

Quick Stats

Agency	Program/Policy Start Date	Number Served Annually	Annual Budget
Administration for Children's Services	December 22, 2011	3,020 families (approximately)	\$22 million*

*Funding is not reflected in total YMI budget.

Problem Statement	<p>In calendar year 2010, 28.5% (19,313) of the abuse and maltreatment investigations conducted by the Division of Child Protection involved teens. These investigations resulted in approximately 1,400 teens being placed in foster care notwithstanding the efforts to hold child safety conferences to identify alternatives to placement. ACS is committed to preventing placement of these teens as long as home-based, therapeutic services will enable the teens to remain safely at home. ACS anticipates that by providing intensive home-based services tailored to the needs of teens and their families at the conferences, ACS will be able to further reduce foster care placements, improve family functioning, reduce truancy and other teen-specific behaviors, and keep families together in their communities.</p>
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Research and Evidence	<p>A needs analysis of the target population was recently conducted to determine the service need. This analysis directly informed the development of the Teen Preventive Service Model. Key findings from our analysis include:</p> <ul style="list-style-type: none"> 4,059 child safety conferences for youth 12 and older were held in 2010 citywide; of these, 1,159 youth were placed following the conference (28.5%) Brooklyn held the greatest number of CSCs for youth 12 and older (1,254) Of the five boroughs, the placement rate was highest in Manhattan - 43% of youth 12 and older (166) were placed following a conference The placement rate was lowest in Queens — 27% of youth 12 and older (163) were placed following a CSC Bronx recorded the greatest number of placements in 2010, with 406 placements of youth 12 and older following a conference; the Bronx also had the highest rate of voluntary placements (23.6% or 96 placements)
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Program Description	<p>As part of its ongoing commitment to keeping families together, the Administration for Children's Services (ACS) is investing in a continuum of programs to serve teenagers who are at risk of out-of-home placement. ACS is procuring a new, robust continuum of evidence-based services to support youth age 12 and older, and their families, who are the subject of a child safety conference with the Division of Child Protection. ACS is committed to preventing placement of these teens as long as home-based, therapeutic services will enable the teens to remain safely at home. ACS anticipates that by providing intensive home-based services tailored to the needs of teens and their families, ACS will be able to reduce foster care placements, improve family functioning, reduce truancy and other teen-specific behaviors, and keep families together in their communities.</p> <p>ACS is implementing this project in two Phases. Phase 1 began on December 22, 2011 in Manhattan and in one zone in the Bronx.</p>
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Implementation	<p>In Phase I, ACS is working with two current providers to provide Evidence-Based Services: Functional Family Therapy – Child Welfare Program (FFT-CW) offered by the New York Foundling, and Multi-Systemic Therapy Program (MST) offered by Children's Village. At every child safety conference involving a teen in Manhattan and in one zone in the Bronx, an ACS staff-person with expertise in these programs will attend and determine whether the family is eligible for one of these two services. If they are eligible and consensus is reached at the child safety conference, ACS will make the referral to the appropriate provider at the end of the conference. During this phase of the project, ACS will be tracking the cases to identify lessons learned to inform city-wide implementation.</p> <p>As part of Phase II, using the new preventive funding base-lined in the budget by the Mayor and City Council that has not yet been allocated, ACS will be issuing a Request for Proposals asking providers to submit proposals for additional Evidence-Based Services and other promising practices that have been implemented successfully with the teen population in child welfare systems.</p>
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Implementation Timeline	<ul style="list-style-type: none"> • December 2011 – Launched Phase I of the pilot program • January 2012 – Released Concept Paper for Preventive Services for Teens • May 2012 – RFP issued • September 2012 - ACS will review and score proposals • April 2013 – Awards will be made and contracts begin • June 2012 – Services begin City-wide
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Target Population	The target population is teens 12-17 year of age at risk of placement in foster care.
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Expected Outcomes	A reduction in the number of teens that enter foster care and residential care. In addition, we anticipate a reduction in the number of Article 10 petitions filed involving teens and teen behavioral issues.
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Quick Stats

Agency	Program/Policy Start Date	Number Served Annually	Annual Budget
Department Health and Mental Hygiene	November 2011	TBD	N/A

Problem Statement	Current clinical guidelines, practices and delivery of services aimed at adolescents are varied and inconsistent.
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Research and Evidence	Providing teen-friendly services to adolescents in an age-appropriate environment is crucial to assuring teens make healthy decisions about their sexual and reproductive health, and increasing use of contraception and condoms to prevent unintended pregnancy and sexually transmitted infections including HIV/AIDS among sexually active teens.
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Program Description	DOHMH will develop best practices and minimal criteria for the provision of teen-friendly clinical services. Finalized criteria will incorporate feedback from HHC, NYSDOH, professional associations, and other key partners, and will be disseminated through various channels including DOHMH and key partners' websites and provider networks.
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Implementation Timeline	<ul style="list-style-type: none"> • November 2011 – Draft teen-friendly best practices • February to April 2012 – Seek endorsements of best practices • Summer 2012 – Finalize teen-friendly criteria and toolkit for providers; finalize web-based database
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Target Population	Adolescents ages 10-24
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Expected Outcomes	<ul style="list-style-type: none"> • Dissemination and adoption of minimum criteria and best practices • Increased access and utilization of sexual and reproductive health care services
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Quick Stats

Agency	Program/Policy Start Date	Number Served Annually	Annual Budget
Department of Health and Mental Hygiene Health and Hospitals Corporation	Spring 2012	TBD	FY 13: \$2,160,000

Problem Statement

Though New York City is the safest big city in America, violence remains concentrated in certain socially and economically deprived neighborhoods. Such neighborhoods tend to have lower rates of employment and educational attainment and are plagued with other social and health disparities. Young men exposed to these social conditions are at risk of both violence victimization and perpetration. Young men, especially those 15-24 years of age, may lack skills to avoid or mediate conflict and may be unaware of the consequences to themselves, their families and their neighbors; violence becomes a learned behavior. Furthermore, community members in violent neighborhoods often acquiesce to the violence, accepting it as 'normal' behavior and feeling powerless to stop it.

Research and Evidence

The CeaseFire program originated in Chicago in an effort to address gang violence and reduce retaliatory killings. Northwestern University's Institute for Policy Research conducted an evaluation of the program, funded by the National Institute of Justice. Researchers examined community-level and client-level outcomes, comparing changes in multiple indicators of violence (e.g., "hot spots" and retaliatory homicides) over time in targeted CeaseFire areas to matched areas that did not have CeaseFire. In every program area (seven catchment areas were examined), there was a substantial decline - that is, 15% to 40% - in shootings in the two years following the introduction of CeaseFire. At the same time, there was no comparable decline in shooting densities in four matched comparison areas. Also, the proportion of homicides due to retaliatory violence dropped to zero in four CeaseFire program areas; and in five CeaseFire program areas the levels of reciprocal homicides declined more than in the comparison areas.ⁱ

Recent rigorous evaluation of replication sites in Baltimore demonstrated similar success. Specifically, compared to areas without the CeaseFire program, neighborhoods in South Baltimore showed large program-related reductions in homicide and nonfatal shooting incidents.ⁱ

Program Description

CeaseFire is an evidence-based violence prevention program that works with communities that have high levels of gun violence. The strategy leverages experiences of young men of color to act as "credible messengers" of an anti-violence message, in order to prevent and reduce youth violence.

Community-based organizations (CBOs), working with staff at public hospitals, will replicate the CeaseFire model in three high-risk New York City communities, focusing on behavior change among the youth at highest-risk of victimization and perpetration, as well as community norms change. The

Program Description	CeaseFire model employs “violence interrupters” and outreach workers from the community who have themselves experienced violence and also have strong relationships with young adults, community leaders, and service providers. Violence interrupters stop conflicts before they happen, and outreach workers re-direct the highest-risk youth away from life on the streets. Outreach workers implement a detailed risk reduction plan that links youth with needed services. These connections result in the cooling of violence hot spots, in addition to positive outcomes for those who participate in the intervention. CBO staff also mobilizes the community to reject violence as a social norm. The project also engages the public hospital system, and partners with two Health and Hospitals Corporation (HHC) hospitals to work with family and friends of victims, provide follow-up services to patient participants, and support community mobilization activities.
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Implementation Timeline	Services started in spring 2012.
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Target Population	The program works with young people aged 15-24 years as well as with community organizations and the public in three high violence neighborhoods in New York City: Central Harlem, Crown Heights, and East New York.
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Expected Outcomes	<p>CeaseFire will:</p> <ul style="list-style-type: none"> • Decrease the number of shootings/homicides; • Change violent behavior and attitudes about violence among high-risk youth • Increase referrals of high-risk youth to education, employment and/or other social and health services; • Increase the number of community members who reject violence
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ⁱ Skogan WG, Hartnett SM, Bump N, Dubois J. *Evaluation of CeaseFire-Chicago*. Chicago, IL: Northwestern University; May 7, 2008. Available at: http://www.ipr.northwestern.edu/publications/ceasefire_papers/mainreport.pdf

ⁱⁱ Webster DW, Whitehill JM, Vernick JS, Curriero FC. Effects of Baltimore’s Safe Streets Program on gun violence: a replication of Chicago’s CeaseFire program. *Journal of Urban Health*, in press. **and** Webster DW, Whitehill JM, Vernick JS, Parker EM, (2012) *Evaluation of Baltimore’s Safe Streets Programs: Effects on Attitudes, Participants’ Experiences and Gun Violence*. Johns Hopkins Center for the Prevention of Youth Violence. Johns Hopkins Bloomberg School of Public Health, Baltimore, MD.

Quick Stats

Agency	Start Date	Number Served Annually	Annual Budget
Health and Hospitals Corporation	Spring 2012	<i>See Outcomes</i>	\$500,000

Problem Statement	Unintended teen pregnancy and sexually transmitted infection rates are remain unacceptably high in NYC, and racial and socioeconomic disparities persist. HHC serves over 850,000 patients aged 11-24 per year, and is therefore in a unique position to improve health outcomes among young people from the communities most in need.
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Research and Evidence	In 2009, 87% of pregnancies to 15-19 year olds were unintended, and teens in high-poverty neighborhoods were 3 times more likely to become pregnant than their peers in low-poverty neighborhoods. Black and Hispanic teens, who are more likely to live in high-poverty neighborhoods, had pregnancy rates five times that of their white peers. ¹ Young Latino men in NYC, aged 16-24, are 2.5 times more likely to have a child than young White men, and nearly twice as likely as their Black peers. ² The chlamydia case rate among Black males aged 15-19 is 57 times that of their White peers ³ , and there were more new HIV cases among Black male youth than among Latino, White, and Asian male youth combined. ⁴ Adolescents obtain health care less often than either younger or older people, and young men are less likely than young women to receive sexual health care services. ⁵ Primary care providers often miss opportunities to identify and address the sexual health care needs of young people, especially young men. ⁶⁻⁹
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Program Description	<p>There are three components of this program:</p> <ol style="list-style-type: none"> 1. Training for HHC staff serving adolescents and young adults on clinical guidelines and skills, customer service for teens and young adults, and special issues in adolescent care. 2. Systems improvements to make HHC facilities more welcoming, appealing, and user-friendly for young patients, to be determined by a needs assessment. 3. Youth engagement programming, which involves young people in improving HHC's service quality and accessibility. This will benefit HHC as well as the young people involved, who will gain valuable job and life skills.
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Implementation Timeline	<ul style="list-style-type: none"> • Summer 2012 – Completed HHC needs assessment, determined youth engagement programming model, formed HHC-wide network of adolescent care professionals and Advisory Panel • Fall 2012 – Training for providers, systems improvements, and community outreach including youth engagement begin in full
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Target Population	Staff training will target pediatrics, and adolescent care staff. Youth engagement will target adolescents, especially males, from the NYC communities with the highest unintended pregnancy and STI rates.
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Expected Outcomes	<ul style="list-style-type: none"> • Increase staff implementation and adherence to best practices in adolescent care • Increase utilization of HHC services for adolescents/young adults • Increase satisfaction with HHC services among adolescent/young adult patients • Increase positive health outcomes among adolescent/young adult patients
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1. Teen Pregnancy in New York City: 2000-2009. New York, NY: New York City Department of Health and Mental Hygiene. <http://www.nyc.gov/html/doh/downloads/pdf/ms/ms-nycpt-2000-09.pdf>

2. Young Men's Initiative: Report to the Mayor from the Chairs. Aug. 2001. http://www.nyc.gov/html/om/pdf/2011/young_mens_initiative_report.pdf
3. 2009 data from New York City Department of Health and Mental Hygiene. Accessed through EpiQuery: <https://a816-healthpsi.nyc.gov/EpiQuery/STD/index.html>
4. New York City HIV/AIDS Annual Surveillance Statistics 2010. New York City Department of Health and Mental Hygiene. Accessed at: <http://www.nyc.gov/html/doh/downloads/pdf/ah/surveillance2010-tables-all.pdf>
5. Marcell AV, Klein JD, Fischer I, Allan MJ, Kokotailo PK. Male adolescent use of health care services: where are the boys? *J Adolesc Health*. Jan. 2002; 30 (1): 35–43.
6. Marcell AV, Bell DL, Lindberg LD, Takruri A. Prevalence of STI/HIV counseling services received by teen males, 1995 to 2002. *J Adolesc Health*. 2010;46(6):553–559.
7. Ma J, Wang Y, Stafford RS. U.S. adolescents receive suboptimal preventive counseling during ambulatory care. *J Adolesc Health*. 2005;36(5):441.
8. Lafferty WE, Downey L, Holan CM, et al. Provision of sexual health services to adolescent enrollees in Medicaid managed care. *Am J Public Health*. 2002;92(11):1779–1783.
9. Lafferty WE, Downey L, Shields AW, Holan CM, Lind A. Adolescent enrollees in Medicaid managed care: the provision of well care and sexual health assessment. *J Adolesc Health*. 2001;28(6):497–508

Quick Stats

Agency	Start Date	Number Served Annually	Annual Budget
City University of New York	February 2012	40	\$340,000

Problem Statement	<p>Across our nation, more than 24 million children are growing up in homes without a father. In New York City, approximately 33 percent of children under the age of 18 are growing up in fatherless households. This crisis disproportionately impacts New York City's black and Latino children. Fifty-one percent of black and 46 percent of Latino children in New York City under the age of 18 are being raised in fatherless households, compared to 11 percent of white children.¹</p> <p>Currently, throughout the country there exist few, if any, efforts to connect fathers to educational and employment opportunities on a college campuses.</p>
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Research and Evidence	<p>Historically, women have headed the majority of single parent households. As a result, the social service safety net and programs meant to strengthen families have disproportionately focused resources on mothers. Fathers play a critical role, however, and the research has demonstrated that fathers' involvement in the lives of their children promotes positive life outcomes not only for themselves but for their children and families. A primary reason non-custodial fathers do not engage in the lives of their children is their inability to contribute financial support to their children. When fathers are unemployed or underemployed they are less likely to engage with their children due to their inability to contribute financially.</p> <p>Furthermore, when men are offered opportunities to pursue the educational opportunities that would facilitate economic stability they are less likely to take advantage of or remain in those programs because they are not connected to employment. These factors speak to the need for an intervention that connects education, employment and fatherhood services.</p>
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Program Description	<ul style="list-style-type: none"> • The CUNY Fatherhood Academy at LaGuardia Community College will strengthen fathers and families and promote responsible fatherhood and economic stability by connecting 40 young fathers to services on a college campus. Specifically, participating fathers will: • Participate in pre-employment workshops to improve their soft skills and qualify for part-time entry-level or better employment; • Develop a plan to help them achieve the education and/or training they need to achieve their long-term employment and career goals; • Have opportunities to improve computer and academic literacy with the goal of advancing least one step along the academic continuum ; • Prepare to sit for the GED exam or to apply to college; • Develop personally through a series of group activities that will address men's health, self-motivation, conflict resolution, and financial literacy; • Initiate or increase engagement with their children.
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Implementation Timeline	<p>February, 2012: Program launched with first cohort</p> <p>Feb, 2012-June, 2014: Program Activities: education classes, college preparation, mentoring, employment readiness, job and internship placement, fatherhood workshops, family engagement activities</p>
Target Population	<p>Young fathers ages 18-24</p>
Expected Outcomes	<ul style="list-style-type: none"> • 80% of fathers will complete an Individual Development Plan that will help guide the delivery of hard and soft skill acquisition as well as development of realistic short and long term goals for advancement. • 35% fathers will obtain unsubsidized employment for at least 20 hours per week. 25% fathers will obtain subsidized employment or participate in an unpaid work experience for at least 15 hours per week. • 15% fathers will achieve an educational milestone (improve 1 level on the TABE or earn a GED). • 25% fathers will also be matched with volunteer mentors identified through CUNY's existing programs. Peer mentoring will also be encouraged and supported. • 45% fathers will complete at least 75% of the parenting modules. The parenting modules will include information about child development from infancy through young adulthood and appropriate relationship-building strategies for each stage. • 40% fathers will report that they have initiated or increased engagement with their children as evidenced by self-reporting surveys.

ⁱ US Census Bureau 2011

Quick Stats

Agency	Program/Policy Start Date	Number Served Annually	Annual Budget
Department Health and Mental Hygiene	November 2011	TBD	N/A

Problem Statement	Major barriers to teens' ability to access and utilize sexual and reproductive health services (SRH), include documentation barriers (such as missing social security numbers) and breaches in confidentiality such as when Explanation of Benefits (EOBs) are sent home
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Research and Evidence	<p>Preliminary data suggest that approximately 900,000 of NYC's population ages 10-24 are eligible but are not enrolled in the Family Planning Benefit Program (FPBP). FPBP can provide free and confidential services but documentation barriers make it difficult to enroll teens in FPBP.</p> <p>In addition, confidentiality concerns are a key reason for forgone care among teens. Ensuring confidentiality by suppressing EOBs being sent to the teens' home address will eliminate this concern for teens with private insurance or Child Health Plus B (CHPB).</p> <p>Policy changes that address these two barriers will increase teens' access to sexual and reproductive health services. This will result in teens making healthier decisions, including increased use of contraception and condoms by sexually active teens.</p>
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Program Description	<p>FPBP is a Medicaid program that can increase teens' access to SRH care and clinic revenues to help support teen-friendly practices. DOHMH is anticipating approval of the State Plan Amendment (SPA) by Centers for Medicare and Medicaid (CMS) for FPBP which will allow for presumptive eligibility. In addition, the establishment of data linkage between HRA and State DOHMH will remove the social security documentation barrier which poses obstacles for teen enrollment.</p> <p>Explanations of Benefits (EOBs) sent by insurers can compromise the confidentiality of teens' sexual and reproductive health care. DOHMH will draft language and advocate for a change in New York State statute to suppress EOBs being sent to teens homes.</p>
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Implementation Timeline	<ul style="list-style-type: none"> Fall 2012 – Anticipate CMS approval of NYSDOH's SPA to allow for presumptive eligibility for FPBP
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Target Population	NYC population ages 10 - 24
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Expected Outcomes	Completion of HRA demonstration of data linkage to obtain SSN documentation on FPBP application and increased enrollment in FPBP
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Quick Stats

Agency	Program/Policy Start Date	Number Served Annually	Annual Budget
ACS/DYFJ CUNY DFTA DHS DOC DOE/LYFE DOHMH DOP DYCD HHC HRA NYCHA NYC Parks NYPD-Comm. Affairs	Varies by agency	City-wide program	Apart from HRA, DYCD and DOE/LYFE city agencies do not assign a specific cost to fatherhood programs in their agency budget.

Problem Statement	Across our nation, more than 24 million children are growing up in homes without a father. In New York City, approximately 33 percent of children under the age of 18 are growing up in fatherless households. This crisis disproportionately impacts New York City's black and Latino children. Fifty-one percent of black and 46 percent of Latino children in New York City under the age of 18 are being raised in fatherless households, compared to 11 percent of white children
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Research and Evidence	<p>Children in father-absent homes are five times more likely to be poor. In 2002, 7.8 percent of children in married-couple families were living in poverty, compared to 38.4 percent of children in female-householder families.ⁱ</p> <p>Even after controlling for income, youths in father-absent households still had significantly higher odds of incarceration than those in mother-father families. Youths who never had a father in the household experienced the highest odds.ⁱⁱ</p> <p>Father involvement in schools is associated with the higher likelihood of a student getting mostly A's. This was true for fathers in biological parent families, for stepfathers, and for fathers heading single-parent families.ⁱⁱⁱ</p>
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Program Description	As Father's Day 2010 approached, the Mayor asked City agencies to conduct an extensive review of their programs, policies and frontline practices to ensure that fathers were not being unintentionally excluded from or missing opportunities to engage in their children's lives. In addition, agencies began to explore how, in a time of budget constraints, they could leverage existing resources to provide fathers more access to City services and to help children develop to their full potential.
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Implementation Timeline	<ul style="list-style-type: none"> • YMI <ul style="list-style-type: none"> ○ February 2012 Launch CUNY Fatherhood Academy ○ March 2012 NYC Mentoring Summit • January 2012: DHS Fatherhood Initiative at 10 shelter sites • June 2012: In partnership with HRA, begin to develop and implement
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Expected Outcomes	<p>voluntary child support agreement program with faith or community based organizations</p> <ul style="list-style-type: none"> • June 2012: Improve access to resources through the enhancement of the NYC Dads website • June 2012: NYC Dads Matter Awards • November 2012: Track Initiative Progress <ul style="list-style-type: none"> • Measure the Year 2 progress of the Fatherhood Working Group • Submit a Year 2 Progress Report to the Mayor and City
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Target Population	Fathers throughout the city especially low-income dads of color.
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Expected Outcomes	<ul style="list-style-type: none"> • Uncover and remove any barriers that fathers may face in interacting with City agencies to make them as “father friendly” as possible • Support fathers as they increase their capacity to be good dads • Assist in the creation of memorable moments between fathers and their children
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ⁱ Source: U.S. Census Bureau, Children’s Living Arrangements and Characteristics: March 2002, P200-547, Table C8. Washington D.C.: GPO, 2003.

ⁱⁱ Source: Harper, Cynthia C. and Sara S. McLanahan. “Father Absence and Youth Incarceration.” Journal of Research on Adolescence 14 (September 2004): 369-397.

ⁱⁱⁱ Source: Nord, Christine Winquist, and Jerry West. Fathers’ and Mothers’ Involvement in Their Children’s Schools by Family Type and Resident Status. (NCES 2001-032). Washington, D.C.: U.S. Department of Education, National Center for Education Statistics, 2001.



Quick Stats

Agency	Program/Policy Start Date	Number Served Annually	Annual Budget
Department of Education	Spring 2012	All middle and high schools	N/A

Problem Statement	New York City is experiencing persistently high rates of risky sexual activity among middle and high school students, and has recently observed an increase in STDs among middle and high school students.
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Research and Evidence	NYC DOHMH STD surveillance data and the Centers for Disease Control and Prevention Youth Risk Behavior Survey (YRBS) capture information about sexual activity among high school students. The most recent YRBS (2009) showed that 21% of sexually active students began having sex before age 13; 57% of DOE high school seniors have had intercourse with at least one person; 15% of sexually active students have had intercourse with four (4) or more partners; and 29% of sexually active students did not use a condom the last time they had sex. Research has shown that students who participate in risk-reduction sex education may be less likely to engage in risk behaviors that can cause pregnancy or transmit HIV/STD.
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Program Description	<p>BACKGROUND: In 2007, the NYC DOE selected recommended health education curricula for middle and high school that included age-appropriate sexual health education. Since 2007, the Office of School Wellness Programs (OSWP) has provided free health education training on the recommended curricula and additional support for teachers and administrators citywide. Over 800 teachers have been trained to date (2008-2011).</p> <p>In addition to health education, reproductive health initiatives in schools seek to provide students with timely and free services with the goal of helping to reduce pregnancy and prevent HIV/STD. The Condom Availability Program in high schools provides free condoms and information to students. School Based Health Centers, now in 42 of 200 high school campuses, provide comprehensive reproductive health services to students. The Office of School Health piloted an onsite reproductive health program called CATCH (Connecting Adolescents to Comprehensive Healthcare) in 2011. CATCH services include emergency contraceptive, oral contraceptive, pregnancy testing, and referrals for healthcare and mental health counseling.</p> <p>SEX ED MANDATE: As part of the YMI initiative, sexual health education is now required in middle and high school as part of the NYSED-required comprehensive health education course. OSWP is ramping up comprehensive health education teacher trainings and using its @ Your Network and @ Your School assistance programs to enhance the capacity of schools to meet the sexual health education mandate. OSWP and OSH staff are collaborating to help schools make the connections between health education and health services in order to help students receive the education, support, and access to care to that can help them make healthy choices and stay safe.</p>
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Implementation Timeline	<ul style="list-style-type: none"> • June 2011 – June 2012 – Trainings on health curriculum offered • January 2012 – Mandate begins • May 2012 – School Health Survey (SHS) sent to public schools • Fall 2012 – Review data from SHS and plan for 2nd year
Target Population	All middle and high school students in NYC public school system
Expected Outcomes	Support schools in providing sexual health education as part of comprehensive health education for middle and high school students. Increase the number of teachers trained to deliver effective comprehensive health education including sexual health education.