated 125 people by the end of April 2007, while the other agency, which targets a more general population, had treated only ten people in the same time period.

2008 Goals

Goal: **Limit the spread of crystal methamphetamine use among high-risk groups in New York City.**

Objective 1: Continue to identify sources of information on local trends in crystal methamphetamine use.

²⁶ NYC DOHMH Health and Nutrition Examination Survey, 2004.

Action Step: Collaborate with the OASAS Street Survey and providers of treatment for crystal methamphetamine to identify areas of high crystal methamphetamine use.

DOHMH will coordinate meetings with OASAS Street Survey staff and with contract-funded providers to monitor population, geographic, and venue-based trends in crystal methamphetamine use.

Objective 2: Promote a coordinated Citywide system of intervention for crystal methamphetamine.

Action Step 1: Ensure that prevention and treatment services are responsive to trends in crystal methamphetamine use.

DOHMH will collaborate with the City Council, community providers, and substance use researchers to establish goals for service delivery to communities affected by crystal methamphetamine. These goals will then be incorporated into intervention and treatment contracts.

Action Step 2: Coordinate outreach, prevention, education, and treatment services Citywide.

Following initial research and establishment of goals and deliverables, DOHMH will introduce quarterly meetings with contract-funded providers of outreach, prevention, education, and treatment services. In these meetings, DOHMH and providers will identify locations and populations to be targeted for outreach and service delivery, and share information regarding emerging trends and effective intervention strategies.

REDUCING ALCOHOL AND OTHER DRUG-RELATED MORBIDITY AND MORTALITY

SBIRT (**S**creening, **B**rief **I**ntervention, and **R**eferral to **T**reatment) is an evidence-based practice to identify and intervene with alcohol and drug users before they reach the point of problem use and dependence. SBIRT's public health orientation emphasizes prevention in general medical and community settings, acting as a complement to treatment in chemical dependency programs. DOHMH is currently implementing SBIRT in hospital emergency departments, primary care clinics, and Department of Homeless Services (DHS) facilities, and is exploring other possible venues.

2007 Accomplishments

- DOHMH continued funding the SBIRT initiative in the emergency departments of four HHC hospitals, Bellevue, Elmhurst, Lincoln and Kings County. To help standardize practice across these sites, DOHMH developed and distributed a screening instrument, and intensified its technical assistance.
- Having begun the SBIRT initiative in hospital emergency departments, DOHMH is now expanding to primary care providers. This expansion began with the Federally Qualified Health Center at the Institute for Urban Family Health (IUFH). IUFH is piloting the

screening instrument in primary care, and exploring opportunities for integration of the screen into the standard protocol for all medical visits.

- DOHMH also trained staff from DHS to implement SBIRT, and implementation across the shelter system is expected to begin in early FY 2008.

2008 Goals

Goal: Increase screening, brief intervention and referral for people who are at risk of developing dependence on alcohol or other drugs.

Objective 1: Promote the use of SBIRT in medical settings.

Action Step 1: Fund HHC hospitals to implement SBIRT.

DOHMH will continue to fund SBIRT implementation in the emergency departments of Bellevue, Elmhurst, Kings County, and Lincoln Hospitals.

Action Step 2: Collaborate with community health centers to train medical providers and implement SBIRT.

While different models of SBIRT implementation exist, their relative feasibility and efficacy under varying conditions in large urban health centers remains uncertain. In FY 2008, DOHMH will fund community health centers to pilot different models of SBIRT implementation. These models may include the use of public health advisors to provide screening, care coordination, and subsequent data collection for program assessment; or the creation of electronic screening and data collection modules for use in routine medical visits.

DOHMH will support these pilots with training for medical providers, clinical directors and non-medical staff at participating sites. Trainings may include overviews of SBIRT and an introduction to motivational interviewing; IUFH trainings will also address the agency's pending conversion to electronic medical records, which will have implications for SBIRT assessment and documentation.

Objective 2: Explore the use of SBIRT in various non-medical settings.

Action Step 1: Pilot the use of SBIRT by the Department of Homeless Services.

DOHMH will collaborate with the Department of Homeless Services to identify settings for the implementation of SBIRT. Such areas might include eviction-prevention programs and other services that target at-risk populations.

Action Step 2: Explore the use of SBIRT in school-based health counseling and education programs.

SBIRT's emphasis on prevention makes it particularly appropriate for youth. DOHMH will collaborate with DOHMH's community-based District Public Health Offices and with school-

based mental health programs to identify opportunities for introducing SBIRT into venues such as school-based counseling services and community youth programs.

Action Step 3: Explore the use of SBIRT in jail-based health counseling and education programs.

The DOHMH Office of Correctional Health Services coordinates comprehensive health services for the entire New York City correctional system. DOHMH will collaborate with this Office to identify programs and activities within the system that may accommodate or complement the use of SBIRT.

Action Step 4: Investigate possible integration of SBIRT into DOHMH's nurse-family partnership program.

The nurse-family partnership program provides home visits by nurses to low-income, first-time mothers, their infants and families. DOHMH will work with the program to explore the possibilities for integrating SBIRT into visiting protocols.

IMPROVING THE QUALITY OF NEW YORK CITY'S CHEMICAL DEPENDENCY TREATMENT SYSTEM

Quality IMPACT, DOHMH's quality improvement initiative, aims to incrementally move the New York City mental hygiene system toward more effective services, better client outcomes, and the integration of evidence-based and innovative practices. The initiative, which advances a unified approach to quality improvement in mental health, chemical dependency and MR/DD treatment programs, encourages broad stakeholder involvement in the planning and implementation of quality improvement activities, provides intensive education and support to participants, and fosters the sharing of knowledge through interactive group meetings and conference calls. The initiative also spearheads collaborations with many external government and institutional partners and supports advocacy issues around priority mental hygiene concerns.

The initiative is now in its fourth year. Chemical dependency treatment programs joined the initiative in its second year in FY 2006; in FY 2008, 31 chemical dependency programs will be participating.

Quality IMPACT has two components: continuous quality improvement (CQI) projects through which participating programs target key service areas for improvement; and consumer perceptions of care surveys through which consumers evaluate services and, in turn, inform programs' improvement efforts.

To date, Quality IMPACT has developed CQI projects to address three system-wide aspects of chemical dependency services in need of improvement: identification and treatment of co-occurring disorders; cultural competence; and access and engagement of adults in treatment. Programs also have the option of developing program-specific CQI projects on topics of their choosing in lieu of participation in one of the system-wide projects. Descriptions of CQI projects and their summary findings follow.

Identification and Treatment of Co-occurring Chemical Dependency and Mental Health Disorders

2007 Accomplishments

- To date, 25 chemical dependency programs and 54 mental health programs have participated in the project for either one or two years, screening 10,537 clients for co-occurring disorders. Of the 2,498 clients who screened positive, 2,160 (86%) had a follow-up assessment within 30 days.
- By the conclusion of the first three years of the project, 1,256 of clients who had screened positive were receiving coordinated or integrated care for their co-occurring disorders.
- In FY 2006, DOHMH began to offer education to project participants on evidence-based practices to improve engagement and retention of clients. DOHMH expanded those offerings in FY 2007.
- Programs report that participation in this project has improved clinicians' capacity and willingness to identify and coordinate treatment for clients with co-occurring disorders. Data from this project underscore the need to focus more on engaging and retaining clients, as dropout rates for co-occurring clients were found to be especially high.

Selected Findings from Quality IMPACT Co-occurring Disorders Project, FY05-FY07				
Program Type / Year of Participation (# of programs)	Incoming Clients Screened	Screened Clients Needing an Assessment	Timely Assessments Occurred (within 30 days)	Clients Receiving Coordinated / Integrated Treatment
Mental Health				
FY05 (22)	2,257	510	479	182
FY06 (31)	2,890	609	585	325
FY07 (26)	2,104	414	407	204
Chemical Dependency				
FY06 (23)	1,580	476	346	263
FY07 (14)	1,706	489	343	282
All Programs / All Years	10,537	2,498	2,160	1,256

Note: In mental health clinics, screenings were done at intake; in chemical dependency clinics, at or soon after admission.

2008 Goals

Goal: **Improve access to, and quality of, treatment services for individuals with co-occurring chemical dependency and mental health disorders.**

Objective: Develop and implement a series of CQI priority projects that promote screening, assessment and coordinated treatment for people with co-occurring disorders in both chemical dependency and mental health outpatient treatment programs.

Action Step1: Educate providers about evidence-based practices for engaging and retaining clients.

DOHMH began training Quality IMPACT participants on evidence-based practices to improve engagement and retention of clients in FY 2006, and the program will continue in FY 2008. 89 mental health and 6 chemical dependency programs will participate.

Action Step 2: Encourage providers to make screening and assessment of co-occurring disorders a regular practice.

Participants in the co-occurring disorders project have demonstrated that standardized screening and assessment for co-occurring disorders is feasible and effective in both chemical dependency and mental health treatment programs. Therefore, beginning in FY 2008, City contract-funded chemical dependency outpatient treatment programs will be required to screen and assess all new clients for co-occurring disorders and to provide coordinated or integrated care. This requirement has been integrated into DOHMH's program audit standards.

Cultural Competence

To be culturally competent is to understand the role that culture plays in defining chemical dependency and mental health disorders, accessing care, and adhering to treatment recommendations. Cultural competence includes addressing barriers to treatment by providing culturally relevant outreach strategies and developing services that are compatible with the consumer's cultural and linguistic needs.

2007 Accomplishments

- To date, 5 chemical dependency programs have participated in the cultural competence project for either one or two years. In that time, the programs have assessed 1,071 clients for cultural factors to include in treatment planning. 853 (80%) of these clients reported significant cultural factors relevant to treatment planning.
- In addition, participating programs have increased their rates of admissions for underserved target populations by an average of five percentage points. 91% of clients in the targeted populations who scheduled a follow-up visit for within 30 days of admission kept the visit.

2008 Goals

Goal: **Reduce disparities in access to services and improve cultural competency and quality of care.**

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 cultural competence and access to treatment.

Although some programs were more successful than others in reaching out to underserved populations, the majority of providers indicated that their participation had enabled them to hone

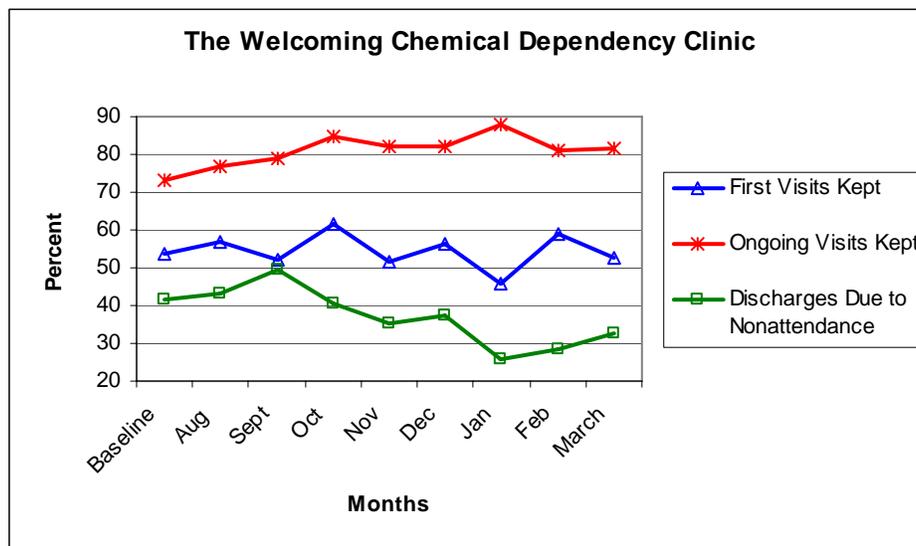
their outreach strategies and identify promising practices in this area, and that they were optimistic about achieving sustained improvement in the future.

The Welcoming Clinic: Improving Access through Client-Centered Services in Mental Hygiene Treatment Programs

The overall goal of this project, which was introduced in FY 2007, was to improve access to treatment by advancing client-centered treatment approaches. Toward that end, providers tried out various strategies at the program level that would increase attendance.

2007 Accomplishments

- Seven chemical dependency clinics participated in the project in its first year. The clinics tracked outcomes for 1,566 first visits, 47,855 ongoing visits and 468 discharges. Improvements were made in client engagement and retention, as measured by aggregate rates of ongoing appointments kept and planned discharges; however, no improvements were made in rates of first visits kept.
- Over the course of the year, programs identified promising practices that, implemented in the future on a broader scale, should lead to more substantive improvements in engagement and retention. For example, reminder calls to clients and referral sources have been found to improve client attendance at scheduled appointments, and educating clinicians about their agencies’ discharge policies has improved rates of planned discharges.



2008 Goals

Goal: Improve access to mental hygiene treatment programs.

Objective: Engage and retain clients in mental hygiene treatment.

Action Step: Pilot client-centered strategies for increasing treatment attendance.

In FY 2008, five chemical dependency programs will participate in the Welcoming Clinic Project, which focuses on changes in clinical practice to improve treatment. Providers will work to improve access and engagement by strengthening their partnerships with clients. The project will emphasize increasing client input into treatment planning, a practice that was identified by DOHMH and participating providers as a priority during FY 2007.

Program-Specific Projects²⁷

2007 Accomplishments

- In FY 2007, one chemical dependency program designed and implemented its own DOHMH-approved project. This program worked on improving show rates for psychiatric evaluations/consultations.

2008 Goals

Goal: **Improve client-focused aspects of service delivery that are identified by individual programs.**

Objective: Provide support and technical assistance to providers that are conducting their own projects.

In FY 2008, 10 chemical dependency programs will be working on program-specific projects, addressing physical wellness, engagement and retention of clients, and improvement of vocational services.

Consumer Perceptions of Care Survey

Consumer surveys, which give consumers a voice in improving the quality of services, are conducted annually. The survey measures consumer perceptions of care in the domains of general satisfaction, access, quality/appropriateness and outcomes.

2007 Accomplishments

- In FY 2007, 25 chemical dependency programs administered the survey, and 1,410 consumers participated (67% of all consumers seen at the participating programs during the two-week survey administration period).
- Results indicate that, in general, consumers feel very positive about the services they receive; on a scale of 1 to 5, with 5 being most positive, all domains received an average rating of at least 4. However, consumers indicated that programs could do better at returning calls more promptly, explaining the possible side-effects of prescribed medications and having more available, culturally and ethnically sensitive staff. In general, Hispanic/Latino consumers, older consumers and women perceive the services they receive more positively than others.

2008 Goals

Goal: **Give mental hygiene consumers a voice in improving the quality of the services they receive.**

²⁷ Formerly called independent projects.

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.

The perceptions of care survey will be conducted again in FY 2008, and results shared with providers for planning and assessment purposes.

Additional Goals for 2008

In light of recent statistics on the increased morbidity and mortality rates of mental hygiene consumers, in FY 2009 Quality IMPACT will introduce a new CQI project that focuses on co-occurring health and mental hygiene disorders. DOHMH will begin to lay the groundwork for that project in FY 2008 by creating a workgroup of stakeholders to advise on the project design.

V. LOCAL GOVERNMENT INITIATIVES: SERVICES FOR SPECIFIC POPULATIONS

Particular populations continue to be underserved by the City's chemical dependency system. Whether these populations are defined by socioeconomic status, patterns of service use, or other factors, they all share a need for focused interventions and greater access to resources. New York City is collaborating with the State to address many of these issues, such as the need for housing, and for enhanced coordination between detoxification and community-based treatment services.

INCREASING ACCESS TO HOUSING FOR THE HOMELESS

While success in treatment and recovery requires safe and stable housing, there remains a critical shortage of housing for homeless people with chemical dependency disorders in New York City. The City and State are now partnering in an initiative known as the New York/New York III Agreement to address this issue by developing supportive housing for this population. Supportive housing is a cost-effective model of independent housing that combines permanent, affordable housing with health and social services, empowering tenants and fostering their recovery from chemical dependency.

Goal: Reduce homelessness among people with chemical dependency disorders.

Objective 1: Develop supportive housing for homeless populations with chemical dependency disorders.

Action Step: Create 2,250 units of supportive housing for various homeless populations with chemical dependency disorders.

The New York/New York III Agreement is a project of unprecedented scope that will generate 9,000 units of supportive housing by the end of FY 2016. 2,250 of those units are intended for individuals with chemical dependency disorders, and families in which the head of the household has a chemical dependency disorder. The City is responsible for procuring 1,500 (66%) of those 2,250; the remaining 750 will be procured by the State Office of Alcohol and Substance Abuse Services (OASAS) and the State Office of Temporary and Disability Assistance (OTDA).

The 2,250 New York/New York III chemical dependency units are designated for particular populations:

- 750 units are designated for single adults who have completed chemical dependency treatment, are homeless or at risk of homelessness, and need transitional supportive housing to sustain sobriety and achieve independent living. Of these 750 units, DOHMH and OASAS are each procuring 125 congregate²⁸ units and 250 scattered site units.

²⁸ Congregate supportive housing refers to permanent affordable apartment housing with on-site services.

- 750 units are reserved for chronically homeless²⁹ single adults who have a chemical dependency disorder that is a barrier to independent living, and who also have a disabling clinical condition (e.g., a medical or mental health condition that further impairs their ability to live independently). DOHMH is responsible for procuring all 750 units, of which 250 are congregate and 500 scattered site.
- Another 750 units are designated for families in which the head of household suffers from a chemical dependency disorder, a disabling medical condition, or HIV/AIDS. These families must also be chronically homeless, or at risk of chronic homelessness. DOHMH and OTDA are each procuring 125 congregate units and 250 scattered site units.

875 (58%) of the units for single adults and 16 (2%) of the units for families should be operational by the end of FY 2008. The remaining 625 single adult and 734 family units will open gradually over the next ten years, due to the difficulty in securing housing sites.³⁰

Objective 2: Move homeless individuals living on the street into housing.

Action Step: Implement a new street outreach service model with a focus on placement of homeless individuals directly into housing or other long-term residential settings.

Many homeless individuals living on the streets suffer from a chemical dependency disorder, often with a co-occurring mental illness. In order to achieve more meaningful outcomes for these clients, DOHMH is putting an increasing emphasis on the need for homeless outreach services that facilitate rapid placement in permanent housing or long-term transitional settings with access to treatment and services.

This new service model was first introduced in 2005 as part of a pilot program. Due in part to the positive results of this pilot, DOHMH and the Department of Homeless Services (DHS) jointly rebid their street outreach portfolios to employ the new housing placement model in November 2006.

This model will be implemented in September 2007, by four new outreach providers located throughout the City. Under these new performance-based contracts, a portion of funding will be contingent on placement of street homeless individuals into housing settings. Providers will also be expected to collect and share client data with DOHMH, DHS, and other relevant agencies.

²⁹ New York/New York III criteria define a chronically homeless individual is anyone who has a disability and has been homeless for at least 365 days of the last two years, not necessarily consecutively.

³⁰ See Appendix G for a table of open and planned supportive housing units for people with chemical dependency disorders.

INCREASING TREATMENT FOR HIGH-UTILIZERS OF MEDICAID-FUNDED SERVICES

Each year, a relatively small number of people generate a disproportionate share of Medicaid expenditures for chemical dependency treatment. In a single year in New York City, 3,073 residents each used more than \$30,000 worth of Medicaid-funded chemical dependency services, for a total expenditure of just over \$200 million.³¹

This level of service use suggests that individuals are not being effectively engaged in community-based treatment following detoxification. This is often because essential, unmet needs such as housing and employment are not being addressed, which negatively impacts participation in treatment.

To stabilize people in treatment, address related service needs, and reduce Medicaid expenditures, OASAS has developed a model of intensive case management for this population. Managed Addiction Treatment Services (MATS) is now being implemented in several New York State counties and in New York City, with an initial focus on intensive users of Medicaid-funded chemical dependency services who are on public assistance. “Intensive users” are defined as those whose Medicaid expenditures for chemical dependency treatment exceeded \$30,000 over the course of the last twelve months. Participation is voluntary; participants must acknowledge their history of chemical dependency and consent to enrollment.

Potential participants are assessed not only for chemical dependence, but also for mental health disorders, medical issues, and housing and social service needs, and are then connected with appropriate services. It is expected that clients will receive services for nine months on average, while those with greater needs may be engaged for up to two years.

In FY 2007, DOHMH and the New York City Human Resources Administration implemented Managed Addiction Treatment Services, with funding from OASAS. The three agencies collaborate in identifying, screening and engaging eligible individuals as they are applying for public assistance at the contracted providers.

2007 Accomplishments

- After a year of planning, MATS began operations on March 14, 2007. Three agencies were contracted to provide MATS services: the National Association on Drug Abuse Problems in Brooklyn; University Behavioral Associates in the Bronx; and the Visiting Nurses Services in Manhattan, Queens and Staten Island. Services provided include case management and linkage to treatment programs and rehabilitative services.
- By the end of May 2007, approximately 200 people had been enrolled in MATS, more than three times the number projected. MATS served approximately 300 clients in FY 2007 (the first three and a half months of operation), and is expected to serve another 730 clients in its first full year of operation.

³¹ Office of Alcoholism and Substance Abuse Services. (2005). *OASAS 2005 Planning Supplement II: Managed Addiction Treatment Services (MATS)*. Albany, NY: Author. Numbers reported are for New York State FY 2002/03.

2008 Goals

Goal: **Improve engagement in treatment and related services of high-utilizers of Medicaid-funded chemical dependency services.**

Objective: Establish a Managed Addiction Treatment Services Program in New York City.

Action Step 1: Implement Year 1 of the MATS Program.

MATS was implemented in mid-March 2007. In the first year of operations, DOHMH will support providers' staff development by training a minimum of 50 staff members on clinical topics such as medical management of opioid addiction.

Action Step 2: Monitor Year 1 activities.

In order to monitor the implementation and quality of the MATS program, DOHMH will establish and review measures of client outcomes and provider performance. These measures will include: retention in services; retention in employment; reduction in drug use; and decrease in Medicaid expenditures. DOHMH, the New York City Human Resources Administration and OASAS will review this data when deciding whether to continue or expand the program at the conclusion of Year 3.

Action Step 3: Implement Year 2.

DOHMH will release an RFP early in FY 2008 to solicit case management and linkage services for Years 2 and 3.

INCREASING COMMUNITY-BASED DETOXIFICATION SERVICES FOR SHELTER RESIDENTS

One group of people who make intensive use of Medicaid-funded chemical dependency services is homeless shelter residents. To address the particular needs of these individuals, OASAS has funded a one-year demonstration project that provides medically supervised outpatient detoxification to shelter residents, then connects them with the next level of rehabilitation services. Housing and other social and medical services are provided to participants by the Department of Homeless Services.

2007 Accomplishments

- DOHMH developed screening tools, program protocols and evaluation measures for the project.
- The first site opened in lower Manhattan in April 2007. The site is operated by Project Renewal, a community-based provider of chemical dependency and mental health services.

2008 Goals

Goal: **Increase the percentage of shelter residents who are engaged in treatment following detoxification.**

Objective: Strengthen linkages between detoxification and treatment for this population.

Action Step 1: Establish shelter-based detoxification demonstration projects at three sites.

The initial Manhattan site was opened by Project Renewal in April 2007. The second site, which will serve male shelter residents in Brooklyn, will be opened by the Woodhull Medical and Behavioral Health Center in FY 2008. The possibility of opening a third site will be explored once the Brooklyn project is operational. The Manhattan and Brooklyn sites each have the capacity to serve 30 individuals for an anticipated seven-day stay, and thus may serve as many as 1,440 clients in one year.

Action Step 2: Evaluate the demonstration projects.

Sites will collect data on a monthly basis. This data will address a number of process and outcome measures, including the number of referrals received, the percent of clients completing the program, the percent of clients referred to the next level of care, and the percent of clients retained in the next level of care for 30 days. This information will be used by OASAS and DOHMH to inform further development of the project.

INCREASING ACCESS TO CHEMICAL DEPENDENCY AND MENTAL HEALTH TREATMENT FOR PEOPLE IMPACTED BY THE SEPTEMBER 11, 2001 ATTACK ON THE WORLD TRADE CENTER.

Thousands of New Yorkers are estimated to continue to suffer from a range of conditions associated with the 2001 attack on the World Trade Center, including post traumatic stress disorder, anxiety and depression. Since September 11, 2001, more than 11,000 people have enrolled in an American Red Cross program that funds mental health and substance abuse treatment to address these conditions. This program will cease operations in December 2007. Based on recommendations of a Mayoral Panel on WTC Health, DOHMH received funding in November 2006 to administer a five-year insurance-like benefit program to address the remaining need for assistance in recovery from the WTC disaster.

Types of Services

The NYC 9/11 Benefit Program will serve all individuals residing in New York City who are experiencing mental health or substance problems as a result of the WTC terrorist attack. The Program will pay for qualified individuals to receive outpatient mental health and substance abuse services from a licensed provider of their choice.³² It will also provide financial assistance for medications prescribed during treatment.

³² The Program will act as a payer of last resort, and payments will be subject to a pre-determined limit.

In addition, the Program will provide funding to Bellevue Hospital to support mental health care services to this population. Beginning in early FY 2008, Bellevue will focus on strengthening its clinical capacity to treat those with long-term mental health needs, including provision of bilingual treatment.

Individuals Served by the Benefit

The Program will serve any child or adult in New York City whose mental health or chemical dependency disorder is related to the attack on the World Trade Center, as indicated by date of onset and exposure to the event. Particular attention will be given to those who were most affected by the attack, whether due to proximity or to the impact on family or living situation. Based on epidemiological data on prevalence and service use, as well as on information gathered from earlier programs such as Project Liberty, DOHMH estimates that more than 11,000 individuals will use the Program.

A particular concern is the children who continue to suffer from psychological distress in the aftermath of 9/11. In addition to the children who were directly impacted by the attack, many children have been affected by the distress suffered by an adult family member. The Program provides coverage for psychological testing as well as mental health services for both children and families.

2007 Accomplishments

- In FY 2007, DOHMH established the WTC Mental Health and Substance Abuse Benefit program office, initiated plans for administration of claims, and developed an agreement with Bellevue Hospital to provide direct services to beneficiaries.

2008 Goals

Goal: Increase access to chemical dependency and mental health treatment for people impacted by the September 11, 2001 attack on the World Trade Center.

Objective 1: Implement administration of the program.

The 9/11 Mental Health and Substance Abuse Benefit Program will implement and monitor the program's financial and logistical operations. DOHMH will coordinate outreach efforts to potential beneficiaries, and implement measures to ensure that beneficiaries receive appropriate, high-quality services.

Objective 2: Enroll and serve beneficiaries.

The Program will begin assessing eligibility and enrolling participants in early FY 2008. DOHMH will contract with an independent benefit administrator to establish participant eligibility, enroll them in the program, and assist them in navigating the claim process. An independent fiscal agent will process reimbursement claims.

Objective 3: Implement outreach activities and educational campaign.

DOHMH will collaborate with the independent benefit administrator to conduct a targeted outreach effort to consumers with on-going needs. Outreach efforts will focus on those users of the previous 9/11 Mental Health and Substance Abuse Program who have limited or no insurance coverage for mental health or substance abuse treatment; on children who were exposed to the attack, or whose family members are suffering mental health effects of the attack; and other high-need, underserved populations.

INCREASING ACCESS TO CHEMICAL DEPENDENCY TREATMENT FOR PEOPLE WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

National studies indicate that approximately 11.5% of adults with mental retardation or developmental disabilities (MR/DD) suffer from chemical dependency disorders.³³ This suggests that as many as 5,520 New York City adults with MR/DD are in need of chemical dependency treatment. Yet treatment options for this population are extremely limited. To address this issue and improve access to services for this population, a workgroup of DOHMH staff and members of the MR/DD Borough Councils of the Federation for Mental Health, Mental Retardation and Alcoholism Services was formed in Fall 2004.

Five inpatient Addiction Treatment Centers (ATCs) in NYC operated by the New York State Office of Alcoholism and Substance Abuse Services at the behest of workgroup members agreed to accept individuals with MRDD who also need drug treatment. One agency in contract with DOHMH was selected to begin making referrals. The workgroup comprised of DOHMH staff and other stakeholders continues to monitor and consult on the operation of this pilot program intended to increase access for MR/DD consumers to addiction treatment."

2007 Accomplishments

- In FY 2006, the workgroup collaborated with an OASAS-operated inpatient Addiction Treatment Center (ATC) in a pilot program intended to improve the ATC's capacity to serve this population. Mechanisms for referral from community-based treatment agencies were identified, and ATC staff were trained in MR/DD issues.
- One outpatient clinic serving consumers with MR/DD and chemical dependency disorders was recruited for the pilot. This agency, which is contracted with DOHMH, has made six referrals through December 2006, and about half of consumers referred have successfully completed the course of treatment. Those consumers who did not complete treatment were discharged primarily for behavioral or medical issues.

³³ Wunsch-Hitzig, R., Engstrom, M., Lee R., King, C. and McVeigh, K. (2003). *Prevalence and Cost Estimates of Psychiatric and Substance Use Disorders and Mental Retardation and Developmental Disabilities in NYC*. New York: NYC Department of Health and Mental Hygiene. (Note that the estimated prevalence rate of 11.5% refers to individuals ages 18-54.)

- An unexpected result of this initiative has been an increase in referrals by the ATC of people with a possible but unconfirmed developmental disability to outpatient MR/DD-chemical dependency clinics.

2008 Goals

Goal: **Increase access to chemical dependency treatment services for adults with mental retardation and/or developmental disabilities (MR/DD).**

Objective: Expand the capacity of chemical dependency providers to meet the needs of consumers with MR/DD.

Action Step 1: Explore possibilities for working with additional chemical dependency providers, both inpatient and outpatient, to develop expertise in working with individuals with MR/DD.

The workgroup is now monitoring the progress of the pilot program. The group has identified a key challenge to such a model, which is the level of structure and programming in ATC programs. This may not meet the needs of MR/DD consumers, most of whom need more supervised services. The workgroup is investigating the possibilities for funding an aide to provide direct care to MR/DD consumers in the ATC.

Action Step 2: Explore possibilities for replicating such programmatic relationships and referral mechanisms Citywide.

Once the pilot program has progressed and challenges such as ATC programming are resolved, the workgroup will explore possibilities for replication.

VI. CONCLUSION

In the past year, DOHMH has intensified its work with the chemical dependency service system and the policy and regulatory issues that influence it. This has included the creation of a dedicated Bureau of Chemical Dependency Services and the introduction of multiple new initiatives, as well as the development of a legislative agenda to direct more resources toward services in the community. DOHMH will continue and further expand these efforts in FY 2008.

VII. PLANNING ASSURANCES

VII. COUNTY PLANNING ASSURANCES

Assurance A

The 2008 Local Services Planning Process for Alcoholism and Substance Abuse Services

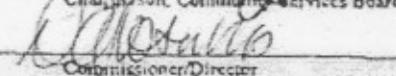
LGU: New York City

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

- Representatives of facilities of the offices of the department; directors of district developmental services offices; directors of hospital-based mental health services; directors of community mental health centers, voluntary agencies, consumers, and consumer groups; and other providers of services have been formally invited to participate in, and provide information for, the local planning process relative to the development of the Local Services Plan;
- The Community Services Board and the Subcommittee for Alcoholism or Alcoholism and Substance Abuse has provided advice to the Director of Community Services and has participated in the development of the Local Services Plan. Additionally, we assure and certify that the full Board and the Subcommittee have had an opportunity to review and comment on the contents of the plan and have received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16 (c);
- The Community Services Board and the Subcommittee for Alcoholism or Alcoholism and Substance Abuse meets regularly during the year, and the Board has established bylaws for its operation, has defined the number of officers and members that will comprise a quorum, and has membership which is broadly representative of the age, sex, race, and 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.

8/23/07 
 Date: _____
 Chairperson, Subcommittee for Alcoholism or Alcoholism and Substance Abuse

9/4/07  Kenneth Topler
 Date: _____
 Chairperson, Community Services Board

9/5/07  David A. Rosin MD
 Date: _____
 Commissioner/Director

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

LGU: NYC

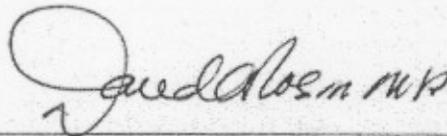
New York State and its local municipalities provide health and human services primarily through arrangements with not-for-profit organizations. As the ethnic composition of New York has changed, newly established organizations have sought funding to serve these new populations. In many cases, these emerging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

9-6-2007



Date

Commissioner/Director

Assurance C: Multi-Disabled Considerations

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

Yes No

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

N/A

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

Yes No

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

The Bureau of Mental Hygiene Policy and Planning, in conjunction with other disability and program bureaus within the Division of Mental Hygiene (DMH), 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, DMH's Quality IMPACT includes projects that address screening and treatment of individuals with 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 for Mental Health, Mental Retardation and Alcoholism Services, which acts as the advisory body to DMH, regularly brings together stakeholders from the mental health, MR/DD, and chemical dependency communities in a Citywide Interdisciplinary Committee. Committee meetings include discussion of the issues related to co-occurring disabilities (including additional disabilities such as physical challenges) and cross-systems coordination. In addition, the Federation includes a dedicated Citywide Committee for People with Co-Existing Disabilities, which is charged with addressing issues related to the needs of this population. 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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VIII. APPENDICES

APPENDIX A: PREVALENCE OF ALCOHOL PROBLEMS IN NEW YORK CITY

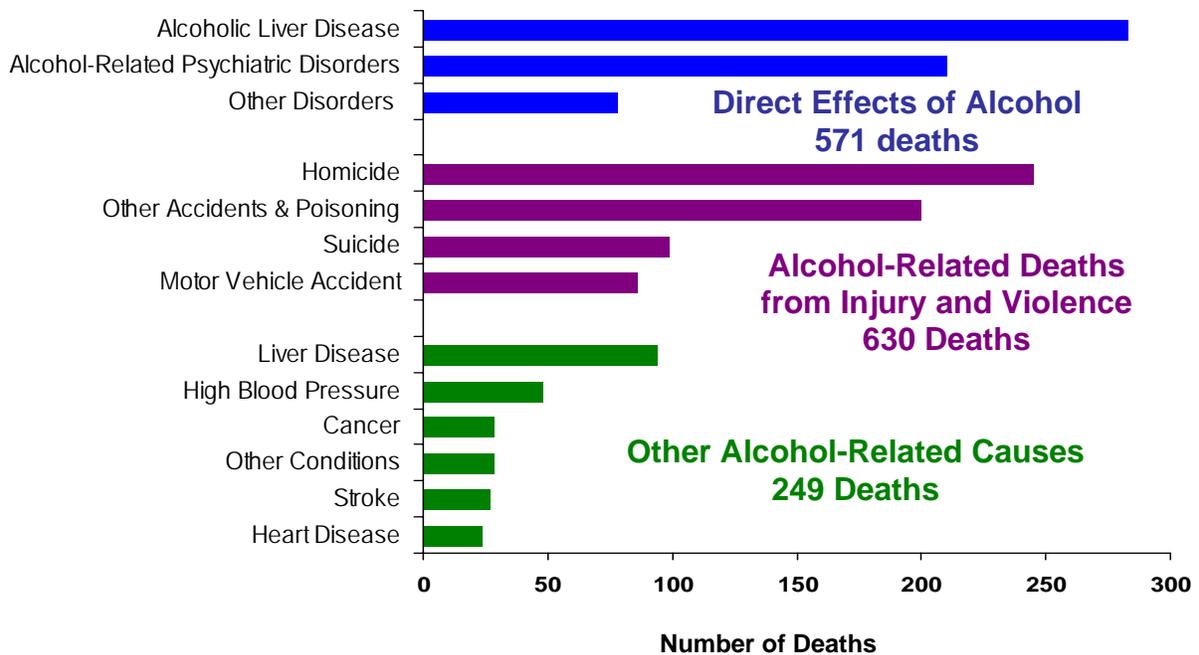
Table I. Prevalence of Drinking and Binge Drinking Among Adolescents, by Borough

Borough	% of Youth with Any Drinking in Last 30 Days	% of Youth with Binge Drinking in Last 30 Days
Bronx	35%	16%
Brooklyn	34%	10%
Manhattan	40%	17%
Queens	31%	12%
Staten Island	46%	24%
New York City	35%	14%

Source: Youth Risk Behavioral Survey, 2005

Chart I. Alcohol-Attributable Mortality, New York City 2005

1,450 Alcohol-Related Deaths



Source: NYC DOHMH Bureau of Vital Statistics

Table II. Demographics of Alcohol-Related Hospitalizations, NYC 2005

Demographic Group	Hospitalizations for Alcohol Psychosis, Abuse or Dependence		Hospitalizations for Alcohol Detoxification or Rehabilitation	
	#	Rate Per 100,000 Population	#	Rate Per 100,000 Population
AGE				
18-24 years	566	70.5	1,036	129.0
25-44 years	14,653	556.9	24,624	935.8
45-64 years	12,870	758.9	15,725	927.3
65+ years	992	105.8	718	76.6
GENDER				
Male	24,541	642.1	34,800	891.7
Female	4,605	105.4	7,311	166.2
BOROUGH				
Bronx	5,631	456.8	11,713	923.6
Brooklyn	7,486	309.0	10,340	422.8
Manhattan	9,859	565.8	12,747	720.9
Queens	4,801	206.4	5,681	241.7
Staten Island	1,369	298.3	1,630	355.7

Table III. Demographics of Drug-Related Hospitalizations, NYC 2005

Demographic Group	Hospitalizations for Alcohol Psychosis, Abuse or Dependence		Hospitalizations for Alcohol Detoxification or Rehabilitation	
	#	Rate Per 100,000 Population	#	Rate Per 100,000 Population
AGE				
18-24 years		222.3	1,652	207.7
25-44 years	23,166	880.4	24,957	948.5
45-64 years	10,172	599.8	11,777	694.5
65+ years	305	32.5	245	26.1
GENDER				
Male	27,801	991.6	30,486	1,087.4
Female	7,627	233.6	8,145	249.5
BOROUGH				
Bronx	11,645	1,245.1	11,505	1,230.1
Brooklyn	9,205	510.6	10,483	581.5
Manhattan	9,590	749.6	11,017	861.2
Queens	3,895	226.4	4,297	249.8
Staten Island	1,093	330.7	1,329	402.2

Source: Statewide Planning and Research Cooperative System, 2005

APPENDIX B: PREVALENCE OF SUBSTANCE USE PROBLEMS IN NEW YORK CITY

**Table I. Prevalence of Substance Use Among Adolescents,
by Type of Substance and Borough**

Type of Substance by Borough	% of Adolescents Reporting Use	Type of Substance by Borough	% of Adolescents Reporting Use
<i>MARIJUANA</i>		<i>HEROIN</i>	
Bronx	29%	Bronx	2%
Brooklyn	28%	Brooklyn	2%
Manhattan	30%	Manhattan	1%
Queens	24%	Queens	2%
Staten Island	38%	Staten Island	2%
New York City	28%	New York City	2%
<i>COCAINE</i>		<i>ECSTASY</i>	
Bronx	3%	Bronx	4%
Brooklyn	3%	Brooklyn	3%
Manhattan	4%	Manhattan	4%
Queens	4%	Queens	3%
Staten Island	8%	Staten Island	7%
New York City	4%	New York City	4%

Source: Youth Risk Behavioral Survey, 2005

**APPENDIX C: SERVICE USE AND ESTIMATES OF UNMET SERVICE NEED,
BY SUBSTANCE OF CHOICE**

Table I. Estimated Treatment Demand by Substance of Choice and Age of User

	Youth & Adults Aged 12+	Youth Aged 12-17	Adults Aged 18+			Youth & Adults Aged 16+
	All Substances	All Substances	Alcohol Only	Non-Opiate Drugs Only	Alcohol & Non-Opiate Drugs	Opiates
BRONX % of group that will seek treatment	33.9%	25.0%	40.0%	40.0%	25.0%	50.0%
BROOKLYN % of group that will seek treatment	32.7%	25.0%	40.0%	40.0%	25.0%	50.0%
MANHATTAN % of group that will seek treatment	33.6%	25.0%	40.0%	40.0%	25.0%	50.0%
QUEENS % of group that will seek treatment	30.7%	25.5%	40.0%	40.0%	25.0%	50.0%
STATEN ISLAND % of group that will seek treatment	31.0%	25.5%	40.0%	40.0%	25.0%	50.0%
NYC TOTAL % of group that will seek treatment	32.5%	25.0%	50.0%	25.0%	40.0%	40.0%

Table II. Substance of Choice of People Admitted to Services, By Service Type

Substance of Choice	Type of Service			
	Crisis	Outpatient	Inpatient Rehabilitation	Residential
Alcohol	60%	33%	50%	15%
Crack	29%	12%	21%	23%
Cocaine	1%	29%	4%	24%
Marijuana	6%	11%	14%	25%
Opiate	3%	12%	8%	11%

Source: OASAS 2007

Table III. Chemical Dependency Service Need, Capacity, and Need Met, by Borough

	Bronx			Brooklyn		
	Need	Capacity	% of Need Met	Need	Capacity	% of Need Met
<i>Crisis Services</i>						
Medically Managed Detoxification	43	104	242%	64	125	195%
Medically Supervised Withdrawal (Inpatient)	49	0	0%	67	10	15%
Medically Supervised Withdrawal (Outpatient)	154	0	0%	170	0	0%
Medically Monitored Withdrawal	80	25	31%	149	0	0%
<i>Outpatient Services</i>						
For Adolescents (12-17)	83,500	29,301		79,360	21,675	27%
For Adults (18+)	390,956	408,620	105%	663,297	429,796	65%
<i>Methadone Treatment</i>	15,954	10,195	64%	17,890	8,200	46%
<i>Inpatient Rehabilitation</i>	123	68	55%	194	0	0%
<i>Residential Services</i>						
Intensive Residential	880	1,069	122%	1,404	0	0%
Community Residential	459	83	18%	0	0	0%
Residential CDY	55	0	0%	51	0	0%

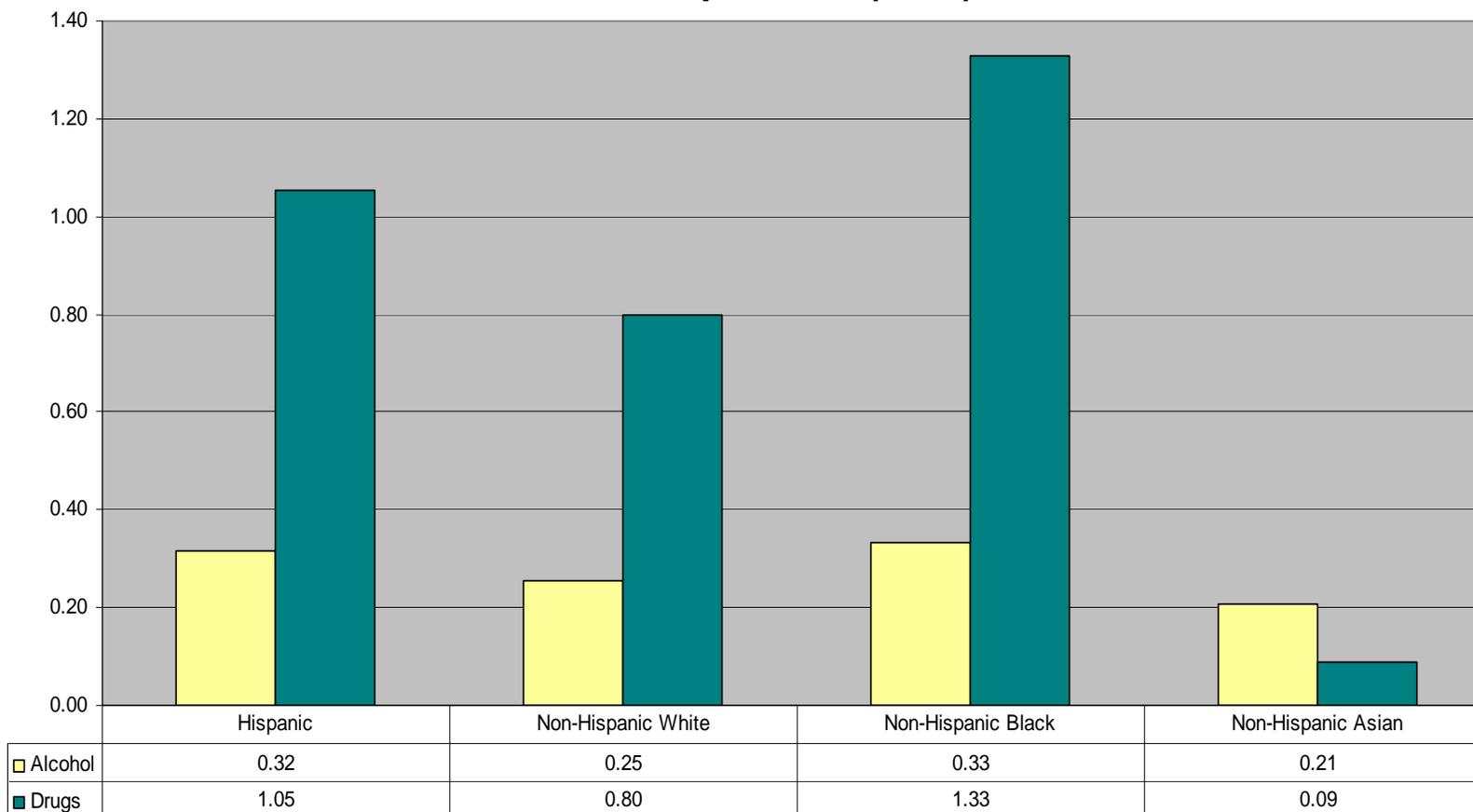
	Manhattan			Queens		
	Need	Capacity	% of Need Met	Need	Capacity	% of Need Met
<i>Crisis Services</i>						
Medically Managed Detoxification	51	211	414%	55	57	104%
Medically Supervised Withdrawal (Inpatient)	55	145	264%	54	0	0%
Medically Supervised Withdrawal (Outpatient)	154	110	71%	117	0	0%
Medically Monitored Withdrawal	108	96	89%	141	36	26%
<i>Outpatient Services</i>						
For Adolescents (12-17)	47,315	14,288	30%	89,625	22,079	25%
For Adults (18+)	718,744	708,520	99%	663,912	359,826	54%
<i>Methadone Treatment</i>	18,488	15,067	82%	8,039	2,455	32%
<i>Inpatient Rehabilitation</i>	157	0	0%	159	0	0%
<i>Residential Services</i>						
Intensive Residential	1,127	0	0%	1,157	0	0%
Community Residential	0	0	0%	0	0	0%
Residential CDY	29	0	0%	57	0	0%

Table III. Continued: Chemical Dependency Service Need, Capacity, and Need Met, by Borough

	Staten Island		
	Need	Capacity	% of Need Met
<i>Crisis Services</i>			
Medically Managed Detoxification	12	103	858%
Medically Supervised Withdrawal (Inpatient)	13	0	0%
Medically Supervised Withdrawal (Outpatient)	32	0	0%
Medically Monitored Withdrawal	29	15	52%
<i>Outpatient Services</i>			
For Adolescents (12-17)	29,245	12,708	44%
For Adults (18+)	130,824	81,697	63%
<i>Methadone Treatment</i>	1,899	770	41%
<i>Inpatient Rehabilitation</i>	33	0	0%
<i>Residential Services</i>			
Intensive Residential	239	0	0%
Community Residential	0	0	0%
Residential CDY	19	0	0%

APPENDIX D: SUMMARY: DEATH RATES DUE TO CHEMICAL DEPENDENCY, BY RACE

Death Rates Due to Alcohol and Drug Use by Race* in NYC per 10,000 Population (2005)



Data Sources: Bureau of Vital Statistics, NYC DOHMH, 2005, and 2005 American Community Survey, US Census Bureau.

*Data unavailable for American Indian and Alaska Natives, Pacific Islanders, and individuals of Mixed Race.

APPENDIX E: OASAS NEEDS ASSESSMENT METHODOLOGY

The basic methodology DOHMH uses to assess local service need involves disaggregating OASAS need estimates, which are generated at the borough level, to the census block level. This disaggregation relies on poverty as a social indicator of need, as poverty has been demonstrated to be the most appropriate indicator of inequalities in health.³⁴ The use of poverty as an indicator is especially appropriate for DOHMH planning, because it identifies those people most likely to use the public mental hygiene system.

The methodology involves the following steps:

- 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 (e.g., 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.

³⁴ 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>.

APPENDIX F: DEFINITIONS OF CHEMICAL DEPENDENCY SERVICE TYPES

Crisis Services

Crisis services treat people suffering from acute effects of chemical dependency disorders, or withdrawal from alcohol or drugs. Clients generally use them briefly, early in recovery, and then transition to less-intensive, on-going care. Medically managed detoxification, medically supervised withdrawal, and medically monitored withdrawal all require that clients receive medical supervision, pharmacological services, counseling, and referral to other services.

Medically Managed Detoxification

Medically managed detoxification services also treat people who are suffering from acute effects of chemical dependency disorders, including those with co-occurring physical or mental health conditions that may complicate withdrawal. The services are provided in Article 28 clinics.

Medically Supervised Withdrawal

Medically supervised withdrawal services offer a less intensive form of care for people experiencing moderate withdrawal with less severe co-occurring physical or mental health disorders. Services may be provided in inpatient or outpatient settings, depending on the needs of the client.

Medically Monitored Withdrawal

Medically monitored withdrawal services are provided in community-based settings for clients who are suffering mild withdrawal or relapse. Unlike the other crisis services, medically monitored withdrawal services need not be provided by a physician, only be a licensed chemical dependency service provider.

Inpatient Rehabilitation

Inpatient rehabilitation is an intensive service for clients who are experiencing complications from chemical dependency, yet are not in need of medical supervision during detoxification. Services are provided in community or hospital settings, and include counseling, education, self-help groups, and other recovery services.

Residential Services

Residential services are used by clients in need of full-time structure and supports to maintain sobriety. There are three types of residential services; all types provide counseling, educational services, recreation and other activities, and additional supports.

Intensive Residential

Intensive residential programs serve people who have a history of relapse and are in need of intensive services and supervision, or who are experiencing psychological or medical problems. In addition to standard residential services, these programs include services such as life skills training, vocational training, and parenting classes.

Community Residential

Community residential programs serve clients who are simultaneously receiving outpatient services. Clients residing in these programs may be homeless, or may have been living in an environment that threatens their recovery.

Supportive Living Services

Supportive living services provide housing for people in need of minimal supervision but who require a sober environment for recovery.

Outpatient Services

Outpatient services come in a range of intensities, and may be provided in community clinics or within other health agencies. They provide support groups; educational and relapse-prevention programming; and counseling for clients and families. They may also provide, or refer clients to, vocational and educational programs. The average length of participation in outpatient services is one year. Depending on the level of client need, outpatient services may be medically supervised or not. For those clients with longer-term needs, outpatient rehabilitation services provide medical supervision and additional staff support for more frequent sessions over a longer duration.

Methadone Treatment

Methadone treatment programs provide methadone and other rehabilitative services on an outpatient basis to clients who have a heroin addiction.

**APPENDIX G: DEVELOPMENT OF SUPPORTIVE HOUSING FOR PEOPLE WITH CHEMICAL
DEPENDENCY DISORDERS UNDER THE NEW YORK/NEW YORK III AGREEMENT**

Open and Planned Chemical Dependency Supportive Housing Units as of July 2007

Population	Total Units Open by 6/30/07	Total Units Open by 6/30/08	Total Units Open by 6/30/16
I. Single Adults with Substance Abuse Disorder (Post-Treatment)			
NYC DOHMH	0	250	375
NYS OASAS/OTDA	0	125	375
Subtotal	0	375	750
II. Single Adults with Substance Abuse Disorder (Primary Barrier)			
NYC DOHMH	0	500	750
NYS OASAS/OTDA	0	0	0
Subtotal	0	500	750
III. Families (Head of Household with Sub. Abuse Disorder or Med. Disability or HIV/AIDS)			
NYC DOHMH	0	16	375
NYS OASAS/OTDA	0	0	375
Subtotal	0	16	750
TOTAL	0	886	2,250

I. Single Adults with Substance Abuse Disorder (Post-Treatment):

Single adults who have completed chemical dependency treatment, are homeless or at risk of homelessness, and need transitional supportive housing to sustain sobriety and achieve independent living.

II. Single Adults with Substance Abuse Disorder (Primary Barrier):

Chronically homeless³⁵ single adults who have a chemical dependency disorder that is a barrier to independent living, and who also have a disabling clinical condition (e.g., a medical or mental health condition that further impairs their ability to live independently).

III. Families (Head of Household with Substance Abuse Disorder or Medical Disability or HIV/AIDS):

Families in which the head of household suffers from a chemical dependency disorder, a disabling medical condition, or HIV/AIDS. These families must also be chronically homeless, or at risk of chronic homelessness.

³⁵ New York/New York III criteria define a chronically homeless individual as anyone who has a disability and has been homeless for at least 365 days of the last two years, not necessarily consecutively.