Human Resources Administration
Department of Homeless Services
Department of Social Services

September 23, 2020

Pursuant to Local Law 115 of 2017 to amend the administrative code of the city of New York, in relation to requiring information on mental health services in shelters, the Department of Social Services respectfully submits the report below.

Those most at risk of homelessness are affected by high rates of poverty, family conflict and domestic violence, as well as poor health, including high rates of chronic disease and behavioral health conditions, coupled with low access to care. At DHS intake points, clients may arrive with a host of complex and interrelated challenges, but have one thing in common: a lack of safe and affordable permanent housing. The contents of this report describe mental health services for individuals experiencing homelessness and should be viewed against the backdrop of the many services HRA and DHS provide to address social and structural determinants of health and homelessness. By working to prevent homelessness, bring people in from the streets 24/7, rehouse those who become homeless, and transform the approach to providing shelter that has been used for 40 years, we are impacting the health of low-income New Yorkers beyond the provision of direct mental health services.

This said, as a result of the 90-day review in 2016, DHS has implemented a series of reforms, including improvements in how DHS delivers and ensures health care for those seeking or residing in shelter. The improvements, for example, include adding appropriately licensed and experienced clinical and professional staff to the DHS Medical Director's office. These individuals assist the Medical Director in designing evidence-based standards of care, planning and implementing newly-expanded program monitoring and oversight, and conducting evaluations of existing programs and services.

Among the improvements identified as part of the 90-day review in 2016, we are:

- Targeting services and programs for clients with mental health needs who may be also have criminal justice involvement
- Addressing unsheltered homelessness through the continued implementation of HOME-STAT, a the largest outreach program of its kind in the nation which partners existing homeless response and prevention programs with a series of new innovations designed to better identify, engage, and transition unsheltered New Yorkers from the streets to low threshold engagement and support services, as well as permanent housing.
- Enhancing and expanding specialized tools and services that support New Yorkers in need: The City has increased safe haven beds, increased the number of drop-in centers, and is working to develop 15,000 units of supportive housing to provide essential tools to address street homelessness.
- Revised the hospital and nursing home referral process to shelter, created an electronic referral form, and trained all shelters and hospitals in the revised process and new form.
- Developed and revised medical and mental health standards for the delivery of services at families with children (FWC) intake and the two single adult assessment shelters that required a new clinic, to ensure that standard assessments are completed, information is collected, clients are assessed for determination of appropriate assignment to program shelters, and needed referrals are made.

- We continue to conduct ongoing analyses of individuals experiencing homelessness and their need for healthcare services to help us better serve this population.

High-quality transitional housing is far more than just a room to sleep in or a roof over one's head. At these sites, we work in partnership with experienced not-for-profit social service providers whose dedicated staff connect clients every day with robust wraparound resources including case management, housing placement assistance, health and mental health services, and employment counseling on site. Cost covers far more than just rent—services, staffing, security, administrative costs and overhead are all included in the contract value.

As we transform a haphazard shelter system decades in the making, we are ending the use of all stopgap measures citywide, including phasing out the 20-year-old cluster program and the use of commercial hotel locations, which dates back on and off to the 1960s, while opening new high-quality sites that more effectively address our clients' unique needs—this includes high-quality shelters that are focused on supporting the needs of specific populations by providing targeted services/programs, including employed/employable New Yorkers, seniors, LGBTQ young persons, New Yorkers experiencing mental health challenges, veterans, etc. As we implement *Turning the Tide*, the City's five-year plan to transform a shelter system that has built up in a haphazard way over decades, we will be ending the use of the cluster program citywide.

When a New Yorker in need presents at an Assessment Site through a DHS Intake Site, staff works to identify what the individual's needs are and which program shelter would best facilitate the client's transition to housing permanency, including:

- General
- Employment
- Mental Health
- Substance Use
- Young Adults
- LGBTQ
- Older Populations
- Veterans

While shelter services are mandated to a great extent by state regulation, with some services specific to the type of shelter, "mental health" shelters are a City-level designation (rather than regulated at State-level), reflecting our recognition that there is no one-size-fits-all solution to the nationwide and citywide challenge of homelessness.

Mental health needs are assessed as individuals in need of shelter are evaluated during intake by DHS program experts, including social workers, nurse practitioners, and psychiatric nurses, to determine which program focus would best address the applicant's needs. These program experts assess individuals' housing and employment histories as well as their psychiatric needs to make the most informed and effective decision about which programs would best help each individual stabilize their lives. Clients in need of shelter, services, and support and also experiencing substantial psychiatric or mental health needs and/or substance misuse challenges are prioritized for facilities with mental health and/or substance misuse treatment programs to connect the applicant to services quickly.

There are a variety of factors we consider to determine a client's appropriateness for a mental health placement, including:

- History of severe mental illness;
- Past or recent psychiatric hospitalizations;
- Client's current functioning and behavior based on self-report and staff observation; and/or
- Clinical recommendation as a result of recent mental health examination or psychiatric evaluation.

Additionally, because clients may not report the challenges they are experiencing at intake, staff sometimes come to understand those challenges only during the course of working directly with clients on-site in shelter. As a result, referrals are also made from other shelters in the Single Adult system to Mental Health shelters on case-by-case basis, based on the assessment conducted by and relationships developed between case managers, housing specialists, social workers, nurse practitioners, and psychological evaluators—a collaborative needs-based determination made by social service staff and Program experts working closely with clients to help them back on their feet.

There is not a strict "label" or specific type of diagnosis required to be placed in a Mental Health shelter. Mental health needs are assessed at an individual level, with shelter-placement recommendations made based on conversations between social service staff and Program experts performing the assessment and those shelter and Program staff on-site at the specific location. If an individual placed in a Mental Health program, which is because DHS staff and the staff on-site at the location have determined, through careful deliberation, that an intensive focus on addressing Mental Health services and supports would best position the individual to obtain housing permanency. For those individuals residing at other facilities that may also experience some mental health challenges, dedicated staff remain focused on working with clients to address those unique needs and connect them with the care and services they need to get back on their feet.

Overall, NYC DHS mental health shelters provide:

- On-site behavioral health and medical services, as well as linkages to off-site care in the community.
- Behavioral health services include: psychiatric assessment, ongoing medication management, individual therapy, and group therapy related to mental illness, substance use, psychoeducation related to trauma, etc.
- Medical Services include: primary care services, episodic care, and assisting the client in accessing urgent care as needed. For clients with co-occurring mental health and substance use disorders, supportive services include harm reduction and health promotion to reduce the frequency and duration of both drug/alcohol and/or psychiatric hospitalizations. For clients with opioid use disorder, medication-for-addiction-treatment is provided onsite or via linkage to care in the community.
- The medical provider is certified by the State to provide overdose prevention training and ensure that staff able to provide overdose prevention responses are present at all times, with any staff that interact with clients, including security staff, equipped to administer live-saving naloxone should they witness an overdose. Facility staff and residents at HRA HASA facilities are also trained in opioid antagonist administration to prevent overdose in these facilities.
- The medical provider also communicates with external service providers and hospitals as needed, including managing visits to emergency departments, admissions, and discharges.

Please note, however, that while shelters with qualified medical providers on site may provide supervised medication administration, generally speaking Mental Health shelters are not assisted living facilities, psychiatric centers, or medical institutions; as such, these locations do not provide skilled nursing services or assistance with activities of daily living.

Overall, the City has made important progress transforming a haphazard shelter system decades in the making by investing in historically underfunded not-for-profit service provider partners and facilities to ensure those partners are appropriately funded to deliver the services our homeless neighbors depend on as they get back on their feet – this includes addressing conditions that have built up over many years and raising the bar for services that we provide our homeless neighbors, moving away from a one-size-fits-all strategy towards people- and community-based system that is response to families' and individuals' unique needs. For example:

- Investing in historically underfunded facilities and providers will help us turn the tide, which is why we've dedicated unprecedented dollars (more than a quarter-billion new dollars annually) to modernizing the outdated rates that our vital provider partners had been receiving for years to ensure those partners are appropriately funded to deliver the services our homeless neighbors depend on as they get back on their feet, while expanding education-focused programs and increasing our social work staffing and mental health services, thanks to First Lady Chirlane McCray's ThriveNYC Initiative.

Overall, our funding for mental health shelters has increased by more than 50 percent since FY14. And our investment in mental health services and supports of course goes beyond funding for Mental Health shelters, including efforts like Mental Health First Aid, which we are providing to all DHS and provider frontline staff systemwide, such as social workers, case managers, facilities, maintenance, fleet, and security staff over the next two years.

Medical Services Providers at Assessment sites:
In addition to the initiatives listed above, we are enhancing our provision of medical services at DHS intake and assessment facilities. Recognizing there is no one-size-fits-all solution to the citywide challenge of homelessness, we remain focused on continually strengthening our assessments of each individual and household's unique needs so that we can most effectively provide New Yorkers experiencing homelessness with the services and supports that would help them stabilize their lives, including connecting them with medical care in the community and developing strong linkages between shelter facilities and community-based service providers, organizations, and sister City Agencies.

By further developing and revising medical and mental health standards for the delivery of services at FWC intake and single adult assessment shelters, we are improving the ways in which our clients are placed in appropriate shelters as well as ensuring they are connected to care.

To that end, in 2018, we issued a request for proposal (RFP) seeking qualified medical providers to deliver enhanced medical and behavioral health services at DHS intake and assessment facilities. Last year, we awarded those contracts, enhancing our front-door evaluations of each client and the factors that may have contributed to their homelessness, and in late 2019 opened assessment clinics:

- 30th Street Assessment Shelter (provider: Care for the Homeless)
- Bedford Atlantic Assessment Facility (provider: NYU-Langone, formerly Lutheran)
- PATH Family Intake (provider: The Floating Hospital)

The service providers at these medical clinics are responsible for:

- assessing the medical and behavioral health needs of New Yorkers seeking shelter from the City upon arrival at assessment;
- communicating with their outside medical providers, if any—and, if none, help connect clients with off-site medical care or other healthcare services within the community;
- performing or referring for recommended health screenings, including preventive health screening;
- providing care coordination and health promotion/health coaching; and
- communicating with hospitals about overall policies, practices, and systems, as well as regarding specific households' needs, including coordinating care and liaising with hospital Emergency Department and in-patient unit staff on clients' behalf and provide crisis prevention and intervention.

In addition, they are helpful in determining if an individual is medically appropriate for shelter. If/when an individual may be determined inappropriate for shelter, clinical staff coordinate with a hospital to refer to medical services.

Following the medical and behavioral health evaluation, shelter staff will identify and prioritize clients who are in need of immediate medical or psychiatric evaluation or episodic care for clients who do not wish to access community services and care coordinators will ensure individuals are promptly connected to community-based medical and behavioral health service providers as recommended by the evaluations.

For clients receiving specialty care (HIV, Hepatitis C, dialysis, etc.) who may have their own specialized care coordinators, the provider will also facilitate care coordination and continuity of care. Through establishing and maintaining contacts with providers in the neighborhood, the care coordinator will advocate for timely and adequate community-based services.

The assessments conducted by service providers at these medical clinics also help shelter staff more effectively assist clients with accessing services and transitioning into permanent housing.

Outlined below is the information for Calendar Year 2019 solicited in Local Law 115 of 2017

1. The number of shelters, domestic violence shelters, and HASA facilities with on-site mental health services, as well as the total number of shelters, domestic violence shelters and HASA facilities

DHS conducted a survey with all the shelter programs, to collect information for on-site mental health services. A total of 64 DHS shelter programs and 1 HRA Domestic Violence shelters provided on-site mental health services (Table 1). DHS's approach is to place clients at the most appropriate location for their particular needs as such, not all shelters specialize in serving clients with mental health needs, given that only a proportion of clients have a mental health condition.

Table 1: Number of shelters programs and shelter programs with on-site mental health services, CY 2019

	Overall number of shelter programs	Number of shelter programs with on-site mental health services
Shelters	**495**	**64**
Single adults	145	36
Safe Haven	20	14
Veterans short term housing /Criminal Justice Shelter	3	1
Adult Families	21	2
Families with Children	306	11
Domestic Violence Shelters	**54**	**1**
Domestic Violence Emergency Shelters	46	0
Domestic Violence Tier II Shelters	8	1
HASA Facilities	**159**	**17**
Emergency SRO / Family Provider Sites	**142**	**0**
Emergency Transitional Provider Sites	**17**	**17**

Note: These are shelter programs that were active as of December 31 of the reporting year

2. A description of the mental health services in each intake center

Families with Children: Families with children enter DHS shelter through the central intake center called the Prevention Assistance and Temporary Housing (PATH) center. All new families that report a health issue at intake (e.g., feeling sick) and those with specific needs, such as pregnant women, families with

infants or who have a member with an acute medical condition or recent hospitalization are seen by the clinical provider at PATH, The Floating Hospital. The on-site clinician conducts a health screening and offers necessary emergency services, referrals as needed, and health education, as well as if needed coordination with the client's existing health care providers. As needed, families are referred to the onsite psychiatric provider for a comprehensive assessment. Once in shelter, clients are encouraged to and assisted in seeking care from their primary care physicians or a local clinic of their choice.

In addition, families self-reporting or observed to be facing mental health or substance use challenges are referred to DHS Resource Room Social Workers for further assessment. Resource Room Social Workers complete mental health and substance use assessments in the DHS CARES system. Assessment findings determine whether or not a call will be placed to 911 for EMS assistance and possible hospitalization.

Further, DHS and ThriveNYC launched an initiative to place licensed Masters' level social workers (LMSWs) in Families with Children shelters. These Social Workers serve as Client Care Coordinators directly in shelters as employees of DHS contracted providers. Client Care Coordinators work with clients to improve access to mental health services in the Families with Children shelter system and to assist families who are homeless as they navigate multiple systems and cope with the stressors and anxiety induced by homelessness.

Adults: After intake, all adults admitted to the shelter system are sent to an assessment shelter where providers conduct a comprehensive assessment including history and physical, brief psychiatric assessment, and substance use assessment. This assessment is used to direct new entrants into the DHS system toward either a general, mental health or substance use shelter, or an employment shelter. Mental health shelters provide specialized mental health services on-site as well as linkage to an array of outpatient mental health services. On-site services include psychiatric assessment, ongoing medication management, individual therapy, group therapy related to mental illness, substance use, psychoeducation related to trauma, etc., and crisis management and de-escalation. The following outpatient services are available to DHS clients with mental health conditions:

- Care Coordination: a specially trained individual or team that helps clients better understand and manage their conditions, works with clients to create a plan of care that meets their physical, mental health and social service needs and assists the client in finding the services and programs that are right for their needs.
- Assertive Community Treatment (ACT): an evidence-based practice model where a team composed of multiple specialized behavioral health providers, including a registered nurse and vocational supports, work together to provide treatment, rehabilitation, care coordination and support to individuals diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services. Since mid-2017, 10 new ACT teams have been assigned to cover all the DHS mental health shelters. Note: these are not DHS-contracted or DHS-operated teams/programs.
- Intensive Mobile Treatment (IMT): a specialized team that provides intensive and non-billable treatment in settings that are convenient to clients who may be unstable. Note: these are not DHS-contracted or DHS-operated teams/programs.
- Mobile Crisis Team (MCT): a team that is contracted by the New York City Department of Health and Mental Hygiene (DOHMH) to respond to mental health crises in the community within 48

hours of receiving a referral. MCTs are staffed by mental health professionals who can assess the referred person and their situation, provide crisis counseling and make referrals to community-based mental health and substance misuse services for ongoing care, and emergency services as needed. The DHS Office of the Medical Director developed mechanisms to improve access to shelters for MCTs. Note: these are not DHS-contracted or DHS-operated teams/programs.

Adult Families: For adult families, self-assessments are conducted at intake centers where individuals respond to questions posed from staff. Clinical assessments are not conducted by a clinician at these sites.

Naloxone in Shelters and HASA Facilities: At intake, all individuals seeking shelter from NYC DHS are assessed for substance use challenges in addition to mental health challenges. Comprehensive Health Assessment Teams (CHAT), for example, help conduct an early assessment of mental health and substance use history to determine if a person may be effectively served and/or eligible for supportive housing. Individuals who are identified as experiencing substance use challenges may be referred to a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) for further referral to in- or out-patient substance use treatment. If a client appears to be in crisis upon arrival at intake, intake staff contact HRA's Customized Assistance Services and request an emergency psychiatric evaluation and possible hospitalization if appropriate.

All shelters, including intake and assessment sites,are equipped with staff who are trained to act as overdose first-responders and to administer naloxone; we continue to train staff on an ongoing basis; and we continue to conduct trainings for clients as well, implementing a train-the-trainer model. To that end, DHS Peace Officers are also trained in naloxone administration and are certified Opioid Overdose Responders. In late 2016, the DHS Medical Office started systematically training DHS staff in naloxone administration to ensure that all shelters have a trained staff capable to administer naloxone to clients suspected of having an overdose on all shifts. In November 2016, DHS became an independent state certified Opioid Overdose Prevention Program (OOPP), led by the Office of the Medical Director. In FY 2020 (July 1, 2019 through June 30, 2020), DHS provided an initial training for 3,267 staff and a refresher training[1] for 510 staff, in addition to training 7,056 clients, for a total of 10,833 individuals trained in administering naloxone.

To reduce the number of overdose deaths, beginning in December 2017, HRA HASA started training facility staff routinely as trainers and responders in the administration of the opioid antagonist, naloxone. Staff who successfully compete the training are State Certified Opioid Overdose Responders. In 2018, HRA HASA implemented an opioid overdose training plan and overdose response policy which includes training facility residents in addition to training facility staff in administering an opioid antagonist, such as naloxone, to clients suspected of having an overdose. In FY 2020 (July 1, 2019 through June 30, 2020),

[1] Refresher training is offered if two (2) years has passed since receiving opioid antagonist administration training. In late 2016, the DHS medical office started systematically training DHS staff in naloxone administration to ensure that all shelters have a trained staff member(s) capable to administer naloxone to clients suspected of having an overdose on all shifts. In 2019, 510 staff members were required to complete a refresher training since two years had passed since their initial training.

HRA HASA has provided an initial training[2] for 459 facility staff in addition to 780 facility residents, for a total of 1,239 individuals trained in administering naloxone.

Mental health services at HASA Emergency Transitional Provider Sites and Permanent Congregate Provider Sites include programs for crisis intervention and referrals for short-term hospitalization for clients diagnosed with mental illness. Treatments include individual therapy, group therapy, recreational therapy and psychological testing. Social service professionals and case managers assist clients with continuing care options that enhance their mental stability and independent functioning.

HRA's Office of Domestic Violence provides oversight for the 24-hour NYC domestic violence hotline which serves as one of the contact points for the domestic violence shelter system, but also provides safety planning and referrals. Safe Horizon, a private not-for-profit social service agency and DV service provider, is the City contracted provider operating the hotline.

Upon arrival at a domestic violence shelter, as required by State mandate a caseworker will conduct the Client Assessment within 48 hours of arrival. As a part of the client assessment process, the following medical and mental health questions are asked:

- Have you or your child (ren) ever been hospitalized? If yes, please explain.
- Have you or your child (ren) ever received psychiatric treatment or counseling? If yes, please explain.
- Is anyone in the family currently in treatment (Yes) or (No)?
- If yes, Name of Psychiatrist, phone#, Treatment schedule, List of medications,
- Is anyone pregnant (Yes) or (No).
    - If yes, who and expected date of delivery?
    - If yes, receiving prenatal care (Yes) or (No)? Where?
    - Any complications with the pregnancy (Yes) or (No), Explain

Depending upon the responses, referrals are made. In every case there is on-going case management at the shelter.

3. A description of the mental health services provided at drop-in centers and safe havens

Drop-in centers provide a low-threshold alternative to traditional shelter for street homeless individuals and offer temporary respite where individuals can shower, eat a meal, see a doctor, and rest. There is on-site case management and housing placement services, as well as a limited number of off-site overnight respite beds.

Services at drop-in centers and safe havens include a psychiatric assessment and referral to care as indicated from the assessment.

[2] Please note that going forward, we will be changing the way that we report on the refresher trainings in order to capture refresher trainings conducted by HRA OOPP for clients who received original trainings from agencies / programs other than HRA OOPP. The current report would not reflect refresher trainings for clients whose initial Naloxone training was carried out by other agencies / programs. As such, the report reflects the number of refresher trainings as "zero". This does not mean that DSS HASA has not revisited sites in an effort to reinforce, but for a variety of reasons those efforts are not reflected in the current report. For example, it is difficult to track clients when they no longer reside at the original training site or when they wish to remain anonymous. Moreover, some many clients do not wish to participate as the trainings are voluntary.

Safe Havens provide an immediate transitional housing alternative for chronic street homeless clients. The street outreach teams are the sole referral source and can place clients into a Safe Haven directly from the street. Safe Havens have flexible program requirements such as no curfew and generally have smaller capacity. The program embraces housing first and harm reduction models. The primary goal is to bring clients off the streets into flexible settings with strong clinical supports to help clients transition to permanent housing. The staffing at Safe Havens is clinically rich. There are MSW level clinicians, CASAC certified staff and psychiatrists. The low client/staff ratio allows for more intensive work with each client.

4. A description of the mental health services provided to the unsheltered homeless population directly and by referral, including the number of removals initiated pursuant to section 9.58 of the mental hygiene law

Outreach teams work from a harm reduction approach, building relationships with individuals who over time have historically rejected services. Outreach teams are also focused on the most vulnerable of those living outside to ensure they are safe and/or not at risk for injury or death. Outreach teams also perform crisis intervention assessments and work on placements to indoor settings through on-going case management and supportive services. This includes linking clients to medical benefits as they continue to work with these individuals throughout their journey. The outreach teams meet people "where they are" both literally and figuratively— whether that means conducting a psychiatric evaluation on a street corner or sending an outreach worker who can speak to a client in his or her native language.

In 2019, there were 15 removals initiated by DHS contracted outreach teams pursuant to section 9.58 of the mental hygiene law.

Overall, DHS Outreach teams provide emergency and crisis intervention, counseling, case management, assistance with entitlements, benefits, housing and other resources, and provides referrals and linkages to health care services, as necessary, to individuals choosing to live on the streets.

5. A list of the 10 most common mental health issues for adults living in shelters, as self-reported at intake/assessment, and the 10 most common medical health issues for children living in shelters, as self-reported at intake/assessment

The tables below outline the top 10 mental health conditions among adults in Adult Families, Single Adults, and Families with Children shelters. This is self-reported data at the time of application from every adult client that spent the night in an adult family, families with children or single adult shelter in 2019. In this data collection method, each client has the ability to report several health conditions and these data are not de-duplicated. These counts include clients that turned 18 while in shelter during 2019.

Table 2. Top Ten Mental Health Conditions from Intake/Assessment for Adults in Adult Families Shelter in 2019

Rank	Mental Health Condition	n
1	Depression	1,195

2	Anxiety	1,108
3	Bipolar disorder	891
4	Post-traumatic stress disorder (PTSD)	475
5	Schizophrenia	324
6	Attention-deficit hyperactivity disorder (ADHD)	247
7	Panic Disorder	238
8	Substance use disorder	156
9	Developmental disability or autism	136
10	Schizoaffective disorder	121

Table 3. Top Ten Mental Health Conditions from Intake/Assessment for Adults in Single Adults in Shelter in 2019

Rank	Mental Health Condition	n
1	Depression	6,476
2	Bipolar disorder	5,928
3	Anxiety	4,180
4	Schizophrenia	3,052
5	Post-traumatic stress disorder (PTSD)	2,144
6	Substance use disorder	1,759
7	Alcohol dependence	1,164
8	Developmental disability or autism	1,100
9	Schizoaffective Disorder	1,043
10	Attention-deficit hyperactivity disorder (ADHD)	862

Table 4. Top Ten Mental Health Conditions from Intake/Assessment for Adults in Families with Children Shelter in 2019

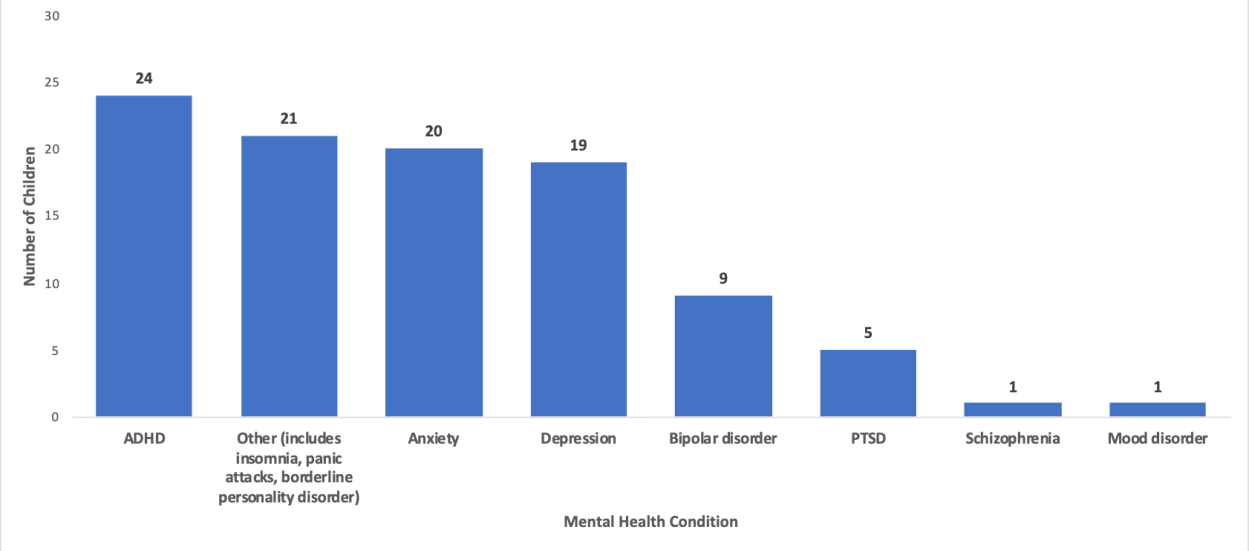
Rank	Mental Health Condition	n
1	Depression	2,417
2	Anxiety	2,092
3	Bipolar disorder	1,376
4	Developmental disability or autism	876
5	Post-traumatic stress disorder (PTSD)	855
6	Attention-deficit hyperactivity disorder (ADHD)	443
7	Panic Disorder	289
8	Schizophrenia	279
9	Substance use disorder	130
10	Schizoaffective Disorder	102

Note: These counts include clients who turned 18 while experiencing homelessness and residing in NYC DHS shelter during 2019

The DHS Office of the Medical Director collects self-reported behavioral health conditions for new families applying for shelter at the Families with Children (FWC) intake center (PATH) that report a health issue at intake (e.g., feeling sick or have a contagious condition) and also collects health information from returning families that have not previously completed the expanded health screening, if they presented to the clinic for another issue (e.g., pregnancy, recent hospitalization).

- In 2019 data were collected for 2,036 children, of those, 92 children (5%) had at least one mental health condition, as reported by the head of the household for each family member. The leading mental health condition among children was depression (Figure 1).
- The health screening captures self-reported mental health information on the seven most common mental health conditions among children plus an option to mark 'other' with the ability to specify what the other conditions entail.
- Figure 1 shows the mental health conditions among children as reported by head of the household for each family member. Some children have more than one mental health conditions.

Figure 1: Mental health conditions among children as reported by head of the household for each



family member at Families with Children intake center, 2019 (N=92)[3]

6. A list of the 10 most common mental health issues for adults living in shelters and the 10 most common mental health issues for children living in shelters, as reported by providers under contract or similar agreement with the department to provide mental health services in shelter

The tables below outline the most common mental health conditions among children (Table 5) and adults (Table 6) living in shelter as reported by the providers at Intake and Assessment. Autism and substance use disorder were the leading mental health condition reported among children and adults, respectively.

Table 5: Most common mental health conditions among children as reported by the medical provider at PATH, CY 2019

Rank	Mental Health Condition
1	Autism
2	Attention-deficit/ hyperactivity disorder
3	Learning disability
4	Anxiety
5	Depression

[3] Some children had more than one mental health conditions.

6	Post-traumatic stress disorder
7	Bipolar
8	Impulse control disorder
9	Oppositional defiant disorder

Table 6: Ten most common mental health conditions among adults as reported by the medical providers at assessment shelters, CY 2019

Rank	**Mental Health Conditions**
1	Substance use disorder
2	Depression
3	Anxiety Disorder
4	Bipolar disorder
5	Post-traumatic stress disorder
6	Schizophrenia
7	Schizoaffective disorder
8	Personality disorder
9	Panic disorder
10	Attention deficit hyperactivity disorder

7. Any metrics relevant to the provision of mental health services reported to the department by any entity providing such services.

Please refer to the new overdose report and the annual mortality report submitted pursuant to LL225 of 2017 and LL63 of 2005, replaced by LL 7 of 2012, respectively.