NEW YORK STATE | Office of Mental Health

Expanded OMH resources and guidance to help prevent and resolve crises

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2023 Budget's Historic Investment in Mental Health

- Improve hospital access and system accountability
- New housing for individuals with mental illness
- Expand outpatient and community-based mental health services
- Outreach and connection services for homeless New Yorkers
- Strengthen children's services

2023 Budget's Historic Investment in Mental Health – Crosscutting Themes

- Strengthen the mental health workforce
- Expand insurance coverage for mental health services
- Integrated Care: physical health, mental health, substance use, and developmental disabilities
- Equity and Diversity
- Services across the lifespan, including at least 25% for youth
- Community based recovery and full integration into community life; peer services throughout the continuum

New Housing Resources

Housing Expansion

Capital and Operational resources to develop 3,500 new Housing Units with emphasis on Housing First Model and integrated services

- *Capital for 2,150 beds:*
  - ✓ 900 transitional step-down
  - ✓ 500 Community Residence SROs
  - ✓ 750 permanent supportive housing beds
- *Additional support for:*
  - ✓ 600 licensed apartment treatment beds
  - ✓ 750 scattered site supportive housing units

Supportive Services: mental health, harm reduction, naloxone availability, substance use etc.

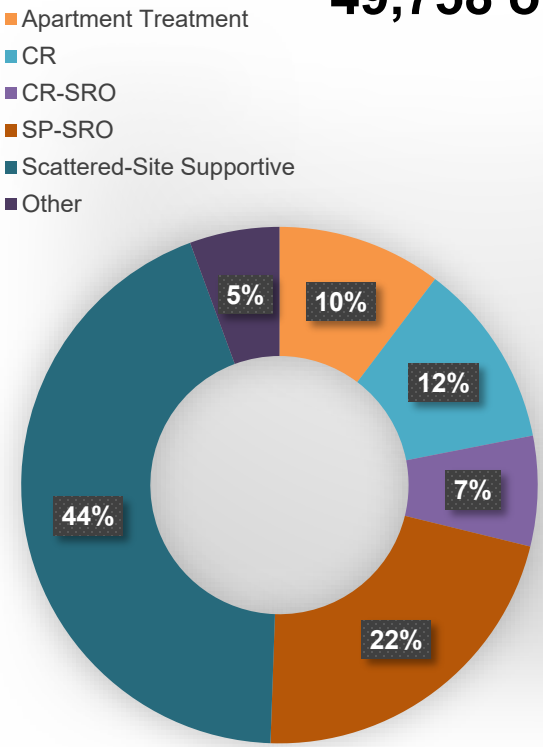
Short Term Transitional Residences

New model of transitional residential program focused on providing intensive, short term supports to enable individuals making transitions to more permanent housing

- 120 day LOS
- Up to 15 units depending on the initiative
- Specialization
  - Co-occurring MH+SUD - 6 programs, one per region, 2 NYC
  - Co-occurring MH+IDD – 5 programs, one per region
  - People returning from Prison – 12 programs in select counties

Current OMH Housing Units in NYS

49,758 operational units of housing currently



- Apartment Treatment: 5,123
- Community Residence (CR): 5,787
- CR-SRO: 3,432
- SP-SRO: 10,813
- Scattered-Site Supportive Housing: 21,805
- Other: 2,798

OMH projects almost 1,907 more beds to open in FY25, with over 7,100 beds in the pipeline total over the next 5 years.

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Homeless Services

Safe Options Support

- An integrated care transitions model that is modeled on and adapted from several evidenced-based interventions:
  - Critical Time Intervention (CTI)
  - Harm Reduction
  - Recovery Orientation
  - Motivational Interviewing
  - Peer Support
- A time-limited intervention for up to a year and designed to help members through a critical transition
- A mobile/community-based multidisciplinary team supporting a member's journey from homelessness into housing
- An intervention that impacts continuity of care and community integration by actively building and linking to the member's network of support
- An adaptable model that can be applied to different settings, populations, and cultures

SOS Teams: NYC Initial Teams

Current outreach focus is on subway transit stations, but SOS referrals can be made by community stakeholders, agencies, family, or other supports. Upon receiving a referral, SOS Teams respond within 24-48 hours to initiate outreach efforts.

11 teams in NYC and 3 overnight teams

Data collected 4/25/22 – 3/29/24:

- Over 23,840 outreach encounters
- Over 3,445 referrals from hospitals, Single Point of Access (SPOA), Department of Homeless Services (DHS), Street Outreach Teams, community stakeholders, etc.
- 1,741 individuals currently receiving SOS services/connections.
- 1,062 individuals accepted temporary residence in Safe Haven/shelter beds through DHS
- 396 individuals (as of 3/29/24) had obtained long-term/permanent housing
- Emergency Department/CPEP/Inpatient Data reflects the following:
  - 183 individuals have been transferred to hospital (inpatient) for medical
  - 163 individuals for psychiatric inpatient
  - 23 individuals for substance use (detox or rehab)
  - 146 individuals to ER – medical
  - 57 individuals to ER – psychiatric
  - Only 6 involuntary 9.58 utilized; all other hospital and ER visits, admissions were voluntary

SOS Teams 11 new teams outside NYC

SOS Region
Capital Region (Albany, Schenectady, Saratoga Counties)
Downstate (Westchester County)
Hudson Valley (Orange, Dutchess Counties)
Long Island (Nassau County, Suffolk County)
Rochester/Finger Lakes(Monroe County)
Southern Tier (Broome, Chenango, Otsego Counties)
Western New York(Erie County)
Central NY (Onondaga, Oswego Counties)
Southern Tier (Chemung, Steuben Counties)
Hudson Valley (Sullivan, Ulster Counties)
Central NY/Southern Tier (Cortland, Tompkins, Tioga Counties)

New and expanding community connections, treatment, psych rehab services

Critical Time Intervention (CTI) Teams

9-12 month phase-based care management approach focused on enhancing continuity of care during transitionals. CTI promotes community integration, self-advocacy, and access to ongoing support by helping individuals develop and utilize strong ties to their support systems during and after transition periods.

- 15 Downstate teams
- 10 Upstate teams
- 4 Rural teams
- Specialization
    - 5 teams MH+IDD linked to STTR

Assertive Community Treatment (ACT) Teams

Mobile treatment and care coordination teams focused on meeting individuals with complex needs who are not well served in place-based settings

- Classic ACT
- Expansion of ACT teams serving special populations
    - Young Adults
    - People with criminal justice involvement (FACT)
    - Older Adults
    - Youth
- New ACT Models
    - Rural ACT
    - Flexible ACT

Certified Community Behavioral Health Clinics (CCBHC)

Enhanced clinic providing integrated mental health and substance abuse services, and an expanded array of other services including: psych rehab, case management, peer and crisis services.

Expanding from 13 to 39 programs, targeting all areas of the state.

- First round of expansion added 6 in NYC and 7 in ROS
- Second Round is pending

Hospital-based Resources

OMH has awarded capital for development of new Inpatient Psychiatric Units and CPEPs

- 9 inpatient awards:
  - 5 in NYC: 2 for youth, 3 for adults
  - 4 in ROS: 1 for youth, 3 for adults
- 9 CPEP awards
  - 5 in NYC
  - 4 in ROS

The underlying goal…

Focus on Individuals with Complex Needs

- Broader system changes:
  - COVID, Bail and Parole reform, Telehealth, Opioid Epidemic
- We need not only better access, more services, but need to knit all these services into a more coherent system
  - Between Hospital and Community Care
  - Among Community treatment and rehab, housing, care coordination
- Establish clear and consistent expectations for the system of care for assessment, communication, admission and discharge practices for hospital and community-based programs.

Hospital and Community Connections

- Guidance to Article 28 and 31 Inpatient Psychiatry Facilities, CPEPs and Article 28 EDs
- Updated regulations to incorporate standards included in guidance

- Community Guidance in development, complementary to Hospital Guidance
- Program Regulations and Guidance to be updated to incorporate new standards

Hospital Guidance

- Focus is on improving the quality of assessment and discharge processes by standardizing practices
- Screening and Assessment process:
  - Suicide and Violence Risk, Substance Use and Social Care Needs
  - Structuring admissions and discharge planning decisions by using level of care tools
- Communication and Collaboration with non-Hospital Providers for both acute admission decisions but also for more routine matters to ensure a full assessment is completed
  - Using PSYCKES and other data sources (SHIN-NY/QE, etc.)
  - Seeking collateral information from referrers (families, treatment housing providers, etc)
- Coordinated Discharge Planning
  - Coordinate person centered discharge planning, including date, time and pick up with outpatient treatment, care management and housing providers
  - Ensure people have confirmed, scheduled appointments within 7 days
  - Share discharge summaries
- Enhanced pre-discharge interventions to improve discharge outcomes for those at specific risk for suicide, community violence or opioid overdose.
  - Develop and share collaborative safety plans for risk areas or offer specific specific treatment modalities to reduce risk

Community Guidance – Housing Providers

- Communication and Collaboration with Hospital Providers
  - Programs must develop practices for communicating information from resident's records to hospital staff seeking information.
  - This function must be available during regular business hours for all programs and 24/7 for licensed housing programs
  - Information provided should include available safety plans and risk assessments, collateral information, recent crises and crisis system involvement
  - Recommend utilizing routinely/automatically updated face sheets to summarize this information
- Coordinated After-care and Discharge Planning
  - Engage with inpatient providers while the resident is admitted and for discharge planning
  - After discharge, check in with the resident daily until the first aftercare appointment
  - If the resident does not attend their first aftercare appointment, support them in rescheduling and continue monitoring and helping them connect to care
  - Identify staff to receive, review and share sign-out and discharge summaries received from hospitals

Thank you!