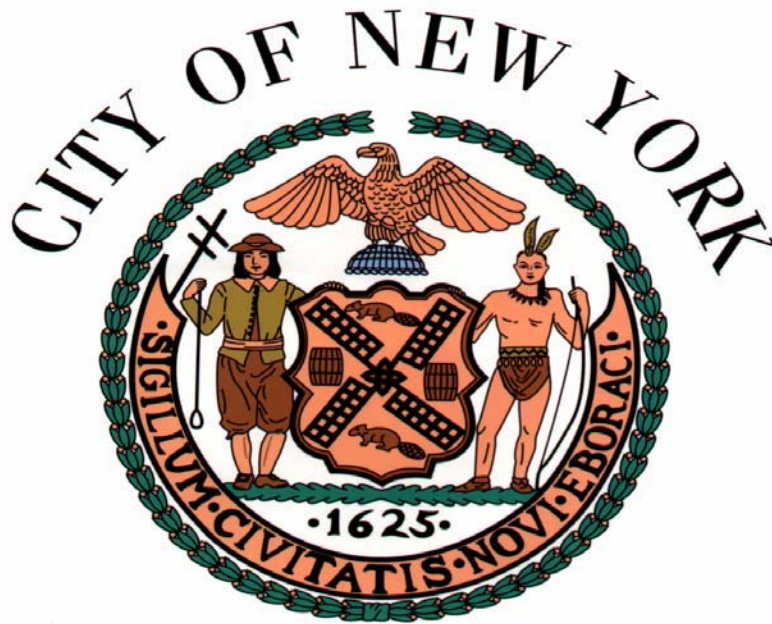


**NEW YORK CITY
DEPARTMENT OF HEALTH
AND MENTAL HYGIENE**



**LOCAL GOVERNMENTAL PLAN
MENTAL HEALTH SERVICES**

2006

**Michael R. Bloomberg
Mayor**

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

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



Message from the Executive Deputy Commissioner

I am pleased to present the 2006 New York City Local Government Plan for Mental Health Services. It has been several years since New York City completed a local mental health plan, and this document represents the commitment of the New York City Division of Mental Hygiene (DMH) of the Department of Health and Mental Hygiene to develop a rigorous and comprehensive mental health planning process.

DMH has much to be proud of. We are delivering on our expanded mission in ways that have a positive impact on the lives of countless tens of thousands of New Yorkers. I am especially proud of the groundbreaking initiatives and superior work DMH is producing in major areas such as quality improvement, depression screening and management, and housing development. Quality IMPACT, our recently launched quality improvement initiative, is a cornerstone of our reinvigorated planning process which we have adopted to promote a continuous quality improvement model of rapid-cycle interventions aimed at identified problem areas. In collaboration with the Health and Hospitals Corporation (HHC), DMH is promoting the use of a tool, called the PHQ-9, which gives primary care physicians a simple, low-burden screening and monitoring tool to assess their patients for symptoms of depression. Furthermore, adequate residential services are a top priority for DMH as no one gets better from mental illness without safe and reliable housing.

We expended significant effort this year to improve the planning process so that our local government plans not only document the work being done, and show how this work is positively affecting the lives of the City's residents, but also identify those areas in need of government attention. Such a population-based approach expands the planning focus of recent years beyond the existing service system and those utilizing it to include those possibly in need who are not presenting for services. We are committed to using our local planning process to better describe unmet need, and to develop recommendations for resource allocation, capacity expansion, and programmatic priorities. DMH is also beginning to move beyond its traditional focus on adults with serious and persistent mental illness and children with serious emotional disturbances to a broader leadership role involving the mental health and well being of all the City's residents.

This Plan, while not a comprehensive document, is a first step toward describing mental health concerns in New York City and what DMH is doing to address them. Over the next several years, we intend to build out this planning process so that the City's local government mental health plan describes the full range of mental health needs of its residents. This will be a multi-year effort, and one that will be enhanced by feedback and suggestions from stakeholders. The following page provides information regarding how you can submit feedback to us.

Thank you for your continued efforts to enhance the system of services for New York City residents with mental illness.



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NEW YORK CITY MENTAL HEALTH LOCAL PLAN – FY2006
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I. INTRODUCTION

This Local Government Plan for Mental Health Services is a first step toward establishing a rigorous annual local planning process that is data-driven and includes as a key component the promotion of quality services. The New York City Division of Mental Hygiene (DMH), Department of Health and Mental Hygiene (DOHMH), has developed and adopted a local planning framework that addresses prevalence, service capacity and need, utilization, quality and the measurement of outcomes. DMH is pleased that the Conference of Local Mental Hygiene Directors (CLMHD) has, with input from DMH and other local government units (LGUs), developed a draft template for the local plan that includes these same elements.

DMH has attempted to utilize this template for this year's New York City (NYC) Plan. Consistent with State Mental Hygiene Law, we have engaged stakeholders in the planning process through a series of meetings with diverse stakeholders to gather information and consensus about priorities for target populations, service needs and planning. Our goal is for the local mental health plan to become the basis for decisions on resource allocation and service development, and an effective means of communicating NYC's needs to our State mental health partner, the Office of Mental Health (OMH).

This year's Plan, while not as comprehensive as we intend it to be in future years, does describe mental health service system concerns in NYC and what DMH is doing to address them. The Plan includes basic demographic information about NYC, the largest and most diverse city in the State. An overview of the existing mental health system of services for both adults and children and adolescents is presented, using the limited available data. Unmet service needs, based on data and stakeholder input, are identified. The Division's approach to ensuring that services are appropriate to people's needs, culturally competent, recovery-oriented and high quality, is described. Finally, multi-year DMH goals, which address areas of identified unmet need, are stated, along with specific goals for 2006 and related objectives.

II. AREAS FOR CITY/STATE COLLABORATION

Needs Methodology

Planning and evaluation efforts in NYC suffer from the lack of a systematic needs methodology that logically derives estimates of unmet service need from prevalence, capacity and utilization data. While DMH can estimate prevalence and calculate capacity, we have no system-wide sources for collecting individual utilization data. DMH has identified a minimum dataset that would provide key individual demographic data, collected at admission and discharge, to allow determination of the frequency and duration of treatment, by diagnosis, for unique individuals receiving mental health services. Implementing a system to collect this data, however, will be expensive, time-consuming and burdensome for this or any LGU, as well as for providers. Furthermore, it would only cover the portion of the service system in contract with the LGU. Therefore, DMH urges OMH, with its broader purview and greater data collection resources, to take the lead on collecting individual-level data and developing a statewide needs methodology. This could be done in collaboration with the counties and NYC through CLMHD, and be flexible

enough to allow for counties and the City to adapt the methodology to their particular characteristics. DMH believes that comprehensive periodic assessments of local mental health needs are essential and that it is within the purview of the State mental hygiene agencies to provide local governments with the necessary resources to do this critical work.

Quality Improvement

The DMH implementation of the Quality IMPACT initiative has successfully introduced data-driven quality improvement efforts into the NYC service system. Through participation in the initiative, providers have completed continuous quality improvement projects and consumer perceptions of care surveys that have enabled them to begin to improve services (to be discussed in depth later in this Plan). However, the current project-based rollout approach is labor-intensive, both for DMH staff and for providers, and cannot be expanded substantially beyond its current limits. To fully realize the vision of a culture of quality, NYC calls on OMH to lend assistance in two critical areas:

- Collaboration in the establishment of fiscal strategies, including increases in Medicaid rates, that will fund quality improvement efforts in programs and provide incentives for exemplary outcomes
- Establishment of a unified approach to quality improvement: i.e., a coordinated roll-out of quality improvement projects and perceptions of care surveys across various regulatory and accrediting bodies, with common standards, deemed compliance and transparent data reporting

With strong incentives and unified standards, what is now a partially realized vision could become standard operating procedure in the City and the State.

High Users of Services

As discussed on page 36, high utilizers of services use a disproportionate amount of services and funding, without appreciable benefit. Many high service utilizers are not being effectively engaged by the mental health service system, which leads to repeated episodes of psychiatric and medical illness, homelessness, overutilization of medical services, incarceration, and other poor outcomes at a very high cost. DMH is targeting three groups of high utilizers of services, and calls upon OMH to assist the City in providing more cost-effective services with better outcomes to these individuals, as follows:

- High utilizers of Medicaid-funded mental health services who are in need of coordinated psychiatric, chemical dependency, medical and residential services – DMH is creating a pilot program designed for 200 high utilizers of services, whose psychiatric and medical treatment, case coordination and housing needs are not being adequately met. This pilot includes as critical program components three Assertive Community Treatment (ACT) teams, and up to 200 units of housing. One of the ACT teams has already been identified along with \$1 million in Reinvestment funding. DMH requests OMH's assistance in funding the other two ACT teams and up to 200 supportive housing beds in support of this initiative.

- Chronically homeless individuals living on the street or in shelters – The lack of adequate residential opportunities is a persistent obstacle to recovery for many City residents with mental illness. The City and State are engaged in talks about the “Supportive Housing Opportunities Partnership,” which, if implemented will develop housing for the chronically homeless or at-risk adults. DMH urges the State to commit to this new agreement.
- Depressed individuals who are not receiving (adequate) treatment – The consequences of untreated depression such as over-utilization of medical services, family burden, diminished productivity, and increased suicide result in high costs to society. DMH has launched a depression screening initiative, the goal of which is to improve detection and treatment of depression in primary care settings. DMH asks for the State’s collaboration in implementing and promoting its depression screening and disease management initiative in NYC, including dissemination of consumer and provider educational materials and capacity expansion of mental health services as need warrants.

III. FINANCE ISSUES

There are four system-level financing issues, which, if addressed, would significantly improve NYC’s local mental health service system. They are:

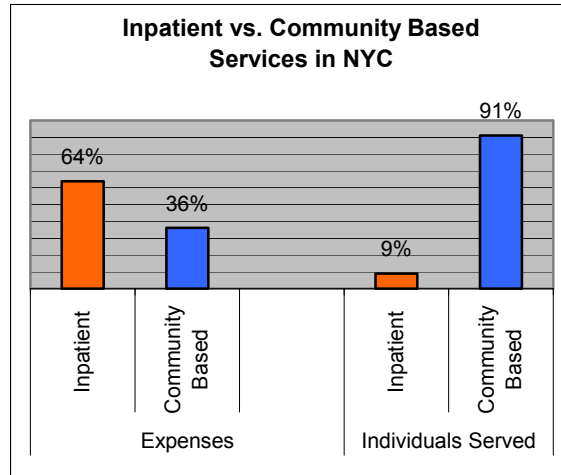
1. Redistribute Funding for Community-Based Services

A disproportionate amount of dollars are spent on inpatient psychiatric care in NYC, compared to the amount spent on community-based services. The most recent data available show that of a total of approximately \$1.893 billion spent on mental health services in 1997, 63.8% were spent on inpatient care¹ for only 8.8% of those consumers receiving mental health services.² More recent Medicaid data show that inpatient care accounts for 55.2 % of paid Medicaid bills, accounting for only 17.6% of individuals who received Medicaid-funded mental health services.³ This surely reflects sub-optimal funding for community-based services, an imbalance that leaves many NYC residents not receiving needed, much less optimal services. Moreover, a stronger network of community-based services would facilitate a decrease in the City’s high inpatient utilization rate. DMH urges OMH to seek to identify opportunities to redistribute resources and to enable the expansion of community-based services.

¹ NYC Chartbook of Mental Health Information: Table C1, 1997 Summary of Expenditures and Revenues by County of Residence and Program Category.

² NYC Chartbook of Mental Health Information: Table B1, 1997 Patient Characteristics Survey Statewide County Summary by Program Category. This data is based on a week-long survey of all those receiving services from a mental health program in New York State.

³ 2003 Paid Medicaid Data. OMH County Planning Reports.



2. Consolidate Multiple Funding Streams

There are currently 51 funding streams through which DMH receives funds from OMH for mental health services. Regulations and restrictions attached to each funding stream result in limited flexibility and unnecessary complexity in contracting for services and managing the local service system. DMH calls on OMH to collapse these funding streams into one unified funding stream. This would facilitate greater efficiency in the use of mental health funding at the local level.

3. Increase Local Government Authority Over Mental Health Services Funding

As deficit funding through contracts continues to be replaced by Medicaid funding of mental health services, DMH has begun to shift its focus from managing budgets to managing quality of services. DMH requests that OMH -- in recognition of the value of local management of the mental health service system -- work to enhance DMH's authority to serve as a quality monitor for government-funded mental health services, including a role in the distribution of Medicaid and funding from other sources.

4. Improve Access to Data on Services Not Funded Through DMH Contracts

DMH is currently limited in its ability to plan and oversee the local mental health system due to a lack of data regarding those services whose funding does not flow through City contracts. As the proportion of the local system that is funded through DMH contracts diminishes, it is increasingly important that DMH have access to system-wide data on services, regardless of their funding source.

IV. STAKEHOLDER PARTICIPATION IN PLANNING

During June 2005, DMH held meetings in order to elicit input for DMH's Local Government Plan for Mental Health Services with various stakeholders: the Greater New York Hospital

Association (GNYHA) and the Health and Hospitals Corporation (HHC); the Coalition of Voluntary Mental Health Agencies (CVMHA); the Federation for Mental Health, Mental Retardation, and Alcoholism Services; the Federation of Mental Health Centers; the National Alliance for the Mentally Ill (NAMI); and NYC consumers (convened by DMH's Office of Consumer Affairs). Each group of stakeholders represented different sectors of the mental health community. A discussion tool specifically developed for these meetings prompted participants to comment on the current mental health service delivery system in NYC in terms of: unmet needs they have encountered; obstacles that they regard hinder effective service provision; aspects of the service system that are working well; changes that would help improve the system; and priority issues that need government attention.

While some barriers and concerns were specific to the different stakeholder groups, other issues were voiced by several groups. There was broad consensus among stakeholders that there is significant need for improvement in five areas:

- Housing
- Services for children and adolescents
- Services for individuals with co-occurring mental illness and chemical dependency
- Workforce issues
- Access to services for specific populations

Housing

Stakeholders agreed that there is an insufficient supply of housing opportunities for individuals with mental illness and that a continuum of housing models is needed. Members of the hospital groups specified that intermediate, or transitional, housing models (falling between acute hospitalization and community residences on the continuum) are needed for those who require assistance in obtaining the skills needed to live in less structured settings. Many stakeholders also noted a need for additional supportive housing opportunities, including Single Room Occupancy residences (SROs). Populations identified as having significant difficulty securing appropriate housing include adolescents/young adults (ages 18-21), women with children, and undocumented immigrants. Without appropriate housing, these individuals are at risk of becoming and/or remaining homeless, on the street or in the shelters.

Services for Children/Adolescents with Mental Illness

Another area of concern mentioned repeatedly was the inadequacy of mental health services for children and adolescents. Specific services needed for children include: respite beds, ACT Teams, Mobile Crisis Teams, residential treatment facilities, home-based and school-based services that are linked to hospitals, early intervention to avoid inpatient care and entry into the criminal justice or shelter systems, and training for teachers regarding referring children for mental health services. It was also noted that children below the age of 5 need mental health services, staff need to be trained in the special needs of this age group, and that there are funding problems for such services. Finally, stakeholders commented that there needs to be better planning for adolescents who are transitioning into the adult service system, as well as programs designed for young adults.

Co-Occurring Mental Illness and Chemical Dependency

Individuals with co-occurring mental illness and chemical dependency disorders were consistently identified as a sizable population in need of services. Once considered a special population, stakeholders commented that they now see this population as the norm. The most common concern raised is the difficulty of coordinating care between the two service systems (mental health and chemical dependency). Providing truly integrated treatment at the consumer level is even more difficult due to different licensure, eligibility and reimbursement rules. It was also noted that individuals with co-occurring mental illness and chemical dependency disorders include adolescents as well as adults, and that more treatment options are needed for adolescents.

Workforce

Stakeholders reported a lack of qualified/certified staff in the mental health service system, especially psychiatrists and nurses. Consumer stakeholders discussed the importance of peer workers, noting that there are not enough peer job opportunities and more training for peer workers is needed. See Section VIII, Workforce Issues (page 42), for further discussion.

Access to Services for Specific Populations

Stakeholders reported that certain populations in NYC experience particular difficulty accessing services, and that culturally competent services need to be more widely available. Special populations identified as needing greater access to services include geriatric consumers, individuals with serious and persistent mental illness who have children, undocumented immigrants, and returning war veterans. It was also noted that more services are needed for the Asian community, where the suicide rate is increasing and the psychological impact of the 9/11 terrorist attack persists for many. Regarding cultural competency, stakeholders noted that the number of trained bilingual staff needs to grow, written documents (especially those related to City initiatives) need to be translated, and culturally specific programs should be geographically situated so consumers do not have to travel too far for services.

Issues that were voiced as priorities by each of the different stakeholder groups are as follows:

Hospitals (GNYHA/HHC)

The overwhelming issue of concern for voluntary and HHC hospitals is the long wait for State psychiatric beds. The group reported that the backlog results in waiting periods as long as 200-300 days, with especially long waits for children/adolescents, women, multiply diagnosed individuals and Asian Americans. Another issue discussed by this group is the lack of outpatient capacity in NYC. Hospitals often have difficulty arranging post-discharge care for patients because of waiting lists for outpatient services (especially for children). As a result, many patients end up back in the emergency department for acute inpatient services.

Community-based Providers (CVMHA)

Community-based providers voiced particular concern regarding the inadequacy of existing funding and the burdensome and unresponsive regulatory structure for outpatient mental health services. Specifically, they noted that the current shift toward Medicaid funding creates a highly restrictive and inflexible atmosphere where service provision and hiring practices are dictated by Medicaid regulations and are not sufficiently responsive to consumers' service needs. Additionally, they expressed frustration that the Medicaid program imposes costly and

burdensome requirements on providers. It was suggested that new, alternative, non-Medicaid sources of funding for mental health services be developed.

Consumers, Families and Providers (Federations/NAMI)

The group spoke of the importance of anti-stigma campaigns. Other issues discussed included the need for better discharge planning in inpatient settings to prevent people from being discharged to shelters, and the need for more programs that divert people from hospitals.

New York City Consumers

The issue of recovery was a major theme in meeting with consumer stakeholders. It was suggested that service providers, especially inpatient care providers, should be monitored and held accountable to ensure they are providing recovery-oriented services, as opposed to simply “warehousing” consumers. The group also noted that there should be more assistance in accessing meaningful activities through employment, education and literacy programs. Clubhouses were noted as an effective model for providing meaningful activities and services, and the group commented that there should be more clubhouses certified by the International Center for Clubhouse Development (ICCD). Anti-stigma campaigns were discussed as a vehicle for reducing discrimination and promoting recovery. Finally, a major concern was voiced regarding the need for more peer workers throughout the mental health service system, and specifically, that ACT teams should each have more than one peer on staff.

V. OVERVIEW OF NEW YORK CITY’S SYSTEM OF CARE FOR ADULTS AND CHILDREN WITH MENTAL ILLNESS

Since the 2002 merger of the NYC Department of Mental Health, Mental Retardation & Alcohol Services and the NYC Department of Health, the Division of Mental Hygiene has been developing a data-driven, epidemiologically informed and population-based public health model of planning and service delivery. While there are still many gaps in the data, this section summarizes available information about the NYC public mental health system as a whole, starting with the general population of the City, and then describing the prevalence of mental illness, service capacity, service utilization, and unmet need. A theme running throughout this description is the effort, still in its beginning stages, to move beyond the Department’s traditional focus on the populations of adults with serious and persistent mental illness (SPMI)⁴ and children with serious emotional disturbances (SED)⁵ to a leadership role focusing on the mental health and well being of all NYC residents.

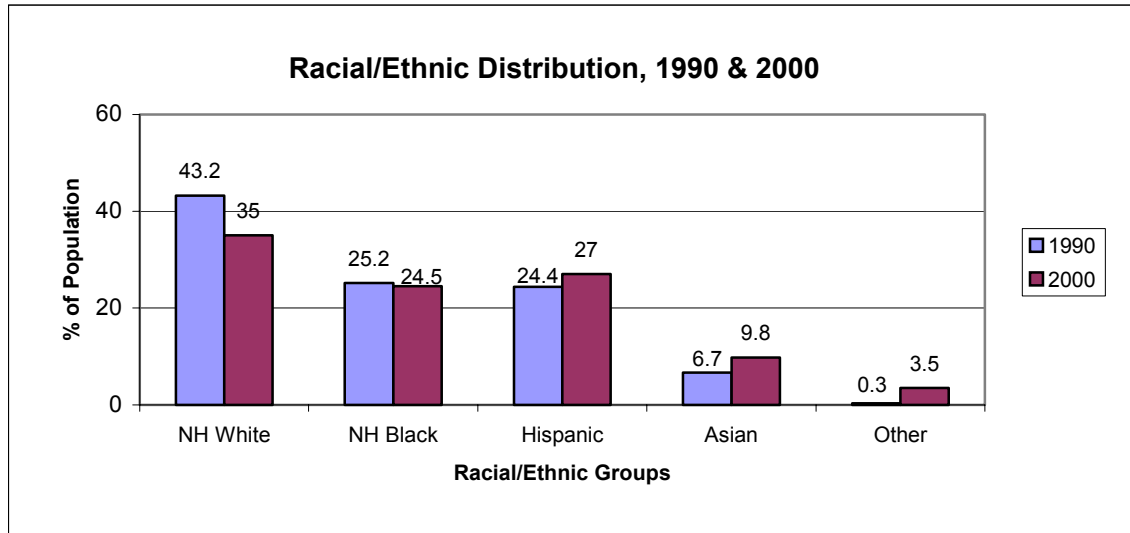
New York City Demographics

According to the latest census figures, NYC’s population grew by more than 9% between 1990 and 2000. The City’s population is now for the first time over 8 million. Immigration played a crucial role in the City’s growth with nearly 1.2 million new immigrants coming to reside in the City during the 1990s. Thirty-six percent of NYC residents are now foreign-born and only about a quarter of them are proficient in English.

⁴ SPMI is defined in endnotes on page 43.

⁵ SED is defined in endnotes on page 43.

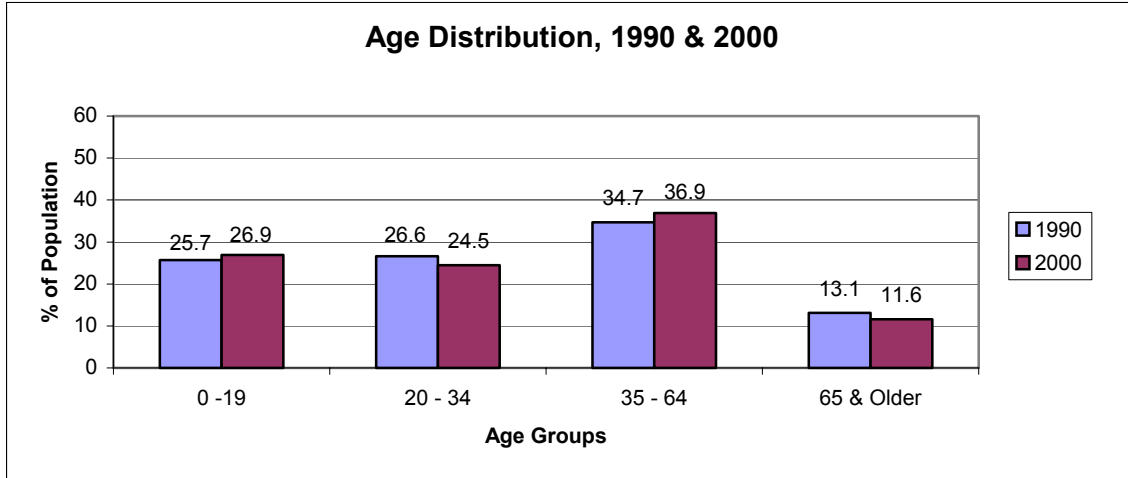
NYC is the largest and most racially and ethnically diverse city in New York State. Thirty-five percent of City residents are Non-Hispanic White, 24.5% are Non-Hispanic Black, 27% are Hispanic, 9.8% are Asian and 3.5% are Other (predominantly Non-Hispanic of mixed race). As indicated in the chart below,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



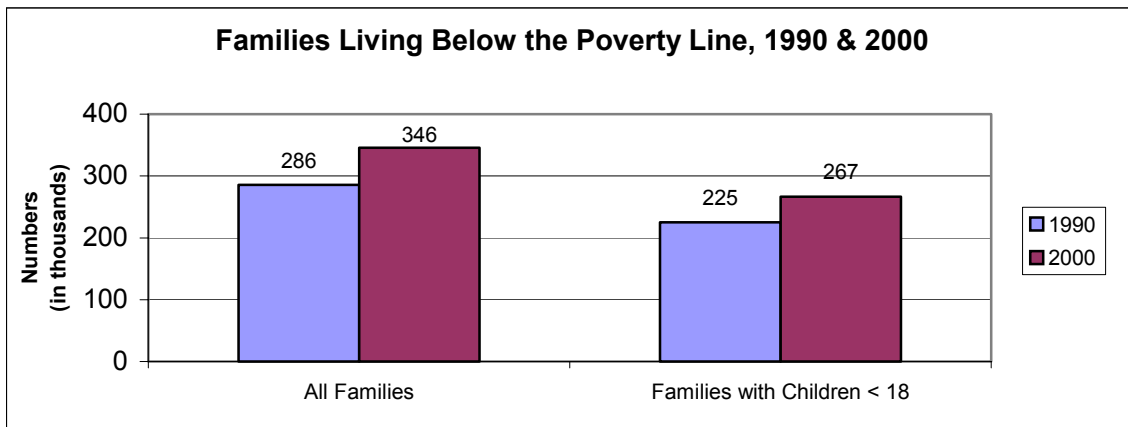
The City’s minority populations originate from many different countries. For example, the five largest Asian populations come from China, India, Korea, the Philippines and Pakistan; and, the five largest Hispanic populations emigrated from Puerto Rico, the Dominican Republic, Mexico, Ecuador and Colombia.

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

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



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



Prevalence of Mental Disorders

Local Estimates of the Prevalence of Mental Disorders

The NYC DOHMH Community Health Survey (CHS) found that in 2003 about 5% of adults experienced serious psychological distress (SPD). SPD, also referred to as serious mental illness (SMI)⁶, was measured with a widely used 6-question scale (K6) developed by Kessler and

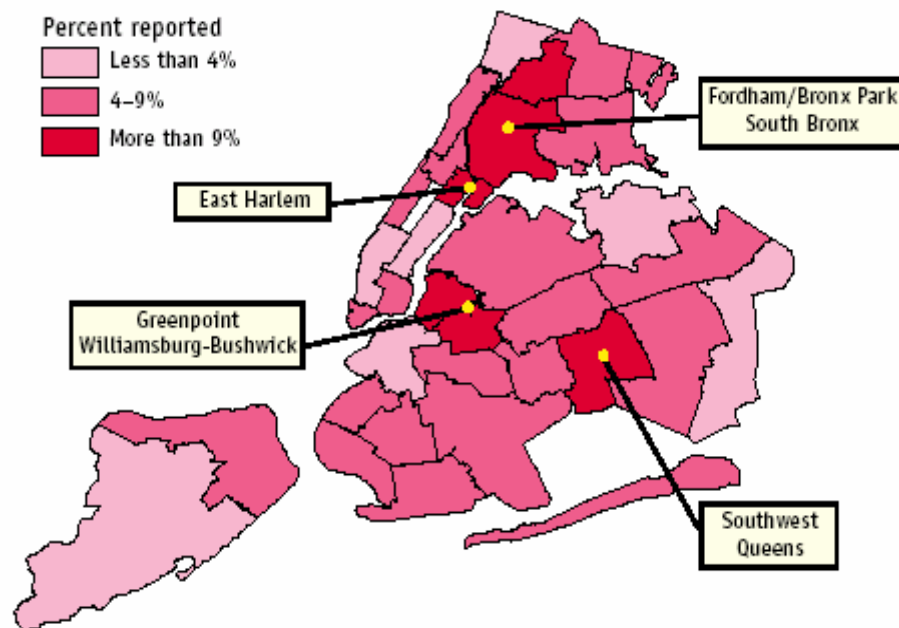
⁶ SMI is defined in endnotes on page 43.

colleagues.⁷ Persons with SPD experience distress consistent with a Diagnostic and Statistical Manual (DSM) diagnosis and report substantial impairment in functioning.

The 2003 CHS found that less than half of those with SPD (41.8%) participated in treatment during the previous year (counseling, medication or both). Barriers to treatment were reported by almost a quarter (23%) of adults with SPD, although about a half of those who reported barriers were in treatment.

The CHS found that neighborhoods with the lowest incomes often have the highest rates of SPD. Fordham/Bronx Park, the South Bronx, East Harlem, Greenpoint/Williamsburg-Bushwick and Southwest Queens have the highest reported rates.

Serious Psychological Distress in New York City Neighborhoods, 2002



The Office of Vital Statistics at DOHMH reports that over the past several years the number of suicides has remained relatively stable. In 2003, the number of suicides among adults (ages 20+) was 465, and the number among youth (younger than age 20) was 19.

Recent DOHMH Youth Risk Behavior Surveys (YRBS) found that symptoms of depression and suicidal ideation in NYC public high school students have been stable and frequent over the past several years. In 2003, the survey found that:

⁷ Kessler R.C., Barker P.R., Colpe L.J., Epstein J.F., Gfroerer J.C., Hiripi E., Howes M.J., Normand S.L., Mandersheid R.W., Walters E.E. & Zaslavsky A.M. (2003). Screening for serious mental illness in the general population. *Archives of General Psychiatry* (60):184-189.

- 32% of students (87,000) reported feeling so sad or helpless almost every day for at least two weeks that they stopped doing their usual activities
- 14% (37,000) considered suicide within 12 months of the survey
- 8% (18,000) attempted suicide
- 2% (4000) were injured in their suicide attempt

In 2004, DOHMH conducted the NYC Health and Nutritional Examination Survey (HANES) which included questions from the World Health Organization Composite International Diagnostic Interview (CIDI) relating to major depression, generalized anxiety disorder and past 12-month treatment history (counseling and/or medication). The data, which are currently being analyzed and should be available for planning purposes in the near future, will for the first time provide NYC diagnostic prevalence rates and a measure of unmet need for these two particular disorders.

Estimates of the Prevalence of Mental Disorders Based on National Studies

Currently, there are no NYC-specific data on the prevalence of particular psychiatric disorders. To obtain City estimates, DMH has had to turn to national studies. By applying national prevalence estimates to the 2000 NYC census data, DMH estimates that more than 1.9 million NYC adults have some psychiatric disorder and that over 950,000 of them have a serious disorder. National studies have found that anxiety and mood disorders are the most prevalent. DMH estimates that about 250,000 NYC adults have a serious anxiety disorder and 260,000 have a serious mood disorder.⁸ Appendix A presents detailed prevalence data for both adults and youth.

National studies suggest that over 20% or about 199,000 NYC youth between the ages of 9 and 17 have a psychiatric disorder. Anxiety disorders have been found to be the most prevalent, followed by disruptive behavior disorders and depression. DMH estimates that about 124,000 NYC youth have anxiety disorders, 98,000 have behavior disorders and 59,000 have depression.⁹

System Capacity

Program capacity data from DMH's information systems and the OMH ConCerts database was compiled and compared to create the capacity data presented in Appendix B. Fifty-seven program types are reported, along with the number of programs of each type, program capacity in slots or beds for those programs for which such data are available, and the population served

⁸ Kessler, R.C., Berglund, P., Demier, O., Jin, R., Merikangas, K.R. & Walters, E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry* (62): 593-602.

U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health. National Institute of Mental Health.

⁹ Shaffer, D., Fisher, P., Duncan, M.K., Davies, M., Piacentini, J., Schwab-Stone, M. et al. (1996). The NIMH Diagnostic Interview Schedule for Children. Version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and performance in the MECA study. *Methods for the Epidemiology of Child and Adolescent Mental Disorders Study*. *Journal of the American Academy of Child and Adolescent Psychiatry* (25): 865-877.

(adult, children or both). DMH, through its contracted services, funds approximately 500 of the 1,367 programs listed, for a total of \$188,992,820.

These data are limited in both accuracy and usefulness. Without more refined utilization data, we cannot know the range and average length of stay of consumers in the various programs, and therefore cannot estimate the number of individuals that can be served annually by the City's mental health service system.

We have the most capacity information about those programs whose funding or licensure is tied to a specific number of program slots or beds:

- 32 ACT teams with the capacity to serve 2,110 consumers at any given time
- 107 case management programs (including blended) with 16,713 slots
- 125 supported housing programs with 4,548 beds
- 77 continuing day treatment programs with 6,580 slots

For other program types, the only capacity data we have is the number of programs; for example:

- 41 outreach programs
- 15 drop-in centers
- 19 peer advocacy programs
- 16 self-help programs
- 27 assisted competitive employment programs

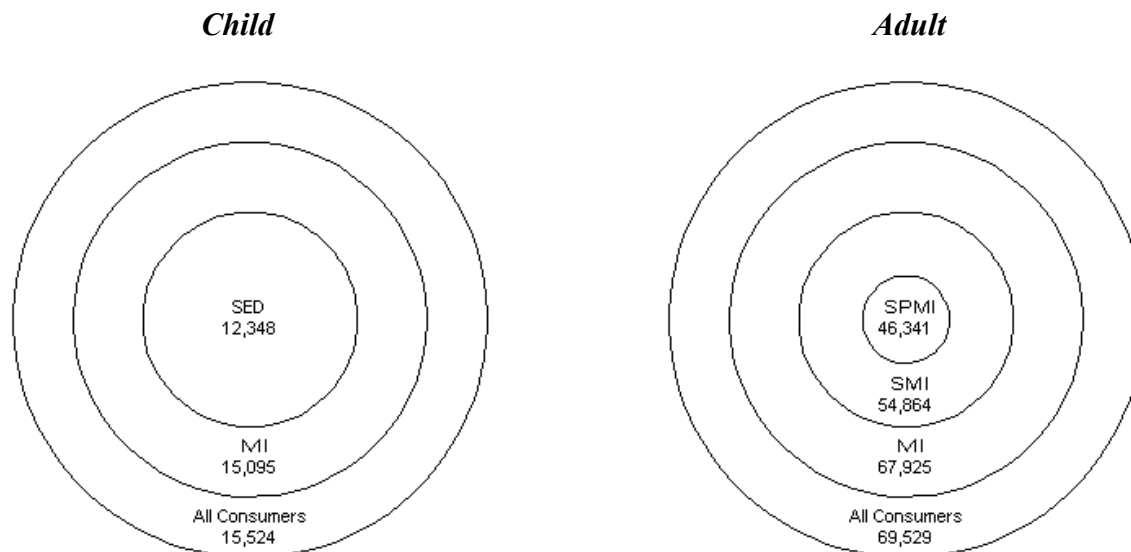
(See Appendix B for a more detailed listing of NYC's mental health programs.)

System Utilization

Data from OMH Patient Characteristics Surveys (PCS) and the NY Statewide Planning and Research Cooperative System (SPARCS) report the numbers of New Yorkers by age, diagnosis, and severity served by the NYC public mental health system. Although both data sets offer utilization figures, the PCS describes individuals served in a range of program types during a survey week, while the SPARCS describes individuals exclusively in acute care hospitals over a year. Highlights of data from both data sets are summarized below, with additional data on service utilization presented in Appendix C.

The 2003 PCS reports that over 15,000 youth (ages 0-17) and 69,000 adults (18+) were served during the survey week. About 80% of the youth had a serious emotional disturbance (SED) and 80% of the adults had a serious mental illness (SMI). As many as 67% of the adults had a serious and persistent mental illness (SPMI). Of those served during that survey week, 10% of the youth and about 24% of the adults had a co-occurring disorder. Among the co-occurring disorders, mental illness and mental retardation and developmental disabilities (MR/DD) were most prevalent among youth and mental illness and chemical dependency the most prevalent among adults.

**Severity of Disability of New York City Residents served in New York City
Mental Health Facilities During a Survey Week, 2003¹⁰**

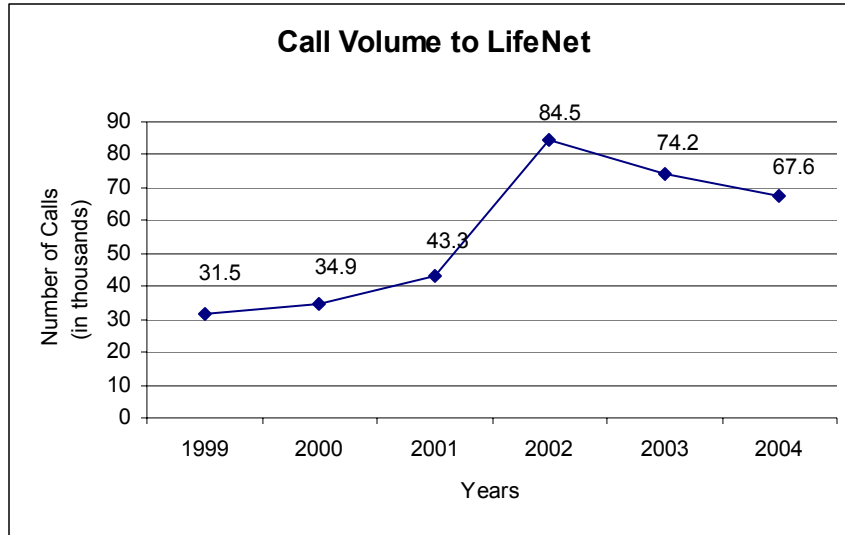


In 2001, the most recent year for which PCS data is available on the numbers of consumers served by diagnosis, nonpsychotic disorders were the most prevalent among youth. Fifty-three percent of the youth seen during the survey week were diagnosed with a nonpsychotic disorder. Among adults, mood disorders were the most prevalent. Thirty-eight percent of adults served had a mood disorder. It is worth reporting that although national prevalence studies suggest that schizophrenia is found in only about 1% of the population, 22% of the consumers served during the survey week suffered from this chronic and disabling disorder.

In 2003, there were over 108,000 discharges from acute care hospitals of NYC residents with a primary diagnosis of a psychiatric or substance use disorder. About 104,000 were adults and another 4,000 were youth. Twenty-six percent of the adult discharges and 9% of the youth discharges were of individuals with co-occurring mental illness and chemical dependency disorders. HHC has begun to collect data to track follow-up outcomes after discharge from the hospital. They will measure the number of patients age six and above who have an ambulatory care visit within seven days of discharge. These data will allow us to assess the rate of timely post-discharge outpatient treatment utilization.

Data from LifeNet, a 24-hour, 7-day a week mental health information and referral hotline funded by DMH, offers additional data on consumer demand for services. In the past several years, call volume to LifeNet has increased significantly, up from 31,525 in 1999 to 67,608 in 2004. Although the largest increase in calls occurred between 2001 and 2002 in response to the 9/11 terrorist attack due to LifeNet's expanded role as the connecting link to crisis counseling services, call volume has remained relatively high these past two years. It has become a major resource for DMH and for the residents of NYC.

¹⁰ The entire population of consumers includes some who do not have mental illness and others for whom no diagnosis is known.



Unmet Need

Currently DMH’s capacity to systematically assess need is limited by the lack of a methodology to relate prevalence, service demand, capacity, and utilization to estimate unmet need. While we are able to obtain aggregate utilization data, as reported in this section, we lack basic consumer-level data to assess patterns of utilization and treatment adequacy. As stated in Section II, DMH has identified a minimum dataset that would provide key individual demographic data collected at admission and discharge. Such data would allow determination of the frequency and duration of treatment by diagnosis for individuals in the system. DMH is currently actively engaged in determining how to most efficiently collect this data and invites State collaboration on such an initiative. Once such data is available, a needs methodology could be established.

That said, there are several areas of need that are repeatedly identified by system stakeholders, as discussed in Section IV. These include housing services, outpatient services for children, treatment services for individuals with co-occurring mental hygiene disorders and services for young adults. The methodologies that have been used to quantify and/or address those needs are discussed under the relevant goals in Section VII of the Plan. There are also needs that have been recognized as part of the national agenda, such as under-detection and treatment of depression in primary care and the mental health needs of war returnees from Iraq and Afghanistan, also discussed in Section VII.

VI. PERFORMANCE AND QUALITY

Quality IMPACT (Improving Mental Hygiene and Communities Together) is DMH’s multi-year continuous quality improvement (CQI) initiative. It represents the efforts of local government to spearhead the improvement of key service outcomes for consumers. Its principles include broad stakeholder involvement in the development process, use of data-driven quality improvement methods, intensive provider education and support, implementation of evidence-based, promising and innovative practices, and transparent reporting of results. Participating programs

implement congregate CQI projects and/or consumer perceptions of care surveys. DMH is committed to collaboration with State partners and other quality improvement entities to integrate CQI principles, standards and projects throughout NYC. Such integration is critical to limiting provider burden, enhancing the spread of improvements and collecting useful system-wide data. Quality IMPACT is being introduced gradually into the mental hygiene community. In FY 2005, a total of 65 programs (38 mental health) participated in the initiative. In FY 2006, it is being expanded to include an additional 65 programs (39 mental health).

Continuous Quality Improvement Projects

DMH draws on traditional CQI methods, as well as many of the innovative and promising practices developed by the Institute For Healthcare Improvement (IHI) to establish a structure to guide groups of programs through the quality improvement process. All participating providers receive training and assistance in establishing CQI in their programs, including: initial staff training on team development and the CQI model; the provision of structured workbooks which offer a step-by-step guide to project planning and implementation; electronic data collection tools and data training, and a timeline for project completion. DMH support also includes ongoing technical assistance, monthly group conference calls for each project group and three day-long Interactive Project Group (IPG) meetings. Expert consultants and trainers assist DMH in staffing the conference calls and IPGs.

Based on a review of National, State and local priorities and a survey of NYC mental health stakeholders, DMH targeted cultural competence and co-occurring disorders as two key areas for service improvement. In consultation with national experts and the NYC mental health community -- consumers, families, providers and advocates -- DMH developed two CQI priority projects for mental health treatment providers:

- Improving Cultural Competence in Mental Health Treatment Programs
- Improving Identification and Coordination of Care for Adults with Substance Use Disorders in Mental Health Treatment

A third option, also intended to improve a consumer-focused aspect of service delivery, was an independent project of a program's own choosing. The cultural competence and co-occurring disorder projects are described as separate agency goals in Section VII of this Plan. The three independent projects selected by providers focused on the following aspects of care:

- Improving consumers' physical health
- Improving intake processes and retention of consumers in care
- Increasing show rates for consumers with regular appointments

In FY 2006, 24 mental health clinics will be conducting independent CQI projects. Programs pursuing independent projects receive the same support as those engaged in priority projects, the only difference being that their IPGs and conference calls are more generically focused.

Consumer Perceptions of Care

Consumer satisfaction with services is widely recognized as an important component of outcome performance.¹¹ Consumers who are satisfied with services tend to follow their treatment/recovery plans and complete their course of services. The collection and analysis of consumer perceptions of care on an annual basis in all disability areas is a cornerstone of Quality IMPACT. Prior to this initiative, there was no systemic collection of this information either by the City, or the State.

Stakeholder workgroups in conjunction with the Offices of Consumer Affairs and Planning & Quality Improvement of DMH select and adapt the surveys used. DMH analyzes the surveys and reports survey data to the participating programs and the public. Priority is given to widely used tools that allow for the comparison of NYC data both across programs and with other cities and states. In addition to their function as program-level outcome measures, perceptions of care data are important for evaluation and planning on the system level. The details of the FY 2005 mental health survey, and plans for FY 2006 are described in Section VII under the goal related to incorporating recovery principles and practices into the City's mental health service system.

The Quality IMPACT Vision: A Culture of Quality

The following represents Quality IMPACT's vision for the years ahead:

- Consumers' and families' perceptions of services shape DMH quality objectives
- CQI is established as standard operating procedure in NYC's mental hygiene programs
- CQI results in meaningful outcome criteria and a standardized process of quality improvement
- Data is used to assess the service system's performance and quality
- Provider burden is minimized through:
 - Common standards across regulatory and accrediting agencies
 - Deemed compliance
- Quality improvement is adequately funded and exemplary performance is incentivized

VII. GOALS AND OBJECTIVES

This section presents multi-year goals ("DMH goals") that DMH is pursuing and for each, specific goals for 2006 with associated objectives. Some goals target adults (A), others children (C) and yet others both adults and children (A&C). The goals and objectives are grouped into two main categories: Goals Targeting System Improvements and Goals Targeting Specific Populations.

¹¹ Donabedian, A. (1980). *The definition of Quality and Approaches to Its Assessment*. Ann Arbor, MI, Health Administration Press.

GOALS TARGETING SYSTEM IMPROVEMENTS

DMH GOAL: Improve cultural competence in mental health treatment programs. (A)

2006 Goal: Increase program admissions of adults from cultural groups that are considered to be underserved, and improve the cultural competence of assessment and treatment of all adults.

Objective

1. Develop and implement a CQI priority project that promotes culturally competent assessment and treatment and increases access, as measured by increased admissions, by underserved populations.

The Quality IMPACT CQI project to improve cultural competence was designed to help providers better meet the treatment needs of NYC's increasingly diverse adult consumer population. During FY 2005, 13 programs participated in this project. During this first year of the project, 800 of the 930 adult consumers (86%) who had an initial assessment were screened for cultural factors using the City-Wide Cultural Assessment (CCA), a tool that was developed by DMH and the mental health community. Of those who were screened, 22% were found to have cultural factors that were important in the development of effective treatment strategies.

Individual programs targeted a particular cultural group for increased admissions based on the demographics of its consumers compared to that of its local population. About 11% of all admissions during the course of the project were from any of the underserved populations identified by the programs (e.g., Caribbean men, Hasidic women and transgender persons). While this did not represent a significant increase above baseline for most of the programs, the participants have honed their community outreach strategies, identified some promising practices and are optimistic about achieving sustained improvement in the second year of the project.

Based on their experiences this past year, ten of the participating programs decided to continue with this project and have plans for expanding its scope in FY 2006. Another program has chosen a different project for this coming year, but has incorporated the CCA into its regular operations. In FY 2006, nine other mental health programs will begin this project.

To better assist providers in meeting their project goals, DMH, with significant input from this past year's participants, recently developed additional and revised tools, including a teaching video for the CCA that will be made available in FY 2006.

DMH GOAL: Facilitate and help lead a process by which a recovery-oriented vision is developed and pursued for NYC consumers, providers and government agencies. (A)

2006 Goal: Identify and pursue opportunities to incorporate recovery principles and practices into the City's mental health service system and within DMH.

Objectives

1. Create a multi-year Recovery Action Plan to guide system transformation.
2. Design and implement a Recovery Assessment Tool to track DMH's progress towards recovery-oriented system transformation.
3. Give mental health consumers a voice in improving the quality of the services they receive through consumer perceptions of care surveys.

The president's New Freedom Commission on Mental Health, in its final report entitled "Achieving the Promise: Transforming Mental Health Care in America," called for recovery to be the "common, recognized outcome of mental health services."¹² Recovery, as a vision and model, is becoming the method for framing service delivery in the mental health world and is "grounded in the idea that people can recover from mental illness, and that the service delivery system must be constructed based on this knowledge."¹³ In the past the service system was focused more on an illness model of care, and was constructed in a way that did not adequately engage consumers as partners in service delivery. Although recovery is a unique process for each individual with mental illness, there are transformations that must occur at the staff, program, community and government levels that can promote and improve recovery outcomes. DMH is committed to moving mental health services in NYC towards a recovery-oriented system.

Objective 1: Create a multi-year Recovery Action Plan to guide system transformation.

DMH is in the process of creating a Recovery Action Plan guided by the following principles:

- Recovery from mental illness is possible
- Recovery can be supported by mental health professionals; however consumers hold the keys to their recovery and thus they have a right to full partnership in all aspects of their recovery, including designing, planning, implementing and evaluating the services that support their recovery
- A recovery perspective promotes a collaborative strength-based treatment approach and facilitates autonomy, self-determination, respect, cultural relevance, individual and family participation and individual responsibility and control

Objective 2: Design and implement a Recovery Assessment Tool to track DMH's progress towards recovery-oriented system transformation.

One of the first steps recommended for providers and governing agencies in developing a plan to implement and expand recovery-oriented services is to assess their current status vis-à-vis recovery. These assessments can guide recovery-oriented planning decisions and resource allocation. DMH is in the process of creating a recovery self-assessment tool designed to track DMH's progress towards recovery-oriented system transformation (See Appendix D for draft tool).

¹² National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation, December 16, 2004.

¹³ Anthony, W.A. (2000). A Recovery-Oriented Service System: Setting some system-level standards. *Psychiatric Rehabilitation Journal* (24)2: 159-168.

The draft self-assessment tool is drawn from the literature on rehabilitation and recovery, and condenses the principles and guiding statements that many persons in recovery agree represent key measurable aspects of a recovery-oriented system. After the tool has been further developed and vetted by consumers, families, providers and advocates, DMH will complete this tool each year and report the results in the Local Government Plan for Mental Health Services. It will serve to chart DMH’s progress in promoting the transformation of NYC’s mental health system into one that is recovery-oriented. Together with the Recovery Action Plan, it will provide guidance and transparency to the complex challenge of system transformation.

Objective 3: Give mental health consumers a voice in improving the quality of the services they receive through consumer perceptions of care surveys.

As part of DMH’s Quality IMPACT initiative, consumers from 31 mental health treatment programs participated in the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey, a nationally recognized survey instrument that was developed for use in the public mental hygiene system and is now widely used by state and local governments. The primary purpose of DMH’s survey effort was to give consumers a voice in improving the quality of the services that they receive and to identify service areas that may benefit from further attention. The survey, which measured consumer perceptions of care related to general satisfaction, access, quality/appropriateness, and outcomes, was self-administered, anonymous and confidential.

In all, 2,250 consumers participated in the survey. Those consumers represented 68.7% of all consumers seen at the 31 participating programs during the two-week survey administration period.

Survey results suggest that the majority of consumers have positive feelings about the services that they receive; however, consumers of clinic services report being more satisfied than consumers of continuing day treatment (CDT) services.

Domain	Percent Expressing Positive Feelings*	
	Average of Clinic Programs	Average of CDT Programs
Overall Satisfaction	94.8%	77.5%
Access	93.4%	76.1%
Quality/Appropriateness	94.4%	77.0%
Outcome	81.2%	73.4%

* Note: Positive feelings defined as “Agreeing” or “Strongly Agreeing” to positively worded statements about the program.

Looking ahead, DMH intends to conduct perceptions of care surveys annually. In FY 2006, a total of 69 mental health treatment programs will be participating. By conducting surveys annually, participating programs will be able to monitor improvements they make in response to consumer concerns. In addition, DMH will be able to aggregate the data from these surveys to evaluate system performance.

DMH GOAL: Coordinate the implementation of PROS in a manner which preserves and strengthens services for adults with SPMI. (A)

2006 Goal: In collaboration with NYC mental health stakeholders, develop the NYC PROS Implementation Plan.

Objectives

1. Establish a participatory planning process through a workgroup of key mental health stakeholders which will guide the PROS planning and implementation process in NYC.
2. Ensure that only programs projected to be viable under PROS are advanced through the planning process to convert to PROS licensure.
3. Preserve service capacity and improve access and consumer choice.
4. Promote recovery-oriented services for adults with SPMI by developing specific recovery-oriented goals for NYC’s PROS programs, and a plan to assist NYC PROS providers in attaining these goals.
5. Develop a mechanism for evaluating the impact of the implementation of PROS on NYC’s service system for adults with SPMI.

Objective 1: Establish a participatory planning process through a workgroup of key mental health stakeholders which will guide the PROS planning and implementation process in NYC.

Cognizant of the significant impact PROS will have in NYC, and the many concerns expressed by both consumers and providers, DMH convened a PROS Stakeholders Implementation Workgroup in late 2003 shortly after OMH requested that counties and NYC submit a PROS implementation plan. The Workgroup serves as a forum for ongoing dialogue between representatives of the key stakeholder groups affected by PROS, and local and state government, as we move through the NYC PROS planning process. Members include: the Association for Community Living (housing providers), CVMHA (community-based mental health providers), GNYHA (hospitals), NAMI – NYC Metro (families), NYC Clubhouse Coalition (consumers and staff), NYAPRS (rehabilitation providers and consumers), DMH and OMH. The Workgroup will continue to meet throughout the remainder of the planning process and well into the implementation of PROS in NYC.

Objective 2: Ensure that only programs projected to be viable under PROS are advanced through the planning process to convert to PROS licensure.

A total of 147 existing NYC programs representing 41 different mental health provider agencies are projected to convert to create 53 licensed PROS programs:

Licensure Category	All PROS Programs	Comprehensive with Clinic	Comprehensive without Clinic	Limited License
# Programs	53	31	13	9

118 of the 147 programs are in program categories that are mandated to convert to PROS:

- 37 Assisted Competitive Employment
- 33 Psychosocial Clubs¹⁴
- 17 Supported Employment
- 10 Intensive Psychiatric Rehab. Treatment
- 7 Affirmative Businesses
- 5 Enclave in Industry
- 4 Transitional Employment Programs
- 2 Client Worker Programs
- 1 On-site Rehabilitation Program
- 1 Supported Education Program
- 1 Special Demonstration

29 of the 147 programs are voluntarily converting to PROS:

- 23 continuing day treatment programs
- 6 clinic treatment programs¹⁵

In total, these 147 programs currently represent an estimated \$68.5 million in funded services. OMH has budgeted a maximum of \$80 million for the NYC PROS conversions.

During the planning process, a lack of fit between the PROS model and some of the City's mandated programs was identified. A number of NYC programs were waived from the requirement to convert to PROS: on-site rehabilitation programs (both shelter-based and residential), because of the potential disruption to their housing settings; and geriatric psychosocial clubs, due to a lack of programmatic fit. Moving forward, these programs will continue to be eligible to receive deficit funding through a contract with DMH, although their funding models may be reviewed with the possibility of including Federal (e.g., Medicaid) participation. Free-standing employment programs will convert to limited license PROS programs, but because they are projected to not generate adequate revenue from Medicaid billing, OMH will explore alternative funding options supplemental to Medicaid revenue.

Objective 3: Preserve service capacity and improve access and consumer choice.

Regarding service capacity (number of consumers served), current projections indicate that service capacity will be preserved. No NYC programs are projecting to close due to PROS, and most providers based their projections on efforts to maintain their operations and continue serving their current consumers. DMH will continue to monitor system service capacity during the upcoming licensing application (PAR) process. Regarding access, one aim of NYC's PROS planning process is to ensure that the City's adults with SPMI have geographic access to services that are both proximate and culturally competent, ideally, with the option to choose among several PROS programs that meet these criteria. NYC's system of rehabilitation and employment services for adults with SPMI is currently geographically diverse, with a number of culturally competent programs. DMH is sponsoring a public hearing in the fall of 2005 to elicit comments relating to how access to services and consumer choice can be optimized through PROS.

¹⁴ Nine of these are ICCD-certified clubhouses.

¹⁵ These clinic programs are affiliated with agencies that operate rehabilitation programs that are converting to PROS.

Objective 4: Promote recovery-oriented services for adults with SPMI by developing specific recovery-oriented goals for NYC’s PROS programs, and a plan to assist NYC PROS providers in attaining these goals.

As NYC’s local mental health authority, DMH has several opportunities to impact the programmatic content of the City’s PROS programs. They include: collaboration with OMH, provider groups and others on pre-conversion and post-conversion training for PROS providers; review of PROS licensing applications (PARs); and operational and quality improvement requirements as specified in the PROS Local Government Unit-provider agreements. DMH intends to partner with provider and consumer stakeholders to utilize these opportunities to help NYC PROS programs attain a limited number of specific recovery-oriented goals.

Objective 5: Develop a mechanism for evaluating the impact of the implementation of PROS on NYC’s service system for adults with SPMI.

Given the magnitude of the PROS conversion in NYC, and the widespread concern about its impact on the City’s mental health service system, DMH has partnered with OMH and the Health Services Research Division at Mt. Sinai Medical Center in planning an evaluation of the implementation of PROS in NYC. The values guiding this evaluation are: transparency, simplicity, independence and timeliness. The plan is to use Medicaid administrative data and comparable administrative data for non-Medicaid PROS consumers. Five aims for the evaluation have been proposed and vetted by the City’s PROS stakeholders: 1) compare actual expenses and revenues with projections; 2) determine the impact of PROS on patterns of service delivery; 3) assess the effect of PROS on access to services; 4) determine how PROS has reconfigured the service system; and 5) evaluate the process of implementing PROS.

Additionally, as part of the evaluation, DMH is seeking data on consumers’ perspectives on PROS through a survey. In partnership with OMH and the State University of New York (SUNY)/Albany’s Research Foundation, DMH is conducting a pre- and post-conversion consumer survey. Each phase aims to survey a stratified random sample of approximately 450 consumers attending 20 programs slated to convert to/recently converted to PROS licensure. Survey results will enable providers, consumers, and local government to have a clearer understanding of consumer perceptions of services both before and after programs convert to PROS.

DMH GOAL: Improve service system response to individuals in psychiatric distress who need assistance in accessing mental health services. (A)

2006 Goal: Implement Phase I of local best practices for Mobile Crisis Teams (MCTs).

Objectives

1. Improve MCT practices in four key areas: timely response; initial face-to-face contact; prioritization of response according to urgency; and disposition of cases.
2. Clarify and enhance the role of the City’s MCTs in the City’s response to a disaster or emergency.

DMH's Mobile Crisis Team (MCT) network facilitates access to mental health services for people who experience psychiatric distress by assessing and rapidly linking them to inpatient or outpatient mental health and chemical dependency services. By 2004 there were 25 MCTs in all five boroughs, 14 of which were in contract with DMH. MCTs are operated by both hospitals and community-based organizations, and many are part of OMH-licensed Comprehensive Psychiatric Emergency Programs (CPEPs).

In the spring of 2004, DMH conducted a study to assess MCT services which led to the creation of a set of best practices for mobile crisis services. The study, "New York City Mobile Crisis Team Survey and Recommendations," was conducted in two parts: collecting qualitative information from MCT directors regarding operations and challenges in service delivery, and a randomized chart review of cases referred to MCTs from eight non-CPEP mobile crisis teams. The study findings identified areas for improvement in the current MCT system, which have been prioritized and will be implemented in phases.

Objective 1: Improve MCT practices in four key areas: timely response; initial face-to-face contact; prioritization of response according to urgency; and disposition of cases.

Starting January 2006, DMH will begin to introduce local best practices and track MCTs' performance relative to the following service targets:

- 100% of referrals to MCTs receive a telephone screening response within 60 minutes (during the hours of operation)
- All teams document at least 3 attempts at initial face-to-face contact prior to closing a case
- A case prioritization system ensures that the most urgent calls receive the fastest response
- 90% of MCT consumers receive successful referrals for appropriate follow-up services

DMH plans to track MCTs performance in these key areas through new program audit standards and reporting of relevant CQI measures.

Objective 2: Clarify and enhance the role of the City's MCTs in the City's response to a disaster or emergency.

As part of DMH's effort to develop coordinated disaster response plans regarding mental health needs, the role of MCTs in disaster response activities is being formalized. Currently, MCTs do not have a standard for response in the event of a disaster or emergency. One of the best practices for inclusion in MCT standards is that they be ready to respond to the scene within two hours of formal notification, by the DMH Office of Mental Health Disaster Preparedness, that an emergency or disaster response has been activated.

2006 Goal: Collaborate with the NYC Police Department (NYPD) to facilitate effective interactions between police officers and individuals with psychiatric disorders, mental health providers and the mental health advocacy community.

<u>Objective</u>

- | |
|---|
| 1. Collaborate with the NYPD to improve triage skills of "911" and "311" operators. |
|---|

NYPD patrol officers are dispatched on calls regarding emotionally disturbed persons (EDPs) almost 200 times daily¹⁶, presenting numerous possibilities for individuals with mental health issues to come in contact with the criminal justice system. To improve these interactions, DMH and the NYPD have formed the Police Mental Health Advisory Committee (PMHAC). More specifically, it is charged with: identifying and evaluating mechanisms to provide mental health services for people with psychiatric disorders who make contact with the police; supporting cross-training of police and mental health personnel; and streamlining communication between mental health service providers, the police, and the mental health advocacy community. The committee's current focus is twofold: to increase the training of "911" and "311" operators in triaging telephone calls concerning behavioral emergencies, and to better prepare police officers who may be dispatched to respond to these calls.

DMH GOAL: Improve funding for outpatient mental health treatment in order to increase treatment capacity. (A&C)

Stakeholders and community surveys consistently portray significant unmet need for treatment services for both children and adults. In 2004, with the assistance and approval of OMH, DMH was able to redistribute a pool of \$1.35 million in unallocated Comprehensive Outpatient Programs (COPS) funding through a competitive Request for Proposals (RFP) process. DMH opened up the RFP process to all licensed mental health clinics, and asked proposers to demonstrate that the proposed expansion in service capacity would target underserved geographic areas and underserved populations, and expand culturally and linguistically competent services.

DMH received 66 proposals from program clinic providers, and approved 15 proposals facilitating a total of 33,700 new treatment visits annually. Awards were given to clinics located in four boroughs (three in the Bronx, two in Queens, four in Brooklyn, and six in Manhattan). The additional clinic capacity was targeted to the following underserved populations: individuals with mental illness and one or more co-occurring conditions (visual impairment/blindness, deafness, mobility impairment, chemical dependency disorders); recent immigrants; ethnic minorities (African-American/Blacks, Hassidic Jews, Latinos); and geriatric individuals.

This modest increase in treatment capacity did little to reduce the significant unmet need. DMH continues to seek opportunities to expand mental health treatment capacity.

2006 Goal: Advocate for the removal of the Medicaid cap in New York State, which restricts access to care for New Yorkers with mental health disorders by limiting needed treatment expansion.

Objective

1. Advocate for OMH to approve licensing applications (PARs) for new and expanded mental health services based on need and quality only, without requiring the identification of funding for the State share of the projected Medicaid funding.

¹⁶ Police Student's Guide, New York Police Department (2003).

DMH opposes the continuing cap on an increase in spending and expansion of mental health services regardless of demonstrated need, commonly referred to as “Medicaid Neutrality” or the “Medicaid Cap.” In Title 14 NYCRR Part 551.13, the regulations governing criteria for additional outpatient programs, it states that “in reviewing outpatient projects, the Office of Mental Health shall consider...for Medicaid or local assistance, **the impact, source, and availability of the State share of such funds.**”

The cap on mental health care prevents the development of needed mental health services, thereby restricting access to care for countless New Yorkers with treatable mental disorders. In essence, the State has placed a moratorium on expansion of outpatient mental health services unless alternative funding sources are identified to cover the anticipated increase in the State share of Medicaid. This cap is effectively the implementation of stigma through policy since it applies to mental health services alone among the health disciplines. There is no cap for treating asthma, heart disease, cancer, or any other medical specialty disorder.

DMH GOAL: Improve coordination of care for children and adolescents who need mental health services. (C)

2006 Goal: Pursue funding to maintain services for the Children’s Coordinated Services Initiative (CCSI).

Objective

1. Continue the ongoing evaluation of the efficacy of CCSI services and develop a plan for the long-term sustainability of CCSI.

One of the ways DMH will continue to improve the mental health system of care for youth with emotional and behavioral problems who are involved with multiple agencies (e.g., State and local mental hygiene, education, juvenile justice, probation of care, and other human services agencies) is through the Coordinated Children’s Services Initiative (CCSI),¹⁷ which has been funded through a six-year grant (2002-2008) by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA).

CCSI is an innovative model of care in NYC for families of youth with special needs who are at risk of being removed from the home into hospitals or residential programs. This model helps youth return to school after long absences and keeps families together and children in the community. The CCSI model uses family network conferences to bring together representatives of all the agencies and community resources involved in a child's treatment. The goal is to serve 250 children and families throughout the 5 boroughs during each year of the grant. CCSI has made considerable strides in meeting its goals, reaching more than the targeted number of children and families in FY 2004 for a total of 311 children and families served.

Objective: Continue the ongoing evaluation of the efficacy of CCSI services and develop a plan for the long-term sustainability of CCSI.

¹⁷ CCSI is administered by the Mental Health Association of NYC (MHA) and has a budget this year of \$3.3 million.

A requirement for the SAMHSA grant, an evaluation was initiated in October 2004 and will follow youth and families for three years. The current measure for progress is the successful linkage of the youth and family with services in the community. Ongoing measures of progress will be developed in the upcoming year. They will track the training of case managers and supervisors in the mental health system in the principles and application of CCSI.

The greatest challenge of CCSI is sustaining the project once Federal funds are no longer available. A strategic planning team is meeting regularly to plan for the long-term sustainability of CCSI.

2006 Goal: Expand the Single Point of Access (SPOA) program for children to all five boroughs so that all youth who need high-end mental health services have a single entry point and timely access to these services.

Objective

1. Issue a Request for Proposal (RFP) to establish a Citywide SPOA program.

Currently, a children's SPOA pilot is operating in the Bronx. Ongoing evaluation has shown that it has been successful in developing a single point of access, providing access to the most appropriate level of care, and decreasing the waiting time for youth who have SED to access high-end mental health services. A 3-month comparison of the Bronx SPOA and the other waiver programs in NYC indicated that SPOA streamlined the referral process, managed a high volume of referrals effectively, and had a short waiting list for waiver services compared to the other programs.

Building on this success, DMH plans to expand SPOA Citywide, through an RFP process for FY 2006. The Citywide SPOA will operate from a centralized location for all boroughs, and assume sponsorship of the Bronx SPOA in a manner that ensures a smooth transition in oversight from OMH to DMH.

GOALS TARGETING SPECIFIC POPULATIONS

DMH GOAL: Improve access to and quality of treatment services for individuals with mental illness and a co-occurring mental hygiene disorder. (A&C)

2006 Goal: Improve the screening and treatment planning for co-occurring mental illness and chemical dependency disorders in adults receiving treatment for either disorder.

Objectives

1. Develop and implement a CQI priority project working with providers to screen and plan treatment for chemical dependency needs of consumers in mental health treatment programs.
2. Develop and implement a CQI priority project working with providers to screen and plan treatment for mental health needs of consumers in chemical dependency outpatient clinics.
3. Offer professional development trainings for mental health and chemical dependency

providers to increase their knowledge and skill level in detecting and treating individuals with co-occurring chemical dependency and mental illness.

Objective 1: Develop and implement a CQI priority project working with providers to screen and plan treatment for chemical dependency needs of consumers in mental health treatment programs.

In FY 2005, 22 mental health treatment programs participated in this Quality IMPACT CQI project, which was designed to screen all newly evaluated adult consumers using the Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD).¹⁸ Consumers who screened positive were further assessed for a chemical dependency disorder. Those who were diagnosed with a chemical dependency disorder were treated either on-site or referred off-site for chemical dependency services. In either case, their progress was monitored in the mental health treatment plan.

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

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

Objective 2: Develop and implement a CQI priority project working with providers to screen and plan treatment for mental health needs of consumers in chemical dependency outpatient clinics.

In FY 2006, DMH will begin to implement this Quality IMPACT CQI project. SAMHSA estimates that 50-70% of patients in chemical dependency treatment programs have a co-occurring mental illness. The 25 providers who are participating in this project in FY 2006 will use a screen that has been validated in chemical dependency settings to help identify and refer for a mental health assessment those consumers who may have a mood, anxiety or psychotic disorder. Once consumers are assessed, providers will provide appropriate services or make referrals for mental health services as needed.

Objective 3: Offer professional development trainings for mental health and chemical dependency providers to increase their knowledge and skill level in detecting and treating individuals with co-occurring chemical dependency and mental illness.

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

¹⁸ Screening tool developed by SAMHSA.

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

2006 Goal: Improve the screening and treatment planning for co-occurring mental illness and mental retardation/developmental disabilities (MR/DD) in children receiving treatment in MR/DD clinics.

Objective

1. Develop and implement a CQI priority project working with providers to screen and monitor mental health needs for children in MR/DD clinics.

This Quality IMPACT project was designed to screen all newly evaluated children (ages 4-18) in MR/DD clinic settings for likely mental health problems and to refer those children who screen positive for further evaluation and treatment, if necessary.

Seven MR/DD clinics participated in this CQI project during FY 2005. Over the nine-month course of this project, 1,192 of the 1,423 newly evaluated children (83%) were screened using the Pediatric Symptom Checklist (PSC)¹⁹ and about half of those screened (56%) were referred for further evaluation.

This project confirmed anecdotal data suggesting that psychiatric evaluations for children with MR/DD are difficult to obtain. Only about half (52%) of the children who were sent for further evaluation had a complete evaluation within 75 days. However, the project also made clear the importance of these evaluations: of those children who had complete evaluations, the majority (82%) was deemed to need mental health services.

The project findings point to a systemic problem that merits attention. DMH needs to better understand the obstacles to obtaining complete mental health evaluations, and to examine the strategies utilized by those clinics that had greater success in accessing evaluations for referred children.

¹⁹ <http://www.dbpeds.org/pdf/psc.pdf>

Based on their experiences this past year, all 7 participating MR/DD programs decided to incorporate this screening and referral project into their regular operations in a manner that meets both consumer and provider needs.

2006 Goal: Increase psychiatric inpatient capacity and acute psychiatric care alternatives for individuals with MR/DD.

Objective

1. Convene a workgroup to assess existing treatment capacity and develop recommendations for creating and implementing effective models.

There is limited information available to assess the need for acute psychiatric services for those with MR/DD and mental illness (MR/DD-MI). Utilization data from a New York State Department of Health study in 1997 indicated that between 2-3% of people admitted to acute psychiatric units in NYC had a diagnosis of MR, representing about 1,000 admissions annually.²⁰ This does not include an unknown number who were in need but unable to access inpatient psychiatric services. Mental health treatment options in NYC geared towards individuals with co-occurring MR/DD-MI are extremely limited, leaving acute care services to the hospitals, which are typically not skilled to work effectively with the MR/DD population.

Objective: Convene a workgroup to assess existing treatment capacity and develop recommendations for creating and implementing effective models.

A workgroup comprised of Federation Borough Council members and DMH staff was established in fall 2004 to address this issue. The workgroup identified two major barriers to providing appropriate psychiatric care to individuals with MR/DD: 1) individuals with MR/DD-MI sometimes present special dispositional issues (i.e., unable to return to their families or community residences) which result in longer lengths of stay, tying up acute care beds and creating a financial disincentive for hospitals to serve them; and 2) specific programming and higher staffing levels are needed to provide the higher level of care required by this population.

The workgroup has developed and is pursuing the following recommendations:

- Develop/expand specialized acute services for the MR/DD-MI population citywide to create a continuum of acute psychiatric care, including: specialized hospital inpatient services; community-based residences; and partial hospital services
- Analyze inpatient data extracted from the SPARCS database to estimate the number of treatment openings needed throughout NYC, which will guide service planning activities
- Develop and provide cross-training for both mental health and MR/DD providers in the identification and referral of individuals with MR/DD-MI

²⁰ Lahrer, S., Greene, E., Browning, C., & Lesser, M. (1999). Do Individuals with Dual Diagnosis Admitted to Acute Psychiatric Hospitals Require More Service and Stay Longer? *Dual Diagnosis and Acute Psychiatric Hospitalization*, 1-8.

DMH GOAL: Expand permanent and affordable housing. (A&C)

Adequate residential services are a top priority for DMH; no one gets better from a mental illness without safe and reliable housing. The need for housing for individuals with mental illness far exceeds the supply, leaving an unacceptably large number of people with psychiatric disabilities homeless or ill-housed. These individuals with housing needs include individuals with SPMI/SED who are:

- Chronically homeless and living in shelters or in the streets
- Discharged from voluntary/HHC (acute care) or state psychiatric hospital stays
- Released from the NYC correctional system or from state prisons
- Living with elderly parents, and will eventually need their own housing
- Homeless parents with dependents
- Youth who will be aging out of the foster care system and will need their own housing as young adults

To meet this need for housing, NYC funds permanent supportive housing as the preferred model. This model, which offers long-term affordable housing with flexible services, has been demonstrated to be cost-effective for individuals with mental illness. A U.S. Department of Health and Human Services study of 896 homeless adults with mental illness provided with supportive housing found a 12-month retention rate of 83.5%, and that participants experienced a decrease in symptoms of schizophrenia and depression.²¹ And local data from the City's NY/NY Housing Program showed an 80% retention rate, with 10% moving on to independent settings, among almost 5,000 homeless individuals with mental illness placed in supportive housing through the Program. Regarding cost, a recent study found that the amount of publicly-funded services (hospital, correctional facilities, shelters, acute psychiatric care) used over the course of a year by homeless people with mental illness in NYC dropped from \$40,449 to \$16,282 after placement in supportive housing (Metraux, Culhane, Hadley, FNMA, 2001).

As of June 30, 2005, a total of 12,779 supportive housing units were operational in NYC, with an additional 818 projected by June 30, 2006. For more details regarding the development of supportive housing beds in NYC, see Appendix E.

One obstacle to developing supportive housing is stigma, as manifest in community opposition to new housing programs for individuals with mental illness. DMH continues to educate the public about supportive housing programs and the consumers they serve, to increase public acceptance of this most essential program type.

2006 Goal: Develop supportive housing for specific high-need groups.

Objectives

1. Issue an RFP for 15-20 supportive housing units to serve families headed by an adult diagnosed with SPMI.

²¹ Making a Difference: Report of the McKinney Research Demonstration Program for Homeless Mentally Ill Adults (1994).

2. Issue an RFP with appropriate service funding, to develop 48 housing units for young adults ages 18-24 diagnosed with mental illness or serious emotional disturbance.
3. In collaboration with the Department of Corrections (DOC) and the Department of Homeless Services (DHS), pilot a discharge planning and supportive housing program for adults with serious mental illness who are chronic users of both the jail and shelter systems.

Objective 1: Issue an RFP for 15-20 supportive housing units to serve families headed by an adult diagnosed with SPMI.

DMH is dedicating funding to supportive housing for families headed by an adult with a diagnosed severe and persistent mental illness, a significantly underserved population. By partnering with DHS and the Administration for Children's Services (ACS) to create a blended funding stream, DMH plans to release an RFP at the end of the year that will fund a number of much needed family units. Estimated operating and service costs total approximately \$23,000 per family unit.

Objective 2: Issue an RFP with appropriate service funding, to develop 48 housing units for young adults ages 18-24 diagnosed with mental illness or serious emotional disturbance.

A serious service gap has existed for many years in the mental health system for young adults ages 18-24 who age out of the children's mental health or residential foster care system into the adult mental health system. DMH will be issuing an RFP for supportive housing for young adults ages 18-24 with SED or SPMI later this year at an annual per unit rate of approximately \$20,000. This is a more appropriate funding level compared to what was available in the past (specifically, one program with an annual per unit rate of \$12,500 failed to provide appropriate services). This pilot program will be a step forward in addressing the housing needs of young adults with psychiatric disabilities.

Objective 3: In collaboration with the Department of Corrections (DOC) and DHS, pilot a discharge planning and supportive housing program for adults with serious mental illness who are chronic users of both the jail and shelter systems.

In conjunction with DOC and DHS, DMH is designing a pilot program called Frequent User Services Enhancement (FUSE), which involves discharge planning and supportive housing aimed at breaking the cycle of incarceration and homelessness among the most chronic users of the jail and shelter systems. The implementation of FUSE would begin to address the need for housing for individuals with SPMI who are discharged from the correctional system.

The goal is to provide enhanced services in permanent supportive housing to individuals who have had at least four total stays in both the shelter and jail systems. The enhanced services will taper off as the consumer becomes more stable. Specifically, \$6,500 per housing unit would fund enhanced staff in mixed-tenancy supportive housing buildings to complement the per unit rate of \$13,500 that DMH currently provides for mental health and operational services, for a total of \$20,000 per unit.

The cost savings realized from the FUSE pilot will be tracked through an internal interagency group comprised of DMH, DHS, DOC and the Corporation for Supportive Housing. Outcomes to be tracked include those related to recidivism rates for both shelter use and jail time.

DMH GOAL: Reduce chronic street homelessness of adults with SPMI by two-thirds by 2009. (A)

2006 Goal: Develop existing and design new housing and outreach models for the street homeless population.

Objectives

1. Sign the “Supportive Housing Opportunities Partnership” between NYS and NYC for the development of housing for the chronically homeless or at-risk adults.
2. Strategize with DHS in designing and investigating new models to provide flexible housing options for the street homeless.
3. Improve homeless outreach and drop-in services citywide to achieve the goal of more housing placements for the chronic street homeless.

DMH is aware that not all individuals who are homeless are ready for or need permanent housing. Therefore, it is working on identifying flexible models for providing housing services that will meet the needs of individuals who are not ready for or do not need supportive housing as well as expanding supportive housing for those who are.

Objective 1: Sign the “Supportive Housing Opportunities Partnership” between NYS and NYC for the development of housing for the chronically homeless or at-risk adults.

As part of Mayor Bloomberg’s plan to end chronic homelessness, DMH has been working in collaboration with other City agencies on a proposal to create a new partnership with the State that would create 9,000 units of supportive housing for populations that have special housing needs. The implementation of this agreement with the State will have a significant impact on meeting the housing needs of homeless and at-risk adults with SPMI, as well as homeless or at-risk families with a parent with a mental illness.

Objective 2: Strategize with DHS in designing and investigating new models to provide flexible housing options for the street homeless.

DMH has been working with DHS to design new housing models for the street homeless population, including permanent and transitional housing programs with a low threshold/ progressive demand approach. This approach is flexible and individualized and creates an environment where individuals are accepted at their own level of recovery, and where housing is not lost because of relapse. These innovative models would be targeted to those who are homeless and have a mental illness and/or a chemical dependency history.

Objective 3: Improve homeless outreach and drop-in services citywide to achieve the goal of more housing placements for the chronic street homeless.

DMH and DHS, along with a group of not-for-profit, private, Federal, State and consumer stakeholders, have been working to reconfigure homeless outreach and drop-in services citywide to achieve the goal of more housing placements for the chronic street homeless population. The goal is to change the way providers reach out to people living chronically on the streets. This work includes expanding the capacity of drop-in centers, and creating an accessible citywide database in order to better coordinate service provision for homeless individuals living on the street.

DMH GOAL: Increase the prevalence of treated depression by 10% by 2008. (A)

In any given year, 9% of the population or about 18.8 million American adults, suffer from depressive illness.²² Depression in workers in the United States costs employers an estimated \$44 billion per year and results in loss of productivity, functional decline, and increased mortality.²³ It is well known that untreated depression causes distress, disability, and most tragically, suicide.²⁴ In addition, depression is often co-morbid with physical illnesses and results in increased somatic symptoms, functional disability, increased morbidity, poor self-care, decreased adherence to treatment regimens, and increased healthcare utilization and costs.

Depression and Medical Co-morbidities²⁵

<u>Illness</u>	<u>Prevalence</u>
Coronary artery disease	18%
Myocardial infarction*	16%
Cancer	20-25%
Diabetes	25%
HIV	36%
Alzheimer’s disease	17-31%
Migraine headaches	22-32%
Multiple Sclerosis	Up to 50%

*Note: At 6-months post-myocardial infarction

Even so, most people with a depressive illness do not seek treatment, although depression is treatable.²⁶ In NYC each year there are an estimated 400,000 adults with depression, which has

²² Robins L.N., & Regier D.A. (1990). *Psychiatric Disorders in America, The Epidemiologic Catchment Area Study*. New York: The Free Press.

²³ Whooley, M.W. & Simon G.S., (2000). Managing Depression in Medical Outpatients. *New England Journal of Medicine* (343):1942-1950.

²⁴ The President’s New Freedom Commission on Mental Health. (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*.

²⁵ Swift, R.G. Diagnosis and Treatment of Depression in the Primary Care Setting from Depression Screening in Primary Care Setting Break-Out Session at the Health and Hospitals Corporation Conference: Meeting the Challenge: Mental Health and Chemical Dependency Service Delivery, June 29, 2004.

²⁶ National Institute of Mental Health (June 30, 2005). www.nimh.nih.gov/publicat/depression

not been accurately diagnosed or treated.²⁷ Depression is more commonly seen in primary care settings than any other condition except hypertension, and primary care physicians and other non-psychiatrists can effectively screen for and manage depression.²⁸ Depression presents a large disease burden in New York, but is very amenable to coordinated action between City agencies, health care providers and individuals. For these reasons, DMH has decided to initiate and support depression screening in the primary care setting.

2006 Goal: Promote screening and quantitative disease management of depression for adults in primary care and other settings using the Patient Health Questionnaire (PHQ-9).

Objectives

1. Implement depression screening and management in HHC primary care practices over the next three years.
2. Expand the depression screening and management initiative to voluntary private hospitals, Federally Qualified Health Centers (FQHCs) and local university health centers.
3. Implement a depression/alcohol screening web- and telephone-based tool for the workforce.
4. Implement depression screening initiatives targeted to the elderly population in the Bronx.
5. Develop and implement a public education campaign to educate primary care providers and the public about depression screening and management and to destigmatize depression and its treatment.

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

Objective 1: Implement depression screening and management in HHC primary care practices over the next three years.

In conjunction with HHC, DMH is promoting the use of an instrument called the Patient Health Questionnaire (PHQ-9), which gives primary care physicians a simple, low-burden tool to assess and track patient progress with respect to symptoms of depression. This tool enables physicians to better identify undetected depressive illness, and treat it or refer to specialty care if necessary. The PHQ-9 provides a score or number that measures the severity of depression much like there is a number for blood pressure and lipid levels, thereby demystifying depression measurement and treatment by primary care physicians, and ensuring accountability through reporting of screening and treatment results.

Objective 2: Expand the depression screening and management initiative to voluntary private hospitals, Federally Qualified Health Centers (FQHCs) and local university health centers.

²⁷ Santora, M. & Benedict, C. (2005). Depressed? New York Screens for People at Risk. *The New York Times* A16, April 13, 2005.

²⁸ Sederer L.I. & Kolodny A.J. (2004). Detecting and Treating Depression in Adults. *City Health Information* 23(1):18.

Over the next 2 years, DMH anticipates that 2-4 hospitals per year will establish depression screening and management in their facilities, and will reach out to approximately 22 FQHCs to encourage their participation. Additionally, DMH plans to meet with local universities to develop a plan to implement depression screening and management in student health centers. Nearly 16% of college women and 10% of college men report having been diagnosed with depression.²⁹

Objective 3: Implement a depression/alcohol screening web- and telephone-based tool for the workforce.

In collaboration with the Department's Bureau of Health Promotion and Disease Prevention, DMH is scheduled to implement depression and alcohol screening for DOHMH employees in October 2005. Employees will have access to the anonymous Screening for Mental Health (SMH) web- and telephone-based interactive screening tool, which will provide screening results and referral information, as needed.

Additionally, approximately 10 business sites are participating in a 3-year multi-phase Centers for Disease Control initiative to promote mental health in the workplace. An estimated 12,000-30,000 employees will be reached through this initiative, for which DMH has developed a mental health module to be used by the Department's Wellness at Work program, a project of the Department's Bureau of Health Promotion and Disease Prevention.

Objective 4: Implement depression screening initiatives targeted to the elderly population in the Bronx.

Severe depression impairs elderly patients' lives more than serious medical illnesses.³⁰ DMH, the Department for the Aging (DFTA) and MHA have joined together to address the mental health of older New Yorkers. The initiative will screen seniors in Bronx Community Districts one through six who attend DFTA senior centers and homebound seniors served by the Project SOS case management program. Seniors will be screened using the PHQ-9. Those who screen positive will be referred to their primary care provider or a mental health specialist for further evaluation and treatment. Primary care practitioners and mental health providers in these Bronx neighborhoods are being contacted about this initiative and will be provided with information to assist with the evaluation and treatment of seniors referred to their practice. This public/private initiative aims to increase early identification of depression and enable seniors to be referred to and treated in primary care.

Objective 5: Develop and implement a public education campaign to educate primary care providers and the public about depression screening and management, and to destigmatize depression and its treatment.

²⁹ American College Health Association, 2001.

³⁰ Hopkins Tanne, J. (2004). Depression affects elderly people's lives more than physical illnesses. *British Medical Journal* (329):1307.

The goal of this public education campaign is twofold, to: 1) increase the number of primary care settings that provide depression screening and management; and 2) increase the number of individuals who seek depression screening and management from their primary care doctors. To accomplish this, DMH is planning a Depression Public Health Detailing campaign starting January 2006, where a depression kit will be distributed to primary care providers in voluntary hospitals and FQHCs, and an informational packet will be distributed to consumers. DMH will also continue to promote depression awareness and screening at health fairs and health screening events held throughout NYC. Finally, DMH is developing a public education anti-stigma campaign that will include information about depression and will encourage the public to ask their primary care doctors for depression screening.

DMH GOAL: Improve access to and engagement in treatment and related services for high-utilizers of Medicaid-funded mental health services who have poor outcomes. (A)

2006 Goal: Create a pilot program for high utilizers which will provide psychiatric, medical, and case management services, coupled with supportive housing.

Objective

1. Design and launch a pilot program for high utilizers of Medicaid mental health services.

New York State spent approximately \$32 billion (NYC \$21 billion) in 2003 on Medicaid expenses, the second largest budget item after education. A recent study³¹ reported that 20% of Medicaid patients represented between 70-80% of expenditures.³² This study reported on those individuals in the high-cost category who were disabled adults, ages 18-64, whose Medicaid costs ranged from \$105,000 to \$137,000 per year. Notably, 3% of individuals with schizophrenia used 20% or \$142 million of all Medicaid expenditures on schizophrenia and 3% of individuals with chemical dependency disorders used 28% or \$106 million of all Medicaid expenditures on chemical dependency.

These high utilizers of Medicaid services are individuals who are not effectively engaged by the service system, and use costly services with poor outcomes. These individuals experience repeated episodes of acute psychiatric and medical illness and social crisis, and frequently lack housing and consistent medical and psychiatric care.

Objective: Design and launch a pilot program for high utilizers of Medicaid-funded mental health services.

DMH is collaborating with OMH to develop this pilot program. It will focus on servicing 200 persons with SPMI or individuals with mental illness and chemical dependency disorders,

³¹ Billings, J. (2004). High Cost Medicaid Patients: An Analysis of NYC Medicaid High Cost Patients. The Robert F. Wagner School for Public Service and the United Hospital Fund.

³² Note: These costs calculated inpatient (medical and psychiatric), outpatient, pharmaceutical and Administration for Children (ACS) costs but did not include Department of Homeless Services (DHS), Department of Corrections (DOC), uncompensated Health and Hospitals Corporation (HHC), New York Police Department (NYPD) and Department of Education (DOE) services or costs. Thus the true cost of care and public expenditures for these individuals is even higher.

starting with one ACT Team in the Bronx and then adding on two additional teams. The service model proposed for this project will be composed of three essential elements:

- 1) An ACT Team and less intensive case management services operated by a community-based provider
- 2) Scatter-site apartments secured by a housing provider (with a policy of low threshold/progressive demand housing)
- 3) Psychiatric and primary medical care provided by community-based organizations

Our hypotheses are that as a result of the pilot program, the 200-consumer population will demonstrate:

- 1) Clinical stability (as evidenced by significant reductions in inpatient medical hospital services, inpatient psychiatric hospital services, episodes of emergency department utilization, episodes of incarceration, episodes of shelter stay) as compared to a population of high users not enrolled in this pilot project
- 2) Consumer satisfaction with housing and mental health services
- 3) Retention in housing when compared to high users not enrolled in the pilot project
- 4) A net reduction in the annual average consumer costs based on the two prior years of Medicaid mental health expenditures for the enrolled consumers

DMH GOAL: Provide for the continued mental health needs of individuals highly impacted by the World Trade Center disaster. (A&C)

Project Liberty, the Federal Emergency Management Agency (FEMA)-funded crisis counseling program implemented in response to the World Trade Center terrorist attacks of September 11, 2001, was the largest public mental health program in history. During the period of September 11, 2001 through December 31, 2004, the \$125 million FEMA-funded grant program provided a total of 860,821 counseling and education sessions to 1,492,107 individuals (See Appendix F for additional data on Project Liberty).

Project Liberty provided targeted outreach to populations at risk of psychological sequelae due to their exposure to trauma associated with the 9/11 attacks. Populations that received the largest volume of counseling sessions included school children, individuals with pre-existing trauma and displaced employees.

Although Project Liberty-funded services have been phased out, a continuing need has been identified for counseling services among NYC uniformed workers, particularly police officers and firefighters, and their families.

2006 Goal: Secure funding to continue post-9/11 mental health services to police officers and firefighters, and their families.

Objective

1. Estimate the continuing mental health services needs of police officers and firefighters, and their families, and the associated cost.

Firefighters and police officers had an unprecedented amount of exposure to trauma-triggering events following the terrorist attacks of 9/11. Many witnessed the fall of the towers and were in physical jeopardy; have relatives, co-workers or both who were killed or injured (343 firefighters and 23 police officers died); or participated in the dangerous, prolonged and agonizing rescue and recovery operation (which lasted 37 weeks and involved at least 11,000 firefighters). This exposure, coupled with their ongoing, critical role in the City's heightened emergency preparedness activities and their ongoing exposure to trauma-triggering events inherent in their routine job responsibilities, puts firefighters and police officers, and their families, at particularly high risk for mental health and chemical dependency disorders relating to 9/11.

The experience of both the FDNY and the NYPD is that many firefighters and police officers and their families demonstrate a continued need for mental health services. As of mid-2004, almost 3 years after the World Trade Center attack, an average of 179 new firefighter contacts were being made each month for counseling. This suggests that it takes several years for some of those suffering from psychological sequelae to access services for the first time.

DMH will fund a consultant to estimate the long-term need (from July 2006 through June 2011) for interventions for post-disaster mental health and chemical dependency problems among NYC firefighters and police officers, and their families. This information will be used to develop and seek funding for a longer-term service plan for this population.

DMH GOAL: Address the mental health needs of war returnees. (A&C)

2006 Goal: Collaborate with the Department of Veterans Affairs (VA) and other agencies to assist the VA in formulating a *War Returnee Initiative* to meet the mental health needs of war returnees and their families.

Objective

1. Collaborate with the VA and other agencies to facilitate the mental health and chemical dependency treatment of war returnees and their families through interventions in public education, information and referral, and detection and engagement.

As we enter the fourth year of deployment of U.S. military personnel to Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) in Iraq, we have identified the mental health treatment needs of war returnees and their families as a significant public health concern. Based on epidemiological modeling, an estimated 5,800 military service personnel (enlisted military, National Guard and Reservists) will return from deployment to NYC from April 2002 to December 2008. Together with an estimated 13,618 family members, there is an estimated total of 19,148 military personnel and their families who are at higher risk for mental health disorders, due to their exposure to these wars.

Post traumatic stress disorder (PTSD) is the most studied mental health consequence of exposure to combat. Previous studies have found current PTSD prevalence rates among Vietnam veterans to be 15% among males and 8% among females, with higher lifetime prevalence rates of 30% and 25% respectively. The wars in Afghanistan and Iraq have distinct characteristics that may

increase the mental health burden to military personnel, including: the chaotic, urban environments with strong insurgencies; the greater proportions of deployed military personnel that are involved in combat; and the greater frequency with which they are facing combat situations.

Preliminary studies have documented higher rates of psychological distress among military personnel returning from Iraq than from other wars. A study published in July 2004 reported that among soldiers and Marines surveyed after returning from deployment in Iraq, one in six met the screening criteria for major depression, generalized anxiety disorder or PTSD.³³ Because those who were discharged early due to injuries were not included in this study, the authors contended that this figure might be an underestimate of the true burden. Corroborating these numbers is the July 2005 testimony of Army Colonel Charles Hoge, Chief of Psychiatry and Behavior Services at the Walter Reed Army Institute of Research who reports that 19 to 21% of returning troops meet the criteria for PTSD, depression or anxiety.³⁴

Due to various eligibility restrictions on treatment through the VA system, reluctance by war returnees to access mental health services through the military health care system, limitations in the services provided within the VA system for dependent family members, and lack of eligibility for non-dependent family members (e.g., parents, siblings), the public mental health system is an important source of mental health treatment for war returnees and their families.

Objective: Collaborate with the VA and other agencies to facilitate the mental health and chemical dependency treatment of war returnees and their families through interventions in public education, information and referral, and detection and engagement.

DMH is engaged in collaborative planning with the VA, along with OMH, the National Center for Post-Traumatic Stress, and various agencies that provide services to veterans. Planned activities include:

- Assisting the VA in their efforts to identify and make contact with veterans (and their families) in order to conduct an early assessment of their mental health needs and engage them in treatment
- Compiling a list of services that the VA provides to assist in determining gaps; service areas will include housing, family counseling, information and referral, and employment training and assistance
- Developing a public education and information campaign designed to educate war returnees and their families about PTSD and available mental health services

DMH GOAL: Expand and upgrade services for children, adolescents, young adults and their families, using best practices as service models where available. (C)

2006 Goal: Target specific populations for service expansion.

³³ Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I. & Koffman, R.L. (2004). Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care. *New England Journal of Medicine*, 35(1).

³⁴ Miles, D. Officials Report Progress, Challenges in Treating Combat Stress. Defenselink website July 28, 2005.

Objectives

1. Fund an early childhood mental health program to provide outreach, consultation, family-focused assessment and treatment services for parents and children under age 5.
2. Create new and expand existing crisis intervention services that will keep children out of the hospital.
3. Fund additional programs and expand existing programs to provide school-based services.
4. Fund additional programs to expand the capacity of services for young adults (ages 16-23).
5. Collaborate with ACS to identify and seek funding to address the need for mental health services for children in foster care.

Objective 1: Fund an early childhood mental health program to provide outreach, consultation, family-focused assessment and treatment services for parents and children under age 5.

National studies report rates of prevalence of emotional disorders in children under age 5 as high as 21%.³⁵ In 2004, the NYC Early Childhood Mental Health Strategic Work Group, an advisory group to DMH, prepared a report which described a crisis of insufficient capacity of services for children under the age of 5, due to the following: 1) the lack of a dedicated service structure in place, and no public monies specifically allocated for early childhood mental health; 2) the inability of the current service structure to address infants', toddlers' and preschoolers' social/emotional needs; and 3) workforce issues, including the lack of trained professional staff.

DMH will issue an RFP for one innovative early childhood mental health program for children under 5 years of age in a high-need neighborhood.

Objective 2: Create new and expand existing crisis intervention services that will keep children out of the hospital.

Research indicates that children who receive community-based treatment have better outcomes at a lower cost than those who are treated in an inpatient setting.³⁶ The Home-Based Crisis Intervention (HBCI) program model was designed to provide children in crisis with the community-based services they need in order to keep them out of the hospital. From 2002-2004, three hospital-based HBCI programs served a total of 298 high-acuity children and adolescents who were at significant risk of psychiatric hospitalization. Because of the intervention, 91% of those served were diverted from the inpatient setting and were able to receive needed services in the community.

In FY 2006 DMH will release an RFP for additional home-based crisis intervention services, which will allow for up to three months of intervention and stabilization (HBCI currently works with families for only six weeks). These services will be provided over three months because analysis of HBCI has shown that some families require services for more than six weeks in order to stabilize and transition to less intensive services.

³⁵ The New York City Early Childhood Mental Health Strategic Workgroup (2004). Promoting the Mental Health and Healthy Development of New York's Infants, Toddlers, and Preschoolers: A Call to Action, Executive Summary.

³⁶ Department of Health and Human Services in collaboration with the Department of Education and the Department of Justice (1999). Report of the Surgeon General's Conference on Children's Mental Health: A National Agenda.

Objective 3: Fund additional programs and expand existing programs to provide school-based services.

School-based mental health programs play a vital role in addressing behavioral and emotional difficulties that threaten to interfere with a child's ability to perform academically.³⁷ When services are provided through schools, mental health professionals can work with parents and teachers and at the same time help children perform better academically. Despite a great need for children's mental health services, there are often high no-show rates at clinics due to a variety of access issues. Providing services in a school setting has been shown to be an effective way to address some of the access issues for children and their families.

DMH currently funds 19 agencies that provide school-based mental health programs, which serve a total of 1,500 students in 73 of the 1,524 schools³⁸ in NYC, leaving a large unmet need.³⁹ DMH will issue an RFP for the expansion of school-based mental health services in high needs areas in NYC.

Objective 4: Fund additional programs to expand the capacity of services for young adults (ages 16-23).

Young adults with SED have a challenging time transitioning into adulthood and adopting adult roles and responsibilities.⁴⁰ They experience the poorest outcomes compared to their peers living with all other types of disabilities, showing very high rates of poor social skills, school dropout, arrests, and probation involvement.^{41,42}

DMH currently runs six programs for adolescent skills development for youth with SED (ages 16-21). Over the next year additional services will be added that will help young adults (ages 16-23) develop employment and life skills, maintain mental health well being, live independently within the community, have access to appropriate supports and services, and effectively address the barriers and unique needs youth with SED face during the transition process to adulthood.

Objective 5: Collaborate with ACS to identify and seek funding to address the need for mental health services for children in foster care.

³⁷ The On-Site School Based Mental Health Steering Committee (May 2005). Preserving School-Based Mental Health Programs: Critical Resources in Promoting Educational Achievement in New York City Public Schools, Executive Summary.

³⁸ Includes pre-school, non-public schools, hospital schools, and community-based pre-k. Excludes charter schools (<http://www.nycenet.edu/offices/stats/default.htm>).

³⁹ The On-Site School Based Mental Health Steering Committee (May 2005). Preserving School-Based Mental Health Programs: Critical Resources in Promoting Educational Achievement in New York City Public Schools, Executive Summary.

⁴⁰ Clark H.B. & Davis M. (2000). *Transition to Adulthood, A resource for assisting young people with emotional or behavioral difficulties*. Baltimore, Maryland: Paul H. Brookes, Company.

⁴¹ Wagner M., Newman L., Cameto R., Garza N. & Levine P. (2005). After high school: A first look at the post school experiences of youth with disabilities. A report from the National Longitudinal Transition Study-2 (NLTS2). Menlo Park, CA: SRI International.

⁴² Advocates for Children of New York (June 2005). Leaving School Empty Handed: A report on graduation and dropout rates for students who receive special education services in New York City.

ACS data for 2005 indicates that there are 22,196 children in foster care. Prevalence estimates of SED in children in foster care range from 23% to 70%.^{43,44} Upon entering foster care, children often present with significant unmet health and mental health needs resulting from prior abuse, neglect or the trauma of being removed from their families.⁴⁵ DMH will work closely with ACS to create a plan that targets specific age groups, points of intervention, and best practices in a joint effort to address the mental health needs of children in foster care.

2006 Goal: Restructure family support services to be more family-driven, evidence-based and integrated with CCSI.

Objective

1. Convene meetings with parent advocates and OMH to guide an effective, sustainable family support service system

The 39 family support service programs funded by DMH need to be improved to better assist parents in advocating for services for their children. These programs are directed at families in which there is a child or adolescent with SED, and include: family support groups, and advocacy, respite, after school, summer, and family recreation programs. Currently, family support services are not coordinated with treatment services or with the five borough-based parent resources centers, leading to fragmentation in how families receive support services and uneven service quality.

The objective of the meetings with parent advocates is to define the roles and responsibilities of parent advocates, youth advocates, and program directors within family support programs. Additionally, the mission of family support will be clarified and will guide the restructuring of current programs. This planning work will culminate in the release of an RFP that will seek to reconfigure family support services.

VIII. WORKFORCE ISSUES

Workforce issues are a major concern voiced by NYC stakeholders. In general, stakeholders noted that there is a lack of qualified/certified staff. This is consistent with the finding of the *Children's Needs Assessment in the Bronx* that 74% of children's clinics in the Bronx identified staff recruitment and retention among the top five challenges they face.⁴⁶ Psychiatrists (especially those specializing in children and geriatric populations) and nurses were noted as being in high demand, and stakeholders expressed a need to recruit other types of clinicians in lieu of psychiatrists. Stakeholders commented that a major barrier to hiring and retaining qualified staff is a lack of funding to offer competitive salaries.

⁴³ Leslie L.K., Hurlburt M.S., Landsverk J., Barth R. & Slymen D.J. (2004). Outpatient Mental Health Services for Children in Foster Care: A National Perspective. *Child Abuse Neglect* 28(6): 699-714.

⁴⁴ Citizen's Committee for Children of New York Inc. (February 2005). Checking-up on Children in New York City Foster Care: Does the Medicaid Per Diem Rate Ensure Access to Care? p. 11.

⁴⁵ *ibid*

⁴⁶ Engstrom, M., Lee, R., Ross, R., Harrison, M., McVeigh, K., Josephson, L., Plapinger, J., Herman, D., King, C., & Sederer, L. (2003). *Children's Needs Assessment in the Bronx*. New York: New York City Department of Health and Mental Hygiene, Division of Mental Hygiene, Bureau of Planning Evaluation and Quality Improvement.

Stakeholders also noted that many staff of mental health programs lack knowledge of and skills in mental health best practices; specifically, relating to cultural competence and recovery-oriented services. Additionally, consumer stakeholders noted that peer positions are limited in NYC, and many that exist are not optimally utilized. They spoke of the importance of peer mentors and training of peer staff, as well as training for professional staff regarding how to work effectively and respectfully with peer colleagues.

DMH is currently committed to several workforce training activities, most notably:

- Promoting the training of minority paraprofessionals working in the City's mental health system through continued funding of the Hunter School of Social Work MSW scholarship program
- Training provider staff (through Quality IMPACT and with MICA training funds) in culturally competent practices and the detection and treatment of individuals with co-occurring mental illness and chemical dependency

Endnotes

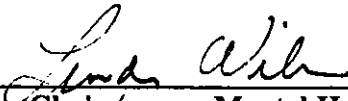
SED: Children and adolescents with serious emotional disturbances are defined as individuals under eighteen years of age who meet criteria established by the commissioner of mental health, which shall include children and adolescents who are in psychiatric crisis, or children and adolescents who have a designated diagnosis of mental illness under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and whose severity and duration of mental illness results in substantial functional disability. (Source: Mental Hygiene Law Sections 1.03(52) and 1.03(53))

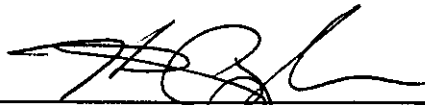
SMI: Persons with serious mental illness are defined as individuals who meet criteria established by the commissioner of mental health, which shall include persons who are in psychiatric crisis, or persons who have a designated diagnosis of mental illness under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and whose severity and duration of mental illness results in substantial functional disability. Persons with serious mental illness shall include children and adolescents with serious emotional disturbances. (Source: Mental Hygiene Law Sections 1.03(52) and 1.03(53))

SPMI: The following criteria for adults with serious and persistent mental illness (SPMI) were developed by OMH in 1987 and have not been superseded. To be considered an adult diagnosed with SPMI an individual must have (over the last 12 months): 1) a designated mental illness diagnosis, 2) current Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) enrollment due to mental illness, 3) extended impairment in functioning due to mental illness (marked by difficulties in self-care, restriction of activities of daily living, difficulties in maintaining social functioning, frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home or school settings or the individual has met criteria for ratings of 50 or less on the Global Assessment of Functioning Scale (Axis V of DSM-IV) due to a designated mental illness over the past twelve months on a continuous or intermittent basis), and 4) reliance on psychiatric treatment rehabilitation and supports.

IX. COUNTY GOVERNMENT ASSURANCES

We certify that the Plan for Mental Health Services, which includes information on programs and services, has been submitted to the Community Services Board, and that the Mental Health Subcommittee of the Board has been authorized to evaluate the Plan for its consistency with the needs of persons with serious mental illness including children and adolescents with serious emotional disturbances.

Date: 9/24/05 (x) 
Chairperson, Mental Health Subcommittee

Date: 9/14/05 (x) 
Chairperson, Community Services Board

Date: 9/14/05 (x) 
Director/Commissioner

Appendix A: Prevalence Tables

Table I. Estimated Twelve-Month Prevalence and Severity of Psychiatric Disorders in NYC Adults (18+), 2000.

Disorder	Estimated Affected Population (%)	Severity		
		Serious	Moderate	Mild
Any Disorder	1,590,000 (26.2)	712,000	469,000	409,000
Any Anxiety Disorder	1,098,000 (18.1)	250,000	370,000	478,000
Panic Disorder	164,000 (2.7)	73,000	48,000	42,000
Agoraphobia without Panic	49,000 (0.8)	20,000	15,000	14,000
Specific Phobia	528,000 (8.7)	16,000	158,000	254,000
Social Phobia	413,000 (6.8)	123,000	160,000	129,000
Generalized Anxiety Disorder	188,000 (3.1)	61,000	84,000	44,000
Posttraumatic Stress Disorder	212,000 (3.5)	78,000	70,000	64,000
Obsessive-Compulsive Disorder	61,000 (1.0)	31,000	21,000	9,000
Separation Anxiety Disorder	55,000 (0.9)	24,000	14,000	17,000
Any Mood Disorder	576,000 (9.5)	260,000	231,000	87,000
Major Depressive Disorder	407,000 (6.7)	124,000	204,000	79,000
Dysthymia	91,000 (1.5)	45,000	29,000	17,000
Bipolar I-II Disorders	158,000 (2.6)	131,000	27,000	0
Any Impulse Control Disorder	540,000 (8.9)	178,000	283,000	80,000
Oppositional-Defiant Disorder	61,000 (1.0)	30,000	25,000	6,000
Conduct Disorder	61,000 (1.0)	25,000	19,000	17,000
Attention-Deficit/Hyperactivity Disorder	249,000 (4.1)	103,000	88,000	59,000
Intermittent Explosive Disorder	158,000 (2.6)	38,000	117,000	3,000

Source: Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, K., Walters, (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 593-602.

Notes: 1. Rates do not include homeless, institutionalized or non-English-speaking adults.

2. Estimates of affected populations are based on 2000 census data for NYC, but are not adjusted for sex or age.

**Table II. Estimated Twelve-Month Prevalence of Psychiatric Disorders
in NYC Adults (18+), 2000.**

Disorder	Estimated Affected Population (%)
Schizophrenia	67,000 (1.1)
Nonaffective Psychosis	12,000 (.2)
Somatization	12,000 (.2)
Antisocial Personality Disorder	91,000 (1.5)
Anorexia Nervosa	6,000 (.1)
Severe Cognitive Impairment	164,000 (2.7)

Source: U.S. Department of Health and Human Services (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Health.

Notes: 1. Rates do not include homeless or institutionalized adults.

2. Estimates of affected populations are based on 2000 census data for NYC, but are not adjusted for sex or age.

**Table III. Estimated Six-Month Prevalence of Psychiatric Disorders
in NYC Youth Ages 9-17, 2000.**

Disorder	Estimated Affected Population (%)
Any Disorder	199,000 (20.9)
Any Anxiety Disorder	124,000 (13.0)
Simple Phobia	25,000 (2.6)
Social Phobia	51,000 (5.4)
Agoraphobia	31,000 (3.3)
Separation Anxiety	37,000 (3.9)
Overanxious	54,000 (5.7)
Any Depression	59,000 (6.2)
Major Depressive Disorder	47,000 (4.9)
Any Disruptive Behavior Disorder	98,000 (10.3)
ADHD	39,000 (4.1)
Oppositional Defiant Disorder	59,000 (6.2)
Conduct Disorder	35,000 (3.7)

Source: Shaffer, D., Fisher, P., Dulcan, M.K., Davies, M., Piacentini, J., Schwab-Stone, M., et al. (1996). The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and performance in the Methods for the Epidemiology of Child and Adolescent Mental Disorders Study (MECA). *Journal of the American Academy of Child and Adolescent Psychiatry*, 25, 865-877.

Notes: 1. Estimates of the affected population are based on 2000 U.S. Census data for NYC.

2. Individuals may have more than one disorder; therefore, the sum of the estimate of the affected populations within subgroups may exceed totals.

Appendix B: System Capacity

New York City Service System Capacity Table

Program Type	Number of Programs	Number of Programs by Population Served			Total Capacity in Number of Slots or Beds
		Adult	Child	Both Adult & Child	
State Psychiatric Center Inpatient	10	6	3	1	
Emergency Unit Clinic Treatment	12			12	
Day Treatment Program ²	35		35		1,735
On-Site Rehabilitation Program	15	15			1,448
Sheltered & Satellite Sheltered Workshop	10	10			
Transitional Employment	7	6	1		
Pre-Admission Screening	6	1	1	4	
Prepaid MH Program	11	7	4		
Respite Care, Free Standing	6	6			255
Alternative Crisis Support	2			2	
Transportation	4	1		3	
Mobile Treatment Team/Crisis Outreach	24	23	1		
Outreach	41	40	1		
Non-Inpatient Crisis Services	5		1	4	
Psychosocial Club	38	38			7,327
Assertive Community Treatment	32	31	1		2,110
Case Management	23	12	1	10	4,057
Blended Case Management	84	61	23		12,656
Crisis Residence	2	2			
Special Demo/Other	12	1	1	10	
Permanent Housing (PHP)	1	1			
Residential Treatment Facility	3		3		125
Comprehensive Psychiatric Emergency	11	4	1	6	
Continuing Day Treatment	77	77			6,580
Vocational Services - Children & Family	6		6		547
Enclave in Industry	4	4			130
Assisted Competitive Employment	27	27			1,665
Single Point of Access	2	1	1		
School Based Initiative	18		18		
Crisis Outreach	9			9	657
Drop In Centers	15	15			
Neighborhood Care Team	3	2		1	
Bridger Program/Transition Mgmt Services	6	6			658
Hospital for Mentally Ill	2	1		1	257
Transient Housing	3	3			
Clinic Treatment ³	257	83	44	130	
Partial Hospital	13	12	1		307
HCBS Waiver Services	6		6		

New York City Service System Capacity Table (continued)

Program Type	Number of Programs	Number of Programs by Population Served			Total Capacity in Number of Slots or Beds
		Adult	Child	Both Adult & Child	
Intensive Psychiatric Rehabilitation Trtmnt	13	11	1	1	477
Affirmative Business/Industry	4	4			93
Self-Help Programs	16	15	1		
Coordinated Children's Service Initiative	1		1		340
General Hospital	52	42	3	7	3,153
Home Based Crisis Intervention	11		11		595
Transitional Care	5	5			
Crisis Intervention	4	1	1	2	
Client/Worker Program	1	1			33
Ongoing Integrated Supprted Emplymnt	15	14	1		
Social Adult Day Care	1	1			55
Supported/Single Room Occupancy	19	19			929
Supported Education	1	1		1	
MICA Network	8	8			
Supported Housing	125	125			4,548
Congregate Care	89	89			2,304
Mobile Mental Health Team	2		2		
C & Y Community Residence	5		5		38
Apartment/Treatment	59	59			1,788

¹Capacity is given where available.

²Additional locations on-site in schools in 4 programs.

³Additional locations on-site in schools in 150 programs.

Source: New York State Office of Mental Health ConCerts database, May 2005 and NYC Department of Health and Mental Hygiene OMIS database. Selected modifications in ConCerts made by NYC DOHMH on age groups served.

Note: A "best estimate" was derived based on guidance from OMH and DMH staff for data discrepancies between the ConCerts and OMIS databases. Therefore, the data provided in this table may be inconsistent with data from other sources.

Appendix C: Utilization Tables

Table I. Number of NYC Residents with Co-occurring Mental Hygiene Disorders Served in NYC Mental Health Facilities During a Survey Week, 2003

Co-Occurring Disorders	Numbers of Consumers Served (% of all Consumers)	
	0-17	18 and Older
All Consumers	15,524	69,529
Mental Illness and Chemical Dependency	300 (2.0)	14,290 (20.6)
Mental Illness and Mental Retardation/Developmental Disability	1,255 (8.1)	1,879 (2.7)
Mental Illness, Chemical Dependency and Mental Retardation/Developmental Disability	20 (0.1)	261 (0.4)

Source: OMH Patient Characteristics Survey, 2003.

Table II. Number of NYC Residents Served in NYC Mental Health Facilities During a Survey Week by Primary Diagnosis and Age, 2001.

Primary Diagnosis	Number of Consumers Served			
	Under 5	5-17	18-64	65 and Older
All Diagnoses	444	14,126	56,011	6,743
Schizophrenia and Related Disorders	36	152	19,470	1,574
Schizophrenia	19	82	12,639	1,192
Mood Disorders	42	2,083	20,672	3,220
Major Depression	18	1,009	13,004	2,358
Dysthymia	16	785	2,989	503
Bipolar	8	289	4,679	359
Other Psychotic Disorders	6	316	1,913	236
NonPsychotic Disorders	267	7,439	11,348	903
Anxiety Disorders	40	1,110	4,125	491
Organic Disorders	2	18	498	422
Other/Unknown Disorders	91	1,340	4,888	388

Source: OMH Patient Characteristics Survey, 2001.

Note: Other/Unknown Disorders may include some nonpsychiatric diagnoses.

Table III. Number of Discharges from Acute Care Hospitals among NYC Residents with a Primary Diagnosis of Psychiatric or Substance Use Disorder, 2003

Primary Diagnosis	Number of Discharges	
	Ages 0-17	Ages 18+
Any Psychiatric or Substance Use Disorder	4,230	104,467
Schizophrenia & Related Disorders	132	17,507
Schizophrenia	63	10,374
Mood Disorders	1,178	16,652
Major Depression	738	8,916
Other Psychotic Disorders	300	3,598
Non Psychotic Psychiatric Disorder	2,465	4,943
Anxiety Disorders	79	789
Organic Mental Disorders	37	2,928
Drug Use Disorder	76	34,906
Alcohol Use Disorder	32	14,280
Alcohol-Related Organic Mental Disorders	10	9,653
Mentally Ill Chemical Abusers (MICA)	369	26,669

Source: New York State Department of Health Statewide Planning and Research Cooperative System, 2003 (updated April 2003).
 Note: Some patients may have had multiple admissions and, therefore, multiple discharges.

Appendix D: Recovery Assessment Tool

This checklist functions as a recovery assessment tool designed to track DOHMH's progress towards recovery-oriented system transformation. The checklist is drawn from literature written by prominent proponents of rehabilitation and recovery-oriented services, and represents a condensing of the principles and guiding statements that many persons in recovery agree represent key measurable aspects of a recovery-oriented system.

	YES	Being Developed	NO
Vision – Strategic plan			
1. Has a vision statement articulating commitment to recovery, which has a consumer-centered systems orientation.			
2. Formal planning process incorporates viewpoints from consumers currently using services as well as those who have previously utilized the service system.			
3. Contracting and auditing processes support improved recovery/rehabilitation outcomes for service users.			
4. Incorporates recovery principles into existing mental health initiatives.			
Community Relations			
5. Promotes understanding that mental health is essential to overall health through recovery-centered public education and anti-stigma campaigns.			
Consumer Involvement			
6. Qualified service users are in senior management/advisory positions.			
Resources			
7. Allocates dollars across services based on consumer demonstrated need towards achieving personally meaningful living and social roles.			
8. Ensures service access to individuals in need who cannot pay.			
Training			
9. Establishes core competency standards regarding knowledge of recovery/rehabilitation principles among provider staff.			
10. Provides training to DOHMH staff on recovery/rehabilitation and best practices.			
11. Provides training to consumers on their role in advocacy and system transformation.			
12. Provides ongoing technical assistance to providers on recovery-oriented services.			
Service Enhancement			
13. Encourages and provides incentives for providers who incorporate evidence-based practices.			
14. Encourages and provides incentives for providers who incorporate services that promote and support recovery outcomes.			
CQI and Outcome Measures			
15. Ensures consumer inclusion in CQI activities.			
16. Performs assessments of consumer perceptions of care			
17. Supports culturally-competent services.			
18. Develops recovery outcome measures with consumer involvement.			
19. Utilizes consumers' perceptions of care as a system monitoring and improvement tool.			
TOTAL			

Note: Sources for Recovery Assessment Tool include:

- American Association of Community Psychiatrists (AACP) Guidelines for Recovery Oriented Services, 2003.
- AACP Recovery Oriented Services Evaluation, 2003.
- Anderson, T., McNelis, D. & Weaver, B. (May 26, 2004). *Creating Recovery Friendly Cultures*. USPRA Conference.
- Anthony, W.A. (Fall 2000). A Recovery-Oriented Service System: Setting Some System Level Standards. *Psychiatric Rehabilitation (24)*2: 159-168.
- Discrimination and Stigma Center, 2004.
- Infusing Recovery-Based Principles into Mental Health Services. (2003). A White Paper by New York State Consumers, Survivors and Ex-patients.
- Making Recovery Real 2004: Services for Adults. South Carolina Department of Mental Health
- Supporting the Recovery System of Care. (February 4, 2003). Presentation to the Provider Advisory Council or Connecticut by the Connecticut Department of Mental Health and Alcoholism Services.
- Townsend, W. Memoranda: Assessment Tool Promotes Recovery. Address.
- Townsend, W. & Maxwell, L. SOAR (Systems Operating to Achieve Recovery): Recovery is Consumer Driven.

Appendix E: Supportive Housing Development in New York City

Table I. Open and Planned Supportive Housing Units as of August 2005

NYC DOHMH	Open as of 6/30/04	Additional by 6/30/05	Total by 6/30/05	Additional by 6/30/06	Total by 6/30/06	Additional by 6/30/07	Total by 6/30/07	Additional by 6/30/08	Total by 6/30/08	Additional by 6/30/09	Total by 6/30/09
Reinvestment	415		415		415		415		415		415
NY/NY I	1,404		1,404		1,404		1,404		1,404		1,404
HOPWA	76	49	125		125		125		125		125
NY/NY II	593	206	799	118	917		917		917		917
High Service Needs I		75	75	122	197	80	277	119	396		396
High Service Needs II				100	100	250	350	250	600	200	800
Family Pilot Program						15	15		15		15
Young Adult Pilot Program						48	48		48		48
DOHMH Subtotal	2,488	330	2,818	340	3,158	393	3,551	369	3,920	200	4,120
NYS OMH											
Congregate Treatment	2,293		2,293		2,293		2,293		2,293		2,293
Apartment Treatment	1,847		1,847		1,847		1,847		1,847		1,847
CR/Supported SROs	1,039	45	1,084	160	1,244	104	1,348	293	1,641	157	1,798
Supported Housing	4,714	23	4,737	318	5,055		5,055		5,055		5,055
SOMH Subtotal	9,893	68	9,961	478	10,439	104	10,543	293	10,836	157	10,993
TOTAL	12,381	398	12,779	818	13,597	497	14,094	662	14,756	357	15,113

Notes on Funding Streams:

- Reinvestment dollars, resulting from the closing of State psychiatric hospitals, funded 30 scattered site programs in all five boroughs. These units became available during City FY 1999 - CFY '03.
- New York/New York I and II: Both the 1990 and 1999 NY/NY Agreements were joint City/State initiatives which together created approximately 5,500 units of supportive housing for homeless mentally ill individuals in NYC -- 2,321 of which are funded through DOHMH.
- Housing Opportunities for Persons with AIDS (HOPWA): With this federal resource, DOHMH funds five scattered site programs for adults with mental illness and HIV/AIDS, as well as families that are headed by an adult with HIV/AIDS and who have mental illness and/or substance abuse histories.
- High Service Needs (HSN): Similar to NY/NY, these agreements are City/State matches which provide housing for mentally ill persons with high service needs. HSN I (State FY 2001) will provide a total of 800 units split between the State and the City. HSN II was initiated in State FY 2004 and State FY 2006 and will provide a total of 1600 units. DMH just released a rolling RFP for our 800 HSN II units in February 2005.
- The Family Pilot Program and the Young Adult Pilot Program will be funded with Reinvestment dollars.

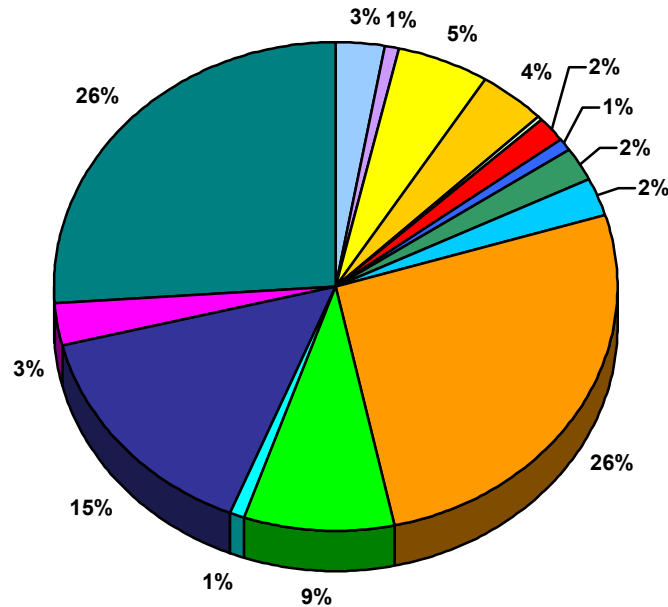
Appendix F: Project Liberty Data

Figure 1. Project Liberty Services Summary

Category of Project Liberty Service	# Sessions Provided	# Individuals Served
Individual crisis counseling	757,523	500,989
Family crisis counseling	51,649	28,207
Group crisis counseling	17,216	223,683
Public education	34,433	739,228
TOTAL	860,821	1,492,107

Note: # Sessions provided do not include numbers for services provided by FDNY outside of the five boroughs.

Figure 2. Total Number of Project Liberty Crisis Counseling Sessions by Risk Categories September 12th, 2001-December 31st, 2004



Family of Missing 3%		Injured 1%		Fire Dept. 5%		Police Dept. 4%		Port Authority	
Other Rescue 2%		Homes Damaged 1%		WTC Evacuees 2%		School Evacuees 2%		School Children 26%	
Displaced Employees 9%		WTC Workers Absent 1%		Pre-Existing Trauma 15%		Physical Disability 3%		Other 26%	