BEHAVIORAL HEALTH DIRECTIVE

of the NY Health & Human Services Planning Council

Purpose

The NYC RWPA Behavioral Health Directive Implementation Research Logic Model (IRLM) supports the implementation of an integrated spectrum of behavioral health services to improve care for PWH who have behavioral health needs.

Abbreviations and Acronyms

ACE: Assess. Connect. Engage
ACEs: Adverse Childhood Experiences
AOD: Alcohol & Other Drugs
AOT: Assisted Outpatient Treatment
BH: Behavioral Health
CTP/Recipient: Care and Treatment Program
Council: Health & Human Services Planning Council of New York
DOHMH: NYC Health Department
HAB: HIV/AIDS Bureau
HASA: HIV/AIDS Services Administration
HRSA: Health Resources and Services Administration
IRLM: Implementation Research Logic Model
IPV: Intimate Partner Violence
MH: Mental Health
NYEMA: New York Eligible Metropolitan Area
PCN: Policy Clarification Notice
PLE: Person w/ Lived Experience
PWH: Person with HIV
RWHAP: Ryan White HIV/AIDS Program
RWPA: Ryan White Part A
SEP: Syringe Exchange Program
SUD: Substance Use[1] Disorder
UHF: United Hospital Fund

Structure of Document

1. Description of the Intervention
2. Implementation Determinants
3. Implementation Strategies
4. Mechanisms
5. Implementation Outcomes
6. Client-Level Outcomes

Description of the Intervention

This intervention seeks to provide integrated mental health, substance use, and psychosocial support care for PWH with behavioral health needs.[2] Same day linkage, navigation and enhanced peer support are some of the evidence-based strategies shown to mitigate barriers to care, increase client engagement, and help improve behavioral health and other health-related outcomes. Requirements of the model:

- Capacity to charge Medicaid for billable services (does not apply to non-SEP Harm Reduction service sites)
- Full deployment of all available funding and resources to improve[3]
    - training,
    - clinical care practices
    - service access
    - and reach of BH programs.

"Parts A, B, C and D Grantee Administration and/or Clinical Quality Management funds may be used to support specific HIV staff training that is designed to enhance an individual's or an organization's ability to improve the quality of services provided to eligible clients, so long as such costs do not exceed the legislatively mandated caps on Grantee Administration and Clinical Quality Management."

- Policy Notice-11-04: Use of Ryan White HIV/AIDS Program

- Increased wrap around services to support behavioral health services for people with SMI.
- Same day linkage to mental health, physical health, and substance use services,
- Service sites available in all 5 boroughs with consideration for disproportionately impacted neighborhoods/UHF/zip codes, sites must serve clients from throughout the EMA
- Distribution of sites must align with UHF/zip code distributions of geographic prevalence of HIV and service need.
- Support staff competency in developing and delivering culturally humble services and embedding anti-stigma, anti-racist, and trauma-informed lenses into services and service delivery.
- Implement Framing Directive guidance as applicable.

This model integrates the HRSA defined service categories per Health Resources and Services Administration (HRSA) PCN 16-02 of Mental Health, Psychosocial Support, and Outpatient Substance Abuse (referred to as Harm Reduction[4] forthwith).[5] All contracted agencies will be responsible for implementing core behavioral health services and implementation strategies. Select specialized services from the HRSA service categories of mental health, harm reduction/substance use and psychosocial services may be combined to create a model of care that best meets the needs of individual clients and the intended service population(s). These models may be modified over time, as agencies and the recipient evolve in their understanding of what is needed to best support clients' quality of life and to improve engagement and viral suppression rates.

Determinants

To understand the local context where implementation occurs and tailor implementation strategies to the setting. Determinants, described below, are factors that make implementation easier (facilitators) or harder (barriers). Multiple types of determinants must be considered to consider the context comprehensively, even if the strategies picked will not address all of them. What contextual factors could influence implementation at the structural, interpersonal, and individual levels?

+/- indicate facilitator/barrier

Mental health [and by extension Behavioral Health] is an integral part of health and well-being, as reflected in the definition of health in the Constitution of the World Health Organization (WHO): "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Mental health, like other aspects of health, can be impacted by a range of socioeconomic factors (described below) that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery in a whole-of government approach….

Determinants of mental health and mental disorders include not only individual attributes, such as the ability to manage one's thoughts, emotions, behaviors and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports. Exposure to adversity at a young age is an established preventable risk factor for mental disorders.

-66th World Health Assembly, Comprehensive Mental Health Action Plan 2013–2020

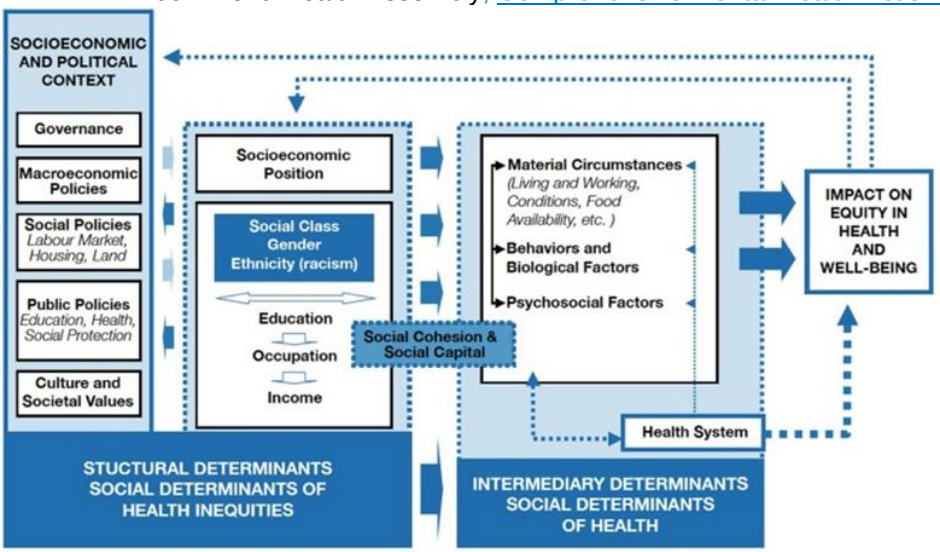


Figure 1 Social determinants of health framework (World Health Organization (WHO), 2010. This directive aligns with the WHO's definition of mental health, found here.

Figure 2 Optimal Mix of Services Pyramid The Mental Health Decree and the WHO Action Plan have set the direction for de-institutionalization and further provision of community mental health services.

Intervention Characteristics

Characteristics of the proposed Behavioral Health integrated services

INTERVENTION SOURCE: Council directives inform RWPA service models. Directives are grounded in evidence-based practices, client testimony, formal and informal feedback from funded agencies, best practices, input from subject matter experts and data analyses. (+)

EVIDENCE STRENGTH AND QUALITY: The use of evidence-based/informed behavioral health interventions[6,7] to improve HIV related outcomes has been extensively studied. Research indicates that behavioral health services play a strong role in helping to stabilize clients and improve health outcomes. (+) Data and privacy restrictions, including those due to handoffs to Medicaid funded services, limit evaluations of the intervention. (-)

RELATIVE ADVANTAGE: For clients with behavioral health needs, these services are an integral part of living their best life. Offering a spectrum of services from multiple service categories both broadens the conception of behavioral health and supports wellness (including social support, exercise/body movement, and other evidence-based practices known to improve behavioral health). Best practice indicates that low threshold supportive counseling, psychotherapy and psychiatric services form a system that meets clients where they are, increasing points of access and support for navigating barriers to care to improve access and engagement.[8] This model leverages increased peer engagement to support clients and facilitate an appropriate level of services to fully meet client needs. Specific services to engage persons with probable serious mental illness are included. (+)

The National Institute of Mental Health defines SMI as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major

life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI. (+)

ADAPTABILITY: Agencies deliver all core behavioral health services and select a complement of category specific services to best meet the needs of the PWH. Services will be tailored both to the needs of clients and the capacity of agencies. The Framing Directive guides all services delivery to support a client experience that supports and centers the client throughout all points of contact, from the front desk through the development and implementation of a client-led collaborative care plan. This model is adaptable to client needs and agency capacity and supports high quality service delivery. Models may also be modified to reflect evolving evidence, best practices and current data to continually improve care. (+)

COMPLEXITY PERCEIVED: Providing a flexible framework for service delivery may facilitate client navigation and management. Same and next day linkage agreements for mental health provide timely interventions to improve client stability and outcomes. These provisions improve service delivery, but treatment for behavioral health disorders may still be complex and mired with structural and systemic barriers. Behavioral health treatment and recovery are not linear. (+/-)

COST: RWPA allocates funding to support eligible BH services, including navigation, accompaniment and case conferencing, which leverage other funded services to appropriately support clients. (+)

Inner Setting

There are two relevant inner settings: the Care and Treatment Program (CTP or Recipient) of the NYC Health Department (DOHMH), & RWPA Funded Organizations.

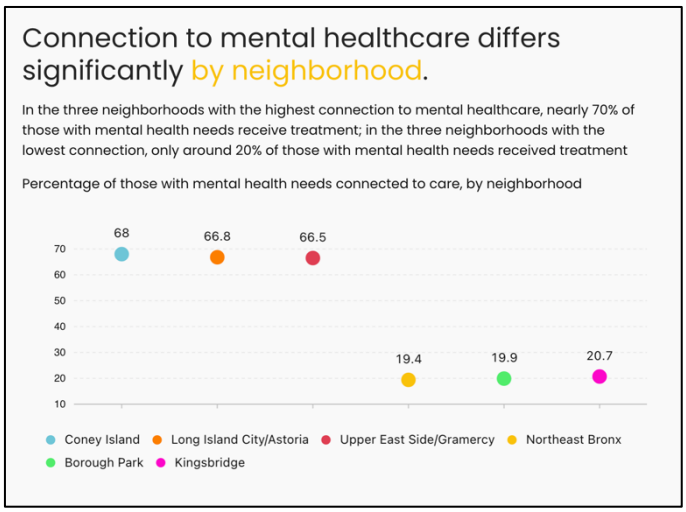
- Staff turnover and burnout at funded organizations leads to inconsistency of service delivery (and impacts behavioral health standardization) and diminishes trust and increases anxiety among consumers when long-term provider relationships end (-)
- Among NYC municipal employees, female employees on average make $.73 to every dollar male employees make.[9]
- Black or African American employees make $.71 to every dollar white employees make, Hispanic or Latino employees make $.75 to every dollar white employees make, and Asian employees make $.85 to every dollar white employees make.[10] Staff turnover results in gaps in training and delays in program development and project implementation (-)
- A lack of continuous opportunity for training and professional development by staff at funded organizations. (-)
- Siloed work within DOHMH, which is then reflected in the work in the community with consumers and with the providers. (-)
- Workgroups and partnerships formed to address agency needs re: meth, overdose prevention, and now alcohol break down silos. (+)
- Grant reporting can be cumbersome (i.e., requirements, limitations, deadlines, and administrative procurement hurdles), disincentivizing community partners to participate (-)
- Data collection and intake requirements serve as a barrier to services for PWH with behavioral health concerns[11] (-)
- Inadequate safety training for outreach staff who may have to reach out to a consumer in crisis or in an extremely unsafe living situation. (-)
- The research and evaluation team regularly runs evaluation reports and conducts statistical analyses that inform quality improvement and policy development. (+)
- Expertise in matching program data to DOHMH surveillance data to ascertain HIV care and viral load outcomes among consumers (+)

- Experience and expertise of staff at DOHMH and funded organizations in behavioral health service delivery (+)

Outer Setting Characteristics

Patient needs and resources, external policies, and incentives

- Given structural inequalities, scholars increasingly underline how anti-racist praxis in mental health must consider macro-level policies (-)[12,13,14]
- Large portions of people with psychiatric disorders do not receive mental health services. In the United States as a whole, fewer than half (45 percent) of people with any mental illness and only two-thirds (66 percent) of people with a serious mental illness received mental health services in the past 12 months (SAMHSA, 2020b). (-)[15]
- Informants highlighted one exception: the model for New York state's certified community behavioral health clinics (CCBHCs)—a community of mental health centers with a broad scope of services and a prospective payment system where integrated care is provided and the costs of addressing patients' needs are covered. (+)



- In the U.S., the average life expectancy of people with a mental illness is approximately eight years less than people without one. Many people with mental illness or substance use disorders experience a substantial gap in the quality of routine medical care, especially when it comes to general medical and cardiovascular care. (-)[16]
- SMI is more than twice as common for adults who live below 200% of the federal poverty level (FPL) compared to those living 200% above it. (-)[17]
- In NYC, most of the young children with reported mental health disorders live in poverty. Of all NYC children between the ages of two and five whose parents report their child being diagnosed with at least one of five common mental health disorders, 90% live in poverty. (-)[18]
- In the United States, African Americans are less likely than whites to be diagnosed with common mental illnesses like depression and anxiety. But when they are diagnosed with a mental illness, African Americans are more likely than whites to experience a persistent and severe illness. This may in part be due to biases in diagnosis. For example, African Americans are more likely to be given a diagnosis of schizophrenia and other psychotic disorders, and that is true even when they have the same symptoms as white people. (-)[19]
- National studies suggest that African Americans can be half as likely as whites to receive community-based mental health care, but as much as twice as likely to be hospitalized. (-)[20]
- According to the Mental Health Data Dashboard, a project of the NYC Mayor's Office of Community Health, there is unequal access to mental healthcare in NYC and the highest poverty neighborhoods have over twice as many psychiatric hospitalizations per capita as the lowest poverty neighborhoods. (-)[21]

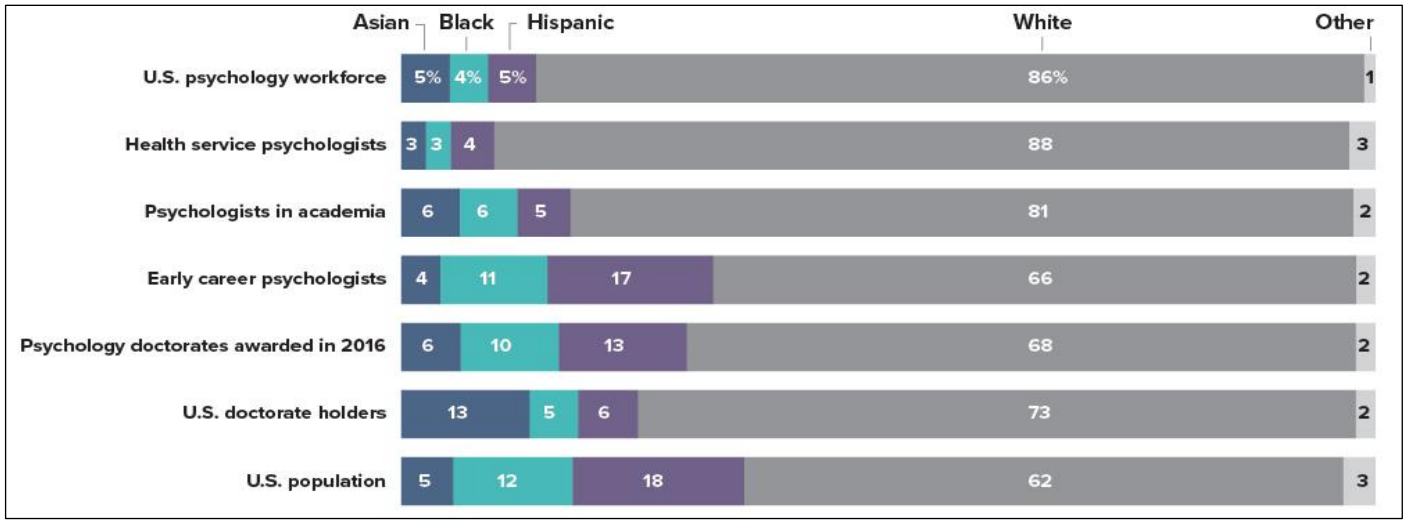


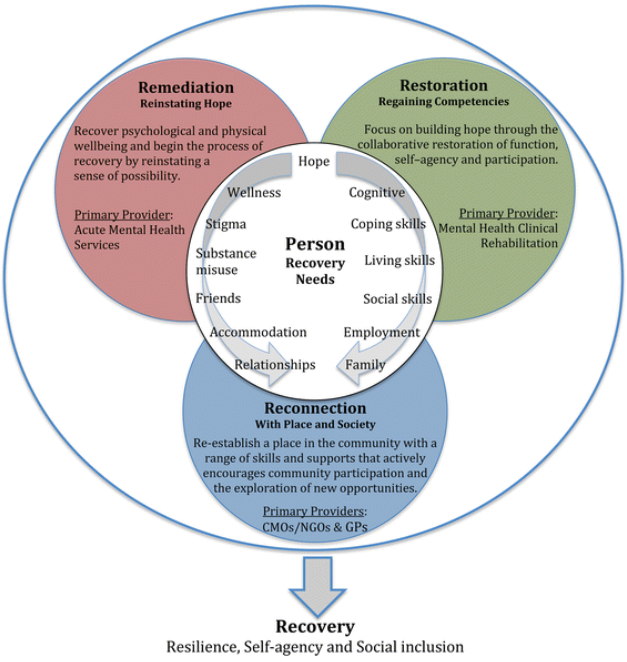
Figure 3 Diversity of the Psychology Workforce[22]

- RWPA funds must comply with payment of last resort requirements. Services that are payable by other MH funders such as Medicaid, OMH and OASAS cannot be funded. (-)
- A dearth of psychiatric care, compounded by staff vacancies and strain of the COVID-19 pandemic, severely limits access to needed care. (-)
- NYS and NYC are seeing a significant outmigration of behavioral health providers due to the COVID-19 pandemic, market forces, mixed investment in city, state and federally funded behavioral health services (i.e., salaries, programming, facilities) including support for recruiting, training a diverse workforce. (-)[23,24]
- Drug policy has shifted significantly with the opening of overdose prevention centers, the decriminalization/legalization of marijuana and more. (-)
- An analysis conducted by the Research and Evaluation Unit of the Care and Treatment Program found that 59% (n=4,335) of 7,317 NYC RWPA clients in GY2018 (who had both received a service and completed at least one MH assessment) had a report of a MH diagnosis, the most frequently reported types of MH diagnosis were: Depression: (49.6%; n=3,629), Anxiety disorder: (28.7%; n=2,097), Bipolar disorder: (17.5%; n=1,283) (-)
    - Among clients with a reported mental health diagnosis, those/PWH with bipolar disorder and psychosis were the least virally suppressed (69.1% and 67.4%, respectively). Viral load suppression for those with Depression was 75.9%, Anxiety, 75.8%, and PTSD 73.9%. (-)
- In NYC, people experiencing mental health crises are frequently incarcerated and/or mandated into psychiatric care.[25] During and upon release from incarceration and mandated treatment, there is a of lack adequate HIV care support and navigation. (-) [26,27,28]
- Inequitable access to care has been exacerbated by the COVID-19 pandemic. (-)
- Technology/telehealth-based care and support services have increased access for some while adding additional barriers for others, particularly older adults. (+/-)[29, 30, 31]

- Informal support for mental health, often found in social circles such as churches, recreation, self-care, are critical in helping a client find stability and balance.[32] (+)
- Staff turnover in MH has impacted care delivery due to vacancies and low morale. (-)
- Among behavioral health services providers exists historical underrepresentation of BIPOC persons. (see chart) (-)

Characteristics of Individuals Implementing the Intervention

Knowledge, beliefs about intervention, and self-efficacy of CTP/DOHMH & RWPA Organizations & Peer Workers



- Providers are largely committed to delivering high quality care (+)
- PWH may not be or feel adequately supported in their participation in Planning Council and other DOHMH or agency activities. (-)
- Stigma is pervasive among clients and often providers, as is a movement to dismantle stigma and racism in service delivery and staff management. (-)

Figure 4 An Integrated Recovery-oriented Model (IRM) for mental health services: evolution and challenges.

Process

Engaging, planning, executing, reflecting & evaluating

Engaging

- PWH participation is legislatively mandated in all Council planning processes. The NY EMA employs an outreach coordinator to support PWH recruitment and ensure a rich diversity of experiences that reflect the epidemic. PWH receive additional supports from the Council to help address barriers to full participation, including technological and financial incentives. (+)
- Council works with the recipient to ensure that Council processes are accessible to all members.
- Lack of monetary compensation for input from PWH; lack of institutional recognition for the value of community outreach (-)

Planning

- The Council relies heavily on subject matter experts throughout the NYC Health Department to compile and analyze data from Ryan White programs.
- The Council invites external subject matter experts, providers and clients to present and compiles additional research to inform planning.

Executing

- Council products should be fully vetted by all members.

Reflecting

- Council receives follow up reports on programming and initiatives.

Evaluating

- In partnership with the Recipient, Council reviews detailed data on all services and service categories, as well as surveillance data, to inform needed changes, improvements and adjustments of the service model as well as planning processes.

The Intervention

Each type of service is separated into core services and implementation strategies. Strategies are the actions programs will take to achieve identified implementation outcomes. Strategies are often multilevel and should align with the determinants that have been prioritized, utilizing facilitators and addressing barriers. Below are the core behavioral health services and accompanying implementation strategies that must be delivered across all behavioral health programs. Strategies are meant to improve adoption, implementation, sustainability, and scale up of effective services.[33]

Core Behavioral Health Services

All services and strategies are to be initiated within one year of contract award, except when noted. Agencies are encouraged to partner to provide the spectrum of required services.

Services include, but are not limited to the following:

Service Eligibility and Access

1. Services must be available to clients in all five boroughs of NYC and Tri-County
2. Provide low threshold services and service delivery, when feasible and as needed, to support client readiness for treatment: crisis counseling, open groups, and check-in sessions, peer support, on-call support, walk-in, late, overnight & weekend hours, drop-in, telehealth, etc. Services must be provided at a consistent location to support client familiarity and access.

   a. All programs will ensure clients have access to crisis services on site or by referral.
   b. Every clinic must have a plan for providing crisis services and after-hours coverage, which must be approved by the Local Governmental Unit (LGU).[34]
3. Provide at home/community-based services to reduce barriers to care.
4. Incentivize the retention of multilingual staff fluent in languages most common to program client population.
5. Provide interpretation services for all client interactions, including case management and navigation.
6. Translated client materials must be available as needed.
7. With respect to client preference for mode of service delivery, leverage technology (telehealth, phone apps, other technology) to reduce barriers to access to services within and external to the organization to support attainment of optimal quality of life for all PWH in their care.
   a. Assist clients in accessing and utilizing technology (i.e., assist with linkage to resources that enable access to devices and internet services, etc.)
8. Programs must have an Article 28 or 31 license to bill for mental health services. For Harm Reduction, the organization must have the capacity to bill Medicaid through an Article 28, 32 or SEP Medicaid billing capacity. Health Homes and care agencies contracted by Health Homes are eligible to apply for these services.
9. Clients will work with providers to determine a client-centered service plan. Outside of intake and re-assessments, clients may select the services they want delivered and opt out/in of services at any time, pending eligibility and availability.

Services

10. BH organizations must support the normalization and routinization of mental health and substance use screenings and assessments by offering a mental health and substance use screening to all clients (by referral or on-site). Consideration must be made for clients who have been over-screened: prioritize respect for clients' time and build portfolio efficiencies into data management systems. Clients should be informed about the additional services and benefits available to eligible clients, and especially to clients who refuse screenings.
    a. The screening and assessment process must:
        i. Employ anti-bias modalities and a trauma-informed approach.
        ii. Provide needed services/referrals and/or a full assessment of all clients with a positive screen.
        iii. Ensure client choice is fully informed and considered, regardless of agency's financial interests.
        iv. Identify and engage clients in the appropriate level of care. Level of appropriate care may also be determined through self-report, and/or confirmed by a psychiatric/mental health evaluation or chart review.
        v. Provide education to raise awareness about IPV and include offering a screening.
    b. All behavioral health screenings must appropriately assess and obtain a diagnosis for all clients who may have SMI using a two-stage process (where clients who qualify are recommended to be screened and provided an assessment on site or by referral)[35,36] to

support accurate identification of all clients who may benefit from more intensive behavioral health services, including support for serious mental illness.[37] The screening and assessment process should:

i. Offer mental health and substance use screenings to all clients in a non-stigmatizing, health promoting manner.
ii. Refer and/or conduct a full assessment of all clients who screen positive.
iii. Screen clients to identify coping strategies and support the development of health promoting coping strategies.
iv. Conduct ACEs assessments for each client: assessment score should relate to the level, variety, and intensity of interventions and care offered to each client.

c. Use a standard measurement tool (i.e., S-BIRT, PHQ, LOCADTR, AUDIT-C and DAST) for AOD, MH and wellness assessments, self-assessment whenever possible.[38]
d. For all individuals who qualify[39] for behavioral health services, the following should be made available, as appropriate and by referral, as needed:
    i. Conduct a mental health evaluation with a psychiatric assessment required for medication. Psychiatric evaluation and follow-up visits, psychiatric re-evaluation, psychotropic medication monitoring and management, and linkage with inpatient psychiatric care when indicated. Services offered should include, medication assisted treatment for clients with a clinically indicated history of or currently using alcohol and other drugs. Client choice must be respected.
        1. Upon availability of evidence-based interventions for crystal meth use, agencies will adopt and implement appropriate medication assisted treatment on site or by referral.
    ii. Provide or refer clients to individual, group, and family services, including pharmacologic interventions for clients with a history of or currently using alcohol and other drugs/substances. Provide individual, group, and family services within the awarded program, and by referral, for specialty services not provided on-site.

11. In partnership[40,41,42,43] with the client, develop and implement a comprehensive and collaborative client-led care plan with individually defined milestones and goals.
12. Offer and provide psychosocial support services to all clients, regardless of client's completion of mental health and/or substance use assessments.
13. Offer navigation and accompaniment to all needed services and referrals, regardless of the funder. Program will complement navigation and accompaniment provided by other funders in line with payer of last resort requirements and not duplicate services.
    a. Leverage peer workers to provide accompaniment and navigation.
14. Screen all clients and provide safety planning and referrals and/or support and services for clients with suicidal ideation.
15. Elicit client perceptions and feelings of safety while receiving services at the agency. Apply trauma-informed care approaches to address clients' perception of and concerns about safety. Safety is a core principle of trauma informed care.
16. Support client's building a network of (chosen) family, friends and peer support.
17. Link clients to safe housing and emergency food access and advocate for immediate placement.

18. Provide accompaniment whenever possible or by referral, if necessary.
19. For all RWPA clients discharged from any mental health inpatient services, including psychiatric hospitals and Assisted Outpatient Treatment (AOT) agencies, programs must provide appropriate navigation services to ensure client stability and care. RWPA eligible clients must be referred to appropriate services, such as intensive outpatient services.
20. Confirm linkage to HIV primary care, including engagement (or reengagement) to care.
21. Conduct multidisciplinary case conferencing, as needed or as requested, to communicate and strategize around primary care status measures, appointment adherence, HIV medication adherence, substance use, psychotropic medication adherence, and other health/mental and behavioral health concerns.
22. Support client readiness, linkage and engagement among HASA clients experiencing behavioral health issues with navigation and accompaniment to RW- and Medicaid-funded programs for people with mental health and/or substance use disorders, as needed. RW services must wrap around HASA and other service providers to provide optimal support to clients.
23. Clients in need of supportive housing will receive advocacy, accompaniment and navigation support from RWPA BH programs.
24. Provide, as appropriate, and by referral, if necessary, in-person or virtual modified Directly Observed Therapy (mDOT) for HIV, HCV, psychiatric medications and other chronic or acute conditions. Coordinate to prevent duplication of services and provide mDOT as often as needed and in line with client preference.
25. Provide home-based services, including clinical services, as available and appropriate to client need.
26. Provide a referral for or offer onsite tobacco cessation or harm reduction services as in line with client's treatment goals.
27. Provide, when possible, materials that support clients' ability to test their substances for purity (e.g., fentanyl test strips). Navigate clients to sites that provide these services.
28. Provide, when possible, bleach kits. Navigate clients to sites that provide these services.
29. Educate and inform clients about the following, as appropriate: adherence counseling, primary care status measures, primary care provider appointment adherence, HIV medication adherence, and psychotropic medication adherence.
30. Conduct outreach for client re-engagement to monitor scheduled appointments and follow-up on a client's missed appointments.
31. PWH receiving BH services may receive accompaniment services to primary care appointments and other medical and support service appointments, as needed and by client preference.
32. In partnership with CTP, develop and distribute a tool kit of resources for psycho-social rehabilitation[44] and assistance to build and support interpersonal relationships that allow PWH with SMI to support interpersonal relationships and improve health outcomes.
33. Assign or refer all clients with complex needs to high intensity case management services that have lower client to provider case loads[45]
    a. Facilitate city and state agreements that link eligible clients to higher level BH services, including ACT teams.

Service Delivery

34. Deliver all services with a harm reduction and trauma-informed care approach to prioritize a client's actual safety and feelings of safety (with provider and agency).
35. Provide services, within HRSA guidance, as appropriate and as needed, to HIV-negative persons chosen as the client's family.
36. Deliver/refer all clients with complex health needs or who are facing complex barriers to high intensity case management with lower client caseloads to sustain and support high quality care & relationship development.
37. Identify, invite and support professional development and promotional opportunities for all staff at all staffing levels.

Training & Staff Support

38. Require staff training on cultural humility, crisis intervention and de-escalation. Develop organization-specific client crisis plans that do not rely on law enforcement.
39. Engage in continuous training on trauma informed supervision for all program staff.
40. Collect and provide feedback from staff to the recipient to improve programming implementation and service delivery.
41. Train all providers to educate clients on and raise awareness about IPV. Train providers on how to determine when a screening is recommended.

Core Implementation Strategies for All Service Categories

Pre-planning implementation strategies

42. When applying for RWPA funding, organizations must submit short written responses that outline:
    a. The impact of racism and other forms of discrimination on behavioral health
    b. Agency specific policies and procedures that address racism, stigma and other forms of discrimination.
    c. Past and ongoing staff trainings on stigma (e.g., implicit bias, racism, sexism, homophobia, and other forms of discrimination).
    d. Past and ongoing projects to support staff healing vicarious and residual trauma and that apply a trauma informed care lens to staff supervision and/ or the provision of services to clients.
    e. Established linkages to other social and support agencies if the agency does not directly provide the following services: rapid HIV testing, medical care, food and nutrition, legal services, medical case management, vocational services/job readiness, housing, behavioral health (outpatient and inpatient mental health and substance use services) and oral health services.
    f. Experience delivering services to individuals and families through a trauma-informed approach. Include situations where clients also may have had substance and/or mental health disorders.

Mechanism: Supports preparation to conduct work with an anti-racist lens.

Policy implementation strategies

43. Help clients, as appropriate, understand their own trauma, concepts of self-care, as well as personal drivers of stress and shame.

Mechanism: Supports wellness and mitigates to staff burnout.

44. CTP will integrate and coordinate care for behavioral health, substance use and HIV care through the development of priority access to all services.
    a. Client access can be accomplished through MOUs and linkage agreements that facilitate referral, follow up and other appointments on par or better than the wider system's wait times.

Mechanism: Incentivizes streamlined access to behavioral health care.

45. CTP will provide agency level behavioral health program care report card dashboards that highlight clients' care status through medication prescriptions, ART access/adherence, and viral load measures.
46. Support the adoption of specific evidence-based interventions (EBI)/best practices (BP) in service delivery for all funded services. These can be proposed by the applying agencies and should be accompanied by data supporting the EBI/BP.

Mechanism: Providers will increase knowledge and access to targeted interventions that support clients across the HIV continuum.

47. Ensure clients are aware of their treatment options both at and external to the agency.
    b. Ensure clients understand that mental health, counseling, and harm reduction work is not linear.
    c. Advise and refer clients to available evidence-based alternative therapies, including therapies not provided by the agency.

Mechanism: Decreases burden on providers through leveraging of external supports for clients.

48. Adjustments of the service model and changes in how services are delivered may occur throughout the program term per CTP guidance and as related to new evidence, program performance and client feedback.

Mechanism: Increases sub/recipient flexibility to adopt effective interventions.

49. Assess for, support linkage to, and track all referrals: offer warm hand-offs (navigation or accompaniment) to client needs such as, but not limited to, referrals to mental health, medical case management, housing, alcohol and substance use, medical care, independent living skills, food and nutrition, and legal services.
50. Programs must collect and report on barriers to ART access/adherence.

Mechanism: Increase key data for comprehensively evaluating client supports.

51. Agencies must streamline access to needed services by strengthening and formalizing partnerships that enhance access to external support services, i.e., HASA, HARP, AOT, ACT teams, psychiatric inpatient providers and providers of other appropriate interventions, and any other support.

Mechanism: Increases agency awareness and linkage to external supports for clients.

52. Programs must either have an MOU with or be a Tier I or Tier II syringe exchange program (SEP). SEP sites must have or ensure the capacity to bill Medicaid or Health Homes post award. For sites interested in acquiring SEP accreditation, CTP will support applications in collaboration with the NYS AI. RWPA funds can be used to fund wrap around services but cannot be used to purchase syringes.
    a. Facilitate the provision of syringes to clients upon request, by SEP or referral. [46]

Mechanism: Decreases stigma by normalizing syringe access.

53. CTP will incentivize the inclusion of community health workers (CHWs), ideally PWH with lived mental health, substance use, and HIV experience, to deliver services to people with Behavioral Health needs. While NYS peer certification is not mandated, appropriate training, as determined by the recipient, is required. Certification is preferred for full time employment of PWH.
    a. CTP will incentivize agency provision of training access and support for CHWs.

Mechanism: Increases support for PWH to deliver services.

54. Provide evidence-based interventions and support for staff to manage vicarious stress.
55. Continuing education is required for all staff, including CHWs and peers, to support continuous improvement in service delivery.

Mechanism: Increases program capacity to adopt and implement service delivery modalities such as trauma informed care.

Training implementation strategies

56. DOHMH and organizational program staff must continuously engage in all federal, state and city required trainings, e.g., Gender Expression & Identity, and must continuously engage in training on harm reduction, person centered care, implicit bias, anti-stigma, e.g., anti-racism, xenophobia, homophobia and other trainings that improve equitable service delivery through a trauma informed care lens.
57. Programs should engage in trainings, webinars and activities that deepen understanding of the relationship between racism and stigma to behavioral health.
58. Providers will engage in organizational audits of provider/agency stigma around crystal meth use and sex seeking behaviors.
    a. Providers will be trained on dismantling provider/agency stigma around crystal meth use and sex seeking behaviors.

Mechanism: Increases provider capacity and knowledge to deliver culturally humble services.

Quality Service Implementation Strategies

59. Agencies will assist in the development of client safety plans.
60. Agencies will support clients in building networks of support, particularly through peer workers.
61. Agencies will use evidence-based interventions involvement movement exercises, i.e., mindfulness-based stress reduction, meditation, yoga, or group support for physical fitness e.g., walking groups,

etc., to connect with clients and support the delivery of services, as requested and necessitated by client. (can this be offered by referral?)

62. Agencies will facilitate client awareness of the connection between mind and body, including offering referral to exercise that is appropriate and engaging to the client population.
    a. Agencies will coordinate physical therapy referrals as needed and when possible.
63. Providers will adhere to Seeking Safety guidance when providing trauma therapy. Providers will also:
    a. provide warm handoffs to specialized therapy, as needed.
    b. work with the client to establish evidence based best practices around trauma as well as a process that supports client's sense of safety.
    c. center client experience.
    d. never mandate or force the recollection of traumatic experiences.
    e. provide extensive support for the continuation of therapy and remove barriers to accessing care.
64. Identify and employ tactics to deescalate client distress.
65. Work with client to strengthen assessment identified health promoting coping strategies
66. To the extent possible, support and facilitate, as allowable by HRSA, calm and comfortable client spaces (waiting rooms, treatment rooms, therapeutic spaces, wellness rooms, safe accommodations, etc.) that mirror comfort and safety (soft lights, gentle music, comfortable seating area, removal of barriers not necessitated by COVID-19)
67. Programs will review CTP-developed reports on trends in the demographics of PWH seeking behavioral health assistance, as well as on common barriers to securing and adhering to behavioral health services among the client population to inform the development of interventions.
68. CTP will ensure all providers are aware of and know how to utilize available interpreter services, as well as resources available for translation services.
69. In line with the NY EMA RWPA Framing Directive, programs will track completion of all client referrals to needed health and supportive services (per agency capacity and per recipient guidance), including, but not limited to: financial entitlements (coordinated with HASA when appropriate), HIV primary health care, mental health care by licensed professionals, substance use and harm reduction treatment services, medical case management and food and nutrition services.
70. Empower and educate clients to understand their condition within the sociopolitical context it occurs, including the multi-level stigma people with behavioral conditions experience.[47]
    - *Alcohol and drug misuse and related substance use disorders (SUDs) affect millions of individuals in the United States and throughout the world, with significant health consequences and economic costs to societies, communities, families, and individuals (Grant et al., 2015; U.S. Department of Health and Human Services [USDHHS], 2016).*
    - *Although evident across all sectors of society, the prevalence and negative consequences of alcohol and drug use are generally greater among groups characterized by disenfranchised social status (e.g., poverty, stigmatized identity; Cerdá et al., 2010; Chartier and Caetano, 2010; Glass et al., 2020; Grant et al., 2015; Green and Feinstein, 2012; Reilly et al., 2019; USDHHS, 2016).*

- *A robust literature has documented the powerful effects of social environment and context on substance use initiation and disorders, their negative consequences, and treatment access and outcomes (Institute of Medicine [IOM], 2006; National Academies of Sciences, Engineering, and Medicine [NASEM], 2017, 2019a, 2019b; Prom-Wormley et al., 2017)*

Mechanism: Increases agency capacity to center clients in all aspects of care.

Peer Supported Mental Health Services for PWH with Complex Behavioral Health Needs or SMI

Services include, but are not limited to the following:

71. Establishment of at least one psychosocial support clubhouse for people with SMI and HIV.[48,49]
72. At least two agencies will be contracted to deliver services to PWH with especially complex needs, including serious mental illness, substance use and mental health co-morbidity, disabilities, etc., in addition to the other services (directly, by subcontract, or by referral) described in this directive. Peers should be utilized to deliver all services, as appropriate.
    a. In partnership with a case finding entity with access to a RHIO and other health data systems/programs, such as ACE, the DOHMH's partner services, selected agencies will manage a cadre of peers to provide navigation and accompaniment to stabilize clients including housing, care appointments, etc.
    b. The entity will:
        i. Provide technical support.
        ii. Identify clients who would benefit from peer navigation based on HIV outcomes.

Care and Treatment Program Services

73. Provide quality management services.
74. Provide access to training on trauma informed care and supervision, staff empowerment, client management and addressing vicarious trauma.
75. Model and structure peer work to replicate and support trauma informed care in all interactions.
76. In partnership with agencies support peer staff and manage staff development
77. Translate the practices of BHHS' ACE program (Assess. Connect. Empower) into
    c. Guidance for agencies working with peers
    a. To develop systems of staff feedback
    b. To guide the embedding of feedback into program improvement
    c. To develop systems of staff support

Agency/Program Provided Services

78. Program must be led and managed by a person with HIV who has experience providing peer services.
    a. CTP must have hire persons experienced in peer service delivery to provide support for these programs.
79. Agency must provide space and administrative (recruitment, hiring) support for peers.

80. Coordinate case conferences with peer support
81. Support development of client-led service plans with available peer assistance supports clearly outlined.
82. Leverage the peer network program to support management of clients with complex care needs, especially those who are out of care or in crisis.
83. Identify additional resources and facilitate support for PWH with SMI.
84. CTP will coordinate resources with the Bureau of Mental Health & Division of Mental Hygiene to address clients in crisis in real time to ensure continuity of care, e.g., access to HIV meds during psych stays.
85. Agencies will seek to acquire RHIO consent for all RWPA clients and execute data sharing agreements with subcontractor(s) to support patient outreach and engagement activities. CTP will facilitate RHIO access to RWPA data.
86. Agencies will analyze information from RHIO or similar databases to
    d. identify and properly support clients who are:
        i. in crisis
        ii. have been discharged from an in-patient (medical or behavioral health) hospital stay
        iii. lost to care
    e. offer peer navigation and accompaniment to client for all related appointments to help stabilize the client.
87. Barring capacity, agencies will accept referrals and provide support for clients from programs throughout RWPA.
88. CTP will develop a resource list of psychosocial rehab programs and identify sources of funding that can facilitate agency referrals for clients who would benefit from such programs. CTP will work with agencies to find resources that support clients' living independently. Agencies will support the development and maintenance of interpersonal relationships that allow people with SMI to live their best lives.
89. In partnership with CTP, agencies will help compile HIV care sites most utilized by PWH with SMI to strengthen crisis management, linkage to psychiatric care and rehabilitative therapy, as well as coordination and additional support.
90. In partnership with CTP, identify and distribute, as needed, resources for psychiatric care and support services available outside of organizational hours: Regional Crisis Call Centers, Crisis Mobile Team Response and Crisis Receiving and Stabilization Facilities.
91. Clients identified as having complex behavioral health needs will be offered the following as needed and within the confines of payment of last resort:
    a. Coordinated cross-organizational case conferencing for relevant service categories.
    b. Care navigation for all core and medical and support services
    c. Case conferencing & continuity of HIV care during interruptions to care
    d. Case conferencing & continuity of care in other care sites

SMI Mental Health Services Implementation Strategies

92. Assist all types of licensed facilities, including Article 28, 31 and 32 providers across all services in navigating newly diagnosed/out-of-care PWH with SMI

93. Utilize, as possible, psychiatric nurse practitioners to support medication management, and liaise and coordinate with HIV primary care.

Mechanism: Integrates alternative models of care that increase capacity to address gaps in the behavioral health system.

Psychosocial Support Service Category

Additional services to be delivered by agencies funded to provide Psychosocial Support Services include, but are not limited to the following:

94. All programs will provide supportive counseling services to ensure a spectrum of intensity in BH services offered. Counseling should support client's achieving an optimal quality of life.
95. Organizations will provide a combination of the following services to ensure client support, promote high quality of life and health outcomes, and to combat isolation. As such, counseling is to include, but not be limited to:
    a. Link clients to culturally humble socialization support services
    b. Provide stabilization services post crisis
    c. Provide family counseling
    d. Provide support groups and linkage to higher intensity group counseling (optional)
    e. Provide crisis intervention
    f. Incentivize activities completed by a peer
    g. Utilize peer and non- peer led psychoeducational groups, exercise, social support and related interventions (relationship-building activities, training, and skills-building activities, counseling toward self-management, treatment readiness and adherence support)
    h. Incorporate evidence-based interventions in peer and paraprofessional service delivery
    i. Provide drop-in activities
    j. Provide the positive life workshop
    k. Provide grief and bereavement counseling (optional)
    l. Provide pastoral care (optional)
    m. Provide support for all peer workers:
        i. Dedicated workspace
        ii. Respect for travel time
        iii. Opportunities for advancement: promotions, trainings, external referrals

Mental Health Service Category

Additional services to be delivered by agencies funded to provide Mental Health Services include but are not limited to the following:

96. Conduct wellness, individual or support groups to educate and monitor clients on key issues related to the client's current mental health needs and potential barriers to mental health treatment.
97. Organizations should conduct case finding to identify clients in need of services:
    a. Targeted Case Finding should occur through outreach in locations where AOD users and others with behavioral health concerns often frequent, including but not limited to

i. overdose prevention centers
ii. places where people use drugs
iii. food pantries
iv. methadone maintenance treatment programs (MMTP)
v. needle and syringe exchange programs
vi. Rikers Island Transitional Health Care Coordination Program (or similar)
vii. hospital emergency departments
viii. HIV/AIDS Services Administration (HASA) sites
ix. congregate housing facilities
x. Optionally, outreach and clinical providers in co-located and affiliated medical and mental health settings may choose to use a standardized brief intervention for referral and treatment (SBIRT).

98. Provide individual, couple, family, and group psychotherapy/counseling and medication management, as appropriate.
99. Incorporate evidence-based interventions into care delivery.
100. Ensure portfolio wide availability of home-based services for clinical purposes including services listed above, as appropriate and necessary.
101. Provide behavioral health case management, as needed:
    b. Engage clients in appropriate level of care. Including psychotherapy, to support an optimal quality of life.
102. Organizations should conduct case finding to identify clients in need of services.

Mental Health Services Implementation Strategies

103. Implement a modified collaborative care model[50] that leverages peers to ensure client's service plan is administered and any needed additional supports are secured.
104. Provide robust linkage for willing and appropriate clients to mental health clubhouses.[51]
105. Identify and distribute, as needed, resources for psychiatric care, and support services available outside of organizational hours: Regional Crisis Call Centers, Crisis Mobile Team Response and Crisis Receiving and Stabilization Facilities.

Mechanism: Increases alternate care models, knowledge and networks that support agency and peer efficacy in retaining clients in care.

Harm Reduction (Substance Use/Recovery) Service Category

Additional services to be delivered by agencies funded to provide Harm Reduction Services include, but are not limited to the following:

106. Identify and deliver individual, couple, family, and group harm reduction services to people, dealing with substance use, without stigma, and support their engagement and goals.
107. Targeted Case Finding should occur through outreach in locations where AOD users often frequent, including but not limited to
    a. overdose prevention centers
    b. places where people use drugs
    c. food pantries
    d. methadone maintenance treatment programs (MMTP)
    e. needle and syringe exchange programs

f. Rikers Island Transitional Health Care Coordination Program (or similar)
g. hospital emergency departments
h. HIV/AIDS Services Administration (HASA) sites
i. congregate housing facilities
j. Optionally, outreach and clinical providers in co-located and affiliated medical and mental health settings may choose to use a standardized brief intervention for referral and treatment (S-BIRT).

108. Programs must consistently offer health promotion services and work to destigmatize service utilization (through delivery of EBIs) to all clients:
    a. Programs will identify one or more evidence-based intervention or practice (EBI or EBP), including interventions that support healthy sexuality and harm reduction, to implement. Curricula will be provided by the NYC Department of Health and Mental Hygiene. Alternatively, EBI training may be provided by an approved training program.
    b. Possible EBIs include Motivational Interviewing, Stages of Change, Contingency Management, Seeking Safety, Therapeutic Education System, Positive Life Workshop, Healthy Living, Healthy Conversations, Dialectical Behavioral Therapy, and Matrix
109. Organizations must ensure access to the following harm reduction treatments and services through either direct service delivery, referral, or formal linkage agreements:
    a. Medication assisted interventions: including, but not limited to, Methadone, Buprenorphine, Naltrexone, and Acamprosate
    b. Auricular acupuncture, as available, specifically for substance use control and to reduce cravings.
    c. Overdose prevention centers, optional and as applicable.

Harm Reduction Implementation strategies:

Policy implementation strategies

110. Coordinate with and between governmental and intergovernmental actors to compile and share best practices/lessons learned, and to develop and/or strengthen already existing policy that facilitates access to behavioral health for PWH.

Mechanism: Increases agencies access to knowledge and networks that can facilitate continuous program improvement and increase adoption of effective interventions.

Mechanisms

A mechanism is the process through which strategies work to achieve outcomes. They reflect something that will change, often related to determinants, before your outcomes can be achieved e.g., increases in provider knowledge and willingness to utilize interventions, improved shared decision-making processes between PWH and providers, reduction in staff burnout and turnover. Mechanisms are also found in bold under implementation strategies.

1. Supports preparation to conduct work with an anti-racist lens.
2. Supports wellness and mitigates to staff burnout.
3. Incentivizes streamlined access to behavioral health care.
4. Providers will increase knowledge and access to targeted interventions that support clients across the HIV continuum.
5. Decreases burden on providers through leveraging of external supports for clients.

6. Increases sub/recipient flexibility to adopt effective interventions.
7. Increase key data for comprehensively evaluating client supports.
8. Increases agency awareness and linkage to external supports for clients.
9. Decreases stigma by normalizing syringe access.
10. Increases support for PWH to deliver services.
11. Increases program capacity to adopt and implement service delivery modalities such as trauma informed care.
12. Increases provider capacity and knowledge to deliver culturally humble services.
13. Increases agency capacity to center clients in all aspects of care.
14. Integrates alternative models of care that increase capacity to address gaps in the behavioral health system.
15. Increases alternate care models, knowledge and networks that support agency and peer efficacy in retaining clients in care.
16. Increases agencies access to knowledge and networks that can facilitate continuous program improvement and increase adoption of effective interventions

Outcomes

Implementation outcomes are the changes we expect to see in adoption, implementation, cost, feasibility, reach, and sustainment of effective HIV interventions delivered throughout the RWPA portfolio of behavioral health services; they are the direct result of the implementation strategies that will then lead to longer-term improved service delivery and client health outcomes.

Service Outcomes

1. % of agencies where staff are extensively trained in anti-racism, anti-stigma and anti-bias service delivery.
2. % of agencies with formal working agreements with external providers that provide additional supports, interventions or services to meet clients' behavioral health needs.
3. % of agencies that become Tier II syringe providers (if not already a SEP).
4. % of agencies providing trauma informed supervision to support trauma informed care in service delivery.

General Behavioral Health Outcomes

1. % of agencies where staff are extensively trained in anti-racism, anti-stigma and anti-bias service delivery.
2. % of agencies able to offer or facilitate same day visits for 70% of clients in need.
3. % of agencies with formal working agreements with external providers that provide additional supports, interventions or services to meet clients' behavioral health needs.
    a. % of agencies that successfully complete referrals for 70% of referred clients.
4. % of agencies that clients rate as 'very good' or 'excellent' in delivering culturally humble care.
    a. % of agencies that become Tier II syringe providers (if not already a SEP)
5. % of agencies providing trauma informed supervision to support trauma informed care in service delivery.

Client Outcomes

- Improvement in behavioral health measures
- Increase in treatment adherence (medical and behavioral health)

- Increase in continuity of care and resulting HIV outcomes among PWH accessing behavioral health services.
- Increase in PWH aware of their status, retained in care, and virally suppressed.
- Increase in PWH reported quality of life[52,53]
- Increase in PWH reported satisfaction with RWPA BH services.
- Decrease in anticipated, internalized, and enacted stigma reported by clients.
- Increase in client knowledge of rights to and options to access behavioral health.

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[1] The NY HIV Health and Human Services Planning Council substitutes the terms 'substance use' and 'harm reduction' to represent the HRSA service category Substance Abuse to de-stigmatize such activities.
[2] Remien RH, Stirratt MJ, Nguyen N, Robbins RN, Pala AN, Mellins CA. Mental health and HIV/AIDS: the need for an integrated response. AIDS. 2019 Jul 15;33(9):1411-1420. doi: 10.1097/QAD.0000000000002227. PMID: 30950883; PMCID: PMC6635049.
[3] For ability to allocate funding to training and capacity building see the following https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/hab-pl-1104.pdf
[4] https://www.samhsa.gov/find-help/harm-reduction#Harm%20Reduction's%20Place%20in%20and%20Among%20Prevention,%20Treatment,%20and%20Recovery

[5] **MENTAL HEALTH SERVICES DESCRIPTION**: *Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.*

MENTAL HEALTH SERVICES PROGRAM GUIDANCE: *Mental Health Services are allowable only for PLWH who are eligible to receive HRSA RWHAP services.*

SUBSTANCE USE SERVICES DESCRIPTION: *Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:*

- *Screening*
- *Assessment*
- *Diagnosis, and/or*
- *Treatment of substance use disorder, including:*
  - *Pretreatment/recovery readiness programs*
  - *Harm reduction*
  - *Behavioral health counseling associated with substance use disorder.*
  - *Outpatient drug-free treatment and counseling*
  - *Medication assisted therapy.*
  - *Neuro-psychiatric pharmaceuticals*
  - *Relapse prevention*

SUBSTANCE USE SERVICES PROGRAM GUIDANCE: *Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA RWHAP, it is included in a documented plan.*
Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific.

PSYCHOSOCIAL SERVICES DESCRIPTION: *Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:*

- *Bereavement counseling*
- *Caregiver/respite support (HRSA RWHAP Part D)*
- *Child abuse and neglect counseling*
- *HIV support groups*
- *Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)*
- *Pastoral care/counseling services*

PSYCHOSOCIAL SERVICES PROGRAM GUIDANCE: *Funds under this service category may not be used to provide nutritional supplements (See Food Bank/Home Delivered Meals). HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation. HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.*

[6] https://www.samhsa.gov/blog/important-role-behavioral-health-addressing-treating-hiv-aids
[7] https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4999.pdf
[8] Remien RH, Stirratt MJ, Nguyen N, Robbins RN, Pala AN, Mellins CA. Mental health and HIV/AIDS: the need for an integrated response. AIDS. 2019 Jul 15;33(9):1411-1420. doi: 10.1097/QAD.0000000000002227. PMID: 30950883; PMCID: PMC6635049.
[9] *New York City Council Releases New Report on City Employee Pay Equity, Legislation to Address Disparities*. (2022, September 22). Press. https://council.nyc.gov/press/2022/09/22/2264/
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[11] https://nyhiv.org/wp-content/uploads/2023/04/NY-EMA-Ryan-White-Part-A-Data-Collection-Workgroup-Recommendations-_Council-Approved-3.30.23.pdf
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[16] UNDERSTANDING NEW YORK CITY'S MENTAL HEALTH CHALLENGE
https://www1.nyc.gov/assets/home/downloads/pdf/press-releases/2015/thriveNYC_white_paper.pdf
[17] Ibid
[18] Ibid
[19] Ibid
[20] Ibid
[21] https://thrivenyc.cityofnewyork.us/dashboard/
[22] Lin, L., Stamm, K., & Christidis, P. (2018, February 1). How diverse is the psychology workforce? Monitor on Psychology, 49(2). https://www.apa.org/monitor/2018/02/datapoint
[23] Remien RH, Stirratt MJ, Nguyen N, Robbins RN, Pala AN, Mellins CA. Mental health and HIV/AIDS: the need for an integrated response. AIDS. 2019 Jul 15;33(9):1411-1420. doi: 10.1097/QAD.0000000000002227. PMID: 30950883; PMCID: PMC6635049.
[24] https://www.wbfo.org/health-wellness/2021-11-10/nys-mental-health-workforce-on-life-support-asks-state-to-release-funds

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[38] https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4999.pdf
[39] https://nyhiv.org/wp-content/uploads/2021/03/2021-3-29-NYC-2020-EHE-Plan-FINAL.pdf
[40] https://www.samhsa.gov/section-223/care-coordination/person-family-centered
[41] https://www.storiicare.com/blog/create-person-centred-care-plan
[42] https://www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf
[43] Front. Psychiatry, 02 August 2021 | https://doi.org/10.3389/fpsyt.2021.681597
[44] Psychosocial Rehabilitation (PSR) Assists individuals in improving their functional abilities to the greatest degree possible in settings where they live, work, learn, and socialize.
Rehabilitation counseling, skill building, and psychoeducational interventions.
https://omh.ny.gov/omhweb/bho/core/
[45] https://www.nyconnects.ny.gov/services/intensive-case-management-omh-pr-504407171070
[46] RWPA providers must document that federal funds are not used to purchase sterile needles or syringes (according to Natl. Monitoring Standards). May want to clarify that facilitating access to syringes/safer use equipment would be via the SEP and/or through referral/linkage.
[47] https://cstms.berkeley.edu/current-events/drugs-politics-and-pariahs-or-how-to-think-historically-about-race-and-harm-reduction-in-an-opioid-epidemic/
[48] https://www.fountainhouse.org/about/clubhouse-model

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