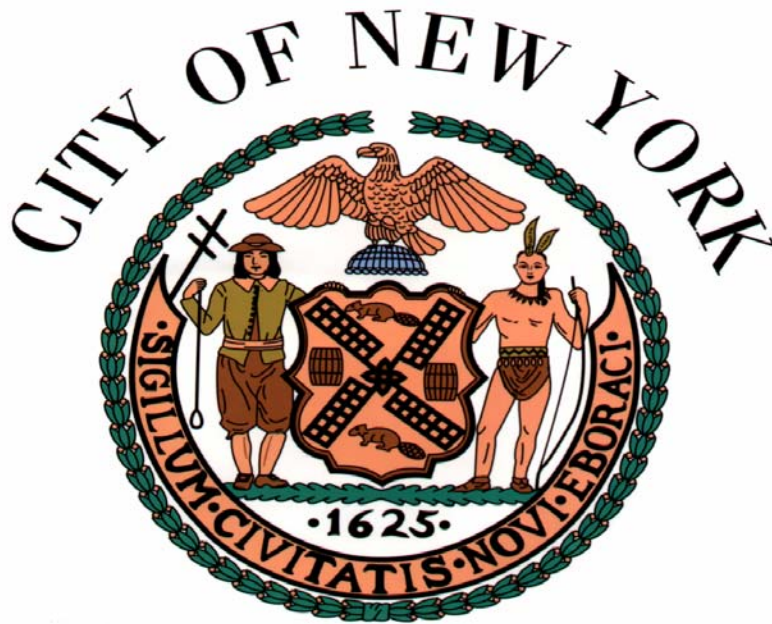


**NEW YORK CITY
DEPARTMENT OF HEALTH
AND MENTAL HYGIENE**



**LOCAL GOVERNMENTAL PLAN
MENTAL HEALTH SERVICES**

2008

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**NEW YORK CITY MENTAL HEALTH PLAN
FOR LOCAL GOVERNMENT SERVICES FY2008**

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EXECUTIVE SUMMARY

The 2008 New York City Local Government Plan for Mental Health Services represents the latest in several years of advances in planning for the New York City mental health service system. It reflects the Department of Health and Mental Hygiene's (DOHMH) progress in collaborating with local stakeholders to identify service priorities, and provides an overview of New York City's large and diverse mental health service system. It also describes both new and on-going DOHMH initiatives to improve that system, as well as increase access to services for targeted populations.

The Plan also presents several priority areas for City/State collaboration in the next year:

- Elimination of the Medicaid neutrality cap;
- Redistribution funding for community-based services;
- Consolidation of DOHMH's multiple funding streams;
- Increase in local government authority over government-funded mental health services;
- Development of a Statewide mental health needs methodology;
- Integration of behavioral and physical health care;
- Access to system-wide data on services, regardless of funding source;
- Increase in rates for NY/NY I and Reinvestment-funding housing; and
- Increase in data-driven quality improvement efforts.

Prevalence of Mental Health Disorders

Recent DOHMH surveys indicate that 6.4% of adult New Yorkers suffer from nonspecific psychological distress (NPD)¹ and 7.5% from depression; less than half of them have received treatment. In addition to posing mental health concerns, NPD and depression are associated with significant physical health risks and conditions.

DOHMH's 2005 Youth Risk Behavior Survey suggests that the mental health of the City's adolescents is a significant concern. One-third of survey participants reported feelings of persistent sadness at some point in the previous year, and 10% reported that they had attempted suicide during the same period.

The 2006 DOHMH Community Health Survey indicates that 4% of New Yorkers are lesbian, gay, bisexual or transgender (LGBT), and that, relative to heterosexuals, they experience higher rates of NPD (8% versus 6%) and depression (7% versus 4%). LGBT New Yorkers are more likely to have received any mental health treatment than are heterosexuals (58% versus 31%); yet they are also more likely to report that they did not always receive treatment when they needed it (27% versus 15%).

¹ "Nonspecific" in this context means that this term encompasses a number of symptoms that are consistent with many diagnoses defined by the Diagnostic and Statistical Manual, but are not specific to any one of them. Thus, the presence of NPD indicates that an individual is experiencing serious mental distress, though the exact nature of that distress may not be defined.

Capacity, Utilization, and Need for Mental Health Treatment Services

The majority of mental health programs in New York City are community support services (36%), outpatient treatment services (26%), and residential services (24%). The remaining program types provide crisis, inpatient and other types of services and system-wide coordination. There are currently 1,448 mental health programs in the City, and system capacity is expected to increase in FY 2008, particularly for children and families, and for people in need of housing.

OMH's most recent Patient Characteristics Survey indicates that in a single week in 2005, 90,282 people were served by the New York City public mental health system, half of all of those people served in the State. Eighteen percent of those served in New York City were children and adolescents under the age of 18. Half of all people served were unemployed due to disability, and the majority received Medicaid. The vast majority of consumers (80%) served had a serious emotional disturbance or serious mental illness.

Stakeholder Priorities

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

1. Increased funding for services and timely reimbursement by the City;
2. Funding to provide agency-specific staff training; and
3. Revision and integration of state regulations to facilitate treatment for co-occurring disorders.

Another five priorities addressed the need for particular services:

1. Housing;
2. In-home mobile services;
3. Child and adolescent day treatment clinics;
4. Vocational services and employment; and
5. Acute psychiatric inpatient children's beds.

Local Government Initiatives: Services for Children and Adolescents

Children and adolescents would be best served by a coordinated system of care, one that integrates all types of treatment and services. Accordingly, DOHMH initiatives are increasingly coordinated with other child-serving agencies to provide higher-quality care.

Service System Improvements for Children and Adolescents

In FY 2007, DOHMH completed Citywide implementation of the Single Point of Access program, which facilitates children's access to services. In the next year, DOHMH will restructure family support programs to better integrate them into the continuum of services for children; and work with the Coordinated Children's Services Initiative to improve coordination across service systems. It will also collaborate with OMH in its Child and Family Clinic Plus initiative to improve identification and treatment of children with serious emotional disturbances; and fund school-based mental health services in high-need areas.

Services for Specific Child and Adolescent Populations

DOHMH initiatives to address the needs of specific child and adolescent populations include funding mental health programs for children under the age of 5, and providing intensive community-based treatment for children and adolescents in acute psychiatric crisis. DOHMH is also funding adolescent skills programs throughout the City for young adults ages 16-23, and collaborating with the NYC Administration for Children's Services to increase the availability of mental health services in the child welfare system.

Local Government Initiatives: Service System Improvements

A critical role of local government is to assist the community in addressing system issues that impact need and service provision. Current DOHMH initiatives seek to respond to widespread mental health disorders such as depression; improve the quality of mental health treatment Citywide; promote the integration of recovery principles into services; and enhance the City's response to mental health needs in the event of a disaster.

Depression Screening and Management in Primary Care

Many adults in NYC who suffer from depression do not receive treatment. DOHMH continues to promote depression screening and management in primary care settings, where people with unidentified depression are most likely to seek help. This initiative includes encouraging providers to use a validated, brief screening instrument, the Patient Health Questionnaire-9 (PHQ-9), and promoting depression screening and management for targeted populations, including seniors, Asian Americans and Hispanics.

A Recovery-Oriented Service System

The Office of Consumer Affairs promotes a recovery-oriented mental health service system by training DOHMH staff and community stakeholders on recovery principles, and evaluating and disseminating models of recovery-oriented practice. These practices include the use of peer staff in treatment programs; implementation of health and wellness workshops; increased participation of consumers in the mental health community; and promotion of transitional employment opportunities for consumers.

Quality Improvement

To date, DOHMH's quality improvement initiative, Quality IMPACT, has addressed three critical aspects of mental health services: identification and treatment of co-occurring disorders; cultural competence; and treatment access and engagement. These projects have increased screening for co-occurring disorders and cultural factors within participating programs, and identified promising practices to increase client attendance and engage families in treatment. In FY 2008, all 224 mental health treatment programs in contract with DOHMH will participate in Quality IMPACT.

Disaster Preparedness and Response

DOHMH's Office of Mental Health Disaster Preparedness and Response works to improve New Yorkers' ability to respond to, and recover from, the psychological impact of disasters and emergencies. This Office collaborates with City, State and national

agencies in such areas as developing guidelines for community organizations' disaster response and crisis communication.

Local Government Initiatives: Services for Specific Populations

Particular populations continue to be underserved by the City's mental health system. New York City is collaborating with the State and local agencies to address needs such as housing for the homeless, and treatment services for people impacted by the attack on the World Trade Center.

Housing for the Homeless

There remains a critical shortage of housing for homeless people with mental health disorders in New York City. The City and State are partnering in the New York/New York III Agreement to develop supportive housing for this population. Supportive housing is a cost-effective model that combines permanent, affordable housing with health and social services. New York/New York III will create 5,550 units of housing for homeless people with mental health disorders by 2016; New York City is responsible for 2,150 of those. 1,125 units will be open by the end of FY 2008.

Treatment for High-Utilizers of Medicaid-Funded Services

A relatively small number of people generate a disproportionate share of Medicaid expenditures for mental health treatment. Among these people are many chronically homeless individuals, and consumers who have repeated episodes of acute psychiatric and medical illness, but lack consistent psychiatric care and permanent housing. To address the needs of this population, DOHMH is supporting a model that links an ACT team with supported housing in order to provide consumers with more effective treatment and services, while reducing Medicaid costs.

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

Thousands of New Yorkers continue to suffer from conditions associated with the 2001 attack on the World Trade Center. In November 2006, DOHMH received funding to administer a five-year benefit program that will serve all New York City residents who are experiencing mental health or chemical dependency problems as a result of the WTC terrorist attack. It will pay for outpatient mental health and chemical dependency services, and provide financial assistance for prescribed medications. In addition, the Program will fund Bellevue Hospital to support mental health services to this population.

Access to Acute Psychiatric Care for People with Mental Retardation and Developmental Disabilities (MR/DD) and Mental Health Disorders

Treatment options in NYC for individuals with co-occurring MR/DD and mental health disorders are limited, and acute care services are usually not equipped to work effectively with this population. DOHMH is collaborating with the State and local advisory boards to explore the possibility of linking trained psychiatric inpatient units to intensive residential programs for MR/DD consumers living in the community.

Conclusion

In FY 2007, DOHMH continued to focus on expanding access to mental health care by integrating mental health screening and management into primary care settings, while also promoting improvement of the quality of care provided within mental health care agencies. It also introduced several new initiatives to meet the needs of special populations, particularly those in most need of housing, services, and stabilization in treatment. DOHMH will continue and further expand these efforts in FY 2008.

I. PRIORITY AREAS FOR CITY/STATE COLLABORATION

ELIMINATION OF MEDICAID NEUTRALITY CAP

Title 14 NYCRR Part 551.13 regulations have essentially 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. The elimination of this Medicaid neutrality cap is critical to continued and improved access to care for individuals in need of mental health services. It can also result in more expensive services and less appropriate oversight of those services, and suggests a broader review and rationalization of licensing issues may be warranted. DOHMH calls on OMH to eliminate this arbitrary restriction.

REDISTRIBUTION OF FUNDING FOR COMMUNITY-BASED SERVICES

Inpatient mental health care is disproportionately funded relative to the need in New York State. DOHMH urges OMH to identify opportunities to redistribute resources and to enable the expansion of community-based services, including transitional and supportive housing.

CONSOLIDATION OF MULTIPLE FUNDING STREAMS

There are currently 52 funding streams through which DOHMH 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. DOHMH calls on OMH to consolidate these funding streams. Local government units currently devote significant human resources to reconciling these multiple funding streams that could be better spent on improving services.

INCREASE IN LOCAL GOVERNMENT AUTHORITY OVER FUNDING OF MENTAL HEALTH SERVICES

As deficit funding through contracts continues to be replaced by Medicaid funding of mental health services, DOHMH has begun to shift its focus from managing budgets to managing quality of services. DOHMH requests that OMH – in recognition of the necessity and value of local management of the mental health service system – enhance its authority to serve as a quality monitor for government-funded mental health services, including greater authority in how and to whom Medicaid and funding from other sources flows.

NEEDS ASSESSMENT METHODOLOGY

Service planning and evaluation efforts in NYC suffer from a lack of a systematic needs assessment methodology that derives estimates of unmet service need from prevalence, capacity and utilization data. Accurate estimates of service need are fundamental to the local planning process and to the identification of local funding priorities. DOHMH continues to urge OMH to take the lead on developing a Statewide need methodology for mental health. OASAS has developed such a planning tool, the OASAS Needs Methodology, which supports the State's local government units in identifying unmet need by service category. A related need is for OMH to collect individual utilization data

and make it available to counties and New York City for planning. These are critical planning responsibilities that are within the purview of the State mental hygiene agencies.

INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTH CARE

People with mental illness have much higher rates of morbidity and mortality due to smoking, problem drinking, heart disease, diabetes and asthma. Mental hygiene needs must be recognized and addressed by primary health care providers, and physical health must become a core commitment for mental hygiene service providers. Through Quality IMPACT (Improving Mental Hygiene and Communities Together) and other initiatives, we hope to collaborate with OMH in the integration of physical and behavioral health care.

DATA ACCESS

DOHMH 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 DOHMH contracts diminishes, it is increasingly important that OMH provide localities with access to system-wide data on services, regardless of funding source.

INCREASE IN RATES FOR NY/NY I AND REINVESTMENT-FUNDED HOUSING

The funding level for NY/NY I housing and State Reinvestment-funded supported housing has increased only minimally since these programs were introduced, and is significantly lower than that for more recent mental health housing initiatives. This disparity puts these older housing programs at serious financial risk. DOHMH requests that OMH raise the NY/NY I and Reinvestment rates to 2007 levels, so that all supported housing for individuals with serious and persistent mental illness in New York City will be funded at the same level.

QUALITY IMPROVEMENT

DOHMH's Quality IMPACT initiative has introduced data-driven quality improvement efforts on a multi-year basis 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 improve services. However, there is opportunity to expand these activities in breadth (i.e., more programs participating) and depth (through coordinated City/State quality improvement goals). To fully realize the vision of a culture of quality, NYC calls on OMH to lend assistance in two critical areas:

- Devising fiscal strategies, including increases in Medicaid rates, to fund quality improvement and provide incentives for exemplary outcomes.
- Implementing a unified approach to quality improvement with joint improvement projects and perceptions of care surveys, common standards, transparent data reporting and uniform auditing standards that can be performed by the local government unit.

II. NEW YORK CITY DEMOGRAPHICS

In the size and diversity of its population, New York City is unique not only in the State but in the country. The City's population has grown steadily since 1990, reaching 8.2 million in 2005 and accounting for 40% of all New York State residents. It is expected to grow to as many as 9.5 million people by 2030.²

Immigration has played a crucial role in this growth: Nearly 1.2 million immigrants arrived in the City during the 1990s; 36% of City residents are foreign-born, and more than half of these may not be proficient in English.³ Immigration is also a key contributor to the racial and ethnic diversity of New York City. The proportion of the City that is white has declined steadily in the last decade, to 35%. In contrast, there has been steady growth in the percentage of residents who are Hispanic (27%) or Asian (10%), or who identify as "other" or mixed race (4%). The proportion of City residents who are African American has remained relatively constant (25%).²

SOCIOECONOMIC INDICATORS

The most recent data from the U.S. Census Bureau indicate that the percentage of New Yorkers living in poverty grew 21% from 1990 to 2005. Approximately one-fifth of New Yorkers, nearly 1.5 million people, were living below the national poverty line in 2005, including one-quarter of youth under the age of 18.⁴

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

The City's demographic profile underscores the challenges faced by local mental health treatment providers and the people they serve. As demonstrated by OMH's 2005 Patient Characteristics Survey, discussed in Chapter III, many consumers of public mental health services are among those New Yorkers most in need of support: half of adult consumers are unemployed due to disability, and three-quarters receive Medicaid. Consumers are also racially and ethnically diverse; as discussed by stakeholders in Chapter IV, the provision of culturally competent, multi-lingual services remains a primary concern.

² NYC Department of City Planning. (2006). *New York City Population Projections by Age/Sex and Borough*. Available at http://www.nyc.gov/html/dcp/pdf/census/projections_briefing_booklet.pdf (accessed July 17, 2007).

³ NYC Department of City Planning. (2006). *Total Population by Mutually Exclusive Race and Hispanic Origin*. Available at <http://www.nyc.gov/html/dcp/pdf/census/pl3a.pdf> (accessed July 17, 2007).

⁴ U.S. Census Bureau. (2005). *2005 American Community Survey, New York City, New York: Poverty status in the last 12 months*. Available at http://home2.nyc.gov/html/dcp/pdf/census/acs_poverty_person.pdf (accessed July 24, 2007).

⁵ NYC Department of City Planning. (2004). *2004 Annual Report on Social Indicators: Summary: Economy and Unemployment*. Available at http://home2.nyc.gov/html/dcp/html/pub/socind04_eco.shtml (accessed July 24, 2007).

III. OVERVIEW OF NEW YORK CITY’S SYSTEM OF MENTAL HEALTH CARE FOR ADULTS AND CHILDREN

This section presents information on the estimated prevalence of mental health disorders, service system capacity and service use among adults, children, adolescents and special populations in New York City. The basis for these estimates can be found in the appendix.

LOCAL ESTIMATES OF THE PREVALENCE OF MENTAL HEALTH DISORDERS

Mental Health of Adults in New York City

There are many ways to define and assess mental disorders in the community; in recent years, a focus of DOHMH’s Community Health Survey (CHS) has been nonspecific psychological distress (NPD).^{6,7} “Nonspecific” in this context refers to the fact that this term encompasses a number of symptoms that are consistent with many diagnoses defined by the Diagnostic and Statistical Manual IV, but are not specific to any one of them. Thus, the presence of NPD indicates that an individual is experiencing serious mental distress, though the exact nature of that distress may not be defined. The 2006 CHS found that the prevalence of NPD among adult New Yorkers was 6.3% in 2006, virtually the same as in previous years,⁸ and twice that reported in national studies.⁹

Both the 2006 CHS and DOHMH’s 2004 NYC Health and Nutrition Examination Survey (HANES), which included in-person interviews with 1,999 adult New Yorkers, also ask about a more specifically defined form of mental distress, depression. The HANES assessed the total prevalence of major depressive disorder in New York City as 7.5%; the CHS indicated that nearly 4% of New Yorkers had been diagnosed with depression in the previous year alone.¹⁰

In addition to those people experiencing NPD and/or depression, another 8% of adult New Yorkers reported that they were suffering from frequent mental distress (FMD). While these respondents did not meet the criteria for NPD and had not recently been diagnosed with depression, they assessed their own mental health as having been “not good” for at least 14 of the last 30 days.¹¹

⁶ NPD is sometimes referred to as serious psychological distress or serious mental illness.

⁷ Kessler, R.C., Barker, P.R., Cople, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J., Normand, S.T., Manderscheid, R.W., Walters, E.E. & Zaslavsky, A.M. (2003). Screening for serious mental illness in the general population. *Arch Gen Psychiatry*, 60: 184.

⁸ The 2003 prevalence of NPD has been reported as 5.0%. Analyses of the 2002-2006 CHS data suggest that rates have actually remained stable (6.3% - 6.4%) and that the lower rate in 2003 is due to a methodological difference.

⁹ The National Health Interview Survey has consistently found that the national rate of NPD is 3.2%. See Mojtabai, J. (2005). Trends in contacts with mental health professionals and cost barriers to mental health care among adults with significant psychological distress in the United States: 1997-2002. *Amer J Pub Health* (95): 2009.

¹⁰ Some survey participants were assessed with NPD and also reported depression; thus the prevalence of NPD and prevalence of recent depression diagnosis cannot be summed for a total combined “NPD/depression” prevalence.

¹¹ Survey participants were asked, “Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” This question is drawn from the Center for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System surveys.

Prevalence of Mental Health Disorders in NYC Adults		
Mental Health Disorder	Prevalence	Est. Number of New Yorkers
Nonspecific Psychological Distress (NPD)*	6.4%	512,530
Currently suffering from depression (regardless of when diagnosed; with or without NPD)	7.5%	600,621
Depression diagnosis in last 12 months* (with or without NPD)	3.9%	312,323
Frequent Mental Distress (FMD) only (no NPD or depression diagnosis in last 12 months)	7.9%	632,654

Source: 2006 DOHMH CHS, with the exception of current depression, which is taken from the 2004 DOHMH HANES.

Receipt of Treatment for Mental Health Disorders

Less than half of people with NDP and/or depression report having received mental health treatment (counseling, medication or both) in the last year. Even fewer of those people with FMD – only 1 in 6 – did so. And even people who receive treatment experience challenges: 16% of all those who did receive some treatment nonetheless reported that they had not always gotten it when they needed it.¹²

Mental Health of Adolescents in New York City

Information about the mental health status of youth in New York City comes from DOHMH's Youth Risk Behavioral Survey (YRBS), a biannual survey of high school youth. This survey indicates that the mental health of the City's adolescents is a significant concern. In 2005, one-third of survey participants reported feelings of persistent sadness at some point in the previous 12 months, consistent with previous years;¹³ 10% of New York City adolescents reported that they had attempted suicide in the last 12 months, an increase from previous years.

YRBS Measures of Mental Health Among Adolescents, NYC and US, 1997-2005					
	1997	1999	2001	2003	2005
Sad almost every day for at least 2 weeks in past 12 mos.					
NYC	NA	33%	33%	32%	32%
US	NA	28%	28%	29%	NA
Seriously considered suicide in past 12 months					
NYC	17%	16%	15%	14%	15%
US	21%	19%	19%	17%	NA
Attempted suicide 1 or more times in past 12 months					
NYC	8%	7%	8%	8%	10%
US	8%	8%	9%	9%	NA

¹² Survey participants were asked, "Was there a time in the past 12 months when you needed treatment for a mental health problem, but did not get it?"

¹³ Survey participants were asked, "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?"

Source: Data from NYC YRBS 1997-2005 dataset, National YRBS 1991-2003 Trend Fact Sheets, and Youth Online. NYC is weighted to NYC public high school population; US is weighted to US public and private high school students.

Demographics and Health Conditions Associated with Mental Health Disorders

Among Adults

As shown in the table below, rates of mental health disorders in New York City rise and decline over the lifespan. Starting from 5% among 18- to 20-year olds, the rate climbs to a high of 11% of 40-59 year olds and then declines to 9%. Women are more likely to experience NPD, depression or FMD than are men (7% versus 10%).

Prevalence of NPD, Recent Depression Diagnosis and FMD by Age and Gender		
Demographic Group	% of Group with NPD and/or Depression Diagnosis in Last 12 Months	% of Group with FMD Only*
AGE		
18-20 years	5.0%	6.5%
21-39 years	7.5%	7.5%
40-59 years	10.7%	8.7%
60+ years	9.2%	8.1%
GENDER		
Male	7.2%	7.5%
Female	10.0%	8.3%

Source: 2006 DOHMH Community Health Survey

*I.e., no current NPD and/or depression diagnosis in last 12 months.

NPD and depression are associated with significant physical health risks and conditions. These include an elevated rate of diabetes (16%, versus 9% of the City's total adult population), and a greater likelihood of being overweight (65% versus 56% of all adult New Yorkers). People with NPD and depression are also much more likely to smoke than other New Yorkers (29% versus 16%).

Physical Health Risks and Conditions by Mental Health Status			
Mental Health Status	% of Group with Diabetes	% of Group that is Overweight	% of Group that Smokes
NPD and/or Recent Depression Diagnosis	15.9%	65.2%	28.8%
FMD Only*	10.8%	55.9%	24.7%
Neither NPD, Recent Depression Diagnosis, Nor FMD	8.5%	55.6%	15.8%

Source: 2006 DOHMH Community Health Survey

*I.e., no current NPD and/or depression diagnosis in last 12 months.

The effects of NPD, depression and FMD can be severe. In 2005, 481 New Yorkers committed suicide; 21 of those (4.4%) were under the age of 19. Suicide is the tenth most common cause of death among this age group, and the eighth most common cause among adults ages 19 to 64.

MENTAL HEALTH IN THE LESBIAN, GAY, BISEXUAL AND TRANSGENDER COMMUNITY

The Plan provides an opportunity to examine the prevalence of mental health disorders and need for services among particular populations. One population often identified as underserved relative to its need is the lesbian, gay, bisexual and transgender (LGBT)¹⁴ community, which is often reported to be underserved by the mental health system.

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

While research on the mental health of people who are LGBT is limited, what literature that exists indicates that LGBT individuals suffer from higher rates of depression and anxiety than do heterosexuals. The 2006 CHS indicated that, relative to heterosexuals, people identifying as LGBT have higher rates of depression (7% versus 4%), nonspecific psychological distress (8% versus 6%), and frequent mental distress (12% versus 8%). Overall, 23% of the LGBT community – approximately 79,000 people, or nearly 1 in 4 LGBT New Yorkers – report having any kind of mental health disorder, as opposed to only 14% of the heterosexual community. These trends are consistent with most national research.¹⁵ The research literature also suggests that people who are LGBT, particularly youth, are more likely to attempt suicide;¹⁶ and that they may be more likely to suffer from co-occurring disorders, particularly substance abuse.¹⁷ The source of these differences is uncertain; while prejudice and stigma almost certainly play a role, other differences in the experience of people who are LGBT may also impact mental health.¹⁸

Participation in treatment and services may pose particular challenges for the LGBT community. The CHS indicated that LGBT New Yorkers are significantly *more* likely to receive mental health treatment than are heterosexuals (58% versus 31%), again, consistent with national research.¹⁹ Yet people who are LGBT are also more likely to report that they did not always receive treatment when they needed it (27% versus 15%).

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

¹⁵ Gilman, S.E., Cochran, S.D., Mays, V.M., Hughes, M., Ostrow, D. & Kessler, R.C. (2001). Prevalences of DSM-III-R disorders among individuals reporting same-gender sexual partners in the National Comorbidity Survey. *American J of Public Health, 91*:933.

¹⁶ Russell, S.T. & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American J of Public Health, 91*:1276.

¹⁷ Sandfort, T.G.M., de Graaf, R., Bijl, R.V. & Schnabel, P. (2001). Same-sex sexual behavior and psychiatric disorders: Findings from the Netherlands mental health survey and incidence study. *Arch of Gen Psychiatry, 58*:85.

¹⁸ Cochran, S.D. (2001). Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter? *American Psychologist, 56*: 931.

¹⁹ Cochran, S.D., Sullivan, J.G. & Mays, V.M. (2003). Prevalence of psychiatric disorders, psychological distress, and treatment utilization among lesbian, gay and bisexual individuals. *J of Consulting & Clinical Psychology, 71*: 53.

There is considerable evidence to suggest that the critical issue for the LGBT population may not be access to services, but receipt of appropriate services, and subsequent retention in treatment. LGBT consumers often report that treatment providers are unresponsive to their unique concerns,²⁰ and recent studies indicate that many mental health providers' attitudes toward LGBT consumers are not always constructive or positive.²¹ The result is that many LGBT consumers, having entered treatment, leave prematurely.²²

These differences in the experience of people who are LGBT suggest that mental health service providers may need to assess their programs and treatment strategies to ensure that they are supportive of people who are LGBT, and responsive to their unique needs and experiences. The ability of community providers to serve this population is particularly critical because of the relative dearth of programs dedicated to serving the LGBT community.

PREVALENCE AND IMPACT OF FORENSIC INVOLVEMENT AMONG PEOPLE WITH MENTAL HEALTH DISORDERS

People with mental illness are overrepresented in the forensic system. Approximately 5% of the U.S. population has a serious mental illness. The rate is estimated to be as high as 16% among people in jail or prison.²³

People with mental illness not only become involved with the justice system, they remain in the system for longer than the general population – in New York City, nearly five times as long – and are at high risk of returning. Approximately one-quarter of incarcerated persons with mental illness have been incarcerated or placed on probation at least three times before.²⁴

Within the 12 jails that constitute the New York City correctional system, approximately one-quarter of inmates – 12,400 people – receive an average of four mental health visits each quarter from dedicated mental health staff. Of those engaged in services, the most prevalent diagnoses are schizophrenia, major mood disorder, and drug disorders. Approximately 10% of inmates are identified as seriously and persistently mentally ill, and at least half have a history of substance abuse.

Once released, persons with mental illness face significant barriers to reintegration within the community. And they face increased difficulty in receiving treatment and services; providers may be reluctant to accept people who have been incarcerated, or unprepared to

²⁰ Garnets, L., Hancock, K.A., Cochran, S.D., Goodchilds, J. & Peplau, L.A. (1991). Issues in psychotherapy with lesbians and gay men. *American Psychologist*, 46:964.

²¹ Bieschke, K.J., McClanahan, M., Tozer, E., Grzegorek, J.L. & Park, J. (2000). Programmatic research in the treatment of lesbian, gay and bisexual clients. In R.M. Perez, K.A. DeBord & K.J. Bieschke (Eds.), Handbook of Counseling and Psychotherapy with Lesbian, Gay and Bisexual Clients. Washington, DC: APA.

²² Liddle, B.J. (1996). Therapist sexual orientation, gender, and counseling practices as they relate to rating on helpfulness by gay and lesbian clients. *J of Counseling Psychology*, 43:394.

²³ Ditton, P.M. (1999). *Mental Health and Treatment of Inmates and Probationers* (Bureau of Justice Statistics, NCJ-174463). Washington, D.C.: U.S. Department of Justice. Available: www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf

²⁴ Weiskopf, G. & Josil, R. (1999) *Forensic Mental Health: Final report presented to the New York State Conference of Local Mental Hygiene Providers*. Clifton Part, NY: Weiskopf Consulting Services. Available at http://www.clmhd.org/itemfiles/TAP_forensic_199912_report.pdf

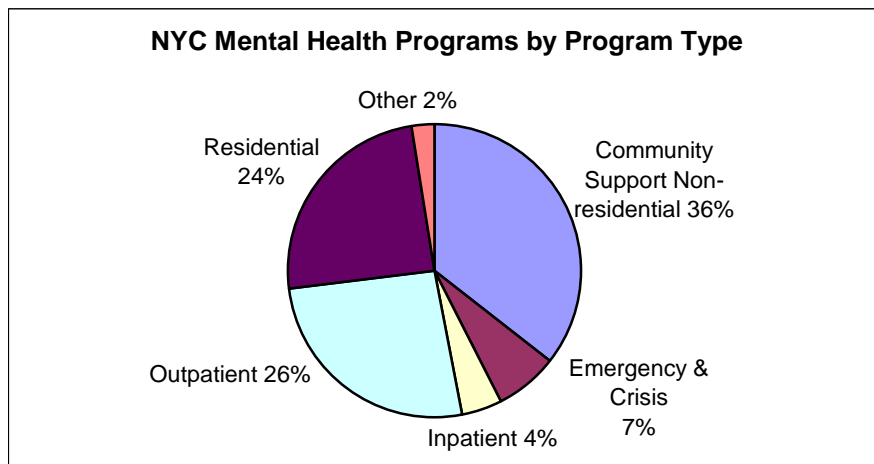
meet their unique needs. Housing can be a particular challenge. In FY 2005, 9% of the 2,842 people with serious and persistent mental illness discharged from New York City jails reported being homeless; all 2,842 were eligible for supportive housing.

SERVICE CAPACITY AND USE IN NEW YORK CITY

System Capacity

Appendix C presents information on the number and capacity of New York City’s mental health programs, including information on program type and population served. The most common program types are community support services such as case management and family support (36% of all programs); outpatient treatment services, such as continuing day treatment and partial hospitalization (26%); and residential (24%) programs.

The remaining programs provide crisis, inpatient and other types of services, as well as system-wide coordination (e.g., Single Point of Access, a system of managing access to intensive mental health services for children and youth).



Total system capacity (the number of programs and the number of people each can serve) is virtually unchanged from last year: There are currently 1,448 mental health programs in New York City, one more than in the previous year.

System capacity is expected to increase in FY 2008, particularly for children and families, and for people in need of housing. New programs developed by DOHMH for children and families are now opening, and the State’s Child and Family Clinic Plus initiative will also expand outpatient mental health care screening and services for young children in FY 2008. Additionally, the City-State New York/New York III Agreement, which commences this year and extends through 2016, will significantly expand the City’s housing capacity.

System Utilization

One source of information on use of the NYS public mental health system is OMH's Patient Characteristics Survey (PCS). The PCS collects information on all clients seen in OMH-funded or licensed mental health programs during a specified one-week period. During the week of the 2005 survey, just over 90,000 consumers used New York City's mental health programs.

The tables below presents selected demographic, socioeconomic and mental health characteristics of those people using the public mental health system during the PCS survey week. People ages 45 to 64 years comprised the greatest share (39%) of those using the system, though another 18% were children and adolescents ages 17 and younger. Men and women were equally likely to have used services.

The vast majority (80%) of consumers served had a serious emotional disturbance or serious mental illness, and just over half received SSI/SSD. Nearly three-quarters received Medicaid.

Characteristics of Consumers Using the Public Mental Health System During the PCS Survey Week			
Characteristic	% of Consumers	Characteristic	% of Consumers
<i>Age Group</i>		<i>Racial Group</i>	
12 years or younger	10%	Caucasian Non-Hispanic	28%
13-17 years	8%	African American Non-Hispanic	32%
18-20 years	2%	Hispanic	34%
21-34 years	14%	Asian/Pacific Islander	3%
35-44 years	19%	Other/Multiracial	4%
45-64 years	39%		
65 years or older	8%		
<i>Diagnosis</i>		<i>Disability & Medicaid</i>	
Schizophrenia & Related Disorders	30%	Receives SSI/SSD	53%
Mood Disorders	36%	Receives Medicaid	75%
Anxiety Disorders	9%		
Other Mental Health Disorders	25%		
Any Serious Emotional Disturbance or Serious Mental Illness	81%		

Unmet Need

DOHMH's capacity to assess need and compare it with service capacity to calculate unmet need is currently limited by a lack of data, particularly individual-level data that would allow us to monitor patterns of service utilization. DOHMH continues to work to identify efficient, reliable means of collecting such data, and invites State collaboration in this effort.

Drawing on their experience in the community, stakeholders continue to identify several areas of service need, as discussed in the next section. These needs include services for children and adolescents; housing services; and services for individuals with co-occurring mental hygiene disorders.

IV. STAKEHOLDER PRIORITIES

The Federation for Mental Health, Mental Retardation and Alcoholism Services serves an advisory role to DOHMH in its mission to partner with consumers, families and providers to improve the lives of New Yorkers with mental hygiene disorders. A critical role of the Federation is to help DOHMH identify and prioritize community needs as part of the annual planning process.

The Federation was restructured in FY 2007, and now encompasses three levels: a total of 15 Borough Councils, one in each borough for each of the three disability areas; three Citywide Committees, one for each disability area; and one Citywide Interdisciplinary Committee. In addition, there are cross-disability Citywide Committees for each of three special populations: children, seniors and people who are lesbian, gay, bisexual and transgender.

With this new structure, the Federation introduced a new process for compiling a prioritized list of needs for each disability area. First, each Borough Council generated a list of five service issues and three system-level issues of concern. The lists from the five boroughs were then reviewed by the Citywide Committee for that disability area and further refined to a total of eight issues. Many of these priorities echoed themes from the previous year, such as integrated services for people with co-occurring chemical dependency and mental health disorders, housing, vocational services, and difficulties attracting and retaining qualified staff. In addition, this year's priorities placed a greater emphasis on the need for attention to special populations, particularly the LGBT community.

SERVICE PRIORITIES

Priority 1: Housing

Stakeholders reported that, at its most extreme, the shortage of housing for consumers may leave them homeless. Of particular concern was the possibility that homelessness might sometimes result from a failure to connect and engage consumers in follow-up services after leaving Acute Psychiatric Units.

Stakeholders in all boroughs also reported a need for alternatives to existing housing. These included supervised housing, which provides more intensive supports than does supportive housing, and housing for people whose current housing situation is tenuous. In this latter category, particular concern was expressed for adolescents aging out of the foster care system, and for adult consumers whose aging parents can no longer care for them at home.

A second concern was housing for populations not eligible for the supportive housing now being created under the City-State New York/New York III Agreement. A population of particular note was people who are re-entering society from prison and are

at high risk of relapse and return to the criminal justice system.²⁵ And stakeholders noted the need to prioritize new and existing housing for other vulnerable populations, such as mothers with children and undocumented aliens.

Priority 2: In-Home Mobile Services

Stakeholders reported that there are not enough in-home mobile services available for clients suffering from serious mental illness; and that the range of service models needs to be expanded. In particular, they noted that the diversity of the growing geriatric population requires culturally and linguistically appropriate outreach strategies and staffing. It was suggested that other special populations, such as people with co-occurring disorders and people who are LGBT, would also benefit from service models developed specifically to meet their needs.

Priority 3: Child and Adolescent Day Treatment Clinics

Stakeholders indicated that there are not enough child and adolescent day treatment clinics to meet the demand. Particular shortages were noted for walk-in clinics and clinics that work with LGBT youth.

Priority 4: Vocational Services and Employment

Stakeholders reported that there are not enough vocational training, support, and employment opportunities within NYC for individuals suffering from mental illness. Consumers in particular stressed the importance of employment to recovery, and the challenges associated with seeking and maintaining employment. It was emphasized that employment opportunities should be tailored to the needs and abilities of individual consumers, and should include on-going support services.

Priority 5: Acute Psychiatric Inpatient Children's Beds

Stakeholders also reported a Citywide shortage of acute psychiatric inpatient children's beds. As a result, children may be hospitalized far from home (sometimes outside of the City), making it difficult for their families to visit or participate in care.

SYSTEM PRIORITIES

Priority 1: Increased Funding

Providers reported that City and State funding of services is inadequate, and that City payments are often delayed. They recommended that rates be increased, and that the City improve the timeliness of reimbursement to contracted providers.

Priority 2: Staff Training

Stakeholders report that, due to factors such as high turnover rates, there is a need for on-going staff training in best practices, cultural competency, and other areas relevant to service provision. Rather than asking the City and State to provide training, providers suggested additional funding for providers to create agency-specific training programs.

²⁵ People released from lengthy prison terms are not eligible for NY/NY III because the definition of "chronic homelessness," which is a criterion for eligibility, does not include periods of incarceration. See footnote 39 for a full description of the NY/NY III eligibility criteria.

Priority 3: Revision and Integration of State Regulations

Stakeholders advocated for the revision of OMH and OASAS regulations to facilitate integrated treatment for people with co-occurring mental health and chemical dependency disorders. Currently, certification and billing requirements make it difficult for agencies to provide integrated treatment to this population.

ALIGNMENT OF STAKEHOLDER PRIORITIES AND DOHMH INITIATIVES

Several DOHMH initiatives address the concerns described here.

- The New York/New York III City-State partnership will create 21,786 units of supportive housing for people with mental health disorders by 2016.²⁶
- Since FY 2005, the Quality IMPACT initiative has supported 116 mental health and chemical dependency programs to improve their screening, referral, and treatment coordination for clients for co-occurring disorders. Building on this initiative, DOHMH will begin in FY 2008 to require all mental health and chemical dependency treatment programs to screen incoming clients for co-occurring disorders, and a new audit standard has been introduced to monitor compliance.
- An Intensive Crisis Stabilization and Treatment program funded by DOHMH is working to provide intensive community-based treatment for children in acute psychiatric crisis. This initiative seeks to maintain youth in psychiatric crisis in the community and minimize acute inpatient hospitalization.

²⁶ For more information on the NY/NY III initiative, see Chapter VI, “Increasing Housing for the Homeless.”

V. LOCAL GOVERNMENT INITIATIVES: SERVICES FOR CHILDREN AND ADOLESCENTS

The challenges of providing mental health treatment to children and adolescents cannot be overstated. While children have many of the same treatment needs as adults, they also pose unique challenges, including the need for parental support and engagement in the treatment process, and developmental issues that render them a heterogeneous group in need of a wide variety of services and treatment approaches.

Children and adolescents would be best served by a comprehensive, coordinated system of care, one that integrates all types of treatment and services, regardless of which agency provided them. Such a system would take a holistic approach to supporting mental, emotional and physical needs, and would be accessible and easily navigable for families. Yet such a system is still in its infancy in New York City. Instead, individual services have been created in isolation to respond to urgent needs.

DOHMH recognizes the need to move New York City from a patchwork of child and adolescent mental health services to a coherent system of mental health care, one that is integrated into the larger system of agencies and programs that serve children and adolescents. As discussed below, the most significant step in this direction has been the establishment of the Coordinated Children's Services Initiative (CCSI), which helps to coordinate the involvement of families, agencies, and others in a child's life. CCSI also works with agencies and systems at the borough and City levels to promote these kinds of collaborative practices more broadly.

The majority of DOHMH initiatives remain stand-alone programs focused on a single issue. These include specific types of mental health services (e.g., family support, access to services), often for particular groups of children and adolescents (e.g., those under age 5, those in psychiatric crisis). Increasingly, however, these initiatives are coordinated with other child-serving agencies, such as the Administration for Children's Services. As described below, DOHMH continues to seek further opportunities for inter-agency collaboration in addressing the mental health treatment needs of New York City children and adolescents.

CHILDREN & ADOLESCENTS: SYSTEM IMPROVEMENTS
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GOAL 1: Ensure that family support services are coordinated, family-driven, and youth-guided, and are integrated into the City's continuum of mental health care and other services for children and adolescents.

Objective: Restructure New York City's portfolio of family support services.

DOHMH currently provides approximately \$4M in funding to 38 family support service programs, which provide support and education to families whose children have emotional or behavioral challenges. In FY 2007, DOHMH developed a strategic plan to

fundamentally revise these services, in order to improve their quality, coordination, cultural competency, and sustainability. The RFP for these restructured programs will be released in late FY 2008, and contracts will be registered and restructuring begun in FY 2009.

GOAL 2: Improve coordination across service systems for children and adolescents with mental health disorders.

Objective: Sustain the Coordinated Children's Services Initiative (CCSI).

CCSI is a model of intervention with youth who have emotional and behavioral challenges and are involved with multiple service systems. The goal of the initiative is to enable children and adolescents to remain in the community, rather than being placed in care. The model relies on "family network" conferences that bring together children and adolescents, their families, and the agencies and individuals involved in their lives to coordinate plans and services. The initiative is funded by a six-year grant from the Federal Substance Abuse and Mental Health Services Administration, and has served 603 children since FY 2004.

In addition to its work with individual children and adolescents, CCSI convenes cross-agency committees to address system issues, and provides training to staff of the City's child-serving agencies. This training is intended to promote system-wide adoption of best practices for serving children and youth, and to increase collaboration across agencies. As of May 2007, 198 service providers had completed the training, including over 95% of all OMH children's case managers. These trainings will continue in FY 2008.

With its six years of grant funding soon to expire, CCSI is now focused on disseminating its values and practices within the City's children's service system. In addition to the Family Network Training Initiative described above, DOHMH is collaborating with OMH to introduce similar training into State initiatives such as Child and Family Clinic Plus. DOHMH is also seeking funding to help incorporate family networks into its revised family support service system.

GOAL 3: Provide timely access to care for children and adolescents with intensive mental health service needs.

Objective: Ensure that Single Point of Access (SPOA) is systematically implemented in each of the five boroughs.

SPOA is a system of managing access to intensive mental health services for children and adolescents between the ages of 5 and 18 who are at high risk of hospitalization and placement in mental health residential settings. SPOA reduces waiting lists and speeds access to services by requiring that children's eligibility for placement into services such as case management and community residences be assessed within five business days of referral.

St. Luke's-Roosevelt Hospital was awarded the Citywide children's SPOA contract in March 2006. By July 2006, SPOA was implemented Citywide, and is now a permanent feature of the City's service system. From October 1, 2006 through March 31, 2007, SPOA received 802 referrals, and consistently met its goal for assessing all children and adolescents within five days of referral.

GOAL 4: Expand the availability and capacity of school-based mental health services.

Objective: Fund the creation or expansion of a school-based mental health program in a high-need area in each of the five boroughs.

School-based mental health programs, which provide clinical mental health services on school premises, can play a vital role in addressing children's behavioral and emotional difficulties.²⁷ Unfortunately, there remains a tremendous unmet need for these programs.²⁸ While the number of the City's 1,456 public schools with such programs increased by 5% from FY 2006 to FY 2007, the vast majority of schools (83%) remain unserved.

In FY 2007, DOHMH chose one provider in each of the five boroughs to expand or create a school-based mental health program in a high-need, impoverished area. The selected providers are the Children's Aid Society (Bronx), Institute for Community Living (Brooklyn), Child Center of New York (Queens), St. Vincent's Medical Center (Manhattan), and Staten Island Mental Health Society. The programs will open in September 2007, and will serve a total of 340 elementary and middle school children.

GOAL 5: Collaborate with OMH to improve the identification and treatment of children with serious emotional disturbances.²⁹

Child and Family Clinic Plus is a Statewide OMH initiative to introduce a unique model of outpatient care for all children with serious emotional disturbances. The model will include outreach, screening, comprehensive assessment, home visits and evidence-based treatment, and will be introduced in middle schools, preventive service agencies, and head start/daycare programs.

Objective 1: Identify populations to be targeted for Child and Family Clinic Plus.

In FY 2007, DOHMH and OMH identified the populations that will be targeted for Child and Family Plus services, and the settings in which services will be offered. Screening services will be offered to public schools (primarily middle schools), child welfare

²⁸ 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*. New York: Author.

²⁹ A serious emotional disturbance may be defined as the presence of a psychiatric diagnosis and significant functional impairment. Costello, E.J., Messer, S.C., Bird, H.R., Cohen, P. & Reinherz, H.C. (1998). The prevalence of serious emotional disturbance. *Journal of Child and Family Studies*, 7(4): 411.

preventive service agencies, and day care/head start programs. The full range of services (including outreach, assessment, home visits and treatment,) will be offered in high-need neighborhoods at sites identified in collaboration with the NYC Department of Education and the NYC Administration for Children's Services.

Objective 2: Advise OMH on the implementation of Child and Family Clinic Plus within NYC.

DOHMH continues to assist OMH in planning for the upcoming implementation of Child and Family Clinic Plus. OMH has selected and is now licensing providers. However, some populations and geographical regions will remain unserved, because no providers bid on them. As a result, seven high-need areas of New York City will not receive anticipated State funding of services. Two areas of Brooklyn will not have screening in public schools; Staten Island will not have screening in its preventive services agency; and Bronx, Staten Island and Brooklyn neighborhoods with health disparities for mothers and their infants will not have screening in early childhood services. This represents a loss of capacity for screening thousands of children a year, and an even more significant loss of treatment capacity expansion for child and adolescent mental health services.

CHILDREN & ADOLESCENTS: SERVICES FOR SPECIFIC POPULATIONS

GOAL 1: Increase the number and availability of mental health services for children under the age of 5 and their families.

Objective: Fund and monitor early childhood mental health programs to provide outreach, consultation, and family-focused assessment and treatment services for this population.

The Early Childhood Consultation and Treatment program is an evidence-based model for the provision of family-focused mental health evaluation, services and treatment. In FY 2007, DOHMH chose the Manhattan Center for Early Learning to implement the program, which will serve children under the age of five in multiple sites within East Harlem. The sites will open in early FY 2008 and will include a special education pre-school, a day care center, a preventive service and foster care program, and a prenatal and primary care facility. The Manhattan Center for Early Learning will provide screening and mental health services to children with mental health disorders and their families at these sites, and will also provide on-going consultation and training to site staff.

In addition, DOHMH oversees four City Council-funded early childhood programs: Safe Space, Seen and Heard Program (Manhattan and Queens); Yeshiva University, Rose F. Kennedy Center-CERC Center (Bronx); University Settlement, Butterflies Program (Manhattan and Brooklyn); and Jewish Board of Children and Family Services (Washington Heights). All programs serve children under five and their families, and consult with an array of professionals such as day care workers and pediatricians.

GOAL 2: Maintain children and adolescents in psychiatric crisis in the community and minimize inpatient hospitalization.

Objective: Provide intensive community-based treatment for children and adolescents in acute psychiatric crisis.

The Intensive Crisis Stabilization and Treatment program was designed by DOHMH as a 12-week intervention and treatment program for children and adolescents in psychiatric crisis and at imminent risk of hospitalization. With funding from DOHMH, the program was introduced in July 2007 by Steinway Child and Family Services in the Bronx and by Kings County Hospital in Brooklyn. Each site is expected to serve nearly 100 children and adolescents between the ages of 5 and 17 years old. DOHMH will collect information on service use and outcomes at the two programs in order to inform further development of the model.

GOAL 3: Expand and enhance evidence-based transitional services for young adults ages 16 to 23 with serious emotional disturbances.

Objective 1: Fund expansion of adolescent skills program capacity throughout the City.

Adolescent skills centers help seriously emotionally disturbed adolescents ages 16 to 23 to develop the skills necessary to assume adult roles and responsibilities. In FY 2007 DOHMH increased the funding of five existing New York City programs in order to enhance their service capacity, and funded a new program in Staten Island, where there were previously no adolescent skills programs. This new center, run by the Staten Island Mental Health Society, opened in fall 2006. It is expected to serve 40 adolescents annually; it served 33 adolescents in its first seven months of operations.

Objective 2: Support adolescent skills programs to adopt an evidence-based model.

In addition to expanding system capacity, DOHMH has encouraged child and adolescent programs to enhance their practice through the introduction of an evidence-based framework for working with young people with serious emotional disturbances. *Transition to Independence* is a youth-centered method of addressing life challenges such as employment, education, and living situation. During the fall and winter of 2006, the Coalition of Behavioral Health Agencies funded and provided training for New York City providers in the elements and implementation of this model; six of the providers also received implementation assistance from the creator of the model.

GOAL 4: Increase the availability of mental health services to children and adolescents in the child welfare system.

Many children and adolescents in foster care have significant mental health needs due to histories of abuse or neglect, or to the trauma of being removed from their families; anywhere from one-quarter to three-quarters of these children and adolescents are estimated to have serious emotional disturbances.^{30,31} DOHMH and the New York City Administration for Children's Services (ACS) are collaborating on three initiatives to address these needs.

Objective 1: Prevent repeated placement of adolescents who are returned to the community from congregate care settings.

The Coordinated Children's Services Initiative/ACS Families for Teens pilot program focuses on the needs of adolescents with emotional and behavioral challenges who have recently been returned to the community from congregate care settings (e.g., group homes). These adolescents are at high risk of being returned to congregate care or moved to another home; the goal of the program is to maintain them in their current homes (e.g., foster care, kinship care).

The pilot began in December 2005 as a collaboration between the Coordinated Children's Services Initiative (CCSI) and the ACS Central Evaluation Services Unit and Families for Teens Program. Staff are employed by the Mental Health Association of New York City and are co-located at ACS.

The program received 14 referrals from September 2006 through February 2007. Of those 14 families, nine went on to receive care coordination from CCSI; the remaining five families were not enrolled, either because they declined services, or because the youth returned to a higher level of care or left the community. These latter outcomes indicate the need for earlier identification of youth who would benefit from the program, before they begin to experience difficulties.

In addition to providing direct services to referred families, the program has helped to implement a new, more family-friendly model of child and family case conferencing for ACS's Central Evaluation Services. Increased collaboration with the ACS Office of Case Management, which oversees agencies contracted with ACS, has also helped to facilitate more effective work between CCSI and those agencies.

Objective 2: Decrease the number of days that children and adolescents remain in the hospital after they are medically cleared for discharge.

The Mental Health Inpatient Coordination Unit (MICU) program helps coordinate care for foster care children and youth who are being discharged from acute psychiatric

³⁰ 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 and Neglect* 28(6): 699-714.

³¹ 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?* New York: Author.

hospital beds to the community. The lack of such coordination often results in children remaining in the hospital after they have been medically cleared for discharge. Beginning in FY 2008, DOHMH and ACS will partner to fund the MICU to assist foster care and inpatient psychiatric unit staff in coordinating a comprehensive aftercare plan for children and adolescents on inpatient units, ensuring that an appropriate living situation is identified and links to critical mental health and other services are made.

Objective 3: Make mental health services easily accessible to children and adolescents in foster care.

In FY 2007, five mental health agencies partnered with five foster care agencies to create satellite clinics in these foster care settings, an initiative that has required collaboration among these agencies: the Coalition of Behavioral Health Agencies, the Council of Family and Child Caring Agencies, OMH, ACS and DOHMH. DOHMH is providing some funding for the resource-intensive project, which is projected to serve a total of 200 children and adolescents annually.

VI. LOCAL GOVERNMENT INITIATIVES: SYSTEM IMPROVEMENTS

A critical role of local government is to assist the community in addressing system issues that impact need and service provision. Current DOHMH initiatives seek to respond to widespread mental health disorders such as depression; improve the quality of mental health treatment Citywide; promote the integration of recovery principles into services; and enhance the City's response to public mental health needs resulting from disasters and emergencies.

IMPROVING DEPRESSION SCREENING AND MANAGEMENT IN PRIMARY CARE

The 2005 HANES suggested that as many as 7.5% of adults in NYC suffer from depression, and that the majority do not receive treatment, particularly if they are African American or Hispanic. Accordingly, DOHMH has identified the need for depression screening and management as a significant public health concern, integrating it into its Take Care New York health policy agenda.

The DOHMH depression initiative focuses on primary care settings, where people with unidentified depression are most likely to seek help. In order both to increase the number of New Yorkers screened for depression, and to ensure that such screening is as effective as possible, DOHMH is encouraging providers to use a validated, brief screening instrument, the Patient Health Questionnaire-9 (PHQ-9).³²

GOAL: Promote depression screening and management in primary care settings.

Objective 1: Expand depression screening and management among HHC hospitals.

All HHC facilities are currently incorporating the PHQ-9 into their electronic medical records. The record will prompt doctors to screen the patient for depression, and then provide the PHQ-9 instrument to do so. This protocol will aid in depression management by promoting universal and accurate screening, including follow-up screenings to determine whether people who have been identified with depression are receiving appropriate treatment.

Objective 2: Increase and improve depression screening, referral and management for seniors in primary care settings.

The Lower East Side (Manhattan), Flushing (Queens) and Boro Park (Brooklyn) are all characterized by large populations of Asian American and Hispanic seniors, who are at high risk for social isolation and depression. To address this issue, DOHMH partnered with the New York City Department for the Aging and the Mental Health Association to introduce education and depression screening in senior centers, with the goal of referring

³² Kroenke, K, Spitzer, RL & Williams, JBW. (2001). The PHQ-9: Validity of a Brief Depression Severity Measure. *J of Gen Internal Med.* 16:606-613.

seniors with positive screens to primary care for further assessment and treatment. This initiative provided depression education and screening to 31 social service agencies serving seniors in these neighborhoods. As of May 2007, more than 100 agency staff members and nearly 825 seniors at 20 senior centers had been educated on depression screening and management, and 660 seniors had been screened for depression with the PHQ-9. Eleven percent of those screened were identified as possibly depressed and were referred to a primary care provider for further assessment.

In addition to increasing screening and referral at senior centers, the initiative also sought to increase primary care providers' ability to respond to seniors referred. To accomplish this, DOHMH staff disseminated educational materials to 435 primary care providers in those neighborhoods.

This program will be continued and expanded in FY 2008 with \$250,000 of combined funding from DOHMH and the Department for the Aging. Seniors' participation in screening will be further encouraged with the introduction of pre-screening educational sessions at senior centers, provided by the Mental Health Association. In addition, DOHMH care managers will follow up with seniors with positive screens to encourage them to connect with a primary care provider.

In FY 2007, the New York City Council awarded \$100,000 to each of 16 community mental health centers and senior centers to provide integrated mental health and physical health services to seniors. DOHMH has provided training in the use of the PHQ-9 to these agencies, which are required to use it by the terms of their award; training will continue in FY 2008. Data shared by the agencies with DOHMH indicates that as of May 2007, a total of 1,156 people had been screened for depression with the PHQ-9. Of those people screened, 192 (17%) were referred to a primary care or mental health provider for further assessment on the basis of their PHQ-9 score.

Objective 3: Provide outreach and education about depression screening and management to primary care practices.

In FY 2006, DOHMH launched an outreach and education campaign targeted to primary care physicians serving high-need adult populations. DOHMH provided education and more than 1,400 depression screening kits to physicians, most HHC facilities, and more than 200 health care providers in the South Bronx, Harlem, and Brooklyn. DOHMH also distributed 100,000 public education bulletins on depression to HHC hospitals, Federally Qualified Health Centers, the New York City Department for the Aging, and mental health and substance abuse providers throughout the City.

DOHMH also joined with the National Association for the Mentally Ill and the New York Business Group on Health in FY 2007 to introduce *One Voice*, a public-private partnership that promotes consistency in screening and depression management among primary care physicians. The collaborative will provide educational materials on depression and the PHQ-9 to 50,000 behavioral and primary care physicians in early FY

2008. The *One Voice* collaborative will continue through FY 2009, and will include additional outreach to primary care physicians and behavioral health providers.

Objective 4: Raise New Yorkers' awareness of their depression status.

In October 2006, 98 NYC health care and service providers, including all of those funded by DOHMH, encouraged New Yorkers to learn their depression status by participating in National Depression Screening Day. Results suggest that as many as 37% of people screened were found positive for depression and referred for further assessment.

To raise awareness of depression among its own staff, DOHMH provided telephone depression screening to employees and dependents for eight months in FY 2007. Of the 448 people who participated in the screening, 12% scored positive, and reported that they would seek further evaluation.

Objective 5: Provide care management support to primary care facilities involved in DOHMH's depression initiative.

Care managers provide telephone follow-up and support to people with depression, assessing their progress and their adherence to prescribed treatment, and referring them to additional care if needed.³³ In November 2006, DOHMH hired two full-time care managers to work with consumers at the Institute for Urban Family Health, a community-based primary care provider and partner in the depression initiative. In late March 2007, DOHMH received a \$195,000 grant from Forest Labs to hire additional care management staff and expand its telephonic care management. DOHMH is now exploring possible sites for these care managers for FY 2008, including Urban Health Plan; the Charles B. Wang Community Health Center; and Lutheran, Elmhurst and Maimonides Hospitals. The Office of Care Management will expand to include five full-time care managers, each serving approximately 130 people, who will provide both on-site and telephonic care management at selected sites.

PROMOTING A RECOVERY-ORIENTED SERVICE SYSTEM

Consumers and providers are increasingly emphasizing the importance of a recovery-oriented mental health system, one that takes a more comprehensive, strengths-based and individualized approach to addressing mental illness.³⁴ Accordingly, a critical goal of DOHMH's Office of Consumer Affairs is to promote a recovery orientation within New York City's mental health service system. This promotion includes training DOHMH staff and community stakeholders on recovery principles and practices, and testing, evaluating and disseminating models for recovery-oriented practice.

³³ Von Korff, M. & Goldberg, D. (2001). Improving outcomes in depression: The whole process of care needs to be enhanced. *Brit Med J.* 323:948-949

³⁴ U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the SurgeonGeneral*. Rockville, MD: U.S. DHHS, SAMHSA, Center for Mental Health Services, NIMH.

GOAL 1: Promote the use of peer staff to deliver recovery-oriented services.

In 2003, the President’s New Freedom Commission on Mental Health reported that “consumer-run services and consumer-providers can broaden access to peer support, engage more individuals in traditional mental health services, and serve as a resource in the recovery of people with a psychiatric diagnosis.”³⁵ Thus, the use of peer staff is a key component of developing a recovery orientation within mental health programs.

Objective 1: Implement a pilot project to demonstrate the value of using peer staff in continuing day treatment programs.

To promote the use of peer staff, DOHMH collaborated with two partners to recruit and train consumers, then place them as peer recovery facilitators within continuing day treatment programs (CDTPs). DOHMH’s partner agencies – the Howie T. Harp Peer Advocacy Center and the Coalition of Behavioral Health Agencies’ Center for Rehabilitation and Recovery – offered on-going technical assistance to both the CDTP and the peer staff.

The objectives of this pilot program were to:

- 1) Demonstrate the benefits of using peer recovery facilitators to develop and deliver recovery-oriented CDTP services;
- 2) Assess the impact of such peer recovery facilitators on the recovery orientation of the programs; and
- 3) Identify ways to promote and sustain the wider use of peer recovery facilitators, including funding sources and programmatic culture change.

Two peers were placed in each of the two programs, working alongside program staff to facilitate groups, assist consumers in developing recovery goals, and link consumers to community supports. Program staff were very positive about the pilot and plan to use peer staff again in the future.

Objective 2: Evaluate the pilot project.

DOHMH is evaluating the program’s success and potential for replication through pre/post-focus groups and surveys with peer facilitators, consumers and CDTP service staff and administrators. The focus of the evaluation is on implementation and operational issues that will allow other sites and organizations to successfully implement such a program. The evaluation will be completed at the end of calendar year 2007.

GOAL 2: Improve the health and wellness of mental health consumers.

In the last few years there has been increasing recognition of the importance of health and wellness among people with mental illness. Poor physical health is not only a serious

³⁵ New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: U.S. DHHS.

concern in itself; it also poses a significant barrier to recovery from mental illness. Moreover, mental health consumers are more likely than the general population to suffer from poor physical health, and just under half of consumers have a chronic physical illness severe enough to limit daily functioning. Shockingly, individuals with serious mental illness who are served by the public mental health systems die, on average, 25 years earlier than the general population.³⁶

Poorer health outcomes among consumers are due to individual factors such as poor nutrition, high rates of smoking, and side effects from antipsychotic medications, as well as to systemic factors such as the inadequate attention of mental health care providers to medical issues and physical wellness.

Objective 1: Establish a Health and Wellness Workgroup to develop and implement interventions and advocacy strategies.

The Workgroup was established in 2005, and consists of representatives from DOHMH, providers and consumers. After surveying 80 consumers regarding medical care and wellness, the Workgroup decided to institute a series of health and wellness workshops.

Objective 2: Develop Health and Wellness Workshops to promote physical, emotional and spiritual well-being.

DOHMH is collaborating with several community-based organizations to sponsor four *Mind Your Health* workshops in FY 2007. These workshops are intended to educate consumers and providers and help to create a culture change that promotes wellness within the community. Workshop topics will include personal empowerment, stress and wellness, creating healthy environments for consumers and staff, and medication side effects. Approximately 100 participants are expected at each workshop. Participants will be asked to complete evaluation forms at the end of each session; that information, in combination with the feedback that participants provide throughout the workshops, will be used to determine next steps for wellness promotion.

Objective 3: Implement an initiative to promote smoking cessation initiatives within the mental health community.

In recent years, New York City has made tobacco control a central focus of its public health efforts. Yet people with serious and persistent mental illness continue to smoke at rates much higher than the general public. Smoking rates are estimated to be as high as 85% among people who have schizophrenia, and 60-70% among those who have bipolar disorder. And not only are consumers more likely to smoke, they smoke more: two to three times as much as other smokers.³⁷

³⁶ Judge David L. Bazelon Center for Mental Health Law. (2004). *Get It Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders*. Washington, D.C.: Author.

³⁷ Lohr, J.B. & Flynn, K. (1992). Smoking and schizophrenia. *Schizophrenia Research*, 8(2):93.

DOHMH is collaborating with DOHMH's Bureau of Tobacco Control to develop a program to support smoking cessation initiatives within mental health agencies. The program will be based on established best practices, the experience of providers and consumers, and the expertise of the Bureau of Tobacco Control. A pilot project with two to three providers is expected to commence in FY 2008.

GOAL 3: Increase the visibility, participation and influence of mental health consumers in the City's mental health community.

Objective 1: Develop and implement training for consumers in leadership, advocacy and recovery.

A recovery orientation integrates consumers into every level of service planning and provision. In order to help consumers gain the skills they need to participate effectively in DOHMH's advisory body, the Federation for Mental Health, Mental Retardation and Alcoholism Services, DOHMH is providing advocacy training to consumers. Monthly sessions, which also address issues such as understanding the mental health system, are currently attended by approximately 15 consumers. These monthly trainings have contributed to increased consumer participation, including the creation of three new Federation consumer subcommittees, in Queens, Brooklyn and the Bronx.

Objective 2: Promote activities that enhance consumers' self-esteem and decrease the stigma associated with mental hygiene disorders.

DOHMH hosted an art show in March 2006 featuring original works created by mental hygiene consumers. The second annual art exhibit will be held in September 2007. These exhibits are intended to enhance the artists' self-esteem while fostering a more nuanced understanding of consumers in the community.

GOAL 4: Promote transitional employment opportunities for consumers.

Employment helps consumers to gain confidence and skills that can enhance their lives. Transitional employment – placement in temporary (6-9 months) or transitional entry-level positions – is one method of facilitating consumers' entry into the workforce.

Objective: Develop one full-time transitional employment slot within DOHMH.

In Fall 2007, DOHMH will introduce a permanent transitional employment position, involving work in DOHMH administrative offices. The position will be full-time (35 hours a week), and will be filled by two or three consumers, each working part-time. After six months, those consumers will be referred to new employment opportunities and other consumers will enter the program. This initiative is intended not only to demonstrate DOHMH's commitment to this issue, but to encourage other organizations to employ consumers.

**IMPROVING THE QUALITY OF NEW YORK CITY'S
MENTAL HEALTH TREATMENT SYSTEM**

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

The initiative is now in its fourth year. The number of participating mental health treatment programs has grown from 39 in FY 2005 to an expected 224 – all of DOHMH's contract mental health treatment service providers – in FY 2008.

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

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

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

2007 Accomplishments

- To date, 54 mental health programs and 25 chemical dependency programs have participated in the project for either one or two years, screening 10,537 clients for co-occurring disorders. Of the 2,498 clients who screened positive, 2,160 (86%) had a follow-up assessment within 30 days.
- By the conclusion of the first three years of the project, 1,256 of clients who had screened positive were receiving coordinated or integrated care for their co-occurring disorders.

- In FY 2006, DOHMH began to offer education to project participants on evidence-based practices to improve engagement and retention of clients. DOHMH expanded those offerings in FY 2007.
- Programs report that participation in this project has improved clinicians' capacity and willingness to identify and coordinate treatment for clients with co-occurring disorders. Data from this project underscore the need to focus more on engaging and retaining clients, as dropout rates for co-occurring clients were found to be especially high.

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

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

2008 Goals

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

Objective: Improve screening, assessment and treatment planning for co-occurring mental health and chemical dependency disorders in adults receiving treatment for either disorder.

In FY 2006, DOHMH began training Quality IMPACT participants on evidence-based practices to improve the evaluation process, engagement and retention rates, and advance integrated treatment. Trainings will continue in FY 2008 when 89 mental health and 6 chemical dependency programs will be participating in this project.

Participants in the co-occurring disorders project have demonstrated that standardized screening and assessment for co-occurring disorders is feasible and effective in both mental health treatment and chemical dependency programs. Therefore, beginning in FY 2008, City contract-funded and COPS mental health outpatient treatment programs, and City contract-funded chemical dependency outpatient treatment programs will be required to screen and assess all new clients for co-occurring disorders and to provide

coordinated or integrated care. This requirement has been integrated into DOHMH's program audit standards.

Cultural Competence

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

2007 Accomplishments

- To date, 26 mental health programs have participated in the cultural competence project for either one or two years. In that time, the programs have assessed 2,475 clients for cultural factors to include in treatment planning. Nine hundred eighty-eight (40%) of these clients reported significant cultural factors relevant to treatment planning.
- In addition, participating programs have increased their rates of admission by an average of six percentage points for populations that they deem to be underserved in their community. Ninety-one percent of clients in the targeted populations who scheduled a follow-up visit for within 30 days of admission kept the visit.

Although some programs were more successful than others in reaching out to underserved populations, the majority of providers indicated that their participation had enabled them to hone their outreach strategies and identify promising practices in this area, and that they were optimistic about achieving sustained improvement in the future.

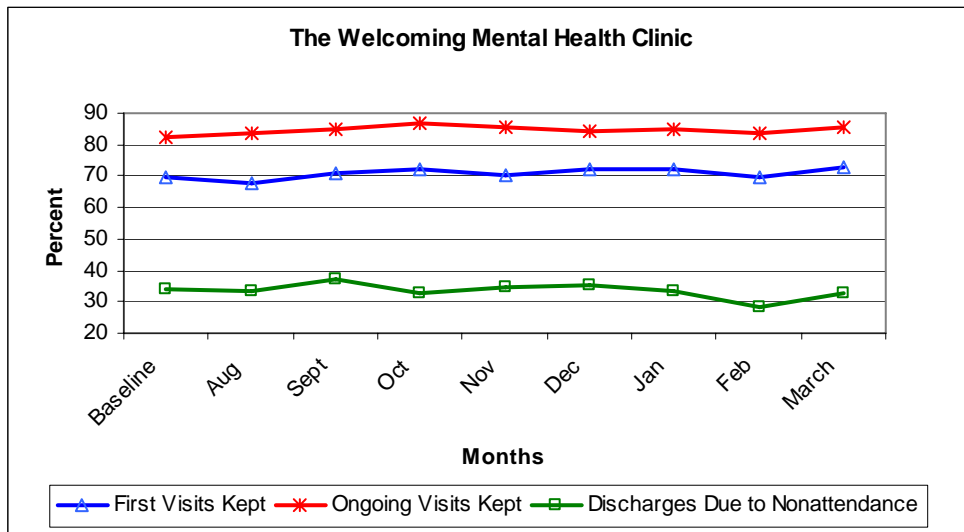
The Cultural Competence Project ended in FY 2007. Beginning in FY 2008, DOHMH will encourage all providers to improve their cultural competence by introducing them to the City-Wide Cultural Competence Assessment (CCA) and to other training tools that it developed to promote cultural competence in treatment settings. Providers who have used the CCA and other DOHMH tools have indicated that the tools are most helpful in their efforts to integrate cultural considerations into treatment planning.

Access and Engagement of Adults in Treatment

2007 Accomplishments

- Forty-four mental health clinics participated in the project in its first year. The clinics tracked outcomes for 13,944 first visits, 405,058 ongoing visits and 7,532 discharges. Few substantive improvements were made in client engagement and retention as measured by aggregate rates of ongoing appointments kept and planned discharges.
- Over the course of the year, programs identified promising practices that, implemented in the future on a broader scale, should lead to more substantive improvements in engagement and retention. For example, reminder calls to clients and referral sources have been found to improve client attendance at scheduled

appointments, and educating clinicians about their agencies' discharge policies has improved rates of planned discharges.



2008 Goals

GOAL: Improve mental health services by strengthening consumer-provider partnerships.

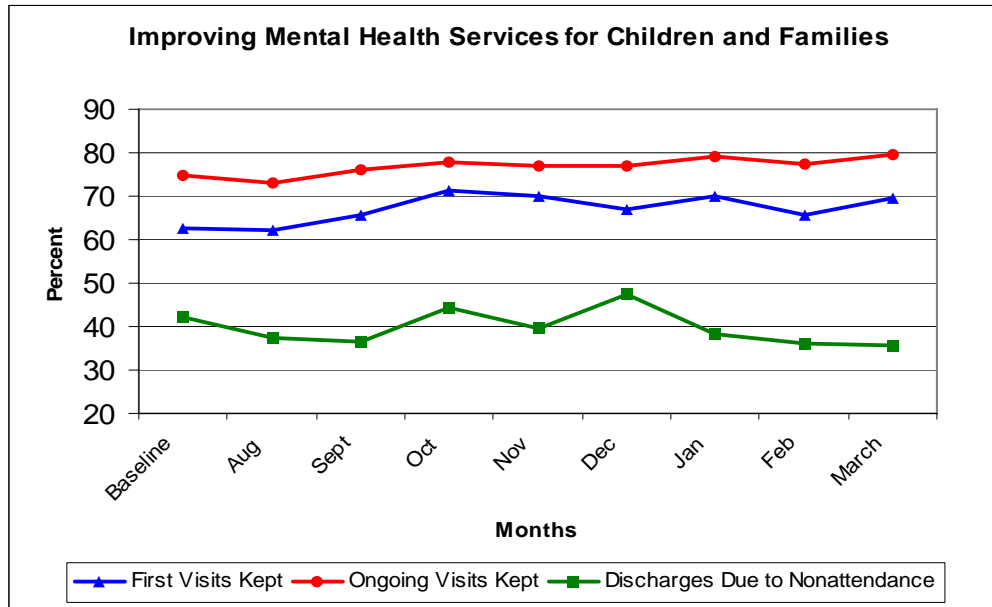
Objective: Improve rates of kept appointments and planned discharges, and increase consumer involvement in treatment planning.

In FY 2008, 25 mental health programs will participate in the Welcoming Clinic Project. In addition to implementing proven strategies such as reminder calls, providers will work to improve access and engagement by strengthening their partnerships with clients. The project will emphasize increasing client input into treatment planning, a practice that was identified by DOHMH and participating providers as a priority during FY 2007.

Engagement of Children and Families in Treatment

2007 Accomplishments

- Twenty-nine mental health clinics participated in the project in its first year. The clinics tracked outcomes for 5,795 first visits, 134,266 ongoing visits and 2,425 discharges. Small, but consistent, improvements were made in engagement and retention, as measured by aggregate rates of visits kept and planned discharges.
- Participation in this project emphasized the importance of family engagement in the treatment process, as engagement of young consumers depends very much on the engagement of their families.



2008 Goals

GOAL: Improve children’s mental health services by strengthening partnerships with families.

Objective: Increase children’s rates of kept appointments and collateral visits.

In FY 2008, 39 providers will participate in the Child Project. Providers will work to strengthen family partnerships so that families are more engaged in their children’s treatment.

By developing stronger family/provider relationships, rates of engagement and retention for children and adolescents should increase. Providers will track rates of attendance at collateral visits as well as at first and ongoing visits. They will also distribute to family members the Family Partnership Feedback Survey, a new survey developed by a workgroup of participating providers, family advocates and DOHMH staff. The survey will inform providers about the family’s perceptions regarding their involvement in treatment planning and help to direct further CQI efforts.

Program-Specific Projects³⁸

2007 Accomplishments

- In FY 2007, 54 mental health programs designed and implemented their own DOHMH-approved project. The majority of these programs worked to improve consumer physical health, engagement and retention, and continuity and coordination of care.

³⁸ Formerly called independent projects.

2008 Goals

GOAL: **Improve select, program-identified aspects of service delivery.**

Objective: Help providers to develop targeted interventions aimed at improving aspects of service delivery they have identified as priorities.

In FY 2008, 55 mental health programs will be working on program-specific projects. These programs will benefit from a new DOHMH mentoring structure that requires experienced CQI staff from DOHMH's Office of Quality Improvement to work one-on-one with these programs to review CQI data and provide needed guidance.

Consumer Perceptions of Care Survey

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

2007 Accomplishments

- In FY 2007, 112 mental health programs administered the survey, and 12,021 consumers participated (64% of all consumers seen at the participating programs during the two-week survey administration period).
- Results indicate that, in general, consumers feel very positive about the services they receive; on a scale of 1 to 5, with 5 being most positive, all domains received an average rating of at least 4. However, consumers indicated that programs could improve at returning calls more promptly, having more culturally and ethnically sensitive staff, and including consumers in treatment planning and feedback. In general, Hispanic/Latino consumers, older consumers and women perceive the services they receive more positively than others.

2008 Goals

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

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

Additional Goals for 2008

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

IMPROVING NEW YORK CITY'S DISASTER PREPAREDNESS AND RESPONSE

In 2003, the Office of Mental Health Disaster Preparedness and Response (OMHDPR) was created within the Division of Mental Hygiene. OMHDPR plans and conducts all mental health disaster preparedness, response and recovery activities for DOHMH, and for many New York City agencies and community groups.

GOAL: Improve New Yorkers' ability to respond to, and recover from, the psychological impact of disasters and emergencies.

Objective 1: Strengthen the ability of New York City agencies to respond to the mental health needs of New Yorkers in a disaster or emergency.

OMHDPR works with City agencies and State and national disaster response organizations to ensure that the City is prepared to recognize and address the mental health needs of New Yorkers in a disaster or emergency. In particular, OMHDPR ensures that plans for community needs assessment, crisis counseling, and distribution of information regarding mental health issues are all integrated into response protocols. OMHDPR has contributed to protocols for responding to such Citywide emergencies as pandemic influenza, release of radioactive material, and coastal storms.

Objective 2: Strengthen the ability of local health providers and community groups to respond to the mental health needs of New Yorkers in a disaster or emergency.

OMHDPR partners with a variety of health care providers and human service agencies to strengthen their response to disaster. Current projects include collaboration with hospitals and State and City partners to develop guidelines for the evacuation of inpatient psychiatric units and the management of quarantine units. Once these guidelines are completed, OMHDPR will disseminate the guidelines and assist hospitals in implementation. OMHDPR also provides training to hospitals and non-governmental agencies on coping skills, assessment of community mental health needs, and risk communication. Between 2004 and 2006, OMHDPR trained more than 3,000 New Yorkers in these fields in mental health disaster response.

OMHDPR also reaches a wider audience through the dissemination of publications on subjects such as crisis communication to treatment and health care providers and community and faith-based groups. In FY 2007, more than 1,500 pocket guides on disaster response were distributed to New York City service providers; 60,000 health care providers received an edition of the City Health Information bulletin on the clinical response to the physical and mental health needs of adults exposed to the World Trade Center disaster. This wide-spread work is complemented by more focused trainings of agency staff and community leaders. In FY 2008, OMHDPR will expand its training efforts by developing a curriculum to credential mental health disaster responders, and offering a greater range of trainings online.

Objective 3: Assist City agencies and community organizations to implement their planned response to mental health needs arising from a disaster or emergency.

In FY 2007, OMHDPR responded to a wide range of emergency events in New York City, providing needs assessment, crisis counseling, education and other forms of support to disaster survivors. Disasters to which OMHDPR responded included a massive power outage; an anthrax case; a plane accident and a fire resulting in several fatalities.

VII. LOCAL GOVERNMENT INITIATIVES: SERVICES FOR SPECIFIC POPULATIONS

Particular populations continue to be underserved by the City's mental health system. Whether these populations are defined by socioeconomic status, patterns of service use, or other factors, they all share a need for focused interventions and greater access to resources.

INCREASING ACCESS TO HOUSING FOR THE HOMELESS

While success in treatment and recovery requires safe and stable housing, there remains a critical shortage of housing for people with mental illness in NYC. In NYC, the primary response to this need has been the development of supportive housing – a cost-effective model of independent housing that combines permanent, affordable housing with health and social services, empowering tenants and fostering their recovery.

GOAL 1: Reduce homelessness among individuals with mental illness.

Currently, NYC has 14,146 operational units of housing for people with mental illness. 3,526 of these units are contracted through DOHMH, and 10,620 through OMH. The two agencies will open an additional 1,850 units by the end of FY 2008.

However, unmet needs remain. Through its own offices and in collaboration with other City and State agencies, DOHMH seeks both to create new housing and to increase access to existing housing, particularly for high-need subpopulations such as the chronically homeless mentally ill.³⁹

Objective 1: Create 2,950 new or rehabilitated units of congregate supportive housing designated for various homeless populations with mental illness.

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

In the next ten years, DOHMH will create 2,950 supportive housing units for homeless mentally ill adults and homeless families in which the head of household is mentally ill. The majority of these, 2,150 units, will be procured by the City as part of the New York/New York III Agreement with the State.

³⁹ A chronically homeless individual is anyone who (1) has a serious and persistent mental illness, as defined below, and has been homeless for at least 365 days of the last two years, not necessarily consecutively; or (2) does not meet the mental illness criteria but has been homeless for two out of the last four years, not necessarily consecutively. The NY/NY criteria for serious and persistent mental illness are a DSM-IV psychiatric diagnosis other than alcohol or drug disorders, developmental disabilities, organic brain syndromes, or social conditions; and eligibility for SSI/SSDI due to mental illness, or extended impairment in functioning due to mental illness.

The New York/New York III Agreement is a project of unprecedented scope that will generate 9,000 units of supportive housing by the end of FY 2016. 5,550 of those units are intended for mentally ill adults, families and young adults, and the City is responsible for procuring 2,150 (39%) of those 5,550.⁴⁰

The 5,550 New York/New York III units are designated for the following particular subpopulations:

- 3,950 units are reserved for chronically homeless single adults who suffer from a serious and persistent mental illness (SPMI), or who are diagnosed with a mental illness and chemical addiction (MICA). DOHMH will develop 1,750 of these as congregate units; OMH will develop another 1,450 congregate units, as well as 750 scattered-site units.
- 400 congregate units will be developed by DOHMH to serve families that are chronically homeless or at serious risk of becoming so, and in which the head of the household suffers from SPMI or MICA.
- 500 congregate and 500 scattered-site units will be developed by OMH for single adults who suffer from SPMI or MICA and who are leaving state psychiatric facilities.
- 200 congregate units to be created by OMH are designated for young adults suffering from SPMI or a serious emotional disturbance.

Both the City and State began work on New York/New York III in FY 2007. OMH has awarded contracts for all of its 400 scattered-site units, and the units are expected to be filled by November 2007. Two more requests for proposals (RFPs) will be released in 2007 and 2008 for the remaining 850 scattered-site units. Contracts have also been awarded for OMH's 1,125 congregate units, and projects are in various stages of development. OMH is now planning for release of an additional RFP in FY 2008 for services in 1,025 units of congregate housing.

DOHMH issued an open-ended RFPs for its 2,150 congregate units in February 2007. Approximately 50 of the family units will be operational by the end of FY 2008, while the units for single adults will open gradually over the next ten years.

In a separate initiative, DOHMH is funding another 800 units of congregate supportive housing for homeless single adults with a mental illness. As of June 2007, 12 proposals had been approved, for a total of 515 new units. 44 of those 515 units began operating in early 2007; the remainder are scheduled to open by FY 2011. Proposals will be accepted on a rolling basis until all 800 units are sited.

⁴⁰ Thus, 5,550 (62%) of the total 9,000 NY/NY III units are designated for the mentally ill; the City is responsible for 2,150 (39%) of those, and the State is responsible for the remaining 3,400 (61%). The remaining NY/NY III units are designated for substance abusers and other high-need populations.

Objective 2: Develop approximately 50 supportive housing units to serve young adults, ages 18-25, diagnosed with SPMI or serious emotional disturbance and who are either chronically or currently homeless; or are aging out of a system of care for youth, and at risk of homelessness.

As noted in Chapter III, stakeholders report a significant service gap for young adults who are aging out of the children's mental health and foster care systems. To address the resulting high rates of homelessness among these youth, DOHMH released an RFP in July 2006 for the development of approximately 50 units of supportive housing. As a result of that RFP, three young adult programs are currently in development, totaling 52 units for young adults. These units will begin opening in FY 2008 and 2009.

GOAL 2: House street homeless individuals.

Objective 1: Implement new street outreach service model with a focus on placement of homeless individuals directly into housing or other long-term residential settings.

Many homeless individuals living on the streets suffer from SPMI and/or an alcohol or substance use disorder. In order to achieve more meaningful outcomes for these clients, DOHMH is putting an increasing emphasis on the need for homeless outreach services to provide clients with rapid placement in permanent housing or long-term transitional settings with access to treatment and services.

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

Four new outreach providers will begin implementing this new model City-wide in September 2007. Under these new performance-based contracts, a portion of funding will be contingent on placement of homeless individuals into housing settings. Providers will also be expected to collect and share client data with DOHMH, the Department of Homeless Services, and other relevant agencies.

IMPROVING TREATMENT FOR HIGH-UTILIZERS OF MEDICAID-FUNDED SERVICES

A relatively small number of Medicaid consumers account for a disproportionately large share of Medicaid expenditures, with 20% of Medicaid consumers representing between 70-80% of costs.^{41,42} These consumers are characterized by repeated episodes of acute psychiatric and medical illness, and lack consistent psychiatric care and permanent housing.

⁴¹ 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.

⁴² Note: These costs calculated inpatient (medical and psychiatric), outpatient, pharmaceutical and Administration for Children costs but did not include Department of Homeless Services, Department of Corrections, uncompensated Health and Hospitals Corporation, New York Police Department and Department of Education services or costs. Thus, the true cost of care and public expenditures for these individuals is even higher.

This level of use of Medicaid services is not only expensive, but reflects a lack of stability in treatment and supports that results in poor outcomes for consumers. DOHMH seeks to remedy the negative effects of this intensive, inconsistent service use by linking an ACT team with supported housing. The resulting Supported Housing Assertive Community Treatment program is expected to provide consumers with more effective treatment and services, as well as permanent housing, while reducing Medicaid costs.

GOAL: To better serve homeless, “high utilizers” of Medicaid services who have been diagnosed with severe and persistent mental illness (SPMI) or co-occurring mental illness and chemical abuse (MICA).

Objective: Develop and implement a model for providing comprehensive services and supported housing to this population by linking an Assertive Community Treatment (ACT) team with supported housing.

There are three criteria for program eligibility:

- Diagnosis of SPMI or MICA;
- Use of more than \$50,000 for mental health inpatient Medicaid services; and
- Chronic homelessness,³⁹ or discharge from an acute care psychiatric hospital or a State-operated psychiatric center without any permanent housing.

In addition, persons who are under an Assisted Outpatient Treatment court order are given priority consideration.

The Supported Housing Assertive Community Treatment program has two key components:

- 1) An ACT team operated by a community-based provider; and
- 2) Scattered-site apartments secured by a housing provider.

The program was designed to include three ACT teams serving a total of 200 individuals. To date, funding has been secured for one ACT team. DOHMH released an RFP in January 2007, and subsequently selected The Bridge to serve 68 clients in the Bronx. The program will be fully operational by the end of December 2007.

DOHMH will maintain a database and develop a reporting system to collect data on client characteristics and evaluate client outcomes, with the aim of determining the costs and benefits of the services provided. These outcome evaluations will include use of Medicaid and other publicly-funded services (e.g., shelter, hospitals, jail or prison) before and after placement in housing, and will be conducted in coordination with the larger NY/NY III housing initiative evaluation.

**INCREASING ACCESS TO MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT FOR
PEOPLE IMPACTED BY THE SEPTEMBER 11, 2001 WORLD TRADE CENTER ATTACK**

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

Types of Services

The NYC 9/11 Benefit Program will serve all individuals residing in New York City who are experiencing mental health or substance problems as a result of the WTC terrorist attack. The Program will pay for qualified individuals to receive outpatient mental health and substance abuse services from a licensed provider of their choice.⁴³ It will also provide financial assistance for medications prescribed during treatment.

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

Individuals Served by the Benefit

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

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

⁴³ The Program will act as a payer of last resort, and payments will be subject to a pre-determined limit.

2007 Accomplishments

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

2008 Goals

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

Objective 1: Implement administration of the program.

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

Objective 2: Enroll and serve beneficiaries.

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

Objective 3: Implement outreach activities and educational campaign.

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

<p>INCREASING ACCESS TO ACUTE PSYCHIATRIC CARE FOR PEOPLE WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES</p>

Treatment options in NYC for individuals with co-occurring MR/DD-MI are extremely limited; acute care services are typically not equipped to work effectively with this population. In 2006, a workgroup of DOHMH staff and members of the MR/DD Borough Councils of the Federation for Mental Health, Mental Retardation and Alcoholism Services was formed to address this problem.

GOAL: Increase psychiatric inpatient capacity and acute psychiatric care alternatives for individuals with mental retardation and developmental disabilities (MR/DD).

Objective: Create specialized, intensive residential programs that can collaborate with accessible acute care hospitals to serve this population.

Since FY 2006, DOHMH and the NYS Office of Mental Retardation and Developmental Disabilities (OMRDD) have been exploring possibilities for increasing the capacity of NYC hospitals to serve MR/DD consumers in psychiatric inpatient units. An assessment of the barriers faced by hospitals in serving this population revealed challenges not only in providing inpatient care, but also in transitioning consumers back into the community. This suggested that addressing hospital capacity in isolation would not resolve the problem, and that hospital services must be integrated into a more comprehensive system of care.

As a result, the group developed a model that would link specially-trained psychiatric inpatient units to intensive residential programs for MR/DD consumers living in the community. The intent was to establish three intensive residential programs, which would each partner with a nearby hospital to collaborate in the treatment of its residents. Consumers admitted to the hospital would be discharged to the residences, which would provide the level of care necessary to help them transition to residential living. The close relationship between the residence and the hospital would facilitate earlier intervention in any subsequent crises, thereby reducing inpatient admissions.

In FY 2007, DOHMH and OMRDD identified a hospital and a residential service provider in Brooklyn who are committed to piloting this model. Planning for implementation of the pilot commenced in early 2007. Consumers are expected to remain in the intensive residential program for approximately 12 to 15 months, after which they will transition to permanent supportive housing or other living situations as appropriate.

In FY 2008, the hospital and residence will finalize implementation and funding plans. Funding this program will be challenging, due to the cross-disability nature of the services, which do not easily conform to existing funding models.

When funding is secured, the pilot will be implemented and outcomes evaluated. If this model proves to be successful, OMRDD may replicate the services in other boroughs. In addition, the workgroup will also consider how this model might be adapted to meet the needs of children and adolescents with MR/DD.

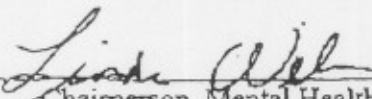
VIII. CONCLUSION

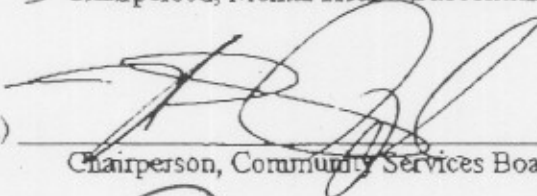
In FY 2007, DOHMH continued to focus on expanding access to mental health care by integrating mental health screening and management into primary care settings, while also promoting improvement of the quality of care provided within mental health care agencies. It also introduced several new initiatives to meet the needs of special populations, particularly those in most need of housing, services, and stabilization in treatment. DOHMH will continue and further expand these efforts in FY 2008.

IX. COUNTY GOVERNMENT ASSURANCES

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: 8/29/07 (x) 
Chairperson, Mental Health Subcommittee

Date: 9/4/07 (x)  Kenneth Popple
Chairperson, Community Services Board

Date: 9/18/07 (x) 
Director/Commissioner

X. APPENDICES

APPENDIX A: PREVALENCE OF MENTAL HEALTH DISORDERS IN NEW YORK CITY

Table I. Prevalence in NYC Adults of Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD)

Demographic Groups	MDD (%)	GAD (%)	MDD or GAD (%)
All NYC Adults	7.5 (6.3-8.9)	3.5 (2.8-4.5)	9.5 (8.1-11.1)
<u>Sex</u>			
Male	5.5 (4.0-7.7)	2.4 (1.4-3.8)	6.6 (4.8-8.9)
Female	9.2 (7.6-11.1)	4.6 (3.5-5.9)	12.0 (10.1-14.1)
<u>Age</u>			
20-39	9.5 (7.7-11.7)	4.1 (2.9-5.8)	11.8 (9.7-14.3)
40-59	7.0 (5.1-9.6)	4.4 (3.1-6.3)	9.5 (7.2-12.4)
60+	4.9 (2.9-8.1)	1.2 (0.4-3.4)	5.3 (3.2-8.6)
<u>Race</u>			
White	7.9 (5.7-10.9)	3.1 (1.9-5.1)	9.3 (6.9-12.4)
Black	9.4 (6.9-12.7)	3.7 (2.2-6.2)	11.5 (8.6-15.2)
Hispanic	7.3 (5.2-10.2)	4.7 (3.3-6.5)	10.5 (8.0-13.5)
Asian/Other	4.7 (2.3-9.3)	2.4 (1.0-5.2)	5.9 (3.2-10.6)
<u>Education</u>			
Less than High School	7.8 (5.4-11.3)	3.6 (2.8-4.6)	10.4 (7.7-13.9)
HS Diploma/GED	7.8 (5.3-11.4)	4.7 (2.9-7.3)	9.7 (7.0-13.3)
More than HS Diploma/GED	7.0 (5.7-8.7)	2.9 (2.1-4.2)	8.7 (7.2-10.6)
<u>Nativity</u>			
US Born	9.6 (7.8-11.8)	4.3 (3.2-5.9)	11.8 (9.7-14.3)
Foreign Born	5.4 (3.9-7.4)	2.8 (1.8-4.1)	7.0 (5.3-9.2)

Source: 2004 DOHMH Health and Nutrition Examination Survey

1. Rates are age-adjusted.
2. MDD rates may include individuals who are also diagnosed with GAD, and GAD rates may include individuals who are also diagnosed with MDD.
3. Treatment rates for past 12 months by diagnoses: MDD only, 36.3 (27.5-46.2); GAD only, 45.7 (26.4-66.4); MDD and GAD, 35.3 (22.8-50.2).

Table II. Prevalence of Mental Health Disorders in LGBT and Heterosexual NYC Adults

Mental Health Disorder	Population		
	LGBT	Heterosexual	TOTAL
Nonspecific Psychological Distress (NPD)	7.9%	5.8%	6.4%
Depression diagnosis in last 12 months (with or without NPD)	7.1%	3.6%	3.9%
Frequent Mental Distress (FMD) only (no NPD or depression diagnosis in last 12 months)	11.9%	7.9%	7.9%

Source: 2006 Community Health Survey

**APPENDIX B: RECEIPT OF TREATMENT BY PEOPLE WITH MENTAL HEALTH DISORDERS
IN NEW YORK CITY**

**Table I. Receipt of Treatment by NYC Adults with
Nonspecific Psychological Distress (NPD), Depression Diagnosis in the Last 12 Months,
or Frequent Mental Distress (FMD)**

	% of those with NPD and/or Depression Dx in Last 12 Mos	% of those with FMD Only¹
Received any mental health treatment (counseling, medication, or both) during the year	45.8%	16.4%
On at least one occasion, did not receive mental health treatment when needed it ² (regardless of whether received treatment on other occasions)	21.0%	8.0%

Source: 2006 DOHMH Community Health Survey

¹ I.e., did not have NPD or a depression diagnosis in the last 12 months.

² Respondents were asked, “Was there a time in the past 12 months when you needed treatment for a mental health problem, but did not get it?”

**Table II. Receipt of Treatment by LGBT and Heterosexual Adults with
Nonspecific Psychological Distress (NPD), Depression Diagnosis in the Last 12 Months,
or Frequent Mental Distress (FMD)**

	Adults with NPD, Depression Dx in Last 12 Months and/or FMD	
	<i>Heterosexual</i>	<i>LGBT</i>
Received any mental health treatment (counseling, medication, or both) during the year	57.6%	31.0%
On at least one occasion, did not receive mental health treatment when needed it (regardless of whether received treatment on other occasions)	14.9%	26.9%

Source: 2006 DOHMH Community Health Survey

APPENDIX C: MENTAL HEALTH SERVICE SYSTEM CAPACITY IN NEW YORK CITY

Program Type	Number of Programs	Number of Programs by Population Served			Total Capacity in Slots or Beds ¹
		Adult	Child	Adult & Child	
<i>Community Support Non-residential Programs</i>					
Advocacy/Support Services	100	11	10	79	268
Affirmative Business/Industry	4	4	0	0	0
Assertive Community Treatment (ACT)	42	42	0	0	2856
Assisted Competitive Employment	31	31	0	0	26
Blended Case Management	69	46	23	0	10252
Bridger Services ²	7	7	0	0	0
Case Management	18	13	2	3	195
Drop In Centers	14	14	0	0	34
Enclave in Industry ³	6	6	0	0	28
Family Support Services – Children & Family	30	0	29	1	123
Home- and Community-Based Services Waiver	6	0	6	0	316
MICA Network	8	8	0	0	0
Multicultural Initiatives	3	2	0	1	41
On-Site Rehabilitation	38	38	0	0	0
Ongoing Integrated Supported Employment Services	16	15	1	0	80
Outreach	38	37	1	0	78
Psychosocial Club	47	46	1	0	539
Recreation	2	2	0	0	6
Respite Services	5	4	1	0	1
Self-Help Programs	16	15	1	0	36
Sheltered Workshop/Satellite Sheltered Workshop	9	9	0	0	27
Supported Education	1	1	0	0	15
Transitional Care	1	1	0	0	0
Transitional Employment	6	5	1	0	46
Transportation	5	2	0	3	40
Vocational Services – Children & Family	6	0	6	0	25
Work Program	2	2	0	0	0
<i>Emergency & Crisis Programs</i>					
CPEP ⁴	12	2	1	9	65
CPEP ⁴ Crisis Intervention	6	1	1	4	11
Crisis Intervention	35	32	3	0	231
Crisis Outreach	7	0	0	7	4
Crisis Residence	2	2	0	0	48
Crisis/Respite Beds	3	3	0	0	4

Program Type	Number of Programs	Number of Programs by Population Served			Total Capacity in Slots or Beds
		Adult	Child	Adult & Child	
<i>Emergency & Crisis Programs Continued</i>					
FEMA Crisis Counseling Assistance and Training	17	0	0	17	0
Home-Based Crisis Intervention	15	0	15	0	115
Mobile Treatment Team/ Crisis Outreach	1	1	0	0	0
Non-Inpatient Crisis Services	0	0	0	0	0
Pre-Admission Screening	4	1	1	2	3
<i>Inpatient Programs</i>					
Hospital for Mentally Ill	2	1	0	1	267
Inpatient Psychiatric Unit of a General Hospital	50	39	3	8	3108
Residential Treatment Facility - Children & Youth	3	0	3	0	125
State Psychiatric Center Inpatient	10	6	3	1	0
<i>Outpatient Programs</i>					
Clinic Treatment	257	83	43	131	0
Continuing Day Treatment	76	76	0	0	6437
Day Treatment	34	0	34	0	1660
Intensive Psychiatric Rehabilitation Treatment	12	9	1	2	442
Partial Hospitalization	13	11	2	0	325
<i>Residential Programs</i>					
Children & Youth Community Residence	9	0	9	0	72
Permanent Housing	1	1	0	0	5
Supported Housing Community Services	171	171	0	0	5514
Supported/Single Room Occupancy	30	30	0	0	1334
Transient Housing – THP, some PHP and some S+C	3	3	0	0	0
Treatment Apartment	60	60	0	0	1847
Treatment Congregate ⁴	89	89	0	0	2309
<i>System-wide Service Utilization & Management</i>					
Coordinated Children's Service Initiative	1	0	1	0	0
Single Point of Access (SPOA)	2	1	1	0	0

Program Type	Number of Programs	Number of Programs by Population Served			Total Capacity in Slots or Beds
		Adult	Child	Adult & Child	
Other					
Children & Youth Sexual Offender Project	2	0	2	0	0
Mobile Mental Health Team	2	0	2	0	100
Pre-Paid (SOMH Managed Care) M.H. Program	14	10	4	0	84
School Program without Clinic	11	0	11	0	35
Special Demo/Other	4	0	1	3	0

Source: New York State Office of Mental Health ConCerts database, June 2007.

¹ Capacity is given where available. Numbers in bold reflect licensed capacity; all other numbers reflect funded capacity.

² Bridger Services: Assistance with transition to a less intensive level of service.

³ Enclave in Industry: Provision of vocational services for individuals with severe disabilities, conducted in small groups in an integrated employment environment.

⁴ CPEP: Comprehensive Psychiatric Emergency Program.

⁵ Treatment Congregate: A group-living residential program featuring interventions that are goal-oriented, intensive, and usually of limited duration.

APPENDIX D: DEVELOPMENT OF SUPPORTIVE HOUSING FOR PEOPLE WITH MENTAL HEALTH DISORDERS UNDER THE NEW YORK/NEW YORK III AGREEMENT

Program	Total Open by 6/30/07	Total Open by 6/30/08	Total Open by 6/30/16
<u>NYC DOHMH</u>			
Reinvestment Housing ⁴⁴	595	595	595
Housing Opportunities for Persons with AIDS ⁴⁵	125	125	125
Community Support Services Program (CSS) ⁴⁶	48	48	48
On-Site Rehab in Supportive Housing ⁴⁷	387	387	387
NY/NY I ⁴⁸	1,431	1,431	1,431
NY/NY II	689	707	707
High Service Needs I ⁴⁹	197	278	400
High Service Needs II	54	272	800
Young Adult with SPMI/SED Pilot Program ⁵⁰		32	52
Supported Housing + ACT ⁵¹		25	68
NY/NY III: Single Adults with SPMI (from community) Families (head of household with SPMI)		50	1,750 400
DOHMH SUBTOTAL	3,526	3,950	6,763
<u>NYS OMH</u>			
Congregate Treatment	2,301	2,301	2,301
Apartment Treatment	1,847	1,847	1,847
Support Programs (CRs/CR-SROs)	1,152	1,266	1,953
Supported Housing	5,324	5,372	5,522
NY/NY III: Single Adults with SPMI (from community) Single Adults with SPMI (from State facilities) Youth with SPMI/SED	205 245	550 525	2,200 1,000 200
OMH SUBTOTAL	11,074	11,861	15,023
TOTAL	14,600	15,811	21,786

⁴⁴ Reinvestment dollars, resulting from the closing of State psychiatric hospitals, funded housing programs in all five boroughs. These units became available during City FY 1999 - City FY 2003.

⁴⁵ Housing Opportunities for Persons with AIDS (HOPWA): With this Federal resource, DOHMH funds five scatter site programs for adults with mental illness and HIV/AIDS, as well as families headed by an adult with HIV/AIDS and who have mental illness and/or substance abuse histories.

⁴⁶ Community Support Services Program (CSS): The Community Support Services program is funded pursuant to Mental Hygiene Law §41.47, and is regulated by Part 575 of the NY Codes, Rules and Regulations. These funds are used to provide community-based mental health services to individuals experiencing serious and persistent mental illness who meet CSS eligibility requirements.

⁴⁷ DOHMH funds on-site services only for adults with serious and persistent mental illness in these housing programs.

⁴⁸ NY/NY I (1990) and II (1999) were joint City/State initiatives which together created approximately 5,200 units of supportive housing for homeless mentally ill individuals in NYC, 2,135 of which are funded through DOHMH. In November 2005, the NY/NY III agreement was signed, creating 9,000 new units to be developed in NYC over 10 years for various populations.

⁴⁹ High Service Needs (HSN): These agreements are City/State matches that provide housing for mentally ill persons with high service needs. HSN I (State FY 2001) will provide 800 units split between the State and the City. HSN II was initiated in State FY 2004 and State FY 2006 and will provide 1,600 units. DMH released a rolling RFP for its 800 HSN II units in Feb 2005.

⁵⁰ The Young Adult Pilot Program will be funded with Reinvestment dollars.

⁵¹ Funding from DOHMH for this new model of scattered site housing will subsidize the rents in 68 apartments as well as the housing staff. The contractor will also receive funding in Medicaid revenue for the ACT team.