BEHAVIORAL HEALTH NEEDS ASSESSMENT

Monroe County, New York

Prepared in July 2025 by

Common Ground Health

NOTE TO THE READER

The mental and behavioral health needs of residents within Monroe County are pronounced and continue to grow. Behavioral health related calls to 211/LIFE LINE, use of public mental health services for children, and emergency department visit rates for behavioral health related concerns all increased in recent years. The complexities and nuances associated with seeking mental and behavioral health treatment made the thought of taking on a behavioral health needs assessment daunting. Did we have a clear focus for what we are trying to accomplish? Did we have the appropriate data to garner meaningful insights? Did we have the right mix of staff to complete the assessment on a short timeline? We had more questions than answers.

True to the nature of Common Ground Health, we decided that "yes, we could do this – in partnership," as we try to do most things. We reached out to community partners to see where they could lean in. Through these partnerships, we defined priority areas for the assessment, worked with additional data sources, and refined analyses into insightful data points.

Throughout this assessment, we use the terms "mental health" and "behavioral health." These terms are not interchangeable. When we say mental health, we are mainly referring to the psychological and emotional well-being of an individual. Behavioral health is broader and encompasses mental health plus behaviors and habits. It is the combination of substance use and mental health issues that are generally referred to when discussing behavioral health, although other behaviors and habits also apply, including exercise, nutrition, and social interactions. Behavioral health treatment addresses emotional and psychological issues while also mitigating potentially harmful behaviors.

We appreciate the sensitivities and nuances pertaining to these topics and the terminology used to describe them. Language and culture continuously evolve. Terminology is regularly updated to become more inclusive, less deficit-oriented, and more precise. Throughout this assessment, we reference terms in different ways depending on the data or its source. This is done to most accurately capture the way in which the data were collected or the diagnostic codes defined. Whenever possible, we use inclusive language in our text. Ultimately, the words we use at the time of publication may fall out of favor and be disregarded for newer terms.

Changes to the political landscape at the federal level and its effects locally weighed heavily on us throughout this assessment. Funding cuts to healthcare and human services are disrupting local service delivery. Significant federal cuts to Medicaid have been approved that could leave one million New Yorkers without coverage, further exacerbating trends and challenges outlined in this assessment.[1]

From the start, we worked to keep this assessment manageable, knowing we could not examine all facets of behavioral health. We took several months to speak with advisors, comb through existing data sources, and review community reports to guide our work. As a result, this document provides a broad look at behavioral health patterns in Monroe County. It offers insight into key areas but is not a comprehensive analysis. We view this assessment as a meaningful starting point, acknowledging that there are areas where we need to dig deeper, explore further, and continue to refine and iterate. We hope that this assessment proves relevant as you make decisions that affect the mental health and well-being of Monroe County residents.

— The Common Ground Health Team

[1] Kaiser Family Foundation. (2025). Estimated Medicaid Enrollment Loss in the House Reconciliation Bill, By State. Found at: https://www.kff.org/medicaid/issue-brief/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-and-enrollment-loss-across-the-states/.

ACKNOWLEDGMENTS

The goal of this assessment was to provide an overview of behavioral health needs and opportunities within Monroe County where increased funding and resources could potentially improve mental health and wellness among residents. Behavioral health is a broad topic including several different components ranging from the individual person experience to the overall healthcare system and beyond. We would like to acknowledge our advisors and community partners who shared data and insights to help us narrow and frame our work, in addition to those who reviewed drafts and provided feedback on analyses. We thank you for your time and energy devoted to this initiative and for your steadfast dedication to the behavioral health and wellness of our community.

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Section 1:
INTRODUCTION

This Behavioral Health Needs Assessment provides a broad overview of Monroe County's behavioral health landscape. It identifies both the growing needs and key opportunities. This assessment goes beyond the traditional medical model that focuses on clinical diagnoses and treatment. It also considers overall emotional well-being and the role of social and community factors in prevention and healing.

The purpose of this assessment is to provide an overview of the behavioral health landscape within Monroe County, as well as identify pathways and/or interventions where increased funding and resources could result in improved behavioral health and wellness among county residents. Behavioral health as a discipline, much like the system that supports it, has immense breadth and depth. It encompasses care delivered in both the medical model and the recovery model, including hospital-based and community-based supports and services. Behavioral health also covers a broad spectrum of concerns and conditions, from mental health challenges to substance use issues, encompassing the extensive complexity of conditions within each of those areas. Undergirding all of this is the workforce that drives the care.

We used a multipronged approach to gain a better understanding of our community's behavioral health needs and select five issues that warranted a focused and deeper analysis for this assessment. We will begin by providing behavioral health data and context within Monroe County before proceeding to more in-depth explorations of each of the five selected focus areas. Behavioral health context for Monroe County includes:

- *Mental and Behavioral Health and Wellness Within Our Community*
    - Self-reported mental and behavioral health status
    - 211/LIFE LINE call data and services requested
    - Public mental health services and utilization
    - Behavioral health emergency department utilization and trends

- *Societal Factors Contribute to Behavioral Well-being*
    - Social drivers of health and behavioral well-being
    - Behavioral health disparities by sex, race and ethnicity, socioeconomic status, and household income
    - Reported stressors and their cumulative effects
    - Sources of support

Mental and Behavioral Health and Wellness Within Our Community

Our mental health ebbs and flows over time based on the conditions in which we live, work and play and the stresses we face as human beings. Mental or behavioral health distress is very difficult to quantify as there is a broad spectrum of conditions and

needs. Self-reported mental health status through surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) and Common Ground Health's My Health Story survey can start to shed light on some of these concerns that may have otherwise been hidden. My Health Story data from 2022 showed that survey participants had a variety of concerns regarding their own behavioral health. Fifty-seven percent of Monroe County respondents reported that in the past year they had at least one of the concerns mentioned for themselves (i.e., stress or overwhelm, anxiety or fear, etc.), as shown in **Figure 1.1**. Additionally, 2021 BRFSS data demonstrated that an estimated 13% of adults (age 18+) in Monroe County reported frequent mental distress, which was defined as 14 or more mentally unhealthy days in prior 30 days.

Figure 1.1

My Health Story 2022 Self-Reported Self Concerns
Monroe County

In the past 12 months, did you have concerns about any of the following for yourself?

Response	Number of Participants	Percent of Participants
Stressed or Overwhelmed	603	27%
Anxiety or Fear	544	24%
Trouble Sleeping	516	23%
Depression or Sadness	398	18%
Alcohol Use	282	12%
Isolation or Loneliness	239	11%
Grief or Loss	216	10%
Feeling Helpless or Hopeless	210	9%
Marijuana Use	162	7%
Anger or Anger Management	88	4%
Prescription Drug Use	69	3%
Other Self Concerns	59	3%
Gambling	48	2%
Drug Use	41	2%
No Self Concerns	969	43%

Source: My Health Story 2022
Unweighted frequencies and percents among Monroe County Participants calculated by Common Ground Health
Total responses = 2,269, non-response = 102

Common Ground Health

An analysis of the Common Ground Health Multipayor Claims database shows an increase in the percentage of the Monroe County population with clinical behavioral health diagnoses. In 2023, 34% of the county residents represented in the database had at least one medical claim with a behavioral health diagnosis (DX), which was up

from 29% in 2016. While the database does not represent the entire population and notably misses individuals without insurance who are often more at risk of behavioral health issues, it does provide a broad view of the county's residents. The most common diagnoses were anxiety and panic disorders (18% of patients) and depressive and other mood disorders (12% of patients). It is also important to recognize that 40% of the individuals with behavioral health diagnoses had multiple conditions. This is a reminder of the complexity of issues that patients and their providers face.

211/LIFE LINE is a resource for residents of Monroe County that provides information about, and referrals to, various human services and crisis and suicide prevention services. Requested services help to illustrate needs that exist within the community. **Figure 1.2** displays the trended counts of behavioral health-related 211 calls, by quarter, between 2019 and 2023 for Monroe County. The number of overall behavioral health calls to 211 grew significantly during this time period, before falling in 2023. In 2023, there were a total of 10,185 behavioral health-related calls, which represented 18% of the total calls made to 211/LIFE LINE. Most of these calls were related to mental health issues, although 778 were related to self-harm and suicide, and 819 were related to substance use.

Figure 1.2

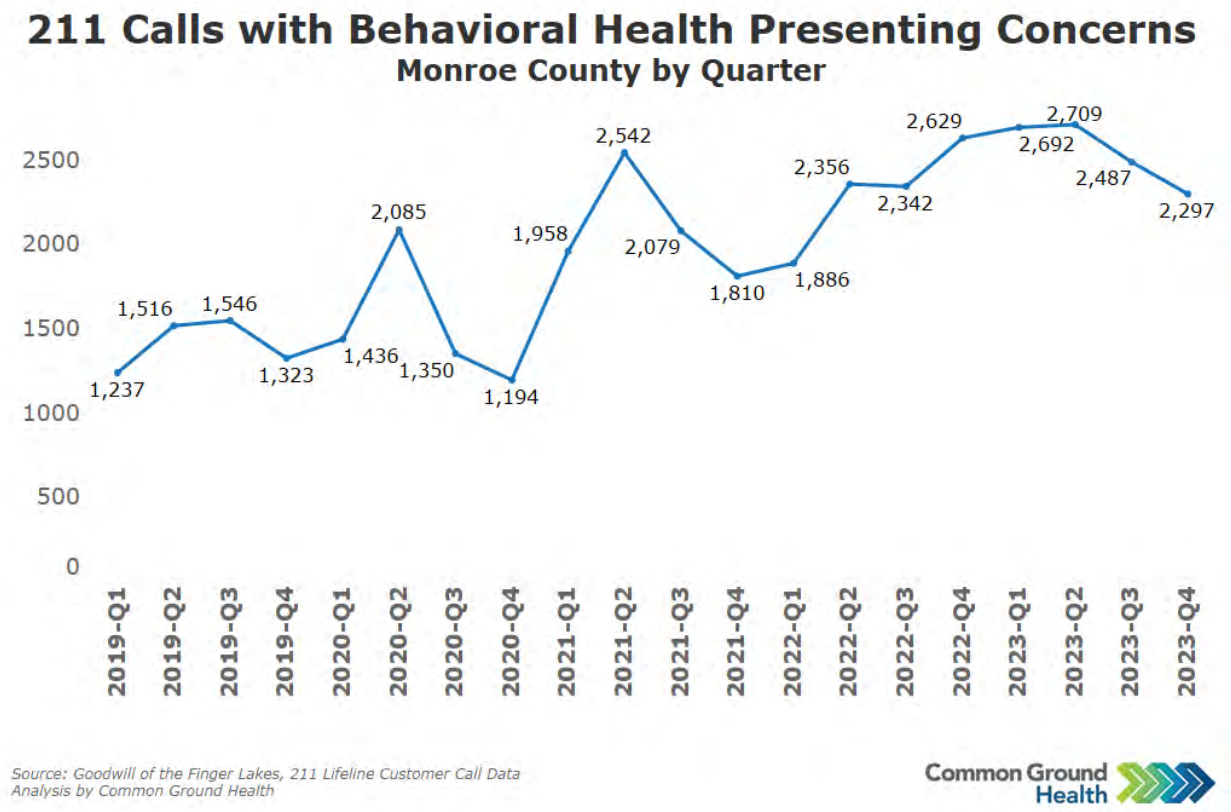


Figure 1.3 shows the most common services requested by 211 callers in 2022-2024 who presented with behavioral health concerns. Overwhelmingly, the most requested service within behavioral health was crisis intervention, with approximately 22,000 calls during that period. While there are several types of requested services on this list that indicate earlier entrance into the behavioral healthcare system for support (such as information and referrals and individual counseling), there are significantly more linked to crisis or emergency mode that indicate immediate need and require a different level of care.

Figure 1.3

Top 25 Services Requested for Behavioral Health Calls
Monroe County 2022-2024

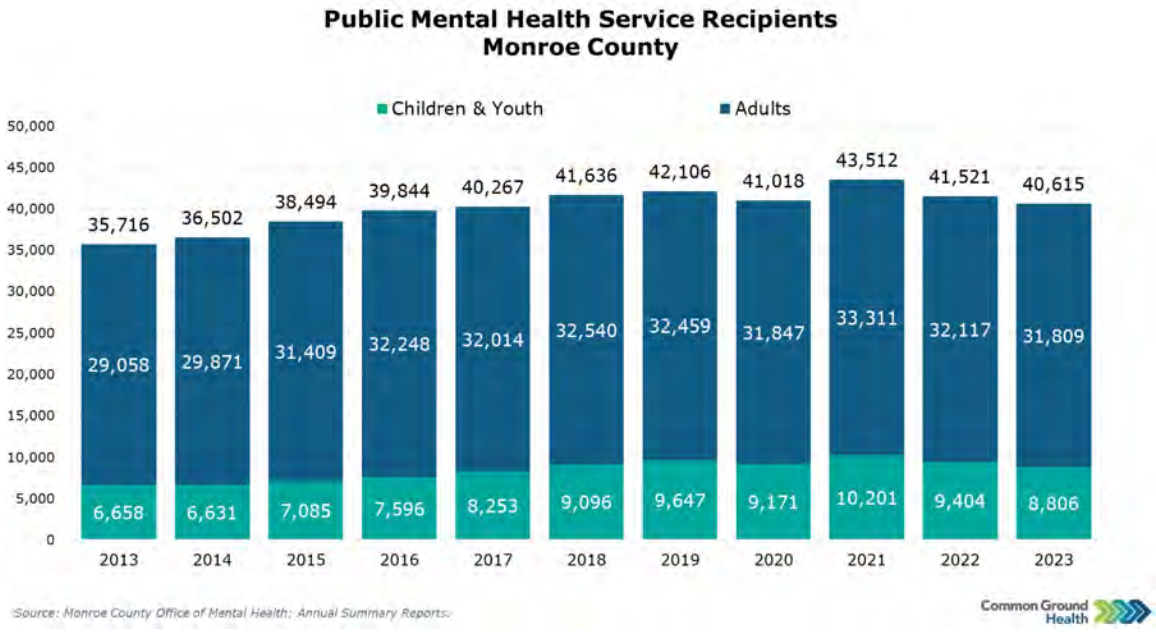
Services Requested	Number of Calls
Crisis Intervention	21,993
Information and Referral	1,735
911 Services	1,199
Outpatient Mental Health Facilities	958
Substance Use Disorder Treatment Programs	897
Individual Counseling	736
Mental Health Evaluation	493
Emergency Food	488
Detoxification	464
Emergency Shelter	432
Case/Care Management	385
Housing Expense Assistance	370
Support Groups	329
Assessment for Substance Use Disorders	318
Emergency Shelter Clearinghouses	306
Counseling Services	302
Personal Goods/Services	287
Advocacy	272
Legal Counseling	248
Inpatient Mental Health Facilities	233
Family Counseling	191
Landlord/Tenant Assistance	169
Transitional Housing/Shelter	165
Housing Search and Information	145
Protective Services	140

Source: Goodwill of the Finger Lakes, 211 Lifeline Customer Call Data Analysis by Common Ground Health

Common Ground Health

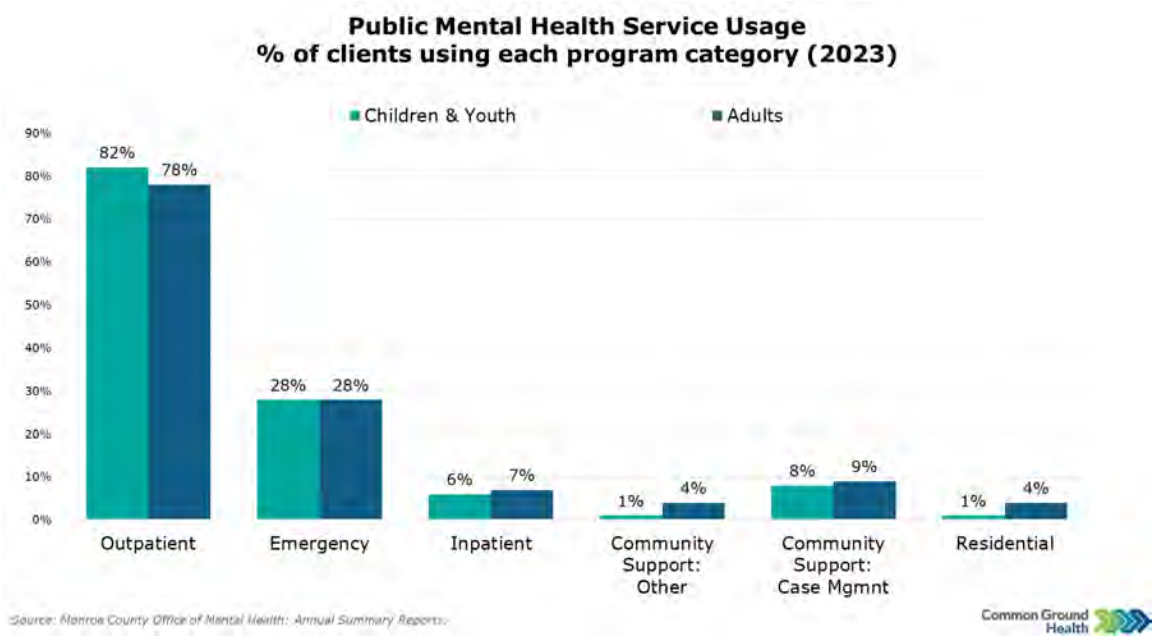
While none of these data sources provide a complete story on their own, piecing them together begins to paint an overall picture of the behavioral health needs within Monroe County. If we now turn to **Figure 1.4**, we see that the number of people served by Monroe County's public mental health services has grown significantly. In 2023, there were 8,806 children and youth served – a 32% increase from 2013. And the number of adults served grew 9% to 31,809. It is difficult to determine whether this indicates more individuals with behavioral health concerns within the county or better awareness of mental health and connection to appropriate services, but, regardless, it does show an increasing demand for providers and services.

Figure 1.4



A closer look at the use of public mental health services shows a variety of types of care utilized (**Figure 1.5**). A large majority of public mental health clients have used at least one of the outpatient services available (78% of adults, and 82% of children/youth). More than a quarter of clients have used one of the emergency services, and smaller percentages of clients have utilized inpatient care, community support, or residential services.

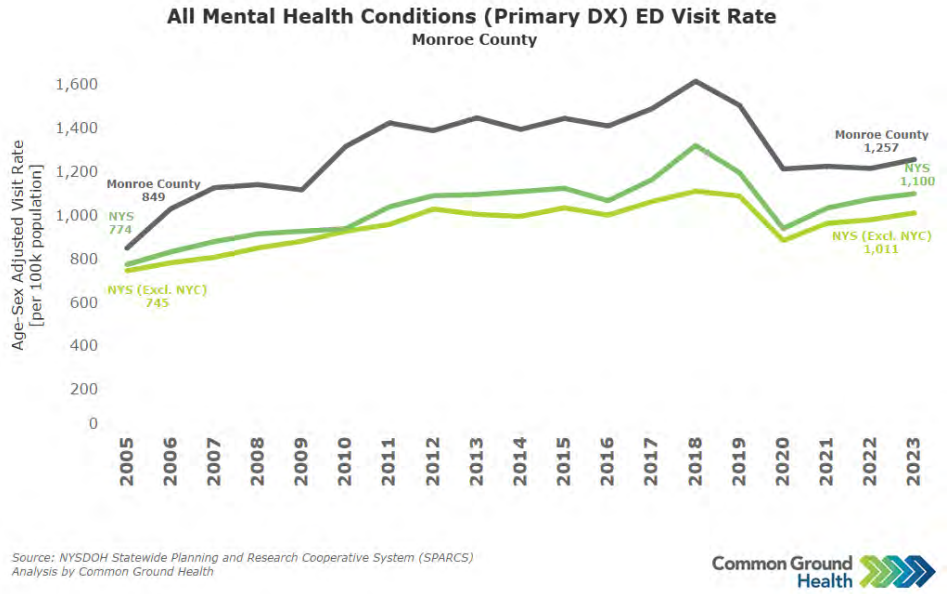
Figure 1.5



While a large percentage of individuals utilize outpatient services to address their behavioral health concerns, many people have behavioral health issues that can reach acute points which then require use of the emergency department or other crisis services.

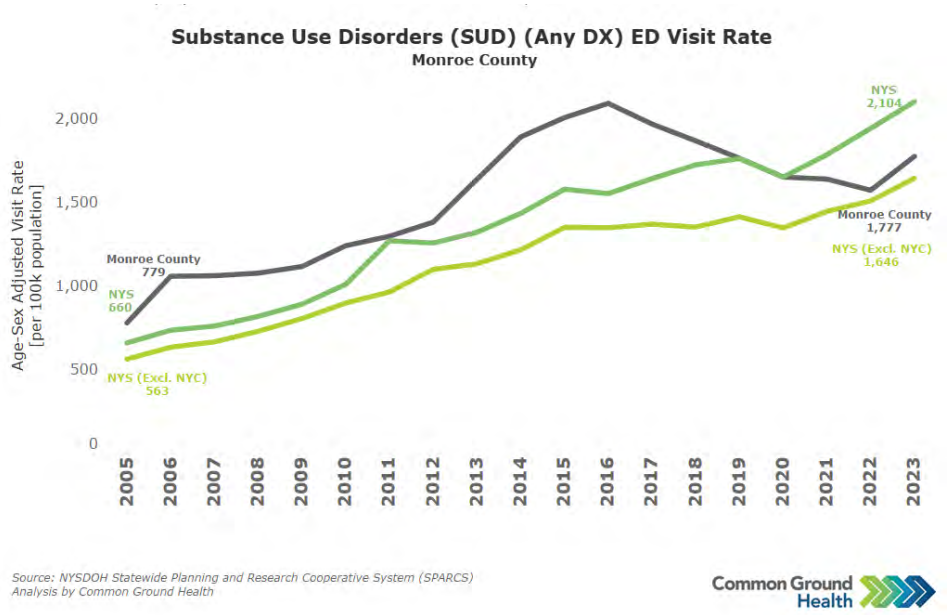
Mental health emergency department (ED) visit rates have risen since 2005, in both Monroe County as well as New York State, although most recently (2023) rates were below the 2018 peak. ED visit rates for mental health conditions were consistently higher within Monroe County compared to the state for the roughly two decades of data shown in **Figure 1.6**.

Figure 1.6



If we examine substance use disorders in a similar fashion, we can see that ED visit rates peaked in 2016. Since then, Monroe County rates have fallen to some degree, in contrast to the state trajectory which continues to rise.

Figure 1.7



Figures 1.6 and 1.7 provided an overview of emergency department utilization for mental health concerns and substance use disorders as broad categories, but upon examining some of the issues within these overarching categories more closely, it was noted that self-harm is a particular area of concern. Figure 1.8 shows 2023 ED utilization within Monroe County for select behavioral health-related conditions, including total visit count and total patient count. Also highlighted, by condition, is the percent of patients with more than one behavioral health-related ED visit within 2023. Of note, the highest number of behavioral health ED visits and individual patients was linked to intentional self-harm, and 85% of patients presenting to the ED for intentional self-harm had at least one other behavioral health ED visit that same year.

Figure 1.8

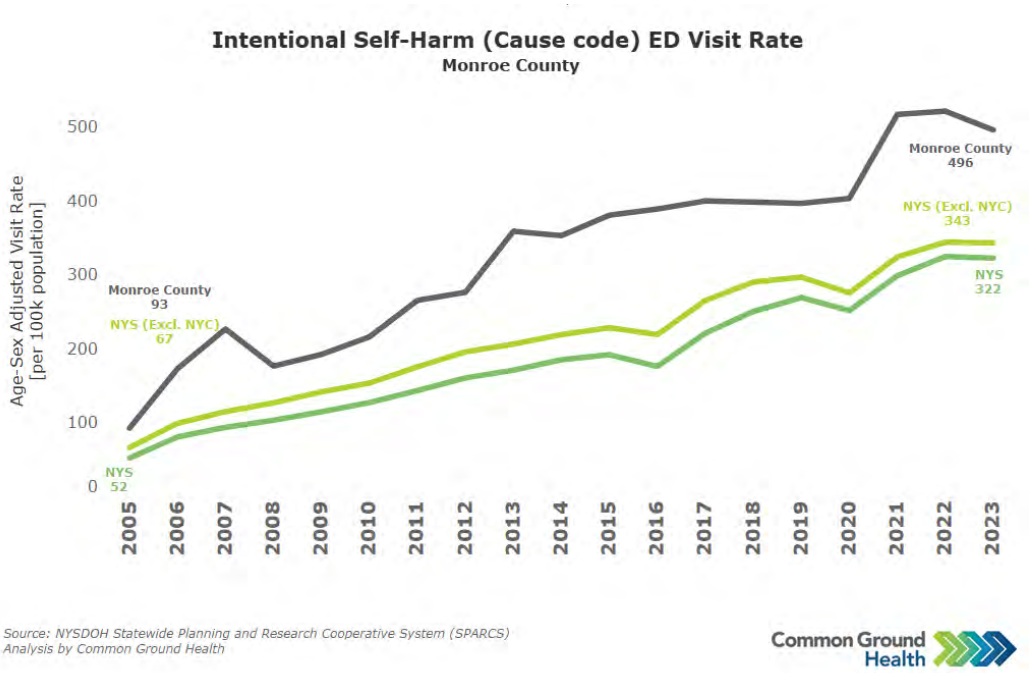
Top Reasons for Behavioral Health ED Visits
Monroe County

Condition	Total Visits	Total Patients	Percent of patients with more than 1 BH ED visit
Intentional Self-Harm	3,492	2,182	85%
Alcohol Use Disorders (AUD)	3,079	2,172	27%
Drug Use Disorders	2,799	1,780	41%
Depressive, Bipolar, and Other Mood Disorders	1,868	1,478	59%
Trauma/Adjustment Disorders	1,443	1,255	47%
Anxiety/Panic Disorders	1,402	1,214	33%
Schizophrenia spectrum and other psychotic disorders	1,304	725	51%
Personality Disorders	1,169	347	71%
Drug Overdose	996	885	27%
Conduct Disorders	731	557	64%

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

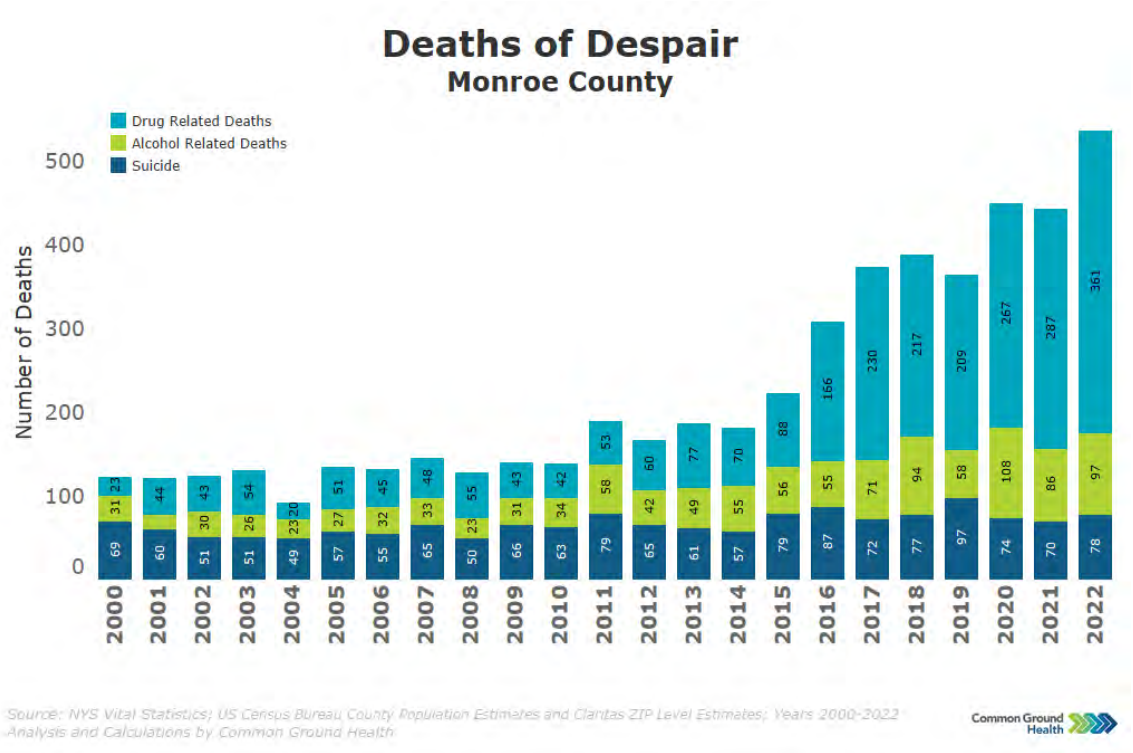
NYS Department of Health Statewide Planning and Research Collaborative (SPARCS) data from 2005 to 2023 shows that the age-sex adjusted visit rates to the ED for intentional self-harm **(Figure 1.9)** have grown substantially, and Monroe County's visit rates have consistently exceeded the state's rates during each of those years.

Figure 1.9



Suicide and other deaths of despair occur when individuals are unable, for many potential reasons, to access the mental and behavioral health care and support that they need. Deaths of despair are defined here as suicide, alcohol-related deaths or drug-related deaths. **Figure 1.10** is based on NYSDOH Vital Statistics data and shows a sharp rise in the number of deaths of despair within Monroe County, with a noticeable increase in drug-related deaths specifically around 2016. In 2022, there were 536 deaths of despair, which accounted for 28% of the county's overall premature mortality as measured by years of potential life lost.

Figure 1.10



Societal Factors Contribute to Behavioral Well-Being

Many different factors contribute to and have the power to impact behavioral well-being, including social drivers of health and socioeconomic stressors. Since these factors have such a profound connection to a person's overall well-being, both mental and physical, we see disparities when data is assessed by demographic characteristics. For instance, Figure 1.11 shows the rate of mental health-driven ED visits segmented by sex, race and ethnicity, and socioeconomic status (SES). While the rates between sexes did not vary greatly, the mental health ED visit rates for Black non-Hispanic individuals were more than 3 times the rate for white non-Hispanic individuals, and the visit rates for those who lived in low SES ZIP codes were nearly 4 times the rate for those who lived in high SES ZIP codes.

Figure 1.11

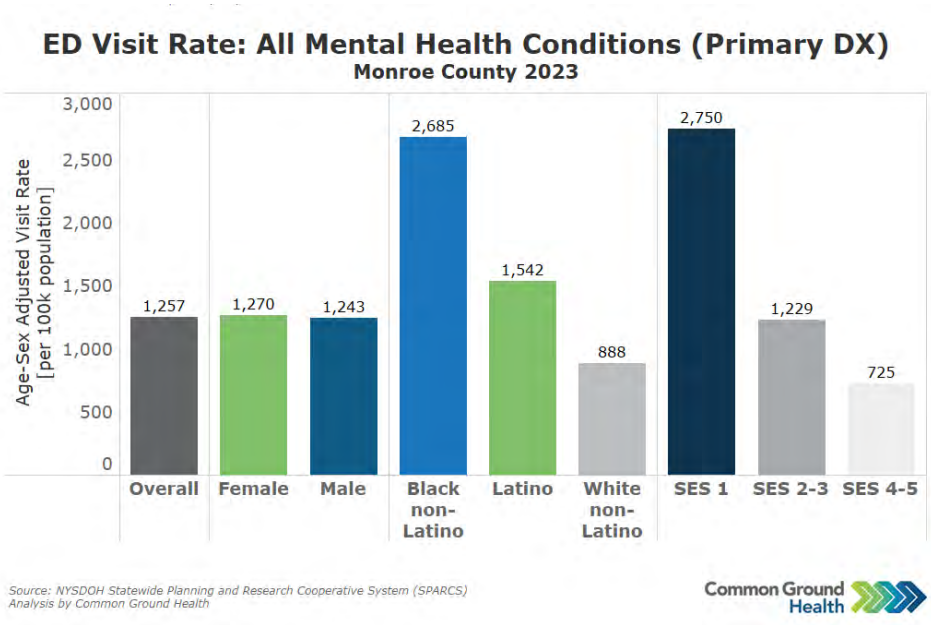


Figure 1.12 displays the same demographic breakdown of SPARCS data as above, except for substance use disorder visit rates rather than mental health. With mental health ED visit rates there hadn't been a significant difference between female and male patients, however ED visit rates for substance use disorder were nearly double for males. Similar patterns were seen here regarding the large disparities among different race and ethnicity identities and socioeconomic status; rates for Black non-Hispanic individuals were nearly 4 times those of white non-Hispanic individuals, and rates for low SES ZIP codes were nearly 5 times the rates of high SES ZIP codes.

Figure 1.12

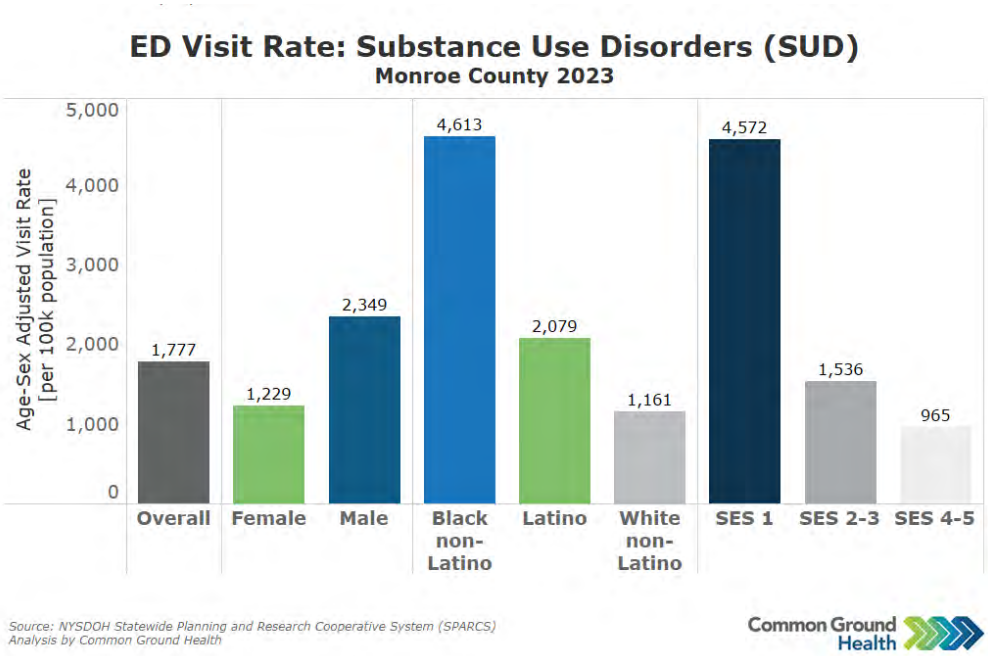
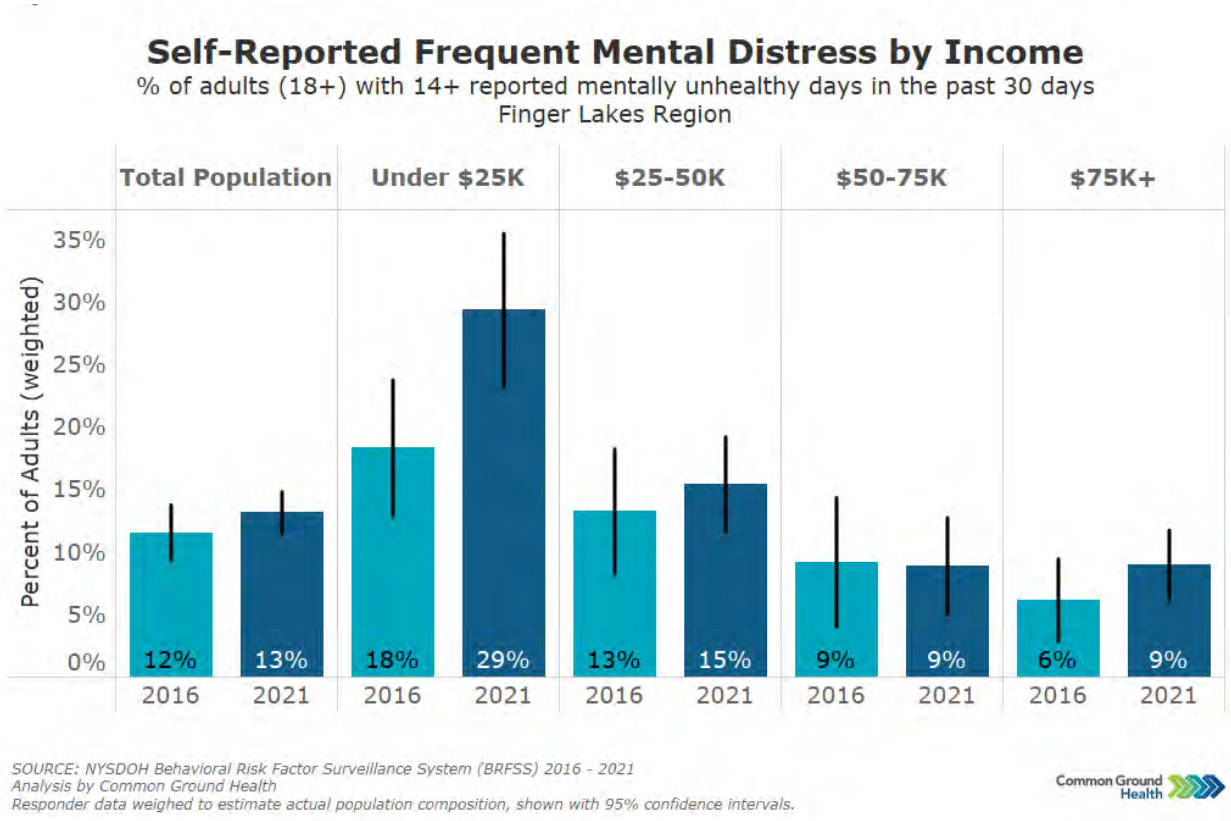


Figure 1.13 revisits BRFSS data mentioned previously on self-reported poor mental health status but broken down by income brackets to show the relationship between household income and mental well-being. As noted above, a large proportion (13%) of the overall population reported frequent mental distress in 2021. The chart also shows a clear pattern between household income and self-reported mental health. The households with highest income ($75K+) were least likely to report frequent mental distress (9%) whereas the lowest-income households (under $25K) were much more likely to report frequent mental distress (29%). Additionally, lowest-income households had the largest increase in percent reporting frequent distress between 2016 and 2021 (from 18% to 29%).

Figure 1.13



People face a lot of day-to-day stressors that can either create new or exacerbate existing behavioral health issues. Common Ground Health's My Health Story 2022 survey asked respondents if, and how often, they were stressed about a variety of items over the past year. Figure 1.14 provides the count of individuals (and percent of total respondents) who replied that they were "sometimes", "often" or "always" stressed about each of the listed issues, some of which include family health, paying rent or mortgage, and work.

Figure 1.14

My Health Story 2022 Self-Reported Stressors
Monroe County

In the past 12 months, how often were you stressed about the following issues?
Number/Percent of Participants who answered Always, Often, or Sometimes

Response	Number of Participants	Percent of Participants
Work	852	54%
Your family's health and well-being	1,040	45%
Your health and well-being	922	42%
Finding/keeping work	328	23%
Quality of your current home	404	19%
Buying healthy food	391	18%
Leaving your home to do daily activities	368	17%
Paying your rent/mortgage	402	17%
Affording medical care	364	17%
Quality of your neighborhood	401	17%
Affording mental health care	317	16%
Paying for prescription medications	274	13%
Obtaining elderly home care services for myself or someone else	206	12%
Being evicted from your current home	164	8%
I was stressed about something else	599	26%

Source: My Health Story 2022
Unweighted frequencies and percents among Monroe County Participants calculated by Common Ground Health
Total responses between 1,429 and 2,332, non-response between 40 and 942

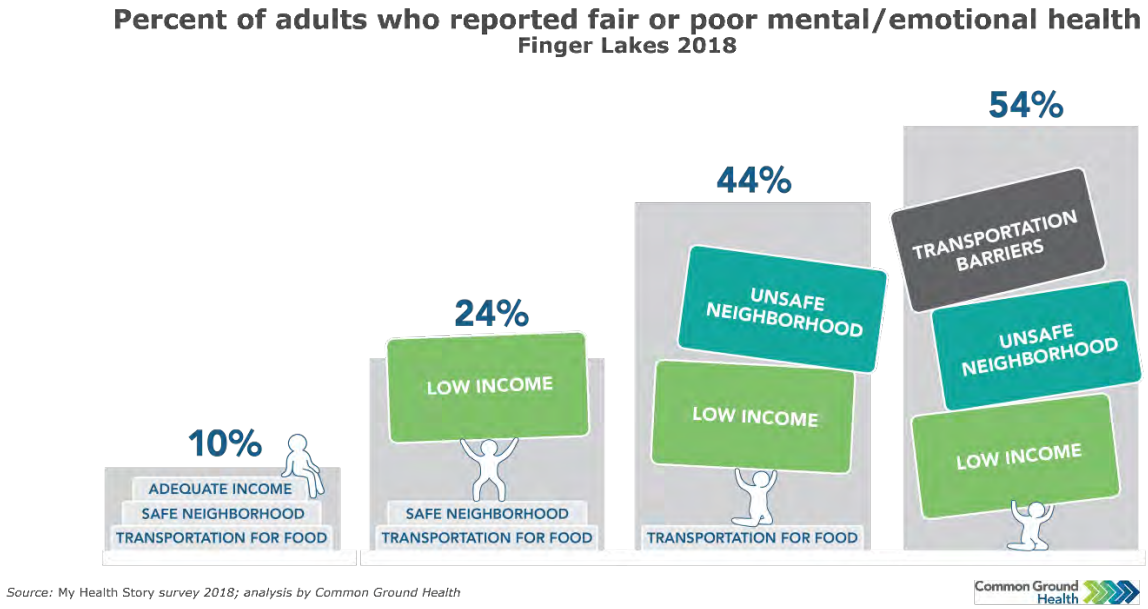
Common Ground Health

To add additional context to these findings, statistical analyses were conducted to show that respondents who were "sometimes", "often" or "always" stressed about their own health and well-being were 8 times as likely as people who were not stressed about this to have also reported having a concern about their own mental health. Similarly, people who said they were stressed about work or their family's health and well-being, compared to those who weren't stressed about these things, were 6 times as likely to have also reported having a concern about their own mental health.

This analysis highlights how various personal and social factors can increase the likelihood of experiencing poor mental health, but what are the cumulative effects of these factors for an individual? **Figure 1.15** below, generated from My Health Story 2018 survey data, demonstrates how the prevalence of poor mental health rises with the convergence of stressors. While it is beyond the scope of this assessment to deeply analyze these underlying issues that contribute to behavioral health and well-being, any

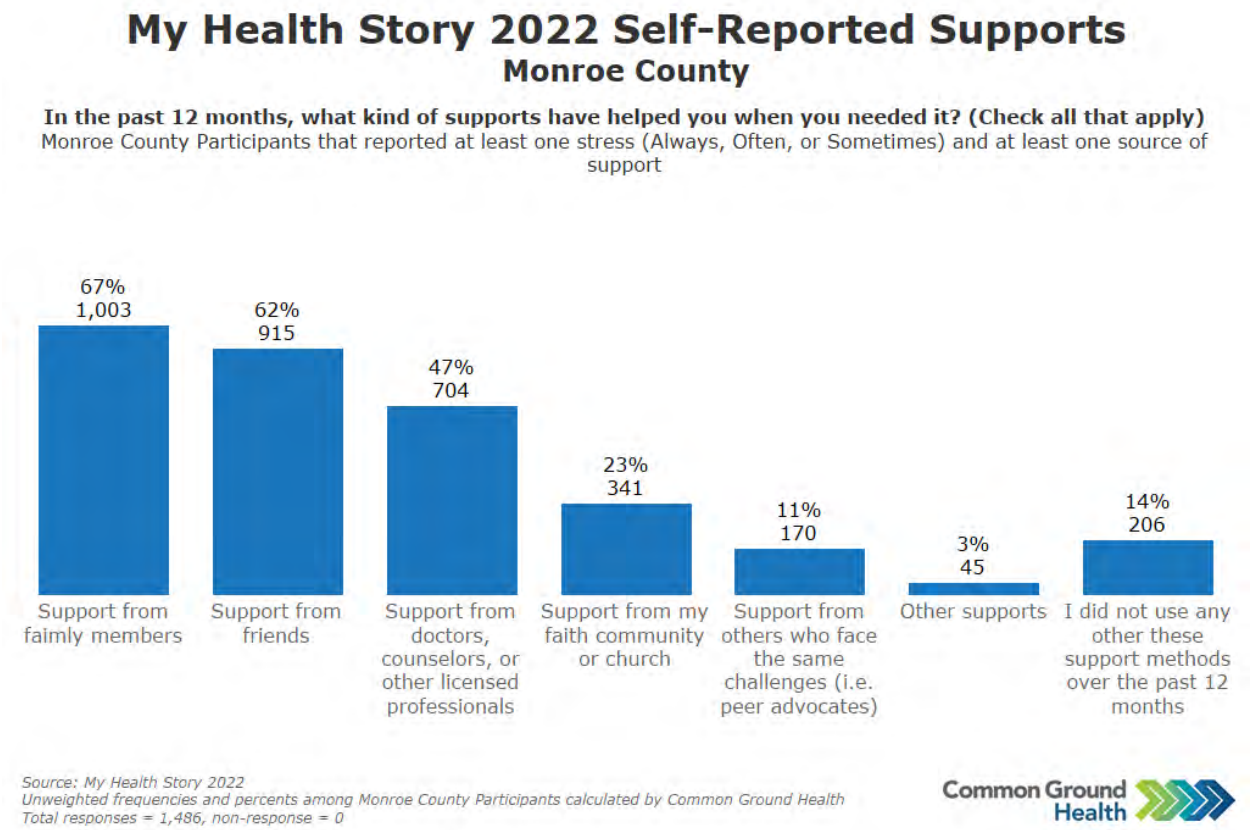
long-term approach to improving behavioral health will require acknowledgement of and interventions geared toward addressing these factors.

Figure 1.15



Adequately addressing mental and behavioral health concerns requires a wide variety of interventions, as there is no one-size-fits-all approach. Every person is an individual with their own blueprint on what is needed to reach mental wellness that could include everything from cultural and linguistic fit and setting and style of intervention, to accessibility of interventions and trust with service providers. There are many places, both within the healthcare system and within the community, where people turn when support is needed (**Figure 1.16**). While not explicitly asking about supports used for behavioral health, but rather supports utilized in general, My Health Story 2022 showed that approximately two-thirds of respondents looked to family members for support, 62% reached out to friends, 47% utilized licensed professionals, and just under a quarter of respondents relied on their faith communities. This alludes to the importance of considering both the clinical and non-clinical behavioral health services and supports within this assessment.

Figure 1.16



The methodology of this assessment will be discussed next, then the remainder of this report will dive into five focus areas using further data analysis and insights from community experts. The information presented here should be retained as it provides relevant context and factors to consider while absorbing and understanding the nuances of this very complex behavioral health system.

Methods

The behavioral health needs assessment consisted of two phases, the first was devoted to development and prioritization of focus areas, followed by the second phase that used qualitative and quantitative methods to further explore selected areas. In Phase I, we explored and analyzed internal data sets, reviewed community and national reports on behavioral health and its workforce for data, context and recommendations,[2] and convened and conducted listening sessions with an advisory group of content experts in the fields of mental and behavioral health. The goal of these listening sessions was to hear expert perspectives pertaining to behavioral health needs, opportunities, and priorities within the county.

We also utilized multiple quantitative data sources to inform this assessment. Our team and partners performed a wide variety of targeted analyses to understand the behavioral health needs of the community. The table below lists the data sources analyzed along with a short description of each. For more information on analytic definitions, please see appendix B.

This assessment incorporates information from a variety of publicly available data sources as well. Links to key sources are provided here, as there is additional information that may be of interest to readers of this report.

- Monroe County Office of Mental Health Summary Reports
- Monroe County Youth Risk Behavior Survey (2023-24 School Year Report)
- City of Rochester Person in Crisis (PIC) Team Dashboard

[2] For a complete list of referenced reports please see "References."

Data Source	Description
SPARCS†	The Statewide Planning and Research Collaborative (SPARCS) reporting system is managed by the NYS Department of Health and collects hospital system data on all inpatient stays and outpatient visits (including emergency department and ambulatory surgery).
My Health Story	My Health Story (MHS) is a public health surveillance survey developed by Common Ground Health and administered to residents in the Finger Lakes region of New York State. The survey was conducted most recently in 2022.
Multipayor Claims	The Common Ground Health Multipayor Claims dataset provides detailed claims-level information (inpatient, outpatient, pharmacy) aggregated from large regional health insurance companies. This dataset covers a very large portion of the region's population and includes commercial, Medicaid, and Medicare claims. However, the data does not cover the entire population and notably does not include information for people without healthcare insurance.
BRFSS	The Behavioral Risk Factor Surveillance System (BRFSS) is a survey developed by the CDC and administered by each state to collect data regarding health-related risk behaviors, chronic health conditions, and use of preventive services.
Vital Statistics - Mortality	The Mortality data from the NYSDOH Vital Records office is based on death records and includes information about cause of death and demographics of the deceased.
211/LIFE LINE Call Trends	Goodwill of the Finger Lakes runs 211 / LIFE LINE, and performed a custom analysis of call volumes, reasons, and patterns to support this Behavioral Health Needs Assessment.
YRBS	The Youth Risk Behavior Survey (YRBS) is conducted by the Monroe County Department of Public Health to collect information about the high school student population.

Based on information gathered from data analysis and report review, we generated a framework to guide the assessment, helping to ensure that advisors were representative across the many parts of the behavioral health system. Advisors to the assessment represented a broad range of organizations and specialties within the behavioral health field. The advisory group contained members from major healthcare systems as well as private practice practitioners, behavioral health peer organizations and peer-led programming, content experts on behavioral health for infants, children, adults, and older adults, community supports such as Emotional Emancipation Circle leaders, healers for the healers, community faith leaders, and coalition members

† This assessment includes charts and analyses produced from raw data provided by the New York State Department of Health (NYSDOH). However, the conclusions derived, and views expressed herein are those of the authors and do not reflect the conclusions or views of NYSDOH. NYSDOH, its employees, officers, and agents make no representation, warranty or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here.

representing African American, Latino, New American populations, and many more.[4] Quotes referenced throughout the report come directly from advisory group participants. While a comprehensive dive into all facets of behavioral health was not feasible for this effort, initial exploration and consultations led us to identify five areas in which to focus the assessment:

1. Crisis services and post-crisis care
2. Mental health of children and youth
3. Systems gaps and coordination issues
4. Retention and diversity of workforce
5. Community connectors and mental health supports

After the identification of priority areas, phase II of the needs assessment consisted of an additional round of each of the three previous steps. We further refined data analyses and literature reviews for each of the priority areas, with a deeper dive into different demographic characteristics as well as barriers and other areas mentioned by advisors during initial listening sessions. We hosted supplementary listening sessions with a combination of existing and new advisors for select priority areas where additional information was needed. This information was then synthesized into an overview of the behavioral health landscape within Monroe County to provide initial context to readers, as well as five sections devoted to each of the selected priority areas.

[4] For a complete list of acknowledgments for the advisory group and participating organizations please see "Acknowledgements."

Section 2:
CRISIS SERVICES & POST-CRISIS CARE

When people use crisis services, it indicates that they have not received the type or level of care needed to treat or manage their behavioral health conditions. Large increases in use of the emergency department (ED) and other crisis services over the last 15 years indicate a growing need within Monroe County.

The Monroe County Office of Mental Health identified crisis services as a priority in its 2024-2027 services plan based on community input. Similarly, the advisory group also highlighted the importance of addressing crisis care, as well as the transition to supportive post-crisis care. When an individual utilizes crisis services, it is an indicator that they likely did not receive the type or level of care needed to treat or manage their behavioral health condition. Thus, looking at data related to crisis services helps to provide a glimpse into unaddressed community needs. As we will see later in this section, the large increase in use of the emergency department (ED) and other crisis services over the last 15 years indicates a growing need from the community. Through discussions with the advisory group and review of community reports, there are some clear opportunities to help prevent crisis from initially occurring, better support patient needs during crisis, and help facilitate a smooth and successful transition to post-crisis care.

The following section is divided into three topics:

- *Overview of Crisis Service Utilization* in which we aim to share and explore available data related to crisis service utilization within Monroe County. The Statewide Planning and Research Cooperative System (SPARCS)[5] database from the New York State Department of Health will largely be used here to first look at ED treat-and-release visit rates by different conditions and demographic characteristics, followed by a look at inpatient hospitalization rates. The data is presented for all behavioral health conditions in aggregate and shown separately for the two primary subcategories of mental health and substance use disorders.
- *Challenges and Opportunities Within Crisis Services* in which we explore areas of continued need and modifications necessary to help improve patient experience and outcomes, as well as ways in which the community could begin to address those needs.
- Similarly, in *Challenges and Opportunities Within Post-Crisis Care,* we explore barriers and opportunities that exist for the transition of care from crisis services to post-crisis support.

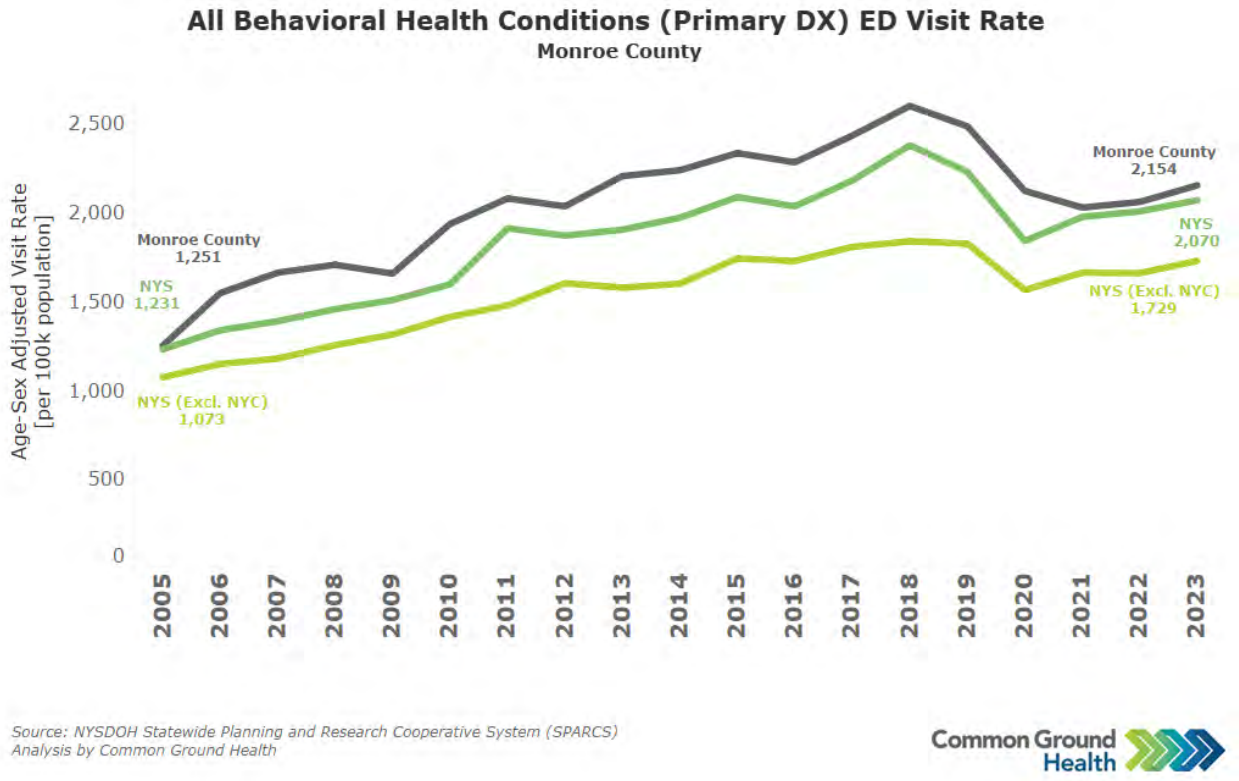
[5] For more information on the SPARCS database, please reference the Methods section of this report.

Overview of Crisis Service Utilization

Emergency Department Treat-and-Release Care

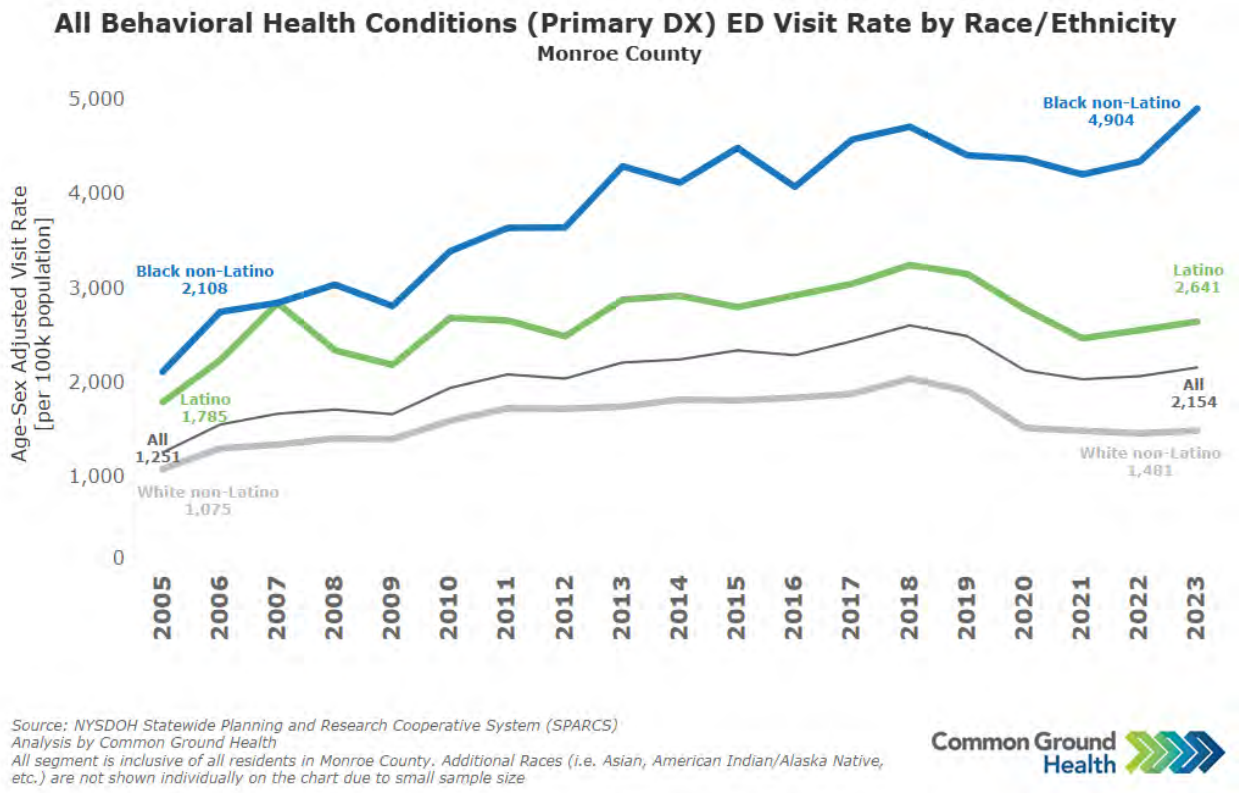
Treat-and-release refers to visits where an individual was treated within the emergency department but then released without being admitted to the hospital for an inpatient stay. **Figure 2.1** illustrates that Monroe County emergency department (ED) treat-and-release visit rates for all ages for behavioral health conditions – based on primary diagnosis (DX) – consistently exceed state rates and nearly doubled for the county between 2005 and 2018. Rates fell significantly in 2020 due to the COVID-19 pandemic and, while they have slowly increased again, they are still significantly lower than the peak in 2018. An advisor noted that, in recent years, new outpatient resources have helped people who otherwise were likely to have needed crisis care via the ED. This is consistent with the general pattern viewed in **Figure 2.1**, with a drop in ED rates in 2020 and less of a rebound in rates afterward compared to the rest of the state. A few examples of these resources include one of the major healthcare systems adding a building in 2020 that doubled their outpatient capacity (roughly boosting overall local capacity by 30%), Forensic Intervention Team (FIT) and Person in Crisis (PIC) providing services to people who otherwise would have ended up in the ED, as well as a new urgent care facility which opened recently within the area.

Figure 2.1



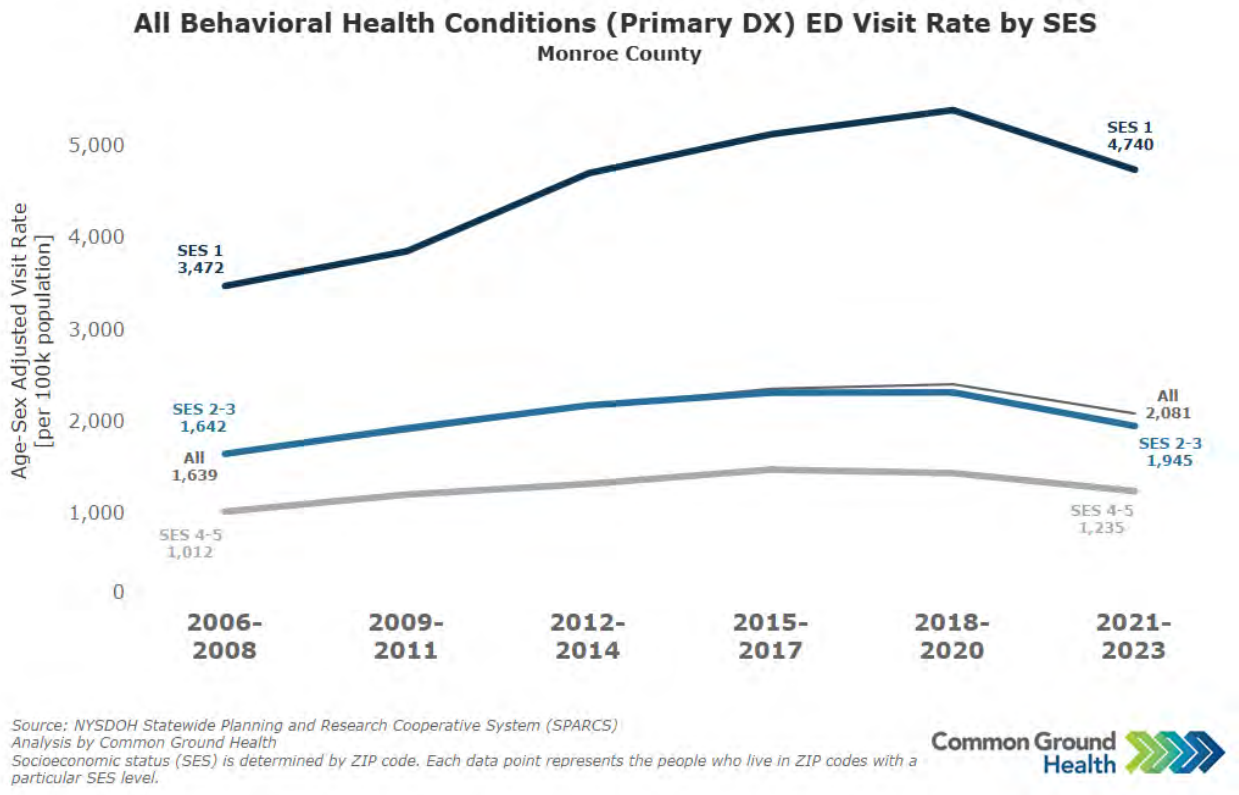
If we look at this same data segmented by race and ethnicity (Figure 2.2), we see that ED visit rates are much higher for the Black non-Latino and Latino populations than the white non-Latino population. Furthermore, the disparity between the Black and white populations has grown. In 2005, the Black non-Latino rate was roughly two times the rate for white non-Latinos. In 2023, this disparity was over three times as great.

Figure 2.2



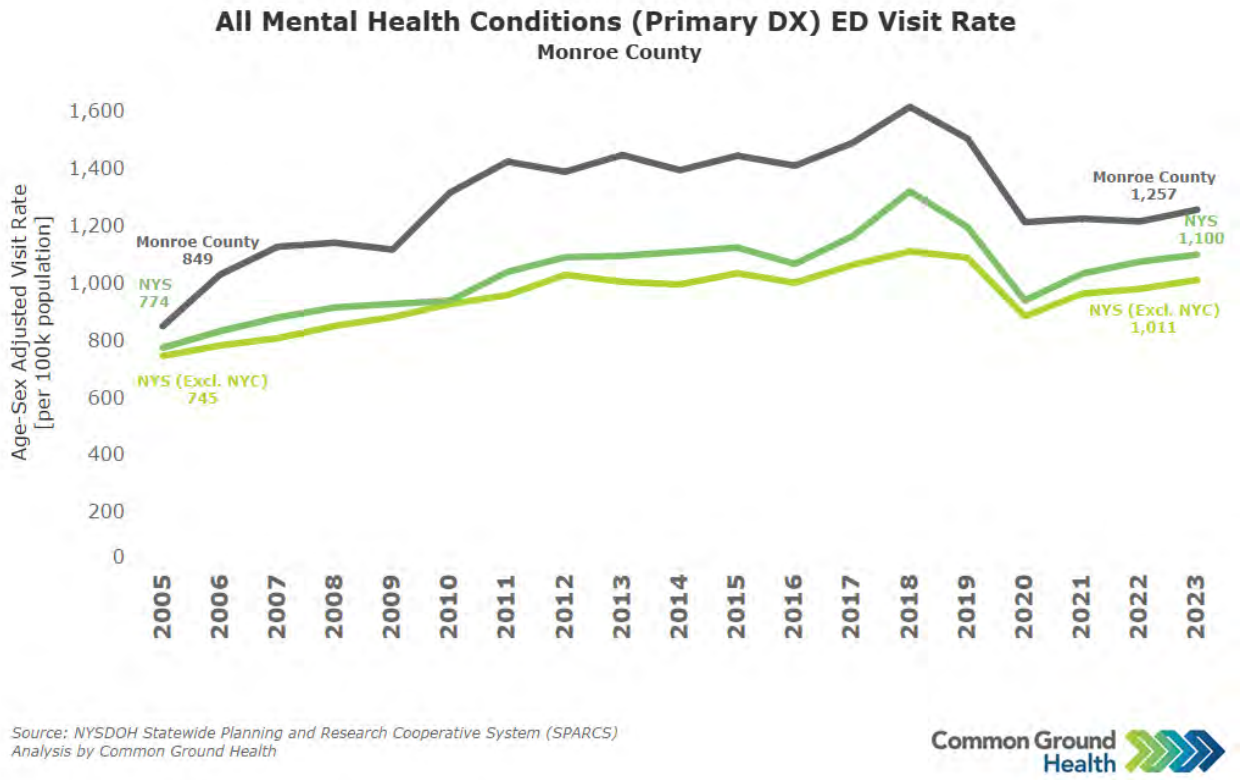
Likewise, if we segment this data by socioeconomic status (SES), it is evident that disparities faced by people living in ZIP codes with low SES have also grown. In 2023, the low SES ZIP codes had an ED visit rate that was nearly four times the rate in high SES ZIP codes (**Figure 2.3**).

Figure 2.3



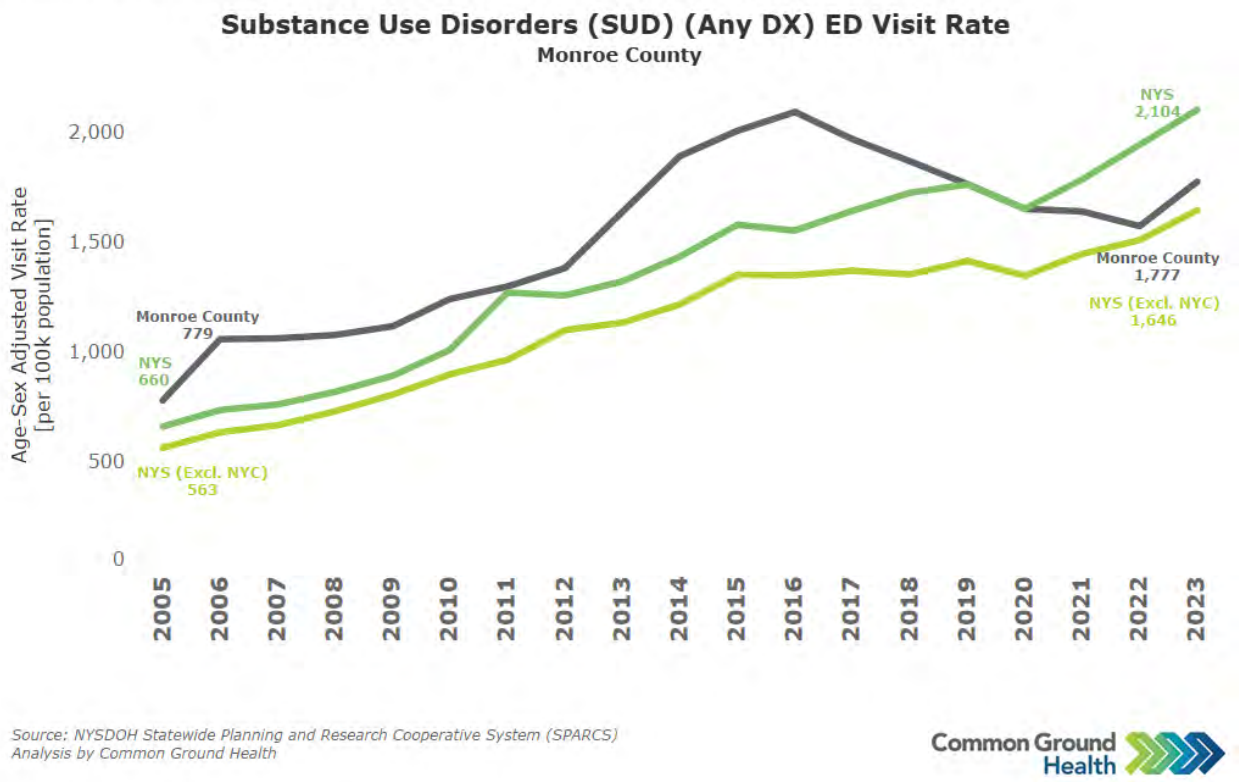
To better understand the behavioral health ED trends, it is helpful to look separately at the data for visits driven primarily by mental health and substance-use disorders, which together comprise the behavioral health data. The mental health ED visit rates (**Figure 2.4**) follow a similar pattern to the overall behavioral health rates within Monroe County. Likewise, the data for mental health is similar regarding race and ethnicity and SES outcomes as well, showing disparities faced by Black non-Latino and low SES populations.

Figure 2.4



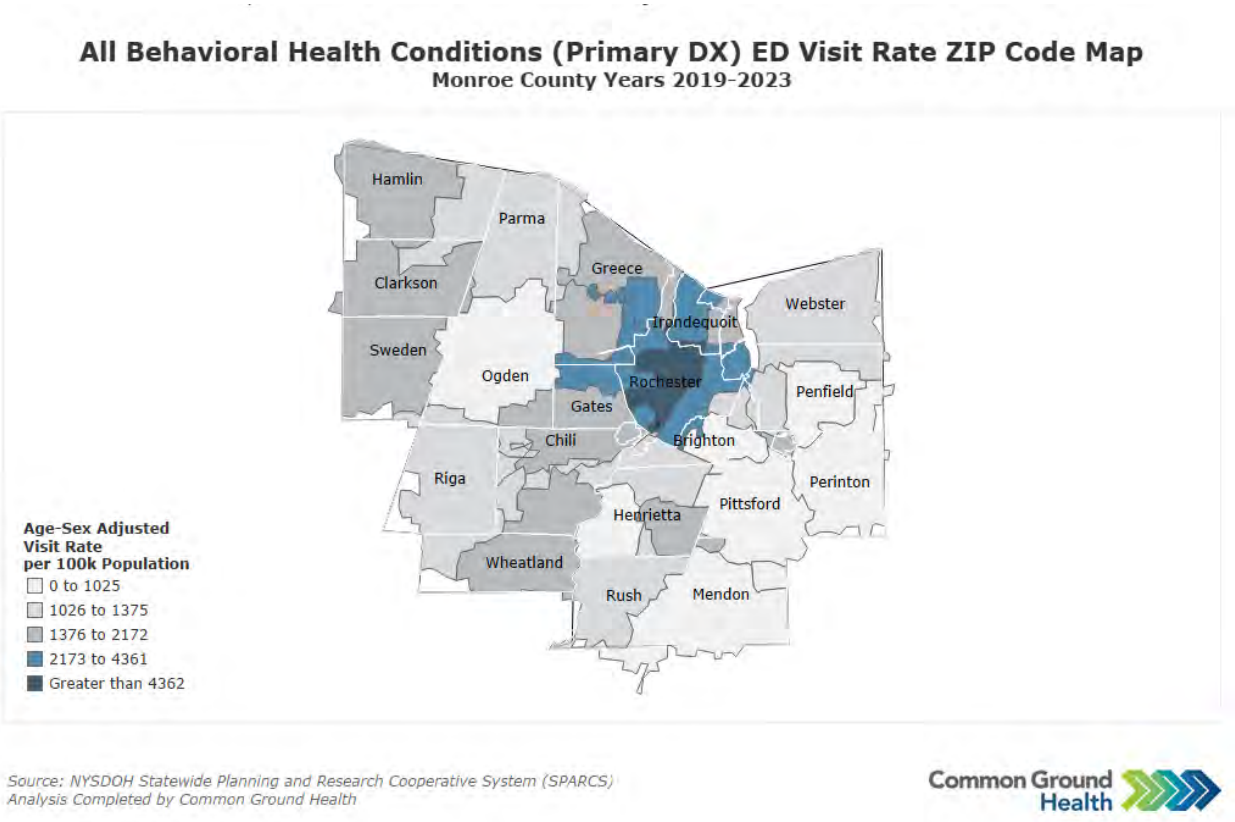
ED visit rates for substance use disorders (SUD) peaked within Monroe County in 2016, with a steady decline until a rise in 2023. Notably, this decline contrasted with a continued rise in the state-level rates, such that Monroe County is no longer significantly above the state as it was in the mid-2010s (**Figure 2.5**). Akin to the patterns viewed within the behavioral health and mental health ED data, higher SUD ED visit rates were seen among Black non-Latino residents when compared to other racial and ethnic groups, and this population also had the largest increase in rates post-COVID. Regarding SES, low SES ZIP codes, again, had significantly higher ED visit rates for SUD.

Figure 2.5



The map below (**Figure 2.6**) provides a more targeted look at the prevalence of behavioral health-driven ED visits based on ZIP code. There are clear and large disparities, with many areas of the City of Rochester having ED visit rates that are five or more times the rates experienced by people living in suburban areas. The ZIP codes with the highest rates of behavioral health-driven ED visits were: 14605, 14608, 14611, 14613 and 14621. The ZIP codes with the lowest rates were: 14534, 14586, 14450, 14618, and 14472.

Figure 2.6



Repeat visits to the ED is another area of consideration, as repeat visits may be indicative of unmet needs or a gap in care. SPARCS analyses provide the following statistics for 2023:

- Of people visiting the ED with a mental health condition as their primary diagnosis, 45% have at least one additional behavioral health-related ED visit within the same year (2023).
- Of people visiting the ED with substance use disorder as their primary diagnosis, 29% have at least one additional behavioral health-related ED visit within the same year (2023).

This demonstrates that a sizeable proportion of individuals who visit the ED for a behavioral health-related reason have reoccurring issues and return to the ED for additional crisis care. These statistics also show that people with mental health concerns as their primary diagnosis tend to return to the ED more frequently than

people who had substance use disorder as their main concern. Additional insights are provided with Figure 2.7 below.

Earlier in this section, overarching categories of behavioral health, mental health and substance use issues were assessed to gain a general understanding of trends within the county. Further breakdown of this data helps to identify more specific areas of concern. The following table provides additional detail about the most common conditions among behavioral health-driven ED visits in 2023. Of the conditions shown, intentional self-harm had the greatest impact with the highest total number of visits and percentage of patients with repeat visits.

Figure 2.7

Top Reasons for Behavioral Health ED Visits
Monroe County

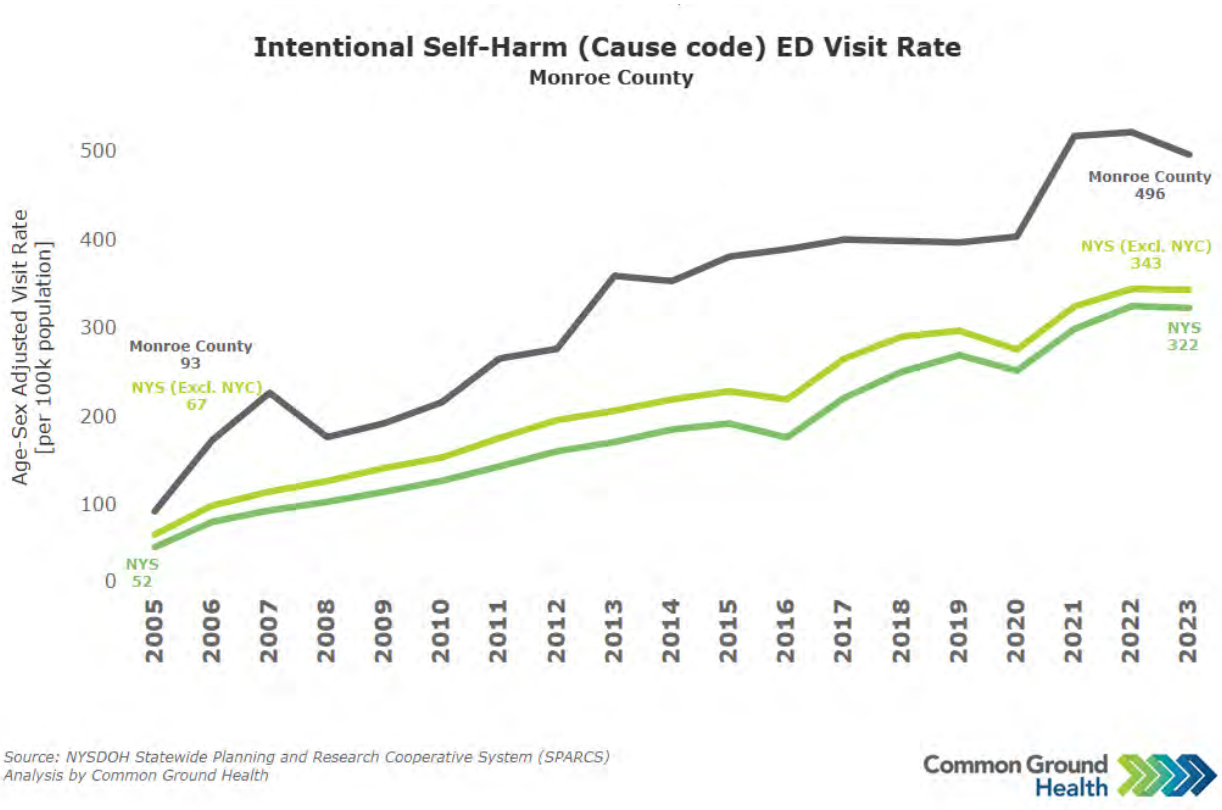
Condition	Total Visits	Total Patients	Percent of patients with more than 1 BH ED visit
Intentional Self-Harm	3,492	2,182	85%
Alcohol Use Disorders (AUD)	3,079	2,172	27%
Drug Use Disorders	2,799	1,780	41%
Depressive, Bipolar, and Other Mood Disorders	1,868	1,478	59%
Trauma/Adjustment Disorders	1,443	1,255	47%
Anxiety/Panic Disorders	1,402	1,214	33%
Schizophrenia spectrum and other psychotic disorders	1,304	725	51%
Personality Disorders	1,169	347	71%
Drug Overdose	996	885	27%
Conduct Disorders	731	557	64%

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

As shown in Figure 2.8, the rate of intentional self-harm visits has grown rapidly over the past 15 years across the state, and especially in Monroe County. A deeper dive by race, ethnicity and SES shows similar patterns to those for the overarching behavioral health data. Black non-Latino residents had much higher visit rates than other groups.

In 2023, the visit rate for the Black non-Latino population was 1062 per 100,000 which was nearly double the rate for the Latino population (542 per 100,000) and nearly triple the rate for the white non-Latino population (375 per 100,000). For comparison, the Monroe County average was 496 per 100,000. Not only was the rate higher, but Black non-Latino residents experienced increasing rates since the COVID-19 pandemic, whereas rates for other racial and ethnic groups leveled off or decreased. When looking at disparities by socioeconomic status, people living in the ZIP codes with low SES had nearly triple the rate of ED visit rates for intentional self-harm than people living in ZIP codes with high SES.

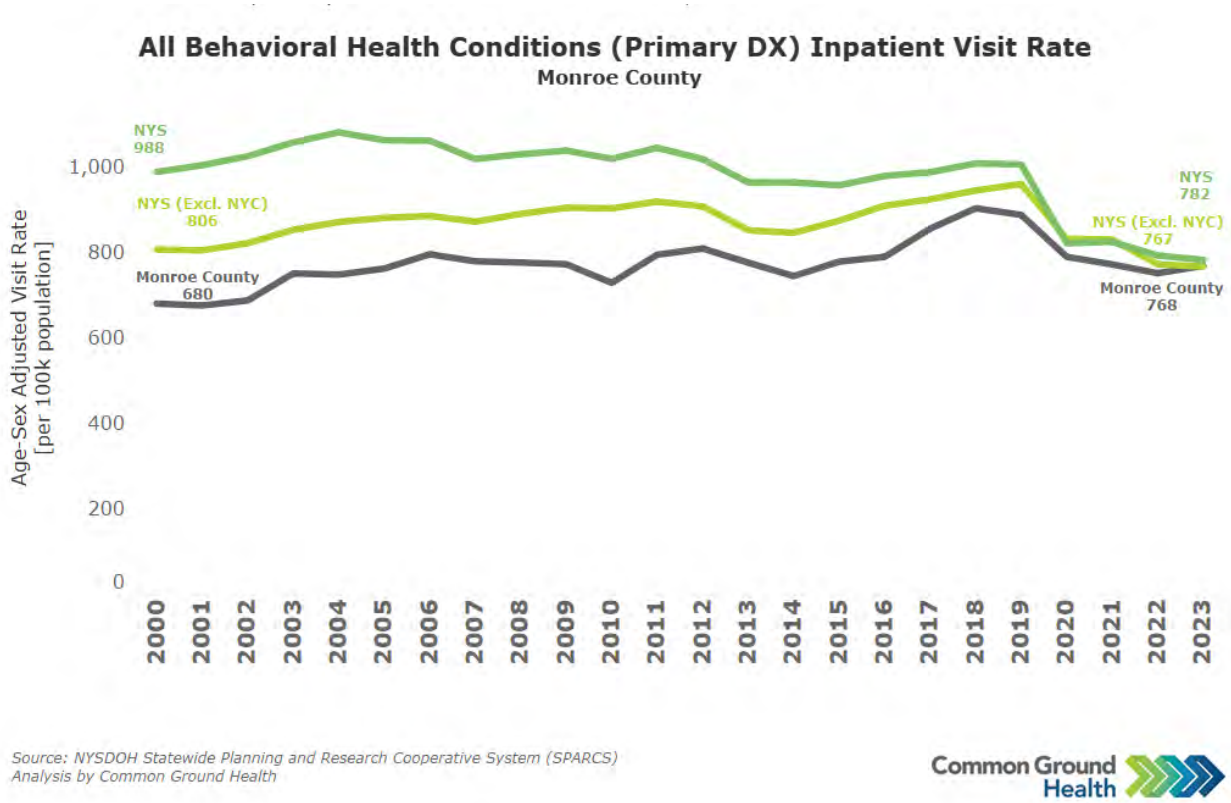
Figure 2.8



Inpatient Care

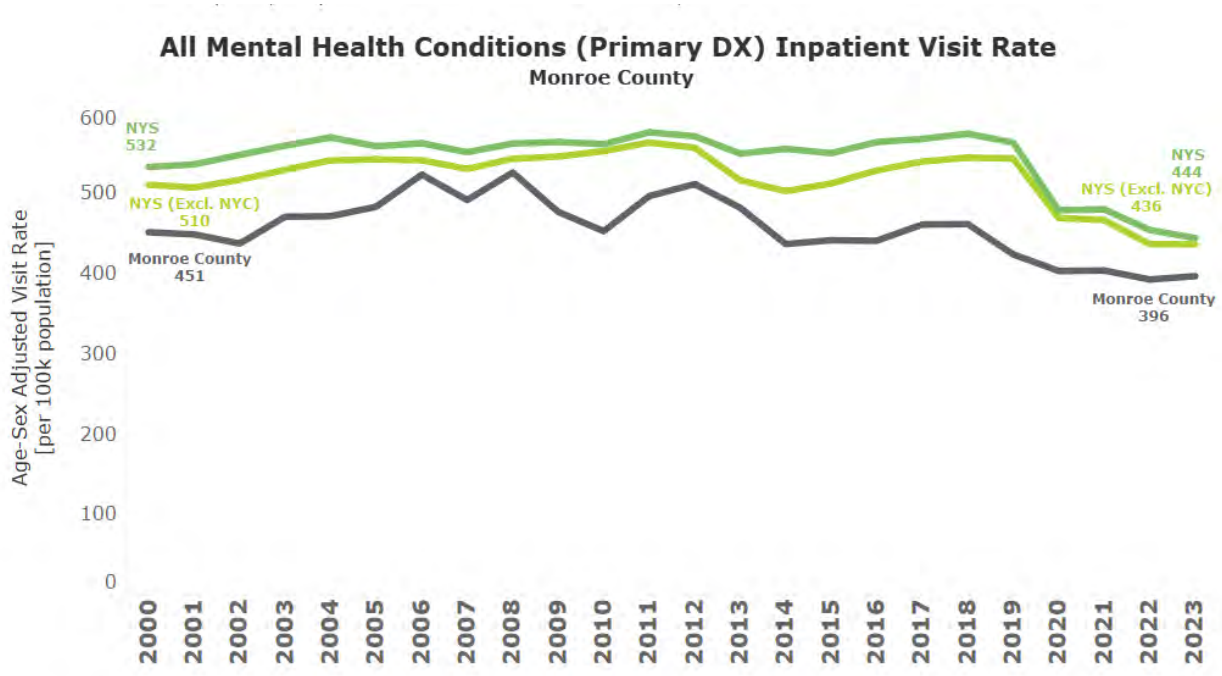
In addition to analyzing patterns in ED usage, we also looked at inpatient admission data to understand the trends of patients needing more intensive care. Unlike ED utilization, which has increased greatly over the past several decades, inpatient admissions have been relatively stable. The inpatient visit rate has consistently been below the overall NYS rate, but since the COVID-19 pandemic, the state rate has fallen to nearly match the county (**Figure 2.9**).

Figure 2.9



A closer look at the causes for admission shows a persistent, gradual decline in admissions for mental health diagnoses, and a rise in admissions for SUD (per **Figure 2.10** and **Figure 2.11**).

Figure 2.10



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Figure 2.11

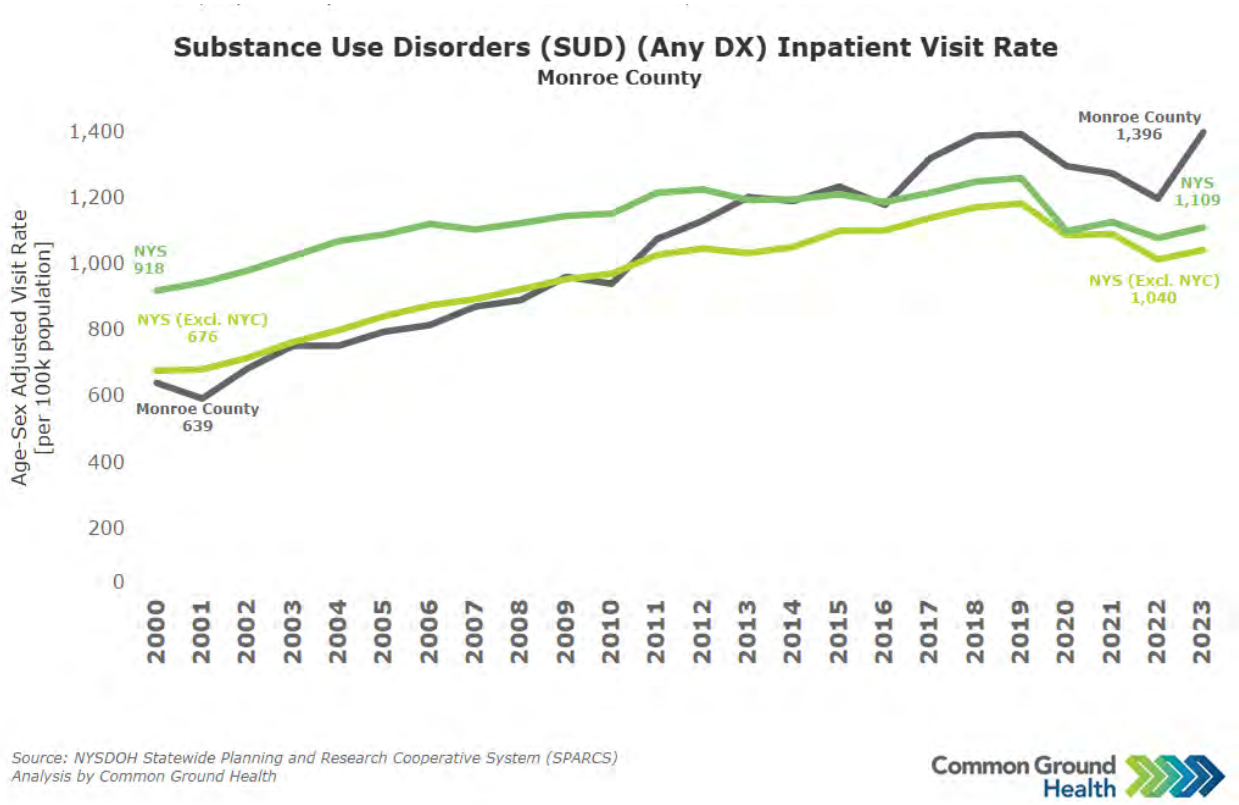


Figure 2.12 shows more detail regarding the most common reasons for behavioral health hospital admissions. As we saw with ED visits, the most common reason in 2023 was intentional self-harm, which had the most total visits and greatest number of individual patients. Alcohol use disorders were the second-most common reason, followed by schizophrenia spectrum and other psychotic disorders, which also had the longest average length of stay (16 days). It's also important to note the large percentage of patients who had more than one visit to the hospital related to a behavioral health concern, which is indicative of unmet needs and potentially unresolved behavioral health issues.

Figure 2.12

Top Reasons for Behavioral Health Inpatient Visits
Monroe County

Condition	Total Visits	Total Patients	Percent of patients with more than 1 BH ED visit	Average Length of Stay	Total Bed Days
Intentional Self-Harm	1,782	1,451	76%	12	20,566
Alcohol Use Disorders (AUD)	1,571	1,105	31%	10	15,048
Schizophrenia spectrum and other psychotic disorders	1,216	903	43%	16	19,963
Drug Overdose	1,097	1,026	14%	9	10,361
Depressive, Bipolar, and Other Mood Disorders	1,002	848	75%	12	11,697
Drug Use Disorders	814	687	30%	15	11,906
Trauma/Adjustment Disorders	157	148	52%	5	832
Anxiety/Panic Disorders	65	61	80%	7	425
Feeding and eating disorders	56	45	40%	12	677

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

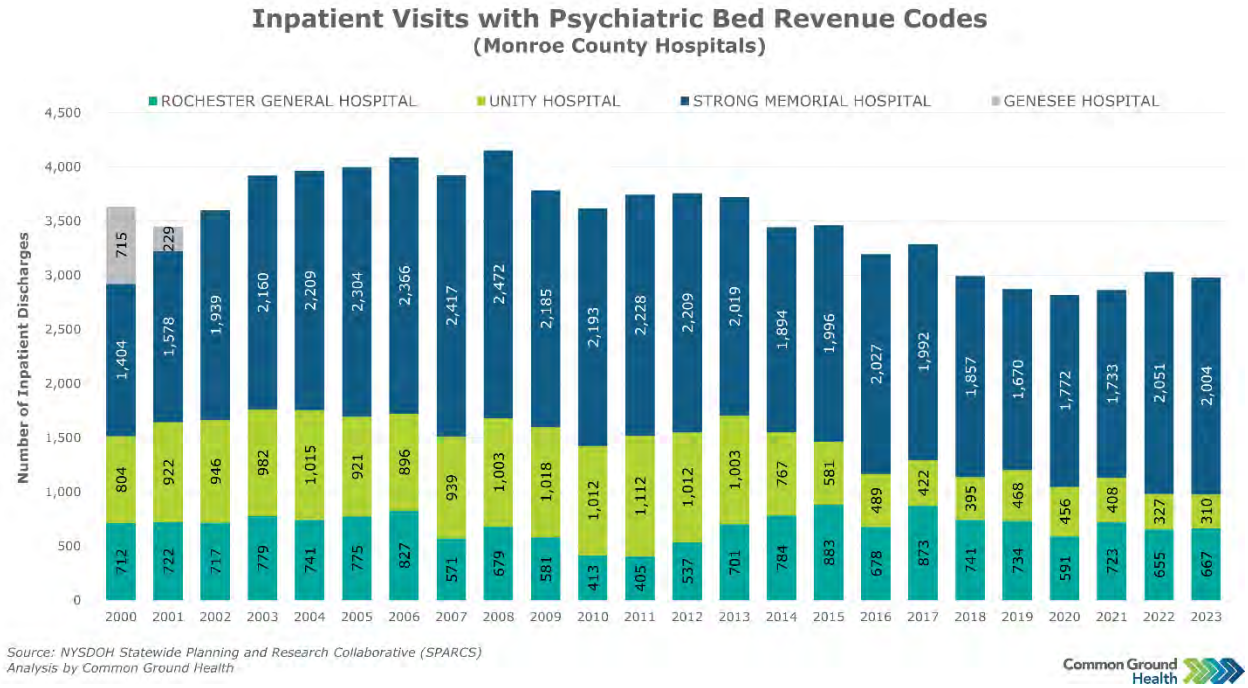
When looking at inpatient utilization trends, we also explored the different types of beds and staffing that are available. In particular, we focused on the availability and use of designated psychiatric hospital beds, since these are specifically designed and staffed to provide around-the-clock care for patients experiencing mental health concerns.

There are currently 132 psychiatric beds in operation in Monroe County: 90 at Strong Memorial Hospital, 30 at Rochester General Hospital, and 22 at Unity Hospital[6]. All of these are intended for adult patients apart from 24 of Strong Memorial's beds which are for pediatric patients. Analysis shows that the number of admissions to psychiatric beds in Monroe County hospitals was significantly lower in recent years compared to

[6] Unity has NYS Certificate of Need (CON) approval for an additional 18 adult beds that are currently offline. Strong Memorial has CON approval for an additional 3 pediatric beds that are expected to be brought online in near future.

15-20 years ago (**Figure 2.13**). This is in part because of an increase in availability of outpatient services to address patient needs without requiring inpatient care. The total utilization (occupied bed days) has also decreased, but not by as much because the average length of stay is longer. Average length of stay increased 17% from 11.3 days in 2010 to 13.2 days in 2023. This is an expected result when more outpatient services are available, which means inpatient care tends to focus on patients who have greater or more complex needs.

Figure 2.13

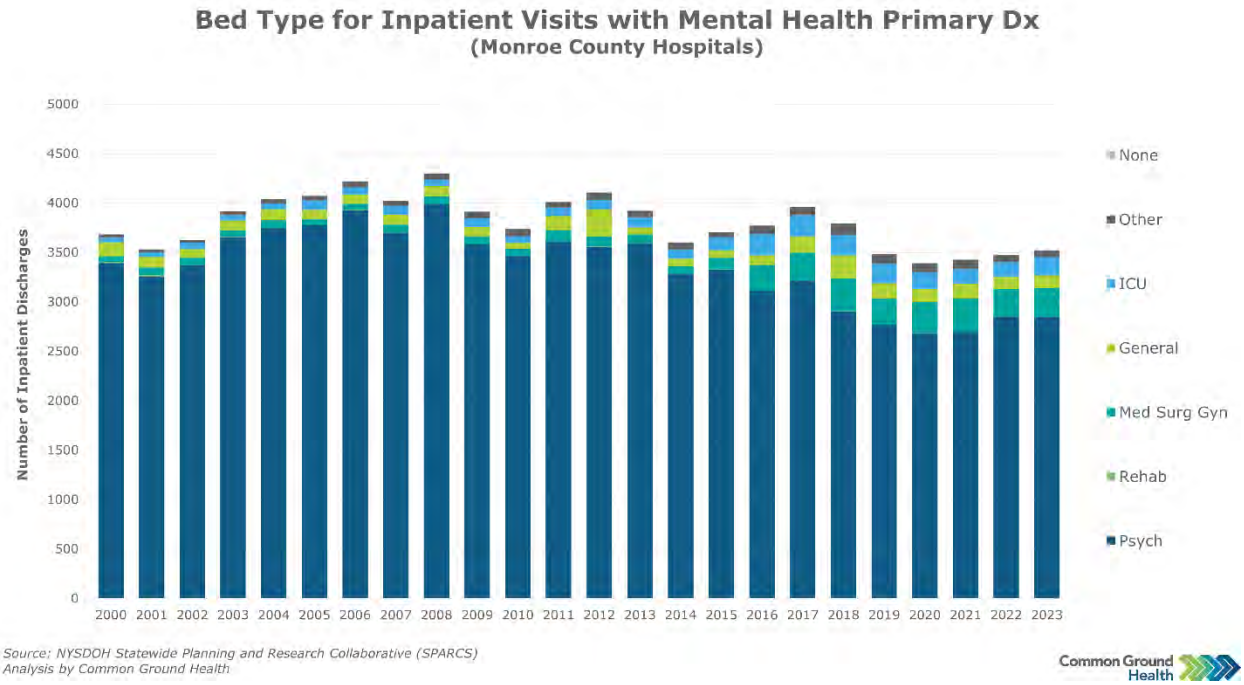


SPARCS data[8] also show that mental health patients are less likely to be assigned a psychiatric bed than in the past. **Figure 2.14** demonstrates a cohort of patients admitted to the hospital with a mental health primary diagnosis and the types of beds they were assigned for their stay. The data show that, in 2000, 92% of these patients were assigned a psychiatric bed, but in 2023 this was down to 80%. Compared to the past, a larger share of patients admitted for mental health concerns are placed in either general, medical/surgical, or beds within the intensive care unit (ICU). Additional

[8] This analysis focused on patients with mental health diagnoses as patients with substance use disorders are typically assigned to either general, medical/surgical, rehab, or ICU beds.

research is needed to determine the reasons for increased use of non-psychiatric beds for these patients, particularly if this is due to lack of available psychiatric beds or if patients require care that can be provided on these other units.

Figure 2.14



The next two subsections of this report explore crisis services and post-crisis care separately, noting challenges and opportunities that exist within each. The transition between the two types of care will also be assessed.

Challenges and Opportunities within Crisis Services

We consulted local advisors within the behavioral and mental health fields to hear their insights on crisis services available to residents of Monroe County, as well as what may be done to help bolster these services to provide the best care possible to those in need. Challenges mentioned by advisors fell within one of three categories:

- Systemic issues

- Interorganizational issues
- Intraorganizational issues

Systemic Issues

The current medical system was noted to be more reactive than preventative in nature, resulting in more behavioral health interventions geared toward current concerns and crises and less aimed at preventing or addressing those concerns earlier in their development. However, this is not an issue unique to the behavioral health field but rather applies to the overall healthcare system. Physical conditions such as diabetes and hypertension are manageable outside of the ED when patients are connected with physicians and specialists and have a care management plan that mitigates social drivers of health and other potential barriers to care, but individuals often end up in the ED due to complications from these conditions that could have been prevented. The same could be said for many behavioral health conditions. To compound this issue, many individuals lack trust in the medical system to have their best interests at heart, which dissuades them from seeking care earlier on and leads to worsened outcomes over time. When people do not receive needed preventative care, they are more likely to need crisis care.

> *"People come to hospitals because it's the only place that can't refuse people…lack of care coordination ends up in emergency settings."*

With a system that is more reactive toward patient care, the emergency department ends up playing a large role in mental and behavioral health stabilization. Multiple advisors indicated that a combination of lack of options to care and programmatic barriers make it difficult to access care, which reduces preventative measures and increases the likelihood of a potential ED visit. Thus, the ED serves as not just a last resort, but the only option that is universally available 24 hours a day, 7 days per week. A clinician remarked, "People come to hospitals because it's the only place that can't refuse people…lack of care coordination ends up in emergency settings."

Furthermore, emergency departments, while valued and critical components of the medical and behavioral healthcare systems, can be chaotic and stressful environments for those seeking care, especially someone seeking mental or behavioral health care. Crisis stabilization centers are good alternatives to the ED that allow patients to get needed care but in a different setting; advisors noted, however, that it is difficult to open these centers in New York State as there are many time-consuming steps and "red tape" that delay or deter this from happening. Funding is often disproportionate to regulatory demands.

Interorganizational Issues

Interorganizational coordination and collaboration is explored further in the System Gaps and Coordination Issues section of this report, but a few points directly apply to crisis services and are worth mentioning here. It was noted that, while there is access to mobile crisis and outreach teams within Monroe County, everything is funded individually, further encouraging a siloed approach that isolates, rather than links, care. Contrary to that strategy, we need to be pooling resources together, inclusive of collective goals and metrics that inspire a collaborative approach rather than competition among organizations.

The need for interorganizational collaboration can be further explored by examining the tragic death of Daniel Prude. In 2020, Prude was restrained by police officers during a mental health emergency and later passed away due to complications sustained from an injury during that encounter. This preventable event highlighted the need for collaboration between law enforcement and behavioral health professionals. To this end, Senator Samra Brouk, Assemblyman Kwani B. O'Pharrow, and Assemblyman Landon Dais introduced Daniel's Law to the New York State Legislature to help create a "compassionate, evidence-based crisis response system built on peer support and consent-based care" that would simultaneously take the pressure off of police departments and provide communities with the trained crisis professionals and support that is needed in those moments (Brouk, 2025). Person in Crisis (PIC) and Forensic Intervention Team (FIT) are great examples of such initiatives.

PIC is part of the City of Rochester's Department of Recreation and Human Services which partners with the Rochester Police Department, EMS and fire departments to

provide emergency response services for those experiencing mental health crises, substance use, homelessness, domestic violence, etc. PIC also connects individuals to other services as needed. FIT is a 24/7 crisis response unit within Monroe County which partners with mental health clinicians and law enforcement agencies to assist individuals who are experiencing a behavioral health crisis and connect them with appropriate care. PIC serves the City of Rochester where FIT primarily responds to calls from the rest of Monroe County (outside of the city) and has some additional capabilities such as involuntary transport.

Crisis response services require coordination with other community services, such as EMS and law enforcement as well as referral services such as 211/LIFE LINE, to streamline patient experience and eliminate time gaps in care that can lead to additional frustration and escalation of the situation. Coordination between these services is critical yet can only be accomplished through building those relationships and establishing buy-in from all participating organizations.

Lastly, behavioral health professionals should uniformly be made aware of all the crisis stabilization resources that are available within the county along with a decision tree that helps to answer the question of what service to use and when.

Intraorganizational Issues

Beyond the systemic and cross-organization challenges, there are also intraorganizational opportunities to provide people with crisis care that better meets their needs. A couple of key opportunities are to improve upon the timeliness of crisis intervention, as well as the need for additional resources to serve populations with specific circumstances and needs. The timeliness of intervention is important throughout the continuum of care but becomes critical when a person is in mental health crisis. One clinician illustrated this point with the example of an individual with suicidal ideations left waiting for 24 hours before care was initiated. Another clinician highlighted, "Most resources close for a certain period of time and people are in crisis 24 hours a day. If a place isn't open, then we can't refer people there. Hard to tell someone 'You can go there in the morning.' If we had more facilities open with longer hours and more places that are accessible and easy to get to [you're] not going to be told 'you have to call back for an appointment' or 'we can schedule you in 6 months.'"

While some after-hours resources exist, there is also a general lack of public awareness of those resources and how to access and navigate them. For those who do connect with these services and receive care, certain barriers may still exist to receiving follow-up care after initial contact. For example, follow-up care may be conducted via telephone, to which not everyone has access.

> *"[We need] more facilities open with longer hours and more places that are accessible and easy to get to [so you're] not… told 'you have to call back for an appointment' or 'we can schedule you in 6 months.'"*

In response to both existing resources and additional areas of identified need, advisors voiced several areas of opportunity, the first suggests having more drop-in mental health centers with open access located in the geographic areas where they are needed. These drop-in centers are, essentially, "psych urgent cares" where people can receive support and psychiatric evaluation services without having to enter the emergency department setting. BHACC and CPEP provide related services to the community:

- Behavioral Health Access and Crisis Center (BHACC): located at St. Mary's Medical Campus and is an alternative to the ED for urgent mental health needs. Provides crisis stabilization, safety planning, and referrals.
- Comprehensive Psychiatric Emergency Program (CPEP): located at Strong Memorial Hospital and provides 24/7 emergency mental health care for those in crisis. Includes an emergency psychiatric unit, extended observation beds, and crisis beds.

Advisors expressed concern over the care of populations with particular conditions as well. There are resources available for those who are experiencing a *mental* health crisis, but some advisors voiced that there are little to no resources available for those experiencing a *behavioral* health crisis (without suicidal ideations). This premise had been articulated throughout the listening sessions: the lack of proper resources for behavioral health crises and individuals with dual diagnoses of mental health and

substance use. Other populations in need of behavioral health services that were specifically mentioned included the unhoused, those who experience domestic violence, and youth. More transitional housing and supports are needed for survivors of domestic violence and youth, and more shelters that are staffed with mental and behavioral health professionals are needed for the unhoused.

Another recommendation was centered around patients with a higher risk for mental health and substance use issues specifically. It was mentioned that, years ago, the Office of Mental Health and OASAS had an interagency council focused on work with people with co-occurring issues and had dual coordinators around the state effectively serving this population. Revisiting this work is one potential avenue to better serve those with dual diagnoses, as well as expanding the use of Crisis Stabilization Centers which could also help to treat those with substance use issues.

The use of peers within crisis care was also highlighted due to their ability to assist in reducing stigma around mental and behavioral health and lend their lived experience to help those in crisis feel more heard, seen and comfortable.

Challenges and Opportunities within Post-Crisis Care

Advisors also spoke to barriers faced within the transition to and delivery of post-crisis care, coupled with opportunities to improve patient care using past and current best practices. This section will be divided into the following topics:

- ED-Visit Follow-Up Data
- Limited Availability of Acute Step-Down Care
- Social Drivers of Health as Limiting Factors to Follow-Up Care
- Advantages and Shortcomings of Case Management and Care Coordination
- Opportunities and Promising Practices

ED-Visit Follow-Up Data

The Common Ground Health Multipayor Claims Database was utilized to see if people were getting follow-up care after behavioral health-driven ED visits. These data were analyzed by insurance type and socioeconomic status (SES) for both mental health conditions and substance use disorders (based on the primary diagnosis of the visit).

Figures 2.15 and 2.16 show the overall follow-up rates at both 7-day and 30-day intervals. Follow-up rates for mental health conditions have steadily increased since 2016, with 39% receiving follow-up within 7 days and 61% receiving follow-up within 30 days as of 2023. Follow-up rates for SUD-driven ED visits were much lower compared to mental health, with 16% follow-up by day 7 and 26% follow-up by day 30. It is important to note that these data only reflect care that was billed to insurance. Any care that was done outside the purview of insurance would not be captured in the analysis. While this means there is likely some additional follow-up care happening, the data nonetheless suggest that many people are not getting the follow-up care they need after an ED visit.

Figure 2.15

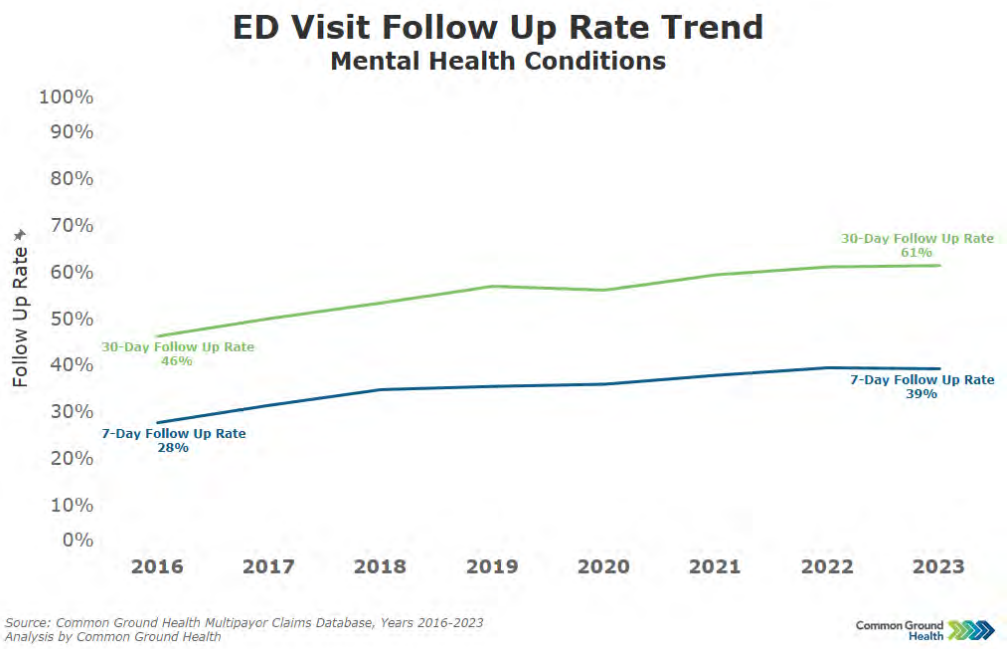
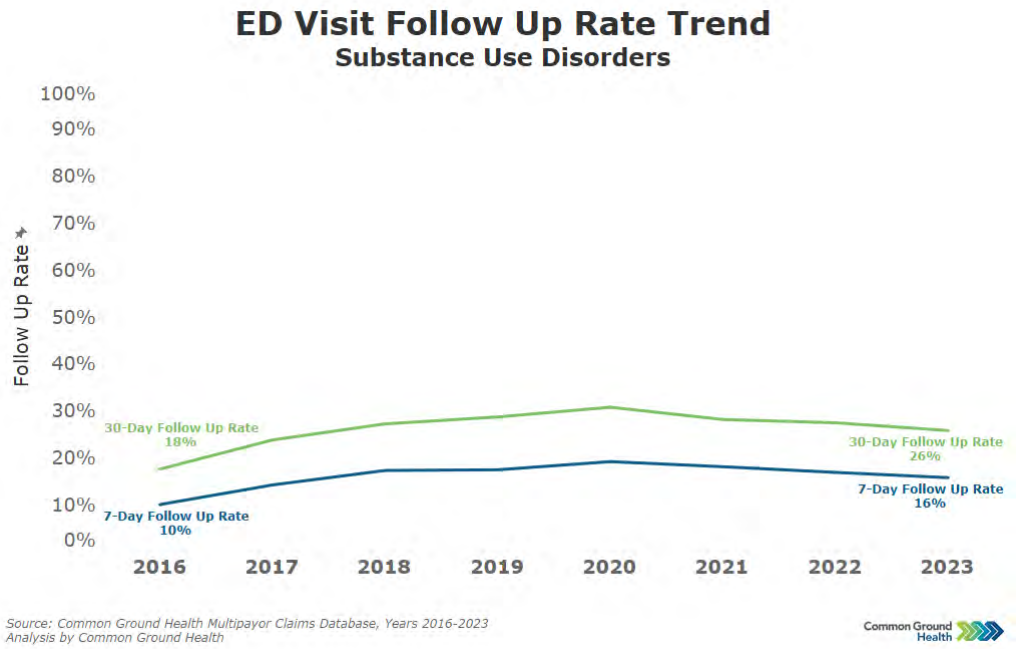


Figure 2.16



The next two Figures (2.17 and 2.18) segment this data by insurance type. For mental health-driven ED visits, people with commercial insurance had the highest follow-up rates. In contrast, for SUD, Medicaid patients had the highest follow-up rates. The latter is somewhat unusual given that we often see less care access by Medicaid population due to reimbursement limitations and other accessibility challenges. Further research would be needed to understand why this analysis shows the commercial population with lower follow-up rates after SUD ED visits, but this could partially be due to additional care received that is not paid for with insurance.

Figure 2.17

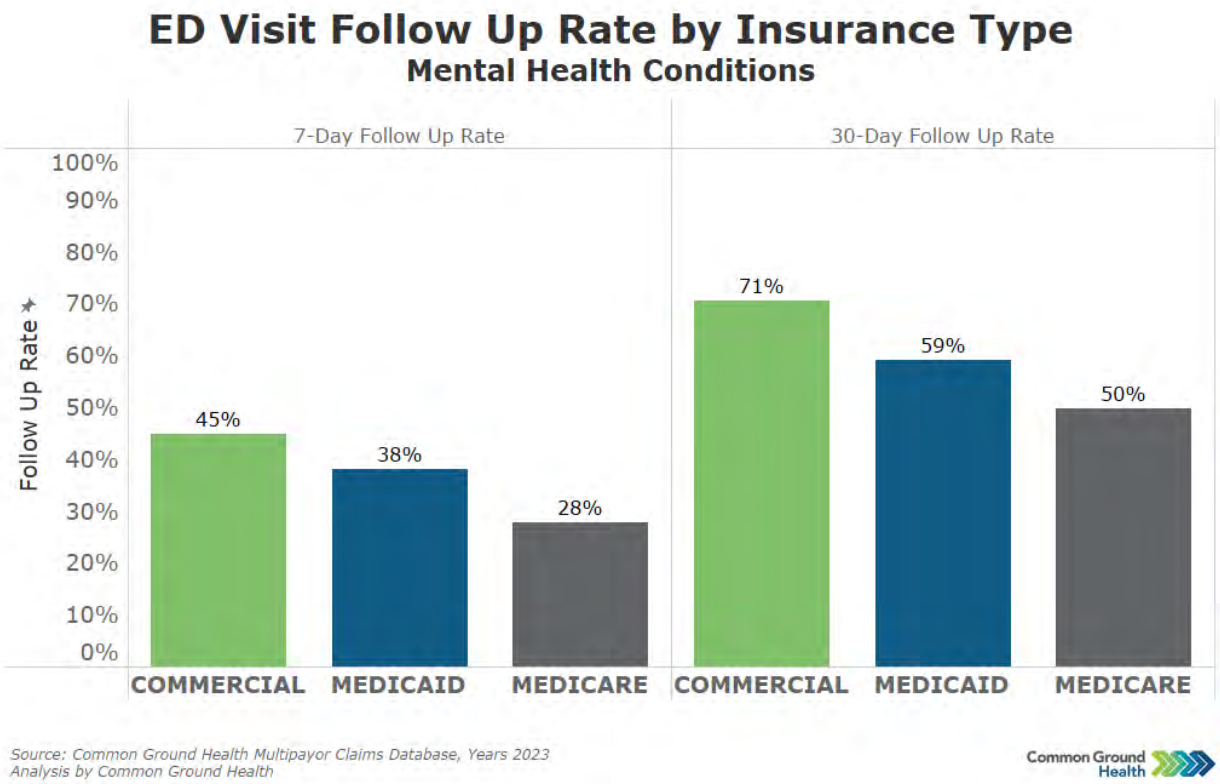

ED Visit Follow Up Rate by Insurance Type
Mental Health Conditions
7-Day Follow Up Rate
30-Day Follow Up Rate
Follow Up Rate
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
45%
38%
28%
71%
59%
50%
COMMERCIAL
MEDICAID
MEDICARE
COMMERCIAL
MEDICAID
MEDICARE
Source: Common Ground Health Multipayor Claims Database, Years 2023
Analysis by Common Ground Health
Common Ground Health

Figure 2.18

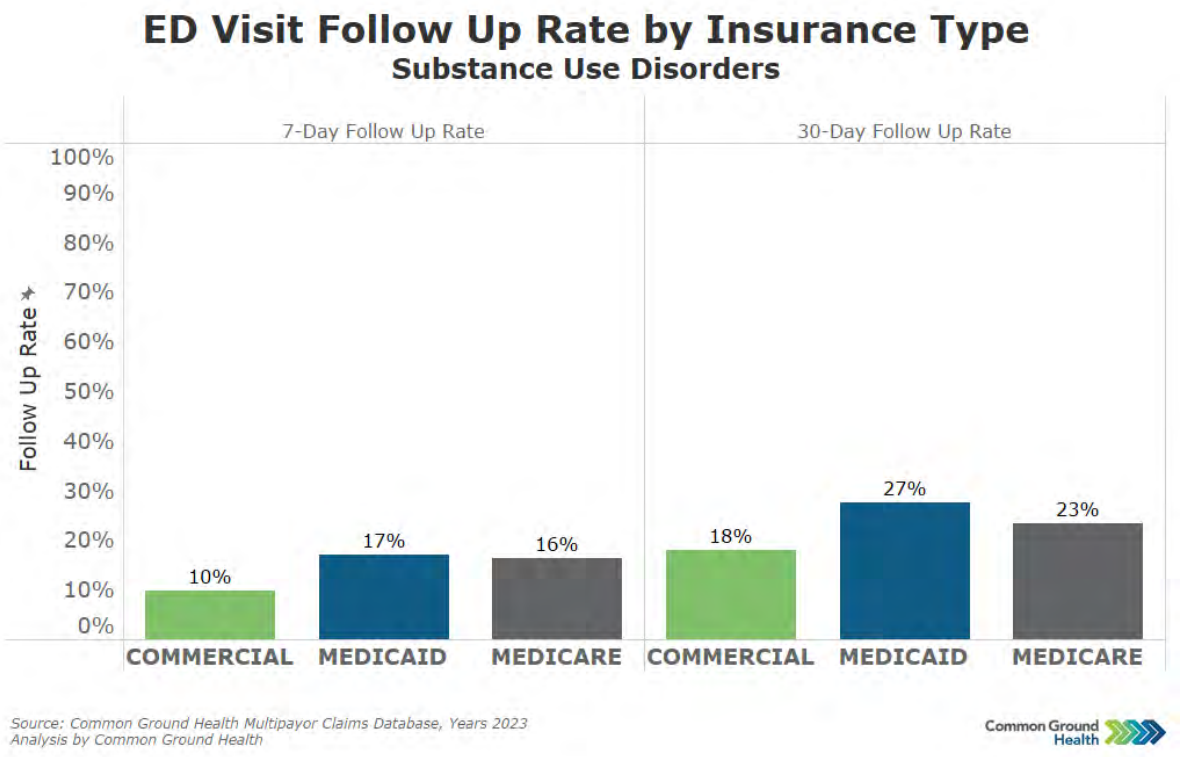


Figure 2.19 shows that post-crisis follow-up rates for mental health conditions tend to be higher for people living in higher SES ZIP codes. Figure 2.20 shows that 7-day follow-up rates for SUD are similar among all SES groups. Thirty-day follow-up rates were similar among low SES (1 and 2) as well as among medium SES (3 and 4); high SES (5) had the lowest rate, though this could be due to access to care outside of insurance. SES is correlated with insurance type (i.e., people living in low SES ZIP codes are more likely to have Medicaid coverage) but also reflects other factors that can impact the accessibility of care.

Figure 2.19

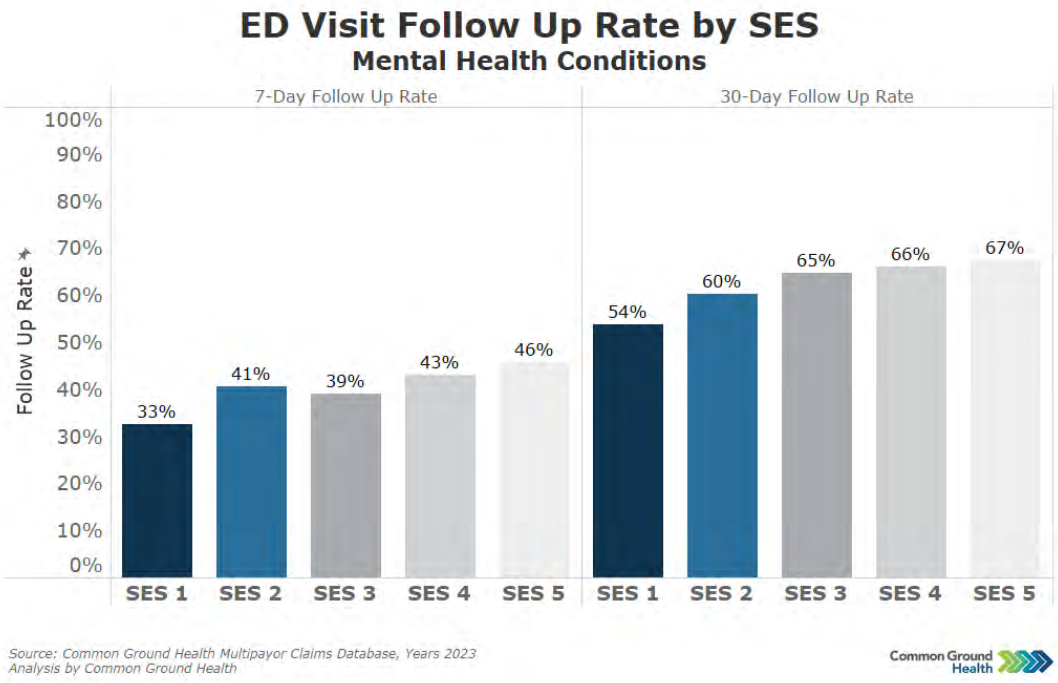
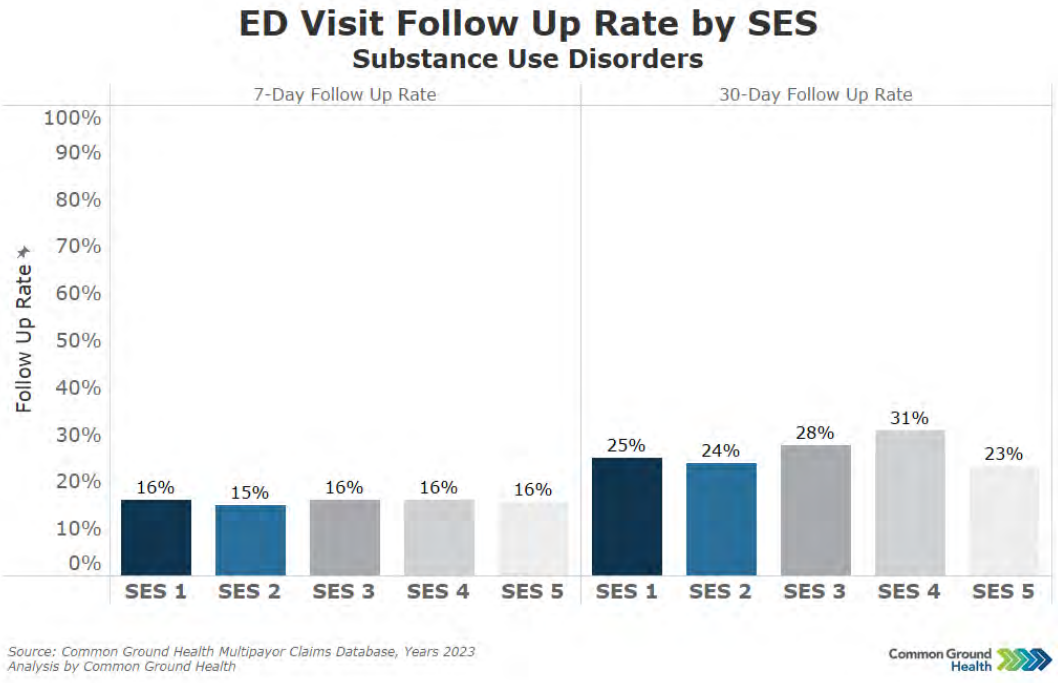


Figure 2.20



In summary, post-crisis follow-up rates have generally improved since 2015, especially among individuals presenting with a mental health condition; however, there is still room for improvement and more systematic follow-up. Disparities are noted within mental health post-crisis follow-up care, specifically for individuals with Medicaid insurance and those who live within a low SES ZIP code, although we did not see that same pattern with SUD post-crisis follow-up. One limitation to this data, however, is that these metrics do not reflect any support or follow-up that people may have received that was not claimed through insurance. Thus, actual follow-up rates are expected to be somewhat higher than shown here, especially for populations that may be more likely to pay out of pocket for services.

Limited Availability of Acute Step-Down Care

Mental and behavioral health crisis stabilization is a short-term, critical step on the journey of improving the emotional well-being of patients, but linking them with the appropriate level of follow-up care is necessary to achieving longer-term goals and reaching wellness. There are many current challenges to successfully making that linkage and supporting the continuum of care. This may exist in the form of accessibility issues with appointments, access to prescribing physicians and psychiatric medications, and not having enough resources to assist people when they are stepping down from a higher level of acute care. Regarding the latter, there need to be more transitional options to avoid too large of a stepdown at once. As an advisor noted, while there is *something* available for patients post-crisis, whether it is a good fit for the individual, or even realistic, is a better question. With the lack of options in post-crisis care comes the lack of patients' choice and autonomy regarding their care, which may lead to a negative overall experience and therefore act as a barrier to seeking care in the future if needed.

As mentioned previously, certain populations face particular challenges in locating appropriate post-crisis care: people with dual mental health and substance use concerns, and people with personality disorders and other similar conditions which are more prone to repeated states of crisis. With regard to the former, the transition from Continuing Day Treatment to PROS (Personalized Recovery Oriented Services) has made it difficult to find placement for people with mental health symptoms and

substance use issues; treatment providers at rehabilitation facilities within the community may be reluctant to work with these individuals because they are not properly equipped with the needed psychiatric resources to accommodate some of the symptoms. Regarding the latter, trying to find the right fit of services for this population is often challenging and unsuccessful, with clinicians hearing "we don't treat those people" or "this isn't for them" when attempting to make those needed connections. This leads to unmet needs and repeated treat-and-release visits from the emergency departments, which frustrates patients and clinicians alike. It was noted by advisors that there is no great system established to help individuals facing these chronic crises, and that often they are not even connected with a primary care provider (PCP) outside of the ED either.

Challenges in post-crisis behavioral health care exist at the operational level as well. As mentioned throughout this report, equity and parity in reimbursement play a major role in the ability of clinicians to effectively treat patients and sustain practices. This comes in two forms: 1) most services being under-reimbursed, and 2) certain types of services being reimbursed at even lower rates compared to others within the field (such as substance use interventions compared to mental health interventions).[9] One clinician noted, "We've had some success stories on our teams and our inpatient units, but the majority of those success stories, we financially lost our shirt. Someone stayed 80 days, and they went out; they left looking better than ever. They looked fantastic. And the reality is that that would put us out of business if we did that for everybody… Let's say we keep someone for 80 days for whatever reason - if we get 15% of what we bill for, we'll be lucky. And not to mention, we spend a lot of labor getting authorizations with payers for them to come back months later denying the whole care. It's an atrocity. So, I know that's probably bigger than Monroe County, but it is a big problem."

In addition to reimbursement concerns, advisors stated the need for consistent, embedded follow-up across all crisis programming, as well as oversight and supporting resources to ensure that the follow-up occurs.

[9] For additional information, please see the Retention and Diversity of Workforce section of this report.

Social Drivers of Health as Limiting Factors to Follow-Up Care

Social drivers of health play a large role in initial access to behavioral health services and treatment, as well as during post crisis care and the recovery process, yet are often insufficiently addressed due to a number of barriers. One clinician stated the following, which was echoed by numerous others: "If you don't have a home or a place to store your things, your clothes, your medicine, yourself... Everything else becomes less important."

Another clinician noted that housing, education and care are all needed components for patient wellness, yet they are separate streams, most of which are not actually considered the mental health system and therefore not included by the billable system. Social drivers of health are known pieces of the puzzle, but there are often constraints on what can be done for clients both during crisis and beyond. If put in terms of Maslow's Hierarchy of Needs, social drivers of health would be located toward the base of the pyramid, whereas behavioral health treatment would be higher up the pyramid, only able to be prioritized upon attainment of those basic resources and supports. An advisor commented on the importance of these factors and how the system is not necessarily set up to promote positive changes that clients are trying to make: "…[people] don't know until they get into the process of trying to sort things out based on that desire how far they've gone into the woods. The turnaround, coming out of the woods, is where systems sometimes fail people. There's not enough beds, the list is always long... same challenges as 20 years ago. Not enough apartments …and even if there is, it's not in a community that embraces their new self."

> *"…[People] don't know until they get into the process of trying to sort things out...how far they've gone into the woods. The turnaround, coming out of the woods, is where systems sometimes fail people."*

Advantages and Shortcomings of Case Management and Care Coordination

Case management and care coordination can assist in connecting patients to additional needs that may be outside the direct realm of mental health providers but are still required for overall wellness and to support their behavioral health treatment plan. However, one major health system within the county noted that the intensive, supportive and tailored case management that existed years prior has been replaced with a "watered-down" case management experience. Many more patients are being screened, which is a positive change, but the sensitivity of the screening tools may be too great where it's capturing and recommending more patients for care coordination services, with some of those patients in great need of those services while others may not actually require them. This stretches the limited number of case management and care coordination staff over a greater number of patients, thereby decreasing the quality of life for patients who are actually in need of that level of support. While this may not be a complete representation of case management and care coordination services within the county, it is worth noting based on how many individuals this system change has the potential to impact.

Opportunities and Promising Practices

Areas of opportunity that derived from these conversations centered on case management and coordination of care efforts, as well as helpful services to have available to the public post-crisis. Including the patient as part of their own healthcare team is a promising practice that some local organizations have already employed by convening relevant providers to discuss coordinated care and including the patient within that conversation. Once a patient is discharged, it is helpful to have someone who can follow the patient and their needs to assist them through the transition and make it more seamless. A local clinician highlighted this need: "There's been some folks that we have kind of kept ties with after discharge and dropped off meals, just kept in contact, gave phone support, answered the call when they called… But those supports are absent for a lot of our population, and many of us have good natural supports and a lot of our population has next to none. And making good choices is a challenge for folks when they're scared or confused or their reality is a little bit distorted."

There were recent grants from New York State to support this type of service, and the state hospital's mobile integration team demonstrates similar efforts by picking patients up from the ED, networking with landlords, and other needed tasks to facilitate that transition. People need assistance with the transition and the multiple moving pieces involved, as well as good clinical support from either a physician, nurse, social worker, etc. To build trust and rapport between the patient and their clinical support, a pre-existing relationship is recommended prior to discharge. Other useful services include Continuing Day Treatment (or similar programs that provide a combination of treatment, community and sense of belonging, and other needs like food and transportation), open access appointments for those exiting acute services, and after-hours phone lines staffed by clinicians at their own clinics (so patients can reach out to someone familiar when needed).

SAMHSA National Behavioral Health Crisis Care Guidance emphasizes the need for a structured approach to crisis and post-crisis care that focuses on stabilization, recovery and building resilience. Included within that approach are clear protocols for immediate intervention and stabilization, ensuring seamless care coordination and rapid follow-up care, engaging peer support networks and integrating trauma-informed practices (SAMHSA, 2025). Several of these components have already been discussed, but advisors were also asked to respond to whether trained peers and nonclinical support people may be helpful as part of patient care. Responses included utilizing these roles for follow-up support post-crisis, answering an after-hours hotline (trained and supervised by a clinician) or an any-time phone line with trained peer support on demand. Further proposed roles for peers included being stationed on site at drop-in centers, ongoing day programs, and at programs like Continuing Day Treatment. Additionally, workforce shortages in rural communities were emphasized, mentioning that the mental health department is often the only option available to individuals. Peers could be another option for those locations; look at who lives there already, enhance their capacity and create a sustainable model. For additional information on the role of peers within the behavioral health field, please reference the "System Gaps and Coordination Issues" and "Community Connectors and Mental Health Supports" sections of this report.

References

Brouk, S. (2025, April 17). *A New Response for a Statewide Crisis: Why Daniel's Law Matters Now*. Retrieved from The New York State Senate: https://www.nysenate.gov/newsroom/articles/2025/samra-g-brouk/new-response-statewide-crisis-why-daniels-law-matters-now

SAMHSA. (2025, January 16). *National Behavioral Health Crisis Care Guidance*. Retrieved from SAMHSA: Substance Abuse and Mental Health Services Administration : https://www.samhsa.gov/mental-health/national-behavioral-health-crisis-care

Section 3:
MENTAL HEALTH OF CHILDREN & YOUTH

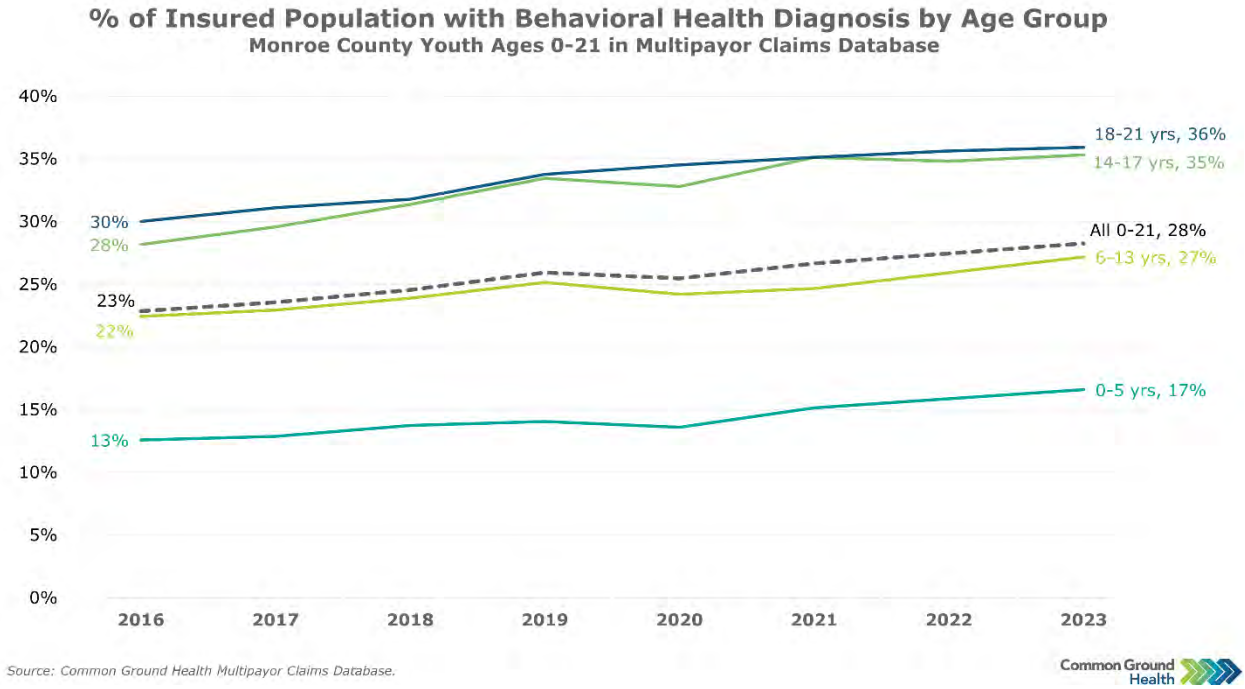
Children and youth today face increased mental health challenges. Complex interactions between physical, emotional, and mental health affect children's abilities to develop healthy relationships, focus at school, and explore the world around them. Inequities persist particularly among children living in poverty, children of color, those identifying as LGBTQ, immigrants and English language learners. They also persist among those with physical, developmental, and/or intellectual disabilities, and those with chronic medical conditions.

Mental and emotional health is an essential component of children's overall and long-term health and well-being. Complex interactions between physical, emotional, and mental health affect children's abilities to develop healthy relationships, focus at school, and explore the world around them. Mental health matters throughout childhood, from infancy through the transition to adulthood.

Children and youth, today, are more likely to experience mental health challenges for a variety of reasons that include the complex interplay between the home environment, school and community settings, experiences during the COVID-19 pandemic, and frequency of smartphone use. Mental and behavioral health inequities persist particularly among children living in poverty, children of color, those identifying as LGBTQ, immigrants and English language learners, those with physical, developmental and/or intellectual disabilities, and those with chronic medical conditions. In addition to the increased likelihood of experiencing mental health challenges, parents and caregivers continue to experience numerous barriers to finding and accessing mental health supports for children and youth.

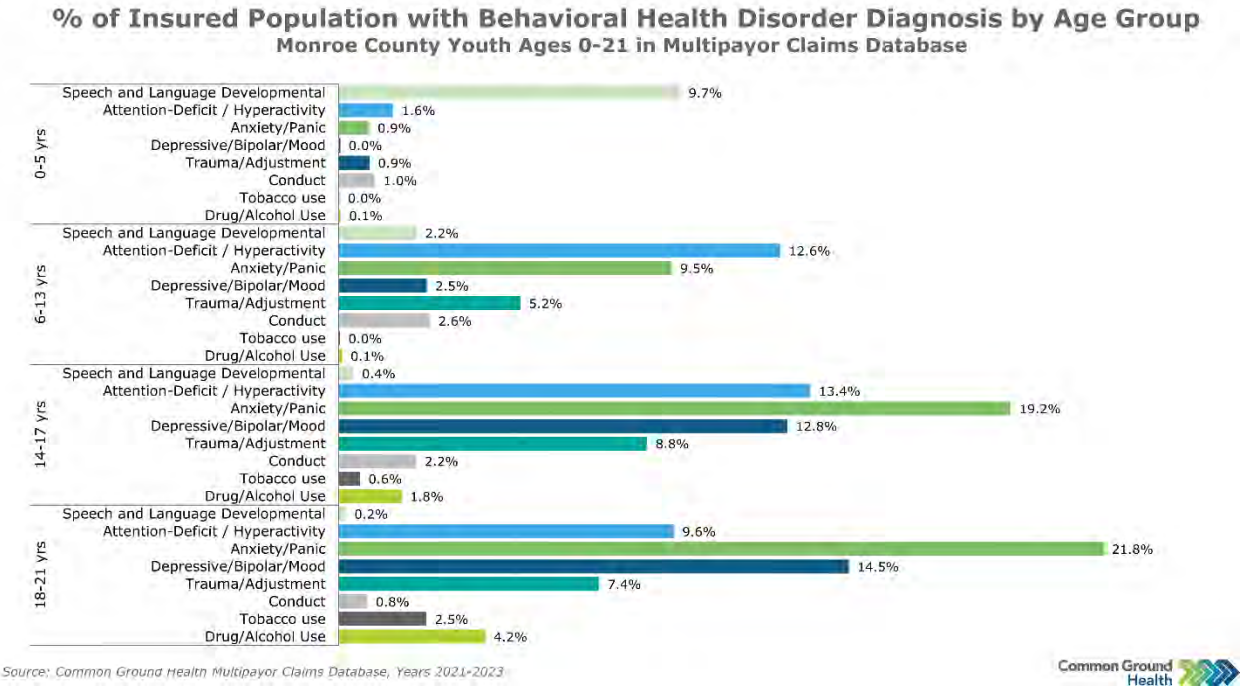
Nationwide, one in five children (ages 3-17) have been diagnosed with a mental, emotional, behavioral, or developmental disorder (U.S. Surgeon General Issues Advisory on Youth Mental Health Crisis Further Exposed by Covid-19 Pandemic, 2019). In Monroe County, approximately 10% of all youth emergency department visits are related to behavioral health, and the percent of youth present within our Common Ground Health Multipayor Claims Database with any behavioral health diagnosis (DX) has grown over time from 23% of all youth in 2016 up to 28% in 2023. Older youth were more likely to have a behavioral health condition with 35% of youth ages 14-17 and 36% ages 18-21 having at least one diagnosis (**Figure 3.1**).

Figure 3.1



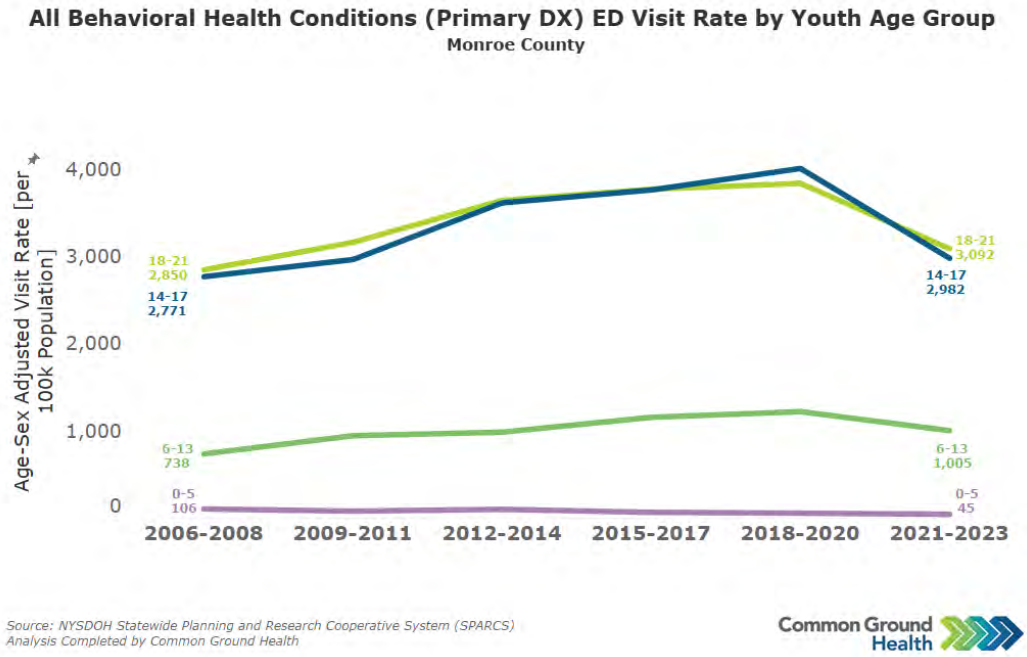
Children and youth can be diagnosed with a behavioral health condition at any age, but we see significant increases in diagnoses between children ages 6-13 who reside in Monroe County as noted in **Figure 3.2**. Amongst our youngest children ages 0-5, speech and language disorders are most common. An ADHD diagnosis is most common among 6–13 year-olds, with anxiety and panic disorders increasing in prevalence as well. For teens 14-17 years old and youth 18-21 who are transitioning from the pediatric- to adult-care systems, anxiety and panic disorders are most common followed by depressive, bipolar, or mood disorders. Anxiety and panic disorders begin to appear as early as five and six years old. Depression is not diagnosed frequently prior to age ten but then grows to be the second most prevalent condition after anxiety and panic disorders.

Figure 3.2



With this rise in behavioral health diagnoses among children and youth, it is no surprise that we also see an increase in the rates of emergency department visits for these conditions. The frequency of emergency department visits for children and youth with behavioral health conditions grew significantly from mid-2000s to a peak in 2018-2020 (figure 3.3). Since that time, visits to the emergency department by older youth dropped by approximately 25%, which is consistent with pattern for adults and may be attributed in part due to the availability of additional outpatient resources providing alternatives to the ED.

Figure 3.3



The most common reasons for children and youth (ages 0-21) with behavioral health conditions presenting in the emergency department are listed below (Figure 3.4). Intentional self-harm is the most frequent of all categories with children and youth tallying nearly 1,000 total visits to the emergency department in 2023 alone. This is followed by depressive, bipolar, and other mood disorders at 600 visits and both trauma / adjustment disorders and conduct disorders accounting for over 500 visits each.

Figure 3.4

Top Reasons for Behavorial Health ED Visits
Monroe County Youth (0-21)

Condition	Total Visits	Total Patients	Percent of patients with more than 1 BH ED visit
Intentional Self-Harm	981	741	84%
Depressive, Bipolar, and Other Mood Disorders	600	451	62%
Trauma/Adjustment Disorders	520	452	51%
Conduct Disorders	510	370	65%
Anxiety/Panic Disorders	385	344	40%
Drug Use Disorders	249	203	34%
Alcohol Use Disorders (AUD)	213	196	20%
Personality Disorders	115	26	69%
Neurodevelopmental disorders	84	63	56%
ADHD	79	66	67%
Drug Overdose	69	68	28%
Schizophrenia spectrum and other psychotic disorders	61	45	53%

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

In general, behavioral health-driven emergency department visits for children and youth rose over time from 2005 – 2019 (**Figure 3.5**). Visits for substance use disorders peaked in 2015. The rate of intentional self-harm has increased the most of all reasons for a behavioral health related visit to the ED, peaking in 2021 and remaining at an elevated rate for children and youth in Monroe County.

Figure 3.5

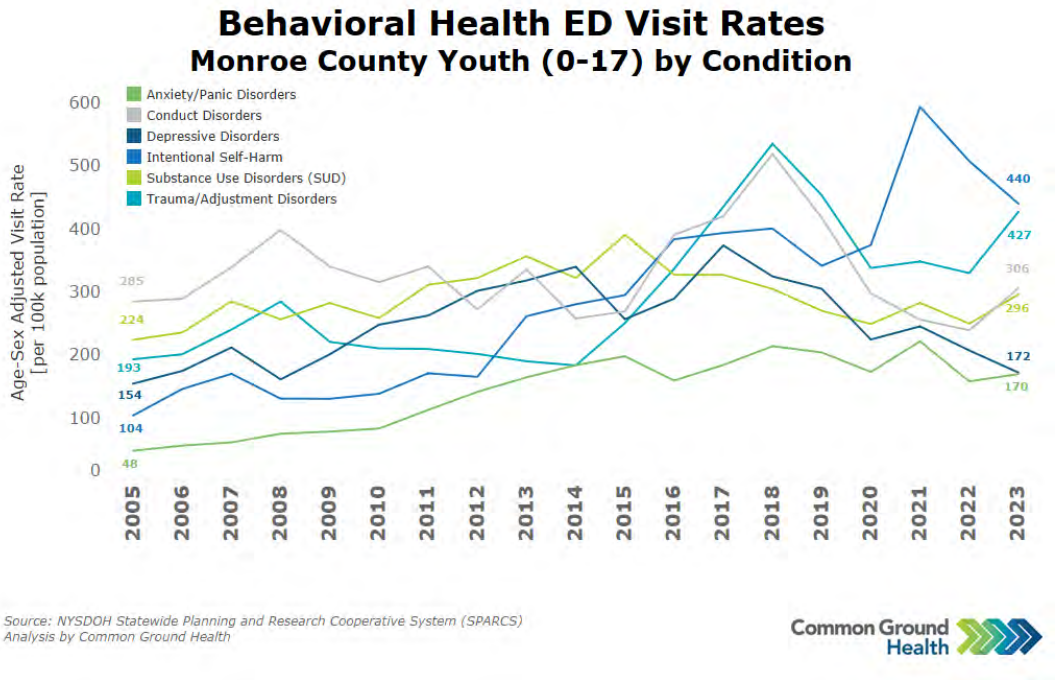
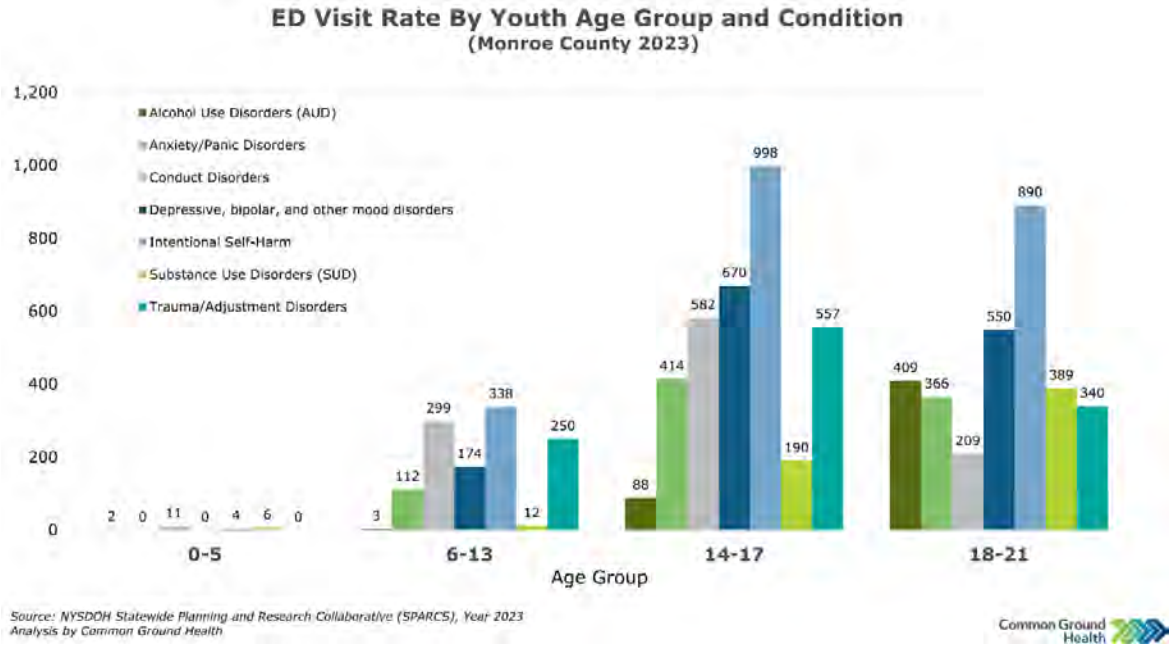


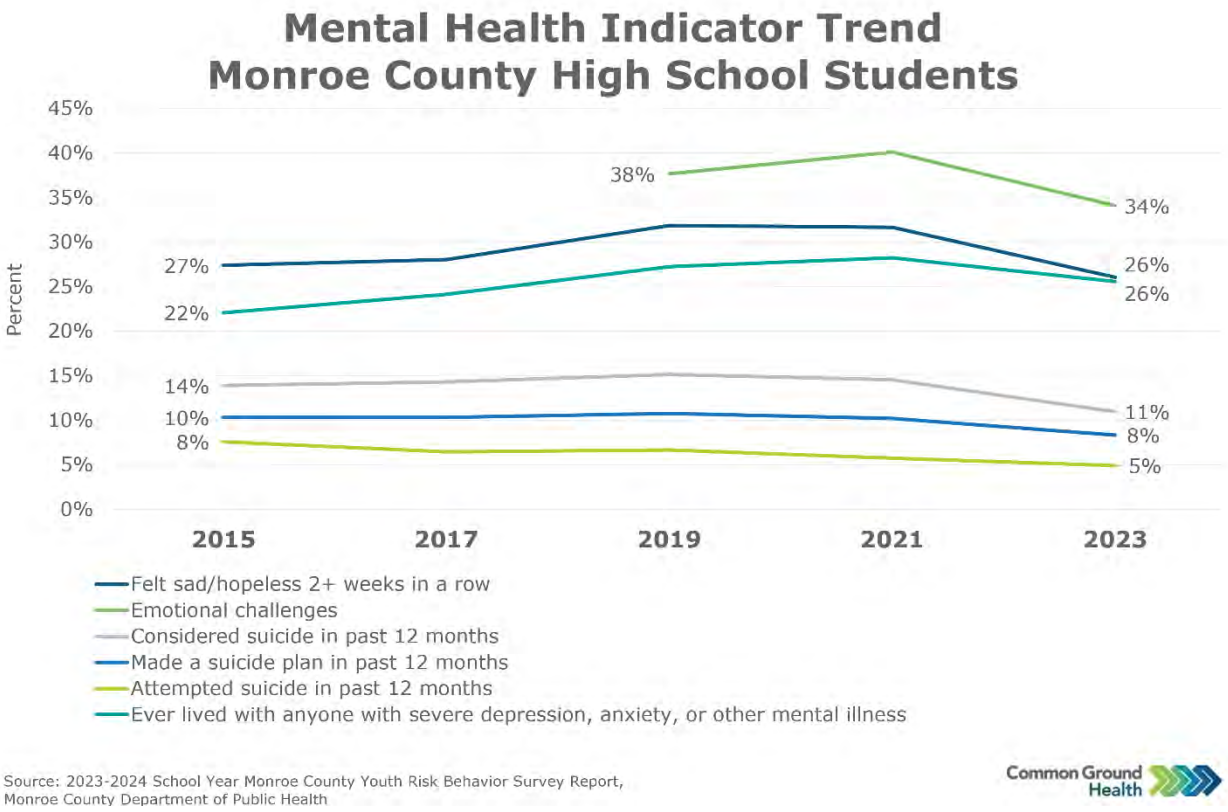
Figure 3.6 below depicts emergency department visit rates for children and youth in Monroe County by age groupings. Emergency department visits for behavioral health related reasons in young kids is rare. By ages 6-13 however, there are significant visits for self-harm, trauma / adjustment disorders, and conduct disorders. Youth ages 14-17 are significantly more likely to visit the emergency department for a behavioral health diagnosis with the most common reason being intentional self-harm. For transition-aged youth (18-21), intentional self-harm is the most common reason for emergency department visits followed by depressive, bipolar and mood disorders with substance and alcohol use disorders increasing in frequency.

Figure 3.6



The Monroe County Department of Public Health conducts the Youth Risk Behavior Survey (YRBS) every two years in partnership with local school districts. This survey asks high school aged youth a series of questions about their health and well-being including adverse childhood experiences and assets, racism / discrimination, grief, mental health, parental influences, physical activity and sleep, sexual behavior, social media, substance use, and violence / bullying. Figure 3.7 documents recent trends. In the most recent survey completed during the 2023-2024 school year with over 17,000 youth, 26% reported that they "felt so sad or hopeless almost every day for two or more weeks in a row that they stopped doing their usual activities, in the past year." Over one-third of all students (34%) reported having "difficulty concentrating, remembering, or making decisions because of mental or emotional challenges." While trends pertaining to suicide ideation have decreased over time, the numbers remain staggering. Nearly 11% of all student respondents reported that they had "seriously considered attempting suicide in the past year," down from its peak in 2019 at over 15%. Furthermore, over 8% of students indicated that they had "made a specific plan about how they would attempt suicide in the past year" and nearly 5% "attempted suicide in the past year." The chart below indicates that rates have lessened since their peak during the COVID-19 pandemic.

Figure 3.7

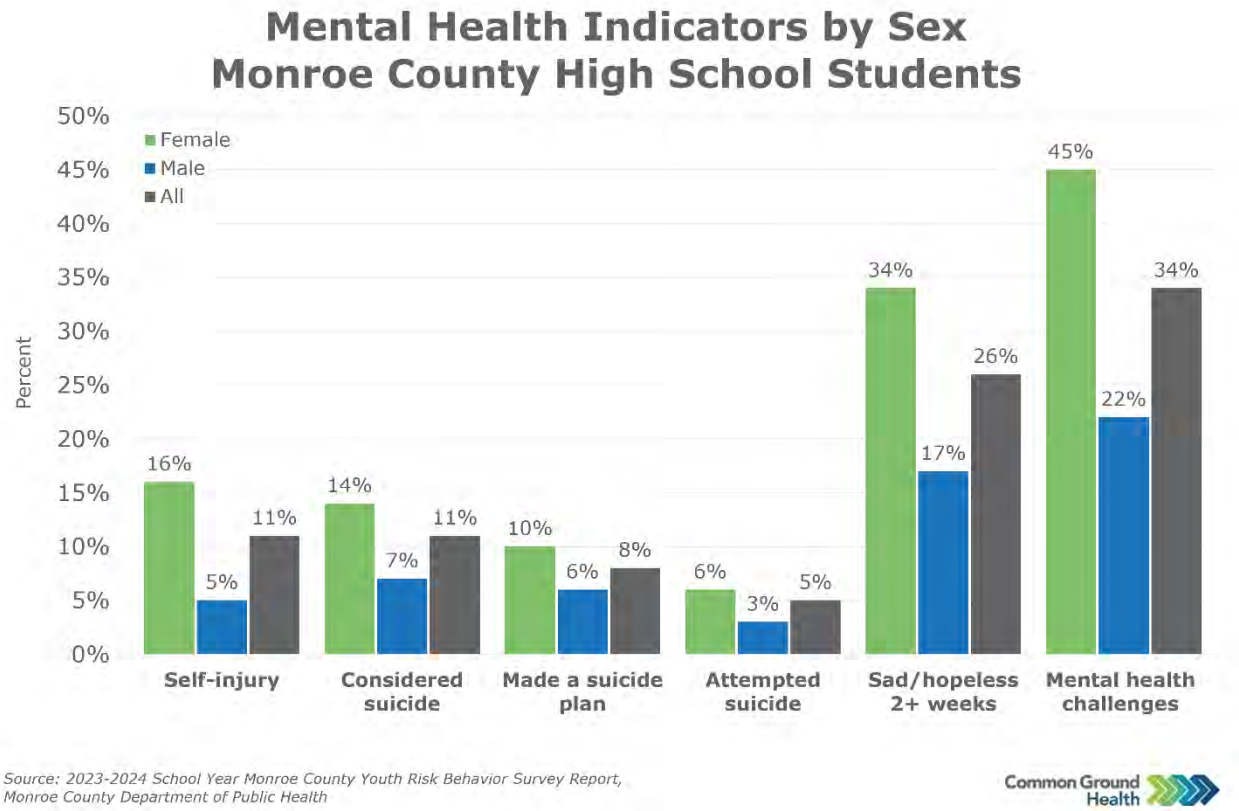


Source: 2023-2024 School Year Monroe County Youth Risk Behavior Survey Report, Monroe County Department of Public Health

Common Ground Health

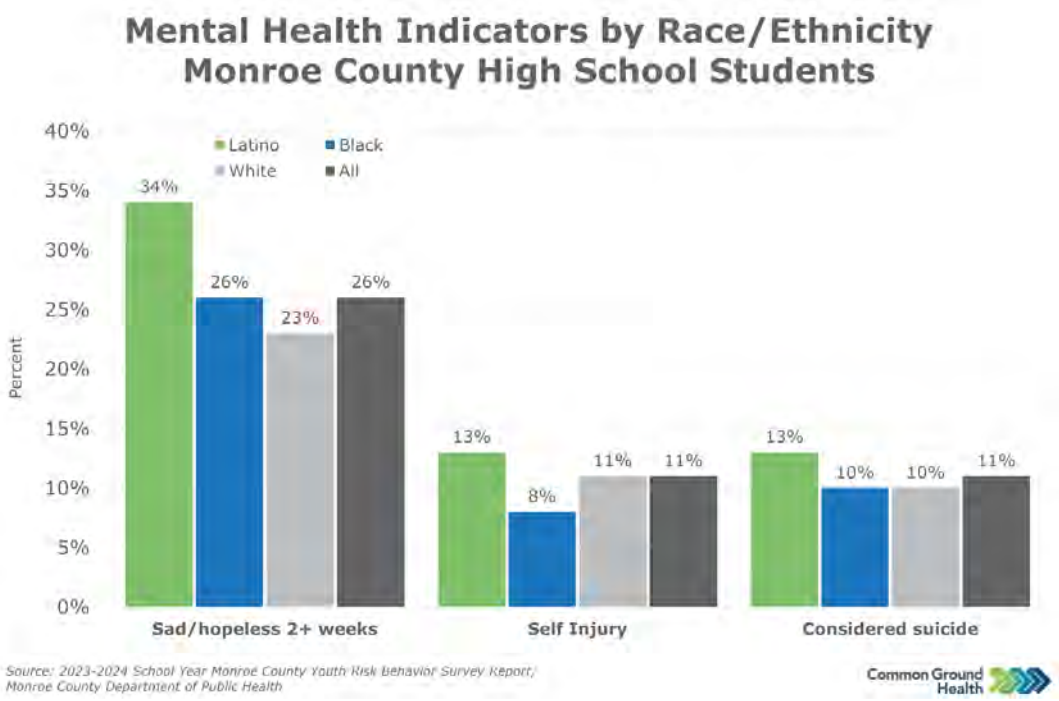
Responses to mental health indicators are often disparate by gender with female students more likely to report mental health concerns including suicidal behavior than their male counterparts (**Figure 3.8**). Female respondents (34%) were twice as likely to report that they, "felt so sad or hopeless almost every day for two or more weeks in a row that they stopped doing their usual activities, in the past year" compared with male students (17%). Female respondents were also significantly more likely to report self-injurious behavior (such as cutting or burning themselves) than male counterparts (16% and 5% respectively), seriously considered attempting suicide (14% and 7% respectively), made a specific plan about how they would attempt suicide (10% and 6% respectively), and attempted suicide (6% and 3% respectively).

Figure 3.8



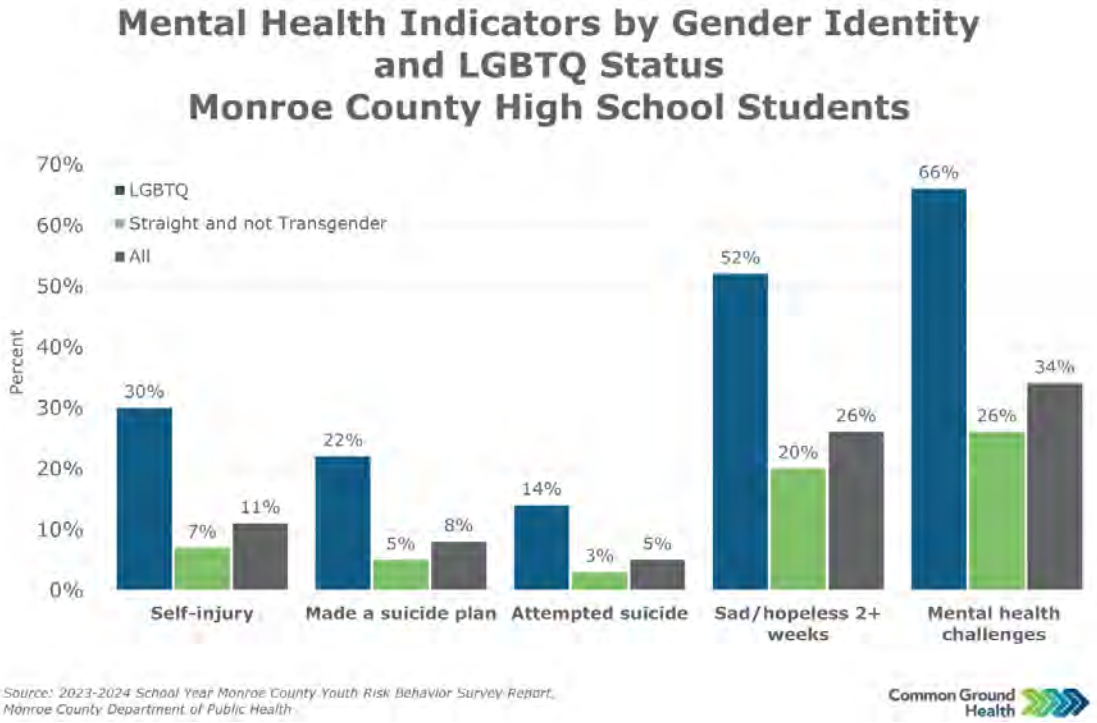
Youth of color were more likely to report that they, "felt so sad or hopeless almost every day for two or more weeks in a row that they stopped doing their usual activities in the past year," with 34% and 26% of Latino and Black respondents respectively (Figure 3.9). Latino students were more likely to report self injury (13%), followed by white students (11%), and Black students at 8%; while 13% of Latino respondents affirmed that they had "seriously considered attempting suicide in the past year," followed by 10% for both Black and white students. These numbers highlight the need for culturally responsive and linguistically appropriate mental health care for childen and youth. As an advisor to this project indicated, "part of the gap in care is that there are not enough [providers] who immediately can gain that connection because they are not a fit culturally for the people who need help."

Figure 3.9



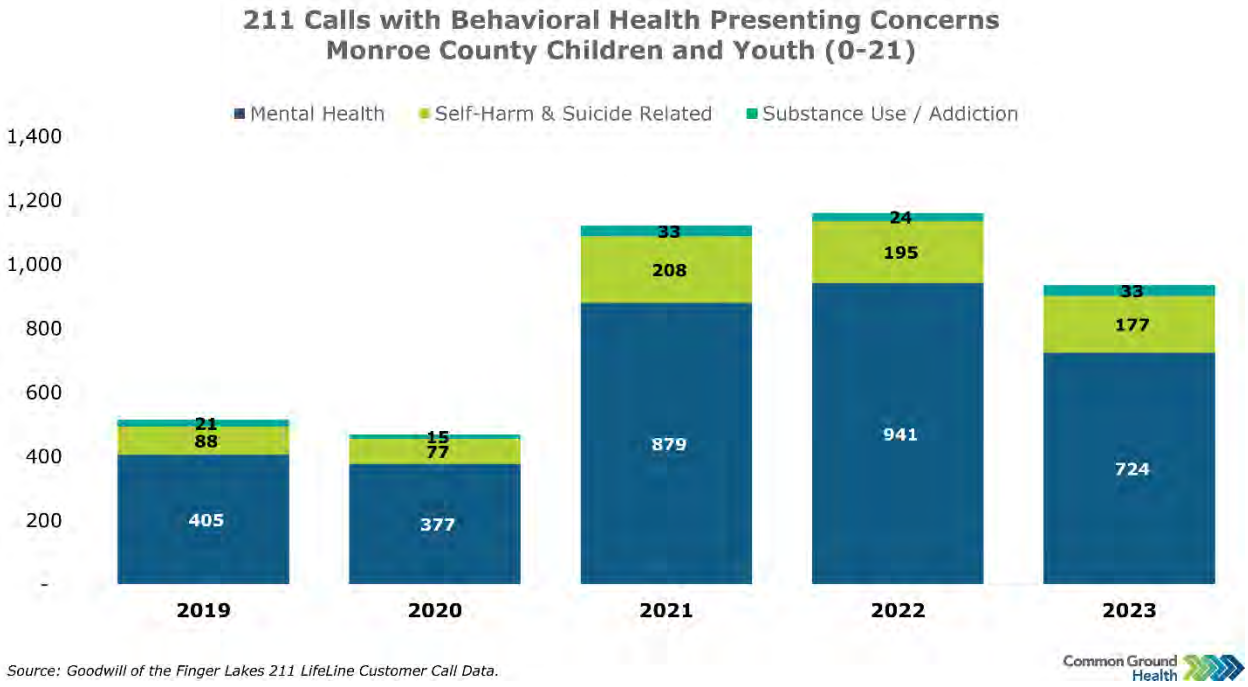
Nationally, there is a significant association between discrimination and victimization of LGBTQ youth and negative mental health outcomes including suicide risk. Locally, our mental health indicators by sexual orientation and gender identity show disparities that are even more pronounced. Figure 3.10 depicts that over half (52%) of lesbian, gay, bisexual, transgender, and/or queer (LGBTQ) student respondents reported that they, "felt so sad or hopeless almost every day for two or more weeks in a row that they stopped doing their usual activities, in the past year." Nearly one-third of students identifying as LGBTQ (30%) reported self-harming behavior in the past year. More than one in five (22%) made a suicide plan, and 14% attempted suicide. Nationwide, 12% of LGBTQ youth attempted suicide in the past year (U.S. National Survey on the Mental Health of LGBTQ+ Young People, 2024); Monroe County is higher than the national rate. Furthermore, half of LGBTQ youth who wanted mental health care were not able to receive it for various reasons including fear of talking about their mental concerns with someone else, cost, not wanting to get permission from a parent or caregiver, not being taken seriously or feeling understood, fear of being "outed" about their identity, and/or previous negative experiences (U.S. National Survey on the Mental Health of LGBTQ+ Young People, 2024).

Figure 3.10



211/LIFE LINE is a free, confidential 24-hour phone, chat, text service, and searchable online database that connects people with resources for things like housing, food access, healthcare, mental health, and more. They provide information, referral, and crisis/suicide prevention services and serve as the designated 988 Center for Monroe County. The data presented below are for 211 calls only; calls to 988 are not included in these analyses. **Figure 3.11** below details 211/LIFE LINE calls with behavioral health presenting concerns for children and youth (ages 0-21) in Monroe County. After 2020, call volume more than doubled and while there was a decline in 2023, the number of calls remains at an elevated level. In each of the last few years, there have been roughly 200 calls related to self-harm and suicide. Nearly half of the time (49%), the 211 calls are made by a parent on behalf of their child. Aproximately one in five calls (22%) was made by the child or youth themselves. Additionally, a provider made 16% of the calls, followed by relatives (7%) and other (6%). These data illustrate the importance of providing parents, caregivers, and adults working with children and youth with education and support to better recognize and identify potential behavioral health issues.

Figure 3.11



From 2022-2024, over four in five calls (83%) made to 211/LIFE LINE for children (under age 18) that referenced a behavioral health concern, were related to a crisis (note data for 2024 go through 9/30/24 only and does not represent the full calendar year). For all calls pertaining to youth, the most common 211/LIFE LINE referrals were for psychiatric mobile response teams with 47% of all calls for children age 0-17 and crisis intervention hotlines with 54% of all calls for youth age 18-21. The most common service referrals after crisis intervention hotlines and psychiatric mobile response teams were for in-person crisis intervention, 911, and outpatient mental health facilities.

While the trend in self-reported suicide ideation for youth over time has decreased, local emergency departments continue to experience increased visits for intentional self-harm among youth. Hospitals have reported a notable increase since the mid-2000s for youth of all ages (**Figure 3.12**).

Figure 3.12

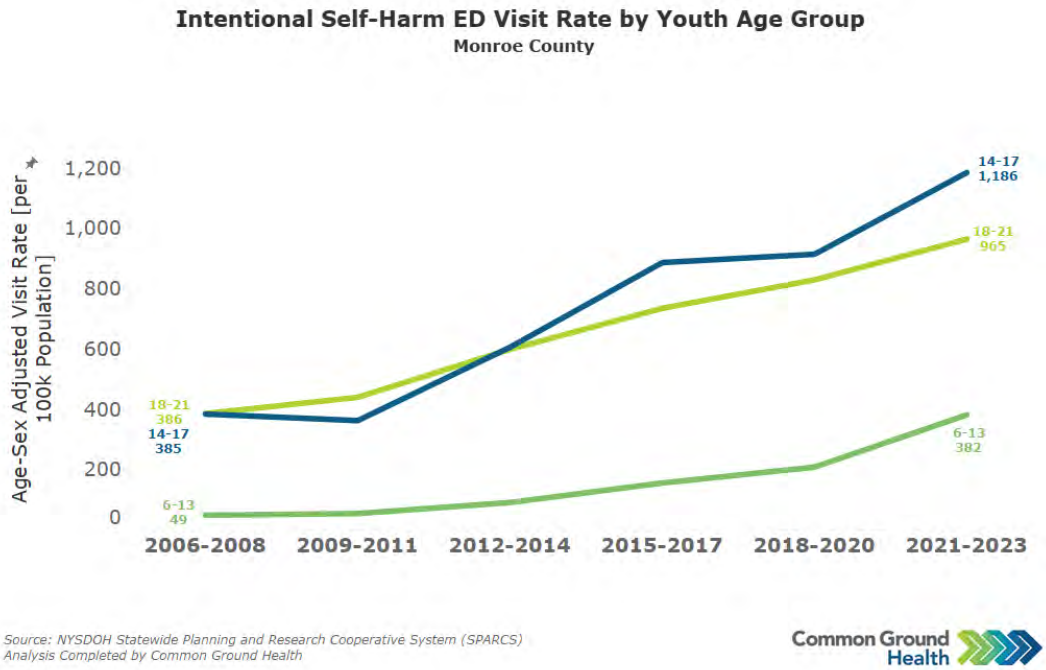


Figure 3.13 below depicts youth inpatient conditions for Monroe County. This table lists the most common behavioral health conditions presenting at inpatient visits for youth ages 0-21 by total number of visits, total patients, percent of patients with more than one behavioral health related emergency department visit, average length of stay (ALOS) and total bed days. Across the board, intentional self-harm has had the largest impact in all categories. Intentional self-harm and depressive disorders (including bipolar and other mood disorders) account for the majority of bed days. While schizophrenia can occur at any age, "the average age of onset tends to be in the late teens to early 20s for men, and the late 20s to early 30s for women," (NAMI, 2025). Because of this, the diagnosis should not be common within this data set with the exception of unspecified psychosis. The cases appearing here occur among older youth with about two-thirds classified as an unspecified psychosis diagnosis.

Figure 3.13

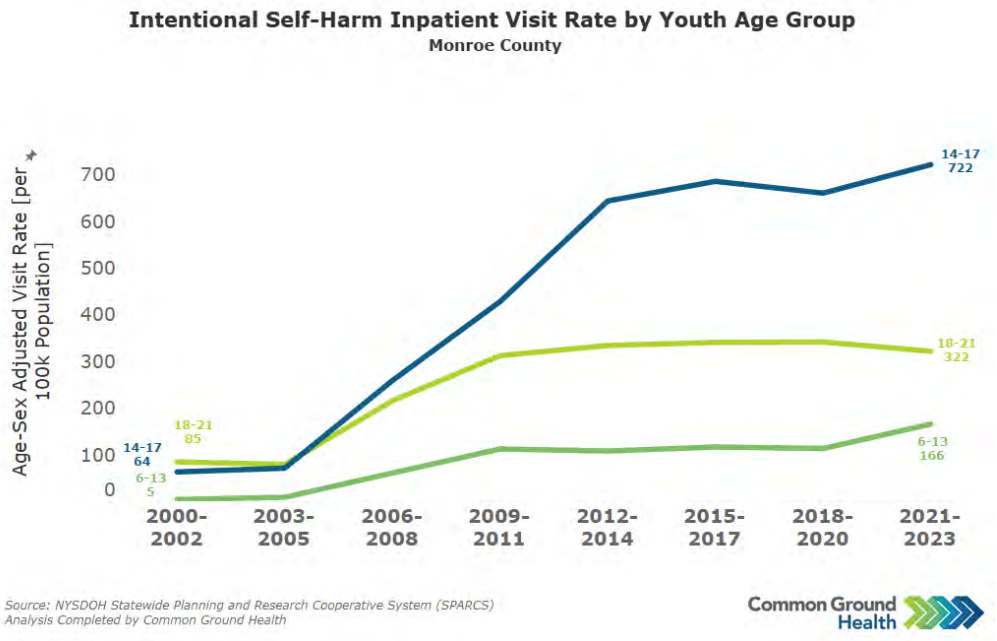
Top Reasons for Behavioral Health Inpatient Visits
Monroe County Youth (0-21)

Condition	Total Visits	Total Patients	Percent of patients with more than 1 BH ED visit	Average Length of Stay	Total Bed Days
Intentional Self-Harm	476	372	89%	10	4,842
Depressive, Bipolar, and Other Moo..	289	243	89%	11	3,157
Schizophrenia spectrum and other p..	140	99	54%	17	2,419
Trauma/Adjustment Disorders	60	56	70%	6	385
Drug Overdose	49	45	18%	9	461
Feeding and eating disorders	48	39	38%	11	533
Anxiety/Panic Disorders	31	27	93%	9	268
Drug Use Disorders	25	21	71%	7	182
Conduct Disorders	23	23	74%	12	284
Neurodevelopmental disorders	14	12	58%	13	186

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

The rate of inpatient visits for intentional self-harm for youth ages 6-21 has increased substantially since 2000-2002 (**Figure 3.14**). Inpatient visits for intentional self-harm among high school age youth specifically have increased at an alarming rate with all age groups increasing from 2000-2002.

Figure 3.14



Mental Health of Parents & Caregivers

The behavioral and mental health concerns of caregivers affect children and youth of all ages, but especially infants and toddlers ages 0-5. A baby's earliest experiences and relationships set their trajectory for lifelong health outcomes. Caregivers who provide babies and toddlers with safe and stable environments and offer loving interactions lay the foundation for optimal brain development (Center on the Developing Child, n.d.). Unfortunately, too many young children "are exposed to early adversity that inhibits optimal growth and development," which may include having a parent or caregiver with mental health and substance use issues (Prenatal-to-3 Policy Impact Center, 2021).

Local survey data show that parents and guardians are particularly likely to experience mental health stressors and challenges. Of participants responding to My Health Story in 2022, three in five parents / guardians who responded to the survey (62%) reported experiencing at least one of the following concerns for themselves in the past 12 months including: depression or sadness, grief or loss, anxiety or fear, trouble sleeping, feeling helpless or hopeless, out of control anger or anger management, isolation or

loneliness, feeling stressed or overwhelmed, alcohol use, marijuana use, drug use, prescription drug use, or gambling. Among parents and guardians, over half (54%) of respondents reported specifically experiencing a mental health concern for themselves in the past 12 months compared to just 45% of Monroe County respondents who were not parents or guardians (depression or sadness, grief or loss, anxiety or fear, trouble sleeping, feeling helpless/hopeless, anger management, isolation or loneliness, stress or overwhelmed). According to the most recent Youth Risk Behavioral Survey, 26% of all student respondents reported that they had "ever lived with anyone who had severe depression, anxiety, or another mental illness, down from its peak of 28% during 2021. As an advisor noted, "what we're recognizing is the adults in kids' lives are in need of support. Our society across the board is so stressed, there's so much distraction. [We] have to prioritize working in those spaces as much as we need to focus on the kids themselves." The mental health and well-being of caregivers directly impacts the well-being of our children and youth.

Early Relationships and Mental Health

What happens in infancy and early childhood affects the long-term future mental and emotional health of individuals. Early experiences create pathways for future behavior, responses, and actions. Depending on the type of experience, either negative or positive pathways are formed. Strong supportive and nurturing relationships are essential to a baby's earliest learning, development, sense of security, and well-being. Most of a baby's brain (approximately 80%) is fully developed by age three and 90% by age five (Bipartisan Policy Center, 2021). Babies who experience ongoing stress, trauma, and lack of parent responsiveness during these critical years often show physiological and psychological symptoms of anxiety, depression, or other mental health challenges increasing the likelihood of poorer mental and physical health in adolescence and adulthood if not addressed early. An advisor expressed the power of play in healing and development: "Play and love are upstream factors that are so important to supporting downstream behavioral health and wellness."

Given the typical variability in infant and young children's emotions and behavior, delays or concerns about mental health can be easily missed or overlooked. Stigma surrounding mental health and the widespread belief that infants can't experience

mental health problems or won't remember stressful or traumatic events also contributes to our system's failure to prioritize supports and services that very young children need for healthy social-emotional development. Several advisors noted, "there's stigma and there's a general lack of knowledge…we normalize a lot of things [and] label it something else. For example…children who are struggling with mental health, we label it as a 'behavior problem' that needs consequences…all behavior is a communication of unmet need…the real issues are beneath the surface."

As referenced above, unaddressed mental health issues can present as problematic behaviors deserving of consequences. These manifestations are pronounced within the early childhood education system and can be seen through disparate rates of preschool and pre-kindergarten suspension and expulsion. Nationally, Black students comprise 18.2% of the preschool population, yet account for 43.3% of suspensions and 38.2% of expulsions with Black boys especially being suspended and expelled at rates three times their share of enrollment (Shafer & benEzra, 2022). When exploring dynamics in preschool classrooms, researchers found that teachers spend more time observing Black students, especially Black boys; findings attributed largely to implicit bias. The propensity to observe some students more than others based on gender and race is likely to explain why those students are reported as misbehaving more frequently (Hathaway, 2016).

> *"Behavior is a communication of unmet need… the real issues are beneath the surface."*

Effects of COVID-19 on Youth Mental Health

The COVID-19 pandemic affected children and youth in ways that were previously unforeseeable. The abrupt closure of schools and many workplaces in March 2020 disrupted daily routines for many individuals, including children and youth. While the physical symptoms of COVID-19 in children and youth were generally less severe, the pandemic severely affected the mental, emotional, and social well-being of young people. Some of the sudden and drastic disruptions to routines included remote learning, social isolation from friends, peers and supportive adults, heightened stress

on families, increased screen time and presence on social media, and uncertainty when planning for the future (Common Ground Health, 2024). One advisor noted that, "since the pandemic, there has been an increase in the number of challenges they face and a reduction in resiliency and adaptability among kids…there has [also] been a rise in social media use which is linked with mental health challenges. Kids are no longer outside playing with friends after school. Kids are going into their rooms, playing video games in their rooms, etc. It is having detrimental outcomes." While the impact of the COVID-19 pandemic was widespread and has impacted all children and youth, its lasting effects have been experienced at higher rates in communities of color where inequitable health outcomes already existed.

COVID also greatly affected family stability and added new pressures that did not previously exist. Parents were under tremendous stress to ensure that children were progressing academically in remote learning conditions. Some parents had to go without childcare altogether or found existing childcare options unreliable. As they navigated these challenges, parents absorbed the stress and the effect on their children and youth, without the benefit of traditional support structures. Many parents reported the deterioration of their own mental health, with rates of alcohol use and suicide increasing (Common Ground Health, 2024).

The COVID-19 pandemic had unique effects on children and youth based on their age at the start of pandemic. Social isolation for parents after the birth of a child could lead to an increase in postpartum depression or stress and anxiety when you cannot call on your "village" for support. Toddlers may have increased speech and language delays as their caregivers may have often been wearing masks, not allowing them to see the way words are formed as you speak; these speech delays can translate into behavior issues. Remote learning was challenging for many, but especially for those in lower elementary grades and/or starting school for the first time. Learning foundational skills like reading, writing and math for the first time in a remote setting provides numerous additional challenges to conveying and processing material, let alone the social development opportunities missed from not being among peers.

For many children, COVID hit during critical developmental and social developmental phases. Missing out on in-person relationships during these periods can lead to negative social and developmental outcomes. Children and youth were more isolated during this time than ever before and had less exposure to supportive adults and

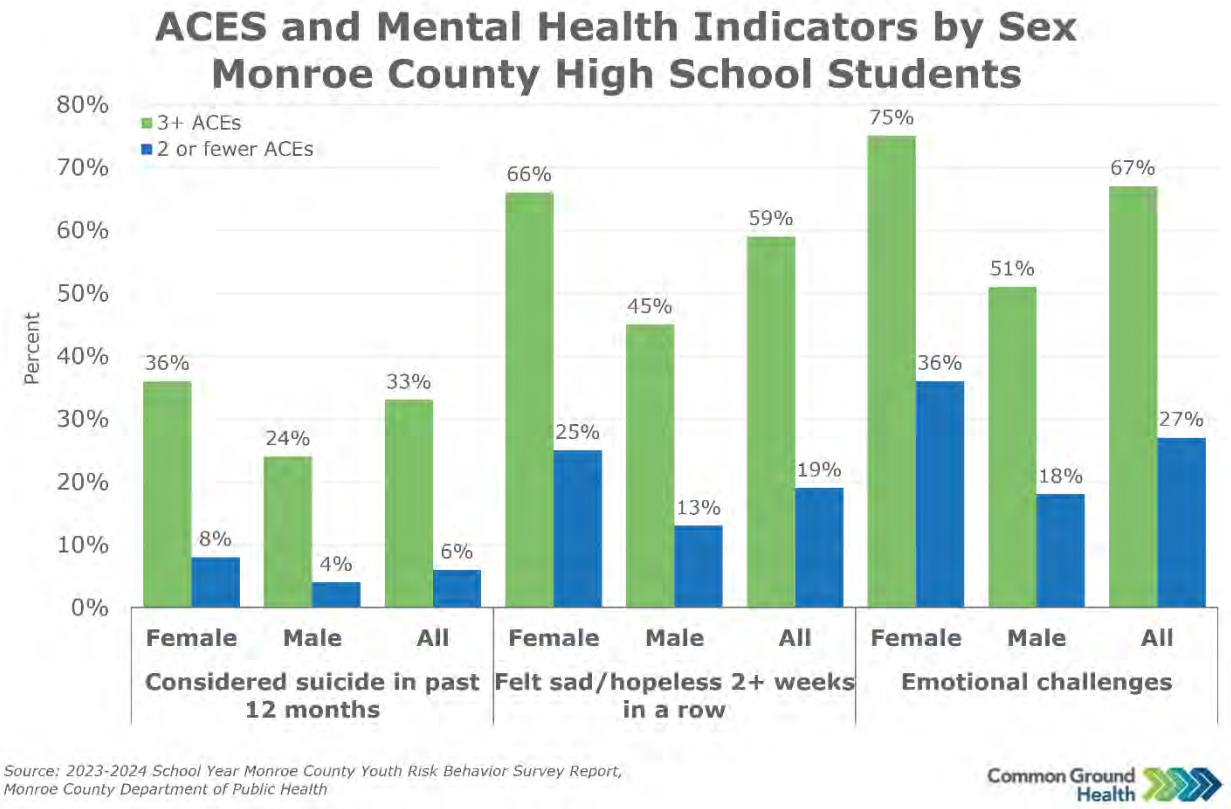
protective factors in their lives. Based on findings from the 2022 My Health Story survey, 42% of respondents identifying as a parent or caregiver agreed with the statement, "at least one of my children has struggled with mental health issues more than usual during the COVID-19 pandemic." While children and youth are resilient in many ways, adults need to be aware of the significant impacts COVID-19 had on youth and provide supportive environments for processing and healing.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs), are specific traumas known to have strong links to an individual's future overall health and include abuse (emotional, physical, or sexual), neglect (emotional or physical), and household challenges (exposure to domestic violence, a member of the household with substance use disorder or mental illness, an incarcerated household member, or parental separation or divorce). Children who have cumulatively experienced more ACEs are more likely to develop mental health conditions such as depression, anxiety, PTSD, and substance use disorders later in life. Early interventions can help identify and mitigate the long-term effects of ACEs and promote resilience among affected individuals.

The most recent Youth Risk Behavior Survey data indicate that 58% of student respondents reported experiencing one or more ACEs and nearly one in five (18%) reported experiencing three or more ACEs (**Figure 3.15**). Generally, this trend is decreasing; down from its peak of nearly 69% experiencing one or more and 26% experiencing three or more in 2015. Students reporting three or more ACEs were significantly more likely to experience mental health concerns including "feeling sad or hopeless for at least two weeks in a row, emotional challenges, and/or having considered suicide within the past 12 months," (Monroe County 2023-24 School Year YRBS Report). The chart below depicts mental health indicators for students reporting prevalence of ACEs by sex.

Figure 3.15

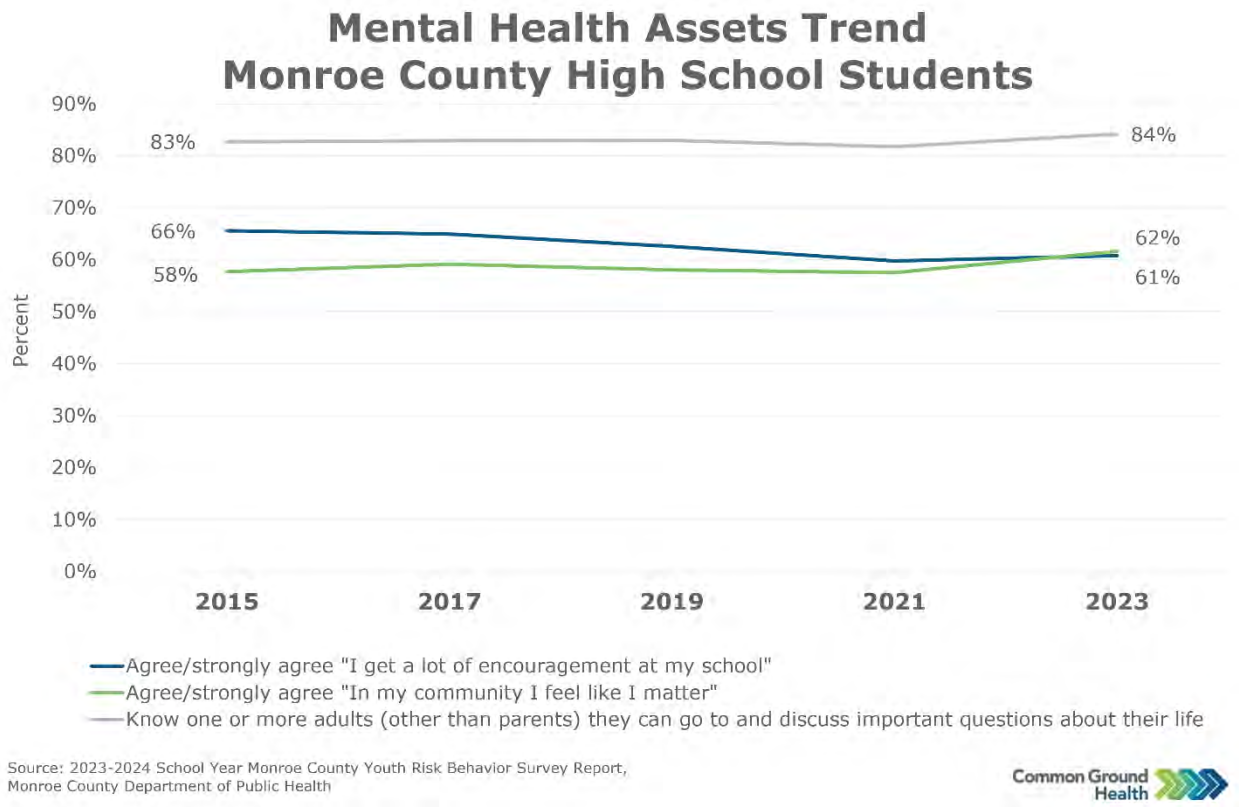


Student respondents who identified as female, Black and/or Latino, and LGBTQ were more likely to report having experienced ACEs. Nearly two-thirds of female students (63%) reported one or more ACEs and over one-fifth (23%) reported three or more. Nearly four-fifths (79%) of students identifying as Black reported one or more ACEs with one in four (24%) reporting three or more. Similar patterns exist for Latino students with over three-quarters (76%) experiencing one or more ACEs and 28% experiencing three or more. In reference to sexual orientation and gender identity, 79% of students who identify as LGBTQ reported one or more ACEs and over one-third (36%) reported three or more.

While Adverse Childhood Experiences are a good indicator for current or future mental health concerns, it would be remiss to assess these experiences without examining the positive strengths and supports that students have from their family, within school, and/or within their community. These supports can mitigate or lessen potential negative effects of ACEs. Overall 86% of student respondents agreed or strongly

agreed with the statement, "My family gives me help and support when I need it," and 84% agreed or strongly agreed that they "know of one or more adults (other than their parents) they can go to and discuss important questions about their life." While the percentage is smaller, the majority of students (61%) agreed or strongly agreed with the statement, "I get a lot of encouragement at my school," and 62% felt like they mattered to people in their community. In general, these trends have remained relatively stable over time (**Figure 3.16**).

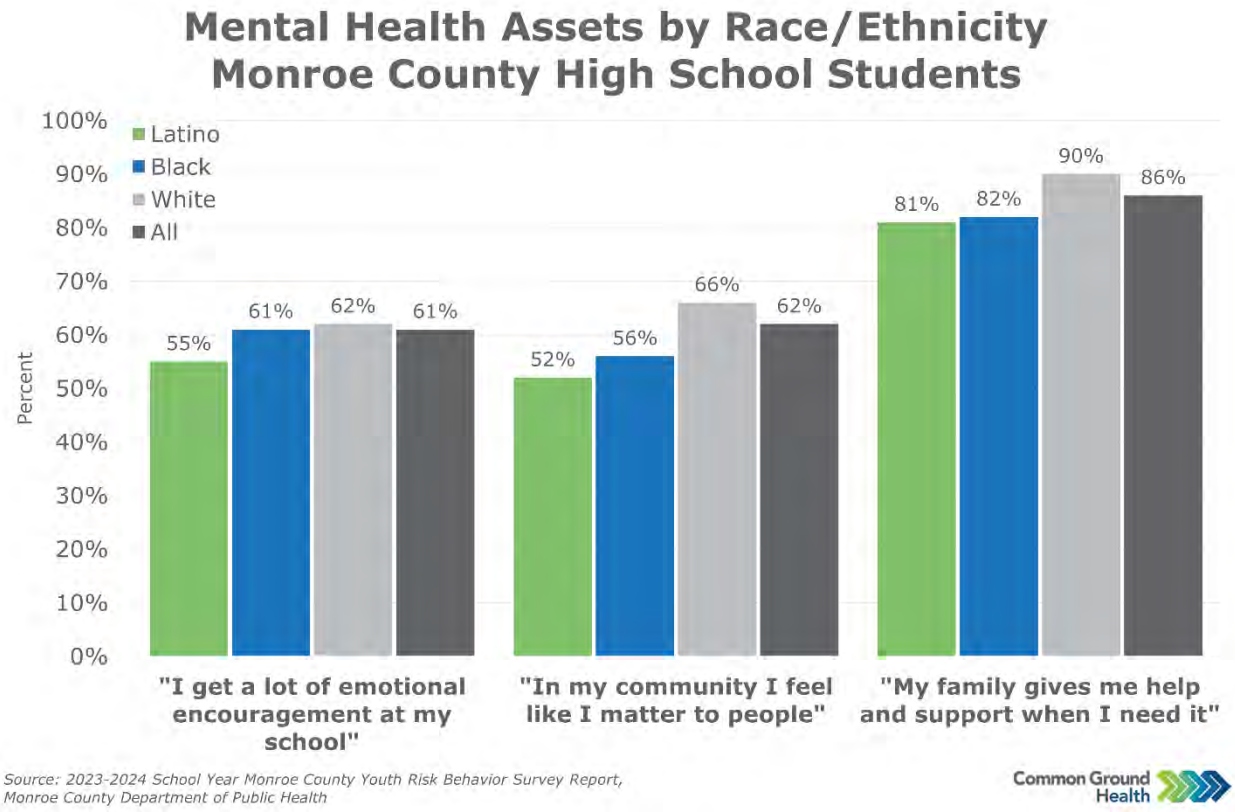
Figure 3.16



When examining assets by race and ethnicity (**Figure 3.17**), more than four-fifths of Latino (81%) and Black student respondents (81%) agreed with the statement, "my family gives me help and support when I need it," with 90% of white students agreeing with the statement. Rates decreased when students were asked about school and community settings. Just over half of all Latino students agreed that they got "a lot of emotional encouragement at [their] school," while 61% of Black students and 62% of

white students agreed with the same statement. Rates were even lower, however, when asked about the community. Just 52% of Latino respondents agreed with the statement, "In my community I feel like I matter to people," with 56% of Black students and 66% of white students agreeing with the same statement." Feeling included in school and community settings can help mitigate behavioral health issues; this is particularly important for youth who are currently less likely to feel supported in these areas. Opportunities for additional support in community and school settings should be explored further.

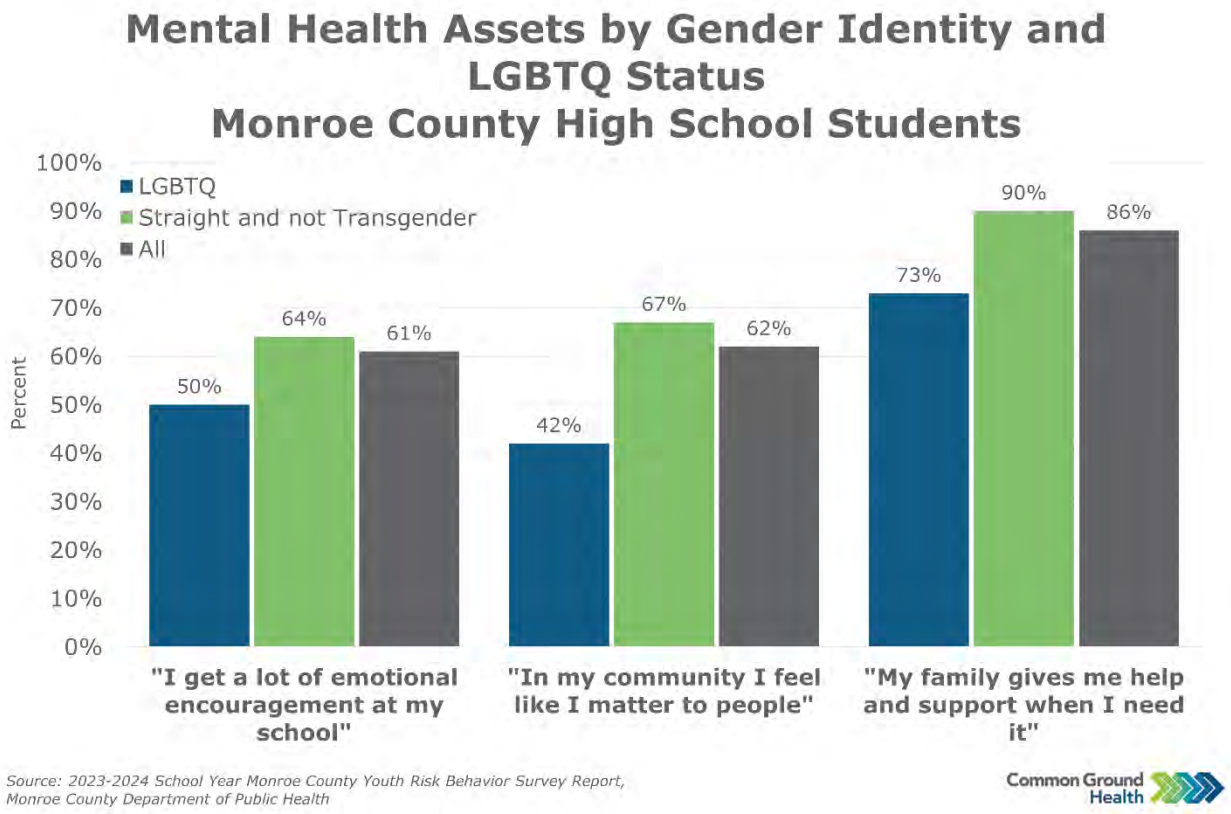
Figure 3.17



When examining assets by sexual orientation and gender identity, students identifying as LGBTQ were less likely to agree with these statements than cisgender students (referring to individuals whose gender identity aligns with the sex they were assigned at birth) (**Figure 3.18**). Only half of LGBTQ students felt that they received "a lot of emotional encouragement at school," and just two-fifths (42%) felt like they mattered

to people in their community. Nearly three-quarters (73%) of LGBTQ agreed with the statement, "my family gives me help and support when I need it." Nationwide, youth who found their schools to be supportive and affirming had lower rates of suicide attempts. Similarly, LGBTQ youth who lived in "very accepting communities attempted suicide at less than half the rate of those who reported living in very unaccepting communities," (National Survey on the Mental Health of LGBTQ+ Young People).

Figure 3.18



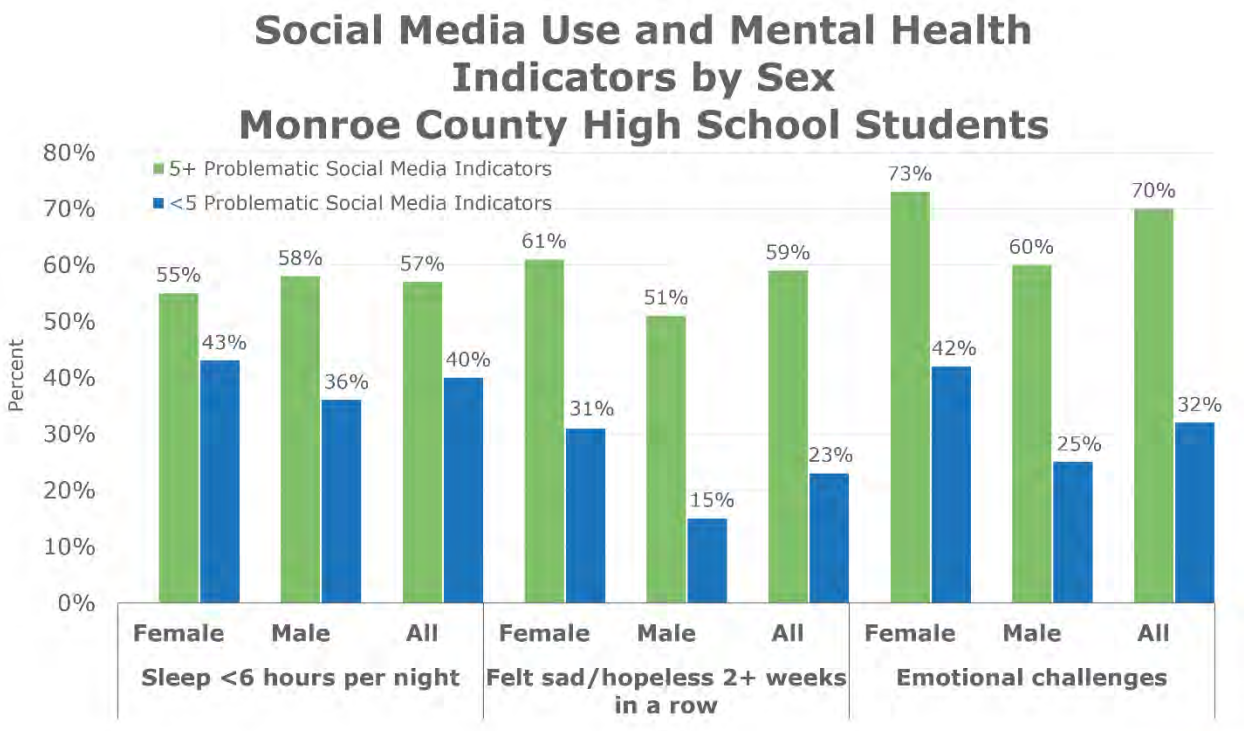
Smartphones and Social Media

A growing body of research is documenting the potential harms of smartphone and social media use amongst children and youth. A recent report from the Pew Research Center indicates that nationally, social media use among youth (ages 13-17) is near universal with 96% of teens being online daily and nearly half (46%) reporting that they are online "almost constantly," (Pew Research Center, 2024). While 13 is the legal age

for most social media platforms, nearly 40% of 8-12 year olds use social media (U.S. Surgeon General's Advisory, 2023).

Locally, the Monroe County Department of Public Health incorporated the Social Media Disorder Scale into the 2023-24 version of the YRBS. Over four-fifths of student respondents (84%) reported that they used social media "several times per day or more," and nearly one-third (32%) reported using social media "more than once per hour," (**Figure 3.19**). Thirty percent of students "tried to spend less time on social media but failed," while one-third (33%) often used social media to escape negative feelings. Social media use across the board was higher among female respondents than male respondents with 40% indicating that they "tried to spend less time on social media but failed" compared with 20% of male respondents, and 16% of female respondents reported having "regularly neglected activities because of social media (hobbies, sports) compared with 8% of male respondents. Problematic social media usage (answered yes to 5 or more questions on the scale) was identified in 10% of female student respondent and 4% of male respondents.

Figure 3.19



Source: 2023-2024 School Year Monroe County Youth Risk Behavior Survey Report, Monroe County Department of Public Health

Common Ground Health

An increased online presence is linked to negative mental health outcomes among children and youth; the link is more apparent with social media use among girls and use of video games among boys. Regardless of the platform, the sheer amount of time youth are connected is problematic as nearly half of 13-17 years olds nationwide are online "almost constantly." Jonathan Haidt, author of "The Anxious Generation," describes the four foundational harms of screen-based leisure time: 1) social deprivation (the loss of close connections and in person relationships); 2) sleep deprivation; 3) attention fragmentation; and 4) addiction (targeted efforts to "hook" children) (Haidt, p. 139). Of these four, the YRBS specifically asks youth to report the number of hours of sleep they get on an average night. Adequate sleep contributes greatly to academic outcomes and improved mental health, and it is recommended that youth ages 13-18 get 8 or more hours of sleep each night. The most recent YRBS indicates that more than two-fifths of all students (41%) get 6 or less hours of sleep on an average school night and just 29% reported getting 8 or more hours of sleep on an average school night.

Use of social media among youth is not all negative. These platforms provide connection with individuals who share identities, abilities, and interests that otherwise would be inaccessible. They can also help maintain friendships and provide access to important information and resources. Connection and social support from peers can prove to be especially important for those often marginalized including youth of color, immigrant youth, and youth identifying as LGBTQ. Based on a recent national study from the Pew Research Center, social media helps teens feel "more connected to what's going on friends' lives" (74%), "like they have a place to show their creative side" (63%), "like they have people to support them through tough times" (52%), and "more accepted" (52%) (Pew Research Center, 2025). In moderation, social media can promote connection and affirm support from peers.

While there is a significant body of research studying the effects of smartphones and social media on children and youth, little research has been done on the effects of smartphone and social media usage amongst parents. The urge to scroll through social media as a form of downtime and/or the amount of time that parents are spending on these platforms can negatively affect the relationship between parents / caregivers and their children. The effects of adult time on these devices warrant further study.

Accessing Mental Health Care for Children and Youth

Despite increased community conversations on the prevalence of mental health conditions and on the importance of addressing mental health conditions early and comprehensively, questions persist on the overall availability of mental health services for children and awareness of existing programming. While the provision of mental health services for children in Monroe County generally has grown, gaps in accessing services still remain—especially for our youngest children (0-5 years old) and transition age youth (18-21). Additionally, providers and families alike are not always aware of existing programming that is available. Several advisors discussed collaboration and coordination. One specifically stated, "capacity building, communication, team building work is helping this. [We] need to make sure all the systems are accessing each other. We weren't referring kids to things that were already available. We were not looking outside of systems and putting people on long wait lists. It doesn't mean we have enough services, but…by pulling all of those systems together in a different way and encouraging them to be more efficient…we're really learning how broken we have been and how siloed and how much bridge building we need to do to make it better." Awareness and availability of services in an uncoordinated system significantly hinder access for children, youth and their families in need of services.

Navigating a complex system of care is another barrier families face when seeking behavioral health services for children and youth. While individual care managers exist in some practices, they are often overwhelmed by the demand for their support. Families may be provided with a list of providers but continue to hear "we're not accepting patients right now," resulting in frustration and missed opportunities for intervention.

Local providers acknowledged that the system is incredibly confusing, and that there are significant disconnects between the places where children and youth can access supports. Diverse sectors such as primary care pediatrics, school, mental and behavioral health are generally working within silos. This is not to minimize existing efforts at the local and state level to integrate systems, but to emphasize that further coordination and integration remains a need locally. Specifically, progress is being made to integrate mental health services into school systems, yet families still need additional support. One advisor summarized, "[there's] still a challenge around how do

we engage families in that process…families struggle to navigate all the systems that impact their lives as well." Families need to be included in the process, have the opportunity to share their experiences, and speak to what is and is not working.

In addition to barriers such as access, awareness, availability, and complex system navigation are social drivers of health that include transportation challenges, insurance coverage and cost of care, poverty, mistrust of the system and discrimination that may further delay or deter care all together. Delays in receiving mental and behavioral health care can further exacerbate conditions making them harder to address later. The basic needs of families need to be acknowledged and met for effective and timely care to be delivered.

Adults working with children and youth also need training and support to be more aware and have a better understanding of how mental and behavioral health concerns may present in these age groups. Educators may have the most contact with children and youth apart from their families, but they have not necessarily been trained to look for or understand signs of mental health distress and that what may present as behavioral issues are often underlying difficulties communicating mental and emotional needs. An advisor focused on youth stated that, "pediatricians and educators are the main mental health serving community [for youth and we] need to make sure they are being supported by people who understand mental health and…early warning signs – and can address them appropriately." Many professionals working with children are not cognizant of early distress signals to look for and how these signals can manifest into potential behavioral issues in the classroom and other settings.

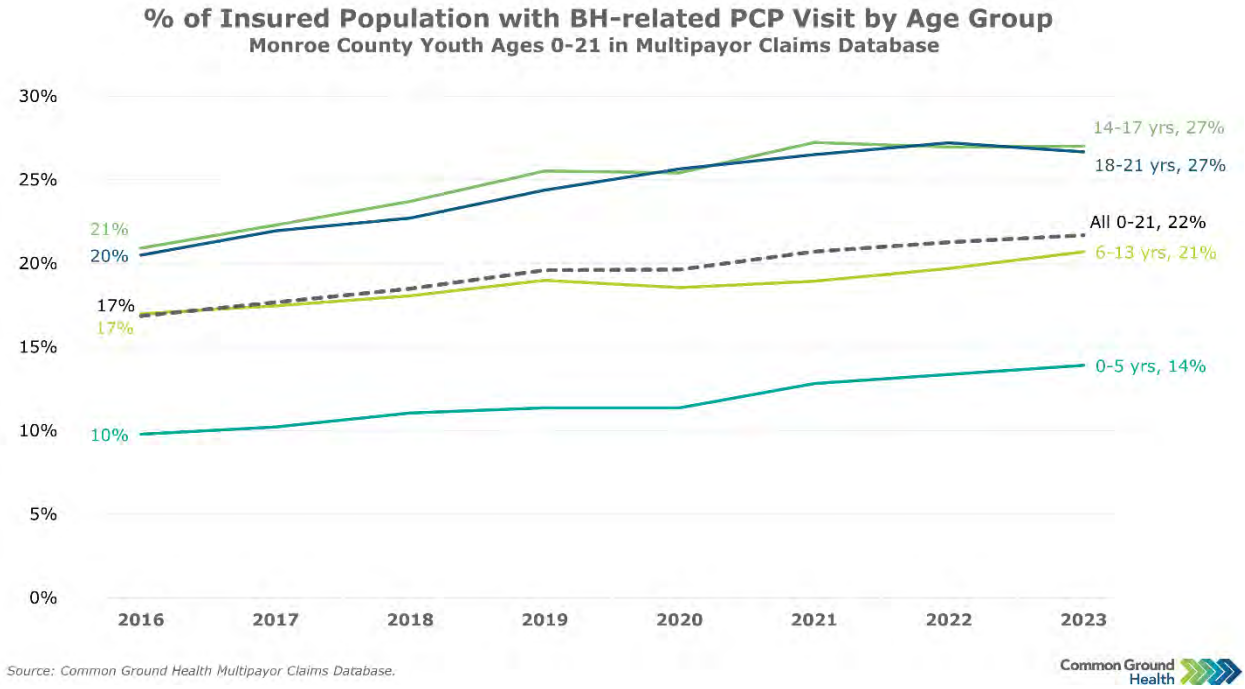
"Pediatricians and educators are the main mental health serving community [for youth, and we] need to make sure they are being supported by people who understand mental health…early warning signs and can address them appropriately."

Behaviors can also affect eligibility for programming and services for toddlers, school aged children, teenagers, and transition aged youth. When mental health conditions present in the form of violent or hurtful behaviors, children may be excluded from certain services that would be extremely helpful. This further limits and complicates treatment options available for families. Advisors noted that, "there's exclusion criteria for programming. Some of the behaviors of concern or way of presentation prevent [children and youth] from engaging in treatment that they may desperately need."

Pediatric primary care providers (PCPs) also need further support. Pediatricians stated that the time they dedicated to addressing mental health with patients has increased substantially over the years. One pediatrician cited the trends in her own practice noting that, "seven years ago (pre-pandemic) my practice spent approximately 50% of time on mental health versus 15-20% when I first started practicing. Now 70% of pediatric primary care time is spent on mental health." Advisors expressed general sentiments that, "[Pediatricians] all care deeply about their kids, but they feel alone and like they're drowning." These rates are overwhelming, and providers are struggling to keep pace with the demand.

Children and youth patients have become increasingly likely to engage with their primary care providers about behavioral health issues. Just as Figure 3.1 showed an increase in the prevalence of behavioral health conditions, Figure 3.20 shows an increase the percentage of insured children and youth who have behavioral health-related visits with their primary care providers. In 2016, 17% of the insured 0-21 age population had a primary care visit with a behavioral health diagnosis code. This grew steadily to 22% in 2023. The percentages are larger for the older youth (14-21) compared to younger youth. These numbers likely understate the extent to which mental and behavioral health issues arise during visits with a primary care physician since this only captures visits where a diagnosis code is listed on the visit record.

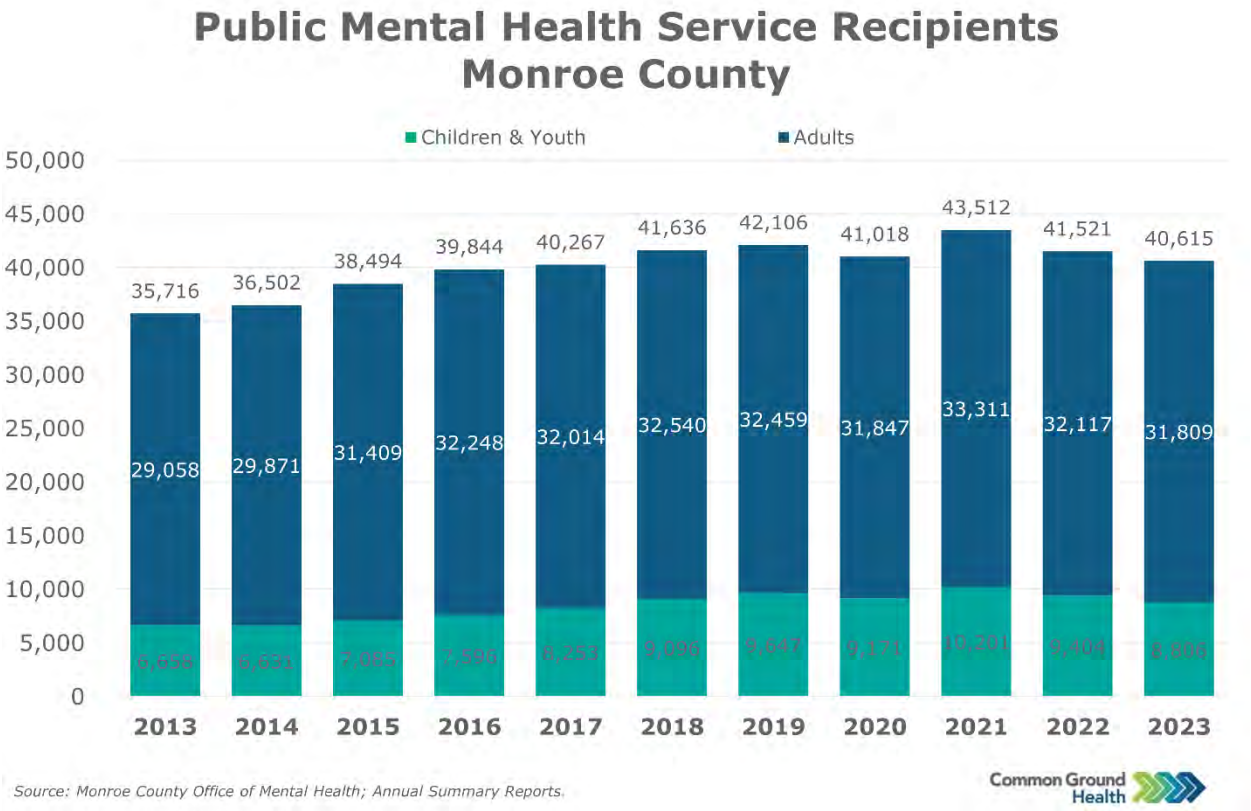
Figure 3.20



Lastly, the aesthetics of many inpatient mental health clinical spaces are not conducive to promoting wellness. Sites have been described as "shamefully outdated," "not health promoting," "not child and family-centered," and that a particular unit "hasn't changed in decades." The coldness of these spaces affects one's willingness to seek out treatment and access care. Warm and inviting spaces are needed to make the site a place that children, youth, and families would be willing to come back to.

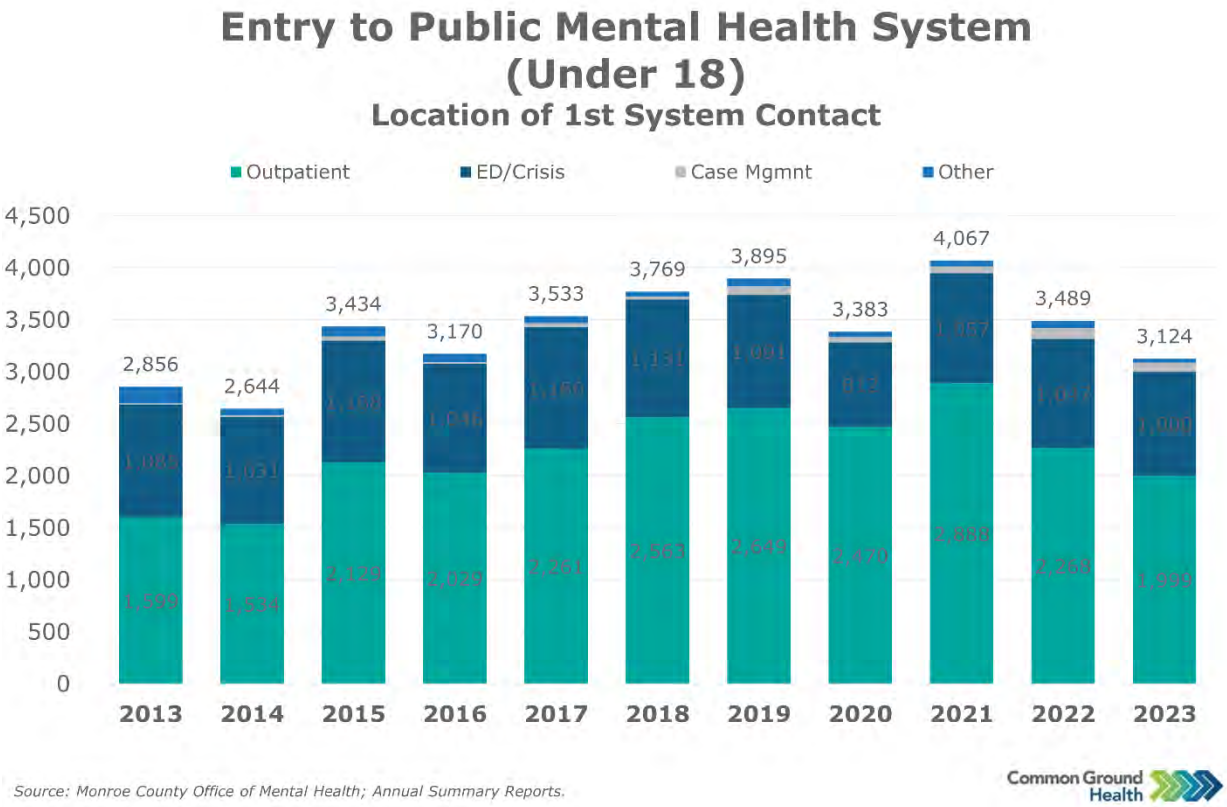
Despite all these barriers children and youth continue to access mental and behavioral health care. The chart below depicts the number of people utilizing public mental health services in Monroe County. Children and youth under age 18 are depicted in green. The number of children and youth accessing public mental health services has grown from under 7,000 in 2013 to over 10,000 in 2021 (**Figure 3.21**).

Figure 3.21



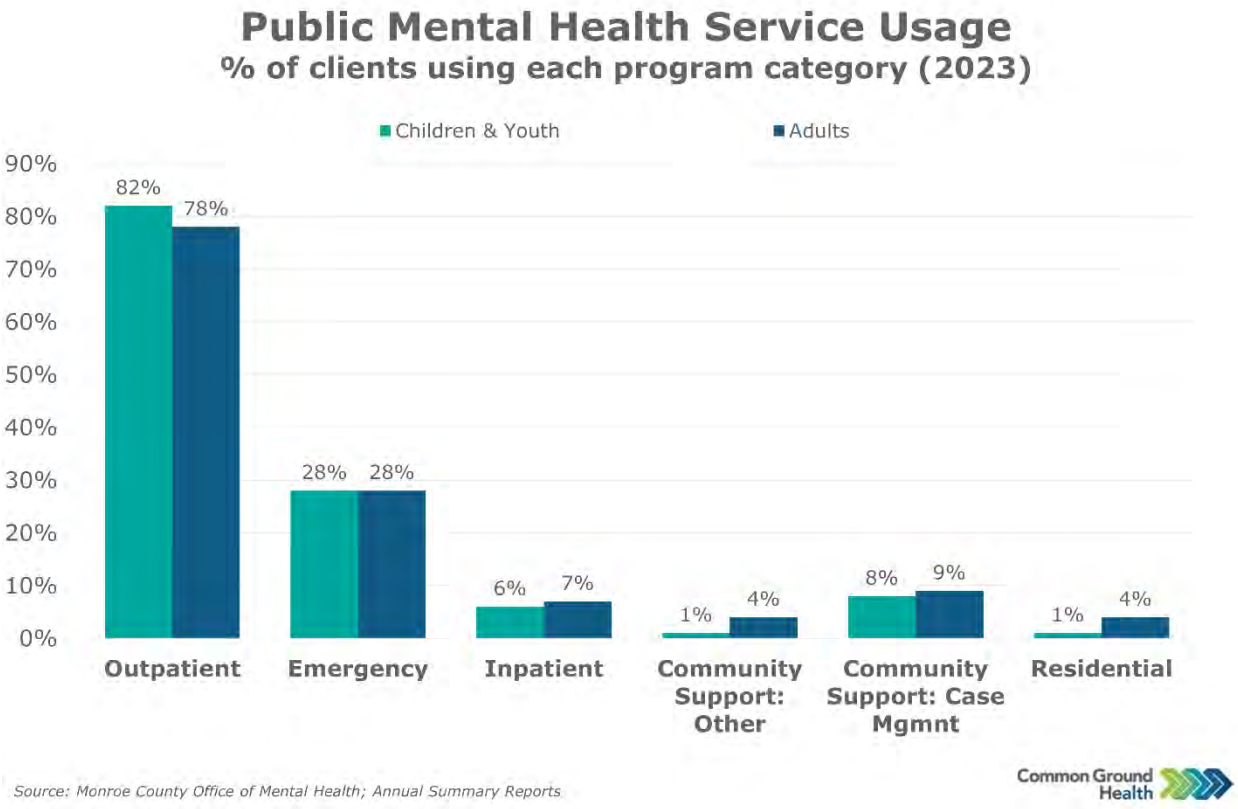
The Monroe County Office of Mental Health continues to serve more children and youth each year. **Figure 3.22** below shows that most new pediatric patients first enter through outpatient services indicating that more children and youth are getting the help and support they need before the onset of a crisis.

Figure 3.22



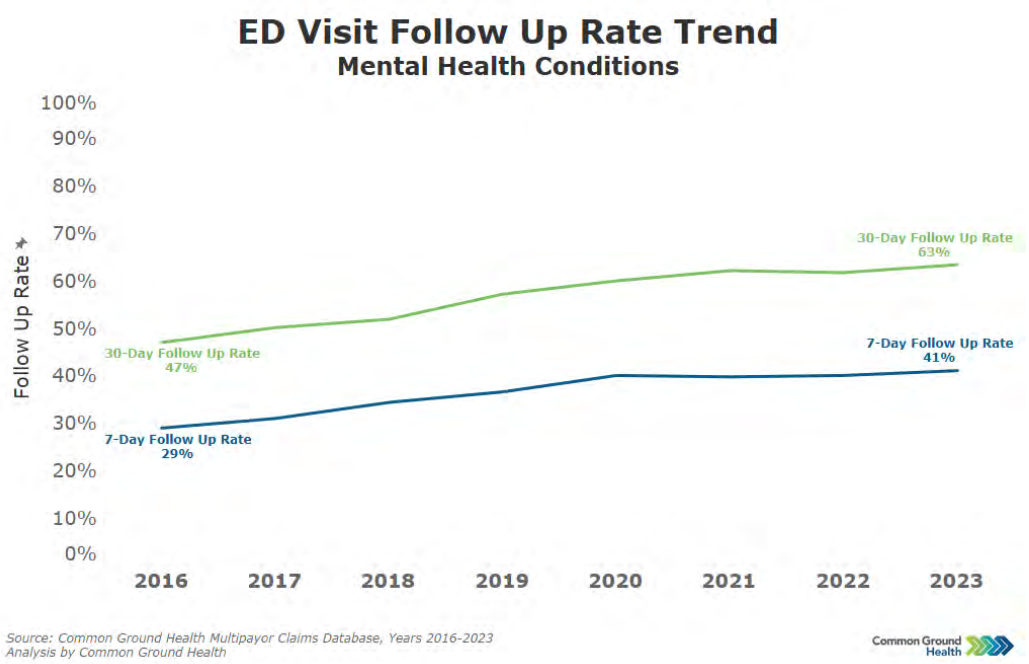
The Monroe County Office of Mental Health offers a range of care services including outpatient, inpatient, emergency, residential, and case management among other community support services. As shown in **Figure 3.23**, most children and youth (82%) are using outpatient services, followed by emergency services (28%), case management (8%), inpatient services (6%), residential services (1%) and other community support services (1%).

Figure 3.23



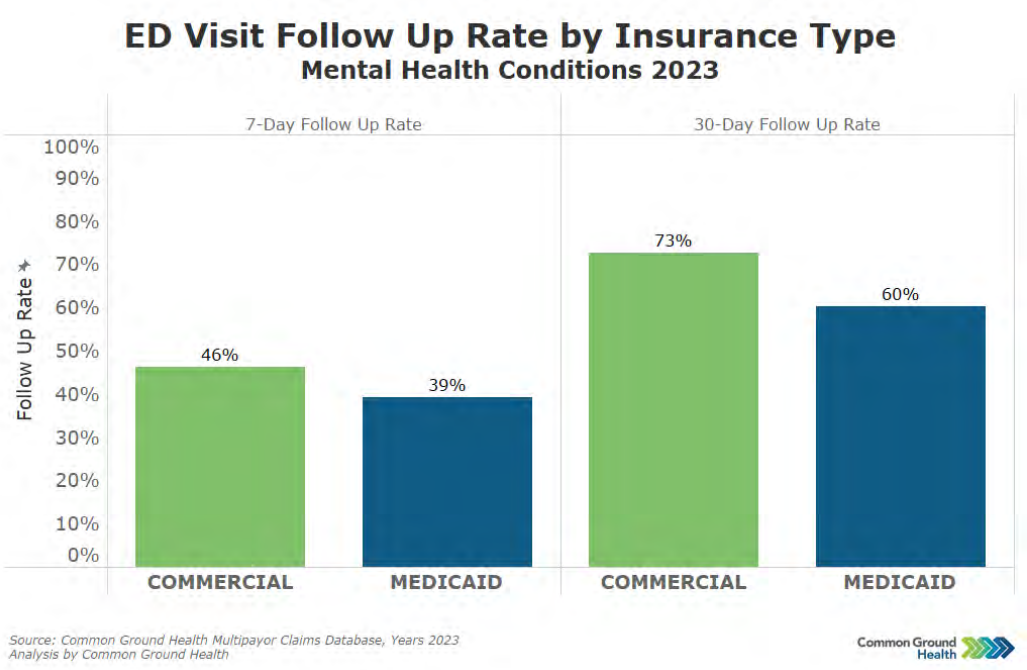
Encouragingly, follow-up rates after an emergency department visit have steadily increased over the years for children and youth ages 6-21, yet improvement is still needed (**Figure 3.24**). In 2016, just 47% of youth had a follow up visit 30 days following an ED visit for mental health related conditions. As of 2023 (only 11 months of data provided for this year), the rate was 63%. This is a significant improvement, but 37% of youth with a mental health ED visit still do not have a claim for a follow-up visit at 30 days.

Figure 3.24



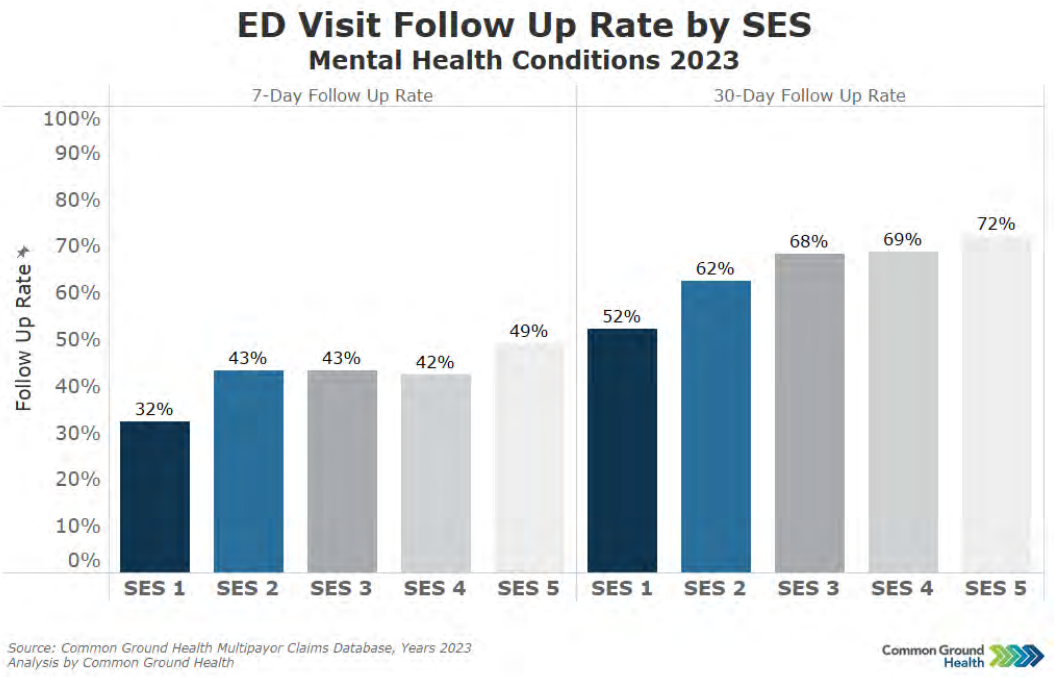
Upon further examination of emergency department visit follow up rates for mental health conditions, it becomes apparent that there are significantly lower follow-up rates for the Medicaid population than for children and youth (ages 6-21) with commercial insurance (**Figure 3.25**). Follow-up rates for Medicaid recipients are just 39% at 7 days and 60% at 30 days compared with commercial members at 46% and 73% respectively.

Figure 3.25



We see similar trends with emergency department visits for mental health condition follow up rates by socioeconomic status (SES). There are significantly lower follow-up rates for people who live in a ZIP code with a lower SES (**Figure 3.26**). This trend is most pronounced with the lowest SES grouping with just 32% of children and youth receiving follow up at 7 days and 52% receiving follow up at 30 days compared with 49% of those in the highest SES bracket at 7 days and 72% at 30 days.

Figure 3.26



Access challenges coalesce to negatively impact children, youth, and families from ZIP codes with lower socio-economic status. While currently underutilized, telehealth could provide additional opportunities for families seeking care in the future. Telehealth visits specifically for behavioral health peaked during the COVID-19 pandemic in 2020 and 2021 and have declined since then. Children and youth utilize telehealth for behavioral health visits at a lower rate than adults and older adults – just 23% of behavioral health visits for youth utilized telehealth in 2023, where approximately one-third of behavioral health visits for adults (34%) and older adults (32%) utilized telehealth services (**Figure 3.27**).

Figure 3.27

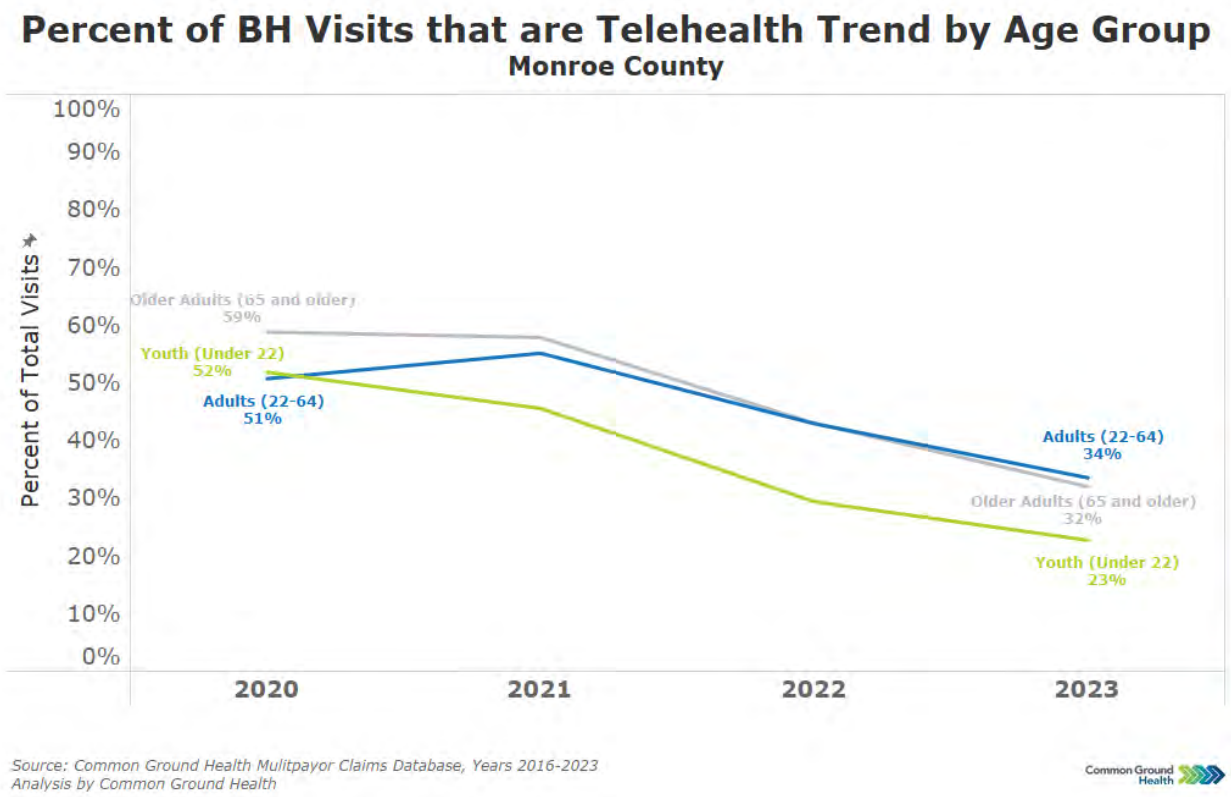
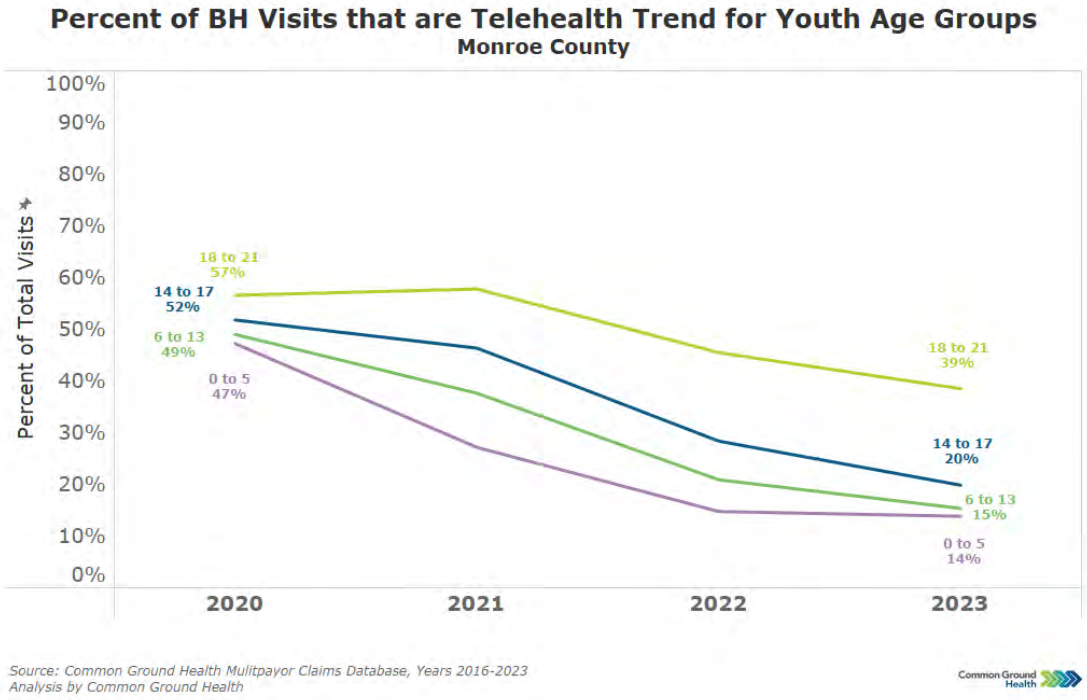


Figure 3.28 below provides further detail by age and the use of telehealth for behavioral health visits. It is not surprising that the percent of total visits has declined since 2021 with many routines shifting back to pre-pandemic norms and that younger children (14% for 0-5; 15% for 6-13) are less likely to utilize telehealth than teens 14-17 (20%) and transition aged youth (39% for 18-21). The reasons behind these rates for children and youth should be explored further.

Figure 3.28



Promising Practices & Opportunities for Children and Youth

While much of the information in this section is concerning, there are many areas where collectively we can improve the mental and behavioral health of children and youth. The external advisory group consulted for this project shared many examples of promising practices that were already being integrated in addition to opportunities that should be further explored. These promising practices and opportunities fall into five main themes:

1. Early detection and prevention
2. Training and support
3. Family-centered approaches
4. Facilitating access and
5. Reducing silos

Early Detection and Prevention

Early detection and prevention are key to helping address mental health conditions in children and youth. Screening children and youth regularly can help identify mental and behavioral health conditions before more intense levels of care are needed. Implementing depression, anxiety, and suicide screenings at regular intervals will reach more children and youth before the onset of a crisis and potentially avoid more intense levels of care. The American Academy of Pediatrics already recommends universal depression screening and will potentially be moving toward anxiety screening in adolescent populations age 12 and up. Many primary practices are already implementing these screenings, in addition to implementing and/or enhancing the quality of suicide screening tools as well. General sentiments included the need to "identify kids earlier, before they are in crisis mode."

> *"Identify kids earlier, before they are in crisis mode."*

In addition to screenings, expanding prevention-based programs such as Healthy Steps, perinatal mental health programs, and resiliency skills for youth among other educational interventions may help. Several advisors affiliated with local hospital systems expressed that, "[We need] levels of care that help avoid more intense levels of care. Hospitals and emergency departments are just about safety. We need to invest in…other interventions (not just therapy) that might prevent the need for higher level of interventions." With support from mental health providers, school teams could implement social emotional health programming to help build resiliency and life skills at a crucial time in development.

Training and Support

Additional opportunities exist for more training and support. Several areas of training have been more pronounced throughout this assessment that include infant mental health and reflective supervision and enhanced training for school professionals. Training in these areas will provide clinicians, early childhood educators, and school staff with the tools they need to help identify and refer children that might have needs.

Additional training was cited specifically for mental health clinicians in the areas of culturally responsive mental health treatment and care. Clinicians need support and training to better serve the diverse communities throughout Monroe County.

Additionally, more adequate support is needed for pediatric clinicians who are not behavioral health providers. Pediatric offices continue to encounter higher percentages of behavioral health related visits. Additional care coordinators and social workers can help support these needs through collaborative care models for primary care pediatric practices that includes a physician who can be an immediate referral to enhance early access for children and families.

Family-centered Approaches

Family and patient-centered approaches help enhance the service and delivery of all programs. Families, children, and youth need active seats at mental and behavioral health tables so they can share what is and what is not working for their families. From program development and implementation to the aesthetics of the space, families and youth need to be included in each phase of the process. Youth advisory groups and family design teams can help create how clinical spaces function and flow from the patient perspective, improving the quality of programming and mental health outcomes. Locally, newer clinical spaces specific to children and youth mental health are proactively being designed with parent advisory boards to influence and define processes. Actions like these are helping to "change the culture and make crisis intervention services more family-centered." The future of mental and behavioral health services is based on "reforming or enhancing services to be more patient and family centered, more culturally [responsive]…the flexibility to know people and the full context of their experiences and match them with what they need, what they are ready for, and what they want." These are elements that will continue to advance the quality of mental and behavioral health care received by children, youth, and families, because, "taking care of families right from the start, integrated and holistic [approaches], contributes to the wellness of our society."

Promoting and Facilitating Access to Mental and Behavioral Health Services

Mental and behavioral health providers continue to implement new programs and initiatives to better reach children, youth, and families in need. Interventions that leverage home visitation, telehealth, community health workers, or school-based

models all help to promote access. Many promising practices exist in this area, but we will highlight just a few.

Locally, there is a perinatal mental health initiative that incorporates universal home visitation with telehealth in addition to connecting families with community health workers and behavioral health specialists. Launched during the pandemic, the initiative is tied to the medical home of the baby and informs the work of the primary care team as they are caring for a patient. It is a light touch model and does not take the place of intensive home visitation programs. It includes an interprofessional team, including an RN who conducts the initial assessment (and is tied to the practice), a behavioral health specialist, and a community health worker. This is making it easier for new parents to access the services they need. Specifically, "it is breaking down the barriers for birthing parents who are experiencing postpartum anxiety or depression to actually access care more readily, because we know there's a whole host of barriers to that happening."

Community schools and the EACH initiative are promising models focused on the school setting. Community schools are public schools that offer services and supports that fit neighborhood needs, making the school a hub for community activity, opportunities, and resources. Health and wellness is a vital element of this model. The EACH initiative stands for Expanding Access to Child Health and Mental Health. Currently this initiative is being built with the Rochester City School District and community partners to expand access to both physical and mental health services through telehealth in schools that is tied to the medical home of children and youth. This is helping to enhance actual direct access to mental health services in schools. This helps expedite the pace at which the child is being seen and treated. Another model is looking to expand school-based mental health clinics. Since 2022 the initiative has gone from two to sixteen mental health clinics in RCSD schools. The program is hoping to have some kind of coverage in all RCSD schools by 2028. This will help to bridge transportation and address attendance issues in addition to helping to provide good quality mental health services in schools because "the education system is an opportunity to really work with the child and the family to develop a life of wellness for the entire family."

Ultimately, much of the success of these initiatives goes back to a core public health principle of "starting where the people are." Expecting children, youth, and families to always come to a clinical setting sets up barriers from the start. Alleviate the barrier of

time and transportation by starting where the people are. Admittedly, people have difficulty prioritizing mental health at times. Therapy is a time commitment to come in for a session. Telehealth has made it easier to access services. Challenges remain, but overall telehealth is helping to mitigate some of the barriers to accessing care.

Reducing Silos

Reducing silos and integrating services and systems remains a challenge. We may often jump to "we need more of this" before assessing the full spectrum of programs and services already available locally. Leaders providing strategic direction are needed to pull diverse systems together and encourage them to be more efficient. A promising practice may be to appoint specific people within organizations to help facilitate collaboration and communication. Enhanced billing rates for engaging in quality improvement projects could help to kickstart these practices by making it more enticing for practices to engage in these types of efforts. Flexibility in billing is important for efforts like these. Being able to bill for parent involvement or collaboration is important and further incentivizes this type of coordination.

The need for peer family advocates to assist with navigating access to care remains a best practice as well. Peer advocates with lived experience offer numerous benefits to families navigating mental and behavioral health systems such as increasing access to services, connecting to community resources, providing support, reducing isolation, understanding their rights, and promoting self-advocacy. Continued coordination and navigation assistance, whether from a peer with lived experience or care coordinator, help families to get children and youth the support and services they need.

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Section 4:
SYSTEM GAPS & COORDINATION ISSUES

Behavioral health care services are diverse in scope and practice. Different types of care are available from a mix of entities, including both medical systems that offer many services and community-based organizations that provide specific types of support. Services span the continuum of care from early prevention to acute crisis care. They also include different modalities ranging from medical-model health care settings to holistic recovery-oriented community-based programs. Due to the fragmented behavioral health landscape, many people struggle to find and access needed care.

Individuals with behavioral health care issues often cannot access care that fits their needs in a timely manner. This section highlights the person-level circumstances and their interplay with systems gaps and coordination issues noted by our external advisors. These dynamics compound the known complexities involved in accessing care across the behavioral health care service spectrum. The section begins by examining examples of long-standing, yet persistent barriers individuals experience that prevent or complicate access to care. The next section highlights examples of system-of-care dynamics that underlie barriers to timely access to the right kind of behavioral health care. The final section details system-level opportunities that could help to reduce barriers to care through actionable changes in care coordination across settings, workforce support and integration, and program policy features noted by the advisors.

Throughout this section, advisors offered comments referring to aspects of the medical model of care. The medical model is the primary philosophy that underlies both behavioral health and general health care in the U.S. The medical model, rooted in Eurocentric values, emphasizes biological disease and treatment. While these are important aspects of health care, the model does not offer a complete picture of the human experience of health and wellness. Specifically, the medical model is incomplete in its ability to fully articulate and address the complexities of people's lives, like the social drivers of health, and how they impact behavioral health and wellness journeys.

Person-level Needs and Barriers

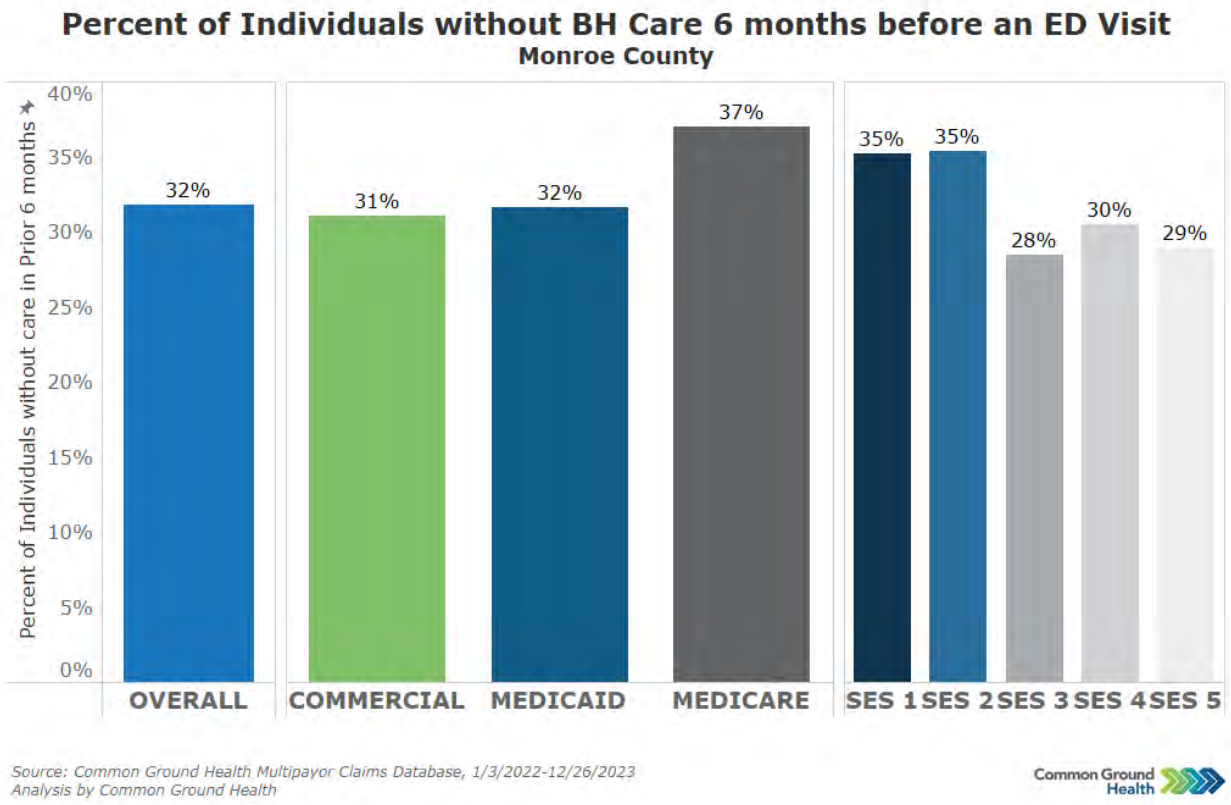
Often, people seeking care are left to navigate the complex factors involved in finding and utilizing behavioral health care, no matter the level of intensity of care that may be needed. Complex factors may include finding an appropriately trained provider, determining if the provider is affordable and/or accepts their insurance, determining if the location of services is geographically accessible, and determining if the setting and provider's availability align with the needs of the person seeking care. People seeking care who have fewer resources to overcome logistical hurdles or not enough financial resources to pursue private-pay options are less able to access care in a timely manner.

We heard from our advisors that providers who seek insurance reimbursement are limited by the medical model of care regulations and policies. They noted that insurance rules and policies restrict how and in what ways treatment and continued eligibility for services are permitted to happen. In other words, providers might want to provide services in ways that fit the context and lifestyle needs of more individuals; however, they would not receive reimbursement for sessions offered outside of the approved structural location and setting on file with the insurance companies.

We also heard from our advisors that often a person's context or lifestyle needs that serve as barriers to care are the same experiences that likely exacerbate mental health or substance use issues. Yet, supporting those context and lifestyle needs are outside the scope of practice of the behavioral health care system. This is especially the case when the needs pertain to receiving access to food, shelter, transportation, care for dependents, or employment flexibility – basic needs that are required to continuously access care in the behavioral health care system. For example, most services are offered during the day and individuals need access to supportive processes and policies that provide them with protected time to attend appointments, utilize public transportation, and secure employment or childcare coverage during absences from daily life activities when treatment options are traditionally available.

An analysis of insurance claims data showed patterns in the utilization of behavioral health care by people who had a severe enough mental health issue to prompt them to go to a hospital emergency department. Specifically, we looked at the billed utilization of behavioral health-related visits or services in the six months prior to the ED visit. The results showed that 35% of these individuals living in ZIP codes with low socioeconomic status (SES) did not have any behavioral health-related billed care in the period before the ED visit, compared to 29% for the people living in high SES ZIP codes (**Figure 4.1**). It is interesting to note that there was no meaningful difference in the rates between Medicaid and commercial insurance patients. This suggests that there are gaps in the system of care beyond insurance coverage type that are associated with experiences specific to each end of the socioeconomic status spectrum that need to be addressed.

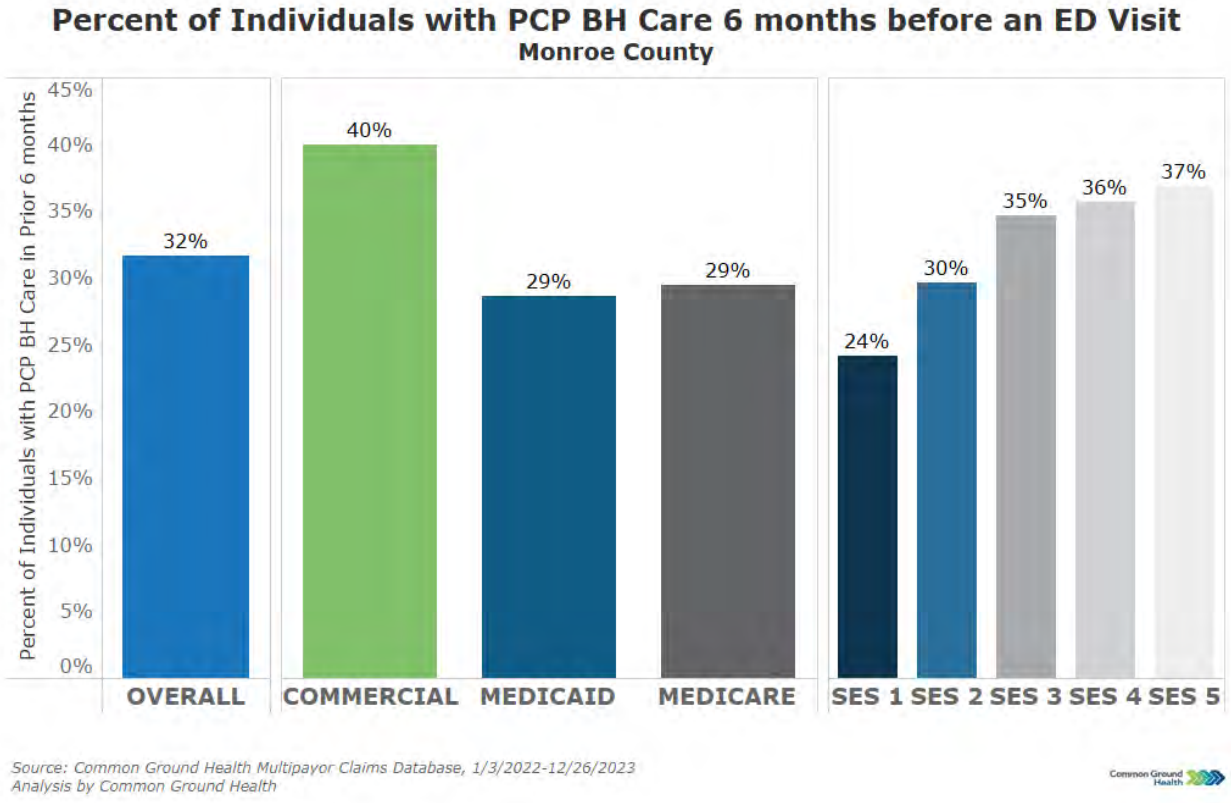
Figure 4.1



An additional barrier to accessing care at the person-level noted by the advisors is the lack of emphasis on the interdependence and interrelatedness of physical health and mental or behavioral health issues. Advisors explained that non-behavioral health care providers in the medical system, such as primary care providers (PCPs) and other medical specialists, as well as persons seeking care, lack knowledge and awareness of the importance of supporting and connecting with behavioral health care alongside medical care for issues like high-blood pressure, heart disease, and even diabetes – chronic medical conditions that may be stress-exacerbated. Our advisors noted that, specifically for people who have lived with the constant stress of racial discrimination and/or persistent financial distress, providers and individuals themselves might not even recognize that there are mental or behavioral health issues present that may be underlying medical issues. Education is needed both for non-behavioral health care medical providers and for communities where talking about mental or behavioral health issues may be negatively stigmatized.

The insurance claims analysis described above also looked specifically at the prevalence of behavioral health-related visits with primary care providers (PCPs). The analysis showed that 32% of the cohort with a mental health ED visit had a billed BH-related PCP visit in the six months prior to the ED visit. However, people with Medicaid were significantly less likely to have a BH-related PCP visit in that period than their commercially insured peers (29% vs 40%) as shown in **Figure 4.2**. This is consistent with three points raised by multiple advisors: 1) Primary care providers are seeing a significant rate of people for behavioral health issues, some of whom end up with acute mental health issues, 2) Primary care offices are burdened with unbillable work relating to referral and connection needs for persons with behavioral health issues, and, 3) Medicaid insured individuals are less likely to access all kinds of care, in general, and this includes being less likely to access primary care visits for behavioral health issues.

Figure 4.2



Additionally, there is a particular shortage of behavioral health providers who are available in a timely manner and have undergone specific training in unpacking the mental health impacts of intergenerational, racialized discrimination. This is a key part of the system gaps and barriers to care for communities of color. Advisors noted that it is not enough that providers have shared identities in common. Providers must also do the work of unpacking their own racialized trauma histories to adequately serve the mental health needs of community members with those histories and experiences. There is a hesitancy among some providers of wanting to coordinate and refer to mental health settings where it is known that there is a lack of culturally congruent, trained providers to address specific needs, such as the interplay of general mental health issues and histories of racial discrimination.

Within these complex factors, the precision of fit or cultural congruence of the provider and the person seeking care is also a crucial component of the quality of care. While some assert that there may be enough providers per population, others note that referral sources are limited for populations for whom identity-based discrimination has been a feature of their own lives.

Multiple advisors noted that parallel to a shortage of culturally aligned providers, there are shortages of investment in effective workforce inclusion of community-located trained peers, defined most broadly as a person with lived mental health or substance use experience. There is also a shortage of peer supervisors and readiness assessments for organizations who seek to incorporate peer models in traditional medical model settings.

Underlying Behavioral Health Care Setting and System Issues

Numerous advisors noted that the traditional medical model is a reactive rather than a preventative system of care. People seeking care have to go to a specific setting, which may not be geographically accessible or scheduled conveniently, to receive services for specific symptoms and might not get immediate or timely care until they are highly distressed. This model doesn't work for everyone. Even when people initiate care, some people stop accessing because there is a mismatch of need versus availability, quality, and immediacy of services. Our advisors noted that, "[The] current medical system is reactive rather than preventative…And so most of our behavioral health

interventions are post-incident types of things or after people have developed long symptoms. And most people delay care anyway. And so, by the time they're coming in, there's already a lot that's happened." The behavioral health care system based on a medical model does not have the adaptability or flexibility to provide recovery-oriented, self-directed care as per the Substance Abuse and Mental Health Services Administration (SAMSHA) principles that the providers themselves desire to adhere to (Substance Abuse and Mental Health Services Administration, 2023). Prevention and wellness promotion are important at all levels of need - from generalized, non-clinical needs through to crisis-level needs.

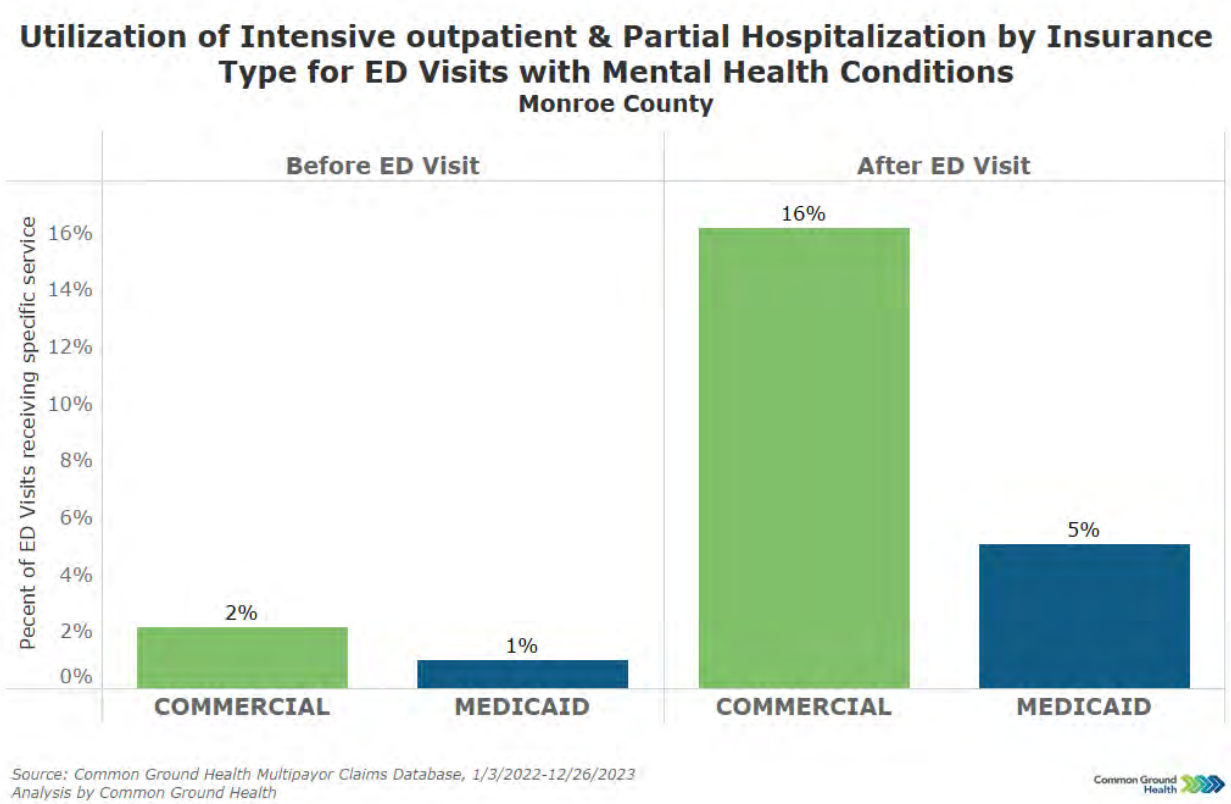
> *"[The] current medical system is reactive rather than preventative…And so most of our behavioral health interventions are post-incident...or after people have developed long symptoms."*

Across the medical model system of care, behavioral health services in Monroe County are often described as being "siloed," meaning that they are isolated or disconnected. This significantly hampers the ability of providers across settings to coordinate care for individuals they serve. This fragmentation is evident across various aspects of the system, from initiating referrals for care through discharge and other transition points between levels of care.

To assess the utilization of higher levels of care, we looked at the patterns of claims for intensive outpatient services, including partial hospitalization, for the cohort of people with mental health-driven ED visits. The analysis found that use of these escalated services was very rare for people prior to their ED visit. Only 2% of commercially insured patients had this type of care in the six months prior to ED visit, and only 1% of Medicaid patients. However, after the ED visit, these services were much more likely to be utilized: in six months after the ED visit, 16% of commercial and 5% of Medicaid patients had claims for intensive outpatient services (**Figure 4.3**). This suggests there are opportunities to provide this level of care to people sooner, potentially averting the

need for ED visits. The data also show a big gap in the use of these services by Medicaid patients.

Figure 4.3



This supports the listening session insight that care is siloed and difficult to coordinate without an emergency department visit. It also aligns with what we heard from the advisors that across all levels of care, Medicaid-insured individuals have difficulty accessing services that they need. People referred to intensive outpatient or partial hospitalization programs often wait six weeks to start services; however, if referred to one of these programs through an ED visit, they will get in faster than on their own. One advisor noted, "If you are inpatient, you can get in...much faster. If they are in the community, and someone wants to do partial hospitalization, a community therapist has to do the referral. It might be a week or two before intake is happening in partial hospitalization, and then weeks before the person is able to be seen. That's way too late." The multipayor claims analysis and our advisors note that even if individuals need

a higher level of care and are interested and available to engage in more frequent or longer duration outpatient therapy appointments, it is difficult to access short-term, higher intensity outpatient mental health service programs without utilizing crisis services such as an emergency department visit. There needs to be an improvement in breaking down silos in care so that individuals who want and are ready for a higher level of care, but who do not need to go to an emergency room for stabilization, can access higher levels of care through non-acute care pathways.

An often-cited barrier is the lack of billable time and funding sources to pay for coordination and communication needed between care settings when initiating referrals or during care setting transition points. In addition, providers have little time to effectively fulfill requests made by other agencies on behalf of clients in common. One advisor said, "We're trying to serve the most vulnerable people with the least amount of resources and the highest regulation…it's not a good recipe. People being served feel the burden." The additional time required to collaborate with other agencies is a significant barrier to service provision. It is also a barrier to partnership and coordination. This issue is further highlighted in the context of addiction treatment, where advisors noted that medication-assisted treatment and harm reduction strategies are not as accessible as they could be.

> *"We're trying to serve the most vulnerable people [who have] the least amount of resources [with] the [most] regulation…it's not a good recipe. People being served feel the burden."*

Specifically, individuals with complex needs are expected to navigate multiple agencies governed by separate regulatory environments, intake processes, and practice-level policies. The involvement of multiple agencies, such as the Office of Persons with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), or the Office of Addictions and Substance Abuse Services (OASAS), in cases involving co-occurring disorders adds another layer of complexity. The system-level barriers faced by people who have no choice but to navigate across these agencies often revolve around the timing and complexity of billing for services and the lack of pathways to provide simultaneously integrated services.

Despite the desire to partner and collaborate at the provider level, silos are also reinforced because of the lack of a clear vision and pathway towards implementation starting at the state level. One advisor said, "There's an emphasis on collaboration and integration at the provider level. But we don't see it at the system level. I don't know that we have a clear integrated vision at the state level or, if there is one, how well it is communicated… we are repeating ourselves much of the time, and I don't know what we're learning or how one is building off of the other."

Efforts to partner or expand outside the behavioral health care system are hindered by technical and funding barriers, including differing nomenclature used by different specialties even within the medical model, such as in primary care compared to behavioral health care settings. Collaboration needs to be prioritized, with executive leadership playing a crucial role in facilitating systems change through information sharing. The Certified Community Behavioral Health Clinic (CCBHC) system of care is valuable, but the fee-for-service environment and the focus on individual entities where service is provided at a common location, rather than on community-level care that can be provided in more widespread community settings, pose significant challenges. An advisor said, "[There is a] lot of red tape in opening new clinics because the funding process takes a while. Opening a satellite location is costly, arduous, and nearly impossible due to regulations." Additionally, another advisor noted that, "Contracts are fixed, many of our contracts have to get pieced together like a puzzle, putting all of these different funding streams together to run an organization. And many of those contracts don't increase. Payment of contracts are also not predictable." Behavioral health care settings need improved provider payment methodology with funding streams that incentivize collaboration and partnering, allowing for more flexibility in care provision settings and content.

There are billable mechanisms and recent legislation mandating trained peer workers be present at various touch points in the mental health care and substance use systems; however, the implementation and fidelity to the peer model is difficult to track, and there is low uptake of billable peer services. Our claims cohort analysis showed that only 2% of patients with mental health-driven ED visits had any billed community treatment or peer services in prior six months. This only increased slightly in six months after ED visit, to 3% (**Figure 4.4**). Notably, the use of these services is more prevalent among Medicaid patients, and nearly non-existent among commercially

insured patients. Also, it is worth calling out that use of community treatment and peer services is more common among a parallel cohort of people with SUD-driven ED visits, with 6% of Medicaid patients having claims for these services before the ED visit and 9% after. For SUD cohort with commercial insurance, the use of these services was lower: 2% before ED visit, and 5% after (**Figure 4.5**).

Figure 4.4

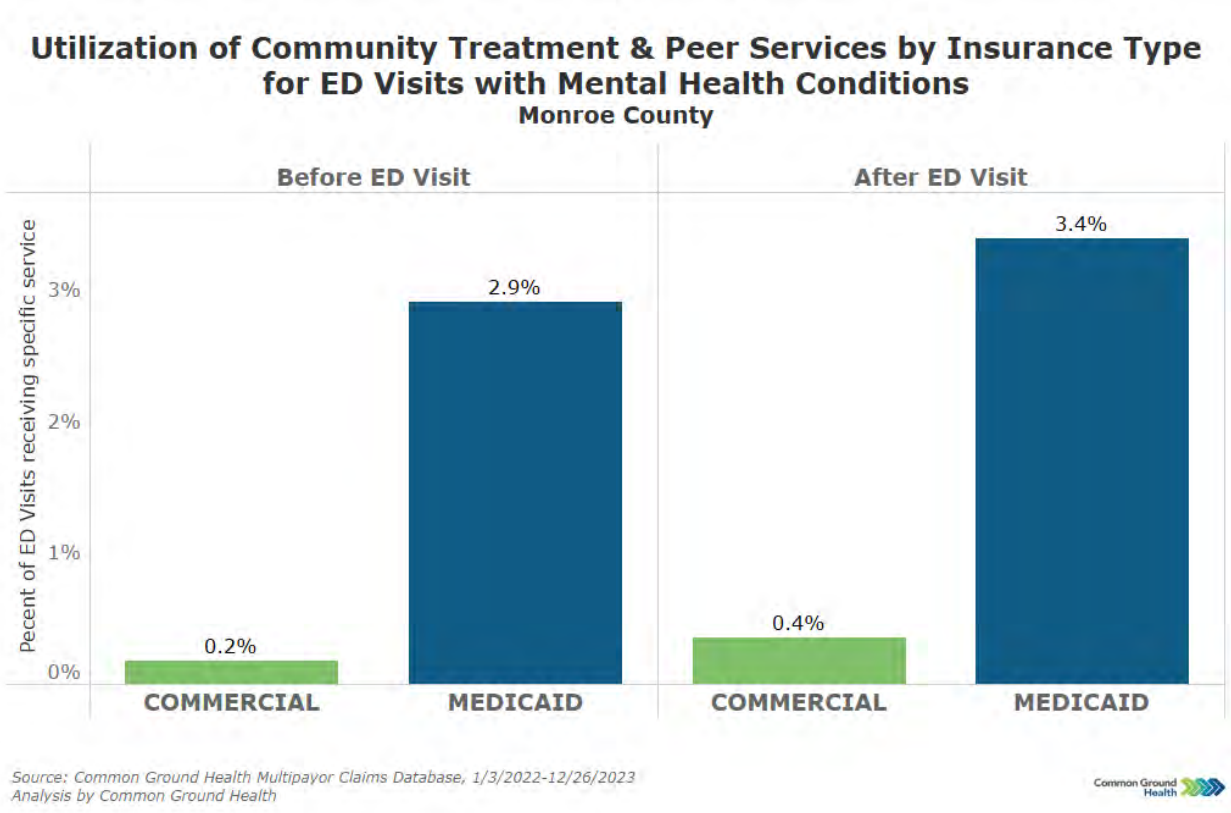
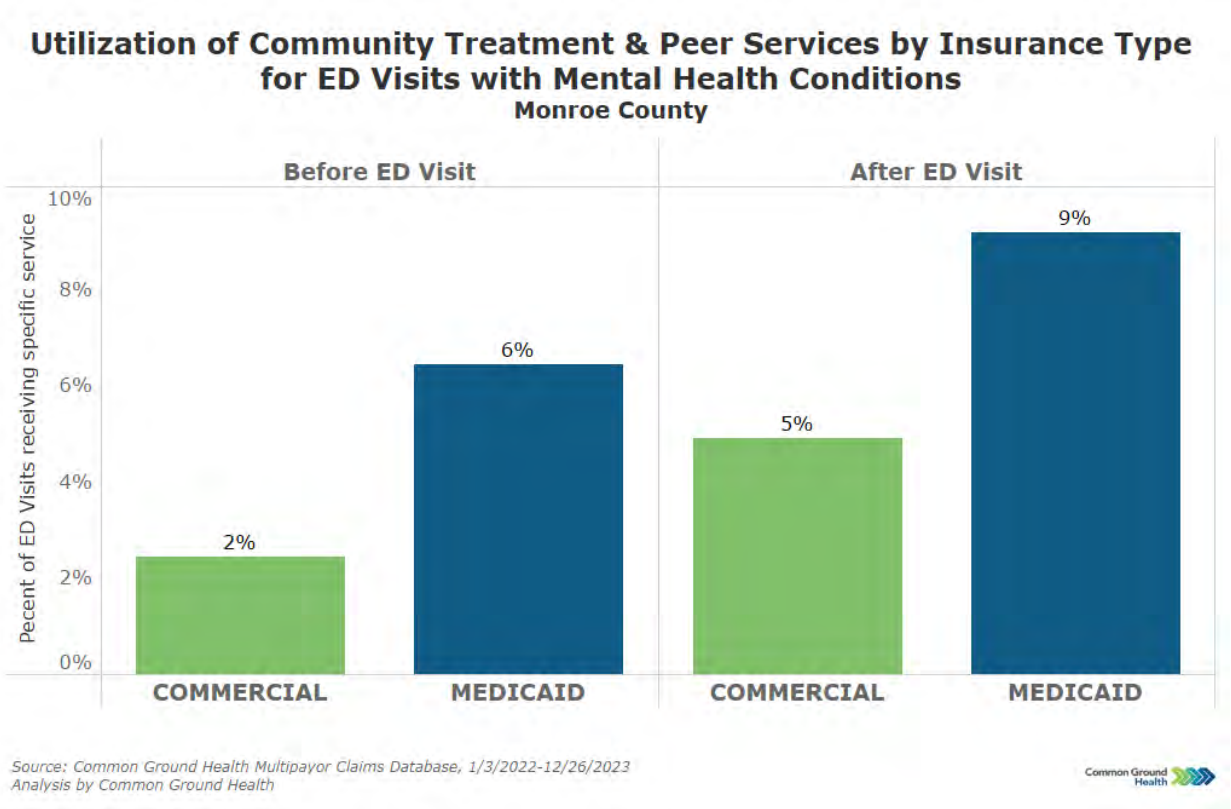


Figure 4.5



These low rates of billed claims before and after ED visits for any behavioral health issue suggest that there are barriers to engagement and implementation of peer services for people overall. However, our analysis suggests that there are even larger barriers to utilization of peer services for those who engage in care due to mental health issues compared to those who engage in care due to substance use issues. This finding aligns with what we heard from our advisors that peer models have been implemented more successfully in substance use settings than in mental health settings. It also illustrates what we heard that there may be peer activity happening outside of billable systems and there is no uniform way across agencies of tracking it to show its effectiveness.

Peer worker roles and settings are varied and distinct, as described in the Community Connectors and Mental Health Supports section of this report. Pertaining to System Gaps and Coordination Issues, these roles can provide natural trust and connection to enable recovery and healing that supports or reduces the need for more formalized, behavioral health care system services. There is a shortage of trained, and adequately

and continuously supported, community peer worker roles to assist others and remain connected with them across and beyond the traditional medical model settings of care. Opportunities to expand peer services for mental health and substance use issues are noted in the following section of this report.

The result of the interplay between underlying systems gaps and person-level needs is that many people struggle to access adequate care. Those without financial means to pursue options outside of the medical model of care, and those whose lives are constrained by basic needs or caretaking responsibilities, often cannot get the help they need. This is because the medical systems of care generally have rigid requirements: fixed locations for treatment, narrow definitions of what qualifies as billable care, and inflexible scheduling.

Opportunities

There is a number of nuanced and distinct action steps suggested by the advisors we spoke to that could mitigate or reduce some of the barriers to care experienced by persons seeking behavioral health services and those experienced by providers and organizations serving them. This section begins with person-level suggestions and ends with program and policy-level suggestions that could help to improve the experience of care and access to care.

Person-Level Actionable Suggestions: Peer Support and Related Community Health Worker Expansion

A broad area of consensus from our advisors was that individuals needing mental health support need someone alternative to a licensed clinician or doctor to support them in getting the care they need. Peer specialists, family navigators, peer advocates, and community health workers are key roles that help people navigate care and find hopefulness and support before, during, and after any medical model care episodes of treatment that might occur in the behavioral health care system. One of the interviewees emphasized the importance of these roles, stating, "Individuals from the community reflect the populations we're serving. Expanding the team to include more community health workers and navigators can help support the work and services that

need to be done." Trained community mental health and substance use peer specialists, for example, aim to support individuals' engagement with whichever component of the formal or community-supported care systems that they need.

Peer support plays a vital role in navigating the complex behavioral health system. Currently, peer support is not being tracked systematically, yet peers provide essential assistance that helps individuals manage their care.

This peer support helps individuals navigate the complexities of the mental health system. When peer programs are free from stigma and are fully embraced by providers who are treating their patients, they can be incredibly valuable—as an ancillary service. One advisor emphasized the importance of lived experience, stating, "Someone with lived experience is an essential component for peers." Peer support has long been a cornerstone of effective substance use and mental health care.

Another example in Monroe County of a peer-led crisis and respite center is East House's peer-run respite home. East House is a community-based location, not at a hospital setting, where individuals seeking support meet others who have struggled similarly, gaining hope and learning from their behavioral health recovery experiences.

"It's actually life-changing… to receive peer support that could actually help someone get out of the cycle of crisis and have the quality of life that they want."

Liberty Resources houses multiple community-based peer support programs that follow people wherever they are, offering and asking permission from people to support them even at transition points in care: "It's actually life-changing… to receive peer support that could actually help someone get out of the cycle of crisis and have the quality of life that they want. In our experience, it's very important that it's long term and community-based—meaning when the person gets discharged from the hospital, we're there that day supporting them, maybe even driving them to the next part of their recovery journey. It's even more ideal if we are able to provide peer support while in the hospital prior to discharge. Without that transitional support during an increased

time of risk, it's one of those cracks in the system that people fall through. It's a very vulnerable time to have a reoccurrence of use again."

There is mental health peer support specialist training available via the Academy of Peer Services, which is asynchronous. However multiple experts have mentioned the need to increase the peer workforce in general and specifically to train people of color with lived experience in mental health issues. An advisor notes, "It would be helpful to have, as far as workforce issues, some financial support for peer programs to have in-person mental health peer training. Whether they do the Academy of Peer Services together or whatnot. Specifically, adding more peers who identify as Black, Indigenous, or people of color peers by making sure that the process is equitable and being offered to BIPOC communities." Funding is needed to support people as they take the training.

Peer support and recovery-oriented models mitigate the medical model's shortcomings in behavioral health care. These approaches emphasize lived experience, holistic wellness, empowerment, and community connection, offering more culturally responsive and person-centered pathways to behavioral health and healing. However, these models and their associated training programs could improve to better emphasize culturally responsive practices. As one advisor notes, current peer support frameworks may still reflect Eurocentric cultural assumptions and lack adequate integration of Indigenous and culturally specific values and experiences. An advisor reflected, "I have said multiple times that I felt like I needed to make a choice. I could be Black or be a peer, and I chose to be Black. While many experiences transcend race, there are many experiences that I have had in my mental health journey that are inextricably linked to my being Black and my Blackness…The way Black people perceive and are perceived in the mental health system is different from our white counterparts."

Affinity circles are one example of peer support arising from African cultural values where interplay between mental health journeys and identity-based experiences are centered. Emotional Emancipation Circles, a local program based on this model, is an example of culturally centered practice. The peer training models are helpful and also incomplete. There is a need to develop trainings and tools to adequately equip all peers to address the issues associated with the inextricable impact of structural oppression on mental health journeys.

Additionally, once trained, the wages and salaries for peer workers need to be raised to meet the level of expertise for the services they are providing. An advisor notes that, "Despite what we know about how having a peer advocate helps keep people in care, they are not valued or compensated in a manner that is commensurate with their value to the system."

Agencies and organizations wanting to employ site-based or include community-based peers as part of their services also need to undergo a process to ensure that the role and function of peers remains clear, such as through conducting an agency readiness assessment. Advisors also noted that planning is needed to make sure that the peer workforce is appropriately supported by supervisors who are peers themselves: "I use the analogy that you wouldn't have a mechanic starting a dentist office and building it up from scratch…the readiness assessment assesses the agency's expertise in being able to implement peers in the way that's aligned and with the fidelity of the peer model. There needs to be more oversight around determining an agency's expertise and readiness to implement peers into their programs. This is a huge gap in the system right now that can cause many unnecessary barriers to successful peer implementation."

The national practice guidelines for peer specialists and supervisors written in 2019 by the National Association of Peer Supporters is a relevant support document for more information about the specifics of implementing peer programs (National Association of Peer Supporters, 2019). Additionally, the Peer Support Services Technical Assistance Center provides support for these activities and hosts the publicly accessible organizational readiness assessment for integration of peers into certified community behavioral health clinics (Alliance for Rights and Recovery and National Council on Mental Wellbeing, date unknown). The Alliance for Rights and Recovery is also a resource offering technical assistance and support for organizations and health care systems aiming to integrate peer services into their behavioral health care model. Additionally, they offer resources and support for peer providers of many kinds and conduct legislative advocacy and education on the benefits and technical aspects of peer services and recovery-oriented practices (Alliance for Rights and Recovery, 2025).

Program and Policy-Level Suggestions: Sustainable Funding, Regulatory Alignment, and Technical Assistance Roles

Adults with mental health issues across all levels of need are burdened with the responsibility of coordinating their own care while simultaneously experiencing feelings that serve as barriers to their own ability to carry out engagement tasks. Various promising practices have emerged that are not limited in scope of service to a specific setting but rather focus on peer support, community health workers, same-day services, open access models, streamlined processes, and integrated care.

Same-day service models are intentionally designed to provide immediate care rather than booking appointments further out. Advisors explained, "Despite walk-in or same day service times being busy, we feel it's important to offer times for people to come when it's convenient and accessible for them, not waiting months on a waiting list." This approach ensures that individuals receive timely care, which is essential for addressing urgent behavioral health needs. The needs assessment highlighted the issue that readiness to accept help needs to be matched with services and providers who are available within a reasonable timeframe so that a person's motivation to access care is not lost due to delayed engagements with provider systems.

> *"Despite walk-in or same day service times being busy, we feel it's important to offer times for people to come when it's convenient and accessible for them, not waiting months."*

Same-day services are also most helpful when referrals from other providers aren't necessary prerequisites to accessing care, such as at drop-in mental health centers. These centers provide immediate access to care without the need for appointments, making it easier for individuals to receive support when they need it. "I do love the idea that drop-in mental health centers have open access and that people can just go." Locating these centers in the community where they are needed is crucial, as accessibility can be a significant barrier if individuals have to travel long distances.

There are other opportunities mentioned by our advisors, such as having a mental health provider in every primary care office to provide short-term care and significantly

improve care coordination. "There should be a mental health provider in every single primary care office and every single school." This philosophy fosters bidirectional learning opportunities for clinicians and benefits both patients and providers. Training future practitioners in this integrated model ensures that they are equipped to work collaboratively, enhancing the overall effectiveness of the behavioral health system.

Additionally, collaboration time between schools (for youth), primary care practices (for all ages), and other entities can be challenging due to the lack of time and funding to support these activities. Distinct work-related routines and tasks across settings make timely, professional-to-professional conversations difficult to schedule. To address this, appointing dedicated individuals at schools and primary care practices to facilitate communication and collaboration is a promising practice. These appointed individuals can help coordinate efforts, ensuring that all parties are working together effectively despite their busy schedules. Most importantly, advisors acknowledged that there needs to be a billable stream where the work done by individuals in these roles is consistently funded.

Referral networks between providers and by trusted social networks in communities of people with shared identity characteristics, including faith-based centers, play a crucial role in helping individuals reduce stigmatizing beliefs and learn about availability of trusted providers – all of which help to mitigate the impact of the naturally siloed behavioral health care system. These networks facilitate warm handoffs, ensuring that individuals are placed in settings that best meet their needs. A barrier to central management of referral sources is that they constantly change, new providers arise and some stop offering services or change elements of their practice. More work could be done to help identify the best methods to support the growth and sustainment of referral networks and to identify support for point people who serve as the connection for warm handoffs between providers, those receiving care, and their social and professional networks. These connections and networks are not limited to behavioral health care – these information and referral pathways also help address social determinants of health more effectively for those with access to care and underlying basic needs barriers to health and well-being.

Advisors also noted that to help with supporting and encouraging these changes at the program level, integration at the state level, such as between Office of Addictions and Substance Use Services (OASAS) and Office of Mental Health (OMH), presents a

significant opportunity that could reduce program and funding barriers. While providers are expected to integrate services, state-level integration can provide a more cohesive framework for these efforts. By aligning policies and resources at the state level, the billing and procedural tracking burden on individual providers who serve Medicaid or Medicare populations can be reduced, leading to more effective and coordinated care.

Our advisors noted that the OASAS has moved farther with creating standards and billable mechanisms for peer specialist roles in addictions recovery. There is some movement in the mental health recovery world which is overseen by OMH but it is not fully implemented. "There is a huge need for OMH to create a mental health peer engagement specialist program like OASAS has for addiction," an advisor said. "That's a huge need because we do have a lot of people that come to us to our OASAS peer program, who really just need mental health peer support and we're not able to include them. They don't fit the intake criteria. So an intensive, community based, long-term integrated peer program that has the ability to provide mental health and addiction peer services would be a game changer towards closing this gap in the system."

Multiple advisors noted that building awareness of the landscape and characteristics of available services across all service settings is a fundamental component of working towards increasing connection in a siloed system. There is a need to identify specific gaps in the type of services needed to meet the demand and ensure that existing resources are fully utilized. Often, there is a tendency to assume that more resources are needed without recognizing the potential of what is already available.

By understanding who is served by existing settings and who is not but may need them, providers can avoid redundancy and target specific improvements in care delivery designed to meet the needs of those currently not receiving services. The needs assessment revealed that specific gaps are not solely related to the relationship between the supply of providers and the demand for providers. Rather, specific gaps in services are identifiable when looking first at the needs individuals seeking care have and then at the features and dimensions of the care system that do not meet those needs. For example, though this needs assessment included a limited set of advisor voices, we heard that there are components of the medical care system culture that serve as barriers to care and limiting the types of services that could be created to fit

the needs of those seeking care, i.e., being able to receive treatment in natural community settings, such as on a walk, in parks or other locations.

Mapping the utilization patterns, intake process, discharge process scope of practice, insurance coverage and fee types for all levels of the formal behavioral health care system, from community-located and prevention services through to emergency room and hospital inpatient services, has not yet been done in Monroe County in a manner that includes interagency settings. Identifying existing services geographically and categorically, across all sizes of agencies, would help reveal where there may be gaps and/or underutilized resources that exist. This birds-eye view may help organizations to queue up relevant questions and develop strategies to increase support for identifying the intra- and interagency-specific policies, practice culture, and/or processes that need improvement to create space for providers themselves to engage with other providers on behalf of common clients, and to improve care.

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Section 5:
RETENTION & DIVERSITY OF WORKFORCE

Monroe County already has shortages of behavioral health professionals, and the demand for providers and services continues to grow. A focus is needed on supporting, training, and retaining the current behavioral health workforce while simultaneously expanding and diversifying the future workforce pipeline.

Current State of the Behavioral Health Workforce

Workforce Trends and Projections

Many different professions seek to improve behavioral health and wellness in our community. These professions are growing or shrinking at different rates, impacting the ability to provide adequate services for the community's needs. Using available data from the U.S. Census Bureau's Public Use Microdata Sample (PUMS) estimates, we see that Monroe County experienced a decrease in the estimated number of counselors and therapists[10] over the illustrated timespan, which followed suit with New York State but to a greater degree. Also noted was the significant decrease in total providers within the City of Rochester compared to Monroe County and New York State, although these are generated estimates and the counts driving some of these estimates (specifically Monroe County Psychologists and Rochester Total Providers) were quite small. PUMS data provide an initial framework to reference, but these data are still inadequate for understanding the full scope of the behavioral health workforce, especially at a local level. Thus, improved monitoring and collection of health workforce data are recommended, with behavioral health included.

[10] "Psychologists" include Clinical and Counseling Psychologists, School Psychologists, and all other Psychologists. "Counselors & Therapists" include Substance Abuse and Behavioral Disorder Counselors, Marriage and Family Therapists, Mental Health Counselors, Rehabilitation Counselors, and all other Counselors. "Social Workers" include Child, Family and School Social Workers, Healthcare Social Workers, Mental Health and Substance Abuse Social Workers, and all other Social Workers. "Total Providers" includes all of these professions mentioned here.

Figure 5.1

Behavioral Health Workforce Estimates: Profession Type

		Profession Type		
		Counselors & Therapists	Psychologists	Social Workers
Monroe County	2018 Estimate	2,231	1,025	3,508
	2023 Estimate	1,765	1,303	3,895
	Percent Change	-21%	27%	11%
New York State	2018 Estimate	47,636	25,292	91,540
	2023 Estimate	46,045	29,262	92,809
	Percent Change	-3%	16%	1%

Source: U.S. Census Bureau. Public Use Microdata Sample (PUMS) 2018 and 2023 5-Year Estimates.
Notes: Professions defined by 2018 Standard Occupational Classification (SOC) codes. Counts weighted using Person Weight.
Geographies defined by Public Use Microdata Areas (PUMAs).

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Figure 5.2

Behavioral Health Workforce Estimates: Total Providers

		Total Providers	Total Population
Rochester	2018 Estimate	2,139	207,927
	2023 Estimate	1,789	209,255
	Percent Change	-16%	1%
Monroe County	2018 Estimate	6,764	744,690
	2023 Estimate	6,963	754,632
	Percent Change	3%	1%
New York State	2018 Estimate	164,468	19,618,453
	2023 Estimate	168,116	19,872,319
	Percent Change	2%	1%

Source: U.S. Census Bureau. Public Use Microdata Sample (PUMS) 2018 and 2023 5-Year Estimates.
Notes: Professions defined by 2018 Standard Occupational Classification (SOC) codes. Counts weighted using Person Weight.
Geographies defined by Public Use Microdata Areas (PUMAs).

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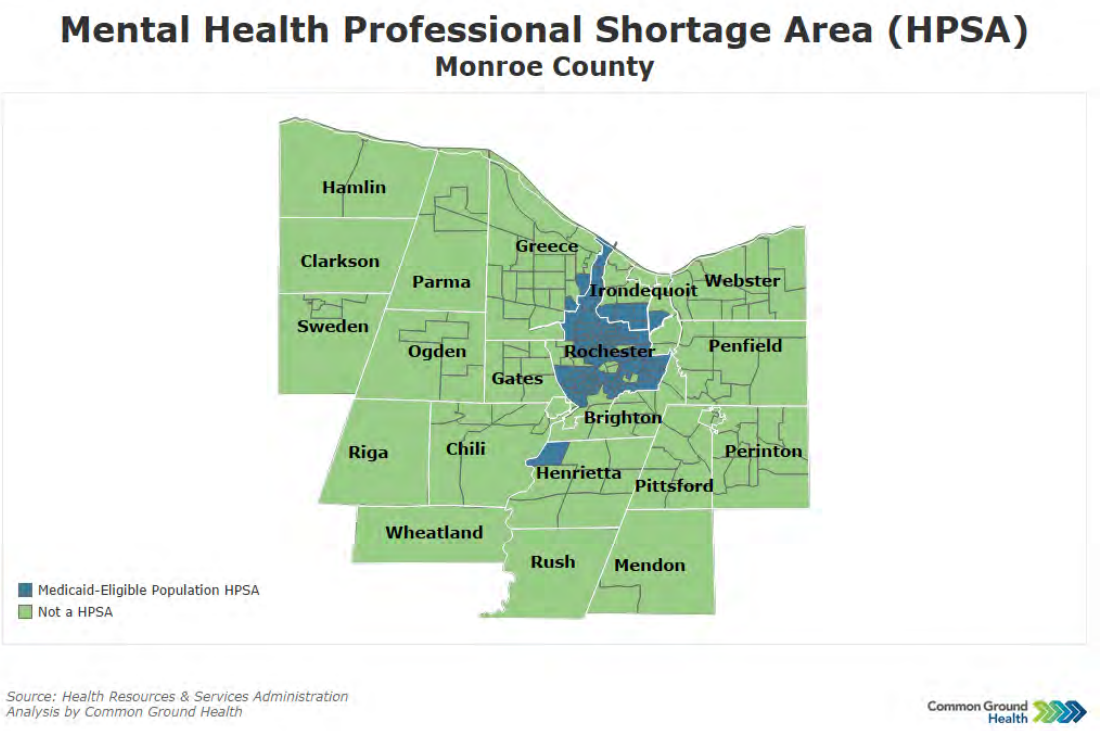
Health Professional Shortage Areas (HPSAs) are designations through the Health Resources & Services Administration (HRSA) that show geographic areas, populations, or facilities with a shortage of providers to serve the population. HPSAs are scored using seven different metrics, a few of which include population-to-provider ratio, percent of population below 100% Federal Poverty Level, and travel time to nearest source of care outside the HPSA designation area. **Figure 5.3** displays the designated Mental Health HPSAs in Monroe County, specifically for the Medicaid eligible population. The majority of the tracts designated as Mental Health HPSAs within the county are located within the City of Rochester.

Figure 5.3



HRSA workforce projections can further assist in understanding the current and future status of the behavioral health workforce in New York State. **Figure 5.4** displays the supply, demand and percent adequacy for each of the professions, as available, starting in 2022 and projecting out to 2037. Those three terms, as defined by HRSA, are below. Additionally, a table defining these professions can be found in Appendix C. One potential limitation of this dataset is that HRSA contains data for all of NYS including NYC, and it is unclear how these data are distributed across the state.

- Supply is defined as the number of workers who are either actively working or seeking employment
- Demand is the number of workers needed to provide services based on patient health-seeking behavior and ability and willingness to pay for those behavioral health services
- Percent adequacy is the relationship between the two (quotient of supply divided by demand). Note: For all professions, a percent adequacy of > 100% does not account for potential maldistribution at smaller geographic areas.

On the supply side, the fields with the largest projected losses by 2037 are addiction counselors (-40% change) and psychologists (-26% change), whereas the fields with the largest projected gains are school counselors (+46% change), psychiatric nurse practitioners (+46% change), and psychiatric physician assistants (+40% change). However, the counts of practitioners within these fields show that psychiatric nurse practitioners and psychiatric physician assistants comprise a relatively small proportion of the behavioral health workforce within New York State. When looking at the need for behavioral health services, the demand for all fields is projected to increase. As a result, the adequacy rate of the behavioral health workforce is projected to fall in all fields, with the exceptions of school counselors and psychiatric nurse practitioners. Compared to 2022 adequacy rates, the 2037 supply of addiction counselors, adult psychiatrists, and mental health counselors will not adequately meet demand, while the supply of psychiatric nurse practitioners and psychiatric physician assistants will continue to meet demand. The adequacy rate of psychologists is projected to fall the most, just meeting demand in 2037 compared to being nearly double the demand in 2022. Supply data, and therefore adequacy rates, are not available at the state level for all professions.

While these quantitative data provide a starting point for understanding the state's behavioral health workforce, that's what it is…a starting point. With data currently available, we are unable to show vital components of the equation such as percentage of providers that are accessible to those with public insurance, percentage of providers who are trained in culturally responsive and trauma-informed practices, and various other aspects that speak to accessibility and proper match of client and provider. Therefore, it is recommended to review and revise data collection practices to include these components to assist in creating a more complete picture of the behavioral healthcare system and its needs.

Figure 5.4

HRSA Behavioral Health Workforce Projections for New York State

Profession	Demand 2022	Demand 2037	Supply 2022	Supply 2037	Adequacy 2022	Adequacy 2037
Child & Adolescent Psychiatry	690	860	1,190	1,380	172%	160%
School Counselors	7,690	10,080	7,760	11,360	101%	113%
Psychologists	6,680	9,140	12,970	9,620	194%	105%
Psychiatric Nurse Practitioners	1,460	2,010	1,360	1,990	93%	99%
Mental Health Counselors	8,770	12,390	10,490	9,470	120%	76%
Adult Psychiatry	3,650	5,110	4,510	3,670	124%	72%
Psychiatric Physician Assistants	240	350	150	210	63%	60%
Addiction Counselors	7,530	10,640	8,470	5,050	112%	47%
Child, Family, and School Social Workers	6,680	9,260				
Psychiatric Technicians	6,290	9,030				
Mental Health and Substance Abuse Social Workers	4,460	6,520				
Healthcare Social Workers	3,460	5,280				
Marriage and Family Therapists	3,320	4,720				
Psychiatric Aides	2,010	2,890				

Source: Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections

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Diversity and Accessibility in the Workforce

We used Psychology Today's online directory to gauge the diversity of the behavioral health workforce within Monroe County by counting providers whose profiles were included when filtered for various demographic characteristics (Sussex Directories, Inc., 2025). On the day these data were accessed, approximately 1300 providers were listed on Psychology Today within the county. These data are comprised of the ways in which providers self-identify; there is no way to find providers who would identify with certain characteristics but who haven't listed it on their profile. Providers may also be included in more than one count if they identify as multiple identity characteristics. Additionally, Psychology Today is a "living directory" that can change daily, so the data mentioned here represent counts for the day the data were accessed only. With that being said, out of approximately 1300 providers, 154 identified as Black or African American, 112 as Hispanic or Latino, and even fewer as Asian (n= 32), Native American (n=11) and/or Pacific Islander (n=2). With regard to languages spoken other than English, 52 noted that they speak Spanish and 10 could communicate via American Sign Language. Seventy-five providers out of the ~1300 noted that their session cost was less than $90 for the client, 80 accepted Medicare, and 30 accepted Medicaid.

Challenges Facing the Behavioral Health Workforce

Behavioral health professionals face several challenges in providing patients with optimal care, some of which reflect our current environment, while others have been reoccurring issues for decades. These challenges span various aspects across the profession, including but not limited to:

- Financial and Reimbursement Issues
- Systemic and Regulatory Barriers
- Staffing and Workforce Pipeline Concerns

We engaged with several local behavioral health professionals as part of this assessment; the following illustrates their thoughts and experiences regarding these barriers.

Financial and Reimbursement Issues

Being able to provide services to the community is dependent upon having the funds to keep those services operating. Regardless of the level of care within the continuum, there is the continuous need for more services with not enough programs and existing staff to meet those needs. Limited budgets make it difficult, if not impossible, to grow and expand needed services, and poor reimbursement rates from both commercial carriers and Medicaid further exacerbate the issue. Low reimbursement rates jeopardize financial viability for providers and their practices. The financial strain from inadequate reimbursement can lead to fewer providers accepting insurance and thereby decreasing access to care for individuals. A 2024 Practitioner Pulse Survey conducted by the American Psychological Association noted that more than one-third of practicing psychologists do not accept insurance, primarily due to low reimbursement rates for services, administrative burdens such as navigating complex billing systems and managing audits, and issues with getting paid and in a timely fashion (Abrams, 2024). These challenges contribute to provider shortages and diminish the quality of care for patients, as providers may feel pressured to see more patients in less time to maintain their income (Abrams, 2024) (Phillips, 2023).

Even within the behavioral health system, mental health and substance use services are reimbursed at different rates, impacting providers and the care that patients can access as less sustainable income streams limit services that can be offered. Additionally, certain organizations rely on volunteers to facilitate programming, yet cannot provide these volunteers with stipends, thereby decreasing retention rates and placing programs at risk. Furthermore, compensation for behavioral health providers needs to match their level of expertise, and this includes the work of peers with lived

experience. The services peers deliver are often reimbursed at much lower rates that do not reflect the quality of care and outcomes they provide to patients and the healthcare system.

Funding challenges also contribute to gaps in the system for patients and insufficient coordination between agencies. For instance, in Monroe County there are no designated funds for suicide prevention work or a coordinator to pull together related resources. Competition between organizations for funding of services further promotes silos over collaboration and leaves the field continuously reinventing the wheel rather than utilizing already-existing services within the community. Additionally, recent changes to bail reform have impacted the stability of certain programs within the behavioral health field. Previously, judges often mandated that people attend specific treatment programs upon release. Individuals now have more autonomy in the choice to seek treatment altogether and in the treatment program they choose. Advances in the behavioral health field have led to a prioritization of self-determination and individual autonomy in the journey to recovery; however, an unintended consequence is that attendance for many of these programs has become sporadic, leading to destabilization of existing funding models.

Systemic and Regulatory Barriers

Additional challenges lie within both system coordination and regulation. Alignment between systems is often lacking, leading to underutilization of available resources, gaps in care, and worse experiences for providers and patients alike. Coordination between different behavioral health organizations is needed to preserve the continuum of care for patients. Providers also need coordinated information and resources to help determine appropriate next steps for their patients.

The heavy regulatory landscape of the field also contributes to pressure and burnout causing some practitioners to leave their positions. For example, some clinics are not permitted to maintain wait lists, while others may have difficulty processing patient insurance claims and receiving reimbursement. Additionally, the time necessary for clinical documentation (patient notes, treatment plans, signoffs, etc.) often leaves providers less focused on actual patient treatment and at times unable to work to the top of their licensure.

Staffing and Workforce Pipeline Concerns

Current staffing within the behavioral health field is a concern, and the future workforce pipeline is not growing at a pace to meet the increasing community need. Monroe County providers are especially stretched as they often serve much of the Finger Lakes region as well. The two tables below from the 2022 Center for Health Workforce Studies (CHWS) report further elaborate on the recent condition of the behavioral health workforce. CHWS works with stakeholders and partners across the state to gather these data through surveys of human resource directors and administrators of health care settings (Center for Health Workforce Studies, 2025). This can provide valuable information regarding recruitment and retention but, due to the method of collection, may not collect all reasons heard anecdotally from professionals (such as not feeling seen or supported, unreasonable workloads and racism). **Figure 5.5** shows the level of difficulty in recruiting behavioral health providers within New York State hospitals in 2020 and the reasons for recruitment difficulty. **Figure 5.6** provides information on retention difficulties for the same occupations within the hospital setting and reasons for difficulties with retention. High levels of recruitment and retention difficulties were reported for occupations such as psychiatrists and licensed clinical social workers, with contributing factors being shortage of workers and non-competitive salaries.

Figure 5.5

Recruitment Difficulties for Behavioral Health Occupations in Hospitals in New York State, 2020

Occupational Title	Percentage of Respondents Indicating Difficulty	Reasons for Recruitment Difficulty		
		Shortage of Workers	Non-competitive Salaries	Non-competitive Benefits
Psychiatrists	88%	81%	40%	10%
Licensed Clinical Social Workers	63%	53%	26%	6%
Certified Alcohol and Substance Abuse Counselors	54%	49%	3%	2%
Licensed Master Social Workers	41%	31%	9%	4%
Psychologists	35%	49%	10%	8%
Substance Abuse and Behavioral Health Counselors	12%	14%	4%	4%
Licensed Mental Health Counselors	11%	8%	3%	5%

Source: Center for Health Workforce Studies, Surverys of Human Resources Directors in Health Care (Recruitment and Retention Survery)

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Figure 5.6

Retention Difficulties for Behavioral Health Occupations in Hospitals in New York State, 2020

Occupational Title	Percentage of Respondents Indicating Difficulty	Reasons for Retention Difficulty: Left for a Better Paying Position	Left for Job Outside of Health Care	Retirement	Family Commitments	Burnout	Workplace Violence	Fear of Exposure to COVID-19
Psychiatrists	72%	39%	0%	0%	4%	2%	0%	4%
Psychologists	60%	4%	0%	0%	2%	2%	0%	4%
Licensed Clinical Social Workers	47%	9%	2%	0%	2%	1%	0%	2%
Licensed Master Social Workers	15%	13%	4%	0%	4%	2%	0%	2%
Licensed Mental Health Counselors	13%	6%	3%	19%	3%	3%	0%	6%
Certified Alcohol and Substance Abuse Counselors	7%	13%	0%	7%	3%	3%	0%	7%
Substance Abuse and Behavioral Health Counselors	4%	4%	2%	13%	4%	2%	0%	4%

Source: Center for Health Workforce Studies, Surverys of Human Resources Directors in Health Care (Recruitment and Retention Survery)

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Providers are feeling overworked, overwhelmed, and frustrated due to these challenges and the difficulties they pose in doing their jobs well. Further frustration stems from having community conversations over the years to address some of these concerns without clear signs of progress. Due to the nature of the work, providers are both susceptible to burnout and exposed to situations that may lead to vicarious trauma. Burnout is defined as a state of physical, emotional, and mental exhaustion from prolonged and excessive stress stemming from high workloads, long hours, emotional strain, administrative burden, lack of support or control, inadequate rewards, and/or workplace environment, among other reasons (Nash, 2024) (SAMHSA, 2022). Studies have shown that burnout impacts between 21% and 61% of mental health practitioners, and typically presents as emotional exhaustion, depersonalization, and feelings of ineffectiveness (Practice Research and Policy Staff, 2013). Burnout can cause practitioners to disengage from their jobs and leave their positions, affecting clients' access, quality and continuity of care (SAMHSA, 2022). As one practitioner noted, "[There's a] spiritual pain that comes with this work because we're being asked to do things and to try to interface with people who we know day in, day out, we cannot meet their needs…if we're honest, these systems weren't designed to heal people. They just weren't. They're for profit…they're based on something else." Another advisor who provides behavioral health services to behavioral health professionals, a

healer to the healers, noted, "Unfortunately, a lot of people end up in roles similar to mine because they find the systems, the clinical systems, to be untenable."

> *"[There's a] spiritual pain that comes with this work because we're being asked to do things and to try to interface with people who we know we cannot meet [all] their needs… If we're honest, these systems weren't designed to heal people. They just weren't. They're for profit…they're based on something else."*

Vicarious trauma, or secondary trauma, occurs when providers are exposed to clients' traumatic experiences and emotional pain, leading to their own emotional and psychological distress (Nash, 2024). Risk factors for vicarious trauma include a personal history of trauma, the type of trauma to which the provider is exposed, team and work culture not being trauma-informed, social isolation, lack of training and/or supervision, as well as being a newer and less experienced employee (The Danya Institute, 2021) (Plumbly, 2022). In August 2020, the American Psychological Association's Division of Trauma Psychology shared results of the Vicarious Trauma Survey that was conducted with 339 psychotherapists; 63% of those providers surveyed reported moderate levels of vicarious trauma (Madrid & Drakulich, 2021). Symptoms of vicarious trauma include emotional exhaustion, increased stress and anxiety, depersonalization and disengagement, decreased empathy, physical symptoms such as headaches and gastrointestinal issues, as well as impaired professional functioning (Nash, 2024).

The COVID-19 pandemic further exacerbated these issues through increased population stress and, thus, increased need for behavioral health providers. This increase in demand came with heavier workloads for behavioral health providers, emotional strain, and challenges with adapting to a new platform of intervention delivery (telehealth). This, ultimately, lead to increased provider burnout and worsened workforce shortages (HRSA Health Workforce, 2024) (National Council for Mental Well-being, 2021). Therefore, it is highly recommended to focus on the mental and emotional well-being of current behavioral health professionals through proper avenues of support.

Lastly, the lack of diversity among providers and the need for culturally responsive training and practice is another workforce concern. Advisors emphasized that there are not enough clinicians of color, nor are there enough who speak languages other than English. Interpretation needs can be difficult to navigate within a clinical setting as interpretation is costly, interpreters do not always have training in behavioral health terminology, and speaking through an interpreter can diminish rapport between patients and providers hindering patients' access to quality behavioral health care. There is a pressing need for more providers who can offer connection support in multiple languages, led by individuals with native language skills. This ensures communities, such as those who are immigrants or refugees, receive the care and support they need in a language they understand, fostering better communication and trust. Multilingual providers can bridge gaps and provide culturally responsive care, which is essential for effective mental health and wellness support. While many different barriers to care exist, such as transportation or insurance coverage, an added layer of distrust often occurs when there are cultural incongruences between client and provider. "Precision of fit" between client and provider certainly includes but also extends beyond race, ethnicity and language as well to overall life experience and openness to understanding that experience. Behavioral health clinicians are historically trained within the traditional Eurocentric model, but more training is needed for all clinicians, regardless of race and ethnicity, in culturally responsive practice beyond the Eurocentric model to help increase the level of understanding between patient and provider and achieve that "fit" that is more conducive to improved well-being. An advisor commented, "How do you get someone who actually understands how you speak…where you don't have to put on the mask and speak "standard." Precision of fit…the relationship with your therapist is one of the most intimate relationships that you'll ever have."

"How do you get someone who actually understands how you [authentically] speak…where you don't have to put on the mask and speak "standard?" Precision of fit…the relationship with your therapist is one of the most intimate relationships that you'll ever have."

Promising Practices for Retention of Behavioral Health Providers

It is vitally important to recognize and understand the challenges that face the behavioral healthcare system, its staff, and its patients, and it is equally important to identify and emphasize promising practices that can help to alleviate these concerns. Local advisors identified several areas of opportunity:

- Workforce Development
- Support for Current Providers
- Community-Based Training and Education
- System-Level Policies and Practices

Workforce Development

An area of opportunity within workforce development includes training and hiring a diverse workforce. One approach to increasing the workforce pipeline and working toward the much-needed "precision of fit" between provider and client is through bridge and development programs for high school, bachelor's degree programs and onward, where individuals could receive stipends, tuition forgiveness, and/or other incentives for working within the behavioral healthcare field. Often scholarships, loan forgiveness and loan repayment programs require providers to practice in a specific geographic area or facility type for a certain number of years. According to the National Health Service Corps (NHSC), an example of a repayment program provider, approximately 88% of the clinicians who participated in NHSC in 2016 stayed at their practice site one year after their obligation had been fulfilled, and 43% intended to stay for 5+ additional years (NCSL, 2022). Not only would this make entering the behavioral healthcare field more accessible to a diverse population of future practitioners, but it could assist with staffing and retention at facilities as well.

In addition to the availability of repayment programs, licensing exams should be assessed for equity and fairness. For instance, the 2023 Social Work Workforce Act advocated to abolish the requirement of the licensing exam due to its bias and, instead, allow those in accredited Master of Social Work (MSW) programs to be able to serve the community upon graduation. It was found that the exam created undue financial burden on social work candidates, and the Association of Social Work Boards (ASWB) released data and reports showing that social workers of color, social workers who were older, and social workers who had a primary language other than English were disproportionally failing the exam. One of the ASWB reports evaluated demographic, educational and employment characteristics that impacted social work

candidates leading up to taking the licensing exam and found that some candidates' pathways to the profession might have been far more disrupted and delayed than others prior to attempting the licensing exam for the first time. For example, when compared to white exam candidates, a higher percentage of Black candidates took longer to earn their social work degree and worked longer in non-direct service jobs before attempting to take the licensing exam. Another report by the ASWB suggested that there would be a smaller gap in exam pass rate if marginalized populations had similar access and opportunities as white candidates (Association of Social Work Boards, 2024). Removing this exam would help with recruitment and retention of social workers, especially those from underrepresented backgrounds and those who spoke languages other than English. Having more providers with language and cultural competency would help with the "precision of fit" between client and provider, which could result in a better partnership and more effective treatment (NAMI-NYC, 2024) (NewYorkSocialWorkEDU.org Contributing Writer, 2025).

A second approach to reaching "precision of fit" is further developing the current workforce through training for providers and the healthcare systems on culturally relevant mental health treatment and care and increasing funding to support training for interpreters in the behavioral health field. To provide accessible and effective behavioral health care to all clients in need, providers and healthcare teams must have a thorough understanding or openness to learn about cultural factors contributing to the behavioral health of their patients including cultural stigma and the resulting hesitancy to discuss mental health, community support for behavioral health, and the need for relatable resources (Lezcano, 2021). Research demonstrates that culturally responsive training for providers increases patient satisfaction and encourages patient retention in mental health care counseling for a longer period (NCSL, 2022) (Grand Rising Staff, 2025).

Additionally, another way to diversify the workforce is within the types of positions offered. Increasing the use of family care advocates, navigators, peers with lived experience, and community health workers could assist with cultural fit, system navigation and improved care for the patients, as well as reduced workload and burden on providers to spend more time on patient care rather than administrative tasks.

Support for Current Providers

Trainings, reflective supervision, affinity groups, or other types of support are important to improving mental health of staff and workforce retention. Further building on these observations, additional strategies to prevent and address burnout and vicarious trauma include encouraging work-life balance and self-care (SAMHSA, 2022)

(NeuroLaunch editorial team, 2024) (Matejko, 2022) (Cleveland Clinic, 2024). Organizational strategies should center around workplace culture and climate, specifically focusing on workload, control, reward, community, fairness and values (SAMHSA, 2022). Various resources are available to assist in identifying and resolving both burnout and vicarious trauma. A few examples include:

Online or National Resources

- The NYS Department of Health offers an online recorded training on Handling Burnout, Compassion Fatigue and Vicarious Trauma in Healthcare (NYS DOH).
- The NYS Trauma Champions Collaborative compiled a list of resources to support organizational work in addressing vicarious trauma. This includes, but is not limited to, tools and assessments such as the Professional Quality of Life Measure (ProQOL) and the Secondary Traumatic Stress Informed Organization Assessment tool (STSI-OA) (NYS Trauma Champions Collaborative).
- American Psychological Association offers special interest groups or affinity groups for members
- National Alliance on Mental Illness (NAMI) offers various support groups and resources for mental health professionals, one of which are affinity groups
- The Emotional PPE Project is a volunteer-run non-profit organization that aims to improve the well-being of healthcare workers by decreasing barriers to seeking behavioral health care
- Project ECHO expands the reach of current behavioral health providers through mentorship opportunities for new behavioral health providers and primary care providers (PCPs) who are located in behavioral health professional shortage areas. National ECHO programs aim to decrease burnout and increase retention through supporting the behavioral health care workforce with trainings and building resilience (Project ECHO, 2024).

Local Resources and Initiatives

- The Monroe County Office of Mental Health has initiatives and resources to support mental health professions in addressing vicarious trauma and establishing workplace well-being (Aycock, 2024).
- BreatheDeep, Inc., the Greater Rochester Health Foundation and community leaders established Project Restore, which is a wellness program for frontline workers aimed at rejuvenating their bodies, minds and souls (Flynn, 2025).
- The University of Rochester Medical Center offers various counseling and wellness programs and resources to mental health providers (NYS Trauma Champions Collaborative).

- Rochester Regional Health provides employee assistance programs that offer counseling and support services (NYS Trauma Champions Collaborative).

Community-Based Training and Education

In supporting current workforce, additional trainings on mental and behavioral health could bolster the awareness and knowledge of partnering professionals to better serve the community. Two examples are enhanced training for school professionals and clinicians within schools so they can help identify and refer children in need, as well as enhanced training for "community connectors" (such as faith leaders) who also could recognize need and connect individuals to the appropriate resources.

The workplace was mentioned as a natural setting to be able to provide mental and behavioral health education; thus, funding for employee wellness would have the capacity to touch and potentially impact many lives. Advisors suggested placing mental health providers in primary care offices and schools for more direct access.

Another promising avenue for delivering behavioral health support comes in the form of culturally relevant and peer-led programming. A few examples of this include the Sharing Hope program (written by and for Black community members), a youth advisory group (to allow youth to provide direct input on mental wellness needs and programming), as well as NAMI on Campus (run by students, for students).

System-Level Policies and Practices

Recommended system-level practices include identifying reimbursable behavioral health approaches and fostering collaboration among settings and systems to enhance care coordination. While positive practices for increasing collaborative efforts among settings and systems are covered within the "System Gaps and Coordination Issues" section of this report, one way to address reimbursement issues is to enforce the mental health parity laws that aim to cover mental health care as thoroughly as physical health care is covered. An investigation by the New York State Attorney General's office (NYAG) found that insurance plans were completing frequent and rigorous utilization review for behavioral health treatment that resulted in unwarranted medical necessity denials and excluded coverage of residential treatment for behavioral health conditions. Therefore, NYAG's office has been working to enforce the mental health parity laws in attempt to decrease barriers to mental health treatment for individuals (NYS Office of the Attorney General, 2018). NAMI also provides a guidebook that both

patients and providers can reference to help educate themselves on what they can do under parity law should a claim be denied (NAMI, 2025).

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Section 6:
COMMUNITY CONNECTORS & MENTAL HEALTH SUPPORTS

Community connectors and mental health support organizations expand the clinical care landscape and broaden what access to support looks like in Monroe County. They augment often overloaded behavioral and mental health systems by providing services that include information and referrals, connection and social support, and healing and wellness. This assessment identified opportunities to integrate and utilize community connectors and mental health supports more widely. By doing so, we can address current unmet needs and to alleviate some of the resource pressure on the formal clinical care system.

The behavioral and mental health care systems play a vital role in our community providing necessary and at times life-saving services for those seeking support. However, not all residents in need of mental or behavioral health support desire or seek out clinical care. Fortunately, numerous community-based mental health support organizations exist in Monroe County providing social support, connection, and resources to residents of all ages.

Community organizations expand the mental health landscape and broaden what access to support looks like in Monroe County, augmenting overloaded behavioral and mental health systems. This section focuses on the dynamics of support, care, and healing that occur external to clinical behavioral and mental health care. Community-based organizations in this space play diverse roles and functions and may be referred to as either community connectors, community supporters, or healers in addition to other roles. These organizations offer services such as information and referrals, connection and social support, and healing and wellness. This section provides an overview of sources of stress in Monroe County and support sought for those stressors, the reasons for and importance of community connectors and supports, community connectors as an extension of the clinical mental health landscape, ways in which to further support community connectors, and future opportunities.

Sources of Stress and Support Sought

Behavioral and mental health conditions are widespread and affect far more people than those with a clinical diagnosis or those who will actively seek clinical care. Anyone experiencing stress, whether caused by a significant life event or persistent stressors from daily life, social isolation, and certain environmental conditions could potentially benefit from some type of mental health support. Specifically, unaddressed stress can significantly affect the physical and mental health of individuals. Overwhelming or chronic stress can lead to anxiety and depression among other mental health conditions often manifesting in symptoms such as irritability, difficulty focusing, mood swings, difficulty sleeping, and trouble with memory and recall.

My Health Story 2022 asked participants to report how often they were stressed about various aspects of their lives, including several social drivers of health. Survey

respondents within Monroe County stated that their most frequent sources of stress included work (55%), the health and well-being of family (48%), and their own health and well-being (42%). These were followed by finding/keeping work (23%), and quality of their current home, paying rent/mortgage, and quality of their neighborhood, all at 19%. Survey participants were also asked to describe their emotional and mental health. One-quarter of all respondents reported that their emotional and mental health was fair or poor, and 59% identified in the past twelve months having at least one self-concern (i.e. feeling stressed or overwhelmed, anxiety or fear, depression or sadness, alcohol use, isolation or loneliness, grief or loss, feeling helpless or hopeless, marijuana use, anger and anger management, prescription drug use, gambling, or drug use). Nearly two-thirds of adults aged 18-34 (64%) and 35-54 (65%) reported at least one self-concern in the past twelve months. Among respondents that reported providing care for another person (of any age), three in five (62%) cited experiencing at least one concern (noted above) in the past twelve months with 55% specifically citing a mental health concern.

Another way to assess needs of Monroe Couty residents is to look at those reaching out to 211/LIFE LINE for support. 211 / LIFE LINE provides information and referral for human services and crisis / suicide prevention services in our region. In 2023, Monroe County residents reached out to 211/LIFE LINE 57,822 times seeking support. The top five services requested included crisis intervention hotlines/helplines (n = 10,817), rent payment assistance (n = 10,152), home delivered meals (n = 9,305), food pantries (n = 9,183), and emergency shelter clearinghouses (n = 5,720). Additional services requested included the need for homeless shelter (n = 4,836), information and referral (n = 4,210), utility service payment assistance (n = 2,433), clothing (n = 2,001), government information services (n = 1,758), eviction prevention assistance (n = 1,682), and involuntary psychiatric intervention (n = 1,041). 211/LIFE LINE is typically able to address the needs of the caller directly or by connecting the caller with another appropriate resource. However, there are times that callers' needs go unmet. The top unmet needs in Monroe County included rent payment assistance (n = 1,240), information and referral (n = 471), homeless shelter (n = 430), and rental deposit assistance (n = 406). Reasons for needs not being met included but were not limited to unavailable services, refused service referrals, individuals not being eligible for services,

suggested referrals were exhausted, or funding was exhausted (Goodwill Vision Enterprises, 2023).

Role of Community Connectors and Mental Health Supports

My Health Story and the 211/LIFE LINE data depict some of the stresses that Monroe County residents experience and efforts to find resources. Many residents may leverage community connectors and supports for assistance prior to connecting with clinical care. In response to the question, "in the past 12 months, what kind of supports have helped you when you needed it?", over four in five respondents (81%) cited that they utilized at least one non-clinically licensed support (My Health Story, 2022). Non-clinically licensed supports include family members, friends, faith communities, other people who face similar challenges (i.e. peer advocate), in addition to other supports.

People seek community-based mental health support for various reasons including shared values, convenient and comfortable settings, trust in the people and organizations they reach out to, and the desire for shared beliefs and identities provided by support givers.

Shared Values

Community connectors and supports may provide a more welcoming environment where individuals feel seen and heard. Instead of power and knowledge resting with the clinician, the person needing support is viewed as the expert in their own experience. Many utilize recovery-oriented principles such as mutual respect, asking permission before engaging, empowering the person receiving support to have self-determination, strategic sharing of one's own story in support of the person receiving help, authentic presence, and connection as healing (National Association of Peer Supporters, 2019). A listening session participant expressed the sentiment that, "we believe that connection is healing, and the way our core values align with fidelity to the peer model embodies those – empathy, compassion, shared lived experience, strength-based, person-driven…so they're driving every moment, not just their treatment or recovery path but every interaction." Community connectors and supports offer a different kind of listening experience and communication style than clinical

interactions, empowering the person in need of support to have self-determination and control.

Convenient and Comfortable Settings

The location or setting in which services are offered can serve as barriers or facilitators to care. Convenient, predictable and known environments alleviate some of the anxiety and/or fear associated with seeking care as well as facilitate access. Home-based programs meet people where they are, providing convenience and comfort. Places of worship and community organizations are additional settings that people may access regularly and feel more comfortable going to. Allowing people to choose the setting for their interactions shifts traditional power balances, giving more agency to those seeking services.

Trust and Authenticity

People with lived experience are a critical source of support for individuals navigating behavioral and mental health systems. They ensure that those seeking care are connected and have a sense of hope. Hope can form from seeing someone who has been through something similar and has found their way to a place of healing and recovery. Authenticity and lived experience provide an additional level of comfort and support. A listening session participant illustrated the impact of a community peer specialist who used lived experience and mutual respect to connect with a patient in a hospital setting. The patient's "immediate response was, 'oh, you're someone who gets me,' and immediately her shoulders relaxed, her face went from tense to more open." Individuals who have done their own healing work have lived experience and a unique lens which can be used to support others. They do not necessarily need to know all the clinical details but are there to listen and provide empathetic support. Training can help them to recognize the power in what they have accomplished through their own healing and how to harness that power to support others through their journey.

> *"[The patient's] immediate response was, 'oh, you're someone who gets me,' and immediately her shoulders relaxed, her face went from tense to more open."*

Shared Beliefs and Identities

A calming presence is another reason that community connectors and supports may be sought out instead of care through a clinical setting. Faith communities often serve in this capacity. Listening session participants from various faith communities highlighted the importance of a calm demeanor with one specifically citing the value of being a "non-anxious presence." He stated that, "that's something that I think I excel at, something that people value in me. And it's really something that people are looking for when their life is spinning out of control." The tradition and sense of belonging that faith communities provide often draw people in, especially when they are experiencing major life events. Many faith leaders have the ability to balance spiritual guidance with practical advice. One example provided was to, "trust God, but also take your medicine…God creates those medicines."

Stigma is another barrier that many people may face but was particularly flagged as a concern among people of color. Stigma is deeply rooted in cultural and societal norms, which can make it difficult for individuals to acknowledge and seek help for their mental health needs. Identity-specific shared experiences can expedite trust and connection among those giving and receiving support. One listening session participant explained that "we were looking for someone who looked like us and could understand where we were coming from. The idea that they're people of color is the primary reason that people utilize them." This underscores the need for identity-related diversity among mental health professionals and mental health supports as sharing similar backgrounds and experiences with the people they serve fosters a sense of understanding and trust that supports healing.

Augmenting the Current Mental Health Landscape

Community mental health support organizations play a vital role in the mental health landscape by alleviating strain on existing systems through the services they offer, facilitating access to clinical services, and augmenting existing services through partnerships with clinicians. They often serve as a bridge between needing and receiving formal care, helping to break down stigma, navigating resources, and providing necessary support until individuals determine whether to seek further services.

Alleviating Strain on Existing Systems

Community connectors and supports provide individuals with guidance and resources that may not be available through common clinical pathways, and this may often be done during their most vulnerable times. Traditional healing methods, typically not found in clinical settings, can reduce stress and create safe spaces for belonging. One advisor to this project brought up the healing power of movement and dance. Specifically, she agreed to provide space for dancing when asked, reflecting that movement "relieves all that stress…no, it's not therapy, but it's highly therapeutic. If it reduces your stress and puts you in a place where you feel safe and nurtured, that's healing." Additional examples include yoga, meditation, and storytelling circles. In these spaces, the process of inclusion helps to facilitate healing, where people can be their authentic selves without adjusting their language, behavior, or appearance to align with dominant cultural norms. The advisor above further elaborated, "space where we can bring our entire selves, take off 'the mask,' and not have to code switch are incredibly therapeutic." Activities such as these, while not traditional forms of therapy, play a crucial role in mental wellness by fostering community and providing a sense of belonging and relaxation.

> *"It relieves all that stress…no, it's not therapy, but it's highly therapeutic. If it reduces your stress and puts you in a place where you feel safe and nurtured, that's healing."*

Facilitating Access to Clinical Services

Non-clinical support organizations also serve as a bridge while people wait for services or decide to engage with clinical care. One listening session participant noted, "so we know that there is a clear line when someone needs to be referred to clinical support. The issue is that the wait time can be very long…people look to us to be that bridge while they are waiting for services." Some of the peer-led programming also helps to dismantle stigma by debunking myths and normalizing conversations about mental health, making it easier to connect with and access care. The same advisor noted, "Stigma is the biggest issue, and these programs help people to know that their voices matter,

and there is help they can get to address [their mental health concerns]….our [peer-to-peer] programs are helping people to feel comfortable asking for help."

Augmenting Existing Clinical Services

Ideally, community support organizations can augment the care received by clinical systems. Community-embedded peer specialist support accompanies the person between and during engagement with different parts of the system, while site-specific support is available in places such as emergency housing shelters, crisis inpatient settings, and addictions recovery or day treatment programs. This dual approach ensures that the support is more accessible. Data from My Health Story indicate that for respondents who reported at least one mental health concern in the past twelve months, nearly half (49%) only utilized clinically licensed support; while just over half (51%) used at least one non-clinically licensed support. Additionally, 23% of survey respondents reporting at least one mental health concern did not utilize any type of support at all. These data indicate that there are significant opportunities for more collaboration between clinical providers, community connectors, and peers that can augment the quality of care individuals receive. Peers are people with experience living with mental health challenges that have received training and certifications to work with their peers in this capacity. They are content area experts in living with mental illness and the impact of the systems that they interact with. As an advisor referenced, "when their role is maximized, peers can be important members of care teams providing critical insight through their lived experience and their ability to connect and make unique relationships with clients." The collaboration between community support providers, healers, and the medical system of care is crucial for holistic health and wellness. Partnerships such as these, however, require dedicated time and resources to nurture and sustain.

Support groups offered throughout the community can also help to augment existing clinical services. These groups offer the time and space to connect people experiencing similar challenges whether related to grief and bereavement, mental health, substance use, surviving violence, veteran experiences, among other issues. Many support groups are anonymous and help to foster a sense of community, build emotional support, hold one another accountable, and provide safe spaces to share experiences and learn new coping strategies. Being in a shared space with others who have experienced similar things can reduce feelings of isolation and promote mental health and well-being.

Accessing Community Connectors & Mental Health Supports

People may access care, support, and healing from community-based mental health support organizations through various pathways including word-of-mouth, social media or web-based groups, service organizations, peers and navigators, and referrals from primary care providers (PCPs). Word of mouth from trusted contacts continues to be one of the most effective means of communicating mental health information and seeking support. These types of referrals are often shared between friends or trusted contacts and may involve a warm hand off rather than just a name or contact number. This method includes pastoral counseling and faith-group leaders, grandparents and older adults, and trusted sources such as barbershops and stylists working with the Get It Done initiative,[11] who are often viewed as credible sources of information. One listening session participant noted the importance of grandparents stating, "I get young people all over town calling me and want to talk. I have a 16-year-old granddaughter, and we're really close. All of her friends call me when they have issues. Older adults that are accessible and open…especially grandparents. They have a special bond and [as a community, we] don't utilize that enough." Another participant shared the importance of personal connections noting, "Even if I send somebody a website, they still call me and say, 'and tell me how to get….'" The validation of a next step or approach from a personal connection who is familiar with the mental health system, can help someone to take the next step in their journey to wellness.

Social media groups on platforms such as Facebook or WhatsApp serve as important sources of mental health support. Many people look online to seek mental health support. Online platforms provide a convenient and accessible way for individuals to find support, whether through formal or informal groups. This ease of access is particularly important for those who may feel uncomfortable seeking help in person; social media groups with active moderators provide safe spaces for people to ask questions and seek guidance. Participants agree to the rules of the group when signing up. Online platforms also allow for easier sharing of personal experiences with fewer privacy and HIPAA-related concerns.

[11] Approximately 25 hair salon and barber shop owners have been trained as community health educators to take blood pressures, counsel clients about HIV prevention, and connect people with health care providers and educational material. They are paid a stipend and required to spend 10 hours on education and health literacy with clients every week.

Community-based organizations such as Action for a Better Community (ABC), Ibero American Action League, Jewish Family Services, and Lifespan play a vital role for specific populations within our community. Those who identify with the population a particular agency serves may benefit from the services offered by that agency whether it be to address basic needs or mental health support. These organizations offer various services and programs designed to meet the needs of their communities, providing a valuable resource for those seeking help. They also sometimes provide programming or refer people to community programming at recreation centers, YMCAs, or at the Jewish Community Center of Greater Rochester.

Peers and navigators also facilitate access to mental and behavioral health resources. There are multiple ways people get connected to or hear about peer specialists, family navigators, and other mental health or substance use peer support roles. Often, it may be through word of mouth from a trusted contact source. It also may occur during contact in a formal medical care or crisis care setting, where trained peer specialists are embedded into service settings, but not employed or supervised by the service setting itself. Outreach and networking efforts with providers and systems are also crucial for getting individuals connected with peer specialists. One participant disclosed that networking within the system was most effective, "attending many different community provider meetings, doing presentations, and just letting the system at least know as much as possible so that when people come in, they can be referred to peer specialists."

Lastly referrals to community connectors and supports may occur through primary care providers. This is especially true for the older adult population. These referrals help connect individuals with the mental health support they need, leveraging the trust and existing relationship they have established with their primary care provider.

Amplifying the Work of Community Connectors & Mental Health Supports

Listening sessions highlighted several ways in which community connectors, peer support, and community-based organizations offering mental health programming

could be amplified that include the areas of training, funding, and support and guidance.

Training

Training for healers and community providers is crucial for ensuring that they take care of themselves while providing support to others. The importance of more awareness and training in the area of self-care, the notion of taking care of yourself and your own well-being so you can be better equipped to support others, was emphasized in particular. Training in self-care is essential for peer and family support group facilitators and connectors. An advisor highlighted, "Sometimes we have someone come in who's really going through something, and they're completely distraught. We do what we can, we talk them down, we hold space, but that stays with us. It can bring up our own stuff, re-traumatize things we've been through. And then there's the question we don't say out loud: what if we hadn't been able to help? What if we couldn't talk them down? Now we're carrying that, trying to figure out how to keep showing up for others, while we don't always have the support we need ourselves. That alone can be traumatizing in itself." One participant highlighted the importance of having external expertise to help individuals manage their well-being and stress levels. Many helpers are overworked and feel the need to always be available, making it crucial to provide them with the tools and support to take care of themselves while helping others.

> *"And then there's the question we don't say out loud: what if we hadn't been able to help? What if we couldn't talk them down? Now we're carrying that, trying to figure out how to keep showing up for others, while we don't always have the support we need ourselves. That alone can be traumatizing in itself."*

In addition to self-care, there is the need for training in specific content areas including boundary setting, approaches to leaving the door open when an individual is not ready to seek clinical care support, racial equity and the myths of white superiority, and recognizing and understanding subtle signs of distress. One participant disclosed, "so a lot of times we see somebody is struggling, but they're really not open at that time

for us to…make that connection to somebody else who can provide some additional support…I think that's when [staff] feel a little lost, like 'well, what do I do now? How best do I support them? Because I'm not a therapist.'" Participants also noted that community connectors and supports must be trained to understand and undo the myths of white superiority and Black inferiority, as this myth fundamentally impacts the mental health and wellness of people of color. Without addressing this history, the mechanisms and systems that perpetuate these harmful beliefs continue. Training providers to recognize and dismantle these myths is crucial for creating a more equitable and supportive health care environment. Lastly, the importance of understanding the specific needs, nuances, and distress signals of individuals seeking care was discussed. Another participant disclosed, "the very first thing I'm doing is trying to really figure out what is the need. So if somebody needs some friendly, supportive conversation, that's great. But I'm the one who really has to be looking to see, is there something more going on here? Do they need something more?"

Sustainable Funding

Sustainable funding remains a persistent challenge for many community-based mental health support organizations. A reliance on grant funding for existing operations and the need for additional grant funding to expand services and programs is a significant challenge for community-based organizations. Many listening session participants explicitly expressed the need for grant funding for sustaining and expanding existing services and programs. They stated that grants could support activities that would make it easier to reach and engage individuals in mental health support including marketing services, providing stipends for facilitators and program operations for peer support groups and educational programming, and helping to pay for services. Specific needs like the importance of creating more programming in select neighborhoods or home-based locations were also mentioned. One listening session participant noted, "we need more supports in the community that can really reach out to clients in their own environment;" however, the demand for services such as these traditionally exceed the funding available. Another participant underscored the need to pay facilitators and individuals participating in Emotional Emancipation Circles, which aim to help heal, and end, the trauma caused by the lie of Black inferiority and white superiority. In this case, providing funding for safe spaces for individuals to heal and

become effective helpers is crucial in addition to ensuring that peer support groups and mental wellness educational programming are accessible to all residents in Monroe County who may be in need.

While participants explicitly stated the need for more grant funding, there appears to be a larger need for support exploring sustainable business models for community-based organizations broadly. Sustainable funding involves creating a diverse portfolio of revenue streams and building strong donor relationships, in addition to managing expenses effectively. Grant awards are often part of the funding portfolio but should be considered in conjunction with earned income, individual donations, corporate sponsorships, and crowdfunding. Establishing diverse funding streams can help with operational costs that are not always supported by grant funding and potentially mitigate some of the effects associated with recent changes in federal funding.

Support and Guidance

Behavioral and mental health are complex fields with many regulatory requirements. There is a need for more support and guidance for community mental health organizations pertaining to peer-model skills and clarity defining roles for family navigators and peer specialists. The implementation of peer roles and programs is inconsistent. There is no administrative organization to provide regulations or guidance and monitor the ways in which peer models are implemented. Understanding and expertise in peer-model supervision is crucial to ensure that peers are effectively integrated into and alongside clinical care settings without friction.

In addition to regulatory requirements, community-based mental health support organizations expressed the need for support for healers and peers themselves. One listening session participant emphasized the need for safe spaces for healers to continue their own healing journeys. The participant called for intentional time set aside, “not just for us to come and rehash or throw darts at one another, but literally what is it going to take for me to continue the journey of healing, or the journey of wellness?” Support to ensure that self-care and healing are proactively integrated into the work and not an afterthought would further support the workforce in this space.

Future Opportunities

Workforce Development

As mentioned in the "Retention and Diversity of Workforce" section of this report, there is a clear need for more people of color to serve in the mental and behavioral health fields, including in community-based mental health support organizations and peer navigator roles. In addition to cultivating a larger pool of peers and community-based mental health providers of color, it is imperative that training, supervision, and support are proactively integrated into workloads, so that these elements are viewed as an essential component of the work and not supplemental activities. Individuals working in mental health, whether in clinical or non-clinical settings, are prone to absorbing the experiences of the people they work with. Without adequate training, supervision, and support, this vicarious trauma can lead to burnout, ultimately negatively affecting retention.

Along with increasing racial and ethnic diversity of the community-based mental health support workforce, is the need for culturally responsive training and support for everyone working in these settings (licensed and non-licensed alike). Specifically, trainings that focus on emotional emancipation models and Indigenous Psychotherapy™ and Anti-Racist, Culturally Competent Treatment for Black Families can help promote wellness in communities of color. Trainings such as these illuminate the myths associated with white superiority and Black inferiority and provide strategies for integrating culturally responsive healing methods into this work. Coupled with training on peer models, these trainings can enhance the level of trust and connection that providers committed to anti-racist practices can make with those seeking support from communities of color, transforming the way that mental health support is delivered and received.

Changing the Culture of Care

Changing the culture of care requires our community to approach mental and behavioral health from a recovery-oriented perspective, while reducing stigma and including a mental health lens in policy implementation and solution design. Community-based mental health support organizations, along with peers, utilize a compassionate approach to help shift the culture to be less deficit-based. Services

received in a non-clinical setting and/or offered through peers with lived experience may be perceived as more supportive and less judgmental than those provided in clinical care.

The notion of stigma is often discussed in the realm of community settings and particularly among communities of color. Less frequently, however, is stigma discussed within medical establishments themselves. Changing the culture of care requires acknowledging the stigma of mental health and addictions experiences that exist within clinical settings and working to reduce the stigma in both clinical and community settings. One listening session participant noted that, "the medical care system has a long way to go to continue to reduce internalized stigma. We have witnessed a lot of stigmatizing behavior, especially in the ED." Efforts centered on shifting the culture to an asset-based model whether focused on de-stigmatization, recovery-oriented principles, or authentic emotional emancipation work, among other endeavors, need to be developed and implemented by or in equal partnership with people with lived experience. For example, there is the "fundamental recognition when you have people in the spaces who are supposed to create the DEI learning [who do not self-identify as diverse], [the learning] doesn't occur because they don't fundamentally understand. It's a checkbox…the burden falls on folks who may have some varying levels of understanding of the fundamental lie of white superiority and Black inferiority." Authentic emotional emancipation work is a crucial cultural component with the potential to transform the mental health and wellness space and beyond, in systems and settings that train those working in the mental health field, whether clinicians or community support roles.

Another dimension of culture of care transformation is the need for mental health and wellness to be discussed and embedded within all community tables and policy discussions. Multiple experts that we spoke with throughout medical and community settings emphasized the lack of integration of mental health discourse within tables and advocacy efforts focused on other social and environmental drivers of health and wellness such as housing issues, food shortages, education, or employment support. A listening session participant emphasized that, "mental health needs to be at every table and integrated into our community, whatever we're engaged in…we have to be on the same page. Mental health is a key component to health, period. We can't have solutions without addressing mental health." As a community, Monroe County is

starting to incorporate elements of this. Another participant noted the way in which local health coalitions have started to work together to try to address common issues like gun violence. This collaborative approach ensures that mental health support is integrated into broader community initiatives, addressing systemic issues that impact mental wellness.

> *"Mental health needs to be at every table and integrated into our community, whatever we're engaged in…Mental health is a key component to health, period. We can't have solutions without addressing mental health."*

Transformative care requires shifts in how mental health has traditionally been discussed and practiced. While clinicians have expertise in their area of focus, acknowledging the expertise that peers and individuals with mental health challenges have as part of their own experience and situation is critical. A listening session participant noted that, "the more peer supporters are embedded, the more we've been told that we're like an oasis for individuals. We're also showing a different approach and compassionately trying to change the mental wellness and care culture to be more compassionate and less deficit-based." Continuing to acknowledge and reduce stigma throughout both clinical and community settings and integrate mental health into broader community conversations will increase our ability to transform the existing mental health care system. Community-based mental health support organizations are critical to this transformation.

Community connectors and supports expand, connect, and augment existing mental and behavioral health services. Without them, there would be the need for more services, fewer linkages and less coordination, and reduced capacity to serve those seeking behavioral and mental health supports.

References

Goodwill Vision Enterprises. (2023). 211 Lifeline Monroe County Summary: Annual Custom Report.

National Association of Peer Supporters (2019). National Practice Guidelines for Peer Specialists and Supervisors. Washington, DC: N.A.P.S.

Section 7:
CONCLUSION

We identified four overarching opportunities that include focusing on early detection and prevention, breaking down silos, investing in workforce, and expanding use of peer and community supports. Additionally, three cross-cutting issues emerged: data collection and monitoring, regulatory environments, and social drivers of health.

The purpose of this assessment was to identify mental and behavioral health needs that exist within Monroe County, along with promising practices and opportunities where additional funding, programmatic change, or policy updates could help address those needs. When consulting with local mental and behavioral health professionals, we heard numerous areas of need. After review of available quantitative and qualitative data, we selected the following areas to focus on for this assessment:

- Crisis Services and Post Crisis Care
- Mental Health of Children and Youth
- System Gaps and Coordination Issues
- Retention and Diversity of Workforce
- Community Connectors and Mental Health Supports

While individual issue briefs and report sections are available for each of the selected focus areas, below are the common needs and themes that emerged throughout the entirety of the assessment. We identified four overarching opportunities that include focusing on early detection and prevention, breaking down silos, investing in workforce, and expanding use of peer and community supports. Additionally, three cross-cutting issues emerged: data collection and monitoring, regulatory environments, and social drivers of health.

Focus on Early Detection and Prevention

- Public Awareness: Raise public awareness around mental and behavioral health signs, symptoms and resources, while simultaneously working to reduce stigma associated with seeking help.
- Prevention: Additional efforts are needed within the prevention realm to help recognize and identify behavioral health concerns earlier, prior to a point of crisis, and connect individuals with care services that will meet their needs. It is important to have access points to behavioral health services in places where people are already engaged, such as schools, workplaces, and primary care offices.

Break Down Silos

- **Systems Coordination:** Many organizations currently work in silos due to time constraints, competition for funding, and/or regulatory barriers, but improved coordination is needed for more efficient use of resources and improved client care. Coordination is needed among healthcare offices and other community touchpoints (such as the educational system and community supports), across different healthcare organizations and systems, and within those individual healthcare organizations and systems. Case management and care coordination could be helpful in streamlining the patient experience through all of these systems, and clinicians need current, up-to-date resources available to them which specify where they can refer their patients for additional needed care.

Invest in Workforce

- **Precision of Fit:** Precision of fit refers to clients being able to find providers who best match their needs to facilitate improved wellness and outcomes. Part of this is ensuring all providers, regardless of race or ethnicity, receive training in culturally responsive and trauma informed care. Another part is to work toward creating a more diverse future workforce through fair licensing requirements, tuition forgiveness, loan repayment programs, etc.
- **Support for Professionals:** Mental and behavioral health professionals are prone to burnout and vicarious trauma, which can lead to deterioration of their own mental health, decreased quality of care for clients, and decreased workforce retention. Resources such as training, reflective supervision, and affinity groups are needed to help support the current behavioral health workforce including clinicians and peers alike.
- **Reimbursement & Billable Services:** Reimbursement rates need to increase to make mental and behavioral health interventions and practices sustainable, to provide equitable compensation for all behavioral health professionals including peers, and to help maintain the current workforce. Broadening the definition of billable services is also needed to allow clinicians to conduct needed activities, such as spending time on client care coordination with other organizations, and to allow for interventions outside of the "norm" that better fit the client's lifestyle, preferences and needs. These modifications should apply to all forms

of insurance inclusive of Medicaid, as data has shown gaps in access to care and preventative services for those with Medicaid when compared to other commercial insurances. There is no one-size-fits-all approach for mental and behavioral health interventions, and we need reimbursement policies that enable providers to give patient-centered care.

Expand Use of Peer and Community Supports

- **Peers & Community Supports:** There is an opportunity to expand the use of family care advocates, navigators, peers with lived experience, community health workers, and other community supports. These resources assist with precision of fit, system navigation, bridge gaps in the continuum of care, and reduce the workload and burden on clinical providers. Many of these supports have established trust within the community which helps break down that barrier to receiving care.

Cross-Cutting Issues

- **Data Collection and Monitoring:** Improved and consistent data collection is necessary to understand community needs along with the capacity and utilization of mental and behavioral health resources. Systematic data collection and monitoring will enable quicker and clearer identification of gaps in workforce and programs, so we know where to invest time, energy and resources. Data should also be collected in a way to facilitate analysis by different demographic characteristics to identify and address disparities and particular needs of different populations.
- **Regulatory Environment:** Reduction in the heavy regulatory landscape is needed to ease burden on clinicians and systems, as well as to help improve client care. Examples of areas where reduced regulation would be helpful include licensing rules that stifle the growth and flexibility of the workforce, regulations that make it overly burdensome to open new needed facilities, and the siloed operation of mental health and behavioral health systems which make it hard to provide coordinated care to people with multiple complex needs.

- Social Drivers of Health: Behavioral health treatment is not likely to be successful unless the client's environment is supportive of the treatment and changes they are trying to make. To illustrate this point, data demonstrates that individuals living in low socioeconomic status areas tend to report and seek help for behavioral health issues at a much higher rate. More attention is needed to create a supportive environment for clients by addressing other needs they may have within their lives. This could take many forms, a few examples of which include addressing the entire family unit instead of the client alone and/or linking the client to additional resources related to social drivers of health (such as food, housing or transportation).

The mental and behavioral health needs of Monroe County residents are pronounced and continue to grow. Many resources to improve mental health and wellness exist, yet they are underutilized in part due to access challenges including eligibility requirements, public and provider awareness, availability of services as it intersects with social drivers of health, and coordination within and across systems. Together, we can connect the seemingly disjointed silos to promote mental health and wellness in our community.

APPENDICES

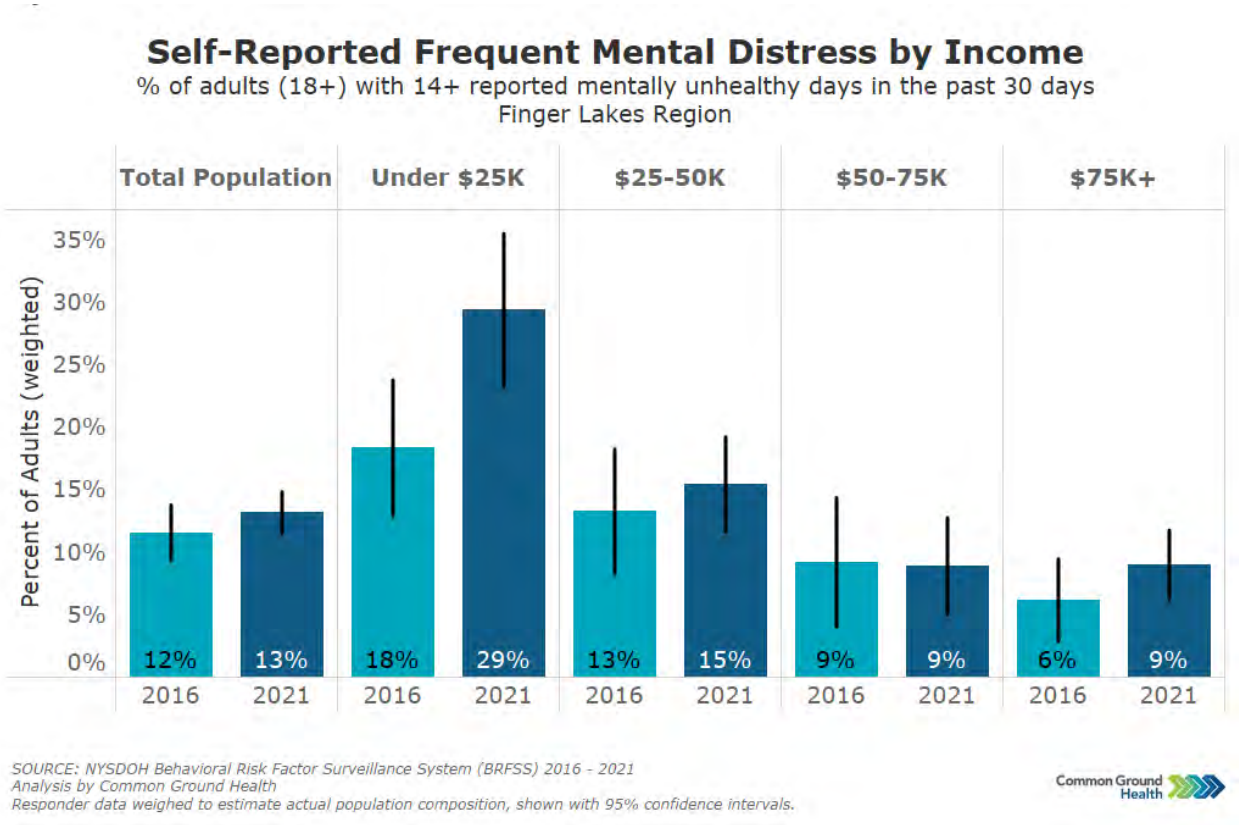
Appendix A: Supplemental Data

Contents

Self Reported Mental Health Status

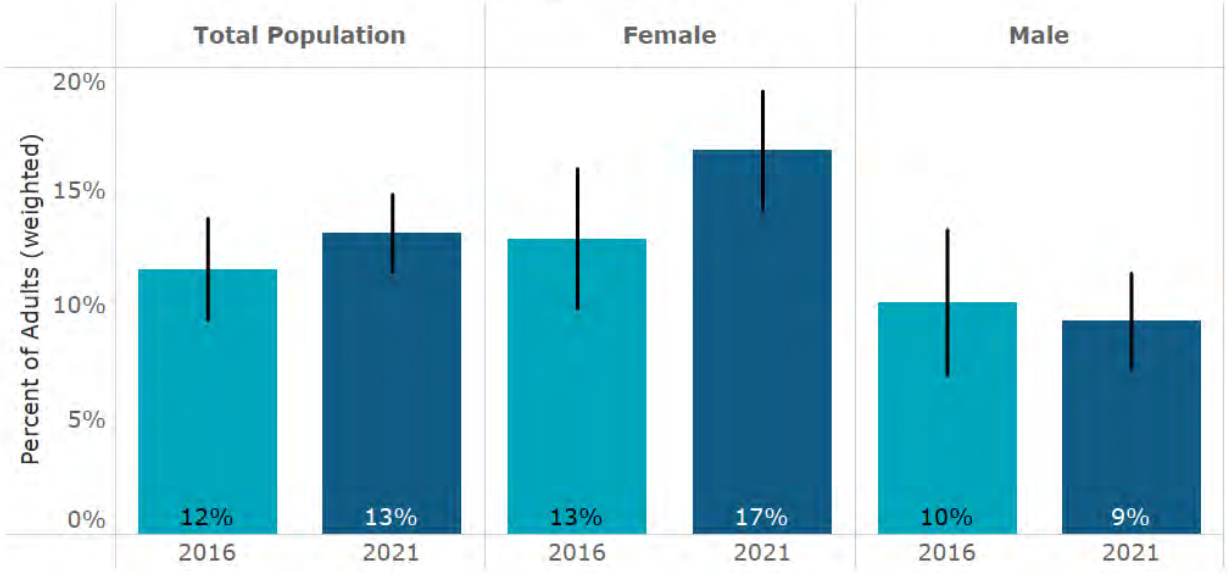
Source: NYSDOH Expanded Behavioral Risk Factor Surveillance System (BRFSS)

Self-Reported Frequent Mental Distress



Self-Reported Frequent Mental Distress by Gender

% of adults (18+) with 14+ reported mentally unhealthy days in the past 30 days
Finger Lakes Region

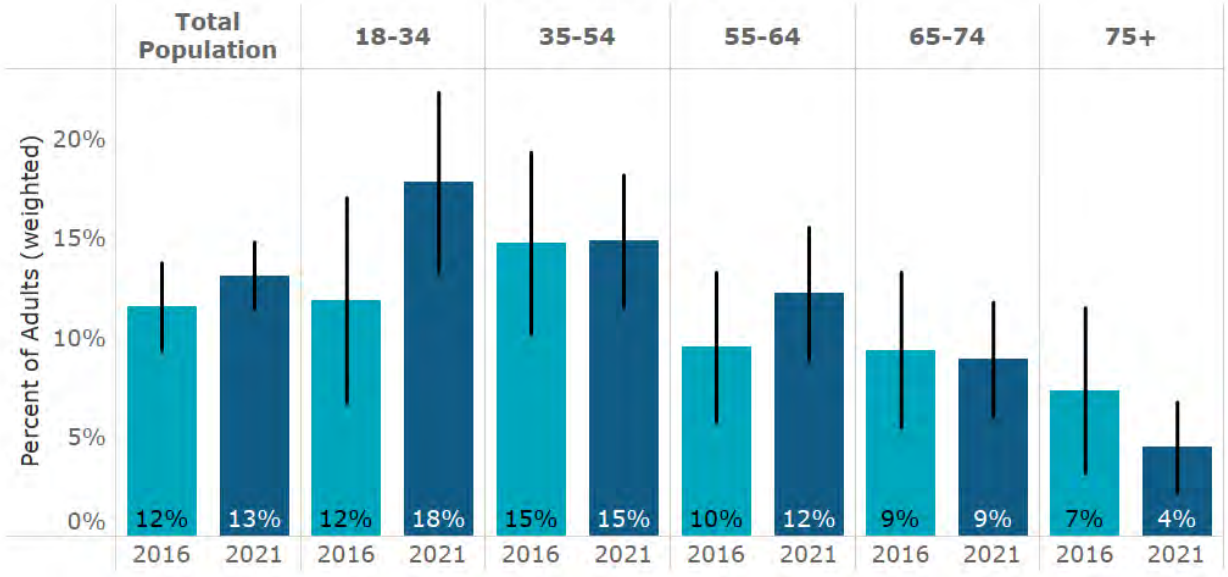


SOURCE: NYSDOH Behavioral Risk Factor Surveillance System (BRFSS) 2016 - 2021
Analysis by Common Ground Health
Responder data weighed to estimate actual population composition, shown with 95% confidence intervals.

Common Ground Health

Self-Reported Frequent Mental Distress by Age Group

% of adults (18+) with 14+ reported mentally unhealthy days in the past 30 days
Finger Lakes Region



SOURCE: NYSDOH Behavioral Risk Factor Surveillance System (BRFSS) 2016 - 2021
Analysis by Common Ground Health
Responder data weighed to estimate actual population composition, shown with 95% confidence intervals.

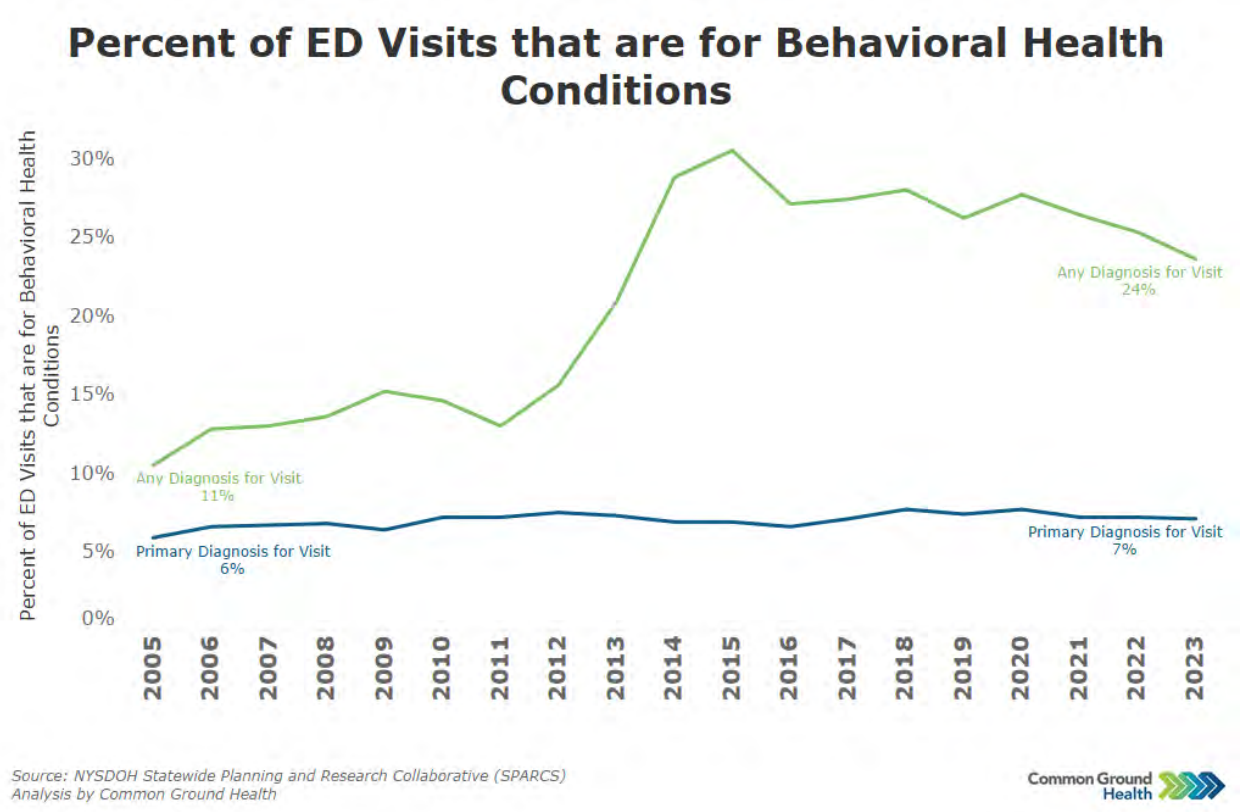
Common Ground Health

Hospital Visit Rates (ED & Inpatient)

Source: NYSDOH Statewide Planning and Research Collaboration (SPARCS)

The following charts were produced from raw data provided by the New York State Department of Health (NYSDOH). However, the conclusions derived, and views expressed herein are those of the authors and do not reflect the conclusions or views of NYSDOH. NYSDOH, its employees, officers, and agents make no representation, warranty or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here.

Overall Trends of Hospital Utilization for Behavioral Health



Percent of Youth (Under 18) ED Visits that are for Behavioral Health Conditions

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Top Reasons for Behavioral Health ED Visits
Monroe County

Condition	Total Visits	Total Patients	Percent of patients with more than 1 BH ED visit
Intentional Self-Harm	3,492	2,182	85%
Alcohol Use Disorders (AUD)	3,079	2,172	27%
Drug Use Disorders	2,799	1,780	41%
Depressive, Bipolar, and Other Mood Disorders	1,868	1,478	59%
Trauma/Adjustment Disorders	1,443	1,255	47%
Anxiety/Panic Disorders	1,402	1,214	33%
Schizophrenia spectrum and other psychotic disorders	1,304	725	51%
Personality Disorders	1,169	347	71%
Drug Overdose	996	885	27%
Conduct Disorders	731	557	64%

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

Common Ground Health

Top Reasons for Behavorial Health ED Visits
Monroe County Youth (0-21)

Condition	Total Visits	Total Patients	Percent of patients with more than 1 BH ED visit
Intentional Self-Harm	981	741	84%
Depressive, Bipolar, and Other Mood Disorders	600	451	62%
Trauma/Adjustment Disorders	520	452	51%
Conduct Disorders	510	370	65%
Anxiety/Panic Disorders	385	344	40%
Drug Use Disorders	249	203	34%
Alcohol Use Disorders (AUD)	213	196	20%
Personality Disorders	115	26	69%
Neurodevelopmental disorders	84	63	56%
ADHD	79	66	67%
Drug Overdose	69	68	28%
Schizophrenia spectrum and other psychotic disorders	61	45	53%

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

Top Reasons for Behavioral Health Inpatient Visits
Monroe County

Condition	Total Visits	Total Patients	Percent of patients with more than 1 BH ED visit	Average Length of Stay	Total Bed Days
Intentional Self-Harm	1,782	1,451	76%	12	20,566
Alcohol Use Disorders (AUD)	1,571	1,105	31%	10	15,048
Schizophrenia spectrum and other psychotic disorders	1,216	903	43%	16	19,963
Drug Overdose	1,097	1,026	14%	9	10,361
Depressive, Bipolar, and Other Mood Disorders	1,002	848	75%	12	11,697
Drug Use Disorders	814	687	30%	15	11,906
Trauma/Adjustment Disorders	157	148	52%	5	832
Anxiety/Panic Disorders	65	61	80%	7	425
Feeding and eating disorders	56	45	40%	12	677

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

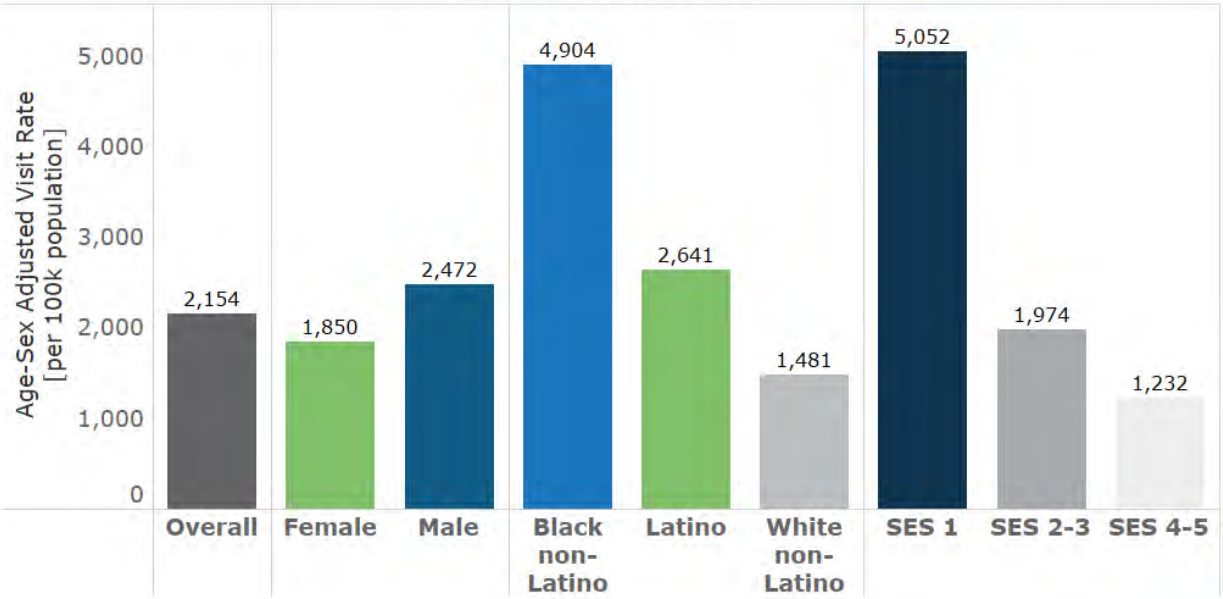
Top Reasons for Behavioral Health Inpatient Visits
Monroe County Youth (0-21)

Condition	Total Visits	Total Patients	Percent of patients with more than 1 BH ED visit	Average Length of Stay	Total Bed Days
Intentional Self-Harm	476	372	89%	10	4,842
Depressive, Bipolar, and Other Mood Disorders	289	243	89%	11	3,157
Schizophrenia spectrum and other psychotic disorders	140	99	54%	17	2,419
Trauma/Adjustment Disorders	60	56	70%	6	385
Drug Overdose	49	45	18%	9	461
Feeding and eating disorders	48	39	38%	11	533
Anxiety/Panic Disorders	31	27	93%	9	268
Drug Use Disorders	25	21	71%	7	182
Conduct Disorders	23	23	74%	12	284
Neurodevelopmental disorders	14	12	58%	13	186

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

Common Ground Health

ED Visit Rate: All Behavioral Health Conditions (Primary DX)
Monroe County 2023

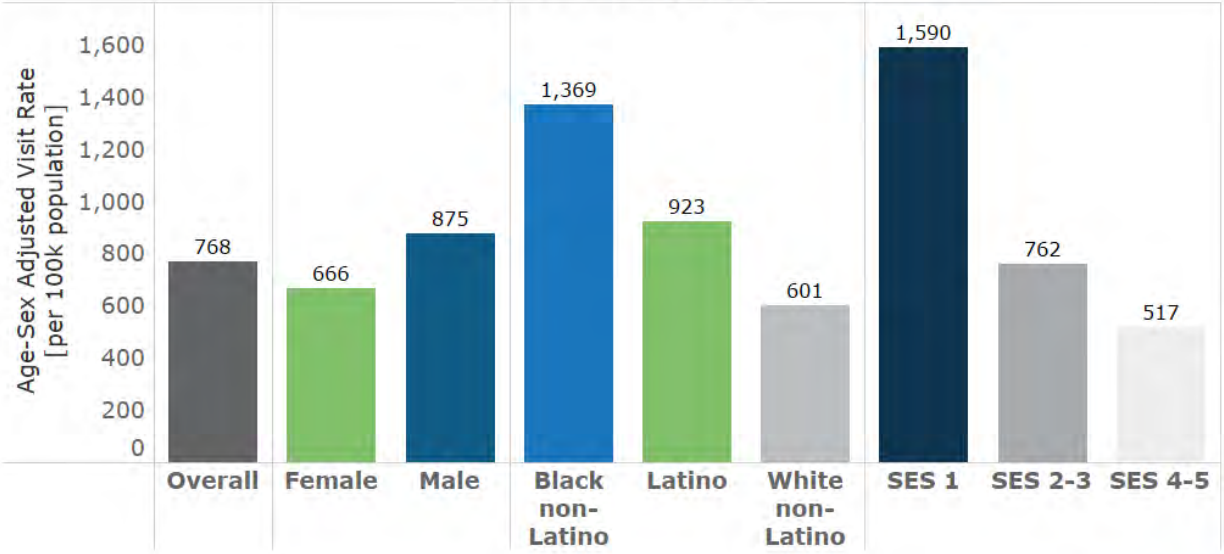


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Inpatient Visit Rate: All Behavioral Health Conditions (Primary DX)

Monroe County 2023

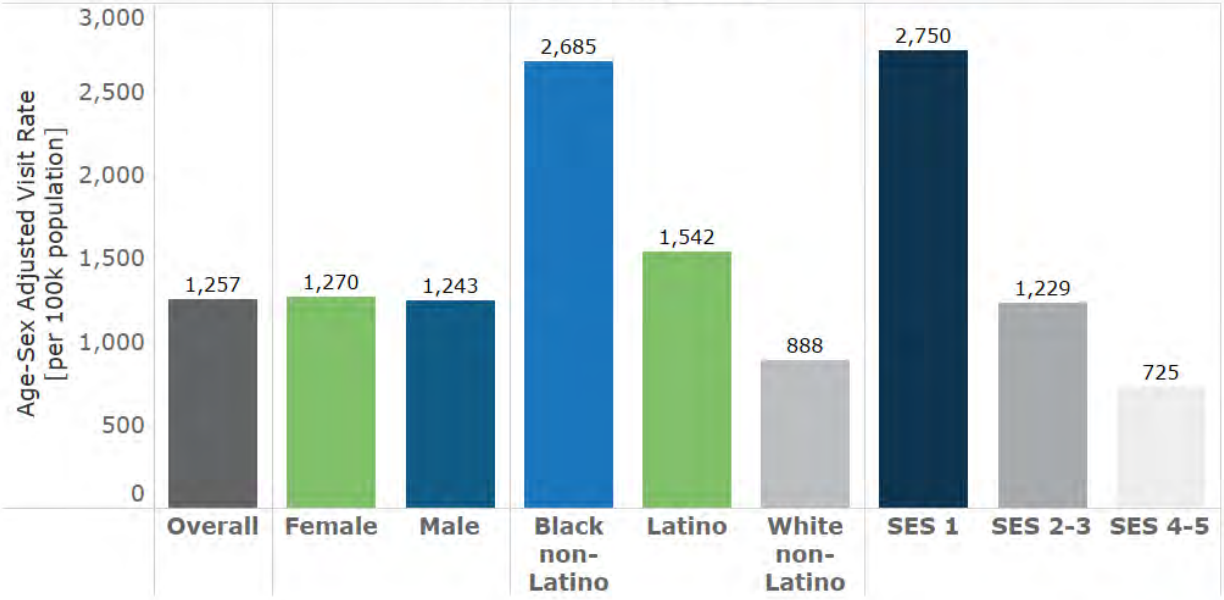


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

ED Visit Rate: All Mental Health Conditions (Primary DX)

Monroe County 2023

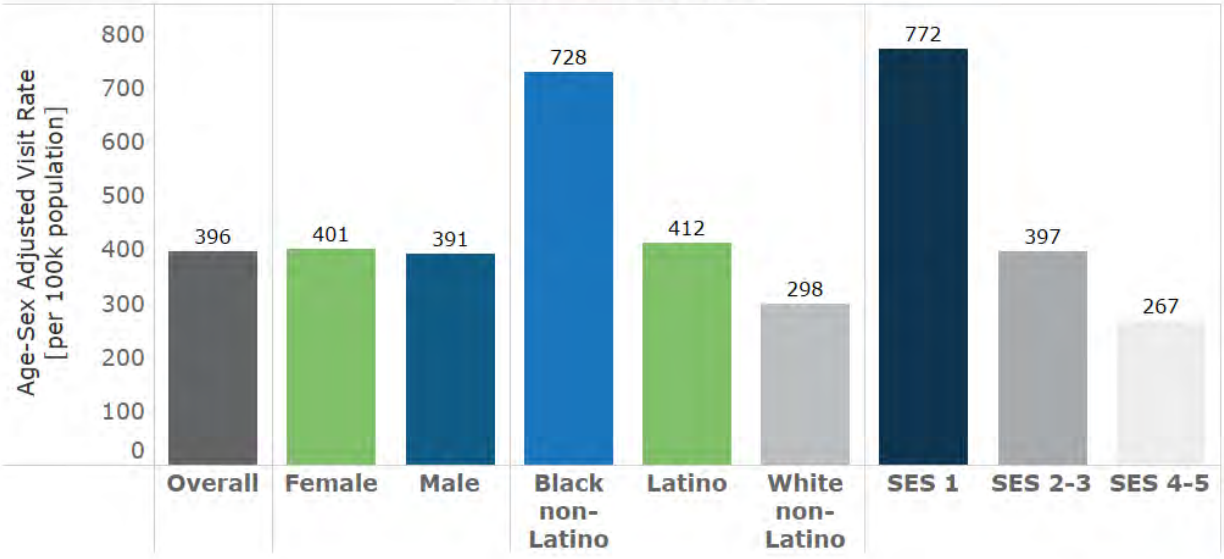


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Inpatient Visit Rate: All Mental Health Conditions (Primary DX)

Monroe County 2023

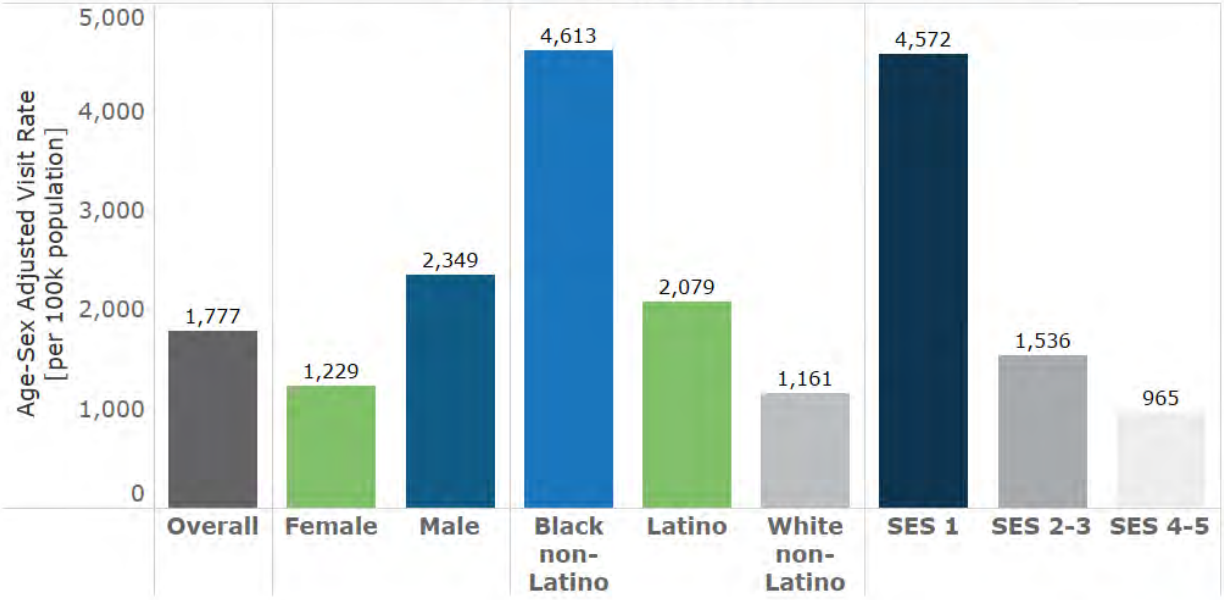


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

ED Visit Rate: Substance Use Disorders (SUD)

Monroe County 2023

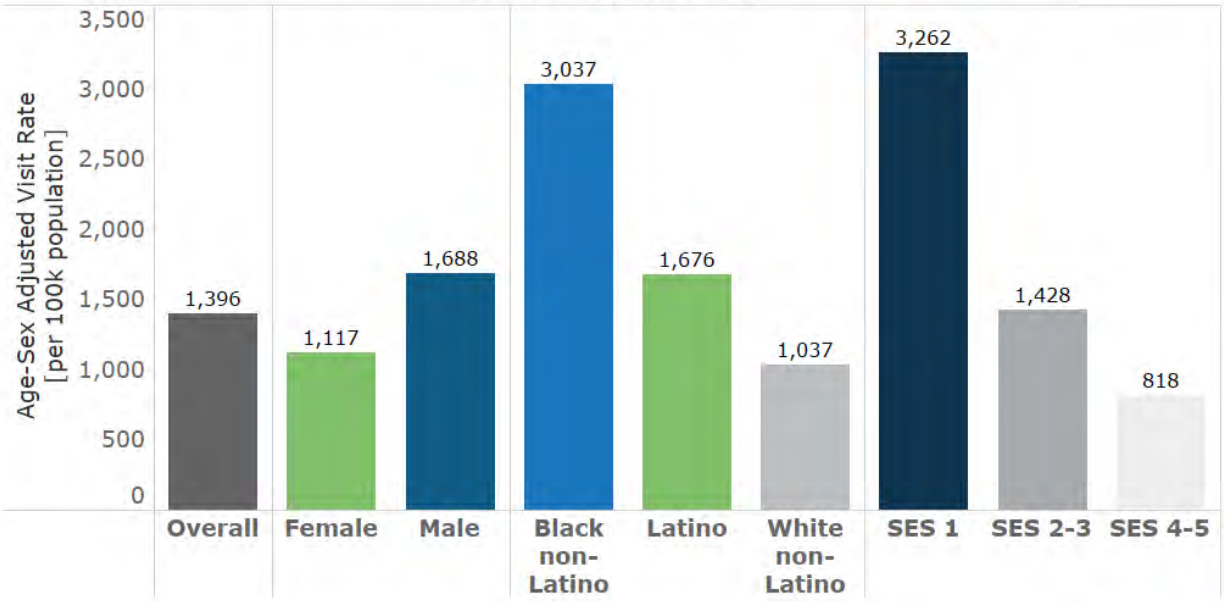


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Inpatient Visit Rate: Substance Use Disorders (SUD)

Monroe County 2023

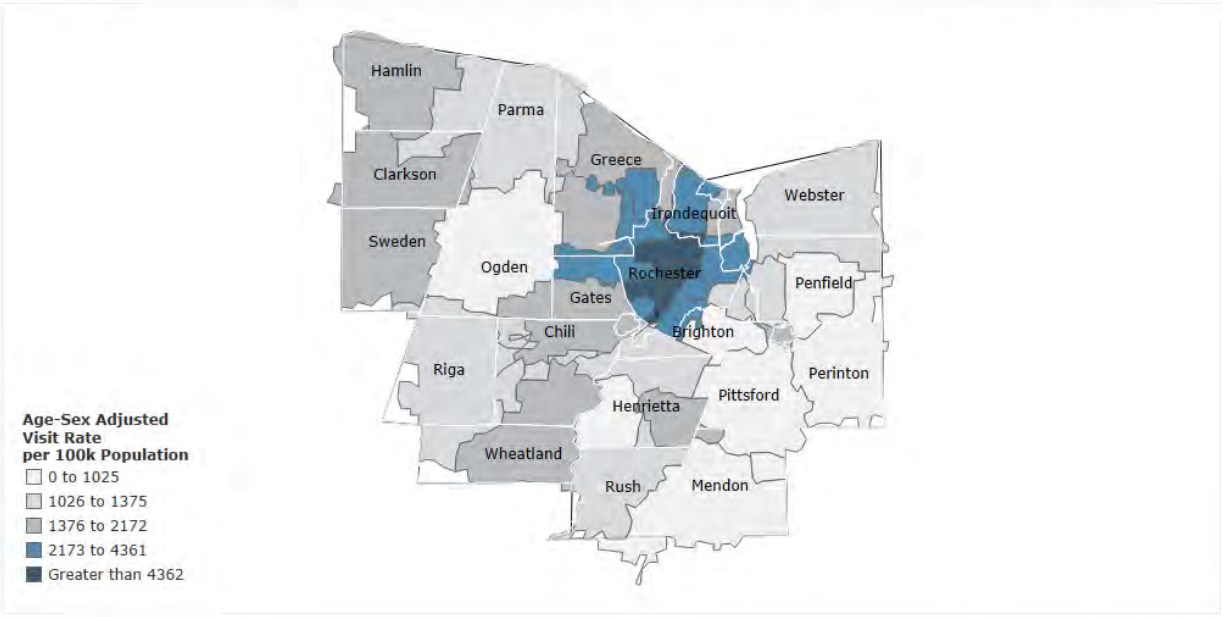


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

ED Utilization Maps (ZIP code and Census Tract)

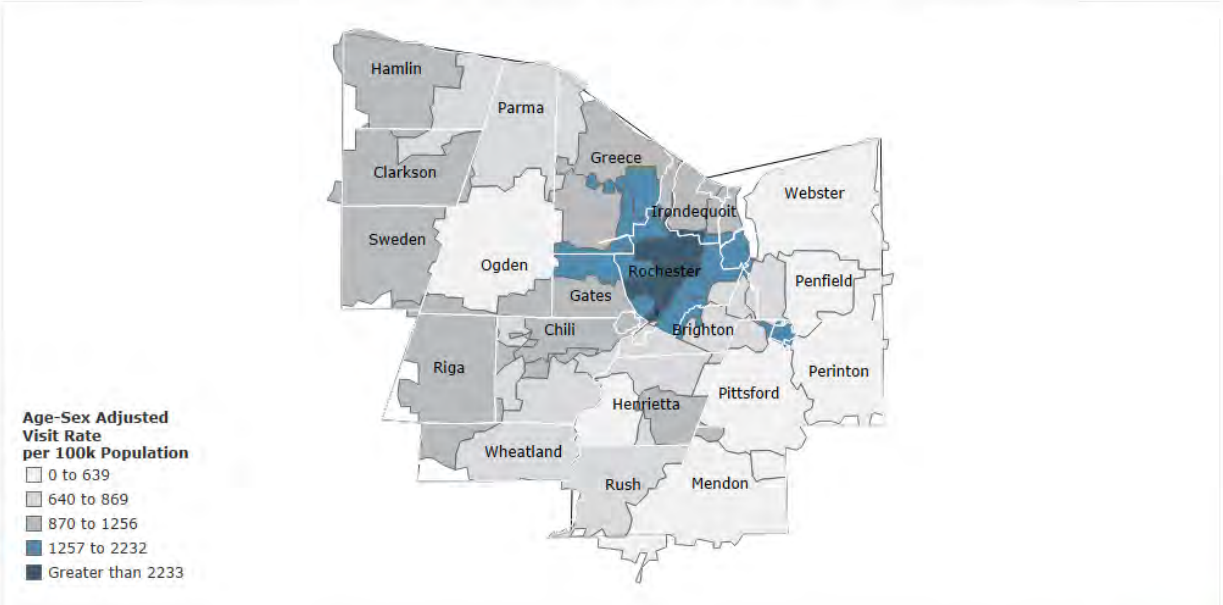
All Behavioral Health Conditions (Primary DX) ED Visit Rate ZIP Code Map
Monroe County Years 2019-2023



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

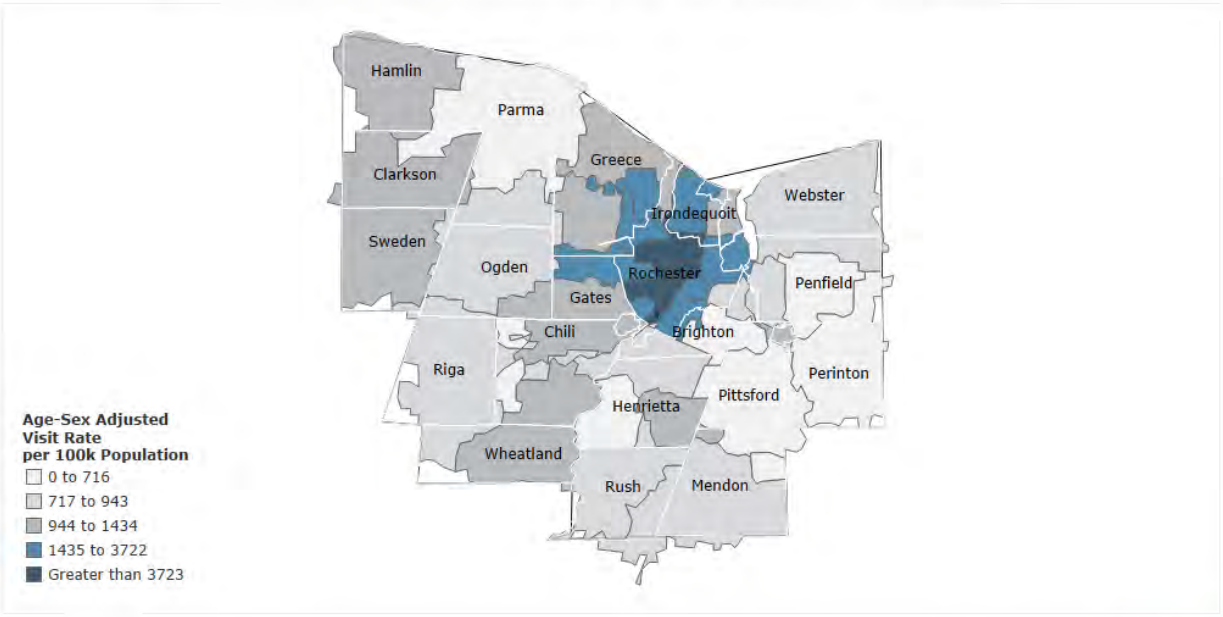
All Mental Health Conditions (Primary DX) ED Visit Rate ZIP Code Map
Monroe County Years 2019-2023



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

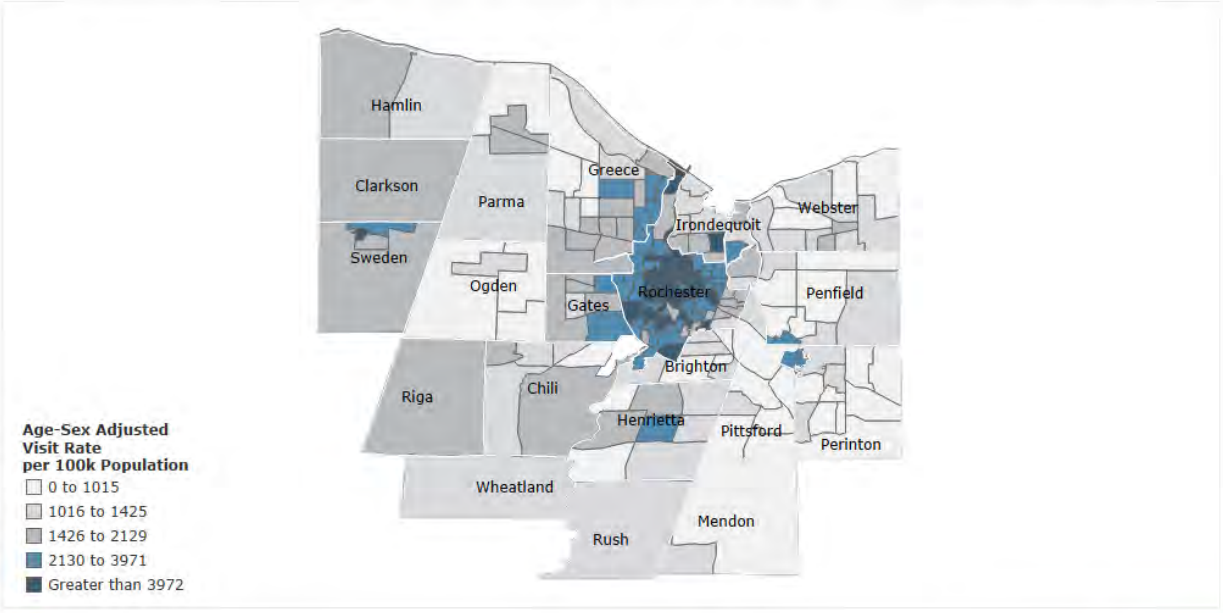
Substance Use Disorders (SUD) ED Visit Rate ZIP Code Map
Monroe County Years 2019-2023



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

All Behavioral Health Conditions (Primary DX) ED Visit Rate Census Tract Map
Monroe County Years 2019-2023

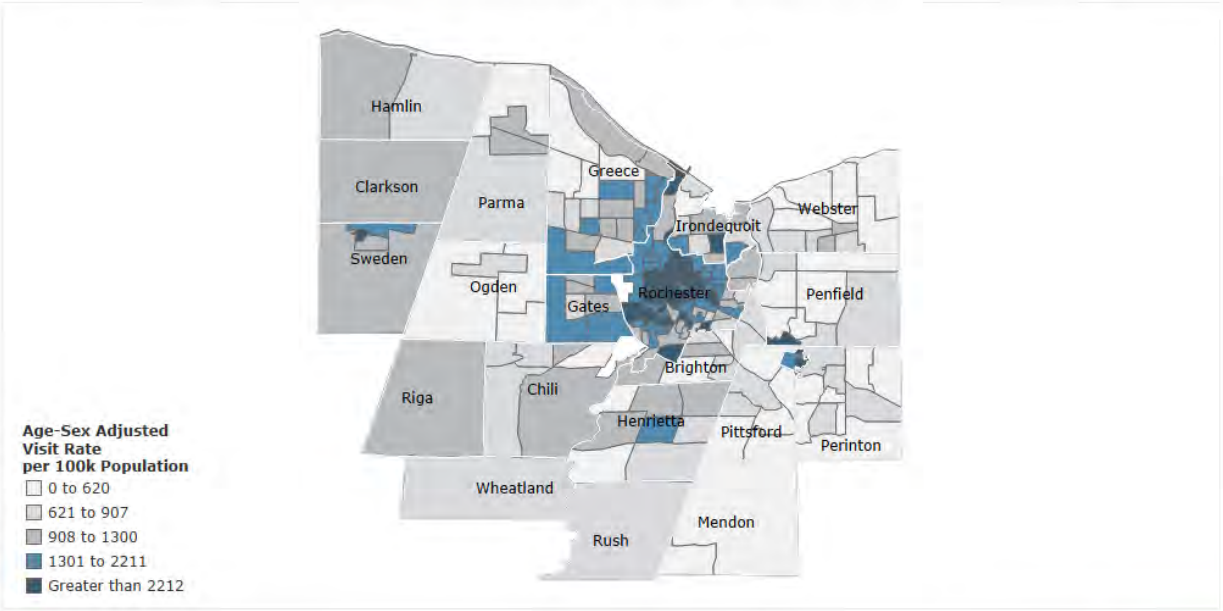


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

All Mental Health Conditions (Primary DX) ED Visit Rate Census Tract Map

Monroe County Years 2019-2023

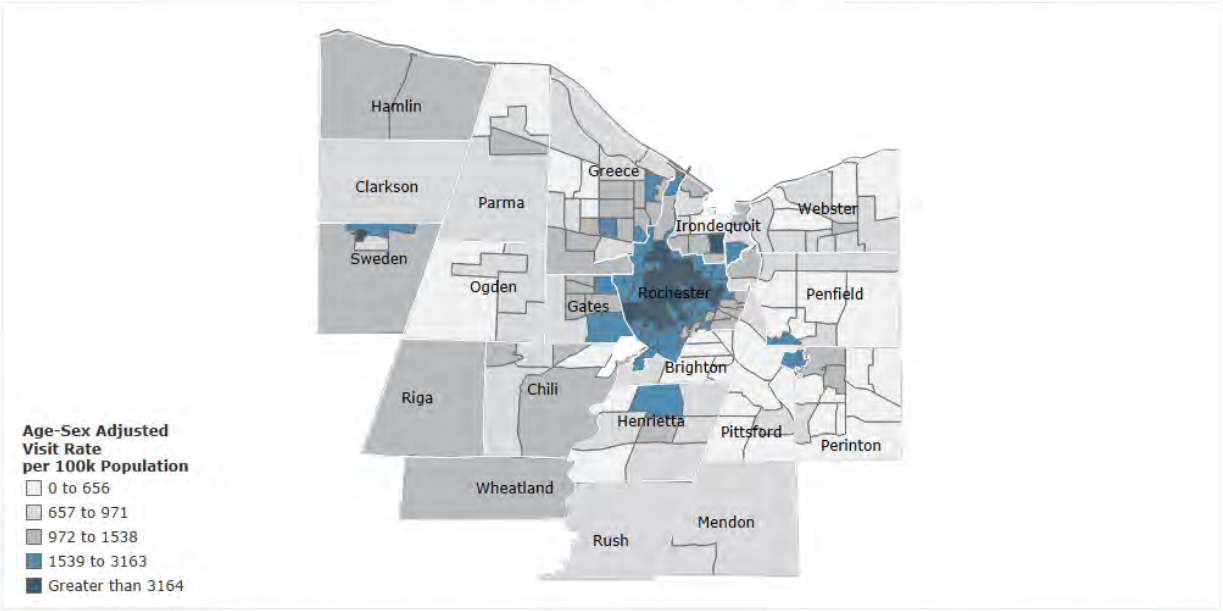


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

Substance Use Disorders (SUD) ED Visit Rate Census Tract Map

Monroe County Years 2019-2023



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

Patients with Multiple ED Visits

Percent of Patients by Number of ED visits in 2023
All Behavior Health Conditions

	Percent of Patients	Number of Patients	Total Patients
1 visit in the year	67%	6,469	9,603
2 visits in the year	20%	1,912	9,603
3 or more visits in the year	13%	1,222	9,603

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

Percent of Patients by Number of ED visits in 2023
Mental Health Conditions

	Percent of Patients	Number of Patients	Total Patients
1 visit in the year	55%	3,166	5,715
2 visits in the year	27%	1,516	5,715
3 or more visits in the year	18%	1,033	5,715

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

Percent of Patients by Number of ED visits in 2023
Substance Use Disorders Conditions

	Percent of Patients	Number of Patients	Total Patients
1 visit in the year	71%	3,262	4,576
2 visits in the year	15%	679	4,576
3 or more visits in the year	14%	635	4,576

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

Percent of Youth (Under 22) by Number of ED visits in 2023
All Behavior Health Conditions

	Percent of Patients	Number of Patients	Total Patients
1 visit in the year	67%	6,469	9,603
2 visits in the year	20%	1,912	9,603
3 or more visits in the year	13%	1,222	9,603

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

Percent of Youth (Under 22) by Number of ED visits in 2023
Mental Health Conditions

	Percent of Patients	Number of Patients	Total Patients
1 visit in the year	54%	931	1,732
2 visits in the year	30%	523	1,732
3 or more visits in the year	16%	278	1,732

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

Common Ground Health

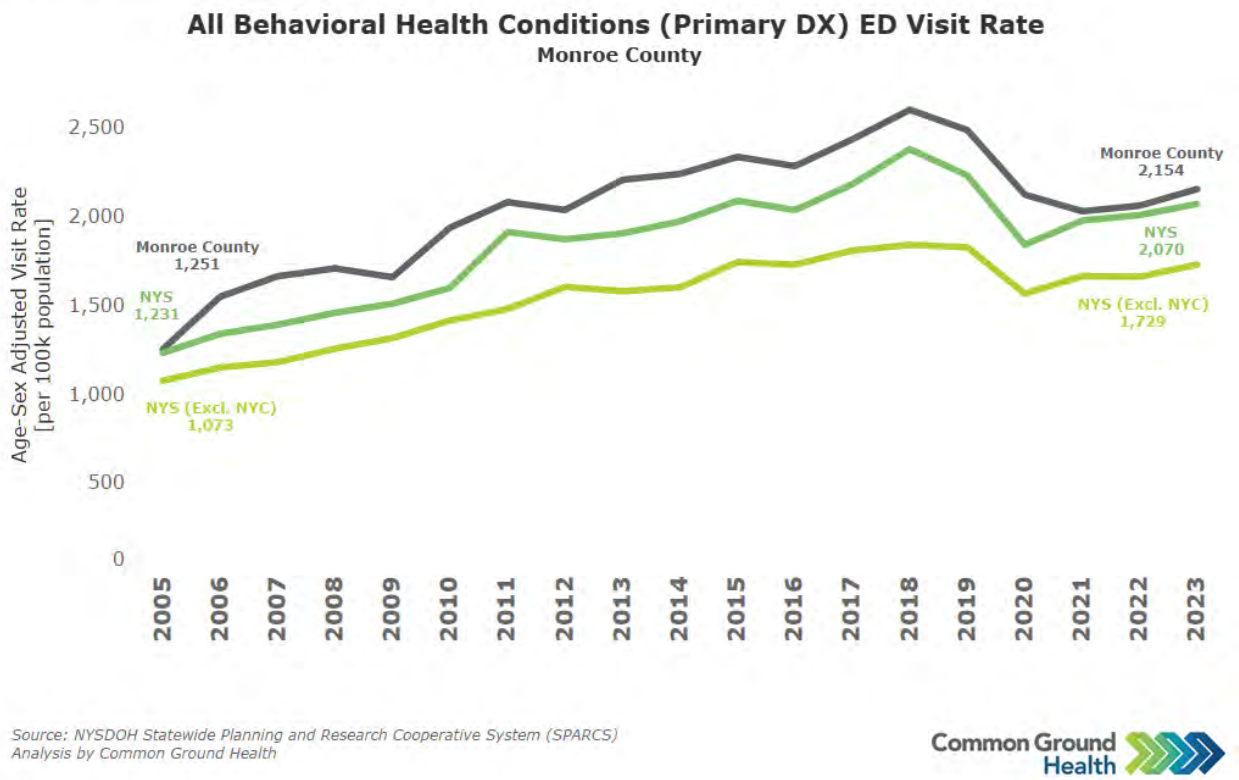
Percent of Youth (Under 22) by Number of ED visits in 2023
Substance Use Disorders Conditions

	Percent of Patients	Number of Patients	Total Patients
1 visit in the year	76%	339	449
2 visits in the year	14%	61	449
3 or more visits in the year	11%	49	449

Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

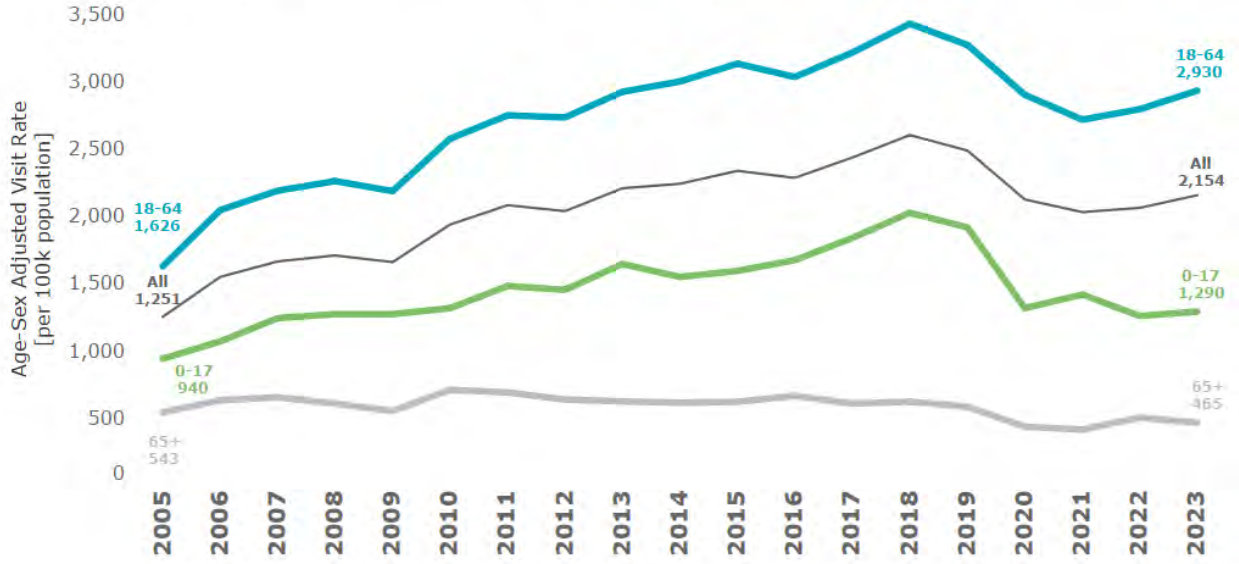
Common Ground Health

ED and Inpatient Visit Trends for All Behavioral Health Conditions



All Behavioral Health Conditions (Primary DX) ED Visit Rate by Age Group

Monroe County

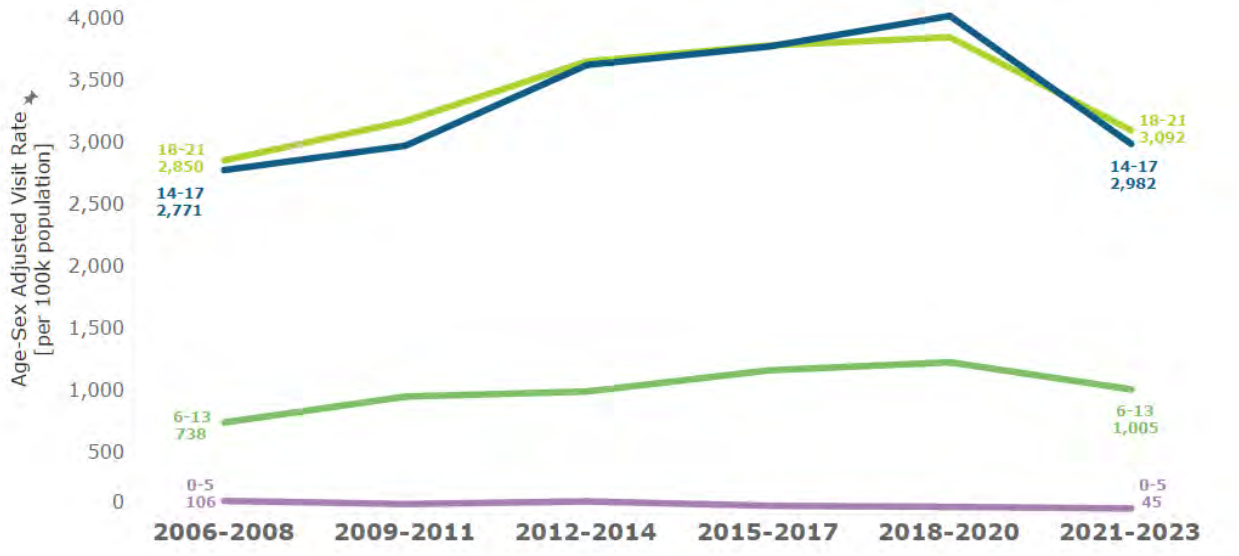


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

All Behavioral Health Conditions (Primary DX) ED Visit Rate by Youth Age Group

Monroe County

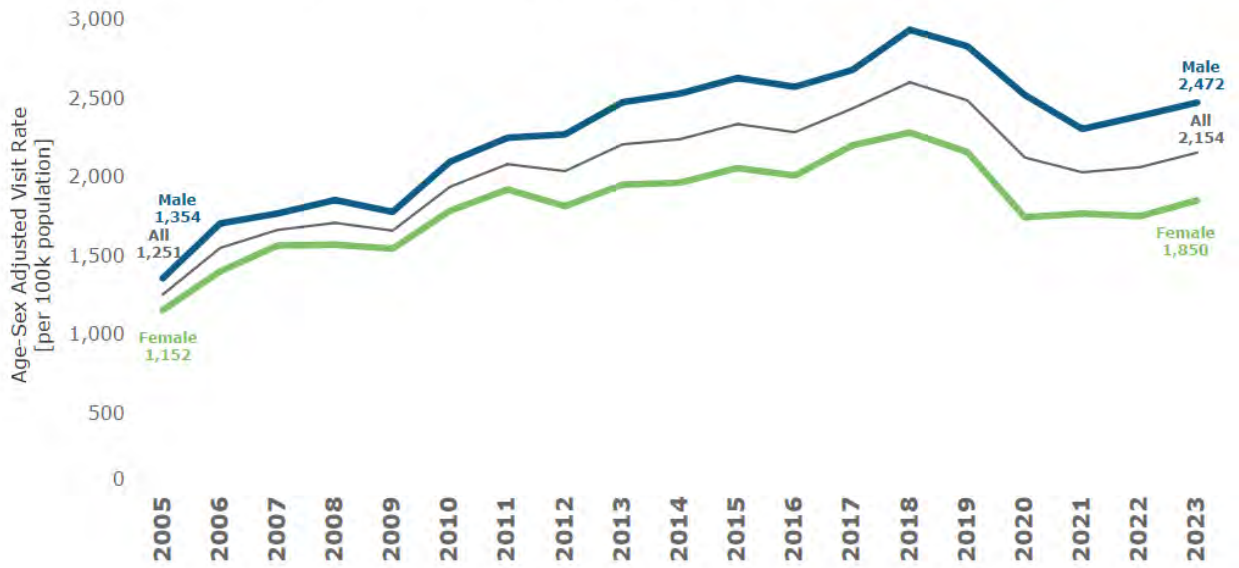


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

All Behavioral Health Conditions (Primary DX) ED Visit Rate by Gender

Monroe County

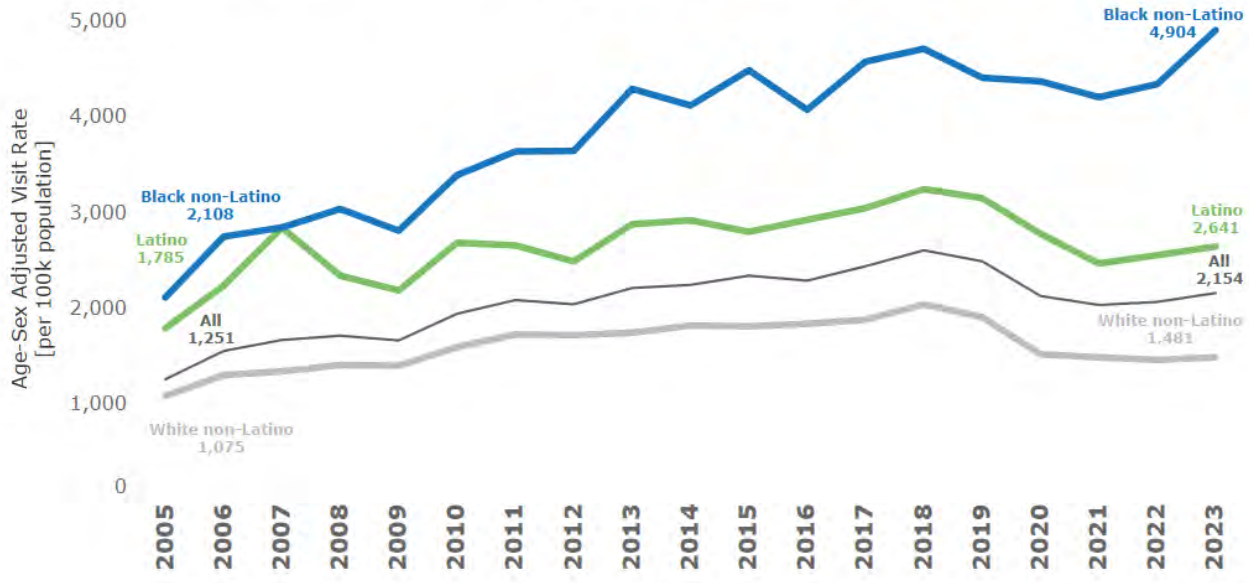


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

All Behavioral Health Conditions (Primary DX) ED Visit Rate by Race/Ethnicity

Monroe County

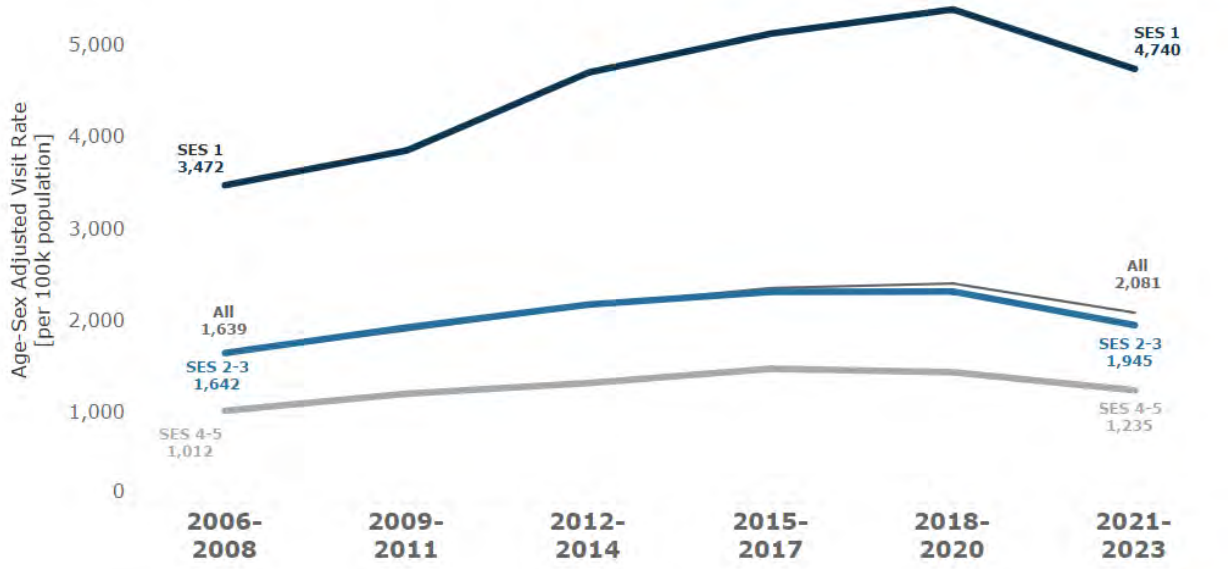


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
All segment is inclusive of all residents in Monroe County. Additional Races (i.e. Asian, American Indian/Alaska Native, etc.) are not shown individually on the chart due to small sample size

Common Ground Health

All Behavioral Health Conditions (Primary DX) ED Visit Rate by SES

Monroe County

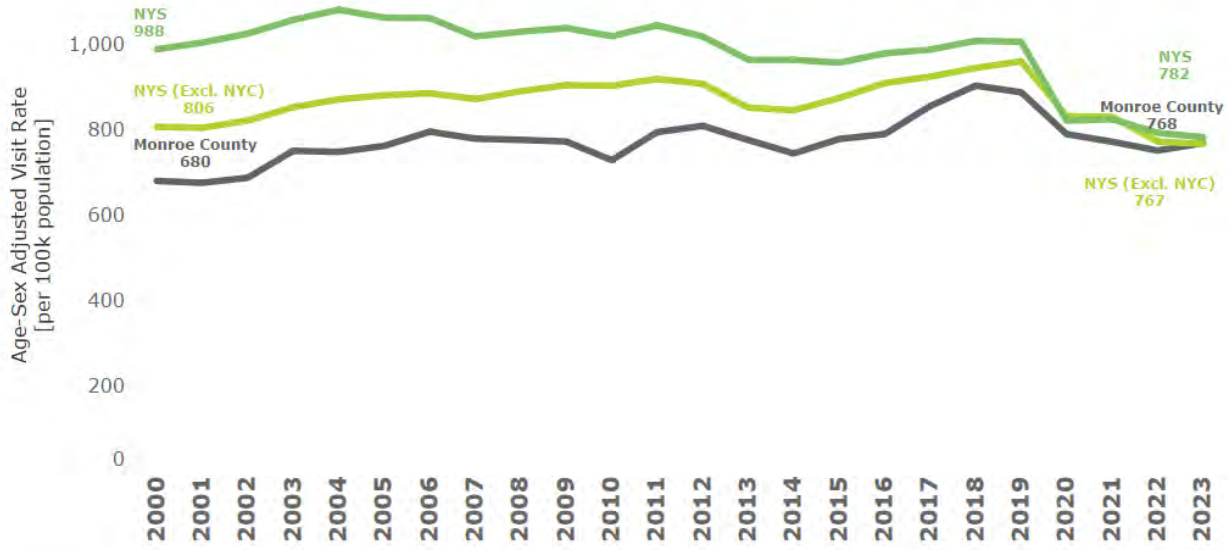


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
Socioeconomic status (SES) is determined by ZIP code. Each data point represents the people who live in ZIP codes with a particular SES level.

Common Ground Health

All Behavioral Health Conditions (Primary DX) Inpatient Visit Rate

Monroe County

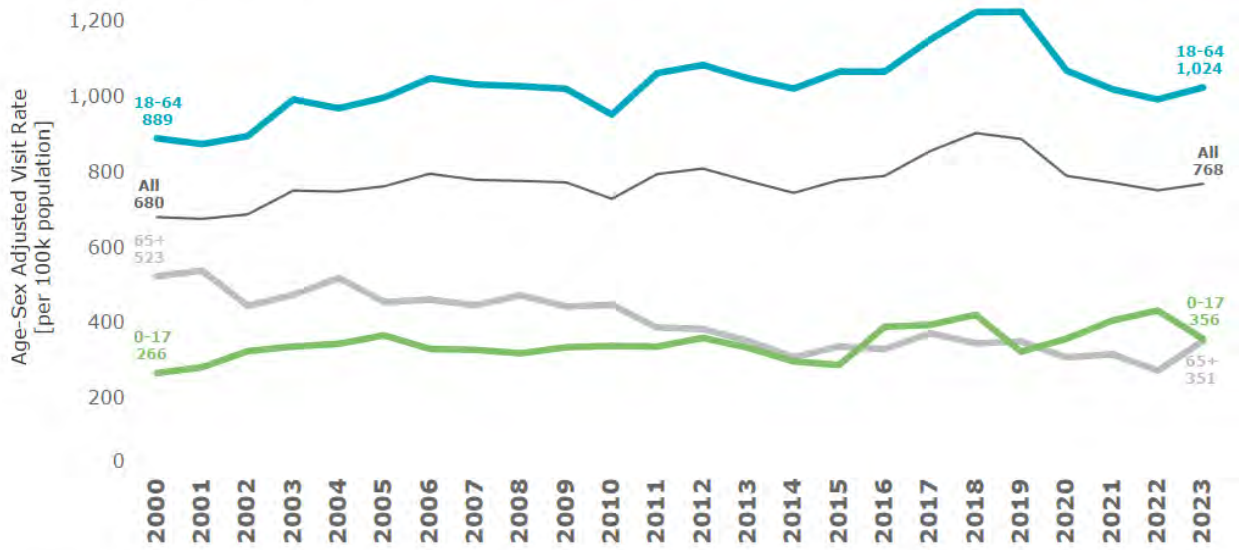


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

All Behavioral Health Conditions (Primary DX) Inpatient Visit Rate by Age Group

Monroe County

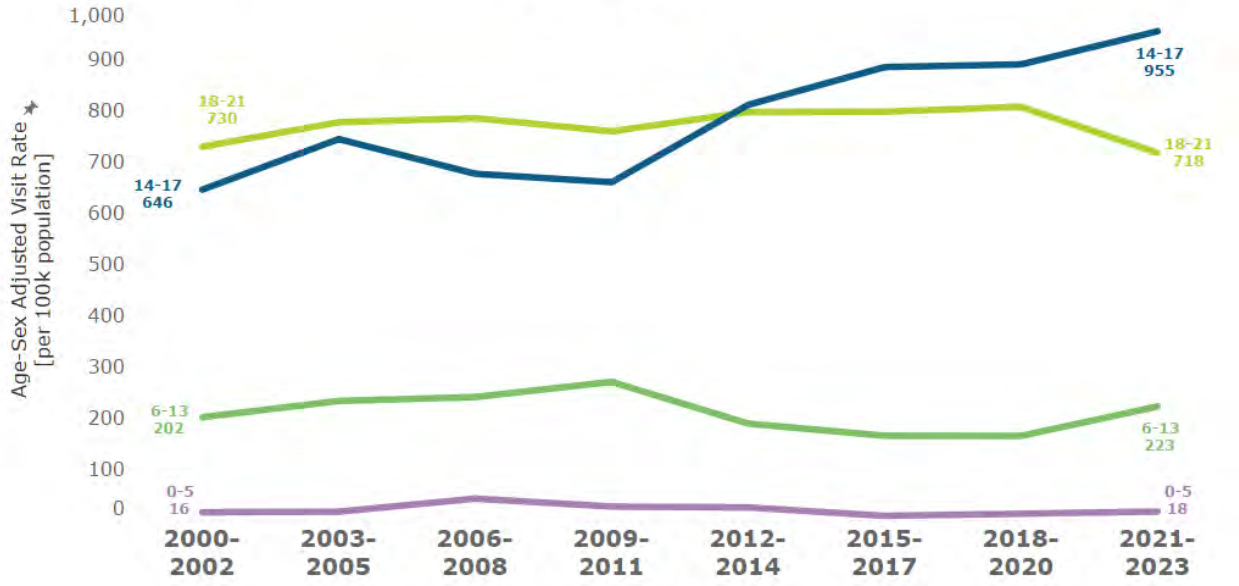


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

All Behavioral Health Conditions (Primary DX) Inpatient Visit Rate by Youth Age Group

Monroe County

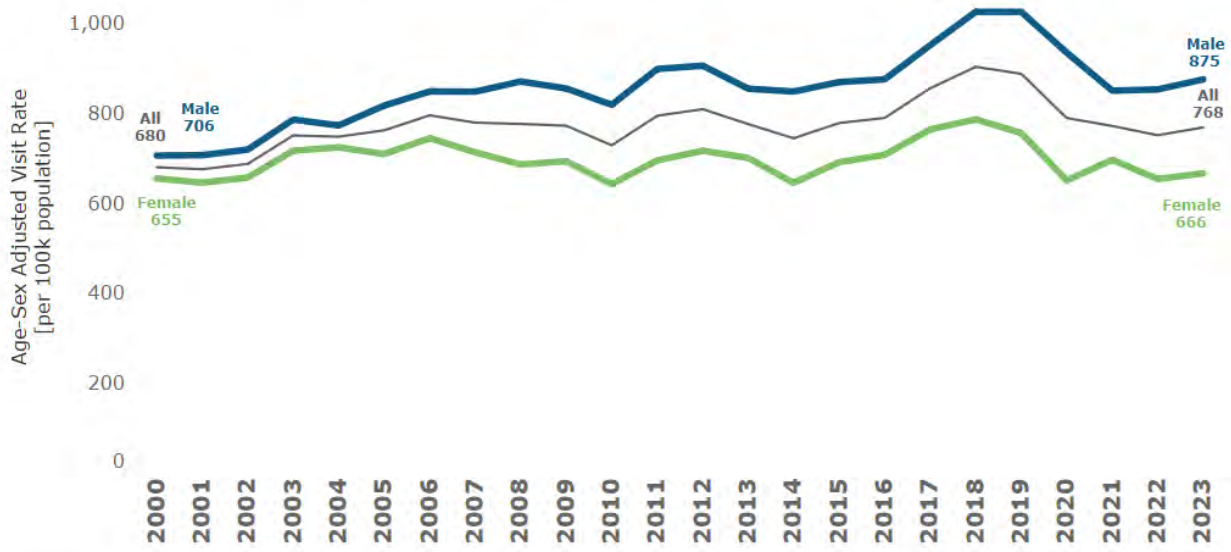


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

All Behavioral Health Conditions (Primary DX) Inpatient Visit Rate by Gender

Monroe County

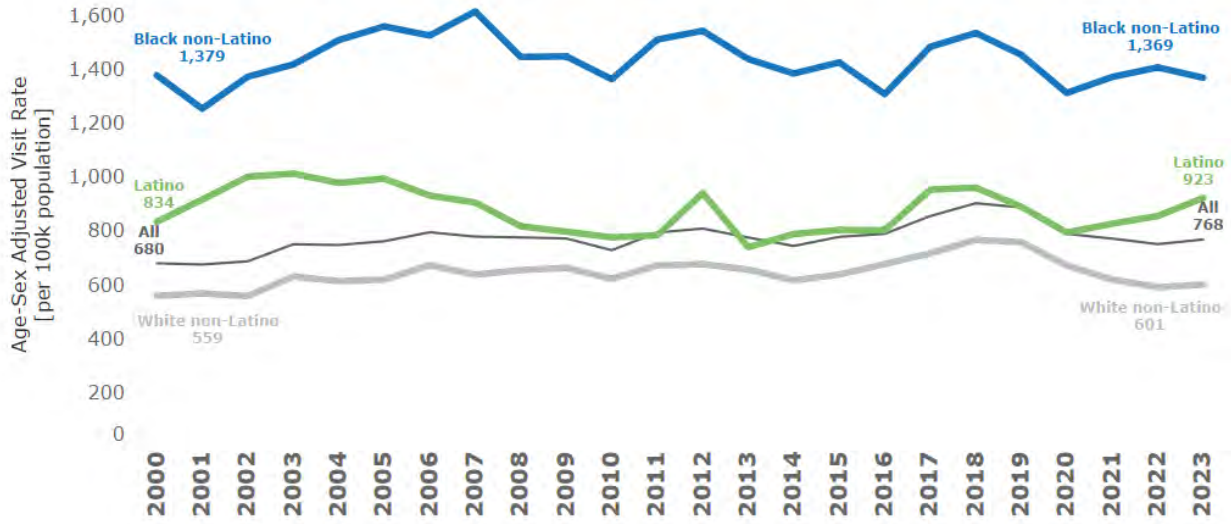


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

All Behavioral Health Conditions (Primary DX) Inpatient Visit Rate by Race/Ethnicity

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
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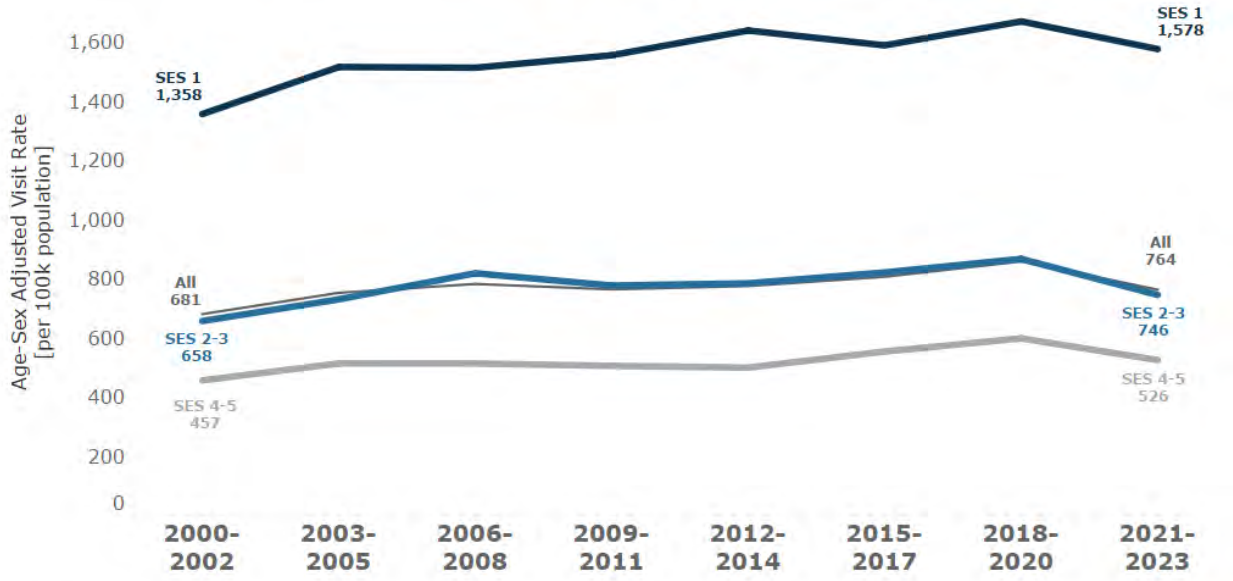
Common Ground Health

All Behavioral Health Conditions (Primary DX) Inpatient Visit Rate by SES

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
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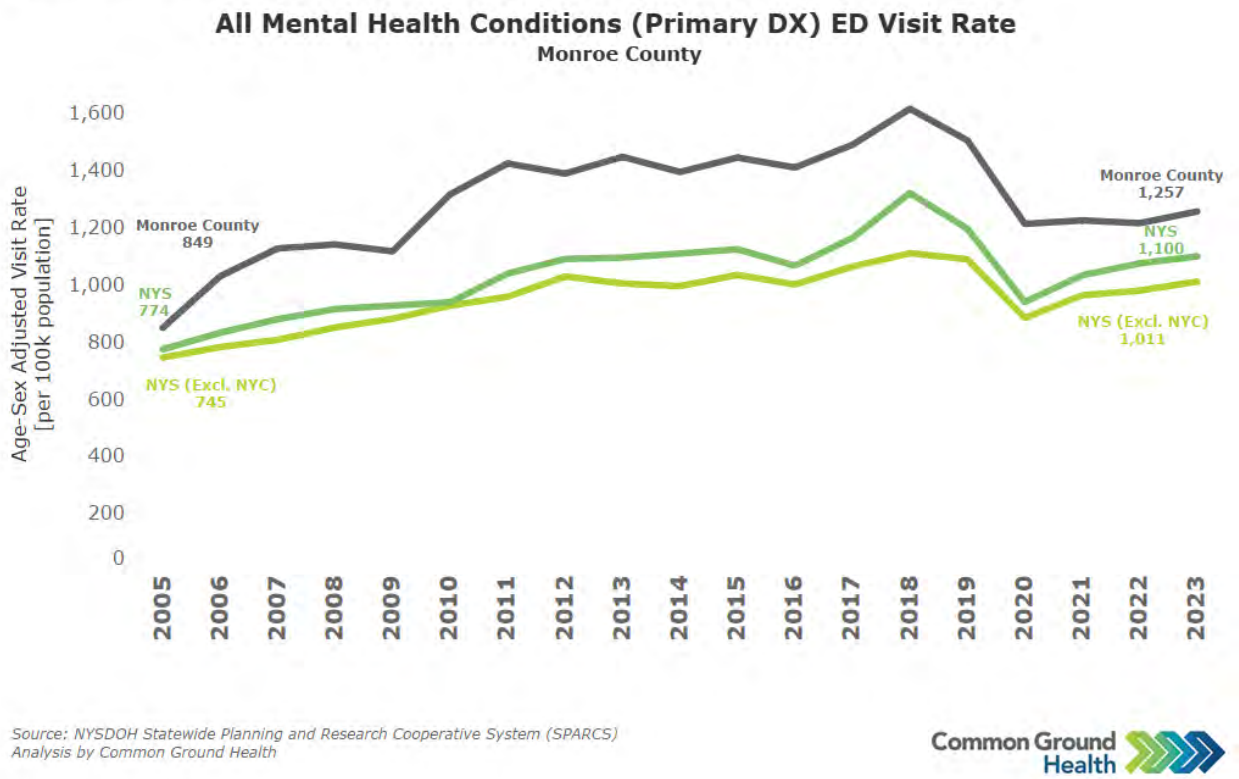
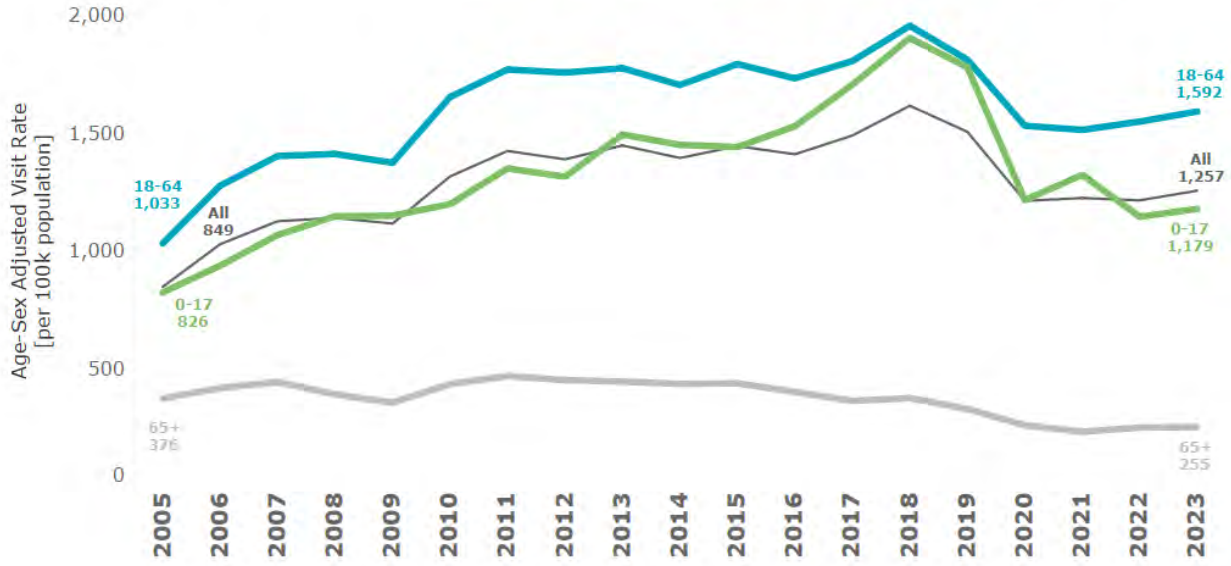
Common Ground Health

ED and Inpatient Visit Trends for All Mental Health Conditions



All Mental Health Conditions (Primary DX) ED Visit Rate by Age Group

Monroe County

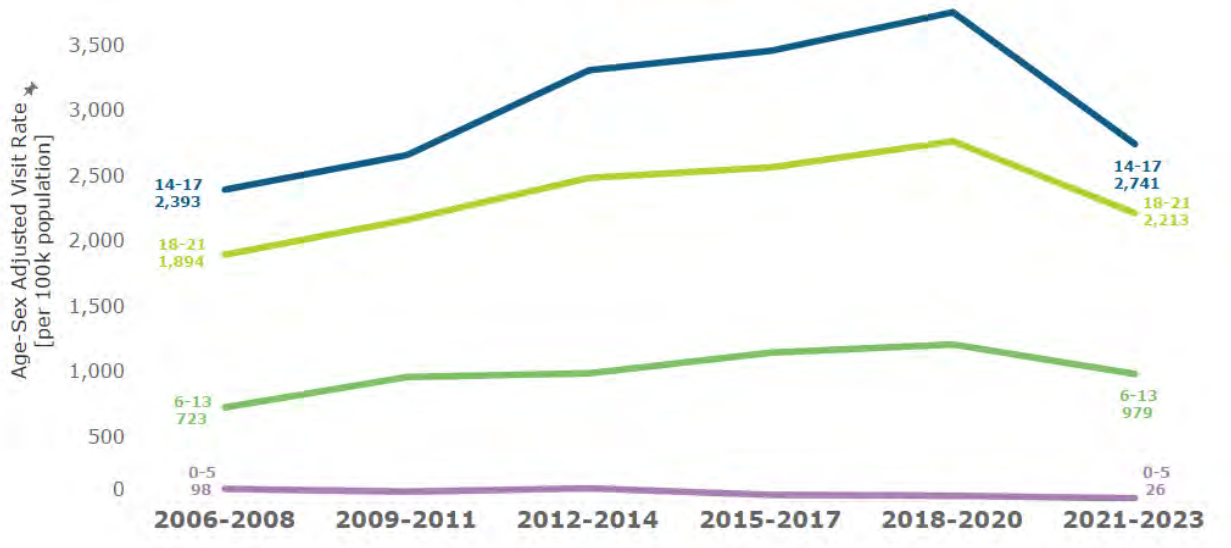


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

All Mental Health Conditions (Primary DX) ED Visit Rate by Youth Age Group

Monroe County

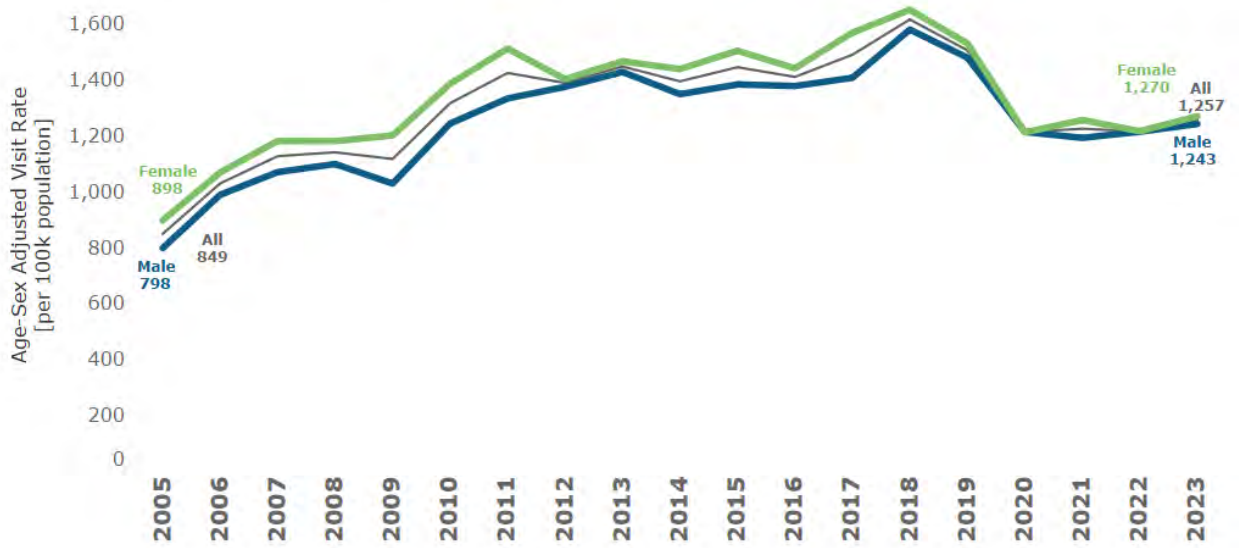


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

All Mental Health Conditions (Primary DX) ED Visit Rate by Gender

Monroe County

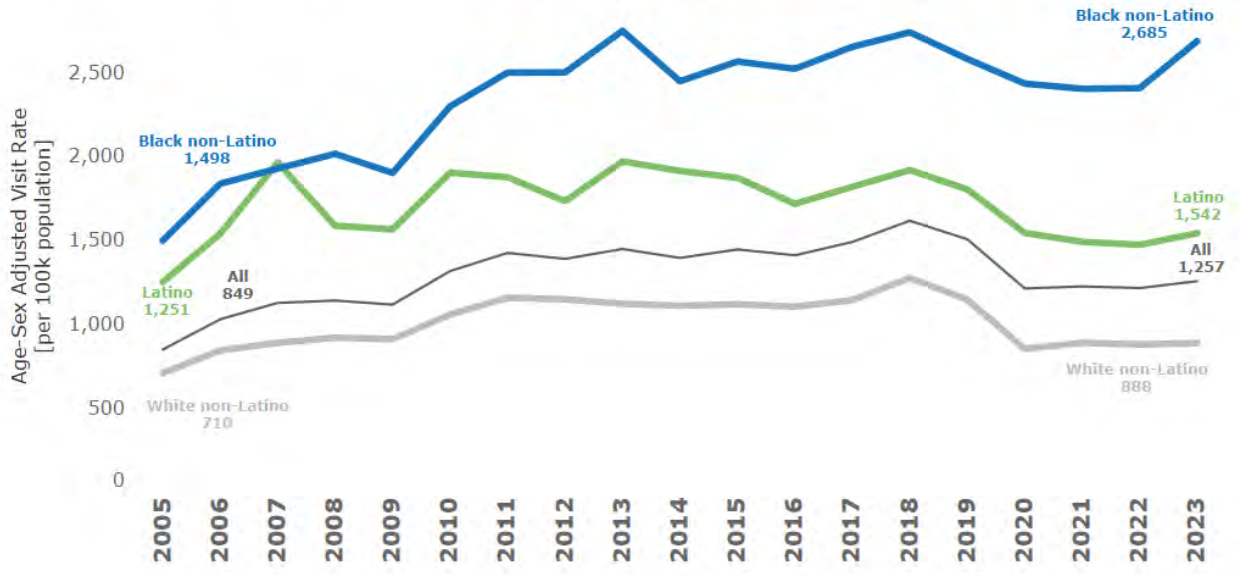


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

All Mental Health Conditions (Primary DX) ED Visit Rate by Race/Ethnicity

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
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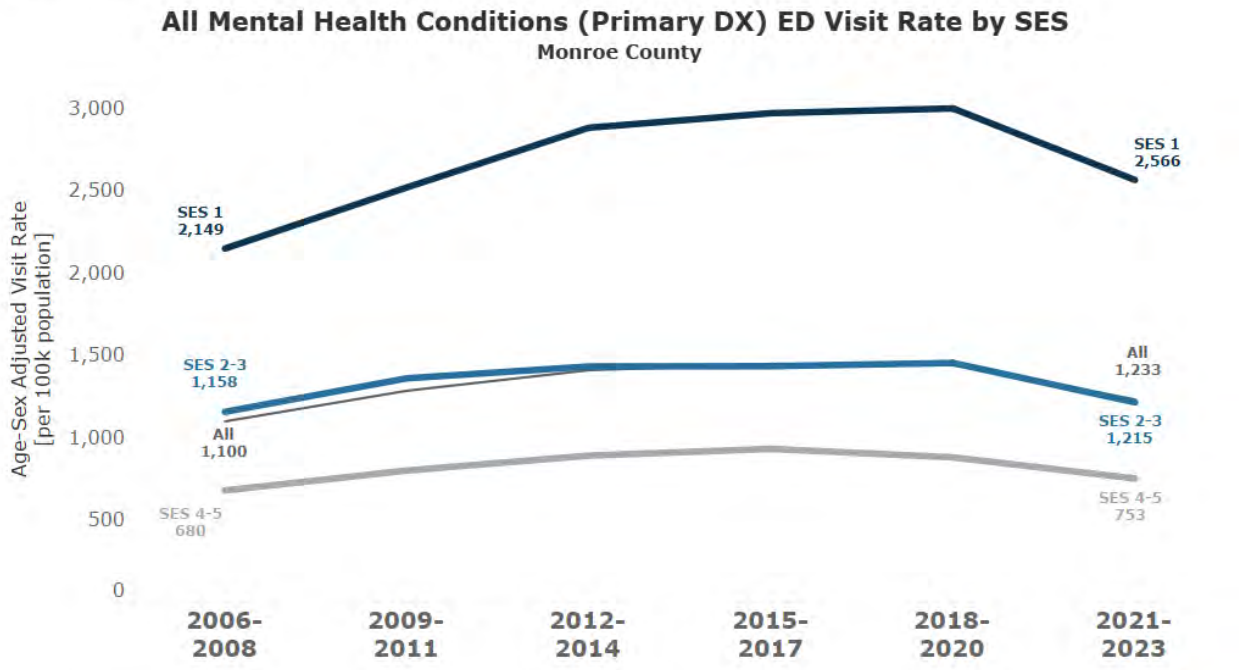
Common Ground Health



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
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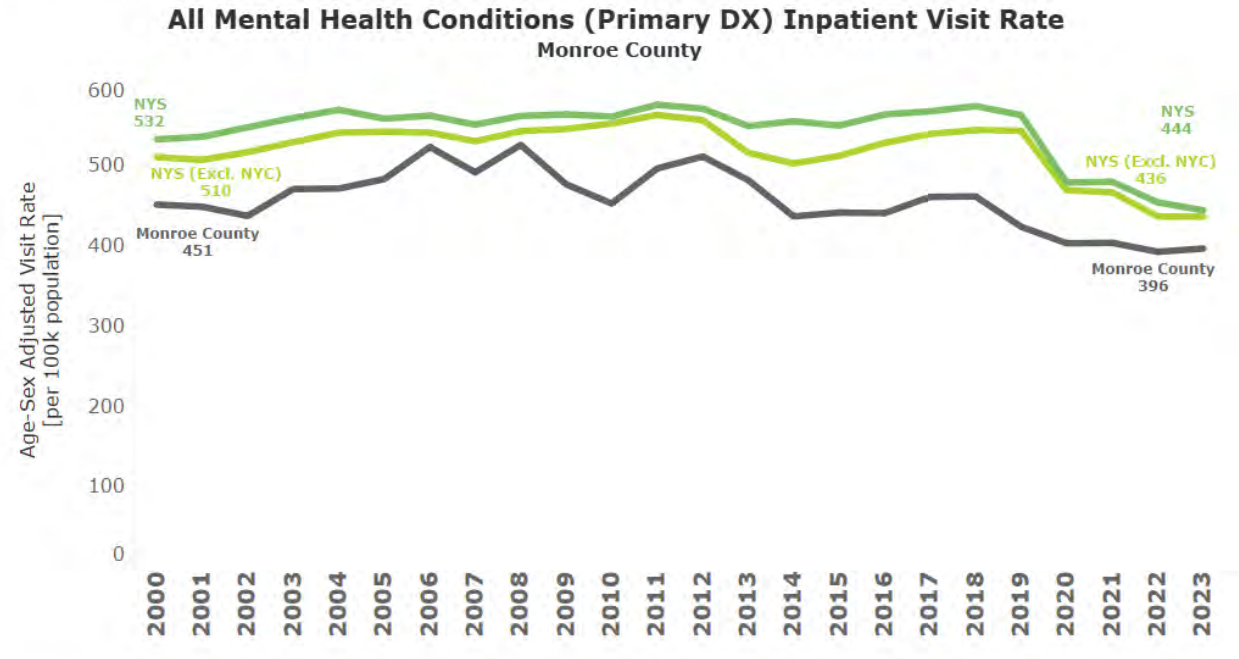
Common Ground Health

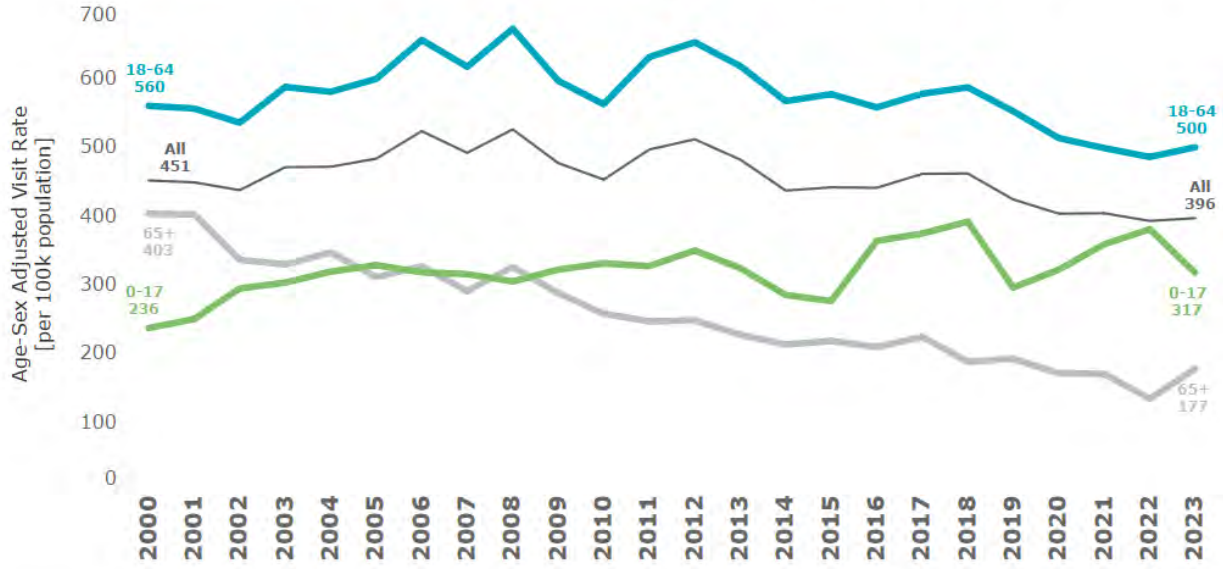


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

All Mental Health Conditions (Primary DX) Inpatient Visit Rate by Age Group

Monroe County

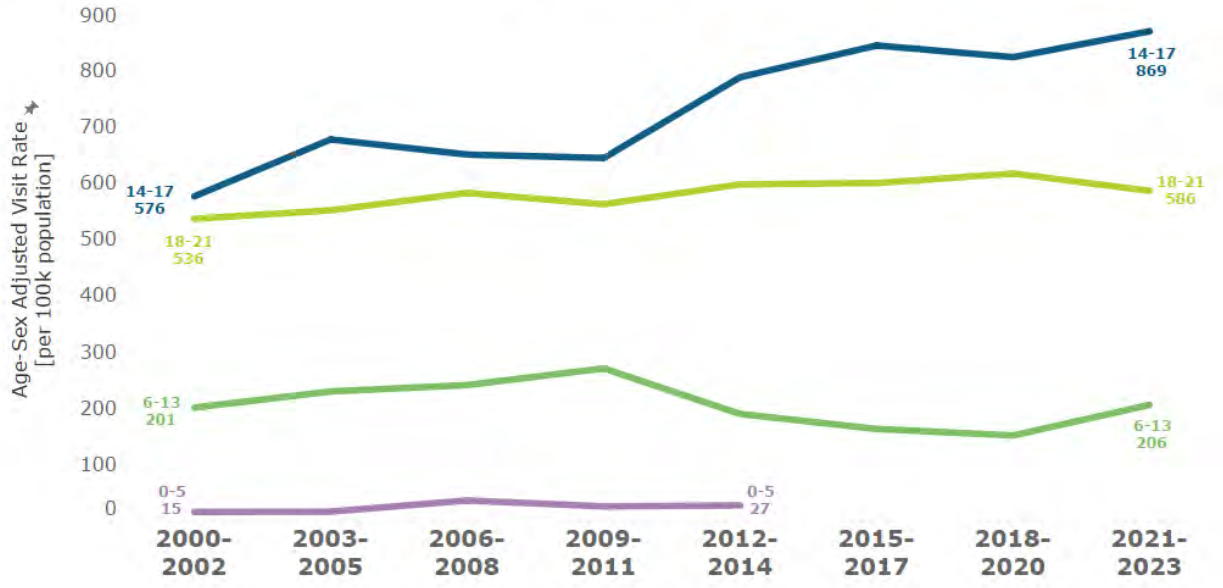


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

All Mental Health Conditions (Primary DX) Inpatient Visit Rate by Youth Age Group

Monroe County

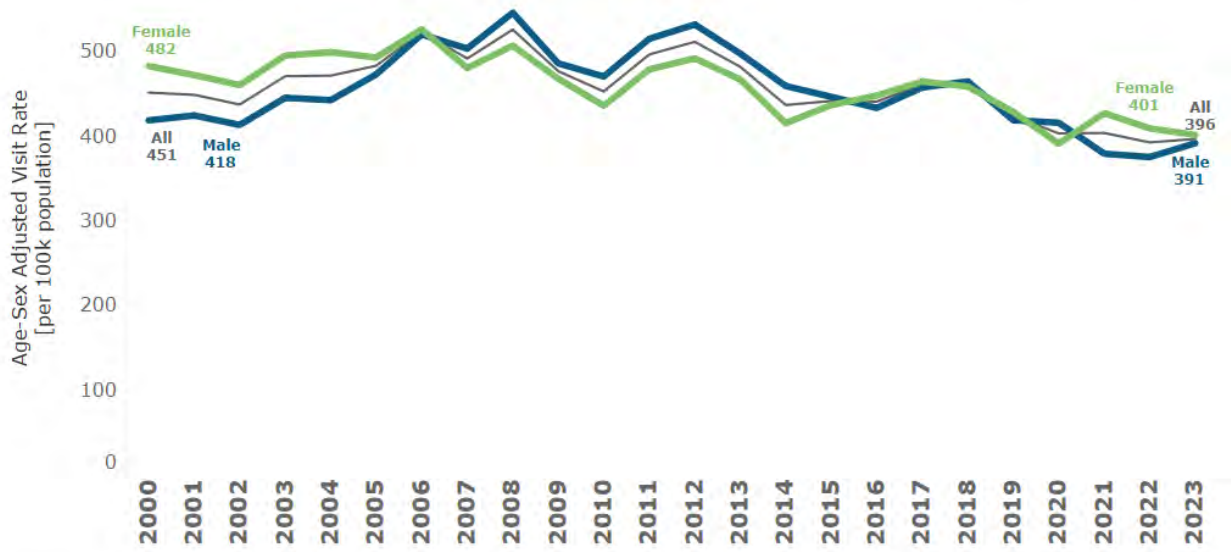


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

All Mental Health Conditions (Primary DX) Inpatient Visit Rate by Gender

Monroe County

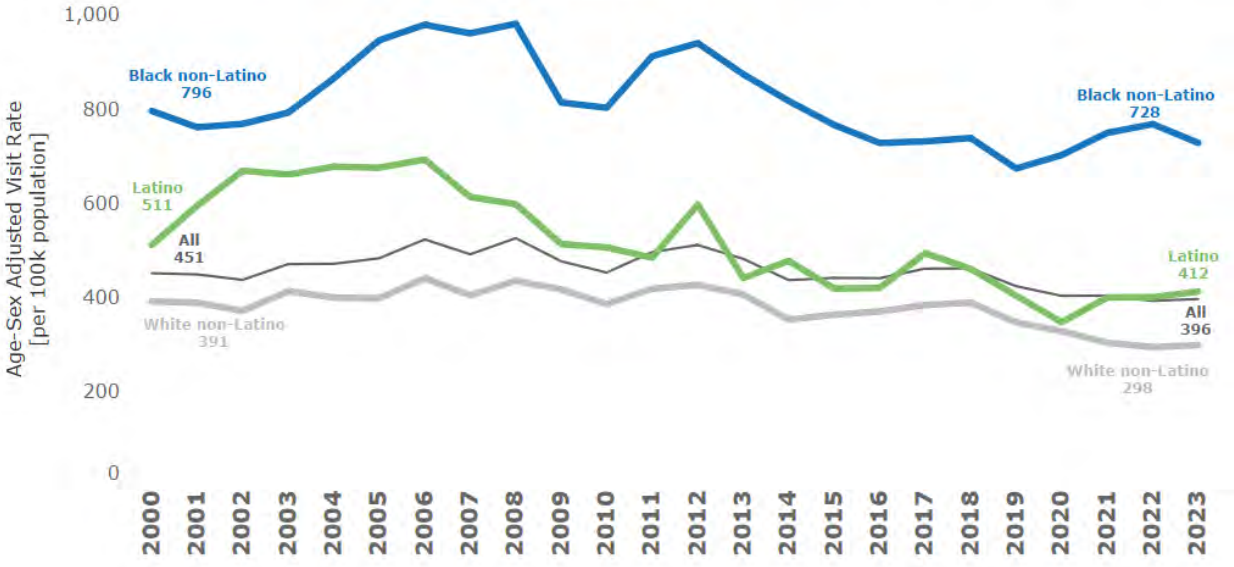


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

All Mental Health Conditions (Primary DX) Inpatient Visit Rate by Race/Ethnicity

Monroe County



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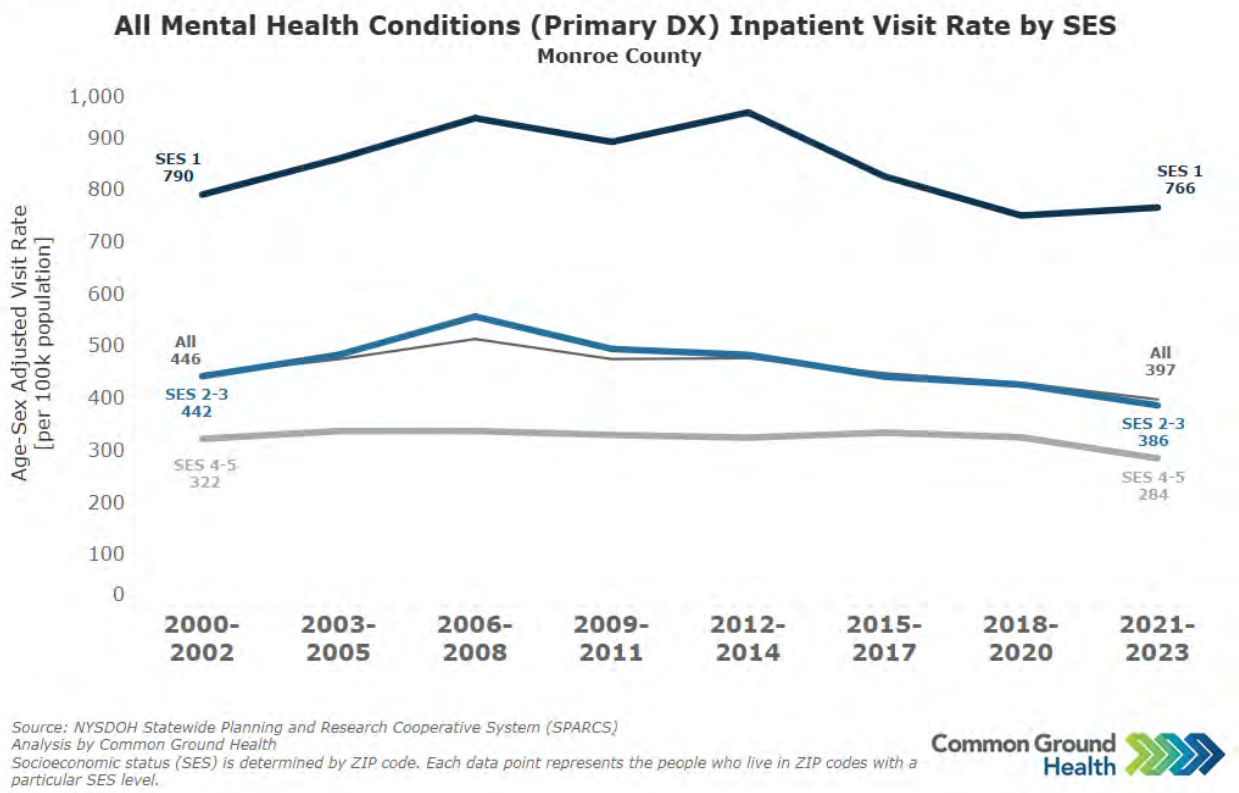
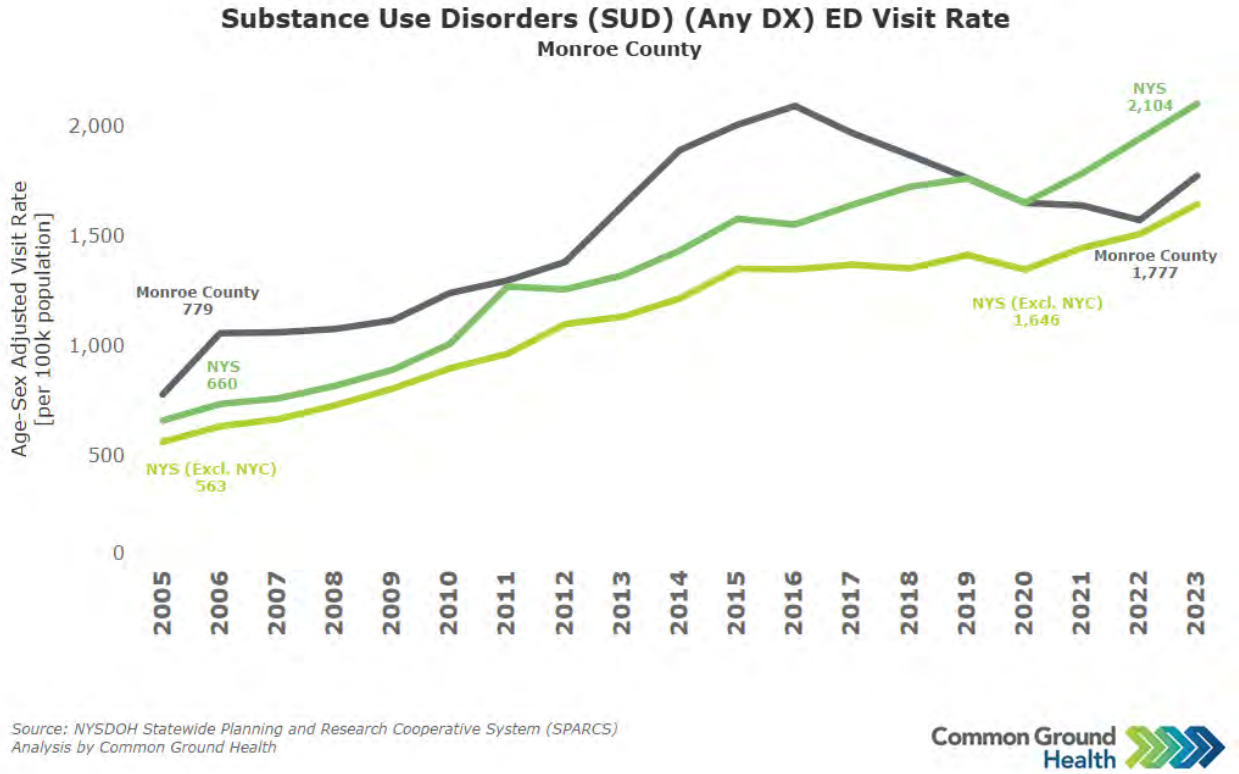
Common Ground Health



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
Socioeconomic status (SES) is determined by ZIP code. Each data point represents the people who live in ZIP codes with a particular SES level.

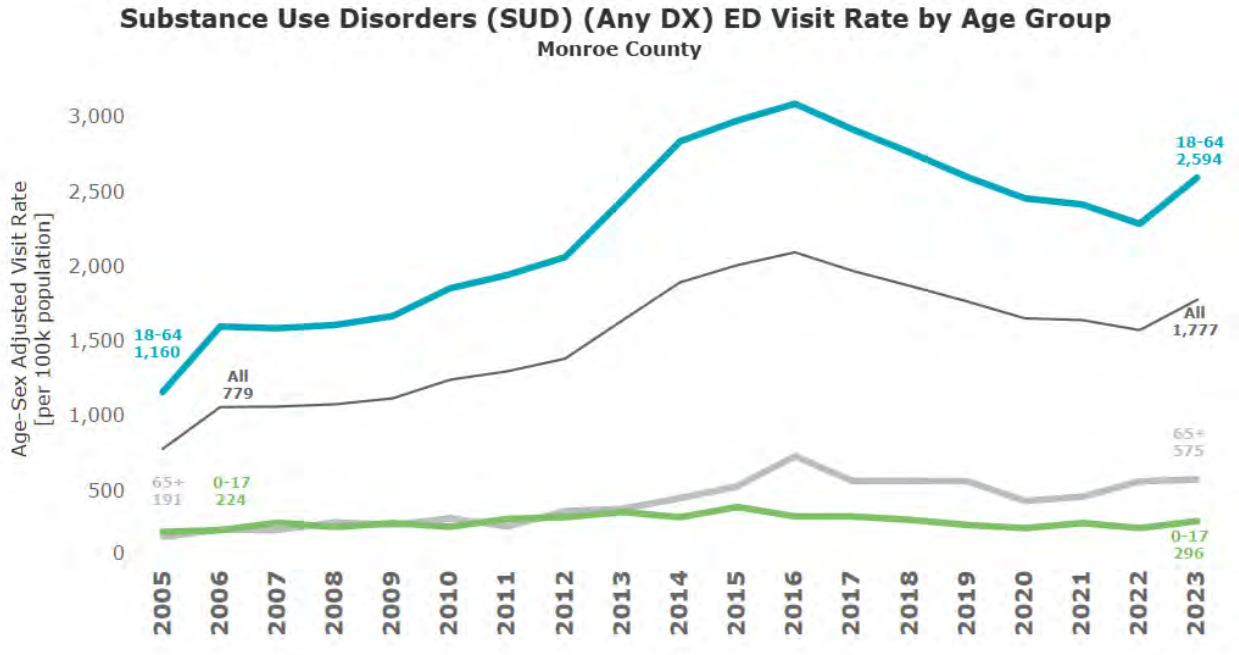
Common Ground Health

ED and Inpatient Visit Trends for Substance Use



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

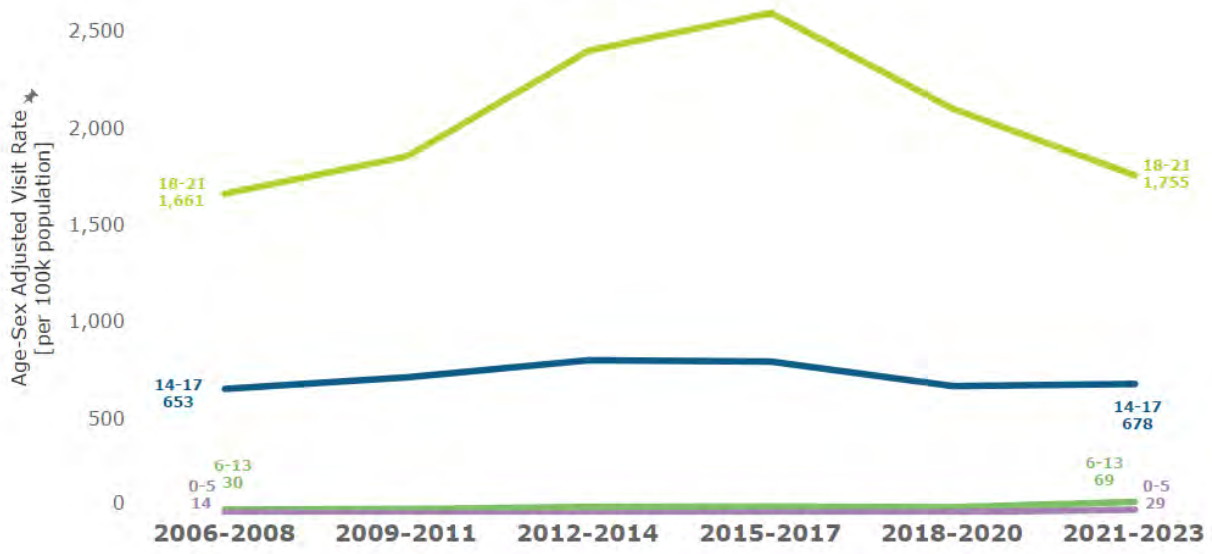


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Substance Use Disorders (SUD) ED Visit Rate by Youth Age Group

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

Substance Use Disorders (SUD) (Any DX) ED Visit Rate by Gender

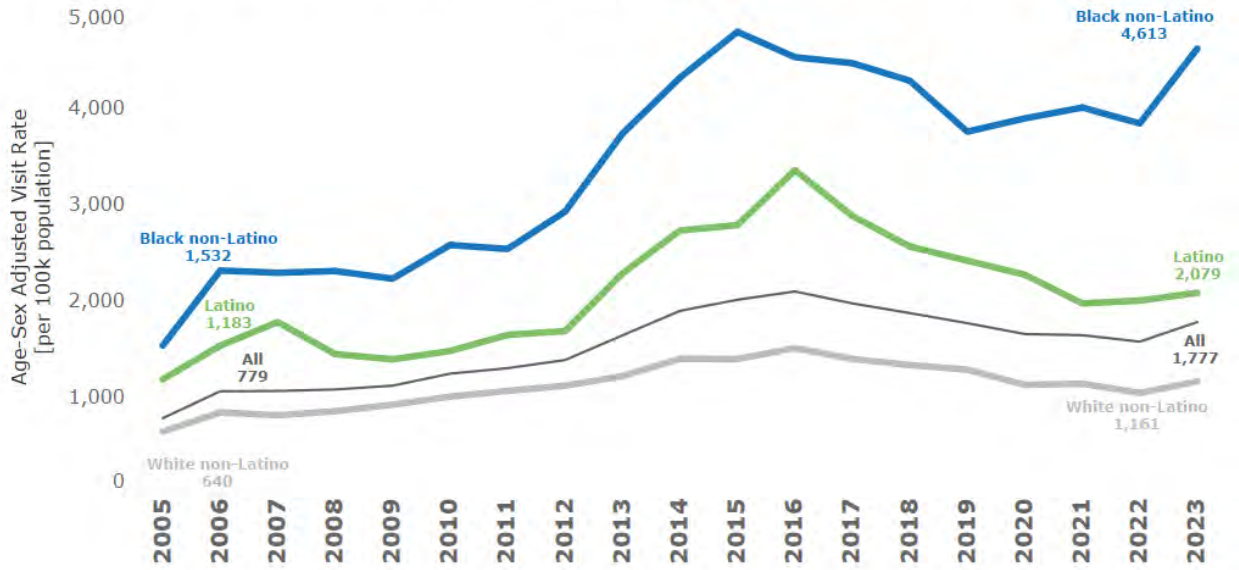
Monroe County

Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Substance Use Disorders (SUD) (Any DX) ED Visit Rate by Race/Ethnicity

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
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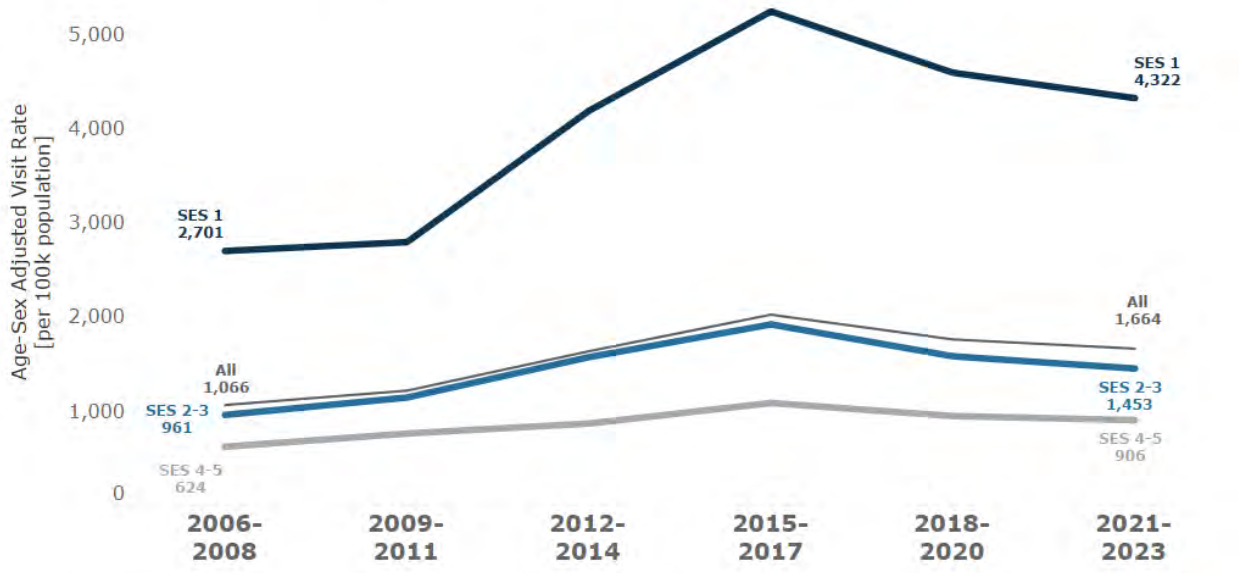
Common Ground Health

Substance Use Disorders (SUD) (Any DX) ED Visit Rate by SES

Monroe County

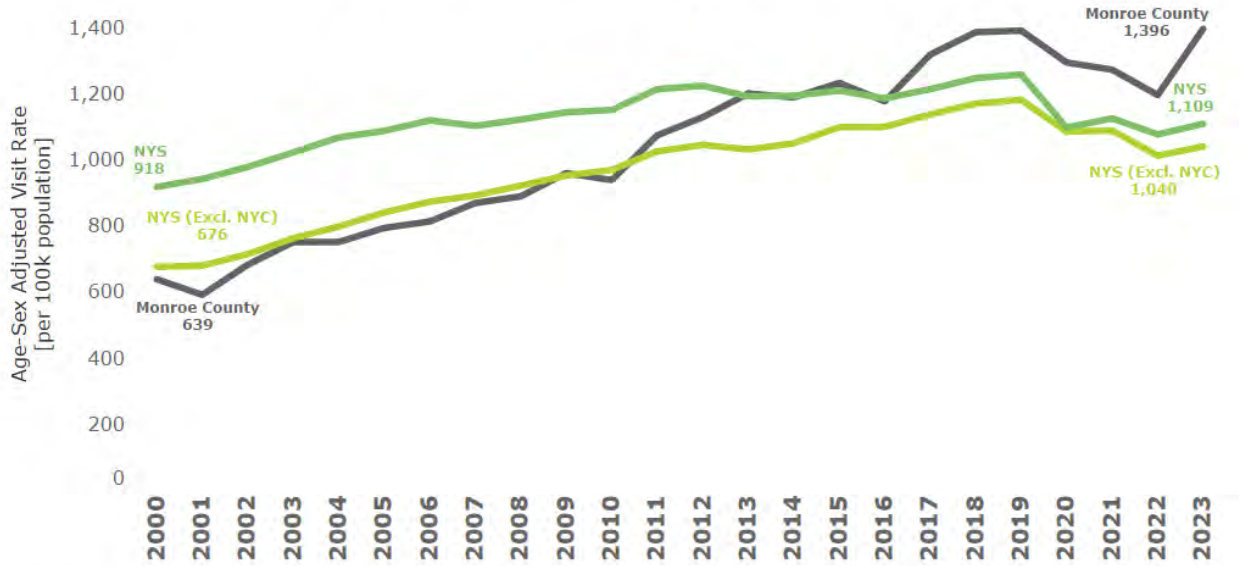


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
Socioeconomic status (SES) is determined by ZIP code. Each data point represents the people who live in ZIP codes with a particular SES level.

Common Ground Health

Substance Use Disorders (SUD) (Any DX) Inpatient Visit Rate

Monroe County

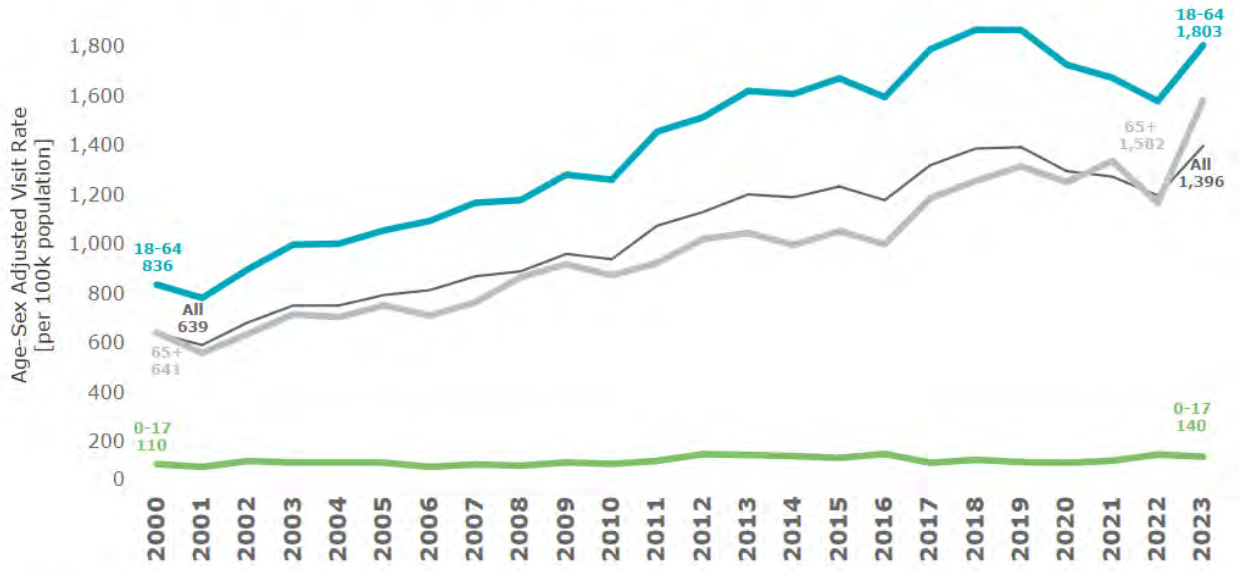


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Substance Use Disorders (SUD) (Any DX) Inpatient Visit Rate by Age Group

Monroe County

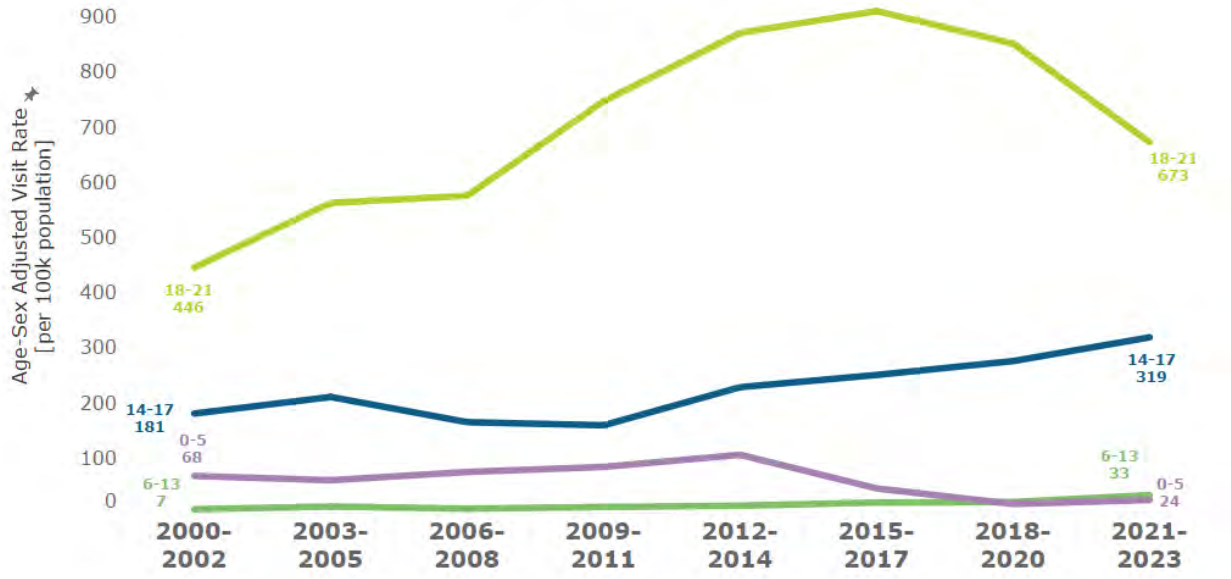


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Substance Use Disorders (SUD) Inpatient Visit Rate by Youth Age Group

Monroe County

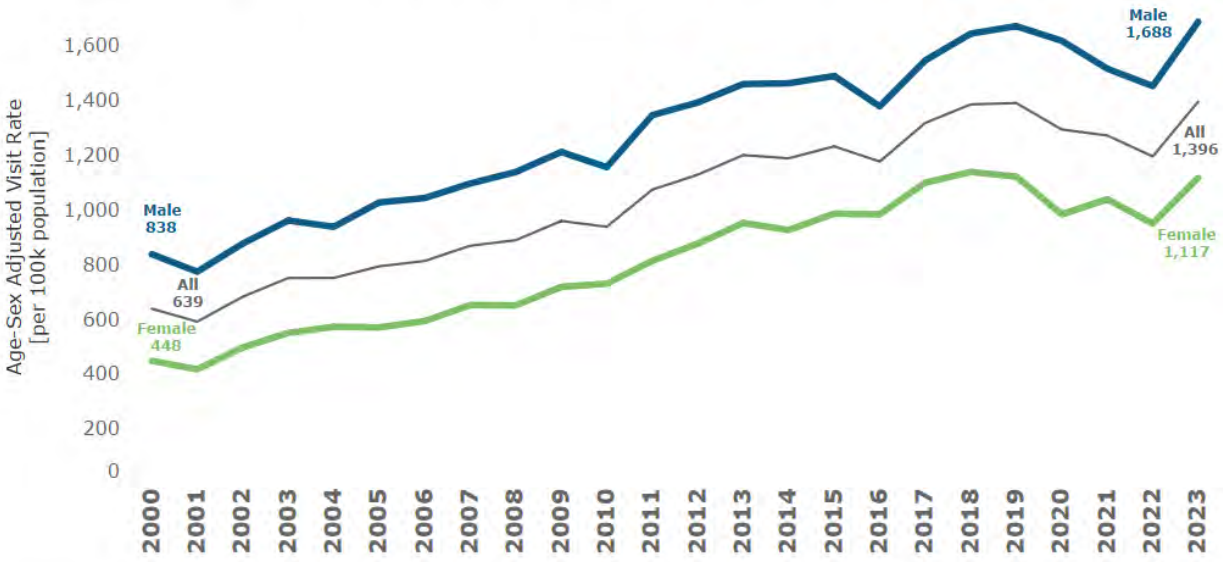


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

Substance Use Disorders (SUD) (Any DX) Inpatient Visit Rate by Gender

Monroe County

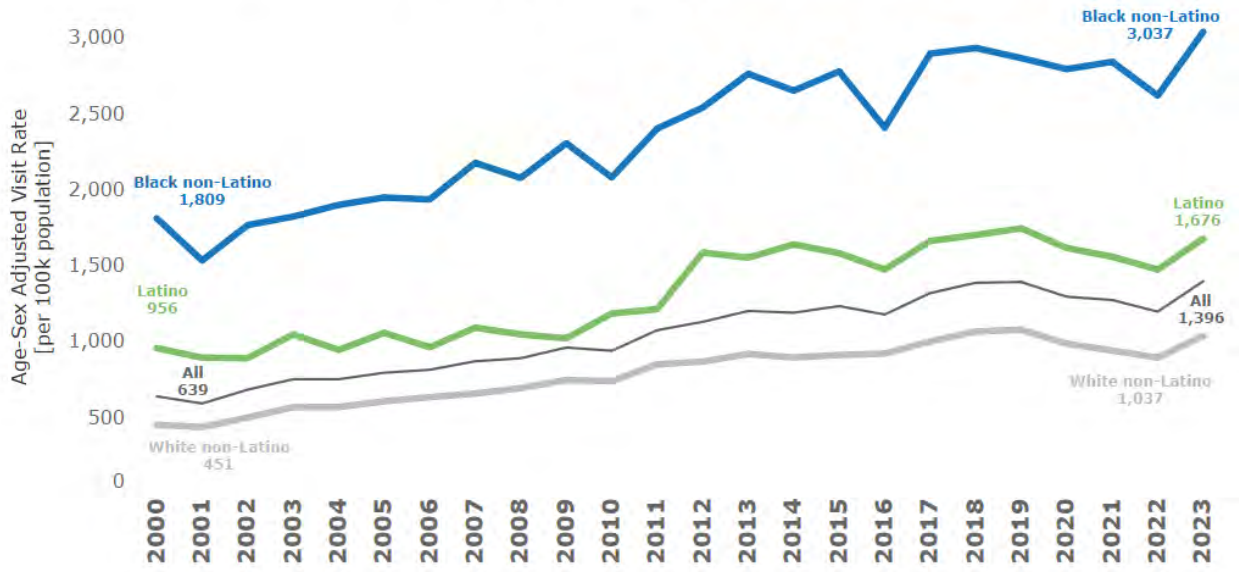


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Substance Use Disorders (SUD) (Any DX) Inpatient Visit Rate by Race/Ethnicity

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
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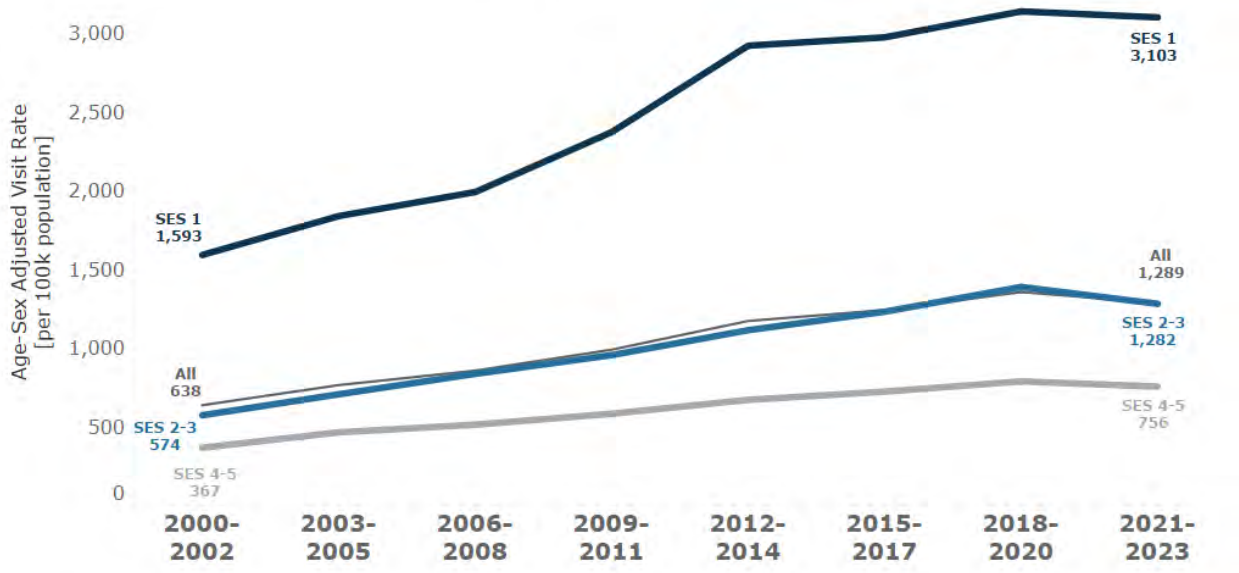
Common Ground Health

Substance Use Disorders (SUD) (Any DX) Inpatient Visit Rate by SES

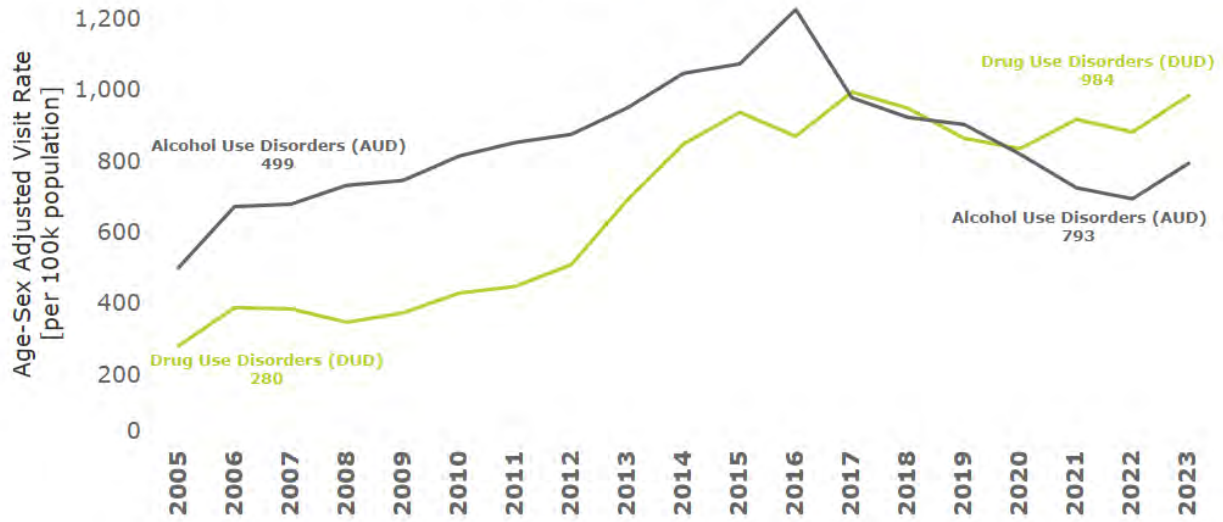
Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
Socioeconomic status (SES) is determined by ZIP code. Each data point represents the people who live in ZIP codes with a particular SES level.

Common Ground Health

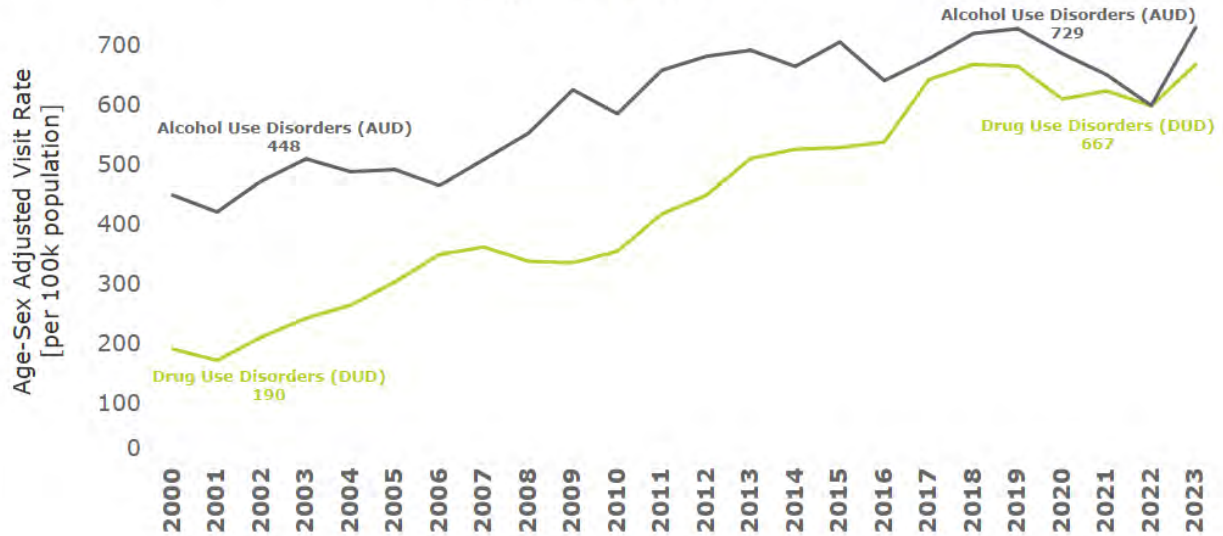
Substance Use Disorder ED Visit Rate
Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

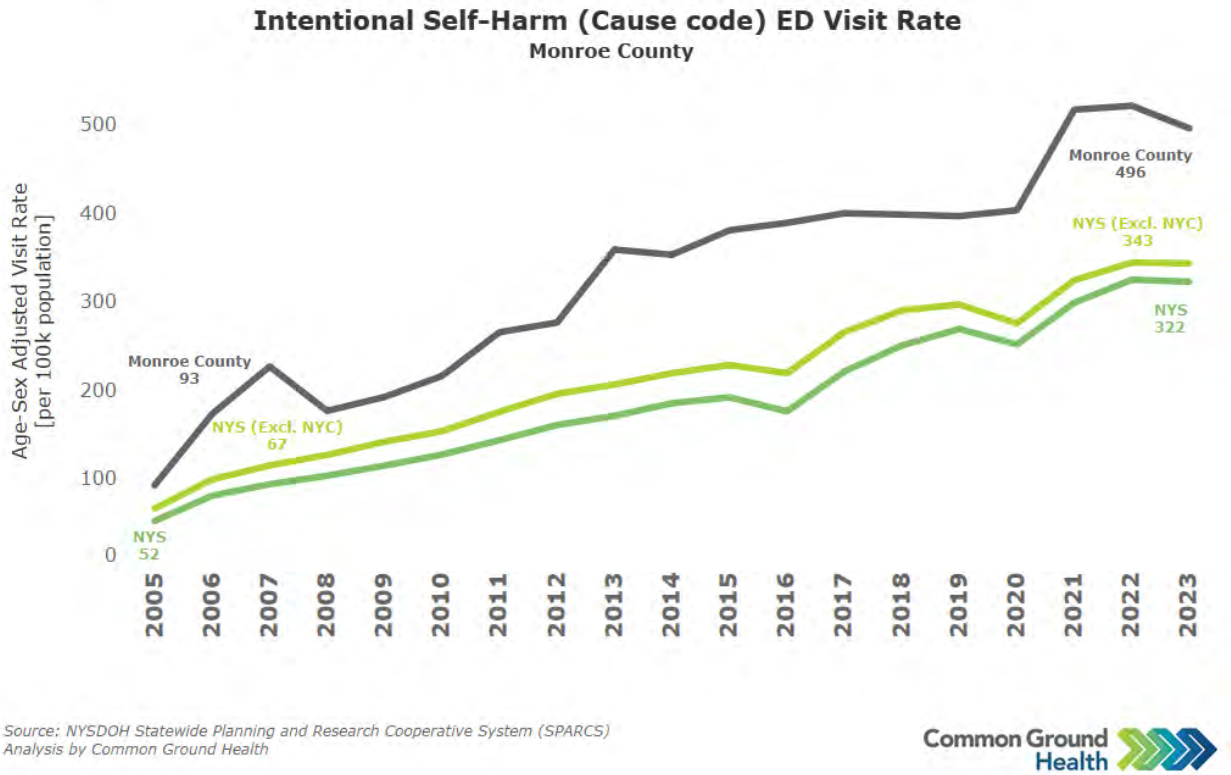
Substance Use Disorder Inpatient Visit Rate
Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

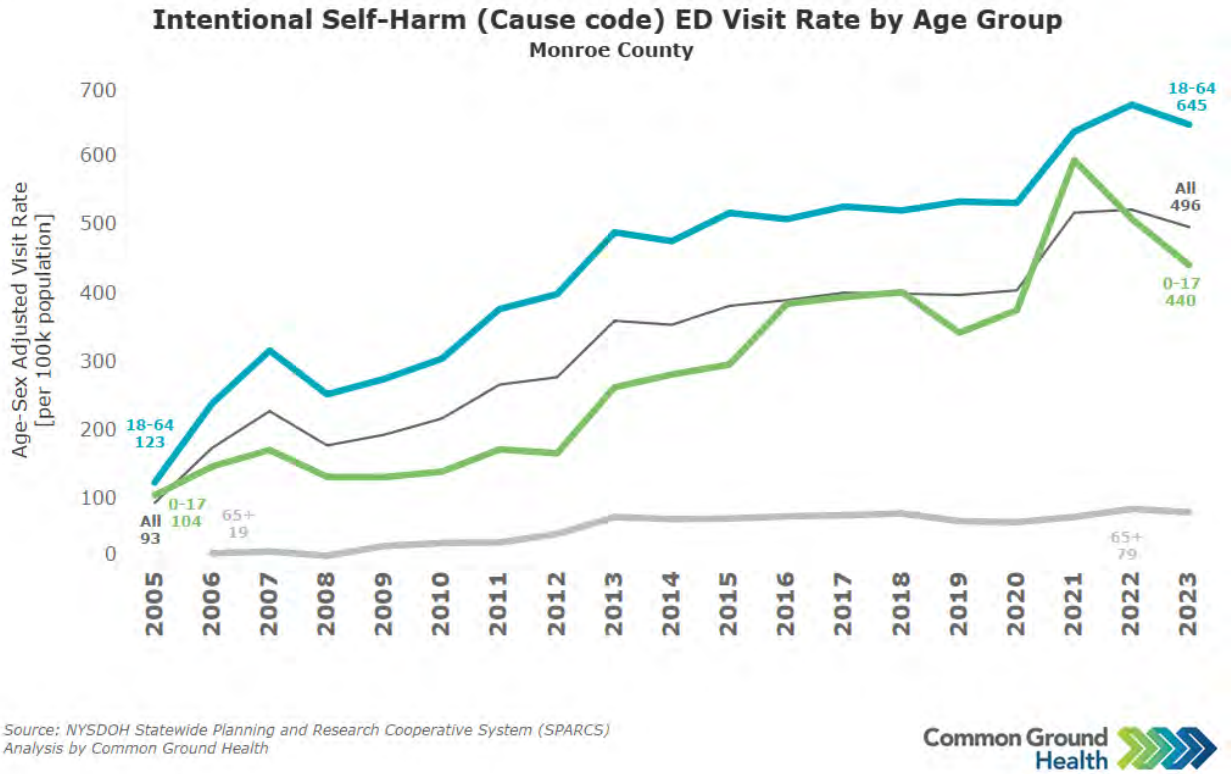
Common Ground Health

ED and Inpatient Visit Trends for Intentional Self-Harm



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

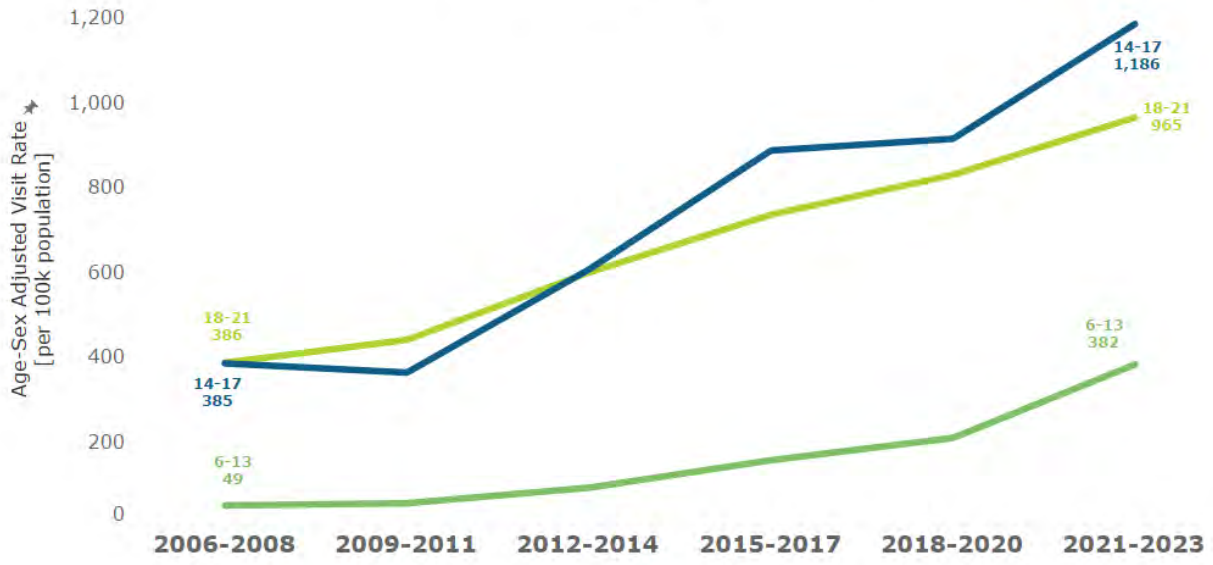


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Intentional Self-Harm ED Visit Rate by Youth Age Group

Monroe County

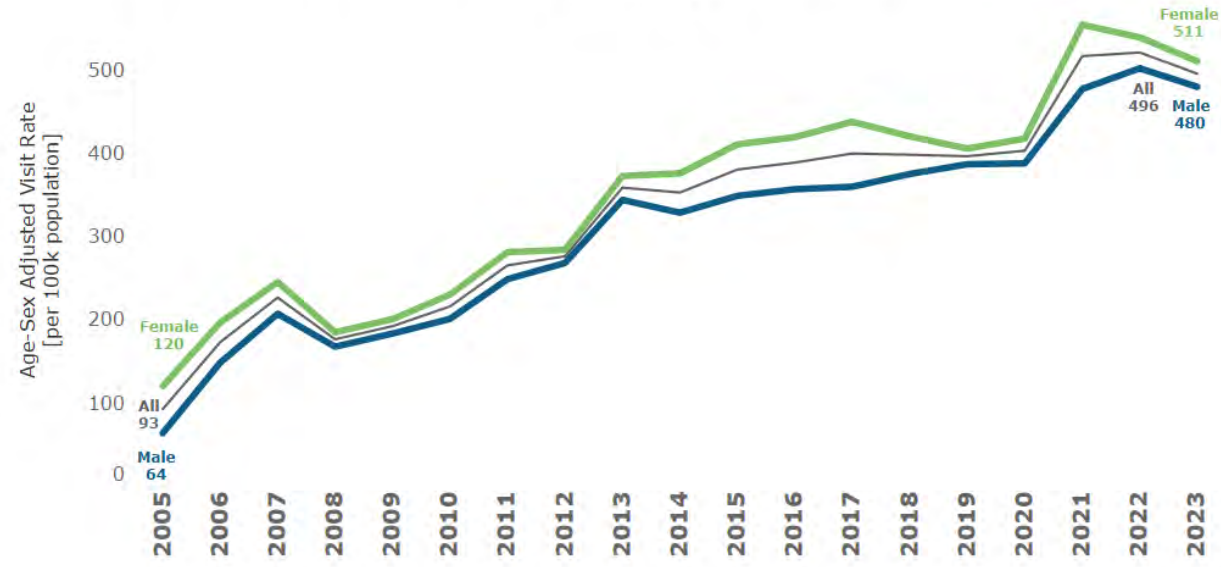


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

Intentional Self-Harm (Cause code) ED Visit Rate by Gender

Monroe County

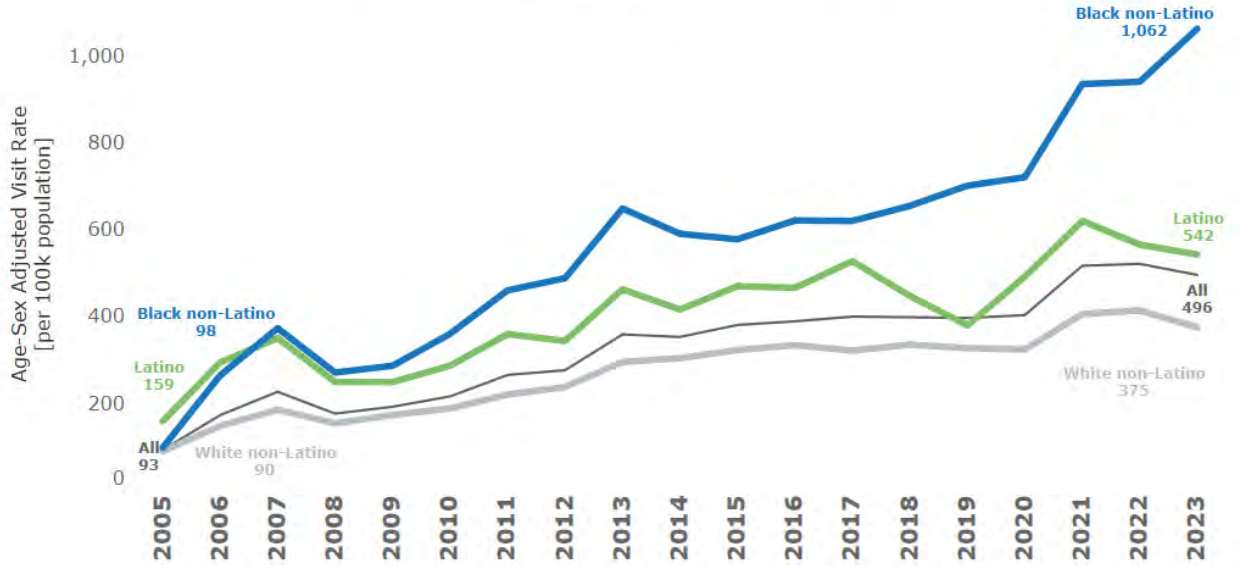


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Intentional Self-Harm (Cause code) ED Visit Rate by Race/Ethnicity

Monroe County

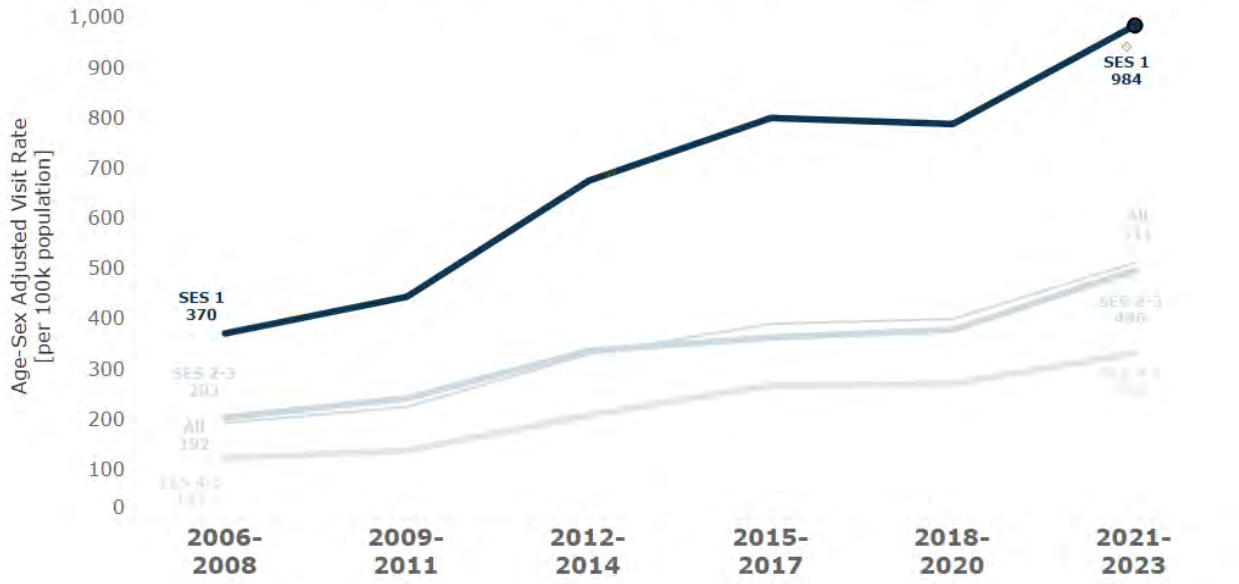


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
All segment is inclusive of all residents in Monroe County. Additional Races (i.e. Asian, American Indian/Alaska Native, etc.) are not shown individually on the chart due to small sample size

Common Ground Health

Intentional Self-Harm (Cause code) ED Visit Rate by SES

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
Socioeconomic status (SES) is determined by ZIP code. Each data point represents the people who live in ZIP codes with a particular SES level.

Common Ground Health

Intentional Self-Harm (Cause code) Inpatient Visit Rate

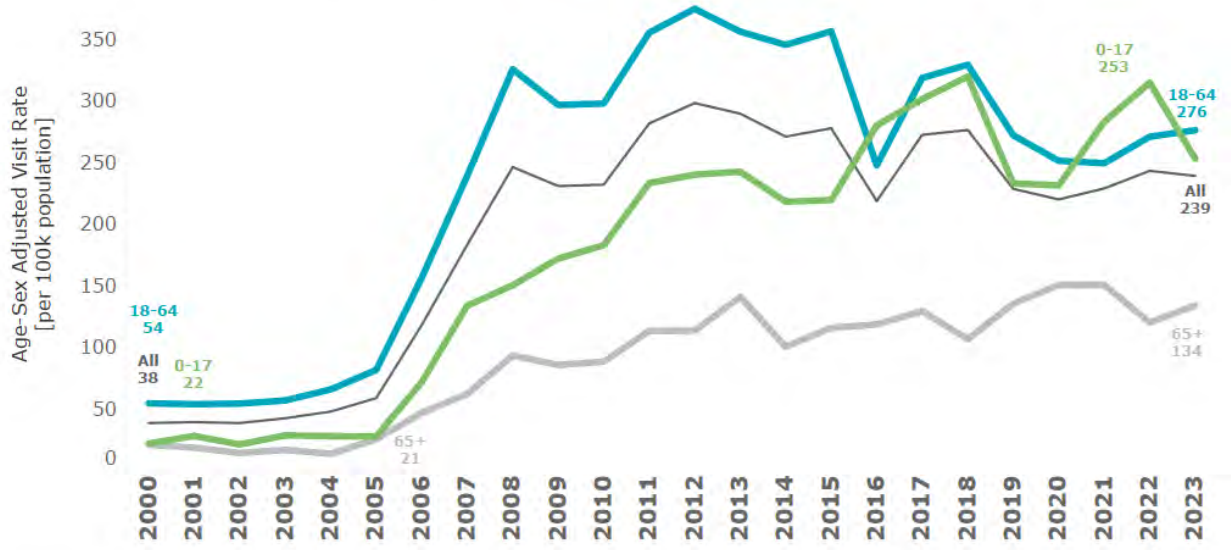
Monroe County

Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Intentional Self-Harm (Cause code) Inpatient Visit Rate by Age Group

Monroe County

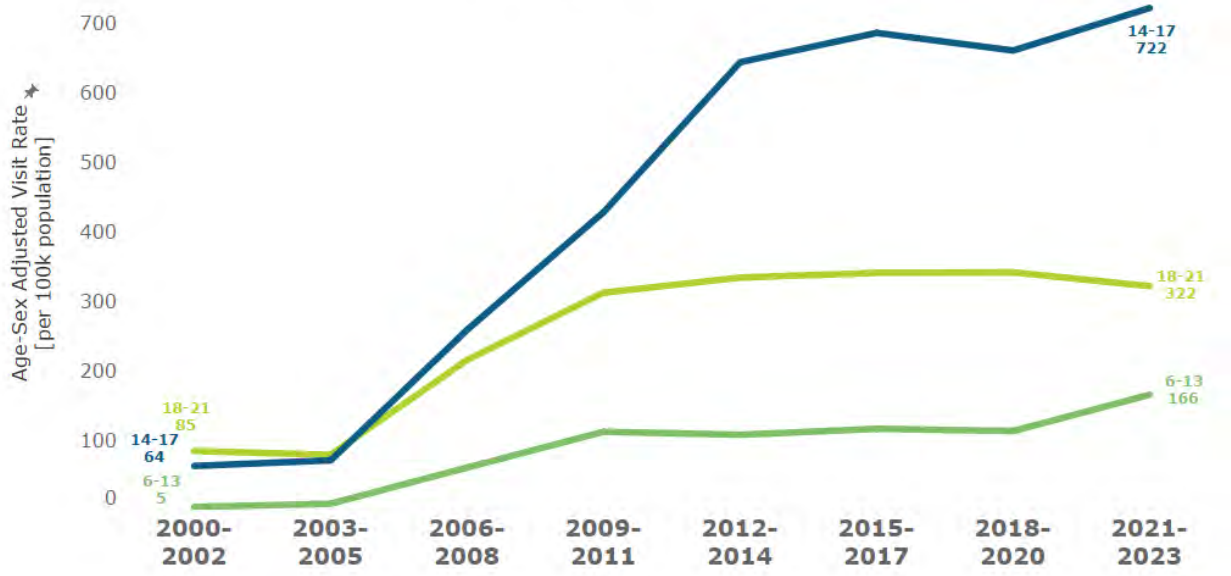


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Intentional Self-Harm Inpatient Visit Rate by Youth Age Group

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

Intentional Self-Harm (Cause code) Inpatient Visit Rate by Gender

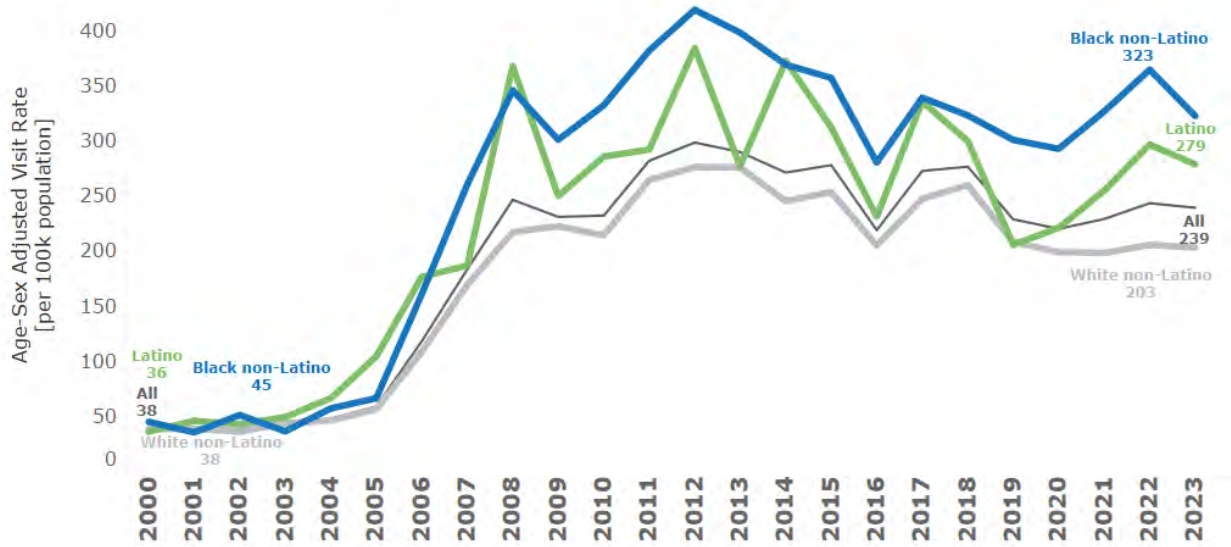
Monroe County

Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Intentional Self-Harm (Cause code) Inpatient Visit Rate by Race/Ethnicity

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
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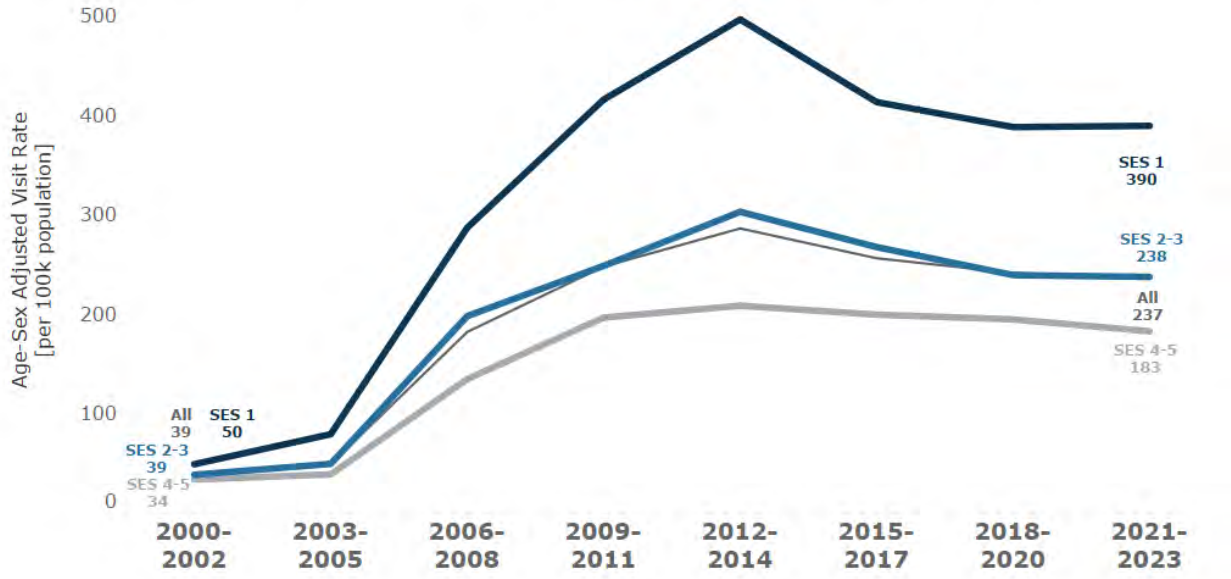
Common Ground Health

Intentional Self-Harm (Cause code) Inpatient Visit Rate by SES

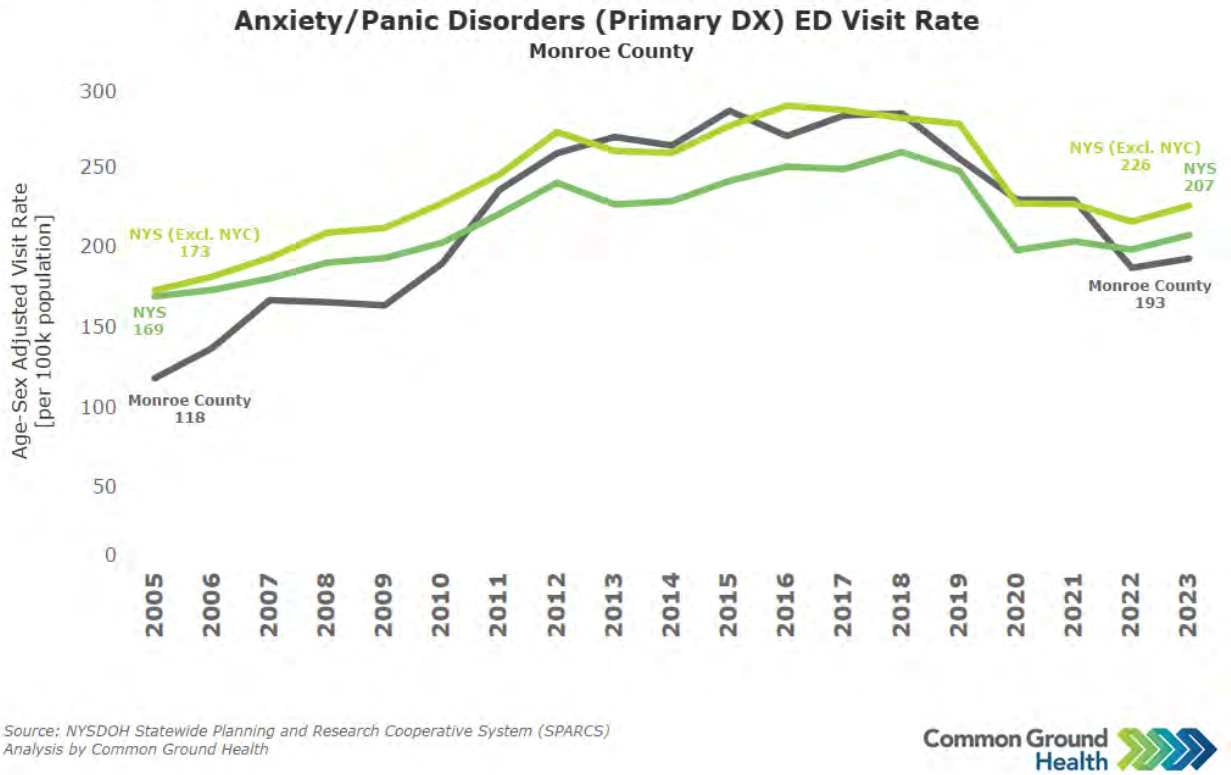
Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
Socioeconomic status (SES) is determined by ZIP code. Each data point represents the people who live in ZIP codes with a particular SES level.

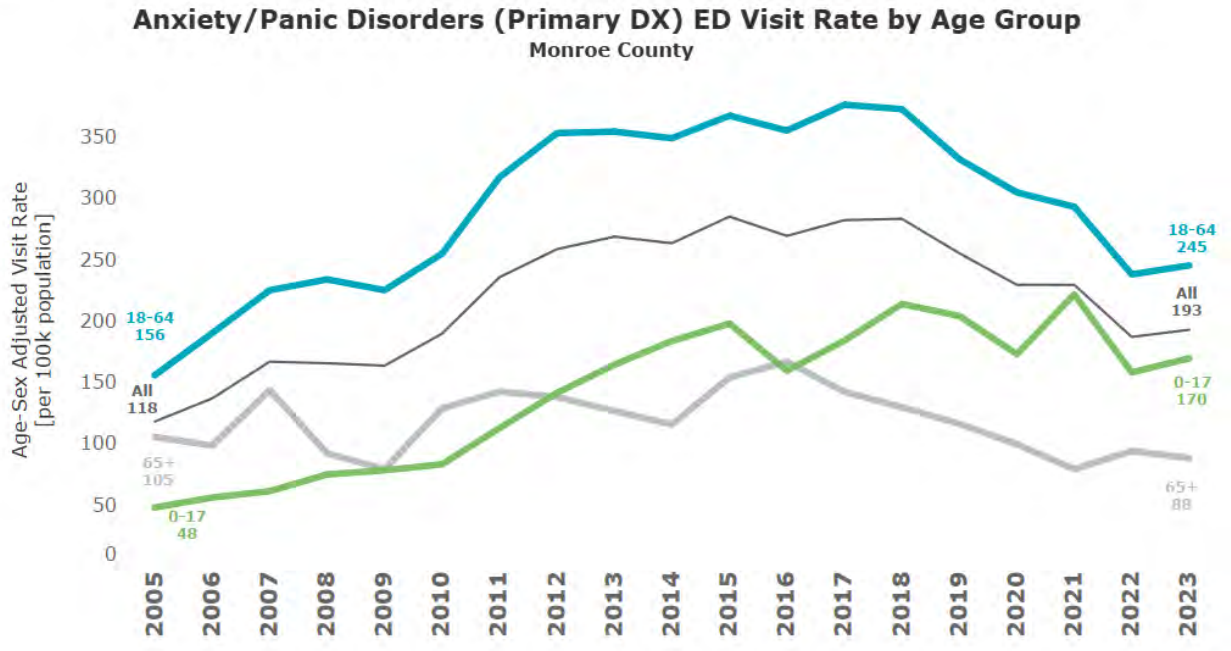
Common Ground Health

ED and Inpatient Visit Trends for Anxiety/Panic Disorders



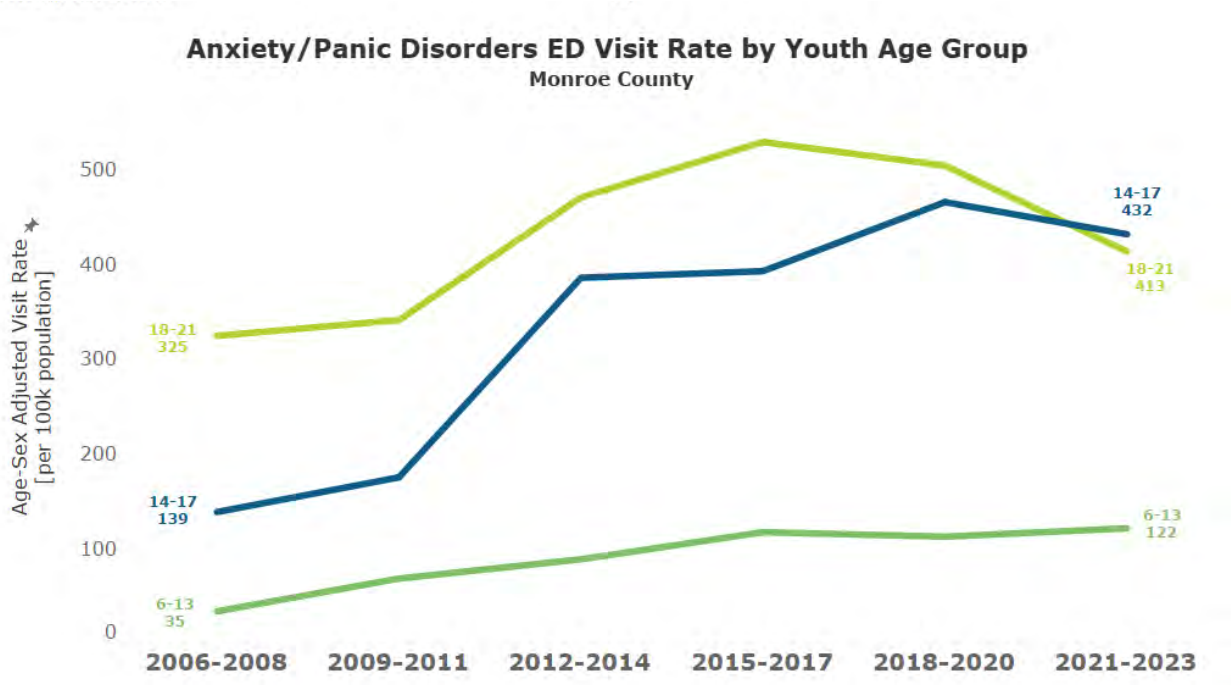
Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health



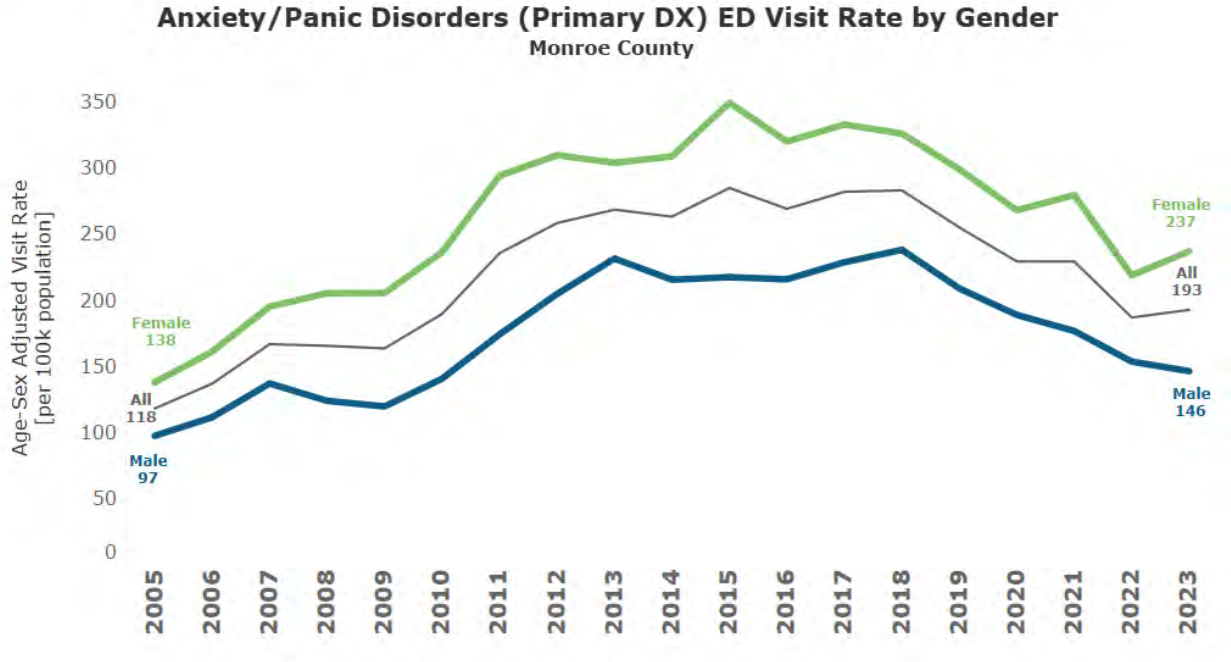
Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

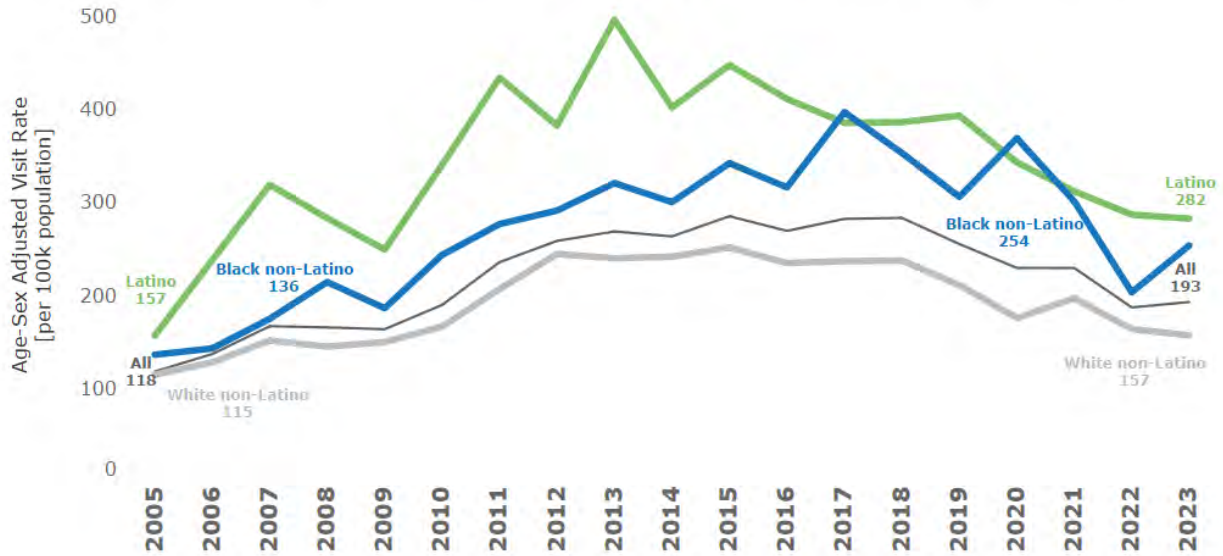


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Anxiety/Panic Disorders (Primary DX) ED Visit Rate by Race/Ethnicity

Monroe County

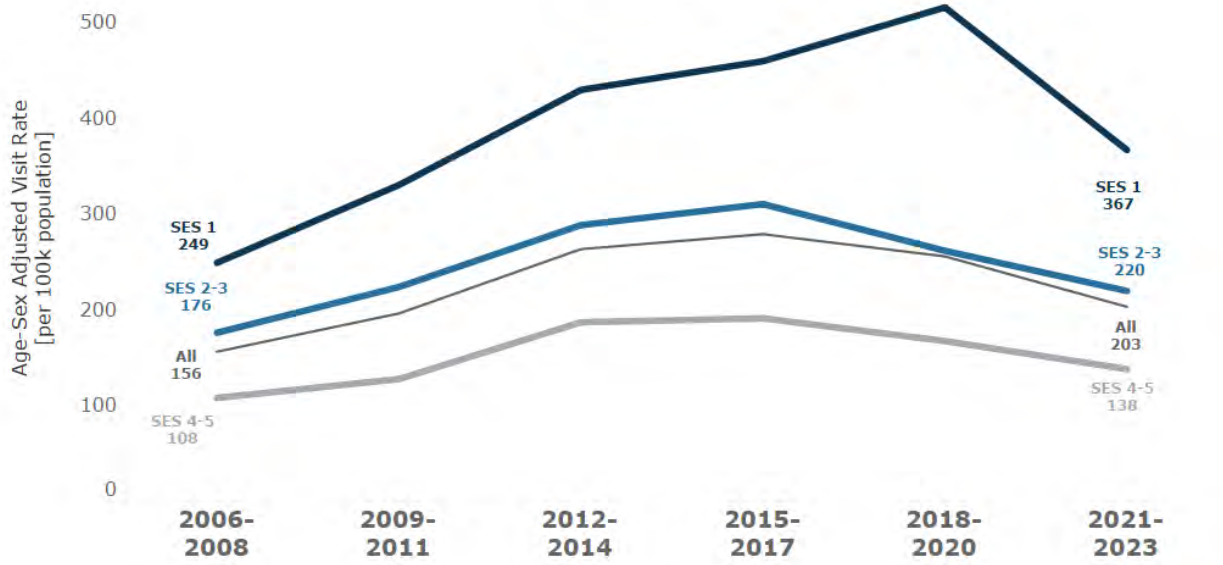


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
All segment is inclusive of all residents in Monroe County. Additional Races (i.e. Asian, American Indian/Alaska Native, etc.) are not shown individually on the chart due to small sample size

Common Ground Health

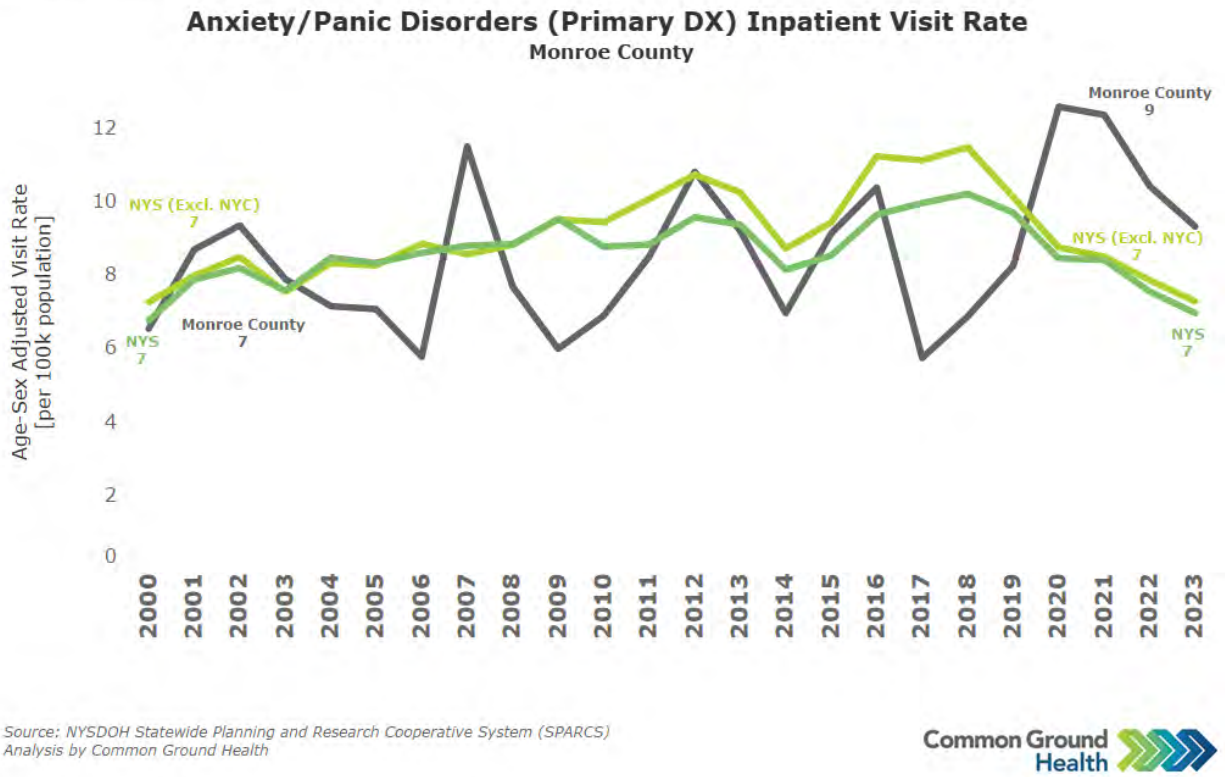
Anxiety/Panic Disorders (Primary DX) ED Visit Rate by SES

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
Socioeconomic status (SES) is determined by ZIP code. Each data point represents the people who live in ZIP codes with a particular SES level.

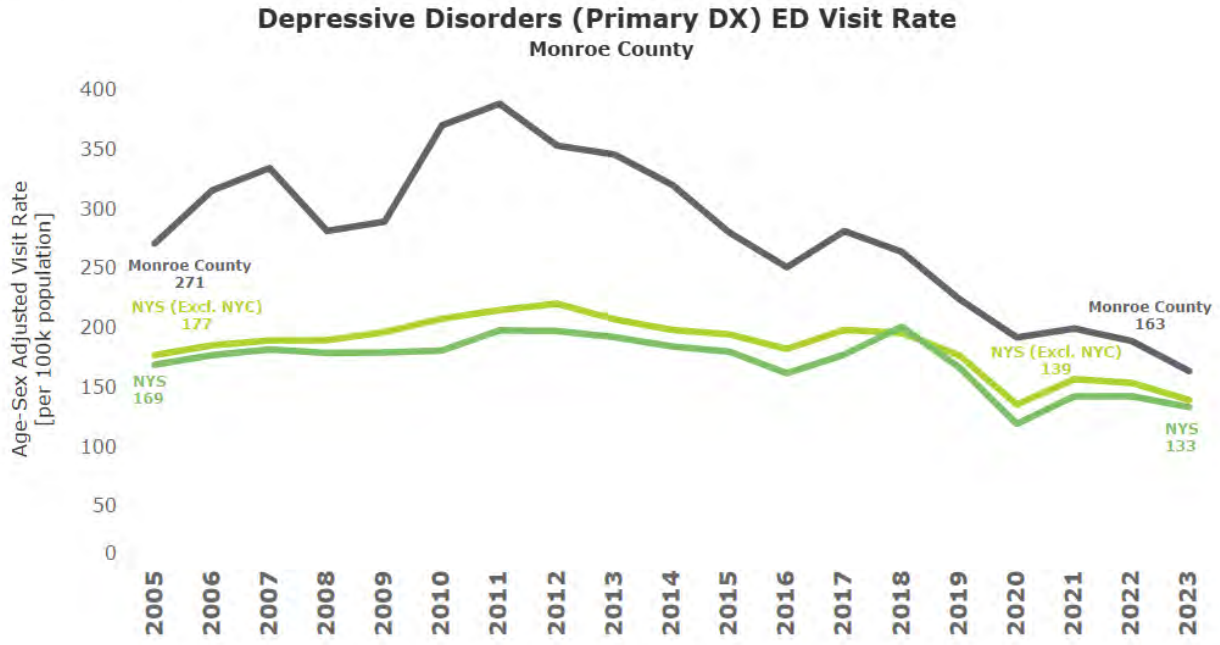
Common Ground Health



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

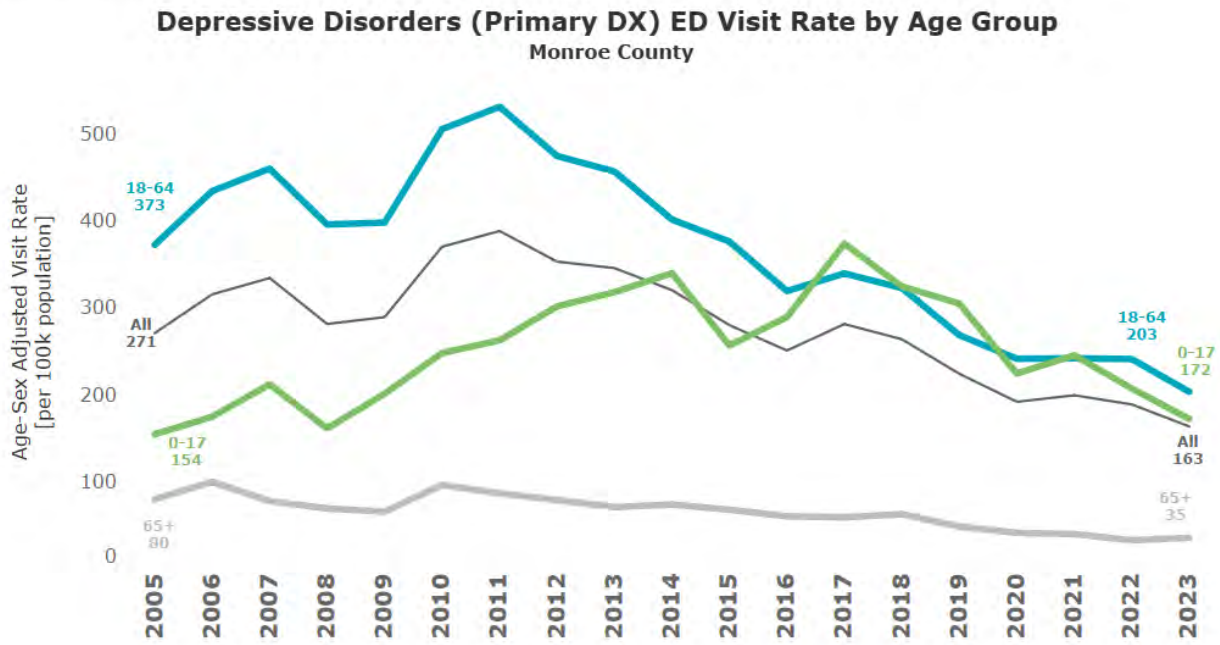
Common Ground Health

ED and Inpatient Visit Trends for Depressive Disorders



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

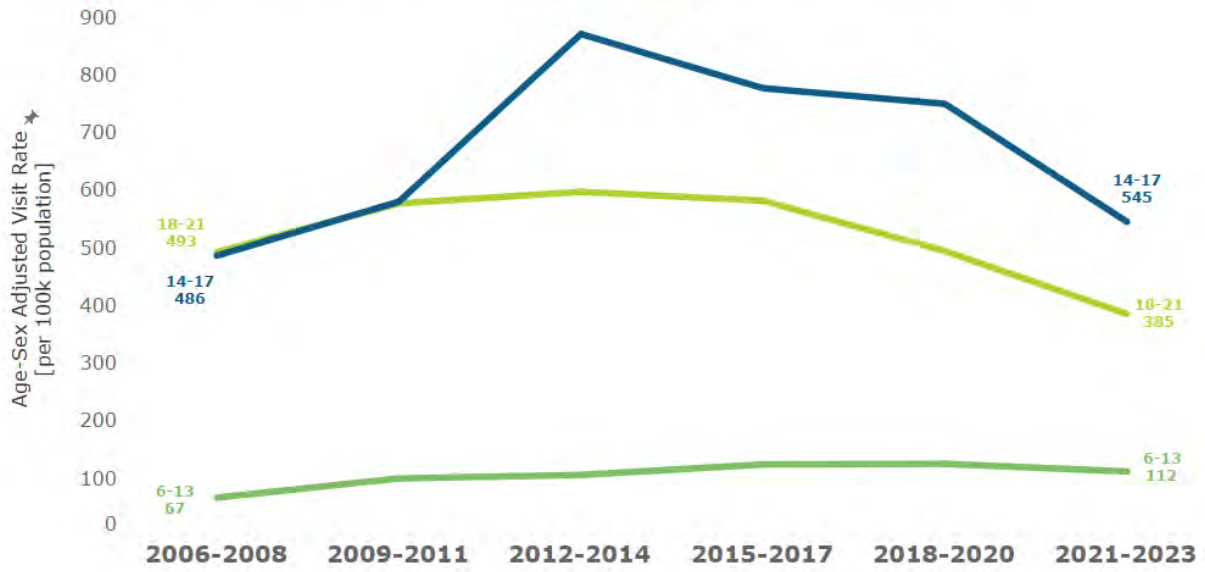


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Depressive Disorders ED Visit Rate by Youth Age Group

Monroe County

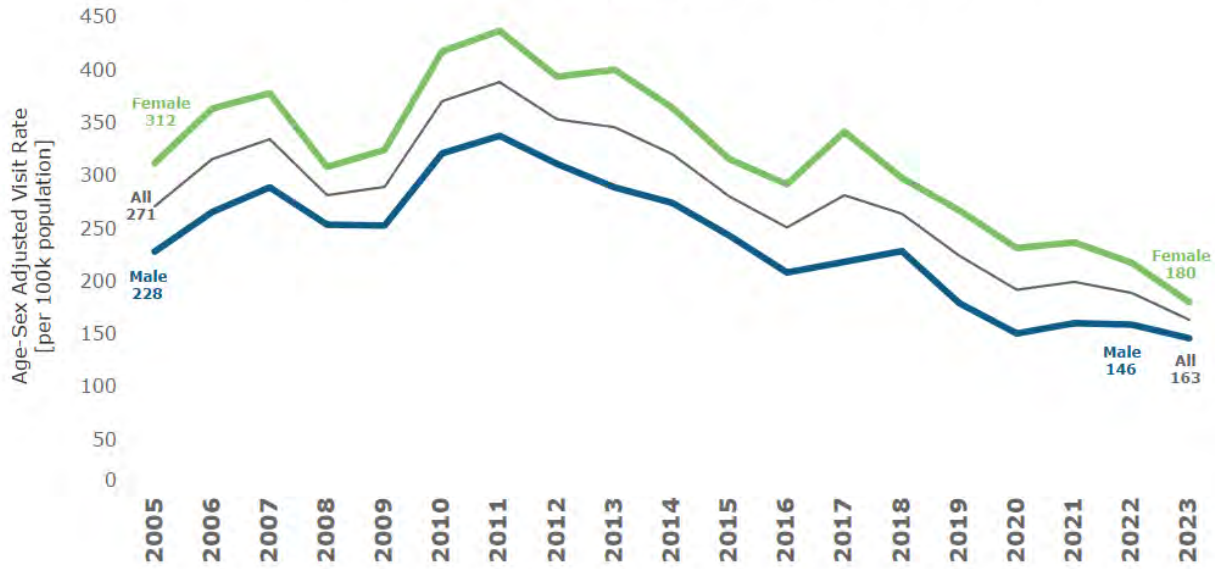


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

Depressive Disorders (Primary DX) ED Visit Rate by Gender

Monroe County

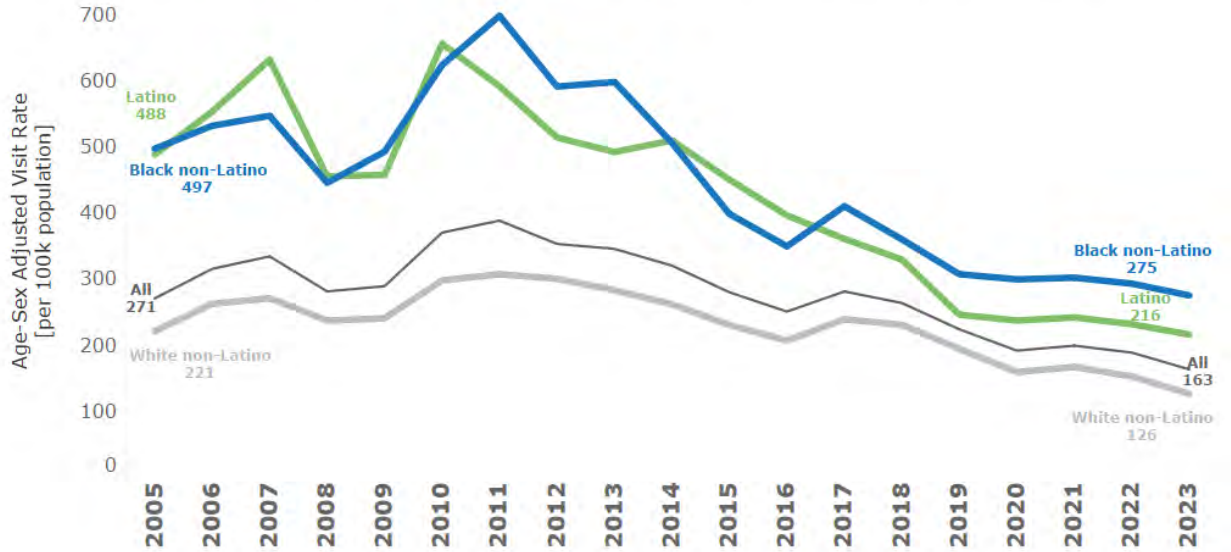


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Depressive Disorders (Primary DX) ED Visit Rate by Race/Ethnicity

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
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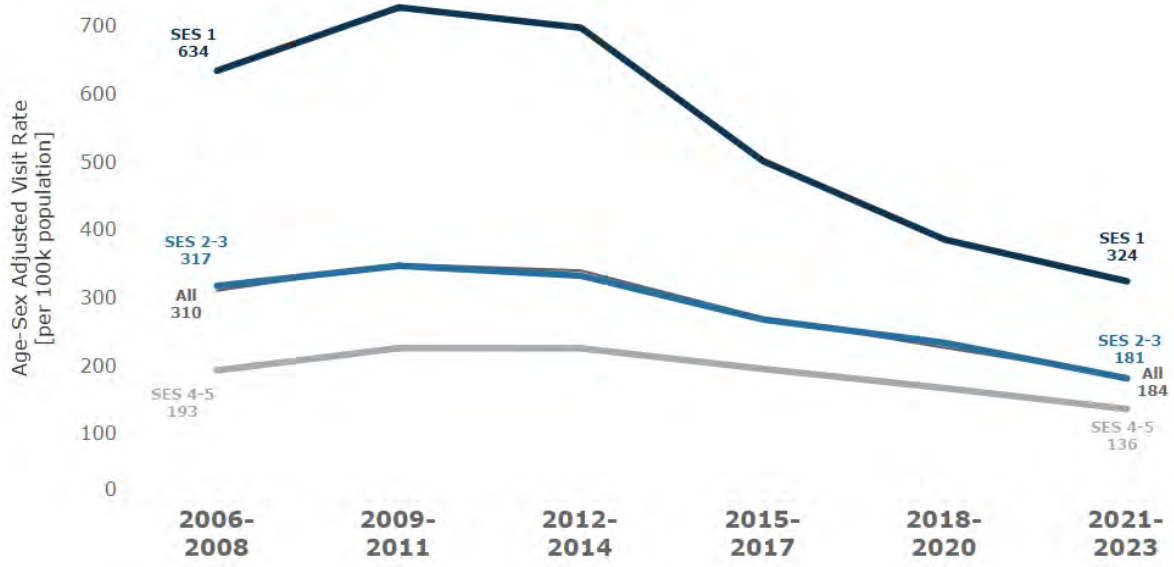
Common Ground Health

Depressive Disorders (Primary DX) ED Visit Rate by SES

Monroe County

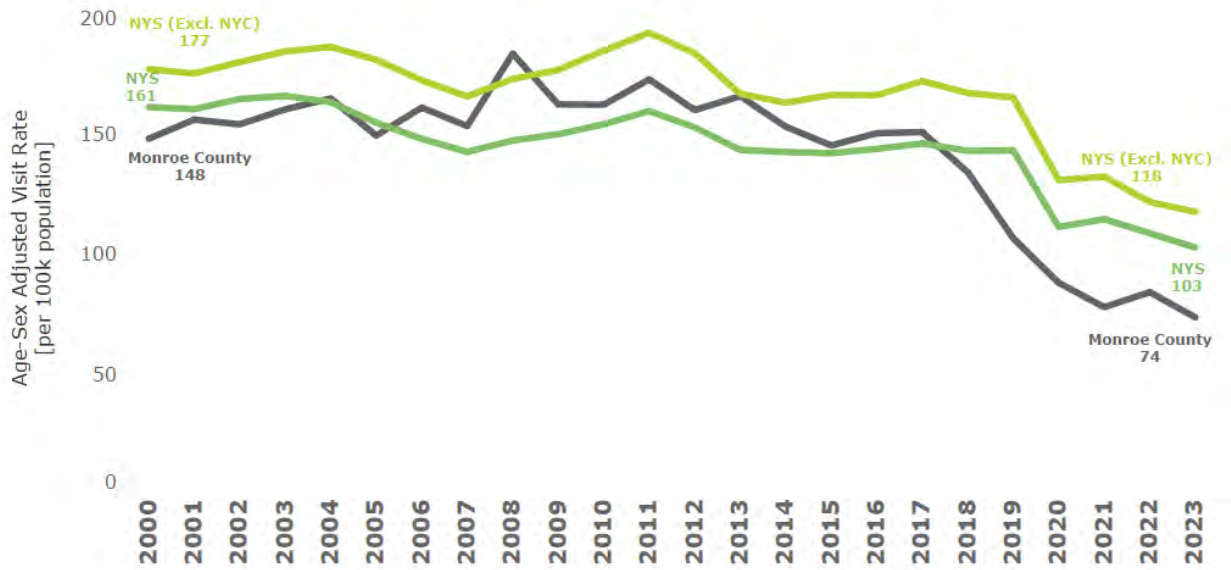


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
Socioeconomic status (SES) is determined by ZIP code. Each data point represents the people who live in ZIP codes with a particular SES level.

Common Ground Health

Depressive Disorders (Primary DX) Inpatient Visit Rate

Monroe County

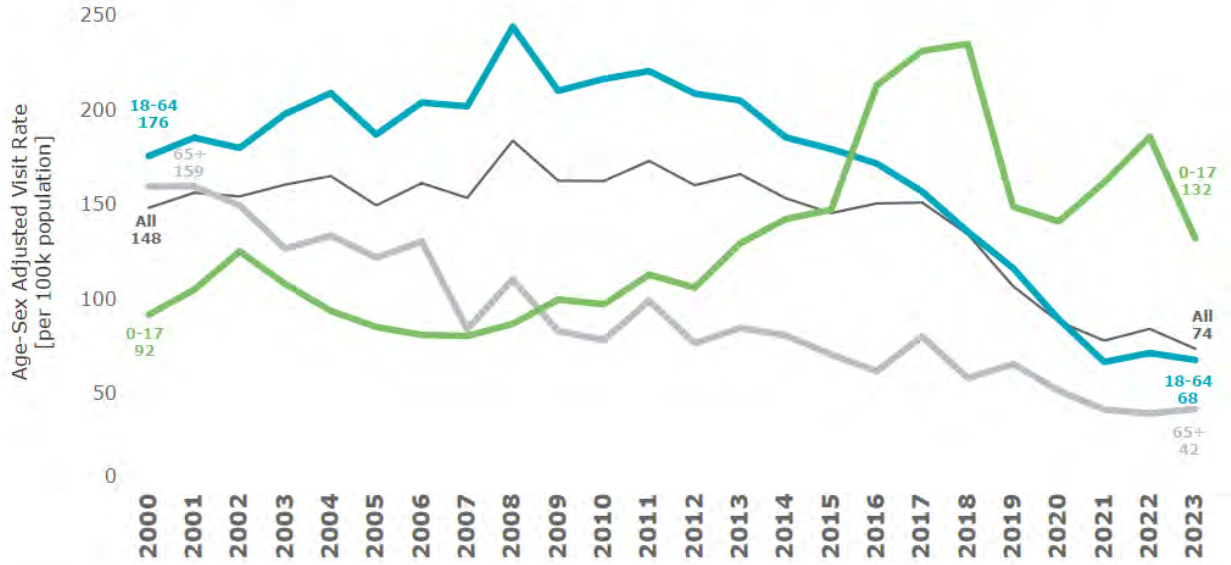


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Depressive Disorders (Primary DX) Inpatient Visit Rate by Age Group

Monroe County

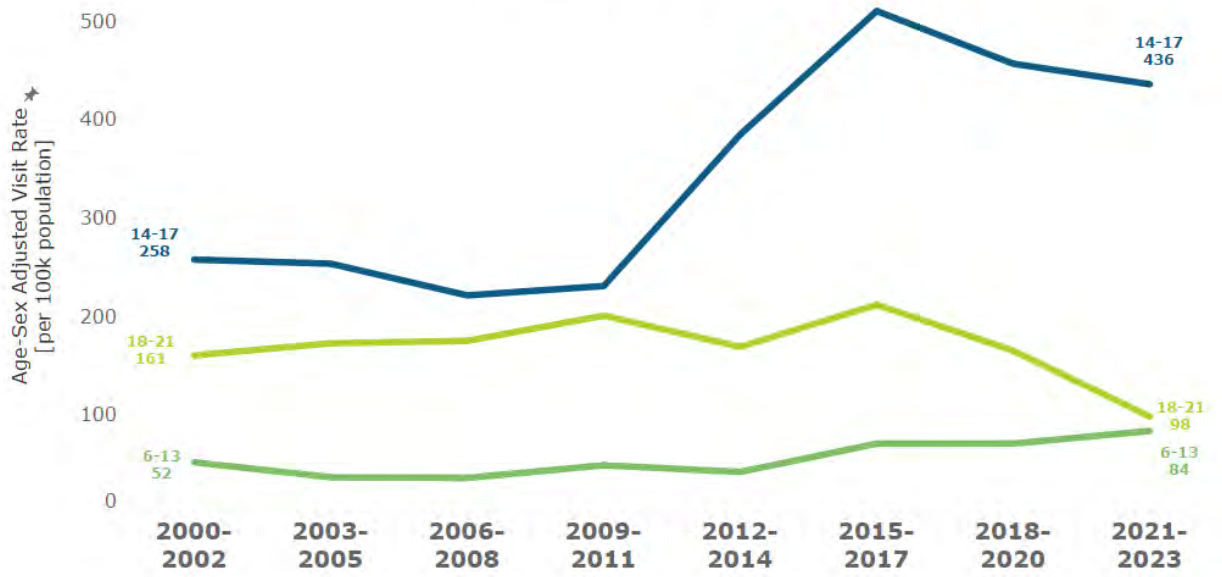


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Depressive Disorders Inpatient Visit Rate by Youth Age Group

Monroe County

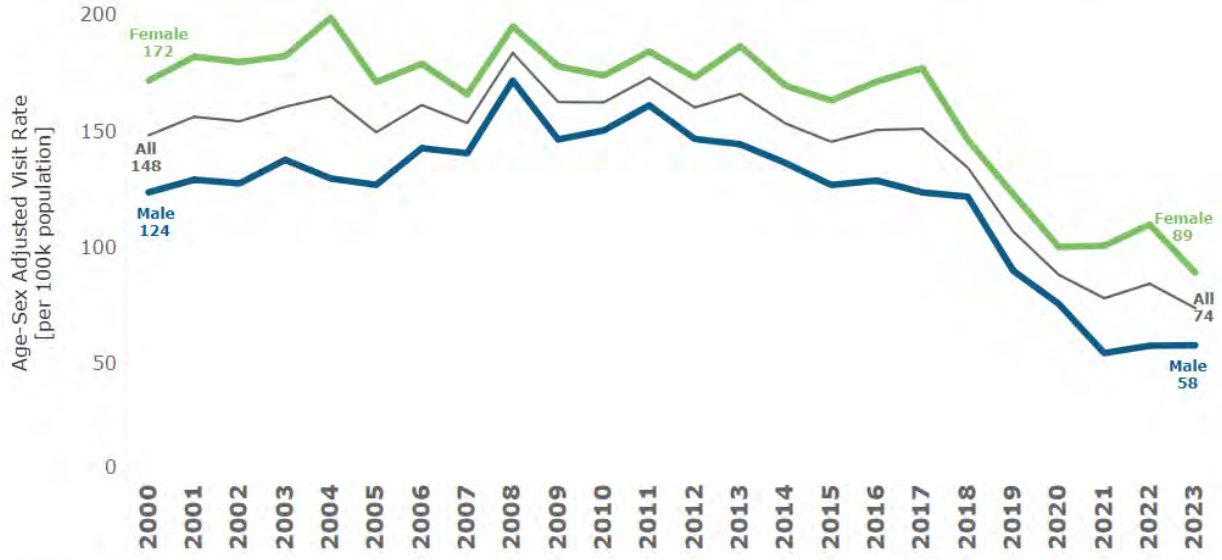


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

Depressive Disorders (Primary DX) Inpatient Visit Rate by Gender

Monroe County

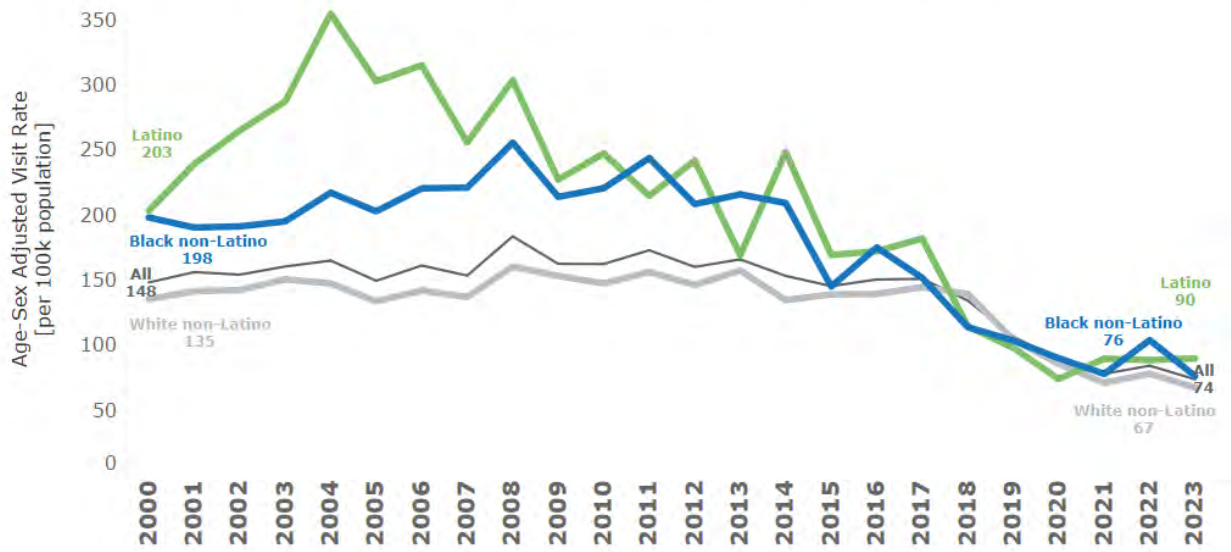


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Depressive Disorders (Primary DX) Inpatient Visit Rate by Race/Ethnicity

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
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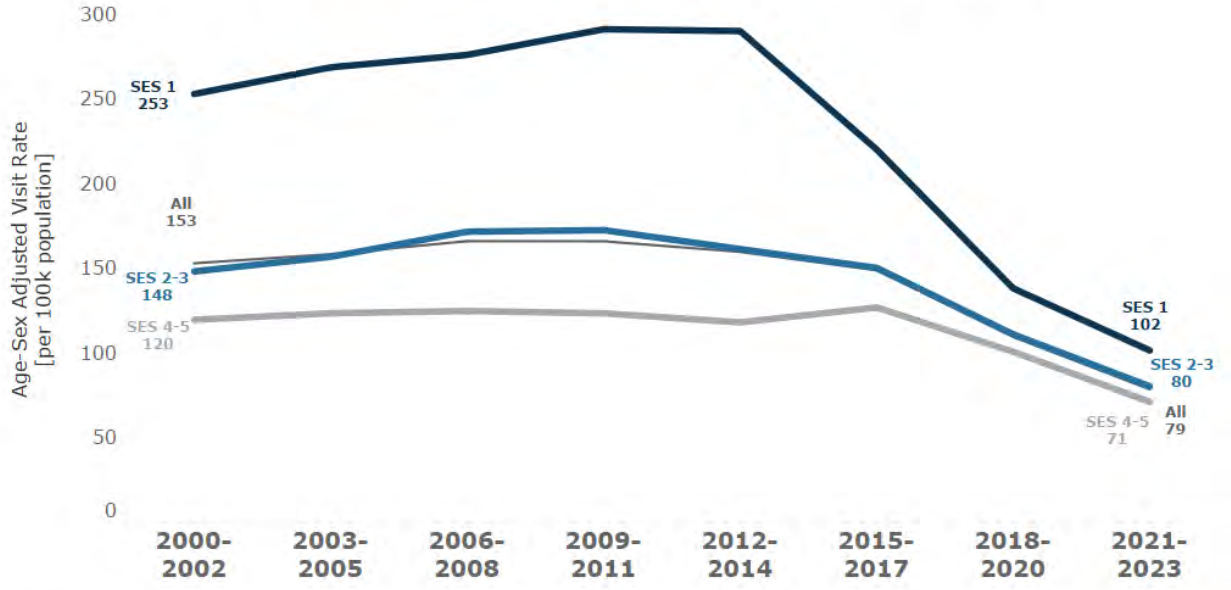
Common Ground Health

Depressive Disorders (Primary DX) Inpatient Visit Rate by SES

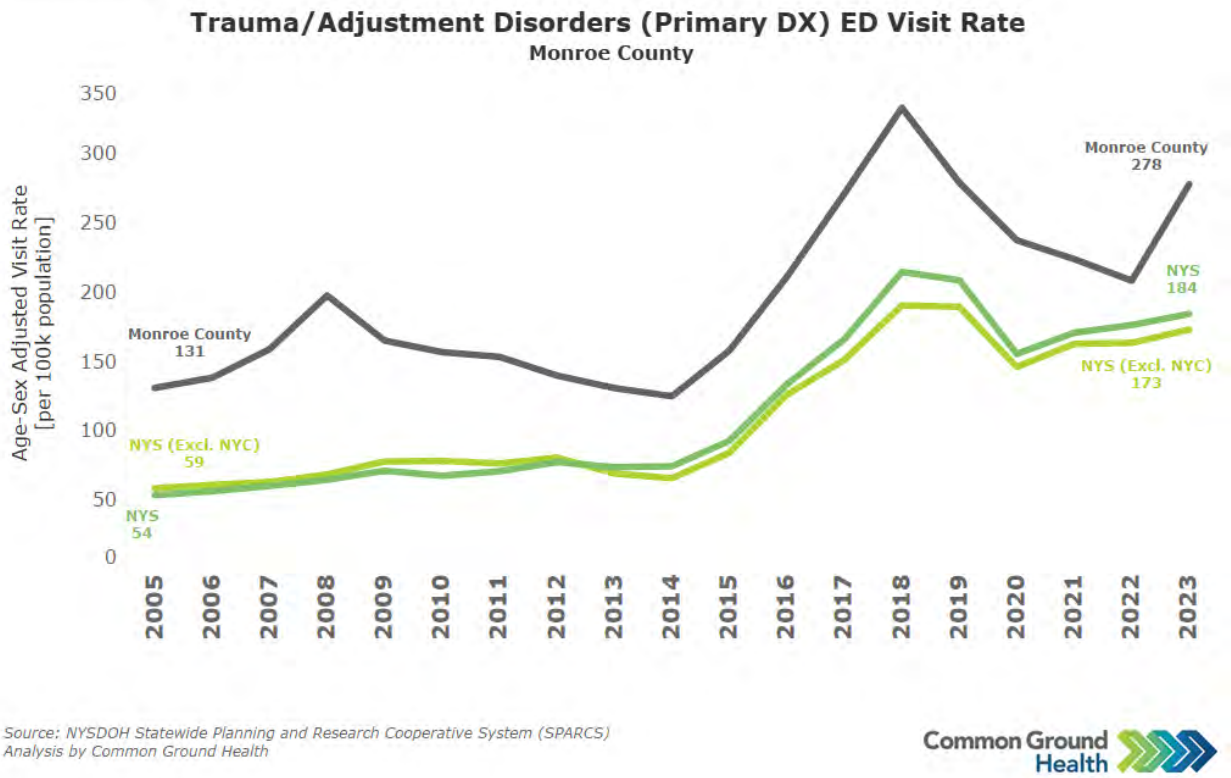
Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
Socioeconomic status (SES) is determined by ZIP code. Each data point represents the people who live in ZIP codes with a particular SES level.

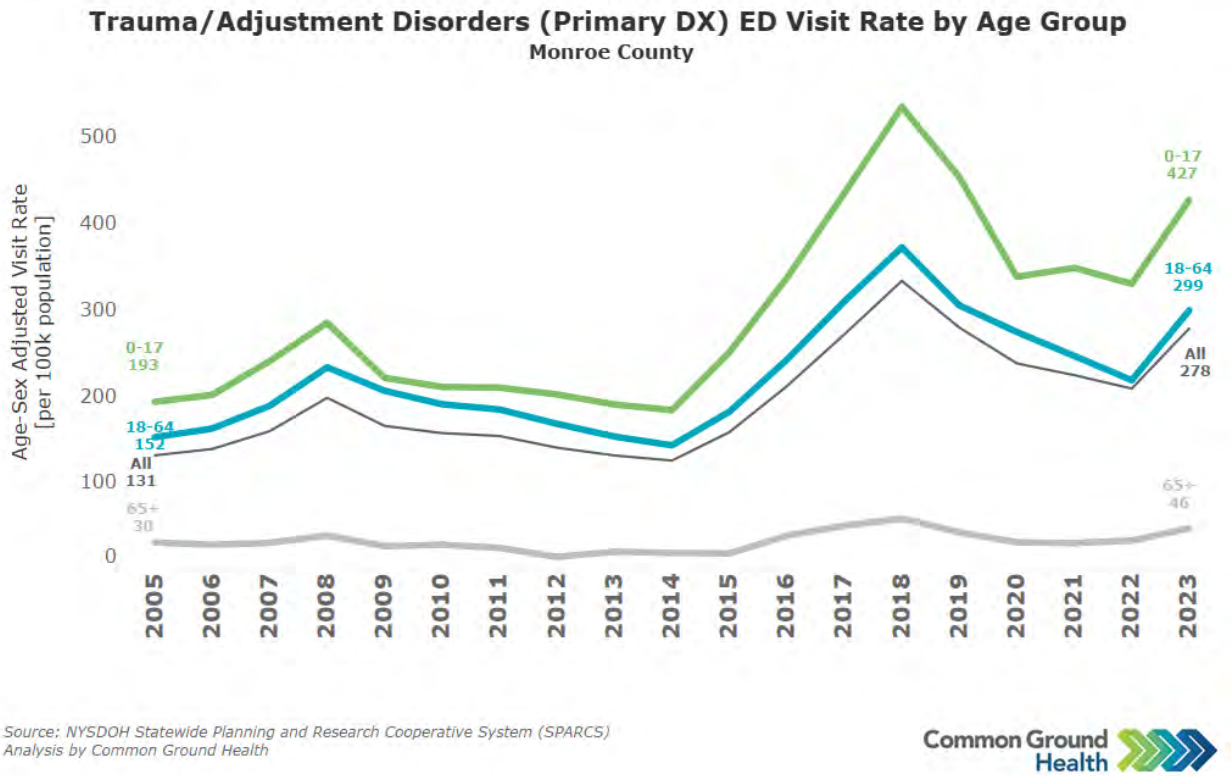
Common Ground Health

ED and Inpatient Visit Trends for Trauma/Adjustment



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

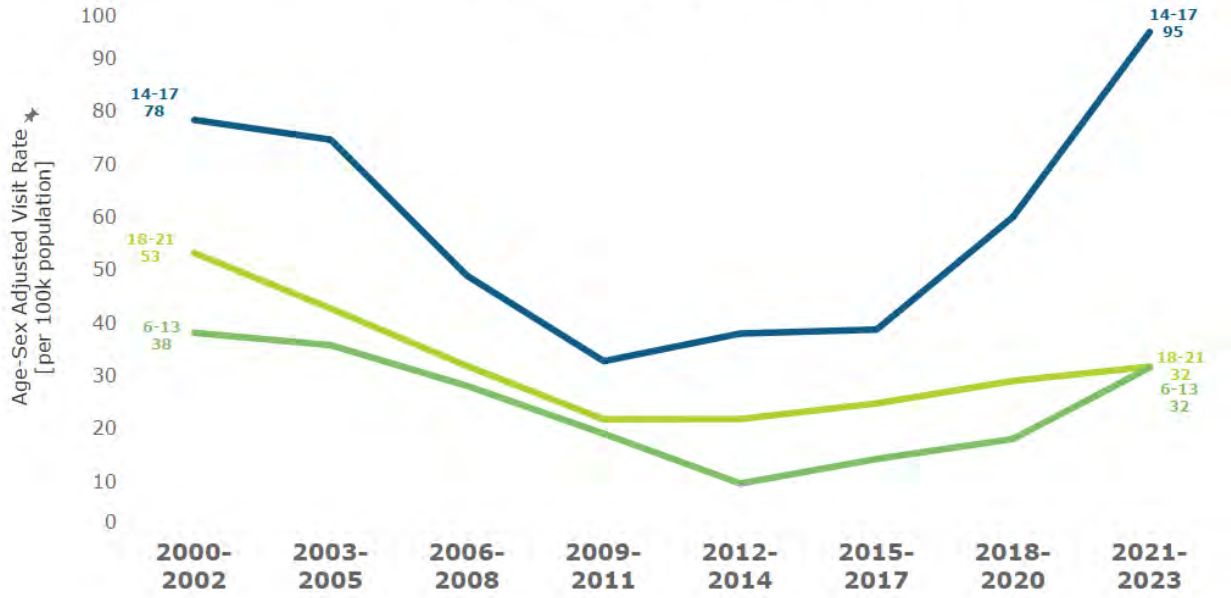


Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Trauma/Adjustment Disorders Inpatient Visit Rate by Youth Age Group

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis Completed by Common Ground Health

Common Ground Health

Trauma/Adjustment Disorders (Primary DX) ED Visit Rate by Gender

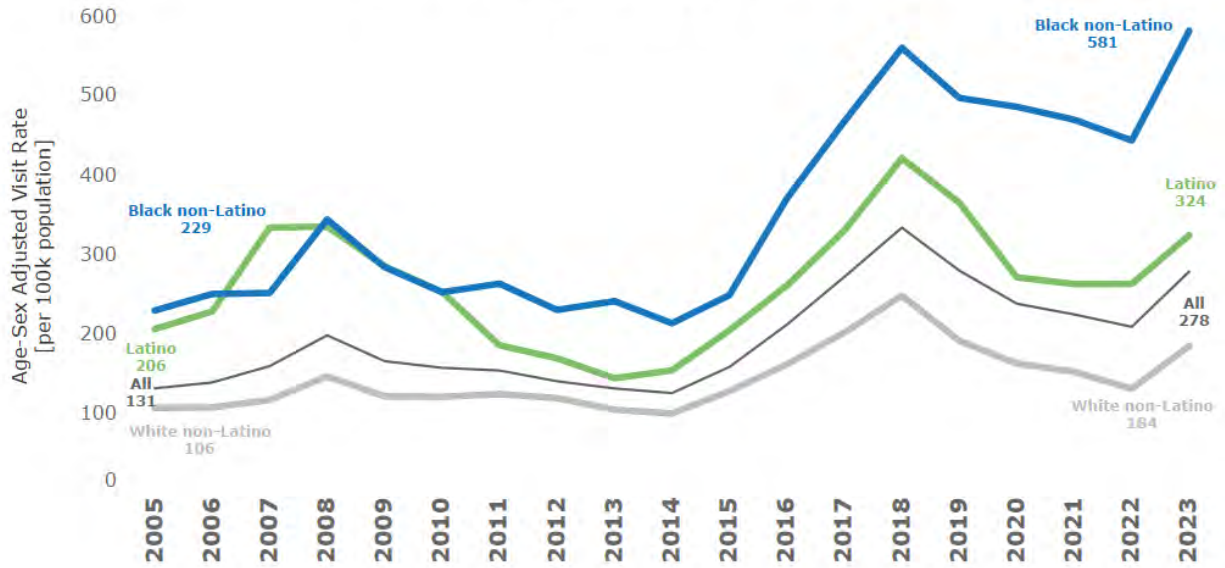
Monroe County

Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Trauma/Adjustment Disorders (Primary DX) ED Visit Rate by Race/Ethnicity

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
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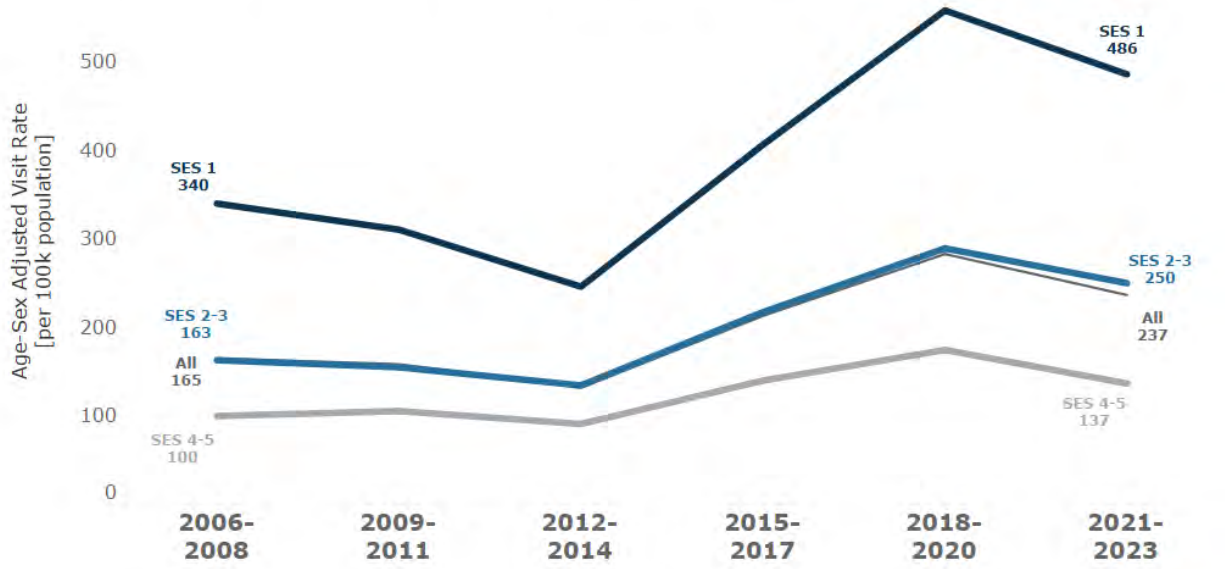
Common Ground Health

Trauma/Adjustment Disorders (Primary DX) ED Visit Rate by SES

Monroe County



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
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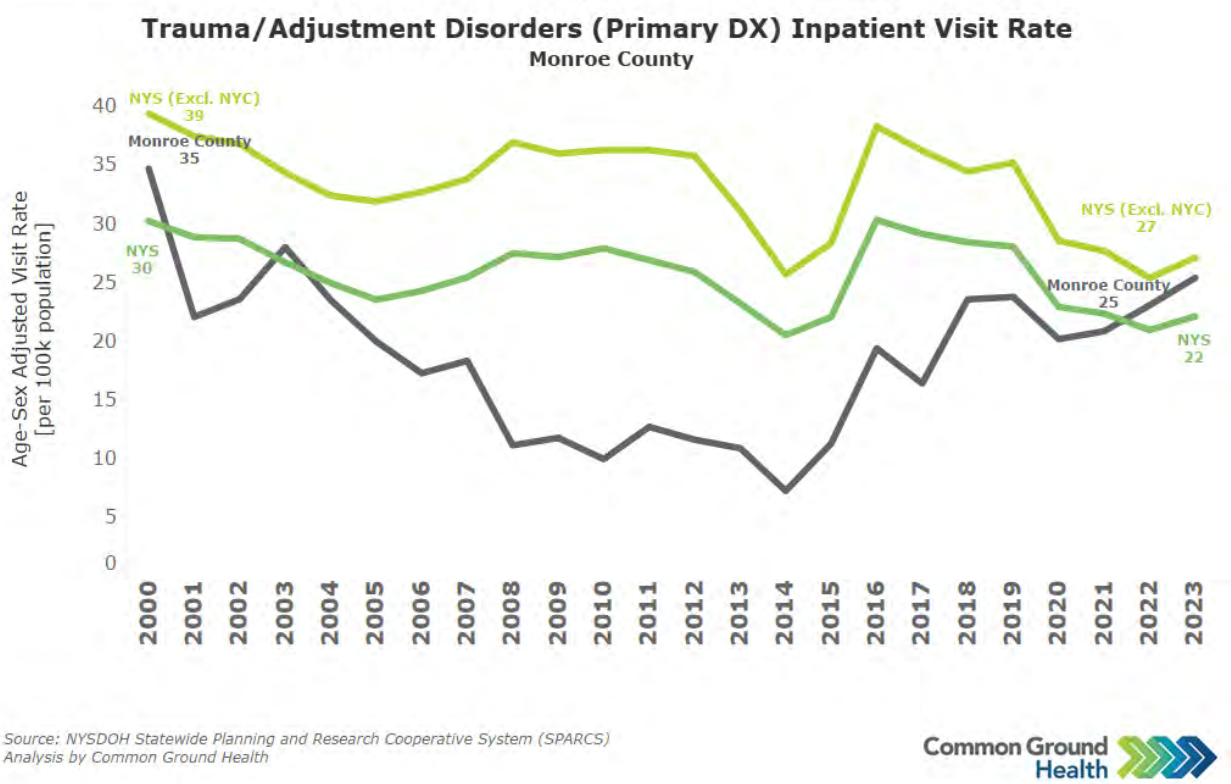
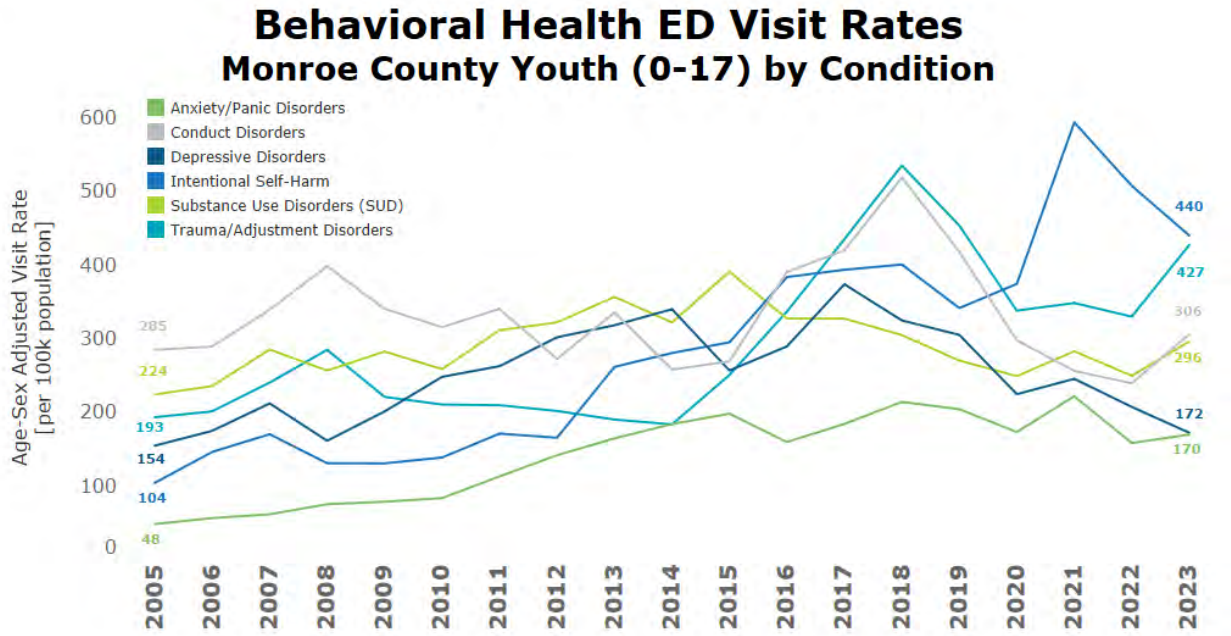
Common Ground Health



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Behavioral Health ED Visit Rates for Youth by Condition



Source: NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
Analysis by Common Ground Health
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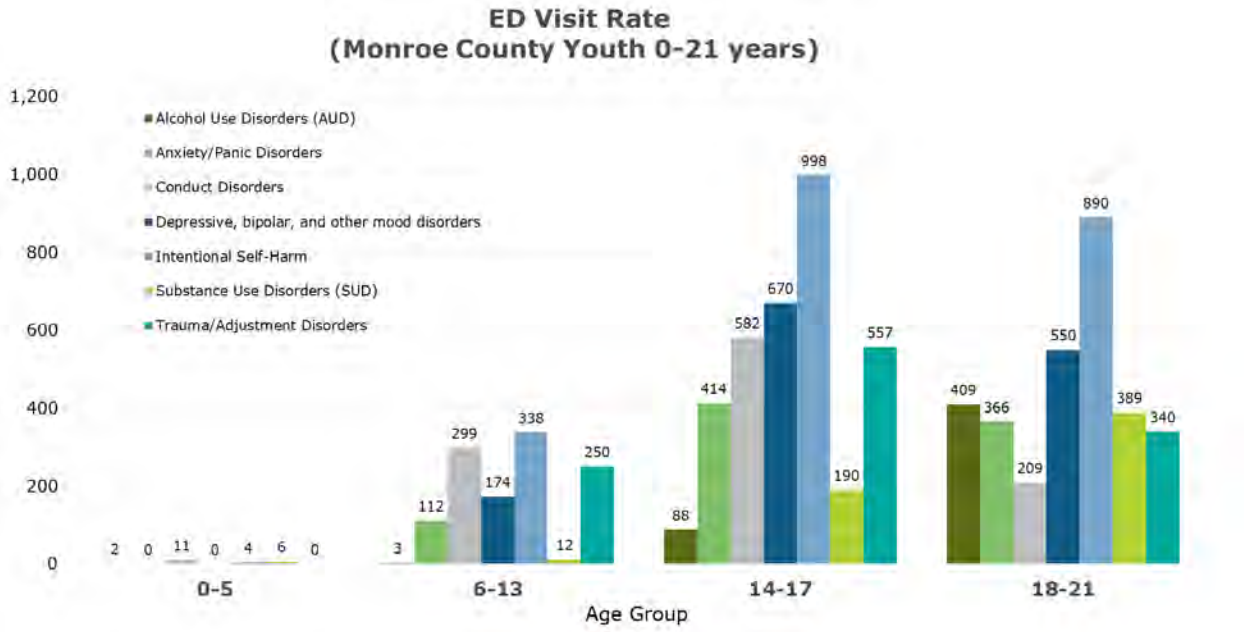
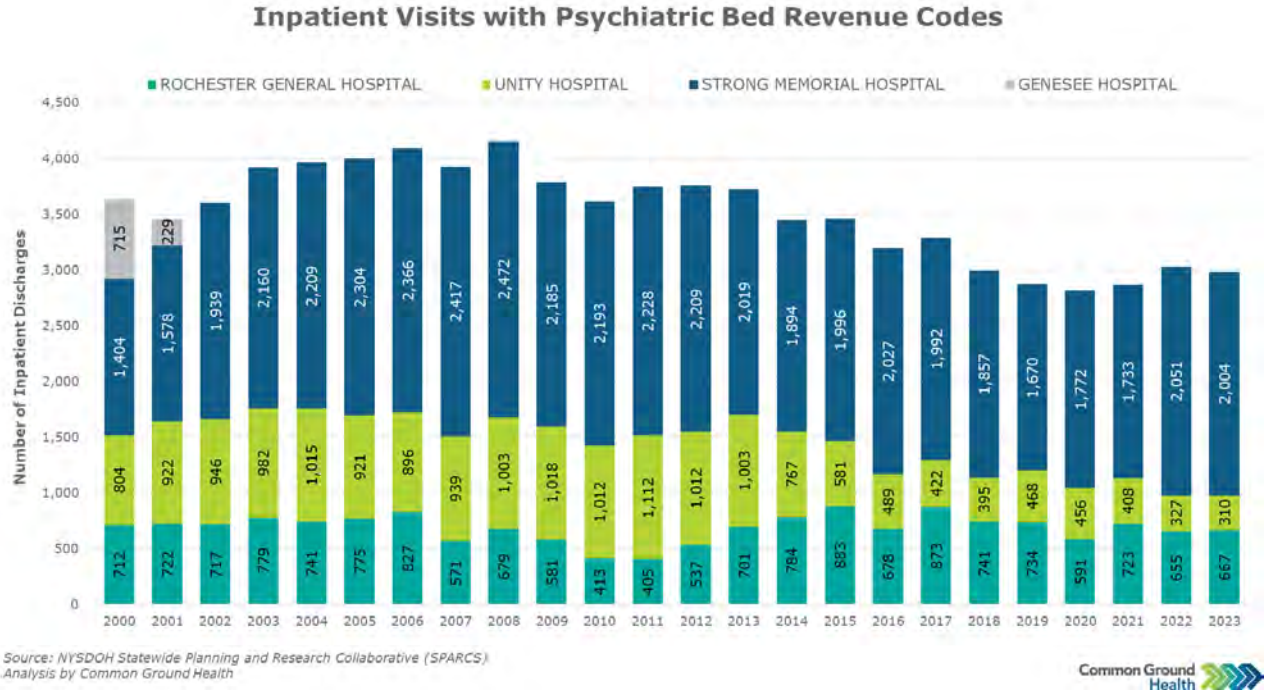
Common Ground Health



Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS), Year 2023
Analysis by Common Ground Health

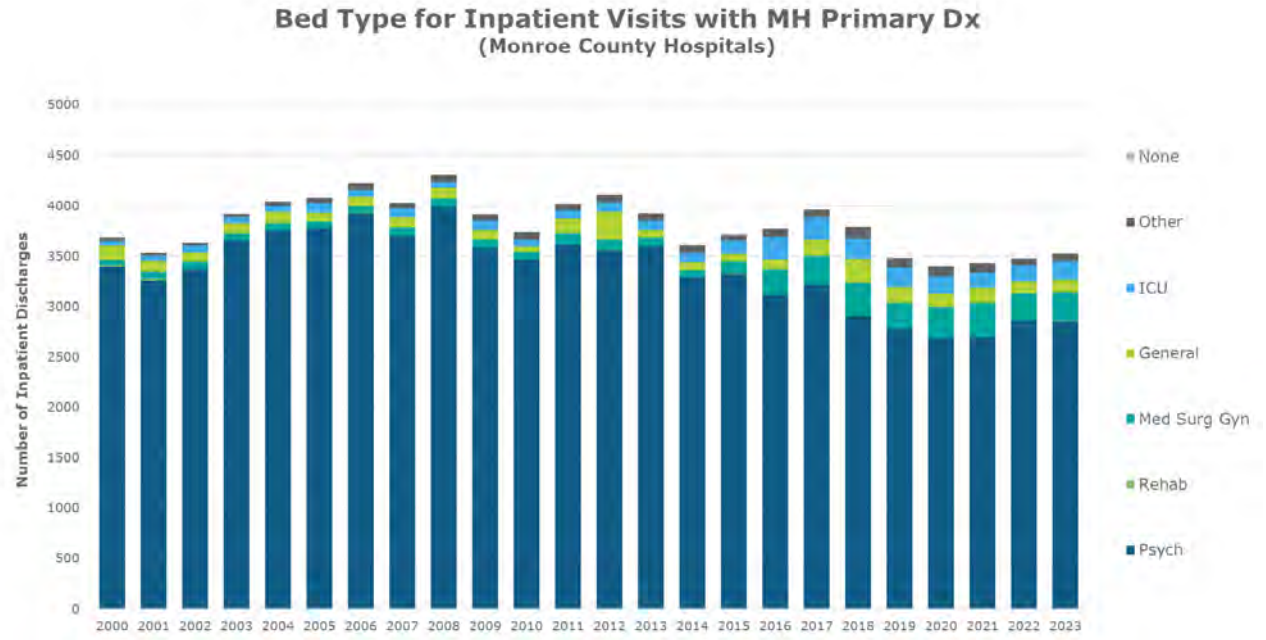
Common Ground Health

Inpatient Bed Utilization



Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS)
Analysis by Common Ground Health

Common Ground Health



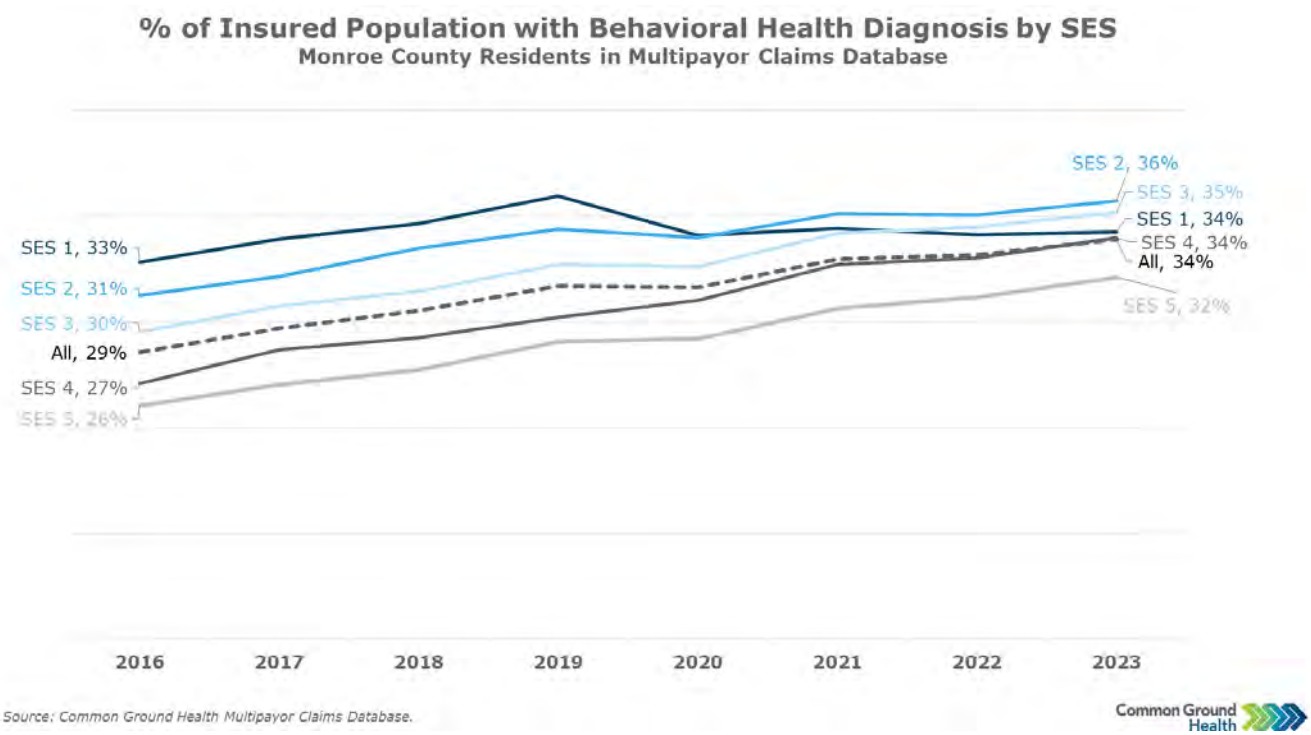
Source: NYSDOH Statewide Planning and Research Collaborative (SPARCS)
Analysis by Common Ground Health

Common Ground Health

Diagnosis Prevalence and Care Utilization of the Insured Population

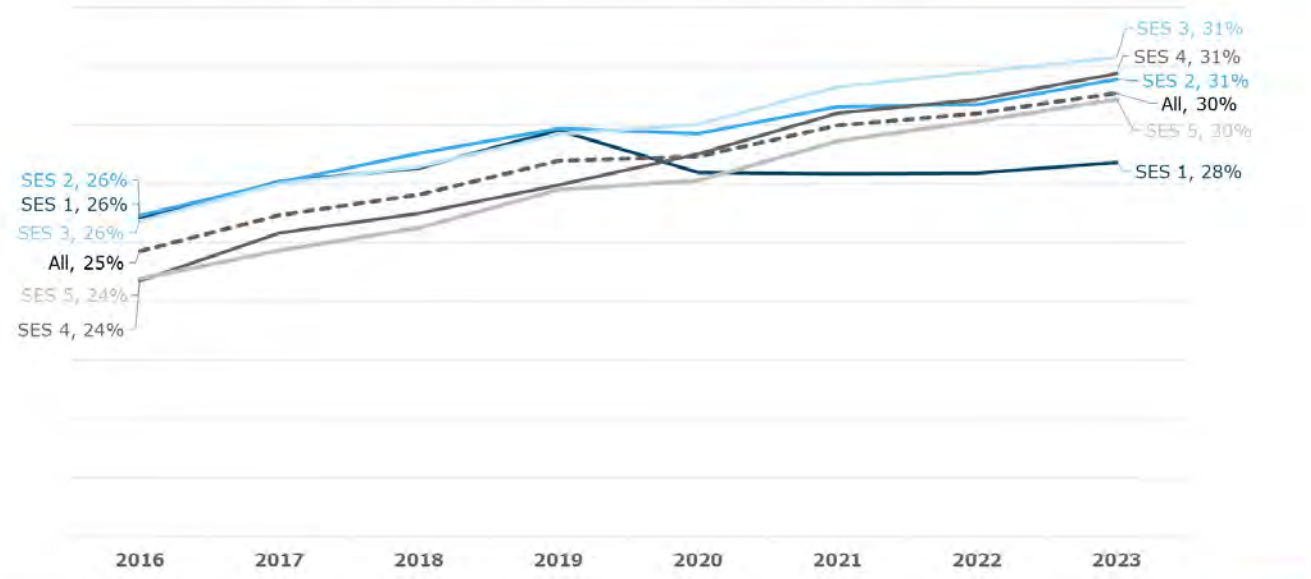
Source: Common Ground Health Multipayor Claims Database Data

Behavioral Health Diagnoses among Insured Population



% of Insured Population with Mental Health Diagnosis by SES

Monroe County Residents in Multipayor Claims Database

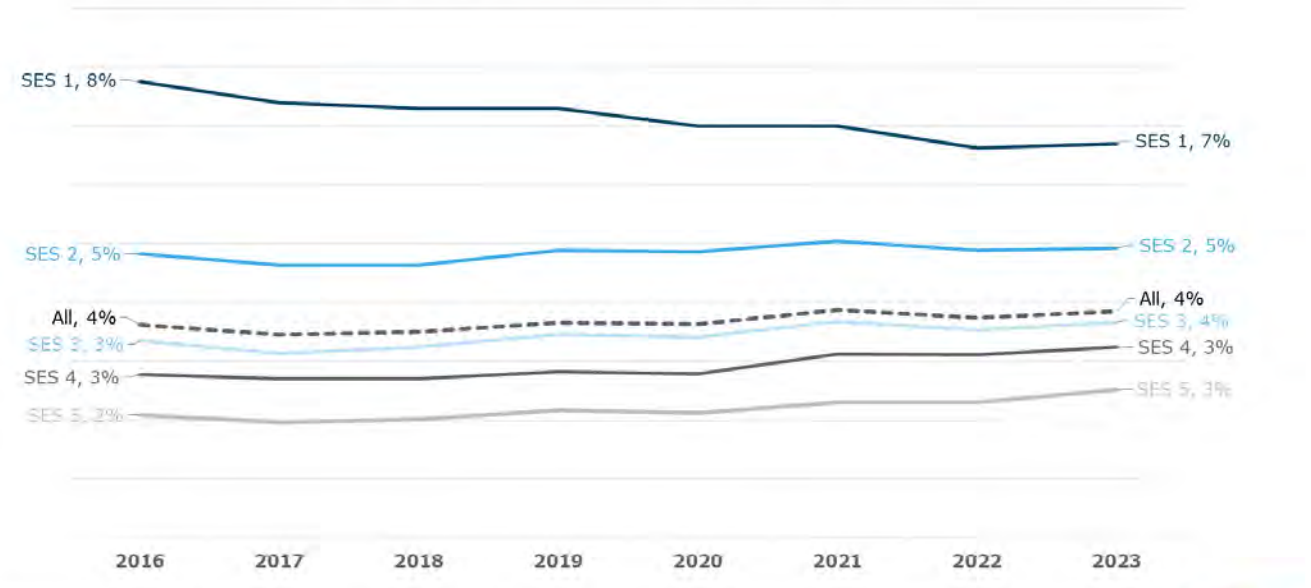


Source: Common Ground Health Multipayor Claims Database.

Common Ground Health

% of Insured Population with Substance Use Disorder Diagnosis by SES

Monroe County Residents in Multipayor Claims Database

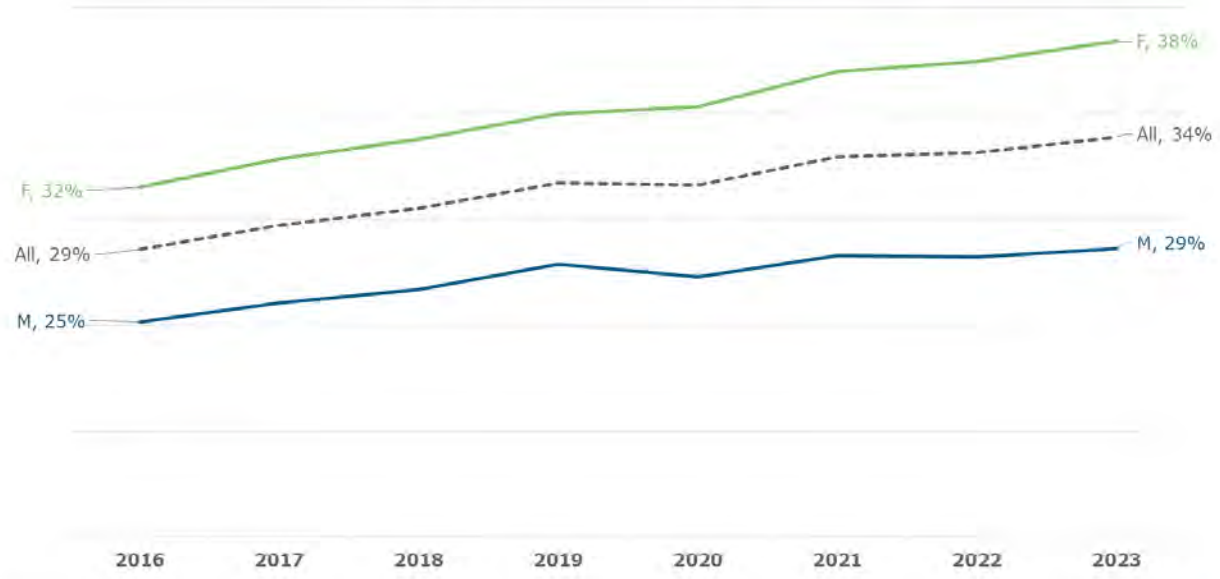


Source: Common Ground Health Multipayor Claims Database. Substance Use Disorders include drug and alcohol use disorders (but not nicotine/tobacco).

Common Ground Health

% of Insured Population with Behavioral Health Diagnosis by Sex

Monroe County Residents in Multipayor Claims Database

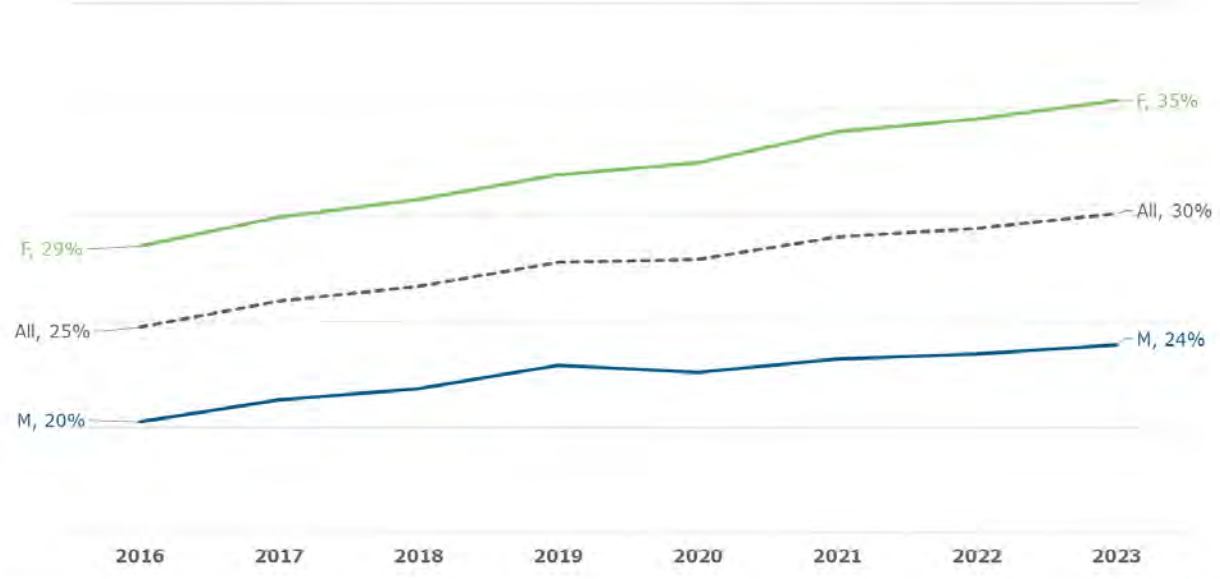


Source: Common Ground Health Multipayor Claims Database.

Common Ground Health

% of Insured Population with Mental Health Diagnosis by Sex

Monroe County Residents in Multipayor Claims Database

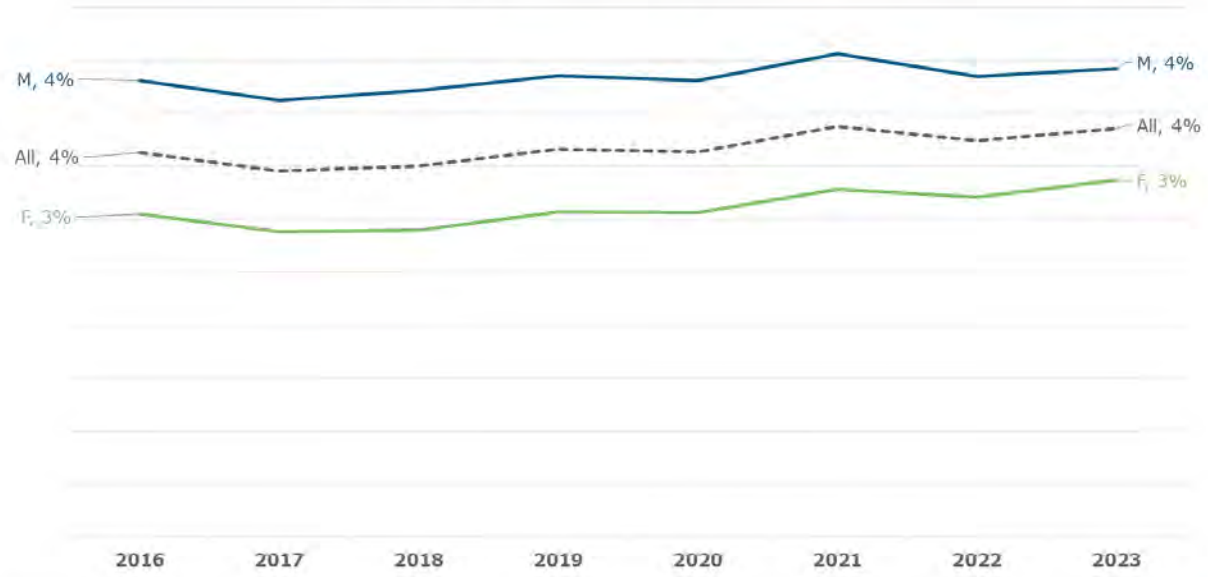


Source: Common Ground Health Multipayor Claims Database.

Common Ground Health

% of Insured Population with Substance Use Disorder Diagnosis by Sex

Monroe County Residents in Multipayor Claims Database

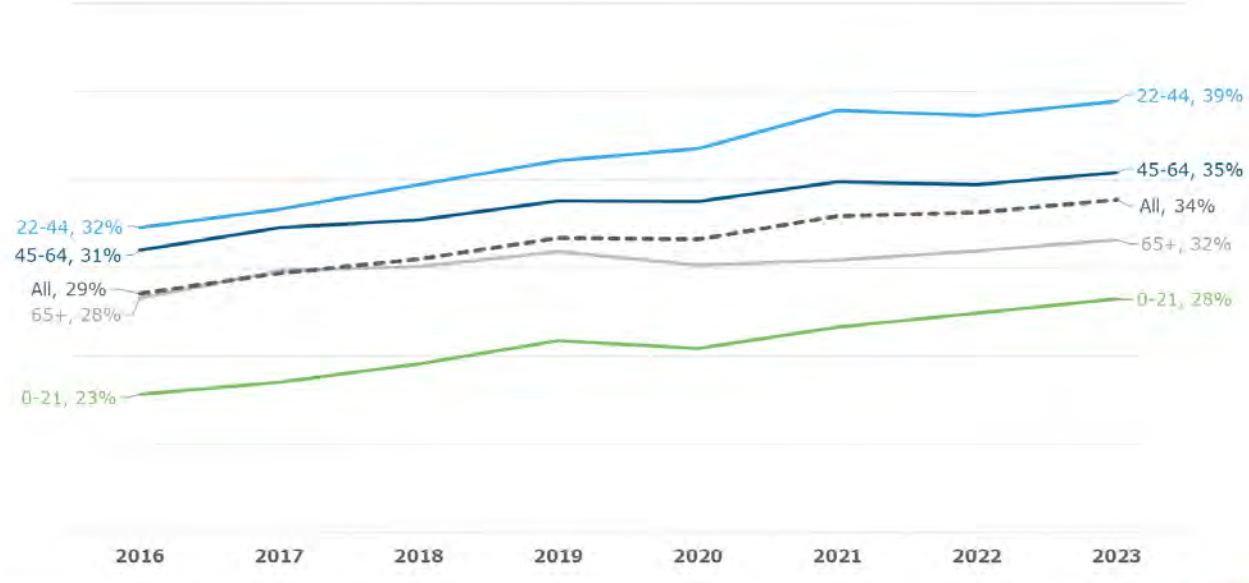


Source: Common Ground Health Multipayor Claims Database. Substance Use Disorders include drug and alcohol use disorders (but not nicotine/tobacco).

Common Ground Health

% of Insured Population with Behavioral Health Diagnosis by Age

Monroe County Residents in Multipayor Claims Database

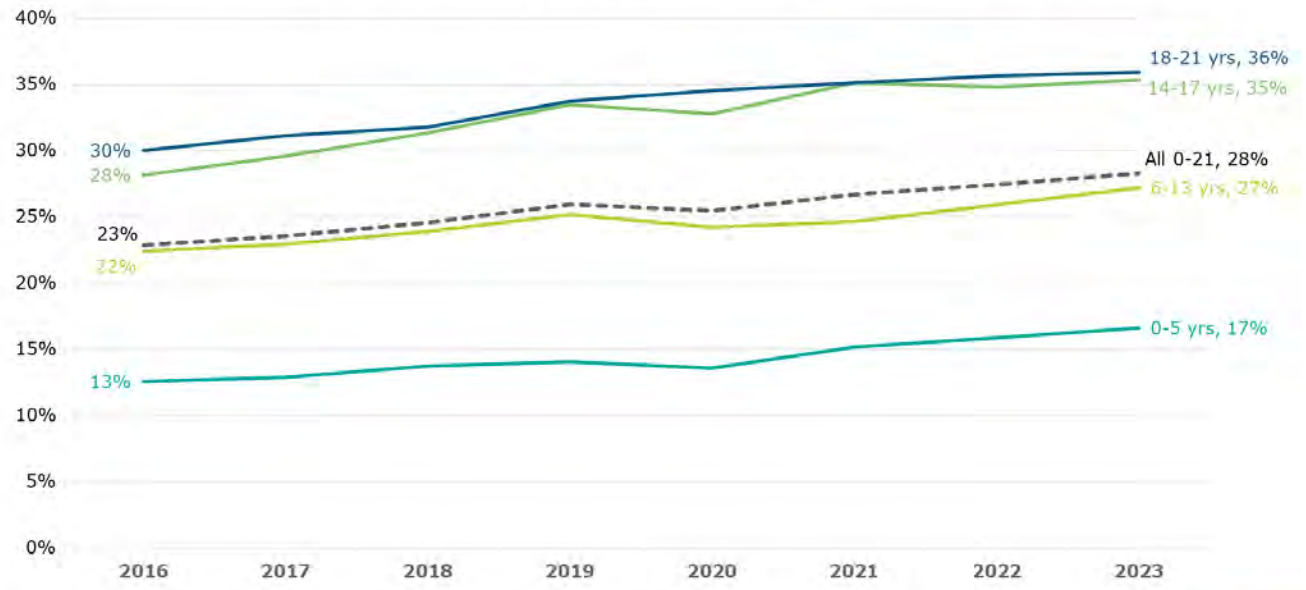


Source: Common Ground Health Multipayor Claims Database.

Common Ground Health

% of Insured Population with Behavioral Health Diagnosis by Age Group

Monroe County Youth Ages 0-21 in Multipayor Claims Database

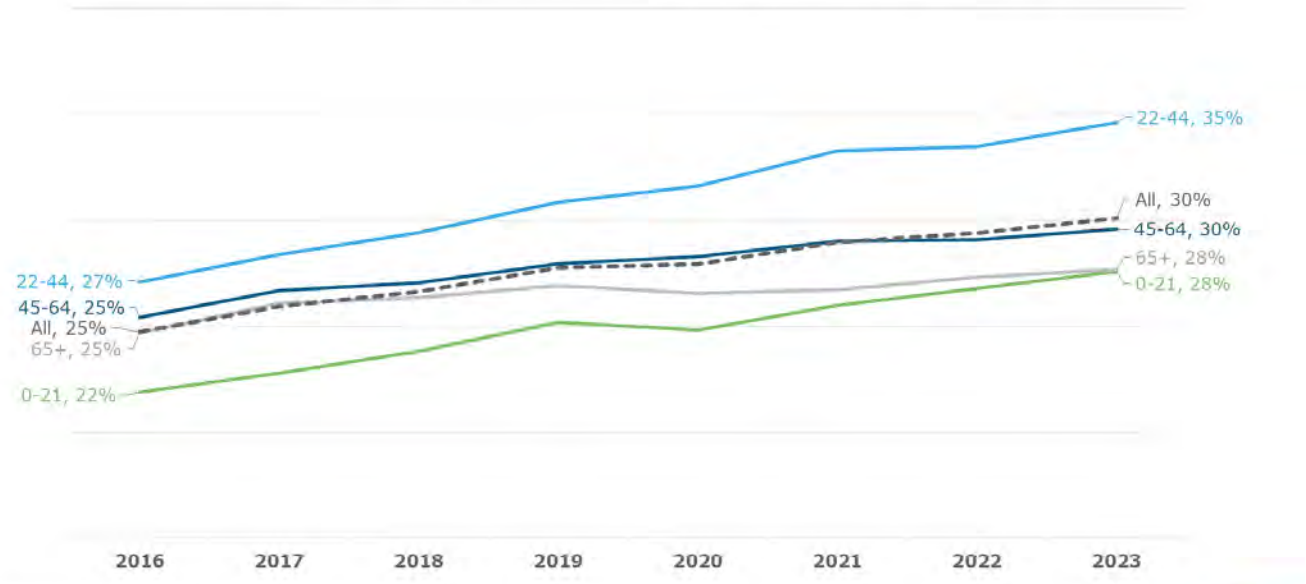


Source: Common Ground Health Multipayor Claims Database.

Common Ground Health

% of Insured Population with Mental Health Diagnosis by Age

Monroe County Residents in Multipayor Claims Database

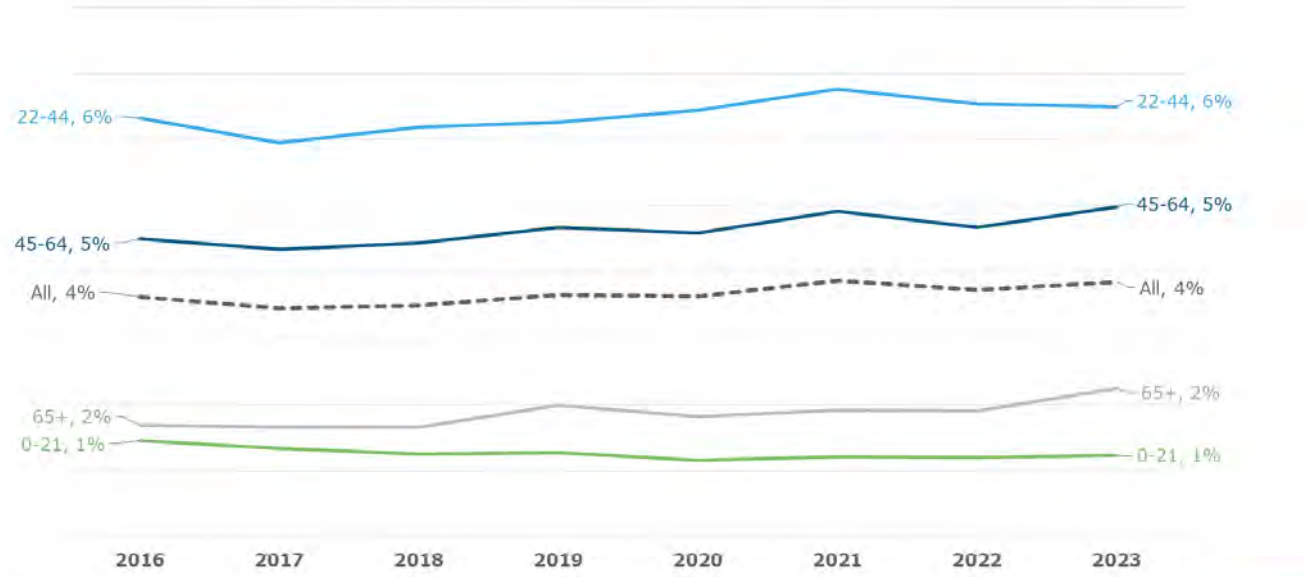


Source: Common Ground Health Multipayor Claims Database.

Common Ground Health

% of Insured Population with Substance Use Disorder Diagnosis by Age

Monroe County Residents in Multipayor Claims Database

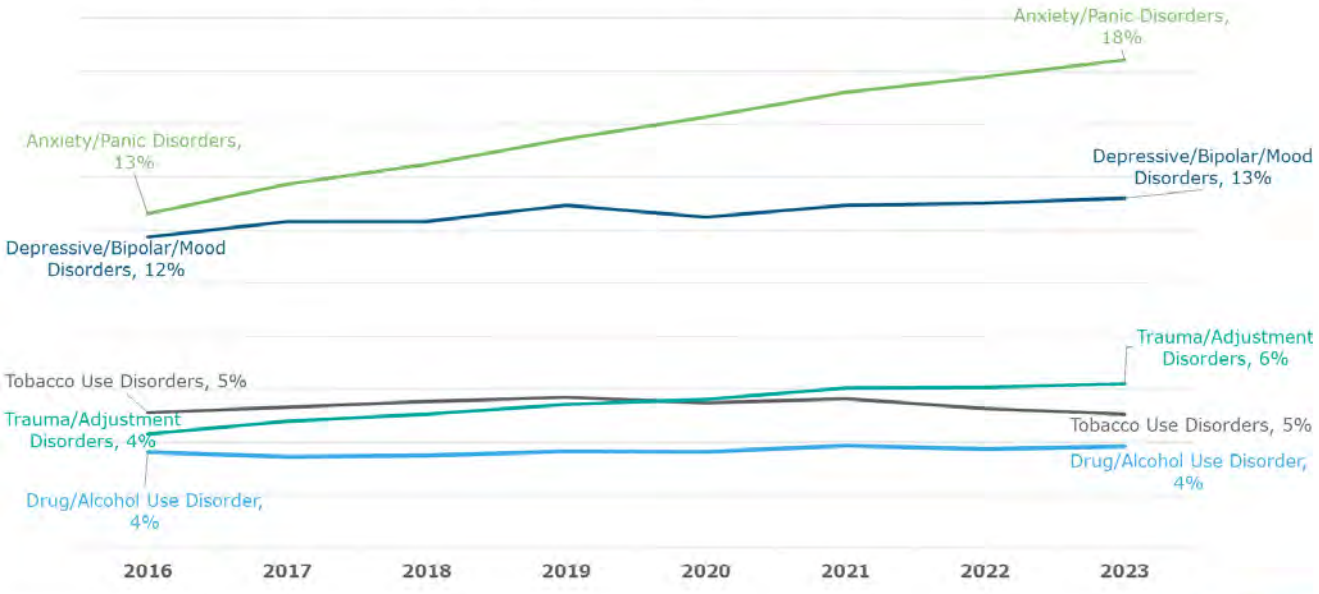


Source: Common Ground Health Multipayor Claims Database. Substance Use Disorders include drug and alcohol use disorders (but not nicotine/tobacco).

Common Ground Health

% of Insured Population with Common Behavioral Health Diagnoses

Monroe County Residents in Multipayor Claims Database

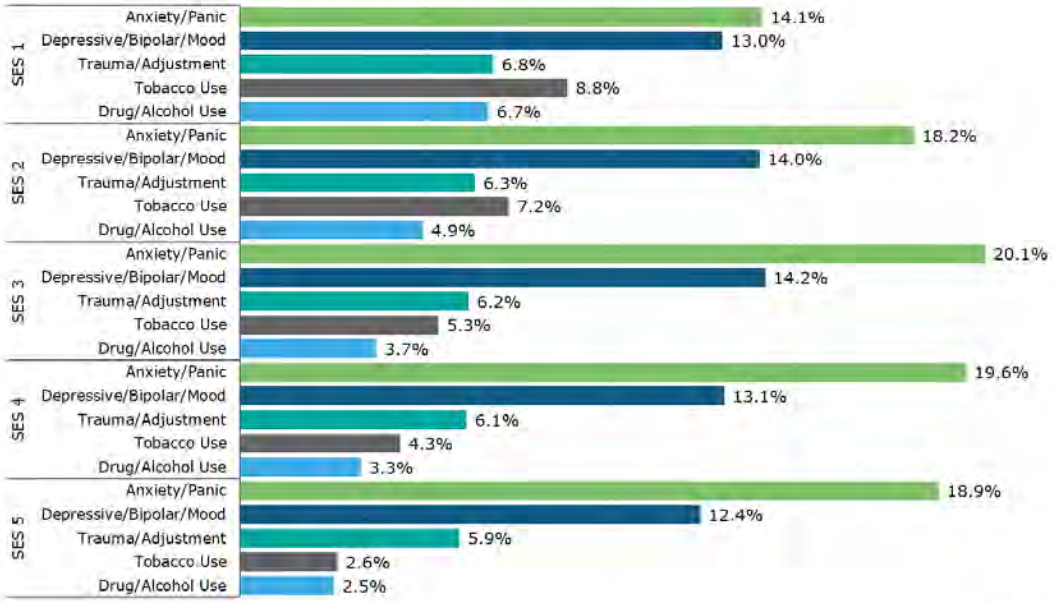


Source: Common Ground Health Multipayor Claims Database.

Common Ground Health

% of Insured Population with Behavioral Health Disorder Diagnosis by SES

Monroe County Residents in Multipayor Claims Database

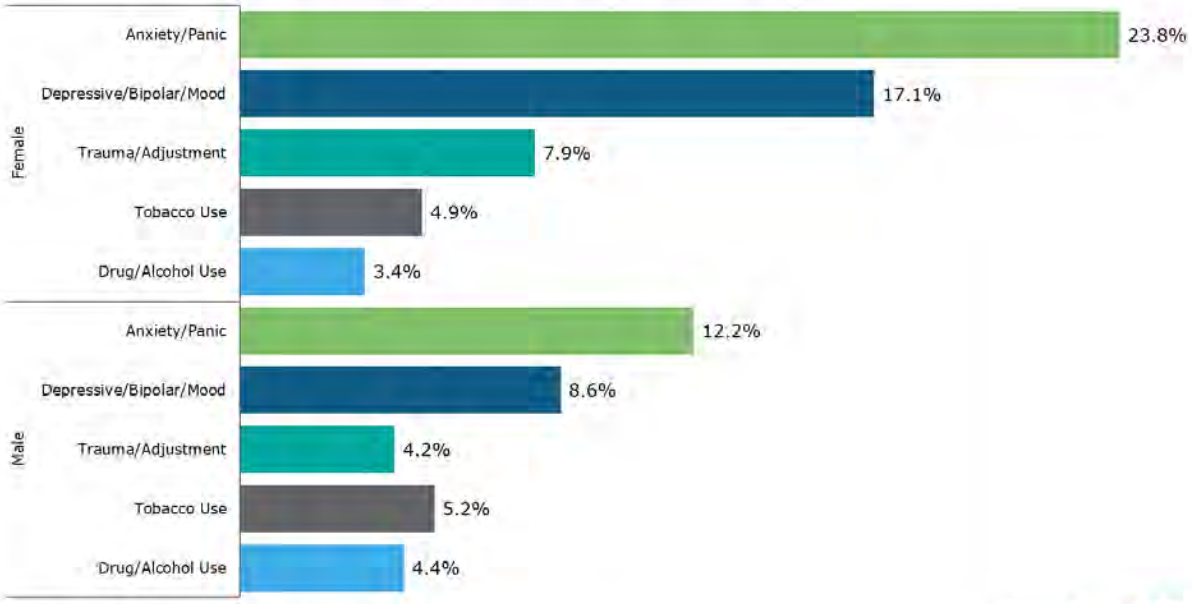


Source; Common Ground Health Multipayor Claims Database, 2023

Common Ground Health

% of Insured Population with Behavioral Health Disorder Diagnosis by Sex

Monroe County Residents in Multipayor Claims Database

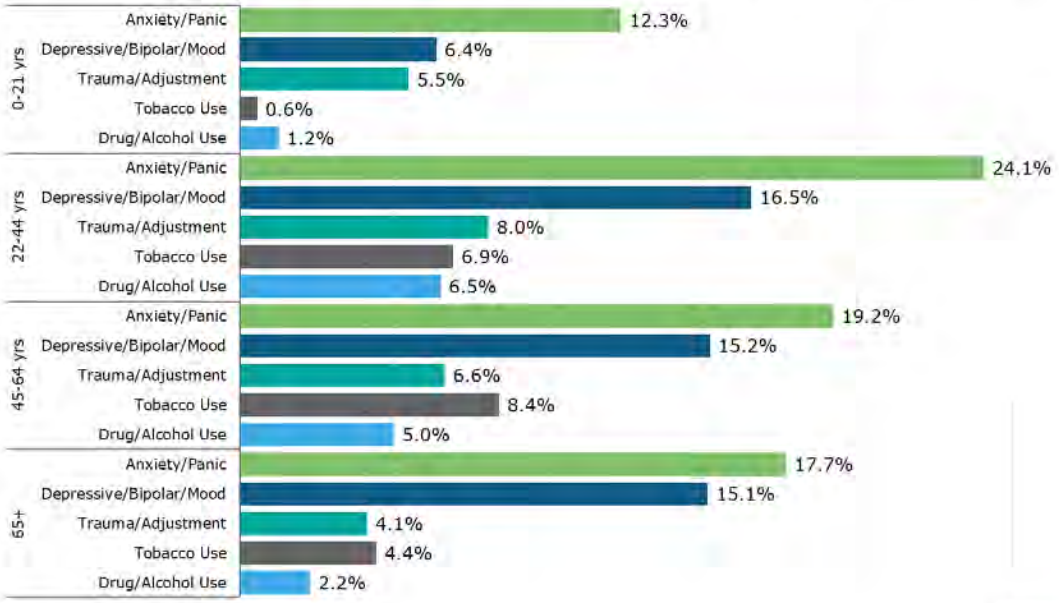


Source; Common Ground Health Multipayor Claims Database, 2023

Common Ground Health

% of Insured Population with Behavioral Health Disorder Diagnosis by Age Group

Monroe County Residents in Multipayor Claims Database

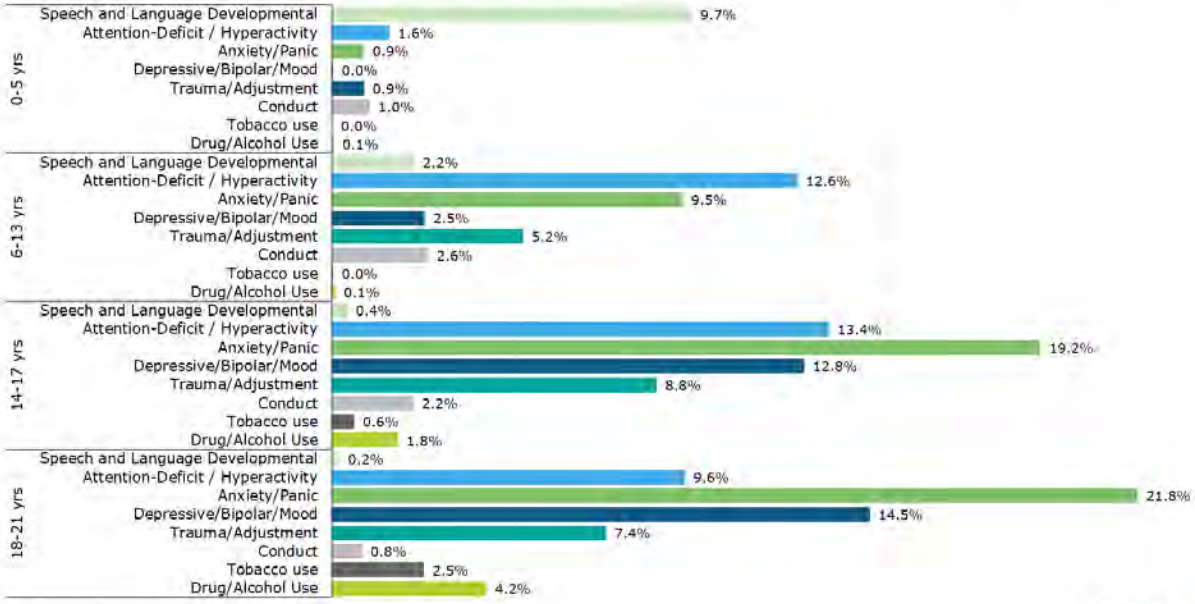


Source: Common Ground Health Multipayor Claims Database, 2023

Common Ground Health

% of Insured Population with Behavioral Health Disorder Diagnosis by Age Group

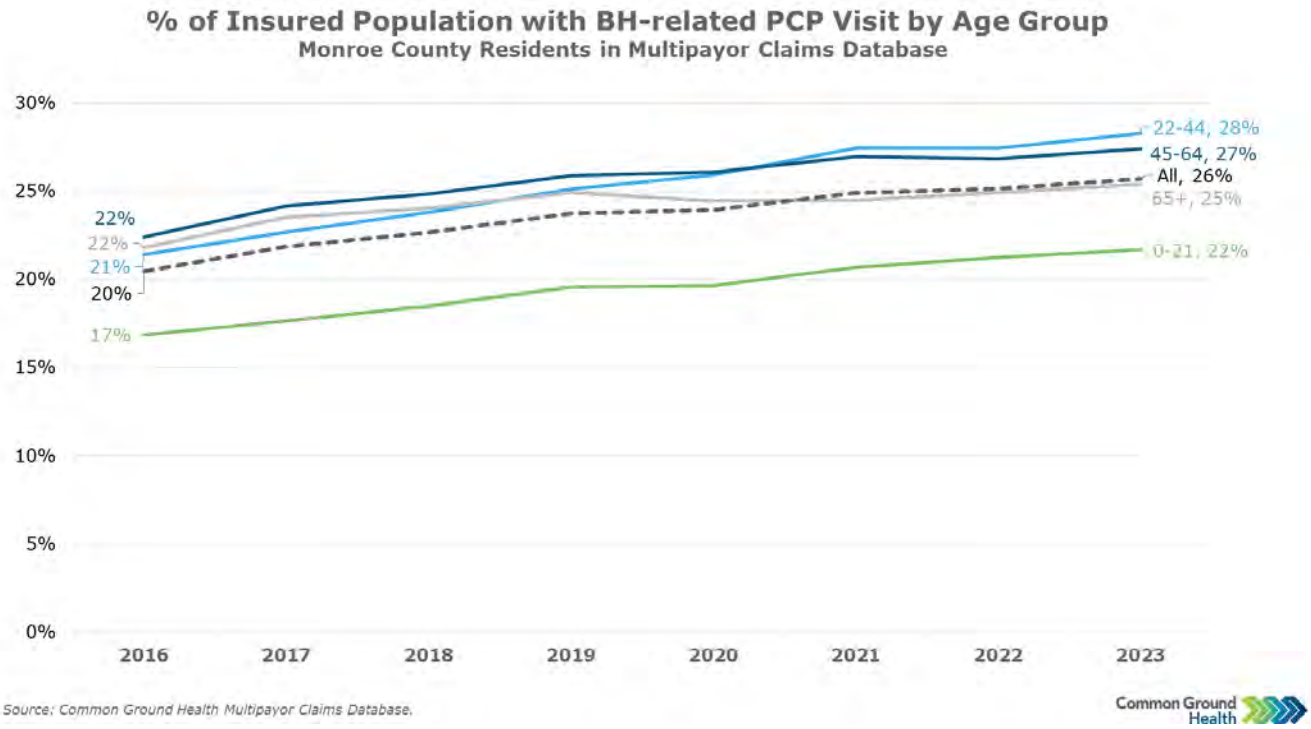
Monroe County Youth Ages 0-21 in Multipayor Claims Database

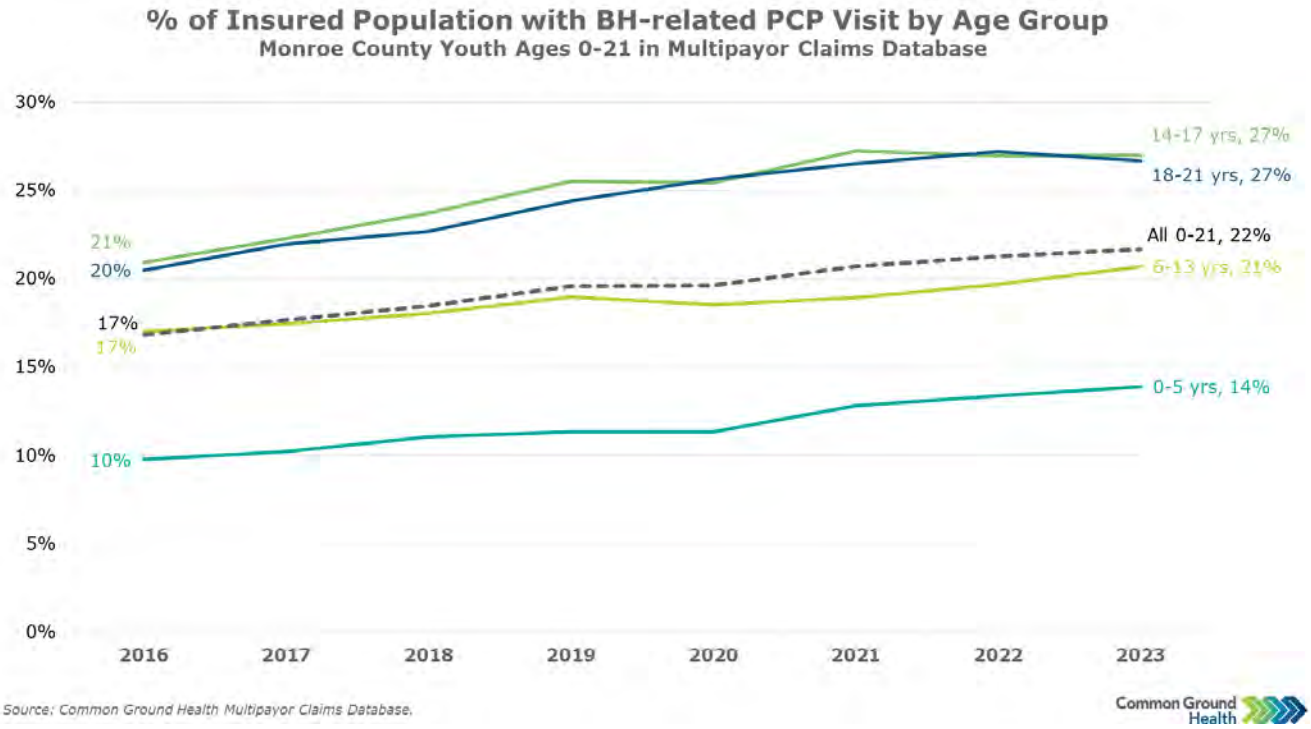


Source: Common Ground Health Multipayor Claims Database, Years 2021-2023

Common Ground Health

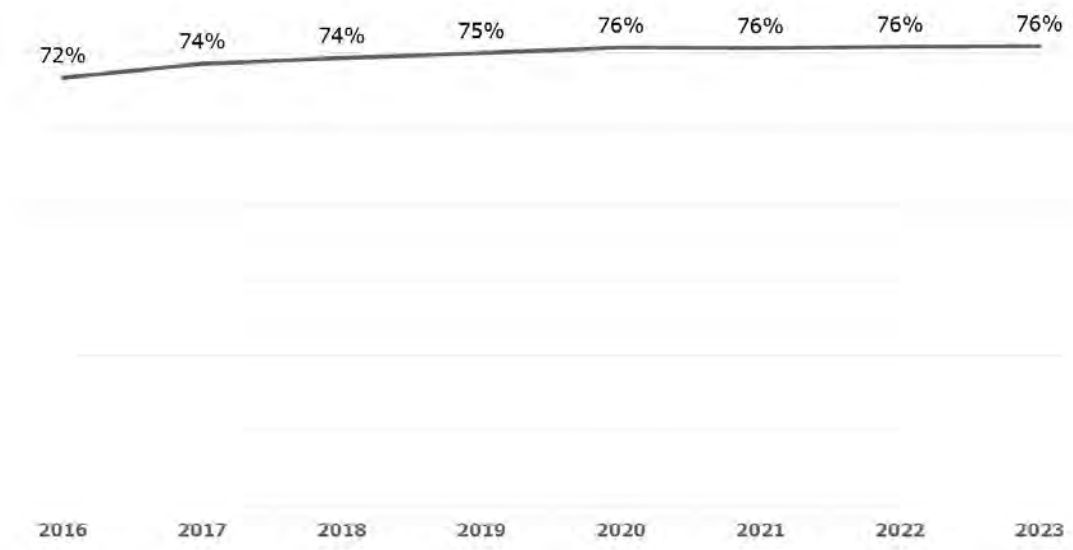
Utilization of Primary Care among Insured Population





% of Population with BH Diagnosis that had BH-related PCP visit

Monroe County Residents in Multipayor Claims Database

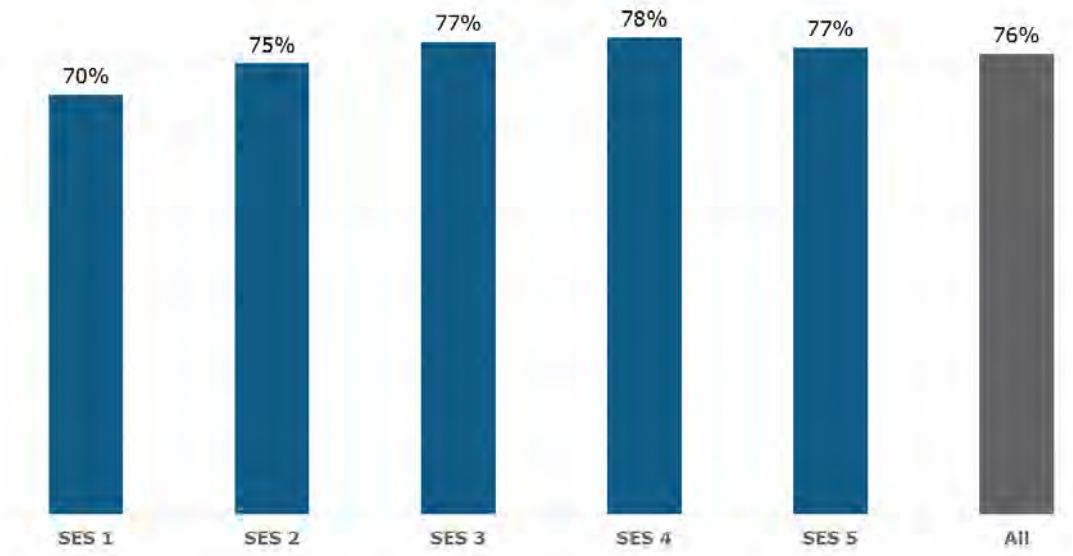


Source: Common Ground Health Multipayor Claims Database.

Common Ground Health

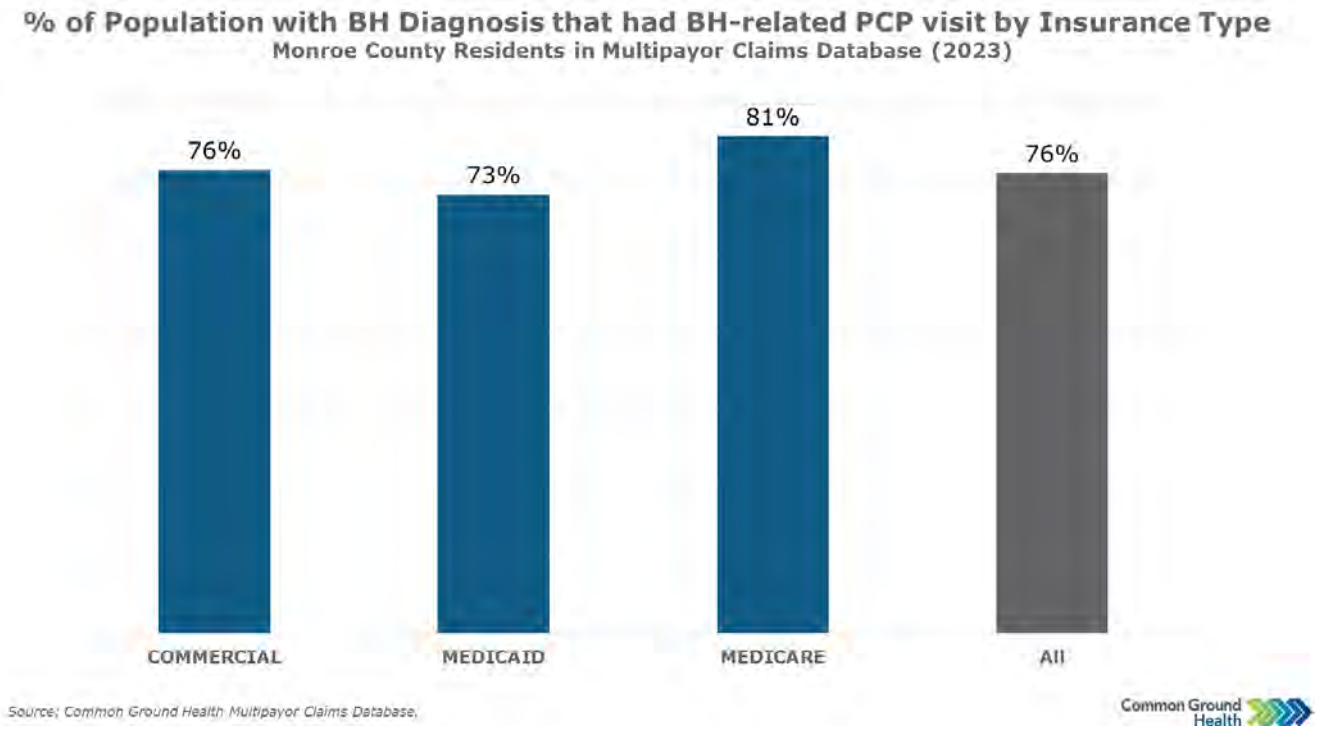
% of Population with BH Diagnosis that had BH-related PCP visit by SES

Monroe County Residents in Multipayor Claims Database (2023)

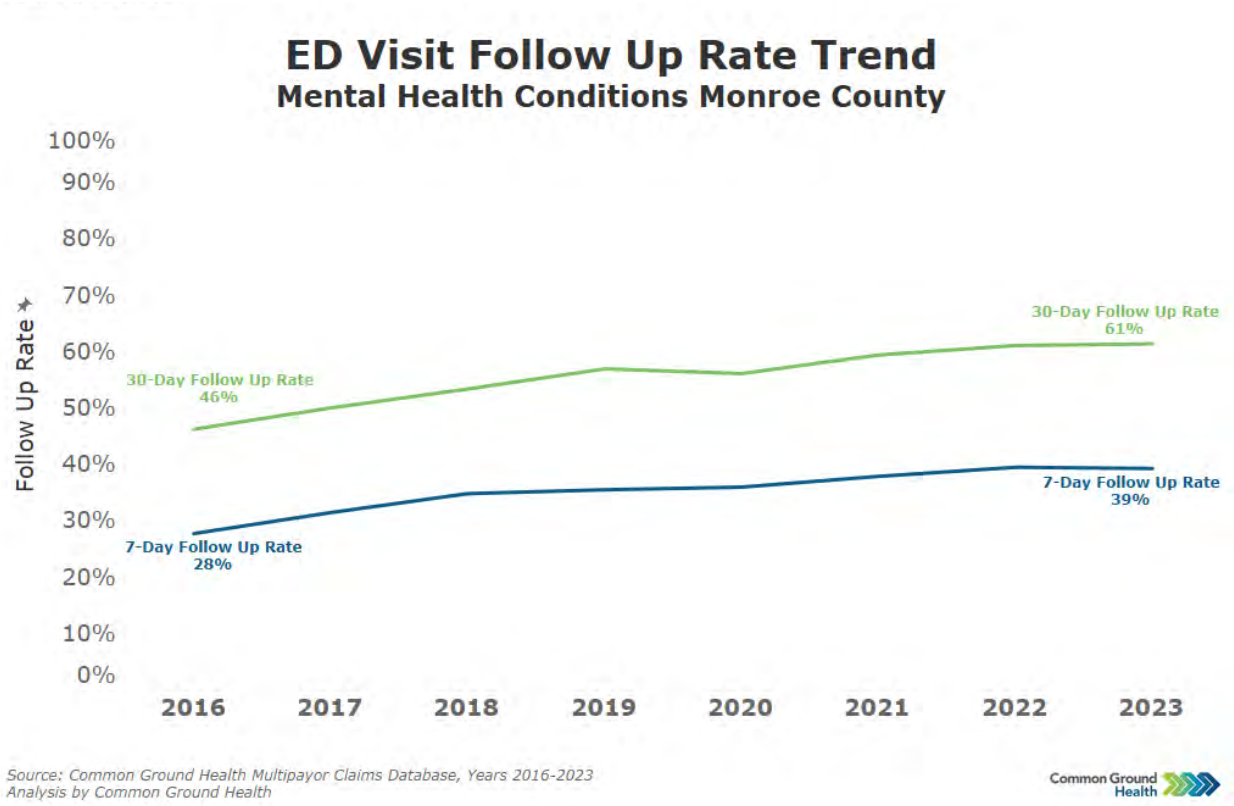


Source: Common Ground Health Multipayor Claims Database.

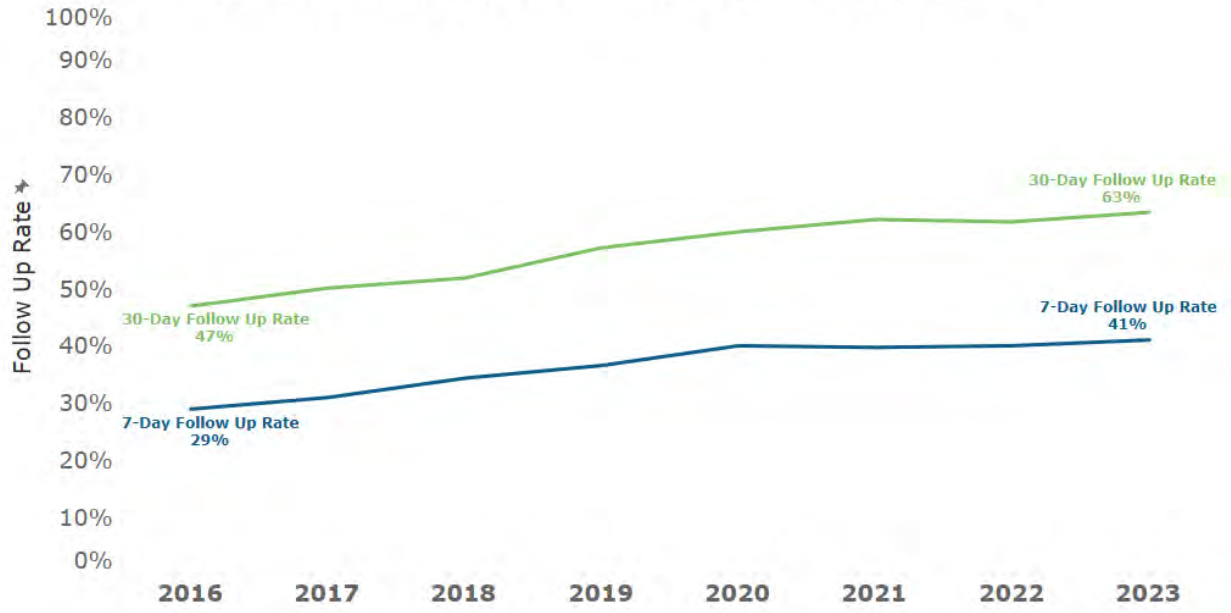
Common Ground Health


% of Population with BH Diagnosis that had BH-related PCP visit by Insurance Type
Monroe County Residents in Multipayor Claims Database (2023)
76%
73%
81%
76%
COMMERCIAL
MEDICAID
MEDICARE
All
Source: Common Ground Health Multipayor Claims Database.
Common Ground Health

Follow Up Rates after ED Visits due to Mental Health Condition



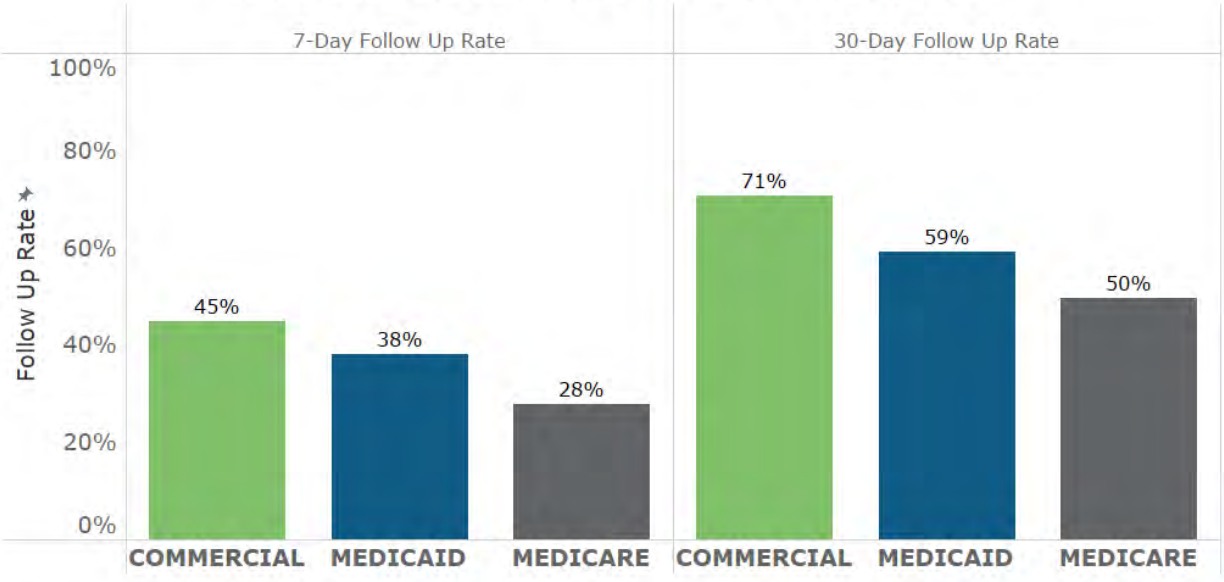
ED Visit Follow Up Rate Trend
Youth (Under 22) with Mental Health Conditions



Source: Common Ground Health Multipayor Claims Database, Years 2016-2023
Analysis by Common Ground Health

Common Ground Health

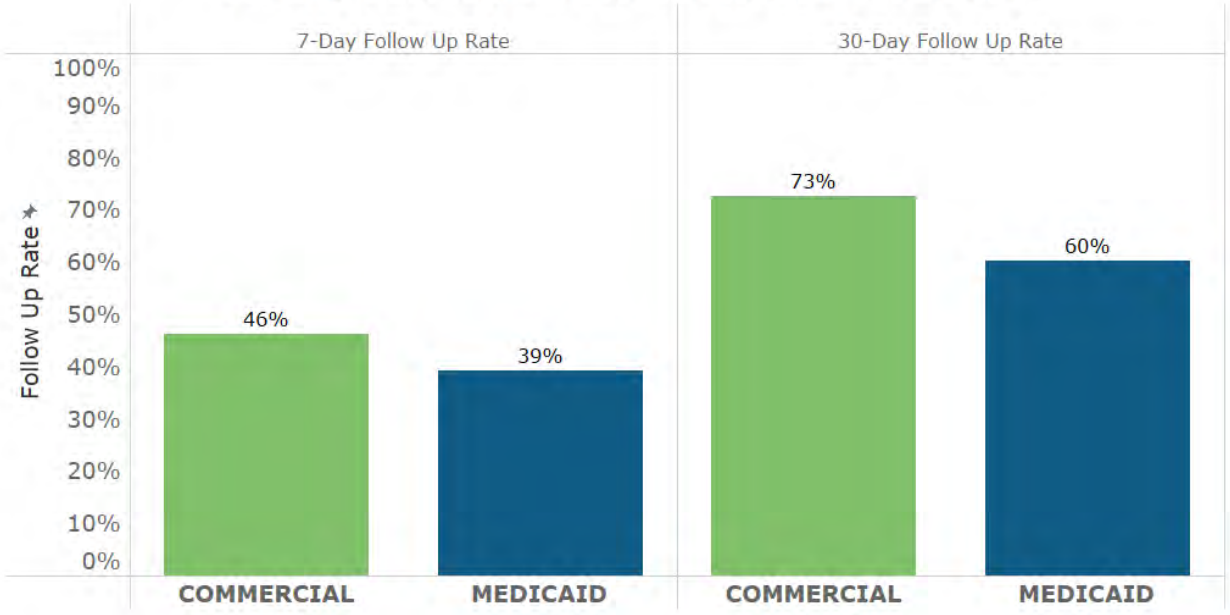
ED Visit Follow Up Rate by Insurance Type
Mental Health Conditions Monroe County 2023



Source: Common Ground Health Multipayor Claims Database, Years 2023
Analysis by Common Ground Health

Common Ground Health

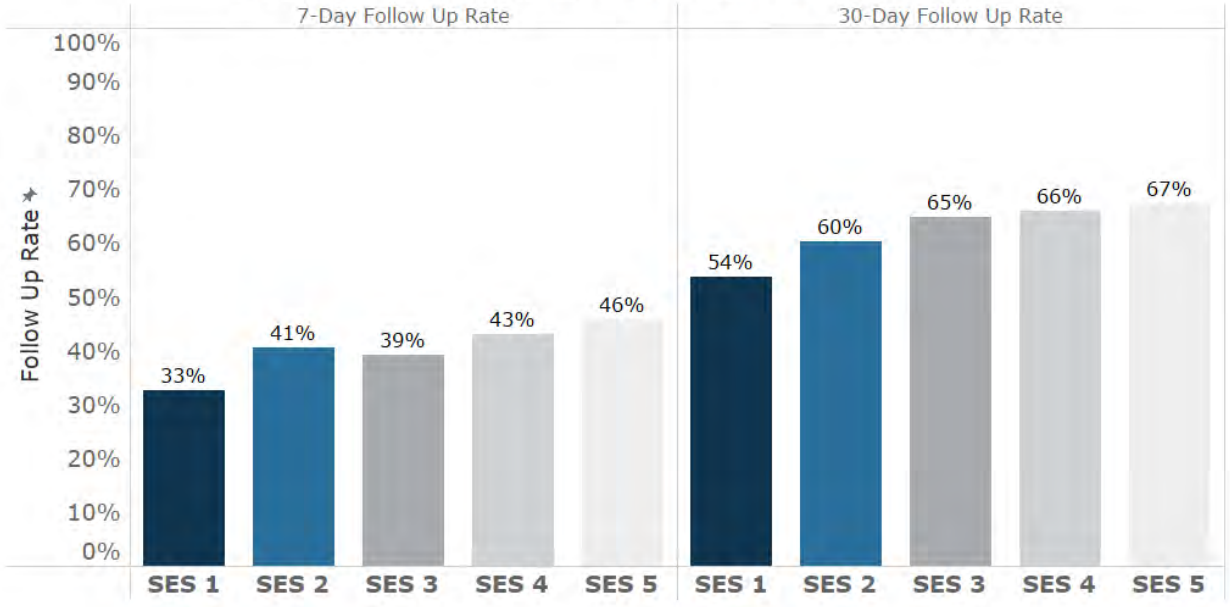
ED Visit Follow Up Rate by Insurance Type
Youth (Under 22) with Mental Health Conditions



Source: Common Ground Health Multipayor Claims Database, Years 2023
Analysis by Common Ground Health

Common Ground Health

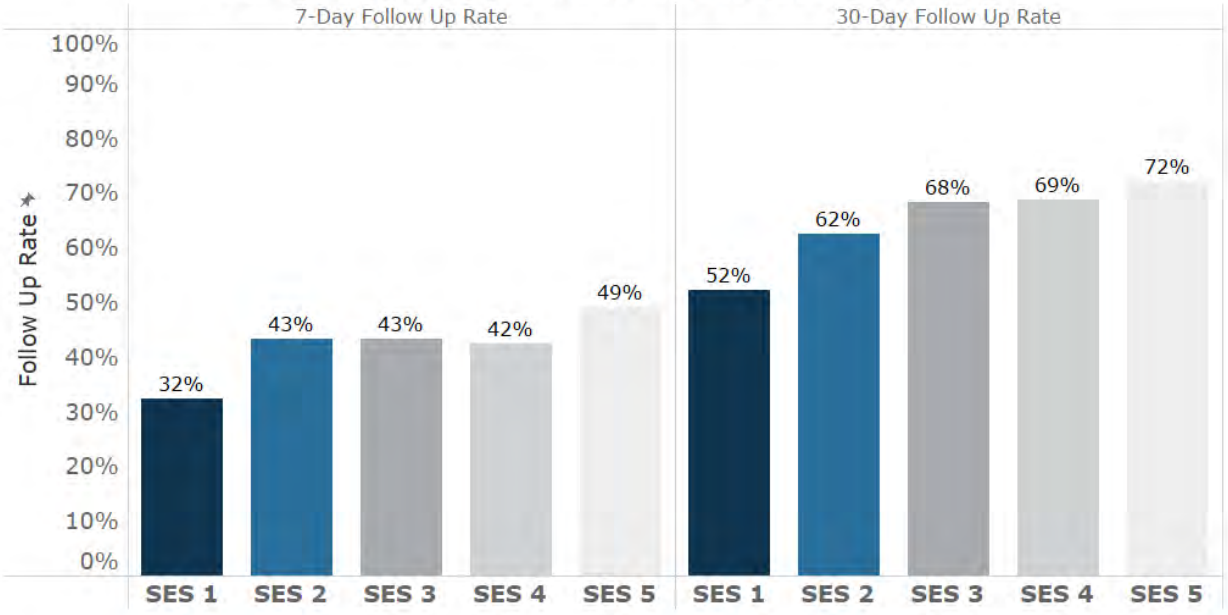
ED Visit Follow Up Rate by SES
Mental Health Conditions Monroe County 2023



Source: Common Ground Health Multipayor Claims Database, Years 2023
Analysis by Common Ground Health

Common Ground Health

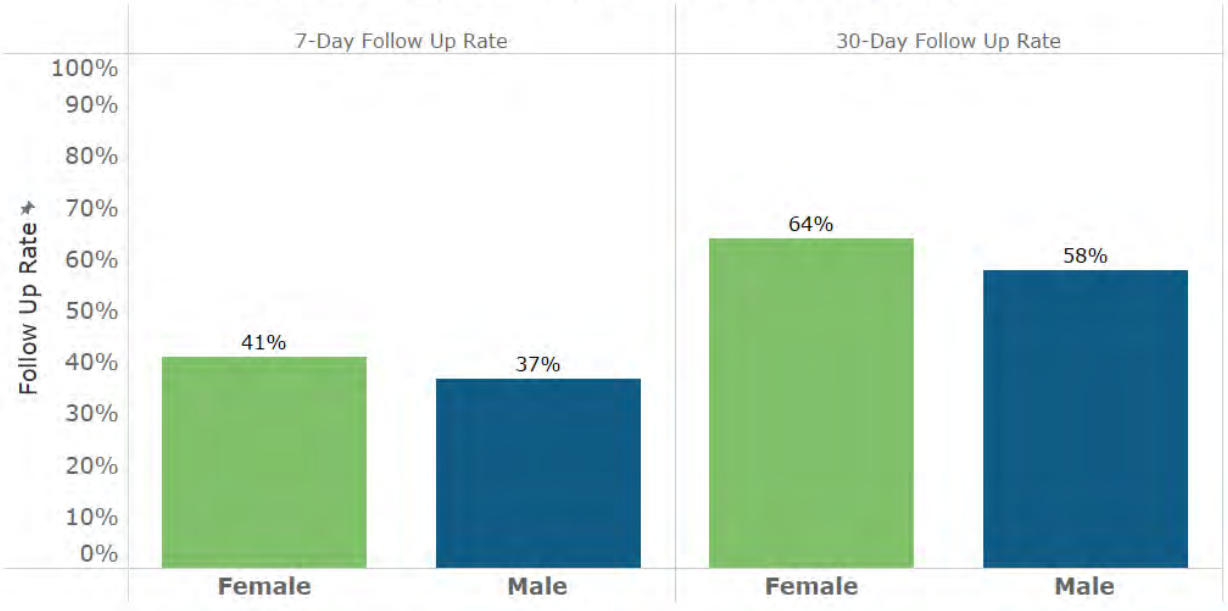
ED Visit Follow Up Rate by SES
Youth (Under 22) with Mental Health Conditions



Source: Common Ground Health Multipayor Claims Database, Years 2023
Analysis by Common Ground Health

Common Ground Health

ED Visit Follow Up Rate by Sex
Mental Health Conditions Monroe County 2023

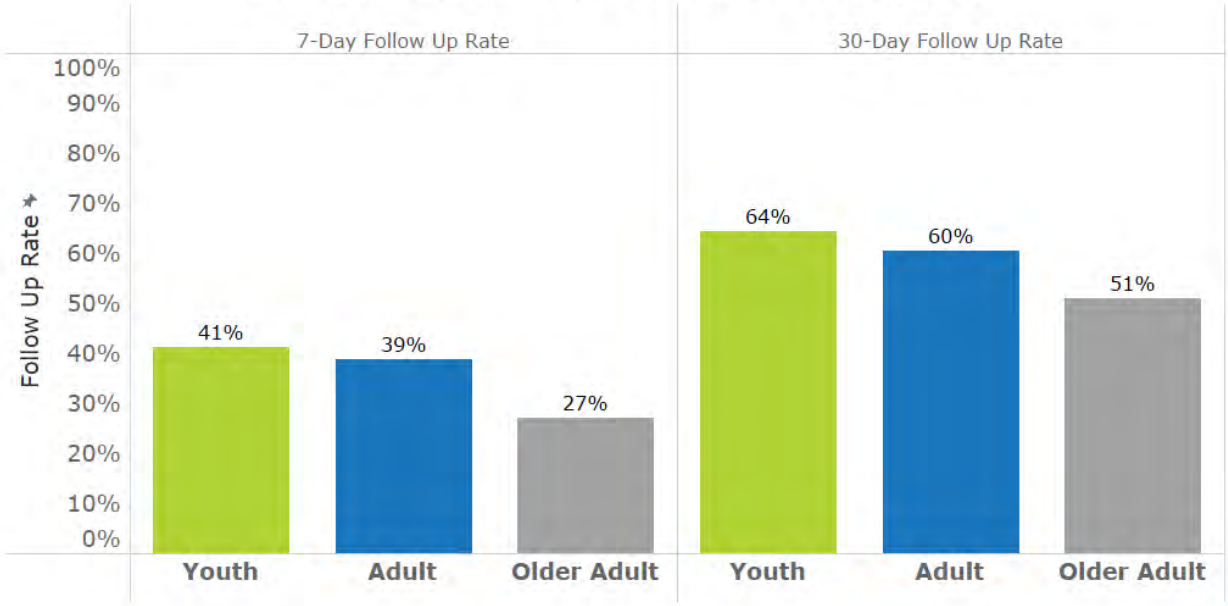


Source: Common Ground Health Multipayor Claims Database, Years 2023
Analysis by Common Ground Health

Common Ground Health

ED Visit Follow Up Rate by Age Group

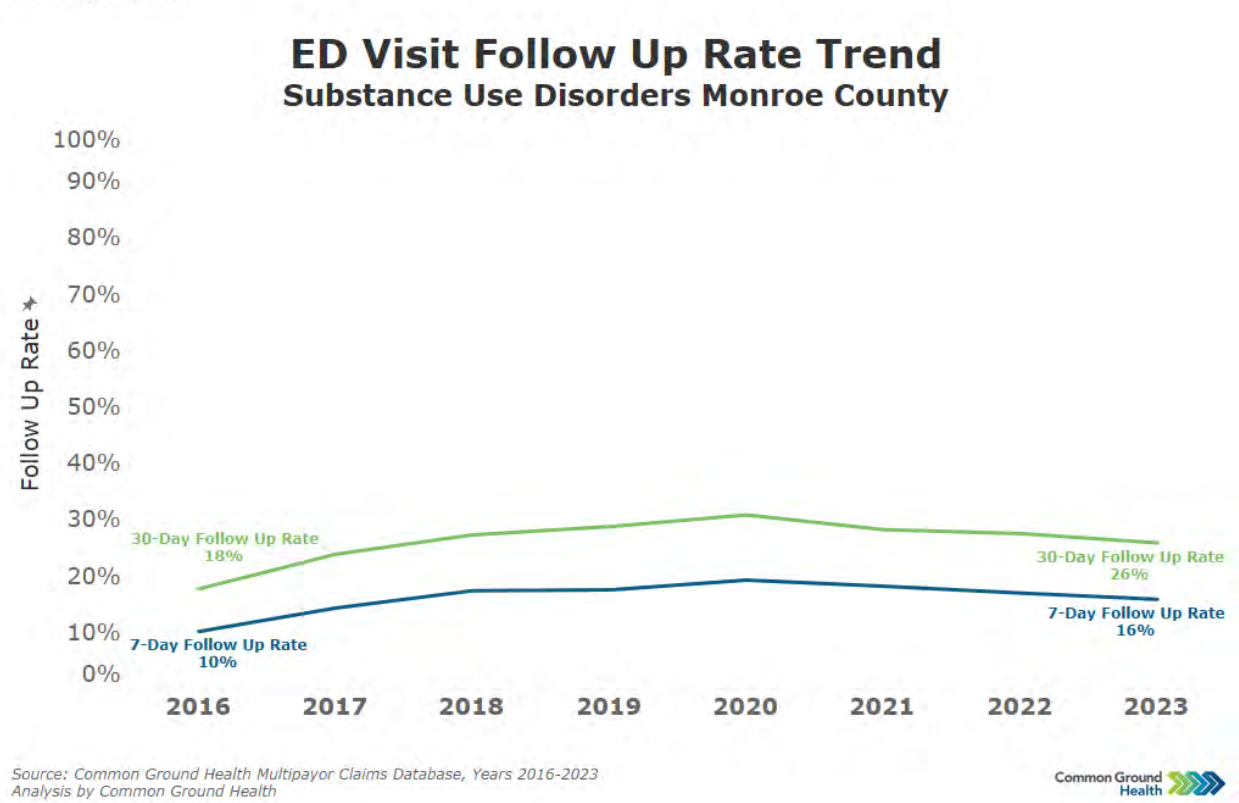
Mental Health Conditions Monroe County 2023



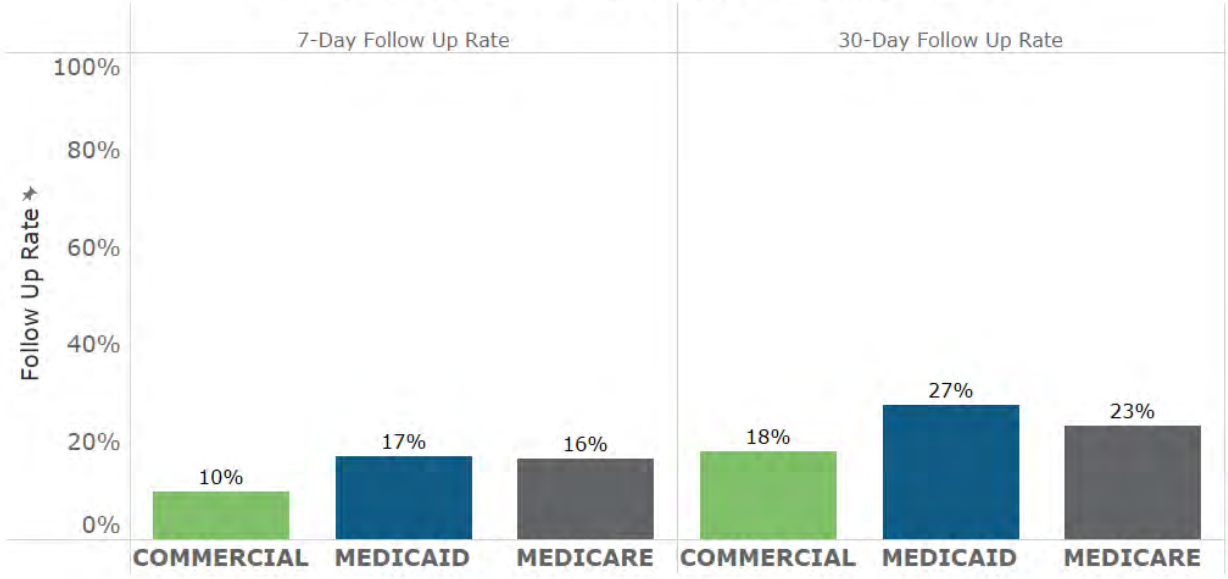
Source: Common Ground Health Multipayor Claims Database, Years 2023
Analysis by Common Ground Health

Common Ground Health

Follow Up Rates after ED Visits due to Substance Use Disorder



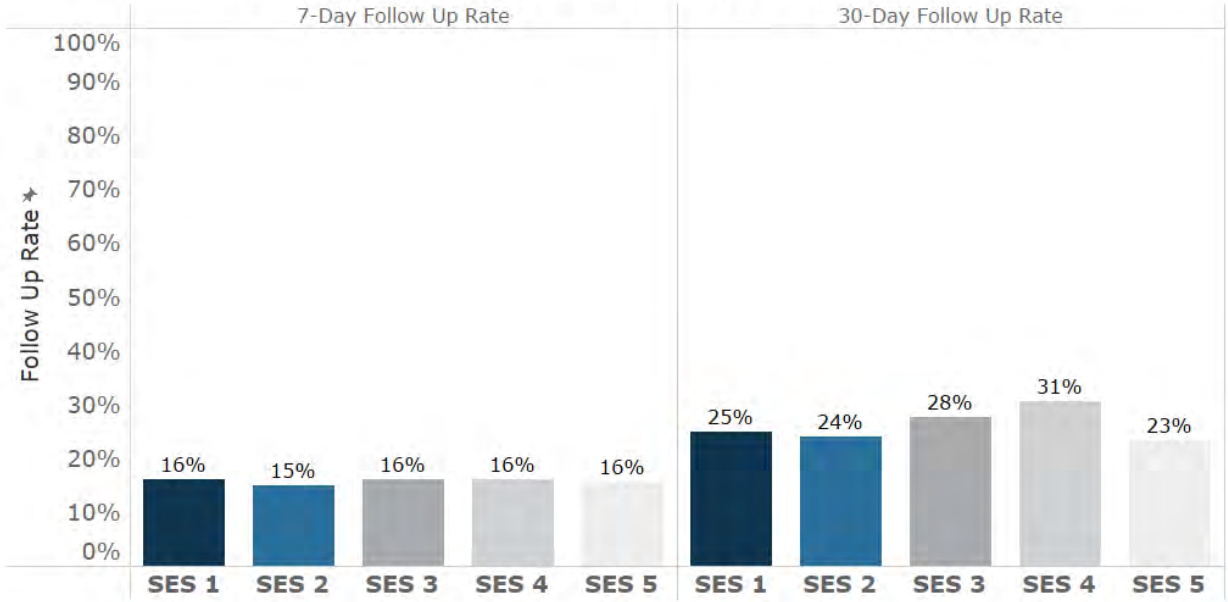
ED Visit Follow Up Rate by Insurance Type
Substance Use Disorders Monroe County 2023



Source: Common Ground Health Multipayor Claims Database, Years 2023
Analysis by Common Ground Health

Common Ground Health

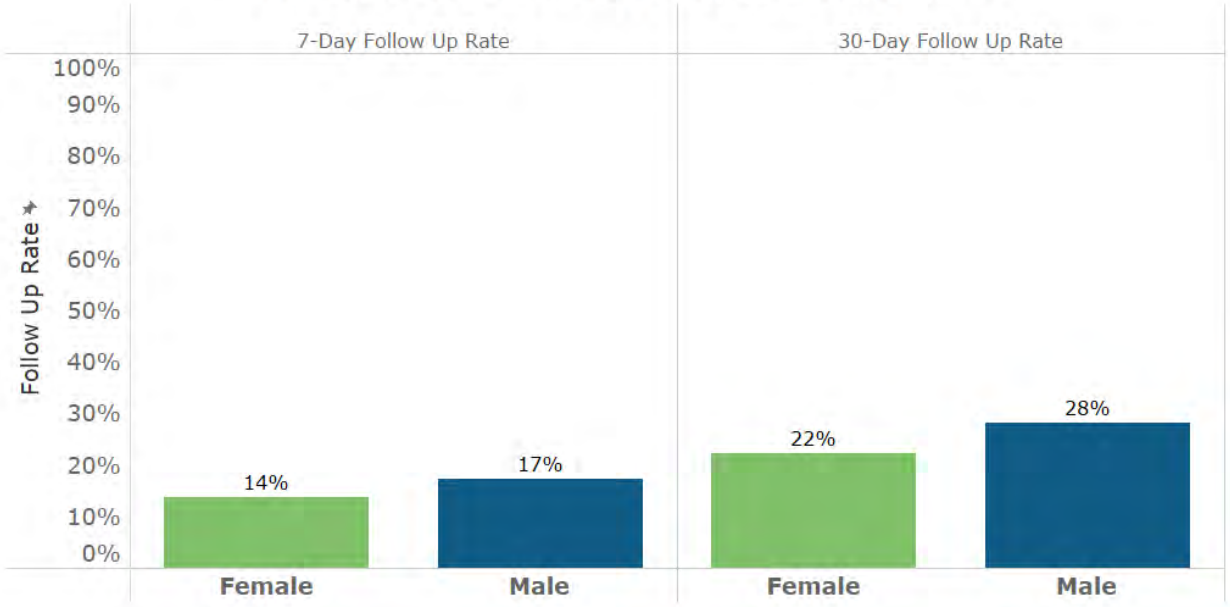
ED Visit Follow Up Rate by SES
Substance Use Disorders Monroe County 2023



Source: Common Ground Health Multipayor Claims Database, Years 2023
Analysis by Common Ground Health

Common Ground Health

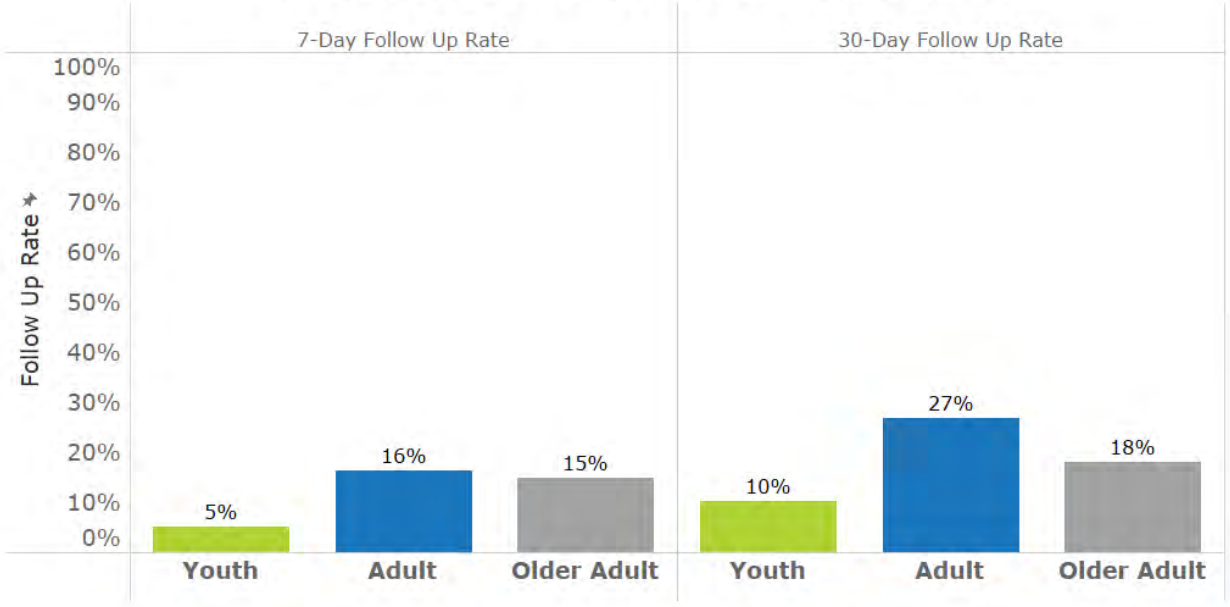
ED Visit Follow Up Rate by Sex
Substance Use Disorders Monroe County 2023



Source: Common Ground Health Multipayor Claims Database, Years 2023
Analysis by Common Ground Health

Common Ground Health

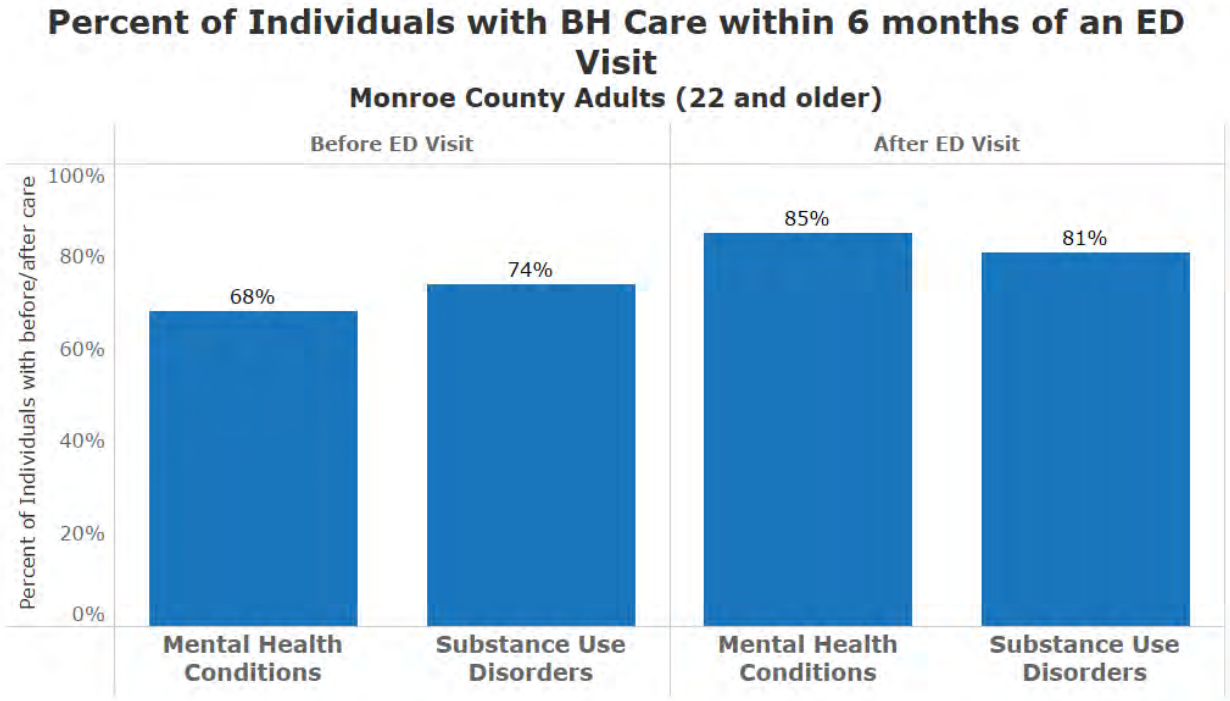
ED Visit Follow Up Rate by Age Group
Substance Use Disorders Monroe County 2023



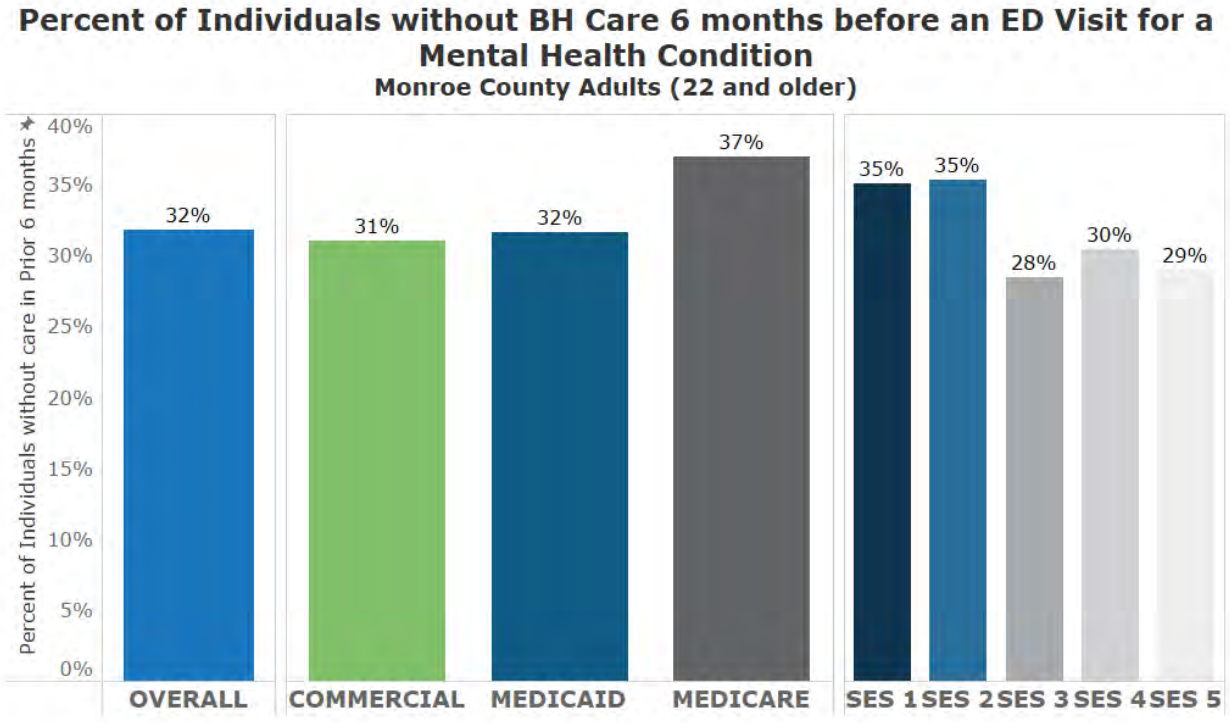
Source: Common Ground Health Multipayor Claims Database, Years 2023
Analysis by Common Ground Health

Common Ground Health

Utilization of Outpatient Care before and after an ED Visit



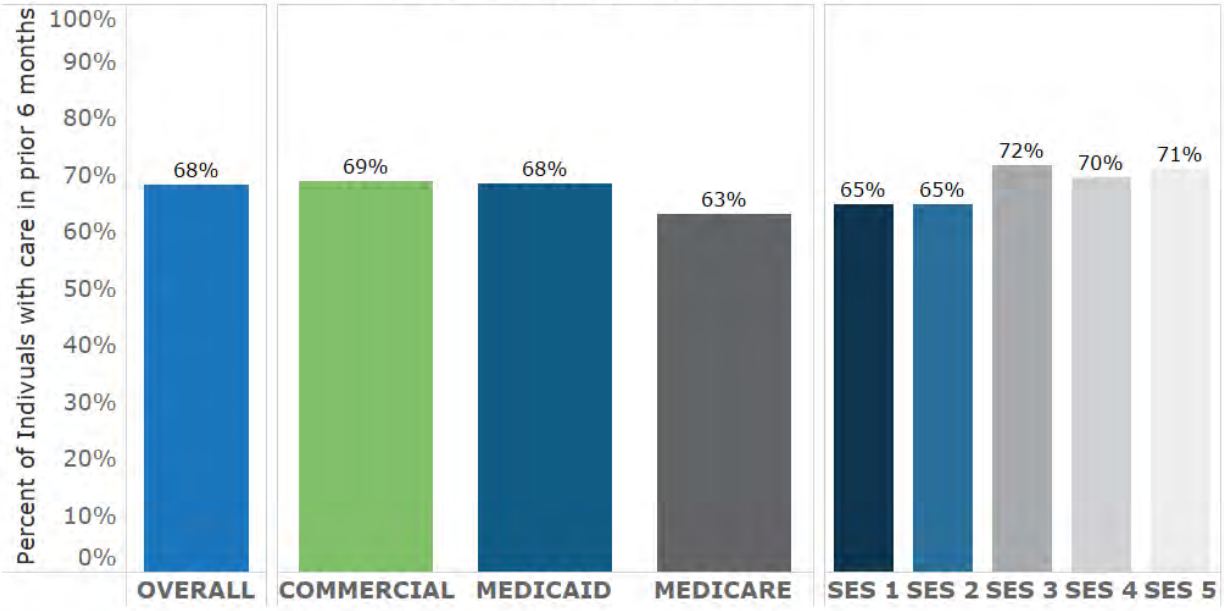
Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health



Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Percent of Individuals with BH Care 6 months before an ED Visit for a Mental Health Condition

Monroe County Adults (22 and older)

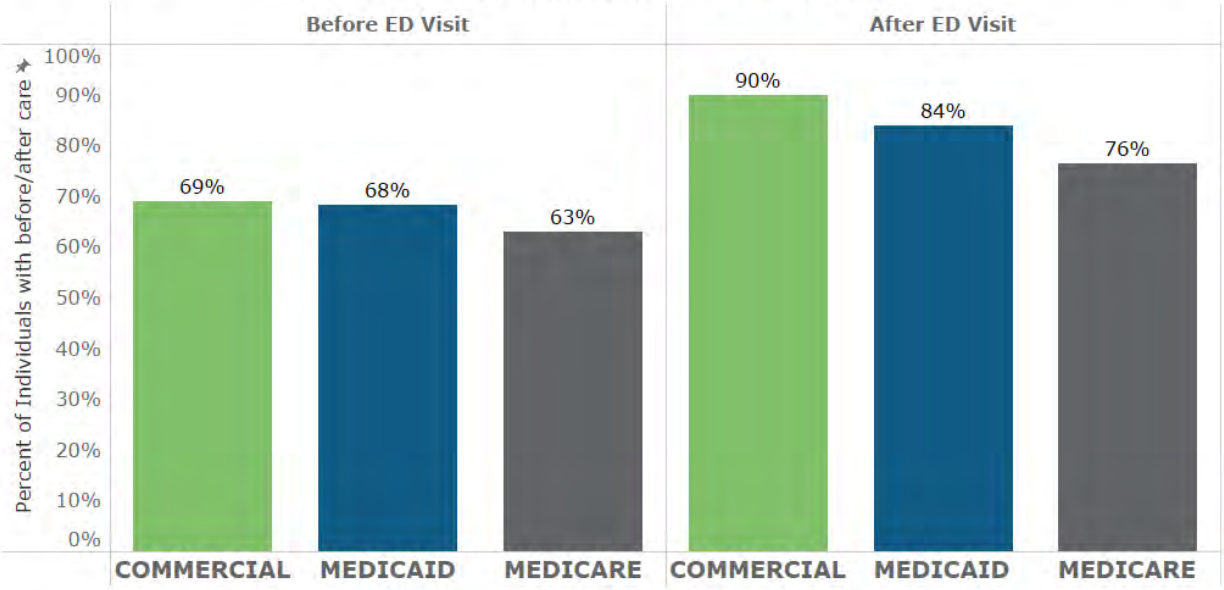


Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Common Ground Health

Percent of Individuals with BH Care within 6 months by Insurance Type for ED Visits with Mental Health Conditions

Monroe County Adults (22 and older)

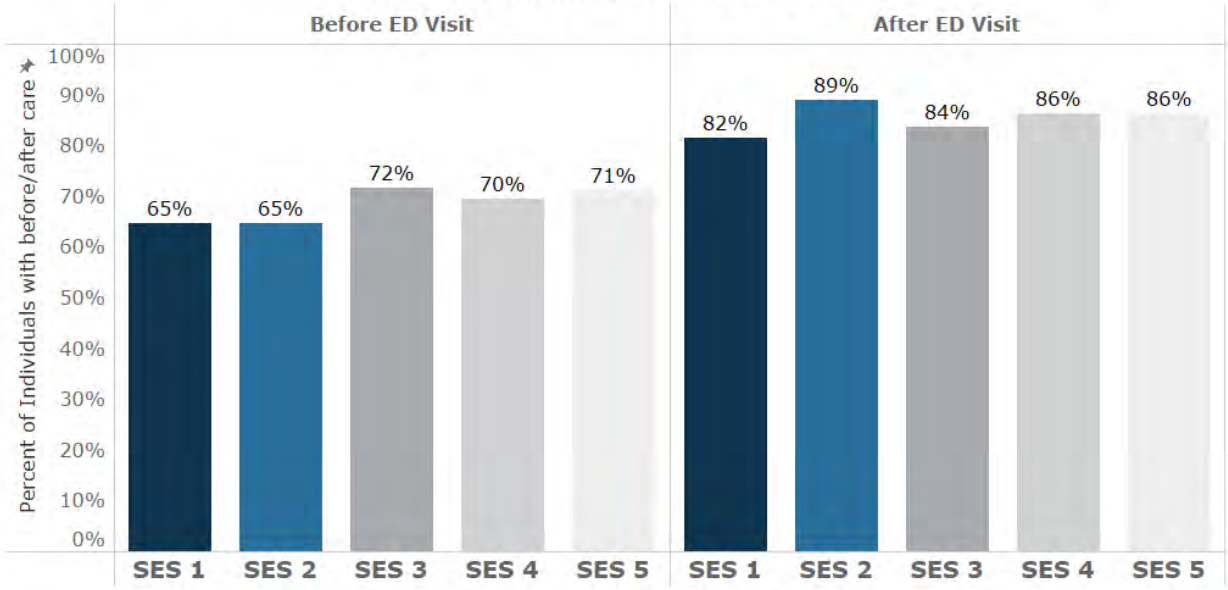


Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Common Ground Health

Percent of Individuals with BH Care within 6 months by SES for ED Visits with Mental Health Conditions Conditions

Monroe County Adults (22 and older)

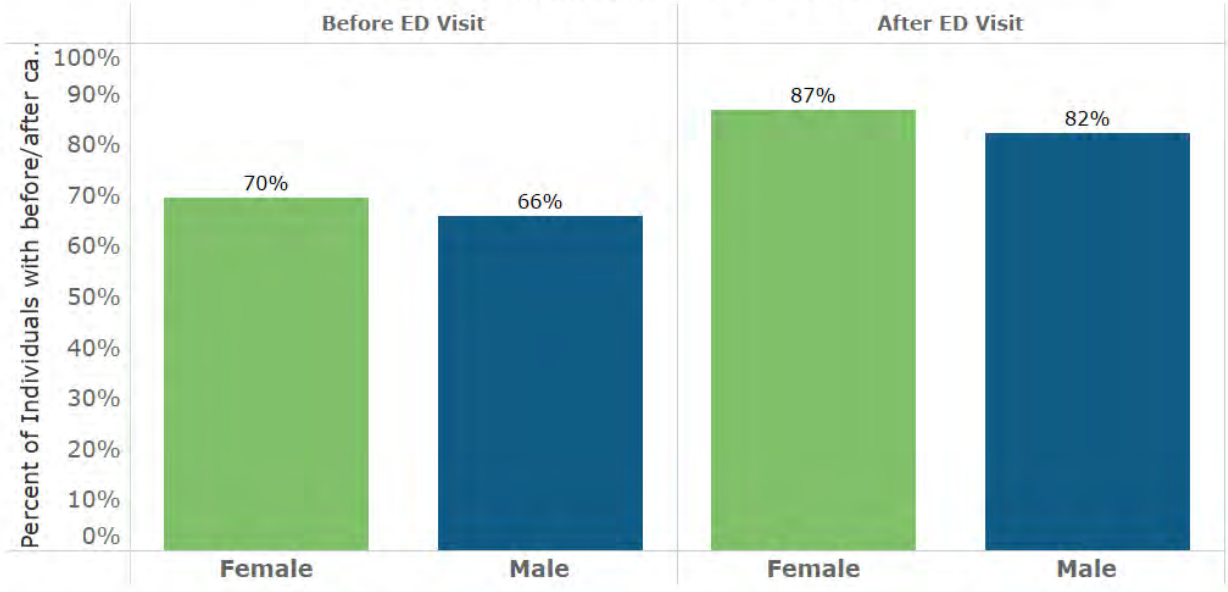


Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Common Ground Health

Percent of Individuals with BH Care within 6 months by Sex for ED Visits with Mental Health Conditions Conditions

Monroe County Adults (22 and older)

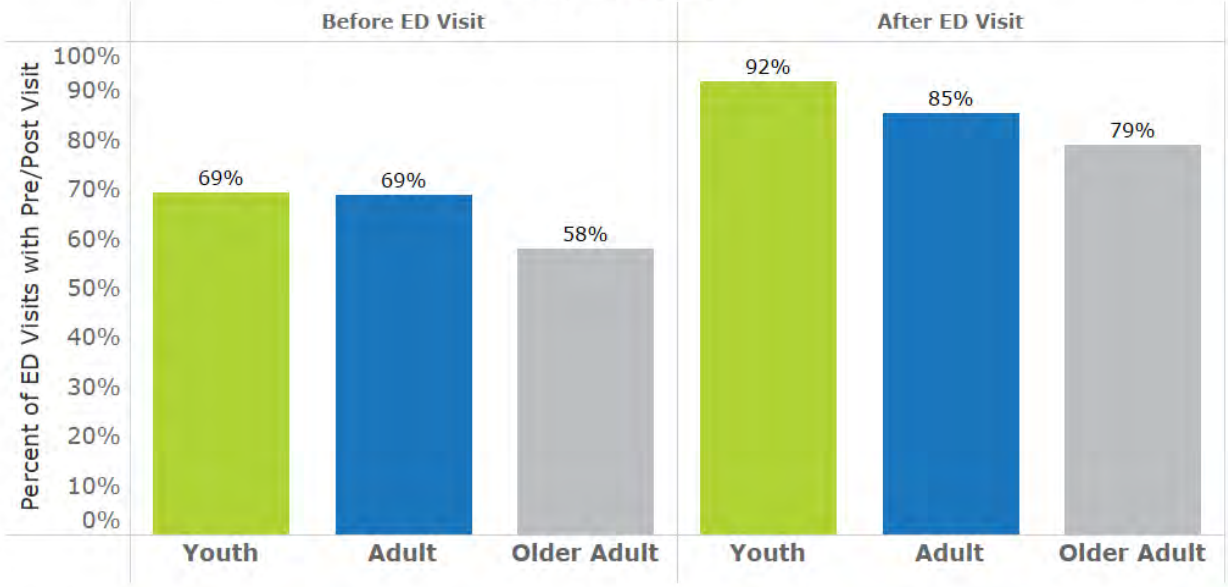


Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Common Ground Health

Percent of Individuals with BH Care within 6 months by Age Group for ED Visits with Mental Health Conditions Conditions

Monroe County

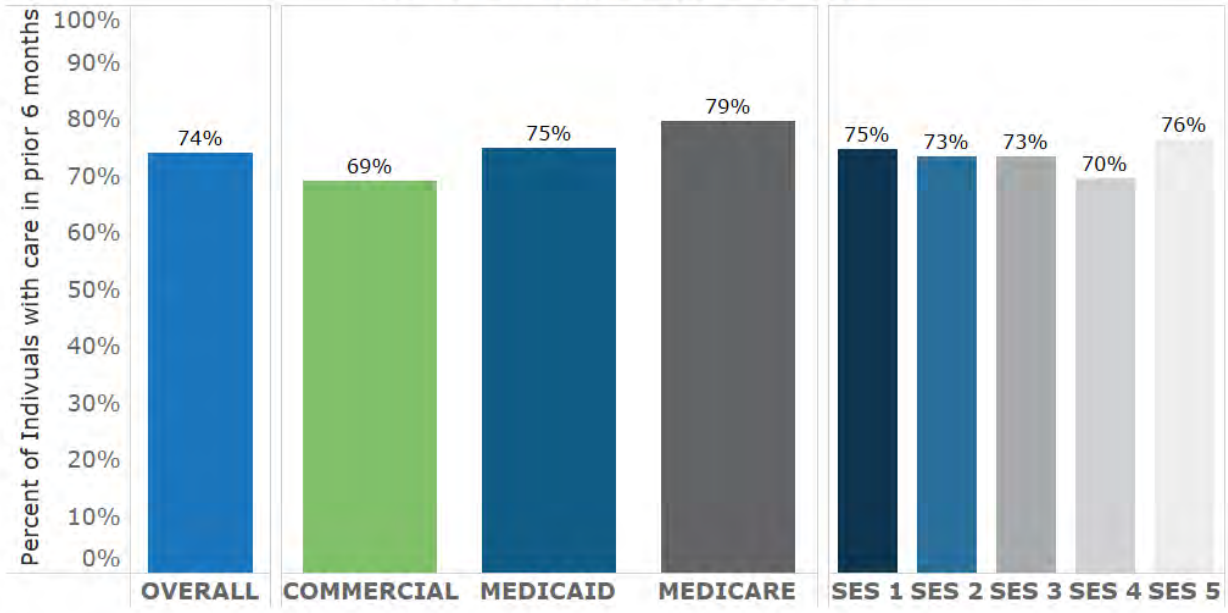


Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Common Ground Health

Percent of Individuals with BH Care 6 months before an ED Visit for a Substance Use Disorder

Monroe County Adults (22 and older)

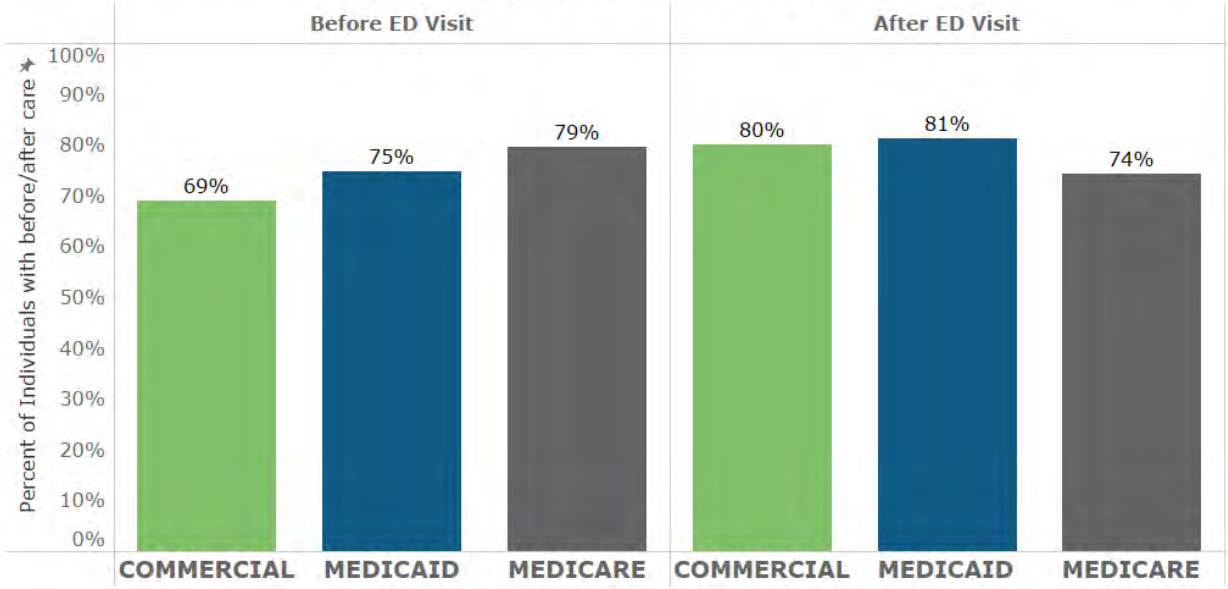


Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Common Ground Health

Percent of Individuals with BH Care within 6 months by Insurance Type for ED Visits with Substance Use Disorders

Monroe County Adults (22 and older)

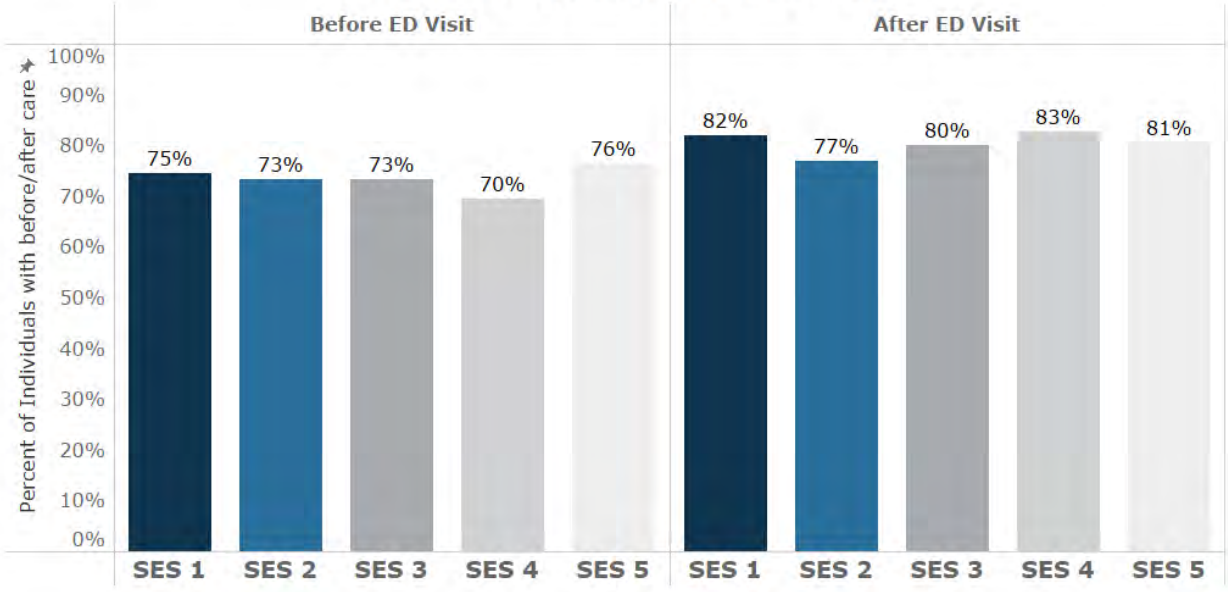


Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Common Ground Health

Percent of Individuals with BH Care within 6 months by SES for ED Visits with Substance Use Disorders Conditions

Monroe County Adults (22 and older)

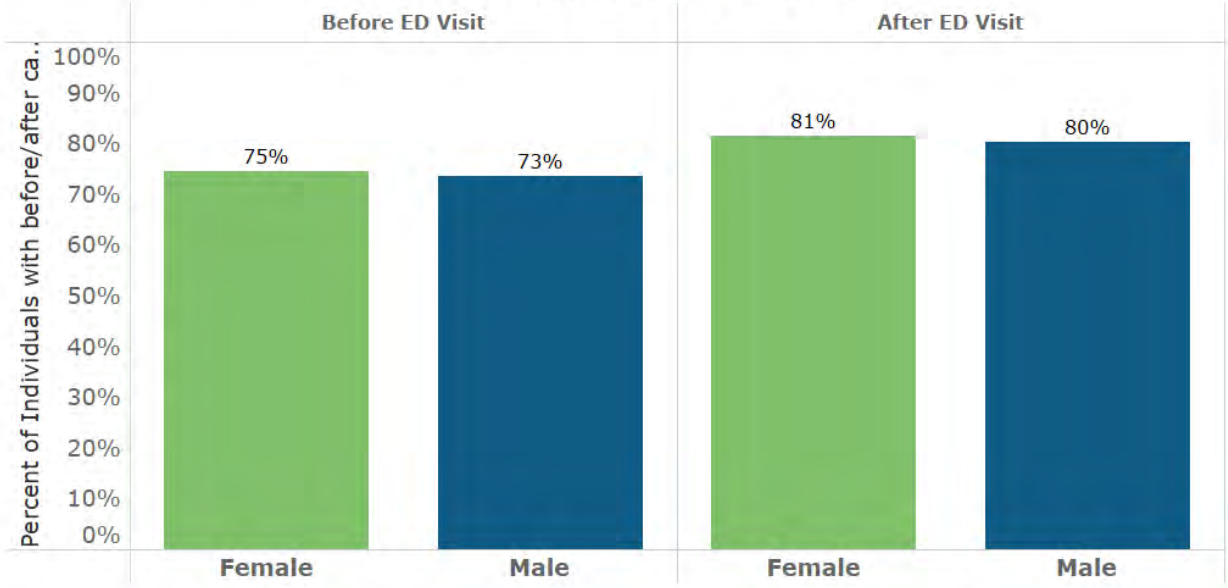


Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Common Ground Health

Percent of Individuals with BH Care within 6 months by Sex for ED Visits with Substance Use Disorders Conditions

Monroe County Adults (22 and older)

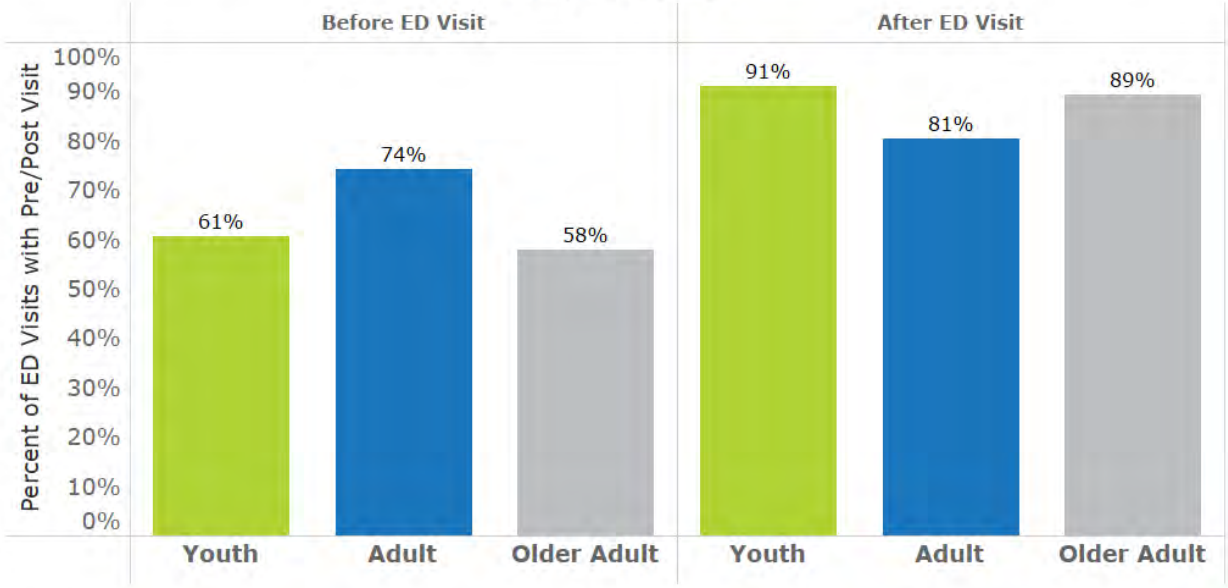


Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Common Ground Health

Percent of Individuals with BH Care within 6 months by Age Group for ED Visits with Substance Use Disorders Conditions

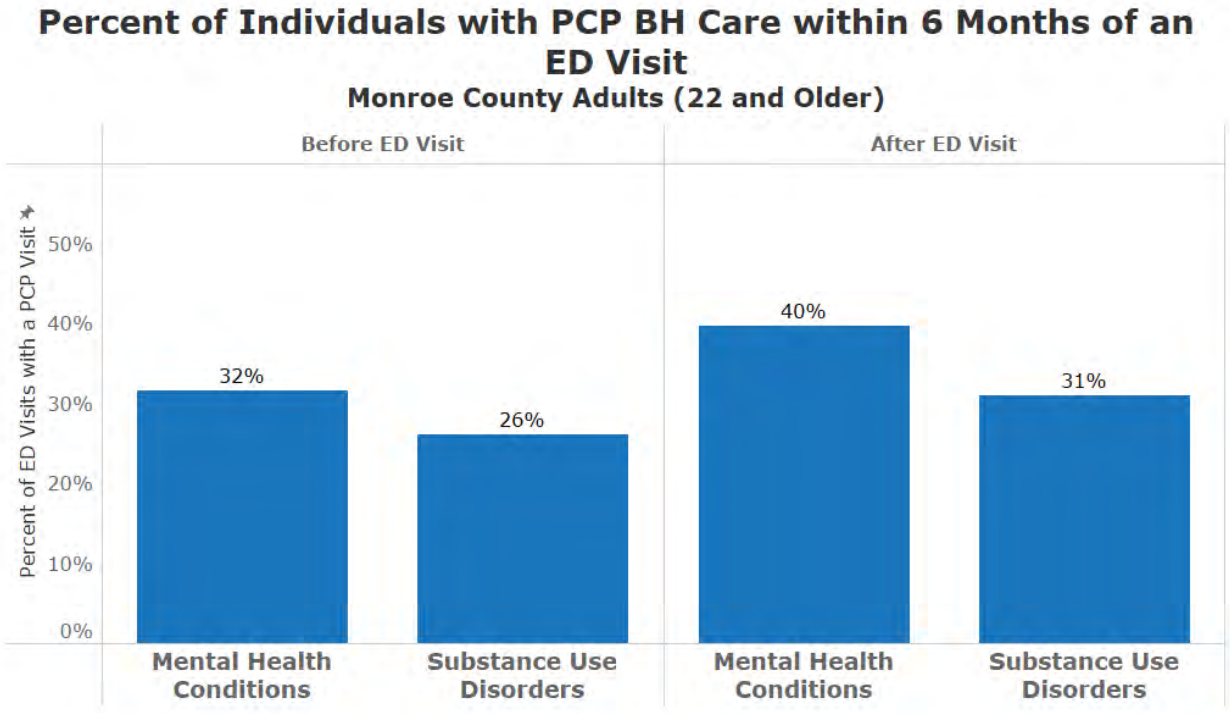
Monroe County



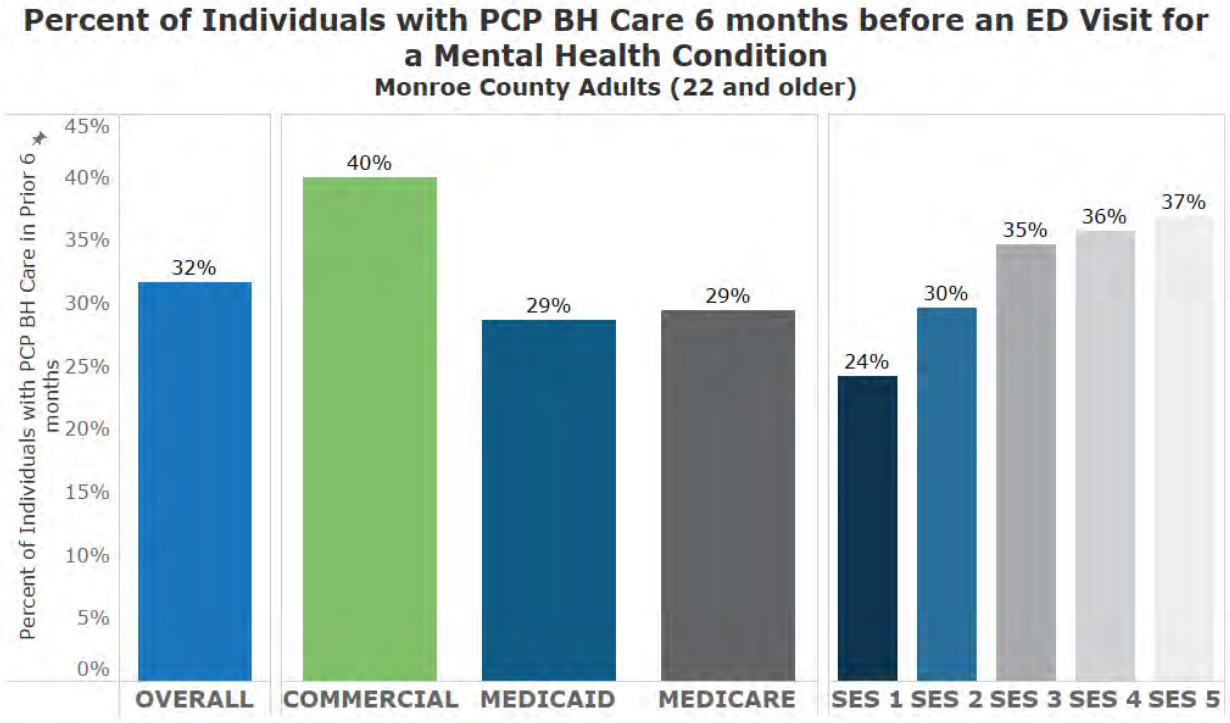
Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Common Ground Health

Utilization of Primary Care before and after an ED Visit



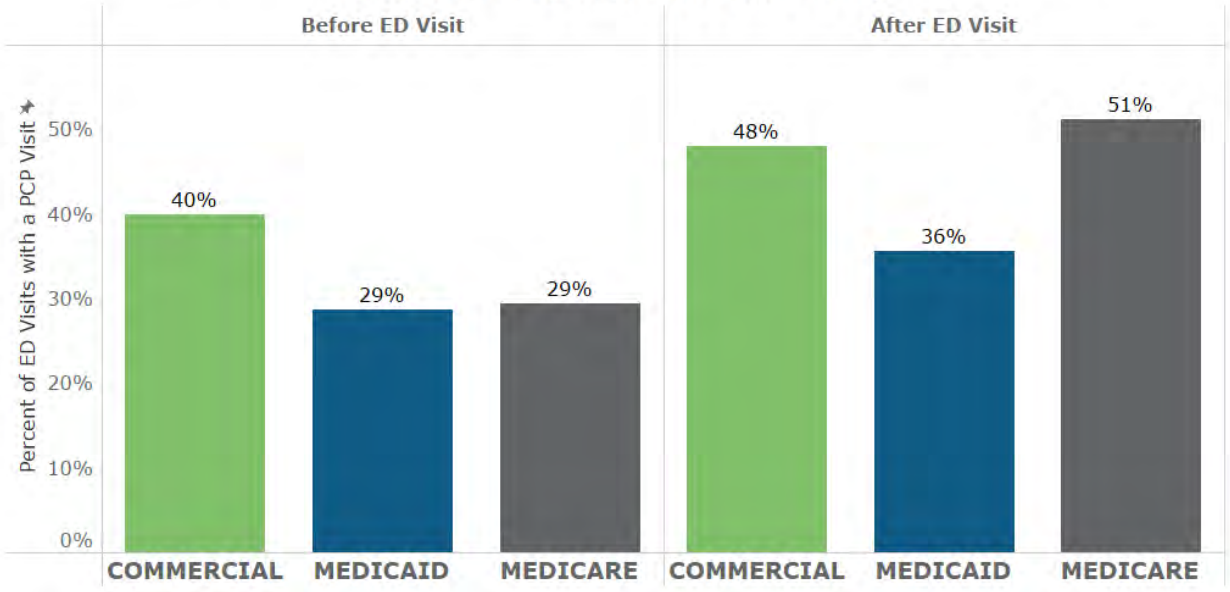
Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health



Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Percent of Individuals with PCP BH Care within 6 Months of an ED Visit for Mental Health Conditions by Insurance Type

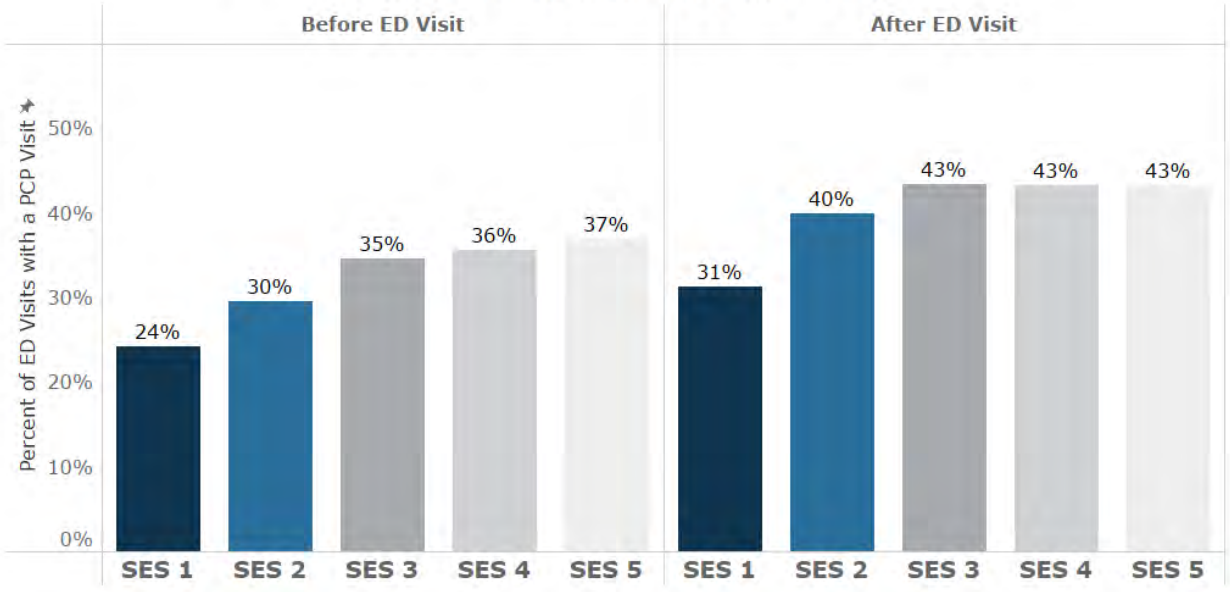
Monroe County Adults (22 and Older)



Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Percent of Individuals with PCP BH Care within 6 Months of an ED Visit for Mental Health Conditions by SES

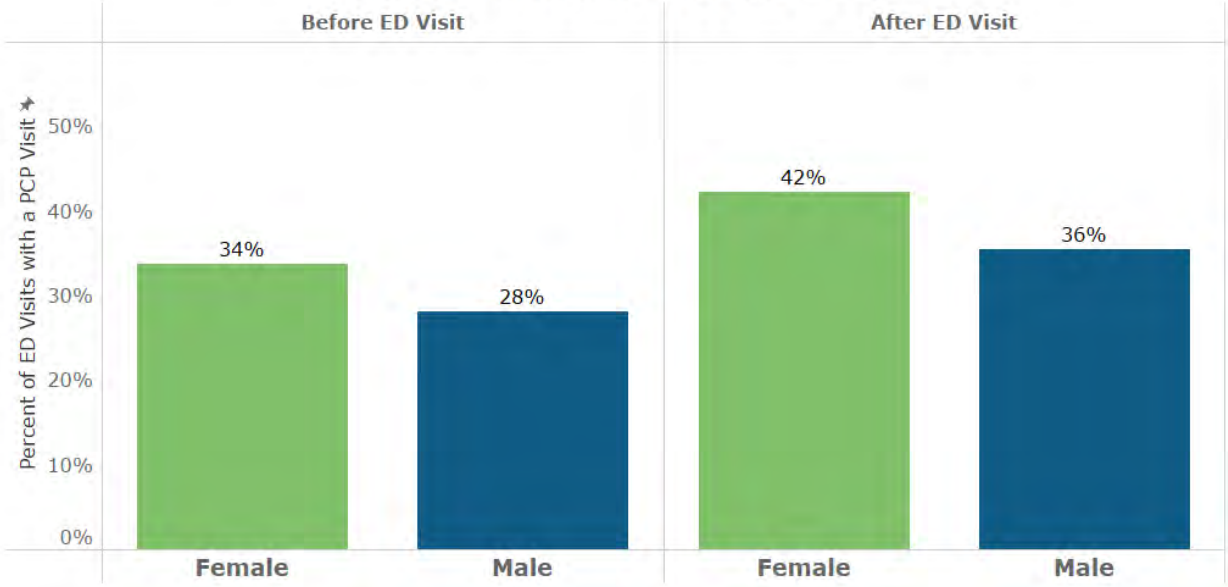
Monroe County Adults (22 and Older)



Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Percent of Individuals with PCP BH Care within 6 Months of an ED Visit for Mental Health Conditions by Sex

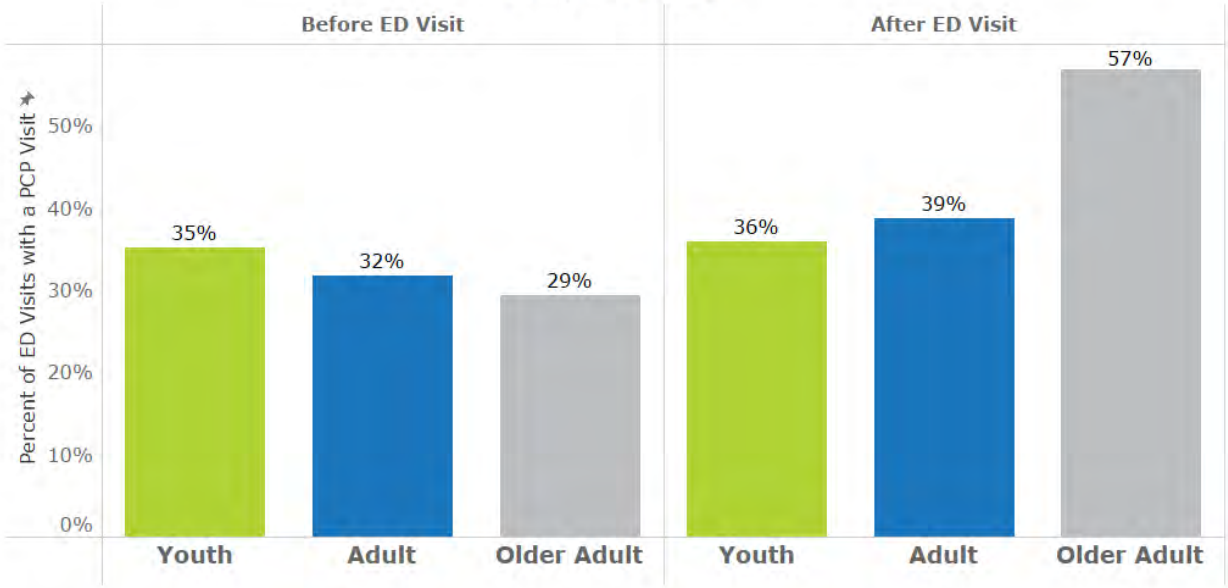
Monroe County Adults (22 and Older)



Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Percent of Individuals with PCP BH Care within 6 Months of an ED Visit for Mental Health Conditions by Age Group

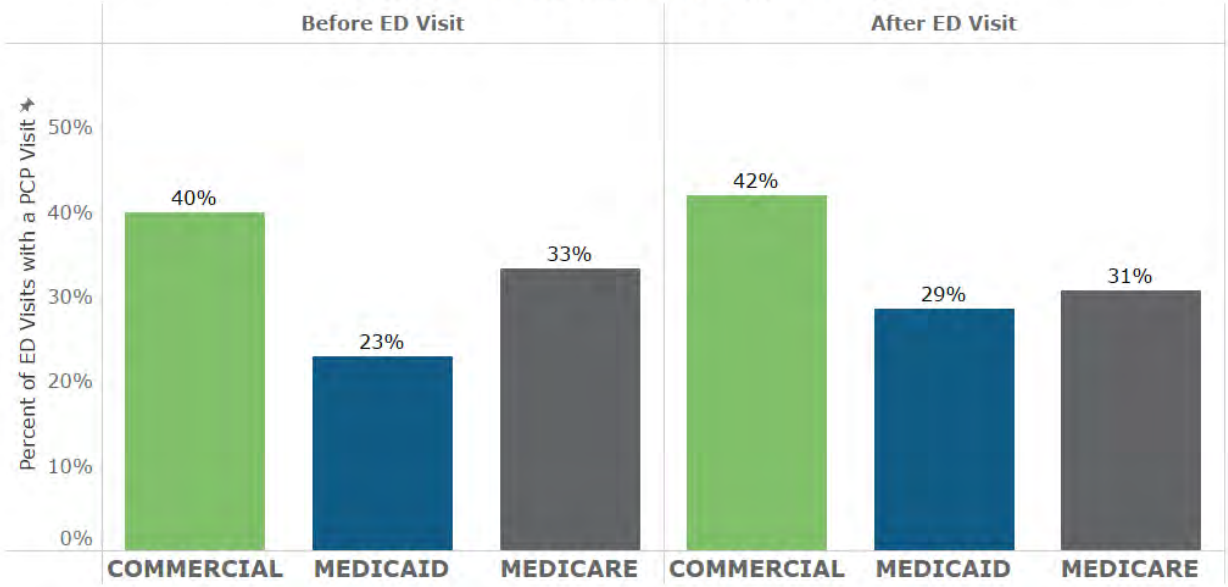
Monroe County



Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Percent of Individuals with PCP BH Care within 6 Months of an ED Visit for Substance Use Disorders by Insurance Type

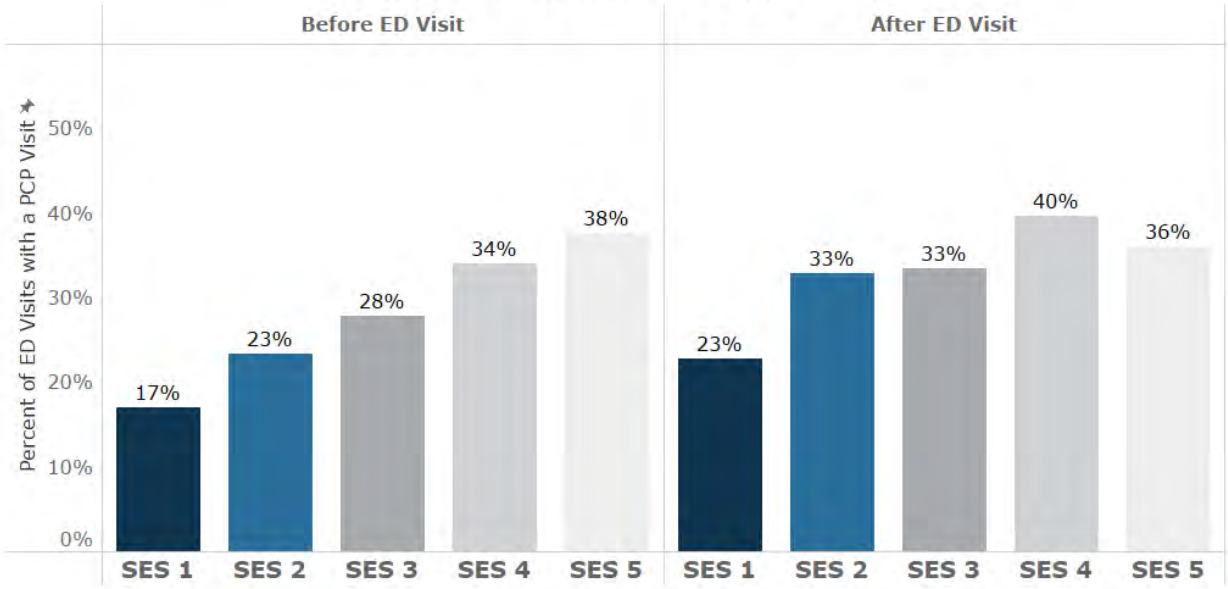
Monroe County Adults (22 and Older)



Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Percent of Individuals with PCP BH Care within 6 Months of an ED Visit for Substance Use Disorders by SES

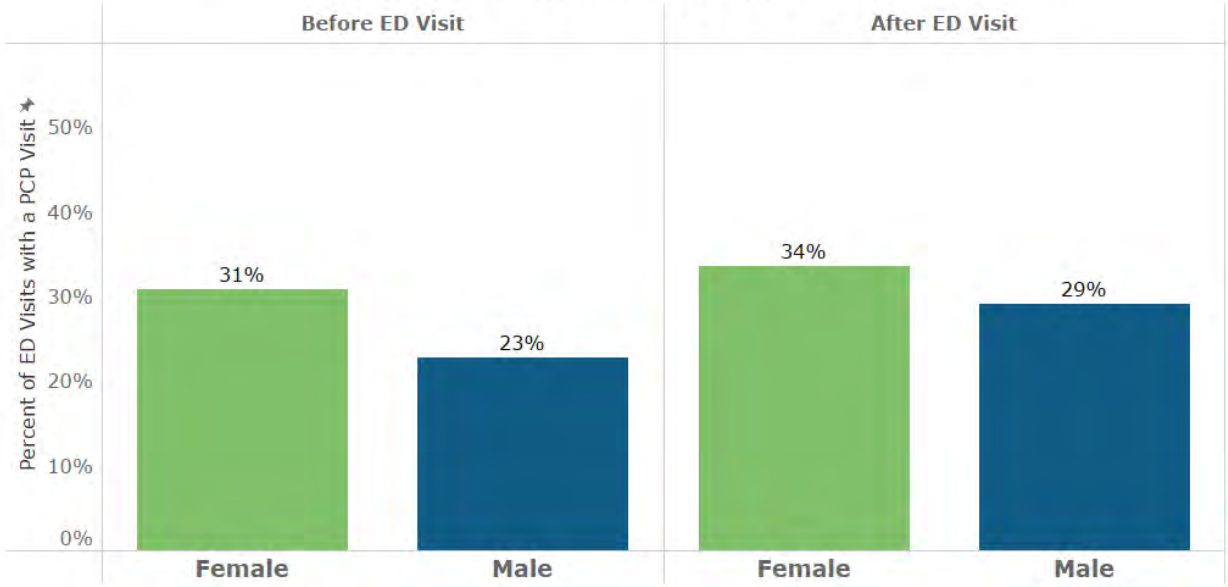
Monroe County Adults (22 and Older)



Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Percent of Individuals with PCP BH Care within 6 Months of an ED Visit for Substance Use Disorders by Sex

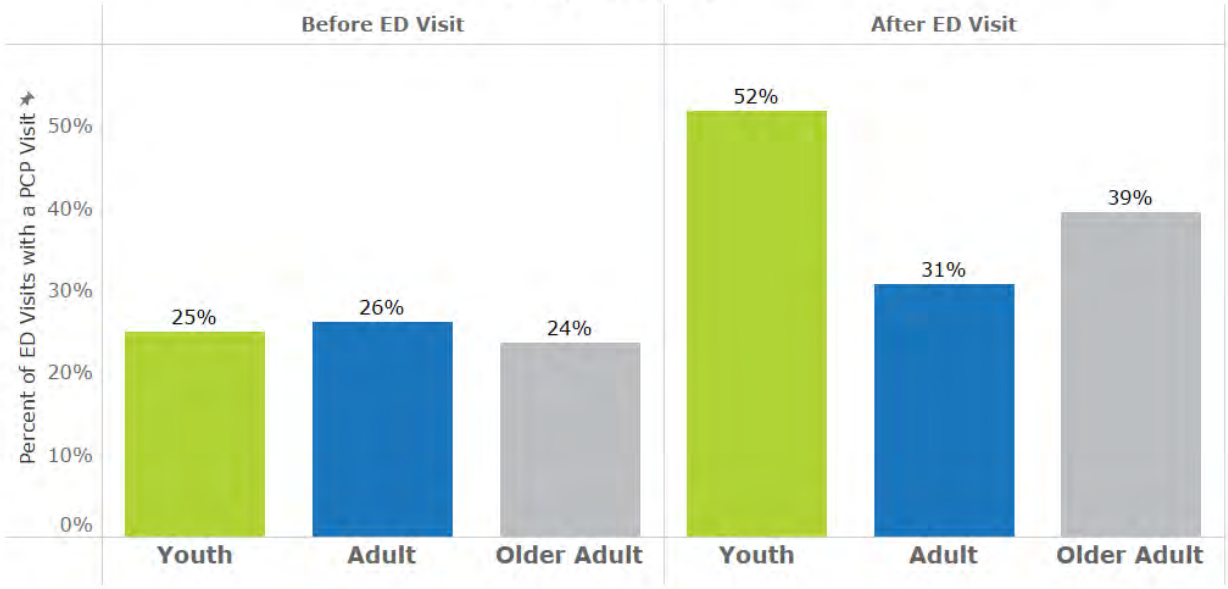
Monroe County Adults (22 and Older)



Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

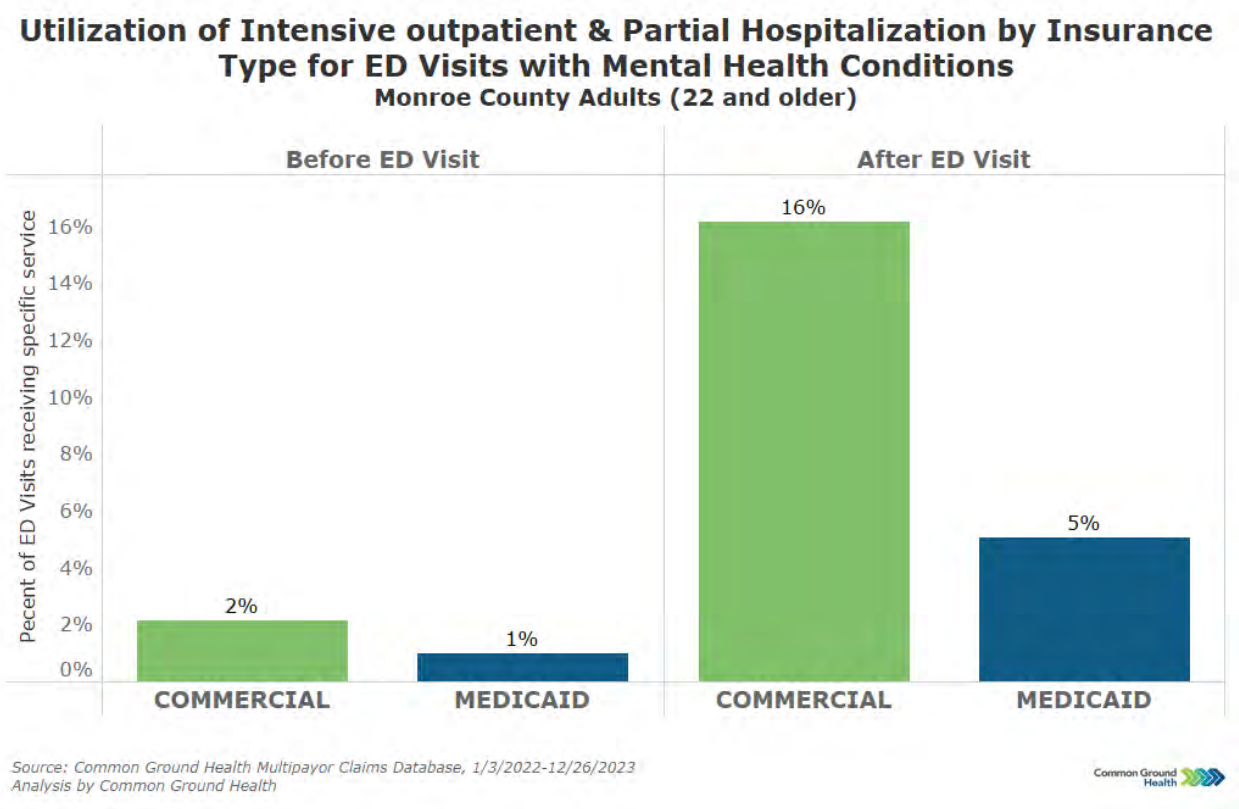
Percent of Individuals with PCP BH Care within 6 Months of an ED Visit for Substance Use Disorders by Age Group

Monroe County



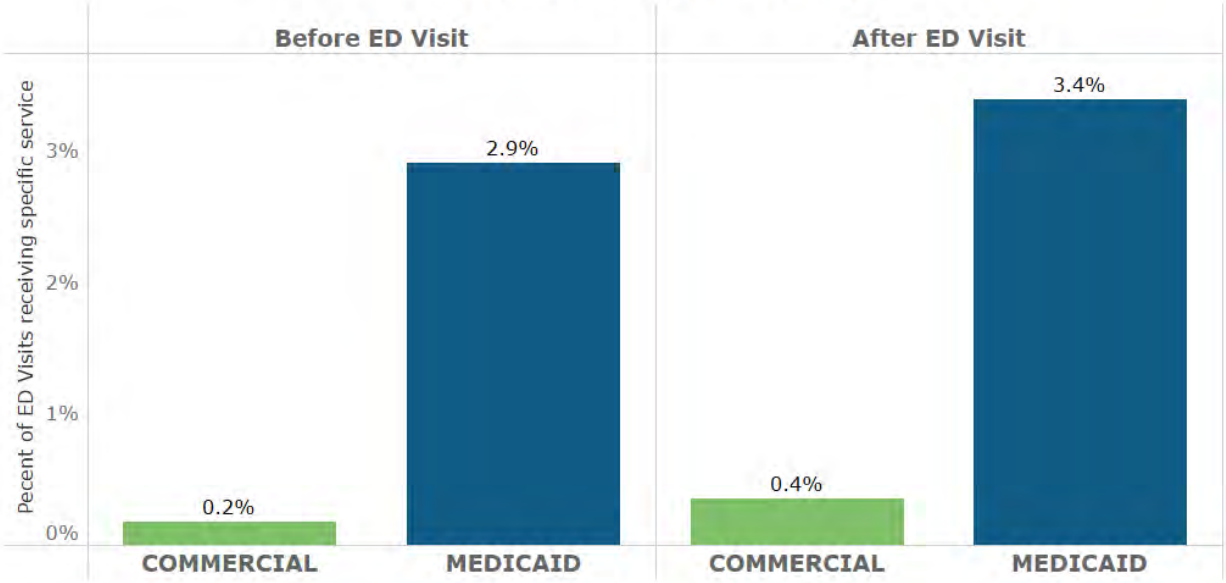
Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

Utilization of Specific Services before and after an ED Visit



Utilization of Community Treatment & Peer Services by Insurance Type for ED Visits with Mental Health Conditions

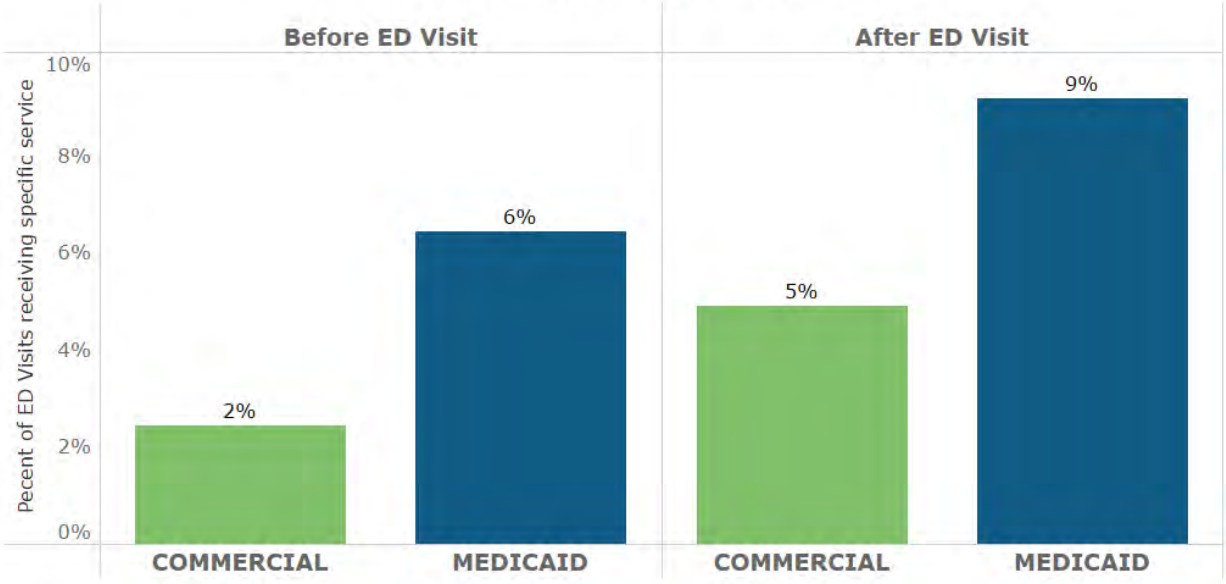
Monroe County Adults (22 and older)



Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

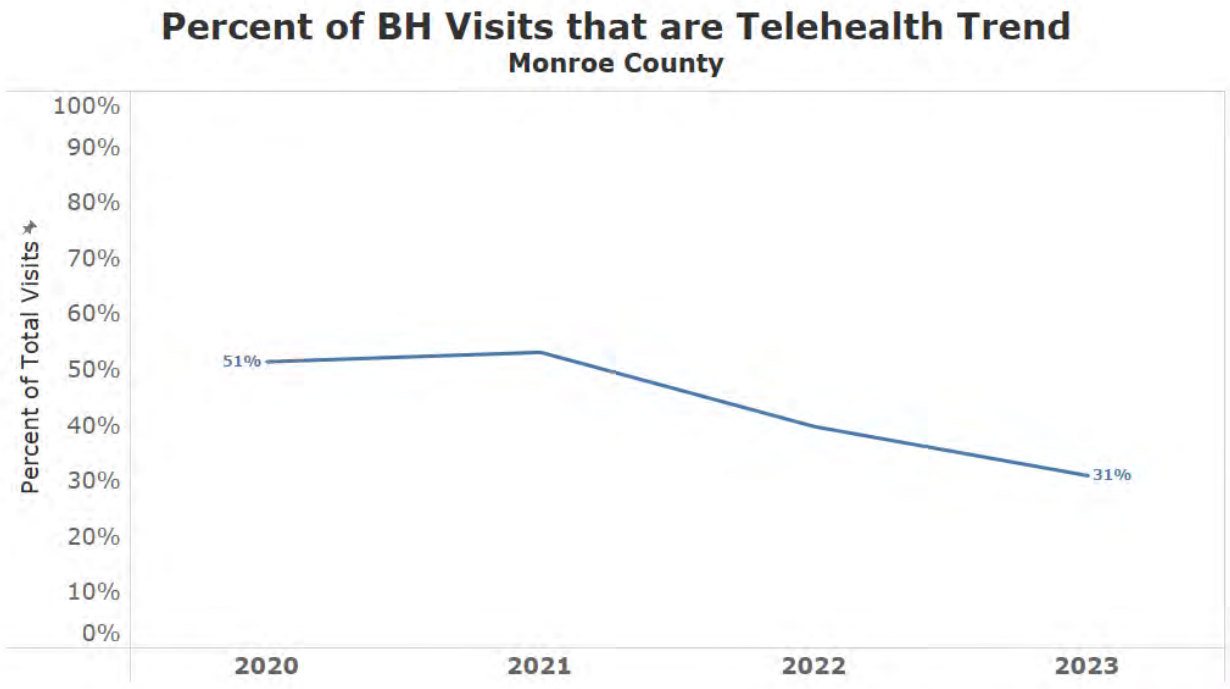
Utilization of Community Treatment & Peer Services by Insurance Type for ED Visits with Substance Use Disorders

Monroe County Adults (22 and older)



Source: Common Ground Health Multipayor Claims Database, 1/3/2022-12/26/2023
Analysis by Common Ground Health

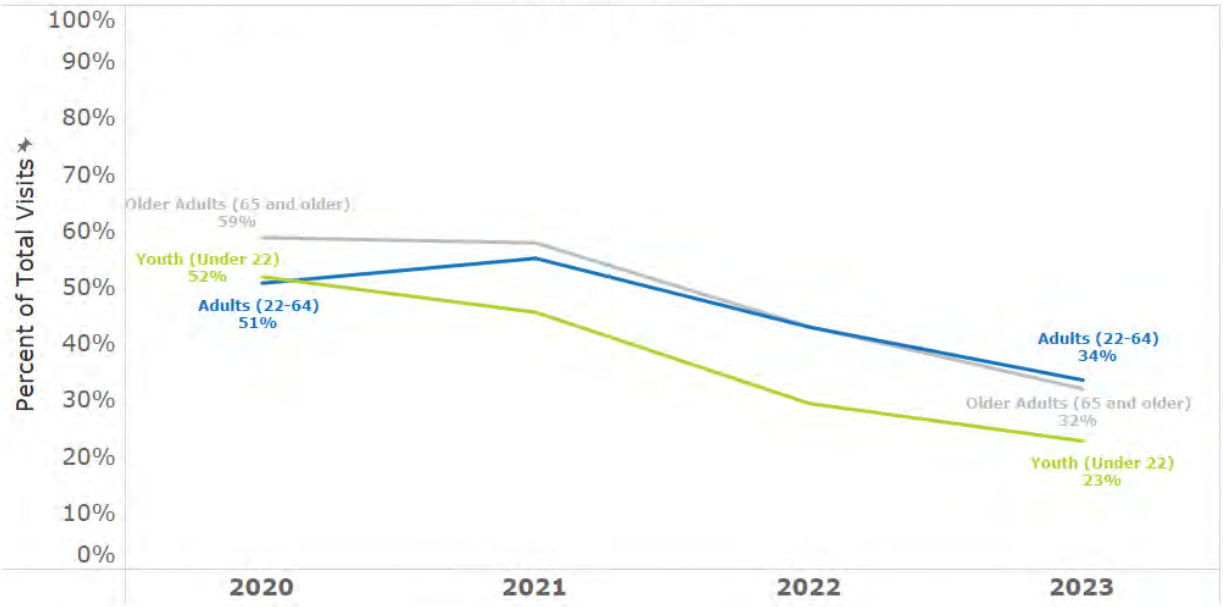
Utilization of Telehealth for Behavioral Health Outpatient Visits



Source: Common Ground Health Mulitpayor Claims Database, Years 2020-2023
Analysis by Common Ground Health

Common Ground Health

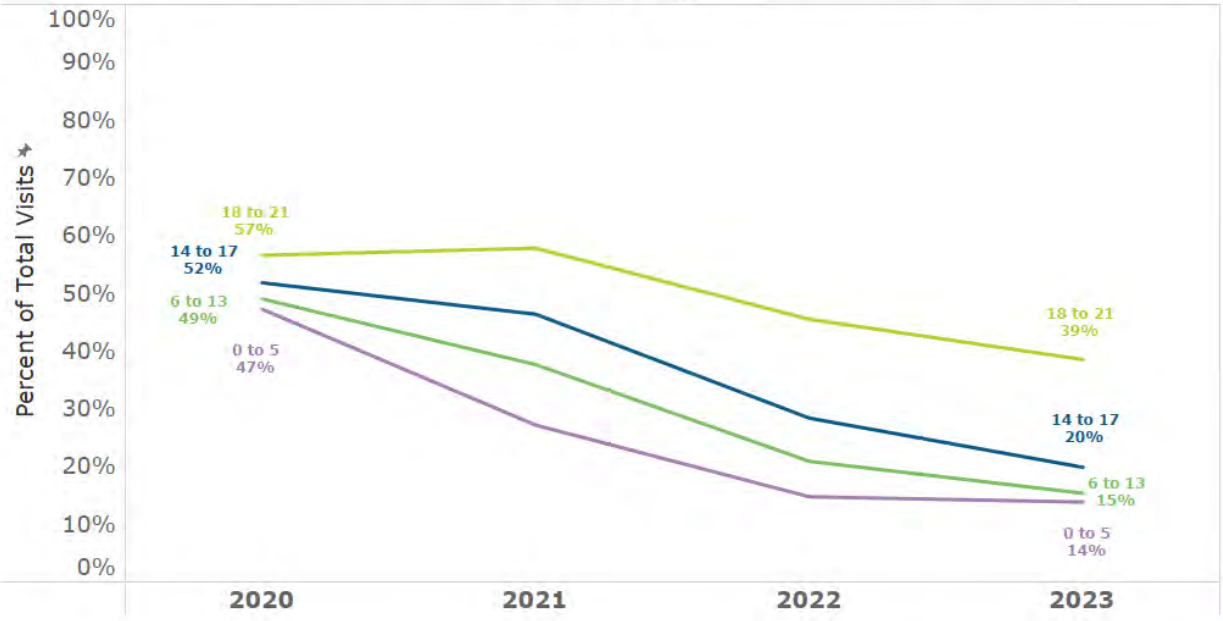
Percent of BH Visits that are Telehealth Trend by Age Group
Monroe County



Source: Common Ground Health Mulitpayor Claims Database, Years 2020-2023
Analysis by Common Ground Health

Common Ground Health

Percent of BH Visits that are Telehealth Trend for Youth Age Groups
Monroe County

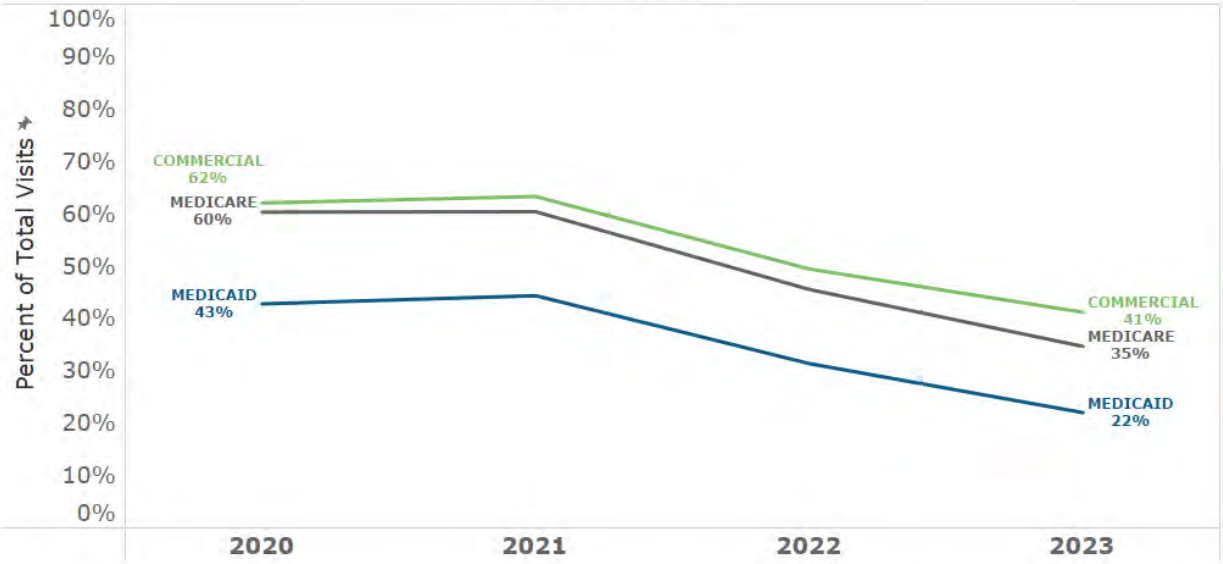


Source: Common Ground Health Mulitpayor Claims Database, Years 2020-2023
Analysis by Common Ground Health

Common Ground Health

Percent of BH Visits that are Telehealth Trend by Insurance Type

Monroe County

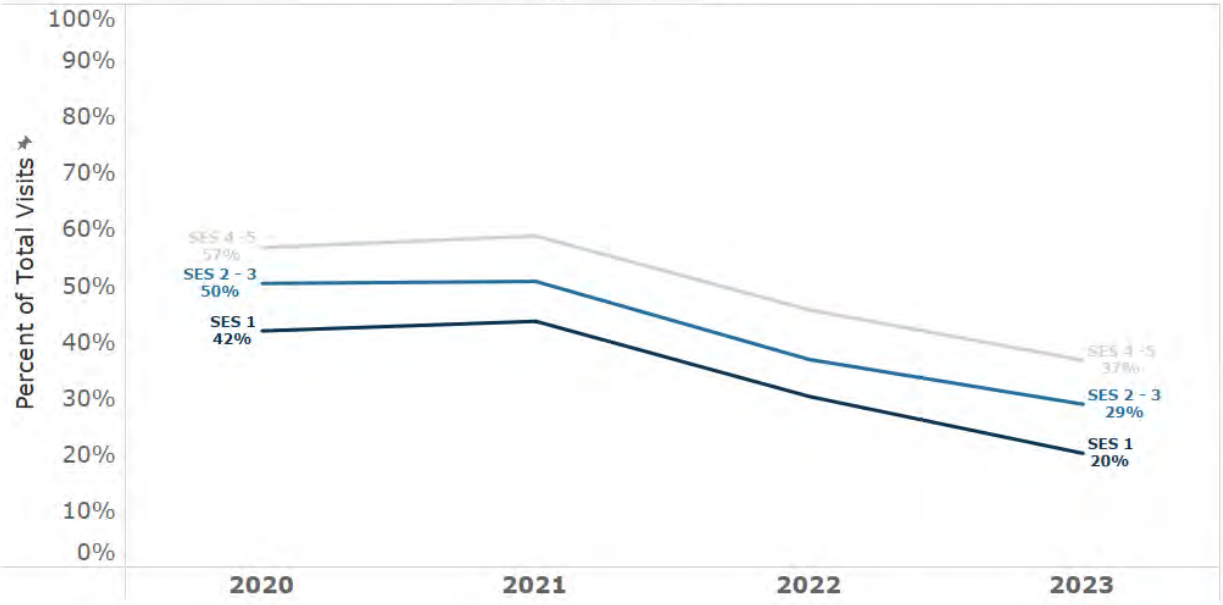


Source: Common Ground Health Mulitpayor Claims Database, Years 2020-2023
Analysis by Common Ground Health

Common Ground Health

Percent of BH Visits that are Telehealth Trend by SES

Monroe County

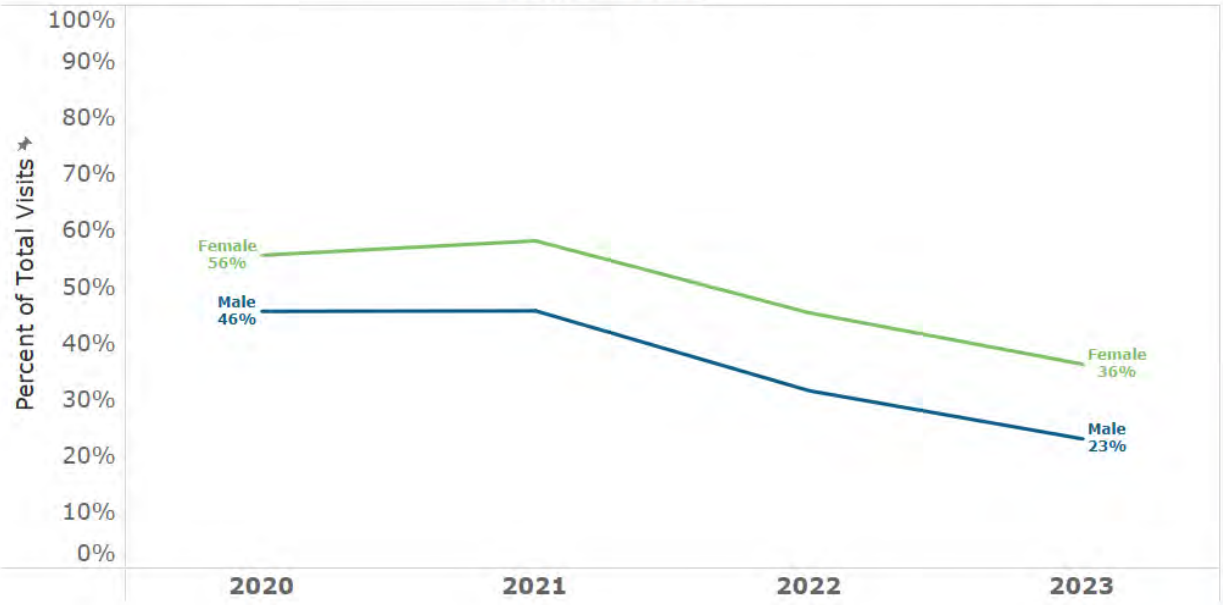


Source: Common Ground Health Mulitpayor Claims Database, Years 2020-2023
Analysis by Common Ground Health

Common Ground Health

Percent of BH Visits that are Telehealth Trend by Sex

Monroe County



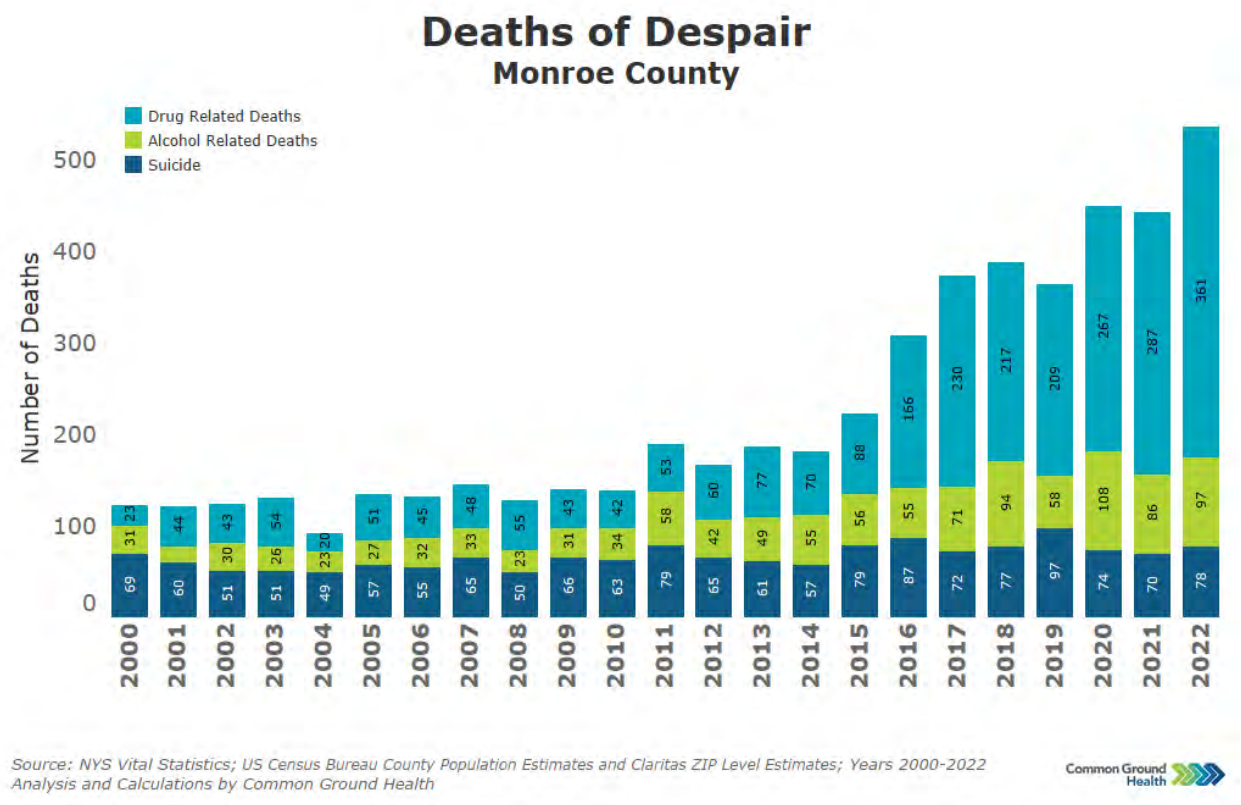
Source: Common Ground Health Mulitpayor Claims Database, Years 2020-2023
Analysis by Common Ground Health

Common Ground Health

Deaths of Despair (Drug-Related, Alcohol-Related, Suicide)

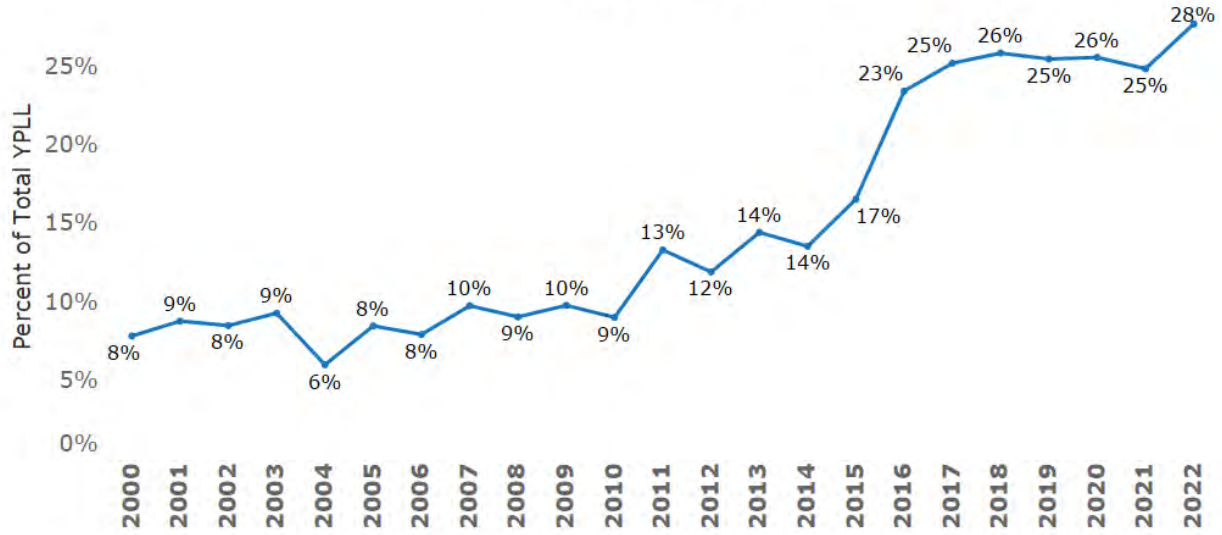
Source: NYSDOH Vital Statistics Death Records Data

Overall Trends for Deaths of Despair



Deaths of Despair as a Percent of Total Years of Potential Life Lost (YPLL)

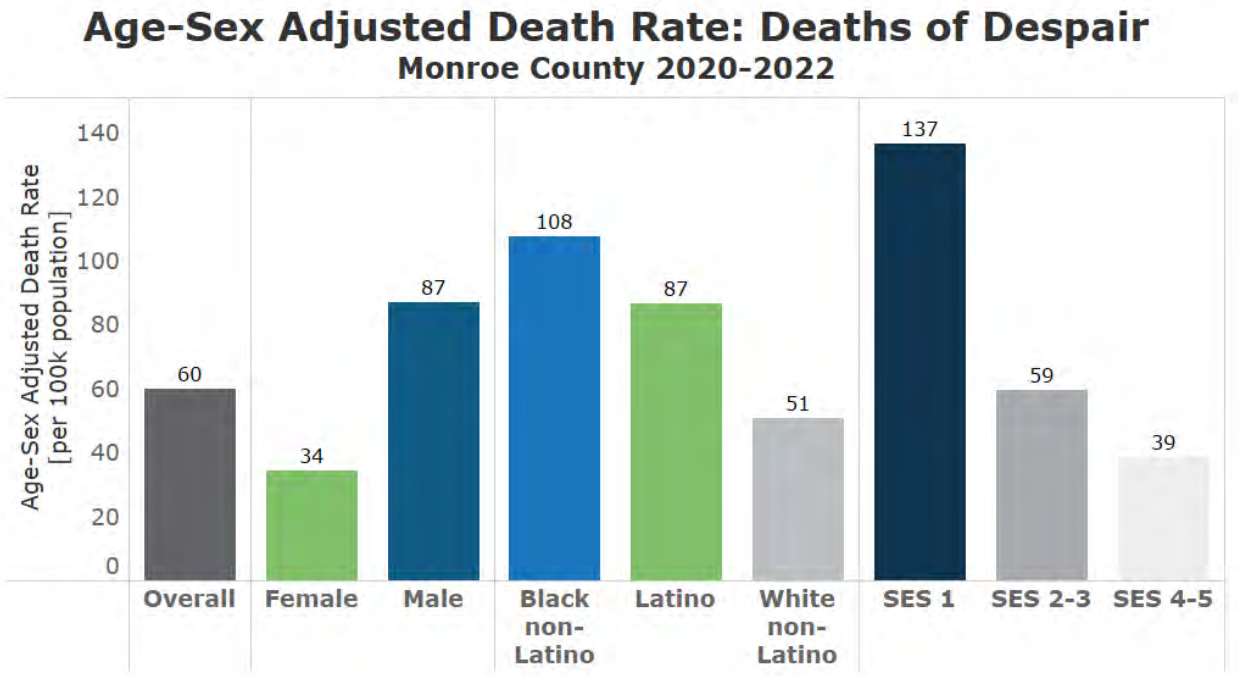
Monroe County



Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2000-2022
Analysis and Calculations by Common Ground Health

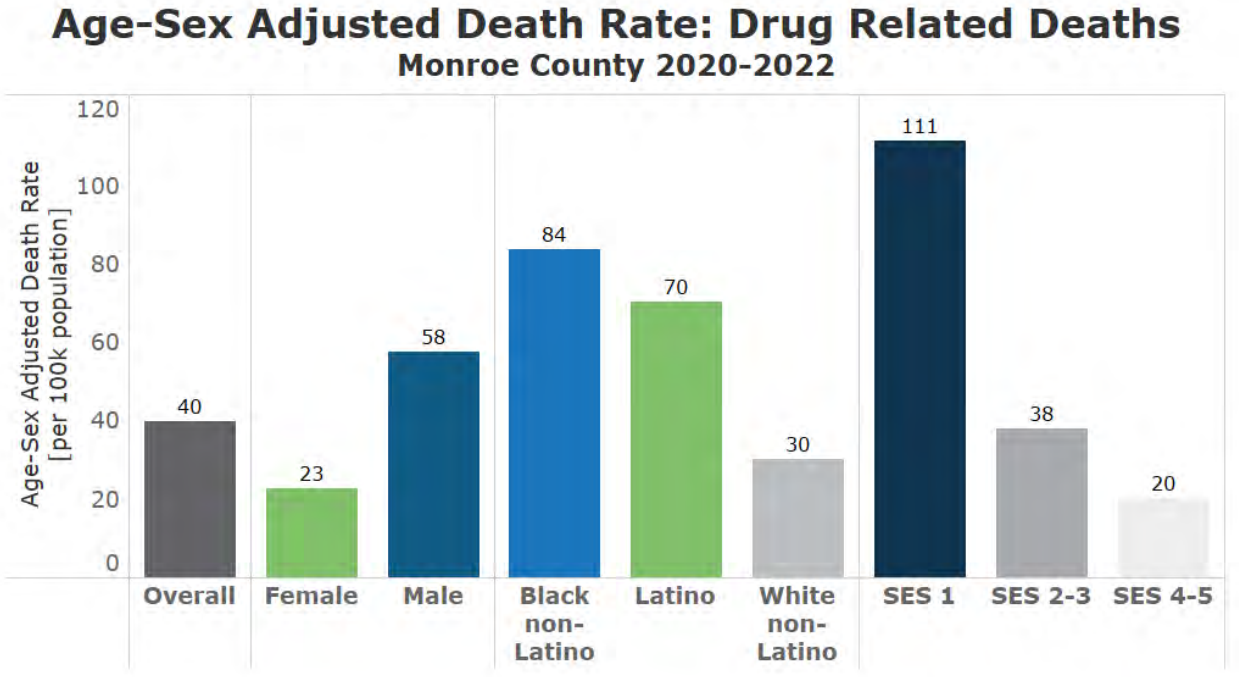
Common Ground Health

Age-sex Adjusted Death rates for Deaths of Despair



Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2020-2022
Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population)

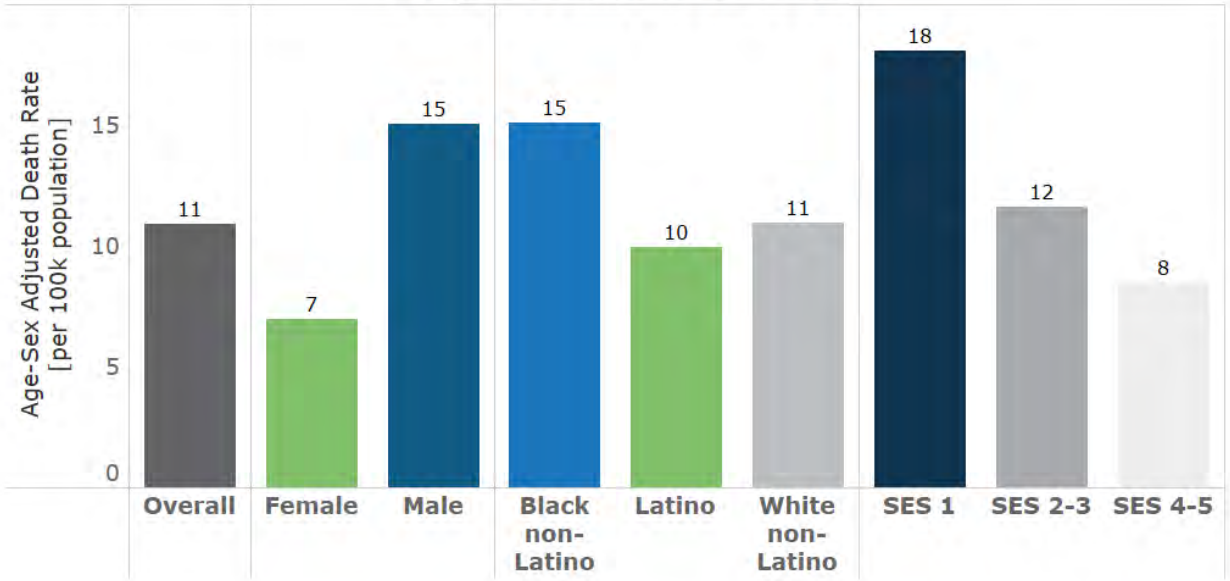
Common Ground Health



Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2020-2022
Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population)

Common Ground Health

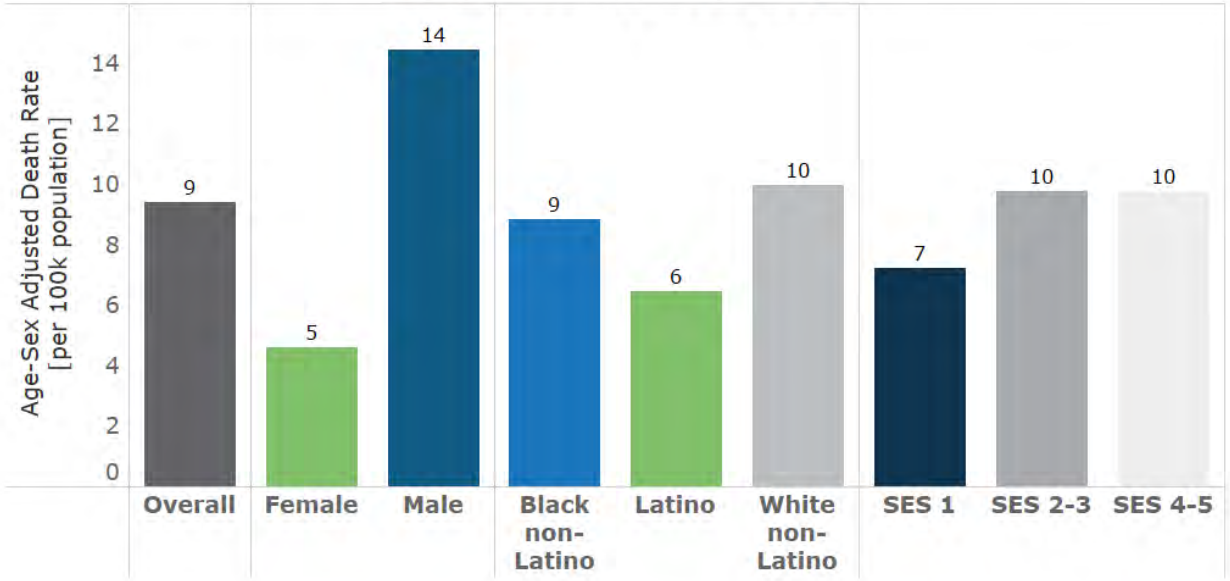
Age-Sex Adjusted Death Rate: Alcohol Related Deaths
Monroe County 2020-2022



Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2020-2022
Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population)

Common Ground Health

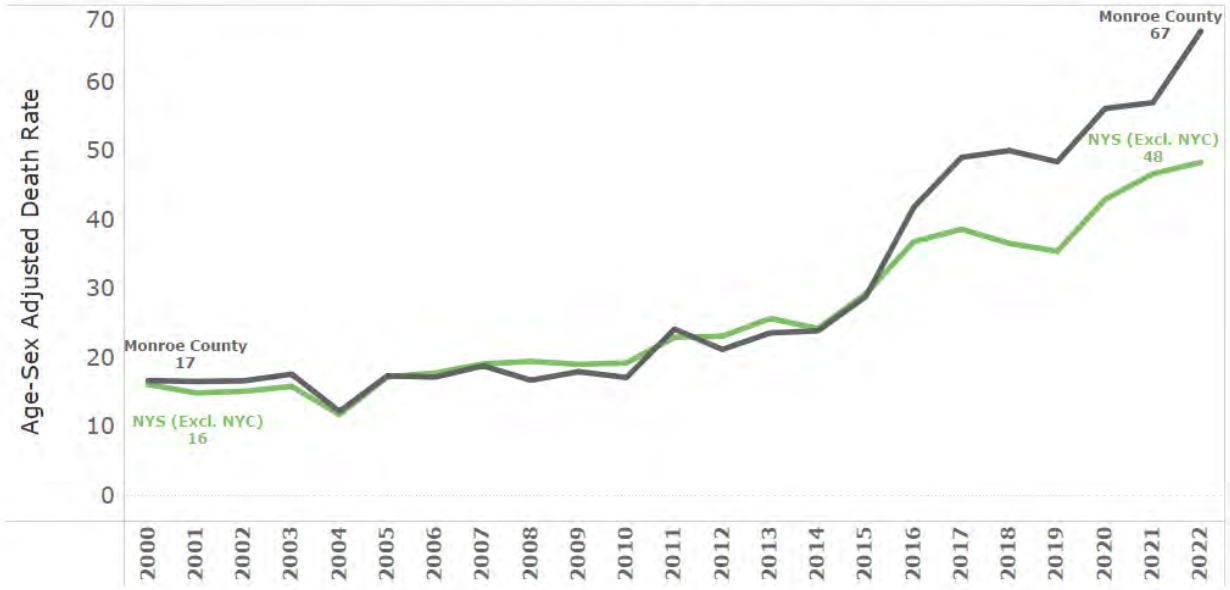
Age-Sex Adjusted Death Rate: Suicide
Monroe County 2020-2022



Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2020-2022
Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population)

Common Ground Health

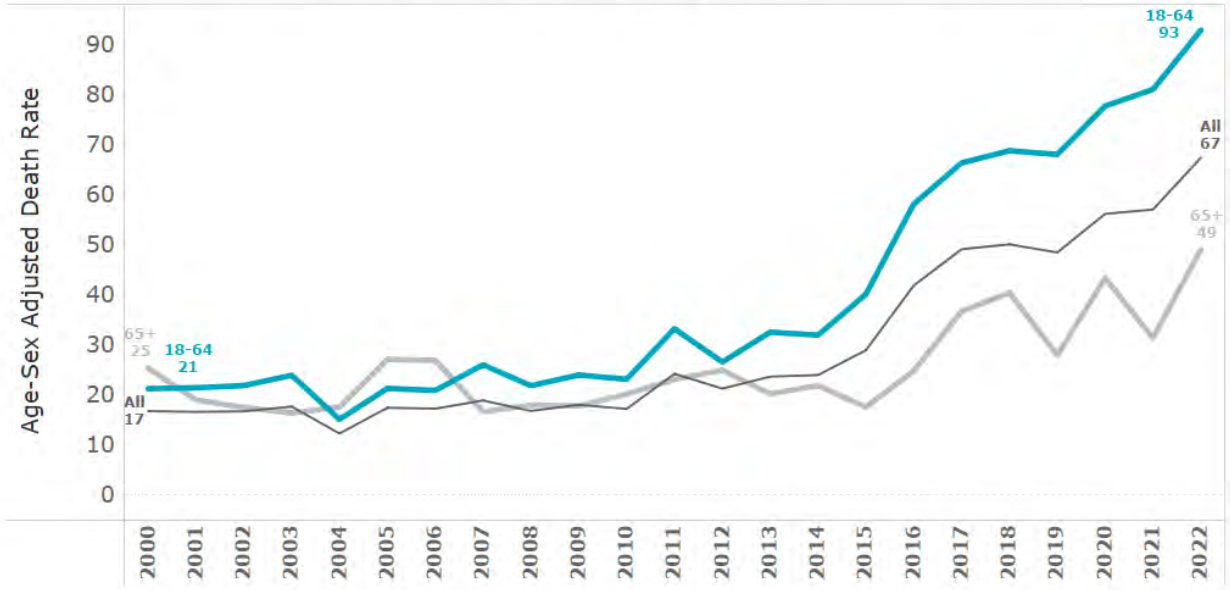
Age-Sex Adjusted Death Rate for Deaths of Despair
Monroe County



Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2000-2022
Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population)

Common Ground Health

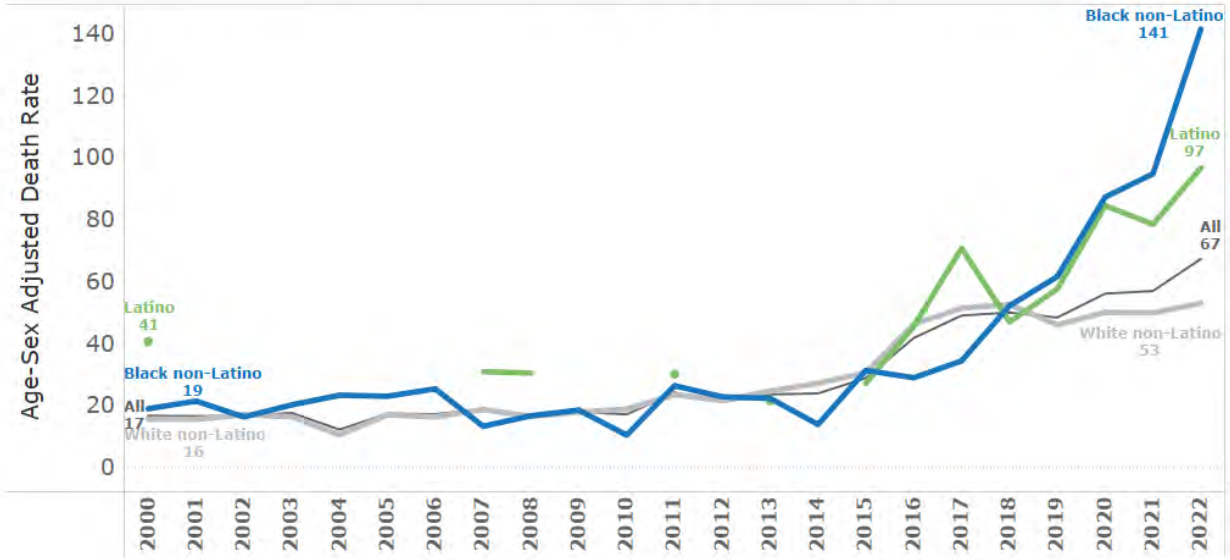
Age-Sex Adjusted Death Rate for Deaths of Despair by Age Group
Monroe County



Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2000-2022
Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population)

Common Ground Health

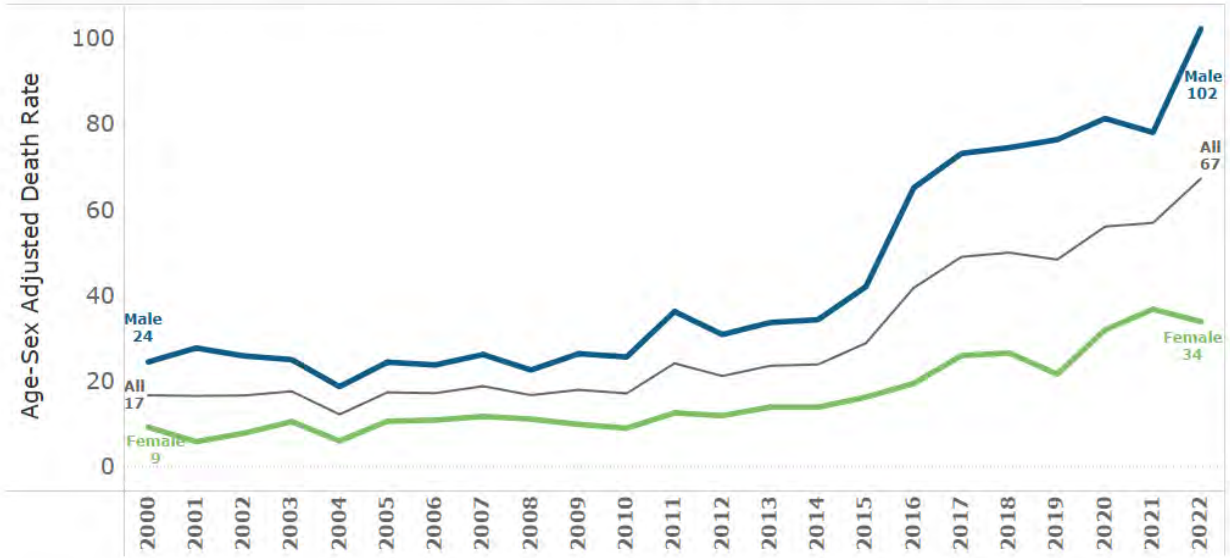
Age-Sex Adjusted Death Rate for Deaths of Despair by Race/Ethnicity
Monroe County



Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2000-2022
Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population)
All segment is inclusive of all residents in Monroe County. Additional Races (i.e. Asian, American Indian/Alaska Native, etc.) are not shown individually on the chart due to small sample size

Common Ground Health

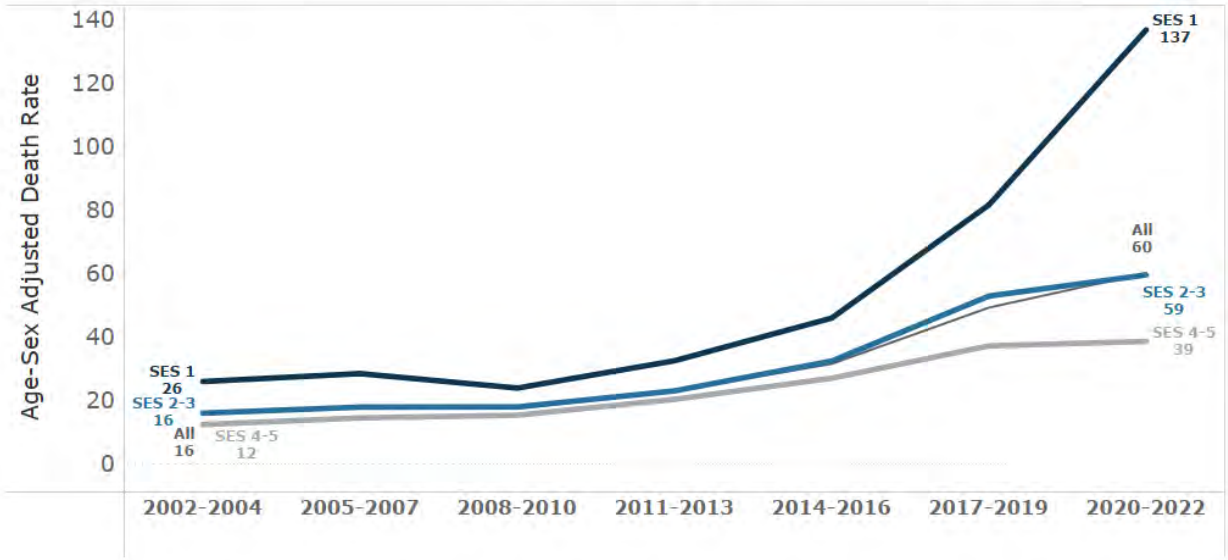
Age-Sex Adjusted Death Rate for Deaths of Despair by Gender
Monroe County



Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2000-2022
Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population)

Common Ground Health

Age-Sex Adjusted Death Rate for Deaths of Despair by SES
Monroe County



Source: NYS Vital Statistics; US Census Bureau County Population Estimates and Claritas ZIP Level Estimates; Years 2000-2022
Analysis and Calculations by Common Ground Health (YPLL/Death Rate per 100k population)
Socioeconomic status (SES) is determined by ZIP code. Each data point represents the people who live in ZIP codes with a particular SES level.

Common Ground Health

Appendix B: Analytic Definitions

Below is information about some of the key measures used throughout this assessment.

- Behavioral Health Condition Definitions
- Socioeconomic Status (SES) Index
- Years of potential life lost (YPLL)

For additional information about the analysis in this assessment, please contact Common Ground Health at hello@commongroundhealth.org.

Behavioral Health Condition Definitions

The table below includes the behavioral health condition definitions used to select diagnosis codes for analyses of SPARCS and Multipayor Claims data.

The specific analytic methodologies used vary depending on the purpose of the analysis. For example, the analyses of SPARCS data are based on the reasons for the ED visit or inpatient admission and therefore generally only use primary diagnosis codes except where otherwise noted. On the other hand, when the Multipayor Claims data is analyzed to estimate the prevalence of behavioral conditions, all listed diagnosis codes (primary and secondary) are considered.

Condition	Condition Definition
Alcohol Use Disorders (AUD)	Alcohol use disorders and alcohol poisoning (overdose), including poisoning cases of intentional self-harm and undetermined intention.
All Behavioral Health Conditions	All mental health conditions and substance use disorders, including intentional self-harm incidents and overdoses.
All Mental Health Conditions	All mental health conditions, including self-harm incidents. This does not include substance use disorders but does contain overdose visits documented as intentional self-harm.
Anxiety/Panic Disorders	A range of diagnoses ranging from generalized anxiety disorder and phobias to drug- or alcohol-induced anxiety and panic.
Attention-Deficit/Hyperactivity Disorder (ADHD)	Includes hyperactive, inattentive, and combined type ADHD.
Conduct Disorders	Includes adjustment disorder with mixed disturbance of emotions and conduct, oppositional defiant disorder, and other specified and unspecified conduct disorders.
Depressive Disorders	Includes unspecified depression, major depressive disorders (whether recurrent or single episode), and mood disorders with depressive-like episodes.
Depressive, Bipolar, and Other Mood Disorders	Depressive Disorder diagnoses (see above) plus bipolar and other specified and unspecified mood disorders.
Drug Overdose	Drug poisoning (overdose), including cases of undetermined intention, but excluding cases of intentional self-harm. Excludes alcohol and tobacco.

Drug Use Disorders	Drug use disorders and drug poisoning (overdose), including poisoning cases of intentional self-harm and undetermined intention. Excludes alcohol and tobacco.
Intentional Self-Harm	Suicidal ideation or self-harm by any means, including poisoning, asphyxiation, a firearm, etc.
Neurodevelopmental Disorders	Includes autism, speech and language developmental disorders, and other specified and unspecified neurodevelopmental disorders. Excludes ADHD as those diagnoses are tracked separately.
Personality Disorders	Includes borderline personality disorder, antisocial personality disorder, and other specified and unspecified personality disorders.
Schizophrenia Spectrum and Other Psychotic Disorders	Schizophrenia, schizoaffective disorder, delusional disorders, and other psychotic disorders.
Speech and Language Developmental Disorders	Includes expressive language disorder, mixed receptive-expressive language disorder, and other specified and unspecified speech and language development disorders.
Substance Use Disorders (SUD)	Substance use disorders and substance poisoning (overdose), including poisoning cases of intentional self-harm and undetermined intention. Includes alcohol and excludes tobacco.
Tobacco-Related Disorders	Nicotine dependence from cigarettes or other sources.
Trauma/Adjustment Disorders	Conditions resulting from stress, adjustment disorders, conversion disorders, or other dissociative or reactionary disorders.

Socioeconomic Status (SES) Index

The SES index ranking was developed by Common Ground Health and calculated using a variety of socioeconomic indicators from the American Community Survey including average income, poverty rates, education levels, housing value, and homeownership. Each ZIP code is assigned a socioeconomic (SES) index ranking from 1 to 5. The lower SES ZIP codes tend to have lower average income, higher poverty rates, lower prevalence of college degrees, etc.

Years of potential life lost (YPLL)

YPLL is a widely used measure to assess the rate of premature mortality. YPLL places a larger weight on the deaths of younger people, in contrast with overall mortality statistics which are dominated by deaths of the elderly. The YPLL rates in Common Ground Health analyses are derived using 75 years as the baseline. A death at age 65 has YPLL of 10, where as a death at age 35 has a YPLL of 40. The rates are calculated per 100,000 population and are age-sex adjusted to account for differences in population distribution.

Appendix C: Health Resources and Services Administration Professions

HRSA Profession Definitions

Profession	Definition
Addiction Counselors	Advise people who suffer from alcoholism, drug addiction, eating disorders, or other behavioral problems. They provide treatment and support to help clients recover from addiction or modify problem behaviors individually and in group sessions.
Adult Psychiatry	Physicians who diagnose and treat mental illnesses and substance use disorders through a combination of modalities, including psychotherapy, psychoanalysis, hospitalization, and the use of medication.
Child & Adolescent Psychiatry	Physicians who diagnose and treat mental illnesses and substance use disorders through a combination of modalities, including psychotherapy, psychoanalysis, hospitalization, and the use of medication. Additional specialized fellowship training in sub-specialties such as child and adolescent psychiatry.
Child, Family, and School Social Workers	Provide social services and assistance to improve the social and psychological functioning of children and their families and to maximize the family well-being and the academic functioning of children. May also advise teachers.
Healthcare Social Workers	Provide individuals, families, and groups with the psychosocial support needed to cope with chronic, acute, or terminal illnesses. Provide patients with information and counseling, and make referrals for other services.
Marriage and Family Therapists	Diagnose and treat behavioral health conditions within the context of marriage and family relationships.
Mental Health and Substance Abuse Social Workers	Assess and treat individuals with mental, emotional, or substance abuse problems, including providing therapy, crisis intervention, case management, client advocacy, prevention, and education.
Mental Health Counselors	Work with individuals and groups to deal with anxiety, depression, grief, stress, suicidal impulses, and other mental and emotional health issues.
Psychiatric Aides	Assist mentally, intellectually, or developmentally impaired patients, typically working under direction of nursing and medical staff in institutional facilities.
Psychiatric Nurse Practitioners	Earn advanced degrees in psychiatric-mental health nursing, and apply the nursing process to treat individuals or families with psychiatric disorders.
Psychiatric Physician Assistants	Perform psychiatric evaluations and assessments, order and interpret diagnostic studies, establish and manage treatment plans, and order referrals as needed.
Psychiatric Technicians	Attend to needs of individuals with mental or emotional conditions or disabilities in accordance with instructions of physicians or other health practitioners. Prepare reports for medical staff on patients emotional well-being, participate in rehabilitation and treatment programs, help patients with hygiene, and administer oral and injectable medications.
Psychologists	Assess, diagnose, and treat mental disorders and learning disabilities, as well as cognitive, behavioral, and emotional problems. Note: Projections only include psychologists that have obtained a doctorate degree.
School Counselors	Work with students through individual and group counseling sessions to help students address academic, emotional, or social problems.

Source: Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections

Common Ground Health

Appendix D: Behavioral Health Services and Programs

Resources are available for Monroe County residents seeking support for mental health and substance use challenges. Below are several ways to find programs and services to address various behavioral health needs.

211/LIFE LINE maintains a broad database of services and programs to help people find the support they need. They provide free, confidential 24-hour phone, text, and chat services, along with a searchable online database. Community members and providers can use 211/LIFE LINE to get information and referrals. This includes services that address specific mental health issues and substance use disorders and also services that provide help for related challenges that can contribute to or exacerbate behavioral health (e.g., housing, transportation, maternal health).

How to access 211/LIFE LINE:

- https://211lifeline.org/
- Call 211 or 1-877-356-9211
- Text 898211

The Monroe Mental Health Mobile App, from the Monroe County Office of Mental Health, provides essential mental and behavioral health information to county residents. The app features acute and outpatient resources, suicide prevention services, and Narcan information and training. Users can also create their own safety plan with actionable steps for harm reduction.

How to access the Monroe Mental Health Mobile App:

- For Apple devices: https://apps.apple.com/us/app/monroe-mental-health/id6450313091
- For Android devices: https://play.google.com/store/apps/details?id=com.ocv.a712
- For more information about the Monroe County Office of Mental Health: https://www.monroecounty.gov/mh

MyWayfinder is an online service that enables people to find the services and support they need. Community members can use the service anonymously or create an account so they can complete screenings and track their own referrals. MyWayfinder is powered by the same database of resources managed by 211/LIFE LINE.

How to access MyWayfinder:

- https://my-wayfinder.org

Appendix E:

ISSUE BRIEFS

BEHAVIORAL HEALTH NEEDS ASSESSMENT MONROE COUNTY

OVERVIEW

This Behavioral Health Needs Assessment provides a broad overview of Monroe County's behavioral health landscape. It identifies both the growing needs and key opportunities. This assessment goes beyond the traditional medical model that focuses on clinical diagnoses and treatment. It also considers overall emotional well-being and the role of social and community factors in prevention and healing.

Growing Needs & Large Disparities

Behavioral health needs in Monroe County have grown in recent years. The percentage of individuals diagnosed with a behavioral health condition has risen from 29% in 2016 to 34% in 2023.[1] Emergency department visits driven by behavioral health issues have surged by 72% from 2005 to 2023.[2] This suggests many more people may not be getting the support necessary to prevent the need for crisis care.

Not all communities experience these challenges equally. Significant disparities persist based on income, race, ethnicity, and insurance coverage. These disparities disproportionately affect marginalized and underserved populations. They also highlight the need for a more inclusive and accessible system of care.

This brief is part of a Behavioral Health Needs Assessment completed in July 2025. This is one of six issue briefs summarizing findings.

All issue briefs, along with the full assessment, are available online at **commongroundhealth.org/bhna25**.

Scan the QR code below with your phone camera to access these resources.

Common Ground Health

Community-Informed Focus Areas

We grounded this assessment in quantitative data and qualitative insights gathered from more than 40 local experts representing a wide variety of roles and perspectives related to behavioral health. Based on their input, we identified five key focus areas for deeper analysis:

- **Crisis Services and Post-Crisis Care**
- **Mental Health of Children and Youth**
- **System Gaps and Coordination Issues**
- **Retention and Diversity of the Workforce**
- **Community Connectors and Mental Health Supports**

Key Opportunities

While each of the focus areas has its own set of findings, we also identified four overarching strategic opportunities:

1. **Focus on Early Detection and Prevention:** Current resources focus heavily on treatment over prevention. There is a critical opportunity to invest in early support that prevents the onset or worsening of behavioral health issues. Prevention efforts include raising public awareness and offering help in everyday settings like schools, workplaces, and primary care.
2. **Breaking Down Silos:** Existing resources are often hard to access, and many individuals struggle to navigate the system. Improving coordination within and across organizations – through enhanced care management and navigator roles – can help people move more easily through the system.
3. **Investing in the Workforce:** Address workforce shortages and burnout by ensuring fair reimbursement, enhancing training and support, and promoting diversity to better match the needs of the community.
4. **Expanding Peer and Community Supports:** Leverage trusted community members to provide support that complements clinical care. This is especially important for populations whose needs are not met by standard medical services.

Cross-Cutting Issues

Additionally, improving the behavioral health of the community depends on addressing underlying factors that can either accelerate or hinder improvement.

- **Regulatory Environment:** Current regulations often limit flexibility in staffing, program coordination, and facility expansion. Reform is needed to enable more responsive and integrated care.
- **Social Drivers of Health (SDOH):** Factors such as housing, transportation, employment, and family dynamics significantly influence behavioral health outcomes. Addressing these drivers is essential to improving access and effectiveness of care.
- **Data Collection and Monitoring:** Robust data systems are needed to identify service gaps, track outcomes, and guide continuous improvement.

Additional details in the full assessment provide Monroe County decision-makers with actionable insights to guide collective efforts toward behavioral health solutions that are proactive, inclusive, and rooted in community needs.

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[1] Common Ground Health Multipayor Claims Database
[2] NYSDOH Statewide Planning and Research Cooperative System (SPARCS). Analysis by Common Ground Health.

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BEHAVIORAL HEALTH NEEDS ASSESSMENT MONROE COUNTY

CRISIS SERVICES AND POST-CRISIS CARE

When people use crisis services, it indicates that they have not received the type or level of care needed to treat or manage their behavioral health conditions. Large increases in use of the emergency department (ED) and other crisis services over the last 15 years indicate a growing need within Monroe County.

Why Focus Here?

High ED Utilization for Behavioral Health Concerns: ED usage for behavioral health conditions nearly doubled from 2005 to 2018 in Monroe County. And while the visit rate has receded from that peak, in 2023 it was still 72% above the 2005 level. The Monroe County visit rate has remained consistently higher than the rest of New York State.

Large Disparities: Black non-Latino residents and those in low socioeconomic status ZIP codes experience especially high ED visit rates related to both mental health and substance use disorders[1].

Repeat Visits Signal Gaps in Care: In 2023, nearly half of individuals with a mental health-related ED visit returned to the ED for additional behavioral health care in the same year. Similarly, 29% of those with a substance use disorder-related ED visit returned to the ED for more behavioral health care in the same year. These repeat visits indicate unmet needs and gaps in care. Return visits to the ED were highest for patients seeking care for intentional self-

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harm, followed by those seeking care for personality disorders.[1]

Timeliness of Intervention: While there are some after-hours alternatives to the ED, people remain unaware of those resources and how to access them.

Key Opportunities

Expand Use of Outpatient Services & ED-Alternatives: Recent expansions in outpatient and drop-in centers have helped increase access to behavioral health "urgent care" and reduced ED reliance. Continued investment in these alternative options could prove an effective and more patient-centered approach to crisis care.

Expand Step-Down and Transitional Care Options: There are few options for patients stepping down from acute care, especially for those with complex or chronic behavioral health needs. Insufficient options lead to repeat crises and ED visits.

Expand Use of Trained Peers and Non-Clinical Supports: Trained peers and community connectors could be used more extensively for better follow-up support after a crisis. Peers reduce stigma around mental and behavioral health by lending their lived experience to help those in crisis feel more heard, seen and comfortable.

Focus on Holistic, Coordinated Support:

- Strengthening case management and care coordination to facilitate follow-up improves long-term outcomes. This is especially important for patients with barriers related to social drivers of health such as lack of transportation or housing.
- Providers need increased awareness of available programs and services so they can make appropriate referrals and connections for patients.
- Enhanced collaboration is needed to better integrate mental health and substance use services for patients as they are heavily intertwined components of well-being.

Advocate for Equity in Reimbursement: Behavioral health professionals need to be paid equitably to sustain practices and effectively treat patients. Reimbursing certain services or professionals at lower rates than others hurts workforce retention and limits the variety of services available for those in need.

> ***"[We need] more facilities open with longer hours and more places that are accessible and easy to get to [so you're] not going to be told 'you have to call back for an appointment' or 'we can schedule you in six months.'"***
>
> ***—Behavioral Health Needs Assessment Advisor***

[1] NYSDOH Statewide Planning and Research Cooperative System (SPARCS). Analysis by Common Ground Health.

BEHAVIORAL HEALTH NEEDS ASSESSMENT MONROE COUNTY

MENTAL HEALTH OF CHILDREN AND YOUTH

Children and youth today face increased mental health challenges. Complex interactions between physical, emotional, and mental health affect children's abilities to develop healthy relationships, focus at school, and explore the world around them. Inequities persist particularly among children living in poverty, children of color, those identifying as LGBTQ, immigrants and English language learners. They also persist among those with physical, developmental, and/or intellectual disabilities, and those with chronic medical conditions.

Why Focus Here?

Mental and behavioral health conditions are a growing concern among children and youth:

- 28% of youth had a behavioral health diagnosis in 2023 (up from 23% in 2016)[1]
- 58% of high school survey respondents reported one or more Adverse Childhood Experiences (ACEs) with 18% experiencing three or more ACEs[2]
- Intentional self-harm is the most common behavioral health reason that children and youth (ages 0-21) go to the emergency department[3]

Exposure to early adversity impacts lifelong health: Our earliest experiences and relationships set the trajectory for long-term health outcomes by creating pathways for future behavior, responses, and actions. Children and youth who experience stress, trauma, and lack of parent responsiveness early in life often display symptoms of mental health challenges.

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Pandemic-related measures affected child development: Sudden and drastic disruptions to routines as a result of the COVID-19 pandemic had unique effects on children and youth. Examples include:

- Speech and language delays in toddlers that manifest as behavior issues
- Challenges with remote learning
- Isolation resulting in delayed social development and missed milestones
- Impacts of living with parents facing increased stress, depression, and anxiety

Smartphone and social media use is increasing: An increased online presence is linked to negative mental health outcomes among children and youth. Students reported difficulties disengaging from social media and used it as a way to escape negative feelings.

Access to mental health care is limited and inequitable: Providers and families are not always aware of existing care options. Services remain difficult to access and navigate, especially for people facing barriers related to social drivers of health. Inequities in accessing care persist with Medicaid populations having lower follow-up rates than children and youth with commercial insurance.

Key Opportunities

Promote Early Detection and Prevention: Screening children and youth regularly can help identify mental health challenges before the need for more intense levels of care. Standard procedures after positive screenings are necessary to ensure timely follow-up care. Additionally, prevention-based programming focused on resiliency and life skills for youth is needed.

Provide Additional Training: Enhance training for professionals working with children and youth by incorporating information on infant and early childhood mental health needs. To better serve communities of color, train clinicians in culturally responsive mental health treatment.

Facilitate Access to Mental and Behavioral Health Services: Interventions that leverage home visitation, telehealth, community health workers, or school-based models help to promote access by mitigating barriers connected with social drivers of health.

Adopt Family-Centered Approaches: Parents, caregivers, children, and youth need to inform all phases of program development and implementation. They should have input into the design of clinical spaces to ensure these spaces are welcoming and functional for children and families.

Reduce Silos: Providers can reduce disconnected care by designating people to facilitate collaboration among systems and organizations. Additional care coordinators and social workers could help pediatric practices meet the increased demand for behavioral health-related services. The ability to bill for collaboration is needed to incentivize this type of coordination.

> ***"Behavior is a communication of unmet need… The real issues are beneath the surface."***
>
> ***—Behavioral Health Needs Assessment Advisor***

[1] Common Ground Health Multipayor Claims Database
[2] 2023-2024 School Year Monroe County Youth Risk Behavior Survey Report, Monroe County Department of Public Health
[3] NYSDOH Statewide Planning and Research Collaborative (SPARCS), 2023. Analysis by Common Ground Health.

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BEHAVIORAL HEALTH NEEDS ASSESSMENT MONROE COUNTY

SYSTEM GAPS AND COORDINATION ISSUES

Behavioral health care services are diverse in scope and practice. Different types of care are available from a mix of entities, including both medical systems that offer many services and community-based organizations that provide specific types of support. Services span the continuum of care from early prevention to acute crisis care. They also include different modalities ranging from medical-model health care settings to holistic recovery-oriented community-based programs. Due to the fragmented behavioral health landscape, many people struggle to find and access needed care.

Why Focus Here?

Fragmented and Siloed Services: Behavioral health services are often separate and disconnected from each other across agencies and even within organizations. This makes coordination difficult as individuals' needs vary and may evolve, requiring different levels and types of care. Despite the interdependence of physical and behavioral health, coordination between these systems of care remains limited. In particular, primary care providers are well-positioned to identify behavioral health issues early but often lack the tools and support to connect patients to appropriate care.

Obstacles to Accessing Care: Individuals face multiple hurdles in accessing care. These include finding providers who are geographically accessible, accept their insurance, and offer appointments that

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fit their schedules. Arranging needed care often takes a combination of persistence and flexibility. This can be particularly difficult for people who face barriers related to transportation, care-giving responsibilities, work schedules, and other social drivers of health.

Shortage of Culturally Congruent Resources: The racial, ethnic, and cultural mix of providers does not match the diversity of people seeking help. Shared identities are a component of meeting client needs in addition to training in areas of cultural responsivity. There is a shortage of behavioral health providers trained to address the mental health impacts of intergenerational and racialized trauma, making it particularly difficult for people of color to find culturally congruent care.

Inadequate Funding and Billing Structures: Providers face challenges due to the non-billable time needed to coordinate care, unpredictable funding streams, and rigid reimbursement policies. These issues hinder collaboration and innovation, limiting services to only what meets the reimbursable definitions of treatment and delivery settings.

Gaps in State-Level Integration and Vision: While providers are encouraged to collaborate, there is limited guidance on a state-level strategy to support integrated care. It is difficult for people with co-occurring conditions to receive coordinated care from multiple state agencies that have different funding streams, eligibility rules, enrollment processes, and other regulatory requirements.

Key Opportunities

Enhance System Coordination and Referral Networks: Appoint fully funded care coordinators to bridge services and providers. Develop centralized, dynamic referral systems that strengthen warm handoff processes and build trust through community-based networks. When possible, provide services in community-based settings such as primary care practices and schools to meet individuals where they already are.

Expand and Support Peer and Community-Based Roles: Increase investment in peer specialists, family navigators, and community health workers. Implementation should include higher compensation for peer workers, clear supervision structures, and adherence to peer support models. Ensure culturally responsive training with equitable access for communities of color.

Implement Flexible, Recovery-Oriented Care Models: Promote same-day service models, drop-in centers, peer and recovery-oriented models of care, and service delivery in community settings. These approaches reduce delays and meet individuals where they are, both physically and emotionally.

Align Funding and Policy at the State Level: Integrate behavioral health oversight across agencies, streamline billing mechanisms, and incentivize collaboration. Conduct service mapping to identify gaps and underutilized resources, guiding strategic improvements.

> ***"[The] current medical system is reactive rather than preventative…And so most of our behavioral health interventions are post-incident…or after people have developed long symptoms."***
>
> ***—Behavioral Health Needs Assessment Advisor***

BEHAVIORAL HEALTH NEEDS ASSESSMENT MONROE COUNTY

RETENTION AND DIVERSITY OF WORKFORCE

Monroe County already has shortages of behavioral health professionals, and the demand for providers and services continues to grow. A focus is needed on supporting, training and retaining the current behavioral health workforce while simultaneously expanding and diversifying the future workforce pipeline.

Why Focus Here?

Resource Gaps: Most of the City of Rochester and some suburban areas within the county are currently designated as Mental Health Professional Shortage Areas (HPSAs) for the Medicaid eligible population.[1] Additionally, demand for all fields of behavioral health professionals is increasing. The workforce pipeline is not growing at a rate fast enough to meet projected needs.[2]

Burnout and Vicarious Trauma: An advisor described vicarious trauma as, "We do what we can…we hold space, but that stays with us. It can bring up our own stuff, re-traumatize things we've been through… trying to figure out how to keep showing up for others, while we don't always have the support we need ourselves. That alone can be traumatizing." Burnout and vicarious trauma impact providers' own mental well-being influencing the care patients receive while also leading to a decrease in workforce retention.

Lack of Workforce Diversity: There is a mismatch between the racial, ethnic, and cultural makeup of the provider pool and the people seeking help. This makes it hard to establish "precision of fit," or

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a good match, between client and provider. The needed diversity extends beyond demographics including different life experiences and perspectives as well.

Funding and Reimbursement Challenges: Low reimbursement rates, specifically disparate rates for behavioral health services, make it difficult to sustain programs and meet existing demand. Another consequence is it dissuades providers from accepting insurance and thereby limits accessibility of services to patients. Additionally, gaps in funding lead to competition between organizations for resources rather than fostering collaboration. This competition can result in fragmented patient care.

Insufficient Data: Currently, we are unable to track the percentage of providers that are accessible to those with public insurance or have training in culturally responsive and trauma-informed practices. These are a few examples of data that would be valuable in assessing "precision of fit" between provider and client. Additionally, many datasets only provide data at a state level. Local and/or regional data is critical for monitoring needs and developing solutions.

Key Opportunities

Support the Current Behavioral Health Workforce: The behavioral health workforce can benefit from an array of supports. These supports help improve the mental health of staff and retain the workforce. Such supports include trainings (culturally responsive care, avoiding burnout, etc.), reflective supervision, and affinity groups, as well as encouraging work-life balance and self-care.

Advance Diversity in Training and Hiring: Increase diversity within the behavioral health workforce pipeline through programs providing stipends and tuition forgiveness. Continue to assess credentialing entities for equity in licensing requirements. Practicing professionals could benefit from training in culturally responsive and trauma-informed care.

Expand Use of Trained Peers and Support Professionals: Increased use of family care advocates, navigators, peers with lived experience, and community health workers would benefit the system. They assist with cultural fit, system navigation and improved care for patients. They could also reduce the workload on providers to allow more time spent on patient care.

Advocate for Equity in Reimbursement: This is needed for mental and behavioral health professionals to be able to effectively treat patients. It will also help sustain practices, contributing to workforce retention.

Collect and Monitor Workforce Data: Consistently collect and monitor workforce data to provide more current and accurate assessments of the workforce's ability to meet public need.

> ***"[There's a] spiritual pain that comes with this work because we're being asked to do things and to try to interface with people who we know we cannot meet [all] their needs…If we're honest, these systems weren't designed to heal people."***
>
> ***—Behavioral Health Needs Assessment Advisor***

[1] Health Resources and Services Administration (HRSA)
[2] Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections

BEHAVIORAL HEALTH NEEDS ASSESSMENT MONROE COUNTY

COMMUNITY CONNECTORS AND MENTAL HEALTH SUPPORTS

Community connectors and mental health support organizations expand the clinical care landscape and broaden what access to support looks like in Monroe County. They augment often-overloaded behavioral and mental health systems by providing services that include information and referrals, connection and social support, and healing and wellness. This assessment identified opportunities to integrate and utilize community connectors and mental health supports more widely. By doing so, we can address current unmet needs and alleviate some of the resource pressure on the formal clinical care system.

Why Focus Here?

Need for Mental and Behavioral Health Support is Pronounced: Many residents in our community experience significant stress and concerns related to mental and behavioral health and leverage community connectors for support and guidance.

- 25% of My Health Story survey respondents in Monroe County indicated that their emotional and mental health was fair or poor[1]
- 59% identified having at least one self-concern related to mental health or substance use in the past 12 months[1]
- 81% used at least one non-clinically licensed support[1]

Established Trust and Rapport: People seek mental health and substance use support from community connectors and organizations for various

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reasons. These include existing rapport with those they reach out to, convenient and comfortable settings, mutual values and beliefs, and shared identities with support givers.

Offer Multiple Pathways for Support: Community connectors and mental health support organizations assist residents in different ways including:

- Normalizing mental and behavioral health issues by dismantling stigma and debunking myths
- Providing culturally responsive healing through traditional methods such as yoga, dance and storytelling circles, and by creating safe spaces for belonging
- Meeting people where they are within their behavioral health journey
- Acting as a "bridge" to connect people to clinical care when needed by providing resources, services and support, and assistance in navigating treatment options

Key Opportunities

Change the Culture of Care: Shifting from deficit-based models to an approach focused on mental wellness requires significant changes to the ways systems currently operate. To improve the culture of care we need to focus on:

- Embedding people with lived experience in development, implementation, and decision making
- Encouraging recovery-oriented perspectives and language
- Reducing stigma broadly throughout the community and also within clinical settings
- Integrating mental health framing throughout policy discussions and community forums

Enhance Partnerships with Clinical Healthcare Systems: Explore areas where community-based organizations can further support clinical care efforts. Encourage collaboration and coordination between healthcare systems and community-based organizations.

Training and Assistance: Additional training and support can increase the impact that community connectors and mental health support organizations have within the communities they serve.

- Specific content areas for additional training include recognizing and understanding signs of distress, boundary setting, and culturally responsive and trauma-informed practices
- Assistance to ensure that community providers prioritize self-care and have safe spaces to continue their own healing journeys
- Support and guidance on implementing peer-models

Increase Workforce Diversity: There is continued need for more people of color in the mental and behavioral health fields. This includes roles at community-based mental health support organizations and in peer navigator programs.

> ***"Spaces where we can bring our entire selves, take off 'the mask,' and not have to code-switch are incredibly therapeutic... If it reduces your stress and puts you in a place where you feel safe and nurtured, that's healing."***
>
> *—Behavioral Health Needs Assessment Advisor*

[1] My Health Story 2022, Common Ground Health.

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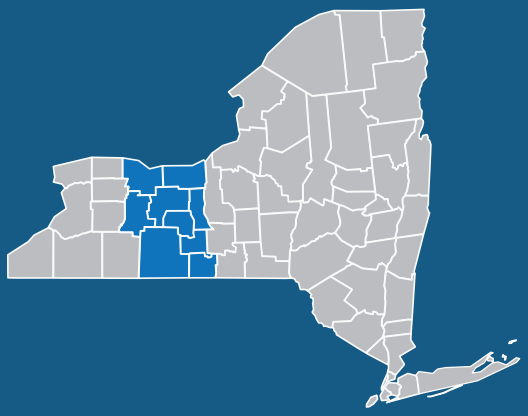

Founded in 1974, Common Ground Health is the health planning organization for the nine-county Finger Lakes region. We bring together health care, education, business, government and other sectors to find common ground on health issues. Learn more about our community tables, our data resources and our work improving population health at www.CommonGroundHealth.org.

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