



**Office of
Mental Health**

OMH Update

Alliance for Rights and Recovery

APRIL 20, 2026

Presenters

Robert Moon - Deputy Commissioner, Community Program Policy and Management

Nicole Haggerty - Deputy Director, Division of Adult Services

Janine Perazzo - Assistant Commissioner, Office of Hospital Care and Community Transitions

Sarah Kuriakose - Director, Division of Crisis Services

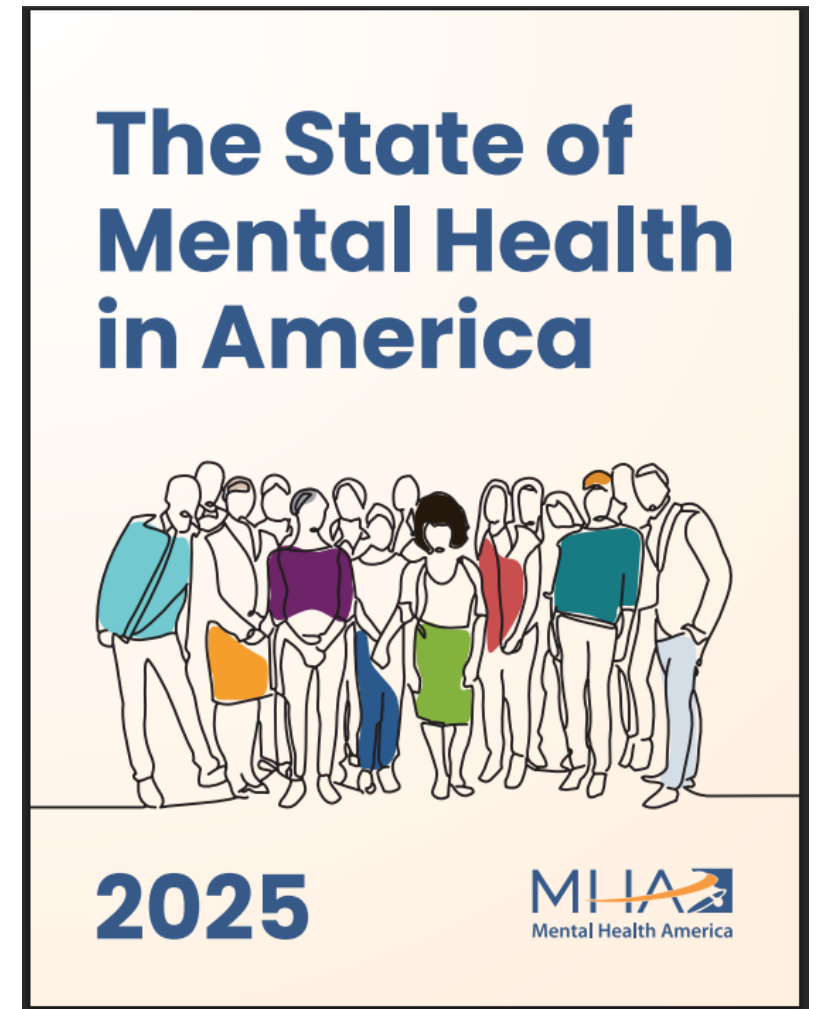
Liz Breier - Chief Advocacy Officer, Office of Advocacy and Peer Support Services

New York State Ranked #1!

In Mental Health America's 2025 report on The State of Mental Health in America*, New York State was ranked # 1 overall on 17 indicators that measure prevalence of mental illness and access to care.

Some of the specific measures that had the largest effect on New York's Overall Ranking were:

- Youth with serious thoughts of suicide (11.30%, ranked 1)
- Youth with a Major Depressive Episode (MDE) in the past year (16.88%, ranked 5), and
- Adults with Any Mental Illness (AMI) who are uninsured (4.20%, ranked 6)



To promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbances

Mission of the NYS Office of Mental Health

Transforming New York's Mental Health System





**Office of
Mental Health**

Approach to Transformation



Leadership Perspective: General Priorities

Developing a continuum of care from prevention to intensive services that help New Yorkers to thrive!

Prevention is a priority- Ensure that New Yorkers are mentally healthy

Ensure access to care and treatment when and where individuals need it

Ensure a comprehensive crisis stabilization system with a full range of services

Ensure a full continuum of intensive services for children, families and adults with complex needs that offers specialized, wrap-around care when and where they need it

Ensure individuals living with mental illness have the resources to live full lives and thrive in their communities

Leadership Perspective: Guiding Principles

The Future: A Culture of Comprehensive Integrated Care

Integrated

Whole person care needs to be **integrated** and include treatment, recovery, and support services for mental health, addiction, intellectual and developmental disabilities, and physical health and wellness.

DEIB

Planning must be guided by **Diversity, Equity, Inclusion, and Belonging** principles.

Lived Experience

Lived experience and **peer support work** are a major emphasis in program and initiative design.

Individualized

Care that is **individualized** to the person means it is designed and implemented with **special populations** in mind as needed.

Community Engagement

Community engagement informs program and initiative design, delivery & implementation.

Historic Mental Health Investments in 2023-2024 Budget

Prevention Services

- ✓ Increase School-based Clinics
- ✓ Including increasing Medicaid rate & Commercial Insurance coverage at the increased rate
- ✓ Expansion of Healthy Steps
- ✓ New Resources to expand Suicide Prevention programs for high-risk youth
- ✓ Expansion of Individual Placements and Supports (IPS)

Community Access

- ✓ 26 New Certified Community Behavioral Health Centers (CCBHC) (tripling the capacity)
- ✓ Expansion of Article 31 Mental Health Clinics
- ✓ Expansion of Home-based Crisis Intervention for youth
- ✓ Funding for 12 New Comprehensive Psychiatric Emergency Programs (CPEPs)
- ✓ Expansion of Assertive Community Treatment (ACT) teams
- ✓ Expansion of Intensive and Sustained Engagement Team (INSET) program
- ✓ Funding for Eating Disorders

Highest Need Individuals

- ✓ 150 State inpatient beds
- ✓ New Inpatient and ER Discharge Protocols and Responsibilities
- ✓ 3,500 new Housing Units
- ✓ 8 Additional SOS teams
- ✓ 50 new Critical Time Intervention (CTI) teams including Medicaid and insurance coverage
- ✓ Expansion of High-Fidelity Wrap Around Services for children and families
- ✓ Increase Health Home Plus capacity for high need individuals
- ✓ Commercial and Medicaid payment for all crisis services and intensive wrap around services

Historic Mental Health Investments in 2024-2025 Budget

Provide Critical Care for Youth

- ✓ Establish a School-based Mental Health Clinic in Any School that wants one
- ✓ Expand Peer-to-Peer Support Programs
- ✓ Establish New Youth ACT Teams Statewide
- ✓ Expand Access to the Partial Hospitalization and Children's Day Treatment Programs
- ✓ Fund Programming for High-need Transition-age Youth
- ✓ Expand Loan Repayment Program for Children's MH Practitioners
- ✓ Convene Youth Mental Health Advisory Boards

Increasing Forensic/Crisis Services

- ✓ Expand Implementation of Fully Integrated Crisis System
- ✓ Open 200 New Psychiatric Inpatient Beds, some specialized in dual diagnosis
- ✓ Improve MH Admission and Discharge decisions by Hospitals
- ✓ Create New Mental Health Courts and Expand Existing Courts
- ✓ Fund Court-Based Mental Health/Integrated Care Navigators
- ✓ Increase Transitional Housing for Individuals referred Through Court System
- ✓ Fund New Community-based Forensic ACT teams
- ✓ Fund Specialized Housing for People with Serious Mental Illness and Criminal History
- ✓ Provide Crisis Intervention Team Training for Law Enforcement

Expand Insurance Coverage and Hold Insurers Accountable

- ✓ Strengthen Mental Health and Substance Use Parity Enforcement
- ✓ Require Increased Commercial Insurance Reimbursement Rates for Mental Health and Substance Use Services
- ✓ Increase Access to Care through Behavioral Health Network Adequacy regulations
- ✓ Issue Guidance on Free Mental Health and Substance Use Screenings
- ✓ Increase Medicaid Reimbursement for Mental Health and Substance Use Services in DOH Facilities and Private Practices

Mental Health Investments in 2025-2026 Budget

Recovery and Community Wellness Initiatives

- \$8 M to Implement Behavioral Health Led Crisis Response pilots and Technical Assistance Center
- \$8 M to expand Clubhouses and Youth Safe Spaces
- \$1.5 M to expand Teen Mental Health First Aid
- \$1.6 M to introduce a pilot Aging in Place Program for OMH licensed residential units
- \$1.5 M to improve Maternal Mental Health by integrating behavioral health in OB-GYN offices

Enhancing Services for Highest Need Individuals

- \$160 M to Expand Forensic Inpatient Capacity on Wards Island
- \$16.5 M to Bolster the Enhanced Services Plans associated with Assisted Outpatient Treatment (AOT)
- \$6.5 M to create Connection Centers for mobile outreach teams to work with unhoused individuals in the subways
- \$2 M to establish hospital-based Peer Bridger Services and expand the Intensive and Sustained Engagement Teams (INSET)
- \$1.5 M to expand OASAS Street Outreach Teams and integrate with SOS teams
- \$1.4 M to add Street Medicine and Street Psychiatry to SOS teams

Prevention Efforts

Prevention Initiatives for Adults

- Community-focused wellness and resilience programs (e.g. Reimagine)
- Community Mental Health Promotion and Support (COMHPS)
- Collaborative Care Medicaid Program
- Strong Employment Initiatives
- Mental Health First Aid
- Mind, Body, Breath
- Healing Circles
- Community Wellness Center located on the campus of Bronx Psychiatric Center
- Suicide Prevention Trainings
- Public Awareness campaigns for general wellness, anti-stigma, and suicide prevention such as:
 - Be Well
 - 988

Prevention Services for Children & Youth

1. Primary Care Services
 - HealthySteps
 - Pediatric Collaborative Care
 - Project Teach
2. Schools
 - School-based mental health clinics
 - Suicide Prevention training
 - Youth Mental Health First Aid
3. Community Organizations (Libraries, etc.)
 - Youth Safe Spaces/Club Houses
 - Mental Health First Aid
4. Faith-Based Community
 - Gatekeeper Training for Suicide Prevention
 - Haven Project
5. Behavioral Health Services
 - Full array of treatment and services to prevent progression of mental health challenges
 - Comunilife/Life is Precious
6. Friends/Social Network
 - Teen Mental Health First Aid
 - Sources of Strength
7. Public Awareness Campaigns
 - 988 and Crisis Text Chat
 - Anti-stigma grants

Children's Services

Summary of Treatment Services for Children and Adolescents

- **HealthySteps:** A child and family development professional, known as a HealthySteps specialist, connects with families with children ages 0-5 as part of the primary care team during pediatric well-child visits. The specialist offers screening and support for parenting challenges, and provides guidance, referrals, care coordination, and home visits.
- **School-based Mental Health Clinics:** Mental health professionals operate in places familiar to students to decrease barriers to mental health access and enhance coordination of care for children and youth.
- **Youth Assertive Community Treatment (Youth ACT):** Transitional multi-disciplinary team provides home and community-based individual- and family-level clinical interventions for youth returning home from a residential or inpatient setting.
- **Home-Based Crisis Intervention (HBCI):** Counselor comes to the home and other places the youth goes, to help settle a crisis and cooperatively develop a plan to avoid unneeded hospital stay.
- **Partial Hospitalization Program (PHP):** Intensive level of outpatient treatment designed to stabilize and improve acute symptoms, to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program.
- **High-Fidelity Wraparound (HFW):** Evidence-based intensive team planning practice model intended to provide coordinated, comprehensive, holistic, youth- and family-driven care for children, youth, and families who have multiple system involvement.
- **Youth and Young Adult Suicide Prevention:** Wrap-around, treatment-adjacent interventions tailored to support high risk, underserved populations such as Hispanic/Latino, Black/African American, Asian American/Pacific Islander, American Indian/Alaskan Native, and LGBTQI+ youth and young adults.

Adult Services
Rehabilitation, Housing and
Recovery

Personalized Recovery Oriented Services (PROS)

- There are currently **71 PROS providers, serving 6,600 individuals**
- Average length of stay is **14 months**

Redesign Efforts:

- Creating a program that is able to serve diverse populations, from young adults focused on school or employment goals to older adults who may have a longer history of hospitalization.
- Improve outcomes for PROS Participants.
- Incorporate Evidence-Based Practices throughout the services and components.
- Promote competitive employment, educational attainment, and other meaningful forms of community membership.
- Ensure the financial and programmatic sustainability of the model for years to come.
- Creating a future-oriented program design through a model that is responsive to the system needs and can move forward with technological advancements (telehealth).
- Create more opportunities for community-based and 1:1 services, in line with the needs and preferences of the population served.

Community Oriented Recovery Services (CORE)

- Community Oriented Recovery and Empowerment (CORE) Services grew out of Adult Behavioral Health Home and Community Based Services (BH HCBS) as a way of getting person-centered, mobile, and flexible rehabilitation and recovery services to the individuals who need it most
- BH HCBS and CORE are unique and innovative in a few ways:
 - Managed in a partnership between OMH and OASAS to meet the needs of individuals with mental health *and* addiction challenges
 - Designed as *services*, not a *program*
 - Community-based and primarily 1:1
 - Focused on person-centered recovery goals related to where and how a person chooses to live, work, learn, or socialize
- Providers have reported that:
 - Length of stay is shorter than with traditional programs, typically months not years
- Preliminary data supports these conclusions:
 - Average length of enrollment per admission is **4.7 months** with an average of **22 claims per admission** (just over one claim per week)*

NYS Clubhouse Expansion

- New York State is expanding the number of accredited Clubhouses in regions outside of NYC (Hudson River, Central, Western, and Long Island Regions) through a competitive procurement process
- Approximately eight (8) new Clubhouses anticipated
- Awarded Clubhouses will become accredited by Clubhouse International and follow the **Clubhouse International Standards**
- This model is evidence-based, member-focused, and non-hierarchical (i.e. members and staff are equals, no “client” role)
- Focus on employment support through the Work-Ordered Day
- Outcomes include: **increased rates of competitive employment, higher job retention, fewer psychiatric hospitalizations, improved recovery, improved social connectedness, increased housing stability, improved quality of life**

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Employment is Recovery!

- Lack of employment is a key social determinant of health, as is poverty. Both lead to poor health outcomes.
- Low employment rates are pervasive for individuals with behavioral health disorders, and the effects are more significant than that of their non-disabled unemployed peers.
- What will improve outcomes is the weaving of employment principles and practices into day-to-day service delivery
- We need to resist the tendency to leave the employment discussion for vocational-only programs

Individual Placement Services (IPS) is offered in all OMH rehab programs. An evidenced-based model of Supported Employment. Discussing employment however should not be left only to programs with employment supports- understanding resources is key.

Improving Data- OMH is working to improve outcome data for Employment Measures across OMH Programs and populations served

Statewide Employment Efforts

Governor Hochul signed Executive Order 40 on 9/20/24 establishing NY as an Employment First State!

- **E1st is a national systems change framework** centered on the premise that **all individuals**, including those with the most significant disabilities, **are capable of** full participation in **Competitive Integrated Employment (CIE)**
- In practice this means that **competitive integrated employment is considered as the first option and preferred outcome** in the planning and delivery of services and supports

OMH incorporates **Individual Placement and Support (IPS)** into over 200 programs statewide

- IPS is the evidenced based model of supported employment for people with mental illness
- Governor Hochul's recent investments have expanded the availability of IPS, enhanced funding to providers, increased staffing to provide training and technical assistance, and improved the necessary data infrastructure to measure long-term outcomes.

OMH is delivering **Employment 101 curricula and companion tools for all program types**

- Targeted focus on *Housing, Treatment, and Rehabilitation Programs and Supports*

OMH Services that Include Psychiatric Rehabilitation for Adults

- Personalized Recovery Oriented Services (PROS)
- Community Oriented Recovery and Empowerment (CORE)/Behavioral Health (BH) Home and Community Based Services (HCBS)
- Certified Community Behavioral Health Clinics (CCBHC)
- Assertive Community Treatment (ACT)
- Individualized Placement and Support (IPS)- state aid funded + a part of the “Rehab” programs

Article 31 Clinic (Mental Health Outpatient Treatment and Rehabilitation)

- Shifted to rehab state plan option allowed for **off-site services** and **peer support**
- Integrated Care efforts
- IOS regulatory work- The MH/SUD Tiers and Physical Health Integration
- Expansion of Complex Care Management definition
- Crisis Intervention services provided in pre-admission = Access/Immediate care
- Exploration of role for the new paraprofessional credential - **Credentialed Mental Health Support Specialist or CMHSS**
- Hospital to Community Transitions: Admissions from hospitals, transitions of care
- Testing Services (developmental, psychological, neurobehavioral status exam) available pre-admission across the lifespan to expand access to these services
- Expansion of eligibility criteria for youth to include *Problem related to unspecified psychosocial circumstance* (Z65.9) which allows MHOTRS to treat youth prior to the full manifestation of a mental health diagnosis

Engaging Individuals with Complex Needs through Community-based Services

Critical Time Intervention (CTI): Phased care management approach during transition out of hospital

- Program began in January 2025 and partners with hospitals to support high need individuals transitioning from hospital to the community; collaborates in discharge and aftercare planning with hospital staff.
- In first month of CTI services, 83% of adults linked to outpatient mental health services and 73% of adults linked to primary care services after hospitalization.

ACT

- **75 expansion teams**, of which 11 are existing adult teams whose capacity was expanded and 64 are new. All are expected to be open in FY 2027.
- Improved educational and employment outcomes, decreased hospitalizations, decreased homelessness, decrease in active AOT orders upon discharge
- **25%** of people on ACT are on AOT orders

HH+

- **198 Specialty Mental Health Care Management Agencies**, 100 serving the AOT population
- Over **13,000 individuals** currently enrolled in HH+

Improving and Strengthening Kendra's Law and the AOT Program

Goal: To ensure local government partners have the resources to administer the AOT program and support individuals in their communities with complex needs.

OMH and the local counties will work with individuals served and their families, community providers, hospitals and the court system in order to decrease poor outcomes, improve connection to services and ensure people are moving off AOT as quickly as possible.

What will the State and Counties do?

- Ensure the use of diversionary options like Enhanced Voluntary Agreements, INSET teams, and other existing and new voluntary resources are considered first.

This is NOT an effort to increase the number of people on AOT.

- OMH will help the counties in administering the program including funding for staff that are dedicated to supporting people on AOT and EVAs, improve communication and coordination of care, and employ a recovery-oriented approach to AOT and service delivery.
- Counties may also use funding for operational needs of the AOT program including MD evaluation, county attorney time, training staff.
- OMH will monitor the Counties on how many people are on EVAs, how long people are on AOT, and how engagement is working after AOT.
- OMH will provide training, technical assistance and policy development.

Safe Options Support (SOS) Implementation & Expansion



- Multidisciplinary teams using Critical Time Intervention approach to provide intensive outreach, engagement, and care coordination services to unhoused individuals until stably housed (approximately 12 months).
- Each team has 9-12 members when fully staffed. Teams are composed of licensed clinicians, care managers, and peer specialists. NYC Teams also include a registered nurse. (Most teams now have a psychiatric practitioner providing services to members one day a week).
- Since the Safe Option Support (SOS) program was created in 2022, **20 teams have been developed in New York City**
 - Specialty teams include 3 overnight outreach teams, 1 Older Adult and Medically Fragile Consult Team, and 2 Young Adult teams
 - A Targeted Response SOS team launched in the Times Square Area in August 2024
- Safe Options Support Teams launched in **Rest of State at the end of 2023** where there are currently 11 teams operational in Upstate New York covering 19 counties

NYC SOS Teams Outcome Data

In New York City, teams have accomplished:

- 92,007 Outreach Encounters
- 4,010 Total Bed Placements (Includes placements to Respite programs, Shelter, Safe Haven Beds, or a DHS Welcome Center)
- 3,370 Enrollments into the SOS Program
- 134,585 Enrolled Contacts
- **1,009 Permanent Housing Placements in OMH Licensed and Unlicensed Housing (Includes Community Residence, Apartment Treatment, Family Care, Supportive Housing, Independent Housing, and Skilled Nursing Facility)**

Rest of State SOS Teams Outcome Data

Data from the Upstate Teams:

- 40,634 Outreach Encounters
- 1,115 Enrollments into the SOS Program
- 480 Currently enrolled into the SOS Program
- 49 Currently enrolled members who are unsheltered
- 49,885 Enrolled Contacts
- **716 Permanent Housing Placements in OMH Licensed and Unlicensed Housing (May include Community Residence, Apartment Treatment, Family Care, Supportive Housing, Independent Housing, and Skilled Nursing Facility)**

Hospital Care & Community Transitions

Updates on OMH Office of Hospital Care & Community Transitions

- OMH created a **new office and new regional teams** to closely partner with hospitals that have a licensed inpatient mental health program as well as community-based programs
- Goal is to strengthen admission, treatment, and discharge practices and related outcomes with a population-based approach
- **New guidance and regulations based on best practices:**
 - Joint Guidance to support hospital regulations for inpatient mental health programs and emergency department coming soon.
 - New guidance is now posted for outpatient MHOTRS programs, housing/residential programs, and care management on communicating with hospitals on admissions and discharges
- New opportunities to train staff, including **TRUST training** and ECHO series
- Tools to streamline and improve efficiency, including **financial best practices**
- **Capacity and access** monitoring and support
- Regional teams are offering **on-site** technical assistance, including support with implementing the new regulations, education on resources, linkages between systems and system navigation

Timeline of Statute, Guidelines & Regulations for Hospitals

FEBRUARY 2022

Interpretive
Guidance for
Transport

OCTOBER 2023

Guidance on Discharge
Practices for CPEP,
9.39 EDs, Inpatient

DECEMBER 2024

Regulations updated for
Psychiatric Inpatient
units (580, 582) & CPEP (590)

May 2025

MHL Amended,
including Inability to
Meet Essential Needs
(effective 8/25)

JANUARY 2026

Joint Guidance
Document with
DOH for ED, CPEP,
Inpatient Released
(

FEBRUARY 2023

Guidance on
Information Sharing

OCTOBER 2024

Guidance for
Outpatient Providers
for Collaborating with
Hospitals

JANUARY 2025

DOH Regulations for
Emergency
Department
updated (405.19)

AUGUST 2025

Updated Guidance on
Transport for Emergency
and Admissions

Timeline of TA & Training for Hospitals

SPRING 2024

Office of Hospital Care and Community Transitions (OHCCT) formed

2024-2025

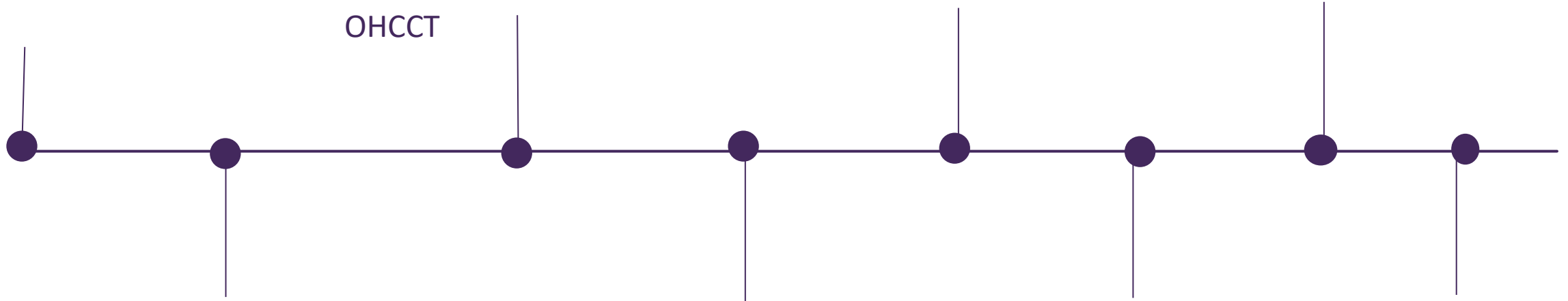
Meeting with hospitals across the state to better understand the needs and challenges and introduce OHCCT

SPRING 2025

OHCCT Regional Teams begin visiting hospitals statewide

FEBRUARY –March 2026

2nd ECHO Training and Six Core Strategies Training for hospitals



January 2025

TRUST Training to Article 28/31 Hospitals on De-escalation hosts first training

MARCH 2025

PSYCKES Training to ED Staff and Hospital Leadership (597 attendees)

OCTOBER 2025

Began ECHO Training on Managing and De-escalating Challenging Behaviors

APRIL 2026

PSYCKES Training to ED Staff and Hospital Leadership

Investments in Training for Hospital Staff

- Training for staff not only helps with quality of care and client experience, but it also helps with staff satisfaction, **recruitment and retention**
- OMH has expanded access to **TRUST** training: Therapeutic Relationships and Universal Safety
 - TRUST approaches are trauma-informed, empathic, person-centered, recovery/resiliency- focused, proactive, and incorporate an integrated team
 - Over the course of 2025 - 2026, OMH offered 11 TRUST Train the Trainer programs to over 220 participants spanning **44** hospitals and **16** RTF/Outpatient providers

Investments in Training for Hospital Staff

- Managing and Deescalating challenging Behavioral in Hospital and Congregate Settings ECHO
 - **Project ECHO** (Extension for Community Healthcare Outcomes) is a cost-effective, virtual training collaborative that provides case-based learning and information sharing
 - The goal is to create a **learning community** to discuss complex system needs and offer expert opinions and tools for practitioners to bring back to their practice settings; OMH awarded Westchester Medical Center to lead this project over the next five years
 - The first ECHO kicked off in **October 2025** with a cohort and just wrapped up 2nd cohort - 21 hospitals have participated thus far
 - Each hospital **across the state** will have the opportunity to participate

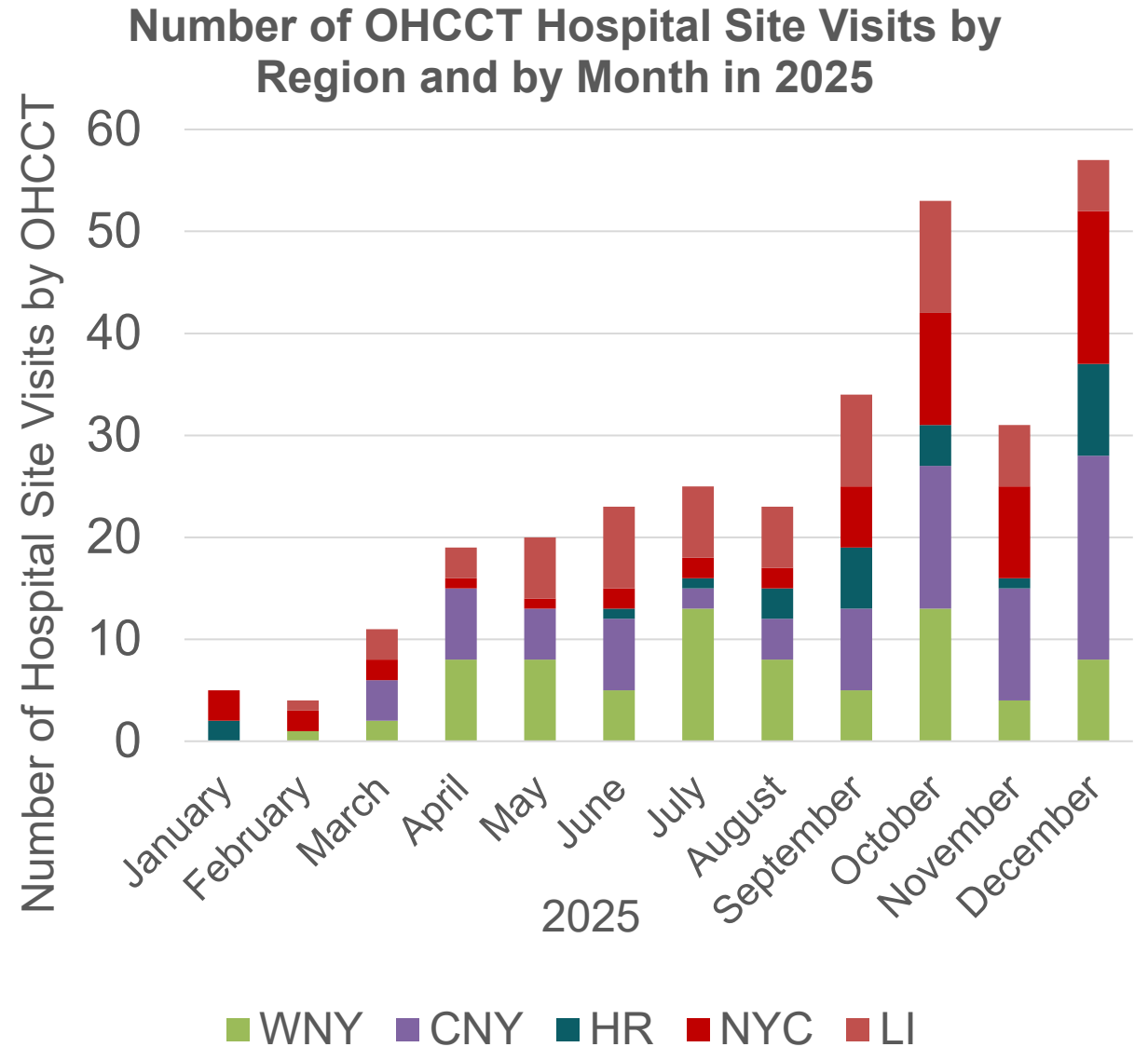
OHCCT Ramping up Number of Site Visits to Hospitals Statewide

Office of Hospital Care and Community Transitions (OHCCT) **regional teams** actively support hospitals

- Offer on-site guidance and technical assistance
- Support implementation of updated Statute, Guidance and Regulations
- Develop tools to improve efficiency, sharing innovations across the state
- Education on resources, linkages between systems, navigation for complex care needs

97% of NYS Hospitals Visited to date

306 in-person, onsite visits/meetings in 2025



Regional Team Leadership



OHHCT Regional Team Leadership

- Katie Merrill, MSW, Director of Regional Teams
- Amanda Rusch, LMHC, Deputy Director for Upstate
- Silvia Diaz-Ferrero, LMSW, Deputy Director for Downstate
- **WNY:** Hollani Goltz, LCSW
- **CNY:** Roxanne Reimer, LCSW
- **HR:** Chaya Rubin, Psy.D.
- **NYC – Team 1:** Juliana Steen, LMSW
- **NYC – Team 2:** Darren Walker, MS
- **LI :** Barbara Smith, MHA

Supporting Regulatory Implementation

- **Educating and informing** key hospital staff about regulatory changes
 - Opportunities for unit and hospital leadership to ask questions and talk through workflows
 - Focus on defining individuals with complex needs and helping hospitals to understand what has changed in regulatory requirements related to serving these individuals
- Providing direct assistance with **identifying communication and collaboration processes**
 - Working with local government to identify their processes to support collaboration with hospitals and sharing that information with hospital staff (e.g., creating a list of local counties and their processes for collaboration related to the discharge of individuals with an elevated risk of violence)
- **Fostering positive working relationships** between hospitals and community providers
 - Discussions with community providers who have concerns about how communication has been working (or not working) and providing direct assistance with introducing key staff, trouble-shooting local concerns, etc.
- **Establishing rapport and partnership with EDs**
 - Taking a hospital-centered approach to learning about ED strengths and challenges; offering education and resources to support 405.19 regulations; learning more about what support will be needed
 - Created **individualized Resource Guides for all counties** to support compliance with regulatory requirements around providing individuals with information about treatment options in the community if they are leaving AMA or refusing aftercare; information is fully vetted and will be regularly updated by our teams to ensure accuracy

OHCCT NEWSLETTER

☎ 518-408-2814

🌐 OMH.NY.GOV

✉ hospitalcare@omh.ny.gov



Welcome!

We are excited to share with you what we have been up to this past month. Keep reading to learn about what's new, what's changed, and how we can help.

FEATURED TOOLS & RESOURCES

- ☎ [OMH DOH Evaluation and Discharge Joint Guidance - 2/2026](#)
- ☎ [NEW LAW: MHL §9.64 Notification to Community Providers](#)
- ☎ [Inpatient MH Regs for General and Stand-Alone Hospitals](#)
- ☎ [Guidance on Sharing PHI, Collaboration, and Care Coordination](#)
- ☎ [Patient Safety Standards Guidelines](#)

Guidance Highlights

OMH and DOH just released joint guidance regarding evaluation and discharge practices for individuals who present with behavioral health conditions within psychiatric inpatient programs, Emergency Departments, and Comprehensive Psychiatric Emergency Programs. Hospitals will find this and other useful OMH Guidance and Clinical Advisories on the [OMH Guidance Website](#).



OHCCT Spotlight

ABOUT THE OHCCT TEAM

The Office of Hospital Care and Community Transitions (OHCCT) is a part of the New York State Office of Mental Health operating under the Division of Planning and Quality Management. The goal of OHCCT is to strengthen admission, treatment and discharge planning practices and related outcomes with a population-based approach. We have a team in Central Office and Regional Teams across the state. We have been visiting hospitals to learn the unique work-flows, strengths, and challenges in ED's, CPEPs and inpatient psychiatric programs to provide individualized assistance implementing new laws and regulations, overcoming system challenges, and advocating for necessary policy changes.

Message from the Assistant Commissioner

"As we embarked on the journey of developing our office, one of the key goals was to improve communication with general and stand-alone MH hospitals. We wanted to create a space where we could provide updates on regulations, training opportunities, share new guidance, and best practices that we are seeing across the state. I hope that you will use this newsletter as a resource for you and your staff."

"I would be remiss, if I did not thank you all for opening your doors to our staff, as we visit your facilities to learn more about what is going well and the challenges you face. We look forward to providing your facility with ongoing technical assistance and support. We value you and all and the work that you are doing to improve the lives of all New Yorkers."

-Janine Perazzo



Practice & Activity Corner

Best Practices

New York City Health + Hospitals (H+H) has implemented a new Complex Care Team through their Office of Behavioral Health (OBH). This team supports all H+H hospitals with identifying individuals with complex care needs who may require enhanced discharge planning support. The team is available to consult directly through the Electronic Health Record (EHR), so guidance and technical assistance can be provided quickly to the EDs, CPEPs, and Inpatient Units that are working with these individuals.

Mount Sinai Behavioral Health Center (Rivington House) implemented a new Care Engagement Team. This pilot model is intended to identify patients with a high utilization history/high chance of readmission who would benefit from more assertive engagement and transitional care coordination. When an individual has been flagged by Mount Sinai as appropriate for this program, the Care Engagement Team will receive rapid notification whenever that individual interacts with their system so that they can quickly begin engaging the individual at admission.

Orwego Health has implemented a "Comprehensive Discharge Assessment" completed by the Social Worker at admission. This document includes the complete biopsychosocial assessment and screens for health-related social needs, mental health status, and substance use. The assessment is updated continuously throughout the individual's episode of care and is used to support person-centered discharge planning that begins at admission. Orwego Health also offers the opportunity to meet their outpatient therapists while still inpatient to begin building a rapport and relationship.

University of Rochester Medical Center - Strong Hospital maintains a listserve of community providers and stakeholders that is used to clearly communicate CPEP boarding numbers, inpatient bed availability, and to notify the community of any CPEP diversions, when applicable.

This Month in Pictures



Views from Adirondack Medical Center's Behavioral Health Unit



Check out Ellis Hospital's new mural inside the Children's Unit



Inside University of Rochester Medical Center's new Adult Inpatient Unit



More from The University of Rochester Medical Center's unit update

Training & Announcements

Be on the lookout for:

Project ECHO Cohort 3

ECHO is a proven approach to create a virtual learning community to share knowledge and receive feedback from trainers and peers. Westchester Medical Center Health Network has received funding from OMH to run an ECHO program focused on managing and deescalating challenging behavior. This is a five-year program available to all hospitals in NY State. Reach out if you would like to join the next cohort.

TRUST 2026 Training Schedule

The TRUST training curriculum covers trauma-informed practice, core concepts, de-escalation, and defensive techniques. Implementing TRUST can help reduce aggression and injury in the hospital. OMH offers TRUST Train-The-Trainers at no additional cost to hospitals. Email us if you would like to schedule a training.

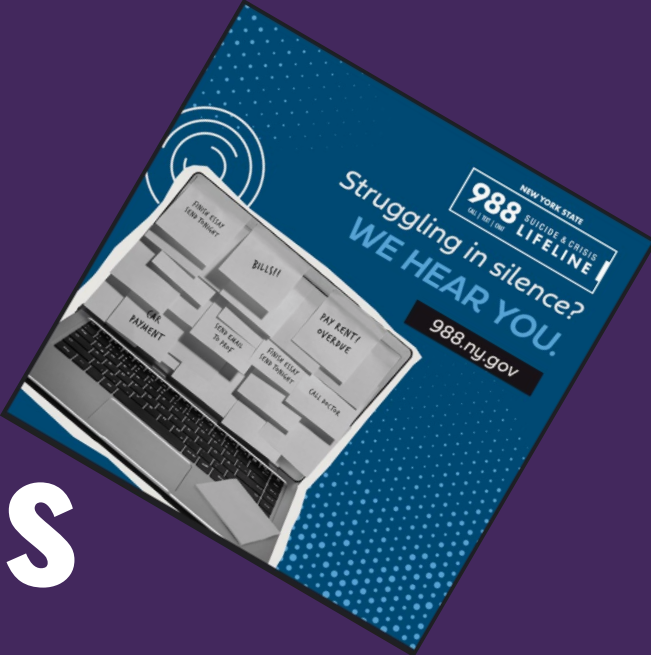
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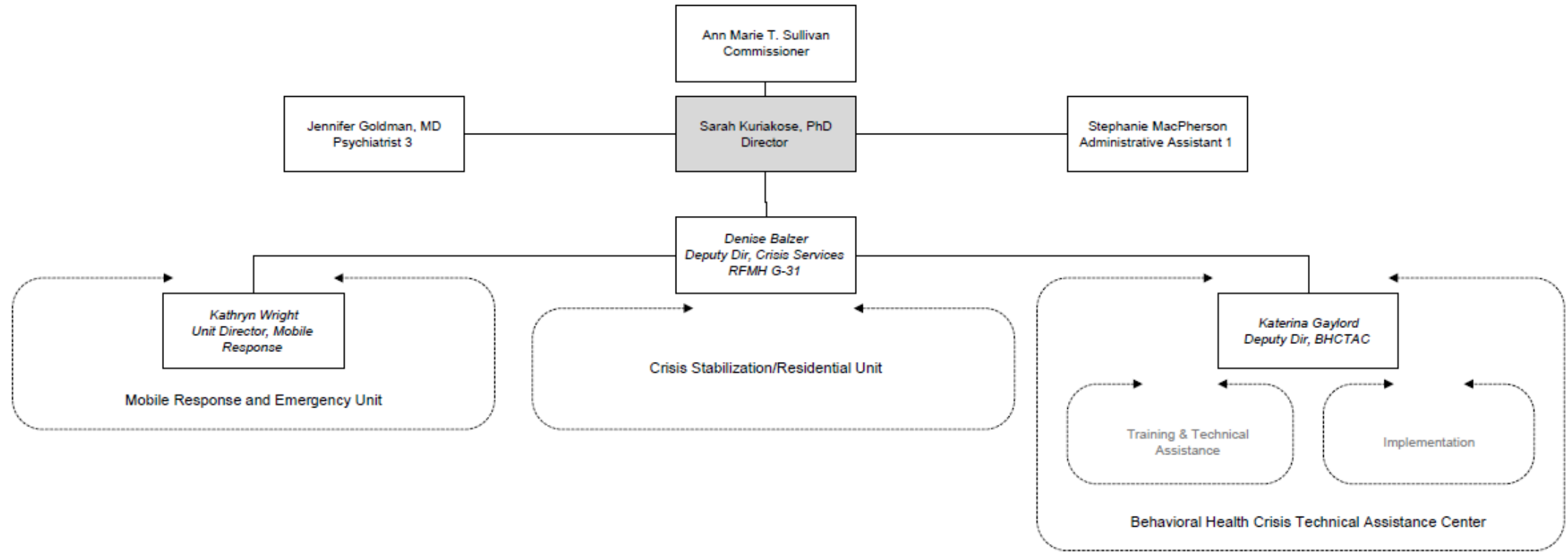
Crisis Services



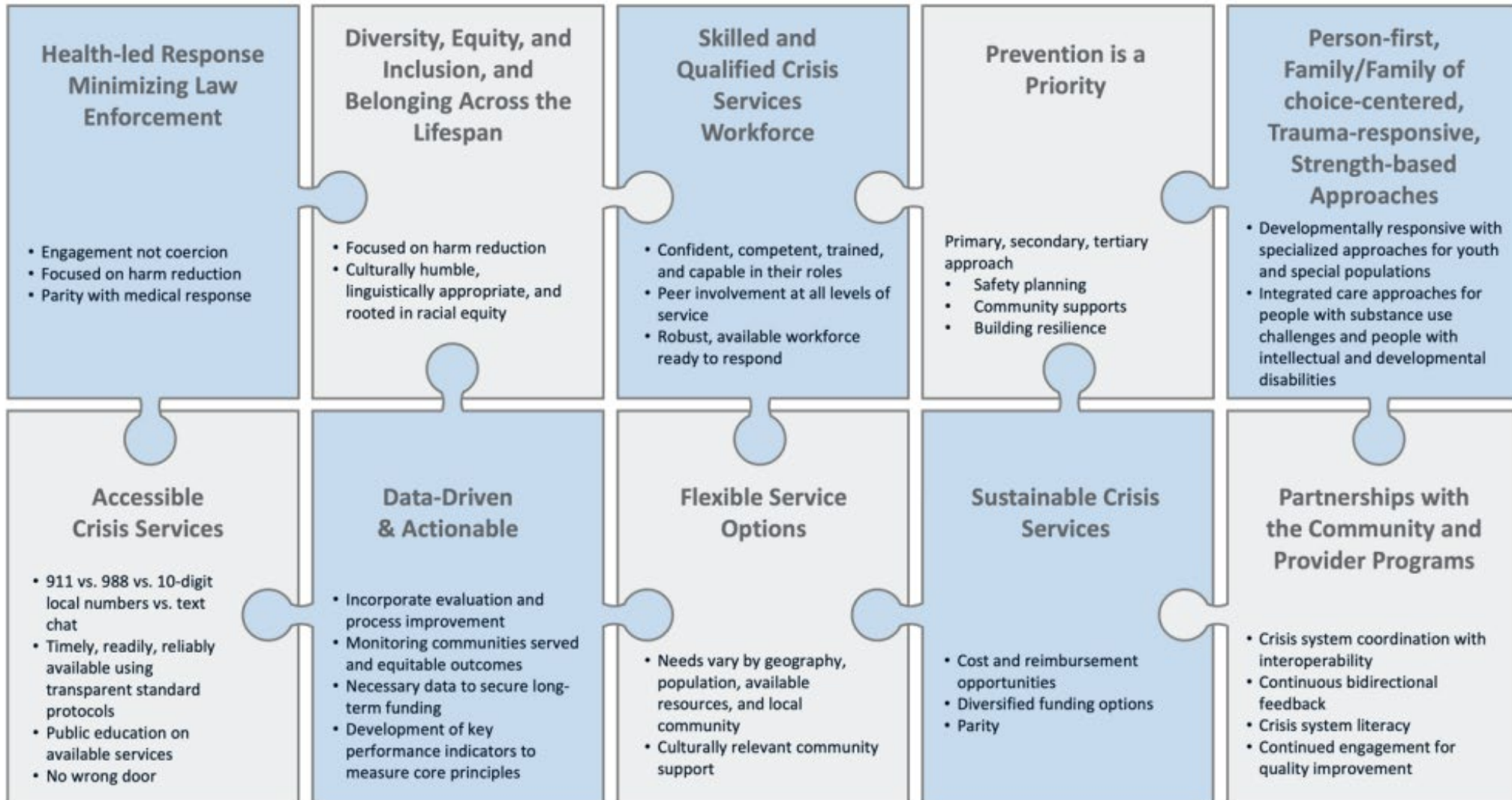
Division of Crisis Services

February 2026

Division of Crisis Services and Behavioral Health Crisis Technical Assistance Center



Core Principles for NYS Behavioral Health Crisis Response



NYS Comprehensive Crisis Response System



Someone to Contact:

- NYS 988 Crisis Contact Centers



Someone to Respond:

- Mobile Crisis Response
- Home Based Crisis Intervention



A Safe Place for Help:

- Crisis Residences
- Crisis Stabilization Centers (CSCs)
- Comprehensive Psychiatric Emergency Programs (CPEPs)

988: 2025 Year in Review

- NYS 988 Contact Centers answered **457,973 calls**, **55,916 texts**, and **51,131 chats**
- **90%** in-state answer rate in 2025
- Average talk time in NYS: **14.3 minutes**
- **Top Reasons** for Contacting 988:
 - Family/Relationship Issues
 - Suicide
 - Depression
 - Anxiety
 - Loneliness

988: Voices from New Yorkers

I feel better now that I am talking with you; I feel like somebody cares about me, and I think it's great, and I appreciate it.

I'm not actively suicidal, but I'm driving over the bridge, and I just wanted to say thank you to you guys for putting that sign up that says, "Call if you need help," and "You are not alone" and that invitation to call because I just needed to vent to a stranger.

NYS Comprehensive Crisis Response System



Someone to Contact:

- NYS 988 Crisis Contact Centers



Someone to Respond:

- Mobile Crisis Response
- Home Based Crisis Intervention



A Safe Place for Help:

- Crisis Residences
- Crisis Stabilization Centers (CSCs)
- Comprehensive Psychiatric Emergency Programs (CPEPs)

Home Based Crisis Intervention: Voices from New Yorkers

My husband & I were very grateful for the time we had with Ellen. She was a great listener and gave us good advice on how to try to deescalate times when Sofia was in a state of crisis. She helped us on so many occasions over the phone even during late night calls... I wish there were many more Ellens in this world.

NYS Comprehensive Crisis Response System



Someone to Contact:

- NYS 988 Crisis Contact Centers



Someone to Respond:

- Mobile Crisis Response
- Home Based Crisis Intervention



A Safe Place for Help:

- Crisis Residences
- Crisis Stabilization Centers (CSCs)
- Comprehensive Psychiatric Emergency Programs (CPEPs)

CPEP Peer Bridge: Voices from New Yorkers

After 3 months of working with S, he told me, “I feel so much better. I hope the depression never comes back.” In S’s case, he not only needed help processing his complex grief but also practical solutions to his living situation. I was able to help relocate him into supportive housing as we continued to work together to process his complex grief. I understood S’s words, “Thank you, Caleb” at our last interaction to mean so much more than just platitudes, as he felt heard and seen beyond his mental illness. Being a peer bridger allows me to be a face of familiarity and support, when going through the most difficult period of one's life: change.

MHL§ 36.07

- (a) The commissioner, in conjunction with the commissioner of the office of addiction services and supports, shall establish a behavioral health crisis technical assistance center within the office of mental health. The commissioners shall jointly be responsible for the structure and operation of the behavioral health crisis technical assistance center.

- (b) The behavioral health crisis technical assistance center, shall:
 - 1. **develop standardized protocols and procedures for a community-based public health-led response to behavioral health crises.** The protocols and procedures shall be designed to:
 - (i) de-escalate situations involving individuals experiencing a mental health or substance use crisis, when possible;
 - (ii) utilize the most appropriate treatment for individuals experiencing a mental health or substance use crisis;
 - (iii) maximize the use of voluntary assessment and voluntary referral of individuals experiencing a mental health or substance use crisis;
 - (iv) minimize physical harm and trauma for individuals who experience a mental health or substance use crisis;
 - (v) deliver culturally competent care;

MHL§ 36.07

2. **assist local government units in the development of local service plans that address their local crisis service needs and implement a community-based public health-led crisis response.** Such assistance shall include tailoring such plans to meet the needs of urban, suburban, and rural communities;
3. **support implementation of standardized procedures and protocols;**
4. in collaboration with the division of homeland security and emergency services and the state emergency medical services council, **pursue efforts to improve coordination between the 9-1-1, 9-8-8, local government units, and statewide emergency response systems;**
5. **provide consultation and training to local government units and local crisis response teams on best practices on the assessment and response to mental health and substance use crises;** and
6. **maintain a database of best practices** for a community-based public health-led response to behavioral health crises.

MHL§ 36.07

(c) In execution of its duties under this section, the technical assistance center shall employ a peer or peers with lived experience and shall consult with, as appropriate: peers with lived experience of mental illness or substance use disorders, or family of such peers and/or peer-led organizations; licensed mental health or addiction clinicians; licensed mental health or addiction counselors; licensed physicians, nurses, or mental health or addiction providers; mental health or addiction counselors; representatives of not-for-profit disability justice organizations; emergency medical technicians; and crisis health care workers.

(d) 1. The center shall prepare an annual report which shall include, but not be limited to, the following information:

(i) data on the extent to which local governmental units have implemented community-based public health-led responses to behavioral health crises and the effectiveness of such efforts;

(ii) a summary of any assistance provided, action taken, or progress made in relation to the duties required under this section;

(iii) recommendations to improve the operation and financing of a behavioral health crisis response system; and

(iv) any other information deemed relevant by the center.

2. Such report shall be submitted to the governor, speaker of the assembly and temporary president of the senate no later than December thirty-first, two thousand twenty-seven and annually thereafter and shall be made available on the official agency website for the office of mental health and the office of addiction services and supports.

BHCTAC FY2026 Funding

BHCTAC was funded in the FY2026 budget

- BHCTAC deliverables are broad and state-wide, as described in § 36.07
- BHCTAC will additionally oversee and support health-led crisis response pilots

Pilots were funded in FY2026 budget for \$6M

- The funding will allow recipients to use teams with trained behavioral health professionals and include peer support staff in their crisis response system. The resulting system will be trauma-informed, community-based, and prioritize racial equity, cultural humility, and harm reduction for New Yorkers across their lifespan.

HEALTH-LED CRISIS RESPONSE PILOTS

- Three (3) awarded health-led crisis response pilot programs
 - **City of Rochester – Urban [Monroe]**
 - **Central Nassau Guidance and Counseling Center – Suburban [Suffolk]**
 - **Children’s Home of Jefferson County – Rural [Jefferson and Lewis]**
- Engaging the seven (7) SFY 2024-2025 legislative add programs
 - **Center for Dispute Settlement Inc.**
 - **City of Rochester**
 - **Family Services of Westchester Inc.**
 - **New York City Department of Health and Mental Hygiene**
 - **Partnership for the Public Good**
 - **St Joseph's Hospital Yonkers**
 - **University of Rochester**

BHCTAC Advisory Council (Task Force Recommendation)

- Per the **Task Force recommendation**, OMH and OASAS have convened an Advisory Council as one of several ways to meet the statutory responsibilities for deep and broad stakeholder engagement, in alignment with the core values for New York State’s crisis response system.
 - “...the technical assistance center... shall consult with, as appropriate: peers with lived experience of mental illness or substance use disorders, or family of such peers and/or peer-led organizations; licensed mental health or addiction clinicians; licensed mental health or addiction counselors; licensed physicians, nurses, or mental health or addiction providers; mental health or addiction counselors; representatives of not-for-profit disability justice organizations; emergency medical technicians; and crisis health care workers.”
- The role of the Advisory Council is to review and advise the work of the Center.
- Members are invited for two-year terms and terms may be renewed.
- Members are asked to attend meetings approximately monthly (virtually), participate substantively through sharing expertise, and support feedback loops to the community.

Peer Support Services

**“Nothing about us, without
us”**

MAIN GOALS OF INSET AND F-INSET

Support people in achieving their self-identified life goals

Encourage a collective response to “crises” and/or periods of increased stress

Provide supports that reduce risk factors associated with arrest, recidivism, and recurring criminal legal system involvement (e.g., probation, parole, incarceration)

Key Features Supporting these Goals:

Enhanced flexibility as non-billable program

- Not time-limited
- No Medicaid eligibility requirements

Focus on relationships and individual choice, voice, and self-determination

- Emphasis on participant’s goals, community membership, and quality of life
- Aids in navigating complex systems and accessing benefits

CURRENT INSET AND F-INSET TEAMS IN NYS

Hands Across Long Island INSET Team (Nassau and Suffolk)

Hands Across Long Island F-INSET Team (Nassau and Suffolk)

Baltic Street Wellness Solutions INSET Team (Kings)

Greater Mental Health of New York INSET Team (Westchester, Rockland, Sullivan, Orange, and Putman)

Recovery Options Made Easy (Monroe)

Monthly average number of individuals supported by INSET is **352** based on the most recent **12 months** of data (3/1/25-2/28/26).

FY26 Budget included funds for developing **1 new INSET team**, expected to become active in July, growing the *capacity* of the program by **60** additional participants.

64 individuals were connected to permanent housing as of February 2026, which is **19%** of the number of (lifetime) enrollments of **334**.

SUCCESS STORIES

- GMH, Feb 2026: “A participant recently moved into his own apartment and adopted his first pet. He has never owned a pet before, and this new responsibility has already had a positive impact on him. Caring for his pet has motivated him to better manage his money and stay on top of his responsibilities. He shared that having a pet has helped reduce his anxiety and loneliness. Since this change, he has felt more confident and motivated to continue working toward additional goals and building further stability in his life.”
- HALI, Jan 2026: “When [the participant] came to INSET they were living in a sober house, navigating an ongoing court case, and struggling to effectively engage with the services available to them. The individual identified that the house they were residing in was not supportive and left, becoming homeless. The INSET Peer supported them in exploring their natural supports, which aided them in connecting with a friend that they were able to use for temporary shelter. With support from the team, the recipient transitioned to new services closer to where they wanted to live. This month, this member secured a long-term temporary housing option and returned to work.”
- Baltic, March 2026: “One of our INSET participants has secured permanent housing through and is currently doing very well in her recovery journey. Following an initial discharge to the Transitional Living Residences (TLRs) in 2023, she experienced a decline in her mental health and required readmission to inpatient care. Through her dedication and active participation in her recovery, she has shown significant progress and is now thriving in the community. She attends the clubhouse daily where she is learning computer skills and expressing enthusiasm about her growth. Her positive energy and determination are evident during every interaction. She is excited about this new chapter. She plans to stay connected with friends at the TLRs and aspires to attend beauty school to enhance her makeup and hairstyling skills.”

ARTICLE 28 PEER BRIDGER FUNDING AND CONTRACT DETAILS

- \$300,000 per year for five years will be awarded to each of three hospital.
- Funds are intended for hiring three NYCPS peer support specialists and covering travel and incidentals
- Eligible applicants include Article 28 facilities with inpatient psychiatric units who are willing to provide Peer Bridger services
 - Throughout their application, they would demonstrate an understanding of peer support values and principles as they relate to Peer Bridging, and a willingness to work with the Office of Advocacy and Peer Support Services, OMH, and training partners toward a successful program implementation and management.

ARTICLE 28 BRIDGER PROGRAM

- Support individuals hospitalized in **Article 28 settings** as they prepare for discharge.
- Establish rapport and connection in the hospital and into the community for a period of **up to one year following discharge**
- Help people navigate challenges, connect with community and valued life goals, and gain support based on shared lived experience
- Provide individualized skills training, systems navigation, and advocacy, emphasizing a “do with rather than for” approach
- Foster hope that individuals can live a life with personal meaning and purpose

ARTICLE 28 PEER BRIDGER TECHNICAL ASSISTANCE

- Fidelity and adherence to the Peer Bridger model is essential to its success;
- It is crucial to develop a technical assistance entity to support individual programs.
- This funding will ensure that **technical assistance** on Peer Support **best practices** is offered to maximize the success of the program, provide in-discipline perspective and direction on the role and function of Peer Bridgers, provide guidance on the supervision of peer support workers that follow the values and principles of the practice of peer support, and collaborate with selected hospitals to ensure that individuals in care are able to live meaningful lives in the communities of their choosing.

Peer Support Professional Development

- Loss of PeerTAC and NY Peer Advancement Network
- Pivoting
- Collaboration with Wellness Collaborative of NY IPA
- Academy of Peer Services

Impact of Federal Actions

Congressional Budget Reconciliation Bill

- Congressional Budget Reconciliation Bill (Bill) enacts federal spending reductions and tax policy changes, including cuts to Medicaid funding, more restrictive eligibility rules, and major revisions to the Affordable Care Act (ACA) Basic Health Program (NYS Essential Plan).
- Medicaid is the single largest payer for U.S. mental health services. Over **60%** of New Yorkers receiving MH services are enrolled in Medicaid.
- New ACA and Medicaid cuts, eligibility hurdles, and service bans are expected to disrupt funding and reduce coverage across New York, resulting in both immediate and long-term consequences for consumers and providers



NYS Medicaid

- New York's Medicaid program, which provides comprehensive health coverage to more than 7.5 million New Yorkers:
 - Medicaid enrollees may lose insurance due to new paperwork and work requirements.
 - Able-bodied adults aged 19-64 must complete at least 80 hours per month of work, education, job training, or other community engagement activities.
 - CMS has not issued guidance around exemptions and is not required to until summer of 2026
 - Mandatory work requirements and other reforms will significantly increase Medicaid administrative costs.

Medicaid Work Requirements and Redeterminations

- New mandates around “community engagement” (work requirements) for the Affordable Care Act Medicaid expansion population:
 - Able-bodied enrollees age 19–64 who do not have dependents must work or participate in approved activities at least 80 hours each month to qualify for Medicaid.
 - New applicants must document at least one month of work/activities before enrollment.
 - Activities include working, community service, a work program, an educational program, or combination of these.
- Medicaid expansion enrollees’ must redetermine eligibility every 6 months (at minimum) starting in 2026 - doubling the current 12-month renewal interval.
 - Eligibility requirements and verification hurdles could disproportionately disenroll New Yorkers with mental health conditions, leading to coverage loss, care disruptions, relapse or hospitalization.
 - Increase in uncompensated care costs for local hospitals and community providers, uninsured individuals delaying or foregoing medical or behavioral health treatment.

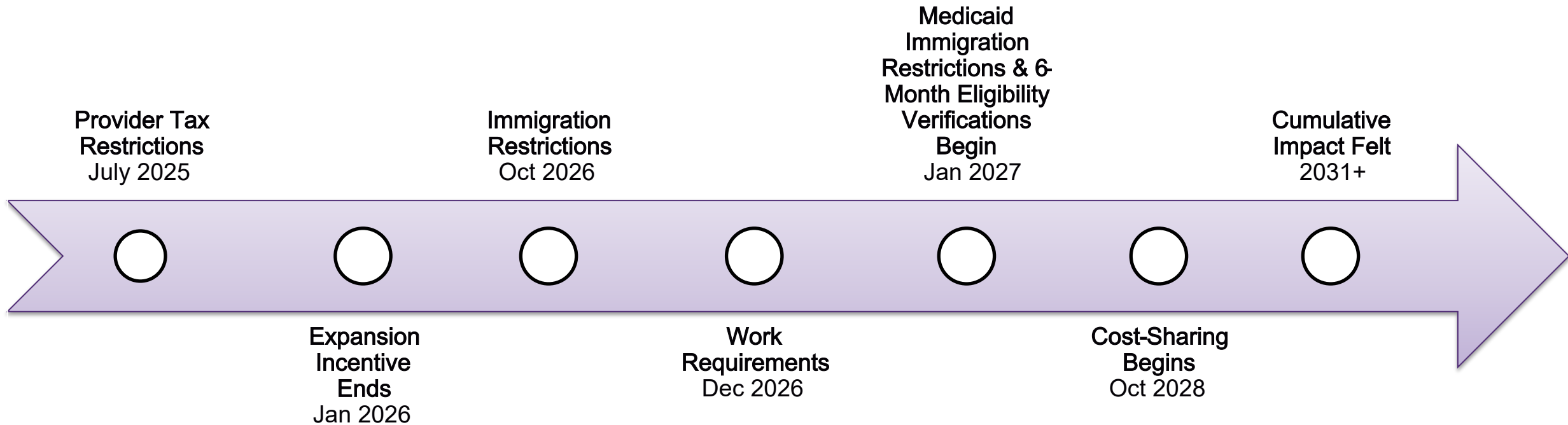
NYS Essential Plan Impacts

- The New York State Essential Plan provides comprehensive, Medicaid-like coverage to more than 1.7 million low- and moderate-income residents, including many lawfully present immigrants who are ineligible for federal Medicaid.
- Federal funding cuts mean New York State can no longer offer expanded Essential Plan eligibility after June 30, 2026.
- Enrollees with incomes between 200% and 250% of the Federal Poverty Level (FPL), (\$31,920 - \$39,900 annual income) will no longer be eligible for the Essential Plan starting July 1, 2026.
 - Enrollees whose eligibility is ending received a notice from NY State of Health on April 1, 2026. **This impacts 450,000 individuals.**
 - There are no changes for the 1.3 million enrollees with income below 200% FPL (income below \$31,920).
- Most people affected by these changes can enroll in a Qualified Health Plan (QHP), with financial assistance.
 - QHPs have monthly premiums and other costs that differ from the Essential Plan. The average silver plan costs \$220 per month after tax credits.
 - The enrollment window opens on May 16, 2026. Impacted enrollees will have until August 30, 2026, to enroll in new coverage without a gap in coverage.
- Impacts may include reduced access to behavioral health services as well as risk for uncompensated care burdens for providers.

SNAP and Nutrition Assistance

- The Supplemental Nutrition Assistance Program (SNAP) issues electronic benefits that can be used like cash to purchase food. SNAP helps low-income working people, senior citizens, the disabled and others feed their families.
- New requirement mandates NYS fund 15 percent of all SNAP benefits starting as early as October 1, 2027, at an estimated cost to the State of \$1.2B per year.
- Cuts in federal share of SNAP administrative costs resulting in additional \$36M in annual costs to NYS, and increased costs for counties and New York City by roughly \$168M annually.
- More than \$900M in lost SNAP benefits projected for New Yorkers due to new program requirements that will make it harder for people to qualify and restrictions on eligibility for legally present noncitizens.
- Residential providers could face increasing costs as individuals in supportive housing may lose access to supplemental food assistance

Implementation Timeline



State Strategies to Protect Access to Care

OMH Regional Forums

- OMH hosted a series of forums to discuss the recent federal actions and plan for potential impacts on New York's mental health system.
 - Five virtual sessions: One in each OMH region and one in-person session in Albany
- Sessions were designed to gather feedback from provider agencies, associations, advocacy organizations, and county leadership through breakout sessions focused on:
 - helping New Yorkers maintain coverage and access to care
 - providing technical support to help agencies maintain revenue streams
 - discussing other topics related to the federal actions

OMH Support

- OMH began work to support providers around three key pillars: revenue maximization, regulatory reform, and improved service design. Some of these actions include:
 - Revising regulations to streamline project approvals and recertifications
 - Expanding telehealth flexibility to better serve rural areas
 - Better leveraging current resources to address specific challenges posed by HR1
 - Enhancing existing data systems to support benefit management needs
 - Expanding access to Groups
 - Developing satellite opportunities for PROS programs to expand reach
 - Increasing programs offering Integrated Care including mental health, substance use, intellectual and developmental disabilities and physical health needs

Working with Providers and other State Agencies

Using PSYCKES to flag Medicaid recertification timelines

How care managers can support benefits navigation

Office Hours for providers and recipients of services

- **How to keep Medicaid while Earning Wages**

The NYESS team- from Benefits 101 to increasing Work Incentive Navigators

- **How to meet and understand work requirements**

- OMH and OTDA partnership
- OMH presentations and information dissemination
- OMH developing resources identifying qualifying work and volunteer opportunities

- **Working with Department of Health (DOH) to develop criteria for “disabling mental disorder” exemption criteria.**

- Analyzing how other states are defining this exemption criteria
- NYS is awaiting additional CMS guidance slated for June 1st, prior to finalizing

Resources

- [SNAP Work Requirements](#)
- [NY State of Health Support & Resources](#)
- [New Federal Changes Fact Sheet](#)
- NYESS Customer Resource Page <https://nyess.ny.gov/customer-information.html>

For More Information

<https://info.nystateofhealth.ny.gov/stay-connected>



Questions?



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