



## Goals and Objectives 2024 NYC Department of Health and Mental Hygiene

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### Goal 1

Goal 1: Title Provide children and youth with mental health care and developmental disabilities services that is timely, culturally responsive, accessible, and affordable

Goal 1: Target Completion Date Dec 31, 2027

Goal 1: Description Provide children and youth with mental health care and developmental disabilities services that is timely, culturally responsive, accessible, and affordable

Goal 1: OASAS? Yes Goal 1: OMH? Yes Goal 1: OPWDD? Yes

Goal 1: Need Addressed 1 Adverse Childhood Experiences

Goal 1: Need Addressed 2

Goal 1: Need Addressed 3

Goal 1, Objective 1: Title Leverage and increase accessibility of telehealth as part of a continuum of care.

Goal 1, Objective 1, Target Completion Date Dec 31, 2027

Goal 1, Objective 1, Description

Goal 1, Objective 2: Title Support youth facing a mental health crisis

Goal 1, Objective 2, Target Completion Date Dec 31, 2027

Goal 1, Objective 2, Description

Goal 1, Objective 3: Title Increase appropriate care for children and youth impacted by inequities leading to disparate mental health outcomes.

Goal 1, Objective 3, Target Completion Date Dec 31, 2027

Goal 1, Objective 3, Description

Goal 1, Objective 4: Title Build out school capacity to provide and connect children and youth to care.

Goal 1, Objective 4, Target Completion Date Dec 31, 2027

Goal 1, Objective 4, Description

Goal 1, Objective 5: Title Guide mental health system improvements informed by the experiences of youth and families.

Goal 1, Objective 5, Target Completion Date Dec 31, 2027

Goal 1, Objective 5, Description

Goal 1, Objective 6: Title Ensure NYC Well is a more youth-friendly service and increase awareness of and use of NYC Well by youth, their families and child/youth-serving providers.

Goal 1, Objective 6, Target Completion Date Dec 31, 2027

Goal 1, Objective 6, Description

### Goal 2

Goal 2: Title Improve access to prevention interventions for children and youth exposed to risk factors

Goal 2: Target Completion Date Dec 31, 2027

Goal 2: Description Improve access to prevention interventions for children and youth exposed to risk factors

Goal 2: OASAS? Yes Goal 2: OMH? Yes Goal 2: OPWDD? Yes

Goal 2: Need Addressed 1 Adverse Childhood Experiences

Goal 2: Need Addressed 2

Goal 2: Need Addressed 3

Goal 2, Objective 1: Title Provide early identification, intervention, and prevention services within systems that serve and support children and youth.

Goal 2, Objective 1, Target Completion Date Dec 31, 2027

Goal 2, Objective 1, Description

Goal 2, Objective 2: Title Expand supports focused on maternal mental health.

Goal 2, Objective 2, Target Completion Date Dec 31, 2027  
Goal 2, Objective 2, Description

Goal 2, Objective 3: Title Create a child and youth mental health "safety net".  
Goal 2, Objective 3, Target Completion Date Dec 31, 2027  
Goal 2, Objective 3, Description

Goal 2, Objective 4: Title Expand mental health knowledge, skills, and strategies among Youth-serving Community Based Organization (CBO) staff that will enhance their capacity to identify and address mental health needs among community youth and their families.  
Goal 2, Objective 4, Target Completion Date Dec 31, 2027  
Goal 2, Objective 4, Description

Goal 2, Objective 5: Title Develop a strong partnership with a mental health clinic partner (MHP) that will facilitate referrals for youth when appropriate. Joint trainings and strategies such as warm handoffs, regular consultation and coaching with CBO staff will support service coordination. Further CBO staff will apply acquired skills such as mental health awareness, screening and "light touch" counseling to expand possible intervention options.  
Goal 2, Objective 5, Target Completion Date Dec 31, 2027  
Goal 2, Objective 5, Description

Goal 2, Objective 6: Title Support development of protective factors for youth at risk of problem substance use by funding community coalitions.  
Goal 2, Objective 6, Target Completion Date Dec 31, 2027  
Goal 2, Objective 6, Description

Goal 2, Objective 7: Title Intensify support and provide early intervention for youth and families affected by problem substance use.  
Goal 2, Objective 7, Target Completion Date Dec 31, 2027  
Goal 2, Objective 7, Description

### **Goal 3**

Goal 3: Title Improve quality of life by increasing investments in stable housing  
Goal 3: Target Completion Date Dec 31, 2027  
Goal 3: Description Improve quality of life by increasing investments in stable housing  
Goal 3: OASAS? Yes Goal 3: OMH? Yes Goal 3: OPWDD? Yes  
Goal 3: Need Addressed 1 Housing  
Goal 3: Need Addressed 2  
Goal 3: Need Addressed 3

Goal 3, Objective 1: Title Make safe and stable housing more available, affordable and accessible to help improve the quality of life of New Yorkers with Serious Mental Illness (SMI) and intellectual/developmental disabilities (I/DD).  
Goal 3, Objective 1, Target Completion Date Dec 31, 2027  
Goal 3, Objective 1, Description

Goal 3, Objective 2: Title Integrate intensive mental health supports for people with SMI to be able to maintain stable housing after leaving a shelter through the NYC Department of Homeless Services Enhanced Aftercare program.  
Goal 3, Objective 2, Target Completion Date Dec 31, 2027  
Goal 3, Objective 2, Description

Goal 3, Objective 3: Title Coordinate with NYS to increase the number of transitional housing units for people with SMI, autism, and dually-diagnosed I/DD who require this support to live safely in the community, especially people coming out of hospitals, jails, or prisons.  
Goal 3, Objective 3, Target Completion Date Dec 31, 2027  
Goal 3, Objective 3, Description

Goal 3, Objective 4: Title Open 8,000 units of permanent supportive housing for people with SMI (note: the City set a goal of developing 15,000 units of supportive housing over 15 years and reached 7,000 to date), and preserve existing supportive housing units for people with SMI while accounting for increasing costs.  
Goal 3, Objective 4, Target Completion Date Dec 31, 2027  
Goal 3, Objective 4, Description

Goal 3, Objective 5: Title Streamline processes through policy changes and reform them across agencies to reduce the time and paperwork to apply for and access permanent supportive housing, as part of implementing Housing Our Neighbors: A Blueprint for Housing and Homelessness.  
Goal 3, Objective 5, Target Completion Date Dec 31, 2027  
Goal 3, Objective 5, Description

Goal 3, Objective 6: Title Increase access to stable housing for people with development disabilities by increasing residential options for people who have aged out of state placements; Increase access to new and existing community-based housing units for people with developmental disabilities, including those who need 24-hour nursing services and those living at home with aging caregivers.

Goal 3, Objective 6, Target Completion Date Dec 31, 2027

Goal 3, Objective 6, Description

Goal 3, Objective 7: Title Expand housing options for people who use drugs.

Goal 3, Objective 7, Target Completion Date Dec 31, 2027

Goal 3, Objective 7, Description

#### **Goal 4**

Goal 4: Title Expand City infrastructure for rehabilitative supports, social services, education, and employment for people with SMI, intellectual/developmental disabilities (I/DD) and/or impacted by the criminal justice system

Goal 4: Target Completion Date Dec 31, 2027

Goal 4: Description Expand City infrastructure for rehabilitative supports, social services, education, and employment for people with SMI, intellectual/developmental disabilities (I/DD) and/or impacted by the criminal justice system

Goal 4: OASAS? Yes Goal 4: OMH? Yes Goal 4: OPWDD? Yes

Goal 4: Need Addressed 1 Non-Clinical supports

Goal 4: Need Addressed 2

Goal 4: Need Addressed 3

Goal 4, Objective 1: Title Ensure that people with SMI are part of the wider community and supported with education, employment and relationship-building opportunities.

Goal 4, Objective 1, Target Completion Date Dec 31, 2027

Goal 4, Objective 1, Description

Goal 4, Objective 2: Title Ensure that families impacted by mental illness are adequately supported.

Goal 4, Objective 2, Target Completion Date Dec 31, 2027

Goal 4, Objective 2, Description

Goal 4, Objective 3: Title Increase and vary employment and internship 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.

Goal 4, Objective 3, Target Completion Date Dec 31, 2027

Goal 4, Objective 3, Description

Goal 4, Objective 4: Title 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 placed in internships or employed.

Goal 4, Objective 4, Target Completion Date Dec 31, 2027

Goal 4, Objective 4, Description

Goal 4, Objective 5: Title Support and invest in people returning to the community from jails and prisons.

Goal 4, Objective 5, Target Completion Date Dec 31, 2027

Goal 4, Objective 5, Description

Goal 4, Objective 6: Title Provide vocational support for people who are chronically excluded from the workforce.

Goal 4, Objective 6, Target Completion Date Dec 31, 2027

Goal 4, Objective 6, Description

Goal 4, Objective 7: Title Increase referral and capacity at the Support and Connection Centers [to connect community members who are at-risk for legal system involvement to physical health, behavioral health, and social support services.

Goal 4, Objective 7, Target Completion Date Dec 31, 2027

Goal 4, Objective 7, Description

Goal 4, Objective 8: Title Increase participant enrollment to NYC's Health Justice Network participant by identifying additional criminal justice serving partner sites to join the HJN network.

Goal 4, Objective 8, Target Completion Date Dec 31, 2027

Goal 4, Objective 8, Description

#### **Goal 5**

Goal 5: Title Serve New Yorkers in mental health crisis through a health-led response

Goal 5: Target Completion Date Dec 31, 2027

Goal 5: Description **Serve New Yorkers in mental health crisis through a health-led response**  
Goal 5: OASAS? **No** Goal 5: OMH? **Yes** Goal 5: OPWDD? **No**  
Goal 5: Need Addressed 1 **Crisis Services**  
Goal 5: Need Addressed 2  
Goal 5: Need Addressed 3

Goal 5, Objective 1: Title **Improve the experience of New Yorkers who are facing a mental health crisis through strengthened connections to a range of community-based supports and acute care services.**  
Goal 5, Objective 1, Target Completion Date **Dec 31, 2027**  
Goal 5, Objective 1, Description

Goal 5, Objective 2: Title **Improve access to and use of crisis stabilization options, including hospitalization and alternatives, for people with SMI in need of intensive and supportive care.**  
Goal 5, Objective 2, Target Completion Date **Dec 31, 2027**  
Goal 5, Objective 2, Description

Goal 5, Objective 3: Title **Collaborate with Asian American, Native Hawaiian, and Pacific Islander (AANHPI) stakeholders to promote awareness, acceptance, and action for mental health concerns, causes, and supports within NYC AANHPI communities.**  
Goal 5, Objective 3, Target Completion Date **Dec 31, 2027**  
Goal 5, Objective 3, Description

Goal 5, Objective 4: Title **Enhance, expand and strengthen programs and initiatives that center behavioral health community preparedness, engagement, and crisis response.**  
Goal 5, Objective 4, Target Completion Date **Dec 31, 2027**  
Goal 5, Objective 4, Description

## **Goal 6**

Goal 6: Title **Advance a range of accessible and high-quality supports and services across the continuum of prevention, treatment, recovery and harm reduction, to reduce the risk of death and drug-related harms and enhance quality of life for individuals with substance use disorders, with a focus on neighborhoods with the highest overdose death rates**  
Goal 6: Target Completion Date **Dec 31, 2027**  
Goal 6: Description **Advance a range of accessible and high-quality supports and services across the continuum of prevention, treatment, recovery and harm reduction, to reduce the risk of death and drug-related harms and enhance quality of life for individuals with substance use disorders, with a focus on neighborhoods with the highest overdose death rates**  
Goal 6: OASAS? **Yes** Goal 6: OMH? **No** Goal 6: OPWDD? **No**  
Goal 6: Need Addressed 1 **Other**  
Goal 6: Need Addressed 2  
Goal 6: Need Addressed 3

Goal 6, Objective 1: Title **Expand citywide naloxone distribution.**  
Goal 6, Objective 1, Target Completion Date **Dec 31, 2027**  
Goal 6, Objective 1, Description

Goal 6, Objective 2: Title **Expand and enhance nonfatal overdose response efforts.**  
Goal 6, Objective 2, Target Completion Date **Dec 31, 2027**  
Goal 6, Objective 2, Description

Goal 6, Objective 3: Title **Optimize and expand overdose prevention services.**  
Goal 6, Objective 3, Target Completion Date **Dec 31, 2027**  
Goal 6, Objective 3, Description

Goal 6, Objective 4: Title **Understand and respond to the risks of an unregulated drug supply.**  
Goal 6, Objective 4, Target Completion Date **Dec 31, 2027**  
Goal 6, Objective 4, Description

Goal 6, Objective 5: Title **Enhance the scope and reach of existing harm reduction, treatment and recovery services.**  
Goal 6, Objective 5, Target Completion Date **Dec 31, 2027**  
Goal 6, Objective 5, Description

Goal 6, Objective 6: Title **Optimize the availability, accessibility and acceptability of evidence-based treatment.**  
Goal 6, Objective 6, Target Completion Date **Dec 31, 2027**  
Goal 6, Objective 6, Description

## **Goal 7**

Goal 7: Title **Support children, families and communities affected by the overdose crisis**

Goal 7: Target Completion Date Dec 31, 2027  
Goal 7: Description Support children, families and communities affected by the overdose crisis  
Goal 7: OASAS? Yes Goal 7: OMH? No Goal 7: OPWDD? No  
Goal 7: Need Addressed 1 Other  
Goal 7: Need Addressed 2  
Goal 7: Need Addressed 3

Goal 7, Objective 1: Title Provide support to families who have lost a loved one to overdose.  
Goal 7, Objective 1, Target Completion Date Dec 31, 2027  
Goal 7, Objective 1, Description

Goal 7, Objective 2: Title Enhance place-based capacity to support and respond to community needs.  
Goal 7, Objective 2, Target Completion Date Dec 31, 2027  
Goal 7, Objective 2, Description

### **Goal 8**

Goal 8: Title Advance systems improvements and equitable access to behavioral health care for NYC residents with public or private insurance  
Goal 8: Target Completion Date Dec 31, 2027  
Goal 8: Description Advance systems improvements and equitable access to behavioral health care for NYC residents with public or private insurance  
Goal 8: OASAS? Yes Goal 8: OMH? Yes Goal 8: OPWDD? Yes  
Goal 8: Need Addressed 1 Cross System Services  
Goal 8: Need Addressed 2  
Goal 8: Need Addressed 3

Goal 8, Objective 1: Title Educate a minimum of 400 NYC service providers and insurance beneficiaries per year on behavioral health parity laws, beneficiary rights, and mechanisms for appeals and complaints.  
Goal 8, Objective 1, Target Completion Date Dec 31, 2027  
Goal 8, Objective 1, Description

Goal 8, Objective 2: Title Continue to implement social media campaigns to raise awareness among NYC residents and service providers regarding behavioral health parity and rights to accessing care.  
Goal 8, Objective 2, Target Completion Date Dec 31, 2027  
Goal 8, Objective 2, Description

Goal 8, Objective 3: Title Assess feasibility within existing city agency services to 1) identify behavioral health parity violations, 2) direct individuals to resources, and 3) elevate issues to state regulatory authorities.  
Goal 8, Objective 3, Target Completion Date Dec 31, 2027  
Goal 8, Objective 3, Description

Goal 8, Objective 4: Title Convene commercial insurance plans, MH and SUD providers, provider and insurer membership associations, and accreditation organizations to fill in information gaps on the MH/SUD care landscape and promote the expansion of behavioral health networks and services covered by commercial insurance plans.  
Goal 8, Objective 4, Target Completion Date Dec 31, 2027  
Goal 8, Objective 4, Description

Goal 8, Objective 5: Title Educate a minimum of 300 NYC providers and beneficiaries per year on Medicaid managed behavioral healthcare by offering trainings and disseminating information via periodic newsletters.  
Goal 8, Objective 5, Target Completion Date Dec 31, 2027  
Goal 8, Objective 5, Description

Goal 8, Objective 6: Title Support NYC's behavioral health providers interested in preparing for Value Based Payment (VBP) arrangements by offering trainings on VBP 101, data collection, and networking.  
Goal 8, Objective 6, Target Completion Date Dec 31, 2027  
Goal 8, Objective 6, Description

Goal 8, Objective 7: Title Increase readiness among NYC behavioral health providers for participation in value based payment arrangements by offering VBP readiness assessments and facilitating connections to payors, hospital systems and primary care partners.  
Goal 8, Objective 7, Target Completion Date Dec 31, 2027  
Goal 8, Objective 7, Description

### **Goal 9**

Goal 9: Title Advance anti-racist health and social policies, laws, and practices that support the well-being of New Yorkers disproportionately impacted and criminalized due to structural racism

Goal 9: Target Completion Date Dec 31, 2027

Goal 9: Description Advance anti-racist health and social policies, laws, and practices that support the well-being of New Yorkers disproportionately impacted and criminalized due to structural racism

Goal 9: OASAS? Yes Goal 9: OMH? Yes Goal 9: OPWDD? Yes

Goal 9: Need Addressed 1 Other

Goal 9: Need Addressed 2

Goal 9: Need Addressed 3

Goal 9, Objective 1: Title Build collaboration and policy support for criminal legal system reforms with internal and external partners.

Goal 9, Objective 1, Target Completion Date Dec 31, 2027

Goal 9, Objective 1, Description

Goal 9, Objective 2: Title Remove the stigma associated with talking about criminal legal system through messaging and outreach.

Goal 9, Objective 2, Target Completion Date Dec 31, 2027

Goal 9, Objective 2, Description

Goal 9, Objective 3: Title Increase awareness of the health disparities among individuals who have been impacted by the criminal legal system.

Goal 9, Objective 3, Target Completion Date Dec 31, 2027

Goal 9, Objective 3, Description

Goal 9, Objective 4: Title Increase awareness of the impact of social determinants of health on populations disproportionately impacted and criminalized due to systemic racism.

Goal 9, Objective 4, Target Completion Date Dec 31, 2027

Goal 9, Objective 4, Description

Goal 9, Objective 5: Title Elevate surveillance data to inform and advance evidence-based policy development and recommendations.

Goal 9, Objective 5, Target Completion Date Dec 31, 2027

Goal 9, Objective 5, Description

Goal 9, Objective 6: Title Enhance reentry services for people impacted by SMI and the criminal legal system.

Goal 9, Objective 6, Target Completion Date Dec 31, 2027

Goal 9, Objective 6, Description

Goal 9, Objective 7: Title Address racial inequities in health care services and treatment for New Yorkers of color with SMI.

Goal 9, Objective 7, Target Completion Date Dec 31, 2027

Goal 9, Objective 7, Description

## **Goal 10**

Goal 10: Title Support provider organizations in recruitment and retention of the behavioral health workforce

Goal 10: Target Completion Date Dec 31, 2027

Goal 10: Description Support provider organizations in recruitment and retention of the behavioral health workforce

Goal 10: OASAS? Yes Goal 10: OMH? Yes Goal 10: OPWDD? Yes

Goal 10: Need Addressed 1 Workforce

Goal 10: Need Addressed 2

Goal 10: Need Addressed 3

Goal 10, Objective 1: Title In collaboration with state partners, explore/develop a mechanism for collecting reliable data on staff attrition in the behavioral health service system.

Goal 10, Objective 1, Target Completion Date Dec 31, 2027

Goal 10, Objective 1, Description

Goal 10, Objective 2: Title Research existing loan forgiveness programs and innovative models for recruitment and retention, including barriers, challenges, and limitations and disseminate among contracted providers.

Goal 10, Objective 2, Target Completion Date Dec 31, 2027

Goal 10, Objective 2, Description

Goal 10, Objective 3: Title Host feedback sessions with different types of providers (i.e., social workers, peer support workers, community health workers, etc.) to assess their experiences in the behavioral health workforce and develop provider-informed strategies for recruitment and retention.

Goal 10, Objective 3, Target Completion Date Dec 31, 2027

Goal 10, Objective 3, Description



Goal 10, Objective 4: Title Work with community partners to assess emerging needs of the expanding peer workforce and identify strategies to support successful workforce integration.

Goal 10, Objective 4, Target Completion Date Dec 31, 2027

Goal 10, Objective 4, Description

Goal 10, Objective 5: Title Partner with State and community partners to assess the need for long-term technology training and develop a strategy to boost and maintain technology skills among the peer workforces.

Goal 10, Objective 5, Target Completion Date Dec 31, 2027

Goal 10, Objective 5, Description

Goal 10, Objective 6: Title Partner with OMH, OASAS, and NYC community partners to assess the current availability of integrated care training for peer support works and develop a strategy to address unmet need.

Goal 10, Objective 6, Target Completion Date Dec 31, 2027

Goal 10, Objective 6, Description

Goal 10, Objective 7: Title Partner up with criminal justice re-entry programs to increase job development and placement for individuals with criminal justice involvement.

Goal 10, Objective 7, Target Completion Date Dec 31, 2027

Goal 10, Objective 7, Description

Goal 10, Objective 8: Title In partnership with OMH and OASAS, mitigate the impact of Adverse Childhood Experiences by collaborating with trauma survivors and trauma champions to advance collective understanding of trauma, improve practice, and support resilience by increasing the availability of training and technical assistance.

Goal 10, Objective 8, Target Completion Date Dec 31, 2027

Goal 10, Objective 8, Description

Goal 10, Objective 9: Title Identify organizations that work with peer educators in congregate, correctional settings and identify partnership opportunities between organizations and providers to create an employment pipeline from the congregate setting to field placement and employment (e.g. Osborne Association, Bard College Prison Initiative, organizations who work with peer educators and find employment pathways for this pool of potential workers).

Goal 10, Objective 9, Target Completion Date Dec 31, 2027

Goal 10, Objective 9, Description



## 2024 Needs Assessment Form NYC Department of Health and Mental Hygiene

### Adverse Childhood Experiences Yes

Applies to OASAS? No

Applies to OMH? Yes

Applies to OPWDD? No

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): Experiences/Adverse Community Environments (ACEs) have been shown to increase risk for a variety of medical, psychological, and behavioral conditions in adulthood.[1] ACEs research also sheds light on the importance of protective factors during childhood and adolescence that promote resiliency and the ability to cope with toxic stress, while also targeting structural risk factors for trauma exposure.[2] NYC DOHMH's 2015 Child Health, Emotional Wellness, and Development Survey found that racial inequities persist in children's exposure to adverse events:

- 89% of Black children and 90% of Latinx children had a regular place to live in the last year compared to 99% of White children.
- 12% of Black children and 8% of Latinx children were reported by their caregiver(s) to have witnessed or been the targets of violence in their neighborhoods compared to 1% of White children.
- 45% of Black children and 46% of Latinx children were experiencing food insecurity, as reported by caregivers, in the last year compared to 12% of White children.

Furthermore, Latinx and Black children in NYC were less likely to live in supportive neighborhoods, defined as feeling that people in families' neighborhoods help each other out, than White children (61% and 72% vs. 84%).[3] The 2021 Health Opinion Poll found that 68% of Asian American/Pacific Islander (AAPI) adults in NYC reported feeling a lack of emotional support compared to 47% of White adults.[4] This is particularly important given the recent spate of Anti-Asian hate crimes, both in NYC and nationally. Reducing children's exposure to adverse events and increasing their access to supportive environments requires us to address the long-standing economic and social ramifications of structural racism in addition to offering trauma-informed care.

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[1] <https://www.cdc.gov/violenceprevention/aces/riskprotectivefactors.html> 5

[2] [https://www.health.ny.gov/statistics/brfss/reports/docs/adverse\\_childhood\\_experiences.pdf](https://www.health.ny.gov/statistics/brfss/reports/docs/adverse_childhood_experiences.pdf) 6



[3] <https://www1.nyc.gov/site/doh/data/data-sets/child-chs.page> 7

[4] <https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief130.pdf> 12

**Crisis Services** Yes

Applies to OASAS? No

Applies to OMH? Yes

Applies to OPWDD? No

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): Acute care is a critical component of our mental health care system and essential for supporting many people when they are in crisis. However, acute care is not a solution to homelessness or other social factors that worsen mental illness. The entry way to our serious mental illness (SMI) care systems is often through emergency response systems, the majority of which have been led by law enforcement. Law enforcement and mental health advocates agree this situation is not ideal, and would prefer a clinical, trauma informed, and health-led response to mental health crises. This recognition is also shared nationally, with the initiation of 988, the National Suicide Prevention Hotline, as a direct connection to compassionate and accessible care for people experiencing emergency mental health needs.

Because community-based mental health care can be difficult and confusing to access, many people end up calling 911 and getting transported to care in emergency and inpatient settings. According to data from the New York Police Department (NYPD), there were an average of nearly 15,000 911 calls per month in 2022 that were related to a mental health emergency and responded to by NYPD. We must improve availability of and funding for health-led response options and reduce police involvement in behavioral crisis while also increasing access to intensive community treatment and support options.

**Cross System Services** Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? No

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): Despite a significant number of ongoing initiatives aimed at improving behavioral health conditions among NYC residents, there continue to be disparities in behavioral health care access, utilization, and outcomes in NYC.

One in five New Yorkers experiences mental illness in a given year, and hundreds of thousands of these New Yorkers are not connected to care.[5] Additionally, 9.2% of NYC public high school students have reported attempting suicide. Moreover, a 2018 study found that 8.3% of NYC adults had current symptomatic depression. Socioeconomic inequalities in mental health persist in NYC and highlight the need for better diagnosis and treatment.

Within the Medicaid funded behavioral health service system, the number of adult and youth Medicaid recipients with at least one mental health or substance use related primary diagnosis in 2022 was 526,137. Despite significant spending on behavioral health care, the current Medicaid funded 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. Throughout the country, as well as in NYS, behavioral healthcare providers also lag behind their primary care counterparts in opportunities to increase their revenue streams including through value-based payment arrangements. During NYC's community feedback process for local services planning, a Community Services Board (CSB) member shared that "smaller organizations are providing mental health services but don't have a system to actually generate revenue, despite the fact that these organizations have been in the communities for decades and have public trust". Another member stated that "it is much easier for primary care professionals who have data and analysis departments to negotiate rates, etc. We have to think boldly and differently and outside the box if we are going to meet all of this unmet need" (December 2022).

Regarding the privately/commercially insured population, research shows that individuals with private insurance may be even more vulnerable to gaps in behavioral health coverage than those with Medicaid. NYC's Community Health Survey conducted in 2020 indicated that approximately 45% of NYC residents are covered by private insurance plans, and a 2019 Kaiser Foundation study showed that 55% of adults with mental illness have private insurance. A 2015 study published in the journal of Psychiatric Services and the National Institute of Health (NIH) stated that U.S. adults with mental illness covered by Medicaid had over 2 to 3 times the odds, of receiving treatment compared to individuals with private insurance that had 1.5 times the odds. As there are currently no NYC specific studies on behavioral health care access by this population, in 2022, NYC DOHMH conducted interviews and focus groups with key stakeholders (n=71) and surveys of insurance beneficiaries (n=194) and healthcare providers (n=88) to gather NYC specific data on this topic. Select results from the beneficiary survey showed that:

#### Service providers:

- 78% cited low reimbursement rates as the main challenge when working with commercial insurance companies
- 85% said a helpline, chat services, or insurance navigators designated for providers to assist in resolving insurance-related issues would be most helpful for their work.
- 61% said standardized administrative process across all insurers would be most helpful
- 50% cited difficulties with denials as a main challenge

#### Insurance beneficiaries:

- 80% have at some point had to seek behavioral health care outside of their insurance network.
- 65% have encountered incorrect insurance acceptance information from a directory, website, or third-party platform like ZocDoc.
- 69% have been denied coverage of BH services by their health insurance plan.

Furthermore, despite the increased attention to the enforcement of behavioral health parity laws, a 2019 report showed that most consumers in NYS regardless of insurance type, experienced denials of mental health and substance use disorder (MH/SUD) coverage due to medical necessity criteria and pre-authorization of services. Most consumers surveyed for the report 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 was concerning financial requirements and pre-authorization. Most 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. (Note: 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 and failure to complete treatment course exclusions etc.). In addition to research and survey data, a NYC CSB member shared that “parity between physical health and behavioral health is key to promoting access and engaging community members in treatment programs” (December 2022).

With regard to youth behavioral health, NYC DOHMH has identified a number of barriers to accessing cross-system behavioral health services among NYC youth and families.

For the Family Pathways to Care project, Public Policy Lab used human-centered research and design methods to understand how families connect with and experience Administration for Children’s Services (ACS)- and DOHMH-contracted mental health and prevention services. Regarding cross-system referrals, they noted that families struggle to find services that are accessible within their neighborhoods and don’t always know what they should be looking for. For example, when searching for services, they may not know what search terms to use or what clinical terms mean when reading program descriptions. Families who are non-English speaking, undocumented, or without community networks face additional fears or barriers to accessing the services they need.

Service providers in child-serving systems also face challenges referring families to mental health services in that they frequently don’t fully understand the range of services available in the mental health system. Strategies and tools for making referrals across agencies are inconsistent. High staff turnover at provider agencies means that institutional knowledge, which is infrequently documented, can be lost as staff come and go. Providers seek up-to-date, easy to access, and approachable information about programs, which they could ideally filter and search by eligibility rules. They need a centralized system for locating appropriate and available services for families. We are working to expand use of NYC Well by service providers and youth and families.

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[5] Mayor's Office of Community Mental Health | Data Dashboard ([cityofnewyork.us](https://cityofnewyork.us).)

### **Housing** Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): NYC currently contracts for approximately 11,200 units of supportive housing. However, despite this investment in supportive housing, homelessness continues to increase and threatens to erase progress made, especially among New Yorkers with behavioral health concerns.[6] Housing instability and homelessness are particularly important social determinants of health

for people with behavioral health concerns; evidence shows that both housing instability and homelessness are linked to morbidity and premature mortality and worse mental and physical health outcomes.[7][8][9] Housing insecurity can worsen symptoms of mental illness and increase the likelihood a person will encounter high-risk situations that lead to avoidable hospitalization or incarceration.

Since 2017, NYC has had more homeless individuals and families sleeping in Department of Homeless Services (DHS) shelters or rough on the streets than at any time since the Great Depression. Many homeless individuals are living with serious mental illness (SMI), substance use disorders (SUD), or other behavioral health concerns, further highlighting the importance of the supportive housing model, which provides subsidized permanent housing alongside wraparound care and social services for residents who need them.[10] In 2020, approximately 13,000 people with SMI experienced homelessness in the NYC shelter system or on the street.[11]

Some people with SMI will be able to maintain independent housing with financial supports and effective services. Others benefit from higher levels of care, including supportive housing, which offers permanent, affordable rental housing with support services.[12][13][14] While many homeless individuals in NYC currently qualify for supportive housing due to SMI, SUD, or other behavioral health issues, there is currently only one available unit of supportive housing for every five eligible applicants. There remains a significant need in NYC for both additional funding for supportive housing and additional units of supportive housing.

Furthermore, stable housing is closely associated with a person's ability to protect and enhance their health and well-being and is associated with improved health and social outcomes for people who use drugs. Unstable housing status and contact with the criminal legal system are both risk factors for overdose and drug-related harms. Drug-related death is the leading cause of death among people experiencing homelessness in NYC.[15] In addition, those who are involved in the criminal legal system are at increased risk of drug-related harms, including but not limited to overdose, HIV and hepatitis C virus infection.[16]

In order to recognize housing as a basic necessity and platform to improve an individual's health, supportive housing and other programs should take a "Housing First" approach, which does not restrict eligibility based on current or previous drug use and provides re/habilitation supports to increase the ability to remain safely housed.

People experiencing homelessness are more vulnerable to criminal legal system involvement, unnecessary hospitalizations, and potential for increased exposure to law enforcement on the subway system.

In addition, housing continues to be a major unmet need for individuals with intellectual/ developmental disabilities (I/DD) in NYC. For the past several years, adequate and accessible housing options for individuals with I/DD has been repeatedly identified as a key barrier to appropriate, continuous care for

individuals and their families. As in the past, this year, housing options was ranked among the top five areas of concern by NYC DOHMH I/DD stakeholders.

More research may be needed to understand ways to expand least-restrictive housing options while maintaining high quality housing for individuals with I/DD. Many advocates, including Self-Advocacy Association of New York State (SANY), believe enhanced regulatory flexibility is needed, and suggest further study of ways to improve regulatory flexibility in the housing arena. Finally, better prioritization of residential placements is needed. Specifically, stakeholders have expressed difficulty with finding placements for people with I/DD who live in the community but need housing as parents age and are no longer able to care for their children.

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[6] <https://www1.nyc.gov/assets/home/downloads/pdf/office-of-the-mayor/2022/Housing-Blueprint.pdf> (pg. 63)

[7] Taylor, L. (2018). "Housing and Health: An Overview of the Literature." *Health Affairs*. <https://doi.org/10.1377/hpb20180313.396577>.

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[10] US Department of Housing and Urban Development. (2015). The 2015 Annual Homeless Assessment Report (AHAR) to Congress, Part 2: Estimates of Homelessness in the United States. US Department of Housing and Urban Development. The 2015 Annual Homeless Assessment Report (AHAR) to Congress Part 2 ([huduser.gov](http://huduser.gov))

[11] U.S. Department of Housing and Urban Development. 2020 Continuum of Care Homeless Assistance

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2023. [https://files.hudexchange.info/reports/published/CoC\\_PopSub\\_CoC\\_NY-600-2020\\_NY\\_2020.pdf](https://files.hudexchange.info/reports/published/CoC_PopSub_CoC_NY-600-2020_NY_2020.pdf)

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doi:10.1016/j.evalprogplan.2023.102245

[15] NYC Department of Health and Mental Hygiene and NYC Department of Homeless Services. Sixteenth annual report on deaths among persons experiencing homelessness. July 1, 2020-June 30, 2021. [https://a860-gpp.nyc.gov/concern/parent/zg64tp214/file\\_sets/j9602313t](https://a860-gpp.nyc.gov/concern/parent/zg64tp214/file_sets/j9602313t)

[16] Freudenberg N, Heller D. A review of opportunities to improve the health of people involved in the criminal justice system in the United States. Annu Rev Public Health. 2016;37:313-333. doi:10.1146/annurev-publhealth-032315-021420

#### **Inpatient Treatment Yes**

Applies to OASAS? Yes

Applies to OMH? No

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): Several hospital-based detoxification programs include their beds under Med-Surg during non-emergencies, which is needed in order to normalize substance use withdrawal as a routine medical need. However, there is continued concern whether beds are made available equitably to those needing medically managed withdrawal when Med-Surg beds are in high demand. NYC DOHMH will review and monitor changes in bed utilization in these settings as well as inviting comment from community groups to ensure proper access to these critical services.

Additionally, NYC's inpatient programs (especially non-hospital based) have continued need of Personal Protective Equipment (PPE) and other materials to support infection control.

#### **Non-Clinical Supports Yes**

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? No

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): The onset of severe mental illness (SMI) often interrupts a person's relationships, education and employment in ways that substantially and negatively impact their quality of life — 45% of New Yorkers with SMI report having low social support, and 29% are at risk for social isolation.[17] Social isolation, in turn, increases the risk of mental health crisis, due to things like falling out of care or off treatment, or even struggling to maintain housing. People with SMI are also more likely to be unemployed and have a lower household income and lower levels of educational attainment.[18] Discrimination due to mental health diagnosis exacerbates the barriers to employment and social inclusion that people of color already face due to structural racism. People with SMI need more social infrastructure to connect with others and form community and relationships. Clubhouses are one-stop



programs offering an array of services including, but not limited to, building strong support networks, socialization through joining a clubhouse community, supported employment, education support, skill building, case management including identifying supportive housing, advocacy, low or no-cost snacks and meals, and recreation in a recovery-oriented environment.

Research shows the clubhouse model reduces people's hospitalization and contact with the criminal legal system, and improves their health and wellness.[19][20] Over the last year, NYC clubhouses have enrolled more than 1,000 new members. This ongoing growth demonstrates a clear demand for these services. By expanding clubhouses, more New Yorkers with SMI will be welcomed into safe, supportive communities and engaged in efforts to advance their quality of life, including social, educational and employment activities, while reducing their risk of isolation and crisis and associated risks like homelessness and hospitalization.

Additional financial investment is needed to expand the capacity and quality of psychiatric rehabilitation services available in NYC, and to promote broader awareness of these resources so that providers more routinely refer people to peer support, supported employment, education support, and clubhouse services similar to referrals for clinical services. More Certified Peer Specialists are needed to staff the expanding field of non-clinical behavioral health services. Considerable investments are needed to grow and support this workforce.

Psychiatric rehabilitation, occupational therapy, and peer support services are important and often overlooked, complementary and/or alternative services to clinical services. After decades of flat enrollment, NYC successfully increased the number of people in clubhouses citywide by 30% with a \$4M investment and coordinated recruitment effort. This expansion demonstrated previously unacknowledged demand for this valuable service. Additional financial investment is needed to expand the capacity and quality of psychiatric rehabilitation and occupational therapy services available in NYC, and to promote broader awareness of these resources so that providers more routinely refer people to peer support, supported employment, education support, clubhouse and recovery services similar to referrals for clinical services. More Certified Peer Specialists and Certified Peer Recovery Advocates are needed to staff the expanding field of non-clinical behavioral health services and considerable investments are needed to grow and support this workforce.

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[17] Unpublished raw data from the 2012 Community Mental Health Survey. NYC Department of Health and Mental Hygiene; 2012. Accessed February 17, 2023

[18] Unpublished raw data from the 2012 Community Mental Health Survey. NYC Department of Health and Mental Hygiene; 2012. Accessed February 17, 2023.

[19] Killaspy H, Harvey C, Brasier C, et al. Community-based social interventions for people with severe mental illness: A systematic review and narrative synthesis of recent evidence. *World Psychiatry*. 2022;21(1):96-123. doi:10.1002/wps.20940

[20] McKay C, Nugent KL, Johnsen M, et al. A systematic review of evidence for the clubhouse model of

**Outpatient Treatment** Yes

Applies to OASAS? No

Applies to OMH? Yes

Applies to OPWDD? No

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): There is insufficient capacity to meet NYC's demand for specialty mental health care: 41% of people with severe mental illness (SMI) (around 100,000 New Yorkers) want treatment but are unable to get it.[21] Many of the greatest mental health provider shortages are concentrated in neighborhoods with the highest proportion of people of color. The services available are complex, inequitable, and difficult to navigate. These access issues are made worse by cost. One in eight (12.1%) New Yorkers are uninsured,[22] and for people who do have insurance, finding affordable mental health services is challenging due to low reimbursement rates. These financial barriers are more significant for people of color, who face greater inequities in access to health insurance and fair wages. New Yorkers need equitable access to culturally responsive, race-conscious, and trauma-informed care to improve mental health outcomes.

A single system for people with SMI to engage in care is necessary to facilitate efficient, well-planned connections from hospitals, jails and shelters to outpatient mental health and social services that tailor support for people to successfully reenter communities. Additionally, expanding access to comprehensive primary and community mental health care is essential for people to be able to establish relationships with trusted providers who can support their whole health over time. Only providers who have continuous relationships with individuals can identify changes in their circumstances that might quickly bring on a crisis, intervene to prevent it, and make sure they have the resources necessary to stabilize and recover. Lastly, people with SMI also may use drugs and alcohol or have a co-occurring substance use disorder (SUD). A holistic approach for people with SMI must include access to evidence-based substance use treatment and harm reduction services.

Significant investment is needed in order to expand access to outpatient mental healthcare for all New Yorkers who need it.

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[21] Unpublished raw data from the 2012 Community Health Survey. NYC Department of Health and Mental Hygiene; 2012. Accessed February 17, 2023.

[22] Unpublished raw data from the 2021 Community Mental Health Survey. NYC Department of Health and Mental Hygiene; 2021. Accessed February 17, 2023.

**Prevention** Yes

Applies to OASAS? No

Applies to OMH? Yes

Applies to OPWDD? No

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): Despite investment in behavioral healthcare services in NYC, including investment specifically aimed at treatment of serious mental illness (SMI), serious psychological distress (SPD) and other behavioral health issues, there is “a considerable need to raise the priority given to the prevention of mental disorders and to the promotion of mental health through action on the social determinants of health.”[23] Prevention is a central tenet of public health practice and yet when it comes to SMI, SPD and other behavioral health issues, prevention receives little attention or funding compared to treatment within the mental healthcare system. The current model in NYC relies on treating behavioral health problems when they arise rather than working to prevent them to begin with.

Prevention is complex and relies on a wide array of resources and stakeholders; it is not relegated to the hospital, the clinic or the physician's office but is diffused throughout the areas of society in which individuals are born, grow, live, work and age.[24] Prevention often operates at the population level and is driven by politics and policy choices, economics, and social and cultural factors—what are often collectively referred to as social determinants of health (SDoH).[25] Decades of research have indicated the outsized impact that these social determinants of health have on patterns of morbidity and mortality and the extent to which addressing upstream social determinants improves health and health outcomes and prevents disease at the population level.

A renewed focus on the social determinants of mental health (SDoMH) is required to adequately address prevention of SMI, SPD and other behavioral health issues in NYC. In line with the World Health Organization's report on the Social Determinants of Mental Health, we call for an approach that follows the concept of proportionate universalism—policies should be universal, across the whole of society and proportionate to need. In practice, such an approach will be grounded in social and economic rights—including the right to housing, healthcare, employment and education—and will rely on publicly run and funded programs to provide these rights to New Yorkers. It is by now well documented that access to stable and affordable housing, healthcare, a living wage and education are health protective in nature and that reducing inequalities in access to these health protective resources also works to reduce health inequalities more broadly.

When it comes to social conditions NYC ranks particularly poorly with high rates of homelessness, income and wealth inequality and poverty as well as unequal access to healthcare and higher education— New Yorkers of low socioeconomic status (SES) are less likely to have stable access to healthcare or access to higher education and are far more likely to experience substandard mental and physical health and worse health outcomes.[26][27] Without meaningful intervention to address this, SMI, SPD and other behavioral health issues will continue to disproportionately impact the most vulnerable New Yorkers and preventable health inequalities will continue to be commonplace.

New Yorkers of low SES are disproportionately represented among those with behavioral health issues, SPD and SMI. According to the 2020 NYC Community Health Survey:

- The prevalence of SPD was significantly higher among those who are unemployed (8.2%) or not in the labor force (8.9%) compared to those who are employed (4.1%).
- The prevalence of SPD among those with an annual household income lower than 200% of the federal poverty level (FPL) was significantly higher (8.8%) than it was among those with household incomes that are greater than 400% of the FPL (4.0%).
- The prevalence of SPD was significantly higher among those with less than a high school education (8.5%), high school graduates (6.6%), and some college (6.5%) compared with those who are college graduates (4.8%).
- The prevalence of SPD was significantly higher among those who delayed paying or were unable to pay rent in the past 12 months (12.7%) compared to those who did not delay paying rent (4.9%).

Such data underscores the importance of an approach to prevention that is grounded in addressing the social conditions in which New Yorkers are born, grow, live, work and age. Concretely this means ensuring that all New Yorkers have access to the health protective benefits of stable housing, healthcare, education and a living wage, while also promoting policies like progressive taxation and wealth taxation that reduce income and wealth inequality and the health inequalities they result in.[28][29] As the WHO report on the Social Determinants of Mental Health notes, “action [to address the social determinants of mental health] needs be universal: across the whole of society and proportionate to need in order to level the social gradient in health outcomes.”

Working to prevent behavioral health issues through action on the SDoMH is also a racial justice issue. Race-based health inequalities are often the result of decades of austerity and disinvestment in black and brown neighborhoods. Ensuring that all New Yorkers have access to housing, healthcare, higher education, and a living wage will disproportionately benefit black and brown New Yorkers and work to reduce racial health inequalities.

We recognize that many of the programs and policies outlined here fall outside of the purview of traditional public health discourse yet have an outsized impact on patterns of morbidity and mortality, mental and physical health outcomes, and health inequalities. For these reasons we believe that a population approach to prevention, grounded in addressing the social determinants of mental health (SDoMH), is urgently needed in NYC.

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[23] World Health Organization. (2014). Social Determinants of Mental Health. World Health Organization. [https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809\\_eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf)

[24] Rose, G. (2001). Sick individuals and sick populations. *Int J Epidemiol.* 30(3):427-34. doi: 10.1093/ije/30.3.427.

[25] BG, Phelan J. (1995). Social conditions as fundamental causes of disease. J Health Soc Behav. Spec No:80-94. PMID: 7560851.

[26] US Department of Housing and Urban Development. (2021). The 2020 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-in-Time Estimates of Homelessness in the United States. US Department of Housing and Urban Development. <https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf>

[27] Sommelier, E. and Price, M. (2018). The New Gilded Age: Income Inequality in the US by State, Metropolitan Area, and County. Economic Policy Institute (EPI). <https://www.epi.org/publication/the-new-gilded-age-income-inequality-in-the-u-s-by-state-metropolitan-area-and-county/>

[28] Pickett KE, Wilkinson RG. (2015). Income inequality and health: A Causal Review. Social Science & Medicine. 128:316-26.

[29] Piketty, T., & Goldhammer, A. (2020). Capital and Ideology. Belknap Press: An Imprint of Harvard University Press.

### **Problem Gambling Yes**

Applies to OASAS? Yes

Applies to OMH? No

Applies to OPWDD? No

Need Applies to: Adults Only

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): Our two contracted programs providing problem gambling treatment services reported experiencing an increase in demand for services and admissions to treatment for mobile gambling since the legalization of online sport betting in NYS in 2021. One program reported the average debt from mobile gambling upon admission is at least \$50,000, and that it's not uncommon for individuals to have debt into the hundreds of thousands. Another program reported that from January to December of 2022, 33% of patients admitted reported mobile gambling as the main type of gambling they engaged in compared to 57% patients reporting this for only the first half of 2023. This program also reports a waitlist due to this increased demand for treatment, thereby necessitating more staff. Given these reports, there is a need for more problem gambling programming in NYC.

### **Refugees and Immigrants Yes**

Applies to OASAS? No

Applies to OMH? Yes

Applies to OPWDD? No

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): In NYC, reports of hate crimes against members of the Asian American, Native Hawaiian, Pacific Islander (AANHPI) community in 2021 outpaced records of similar complaints in 2020.[30] In addition to being targeted for hate crimes, the prevalence of experiencing physical violence by an intimate partner among U.S.-born AANHPI adults is about three times that of AANHPI adults born outside of the U.S. (8% vs. 2%).[31] AANHPI adults willing to report intimate partner violence may face barriers due to language accessibility in our health systems or lack of knowledge of resources. NYC DOHMH anticipates that the AANHPI community will require additional support and culturally competent services to ensure safety and wellness.

Furthermore, NYC has provided services to more than 14,000 asylum seekers arriving from the southern border of the United States since May 2022.[32] NYC's Office of Immigrant Affairs (MOIA), in conjunction with NYC Emergency Management (NYEM) and other City agencies, has tapped NYC DOHMH to

provide health insurance enrollment, mental health support, and referrals to pediatric care and immunizations. NYC DOHMH is the lead agency providing emotional support services to incoming asylum seekers and staff at the Resources Navigation Center. Services include supporting those in distress to cope better with stressors while accessing services. Additional support services include crisis counseling and facilitating connections to case management services for ongoing support.

NYC DOHMH anticipates that this unprecedented influx of asylum seekers and refugees will continue into the foreseeable future and will require additional resources and funding in 2024 to meet mental health needs of the individuals and families currently experiencing crisis. NYC DOHMH recognizes that the refugees arriving to New York are predominantly from Central and South America and will need to ensure that services provided are culturally sensitive and, to the extent possible, in-language to promote engagement.

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[30] NYPD Hate Crimes Dashboard. (n.d.).

[31] NYC Health Department. (2021, September). Health of Asians and Pacific Islanders - New York City. Retrieved January 29, 2023, from <https://www1.nyc.gov/assets/doh/downloads/pdf/episrv/asian-pacific-islander-health-2021-summary.pdf>

[32] Mayor Adams Releases "The Road Forward," New Blueprint to Handle Asylum Seeker Crisis Moving Forward | City of New York (nyc.gov)

#### **Residential Treatment Services** Yes

Applies to OASAS? Yes

Applies to OMH? No

Applies to OPWDD? No

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): Congregate care settings, including crisis and residential bedded programs, experienced challenges in maintaining social distancing amongst participants and staff during the COVID-19 pandemic. The most recent guidance issued on February 16, 2023, permits all programs to return to admitting and discharging participants based on criteria, but also requires programs to adhere to infection control guidance from OASAS, state and local health departments. Masking is encouraged but not mandated. DOHMH Office of Emergency Response has coordinated with OASAS and OMH to receive regular transmission of program location and contact data in order to expedite communication around outbreaks and other regional disasters.

#### **Transition Age Services** Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? No

Need Applies to: Youth Only

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): DOHMH is a partner organization in NYC's plan to prevent and end Youth Homelessness ("Opportunity Starts with a Home")[33] led by the Department of Youth and Community Development (DYCD). NYC DOHMH participated in DYCD's community coordinated planning process to support the health and well-being of youth experiencing homelessness, called "Opportunity Starts with a



Home.” The Youth Advisory Board (YAB) recommended that the city address the following needs for youth and young adults (YYA):

- Hire mental health professionals within DYCD shelters for more accessible mental health supports.
- Improve access to existing health-related resources that meet a broad array of YYA basic needs, provide ongoing support, and offer training for YYA to lead healthy lives.
- Ensure that YYA have a broad array of options to engage in social activities that help them build relationships, develop skills, relieve stress, contribute to the community, and enjoy themselves.
- Increase opportunities for YYA survivors of violence to build healthy relationships and support their wellbeing. Please enter needs assessment here. Please cite sources as comments.

Additionally, through this initiative DOHMH has committed to working on following action steps to improve access to mental health and harm reduction/addiction supports and services for homeless youth and young adults (YYA):

- Work with DYCD and community-based organizations to increase awareness and accessibility of Crisis Respite/Residence Centers to support YYA experiencing mental or emotional health crises, including family conflict.
- Explore creating a connection between the Runaway and Homeless Youth (RHY) drop-in centers.

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[33] <https://www.nyc.gov/assets/home/downloads/pdf/press-releases/2022/NYC-Community-Plan-DIGITAL.pdf>

**Workforce Yes**

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): According to a recent report from the Center for Health Workforce Studies (CHWS) on Health Worker Recruitment and Retention in NYC, behavioral health providers are some of the most difficult health care occupations to recruit and retain. The report identifies psychiatrists in particular as one of the most difficult behavioral health occupations to recruit and retain. This aligns with observations made by the NYC Community Services Board (CSB), who have also raised concerns about a shortage of child psychiatrists in particular, as well as widespread workforce shortages in community-based settings.

The findings from the CHWS report on the reasons for difficulties in retention and recruitment generally align with those identified by NYC CSB members, including:

- Demand outstripped supply: The COVID-19 pandemic exacerbated health workforce shortages in NYC, dramatically increasing the number of occupations in short supply as well as the magnitude of the shortages. This aligns with observations made by the NYC CSB, who have stated that the demand for behavioral health services have grown exponentially, but staffing hasn't grown to meet the demand. The NYC CSB have continually advocated for the expansion of professional development pipelines that connect new behavioral health providers to community-based organizations (CBOs) in need of staff, particularly for social workers.
- Noncompetitive salaries: This finding in the CHWS report aligns with observations made by the NYC CSB, particularly regarding higher starting salaries for behavioral health occupations in private sectors that CBOs are unable to compete with. Noncompetitive salaries (and low entry level pay in particular), in combination with the high cost of living in NYC and limited affordable housing opportunities, may have driven workers out of the behavioral health sector and the city entirely. While the proposed FY24 NYS Budget recommends \$38 million to support minimum wage increases for existing staff at programs licensed, certified, or otherwise authorized by OPWDD, OMH, and OASAS, continued funding and opportunities for permanent or long-term wage increases may need to be explored.
- Lack of flexible scheduling: In alignment with observations made by the NYC CSB about the behavioral health workforce in NYC, the CHWS report shows that there is a significant generational and workforce culture shift among health care occupations, indicating that the younger workforce is more concerned with work-life balance and opportunities for flexible scheduling, including remote telework. Similarly, the NYC CSB has elevated the need for new types of incentives to ensure retention, including innovative scheduling models that provide flexible hours, as well as opportunities to meet childcare, eldercare, and other needs to better prevent burnout. In Mayor Adams's newly released Care, Community, Action: A Mental Health Plan for NYC, the City committed to reduce burnout by increasing quality supervision and appropriate staffing ratios (which requires a sufficient workforce), supporting continuing education and advancement, and creating financial incentives to make sure mental health staff can meet their work-related needs.

Concerning the peer workforce in particular, community input continues to identify peer support workers as integral components of the behavioral health workforce in NYC. Their specialized training and intentional use of lived experience has uniquely positioned them to engage and support clients burdened with a mental health concern(s), substance use disorder, and intellectual/developmental disabilities. Despite the promise of the peer support workforce, challenges such as limited opportunities for career advancement and provider readiness continue to be identified as barriers to workforce integration. Moreover, as New York State considers expansion of the peer workforce through the 1115 Waiver by including Community Health Workers and other healthcare titles that prioritize lived experience, it will be critical to better understand their unique needs and develop strategies to ensure that are successfully integrated into the behavioral health workforce.

Telehealth and tele-support have become commonplace in the provision of behavioral health services, requiring peer support workers to adapt their services to virtual, digital, and telephonic platforms. Although the provision of in-person services have increased post-pandemic, there will be an ongoing need for peer support workers to successfully use technology in their practice. However, this segment of the workforce continues to experience barriers in accessing and using technology to provide telehealth

peer support. Moreover, there is some concern that principles of peer support may not be easily translated through tele-support, which will require additional training for the peer workforce.

In 2021, NYC conducted a survey on the Effects of COVID-19 on Peer Support Workforce (n= 275). Findings included:

- 50% of Peer support workers said the in-ability to meet in-person was the biggest barrier to delivering services during the pandemic.
- 48% reported technology as the most critical new skill they learned, yet 45% felt they were not very well or only somewhat supported in learning how to use technology.

The New York State Office of Mental Health also conducted a survey that included peer support workers and managers/supervisors on competencies in peer telehealth during the COVID-19 (n=313, n=164)[34] found that competency-based training and performance-based training was needed to preserve the unique nature of peer support services in the provision of Peer Telehealth.

These findings suggest there is an area of ongoing need for peer support workers and their supervisors/managers to ensure that they are able to successfully integrate technology into their work. As New York State continues to build its digital telehealth structure, targeted resources are needed to study potential barriers to successful integration of the technology and develop strategies to increase workforce literacy as needed.

A centralized system for receiving workforce information and updates has also been identified as essential to the advancement of the Peer and Community Health Worker workforce. This need has become increasingly evident as Peer and Community Health Workers complete dual certifications. However, there is currently no central point of access for all peer support workers (PSWs) to obtain information on training, continuing education units (CEU) and professional development opportunities, or general community resources of interest to the workforce.

While peer support workers are considered to be especially vulnerable to burnout and stress, many have noted that this stress is often in reaction to toxic workplace culture and is pervasive in organizations regardless of title. Since the onset of the pandemic, the workforce has been increasingly complex which has contributed to heightened levels of stress and burnout among many workers. Studies indicate that:

- 80% of workers reported that workplace stress affects their relationships with friends, family, and coworkers. Only 38% of those who knew about their organization's mental health services would feel comfortable using them.[35]
- It is estimated that cost employers in the United States up to \$193.2 billion annually in lost earnings due to absenteeism and presenteeism. Anxiety and depression cost the global economy over \$1

trillion in lost productivity yearly.[36]

- Workplace stress costs U.S. employers \$500 billion annually in lost productivity.

As NYC's workforce continues to adapt and evolve, there is an urgent need to increase access to resources and tools to support the well-being of the workforce. Many of these strategies are currently being used but will need to be built to scale such as:

- Assuring access and connection to culturally responsive resources and services that address traumatic stress and loss.
- Employing supports and resources that address underlying complex trauma due to historical or racial trauma and its disproportionate impact on historically underrepresented workers- LGBTQIA+, BIPOC, differently abled, neurodivergent, etc.
- Increasing awareness of trauma-specific treatment modalities.

Ongoing development of tools to track the impact of COVID-19 associated collective trauma and the needs of frontline workers.[37]

Concerning the I/DD workforce, recruitment and retention have been repeatedly identified as a key barrier to appropriate, continuous care for individuals with I/DD and their families. The COVID-19 pandemic has further exacerbated a historic need to strengthen I/DD workforce recruitment and retention. While OPWDD has begun crucial work in this area, including dedicating 76% of the American Rescue Plan Act (ARPA) to workforce development grants and workforce incentives and bonuses, a variety of structural factors impact the DD workforce. These include high stress, low wages, a lack of professional development opportunities, a lack of retention incentives, and insufficient and/or ineffective marketing of DD workforce careers.

Direct Support Professionals (DSPs), both those employed directly by OPWDD as well as contracted providers through the nonprofit sector, remain the backbone of the I/DD workforce. These critical staff contribute to community habilitation programs, respite services, and congregate settings, among others, and essential to day-to-day programming. Chronic underfunding continues to create barriers to a sustainable, well-trained, and supported workforce.

Stakeholders, including Self-Advocacy Association of New York State (SANYS) and the Interagency Council of Developmental Disabilities Agencies (IAC), have advocated for increased incentives for DSP training and professional development and have recommended that OPWDD promote opportunities for people to make their work a long-term career.

Addressing challenges with the DD workforce can have a cascading effect in improving other areas of unmet need impacted by staffing shortages, such as crisis services and service continuity for of

individuals with developmental disabilities. NYC DOHMH will consider the merits of conducting a research study to better understand underlying I/DD workforce recruitment and retention concerns. Such a study would be conducted in collaboration with intergovernmental partners (OPWDD, etc.) and among contractors for services.

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[34] Spagnolo, A. B., Pratt, C. W., Jia, Y., DeMasi, M., Cronise, R., & Gill, K. (2022) The Competencies of Telehealth Peer Support: Perceptions of Peer Support Specialists and Supervisors During the COVID-19 Pandemic. *Community mental health journal*, 58(7), 1386–1392.

[35] Reinert, Nguyen, & Fritze. (2021) *The State of Mental Health in America*. Mental Health America, Alexandria VA.

[36] Adams & Nguyen. (2022) *Mind the Workplace 2022 Report: Employer Responsibility to Employer Mental Health*. Mental Health America, Alexandria VA.

[37] <https://omh.ny.gov/omhweb/statistics/2021-needs-of-frontline-workers-interim-report.pdf>

#### **Harm Reduction Services to Combat Overdose Epidemic** Yes

Applies to OASAS? Yes

Applies to OMH? No

Applies to OPWDD? No

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): The unintentional overdose rate in NYC is at an all-time high, with 2,668 overdose deaths reported in 2021, making it the deadliest year on record. As a result, there is a need to strengthen and enhance the following services and initiatives, many of which exist but could be broadened/bolstered across the harm reduction service continuum:

- Identifying sustainable funding to support enhancement of low threshold wraparound services at SSPs, including mental health, primary care, SUD treatment, and meeting basic needs (e.g., food, showers, laundry), with a focus on neighborhoods with high overdose mortality rates
- Expanding additional OPC services throughout NYC including in areas with high overdose mortality rates
- Building greater capacity to address access to fentanyl test strips through various types of service providers
- Expanding access to drug checking technology (e.g., tests drug sample for fentanyl and xylazine) so participants can make better informed decisions around their use
- Promoting safer means of syringe disposal including more syringe litter kiosks
- Creating post-use clinical observation programs

#### **Racial Equity and Justice-Impacted Populations** Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): Communities of Color in the U.S. experience significant health inequities laid bare and exacerbated by the COVID 19 pandemic; these inequities severely impact persons with criminal legal system involvement.

The impact of long-standing systemic racism is evident in the US criminal legal system (CLS), with persons of color experiencing disproportionately high incarceration rates.[38] Persons with criminal legal system involvement (CLSI) also face systemic racism and other barriers when re-entering the community, experiencing poorer health outcomes, higher rates of heart disease, trauma, hypertension, behavioral health conditions,[39], and premature mortality.[40] Housing insecurity is widespread, with persons with CLSI experiencing almost 10 times the rate of homelessness compared to the general population.[41] Persons with CLSI also face numerous barriers to employment, with only 55% of individuals report having any income during the first year following release.

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[38] The Sentencing Project. Lifetime likelihood of imprisonment of US residents born in 2001. <https://www.sentencingproject.org/criminal-justice-facts/> Accessed May 6, 2020

[39] Siegler A, Bersofsky M, Unangst J. Medical problems of state and prisoner and jail inmates. 2011-2012. US Department of Justice. 2015

[40] Binswanger IA, Stern CF, Deyo RA, et al. Release from prison — a high risk of death for former inmates. *N Engl J Med.* 2007;356(5):157-165. doi:10.1056/NEJMsa064115.

[41] <https://www.prisonpolicy.org/reports/housing.html>

### **Emergency Preparedness in the Behavioral Health Service System Yes**

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): Research and anecdotal evidence from previous disasters and public health emergencies highlighted the need for a better prepared behavioral health service system to address the impact of these events on their workforce and the population they serve. This need was further exacerbated by the COVID-19 pandemic.

Disaster planning and preparedness often neglects to adequately consider the unique event related needs of the service recipients of all three areas of the behavioral health service system. This can lead to inadequate response to their event-related behavioral health needs and contribute to adverse outcomes such as impaired coping, inability to access needed care, worsening of existing conditions, and



diminished chance for recovery. Evidence also indicates lack of adequate readiness and failure to engage the staff of the Behavioral Health Service System in disaster planning and pre-tenders negatively affects their health and functioning during an event, with high rates of burnout and turn around. It also increases their risk for event related mental health illnesses, such as depression anxiety, and alcohol and substance use.

NYC DOHMH identified three main gaps in the Behavioral Health Service System planning, preparedness, response. Addressing these will be essential to improve future response outcomes. Activities need to focus on 1) Engaging staff in planning and preparedness and enhancing their resilience and supporting their emotional health and well-being to prevent burnout and costly high turn around. 2) providing adequate and timely behavioral health support services to individuals and communities most impacted by the incident. 3) planning to coordinate response among Behavioral Health Service providers

NYC DOHMH requires support from city and state leadership to enhance its behavioral health care system's response readiness, most urgently to develop comprehensive, standardized, and scalable disasters and public health emergencies response plans with corresponding tools, protocols, and trainings, and to build and strengthen systems for collaboration among behavioral health care providers around resource sharing.

**LGU Representative:** Kirklyn Escondo

**Submitted for:** NYC Department of Health and Mental Hygiene