

# 2021 Mental Hygiene Executive Summary

## NYC Dept. of Health and Mental Hygiene

Certified: [Kirklyn Escondo](#) (9/25/20)

### Community Input

The Division of Mental Hygiene at the New York City Department of Health and Mental Hygiene (NYC DOHMH) continuously seeks opportunities to obtain community input in order to understand the mental health, substance use, developmental disability, and criminal justice impacted needs of New Yorkers.

The NYC DOHMH's Take Care New York 2020 (TCNY) plan solicits community input for developing priorities and strategies for improving every community's health, especially among those groups with the worst health outcomes. TCNY initiatives are implemented every four years, and the NYC DOHMH is currently in the process of developing priorities for TCNY 2024. Additionally, the NYC DOHMH monitors the citywide unmet mental health need through its Community Health Survey. The Community Health Survey (CHS) has been conducted annually by the NYC DOHMH since 2002. Data collected from the CHS are used to better understand the health and risk behaviors of New Yorkers and to track key indicators over time. The most recent CHS results (2018) showed that among adult New Yorkers with serious psychological distress, 21% reported having an unmet need for mental health treatment in the last 12 months.

The NYC DOHMH also continuously obtains community input from consumers, advocates and service providers on the needs of New Yorkers receiving Medicaid managed behavioral health services via its Regional Planning Consortium (RPC) steering group meetings and advisory board. Additionally, each quarter, we convene our Community Services Board (CSB) and CSB subcommittees in the three areas of mental health, substance misuse, and developmental disabilities to receive input on our program planning and policy efforts. The NYC DOHMH also convenes discretionary CSB subcommittees that share their expertise in criminal justice and LGBTQ issues as they relate to behavioral health. Our Community Services Board and CSB subcommittees have been an integral part of the local services planning process and we frequently hear concerns about unmet mental health and substance use-related needs from these stakeholders.

Furthermore, alongside the RPC and CSB, the Division of Mental Hygiene regularly convenes Consumer Advisory Boards (CABs), the Developmental Disabilities Borough Councils, contracted service provider staff, and a number of different communities such as faith-based leaders, through a variety of initiatives to understand the behavioral health needs of the community.

### The Behavioral Health Impact of COVID-19 in New York City

The impact of the COVID-19 pandemic in the early months of 2020 will likely exacerbate existing mental health needs in New York City. As of September 22, 2020, more than 236,000 residents of New York City have tested positive for COVID-19.[1] New York City has seen over 19,000 confirmed deaths due to the coronavirus, with an additional 4,600 deaths categorized as probable, or reported as "COVID-19" or equivalent without a positive laboratory test.[1] Citywide infection rates and preliminary mortality data disaggregated by race suggest that Black and Latino/Hispanic communities are disproportionately impacted by COVID-19.

The COVID-19 pandemic is unprecedented in both scope and impact, and residents of NYC, as the pandemic's current epicenter, will experience profound social, economic, and psychological effects. The psychological and behavioral health impact due to the direct and indirect effects of the pandemic are likely to be complex and long lasting. These direct and indirect psychological and mental health consequences of the pandemic arise from widespread loss of life, illness without full physical recovery, the potentially long duration of the full and partial quarantine, and economic losses and insecurity.

### Considerations for Racial Equity in the Face of the COVID-19 Pandemic

The NYC DOHMH recognizes significant inequities in mental health across race and ethnicity in New York City, and these existing racial inequities have been magnified in the COVID-19 pandemic. Preliminary COVID-19 mortality data, disaggregated by race, indicates a racial disparity across New York City. Latinos represent nearly 31 percent of total confirmed deaths due to COVID-19, while Black New Yorkers represent 28 percent

of confirmed deaths. [1] Race and ethnicity information is most complete for people who are hospitalized or have died, and much less demographic data is currently available for non-hospitalized cases; therefore, it is possible that mortality rates are greater than currently reported.

These results suggest that COVID-19 has placed a disproportionate burden on the health and well-being of low-income communities of color in New York City, and will have long-reaching consequences on the physical and mental health of these vulnerable communities in the foreseeable future. The City must be equipped to support communities of color, particularly those suffering from severe mental illness (SMI) and substance abuse disorder (SUD) and are coping from circumstances as a result of the coronavirus.

### **Priority Issue Areas**

Per the State's requirement to select five priority issue areas, NYC DOHMH would like to select the following five:

- Housing
- Crisis Services
- Racial Equity
- Workforce Recruitment and Retention
- Heroin and Opioid Programs and Services

### **Resource Needs:**

The 2021 Local Services Plan includes NYC's efforts to address unmet need but does not account for needed collaboration with the state to strengthen our service system. Hence, we seek support and collaboration on the following:

#### ***I. Mental Health:***

- **Supportive housing:** The NYC DOHMH requests a collaborative process with state partners to increase supportive housing rates in order to preserve existing supportive housing units. Without additional funding, NYC is at risk for loss of units, as providers will terminate contracts due to insufficient funding, eliminating permanent homes for people and leading tenants with serious mental illness, substance use disorders and developmental disabilities to potentially become homeless.
- **Rethinking NYC's Crisis Response Services:** The NYC DOHMH requests the state's support in rethinking how crises are defined. As we move toward 2-hour response times, individuals who require mobile crisis services (MCT) but can be seen in the longer 3- to 48-hour response window should be shifted from "crisis" to another term that appropriately defines the level of care that these individuals require. We ask the state to standardize terminology across the state so that "crisis" refers to individuals who must be seen by MCTs within 2 hours. In addition, the NYC DOHMH asks for the state's support for outpatient providers to better address crises. While this is a new area of care for many outpatient providers, they know their patients best and are in a better position to be able to care and advocate for these individuals in crises, especially those who can be treated in the 3- to 48-hour window. The NYC DOHMH asks the state to encourage outpatient providers to manage crises among their clients, and support these providers in doing so through education and funding.
- **Workforce Recruitment and Retention:** There is a need for increased funding to support the recruitment and retention of our behavioral health workforce by increasing their compensation. The vital role this workforce plays in supporting adults, children and their families they serve often leaves a major gap in care when providers opt out of accepting insurance because reimbursement rates are too low to sustain their business. We ask the state to take more significant steps to enforce existing parity regulations and to enhance parity requirements to ensure that behavioral health providers are compensated at rates on par with physical health care providers. We also ask the state to take the lead in developing a unified measure of retention by job title using statewide title codes, which will allow for more accurate data on workforce recruitment and retention.
- **Employment/Job Opportunities:** Unemployment rates among people with serious mental illness (SMI) and developmental disabilities remain high. In 2018, approximately 59% of New Yorkers with depression were unemployed or not in the labor force.[2] Despite high rates of unemployment, providers struggle placing and supporting people with SMI due to a lack of knowledge about existing

services. Furthermore, individuals with developmental disabilities have limited options for developing on-the-job employment skills and employment options. Both providers and consumers need information on employment services and their impact on benefits. We ask for the state's support in ensuring that providers are able to make employment referrals and recommendations for clients. With the economic crisis due to COVID-19, it is likely that employment opportunities will worsen.

## **II. Substance Use Disorders:**

The NYC DOHMH identifies a number of areas in which additional services and funding are needed to offer sufficient prevention of substance use disorders, as well as treatment and recovery supports for New Yorkers with substance use disorders.

New York City needs additional resources to increase the number of individuals, families, and adolescents receiving recovery services, to expand prevention services for New Yorkers at risk for developing substance use disorders, to implement strategies to reduce stigma against medications for opioid use disorder (MOUD), and to increase salaries for Peer Support Specialists, who are integral components of the behavioral health workforce. The NYC DOHMH also requests that the state require SUD Residential Treatment Services to use medications for opioid use disorder in residential treatment settings, as well as implement mechanisms of oversight and auditing of programs to facilitate this goal. The NYC DOHMH also requests state support in collaborating with criminal justice agencies to lower eligibility criteria for diversion to treatment programs and ensure connection to effective treatment for individuals with opioid use disorder who are released on bail.

The NYC DOHMH has also identified a number of new resource needs that have come as a consequence of the behavioral health impact of the COVID-19 pandemic. Due to COVID-19, reductions in state funding for licensed substance use disorder treatment programs are anticipated. We are requesting state support in identifying sources for additional funding to address anticipated funding shortages among substance use disorder programs. Additional funding is also required to ensure that treatment providers and patients have adequate access to necessary technologies to provide and access telehealth services during the COVID-19 pandemic and in its aftermath.

**SUD Outpatient Treatment Services:** Numerous changes in federal regulations of buprenorphine and methadone treatment were implemented to mitigate the spread of COVID-19 and prevent treatment disruptions among MOUD patients. These include the following:

- On March 16, 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) allowed Opioid Treatment Program (OTP) providers to provide up to 28 days of methadone to stable patients, and up to 14 days of methadone to less stable patients.
- On March 16, 2020, the United States Drug Enforcement Administration (DEA) allowed for the provision of "doorstep" deliveries of methadone to patients quarantined due to COVID-19.
- On March 31, 2020, the DEA allowed for the use of telehealth services to induct new buprenorphine patients and continue the provision of buprenorphine to existing patients.

In response to these changes in federal regulations, NYC DOHMH established a Methadone Delivery System to deliver methadone to patients who are in isolation or quarantine because they have COVID, COVID-like symptoms, or comorbidities that place them at high risk of experiencing serious illness if they develop COVID. Furthermore, the NYC DOHMH continued to provide technical assistance and support to Nurse Care Manager sites and Syringe Service Programs in their continued provision and induction of buprenorphine treatment through telehealth services. The NYC DOHMH worked with the NY State Office of Addiction Services and Supports to monitor and recommend to providers increases in the provision of extended take-home methadone doses for patients.

New York City is requesting state support to continue implementation of the Methadone Delivery System and ensure methadone access to all patients who are presumed or confirmed COVID-positive, patients who are 50 years and older AND have a comorbid health condition AND can receive at least 7 days of medication, and all patients referred for delivery by the OTP Medical Director. In addition, state support will be critical in our capacity to continue providing technical assistance and support to buprenorphine treatment providers to conduct buprenorphine inductions and uninterrupted treatment provision through telehealth services, as well as addressing needs for phones and technological resources among patients and providers to facilitate telehealth services. We aim to continue encouraging the increased provision of extended take-home methadone doses among OTP providers, and advocating for the continuation of emergency methadone regulations to allow for the provision of extended take-home doses among patients, the continuation of emergency regulations allowing for the buprenorphine induction and treatment provision through telehealth, and the continuation of changes in reimbursable rates that allow for telehealth substance use treatment

services to be reimbursed at comparable rates to in-person treatment services.

**Heroin and Opioid Programs and Services:** Finally, state funding is required to develop outreach mechanisms to provide naloxone, sterile drug use equipment, and other services to people who use drugs, due to reductions in services provided by OOPPs and SSPs during the COVID public health emergency. Additionally, funding is required to support the expansion of Relay to additional Emergency Department sites. We request state support in establishing pharmacies as points of dispensing of free naloxone kits, focusing on neighborhoods with the highest rates and numbers of overdose. State support would also be critical in identifying alternate mechanisms for the distribution of naloxone and sterile drug use equipment. We also advocate for increased support for SSPs to facilitate the continuation of outreach and service provision to people who use drugs.

### **III. Developmental Disabilities:**

The NYC DOHMH remains intent on developing collaborative processes with state partners to determine unmet needs and to identify and analyze reliable data for evaluating and planning local services for people with intellectual/developmental disabilities (I/DD) in NYC. Collaboration around OPWDD system data on population demographics, Medicaid utilization, non-Medicaid state-funded services, care coordination services, and new enrollments will enable the Local Governing Unit (LGU) to identify emerging needs, identify and address gaps in access to I/DD services, and prioritize areas for program and services development and for policy discussion. Strengthening such collaboration among city and state partners is particularly important as the I/DD population increasingly integrates into the larger community; as they and their care givers age; as the nature and number of service needs increases, changes, and intensifies. Fall-out from the COVID-19 pandemic increases the urgency for coordinated management and use of critical data points and sources.

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#### **LSP SUBMISSION NOTICE:**

Please note that due to current events and strong recommendations from our Community Services Board, Racial Equity has been added as "Other Need 1"; however, two other important Needs have been identified: Medicaid Redesign (included in CPS form as Other Need 2) and Behavioral Health Parity, which was not entered into CPS but is included in the attached PDF documents:

- 2021 NYC Local Services Plan (Full)
- 2021 NYC LSP - Other Need 3 (Other Need 3 only)

[1] NYC DOHMH Covid-19 Data. <https://www1.nyc.gov/site/doh/covid/covid-19-data.page>

[2] Community Health Survey, 2018.

**Office of Addiction Services and Supports**

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# NYC Local Services Plan

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2021



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

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<sup>2</sup> Community Health Survey, 2018.

## **Substance Use Disorders:**

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

- **Heroin and Opioid Programs and Services:** Finally, state funding is required to develop outreach mechanisms to provide naloxone, sterile drug use equipment, and other services to people who use drugs, due to reductions in services provided by OOPPs and SSPs during the COVID public health emergency. Additionally, funding is required to support the expansion of Relay to additional Emergency Department sites. We request state support in establishing pharmacies as points of dispensing of free naloxone kits, focusing on neighborhoods with the highest rates and numbers of overdose. State support would also be critical in identifying alternate mechanisms for the distribution of naloxone and sterile drug use equipment. We also advocate for increased support for SSPs to facilitate the continuation of outreach and service provision to people who use drugs.

### **Developmental Disabilities:**

The NYC DOHMH remains intent on developing collaborative processes with state partners to determine unmet needs and to identify and analyze reliable data for evaluating and planning local services for people with intellectual/developmental disabilities (I/DD) in NYC. Collaboration around OPWDD system data on population demographics, Medicaid utilization, non-Medicaid state-funded services, care coordination services, and new enrollments will enable the Local Governing Unit (LGU) to identify emerging needs, identify and address gaps in access to I/DD services, and prioritize areas for program and services development and for policy discussion.

Strengthening such collaboration among city and state partners is particularly important as the I/DD population increasingly integrates into the larger community; as they and their care givers age; as the nature and number of service needs increases, changes, and intensifies. Fall-out from the COVID-19 pandemic increases the urgency for coordinated management and use of critical data points and sources.

## Needs Assessment

How has the level of unmet service needs <u>changed</u> in the past year? (By Population)			
POPULATION	IMPROVED 	STAYED THE SAME 	WORSENERD 
Mental Health Service Needs			
Substance Use Disorder Needs			
Developmentally Disabled Needs			

The NYC DOHMH is unable to complete the Needs Assessment table for the 2021 LSP. Due to the constantly shifting behavioral health landscape during the COVID-19 pandemic in 2020 and inadequate data on the pandemic’s impact on the behavioral health system, it has been extremely difficult to make broad determinations about unmet service needs in the past year (2020).

### **Mental Health Needs:**

In the past year, NYC has made significant new investments in enhancing services and connections to support New Yorkers living with SMI, and to improve the City’s system for responding to New Yorkers experiencing a behavioral health crisis. These investments were made through two complementary efforts coordinated across City government: the NYC Crisis Prevention and Response Task Force (overseen by the Mayor's Office of ThriveNYC), and the 30-Day Review of NYC’s mental health intervention programs. The results of this work are: expanded mobile crisis team services, expanded community-based services for people with serious mental illness (Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), and Intensive Mobile Treatment (IMT)). We’ve accomplished 2-hour mobile crisis response times, seven days a week during daytime hours in Manhattan and Staten Island; we expect that to be available city wide in 2021 and will include overnight hours. Finally, we are systematically incorporating peers into the teams and expanding availability of substance use-only mobile crisis services.

Despite the City’s investments, we continue to hear about increasing unmet mental health needs from the community and from our CSB. We ask our state partners to support us as we expand our portfolio of services to better address the mental health needs of New Yorkers. Our CSB regularly reports workforce shortages due to unsustainably low reimbursement rates. Providers are unable to offer competitive living wages, which leads to high staff turnover and worsening quality and availability of services. Additionally, funding for supportive housing does not account for NYC’s unique increases in housing costs year to year, leading to perpetual instability and uncertainty among housing providers in NYC. Finally, patients who present to the emergency department for treatment and who are discharged directly to the community may be experiencing barriers to appropriate and relevant community care. In 2015 there were over

75,000 such visits that resulted in discharge directly to community care<sup>3</sup>. These ED visits are costly and potentially preventable.

Demand remains high for NYC Well, the City's 24/7 behavioral health crisis counseling, peer support, information and referral service. NYC Well answered over 263,642 calls, texts and chats in calendar year 2019. While the NYC Well contact center is supporting many individuals, those who require referral are likely to be met with long waitlists at understaffed clinics, particularly clinics serving low income New Yorkers.

In 2017, the most recent year for which data are available, there was a significant average annual increase of 1% in the overall suicide rate over the past 10 years (6.3 per 100,00 in 2017). Individuals ages 45-64 continue to have the highest rate of suicide deaths (9.9 per 100,000 in 2017). Overall, the suicide rate of White New Yorkers continues to be higher compared to the suicide rate of individuals from other racial/ethnic backgrounds (9.2 per 100,000 in 2017). There was a significant increase in suicide rates in the past 10 years for Blacks (4% average annual increase), and Whites (2% average annual increase).

Furthermore, the direct and indirect psychological and mental health consequences of the COVID-19 pandemic are profound. While behavioral health-related emergency department (ED) visits have been lower than 2019 levels during the same time period, more New Yorkers have reported symptoms of anxiety, depression, and financial stress due to circumstances resulting from the coronavirus.

### **Substance Use Disorder Needs:**

In 2018, there were 1,444 unintentional drug overdose deaths in NYC, a reduction of 38 deaths from 2017. While we are heartened by the reduction in overdose deaths, the number of drug overdoses in NYC remains at epidemic levels as fentanyl – a highly potent synthetic opioid – continues to be present in the illicit drug supply.<sup>4</sup> For the second consecutive year, fentanyl was the most common drug involved in overdose deaths in NYC. In 2018, fentanyl was involved in 60% of all drug overdose deaths.<sup>4</sup>

Although the rate of drug overdose death decreased from 2017 to 2018, decreases were not evenly distributed by demography or geography. From 2017 to 2018, overdose deaths increased among residents of the Bronx, Staten Island, and Manhattan, and decreased among residents of Brooklyn and Queens.<sup>4</sup> By race/ethnicity, the rate of overdose death increased 5% among Latinx New Yorkers, and for the first time since prior to 2000, Latinx New Yorkers had the highest rate of overdose death<sup>4</sup>. In contrast, the rate of drug overdose decreased 5% among White New Yorkers and decreased by 13% among Black New Yorkers during this time period.<sup>4</sup> Finally, the rate of overdose death also increased among women and older New Yorkers ages 55 to 84 from 2017 to 2018.<sup>4</sup>

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<sup>3</sup> Protacio A, Norman C. Mental Health Emergency Department Visits among New York City Adults, 2015. New York City Department of Health and Mental Hygiene: Epi Data Brief (107); November 2018.

<sup>4</sup> Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019.

Significant geographic disparities persist in the burden of drug overdose death. By neighborhood of residence, East Harlem residents had the highest rate of fatal drug overdose in 2018 at 56.1 per 100,000, followed by residents of Crotona-Tremont and Hunts Point-Mott Haven (49.5 and 49.2 per 100,000, respectively).<sup>4</sup> Rates of fatal drug overdose among residents of these three neighborhoods were more than double the citywide rate of 20.5 per 100,000.<sup>4</sup>

### **Developmental Disabilities Needs:**

Stakeholders across NYC report that for the past 12 months, improvements have been observed in some areas of the service system, while there is worsening in other areas. Specifically, improvements are noted in well-placed transportation initiatives and improvements in front door access during the COVID-19 pandemic. The service system's transition from the Medicaid Service Coordination (MSC) program to Health Home Care Management through Care Coordination Organizations (CCOs) continues to unfold and presents with a number of issues; in particular, there are ongoing staffing concerns and administrative issues (assignment of a Care Coordinator, being connected to services, and responsiveness to appeals) that result in service delays, disruptions, and general dissatisfaction. Other areas that contribute to the quality and availability of care and an overall worsening of the level of unmet I/DD service needs in all major service areas over the past 12 months include many issues that were included in the 2020 Local Services Plan, namely workforce recruitment and retention owing to ongoing inadequate wages and other supports for Direct Services Professionals which lead to staff turnover and recruitment challenges; financial challenges and long-term planning and sustainability for specialized DD clinics; services transitions at all levels; increasing numbers of individuals and families who outpace available services; inadequate supports and services to address the emerging needs of aging individuals with I/DD and aging family caregivers; general workforce recruitment, retention, and NYC advancement issues; and the need for greater integration of health and medical services with other supports.

Though its impact did not emerge until early March 2020, the COVID-19 pandemic importantly contextualizes 2021 local services planning for New Yorkers with I/DD. The impact of the health crises is still unfolding, and we do not have sufficient data to quantify changes in the level of unmet needs for New Yorkers with I/DD. To assess system needs changes over the past twelve months the NYC Health Department engaged informed stakeholders including the NYC Regional Office of OPWDD, the five borough DD Councils, Community Services Board DD Subcommittee members, Borough Advisory Councils, people with I/DD, providers, families and family advocates representing the five NYC boroughs. Stakeholders helped identify local needs that inform the local services plan for individuals with I/DD in NYC and their families.

The advent of the recent health pandemic exacerbates concerns for this especially vulnerable population, many of whom have underlying health conditions, live in congregate settings and require personal assistance. This points to a need to emphasize and enhance CCO, Front Door, and respite services in NYC.

# Housing

## **Housing Background Information:**

According to data and community stakeholder input, the most pressing issue to address is the lack of accessible and affordable housing options for individuals with serious mental illness, substance use disorder, and intellectual/developmental disabilities (I/DD) who are chronically homeless. Without quality, affordable housing for people with mental illness, substance use disorders, and or intellectual/developmental disabilities, we will continue to see significant homelessness and poor outcomes for these populations.

In fiscal year 2019 (July 2018 to June 2019), over 68,476 unique men, women, and children slept in New York City shelters.<sup>5</sup> Approximately one quarter of New Yorkers with depression received rental assistance or lived in public housing in 2018. Based on a survey of psychiatric hospital inpatients, just under one fifth of psychiatric inpatients reported being homeless or unstably housed prior to hospitalization; a similar proportion continued to be homeless or unstably housed 3-5 months post-discharge.<sup>6</sup>

In addition to chronic homelessness among individuals with psychiatric conditions, accessible housing continues to be an unmet need among individuals with intellectual/developmental disabilities. There are a significant number of individuals with I/DD who are in need of, and are awaiting, residential placement in NYC. In addition, many individuals with I/DD reside with aging and medically involved caregivers. Accessible housing options should be available to individuals with I/DD who want to live more independently and/or are in need of varying levels of support. Housing options are particularly needed for individuals with I/DD and serious physical and behavioral challenges, individuals with I/DD in crisis, individuals with I/DD who have additional medical needs, and aging individuals with I/DD.

Evidence has shown that more than any medical intervention, supportive housing keeps people safe and healthy, particularly individuals burdened with mental illness, substance use disorders, and/or I/DD. Despite the relationship between mental health and housing, there remains a lack of affordable housing specifically for these populations. Supportive housing funding, including all NY/NY initiatives (I, II, and III), are unable to keep up with NYC rental costs, and rent in NYC has outpaced contractual budgets. While NYC 15/15 and NY/NY III units continue to be awarded and developed, providers have expressed difficulty finding affordable units for scattered site housing for NYC 15/15.

## **The Impact of COVID-19 on Housing:**

The COVID-19 pandemic and its aftermath are expected to further strain the system of services and call for additional residential supports; this will be true for individuals who reside in congregate settings as well as for those residing in the community (some of whom may face the illness or death of care providers). Residents of congregate care settings in particular are at higher risk due to proximity and shared public spaces, so the NYC DOHMH has been working to support providers in establishing safe practices.

<sup>5</sup> NYC Department of Homeless Services <https://www1.nyc.gov/site/dhs/about/stats-and-reports.page>

<sup>6</sup> MHNAS 2018



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**Goal:** Increase access to stable housing for those with serious mental illness, substance use issues, and intellectual/developmental disabilities.

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1. Advocate for rate increases in supportive housing in line with the housing market in New York City, including a yearly escalator to account for increases in the housing market.
2. Increase access to new and existing community-based housing units for people with developmental disabilities, including those who need 24-hour nursing services.
3. Develop residential options to support persons with urgent needs or in need of Crisis Services.
4. Increase residential options for people with developmental disabilities who have aged out of Out-of-State Placements, but who need enhanced residential support.
5. Increase options for people with I/DD living in certified settings who are aging and developing complex medical conditions to age in place if desired and assessed as appropriate.
6. Increase the number of individuals who are currently served in 24-hour supervised residences and who are evaluated by their agency for placement in less restrictive settings (e.g. supported IRA, Family Care, Individualized Support Services (ISS) and Self-Directed Services (SDS)).
7. Increase the number of accessible homes or modifications of existing homes, developed by agencies that allow individuals to age in place.
8. Increase residential development with innovative support (i.e. Apartment Sharing, Home Sharing, and Family Care).
9. Support and participate in congregate contact tracing
10. Help providers implement strategies for isolation and social distancing

## Crisis Services

### Crisis Services Background Information

In 2015, 68% of mental health-related emergency department (ED) visits in New York City did not result in admission to the hospital.<sup>7</sup> In addition, 19% of inpatient psychiatric hospitalizations were for 3 days or less.<sup>8</sup> These data indicate that more crisis respite and outpatient treatment services are needed to promote diversion from EDs, in addition to immediate care without the need for hospitalization. These services are particularly needed in neighborhoods with high poverty, which are shown to have the highest rates of ED visits that do not result in admission.<sup>9</sup> However, data from the NYC Mental Health Needs Assessment Survey (NYC MHNAS) conducted from 2013-2014 shows that many psychiatric inpatients are not aware of outpatient services that can be used in place of hospitalizations.<sup>10</sup>

In light of this evidence, New York City has increased its provision of crisis response services in the past year. New York City's NYC Crisis Prevention and Response Task Force, composed of over 80 experts including advocates, city agency leadership, and community stakeholders with lived experience, recommended ways to improve and fill gaps in the City's Crisis Response System. In response to this taskforce's recommendations, New York City allocated additional funding to expand and enhance Mobile Crisis Teams to ensure rapid response to urgent mental health situations. This expansion will bring average response time down to two hours citywide, provide overnight responses, and extend services to include substance-use only crises. Finally, we've seen a 57 percent increase in our capacity to provide Intensive Mobile Treatment to individuals with the highest mental health needs and who may be poorly served by traditional treatment models (from the current capacity of 189 up to 297).

Adult Mobile Crisis Teams (MCTs) defuse behavioral and mental health crisis situations and link adults to community services as an alternative to ED use and hospitalization. MCTs receive approximately 21,000 referrals annually. Based on current state requirements, Adult MCTs have up to 48 hours to respond to referrals. With enhanced response times, MCTs will be able to better meet the needs of New York City adults and prevent emergency room use and hospitalization.

Similarly, dedicated Children's Mobile Crisis teams (CMCTs) defuse behavioral and mental health crisis situations and link children and their families to community services as an alternative to ED use and hospitalization. CMCTs citywide receive over 1,500 referrals annually. Performance data collected to assess and review service utilization show an increase in children and youth receiving CMCT services beginning in FY17. The CMCTs report that the youth/families referred for crisis intervention have multiple stressors, and many families do not have community supports in place prior to the intervention. In response to the demand for crisis services, the NYC DOHMH has received additional City funding to address the need beginning in FY21. CMCTs will be increasing in size to address the growing demand for crisis services

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<sup>7</sup> SPARCS 2015 Data

<sup>8</sup> SPARCS 2014 Data

<sup>9</sup> SPARCS 2015 Data

<sup>10</sup> MHNAS 2013-2014

with an additional two teams per borough. In addition, CMCTs will begin serving youth aged 18-20 with substance use needs.

These Mobile Crisis Teams are also important when people who use drugs experience crisis events and encounter law enforcement. Law enforcement responses to crisis events involving people who use drugs continue to be a large driver of potentially avoidable criminal justice interactions and hospital ED use. Several initiatives have sought to reduce costs while simultaneously improving client outcomes, including front-end diversion stabilization services, specialized law enforcement responses (such as Crisis Intervention Training (CIT)), and Co-Response teams. These purposeful structuring of law enforcement and mental health responses to crisis calls can improve client outcomes and save valuable resources. However, there is still considerable need for non-law enforcement and/or non-criminal justice responses when people who use drugs experience crises or behavioral health events. Preliminary evaluation of existing pre-arrest diversion programs suggests expanding eligibility criteria would increase access to those who may need services most.

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**Goal:** Improve outcomes for people experiencing mental health and drug related crises.

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1. Enhance the current crisis system to ensure individuals in crisis receive rapid services by coordinating with providers, payers, and state partners and allocating resources to better meet community needs.
2. Provide ongoing behavioral health treatment that is responsive to people experiencing complex life situations, including crisis; supports recovery from mental illness and substance misuse; maximizes continuity of care; reduces the recurrence of crisis; and decreases intersections with law enforcement.
3. Expand eligibility criteria for existing pre-arrest diversion programs.
4. Open remaining Support and Connection Center to provide NYPD a health-focused alternative to avoidable emergency room visits or criminal justice intervention.
5. Continue to utilize the Co-Response Team (CRT) to improve law enforcement's response to persons identified as presenting with elevated risk of harm to self and/or others in the community with the aim of connecting them to services.
6. Continue to work with the Crisis Taskforce, comprised of citywide partners, to implement approved recommendations to improve the City's response to those experiencing emotionally distress.
7. Continue to train NYPD Officers in Crisis Intervention Team (CIT) Training to better manage crisis and increase diversion. Prioritize trainings for NYPD members working on collaborative efforts, such as the Support and Connection Centers and Co-Response Teams.
8. Enhance services delivery of the children's mobile crisis teams by providing services to older youth, ages 18-20, addressing crises that involve substance use, and establishing overnight response.

## Workforce Recruitment and Retention (Service System)

### **Workforce Recruitment and Retention Background Information:**

The NYC DOHMH and partner entities have conducted a number of surveys to assess the barriers to recruiting and retaining a robust behavioral health workforce in New York City. Between 2016-2018, workforce surveys conducted by the New York State Care Management Coalition, Community Health Care Collaborative in NYC, and the NYC Regional Planning Consortium (RPC) assessed turnover among care management staff across New York State. In January 2019, we worked with OMH to survey OMH licensed clinics regarding difficulties in the recruitment and retention of their workforce. In addition, community input has consistently touted the value of peer support specialists as an integral component of the behavioral health workforce in New York City, due to their unique position to engage and support clients burdened with mental illness, substance use disorder, and intellectual/developmental disabilities.

According to the workforce surveys conducted from 2016-2018, there is a 55% turnover rate among care management staff both in New York City and across the state. Results showed a variety of reasons for this high turnover rate, including heavy caseloads, burdensome documentation, and the inability of community-based organizations to offer higher wages and benefits compared to what state-operated facilities, healthcare systems, and managed care organizations offer for similar jobs. According to the NYS Care Management Coalition, 52% of care management agencies surveyed also experienced challenges in recruitment due to the demanding nature of the job and educational qualifications expected. Nearly 31% stated that when qualified applicants are found, they are uninterested in pursuing a career in care management due to the low wages and benefits.

Similar results were shown in the citywide survey for OMH licensed clinics, conducted by the NYC DOHMH in conjunction with the OMH Field Office in 2019. This survey included questions around recruitment and retention difficulties, their capacity to serve the community, and questions specific to clinics serving children five and under. The survey had a 69.2% response rate. The preliminary results of the first category of questions, recruitment and retention difficulties, show that:

- “Salary is not competitive” is the most persistent reason for both recruitment and retention difficulty.
- The most difficult title to both recruit and retain was reported to be Child Psychiatrist.
- Other titles difficult to recruit include Psychiatrist (Adult and Geriatric), Psychologists, Nurse Practitioners, Physician Assistants, Licensed Clinical Social Workers (LCSW), and Peer Specialists.
- When asked which two titles had the most impact on the operations of the clinic when there was recruitment or retention difficulties, respondents chose LCSW, Adult Psychiatrist and Child Psychiatrist. Respondents chose the same titles when asked which titles had the most impact on the clinic’s ability to serve the community.
- Clinics reported the most difficulty recruiting or retaining bilingual clinicians who spoke Spanish, Chinese, and Bengali.

The NYC DOHMH solicited feedback from its Community Services Board (CSB) and CSB Mental Health Subcommittee about ways to address the workforce challenges identified in the 2019 survey. Feedback overwhelmingly centered on lack of reimbursement parity, low pay, provider burnout, and the inability of provider agencies to provide professional development and employee support due to employee time nearly entirely dedicated to service delivery. Moreover, in gathering feedback from community members, the NYC DOHMH repeatedly hears about long waitlists and high costs for care because providers infrequently accept insurance, and have shifted to cash-only models. This problem is particularly significant for low-income individuals in New York City.

Hiring and employing peer support specialists as a part of the behavioral health workforce is an effective strategy for promoting a robust and diverse behavioral health workforce that meets the mental and behavioral health needs of New Yorkers. For example, peer support specialists with lived experiences related to substance use disorder are effective in engaging people who are at high risk of overdose or engage in risky substance use. Peers are effective at providing tailored and sensitive information to individuals during vulnerable periods in their life, and can effectively educate people who use alcohol and other substances about risk reduction and treatment options. Treatment providers and other organizations who work with people who use drugs frequently identify a need for peers, as well as request assistance with incorporating peers into workflows and support with ongoing peer training and career advancement. The NYC DOHMH has implemented Peer Corps, which provides training and support to 20 peer Americorps members and works with host sites to integrate peers into workflows. In addition, the NYC DOHMH provides technical assistance on recovery peer integration to treatment providers in order to promote sustainable positions and services.

Similarly, peer support specialists with lived experiences related to caring for children with behavioral health challenges are particularly effective. Their lived experience allows them to build trusting relationships with parents and empower them to become more actively engaged in their children's services.<sup>11</sup> The benefits of peer-provided support for parents of children with emotional and behavioral challenges include increased hopefulness, improvements in caregiver self-care, empowerment when dealing with family issues and children's services, reduced maternal anxiety, improved activation in seeking care, and higher rates of service initiation. In addition to providing much-needed support for parents and caretakers, Family and Youth Peer Support (FYPS) Services support and empower children and youth who are experiencing social, emotional, developmental, and/or behavioral challenges, including substance misuse. Family support services can be adapted to the needs of different families and help them enter the mental health service system; as such, these services may be especially helpful for families who have avoided mental health services because of stigma or cultural issues.

Maintaining a well trained, ready, and culturally competent workforce is essential to providing quality services and supports for individuals with mental illness, substance use disorder, and intellectual/developmental disabilities, and their families and caretakers. This can be accomplished by promoting and ensuring continuing education programs for all levels of staff,

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<sup>11</sup> Alegría, M., Polo, A., Gao, S., Santana, L., Rothstein, D., Jiménez, A., Normand, S.-L. T. (2008). Evaluation of a patient activation and empowerment intervention in mental health care. *Medical Care*, 46(3), 247-256

adequate supervision, career planning and professional development support, retention incentives, adequate compensation, and providing opportunities for students and young people to learn about the field.

**The Impact of COVID-19 on Workforce Recruitment and Retention:**

The COVID-19 pandemic presents with increased likelihood that staffing challenges will be aggravated. As a result, there is a need for greater emphasis on this already burdened area of need. However, innovative technological strategies for engaging hard-to-reach clients have emerged due to the necessities of social distancing. The COVID-19 pandemic has forced providers to move from providing face-to-face appointments to quickly moving to providing services almost exclusively via phone and video. Both providers and clients have reported that the flexibility of telehealth services have provided has increased client satisfaction and their ability to seek and maintain regular services. In fact, providers have reported more kept appointments than face-to-face appointments in the past. Telehealth services allows engagement with individuals that the mental and behavioral health service system has previously not been able to engage fully in treatment. It will be critical for the behavioral health workforce to fully integrate telehealth services into their practice during the COVID-19 pandemic and beyond.

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**Goal:** Increase recruitment and retention rates of behavioral health professionals in NYC.

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1. Continue to enhance and promote the Peer and Community Health Workforce toolkit to assist service providers with successful integration of peers.
2. Collaborate with Regional Planning Consortium (RPC) stakeholders to reduce the workforce turnover rate among care management and behavioral health providers in NYC.
3. Increase cultural diversity training opportunities for health care professionals and other providers to enhance staff sensitivity to the cultural background of the individuals served, including understanding how to address the complex needs of individuals with developmental disabilities and are approaching or have reached advanced ages/human life expectancy.
4. Increase the number of professional training opportunities for direct support staff, including those working in family homes, respite care programs, and recreational programs, and Care Managers, and opportunities to include an increase in the number of agencies with established mentoring programs to provide one-on-one support to newer direct care staff.
5. Create opportunities for direct care staff, managers, Care Managers and other staff that provide skills training, leadership development and supervision through partnerships with CUNY or SUNY.
6. Encourage and support efforts to attract private sector professionals for not-for-profit positions that serve individuals with developmental disabilities.
7. Maintain, expand, and launch new initiatives to integrate evidence-based practices, recruit peers, support workforce development and advancement opportunities for peers, and work with employers to better integrate peer workers into workflows.

8. Continue to work with CUCS's Academy for Justice Informed Practice to train 3,300 legal, law enforcement, and healthcare professionals on the intersection of health and criminal justice
9. Advocate for increases in funding for nonprofits in the human service sector to allow for better recruitment and retention of BH providers and better continuity of care.
10. Identify ways to allow providers to continue practicing telehealth services post- COVID-19 pandemic.

## Prevention

### **Prevention Background Information:**

Preventing mental health and substance use issues before they interfere with New Yorker's lives is the surest way to improve mental wellbeing and reduce the impact of mental illness and substance use on the City as a whole. The NYC DOHMH is focused on mitigating the effects of first-episode psychosis, reducing rates of suicide and suicide-related emergency department (ED) visits, and addressing alcohol and substance use among New York City youth and adolescents.

The NYC Health Department estimates that approximately 2,000 new cases of psychotic illness develop each year in New York. A recent study showed that people experiencing first episode psychosis have much higher mortality rates than the general population, particularly within the first 12 months of diagnosis.<sup>12</sup> However, early identification and intervention can significantly reduce the duration and impact of psychosis.<sup>13</sup> In response, New York City has implemented a first-episode psychosis engagement and connection to treatment program, NYC Supportive Transition and Recovery Team (NYC START), which aims to engage people as early as possible after diagnosis. NYC START connected 91.3% of those participating in the program in 2019 to outpatient mental health services, and 87.1% were connected to care in the first 30 days following discharge from a hospital. NYC START amended the health code to include mandated reporting starting at age 16 effective January 2019 in order to reach younger people presenting for care after an episode of psychosis.

In addition to mitigating the impact of first-episode psychosis among New Yorkers, preventing suicide is also a significant area of concern. Though suicide rates in New York City are lower than overall rates across New York State and the United States, the total number of lives lost remains high due to population density. According to Vital Statistics, there were 565 suicides in NYC (551 adults; 14 youth) in 2017. Males, non-Latino Whites, and adults ages 45-64 had the highest rates of suicides. The rate of suicide among males was nearly three times that of females (9.6 per 100,000 compared to 3.4 per 100,000). However, the rate of suicide among females increased approximately 4% annually between 2008 to 2017; no significant change among males was observed. Non-Latino Whites had a suicide rate of 9.2 per 100,000 compared to 5.3 for Blacks, 4.3 for Latinos, and 4.7 for Asian/Pacific Islanders.<sup>14</sup> In addition to suicide deaths, there were approximately 40,000 suicide-related emergency department visits to NYC hospitals in 2019. These visits were for suicidal ideation, intentional self-harm, and suicide attempts. The majority (59%) of visits were made by males. Approximately 28% of visits were made by individuals less than 25 years old.<sup>15</sup>

<sup>12</sup> Schoenbaum, M., Sutherland, J., Chappel, A., Azrin, S., Goldstein, A., Rupp, A., Heinssen, R. Twelve-Month Health Care Use and Mortality in Commercially Insured Young People with Incident Psychosis in the United States. *Schizophrenia Bulletin*, April 6, 2017.

<sup>13</sup> Heinssen RK, Goldstein AB, Azrin ST. Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care. National Institute of Mental Health; 2014.

<sup>14</sup> 2017 Vital Signs Report

<sup>15</sup> Capua J, Blachman-Forshay J, Mello E, Nolan ML, Paone D. Drug Use among Youth in New York City Public High Schools, by Sexual Orientation and Gender Identity, 2015. New York City Department of Health and Mental Hygiene: Epi Data Brief (92); June 2017.



Due to the circumstances resulting from the COVID-19 pandemic, suicide may become a more pressing concern as the pandemic spreads and has longer-term effects. While there was not a clear link between the 2008 recession and an increase in suicide, it is possible that the combination of provider burnout, weakened health infrastructure, economic insecurity and changes in business cycles, job loss or unemployment, and loss of social connection may be associated with increased risk of suicide during and after the COVID-19 pandemic. Historically, there is some evidence that deaths by suicide increased in the United States during the 1918–19 influenza pandemic and among older people in Hong Kong during the 2003 severe acute respiratory syndrome (SARS) epidemic. Therefore, efforts to engage individuals at highest risk for suicide will need to be increased as the aftereffects of the pandemic becomes clear. The NYC DOHMH is working to address suicide risk through NYC Well, its crisis contact center, as well as by increasing access to mobile crisis and mobile treatment teams. Furthermore, the NYC DOHMH uses surveillance data to identify and locally respond to trends in suicide-related ED visits.

The NYC DOHMH’s prevention strategy is also focused on addressing alcohol and substance use among youth and adolescents. In 2015, 21 percent of surveyed New York City public high school students had >1 alcoholic drink in the 30 days prior to being surveyed, a decrease from 25% in 2013.<sup>15</sup> Among youth who reported drinking in 2015, 44% reported binge drinking at least once during the past month.<sup>16</sup> In 2017, 9% of NYC youth in public high schools reported ever having used an illicit drug in their lifetime, including cocaine, heroin, ecstasy, and synthetic cannabinoids. The prevalence of substance use among New York City youth differs by demographic group. The 2017 New York City Youth Risk Behavior Survey found that 10 percent of Latinx and 9 percent of White public high school students reported ever using (also known as “lifetime use”) any illicit drug, compared with 7 percent of Black and 5 percent of Asian students in NYC public high schools.<sup>17</sup> Male students reported significantly higher levels of both lifetime illicit drug use and past-year non-medical prescription drug misuse than female students.

LGBTQ+ youth are especially at risk for alcohol and substance use. In 2015, a total of 16 percent of students who identified as lesbian, gay, or bisexual, and 17 percent of students who identified as questioning their sexual orientation, reported ever using illicit drugs. This is two times higher than their straight counterparts (8 percent). Differences were also seen by gender identity, where 37 percent of transgender students in NYC public high schools reported ever using illicit drugs in 2015 compared with 8% of students who do not identify as transgender.<sup>18</sup>

### **Considerations for Racial Equity in Prevention**

Strategies for preventing mental health and substance use issues must account not only for the evidence-based interventions and services that our communities need, but also for their cultural

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<sup>16</sup> Blachman-Forshay J, Mello E, Capua J, Tuazon E, Paone D. Alcohol Consumption among Youth in New York City Public High Schools, by Sexual Orientation and Gender Identity, 2015. New York City Department of Health and Mental Hygiene: Epi Data Brief(94); Nov 2017.

<sup>17</sup> Ko C, Tuazon E, Paone D. Illicit Drug Use and Prescription Drug Misuse among Youth in New York City Public High Schools, 2017. New York City Department of Health and Mental Hygiene: Epi Data Brief (120); November 2019.

<sup>18</sup> Blachman-Forshay J, Mello E, Capua J, Tuazon E, Paone D. Alcohol Consumption among Youth in New York City Public High Schools, by Sexual Orientation and Gender Identity, 2015. New York City Department of Health and Mental Hygiene: Epi Data Brief(94); Nov 2017.

and linguistic needs. These strategies must also name and seek to undo structural racism. Our CSB Mental Health Subcommittee has reported that there are variations in how different racial and ethnic groups view mental health, substance use, and accessing treatment, as well as how they might be treated while accessing services. Additionally, we recognize there are important variations within particular groups, such as Asian Americans. This Subcommittee has also reported that the lack of workforce that is representative of the community it serves is a barrier to engagement and care.

The NYC DOHMH recognizes that preventative and treatment services are only effective when they reach those they are intended to benefit. When they are not in the languages of our communities, or the translations are ineffective at conveying the correct message, and when communications about our services do not take into consideration cultural beliefs about mental illness and substance use, our services will not reach those who truly need them. Therefore, the NYC DOHMH will promote language access in our prevention strategy, and is committed to building a behavioral health workforce that is representative of the communities in which they serve.

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**Goal:** Address key risk factors across the lifespan for mental health issues through comprehensive prevention strategies to prevent or reduce mental health and substance use issues.

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1. Continue to support 14 Community Based Organizations (CBOs) and their dedicated Mental Health Provider partners to build their ability to adopt and adapt task-sharing mental health skills among CBOs by enabling them to implement core skills and strategies, including motivational interviewing, Mental Health First Aid, screening, psychoeducation, and quality improvement.
2. Engage survivors of trauma regarding the importance of trauma-informed approaches and partner with them to increase awareness through education and advocacy.
3. Conduct public awareness campaigns, and targeted and broad outreach to prescribers to educate on preventing future cases of opioid addiction as well as on overdose prevention, including use and co-prescribing of naloxone.
4. Reduce misuse of alcohol and drugs among youth, especially among LGBTQ+ young people, by launching media literacy curricula designed to equip youth with critical thinking and analytic skills and continuing to provide technical assistance to community coalitions working to create more affirming environments for LGBTQ youth.
5. Utilize and expand the Health Engagement and Assessment Teams (HEAT) to increase direct community engagement to meet the behavioral health, physical health, social service needs of individuals residing in communities with the high rates of COVID-19 morbidity and mortality, behavioral health crises, and overdose mortality.
6. Work with contracted providers to launch new training center that offers trainings in evidence-based parenting and family support models to staff in community-based and clinical settings to expand the reach and availability of supports to families that promote secure attachment and positive mental health among children and adolescents.

7. Launch new networks of community-based family and youth peer support programs in each borough for parents/caregivers of children and youth (birth – age 24), who are experiencing social, emotional, developmental, behavioral, and/or substance use challenges, and for the youth themselves.
8. Maintain high percent of NYC START participants who attend mental health services, including Coordinated Specialty Care, following hospitalization for first episode psychosis.
9. Advocate for continued steps to address workforce shortages, especially shortages in communities of color, in order to increase cultural competency among mental health workers and their capacity for culturally appropriate mental health care in communities of color.
10. Develop and implement a citywide suicide prevention strategy that accounts for the unique needs of communities and social groups disproportionately impacted by suicide and suicidal behaviors and populations that have been disproportionately impacted by the COVID-19 pandemic. Use established suicide surveillance protocol for identification and response to increases in suicide related emergency department visits and suicide deaths as one component of pandemic response and suicide prevention planning.

## Reducing Stigma

### **Reducing Stigma Background Information:**

Numerous stakeholders representing a wide range of NYC communities have identified stigma as a significant barrier to accessing services, care, and treatment for people with mental disorders, people who use drugs, people with substance use disorders, or people with co-occurring substance use/mental health disorders. The emphasis on stigma is supported by results of the NYC Health Opinion Poll, conducted by the NYC DOHMH between April and May 2019. According to the NYC Health Opinion Poll, 64.0% of citywide respondents agreed or strongly agreed that people with mental illness are more dangerous or violent than the average person; 50.0% agreed or strongly agreed that a person who has a mental illness is less trustworthy than the average person; 29.4% agreed or strongly agreed that they think less of a person who has a mental illness; and 23.0% agreed or strongly agreed that having a mental illness is a sign of personal failure.

In the light of these Health Opinion Poll results, the NYC DOHMH recognizes that increased community engagement and education is critical for raising awareness of and reducing stigma around mental and substance abuse disorders. In particular, stakeholders in our Regional Planning Consortium (RPC) have expressed that faith-based organizations and community-based organizations specifically addressing social determinants of health could play an impactful role in raising awareness about mental illness and substance use issues.

### **The Impact of COVID-19 on Reducing Stigma**

While the COVID-19 pandemic has largely made a negative impact in the health infrastructure of New York City, clients and providers have reported a silver lining in the impact of telehealth on reducing stigma. Clients have reported that telehealth services have allowed them to feel less stigma and fear around reporting mental health issues to a provider. Continuing to allow telehealth services to occur will allow the mental health system to engage individuals they haven't been able to engage in services in the past, including individuals that face stigma associated with mental health issues due to their cultural background.

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**Goal:** Increase awareness of behavioral health conditions.

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1. Expand outreach to underserved and hard to serve communities via highly skilled trainers representing those communities to address mental health related stigma and trauma.
2. Implement the Clergy Clinician Community Collaboration (4Cs) and the Reclaiming Our Health (ROH) initiatives, (formerly known as Community Partners in Care (CPIC)), to promote mental health awareness and prevention through technical assistance, skills building support, guidance and collaborative planning. Efforts are guided by community engagement, quality improvement and task sharing approaches to address gaps in providers' cultural competency, community traditional beliefs, and stigma.
3. Deliver ongoing presentations from the behavioral health peer perspective to behavioral health community stakeholders and educational institutions.

4. Develop and conduct public awareness and education campaigns to reduce stigma toward people who use drugs, drug use, and drug treatment.
5. Continue to educate healthcare and other service providers on the health risks of criminal justice system involvement and how they can best support their justice involved patients/clients using a trauma-and-resilience-informed approach.
6. Continue to utilize the Health Engagement and Assessment Teams (HEAT) team to reduce the stigma around mental health, substance use, and the criminal justice system.
7. Develop an agency-wide action plan that outlines the health impact of the criminal justice system and its impact and identify opportunities to facilitate improvements.
8. Advocate with the State to allow providers to continue to bill for telehealth services post pandemic.

## Employment/Job Opportunities

### **Employment/Job Opportunities Background Information:**

Unemployment rates among people with mental illness, substance use disorders, and intellectual/developmental disabilities remain high. 71 percent of individuals with SMI were looking for full-time work in 2012.<sup>19</sup> Individuals with developmental disabilities in particular have limited options for employment and for developing on-the-job employment skills. In 2018, approximately 59% of New Yorkers with depression were unemployed or not in the labor force.<sup>20</sup> Individuals with developmental disabilities in particular have limited options for employment and for developing on-the-job employment skills. Despite high rates of unemployment, providers struggle placing and supporting people with SMI due to a lack of knowledge about existing services. Both providers and consumers need information on employment services and their impact on benefits.

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**Goal:** Increase employment opportunities and reduce employment disparity for individuals with serious mental illness, substance use disorder, and/or intellectual/developmental disabilities.

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1. Host a minimum of two annual conferences that provide professional development opportunities for the NYC peer specialist workforce.
2. Engage stakeholders through existing meetings and phone based technical assistance to assist them in hiring peer specialists.
3. Increase and vary employment opportunities to increase the number of people with developmental disabilities who are employed so that employment is person-centered and customized. Efforts may include promotional events such as career fairs and collaborative efforts with OPWDD DDROs, local Chambers of Commerce and other local partners, including not-for-profit entities.
4. Ensure that individuals who are not able to be employed PT or FT have adequate resources and options, including integrated supported day opportunities.
5. Explain benefits and maintain classifications (e.g., SSI, MA) even when the individual in question is employed/employable.
6. Through local contracting with vocational support service providers in all 5 boroughs, increase the number of individuals with I/DD (who are not eligible for OPWDD employment support services) who are successfully employed.
7. Maintain and expand the HJN and Health Engagement and Assessment Team (HEAT) to increase employment opportunities for individuals with justice system involvement and continue to improve community health worker integration into their home organizations.
8. Develop foundational education for healthcare hiring staff about (1) the criminal justice process and (2) common guidance on criminal background disclosure.

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<sup>19</sup> CMHS 2012

<sup>20</sup> CHS 2018

9. Engage re-entry organizations to assist in educating potential job applicants with criminal records about requirements and hiring processes of hospital employers.

## Mental Health Care Coordination

### **Mental Health Care Coordination Background Information:**

The NYC DOHMH aims to identify ways to ensure that children and youth with the highest mental health needs receive effective care coordination, especially those not fully achieved through the existing care management programs such as Health Homes Serving Children and Children’s Non-Medicaid Care Coordination. The NYC DOHMH, in partnership with OMH and NYC stakeholders, is conducting a demonstration project to implement and evaluate High Fidelity Wraparound (HFW), an intensive, individualized planning and management process for children and youth with serious social, emotional or behavioral concerns who are involved in multiple systems. Specifically, HFW is an evidence-based model of care coordination that, when practiced to fidelity, improves outcomes and lowers rates of hospitalization and residential treatment for youth with serious mental health needs and who are also involved in the child welfare, juvenile justice, or special education systems.

Since the start of the HFW demonstration project in 2019, the two HFW teams serving youth and their families in Brooklyn and the Bronx have enrolled and served a total of 22 youth. The two teams have the capacity to continue to serve approximately a total of 20 youth and their families annually. With NYC’s continued participation with other select NY State pilot counties, we aim to also (1) test newly developed training, coaching, supervision and workforce credentialing required for individuals to practice this model to fidelity, (2) identify and implement a standardized system for data collection and reporting that future providers would need in order to implement and bill for this model, (3) identify sustainable payment methods of this model to ensure service is fiscally viable and (4) demonstrate cost effectiveness.

Additionally, demonstrated need to improve systems and practices to reduce hospitalization and Residential Treatment Facility (RTF) placement among youth may be met by the HFW model that has been shown to lower rates of hospitalization and residential treatment. NYS is undertaking a complementary effort to reduce use of residential treatment and help children to transition successfully back to the community upon discharge. A 2019 workgroup convened by the NYS Coalition for Children’s Behavioral Health recommended High Fidelity Wraparound (HFW) to avert the need for RTFs and assist families in addressing barriers to a child’s return to the community upon discharge.<sup>21</sup> NYC Health Department is further exploring how the current demonstration project can be expanded to focus on youth who have been referred to or recently discharged from a RTF.<sup>22</sup>

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**Goal:** Improve mental health care coordination and cross system collaboration needed to serve children and youth with the highest mental health needs.

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<sup>21</sup> Reforming NYS OMH Residential Treatment Facilities by the NYS Coalition for Children’s Behavioral Health.

<sup>22</sup> These provide comprehensive mental health treatment in a residential setting for youth requiring longer-term care than an inpatient hospital setting can provide, with stays that exceed 180 days



1. Implement and evaluate High Fidelity Wraparound (HFW) in NYC for 20 children and their families, through a demonstration project.
2. Develop network of organizations servicing children of incarcerated parents to connect to necessary mental health, physical health, and other support services.

## Recovery and Support Services

### **Recovery and Support Services Background Information:**

Recovery and support services in NYC have expanded, but New Yorkers would benefit from additional services in this area. Almost 70% of New Yorkers with SMI reported needing some or a lot of help meeting people for social support. NYC Well, which launched October 2016, provides City-funded support: about 15% of people calling, texting, or chatting are choosing to connect with a peer specialist<sup>23</sup>.

Recovery and support services are especially critical for people who use drugs, particularly among communities that are at higher risk for overdose deaths. After seven consecutive years of increasing overdose deaths, the number and rate of overdose deaths finally decreased in 2018.<sup>24</sup> However, the decrease in overdose deaths citywide was not evenly distributed across demographic groups and neighborhoods. Overdose deaths increased among Latinx residents and older New Yorkers ages 55 to 84. Overdose deaths also increased among residents of the Bronx, Staten Island, and Manhattan, while decreasing substantially among residents of Brooklyn and Queens. In addition, large geographic disparities in overdose rates persist. Residents of East Harlem, Crotona-Tremont, and Hunts Point-Mott Haven had the highest rates of overdose death—more than twice the rate of overdose death citywide.

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**Goal:** Increase the number of individuals, adolescents, and families receiving appropriate recovery-oriented services for substance use.

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1. Provide opportunities for behavioral health peer specialists and family members of people suffering from behavioral health issues to attend conferences and workshops that enhance their advocacy skills and knowledge of recovery.
2. Work with syringe service programs to increase outreach to and engagement of people who use drugs.
3. Continue to support OASAS effort to develop new models for engaging and treating adolescents.
4. Continue to work with OASAS to implement evidence-based practices for both adolescent treatment and substance use prevention programs for adolescents.
5. Increase treatment available to adolescents and young adults that include medications for opioid use disorder (MOUD) as a treatment option.

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<sup>23</sup> Postpartum Depression NYC Vital Signs 2017

<sup>24</sup> Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019.

## Adverse Childhood Experiences

### **Adverse Childhood Experiences Background Information:**

Early childhood experiences of adversity and trauma, including domestic violence, are associated with increased risk for chronic diseases and threats to mental health in adulthood.<sup>25,26</sup>

Adolescents exposed to adverse childhood experiences (ACEs), including family malfunctioning, abuse, neglect, violence, and economic adversity, are nearly twice as likely to experience the onset of mental disorders as compared to children without these traumatic experiences. Furthermore, the risk to mental health grows with additional exposures, and unresolved trauma as a result of ACEs can also negatively impact development across the life span and intergenerationally, contributing to substance misuse, child abuse, poverty, incarceration, diminished productivity in the workplace and in all aspects of an individual's life.

As public health practitioners and policymakers increasingly recognize the long-term impact of adversity and trauma in early childhood, there is increased attention on young children's social-emotional development and mental health.<sup>27</sup> Evidence has shown that the provision of safe, nurturing environments and equitable opportunities for children to build key skills provide the foundation for healthy development and success at school and in life.<sup>28</sup> A growing body of evidence highlights the importance of ensuring early and accurate identification of these developmental, emotional, and behavioral concerns, as well as the value of effective, evidence-based treatments and supports.<sup>29,30</sup> Specifically, family-focused, evidence-based therapeutic interventions have been shown to reduce symptoms, improve attachment, strengthen children's resilience, and support their healthy development.

Despite these advances in early childhood development, many young children and their families do not have equitable access to appropriate treatments for the challenges they face because of insufficient numbers of clinics and professionals serving this population. Practitioners need a set of specialized skills and competencies to work effectively with young children. Nationally, there is a recognized shortage of professionals specifically trained to meet the mental health needs of children aged 0 to five and their families.<sup>31</sup>

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<sup>25</sup> Chapman, D.P., Whitfield, C.L., Felitti V.J., Dube S.R., Edwards, V.J, Anda, R.F. Adverse Childhood Experiences and the Risk of Depressive Disorders in Adulthood. *Journal of Affective Disorders*. 82: 217– 225 2004, 2004.

<sup>26</sup> Halfon, N, Wise, P.H. and Forrest, C.B. The Changing Nature of Children's Health Development: New Challenges Require Major Policy Solutions *Health Affairs* 33, no.12:2116-2124 doi: 10.1377/hlthaff.2014.0944, 2014.

<sup>27</sup> Zero to Three, & Manatt. (2016). Planting seeds in fertile ground: Actions every policymaker should take to advance infant and early childhood mental health. Retrieved from <https://www.zerotothree.org/resources/1221-planting-seeds-in-fertile-ground-steps-every-policymaker-should-take-to-advance-infant-and-early-childhood-mental-health>] Annie E. Casey Foundation. (2014). Race for results: Building a path to opportunity for all children.

<sup>28</sup> National Scientific Council on the Developing Child. (2007). *The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do*. Retrieved from [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu)

<sup>29</sup> Center on the Developing Child at Harvard University. (2016). *From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families*. Retrieved from [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu).

<sup>30</sup> National Research Council. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*.

<sup>31</sup> Cohen, J., Oser, C., & Quigley, K. (2012). Making it happen: Overcoming barriers to providing infant-early childhood mental health. *Zero to Three*, 1-20.

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**Goal:** Increase providers' knowledge of the impact of trauma on children and caregivers, and how to use trauma- and resilience-informed approaches.

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1. Through the Early Childhood Mental Health Training and TA Center, train early childhood mental health and allied professionals on best practices for using trauma- and resilience-informed approaches in their work.
2. Through the new EmPWR project (Environments Promoting Wellness and Resilience), use a participatory approach to train staff in Domestic Violence shelters to enhance trauma- and resilience-informed environments that promote wellness and resilience for survivors, their children, and staff.
3. Engage survivors of trauma regarding the importance of trauma-informed approaches and partner with them to increase community awareness through education and advocacy.

## Inpatient Treatment Services

### **Inpatient Treatment Services Background Information:**

Psychiatric hospital readmission remains an issue for many people with mental illness in New York City. The CSB Mental Health Subcommittee reports that long wait times for needed support and services have the result of excluding people from the outpatient system simply because they are unable to obtain appointments within a reasonable timeframe. When individuals who know they need help cannot get that help in a timely manner, this can result in decompensation and readmission. If the ambulatory care system is unable to meet the needs of the community, readmissions cannot be reduced.

In light of this, New York City is increasing availability of Mobile Crisis Teams, as well as post-hospitalization services such as Assertive Community Treatment (ACT), Intensive Mobile Treatment (IMT), and New York City’s contact center, NYC Well. Many more services, including outpatient clinic care, experience chronic workforce shortages that force clinics to manage long waitlists as they see more need than they have resources to meet. Moreover, as discussed elsewhere in this Local Services Plan, while Mobile Crisis Teams are ideal for helping individuals in acute crisis within 2 hours, outpatient clinics are best suited to support individuals who require urgent mental health care that does not rise to the level of the Mobile Crisis Teams’ 2-hour response. However, outpatient clinics are unable to do so effectively because they are under-resourced, overburdened, and have not traditionally been expected or supported to take on this role.

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**Goal:** Reduce avoidable psychiatric hospital readmissions

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1. Provide ongoing behavioral health treatment that is responsive to people experiencing complex life situations, including crisis; supports recovery from mental illness and substance misuse; maximizes continuity of care; and reduces the recurrence of crisis.
2. Advocate for reducing/eliminating workforce shortages by increasing reimbursement rates and making other investments in the mental health and human services systems to support these workers in their communities.
3. Advocate for the state’s support in shifting non-acute crisis care to outpatient clinics, such as through state financial investment in clinics to expand their capacity to support these individuals. (See more information in the Crisis Issue Area.)

## Other Mental Health Outpatient Services (Non-clinic)

### **Other Mental Health Outpatient Services Background Information:**

Providing mental health services in community settings promotes better outcomes for those with serious mental illness. Due to significant need in New York City, we continue to see long waitlists for our enhanced services such as Assertive Community Treatment (ACT), and have difficulty engaging the individuals who are hardest to reach. The NYC DOHMH aims to offer more flexible treatment models like Intensive Mobile Treatment (IMT) moving forward. Greater flexibility in how mobile treatment is delivered allows providers to meet individuals where they are, especially individuals who have not traditionally connected well with mental health services.

The IMT model also allows for recruiting more culturally and linguistically appropriate staff because it does not rely on the low, unsustainable reimbursement rates set by the state. Instead, teams are able to focus on how to best serve the unique, individual needs of each client. The predominantly white, female workforce has not been designed to meet the needs of many people, resulting in a system that some people with mental illness do not want to or not able to access. In gathering community feedback in many settings, we found that cultural competency to be essential in ensuring that New Yorkers who have not traditionally connected well with mental health services are cared for in ways that best meet their needs.

In addition to promoting cultural competency among the behavioral health workforce, the NYC DOHMH aims to address the significant physical health needs of people with SMI, particularly the health conditions and social determinants that contribute to the higher rates of premature mortality among New Yorkers with SMI. Tobacco use is a particular concern in NYC DOHMH-contracted programs serving people with SMI. More people with current depression are current smokers compared to those without current depression (25% compared with 12.0%).<sup>32</sup> While people with SMI are as motivated to quit as smokers without SMI, providers report being hesitant to address the issue of cessation.

Individuals in supportive housing are at increased risk for smoking. In a 2017 survey, 47 percent of supportive housing residents reported current tobacco use. Of those, 23 percent were engaged in smoking cessation counseling and treatment. This increased slightly over a 3-month period, but it remains difficult for supportive housing providers, as non-treatment providers, to deliver the proper cessation education and support to residents. NYC Tobacco Cessation Training and Technical Assistance Center (NYC TCTTAC) aims to build the capacity of the behavioral health providers to provide effective tobacco dependence treatment to New Yorkers with co-occurring conditions. This includes promoting nicotine replacement therapies and advocating for individuals with SMI to try them without pressure to quit smoking. This strategy supports the individuals' autonomy, recognizes the place nicotine can have in the life of an individual with SMI, and the challenges individuals with SMI have when it comes to quitting, and allows for a slower, nonjudgmental shift away from smoking.

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<sup>32</sup> Community Health Survey, 2017.

The NYC Mental Health Subcommittee of the Community Services Board (CSB) has also expressed concerns about the impact of the political climate on immigrants' access to mental health treatment and support. Some members of the Subcommittee affiliated with provider agencies have anecdotally reported a decline in mental health service utilization by immigrants, which they attributed to a fear of federal immigration repercussions, despite efforts to encourage the use of mental health services in these communities.

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**Goal:** Promote holistic health of people living with serious mental illness and increase engagement with people who the mental health system has not effectively engaged in the past.

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1. Advocate for the state to adopt some of the principles that make IMT successful, including flexibility, frequency and duration of contact.
2. Advocate for the state to consider offering more flexibility for ACT teams to reopen cases for people they saw last year who dropped out of care and then came back (to allow them to go above their cap in service of continuity of care while bring careful not to dilute the intensity of the service).
3. Implement nicotine replacement therapy pilot among certain providers and conduct pre- and post-evaluation to determine effectiveness as reducing cigarette smoking.
4. Develop culturally sensitive communications strategies to promote mental health resources for all communities of color, including immigrant communities.
5. Implement communication tools and strategies to reach and educate housing and behavioral health providers on maintaining smoke-free environments by using nicotine replacement therapies.

## Developmental Disabilities Clinical Services

### **Developmental Disabilities Clinical Services Background Information:**

While autism services are identified as a separate issue area, it is being included in DD Clinic Services as a sub-category. Autism behavioral services, also known as Applied Behavioral Analysis, remain an important treatment services area for those with autism spectrum disorder. Because of the lack of therapists for this treatment modality, it should be included under DD Clinic Services.

Many individuals with developmental disabilities have complex healthcare needs. This includes both aging and medically fragile individuals. Ensuring that preventive and quality medical, psychiatric, and dental care is accessible and available are ongoing health priorities for this population. In addition to clinic services, residential opportunities are needed to serve medically fragile individuals who require palliative care and whose medical care needs are difficult to meet within an IRA or home setting.

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**Goal:** Improve access to and availability of all services to meet the medical and dental needs of children and adults with developmental disabilities, including aging individuals and medically fragile children and adults (OPWDD), and adjust payment schemes (CMS).

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1. Provide services for individuals with I/DD in NYC who are not eligible for OPWDD clinic services.
2. Collaborate with OPWDD to develop appropriate residential opportunities for medically fragile individuals who require palliative care.
3. Collaborate with OPWDD to increase availability of medical and dental services to meet the needs of individuals with developmental disabilities, including those who are aging, have complex healthcare needs, and/or are medically fragile.
4. Collaborate with state and other appropriate stakeholders to promote the development of reimbursement mechanisms to accommodate the delivery of telehealth services, where appropriate and feasible.



## Transportation

### **Transportation Background Information:**

Accessible transportation options are critical for people with developmental disabilities, including individuals who use wheelchairs, walkers, canes, and accessible devices to ensure they are able to travel to and from outside activities.

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**Goal:** Expand the availability of transportation options for people with developmental disabilities by creating specific payment allowances to providers (OPWDD), and promoting public transportation enhancements.

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1. Collaborate with OPWDD to increase provider ability to support program participants' needs to travel to and from outside activities.
2. Collaborate with appropriate stakeholders to increase the number of wheelchair accessible taxis and other livery services in all five boroughs in New York City.
3. Collaborate with OPWDD to increase travel training opportunities.
4. Collaborate with MTA to explore eligibility criteria to increase the number of individuals with disabilities who receive reduced fare Metro cards.
5. Collaborate with appropriate stakeholders to assure the safety and reliability of transportation services for individuals with disabilities, including Medicaid-funded ambulette and other transportation services.
6. Collaborate with appropriate stakeholders to expand subscription services with enhanced eligibility and reliability through Access-a-Ride and Logisticare.

## Developmental Disability Student/Transition Services

### **Student Transition Services Background Information:**

Support services for individuals with developmental disabilities and their families are particularly important during periods of transition. This includes services that support transitions from preschool to school and from school to adult day services or work settings. OPWDD and SDOE should assure that information and education about managing transition issues is disseminated in schools and other settings.

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**Goal:** Ensure support for individuals and families is available during transition periods.

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1. Coordinate efforts with OPWDD to increase outreach and support services, including family education and training, available to assist individuals and families with transitions.
2. Collaborate with OPWDD to increase coordination with NYC DOE District 75 and other districts, community, parochial and private special education schools to educate and inform parents and families about transition issues (including that the transition process should begin no later than age 14 years) and available support. Includes working with transition coordinators, and attending transition school fairs and PTA meetings.
3. Coordinate efforts with appropriate stakeholders to support Early Intervention programs to educate families about transition and available services.
4. Coordinate efforts with OPWDD to disseminate information and enforce adherence to relevant legislation surrounding transition periods and processes.
5. Collaborate with OPWDD to enhance opportunities for accessing adult day program services for graduates.
6. Collaborate with appropriate stakeholders to ensure the coordination of efforts for the current graduates between the DOE, DDRO, and voluntary agencies.

## Developmental Disability Family Supports

### **Developmental Disability Family Supports Background Information:**

While developmental disability respite services, developmental disability children services, and developmental disability care coordination are identified as separate issue areas, they are being included in Family Supports as sub-categories.

Families living with and caring for individuals with developmental disabilities at home need access to appropriate support services. Greater availability of a range of family support services can help sustain families, whose resources are often stretched, and can help families prevent or cope with crisis situations.

The COVID-19 pandemic can be expected to create additional need in family supports. A need for respite and similar services can be expected to surge, possibly for more than the short and medium term as families do their best to recuperate from various levels and types of loss. Care coordination and children services may be expected to be in similar heightened demand for the foreseeable future. OPWDD should treat these service areas as essential family supports, and prioritize them for 2021 local services planning.

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**Goal:** Collaborate with OPWDD to enhance support and access to services to sustain families who care for individuals with developmental disabilities at home and/or those awaiting residential placement.

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1. Collaborate with OPWDD to provide services for families and individuals with Autism Spectrum Disorder in NYC who are not eligible for OPWDD waived family support services.
2. Collaborate with OPWDD to expand person-centered out-of-home family support options, such as recreation and overnight respite, for people who are non-ambulatory.
3. Collaborate with OPWDD to expand local intensive behavioral supports, including short-term residential treatment options for people with severe behavioral challenges.
4. Collaborate with OPWDD to expand person-centered, out of home recreation and socialization supports for people with I/DD living on their own in non-certified residential settings.
5. Collaborate with OPWDD to increase availability of crisis intervention and respite programs as well as afterschool, evening, weekend, and holiday, recreational and socialization programs geared specifically for children and adults with developmental disabilities.
6. Coordinate efforts with appropriate stakeholders to disseminate information about and expand access to educational and support groups for families and caretakers including internet-based and webinar trainings, via electronic and other media and outreach methods.

7. Coordinate efforts with appropriate stakeholders to provide training for families and caretakers in addressing and managing the needs of individuals with challenging behaviors.
8. Coordinate efforts with appropriate stakeholders to facilitate entrance to and maintenance of benefits, eligibility and governmental entitlements, including OPWDD Front Door.
9. Coordinate efforts with appropriate stakeholders to provide additional training to the Care Coordinators to ensure they are aware of all of the resources that are available.

## Developmental Disability Care Coordination

### **Developmental Disabilities Care Coordination Background Information:**

Very few services are available for people who have both a developmental and a behavioral health or psychiatric disability, including people with co-occurring substance abuse treatment needs. There continues to be a large demand for inpatient and outpatient behavioral health services for individuals who are dually diagnosed.

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**Goal:** Increase support for dually diagnosed individuals (including inpatient treatment for intervention and assessment) through program development and system collaboration.

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1. Identify program development opportunities through collaboration with OPWDD, OASAS, OMH, Access-VR, DFTA and other partners that can meet the needs of individuals with developmental disabilities and co-occurring behavioral health conditions.
2. Collaborate efforts with OPWDD to develop transitional residences and out-of-home respite for persons with dual diagnoses who are in crisis and living with their families.

## Developmental Disability Front Door

### **Developmental Disability Front Door Background Information:**

Informing and educating individuals with developmental disabilities, families/caretakers, providers, and professionals about available services and benefits will help to increase the number of individuals accessing and benefiting from services that meet their needs. OPWDD Front Door remains the initial entry point into the community system of services for individuals with I/DD; as a result, the Front Door is an essential component of services information/education.

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**Goal:** Individuals with developmental disabilities, families/caretakers, providers, and professionals will have increased access to information about available services, starting with the NYS OPWDD Front Door.

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1. Encourage interagency public outreach efforts that will inform the target population of available supports and services and linkages to those services. Efforts may include holding county town hall meetings, Family Support fairs, educational conferences, outreach to religious institutions, medical offices and senior centers, and use of social media and other innovative methods such as 311, public service announcements, NY Connects, and outreach to Community Boards.
2. Increase coordination with NYC DOE District 75 and other districts, community, parochial and private special schools to educate and inform parents and families about transition issues (including that the transition process should begin no later than age 14 years) and available support. Includes working with transition coordinators, and attending transition school fairs and PTA meetings.
3. Work with Early Intervention programs to educate families about transition and available services.
4. Coordinate efforts with OPWDD and other appropriate stakeholders to disseminate information and enforce adherence to relevant legislation surrounding transition periods and processes.

## SUD Outpatient Services

### **SUD Outpatient Treatment Services Background Information:**

In New York City, fentanyl is now the most common drug involved in overdoses. Furthermore, the burden of overdose is not spread evenly across communities and neighborhoods. Given the current drug overdose epidemic in NYC, there is substantial need for treatment and other services for people who use drugs. Specifically, increasing access to medications for opioid use disorder (MOUD) — the gold standard of treatment for opioid use disorder — is critical. The NYC DOHMH is seeking to increase the number of New Yorkers receiving medication treatment for opioid use disorder. However, there are disparities in access to buprenorphine, and buprenorphine is heavily regulated (prescribers must seek a waiver in order to prescribe buprenorphine). Additionally, not all people who use drugs are ready to stop their drug use. Therefore, there is substantial need to increase access to substance use disorder treatment and other kinds of flexible and non-abstinence focused outpatient services for people who use drugs. Engaging people who use drugs in other services, such as harm reduction services, and connecting them to other resources may reduce risk of drug overdose and other health consequences of drug use.

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**Goal:** Increase demand for, and uptake into, medications for opioid use disorder (MOUD)

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1. Conduct buprenorphine prescriber waiver trainings for MDs, NPs, and PAs.
2. Provide funding and technical support to safety-net primary care clinics utilizing the buprenorphine nurse care manager model to provide integrated, office-based treatment for opioid use disorder.
3. Increase number of people receiving buprenorphine at syringe service programs and buprenorphine nurse care manager sites, as well as increase availability of buprenorphine in hospital emergency department settings.
4. Conduct health care provider education outreach to address providers' stigma about MOUD as well as encourage use of MOUD, as well as stigma related to drug use, people who use drugs, and harm reduction principles.
5. Continue public education and awareness campaigns to address stigma around MOUD and people who use drug use.
6. Work with syringe service programs to expand engagement of people who use drugs and other services that may reduce risk of drug overdose and other health consequences of drug use.
7. Continue to advocate for and explore strategies to reduce or eliminate financial barriers to MOUD.

## SUD Residential Treatment Services

### **SUD Residential Treatment Services Background Information:**

People with lived experiences, advocates, and many others have reported that residential treatment still does not always include medication treatment as part of their services. Although the NYC DOHMH has worked with providers to increase access to medications for opioid use disorder (MOUD), there is still significant need.

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**Goal:** Increase demand for, and uptake into, medications for opioid use disorder (MOUD)

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1. Work to expand access to MOUD in residential treatment settings, by either promoting or ensuring that all residential treatment programs offer MOUD and promoting or ensuring residential treatment programs remove policies/practices that limit access to MOUD in ways inconsistent with research and clinical guidelines on best practices.



## Heroin and Opioid Programs and Services

### **Heroin and Opioid Programs and Services Background Information:**

In 2018, there were 1,444 unintentional drug overdose deaths in New York City, of which 80% involved opioids. In 2018, there were 1,151 opioid overdose deaths in New York City, a decrease of 58 deaths from 2017. Fentanyl involvement in opioid overdose deaths in New York City continued to increase in 2018; fentanyl was involved in three-quarters of opioid overdose deaths in New York City in 2018.<sup>33</sup>

Although the number of opioid overdose deaths decreased from 2017 to 2018, this decrease was not distributed equally. From 2017 to 2018, the number of opioid overdose deaths increased among residents of the Bronx, Manhattan, and Staten Island. Opioid overdose deaths also increased among women, Latinx New Yorkers, and older New Yorkers ages 55 to 84.<sup>33</sup>

Syringe Services Programs and other harm reduction services are critical services for people who use heroin and other drugs.

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**Goal:** Reduce opioid overdose deaths and expand access to and uptake of medications for opioid use disorder (MOUD) for patients with opioid use disorder

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1. Continue to expand the NYC DOHMH’s overdose education and naloxone initiative, which aims to expand the network of opioid overdose prevention programs (OOPPs), distribute naloxone to OOPPs in communities with high overdose rates or high risk of overdose, strategically target naloxone dispensing to individuals at high risk of experiencing or witnessing overdose, and promote and provide high-quality trainings on overdose response citywide.
2. Continue to distribute at least 100,000 naloxone kits citywide annually.
3. Promote best practices for addressing substance use, including treatment, among health care providers through outreach and education efforts as well as by disseminating useful tools and resources.
4. Raise awareness about overdose prevention, naloxone availability, and medications for addiction treatment through public education campaigns.
5. Increase access to buprenorphine for opioid use disorder treatment in primary care settings as well as other settings where people who use drugs access services, specifically syringe service programs and emergency departments.
6. Continue to advocate for increased funding for harm reduction services for people who use heroin and other opioids, including the establishment of four overdose prevention centers in NYC, increased funding for syringe services programs, among others.

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<sup>33</sup> Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019.

7. Continue to advocate for and explore strategies to reduce or eliminate financial barriers to MOUD.

## Coordination/Integration with Other Systems for SUD Clients

### **Coordination/Integration Background Information:**

Improved integration and coordination with the health care, mental health care, and social services sector remains a challenge in NYC. Similarly, law enforcement and criminal justice entities are frequently the first responders to people experiencing behavioral health events where substance use is a component. More effective coordination and integration with other systems has been identified as a need by DOHMH partners as well as people who use drugs and their friends and families.

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**Goal:** Increase use of diversion programs to substitute criminal justice measures with increased support and services.

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1. Building on the Staten Island Heroin Overdose Prevention and Education (HOPE) Project, expand eligibility criteria based on prior criminal justice histories for pre-arrest/pre-arraignment diversion programs for people who use drugs and are facing arrest or prosecution in Staten Island, Bronx, Kings, and New York Counties.

## Other Need 1: Racial Equity

### **Racial Equity Background Information:**

There are significant racial and ethnic inequities in behavioral health care access, utilization, and outcomes in New York City (NYC). For example, the prevalence of depression was highest among Latinx New Yorkers compared to Asian, Black, and White New Yorkers in 2016, 2017, and 2018.<sup>34</sup> Additionally, experiences of discrimination and racism are associated with an increased prevalence of serious psychological distress (SPD). Studies show that the prevalence of SPD was higher among adults who experienced racism “some,” “a lot” or “always” compared with those who faced racism “a little” or “not at all” in the past 12 months (15% vs. 5%).<sup>34</sup>

Furthermore, studies have shown that the U.S. criminal justice system disproportionately affects Black and Latinx communities, and adults who have experienced criminal justice system involvement report poorer mental health than those who have not. Black New Yorkers were almost twice as likely as white New Yorkers to have been incarcerated or under community supervision (14% vs. 8%) and over three times as likely to have ever been physically threatened or abused by police (16% vs. 5%), or to have an immediate family member incarcerated or under community supervision in the past five years (13% vs. 4%).<sup>35</sup> Adults who have been incarcerated, or under community supervision, were twice as likely to report poor mental health (27% vs. 13%) than individuals who have never been incarcerated. Similarly, people who have been physically threatened or abused by police, or even stopped, searched, or questioned by police, were more likely to report poor mental health than those who have never been (27% vs. 14%, 20% vs. 12%, respectively). Adults who have experienced criminal justice involvement were also more likely to report binge drinking than those without experiences of criminal justice involvement.<sup>35</sup>

Communities of color in NYC are also disproportionately affected by unintentional drug overdose deaths. Although the overall rate of unintentional drug overdose death decreased in NYC from 2017 to 2018, this decrease was not equally distributed citywide.<sup>36</sup> Rates of overdose death increased 5% among Latinx New Yorkers (from 23.7 per 100,000 in 2017 to 24.8 per 100,000 in 2018) and, for the first time since prior to 2000, Latinx New Yorkers had the highest rate of overdose death. In contrast, the rate of drug overdose decreased 5% among white New Yorkers (from 25.0 per 100,000 in 2017 to 23.8 per 100,000 in 2018) and decreased by 13% among Black New Yorkers (from 25.2 per 100,000 in 2017 to 21.9 per 100,000 in 2018) during this time period.<sup>36</sup>

As mentioned in various sections of the LSP, the COVID-19 public health emergency has exacerbated and magnified a number of persistent societal issues, including systemic racism and racial disparities in physical and behavioral health access, utilization, and outcomes. NYC DOHMH works to advance health equity and eliminate racialized behavioral health disparities, and to foster anti-racism and racial literacy in our external programs and partnerships and our

<sup>34</sup> Community Health Survey, 2017; Social Determinants of Mental Health among New York City Adults, Epi Data Brief, 2019.

<sup>35</sup> Zweig KC, Baquero M, Meropol SB, Vasani A. Criminal Justice System Involvement and Measures of Health among New York City Residents, 2017. New York City Department of Health and Mental Hygiene: Epi Data Brief 109; June 2019.

<sup>36</sup> Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019.

internal policies and structures. For example, NYC DOHMH will hold a racial equity webinar series for behavioral health providers across NYC.

NYC DOHMH is working internally to apply a racial equity and social justice lens to internal practices, processes, and procedures, including unlearning, challenging, and dismantling racism from within the Division.

In light of the significant racial and ethnic inequities in behavioral health care access, utilization, and outcomes in NYC, NYC DOHMH proposes a Racial Equity goal for the LSP. This goal will guide behavioral health processes, programs and interventions to be deliberately reimaged through an anti-racist sustainable equity and racial justice.

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**Goal:** Systematically identify and reduce racial and ethnic inequities and embed racial equity into the behavioral health service system.

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1. Improve data collection, analysis, and reporting practices for demographic characteristics and outcome data.
2. Create an equitable approach to procurement processes to ensure equity in resources allocation.
3. Engage communities of color in service/program planning, decision making, and policy formation and evaluation, including conducting community engagement efforts to learn about the behavioral health needs of New Yorkers.
4. Develop and host a webinar series about racial equity in the field of mental health.
5. Increase cultural diversity training opportunities for health care professionals and other providers to enhance staff sensitivity to the cultural background of the individuals served, including understanding how to address the complex needs of individuals with developmental disabilities and are approaching or have reached advanced ages/human life expectancy.
6. Provide communities experiencing overdose outbreaks or with high numbers or sustained trends of drug overdoses with culturally relevant overdose risk reduction education, harm reduction education, and other essential resources and information on how to prevent consequences associated with substance use.
7. Address racial and geographic inequities in access to medication for opioid use disorder by promoting buprenorphine uptake through syringe service programs, nurse care manager sites, and hospital emergency department settings.
8. Address racial inequities in eligibility for criminal justice diversion to drug treatment programs by advocating for expanded eligibility based on prior criminal justice histories.
9. Continue to facilitate access to methadone treatment, which is utilized at higher rates among Black and Latinx New Yorkers, by a) delivering methadone to patients who need to isolate or quarantine during COVID-19, and b) advocating for the continuation of federal regulations which allow for the use of extended take-home doses and methadone delivery during COVID-19.

10. Monitor enrollment, referrals, and discharge plans as stratified by race and ethnicity for programs specifically for justice-impacted populations, including the NYC Health Justice Network (HJN) and the Support and Connection Centers (SCCs).

## Other Need 2: Medicaid Redesign

### **Medicaid Redesign Background Information:**

The number of Medicaid recipients in New York City with at least one mental health or substance use related primary diagnosis in 2018 was 510,878. Despite significant spending on behavioral health care, a variety of stakeholders of New York City's Medicaid funded behavioral health service system have stated that the current system still struggles to offer comprehensive and-equitable care to the highest-need individuals, and to effectively integrate behavioral health services with physical health care. There are also significant disparities in behavioral health care access, utilization, and outcomes in New York City.

NYC DOHMH has received feedback from adults living with mental illness that they continue to find Health Homes confusing to understand and use. A number of stakeholders have shared that the Health Home model is not comprehensible to the people it is serving. Care coordinators have expressed that the universe of services about which the coordinator must know is too expansive for the amount of reimbursement a care coordinator receives. Care coordinators have frequently mentioned staff turn over due to low salaries and we believe higher reimbursement levels would help care management agencies recruit and retain well-experienced care managers.

Additionally, in 2019 and 2020, several children's behavioral health services transitioned into Medicaid managed care. This includes the newly created Children and Family Treatment and Support Services (CFTSS), the expansion of HCBS Waiver eligibility, and the transition of care management into Health Homes Serving Children.

To address challenges in the shifts in the behavioral health service system, NYC DOHMH works collaboratively with the state Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) to continue to implement the transition of behavioral health services into Medicaid managed care in NYC. NYC DOHMH also established the Regional Planning Consortium (RPC) and has continued to meet regularly with multiple, diverse sets of stakeholders including Medicaid Managed Care Plans, beneficiaries, Health Homes, Delivery System Reform Incentive Program (DSRIP) performing provider systems, care managers, behavioral health service providers, and city agencies to obtain stakeholder input on the transition.

During the latter part of 2020 and in 2021, New York City will focus its Medicaid redesign efforts to 1) identify and retain best practices temporarily implemented during the COVID-19 state of emergency, 2) assist providers in preparing for value-based payment and 3) support providers of children's behavioral health services in identifying local solutions to challenges in the transition to managed care. NYC will also continue to engage its large health systems such as any new iteration of the DSRIP PPSs, Behavioral Health Care Collaboratives (BHCCs), Medicaid Managed Care Organizations (MCOs) and Health Homes in promoting and/or in pursuing value-based payment arrangements or alternative payment models.

Furthermore, for the children's service sector, the NYC DOHMH is beginning to utilize available data systems to monitor the number of children receiving these new and expanded behavioral health services, and partnering with the local Coordinated Care Services structure by

offering an educational series on the Medicaid Transformation for family members. The NYC DOHMH also continues to engage other cross-systems stakeholders to learn about their Medicaid redesign priorities that might be incorporated into our local planning.

**The Impact of COVID-19 on Medicaid Redesign:**

Since the COVID-19 pandemic has significantly affected a variety of stakeholders in the Medicaid managed behavioral health service system, the NYC RPC and NYC DOHMH will continue to engage its stakeholders to work collaboratively to support them, disseminate relevant guidance, and to examine effective temporary practices that can be retained via permanent policy changes.

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**Goal:** Advance systems improvements through Medicaid to increase access to integrated, equitable, and high-quality care to all adult and child Medicaid recipients in New York City.

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1. Continue to engage NYC stakeholders via the Regional Planning Consortium (RPC) for ongoing monitoring and problem solving around the adult and children’s Medicaid managed care transitions and readiness for value-based payment.
2. Release Electronic Health Record (EHR) technical specifications for children’s Medicaid Home and Community Based (HCB) and Children and Family Treatment and Support Services (CFTS) Services.
3. Support NYC based children’s Medicaid Home and Community Based (HCB) and Children and Family Treatment and Support Services (CFTS) Services providers in adopting a suitable electronic health record or upgrading to additional modules.
4. Design and implement a short-term project to educate select DOHMH contracted providers on financial sustainability of select behavioral health services and the use of a selected financial modeling tool.
5. Engage hospital Systems, Behavioral Health Care Collaboratives (BHCC) and Medicaid Managed care Plans via the Regional Planning Consortium to share best practices from their mutual collaborations, with behavioral health providers considering value-based payment arrangements.
6. Streamline storage, processing and analysis of Medicaid claims data for the NYC behavioral health population to facilitate reporting of behavioral health service utilization to improve policy, planning and service delivery.
7. Monitor the access to new State Plan Services / CFTSS and HCBS through MDW and other data sources.
8. In collaboration with Regional Planning Consortium stakeholders, examine best practices in telehealth and remote service provision implemented during the COVID-19 state of emergency and recommend regulatory amendments and policy changes at the State and city level.



## Other Need 3: Behavioral Health Parity

### **Behavioral Health Parity Background Information:**

There has been an increasing amount of attention paid to the enforcement of behavioral health parity in the recent years in New York State. In November 2019, the State Office of Mental health (OMH) issued guidance on the review and approval of clinical review criteria for mental health services, to be used by utilization review (UR) agents when determining mental health treatment coverage. In December 2019, Governor Cuomo released new requirements for health insurers, mandating expanded coverage for New Yorkers seeking treatment for mental health and substance use disorder issues. In conjunction, the Department of Financial Services (DFS) issued FAQs and guidance letters on insurance law changes that impact parity.

In line with the increased attention paid to this issue by the State, a 2019 parity report<sup>37</sup> showed that most NYS consumers experienced denial of mental health and substance abuse (MH/SUD) coverage due to medical necessity criteria and pre-authorization of services. Most of the consumers surveyed (n=211) had little to no knowledge of MH/SUD visit and prior approval limitations and needed more information on how to challenge treatment denials. The most common insurance-related parity barrier cited by NYS providers (n= 67) was related to financial requirements and pre-authorization. Most of the providers mentioned that they would be willing to file appeals on behalf of their patients but required more information on Non-Quantitative Treatment Limitations (NQTLs) since claims denials was not their area of expertise. (NQTLs include utilization review practices, preauthorization/medical necessity criteria, step therapy/fail-first policies, formulary design for prescription drugs, geographic/facility, type/scope, or duration of benefits limits, failure to complete treatment course exclusions, etc.). After discussing with OMH, OASAS and several New York City based organizations actively working on parity issues such as the Legal Action Center, the Community Services Society and the Coalition for Behavioral Health, and reviewing relevant data from the Parity at 10 Coalition and the Kennedy Forum/Milliman<sup>38</sup>, etc. , the NYC DOHMH has identified an unmet need in consumer and provider knowledge of behavioral health parity that can be met by educating consumer and provider audiences. The NYC DOHMH is well positioned to offer these trainings given its stakeholder engagement work and extensive local partnerships. Additionally, we believe that training providers will enable them to work more effectively on behalf of their clients.

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**Goal:** Increase equitable coverage between behavioral health benefits and physical health benefits among NYC’s public and commercial health insurance plans by increasing transparency around compliance with the parity law.

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<sup>37</sup> Parity At 10 Coalition’s report Consumer Health Insurance Knowledge and Experience Survey: Report of Findings [http://parityat10.org/wp-content/uploads/2019/03/Consumer-Health-Insurance-Knowledge\\_ExperienceSurvey-Report-030719.pdf](http://parityat10.org/wp-content/uploads/2019/03/Consumer-Health-Insurance-Knowledge_ExperienceSurvey-Report-030719.pdf)

<sup>38</sup> <https://www.parityregistry.org/states/new-york/>

1. Identify gaps in behavioral health (BH) parity knowledge in NYC in partnership with State and City stakeholders.
2. Increase transparency and compliance with parity by disseminating existing parity resources to NYC stakeholders.
3. Educate New York City providers and beneficiaries on the Mental Health Parity and Addiction Equity Act, beneficiary rights related to the law and avenues for appeals and complaints.

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# Mental Hygiene Goals and Objectives Form

NYC Dept. of Health and Mental Hygiene (70550)  
Certified: [Kirklyn Escondo](#) (9/23/20)

Mental Hygiene Law, § 41.16 "Local planning; state and local responsibilities" states that "each local governmental unit shall: establish long range goals and objectives consistent with statewide goals and objectives." The Goals and Objectives Form allows LGUs to state their long-term goals and shorter-term objectives based on the local needs identified through the planning process and with respect to the State goals and objectives of each Mental Hygiene agency.

The information input in the 2020 Goals and Objectives Form is brought forward into the 2021 Form. LGUs can use the 2020 information as starting point for the 2021 Plan but should ensure that each section contains relevant, up-to-date responses.

Please indicate below if the overall needs of each disability population got better or worse or stayed about the same over the past year. Completion of these questions is required for submission of the form.

**New** To assist LGUs in the assessment of local substance use disorder (SUD) needs, OASAS Planning has developed a county-level, core-dataset of SUD public health data indicators. These reports are based on the recommendations of the Council of State and Territorial Epidemiologists and the regularly updated county-level datasets available in New York State. Each indicator compares county-level population-based rates to statewide rates. Reports for all counties are available in the County Planning System Under **Resources -> OASAS Data Resources -> Substance Use Disorder Key Indicators**

## 1. Overall Needs Assessment by Population (Required)

Please explain why or how the overall needs have changed and the results from those changes.

The question below asks for an overall assessment of unmet needs; however certain individual unmet needs may diverge from overall needs. Please use the text boxes below to describe which (if any) specific needs have improved, worsened, or stayed the same.

a) Indicate how the level of unmet **mental health service needs**, overall, has changed over the past year:  Improved  Stayed the Same  Worsened

Please describe any unmet **mental health** service needs that have **improved**:

Please describe any unmet **mental health** service needs that have **stayed the same**:

The NYC DOHMH is unable to complete the overall Needs Assessment for the 2021 LSP. Due to the constantly shifting behavioral health landscape during the COVID-19 pandemic in 2020 and inadequate data on the pandemic's impact on the behavioral health system, it has been extremely difficult to make broad determinations about unmet service needs in the past year (2020).

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In the past year, NYC has made significant new investments in enhancing services and connections to support New Yorkers living with SMI, and to improve the City's system for responding to New Yorkers experiencing a behavioral health crisis. These investments were made through two complementary efforts coordinated across City government: the NYC Crisis Prevention and Response Task Force (overseen by the Mayor's Office of ThriveNYC), and the 30-Day Review of NYC's mental health intervention programs. The results of this work are: expanded mobile crisis team services, expanded community-based services for people with serious mental illness (Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), and Intensive Mobile Treatment (IMT)). We've accomplished 2-hour mobile crisis response times, seven days a week during daytime hours in Manhattan and Staten Island; we expect that to be available city wide in 2021 and will include overnight hours. Finally, we are systematically incorporating peers into the teams and expanding availability of substance use-only mobile crisis services.

Despite the City's investments, we continue to hear about increasing unmet mental health needs from the community and from our CSB. We ask our state partners to support us as we expand our portfolio of services to better address the mental health needs of New Yorkers. Our CSB regularly reports workforce shortages due to unsustainably low reimbursement rates. Providers are unable to offer competitive living wages, which leads to high staff turnover and worsening quality and availability of services. Additionally, funding for supportive housing does not account for NYC's unique increases in housing costs year to year, leading to perpetual instability and uncertainty among housing providers in NYC. Finally, patients who present to the emergency department for treatment and who are discharged directly to the community may be experiencing barriers to appropriate and relevant community care. In 2015 there were over 75,000 such visits that resulted in discharge directly to community care. [1] These ED visits are costly and potentially preventable.

Demand remains high for NYC Well, the City's 24/7 behavioral health crisis counseling, peer support, information and referral service. NYC Well answered over 263,642 calls, texts and chats in calendar year 2019. While the NYC Well contact center is supporting many individuals, those who require referral are likely to be met with long waitlists at understaffed clinics, particularly clinics serving low income New Yorkers.

In 2017, the most recent year for which data are available, there was a significant average annual increase of 1% in the overall suicide rate over the past 10 years (6.3 per 100,00 in 2017). Individuals ages 45-64 continue to have the highest rate of suicide deaths (9.9 per 100,000 in 2017). Overall, the suicide rate of White New Yorkers continues to be higher compared to the suicide rate of individuals from other racial/ethnic backgrounds (9.2 per 100,000 in 2017). There was a significant increase in suicide rates in the past 10 years for Blacks (4% average annual increase), and Whites (2% average annual increase).

Furthermore, the direct and indirect psychological and mental health consequences of the COVID-19 pandemic are profound. While behavioral health-related emergency department (ED) visits have been lower than 2019 levels during the same time period, more New Yorkers have reported symptoms of anxiety, depression, and financial stress due to circumstances resulting from the coronavirus.

[1] Protacio A, Norman C. Mental Health Emergency Department Visits among New York City Adults, 2015. New York City Department of Health and Mental Hygiene: Epi Data Brief (107); November 2018.

Please describe any unmet **mental health** service needs that have **worsened**:

b) Indicate how the level of unmet **substance use disorder (SUD) needs**, overall, has changed over the past year:  Improved  Stayed the Same  Worsened

Please describe any unmet **SUD** service needs that have **improved**:

Please describe any unmet **SUD** service needs that have **stayed the same**:

The NYC DOHMH is unable to complete the overall Needs Assessment for the 2021 LSP. Due to the constantly shifting behavioral health landscape during the COVID-19 pandemic in 2020 and inadequate data on the pandemic's impact on the behavioral health system, it has been extremely difficult to make broad determinations about unmet service needs in the past year (2020).

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In 2018, there were 1,444 unintentional drug overdose deaths in NYC, a reduction of 38 deaths from 2017. While we are heartened by the reduction in overdose deaths, the number of drug overdoses in NYC remains at epidemic levels as fentanyl – a highly potent synthetic opioid – continues to be present in the illicit drug supply.[1] For the second consecutive year, fentanyl was the most common drug involved in overdose deaths in NYC. In 2018, fentanyl was involved in 60% of all drug overdose deaths.<sup>4</sup>

Although the rate of drug overdose death decreased from 2017 to 2018, decreases were not evenly distributed by demography or geography. From 2017 to 2018, overdose deaths increased among residents of the Bronx, Staten Island, and Manhattan, and decreased among residents of Brooklyn and Queens.<sup>4</sup> By race/ethnicity, the rate of overdose death increased 5% among Latinx New Yorkers, and for the first time since prior to 2000, Latinx New Yorkers had the highest rate of overdose death.<sup>4</sup> In contrast, the rate of drug overdose decreased 5% among White New Yorkers and decreased by 13% among Black New Yorkers during this time period.<sup>4</sup> Finally, the rate of overdose death also increased among women and older New Yorkers ages 55 to 84 from 2017 to 2018.<sup>4</sup>

Significant geographic disparities persist in the burden of drug overdose death. By neighborhood of residence, East Harlem residents had the highest rate of fatal drug overdose in 2018 at 56.1 per 100,000, followed by residents of Crotona-Tremont and Hunts Point-Mott Haven (49.5 and 49.2 per 100,000, respectively).<sup>4</sup> Rates of fatal drug overdose among residents of these three neighborhoods were more than double the citywide rate of 20.5 per 100,000.<sup>4</sup>

[1] Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019.

Please describe any unmet **SUD** service needs that have **worsened**:

c) Indicate how the level of unmet needs of the **developmentally disabled** population, overall, has changed in the past year:  Improved  Stayed the Same  Worsened

Please describe any unmet **developmentally disability** service needs that have **improved**:

Please describe any unmet **developmentally disability** service needs that have **stayed the same**:

The NYC DOHMH is unable to complete the overall Needs Assessment for the 2021 LSP. Due to the constantly shifting behavioral health landscape during the COVID-19 pandemic in 2020 and inadequate data on the pandemic’s impact on the behavioral health system, it has been extremely difficult to make broad determinations about unmet service needs in the past year (2020).

\*\*

Stakeholders across NYC report that for the past 12 months, improvements have been observed in some areas of the service system, while there is worsening in other areas. Specifically, improvements are noted in well-placed transportation initiatives and improvements in front door access during the COVID-19 pandemic. The service system’s transition from the Medicaid Service Coordination (MSC) program to Health Home Care Management through Care Coordination Organizations (CCOs) continues to unfold and presents with a number of issues; in particular, there are ongoing staffing concerns and administrative issues (assignment of a Care Coordinator, being connected to services, and responsiveness to appeals) that result in service delays, disruptions, and general dissatisfaction. Other areas that contribute to the quality and availability of care and an overall worsening of the level of unmet I/DD service needs in all major service areas over the past 12 months include many issues that were included in the 2020 Local Services Plan, namely workforce recruitment and retention owing to ongoing inadequate wages and other supports for Direct Services Professionals which lead to staff turnover and recruitment challenges; financial challenges and long-term planning and sustainability for specialized DD clinics; services transitions at all levels; increasing numbers of individuals and families who outpace available services; inadequate supports and services to address the emerging needs of aging individuals with I/DD and aging family caregivers; general workforce recruitment, retention, and NYC advancement issues; and the need for greater integration of health and medical services with other supports.

Though its impact did not emerge until early March 2020, the COVID-19 pandemic importantly contextualizes 2021 local services planning for New Yorkers with I/DD. The impact of the health crises is still unfolding, and we do not have sufficient data to quantify changes in the level of unmet needs for New Yorkers with I/DD. To assess system needs changes over the past twelve months the NYC Health Department engaged informed stakeholders including the NYC Regional Office of OPWDD, the five borough DD Councils, Community Services Board DD Subcommittee members, Borough Advisory Councils, people with I/DD, providers, families and family advocates representing the five NYC boroughs. Stakeholders helped identify local needs that inform the local services plan for individuals with I/DD in NYC and their families.

The advent of the recent health pandemic exacerbates concerns for this especially vulnerable population, many of whom have underlying health conditions, live in congregate settings and require personal assistance. This points to a need to emphasize and enhance CCO, Front Door, and respite services in NYC.

Please describe any unmet **developmentally disability** service needs that have **worsened**:

The second section of the form includes; goals based on local need; goals based on state initiatives and goals based in other areas. The form allows counties to identify forward looking, change-oriented goals that respond to and are based on local needs and are consistent with the goals of the state mental hygiene agencies. County needs and goals also inform the statewide comprehensive planning efforts of the three state agencies and help to shape policy, programming, and funding decisions. For county needs assessments, goals and objectives to be most effective, they need to be clear, focused and achievable. The following instructions promote a convention for developing and writing effective goal statements and actionable objectives based on needs, state or regional initiatives or other relevant areas.

**2. Goals Based On Local Needs**

Please select any of the categories below for which there is a **high level of unmet need** for LGU and the individuals it serves. (Some needs listed are specific to one or two agencies; and therefore only those agencies can be chosen). When considering the level of need, compare each issue category against all others rather than looking at each issue category in isolation.

- **For each need identified you will have the opportunity to outline related goals and objectives, or to discuss the need more generally if there are no related goals or objectives.**
- **You will be limited to one goal for each need category but will have the option for multiple objectives.** For those categories that apply to multiple disability areas/state agencies, please indicate, in the objective description, each service population/agency for which this unmet need applies. **(At least one need category must be selected).**

Issue Category	Applicable State Agenc(ies)		
	OASAS	OMH	OPWDD
a) Housing	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
b) Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c) Crisis Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
d) Workforce Recruitment and Retention (service system)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

e)	Employment/ Job Opportunities (clients)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
f)	Prevention	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
g)	Inpatient Treatment Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
h)	Recovery and Support Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
i)	Reducing Stigma	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
j)	SUD Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k)	SUD Residential Treatment Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l)	Heroin and Opioid Programs and Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m)	Coordination/Integration with Other Systems for SUD clients	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n)	Mental Health Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o)	Other Mental Health Outpatient Services (non-clinic)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
p)	Mental Health Care Coordination	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
q)	Developmental Disability Clinical Services			<input checked="" type="checkbox"/>
r)	Developmental Disability Children Services			<input type="checkbox"/>
s)	Developmental Disability Student/Transition Services			<input checked="" type="checkbox"/>
t)	Developmental Disability Respite Services			<input type="checkbox"/>
u)	Developmental Disability Family Supports			<input checked="" type="checkbox"/>
v)	Developmental Disability Self-Directed Services			<input type="checkbox"/>
w)	Autism Services			<input type="checkbox"/>
x)	Developmental Disability Front Door			<input checked="" type="checkbox"/>
y)	Developmental Disability Care Coordination			<input checked="" type="checkbox"/>
z)	Other Need 1(Specify in Background Information)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
aa)	Other Need 2 (Specify in Background Information)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
ab)	Problem Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ac)	Adverse Childhood Experiences (ACEs)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**(After a need issue category is selected, related follow-up questions will display below the table)**

## 2a. Housing - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

### Housing Background Information:

According to data and community stakeholder input, the most pressing issue to address is the lack of accessible and affordable housing options for individuals with serious mental illness, substance use disorder, and intellectual/developmental disabilities (I/DD) who are chronically homeless. Without quality, affordable housing for people with mental illness, substance use disorders, and or intellectual/developmental disabilities, we will continue to see significant homelessness and poor outcomes for these populations.

In fiscal year 2019 (July 2018 to June 2019), over 68,476 unique men, women, and children slept in New York City shelters. [1] Approximately one quarter of New Yorkers with depression received rental assistance or lived in public housing in 2018. Based on a survey of psychiatric hospital inpatients, just under one fifth of psychiatric inpatients reported being homeless or unstably housed prior to hospitalization; a similar proportion continued to be homeless or unstably housed 3-5 months post-discharge.[2]

In addition to chronic homelessness among individuals with psychiatric conditions, accessible housing continues to be an unmet need among individuals with intellectual/developmental disabilities. There are a significant number of individuals with I/DD who are in need of, and are awaiting, residential placement in NYC. In addition, many individuals with I/DD reside with aging and medically involved caregivers. Accessible housing options should be available to individuals with I/DD who want to live more independently and/or are in need of varying levels of support. Housing options are particularly needed for



individuals with I/DD and serious physical and behavioral challenges, individuals with I/DD in crisis, individuals with I/DD who have additional medical needs, and aging individuals with I/DD.

Evidence has shown that more than any medical intervention, supportive housing keeps people safe and healthy, particularly individuals burdened with mental illness, substance use disorders, and/or I/DD. Despite the relationship between mental health and housing, there remains a lack of affordable housing specifically for these populations. Supportive housing funding, including all NY/NY initiatives (I, II, and III), are unable to keep up with NYC rental costs, and rent in NYC has outpaced contractual budgets. While NYC 15/15 and NY/NY III units continue to be awarded and developed, providers have expressed difficulty finding affordable units for scattered site housing for NYC 15/15.

### The Impact of COVID-19 on Housing:

The COVID-19 pandemic and its aftermath are expected to further strain the system of services and call for additional residential supports; this will be true for individuals who reside in congregate settings as well as for those residing in the community (some of whom may face the illness or death of care providers). Residents of congregate care settings in particular are at higher risk due to proximity and shared public spaces, so the NYC DOHMH has been working to support providers in establishing safe practices.

[1] NYC Department of Homeless Services <https://www1.nyc.gov/site/dhs/about/stats-and-reports.page>

[2] MHNAS 2018

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Housing Goal:** Increase access to stable housing for those with serious mental illness, substance use issues, and intellectual/developmental disabilities.

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Advocate for rate increases in supportive housing in line with the housing market in New York City, including a yearly escalator to account for increases in the housing market.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Increase access to new and existing community-based housing units for people with developmental disabilities, including those who need 24-hour nursing services.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Develop residential options to support persons with urgent needs or in need of Crisis Services.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Increase residential options for people with developmental disabilities who have aged out of Out-of-State Placements, but who need enhanced residential support.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Increase options for people with I/DD living in certified settings who are aging and developing complex medical conditions to age in place if desired and assessed as appropriate.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Increase the number of individuals who are currently served in 24-hour supervised residences and who are evaluated by their agency for placement in less restrictive settings (e.g. supported IRA, Family Care, Individualized Support Services (ISS) and Self-Directed Services (SDS).

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Increase the number of accessible homes or modifications of existing homes, developed by agencies that allow individuals to age in place.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Increase residential development with innovative support (i.e. Apartment Sharing, Home Sharing, and Family Care).

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Support and participate in congregate contact tracing

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Help providers implement strategies for isolation and social distancing

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2b. Transportation - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

#### Transportation Background Information:

Accessible transportation options are critical for people with developmental disabilities, including individuals who use wheelchairs, walkers, canes, and accessible devices to ensure they are able to travel to and from outside activities.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Transportation Goal:** Expand the availability of transportation options for people with developmental disabilities by creating specific payment allowances to providers (OPWDD), and promoting public transportation enhancements.

#### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Collaborate with OPWDD to increase provider ability to support program participants' needs to travel to and from outside activities.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Collaborate with appropriate stakeholders to increase the number of wheelchair accessible taxis and other livery services in all five boroughs in New York City.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Collaborate with OPWDD to increase travel training opportunities.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Collaborate with MTA to explore eligibility criteria to increase the number of individuals with disabilities who receive reduced fare Metro cards.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Collaborate with appropriate stakeholders to assure the safety and reliability of transportation services for individuals with disabilities, including Medicaid-funded ambulette and other transportation services.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Collaborate with appropriate stakeholders to expand subscription services with enhanced eligibility and reliability through Access-a-Ride and Logisticare.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5:

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2c. Crisis Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

#### Crisis Services Background Information

In 2015, 68% of mental health-related emergency department (ED) visits in New York City did not result in admission to the hospital.[1] In addition, 19% of inpatient psychiatric hospitalizations were for 3 days or less.[2] These data indicate that more crisis respite and outpatient treatment services are needed to promote diversion from EDs, in addition to immediate care without the need for hospitalization. These services are particularly needed in neighborhoods with high poverty, which are shown to have the highest rates of ED visits that do not result in admission.[3] However, data from the NYC Mental Health Needs Assessment Survey (NYC MHNAS) conducted from 2013-2014 shows that many psychiatric inpatients are not aware of outpatient services that can be used in place of hospitalizations.[4]

In light of this evidence, New York City has increased its provision of crisis response services in the past year. New York City's NYC Crisis Prevention and Response Task Force, composed of over 80 experts including advocates, city agency leadership, and community stakeholders with lived experience, recommended ways to improve and fill gaps in the City's Crisis Response System. In response to this taskforce's recommendations, New York City allocated additional funding to expand and enhance Mobile Crisis Teams to ensure rapid response to urgent mental health situations. This expansion will bring average response time down to two hours citywide, provide overnight responses, and extend services to include substance-use only crises. Finally, we've seen a 57 percent increase in our capacity to provide Intensive Mobile Treatment to individuals with the highest mental health needs and who may be poorly served by traditional treatment models (from the current capacity of 189 up to 297).

Adult Mobile Crisis Teams (MCTs) defuse behavioral and mental health crisis situations and link adults to community services as an alternative to ED use and hospitalization. MCTs receive approximately 21,000 referrals annually. Based on current state requirements, Adult MCTs have up to 48 hours to respond to referrals. With enhanced response times, MCTs will be able to better meet the needs of New York City adults and prevent emergency room use and hospitalization.

Similarly, dedicated Children's Mobile Crisis teams (CMCTs) defuse behavioral and mental health crisis situations and link children and their families to community services as an alternative to ED use and hospitalization. CMCTs citywide receive over 1,500 referrals annually. Performance data collected to assess and review service utilization show an increase in children and youth receiving CMCT services beginning in FY17. The CMCTs report that the youth/families referred for crisis

intervention have multiple stressors, and many families do not have community supports in place prior to the intervention. In response to the demand for crisis services, the NYC DOHMH has received additional City funding to address the need beginning in FY21. CMCTs will be increasing in size to address the growing demand for crisis services with an additional two teams per borough. In addition, CMCTs will begin serving youth aged 18-20 with substance use needs.

These Mobile Crisis Teams are also important when people who use drugs experience crisis events and encounter law enforcement. Law enforcement responses to crisis events involving people who use drugs continue to be a large driver of potentially avoidable criminal justice interactions and hospital ED use. Several initiatives have sought to reduce costs while simultaneously improving client outcomes, including front-end diversion stabilization services, specialized law enforcement responses (such as Crisis Intervention Training (CIT)), and Co-Response teams. These purposeful structuring of law enforcement and mental health responses to crisis calls can improve client outcomes and save valuable resources. However, there is still considerable need for non-law enforcement and/or non-criminal justice responses when people who use drugs experience crises or behavioral health events. Preliminary evaluation of existing pre-arrest diversion programs suggests expanding eligibility criteria would increase access to those who may need services most.

[1] SPARCS 2015 Data

[2] SPARCS 2014 Data

[3] SPARCS 2015 Data

[4] MHNAS 2013-2014

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Crisis Services Goal:** Improve outcomes for people experiencing mental health and drug related crises.

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Enhance the current crisis system to ensure individuals in crisis receive rapid services by coordinating with providers, payers, and state partners and allocating resources to better meet community needs.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Provide ongoing behavioral health treatment that is responsive to people experiencing complex life situations, including crisis; supports recovery from mental illness and substance misuse; maximizes continuity of care; reduces the recurrence of crisis; and decreases intersections with law enforcement.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Expand eligibility criteria for existing pre-arrest diversion programs.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Open remaining Support and Connection Center to provide NYPD a health-focused alternative to avoidable emergency room visits or criminal justice intervention.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Continue to utilize the Co-Response Team (CRT) to improve law enforcement's response to persons identified as presenting with elevated risk of harm to self and/or others in the community with the aim of connecting them to services.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Continue to work with the Crisis Taskforce, comprised of citywide partners, to implement approved recommendations to improve the City's response to those experiencing emotionally distress.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Continue to train NYPD Officers in Crisis Intervention Team (CIT) Training to better manage crisis and increase diversion. Prioritize trainings for NYPD members working on collaborative efforts, such as the Support and Connection Centers and Co-Response Teams.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Enhance services delivery of the children's mobile crisis teams by providing services to older youth, ages 18-20, addressing crises that involve substance use, and establishing overnight response.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### **Change Over Past 12 Months (Optional)**

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### **2d. Workforce Recruitment and Retention (service system) - Background Information**

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

#### **Workforce Recruitment and Retention Background Information:**

The NYC DOHMH and partner entities have conducted a number of surveys to assess the barriers to recruiting and retaining a robust behavioral health workforce in New York City. Between 2016-2018, workforce surveys conducted by the New York State Care Management Coalition, Community Health Care Collaborative in NYC, and the NYC Regional Planning Consortium (RPC) assessed turnover among care management staff across New York State. In January 2019, we worked with OMH to survey OMH licensed clinics regarding difficulties in the recruitment and retention of their workforce. In addition, community input has consistently touted the value of peer support specialists as an integral component of the behavioral health workforce in New York City, due to their unique position to engage and support clients burdened with mental illness, substance use disorder, and intellectual/developmental disabilities.

According to the workforce surveys conducted from 2016-2018, there is a 55% turnover rate among care management staff both in New York City and across the state. Results showed a variety of reasons for this high turnover rate, including heavy caseloads, burdensome documentation, and the inability of community-based organizations to offer higher wages and benefits compared to what state-operated facilities, healthcare systems, and managed care organizations offer for similar jobs. According to the NYS Care Management Coalition, 52% of care management agencies surveyed also experienced challenges in recruitment due to the demanding nature of the job and educational qualifications expected. Nearly 31% stated that when qualified applicants are found, they are uninterested in pursuing a career in care management due to the low wages and benefits.

Similar results were shown in the citywide survey for OMH licensed clinics, conducted by the NYC DOHMH in conjunction with the OMH Field Office in 2019. This survey included questions around recruitment and retention difficulties, their capacity to serve the community, and questions specific to clinics serving children five and under. The survey had a 69.2% response rate. The preliminary results of the first category of questions, recruitment and retention difficulties, show that:

- "Salary is not competitive" is the most persistent reason for both recruitment and retention difficulty.
- The most difficult title to both recruit and retain was reported to be Child Psychiatrist.
- Other titles difficult to recruit include Psychiatrist (Adult and Geriatric), Psychologists, Nurse Practitioners, Physician Assistants, Licensed Clinical Social Workers (LCSW), and Peer Specialists.
- When asked which two titles had the most impact on the operations of the clinic when there was recruitment or retention difficulties, respondents chose LCSW, Adult Psychiatrist and Child Psychiatrist. Respondents chose the same titles when asked which titles had the most impact on the clinic's ability to serve the community.
- Clinics reported the most difficulty recruiting or retaining bilingual clinicians who spoke Spanish, Chinese, and Bengali.

The NYC DOHMH solicited feedback from its Community Services Board (CSB) and CSB Mental Health Subcommittee about ways to address the workforce challenges identified in the 2019 survey. Feedback overwhelmingly centered on lack of reimbursement parity, low pay, provider burnout, and the inability of provider agencies to provide professional development and employee support due to employee time nearly entirely dedicated to service delivery. Moreover, in gathering feedback from community members, the NYC DOHMH repeatedly hears about long waitlists and high costs for care because providers infrequently accept insurance, and have shifted to cash-only models. This problem is particularly significant for low-income individuals in New York City.

Hiring and employing peer support specialists as a part of the behavioral health workforce is an effective strategy for promoting a robust and diverse behavioral health workforce that meets the mental and behavioral health needs of New Yorkers. For example, peer support specialists with lived experiences related to substance use disorder are effective in engaging people who are at high risk of overdose or engage in risky substance use. Peers are effective at providing tailored and sensitive information to individuals during vulnerable periods in their life, and can effectively educate people who use alcohol and other substances about risk reduction and treatment options. Treatment providers and other organizations who work with people who use drugs frequently identify a need for peers, as well as request assistance with incorporating peers into workflows and support with ongoing peer training and career advancement. The NYC DOHMH has implemented Peer Corps, which provides training and support to 20 peer Americorps members and works with host sites to integrate peers into workflows. In addition, the NYC DOHMH provides technical assistance on recovery peer integration to treatment providers in order to promote sustainable positions and services.

Similarly, peer support specialists with lived experiences related to caring for children with behavioral health challenges are particularly effective. Their lived experience allows them to build trusting relationships with parents and empower them to become more actively engaged in their children's services.[1] The benefits of peer-provided support for parents of children with emotional and behavioral challenges include increased hopefulness, improvements in caregiver self-care, empowerment when dealing with family issues and children's services, reduced maternal anxiety, improved activation in seeking care, and higher rates of service initiation. In addition to providing much-needed support for parents and caretakers, Family and Youth Peer Support (FYPS) Services support and empower children and youth who are experiencing social, emotional, developmental, and/or behavioral challenges, including substance misuse. Family support services can be adapted to the needs of different families and help them enter the mental health service system; as such, these services may be especially helpful for families who have avoided mental health services because of stigma or cultural issues.

Maintaining a well trained, ready, and culturally competent workforce is essential to providing quality services and supports for individuals with mental illness, substance use disorder, and intellectual/developmental disabilities, and their families and caretakers. This can be accomplished by promoting and ensuring continuing education programs for all levels of staff, adequate supervision, career planning and professional development support, retention incentives, adequate compensation, and providing opportunities for students and young people to learn about the field.

### The Impact of COVID-19 on Workforce Recruitment and Retention:

The COVID-19 pandemic presents with increased likelihood that staffing challenges will be aggravated. As a result, there is a need for greater emphasis on this already burdened area of need. However, innovative technological strategies for engaging hard-to-reach clients have emerged due to the necessities of social distancing. The COVID-19 pandemic has forced providers to move from providing face-to-face appointments to quickly moving to providing services almost exclusively via phone and video. Both providers and clients have reported that the flexibility of telehealth services have provided has increased client satisfaction and their ability to seek and maintain regular services. In fact, providers have reported more kept appointments than face-to-face appointments in the past. Telehealth services allows engagement with individuals that the mental and behavioral health service system has previously not been able to engage fully in treatment. It will be critical for the behavioral health workforce to fully integrate telehealth services into their practice during the COVID-19 pandemic and beyond.

[1] Alegría, M., Polo, A., Gao, S., Santana, L., Rothstein, D., Jiménez, A., Normand, S.-L. T. (2008). Evaluation of a patient activation and empowerment intervention in mental health care. *Medical Care*, 46(3), 247-256

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Workforce Recruitment and Retention Services Goal:** Increase recruitment and retention rates of behavioral health professionals in NYC.

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Continue to enhance and promote the Peer and Community Health Workforce toolkit to assist service providers with successful integration of peers.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Collaborate with Regional Planning Consortium (RPC) stakeholders to reduce the workforce turnover rate among care management and behavioral health providers in NYC.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Increase cultural diversity training opportunities for health care professionals and other providers to enhance staff sensitivity to the cultural background of the individuals served, including understanding how to address the complex needs of individuals with developmental disabilities and are approaching or have reached advanced ages/human life expectancy

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Increase the number of professional training opportunities for direct support staff, including those working in family homes, respite care programs, and recreational programs, and Care Managers, and opportunities to include an increase in the number of agencies with established mentoring programs to provide one-on-one support to newer direct care staff.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Create opportunities for direct care staff, managers, Care Managers and other staff that provide skills training, leadership development and supervision through partnerships with CUNY or SUNY.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Encourage and support efforts to attract private sector professionals for not-for-profit positions that serve individuals with developmental disabilities.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Maintain, expand, and launch new initiatives to integrate evidence-based practices, recruit peers, support workforce development and advancement opportunities for peers, and work with employers to better integrate peer workers into workflows.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Continue to work with CUCS's Academy for Justice Informed Practice to train 3,300 legal, law enforcement, and healthcare professionals on the intersection of health and criminal justice

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Advocate for increases in funding for nonprofits in the human service sector to allow for better recruitment and retention of BH providers and better continuity of care.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Identify ways to allow providers to continue practicing Telehealth services post- COVID-19 pandemic.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2e. Employment/ Job Opportunities (clients) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

### Employment/Job Opportunities Background Information:

Unemployment rates among people with mental illness, substance use disorders, and intellectual/developmental disabilities remain high. 71 percent of individuals with SMI were looking for full-time work in 2012. [1] Individuals with developmental disabilities in particular have limited options for employment and for developing on-the-job employment skills. In 2018, approximately 59% of New Yorkers with depression were unemployed or not in the labor force.[2] Individuals with developmental disabilities in particular have limited options for employment and for developing on-the-job employment skills. Despite high rates of unemployment, providers struggle placing and supporting people with SMI due to a lack of knowledge about existing services. Both providers and consumers need information on employment services and their impact on benefits.

[1] CMHS 2012

[2] CHS 2018

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Employment/Job Opportunities Goal:** Increase employment opportunities and reduce employment disparity for individuals with serious mental illness, substance use disorder, and/or intellectual/developmental disabilities.

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Host a minimum of two annual conferences that provide professional development opportunities for the NYC peer specialist workforce.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Engage stakeholders through existing meetings and phone based technical assistance to assist them in hiring peer specialists.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Increase and vary employment opportunities to increase the number of people with developmental disabilities who are employed so that employment is person-centered and customized. Efforts may include promotional events such as career fairs and collaborative efforts with OPWDD DDROs, local Chambers of Commerce and other local partners, including not-for-profit entities.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Ensure that individuals who are not able to be employed PT or FT have adequate resources and options, including integrated supported day opportunities.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Explain benefits and maintain classifications (e.g., SSI, MA) even when the individual in question is employed/employable.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Through local contracting with vocational support service providers in all 5 boroughs, increase the number of individuals with I/DD (who are not eligible for OPWDD employment support services) who are successfully employed.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Maintain and expand the HJN and Health Engagement and Assessment Team (HEAT) to increase employment opportunities for individuals with justice system involvement and continue to improve community health worker integration into their home organizations.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Develop foundational education for healthcare hiring staff about (1) the criminal justice process and (2) common guidance on criminal background disclosure.



Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Engage re-entry organizations to assist in educating potential job applicants with criminal records about requirements and hiring processes of hospital employers.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2f. Prevention - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

#### Prevention Background Information:

Preventing mental health and substance use issues before they interfere with New Yorker's lives is the surest way to improve mental wellbeing and reduce the impact of mental illness and substance use on the City as a whole. The NYC DOHMH is focused on mitigating the effects of first-episode psychosis, reducing rates of suicide and suicide-related emergency department (ED) visits, and addressing alcohol and substance use among New York City youth and adolescents.

The NYC Health Department estimates that approximately 2,000 new cases of psychotic illness develop each year in New York. A recent study showed that people experiencing first episode psychosis have much higher mortality rates than the general population, particularly within the first 12 months of diagnosis.[1] However, early identification and intervention can significantly reduce the duration and impact of psychosis.[2] In response, New York City has implemented a first-episode psychosis engagement and connection to treatment program, NYC Supportive Transition and Recovery Team (NYC START), which aims to engage people as early as possible after diagnosis. NYC START connected 91.3% of those participating in the program in 2019 to outpatient mental health services, and 87.1% were connected to care in the first 30 days following discharge from a hospital. NYC START amended the health code to include mandated reporting starting at age 16 effective January 2019 in order to reach younger people presenting for care after an episode of psychosis.

In addition to mitigating the impact of first-episode psychosis among New Yorkers, preventing suicide is also a significant area of concern. Though suicide rates in New York City are lower than overall rates across New York State and the United States, the total number of lives lost remains high due to population density. According to Vital Statistics, there were 565 suicides in NYC (551 adults; 14 youth) in 2017. Males, non-Latino Whites, and adults ages 45-64 had the highest rates of suicides. The rate of suicide among males was nearly three times that of females (9.6 per 100,000 compared to 3.4 per 100,000). However, the rate of suicide among females increased approximately 4% annually between 2008 to 2017; no significant change among males was observed. Non-Latino Whites had a suicide rate of 9.2 per 100,000 compared to 5.3 for Blacks, 4.3 for Latinos, and 4.7 for Asian/Pacific Islanders.[3] In addition to suicide deaths, there were approximately 40,000 suicide-related emergency department visits to NYC hospitals in 2019. These visits were for suicidal ideation, intentional self-harm, and suicide attempts. The majority (59%) of visits were made by males. Approximately 28% of visits were made by individuals less than 25 years old.[4]

Due to the circumstances resulting from the COVID-19 pandemic, suicide may become a more pressing concern as the pandemic spreads and has longer-term effects. While there was not a clear link between the 2008 recession and an increase in suicide, it is possible that the combination of provider burnout, weakened health infrastructure, economic insecurity and changes in business cycles, job loss or unemployment, and loss of social connection may be associated with increased risk of suicide during and after the COVID-19 pandemic. Historically, there is some evidence that deaths by suicide increased in the United States during the 1918–19 influenza pandemic and among older people in Hong Kong during the 2003 severe acute respiratory syndrome (SARS) epidemic. Therefore, efforts to engage individuals at highest risk for suicide will need to be increased as the aftereffects of the pandemic becomes clear. The NYC DOHMH is working to address suicide risk through NYC Well, its crisis contact center, as well as by increasing access to mobile crisis and mobile treatment teams. Furthermore, the NYC DOHMH uses surveillance data to identify and locally respond to trends in suicide-related ED visits.

The NYC DOHMH's prevention strategy is also focused on addressing alcohol and substance use among youth and adolescents. In 2015, 21 percent of surveyed New York City public high school students had >1 alcoholic drink in the 30 days

prior to being surveyed, a decrease from 25% in 2013.<sup>15</sup> Among youth who reported drinking in 2015, 445 percent reported binge drinking at least once during the past month.<sup>[5]</sup> In 2017, 9% of NYC youth in public high schools reported ever having used an illicit drug in their lifetime, including cocaine, heroin, ecstasy, and synthetic cannabinoids. The prevalence of substance use among New York City youth differs by demographic group. The 2017 New York City Youth Risk Behavior Survey found that 10 percent of Latinx and 9 percent of White public high school students reported ever using (also known as “lifetime use”) any illicit drug, compared with 7 percent of Black and 5 percent of Asian students in NYC public high schools.<sup>[6]</sup> Male students reported significantly higher levels of both lifetime illicit drug use and past-year non-medical prescription drug misuse than female students.

LGBTQ+ youth are especially at risk for alcohol and substance use. In 2015, a total of 16 percent of students who identified as lesbian, gay, or bisexual, and 17 percent of students who identified as questioning their sexual orientation, reported ever using illicit drugs. This is two times higher than their straight counterparts (8 percent). Differences were also seen by gender identity, where 37 percent of transgender students in NYC public high schools reported ever using illicit drugs in 2015 compared with 8% of students who do not identify as transgender.<sup>[7]</sup>

### Considerations for Racial Equity in Prevention

Strategies for preventing mental health and substance use issues must account not only for the evidence-based interventions and services that our communities need, but also for their cultural and linguistic needs. These strategies must also name and seek to undo structural racism. Our CSB Mental Health Subcommittee has reported that there are variations in how different racial and ethnic groups view mental health, substance use, and accessing treatment, as well as how they might be treated while accessing services. Additionally, we recognize there are important variations within particular groups, such as Asian Americans. This Subcommittee has also reported that the lack of workforce that is representative of the community it serves is a barrier to engagement and care.

The NYC DOHMH recognizes that preventative and treatment services are only effective when they reach those they are intended to benefit. When they are not in the languages of our communities, or the translations are ineffective at conveying the correct message, and when communications about our services do take into consideration cultural beliefs about mental illness and substance use, our services will not reach those who truly need them. Therefore, the NYC DOHMH will promote language access in our prevention strategy, and is committed to building a behavioral health workforce that is representative of the communities in which they serve.

[1] Schoenbaum, M., Sutherland, J., Chappel, A., Azrin, S., Goldstein, A., Rupp, A., Heinsen, R. Twelve-Month Health Care Use and Mortality in Commercially Insured Young People with Incident Psychosis in the United States. Schizophrenia Bulletin, April 6, 2017.

[2] Heinsen RK, Goldstein AB, Azrin ST. Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care. National Institute of Mental Health; 2014.

[3] 2017 Vital Signs Report

[4] Capua J, Blachman-Forshay J, Mello E, Nolan ML, Paone D. Drug Use among Youth in New York City Public High Schools, by Sexual Orientation and Gender Identity, 2015. New York City Department of Health and Mental Hygiene: Epi Data Brief (92); June 2017.

[5] Blachman-Forshay J, Mello E, Capua J, Tuazon E, Paone D. Alcohol Consumption among Youth in New York City Public High Schools, by Sexual Orientation and Gender Identity, 2015. New York City Department of Health and Mental Hygiene: Epi Data Brief(94); Nov 2017.

[6] Ko C, Tuazon E, Paone D. Illicit Drug Use and Prescription Drug Misuse among Youth in New York City Public High Schools, 2017. New York City Department of Health and Mental Hygiene: Epi Data Brief (120); November 2019.

[7] Blachman-Forshay J, Mello E, Capua J, Tuazon E, Paone D. Alcohol Consumption among Youth in New York City Public High Schools, by Sexual Orientation and Gender Identity, 2015. New York City Department of Health and Mental Hygiene: Epi Data Brief(94); Nov 2017.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Prevention Goal:** Address key risk factors across the lifespan for mental health issues through comprehensive prevention strategies to prevent or reduce mental health and substance use issues.

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Continue to support 14 Community Based Organizations (CBOs) and their dedicated Mental Health Provider partners to build their ability to adopt and adapt task-sharing mental health skills among CBOs by enabling them to implement core skills and strategies, including motivational interviewing, Mental Health First Aid, screening, psychoeducation, and quality improvement.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Engage survivors of trauma regarding the importance of trauma-informed approaches and partner with them to increase awareness through education and advocacy.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Conduct public awareness campaigns, and targeted and broad outreach to prescribers to educate on preventing future cases of opioid addiction as well as on overdose prevention, including use and co-prescribing of naloxone.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Reduce misuse of alcohol and drugs among youth, especially among LGBTQ+ young people, by launching media literacy curricula designed to equip youth with critical thinking and analytic skills and continuing to provide technical assistance to community coalitions working to create more affirming environments for LGBTQ youth.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Utilize and expand the Health Engagement and Assessment Teams (HEAT) to increase direct community engagement to meet the behavioral health, physical health, social service needs of individuals residing in communities with the high rates of COVID-19 morbidity and mortality, behavioral health crises, and overdose mortality.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Work with contracted providers to launch new training center that offers trainings in evidence-based parenting and family support models to staff in community-based and clinical settings to expand the reach and availability of supports to families that promote secure attachment and positive mental health among children and adolescents.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Launch new networks of community-based family and youth peer support programs in each borough for parents/caregivers of children and youth (birth – age 24), who are experiencing social, emotional, developmental, behavioral, and/or substance use challenges, and for the youth themselves.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Maintain high percent of NYC START participants who attend mental health services, including Coordinated Specialty Care, following hospitalization for first episode psychosis.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Advocate for continued steps to address workforce shortages, especially shortages in communities of color, in order to increase cultural competency among mental health workers and their capacity for culturally appropriate mental health care in communities of color.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Develop and implement a citywide suicide prevention strategy that accounts for the unique needs of communities and social groups disproportionately impacted by suicide and suicidal behaviors and populations that have been disproportionately impacted by the COVID-19 pandemic. Use established suicide surveillance protocol for identification and response to increases in suicide related emergency department visits and suicide deaths as one component of pandemic response and suicide prevention planning.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### **Change Over Past 12 Months (Optional)**

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### **2g. Inpatient Treatment Services - Background Information**

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

**Inpatient Treatment Services Background Information:**

Psychiatric hospital readmission remains an issue for many people with mental illness in New York City. The CSB Mental Health Subcommittee reports that long wait times for needed support and services have the result of excluding people from the outpatient system simply because they are unable to obtain appointments within a reasonable timeframe. When individuals who know they need help cannot get that help in a timely manner, this can result in decompensation and readmission. If the ambulatory care system is unable to meet the needs of the community, readmissions cannot be reduced.

In light of this, New York City is increasing availability of Mobile Crisis Teams, as well as post-hospitalization services such as Assertive Community Treatment (ACT), Intensive Mobile Treatment (IMT), and New York City’s contact center, NYC Well. Many more services, including outpatient clinic care, experience chronic workforce shortages that force clinics to manage long waitlists as they see more need than they have resources to meet. Moreover, as discussed elsewhere in this Local Services Plan, while Mobile Crisis Teams are ideal for helping individuals in acute crisis within 2 hours, outpatient clinics are best suited to support individuals who require urgent mental health care that does not rise to the level of the Mobile Crisis Teams’ 2-hour response. However, outpatient clinics are unable to do so effectively because they are under-resourced, overburdened, and have not traditionally been expected or supported to take on this role.

**Do you have a Goal related to addressing this need?**  Yes  No

**Goal Statement-** Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Inpatient Treatment Services Goal:** Reduce avoidable psychiatric hospital readmissions

**Objective Statement**

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Provide ongoing behavioral health treatment that is responsive to people experiencing complex life situations, including crisis; supports recovery from mental illness and substance misuse; maximizes continuity of care; and reduces the recurrence of crisis.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Advocate for reducing/eliminating workforce shortages by increasing reimbursement rates and making other investments in the mental health and human services systems to support these workers in their communities.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Advocate for the state’s support in shifting non-acute crisis care to outpatient clinics, such as through state financial investment in clinics to expand their capacity to support these individuals. (See more information in the Crisis Issue Area.)

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

**Change Over Past 12 Months (Optional)**

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

**2h. Recovery and Support Services - Background Information**

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

**Recovery and Support Services Background Information:**

Recovery and support services in NYC have expanded, but New Yorkers would benefit from additional services in this area. Almost 70% of New Yorkers with SMI reported needing some or a lot of help meeting people for social support. NYC Well, which launched October 2016, provides City-funded support: about 15% of people calling, texting, or chatting are choosing to connect with a peer specialist.[1]

Recovery and support services are especially critical for people who use drugs, particularly among communities that are at higher risk for overdose deaths. After seven consecutive years of increasing overdose deaths, the number and rate of overdose deaths finally decreased in 2018.[2] However, the decrease in overdose deaths citywide was not evenly distributed across demographic groups and neighborhoods. Overdose deaths increased among Latinx residents and older New Yorkers ages 55 to 84. Overdose deaths also increased among residents of the Bronx, Staten Island, and Manhattan, while decreasing substantially among residents of Brooklyn and Queens. In addition, large geographic disparities in overdose rates persist. Residents of East Harlem, Crotona-Tremont, and Hunts Point-Mott Haven had the highest rates of overdose death—more than twice the rate of overdose death citywide.

[1] Postpartum Depression NYC Vital Signs 2017

[2] Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Recovery and Support Services Goal:** Increase the number of individuals, adolescents, and families receiving appropriate recovery-oriented services for substance use.

**Objective Statement**

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Provide opportunities for behavioral health peer specialists and family members of people suffering from behavioral health issues to attend conferences and workshops that enhance their advocacy skills and knowledge of recovery.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Work with syringe service programs to increase outreach to and engagement of people who use drugs.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Continue to support OASAS effort to develop new models for engaging and treating adolescents.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Continue to work with OASAS to implement evidence-based practices for both adolescent treatment and substance use prevention programs for adolescents.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Increase treatment available to adolescents and young adults that include medications for opioid use disorder (MOUD) as a treatment option.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5:

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2i. Reducing Stigma - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

#### Reducing Stigma Background Information:

Numerous stakeholders representing a wide range of NYC communities have identified stigma as a significant barrier to accessing services, care, and treatment for people with mental disorders, people who use drugs, people with substance use disorders, or people with co-occurring substance use/mental health disorders. The emphasis on stigma is supported by results of the NYC Health Opinion Poll, conducted by the NYC DOHMH between April and May 2019. According to the NYC Health Opinion Poll, 64.0% of citywide respondents agreed or strongly agreed that people with mental illness are more dangerous or violent than the average person; 50.0% agreed or strongly agreed that a person who has a mental illness is less trustworthy than the average person; 29.4% agreed or strongly agreed that they think less of a person who has a mental illness; and 23.0% agreed or strongly agreed that having a mental illness is a sign of personal failure.

In the light of these Health Opinion Poll results, the NYC DOHMH recognizes that increased community engagement and education is critical for raising awareness of and reducing stigma around mental and substance abuse disorders. In particular, stakeholders in our Regional Planning Consortium (RPC) have expressed that faith-based organizations and community-based organizations specifically addressing social determinants of health could play an impactful role in raising awareness about mental illness and substance use issues.

#### The Impact of COVID-19 on Reducing Stigma

While the COVID-19 pandemic has largely made a negative impact in the health infrastructure of New York City, clients and providers have reported a silver lining in the impact of telehealth on reducing stigma. Clients have reported that telehealth services have allowed them to feel less stigma and fear around reporting mental health issues to a provider. Continuing to allow telehealth services to occur will allow the mental health system to engage individuals they haven't been able to engage in services in the past, including individuals that face stigma associated with mental health issues due to their cultural background.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Reducing Stigma Goal:** Increase awareness of behavioral health conditions.

#### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Expand outreach to underserved and hard to serve communities via highly skilled trainers representing those communities to address mental health related stigma and trauma.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Implement the Clergy Clinician Community Collaboration (4Cs) and the Reclaiming Our Health (ROH) initiatives, (formerly known as Community Partners in Care (CPIC)), to promote mental health awareness and prevention through technical assistance, skills building support, guidance and collaborative planning. Efforts are guided by community engagement, quality improvement and task sharing approaches to address gaps in providers' cultural competency, community traditional beliefs, and stigma.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Deliver ongoing presentations from the behavioral health peer perspective to behavioral health community stakeholders and educational institutions.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Develop and conduct public awareness and education campaigns to reduce stigma toward people who use drugs, drug use, and drug treatment.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Continue to educate healthcare and other service providers on the health risks of criminal justice system involvement and how they can best support their justice involved patients/clients using a trauma-and-resilience-informed approach.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Continue to utilize the Health Engagement and Assessment Teams (HEAT) team to reduce the stigma around mental health, substance use, and the criminal justice system.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Develop an agency-wide action plan that outlines the health impact of the criminal justice system and its impact and identify opportunities to facilitate improvements.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Advocate with the State to allow providers to continue to bill for telehealth services post pandemic

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2j. SUD Outpatient Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

#### SUD Outpatient Services Goal Background Information:

In New York City, fentanyl is now the most common drug involved in overdoses. Furthermore, the burden of overdose is not spread evenly across communities and neighborhoods. Given the current drug overdose epidemic in NYC, there is substantial need for treatment and other services for people who use drugs. Specifically, increasing access to medications for opioid use disorder (MOUD) — the gold standard of treatment for opioid use disorder — is critical. The NYC DOHMH is seeking to increase the number of New Yorkers receiving medication treatment for opioid use disorder. However, there are disparities in access to buprenorphine, and buprenorphine is heavily regulated (prescribers must seek a waiver in order to prescribe buprenorphine). Additionally, not all people who use drugs are ready to stop their drug use. Therefore, there is substantial need to increase access to substance use disorder treatment and other kinds of flexible and non-abstinence focused outpatient services for people who use drugs. Engaging people who use drugs in other services, such as harm reduction services, and connecting them to other resources may reduce risk of drug overdose and other health consequences of drug use.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**SUD Outpatient Services Goal:** Increase demand for, and uptake into, medications for opioid use disorder (MOUD).

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Conduct buprenorphine prescriber waiver trainings for MDs, NPs, and PAs.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Provide funding and technical support to safety-net primary care clinics utilizing the buprenorphine nurse care manager model to provide integrated, office-based treatment for opioid use disorder.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Increase number of people receiving buprenorphine at syringe service programs and buprenorphine nurse care manager sites, as well as increase availability of buprenorphine in hospital emergency department settings.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Conduct health care provider education outreach to address providers' stigma about MOUD as well as encourage use of MOUD, as well as stigma related to drug use, people who use drugs, and harm reduction principles.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Continue public education and awareness campaigns to address stigma around MOUD and people who use drug use.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Work with syringe service programs to expand engagement of people who use drugs and other services that may reduce risk of drug overdose and other health consequences of drug use.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Continue to advocate for and explore strategies to reduce or eliminate financial barriers to MOUD.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2k. SUD Residential Treatment Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

### SUD Residential Treatment Services Background:



People with lived experiences, advocates, and many others have reported that residential treatment still does not always include medication treatment as part of their services. Although the NYC DOHMH has worked with providers to increase access to medications for opioid use disorder (MOUD), there is still significant need.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**SUD Residential Treatment Services Goal:** Increase demand for, and uptake into, medications for opioid use disorder (MOUD).

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Work to expand access to MOUD in residential treatment settings, by either promoting or ensuring that all residential treatment programs offer MOUD and promoting or ensuring residential treatment programs remove policies/practices that limit access to MOUD in ways inconsistent with research and clinical guidelines on best practices.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

## 2I. Heroin and Opioid Programs and Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

### Heroin and Opioid Programs and Services Background:

In 2018, there were 1,444 unintentional drug overdose deaths in New York City, of which 80% involved opioids. In 2018, there were 1,151 opioid overdose deaths in New York City, a decrease of 58 deaths from 2017. Fentanyl involvement in opioid overdose deaths in New York City continued to increase in 2018; fentanyl was involved in three-quarters of opioid overdose deaths in New York City in 2018.[1]

Although the number of opioid overdose deaths decreased from 2017 to 2018, this decrease was not distributed equally. From 2017 to 2018, the number of opioid overdose deaths increased among residents of the Bronx, Manhattan, and Staten Island. Opioid overdose deaths also increased among women, Latinx New Yorkers, and older New Yorkers ages 55 to 84.[1]

Syringe Services Programs and other harm reduction services are critical services for people who use heroin and other drugs.

[1] Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019.

Do you have a Goal related to addressing this need?  Yes  No

**Goal Statement-** Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Heroin and Opioid Programs and Services Goal:** Reduce opioid overdose deaths and expand access to and uptake of medications for opioid use disorder (MOUD) for patients with opioid use disorder.

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Continue to expand the NYC DOHMH's overdose education and naloxone initiative, which aims to expand the network of opioid overdose prevention programs (OOPPs), distribute naloxone to OOPPs in communities with high overdose rates or high risk of overdose, strategically target naloxone dispensing to individuals at high risk of experiencing or witnessing overdose, and promote and provide high-quality trainings on overdose response citywide.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Continue to distribute at least 100,000 naloxone kits citywide annually.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Promote best practices for addressing substance use, including treatment, among health care providers through outreach and education efforts as well as by disseminating useful tools and resources.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Raise awareness about overdose prevention, naloxone availability, and medications for addiction treatment through public education campaigns.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Increase access to buprenorphine for opioid use disorder treatment in primary care settings as well as other settings where people who use drugs access services, specifically syringe service programs and emergency departments.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Continue to advocate for increased funding for harm reduction services for people who use heroin and other opioids, including the establishment of four overdose prevention centers in NYC, increased funding for syringe services programs, among others.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5:

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2m. Coordination/Integration with Other Systems for SUD clients - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

## Coordination/Integration with Other Systems for SUD Clients Background:

Improved integration and coordination with the health care, mental health care, and social services sector remains a challenge in NYC. Similarly, law enforcement and criminal justice entities are frequently the first responders to people experiencing behavioral health events where substance use is a component. More effective coordination and integration with other systems has been identified as a need by DOHMH partners as well as people who use drugs and their friends and families.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Coordination/Integration with Other Systems for SUD Clients Goal:** Increase use of diversion programs to substitute criminal justice measures with increased support and services.

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Building on the Staten Island Heroin Overdose Prevention and Education (HOPE) Project, expand eligibility criteria based on prior criminal justice histories for pre-arrest/pre-arraignment diversion programs for people who use drugs and are facing arrest or prosecution in Staten Island, Bronx, Kings, and New York Counties.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

## 2o. Other Mental Health Outpatient Services (non-clinic) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

### Other Mental Health Outpatient Services (Non-Clinic) Background:

Providing mental health services in community settings promotes better outcomes for those with serious mental illness. Due to significant need in New York City, we continue to see long waitlists for our enhanced services such as Assertive Community Treatment (ACT), and have difficulty engaging the individuals who are hardest to reach. The NYC DOHMH aims to offer more flexible treatment models like Intensive Mobile Treatment (IMT) moving forward. Greater flexibility in how mobile treatment is delivered allows providers to meet individuals where they are, especially individuals who have not traditionally connected well with mental health services.

The IMT model also allows for recruiting more culturally and linguistically appropriate staff because it does not rely on the low, unsustainable reimbursement rates set by the state. Instead, teams are able to focus on how to best serve the unique, individual needs of each client. The predominantly white, female workforce has not been designed to meet the needs of many people, resulting in a system that some people with mental illness do not want to or not able to access. In gathering community feedback in many settings, we found that cultural competency to be essential in ensuring that New Yorkers who have not traditionally connected well with mental health services are cared for in ways that best meet their needs.

In addition to promoting cultural competency among the behavioral health workforce, the NYC DOHMH aims to address the significant physical health needs of people with SMI, particularly the health conditions and social determinants that contribute to the higher rates of premature mortality among New Yorkers with SMI. Tobacco use is a particular concern in NYC DOHMH-contracted programs serving people with SMI. More people with current depression are current smokers compared to those without current depression (25% compared with 12.0%).<sup>[1]</sup> While people with SMI are as motivated to quit as smokers without SMI, providers report being hesitant to address the issue of cessation.

Individuals in supportive housing are at increased risk for smoking. In a 2017 survey, 47 percent of supportive housing residents reported current tobacco use. Of those, 23 percent were engaged in smoking cessation counseling and treatment. This increased slightly over a 3-month period, but it remains difficult for supportive housing providers, as non-treatment providers, to deliver the proper cessation education and support to residents. NYC Tobacco Cessation Training and Technical Assistance Center (NYC TCTTAC) aims to build the capacity of the behavioral health providers to provide effective tobacco dependence treatment to New Yorkers with co-occurring conditions. This includes promoting nicotine replacement therapies and advocating for individuals with SMI to try them without pressure to quit smoking. This strategy supports the individuals' autonomy, recognizes the place nicotine can have in the life of an individual with SMI, and the challenges individuals with SMI have when it comes to quitting, and allows for a slower, nonjudgmental shift away from smoking.

The NYC Mental Health Subcommittee of the Community Services Board (CSB) has also expressed concerns about the impact of the political climate on immigrants' access to mental health treatment and support. Some members of the Subcommittee affiliated with provider agencies have anecdotally reported a decline in mental health service utilization by immigrants, which they attributed to a fear of federal immigration repercussions, despite efforts to encourage the use of mental health services in these communities.

[1] Community Health Survey, 2017.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Other Mental Health Outpatient Services (Non-Clinic) Goal:** Promote holistic health of people living with serious mental illness and increase engagement with people who the mental health system has not effectively engaged in the past.

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Advocate for the state to adopt some of the principles that make IMT successful, including flexibility, frequency and duration of contact.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Advocate for the state to consider offering more flexibility for ACT teams to reopen cases for people they saw last year who dropped out of care and then came back (to allow them to go above their cap in service of continuity of care while bring careful not to dilute the intensity of the service).

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Implement nicotine replacement therapy pilot among certain providers and conduct pre- and post-evaluation to determine effectiveness as reducing cigarette smoking.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Develop culturally sensitive communications strategies to promote mental health resources for all communities of color, including immigrant communities.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Implement communication tools and strategies to reach and educate housing and behavioral health providers on maintaining smoke-free environments by using nicotine replacement therapies.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5:

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2p. Mental Health Care Coordination - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

#### Mental Health Care Coordination Background:

The NYC DOHMH aims to identify ways to ensure that children and youth with the highest mental health needs receive effective care coordination, especially those not fully achieved through the existing care management programs such as Health Homes Serving Children and Children's Non-Medicaid Care Coordination. The NYC DOHMH, in partnership with OMH and NYC stakeholders, is conducting a demonstration project to implement and evaluate High Fidelity Wraparound (HFW), an intensive, individualized planning and management process for children and youth with serious social, emotional or behavioral concerns who are involved in multiple systems. Specifically, HFW is an evidence-based model of care coordination that, when practiced to fidelity, improves outcomes and lowers rates of hospitalization and residential treatment for youth with serious mental health needs and who are also involved in the child welfare, juvenile justice, or special education systems.

Since the start of the HFW demonstration project in 2019, the two HFW teams serving youth and their families in Brooklyn and the Bronx have enrolled and served a total of 22 youth. The two teams have the capacity to continue to serve approximately a total of 20 youth and their families annually. With NYC's continued participation with other select NY State pilot counties, we aim to also (1) test newly developed training, coaching, supervision and workforce credentialing required for individuals to practice this model to fidelity, (2) identify and implement a standardized system for data collection and reporting that future providers would need in order to implement and bill for this model, (3) identify sustainable payment methods of this model to ensure service is fiscally viable and (4) demonstrate cost effectiveness.

Additionally, demonstrated need to improve systems and practices to reduce hospitalization and Residential Treatment Facility (RTF) placement among youth may be met by the HFW model that has been shown to lower rates of hospitalization and residential treatment. NYS is undertaking a complementary effort to reduce use of residential treatment and help children to transition successfully back to the community upon discharge. A 2019 workgroup convened by the NYS Coalition for Children's Behavioral Health recommended High Fidelity Wraparound (HFW) to avert the need for RTFs and assist families in addressing barriers to a child's return to the community upon discharge.[1] NYC Health Department is further exploring how the current demonstration project can be expanded to focus on youth who have been referred to or recently discharged from a RTF. [2]

[1] Reforming NYS OMH Residential Treatment Facilities by the NYS Coalition for Children's Behavioral Health.

[2] These provide comprehensive mental health treatment in a residential setting for youth requiring longer-term care than an inpatient hospital setting can provide, with stays that exceed 180 days

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Mental Health Care Coordination Goal:** Improve mental health care coordination and cross system collaboration needed to serve children and youth with the highest mental health needs.

## Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Implement and evaluate High Fidelity Wraparound (HFW) in NYC for 20 children and their families, through a demonstration project.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Develop network of organizations servicing children of incarcerated parents to connect to necessary mental health, physical health, and other support services.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

## Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

## 2q. Developmental Disability Clinical Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

### Developmental Disability Clinic Services Background:

While autism services are identified as a separate issue area, it is being included in DD Clinic Services as a sub-category. Autism behavioral services, also known as Applied Behavioral Analysis, remain an important treatment services area for those with autism spectrum disorder. Because of the lack of therapists for this treatment modality, it should be included under DD Clinic Services.

Many individuals with developmental disabilities have complex healthcare needs. This includes both aging and medically fragile individuals. Ensuring that preventive and quality medical, psychiatric, and dental care is accessible and available are ongoing health priorities for this population. In addition to clinic services, residential opportunities are needed to serve medically fragile individuals who require palliative care and whose medical care needs are difficult to meet within an IRA or home setting.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Developmental Disability Clinical Services Goal:** Improve access to and availability of all services to meet the medical and dental needs of children and adults with developmental disabilities, including aging individuals and medically fragile children and adults (OPWDD), and adjust payment schemes (CMS).

## Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Provide services for individuals with I/DD in NYC who are not eligible for OPWDD clinic services.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Collaborate with OPWDD to develop appropriate residential opportunities for medically fragile individuals who require palliative care.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Collaborate with OPWDD to increase availability of medical and dental services to meet the needs of individuals with developmental disabilities, including those who are aging, have complex healthcare needs, and/or are medically fragile.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Collaborate with state and other appropriate stakeholders to promote the development of reimbursement mechanisms to accommodate the delivery of telehealth services, where appropriate and feasible.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5:

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5:

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2s. Developmental Disability Student/Transition Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

#### Developmental Disability Student/Transition Services Background:

Support services for individuals with developmental disabilities and their families are particularly important during periods of transition. This includes services that support transitions from preschool to school and from school to adult day services or work settings. OPWDD and SDOE should assure that information and education about managing transition issues is disseminated in schools and other settings.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Developmental Disability Student/Transition Services Goal:** Ensure support for individuals and families is available during transition periods.

#### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Coordinate efforts with OPWDD to increase outreach and support services, including family education and training, available to assist individuals and families with transitions

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Collaborate with OPWDD to increase coordination with NYC DOE District 75 and other districts, community, parochial and private special education schools to educate and inform parents and families about transition issues (including that the transition process should begin no later than age 14 years) and available support. Includes working with transition coordinators, and attending transition school fairs and PTA meetings.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Coordinate efforts with appropriate stakeholders to support Early Intervention programs to educate families about transition and available services.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Coordinate efforts with OPWDD to disseminate information and enforce adherence to relevant legislation surrounding transition periods and processes.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Collaborate with OPWDD to enhance opportunities for accessing adult day program services for graduates.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Collaborate with appropriate stakeholders to ensure the coordination of efforts for the current graduates between the DOE, DDRO, and voluntary agencies.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

## 2u. Developmental Disability Family Supports - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

### Developmental Disability Family Supports Background:

While developmental disability respite services, developmental disability children services, and developmental disability care coordination are identified as separate issue areas, they are being included in Family Supports as sub-categories.

Families living with and caring for individuals with developmental disabilities at home need access to appropriate support services. Greater availability of a range of family support services can help sustain families, whose resources are often stretched, and can help families prevent or cope with crisis situations.

The COVID-19 pandemic can be expected to create additional need in family supports. A need for respite and similar services can be expected to surge, possibly for more than the short and medium term as families do their best to recuperate from various levels and types of loss. Care coordination and children services may be expected to be in similar heightened demand for the foreseeable future. OPWDD should treat these service areas as essential family supports, and prioritize them for 2021 local services planning.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or



"continuing" activity that simply maintains the status quo.

**Developmental Disability Family Supports Goal:** Collaborate with OPWDD to enhance support and access to services to sustain families who care for individuals with developmental disabilities at home and/or those awaiting residential placement.

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Collaborate with OPWDD to provide services for families and individuals with Autism Spectrum Disorder in NYC who are not eligible for OPWDD waived family support services.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Collaborate with OPWDD to expand person-centered out-of-home family support options, such as recreation and overnight respite, for people who are non-ambulatory.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Collaborate with OPWDD to expand local intensive behavioral supports, including short-term residential treatment options for people with severe behavioral challenges.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Collaborate with OPWDD to expand person-centered, out of home recreation and socialization supports for people with I/DD living on their own in non-certified residential settings.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Collaborate with OPWDD to increase availability of crisis intervention and respite programs as well as afterschool, evening, weekend, and holiday, recreational and socialization programs geared specifically for children and adults with developmental disabilities.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Coordinate efforts with appropriate stakeholders to disseminate information about and expand access to educational and support groups for families and caretakers including internet-based and webinar trainings, via electronic and other media and outreach methods.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Coordinate efforts with appropriate stakeholders to provide training for families and caretakers in addressing and managing the needs of individuals with challenging behaviors.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Coordinate efforts with appropriate stakeholders to facilitate entrance to and maintenance of benefits, eligibility and governmental entitlements, including OPWDD Front Door.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Coordinate efforts with appropriate stakeholders to provide additional training to the Care Coordinators to ensure they are aware of all of the resources that are available.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2x. Developmental Disability Front Door - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)

- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

**Developmental Disability Front Door Background Information:**

Informing and educating individuals with developmental disabilities, families/caretakers, providers, and professionals about available services and benefits will help to increase the number of individuals accessing and benefiting from services that meet their needs. OPWDD Front Door remains the initial entry point into the community system of services for individuals with I/DD; as a result, the Front Door is an essential component of services information/education.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Developmental Disability Front Door Goal:** Individuals with developmental disabilities, families/caretakers, providers, and professionals will have increased access to information about available services, starting with the NYS OPWDD Front Door.

**Objective Statement**

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Encourage interagency public outreach efforts that will inform the target population of available supports and services and linkages to those services. Efforts may include holding county town hall meetings, Family Support fairs, educational conferences, outreach to religious institutions, medical offices and senior centers, and use of social media and other innovative methods such as 311, public service announcements, NY Connects, and outreach to Community Boards.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Increase coordination with NYC DOE District 75 and other districts, community, parochial and private special schools to educate and inform parents and families about transition issues (including that the transition process should begin no later than age 14 years) and available support. Includes working with transition coordinators, and attending transition school fairs and PTA meetings

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Work with Early Intervention programs to educate families about transition and available services.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Coordinate efforts with OPWDD and other appropriate stakeholders to disseminate information and enforce adherence to relevant legislation surrounding transition periods and processes.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

**Change Over Past 12 Months (Optional)**

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

**2y. Developmental Disability Care Coordination - Background Information**

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

### Developmental Disability Care Coordination Background Information:

Very few services are available for people who have both a developmental and a behavioral health or psychiatric disability, including people with co-occurring substance abuse treatment needs. There continues to be a large demand for inpatient and outpatient behavioral health services for individuals who are dually diagnosed.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Developmental Disability Care Coordination Goal:** Increase support for dually diagnosed individuals (including inpatient treatment for intervention and assessment) through program development and system collaboration

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Identify program development opportunities through collaboration with OPWDD, OASAS, OMH, Access-VR, DFTA and other partners that can meet the needs of individuals with developmental disabilities and co-occurring behavioral health conditions

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Collaborate efforts with OPWDD to develop transitional residences and out-of-home respite for persons with dual diagnoses who are in crisis and living with their families.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2z. Other Need (Specify in Background Information) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

### Racial Equity Background Information:

There are significant racial and ethnic inequities in behavioral health care access, utilization, and outcomes in New York City (NYC). For example, the prevalence of depression was highest among Latinx New Yorkers compared to Asian, Black, and White New Yorkers in 2016, 2017, and 2018.[1] Additionally, experiences of discrimination and racism are associated with an increased prevalence of serious psychological distress (SPD). Studies show that the prevalence of SPD was higher among adults who experienced racism "some," "a lot" or "always" compared with those who faced racism "a little" or "not at all" in the past 12 months (15% vs. 5%).[1]

Furthermore, studies have shown that the U.S. criminal justice system disproportionately affects Black and Latinx communities, and adults who have experienced criminal justice system involvement report poorer mental health than those

who have not. Black New Yorkers were almost twice as likely as white New Yorkers to have been incarcerated or under community supervision (14% vs. 8%) and over three times as likely to have ever been physically threatened or abused by police (16% vs. 5%), or to have an immediate family member incarcerated or under community supervision in the past five years (13% vs. 4%).<sup>[2]</sup> Adults who have been incarcerated, or under community supervision, were twice as likely to report poor mental health (27% vs. 13%) than individuals who have never been incarcerated. Similarly, people who have been physically threatened or abused by police, or even stopped, searched, or questioned by police, were more likely to report poor mental health than those who have never been (27% vs. 14%, 20% vs. 12%, respectively). Adults who have experienced criminal justice involvement were also more likely to report binge drinking than those without experiences of criminal justice involvement.<sup>[2]</sup>

Communities of color in NYC are also disproportionately affected by unintentional drug overdose deaths. Although the overall rate of unintentional drug overdose death decreased in NYC from 2017 to 2018, this decrease was not equally distributed citywide.<sup>[3]</sup> Rates of overdose death increased 5% among Latinx New Yorkers (from 23.7 per 100,000 in 2017 to 24.8 per 100,000 in 2018) and, for the first time since prior to 2000, Latinx New Yorkers had the highest rate of overdose death. In contrast, the rate of drug overdose decreased 5% among white New Yorkers (from 25.0 per 100,000 in 2017 to 23.8 per 100,000 in 2018) and decreased by 13% among Black New Yorkers (from 25.2 per 100,000 in 2017 to 21.9 per 100,000 in 2018) during this time period.<sup>[3]</sup>

As mentioned in various sections of the LSP, the COVID-19 public health emergency has exacerbated and magnified a number of persistent societal issues, including systemic racism and racial disparities in physical and behavioral health access, utilization, and outcomes. NYC DOHMH works to advance health equity and eliminate racialized behavioral health disparities, and to foster anti-racism and racial literacy in our external programs and partnerships and our internal policies and structures. For example, NYC DOHMH will hold a racial equity webinar series for behavioral health providers across NYC.

NYC DOHMH is working internally to apply a racial equity and social justice lens to internal practices, processes, and procedures, including unlearning, challenging, and dismantling racism from within the Division.

In light of the significant racial and ethnic inequities in behavioral health care access, utilization, and outcomes in NYC, NYC DOHMH proposes a Racial Equity goal for the LSP. This goal will guide behavioral health processes, programs and interventions to be deliberately reimaged through an anti-racist sustainable equity and racial justice.

[1] Community Health Survey, 2017; Social Determinants of Mental Health among New York City Adults, Epi Data Brief, 2019.

[2] Zweig KC, Baquero M, Meropol SB, Vasan A. Criminal Justice System Involvement and Measures of Health among New York City Residents, 2017. New York City Department of Health and Mental Hygiene: Epi Data Brief 109; June 2019.

[3] Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Racial Equity Goal:** Systematically identify and reduce racial and ethnic inequities and embed racial equity into the behavioral health service system.

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Improve data collection, analysis, and reporting practices for demographic characteristics and outcome data.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Create an equitable approach to procurement processes to ensure equity in resources allocation.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Engage communities of color in service/program planning, decision making, and policy formation and evaluation, including conducting community engagement efforts to learn about the behavioral health needs of New Yorkers.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Develop and host a webinar series about racial equity in the field of mental health.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Increase cultural diversity training opportunities for health care professionals and other providers to enhance staff sensitivity to the cultural background of the individuals served, including understanding how to address the complex needs of individuals with developmental disabilities and are approaching or have reached advanced ages/human life expectancy.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Provide communities experiencing overdose outbreaks or with high numbers or sustained trends of drug overdoses with culturally relevant overdose risk reduction education, harm reduction education, and other essential resources and information on how to prevent consequences associated with substance use.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Address racial and geographic inequities in access to medication for opioid use disorder by promoting buprenorphine uptake through syringe service programs, nurse care manager sites, and hospital emergency department settings.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Address racial inequities in eligibility for criminal justice diversion to drug treatment programs by advocating for expanded eligibility based on prior criminal justice histories.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Continue to facilitate access to methadone treatment, which is utilized at higher rates among Black and Latinx New Yorkers, by a) delivering methadone to patients who need to isolate or quarantine during COVID-19, and b) advocating for the continuation of federal regulations which allow for the use of extended take-home doses and methadone delivery during COVID-19.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Monitor enrollment, referrals, and discharge plans as stratified by race and ethnicity for programs specifically for justice-impacted populations, including the NYC Health Justice Network (HJN) and the Support and Connection Centers (SCCs).

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### 2aa. Other Need 2 (Specify in Background Information) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

### Medicaid Redesign Background Information:

The number of Medicaid recipients in New York City with at least one mental health or substance use related primary diagnosis in 2018 was 510,878. Despite significant spending on behavioral health care, a variety of stakeholders of New York City's Medicaid funded behavioral health service system have stated that the current system still struggles to offer comprehensive and equitable care to the highest-need individuals, and to effectively integrate behavioral health services with physical health care. There are also significant disparities in behavioral health care access, utilization, and outcomes in New York City.

NYC DOHMH has received feedback from adults living with mental illness that they continue to find Health Homes confusing to understand and use. A number of stakeholders have shared that the Health Home model is not comprehensible to the people it is serving. Care coordinators have expressed that the universe of services about which the coordinator must know is too expansive for the amount of reimbursement a care coordinator receives. Care coordinators have frequently mentioned staff turn over due to low salaries and we believe higher reimbursement levels would help care management agencies recruit and retain well-experienced care managers.

Additionally, in 2019 and 2020, several children's behavioral health services transitioned into Medicaid managed care. This includes the newly created Children and Family Treatment and Support Services (CFTSS), the expansion of HCBS Waiver eligibility, and the transition of care management into Health Homes Serving Children.

To address challenges in the shifts in the behavioral health service system, NYC DOHMH works collaboratively with the state Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) to continue to implement the transition of behavioral health services into Medicaid managed care in NYC. NYC DOHMH also established the Regional Planning Consortium (RPC) and has continued to meet regularly with multiple, diverse sets of stakeholders including Medicaid Managed Care Plans, beneficiaries, Health Homes, Delivery System Reform Incentive Program (DSRIP) performing provider systems, care managers, behavioral health service providers, and city agencies to obtain stakeholder input on the transition.

During the latter part of 2020 and in 2021, New York City will focus its Medicaid redesign efforts to 1) identify and retain best practices temporarily implemented during the COVID-19 state of emergency, 2) assist providers in preparing for value-based payment and 3) support providers of children's behavioral health services in identifying local solutions to challenges in the transition to managed care. NYC will also continue to engage its large health systems such as any new iteration of the DSRIP PPSs, Behavioral Health Care Collaboratives (BHCCs), Medicaid Managed Care Organizations (MCOs) and Health Homes in promoting and/or in pursuing value-based payment arrangements or alternative payment models.

Furthermore, for the children's service sector, the NYC DOHMH is beginning to utilize available data systems to monitor the number of children receiving these new and expanded behavioral health services, and partnering with the local Coordinated Care Services structure by offering an educational series on the Medicaid Transformation for family members. The NYC DOHMH also continues to engage other cross-systems stakeholders to learn about their Medicaid redesign priorities that might be incorporated into our local planning.

#### **The Impact of COVID-19 on Medicaid Redesign:**

Since the COVID-19 pandemic has significantly affected a variety of stakeholders in the Medicaid managed behavioral health service system, the NYC RPC and NYC DOHMH will continue to engage its stakeholders to work collaboratively to support them, disseminate relevant guidance, and to examine effective temporary practices that can be retained via permanent policy changes.

**Do you have a Goal related to addressing this need?**  Yes  No

**Goal Statement-** Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Medicaid Redesign Goal:** Advance systems improvements through Medicaid to increase access to integrated, equitable, and high-quality care to all adult and child Medicaid recipients in New York City.

#### **Objective Statement**

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Continue to engage NYC stakeholders via the Regional Planning Consortium (RPC) for ongoing monitoring and problem solving around the adult and children's Medicaid managed care transitions and readiness for value-based payment.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Release Electronic Health Record (EHR) technical specifications for children's Medicaid Home and Community Based (HCB) and Children and Family Treatment and Support Services (CFTS) Services

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Support NYC based children's Medicaid Home and Community Based (HCB) and Children and Family Treatment and Support Services (CFTS) Services providers in adopting a suitable electronic health record or upgrading to

additional modules.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 4: Design and implement a short-term project to educate select DOHMH contracted providers on financial sustainability of select behavioral health services and the use of a selected financial modeling tool.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Engage hospital Systems, Behavioral Health Care Collaboratives (BHCC) and Medicaid Managed care Plans via the Regional Planning Consortium to share best practices from their mutual collaborations, with behavioral health providers considering value-based payment arrangements.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Streamline storage, processing and analysis of Medicaid claims data for the NYC behavioral health population to facilitate reporting of behavioral health service utilization to improve policy, planning and service delivery.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: Monitor the access to new State Plan Services / CFTSS and HCBS through MDW and other data sources.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 5: In collaboration with Regional Planning Consortium stakeholders, examine best practices in telehealth and remote service provision implemented during the COVID-19 state of emergency and recommend regulatory amendments and policy changes at the State and city level.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### **Change Over Past 12 Months (Optional)**

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

### **2ac. Adverse Childhood Experiences (ACEs) - Background Information**

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

### **Adverse Childhood Experiences (ACEs) Background:**

Early childhood experiences of adversity and trauma, including domestic violence, are associated with increased risk for chronic diseases and threats to mental health in adulthood.[1],[2] Adolescents exposed to adverse childhood experiences (ACEs), including family malfunctioning, abuse, neglect, violence, and economic adversity, are nearly twice as likely to experience the onset of mental disorders as compared to children without these traumatic experiences. Furthermore, the risk to mental health grows with additional exposures, and unresolved trauma as a result of ACEs can also negatively impact development across the life span and intergenerationally, contributing to substance misuse, child abuse, poverty, incarceration, diminished productivity in the workplace and in all aspects of an individual's life.

As public health practitioners and policymakers increasingly recognize the long-term impact of adversity and trauma in early childhood, there is increased attention on young children's social-emotional development and mental health.[3] Evidence has shown that the provision of safe, nurturing environments and equitable opportunities for children to build key skills provide the foundation for healthy development and success at school and in life.[4] A growing body of evidence highlights the importance of ensuring early and accurate identification of these developmental, emotional, and behavioral concerns, as well as the value of effective, evidence-based treatments and supports.[5],[6] Specifically, family-focused, evidence-based therapeutic interventions have been shown to reduce symptoms, improve attachment, strengthen children's resilience, and support their healthy development.

Despite these advances in early childhood development, many young children and their families do not have equitable access to appropriate treatments for the challenges they face because of insufficient numbers of clinics and professionals serving this population. Practitioners need a set of specialized skills and competencies to work effectively with young

children. Nationally, there is a recognized shortage of professionals specifically trained to meet the mental health needs of children aged 0 to five and their families.[7]

[1] Chapman, D.P., Whitfield, C.L., Felitti V.J., Dube S.R., Edwards, V.J, Anda, R.F. Adverse Childhood Experiences and the Risk of Depressive Disorders in Adulthood. Journal of Affective Disorders. 82: 217– 2252004, 2004.

[2] Halfon, N. Wise, P.H. and Forrest, C.B. The Changing Nature of Children's Health Development: New Challenges Require Major Policy Solutions Health Affairs 33, no.12:2116-2124 doi: 10.1377/hlthaff.2014.0944, 2014.

[3] Zero to Three, & Manatt. (2016). Planting seeds in fertile ground: Actions every policymaker should take to advance infant and early childhood mental health. Retrieved from <https://www.zerotothree.org/resources/1221-planting-seeds-in-fertile-ground-steps-every-policymaker-should-take-to-advance-infant-and-early-childhood-mental-health2> Annie E. Casey Foundation. (2014). Race for results: Building a path to opportunity for all children.

[4] National Scientific Council on the Developing Child. (2007). The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do. Retrieved from [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu)

[5] Center on the Developing Child at Harvard University. (2016). From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families. Retrieved from [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu).

[6] National Research Council. (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.

[7] Cohen, J., Oser, C., & Quigley, K. (2012). Making it happen: Overcoming barriers to providing infant-early childhood mental health. Zero to Three, 1-20.

**Do you have a Goal related to addressing this need?**  Yes  No

**Goal Statement-** Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

**Adverse Childhood Experiences (ACEs) Goal:** Increase providers' knowledge of the impact of trauma on children and caregivers, and how to use trauma-and resilience-informed approaches.

### Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Through the Early Childhood Mental Health Training and TA Center, train early childhood mental health and allied professionals on best practices for using trauma- and resilience-informed approaches in their work.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: Through the new EmPWR project (Environments Promoting Wellness and Resilience), use a participatory approach to train staff in Domestic Violence shelters to enhance trauma- and resilience-informed environments that promote wellness and resilience for survivors, their children, and staff.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: Engage survivors of trauma regarding the importance of trauma-informed approaches and partner with them to increase community awareness through education and advocacy.

Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

### Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.



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# NYC Local Services Plan

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2021



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

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## Executive Summary

### Community Input

The Division of Mental Hygiene at the New York City Department of Health and Mental Hygiene (NYC DOHMH) continuously seeks opportunities to obtain community input in order to understand the mental health, substance use, developmental disability, and criminal justice impacted needs of New Yorkers.

The NYC DOHMH's Take Care New York 2020 (TCNY) plan solicits community input for developing priorities and strategies for improving every community's health, especially among those groups with the worst health outcomes. TCNY initiatives are implemented every four years, and the NYC DOHMH is currently in the process of developing priorities for TCNY 2024. Additionally, the NYC DOHMH monitors the citywide unmet mental health need through its Community Health Survey. The Community Health Survey (CHS) has been conducted annually by the NYC DOHMH since 2002. Data collected from the CHS are used to better understand the health and risk behaviors of New Yorkers and to track key indicators over time. The most recent CHS results (2018) showed that among adult New Yorkers with serious psychological distress, 21% reported having an unmet need for mental health treatment in the last 12 months.

The NYC DOHMH also continuously obtains community input from consumers, advocates and service providers on the needs of New Yorkers receiving Medicaid managed behavioral health services via its Regional Planning Consortium (RPC) steering group meetings and advisory board. Additionally, each quarter, we convene our Community Services Board (CSB) and CSB subcommittees in the three areas of mental health, substance misuse, and developmental disabilities to receive input on our program planning and policy efforts. The NYC DOHMH also convenes discretionary CSB subcommittees that share their expertise in criminal justice and LGBTQ issues as they relate to behavioral health. Our Community Services Board and CSB subcommittees have been an integral part of the local services planning process and we frequently hear concerns about unmet mental health and substance use-related needs from these stakeholders.

Furthermore, alongside the RPC and CSB, the Division of Mental Hygiene regularly convenes Consumer Advisory Boards (CABs), the Developmental Disabilities Borough Councils, contracted service provider staff, and a number of different communities such as faith-based leaders, through a variety of initiatives to understand the behavioral health needs of the community.

### The Behavioral Health Impact of COVID-19 in New York City

The impact of the COVID-19 pandemic in the early months of 2020 will likely exacerbate existing mental health needs in New York City. As of September 22, 2020, more than 236,000 residents of New York City have tested positive for COVID-19.<sup>1</sup> New York City has seen over 19,000 confirmed deaths due to the coronavirus, with an additional 4,600 deaths categorized as

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<sup>1</sup> NYC DOHMH Covid-19 Data. <https://www1.nyc.gov/site/doh/covid/covid-19-data.page>

probable, or reported as “COVID-19” or equivalent without a positive laboratory test. Citywide infection rates and preliminary mortality data disaggregated by race suggest that Black and Latino/Hispanic communities are disproportionately impacted by COVID-19.<sup>1</sup>

The COVID-19 pandemic is unprecedented in both scope and impact, and residents of NYC, as the pandemic’s current epicenter, will experience profound social, economic, and psychological effects. The psychological and behavioral health impact due to the direct and indirect effects of the pandemic are likely to be complex and long lasting. These direct and indirect psychological and mental health consequences of the pandemic arise from widespread loss of life, illness without full physical recovery, the potentially long duration of the full and partial quarantine, and economic losses and insecurity.

### **Considerations for Racial Equity in the Face of the COVID-19 Pandemic**

The NYC DOHMH recognizes significant inequities in mental health across race and ethnicity in New York City, and these existing racial inequities have been magnified in the COVID-19 pandemic. Preliminary COVID-19 mortality data, disaggregated by race, indicates a racial disparity across New York City. Latinx New Yorkers represent nearly 31 percent of total confirmed deaths due to COVID-19, while Black New Yorkers represent 28 percent of confirmed deaths.<sup>1</sup> Race and ethnicity information is most complete for people who are hospitalized or have died, and much less demographic data is currently available for non-hospitalized cases; therefore, it is possible that mortality rates are greater than currently reported.

These results suggest that COVID-19 has placed a disproportionate burden on the health and well-being of low-income communities of color in New York City, and will have long-reaching consequences on the physical and mental health of these vulnerable communities in the foreseeable future. The City must be equipped to support communities of color, particularly those suffering from severe mental illness (SMI) and substance abuse disorder (SUD) and are coping from circumstances as a result of the coronavirus.

### **Priority Issue Areas:**

Per the State’s requirement to select five priority issue areas, NYC DOHMH would like to select the following five:

1. Housing
2. Crisis Services
3. Racial Equity
4. Workforce Recruitment and Retention
5. Heroin and Opioid Programs and Services

### **Resource Needs:**

The 2021 Local Services Plan includes NYC’s efforts to address unmet need but does not account for needed collaboration with the state to strengthen our service system. Hence, we seek support and collaboration on the following:

**Mental Health:**

- **Supportive housing:** The NYC DOHMH requests a collaborative process with state partners to increase supportive housing rates in order to preserve existing supportive housing units. Without additional funding, NYC is at risk for loss of units, as providers will terminate contracts due to insufficient funding, eliminating permanent homes for people and leading tenants with serious mental illness, substance use disorders and developmental disabilities to potentially become homeless.
- **Rethinking NYC’s Crisis Response Services:** The NYC DOHMH requests the state’s support in rethinking how crises are defined. As we move toward 2-hour response times, individuals who require mobile crisis services (MCT) but can be seen in the longer 3- to 48-hour response window should be shifted from “crisis” to another term that appropriately defines the level of care that these individuals require. We ask the state to standardize terminology across the state so that “crisis” refers to individuals who must be seen by MCTs within 2 hours. In addition, the NYC DOHMH asks for the state’s support for outpatient providers to better address crises. While this is a new area of care for many outpatient providers, they know their patients best and are in a better position to be able to care and advocate for these individuals in crises, especially those who can be treated in the 3- to 48-hour window. The NYC DOHMH asks the state to encourage outpatient providers to manage crises among their clients, and support these providers in doing so through education and funding.
- **Workforce Recruitment and Retention:** There is a need for increased funding to support the recruitment and retention of our behavioral health workforce by increasing their compensation. The vital role this workforce plays in supporting adults, children and their families they serve often leaves a major gap in care when providers opt out of accepting insurance because reimbursement rates are too low to sustain their business. We ask the state to take more significant steps to enforce existing parity regulations and to enhance parity requirements to ensure that behavioral health providers are compensated at rates on par with physical health care providers. We also ask the state to take the lead in developing a unified measure of retention by job title using statewide title codes, which will allow for more accurate data on workforce recruitment and retention.
- **Employment/Job Opportunities:** Unemployment rates among people with serious mental illness (SMI) and developmental disabilities remain high. In 2018, approximately 59% of New Yorkers with depression were unemployed or not in the labor force.<sup>2</sup> Despite high rates of unemployment, providers struggle placing and supporting people with SMI due to a lack of knowledge about existing services. Furthermore, individuals with developmental disabilities have limited options for developing on-the-job employment skills and employment options. Both providers and consumers need information on employment services and their impact on benefits. We ask for the state’s support in ensuring that providers are able to make employment referrals and recommendations for clients. With the economic crisis due to COVID-19, it is likely that employment opportunities will worsen.

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<sup>2</sup> Community Health Survey, 2018.

## **Substance Use Disorders:**

The NYC DOHMH identifies a number of areas in which additional services and funding are needed to offer sufficient prevention of substance use disorders, as well as treatment and recovery supports for New Yorkers with substance use disorders.

New York City needs additional resources to increase the number of individuals, families, and adolescents receiving recovery services, to expand prevention services for New Yorkers at risk for developing substance use disorders, to implement strategies to reduce stigma against medications for opioid use disorder (MOUD), and to increase salaries for Peer Support Specialists, who are integral components of the behavioral health workforce. The NYC DOHMH also requests that the state require SUD Residential Treatment Services to use medications for opioid use disorder in residential treatment settings, as well as implement mechanisms of oversight and auditing of programs to facilitate this goal. The NYC DOHMH also requests state support in collaborating with criminal justice agencies to lower eligibility criteria for diversion to treatment programs and ensure connection to effective treatment for individuals with opioid use disorder who are released on bail.

The NYC DOHMH has also identified a number of new resource needs that have come as a consequence of the behavioral health impact of the COVID-19 pandemic. Due to COVID-19, reductions in state funding for licensed substance use disorder treatment programs are anticipated. We are requesting state support in identifying sources for additional funding to address anticipated funding shortages among substance use disorder programs. Additional funding is also required to ensure that treatment providers and patients have adequate access to necessary technologies to provide and access telehealth services during the COVID-19 pandemic and in its aftermath.

- **SUD Outpatient Treatment Services:** Numerous changes in federal regulations of buprenorphine and methadone treatment were implemented to mitigate the spread of COVID-19 and prevent treatment disruptions among MOUD patients. These include the following:
  1. On March 16, 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) allowed Opioid Treatment Program (OTP) providers to provide up to 28 days of methadone to stable patients, and up to 14 days of methadone to less stable patients.
  2. On March 16, 2020, the United States Drug Enforcement Administration (DEA) allowed for the provision of “doorstep” deliveries of methadone to patients quarantined due to COVID-19.
  3. On March 31, 2020, the DEA allowed for the use of telehealth services to induct new buprenorphine patients and continue the provision of buprenorphine to existing patients.

In response to these changes in federal regulations, NYC DOHMH established a Methadone Delivery System to deliver methadone to patients who are in isolation or

quarantine because they have COVID, COVID-like symptoms, or comorbidities that place them at high risk of experiencing serious illness if they develop COVID. Furthermore, the NYC DOHMH continued to provide technical assistance and support to Nurse Care Manager sites and Syringe Service Programs in their continued provision and induction of buprenorphine treatment through telehealth services. The NYC DOHMH worked with the NY State Office of Addiction Services and Supports to monitor and recommend to providers increases in the provision of extended take-home methadone doses for patients.

New York City is requesting state support to continue implementation of the Methadone Delivery System and ensure methadone access to all patients who are presumed or confirmed COVID-positive, patients who are 50 years and older AND have a comorbid health condition AND can receive at least 7 days of medication, and all patients referred for delivery by the OTP Medical Director. In addition, state support will be critical in our capacity to continue providing technical assistance and support to buprenorphine treatment providers to conduct buprenorphine inductions and uninterrupted treatment provision through telehealth services, as well as addressing needs for phones and technological resources among patients and providers to facilitate telehealth services. We aim to continue encouraging the increased provision of extended take-home methadone doses among OTP providers, and advocating for the continuation of emergency methadone regulations to allow for the provision of extended take-home doses among patients, the continuation of emergency regulations allowing for the buprenorphine induction and treatment provision through telehealth, and the continuation of changes in reimbursable rates that allow for telehealth substance use treatment services to be reimbursed at comparable rates to in-person treatment services.

- **Heroin and Opioid Programs and Services:** Finally, state funding is required to develop outreach mechanisms to provide naloxone, sterile drug use equipment, and other services to people who use drugs, due to reductions in services provided by OOPPs and SSPs during the COVID public health emergency. Additionally, funding is required to support the expansion of Relay to additional Emergency Department sites. We request state support in establishing pharmacies as points of dispensing of free naloxone kits, focusing on neighborhoods with the highest rates and numbers of overdose. State support would also be critical in identifying alternate mechanisms for the distribution of naloxone and sterile drug use equipment. We also advocate for increased support for SSPs to facilitate the continuation of outreach and service provision to people who use drugs.




### **Developmental Disabilities:**

The NYC DOHMH remains intent on developing collaborative processes with state partners to determine unmet needs and to identify and analyze reliable data for evaluating and planning local services for people with intellectual/developmental disabilities (I/DD) in NYC. Collaboration around OPWDD system data on population demographics, Medicaid utilization, non-Medicaid state-funded services, care coordination services, and new enrollments will enable the Local Governing Unit (LGU) to identify emerging needs, identify and address gaps in access to I/DD services, and prioritize areas for program and services development and for policy discussion.



Strengthening such collaboration among city and state partners is particularly important as the I/DD population increasingly integrates into the larger community; as they and their care givers age; as the nature and number of service needs increases, changes, and intensifies. Fall-out from the COVID-19 pandemic increases the urgency for coordinated management and use of critical data points and sources.

## Needs Assessment

How has the level of unmet service needs <u>changed</u> in the past year? (By Population)			
POPULATION	IMPROVED 	STAYED THE SAME 	WORSENERD 
Mental Health Service Needs			
Substance Use Disorder Needs			
Developmentally Disabled Needs			

The NYC DOHMH is unable to complete the Needs Assessment table for the 2021 LSP. Due to the constantly shifting behavioral health landscape during the COVID-19 pandemic in 2020 and inadequate data on the pandemic’s impact on the behavioral health system, it has been extremely difficult to make broad determinations about unmet service needs in the past year (2020).

### **Mental Health Needs:**

In the past year, NYC has made significant new investments in enhancing services and connections to support New Yorkers living with SMI, and to improve the City’s system for responding to New Yorkers experiencing a behavioral health crisis. These investments were made through two complementary efforts coordinated across City government: the NYC Crisis Prevention and Response Task Force (overseen by the Mayor's Office of ThriveNYC), and the 30-Day Review of NYC’s mental health intervention programs. The results of this work are: expanded mobile crisis team services, expanded community-based services for people with serious mental illness (Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), and Intensive Mobile Treatment (IMT)). We’ve accomplished 2-hour mobile crisis response times, seven days a week during daytime hours in Manhattan and Staten Island; we expect that to be available city wide in 2021 and will include overnight hours. Finally, we are systematically incorporating peers into the teams and expanding availability of substance use-only mobile crisis services.

Despite the City’s investments, we continue to hear about increasing unmet mental health needs from the community and from our CSB. We ask our state partners to support us as we expand our portfolio of services to better address the mental health needs of New Yorkers. Our CSB regularly reports workforce shortages due to unsustainably low reimbursement rates. Providers are unable to offer competitive living wages, which leads to high staff turnover and worsening quality and availability of services. Additionally, funding for supportive housing does not account for NYC’s unique increases in housing costs year to year, leading to perpetual instability and uncertainty among housing providers in NYC. Finally, patients who present to the emergency department for treatment and who are discharged directly to the community may be experiencing barriers to appropriate and relevant community care. In 2015 there were over

75,000 such visits that resulted in discharge directly to community care<sup>3</sup>. These ED visits are costly and potentially preventable.

Demand remains high for NYC Well, the City's 24/7 behavioral health crisis counseling, peer support, information and referral service. NYC Well answered over 263,642 calls, texts and chats in calendar year 2019. While the NYC Well contact center is supporting many individuals, those who require referral are likely to be met with long waitlists at understaffed clinics, particularly clinics serving low income New Yorkers.

In 2017, the most recent year for which data are available, there was a significant average annual increase of 1% in the overall suicide rate over the past 10 years (6.3 per 100,00 in 2017). Individuals ages 45-64 continue to have the highest rate of suicide deaths (9.9 per 100,000 in 2017). Overall, the suicide rate of White New Yorkers continues to be higher compared to the suicide rate of individuals from other racial/ethnic backgrounds (9.2 per 100,000 in 2017). There was a significant increase in suicide rates in the past 10 years for Blacks (4% average annual increase), and Whites (2% average annual increase).

Furthermore, the direct and indirect psychological and mental health consequences of the COVID-19 pandemic are profound. While behavioral health-related emergency department (ED) visits have been lower than 2019 levels during the same time period, more New Yorkers have reported symptoms of anxiety, depression, and financial stress due to circumstances resulting from the coronavirus.

### **Substance Use Disorder Needs:**

In 2018, there were 1,444 unintentional drug overdose deaths in NYC, a reduction of 38 deaths from 2017. While we are heartened by the reduction in overdose deaths, the number of drug overdoses in NYC remains at epidemic levels as fentanyl – a highly potent synthetic opioid – continues to be present in the illicit drug supply.<sup>4</sup> For the second consecutive year, fentanyl was the most common drug involved in overdose deaths in NYC. In 2018, fentanyl was involved in 60% of all drug overdose deaths.<sup>4</sup>

Although the rate of drug overdose death decreased from 2017 to 2018, decreases were not evenly distributed by demography or geography. From 2017 to 2018, overdose deaths increased among residents of the Bronx, Staten Island, and Manhattan, and decreased among residents of Brooklyn and Queens.<sup>4</sup> By race/ethnicity, the rate of overdose death increased 5% among Latinx New Yorkers, and for the first time since prior to 2000, Latinx New Yorkers had the highest rate of overdose death<sup>4</sup>. In contrast, the rate of drug overdose decreased 5% among White New Yorkers and decreased by 13% among Black New Yorkers during this time period.<sup>4</sup> Finally, the rate of overdose death also increased among women and older New Yorkers ages 55 to 84 from 2017 to 2018.<sup>4</sup>

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<sup>3</sup> Protacio A, Norman C. Mental Health Emergency Department Visits among New York City Adults, 2015. New York City Department of Health and Mental Hygiene: Epi Data Brief (107); November 2018.

<sup>4</sup> Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019.

Significant geographic disparities persist in the burden of drug overdose death. By neighborhood of residence, East Harlem residents had the highest rate of fatal drug overdose in 2018 at 56.1 per 100,000, followed by residents of Crotona-Tremont and Hunts Point-Mott Haven (49.5 and 49.2 per 100,000, respectively).<sup>4</sup> Rates of fatal drug overdose among residents of these three neighborhoods were more than double the citywide rate of 20.5 per 100,000.<sup>4</sup>

### **Developmental Disabilities Needs:**

Stakeholders across NYC report that for the past 12 months, improvements have been observed in some areas of the service system, while there is worsening in other areas. Specifically, improvements are noted in well-placed transportation initiatives and improvements in front door access during the COVID-19 pandemic. The service system's transition from the Medicaid Service Coordination (MSC) program to Health Home Care Management through Care Coordination Organizations (CCOs) continues to unfold and presents with a number of issues; in particular, there are ongoing staffing concerns and administrative issues (assignment of a Care Coordinator, being connected to services, and responsiveness to appeals) that result in service delays, disruptions, and general dissatisfaction. Other areas that contribute to the quality and availability of care and an overall worsening of the level of unmet I/DD service needs in all major service areas over the past 12 months include many issues that were included in the 2020 Local Services Plan, namely workforce recruitment and retention owing to ongoing inadequate wages and other supports for Direct Services Professionals which lead to staff turnover and recruitment challenges; financial challenges and long-term planning and sustainability for specialized DD clinics; services transitions at all levels; increasing numbers of individuals and families who outpace available services; inadequate supports and services to address the emerging needs of aging individuals with I/DD and aging family caregivers; general workforce recruitment, retention, and NYC advancement issues; and the need for greater integration of health and medical services with other supports.

Though its impact did not emerge until early March 2020, the COVID-19 pandemic importantly contextualizes 2021 local services planning for New Yorkers with I/DD. The impact of the health crises is still unfolding, and we do not have sufficient data to quantify changes in the level of unmet needs for New Yorkers with I/DD. To assess system needs changes over the past twelve months the NYC Health Department engaged informed stakeholders including the NYC Regional Office of OPWDD, the five borough DD Councils, Community Services Board DD Subcommittee members, Borough Advisory Councils, people with I/DD, providers, families and family advocates representing the five NYC boroughs. Stakeholders helped identify local needs that inform the local services plan for individuals with I/DD in NYC and their families.

The advent of the recent health pandemic exacerbates concerns for this especially vulnerable population, many of whom have underlying health conditions, live in congregate settings and require personal assistance. This points to a need to emphasize and enhance CCO, Front Door, and respite services in NYC.

# Housing

## **Housing Background Information:**

According to data and community stakeholder input, the most pressing issue to address is the lack of accessible and affordable housing options for individuals with serious mental illness, substance use disorder, and intellectual/developmental disabilities (I/DD) who are chronically homeless. Without quality, affordable housing for people with mental illness, substance use disorders, and or intellectual/developmental disabilities, we will continue to see significant homelessness and poor outcomes for these populations.

In fiscal year 2019 (July 2018 to June 2019), over 68,476 unique men, women, and children slept in New York City shelters.<sup>5</sup> Approximately one quarter of New Yorkers with depression received rental assistance or lived in public housing in 2018. Based on a survey of psychiatric hospital inpatients, just under one fifth of psychiatric inpatients reported being homeless or unstably housed prior to hospitalization; a similar proportion continued to be homeless or unstably housed 3-5 months post-discharge.<sup>6</sup>

In addition to chronic homelessness among individuals with psychiatric conditions, accessible housing continues to be an unmet need among individuals with intellectual/developmental disabilities. There are a significant number of individuals with I/DD who are in need of, and are awaiting, residential placement in NYC. In addition, many individuals with I/DD reside with aging and medically involved caregivers. Accessible housing options should be available to individuals with I/DD who want to live more independently and/or are in need of varying levels of support. Housing options are particularly needed for individuals with I/DD and serious physical and behavioral challenges, individuals with I/DD in crisis, individuals with I/DD who have additional medical needs, and aging individuals with I/DD.

Evidence has shown that more than any medical intervention, supportive housing keeps people safe and healthy, particularly individuals burdened with mental illness, substance use disorders, and/or I/DD. Despite the relationship between mental health and housing, there remains a lack of affordable housing specifically for these populations. Supportive housing funding, including all NY/NY initiatives (I, II, and III), are unable to keep up with NYC rental costs, and rent in NYC has outpaced contractual budgets. While NYC 15/15 and NY/NY III units continue to be awarded and developed, providers have expressed difficulty finding affordable units for scattered site housing for NYC 15/15.

## **The Impact of COVID-19 on Housing:**

The COVID-19 pandemic and its aftermath are expected to further strain the system of services and call for additional residential supports; this will be true for individuals who reside in congregate settings as well as for those residing in the community (some of whom may face the illness or death of care providers). Residents of congregate care settings in particular are at higher risk due to proximity and shared public spaces, so the NYC DOHMH has been working to support providers in establishing safe practices.

<sup>5</sup> NYC Department of Homeless Services <https://www1.nyc.gov/site/dhs/about/stats-and-reports.page>

<sup>6</sup> MHNAS 2018

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**Goal:** Increase access to stable housing for those with serious mental illness, substance use issues, and intellectual/developmental disabilities.

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1. Advocate for rate increases in supportive housing in line with the housing market in New York City, including a yearly escalator to account for increases in the housing market.
2. Increase access to new and existing community-based housing units for people with developmental disabilities, including those who need 24-hour nursing services.
3. Develop residential options to support persons with urgent needs or in need of Crisis Services.
4. Increase residential options for people with developmental disabilities who have aged out of Out-of-State Placements, but who need enhanced residential support.
5. Increase options for people with I/DD living in certified settings who are aging and developing complex medical conditions to age in place if desired and assessed as appropriate.
6. Increase the number of individuals who are currently served in 24-hour supervised residences and who are evaluated by their agency for placement in less restrictive settings (e.g. supported IRA, Family Care, Individualized Support Services (ISS) and Self-Directed Services (SDS)).
7. Increase the number of accessible homes or modifications of existing homes, developed by agencies that allow individuals to age in place.
8. Increase residential development with innovative support (i.e. Apartment Sharing, Home Sharing, and Family Care).
9. Support and participate in congregate contact tracing
10. Help providers implement strategies for isolation and social distancing

## Crisis Services

### Crisis Services Background Information

In 2015, 68% of mental health-related emergency department (ED) visits in New York City did not result in admission to the hospital.<sup>7</sup> In addition, 19% of inpatient psychiatric hospitalizations were for 3 days or less.<sup>8</sup> These data indicate that more crisis respite and outpatient treatment services are needed to promote diversion from EDs, in addition to immediate care without the need for hospitalization. These services are particularly needed in neighborhoods with high poverty, which are shown to have the highest rates of ED visits that do not result in admission.<sup>9</sup> However, data from the NYC Mental Health Needs Assessment Survey (NYC MHNAS) conducted from 2013-2014 shows that many psychiatric inpatients are not aware of outpatient services that can be used in place of hospitalizations.<sup>10</sup>

In light of this evidence, New York City has increased its provision of crisis response services in the past year. New York City's NYC Crisis Prevention and Response Task Force, composed of over 80 experts including advocates, city agency leadership, and community stakeholders with lived experience, recommended ways to improve and fill gaps in the City's Crisis Response System. In response to this taskforce's recommendations, New York City allocated additional funding to expand and enhance Mobile Crisis Teams to ensure rapid response to urgent mental health situations. This expansion will bring average response time down to two hours citywide, provide overnight responses, and extend services to include substance-use only crises. Finally, we've seen a 57 percent increase in our capacity to provide Intensive Mobile Treatment to individuals with the highest mental health needs and who may be poorly served by traditional treatment models (from the current capacity of 189 up to 297).

Adult Mobile Crisis Teams (MCTs) defuse behavioral and mental health crisis situations and link adults to community services as an alternative to ED use and hospitalization. MCTs receive approximately 21,000 referrals annually. Based on current state requirements, Adult MCTs have up to 48 hours to respond to referrals. With enhanced response times, MCTs will be able to better meet the needs of New York City adults and prevent emergency room use and hospitalization.

Similarly, dedicated Children's Mobile Crisis teams (CMCTs) defuse behavioral and mental health crisis situations and link children and their families to community services as an alternative to ED use and hospitalization. CMCTs citywide receive over 1,500 referrals annually. Performance data collected to assess and review service utilization show an increase in children and youth receiving CMCT services beginning in FY17. The CMCTs report that the youth/families referred for crisis intervention have multiple stressors, and many families do not have community supports in place prior to the intervention. In response to the demand for crisis services, the NYC DOHMH has received additional City funding to address the need beginning in FY21. CMCTs will be increasing in size to address the growing demand for crisis services

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<sup>7</sup> SPARCS 2015 Data

<sup>8</sup> SPARCS 2014 Data

<sup>9</sup> SPARCS 2015 Data

<sup>10</sup> MHNAS 2013-2014

with an additional two teams per borough. In addition, CMCTs will begin serving youth aged 18-20 with substance use needs.

These Mobile Crisis Teams are also important when people who use drugs experience crisis events and encounter law enforcement. Law enforcement responses to crisis events involving people who use drugs continue to be a large driver of potentially avoidable criminal justice interactions and hospital ED use. Several initiatives have sought to reduce costs while simultaneously improving client outcomes, including front-end diversion stabilization services, specialized law enforcement responses (such as Crisis Intervention Training (CIT)), and Co-Response teams. These purposeful structuring of law enforcement and mental health responses to crisis calls can improve client outcomes and save valuable resources. However, there is still considerable need for non-law enforcement and/or non-criminal justice responses when people who use drugs experience crises or behavioral health events. Preliminary evaluation of existing pre-arrest diversion programs suggests expanding eligibility criteria would increase access to those who may need services most.

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**Goal:** Improve outcomes for people experiencing mental health and drug related crises.

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1. Enhance the current crisis system to ensure individuals in crisis receive rapid services by coordinating with providers, payers, and state partners and allocating resources to better meet community needs.
2. Provide ongoing behavioral health treatment that is responsive to people experiencing complex life situations, including crisis; supports recovery from mental illness and substance misuse; maximizes continuity of care; reduces the recurrence of crisis; and decreases intersections with law enforcement.
3. Expand eligibility criteria for existing pre-arrest diversion programs.
4. Open remaining Support and Connection Center to provide NYPD a health-focused alternative to avoidable emergency room visits or criminal justice intervention.
5. Continue to utilize the Co-Response Team (CRT) to improve law enforcement's response to persons identified as presenting with elevated risk of harm to self and/or others in the community with the aim of connecting them to services.
6. Continue to work with the Crisis Taskforce, comprised of citywide partners, to implement approved recommendations to improve the City's response to those experiencing emotionally distress.
7. Continue to train NYPD Officers in Crisis Intervention Team (CIT) Training to better manage crisis and increase diversion. Prioritize trainings for NYPD members working on collaborative efforts, such as the Support and Connection Centers and Co-Response Teams.
8. Enhance services delivery of the children's mobile crisis teams by providing services to older youth, ages 18-20, addressing crises that involve substance use, and establishing overnight response.



## Workforce Recruitment and Retention (Service System)

### **Workforce Recruitment and Retention Background Information:**

The NYC DOHMH and partner entities have conducted a number of surveys to assess the barriers to recruiting and retaining a robust behavioral health workforce in New York City. Between 2016-2018, workforce surveys conducted by the New York State Care Management Coalition, Community Health Care Collaborative in NYC, and the NYC Regional Planning Consortium (RPC) assessed turnover among care management staff across New York State. In January 2019, we worked with OMH to survey OMH licensed clinics regarding difficulties in the recruitment and retention of their workforce. In addition, community input has consistently touted the value of peer support specialists as an integral component of the behavioral health workforce in New York City, due to their unique position to engage and support clients burdened with mental illness, substance use disorder, and intellectual/developmental disabilities.

According to the workforce surveys conducted from 2016-2018, there is a 55% turnover rate among care management staff both in New York City and across the state. Results showed a variety of reasons for this high turnover rate, including heavy caseloads, burdensome documentation, and the inability of community-based organizations to offer higher wages and benefits compared to what state-operated facilities, healthcare systems, and managed care organizations offer for similar jobs. According to the NYS Care Management Coalition, 52% of care management agencies surveyed also experienced challenges in recruitment due to the demanding nature of the job and educational qualifications expected. Nearly 31% stated that when qualified applicants are found, they are uninterested in pursuing a career in care management due to the low wages and benefits.

Similar results were shown in the citywide survey for OMH licensed clinics, conducted by the NYC DOHMH in conjunction with the OMH Field Office in 2019. This survey included questions around recruitment and retention difficulties, their capacity to serve the community, and questions specific to clinics serving children five and under. The survey had a 69.2% response rate. The preliminary results of the first category of questions, recruitment and retention difficulties, show that:

- “Salary is not competitive” is the most persistent reason for both recruitment and retention difficulty.
- The most difficult title to both recruit and retain was reported to be Child Psychiatrist.
- Other titles difficult to recruit include Psychiatrist (Adult and Geriatric), Psychologists, Nurse Practitioners, Physician Assistants, Licensed Clinical Social Workers (LCSW), and Peer Specialists.
- When asked which two titles had the most impact on the operations of the clinic when there was recruitment or retention difficulties, respondents chose LCSW, Adult Psychiatrist and Child Psychiatrist. Respondents chose the same titles when asked which titles had the most impact on the clinic’s ability to serve the community.
- Clinics reported the most difficulty recruiting or retaining bilingual clinicians who spoke Spanish, Chinese, and Bengali.

The NYC DOHMH solicited feedback from its Community Services Board (CSB) and CSB Mental Health Subcommittee about ways to address the workforce challenges identified in the 2019 survey. Feedback overwhelmingly centered on lack of reimbursement parity, low pay, provider burnout, and the inability of provider agencies to provide professional development and employee support due to employee time nearly entirely dedicated to service delivery. Moreover, in gathering feedback from community members, the NYC DOHMH repeatedly hears about long waitlists and high costs for care because providers infrequently accept insurance, and have shifted to cash-only models. This problem is particularly significant for low-income individuals in New York City.

Hiring and employing peer support specialists as a part of the behavioral health workforce is an effective strategy for promoting a robust and diverse behavioral health workforce that meets the mental and behavioral health needs of New Yorkers. For example, peer support specialists with lived experiences related to substance use disorder are effective in engaging people who are at high risk of overdose or engage in risky substance use. Peers are effective at providing tailored and sensitive information to individuals during vulnerable periods in their life, and can effectively educate people who use alcohol and other substances about risk reduction and treatment options. Treatment providers and other organizations who work with people who use drugs frequently identify a need for peers, as well as request assistance with incorporating peers into workflows and support with ongoing peer training and career advancement. The NYC DOHMH has implemented Peer Corps, which provides training and support to 20 peer Americorps members and works with host sites to integrate peers into workflows. In addition, the NYC DOHMH provides technical assistance on recovery peer integration to treatment providers in order to promote sustainable positions and services.

Similarly, peer support specialists with lived experiences related to caring for children with behavioral health challenges are particularly effective. Their lived experience allows them to build trusting relationships with parents and empower them to become more actively engaged in their children's services.<sup>11</sup> The benefits of peer-provided support for parents of children with emotional and behavioral challenges include increased hopefulness, improvements in caregiver self-care, empowerment when dealing with family issues and children's services, reduced maternal anxiety, improved activation in seeking care, and higher rates of service initiation. In addition to providing much-needed support for parents and caretakers, Family and Youth Peer Support (FYPS) Services support and empower children and youth who are experiencing social, emotional, developmental, and/or behavioral challenges, including substance misuse. Family support services can be adapted to the needs of different families and help them enter the mental health service system; as such, these services may be especially helpful for families who have avoided mental health services because of stigma or cultural issues.

Maintaining a well trained, ready, and culturally competent workforce is essential to providing quality services and supports for individuals with mental illness, substance use disorder, and intellectual/developmental disabilities, and their families and caretakers. This can be accomplished by promoting and ensuring continuing education programs for all levels of staff,

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<sup>11</sup> Alegría, M., Polo, A., Gao, S., Santana, L., Rothstein, D., Jiménez, A., Normand, S.-L. T. (2008). Evaluation of a patient activation and empowerment intervention in mental health care. *Medical Care*, 46(3), 247-256

adequate supervision, career planning and professional development support, retention incentives, adequate compensation, and providing opportunities for students and young people to learn about the field.

**The Impact of COVID-19 on Workforce Recruitment and Retention:**

The COVID-19 pandemic presents with increased likelihood that staffing challenges will be aggravated. As a result, there is a need for greater emphasis on this already burdened area of need. However, innovative technological strategies for engaging hard-to-reach clients have emerged due to the necessities of social distancing. The COVID-19 pandemic has forced providers to move from providing face-to-face appointments to quickly moving to providing services almost exclusively via phone and video. Both providers and clients have reported that the flexibility of telehealth services have provided has increased client satisfaction and their ability to seek and maintain regular services. In fact, providers have reported more kept appointments than face-to-face appointments in the past. Telehealth services allows engagement with individuals that the mental and behavioral health service system has previously not been able to engage fully in treatment. It will be critical for the behavioral health workforce to fully integrate telehealth services into their practice during the COVID-19 pandemic and beyond.

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**Goal:** Increase recruitment and retention rates of behavioral health professionals in NYC.

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1. Continue to enhance and promote the Peer and Community Health Workforce toolkit to assist service providers with successful integration of peers.
2. Collaborate with Regional Planning Consortium (RPC) stakeholders to reduce the workforce turnover rate among care management and behavioral health providers in NYC.
3. Increase cultural diversity training opportunities for health care professionals and other providers to enhance staff sensitivity to the cultural background of the individuals served, including understanding how to address the complex needs of individuals with developmental disabilities and are approaching or have reached advanced ages/human life expectancy.
4. Increase the number of professional training opportunities for direct support staff, including those working in family homes, respite care programs, and recreational programs, and Care Managers, and opportunities to include an increase in the number of agencies with established mentoring programs to provide one-on-one support to newer direct care staff.
5. Create opportunities for direct care staff, managers, Care Managers and other staff that provide skills training, leadership development and supervision through partnerships with CUNY or SUNY.
6. Encourage and support efforts to attract private sector professionals for not-for-profit positions that serve individuals with developmental disabilities.
7. Maintain, expand, and launch new initiatives to integrate evidence-based practices, recruit peers, support workforce development and advancement opportunities for peers, and work with employers to better integrate peer workers into workflows.

8. Continue to work with CUCS's Academy for Justice Informed Practice to train 3,300 legal, law enforcement, and healthcare professionals on the intersection of health and criminal justice
9. Advocate for increases in funding for nonprofits in the human service sector to allow for better recruitment and retention of BH providers and better continuity of care.
10. Identify ways to allow providers to continue practicing telehealth services post- COVID-19 pandemic.

## Prevention

### **Prevention Background Information:**

Preventing mental health and substance use issues before they interfere with New Yorker’s lives is the surest way to improve mental wellbeing and reduce the impact of mental illness and substance use on the City as a whole. The NYC DOHMH is focused on mitigating the effects of first-episode psychosis, reducing rates of suicide and suicide-related emergency department (ED) visits, and addressing alcohol and substance use among New York City youth and adolescents.

The NYC Health Department estimates that approximately 2,000 new cases of psychotic illness develop each year in New York. A recent study showed that people experiencing first episode psychosis have much higher mortality rates than the general population, particularly within the first 12 months of diagnosis.<sup>12</sup> However, early identification and intervention can significantly reduce the duration and impact of psychosis.<sup>13</sup> In response, New York City has implemented a first-episode psychosis engagement and connection to treatment program, NYC Supportive Transition and Recovery Team (NYC START), which aims to engage people as early as possible after diagnosis. NYC START connected 91.3% of those participating in the program in 2019 to outpatient mental health services, and 87.1% were connected to care in the first 30 days following discharge from a hospital. NYC START amended the health code to include mandated reporting starting at age 16 effective January 2019 in order to reach younger people presenting for care after an episode of psychosis.

In addition to mitigating the impact of first-episode psychosis among New Yorkers, preventing suicide is also a significant area of concern. Though suicide rates in New York City are lower than overall rates across New York State and the United States, the total number of lives lost remains high due to population density. According to Vital Statistics, there were 565 suicides in NYC (551 adults; 14 youth) in 2017. Males, non-Latino Whites, and adults ages 45-64 had the highest rates of suicides. The rate of suicide among males was nearly three times that of females (9.6 per 100,000 compared to 3.4 per 100,000). However, the rate of suicide among females increased approximately 4% annually between 2008 to 2017; no significant change among males was observed. Non-Latino Whites had a suicide rate of 9.2 per 100,000 compared to 5.3 for Blacks, 4.3 for Latinos, and 4.7 for Asian/Pacific Islanders.<sup>14</sup> In addition to suicide deaths, there were approximately 40,000 suicide-related emergency department visits to NYC hospitals in 2019. These visits were for suicidal ideation, intentional self-harm, and suicide attempts. The majority (59%) of visits were made by males. Approximately 28% of visits were made by individuals less than 25 years old.<sup>15</sup>

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<sup>12</sup> Schoenbaum, M., Sutherland, J., Chappel, A., Azrin, S., Goldstein, A., Rupp, A., Heinssen, R. Twelve-Month Health Care Use and Mortality in Commercially Insured Young People with Incident Psychosis in the United States. *Schizophrenia Bulletin*, April 6, 2017.

<sup>13</sup> Heinssen RK, Goldstein AB, Azrin ST. Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care. National Institute of Mental Health; 2014.

<sup>14</sup> 2017 Vital Signs Report

<sup>15</sup> Capua J, Blachman-Forshay J, Mello E, Nolan ML, Paone D. Drug Use among Youth in New York City Public High Schools, by Sexual Orientation and Gender Identity, 2015. New York City Department of Health and Mental Hygiene: Epi Data Brief (92); June 2017.

Due to the circumstances resulting from the COVID-19 pandemic, suicide may become a more pressing concern as the pandemic spreads and has longer-term effects. While there was not a clear link between the 2008 recession and an increase in suicide, it is possible that the combination of provider burnout, weakened health infrastructure, economic insecurity and changes in business cycles, job loss or unemployment, and loss of social connection may be associated with increased risk of suicide during and after the COVID-19 pandemic. Historically, there is some evidence that deaths by suicide increased in the United States during the 1918–19 influenza pandemic and among older people in Hong Kong during the 2003 severe acute respiratory syndrome (SARS) epidemic. Therefore, efforts to engage individuals at highest risk for suicide will need to be increased as the aftereffects of the pandemic becomes clear. The NYC DOHMH is working to address suicide risk through NYC Well, its crisis contact center, as well as by increasing access to mobile crisis and mobile treatment teams. Furthermore, the NYC DOHMH uses surveillance data to identify and locally respond to trends in suicide-related ED visits.

The NYC DOHMH’s prevention strategy is also focused on addressing alcohol and substance use among youth and adolescents. In 2015, 21 percent of surveyed New York City public high school students had >1 alcoholic drink in the 30 days prior to being surveyed, a decrease from 25% in 2013.<sup>15</sup> Among youth who reported drinking in 2015, 44% reported binge drinking at least once during the past month.<sup>16</sup> In 2017, 9% of NYC youth in public high schools reported ever having used an illicit drug in their lifetime, including cocaine, heroin, ecstasy, and synthetic cannabinoids. The prevalence of substance use among New York City youth differs by demographic group. The 2017 New York City Youth Risk Behavior Survey found that 10 percent of Latinx and 9 percent of White public high school students reported ever using (also known as “lifetime use”) any illicit drug, compared with 7 percent of Black and 5 percent of Asian students in NYC public high schools.<sup>17</sup> Male students reported significantly higher levels of both lifetime illicit drug use and past-year non-medical prescription drug misuse than female students.

LGBTQ+ youth are especially at risk for alcohol and substance use. In 2015, a total of 16 percent of students who identified as lesbian, gay, or bisexual, and 17 percent of students who identified as questioning their sexual orientation, reported ever using illicit drugs. This is two times higher than their straight counterparts (8 percent). Differences were also seen by gender identity, where 37 percent of transgender students in NYC public high schools reported ever using illicit drugs in 2015 compared with 8% of students who do not identify as transgender.<sup>18</sup>

### **Considerations for Racial Equity in Prevention**

Strategies for preventing mental health and substance use issues must account not only for the evidence-based interventions and services that our communities need, but also for their cultural

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<sup>16</sup> Blachman-Forshay J, Mello E, Capua J, Tuazon E, Paone D. Alcohol Consumption among Youth in New York City Public High Schools, by Sexual Orientation and Gender Identity, 2015. New York City Department of Health and Mental Hygiene: Epi Data Brief(94); Nov 2017.

<sup>17</sup> Ko C, Tuazon E, Paone D. Illicit Drug Use and Prescription Drug Misuse among Youth in New York City Public High Schools, 2017. New York City Department of Health and Mental Hygiene: Epi Data Brief (120); November 2019.

<sup>18</sup> Blachman-Forshay J, Mello E, Capua J, Tuazon E, Paone D. Alcohol Consumption among Youth in New York City Public High Schools, by Sexual Orientation and Gender Identity, 2015. New York City Department of Health and Mental Hygiene: Epi Data Brief(94); Nov 2017.

and linguistic needs. These strategies must also name and seek to undo structural racism. Our CSB Mental Health Subcommittee has reported that there are variations in how different racial and ethnic groups view mental health, substance use, and accessing treatment, as well as how they might be treated while accessing services. Additionally, we recognize there are important variations within particular groups, such as Asian Americans. This Subcommittee has also reported that the lack of workforce that is representative of the community it serves is a barrier to engagement and care.

The NYC DOHMH recognizes that preventative and treatment services are only effective when they reach those they are intended to benefit. When they are not in the languages of our communities, or the translations are ineffective at conveying the correct message, and when communications about our services do not take into consideration cultural beliefs about mental illness and substance use, our services will not reach those who truly need them. Therefore, the NYC DOHMH will promote language access in our prevention strategy, and is committed to building a behavioral health workforce that is representative of the communities in which they serve.

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**Goal:** Address key risk factors across the lifespan for mental health issues through comprehensive prevention strategies to prevent or reduce mental health and substance use issues.

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1. Continue to support 14 Community Based Organizations (CBOs) and their dedicated Mental Health Provider partners to build their ability to adopt and adapt task-sharing mental health skills among CBOs by enabling them to implement core skills and strategies, including motivational interviewing, Mental Health First Aid, screening, psychoeducation, and quality improvement.
2. Engage survivors of trauma regarding the importance of trauma-informed approaches and partner with them to increase awareness through education and advocacy.
3. Conduct public awareness campaigns, and targeted and broad outreach to prescribers to educate on preventing future cases of opioid addiction as well as on overdose prevention, including use and co-prescribing of naloxone.
4. Reduce misuse of alcohol and drugs among youth, especially among LGBTQ+ young people, by launching media literacy curricula designed to equip youth with critical thinking and analytic skills and continuing to provide technical assistance to community coalitions working to create more affirming environments for LGBTQ youth.
5. Utilize and expand the Health Engagement and Assessment Teams (HEAT) to increase direct community engagement to meet the behavioral health, physical health, social service needs of individuals residing in communities with the high rates of COVID-19 morbidity and mortality, behavioral health crises, and overdose mortality.
6. Work with contracted providers to launch new training center that offers trainings in evidence-based parenting and family support models to staff in community-based and clinical settings to expand the reach and availability of supports to families that promote secure attachment and positive mental health among children and adolescents.

7. Launch new networks of community-based family and youth peer support programs in each borough for parents/caregivers of children and youth (birth – age 24), who are experiencing social, emotional, developmental, behavioral, and/or substance use challenges, and for the youth themselves.
8. Maintain high percent of NYC START participants who attend mental health services, including Coordinated Specialty Care, following hospitalization for first episode psychosis.
9. Advocate for continued steps to address workforce shortages, especially shortages in communities of color, in order to increase cultural competency among mental health workers and their capacity for culturally appropriate mental health care in communities of color.
10. Develop and implement a citywide suicide prevention strategy that accounts for the unique needs of communities and social groups disproportionately impacted by suicide and suicidal behaviors and populations that have been disproportionately impacted by the COVID-19 pandemic. Use established suicide surveillance protocol for identification and response to increases in suicide related emergency department visits and suicide deaths as one component of pandemic response and suicide prevention planning.



## Reducing Stigma

### **Reducing Stigma Background Information:**

Numerous stakeholders representing a wide range of NYC communities have identified stigma as a significant barrier to accessing services, care, and treatment for people with mental disorders, people who use drugs, people with substance use disorders, or people with co-occurring substance use/mental health disorders. The emphasis on stigma is supported by results of the NYC Health Opinion Poll, conducted by the NYC DOHMH between April and May 2019. According to the NYC Health Opinion Poll, 64.0% of citywide respondents agreed or strongly agreed that people with mental illness are more dangerous or violent than the average person; 50.0% agreed or strongly agreed that a person who has a mental illness is less trustworthy than the average person; 29.4% agreed or strongly agreed that they think less of a person who has a mental illness; and 23.0% agreed or strongly agreed that having a mental illness is a sign of personal failure.

In the light of these Health Opinion Poll results, the NYC DOHMH recognizes that increased community engagement and education is critical for raising awareness of and reducing stigma around mental and substance abuse disorders. In particular, stakeholders in our Regional Planning Consortium (RPC) have expressed that faith-based organizations and community-based organizations specifically addressing social determinants of health could play an impactful role in raising awareness about mental illness and substance use issues.

### **The Impact of COVID-19 on Reducing Stigma**

While the COVID-19 pandemic has largely made a negative impact in the health infrastructure of New York City, clients and providers have reported a silver lining in the impact of telehealth on reducing stigma. Clients have reported that telehealth services have allowed them to feel less stigma and fear around reporting mental health issues to a provider. Continuing to allow telehealth services to occur will allow the mental health system to engage individuals they haven't been able to engage in services in the past, including individuals that face stigma associated with mental health issues due to their cultural background.

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**Goal:** Increase awareness of behavioral health conditions.

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1. Expand outreach to underserved and hard to serve communities via highly skilled trainers representing those communities to address mental health related stigma and trauma.
2. Implement the Clergy Clinician Community Collaboration (4Cs) and the Reclaiming Our Health (ROH) initiatives, (formerly known as Community Partners in Care (CPIC)), to promote mental health awareness and prevention through technical assistance, skills building support, guidance and collaborative planning. Efforts are guided by community engagement, quality improvement and task sharing approaches to address gaps in providers' cultural competency, community traditional beliefs, and stigma.
3. Deliver ongoing presentations from the behavioral health peer perspective to behavioral health community stakeholders and educational institutions.

4. Develop and conduct public awareness and education campaigns to reduce stigma toward people who use drugs, drug use, and drug treatment.
5. Continue to educate healthcare and other service providers on the health risks of criminal justice system involvement and how they can best support their justice involved patients/clients using a trauma-and-resilience-informed approach.
6. Continue to utilize the Health Engagement and Assessment Teams (HEAT) team to reduce the stigma around mental health, substance use, and the criminal justice system.
7. Develop an agency-wide action plan that outlines the health impact of the criminal justice system and its impact and identify opportunities to facilitate improvements.
8. Advocate with the State to allow providers to continue to bill for telehealth services post pandemic.

## Employment/Job Opportunities

### Employment/Job Opportunities Background Information:

Unemployment rates among people with mental illness, substance use disorders, and intellectual/developmental disabilities remain high. 71 percent of individuals with SMI were looking for full-time work in 2012.<sup>19</sup> Individuals with developmental disabilities in particular have limited options for employment and for developing on-the-job employment skills. In 2018, approximately 59% of New Yorkers with depression were unemployed or not in the labor force.<sup>20</sup> Individuals with developmental disabilities in particular have limited options for employment and for developing on-the-job employment skills. Despite high rates of unemployment, providers struggle placing and supporting people with SMI due to a lack of knowledge about existing services. Both providers and consumers need information on employment services and their impact on benefits.

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**Goal:** Increase employment opportunities and reduce employment disparity for individuals with serious mental illness, substance use disorder, and/or intellectual/developmental disabilities.

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1. Host a minimum of two annual conferences that provide professional development opportunities for the NYC peer specialist workforce.
2. Engage stakeholders through existing meetings and phone based technical assistance to assist them in hiring peer specialists.
3. Increase and vary employment opportunities to increase the number of people with developmental disabilities who are employed so that employment is person-centered and customized. Efforts may include promotional events such as career fairs and collaborative efforts with OPWDD DDROs, local Chambers of Commerce and other local partners, including not-for-profit entities.
4. Ensure that individuals who are not able to be employed PT or FT have adequate resources and options, including integrated supported day opportunities.
5. Explain benefits and maintain classifications (e.g., SSI, MA) even when the individual in question is employed/employable.
6. Through local contracting with vocational support service providers in all 5 boroughs, increase the number of individuals with I/DD (who are not eligible for OPWDD employment support services) who are successfully employed.
7. Maintain and expand the HJN and Health Engagement and Assessment Team (HEAT) to increase employment opportunities for individuals with justice system involvement and continue to improve community health worker integration into their home organizations.
8. Develop foundational education for healthcare hiring staff about (1) the criminal justice process and (2) common guidance on criminal background disclosure.

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<sup>19</sup> CMHS 2012

<sup>20</sup> CHS 2018

9. Engage re-entry organizations to assist in educating potential job applicants with criminal records about requirements and hiring processes of hospital employers.

## Mental Health Care Coordination

### **Mental Health Care Coordination Background Information:**

The NYC DOHMH aims to identify ways to ensure that children and youth with the highest mental health needs receive effective care coordination, especially those not fully achieved through the existing care management programs such as Health Homes Serving Children and Children’s Non-Medicaid Care Coordination. The NYC DOHMH, in partnership with OMH and NYC stakeholders, is conducting a demonstration project to implement and evaluate High Fidelity Wraparound (HFW), an intensive, individualized planning and management process for children and youth with serious social, emotional or behavioral concerns who are involved in multiple systems. Specifically, HFW is an evidence-based model of care coordination that, when practiced to fidelity, improves outcomes and lowers rates of hospitalization and residential treatment for youth with serious mental health needs and who are also involved in the child welfare, juvenile justice, or special education systems.

Since the start of the HFW demonstration project in 2019, the two HFW teams serving youth and their families in Brooklyn and the Bronx have enrolled and served a total of 22 youth. The two teams have the capacity to continue to serve approximately a total of 20 youth and their families annually. With NYC’s continued participation with other select NY State pilot counties, we aim to also (1) test newly developed training, coaching, supervision and workforce credentialing required for individuals to practice this model to fidelity, (2) identify and implement a standardized system for data collection and reporting that future providers would need in order to implement and bill for this model, (3) identify sustainable payment methods of this model to ensure service is fiscally viable and (4) demonstrate cost effectiveness.

Additionally, demonstrated need to improve systems and practices to reduce hospitalization and Residential Treatment Facility (RTF) placement among youth may be met by the HFW model that has been shown to lower rates of hospitalization and residential treatment. NYS is undertaking a complementary effort to reduce use of residential treatment and help children to transition successfully back to the community upon discharge. A 2019 workgroup convened by the NYS Coalition for Children’s Behavioral Health recommended High Fidelity Wraparound (HFW) to avert the need for RTFs and assist families in addressing barriers to a child’s return to the community upon discharge.<sup>21</sup> NYC Health Department is further exploring how the current demonstration project can be expanded to focus on youth who have been referred to or recently discharged from a RTF.<sup>22</sup>

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**Goal:** Improve mental health care coordination and cross system collaboration needed to serve children and youth with the highest mental health needs.

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<sup>21</sup> Reforming NYS OMH Residential Treatment Facilities by the NYS Coalition for Children’s Behavioral Health.

<sup>22</sup> These provide comprehensive mental health treatment in a residential setting for youth requiring longer-term care than an inpatient hospital setting can provide, with stays that exceed 180 days

1. Implement and evaluate High Fidelity Wraparound (HFW) in NYC for 20 children and their families, through a demonstration project.
2. Develop network of organizations servicing children of incarcerated parents to connect to necessary mental health, physical health, and other support services.

## Recovery and Support Services

### **Recovery and Support Services Background Information:**

Recovery and support services in NYC have expanded, but New Yorkers would benefit from additional services in this area. Almost 70% of New Yorkers with SMI reported needing some or a lot of help meeting people for social support. NYC Well, which launched October 2016, provides City-funded support: about 15% of people calling, texting, or chatting are choosing to connect with a peer specialist<sup>23</sup>.

Recovery and support services are especially critical for people who use drugs, particularly among communities that are at higher risk for overdose deaths. After seven consecutive years of increasing overdose deaths, the number and rate of overdose deaths finally decreased in 2018.<sup>24</sup> However, the decrease in overdose deaths citywide was not evenly distributed across demographic groups and neighborhoods. Overdose deaths increased among Latinx residents and older New Yorkers ages 55 to 84. Overdose deaths also increased among residents of the Bronx, Staten Island, and Manhattan, while decreasing substantially among residents of Brooklyn and Queens. In addition, large geographic disparities in overdose rates persist. Residents of East Harlem, Crotona-Tremont, and Hunts Point-Mott Haven had the highest rates of overdose death—more than twice the rate of overdose death citywide.

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**Goal:** Increase the number of individuals, adolescents, and families receiving appropriate recovery-oriented services for substance use.

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1. Provide opportunities for behavioral health peer specialists and family members of people suffering from behavioral health issues to attend conferences and workshops that enhance their advocacy skills and knowledge of recovery.
2. Work with syringe service programs to increase outreach to and engagement of people who use drugs.
3. Continue to support OASAS effort to develop new models for engaging and treating adolescents.
4. Continue to work with OASAS to implement evidence-based practices for both adolescent treatment and substance use prevention programs for adolescents.
5. Increase treatment available to adolescents and young adults that include medications for opioid use disorder (MOUD) as a treatment option.

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<sup>23</sup> Postpartum Depression NYC Vital Signs 2017

<sup>24</sup> Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019.

## Adverse Childhood Experiences

### **Adverse Childhood Experiences Background Information:**

Early childhood experiences of adversity and trauma, including domestic violence, are associated with increased risk for chronic diseases and threats to mental health in adulthood.<sup>25,26</sup>

Adolescents exposed to adverse childhood experiences (ACEs), including family malfunctioning, abuse, neglect, violence, and economic adversity, are nearly twice as likely to experience the onset of mental disorders as compared to children without these traumatic experiences. Furthermore, the risk to mental health grows with additional exposures, and unresolved trauma as a result of ACEs can also negatively impact development across the life span and intergenerationally, contributing to substance misuse, child abuse, poverty, incarceration, diminished productivity in the workplace and in all aspects of an individual's life.

As public health practitioners and policymakers increasingly recognize the long-term impact of adversity and trauma in early childhood, there is increased attention on young children's social-emotional development and mental health.<sup>27</sup> Evidence has shown that the provision of safe, nurturing environments and equitable opportunities for children to build key skills provide the foundation for healthy development and success at school and in life.<sup>28</sup> A growing body of evidence highlights the importance of ensuring early and accurate identification of these developmental, emotional, and behavioral concerns, as well as the value of effective, evidence-based treatments and supports.<sup>29,30</sup> Specifically, family-focused, evidence-based therapeutic interventions have been shown to reduce symptoms, improve attachment, strengthen children's resilience, and support their healthy development.

Despite these advances in early childhood development, many young children and their families do not have equitable access to appropriate treatments for the challenges they face because of insufficient numbers of clinics and professionals serving this population. Practitioners need a set of specialized skills and competencies to work effectively with young children. Nationally, there is a recognized shortage of professionals specifically trained to meet the mental health needs of children aged 0 to five and their families.<sup>31</sup>

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<sup>25</sup> Chapman, D.P., Whitfield, C.L., Felitti V.J., Dube S.R., Edwards, V.J., Anda, R.F. Adverse Childhood Experiences and the Risk of Depressive Disorders in Adulthood. *Journal of Affective Disorders*. 82: 217– 225 2004, 2004.

<sup>26</sup> Halfon, N. Wise, P.H. and Forrest, C.B. The Changing Nature of Children's Health Development: New Challenges Require Major Policy Solutions *Health Affairs* 33, no.12:2116-2124 doi: 10.1377/hlthaff.2014.0944, 2014.

<sup>27</sup> Zero to Three, & Manatt. (2016). Planting seeds in fertile ground: Actions every policymaker should take to advance infant and early childhood mental health. Retrieved from <https://www.zerotothree.org/resources/1221-planting-seeds-in-fertile-ground-steps-every-policymaker-should-take-to-advance-infant-and-early-childhood-mental-health>] Annie E. Casey Foundation. (2014). Race for results: Building a path to opportunity for all children.

<sup>28</sup> National Scientific Council on the Developing Child. (2007). *The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do*. Retrieved from [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu)

<sup>29</sup> Center on the Developing Child at Harvard University. (2016). *From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families*. Retrieved from [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu).

<sup>30</sup> National Research Council. (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.

<sup>31</sup> Cohen, J., Oser, C., & Quigley, K. (2012). Making it happen: Overcoming barriers to providing infant-early childhood mental health. *Zero to Three*, 1-20.



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**Goal:** Increase providers' knowledge of the impact of trauma on children and caregivers, and how to use trauma- and resilience-informed approaches.

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1. Through the Early Childhood Mental Health Training and TA Center, train early childhood mental health and allied professionals on best practices for using trauma- and resilience-informed approaches in their work.
2. Through the new EmPWR project (Environments Promoting Wellness and Resilience), use a participatory approach to train staff in Domestic Violence shelters to enhance trauma- and resilience-informed environments that promote wellness and resilience for survivors, their children, and staff.
3. Engage survivors of trauma regarding the importance of trauma-informed approaches and partner with them to increase community awareness through education and advocacy.

## Inpatient Treatment Services

### **Inpatient Treatment Services Background Information:**

Psychiatric hospital readmission remains an issue for many people with mental illness in New York City. The CSB Mental Health Subcommittee reports that long wait times for needed support and services have the result of excluding people from the outpatient system simply because they are unable to obtain appointments within a reasonable timeframe. When individuals who know they need help cannot get that help in a timely manner, this can result in decompensation and readmission. If the ambulatory care system is unable to meet the needs of the community, readmissions cannot be reduced.

In light of this, New York City is increasing availability of Mobile Crisis Teams, as well as post-hospitalization services such as Assertive Community Treatment (ACT), Intensive Mobile Treatment (IMT), and New York City’s contact center, NYC Well. Many more services, including outpatient clinic care, experience chronic workforce shortages that force clinics to manage long waitlists as they see more need than they have resources to meet. Moreover, as discussed elsewhere in this Local Services Plan, while Mobile Crisis Teams are ideal for helping individuals in acute crisis within 2 hours, outpatient clinics are best suited to support individuals who require urgent mental health care that does not rise to the level of the Mobile Crisis Teams’ 2-hour response. However, outpatient clinics are unable to do so effectively because they are under-resourced, overburdened, and have not traditionally been expected or supported to take on this role.

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**Goal:** Reduce avoidable psychiatric hospital readmissions

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1. Provide ongoing behavioral health treatment that is responsive to people experiencing complex life situations, including crisis; supports recovery from mental illness and substance misuse; maximizes continuity of care; and reduces the recurrence of crisis.
2. Advocate for reducing/eliminating workforce shortages by increasing reimbursement rates and making other investments in the mental health and human services systems to support these workers in their communities.
3. Advocate for the state’s support in shifting non-acute crisis care to outpatient clinics, such as through state financial investment in clinics to expand their capacity to support these individuals. (See more information in the Crisis Issue Area.)

## Other Mental Health Outpatient Services (Non-clinic)

### **Other Mental Health Outpatient Services Background Information:**

Providing mental health services in community settings promotes better outcomes for those with serious mental illness. Due to significant need in New York City, we continue to see long waitlists for our enhanced services such as Assertive Community Treatment (ACT), and have difficulty engaging the individuals who are hardest to reach. The NYC DOHMH aims to offer more flexible treatment models like Intensive Mobile Treatment (IMT) moving forward. Greater flexibility in how mobile treatment is delivered allows providers to meet individuals where they are, especially individuals who have not traditionally connected well with mental health services.

The IMT model also allows for recruiting more culturally and linguistically appropriate staff because it does not rely on the low, unsustainable reimbursement rates set by the state. Instead, teams are able to focus on how to best serve the unique, individual needs of each client. The predominantly white, female workforce has not been designed to meet the needs of many people, resulting in a system that some people with mental illness do not want to or not able to access. In gathering community feedback in many settings, we found that cultural competency to be essential in ensuring that New Yorkers who have not traditionally connected well with mental health services are cared for in ways that best meet their needs.

In addition to promoting cultural competency among the behavioral health workforce, the NYC DOHMH aims to address the significant physical health needs of people with SMI, particularly the health conditions and social determinants that contribute to the higher rates of premature mortality among New Yorkers with SMI. Tobacco use is a particular concern in NYC DOHMH-contracted programs serving people with SMI. More people with current depression are current smokers compared to those without current depression (25% compared with 12.0%).<sup>32</sup> While people with SMI are as motivated to quit as smokers without SMI, providers report being hesitant to address the issue of cessation.

Individuals in supportive housing are at increased risk for smoking. In a 2017 survey, 47 percent of supportive housing residents reported current tobacco use. Of those, 23 percent were engaged in smoking cessation counseling and treatment. This increased slightly over a 3-month period, but it remains difficult for supportive housing providers, as non-treatment providers, to deliver the proper cessation education and support to residents. NYC Tobacco Cessation Training and Technical Assistance Center (NYC TCTTAC) aims to build the capacity of the behavioral health providers to provide effective tobacco dependence treatment to New Yorkers with co-occurring conditions. This includes promoting nicotine replacement therapies and advocating for individuals with SMI to try them without pressure to quit smoking. This strategy supports the individuals' autonomy, recognizes the place nicotine can have in the life of an individual with SMI, and the challenges individuals with SMI have when it comes to quitting, and allows for a slower, nonjudgmental shift away from smoking.

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<sup>32</sup> Community Health Survey, 2017.

The NYC Mental Health Subcommittee of the Community Services Board (CSB) has also expressed concerns about the impact of the political climate on immigrants' access to mental health treatment and support. Some members of the Subcommittee affiliated with provider agencies have anecdotally reported a decline in mental health service utilization by immigrants, which they attributed to a fear of federal immigration repercussions, despite efforts to encourage the use of mental health services in these communities.

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**Goal:** Promote holistic health of people living with serious mental illness and increase engagement with people who the mental health system has not effectively engaged in the past.

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1. Advocate for the state to adopt some of the principles that make IMT successful, including flexibility, frequency and duration of contact.
2. Advocate for the state to consider offering more flexibility for ACT teams to reopen cases for people they saw last year who dropped out of care and then came back (to allow them to go above their cap in service of continuity of care while bring careful not to dilute the intensity of the service).
3. Implement nicotine replacement therapy pilot among certain providers and conduct pre- and post-evaluation to determine effectiveness as reducing cigarette smoking.
4. Develop culturally sensitive communications strategies to promote mental health resources for all communities of color, including immigrant communities.
5. Implement communication tools and strategies to reach and educate housing and behavioral health providers on maintaining smoke-free environments by using nicotine replacement therapies.

## Developmental Disabilities Clinical Services

### **Developmental Disabilities Clinical Services Background Information:**

While autism services are identified as a separate issue area, it is being included in DD Clinic Services as a sub-category. Autism behavioral services, also known as Applied Behavioral Analysis, remain an important treatment services area for those with autism spectrum disorder. Because of the lack of therapists for this treatment modality, it should be included under DD Clinic Services.

Many individuals with developmental disabilities have complex healthcare needs. This includes both aging and medically fragile individuals. Ensuring that preventive and quality medical, psychiatric, and dental care is accessible and available are ongoing health priorities for this population. In addition to clinic services, residential opportunities are needed to serve medically fragile individuals who require palliative care and whose medical care needs are difficult to meet within an IRA or home setting.

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**Goal:** Improve access to and availability of all services to meet the medical and dental needs of children and adults with developmental disabilities, including aging individuals and medically fragile children and adults (OPWDD), and adjust payment schemes (CMS).

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1. Provide services for individuals with I/DD in NYC who are not eligible for OPWDD clinic services.
2. Collaborate with OPWDD to develop appropriate residential opportunities for medically fragile individuals who require palliative care.
3. Collaborate with OPWDD to increase availability of medical and dental services to meet the needs of individuals with developmental disabilities, including those who are aging, have complex healthcare needs, and/or are medically fragile.
4. Collaborate with state and other appropriate stakeholders to promote the development of reimbursement mechanisms to accommodate the delivery of telehealth services, where appropriate and feasible.

## Transportation

### **Transportation Background Information:**

Accessible transportation options are critical for people with developmental disabilities, including individuals who use wheelchairs, walkers, canes, and accessible devices to ensure they are able to travel to and from outside activities.

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**Goal:** Expand the availability of transportation options for people with developmental disabilities by creating specific payment allowances to providers (OPWDD), and promoting public transportation enhancements.

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1. Collaborate with OPWDD to increase provider ability to support program participants' needs to travel to and from outside activities.
2. Collaborate with appropriate stakeholders to increase the number of wheelchair accessible taxis and other livery services in all five boroughs in New York City.
3. Collaborate with OPWDD to increase travel training opportunities.
4. Collaborate with MTA to explore eligibility criteria to increase the number of individuals with disabilities who receive reduced fare Metro cards.
5. Collaborate with appropriate stakeholders to assure the safety and reliability of transportation services for individuals with disabilities, including Medicaid-funded ambulette and other transportation services.
6. Collaborate with appropriate stakeholders to expand subscription services with enhanced eligibility and reliability through Access-a-Ride and Logisticare.

## Developmental Disability Student/Transition Services

### **Student Transition Services Background Information:**

Support services for individuals with developmental disabilities and their families are particularly important during periods of transition. This includes services that support transitions from preschool to school and from school to adult day services or work settings. OPWDD and SDOE should assure that information and education about managing transition issues is disseminated in schools and other settings.

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**Goal:** Ensure support for individuals and families is available during transition periods.

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1. Coordinate efforts with OPWDD to increase outreach and support services, including family education and training, available to assist individuals and families with transitions.
2. Collaborate with OPWDD to increase coordination with NYC DOE District 75 and other districts, community, parochial and private special education schools to educate and inform parents and families about transition issues (including that the transition process should begin no later than age 14 years) and available support. Includes working with transition coordinators, and attending transition school fairs and PTA meetings.
3. Coordinate efforts with appropriate stakeholders to support Early Intervention programs to educate families about transition and available services.
4. Coordinate efforts with OPWDD to disseminate information and enforce adherence to relevant legislation surrounding transition periods and processes.
5. Collaborate with OPWDD to enhance opportunities for accessing adult day program services for graduates.
6. Collaborate with appropriate stakeholders to ensure the coordination of efforts for the current graduates between the DOE, DDRO, and voluntary agencies.

## Developmental Disability Family Supports

### **Developmental Disability Family Supports Background Information:**

While developmental disability respite services, developmental disability children services, and developmental disability care coordination are identified as separate issue areas, they are being included in Family Supports as sub-categories.

Families living with and caring for individuals with developmental disabilities at home need access to appropriate support services. Greater availability of a range of family support services can help sustain families, whose resources are often stretched, and can help families prevent or cope with crisis situations.

The COVID-19 pandemic can be expected to create additional need in family supports. A need for respite and similar services can be expected to surge, possibly for more than the short and medium term as families do their best to recuperate from various levels and types of loss. Care coordination and children services may be expected to be in similar heightened demand for the foreseeable future. OPWDD should treat these service areas as essential family supports, and prioritize them for 2021 local services planning.

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**Goal:** Collaborate with OPWDD to enhance support and access to services to sustain families who care for individuals with developmental disabilities at home and/or those awaiting residential placement.

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1. Collaborate with OPWDD to provide services for families and individuals with Autism Spectrum Disorder in NYC who are not eligible for OPWDD waived family support services.
2. Collaborate with OPWDD to expand person-centered out-of-home family support options, such as recreation and overnight respite, for people who are non-ambulatory.
3. Collaborate with OPWDD to expand local intensive behavioral supports, including short-term residential treatment options for people with severe behavioral challenges.
4. Collaborate with OPWDD to expand person-centered, out of home recreation and socialization supports for people with I/DD living on their own in non-certified residential settings.
5. Collaborate with OPWDD to increase availability of crisis intervention and respite programs as well as afterschool, evening, weekend, and holiday, recreational and socialization programs geared specifically for children and adults with developmental disabilities.
6. Coordinate efforts with appropriate stakeholders to disseminate information about and expand access to educational and support groups for families and caretakers including internet-based and webinar trainings, via electronic and other media and outreach methods.



7. Coordinate efforts with appropriate stakeholders to provide training for families and caretakers in addressing and managing the needs of individuals with challenging behaviors.
8. Coordinate efforts with appropriate stakeholders to facilitate entrance to and maintenance of benefits, eligibility and governmental entitlements, including OPWDD Front Door.
9. Coordinate efforts with appropriate stakeholders to provide additional training to the Care Coordinators to ensure they are aware of all of the resources that are available.

## Developmental Disability Care Coordination

### **Developmental Disabilities Care Coordination Background Information:**

Very few services are available for people who have both a developmental and a behavioral health or psychiatric disability, including people with co-occurring substance abuse treatment needs. There continues to be a large demand for inpatient and outpatient behavioral health services for individuals who are dually diagnosed.

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**Goal:** Increase support for dually diagnosed individuals (including inpatient treatment for intervention and assessment) through program development and system collaboration.

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1. Identify program development opportunities through collaboration with OPWDD, OASAS, OMH, Access-VR, DFTA and other partners that can meet the needs of individuals with developmental disabilities and co-occurring behavioral health conditions.
2. Collaborate efforts with OPWDD to develop transitional residences and out-of-home respite for persons with dual diagnoses who are in crisis and living with their families.

## Developmental Disability Front Door

### **Developmental Disability Front Door Background Information:**

Informing and educating individuals with developmental disabilities, families/caretakers, providers, and professionals about available services and benefits will help to increase the number of individuals accessing and benefiting from services that meet their needs. OPWDD Front Door remains the initial entry point into the community system of services for individuals with I/DD; as a result, the Front Door is an essential component of services information/education.

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**Goal:** Individuals with developmental disabilities, families/caretakers, providers, and professionals will have increased access to information about available services, starting with the NYS OPWDD Front Door.

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1. Encourage interagency public outreach efforts that will inform the target population of available supports and services and linkages to those services. Efforts may include holding county town hall meetings, Family Support fairs, educational conferences, outreach to religious institutions, medical offices and senior centers, and use of social media and other innovative methods such as 311, public service announcements, NY Connects, and outreach to Community Boards.
2. Increase coordination with NYC DOE District 75 and other districts, community, parochial and private special schools to educate and inform parents and families about transition issues (including that the transition process should begin no later than age 14 years) and available support. Includes working with transition coordinators, and attending transition school fairs and PTA meetings.
3. Work with Early Intervention programs to educate families about transition and available services.
4. Coordinate efforts with OPWDD and other appropriate stakeholders to disseminate information and enforce adherence to relevant legislation surrounding transition periods and processes.

## SUD Outpatient Services

### **SUD Outpatient Treatment Services Background Information:**

In New York City, fentanyl is now the most common drug involved in overdoses. Furthermore, the burden of overdose is not spread evenly across communities and neighborhoods. Given the current drug overdose epidemic in NYC, there is substantial need for treatment and other services for people who use drugs. Specifically, increasing access to medications for opioid use disorder (MOUD) — the gold standard of treatment for opioid use disorder — is critical. The NYC DOHMH is seeking to increase the number of New Yorkers receiving medication treatment for opioid use disorder. However, there are disparities in access to buprenorphine, and buprenorphine is heavily regulated (prescribers must seek a waiver in order to prescribe buprenorphine). Additionally, not all people who use drugs are ready to stop their drug use. Therefore, there is substantial need to increase access to substance use disorder treatment and other kinds of flexible and non-abstinence focused outpatient services for people who use drugs. Engaging people who use drugs in other services, such as harm reduction services, and connecting them to other resources may reduce risk of drug overdose and other health consequences of drug use.

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**Goal:** Increase demand for, and uptake into, medications for opioid use disorder (MOUD)

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1. Conduct buprenorphine prescriber waiver trainings for MDs, NPs, and PAs.
2. Provide funding and technical support to safety-net primary care clinics utilizing the buprenorphine nurse care manager model to provide integrated, office-based treatment for opioid use disorder.
3. Increase number of people receiving buprenorphine at syringe service programs and buprenorphine nurse care manager sites, as well as increase availability of buprenorphine in hospital emergency department settings.
4. Conduct health care provider education outreach to address providers' stigma about MOUD as well as encourage use of MOUD, as well as stigma related to drug use, people who use drugs, and harm reduction principles.
5. Continue public education and awareness campaigns to address stigma around MOUD and people who use drug use.
6. Work with syringe service programs to expand engagement of people who use drugs and other services that may reduce risk of drug overdose and other health consequences of drug use.
7. Continue to advocate for and explore strategies to reduce or eliminate financial barriers to MOUD.

## SUD Residential Treatment Services

### **SUD Residential Treatment Services Background Information:**

People with lived experiences, advocates, and many others have reported that residential treatment still does not always include medication treatment as part of their services. Although the NYC DOHMH has worked with providers to increase access to medications for opioid use disorder (MOUD), there is still significant need.

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**Goal:** Increase demand for, and uptake into, medications for opioid use disorder (MOUD)

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1. Work to expand access to MOUD in residential treatment settings, by either promoting or ensuring that all residential treatment programs offer MOUD and promoting or ensuring residential treatment programs remove policies/practices that limit access to MOUD in ways inconsistent with research and clinical guidelines on best practices.

## Heroin and Opioid Programs and Services

### **Heroin and Opioid Programs and Services Background Information:**

In 2018, there were 1,444 unintentional drug overdose deaths in New York City, of which 80% involved opioids. In 2018, there were 1,151 opioid overdose deaths in New York City, a decrease of 58 deaths from 2017. Fentanyl involvement in opioid overdose deaths in New York City continued to increase in 2018; fentanyl was involved in three-quarters of opioid overdose deaths in New York City in 2018.<sup>33</sup>

Although the number of opioid overdose deaths decreased from 2017 to 2018, this decrease was not distributed equally. From 2017 to 2018, the number of opioid overdose deaths increased among residents of the Bronx, Manhattan, and Staten Island. Opioid overdose deaths also increased among women, Latinx New Yorkers, and older New Yorkers ages 55 to 84.<sup>33</sup>

Syringe Services Programs and other harm reduction services are critical services for people who use heroin and other drugs.

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**Goal:** Reduce opioid overdose deaths and expand access to and uptake of medications for opioid use disorder (MOUD) for patients with opioid use disorder

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1. Continue to expand the NYC DOHMH’s overdose education and naloxone initiative, which aims to expand the network of opioid overdose prevention programs (OOPPs), distribute naloxone to OOPPs in communities with high overdose rates or high risk of overdose, strategically target naloxone dispensing to individuals at high risk of experiencing or witnessing overdose, and promote and provide high-quality trainings on overdose response citywide.
2. Continue to distribute at least 100,000 naloxone kits citywide annually.
3. Promote best practices for addressing substance use, including treatment, among health care providers through outreach and education efforts as well as by disseminating useful tools and resources.
4. Raise awareness about overdose prevention, naloxone availability, and medications for addiction treatment through public education campaigns.
5. Increase access to buprenorphine for opioid use disorder treatment in primary care settings as well as other settings where people who use drugs access services, specifically syringe service programs and emergency departments.
6. Continue to advocate for increased funding for harm reduction services for people who use heroin and other opioids, including the establishment of four overdose prevention centers in NYC, increased funding for syringe services programs, among others.

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<sup>33</sup> Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019.

7. Continue to advocate for and explore strategies to reduce or eliminate financial barriers to MOUD.

## Coordination/Integration with Other Systems for SUD Clients

### **Coordination/Integration Background Information:**

Improved integration and coordination with the health care, mental health care, and social services sector remains a challenge in NYC. Similarly, law enforcement and criminal justice entities are frequently the first responders to people experiencing behavioral health events where substance use is a component. More effective coordination and integration with other systems has been identified as a need by DOHMH partners as well as people who use drugs and their friends and families.

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**Goal:** Increase use of diversion programs to substitute criminal justice measures with increased support and services.

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1. Building on the Staten Island Heroin Overdose Prevention and Education (HOPE) Project, expand eligibility criteria based on prior criminal justice histories for pre-arrest/pre-arraignment diversion programs for people who use drugs and are facing arrest or prosecution in Staten Island, Bronx, Kings, and New York Counties.



## Other Need 1: Racial Equity

### **Racial Equity Background Information:**

There are significant racial and ethnic inequities in behavioral health care access, utilization, and outcomes in New York City (NYC). For example, the prevalence of depression was highest among Latinx New Yorkers compared to Asian, Black, and White New Yorkers in 2016, 2017, and 2018.<sup>34</sup> Additionally, experiences of discrimination and racism are associated with an increased prevalence of serious psychological distress (SPD). Studies show that the prevalence of SPD was higher among adults who experienced racism “some,” “a lot” or “always” compared with those who faced racism “a little” or “not at all” in the past 12 months (15% vs. 5%).<sup>34</sup>

Furthermore, studies have shown that the U.S. criminal justice system disproportionately affects Black and Latinx communities, and adults who have experienced criminal justice system involvement report poorer mental health than those who have not. Black New Yorkers were almost twice as likely as white New Yorkers to have been incarcerated or under community supervision (14% vs. 8%) and over three times as likely to have ever been physically threatened or abused by police (16% vs. 5%), or to have an immediate family member incarcerated or under community supervision in the past five years (13% vs. 4%).<sup>35</sup> Adults who have been incarcerated, or under community supervision, were twice as likely to report poor mental health (27% vs. 13%) than individuals who have never been incarcerated. Similarly, people who have been physically threatened or abused by police, or even stopped, searched, or questioned by police, were more likely to report poor mental health than those who have never been (27% vs. 14%, 20% vs. 12%, respectively). Adults who have experienced criminal justice involvement were also more likely to report binge drinking than those without experiences of criminal justice involvement.<sup>35</sup>

Communities of color in NYC are also disproportionately affected by unintentional drug overdose deaths. Although the overall rate of unintentional drug overdose death decreased in NYC from 2017 to 2018, this decrease was not equally distributed citywide.<sup>36</sup> Rates of overdose death increased 5% among Latinx New Yorkers (from 23.7 per 100,000 in 2017 to 24.8 per 100,000 in 2018) and, for the first time since prior to 2000, Latinx New Yorkers had the highest rate of overdose death. In contrast, the rate of drug overdose decreased 5% among white New Yorkers (from 25.0 per 100,000 in 2017 to 23.8 per 100,000 in 2018) and decreased by 13% among Black New Yorkers (from 25.2 per 100,000 in 2017 to 21.9 per 100,000 in 2018) during this time period.<sup>36</sup>

As mentioned in various sections of the LSP, the COVID-19 public health emergency has exacerbated and magnified a number of persistent societal issues, including systemic racism and racial disparities in physical and behavioral health access, utilization, and outcomes. NYC DOHMH works to advance health equity and eliminate racialized behavioral health disparities, and to foster anti-racism and racial literacy in our external programs and partnerships and our

<sup>34</sup> Community Health Survey, 2017; Social Determinants of Mental Health among New York City Adults, Epi Data Brief, 2019.

<sup>35</sup> Zweig KC, Baquero M, Meropol SB, Vasan A. Criminal Justice System Involvement and Measures of Health among New York City Residents, 2017. New York City Department of Health and Mental Hygiene: Epi Data Brief 109; June 2019.

<sup>36</sup> Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019.

internal policies and structures. For example, NYC DOHMH will hold a racial equity webinar series for behavioral health providers across NYC.

NYC DOHMH is working internally to apply a racial equity and social justice lens to internal practices, processes, and procedures, including unlearning, challenging, and dismantling racism from within the Division.

In light of the significant racial and ethnic inequities in behavioral health care access, utilization, and outcomes in NYC, NYC DOHMH proposes a Racial Equity goal for the LSP. This goal will guide behavioral health processes, programs and interventions to be deliberately reimaged through an anti-racist sustainable equity and racial justice.

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**Goal:** Systematically identify and reduce racial and ethnic inequities and embed racial equity into the behavioral health service system.

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1. Improve data collection, analysis, and reporting practices for demographic characteristics and outcome data.
2. Create an equitable approach to procurement processes to ensure equity in resources allocation.
3. Engage communities of color in service/program planning, decision making, and policy formation and evaluation, including conducting community engagement efforts to learn about the behavioral health needs of New Yorkers.
4. Develop and host a webinar series about racial equity in the field of mental health.
5. Increase cultural diversity training opportunities for health care professionals and other providers to enhance staff sensitivity to the cultural background of the individuals served, including understanding how to address the complex needs of individuals with developmental disabilities and are approaching or have reached advanced ages/human life expectancy.
6. Provide communities experiencing overdose outbreaks or with high numbers or sustained trends of drug overdoses with culturally relevant overdose risk reduction education, harm reduction education, and other essential resources and information on how to prevent consequences associated with substance use.
7. Address racial and geographic inequities in access to medication for opioid use disorder by promoting buprenorphine uptake through syringe service programs, nurse care manager sites, and hospital emergency department settings.
8. Address racial inequities in eligibility for criminal justice diversion to drug treatment programs by advocating for expanded eligibility based on prior criminal justice histories.
9. Continue to facilitate access to methadone treatment, which is utilized at higher rates among Black and Latinx New Yorkers, by a) delivering methadone to patients who need to isolate or quarantine during COVID-19, and b) advocating for the continuation of federal regulations which allow for the use of extended take-home doses and methadone delivery during COVID-19.

10. Monitor enrollment, referrals, and discharge plans as stratified by race and ethnicity for programs specifically for justice-impacted populations, including the NYC Health Justice Network (HJN) and the Support and Connection Centers (SCCs).

## Other Need 2: Medicaid Redesign

### **Medicaid Redesign Background Information:**

The number of Medicaid recipients in New York City with at least one mental health or substance use related primary diagnosis in 2018 was 510,878. Despite significant spending on behavioral health care, a variety of stakeholders of New York City's Medicaid funded behavioral health service system have stated that the current system still struggles to offer comprehensive and-equitable care to the highest-need individuals, and to effectively integrate behavioral health services with physical health care. There are also significant disparities in behavioral health care access, utilization, and outcomes in New York City.

NYC DOHMH has received feedback from adults living with mental illness that they continue to find Health Homes confusing to understand and use. A number of stakeholders have shared that the Health Home model is not comprehensible to the people it is serving. Care coordinators have expressed that the universe of services about which the coordinator must know is too expansive for the amount of reimbursement a care coordinator receives. Care coordinators have frequently mentioned staff turn over due to low salaries and we believe higher reimbursement levels would help care management agencies recruit and retain well-experienced care managers.

Additionally, in 2019 and 2020, several children's behavioral health services transitioned into Medicaid managed care. This includes the newly created Children and Family Treatment and Support Services (CFTSS), the expansion of HCBS Waiver eligibility, and the transition of care management into Health Homes Serving Children.

To address challenges in the shifts in the behavioral health service system, NYC DOHMH works collaboratively with the state Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) to continue to implement the transition of behavioral health services into Medicaid managed care in NYC. NYC DOHMH also established the Regional Planning Consortium (RPC) and has continued to meet regularly with multiple, diverse sets of stakeholders including Medicaid Managed Care Plans, beneficiaries, Health Homes, Delivery System Reform Incentive Program (DSRIP) performing provider systems, care managers, behavioral health service providers, and city agencies to obtain stakeholder input on the transition.

During the latter part of 2020 and in 2021, New York City will focus its Medicaid redesign efforts to 1) identify and retain best practices temporarily implemented during the COVID-19 state of emergency, 2) assist providers in preparing for value-based payment and 3) support providers of children's behavioral health services in identifying local solutions to challenges in the transition to managed care. NYC will also continue to engage its large health systems such as any new iteration of the DSRIP PPSs, Behavioral Health Care Collaboratives (BHCCs), Medicaid Managed Care Organizations (MCOs) and Health Homes in promoting and/or in pursuing value-based payment arrangements or alternative payment models.

Furthermore, for the children's service sector, the NYC DOHMH is beginning to utilize available data systems to monitor the number of children receiving these new and expanded behavioral health services, and partnering with the local Coordinated Care Services structure by

offering an educational series on the Medicaid Transformation for family members. The NYC DOHMH also continues to engage other cross-systems stakeholders to learn about their Medicaid redesign priorities that might be incorporated into our local planning.

**The Impact of COVID-19 on Medicaid Redesign:**

Since the COVID-19 pandemic has significantly affected a variety of stakeholders in the Medicaid managed behavioral health service system, the NYC RPC and NYC DOHMH will continue to engage its stakeholders to work collaboratively to support them, disseminate relevant guidance, and to examine effective temporary practices that can be retained via permanent policy changes.

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**Goal:** Advance systems improvements through Medicaid to increase access to integrated, equitable, and high-quality care to all adult and child Medicaid recipients in New York City.

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1. Continue to engage NYC stakeholders via the Regional Planning Consortium (RPC) for ongoing monitoring and problem solving around the adult and children’s Medicaid managed care transitions and readiness for value-based payment.
2. Release Electronic Health Record (EHR) technical specifications for children’s Medicaid Home and Community Based (HCB) and Children and Family Treatment and Support Services (CFTS) Services.
3. Support NYC based children’s Medicaid Home and Community Based (HCB) and Children and Family Treatment and Support Services (CFTS) Services providers in adopting a suitable electronic health record or upgrading to additional modules.
4. Design and implement a short-term project to educate select DOHMH contracted providers on financial sustainability of select behavioral health services and the use of a selected financial modeling tool.
5. Engage hospital Systems, Behavioral Health Care Collaboratives (BHCC) and Medicaid Managed care Plans via the Regional Planning Consortium to share best practices from their mutual collaborations, with behavioral health providers considering value-based payment arrangements.
6. Streamline storage, processing and analysis of Medicaid claims data for the NYC behavioral health population to facilitate reporting of behavioral health service utilization to improve policy, planning and service delivery.
7. Monitor the access to new State Plan Services / CFTSS and HCBS through MDW and other data sources.
8. In collaboration with Regional Planning Consortium stakeholders, examine best practices in telehealth and remote service provision implemented during the COVID-19 state of emergency and recommend regulatory amendments and policy changes at the State and city level.

## Other Need 3: Behavioral Health Parity

### **Behavioral Health Parity Background Information:**

There has been an increasing amount of attention paid to the enforcement of behavioral health parity in the recent years in New York State. In November 2019, the State Office of Mental health (OMH) issued guidance on the review and approval of clinical review criteria for mental health services, to be used by utilization review (UR) agents when determining mental health treatment coverage. In December 2019, Governor Cuomo released new requirements for health insurers, mandating expanded coverage for New Yorkers seeking treatment for mental health and substance use disorder issues. In conjunction, the Department of Financial Services (DFS) issued FAQs and guidance letters on insurance law changes that impact parity.

In line with the increased attention paid to this issue by the State, a 2019 parity report<sup>37</sup> showed that most NYS consumers experienced denial of mental health and substance abuse (MH/SUD) coverage due to medical necessity criteria and pre-authorization of services. Most of the consumers surveyed (n=211) had little to no knowledge of MH/SUD visit and prior approval limitations and needed more information on how to challenge treatment denials. The most common insurance-related parity barrier cited by NYS providers (n= 67) was related to financial requirements and pre-authorization. Most of the providers mentioned that they would be willing to file appeals on behalf of their patients but required more information on Non-Quantitative Treatment Limitations (NQTLs) since claims denials was not their area of expertise. (NQTLs include utilization review practices, preauthorization/medical necessity criteria, step therapy/fail-first policies, formulary design for prescription drugs, geographic/facility, type/scope, or duration of benefits limits, failure to complete treatment course exclusions, etc.). After discussing with OMH, OASAS and several New York City based organizations actively working on parity issues such as the Legal Action Center, the Community Services Society and the Coalition for Behavioral Health, and reviewing relevant data from the Parity at 10 Coalition and the Kennedy Forum/Milliman<sup>38</sup>, etc. , the NYC DOHMH has identified an unmet need in consumer and provider knowledge of behavioral health parity that can be met by educating consumer and provider audiences. The NYC DOHMH is well positioned to offer these trainings given its stakeholder engagement work and extensive local partnerships. Additionally, we believe that training providers will enable them to work more effectively on behalf of their clients.

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**Goal:** Increase equitable coverage between behavioral health benefits and physical health benefits among NYC’s public and commercial health insurance plans by increasing transparency around compliance with the parity law.

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<sup>37</sup> Parity At 10 Coalition’s report Consumer Health Insurance Knowledge and Experience Survey: Report of Findings [http://parityat10.org/wp-content/uploads/2019/03/Consumer-Health-Insurance-Knowledge\\_ExperienceSurvey-Report-030719.pdf](http://parityat10.org/wp-content/uploads/2019/03/Consumer-Health-Insurance-Knowledge_ExperienceSurvey-Report-030719.pdf)

<sup>38</sup> <https://www.parityregistry.org/states/new-york/>

1. Identify gaps in behavioral health (BH) parity knowledge in NYC in partnership with State and City stakeholders.
2. Increase transparency and compliance with parity by disseminating existing parity resources to NYC stakeholders.
3. Educate New York City providers and beneficiaries on the Mental Health Parity and Addiction Equity Act, beneficiary rights related to the law and avenues for appeals and complaints.

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**COMPLETE**

Wednesday, September 23, 2020 3:36:20 PM

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Page 1

**Q1**

Contact Information

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**Q2**

**NYC Dept. of Health and Mental Hygiene**

LGU:

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### Q3

a. Indicate how your local mental hygiene service system (i.e., mental health, substance use disorder and problem gambling, and developmental disability populations), overall, has been affected by the COVID-19 pandemic: Please specifically note, Any cross-system issues that affect more than one population; Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

The New York City Department of Health and Mental Hygiene (NYC DOHMH) recognizes that the COVID-19 pandemic has exacerbated existing behavioral health needs in New York City (NYC), and will have continued adverse consequences on New Yorkers and the providers that serve them. As of September 22, 2020, more than 236,000 residents of New York City have tested positive for COVID-19.[1] New York City has seen over 19,000 confirmed deaths due to the coronavirus, with an additional 4,600 deaths categorized as probable, or reported as "COVID-19" or equivalent without a positive laboratory test.[1]

NYC DOHMH also recognizes significant racial and ethnic inequities in the behavioral health services system in NYC that have been amplified during the COVID-19 pandemic. Citywide infection rates and preliminary mortality data disaggregated by race suggests that Black and Latinx communities are disproportionately impacted by COVID-19. Latinx New Yorkers represent nearly 31 percent of total confirmed deaths due to COVID-19, while Black New Yorkers represent 28 percent of confirmed deaths.[1] Race and ethnicity information is most complete for people who are hospitalized or have died, and much less demographic data is currently available for non-hospitalized cases; therefore, it is possible that mortality rates are greater than currently reported.

These results suggest that the COVID-19 pandemic has placed a disproportionate burden on the health and well-being of communities of color in NYC and will have long-reaching consequences on the physical and mental health of these communities in the foreseeable future. The City must be equipped to support communities of color, particularly those individuals suffering from severe mental illnesses (SMI) and substance abuse disorders (SUD) in addition to extenuating circumstances attributed to the coronavirus.

#### Expansion of Telehealth Services:

While the pandemic has created widespread adoption of remote telehealth services, this largely occurred so quickly that many providers scrambled to assess and adjust their telehealth infrastructure amid concerns about their short- and long-term fiscal sustainability. However, both providers and clients have reported that the flexibility of telehealth services has promoted increased client satisfaction and their ability to seek and maintain regular services. Providers have reported more kept telehealth appointments than face-to-face appointments in the past. Clients have reported that telehealth services have allowed them to feel less stigmatized and fearful of reporting mental health issues to a provider. Telehealth services have also allowed for increased behavioral health care engagement with individuals who would previously not access services due to the stigma of being labelled with mental health issues given their cultural backgrounds. It will be critical for the behavioral health workforce to fully integrate telehealth services into their practice during the COVID-19 pandemic and beyond.

Adult service providers in particular reported that telehealth has allowed them to see and interact more with the client's family members and their home, and that it has provided them with increased ability to reach out to more clients. Adult service providers were also able to quickly make the transition from fax to email communications, which has allowed for limited downtime in processing claims. Providers also noted that they are able to better engage with clients now that they are able to bill for shorter amounts of time throughout the day (i.e., they are able to provide three 20-minute calls or remote face-to-face visits, instead of one 60-minute visit, which clients don't always need or want). Clients have appreciated not having to miss appointments when traveling. From the workforce perspective, Home and Community Based Service (HCBS) organizations and Children's Care Management Agencies (CMAs) have noted increased productivity of staff and appreciation of the flexibility that comes with working from home.

Children's service providers report that families have welcomed the flexibility that telehealth has offered, which has allowed them to keep their appointments. Children's program consultants have had significant engagement with contracted providers in order to support their adaptation to remote service provision and their use of innovative practices to engage children, youth and families during the pandemic. These include:

1. Offering supports to parents such as "parenting in quarantine" groups for parents of young children,
2. Interactive zoom sessions with preschool children to engage them in physical activity, art and mindfulness

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2. Interactive zoom sessions with preschool children to engage them in physical activity, art and mindfulness,
3. Providing telehealth services to LGBTQ youth using chat/text-based services and distributing tablets to facilitate youth's access,
4. Hosting a talent show for program participants through zoom.

The NYC DOHMH also conducted outreach to family and youth peer advocates to ensure that they can continue to engage and support youth and families through telehealth individual and group video calls.

### Challenges in Telehealth Service Provision:

Some adult service providers reported difficulty in trying to engage certain clients using telehealth, including those with significant mental health issues (e.g. schizophrenia that is not well-managed), substance use disorder concerns, younger individuals and some individuals with intellectual and developmental disabilities (I/DD), individuals experiencing intimate partner and other types of domestic violence as well as transient clients. Providers also saw significant technology gaps for some clients. Despite many providers having used funds to provide clients with tablets, phones, internet access, and cell phone minutes, these efforts did not eliminate technology gaps, such as lack of access to the internet or Wifi and limited data plans that make access for video sessions challenging. For individuals with I/DD in particular, specific attention and communication needs cannot be readily met by services delivered remotely.

Some providers reported difficulty engaging very young children via telehealth, and that some older youth are uncomfortable speaking with providers via telehealth due to privacy concerns with others in their home. Some providers also noted that telehealth limits the ability to observe situations of abuse and neglect, intimate partner violence, or other forms of abuse and neglect. CMAs have noted that it has been more difficult during the pandemic to connect clients to behavioral health providers as a result of illness or closed agencies.

### Impact of COVID-19 on Specific Populations:

LGBTQ+ people of color have disproportionately experienced economic hardship as a result of COVID-19. Specifically, 38% of LGBTQ+ people of color have had their work hours reduced compared to 24% of the general population, and 22% of LGBTQ+ people of color became unemployed compared to 13% of the general population during the pandemic. In addition, LGBTQ+ people of color are twice as likely as the general population to have asked for delays in paying their rent.[2] From a health disparities perspective, LGBTQ+ individuals are both less likely to have health insurance (17% versus 12%) and more likely to use tobacco than their non-LGBTQ+ counterparts (37% versus 27%), increasing the potential for health complications from acquiring COVID-19.[3] This research is national in scope, and specific research at the local level can help to shed light on economic, health, and behavioral health impacts of COVID-19 on LGBTQ+ populations.

Furthermore, services specifically for justice-impacted populations have also been affected by the COVID-19 pandemic. The Health Justice Network (HJN) program provides connections to emergency needs such as phones, clothing and vital documents for justice-impacted individuals. As the HJN program shifted from in-person to remote operations on March 16, 2020, access to phones and phone service become critical. Many active participants and new referrals do not have phones, which creates connection barriers to remote services. Despite these challenges, each HJN partner site provided remote services during NYS Pause, and HJN site supervisors, liaisons, and Community Health Workers (CHWs) have been active and communicative with clients in the HJN program. As a result, there were increases in referrals, enrollments, average number of participant interactions with CHWs, and connections to available services.

However, several critical services and interventions for justice-impacted communities with compounding mental health issues have decreased in activity or suspended due to the COVID-19 pandemic. The two Support and Connection Centers, which offer short-term stabilizing services for individuals with mental health, substance use, physical health and/or social service needs brought in by the police as an alternative to incarceration or emergency room visits, in one case had to delay its launch and in the other had to pause services in March 2020. Similarly, the Co-Response Team (CRT), comprised of clinical and law enforcement professionals who connect justice-impacted individuals with mental illness and/or substance use disorders to care and services, and the Health Engagement and Assessment Team (HEAT), a short-term intervention designed to assess, stabilize, and link clients to supports and services, have both seen a significant decrease in referrals, and deployments and encounters for both programs paused during the peak of COVID-19 in NYC.

[1] NYC DOHMH Covid-19 Data. <https://www1.nyc.gov/site/doh/covid/covid-19-data.page>

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[2] Human Rights Campaign. The Impact of COVID-19 on LGBTQ Communities of Color.

[https://assets2.hrc.org/files/assets/resources/COVID\\_19\\_EconImpact-CommunitiesColor052020d.pdf](https://assets2.hrc.org/files/assets/resources/COVID_19_EconImpact-CommunitiesColor052020d.pdf)

[3] Human Rights Campaign. The Lives and Livelihoods of Many in the LGBTQ Community are At Risk Amidst COVID-19 Crisis.

<https://assets2.hrc.org/files/assets/resources/COVID19-IssueBrief-032020-FINAL.pdf>

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## Q4

b. Indicate how your mental health service needs, overall, have been affected by the COVID-19 pandemic: Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

The NYC DOHMH's Single Point of Access (SPOA) continued to review applications and determine eligibility for field based behavioral health treatment and care coordination services throughout the pandemic. SPOA accessible services continued to accept new referrals and provide treatment and support to their existing caseloads. The volume of new referrals to Assisted Outpatient Treatment and to SPOA accessible services, which are largely focused on people with SMI was very low in the beginning of the pandemic but has recently returned to a closer to average level.

The NYC DOHMH is currently in the process of collating data from contracted providers to establish utilization rates for all providers contracted to provide services to children, youth, and/or families. There are a small subset of providers that report programmatic census data more frequently than others (CSPOA, CMCTs, HBCI and FRCs); and based on those reports, caseloads appear to have decreased since the start of NYS Pause. We hypothesize that this decrease in census will also hold true for most of our contracted providers, particularly for those providers that stopped intake. We are awaiting final results from our contracted provider survey to assess whether this hypothesis is accurate.

Both Single Point of Access (SPOA) for adults and Children's SPOA (CSPOA) have experienced a low volume of calls since the beginning of the pandemic. In May and June the number of calls increased, but they still remain lower than this time last year.

The volume of calls, texts, and chats to NYC Well increased in April 2020 through July 2020 compared with the same time period in 2019. The number of calls to NYC Well for concerns relating to children and youth ages 10-24 have also been higher than 2019 averages and are continuing to increase, particularly for ages 15-24.

Finally, crisis providers report contending with higher rates of referrals for youth experiencing depression or suicidal ideation than this time last year.

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## Q5

c. Indicate how your substance use disorder (SUD) and problem gambling needs, overall, have been affected by the COVID-19 pandemic: Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

Numerous changes in federal regulations of buprenorphine and methadone treatment were implemented to mitigate the spread of COVID-19 and prevent treatment disruptions among patients prescribed Medication for Opioid Use Disorder (MOUD). These include the following:

1. On March 16, 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) allowed Opioid Treatment Program (OTP) providers to provide up to 28 days of methadone to stable patients, and up to 14 days of methadone to less stable patients.
2. On March 16, 2020, the United States Drug Enforcement Administration (DEA) allowed for the provision of "doorstep" deliveries of methadone to patients quarantined due to COVID-19.
3. On March 31, 2020, the DEA allowed for the use of telehealth services to induct new buprenorphine patients and continue the provision of buprenorphine to existing patients.

In response to these changes in federal regulations, the NYC DOHMH established a Methadone Delivery System to provide methadone to patients who are in isolation or quarantine because they have COVID-19, COVID-like symptoms, or comorbidities that place them at a high risk of experiencing serious illness if they develop COVID-19. Furthermore, the NYC DOHMH continued to provide technical assistance and support to Nurse Care Manager sites and Syringe Service Programs in their continued provision and induction of buprenorphine treatment through telehealth services. The NYC DOHMH worked with the NY State Office of Addiction Services and Supports (OASAS) to monitor and recommend to providers increases in the provision of extended take-home methadone doses for patients.

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## Q6

d. Indicate how the needs of the developmentally disabled population, overall, have been affected by the COVID-19 pandemic: Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

The COVID-19 pandemic importantly contextualizes 2021 local services planning for New Yorkers with I/DD. The impact of the health crises is still unfolding, and we do not have sufficient data to quantify how COVID-19 may have impacted changes in the level of unmet needs for New Yorkers with I/DD. Our assessment of the impact of COVID-19 on DD service gaps and needs is based on our oversight and monitoring of service delivery, in addition to ongoing discussions held with informed stakeholders such as the NYC Regional Office for People With Developmental Disabilities (OPWDD), the five borough DD Councils, Community Services Board DD Subcommittee members, Borough Advisory Councils, people with I/DD, providers, families and family advocates representing the five NYC boroughs.

By all accounts, the recent health pandemic exacerbates concerns for this especially vulnerable population, many of whom have underlying health conditions, live in congregate settings and require personal assistance. This points to a need to emphasize and enhance Care Coordination Organizations (CCO), Front Door, and respite services in NYC.

**Q7**

a. Mental Health providers

The NYC DOHMH and the NYC Regional Planning Consortium (RPC) played an important role in disseminating state guidance to NYC DOHMH contracted providers and RPC member providers. RPC member providers have generally stated that they found the guidance and materials have been helpful. The NYC DOHMH produced over 20 guidance documents related to disaster response, pandemic-related mental health and substance use concerns, and behavioral health provider operations and distributed this information on the NYC DOHMH website, by email, and through other venues.

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**Q8**

b. SUD and problem gambling service providers:

In general, most SUD programs have been overwhelmed by the level of guidance, resources, and materials issued by various federal, state, and city agencies. Through various means including email, technical assistance, and provider office hours, we have attempted to distill and repeatedly reinforce the most important key messages from these different sources of guidance. Some of the smaller programs have been more challenged in developing policies and procedures for their telehealth designation applications to NYS OASAS and are either taking longer to develop them and/or hiring consultants to assist with this work due to limited bandwidth.

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**Q9**

c. Developmental disability service providers:

Additional guidance/training on the effective use of tele-communication to deliver services would be beneficial for I/DD providers. In addition, guidance on reimbursement planning can help providers understand approaches to minimize financial loss and promote financial sustainability.

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**Q10**

a. Since March 1, 2020, how would you describe DEMAND for mental health services in each of the following program categories?

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	N/A
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	N/A
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	N/A
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	N/A
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	N/A

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**Q11**

If you would like to add any detail about your responses above, please do so in the space below:

Overall, NYC DOHMH does not have accurate information on 'Demand' for mental health services because significant disruptions in service access across the system made it impossible to ascertain how much need there really was.

However, we received fewer SPOA referrals since March 1, 2020, which may reflect the general decrease in services being provided, in turn leading to fewer opportunities to make referrals.

NYC Well, New York City's talk, text, and chat line staffed with trained counselors, answered significantly more calls, texts, and chats in April and May than in the previous year. COVID-19 content is not easily measurable but anecdotal reports indicate many people were seeking support for COVID-related anxiety and grief.

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**Q12**

b. Since March 1, 2020, how would you describe ACCESS to mental health services in each of the following program categories?

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	<b>Decreased</b>
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	<b>Decreased</b>
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	<b>Decreased</b>
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	<b>Decreased</b>
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	<b>Decreased</b>

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**Q13**

If you would like to add any detail about your responses above, please do so in the space below:

Inpatient psychiatric units closed or were used for non-psychiatric patients. Emergency Department (ED) visits have decreased and continue to be lower than 2019 average levels, which may be due to individuals being concerned about going to the ED due to fear of contracting COVID. Outpatient treatment has been challenging for both providers and clients given the move to telemental health. Youth providers report access challenges for families seeking community-based supports.

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**Q14**

a. Since March 1, 2020, what number of mental health program sites in your county closed or limited operations due to COVID-19, apart from transition to telehealth?

7

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**Q15**

If you would like to add any detail about your responses above, please do so in the space below:

Three (3) mental health clinics closed specifically due to COVID-19. Four crisis (4) respite centers closed due to COVID-19, and at the request of OMH, two of those crisis respites managed people discharged from inpatient psychiatric programs when those programs closed to allow for additional room for COVID-19 patients.

There were a few additional clinics that closed since March; however, they were either planned prior to COVID-19 or were administrative closures in which the sites did not have any people enrolled prior to COVID-19.

Training, vocational and educational groups, recreation and socialization activities, support groups, and escorts and travel unrelated to providing essential items under Non-Medicaid Care Coordination, were temporarily placed on hold and not offered remotely.

Clubhouses, assisted competitive employment, supported education, advocacy and Bridger programs suspended nearly all in person services except where the program was instrumental in reducing food insecurity, such as clubhouses that serve meals. Some clubhouses maintained food to-go operations during the pandemic. Client contact continued remotely; however, frequency and duration of contact vary greatly.

Crisis respite centers closed temporarily

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**Q16**

b. What number of mental health program sites in your county remain closed or are offering limited services now, apart from transition to telehealth?

3

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**Q17**

If you would like to add any detail about your responses above, please do so in the space below:

Three (3) mental health clinic satellites remain closed. Four crisis respites reopened. Clubhouses, assisted competitive employment, supported education, advocacy and Bridger programs remain closed or are offering limited services.

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**Q18**

**No**

c. If your county operates services, did you maintain any level of in-person mental health treatment

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**Q19**

If you would like to add any detail about your responses above, please do so in the space below:

NYC START is a DOHMH-operated program that provides direct behavioral health service; this program operated exclusively remotely.

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**Q20**

Yes (please list program name(s) and type(s)):  
See below

d. As a result of COVID-19, are any mental health programs in your county closing operations permanently? If yes, list program name(s) and type(s).

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**Q21**

If you would like to add any detail about your responses above, please do so in the space below:

The Child Center – South Jamaica satellite was planning to renovate and transferred clients to another clinic. They decided to permanently close due to the economic environment resulting from COVID-19. Similarly, the Catholic Charities Neighborhood Services satellite at Dr. Sami's primary care office was also permanently closed due to COVID-19.

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**Q22**

Yes (please list program name(s) and type(s)):

Response is "Unknown"

e. Did any mental health programs in your county close due to workforce issues (e.g. staff infections, recruitment/retention issues)?

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**Q23**

If you would like to add any detail about your responses above, please do so in the space below:

Unknown

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**Q24**

a. Apart from telehealth, during COVID-19, did your county or mental health providers within your county develop any innovative services or methods of program delivery that may be continued post-COVID? If yes, please describe.

Yes (please describe):

1. The Institute for Community Living ICL (4C program) set up a hotline to help connect people in East New York with resources, and some of the clergy set up wellness and collective recovery activities including singing and informal support groups. ICL also rolled out a virtual "Let's Talk About It" series for mental health awareness. 2. The Arab American Family Support Center (Reclaiming Our Health) continued their introduction to mental health series online with several webinars. 3. Mental Health Providers participating in the Connections to Care (C2C) initiative have continued to work with their community-based organization (CBO) partners to deliver a range of mental health promotion and treatment supports, by: 1) hosting online community workshops or group counseling sessions on topics such as managing stress, positive parenting behaviors, substance use, and grief, 2) providing remote coaching and supervision to CBO staff who have been trained to deliver mental health skills, 3) supporting clinicians at CBOs to extend and strengthen the mental health services they provide. For example, with support from NYU Langone, Red Hook Initiative's Social Work Team is developing a "Healing Justice Community Counseling" model that integrates trauma informed therapy with psychoeducation, community education, and social advocacy, and 4) supporting CBOs to adapt and strengthen practices and protocols for identifying and responding to crises, including mental health crises, during COVID-19. 4. NYC paused in-person Mental Health First Aide training and transitioned to offering virtual sessions about the mental health and trauma impacts of COVID-19. The program is called 3C, "Community Conversations about COVID."

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**Q25**

b. During COVID-19, did any mental health providers within your county form any partnerships with other providers that may be continued post-COVID? If yes, please describe.

Yes (please describe):

1. Some NYC RPC member Care Management Agencies (CMAs) have partnered with inpatient psychiatric units for increased referrals and have been using Recovery Coordination Agencies (RCAs) more robustly in order to connect with clients. In fact, a number of providers have partnered with technology providers in order to provide their clients with adequate technology for telehealth services. 2. The Red Hook Initiative reported a new partnership between NYU Langone's Community Health Worker program and the Red Hook Community Health Network, a group of Red Hook-based social service providers that includes C2C provider Red Hook Initiative (RHI). This expanded partnership builds on the existing C2C partnership between RHI and NYU Langone's Sunset Terrace Family Health Behavioral Health program and allows community members to access medical referrals within the NYU Langone system, in addition to the behavioral health support that was already available through the RHI/NYU Langone C2C partnership. 3. The Hetrick-Martin Institute (HMI) partnered with CenterLink's "Q Chat Space" to provide online support groups to LGBTQ+ young people ages 13-19 in chat rooms that are moderated by HMI staff.

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**Q26**

a. During COVID-19, how many mental health providers within your county implemented existing continuity of operations plans?

0

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**Q27**

If you would like to add any detail about your responses above, please do so in the space below:

All providers were expected to implement existing continuity of operations plans.

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**Q28**

b. During COVID-19, how many mental health providers within your county did not implement existing continuity of operations plans?

0

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**Q29**

If you would like to add any detail about your responses above, please do so in the space below:

The number of mental health providers within our county that did not implement existing continuity of operation plans is UNKNOWN.

**Q30**

**None**

c. During COVID-19, did your county LGU or Office of Emergency Management (OEM) assist any mental health providers in the development or revision of continuity of operations plans?

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**Q31**

If you would like to add any detail about your responses above, please do so in the space below:

DOHMH program specialists worked closely with programs on issues related to continuity but were not expected to directly support development or revision of continuity of operations plans.

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**Q32**

During COVID-19, what OMH guidance documents were beneficial to your disaster management process?

**Program-level Guidance,  
Telemental Health Guidance,  
Infection Control Guidance,  
Fiscal and Contract Guidance,  
FAQs,**

Please provide any feedback on OMH's guidance resources::

This guidance was and continues to be beneficial to both the NYC DOHMH and to our contracted and RPC member providers. The NYC DOHMH and the NYC RPC routinely shared and continues to share OMH guidance, particularly related to telemental health, fiscal and contract guidance, FAQs, and program-level guidance with NYC DOHMH contracted providers and RPC member providers.

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**Q33**

1. Please indicate any needs for or issues with SUD and problem gambling prevention, treatment, and recovery providers acquiring Personal Protective Equipment (PPE), face masks, cleaning or disinfectant supplies, or similar materials related to the COVID-19 pandemic:

Due to severe shortages in PPE, behavioral health providers had difficulty obtaining these supplies. NYC, which had limited PPE, initially prioritized hospitals, nursing homes, and congregate care for people with developmental disabilities; as supplies became more available, NYC was able to provide some PPE to behavioral health providers. OASAS was able to send some supplies (hand sanitizer, gloves and masks) to the community in late April and DOHMH was able to send out PPE supplies (face shields, gowns, masks and gloves) to the OASAS residential and opioid treatment systems beginning in early June.

Providers were instructed to use projected underspending of city and state allocated funding to purchase PPE, as supply lines began to loosen and production increased to match demand. Programs experiencing significant revenue losses due to decreased ability to provide services during the beginning of NYS Pause will continue to struggle to use funds to make these purchases.

Note: Problem gambling has been folded into all addiction prevention, treatment and recovery programs as a service. It is no longer a stand-alone program.

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**Q34**

a. How has COVID-19 affected the delivery of and demand for SUD and problem gambling prevention services in your county?

For our adolescent prevention providers who have historically provided services mainly in the NYC Department of Education (DOE) schools, the pandemic initially made it difficult for these programs to directly connect with their participants. Schools were overwhelmed as they were trying to implement full online learning in a relatively short amount of time and their communication with prevention providers fell off as a result. Prevention programs also noted initial challenges in their shift to virtual parenting groups; parents had varying levels of tech-literacy, and all groups required extra time to address participant questions related to COVID-19. Additionally, prevention programs noted increased referrals from schools for non-substance use-related individual counseling around adjusting to trauma and loss. Problem gambling prevention has been limited in scope as it is often based on outreach and presentations, and though this can be done remotely, a number of community organizations are occupied in their own response to the pandemic and have deferred engagement.

Furthermore, our Office of Consumer Affairs (OCA), reported that the number of 12-step support groups have significantly increased as people have access to meetings in English, taking place all around the world.

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**Q35**

b. How has COVID-19 affected the delivery of and demand for SUD and problem gambling recovery services in your county?

Amongst our contracted programs providing recovery services, including vocational rehabilitation and job placement programs, peer services, and a youth clubhouse, we have noted the following changes in service delivery:

- 1) For vocational programs, service provision has continued typically in the same format as the programs it serves (e.g. remote services to Opioid Treatment Programs (OTPs), and outpatient programs and on-site services to residential program). This is a particularly important need due to economic effects of the COVID-19 pandemic increasing unemployment.
  - 2) Peer support services have largely been delivered remotely, but occasional socially distanced in-person meetings have occurred in the community. Peers have been instrumental in assisting program participants to adapt to changes in service delivery during the pandemic, including using telehealth to assist participants to apply for health insurance, working on addressing participants' complex socioeconomic needs (e.g., applying for unemployment, assistance in paying rent, obtaining free air conditioners, and applying for free phones), and providing assistance to participants experiencing technical difficulties in the transition to telehealth services.
  - 3) Our contracted Youth Clubhouse program initially had a slow start in transitioning to remote, virtual online groups, but after six weeks by early June 2020, they were offering all pre-COVID programming remotely with strong participant attendance.
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**Q36**

c. How has COVID-19 affected the delivery of and demand for problem gambling treatment services in your county?

Since the start of the COVID-19 pandemic, our NYC SUD treatment service system has experienced dramatic changes in how they deliver services and how they respond to a traumatic situation steeped in loss. The following is a summary of valuable anecdotal information from our contracted treatment programs, collected since the week of March 20, 2020:

Due to COVID-19 and with very little notice, our treatment service providers needed to switch from on-site, face-to-face services to remote services offered via telehealth and/or telephonic platforms to maximize social distancing, isolate those with COVID-19, and quarantine those who may have been exposed. After an initial couple weeks of scrambling in March 2020, with a multitude of guidance documents issued by NYS OASAS and the NYC DOHMH, and scrambling to set up staff to work and deliver services from home, all of our providers weathered this transition while maintaining most of their services. Remote services included intakes and assessment, individual sessions, psychiatric follow-up, and medication management. Group services were cancelled initially, but slowly restarted as providers negotiated how to deliver them online via various platforms, how to assist their participants through the transition, and how to maintain participant engagement in a very different medium.

At the beginning of NYS Pause, most programs, especially outpatient settings with late evening and weekend hours initially cancelled these extended hours. However, these programs have since been exploring how to best phase them back in as needed for high-risk participants (e.g. assigning designated days for crisis/walk-in visits, or for those participants unable to participate in telehealth service delivery).

Opioid Treatment Programs (OTPs) have adapted services dramatically as they typically require multiple in-person visits each week for dispensing medication and providing other support and follow-up, for example:

- **Tracking OTP Pick-up Schedules:** Due to shifted guidance and encouragement from the federal and state agencies allowing regulatory flexibility for extended take-home doses, we began collecting and tracking methadone pick-up schedules for all our contracted OTPs starting March 28, 2020. During the first week of data collection, 37% of patients came in two times to six times per week. Approximately 62% of patients had less frequent schedules (once a week, twice a month, once a month). It is important that OTPs continue to offer less frequent pick-up schedules for the majority of patients, given the necessity of social distancing and other protection measures during COVID-19.
- **Implementing a Methadone Delivery System:** With local and state agencies, we developed a system to deliver methadone directly to participants who could not pick it up themselves (due to illness or quarantine) nor could they send a designated person to pick up their medication. The system began delivering methadone the week of April 20, 2020, and since inception has made over 1000 deliveries. Efforts continue to be made to increase the OTP programs' use of this service.

Knowing that providers would experience challenges in maintaining social distancing amongst participants and staff for our congregate care settings (including crisis and residential programs); NYS OASAS issued guidance encouraging programs to reduce their census by discharging stabilized participants who had a safe place to isolate off-site and minimizing new admissions that occurred in March-early April 2020. Some programs also reduced participant census due to staffing shortages.

- **Hoteling:** In another initiative to work across various local and state agencies, a hoteling option was developed in order to provide eligible congregate care providers who did not have the facility set-up nor enough space on-site to isolate COVID-19+ participants or quarantine participants with COVID-like illness (CLI). A handful of providers were able to make use of this resource.



**Q37**

d. Since March 1, 2020, how would you describe DEMAND for SUD Treatment services in each of the following program categories?

INPATIENT	<b>Decreased</b>
OUTPATIENT	<b>Increased</b>
OTP	<b>No Change</b>
RESIDENTIAL	<b>Decreased</b>
CRISIS	<b>Decreased</b>

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**Q38**

If you would like to add any detail about your responses above, please do so in the space below:

From our Local Government Unit (LGU) access to the New York State Office of Addiction Services and Supports (OASAS) Client Data System, we noted the following:

During 2020, admissions to all treatment program types fell from 8,941 in January to 3,724 in April (a 58% decrease) across New York City. The number of admissions decreased the most for crisis and outpatient programs. It is unclear if these drops are due to COVID-19-related programmatic changes or delayed data entry.

Consistent with 2019, alcohol was the most common primary substance at admission for all non-methadone programs from January through April, accounting for approximately 45% of admissions. Heroin was the second most common primary substance at admission.

Admissions to all programs were more likely to reside in Manhattan and the Bronx from January through April. Similar to 2019, Manhattan residents comprised a higher proportion of crisis programs, while methadone admissions were highest among Bronx residents. Month to month, the proportion of admissions by borough of residence in 2020 have not differed greatly compared to 2019.

Compared to November 2019, monthly census for crisis, inpatient, and residential treatment has declined through April 2020. Monthly census for methadone has remained relatively stable, while monthly census to outpatient treatment has increased.

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**Q39**

e. Since March 1, 2020, how would you describe ACCESS to SUD Treatment services in each of the following program categories?

INPATIENT	<b>Decreased</b>
OUTPATIENT	<b>Increased</b>
OTP	<b>No Change</b>
RESIDENTIAL	<b>Decreased</b>
CRISIS	<b>Decreased</b>

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**Q40**

If you would like to add any detail about your responses above, please do so in the space below:

Per OASAS Guidance issued early in the pandemic (on March 20, 2020), all OASAS licensed, non-hospital-based inpatient and residential programs were instructed to limit admissions to only those individuals who met level-of-care criteria for withdrawal management/stabilization and to essentially discharge all other individuals not meeting this criteria to safe, temporary living arrangements and connections to ongoing outpatient or remote, telehealth services. The purpose of this action was to reduce COVID-19 risk to participants and staff and to reserve care for those most in clinical need. As the pandemic continued, these criteria reverted back to applicable level-of-care criteria for the given program type; however, in order to maximize social distancing in congregate programs, programs have generally maintained a reduced bed capacity.

OTPs shifted most patients to extended take-home schedules, with 62% of patients at DOHMH-contracted OTPs receiving dosages of 1 week or longer, as of 3/28/2020. To support this, OASAS created bundled billing rates, which offered some revenue protection as long as programs maintained at least weekly contact with participants remotely. Thus, access has been maintained. Additionally, NYC DOHMH and OASAS launched a Methadone Delivery System to deliver methadone directly to participants who could not pick up the medication themselves or through a designated surrogate (e.g. due to COVID-19 illness and need for isolation, related illness, being quarantined, or being higher at risk for COVID-19 due to age and other co-morbid factors).

As indicated by increased admissions, outpatient programs successfully transitioned to offering remote, telehealth services and have thus been able to maintain if not increase engagement and access to care. The important exception to this increased access is among participants who lack telephone, smartphone, online internet access or have limited technology literacy to navigate new telehealth systems. Another limitation has been individuals including adolescents who may lack private, confidential space to have sessions.

**Q41**

a. Apart from telehealth, during COVID-19, did your county or SUD and problem gambling service providers within your county develop any innovative services or methods of program delivery that may be continued post-COVID? If yes, please describe.

Yes (please describe):

In response to the COVID-19 pandemic, numerous changes to federal regulations of methadone treatment were implemented to mitigate the spread of COVID-19 and prevent treatment disruptions among methadone patients. These include changes to Substance Abuse and Mental Health Services Administration (SAMHSA) regulations allowing for the provision of extended take-home medication for up to 28 days for stable patients and 14 days for less stable patients, and Drug Enforcement Administration (DEA) regulations allowing for the provision of "doorstep" deliveries of methadone. In response, NYC DOHMH worked with OASAS and the Coalition for Medication-Assisted Treatment Providers and Advocates (COMPA) to establish the Methadone Delivery System (MDS). The purpose of MDS is to prevent treatment disruptions among patients who have to isolate or quarantine because they have COVID-19, COVID-like illness (CLI), or comorbidities that place them at high risk of experiencing serious illness if they develop COVID. In addition, MDS plays an important role in mitigating the spread of COVID-19 by reducing the frequency of clinic visits among patients. MDS launched on April 20, 2020, From its launch on April 20, 2020 to August 19, 2020, MDS made 959 deliveries to New Yorkers isolating or quarantining at NYC-run isolation hotels or in their homes.

**Q42**

b. During COVID-19, did SUD and problem gambling service providers within your county form any partnerships with other providers that may be continued post-COVID? If yes, please describe.

Yes (please describe):

ASAP (Alcohol and Substance Abuse Providers) and COMPA (Coalition of Medication Assisted Treatment Providers and Advocates) were both very active during COVID in providing support to providers. ASAP extended their support beyond their paid membership.

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**Q43**

1. Has your county conducted analysis on the impact of COVID related to IDD services/OPWDD service system? If yes, please explain.

Yes (please explain):

The NYC DOHMH conducted two surveys in April and August 2020 to department-contracted providers in order to assess the impact of COVID-19 on service delivery. Survey questions targeted provider experiences delivering services using tele-communications, staff availability, and levels of participation, among others. Survey responses will be analyzed and results summarized.

**Q44**

2. What are the greatest challenges your county will be facing over the next 12 months related to IDD services?

We anticipate that continuity of care, proper and sufficient staffing, and means for isolation/quarantine are key areas for concern over the next few months for I/DD services. During the initial phases of the pandemic, NYC DOHMH provided guidance and technical assistance to providers including around outbreak management, surge staffing, and PPE. NYC DOHMH also provided PPE to congregate care providers. The ongoing needs for PPE and staffing relief, especially for providers of residential congregate services were of concern to the DD system. As we plan for a potential resurgence of COVID-19 illness in NYC, we are working with providers to anticipate and avoid similar gaps. We are examining the possible need for creating specialized isolation/quarantine options for individuals living in the community-at-large, and for those who may not be readily contained within the residential congregate network.

According to feedback received from providers and other system stakeholders (e.g., the Community Services Board (CSB), etc.) families are experiencing hardship. For some families, it is neither convenient nor fulfilling to have services provided at home. In these cases, contributing factors may include attention and communication needs that are not readily met by tele-communications/tele-servicing. For other families, difficulties may exist because of other infrastructural and/or social issues, including lack of space, privacy and access to technology.

Providers and other stakeholders also report that the static reimbursement rate, in spite of the increasing complexities of delivering services, is creating barriers to the continuity of quality care. While many programs were kept financially whole using "Retainer Days," a program designed to permit staff reassignment and support services continuation this option has ended, leaving providers to bill directly for services. This is in spite of the fact that service delivery is in flux, and activity levels are far from ordinary. In addition to reimbursement inflexibility and the absence of incentives, the system is poised for significant budget cuts which may result in layoffs and compromised service delivery.

Providers also have mentioned that in the absence of instructions and guidance, they are uncertain about best practices for effective and efficient delivery of tele-services. This is an area that NYC DOHMH would welcome further discussion.

**Q45**

3. Is there data that would be helpful for OPWDD to provide to better information the local planning process? Please list by order of priority/importance.

It would be helpful to have Office for People With Developmental Disabilities (OPWDD) data regarding:

- Staff departures/surge
  - Transportation: How many programs still have transportation in effect?
  - Service utilization and disparities
  - Data matches for residential/congregate sites
  - Changes in service lags
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**Q46**

Please use the optional space below to describe anything else related to the effects of COVID-19 on Mental Hygiene service delivery that you were not able to address in the previous questions:

N/A

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