

Adult Services

Lawmakers, state and local governments, and the public continue to struggle daily with the realities of rising health care costs in the face of diminishing public and private funds. We continue in challenging fiscal times, where mental health care needs increase and mental health care plays a pivotal role in overall health care costs. A study last year confirms that medical spending for various health conditions in the United States (U.S.) is highest for mental health conditions, outpacing expenditures for cardiac conditions.¹ Rates of mental health problems are higher among people with other health problems, but “comorbid” mental health problems are usually undetected and untreated, increasing hospital admissions and lengths of stay for the other illness.

Recessionary times predict increased mental health problems.² Mental health problems related to economic stresses have effects across the lifespan, for example, among youth who show higher use of public mental health services during times following mass layoffs.³ Moreover, economic contraction is associated strongly with depression and substance abuse, moderately associated with antisocial behavior, and a causal risk factor for suicide.⁴ Such evidence reinforces the need to protect mental health services during down-turns and to better detect and treat mental health problems in the larger health care picture. Mental health is not an add-on; it is essential to overall health.

Considering the economy

Challenges for the National and State Economies

In a speech this August to a Conference meeting of the Council of State Governments, Federal Reserve Chair Bernanke acknowledged the deep recession our nation has endured on the heels of the most severe financial crisis since the Great Depression. Noting that the economy appears to have stabilized, he cautioned that we have a considerable way to go before achieving recovery. Many Americans are still grappling with being out of work, home foreclosures, and lost savings. In addition, state governments continue to cope with very challenging economic and financial conditions that have developed as a result of the recession.⁵ State government revenues usually improve slower than the overall economy, predicting challenges ahead for New York State (NYS) mental health system.

Drops in revenues and rising Medicaid spending have squeezed state budgets. Forty-six states have faced budget shortfalls this year and 39 have already indicated substantial shortfalls for the coming fiscal year.⁶ In some states, taxes have been raised, and in others legislators have had difficulty in finding new revenue sources to close budget gaps. Assis-

The recession — as all of you know too well — has also battered the budgets of state and local governments, primarily because tax revenues have declined sharply. Many states and localities continue to face difficulties in maintaining essential services and have significantly cut their programs and work forces. These cuts have imposed hardships in local jurisdictions around the country and are also part of the reason for the sluggishness of the national recovery.

Ben S. Bernanke, August 2, 2010

tance from the federal stimulus package has softened but not eliminated budget difficulties. If stimulus funding is not extended, the depth and length of the recession plus rising costs and slow revenue recovery will pose dramatic challenges for NYS and many other states over the next two years. The Center on Budget and Policy Priorities projects that the budget shortfall in NYS for Fiscal Year 2012 will be \$14.6 billion.⁷ (The budget shortfall of \$9.2 billion for State Fiscal Year 2010-2011 was closed in August with passage of the final State budget.⁸)

Mental Health Budgets

Even with federal stimulus funding, states take actions that have consequences for their most vulnerable citizens. A National Association of State Mental Health Program Directors study in late 2008 found that 32 states reported budget cuts. The most common cuts occurred with adult state inpatient, clinic, day treatment, and targeted case management services and children's state inpatient, clinic and targeted case management. Other cuts included services for the uninsured, peer support and school consultation.

New York State Office of Mental Health (OMH) 2010-2011 Enacted Budget

In June, the OMH 2010-2011 Budget was enacted with the passage of health and mental hygiene appropriation bills. Since passage of the final State Budget on August 3, the health and mental hygiene bills are now considered complete. The contingency plan to raise more than \$1 billion through across-the-board cuts to State programs was also passed as part of the final State Budget.

OMH has continued on its course of deferring new commitments wherever possible, and continuing with the restructuring of services to produce better outcomes and value at lower relative costs. This course has built on several years of attention to spending controls, and has included shifting payment for long-standing mental health services away from State general funds to other sources, primarily Medicaid.

As outlined in last year's Plan, budget reductions taken during 2008 focused on cost savings via transforming care (e.g., from costly inpatient programs to less costly residential care), and reductions to services of lower priority while preserving core services. Additional budget actions during 2009 continued this trend. New programs that had been authorized but were not yet operational were postponed. OMH also redirected a small amount of funding to facilitate employment and peer support among adults engaged in mental health services and to implement recommendations of The Children's Plan, which is covered in Chapter 4.

As described in the OMH Budget Recommendations for 2010-2011 (<http://www.omh.state.ny.us/omhweb/budget>

/2010/state_ops.pdf), among the State Operations actions taken by OMH was the conversion of some inpatient capacity into Transitional Placement Programs that foster community reintegration for people who have had long inpatient stays. OMH State Operations spending was increased by \$1 million from the Executive Recommendation because of the Legislature's rejection of video-conferencing for certain sex offender management hearings.

Aid to Localities actions were aimed primarily at reorienting programs toward recovery and resiliency (see http://www.omh.state.ny.us/omhweb/budget/2010/aid_to_localities.pdf). The Budget reduced the rate of growth in spending by promoting efficiencies in certain high-cost services and by deferring new spending commitments until they are affordable. Clinic restructuring efforts were supported to expand outpatient clinic access and rationalize reimbursement for consistency with federal requirements; increase peer support; and advance a multiyear remedial plan in response to a federal court ruling for people with mental illness in adult homes.

With passage of the final Budget, the Aid to Localities budget is \$5 million less than proposed in the Executive Recommendations. The reduction will result in delays in conversions to the new Personalized Recovery-Oriented Services Program (PROS), and delays in the development of new residential beds.

The Impact of Health Care Reforms

Two important national milestones promise fundamental changes in health care for persons with serious mental illness: the Mental Health Parity and Addiction Equity Act, known as "mental health parity," and the Patient Protection and Affordable Care Act or "health reform."

Mental health parity

In NYS, Timothy's Law, which took effect in 2007 and was made permanent in June 2009, requires health insurers to offer mental health coverage on par with other medical benefits. Specifically, the legislation requires insurers issuing group/school health insurance policies or contracts in New York to provide minimum inpatient days and outpatient visits for the treatment of mental health conditions. Timothy's Law also requires health insurance policies with more than 50 employees or members to provide coverage for adults and children diagnosed with biologically based mental illnesses and children diagnosed with serious emotional disturbances at the same level of coverage as is provided for other health conditions.

Timothy's Law covers consumers in health plans regulated by NYS; the federal mental health parity law extended similar protection to consumers in other health plans. Parity

regulations affect plans beginning on or after July 1, 2010.⁹ Enacted in October 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, while not mandating that employers provide mental health coverage, requires employers who have more than 50 employees and who offer health insurance to provide mental health benefits in full parity with other medical benefits covered under the policy. Regulations to implement the federal parity law require insurance companies providing mental health benefits to have them managed as other medical benefits, with similar co-payments, deductibles, treatment limits, lifetime and annual limits, and out-of-network benefits.

Even with parity, access to mental health care remains problematic, and most people with mental health problems still get no care. Barriers include recognizing there is a problem, overcoming the stigma of seeking care, getting the problem diagnosed (especially in general medical settings, where most people turn for help) and getting enough of a relevant treatment(s).

Health reform

Signed into law on March 23, 2010, the Patient Protection and Affordable Care Act law puts into place comprehensive health insurance reforms that expand coverage, and offer many attempts to “bend the curve” of health care costs.

For many people with mental illness and serious mental health challenges, insufficient insurance coverage has served as a barrier to getting necessary and effective treatment. Expanded coverage plus parity offer great hope. As noted by the Bazelon Center for Mental Health Law, effective treatment and support will be aided by a number of provisions under the law, which:

- ◆ Set minimum standards for health insurance policies that

businesses and individuals can purchase through state-level exchanges

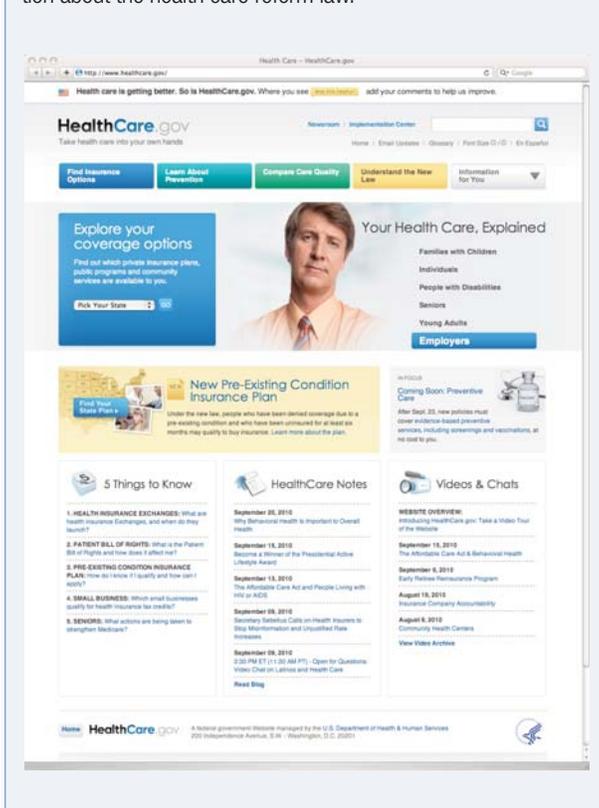
- ◆ Increase the number of people who can qualify for the mental health services under Medicaid (most of these individuals are already covered in New York, which greatly expanded Medicaid eligibility in recent years prior to federal reform)
- ◆ Promote better coordination of primary care and mental health services for people using the public mental health system
- ◆ Encourage “medical homes”¹⁰ that address a person’s total health care needs, including mental health and substance abuse needs
- ◆ Create several new options for long-term care for people with disabilities
- ◆ Authorize demonstration programs that test approaches aimed at improving the quality of health care

Other requirements of the law will help people with mental health needs, including prevention, an improved Medicare drug benefit, a new insurance plan for long-term community care, and reauthorization of the children’s state health insurance program.

Read more about health care reform for people with serious mental illness at <http://www.bazelon.org/LinkClick.aspx?fileticket=HJ7Q6AM8AHM%3d&tabid=218>.

So, what’s the buzz on health care reform . . .

Under provisions of the Patient Protection and Affordable Care Act, the Department of Health and Human Services launched a new online resource center on July 1, 2010. HealthCare.gov is helping Americans take control of their health care by connecting them to vital information and resources. The site offers tools that are easy to use and understand. It aids people in examining different insurance options, comparing the quality of care in local hospitals, learning about prevention and preventive measures to be covered under health reform, and it provides information about the health care reform law.



Staying the Course in Tough Economic Times

Despite very challenging economic times, OMH remains grounded by our core mission and focuses on reform efforts to create a more responsive, accountable, and recov-

ery-focused system of care. The reforms—which address the mental health needs of New Yorkers from their early years into late adulthood—are aimed at strengthening essential programs and ensuring quality of care and quality of life for individuals with the most serious mental health conditions. They support a public health approach to preventing illness,

A rising tide floats all boats: The story of Onondaga County's Clinic Access Project

Matt Roosa, Director of Planning and Quality Improvement, Onondaga Department of Mental Health

Like many other counties, Onondaga County has struggled to improve access to mental health clinics. Providers have worked hard to expand services in the face of difficulties recruiting required practitioners, preparing for clinic reform, and dealing with financial implications of the current economic climate. While expansion remains a goal, the County Department of Mental Health has focused on the best, most immediate ways to improve access by improving the efficiency of services.

Fortunately for the Department, some good work taking place in other parts of the service system has served as the basis for positive change. The approach taken by the Department builds on the Network for the Improvement of Addiction Treatment (NIATx) method to process improvement undertaken by Central New York Services with the support of the Robert Wood Johnson Foundation. The NIATx model is one targeted at behavioral health care settings that desire improved access and retention in treatment. The provider's experience, coupled with similar quality improvement efforts by other providers, and participation by the Department, led to the rapid-cycle Plan-Do-Study-Act (PDSA) approach taking root in the community. In the fall of 2006, the County used the NIATx model to create a local learning collaborative, which successfully implemented evidence-based practices among chemical dependency providers. This led the way to the Clinic Access Project for mental health providers in 2009.

The Clinic Access Process Project involved six mental health clinics and included providers that were public and private, adult and child serving, and of small-to-large staffing sizes. With a diversity of clinics participating, it was decided not to select a particular evidence-based process improvement model. Rather, in the spirit of maintaining the collaborative approach, providers were encouraged to choose from a wide range of process improvement changes that would enhance access and could be implemented with the rapid-cycle PDSA model.

Clinics received training on the NIATx model and participated in site visits with the consultant retained by the Department to coach the project. Efforts were made to orient the project with a person-centered, recovery-oriented, and family-driven vision. Clinic Change Leaders developed internal Change Teams that began

meeting regularly, and also began meeting monthly with representatives from the Department, the OMH Field Office, and the consultant who provided coaching via phone. Successful change projects included clinics' increasing the percentage of treatment sessions through the use of appointment reminder calls, increasing the number of treatment sessions through the use of a centralized intake process, and reducing the number of unscheduled requests for medication through adapted procedures and new educational approaches.

These and other changes resulted from use of the rapid-cycle model, whereby data were gathered and onsite change team was used to Plan the change, Do the change, Study the results, and then take Action on the results. Initially skeptical clinic staff, including some in leadership positions, became enthusiastic participants. They found that they were able to make changes with existing resources that helped them to serve more people, and serve them better, with the same or fewer resources. Among the valuable lessons learned by the participants were the following:

- ◆ Data fuels engagement: Using the NIATx model to discuss how to adjust changes based upon the results led to strong learning and community-wide teamwork.
- ◆ Quality over quantity: Implementing a local learning collaborative is like driving on ice: gain traction first, and then accelerate carefully.
- ◆ One size does not fit all: Diversity of implementation among collaborative members ensures ongoing relevance for all participants.
- ◆ Pay for participation: Providers are less likely to volunteer to participate if they feel that they will have to lose money (lost billings, etc.) to do so.
- ◆ Coaches – New voice and vision: Individualized coaching is a critical supplement to the community-wide collaborative meetings.
- ◆ A rising tide floats all boats: Local learning collaboratives, with transparent communication of challenges and struggles, help to move participants toward a community vision for enhancing service access.

If you would like more information about the project, you may contact Mr. Roosa at mathewroosa@ongov.net.

intervening early once detected, and promoting the mental well-being among New York's citizens.

The 2010–2011 Enacted Budget continues to reinforce the strategic direction OMH articulated in 2007 and with a set of clear priorities:

- ◆ Balance a change agenda with stability and attention to the challenges of change.
- ◆ Maintain the quality of care and the pace of reform in the face of State staffing constraints, community care resource limits, and heightened oversight and controls.
- ◆ Continuously collaborate and communicate internally and laterally.

We have sought to create a predictable resource environment to improve efficiency and responsiveness of both state and local programs, while encouraging local adaptation toward recovery- and resiliency-driven approaches to care.

Clinic and Ambulatory Restructuring for Adults

The 2006–2007 Enacted Budget directed OMH to review the current system of mental health services financing and reimbursement and to make recommendations for changes that would provide for the equitable reimbursement of providers of mental health services and be conducive to the provision of effective, high-quality services.^{11, 12}

OMH gathered a broad range of stakeholders representing local government, the provider community, and advocates. Six goals were identified: improving access to clinic and ambulatory services through funding reforms; improving quality through the provision of incentives for positive outcomes; refocusing oversight toward good clinical practice; providing technical assistance to improve clinical competencies; addressing the overutilization of inpatient care; and improving the coordination and integration of care.

Since October 2009, OMH has used these goals to develop an approach to “clinic restructuring” that seeks to sustain capacity, improve quality, and ensure that clinic services remain a foundation of community mental health care. The restructuring work continues in four key areas:

1. Redefined and more responsive set of clinic treatment services and greater accountability for outcomes

Clinic treatment—like primary care in the health system—is the foundation of the mental health system, which includes other services, such as case management, vocational support and inpatient care. The level of mental health services provided in clinics is similar to the level of care provided by physician practices or medical/health clinics in the health system.

Clinic restructuring aims to reimburse for a broader

array of mental health services such as outreach and engagement, crisis response, psychotherapy, complex care management, and medication management. Services will be reimbursed based on consumer need and include wellness screening and monitoring, and offsite psychiatric consultation. The redefined set of clinic treatment services will provide a clinically grounded set of services that are a dramatic improvement over the current “threshold visit” method. Reform will allow consumers to receive multiple needed services (e.g., a physician visit and a group counseling session) on the same day—a practice that was previously prohibited and tended to fragment care.

2. Phasing out the complex Comprehensive Outpatient Services (COPS) method and increasing consistent Medicaid clinic rates

The COPS supplemental rate strategy was developed about 20 years ago to provide Medicaid coverage as an alternative to general fund budget cuts. The method is complicated and has become unsustainable. COPS will be phased out and reimbursements will be based upon comparable payment for similar services delivered by similar providers. Called Ambulatory Patient Groups (better known as “APGs”), the new outpatient reimbursement method is like the one used for medical outpatient services. This approach to payment facilitates consistency across outpatient programs supported by Department of Health (DOH) and the mental hygiene agencies.

3. HIPAA-compliant, procedure-based payment system

The Health Insurance Portability and Accountability Act (HIPAA) sets national standards for electronic health care transactions and billing. Under reform, billing for clinic services will be compliant with HIPAA requirements and permit payment to reflect differences in costs for services, such as higher rates for those offered during night and weekend hours or in languages other than English.

4. Indigent care provisions

Providing access to mental health clinic services is essential for people who are not insured or are among the working poor. As part of restructuring, the State has requested a federal waiver to permit expansion of indigent care to include freestanding OMH-licensed mental health clinics.

Many efforts (e.g., educational forums, financial projection model, readiness tools) have been made to facilitate successful implementation of the new reimbursement and program elements.

Peers bringing a “Feet on the Street” approach to integrated care

Peer support and engagement specialists are taking to the streets of Queens and the Bronx, pounding the pavement to help enrollees of an innovative demonstration project that aims to improve health and well-being.

Just one of several chronic illness demonstration grants under way in NYS, the “Live Healthy Care Management Program,” is being managed by OptumHealth and carried out with a number of community partners (e.g., preventive care, community social services, psychiatric rehabilitation, homecare, medical care, cultural competence). All partners work together to integrate medical and behavioral care for people participating in Medicaid fee-for-service care who are eligible to take part in the managed care demonstration project.

Drawing upon their own personal experiences with care and familiarity with the community, peer wellness coaches bring a number of assets to the project. They have been trained formally in peer wellness coaching, have years of experience as peer bridgers (New York Association of Psychiatric Services [NYAPRS] model), believe deeply in the value of the work being done, know community strengths and resources, and possess engaging personalities.

Under the direction of the NYAPRS, peer wellness coaches are seeking out people eligible to participate in the project, explaining what it offers, encouraging enrollment, and helping to complete the necessary paper work. They work hard to form trusting relationships built on hope for positive change. They help enrollees look at their lifestyle factors and



consider changes they would like to make, plan to achieve their wellness goals, and bridge them to community resources that best meet their needs. Here's what success is looking like:

- ◆ A peer wellness coach met with Mr. A and his mother in their home, learning that his Medicaid had lapsed as well as medications. Immediately, the coach called the Human Resources Administration, the pharmacy, and Optum staff, and then turned attention to beginning to build that trusting relationship. The coach listened to Mr. A discuss how he achieved more than a year of sobriety, lived in an unsafe residence, and was challenged in managing diabetes. Through a give-and-take conversation of shared experience and mentoring, the peer wellness coach made a commitment to work with Mr. A so that he could meet the goals that were important to him.

- ◆ The results are remarkable: the peer wellness coach helped speed up Medicaid reinstatement, established a good rapport and trust, helped Mr. A create a personalized wellness plan with actions steps and ways to measure success, played to Mr. A's strengths, helped him to see his role in maintaining his own wellness, and attended 12-step meetings with him to help him connect to natural community supports. And, in addition to contact several times during the week, every Friday they would get together to discuss progress with the wellness plan. (Mr. A has also been supported to achieve more than 120 days of abstinence to alcohol and drugs.)

Would you like to learn more about this project and the role of peer bridgers? Email Tanya Stevens at tanyas@nyaprs.org.

OMH amended its regulations to implement the restructured clinic program, which is set to become operational October 1, 2010. Also, separate from the regulations, the State has adopted the requirement that Medicaid managed care companies pay comparable rates for mental health clinic services to those paid through fee-for-service. This is a crucial aspect of reform that may be unique to NYS, and is of great importance because of the growing significance of health plan arrangements.

OMH will be monitoring implementation in collaboration with a representative stakeholder group. Administrative data sets (e.g., Medicaid, consolidated fiscal reporting) will be used to evaluate changes to clinic services over the four-year implementation. Adjustments and course corrections will be made as indicated.

Increasing Collaboration between OMH and DOH

DOH and OMH have increased collaboration on multiple fronts beyond clinic restructuring. Another critical initiative is to address significant downsizing of inpatient mental health capacity, particularly in downstate New York. Addressing capital needs has been recognized as critical to quality inpatient and outpatient care. To respond to these issues, DOH, in collaboration with OMH and the Dormitory Authority of NYS, issued a request for grant applications in late July to address service needs arising from hospital closures, aging infrastructure and changes in treatment modalities.

The \$38.5 million in funding awarded September 22, 2010, under the Health Care Efficiency and Affordability Law for New Yorkers (HEAL-NY) acknowledges the significant changes in behavioral health care delivery over the years

brought on by new treatment approaches, a shift toward outpatient services, and the continued need for high-quality inpatient services. The grants will be used primarily for capital projects involving the consolidation, renovation, and expansion of treatment space. Projects will enable hospitals and clinics to address service needs arising from aging physical plants, hospital closures, and innovations in mental health treatment modalities that will provide services for clients in the community and prevent unnecessary hospitalizations.

OMH and DOH have also defined areas of activity to deal with other challenges. Acute inpatient care reimbursement under Medicaid is being updated to reduce inequities in reimbursement, and to provide incentives for accessible care. Recognizing the interdependence of mental health and general health problems, both agencies are also looking at patterns of expensive and repeat care, and considering ways to both improve and integrate care.

Other collaborative activities include:

- ◆ Medicaid managed care coordination—In consultation with OMH and the Office of Alcoholism and Substance Abuse Services (OASAS), DOH has several chronic illness demonstration projects statewide for integrating care for persons with complex physical, mental health and substance abuse needs. The main goal of these demonstrations is to establish innovative, interdisciplinary models to improve the quality of care, ensure appropriate use of services, enhance clinical outcomes, and ultimately reduce the cost of care.

- ◆ Psychiatric Clinical Knowledge Enhancement System (PSYCKES)—This online system—a finalist in a national competition for most innovative state information technology solutions—helps clinicians to improve clinical decision making and the quality of care. It provides them with Medicaid data on their consumers’ service use, with guidelines to manage psychiatric prescription treatments and monitor health risks closely. Clinicians also receive expert guidance in reducing the use of more medication than is clinically indicated and in lowering the risk for the development of medication side effects such as diabetes and obesity. PSYCKES use has led to significant reductions in antipsychotic medication “polypharmacy” in OMH Psychiatric Center

hospitals. The system, now in place (August 2010) in 334 free-standing mental health clinics statewide, is being enhanced through educational resources for mental health consumers as well as a continuous quality improvement project statewide aimed at strengthening clinician prescribing practices. The consumer version of PSYCKES, called MyPSYCKES, is being pilot tested and is expected to be introduced into clinics over the next year, providing an innovative way to make care more person-centered. OMH is also piloting and expanding the clinician version of PSYCKES for assertive community treatment, emergency rooms, and hospital clinics.

- ◆ Care Monitoring Initiative—Following participation by OMH in the joint NYS and City Mental Health/Criminal Justice Review Panel to review incidents of violence and criminal justice problems for people recovering from mental illness, the Panel issued a set of recommendations in 2008 (see http://www.omh.state.ny.us/omhweb/justice_panel_report/) to improve care for individuals with high need and to promote community safety. One of the Panel’s key recommendations was the development of a database to track and follow up on problematic care—for example, gaps in care, frequent emergency room visits—for people with substantial mental health histories who should be receiving care. The first Care Monitoring Team started in Brooklyn in October 2009 and a second team will begin in the fall 2010 in the Bronx.

Using Medicaid claims data, clinically trained care monitors review monthly notification reports and establish contact with providers who last served the identified individuals. The care monitors discuss procedures used by providers to reach and retain individuals in services and rely upon the OMH Mental Health Clinic Standards of Care for Adults (see http://www.omh.state.ny.us/omhweb/clinic_restructuring/appendix1.html) to guide the providers in formulating appropriate outreach and engagement strategies. They also follow up to ensure re-engagement into appropriate care.



Read more at <http://www.psyckes.com/PSCContent/QI-CardioSheet.pdf>

Aligning Financing with Quality Care

Expanding housing

Experience tells us that individuals with serious mental illness are among the largest sub-population and the “worst-housed” group of persons and households identified by the U.S. Department of Housing and Urban Development as “worst case needs.”¹³ The dynamics include living in extreme poverty (where often the total income comes from Social Security Income ([SSI] food stamps), having an “invisible disability,” and dealing with an increasingly dwindling supply of housing affordable to the very poor.

Additionally, because of stigma, extreme poverty and disability, people with mental illness fair poorly in mainstream low-income housing arrangements, and efforts to generally improve or strengthen these housing programs for people with disabilities (e.g., the development of local consolidated plans, access to elderly housing) have often worsened access to people with serious mental illness. The lack of adequate and safe housing creates a serious barrier to a decent life for anyone and particularly for persons living with psychiatric disabilities.

OMH has done an extraordinary job of developing housing at the same time it has moved from specialized units to supported housing. The State stands out as a leader with community mental health models of housing such as “Housing First,” which recognizes the importance of safe housing for homeless persons in need of mental health treatment, or the New York/New York (NY/NY) housing agreements between the State and City.

To date, more than 6,100 individuals with documented histories of street and/or sheltered homelessness, in addition to serious mental illness, have moved into new, safe and affordable housing developed under the NY/NY housing agreements. Additional units are in development and will open over the next five years. Under these agreements, the

NYS and New York City (NYC) share capital development costs, with the State paying for operating and services costs for all units targeted to people with mental illness who are homeless.

Across all categories more than 34,000 units of housing are in place across New York. Nonetheless, the scope of the housing affordability problem, the limited federal response and State budget limits means that housing for New Yorkers with serious mental illness is the epicenter of the nation’s housing crisis. Federal and State support for people with disabilities provides them with incomes far too low to obtain decent market-rate housing. On average, a person in NYC with a disability who receives SSI would have to allot 163% of his or her monthly income for a modest one-bedroom unit.^{14,15} In most of the State, the cost of rental far exceeds consumers’ total income. The problem has been exacerbated also by the recession and mortgage crisis, slowing development and forcing former homeowners into an already tight rental housing market.¹⁶ In addition, people with mental health conditions face discrimination and stigma in finding housing. Because of a lack of adequate housing,

OMH is striving to increase housing options for persons with psychiatric disabilities.

OMH continues to work closely with the State Division of Housing and Community Renewal, the Office of Temporary and Disability Assistance, and the Housing Finance Agency in developing mixed-use/integrated housing. In May, for example, a supportive project was announced for 65 studio apartments in NYC for persons with serious mental illness and who have histories of chronic homelessness and another for 55 efficiency apartments for persons with co-occurring serious mental illness and chemical dependency conditions. Such progress continues to be challenging in an environment of fiscal stress and budget cuts and where it is complex to sustain the financing, operation, and maintenance with a mix of federal, State, local and private funding streams.

"Some people think when you give housing away that you're actually enabling people as opposed to helping them get better. Our experience has been that the offer of housing first, and then treatment, actually has more effective results in reducing addiction and mental health symptoms, than trying to do it the other way. The other way works for some people, but it hasn't worked for the people who are chronically homeless."



Sam Tsemberis, PhD
Founder & CEO, Pathways to Housing

To learn more about Pathways to Housing work in NYC and other sites around the country, go to <http://www.pathwaystohousing.org>



The State Most Integrated Setting Coordinating Council is supporting the “Find Your Way Home” website to help increase awareness of the need for affordable housing opportunities and link individuals to them. Visit the site at <http://www.nyhousingsearch.gov/>.

Increasing the efficiency of and access to inpatient and outpatient care

OMH adult Psychiatric Centers have been working to improve accessibility to hospital care while reducing less valuable long-stay care for people needing structured community supports. Over a number of years, the State facilities serving adults assumed a backup, long-term care role. Like some other states, New York was meeting the need for acute care through general hospital units.¹⁷ With a stressed economic climate, general hospital units are continuing to close. This situation continues to make accessible care even more challenging.

In 2009 OMH focused on a series of actions to improve the efficiency and productivity within its hospitals and to increase access to acute care. During calendar year 2009, adult hospitals admitted 4,044 individuals into about 3,600 beds, representing 425 more admissions than in 2008, an increase of 10.1% in admissions but a 27% increase in admissions per inpatient bed. The gain occurred with fewer beds, substantial reductions in overtime among staff and no significant change in readmission rates, reflecting increased productivity and efficiency in hospital operations. Between January and June 2010, the trend is continuing, with admissions up 6% but the number of beds down 5.5% compared to the same period during 2009.

OMH—through its Center for Practice Innovations—hosted a daylong working session in June to better understand the housing crisis in the State for people with serious mental illness and develop a set of recommendations to guide future directions. The recommendations will aim to expand housing policies and programs to increase access to housing; step up efforts to promote education and eliminate barriers to housing due to stigma and discrimination; find viable housing solutions; and strengthen research and evaluation to demonstrate the effectiveness of housing (e.g., quality of life, employment, reduced institutional costs) for well-being and recovery.



Local, state, and national policy officials, as well as experts on community housing, development, and homelessness discuss strategies to address the growing problem of insufficient affordable housing for people with psychiatric disabilities during August 2010 Symposium.

These gains in access have also occurred in part by reducing very long-term hospitalization (lasting over a year), which is extremely expensive and often counterproductive. People hospitalized for long periods can become dependent on institutional life. OMH is addressing this challenge in part via its new residential approach called the Transitional Placement Program. This program aids the transition to community living for persons who have received maximum benefit from inpatient treatment, but need help with the skills of community living. By the end of the 2009–2010 fiscal year, OMH converted 325 hospital unit beds to Transitional Placement Program units; the 2010–2011 Enacted Budget calls for the addition of more transitional capacity.

Transformation planning collaborations between State Psychiatric Centers, OMH Field Offices, and local governments have enhanced these efforts. The partnerships aim to ensure that OMH hospital outpatient services are delivering maximum value and are in harmony with services offered by nonprofit organizations and general hospitals. These approaches “reengineer” the mental health basics of hospital and clinic care.

Promoting recovery and success with living

OMH has been using small investments and large commitments to change and advance recovery and resiliency through efforts such as peer services and support, competitive employment, and consumer-centered wellness initiatives.

Peer education and training aimed at competitive employment

Individuals who have made significant progress in their recovery from mental illness often play a pivotal role in helping others in their recovery journeys. They do this by sharing their own knowledge and skills.¹⁸ Research shows that peer support services are effective in reducing isolation and providing compassionate, empathetic care.^{19, 20} Peer support is also beneficial in helping to stabilize crises,²¹ reduce hospitalizations and contribute to shorter stays,²² and improve the outcomes from case management services.²³ Moreover, evidence indicates that a majority of peers maintain their employment following training, and report satisfaction with their jobs and collegial relationships.²⁴ They also describe personal growth, enhanced coping abilities, higher self-esteem, and hope for the future.²⁵

Supported by one-time federal stimulus funding and in conjunction with the NYS Department of Labor (DOL), OMH offered persons engaged in mental health treatment the opportunity this year to obtain the education and training necessary for competitive employment as peer providers in community mental health settings. The “Employment

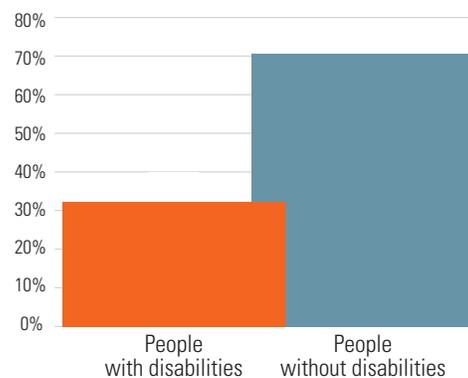
through Education” program required each student to have a commitment from an employer for consideration of employment upon completion of training. Students were given the opportunity to complete the course work via full-time study or on a part-time basis to gain the necessary skills, knowledge, and preparation. The education program also offered support services usually associated with this type of program, such as counseling, developing individual employment plans, and testing. This program supported 84 full- and part-time students who were sponsored by 18 community mental health providers. Close to one-half of the students have completed training and already nine have begun work.

New York Makes Work Pay

Evidence-based models such as supported employment in conjunction with mental health treatment are most effective in helping people get and keep competitive jobs.^{26, 27} This came to life in NYS last year when the U.S. Department of Health and Human Services awarded a \$5.9 million Medicaid Infrastructure Grant to NYS government. The grant is administered by OMH and its partners, the Burton Blatt Institute at Syracuse University and the Employment and Disability Institute at Cornell University. The project, which is aimed at supporting all New Yorkers with disabilities, including mental illness, also receives collaborative support of the Employment Committee of the NYS Most Integrated Setting Coordinating Council, the body charged with enhancing services and supports to enable each person, regardless of disability, to live in the most integrated setting.

A disability more than halves a persons chances to be employed

Employment rates in NYS for people with and without disabilities in New York State



To view state and county-level reports (2009) go to:
<http://www.ilr.cornell.edu/edi/nymakesworkpay/status-reports/index.cfm>

PEER Connection, hope and understanding go a long way toward stronger communities

By Douglas Usiak, Executive Director, Mental Health PEER Connection, Western New York Independent Living Center

Twenty years ago, after cutting her family out of her life, living on the streets and experiencing 13 psychiatric hospitalizations, a woman found her way to the Western New York Independent Living Center (WNYILC). Out of that initial contact, she was helped in making the decision that she no longer wished homelessness. She moved in with some friends and became a peer advocate at the Center. As an advocate, she used her experience with getting out of the hospital to help people diagnosed with mental illness to make their own transitions. She then went on to make a new transition for herself as an advocate for individuals with mental illnesses facing community barriers. In her new role, she was appointed to a Homeless Commission and began grading Erie County on its housing proposals for yearly funding. And, the transitions continued. She wrote several proposals for peer services to the tune of more than \$1 million in funding. And, yes, she did go on to become Director of WNYILC Mental Health PEER Connection and a homeowner. She reunited with her family and has not had a hospitalization in more than 15 years.

Each staff person and administrator has similar stories of "connecting" with peers from PEER Connection and embracing a lifestyle informed by recovery. Using their personal experiences, peers help people leave institutions, obtain safe affordable housing, become discharged from court-ordered treatment, live on their own, be free of government entitlements, become employed, earn health care and retirement benefits, become homeowners, and leave the world of poverty and discrimination. The doors open to a world of economic, mental, social, and physical self-sufficiency.



Located in Buffalo, the PEER Connection serves people with psychiatric disabilities, individually and on a community basis. It has satellite locations in the State and local psychiatric centers, in the prisons and County jail, in the crisis services office and in outpatient mental health clinics.

The uniqueness of the PEER Connection is embodied in its staff. They have recovered or are recovering from mental illness and/or substance use addictions. As recipients of services, staff members know the complications that go along with serious mental illness and being institutionalized in hospitals, jails, and prisons. They know firsthand the barriers to community integration: poverty, homelessness, unemployment, crime, drug-infested streets and, family and community prejudice. They know what it means to be on parole or probation, be regarded by the system as "difficult," and obtain disability benefits and government services from systems that are complex and often insurmountable for those with psychiatric disabilities. PEER Connection staff are experts because of their own experiences and, importantly, they are experts in the delivery of "hope."

The PEER Connection benefits from its administration, volunteer board members, council members, peer counselors, phone line counselors, and advisory councils. Every person involved has a psychiatric disability and many wish to give back to the PEER Connection for what they received.



Quality services and supports are of high priority. Input is sought about services from each person served. Moreover, everyone served is asked also to serve, from sitting on the board or committees, participating in town meetings, filling out consumer satisfaction surveys and being involved with empowering events to promote the PEER Connection's mission of recovery. Simply put, at PEER Connection, the motto is: We are "them" and they are "us."



And the rewards? Improving the lives of people with psychiatric disabilities and making stronger communities—by using resources most effectively, saving taxpayer money, and helping people to live full productive lives in their communities as neighbors, friends, workers, homeowners or renters, and more. Most important, community change is occurring as people become better educated about and come to understand that people with mental illness and mental health challenges do recover and contribute to an improved quality of life for the entire community.

Visit the PEER Connection website at <http://www.wnyil.org/mhpc/>.

Called “New York Makes Work Pay,” the program is funded through 2010 and provides services to persons with disabilities, the agencies and advocates that serve them, and employers. The program’s major goals are to foster competitive and integrated employment through education and training; increase the capacity of State agencies and employment service providers to improve employment outcomes for people with disabilities; remove barriers created by policies, regulations, and practices; conduct research to improve knowledge and identify best and promising practices; and redesign the service system so that persons with disabilities experience a “No Wrong Door Approach” to employment services and supports statewide.

The program is meeting its goals in part by enhancing the talents and assets of New Yorkers, increasing the use of work incentives, and increasing participation in the Medicaid Buy-In Program for Working People with Disabilities, as well as the Social Security Plan for Achieving Self-Support (PASS), and the federal Earned Income Tax Credit program.

As continued federal funding for this initiative is being sought this year, its major goals are continuing to align ex-

isting employment efforts to the strengths of the New York Makes Work Pay program. See <http://www.ilr.cornell.edu/edi/nymakesworkpay/index.cfm> to learn more about the program.

Personalized Recovery-Oriented Services (PROS)

PROS emphasizes recovery-focused services tailored to individual goals and needs (see <http://www.omh.state.ny.us/omhweb/pros/>). The model supports the delivery of evidenced-based practices with a strong emphasis on person-centered planning and employment. By June 2010, OMH had licensed 39 PROS programs in 10 counties, serving more than 4,300 individuals. From June 2009 to June 2010, with the intense implementation of PROS in NYC, the program has grown by 105%.

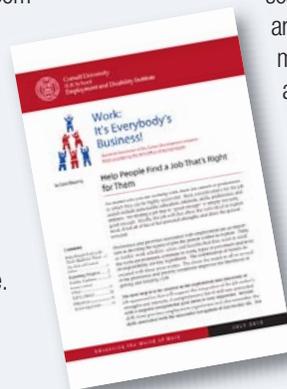
PROS relies upon a person-centered, strength-based recovery culture that incorporates both professional and natural supports. Services are individualized; the person being served is a partner in choosing supports, skill-building activ-

Passion for excellence leads to citizen-centered leadership

Work Is Everybody's Business is motivating innovation and change across our 16 adult State Psychiatric Centers. Each Center has developed specific goals toward increasing employment rates of persons engaged in services, taking into account the barriers and opportunities within its service area. Two Psychiatric Centers—Hudson River and Rochester—are involved in a process that goes beyond the traditional approaches toward achieving employment goals. They are engaged in a process that involves not only rehabilitation staff, but includes all staff, families, and persons engaged in helping people to meet their recovery goals.

The way change is taking place is through Communities of Practice, where participants engage in a process of collective learning in a shared domain of human endeavor: In this case, it is a comprehensive approach for imagining and realizing the full community inclusion of individuals with disabilities in typical community settings. It places the leadership in the role of citizen and uses this vantage for leveraging change.

Traditional systems of care are not typically funded or designed to facilitate and support truly integrated and person-centered community inclusion, yet key stakeholders ask for this type of support. The Communities of Practice, then, are aiming to address this reality by gaining knowledge and looking at strategies that will help lessen



the deep and often sole reliance on the service delivery system as the primary support in people's lives, while, at the same time, building strong community connections via natural supports within communities.

And how are the Hudson River and Rochester Psychiatric Centers bringing these goals to life and producing fundamental change? They are examining how their Communities of Practice can align their work with the values of recovery and resiliency, person-centered, and culturally competent services and supports. In addition, they are participating in a variety of distance learning and live sessions to increase skills and knowledge across critical areas such as leadership, person-centered planning, community-building, cultivating employment and taking action, all leading to the development and implementation of individualized plans for recovery and community membership.

If you ask John Allegretti-Freeman, OMH Director of Community and Rehabilitation Services, he'll tell you these are exciting times. He credits the Psychiatric Centers for their commitment to improving the lives of people they serve and to entering into the Communities of Practice, with the support of the Career Development Initiative.

The Initiative is a partnership between OMH and the Cornell University Employment and Disabilities Institute. Visit the Career Development website at <http://www.ilr.cornell.edu/edi/p-careerDev.cfm>.

ities and treatment. A number of evidence-based practices are crucial to PROS and recovery-oriented care. These include integrated care for co-occurring disorders, managing wellness, preparing for and gaining competitive employment and involving family members in psychoeducation.

Trauma-informed care

In the news most recently because of military post-traumatic stress disorder (PTSD) in individuals returning from active duty, trauma has a different impact on different people. Its effects may be physical and psychological and include depression and anxiety, feelings of worthlessness, difficulty with relationships, sleep disturbances, flashbacks and addiction. Responses to trauma are affected by whether

individuals have a history of prior trauma, physical and emotional health, and coping abilities and resilience.²⁸ Trauma-informed programs and services ask about prior exposure to trauma and provide supports for persons whose histories include violence and trauma.

Interventions for treating trauma are designed specifically to help people manage consequences of trauma (e.g., learning that events can trigger stress-related symptoms may not really be dangerous) and facilitate healing. For many, it helps to understand the relationship between trauma and its symptoms (e.g., substance abuse, depression, anxiety); and build connections with other survivors, and their family, friends and other supports.²⁹

Efforts to strengthen trauma-informed care within OMH Psychiatric Centers were bolstered late in 2009 when the

From a seedling in one clinic to a fully integrated service: Supporting victims of partner abuse

By Sylvana Trabout, R-LCSW, Assistant Director, Westchester Jewish Community Services (WJCS) Treatment Center for Trauma and Abuse, and, Director of the Partner Abuse Intervention Program

As an advocate for victims of domestic violence, one of the most important things I have learned is to “listen to the client.” She survived the abuse and has more knowledge about cues and warning signs than anyone else. I also learned that it is important to empower her. Social work values encourage the therapist to “meet the client where she is” and to work with the client towards mutually established goals. After working for several years in a victim advocacy program and then in shelter-based non-residential services, it became clear to me that for many victims of domestic violence, their personal struggles with mood, self-control and self-esteem can precede the abuse. Even though survivors are sometimes living with these disabilities, they are often distinctively strong, resilient and resourceful.

At WJCS, our Partner Abuse Intervention Program was started to help individuals who need the extra support of mental health professionals who do not judge them or blame them for their abusers’ behaviors. We help clients regain authority and control over their own lives, and better manage their stressors and mood issues such as depression or anxiety. Many of our clients work on both abuse issues and mental health concerns simultaneously.

If there are children in the household, the clients learn to talk about the problems in the family with a positive voice, knowing that this



*Sylvana Trabout, R-LCSW,
Director of the Partner Abuse
Intervention Program*

is necessary to break the cycle of violence. For instance, a parent will “notice” the good things a child does, and say so, directly to the child. Children can also learn about feelings and how to express them appropriately. Parents or caregivers can help children understand that domestic abuse is NOT their fault. Sometimes, having a safe place and the encouragement to draw, write or talk about their experiences is helpful to the children. It can open the door to breaking the silence, and ending the cycle of violence.

A word about male victims of domestic violence—yes, there are men who are abused by their female and male partners. They suffer the same indignity, pain and anguish as women who are abused. When I first met “Joe,” he had bruises over his arms and legs and was ashamed to talk about what happened to him. He came for several weeks and just sat and talked about his family, work and future plans before he began to speak about the pain and sadness. It was important to him that I understood his strengths before we could begin to look at the abuse. He wanted to ensure that I didn’t think of his wife as a bad person, and to know that he and she were good parents to their children. I understood from working with Joe how important it is to attend to people’s individual cul-

tural markings, be they related to gender, race, sexual orientation, faith or culture.

As Director of the WJCS Partner Abuse Intervention Program for the last 13 years, I’ve strived to grow the program from a seedling in one WJCS mental health clinic to a fully integrated service in

Continues on next page

four clinics serving all of Westchester County. When I started doing this work, I could not mention “mental health” and “domestic violence” in the same sentence without being accused of “blaming the victim” or labeling her as “mentally ill.” Perhaps that paralleled the culture of “blaming” people who suffered from mental illness for having such a struggle. Over time, I learned from abuse victims that when someone is staging a daily attack against the character, intelligence, ability and self-esteem of another person, one of the results is frequently depression or anxiety. For some, dealing with mental illness is a lifelong struggle that precedes being in a relationship where they are abused.

The real light bulb moment came when I was working with “Alice,” a woman with two children who was coming to a weekly group. She started to miss sessions and would call to come back, weeks or months later. Alice came in and out of the group for about two years and brought her children to all the programs organized to support the family. There were holidays and back-to-school events where gifts and supplies were distributed, and Alice was certain to come. Soon, Alice stopped coming to group as she had done in the past, and I thought, “She’ll be back in a few months.” After some time passed, I became concerned and called her only to find all the phone numbers that I had were disconnected, and a letter that was sent was returned stamped “unknown.” I recall feeling worried (Did her abuser who had stalked her and threatened her in the past get to her?), guilty (Should I have reached out sooner), sad (Is this how it ends, without any closure or goodbye?) and afraid for her children. It was the first time I understood that I needed to be there with my clients according to their needs in the moment. There was no promise of a neat conclusion or closure. Armed with this knowledge, I began shifting not only my thinking but my approach to treatment. I encouraged my clients to trust that they

know what they need, and could view my role as much more of a support “in the moment,” to help them establish goals and stay focused. Of course, we make sure that a safety plan is in place first, and address emotional difficulties along with basic needs and referrals to legal services if warranted.

Sometimes, abuse survivors stay in therapy a short time and establish their lives anew. It is as if they need a major overhaul to reorganize their life situation. Others stay in treatment longer to get stronger and receive ongoing support with emotional and mental health issues. Some stay a while, move on with their lives and return to treatment months or years later, when an issue related to abuse surfaces. I think of that as a “tune up.”

About two years after Alice stopped coming, she called to say thank you. She said that even though it may seem like she was in and out of treatment, she was paying close attention to the work we were doing. She wanted me to know that she had gone back to school and now had a good job in a new state, where she was free from abuse and her children were “happy to be playing outside.” That phone call was a gift that will last a lifetime, and a reminder that we as therapists may not always know the outcome of our work, but we can trust that our clients will get what they need in their own time. Thank you, Alice.

For more information about this and other Treatment Center for Trauma and Abuse programs, contact Ms. Trabout at (914) 949-7699, Ext. 371, or via email at strabout@wjcs.com. The WJCS Center for Trauma and Abuse web site can be found at <http://www.wjcs.com/index.php?src=gendocs&ref=TreatmentCenterforTraumaAbuse&category=What%20We%20Offer>.

Substance Abuse and Mental Health Services Administration (SAMHSA) provided trauma-informed care training to about 200 professional and paraprofessional staff members statewide. The two-day training sessions utilized the 15-module Trauma, Addictions, Mental Health, and Recovery Manual. The training delivered basic education on trauma, its developmental effects on symptoms and current functioning, symptom appraisal and management, the impact of early chaotic relationships on healthcare needs, the development of coping skills, preventive education concerning pregnancy and sexually transmitted diseases, sexuality, and help in dealing with role loss and parenting issues.

In March of this year, through the State University of New York at New Paltz, Institute for Disaster Mental Health, OMH sponsored two days of training available statewide on cognitive processing therapy, one of the most effective evidence-based treatments for PTSD. The treatment is delivered over 12 sessions and helps people struggling with PTSD symptoms to make sense of the trauma by giving them new

strategies for handling distressing thoughts and a better understanding of how going through a trauma changes the way they look at themselves, the world, and others.³⁰ Led by the therapy’s developer, Dr. Patricia Resick, the training drew 350 participants on-site in New Paltz and more than 600 additional clinicians by remote-site live webcast.

Recovery centers

Experience in New York and elsewhere shows that excellent peer-run programs supplement the work of more traditional treatment and rehabilitation programs. OMH is working toward bringing a new generation of recovery support services to fruition as “recovery centers.” Based on exploratory work and planning conducted with SAMHSA grant funding, OMH has reviewed the literature (see http://www.omh.state.ny.us/omhweb/adults/transformation_transfer/report.pdf), sought broad stakeholder input and received expert consultation to plan the transformation of tra-

ditional peer support programs (e.g., drop-in centers) to more dynamic recovery centers.

Recovery centers will emphasize organized peer support to build recovery and resiliency. Centers will support individuals in connecting to natural community groups, organizations, networks or places that nurture life's passions.



Resources to enable consumer peer-run organizations to be self-sustaining and strong can be found at the National Consumer Supporter Technical Assistance Center. Go to <http://www.ncstac.org/>

Recovery centers will be assisted in managing their peer-owned, not-for-profit organizations by a technical assistance and support center to be funded by OMH. The technical assistance center's goals will be to increase individual peer-run organization staff competencies; promote skill development with an emphasis on leadership and business management; and provide training and support to ensure that peer-run organizations are providing evidenced-based services that promote recovery. A request for proposals for development of the technical assistance center was issued in July, with an anticipated start in the fall of 2010.

Recovery-oriented support to divert people from the criminal justice system into treatment

Care for persons with a mental illness involved in the criminal justice system is guided by a model of care known as "Sequential Intercept."³¹ The goal is to use natural points of criminal justice activity (e.g., police contact, booking, jail time, trial) to intervene and, where appropriate, reduce the likelihood that someone will go further into the criminal justice system. Some of the collaborative approaches include:

- ◆ Improving the Mental Health Crisis Response—an important collaboration with the Division of Criminal Justice Services (DCJS) and Policy Research Associates has been taking place over the last year, when these two collaborators sponsored a summit in 2009 that engaged community stakeholders from seven counties in developing plans for improving local mental health crisis responses. As a result of the summit and ongoing technical assistance through June of this year, the counties have been striving to improve their mental health crisis response. They have been developing or enhancing a cross-agency task force aimed at improving the crisis response, integrating help and crisis lines with 911 dispatch services, improving communications between law enforcement and emergency depart-

With a song in their hearts . . . Community orientation and re-entry

*By Ellen Healion, MA,
Executive Director of Hands Across Long Island*

From inside the walls of Sing Sing are men with serious mental health challenges who are trying to reclaim their lives. Before the staff of Hands across Long Island (HALI) started to work with these men, 8 out of 10 were destined to return to jail. Within one year of starting its Community Orientation and Re-Entry Program, however, HALI helped to drop that rate to just under 2 out of 10, a remarkable accomplishment and a testament to peer support, care and concern for others.

Each week, members of HALI meet with prisoners diagnosed with mental illness being prepared for release from prison. Staff helps each individual to know what he'll encounter upon return to the community. They meet him at the gate and help him to begin that transition into the real world.

Because housing is in such short supply and finding housing for people released from jail with mental illness can be a challenge, HALI has a small pilot under way to provide very structured community housing. The home holds four persons and is staffed by two forensics staff members who have strong mental health and addictions experience. Suffolk County provides assistance with clothing, treatment, and medications.

The expectations are high. The home is inspected daily each morning. The residents work, meet with parole officers, or attend therapeutic programming during the day. After an afternoon break, they have dinner and 12-step program obligations. This routine is to replicate life in the community: work, community obligations, recovery obligations and maintaining a home and relationships with friends, coworkers and neighbors. The goals are to give these men a foundation in living full and productive lives within their communities, and expect success.

HALI also provides services within the County jail system, working with men and women to identify what brought them into the jail and make plans to avoid people, places and things that will bring them back. Anger management and criminal thinking are among the target areas presented by HALI forensic intervention specialists.

While there has been a learning curve to serving people with mental illness returning to the community from prison or jail, HALI members use their lived experiences to help them succeed. It's common sense and makes a difference.

You may email Ms. Healion at ehealion@hali88.org or visit the HALI web site at <http://www.hali88.org/>.

ments, adding a focus on the needs of veterans, and increasing mental health training among law enforcement officers and across systems of care. Under the second strategy, DCJS, in collaboration with OMH, has revised the mental health portion of the Emergency Services Dispatch Course curriculum to improve knowledge and understanding of mental health issues among 911 dispatchers and enable them to be better prepared members of the crisis response team. The revised mental health curriculum has been piloted and approved for incorporation into the mandated training. It is also being considered as a stand-alone unit for yearly in-service training.

- ◆ **Supporting Wellness Self-Management**—The Center for Urban Community Services, in conjunction with the Division of Parole, Department of Correctional Services (DOCS) and OMH, expanded its pilot project this past year, offering the evidence-based wellness self-management program to persons in three more State correctional facilities. (More on the program appears in the section on “Advancement of Evidence-Based Practices.”) Initial evaluation data reveal, when compared to controls, participants in the wellness self-management program experience significant benefits in managing symptoms and facilitating recovery. Wellness self-management training for OMH, Parole and DOCS staff members, and joint sessions for inmates co-led by OMH and DOCS, will permit the project to continue after the pilot ends. Additionally, a longitudinal study of the effectiveness of

wellness self-management will continue to look at how well the program helps in reducing psychiatric symptoms, managing stressors of incarceration, and facilitating recovery.³²

- ◆ **Facilitating Recovery through Consultation**—“Project Connect” was a focused effort over a year-long period from June 2009 to June 2010 aimed at meeting the needs of adults in treatment for serious mental illness who are under probation supervision through staff development and technical assistance. The Connect partnership between OMH, the New York Association of Psychiatric Rehabilitation and the Division of Probation and Correctional Alternatives included a summit with the participating counties, follow-up conference calls and technical assistance through June of this year. County planning teams were enhanced with peer consultants who helped to bring a recovery and resiliency focus to the project.

A number of actions were taken by the counties to improve communications between behavioral health agencies and law enforcement. Among the diverse, locally tailored actions have been enhanced membership of existing committees and a focus on addressing issues identified during the summit; analysis of 911 responses to mental health emergencies and improved coordination of information sharing, improved emergency responder coordination and information sharing with law enforcement and start-up of cross-systems training and expanded law enforcement training to counties not participating in the project.

Six months later, training shows success in equipping police to respond to psychiatric crises

Law enforcement training this past spring is helping police to deal more effectively with people having behavioral and emotional issues in Broome County, according to a September 8, 2010, Binghamton Press and Sun-Bulletin article.

Binghamton has also become the third city in NYS (Rochester and Troy) to have an “Emotionally Disturbed Persons Response (EDPR)” team. Team members on each shift are called when their expertise is required. The training has equipped them to rely upon special communication skills and tools to help deescalate problems.

Twenty-seven officers were trained in April, from Binghamton, Endicott and Vestal, as well as staff from the Broome County Sheriff’s Office and Broome County Emergency Services. Overall, the new EDPR program has improved communication between mental health and law enforcement personnel. In fact, the Binghamton Police Department is developing written policy for responding to

persons in emotional crisis. It is working with United Health Services, which runs the crisis center as well as caseworkers and other providers to ensure that they all preserve patient dignity and privacy in the least restrictive manner possible.

In kicking off the training in April, Binghamton Police Chief Zikuski expressed hope that the training would help keep people with mental health conditions out of the criminal justice system and keep these individuals in mental health treatment. He also credited Mental Health Commissioner Johnson for his role in bringing the week-long training to fruition.

Read more about the program by going to <http://www.pressconnects.com/apps/pbcs.dll/article?AID=20109070353> and <http://www.cityofbinghamton.com/viewarticle.asp?a=3325>.

The evaluation of Project Connect was completed in March of this year. Overall, counties reported improved emergency response planning as a result of participating, improved communications, and positive systems change. Committees have continued to meet and sustain progress. It is likely participation will broaden and generate further improvement in collaboration, coordination, and more effective crisis response.

- ◆ Expanding Comprehensive Care—OMH and DOCS opened a Residential Mental Health Unit in December 2009 at the Marcy Correctional Facility. This innovative program is the first of its kind to divert individuals directly from disciplinary housing units to highly structured residential units with treatment integrated with custody. The Unit is expected to be at full census by December 31 of this year and planning is under way to open a second unit during fiscal year 2011–2012.

Support of physical and mental wellness

LifeSPAN was initiated early in 2008, reinforced in 2009 with the introduction of an online toolkit, and identified this year as a vital resource for OMH as it strives to meet its commitment to the SAMHSA 10 x 10 Wellness Campaign (see Chapter 2). Created for persons engaged in services, family members and providers, LifeSPAN is designed to counter the development of medical conditions, which, when not treated, lead to illness and death in persons diagnosed with serious mental illness (e.g., lung disease related to smoking, heart disease due to obesity).³³

The four pillars of LifeSPAN are: Stop smoking, Practice prevention, increase Activity, and improve Nutrition. The toolkit provides guidance in preventing illness, for example, through routine screenings and regular immunizations; in staying physically fit; in understanding nutritional labeling; and in adopting strategies to quit smoking successfully. In the past year, more than 1,000 toolkits were distributed in training sessions.

On other fronts, OMH is actively promoting a smoking cessation agenda. The multifaceted approach includes collaboration and educational strategies to aid people in adopting healthier lifestyles. In January 2010, it sponsored a statewide meeting to explore the development of a strategic plan—based on a strong public-private partnership—to address tobacco dependence for persons with serious mental illness. This planning process is being augmented this fall when OMH will convene a strategic planning summit with the support of the Smoking Cessation Leadership Center at the University of California, San Francisco, and SAMHSA.

In its own outpatient programs, OMH is measuring and monitoring three critical indicators of health and health risk

among persons engaged in care: body mass index, blood pressure, and smoking status. The initiative enables people to better understand factors associated with their health and well-being, be partners in improving their health, and track their progress. Right now, more than 2/3 of persons in care are screened every 90 days or fewer.

Advancement of evidenced-based practices

Research-proven or “evidence-based” interventions are the gold standard for effective treatment. In 2008, OMH established the Evidence-Based Practices Technical Assistance Center at the NYS Psychiatric Institute to promote the widespread delivery of these practices. In the past year, the Center has been renamed to the Center for Practice Innovations (<http://www.practiceinnovations.org/>), in keeping with its mission to use innovative approaches to build stakeholder collaborations, develop and maintain practitioners’ expertise, and strengthen agency infrastructures that support implementing and sustaining evidence-based practices. The Center has several major thrusts of activity:

- ◆ Wellness Self-Management initiative—Wellness self-management is a comprehensive curriculum providing information, knowledge, and skills development that enables staff to work effectively with people to make decisions that support their recovery. The curriculum is delivered by trained staff and peer specialists. Compiled into a personal workbook, the curriculum spans topics such as mental health symptoms, treatment, and causes; the importance of social support and community resources in helping recovery; and the identification of effective

Looking for other wellness resources in New York State?

Try the Network of Care. Currently, the five boroughs of New York City, as well as Allegany, Chemung, Essex, Franklin, Jefferson, St. Lawrence and Steuben counties are participating.

The Network of Care is a highly interactive place where consumers, community-based organizations and municipal government workers all access a wide variety of important information. The site includes a comprehensive service directory, links to pertinent websites from across the U.S., a library with a broad array of resources, community message boards and more. Go to <http://networkofcare.com/index2.cfm?productid=2&stateid=37> to learn more about resources in NYS.



coping strategies.

The Center is also adapting and field testing the curriculum to meet the specific needs of persons with co-occurring mental health and substance abuse problems, of youth and young adults, and of inmates with serious mental illness.

- ◆ **Assertive Community Treatment Institute**—Since joining the Center for Practice Innovations in the summer of 2009, the Assertive Community Treatment Institute continues to provide teams statewide with training and technical assistance. In addition to providing training and consultation to Assertive Community Treatment teams this year, the Institute recently conducted a comprehensive review and redesign of its core curriculum, and the creation of a web-based introductory training module that reflects current research and knowledge. Piloted in July, the revised curriculum was just introduced in September.
- ◆ **Individual Placement and Support (IPS) approach to supported employment**—IPS promotes the most effective employment strategies for people with mental illness. Program elements include ongoing assessment, rapid job search, competitive employment, integrated mental health support, attention to each person's preferences, and continuous support. In light of the strong outcomes associated with the IPS model, OMH has begun to take actions to infuse the model within the service delivery system. As the first step, all PROS programs are being required to provide the IPS model of supported employment, and funding was added to the PROS model for IPS efforts (which are largely not Medicaid reimbursable).
- ◆ **Integrated Care for Dual Diagnoses**—The collaboration between OMH and OASAS is strengthening integrated care across the State with services that are more effective than parallel or sequential treatment for mental illness and addiction. (Please see the next section for additional information.)

Integration of care for dual disorders

Through a memorandum of understanding between OMH and OASAS, both agencies have emphasized integrated or “whole-person” care for those with co-occurring mental health and substance use disorders. No matter through which door people seek treatment—OMH or OASAS—they should receive care that incorporates both mental health and addiction screening, assessment, and counseling. Providing integrated care is consistent with and necessary for success in resolving the principal diagnosis that made admission necessary.

OMH-licensed and OASAS-certified providers are supported by the Center for Practice Innovations. Its web-based training approach, called Focus on Integrated Treatment, features concise, half-hour learning modules that allow practitioners to choose when and where to take their training. The modules engage learners through inspiring personal recovery stories, clinical vignettes, interactive exercises, and expert panel presentations. They include tests of understanding and competence and a way to track staff mastery across an agency. This training helps practitioners gain a firm foundation in evidence-based integrated treatment for co-occurring disorders, including screening and assessment, stage-wise treatment, motivational interviewing, and more. Additional modules help clinical supervisors develop their supervision skills and guide agency leaders through changes to ensure sustainability of integrated treatment.



<http://www.practiceinnovations.org/FocusonIntegratedTreatmentFIT/tabid/99/Default.aspx>

At the end of July 2010, 25 modules had been introduced and the remaining 13 will be added to the training in December 2010. Implementation support is ongoing and includes webinars, ask-the-expert forums, and discussion threads.

Integration of care for older adults

Demonstration programs developed under recommendations made by the Geriatric Mental Health Planning Council (<http://www.omh.state.ny.us/omhweb/geriatric/>) continue to examine model practices for meeting the mental health needs of older adults, a population that will increase by more than 50% over the next 15 years. Three “gatekeeper” programs are operating in Westchester and Onondaga counties and in Manhattan. They are looking at the effectiveness of utilizing individuals whose everyday work activities bring them into contact with older adults (e.g., cable television workers, clergy). These workers are taught how to recognize signs that might indicate a need for professional intervention and how to make appropriate referrals. Once referred to the program, the gatekeeper coordinator works to engage the individual and help connect him or her to appropriate services as needed.

The other programs focus on physical health and mental health integration through the co-location of primary and mental health services or through stronger collaborations between providers. These are operating in NYC, on Long Island, and in Monroe, Warren and Washington counties. Greene County has also developed an innovative program to integrate care by establishing mental health clinic satellites at primary care physician offices throughout the county.

Since the inception of the physical health and mental health integration programs, more than 4,600 individuals have been screened for depression and anxiety. Of these, approximately 2,000 (43%) received full assessments and 860 (19%) were determined to have clinically significant depression or anxiety requiring treatment. The three-month follow-up results for the individuals receiving treatment are very favorable, with 62% showing improvement in depression and 57% in symptoms of anxiety.

Support of military personnel, veterans and families

As an active member of the NYS Council on Returning Veterans and Their Families, OMH supports the Council's comprehensive action plan, which has at its core five goals:

- ◆ More comprehensive formal outreach, materials development, and campaign
- ◆ Better education of policy makers, employers, academic institutions, and community leaders on the needs of returning veterans and their families
- ◆ Better education and information sharing among partners to enhance the “No Wrong Door” approach to service provision
- ◆ Uniform, effective and innovative ways to reach out to veterans and families and, when indicated, engage them in receiving services and supports, and track their progress
- ◆ Improved techniques to ensure that veterans and their families have knowledge and information that enable them to access earned benefits

Among the many public mental health approaches for military personnel, veterans and their families are the supportive services provided by the OMH Community Outreach Office to the National Guard Yellow Ribbon Reintegration events (<http://dmna.state.ny.us/family/reintegration.php>), staged regularly for returning Guard members and their families. Information, education, on-demand counseling, and referral services are provided pre-deployment to help families prepare for the impending separation; mid-deployment to see how families are doing; and post-deployment when soldiers return home. OMH continues its support by participating in all Yellow Ribbon events as a provider.

The acclaimed Talk, Listen and Connect initiative—featuring Sesame Street characters and supported by a number of national and local collaborators including OMH—is on track to add a third resource kit in 2010. The newest kit will respond to the traumatic grief a child and family experiences when their loved one dies. It will be available in New York communities in two versions, one for military families and one for the general population.

Fort Drum, New York's largest military installation, is home to the Army's 10th Mountain Division. For the families of soldiers in different stages of deployment, the Family Readiness Center offers a place to gather for meetings and classes, as well as a place to find the company and support of other spouses experiencing deployment. The Center also has video teleconferencing rooms to make communicating with deployed soldiers easier. Learn more about family support for military families at <http://www.drummwr.com/DeploymentInformation.htm>.



With a rising concern in communities for preventing suicide, especially among military personnel and veterans returning from war, OMH remains focused on saving lives through suicide prevention and providing support to loved ones, friends and other community members.

Research to help alter the course of schizophrenia

Research suggests that early treatment can alter the course of schizophrenia and related psychotic disorders by dramatically slowing their progression; reducing disability, mortality, and the expense of care; and increasing recovery. With support from the National Institute of Mental Health, researchers in NYS are heading two independent teams to develop and test new therapeutic strategies for treating people experiencing a first episode of the psychotic symptoms of schizophrenia. Called the Recovery After an Initial Schizophrenia Episode (RAISE) studies, the teams are examining whether early intervention with optimal treatments and services can alter the course of the illness, reduce disability, and promote recovery.

The research team from the NYS Psychiatric Institute is being led by Dr. Jeffrey A. Lieberman. The award is enabling the research team to demonstrate how a strategically timed intervention at the onset of symptoms can prevent the debilitating effects of schizophrenia. It is helping determine whether intervention that is started early, incorporates diverse treatment and rehabilitation approaches, and is sustained

over time can make it possible for more people with schizophrenia to return successfully to work and school. The intervention is being designed and tested from the start to be readily adopted in real-world health care settings. The hope is that such a coordinated approach tailored to each individual and sustained over time may make lasting differences in the engagement in and acceptability of treatment and overall functioning. New York is also home to a RAISE research team headed by Dr. John Kane at Hillside Zucker Hospital of the Long Island Jewish health care system.

Summary

As we struggle with challenging fiscal times, it is clear that the mental health community in New York continues to pull together to sustain services and create a more responsive, recovery-focused and culturally and linguistically competent system of care. A shared commitment to recovery and resilience will provide the fuel necessary to achieve the best outcomes for adults with serious mental illness and mental health conditions.

Appendix 3 contains descriptions of programs and initiatives organized by strategies that have been guiding and will continue to guide transformation of the system of care serving adults.

Chapter 3 endnotes

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- 9 While regulations for the Mental Health Parity and Addiction Equity Act of 2008 went into effect for plan years beginning on or after July 1, 2010, plans have been required to make a good faith effort to comply with the Act since it went into effect on October 3, 2009.
- 10 The National Committee on Quality Assurance defines a medial home as “a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.” See <http://www.ncqa.org/tabid/631/default.aspx>
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- 12 OMH continues to address the redesign process separately and in parallel for children, enabling it to respond to the complex and diverse needs of persons served by each ambulatory system.
- 13 Worst case housing needs are experienced by unassisted very low-income renters who either pay more than one-half of their monthly income for rent or live in severely inadequate conditions, or both. HUD defines “very low-income” as below 50% of the local area median income (AMI) and “extremely low-income” as below 30% of AMI. U.S. Department of Housing and Urban Development. (2010, May). Worst-case housing needs: A report to Congress. Washington, DC: Author. Available online at http://www.huduser.org/Publications/pdf/worstcase_HsgNeeds07.pdf
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