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Sent: Thursday, November 26, 2015 3:15 PM
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Subject: Please share this with Blue Ribbon Commission and the Behavioral Health Board

Background: There was an editorial in The New York Times- "Treating Mental Illness, From All Angles" (November 26, 2015). There are elements of this which, I believe, have direct applicability to provision of mental health services in all settings, including jails.

The link for Thrive New York is: <https://thrivenyc.cityofnewyork.us>

Please share this with my colleagues on the Blue Ribbon Commission, staff and the public.

Thank you,
Gail Price

Table of Contents

- 4 Letter from Mayor Bill de Blasio
- 6 Letter from First Lady Chirlane McCray
- 8 Executive Summary

Section 1

16

Understanding New York City's
Mental Health Challenge

Section 2

32

A Foundation for Change:
6 Guiding Principles and 54
Targeted Initiatives

Appendix

94

- 95 Roadmap Feedback
Group Participants
- 98 Acknowledgments
- 100 Endnotes
- 105 Maps

Do You Need Help?

112

Information on Common
Mental Health Issues

Letter from Mayor Bill de Blasio

New York City's greatness is founded on a simple promise: you can thrive here, no matter where you come from or where you want to go in life.

But for too many New Yorkers, poor mental health interrupts the realization of that great promise. As City leaders, we are obligated to use every tool and power of government to make sure there is a path to health and happiness for all New Yorkers. For that to be possible, we need a true and effective mental health system.

We take a huge step forward on that journey with the release of *ThriveNYC: A Mental Health Roadmap for All*.

The mental health crisis facing the residents of our city has been decades in the making. Mental health issues have not been treated by the public or private sectors with the same urgency as physical health issues—even as illness and other threats to mental health affect the lives of nearly every family in the five boroughs each year.

Public initiatives to support the mental health of New Yorkers have been underfunded by billions. Commercial insurers have only been required to provide comparable coverage for mental health treatment under all policies since 2010, and they have a long way to go in providing full and fair coverage.

This legacy of scarce resources, and scarcer attention, has prompted a practical and moral obligation for City government to take up this work. We are serious about getting New Yorkers the help they need to overcome the symptoms of mental illness. But we are also determined to prevent mental illness whenever we can, and that means doing everything we can to alleviate the severe stresses that are at the root of many conditions.



So while we strive to make sure every New Yorker in every community has access to a mental health professional, we simultaneously need to keep building and preserving affordable housing in those communities—so more families are freed from worrying every waking moment about whether they'll be able to make rent that month.

As we work to identify and treat new mothers who suffer from postpartum depression, we must simultaneously provide more working parents with protections like Paid Sick Leave, so no one has to choose between their child's health and their job.

And as we build toward a time when all of our schools offer mental health services to their children, we also need to make sure our kids have essential social-emotional supports in pre-kindergarten and after-school programs.

By following the path laid out in this Roadmap, we will change the trajectory of the lives of so many New Yorkers, and help them become better parents, friends, co-workers, and students.

To make this future a reality, we need your help. If your life has been touched by mental illness, please share your story with someone you trust. And if someone you know is going through a tough time, take a moment to hear them out. There are now more and better resources that are easier for New Yorkers to access. A crisis decades in the making won't be resolved overnight, but *ThriveNYC* is the first step in our mission to help our citizens fulfill their potential.

As the First Lady says, there is no health without mental health. Let's get healthy together.

A handwritten signature in black ink that reads "Bill de Blasio". The signature is written in a cursive, flowing style.

Mayor Bill de Blasio

Letter from First Lady Chirlane McCray



In January 2015, I had the honor of announcing an unprecedented commitment by the City of New York to create a mental health system that works for all New Yorkers. Since then, I have traveled throughout the five boroughs and talked to hundreds of people about their experiences.

I heard many stories of triumph that reminded me of a fundamental truth: Mental illness is treatable. When people have access to the resources they need, they can live their lives to the fullest.

I also heard many stories of suffering, which speaks to another reality: *Every* family has been touched by mental illness. And that certainly includes my own.

A few years ago, our daughter, Chiara, revealed that she was suffering from addiction, depression, and anxiety. I felt everything you'd expect a mother to feel: love, sadness, fear, and a whole lot of uncertainty. But I didn't know where to turn. There was no established series of steps for us to refer to. Bill and I had to trust the recommendations of people we didn't really know, and make some major decisions based on faith alone.

In the end, we found enough of what we were looking for. But even after our crisis subsided, we couldn't forget everything we'd been through. Why had it been so difficult to find the right help? And what can we do for the many New York City families who don't have access to as many resources as we did?

ThriveNYC: A Mental Health Roadmap for All begins to answer those questions, and many others. Now, finally, New York City has a plan of action to encourage the mental well being of all New Yorkers and begin helping those who have been falling through the cracks. I am grateful to everyone who helped make this Roadmap possible, especially our world class Department of Health and Mental Hygiene; Executive Deputy Commissioner for Mental Hygiene, Dr. Gary Belkin; and Commissioner Dr. Mary T. Bassett.

We will work with our partners to create new programs, make existing programs even better, and make *all* programs easier to access. With each success, as people find solutions, we will move one step closer to changing our mindset around the mind and building a culture that values and supports mental health.

I still remember when people were afraid to say “breast” and “cancer” out loud. I still remember when that disease was only discussed between sisters and girlfriends in stolen whispers. Thankfully, that has changed. Today, breast cancer survivors are proud to tell their stories, because they know the community has their back.

It's time to do the same when it comes to treating mental illness and promoting mental health. The work won't be easy or fast. But if we follow the guideposts laid out in the Roadmap, we can create a city where it's as easy to get help for anxiety as it is to get a flu shot – a city where every New Yorker can live with dignity.

A handwritten signature in black ink that reads "Chirlane McCray". The signature is fluid and cursive, with a long, sweeping underline.

First Lady Chirlane I. McCray

Executive Summary



One in five.

That's how many adult New Yorkers experience a mental health disorder in any given year.¹ And that's a conservative estimate.

But one in five doesn't begin to capture the devastating impact of mental illness on our city. The consequences of this quiet crisis are everywhere, and affect all of us.

We see it in our schools, where 8% of public high school students report attempting suicide.²

We see it in our homeless shelters, where approximately 35% of clients suffer from a serious mental illness.³

We see it in our hospitals, which grapple with 70,000 alcohol-related emergency room visits and 1,800 alcohol-related deaths among 18- to 64-year-olds every year.⁴ Substance misuse is among the leading contributors to premature death throughout New York City.⁵

We see it in our jails, where over a third of detained people are diagnosed with a mental illness.⁶

We see it among those who are grieving, with one-third of widows and widowers—most of whom are senior citizens—meeting criteria for depression in the first month after the death of their spouse. Half remain clinically depressed a year later.⁷

We see it in our economy, with \$14 billion in estimated annual productivity losses in New York City tied to depression and substance misuse.⁸

And we see it around our dinner tables, in our living rooms, at our places of worship. At any given time, over half a million adult New Yorkers are estimated to have depression, yet less than 40% report receiving care for it.⁹



“It’s all of us. Whether you’re getting hospitalized in the ER or whether you’re feeling unable to get out of bed because of a particular situation that happened the previous day, it’s all of us. There are no exceptions.”

Professor, New York University

For so long, our city has not done enough to support the emotional well-being of its residents. Too many New Yorkers have not gotten the help they needed for any number of reasons. Perhaps they were afraid to reveal their pain, the help they needed was hard to access, they couldn't find someone who understood their culture, they didn't think it would help, or they simply couldn't afford it. All told, 41% of adult New Yorkers with a serious mental illness (SMI)¹⁰ said they needed treatment at some point in the past year but did not receive it or delayed getting it.¹¹

Clearly, mental illness isn't just disrupting the lives of individual New Yorkers—it is exacting a terrible social, financial, and emotional cost on our city.

What is needed—and what New York City currently lacks—is a major commitment to mental health, one that is backed up by resources that are commensurate to the challenge. Tackling a problem that directly affects 20% of New Yorkers—in addition to all of the people in their lives—requires a population-wide response.

And to be successful, that response must assertively support and promote mental *health* in addition to addressing mental illness. The World Health Organization defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”¹² **In other words, our ability to thrive—as human beings and as a city—is closely tied to our mental health.**

At the most basic level, this new commitment is about thinking big and thinking differently. A public health solution must include all the following elements: prevention of illness, promotion of mental health, early detection of problems, and treatment. By themselves, mental health professionals cannot stem the tide of one of our society's most difficult and pervasive health challenges. To achieve lasting success, we must treat not only the individual, but also the conditions in our society that threaten mental health. **We must identify when people are at greater risk and why, while paying close attention to the range of factors—both individual and social—that can either make us more vulnerable or prevent the onset or worsening of mental illness.**¹³

Getting to where we need to go requires a broad campaign that engages every sector of society. Lawmakers must devote political capital and financial resources to the challenge at hand. Government agencies must implement new policies. The media must be engaged in the work of

increasing public awareness and accurately representing mental illness. Health professionals must use techniques that promote mental health and more effectively prevent, as well as treat, illness. And crucially, New Yorkers from every community must play an active role in both shaping and implementing this effort.

As an example, consider New York City's successful effort to curb smoking. For decades, Americans settled for incremental change when it came to the fight against tobacco. In New York City, the decline in adult smoking had stalled. Then, in 2003, the City's landmark Smoke-Free Air Act went into effect, banning smoking in bars and restaurants. This signaled the beginning of a sweeping public health campaign. City officials coordinated an anti-smoking communications strategy that blanketed our airwaves, newspapers, and subway cars. Lawmakers raised federal, state, and local excise taxes. And health officials developed innovative ways to provide New Yorkers with treatment tools, such as inviting people to call 311 and request free nicotine patches. We monitored our progress and stayed on track with help from an annual survey that tracked how many people smoked.

Together, these efforts achieved tremendous results. The adult smoking rate declined by 35% between 2002 and 2014,¹⁴ and the youth smoking rate fell by a stunning 53% from 2001 to 2013.¹⁵ It is estimated that nearly 50,000 adult New Yorkers who quit smoking as a result of tobacco control efforts from 2002-2010 will avoid a premature smoking-related death before the age of 75.¹⁶ These successes were reached decades after learning of the harms of smoking. Public health strategies take time to learn what will lead to population-level improvements in health. The same will be true for making an impact on mental health. This Roadmap identifies the key new directions needed to do so, and a robust but initial set of initiatives to move in that direction.

Smoking is just one example of a successful public health campaign that changed the lives of tens of thousands of New Yorkers; there are many others. Together, we reduced teen pregnancy to record lows.¹⁷ Between 2000 and 2013, we reduced the annual number of mother-to-child HIV transmissions by 92%.¹⁸ And within the last decade, we reduced the number of children with dangerous levels of lead in their blood by 70%.¹⁹

We can and should have equally big ambitions and long-term strategies when it comes to mental health. Together, over years, we can lay the foundation for lifelong emotional health for all children. We can protect new mothers from depression. We can prevent suicides and reduce harmful consequences of substance misuse. We can close gaps in access to mental health services. We can help more people with chronic and disabling mental illness lead active lives. We can provide people who have previously cycled in and out of the system with the comprehensive and

compassionate network of care they need. **We can make it our goal to not only reduce the toll of mental illness, but also promote mental health and protect New Yorkers' resiliency, self-esteem, family strength, and joy.**

Our plan for achieving these goals and many others is described in this Roadmap, which lays out:

- The challenges we face;
- The principles that will guide our effort to meet those challenges;
- A broad array of solutions that build upon our principles; and
- A plan to achieve long-term change.

Our work will be shaped by six guiding principles. They are based on research, the experience of other cities and countries, input from hundreds of local organizations that are working to promote mental health, and individual New Yorkers with experience battling mental illness who bravely shared their stories with us.

We will advance these principles in part through 54 targeted initiatives—representing an investment of \$850 million over four years—that together comprise an entirely new and more holistic approach to mental health in New York City, and set a foundation for taking on this public health challenge in the years ahead.

Six Guiding Principles



1. Change the Culture

Make mental health everybody's business. It's time for New Yorkers to have an open conversation about mental health.

Key Initiatives:

- **Mental Health First Aid Training:** We will train 250,000 New Yorkers in Mental Health First Aid, which teaches people how to help friends, family members, and co-workers who may be suffering.
- **Public Awareness Campaign:** We will launch a citywide campaign to change the conversation around mental health and help individuals and communities take action.



2. Act Early

Give New Yorkers more tools to weather challenges and capitalize on opportunities by investing in prevention and early intervention.

Key Initiatives:

- **Social-Emotional Learning for the Youngest New Yorkers:** The City will embark on an expansion of Social Emotional Learning (SEL) in early childhood education and care settings. We will increase opportunities for children to realize their potential by building a foundation of social emotional skills during a critical stage of development.
- **Create a Network of Mental Health Consultants Serving All Schools:** While different schools have different levels of need when it comes to mental health, every school should have access to professional support. Starting immediately, the City will hire 100 School Mental Health Consultants (SMHCs) who will work with every school citywide to ensure that staff and administrators have an outlet to connect students with the highest immediate needs to care.



3. Close Treatment Gaps

Provide New Yorkers in every neighborhood—including those at greatest risk—with equal access to care that works for them and their communities, when and where they need it.

Key Initiatives:

- **Closing Gaps on Maternal Depression:** New York City is setting a goal to screen and treat all pregnant women and new mothers for pregnancy related depression. NYC Health + Hospitals and Maimonides Medical

Center have committed to reach and serve each of these women in their care within two years. And beginning this year, NYC Health + Hospitals and Maimonides, along with the Greater New York Hospital Association, will lead a collaboration across other City hospital systems to close this treatment gap.

- **NYC Support:** People throughout New York City often complain about being forced to navigate a confusing and unresponsive mental health and substance use treatment system largely on their own. The City will address this challenge with the creation of NYC Support, which will serve as a point of entry to the City's behavioral health services. New Yorkers will be able to access NYC Support via phone, text messaging, or the web. In addition to robust crisis counseling, NYC Support will provide referrals, help New Yorkers schedule appointments with mental health providers, and follow up with New Yorkers until they find the appropriate care.



4. Partner with Communities

Embrace the wisdom and strengths of local communities by collaborating with them to create effective and culturally competent solutions.

Key Initiatives:

- **NYC Mental Health Corps:** We will begin creating a Corps of approximately 400 physicians and recently graduated Masters and Doctoral level clinicians to work in substance use programs, mental health clinics, and primary care practices in high need communities throughout the city. When fully staffed, the Corps will provide approximately 400,000 additional hours of service in the communities where they are needed most, including at primary care settings, which is where most New Yorkers receive their regular medical care. We will work with communities to determine where Corps members can do the most good.
- **Virtual Learning Center for Community-Based Organizations:** The City will develop a free, universally available web based Learning Center for community organizations. Our initial outreach will focus on faith based and immigrant serving organizations. The website will provide a skills training library that offers non clinicians effective and executable task shifting, prevention strategies, and information on how to help people access care. It will include videos, guides to test skills, handouts of tips and information summaries, assessments, and links to other resources. The website will also be a forum to facilitate partnerships between community groups and providers.



5. Use Data Better

Work with all stakeholders to address gaps, improve programs, and create a truly equitable and responsive mental health system by sharing and using information and data better.

Key Initiative:

- **Mental Health Innovation Lab:** We will establish a Lab that will make sure City agencies, treatment providers, and others with a stake in promoting mental health have the most up to date and accurate information and tools. The Lab will serve as the research and development arm of our Roadmap effort, with a focus on developing new ways to both collect information and help stakeholders put it to work.



6. Strengthen Government's Ability to Lead

Affirm City government's responsibility to coordinate an unprecedented effort to support the mental health of all New Yorkers.

Key Initiatives:

- **New Supportive Housing for Vulnerable New Yorkers:** The number of New Yorkers who qualify for supportive housing is almost five times greater than the number of available units. To meet this need, the City is committing to bring on 15,000 apartments for supportive housing over the next 15 years. The new supportive housing will serve a number of vulnerable populations, including homeless families, homeless single veterans, domestic violence survivors, young adults who have recently left foster care or who have been in foster care and are at risk of homelessness, and individuals receiving nursing home care.
- **Mental Health Council:** We will bring together a cross section of City agencies to coordinate a comprehensive mental health effort. The Council will work closely with hospitals, insurance companies, community based organizations, our partners at other levels of government, clergy, advocates, and people with lived experience to turn the Roadmap into reality and establish the City as a policy leader.

We hope you will join us in putting this Roadmap into action. Just as every community knows the pain of mental illness, every community has valuable wisdom and resources to contribute. By closing the gaps in our mental health system, we can also help close the gaps that exist within our neighborhoods, our families, and even within ourselves. Together, we can achieve the goals of this Roadmap and build a healthier, happier New York City.

Section 1

Understanding New York City's Mental Health Challenge

While statistics alone cannot capture the devastating human costs of mental illness, they drive home the scope of the mental health crisis facing New York City.



At least one in five adult New Yorkers is **likely to experience a mental health disorder** in any given year.

Youth Issues

(NYC Public High School Students)

Report attempting suicide



Report feeling sad or hopeless each month²⁰



The stigma of mental illness has been found to have serious negative effects on hope and an individual's sense of self-esteem. Stigma also increases the severity of psychiatric symptoms and decreases treatment adherence.²⁴

Depression



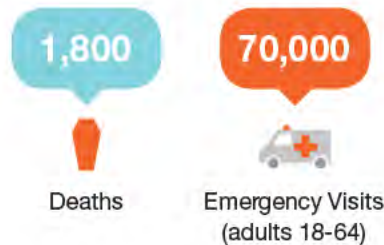
- Approximately 8% of adult New Yorkers experience symptoms of depression each year.²¹
- 12% of NYC mothers exhibit symptoms of depression in the months after giving birth.²²
- **Major depressive disorder** is the single greatest source of disability in NYC.²³

18 Yankee Stadiums could not hold all of the New Yorkers with a **lifetime diagnosis of depression.**

Substance Abuse

Consequences of substance misuse are among the leading causes of premature death in every neighborhood in New York City.

Alcohol use causes (per year)



Unintentional drug overdose deaths outnumber both homicide and motor vehicle fatalities.²⁵

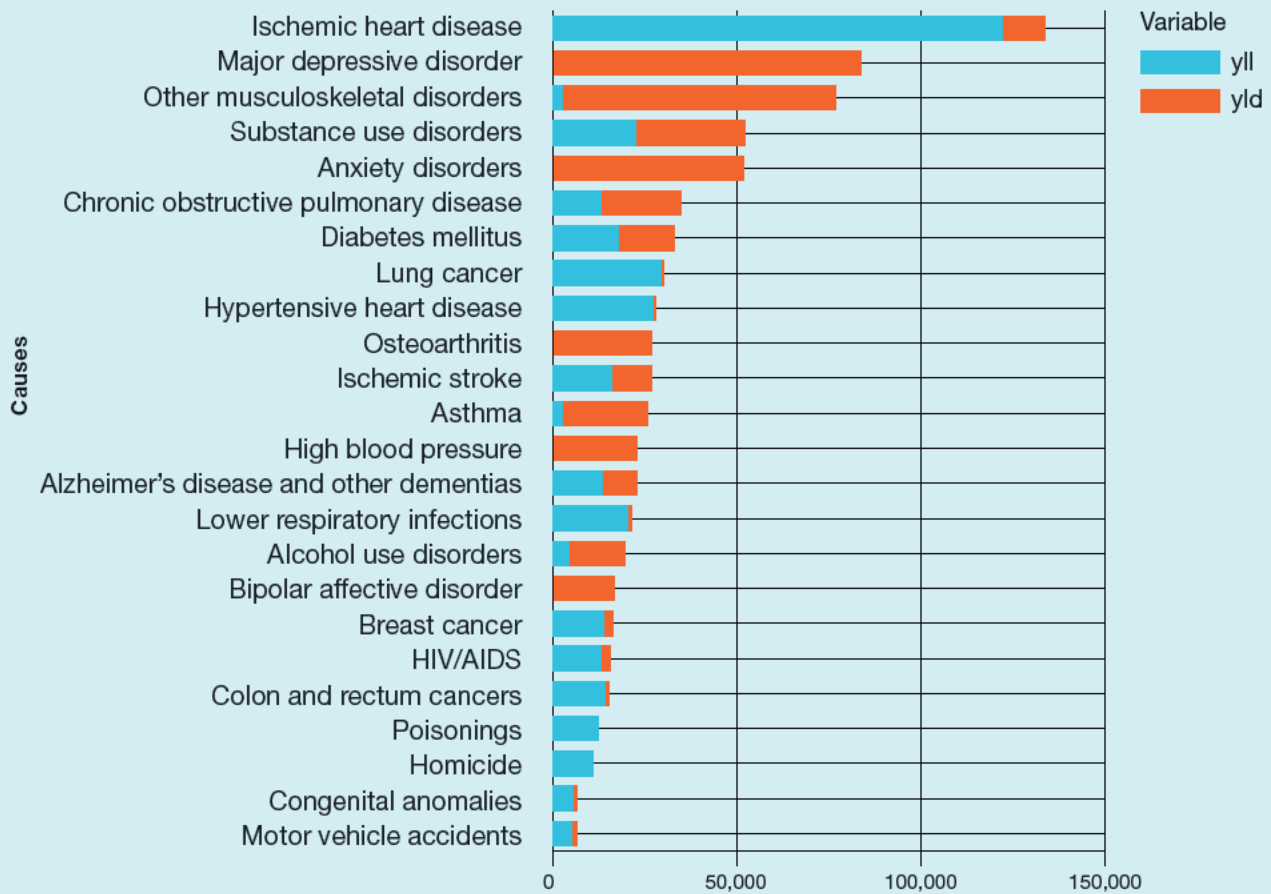


Clearly, the mental health crisis is both broad and deep. The first step toward solving it is digging deeper into the data and developing a more complete understanding of the risk factors and root causes that result in certain populations experiencing more—and more serious—mental health challenges.

Mental illness exacts a devastating social and economic cost on New Yorkers and the communities they call home.

Disability Adjusted Life-Years

Selected Causes of DALYs, NYC 2013



One metric frequently used to describe the impact of mental illness on society relative to other health problems is Disability Adjusted Life-Years (DALYs), which measures the number of years lost to a given disease as a result of loss of life (YLL) or disability (YLD). Together, these are often referred to as the “disease burden.”

In other words, DALYs quantify what makes us feel sick and what kills us.

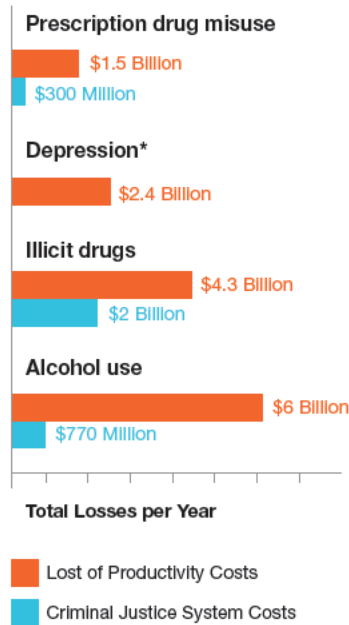
The figure shows that mental illness and substance use disorders are among the leading contributors to the disease burden for New Yorkers, with depressive illness the single largest contributor after heart disease.²⁶ **If the impact of alcohol use disorders and other substance use disorders are added together (they are separated in this figure), they would be the second leading contributor to overall disease burden in New York City.**

Disability related to mental illness can have significant real-life consequences for New Yorkers. It can lead to job loss, dropping out of school, struggles with parenting, losing one’s housing, having difficulty making and keeping friends, and other challenges.

But DALYs only show a part of the impact. They do not capture the wide variety of related health problems that often afflict people with mental illness, and therefore underestimate the full extent of their suffering. A few additional statistics make this clear:

- In the U.S., the average life expectancy of people with a mental illness is approximately eight years less than people without one.²⁷ Many people with mental illness or substance use disorders experience a substantial gap in the quality of routine medical care, especially when it comes to general medical and cardiovascular care.²⁸
- Experiencing a period of mental illness increases a person’s likelihood of developing a physical illness, including diabetes, hypertension, and high cholesterol.^{29,30,31,32}
- Adults in NYC with SMI are three times more likely to smoke, and they are less likely to exercise or eat fruits or vegetables. It is therefore not surprising that they are twice as likely to have two or more chronic medical illnesses when compared to adults without an SMI.³³
- In the U.S., prolonged depression can more than double the risk of stroke in people over 50 years of age.³⁴

Economic Losses from Mental Health and Substance Use Factors³⁵ (NYC-wide annual estimate)



*Estimates for depression-related criminal justice system costs are unavailable

DALYs also do not capture people who may not have a diagnosable mental *illness*, but who still may suffer from poor mental *health*. To support the mental well-being of all New Yorkers and move the needle on DALYs, we also need to focus on our society itself—which means addressing big issues like racism, income inequality, and disparities in community resources or access to education and opportunity while also providing targeted individual care when needed.

The economic burden of mental illness

Finally, DALYs do not capture the considerable economic burden mental illness and substance misuse exact on society. In New York City, mental illness and substance misuse together have a tremendous impact on a variety of societal costs, including health care, criminal justice, and lost productivity.³⁶

- Alcohol misuse is estimated to cost NYC nearly \$6 billion in citywide economic productivity losses every year, while depression accounts for \$2.4 billion.
- Misuse of illicit and prescription drugs and alcohol in NYC together cost approximately \$3 billion in criminal justice expenditures annually.

As troubling as these numbers are, they reflect only a fraction of the total costs. For instance, measuring the cost of productivity losses to a business may not fully capture the cost of mental illness in the workplace. In a study in London, for example, estimates of lost earnings for individuals with mental illness were double the estimate of economic losses in productivity.³⁷ In addition, these figures also do not fully account for costs incurred by caregivers, family members, and the community at large.

It is also important to consider the enormous amount of money we spend on overall health care costs. In 2013, more than 630,000 New Yorkers with health insurance (Medicaid, Medicare, or commercial insurance) saw a provider who diagnosed a mental illness. While this group accounted for 8.3% of the population, the cost of their health care—almost \$17 billion—represented approximately 25.6% of total health care expenditures paid by these insurance sources in New York City. This figure does not capture the cost of care for the many New Yorkers who are uninsured.^{38,39}

The Cost of Mental Illness in NYC



25.6% of ALL
health care expenditures
involve patients with
mental illness.



Almost
\$17 billion
was paid by insurance
for their health care.

Risks to mental health affect New Yorkers at every stage of their lives

Mental illness or distress can occur at any point during our lives. But there are certain stages that present greater risks to mental health—and also a greater opportunity to intervene with effective support that could provide the tools to achieve long-term mental wellness.

Early years

The first few years of life play a profound role in a person’s ability to manage emotions in a healthy way. Childhood exposure to adverse events—such as domestic violence, neglect, abuse, family financial strain and divorce, or certain community conditions such as unsafe neighborhoods—are all associated with chronic diseases and threats to mental health in adulthood.^{40,41}

These circumstances can also contribute to toxic stress, which is the strong, unrelieved activation of the body’s stress management system in the absence of protective support. Toxic stress can change the architecture of the developing brain and have a devastating lifelong impact.⁴² For example:

- Adolescents exposed to childhood adversity, including family malfunctioning, abuse, neglect, violence, and economic adversity, are nearly

2x as likely to experience the onset of mental disorders,

and the risk to their mental health grows with additional exposures.⁴³

- Even neighborhood violence that a child does not directly experience, such as a nearby homicide, has been shown to reduce cognitive performance.⁴⁴
- Experiencing two or more adverse events during childhood is associated with a two- to eight-fold increase in depression, anxiety, and tobacco and marijuana use.⁴⁵
- Early identification of developmental delays and disabilities in young children through timely screening can reduce the risk for depression, anxiety, and overall psychological distress.⁴⁶

Tragically, far too many young New Yorkers are at risk for poor mental health. A 2011-2012 survey found that approximately 18% of children in New York State between the ages of zero and 17 experienced two or more adverse family experiences in their lifetime, which predicts poor mental health and physical health outcomes later in life.⁴⁷ In order to help these children, we need to do a better job of assessing them for mental health risks when they have contact with City agencies or the health system and then connecting them to appropriate resources.

Lesbian, gay, bisexual, and transgender (LGBT) youth

Gay and lesbian youth in New York City experience nearly twice as much bullying on school property as heterosexual youth, and are more than twice as likely to attempt suicide. LGBT youth of color may also experience compounded stressors related to racism and discrimination.⁴⁸



“I had a breakdown during my senior year of Dartmouth. I did not pass my last class and was suspended. Then overwhelming disappointment followed by a few hospitalizations and outpatient treatment—I was hearing voices. My treatment helped and I was able to get placement in adult home. I was able to return to college after 18 years. If I’d had help during or before my breakdown, I could have returned to college years sooner.”

J., Brooklyn

Adolescence

Adolescence is period when mental health conditions often first emerge, ranging from substance misuse to psychosis.^{49,50}



- In a biennial survey of NYC public high schools, more than one in four students reported feeling persistently sad or hopeless in the past year. This is a common predictor of depressive illness.⁵¹
- In 2013, one in ten NYC public high school students reported being hit, slapped, or physically hurt by someone they were dating or going out with within the past year.⁵²
- A young person who is exposed to pervasive violence has a 50% increased risk of having elevated depressive symptoms and anxiety.⁵³ Each episode of violence (dating violence, bullying, physical fighting, family violence) is associated with an increased risk of that young person also being a perpetrator of violence by anywhere from 35% to 144%.⁵⁴
- An estimated 7,000 emergency room visits each year in NYC involve alcohol use among individuals under 21 years of age.⁵⁵
- 8% of NYC public high school students report attempting suicide.⁵⁶ That percentage doubles if a student has been bullied on school grounds, which 18% of students experience.⁵⁷

Young adulthood

Young adulthood is a time of continuing brain development and the creation of lifelong social networks and habits. It is also often a period when mental illnesses emerge, especially mood, psychotic, and substance use disorders. **According to national studies, three quarters of all mental health and substance use disorders start by age 24.**⁵⁸

Among 1,000 City University of New York undergraduates who responded to a campus survey⁵⁹:

Met criteria for depression



Only 10% received help from their college counseling or health center.

Reported significant anxiety





In New York City, over 1 in 10 women who recently gave birth experience symptoms of post-partum depression

Veterans

New York City is home to 230,000 veterans, nearly a quarter of whom have a probable diagnosis of post traumatic stress disorder and/or major depression.⁶⁹

Parenthood

Becoming a parent can be a joyful experience, but it is also associated with a number of mental health risks. While this is true for both fathers and mothers, depression in mothers is more common.⁶⁰ A mother's depression affects her own mental and physical health, heightens the child's risk of psychiatric illness, lowers the chances of the child developing emotional strength and resilience, and decreases the child's likelihood of receiving optimal health care.⁶¹

Despite the important effect of parenting on mental health, we have limited data when it comes to identifying individuals or areas of the city where risk is high. Here is what we do know:

- 12% of NYC mothers exhibit symptoms of depression in the months after giving birth.⁶²
- Studies suggest rates of depression after pregnancy among lower-income mothers can be at least double overall rates.⁶³
- While a higher risk of depression persists in mothers with young children up to five years of age, more than one-third of these mothers, and the majority of pregnant women, do not get help.^{64,65}
- Parent caregivers of children with chronic illness, including intellectual/developmental disabilities, are at greater risk for depression as well.⁶⁶
- Women younger than 19 years old also report experiencing post-partum depression at higher rates than women 20 years old and older.⁶⁷

Acting early with parents also helps us act early for their children. Evidence shows that providing parents with preventive interventions for mental illness reduces the risk of their child developing a mental disorder and psychological symptoms later in life by 40%.⁶⁸

Adulthood

Adult mental illness often builds upon earlier events, but this period of life can present additional threats to mental health such as the loss of a job, economic vulnerability, and divorce. Overall, bipolar illness, schizophrenia, PTSD, OCD, and other anxiety disorders can also exert their greatest impact in adulthood, contributing to disability and social and economic difficulties and challenging families. Family support is a key promoter of resilience, mental health, and connection to quality care for people suffering from these disorders.^{70,71,72} Employment is another crucial factor for self-sufficiency in adults^{73,74} and yet individuals experiencing mental illness and intellectual and developmental disabilities are significantly underrepresented in the workforce.^{75,76,77}

Justice-involved New Yorkers

On any given day in New York City jails, as many as 40% of those detained have an identified mental health related problem, not even including substance misuse or dependence.⁷⁸

People who are homeless

Approximately 35% of NYC Department of Homeless Services shelter clients have a serious mental illness. This figure is closer to 40% among people who are street homeless.⁷⁹

Adulthood can also be a time of trauma, especially in the form of intimate partner and other violence. Nearly one out of every 50 adult New Yorkers reports that they are physically fearful of their partner.⁸⁰ And this is an issue that cuts across every demographic—our Family Justice Centers, which serve victims of domestic violence, have worked with clients from every residential zip code in New York City. It is also important to note that abuse isn't always physical. According to a 2011 study by the Centers for Disease Control, “nearly half of all women and men in the United States have experienced psychological aggression by an intimate partner in their lifetime (48.4% for women and 48.8% for men).” The same study found that more than 20% of individuals who suffered intimate partner abuse also suffered from one or more symptoms of Post-Traumatic Stress Syndrome.⁸¹

Late adulthood

Our eldest citizens, especially if they are socially isolated or impaired from diminished overall health, have an escalated risk for depression and suicide.

- The incidence of depression is higher among subpopulations of elders compared to the general population, with rates of major depression occurring in 13.5% of elder home health care recipients.⁸²
- As mentioned, in some studies roughly one-third of widows and widowers meet the criteria for depression in the first month after the death of their spouse. Half of these individuals—most of whom are senior citizens—remain clinically depressed a year later.⁸³



In the U.S. the suicide rate of older adults (65+) is roughly 50% higher than the general population.



Older white men over 85 commit suicide at four times the rate of the general population.⁸⁴

- Information from the National Household Survey on Drug Use predicted that as baby boomers age, treatment rates for substance use disorders among older adults (50+) may increase by as much as 70%.⁸⁵ Many of our communities will need a significant increase in resources to handle this challenge (see map).
- Older parent caregivers of those with intellectual/developmental disabilities may be at a relatively greater risk for psychological stress and other mental health conditions.⁸⁶
- 92 out of every 1,000 older New York City residents were victims of elder abuse in a one year period.⁸⁷

Mental Health and Substance Use Treatment Service for Seniors: Staten Island

● Services to Seniors (65+)



Summary

In order to effectively tailor both our treatment and prevention efforts, we must have a thorough and data-based understanding of how mental illness, substance misuse, and threats to mental health manifest in the various stages of life. We must also recognize that our city is not simply a collection of individual residents with distinct needs; when one person in our family, our neighborhood, our church, or our community suffers, so do the rest of us. We must invest in mental health promotion for the whole city by reducing stressors and traumas—including growing inequality, housing instability, and discrimination—while also equipping individual New Yorkers with the skills and tools to manage daily challenges, and promoting mental health. If we achieve these goals, we will bolster community resilience and social cohesion, and our city will thrive.

Mental health varies across the city

We all face threats to our mental health. But these threats are distributed unequally, and are especially present in neighborhoods where historic neglect has resulted from racial discrimination and other longstanding structural inequities.



“I have bipolar disorder and am Japanese. Asian cultures have arguably the strongest stigma problems in the world and the general society immediately puts us in the “crazy” category. Many Asians with serious mental illness remain in denial for many years and some never acknowledge so we don’t tend to seek treatment of any kind. As a result, I suffered with the illness for over a decade and attempted suicide in my late teens. But when I finally got sick and tired of being sick and tired, I decided to get help. I took advantage of different kinds of talk therapy and finally after much tweaking of the cocktail of medications found one that worked. One big element of my recovery and wellness is peer support, which helped me to understand that there wasn’t something ‘wrong’ with me personally.”

Y., Manhattan

Poverty

In New York City, the distribution of mental illness varies strongly by income:

- SMI is more than twice as common for adults who live below 200% of the federal poverty level (FPL) compared to those living 200% above it.⁸⁸
- In NYC, most of the young children with reported mental health disorders live in poverty. Of NYC children between the ages of two and twelve whose parents reported their child being diagnosed with at least one of five common mental health disorders, as many as 70% live in poverty.⁸⁹

Race and ethnicity

The prevalence, diagnosis, and treatment of mental illness can vary widely among racial and ethnic groups. For example:

- In New York City, Latina adolescents feel disproportionately sad or hopeless and are more likely to attempt suicide.⁹⁰
- In the United States, African Americans are less likely than whites to be diagnosed with common mental illnesses like depression and anxiety. But when they *are* diagnosed with a mental illness, African Americans are more likely than whites to experience a persistent and severe illness.^{91,92} There are also biases in diagnosis. For example, African Americans are more likely to be given a diagnosis of schizophrenia and other psychotic disorders, and that is true even when they have the same symptoms as whites.⁹³

This highlights a significant challenge to understanding the prevalence of mental illness in a given population. Provider biases can affect the diagnosis and treatment of mental illness, and the use of mental illness labels can sometimes be driven by social judgments and prejudice.⁹⁴ It is therefore uncertain to what degree data on racial, ethnic, or gender differences in mental health reflects true presence of illness.

We must also look closely at differences within racial groups. While diagnosis rates for depression and anxiety among adult Latinos in recent years are relatively comparable to whites,⁹⁵ there are large variations

within Latinos. For example, people of Puerto Rican descent were 54% more likely to have more severe depressive symptoms than people of Mexican descent.⁹⁶

Every New Yorker is shaped by factors such as race, culture, ethnicity, income, and geography in unique and complex ways. Because an individual simultaneously occupies more than one identity, and because of the many social prejudices and obstacles that can accompany each of these identities, a better understanding of how these different experiences and histories shape mental health outcomes—whether as a diagnosable illness, or as other emotional suffering that needs better solutions—is critical to designing effective responses.

Access to care varies throughout the city

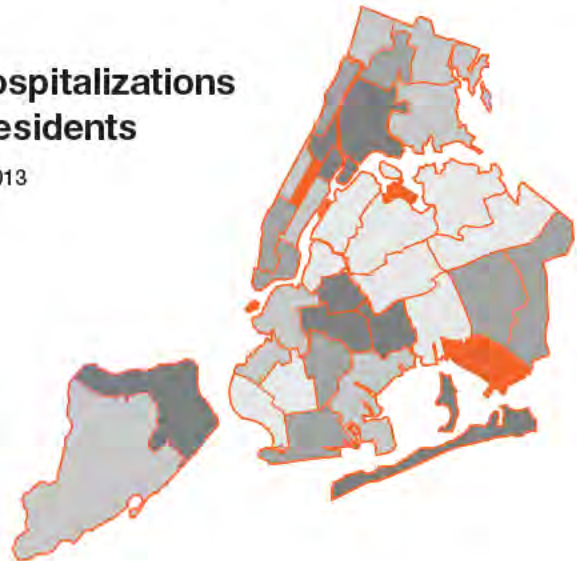
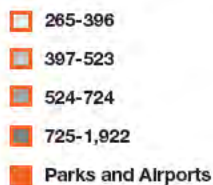
Despite the fact that people of color and those in poverty bear the greatest mental health burden, they are among the least likely to get help.

- African Americans and Asians are less likely to receive counseling/therapy or take medication for their illness than whites, according to a survey of NYC residents.⁹⁷
- Receipt of mental health treatment has been found to be lower for African Americans and Latinos compared to whites.⁹⁸
- National studies suggest that African Americans can be half as likely as whites to receive community-based mental health care, but as much as twice as likely to be hospitalized.^{99,100}

The likelihood of someone having a psychiatric hospitalization in New York City varies dramatically by neighborhood and income (see map).

Psychiatric Hospitalizations per 100,000 Residents

Source: NYS SPARCS, 2013



A public health approach means that we cannot limit ourselves to advocating for access to treatment—we must also examine why certain communities bear such a disproportionate share of the burden.

As the map suggests, people from the city’s lowest income neighborhoods are twice as likely to be hospitalized for mental illness compared to residents from the highest income neighborhoods.¹⁰¹

The reasons behind these variations across our neighborhoods reflect more than a need for hospitalization; they also reflect a lack of other options. High rates of psychiatric hospitalization likely reflect the challenges residents of some neighborhoods face, including difficulty accessing preventive services and early care, greater exposure to stressors, and interruptions in health insurance.

Taking a public health approach to mental illness means examining these root causes. In other words, we cannot limit ourselves to treating mental illness—we must also examine the context that results in certain communities bearing such a disproportionate share of the collective burden.

People are not connected to the right care when they need it

Our mental health treatment system is often criticized as not being a “system” at all, for the simple reason that it doesn’t do a good job of reaching people, directing them to effective care, and making sure they actually receive the care they need. As noted, **41% of New York City adults with an SMI said they needed treatment at some point in the past year but did not receive it or delayed getting it.** And when New Yorkers do receive care, it is often inefficient and ineffective.

Medicaid spending on mental health in NYC

| | No Mental Health or Substance Use Diagnosis | Mental Health or Substance Use Diagnosis | Mental Health and/or Substance Use Diagnosis |
|------------------------------|---|---|---|
| Cost | \$ | \$\$\$ | \$\$\$\$ |
| Days in Hospital (inpatient) |  |  |  |
| ER Visits |  |  |  |

Consider Medicaid spending on mental health in New York City (see figure). Medicaid is the source of health insurance for approximately 3 million New Yorkers. In 2013, the overall health costs for people with a mental illness or substance use-related diagnosis were more than three times the cost for people without these diagnoses.

Individuals with any mental illness diagnosis or indication of substance misuse experience three times the number of emergency room visits for physical health care issues, and six times the number of medical inpatient hospital days compared to people without those conditions.¹⁰² These overall patterns hold for other sources of insurance as well.¹⁰³ And other data suggests that older patients with symptoms of depression have roughly 50% higher overall health care costs than non-depressed seniors.^{104,105}

Although high-cost mental health and medical care services clearly fuel each other, they are generally not well coordinated or well integrated. This serves to further escalate costs. It's not just that hospitalization is expensive—it is also ineffective if not followed by regular, ongoing outpatient treatment in the community. Yet in the first six months of 2014, only about one in three people who completed a psychiatric hospitalization in New York City were successfully linked to follow-up outpatient treatment within 30 days of leaving the hospital.¹⁰⁶

This illustrates a fundamental problem: **Despite the substantial resources we invest and spend on mental health, the treatment system falls short on results. A big reason for this failure is the fact that care is often not evidence-based,** in two key ways:

- **The treatment often doesn't fit the need.** Too often, we connect people to resources and treatment that do not get to the heart of the problem. For example, a disproportionate share of Medicaid dollars is devoted to families with complex needs that are affected by poverty, abuse, neglect, and mental health challenges. While children in these families who suffer from mental illness may receive treatment or support services, the services typically focus on the child and fail to use more specialized approaches that address the family as a whole.¹⁰⁷ On the other hand, specialized treatment options are often used where lighter touches, such as support groups or self-care, would be more effective instead.
- **Much of the care is not delivered optimally.** Examples of this abound:
 - Approximately half of all treatment for major depressive illness in the U.S. does not follow expert-recommended best practices.^{108,109,110}
 - Almost three-quarters of youth insured by Medicaid who receive antipsychotics were prescribed these drugs “off-label”, that is, for conditions not approved by the Food and Drug Administration. While off-label use is common and not illegal, the use of these



medications for children in the absence of firm evidence of their efficacy has garnered significant concern and scrutiny.¹¹¹

- A recent national study suggests that increased access to mental health treatment for youth over the last decade may contribute to the overuse of anti-depressant and stimulant medications.¹¹²

It is important to decrease inequities in access to proven effective medications that alleviate suffering in many people with mental illness. We must also guard against inappropriate prescribing of medications, and encourage the use of other treatment options when appropriate.

The challenge before us is restructuring the way we deliver care. We need to create more “upstream” prevention options while using “downstream” treatment options more wisely.

We need more information to be effective

Despite the many data points included in this section, we still have many questions about where and how mental health threats take root, how to better match what we are doing with where we can make the biggest impact, and the comparative value and quality of treatment and intervention options.

We should rethink traditional methods for gathering information about mental health.¹¹³ This could include partnering with local providers and community groups to both gather and use information and web-based crowdsourcing methods.

We should also strive to measure mental *health* itself through the use of sound data and effective measuring tools. Some countries, including the United Kingdom, are beginning to measure “well-being” and the positive attributes of mental health.¹¹⁴ Similarly, it would be useful to capture not just neighborhood effects that pose threats to mental health, but also positive attributes that contribute to the resiliency of individuals and communities. If we know where mental health assets are located, we can do a better job of maximizing them. And if we have better data about crucial factors like user experience, access, impact, and cost effectiveness, we can make better decisions and smarter investments.

Section 2

A Foundation for Change

**6 Guiding Principles and
54 Targeted Initiatives**

As detailed in the Executive Summary, we are taking a public health approach to securing mental health for all New Yorkers. Like other public health campaigns, our effort will be built around three objectives:

- **Identify and address root causes.** Threats to mental health include a range of things we can act on—from enhancing early developmental experience, resilience, and ongoing social supports to addressing issues such as discrimination, poverty, inadequate housing, social isolation, violence, and economic instability.
- **Focus on those who are at highest risk.** We will devote significant resources to work with groups that may be at higher risk for illness or face greater threats to mental health and would benefit from early intervention or prevention.
- **Provide treatment options that are easy to access and make a real difference.** We will provide high-quality services when and where people need them—services that also meet the larger needs of the community.

We began laying the groundwork in January 2015. Our early work focused on gathering information and advice from potential partners from across the five boroughs and beyond.

- We organized 25 focus groups that included treatment specialists, clergy, advocates, educators, researchers, and business leaders representing more than 250 organizations.
- We convened a Scientific Advisory Group comprised of experts from across the country.
- We met with hundreds of stakeholders at Town Halls in every borough.

The insights and advice shared at those meetings is reflected in this document, and distilled into the six principles that will guide our work in the years to come.



Six Guiding Principles



1. Change the Culture

Make mental health everybody's business. It's time for New Yorkers to have an open conversation about mental health.



2. Act Early

Give New Yorkers more tools to weather challenges and capitalize on opportunities by investing in prevention and early intervention.



3. Close Treatment Gaps

Provide New Yorkers in every neighborhood—including those at greater risk—with equal access to care that works for them and their communities, when and where they need it.



4. Partner with Communities

Embrace the wisdom and strengths of local communities by collaborating with them to create effective and culturally competent solutions.



5. Use Data Better

Work with all stakeholders to address gaps, improve programs, and create a truly equitable and responsive mental health system by sharing and using information and data better.



6. Strengthen Government's Ability to Lead

Affirm City government's responsibility to coordinate an unprecedented effort to support the mental health of all New Yorkers.

Just as these principles were developed collectively, they must be implemented collectively. This Roadmap is an invitation for all New Yorkers to work with us to improve mental health in our city.

This section describes each of the six principles. At the broadest level, the principles have the potential to align how providers treat mental illness, what insurers pay for, how philanthropic foundations foster innovation, how educational institutions train the next generation of providers and decision-makers, how policy is developed, and how communities coordinate all of these elements. At the individual level, these principles can transform how we think about mental health, the type of mental health treatment we receive, and the investments we make in prevention.

54 targeted initiatives

City government must play a central and active role in promoting mental health for New Yorkers. That means bringing services into City-run locations like schools, senior centers, and criminal justice institutions. It also means taking advantage of our scale as a city to advocate for changes at the state and federal level that reflect and support the wisdom and experience of our partners. In Fiscal Year (FY) 2015, the City's budget funded \$1.46 billion in mental health spending. In addition, NYC Health + Hospitals spent nearly \$1 billion to provide mental health services.





Credit: Mayoral Photography Office

Over the past year, the de Blasio Administration has built on this foundation while positioning City government to better focus these resources around the public health approach outlined in this Roadmap, committing \$548 million in new mental health and substance use services over the next four years (FY16-FY19). But still more needs to be done.

In our work around mental health and substance use, the de Blasio Administration has had strong partners in the New York City Council and Speaker Melissa Mark-Viverito. Council members have contributed to this plan, suggesting areas of focus and specific programs that are reflected in the Roadmap. These include investments in peer support services, an easy point of access to help New Yorkers navigate the behavioral health system, expanded resources in schools, and mechanisms for early intervention.

This roadmap includes 23 new initiatives. These new initiatives represent an additional commitment of \$305.1 million investment over four years. In addition to these initiatives and resource commitments, the City is making an historic investment in 15,000 apartments of supportive housing.

All of the initiatives in this Roadmap—both those being newly introduced here and those the de Blasio Administration has already announced—advance and exemplify our six guiding principles. They are designed to be models for action that will guide not only the City's work, but also the work of other stakeholders, including consumers, insurers, providers, health foundations, educators, and community-based organizations.



-
- Engage every sector of the city in a conversation that reduces stigma and directs people to help.
 - Provide a broad array of New Yorkers with information and training.
 - Create public messaging to promote ways people can support their own mental health or the health of those they care about.
 - Shift the action from punishment to healing when addressing behaviors in the community.

Change the Culture

Make mental health everybody’s business. It’s time for New Yorkers to have an open conversation about mental health.

Changing the culture around mental health is a foundational building block of this Roadmap. Far too many of us still think of “depression” and “addiction” as dirty words—shameful afflictions that must be hidden at all costs. And far too many of us still don’t think about mental wellness the same way we think about physical wellness—as something that can be actively improved and strengthened as part of an everyday commitment to overall health.

Spreading the word

The most obvious strategy for changing the way our society thinks about mental health is through a broad public media campaign designed to educate New Yorkers on steps they can take to improve their mental well-being and better understand mental illness. Our campaign will make the most of City government’s unmatched ability to reach New Yorkers to ensure that every community hears our message.

But messaging alone will not change the culture. We must also begin to infuse mental health work into civil society’s core functions, including education, health, and justice. No single effort will achieve this goal, but it is possible to create a snowball effect by launching a comprehensive array of initiatives that together showcase the value of investing in mental wellness.



Criminal justice

In the criminal justice system, for example, our goal is to provide law enforcement professionals with new public health solutions to issues that were previously handled through punishment. This represents a win for everyone:

- Police officers and correction officials will have a broader array of options from which to choose;
- People with behavioral health issues who do not pose a public safety threat will be diverted to services instead of being arrested; and
- Communities will be safer.

This work is guided by an action plan developed by the Mayor’s Task Force on Behavioral Health and the Criminal Justice System, a group of more than 400 providers, court personnel, clinicians, law enforcement personnel, advocates, and people with lived experience. The action plan outlines a comprehensive blueprint to continue driving down crime while also reducing the number of people with behavioral health issues who cycle through the criminal justice system.

Keeping New Yorkers—and those who protect us—safe is always our top priority. We must keep dangerous criminals off our streets. And we know there are many people in our criminal justice system suffering from behavioral health disorders who belong in treatment, not jail.

The recommendations of the Task Force focus on ensuring that people who need to be in jail go to jail; but when appropriate, individuals with behavioral health disorders:

- Do not enter the criminal justice system in the first place;
- If they do enter, they are treated outside of a jail setting;
- If they are in jail, they receive treatment that is therapeutic rather than punitive in approach; and
- Upon release, they are connected to effective services.

The Task Force developed 24 interlocking public health and public safety strategies that address each point in the criminal justice system and the overlap among those points. A number of these strategies are included in the Roadmap.

We must also make sure that our first responders—police officers, firefighters, and emergency medical services personnel—have the support they need. Routine exposure to traumatic events puts first responders at greater risk for developing PTSD (post-traumatic stress disorder) when compared to other occupations. In addition, studies have shown that first responders are at an elevated risk for depression, chronic fatigue, and difficulties with alcohol.¹¹⁵ The City offers a number of services for our bravest and finest, including:

- NYPD Psychological Services Section offers counseling and other mental health services to officers; and
- FDNY Counseling Service Unit provides mental health evaluations, direct treatment (including individual counseling, group therapy, family therapy, and substance use treatment) and appropriate referrals for all employees, firefighters, and EMS technicians.

Initiatives in this Roadmap should benefit our first responders, whose work frequently brings them into contact with those who are suffering from untreated or under-treated mental illness.



Veterans, service members, and their families

Veterans and service members face disproportionate risk of trauma-related mental illness. And despite their heroism, they must still contend with the stigma of mental illness, which prevents many from getting proper treatment after they return to civilian life.^{116,117} Two-thirds of New York City veterans with a probable diagnosis of PTSD and/or major depression reported that they did not seek mental health treatment, mainly due to professional or personal stigma.¹¹⁸

As a city, we must work together to break down the shame that too often accompanies these invisible wounds. Our public education campaign will rally civilians to support veterans and their families; mobilize local and national mental health resources for service members, veterans, and their family members; and ultimately lead more service members and veterans to the help they need and deserve.



Education

Our public schools educate 1.1 million children every year, but too many schools lack the resources necessary to provide students with a healthy and supportive environment. That's why we are reducing our reliance on traditional punitive disciplinary strategies like suspension, and are instead using research-based restorative approaches that do a better job of addressing the root causes of misbehavior. We are also investing in an effort to improve the climate in our schools, so all of our students feel comfortable speaking honestly with their teachers and counselors about any issue that might hinder not just their intellectual development, but also their emotional development. This will improve academic achievement and, ultimately, graduation rates.

All of the initiatives outlined here will help both individuals and organizations think more broadly about the role they can play in a shared effort to make mental health everyone's business.

On an individual level, that could mean encouraging New Yorkers to work with their employers to adopt strategies for improving mental well-being in the workplace,¹⁹ sign up for a mental health first aid class, or simply take the time to talk to a neighbor who is going through a tough time. The bottom line is that we all have a role to play in changing the way we deal with this complex issue.

CHANGE THE CULTURE INITIATIVES

1) Mental Health First Aid Training—NEW! (DOHMH)

The City will fund and facilitate training for 250,000 New Yorkers in Mental Health First Aid (MHFA) over the next five years. MHFA educates people on how to support others who may be suffering from a mental health condition, helps to reduce biases against mental illness and allows people to more comfortably engage with mental health issues.

MHFA is an in-person training that teaches individuals to:

- Have a greater knowledge of the signs, symptoms, and risk factors of mental illness and addictions;
- Identify multiple types of professional and self-help resources for individuals with a mental illness or addiction;
- Help an individual in distress become more confident about the help they provide; and
- Develop increased mental well-being themselves, and diminish any stigma and discomfort they have about mental illness.

To achieve our goal, the City will train and certify 500 individuals as MHFA instructors. In Years One and Two, we will prioritize training for tens of thousands of City employees and contractors who provide frontline services, including our police officers, firefighters, emergency medical professionals, and correction officers. The City will also offer trainings at no cost to faith-based leaders, grassroots neighborhood institutions, community-based organizations, and businesses. Together, this new team of instructors will play an important role in growing and sustaining our larger mental health effort.

2) Public Awareness Campaign—NEW!

(Mayor's Office [Public Engagement Unit], DOHMH)

A culture of stigma currently inhibits many people from seeking help. In addition to closing treatment gaps, we must take the lead on reframing the way people think and talk about mental health. We must also provide New Yorkers with clear and useful information on how to access services.

The City will launch a culturally competent public awareness campaign built around two overarching objectives:

- Reshaping the conversation around mental health, focusing on mental health promotion and early intervention; and
- Helping New Yorkers understand how to access services if they or someone they know are experiencing mental health issues.

Our approach will be fact-based, positive in tone, and provide a clear path to action. The materials we create will be inclusive and relevant to a broad population of New Yorkers. At the same time, we will create targeted messaging and outreach strategies aimed at the most at-risk populations.

Media Campaign

To that end, we will share our message with New Yorkers in many different ways. To reach the widest audience, we will place paid media ads on television, in the subway, on bus shelters, and online. All of the materials will feature a clear and distinct message about mental health awareness that will reinforce our larger campaign.

Community Engagement

On the community level, we will partner with experts, community groups, cultural groups, health service providers, and elected officials in high-need neighborhoods to amplify our message.

First Lady Chirlane McCray walks over the Brooklyn Bridge as the Grand Marshall of the National Alliance on Mental Illness's NAMIWalks and Run NYC.

Credit: Demetrius Freeman/Mayoral Photography Office.



3) Roadmap Website and Program Finder—NEW!

(NYC Digital, DOHMH)

Just as we must bring mental health promotion and treatment efforts to where people live, we must also bring information to where people look—and that place is increasingly online and on smartphones. The Roadmap includes two exciting new web-based, mobile-friendly tools:

- **Roadmap Webpage:** We have launched a website that brings the Roadmap online and includes a number of exciting features:
 - Information on what mental health looks like;
 - Easy-to-read guidance on how to get help for common mental health conditions;
 - An animation that brings the Roadmap to life;
 - Information on how to support the Roadmap; and
 - A mechanism for providing us with feedback.
- **Mental Health Program Finder:** We have developed and launched a prototype that will allow New Yorkers to quickly and easily find mental health and substance use services that meet their needs. The finder allows users to conduct a search that factors in four key variables:
 - Age;
 - Payment accepted (e.g., Medicare/Medicaid, no insurance, private insurance);
 - Type of service (mental health, substance use, or both); and
 - Optional demographic data (e.g., LGBT, veteran).

Users have the option to see results tailored to their location. All of the program listings includes contact information. This tool is a prototype and will be improved as we learn more about how New Yorkers use it. It represents an initial step in an ongoing effort to use digital tools to promote mental health in New York City.



4) Improve School Climate (DOE)

School climate can have a notable impact not just on a student's ability to learn and socialize, but also on mental health. In February 2015, we announced a package of reforms that is being overseen by the City's School Climate Leadership Team, which is composed of principals, parents, students, and union representatives, as well as representatives from the Department of Education (DOE), the NYPD, the Mayor's Office, the Mayor's Office of Criminal Justice, the City Council, and community groups. The package includes a number of changes that will benefit student mental health:

- Decrease reliance on 911 calls to address DOE student behavioral issues. DOE created a new Chancellor's Regulation designed to provide guidance to schools on how to safely de-escalate behavioral crises using school staff and resources, while also reducing inappropriate reliance on 911 calls.
- Implement Restorative Approaches in schools. Since July 2013, DOE has provided training for more than 2,000 staff members on progressive discipline approaches aimed at developing a sense of social responsibility and shared accountability. Specifically, staff receives training in Restorative Approaches (Restorative Circles and Formal Conferencing), Conflict Resolution, Therapeutic Crisis Interventions in

Schools, and Life Space Crisis Intervention. All of these skills will help staff de-escalate conflicts and teach students how to manage their anger.

- **Implement strategies to support court-involved students.** In support of the Mayor’s commitment to help young people in the criminal justice system stay in school and achieve their full potential, we will provide each student in detention with a DOE counselor. In collaboration with the Administration for Children’s Services (ACS), Department of Correction (DOC), and community partners, these specialized professionals will provide counseling, transition planning, tracking, and support to students, their families and their home schools.
- **Expand training for school safety agents(SSAs) and police officers assigned to the School Safety Division.** School safety agents and the NYPD are partnering in innovative ways to make our schools safer:
 - All SSAs and police officers assigned to the School Safety Division have received training in Collaborative Problem Solving and Restorative Justice;
 - All SSAs are receiving Conflict Resolution training as part of the two-week expansion of the SSA Recruit training as well as ongoing refresher courses;
 - SSAs and police officers assigned to five school campuses are being trained in the use of warning cards, which can serve as an alternative to the issuance of a criminal summons for disorderly conduct or the unlawful possession of marijuana; and
 - Starting with the 2015-2016 school year, the City has placed School Climate Managers in each of the Borough Field Support Centers to help school staff promote a safe and supportive climate and culture. The School Climate Managers will examine issues faced by at-risk youth and design and promote innovative strategies to address them. School Climate Managers will offer on-the-ground support for school staff, particularly at high-need schools.

5) Addressing the Trauma of Crime Victims (NYPD)

The City will place Victim Advocates at all 77 NYPD precincts and Housing Bureau Police Service Areas (PSA). Seventy-one precincts and all nine Housing Bureau PSAs will have both a General Victim Advocate and a Domestic Victim Advocate. The remaining six precincts will have one Victim Advocate who will serve general victims and domestic violence victims.

Victims of crime are important partners in the NYPD’s twin missions of 1) crime prevention and control and 2) building community trust. The goal of this program is to provide a more effective response to victims of crime at the time of the incident, and in the critical days, weeks, and months

following the crime. Each crime victim will have access to an advocate, who will be able to:

- Answer questions about the experience of victimization, the criminal justice process, and safety planning;
- Refer victims to resources;
- Assist in the preparation of paperwork for compensation purposes;
- Offer supportive and crisis counseling to crime victims;
- Engage in safety planning with victims;
- Advocate on the crime victim's behalf to third parties; and
- Engage in limited case management.

6) Police Crisis Intervention Team Program and Training (NYPD, DOHMH)

NYPD and DOHMH are partnering to implement a NYC Crisis Intervention Team (CIT) Program. CIT includes three key components: police training, drop-off options for officers, and community involvement. A total of 5,500 officers will participate in a four-day training to help them recognize the behaviors and symptoms of mental illness and substance misuse. They will also learn techniques for engaging people in respectful, non-stigmatizing interactions that de-escalate crisis situations. This initiative is part of the Behavioral Health Task Force action plan.

7) Public Health Drop-Off Centers (DOHMH, NYPD)

DOHMH will open two new Public Health Drop-Off Centers, which will provide NYPD with a new treatment-based option for people they encounter who show signs of mental illness and/or substance misuse and would benefit from diversion to an alternative to hospitalization or the criminal justice system. The Centers will operate 24/7/365 with a no-refusal policy for persons brought in by the police. Our goal is to create more Centers and ultimately provide citywide coverage. In selecting clients for the Centers, we will be careful to ensure that we are advancing mental health while protecting public safety.



Act Early

Give New Yorkers more tools to weather challenges and capitalize on opportunities by investing in prevention and early intervention.

-
- Reach people when we can have the most impact.
 - Make it easy to identify and act on early signs of illness.
 - Use proven prevention and promotion measures especially for children and parents.

Prevention and promotion must be at the core of any public health campaign. Broadly speaking, promotion efforts focus on helping people develop tools like resilience, strong parent attachments, and mindfulness.¹²⁰ These basic skills have the capacity to prevent mental illness and strengthen every aspect of our daily lives, including our mental health. That's why many of the initiatives in this Roadmap include mental health promotion elements.

Prevention efforts are designed to help people avoid illness before they get sick, or to treat problems early. We will focus on two key areas:

- Early childhood support; and
- Early diagnosis and linkages to care for vulnerable populations.

Acting early is about helping New Yorkers promote their emotional fitness—which means that more of us will develop positive coping skills, fewer of us will develop mental illness, and those who do will recover more quickly and completely.



Childhood

If we want to stem the tide of mental illness, we must focus on childhood for the simple reason that half of all mental health conditions and substance use disorders start before the age of 14.¹²¹ And some conditions that appear in childhood—such as conduct disorder—are associated with the development of other risks later in life—such as substance misuse.¹²² It is therefore imperative that we identify challenges and intervene as early as possible, before small problems become large problems that inflict major damage on an individual and the people in her life.

A first step is helping caregivers and children build strong bonds with each other. The degree to which a young child feels safe seeking comfort from a parent and exploring the world freely,¹²³ which is known as “secure attachment,” is a strong predictor of lifetime mental health, especially when the child has been exposed to adverse events. When children have strong relationships with their parents, they are often more resilient in the face of adversity.

However, building this type of secure attachment is especially challenging when parents or caregivers are stressed, have mental health or substance misuse issues themselves, grew up in poorly attached relationships, are teenage or single parents with limited support, or live in demanding and stressful environments.

One proven response to this challenge is helping new and first time parents develop parenting styles that enhance attachment.¹²⁴ Many studies, including work by DOHMH, have shown that providing parents with peer coaching and other socio-emotional interventions can have a positive impact on outcomes and can be incorporated into familiar settings like community centers, schools, and doctor’s offices.¹²⁵

There are many other methods that can be used to promote socio-emotional health in children to help them achieve lifelong mental health. A public health response, however, also recognizes that offering direct support will ideally occur alongside broader efforts to improve things like neighborhood public safety, access to childcare and family planning, and job security.



“As a child growing up, my parents were very bullying towards me, and I was a sensitive baby. They didn’t have time for me. They were so busy trying to keep a roof over their heads and keeping their jobs... I didn’t know how to fend for myself. I never said anything about what was done to me and so it was internalized. I wish somebody was there that could help me with my fears and could help me with what was happening to me. But there wasn’t anyone so I had to go through life figuring things out for myself.”

— G.

Early diagnosis and linkages to care for vulnerable populations

Prompt recognition of the warning signs for a first episode of psychosis,^{126,127} mood disorder,¹²⁸ and other illnesses can reduce their severity or odds of recurrence. Yet on average, treatment begins late, as much as a decade after the first symptoms appear.¹²⁹ Greater investment in prevention and early detection is essential. Greater vulnerability to poor mental health outcomes can be signaled by high absenteeism from school, violent behavior, or experiencing violence or bullying; recent unemployment; harmful patterns of substance use; living in areas with high unemployment or violence; any experience of trauma; early psychosis; and social isolation, which afflicts many elderly people.

We must increase the availability of screening and early support that promotes mental health, especially among those with heightened risks. Positive change is possible when City government and our partners commit to launching initiatives that have been proven to work.

ACT EARLY INITIATIVES

1) Social-Emotional Learning in Early Care and Education —NEW! (DOE, ACS, DOHMH)

The City will embark on an expansion of Social Emotional Learning (SEL) to all Pre K for All classrooms and ACS EarlyLearn Centers. We will increase opportunities for children to realize their potential by building a foundation of social emotional skills during a critical stage of development.

Early childhood is a unique window of opportunity for social-emotional learning and growth; 85% of brain growth in children occurs by the age of five.^{130, 131} By building adults' capacity to support children's social and emotional development early on, children will be better equipped to handle various circumstances and seize opportunities throughout their lives.

Over the next three years, the City will train approximately 9,000 teachers, assistants and school leaders to support social-emotional competencies in the approximately 100,000 children ages birth-five. Children will get more support to be aware of and comfortable with their own emotions, including how to self-regulate and how to adapt to new situations. Challenging behaviors decrease and social skills improve when children develop a positive sense of self and understand their own emotions, handle conflicts, and develop relationships with others.¹³² Parents and caregivers will learn



Credit: Mayoral Photography Office

techniques to reinforce these new skills at home. Promoting SEL in early childhood settings makes fiscal sense, with every dollar invested reaping as much as a tenfold return.^{133,134,135}

For children younger than age five that have greater behavioral health needs, the City will also expand resources to support an additional 20,000 clinical visits and consultations for an estimated 3,500 children and their parents or caregivers annually.

2) Mental Health Clinics in Additional High-Need Schools—NEW! (DOHMH, DOE)

Building on the expansion of mental health services in the Community Schools, the City will assess the mental health service needs at an additional 52 public schools starting in the 2017 school year. These schools account for a disproportionate share of suspensions. The availability of on-site mental health services has been linked to higher GPA scores, reduced absenteeism, and improvements in graduation rates. Providing mental health services in a school also improves school environment and provides teachers, other school staff, and parents with additional resources to address the emotional

and behavioral needs of students. This effort will be modeled after the expansion of mental health services in Community Schools (see below).

3) Create Network of Mental Health Consultants Serving All Schools—NEW! (DOHMH, DOE)

While different schools have different levels of need when it comes to mental health, every school should have access to professional support. Starting immediately, the City will hire 100 School Mental Health Consultants (SMHCs) who will work with every school citywide to ensure that staff and administrators have an outlet to connect students with the highest immediate needs to care.

The SMHCs will be Masters-level social workers or counselors. They will be charged with providing the following services:

- Conduct needs assessments that allow schools to identify priority areas and determine 1) how to best leverage existing resources from DOE, DOHMH, and other city partners; and 2) what additional resources are needed to support the mental health of their students;
- Provide support, training, and technical assistance so schools can successfully plan and implement new or enhanced programs and services—from using prevention and promotion methods that address many students at once to getting direct care to individual students in need; and
- Facilitate emergency response and linkages by forging connections with existing DOE resources and community-based partners. The SMHCs will also provide school support staff with guidance on clinical assessment and referral protocols to ensure appropriate and timely referrals to services and minimize emergency room visits.

4) Mental Health Training for School Staff—NEW! (DOHMH, DOE)

When it comes to safeguarding the mental health of our students, our teachers and school staff have an unmatched level of trust and credibility in the eyes of both students and parents. In support of this Roadmap, we are launching three new mental health training efforts:

- Train selected staff of middle and high schools in Youth Mental Health First Aid (YMHF), a five-step action plan for assessing, identifying, and offering assistance for youth 12-18 years old in crisis;
- Train the school staff in Youth Suicide Prevention using an evidence-based suicide prevention model called Making Education Partners (MEP) that focuses on all school staff in suicide awareness and identification; and

- Offer At-Risk Training to all full-time staff of elementary, middle, and high schools. At-Risk Training is an online training that uses interactive online role play to educate teachers on how to recognize early signs and symptoms of psychological distress and connect students to resources within school setting.

5) Mental Health Services in All Community Schools (DOHMH, DOE)

Community Schools are neighborhood hubs where students receive high-quality academic instruction, families can access social services, and communities congregate to share resources and address their common challenges. In order to establish Community Schools as a trusted place where students can go for a wide variety of essential services, all 130 schools will offer mental health services.

Additionally, the City will open Mental Health Clinics at a number of Community Schools following an evaluation of student needs and available space in the buildings. This expansion will follow a model that uses mental health staff to not only treat individuals, but also to help the entire school staff play a role in providing more preventive interventions. This could include training staff to better identify and support at-risk students, de-escalate conflicts, or lead mindfulness and relaxation groups. Engaging more school leaders in the effort to carry out mental health promotion will ultimately help improve overall school climate. This model can then be shared with other schools across the city.

6) “Talk to Your Baby, Their Brain Depends On It” Campaign (NYC Children’s Cabinet, DOHMH)

“Talk To Your Baby, Their Brain Depends On It” is a major public awareness campaign that urges parents to talk, read, and sign to their babies from birth. Former Secretary of State Hillary Rodham Clinton, First Lady Chirlane McCray, and Deputy Mayor Richard Buery announced the initiative in April 2015. It is a collaboration between the New York City Children’s Cabinet and Too Small to Fail, which is a joint initiative of the Bill, Hillary & Chelsea Clinton Foundation and Next Generation aimed at helping parents, communities,

and businesses take meaningful actions to improve the health and well-being of children ages zero to three.

The initiative promotes parent bonding and early brain development among children ages zero to three. As First Lady McCray said, “When we talk, read, and sing to our babies, we are building their brains and strengthening their bond with us.” The initiative includes:

- Subway advertisements;
- Weekly text messages to the parents and caregivers of young children featuring coaching tips and information on language development, attachment-encouraging behavior, and socio-emotional health; and
- 200,000 Baby Book Bundles, to be distributed over the next two years to families with children ages zero to three through City agencies and the Reach Out and Read program. This is made possible by a \$1.5 million book donation from Scholastic Inc.

7) Expansion of Newborn Home Visiting Program (DOHMH)

The Newborn Home Visiting Program (NHVP) is expanding services to 1,600 additional mothers of newborns in all family shelters across New York City. An enhanced model is currently in development to meet the particular needs of families in shelters. NHVP supports the families of newborns in the first few weeks after birth. A public health professional makes an in-person visit and provides educational information and materials on a range of topics, including child development, secure attachment and bonding, safe sleep practices, and breastfeeding. The professional also connects families to community resources and can screen mothers for depression.

8) Mental Health Service Coordination in All Contracted Family Shelters (DHS)

The City will place Licensed Clinical Social Workers as client care coordinators in all 72 contracted Family Shelters. This initiative will provide 8,900 families with access to clinical mental health services, allowing them to access care at an especially vulnerable time in their lives.

9) Attachment and Biobehavioral Catch-up (ACS)

Attachment and Biobehavioral Catch-up (ABC) is an attachment-focused, strengths-based therapeutic model that helps foster parents, birth parents, and other primary caregivers more effectively nurture and engage children between the ages of six months and three years. Weekly one-hour sessions are held in the home for 10 weeks and are facilitated by parent coaches who provide caregivers with “in the moment” guidance that is supported by video feedback. Coaches help primary caregivers provide a responsive and nurturing environment for their infant. The model has been shown to ameliorate the impact of trauma on very young children by helping them build strong attachments with caregivers and strengthen their ability to self-regulate and self-calm during times of stress.

The program will launch in Brownsville and East New York before expanding to high-need neighborhoods in all five boroughs. We eventually expect the initiative to include 47 coaches serving 1,800 child-caregiver pairs each year.

10) Trauma Services for Families with Young Children (ACS)

ACS’s new trauma-focused services initiative will create clinically enhanced, community-based services that provide specialized counseling and other interventions to support mothers (and in some cases fathers) with very young children. The model will include clinical supports and wraparound services for parents who have themselves experienced trauma and depression. The initiative will serve at least 480 families per year.

11) Relationship Counseling for All Foster Care Teens (OCDV, ACS)

The City will provide healthy relationship training to all New York City teens in foster care in order to help young people prevent, recognize, and respond to dating violence. This investment will provide 5,000 youth between the ages of 11 and 21 with healthy relationship training at 300 workshops annually. The training offers interactive workshops on dating violence and cyber abuse for adolescents, young adults, parents, and service providers. Workshops are facilitated by trained peer educators who encourage discussion and critical thinking.

12) Training on Intimate Partner Violence and Teen Dating Violence for Community School Staff (OCDV, DOE)

The City is training staff at all 130 Community Schools on how to help students and families experiencing intimate partner violence or teen dating violence. Staff will learn how to connect people to our NYC Family Justice Center and NYC Healthy Relationship Training Academy.





Close Treatment Gaps

Provide New Yorkers in every neighborhood with access to proven programs when and where they need them, including those at greatest risk.

-
- Redesign care to be more reliable and accessible to all.
 - Encourage providers to emphasize prevention, promotion, and self care in addition to treatment.
 - Use technology to broaden access.
 - Take steps to make care more cost effective.
 - Ensure that care is improving communities.

As Section 1 makes clear, New York City faces substantial treatment gaps. Therefore, a key element of our vision for a thriving New York City involves expanding access to care. But availability of care is not the only gap in treatment that needs to be closed. We're also striving for care that is:

- High-quality;
- High-impact;
- Culturally competent;
- Linguistically diverse;
- Cost-effective;
- Matched to the city's most pressing needs;
- Maximizing the talents and resources of service providers;
- Aligned with our promotion and prevention efforts; and
- Engaging communities and expanding their capacity to be part of the solution.

Over time, by directing existing resources intelligently and purposefully, City government and its partners can be a catalyst to “re-engineer” care so that it bridges all of these gaps.





“Working as a peer specialist at Goodwill has helped me tremendously; it was the only place where I didn’t have to make something up about my employment history because I was hospitalized so many times. I just said: ‘Yeah, I was in the hospital and I got better.’ So it helped me a lot, not only by helping others but I was able to talk about my story, about the recovery process and to see that it is possible to get better.”

— M., Queens



“I have resources. And I have a 16-year-old that had some mental illness. Even for someone with resources it was unbelievably difficult, and I’m in the field. I was clueless. It is a terrible, terrible disease. Mental health treatment is just not accessible.”

— Primary Care Doctor, Queens

Task-sharing, task shifting, and care pathways

Closing treatment gaps is not only a matter of expanding the quantity of clinical services for mental illness and substance use disorders and misuse. Because of significant mental health workforce shortages and an overall inconsistency of care even when specialists are available, we need new ways to organize those services and make sure they align with the goals listed above:

- Task-sharing, also known as task-shifting, is built around the idea that many types of care, prevention, and promotion initiatives can be provided, at least in part, by a range of non-specialists, including peers, family, co-workers, and neighborhood groups that are supported by more specialized providers.
- Care pathways are an agreed upon set of key steps for treating a condition. The goal is to keep the work on track and keep people focused on what works. In many cases, certain steps in a pathway can be provided by non-specialists through task-shifting.

For example, non-specialists, including trained peers or community health workers (CHWs),¹³⁶ could help spread access throughout the city by managing many of the steps in care. For example, by keeping people engaged in treatment, providing counseling in depression care, or using early support or self-care methods that can prevent depression in the first place. Their familiarity and credibility often allows CHWs to be more successful than professionals. The Collaborative Care approach, which has been shown to improve outcomes for depression and anxiety by 30-50% compared to usual care, similarly shifts defined care tasks across a team that can include nurses, physician assistants, social workers, peers or other CHWs, and a consulting psychiatrist.^{137,138} This kind of task-sharing within the health care team could yield better outcomes for other conditions, such as early psychosis,^{139,140,141} bipolar illness,^{142,143,144} anxiety,¹⁴⁵ and alcohol misuse.¹⁴⁶

Task-shifting and pathways can make care more rational, responsive, empathic, and effective. They can help us repair gaps in accessibility, quality, and retention. They can help us reach and retain people who would otherwise cycle in and out of care. And they can close the gap between treatment and prevention as shown in these examples:

- Maternal depression can be prevented by re-engineering access to simple supports and counseling for more at-risk pregnant women. Home visitation by counselors and/or nurses and the use of peers,

phone calls, or web-based counseling can help new mothers cope with emotional challenges. Research suggests that if New York City applied certain prevention interventions, nearly 3,000 fewer women would suffer from post-partum depression each year.¹⁴⁷

- If New York City teachers were given the training and support they need to deliver tools such as the Good Behavior Game, a classroom activity that promotes impulse control and social and emotional growth, we could halve the likelihood of children having suicidal thoughts when they reach adolescence.¹⁴⁸ Early impulse control is a powerful predictor of lifetime mental health. People with the ability to regulate their emotions tend to have better long-term physical and mental health.
- Studies have shown that adolescent boys with a history of school absenteeism or fighting who engage in school-delivered skill groups based on principles of cognitive behavioral treatment (CBT)—where they learn to anticipate consequences and rehearse behavior—show less risk for violence and arrests.^{149,150} CBT is a short-term, goal-focused approach to helping people become aware of patterns of thinking.
- When it comes to preventing suicide, we must change public policies around issues like gun access while creating reliable treatment pathways that address mental health conditions and other risk behaviors such as alcohol use.¹⁵¹ Zero Suicide¹⁵² is a national campaign founded on evidence that the health and behavioral health systems are a key resource when it comes to suicide prevention. Their efforts focus on strengthening and expanding established care pathways.¹⁵³
- In Los Angeles, Community Partners in Care (CPIC) connected beauty shops, parks, fitness centers, faith-based organizations, and local non-profits in a task-sharing effort designed to improve depression outcomes. CPIC held more than 100 conferences and trainings that provided neighborhood residents with the tools and knowledge they needed to serve as community health workers. As trusted members of the community, these workers were well equipped to bring and keep people in care. By deeply embedding treatment and mental health promotion within established social and community networks, CPIC has succeeded not only in reducing depression, but also in lowering both the risks of homelessness as well as rates of hospitalizations for behavioral health conditions.^{154, 155}
- Closing “treatment” gaps should include expanding harm reduction services, which substantially reduce the negative health consequences of potentially risky behaviors. For example, syringe exchange programs can reduce HIV transmission in injection drug users, provide individuals with valuable health-promoting and overdose-prevention services, and increase the likelihood of entry into treatment for substance use disorders.¹⁵⁶



Technology

Harnessing technology can also close treatment gaps. Web developers and health professionals have created promising mobile applications that provide self-administered mental health screening, monitoring of symptoms, and coaching on self-care.¹⁵⁷ While still evolving, these mobile and other web-based applications have opened up a wide variety of readily available ways for people to get help for illness, and gain skills and support for maintaining their mental health. These applications include:

- Social networks that provide supportive feedback;¹⁵⁸
- New ways to access therapists and care, including through text messaging; and^{159,160}
- Internet-supported educational and self-care guides for anxiety and depression.^{161,162}

Cost-benefit analyses

An essential element of closing these gaps is matching treatment to need, and optimizing its value. Cost-benefit analyses suggest that certain well-delivered, evidence-based treatments can yield savings, including reducing other kinds of health care or treatment costs. Many factors go into determining the best investments and priorities for care. A cost-benefit ratio can help discern where value lies, but that’s only part of the story. For example, the table below illustrates the estimated benefit-to-cost ratio for a number of interventions. This ratio indicates a high likelihood that the given treatments will save the dollar amount shown for each dollar spent.

However, while calculations like these do shed light on how to make the most of our mental health dollars, they don’t answer many important questions that factor into priorities such as how many or which people or problems a given intervention can reach. For example, an intervention with a high cost-benefit ratio that only benefits a few people or does not address the highest priority needs may not be a better buy.

Closing all these gaps—in availability, impact, and scale—is a big undertaking. It will require building additional capacity in the current system. And, it will also require a wide and coordinated array of responses, including using resources better, matching treatment to needs, implementing task sharing and new care pathways, designing care that also supports prevention, and developing new technologies. It will also mean recognizing the crucial role friends, family, and other supports play when it comes to treating illness and maintaining mental health. But mere recognition isn’t enough—we must also provide friends, peers, and family with the support and skills they can use.^{163,164,165} By pursuing all of these strategies simultaneously, we increase our odds of success.

| Population Served | Intervention Name | ^{166,167,168} Benefit to Cost Ratio |
|--------------------------|--|--|
| Children’s Mental Health | Cognitive Behavioral Therapy (CBT) for anxiety | \$7.56 |
| Children’s Mental Health | Parent Coaching for disruptive behavior | \$1.74 |
| Substance Use Disorder | Cognitive Behavior Coping Skills Therapy | \$189.66 |
| Unhealthy Alcohol Use | Brief Intervention in Primary Care | \$27.43 |
| Adult Mental Health | CBT for depression | \$112.16 |
| Adult Mental Health | Collaborative Care for depression | \$6.50 |
| Adult Criminal Justice | Cognitive Behavioral Treatment | \$26.47 |
| Juvenile Justice | Functional Family Therapy | \$11.21 |

CLOSE TREATMENT GAPS INITIATIVES

1) Close Gaps on Maternal Depression—NEW!

(NYC Health + Hospitals, DOHMH)

Depression in mothers during and immediately following pregnancy is common and sometimes has a negative impact on both infant health and the mother's lifelong mental health. All told, there are well over 10,000 cases of maternal depression each year in New York City. Studies suggest that the majority of women do not get treatment for maternal depression, with blacks and Latinas having a lower likelihood of starting and continuing treatment.^{169,170}

This is unacceptable. Our goal is to ensure that every New York City mother who experiences depression before or after the birth of her child be screened and connected to treatment when appropriate.

As the first step toward this goal, NYC Health + Hospitals and Maimonides Medical Center—which on average deliver almost one-quarter of all births in New York City—have committed to universal screening and treatment for this condition within two years. They will reach and treat every pregnant and post-partum woman in their care who experiences maternal depression. This effort will be aided by a recent policy announcement: As of October 2015, New York State Medicaid reimburses physicians for screening mothers for maternal depression.

NYC Health + Hospitals and Maimonides, along with Greater New York Hospital Association, will also lead a citywide effort to work with other hospital systems across New York City to adopt the goal of universal screening and care for women experiencing maternal depression. Participating hospitals will work together to implement evidence-based practices and operational strategies that enhance system workflow, optimize care transitions, and promote better outcomes for mothers and infants.

2) NYC Support—NEW! (DOHMH)

People throughout New York City often complain about being forced to navigate a confusing and unresponsive mental health and substance use treatment system largely on their own. For the last few decades, one of the City's primary tools for addressing this concern has been a 24/7 phone-based crisis center. But New Yorkers need more than access to behavioral health services when in crisis—they also need a clear path to care before a crisis occurs.

By September 2016, the City will rise to this challenge with the creation of NYC Support, a more robust and accessible system that will serve as an easy point of entry to the City's behavioral health services. The City is stepping up to perform this function due to a general failure of the current

system to facilitate care for New Yorkers. Managed care plans are ramping up their efforts to provide New Yorkers with the information and care they need, and the City looks forward to working with plans and providers to leverage their infrastructure and strengths. But in the meantime, New Yorkers need help, which is why we are launching this initiative as quickly as possible.

Through NYC Support, we will:

- Bolster the capacity of our phone-based crisis hotline;
- Add the ability to access resources via text messaging and the web;
- Significantly expand our services to include providing non-crisis connections to behavioral health services; and

No longer will New Yorkers be left alone to navigate what can be a confusing system on their journey to mental well-being.

Resource Referral and Appointment Scheduling:

NYC Support commits the City to playing a much more proactive role in facilitating access to services and helping people enter care. We will do this by:

- Providing referrals and help New Yorkers schedule appointments with mental health providers based on their needs, insurance status, and geography, where possible;
- NYC support will provide proactive follow-up in the form of reminders and encouragement in the days before their first scheduled appointment, which can markedly reduce no-show rates for service appointments and hand-offs;¹⁷¹
- NYC Support will check in with clients via phone, web, or text messaging and provide brief counseling sessions as a bridge while they wait for their appointment, when necessary; and
- NYC Support will work in concert with 311 and feature an online service directory.

Crisis/Suicide Counseling:

- NYC Support will include a 24/7 hotline that will provide crisis intervention, suicide prevention, and resource referral services. High-risk callers will receive more comprehensive follow-up services;
- NYC Support will provide phone-based and text-based crisis counseling;
- NYC Support will have the capacity to activate mobile crisis teams citywide;

CASE STUDY: Mental health apps in action

Digital mental health apps present new opportunities to close treatment gaps by bringing self-help programs and other assistance directly to the public, both to complement in-person care and to otherwise engage or promote mental health for individuals who are not connected to care.

- Koko is a social network where people can post about problems in their life. Other users—who receive coaching on cognitive therapy through the site—are invited to provide helpful insights and advice. Apps like this could provide a novel means of encouraging participation in support groups, which have been known for years to reduce feelings of isolation, increase practical knowledge, and sustain coping efforts.
- What’s My M3 allows users to complete a mental health self-assessment and receive a baseline assessment of symptoms. Every user is also directed to additional support, regardless of how he or she scores.

Regardless of their approach, the best apps are the products of collaboration between experienced treatment providers and skilled web developers.

In creating and monitoring this system, we will collect new data that will provide us with a clearer picture of the challenges New Yorkers face when it comes to making appointments and getting follow-up help, both from the system at large and from specific providers and plans. This knowledge will allow the City to provide more effective oversight and advocate for needed services.

3) Peer Specialist Training—NEW! (DOHMH)

Peers are a critical component of any plan to address the mental health challenges facing New Yorkers. Drawing from both lived experience and specialized training, Peer Support Specialists have a unique ability to engage people whose needs might not be fully recognized and understood by the traditional health care workforce. Research has shown that peer support facilitates sustained recovery and can reduce overall treatment costs.

As of January 2016, New York State is providing coverage for peer support services delivered by professionally certified Peer Specialists to adults enrolled in Health and Recovery Plans. Coverage for these services is expanding to include children beginning in January 2017.

To facilitate the expansion of these pivotal services that is being driven by these changes in State payment practices, the City will invest in the training of additional peer specialists. This training will equip individuals who have lived experience with mental illness and substance use to take on workforce positions in the health care system and obtain their NYS Peer Specialist Certification. The City will graduate 200 peer specialists from this program per year beginning in Fiscal Year 2017.

4) CUNY Mental Health Digital Platform—NEW! (CUNY, DOHMH)

The City will make high-quality, low-cost mental health services and self-care resources available to CUNY students through web-based and mobile-supported media. After launching pilot efforts at selected campuses and identifying the most effective mix of services, CUNY plans to expand these opportunities, ultimately reaching the total population of close to 300,000 degree-enrolled university students.

As described earlier, one in five CUNY students who responded to a survey met criteria for depression; of those students, only 10% received help from their college counseling or health center.¹⁷² Bringing evidence-based treatment to students should

increase two- and four-year graduation rates and improve the overall health of the CUNY student body. Through a collaboration with CUNY School of Public Health and CUNY Health Services, the City will take the first steps toward providing access to tested and established web-based portals and apps to self-manage mental health. The campaign will begin in the 2016-2017 academic year.

5) Veterans Outreach Team Expansion—NEW! (MOVA)

Nearly one-quarter of veterans in New York City have a probable diagnosis of post-traumatic stress disorder (PTSD) and/or major depression.¹⁷³ The effects of PTSD on veterans and their families can be profound. PTSD is associated with increased risk of suicide, depression, substance use disorders, intimate partner violence, unemployment, and persistently low quality of life.¹⁷⁴ In addition, trauma and PTSD are associated with high rates of co-morbidity and disability, including coronary artery disease, arthritis, asthma, and gastrointestinal problems.^{175, 176}

While many services are available to those in need, more than 40% percent of veterans in New York City report being unaware of what help is available, or uncertain about how to navigate the systems that provide assistance. Additionally, 26% were unsure of how to get their questions about benefits answered.¹⁷⁷ This data suggests a great and immediate need to address gaps in information and coordination services for veterans in order to improve the efficacy and reach of existing systems of care.

The NYC Veterans Outreach Team will enhance access to veteran services, with an emphasis on prevention and early intervention. The City will invest \$500,000 to expand the Outreach team to provide additional navigation assistance and care coordination to veterans and their families. Additionally, for veterans in crisis the City will integrate the VA Suicide Hotline into the 311 information system so the public will have immediate access to the Veterans Crisis Line phone, chat, and text resources. By addressing barriers to obtaining medical, psychological, and social services, the City will help promote a community-based and accessible system of care for veterans and their families.

6) Veterans Mental Health Holistic Treatment Fund—NEW! (DOHMH)

As with many other mental health conditions, there is no one-size-fits-all treatment for PTSD. Ideally, veterans will have access to a wide array of options, including traditional clinical treatment, holistic skill-based services, peer support, and programming that addresses the culture of silence.

New York City's behavioral health delivery system currently offers an array of traditional clinical treatment options for PTSD. However, new research

suggests that holistic services can provide lasting relief to veterans who choose not to engage in traditional psychotherapy, and also those who might need additional support to cope with symptoms such as chronic pain, anxiety, or insomnia.¹⁷⁸ As a City, we must ensure that the brave men and women who put their lives on the line to protect us have access to the most innovative and effective tools to alleviate their suffering.

To accomplish this goal, the City will create a Veterans Holistic Treatment Fund of \$1 million dollars that will provide grants to organizations that serve veterans and their families in order to bridge the gap between mind-body medicine and traditional clinical care. The grants will allow a variety of community-based settings to host evidence-based restorative practices. Data and lessons learned will be used to influence local and federal policy for trauma-related services.

7) Investing in NYC’s Mental Health Workforce—NEW! (CUNY, DOHMH)

In order to create a mental health system that is culturally competent, reaches every community, and reflects our core principles, we must invest in reshaping and growing our mental health workforce. That means making sure clinicians have what they need to implement a public health approach, while also enlarging the entire workforce by providing mental health training and financing to support non-clinicians. Through such efforts, we will shrink treatment gaps, reduce disparities in treatment access and quality, and incorporate public health activities into mental health care. The City will convene a process to advance these goals, starting with a workforce summit in May 2016 that will join the stakeholders and decision-makers who must work together to innovate and expand the mental health workforce. They will focus on these four key areas:

- Identify and act on strategies that help health and mental health professionals, such as psychiatrists, nurses, and social workers implement and lead collaborative models and coach and support task-shifted roles;
 - 1) Implement and lead collaborative models;
 - 2) Coach and support task-shifted roles;
- Diversify the field by creating strategies to attract and recruit a workforce that is more ethnically and socio-economically representative;
- Develop standardized workforce data that can be collected and analyzed on a regular basis; and
- Facilitate the growth and optimized use of task-shifted roles and careers, such as community health workers and peer counselors. We

want to make sure these roles are being filled in every community. This effort will entail building our collective training capacity, creating certification protocols, agreeing on core competencies, and improving payment structures.

8) Expand Access to Buprenorphine in Primary Care Settings—NEW! (DOHMH)

Buprenorphine is a life-saving medication used to treat opioid use disorder by stopping cravings and preventing withdrawal symptoms. Buprenorphine is available from general physicians in office-based primary care settings. Despite its many benefits, the availability of buprenorphine remains low, which leaves many individuals who suffer from opioid use disorders without the treatment they need. Starting in 2016, we will launch a new and ambitious initiative to add 1,000-1,500 new providers trained and authorized to prescribe buprenorphine over the next three years. This is in addition to a previously announced effort to implement a Nurse Care Manager model, adapted from a successful program in Massachusetts, that will increase buprenorphine treatment capacity in primary care.

9) Expand Access to Naloxone (DOHMH)

Naloxone is a medication that reverses overdose from both opioid analgesics and heroin. It has been legal in New York State since 2006 for laypeople to be trained in recognizing overdose and administering naloxone. This simple first-aid activity is proven to reduce overdose mortality in communities where sufficient numbers of people are trained. Recent new funding will allow DOHMH to provide trained laypeople in those neighborhoods with the highest opioid-involved overdose deaths with enough naloxone to reach more than 7,000 New Yorkers.

10) NYC Safe (MOCJ, DOHMH, NYPD, DHS)

Most people who suffer from mental illness are not violent. In fact, people with mental illness are more likely than the average person to be the victims of violence.¹⁷⁹ However, those people with mental illness who are violent have an outsized impact on the lives of their loved ones, their families, and the communities where they live. NYC Safe is an evidence-driven program designed to support the narrow population of New Yorkers with more complicated mental illness who pose a concern for violent behavior. NYC Safe changes the way the City intervenes to stop and respond to violence that may be committed by those living with mental illness by establishing a centralized oversight body that coordinates public safety and public health. Now the City can respond more rapidly and appropriately to prevent violence, and react more assertively when it happens. NYC Safe includes a series of interventions that together create a continuum of services and new oversights to help keep people who need care, in care. These interventions include seven new mobile teams,

increased resources for existing ACT teams, expansion of the City's ability to appropriately use AOT, and new joint NYPD-DOHMH response teams.

11) Reduce Violence and Address Treatment in the City's Jails (DOC)

The City recently adopted and will continue to implement strategies to improve the care and safety of people with behavioral health needs within City jails. These strategies will rely on de-escalation and evidence-based staffing and programming. They include:

- Department of Correction Crisis Intervention Teams that work to decrease violence. The Teams are specially trained in de-escalation and symptom identification;
- Specialized mental health care units where inmates with serious mental illness can receive more intensive and frequent mental health care;
- Additional mental health training for 2,600 correction officers. This material has been incorporated into the training curriculum for new recruits;
- Specialized services for adolescents, including trauma-informed care;
- Reducing the officer-to-inmate ratio to 1:15 in adolescent units; and
- Expansion of substance use disorder treatment.

This initiative is part of the Behavioral Health Task Force action plan.

12) Mental Health Services for All Youth in Runaway and Homeless Youth Shelters (DYCD)

For the first time, the City will add funds dedicated to enhancing mental health services at Runaway and Homeless Youth Drop-In Centers, Crisis Shelters, and Transitional Independent Living programs. In Fiscal Year 2015, residential programs served more than 2,200 youth under age 21, nearly 40% of whom report as LGBT. Mental health supports will be embedded into programs and could include evaluations, counseling, and direct clinical services.

13) Cognitive Behavioral Therapy Plus (ACS)

ACS is implementing Partnering for Success (PFS) at 18 of their 23 contracted family foster care agencies. PFS is a framework to improve access to and delivery of behavioral health services for children in foster care and their families. The initiative promotes stronger collaboration between frontline workers in child welfare and mental health clinicians who serve foster children. The PFS infrastructure supports greater access to and availability of Cognitive Behavioral Therapy Plus (CBT+), which is a

suite of four evidence-based adaptations of cognitive behavioral therapy (CBT): CBT for Anxiety, CBT for Depression, CBT for Behavior Problems, and Trauma-Focused CBT.

The initiative includes training 200 mental health clinicians and more than 1,000 case planners to support the delivery of CBT+ and other behavioral health services to children and youth in foster care. The initiative also includes ongoing coaching and case consultations. Up to 40% of children aged six or older in family foster care will benefit from CBT+.

14) Mental Health and Substance Use Programming for All Youth at Rikers Island (DOC, NYC Health + Hospitals)

At Rikers Island, the City will provide psychiatric assessments and after-school therapeutic arts programming for all youth under 21, and substance misuse programming for 16- to 21-year-olds. This initiative is part of the Behavioral Health Task Force action plan. Youth who are involved with the criminal justice system are vulnerable to a range of negative outcomes, including substance misuse, mental illness, and victimization. Arts therapy programs in youth detention centers and jails have been shown to reduce recidivism, boost academic engagement, and improve self-esteem.^{180,181,182,183}

15) Mental Health Services in All Family Justice Centers (OCDV, NYC Health + Hospitals)

The City will expand onsite mental health services at all five of the city's Family Justice Centers, which last year served more than 37,000 domestic violence survivors. The staff will provide direct care and also offer mental



health promotion support, skill-building opportunities, and mentoring to other Family Justice Center staff. The new program will be able to accommodate 1,000 clients per year.

16) Geriatric Mental Health in Senior Centers (DFTA)

The NYC Department for the Aging (DFTA) will place a Licensed Clinical Social Worker or a professional with similar skills in up to 25 of our largest senior centers. This initiative will evaluate the efficacy of placing mental health services and professionals in senior centers in order to provide expert on-site assistance. The mental health professionals, who will also serve seniors from nearby centers, will reach a total of approximately 3,750 people annually. If the initiative is successful, we will consider scaling it to other centers.

17) Integrated Brief Intervention for Substance Misuse (DOHMH)

Introduce substance use screening, brief intervention, and referral to treatment (SBIRT) services in all eight of the City's sexually transmitted disease (STD) clinics. From February 1, 2012 through April 30, 2015, more than half of all patients reporting to the City's STD clinics screened positive for substance misuse, which is much higher than the national average of 23%. SBIRT has been shown to effectively address both STD and risky alcohol use. Patients identified as high risk for substance misuse are offered up to 12 extended brief intervention (EBI) sessions with a social worker/mental health counselor or a referral to formal substance use disorder treatment.

18) Expand and Enhance Discharge Planning Services (DOC, NYC Health + Hospitals)

People who leave our City jails represent a group with high levels of mental health and substance use needs. In addition, those who have previously been incarcerated have a higher likelihood of being re-arrested and re-incarcerated. Connecting people to care will not only improve their mental health, but can also help reduce the risk of re-incarceration and improve public safety overall. The City will:

- Expand Medicaid enrollment application submissions for more incarcerated people prior to discharge
- Expand existing jail discharge services to serve an additional 8,100 people who leave jail, through the Department of Correction's expanded I-CAN program and the Health and Hospital Corporation's new substance-use discharge planning program.

This initiative is part of the Behavioral Health Task Force action plan.



Partner with Communities

Embrace the wisdom and strength of local communities by collaborating with them to create effective and culturally competent solutions.

-
- Make communities sources of mental health.
 - Help local groups and institutions host interventions and mental health promotion activities.
 - Support community efforts to serve as a source of knowledge and planning.

The success of any public health campaign hinges on sharing leadership with communities, and that is especially true of our mental health effort.

Share leadership with community members and organizations

Mental health is a deeply personal issue, and when people are ready to seek help they often turn to the people with whom they are closest, both emotionally and geographically. This could include family members, friends, faith leaders, neighborhood elders, or a friendly staff member at a local civic organization. These are the same people who are often our most important sources of support, well-being, and mental health.

If we want to improve the mental health of New Yorkers, then we must help both community organizations and individual community members connect with each other. We must provide them with the options and information they need to be of service when one of their neighbors is dealing with a mental illness, and recognize that strengthening social ties and creating vibrant communities is the foundation for mental health. We must speak their language, in every sense. And we must respect and enhance the central—and often driving—role they can play when it comes to designing, targeting, prioritizing, testing, and implementing mental health solutions.

City government is already putting this truth into action. We are partnering with a range of community stakeholders and organizations to provide the resources, training, and planning methods they need to both help individuals and also engage entire communities. This work recognizes that the stigma of mental health is real, and if we want to expand the range of treatment and promotion options, then we must also broaden the range of people who are able to act.



“I talk to our community advisory board about this a lot. What they’ve said is there is a lack of trust in the health care system. They would like to take it on a more community basis, to the schools, to the religious leaders of the community. We need to involve our communities in what they think would work... But the reimbursement system doesn’t work that way.”

Hospital Administrator

Address structural deficiencies

Community engagement must also extend beyond individuals and organizations and address the larger structural deficiencies that so often have a profound impact on mental health. Too many New Yorkers live in neighborhoods with concentrated poverty, job insecurity, violence, or unequal application of drug laws and other penalties, which prompt more frequent interactions with the criminal justice system and increase the likelihood of experiencing discrimination. These neighborhood effects and other stress factors increase the risk of onset of depressive symptoms, diagnosis of major depressive or post-traumatic disorder, misuse of substances, and anxiety.¹⁸⁴

In other words, people in vulnerable neighborhoods are *made* more vulnerable by the conditions that surround them. In one survey, lower-income New Yorkers who reported mental health problems such as depression or anxiety viewed those problems as stemming from socio-economic factors, including unemployment, immigration experiences, lack of affordable housing, and poverty.¹⁸⁵ If we want to treat not just the symptoms but also the root causes of mental illness and threats to mental health, then we must implement structural interventions that reduce discrimination, fundamentally strengthen the entire fabric of a community, and enable local groups to advance solutions that contribute to these goals.¹⁸⁶ We must work from both the bottom up, and from the top down.



Credit: Mayoral Photography Office

Policies to Address Structural Risk Factors



Create an Active Labor Market for People Who Are Unemployed

Layoffs and unemployment lasting longer than one month are associated with increased suicide risk.¹⁸⁷ Individuals who are unemployed have more psychological problems (34%) than employed individuals (16%).¹⁸⁸



Create Affordable, Quality Housing

Housing instability, characterized by frequent moves, doubles the risk of depression in men and triples the risk of depression in women.¹⁸⁹ Poor housing quality—including structural problems, mold, and pest infestation—also increases the risk of depression in adults.¹⁹⁰



Support Family Leave

Mothers in California who took less than 12 weeks of maternity leave or less than 8 weeks of paid leave had increased depressive symptoms when surveyed nine months after childbirth.¹⁹¹



Support Health Insurance Parity, Access, and Accountability

Individuals with Medicaid insurance are less likely to screen positive for depression and showed greater improvement in depressive symptoms compared to individuals with no health insurance.¹⁹²



Support Education

Educational attainment and success are among the strongest predictors of lifetime mental health.^{193,194}



Enhance the Environment and Use Land and Public Space Wisely

Public space, public art, parks, schools, and workplace design all have a direct impact on our mental health. Mental health, for example, is significantly related to how far someone lives from a park,^{195,196,197} and public art and murals can promote social ties.^{198,199}

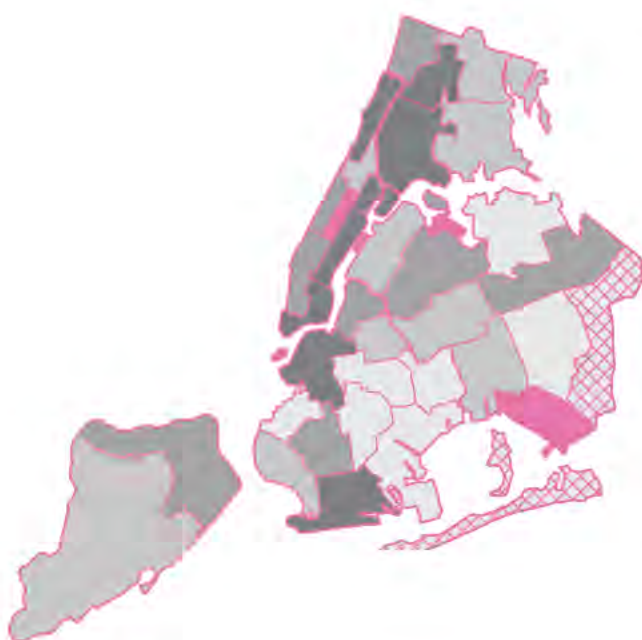
Our success in this work will be judged according to two factors:

- **Community resilience** characterizes the extent to which a community as a whole can respond to the emotional challenges, traumas, or burdens it faces. A community’s resilience is linked to its schools, organizations, economic fabric, social places, and physical space.
- **Collective efficacy** is the mutual support and social cohesion that exists among people living in a community.²⁰⁰

Both factors shape, but can also be shaped by, the presence of social supports, securely bonded families, and the value placed on emotional self-care in communities—all of which can be purposefully supported and nurtured.

In this interaction, community resilience and collective efficacy protect community members from threats to mental health, and are themselves bolstered by efforts that improve and promote the mental health of individuals. Mental health specialists can therefore play a crucial role in supporting this virtuous cycle by helping communities promote mental health activities. And government can also support policies that address income inequality and insecurity, discrimination, and social instability.

So when we observe how mental health varies across the city (see the variation in depression in map), we need to also look at neighborhood differences in many other factors: economic opportunity, urban design, neighborhood effects, and public safety. This variation also reflects differences in access to care, untreated or poorly treated illness, population distress, and opportunities for prevention or promotion. A public health response will address these multi-layered and interacting realities.



Lifetime Depression

Source: NYC Community Health Survey, 2013

- 5.7% – 11.3%
- 11.4% – 14.5%
- 14.6% – 17.9%
- 18.0% – 22.1%
- x

 Estimate Potentially Unreliable
- Parks and Airports

CASE STUDY: Cure violence

New York City's Cure Violence (CV) program deploys specially-trained staff to work with at-risk young people in communities with high levels of gun violence. These Violence Interrupter and Outreach Worker staff are from the communities they serve and have first-hand life experience with violence and imprisonment, which gives them invaluable credibility when it comes to talking with these at-risk youth about the obstacles they face and ways to manage them. CV staff receives training on a goal-orientated, client-centered interviewing technique that was specially redesigned by them, which makes it a much more effective and culturally sensitive coaching tool.²⁰¹

PARTNER WITH COMMUNITIES INITIATIVES

1) NYC Mental Health Corps—NEW! (DOHMH)

Starting this year, we will begin creating a Corps of approximately 400 physicians and recently-graduated Masters and Doctoral-level clinicians to work in substance use programs, mental health clinics, and primary care practices in high-need communities throughout the city. When fully staffed, the Corps will provide approximately 400,000 additional hours of service in those communities where they are needed most. This number approaches the number of outpatient behavioral health visits made by NYC Health + Hospitals in 2013.²⁰²

We will work with communities to determine where Corps members can do the most good. Corps members will partner with community members and their clinical teammates to expand the use of evidence-based treatment and mental health promotion methods in the neighborhoods they serve. This will include using the Collaborative Care model with primary care patients dealing with depression, anxiety, and substance misuse. Many Corps members will be placed at primary care settings, which is where most New Yorkers receive their regular medical care. Not only will this make mental health services easier to access, it will also reduce the stigma of receiving mental health care by connecting it with physical primary care.

The Corps will also spur innovation among the mental health and substance use workforce. Corps members, who can put the hours they work toward meeting licensing requirements, will receive training, supervision, and coaching rooted in the principles laid out in this Roadmap. They will be a source of increased capacity, and a force for broader adoption of innovative treatment and mental health promotion practices.

2) Virtual Learning Center for Community-Based Organizations—NEW! (DOHMH)

During our meetings with clergy, community groups, and agency leaders, we received many requests for education and skill-building materials they can use to better meet the mental health needs of their congregations and clients. In response, the City will develop a free, universally available web-based Learning Center for community organizations. Our initial outreach will focus on faith-based and immigrant-serving organizations. The website will provide a skills training library that offers non-clinicians effective and executable task-shifting and prevention strategies. It will include videos, tools that test your skills, handouts of tips and information summaries, patient assessments, and links to other resources. The website will also be a forum to facilitate partnerships between community groups and providers.

3) “Friendly Visiting” to Combat Social Isolation Among Seniors—NEW! (DFTA)

Social isolation among the elderly is associated with a dramatically higher incidence of a variety of physical and mental health issues. Friendly Visiting is a light-touch approach for reaching substantial numbers of older people. DFTA will work with and fund 12 case management agencies to identify 1,200 homebound clients who are suffering from the ill effects of social isolation, including high rates of depression and anxiety, and connect them to trained volunteers. The volunteers will make regular home visits and telephone calls, where they will provide meaningful social contact and be on the lookout for possible issues requiring follow up. DFTA will engage a researcher to measure the impact of the program.

4) Early Years Collaborative—NEW!

(Mayor’s Office, DOHMH, ACS)

The Early Years Collaborative (EYC) is an example of how government can help communities across New York City be more effective planners and catalyze action. The aim of EYC is to improve the health and well-being of young children in New York City using methods that put local groups at the center of the idea testing process. Led by Mayor de Blasio’s Children’s Cabinet, EYC will connect staff from City agencies with community-based organizations (CBOs), starting with two neighborhoods: the South Bronx and Brownsville. The Cabinet selected these neighborhoods after identifying them as areas with significant City investments, strong networks of community-based organizations, and a large population of children between the ages of zero and three who need and deserve improved outcomes.

Together, City agencies and CBOs will promote three objectives that will make a big difference in the lives of young community residents and their families:

- 1) Healthy pregnancy
- 2) School readiness
- 3) Secure parent-child attachment, safety, and stability

The City agencies and CBOs selected for this initiative will work as a team to strengthen coordination, maximize existing resources, and adopt proven Quality Improvement methods that will build the community’s capacity to play a lead role in advancing these three objectives.

CASE STUDY: Communities leading the way on mental health

Communities That Care (CTC) is a strategy for reducing youth violence, substance use, and crime. Community members come together to select evidence-based solutions to their most pressing mental health issues. The community then implements the solutions and uses an ongoing evaluation process to fine-tune them.²⁰³

For instance, the Five Town CTC program in Maine operates an after-school program and mentoring programs focused on math and literacy. Five Town CTC also conducts a free “Guiding Good Choices” workshop series for parents and caregivers that focuses on parenting skills. Between 2004 and 2014, adolescents in the Five Town community were less likely to drink alcohol, smoke marijuana, perpetrate violence, get suspended from school, shoplift, or participate in vandalism.²⁰⁴

CTC’s prevention-focused approach is also cost-effective. Every dollar invested in CTC returns \$5.30—thanks to reduced smoking-related mortality, better health, lower medical expenditures, and lower criminal justice system and crime victimization costs in the near and long term.²⁰⁵

Brownsville Partnership for Mental Health is a joint project of some 30 organizations that brings together residents, government agencies, community-based organizations, hospitals, and providers in order to build a web of mental health and wellness support for Brownsville families. The effort uses the Collective Impact model, which is a proven tool to help groups create effective change.

Early Years Collaborative (EYC) is a Scottish effort that brings together 40 cities and 2,000 individuals to test locally-identified efforts to expand early-child well-being interventions. Local groups are trained to use Quality Improvement methods to realize their goals. This effort partially inspired New York City’s EYC.

Shared Art: Since 2007, the Mural Arts Program and the Philadelphia Department of Behavioral Health and Intellectual Disability Services (DBHIDS) have collaborated with community-based organizations to co-create public art that functions as both an expression of community resilience and also as a vehicle for personal and community healing. So far, they have completed 18 arts projects.

Parks and Paths: When you strengthen the social and physical connections among neighborhoods, you also strengthen their collective mental health. Psychiatrist Mindy Thompson Fullilove recognized that the cliff-side parks of Northern Manhattan—specifically, Morningside Park, St. Nicholas Park, Jackie Robinson Park, and Highbridge Park—could serve to link the neighborhoods of Morningside Heights, Harlem, Washington Heights, and Inwood. She worked with area residents to create a hiking trail connecting the parks called the “Giraffe Path.” She was also a leader of the successful effort to reopen the High Bridge, which connects the Bronx and Manhattan.



The CBOs and City agencies will:

- Identify areas of focus within the three EYC goals that align with community priorities;
- Identify measurable, time-bound, and ambitious goals that cannot be achieved simply by working harder, but will instead require systems-level change to achieve;
- Collaboratively brainstorm and rapidly test tangible improvements to existing systems that will in turn lead to improved child outcomes; and
- Implement, test, and measure the effectiveness of these improvements/changes during 90-day action periods.

Through this process, the EYC will identify scalable changes/improvements that can be implemented more broadly within the neighborhood or across the city to move the needle on the EYC objectives. These improvements could include reshaping how and where the City allocates resources.

5) Connections to Care (C2C)

(Mayor's Fund to Advance NYC, DOHMH, CEO)

In July 2015, First Lady Chirlane McCray announced Connections to Care (C2C), a \$30-million public-private partnership that will help integrate mental health services into programs that already serve low-income communities. This initiative receives significant funding from the Corporation for National and Community Service, a signal of the federal government's support for our vision. C2C will target a number of high-need populations, including low-income expectant mothers and parents of young children; young adults who are out of school and out of work; and low-income adults who are unemployed or underemployed.

C2C showcases three key elements of our effort to Close Treatment Gaps:

- **Task-Sharing:** Staff at community-based organizations in low-income communities will partner with health providers to receive training on how to identify and take steps to promote mental health or address mental illness and substance misuse;
- **Extend Care Pathways:** Extending these skills to people who aren't mental health specialists will increase the reach of our mental health system; and
- **Put the Expertise of Our Provider Community to Work:** The training and ongoing coaching will be provided by organizations with expertise in mental health.

The City will also fund a study to better understand the impact of C2C on those who will receive services. It will track the experience of service provider organizations in order to promote real-time information sharing and best practices, and assess the sustainability of the program. Our ultimate goal is to expand this model throughout the city.

6) Mental Health Weekend for Faith-Based Communities— NEW! (DOHMH and CAU)

Clergy we spoke with also expressed great interest in partnering with the City to let their congregations know that mental illness is nothing to be ashamed of, that services are available for those in need, and that the City wants and needs their help to create an effective mental health system. We will therefore work with clergy members of different faiths to organize a citywide Faith-Based Mental Health Weekend. On the designated weekend, faith leaders across the City will be invited to preach on the topic of mental health.



7) Create Employment Opportunities for Individuals with Developmental Disabilities— (DOHMH and CAU)

We will sponsor new programs in each borough to increase the number of individuals with developmental disabilities who have good jobs. The programs will be provided to those who are not eligible for state vocational services and will teach basic workplace skills, interpersonal skills, and specific job skills. They will also help participants excel in their work and get involved in their communities.



Use Data Better

Work with all stakeholders to address gaps, improve programs, and create a truly equitable and responsive mental health system by sharing and using information and data better.

- Develop new measures and methods to understand mental health needs and priorities.
- Enable others to use data to test, adopt, and improve their practices.
- Identify, evaluate, and disseminate promising mental health strategies.



Data collection and analysis are a key part of any evidence-based decision-making process. When providers routinely use real-time data on individual care outcomes, it can markedly improve their ability to ensure that the patient is receiving the right care in the right order.²⁰⁶ More broadly, there is still much that we don't know about the mental health of New Yorkers and the effectiveness of services. Coming up with useful answers will require the use of traditional surveillance instruments and epidemiologic studies, but also more innovative tools such as crowd-sourcing information to provide real-time data. City government will invest in both; our goal is to expand the traditional surveillance of mental health outcomes, especially for the youngest New Yorkers, and explore ways to harness



“We have very little to measure quality of services in mental health. We really don’t have measurements of recovery for either kids or adults that are meaningful to the people around the table. Such as, are you doing well on your job? Are you doing well in your school? I think we need to think of quality outcomes. How are we going to better measure the success of what we have to offer to people?”

— Community Advocate

technology and “big data” to improve mental health citywide. We will also support better uses of data to advance the Roadmap.

Better data can help to guide our City’s unmet mental health needs. It can enable us to visualize these needs disaggregated by geography or demographic profile, which will allow for better targeting. It can also help us track both the impact of treatment as well as gaps in coverage and quality. Investing in better surveys and research will enable providers to make meaningful comparisons of different approaches for mental health, including cost-benefit analyses. New technologies can also help create maps to visualize inequities, focus on bottlenecks, access services in real-time, connect residents to care, and troubleshoot problems in community mental health.

The de Blasio Administration’s first investment toward this goal will be a new Mental Health Innovation Lab. The Lab will:

- Scan, gather, synthesize, and disseminate knowledge of effective mental health strategies;
- Adopt new techniques and data sources that will allow us to better track, measure, and address population needs;
- Evaluate smart choices and make recommendations for new practices;
- Help test, evaluate, and support innovation and implementation; and
- Enable better use of information and best practices among community-based partners and providers, City agencies, and the Mental Health Council.

In all of our work to improve the use of data, we will be vigilant when it comes to protecting the privacy of New Yorkers.

The Innovation Lab will help others test new strategies and interventions in New York City through public-private and community-based partnerships that spread the use of evaluation and planning tools. This can enable more people and places to adapt evidence-based practices to the city’s unique needs, with an emphasis on efforts that close treatment gaps, diminish inequities, and expand mental health prevention and promotion.

Everyone in the mental health system—providers, clients, advocates, organization leaders and managers, and government—can play a role in using and contributing to the data needed to advocate and act for change, improve results, and inform decision-making.

USE DATA BETTER INITIATIVES

1) Mental Health Innovation Lab—NEW! (DOHMH)

The mental health field is undergoing great changes, and providers of mental health services are in the middle of the tumult. The change is being spurred by action at the federal and state level, including the 2010 Mental Health Parity and Addiction Equity Act and ongoing efforts to redesign Medicaid. These payer-driven transitions offer opportunities for better primary care integration and quicker implementation of evidence-based practices by providers. However, in order to take full advantage of these opportunities, providers need support—and do not currently get enough.

In recognition of these needs, and to ensure that data is used to make real change, the City will establish a Mental Health Innovation Lab to provide necessary technical assistance and support to local service providers, including other City agencies.

The Lab will help drive the use of evidence-based best practices throughout the field and design better methods for getting the data we need, which will lead to more innovative and effective programs. The Lab will:

- Evaluate, disseminate, and advise on the use of evidence-based best practices;
- Provide hands-on support in the use of implementation science to help others close treatment gaps, promote prevention, and use data better;
- Provide better data to mental health stakeholders by sharing and developing innovative survey and screening methods for mental wellness as well as illness; information collection; new metrics that better capture the need for and impact of mental health and substance use services; and cost-benefit analyses;
- Produce reports and materials to help the City better advocate on behalf of providers who use high-quality, evidence-based methods while navigating these major transitions; and

- Work with the Mayor’s Office of Labor Relations (OLR) to better understand city employees’ behavioral health needs and support OLR in their work to promote mental well-being among the city’s workforce.

The Lab will be based on existing and successful models, including those established by 1) the University of Chicago’s Health Lab, which uses academic and big data strategies to identify new policy solutions, and 2) the Center for Addiction and Mental Health in Ontario, which developed a model to improve community-based mental health services. The Lab will also develop a network of academic partners who will join us in this work.

2) Evaluate Financial Sustainability of School-Based Mental Health Services (DOE, DOHMH)

Approximately 200 DOE schools currently have school-based mental health clinics, and in the year to come the City plans to locate additional school-based mental health clinics in Community Schools. These clinics provide students and families with easy access to high-quality mental health counseling and services. Some clinics also provide teachers and administrators with training and skills development throughout the year.

Whether a school-based mental health clinic is able to survive financially on insurance reimbursement (Medicaid and private) alone varies significantly. Many of the services that make clinics effective are not billable to insurance, including classroom observations, teacher consultations, and schoolyard interventions.

As a result, clinics are often unable to provide skills development to other staff throughout the school. Some rely on partners—such as academic medical centers or private foundations—to underwrite their work, which makes funding a year-to-year struggle. DOHMH and DOE will evaluate the various existing financial models in order to better understand how we might scale more comprehensive school-based mental health services.

3) Evaluate Existing Assertive Community Treatment (ACT) Teams (DOHMH)

Assertive Community Treatment provides the highest level of mental health care available to New Yorkers with serious mental illnesses who are stable enough to live in their communities. There are currently 44 ACT teams in New York City. To improve the effectiveness of all teams, the City is adding additional resources to these teams and is funding an evaluation to determine what interventions are successful.

4) Ensure the City Uses Jail and Diversion Programming Effectively (MOCJ, DOC)

The City uses a broad risk-based approach to inform decisions about which defendants should receive an expanded array of supervised release programs. This approach can improve public safety while providing more effective mental health treatment to people in the mental health system. Strategies/tools include:

- Expanded supervised release;
- Scientifically-validated risk assessment tool;
- Universal screening for physical and mental health problems;
- Reduced reliance on monetary bail;
- Crisis intervention teams;
- Dramatically reduced use of punitive segregation; and
- Strategy to significantly shorten case processing times.

This initiative is part of the Behavioral Health Task Force action plan.



5) Child Health Survey (DOHMH)

The Child Health, Emotional Wellness and Development Survey (CHEWDS) is a cross-sectional survey of more than 3,000 families that was undertaken by DOHMH for the first time in 2015 to collect reliable, representative, citywide data on the health, emotional wellness, and development of children ages 12 and younger living in New York City, including their service usage and needs. It will provide us with an accurate picture of the connections that exist between factors such as adverse events facing children and families, mental health threats to both children and their parents, and access to care.



Strengthen Government's Ability to Lead

Affirm City government's responsibility to coordinate an unprecedented effort to support the mental health of all New Yorkers.

- Use government assets to promote mental health.
- Use the City workforce to reach more people.
- Agree upon shared aims across City agencies.
- Coordinate resources and increase communication across agencies.
- Set an ambitious agenda for action and advocacy beyond City government.

Every day, City agencies reach hundreds of thousands of New Yorkers, including many of the most vulnerable. And every day, City agencies work with stakeholders from the public, private, and non-profit sectors on policies with the potential to improve the lives of communities throughout the five boroughs. In order to achieve our goal of protecting the mental health of all New Yorkers and lead on this issue, City government must consider mental health when approaching our work.

As documented in this Roadmap, the City already devotes a significant amount of resources to mental health efforts. But the sum of these efforts is not yet greater than the whole, and that is because they are not yet aligned around a single shared strategy. In order to achieve our ambitious goals and create long-term systems change, we are undertaking an unprecedented effort to bring the de Blasio Administration, City Council, City agencies, community partners, and other branches of government together in pursuit of our shared objectives. This work will start at the very top, with Mayor de Blasio, First Lady McCray, and Deputy Mayor Richard Buery working with Commissioners in every sector to put the full force of the City behind the Roadmap.



Credit: Mayoral Photography Office

Our work in this arena will center on three goals:

- 1) Connect and assist City agencies;
- 2) Help shape monumental changes in how we pay for mental health care;
- 3) Establish New York City as a leader on mental health; and

In everything we do, we will embrace our responsibility to lead—and to listen.

STRENGTHEN GOVERNMENT'S ABILITY TO LEAD INITIATIVES

Connect and assist City agencies

1) Launch NYC Mental Health Council—NEW!

(City Hall, DOHMH)

City government has an unparalleled capacity to provide and promote prevention and treatment activities, while also advancing the range of policies needed to take on the structural issues at the root of so many mental health conditions. With this in mind, we are establishing a Mental Health Council comprised of more than 20 City agencies from every sector of government, including health, human services, law enforcement, education, youth development, labor relations, and parks. The Council will serve as a key vehicle for managing mental health initiatives, policy-making, and problem-solving across City government. It will also ensure that the City is effectively implementing these initiatives, especially those that involve multiple agencies, by tracking their progress and engaging in collaborative problem solving.

The Council will report directly to Mayor de Blasio and be led by First Lady Chirlane McCray and Deputy Mayor Richard Buery, ensuring that mental health remains at the forefront of City policy. DOHMH will provide technical leadership to the Council and the larger community. The Council will report publicly on the progress of the Roadmap, adding another layer of accountability.

A central element of the Council's work will be developing new ways for City employees to play a key role in the care pathway. A great example of this is our new effort to train early childhood educators on Social-Emotional Learning (see Act Early initiatives). Teachers are well-positioned to provide our children with the tools they need to protect their mental health, but we need to connect our teachers to the appropriate training and resources. And teachers are far from the only City workers whose potential is just waiting to be tapped—we must also enlist caseworkers, probation officers, parks employees, and so many more to join our mental health campaign. The Council will lead an effort to identify partnership opportunities, share best practices, and provide City agencies with the tools they need to help their employees and their programs contribute to our mental health effort.

As emphasized previously, if we want to make a real difference on mental health, we cannot shy away from addressing big issues like income inequality, racial discrimination, use of public space, and housing



Credit: Ed Reed/Mayoral Photography Office.

First Lady Chirlane McCray visits City Hall Senior Center

instability. The de Blasio Administration has already launched numerous multi-sector initiatives that address these issues head-on, but the City also needs an entity to analyze these efforts through a mental health lens and determine where additional work is required. The Council will take on this role and work with member agencies to create new shared policies to advance the Roadmap.

Specifically, within the first 150 days of the Roadmap's release, the Council will develop a set of specific agency goals, larger objectives the Council will pursue together, and a proposed federal and state legislative agenda to support the Roadmap goals.

2) Reshape the Community Services Board (DOHMH)

The Community Services Board is a City Charter-mandated body that advises DOHMH's mental health work. We will fundamentally enhance the role of the Board by inviting new members that represent a broad spectrum of communities, organizations, and viewpoints. Our goal is to engage stakeholders whose voices have previously gone unheard, including not just mental health experts and providers, but also people who have been through the system and their family members.

But this restructuring isn't only about bringing new people to the table—they will also take on new mission-critical responsibilities. Specifically, the Board will collaborate with the Mental Health Council to produce an annual Council Report updating New Yorkers on the progress of the Roadmap.

CASE STUDY: Sweden

With its 2012-2016 Plan, Sweden launched “Don’t Wait,” a national campaign to improve mental health outcomes for children and young people through evidence-based prevention, promotion, and treatment options. The government launched a cross-agency “social investment fund” to support proven prevention strategies. Any gains that City agencies achieved by acting early went back into their budgets. The city of Norrköping, for example, pooled funding from social service and education agencies to improve outcomes for children in foster homes. Within five years, the cost savings achieved by the Swedish Department of Social Services was three times greater than the costs to implement the program.

Help shape monumental changes in how we pay for mental health care

3) Continue working closely with the State on the transition to Medicaid managed care (Mayor’s Office, DOHMH)

A Time of Transition

We are living through a time of seismic change in how we pay for mental health and substance use treatment, both here in New York and nationally. This change brings with it the potential for new resources for providers to deliver better and more innovative care aligned with the six guiding principles in this Roadmap. However, turning this potential into better outcomes will require us to make better use of these resources and improve our monitoring capacity.

Of all the changes that are afoot, perhaps the most important is the shift in New York State’s Medicaid program to include behavioral health services in managed care. Starting in October 2015 and proceeding in phases, New York State is transitioning behavioral health services in its Medicaid program to a managed care model. The new model includes Health and Recovery Plans (HARPs) for adults with significant behavioral health needs and an expanded Children’s Behavioral Health Benefit that will serve specialized populations of children including children in foster care, medically fragile children, and children with serious emotional disorders. As a result of these changes, managed care insurance plans will increasingly play a significant role in managing and coordinating the care their members receive.

This transition to Medicaid managed care creates a single point of accountability—in the managed care plans—and with the right oversight and standards this is an opportunity to raise the level of care across the board. Given that Medicaid serves approximately 3 million New Yorkers, this is a substantial transformation in the way we pay for treatment, integrate fragmented services, and coordinate people’s behavioral health care. We are committed to partnering with Medicaid managed care plans to foster the next generation of behavioral health care by promoting and implementing many of the strategies presented in this Roadmap, including better coordination of care; integration of physical and behavioral health needs; use of appropriate, evidence-based interventions; mental health promotion and prevention efforts; and providing care through task-shifting.

However, significant questions remain. The transition of behavioral health Medicaid services from fee-for-service to managed care is an area of significant concern for providers in the City, including NYC Health + Hospitals. Managed behavioral health rates are largely determined based upon historical fee-for-service rates, which rarely cover actual costs of providing these services. (NYC Health + Hospitals estimates roughly 60% of

its behavioral health costs are covered by Medicaid rates.) Already, there is an insufficient supply of qualified professionals to meet patient demand, particularly for low-income patients. It is incumbent on the State to fund Medicaid behavioral health services at a sufficient, sustainable level. The new model needs to make it easier for all enrollees to get the care they need, when and where they need it. This is what New York City needs—and City government will be vigilant and vocal in making sure we get it.

City Leadership

The City—through DOHMH—has already played a significant role in shaping the new system.

In light of the significant impact the transition is sure to have on New York City, the Governor and State Legislature authorized a joint oversight role of managed care plans for the City of New York. In partnership with the New York State Department of Health (DOH), Office of Mental Health (OMH), and Office of Alcoholism and Substance Abuse Services (OASAS), DOHMH has helped to:

- Draft the Request for Qualifications for Medicaid managed care plans;
- Draft the managed care model contract;
- Develop service manuals and designate Home- and Community-Based Service providers;
- Conduct on-site readiness reviews of managed care plans; and
- Develop consumer education material, among other efforts.

Additionally, a Quality Steering Committee (QSC) comprised of representatives from NYS DOH, OMH, OASAS, and NYC DOHMH will be established to coordinate monitoring and oversight of Behavioral Health in Medicaid Managed Care Plans that serve residents of New York City. To support this role, DOHMH is expanding its Medicaid data access and analytic capacity to regularly review data related to this transition. This will enable DOHMH to monitor issues such as access to care and service capacity, service quality and efficiency, and consumer outcomes, among others. The Regional Planning Consortium (RPC), a multi-stakeholder behavioral health advisory body convened by DOHMH, has also been established to promote cross-system community collaboration and to obtain real-time community-level information on challenges that arise in managed care.

The City is also monitoring another promising aspect of Medicaid redesign: Delivery System Reform Incentive Payment (DSRIP) Program. DSRIP is designed to support and accelerate the transition of the health care system from treating people when they are already sick to a system that promotes life-long health. To earn DSRIP payments, health care

providers must engage in delivery system transformation projects that improve care for low-income patients, reducing by 25% avoidable hospitalizations of Medicaid patients. Better access to high-quality community-based behavioral health care is essential to meet the goals and performance measures of DSRIP. All 11 Performing Provider Systems (PPS) in NYC have selected the Primary Care and Behavioral Health Integration project as one of their DSRIP transformation projects, presenting an opportunity for large-scale improvement in access to behavioral health care services as a routine part of primary care across the city. Under this DSRIP project, more of an individual's care can be delivered under one roof by known health care providers using evidence-based models.

In New York City, the amount of DSRIP payments is expected to be more than \$4.2 billion over five years. Most of these payments will be allocated to large hospital-led provider networks. Many stakeholders, including the City, will act to ensure that this significant funding is used to improve the behavioral health care services delivered to New Yorkers.

This is a pivotal moment where health care reform is moving beyond extending health care insurance coverage to transforming how health care services meet people's needs and promote health. Put simply, the success of the public health campaign we are undertaking, with its focus on promoting mental health, acting early, and closing treatment gaps, is closely tied to our ability to maximize the investment during this time of change to set a new paradigm for primary and preventive care that includes behavioral health services on an equal footing. Working in partnership with New York State, City government must—and will—use every tool and authority at our disposal to make sure the new system achieves real progress and results for New Yorkers.

Beyond Medicaid

Of course, Medicaid isn't the only funding source that requires our attention. We are also responsible for helping those who are left out of the marketplace—specifically, people without insurance and undocumented immigrants. Earlier this year the de Blasio Administration announced the 2016 launch of a health care access program as part of a plan to improve immigrant access to health care services. The program is designed to provide uninsured immigrants and others with access to coordinated primary and preventive health care services, based on direct access models in other jurisdictions. The initial launch, targeted at enrolling approximately 1,000 participants, will enable the City to collect necessary data and evaluate the program structure to shape a successful citywide model for the future. This health access program will be closely aligned with the principles in this Roadmap. All primary health care providers participating in the health access program will be federally-qualified health centers, whose primary care model stresses behavioral health integration with behavioral health care providers on site. In addition,

the Mental Health Corps announced in this Roadmap will be placed in underserved communities, including immigrant communities, and at high-need FQHCs (Federally Qualified Health Center) and Gotham Clinics participating in the City's immigrant health access program.

Of course, Medicaid isn't the only funding source that requires our attention. We are also responsible for helping those who are left out of the marketplace—specifically, people without insurance and undocumented immigrants. Commercial insurers also have a significant role to play. Surveyed individuals with commercial insurance in New York City were even less likely than Medicaid insured individuals to report getting care.

Since its enactment in 2008, the Mental Health Parity and Addiction Equity Act (MHPAEA) has been changing the landscape regarding insurance coverage for mental health and substance use disorder treatment. The legislation was intended to end the discriminatory practices that were previously commonplace in insurance coverage where it was not unusual for mental health and substance use treatment to be covered at lower levels than other medical treatment or even completely excluded from coverage. Parity assures individuals, families, and providers that all behavioral health conditions are eligible for the same insurance coverage as any other medical condition, removing some of the financial barriers to accessing treatment.

Parity compliance is a complex issue and many compliance issues still remain today. Final protections under the law only came fully into effect on January 1, 2015. The City has an important interest in seeing the aims of the Parity Act reached for all New Yorkers. And we support the ongoing efforts of advocates to ensure that patients and providers have access to the information and tools they need to assert their rights under the MHPAEA.

Achieving the goals in this Roadmap will require the City and our partners to play an active and ongoing role in the reform process. We will therefore meet regularly with federal and state policymakers, the private hospital sector, commercial insurers, providers, and advocates to ensure that the needs of our city are met. Working collaboratively, we will seek to promote innovation, secure new resources, and set stringent accountability measures, some of which may require new legislation.

Establish New York City as a leader on mental health

4) New Supportive Housing for Vulnerable New Yorkers—**NEW!** (HPD, DOHMH, HRA, DHS, ACS, MOVA)

For decades, New York City and State have collaborated to provide supportive housing to vulnerable New Yorkers, including homeless adults

with serious mental illness and young people exiting the foster care system. Supportive housing is a combination of affordable housing and support services designed to help individuals and families use housing as a platform for health and recovery. It has been found to reduce the use of costly services such as shelters, hospitals, and jails.

Today, however, the need for supportive housing far outweighs the availability. Right now, the number of New Yorkers who qualify for supportive housing is almost five times greater than the number of available units. The Corporation for Supportive Housing recently released a report estimating the current need in New York City at more than an additional 24,000 units of supportive housing.

While all previous supportive housing efforts in New York State have been joint ventures of the City and State governments, the people of New York who are most vulnerable need aggressive action now. That's why the City is committing to bring on 15,000 apartments of supportive housing over the next 15 years.

The new supportive housing will serve homeless families, homeless single veterans, homeless single adults, and street homeless individuals who are suffering from or in recovery for a variety of behavioral or medical conditions. It will also serve domestic violence survivors, young adults who have recently left foster care or who have been in foster care and are at risk of homelessness, medically frail individuals, and individuals receiving nursing home care.

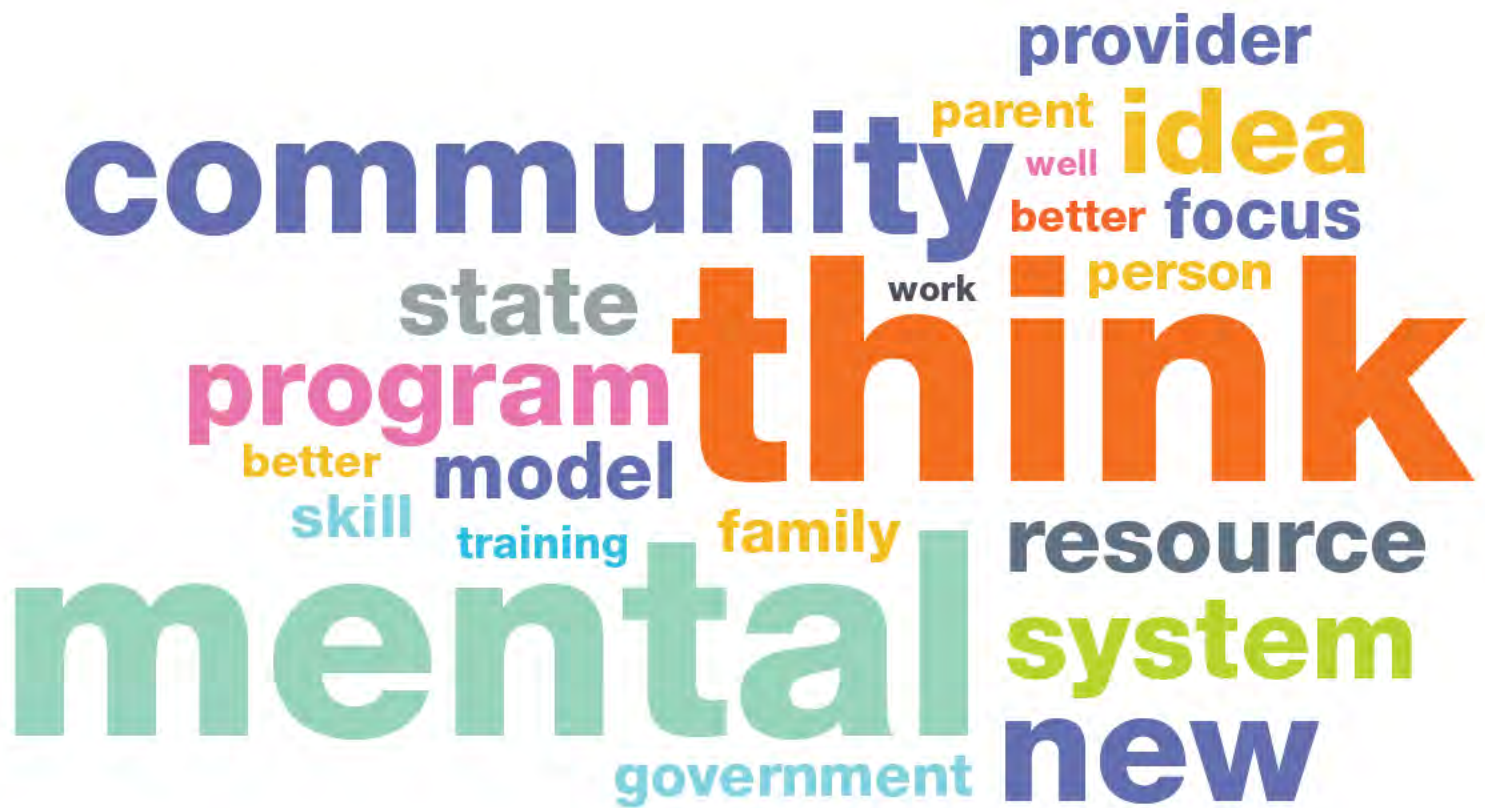
5) Host the first Mayors Conference for Mental Health—NEW! (Mayor's Office, DOHMH)

Just as New York City was at the forefront of efforts to curb smoking, reduce mother-to-child HIV transmission, and relegate lead poisoning to the history books, we are committed to inspiring others to take a public health approach to mental health.

In September 2015, the United Nations hosted a meeting of heads of state from around the world that endorsed a new global blueprint for social and economic policy called the Sustainable Development Goals (SDGs). The blueprint named mental health as a goal of international development for the very first time.

Building on this effort, the City of New York will host the first Mayors Conference for Mental Health in 2016. The Conference will bring cities together to share new ideas and promising mental health initiatives, including our own.

To create this graphic, we compiled transcripts from our 25 mental health feedback groups—approximately 50 hours' worth of conversations that informed every aspect of this Roadmap. We then created an Infographic that illustrates the relative use of the 50 most frequently used non-common words.



A word cloud featuring various terms related to mental health and social services. The words are arranged in a dense, overlapping cluster. The most prominent words are 'people' (large blue), 'health' (large pink), 'city' (large blue), 'service' (large green), and 'care' (large orange). Other visible words include 'public' (green), 'school' (blue), 'organization' (yellow), 'social' (orange), 'service' (yellow), 'substance' (yellow), 'build' (pink), 'opportunity' (dark blue), 'population' (light blue), 'agency' (grey), 'new york' (green), 'worker' (yellow), 'start' (grey), 'help' (grey), 'department' (grey), 'treatment' (yellow), 'support' (dark blue), 'talking' (light blue), and 'behavioral' (green).

Appendix

Roadmap Feedback Group Participants

Participation in Mental Hygiene Roadmap feedback session(s) does not imply agreement with the findings and recommendations presented in this report.

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|--|---|---|
| 1199 SEIU | CAB | Columbia University |
| 32BJ Funds | CAMBA | Columbia University Mailman School of Public Health |
| Addabbo Family Health Center | Catholic Charities Community Services | Columbia University Medical Center |
| Ades Integrated Health Strategies | Catholic Charities Neighborhood Services | Columbia University School of Social Work |
| Administration for Children’s Services | Catholic Charities of Brooklyn and Queens | Columbia University Teachers College |
| Affinity Health Plan | Center for Alternatives and Employment Services (CASES) | Commission on the Public’s Health System |
| Albert Einstein College of Medicine | Center for Children’s Initiatives | Committee on Hispanic Children and Family |
| American Express | Center for Community Alternatives | Common Ground |
| American Psychiatric Association | Center for Court Innovation | Community Healthcare Association of NYS (CHCANYS) |
| American Psychiatric Nurses Association | Center for Economic Opportunity | Community Healthcare Network NYC |
| AmidaCare | Center for Human Development and Family Services (CHDFS) | Community Service Society of NY |
| Anthem Blue Cross Blue Shield | Center for Innovation through Data Intelligence, Office of the Deputy Mayor for Health and Human Services | COMPA |
| Aon Hewitt | Center for Urban Community Services | Comunilife |
| Apicha Community Health Center | CHC Richmond | Con Edison |
| Arab American Association | Child and Family Institute | Concorde Baptist Church |
| Beacon Christian Community Health Center | Child Center of New York | Coney Island Hospital |
| Bellevue Hospital Center | Children’s Aid Society | Cornell Weill Medical Center |
| Bellevue/NYU Program for Survivors of Torture | Children’s Arts and Science Workshops | Cornell Weill Medical College |
| Bowery Residents’ Committee | Children’s Defense Fund Leave No Child Behind | Correctional Association of NY |
| Brain & Behavior Research Foundation | Citizens’ Committee for Children | Council of Family & Child Caring Agencies |
| BrightPointHealth (Help/PSI) | City of New York Office of Labor Relations | Covenant House |
| Bronx Health Link | CityMD | CUNY Med |
| Bronx Lebanon Hospital | Coalition for Asian American Children & Families | CUNY/Creative Arts Team, Inc. |
| Brooklyn Community Services | Coalition of Behavioral Health Agencies | Department for the Aging |
| Brooklyn Defender Services | Columbia Psychiatry | Department of Consumer Affairs |
| Brooklyn Interfaith Advisory Group | | Department of Education |
| Brownsville Multi Service Family Health Center | | Department of Homeless Services |
| Buddhist Council of New York | | |

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|---|--|---|
| Deutsche Bank | Health Plus Amerigroup | Legal Action Center |
| Docs for Tots | Healthfirst | Lenox Hill Hospital |
| Department of Health and Mental Hygiene | Helene Fuld College of Nursing | LGBT Community Center |
| DOHMH, Brooklyn District Public Health Office | Henry Street Settlement, Inc. | LIFT New York |
| Drug Policy Alliance | Hillside Hospital North Shore LIJ Health System | Maimonides Infants & Children's Hospital |
| Dynamic Transitions Psychological Counseling LLP | Hispanic Family Services of New York | Maimonides Medical Center |
| Education & Assistance Corporation | Hofstra North Shore LIJ School of Medicine | Maimonides Medical Center Brooklyn Health Home |
| Elmhurst Hospital Center | Homeless Services United | Make It Happen Mental Health Counseling |
| Empire Blue Cross Blue Shield | Housing Preservation and Development | Mayor's Office for People with Disabilities |
| Exponents | HousingWorks | Mayor's Office of Veterans' Affairs |
| Federation of Mental Health Centers | Howie the Harp | Mayor's Task Force on Behavioral Health and Criminal Justice |
| Federation of Protestant Welfare Agencies | Human Resources Administration | MDRC |
| First Central Baptist Church | Human Services Council | Mental Health Association of NYC |
| Flushing Hospital Medical Center | Hunter College School of Public Health | Mentoring Partnerships of New York and Long Island |
| Fortune Society | Hunter College Silberman School of Social Work | MetroPlus Health Plan |
| Foundation for Child Development | I Will Listen Campaign | Metropolitan Hospital Center |
| Fountain House | Icahn School of Medicine | NYC Health + Hospitals |
| Gay Men's Health Crisis | ICL | Montefiore Medical Center |
| God's Battalion of Prayer Church | IDEAS | Montefiore Medical Center Wakefield Division |
| Good Shepherd Services | Immigrant Affairs | Morris Heights Health Center |
| Gracie Square Hospital | Institute for Family Health | Mount Sinai Adolescent Health Center |
| Greater New York Conference of Seventh Day Adventists | InterAgency Council of Developmental Disabilities Agencies, Inc. (IAC) | Mount Sinai Behavioral Health System |
| Greater New York Hospital Association | Interfaith Medical Center Inc. | Mount Sinai Beth Israel |
| Group for Advancement of Psychiatry | Islamic Society of Bay Ridge | Mount Sinai Medical Center |
| Harlem Center Police Athletic League | Jacob A. Riis Neighborhood Settlement | National Alliance on Mental Illness |
| Harlem Hospital Center | Jamaica Hospital Medical Center | National Alliance on Mental Illness Metro Family Advisory Board |
| Harlem United | Jewish Association Service for the Aged GMHOS | National Alliance on Mental Illness Metro Family Peer to Peer |
| Harm Reduction Coalition | Jewish Board of Family and Children Services | National Alliance on Mental Illness Parent Support |
| Harris Rothenberg International | John Jay College of Criminal Justice, CUNY | National Association of Social Workers NYC |
| Health & Hospitals Corporation | Kings County Hospital Center | National Center for Children in Poverty |
| Health & Hospitals Corporation Kings County Hospital Center | Kingsbrook Jewish Medical Center | |
| Health & Hospitals Corporation Queens Hospital Center | Langeloth Foundation | |
| Health Care for All New York | | |

| | | |
|--|---|--|
| National Development and Research Institutes | Ohel Bais Ezra / Lifetime Care Foundation | The Bridge |
| New York Academy of Medicine | Osborne Association | The Brookdale University Hospital and Medical Center |
| New York Center for Child Development | Parent Advocate Program | The Fund for Public Health NY |
| New York Community Trust | Pesach Tikvah Hope Development | The Interfaith Center of New York |
| New York Immigration Coalition | Phipps Neighborhoods | The Jed Foundation |
| New York Presbyterian Hospital | Primary Care Development Corporation | The Mayor's Fund to Advance NYC |
| New York State Psychiatric Association | Primitive Christian Church | The Medisys Health Network |
| New York State Psychiatric Institute | Prisoner Reentry Institute, John Jay College of Criminal Justice | The Mental Health Association of New York City (MHA NYC) |
| Northeast Business Group on Health | Private Practice Psychologist | Touro College |
| Northeastern Conference of Seventh Day Adventist Church | PSCH | Turning Point for Women and Families |
| Northern Manhattan Perinatal Partnership | Public Health Solutions/Jamaica Southeast Queens Healthy Start | Union Settlement Association |
| Northside Center for Child Development | Quality Healthcare Solutions | United Hospital Fund |
| NY Alcohol Policy Alliance | Queens Consortium of Alcoholism & Substance Abuse | United Jewish Organization |
| NY Association of Alcoholism and Substance Abuse | Queens Supreme Court Judge | United Sikhs |
| NYC Administration for Children's Services, Child Welfare Support Services | Robin Hood Foundation | University Settlement |
| NYC City Planning | Safe Horizon | Urban Health Plan |
| NYC Housing Authority, Office of Public/Private Partnerships | Samaritan Village | Urban Justice Center |
| NYS Psychiatric Institute | SCO Family of Services | VA NY Harbor Healthcare System |
| NYU | SEIU Benefit and Pension Funds | Van Ameringen |
| NYU Center for the Study of Asian American Health (CSAAH) | Service Program for Older People | Vera Institute for Justice Substance Use and Mental Health Program |
| NYU Child Study Center | Settlement Health and Medical Services | Visiting Nurse Services New York |
| NYU College of Nursing | Sisterlink | Vocal NY |
| NYU Langone Medical Center | Sky Light Center | Wagner College |
| NYU School of Medicine | Small Business Services NYC | William F. Ryan Health Center |
| NYU Silver School of Social Work | South Bronx Rising Together Phipps Neighborhoods/Children's Aid Society | Woodhull Medical & Mental Health Center |
| NYU Steinhardt School of Culture, Education and Human Development | Spanish Family to Family Teacher | YMCA of Greater NY |
| NYU Wagner Graduate School of Public Service | St. Barnabas Health Care System | Youth Communication |
| Office of Mental Health FTNYS | St. John's Episcopal | Youth Represent |
| Office of Mental Health New York City Field Office | St. Luke's Roosevelt Hospital Center | |
| Office of the Mayor, City of NY | St. Paul's Community Baptist Church | |
| | Staten Island Mental Health Society | |
| | Staten Island Partnership for Community Wellness | |
| | Supported Housing Network of NY | |

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Department for the Aging

Department of Consumer Affairs

Department of Correction

Department of Education

Department of Health and Mental Hygiene

Department of Homeless Services

Department of Parks and Recreation

Department of Probation

Fire Department of New York

Fund for Public Health in New York

NYC Health + Hospitals

Housing Preservation and Development

Human Resources Administration

Mayor's Fund to Advance New York City

Mayor's Office to Combat Domestic Violence

Mayor's Office of Criminal Justice

Mayor's Office of People with Disabilities

Mayor's Office of Veterans Affairs

New York City Housing Authority

New York Police Department

Small Business Services

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Mary Bassett Commissioner

Oxiris Barbot First Deputy Commissioner

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Mayor's Fund to Advance New York City

Chapman Perelman Foundation
Cheryl Cohen Effron
Steven Feldman
Fountain House
HBO
Cynthia C. Wainwright

Endnotes

- ¹ There is surprisingly limited data on which to base very specific descriptions of mental illness in our communities. And as will be discussed in this report, formal definitions of “illness” and information we have about them only capture a part of how threats to mental health affect so much of our lives. This is one reason why this Roadmap will underscore the need for developing better information gathering methods to support a strong program for mental health. Existing studies indicate that somewhere near the range of 18-26% of adults each year experience a defined mental health disorder—a term which throughout this report is intended to also include substance use disorders. (1) The National Comorbidity Survey-Replication (NCS-R) estimates 26% of US adults have a mental health disorder in a given year, using a gold-standard survey method that uses a diagnostic checklist and assessed for several disorders including anxiety, mood, impulse control, and substance use disorders. (2) The National Survey on Drug Use and Health (NSDUH) estimates prevalence of mental health disorders based on extrapolating predictions from a similar diagnostic interview. Based on these predictions, approximately 19% of adults in New York State have a mental health disorder in a given year, not including substance use disorders. (3) Using a similar model, our own NYC data estimates the prevalence of mental health disorders—though excluding substance use disorders—at 21%. Given that (4) the NSDUH estimates 8% of New York State adults have a substance use disorder in a given year, the overall NYC prevalence of mental illness is potentially even higher than 21%. Sources: 1) Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication, *Archives of General Psychiatry*, (2005) 62: 617-627; 2) <http://www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2013/NSDUHsaeNewYork2013.pdf>; 3) New York City Department of Health and Mental Hygiene. New York City Health and Nutrition Examination Survey (NYC HANES 2013–2014), Unpublished Raw Data, 2013. 4) <http://www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2013/NSDUHsaeNewYork2013.pdf>
- ² New York City Department of Health and Mental Hygiene. New York City Youth Risk Behavior Survey Unpublished Raw Data, 2013. <http://www.nyc.gov/html/doh/html/data/youth-risk-behavior.shtml>
- ³ Communication with Department of Homeless Services HS, Office of Deputy Commissioner of Adult Services, 2015.
- ⁴ New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS) Unpublished Raw Data, 2012.
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- Methodology:** The Mayor's Office of Correspondence merged the data sets and cross-referenced the facilities in order to identify and remove duplicate entries. The NYC Center for Innovation through Data Intelligence (CID) then took the full data set and created this collection of maps using NYC Department of City Planning's Neighborhood Tabulation Areas to determine neighborhood names.
- Key:** The maps categorize providers by their primary focus: mental health facilities, substance use facilities, facilities with substance use and mental health services, or general health services. General health services providers also offer primary care services, in addition to mental health and/or substance use treatment options. These facilities are included on the map only when the facility also offers mental health or substance use treatment and to specify that it offers comprehensive care.

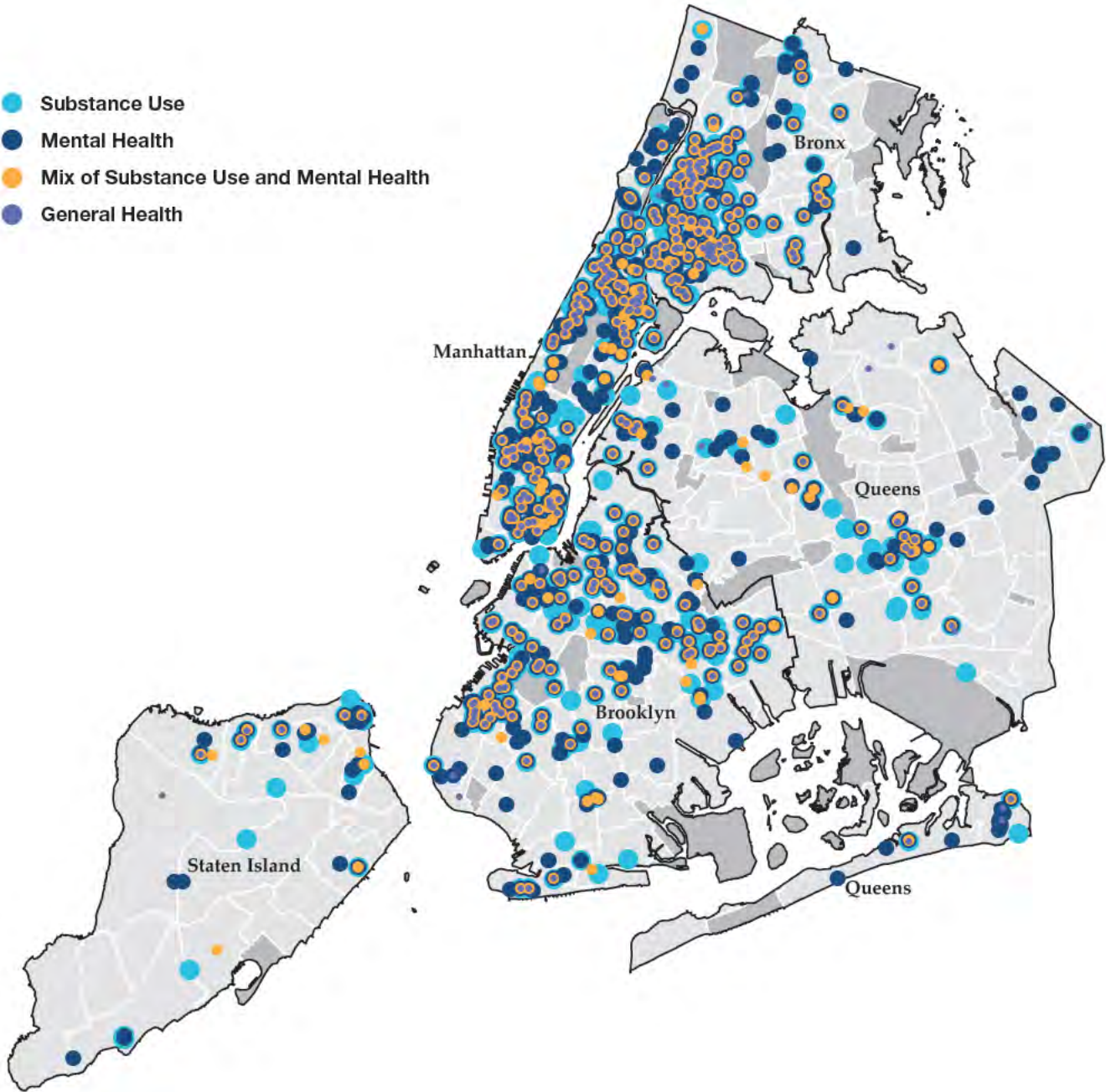
Mapping the Need

The following maps illustrate the location of mental health and substance use facilities in New York City. They also serve to highlight the variation across neighborhoods when it comes to accessing care.

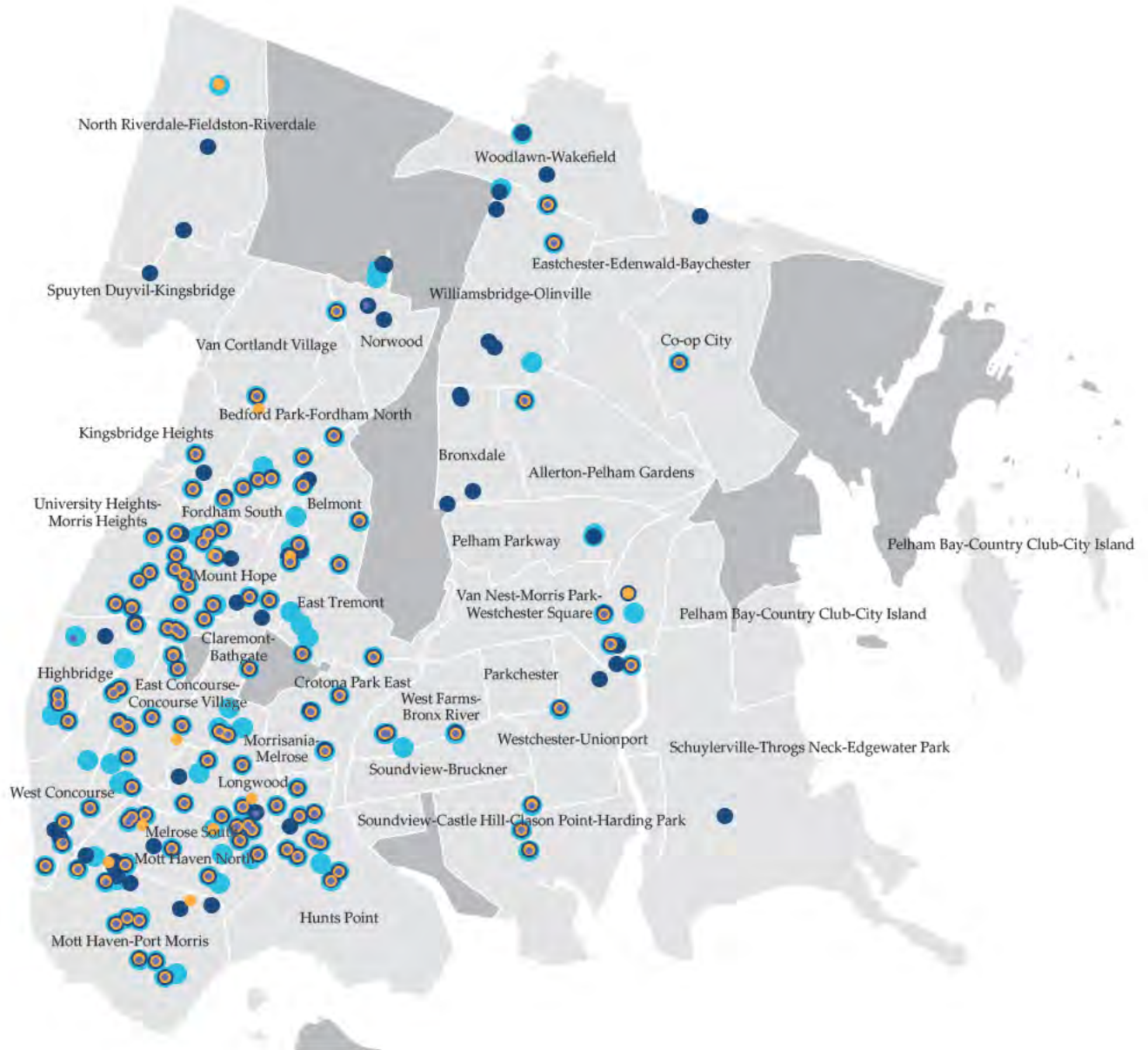
These maps only include licensed or public contracted clinics. They do not include independent practices or private providers.²⁰⁷

New York City

- Substance Use
- Mental Health
- Mix of Substance Use and Mental Health
- General Health

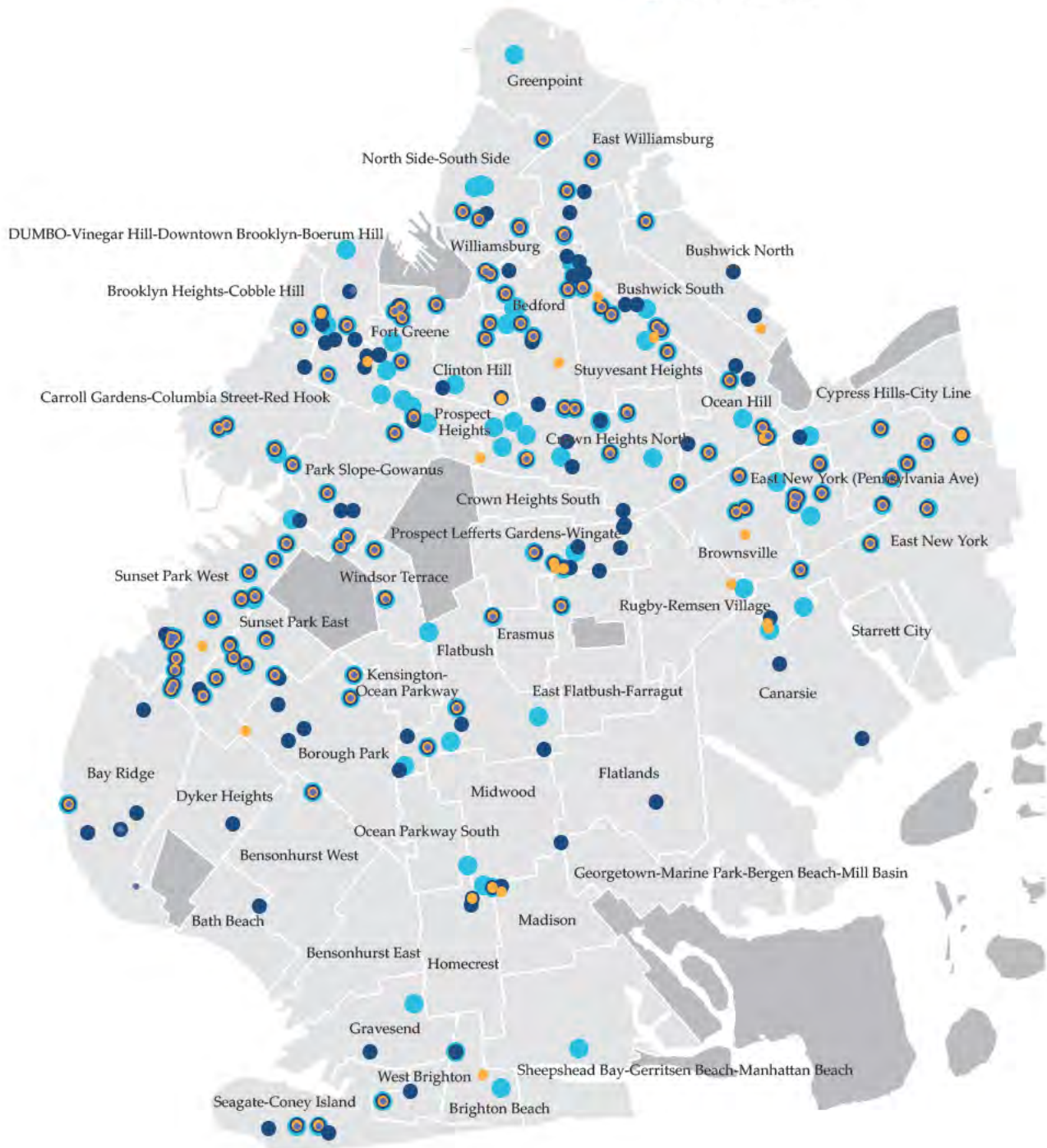


Bronx

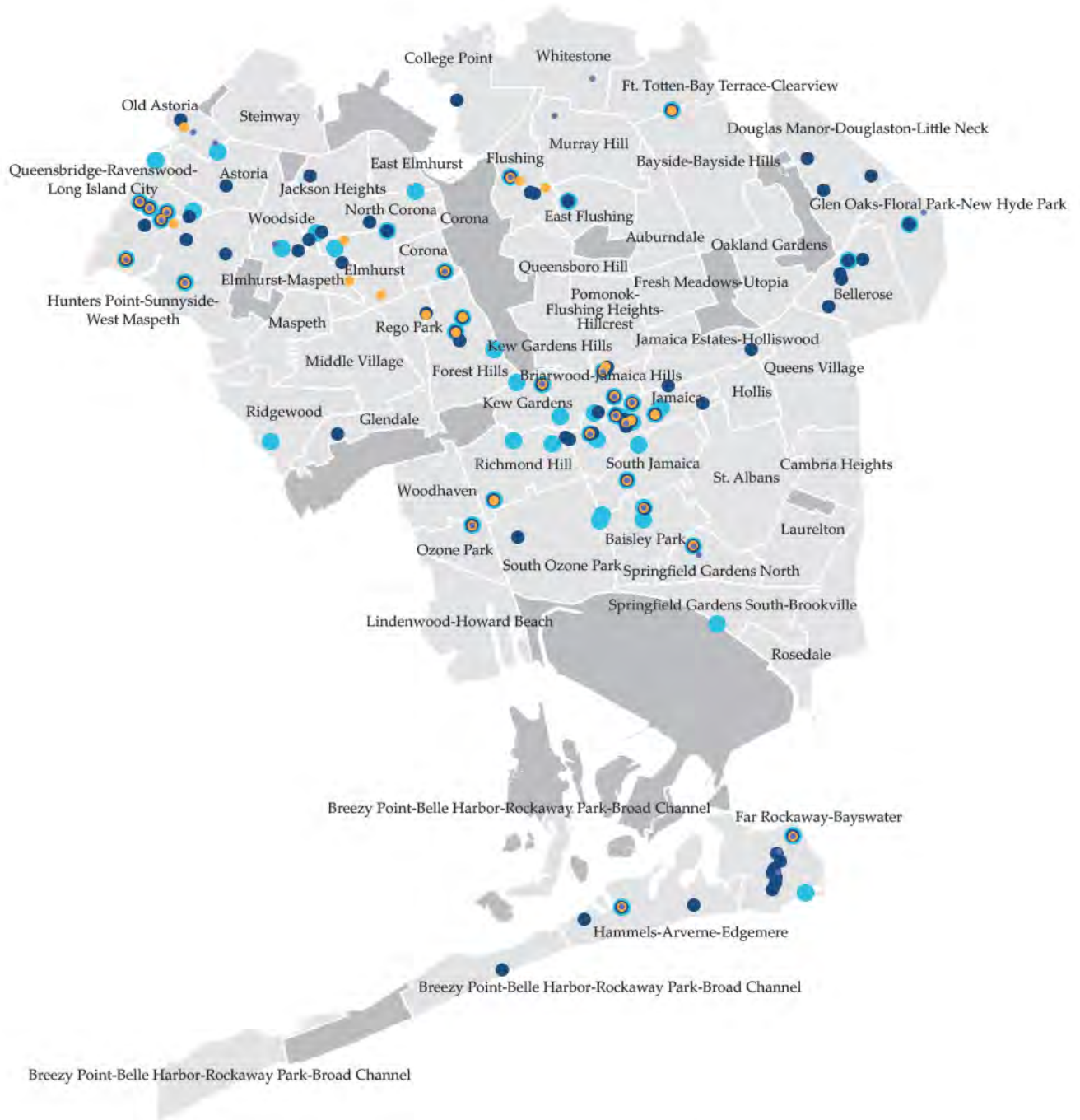


Brooklyn

- Substance Use
- Mental Health
- Mix of Substance Use and Mental Health
- General Health

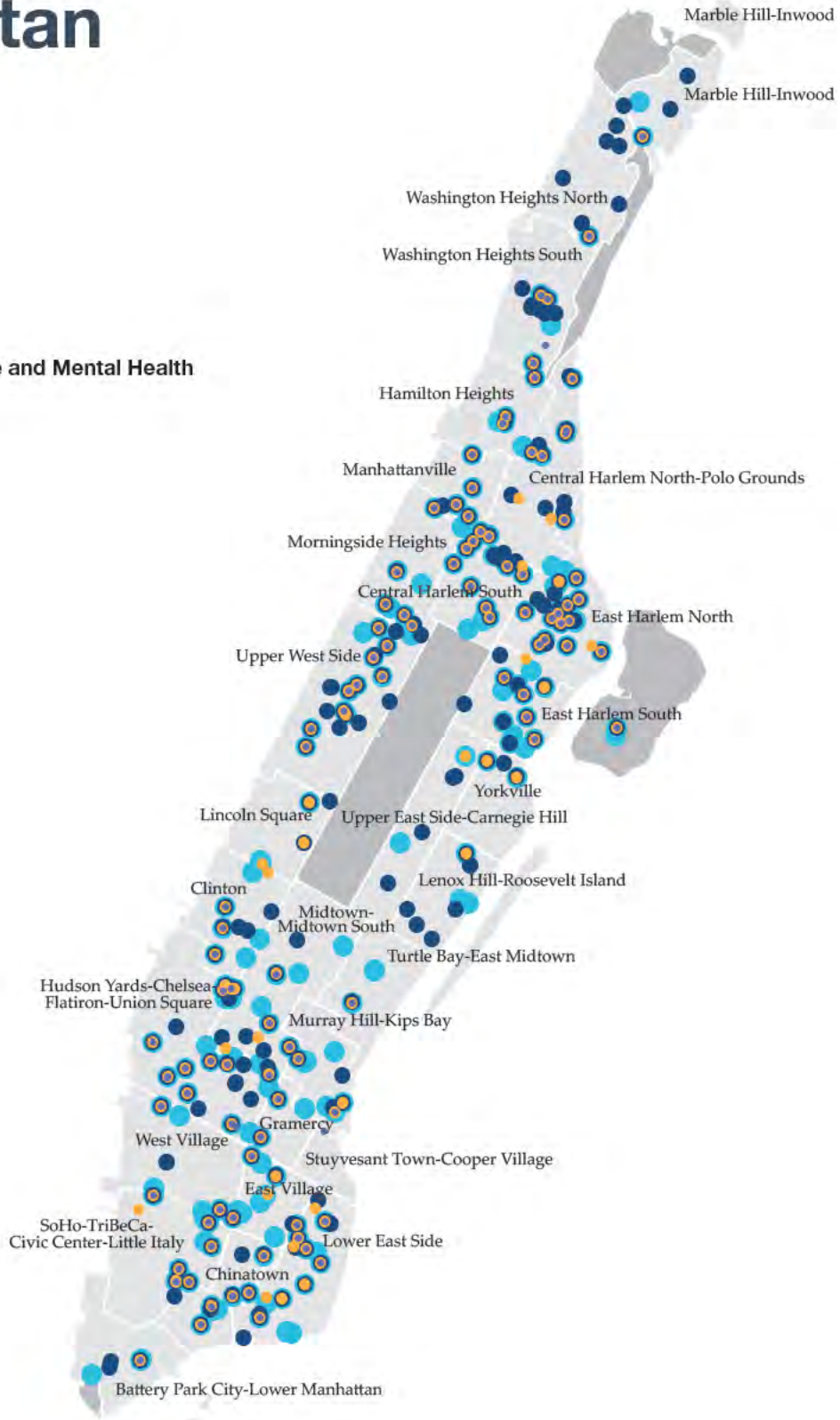


Queens

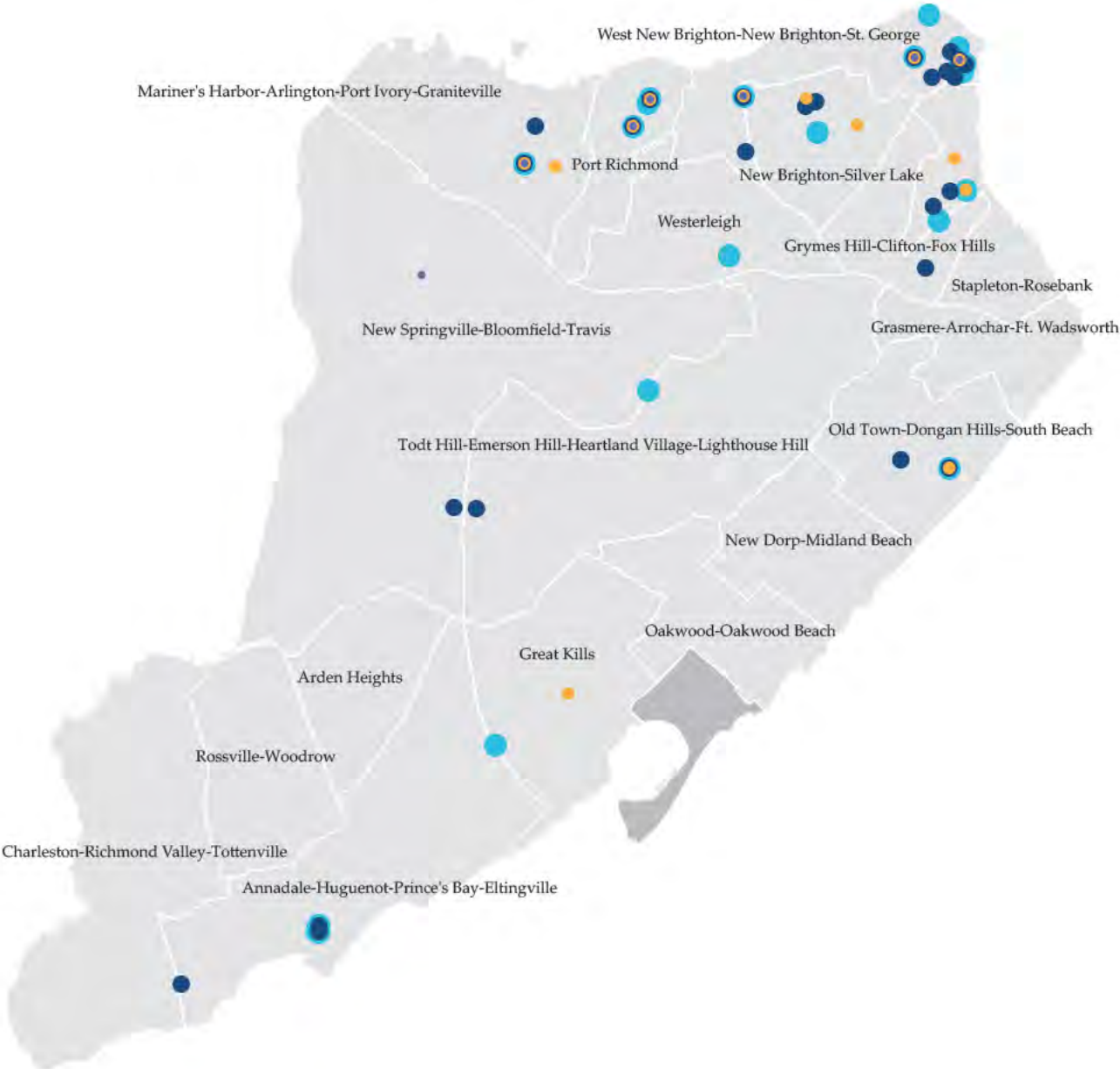


Manhattan

- Substance Use
- Mental Health
- Mix of Substance Use and Mental Health
- General Health



Staten Island



Do You Need Help?



Information on Common Mental Health Issues



Help for Young People



Trauma in Young Children

When children are repeatedly exposed to stressful events, it can have a big impact on their ability to manage emotions in a healthy way.

Luckily, a soothing and sensitive caregiver who knows how to set limits with love can make a huge difference in the life of a traumatized child.

Be alert to possible signs of trauma in your young child:

- Difficulty sleeping, eating, or toileting
- Frequent and severe tantrums
- Delay in achieving milestones
- Difficulty with transitions

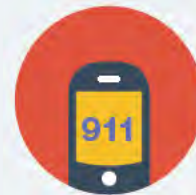
What can contribute to trauma?

- Has your home life changed in any significant way? This could include moving, new people in the home, or people leaving the home.
- Are there behavior problems with the child at home, school, or in the neighborhood?
- Has anything sad, bad, or scary happened to the child recently, or to you?

It's okay to ask for help!

- You can always talk to your pediatrician about your child's behavior or any changes in your life.
- Get help for yourself! You are the most important person in your child's life.

You can also find help by calling 1-800 LifeNet. It is a free, confidential helpline, available 24/7. For English call 1-800-543-3638, Spanish: 1-877-298-3373, Chinese: 1-877-990-8585, TTY: 1-212-982-5284. Ask for a Family Resource Center near you.



If you are in immediate danger of harming yourself or someone else, call 911.

Teens and Depression

According to a 2013 survey, 27% of New York City public high school students reported feeling sad or hopeless almost every day for two or more weeks. And yet only 18% of these students received help from a counselor.

Everyone feels sad, irritable, or down sometimes. But if these feelings go on for a few weeks and you're having a hard time dealing with them, you may suffer from depression.

You may be depressed if you:

- Feel sad, irritable, or angry most of the time
- Feel hopeless or helpless
- Feel like nothing is fun anymore and don't enjoy things you used to
- Have trouble concentrating, making decisions, or thinking clearly
- Have no energy
- Feel worthless or bad about yourself
- Have no appetite, or overeat
- Avoid friends or doing anything social
- Have trouble falling asleep, wake up during the night, or sleep longer than usual
- Have thoughts about ending your life

Consider talking to someone

There are treatments for depression that work. You might find it helpful to talk to a counselor or a doctor, who can help you decide if medication could help.

There are things you can try on your own

- Eat well
- Get moving
- Relax in some green space
- Keep a feelings journal
- Skip the drugs and alcohol

What to do when depressed?

If you think that you may be depressed, talk to your doctor or seek help from a mental health professional.

You can also find help by calling 1-800 LifeNet. It is a free, confidential helpline, available 24/7. For English call 1-800-543-3638, Spanish: 1-877-298-3373, Chinese: 1-877-990-8585, TTY: 1-212-982-5284.

If you are in immediate danger of harming yourself or someone else, call 911.

Help for Adults

Depression

Depression is more than just being sad from time to time. It is a potentially serious medical condition that can affect anyone.

It is important to understand that depression is treatable. People can recover with help from medication, talk therapy, lifestyle changes, and learning new coping skills. Unfortunately, many people who are depressed do not seek help because they feel ashamed and stigmatized.

How can you tell if you are depressed?

Many people with depression are not aware of their illness. That's why it is important to know the symptoms. You may be depressed if you:

- Feel persistently sad and tired
- Feel hopeless or worthless
- Lose interest in things you used to enjoy
- Have problems with sleeping and your appetite
- Have trouble concentrating, remembering, or making decisions
- Have thoughts of death or suicide

If you think you may be depressed, talk to your doctor or seek help from a mental health professional.

You can also find help by calling 1-800 LifeNet. It is a free, confidential helpline, available 24/7. For English call 1-800-543-3638, Spanish: 1-877-298-3373, Chinese: 1-877-990-8585, TTY: 1-212-982-5284.

Anxiety

It's normal to worry and feel anxious from time to time, especially when life is stressful. However, when anxiety becomes overwhelming and impacts your ability to function, it may be a sign of generalized anxiety disorder, or GAD.

Anyone can develop GAD. Seeking help is important because living with GAD can be very challenging. Luckily, GAD is treatable. Most people recover through a combination of medication, talk therapy, lifestyle changes, and learning new coping skills.

How can you tell if you have GAD?

The symptoms vary, but you may have GAD if you:

- Persistently experience worry that is out of proportion to its cause
- Feel irritable, restless, and on edge
- Find it hard to relax
- Struggle with concentration (your mind "goes blank"), remembering things, and making decisions
- Have problems with sleeping and eating
- Tire easily
- Sweat excessively
- Feel nauseous
- Experience headaches, muscle tension, and shaking
- Experience a pounding or racing heart
- Experience chest pain and tightness that feels like having a heart attack
- Experience choking sensations and shortness of breath
- Experience dizziness



If you are in immediate danger of harming yourself or someone else, call 911.

What to do when anxiety and worry become overwhelming?

It is important to seek professional help for GAD early on. Your symptoms are unlikely to go away on their own, and there's a good chance they will worsen over time.

If you think that you may suffer from GAD, talk to your doctor or seek help from a mental health professional.

You can also find help by calling 1-800 LifeNet. It is a free, confidential helpline, available 24/7. For English call 1-800-543-3638, Spanish: 1-877-298-3373, Chinese: 1-877-990-8585, TTY: 1-212-982-5284.



If you are in immediate danger of harming yourself or someone else, call 911.

Alcohol and Substance Use

Problematic alcohol and substance use is common. Among New Yorkers age 12 or older, 26% reported binge drinking in the past month, and 10% reported using illicit drugs, not including marijuana.

Substance use disorders can have many negative consequences, including physical or mental health problems and failing to meet responsibilities at work, school, or home. Changes to the brain associated with drug or alcohol dependence can make a person crave the substance, despite all of the damage it is causing.

It is important to understand that substance use disorders are treatable. People can recover with help from treatment, lifestyle changes, and learning new coping skills. Unfortunately, many people do not seek help because they feel ashamed and stigmatized.

Treatment options vary, and include counseling and the use of medications such as methadone or buprenorphine. Treatment works best when it is tailored to the individual and takes into account not only substance use, but also other social, emotional, and health issues. Like other chronic diseases, substance use can recur. Relapse is not a sign of personal failure but of the need to adjust treatment and provide additional support.

How can you tell if you need help?

- You need alcohol and/or drugs to feel well. This can indicate a substance use disorder.
- Friends and family tell you to cut down on your use
- You miss work or other commitments because of your alcohol and/or drug use
- You experience negative consequences such as the loss of a relationship, a job, or housing due to your alcohol and/or drug use

If you or a loved one's alcohol and/or substance use is becoming a problem, talk to a medical or behavioral health professional.

You can also find help by calling 1-800 LifeNet. It is a free, confidential helpline, available 24/7. For English call 1-800-543-3638, Spanish: 1-877-298-3373, Chinese: 1-877-990-8585, TTY: 1-212-982-5284.

Trauma and Mental Health

Most people will experience some form of traumatic event during their lifetime. This could be personal events such as abuse, the death of a loved one, job loss, or divorce. It could also include larger-scale events such as fire, neighborhood violence, natural disasters, or a terrorist attack.

For almost all of us, traumatic events tend to cause some degree of distress, fear, and anxiety. But with the support of family and friends, most people manage to effectively cope with trauma.

However, some people may develop mental health conditions as a result of their experience. The most common such conditions are post-traumatic stress disorder (PTSD), depression, generalized anxiety disorder (GAD), and substance use disorders. People who have experienced multiple traumatic events and those with existing mental health conditions are at higher risk.

It is important to understand that these conditions are treatable. People can recover with help from medication, talk therapy, lifestyle changes, and learning new coping skills. Unfortunately, many people who suffer from depression feel ashamed and stigmatized because of their condition, and as a result of it, do not seek help.

How can you tell if you need help?

If four weeks or more have passed since the traumatic events and you are experiencing any of the following conditions, you may need help:

- You are still reliving the event and having frequent nightmares
- You feel unable to perform basic daily activities
- You are unable to enjoy life the way you used to
- You still feel fearful and upset
- You continue to have intense, distressing feelings
- You try to cope in ways that cause additional problems, such as smoking or increased use of alcohol or drugs

What should I do when coping is difficult?

If you think you need help coping, talk to your doctor or seek help from a mental health professional.

You can also find help by calling 1-800 LifeNet. It is a free, confidential helpline, available 24/7. For English call 1-800-543-3638, Spanish: 1-877-298-3373, Chinese: 1-877-990-8585, TTY: 1-212-982-5284.



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From: Amy Le [REDACTED]
Sent: Thursday, November 26, 2015 4:20 PM
To: Schroeder, Rhonda
Subject: Re: Please send questions here custodyopcommission@cob.sccgov.org

Question:

1. Is the jail provide complaint information/process in Spanish and Vietnamese?
2. If an inmate/citizen does not speak English how can they file a complaint?

On Saturday, November 21, 2015 1:51 PM, "Schroeder, Rhonda" <Rhonda.Schroeder@cob.sccgov.org> wrote:

The appropriate email box is: custodyopcommission@cob.sccgov.org

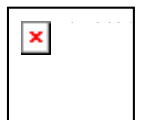
All correspondence should be sent to this email box and then will be distributed on a daily basis to the commission. Items are sent as a BCC to prevent possible Brown Act violations.


Please let me know if you have any questions,

Best regards,

Rhonda Schroeder
Division Manager, Board Operations
Office of the Clerk of the
Board of Supervisors
408-299-5067
408-938-4525 FAX

NOTICE: This email message and/or its attachments may contain information that is confidential or restricted. It is intended only for the individuals named as recipients in the message. If you are NOT an authorized recipient, you are prohibited from using, delivering, distributing, printing, copying, or disclosing the message or content to others and must delete the message from your computer. If you have received this message in error, please notify the sender by return email.



 **Just so you know, no trees were killed in sending this e-mail but many electrons and some silicon were inconvenienced in this process! Please help us save the trees and do not print this if avoidable.**

From: Gail Price [REDACTED]
Sent: Saturday, November 28, 2015 4:09 PM
To: CustodyOpCommission
Subject: Request for reports/information for Blue Ribbon Commission

Information request for Blue Ribbon Commission: I would like to request links to reports conducted by consultants or in-house staff regarding Custodial Operations in the last 10 years, including audits completed via contract to Harvey Rose.

We need to be familiar with the status of all of the recommendations in those reports.

Information request:

A complete list of "Use of Force" incidents and the status of the review and outcome of each incident for the last 10 years. How many of the inmates involved in these incidents had identified or likely mental health conditions or challenges?

Same request as directly above but related to a reporting of deaths in the jails and details about the circumstances of each death.

Questions:

Do the existing and pending RFPs include a comprehensive review of the availability, quality, and results of all programs and services for inmates, including behavioral health (substance abuse and mental health and inmates with dual diagnoses)?

How will the comments and issues brought forward by the public and the Jail Reform Coalition via the Human Relations Commission, the Behavioral Health Board and the Blue Ribbon Commission be addressed by staff and consultants? Timetable?

Thank you,
Gail Price
Blue Ribbon Commission on Improving Custody Operations

From: LaDoris Cordell <[REDACTED]>
Sent: Sunday, November 29, 2015 7:55 PM
To: CustodyOpCommission
Subject: URGENT request to the sheriff's department for the missing pages to the pdf re the internal affairs policy 1.19
Attachments: ladoris.vcf

the department's internal affairs policy, policy number 1.19 is missing five pages. there are 11 pages in this section, but the pdf emailed to the commission has only the odd numbered pages; please provide the entire document ASAP so that we can review the document before the commission's meeting on december 5th. thanks. --- judge cordell

From: LaDoris Cordell <[REDACTED]>
Sent: Sunday, November 29, 2015 8:04 PM
To: CustodyOpCommission
Subject: URGENT; request for complete inmate grievance policy
Attachments: ladoris.vcf

the inmate grievance policy emailed to us by the department is missing four pages. the pdf contains only the odd-numbered pages. the document has 8 pages; the pdf contains just 4. please email to the commission ASAP the entire document so that we can review it before our meeting on december 5th. thanks. --- judge cordell

From: Christine Clifford [REDACTED]
Sent: Monday, November 30, 2015 9:50 AM
To: CustodyOpCommission
Cc: Leon, David; Schroeder, Rhonda
Subject: documents sent missing pages?/ questions regarding grievance and IA processes

Hello,

Here are my initial questions and some from families of the incarcerated/DeBug/PACT

1. The copies I received of Document 1.19 on IA and Document 14.05 on Inmate Rights are missing all the even numbered pages. It is difficult to fully formulate questions without the entire document. Can you please re-send, or send the missing pages?

2. Document 1.19 on IA indicates it was last revised in 2009. Document 14.05 on inmate rights indicates it was last revised in 2008. General Order 14.00 regarding complaints by the public and General Order 14.01 regarding IA policy and procedures indicates they were last revised in 2010.

-When are these due for updates?

-Who determines the need and who revises policy and procedures?

-Is any input from the public or detainees included in making revisions?

3. Who is assigned to IA?

-What is their background, qualifications and training?

-How many are assigned and how is their work evaluated?

4. How is an allegation or situation determined to be "serious" vs. "non-serious", vs. "frivolous".

-Who makes that determination?

-Are there guidelines to determine this?

5. Who has access to IA documents.

-how long are they kept?

6. The 1.19 IA document appears to primarily involve grievances or allegations of excessive force, but also states investigation of "suspected breach of integrity or case of moral turpitude". Please give examples of what that might include.

7. Since detainees and the public are not privy to policies and procedures involving areas such as use of force, cell extraction, and classification, how do they determine if these policies and procedures have been violated?

-How do they file a grievance or challenge the outcome of a grievance if they are not aware if there has been a violation of their rights or of a policy or procedure?

8. The document states that IA will conduct investigations in a timely manner. What are the ranges of times involved in completing investigations?

9. Are detainees or members of the public who have filed grievances or complaints that have gone to IA made aware of the outcome of the investigation?

- If not, why?

10. What recourse do detainees or members of the public have if they do not agree with the outcome of an internal investigation?

11. Are any 3rd party impartial agencies or individuals involved in investigating allegations.

12. Under "Statistical Reports" in document 1.19 it states that the IA unit will provide the Chief of corrections with an annual report detailing the type and nature of complaints, disposition, and any clearly established patterns as to teams or facilities generating complaints.

- Can the Blue Ribbon Commission be supplied with those reports for the past 5 years?

- Since the administration no doubt takes actions on areas that are a concern, how frequently are patterns and data reported prior to this annual report?

- Does this data include all grievances or only those assigned to IA?

Regarding Inmates Rights/grievances:

13. What accommodations or assistance is given to the mentally ill, disabled, illiterate or non-English speaking population to file grievances or understand their right to file?

14. How is data kept regarding the number, nature, and disposition of grievances that are not referred to IA?

- Is this information made available to the facilities commanders on a regular basis to determine if there are patterns or areas of concern, or does it not go beyond the lowest level it where was deemed "resolved".

- How frequently is it reviewed by the Captains/facilities commanders?

15. Is there any process for evaluating which staff deals effectively and promptly with grievances vs. minimizing them/discouraging them?

16. Some inmates report a lack of response to request forms/grievances or never receiving an answer. Some report not being given receipts.

- What is the time line for inmate requests and grievances, and what is their recourse if they do not receive a reply?

17. How are Grievance Counselors assigned, trained and selected?

- What criteria do they use to decide if a grievance advances to the next stage or is resolved in the eyes of those filing?

18. Inmates report that when they file a grievance regarding a particular CO, they may have to face the CO during attempted resolution. This makes many feel intimidated or reluctant to file a grievance for fear of retaliation or further difficulties.

- What can be done to alter this practice and/or make inmates more comfortable with voicing concerns about treatment in the grievance process..

19. Who has access to inmate grievances?

- How long are they kept?

20. How can inmates determine if the filing of a grievance regarding their classification or contents of their file is valid?

- Families and inmates often report filing grievances regarding classification and lack of programming. They report receiving responses of "you are properly housed", "maintain appropriate behavior"

or “you will not be considered for down classing” with no further explanation. As was pointed out in the Grand Jury findings at Elmwood and in the recent suit brought by the Prison Law Office, inmates report being denied down classing despite having no infractions or disciplinary measures, and of being sent to more restrictive settings without explanation, warning or hearings.

- Since inmates are not allowed to see their classification files or be told what has been involved in deciding their classification and housing assignment, how can they determine if any information contained in their files is false, subjective or inaccurate?

-How can they challenge the content of their file or grieve it’s content if they are not allowed to know what’s in it?

21. If an inmate has filed a grievance regarding areas such as the lack of opportunity to down class and lack of programs, has grieved the response and filed appeals with no resulting change of status, what recourse do they have after having exhausted all their administrative options?

22. After exhausting all administrative options regarding programming and conditions of confinement, what recourse do inmates have regarding requests to improve the conditions of their confinement or increase programming options?

-Inmates and families report filing grievances regarding lack of programming or being contained in their cells for excessive periods of time, some for years while awaiting court processes.

-Programs are limited to many due to their classification and housing assignment. Access to equipment outdoors or activities inside are very limited and many inmates in MJN and MJS with access primarily to one program called “Road maps to Recovery”. This was also reported in Grand Jury findings to be the case for women at Elmwood who are in higher level security classifications.

- As per the recent suit from the Prison Law Office, too many detainees are confined to their cells in excess of 22 hours per day with no programs.

- How are grievances and concerns regarding lack of programming and hours confined to cells being addressed?

-Regarding families/friends of the incarcerated:

23. What measures are taken to insure that the public knows how to file complaints and grievances?

-Currently there is information posted for people going up in elevators for visits in MJN, with no way of copying it down since they are not allowed to take writing instruments to visits.

- It is not posted in MJS, where the worst living conditions exist.

- Is it posted at Elmwood?

- What can DOC do to provide easy, visible ways for the public to take information regarding how to file grievances or complaints in the facilities? (fliers or business sized cards in multiple languages at the visiting desks or in the visiting areas of all facilities? Posted on the DOC website regarding the jails)?

24. The Jail Observer Program, which takes calls from inmates and the public regarding jail concerns/grievances is currently funded for 14 hours a week. Given the importance of receiving and responding to concerns in a timely manner, how can this position be increased?

Thank you,
Christine Clifford
Silicon Valley DeBug
PACT
Family representative

On Nov 30, 2015, at 2:15 PM, CustodyOpCommission <CustodyOpCommission@cob.sccgov.org> wrote:

Who is the best person to respond to this request for information?

Rhonda
(408) 299-5067



From: Gail Price [REDACTED]
Sent: Saturday, November 28, 2015 4:09 PM
To: CustodyOpCommission <CustodyOpCommission@cob.sccgov.org>
Subject: Request for reports/information for Blue Ribbon Commission

Information request for Blue Ribbon Commission: I would like to request links to reports conducted by consultants or in-house staff regarding Custodial Operations in the last 10 years, including audits completed via contract to Harvey Rose.
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How will the comments and issues brought forward by the public and the Jail Reform Coalition via the Human Relations Commission, the Behavioral Health Board and the Blue Ribbon Commission be addressed by staff and consultants? Timetable?

Thank you,
Gail Price
Blue Ribbon Commission on Improving Custody Operations

From: CustodyOpCommission
Sent: Monday, November 30, 2015 11:06 AM
To: Martha Wapenski; CustodyOpCommission
Cc: John Hirokawa; LaDoris Cordell [REDACTED]
Subject: RE: Please send questions here custodyopcommission@cob.sccgov.org
Expires: Saturday, May 28, 2016 12:00 AM

It appears the Internal Affairs Policy and the Inmate Grievance Policy are both missing pages. Can you please forward the entire documents as I have several commissioners asking.

Thanks,

Rhonda
(408) 299-5067



From: Martha Wapenski [<mailto:Martha.Wapenski@sheriff.sccgov.org>]
Sent: Tuesday, November 24, 2015 3:25 PM
To: CustodyOpCommission <CustodyOpCommission@cob.sccgov.org>
Cc: Schroeder, Rhonda <Rhonda.Schroeder@cob.sccgov.org>; John Hirokawa <John.Hirokawa@sheriff.sccgov.org>
Subject: RE: Please send questions here custodyopcommission@cob.sccgov.org

Rhonda,
Attached are copies of the internal affairs, complaint process, and inmate grievance policies requested by Judge Cordell for the Blue Ribbon Commission.

Martha Wapenski
Director of Administrative Services
Office of the Sheriff
County of Santa Clara
55 West Younger Avenue
San Jose, CA 95110
(408) 808-4913

From: CustodyOpCommission [<mailto:CustodyOpCommission@cob.sccgov.org>]
Sent: Tuesday, November 24, 2015 3:00 PM
To: Martha Wapenski
Subject: FW: Please send questions here custodyopcommission@cob.sccgov.org

Do you have a copy of the DOC grievance procedures that we would be able to send to the Blue Ribbon Commission?

Rhonda
(408) 299-5067



From: Christine Clifford [REDACTED]
Sent: Tuesday, November 24, 2015 8:03 AM
To: Schroeder, Rhonda <Rhonda.Schroeder@cob.sccgov.org>
Subject: RE: Please send questions here custodyopcommission@cob.sccgov.org

Hello again Rhonda,
I'm afraid I missed something here along the way. Is there a specific site to check into for information and postings? I have only received a few from you and a few other people in your office. I believe we were supposed to receive a copy of the grievance procedures the DOC uses so we could send in questions to a site/Judge Cordell prior to the next meeting? It's difficult to formulate questions when you don't know the particulars of the written procedure. Can you let me know if there is a site I am supposed to be checking and/or when we might expect to receive these procedures?
Thank you,
Christine Clifford

From: Schroeder, Rhonda [<mailto:Rhonda.Schroeder@cob.sccgov.org>]
Sent: Saturday, November 21, 2015 1:51 PM
To: CustodyOpCommission <CustodyOpCommission@cob.sccgov.org>
Cc: Doyle, Megan <Megan.Doyle@cob.sccgov.org>
Subject: Please send questions here custodyopcommission@cob.sccgov.org

The appropriate email box is: custodyopcommission@cob.sccgov.org


All correspondence should be sent to this email box and then will be distributed on a daily basis to the commission. Items are sent as a BCC to prevent possible Brown Act violations.

Please let me know if you have any questions,

Best regards,

Rhonda Schroeder
Division Manager, Board Operations
Office of the Clerk of the
Board of Supervisors
408-299-5067
408-938-4525 FAX

NOTICE: This email message and/or its attachments may contain information that is confidential or restricted. It is intended only for the individuals named as recipients in the message. If you are NOT an authorized recipient, you are prohibited from using, delivering, distributing, printing, copying, or disclosing the message or content to others and must delete the message from your computer. If you have received this message in error, please notify the sender by return email.

 Just so you know, no trees were killed in sending this e-mail but many electrons and some silicon were inconvenienced in this process! Please help us save the trees and do not print this if avoidable.




From: Fletcher Dobbs <Fletcher.Dobbs@sheriff.sccgov.org>
Sent: Monday, November 30, 2015 11:45 AM
To: CustodyOpCommission
Cc: Martha Wapenski
Subject: Re-Send of DOC Policies
Attachments: 2015-11-24 - Policy on IM Grievances provided to COB for Blue Ribbon Commission.pdf; 2015-11-24 - Policy on Internal Affairs Unit provided to COB for blue Ribbon Commission.pdf

Hello,

PDF copies of the attached policies that were supplied earlier were inadvertently supplied with pages missing. The attached copies include the complete policies, including all pages. Please accept our apologies.

Fletcher Dobbs
Office of the Sheriff, Administration
County of Santa Clara
55 West Younger Ave, 4th Floor
San Jose, CA 95110
Office: 408-808-4912
fletcher.dobbs@sheriff.sccgov.org

COUNTY OF SANTA CLARA

| | |
|--|--|
| <p align="center">Department of Correction</p> <p align="center">Policy and Procedure Manual</p> | <p>Policy Number: 14.05 No. of Pages: 8 Date of Origin: 01 Aug 1994 Date of Revision: 13 Aug 2008</p> |
| <p>Chapter: Inmate Rights</p> | <p>Subject: Inmate Grievance Process</p> |
| <p>Supersedes: Policy 14.05, Inmate Grievances, dated 07/24/06.</p> | <p>Distribution: Unrestricted</p> |
| <p>References: ACA 3C-22, 3E-01, 3E-11, 5D-06, California Code of Regulations, Title 15, Chapter 1, Article 8, Section 3084.4, and Subchapter 4, Article 6, Section 1073, 42 U.S.C. Section 1997e</p> | |
| <p align="center">Signature of Issuing Authority</p>  <p align="center">Edward C. Flores, Chief of Correction</p> | <p align="center">Current Policy Review</p> <p>Date of Review: 13 Aug 2008 Revisions Made: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> |

POLICY: It is the policy of the Department of Correction to provide a viable complaint process to all inmates, which will allow systematic redress of conditions relating to confinement.

PURPOSE: To describe the inmate grievance and appeal process as prescribed under Title 15 of the California Code of Regulations. To encourage internal problem-solving at the level of most direct inmate contact, offer Division Administrators a means for continuous review of administrative policy and procedure, and provide written documentation of inmate complaints.

DEFINITIONS: Inmate Grievance: An inmate complaint arising from circumstances or conditions relating to his or her confinement.

Inmate Grievance Form: A form that enables inmates to file grievances and complaints.

Grievance Control Number: A sequential number assigned to each grievance for tracking purposes.

Grievance Coordinator: An employee responsible for ensuring timely collection, tracking, distribution, and response to all inmate grievances received within or pertaining to his or her assigned Complex.

PROCEDURE:

I. Inmate Grievance Process

- A. The inmate grievance process provides inmates with a documented means of transmitting appeals and complaints, affords inmates due process and access to Administrative staff, and provides a method of monitoring possible problem areas.
- B. A grievance may be submitted any time within 15 days after a potentially grievable event has occurred; an inmate may file a formal written grievance.
- C. Released inmate who have a pending grievance, lose all standing with respect to any further internal administrative remedy of the matter under consideration.
- D. A carbonless Inmate Grievance form set will be made available to inmates upon request.
- E. The grievance process is explained to inmates during the orientation process and is further explained in the Inmate Rulebook, which is issued to each inmate and/or posted in the inmate housing areas.
 - 1. Inmates have the responsibility for knowing and abiding by the rules, procedures, and schedules of their assigned facility.
 - 2. Inmates also have the responsibility to be honest and truthful in presenting their grievances.
- F. Inmates may appeal and have resolved grievances relating to any conditions of confinement, including but not limited to:
 - 1. Medical care
 - 2. Classification actions
 - 3. Disciplinary actions
 - 4. Program participation
 - 5. Telephone, mail and visiting policy and procedures
 - 6. Food
 - 7. Clothing
 - 9. Bedding
- E. Inmates filing grievances relating to conditions of confinement are required to exhaust all available Administrative grievance/appeal procedures before applying to the courts.

- F. Resolution of a grievance is expected at the lowest appropriate staff level. Training on the effective use of the grievance process and how to resolve matters at the lowest possible staff level is provided to staff during their on-the-job core training. The employee on duty, the shift Sergeant/Supervisor, Lieutenant and the Division Commander or designee, in that order, reviews the written grievances.
- G. Inmate grievances will be issued a grievance control number for tracking purposes by the Grievance Coordinator.

II. Processing of Inmate Grievances by Staff

- A. Informal resolution between inmates and employees is strongly encouraged, both to provide immediate response to the inmate and to avoid overburdening the grievance process.
- B. If the employee cannot resolve the complaint or problem, and resolution cannot be accomplished through the available Sergeant/Supervisor, an Inmate Grievance Form shall be provided to the inmate. If the grievance pertains to a particular employee, the inmate may submit the grievance to another employee.
 - 1. Employees will not deny a grievance form to an inmate.
 - 2. Employees will not destroy or fail to process a completed grievance form.
 - 3. Employees will not discuss the specific content of a grievance filed by one inmate with another inmate or show an inmate's grievance to another inmate.
- C. Upon receipt of a grievance form, it is the employee's responsibility to review the complaint and attempt to handle the matter whenever possible. The employees will:
 - 1. Check the form for completeness (e.g. name, full booking number, and legible writing), sign and date the form, and return the pink copy (initial receipt) to the inmate.
 - 2. Contact the Sergeant/Supervisor immediately when a grievance is of an emergency nature and indicates a threat to the health or welfare of an inmate.
 - 3. Note directly on the form the result of any investigation completed and details of the actions taken to resolve the grievance.
 - 4. Forward all grievance forms to the Sergeant/Supervisor whether or not the grievance has been resolved. Only the PINK copy of the form should be

given to the inmate at this point in the grievance process. A Sergeant/Supervisor must review the grievance and a tracking number must be assigned prior to the inmate getting the final disposition copy.

- a. If the grievance is not resolved, the employee will mark the box "Refer to Level II" and forward the grievance to the Sergeant/Supervisor.
- b. If the grievance is resolved, the employee will document his or her response under "responding Officer's statement," mark the box "resolved" and forward the grievance to the Sergeant/Supervisor.

III. Processing of Inmate Grievances by Sergeants/Supervisors

- A. It is the responsibility of the Sergeant/Supervisor to review all grievances forwarded by employees and attempt to handle the matter whenever possible. Grievances can provide a Sergeant/Supervisor with an overview of what is occurring in the facility. Employees are required to forward all grievances to the Sergeant/Supervisor for processing. The Sergeant/Supervisor will:
 1. Review all grievances submitted for completeness and determine if the Employee's response or handling of the complaint was appropriate to the complaint.
 2. Determine if the grievance requires further response from Support Services staff, Medical/Mental Health staff, Programs staff, Administrative Booking staff or any other county agency/division.
 3. Sign and date the grievance form and note directly on the form the result of any investigation completed and/or details of the actions taken.
 - a. If the grievance is not resolved or if the grievance requires a response from other staff, the Sergeant/Supervisor will mark the box "Refer to Level III" and forward the grievance to the Grievance Coordinator.
 - b. If the grievance is resolved, the Sergeant/Supervisor will document his or her response under "Supervisor's action," mark the box "resolved" and forward the grievance to the Grievance Coordinator.
- B. The Sergeant/Supervisor shall forward all grievance forms to the Division's Grievance Coordinator for processing and tracking. The Grievance Coordinator, not the Sergeant/Supervisor, will handle forwarding inmate grievances that cross over the lines of custody staff responsibility. (Example: If the inmate complaint involves

a medical issue, the Grievance Coordinator will forward the grievance to the appropriate medical manager for response.)

IV. Processing of Inmate Grievances by the Grievance Coordinator

- A. It is the Grievance Coordinator's responsibility to collect, review and process all grievance forms for final disposition. Sergeants/Supervisors must forward all grievances to the Grievance Coordinator for processing and tracking. The Grievance Coordinator will:
 1. Issue a tracking number, from the Department's Jail Information System, to every grievance received. The automated numbering system will issue a number and calculate a due date based on the date the grievance was received. The Grievance Coordinator will log the following information into the computer tracking system:
 - a. Grievance date
 - b. Complaint category
 - c. Receiving employee's name, badge and team
 - d. Grievor employee's name if applicable
 2. Assess whether or not the grievance is ready for review by the Division Commander/designee or requires further response from the team lieutenant, Support Services staff, Medical/Mental Health staff, Programs staff, Administrative Booking staff or any other county agency/division and process as follows:
 - a. If the grievance is ready for review (e.g. marked "resolved") by the Division Commander/designee, forward the Original Grievance form to the Division Commander/designee for review, final disposition and signature. The Division Commander/designee can concur, modify, or reverse the decision.
 - b. If the grievance requires further response from other staff, make a copy of the Grievance form and forward the Original Grievance form to the appropriate staff for response. Once a response is received, forward the Original Grievance form to the Division Commander/designee for review, final disposition and signature.
 3. Track the Grievances until final disposition to ensure the inmate receives a final disposition within **30** days or as soon as possible. Under some limited circumstances, a grievance may require additional time to resolve. Such circumstances may include:

- a. The employee named in the grievance is not at work due to illness or vacation leave.
- b. The nature of the complaint is so serious or complex (e.g., allegations of staff misconduct) as to require additional time to investigate.
- c. The subject matter of the grievance requires a legal response from County Counsel.
- d. Any other circumstance as authorized by a Division Commander.

V. Grievance Appeals by Inmates

- A. If an inmate is not satisfied with the response indicated on the grievance, he or she may appeal the grievance.
- B. A letter should be written and directed to the appropriate Division Commander within **15** days stating that an appeal on the response of the grievance is requested.
- C. The Division Commander will review the grievance and the action taken in response to the grievance.
- D. The Division Commander will forward a written response to the inmate within a reasonable time. If the appeal is denied, the response will include the final decision and the rationale for that decision.

VI. Abuse of the Grievance Process

- A. Inmates will not incur administrative limitations on their ability to file grievances under the Department's grievance process unless they demonstrate a pattern of abuse of the process, as determined by the Division Commander.
 1. Actions that demonstrate an abuse of the grievance process include, but are not limited to, filing grievances that:
 - a. Are frivolous in nature or knowingly false.
 - b. Are repetitious or excessive (e.g. multiple grievances referencing a particular issue that has already been appropriately addressed).
 - c. Contain profanity, threats or abusive and demeaning language.

- d. Cannot be understood or are obscured by irrational language or excessive documentation not related to the subject matter of the grievance.
- B. The Division Commander may impose grievance sanctions on inmates who he or she has determined to be abusing the grievance process.
1. Imposed sanctions should be commensurate to the degree of the abuse. Sanctions may include, but are not limited to:
 - a. Suspension of an inmate's ability to file grievances for a stated period of time not to exceed six months.
 - b. Limitations on the number of grievances that an inmate may file for a stated period of time not to exceed six months.
 2. Whenever the Division Commander imposes sanctions, he or she will notify the inmate in writing, indicating the reasons for the sanctions and noting the conditions of the imposed restrictions, including any time periods associated with those restrictions.
 3. Grievances filed in conflict with the restrictions of imposed sanctions will be returned unprocessed and not be subject to the appeals process.
 4. Inmates with imposed sanctions will normally be allowed to file grievances of an emergency nature, as determined by the Division Commander, separate from the imposed conditions of the sanctions. However, abuses involving filing emergency grievances may lead to additional restrictions being imposed.

VII. Confidential Letters

- A. An inmate may elect to write a confidential letter directly to any Division Commander or the Chief of Correction. The address is posted in each housing unit and Inmate Rulebook.
- B. Letters addressed to the Chief of Correction will be read and forwarded to a Division Commander for investigation and response. The Chief's staff will prepare a letter to the inmate acknowledging receipt of the letter and notifying the inmate of who is responsible for the response.

- C. Letters addressed to a Division Commander will be opened, date stamped, and assigned a tracking control number by administrative staff. Administrative staff will then forward them to the Division Commander or designee to investigate and respond within **30** days or as soon as reasonably practicable if additional time is required to investigate.
 - 1. The Division Commander may delegate the investigative responsibility to staff and request a draft response letter.
 - 2. The official response letter to the inmate will be from the Division Commander or Assistant Division Commander.
 - 3. The inmate's letter, a copy of the response and all reports shall be retained in the Department of Correction Administration files and/or the Division Administration file.

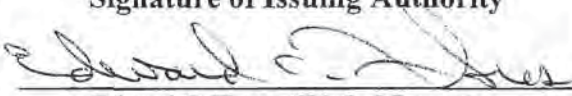
VIII. Audit and Statistical Analysis

- A. Inmate grievance statistics shall be maintained to provide Division Administrators the necessary information needed to manage the inmate population effectively and provide a method of monitoring potential problem areas for immediate attention.
- B. Inmate grievance statistics shall be maintained and tracked by:
 - 1. Housing Unit
 - 2. Race
 - 3. Nature of Complaint
 - 4. Team
 - 5. Date
 - 6. Other criteria as determined by the Division Commanders
- C. The Division Commander/designee shall review inmate grievance statistics at least once per quarter and generate a report based on his or her findings.

IX. Policy Revision

- A. All Department policies will be reviewed not less than once a year. The Professional Compliance and Audit Unit will establish an annual schedule identifying policies to be reviewed during a specific month.

COUNTY OF SANTA CLARA

| | |
|---|--|
| Department of Correction Policy and Procedure Manual | Policy Number: 1.19 No. of Pages: 11 Date of Origin: 01 Mar 1992 Date Revised: 22 May 2009 |
| Chapter: Administration, Organization and Management | Subject: Internal Affairs Unit |
| Supersedes: Policy 1.19 Internal Affairs Unit, rev. 12/18/2001 | Distribution: Unrestricted |
| References: California Government Code Sections 3300-3311 California Civil Procedure Section 128.5 California Penal Code Sections 118, 832.5, 832.7 & 832.8 Evidence Code Sections 1043, 1044 & 1045 Attorney General Opinion 05-903 | |
| Signature of Issuing Authority  Edward C. Flores, Chief of Correction | Current Policy Review Date of Review: 22 May 2009 Revisions Made: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |

POLICY: It is the policy of the Department of Correction to receive, record, and investigate all complaints alleging misconduct on the part of Department personnel.

PURPOSE: To establish Department policy and operational procedures for the investigation of all matters and complaints alleging misconduct on the part of Department personnel.

APPLICABILITY: This policy applies to all Department of Correction employees.

RESPONSIBILITY: It is the responsibility of all employees of the Department of Correction to adhere to this policy.

DEFINITIONS: Allegation: A claim or assertion of misconduct on the part of Department personnel. Allegations may be written or oral.

Complainant: The person making a complaint against Department personnel.

Complaint: An allegation that misconduct may have been committed by Department personnel.

Finding: The investigator's end work product of an investigation. The investigator arrives at a finding by applying the facts developed by the investigation to the allegation.

Formal Investigation: A full investigation which includes the preliminary inquiry, interviews of involved employees, statement of allegation, and a finding.

Internal Affairs Investigation (Administrative Investigation): The process used by the Department to determine whether the allegation in the complaint can or cannot be supported on a factual basis. This investigation can be a preliminary inquiry or a formal investigation.

Involved Employee: An employee who has been accused of misconduct or is the focus of the complaint.

Misconduct:

- Commission of a criminal offense.
- Violation of County or Department policies, rules, regulations, procedures or orders.
- Negligence in the performance of duty.
- Conduct which reflects unfavorably upon the Department, County, County service, or its personnel.

Non-Alleged Violation: A violation of rules, laws, policies or procedures which were discovered during the course of an investigation, but not listed in the statement of allegation. Non-alleged violations will also result in a finding by the investigator.

Personnel: All employees, sworn and non-sworn, under the control of the Chief of Correction, and any other person associated with the Department whose actions or conduct may discredit the Department.

Preliminary Inquiry: An initial fact-finding investigation which may include, but is not limited to, interviews of complainants or witnesses, review of reports, video tapes, and other pertinent records, documents, and files. Preliminary inquiries are documented on a closing report form and can only have a finding of “closed” or “frivolous.” A preliminary inquiry is different from a formal investigation in that a preliminary inquiry does not involve a statement of allegation or an interview of the involved employee.

Reporting Party: Persons advising the Department of the alleged misconduct, who may or may not be the complainant.

PROCEDURE:

I. Organization and Authority

- A. The Internal Affairs Unit will be responsible for assignment of I.A. case numbers. Allegations and complaints must be reviewed by the I.A.U. Commander or his/her designee, prior to the issuance of any I.A. case number.
- B. The Internal Affairs Unit will be responsible to, and report directly to, the Chief of Correction.
- C. The Internal Affairs Unit will be concerned with serious violations on the part of Department personnel, as determined by the Chief of Correction. Investigations of any crime in a Department of Correction facility will be the responsibility of the Sheriff's Office Jail Investigation Unit. In these cases, the Internal Affairs Unit may conduct a parallel administrative investigation.
- D. The Internal Affairs Unit will attempt to establish innocence or guilt by the preponderance of the evidence obtained. The Internal Affairs Unit has the responsibility and authority to conduct thorough and impartial investigations or directly assist other Divisions in the investigation of the following situations or circumstances, and to make appropriate reports:
 - 1. Any allegation or complaint of conduct made by any person against the Department or any of its personnel.
 - 2. Any alleged or suspected breach of integrity or case of moral turpitude.
 - 3. Any situation in which a person has been seriously injured or killed by any member of the department.
 - a. The criminal investigation will be the responsibility of the Sheriff's Office Jail Investigation Unit or sworn Sheriff's Office personnel assigned to the Department of Correction, unless the incident occurs in another police agency's jurisdiction.
 - b. The Internal Affairs Unit will be responsible for the administrative investigation.
- E. When, during a course of an Administrative Investigation, it becomes apparent that a criminal violation has occurred, the IAU Commander will be advised of the details and forward the complaint to the Sheriff's Office Jail Administration, or to the appropriate agency of jurisdiction.
- F. A concurrent investigation by both Sheriff's Office criminal investigators and Department of Correction administrative investigators may, upon occasion, be desirable. The criminal investigation will determine if there is a law violation, and

the administrative investigation will determine if there has been a violation of administrative policy and procedure.

1. The person assigned to conduct the criminal investigation cannot be the same person assigned to conduct the administrative investigation.
- G. Anytime an allegation of excessive or unnecessary use of force, an assault under the color of authority, an assault by any employee is alleged, or any complaint inferring a possible criminal violation by any employee, an IAU case number will be issued and the Sheriff's Office will be notified by the "Sheriff's Office Referral Form." The form will be completed by the on-duty Watch Commander, or his/her designee, and faxed to the Internal Affairs Unit and the Sheriff's Jail Administration. The original form will be filed with the IAU case file. The on-duty Sheriff's Sergeant will also be notified as soon as possible.
- H. The public will be encouraged to report matters of misconduct to the Department openly and with identification, or anonymously, if requested, by the complainant or reporting party.

II. Findings

- A. The standard of proof for findings indicates that at the conclusion of the investigation or inquiry, a preponderance of evidence exists resulting in one of the findings as listed below. Findings need not be proven beyond a reasonable doubt.
1. Unfounded: Where the investigation shows that the act or acts complained of did not occur or were misconstrued.
 2. Exonerated: Where the acts which provided the basis for the complaint occurred, but the investigation shows such acts justified, lawful or proper.
 3. Not Sustained: Where the investigation discloses insufficient facts to prove or disprove the allegations made in the complaint.
 4. Sustained: Where the investigation discloses sufficient facts to prove the allegations made in the complaint.
 5. Closed: Where insufficient information is developed during the preliminary inquiry to issue an allegation. The complainant failed to disclose promised information to further the investigation; or the investigation revealed that another agency was involved and the complaint or complainant has been referred to that agency; or the complainant wishes to withdraw the complaint; or the complainant is no longer available for clarification.
 6. Frivolous: Only used for preliminary investigations where the allegation is totally and completely without merit, or for the sole purpose of harassing an

opposing party. Frivolous findings will be supported by a detailed explanation.

III. Receiving Complaints at the Division Level

- A. During normal business hours, should a complaint be received by a division commander/unit manager and it is of such a minor nature that she/he can rectify the situation to the mutual satisfaction of both parties, no further action need be taken. The complainant will be advised of the disposition and informed that they may contact the Internal Affairs Unit directly if they have further concern.
- B. After normal business hours, all complaints will be referred to the watch commander at the involved facility.
 - 1. If the complaint is of such a serious nature that immediate action is required, the watch commander will, after receiving authorization from the division commander, advise the IAU commander to initiate an immediate investigation into the allegation.
 - 2. If the complaint is of a criminal nature, the watch commander will advise the on-duty Sheriff's Office personnel and complete a "Sheriff's Office Referral Form."
 - 3. If the complaint does not require immediate action, the watch commander will:
 - a. Record the complainant's name, address and telephone number and forward that information, along with a synopsis of the allegation, to the division commander for review.
 - b. Assign a supervisor to conduct a preliminary inquiry to determine additional facts which will be presented to the division commander.
 - 1) The watch commander will advise the reporting party that she/he will be contacted by an investigator on the next working day.
 - 2) The assigned investigator will, on the next working day, make contact with the reporting party and obtain a complete recorded statement. If the aggrieved person is not the reporting party, a recorded statement will be obtained from both parties. For persons not in custody, the taking and recording of the statement may be completed over the telephone.
 - c. If the complaint is of such a minor nature that the watch commander can rectify the situation to the mutual satisfaction of both parties, no

further action need be taken. The complainant will be advised of this disposition and informed that they may contact the Internal Affairs Unit directly if they have further concern.

- d. Complaints regarding Department procedures will be referred directly to the concerned facility.

IV. Receiving Complaints at the Internal Affairs Unit

- A. Complaints will be accepted in any form. They will be taken in person, by telephone, in writing, third party or from an anonymous complainant.
- B. Complaints and allegations will be handled with discretion and confidentiality. Internal Affairs personnel will demonstrate credibility and responsiveness while assuring citizens that their grievances will be taken seriously.
 1. Many complaints may be resolved at the time of initial contact simply by employing patience, understanding and empathy toward the complainant.
 2. If a complaint is deemed frivolous at the time of intake, the IAU investigator will document the complaint and the reason it was deemed frivolous and file the documentation in the "Closed at Intake/Frivolous Log Book".
- C. Upon receipt of a complaint, the Internal Affairs Unit will take the following action:
 1. Take the initial complaint.
 2. Prepare a "Complaint Worksheet".
 3. Confer with the IAU Commander, who will determine a course of action, and whether an I.A. case number will be assigned.
 4. IAU will conduct the investigation or refer the case to the respective division commander.
- D. The IAU Commander will review the "Complaint Worksheet" and take one of the following actions based on the seriousness of the allegation:
 1. Report the allegation to the Chief of Correction and/or the Assistant Chief of Correction for review and assignment.
 2. Report the allegation to the division commander/unit manager or assistant division commander of the involved facility/unit and request that a preliminary investigation be completed by the supervisor of the involved employee within ten calendar days. Copies of the "Complaint Worksheet" and the memorandum referring the complaint will be sent to the division

commander/unit manager or Assistant Division Commander on the date received.

3. The division commander/unit manager or assistant division commander of the involved personnel will be advised of the allegation in all cases, unless deemed confidential by the Chief of Correction.
4. In all cases, except where disclosure would adversely affect the investigation or identify a complainant who wishes to remain anonymous, once it has been determined a formal investigation is warranted, the involved personnel will be made aware of the investigation, that a complaint has been received and that they are the subject of an investigation. This will be accomplished by providing them with a statement of allegations setting forth the specific rules, policies or procedures violated, and listing a factual basis for the complaint. The involved personnel will be afforded the opportunity to prepare written reports, secure witnesses and gather any other information pertinent to the complaint.

V. Investigative Process

- A. The assigned investigator will contact the reporting party and complainant(s) and take a recorded statement.
- B. The assigned investigator will obtain a signed "Consent to Release Medical Information Form" from the complainant(s) if any injury is alleged, and obtain medical and/or mental health records concerning the incident.
- C. The assigned investigator will obtain a signed, "Informational Advisory Form." This form will be read verbatim to the complainant by the investigator taking the complaint (Penal Code Section 118).
- D. The assigned investigator will obtain copies of all records related to the incident, including, but not limited to, the following:
 1. Booking records
 2. Employee Reports
 3. Crime Reports
 4. Post Logs
 5. Activity Logs
 6. Staffing Reports
 7. Custody and housing records
- E. The assigned investigator will determine if any video/audio recordings were made and collect all video/audio tapes. If policy requires video taping and one was not done, attempt to determine the reasons why a video taping was not done.

- F. The assigned investigator will determine if there were any potential witnesses and report their identity. Include all names and booking numbers of inmates believed to be in the area of the incident.
- G. The assigned investigator will determine all facts known about the incident necessary to prepare a conclusion. The involved employee(s) should not be interviewed or required to complete any reports not requested at the time of the incident until a statement of allegation has been sent and a formal investigation has been assigned.
 - 1. If a formal investigation is assigned, it will consist of the following:
 - a. A complete search for, and review of, all materials, evidence, reports and recordings in accordance with the law;
 - b. Identification and interview of all witnesses. An audio recording of all interviews is preferred;
 - c. A "Statement of Allegation" and "Letter of Intent" to interview involved employees;
 - d. Formal, recorded Lybarger interview or voluntary responses from all involved officers with attachments of all known documents;
 - e. All other investigative steps necessary to prove or disprove the allegation.
- H. The investigation will have a completed investigative report detailing the information gathered during the formal investigation. Conclude the report with a detailed synopsis of the facts obtained which supports the investigator(s) findings.
- I. The completed investigation will be forwarded to the IAU Commander and then distributed to the appropriate division commanders for completion of the process.
- J. A completed investigation handled at the division level will be forwarded to the Internal Affairs Unit with a "Cover Sheet Form" signed by the division commander. After his/her review, the IAU Commanders will forward the investigation to the Assistant Chief for approval and further processing.

VI. Administrative Process

- A. The IAU Commander will forward the completed final investigation to the affected employee's division commander/unit manager, who may concur with the finding and recommend discipline, if appropriate. If the division commander/unit manager does not concur with the finding, she/he must document reasons for their conclusion.

1. The division commander/unit manager will forward the final investigation to the Assistant Chief, who will concur or not concur with the finding and recommended discipline. If the Assistant Chief does not concur with the finding, reasons for this conclusion will be so documented.
- B. Upon review by the division commander/unit manager, one of the following recommendations will be made:
1. Minor Violation: A violation in which the Department would not normally seek discipline.
 - a. The case will be returned to the supervisor, who will provide the employee with:
 - 1) Documented oral counseling
 - 2) Training, coaching, mentoring.
 2. Major Violation: A sustained violation in which the Department would normally seek disciplinary action up to, and including, termination.
- C. The Assistant Chief will forward the final investigation to the Chief of Correction, who will determine and approve the findings of the investigation.
1. This process is to be completed as part of the time requirement for completion of the final investigation.
- D. Upon the completion of the investigation, the Chief of Correction or designee will notify the complaining party of the investigation disposition per Penal Code Section 832.7.
1. The completed investigation will be returned to the Internal Affairs Unit and maintained in accordance with applicable law.
 2. The affected employee(s) will be notified by the Chief of Correction or designee of the final decision upon completion of the investigation.
 3. The affected employee's division commander/unit manager will be notified of the decision of the Chief of Correction.

VII. Investigation Timelines

- A. It will be the goal of this Department to complete administrative formal investigations in a timely manner and in accordance with California Government Code.
1. Every reasonable effort will be made to comply with the time limits indicated by the Public Safety Officers Procedural Bill of Rights Act or

applicable labor agreement. Essential to an investigative process is the prompt resolution to complaints or allegations.

2. Through the commitment of supervisors and managers, all investigations shall be completed in a timely manner not to exceed the time limits imposed by the law, labor agreements or the Public Safety Officers Procedural Bill of Rights Act.
 3. Per Government Code Section 3304(d), the agency must complete its investigation and notify the public safety officer of proposed disciplinary action within one year of the agency's discovery of the allegation of an act, omission, or other allegation of misconduct occurring on or after January 1, 1998, except in any of the circumstances listed below:
 - a. If the act, omission, or other allegation of misconduct is also the subject of a criminal investigation or criminal prosecution;
 - b. If the public safety officer waives the one year time period in writing;
 - c. If the investigation is a multi-jurisdictional investigation that requires a reasonable extension for coordination of the involved agencies;
 - d. If the investigation involves more than one employee and requires a reasonable extension;
 - e. If the investigation involves an employee who is incapacitated or otherwise unavailable;
 - f. If the investigation involves a matter in civil litigation where the public safety officer is named as a party defendant;
 - g. If the investigation involves a matter in criminal litigation where the involved employee is a criminal defendant;
 - h. If the investigation involves an allegation of worker's compensation fraud on the part of the public safety officer.
 - i. Or any other reason pertaining to the case, which falls under the special circumstances listed in section California Government Code Section 3304(d).
- B. Extensions of time must be justified, documented and approved by the Chief or Assistant Chief as designated.

VIII. Internal Affairs Unit Record Keeping

- A. The Internal Affairs Unit will be responsible for:
 - 1. A log of IAU case numbers
 - 2. Tracking investigations
 - 3. Completed cases and completion dates
 - 4. Findings
 - 5. Sheriff's Office Criminal Referral Log
 - 6. Frivolous Log
 - 7. IAU Preliminary Inquiry File

IX. Statistical Reports

- A. To assist in Department management, the Internal Affairs Unit will provide the Chief of Correction with an annual statistical report detailing the information listed below:
 - 1. Type and nature of complaints
 - 2. Disposition
 - 3. Any clearly established patterns as to teams or facilities generating complaints.

X. Policy Review

- A. All Department policies will be reviewed by the Professional Compliance and Audit Unit.

From: LaDoris Cordell <[REDACTED]>
Sent: Monday, November 30, 2015 3:43 PM
To: CustodyOpCommission
Subject: questions from Judge Cordell for BR Commission's study session re the complaint process
Attachments: ladoris.vcf

The following questions pertain only to those Department employees involved in the operation of the jails (and not to Department employees who are patrol officers). /Note: I may propose additional questions when the Commissioners are provided all of the pages to policies 1.19 and 14.05. /

1. What is the difference between a "grievance" and a "complaint"?

Please identify the source/rule/policy for your response.

a. Why were both terms listed on the use of force data for 2015, but not for prior years, when only "complaint" was listed?

b. Are there separate procedures for handling grievances and complaints? If so, what are they? Please provide documentation, if any, for these procedures.

2. Does the Department maintain (1) records of complaints from the public and (2) records of department-initiated complaints? If so, how and where are each maintained?

3. The following questions pertain to department-initiated (DII) complaints for those employees who work in the jails:

a. How many DII's complaints were received by the department in 2010, 2011, 2012, 2013, 2014 and 2015?

b. How were the allegations in those complaints classified in each of those years (force, courtesy, neglect of duty, etc.)?

c. How many DII complaints were investigated in any manner by Internal Affairs in each of those years?

d. How many DII complaints were closed without formal investigations by IA in each of those years?

e. Why were there no formal investigations and who made those decisions?

f. What were the findings for each of the DII allegations investigated by IA in each of those years?

g. Did any of the DII complaints concern alleged use of force on inmates? If so, how many complaints of this type were there for each of those years?

4. The following questions pertain to complaints from the public (including inmates):

a. How many public-generated complaints were received in 2010, 2011, 2012, 2013, 2014, and 2015?

b. How many of those complaints were filed by inmates in each of those years?

c. What were the classifications of allegations in those complaints in each of those years?

d. How many complaints were closed without formal investigations by IA in each of those years?

e. What were the findings for each of the allegations investigated by IA in each of those years?

f. How many of the complainant-inmates were classified as mentally ill?

g. How many of the non-inmate complainants were family members of mentally ill inmates?

5. When an inmate files a complaint the correctional deputy who is the subject of the complaint notified of the name of the inmate-complainant?

If so, when, how and why? If there is a written procedure for this notification, please provide it.

6. Have there been any instances in which inmates have complained of retaliation for complaining about correctional deputies? If so, how were the retaliation complaints handled and by whom?

7. Did any IA investigations into complaints from members of the public exceed one year (from the time the complaints were received)? If so, how many exceeded one year in each of the years 2010-2015?
8. Does Internal Affairs prepare annual written reports to the Sheriff about the complaints/grievances with respect to the operation of the jails? Do the reports contain information about DII's? Please provide all such reports for 2010 through 2015.
9. In what manner does Internal Affairs "report to the . . . community" pursuant to General Order #14.01, section A(3) (i)?
10. Please provide the Department's Duty Manual aka Patrol Operations Manual's definitions for the following classifications of misconduct allegations: use of force, courtesy, bias-based policing, neglect of duty, procedure, arrest/detention, search/seizure, and conduct unbecoming an officer.
11. What is the Department's use of force policy? Please provide a copy of this policy.
12. Is training provided to correctional deputies about the complaint process and/or the grievance process? If so, what is the training, who gives the training, and when is the training given?
13. Are all inmates informed about the complaint process? If so, how, by whom, and when?
14. Are inmates housed on the 8th floor, Unit A informed about the complaint process? If so, how, by whom and when?
15. Describe the process used to "informally resolve" an inmate grievance (pursuant to Policy 14.05, Section II. A)?
16. For each year (2010-2015), how many inmate grievances were informally resolved?
17. What are the qualifications of the Grievance Coordinator? Who selects her/him? For how long does the Grievance Coordinator serve?
18. How many confidential letters have been submitted by inmates pursuant to Policy 14.05, Section VII for each of the years from 2010-2015?
 - a. Who receives these letters?
 - b. Is there a follow-up procedure to ensure that all such letters have been addressed? If so, describe that process?
19. How does the Department define complaints "of a serious nature" in Policy 1.19, Section III (B) (1)? What criteria is used to make this determination?
20. How does the Department define complaints "of a minor nature" in Policy 1.19, Section III (A)? What criteria is used to make this determination?
21. In your opinion, could the Department benefit from independent civilian oversight of the complaint process? Why or why not?

From: Gail Price [REDACTED]
Sent: Monday, November 30, 2015 4:21 PM
To: CustodyOpCommission
Subject: Information for Blue Ribbon Commission - Information to share
Attachments: CSWJailReport2015.Final.pdf

Thought this report would be of interest to my Blue Ribbon Commission colleagues and the public.
Thank you,
Gail Price

S C C C O M M I S S I O N O N T H E S T A T U S O F W O M E N

REPORT BY WOMEN'S JAIL MONITORS

Female Inmates in Santa Clara County & the Need for a Gender Responsive Protocol



ABOUT CSW, DOC AND OWP

The Commission on the Status of Women (CSW) was established in 1973 and is the official advisory body to the Board of Supervisors on all issues relating to women and girls. As official jail monitors for female inmates, CSW commits all monitors to complete the OWP Monitoring Training, write summaries of observations, participate in annual monitoring review with OWP and DOC, and collaborate with OWP in the preparation of an Annual Report and presentation.

The Department of Correction (DOC) oversees the 5th largest jail system in California and is among the 20 largest systems in the United States. The DOC mission is to serve and protect the citizens of Santa Clara County and the State of California by detaining the people under its supervision in a safe and secure environment while providing for their humane care, custody, and control. To support the monitoring of female inmates the DOC commits to provide a DOC Liaison to OWP and CSW, to approve clearance for all monitors, facilitate observation tours, provide data to OWP and CSW, participate in the Annual Monitoring Review and provide feedback on the annual report and presentation.

The Office of Women's Policy (OWP) was developed in 1988 in the spirit of collaboration between County and the community and is a leading voice in Silicon Valley on the needs of women and girls, serving as a catalyst for awareness and action on current and emerging issues that impact women's health, safety, and security. Through analysis, research, and strategic collaboration, OWP works to ensure that programs, services, systems, and policy support women's leadership, full equality and advancement in the home, at work, and in the community. As partners to ensure successful monitoring of female inmates, OWP commits to providing training for all monitors, facilitates security clearance for monitors, maintains a database of all monitoring, hosts annual monitoring reviews, and prepares the final and report and presentation with CSW.

2015 Commission on the Status of Women

Guadalupe Rodriguez, Chair
Chandra Lopez Brooks, Vice Chair
Michelle Osorio, Treasurer

Commissioners:

| | |
|------------------|------------------------|
| Einat Bauman | Shanta Franco-Clausen |
| Jennifer Briscoe | Maria Garcia |
| Marian Brown | Naomi Nakano-Matsumoto |
| Suzanne Doty | Christina Ramos |
| Gladys Eng | Yan Zhao |
| Yvette Farias | |

2015 Women's Jail Monitors

Maria Garcia, Committee Chair

Monitors:

| | |
|----------------------|------------------------|
| Marian Brown | Sarah Lucha |
| Suzanne Doty | Naomi Nakano-Matsumoto |
| Karina Dominguez | Christina Ramos |
| Yvette Farias | Guadalupe Rodriguez |
| Chandra Lopez Brooks | |

Additional Women's Jail Monitors, 2013 - 2014:

| | |
|-----------------|---------------------|
| Breanna Gilbert | Victoria Ramirez |
| Ann Grabowski | Lynda Ramirez Jones |
| Nicole Johnson | Dorothy Thomas |
| Marisela Nuñez | Shirlee Victorio |

Women's Jail Monitor Staff

Carla Collins, OWP, 2013 – Present
Esther Peralez-Dieckmann, OWP, 2013 – Present

Women's Jail Monitor Staff

Lt. Adrienne Etheridge, DOC, July 2015 – Current
Lt. Kris Pantiga, DOC, 2014 – May 2015
Lt. Janet Fischer, DOC, 2013

TABLE OF CONTENTS

| | |
|--|-----------|
| INTRODUCTION | 4 |
| Background: Gender Matters | 6 |
| Who Are the Women at Elmwood? A Demographics Snapshot | |
| Table A | |
| Table B | |
| Programming | 7 |
| Table C | |
| Issues of Equity: Programming | |
| Table D | |
| Table E | 8 |
| Issues of Equity: Classification & Programming | 9 |
| Issues of Equity: An Aging Facility | |
| Monitoring Components: Interaction with Staff | 10 |
| Monitoring Components: Interaction with Women who are Incarcerated | 11 |
| Monitoring Components: Observations | |
| Monitoring Components: Focus Groups | |
| Housing | |
| Recovery | |
| Access to Services/Programs | |
| Health | |
| Addressing the Need for a Gender-Responsive Re-Entry Center | 12 |
| Addressing the Need for a Gender Responsive Facility | |
| Trauma-Informed Training | |
| Vicarious Trauma Training | |
| Gender-Responsive Training | |
| Gender Specific Training | |
| Classification System Validated by Gender | 13 |
| Programming | |
| High Risk Population Programming | |
| CLOSING | 14 |
| Jail Monitor Recommendations | |
| Additional Questions | |
| RESOURCES | 15 |

“In the last 25 years, the number of women and girls caught in the criminal justice system has skyrocketed; many have been swept up in the “war on drugs” and subject to increasingly punitive sentencing policies for non-violent offenders. There are now more than 200,000 women behind bars and more than one million on probation and parole. Many of these women struggle with substance abuse, mental illness, and histories of physical and sexual abuse. Few get the services they need. The toll on women, girls, and their families is devastating.”

*- American Civil Liberties Union,
Women & the Criminal Justice System*

The following report summarizes the efforts to date and findings of the Jail Monitors. The MOU that established monitoring was designed with the intent to document the needs of female inmates by using a gender-responsive lens. While other monitoring efforts exist they are often complaint-based or fail in other ways to recognize all the pieces that must come together to successfully operate the 5th largest county jail system in California. Monitoring for female inmates is also not about individuals (good or bad) but allows for a deeper understanding of the systems, policies and practices. It is based on a collaborative effort to support good governance and the efficient use of public funds. Further, it is structured to support gender-responsive, trauma-informed, recovery-oriented systems analysis.

The National Institute of Corrections affirms that strategies guided by gender-responsive, culturally competent, trauma-informed and recovery-minded programs, environments, and staff training are the best practices for treating and working with female inmates. Research shows that when implemented, these gender-responsive strategies will not only improve working conditions for staff and living conditions for inmates, but they will also increase the likelihood that women will successfully re-enter their community.

In 2005, the Board of Supervisors approved funding for the first gender analysis of a county jail anywhere in the country. The award winning initiative and the 2008 final report titled “Breaking Cycles, Rebuilding Lives” provided key recommendations to the Supervisors for improving programs and services for female offenders, including information about their re-entry needs. While some changes initially occurred, there has been limited progress on implementing key recommendations.

Two major policy changes occurred since the release of the initial report that impacted the momentum for a focus on women at Elmwood. In 2011 oversight of the jail facility was returned to the Office of the Sheriff and a significant amount of transition time was required for this major shift. Additionally in 2011, Governor Edmund G. Brown Jr. signed Assembly Bill (AB) 109 and AB 117—historic legislation to help reduce the numbers of low-level inmates cycling in and out of state prisons. A considerable amount of planning, funding and staffing has been allocated for the implementation of these efforts.

Since this time, the Office of Women’s Policy and the Commission on the Status of Women have continued to develop and implement initiatives to help address the

women's in-custody and re-entry needs. This includes several in-custody programs and services: including support groups; GED materials; a nursing chair privacy screen, breast pumps and other supplies for nursing inmates, a television with videos and materials for higher security level women to access programs; the children's book recording project; on-going meditation classes and funding for an environmental chaplain to teach sustainable gardening and meditation for both the men and women. In FY 2012, the Office of Women's Policy implemented the "Skills to Succeed" Pilot program which was a \$400,000 workforce initiative that placed 57 women in non-traditional jobs, full and part-time employment, and enrollment in community college. This effort confirmed that when given access to vocational programs and job training, women are interested and will successfully pursue careers in non-traditional sectors. Further, despite positive feedback and outcomes, these pilots have been limited one-time efforts.

In 2012, concerned about the overall lack of focus and the minimal progress to address and improve programs, services and conditions for women offenders at Elmwood, the Commission on the Status of Women began discussion with the Department of Correction to revisit the original recommendations from the "Breaking Cycles" report. In 2013, the Department of Correction, Commission on the Status of Women and the Office of Women's Policy established an MOU for what is believed to be the first County Jail Monitoring Program in California for a Women's Facility in order to maintain a consistent focus on the needs of female offenders and for the development of an annual report on the progress being made. The Office of Women's Policy provides the initial training for jail monitors and coordinates this effort which to date has trained 18 Commissioners and community volunteers to conduct "observation tours," focus groups and interviews with staff and female inmates.

Through this work the Jail Monitors have achieved greater understanding of the issues experienced by and impacting women at the Elmwood facility. Subsequently, the Jail Monitors have formulated solutions that can help alleviate the needs and support the rehabilitation of incarcerated women as they prepare to reenter their communities, and for a majority of them, reunify with their children.

Guiding by an overarching goal to adopt a system-wide gender-responsive protocol, Jail Monitors envision an environment that fuels cultural competence and respect between inmates and staff, increases safety, and enhances successful re-entry into the community.

Recommendations based on the first analysis of monitoring include implementation of the following:

1. Explore the feasibility of staffing the women's section as an autonomous facility
2. Develop and implement a department-wide gender-responsive protocol
3. Gender-responsive training for all staff beginning at the Academy level
4. Gender-responsive, trauma-informed, recovery-oriented, culturally appropriate programming and services for inmates
5. Implement a classification system validated by gender
6. Ensure that all inmates leave the facility with an exit plan that includes preparation and orientation about support programs for re-entry

The most urgent recommendation is that the DOC considers reorganizing the Women's facility at Elmwood to allow it to operate as its own entity focused on creating gender-specific structures, protocols and programs for women inmates. It is worth noting that although the MOU was signed in September of 2013, it wasn't until a female lieutenant was assigned to the women's facility with greater scope of authority in January of 2014 that monitors began to make headway with the Jail Monitoring Program. The role of the lieutenant must be strengthened and given increased authority over correctional staff in order to implement changes that will improve conditions and outcomes for women at Elmwood.

The following highlights the efforts to date and summarizes the findings of the Jail Monitors.

Background: Gender Matters

An enduring question remains that should be central to all planning and programming for correctional systems: "How will this decision impact women?" It is an often overlooked question but one that should be applied to virtually every aspect of incarceration: from booking, to classification, to programming and finally, to exit planning. This question must be applied to even the most basic details, from uniform design to the number of feminine hygiene products offered to women. The information in this first annual report which includes the input of the women themselves, highlights the importance of this question to the effective management of the correctional and rehabilitative systems.

Who are the Women at Elmwood?

A Demographics Snapshot

A snapshot of Elmwood women's population affirms gender-responsive theory that says that women's paths to criminality are different from men's, that women are relational, and that much of women's incarceration is largely a result of the criminalization of addiction and untreated complex trauma. While AB109 has affected the population, the women at Elmwood still reflect a low-

level, non-violent profile. The average length of stay has increased from 110 to 150 days and monitors are more likely to meet women with sentences measured in years, not months. Regardless of their charges, many of these women have histories of domestic violence and childhood abuse. Many are mothers and most mothers are the custodial parent.

*"I miss my kids. I just really miss them."
- Inmate to Monitor*

The daily census for female inmates through the years has fluctuated but in general has remained between 500 and 600 inmates. Between 2007 and 2010, the female population decreased by 15%, but the number of female inmates is on the rise again and last stood at 531 inmates in 2013. As the DOC has stated repeatedly and the latest Jail Needs Assessment notes, the facilities at Elmwood are not large enough to adequately accommodate the increased numbers of offenders, including the women.

The ethnic breakdown of inmates through the years has remained similar in that the numbers of Hispanic and Caucasian inmates have been the most prevalent numbers. As demonstrated in Table B, the population numbers in terms of race and ethnic background reflect that Hispanic and African American inmates are disproportionately represented as compared to the proportion of these groups in the Santa Clara County population.

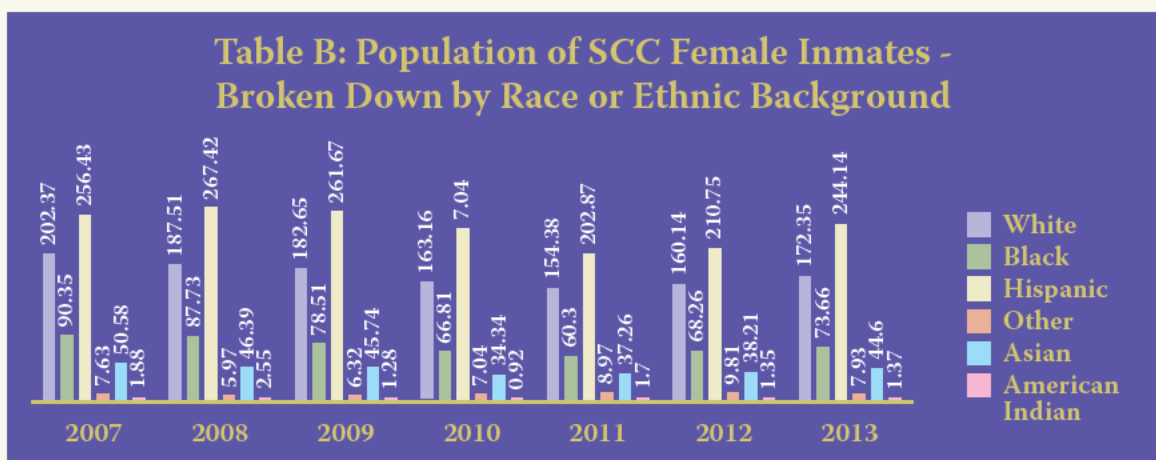
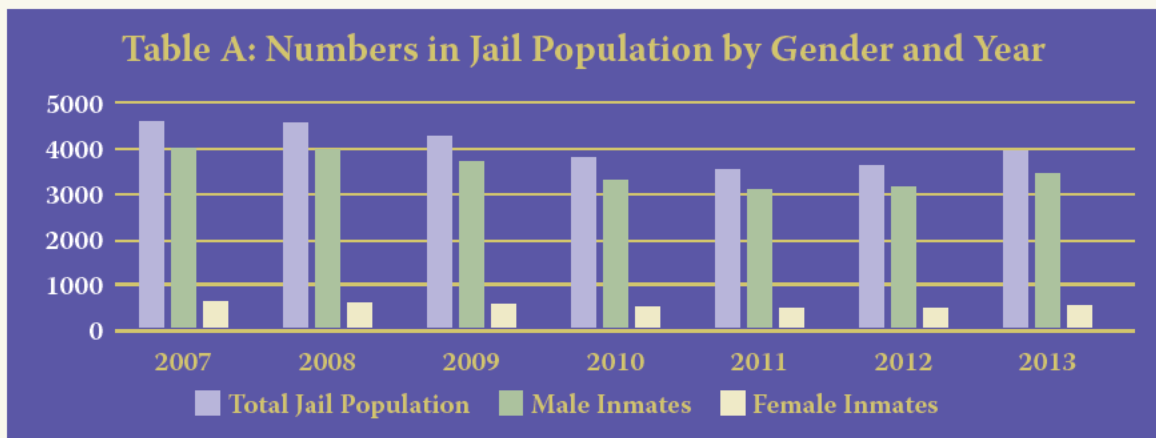


Table C illustrates that most inmates have been between the ages of 25-34, followed by women between the ages of 35-44. This drives home the finding from the “Breaking Cycles” report that female inmates are more likely to be custodial parents and the impact to the whole family is both profound and different when a mother is incarcerated. Effective programming that addresses the relational needs and realities of women should include family reunification best practices.

Another troubling trend in the age distribution of inmates is that there have been increases in the population of inmates who are 55 and older. This may have something to do with the influx of AB 109 inmates, but may also suggest that there may be conditions that are increasing the number of older women in the community who are being incarcerated. Addressing the needs of our aging population demands further study.

Programming

“I have gone through the same Re-Entry Correction Program curriculum three times, even though I am not learning new information, it is better than sleeping all day.”
- Inmate to Monitor at Monthly Monitor Visit

DOC provided all programming data reviewed by monitors. Overall, for both genders, the majority of the inmate population are not receiving any kind of programming. Only a stark

19% of all inmates are participating in programs. According to Table D, out of the total population of inmates, of both genders who are participating in programs, females are sorely underrepresented at only 13%. However, 2014 data provided by DOC Programming indicates a 6% increase with 19% of women participating in programs.

“I had forgotten about the beauty. About the goodness of people. Tonight I felt the beauty. Thank you, thank you for coming and sharing this (program) with us.”
- Inmate Participant in Meditation Pilot at Elmwood, June 2014

Issues of Equity: Programming

As a percentage of the total female population at Elmwood, female inmates receiving programming in 2013 were less than 20%, and this percentage has varied only slightly since 2007 as seen in Table E. One might expect that with the realignment funding from AB 109 there might be an increase in the proportion of inmates who are receiving programming, but the numbers actually show the opposite. The percentage of female inmates who are in programs has decreased since 2007.

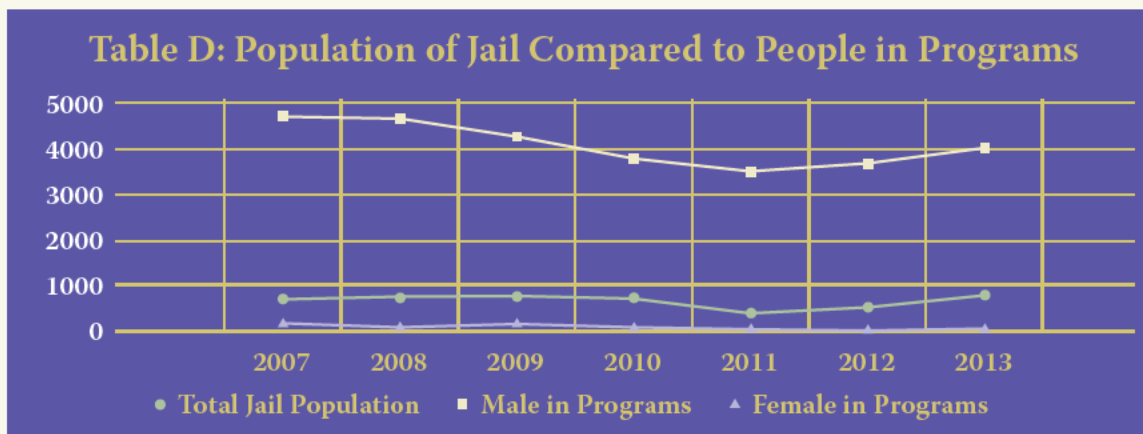
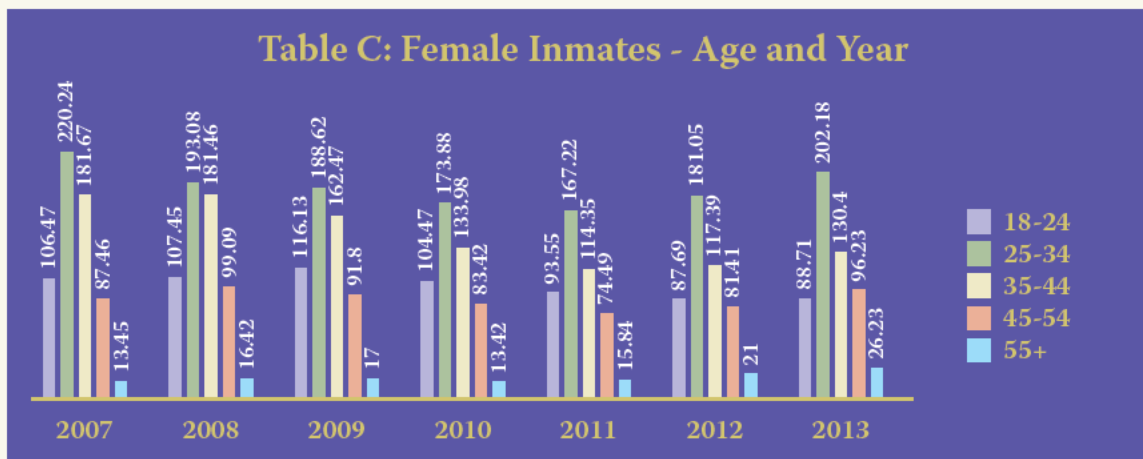
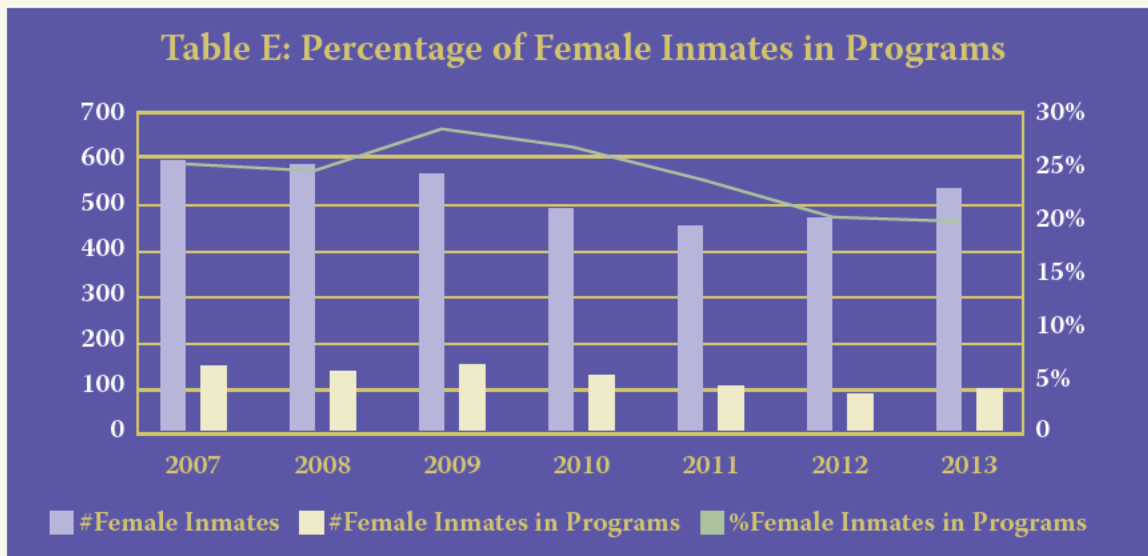


Table E: Percentage of Female Inmates in Programs



Through an examination of women’s programs, there is often confusion between the notion that women are receiving “equal” access to programs and services versus giving women “equitable” programs and services. It is true that both men and women at Elmwood have access to programs but through our observation, what is offered to men is typically both higher in quantity and quality. One example of this comes out of the highly regarded Sustainability Program at Elmwood. Men and women have equal access to the program but monitors observed the outcome brought significant improvements on the men’s side to “Candlestick” which included an improved sports field, refurbished exercise equipment and landscaping. The women’s side received landscaping improvements and a new flower bed around the “Flag Pole.” This program is a good example of the importance of innovative collaboration but must go one step further to ensure that women have equal benefit in addition to equal access. Some of this could be addressed in FY16 with the development of the women’s “Healing Garden” which will include a labyrinth and meditation area to further support the success of the ongoing medication classes, too.

Other examples of this inequity are evident in vocational programming which for the men includes such offerings as automotive repairs and wood and metal work, while the vocational program frequently highlighted for the women is the Embroidery Program which includes digital screening, sewing machines and the development of business plans.

It should be expected that any programs allowing the women to leave their confined sleeping quarters will be well-received. However, more attention should be placed on whether programs meet the specific needs of women, especially vocational programs that can put women on a path to better paying jobs and economic security after release.

*“I have done their classes. TWICE.
I need something different.”*

“Ni siquiera hay nada para leer en español. Nada. Si pudiéramos tener incluso algunos libros, algo que leer para pasar algo de tiempo...”
 (“There’s not even anything to read in Spanish. Nothing. If we could have even some books, something to read to pass some time...”)
 -Inmates to Monitors
 during Monthly Monitor Visits

Table E demonstrates similar trends regarding female inmates’ underrepresentation with less than 20% receiving programming in 2013. What is surprising, however, is that despite 2011 realignment funding from AB109, the percentage of women receiving programming from 2011 to 2013 decreased slightly.

According to data provided by DOC Programming, in Fiscal Year (FY) 2014, Elmwood offered a total of 29 programs, of which 27 were available to men, 12 to women, and 10 overlapped for both groups, of that, a total of 802 were served in programs.

While conversing with the women at Elmwood and through an assessment of the current program offerings, monitors learned that the majority of programs offered to the women do not address their specific needs. Travis (1998) notes the distinct differences for female offenders, including victimization from sexual and physical abuse, primary responsibility for children, and women offenders are more likely than men to have become addicted to drugs, have mental illnesses, and unemployment prior to incarceration. Programming must shift from a one-size fits all model to establish a criteria for services that take into account women’s current needs and life circumstances.

Issues of Equity: Classification & Programming

The women at Elmwood are divided into different security levels, ranging from minimum, medium, to maximum security and Protective Custody. Program accessibility ranges and is based on the security level the Classification Department assigns to each inmate. Their classification system has never been validated by gender and is a complex analysis including two key factors: the crime committed and behavior while at Elmwood. Much analysis shows that programming has better recidivism outcomes when applied to higher risk and higher security inmates yet minimum security women have more accessibility to programs compared to medium security women. Maximum security women are allowed only one (1) hour of recreational time every other day and it is common for the women to refer to this time as “programming”. Monitors learned that “programming” does not necessarily mean to engage in an actual rehabilitation program; rather, it can mean a variety of activities allowed to an inmate such as a shower, a phone call, or spending time out of her jail cell.

Protective Custody women have access to two programs: Roadmap to Recovery, a self-led journaling program and occasional classes offered by the Chaplain. One highly regarded program is the PACT program, which includes an extended contact visit between parent and child. Unfortunately, PACT is not available to women in Protective Custody. This was interesting to learn, especially since research shows that approximately 78% of incarcerated women are the primary custodial parent.

A recurring theme heard from the women at Elmwood was the need for programs specifically tailored to their needs. Just as important was the need to provide programs that are aligned to their sentencing. During one visit monitors spoke with a woman in minimum security who was serving a two-year sentence and preparing to reunify with her daughter. She indicated that she had gone through the same Re-Entry Correction Program three times. Rather than spend her time watching TV or sleeping, she opted to go through the same program multiple times.

Aside from a lack of programs that are conducive to their needs, many women explained that they also do not have a clear exit plan once they are released from jail. This is a critical area that must be addressed. For example, it is especially important that a victim of domestic violence receive a proper exit plan, including safety planning and clear steps to move to greater self-sufficiency. Without this, women may have little choice but to return to an abusive situation. Effective support can better ensure the wellbeing of the inmate, her family, and of the community as a whole.

As the pilot efforts for programs led by OWP and CSW have demonstrated, providing programs and services with a gender-responsive framework provides the foundation for a new model that takes into account the realities of women, creating programs that do support their realities and better prepare women for life on the outside.

According to the 2012 Recidivism Study of the Santa Clara County Department of Corrections by Husky & Associates, there is a sense of urgency for the County to invest in inmate programs that reduce recidivism to make the community a safer place to live and work. The report further highlights that individuals who participated in treatment were significantly less likely to be rearrested or reconvicted at 6, 12, and 24 months compared to similar individuals who did not participate in treatment. Therefore, as the investment in programs is developed and implemented it is imperative that a gender-responsive framework is used.

“I want to get my GED but we cannot in here (protective custody). We do not have NA or AA or anything. I have been here for 2 years already. I should be taking college classes and I cannot even get my GED.”

*-Inmates to Monitors
during Monthly Monitor Visits*

Issues of Equity: An Aging Facility

The women’s facility was established in 1964 and during observation tours the monitors take into account the state of the facility, ensuring that it is clean and well maintained. For the most part, the facility is kept fairly clean. There have been instances where certain cells in the medium and high security area need extra attention. Issues that monitors bring to the attention of the Lieutenant following tours are quickly addressed and monitors are able to see results at their next visit. In addition to the maintenance of the facility, monitors also check if resources for crisis and community services, including grievance procedures, are visibly displayed and accessible to the women. Monitors have seen some posters during visits, but this is an area that can be improved.

The facility was never designed to accommodate the populations it now must house. The before-mentioned examples (page 6) demonstrate how facility inequities manifest themselves in stark differences for the men and women: sustainability projects that look like candlestick v. a flagpole; exercise equipment that is new or old; vocational training in a training warehouse or an embroidery class in a refurbished dining hall. Still another example of inequity is the library system. For men this includes a well-stocked, open-spaced library with daily hours of

operation. For women it is another repurposed storage room with limited weekly access.

There is even greater consequence when it comes to the facility and meeting the mental health needs of the women. Consider data that staff shared from a three-week assessment of mental health referrals noted 109 requests from women and 27 from men.

There is currently one inpatient psychiatric unit to house both male and female inmates. It is called 8A and located at the Main Jail. Staff consensus is that the 8A unit has increased significantly, trending upwards of 45 patients, when in the past it has been as low as 15 to 20. Monitors are concerned that this could mean that both our male and female mentally ill inmates are getting released from intensive care sooner than they should. Monitors learned from staff that the trickle-down effect of that is when women are discharged to special management (mental health) housing from 8A and are not as stable as they could be they have only two places to go to at Elmwood: W4C2 and W4A. Most of our very ill go to W4C2 because they have committed violent crimes, have tried to assault an officer or done something similar to be labeled as a "problem." These are the level 4 inmates so they have the highest classification. The comparison of this type of placement would be sending a man from 8A directly to 4A, 4B, or 4C at main jail who has severe mental illness. (Staff noted it happens but less frequently as they have ensured there are no overflows anymore. Since this change incidents have dramatically declined.) If you compare these two populations they are horribly unequal but are housed in almost the same exact way. Men at main jail also have 8B to go to which is like a step down unit similar to W4A and 8C which, although not explicitly labeled as a mental health unit, houses the mentally ill. However, men also have dorm-style mental health housing. In this housing Level 2 Special Management inmates live in dorm-style settings. **There is nothing like this for the women and this must be addressed with any new facility design.** Women under mental health special management are only housed in W4C2 or W4A. Monitors encountered at least three older women who appeared to have Parkinson's and Dementia and they are housed in mental health housing but without special attention to address dementia type illnesses. Another relevant note in terms of housing is that dementing and older male inmates are typically housed in the infirmary or in a dorm-style setting in the south jail. At main jail they essentially have an "old man's dorm." Nothing like that exists for the women and many of the women with mental health issues are essentially set up for failure simply because there is no space available to be down-classed.

While space to down-class is an issue, there are other options. Reconsidering treatment that could be done in small groups (perhaps 3-4 women at a time) would be beneficial for women in W4C2. They have the most unremitting symptoms of mental illness that are pervasive, from a

psychological perspective. These symptoms do not mean that they are going to be violent when in custody so there is potential that they could be out together and do just fine. Psychological research endorses that both social skills training and social support benefit patients with psychotic illnesses. When women go from 8A to W42 it has potential to exacerbate symptoms from confinement and lack of interaction because it is similar to an "administrative segregation" type housing. Although other inmates are around they are unable to have face to face contact or be out with others. If they are then released to programs as many of them are, they have trouble with interpersonal boundaries and social skills because they have been isolated the entire time. However, if they could have controlled exposure to others it would ease them into the reality of the community and has potential to increase success. Since women are also more relational, peer support and accountability from peers is sometimes the key to recovery and treatment compliance. If one woman in a group disapproves the other sometimes follow and then they work to problem-solve and support their peers. Also, in terms of allocation of mental health resources, staff would be able to see many more patients in a group, freeing up their time for other mental health services. Further, by providing these women with treatment similar to what they would get in the community and when they get to a program it supports a trauma-informed way to set them up for success and avoids triggers for common ailments such as PTSD.

Effects of an aging facility are far-reaching, particularly for women with mental health issues. Early intervention and detection of symptoms, behaviors and need for medication with close monitoring from mental health staff has the potential to stop or at least decrease adverse outcomes (pepper spray incidents, officer injuries, worker's compensation, attrition of staff). For both the inmates and the staff a lot of physical, financial and emotional harm could be prevented if some additional support and rearrangement of things occurs. Addressing mental health needs could be done more effectively than how it is being done and there is an unequal way in which men and women are managed.

Monitoring Components: Interaction with Staff

During visits monitors converse with the Department of Correction staff to learn about their day-to-day experiences and responsibilities. Some staff have expressed interest in receiving gender-responsive training and believe that it would be beneficial to their day to day interactions with the women at Elmwood. A critical piece is the ratio between staff and incarcerated women. During one observation monitors entered the medium security level and noticed that there were 60 women, all with high needs including medical and psychological issues, to one (1) staff member. Even for the most exceptional staff that monitors have observed, this is not adequate.

Monitoring Components: Interaction with Women who are Incarcerated

Tours provide the opportunity to speak to the women from all security levels, to better understand their experiences, what is working well and what can be improved. Several issues have emerged from these conversations:

- **Access to Medical Care** - The women explained that it takes approximately 30 days to see a doctor once they submit their medical request (aka white card). For women who have commissary money, each new request costs \$3, for those who do not have commissary money the visit is free of charge. They have also stated that they wish there was a better process to address urgent medical needs. Based on feedback from the women, there is no clear policy or structure set in place to receive urgent medical care. Monitors are also concerned that there was a charge for a service that inmates are legally guaranteed and support the policy change that eliminated this fee as of July 1, 2015.

- **Timely Meals** - A typical day for the women at Elmwood begins at 4:30AM with breakfast. While they are required to throw away any leftover food it is not uncommon for women to hold on to food to snack on until lunch is served at 10:30AM. The same practice is applied to lunch when they will hold on to leftover food until dinner is served at 4:30PM. Some explained that there is a large gap between meals. If they have commissary money they are able to purchase snacks, but if they do not have any funds, they must wait until the next meal is served and for many, especially expectant mothers, the time gap between meals is significant. As discussed in the Program Section, depending on the security level, some women have the option to a few programs. If no programming is available they spend the majority of their time in their cells.

- **Basic Hygiene** - Self-care for women is very important and during visits monitors have observed women doing their hair, make-up, and trying to maintain their hygiene. Many women have explained that even though they understand that they are incarcerated they still like to take pride in themselves. Clean uniforms and undergarments are very important to them. An area of concern was centered on the timing of the distribution of the clean uniforms. Policy is that women receive seven (7) pairs of undergarments, three (3) bras, and two (2) outer garments. Women receive uniforms twice a week, therefore if a woman is placed at Elmwood on a Thursday, she might not have clean undergarments until the next round, which takes anywhere from 3-5 days. Women reported that in those situations they depended on their cellmates for clean undergarments. One major barrier to address-

ing the clothing needs of the women is that residential grade washers and dryers were used. DOC replaced these machines in the FY16 budget with industrial grade washers and dryers and it is believed that this will eliminate any delay that could periodically happen in the past.

Monitoring Components: Observations

The Jail Monitors have toured the Elmwood Facility, Main County Jail, and the Re-Entry Center. To date, monitors have conducted four visits to Elmwood and have recurring monthly monitoring sessions scheduled every third Friday of the month. Monitors have had the opportunity to take an in-depth look at the facility, talk to the women first hand, and learn more about the different institutional systems and processes.

Monitoring Components: Focus Groups

Two focus groups were conducted, one in custody and one post custody. Participants provided verbal responses to the questions posed by the Jail Monitors. Key themes, needs and opportunities emerged and are highlighted.

Housing:

- Housing was voiced as the top priority and concern—specifically, finding housing, affordable housing and housing for families with children.
- Transition Housing Units (THU): There is a waitlist for these housing services, which are described as becoming like more of a “new-age shelter.”
- Focus Group participants shared how important it is for women who are getting ready to reenter to understand the intricacies, challenges and expectations they will encounter. Rather than just looking forward to their release, it is best for reentering women to be informed and provided with concrete facts along every step of the reentry process.

Recovery:

- Support in Recovery from alcohol and substance abuse was voiced as the second greatest need.

Access to Services/Programs:

- While at Elmwood, women learn about available services through word of mouth, which was described as the best way to disseminate information regarding programs.
- There are no clear systems in place for communicating service options to female inmates.

Health:

- Homeless Connect: Located on Alexian Drive, this health clinic provides patients with a full range of medical services, including same day medication but only one participant was aware of this service and she wished she had learned of it much sooner.
- VMC Urgent Care: VMC is another option for medical services, but patients do not always receive their medications on the same day.

“What would I tell the women at Elmwood about being out? Get ready. It’s harder than I thought it’d be. It’s just really, really hard.”
- Post-Custody
Focus Group Participant

Addressing the Need for a Gender-Responsive Re-Entry Center

The Re-Entry Resource Center is a centralized location for custodial and non-custodial individuals to receive referral and wrap around services. Its vision is to build safer communities and strengthen families through successful reintegration and reentry of formerly incarcerated individuals back into Santa Clara County. As such, the Re-Entry Center is a critical component to meet the needs of women and jail monitors toured the Re-Entry Center to see firsthand the continuum of care available. The Center provides alcohol and drug treatment and care, counseling, general assistance benefits, and health referrals, just to name a few critical services. The mission of the Re-Entry Center is to reduce recidivism by using evidence-based practices in implementing a seamless system of services, supports, and supervision.

The tour provided monitors the opportunity to identify if and how the needs of women are being met and what can be done to improve the experience of those who utilize the Center.

Overall, the facility was well maintained and clean. During a visit, it was noticed that two Sheriffs greeted individuals as they entered the Re-Entry Center. Monitors learned from staff that this may be intimidating for the individuals who seek services but they noted the County was in the process of filling that position with a non-badge classification.

Further, a section of the Center serves as a referral and resource center for which numerous non-profit organizations are housed to provide critical information to individuals. The information is pivotal to supporting custodial

and non-custodial individuals. However, what was not noticed were posters that displayed phone numbers for crisis services, breastfeeding support, child care support, or ways to report a grievance. It is important to display this information and to make it easily accessible.

An opportunity to observe a class was presented and what was observed was that it was predominantly attended by men. As members spoke to staff, it was learned that child care is not a resource provided at Re-Entry. The lack of child care creates a barrier for parents to utilize the services or participate in any classes.

The Re-Entry Center plays an instrumental role in the rehabilitative support of non-custody individuals and there are some wonderful things happening there. However, there were limited numbers of women visiting the center and a lack of gender-responsive programming and services. It is worth exploring how well the faith-based re-entry centers are meeting the needs of women and where women are going for reentry support as well as supporting any Re-Entry Center efforts to better address the needs of women.

Some women noted that they were intimidated by the “government atmosphere” of the Re-Entry Center. Others noted that they went expecting to be placed in housing, programming or with other services and instead received a list of agencies and phone numbers. For a woman exiting jail with no cell phone, computer access or money, the added expectation that she must find services is overwhelming. One woman explained that she just didn’t think to ask for a bus pass and later found out the center can provide them. And although she was helped by a center worker, a bus pass was not offered. Phone access was also not offered so she took her list and hoped to connect with someone who would let her use their phone to make some calls.

Based on data provided by Re-Entry staff, 18% of clients accessing the County’s Re-Entry Resource Center each month are female and 14% of these women are AB109 Realignment Population.

Since spring 2014 when CSW toured the Re-Entry Resource Center, the Office of Re-Entry Services has made significant improvements in triaging clients to services within the Center and to community services. Some of the improvements include implementing a new interim referral tracking systems to automate the client registration process, increasing subsidized employment slots through Goodwill Industries, contracting with Gardner Family Care to provide family reunification and support services, contracting with Bay Area Legal Aid and Pro Bono Project to provide legal services to address issues of child custody, fees & fines, housing and employment discrimination, and regaining access to driver’s license, increasing the Reentry Mobile Medical Clinic from 1 day to 2.5 days per week with access to psychiatry services, adding dental services once day per week, working with DOC to develop

transition plan for moderate and high risk individuals 30 days prior to release, and funding four faith-based reentry resource centers located through the County.

Addressing the Need for a Gender Responsive Facility

The DOC, OWP and CSW have committed to working together to address the needs of female offenders. This includes further planning for the following:

Consistent with the research that shows when correctional facilities incorporate gender responsive programs and practices there are benefits both for the inmates, the staff and the system itself, monitors offer some practical examples for DOC to consider as we work toward a gender-responsive strategic plan for justice involved women.

Provide Trauma-informed training for all staff that work with incarcerated women. This includes understanding the backgrounds of trauma and abuse, establishing trust, respect and recognizing a woman's strengths. One way of establishing trust is by using trauma-informed language as shown in these examples (Dezial, 2014). Given the nearly universal rates of violence and victimization, communication with female offenders, especially verbal interactions with male staff, must be carefully examined. Training to give staff the tools to more effectively communicate and de-escalate situations can transform the institution.

| INSTEAD OF | CONSIDER |
|-----------------------------------|------------------------------------|
| Referring to inmates by last name | Refer to them as "Ms. Smith" |
| Referring to staff by last name | Refer to them as "Sergeant Smith" |
| Saying "cells" | Saying "rooms" |
| Saying "blocks" or "walks" | Saying "pods" or "wings" |
| Saying "shake-down" | Saying "safety check" |
| Saying "lug her" | Saying "take her to a secure area" |

Vicarious Trauma training will be a component that provides staff with the opportunity to debrief and heal and connect as a team so they can effectively do their work in the DOC.

Gender-Responsive training will be provided for all staff working with women. This will include, but is not limited to, correctional officers and any other staff coming into contact with women such clergy, health care, social services and case management workers.

Gender Specific training will be provided. Staff will be trained regarding critical information that should be collected when assessing women offenders.

This information includes:

1. History of Abuse
2. Relationship Status Issues
3. Self-esteem
4. Mental Health (depression, anxiety, PTSD)
5. Parental Related Stress (regarding managing children, number of children)
6. Degree of Family Support or Conflicts
7. Finances/Poverty
8. Safety (violence abuse)
9. Strengths & Protective Factors

Classification System Validated by Gender

DOC staff indicated a need for the women's side to be classified independently from the men's side for several reasons. The first reason being a matter of structure: under the current system, the administrative lieutenant does not have full control over the women's side, which should be under her jurisdiction. A classification system validated by gender should also be explored and implemented. National research affirms that systems not validated by gender typically over-classify women and this was also highlighted in the recent Jail Needs Assessment Report presented to the Board of Supervisors (May 2015).

Programming

Another reason for classifying the women's side independently from the men's involves programming. Both quantity and quality are issues affecting women's programming. The AB109 population is represented by 10-13% of inmates, which means that there are more women serving longer sentences. However, programming has not yet adapted to reflect the needs of this high-risk population.

High-Risk Population Programming

Specific programming needs for high-risk female populations should address their mental, physical, social and spiritual needs and include the following program areas:

- Domestic Violence
- Parent Reunification
- Education & Employment Training
- Substance Abuse/Recovery-Oriented

IN CLOSING

As these observations have elucidated, a better system is one that provides services to female inmates at a gender-responsive facility with culturally competent programming. Further, a trauma-informed, recovery orientation is necessary in order to ensure that the women are able to re-enter society as more productive and integral members.

There are also risk factors and experiences which are unique to gender. The table below illustrates the difference between gender neutral verses gender specific risk factors (National Institute of Corrections, 2012).

| RISK FACTORS FOR WOMEN OFFENDERS | |
|---|--|
| GENERAL NEUTRAL RISK FACTORS | GENDER RESPONSIVE RISK FACTORS |
| <ul style="list-style-type: none"> • Criminal History • Antisocial Attitudes • Antisocial Associates • Educational Challenges • Employment/Financial <ul style="list-style-type: none"> • Family Conflict • Substance Abuse History • Dynamic Substance Abuse • History of Mental Illness | <ul style="list-style-type: none"> • Mental Health History • Depression Symptoms • Psychotic Symptoms • Child Abuse (Institutions) • Relationship Conflict <ul style="list-style-type: none"> • Family Conflict • Parental Stress • Housing Safety • Adult Victimization (Sample Variations) • And Strengths (Self-efficacy, Self-esteem, Family) |

Monitors recognize that resources for female inmates are not abundant, that facilities are old and programming is severely limited, but with appropriate training and investment in programming, the DOC may be able to have more success in rehabilitation, be more cost-effective for the community in the long-run, and create a detention facility that speaks to the realities of these women's lives.

In attempts to get the firsthand perspective of the female inmates themselves, the Jail Monitors have visited the inmates and toured facilities. Jail Monitors have observed several needs that can be addressed to ensure that the inmates are able to serve their time in humane conditions with an emphasis on rehabilitation. The Jail Monitors believe that there can be improvements in crisis services and grievance procedures. Also, the need for more staff is something that is imperative both for staff and for the inmates in order to increase the security and conditions that the women live in.

The Jail Monitors have also done focus groups in order to understand more closely what the challenges are for the inmates in their experiences in custody and their experiences re-entering into their communities. The focus groups gave the Jail Monitors insight into challenges faced by inmates such as their feeling of frustration over the lack of programming or other rehabilitative activities. The focus groups yielded insights into the alarming lack of support for and resources for women who are released from jail. Inmates noted that housing was especially difficult for them to come by, and something that often led them to return to the conditions and pathways to prison.

Future focus groups will likely target specific demographics such as pregnant women, self-identified lesbians, women in programming, women about to be released, and women who only speak a language other than English, such as Spanish speaking women.

Additionally, our County hosts a model Re-Entry Center that can be a source of integral support for women once they have left the correctional facility. The Re-Entry Center can play an instrumental role in the continued rehabilitation and making it more accessible for women must be prioritized.

Jail Monitor recommendations include implementation of the following:

1. Explore the feasibility of staffing the women's section as an autonomous facility
2. Develop and implement a department-wide gender-responsive protocol
3. Gender-responsive training for all staff beginning at the Academy level
4. Gender-responsive, trauma-informed, recovery-oriented, culturally appropriate programming and services for inmates;
5. Implement a classification system validated by gender
6. Ensure that all inmates leave the facility with an exit plan that includes preparation and orientation about support programs for re-entry

Women's Jail Monitoring is intentionally designed to be something that is more than a response to complaints and unlike other monitoring programs. However, future Jail Monitor Reports should include an analysis of grievances. That data was not available this year.

Additional questions monitors have and ask Supervisors to explore and continue to address with staff include:

- The need for improved data in general and by gender
- Classification: the number of reclassifications requested and approved (by gender) as well as the time it takes to process a reclassification request
- Analysis of grievances and infractions
- A comparison of programming for women and men
- A deeper analysis of lockdown times and other time when women, particularly in minimum camp, must remain on their bunks
- An analysis of mental health referrals by gender

“Thank you for visiting us. I can’t believe you’re here. I sometimes feel completely forgotten.”

- Inmate to Monitor at Monthly Visit

Prisons were created to keep very dangerous men away from society. The model just doesn’t work when applied to the typical low-level, non-violent female inmate. The goal for all working with women in the criminal justice system should be to decrease the number of inmates—through the one control that the DOC has—by providing a space where offenders can rehabilitate and change their lives in an effort to rejoin the community as contributing members of society. CSW has a good working relationship with OWP and DOC and by working directly with the Elmwood Administration we strive to bring equality and positive changes to the female in-custody population.

In the dialogue among criminal justice agencies and departments there has been recognition that more must be done for women and girls in this system. This report is an important piece to a complex puzzle but if thoughtfully considered and its recommendations integrated, we will move closer toward a truly rehabilitative correctional system that allows women to effectively break the cycle of incarceration and rebuild their lives.

The Commission on the Status of Women thanks the Department of Correction and Office of Women’s Policy for working with us toward this end.

Meeting the Needs of Women in California’s County Justice Systems: A Toolkit for Policymakers & Practitioners, Barbara Bloom, May 2015

Final Report, Department of Correction Needs Assessment/Facility Report, December 2014

Santa Clara County Sheriff’s Office, Custody Bureau, Programs Unit Document on Programs, 2014

Program Units Support Services Division FY14 Report on In-Custody Programs Statistics and Rehabilitation Officer Activities, July 1, 2013 – February 28, 2014

Program Units Support Services Division FY13 Report, July 1, 2012 – June 30, 2013

New York Times Women Inmates: Why the Male Model Doesn’t Work, Melanie Dezial, April 2014

Huskey & Associates Report, 2012

Addressing the Needs of Women and Girls: Developing Core Competencies for Mental Health and Substance Abuse Service Professionals, SAMHSA 2011

Report of the Federal Partners Committee on Women & Trauma: A Federal Intergovernmental Partnership on Mental Health Transformation: Women & Trauma, June 2011

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From: Dale Weatherspoon [REDACTED]
Sent: Monday, November 30, 2015 4:41 PM
To: CustodyOpCommission
Subject: Questions for the commission
Attachments: BRC questions.pdf

My questions are attached is a document.

Thank you!

Rev. Dr. Dale M. Weatherspoon

To the Blue Ribbon Commission:

I have two questions, each with sub-questions to which I would like answers. At our first two meetings the concern of redundancy was voiced. Is the establishment of this commission a redundant act? These questions go to the matter of transparency and accountability. I believe having this information would be helpful to the commission and to the public.

At our November 21 commission meeting we defined the scope of our work. It is possible other studies have reported findings we will uncover in the scope of our work. Having answers to the questions below, I believe will help the commission be more focused and ensure implementation of our findings.

1. What studies of the Santa Clara County jails have been commissioned/contracted by Santa Clara County since 2000? Who or what companies were contracted? What was the focus of the studies? What was the cost of each of these studies?
2. What were the recommendations from each of the studies commissioned above? Which of the recommendations have been implemented? What was the cost to implement each recommendation? What has been the effectiveness of the recommendations implemented? For those recommendations not implemented, why have they not been implemented?

Sincerely,
Rev. Dr. Dale M. Weatherspoon – BRC member

From: Gail Price [REDACTED]
Sent: Monday, November 30, 2015 4:58 PM
To: CustodyOpCommission
Subject: Complaint Process Questions for Dec. 5 meeting.

Hi, These are my questions for the Complaint Process discussion for Dec. 5.

1. Is there a written inmate grievance process in place and how are all inmates made aware of procedures for filing grievances? Are there alternatives to written grievances if language is an issue?
2. Same question above applied to friends and family members of inmates.
3. What are the specific guidelines for filing, investigations, response and documentation of all grievances? In what format are these issues reported out on quarterly or annual basis?
4. If employees want to report behaviors, incidents, and actions of colleagues that impact the physical and mental well-being of inmates how is that done?
Results of this type of reporting?
5. What were the internal or external inspection reports related to complaints/grievances in the last five years and what corrective actions have taken place related to deficiencies identified?

Thank you.
Gail Price

From: LaDoris Cordell <[REDACTED]>
Sent: Monday, November 30, 2015 6:12 PM
To: CustodyOpCommission
Subject: additional questions from judge cordell re BR commission study session on complaint process
Attachments: ladoris.vcf

21. Please provide a copy of the Inmate Rule Book referred to in Policy 14.05, section I (E).

22. Please provide the grievance statistics reports for each year (2010-2015) prepared by the Division Commander/designee pursuant to Policy 14.05, section C.

23. Policy 14.05, section I (F) states that "Inmates may appeal and have resolved grievances relating to any conditions of confinement, including but not limited to:

1. medical care
2. classification actions
3. disciplinary actions
4. program participation
5. telephone, mail and visiting policy and procedures
6. food
7. clothing
8. bedding.

Is an inmate's complaint of excessive force or other misconduct against a correctional deputy appropriate subject matter for a grievance?

24. When inmates complain about mental health staff or medical staff, to whom are the complaints referred?

- a. What is the procedure that inmates must follow to lodge these complaints?
- b. What process is utilized for investigating these complaints?
- c. Does the Department or other county agency track these complaints? If so, where are the records maintained?
- d. How many inmate complaints have been lodged against mental health staff in each of the years (2010-2015)?
- e. How many inmate complaints have been lodged against medical staff in each of the years (2010-2015)?