

Just and Equitable Behavioral Health for Immigrant New Yorkers: A Policy Agenda

*By the Health Policy Program
of the New York Immigration Coalition*

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*Produced with the support
of the van Ameringen Foundation*

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About the New York Immigration Coalition (NYIC)

The NYIC advocates for laws and policies to improve the lives of immigrants and all New Yorkers, particularly those that live in lower-income communities. We envision a New York State that is stronger because all people are welcome, treated fairly, and given the chance to pursue their dreams. Our mission is to unite immigrants, our 200+ member organizations, and allies so all New Yorkers can thrive.

About the NYIC Health Policy Program

The NYIC Health Policy program is dedicated to improving immigrant health by increasing access to health coverage and care and strengthening capacity within immigrant-serving community organizations to help overcome barriers to care.

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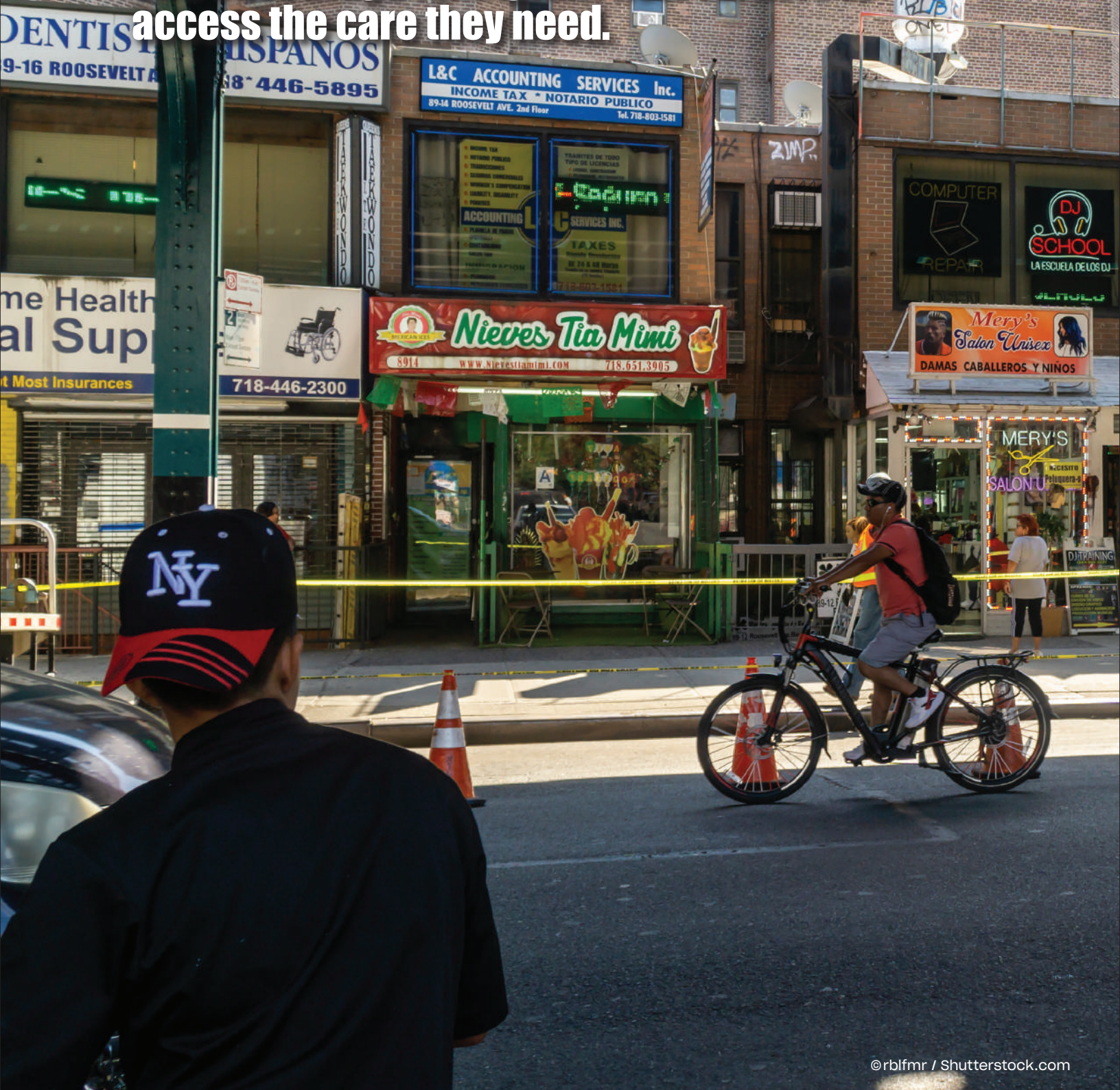
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This report specifies actions to strengthen New York City's behavioral health system and encourage immigrant New Yorkers to access the care they need.



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Executive Summary

Sociopolitical Moment

Starting with the announcement of his 2016 presidential campaign, Donald Trump's xenophobic rhetoric has prompted a culture of anxiety and fear among immigrants in the U.S. The Trump administration's anti-immigrant policies have compounded this anxiety. Stress from perceived threats and trauma from policy impacts have led to a behavioral health crisis among immigrants. This crisis has further strained a behavioral health infrastructure that already provided inconsistent and inadequate care to immigrant New Yorkers. In light of the compounding effects of current immigration and health policy on the well-being of immigrant New Yorkers, this report specifies municipal-level and state-level actions that can be taken to strengthen New York City's behavioral health service delivery system and encourage immigrant New Yorkers to access the care they need.

Recommendations

The report divides recommendations into four overlapping areas described in detail in the body of the report. The areas and recommendations are:

Building the Diversity of the Behavioral Health Workforce

- Support efforts to increase behavioral health professional opportunities in high-need immigrant communities
- Improve educational affordability by growing low-cost advanced degree programs at public institutions and implementing state-based behavioral health professional loan forgiveness programs
- Implement measures to engage and support New York's community health worker and peer specialist workforce
- Seek Mental Health Care Health Professional Shortage Area designations based on immigrant density in neighborhoods

The Right Services in the Right Places at the Right Times

- Include \$13 million in the FY2021 Executive Budget to extend Connections to Care and expand the program to more immigrant-serving and immigrant-led community-based organizations
- Support bi-directional community-based organization/clinical provider collaborations to support welcoming, comfortable, culturally humble services in both types of settings

- Develop Spanish-language versions of the New York State Office of Mental Health and Office of Alcoholism and Substance Abuse Services patient websites, and comply fully with Executive Order 26¹ by creating and promoting a comprehensive library of patient materials in top six languages spoken in the state
- Sustain and build the capacity of New York City schools to provide direct mental health support for students by investing in the Mental Health Continuum in 100 schools that serve immigrant students

Increasing System Capacity Through Financing and Resources

- Expand health insurance coverage to ineligible immigrants
- More faithfully enforce mental health parity laws
- Redistribute existing uncompensated care funds more equitably and increase the size of these funding pools
- Increase Medicaid rates for behavioral health services and safety-net hospitals
- Fully fund uninsured care programs
- Sustain and enhance municipal funding streams that support existing clinical service sites and other community-based organizations

Making People Feel Comfortable Seeking Services

- Expand citywide campaigns that increase recognition of behavioral health concerns and availability of services
- Incorporate cultural assessment into regular behavioral health practice
- Make Mental Health First Aid training available in more languages and in more places
- Convene a coordinated citywide faith-based task force on behavioral health for immigrant communities
- Provide funding for New York City public schools to recruit, assess language skills, and train bilingual and bicultural school guidance counselors to offer mental health education in non-English languages
- Support a New York City community mental health interpreter bank

Introduction

Sociopolitical Moment

Successive waves of immigration from across the globe have made New York City the place it is today. Whether because someone is fleeing poverty, seeking economic opportunity, or pursuing education, the process of navigating an unfamiliar environment or a new culture represents a profound adaptation. For individuals propelled on long and dangerous journeys because of civil unrest, persecution, or violence, there may be additional layers of loss and trauma that impact how they feel on a day-to-day basis. Once in New York, additional forces such as acculturative stress and discrimination can undermine immigrants' daily mental well-being. Even under the best circumstances, newcomers must navigate unfamiliar laws and service systems to access health care, find work, and enroll their children in school.

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Since his 2016 campaign launch, President Trump's anti-immigrant words and actions have created a culture of fear and anxiety among immigrants in the U.S. Trump has alluded to an immigrant "invasion" and "infestation";² has referred to immigrants as "criminals," "animals," "terrorists," and "rapists"; has falsely blamed immigrants for myriad social problems that he claims demand a crackdown on immigrants' rights;³ and has transparently rejected the principle of migrants' human rights and the nation's practice of welcoming refugees and asylum seekers.⁴

The Trump administration's anti-immigrant policies and threats have compounded the anxiety stemming from this xenophobic public discourse. These include, among many others, the systematic denial of asylum and refugee applications;⁵ Justice Department advocacy for indefinite detention of migrant children;⁶ a ban on immigration from many Muslim countries;⁷ a deliberate migrant family separation program;⁸ border agents shooting tear gas at migrant women and children;⁹ expansion of privatized immigrant detention centers with little oversight;¹⁰ and the mass incarceration and deportation of undocumented immigrants with no criminal record.¹¹

Previous research indicates a strong link between anti-immigrant policy and poor behavioral and physical health outcomes.

an association between immigration enforcement and poorer physical health outcomes (like low birthweight) and with poorer mental health outcomes (heightened distress, anxiety, and depression). Previous research has also found a link between immigration

Previous research indicates a strong link between anti-immigrant policy and poor behavioral and physical health outcomes.^{12,13} Studies from across the nation have documented

raids and adverse birth outcomes among infants born to Latina mothers,¹⁴ demonstrating the potentially life-long consequences of immigration-related health outcomes.¹⁵ Section 287(g) cooperation agreements between federal immigration authorities and state and local law enforcement enabled by the 1996 Illegal Immigration Reform and Immigrant Responsibility Act create situations in which simply undertaking activities of daily life places individuals and families at greater risk for detention or deportation.^{16,17} Focus groups conducted during the first year of the Trump administration showed a heightened sense of fear and uncertainty contributing to compounded stress among immigrant families in several cities around the country.¹⁸ Providers working with Central American migrants along the U.S.-Mexico border have identified depression as the single most prevalent health problem they confront.¹⁹

The Trump administration's attempts to strip immigrants of their status and restrict their access to social programs have exacerbated the trauma and stress caused by such policies. The administration has sought to terminate the Deferred Action for Childhood Arrivals and Temporary Protected Status programs, through which more than one million immigrants qualify for work authorization, protection from deportation, and health coverage in some states, including New York.²⁰ The administration has also sought to change existing "public charge" rules to prevent families that use basic public benefit programs from becoming permanent residents, thereby discouraging tens of millions of eligible immigrants from using social programs that ensure health coverage for pregnant women, nutrition assistance for children, and affordable housing for low-income families, among other benefits.²¹ Building on the use of administrative rulemaking as a tactic to bypass Congress and implement ever-harsher anti-immigrant policy, the administration has further attacked immigrants' access to the social safety net by proposing a rule to evict mixed-status families from public housing and issuing a memo directing federal agencies to enforce sponsor liability and sponsor deeming policies that make it more difficult for immigrant families to be eligible for and use needed public benefits.

New York City (NYC) and New York State (NYS) have at times responded to federal attacks on immigrant families by enacting local and state laws to protect families, including limiting police collaboration with Immigration and Customs Enforcement. NYC and NYS have also affirmed the key role of immigrants in New York's social and economic fabric by investing in immigration legal services,²² access to higher education for undocumented New Yorkers,²³ and access to health care services.²⁴

Despite these efforts, the broader sociopolitical context nonetheless has a considerable impact on the wellbeing of immigrant New Yorkers and underscores the need for an accessible behavioral health service system. NYC has a rich network of health care and social service providers, and is a hub of behavioral health service innovation. Billions of dollars in delivery system redesign resources flow into health care organizations, in part to better integrate mental and physical health services. Despite the wealth of training

and expertise, it is often very difficult to get needed mental health care services. The full range of services available in NYC is sharply constrained for patients who depend on publicly-financed insurance, and even more for uninsured patients. Getting an appoint-

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ment with a therapist can take months, and finding a psychiatrist or someone who provides a specific type of therapy or service can be prohibitively difficult. Primary care providers in safety net settings report that limited time and capacity often prevent them from making referrals for specific therapeutic approaches (e.g., cognitive behavioral therapy). The frequent need for services in languages other than English further complicates access. Even when those services are available and affordable, community members may believe that they do not exist, will be unavailable to them, or will bring immi-

gration enforcement-related consequences. The launch of the NYC Care program for uninsured New Yorkers in August 2019 was an important step forward, but it remains to be seen whether this translates into more readily available mental health services.

The size of the affected population underscores the urgent need to address the access crisis. NYC is home to 3.1 million immigrants who comprise approximately 38% of the city's total population.²⁵ Approximately 54% of immigrant New Yorkers are naturalized U.S. citizens. NYC is also home to approximately 477,000 undocumented immigrants who are categorically barred from public insurance.²⁶ Immigrants face a set of concerns that severely limit their access to needed care. Federal policies that exclude immigrants from public benefit programs based on immigration status, combined with the toxic environment described here, cause many immigrants to have a limited understanding of their right to behavioral health care, including counseling and treatment services. Safety-net patients who participated in focus groups with the NYIC on health access and quality report that racism and discrimination, the stigma of being undocumented and uninsured, and the lack of culturally responsive services add further barriers.^{27, 28}

Structure and Purpose of the Roundtables and Report

Given the current environment and persistent reports by NYIC members of an increasing demand for behavioral health services in immigrant communities, we designed a structured process to seek input from key stakeholders on how to improve access to behavioral health services for immigrant New Yorkers through policy change. The main data collection mechanism was a series of five roundtable meetings held between May 2018 and May 2019. A detailed list of the roundtable participants and the structure of the process are included in [Appendix A](#). Based on consultation with the roundtable participants, we also conducted key informant interviews to fill gaps and deepen knowledge on certain

issues that arose in the roundtables. This report is the culmination of the meetings and interviews, and includes specific and actionable policy recommendations to be used by the NYIC, our member organizations, and other allied groups to conduct advocacy to improve access to behavioral health services for immigrants in NYC.

The capacity to carry out this process was supported by a grant from the van Ameringen Foundation. This project and its results build on previous work by many organizations to tackle the persistent difficulties that immigrant New Yorkers face in accessing behavioral health services. In particular, we acknowledge the Asian American Federation of New York's 2017 report *Overcoming Challenges to Mental Health Services for Asian New Yorkers*²⁹ as a model for incorporating the input and expertise of multiple stakeholders.

This report is designed to help organizations that want to promote programs and policies to increase access to behavioral health services and coverage for immigrants in NYC. The statewide focus of the NYIC's work and membership, and the fact that many health system changes can only be implemented by the state, mean that some of our recommendations are state-level even though the specific focus of the report is NYC. To facilitate the process of developing geographically-specific behavioral health advocacy agendas, we indicate in [Appendices B and C](#) which recommendations are targeted at NYC government and which are state-level.

The challenges to improving access to behavioral health services for immigrant New Yorkers are complex and cut across the health care system and the communities the system is designed to serve. Some of the challenges are specific to behavioral health services, while others are symptomatic of the broader system of care or the social determinants of health — including immigration status and access to safe housing, food, education, and economic stability — that are not health services-related but have an outsized impact on health care access and outcomes. Some are specific to immigrant communities and immigration status, while others reflect system shortcomings for all low-income communities irrespective of status. In an attempt to make these multifaceted and overlapping challenges more digestible, we identified through the roundtable process four broadly conceived buckets in which to group our recommendations. The four interlocking and equally important areas, explored in detail for the rest of this report, are:

- building the diversity and capacity of the behavioral health workforce;
- the right services in the right places at the right times;
- increasing system capacity through financing and resources; and
- making people feel comfortable seeking services.

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Building the Diversity and Capacity of the Behavioral Health Workforce

Throughout the project, roundtable participants and key informants underscored the fact that closing gaps in quality and access requires a diverse, culturally responsive workforce. Although this is a broad, complex goal involving numerous institutions across multiple sectors, we highlight key steps that NYC and NYS can take to foster this. In this section, we outline proposals aiming to increase immigrant New Yorkers' access to behavioral health services by broadening, deepening, and further diversifying the population of people providing these services.

Current Gaps

NYC — and immigrant NYC, in particular — is witnessing a critical staffing shortage across its behavioral health workforce. NYIC members and partners consistently report that finding behavioral health providers who speak languages other than English can be nearly impossible. Additionally, many New Yorkers live in Mental Health Care “Health Professional Shortage Areas” (HPSAs) — regions that collectively encompass almost five million New Yorkers.³⁰ These designations don't include factors like immigrant density and language access needs in neighborhoods.³¹ Indeed, large swaths of New York's high-density immigrant neighborhoods — including several served by roundtable attendees — do not have HPSA designations,³² suggesting an understatement of the scope of staffing gaps and challenges for immigrant New Yorkers.

The roundtable process highlighted the need for more providers who represent New York's immigrant communities to improve provision and quality of service for those communities. Multiple participants in the roundtable process affirmed the importance of patients receiving behavioral health services from providers who understand their cultural context and speak their preferred language.

Improvements in methods of offering language access and strengthening the cultural humility of all providers are important, but it is especially critical to increase the diversity of the workforce in behavioral health. While interpretation is an appropriate access facilitator, use of interpreters in some behavioral health settings can inhibit providers from establishing trust with their patients or fully understanding the nuances of issues frequently explored in therapy.³³

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Expanding first- and second-generation immigrant representation in New York’s behavioral health workforce requires a multi-pronged effort sustained over many years, accounting for the barriers immigrants currently face in entering and building a successful career in these fields, particularly in education. These efforts must begin in early grades by adding careers in behavioral health to the list of professional pathways that school-aged children are encouraged to pursue. Workforce challenges cannot be fully addressed without considering the cost of higher education, the need for support and mentorship, and other supports for young people interested in careers in social work, psychology, psychiatry, or addiction treatment. Immigrant New Yorkers have been indirectly affected by the national crisis in the rising cost of public university education, where higher education costs and student loan debt have steadily risen over several decades. Applications for federal student loan forgiveness are currently rejected at a 99% rate,³⁴ highlighting the need to guarantee accessible eligibility criteria for state-based student loan forgiveness programs to all New Yorkers. Although NYS recently took an important step forward in supporting undocumented students by passing the José Peralta New York State DREAM Act, prospective behavioral health professionals continue to need a variety of supports to successfully build careers caring for New York’s diverse communities.

Existing Assets

An important potential pathway for newly trained clinicians is New York’s Mental Health Service Corps (MHSC) — a key initiative of ThriveNYC initially led by the NYC Department of Health and Mental Hygiene (NYC DOHMH) and the City University of New York (CUNY) that is transitioning to be led by NYC Health + Hospitals (H+H) starting in 2020. Prior to the recent shift, MHSC identified, trained, and placed in community-based organizations (CBOs) early-career behavioral health clinicians, with the goal of increasing access to holistic, evidence-based behavioral health care in New York’s communities “where it is needed most.”³⁵ The MHSC program was first implemented in 2015, with each program participant’s course of training and service to run three years³⁶ (though retention of staff has been a reported issue for the program).³⁷ The program premise is consistent with existing evidence-based approaches toward effective incorporation of culturally responsive clinicians in behavioral health settings.³⁸

NYC is the home of several federally-funded programs for innovative and evidence-based behavioral health training programs in New York HPSAs. A number of programs funded federally by the Health Resources and Services Administration (HRSA) are specifically tailored toward training programs (e.g. the Graduate Psychology Education Program grant)³⁹ that equip organizations to provide frontline mental health services to diverse populations. For example, Callen-Lorde, a federally qualified health center (FQHC), has a Graduate Student Training Program that aims to provide social work and psychology students with training in culturally responsive behavioral health care in a clinic primarily serving NYC’s LGBTQ population.⁴⁰

Another critical avenue for improving the capacity of the workforce to meet the needs of immigrant communities is to support community health workers (CHWs) and peer support specialists to improve access and quality in behavioral health. One innovative practice is “task shifting” of routine responsibilities (e.g. screening or psychoeducation) from clinically trained providers to personnel with less training such as case managers, staff at CBOs, and CHWs.

NYS has several local networks of CHWs, including the Community Health Worker Network of New York City, a long-standing coalition of CHW groups that have advocated measures advancing sustainable careers for CHWs and financing for the work CHWs perform. Members of the roundtable also identified these as important potential pathways to improve system capacity in a sustained manner. CHWs are frequently hired through short-term grants that inherently limit CHW job security and the sustainability of CHW interventions.⁴¹ Additionally, CHW reimbursement is frequently limited to payment schemes that compensate for a limited range of services, such as provider referrals for patients, that do not fully encompass the range of interventions CHWs provide.⁴² The lack of NYS certification for CHWs is a further barrier which New York CHWs have highlighted through the years.^{43, 44}

A critical avenue for improving the capacity of the workforce to meet the needs of immigrant communities is to support community health workers and peer support specialists to improve access and quality in behavioral health.

Peer support specialists are also a critical segment of the behavioral health workforce. NYS offers avenues for individuals with lived experience in the mental health system to work in mental health and human services. Training and certification are accessible through the Academy of Peer Services Virtual Learning Community⁴⁵ and New York State Peer Specialist Certification Board.⁴⁶ Organizations like Community Access also offer the “Howie the Harp” training program, which prepares individuals with lived experience in the mental health system for a variety of roles in the human services field. Family and youth peer advocates are also a vital part of the mental health service system with their own training and certification processes. Family Peer Advocates are credentialed through Families Together of NYS and provide support to parents/caregivers of children and youth with social, emotional, developmental, substance use, and/or behavioral challenges. Youth Peer Advocates support the youth themselves and have a new credentialing process through Youth Power.⁴⁷ These approaches leverage the expertise of individuals with mental health diagnoses, create pathways to self-sufficiency for individuals managing challenging diagnoses, and enhance the quality of mental health services. However, there are limited pathways to peer support careers in languages other than English.

POLICY RECOMMENDATIONS

Support efforts to increase behavioral health professional opportunities in high-need immigrant communities

The Mental Health Service Corps (MHSC) contributes to the principle that people from immigrant communities can most effectively provide behavioral health interventions in their communities. However, low recruitment and retention of MHSC staff with appropriate cultural responsiveness and language ability have been cited by the NYC DOHMH as a barrier to the program's success.⁴⁸ CBOs have expressed similar concerns. Measures should be taken to recruit and retain MHSC members with appropriate competencies, including immigrant New Yorkers who are members of the communities they aim to serve.

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There has been limited evaluation to date of the impact of the MHSC, a fact that was highlighted during ThriveNYC's preliminary hearings on the FY2020 city budget.⁴⁹ Officials may ultimately be persuaded to increase

MHSC funding if research is carried out demonstrating the effectiveness of the program's interventions on factors such as increased provider diversity, patient satisfaction, and mental health outcomes. The wealth of rigorous, existing studies on the impact of cultural competence on these outcomes might serve as a basis for MHSC evaluation design.⁵⁰ Ongoing evaluation of other ThriveNYC initiatives, like Connections to Care (C2C), discussed in greater detail below, may also serve as a model.⁵¹ The changes announced as part of the FY2020 budget agreement, including a restructuring of the program to be coordinated by H+H, may help resolve some of the oversight issues that hearings have identified. In spite of these growing pains, efforts like the MHSC should be supported and structured in such a way as to increase opportunity for immigrant New Yorkers while providing appropriate oversight to early-career clinicians that expands the capacity of the behavioral health service system in immigrant communities.

Improve educational affordability by growing low-cost advanced degree programs at public institutions and implementing state-based behavioral health professional loan forgiveness programs

The fundamental cost barriers to higher education in NYC, NYS, and the US overall are intractable problems that require broad systems-level change like tuition-free education. A full accounting of educational barriers is beyond the scope of this report, but in the immediate term NYC and NYS should grow low-cost advanced degree programs at CUNY and the State University of New York (SUNY), and expand state-based loan

forgiveness programs. These steps would mitigate some of the symptoms of the current crisis and increase access to affordable clinical behavioral health careers for low-income New Yorkers.

The CUNY and SUNY systems collectively offer at least six clinical psychology programs, but interest (based on number of applications) far surpasses capacity and makes it extremely difficult for many people to access these relatively low-cost public systems. Investing in expansions of these programs would be an investment in the ability of low-income and immigrant community members to pursue clinical behavioral health careers.

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For those who have completed degree programs, there are federal National Health Service Corps loan forgiveness programs tailored to behavioral health clinicians, but they only cover federal loans with legal status requirements that automatically exclude many immigrant New Yorkers.⁵² However, there are a range of existing state-based loan forgiveness models for behavioral health professionals — accessible regardless of status — that NYS could implement to improve upon existing loan forgiveness policies. These would facilitate pursuit of clinical behavioral health careers by all New Yorkers, including many immigrants.

As of 2019, NYS' only loan forgiveness program for clinicians who work in behavioral health covers licensed social workers (LSWs).⁵³ The program applies broadly to LSWs working for five years in “critical human service areas” and is not tailored to behavioral health. NYS loan forgiveness programs could be tailored for clinicians with behavioral health training or employment in behavioral health settings as other states have done. Texas has implemented student loan forgiveness programs for behavioral health clinicians based upon employment in facilities delivering behavioral health services (like an FQHC within a HPSA) for a fixed period of time.⁵⁴

Also following on other states, and after many years of advocacy, the passage of the DREAM Act in New York opened up state financial aid to all New Yorkers, regardless of immigration status.⁵⁵ However, the limited scope of existing NYS loan forgiveness programs means immigrant New Yorkers are less likely to take on a loan to pursue a career in behavioral health than they otherwise would. To remedy this, NYS should expand the range of loan forgiveness programs for behavioral health clinicians beyond LSWs, as several other states have,⁵⁶ to include psychiatrists, psychologists, advanced practice nurses with board certification in psychiatric or mental health nursing, licensed marriage and family therapists, and licensed chemical dependency counselors.

Implement measures to engage and support New York's community health worker and peer specialist workforce

CHWs in NYS and their allies have advocated for decades to highlight the effectiveness of CHWs in health care broadly, and for mechanisms to facilitate career opportunities. Nevertheless, New York's CHW workforce continues to face critical obstacles. One barrier that CHWs and advocates have stressed and that was emphasized several times during the roundtable process is the lack of mechanisms in NYS for sustainable CHW employment. CHWs are often employed on fixed-term grants and reimbursements are limited, as previously described.

CHW employment constraints may be limiting immigrant New Yorkers' access to effective, evidence-based CHW interventions, particularly in behavioral health care, where emerging evidence points to the effectiveness of CHW interventions.⁵⁷ Programs in chronic and behavioral health care like City Health Works in Harlem and the Family Van and Vinfen programs in Boston speak to the successful replicability of CHW interventions in clinical settings in urban environments.⁵⁸ Even within their traditional roles of helping patients navigate physical health care services, CHWs could be powerful allies in conducting screening and psychoeducation, and linking individuals with undiagnosed anxiety or depression to appropriate behavioral health services.

NYS should follow the lead of other states and include Medicaid reimbursement for additional CHW services in a future Medicaid Section 1115 waiver application. Massachusetts and California have requested such waivers in order to finance CHW interventions.⁵⁹ The waivers targeted physical health interventions but waiver applications could also be submitted for behavioral health programs.

Other states, including New Mexico and Michigan, have addressed an increased role for CHWs by requiring managed care organizations to maintain minimum ratios of CHWs in their networks, allowing CHWs to be employed in a longer-term capacity.⁶⁰ NYS should consider the same.

Another option that has been explored is formal certification of CHWs, as a means of establishing standards for the scope of the CHW profession and, under current rules, as a necessity for obtaining Medicaid reimbursement, which requires training, certification, and a clearly-defined scope of practice.⁶¹ New York CHWs have voiced both philosophical and practical concerns about the potential costs of professionalizing community health work. If certification efforts were to advance, they must include a free training component (such as those offered by Make the Road New York)⁶² and application (as in states like Texas),⁶³ and be accessible to New Yorkers of various linguistic backgrounds, legal statuses, criminal justice involvement histories, and medical knowledge bases. The New York CHW community has also stressed a need for certification that builds on CHWs' basic competencies as community liaisons and not simply as a didactic exercise in medical training.⁶⁴

A possibility for addressing the above concerns while meeting reimbursement requirements for defining the CHW scope of practice is to make training and certification of CHWs voluntary — as in states like Florida, Arizona, and New Mexico — and to include “grandfather” provisions in certification models, which recognize the contributions and strengths of those who have been working as CHWs for years and for whom certification might not be desirable or accessible due to linguistic, economic, and other barriers.⁶⁵

Additionally, peer support specialists are pillars of mental health and substance use service provision. Whereas CHWs are typically more focused on physical health, peer support specialists excel at supporting individuals with behavioral health diagnoses in navigating care and treatment. Unlike CHWs, peer specialists receive certification through the New York State Peer Specialists Certification Board, which is supported by the NYS Office of Mental Health (NYS OMH). Peer specialists bring to bear their lived experience with mental illness and treatment in their work with patients. Additional resources to enable limited English proficient (LEP) New Yorkers to receive peer specialist training would dramatically enrich quality and accessibility for LEP immigrants suffering from mental illness. Specifically, NYS should allocate resources to conduct outreach on peer specialist training initiatives to LEP communities, and determine if there is a need to create translated training modules on the Academy of Peer Services Learning Community Website.

Additional resources to enable limited English proficient New Yorkers to receive peer specialist training would dramatically enrich quality and accessibility for LEP immigrants suffering from mental illness.

Seek Mental Health Care Health Professional Shortage Area designations based on immigrant density in neighborhoods

HRSA’s Mental Health Care HPSA designations are used to identify areas with insufficient numbers of mental health professionals. The designations are used as a basis to determine locations of FQHCs, which can be awarded HRSA grants for behavioral health programming. Typical Mental Health Care HPSA designations evaluate standard national data sets based on several factors, including population to provider ratio; percentage of the population below 100% of the Federal Poverty Level (FPL); travel time to the nearest source of care outside the HPSA; elderly ratio; youth ratio; alcohol abuse prevalence; and substance abuse prevalence.⁶⁶

Existing HPSA designations leave out many NYC immigrant neighborhoods. This may in part be because designations ignore factors like immigrant density. The NYS Department of Health (NYS DOH) should request that HRSA use an alternative HPSA formula to more accurately reflect the substantial needs of immigrant New Yorkers. This would require the



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NYS DOH to submit additional demographic and health data to HRSA highlighting behavioral health needs and workforce shortages in New York's immigrant communities.

A HPSA designation formula including considerations like immigrant density in neighborhoods and language access needs could expand the range of FQHCs in New York eligible for HRSA grants, which could in turn fund evidence-based behavioral health programs. These, in turn, would increase immigrant New Yorkers' access to behavioral health services. If alternative HPSA designation requests are successful, the NYS DOH should follow the example of other states, such as the Minnesota Department of Health, by informing providers in new HPSAs about available HRSA funding opportunities.⁶⁷

The Right Services in the Right Places at the Right Times

A second focus of the roundtable discussions was how to ensure that the full breadth of behavioral health services are accessible to all NYC residents. This is essential both when there are opportunities for prevention as well as when individuals and families are managing more acute moments of crisis or trauma. Immigrant communities benefit when behavioral health services are integrated into settings in which they already feel comfortable and welcome. The success of medical-legal partnerships like Terra Firma and LegalHealth's hospital-based services provide potential models for co-locating behavioral health services or linkages in settings where immigrants seek legal services, take classes, or enroll in benefits.

Adult Counseling and Psychiatry Services

Immigrants in NYC access behavioral health services in H+H ambulatory care settings, through neighborhood primary care providers, in Article 28, Article 31, and Article 32 facilities, and in CBOs. Although having Medicaid or the Essential Plan can expand the number of options available to enrollees, many behavioral health services providers limit the types of insurance they accept. The fact that many private practitioners do not take insurance at all contributes to restricted access by limiting the time and availability of providers who do accept insurance, especially publicly-financed coverage. Even as meaningful steps have been put in place to link people to behavioral health services, barriers may prevent them from finding the services that would be best for them. Based on our conversations with individual clinicians, we conclude that an uninsured patient who needs couples therapy, anger management therapy, or cognitive behavioral therapy might not be able to receive those services in a timely manner.

Some immigrants access behavioral health services through their primary care providers in health centers or ambulatory care settings with a collaborative care structure,

which supports a team-based approach to primary care and behavioral health services.⁶⁸ These services might be enough for some individuals who benefit from medications for illnesses like depression, anxiety or substance use disorders. Individuals who

Individuals who prefer therapy or who have more persistent or complex needs may encounter barriers in finding a psychiatrist or other therapist to support their treatment.

prefer therapy or who have more persistent or complex needs may encounter barriers in finding a psychiatrist or other therapist to support their treatment. Uninsured New Yorkers are much more dependent on providers in safety-net settings like H+H and often experience months-long waits for an appointment. Anecdotes from providers and patients suggest to us that in some cases they may be offered medication management instead of therapy. If they have Medicaid there may be more options for referrals through a primary pro-

vider, but even with insurance there can be long delays for new appointments. Successfully being referred often depends on the capacity of a primary care provider to advocate for their patient and their knowledge of existing resources.

Administrative and clinical procedures within health centers or hospital networks may also create barriers. It is important for health care providers to ensure that preventive and more urgent mental health services are available to patients seeking support for a variety of stressors. Use of screening tools to determine whether therapy is indicated may have the unintended consequence of triaging out patients who could still benefit from services. One key informant described the case of a highly distressed woman in an H+H clinic setting whose therapy referral from her primary care doctor was declined because her PHQ-9 score for depression was not high enough. Ideally, there would be a baseline set of supports available to anyone seeking services regardless of scales.

Substance Use Treatment

There are multiple pathways to substance use services, including through emergency departments, referral from a primary care physician, NYC Well, NYS Office of Alcoholism and Substance Abuse Services (NYS OASAS) websites, and through word of mouth. However, there are important gaps affecting immigrant communities. Although handouts and brochures are translated into Spanish and several are also offered in Chinese, the majority of the consumer information on the NYS OASAS websites is only available in English.^{69,70} NYS OASAS funds a percentage of net deficit funding to treatment providers who accept funding from the agency, and no individual seeking services may be turned away based on ability to pay. NYS OASAS will intervene if someone is declined services. In practice, however, people seeking treatment may not know of these guarantees or may still encounter barriers. Key informant providers report that self-pay patients are frequently unable to access services because fee scales are prohibitive.

Language access is another critical challenge. Gaps are especially pronounced for substance use treatment programs. One provider noted to us that finding language-accessible detox for Chinese speakers is virtually impossible.

Substantial progress has been made by NYC and NYS in linking residents to substance use services through primary care. The capacity of primary care doctors to prescribe buprenorphine in their offices is an important facilitator of access. However, the requirement to apply for a waiver, take a certain number of hours of waiver classes from the US Drug Enforcement Administration, and the limit on the number of patients that providers may see in order to prescribe medications create multiple barriers to treatment and bottlenecks for patients seeking services. Separately, office-based addiction treatment is not available to individuals who are prescribed methadone, who must travel to a clinic to receive treatment.

Child and Adolescent Services

Immigrant children experience a range of challenges related to their own migration and the impact of adjusting to a new place. Given the increase in interior immigration enforcement, the publication of the final “public charge” rule, the volume of news on family separation at the border, and the well-established link between trauma and poor physical and mental health outcomes, creating access to the right services for immigrant children is critical. Conversations with parents reinforce concerns of stress among young people in the current political moment, especially for those living in mixed-status households. There is an immediate need to increase capacity for services in clinical, community, and school settings. We heard particularly wrenching accounts from mothers in two households who reported that their teenage children and their friends are suffering acute stress because of immigration concerns. In these cases, there was nowhere for the young people to seek services in their neighborhoods, and their mothers were concerned about their children and their friends’ potential for substance use as a coping strategy.

We heard particularly wrenching accounts from mothers in two households who reported that their teenage children and their friends are suffering acute stress because of immigration concerns.

Models like Terra Firma — a collaboration of clinicians from Montefiore Medical Center, the Children’s Health Fund, and Catholic Charities — successfully offer holistic, trauma-informed, family-based care to young people who came to the US as unaccompanied minors and their families.⁷¹ Despite the success of this model, there is no immediate vehicle for scaling up and incorporating elements of this approach into broader, less-specialized services available to immigrant children throughout NYC.

Immigrant children in NYC get mental health care in pediatric and adolescent clinic settings, in specialized mental health clinics targeting children and families, and in school health settings. In addition to direct mental health services, schools and agencies with a mission to serve children also provide training and orientation to all school staff on the impact of immigration policies on individual students and families.

Direct mental health services are available to immigrant students in a fraction of NYC public schools that have health clinics. A limited number of schools have Article 28 school-based health centers with mental health services. Child advocates have expressed concerns about the sustainability of these centers with current financing options. These clinics can bill Medicaid for services, but this funding stream does not support services to all students in these schools. Article 31 school-based mental health clinics, regulated by the NYS OMH, and run by some community health providers, also struggle with sustainability and resource issues. While some schools have NYC Department of Education (NYC DOE) social workers, their services are generally limited to students with Individualized Education Plans, which provide mandated services to young people with special needs. Child advocates note that school psychologists and guidance counselors may be precluded from providing mental health services because of testing and administrative responsibilities.

Direct mental health services are available to immigrant students in a fraction of NYC public schools that have health clinics.

In 2017, there were 1,183 social workers citywide, at the time working out to 900 students per social worker.⁷² The National Association of Social Workers recommends 1 social worker to 250 general education students, and a 1-to-50 ratio when serving students with intensive needs.⁷³ Starting in FY2020, the City will add 285 new social workers (including 85 licensed clinical social workers that were newly baselined but funded previously) through Thrive NYC to better support students facing emotional distress.⁷⁴ The City Council and advocates have recommended that the City invest in direct social and emotional supports for

students while hiring more social workers and guidance counselors, as well as by establishing a Mental Health Continuum to provide direct mental health services to students with advanced behavioral needs.

Children in immigrant families also benefit from programs of the Office of School Mental Health (SMH), a collaboration of the NYC DOHMH and NYC DOE. Using a three-tiered public health model, NYC SMH programs include the School-based Mental Health Consultant program, the Community Schools Initiative (which pairs certain schools with a lead CBO and facilitates access to mental health service providers), the School Mental Health Prevention and Intervention Program (which offers three tiers of mental health services to selected schools with support from community-based mental health providers), and the 100 Schools Project, a collaboration with several NYS Delivery System Reform Incentive Payment Program Performing Provider Systems, and school-based health clinics. By

having services onsite, providers act early and prevent mental health issues from becoming major challenges to youth and their families. The NYC DOHMH also funds children's mobile crisis teams that respond to children in schools and other community-based settings. Advocates note that at the time of writing this initiative has not yet fully launched.⁷⁵

Although the focused coordination and leadership of two key city agencies represents a critical resource in meeting the mental health needs of immigrant students, child advocates remain concerned that the students who need help the most are not receiving all the direct mental health services and behavioral supports they need. There is concern among advocates that the School-based Mental Health Consultant program and the 100 Schools Projects of ThriveNYC are not the most strategic use of resources. Consultants serve 10 schools each and 100 Schools Project staff provide input on conducting assessments, setting up referrals, and training for teachers and staff. This prevention program aims to build capacity for schools to address mental health issues, decrease stigma, and change the culture of the schools. Child advocates maintain that these investments in clinically-trained mental health professionals should be allocated to expanding direct services for students who desperately need them.⁷⁶

Child advocates have also noted the vulnerability for children when mental health services bring them into contact with law enforcement. Specifically, in some cases, children with behavioral health issues are sent to local emergency departments for assessment. We heard from clinicians about instances in which children are mixed with the adult patient population in these settings.⁷⁷ To address this problem, H+H/Metropolitan has initiated a two-part program to change the assumptions around — and outcomes of — teen behavioral health care. The first part standardizes the emergency triage process to route behavioral health referrals that are not psychiatric to general pediatricians and ensure that any assessment of children takes place in areas exclusive to children. The second part addresses the flow of youth behavioral health referrals. It offers group leadership coaching opportunities for teens in local schools and works with CBOs to act on youth behavioral health challenges. The initiative could serve as a model for other health care facilities.

Services for Elders

Although we did not have an opportunity to systematically explore services for immigrant elders through the roundtables, it is important to note that immigrant elders are at higher risk for linguistic and social isolation and mental health challenges associated with aging in an unfamiliar place. Cultural and linguistic differences may also impede appropriate care for immigrant elders with dementia. As roundtable members noted, mental health services are not well-oriented to

Mental health services are not well-oriented to elderly people in general, and elders with language barriers may be especially vulnerable to suffering without support.

elderly people in general, and elders with language barriers may be especially vulnerable to suffering without support. Organizations like India Home provide culturally responsive and linguistically accessible services and need support to address mental health challenges in their communities. Another potential model is the CMS-sponsored PACE (Program of All-Inclusive Care for the Elderly) Program, which aims to support the elderly in their homes through multidisciplinary teams that include mental health providers.⁷⁸

Promising Advances in Community-based Mental Health Services

CBOs are another important setting in which immigrants receive mental health services. CBOs created to serve the needs of specific immigrant communities often are culturally responsive and trusted as the first stop for information and services. CBOs typically assist clients with housing referrals, health insurance enrollment, screening for other public benefits, legal and immigration services, adult education, food pantries, and health promotion and education. They are often staffed by members of the community they serve and have an enhanced capacity for cultural humility and responsiveness. In some cases, CBOs have been able to offer mental health services onsite by partnering with another health care provider or engaging a mental health professional to serve on staff, though it can be very challenging for non-Medicaid billing organizations to sustain these collaborations. Although some CBOs are capable of complying with NYS OMH regulations, they may encounter barriers in contracting with Medicaid Managed Care Organizations (MCOs) carriers. Because of changes to managed care, providers must now have contracts with multiple MCOs, each with their own billing process, utilization review, rates, and rejections.

One important potential model to leverage the expertise and reach of CBOs is the Connections to Care program (C2C), which pairs CBOs and clinical service providers to “address the needs of participants along a chain of care, and improve mental health

One important potential model to leverage the expertise and reach of CBOs is the Connections to Care program.

and social service outcomes for low-income participants.”⁷⁹ C2C links CBOs with a direct referral partner or in some cases co-locates mental health services onsite at the CBO. It also recently expanded to 10 Jobs-Plus sites for residents of New York City public housing. All CBO staff are trained in a variety of mental health strategies including screening for common mental health challenges, motivational interviewing, mental health first aid, and psychoeducation. Staff have incorporated

mental health and substance use screenings into their general intake processes and have taken on tasks that in the past would only have been performed by a clinician. This frees up more time for clinicians to work with clients who have more severe mental health challenges. The executive director of a CBO participating in C2C noted that the program dramatically broadened the way staff think about mental health. She observed that staff in

her organization are more patient with client needs and challenges and that motivational interviewing has been incorporated into management practices. Other participating CBOs noted that there is high demand for ongoing trainings.

C2C also has challenges for participating CBOs. Not every collaboration has yielded seamless access to mental health services because some clinical partners have much more linguistic capacity and staff than others. One organization noticed that once they started screening people, they uncovered more need for trauma-informed work than they could deliver. All participating organizations interviewed expressed a desire to have full-time mental health providers onsite. Required reporting in multiple databases placed a substantial administrative burden on participating CBOs. If the speed of implementation and uptake within the organization does not align, there may be challenges for the CBO to incorporate a new area of practice. Participation in the project also created new challenges, in one case generating vicarious trauma for CBO staff. C2C would be more sustainable if reporting could be streamlined and implementation could be tailored to the specific context of each participating organization.

POLICY RECOMMENDATIONS

Include \$13 million in the FY2021 Executive Budget to extend Connections to Care and expand the program to more immigrant-serving and immigrant-led community-based organizations

More CBOs should be given the opportunity to offer mental health services through co-location, supervision, staff training, and technical assistance. C2C has been financed with support from private funding through the Mayor's Fund. Based on conversations with immigrant-serving organizations that participate in C2C, we conclude it has been a critical means to expand and destigmatize mental health services among hard-to-reach immigrant communities. C2C should be baselined in the Mayor's Executive Budget rather than its current pilot status, with an expansion to new sites whose primary mission is to serve immigrant communities. Administrative and design adaptations described above should be incorporated into the expansion.

Support bi-directional community-based organization/clinical provider collaborations to support welcoming, comfortable, culturally humble services in both types of settings

The scope of need and the immediacy of the mental health crisis emerging from the federal policy environment mean that CBO-based services cannot be the only avenue to improve access and quality in this moment. We hear innumerable reports from our members about the difficulty their clients have in finding services, leading us to conclude that expansions and improvements to both mental health clinic settings and CBOs are

essential. We propose a funding mechanism to incentivize the incorporation of CBO expertise into services across NYC. CBOs need clinical services, supervision, and expertise to participate in mental health service provision. Behavioral health clinics can benefit from CBO expertise and work in providing culturally humble social services to low-income, racially and ethnically diverse, immigrant or LEP populations. A funding initiative that incentivizes a broad range of partnerships between mental health service providers and CBOs with expertise in particular immigrant communities would be ideal for the Mayor's Fund, especially if the City commits to baselining C2C in the Executive Budget.

Develop a Spanish-language version of the New York State Office of Mental Health and New York State Office of Alcoholism and Substance Abuse Services patient websites, and patient materials in top six languages spoken in the state

Both the NYS OASAS and NYS OMH websites have a wealth of consumer information on treatment, prevention, recovery, and services, but almost all content is exclusively in English. Although there is a library of brochures that are translated into Spanish and a few materials are in Russian and Chinese, much of the consumer-targeted information on both agency websites is only in English. This represents a missed opportunity to disseminate information to immigrant communities on mental wellness, substance use issues, and prevention in both areas. Using the New York State of Health (NYSOH) website as a model, pages with consumer-focused content should have both English and Spanish versions. Prominent top-line labels should guide users to a library of material in the top six languages spoken in NYS.

Sustain and build the capacity of New York City schools to provide direct mental health support for students by investing in the Mental Health Continuum in 100 schools that serve immigrant students

As part of the FY2020 budget, the city allocated \$36.4 million for 200 new and 85 newly-baselined social workers for high-needs schools. This included funding that was reallocated from ThriveNYC to create a new unit of 85 licensed clinical social workers to better support students facing crises and to reduce the need for school staff to call emergency services. It also included \$14.8 million for 115 new (non-Thrive) social workers, as well as allocations for "Bridging the Gap" social workers to work with children living in the shelter system. Monitoring implementation of these hires to ensure that these commitments translate into interventions reaching immigrant students remains a top priority. This is a good first step, but much more work remains to be done. In particular, the City should invest in a Mental Health Continuum involving school partnerships with hospital-based mental health clinics, school response teams, and whole-school training to guarantee the Mental Health Continuum so students who need the most help receive direct mental health supports to stay in school.



The single most significant action New York State can take to improve financial access to behavioral health services is to create a system of universal coverage.

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Increasing System Capacity through Financing and Resources

The third broad area of improvement identified in the roundtable process is to inject more financial resources into the behavioral health care delivery system while more equitably distributing existing funding. Some of our proposals create new revenue streams; others build upon existing programs at the municipal, state, and federal levels designed to facilitate access to care for immigrant, uninsured, and low-income communities.

Existing Assets

Federal parity laws mandate equality of coverage between physical and behavioral health services and are buttressed by NYS through laws such as Timothy's Law and the Mental Health and Substance Use Disorder Parity Report Act of 2019, which mandates the Department of Financial Services to make information about insurance company compliance with parity for mental health and substance use services available to the public annually.

The federal government also supports the funding of hospital-based behavioral health care to uninsured New Yorkers, including many immigrants, through Disproportionate Share Hospital (DSH) funds that the state augments with Health Care Reform Act surcharges on health insurance plans, both of which are designed to reimburse providers for uncompensated care. Additional funds from the state are available through funding streams administered by the NYS OMH, including the so-called Safety Net, which reimburses independent mental health clinics that are licensed by the NYS OMH and not affiliated with hospitals for a portion of the financial losses incurred by providing care to uninsured and underinsured patients.

New York has additional funding streams specific to the behavioral health needs of low-income and uninsured New Yorkers, among them the NYS OASAS and NYC DOHMH, which together support about 65 percent of all substance use treatment centers in the city. NYS OASAS also supports Addiction Treatment Centers that provide care to anyone,

regardless of immigration status, insurance coverage, or income, across NYS.

In spite of coverage mechanisms, programs, and other funding streams, the city's behavioral health care system suffers from a severe lack of financial resources to meet the increasing needs of immigrant New Yorkers.

More specifically to immigrant communities, the state builds upon the federal government's restrictive health insurance eligibility classifications of "qualified"

and “lawfully present” by extending eligibility to anyone who is “permanently residing under color of law,”⁸⁰ undocumented pregnant women, and all children under the age of 19 regardless of immigration status. NYC further promotes access to care by directly funding programs designed for uninsured and/or low-income city residents such as NYC Care, many of the initiatives of ThriveNYC, and the City Council-funded Mental Health Services for Vulnerable Populations Initiative and Immigrant Health Initiative, designed to support CBOs, clinical service providers, and advocacy networks on a range of services for populations including immigrants and LEP people.

In spite of these coverage mechanisms, programs, and other funding streams, the city’s behavioral health care system suffers from a severe lack of financial resources to meet the increasing needs of immigrant New Yorkers, as outlined by the safety-net capacity difficulties described earlier in this report. As such, we outline here six principal recommendations to increase system capacity and resources.

POLICY RECOMMENDATIONS

Expand health insurance coverage to ineligible immigrants

The single most significant action NYS can take to improve financial access to behavioral health services is to create a system of universal coverage. Studies have consistently shown the importance of health insurance coverage as a measure of access to care, and NYS has demonstrated its willingness and ability to provide health insurance coverage to some low-income state residents who are not eligible for federal coverage. It should do the same for the more than 400,000 undocumented adult New Yorkers who remain uninsured as a result of their status. This can be achieved in part through the creation of a state-funded Essential Plan that mirrors the existing plan for citizens and lawfully present immigrants with incomes up to 200% FPL.⁸¹ For the 2019-2020 Legislative Session, these bills are A5974⁸²/S3900.⁸³

Expanding coverage to undocumented adults not only moves New York away from an entrenched system of health insurance discrimination, but also alleviates transitions for people who are temporarily eligible for insurance but face a loss of coverage at life-altering moments. One such example is undocumented adult women, whose Medicaid covers their full term of pregnancy and birth but drops them from coverage two months into postnatal care when the risk of postpartum depression is still high.

Expanding coverage to undocumented adults not only moves New York away from an entrenched system of health insurance discrimination, but also alleviates transitions for people who are temporarily eligible for insurance but face a loss of coverage at life-altering moments.

Ultimately, the state should adopt the New York Health Act, which would create a single-payer health care system with comprehensive behavioral health services open to all New Yorkers regardless of immigration status. For the 2019-2020 Legislative Session, these bills are A5248⁸⁴/S3577.⁸⁵

More faithfully enforce mental health parity laws

Despite the federal Mental Health Parity and Addiction Equity Act and strengthened protections in the Affordable Care Act, and NYS' own efforts to guarantee access to behavioral health services through Timothy's Law and the Mental Health and Substance Use Disorder Parity Report Act of 2019, private insurance claims for mental health services are still denied or subjected to increased scrutiny at a higher rate than physical health services.⁸⁶ These barriers may disproportionately affect LEP people and those who are less familiar with the claims appeals process, and thus represent an outsized threat to immigrant communities' access to covered services.

In part as a response to ongoing violations of parity laws, the NYS Attorney General began pursuing in 2013 an industry-wide investigation into parity, recovering as of

The law should be strengthened to explicitly include defined penalties for plans that fail to observe parity guidelines.

2018 more than \$2 million in out-of-pocket costs for consumers and assessing \$3 million in penalties to insurance plans for violations.⁸⁷ Future oversight of parity will be enhanced by the Mental Health and Substance Use Disorder Parity Report Act of 2019, although the law does not include any enforcement mechanisms and it is too soon to measure its impact. Enhanced transparency under the law should further improve insurers' fidelity to parity

rules, but the law should be strengthened to explicitly include defined penalties for plans that fail to observe parity guidelines.

Even with greater transparency and enforcement, consumer assistance to help New Yorkers enjoy the full range of covered behavioral health services will remain critical. The Community Health Access for Addiction and Mental Health Care Project (CHAMP) is a promising model. CHAMP, which launched in late 2018, is an ombuds service funded by the state that offers multilingual, free, and culturally responsive consumer assistance for mental health and substance use disorder benefits. It is the first program of its kind in the state dedicated specifically to helping consumers understand and use mental health and substance use benefits, appeal denials of mental health and substance use disorder services, and identify parity violations. The program is run through a statewide hotline and partnerships with CBOs in five regions of New York for on-the-ground support and local expertise. The state should expand funding of CHAMP services from \$1.5 million to \$3 million to include CBO capacity across NYS, including in NYC, where there currently are

no contracted CHAMP CBOs outside of Staten Island. A portion of the enhanced funding should be dedicated to incorporating additional immigrant-serving CBOs into the network.

Redistribute existing uncompensated care funds more equitably and increase the size of these funding pools

DSH funds, including the Indigent Care Pool (ICP), are an important revenue source for health care systems such as H+H that provide large volumes of uncompensated care to uninsured patients and Medicaid enrollees. However, current distribution methodologies are inequitable and do not reflect the actual provision of care for Medicaid enrollees and uninsured New Yorkers across NYS' health care safety net.^{88,89} As such, they represent a gross misallocation of existing resources and a missed opportunity to better support the health care systems that disproportionately provide behavioral health services to immigrant New Yorkers. Bills in the state Legislature (A6677-A⁹⁰/S5546⁹¹) for the 2019-2020 Legislative Session would rectify this issue by, among other provisions, eliminating the ICP “transition collar” that allows non-safety-net hospitals to continue receiving ICP funds despite failing to serve uninsured patients, and leveraging the ability of public hospitals such as H+H to access federal DSH funds. We further urge the NYS DOH to release \$76 million in safety-net hospital funding that was allocated in the state budget for FY2018-2020 but has not been disbursed to some of NYS' most critical providers.

The aptly-named “Safety Net Pool” is an additional source of uncompensated care funds designed specifically for diagnostic and treatment centers (D&TCs), which are clinics unaffiliated with hospital systems. These funds reimburse non-hospital clinics for the uncompensated care they provide to uninsured patients. In addition to FQHCs, clinics licensed by the NYS OMH that are not affiliated with a hospital are among the D&TCs that receive this funding. Advocacy in recent years has called for a \$20 million increase in the “Safety Net Pool” to improve the financial standing and care of these critical safety-net institutions, increasing the ability of NYS OMH clinics and FQHCs, many of which provide mental health services, to offer more care to immigrant New Yorkers.⁹² We endorse the call to increase the Safety Net Pool, particularly at a time when many eligible immigrants may forego insurance coverage because of fears about threatened changes to “public charge” rules.

Behavioral health services are consistently reimbursed at rates lower than both primary and specialty physical health services.

Increase Medicaid rates for behavioral health services and safety-net hospitals

Bills A6677-A/S5546 would additionally increase Medicaid rates for health care systems that are true safety net hospitals, improving the overall financial standing of the systems that disproportionately care for low-income immigrant New Yorkers. Rate increases

specifically for behavioral health services are an additional recommendation to improve access at safety-net health care providers, and particularly at H+H. Behavioral health services are consistently reimbursed at rates lower than both primary and specialty physical health services.⁹³ It has historically been difficult to even maintain the existing Ambulatory Patient Groups (APG) rates that establish minimum Medicaid payments to providers. APG rates should be maintained and ultimately increased to ensure the viability of safety-net behavioral health care providers. While low reimbursement rates for behavioral health services are a problem across the health care system because they discourage providers from accepting patients enrolled in Medicaid, they are particularly problematic for H+H because of the dramatically disproportionate share of all types of behavioral health services that the public system provides in NYC.⁹⁴

Fully fund uninsured care programs

The NYC Care program is a promising model of coordinated direct access to care for uninsured New Yorkers, about half of whom are undocumented immigrants. The program's components that go beyond the existing standard of care at H+H — navigation and

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coordination assistance through a primary care home assignment, a membership card and dedicated customer service line, increased pharmacy accessibility, expansion of the collaborative care model across all H+H sites, and a clear welcoming message that encourages uninsured New Yorkers to seek care on an ongoing and preventive basis through membership in a branded program — are encouraging. However, as the program ramps up and is fully implemented across the city with the goal of guaranteeing improved access to care for all of NYC's 600,000 uninsured residents, the currently planned \$100 million investment, targeted to new uninsured H+H patients, will quickly become insufficient.

NYC Care should also be sufficiently funded to extend its reach beyond H+H and incorporate FQHCs outside H+H's Gotham Health network that serve uninsured and low-income immigrant New Yorkers across the city. FQHCs have an increasing focus on incorporating behavioral health services into their original primary care missions and will continue to provide care to immigrants across NYC, NYS, and the country. The ActionHealthNYC pilot clearly demonstrated the integral role that FQHCs play in health access and continuity of care.⁹⁵ Improving linkages between FQHCs and H+H must continue to be a priority in efforts to improve access to care for uninsured New Yorkers, particularly for FQHC patients in need of more intensive behavioral health care than FQHCs can provide. Meaningful incorporation of FQHCs into NYC Care requires funding a common information-sharing platform and payments to primary care homes to support

care coordination and navigation efforts that facilitate referrals between FQHCs and H+H, as the ActionHealthNYC pilot demonstrated. This funding should be in addition to the original \$100 million investment and any increases to it to support the program's implementation at H+H. At the time of this report's writing, the NYC Care program was in its infancy, so calculating a specific dollar amount needed to broaden its reach is unrealistic.

Sustain and enhance municipal funding streams that support existing clinical service sites and other community-based organizations

The NYC Council funded several mental health initiatives in FY2020, the most recent year for which information was available for this report. The Mental Health Services for Vulnerable Populations initiative included \$2.32 million to support 20 CBOs and advocacy networks. While immigrants are specifically highlighted as a population of interest for the initiative overall, enhanced funding would allow more of the programs funded by the initiative to target immigrant communities as their priority.

The Council also funded Access Health NYC at \$2.5 million in FY2020 to support 36 organizations to conduct outreach and education on health care access options and rights in historically underserved communities. The initiative helps to create and disseminate linguistically appropriate educational materials that increase awareness about existing services, including behavioral health options. The initiative should be sustained in future years and enhancements considered to support efforts to increase knowledge, awareness, and destigmatization of behavioral health services.

Among the Council's immigration initiatives is the Immigrant Health Initiative (IHI), funded at \$2 million in FY2020 to support "programs that focus on decreasing health disparities among foreign-born New Yorkers by focusing on the following three goals: improving access to health care; addressing cultural and language barriers; and targeting resources and interventions. Additionally, funding will support mental health services for vulnerable immigrant New Yorkers."⁹⁶ Six of the funded organizations, representing \$385,000 of the total initiative, focus their projects on mental health. IHI represents an important investment in the health of immigrant communities and should continue to be funded moving forward with enhancements in overall financing designed to incorporate additional organizations with a mission to improve access to behavioral health services in immigrant communities.

While these initiatives and future enhancements are important investments, they are relatively small in the broader context of behavioral health services access and in no way address the need to more fundamentally restructure and underwrite major investments in coverage and access that City Council initiatives do not have the capacity to accomplish.



Even when an individual is ready to seek treatment, there are linguistic and economic barriers to accessing behavioral health services.

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Making People Feel Comfortable Seeking Services

The fourth area of improvement identified in the roundtable process is to ensure that immigrant community members feel comfortable, welcome, and confident in seeking the services available to them. Immigrants face unique challenges such as cultural and linguistic barriers, separation from family, and adjustment to a new environment. Receiving treatment is effective in addressing distress, yet immigrants are less likely to access mental health services when compared with their US-born counterparts.⁹⁷ Mental health is stigmatized in many immigrant communities. It is often socially unacceptable to have a mental health illness, let alone talk about it or seek formal treatment. Even when an individual is ready to seek treatment, there are linguistic and economic barriers to accessing behavioral health services.

Immigrants face unique challenges such as cultural and linguistic barriers, separation from family, and adjustment to a new environment.

Existing Assets

The NYS OMH has worked to increase the cultural responsiveness of its services to better understand and meet the needs of all New Yorkers. The enacted Amendment to the 2007 NYS Mental Hygiene Law established two Centers of Excellence for Cultural Competence (CECC) at the Center for Research on Cultural and Structural Equity in Behavioral Health (C-CASE) and the NYS Psychiatric Institute. These two research centers are mandated by the Legislature to:

- enhance the availability of culturally and linguistically appropriate services in NYS;
- produce results that could be disseminated statewide; and
- work closely with individuals seeking mental health services and their family members.

The two centers have developed and disseminated assessment tools, instruments, and educational materials to provide specific steps, desirable behaviors, and considered responses for improving services at the organizational, program, intervention, provider, and consumer levels of the health care system.

C-CASE has developed tools such as the Cultural Competency Assessment Scale as well as toolkits that guide the adaptation of evidence-based practices for a specific cultural group such as the Toolkit for Modifying Evidence-Based Practices to Increase Cultural

Competence. In addition to these resources, a series of cultural profiles were compiled to highlight cultural traits that need to be taken into consideration in order to provide meaningful mental health services that meet the needs of the target populations. These cultural profiles include demographic and immigration background, prevalence of mental illness, views of mental illness, cultural perspectives that impact mental health service use, barriers to seeking care, and the impact of the acculturation process.

The NYS Psychiatric Institute-CECC has six research initiatives, including:

- Integration of Physical and Mental Health Services for People with Serious Mental Illness
- Best Practices for Interpreting and Cultural Brokering Services
- Diagnosis and Engagement
- Prevention of Suicidal Behavior in Diverse Populations
- Promoting Culturally-Competent Policy Research
- First-Episode Psychosis

The goal of the Best Practices for Interpreting and Cultural Brokering Services Initiative is to promote access to language-appropriate mental health services through the use of bilingual clinicians and high-quality interpretation services. In recognition of the importance of access to linguistically-appropriate mental health services, the initiative published “Interpreter Do’s and Don’ts tool: Guidelines for Clinicians Working with Interpreters in Mental Health Settings,” a hands-on guide with best practices for clinicians working with interpreters in mental health settings.

The Cultural Formulation Interview framework recognizes the profound impact patients’ cultures and life experiences have on their understanding of their symptoms and attitudes towards care.

The New York State Psychiatric Institute also introduced the Cultural Formulation Interview (CFI) framework to recognize the profound impact patients’ cultures and life experiences have on their understanding of their symptoms and attitudes towards care. The CFI was developed to provide an evidence-based, standardized

narrative framework to guide clinicians in conducting a full cultural assessment in routine mental health settings.

In addition to research innovations, several citywide campaigns were launched as part of ThriveNYC in an effort to change the conversation around mental health and encourage the use of mental health services. In May 2018, the NYC DOHMH launched the “We’re Here”

campaign to encourage New Yorkers to contact the NYC Well hotline for mental health support. NYC Well is part of ThriveNYC and offers free, around-the-clock crisis counseling and information and referral to ongoing mental health services regardless of immigration or insurance status in more than 200 languages via trained counselors and peer support specialists. The “We’re Here” campaign was placed on the subway, newspapers, the Staten Island ferry, TV, and social media, as well as in neighborhood bodegas, nail and hair salons, laundromats, and check-cashing facilities.

In January 2018, the NYC DOHMH committed \$5 million in annual investment through 2020 and launched the “Choose the Best Words” campaign to expand the Mental Health First Aid (MHFA) program to help people talk to family and friends struggling with depression, anxiety and other mental health issues. MHFA offers a free, one-day training on the skills needed to identify, understand, and respond to signs of behavioral health challenges, including anxiety, depression, suicidal behavior, overdose, and withdrawal. This additional funding has allowed the city to translate MHFA training materials into languages such as French, Arabic, and Haitian Creole, and to provide more free training sessions citywide.

There is also a citywide mental health awareness campaign in NYC public schools. “There’s Help All Around You” launched in November 2018 and aimed to reach over 1.1 million students. The campaign is tailored for elementary, middle, and high school students, and is available in Spanish, Arabic, Bengali, and Chinese. It promotes mental health understanding and dialogue, and decreases shame, prejudice, and uncertainty surrounding these challenges. The campaign also points students and parents to available resources in schools and communities including guidance counselors, social workers, school mental health consultants, substance use prevention and intervention specialists, and community mental health providers.

There are also examples of community-led efforts to reduce mental health stigma and drive community empowerment. The Arab-American Family Support Center, with the support of Community Care of Brooklyn/Maimonides Medical Center, recently launched Reclaiming our Health (ROH), a community-based initiative to reduce mental health stigma and increase access to services by building on existing resources for Arab, Middle Eastern, Muslim, and South Asian communities. The goal of ROH is to engage with trusted community leaders and partner with them to provide education and skills-based training to increase awareness, reduce stigma, and offer tangible support for community members at risk for depression and other mental health concerns.

Building on these significant efforts, more can be done to promote innovations and lift up community-based expertise to make immigrant New Yorkers more comfortable seeking services.

POLICY RECOMMENDATIONS

Expand citywide campaigns that increase recognition of behavioral health concerns and availability of services

Sustained campaigns with welcoming messages that acknowledge behavioral health concerns and highlight the availability of services are necessary to counteract the unprecedented levels of fear and anxiety caused by the Trump administration's persistent attacks on immigrant children and families. In addition to increased funding for existing campaigns, NYC should expand campaigns in non-English language media in an effort to encourage immigrant communities to seek mental health services without fear of eligibility or immigration enforcement activity.

Incorporate cultural assessment into regular behavioral health practice

Professional organizations and government guidelines recommend cultural competence training for providers, but there is no standardized assessment. Incorporating tools such as the CFI can make it easier for providers to account for the influence of patients' multiple cultures in their clinical work to enhance communication and improve outcomes. Cultural formulation covers the impact of language on evaluation and treatment, culture-specific syndromes, folk belief systems, and other issues that reflect the impact of culture on one's identity and on psychiatric illness. Instituting CFI into clinical training and practices is a vital approach to develop culturally-sensitive and astute practitioners.

Make Mental Health First Aid training available in more languages and in more places

The NYC DOHMH offers free, eight-hour MHFA training provided every week in every borough. The training is regularly conducted in English, Mandarin, and Spanish. The NYC DOHMH should provide MHFA in other top languages spoken in NYC, including French, Arabic, Korean, and Haitian Creole. Additionally, the NYC DOHMH should seek more opportunities to support provision of MHFA training in more settings like Muslims Thrive, a local CBO that has provided MHFA training at Masajid Islamic Centers and at Islamic schools in an effort to combat cultural and spiritual barriers to seeking mental health services in NYC's Muslim communities.

Convene a coordinated citywide faith-based task force on behavioral health for immigrant communities

Faith providers are an important source of informal mental health support and may be a conduit for referrals and a promising partner for collaborations with formal service systems. We recommend creating an interagency government-community task force comprised of faith leaders, behavioral health specialists, and government agencies to help

raise awareness about behavioral health challenges in immigrant communities. The role of the task force would be to guide decision-making about policy and programming and enhance access and quality of culturally and linguistically appropriate behavioral health services in immigrant communities. A recent collaboration between the NYC DOHMH and local nonprofit ICL to convene faith leaders in East New York around mental health access could serve as a small-scale model for this concept.⁹⁸

Provide funding for New York City public schools to recruit, assess language skills, and train bilingual and bicultural school guidance counselors to offer mental health education in non-English languages

As of July 1, 2018, NYS public schools are required to incorporate mental health into their curriculum. Public school teachers are asked to incorporate the topic of mental illness into subjects such as science, literature, history, and social studies. Many training resources are available from the School Mental Health Resource and Training Center that was established by the Mental Health Association in New York State, to help schools comply with the new law. The training center also provides free online mental health training (Continuing Teacher and Leader Education-eligible) and instructional resources for educators, as well as mental health resources for parents and guardians, students, and community-based mental health providers.

In addition to having linguistic barriers, immigrant students can have complex trauma and may have an intensive need for psychological and social supports. Improving access to robust mental health outlets for immigrant students is a critical component of addressing the dropout rate and boosting graduation rates. In order to support public schools with a large population of LEP immigrant students, there should be a concerted effort to recruit bilingual and bicultural school guidance counselors who can take an active role in ensuring their school has a welcoming environment towards all students regardless of background. This can be done by providing support groups consisting of peers and school staff, as well as connecting schools with local CBOs and community members, and incorporating mental health education that is culturally responsive and linguistically respectful. Moreover, priorities should be made to place bilingual and trauma-informed counselors in schools with substantial multilingual learner populations to ensure students remain on track for graduation.

We recommend creating an interagency government-community task force comprised of faith leaders, behavioral health specialists, and government agencies to help raise awareness about behavioral health challenges in immigrant communities.

Support a New York City community mental health interpreter bank

Mental health is rooted in culture and language. Conversations about thoughts and feelings that are translated through telephonic interpretation may delete nuance and edit out clues to the patient's path to wellness. Although some facilities provide therapy in Spanish, availability of behavioral health services in other languages is limited. As a result, the need for culturally and linguistically responsive mental health services far exceeds the available number of bilingual and bicultural mental health professionals. Cultural and linguistic barriers impact the ability of people to identify and access behavioral health services. The shortage of trained bilingual and bicultural mental health professionals

makes it extremely challenging for many LEP New Yorkers to obtain referrals and timely, appropriate services. We propose that NYC provide funding to a community-based nonprofit organization to establish a Community Mental Health Interpreter Bank. Upon successfully completing a language assessment, potential interpreters would be recruited, trained, and dispatched to mental health providers where there is a lack of language capacity.

The need for culturally and linguistically responsive mental health services far exceeds the available number of bilingual and bicultural mental health professionals.



The need for a multi-faceted, macro-level approach with concrete policy and service improvements has never been greater.

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Conclusion

Immigrant New Yorkers face formidable barriers to behavioral health services. Some of them — such as a lack of linguistically and culturally appropriate care, the stigma associated with behavioral health services, and restrictive health insurance eligibility standards based on immigration status — predate the crisis caused by the Trump administration’s relentless attacks on immigrant communities. Others — such as the increased strain on safety-net providers caused by increased demand for services and the greater need for school-based services for children dealing with the trauma of family separation — were created or exacerbated by the administration. The need for a multi-faceted, macro-level approach with concrete policy and service improvements has never been greater. The recommendations described in this report, if implemented, aim to achieve that.

In addition to implementing these recommendations, NYS should articulate a clearer vision of how the current patchwork of programs and funding streams, and future plans to improve access, coalesce into a more universal system of equitable behavioral health services for all New Yorkers. ThriveNYC does this in part for NYC by aspiring to be a comprehensive mental health plan for the city. While concerns about aspects of ThriveNYC are described elsewhere in this report, the conceptualization of a comprehensive roadmap is laudable. An effort to develop a broader vision of access to behavioral health services, with accompanying resource allocations, is also necessary for NYS.

As a statewide organization, the NYIC acknowledges that circumstances vary dramatically from one part of the state to another. The focus of this report is NYC, which for many reasons is incomparable to other parts of the state, including the presence of the nation’s largest public health care system and a more active and well-funded municipal government than most other towns and cities. However, we have outlined state-level solutions to some problems that cannot be resolved at the municipal level and that will improve access to behavioral health services for immigrants across NYS. We also expect that some of the initiatives undertaken in NYC, such as stronger links between CBOs and mental health providers, can serve as models for other municipalities.

None of the solutions described here individually resolve all access barriers, and all of them are part of a larger fight toward equity, justice, and human dignity that require policy changes beyond the health care service delivery system that is the focus of this report. However, if NYC and NYS follow through on the recommendations outlined here in partnership with CBOs, clinical service providers, and immigrant communities, we can meaningfully improve access to behavioral health care.



New York State should articulate a clearer vision of how programs, funding streams, and future plans coalesce into a more universal system of equitable behavioral health services for all New Yorkers.

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APPENDIX A - Roundtable Process and Methods

As indicated in the *Structure and Purpose of the Roundtables and Report* section, the primary data collection mechanism for this report was a series of five roundtables held between May 2018 and May 2019. The NYIC compiled a list of stakeholders to invite to participate based on their representation of distinct community and consumer groups and areas of the behavioral health care delivery system, including affected community members, peer specialists, youth advocates, staff of CBOs serving immigrant communities, NYC and NYS agencies that provide behavioral health care and/or oversight, public and private clinical service providers and administrators, and researchers. This is the full list of organizations and entities that participated in the roundtable process:

- Arab-American Family Support Center
- African Services Committee
- Asian American Federation
- Catholic Charities
- Community Access NYC
- CUNY School of Public Health
- Fordham University
- Institute for Family Health
- Korean Community Services
- Make the Road New York
- New York City Department of Health and Mental Hygiene
- New York City Health + Hospitals - Central Office, Bellevue, Harlem
- New York City Mayor's Office of Immigrant Affairs
- New York State Department of Health
- New York State Office of Mental Health
- SUNY-Stony Brook
- Terra Firma
- ThriveNYC
- Vibrant Emotional Health
- Youth Advocacy Corps Mental Health Awareness Project

The roundtables were designed to occur over a one-year period to allow ample time for data collection and to monitor changes occurring during the project given the volatility of the current federal policy environment. The topics for the five roundtables were:

- Roundtable 1 (May 10, 2018): Characterization of the Scope of the Problem
- Roundtable 2 (July 27, 2018): Acute Emotional Distress and Behavioral Wellness - Gaps in the Behavioral Health Infrastructure
- Roundtable 3 (September 13, 2018): Strategies to Improve the Availability of Immediate and Longer-Term Behavioral Health Services for Immigrant New Yorkers
- Roundtable 4 (November 8, 2018): Recommended Policies to Address the Behavioral Health Needs of Immigrant New Yorkers
- Roundtable 5 (May 9, 2019): Reviewing and Validating Policy Recommendations

Based on feedback from the roundtable participants, we also conducted key informant interviews to fill gaps and deepen knowledge on certain issues that arose in the roundtables, particularly related to substance use disorder treatment services.

We are very grateful to the following individuals for reading and/or providing thoughtful comments on the contents of the report: Scott Bloom (NYC DOHMH); Alice Bufkin, (Citizens' Committee for Children of New York), Zoraida Diaz (NYS OASAS), Gail Goldstein (NYC DOHMH), Julia Gruberg (Center for Faith and Community Partnerships, Community Affairs Unit, NYC Office of the Mayor), JJ Hung (Hamilton Madison Houses), Christine Kajetzke (Park Slope Center for Mental Health), Kelly Kyanko (NYU Langone Medical Center), Pat Lincourt (NYS OASAS), Nain Martinez (NYS OASAS), Ilyana Meltzer (NYS OASAS), Sarah Solon (Mayor's Office of ThriveNYC), Dawn Yuster (Advocates for Children).

The roundtable process was led by the NYIC's Health Policy team. Angela Martínez served as a consultant to the NYIC in preparing and conducting the first four roundtables.

APPENDIX B - Suggested Advocacy Agenda for New York City

This report includes a combination of municipal-level and state-level recommendations. The list below includes municipal-level recommendations to facilitate the development of an advocacy agenda specific to New York City. Some of the recommendations may also be relevant to other municipalities. For additional details on these recommendations, see their descriptions in the body of the report.

- Support efforts to increase behavioral health professional opportunities in high-need immigrant communities
- Include \$13 million in the FY2021 Executive Budget to extend Connections to Care and expand the program to more immigrant-serving and immigrant-led community-based organizations
- Support bi-directional community-based organization/clinical provider collaborations to support welcoming, comfortable, culturally humble services in both types of settings
- Sustain and build the capacity of New York City schools to provide direct mental health support for students by investing in the Mental Health Continuum in 100 schools that serve immigrant students.
- Fully fund uninsured care programs
- Sustain and enhance municipal funding streams that support existing clinical service sites and other community-based organizations
- Expand citywide campaigns that increase recognition of behavioral health concerns and availability of services
- Make Mental Health First Aid training available in more languages and in more places
- Convene a coordinated citywide faith-based task force on behavioral health for immigrant communities
- Provide funding for New York City public schools to recruit, assess language skills, and train bilingual and bicultural school guidance counselors to offer mental health education in non-English languages
- Support a New York City community mental health interpreter bank

APPENDIX C - Suggested Advocacy Agenda for New York State

This report includes a combination of municipal-level and state-level recommendations. The list below includes state-level recommendations to facilitate the development of an advocacy agenda specific to New York State. For additional details on these recommendations, see their descriptions in the body of the report.

- Support efforts to increase behavioral health professional opportunities in high-need immigrant communities
- Improve educational affordability by growing low-cost advanced degree programs at public institutions and implementing state-based behavioral health professional loan forgiveness programs
- Implement measures to engage and support New York's community health worker and peer specialist workforce
- Seek Mental Health Care Health Professional Shortage Area designations based on immigrant density in neighborhoods
- Develop a Spanish-language version of the New York State Office of Mental Health and New York State Office of Alcoholism and Substance Abuse Services patient websites, and patient materials in top six languages spoken in the state
- Expand health insurance coverage to ineligible immigrants
- More faithfully enforce mental health parity laws
- Redistribute existing uncompensated care funds more equitably and increase the size of these funding pools
- Increase Medicaid rates for behavioral health services and safety-net hospitals



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