COVID-19 Impact Survey for Recipients of Mental Health Services 2021

INTRODUCTION

The Office of Mental Health is conducting a survey to help us better understand the impacts and aftermath of the COVID-19 pandemic in our community. Your input is critical to helping us understand the needs of the community and helping us prioritize policy and program decisions. This survey is anonymous.

We are looking for responses from and perspectives of people (children/adolescents, young adults, adults) who receive services from any OMH licensed, funded or designated programs. These programs can include, but are not limited to clinic, supportive housing, Personalized Recovery Oriented Services, Recovery Centers, Home and Community Based Services, Peer Services, and inpatient services.

A comprehensive list of OMH programs can be found on the next two pages as well as at the following link: https://my.omh.ny.gov/bi/pd.

OMH PROGRAM TYPES

Emergency

- **Comprehensive Psychiatric Emergency Program**
  - Comprehensive Psychiatric Emergency Program
    - CPEP Crisis Intervention
    - CPEP Crisis Outreach
    - CPEP Crisis Beds
    - CPEP Extended Observation Beds
- **Crisis**
  - Children's Crisis Residence
  - Crisis Intervention
  - Crisis Residence
  - Crisis/Respite Beds
  - Home-Based Crisis Intervention
  - Mobile Crisis Services
  - FEMA Crisis Counseling Assistance & Training
  - Residential Crisis Support

Inpatient

- Inpatient Psychiatric Unit of a General Hospital
- Private Psychiatric Hospital
- Residential Treatment Facility - Children & Youth
- State Psychiatric Center Inpatient

Outpatient

- Assertive Community Treatment (ACT)
- Clinic Treatment
- Continuing Day Treatment
- Day Treatment
- Partial Hospitalization
- **Personalized Recovery-Oriented Services**
  - Comprehensive PROS with Clinical Treatment
  - Comprehensive PROS without Clinical Treatment
- **Support**
  - CFTSS: Mental Health Rehabilitation Services
- **OnTrackNY**
- **Certified Community Behavioral Health Clinic (CCBHC)**

Residential

- **Support Program**
  - Apartment/Support
  - Congregate/Support
- **Family Care**
- **Treatment Program**
  - Apartment/Treatment
  - Community Residence for Eating Disorder Integrated Treatment
  - Congregate/Treatment
  - Children & Youth Community Residence
  - SRO Community Residence
- **Transient Housing**
- **Unlicensed Housing**
  - Supportive Housing
  - Supportive Single Room Occupancy (SP-SRO)

Support

- **Care Coordination**
  - Adult Home Supportive Case Management
  - Children's HCBS Waiver Individualized Care Coordination

    - Geriatric Demo Physical Health-Mental Health Integration
    - Health Home Care Management
    - Health Home Non-Medicaid Care Management
    - Homeless Placement Service
    - Non-Medicaid Care Coordination
    - Transition Management Services
    - Adult BH HCBS
        - Education Support Services (ESS)
        - Empowerment Services- Peer Supports
        - Family Support and Training (FST)
        - Habilitation
        - Intensive Supported Employment (ISE)
        - Ongoing Supported Employment (OSE)
        - Pre-Vocational Services
        - Psychosocial Rehabilitation
        - Self-Directed Care
        - Short-term Crisis Respite
        - Transitional Employment
- **Education**
    - Promise Zone
    - School Mental Health Program
    - Supported Education
- **Forensics**
    - Prison-based Forensic Mental Health Units
- **General Support**
    - CFTSS
        - Community Psychiatric Support and Treatment (CPST)
        - Family Peer Support Services (FPSS)
        - Mobile Crisis Intervention (CI)
        - Other Licensed Practitioner (OLP)
        - Psychosocial Rehabilitation (PSR)
        - Youth Peer Support (YPS)
    - Early Recognition Coordination and Screening Services
    - Family Peer Support Services - Children & Family
    - Geriatric Demo Gatekeeper
    - Home-Based Family Treatment
    - MICA Network
    - Mobile Integration Team
    - Multi-Cultural Initiative
    - Nursing Home Support
    - On-site Rehabilitation
    - Outreach
    - Recreation and/or Fitness
    - Residential Treatment Facility Transition Coordinator-Community
    - Respite Services
    - Transportation
- **Self-Help**
    - Advocacy/Support Services
    - Drop In Centers
    - Peer Wellness Center
    - Psychosocial Club
    - Recovery Center
    - Self Help Programs
- **Vocational**
    - Affirmative Business/Industry
    - Assisted Competitive Employment
    - Ongoing Integrated Supported Employment Services
    - Transformed Business Model
    - Transitional Employment Placement (TEP)
    - Vocational Services - Children & Family (C & F)
    - Work Program

We recognize that some service recipients may have trouble accessing the survey, so we're asking service providers and advocates to reach out to service recipients and complete the survey on their behalf. **If you receive OMH services, please answer all of the questions for yourself. If you are filling out the survey on behalf of someone else who receives OMH services, please answer consistently as that individual.** This should include all demographic questions, such as age, race/ethnicity, and gender identity as well.

1. * Please select the statement that best describes yourself (select one):
   - ○ I receive services and I am responding on my own behalf
   - ○ I am a family member/ chosen family member of a service recipient responding on behalf of the service recipient
   - ○ I am a friend of a service recipient responding on behalf of the service recipient
   - ○ I am a caregiver of a service recipient responding on behalf of the service recipient
   - ○ I am a service provider of a service recipient responding on behalf of the service recipient
   - ○ I am a peer of a service recipient responding on behalf of the service recipient

   * This question is required.

2. * Please identify which program types you have had services from in the past year (select all that apply):
   - ☐ Assertive Community Treatment
   - ☐ Care Coordination
   - ☐ Children and family treatment and Support Services
   - ☐ Clinic Services
   - ☐ Crisis Services
   - ☐ Day treatment
   - ☐ Education Services
   - ☐ Family Services
   - ☐ Home and Community Based Services
   - ☐ Inpatient Services
   - ☐ Personalized Recovery Oriented Services
   - ☐ Residential Housing Services and Supports
   - ☐ Self-Help Services and Supports
   - ☐ Vocational Services
   - ☐ Certified Community Behavioral Health Clinics
   - ☐ OnTrackNY

   * This question is required.

3. On the lines below, please write each of the program types you selected in Question 2. For each of these program types, respond to the prompts to the right. You can answer for up to 5 program types. **Please do not write the specific name of the program/agency/facility.**

Program Type 1: _____

Over the past 6 months my treatment and service team members have changed:

- ○ Yes
- ○ No
- ○ Unsure
- ○ Not applicable

My program/provider has peer supports/ employs peers:

- ○ Yes
- ○ No
- ○ Unsure
- ○ Not applicable

Program Type 2: _____

Over the past 6 months my treatment and service team members have changed:

- ○ Yes
- ○ No
- ○ Unsure
- ○ Not applicable

My program/provider has peer supports/ employs peers:

- ○ Yes
- ○ No
- ○ Unsure
- ○ Not applicable

Program Type 3: _____

Over the past 6 months my treatment and service team members have changed:

- ○ Yes
- ○ No
- ○ Unsure
- ○ Not applicable

My program/provider has peer supports/ employs peers:

- ○ Yes
- ○ No
- ○ Unsure
- ○ Not applicable

Program Type 4: _____

Over the past 6 months my treatment and service team members have changed:

- ○ Yes
- ○ No
- ○ Unsure
- ○ Not applicable

My program/provider has peer supports/ employs peers:

- ○ Yes
- ○ No
- ○ Unsure
- ○ Not applicable

Program Type 5: _____

Over the past 6 months my treatment and service team members have changed:

- ○ Yes
- ○ No
- ○ Unsure
- ○ Not applicable

My program/provider has peer supports/ employs peers:

- ○ Yes
- ○ No
- ○ Unsure
- ○ Not applicable

DEMOGRAPHICS

If you receive OMH services, please enter your own demographic information. If you are filling out the survey on behalf of someone else who receives OMH services, please enter that individual's demographic information.

4. Age (select one):
   - ○ Under 18
   - ○ 18-24
   - ○ 25-34
   - ○ 35-44
   - ○ 45-54
   - ○ 55-64
   - ○ 65+

5. Region (select one):
   - ○ Central New York Region (Broome, Chenango, Cayuga, Clinton, Delaware, Essex, Cortland, Onondaga, Oswego, Otsego, Jefferson, Lewis, St. Lawrence, Madison, Oneida, Montgomery, Fulton, Franklin, Herkimer, and Hamilton Counties)
   - ○ Hudson River Region (Warren, Washington, Saratoga, Schenectady, Schoharie, Albany, Rensselaer, Columbia, Greene, Ulster, Dutchess, Orange, Putnam, Westchester, Rockland, Sullivan Counties)
   - ○ Long Island (Nassau & Suffolk Counties)
   - ○ New York City (Manhattan, Brooklyn, Bronx, Queens, Staten Island)
   - ○ Western New York Region (Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, and Yates Counties)

6. Hispanic/Latinx Ethnicity (select one):
   - ○ No, not of Hispanic, Latinx, or Spanish origin
   - ○ Yes, Mexican, Mexican American, Chicano
   - ○ Yes, Puerto Rican
   - ○ Yes, Cuban
   - ○ Yes, another Hispanic, Latinx, or Spanish origin

7. Race (select all that apply):
   - ☐ American Indian/Alaskan Native
   - ☐ Asian
   - ☐ Black/African American
   - ☐ Native Hawaiian/Other Pacific Islander
   - ☐ White
   - ☐ Other
   - ☐ Unknown

8. Preferred language (select one):
    - ○ English
    - ○ Spanish/Spanish Creole
    - ○ African Languages
    - ○ Arabic
    - ○ Cantonese
    - ○ French/Haitian Creole
    - ○ Fujianese
    - ○ Hebrew
    - ○ Hindi
    - ○ Italian
    - ○ Korean
    - ○ Mandarin
    - ○ Other Asian
    - ○ Other Indi (e.g., Sindhi)
    - ○ Other Indo-European
    - ○ Polish
    - ○ Portuguese/Creole
    - ○ Russian
    - ○ Sign Language
    - ○ Tagalog
    - ○ Urdu
    - ○ Vietnamese
    - ○ Yiddish/Pennsylvania Dutch/other West Germanic
    - ○ Other
    - ○ Unknown

9. Gender identification (select one):
    - ○ Female
    - ○ Male
    - ○ Non-binary, gender non-conforming, and/or other
    - ○ Transgender, female to male
    - ○ Transgender, male to female

The following questions will ask about your mental well-being and experiences with various challenges in life during the past 6 months of the COVID-19 pandemic, including experiences regarding alcohol and substance use and thoughts of suicide. This survey is anonymous, so we cannot provide direct support. If you are in need of immediate support, please contact the National Suicide Prevention Lifeline, 1-800-273-TALK (8255) or chat line.
If you receive OMH services, please answer all of the questions for yourself. If you are filling out the survey on behalf of someone else who receives OMH services, please answer consistently as that individual.

10. How have your anxiety and stress levels changed during the past 6 months of the COVID-19 pandemic?
    - ○ Anxiety and/or stress have not been impacted by the crisis
    - ○ Slight increase in anxiety and/or stress
    - ○ Moderate increase in anxiety and/or stress
    - ○ Significant increase in anxiety and/or stress

11. How have your feelings of sadness and/or depression changed during the past 6 months of the COVID-19 pandemic?
    - ○ Feelings of sadness and/or depression have not been impacted by the crisis
    - ○ Slight increase in feelings of sadness and/or depression
    - ○ Moderate increase in feelings of sadness and/or depression
    - ○ Significant increase in feelings of sadness and/or depression

12. Consider the condition(s) for which you receive mental health services. How have your symptoms changed during the past 6 months of the COVID-19 pandemic?
    - ○ Symptoms have not been impacted by the crisis
    - ○ Slight increase in symptoms
    - ○ Moderate increase in symptoms
    - ○ Significant increase in symptoms

13. The following question asks about your thoughts of suicide. This survey is anonymous, so we cannot provide direct support. If you are in need of immediate support, please contact the National Suicide Prevention Lifeline, 1-800-273-TALK (8255, or chat line).
    If you are comfortable responding, please select the option that best reflects your experience with thoughts of suicide or self-harm during the past 6 months of the COVID-19 pandemic:
    - ○ No change in thoughts of suicide or self-harm
    - ○ A slight increase in thoughts of suicide or self-harm
    - ○ A significant increase in thoughts of suicide or self-harm
    - ○ A decrease in thoughts of suicide or self-harm
    - ○ I have not experienced thoughts of suicide or self-harm

14. Many people have had difficulty coping with the COVID-19 pandemic and may be drinking or using drugs more frequently than they did before the pandemic. If you're comfortable responding, please select the option that best reflects your experience with drug and alcohol use during the past 6 months of the COVID-19 pandemic:
    - ○ No change in the use of alcohol or drugs
    - ○ A slight increase in the use of alcohol or drugs
    - ○ A significant increase in the use of alcohol or drugs
    - ○ A decrease in the use of alcohol or drugs
    - ○ I never use alcohol or drugs

15. During the past 6 months, please select areas where you experienced challenges as a result of the COVID-19 pandemic. (Select all that apply):
    - ☐ Housing
    - ☐ Income/benefits
    - ☐ Employment
    - ☐ Food
    - ☐ Toiletries and clean clothes
    - ☐ Transportation
    - ☐ Education/online education
    - ☐ None of the above

16. Do you feel like you are receiving enough support?
    - ○ Yes
    - ○ No

    *If you selected **YES** to **Question 16**, from whom are you receiving support (select all that apply)? If you selected **NO**, please skip this question.*
    - ☐ Providers and professional counselors
    - ☐ Peer specialists or advocates
    - ☐ Family and/or friends
    - ☐ Faith-based supports
    - ☐ Other community supports (including but not limited to housing, transportation, and food supports)

17. Other than professional supports, are you using technology to connect to others for support?
    - ○ Yes
    - ○ No

The following questions will ask you about your experiences receiving healthcare during the past 6 months of the COVID-19 pandemic. If you receive OMH services, please answer all of the questions for yourself. If you are filling out the survey on behalf of someone else who receives OMH services, please answer consistently as that individual.

18. Do you prefer in-person, video, or telephone visits for your mental health care?
    - ○ In-person
    - ○ Videoconference
    - ○ Telephone call
    - ○ No preference

    *If you selected a preferred method in **Question 18**, are you able to access that method of care? If you did not, please skip this question.*
    - ○ Yes
    - ○ No

19. Have you received in-person services within the past 6 months?
    - ○ Yes
    - ○ No

20. How has your amount of contact with your mental health provider changed during the past 6 months (compared to the immediate 6 months prior)?
    - ○ Less contact with providers
    - ○ Same amount of contact with providers
    - ○ More contact with providers

21. Have you participated in telehealth appointments? This means talking with a provider by phone or computer.
    - ○ Yes
    - ○ No

    *If you selected **YES** to **Question 21**, please select the mode(s) of communication (please select all that apply):*
    - ☐ Telephone
    - ☐ Video Conference on a cell phone
    - ☐ Video Conference on an iPad, tablet, or computer

    *If you selected **YES** to **Question 21**, please rate your comfort level with telehealth:*
    - ○ Very Comfortable
    - ○ Comfortable
    - ○ Neutral
    - ○ Uncomfortable
    - ○ Very Uncomfortable

    *If you selected **NO** to **Question 21**, what is preventing you from using telehealth services (please select all that apply)?*
    - ☐ Not offered telehealth services
    - ☐ Don’t have a phone
    - ☐ Not enough minutes or data support
    - ☐ No computer
    - ☐ Broadband or wireless service unreliable
    - ☐ No broadband or wireless service

22. If you have needed urgent mental health services, how did you seek help?
    - ○ I did not need an urgent mental health Service
    - ○ Called a crisis helpline
    - ○ Texted a crisis helpline
    - ○ Called your treatment provider or a provider you know about
    - ○ Called emergency services (e.g., 911)
    - ○ Visited an emergency room or urgent care clinic

23. If you need urgent mental health services in the future, which method would you prefer?
    - ○ Call a crisis helpline
    - ○ Text a crisis helpline
    - ○ Call your treatment provider or a provider you know about
    - ○ Call emergency services (e.g., 911)
    - ○ Visit an emergency room or urgent care clinic
    - ○ Unsure

24. During the past 6 months, my physical healthcare has been
    - ○ More accessible than mental healthcare
    - ○ Equally accessible to mental healthcare
    - ○ Less accessible than mental healthcare

The following questions will ask you about your experiences with the COVID-19 vaccine. If you receive OMH services, please answer all of the questions for yourself. If you are filling out the survey on behalf of someone else who receives OMH services, please answer consistently as that individual.

25. Have you received a COVID-19 vaccine?
    - ○ Yes, I have received one dose of a two-dose vaccine (i.e., Pfizer, Moderna).
    - ○ Yes, I have received both doses of a two-dose vaccine (i.e., Pfizer, Moderna).
    - ○ Yes, I have received one dose of a single-dose vaccine (i.e., Johnson & Johnson).
    - ○ No, I have not received a vaccine, but I intend to.
    - ○ No, I have not received a vaccine and I do not intend to.

*If you answered **YES** to **Question** 25 and received a COVID-19 vaccine **after initially delaying**, what prompted you to get it (select all that apply)? **If you have not received a COVID-19 vaccine, please skip this question**.*

- ☐ I got my vaccine as soon as I was eligible; there was no delay.
- ☐ I knew unvaccinated people who became sick with or died from COVID-19 illness, and it motivated me to get vaccinated.
- ☐ A trusted friend, family member, or health care provider answered the questions I still had about the vaccine.
- ☐ I needed to be vaccinated to return to work or attend educational/ vocational institutions.
- ☐ I was interested in one or more of the available incentives.
- ☐ Personal considerations (e.g., I was pregnant when I became eligible and wanted to wait until I delivered, I had recently recovered from COVID-19 and thought I did not need the vaccine right away).

*If you answered NO to **Question 25,** there are many reasons why you may not have received a COVID-19 vaccine. If any of the reasons below apply to you, please check the boxes next to each reason (select all that apply). **If you have received a COVID-19 vaccine, please skip this question**.*

- ☐ I have concerns that I would need to disclose sensitive information about myself to receive a vaccine.
- ☐ I have had difficulty accessing vaccines due to physical limitations or transportation issues.
- ☐ It has not been convenient enough to access vaccines.
- ☐ I have concerns that receiving a vaccine would be unaffordable.
- ☐ I have not been able to take time off from work or other responsibilities to get a vaccine.
- ☐ I do not believe I am at risk of contracting COVID-19.
- ☐ I believe that if I contracted COVID-19, I would not get very ill or die.
- ☐ I recovered from COVID-19 illness and believe I am protected enough.
- ☐ I do not trust that the vaccines work or are safe.
- ☐ I have concerns about immune reactions I may experience from receiving a vaccine.
- ☐ I am pregnant or planning to become pregnant and believe the vaccine poses risks to my fertility or infant's health.
- ☐ I do not trust the health care system, the government, or pharmaceutical manufacturers.
- ☐ My peers (family, friends, etc.) are not vaccinated either.
- ☐ I do not think my choice not to be vaccinated impacts other people.
- ☐ No one has asked me outright to be vaccinated.
- ☐ I mean to be vaccinated but I need more reminders.
- ☐ I have been instructed not to receive the vaccine due to a medical contraindication (e.g., a severe allergy to polyethylene glycol (PEG) or polysorbate 80).

Considering your lifetime of experiences, please respond to the following questions about your experiences regarding racism or gender discrimination. If you receive OMH services, please answer all of the questions for yourself. If you are filling out the survey on behalf of someone else who receives OMH services, please answer consistently as that individual.

26. How often have you perceived others have held racist beliefs or treated you unequally because of your race, ethnicity, or the color of your skin?
    - ○ Never
    - ○ Rarely
    - ○ Sometimes
    - ○ Often

27. How often do you feel you have experienced discrimination when receiving mental health care because of your race, ethnicity, or the color of your skin?
    - ○ Never
    - ○ Rarely
    - ○ Sometimes
    - ○ Often

28. How often have you experienced harassment, verbal abuse, or a physical attack because of your race, ethnicity, or the color of your skin?
    - ○ Never
    - ○ Rarely
    - ○ Sometimes
    - ○ Often

29. How often have your mental health and well-being been negatively impacted because of your race, ethnicity, or the color of your skin?
    - ○ Never
    - ○ Rarely
    - ○ Sometimes
    - ○ Often

30. How has the pandemic changed the frequency of these experiences related to racism and discrimination? They have:
    - ○ Become less frequent
    - ○ Remained the same
    - ○ Become more frequent

31. How often have you perceived others have held negative beliefs or treated you unequally because of your gender identity?
    - ○ Never
    - ○ Rarely
    - ○ Sometimes
    - ○ Often

32. How often do you feel you have experienced discrimination when receiving mental health care because of your gender identity?
    - ○ Never
    - ○ Rarely
    - ○ Sometimes
    - ○ Often

33. How often have you experienced harassment, verbal abuse, or a physical attack because of your gender identity?
    - ○ Never
    - ○ Rarely
    - ○ Sometimes
    - ○ Often

34. How often have your mental health and well-being been negatively impacted because of your gender identity?
    - ○ Never
    - ○ Rarely
    - ○ Sometimes
    - ○ Often

35. How has the pandemic changed the frequency of these experiences related to gender identity? They have:
    - ○ Become less frequent
    - ○ Remained the same
    - ○ Become more frequent

Thank You!

Thank you for taking the time to complete this survey!

Your input is critical in helping us understand the needs of the community and helping us prioritize policy and program decisions. Use our website and social media to find services and connect with the NYS Office of Mental Health.

NYS Office of Mental Health: https://omh.ny.gov
For a comprehensive list of OMH programs: https://my.omh.ny.gov/bi/pd
Social Media:
Facebook.com/NYSOMH
Twitter.com/NYSOMH
Instgram.com/officeofmentalhealth