



New York State Office of Mental Health

Statewide Comprehensive Plan

2010-2014



New York State
omh
Office of Mental Health

October 1, 2010

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Recovery and Resilience: The Foundation for Planning

Last year's *Statewide Plan for Mental Health Services* opened with consumer/survivor¹ Dr. Pat Deegan's compelling question: How do we create hope filled, humanized environments and relationships in which people can grow?²

Recognizing that our environment and our relationships can have a profound effect on lives, we hope that our mental health system can begin to answer that question. The never-ending transformation of the mental health system should expand hope, raise expectations, and nurture growth. The passion for helping others that brought us to mental health work provides energy for the changes that can answer Dr. Deegan's question.

Transformation of the mental health delivery system rests on two principles articulated in the 2003 New Freedom Commission on Mental Health final report. The first is that services and supports must be more clearly centered on the person and family³ members engaged in care, rather than oriented toward the "requirements of bureaucracies." This is no small task in a time when insurance coverage—especially Medicaid—has become how most care is paid for. The second is that services and supports cannot just help with symptoms, but must also enhance abilities to cope successfully with life's challenges, facilitate recovery, and build resilience.⁴

Recovery and resilience reflect journeys rather than destinations and they reflect qualities of individuals and communities:

- ◆ Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.⁵
- ◆ Resilience comprises the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses—and to go on with life with a sense of mastery, competence, and hope. Resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely-knit communities and neighbor-

hoods are also resilient, providing supports for their members.⁶

As noted in last year's Plan, change within the public mental health system is "bottom up" as much as "top down." Transformation (like recovery) must take into account our very challenging times. The mental health system is not growing, few new resources are available, constraining forces are present, and local systems of care have diverse and unique needs—as well as unique strengths and opportunities.

The Office of Mental Health (OMH) expects its annual Plan to spur feasible actions at any level of the system and by anyone who is ready to make change. The Plan is an OMH contribution to an ongoing dialogue in which we exchange ideas, learn, and use knowledge to improve the lives of New York's citizens. The Plan centers attention on collaborative solutions.

Last year's Plan built on first-person accounts of individuals and family members who were engaged in New York State's (NYS) system of care and achieving remarkable things. While each person's background and experiences were unique, their stories offered us insight and motivation for change. This year's Plan takes a look at some "environments"—programs, organizations, and special initiatives—in NYS that are offering hope, opportunities for change and growth, individual and cultural relevance, and better lives for New Yorkers coping with and recovering from mental illness. Many examples exist within our State, and this Plan takes the opportunity to highlight just a handful of services and supports that people say are making a difference. Please also see the Directory of Programs and Initiatives that stakeholders have noted as "making a difference" that follows Chapter 7.

This chapter provides an update to the overview of the importance of mental health to overall health and reminds us of why we need to care about mental health and well-being.

Mental health is an intricate part of overall health

Since 1948 when the World Health Organization (WHO) declared health to be a “state of complete physical, mental and social well-being and not merely the absence

of disease or infirmity,” WHO has reminded us regularly—as did Surgeon General David Satcher—that there is no health without mental health.⁷ Mental health is of chief importance to personal well-being, our capacity for forming meaningful and caring relationships, and our ability to contribute to society.

Family roundtables empower, inspire confidence, and improve services

Friendly kitchen tables—where neighborhood friends gather, share stories, learn from each other, and work collectively to affect change—seem to be disappearing. But at Better Days Ahead, the family-run service program of the Mental Health Association in Rochester, this custom is being brought to life in a new way through its System of Care Family Roundtables. They are places where families share, teach, learn and become empowered. They are also places for educating and strengthening families and communities. As a family-run organization, Better Days Ahead employees have firsthand knowledge of the trials and struggles that families of children with mental, emotional, and behavioral challenges face as well as a keen understanding of the systems that they must navigate to get the necessary help for their children. Better Days Ahead translates this knowledge into a model that works for families, systems, and the community.

There are currently three System of Care Family Roundtables operating within Monroe County—one located in the heart of downtown Rochester, another in the community's largest suburb of Greece, and the third, which is operated entirely in Spanish, within the city's Latino community. The Family Roundtables are based on the values of equity, respect, and reciprocity. A strengths-based approach is central to all aspects of the work done in the Roundtables. They reach across cultural, ethnic, socioeconomic and geographic boundaries to meet families, providers, and community members where they are. There is a “no blaming/shaming zone” in place that exists for all partners.

Each Roundtable comes together as a table of equals. Everyone has a perspective, knowledge, and experience to bring to the table and they are all valued, respected, and heard. The basic structure of the model allows for it to be adapted to fit the cultural norms of the group being served. For example, one Roundtable operates completely in Spanish with Latino staff from a long-trusted community organization. This group addresses both the cultural and linguistic needs of the Latino community through the recognition of the established cultural beliefs and norms of the group and uses them as a platform for the introduction of new information related to mental wellness.

The Family Roundtables have given individuals/families a place where their voices are heard and respected. Families don't shut

down. They look forward to attending and participating. They become more informed and in turn more confident in the decisions that they make, not only for their children but also as representatives of the families of the children of Monroe County. Empowered with additional knowledge, they feel confident in knowing they are making well-informed decisions.

By being a part of the Family Roundtable, families know that they are not alone in whatever they may be going through with their children. Individuals and families come to realize that their ideas or concerns are valid and not criticized, but embraced. This empowerment is infectious in that it allows individuals and families to spread what they have learned with other families with confidence, and in turn, those individuals and families may also end up becoming participants in a Family Roundtable.

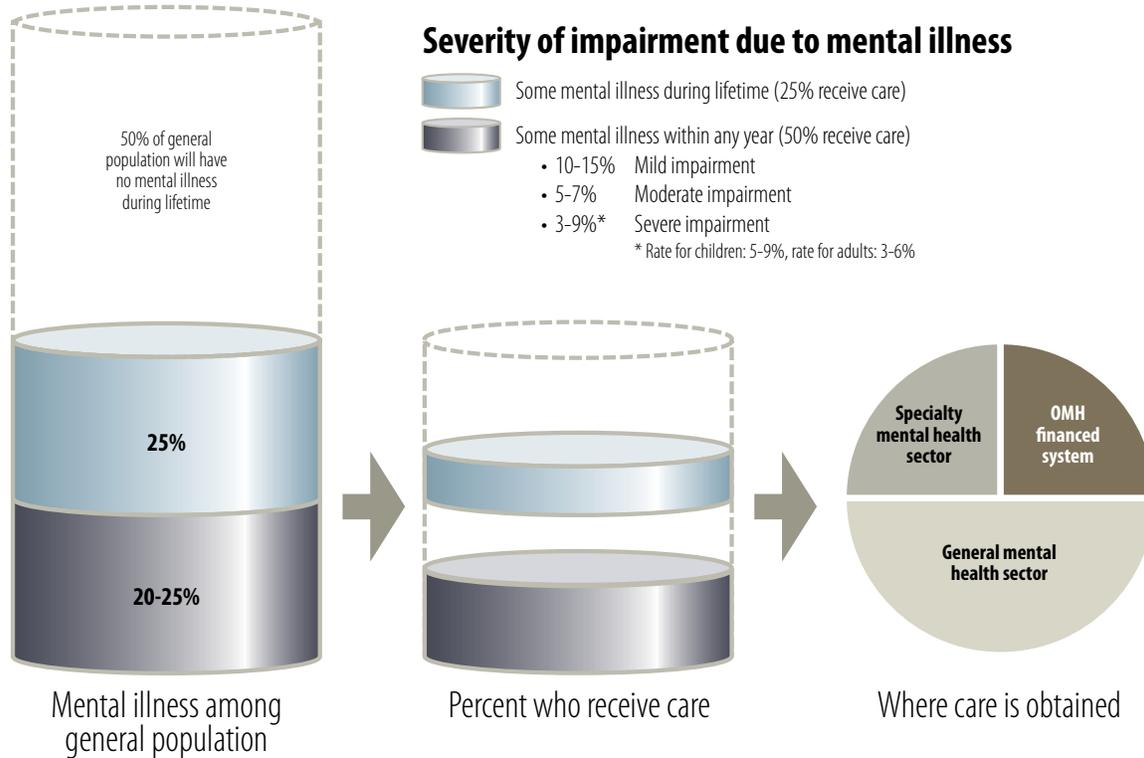
Through the partnership with providers across the System of Care, including mental health, school, child welfare and juvenile justice, the provider community is able to see families in a different light. This creates opportunities for families to become involved in areas of the entire child-serving system where historically there has been limited family involvement. Both the families and the provider partners are

able to interact and, in a safe and welcoming environment, address myths, misconceptions, or misjudgments they may have about one another. This is a win/win for everyone. The families become more knowledgeable and in turn more empowered. This makes the families better partners, which is helpful to the providers, and ultimately the children and youth do better.



To learn more about the Roundtables, contact Melanie Funchess via email at mfunchess@mharochester.org. Also learn more about the Roundtables by visiting the Monroe County System of Care website at <http://monroecountysystemof-care.org/>.

Patterns of Mental Illness and Mental Health Care



While mental health can be promoted and mental illness can sometimes be prevented, mental illness and mental disorders are prevalent and have an impact on our families, communities, workplaces, schools and the military. Interestingly, many people—erroneously—think mental illness is rare, something that only happens to others, and is unlikely to affect them.⁸

Even when mental illness is close to us, its significance is often overlooked. That is because mental illness and even mental health treatment are distorted by stigma and discrimination. As actress Glenn Close notes, in the face of remarkable progress in medical science and treatment, stigma stubbornly persists.

And because of this and despite the enormous cost and impact of mental disorders, mental health is generally not a high public priority.

Mental health problems are widespread and troubling

Widespread and troubling, mental health problems affect about one in four Americans ages 18 and over and similar numbers of adolescents each year. Even though mental disorders are prevalent, the most intense burden of illness is concentrated in a much smaller proportion of adults—about one in 17—who have serious mental illness.⁹ We are also learning that mental health problems begin earlier—and are often more serious for children—than was long understood. Recent results from a national survey tracking the rates of common mental disorders among children ages 8 to 15 found that 13% of respondents met criteria for having at least one of six mental disorders within the last year, with attention deficit hyperactivity disorder, depression, and conduct disorder ranking at the top.¹⁰ And for the half of us who will experience a mental illness in our lifetime, 50% will experience the first symptoms by the age of 14.¹¹

Within NYS, of the 173,683 people served in the public mental health system during a single week in 2009, a little more than 8 out of 10 had a diagnosis of serious mental ill-

ness or serious emotional disturbance.¹² Of these individuals, nearly 20% were children below the age of 18.¹³

For many, obtaining good results from mental health care involves countless barriers that must be overcome. Obstacles include being unable to recognize that problems exist (symptoms themselves may impair our judgment), overcoming the fear that seeking help could cause problems due to discrimination, dealing with insurance limits, not knowing where to begin to find treatment and support, and sticking with treatment when the response may be slow, incomplete, and sometimes painful.

The difficulty of overcoming such obstacles is amply illustrated by research. Worldwide, and for all age groups, depression, bipolar disorder and schizophrenia are among the most disabling conditions, with depression ranked third.^{14,15}

By 2030, WHO estimates that depression will become the leading cause of disease burden internationally. With a “global” mortality rate of 16 per 100,000 individuals, suicide is the most serious consequence of depression.¹⁶

Suicide is the 11th leading cause of death in the U.S., with 34,598 reported suicide deaths in 2007, and 1,396 in NYS.¹⁷ About every 15 minutes, a person dies in our nation from suicide¹⁸—a preventable and tragic form of death. While treatment for depression is effective 60 to 80% of the time, less than one-quarter of people with depression receive appropriate treatment.¹⁹ Mental illness is also a major contributor to physical illness and premature death due to cardiovascular and pulmonary diseases associated with psychiatric medication side effects (e.g., diabetes, obesity), smoking, poor physical health care, and substance use disorders.

Mental health concerns are a leading reason for school failure, the leading cause of adult disability, and the third leading cause of death by suicide of young adults. Inadequate and ineffective treatment of mental

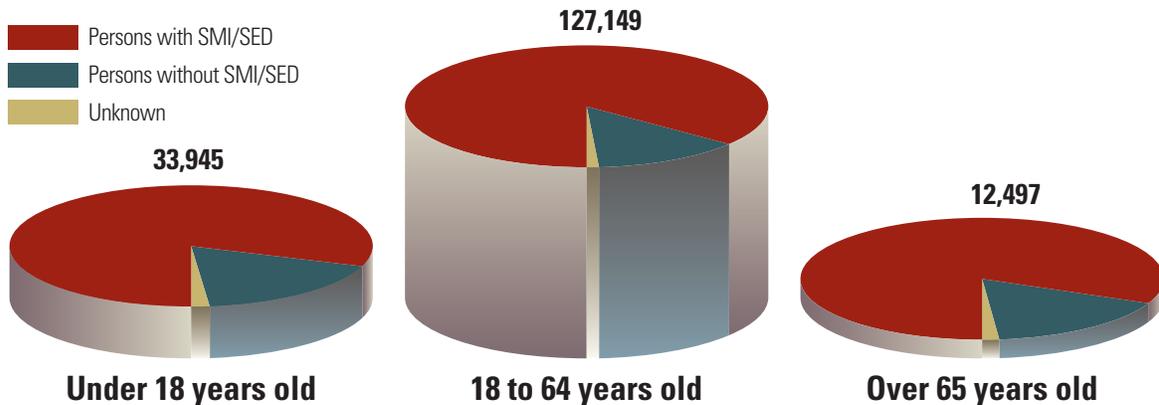
disorders in older persons are associated with significant disability and impairment, including a compromised quality of life and ability for community living, cognitive impairment, increased caregiver stress, increased mortality, and poor health outcomes.²⁰ Moreover, the unmet needs, poor qual-

An estimated 900,000 people die by completing suicide each year... the equivalent of one death every 40 seconds.

Worldwide, suicide ranks among the three leading causes of death among people 15 to 44 years of age.

World Health Organization

Severe Mental Illness/Serious Emotional Disturbance Status By Age Group Survey Week 2009, Statewide, All Gender



Source: NYS OMH Patient Characteristics Survey

Diversity, inclusiveness and hope

By Ellen Pendegar, MS, RN, PMHCNS-BC, Chief Executive Officer of the Mental Health Association in Ulster County, Inc.

If you would like to know how you can create and sustain lesbian, gay, bisexual, transgender, and queer (a term that is preferred by some in the LGBTQ community) affirming practices throughout all levels of a mental health agency, you'll be pleased to know there is guidance right here in NYS to help.

The Mental Health Association (MHA) in Ulster County, Inc., had the pleasure several years ago to become involved in a joint project with Planned Parenthood Mid-Hudson Valley, Inc., University of Maryland Center of Mental Health Services Research, and the New York Association for Gender Rights Advocacy. The project, which centered on the creation of a cultural competence toolkit, received generous funding from the Gill Foundation.

Now in its second edition, *Enhancing Cultural Competence: Welcoming Lesbian, Gay, Bisexual, Transgender and Queer People in Mental Health*, has become a "living and breathing" document, reflecting the developers' intent for the LGBTQ toolkit to evolve and improve over time. The latest edition, for example, contains enhancements to the section addressing transgender issues. Each toolkit user is encouraged to participate in the ongoing development of the toolkit by suggesting edits, additions, etc. It is available free online at http://www.mhainulster.com/Attachments/2ndEd_LGBT_KIT_11-07final.pdf.

One of the strengths of the toolkit is that it provides opportunities to expose insensitive practices while offering strategies to correct these practices. The toolkit contains resources, such as agency-wide assessment tools, that any mental health provider can use. It also is designed for use by individual practitioners as well as people at differing levels of the system of care — direct care, agency/management, community and public policy. As part of MHA's commitment to this toolkit, work was done along with Planned Parenthood to distribute the kit in as many mental health venues as possible. Toolkit training has also been provided locally, statewide, and nationally, even at an annual American Psychological Association Convention.

What prompted the development of this toolkit? Several concerns...

- ◆ The reality that generally mental health services in the U.S. fail to address sexuality at all
- ◆ The need for recognizing that rarely is a person's sexuality, as a healthy and normal facet of adult functioning, explored as a means to recovery
- ◆ The lingering pathologization of LGBTQ identities; as noted in the toolkit, up until 1973, being "homosexual" deemed one as having mental illness (American Psychiatric Association Diagnostic and Statistical Manual)

- ◆ Persistent myths and false beliefs (e.g., "homosexuality" causes mental illness, mental illness causes "homosexuality"), contributing to negative attitudes, stigma and discrimination experienced by many persons in the LGBTQ community
- ◆ Mental health care being affected by providers' behaviors, attitudes and fears (e.g., an MHA participant described not receiving help from a therapist who, rather than focusing on the adolescent's thoughts of suicide after his "first love" broke up with him, chose to concentrate on the fact that the relationship was with a same-sex partner)

In addressing these concerns, the toolkit has evolved into a vehicle for change. Using the toolkit itself, MHA started the Rainbow Connection group for individuals who are LGBTQ and have mental health problems. People welcomed the group in which their sexuality was "accepted" and where they felt they had the room to concentrate on recovery from their mental health problems.

The toolkit has also spurred other change at the MHA. Its policies have been examined and fine tuned. For example, it now includes gender identity as part of its nondiscriminatory practice policy and it has examined the use of restroom facilities, with increasing sensitivity to transgender issues. The growth has extended well beyond the walls of the MHA. In addition to reaching out widely with its toolkit and using feedback to improve it, the MHA has joined the LGBTQ Center in Kingston on several projects, most notably, a successful No Name Calling Week in the spring of 2010. This was an important protective approach aimed at non-heterosexual youth who have a high risk of being bullied, developing suicidal thoughts/actions, and becoming depressed.



There is no doubt that this area of cultural competency is critical to providing quality mental health services. Through vital partnerships, strong foundation support, and user feedback, the toolkit will endure and serve as a basis for creating a welcoming environment in which people who are LGBTQ can engage in care and work toward recovery. It will be a vital tool for staying attuned to each person's unique needs, and treating all people with dignity and respect.

To learn more about the toolkit, contact Ms. Pendegar at ependegar@mhainulster.com. Visit the MHA website at <http://www.mhainulster.com/adult-services.html>.

The costs of social services for persons with these chronic, disabling illnesses will likely continue to climb. The questions we must ask ourselves are not new, but they remain urgent: How can we ensure that mental health care is cost-efficient as well as effective for patients? How will we reduce homelessness, job loss, and incarceration? And perhaps most importantly, how much should we invest in disseminating effective treatments and finding better treatments in order to reduce these costs?

Thomas R. Insel, MD
June 2008 *American Journal of Psychiatry*

ity mental health services, and persistent disparities in the health status of racial and ethnic minority populations are influencing the well-being of our nation.²¹

The impact of mental illness is seen widely across the criminal justice system, where more than one-half of the jail inmates experience mental health problems and 16% of prison inmates have a mental illness.²² The impact is also seen in its overrepresentation among persons who are chronically homeless, with more than 60% having experienced lifetime mental health problems.²³ In 2003, New York City police officers responded to calls dispatched as involving a person designated as being "emotionally disturbed" (e.g., person in domestic violence situation, person in mental health crisis) every 6.5 minutes.²⁴

Though mental illness takes a substantial toll on individuals and families, it also has heavy economic costs: about \$317 billion each year. The indirect costs are staggering, with \$193 billion in income lost each year due to mental illness.²⁵ Thus, while health care costs are the greatest proportion of overall illness burden, they are a smaller portion of mental health costs compared with the indirect costs of NOT getting adequate care.

A report this year by the Rand Corporation examined the long-term economic consequences of childhood psychological disorders, revealing that mental health conditions cost a stunning \$2.1 trillion over the lifetimes of affected Americans.²⁶ Understanding the large toll that mental health problems and illness take across our nation and in NYS, we continue to focus on the components of good care.

What does good mental health care look like?

Good care is accessible

The delay of nine years between identifying mental health problems and becoming engaged in care would be unacceptable for any other health condition, and particularly when such delays contribute to lifelong disability. For many families, the challenge is how to get the treatment and support their children need in a timely way. When children display difficulty in regulating behaviors in preschool classrooms, for example, expelling them is not a productive answer—although too often it is the response. Rather, we should provide immediate support to children identified as having behavioral problems and to their teachers. Mental health professionals should be available to early childhood educators to promote healthy development, while reducing challenging behaviors. Parents and caregivers should have access to now-proven preventive resources, to gain the skills necessary for good parenting of kids with challenging behaviors.

Good care is personalized, continuous, and integrated

Having a mental health condition does not mean that life will be marked by chronic illness. Despite the evidence that some mental health problems can be long term and episodic in nature, the reality is that mental health problems are like other health conditions such as diabetes or multiple sclerosis. There may be times of good health and times when illness flares up. Learning to manage symptoms and adjust one's life to the illness is the essence of recovery.

Another essential element to recovery is having care based on continuous, healing relationships such as professionals and peers. Recovery is enhanced by providers and peers²⁷ who sustain hope, incorporate wellness into care, work at the healing relationship continuously, and communicate respect and hope.

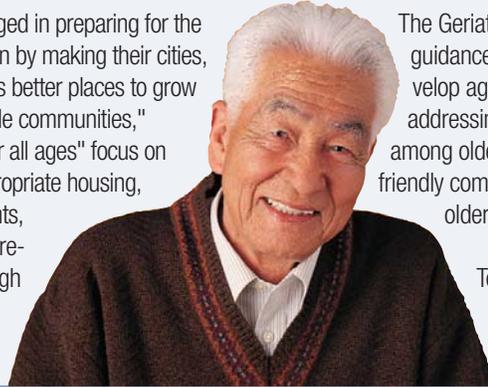
Although there are many pathways to recovery, several factors stand out. They include a home, a job, friends and integration in the community. They also include hope, relearned optimism and self-sufficiency.

Courtenay Harding
Beautiful Minds Can Be Reclaimed
New York Times 3/10/2002

Caring for older adults with mental health challenges

Over the next 25 years the population of older adults in the U.S. will double to the point that there will be roughly the same number of older adults as there are children.

Many local communities are engaged in preparing for the growth of the older adult population by making their cities, towns, villages, and neighborhoods better places to grow old. These efforts, known as "livable communities," "age-friendly cities," and "cities for all ages" focus on needs and amenities such as appropriate housing, safe and easy-to-walk environments, supportive services, social and recreational opportunities, accessible high quality health services, and adequate transportation. Unfortu-



nately, these efforts rarely address the importance of mental health for older adults, who cannot realize their potential to age well if they suffer from significant mental or substance use disorders.

The Geriatric Mental Health Alliance of New York offers guidance to communities desiring to strengthen or develop age-friendly communities. It includes information addressing mental and substance abuse problems among older adults, geriatric mental health in age-friendly communities, and the mental health needs of older residents.

To learn more, visit the Alliance website at <http://www.mhaofnyc.org/media/1251/agefriendly.pdf>.

Good care happens when a person's needs and preferences are met in a flexible manner with convenient access. Co-located general medical and mental health care, primary care providers who work in mental health settings, and mental health providers who work in primary care settings all help to promote good care. Good care is care offered by providers with the skills and knowledge to meet a person's cultural and linguistic needs.²⁸

Good care emphasizes the ability of each person to live, learn, work and participate fully in his or her community

Person- and family-centered care, medications, evidence-based behavioral interventions and psychotherapy help people manage their symptoms. Good care uses high-quality treatment and supports as the means to a more important end: helping people to figure out how to live their lives, build on their strengths, and learn to work around and manage symptoms. The best practitioners and programs emphasize person-centered/family-driven approaches that anticipate optimistic and realistic outcomes.

Work is an essential approach to wellness and greatly valued by people with mental illness. Employment leads to improved income, self-esteem and quality of life.²⁹ A recent study of supported employment, a nationally recognized clinical best practice, shows the huge therapeutic impact that work has on reducing health care costs.³⁰ Similarly, the work of children—school—is supported positively through attention to social and emotional development and learning as well as symptom remission.

As can be seen by the competitive employment picture for adults 18 years of age and older in NYS served during a one-week period in 2009, the low rates of employment, consistent with what is seen nationally, indicate the urgency of incorporating employment support into good mental health care.^{31,32}

A hopeful sign for continued movement toward good care, aligning mental health financing with evidence-based practices, is the recent passage of the Mental Health Parity and Addiction Equity Act of 2008. The legislation requires employer-sponsored health plans (specifically, large group health plans that already offer mental health and substance abuse benefits) to provide coverage for mental health and substance abuse conditions on par with other health prob-

Employment Status for Adults in Community Settings by Region, Survey Week 2009



Source: NYS OMH Patient Characteristics Survey

Breaking the silence

If you ask the creators of the Lake Success, New York, Breaking the Silence educational program, the best thing to ever happen was having the campaign break out of Lake Success and take off nationally and internationally.

Breaking the Silence is an educational program with fully scripted lesson plans, board game, and posters for upper elementary, middle and high school classrooms to educate students about the facts and myths of mental illness. The materials explain the causes, symptoms, and warning signs of mental illness; tell what a person can do to overcome the stigma associated with mental illness and help others; foster tolerance; and promote early intervention and treatment.

Many students have already had experiences with someone who has a mental illness, whether a family member, a friend, a school-mate, or someone attending a public event. The experiences and interactions with someone who has a mental illness can make children and adolescents feel discomfort and confusion because they lack knowledge about what is taking place. As the National Institutes of Health notes, many students also do not have a foundation for understanding that mental illness is biologically based and, therefore, not that different from other illnesses or diseases.

There is a great deal of variance in what students learn about mental health in schools—oftentimes not enough—and a scarcity of age-



appropriate curricula for teaching students about mental health as a part of overall health. To respond to the need, in the late 1990s, veteran teachers who are also parents of children with mental illness, created separate, engaging lesson plans, together with a board game and posters, for upper elementary, middle, and high school students. Through the tailored curricula, students learn the warning signs of mental illnesses, learn that mental illness can be treated successfully, and learn how to recognize and combat stigma. Breaking the Silence also has the relatively unique feature that it is delivered by regular teachers rather than by outside experts. The program has been available for more than 10 years and has been widely used across the U.S. and in other countries.

With funding from the National Institute of Mental Health, researchers recently examined whether middle school students exposed to the curriculum had improvements in knowledge, attitudes and/or behaviors related to mental illness. Just-published findings show that even brief instruction of 2 1/2-3 hours can change how students understand mental illnesses.

Overall, the research demonstrates that the curriculum is promising for improving the way children perceive and respond to mental illness by increasing knowledge and changing attitudes and behavior.

To read more about the evaluation or for further information about Breaking the Silence, go to www.btslessonplans.org.

lems, including standard medical and surgical coverage (e.g., out-of-pocket costs, benefit limits). New rules issued this year indicate that practices must be based on the same level of scientific evidence used by the insurer for medical and surgical benefits.³³ Moreover, the legislation encourages better coordinated primary care and specialty mental health care, promotes preventive services, fosters workforce development initiatives, and calls for other changes to improve the quality and availability of services that people receive. Overall, the law is a step forward for people with psychiatric disabilities and will be important in promoting recovery and resilience.³⁴

Good care rests on the principles of cultural and linguistic competence

The diversity of the nation is ever changing and growing. While about one-third of the population in 2000 belonged

to a racial or ethnic minority, by 2100 it is expected that approximately 4 out of 10 Americans will be non-Hispanic white.³⁵ This forecast makes more compelling the Surgeon General's findings in 2001, when he declared clearly that the devastating effects of mental illnesses touch people of all ages, colors, and cultures. Affirming that disparities in mental health services exist for racial and ethnic minorities, the Surgeon General underscored the reality that mental illness exacts a greater toll on the overall health and productivity of racial and ethnic minorities.³⁶

Person-centered care is perhaps more important in mental health than any area of health care, and an understanding of culture is a crucial element of individualizing care. The essence of good care lies in safeguarding individual rights and treating every individual with compassion, dignity and respect. Across the lifespan, access to and engagement in treatment services and supports require close attention to

In collaboration with the Ad Council, this public service announcement (PSA) is part of a larger multicultural public service effort begun in July 2010 to reach Hispanic/Latino, American Indian, Chinese American, and African American communities. The Center for Mental Health Services Office of Consumer Affairs worked with the National Network to Eliminate Disparities in Behavioral Health to develop messages that were culturally informed, meaningful, appealing and acceptable. The messages were designed each to have the greatest potential to penetrate and connect with culturally, racially, and ethnically diverse communities. To read more, go to http://nned.net/index-nned.php/NNED_content/news_announcement/multicultural_campaign.



personal and cultural characteristics such as ethnicity, race, age, gender, sexual orientation, and personal experiences such as trauma and abuse. Similarly, culturally and linguistically competent care for families are vital for addressing the many assets, needs and preferences of families engaged in care. In addition to a number of places throughout the Plan, Chapter 2 provides more information on the crucial nature of cultural and linguistic competence to good care.

Summary

To meet these expectations, we are steadfast in our commitment to a vision and principles that place people, families and loved ones, and communities at the heart of our system of services and supports. We look to strengthen individual and community mental health and well-being. We look to concentrate services and supports on individuals and their families, rather than on the service system itself.

Chapter 1 endnotes

- 1 People who have first-hand experience with mental health services use a number of terms to describe themselves, for example, consumer, survivor, ex-patient, patient, client and recipient. In this Plan, these terms may be used interchangeably, with an emphasis on the use of people-first language.
- 2 Deegan P. (1996). Recovery and the conspiracy of hope. Presented at the Sixth Annual Mental Health Services Conference of Australia and New Zealand in Brisbane, Australia. Available at <http://www.bu.edu/resilience/examples/index.html>.
- 3 Drawing upon the NYS Council on Children and Families definition of family, in this Plan “family” and “parent” describe persons who are bound together over time by mutual consent, birth, and/or adoption or placement. This definition of family emphasizes not only what families look like, but also equally, what they do in assuming responsibility for care, socialization, and support of one another. It is a definition that acknowledges and respects heterosexual and same-sex couples; lone-parent families; extended patterns of kinship, stepfamilies, and blended families; couples with children and those without. New York State early childhood plan: Ensuring a great start for every child, 2009.
- 4 New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America. Final report. Rockville, MD: Department of Health and Human Services Pub. No. SMA-03-3832. Available online at <http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf>.
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Facilitating Recovery and Resilience

Last year’s Plan highlighted the importance of recovery, resiliency, and stigma and discrimination to well-being. This chapter builds on these concepts by looking at facets of recovery and resiliency in the real world. Moreover, it seeks to re-energize interest in recovery, reinforcing the belief that recovery is possible and identifying areas where each of us can take action. This chapter explores the notions of cultural competence, wellness, employment, and community connections as crucial parts of any person’s life.

Before exploring these facets of recovery and resilience, it is important to know that several themes are woven throughout this Plan, and taken together reflect our collective efforts to create conditions that enable recovery and resilience to flourish. The themes are embodied in the Recovery Framework, illustrated here, and in the Child and Adolescent Service System Program (CASSP) principles outlined in the Children’s chapter of this Plan. The themes reflect a system of care oriented toward the provision of treatment and supports that:

- ◆ Regard the individualized needs of very young to older adults engaged in services and their families
- ◆ Are informed by science and show promise in producing positive outcomes and better lives for adults, children and families
- ◆ Integrate care across health, mental hygiene, social services, early childhood and educational settings, military, criminal justice, and specialty (e.g., care of older adults, children in day care) systems and focus on producing the best outcomes possible

- ◆ Take into account the diversity of communities in New York State (NYS), examine where disparities exist, move toward cultural congruence and reap the benefits of inclusive, culturally and linguistically competent services and supports

A Recovery Framework for New York State

National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation

<p>Hope Hope is the catalyst of recovery. People can and do overcome the barriers and obstacles that confront them. Mental health recovery is central to personal fulfillment in living, working, learning, and participating in community life, and to an enriched American society.</p>	<p>Individualized/Person-Centered Recovery takes into account each person’s strengths, needs, preferences, beliefs, traditions, experiences, and culture. It is a personal journey and a way toward wellness and optimal mental health.</p>
<p>Non-Linear Recovery reflects the natural ebbs and flows of life. It is based on awareness that change is possible, as are continual growth, occasional setbacks, and learning from experience.</p>	<p>Self-Direction Recovery is self-directed and reflects self-defined goals. To the greatest degree possible, people are in charge of their own recovery and draw on their own strengths and the support of others in determining their own paths toward recovery.</p>
<p>Respect Respect and regard for the dignity of each person ensures the inclusion and full participation of people with mental health challenges in all aspects of their lives. Acceptance, appreciation, rights protections, and elimination of stigma and discrimination are crucial to achieving recovery.</p>	<p>Responsibility People have responsibility for their own self-care and for their own recovery. This involves being courageous, gaining an understanding of and giving meaning to their individual experience, and identifying healthy coping strategies and healing processes to promote wellness.</p>
<p>Empowerment People choose from a range of options and participate in all decisions that will affect their lives, and they are educated and supported in so doing. They may join with others in speaking for themselves about their needs, wants, desires, and aspirations. They have control of their own destiny and the ability to influence the organizational and societal structures in their lives.</p>	<p>Peer Support Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Peer support provides a sense of belonging, supportive relationships, valued roles, and community.</p>
<p>Strengths-Based Our capacities, resilience, talents, coping abilities, and inherent worth form the basis for recovery. Building on these strengths engenders engagement in new life roles (e.g., partner, caregiver, friend, student, employee) and meaningful supportive and trusting relationships.</p>	
<p>Holistic Recovery encompasses a person’s whole life, including mind, body, spirit, and community. It touches housing, employment, education, family and social relationships, spirituality, creative endeavors, social networks, community participation, traditional and integrated physical and mental health services, and complementary and naturalistic services.</p>	

Facets of recovery and resilience: cultural competence, wellness, employment, and community connections

Cultural and Linguistic Competence

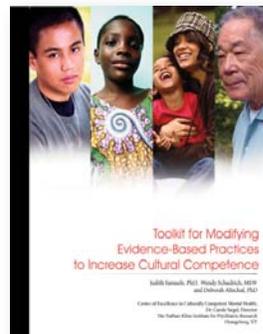
Cultural and organizational factors influence the use and delivery of mental health services.^{1,2,3} Culture affects how symptoms of mental illness are exhibited, the types of coping mechanisms used, social support received, and willingness to seek care. In addition, cultural and social factors, such as poverty, racism, and other forms of discrimination may impact mental well-being.

Obstacles to seeking and participating in care range from mistrust of the system based on previous experience, the stigma and discrimination associated with having mental illness, historical oppression, individual and institutional discrimination and differing ideas of what constitutes mental well-being and mental illness.⁴ Breaking down barriers, improving access, engaging people, and providing excellent care all lead to better use of services and improvements in the quality of people’s lives. Cultural competence—congruent behaviors, attitudes, and policies that promote cross-cultural efforts in groups, organizations, and systems—is seen as essential to eliminating disparities in mental health services and improving outcomes.^{5,6,7}

With funding allocated late in 2007 by the State Legislature, the Office of Mental Health (OMH) established Centers of Excellence for Cultural Competence—one at the Nathan Kline Institute (NKI) for Psychiatric Research and the other at the NYS Psychiatric Institute (NYSPI). Since their inception, both centers have been pursuing complementary research agendas to enhance the availability of culturally and linguistically appropriate services.

- ◆ The Center of Excellence at NKI (<http://ssrdqst.rfmh.org/cecc/>) focuses on adapting evidence-based practices for Latino, African American and Asian American populations. It also studies promising programs for cultural groups that have been identified by key community leaders, with the goal of bringing these programs up to the level of evidence-based practices (see Cultural Elements in Community-Defined Evidence-Based Mental Health Programs at <http://ssrdqst.rfmh.org/cecc/sites/ssrdqst.rfmh.org/cecc/UserFiles/DOCUMENTING%20CC%20IN%203%20PROMISING%20PRACTICES.pdf>). In 2009, the Center also made an important contribution to quality care by introducing a toolkit that aids in adapting evidence-based practices so they promote cultural

competence (see <http://ssrdqst.rfmh.org/cecc/sites/ssrdqst.rfmh.org/cecc/UserFiles/ToolkitEBP.pdf>). The Center also develops cultural competency measures and screening instruments and is currently validating a depression screening tool for Latinos in a New York City (NYC) primary care setting.



The Center contributes to the capacity for solid cultural research in NYS through its website, which provides a rich array of online resources such as cultural group maps and data, and full profiles of major cultural groups in the State; moreover, it is providing OMH with statistical tools for monitoring disparities.

- ◆ The NYSPI Center of Excellence (<http://nyspi.org/culturalcompetence/index.html>) dedicates its work to the study and development of culturally and linguistically appropriate mental health services for people in recovery from serious mental illness. The Center combines intervention, services, and community-based participatory research to improve service availability, accessibility, and quality of care. Among major research projects has been a community assessment of culturally and linguistically appropriate physical health services to individuals being treated for mental illness in NYC. The Center continues to add to its clearinghouse of issue briefs, with recent briefs focused on culturally tailored mental health literacy programs for Hispanics with limited English proficiency.



The OMH Bureau of Cultural Competence launched its online website this year, which acquaints visitors with the Bureau and its work (see http://www.omh.state.ny.us/omhweb/cultural_competence/about_us.html). With substantive support from its Centers of Excellence, the OMH Multicultural Advisory Committee, and an agency workgroup, the Bureau has nearly completed its first formal plan to promote cultural and linguistic competence and eliminate disparities. The plan seeks to eliminate, mitigate, and prevent mental health disparities experienced by traditionally underserved and underrepresented individuals, which is consonant with the OMH goal of providing services that

move children, youth, adults, and families toward recovery and resilience.

Complementing the plan development was a survey of counties this spring conducted by the Interagency Mental Hygiene Planning Committee. Following a presentation given to the group by the OMH Director of Cultural Competence, the Committee established cultural competence as a priority for improving the quality of care across the three mental hygiene agencies. Sixty of 62 counties responded to the survey. The data are providing OMH and its mental hygiene partners with opportunities to work synergistically in strengthening the delivery of culturally competent care and integrating culturally and linguistically competent care across all levels of the services system. A copy of the report is available in Appendix I.



Wellness

In January 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA) introduced its 10 x 10 Wellness Campaign to promote the importance of increasing life expectancy for persons with mental health problems by 10 years over the next 10 years.⁸ Why this goal?

With the introduction of the NYS Office of Consumer Affairs website this year, wellness resources have become highly accessible. In addition, visitors can find links to information sources compiled by and used with the permission of the New Jersey Division of Mental Health Services. Check them out at http://www.omh.state.ny.us/omhweb/consumer_affairs/lifespan/NJDMHS.html.



People with serious mental health problems are losing years from their lives due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care.⁹ A recent study confirms these findings, showing that people with serious mental illness lost 14.5 years of potential life, dying at an average of 73.4 years, while other people in the same community lost 10.3 years of potential life and died at an average age of 79.6 years.¹⁰

The disparity in years of potential life lost can be addressed and enable people with mental health problems to pursue optimal health, happiness, recovery, and full and satisfying community living. Effective services, supports, and resources that focus on improving overall well-being are essential.

The 10 x 10 Wellness Campaign highlights the importance of recovery from mental health problems. Wellness serves as a bridge to reducing the burden of mental health problems, illness and premature death. The Campaign presents a model of wellness conceptualized along eight dimensions. Built upon the Hettler model¹¹ and adapted and enhanced by Swarbrick and colleagues¹² from the Collaborative Support Programs of the New Jersey Institute for Wellness and Recovery Initiatives, the model features the following dimensions:

1. **Social**—having a sense of connection and satisfying relationships with family, friends and associates; being active in community affairs; and being in harmony with people and the environment
2. **Physical**—recognizing the need for physical activity, adequate sleep, and good nutrition; avoiding risky practices such as tobacco use, drug abuse, and excessive alcohol consumption
3. **Emotional**—having the ability to acknowledge feelings, strengths and limitations; having the ability to cope effectively with stress, challenges, and conflict
4. **Spiritual**—having beliefs and values that give purpose to life; looking for and coming to appreciate the meaning of life in the larger world
5. **Occupational**—deriving personal satisfaction and enrichment from one's work; achieving balance between work and leisure activities; enjoying work responsibilities
6. **Intellectual**—being challenged creatively and mentally; tapping into existing resources to expand knowledge, enhance skills, and share with others
7. **Environmental**—fostering good health by living in pleasant, stimulating environs that supports well-being



8. **Financial**—being satisfied with one’s current financial situation; having tools and knowledge for financial decision making, managing financial resources, saving money and building assets; and planning for the future

A variety of efforts at the national, state and local levels build on these dimensions and promote good health and well-being. In addition to the 10 x 10 Campaign, some of the more visible activities include stop-smoking programs, promotion of good medical care to prevent the development of obesity and diabetes associated with psychiatric medications, health literacy campaigns, and peer wellness coaching. More about these areas appear throughout this Plan.

BAM! Body and Mind

BAM! Body and Mind is an online website for kids between 9 and 13 created by the Centers for Disease Control and Prevention. BAM! gives children information to make healthy lifestyle choices. The topics engage children using kid-friendly lingo, games, quizzes, and other interactive features. BAM! also aids teachers, providing them with interactive, educational, and fun activities that are linked to the national education standards for science and health.



To learn more, go to <http://www.bam.gov/index.html>.

Employment

Mental wellness and mental well-being reflect our capacity to learn and grow, be creative and productive, form nurturing relationships, and make contributions to our communities. Work (and school, which is the main work of children) plays an important role in promoting our well-being.¹³ It is the medium for achieving personal goals and for having a sense of purpose in life.

While the experience of unemployment is complex and differs for many individuals and groups of people, the effects of unemployment are well documented in the literature. Studies show that people who are unemployed experience

poorer mental health outcomes and more signs of psychological distress.¹⁴ Research also reveals serious medical risks associated with job loss, including high blood pressure, heart disease, stroke and diabetes¹⁵ as well as increased mortality, especially from suicide or accidents.^{16,17}

The negative effects of not being employed—anxiety, depression, physical illness and a loss of self-confidence, along with the loss of structure, self-direction and identity—are heightened for people with serious mental illness.¹⁸ One of the most devastating effects of serious mental illness, furthermore, is poverty. While the causal nature of the relationship between mental illness and poverty continues to be studied, there does appear to be a bidirectional quality to it: The experience of living in poverty appears to contribute to poor mental health and people living with serious mental health problems are more likely to experience poverty.¹⁹ No matter which direction, research demonstrates that mental illness is detrimental to a person’s ability to earn wages. Effects include difficulties with finding work because of stigma, holding onto jobs especially when workers perceive that taking time away for treatment might be viewed by employers as being “unreliable,” and feeling unsupported by employers or colleagues who lack knowledge about mental illness.²⁰

Despite such challenges, not everyone with a serious mental illness is disabled by it and, even when disabling effects are experienced, people with mental illnesses want and need to work.²¹ Indeed, research shows that people with serious mental illness are able, desirous, and willing to be employed or engaged in other meaningful work.^{22,23,24} For people with the most serious mental health conditions, such as schizophrenia, nonetheless, unemployment rates reach 80 to 90%,²⁵ contributing to people with serious mental illness making up the largest group of people now receiving Social Security benefits.^{26,27}

A growing body of evidence is showing that serious mental illness does not need to lead to a life of dependency and disability benefits. Refined approaches to seeking and keeping competitive jobs, known as supported employment, are enabling people with serious mental health challenges and illness to participate in jobs they prefer, to the degree they desire, and with a level of support that enables their success. An important alternative to traditional sheltered workshops,²⁸ supported employment is designed to help people with serious disabilities find and keep competitive work in ways that are consistent with their strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.²⁹

One widely regarded model of supported employment is Individual Placement and Support (IPS). The competitive employment outcomes with supported employment, when compared to alternative vocational services, are better regardless of a person’s background and other clinical and employment characteristics. In fact, research shows that on average 61% of people with serious mental illness become

Factors promoting a mentally healthy workplace

- ◆ A culture and workplace that embrace caring, respect and support
- ◆ Policies and procedures that promote supportive practices
- ◆ Work approaches that foster peer relationships
- ◆ Accessible and supportive managerial practices
- ◆ Flexibility and adaptability of roles and workload to accommodate individual worker needs
- ◆ Effective management of workplace change and of transitions for individuals

From *Employees Perspectives on Mental Health in the Workplace* by McCollam, Maclean & Durie, 2003, Scottish Development Centre for Mental Health, Edinburgh.

employed when they have access to evidence-based supported employment, while 23% find jobs when they receive other types of vocational program services.³⁰ The IPS model is well researched, effective with young to older adults, and suitable in urban and rural communities. Features of the IPS evidence-based supported employment program³¹ include:

Supported employment is open to anyone with an interest.

Because motivation to work is predictive of success, people are eligible to participate in the face of psychotic symptoms, unmet personal presentation, recent job losses, substance abuse, missed mental health appointments, or other reasons.

Mental health and vocational services are integrated.

By co-locating employment and treatment services, the “treatment team” (e.g., case manager, psychiatrist, employment specialist) meets regularly to help find strengths-based solutions to problems. Family participation in the team helps with identifying strengths.

Benefit planning is comprehensive and ongoing.

People enrolled in the program are given accurate and comprehensive information about the impact of earned income and work incentives on their specific circumstances. They also are offered ongoing help with benefits planning and management as their goals and jobs change.

Client preferences are important.

Employment specialists honor the preferences of individuals engaged in services (e.g., type of work, job location, work hours) and spend time in the community with them to learn more about them as individuals.

Competitive employment is the goal.

Supported employment links people to regular jobs in the community—not jobs created for people with disabilities—and to part- and full-time work that pays minimum wage and more.

Job searches are rapid.

Employment specialists help clients to begin their job searches within a few weeks of their first appointment; people engaged in the program are not asked to take part in vocational evaluation, work adjustment programs or prevocational groups.

Follow-along supports are continuous.

Employment specialists collaborate with each person to develop an individualized plan of follow-along services, and meet with clients, helping them to be successful and make progress in the world of work. When granted permission by a client, the specialist may also provide support to the employer. Once a client has been working successfully, he or she may transition to a case manager or another practitioner for ongoing support.

Clients are supported when they make job changes.

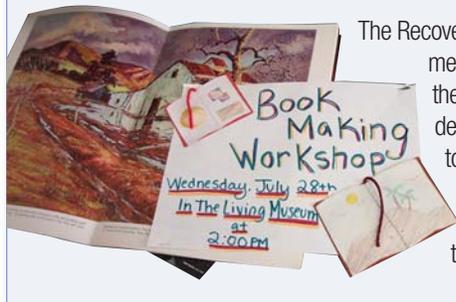
When clients lose jobs, they are supported in their choices by the employment specialists and mental health teams so they can learn as much as possible from the experience and obtain help with finding other jobs. Employment specialists also help clients with career planning and advancement.

The importance of families and peers to the success of supported employment is beginning to be seen nationally. Peers are stepping into the role of employment specialists, bringing their lived experiences to helping others. They are providing supportive functions and conducting groups that enable people in competitive employment to discuss shared concerns and deal with common work issues. The Dartmouth University IPS Supported Employment Center—in partnership with Johnson & Johnson, the National Alliance on Mental Illness (NAMI), and three states—is examining ways in which families can promote supported employment and advocate for high-quality supported employment services for their loved ones.

Nurturing Recovery: The Recovery Center at Rockland Psychiatric Center

On any weekday, the first floor South wing of Building 57 is abuzz with activity. It holds hope for people like Donna, who has thrived in her role as a member representative of the Recovery Center. In this leadership role, she has designed the Center's brochure and oversees the production of its monthly newsletter. She appears in the Recovery Center's Public Service Announcement (PSA) on YouTube and a TV talk show featuring the Recovery Center. She volunteers for the National Alliance on Mental Illness (NAMI) and is a speaker in its In Our Own Voice program. Kudos to Donna. She has worked hard to achieve all of this, while still being hospitalized and attending the Recovery Center outpatient program at Rockland Psychiatric Center.

full and independent lives. In addition to special consideration for persons hospitalized in the Psychiatric Center, the Recovery Center also accepts people already living in the community who wish to work on recovery goals.



The Recovery Center assists members to recover the skills and confidence that will lead to their success in moving back into their communities and leading

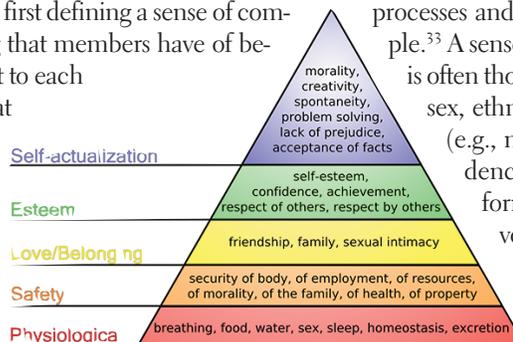
The Recovery Center focuses on employment and volunteerism, skills development, health and wellness management, access to community resources, and the creative arts through its Living Museum. The Recovery Center is peer run and structured around a series of recovery-oriented work units, co-led by staff and peers. Everyone works toward the shared value of promoting individual recovery goals. For example, members' charts are literally their charts, where they write daily notes detailing their activities and accomplishments, and their own monthly progress notes based on their own person-centered recovery goals. The success of the

Continues next page

Community Connections

Most of us are familiar with Maslow's Hierarchy of Needs, proposed more than six decades ago, whereby human needs are ordered from the most basic to the more complex. Within the pyramid, Maslow illustrated and described our fundamental human need to belong, to be a part of a community. The social needs of love and belonging are represented as the third level of need—the desire to be accepted, build relationships, form friendships, become a part of peer and other groups, achieve intimacy, have families and connect to our communities.

Since Maslow's seminal work, much attention has been focused in the literature on a sense of community and the psychology of human relationships, including social support, social networks, social ties, and social exclusion. McMillan and Chavis are credited with first defining a sense of community in 1986 as "a feeling that members have of belonging and being important to each other, and a shared faith that members' needs will be met by the commitment to be together."³² The four dimensions of a sense of community they described include:



- ◆ **Membership** essentially confers a sense of identity, emotional support, and a commitment to the good of the community.
- ◆ **Influence** connotes a give-and-take process. While individuals affect a group's decisions and functioning, the group also has influence over members.
- ◆ **Satisfaction of needs and integration** occur when people experience the benefits of membership (e.g., status of belonging, opportunity to tap into mutual values).
- ◆ **Shared emotional connection** results from sharing experiences and taking part in events that lead to emotional connections and bonds.

Community connections can be thought of as a social phenomenon rooted in psychological, social, and cultural processes and interactions that take place between people.³³ A sense of community is interpreted diversely and is often thought of in terms of demographics (e.g., age, sex, ethnicity, time living in community), location (e.g., neighborhoods, schools, rehabilitation residences, senior centers) and processes (e.g., informal networks characterized by their voluntary nature).

Research demonstrates time and again that having opportunities to form meaningful relationships and participate in

Center stems largely from the talent and energy of its members who are supported by a caring staff. The collaborations have yielded wonderful results:

- ◆ As noted in the introduction, members of the Center, along with members of the Psychiatric Center Consumer Advisory Board, filmed a PSA to address concerns about stigma toward people with mental illness. The PSA was written directly by members from discussions about what they felt was important to convey and what they wanted to get out of the experience. The YouTube address for the PSA is <http://www.youtube.com/watch?v=zPH3Qt2uSqs>.
- ◆ One member, a certified public accountant, provided members with a budgeting workshop.
- ◆ Three members of the Center and a staff member attended a Social Security and benefits seminar, after which they designed



social networks are crucial for healthy functioning and longevity.

A review of nearly 150 studies by researchers from Brigham Young University published this summer, for example, indicates that when people have strong ties to their families, friends and work colleagues, they have a 50% lower risk of dying over a given period than those with fewer social connections.³⁴ The researchers also found that weak community connections and not having many friends are harmful to health, just as with smoking, alcohol abuse and obesity.

It is well documented that people diagnosed with mental health conditions often experience difficulties in forming and sustaining relationships and their social circles tend primarily to include mental health professionals, family members, and peers with mental health problems.^{35,36} Further, people with serious mental illness are subject to stigma and discrimination, as well as the effects of poverty and poor health, making it difficult for them to participate meaningfully in social and community activities.³⁷

Despite real challenges to community connection and integration, persons with serious mental health conditions do have opportunities for mutual support, self-help, and participation in peer-run programs. They are also able to be a part of natural support networks in communities, such as Compeer, faith-based groups and schools. The nurturing of social support and community connections—whether by

a series of informational workshops they are now offering to the Recovery Center community.

- ◆ Two members and the Center's Director were featured on Health First, a TV show currently showing in Westchester County.
- ◆ Members and staff visited Fountain House in NYC and now are using the experience to introduce new ideas, for example, structuring email addresses on individual computers to promote better member communication.
- ◆ Members participating in the community access unit have been shown by their leaders how to read bus schedules and maps and then they have been accompanied on trial runs. One member reported afterwards, "I took my first bus ride in eight years, and I feel great."
- ◆ Members held the Center's first Open House during the summer. A member who ran her own events planning company taught others how to make a balloon arch for the entrance and members decorated the space with their own artwork. The Center choir performed songs and members also provided tours for guests from the community. Three paintings from the Center's Living Museum sold at the Open House, and all proceeds went to the artists.

If you would like to know more about the program, please contact Inge Curran, Deputy Director of the Recovery Center, at (845) 680-8120.

professionals, loved ones, or friends—is especially important for the health, well-being and resilience of persons challenged with serious mental health problems. As we consider ways we all can help strengthen community connections for people with serious mental illness, we might wish to be guided by some key questions posed by psychologist Sam Goldstein:³⁸

- ◆ Where are my connections located? How well balanced are they?
- ◆ Who are the people in my life with whom I feel most connected? In what ways do I feel connected to each?
- ◆ What do I do to express and demonstrate feelings of connectedness, keeping the relationships I value vibrant and alive?
- ◆ What activities in my life help me to stay connected and be a part of my community?

Just as important as examining community connections in our own lives and helping people with mental health conditions to do the same is the integration of social well-being measures into regular medical care. A regular physical exam, for example, may serve as an important point for medical professionals to identify when clients might benefit from enhanced social relationships and community connections.³⁹

Still rolling with it . . . Schenectady County's resiliency continues to grow one year later

As the one year anniversary passed in the aftermath of what has been classified as a "Suicide Cluster" in Schenectady County, Director of Community Services, Darin Samaha, reflected on the event, the impact it had on the community, the continuing challenges and the tremendous gifts that have emerged from the tragedy. (See "Becoming resilient: One community's journey to recover from tragedy" on page 70 of last year's Plan at http://www.omh.state.ny.us/omhweb/planning/statewide_plan/2009_to_2013/full.pdf.)

The most immediate and important impact continues to be the collaboration that occurred when representatives from all agencies convened a task force to review events and responses on a daily, weekly, biweekly and monthly basis depending on the needs and crises of the day. While tension in the group was initially discernable, over time a common cause resulted in a shared cohesion to keep kids alive.

A special clinical team, first formed to review 150 high risk kids on a weekly basis, has remained intact. The kids come and go off the list, but the team and its goal—to continuously assess, review and take action on behalf of 120 youth who may be in trouble—remains.

A task force of community partners consisting of the police, probation, mental health, social services, school and interested citizens formed to manage the initial crisis, remains together and active. The task force is critical, since it is the key organizing force in the community when problems occur. Members of the task force now relate to each other quickly and freely. For example, when two youngsters in the City became victims of a shooting recently, the event triggered an immediate alert and notification went to the entire community outlining resources and supports available to affected families and friends.

While more than 400 staff and community volunteers were initially trained in screening, assessing and treating youth at risk of suicide, the training activities continue. An additional 100 people have been trained over the past year, as the County moves toward meeting its goal of providing this training to 1,500 or 1% of the population in Schenectady. Right now, more than 1,500 people

have received training on topics from the basics of suicide prevention to the use of the Columbia University Suicide Severity Rating Scale. Training continues to play an important role in the suicide prevention efforts.

Drop-in centers, both in the community and in the high school, opened to create opportunities for kids to have a place to express themselves creatively, have a physical outlet for exercise and express their feelings in a positive way. The goal is always to reach more kids earlier, to identify problems before they become tragedies.

Despite the ongoing challenges, one year later, "Divine Intervention" is obvious. Two parents in the community, one of whom had a child who completed suicide, have organized events and activities, including the "Peaceful Summer Kickoff" to help keep kids safe. As more and more community members become involved, the watchfulness of this community gains strength. In the year and a half since all the activities began, there has not been a loss of life of a child in this community due to suicide contagion.

There is no time to be complacent, however. Lessons such as establishing a blame-free environment, shared expectations of collaboration and mutual support, and a strong network of support for children and youth are being applied to other populations, including at-risk adults. The goal is to create a more integrated system of care for all citizens in the Schenectady community that has grown stronger through the experiences it has been provided.

Strategic framework

In the 2009-2013 Statewide Plan, OMH presented a newly revised strategic framework that included substantial input from OMH advisory bodies and numerous external organizations (e.g., YOUTH POWER!, New York Association of Psychiatric Rehabilitation Services, Mental Health Empowerment Project). Stakeholders provided valuable feed-

back on how best to reflect a recovery orientation in the framework and were instrumental in guiding OMH toward this goal. More information on the process used in developing the revised framework appears in Chapter 5 of the 2009-2013 Statewide Plan at http://www.omh.state.ny.us/omhweb/planning/statewide_plan/2009_to_2013/Chap_5.pdf.

This past spring, stakeholders revisited the revised framework and offered suggestions to make it even stronger. Refinements incorporated upon the recommendation of stakeholders are described in Appendix 2.

As with every chapter, Chapters 3 and 4 (adult services and children and family services) continue highlighting a number of examples of a system of care in recovery through

the eyes of providers and programs. By no means do these chapters serve to capture every program and initiative, which is well beyond the scope of this Plan. Rather, they draw attention to approaches people say are making a difference in their lives and the lives of their families and loved ones. The chapters bring emphasis to ways in which the innovation

Family support, friendships and community connections

Friendship Network is the brainchild of Alice Cohen, inspired by difficulties experienced by a member of her family. Recognizing that establishing a social life is a crucial part of recovery, Alice founded Friendship Exchange, now Friendship Network (FN), close to 25 years ago to bring people together for the purpose of friendship and socialization. (See Matchmaker's Niche in the December 14, 1992, issue of the NY Times, at <http://www.nytimes.com/1992/12/14/nyregion/matchmaker-s-niche-the-lonely-mentally-ill.html?pagewanted=all>.)



Nancy Schlessel and FN member, Mildred – walking for the Friendship Network Team at the NAMI Walk, May 2010.

Today the Network is managed by Alice with Barbara Garner and Nancy Schlessel, LMSW, who share the goal of helping to alleviate the isolation and loneliness experienced by its members, adults living in the community with mental illness. The Network serves the five boroughs of NYC, Long Island, Westchester County and Northern New Jersey, introducing men and women recovering from mental illness to one another for the purpose of friendship. In addition to individual introductions between members, FN provides a weekly cultural discussion or socialization activity group. The Network enables its members to strengthen social skills, develop



Friendship Network Fitness Class – Group lesson followed by the group going out for a snack and conversation at a local diner.

friendships and gain the confidence necessary to expand their social horizons beyond the Network. FN identifies that establishing a social life is a crucial part of a member's recovery and the ability to be independent and successful.

FN staff continuously speaks with members on the phone, providing ongoing feedback throughout the socialization process. At any given moment, they serve about 200 individuals and offer help with the logistics of travel or where to go and what to do. Sometimes, a member needs to be eased into a situation by role-playing. Once a member meets a new person, he or she must report back to the FN staff. If there is any hint of a potential difficulty, a call is made to the therapist immediately. As would be expected with this type of work, Alice, Barbara and Nancy are empathetic, sensitive, caring, supportive and personable.

A member of the Network captured its importance in a recent newsletter submission:

What the Friendship Network Means to Me

A friendship can be like a flower, beautiful and sweet. It only needs a warm hello to start out and make it grow. Throughout the year I've been with FN I've made many new friends and enjoyed some fun and exciting events. For me personally, it's been a long time since I've had so much to do. Because of this, the loneliness faded and blossomed to brightness and hope; the sun came shining through. I know others may have similar feelings.

Friendship Network is an organization that really creates friendships and enjoyment. It can keep you busy and help you stay away from the negative feelings that brought you to the group to begin with. I hope FN stays in existence for a very long time because the smiles and happiness it can bring is truly something to be cherished. My thanks to FN and all those involved with it that make it the special and fun place that it is.

FN is an integral part of NAMI Queens/Nassau. To learn more about the Network and how it is making a difference in the lives of its members, go to <http://www.friendshipnetwork.org/>.

and hard work of providers are producing positive outcomes and better lives for the people they engage in services.

Chapter 5 updates ways that OMH is working in partnership with localities and its sister mental hygiene agencies

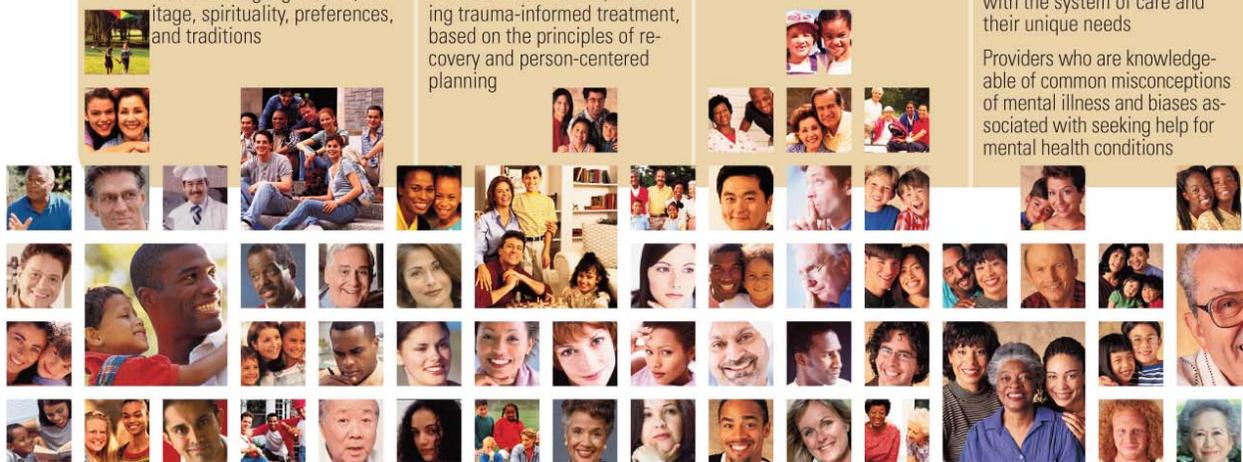
to promote stronger systems of care and advance integrated mental health services. Chapter 6 emphasizes directions for strengthening quality and accountability. As with last year's Plan, the final chapter provides more guidance in how we



STRATEGIC FRAMEWORK

	People First	Person-Centered Decision Making	Basic Needs Are Met	Relationships
Goals	Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.	Provide supports and treatment based on self-defined needs, while enhancing personal strengths.	Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.	Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.

Desired Outcomes	<p>The expectation for personal growth and recovery, resilience, and confidence that life's challenges can be met</p> <p>Trusting relationships that demonstrate respect for individuality and validate humanity</p> <p>Regard for the importance of people-first language and training that reinforce their importance for recovery, resiliency, and person-centered care</p> <p>People being well educated about recovery and having easy access to recovery information</p> <p>Joint recovery-oriented training, with recovery dialogues between clinicians and people engaged in services</p> <p>Services and supports that respect and meet individual, cultural and language needs, heritage, spirituality, preferences, and traditions</p>	<p>With clinician guidance, develop self-directed, family-driven and youth-guided plans of care that capture personal interests, preferences, and goals</p> <p>Ability to assess personal capabilities, strengths, values, culture, beliefs, spirituality and preferences</p> <p>Inclusion of family, significant others, and natural supports as desired in recovery-oriented treatment planning</p> <p>Ongoing review and adjustment to treatment plans and measurement of progress toward goals</p> <p>Access to and the ability to review and comment on health records</p> <p>Access to clinicians adequately trained to deliver care, including trauma-informed treatment, based on the principles of recovery and person-centered planning</p>	<p>Finding and keeping safe, affordable housing from among a broad range of housing opportunities</p> <p>Resources to support employment, training, and educational goals (e.g., on-the-job training opportunities, educational stipends and scholarships)</p> <p>Ability to access skills that would help in meeting education, work and community activity goals</p> <p>Truly being a part of the community in which one lives</p> <p>Access to clothing, shelter, reliable transportation, income, health and other resources essential for daily living</p>	<p>Ability to maintain normal life roles (e.g., parent, student, employee) outside of the mental health system and experience family connectedness, and satisfying peer and personal relationships</p> <p>Ability to tap into community resources and activities that enable growth and recovery</p> <p>Availability of public education to increase awareness of mental health challenges, the reality that people can and do recover, and to eliminate stigma, discrimination and racial disparities</p> <p>Availability of community partnerships to promote social integration and mental well-being</p> <p>Participation by families in training providers and clinicians about their experiences with the system of care and their unique needs</p> <p>Providers who are knowledgeable of common misconceptions of mental illness and biases associated with seeking help for mental health conditions</p>
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can work toward taking action, how we can help build empowering services from the ground up. It does this by featuring change taking place in one system of care in NYS.

The appendices offer resources and concrete information to assist in these efforts. (To read about Mission, Vision and Values, see the tabloid framework posted with this plan.)

Providing mental health care to New Yorkers that embraces diversity, transformation, recovery and resilience

Living a Healthy Life	Mental Health Treatment and Supports	Self-Help, Peer Support, Empowerment	Mental Health System of Care, Workforce and Accountability
<p>Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.</p>	<p>Foster access to treatment and supports that enable people to lead satisfying lives in their communities.</p>	<p>Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.</p>	<p>Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.</p>
<p>Development of personal assets, abilities and plans to avert unhealthy stress and crises</p> <p>Access to tools, education and training for developing wellness (recovery) plans necessary to succeed in meeting personal goals</p> <p>Access to education and training on advance directives and support, if desired, for developing advance directives</p> <p>Access to alternative, healthy approaches to wellness (e.g., yoga, meditation)</p> <p>Accessible community respite, peer respite, crisis services, warm line and peer support in emergency rooms and other settings</p> <p>Access to regular physical health assessment and services for people with mental health challenges and improved integration of physical and mental health care</p>	<p>Access to treatment that is not forced, rather to treatment that includes the innovative and safe alternatives to healing and recovery</p> <p>Informed choice as the cornerstone of treatment decision making</p> <p>Ready access to a wide array of evidence-based treatments and supports that aid productive community living</p> <p>Care for mental health and co-occurring disorders that is seamless, integrated, and delivered by staff trained in co-occurring disorders</p> <p>Care that is integrated and well-coordinated across social services/child welfare, health, education, criminal/juvenile justice, mental health and other systems of care</p> <p>Access to trauma-informed practices, treatment, and supports</p>	<p>Access to peers in recovery to provide hope and support to other persons in recovery</p> <p>Access to self-help, empowerment, naturally occurring support groups, peer support and peer-run services</p> <p>Policies, practices, research and funding that provide access to self-help, peer support and peer-run services</p> <p>Access to employment and meaningful work for persons who have been or are engaged in mental health services</p> <p>Peers that work alongside of clinicians and make evident that people can and do recover</p>	<p>A diverse workforce that believes in recovery, demonstrates recovery competencies, improves the quality of care, and creates cultures where recovery is highly valued</p> <p>Participation of people who have received/are receiving services in delivering provider training and continuing education</p> <p>Incorporation of effective recovery-oriented practices into professional training and academic curricula</p> <p>Strong stakeholder participation in developing state and local mental health planning, policy/funding, practice and research</p> <p>Well-developed recovery standards, ongoing surveys and assessments of care, and regular licensing reviews of mental health programs</p> <p>Clear, accessible, and simple processes for filing complaints and formal grievances</p>

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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

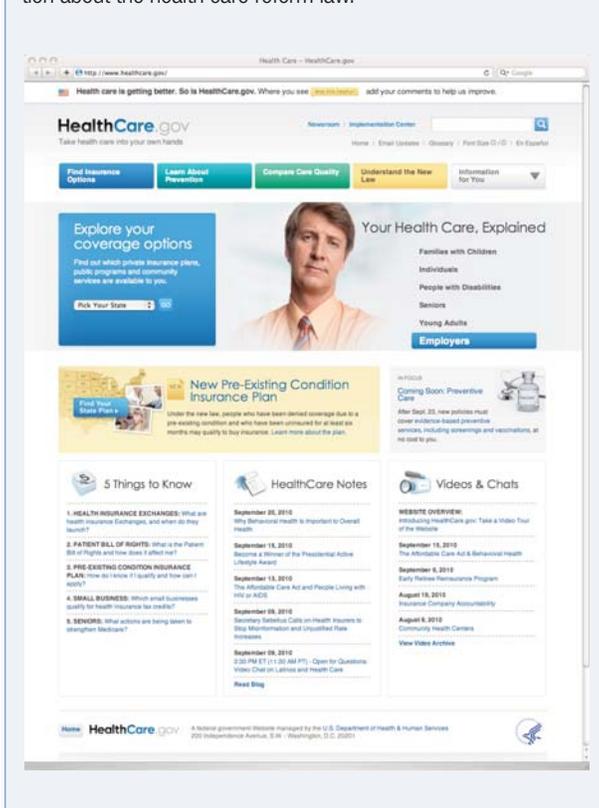
- ◆ Increase the number of people who can qualify for the mental health services under Medicaid (most of these individuals are already covered in New York, which greatly expanded Medicaid eligibility in recent years prior to federal reform)
- ◆ Promote better coordination of primary care and mental health 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

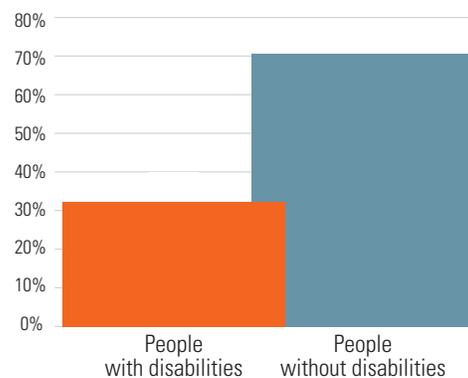
through Education” program required each student to have a commitment from an employer for consideration of employment upon completion of training. Students were given the opportunity to complete the course work via full-time study or on a part-time basis to gain the necessary skills, knowledge, and 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%.

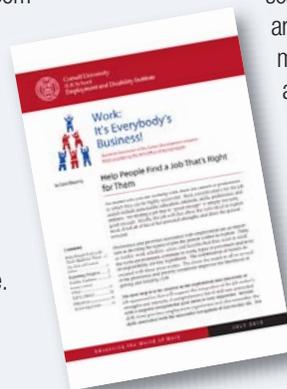
PROS relies upon a person-centered, strength-based recovery culture that incorporates both professional and natural supports. Services are individualized; the person being served is a partner in choosing supports, skill-building activ-

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.



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/>

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.”⁷³¹ 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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Services for Children and Families

Children’s mental health care has undergone significant changes over the last 30 years, both nationally and in New York State (NYS). Incorporating a public health approach into mental health policy and program design is one crucial development. Research demonstrates that prevention and early recognition, intervention and treatment in natural settings yield better results. It shows that an investment in children’s social and emotional development today produces success and avoids costly, long-term failures.

Confirming these findings, a report last year from the National Research Council and Institute of Medicine called for federal leadership in making a national priority the prevention of mental, emotional, and behavioral disorders and promotion of mental health in young people. Disorders such as depression, anxiety, conduct disorder, and substance abuse in children and adolescents are about as “common as fractured limbs in children and adolescents.” In terms of treatment and lost productivity, they cost our nation an estimated \$247 billion each year.¹

Making effective investments in children’s mental health care is as challenging as in the adult system of care. Despite substantial spending, a large portion of children and youth—between 75 to 80%—in need of services do not receive them.² Even though research strongly supports the value of evidence-based prevention and early intervention services,³ funding is targeted more toward traditional intensive and expensive services such as hospital

and residential care. For instance, there continues to be a large imbalance between spending on community and residential care, despite knowledge that early identification and intervention lead to the best outcomes.

In the face of such challenges, the Office of Mental Health (OMH) continues its focus on aligning children’s services with the vision and values articulated in The Children’s Plan. Enhancing these efforts is a group of stakeholders that is working with OMH to continue to achieve change in the system. The Children’s Ambulatory Workgroup—composed of providers, other state agencies, advocates, family members and youth—is providing feedback about the ambulatory system for children and their families. The Children’s Ambulatory Workgroup has recommended improve-

ments in the day treatment, waiver, and case management services and to the single-point-of-access (SPOA) initiative. In 2011, stakeholders will look in more detail at models for improving waiver, case management and SPOA. It is anticipated that new day treatment regulations will be advanced in 2012.

Synergy created through these efforts and a strong network of family advocacy and support have continued to sustain a system that concentrates on prevention, early intervention and home and community care, while striving to provide inpatient and residential care for children in need of intensive services.

Surprising Facts

- ◆ Major mental illness may occur as early as 7 years of age.
- ◆ About one-half of all lifetime mental health disorders start by the mid-teens.
- ◆ Children and youth from diverse racial and ethnic groups and from families with language barriers are less likely to receive services for their mental health problems than white children and youth.
- ◆ Sixty-seven to 70% of youth in the juvenile justice system have a diagnosable mental health disorder.
- ◆ Children and youth in military families tend to have higher rates of mental health problems, with problems being more pronounced during a parent’s deployment.
- ◆ Preschool children face expulsion rates three times higher than children in grades K–12, due in part to a lack of attention to their social-emotional needs.
- ◆ More than 10% of high school dropouts are attributable to mental health disorders.
- ◆ About 3 out of 10 youth expressing thoughts about suicide in the prior year receive mental health services.

National Center for Children in Poverty, Children’s Mental Health: What every policymaker should know. Available online at http://nccp.org/publications/pdf/text_929.pdf.

Population with SED in Children Served Weekly in NYS

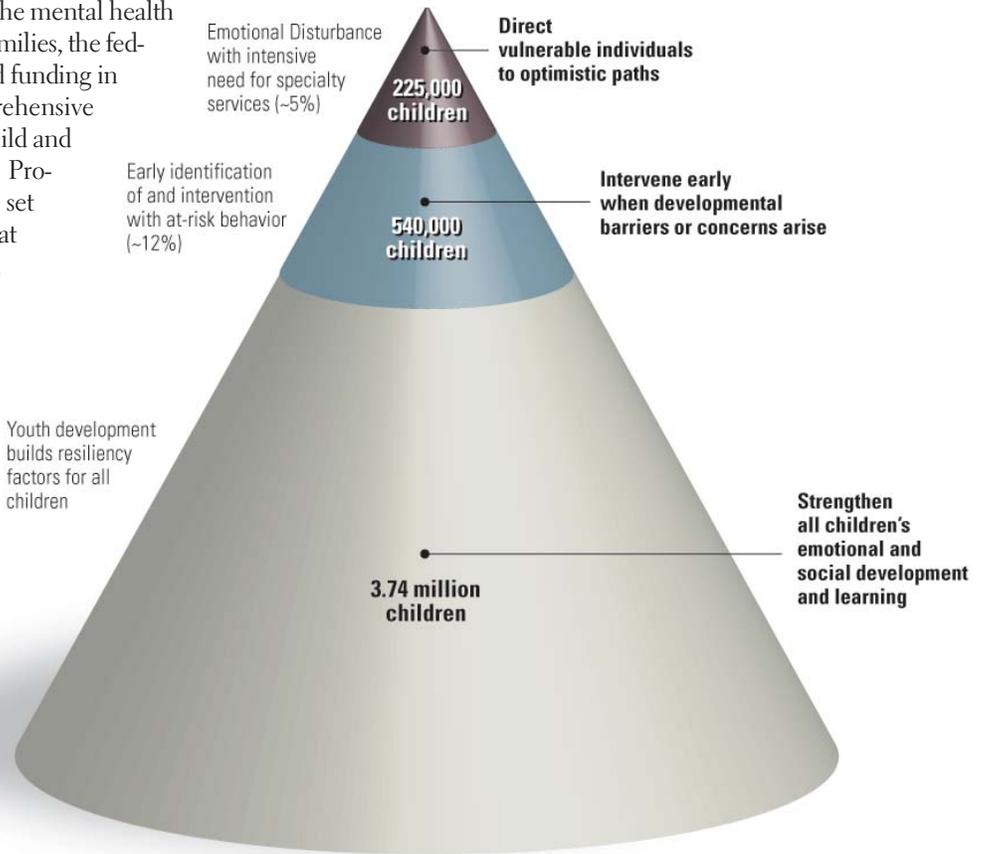
	Age 8 and below	Ages 9–17	
	SED Served	Prevalence of SED*	SED Served
Western Region	956	42,446	3,708
Central Region	686	27,687	2,669
Hudson River Region	955	50,211	3,695
New York City Region	2,812	111,963	9,610
Long Island Region	248	43,576	1,803
Statewide	5,657	275,884	21,485

Source: OMH Patient Characteristics Survey, 2009
 * From U.S. Census Bureau 2008 population estimates.
 Children with serious emotional disturbance (SED) = 12% of child population, ages 9-17.
 U.S. Department of Health and Human Services, Mental health: A report of the surgeon general.
 A prevalence rate for children between ages 0–8 has not been estimated.

Values and principles underlying effective care

To be more responsive to the mental health needs of children and their families, the federal government appropriated funding in 1984 to build such a comprehensive system of care. Called the Child and Adolescent Service System Program (CASSP), the program set forth principles of care that have guided service provision since.

The CASSP values recognize that preserving mental health and promoting well-being begins before children are born, throughout each stage of normal growth and development from the youngest years to older adulthood. This life-course perspective suggests that there is an intricate interchange between biological, behavioral, psychological and social risk and protective factors that contribute to health status



Visual Framework for social emotional development and learning in New York State (0-18yrs population 4.5 million 2006 US census estimate)

across the span of a person's life. Being cognizant of the trajectory our lives may take from the earliest of years provides opportunities to reduce risk and bolster protective factors. Public health approaches and interventions make a difference in ultimately creating communities that are strong, healthy, and thriving.⁴ The values espoused under CASSP, therefore, bring recognition to the importance of developing and supporting resilience and developmental assets within a system of care.

The values guide services and supports that are family-driven and youth-guided, community-based, culturally and linguistically competent, and evidence informed. Principles underlying these values specify that services provided to children, youth, and families should be comprehensive, integrated, and coordinated; individualized and flexible based on the strengths and needs of the child and family; provided in the least restrictive, appropriate setting; based on families as full partners in all decision making; focused on early identification and intervention; and accountable, demonstrating positive outcomes.⁵

More recently, attention has shifted to adapting recovery principles from the field of adult mental health for youth and their families. Such an orientation brings youth a sense of hope and optimism about their futures.⁶ Moreover, it is being increasingly recognized as crucial to youth development and wellness, where, for example, studies show that up to 59% of young people with post-traumatic stress disorder (PTSD) going on to develop substance abuse problems.^{7,8}

While some believe that the concept of recovery lacks a developmental perspective, many youth, family members and providers find that the integration of recovery into system-of-care principles is “value added.”⁹ Hope is a crucial element of successful maturation and development, particularly during transition from adolescence to adulthood.^{10,11} Similarly, hope is an integral piece of resilience.

Research findings from long-term studies show that at least one-half, and often close to 70%, of youth growing up in high-risk situations develop the resilience to go on to live successful lives.¹² When nurtured and supported, resilience enables young people to do well in school, maintain friendships and other relationships, and find success in employment, even when they may be struggling with significant mental health challenges. It also equips youth to handle transitional experiences, like moving to a new school, going into a residential placement, or breaking up with a boyfriend or girlfriend.

Responding to Adolescent Needs: CASSP Principles with the Addition of a Recovery Orientation

- ◆ **Comprehensive**—Address developmental, physical, emotional, social, spiritual, educational, and concrete daily living needs (e.g., housing).
- ◆ **Individualized**—Center on the needs of child and family, based on strengths and assets; reduce risks and increase factors that are protective; and consider positive family and community contexts.
- ◆ **Least Restrictive, in the Community**—Draw on formal (e.g., mental health) and informal (e.g., religious group) supports to promote successful community living.
- ◆ **Culturally and linguistically competent**—Recognize and respect behaviors, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, preferences and characteristic of particular groups of people.
- ◆ **Early Intervention**—Promote social and emotional development; screen, identify early, and intervene in a timely fashion.
- ◆ **Family-Driven**—Promote family-led decision making and planning.
- ◆ **Youth Guided**—Nurture the capacity of young people to be effective self-advocates, managers of their own lives, and active participants in treatment planning and service coordination.
- ◆ **Service Coordination & Interagency Collaboration**—Provide families with support to navigate service systems in their communities, and collaborate with other systems to foster integrated care.
- ◆ **Protection of Rights**—Encourage respect and regard for decision making, safety, and effective evidence-based treatment and acceptance of differences.
- ◆ **Support for Transitions**—Prepare youth for adulthood through social and emotional skill development, attention to reducing risks and enhancing protective factors, and more support through transitional periods.

Adapted from The concept of recovery: “Value added” for the children’s mental health field

The public health approach

As noted above, an important shift in the children's mental health system is toward a public health approach. While continuing to meet the needs of children diagnosed with serious emotional disturbance requiring high levels of care, the children's system in NYS emphasizes the promotion and prevention of mental health challenges. This new emphasis continues to be fueled by the aims of reducing mental health problems when they have been identified and helping every child to have the best possible mental health. Improving each child's overall health, capabilities, and strengths may promote better function and satisfaction into adulthood. Such improvements can also carry substantial benefits for

society from economic well-being, greater global competitiveness and national security, and improved quality of life.¹³

The public health approach is being accomplished mainly through a sustained focus on social and emotional development. The goal is to be more proactive and support children's mental health, rather than being reactive to a diagnosed mental illness. Further, the public health approach requires that we recognize that a child's social and emotional development is equally as important as brain and physical development. Like other important developmental milestones—such as walking and talking—the development of social and emotional skills takes time and practice. Unlike learning to walk and talk, however, social and emotional skills are not as easy to see.¹⁴ The public health approach re-

Faith and hope: PASS it on

In Broome, Erie and Monroe counties, youth are attending classes that go well beyond reading, writing, and mathematics. These youth are uniquely involved in classes that help them deal with life's lessons.

Called Prevention, Access, Self-Empowerment and Support (PASS), this innovative program was created in the mid-1990s to support positive social and emotional development, academic success and community participation in teens experiencing emotional and behavioral challenges or teens whose parents are diagnosed with serious mental illness. In working with parents and children together, the program seeks to improve their relationships in culturally respectful and sensitive ways. It builds on the strengths of the child and family and fosters their abilities to believe they *will* be successful.

When you listen to youth and parents talk about PASS, you begin to realize the value of a curriculum that is tailored to youth and family needs and delivered by adult and youth mentors and skilled community members. (The curriculum focuses on life skills areas such as goal setting, discipline, interpersonal communications, and affirmation.) The PASS "way of doing business" is to ensure that relationships between the youth, family and program are based on mutual respect.

One mother spoke of her family's recent journey through the PASS program. Her son was a graduate of the class of 2009. When she saw that he was having difficulty, she just didn't know where to turn for help. Fortunately, she learned that her nephew had graduated from the PASS program three years before, so she checked it out. "The biggest thing I have learned is that you look for the good in a situation. I had to learn and embrace this rather than to focus on the negative." She enjoyed parent support groups where she found she was not alone and could "kick around ideas." She noted how she came to appreciate that "not only does the child need to change, but also the family."

Her son smiled as he recalled his early days in PASS. "I wasn't really excited about the program, but talking with my peers and peer mentors helped me to warm up to it. These people are my family." And, he continued to beam as he added, "I'm doing better in school and I am communicating better with my mother. I'm thankful for that."

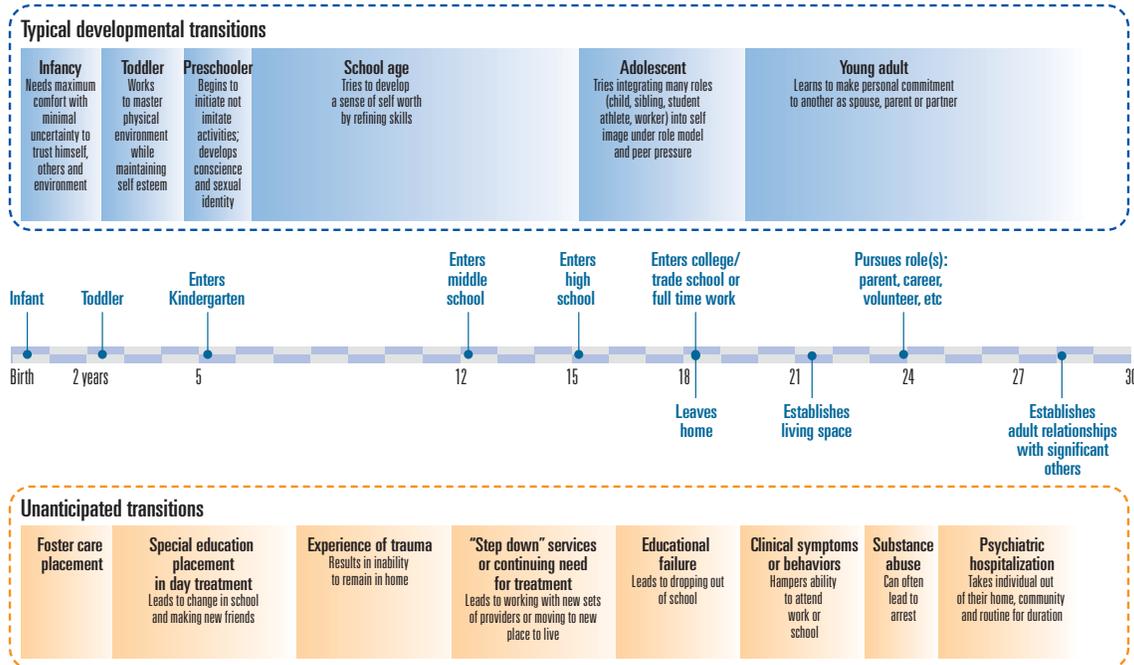
Another PASS youth participant, now a peer mentor, proudly described how he is "paying it forward" and giving back to the program. A graduate of the class of 2004, he hated school and joined PASS "to get away from his parents." Little did he know then that he would take its lessons to heart, actually grow closer to his family, and become a mentor and help others.

Coordinated Care Services, Inc. of Rochester manages the program on behalf of the Monroe County Office of Mental Health. The program, which serves the entire state, is rooted in the beliefs that teens can be empowered to make informed choices, learn and use skills that enable successful community living, serve as examples for other youth who are experiencing difficulties, be active in improving communications with parents and family members, and work effectively in an environment tailored to the unique and cultural needs of youth.

"What we do is magic," says Program Director Neville Morris, "but the real magic comes from the youth. PASS gives hope."

PASS was recognized May 3, 2010, by OMH during Children's Mental Health Day, and celebrated as a "program uniquely impacting the lives of young people and families." To learn more about the PASS program, contact Lenora Reid-Rose, Director, Cultural Competency & Diversity Initiatives at Coordinated Care Services, Inc., in Rochester at lreid-rose@ccsi.org or go to <http://www.ccsi.org/cultural-linguistic-competence.aspx>.

Transitions across the early lifespan:
viewed from developmental and mental health imperatives



quires that we integrate the identification of mental health challenges into our systems of care the same way we do checkups for hearing, vision, and teeth.

Promoting social and emotional development is an immense undertaking. It involves supporting healthy development and well-being, identifying challenges when they arise, and intervening early. It takes families, surrounded by a close-knit community of caring adults who support the family's efforts to help the child grow and prosper. Parents, partners, family members, teachers, doctors, clergy, social group

leaders, and friends all contribute to the social and emotional well-being and resiliency of children.

Recognizing that systems of care—education, child welfare, juvenile justice and others—do share responsibility for policies and practices for children and their families, nine NYS Commissioners of agencies serving children and their families came together in 2008 to collectively endorse a plan to redefine children's mental health. The Children's Plan reflects cooperative goals to break down barriers between systems and achieve social and emotional well-being for all children throughout NYS.

Rites of passage in Wyoming and Suffolk counties: Fun-filled summer days

For many families, a rite of passage for their children is the summer camp experience—going on scavenger hunts, learning to paddle a canoe, singing songs around the campfire, performing skits on rainy days, and making friends that last a lifetime.

For the last eight years, this rite of passage has been at the core of Camp Get-A-Way in the 4-H Camp Wyomoco setting. Affiliated with Cornell Cooperative Extension, the camp is located in beautiful Wyoming County and been home to a safe, supportive, and recreational camping experience for families of children diagnosed with serious social, emotional or behavioral challenges.

One mom relates how after adopting a child who has a mental health diagnosis, she met Pam Brannan, President of the Camp Get-A-Way Board of Directors, and Nancy Craig, Parent Advisor of the OMH Western New York Field Office. "They're my

angels," she says, as she describes how much she, her husband, and all the kids learned and what real fun she and her family could have together. The entire family has driven the seven-to-eight hour drive each year from Long Island to attend. "It has given me hope. I



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see that other families do it and I can do it too.” One of her children says the drive was “definitely worth it,” adding that Camp helped her to be more “patient and understanding” of her brother.

Camp Get-A-Way is a place where families go to rediscover the joys of being a family and experience the comfort of being a part of a close-knit community where children can explore new interests, learn essential life skills, be encouraged to improve peer relationships and relationships across the lifespan, gain experience as leaders, and simply gain pleasure from just being children. The camp also provides adults with opportunities to strengthen parenting skills and be with other adults who share the delights and challenges of parenting children with special and unique needs. It’s a supportive, normalizing environment that brings hope and happy memories, and it lets “no one fail.”

In each of three summer sessions, families drive from all around the State to spend four days and three nights together, and the October Columbus weekend for two nights and three days. The camp is entirely run by volunteers, from all occupations, and from the entire state, including people and agency staff from the Wyoming County community (e.g., offices of mental health, aging, social

services). Camp activities are family driven and based on the “Learn, Use and Teach” philosophy. They encourage adults, children and youth to learn about rights and responsibilities, become knowledgeable about how to achieve them, and to flourish with natural community support that promotes success.

The good news is that this year, families from Long Island and neighboring downstate communities were provided with another option. The newest Camp Get-A-Way opened in June 2010. A collaboration with the Episcopal Diocese of Long Island, Camp De-Wolfe is located in Wading River overlooking Long Island Sound.

All in all, Camp Get-A-Way in Wyoming and Suffolk counties are where families and children’s dreams come true. “I just wouldn’t have it any other way,” says one of its enthusiastic campers.

Camp Get-A-Way was recognized May 3, 2010, by OMH during Children’s Mental Health Day, and celebrated as a “program uniquely impacting the lives of young people and families.” To learn more about Camp Get-A-Way, contact Board President Pam Brennan at campgetaway@buffalo.com. You may also visit its web site at <http://www.cgaw.org/>



The children's plan

The Children's Plan evolved from legislation requiring OMH to create a strategic plan for the next five to ten years for improving services to children and their families. What began as the "Children's Mental Health Plan" turned into a broad cross-systems, multi-stakeholder document recommending fundamental changes in the way we do business. The Plan directly reflects the knowledge and expertise of young people, parents and caregivers, family members, educators, community leaders, youth development experts, youth service providers, advocates and State policy leaders from multiple agencies.

Serving as a call to action, the Plan charges child-serving systems to act in accordance with the values it set forth. The recommendations focused on changing the face of children's well-being and mental health by ensuring the achievement of important developmental milestones and healthy growth. They called for expansion of supports and services for youngsters and their families from infancy to young adulthood. They emphasized the importance of prevention, early identification and effective interventions. They stressed the value of enabling smooth transitions during growth and development. They also acknowledged that promoting children's social and emotional development does not rest within any one agency, but rather is the responsibility of all.

Since the Commissioners of the child-serving state agencies¹⁵ stepped up to the challenge, they continue to focus on their common goal of promoting children's social and emotional development and learning. As noted in last year's Statewide Plan for Mental Health Services, Governor Paterson signed legislation amending the Children's Mental Health Act, which captures the more holistic nature of the plan and incorporates the involvement of all nine child-caring agencies and family and youth partners. It invested responsibility for coordinating activities among the agencies and stakeholders in the Council on Children and Families (CCF). It also gives CCF, with the assistance of OMH, the role of developing future reports and plans for The Children's Plan.

Under the leadership of CCF and the Statewide Director¹⁶ of the Children's Plan, work progresses in the Commissioners' Committee on Cross-Systems Services for Children and Youth. Agencies remain focused on a set of joint initiatives to increase community awareness of social and emotional development; enhance youth, family and parent involvement and education; provide consultation and training on children's mental health in the other service systems; and expand our capacity to provide effective mental health services. The initiatives aim to reverse patterns such as child neglect, preschool expulsion, in-school violence, and institutionalization. Below is a summary of some major Plan activities under way.

Promoting Wellness in the Early Years

Historically, the children's mental health system has not played an active role in early childhood programs and services for children under the age of 5 and their families. The Children's Plan, however, highlights the growing need to support young children who are having serious problem behaviors. As a result, OMH has become more engaged in two early childhood efforts through its participation in the State Early Childhood Comprehensive Systems Initiative and Early Childhood Advisory Council.¹⁷ One involves an Office of Children and Family Services (OCFS) Community Demonstration Project to support training and implementation of social and emotional development consultation in four early childhood programs in the State. The other involves Project LAUNCH, one of the more recent initiatives to take form under The Children's Plan.

Project LAUNCH: Energizing Systems Serving Children and Their Families

Research shows that infants and young children raised in healthy, secure, nurturing environments grow up to have more productive lives, contribute positively to their communities and raise healthy children themselves. Investing in the social emotional learning and development of children early is likely to be more effective and less costly. Fortunately, NYS was awarded last fall a \$4.25 million grant over five years for Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) to strengthen the physical, emotional, social, cognitive and behavioral well-being of New York's youngsters. Project participants include CCF, Department of Health (DOH), OMH, OCFS, and several partner organizations in Westchester County.

Project LAUNCH builds on existing innovation in Westchester County. Through the County Community Network—a unique wraparound service system for children and families—it seeks to strengthen and enhance early childhood systems in three County locations: the large city of Yonkers, the small city of Port Chester, and the village of Ossining. This approach is examining how municipalities of different sizes, with different infrastructures and resources, can support a holistic approach to childhood wellness. The three target areas comprise culturally and linguistically diverse immigrant and minority populations. Families are often medically underserved, with parents often holding two or three jobs and struggling with acculturation issues, especially when English is their second language.

Overall, the project seeks to integrate programs that together provide a complete range of developmentally supportive services to families with young children. Health care, home visiting, parenting education, and early care and education programs are being expanded to locations where they are missing, strengthened where they exist, and integrated

Helping youth to reach new heights: The Respite Wilderness Program

Challenging hikes are not for the faint of heart, particularly for youth dealing with serious emotional and behavioral health challenges. But, a program out of the North Shore Child and Family Guidance Center is helping youth to see their strengths one step at a time.

Now in its 12th year, the Center's Respite Wilderness Program is engaging adolescents with serious emotional disturbances in healthy and demanding outdoor group experiences. The program has been helping to fill a vital gap in the lives of these children and their families. Often families are hard pressed to find activities and structure for their teens who just don't fit into usual teams or clubs and who are at risk for isolation. Without wilderness activities, they would likely spend time alone in their bedrooms in front of computers or television screens.



The Center offers 36 Saturday wilderness challenges each year to youth between 12 to 18 years of age. The program uses the trails, beaches and mountains of County and State parks in NYS, where classrooms and office walls are replaced by trees, trails, sand, mountains, lakes and streams. Social workers and leaders actively participate in the day's challenge with the youth, and all are subject to the same physical and climate challenges as the rest of the group. The wilderness

group experience is a powerful "rite" of passage for youth, leaders and the entire group. Each experience is unique.

On one hike, Joey had a particularly difficult time climbing a steep, rocky incline at Harriman State Park. Frightened, hyperventilating and whimpering, he repeatedly cried, "I can't do this!" But he wasn't alone. With the help and patient support of the group leader

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across disciplines to achieve the vision articulated in two State plans—the Early Childhood Plan and The Children’s Plan—that have each received strong endorsement from NYS’s child- and family-serving agencies.

To learn more about Project LAUNCH, go to <http://projectlaunch.promoteprevent.org/> and to learn more about the Westchester County children’s system of care, read the annual report at <http://www.westchestergov.com/MentalHealth/pdfs/AnnualReport2009.pdf>.

Enhancing the Youth Voice

During The Children’s Plan development, youth offered essential recommendations for shaping a person-centered, family-driven and youth-guided system of care. During discussions then, youth pointed to the value of empowerment, advocacy and peer support to their recovery. They called for more peer support programs and services, indicating that when youth serve as trainers, advocates, and policy makers, they improve the system, and gain necessary developmental and professional skills needed for success.

In recognition of the important role of youth in helping to strengthen recovery-oriented services and supports, this year, through Families Together in NYS, young people are being hired and have begun to be introduced into OMH regions as “Regional Youth Partners.” The Regional Youth Partners are responsible for supporting local youth groups, hosting regional forums for youth to connect with each other and network, and providing technical assistance and training. Regional Youth Partners are expected to bring their own unique experiences with receiving mental health services and to use them in developing as peer support specialists for children engaged in services.

Supporting Primary Care Physicians in Treating Children and Their Families

Through funding provided under The Children’s Plan and in collaboration with DOH, Conference of Local Mental Hygiene Directors, American Academy of Pediatrics and the NYS Academy of Family Physicians, psychiatric consultation is being made available to primary care physicians (pe-

and other youth in the group, Joey inched his way up, step-by-step, crawling when he was too scared to stand, until he reached the summit. His experience stayed with him, when two weeks later, during discussion of a future hike, Joey requested that the group hike the same difficult, terrifying trail. Having thought often of the hike, he discovered a new-found sense of pride in his accomplishment. He was visibly proud for pushing himself far beyond what he considered his physical and emotional limits. He expected that he would be able to hike up that same trail again, but this time without fear—and he did!

The Respite Wilderness Program is designed to provide Saturday respite for families whose children have serious emotional and behavioral conditions by offering youth engaging wilderness activities that bolster confidence and competence. It promotes social skills, helps youth to understand what mutual support truly means, provides opportunities for identifying difficult behaviors and adopting more healthy coping mechanisms, builds a sense of belonging and camaraderie, and enables youth to make contributions to their community through environmental conservation.

Adolescents are referred to the program by local mental health centers, intensive case managers, probation officers, day treatment programs, foster care and group homes, private clinicians, school personnel, parent advocates and others working with youths who are troubled, in trouble or causing trouble. Youth who participate have an array of emotional and behavioral disturbance diagnoses; some have emotional disturbance and developmental disabilities. With some teens participating up to two to three years, the program’s leadership

has been consistent under its founder and coordinator, Bruce Kaufstein. And, for the past five years he has had the same co-leader and a number of volunteers including other agency staff members.

The leadership ensures that hikes and activities maximize the potential for successful completion by all members, even the weakest, and are safe and appropriate for members’ physical abilities. The program also promotes “greening” ecology and conservation projects on Long Island. This includes assisting park officials at Caumsett State Park to contain the aggressive, invasive “Mile a Minute Weed.” It also involves collecting plastic bottles and debris on Beach Clean-Ups at Robert Moses State Park. Actively participating in environmental projects reinforces the capability of each youth to contribute to the “greening” of society.

The good news about the program is that youth eventually realize how far they have come from being isolated in their bedrooms playing computer games to mastering difficult challenges and making a difference. Just stop by the Center some time and see the smiles and gleaming faces of group members when they watch the DVDs of their conservation efforts and painstaking steep mountain climbs. The smiles attest to their accomplishments, achievements and pride, but they don’t stop there. They continue as the youth share these filmed chronicles with friends and family.

To learn more about the Respite Wilderness Program, contact Bruce Kaufstein, LCSW, Director of Clinical Services and Respite Wilderness Coordinator, at bkaufstein@northshorechildguidance.org.

Where children are encouraged to mend their hearts

Through its trauma-informed programs, the Jewish Board of Family and Children's Services (JBFCS) is making a difference one child at a time. "Now that I feel safe," one child served in residential treatment by JBFCS shyly says, "I want to help animals."

It does not seem unusual that a child who has gained a sense of security and trust would seek to help others, whether people or animals. It is the power of being in a culture of healing that helps to mend hearts at JBFCS.

Clinical treatment at the JBFCS residences encompasses a wide variety of therapeutic methods, including individual and family therapy. The trauma-based treatment model called Sanctuary® encourages a safe, therapeutic environment for healing the scars left by the trauma experienced in the lives of these young people.

At the heart of the healing culture are commitments to nonviolence, safety, and compassion; social and emotional learning and development; development of trust and respect for boundaries; social responsibility; and the capacity to cope positively with change.

Helping to create this culture is the staff of the JBFCS Center for Trauma Program Innovation, which provides training, information and consultation about state-of-the-art evidence-based trauma services and treatment approaches throughout New York City and NYS. Since its founding in 1998, it has developed innovative programs that address family, community and societal violence and the impact of disasters and terrorism. The Center is a program of the Martha K. Selig Educational Institute, the training and education center of JBFCS. The Center for Trauma Program Innovation promotes the development of new trauma services for children and their families, both on the local and national level. Over the last three years, it provided

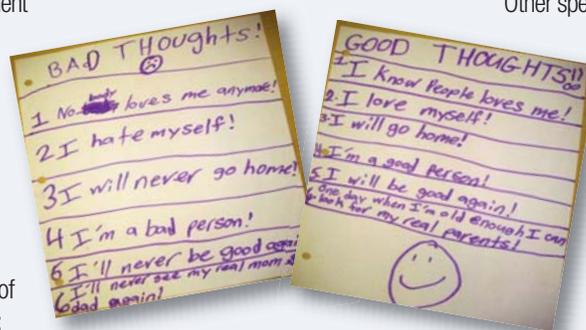
trauma training to more than 5,000 professionals from both JBFCS and community agencies and schools.

Training areas include grief and loss in children and traumatic bereavement; cognitive behavioral therapies and school interventions, incorporating play therapy, and parenting skills programs; the needs of lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth in treatment and the creation of safe, affirming and therapeutic environments for LGBTQ youth; disaster first aid and coping, with attention to suicide risk assessment; and an array of trauma offerings (introduction to trauma and PTSD, community trauma, assessment and treatment, complex trauma and more).

Other specialized treatment models such as art therapy, music, dance, and drama programs, as well as writing groups are utilized to help the children and adolescents express their feelings and deal with their trauma. An example of how training is translating into clinical care can be seen from among the children's contributions to a "Stop the Violence" art project. As the accompanying art work shows, young children can and do use

art to understand where feelings reside and, in doing so, deepen their awareness of the relationships between thoughts, feelings and actions. The art work poignantly shows how training translates to treatment practices directed toward nurturing growth and compassion and helping children deal with the traumas in their lives.

The JBFCS Center for Trauma Program Innovation was recognized May 3, 2010, by OMH during Children's Mental Health Day, and celebrated as a "program uniquely impacting the lives of young people and families." To learn more about the Center for Trauma and Innovation at JBFCS, contact its Director of Trauma Services and Training, Christina Grosso, at CGrosso@JBFCS.org or visit the website at http://www.seliginstitute.org/course_inv.html.



pediatricians and family physicians) who treat children and youth with emotional and behavioral conditions.

Primary care physicians are often the first point of contact for families seeking help and information about their children's emotional and behavioral health. While primary care physicians do provide a majority of treatment to children with emotional and behavioral issues, many of these providers lack the expertise and necessary training for dealing with complex psychiatric needs of children.¹⁸ To support the critical role that pediatricians and primary care physicians are playing in identifying and treating emotional dis-

turbances in children, OMH, in collaboration with its partners, is supporting Project TEACH (Training and Education for the Advancement of Children's Health). Project TEACH aims to link primary care physicians with child mental health experts across NYS. The goals are to provide ongoing training and consultation services to better meet the mental healthcare needs of some children seen in primary care practices and to provide a mechanism for systematic referrals to specialists for treatment or supports for children requiring complex care and their families.

Project TEACH services are being provided by the University Psychiatric Practice (of the University of Buffalo) and Four Winds Foundation. The University Psychiatric Practice represents an innovative and unprecedented partnership of academic medical centers to support this initiative: the psychiatry departments from the University of Buffalo, University of Rochester, Columbia University, State University of New York Upstate Medical University in

Syracuse, and Long Island Jewish/North Shore University Health System. The partnership also includes the REACH (Resource of Advancing Children's Health) Institute, which is supporting the training component. From these academic centers, consultation and training are being provided to physicians in their respective geographic regions.

Mobile services offering hope and support for Capital District families, children and youth

Any day in Schenectady, Albany and Rensselaer counties are two teams of mental health specialists quietly responding to children, youth and families and helping them find solutions that fit their needs. Their offices are often the homes and streets of their communities, wherever a family with a child or youth—particularly youth up to age 18 who have both mental health challenges and developmental disabilities—is experiencing a crisis or struggling with uncontrollable behavior.

Founded in 2007, the Parsons Child and Adolescent Mobile Crisis Team (CAMT) serves any family whose child or adolescent is having an emotional/behavioral health crisis at home, or even in emergency care settings. The CAMT staff provides consultation and information, crisis assessment, intervention and stabilization. When necessary, it helps to find alternate levels of after-crisis phone support to help the family plan next steps for preventing or dealing with future crises. An important focus of CAMT is to ensure that the children are safe and receiving support to get them through the crisis.

Underlying the work of CAMT is the guiding principle to assist children and families in the least intrusive, least traumatizing manner possible. "It's all about the child, parents and siblings," says Richard Johnson, CAMT Project Director. Families, he adds, are pivotal to resolving crises. "It is essential that families have hope and have their strengths recognized. Our job is to support the family, and be in and out, except for follow-up."

Youth and families are helped in different ways. When called upon by the police to respond to a distressed teen who was voicing suicidal thoughts, the CAMT immediately went to her home to help. The team quickly formed a relationship with the young woman, assessed her mental health status, and worked with her and her parents—



CAMT staff provide consultation and information, crisis assessment, intervention and stabilization.

who were out of state for the day—to come up with a plan to manage the situation. The safety plan they developed required the constant presence of an adult family friend until her parents were able to return home. Follow-up care by the CAMT case manager involved

connecting the young woman to an outpatient therapist with whom she was willing to work. This was an important milestone, because the young woman had rejected offers of help up to this point.

The consultation, assessment, crisis intervention, and stabilization services offered by CAMT are the result of a collaborative, intergovernmental program of the three counties. It is managed by Parsons Child

and Family Center and operates between 1:30 to 9:30 p.m., Monday through Friday. CAMT services can be accessed via each county's system of care and links to its providers.

The outcomes are impressive. Since its start, 8 out of 10 youth receiving CAMT services have been diverted from a higher level of care and remained at home in their own communities. Children presenting at the crisis intervention unit of the Capital District Psychiatric Unit during the same period (for the hours of CAMT operation) declined by 7%. When a higher level of care was required to maintain wellness and safety, CAMT teams were able to facilitate appropriate services. And, the program has resulted in cost savings while delivering effective services and supports.

The Parsons Child and Family Center CAMT program was recognized May 3, 2010, by OMH during Children's Mental Health Day, and celebrated as a "program uniquely impacting the lives of young people and families." To learn more about CAMT, contact Mr. Johnson at johnsor@parsonscenter.org or visit the CAMT web page at the Parsons website at http://www.parsonscenter.org/site/PageServer?pagename=programs_mobile_team.

Integrating Treatment for Youth with Co-Occurring Disorders

Co-occurring substance abuse and mental health disorders are highly prevalent in adolescents and difficult to treat. Without effective interventions, youth with co-occurring disorders generally have poor outcomes and are at greater risk for medical and legal problems, contact with the criminal justice system, school difficulties and dropout, unemployment, poor relationships, and suicide. Today, many mental health clinicians are ill-equipped to handle youth with substance abuse disorders, and conversely chemical abuse counselors are unable to adequately address the mental health needs of the youth they serve.¹⁹

Work continues on implementing recommendations from the OMH and OASAS Task Force on Co-occurring Disorders Youth and Adolescents Report (http://www.omh.state.ny.us/omhweb/resources/publications/co_occurring/). Since issuing the report, OMH has continued its partnership with OASAS, facilitating use of an evidence-based substance use screening tool in outpatient settings. It has also held joint statewide train-the-trainer education with a cadre of chemical dependency and mental health clinicians on adolescence and co-occurring disorders. Future activities include ongoing training to promote integrated care across systems, consideration of motivational enhancement training, and opportunities to advance the Task Force recommendations.

Showing Promise for At-Risk Youth

Nationally recognized practices for school success are being piloted in NYS via the Promise Zones initiative. Through targeted delinquency prevention funding from the Division of Criminal Justice Services, the Promise Zones initiative is rooted in promoting school engagement and success for high-risk youth. A collaboration spearheaded by OMH and the State Education Department, the initiative aims to mitigate the powerful risk factors for time out of school due to truancy, suspension, expulsion, or arrest, and poor school performance. As such, when implemented in Syracuse, NYC and Buffalo this fall, the designated Promise Zones will strive to connect high need youth with necessary community-based supports; create learning environments that engage students so that they are on task and ready to learn; and alter school culture and climate in ways that foster individual social and emotional competencies, school attendance and achievement.

Already established Promise Zones are participating and focusing on improving access to critical community-based resources. They are striving to facilitate access to community resources that provide the right services at the right time. Aiding this effort will be instructional and student support teams. The partnership at the State level will help to incor-

porate evidence-based practices that are associated with student engagement, academic achievement, and dropout prevention in schools serving at-risk children with high need.

Finding Community Solutions

In July, OMH and OCFS announced a comprehensive solution to address the chronic need for community-based mental health alternatives in Brooklyn for children and their families. The overall plan also responds to a lack of intensive residential treatment in NYC for court-involved youth who have mental health problems.

The plan is designed to dramatically improve mental health care for children and youth, creating the first-of-its-kind State-operated comprehensive mental health center to serve 600 children and their families each year, helping to avoid disruptions to families caused by the overuse of institutional care. Located at the Brooklyn Children's Center, the new center will offer clinic services, counseling and family therapy, community-based brief crisis care for youth, intensive day treatment and family and home-based support.

The plan also calls for the first residential treatment facility in the State dedicated to serving youth in the juvenile justice system with major mental health needs. Currently, many of these children are far from home in upstate facilities. The new 24-bed residence will be located on the campus of Brooklyn Children's Center in a distinct space separate from the outpatient mental health programs.

Finally, the plan will expand the overall mental health services capacity in the other boroughs of the City. It will create a new State-operated mental health clinic at Bronx Children's Psychiatric Center to serve 250 children. It will expand intensive case management services in Queens and in the Bronx. It will also add a small number of beds at the Bronx Children's Psychiatric Center, Queens Children's Psychiatric Center, and South Beach Psychiatric Center.

Other vital children's services

Day-to-day operations of OMH's Division of Children and Family Services are guided by the values underlying The Children's Plan. Among Division goals are strengthening ties between family and youth and the work of the Division, improving access to psychiatric consultation services, enhancing data-informed decision making and nurturing workforce skills and competencies. These priorities are being addressed by a number of ongoing initiatives, a few of which are highlighted below.

Espwa fè viv: Hope makes life

The devastating earthquake that struck Haiti on January 12, 2010, was characterized as the worst in more than 200 years, leaving the country in shambles. The Haitian government reported that an estimated 230,000 people died, 250,000 were injured, and nearly one quarter were made homeless. As the country and the international community reacted to the chaos and destruction, family members in Brooklyn, home to one of the largest Haitian communities in the nation, braced for the worst. Survivors—adults and children—who left Haiti and joined family members in NYC recounted the trauma and fears they experienced. Some of these children and children who were relatives of survivors attended schools where the Interborough Developmental and Consultation Center operates Clinic-Plus and outpatient services programs.

Interborough immediately responded with psychological first aid. Bilingual psychotherapist Tatiana Michel, LMSW, recalls that the days after the earthquake at Brooklyn Tilden High School campus. “There was a dark cloud over the school, an uneasy silence and anxiety.” The crisis intervention team introduced art and music therapy to reach out, identify and support students coping with traumatic stress. The team also reached out to parents and caregivers, providing education, engaging with them, and securing parental consent for treatment when assessed as being clinically appropriate.

Out of the care and concern, children and youth expressed their fears and discussed their experiences. Children and youth described seeing neighbors and friends in Haiti “dead on the streets everywhere.” They talked about the horrible smell and seeing bodies “collected like they were trash and dumped in big holes.” Children and youth said they worried about

family members in Haiti, facing the impending hurricane season, having no water to drink, and waiting for shelter. They spoke of their personal difficulties eating, not sleeping well, having nightmares, and feeling guilty that they could not help.

Haiti Living in Hell

by Kerline Louis

*7.0 magnitudes earthquake
How does it feel to be there?
Shake right to the heart and soul.
The pictures of love one
Start falling off the wall.
The house start shaking
Plunging right to the ground.
The house is tearing apart.
Blacks start to collapse
Young children start cry
Jezi jezi edem!
Jesus Jesus help me!
Mother crying out
Kote timoun mwen yo
Where are my kids?*

*Father reaching out to his son
Sister out there can't help her brother.
2 month old baby
New to the world
Being a victim of broken bones.
12 years old girl
Seeing such a disaster
And still surviving after 6 days under concrete.
Port au prince now without a port.
3 million now traumatic.
The capital had turn
Into the capital of dead bodies.
200k throwing into the truck
And get dump over the mountain.
People crying for help
The president is now homeless.*

*No power no electricity
Mostly no food and water.
Haiti is now on the big screen
The voice of help is reaching out to heaven
Had god forsaken them
Voices of the world,
USA, Europe, Africa, Asia
Unite as one to help.
Haiti is now a living hell.*

But, despite a general reluctance in the Haitian community to seek mental health support (partly from not understanding the effects of trauma and partly from fear of stigma and discrimination), many families embraced the support and their children were helped. One child summed it up best by saying, “Before coming to therapy, I used to feel like I was suffocating at home sometimes. Therapy is helping me to learn more about myself and talk about my problems. I feel more comfortable expressing my feelings and I feel liberated. My dreams have grown and I feel everything is possible for me.”

It is through the modalities of art and music and connections to caring adults in the community, particularly through the culturally sensitive services provided by Interborough, children have expressed feelings, coped with their fears and regained a sense of hope. It is through the compelling poem of a youth who experienced the earthquake that (see box in center) we are reminded that giving voice to our experiences is restorative and healing.

The Interborough Developmental and Consultation Child and Family Clinic-Plus program was recognized May 3, 2010, by OMH during Children's Mental Health Day, and celebrated as a “program uniquely impacting the lives of young people and families.” To learn more about the program, contact Joanne Siegel, LCSW, Director of the Child and Family Clinic-Plus Program at jsiegel@interborough.org.

Strengthening Family Support

Compared to traditional clinical care for mental health problems, family support services uniquely aid parents in better understanding their own needs; in feeling less isolated and stressed; and in taking an active role in their children's services. It is expected that family support services will continue to expand, particularly because they are adaptable to family and individual needs, thought to be cost-effective, and serve as a natural link to mental health services for parents who might otherwise avoid engagement because of stigma, or negative experiences with care.²⁰

A new development in the area of family support services is movement toward professionalization of the services, billable mental health services, and the creation of credentials that enable parent providers to deliver the services. In light of rising workforce shortages, the role of the family support specialist is likely to provide the service system with highly qualified professional family advisors that are able to deliver effective family support services.²¹

In collaboration with Families Together in NYS and Columbia University, as well as with representatives of local family organizations and mental health providers, OMH is putting in place a credentialing program that takes advantage of the Parent Empowerment Program (PEP) model. PEP basic training includes a focus on engagement skills, information and education, emotional support, advocacy support and workforce integration.²² PEP basic trainings will be held annually and the credentialing program is set to begin later this year.



Increasing Access to Psychiatric Services

A growing body of literature suggests that telepsychiatry has the potential to address the workforce shortage problem that directly affects access to care, especially in remote and underserved areas. Provided by live, interactive communication and videoconferencing, telepsychiatry has become an important modality for providing care and education.²³

The Children's Telepsychiatry Initiative, which provides psychiatric consultation services particularly in the more rural counties of the State, continues to expand. In recognition of a growing need for this service, the OMH Division of



Children and Family Services has established the New York Child and Adolescent Telepsychiatry program. Services are being delivered by the Columbia University Division of Child and Adolescent Psychiatry to the OMH regions of New York City, Long Island and Hudson River. The Upstate Medical University Professional Practice Group is covering the Western and Central Regions. Among services offered are evaluation by a child and adolescent psychiatrist, diagnostic consultation, treatment planning, medication management, and discharge planning.

Advancing Evidence-Based Treatment

An evidence-based treatment is one that integrates the best research evidence with clinical expertise and values of the person being served.²⁴ Scientific findings are crucial to

Nurturing trust and strengths: Helping parents with disabilities

It's happening in New York communities daily. A parent is diagnosed and hospitalized with a disabling condition such as cancer and neighbors mobilize to help out with the children. Casseroles are baked, laundry and ironing done, and help with homework and school activities are offered. In many a community, however, there are a number of parents struggling with the invisible disability of mental illness and support is lacking. Their situations may reflect stigma, fear of the unknown, and simply a lack of knowledge about how to support these families.

Today there continues to be hope and a growing recognition that parents with psychiatric disabilities need support in facing the unique challenges they encounter in their role as parents. Through initiatives like the Jefferson County Invisible Children's Program, parents are provided with case management services where the value of doing whatever it takes to meet a parent's needs underlies the work of each case manager. Much like the casseroles and home work help, the program helps families to experience support that makes a difference in their lives.

The nurturing environment parents find in the Invisible Children's program encourages parents to take ownership of their own recovery, as well as the program itself. This level of recovery is a tremendous victory for members who have felt alone, fearful and uninvolved in their own recovery for a majority of their lives. Encouraged, empowered and beginning to experience success, parents become supportive of one another and of the group as a whole.

Parents are motivated to work diligently and given tools to help them maintain or regain custody of their children. Many come to understand the value of turning their fears of child protective services involvement into taking steps to be proactive and address problems as they occur. The milieu of nonjudgmental, person-centered support they encounter in the program is critical to helping parents gain trust, put aside their fears, and with assistance move forward. It also helps that members of the program are taught

Continues on next page

the development of an informed partnership between providers, individuals and families, where scientific knowledge, clinical expertise, experience, and values are weighed in health care decision making.²⁵

Dissemination of best practices

Through the Evidence-Based Treatment Dissemination Center (EBTDC), OMH is helping to enhance the quality of life for children and families by increasing access to treatments shown to be effective. The Center provides mental health clinicians with intensive training and support in evidence-based treatments. Each year, the EBTDC offers a three-day training program in evidence-based practices proven effective with children and their families (e.g., disruptive behavior disorders treatment). Following training, clinicians are offered a year of clinical consultation to help the treatment to take hold in daily practice. Training is provided directly by the experts or their associates who developed the treatment models.

Trauma-informed care

The EBTDC has trained more than 400 clinicians statewide on trauma-focused cognitive behavioral therapy. Building upon this, OMH is updating and revising the staff orientation training curriculum for use in State children's psychiatric centers so that it includes content and guidance for trauma-informed care. Supplemental training on trauma-informed care is now an annual requirement for staff. The EBTDC is also piloting extensive trauma-informed care training and consultation for clinicians in a small number of psychiatric and residential treatment facilities. The results

of the pilots will help with replication of training in other psychiatric centers and residential treatment facilities.

Summary

To continue to create the conditions for success, OMH will focus on a holistic approach to promoting social and emotional wellness as well as promotion and prevention, and early identification of and intervention for mental health problems. It strives for integrated and effective services and supports based in individualized care, one family, and one plan. Appendix 4 provides background on many efforts aimed toward this transformation. The descriptions of programs and initiatives are organized by the goals that have been directing and will continue to direct ongoing transformation of the system of care serving very young children to youth and their families. These goals include:

- ◆ Social and emotional development and learning should form the foundation for success in school, in work and in life.
- ◆ Every action should strengthen our capacity to engage and support families in raising children with emotional health and resilience.
- ◆ Integrated and effective services and supports should be based on the ability to deliver individualized care: one family, one plan.
- ◆ The right service should be available at the right time and in the right amount.
- ◆ An adequately sized workforce that is culturally and linguistically competent and steeped in a new paradigm of integrated, family-driven care should be developed and sustained.

about and prepared to deal with the stigma and discrimination they may find both inside and outside of the mental health system.

Issues with stigma, prejudice and discrimination are huge and difficult for parents to deal with alone. Many times, they feel ashamed, discouraged and traumatized after seeking help from providers and family members. Many relate horror stories where their pleas for assistance led to a lack of confidence, loss of trust and traumatic experiences that caused more harm than good. The program is crucial in helping parents regain trust and face their fears that might otherwise end up disabling them in their roles as parents and adults.

Believing in each member's capacity for strength, growth and desire to be the best parent possible, the program empowers members. Case managers help parents to take ownership and gain confidence. The case managers accompany parents to meetings, assist with completing paperwork, listen with compassion, and help them to sort through possible solutions in a way that is com-

fortable for them. What is nice to see is the considerable progress members make when they are treated with respect and are actively involved in decision making that reflects their concerns and feelings. The key is that recovery is in their hands and supported by peers and the Invisible Children's program staff.

The Invisible Children's Project started in 1993 as a program of the Mental Health Association in Orange County, New York, and has expanded nationally. As designed, the Invisible Children's program, which is considered among promising programs, brings essential services to parents that help improve their abilities to parent and create safe and nurturing environments for their children.

You may obtain more information about the program model at the Mental Health America website at http://www.nmha.org/go/icp_project. For more information about the Jefferson County Invisible Children's Program, contact Melanie Chapman, the Program Director, at mchapman@mhajc.org.

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Local Planning and Priority Setting

Local mental health services planning is very challenging in the face of external pressures, scarce resources, and a changing system of care. Communities are targeting resources toward the most effective practices and care, enabling recovery and resiliency for their many residents. Together, community services boards, mental health advocacy organizations, professional mental health and other service providers, including peers, people engaged in services, family members, policy makers and planners are working to address their unique cultures and community characteristics to meet local mental health needs effectively. Robust planning processes are central to well-developed systems of care that support individuals in living, learning, working and participating fully in their communities. Such processes nurture bottom-up change and improvements in the quality of care.

The Office of Mental Health's (OMH) goal is to continue support for integrated planning across the mental health, health, developmental disabilities and substance abuse areas. Drawing upon input from New York's diverse communities, the partnerships between the State Psychiatric Centers and the localities they serve are vital to meeting the goal. Also important is OMH's participation in the Interagency Mental Hygiene Planning Committee with its partner, the Conference of Local Mental Hygiene Directors (CLMHD).

Strengthened collaborations between adult State Psychiatric Centers and localities

In January 2009, Commissioner Hogan initiated a series of planning meetings between adult Psychiatric Centers, including forensic facilities, and the localities they serve. The meetings focused on Psychiatric Center outpatient services transformation in conjunction with local planning. Recognizing that most localities plan well for children's services, OMH challenged its adult Psychiatric Centers, in collabora-

tion with localities, to apply the same planning and systems-of-care principles to adult and forensic services.

OMH's five Field Offices continue to facilitate the process toward one that continually gives priority to community need. In conjunction with the Office of Planning, Field Office Directors assist Psychiatric Centers and localities in resource, utilization, needs, and capacity options. The process is also enhanced through the Mental Hygiene Planning Committee resources via the online County Planning System (CPS), where counties specify their annual local priorities.

During this year's annual planning cycle, counties reported voluntarily in the CPS on progress being made under the Psychiatric Center—local partnerships. Specifically, within the context of clinic restructuring, they described what outcomes had been achieved through collaboration over the last year and major goals for this coming year. About one-third of the counties responded, indicating a continuum from strong, well-established working relationships to newly established or renewed partnerships.

Examples of well-established working relationships include Chemung County, where the Elmira Psychiatric Center is well connected to the community, very active in community-based planning with the Community Services Board, and relies upon well-established mechanisms for triaging cases and working with the Elmira City School District; and Onondaga County, which enjoys an ongoing partnership with Hutchings Psychiatric Center. The County and Psychiatric Center work together on person-centered planning and other key initiatives, including the County's Clinic Access Project (described in Chapter 3).

Newly formed relationships are represented by the work under way between Rensselaer County and the Capital District Psychiatric Center to help persons who have had long inpatient stays to resettle successfully in their communities; and in Cattaraugus County, where the Psychiatric Center and County are improving discharge planning for individuals who will be transitioning out of the hospital by using targeted strategies such as improved physician-to-physician communication. Also, Monroe County and the Rochester Psychiatric Center have collaborated on a new outpatient

Having faith: Supporting a personal journey of recovery

To be of use and to feel productive . . .

For many of us, we think of our jobs. But what if finding or keeping that job was a challenge? What if your mental health became a barrier to employment?

For Astha, a 29-year-old woman of South Asian heritage, numerous relapses and hospitalizations for debilitating anxiety disrupted many areas of her life, including completing her educational goal and finding that long hoped-for job.

Although she had completed a bachelor's degree, Astha experienced an overwhelming sense of anxiety that led to a self-imposed isolation and fear of being "labeled." It was these symptoms that brought her to the Synergy Center at Clubhouse of Suffolk in the early 2000s. She asked for help in dealing with her mental health issues and, when ready, help in finding and keeping the job she desired.

At the Synergy Center, which in May 2007 became a licensed PROS program, Astha found services grounded in the belief that meaningful employment—a salaried job or volunteer position that provides a sense of satisfaction—is often essential for personal fulfillment and good mental health. She found skilled, respectful, and passionate staff trained in evidence-based practices. She found people who desired to help her manage her symptoms and work on her own goals. Astha learned what "meaningful work" meant to her, and she recognized that her greatest strength was writing. With staff, she mapped out a plan and specific activities to help her reach her goals.

As Astha worked closely with an employment specialist, she determined that her top priorities were to earn an advanced college degree and gain full-time employment in her chosen field of education. Stigma and family cultural expectations, along with the related anxiety, were challenges that needed to be addressed. Staff worked through these challenges with her and with this support, she came to realize her own unique strengths and skills. Drawing upon them, she addressed barriers to pursuing a job and enrolled in a graduate study program with pride and confidence.

The year after she secured a position as a teacher's assistant, Astha was accepted into a graduate studies program in education. Despite ongoing feelings of anxiety, she maintained her job until she suffered a relapse and was hospitalized for a month. While she did lose her job, she did begin medication during the hospitalization that helped her manage the symptoms of anxiety. Following



her discharge, she started her graduate classes and was able to secure another teacher assistant position.

Recovery from a diagnosed mental illness is a journey, sometimes with unexpected detours, as Astha recounts: "After graduating with my master's degree, I had a relapse and had to go back to the hospital for a month. I contacted Clubhouse and began receiving services at Synergy Center again. I attended classes on yoga and meditation skills, medication management, and constructed a relapse prevention plan with my vocational rehabilitation counselor."

"We worked on my personal recovery and job search, and after about five months after my relapse, I found a full-time position as a clerk/research assistant at a local university. I worked for about a year and had another relapse. This time, I took the advice of my vocational counselor to disclose my health situation to my employer. When I felt better, I returned to the *same* workplace. . . something I didn't think was possible after disclosure. The staff at Synergy Center ensured me that my disclosure would be treated with privacy by my employer and that going back to the same workplace was not going to be a problem. Sure enough, I have been back at work for over a year."

Astha's journey reminds us that good mental health, like all areas of health, must be attended to and nurtured. Our journeys differ, but the process is one that we each define. For Astha, she now has the skills to do her job while managing her health and she is doing both well.

To learn more about the PROS program and employment support offered at Synergy Center, Clubhouse of Suffolk, contact Lisa Koop at Lisa.Koop@clubhouseofsuffolk.org or visit the website at <http://www.clubhouseofsuffolk.org/index.cfm>.

clinic (Steve Schwarzkopf Community Mental Health Center) on the grounds of the Psychiatric Center, using the mo-

bile community-based model to meet the needs of high-need individuals.

Sharing growth and success: The power of “having been there and done that”

By Steven Duke, LCSW-R, CPRP

In 1995, a small group of innovative and creative people seized the opportunity to obtain funding from the New York City (NYC) Department of Mental Hygiene (DOMH) to start up a peer-run agency based on the belief that individuals who have shared similar experiences can serve as role models for success while helping themselves and their peers through self-help, mutual support, peer support, education and advocacy.

The idea was welcomed and funded by DOMH and the seeds for cultivating the grassroots program of Baltic Street AEH (Advocacy, Employment, Housing) were sown. A core group of motivated, talented and dedicated peers in Brooklyn signed up to provide peers in NYC with personalized, quality services that would help them sustain themselves in their communities with dignity and self-respect. They desired a place they could be a part of, a place where helping others and giving back would become a part of their healing process. This ability to give back and see other people accomplish their dreams with support from us has always been and will always continue to be the catalyst of passion and inspiration that motivates our staff every day of their lives.

Since 1996, Baltic Street AEH has grown from a group of five peers serving 400 people a year to 100 peers serving 5,000 peers a year. Baltic Street is now one of the largest peer-run organizations in the country and boasts having 13 programs in four of the five NYC boroughs. The agency has shown remarkable success in providing advocacy, employment, housing, and wellness services based on best practice models of recovery and self-help.

Of great pride is that one of the original peers, Isaac Brown, has returned as the Chief Executive Officer, and another original peer, Janice Jones, is currently the Chief Operations Officer. Both are dedicated to assuring that the agency remains true to its original mission and values—improving the quality of life for people living with mental illness through recovery-oriented services and helping recipients obtain jobs, housing, social supports, education, vocational training, entitlements, and other life-enhancing services. All services are delivered through partnerships between clients and our staff of professional peers who can safely say that they have “been there and done that.” They help empower clients to attain their recovery goals.

The concept of peer-to-peer service delivery is the backbone of our agency. It is essential that the individual is always an equal partner involved in planning and carrying out their own goals for recovery. People are urged to “define, discover, and take credit for finding meaning and purpose in their daily lives,” while living in



Baltic Street's Issac Brown & Janice Jones

their own communities. Our services help clients improve their physical and emotional well-being, create opportunities for developing friendships and relationships, find stable and affordable living conditions and engage in productive activity through hobbies and positive work experiences, including competitive employment, and more.

By facilitating the process of recovery, we naturally decrease, and at times totally remove the stigma and alienation related to mental health labels. This process of helping people reconstruct their lives not only requires planning, but also requires action as well. Our staff is continually trained to be competent human services workers and develop partnerships based on principles of shared decision making. Through their relationships with peer service providers, many of our clients have been able to make their dreams a reality by getting step-by-step assistance to set goals and develop skills that bring their ambitions to life. Our doors are always open and our clients can remain active in our programs as long as they want to and feel it necessary to achieve and maintain their goals. All of our services are geared toward helping people balance their lives in the real world.

With confidence, we can say that we have repeatedly been able to make remarkable differences in the lives of many individuals. There are many stories of accomplishments that people never thought would be possible such as leaving a hospital, finding a home, finding a job, finding friends, increasing their financial status, improving their health, and achieving other identified goals that lead toward recovery and satisfying lives.

We are very proud of who we are and what we do. We hope that we can continue to be there to help people to improve their overall quality of life in the community by providing them with a caring support system that is available to them at all times.

To learn more about Baltic Street AEH, visit its website at <http://www.balticstreet.org/index.htm> or contact Steven Duke at sduke@balticstreet.org



New county planning data resources

Based on feedback from localities, the Office of Planning formed a workgroup early this year with members of the Office of Performance Management and Evaluation and the Information Technology Office to provide online data resources for localities and Psychiatric Centers. The workgroup recently completed a series of reports, giving each locality a snapshot of key indicators to aid planning.

Called the “County Mental Health Profiles,” data on the page will be available publicly via the OMH website in October. The page offers a consolidated, high-level view or “dashboard” of key county community characteristics, mental health services, expenditures, and outcomes. It is the focal point of the 2010 Office of Planning initiative to make data more accessible to county planners, thus allowing planners to identify mental health service gaps and disparities and plan improved service delivery.

The reports provide quick, at-a-glance views of county mental health data, and offer comparative statewide statistics. They are presented in nine domains:

Community Characteristics

This report presents key demographic and vital statistics of a county’s overall population and the population of mental health consumers. Data for the mental health population are presented by the county of the provider.

Service Use Snapshot

This report compares counts and percentages of adult consumers and children who received public mental health emergency, inpatient, outpatient, residential and support services during the 2009 Patient Characteristics Survey week (October 26 to November 1, 2009). Data are displayed for the selected county of the provider and for New York State (NYS). Rates are based on the calculation of individuals served divided by total county population times 10,000. County population values are displayed under Community Characteristics.

Adult Medicaid Expenditures Summary

This report displays summary information of the selected county and NYS annual Medicaid expenditures for mental health services provided to adults who were Medicaid eligible on the date of service within the 2008 Local Fiscal Year (Calendar Year 2008 for all counties except NYC; July 1, 2007-June 30, 2008 for NYC counties).

Average Daily Inpatient Census

This is a display of average daily inpatient census for the selected county of residence as reported by licensed Article 28 (inpatient unit of general hospital), Article 31 (private psychiatric hospital) and State psychiatric facilities for adults (18 years and older). Inpatient census rates per 10,000 adults are also shown. Rates are based on the calculation of daily census divided by total adult county population times 10,000. County population values are displayed under Community Characteristics. Statewide figures are provided for comparison purposes.

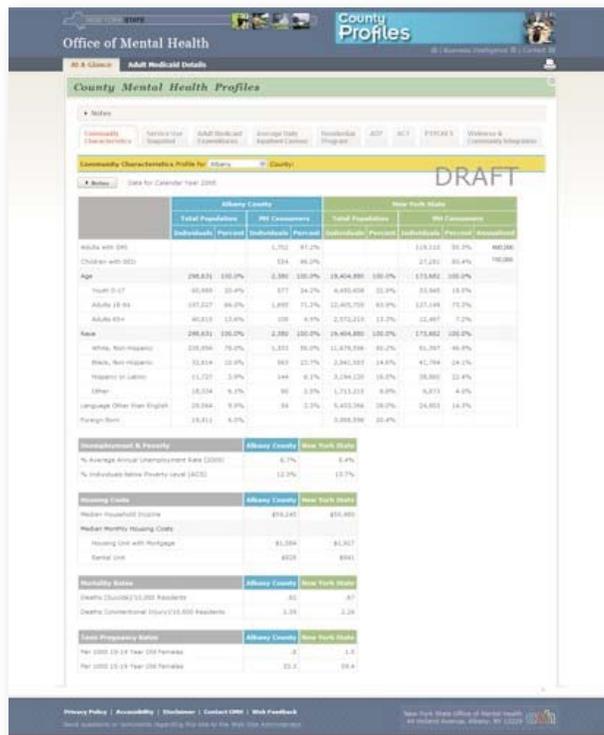
Residential Program

The adult residential program data provide selected program benchmarks and performance measures, by county and statewide, for adult residential program types: congregate treatment, apartment treatment, congregate and apartment support, and supportive housing. Two tables show the number of county and statewide beds in each program type

and eight key performance measures from the Adult Housing data mart. Also shown are county and statewide residential bed rates, per 10,000 adult populations, for each of the program types. Bed rate calculations are based on the number of adults in the total county and state populations, using the 2008 population estimates shown in the Community Characteristics data domain.

Assisted Outpatient Treatment

The Assisted Outpatient Treatment program was created in response to Kendra’s Law, which establishes a procedure for obtaining



court orders for certain individuals with mental illness and a history of hospitalizations or violence who participate in community-based services appropriate to their needs. This report displays selected up-to-date statistical data relative to program operation, recipient outcomes and demographic characteristics.

Assertive Community Treatment

Assertive Community Treatment is an evidence-based practice model designed to provide treatment, rehabilitation and support services to individuals who are diagnosed with serious mental illness and whose needs have not been well met by more traditional mental health services. This report displays selected, up-to-date statistical data on county program operations, recipient outcomes and demographic characteristics.

Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)

Initially developed for use in State psychiatric facilities, where it supported significant improvement in medication practices, PSYCKES is an award-winning portfolio of web-based tools designed to improve the quality and efficiency of psychotropic prescribing practices in NYS. Psychotropic polypharmacy is a particular concern due to potential side effects such as weight gain, diabetes, and metabolic syndrome, as well as increased risks of drug interactions. This report displays PSYCKES youth polypharmacy, adult polypharmacy, and cardiometabolic indicators for the selected county and NYS for Calendar Year 2009.

Wellness and Community Integration

The 2007 and 2009 Patient Characteristics Surveys include questions on chronic medical conditions, special education services for children, parental custody of minors, living situation and employment in a community setting. This report displays measures deemed relevant to client wellness and community integration for a selected county and NYS. The site also provides competitive employment data by county of residence.

The report is organized with a tab at the top of each page representing a different section or domain of information. When a user clicks on the tab of interest, he or she will see a summary report and, in many instances, a corresponding chart to aid understanding. Most of the sections also have a “Related Reports” button that links the user to other websites containing additional information. And, next to this button is an indication of the time frame for data being displayed (e.g., Data represents Calendar Year 2008).

The original home page for this site, called “Adult Medicaid Details,” has been moved to a separate menu item, located at the top of the page. The Adult Medicaid Details report, first introduced in December 2009, contains summary information about mental health service utilization funded through Medicaid for Local Fiscal Years 2007 and 2008. Program totals are based on date of service and data are refreshed on a monthly basis. Each report summary displays counts of individuals, service units, and Medicaid expenditures by program type. The reports also include program expenditure rates service rates. Data may be displayed regionally and by the provider county within regions.

Integrated mental hygiene county planning

OMH continues a strong partnership with its sister mental hygiene agencies and localities through the Mental Hygiene Planning Committee— a collaboration between CLMHD and the three mental hygiene agencies. The Mental Hygiene Planning Committee is a part of the Inter-Office Coordinating Council (IOCC), which represents OASAS, OPWDD and OMH. The role of the IOCC, among other duties, is to ensure comprehensive planning, implementation, and evaluation of State policy for the prevention, care, treatment and rehabilitation of mental illness, developmental disabilities and addictions. The Council also strives for the elimination of gaps in services to individuals with more than one disability.

An important product of the collaboration is to incorporate county priorities into planning at the State level, helping to align State priorities to those of the counties. For the purpose of analysis, OMH examined the top two mental health priorities for each county. A summary of findings follows. In addition, the Committee queried counties this year on planning related to cultural competence, clinic restructuring and Personalized Recovery-Oriented Services (PROS).

Mental Health Priorities

Fifty-eight of 62 counties submitted and certified their priorities in the CPS as part of the annual planning cycle. Counties declared varying numbers of priorities, but for the purpose of this analysis, the top two for each county were examined through the lens of mental health to understand more fully general areas of emphasis across counties. The analysis included mapping of priorities by region to the strategic framework.¹

OMH and OPWDD: Building collaborative approaches to advance integrated care

Many of us are aware of the challenges that exist when two bureaucracies attempt to join forces to solve common problems. For OMH and the Office of Persons with Developmental Disabilities (OPWDD), the challenge has been to provide appropriate services for people recovering from mental illness who also have developmental disabilities.

Each agency defines who will be served and outlines specific criteria to follow in accepting individuals for services funded along these guidelines. In a bureaucracy, this approach makes perfect sense on paper. Unfortunately, however, significant numbers of people around the State could benefit from services from both organizations. Frustrating to service providers, families, bureaucrats, and others, such individuals may not meet eligibility standards set by the OPWDD, but may have IQ scores that make it difficult for them to benefit from traditional forms of cognitive therapy provided by the OMH system.

Since the late 1970s, these persons have been labeled the “multi-disabled” or “dually diagnosed,” terms that reflect the time when the NYS Department of Mental Hygiene was in operation and mental health and developmental disabilities were in the same agency (along with substance abuse and alcoholism services). Not surprising, when the Department split, people served did not divide clearly by agency jurisdiction. Although memoranda of understanding were written to guide the provision of primary care, the two agencies have struggled to find ways to serve these individuals.

Some persons end up in local hospital emergency rooms or hospital inpatient units until suitable placements can be made.

In 2007, an important event occurred when the People First listening forums brought together Commissioners from OMH, OPWDD, Office of Alcohol and Substance Abuse Services (OASAS) and the Department of Health to listen to stakeholders describe challenges in trying to obtain services from the various systems. Agency leaders heard the message: Find a better way. The listening forums, then, set the stage for OMH and OPWDD to think about people as people with needs rather than as people as “disabilities.”

As a result, the OMH Field Offices and OPWDD Developmental Disabilities Service Organizations (DDSO) developed teams to identify and solve problems for people whose needs crossed the two systems. OMH Psychiatric Centers and Developmental Centers also encouraged collaborative projects. Relationships in some areas grew out of solving problems for people, one at a time. A statewide training initiative, “Navigating the Two Systems,” was developed to facilitate staff understanding and shared problem solving between the two systems. While Medicaid and financing rules have proven to be difficult to bend, several new, cost-effective strategies have resulted in people receiving improved access to care.

Here is how one community has created a pocket of innovation. The Capital District Psychiatric Center (CDPC) Director Lewis

Continues on next page

The analysis takes into account the 116 top two priorities that counties indicated were of chief concern for the delivery of mental health services and supports. The majority of the priorities relate solely to mental health (56.9%); the others are shared with one of the other two mental hygiene areas or among all three. Mental health/developmental disabilities priorities account for 17.2%. The percentage of priorities is split equally between the mental health/substance abuse and

all three areas, each with 12.9%. While the distribution reflects much attention to priorities that relate to mental health services alone, it also points to a continuing emphasis within mental health to cross-systems, comprehensive, integrated person-centered services and supports necessary for individual and family health and well-being.

Mental Health Focus of Top-Two County Priorities by OMH Regions

Region	MH	MH/DD	MH/SA	MH/DD/SA	YET TO RESPOND	Total
Central	20	7	4	7	2	40
Hudson River	17	6	5	2	2	32
Long Island	2	1	0	1	0	4
New York City	10	0	0	0	0	10
Western	17	6	6	5	4	38
Total	66	20	15	15	8	124

Campbell and recently retired Capital District DDSO Director David Slingerlands put their heads together to find solutions. Community services and program operations staff from the two agencies meet bi-monthly. Once they identify people who are ready for discharge from CDPC, but who would be better served in the OPWDD system, staff members work closely to blend resources and bring about appropriate placement. Since 2008, 10 persons discharged from CDPC are now living in community settings operated by OPWDD and another seven are close to placement. These are persons who had lived or have been living at CDPC for up to 20 years.

From Mr. Slingerland's perspective, what makes the collaboration work is trust. CDPC promised it would support persons after discharge and it is doing this, for instance, by providing on-site community staff support, temporary financing for day programming, and return to the hospital if needed. From Mr. Campbell's perspective, whatever helps people to make positive change and transition is well worth the investment of resources. Some examples of cross-systems program initiatives that have developed out of this fruitful partnership include:

- ◆ **Family Care Discharge Project:** First in the State to do so, CDPC and the DDSO arranged to have a long-term resident of CDPC eligible for OPWDD services to be placed in an OPWDD licensed family care home. Before placement, the CDPC resident visited with the family care provider, enjoyed weekend passes to the home, and completed a week-long pass. CDPC covered the cost of visits to the family care provider, the resident attended an OPWDD dayhab program, and CDPC supported her on-site transition to the day program. While staff was confident of successful placement, the resident was

placed on convalescent care status for one month prior to discharge as a good faith effort to facilitate her return to the hospital if the placement did not work out.

- ◆ **Child and Adolescent Mobile Crisis Team (CAMT):** In 2007, CDPC entered into a partnership with Parsons Child and Family Center, Rensselaer County, Albany County, Schenectady County and the OPWDD to fund a mobile crisis team that would serve children and families in crisis throughout the three counties. While CDPC contributes four staff, OPWDD and the counties contribute funds. As noted in Chapter 4, since its inception, the team has made a significant difference to the communities it serves.
- ◆ **Shared Respite Resources:** The DDSO has agreed to make available to CAMT its Respite House for 24–48 hour respite for children and youth in crisis and in need of safety/crisis stabilization. This much-needed community service should result in reduced hospitalization, while providing safe crisis care.
- ◆ **Shared Program Space:** The DDSO and CDPC have agreed that CDPC satellite clinic staff will share space at the DDSO within the Glens Falls Medicaid Service Coordinator offices. Shared space will allow staff from both agencies to exchange information, provide consultations for adults and children, and increase understanding of agency eligibility requirements and services. CDPC clinic staff includes psychiatrists, psychologists and social workers who will be available for interagency trainings and consults.

In an era of declining resources, ingenuity is the star that guides.

Priorities in Relation to Strategic Framework

The strategic framework brings structure to the values and principles guiding recovery-oriented, person-centered, family-driven and youth-guided services and supports. They include:

1. **People First**
Respect individuality by demonstrating hope and positive expectations, a belief in recovery, and regard for diversity.
2. **Person-Centered Decision Making**
Provide supports and treatment based on self-defined needs, while enhancing personal strengths.
3. **Basic Needs Are Met**
Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.
4. **Relationships**
Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.

5. Living a Healthy Life

Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.

6. Mental Health Treatment and Supports

Foster access to treatment and supports that enable people to lead satisfying lives in their communities.

7. Self-Help, Peer Support, Empowerment

Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.

8. Mental Health System of Care, Workforce and Accountability

Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.

Across the State, priorities fall largely into Domain 6, with 50 of the top 116 top two priorities relating to Mental Health Treatment and Supports (43.1%). Domains 5 and 8 are the

Regional Priorities by Framework Domain

Region	1 People First	2 Person-Centered Decision Making	3 Basic Needs are Met	4 Relation- ships	5 Living a Healthy Life	6 MH Treat- ment & Supports	7 Self-Help, Peer Sup- port, Em- powerment	8 MH System of Care, Workforce & Accounta- bility	9 Other	Yet to Respond	Total
Central	0	1	5	0	5	18	0	8	1	2	40
Hudson River	1	0	8	1	3	9	3	4	1	2	32
Long Island	0	0	2	0	0	1	0	1	0	0	4
New York City	0	0	0	0	0	10	0	0	0	0	10
Western	1	1	8	1	3	12	1	7	0	4	38
Total	2	2	23	2	11	50	4	20	2	8	124

next two areas of chief concern among counties, with 23 (19.8%) relating to Basic Needs and 20 (17.2%) to the System of Care, Workforce and Accountability issues.

Overall, the data appear to indicate an ongoing commitment to ensure quality mental health treatment and supports, help people meet basic needs that promote productive community living, and make sure the workforce and system of care bolster quality, integrated care. They also point to efforts under way across the State and localities to prepare for ambulatory and clinic restructuring; to continue strengthening the quality of care through standards of care, evidence-based practices, and a commitment to the principles of recovery and resiliency; and to examine effective and efficient ways to help people improve the quality of their lives in stressed fiscal times.

Regional Priorities

Central New York Region

Among the priorities under Domain 6, most focus on improving access to an array of integrated services that meet the needs of persons with co-occurring and dual disorders and those at risk for hospitalization or contact with the criminal justice system. Counties often call for better collaboration, recognizing the importance of integrated care across the systems of care.

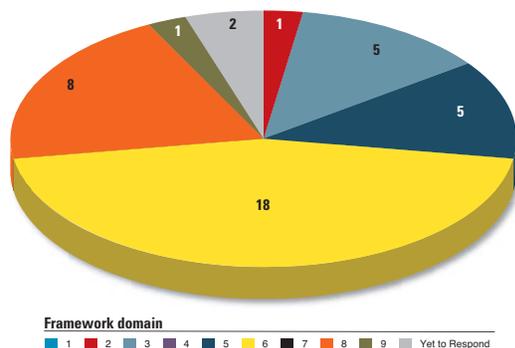
With respect to improving workforce and accountability, counties indicate a number of strategies to strengthen their systems of care to meet the needs of elderly adults, particularly those with co-occurring disorders, better educate parents and professional staff about dual mental health and developmental disability disorders, promote the value of the recovery orientation to care, and enhance care for children and youth.

Of interest is that counties show nearly equal interest between Domain 5, where safe, affordable housing is most often cited as a priority, and Domain 3, where living a healthy life is highly valued. For the latter priorities, counties point to the need for accessible community respite, peer respite and crisis services not only for promoting good health, but also for providing a continuum of services that allows people to maintain health and well-being in their communities.

Hudson River Region

In the Hudson River Region, counties identified priorities mainly in Domains 3 and 6. Under Basic Needs, the eight priorities all dealt with safe, affordable housing. A number of

Central Region priorities by framework domain (n=40)



STEL leading the way and filling the housing gap—innovatively

Responding to the lack of suitable housing stock and limited funding from OMH, the Southern Tier Environments for Living (STEL) has worked tirelessly since the mid-2000s to develop and put in place alternate funding techniques to accomplish an important goal: safe and affordable housing for persons with mental health conditions.

STEL looked to the U.S. Department of Housing and Urban Development, NYS Office for Temporary and Disability Assistance, NYS Division of Housing and Community Renewal, Low Income Tax Credits and private banks to fund a 16-apartment unit in Olean. Out of its efforts came a huge success. STEL developed an integrated apartment facility, with one-half certified treatment apartments and one-half generic affordable housing. STEL also shared with OMH its financing technique, which leveraged dollars and saved on the State's capital investment.

A major additional benefit turned out to be the socialization experience that evolved naturally for residents of the treatment apartments who interacted daily with occupants from the affordable housing apartments.

The experience in Olean led STEL to utilize this funding technique and apartment distribution system in future developments. It proved so successful that OMH asked STEL to partner with other State mental health agencies and to “show them the way.” STEL has also developed a second important function in the mental health field. It has gathered together a Housing Development Consulting Services team, which uses its unique knowledge and expertise to work with other agencies in planning, financing and constructing special needs housing.

Following the Olean financial formula, work was completed on a mixed-use 37-unit apartment project in Dunkirk in 2006. Typically, there is a 50-family waiting list. It took less than two weeks to achieve qualified full occupancy. Also that year STEL took over the operation of an 18-unit apartment building in South Dayton and re-structured it into 21 mixed-use apartments in the next year.

In 2007 two projects were developed using similar cooperative planning, financing and oversight formulas. A 25-unit single-room occupancy project was built in Buffalo and a 24-unit adult home project was completed in Chautauqua County. Both used tax credits as a major source of funding. In 2008 the STEL Housing Development Team collaborated in helping construct the Ridgeview Special Needs Apartments in Rochester; it contains 64 studio apartments for persons with mental illness and is the first-ever project to utilize tax-ex-



empt bonds to finance OMH housing. Also that year STEL participated in the Ithaca Special Needs Apartments project of 38 single-room occupancy units funded by Low Income Housing Tax Credits and a market rate loan from Community Preservation Corporation.

Established in 1980 in Dunkirk, STEL is a nonprofit corporation that operates using the Psychiatric Rehabilitation Model adopted from Boston University. STEL enables people with psychiatric disabilities to obtain the skills necessary to live, learn and work in environments of their choice. In addition to addressing housing needs, STEL provides its own support services, partners with area treatment agencies, and fosters the abilities of residents to transition to various levels of independence.

STEL is the primary provider of a broad spectrum of residential options in a four-county area that includes all of Allegany, Cattaraugus, and Chautauqua counties and parts of Erie County. Because of the rural nature of this service area, housing stock to match various stages of recovery is often not available. And, as noted, STEL has risen to the challenge by taking on the role of conversion and construction of various levels of appropriate housing.

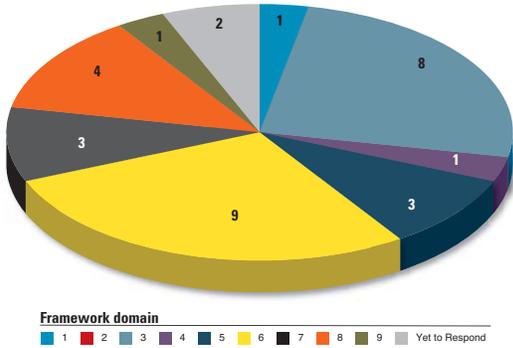
This rural character of STEL's service area has also encouraged the agency to take the lead in establishing services once not available to their clients. It has, for example, established the only area diversion program serving as support for young people with mental health problems who have been incarcerated. It also has played a leading role in helping to establish a Mental Health Court and later a Drug Court and has followed this up with full participation in these functions.

Currently, the agency manages seven larger congregate facilities, single-room occupancy units, supported housing, a treatment apartment program and affordable housing units. Together it has 360 units of housing, many newly designed and constructed specifically for their purpose. Present capacity serves 154 persons with psychiatric disabilities in housing licensed by OMH and 207 individuals through non-licensed housing. With an occupancy rate averaging 95%, STEL's annual budget for residential services is approximately \$7 million, 93% of which goes to direct client care.

Apart from its strong housing program, STEL also offers services through Workforce, a supported employment program; Compeer Chautauqua, a friendship/mentoring program; and the Cattaraugus Case Management program.

To learn more about housing programs or other services offered by STEL, contact Tom Whitney at whitneyt@stel.org or visit the STEL website at <http://www.stel.org/>.

Hudson River Region priorities by framework domain (n=32)



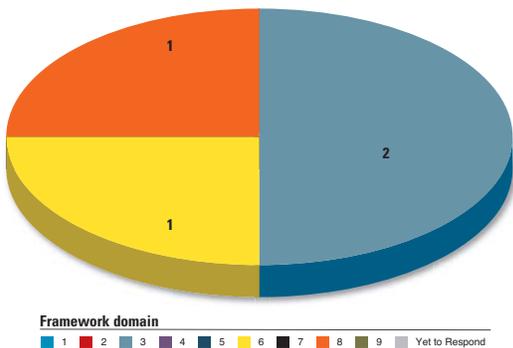
counties cite the importance of providing safe, affordable housing opportunities, particularly for people with special needs (e.g., dual diagnosis, youth in transition, sober housing).

Counties affirm the priority of integrated, coordinated, and collaborative treatment and supports that are responsive to the complex needs of individuals with mental hygiene and other disabilities. The nine priorities under Domain 6 focus on older adults, people with co-occurring substance abuse and mental illness, children and families, and persons with serious mental illness and criminal justice contact. Priorities also address the need for healthy living, self-help and peer support services, and work toward stronger local systems of care as the transition to clinic restructuring occurs.

Long Island Region

On Long Island, two priorities deal with Domain 3, one with Domain 6, and one with Domain 8. Each county endeavors to address housing shortages for individuals and families having mental illness, developmental disabilities and substance abuse. They note the particularly challenging circumstances they encounter in trying to address critical basic needs (e.g., very high housing and living costs, matching available housing to specific needs, finding housing for people who traditionally are difficult to place).

Long Island Region priorities by framework domain (n=4)



Local solutions and innovation: Watching out for our veterans and their families

By John Javis, Director of Special Projects, Mental Health Association of Nassau County

You might be surprised to know that among the approximate 1,000,000 veterans in NYS nearly 20% (174,000) live on Long Island. In fact, Long Island is second only to San Diego in the percentage of veterans among its citizens. Even though Long Island is not home to a major military installation, it has provided heavy representation in the armed services, especially after 9/11.

In 2007, the Veterans Health Alliance of Long Island, a project of the Mental Health Association of Nassau County, formed with the help of a passionate group of individuals who were military veterans or family members of veterans with post-traumatic stress disorder (PTSD), or who knew a veteran who completed suicide. One of the benefits of the Alliance has been its encouragement of longtime leaders of Long Island's mental health community to talk openly about veterans' experiences. Today, the Alliance comprises representatives from state and county government, the Veterans Administration, veterans' organizations, mental health and substance abuse providers, universities, businesses and individual veterans. Its mission is to promote the health and well-being of Long Island veterans and their families through advocacy and a broad array of services.

The Alliance's reach and strength in supporting veterans is evident by "Luis's" experience. After joining the Marines following the 9/11 World Trade Center attacks, Luis was seriously injured during the "Battle of Fallujah," when the vehicle in which he was riding was hit by a suicide car bomber. Luis suffered a wound that earned him a Purple Heart, and he also sustained a traumatic brain injury from the blast. After a brief transition period, he was discharged home to Long Island. He was not educated, however, about the signs and symptoms of PTSD, or about the availability of veterans' benefits and services.

Once home, his family and friends noticed that he was different. He seemed distant and angry. When he drove his car he sometimes envisioned that the car behind him contained an explosive device. Realizing that he was having difficulties, Luis reached out to the student counseling center where he was taking college courses. Center staff educated him about PTSD, let him know about a non-profit agency on Long Island that specialized in the care of returning veterans, and linked him to free counseling services with the agency.

Continues on next page

Luis's journey brought him to the Veterans Health Alliance of Long Island, where he met a number of Vietnam veterans who shared with him their stories of transition decades earlier. Luis then began to work as a peer veteran outreach worker for the Mental Health Association of Nassau County. In that role he helped enhance social services provider training sessions by sharing the story of his experience with PTSD and recovery. He also courageously went on local television and disclosed the story of his recovery. He attended Veteran Stand Down



events and encouraged his fellow veterans to seek services. (The Stand Down concept took hold during the Vietnam War to provide a safe retreat for units returning from combat operations. Today, Stand Down events provide an array of services, from food and shelter to access to numerous medical, legal, employment, benefits and social services.) Luis recently completed his education, is in a fulfilling relationship, and is now embarking upon a successful civilian career.

If you have read the recent Rand Corporation Study, *The Invisible Wounds of War*, you would be inclined to think that the odds have been in Luis's favor. The study estimates that 31% of service members returning from Iraq and Afghanistan have either PTSD or traumatic brain injury. Only about 50% of those service members have sought help for their conditions, and, of those seeking help, about one-half receive "minimally adequate care." The Veterans Health Alliance is helping to make a difference. It does this daily by reaching out to veterans in need; participating actively in Veteran Stand Down Events and National Guard Yellow Ribbon Events (which provide information, services, referrals and proactive outreach programs to Service members of the National Guard and Reserves and their families through all phases of the deployment cycle); and helping to engage with veterans who are homeless.

Good training is crucial to the Alliance's success. Training efforts are spearheaded by the OMH Long Island Field Office and focus

on improving providers' understanding of the military culture and how to treat combat-related PTSD. It also helps members of the public and others not involved in clinical care to recognize the early signs of emotional distress and equip them with information and resources they can offer the veteran. To date, the training, which is a partnership between clinical experts and combat veterans, has been provided to more than 2000 mental health and substance abuse clinicians, other social service providers, members of law enforcement, veterans and family

members. They have received education on PTSD, substance abuse, suicide prevention, and traumatic brain injury. The training is often done as a partnership between clinical experts and combat veterans.

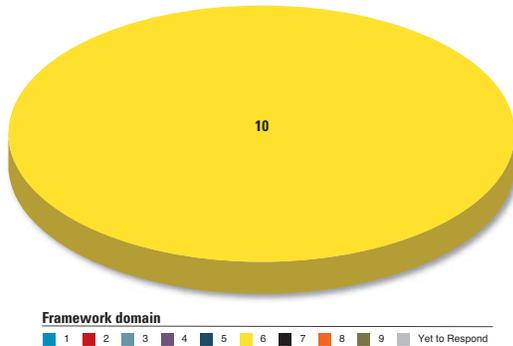
The principles and values underlying the Alliance's work are taking root in other communities. Recently, in collaboration with the NYS Health Foundation and Mental Health Association of NYC, the Alliance helped to found a sister organization, the Veterans Mental Health Coalition of New York City. Plans are also under way to reach out around the State and encourage development of similar alliances.

The key to the Veterans Health Alliance is that it is truly a collaborative effort among so many individuals and groups. In fact, supporters of the Alliance are so passionate that every summer a group of them parachutes out of "perfectly good airplanes" as a fundraising event! Now, that's ardent support, wouldn't you say?

To learn more about the Veterans Health Alliance of Long Island, go to its website at <http://www.mhanc.org/?PageID=789> or contact John Javis at jjavis@mhanc.org. You may also learn about the Veterans Health Coalition of New York City by going to <http://www.mhaofnyc.org/advocacy/veterans-mental-health-coalition.aspx>

Suffolk County is also giving priority to developing PROS so that they become a wide-scale method of treatment and recovery while increasing the county’s capacity for clinic treatment services. In Nassau County, much attention focuses on integrating the substance abuse, mental health and developmental departments into one. The merger presents opportunities to facilitate cross training, develop leadership that fosters the integration of treatment philosophies, proto-

New York City Region priorities by framework domain (n=10)



cols, regulations and barriers to treatment, and comprehensive service provisions to those with multiple disabilities.

New York City Region

New York City has declared two priorities that fall into Domain 6, covering each of the City’s five counties. (The priorities were given the weight of two for each county, totaling to 10.)

The first priority deals with facilitating access to the services and supports that will enable people to reach their full potential and lead personally meaningful lives through housing, employment, and educational opportunities.

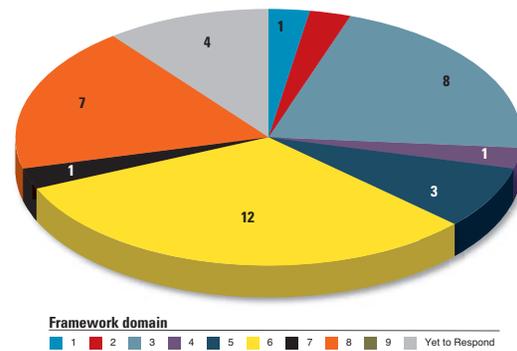
The second priority includes striving to have children from birth to five years of age reach their optimum developmental potential through assessment and early mental health intervention, when indicated. The priority aligns with the goals of The Children’s Plan to promote the social and emotional growth and development of New York’s children.

Western New York Region

Priorities for Western New York cluster mainly around Domains 3, 6 and 8, and focus on Basic Needs, Treatment and Supports, and the System of Care, Workforce and Accountability.

Priorities addressing basic needs include residential housing for children as well as housing for persons with co-occurring mental health/developmental disabilities and substance abuse/mental health disorders. Provision of sup-

Western Region priorities by framework domain (n=38)



ported employment is crucial for one county, while another is centering its attention on helping transition-age youth meet basic needs for housing, education, employment and community living. Others are addressing issues unique to rural counties such as transportation to health appointments, classes, work and recreation.

Mental health treatment priorities tend to concentrate on the specific needs of populations served by mental health and other providers. The priorities call for strengths-based, person-centered care coordination and integrated services across systems of care for high-need, high-risk populations (e.g., dual disorders, multiple disabilities, criminal justice contact) and for strengthened System of Care efforts on behalf of children with serious emotional and behavioral challenges and their families.

System, Workforce and Accountability priorities vary, with three counties noting the need to expand psychiatry services through recruitment of child psychiatrists and/or use of tele-psychiatry. Another county indicates that it will be assessing the level of services needed for children and families, while another will be examining how it can increase access to children’s services. Staff development is another theme to emerge, with one county focusing on use of screening tools to improve care across disability areas and another looking at how it can improve provider education for providers serving people with co-occurring mental health and substance abuse disorders.

Surveys of Cultural Competence, Clinic Restructuring, and PROS

As noted in Chapter 2, a report of findings from the cultural competence survey is presented in Appendix I. While the data from the clinic restructuring and PROS surveys are still being analyzed, preliminary data from the clinic restructuring survey were shared with the Division of Adult Services to be used for training and education sessions prior to the implementation of restructuring on October 1. Once the data analysis has been completed, the findings will be

presented to local planners and agency staff and made available in the CPS.

Chapter 5 endnote

- 1 Regions as defined by OMH: *Hudson River*: Albany, Columbia, Dutchess, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, Westchester. *Western*: Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates. *Central*: Broome, Cayuga, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, St. Lawrence. *Long Island*: Nassau, Suffolk. *NYC*: Bronx, Kings, New York, Queens, Richmond.

Maintaining Quality: Quality Management, Accountability, Performance Management, and Health Information Technology

Quality care is a measure of the degree to which services are consistent with the scientific evidence and achieve the desired outcomes. Quality care respects each person's dignity and culture, emerges from individual, self-directed plans of care that include family involvement, and depends on treatment and an array of peer and other supports that help reduce symptoms and improve life.

Quality care enables children and youth to develop socially and emotionally and youth and adults to draw on their inner strengths in managing their health. It supports recovery and resiliency and exists across all facets of treatment, from acute hospital to community care.¹ Quality care signals a good investment of public funding toward the goal of improving the mental and overall health of New York's citizens.

This chapter focuses specifically on four aspects of maintaining and enhancing quality: quality management, accountability and oversight, performance management, and health information technology.

Quality management: Aligning quality with recovery and resiliency

Progress continues in enhancing quality recovery-focused care. The following two changes demonstrate how the Office of Mental Health (OMH) is shifting its emphasis from monitoring the structure and number of services to evaluating the impact of services and supports on the outcomes valued by people engaged in services and their families.

Revising the Licensing Survey Process

Before OMH implemented its new clinic licensing reforms, clinics were licensed according to a tiered certification

process that focused on compliance with a host of specific regulations. Today, OMH licenses clinics using a new method—the tracer methodology—that incorporates the OMH Clinic Standards of Care. The tracer methodology is a crucial part of surveys conducted by both the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC).

As employed by CMS and TJC, the method involves the selection of a sample of individuals engaged in services by a surveyor who “traces” each individual's experience throughout the organization. A new licensing instrument provides standards and examples of exemplary and adequate performance, along with samples where there are opportunities for improvement. The standards emphasize access, collaboration among service providers, engagement of individuals and families served, risk assessment, person-centered mental health treatment, and attention to both physical health and co-occurring disorders.

Licensing surveyors seek evidence of effective and appropriate clinical services, care plans that reflect the needs and preferences of individuals engaged in care, attention to co-occurring needs, responsiveness to an individual's changing life circumstances, and support for chosen life roles. The clinical Standards of Care emphasize engagement and collaboration between the clinic, the recipient, and those individuals identified as sources of support for the recipient. In addition, a set of administrative standards addresses issues such as staff training and appropriate supervision, and also focuses on mechanisms that ensure responsiveness to persons engaged in care and families. As part of the process, surveyors conduct interviews with staff and leadership, recipients, significant others and other service providers to evaluate a person's course of service.

Overall, the use of the tracer methodology permits surveyors to examine systems issues at the individual and organizational levels of care. With the length of an operating certificate depending on adherence to care standards, OMH encourages exemplary practices through recognition and in-

centives. While the revised licensing process sets high standards for the delivery of clinic services that are individualized, integrated and effective, this initiative also includes efforts to identify and make available resources to assist clinics in meeting this challenge. These are available and updated regularly on the OMH website at http://www.omh.state.ny.us/omhweb/clinic_standards/.

Reducing Restraint and Seclusion with Trauma-Informed Care

Providing safe and comforting care

In late 2008, OMH distributed a guidance document for creating comfort rooms (http://www.omh.state.ny.us/omhweb/resources/publications/comfort_room/comfort_rooms.pdf). The goal was to promote a therapeutic, trauma-informed culture of healing and recovery in inpatient settings, while significantly reducing the use of restraint and seclusion. All State-operated children's Psychiatric Centers and children's units have created or are creating comfort rooms.

A large body of evidence demonstrates that behavioral approaches to care can provide important alternatives to reliance on restraint and seclusion.² Comfort rooms represent

a behavioral alternative and provide children and youth with a positive choice for managing their feelings and behaviors. Comfort rooms exemplify work by OMH and providers to educate direct care staff in the principles of recovery and wellness, trauma-informed care, and environments that are conducive to reducing violence and coercion. Comfort rooms work equally well with adults, so OMH is promoting and developing strategies for their use in adult inpatient settings. As described below, more attention will begin to be focused this fall on expanding such efforts to OMH-operated and licensed hospitals and residential treatment facilities (RTFs).

Guiding effective medical interventions

In May 2010, the Office of the Medical Director issued guidance on the use of medications when indicated (PRN) in urgent situations. The guidance reinforces OMH's belief that recipients and families are served best when decisions are made after consideration and discussion of all relevant clinical information, including the risks and benefits of any treatment. The document recognizes that, as with all medical illness, there are times when emergency situations arise that require urgent intervention to ensure the health and safety of an individual and others. To this end, the document

Tickling that funny bone: Good humor, good health

By Sarah Stimm, Board Chair, Healthy Alternatives through Healing Arts (HA-HA)

HA-HA, a program in Buffalo, has been helping people since 2001 to learn about holistic alternatives for maintaining good physical and mental health. HA-HA's team consists of a volunteer board of directors, 51% of whom are former or present recipients of mental health services. HA-HA provides services designed to further the holistic healing goals through informational services related to the body, mind and spirit. The annual conference and workshops provide hands-on information of the various alternative therapies available by trained professionals. Conference attendance includes mental health practitioners, mental health recipients, family members, and professionals, youth and children.

HA-HA believes that we can no longer depend solely on the doctors to cure us—we need to help ourselves. We need to incorporate good healthy activities into our lives. Many of the alternatives HA-HA offers at its annual conference and mini conferences throughout the year have been shown to help people with their mental and physical health. HA-HA does not want people to stop receiving regular medical and mental health help. We want them to learn about the holistic alternatives and work with their doctors or therapists in incorporating these into a healthy lifestyle.

Although some people with mental health problems recover using alternative methods alone, most people combine them with other, more traditional treatments such as therapy and, perhaps, medication. HA-HA is aware that many of these holistic alternatives can be expensive. That is why HA-HA is here. We try to bring knowledge of these alternatives to people who can't afford them.

We encourage people to begin their own journeys to getting healthy. Go to the library, read books and watch videos on holistic alternatives, watch Public Broadcasting Service stations, go on the internet and find good sites that can teach you about healthy choices.



Kathy Lynch, dressed up as "Strawberry Shortcake" at a HA-HA conference.

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presents guidance to staff in hospitals under the jurisdiction of OMH to ensure safe, trauma-informed and appropriate care. The guidance demonstrates OMH's attention to medications that are used as a restraint;³ management of agitation appropriately, using primary prevention strategies that reduce stress and coercion and encourage the use of coping skills; and emphasis on the rights of individuals to refuse medication.

Teaching “old dogs new tricks”: Adopting innovative approaches to trauma-informed care

Through grant support from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Western New York Children's Psychiatric Center this year introduced a silky white therapy poodle into day-to-day life. “Tommy” provides an important adjunct to therapeutic care and helps children to appreciate the importance of caring for and caring about others. Tommy's presence contributes to a coercion-free treatment setting, providing comfort and important life lessons for some children who express joy in accompanying Tommy on walks, feeding him or simply playing catch the ball with him.

Much preparation went into Tommy's introduction: developing an infection control policy that deals with the care



Tommy, a therapy poodle at Western New York Children's PC.

and handling of pets, establishing a policy for children with dog allergies, and encouraging hand washing after playing with the dog. Tommy is current with all immunizations, well groomed and kept on a leash. And, a TJC article, “When Comfort Has a Cold Nose” published in the December

HA-HA conferences are a lot of fun! Keynote speakers have had the audiences rolling with laughter. Some of the classes over the years have included:

- Feng Shui – to help with understanding why clutter is in your life and to feel good about your surroundings
- Yoga – to learn the importance of breath and gentle stretching to release tension
- Drumming – to experience empowerment, enjoyment, rhythm, mastery, nurturing and transcendence
- Change Your Words, Change Your Life – to learn to listen and stop giving yourself negative messages
- EFT (Emotional Freedom Technique) – to learn tapping of meridian points for physical/emotional healing
- Qi Gong – to use breathing techniques, gentle movement, and meditation to cleanse, strengthen, and circulate the life energy
- Tai Chi – to use gentle flowing movements to reduce the stress of today's busy lifestyles and improve health

What are people saying about HA-HA?

- Carol – “I was a little nervous to start yoga. I had never done yoga before, but the instructors were so welcoming, I quickly felt comfortable in the class. The teachers are very knowledgeable in what is happening with your body and mind. They explain what the different postures are doing and how to do them correctly and safely.”
- Monique – “Since starting to learn about Yoga, my life has really opened up into so many wonderful experiences. My rela-

tionships have become much better. Yoga has supported me through many challenges and has taught me to find peace, balance and strength from within.”

- Tom – “I do yoga to be able to be a better me.”
- Sean – “I have suffered from depression and chronic pain for years. I learned about Qi Gong at a HA-HA conference a few years ago. I couldn't afford to take classes so I learned about it more from the internet. I now practice every day. My pain is half of what it used to be and I feel much happier and have hope that I can conquer this. Thank you HA-HA for introducing this to me!”
- Jessie – “I took the Feng Shui class and it made me think that maybe I was so stressed because I had stuff everywhere in my house. I learned that clutter could do this. She (the instructor) gave me lots of ideas. I went home and started getting rid of a lot of junk in my house. I feel better and not so anxious.”

Laughter is one of the keys to good physical and mental health. Laughter is good medicine! It helps calm stress, pain, and conflict. Nothing works faster to bring your mind and body back into balance than a good laugh. Humor makes your troubles seem less, inspires hopes, connects you to others, and keeps you connected, focused and alert.

To learn more about HA-HA, contact Ms. Stimm at sarah@compeerbuffalo.org.

2009 Environment of Care News, continues to aid in allaying any fears about therapy dogs.

Using data to monitor progress

In December of 2009, OMH added restraint and seclusion rates in children's State facilities as new quality indicators of organizational performance to its Balanced Scorecard. The Scorecard provides quantitative data to compare actual performance against specific measurable targets.

The inclusion of restraint and seclusion rates on the Balanced Scorecard was suggested by members of the Advisory Board to YOUTH POWER!, a statewide network of young people with disabilities and social emotional challenges who are on the road to recovery. In a meeting with the Commissioner and the Director of the Division of Children and Family Services earlier in the year, YOUTH POWER! Board members requested that restraint and seclusion data be published as part of the online Scorecard. You may view

the restraint and seclusion data online at <http://bi.omh.state.ny.us/scorecard/view>.

Learning opportunities and recognition for creating coercion- and violence-free environments

Under its Positive Alternatives to Restraint and Seclusion initiative, OMH sponsored a two-day seminar in March 2010 aimed at addressing challenges of providing safe and coercion-free environments. The seminar provided an overview of the neurobiological and psychological effects of trauma, assumptions about the use of restraint and seclusion, trauma-informed care, and how organizations could work toward preventing restraint and seclusion.

The seminar also provided OMH with the opportunity to recognize exemplary work and success in reducing restraint and seclusion by three providers. Each received a \$5,000 award to further their programs' restraint/seclusion reduction efforts. In addition, eight providers received \$1,000

Where the pastures are greener: Executive Director Joe Whalen talks about helping children grow and prosper



There's something healing about country life. From the rooster's crowing to signal the dawn of a new day to the teamwork required to run a farm. Back in 1947, Sam Ross Jr. had a dream: to create a school on a farm where children and animals could be together. Little did he realize the facility he created just 65 miles north of New York City (NYC)—Green

Chimneys—would become a world-renowned and respected model of mental health care.

Throughout our six decades of service, we've remained committed and passionate about providing the best care possible for youth with emotional, behavioral, social and learning challenges. What differentiates Green Chimneys from other mental health service organizations is our animal-assisted and nature-based therapy and activities programs. We have more than 200 animals—many of them rescued—at our Farm and Wildlife Rehabilitation Center. Our children work with staff to care for the animals. For many, the connection with an animal provides a bridge to communication. As students care for and develop a relationship with the animals, they learn



to relate to others in their lives—teachers, family members, peers. It's a powerful, healing connection.

Like the vegetables and flowers grown from seeds in our Children's Garden and Boni-Bel Farm, our youth blossom. With the rich broth of programs that address emotional, educational, recreational and therapeutic needs, they grow and develop self-esteem. Our staff is passionate about caring for and helping children, which can be seen by anyone visiting our main campus in Brewster or our satellite programs at Clearpool Education Center in Carmel or

our lesbian, gay, bisexual, transgender, and questioning (LGBTQ) program in NYC. Treatment teams focus on maximizing the potential of youth, and preparing them for a brighter future so they can return to their community and family.

While we may be best known for our signature animal and nature programs, Green Chimneys focuses on quality, safety and innovation. We are working toward accreditation in the Sanctuary Model and have upgraded our school programs. We always look for ways to do things better, or in a new way. Back in the 1960s, we launched a groundbreaking visual arts program by putting cameras in the hands of children to

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awards for their efforts to create therapeutic environments through positive, coercion-free, recovery-focused treatment. The award money was made possible through a State Incentive Grant to Build Capacity for Alternatives to Restraint and Seclusion, awarded to OMH by SAMHSA.

These and other opportunities make clear that advances occur when everyone becomes involved with improving the quality of care in OMH-operated and licensed hospitals and RTFs. With this in mind, OMH continues to stimulate innovation. This fall it will initiate learning collaboratives to help the agency, experienced leaders, experts in the field, recipients and families, and mental health providers to come together to strengthen trauma-informed practices and care.

Informing the collaboratives will be “Six Core Strategies to Reduce the Use of Seclusion and Restraint” (organizational leadership for effective change, data-informed practice, workforce development care based on principles of recovery and resiliency, use of restraint and seclusion prevention tools, inclusion of consumers and family members,

and the debriefing analysis). The strategies stem from the National Association of State Mental Health Program Directors⁴ as well as principles of recovery-based, trauma-informed care. Participating providers have established within their own organizations multidisciplinary teams to guide the process of developing, implementing, monitoring progress, and evaluating the results. The collaboratives are set to run through March 2011.

Mental health oversight and accountability

The model guiding oversight and accountability was finely tuned in 2009 to illustrate how OMH is working to stimulate transformation from the bottom up. The refined



tell their stories. For many, it provided a vehicle to communicate their feelings. Today, our students produce

animated films, one of which was the Grand Champion prize winner at our County Fair.

We were one of the first organizations to address the mental health and housing needs of LGBTQ youth with a range of programs for youth in foster care in NYC.

During my nearly 40-year tenure at Green Chimneys, I've seen so many changes. We've evolved from a private school model to a social services agency. Now, we are returning to our roots as more of a private model, but still focusing on student success.

There are so many magical moments here. One of the most moving was a phone call from a former student writing about Green Chimneys for his medical school application. He could barely remember staff names, but he remembered the animal that helped him.

"I used to work with Hazel," he said, reminiscing on his favorite farm animal. "I'm sure she's been gone for years."

"Hazel, the Jacob's sheep?" asked our farm director incredulously. "She's still here."

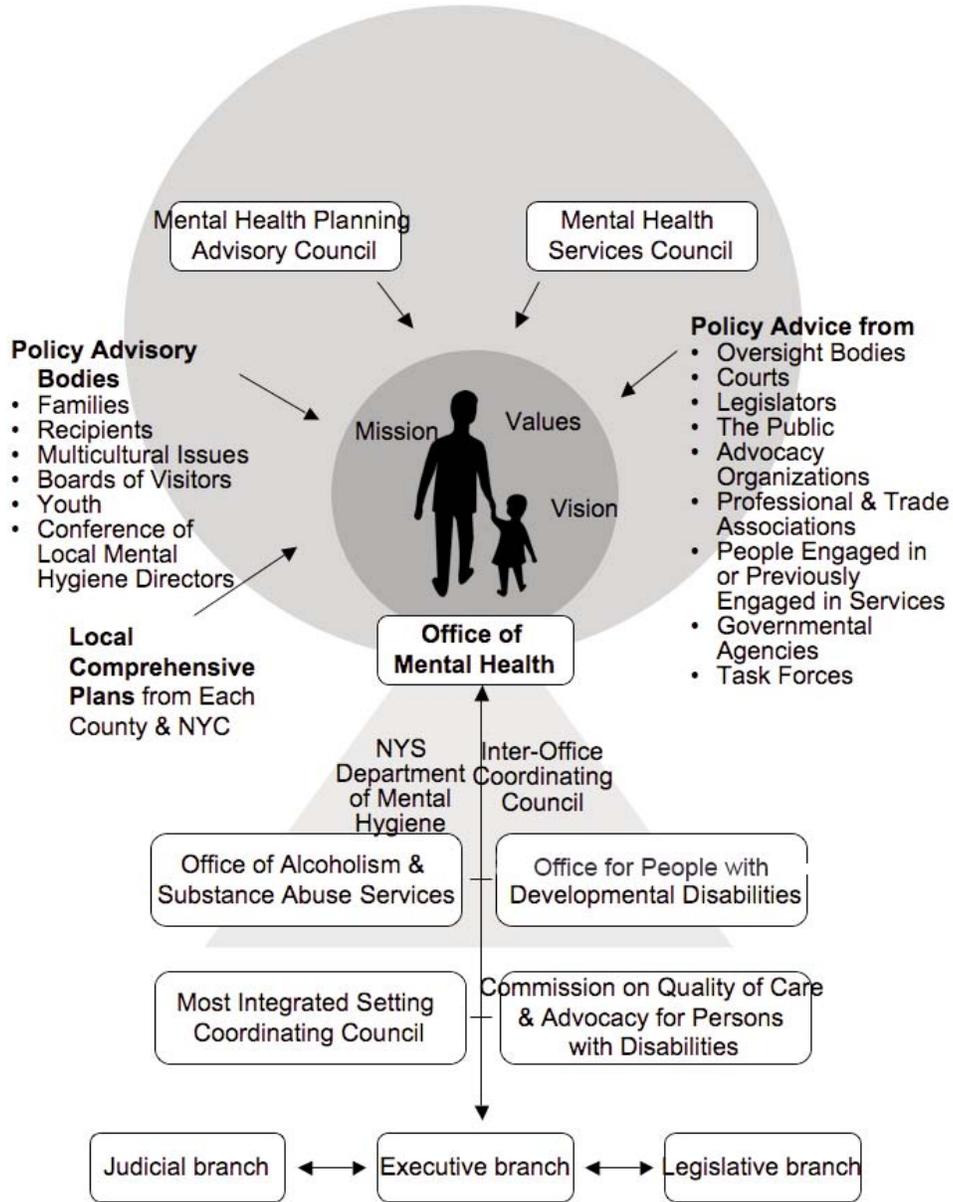
The young man's voice filled with emotion as he arranged for a visit back to the place that put him on the right track. By the way, he is currently in medical school.

The success of our alumni is what makes my job so rewarding. My favorite day is Alumni Day. It's heart-warming to see children who struggled with mental health or emotional issues return to campus as successful adults, often with family in tow. They come back to share the place that made a difference in their lives with their loved ones. Our work matters.

Today, we serve more than 67 school districts. In our residential and day programs on our main campus, we have close to 200 students with unique educational and emotional needs. Since 2000, we've invested more than \$30 million in new facilities to meet future demands. It's the biggest capital improvement campaign in our history. We've opened a new Health & Wellness Center, horse barn and wildlife center building. In 2011, we will add new residential housing, providing a safer environment for students and staff. Green Chimneys' future is strong because of these investments and our proven ability to provide specialized services that our community values and needs.

For more information about Green Chimneys, visit its website at http://www.greenchimneys.org/index.php?option=com_content&view=frontpage&Itemid=1, or via email at dbernstein@greenchimneys.org.

Providing an Accountable Mental Health System



Tapping into strengths and abilities: Training forensic/peer specialists

Research demonstrates that peer support leads to improved social functioning, self-esteem, social support and quality of life; it also is associated with less frequent use of hospitals and crisis services and strengthened self-advocacy skills. Findings like these underscore the importance of the work being done at the Howie the Harp Peer Advocacy and Training Center in NYC to prepare future generations of peer specialists. What follows is a brief summary of

the Howie the Harp training model, which is aimed toward competitive employment.

What are the benefits of forensic/peer specialist training?

The Forensic/Peer Specialist Training Program creates a safe, recovery-oriented environment that empowers persons with psychi-

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atric disabilities, criminal histories, and substance abuse disorders to achieve their dreams. The program trains and ultimately places individuals in full and/or part-time employment positions within human services agencies. Some graduates even provide direct services for persons coming out of jail or prison. Individuals with mental illness who have experienced the criminal justice system are often stigmatized twice—once for having a psychiatric disability and again for having been incarcerated. The training program provides vocational training and job placement, counseling and varied support services, which are helpful in combating this stigma and discrimination. As such, the program provides alternatives to incarceration, promotes community reintegration through structured vocational training activities and job placement opportunities, and aids in decreasing exposure to risk-taking behaviors.

Who is the program helping?

Every person accepted for service must have an Axis I diagnosis (these diagnoses usually include depression, anxiety disorders, bipolar disorder, ADHD, autism spectrum disorders, and schizophrenia), a history of abusing illegal substances, and/or having been incarcerated within the criminal justice system. To be considered for the program, applicants must have at least six months of self-reported sobriety or clean time from illegal substance use. Candidates are also expected to have stable housing, receive entitlements such as public assistance, and/or Social Security Income/Social Security Disability (SSI/SSD), and be stable psychiatrically. The advocacy program also accepts persons currently working nights, weekends or per-diem who wish to improve their employment opportunities. The minimum educational requirement for participation in the program is a high school diploma, a general educational development (GED) high school equivalency diploma, or a realistic plan for achieving a GED within a one-year period.

What is the process for entering the training program?

The process has many steps, and all aim to help each person succeed. Intake can start over the phone or in person. With the initial contact, the prospective participant is assigned to attend one of the weekly mandatory group or individual orientation sessions. Once orientation is completed, the prospective participant attends a series of face-to-face intake interviews over about 30 days. During the interviews, in-depth assessments of strengths and weaknesses are conducted. The final step before acceptance requires the applicant to file necessary documentation requested by intake staff. After acceptance into the Forensic/Peer Specialist Training Program, each participant undergoes vocational assessment and a career exploration interview for the field of human services. The participant's employment history, vocational interests, needs, strengths, values, skills, supports, barriers and challenges to obtaining or maintaining employment are evaluated and strategies for obtaining competitive employment are explored.

What does the training program include?

The Forensic/Peer Specialist Training Program includes six months of intensive training, as well as an internship in the field of human services. Classroom training is conducted five days per week and provides approximately 150 hours of in-class instruction in such areas as professional ethics, service coordination, information and referral, conflict resolution and substance abuse and relapse prevention. Trainees have the opportunity to provide regular feedback to the program management via surveys. Upon completion of classroom and internship training, participants are then assisted to obtain employment. This commitment to six months of classroom training and three to six months of a supervised internship serves a dual purpose. The first is to expose people with mental health challenges who may have histories of incarceration to the technical concepts of wellness and recovery and gain the skills and knowledge necessary to serve as mentors to others. The second is to provide ongoing supports that allow trainees to incorporate these concepts into their own individual experiences, thus contributing to their own personal wellness and recovery.

How does Howie the Harp support its graduates?

Howie the Harp faithfully offers supports that enable people to meet their own employment goals successfully. Three major areas of support are offered: the weekly Career Club for graduates, facilitated by the Employment Coordinator, for sharing job search struggles, job leads and job search strategies; individual job search support with computers, email, telephones and fax machines; and on-the-job support through staff site visits, continuing education and career development services, and support groups (e.g., Narcotics Anonymous, Relapse and Recovery).

What makes this program unique?

Program trainees and graduates are invited, for a lifetime, to attend different culturally diverse recreational/social activities held at Howie the Harp. These include drama workshops, an uptown Friday night group, creative writing group, annual health and job fairs, and culturally diverse holiday celebrations. The Howie the Harp Advocacy Program is exceptional in that it is a premier peer-run program. More than 50% of the staff members are persons who are or have been engaged in mental health services. Having "been there," they understand the importance of treating every person as a whole person, not a diagnosis or disability. They focus on strengths and abilities, self-determination and self-help, and the pursuit of productive lives and dreams.

To learn more about Howie the Harp, visit <http://www.communityaccess.org/what-we-do/employment-a-recovery/hth-peer-advocacy-ctr>.

model makes clear that our collective responsibility is to keep the people at the heart of the system.

The top of the model shows OMH striving to promote mental well-being, healthy growth and development, and effective treatment and supports for mental health conditions and serious illness. The advice and policy direction offered by stakeholders—including advocates, providers and provider associations, and trade associations—make this possible. In New York State (NYS), two statutorily required policy advisory bodies also play a central role: the Mental Health Services Council (MHSC) and Mental Health Planning Advisory Council (MHPAC). In particular, the MHSC is charged by law to work with OMH in setting statewide goals and objectives for the system of care, while the MHPAC focuses on federally mandated requirements for receipt of block grant funding. Much of the input received from stakeholders of the system this year is incorporated throughout the Plan, and also presented in Appendix 5.

At the middle level are the three agencies that make up the “Department of Mental Hygiene.” The Department reorganized in 1978 to form three distinct offices: the Office of Alcoholism and Substance Abuse (OASAS), the Office of Mental Retardation and Developmental Disabilities (OMRDD), and OMH. In July 2010, Governor Paterson signed into law a change of name for the agency, now the Office for People with Developmental Disabilities. The Inter-Office Coordinating Council (IOCC) headed by the three commissioners is responsible for oversight and coordination of activities among the agencies. Reinvigorated in 2007, the IOCC aims to eliminate barriers to care and improve coordination of services for people with disabilities, particularly for people whose disabilities span the systems of care. IOCC activities are closely linked to other human services agencies (e.g., health, social services, criminal justice, education), maximizing the capacity of all systems to better serve and improve the well-being and overall health of New York’s citizens. Input into this year’s Plan from stakeholders and localities is also presented in Appendix 5.

The bottom of the model represents the specific actions that have been endorsed to obtain the desired results for improving public mental health and well-being. It indicates the roles of the legislative, executive and judicial branches of our State government in developing, supporting, implementing and evaluating public mental health policy. While the model pictorially captures building blocks of accountability, it does not show its dynamic nature. Good policy depends upon good collaboration. The people who form the collaborations help to inspire our commitment and action, foster our ability to solve problems together, provide a foundation for broad involvement, and sustain our hope for success.⁵

Performance management information

OMH makes a broad range of data and information resources publically available on its website at <http://www.omh.state.ny.us/>. This section highlights performance management information readily accessible via the internet to New Yorkers interested in monitoring care processes and quality.

Finding Mental Health Programs in Communities

The Mental Health Programs Directory helps New Yorkers find mental health treatment and supports in their own communities or neighboring communities. This online directory provides a searchable list of programs (other than residential) licensed by OMH. In addition, it includes programs funded by OMH, but not requiring a license to operate. The directory allows users to search for mental health programs by county, program category or subcategory. Within the listings are program details (e.g., address, phone number).

The directory also contains information to help people use the tool more effectively, such as answers to common questions (e.g., what is a licensed program?), descriptions of service types, and explanations of how to navigate the site and use it effectively. The directory, which is updated regularly, is available at <http://bi.omh.state.ny.us/bridges/index>.

Statistics and Reports

OMH provides access to a number of online data information resources. The information comes from the Office of Performance Management and Evaluation which carries out an interrelated set of functions for collecting, analyzing, evaluating, and identifying quality improvement opportunities for mental health program organization, performance and policy issues. The Office of Information Technology plays a large role in preparing and making available the online “portals.”⁶

Many of the data portals provide comprehensive views of specific program areas. One in particular, the Patient Characteristics Survey (PCS), provides a broad view of service delivery during a one-week period. All of the portals described briefly below are also accessible from the Statistics and Report page at <http://omh.state.ny.us/omhweb/statistics/>. The page also contains a number of agency reports issued over the past few years, such as the OMH Assessment of Clinical Care, Professional Workforce, Research, and Local Government Opportunities.

South Beach wellness and recovery: Where “brite” ideas flourish

*By Gary Klemuk, MA, LMHC, Chief of Service
Wellness and Recovery Services, South Beach Psychiatric Center*

At the heart of the South Beach Psychiatric Center's (SBPC) mission to promote individualized recovery outcomes is the longstanding tradition of utilizing person-centered practices in the delivery of rehabilitation services. Consumers at SBPC have clearly expressed the importance of achieving employment as essential to their recovery. SBPC has, therefore, sought to cultivate the conditions to facilitate successful vocational outcomes. The following is a brief description of SBPC's vision of supported employment and one “brite” example of community integrated supported employment.

In 2001, SBPC, along with Advocates for Human Potential and the Matrix Research Institute, partnered to design a template for supported employment. “The Jobs Project,” supported by a two-year SAMHSA Community Action grant, sought to change the ways communities, clinicians, employers and consumers viewed and addressed employment. This project provided the key principles for SBPC's supported employment approach:

1. Honor consumers' choices
2. “Zero Exclusion” based upon presumed job readiness
3. “Whatever it takes” – create services responsive to needs
4. Ongoing post employment support as long as it is needed
5. Honor employers' needs for workers that can do the job
6. Collaborations between stakeholders as key to success
7. Supported employment must be in mainstream, community settings

Interested clinical and rehabilitation staff members were provided training and supervision by the Columbia University Workplace Center to establish and run “Career Clubs” at each outpatient site in Staten Island and Brooklyn. Workplace Center training on local labor market development followed. Additional training covered a variety of topics related to systems change, including supported employment, person-centered career planning, job development and job coaching. Training was provided through the OMH contract with the Cornell University Employment and Disability Institute. These trainings continue to be available for staff through the “Foundations to Recovery” catalog of courses.

An Employment Services Team, made up of trained staff committed to supported employment, was created as part of the SBPC Wellness and Recovery Service. This team is solely devoted to providing employment services and ongoing support for consumers. The focus of the Employment Services Team has been to improve the delivery of employment services and expand these connections throughout Brooklyn and Staten Island.

A key to achieving positive vocational outcomes is the establishment of community business partnerships. As an outgrowth of “The Jobs Project,” a stakeholder, The Shorefront Mental Health Board, sponsored and developed an affirmative business. Consumers offered recommendations on the type of business they wished to become involved with. The overwhelming preference was for a janitorial services business, primarily because consumers believed that they could learn a skill set that they could perform effectively and that would be most marketable for those who wanted to pursue this as a long-term vocational goal.

“Brooklyn Brite” opened as an affirmative business in 2002. Goals of the business were to provide training commensurate with the caliber of cleaning services expected by employers and provide employment opportunities and a career ladder for consumers interested in environmental services. The community board pursued and was awarded custodial contracts over time at various SBPC and Vocational and Educational Services for Individuals with Disabilities' sites in Brooklyn, Staten Island and Manhattan. Psychiatric rehabilitation budget funds have been used to pay for consumer training and to fund community internships for consumers.

Since the inception of Brooklyn Brite, more than 150 consumers have received training in environmental services. Several clients have gone on to competitive positions in this field following the conclusion of their internships. Many other participants have used this experience to work at other types of jobs in the community. They have reported that engaging in a “real world” job experience prepared them for work in fields that they learned held a greater interest for them.

Several workers have been so valued that Brooklyn Brite has hired them on as employees. This includes individuals who have been hired in supervisory positions and have several years of tenure with the company. There have been clear promotional steps for workers, including raises as warranted—the same as would be the case in any janitorial services company. There are currently 13 individuals paid in part or wholly by Brooklyn Brite and 10 other interns, many who will be joining the ranks of company employees. The company also has employees that are not mental health consumers.

If you wish to learn more about SBPC community integrated supported employment opportunities, contact Mr. Klemuk at SBIS-GMK@omh.state.ny.us or visit the SBPC website at <http://www.omh.state.ny.us/omhweb/facilities/sbpc/facility.htm>.

Adult Housing

http://bi.omh.state.ny.us/adult_housing/index



The Adult Housing web page presents the residential program indicators (RPI) report. The report provides county, regional, and statewide averages.

Assertive Community Treatment (ACT) Reports

<http://bi.omh.state.ny.us/act/index>



The ACT web page provides an overview of the program, up-to-date statistical data on program operations, demographic and diagnostic characteristics of recipients, and recipient outcomes. Statewide, regional, county and program data are available.

Assisted Outpatient Treatment (AOT) Reports

<http://bi.omh.state.ny.us/aot/about>



The AOT Reports page contains demographic and diagnostic characteristics of recipients and outcomes. Statewide, regional and county data are available.

Balanced Scorecard

<http://bi.omh.state.ny.us/scorecard/index>



The OMH Balanced Scorecard contains data to measure progress toward specific goals. It uses data to compare actual performance against measurable targets. Updated quarterly, the scorecard focuses on outcomes, results of public mental health efforts, and critical indicators of organizational performance.

Children, Teens and Families Indicators Portal

<http://bi.omh.state.ny.us/kids/index>



The “Kids Indicators” also included indicators of youth and family services. It contains reports based on data received from providers as well as from two assessments of care surveys, one from youth and one from families.

Clinic-Plus Services Statistics

<http://bi.omh.state.ny.us/clinicplus/index>



The Clinic-Plus portal displays cumulative quarterly reports starting in 2007. Data include numbers of children screened, and those receiving comprehensive assessments, admitted to clinic treatment, and receiving in-home treatment.

PCS Portal

<http://bi.omh.state.ny.us/pcs/index>



The PCS provides a comprehensive one-week “snapshot” of the population served by the State public mental health system—demographic, clinical, and service-related information for each person who receives a mental health service during the specified one-week period. It also contains summary reports describing client characteristics and planning reports with penetration rates and national outcome measures. Historic reports provide data from surveys back to 1999. In April 2010 the PCS portal was updated with data from 2009 survey year. In addition to the summary and planning reports, new data were added to describe chronic health conditions, co-occurring disorders and Committee on Special Education classifications.

Office of Planning Web Page



The site provides users with a catalog of links to an array of data, reports and planning resources. It also houses information for the Mental Health Services Council, which was established by law to consider and advise the Commissioner on matters relating to the improvement of mental health services in the State.

Future Development

In 2011, the portals will expand with the inclusion of consumer assessment of care data. The data will come from a survey being conducted across OMH outpatient programs and provide recipient reviews of quality, access and appropriateness of care. The survey data will also shed light on outcomes and quality of life indicators.

Mental health information technology

The NYS public mental health system is increasingly reliant upon OMH information systems. OMH-operated facilities depend upon them for patient care, financial and human resources management, and communication. More than 2,500 locally operated mental health programs use them for required financial reporting, and increasingly for care coordination and outcomes reporting. County and City mental health authorities use them for planning and oversight of their local systems. Overall, OMH information technology resources are directed toward information systems

management, data communications and data processing for the Central Office, Field Operations, and outpatient and inpatient hospital settings and designed to enhance the accountability of publicly funded mental health services.

Information technology is a powerful tool for bringing data and technology resources to improve the quality and outcomes of health care. Studies show that health information technology holds potential for transforming the delivery of health care, making it safer, more effective, and more efficient. In ambulatory settings, a small set of high quality studies shows that implementation of a comprehensive outpatient electronic health record (EHR) leads to improvements in the structure of care delivery, clinical processes, and outcomes. Studies also show that the quantifiable benefits of an EHR system include savings from capturing and accessing data; improved efficiency, quality and safety of care through supported decision making; improved billing and staffing business management; and improved access and patient flow.

OMH information technology resources are aligned with the strategic direction of the agency (e.g., clinic restructuring, improving clinical care, supporting recovery and resiliency) through a number of targeted approaches. Among priority areas of the Division, in collaboration with other OMH divisions and other stakeholders, are:

- ◆ Clinical Services—Piloting of EHRs at State Psychiatric Centers, including computerized entry of physician orders and bar-coded medication administration, both designed to enhance patient safety; continuing support for use of the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) throughout OMH inpatient and outpatient settings and expansion of PSYCKES to community care settings
- ◆ Productivity/Workforce Enhancements—Improving employment services and supports by contributing to the cross-agency platform that will match recipients' work goals with work opportunities; using videoconferencing for collaboration while reducing meeting travel and related costs
- ◆ Financial Management—Consolidating billing codes and modernizing the billing system, and incorporating changes related to clinic restructuring; enhancing county contract management processes for efficiency and effectiveness
- ◆ Facility Improvements—Incorporating elements for improving the quality and efficiency of care, including, a Joint Commission reporting tool, and staff and outpatient appointment schedulers

Summary

On a number of fronts, OMH strives for a system of care based on what helps to engage people in obtaining treatment and support, when needed, and to maintain mental health and the best functioning possible. This requires constant and systematic attention to what people say matters—care that is empowering, culturally and linguistically competent, driven by the needs of the individual, youth and families, and oriented toward building individual and community recovery and resiliency.

Chapter 6 endnotes

- 1 Funk M, Saraceno B, Lund C. et al. (2003). Quality improvement for mental health. Geneva: World Health Organization.
- 2 Donat DC. (2005). Encouraging alternatives to seclusion, restraint, and reliance on PRN drugs in a public psychiatric hospital. *Psychiatric Services*, 56, 1105-8.
- 3 Drug used as a restraint means a drug or medication when it is used as a restriction to manage a patient's behavior or restrict his/her freedom of movement and is not a standard treatment or dosage for the patient's medical or psychiatric condition, or as otherwise defined in federal regulations of the Centers for Medicare and Medicaid Services.
- 4 Huskshorn KA. (2006). A Snapshot of Six Core Strategies for the Reduction of S/R: Creating violence free and coercion free mental health treatment environments for the reduction of seclusion and restraint Alexandria, VA: Author, National Technical Assistance Center. Available online at http://www.nasmhpd.org/general_files/publications/ntac_pubs/SR%20Core%20Strategies%20Snapshot%2011-2006%20src%20edits.pdf.
- 5 Townsend S. (2007). How judges can build multidisciplinary collaborations to benefit children and families. In C Flango, C Campbell, & N. Kauder (Eds.), *Future trends in state courts* (pp. 46-49). Williamsburg, VA: National Center for State Courts.
- 6 A portal is an online web page that presents information from diverse sources in a unified way and allows the user to display the information with a consistent look and feel.

Toward Recovery Transformation

Last year's Plan ended with an invitation from Dr. Mark Ragins, medical director of the nationally recognized Village in Long Beach, to imagine mental health systems where our collective wisdom and ideas help people recover. Then, he urged that we “reach out and grab it.”¹

Despite times of enormous challenge and pressure, so many organizations—from peer-run, family-driven, advocacy to clinical—continue to forge ahead with great courage, passion, and intent to make a difference in people's lives. This is evident from profiles throughout the Plan that highlight how individuals, when coming together with a mission and a clear plan, do create a legacy of growth and achievement.

What distinguishes these clinics and programs—and many other fine programs in New York State (NYS) like them—is that they have identified opportunities for improvement, integrated what's new and different into their existing actions and decisions, and emerged stronger and healthier. This has not happened simply with the adoption of new programs or refined communication strategies. Such change results from clarity of mission, strong leadership, a

continued focus by all involved on the strategies toward desired outcomes, and anticipation of and attention to new challenges and pressures.² Successes by these and other programs have stemmed in part from leadership and staff seizing opportunities to think about what they were doing. They considered the factors affecting, and connections between, their everyday activities and anticipated outcomes. They created plans that enabled everyone to work together for positive change in their organizations and communities. In a sense, the paths they have chosen are making a difference and making a difference is translating into improved lives for people with serious mental illness and mental health challenges.

Such change can seem daunting in the face of the realities of daily operations and responsibilities. But, as Dr. Ragins points out, “. . . to transform our system, we have to stop planning and discussing, and actually do something different in our day to day work.”

What follows is a case study demonstrating how one county and provider agency in New York State, faced with significant administrative and fiscal challenges, stepped up to create change.

CASE STUDY

Transforming a mental health system from the ground up: How Westchester County's service delivery system began its recovery

It all started with an alignment of stars. A new OMH Mental Health Commissioner with a clearly articulated framework for developing a recovery-focused system. A new Westchester County Mental Health Commissioner who knew from years of experience in the community what did not work and how the system had failed many of the people receiving services. A new agency executive with a fresh perspective on what services should look like for people who are recovering from mental illness.

What are the chances that three like-minded, tenacious individuals would come together, at the same point in time, to take action to change the mental health system?

Fortunately, Michael Hogan, PhD, OMH Commissioner of Mental Health, Grant Mitchell, MD, Westchester County Department of Mental Health and Amy Kohn, DSW, Chief Executive Officer, for the Mental Health Association (MHA) of Westchester County, Inc., held individual perspectives on recovery that converged to create a wave of change in one community.

It started with Grant Mitchell's conviction that the system had failed to engage some people and the knowledge that we simply need to do a better job in helping people to recover. Using a demonstration project based in Western New York as a template, Dr. Mitchell and

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Deputy Director, Melissa Staats, received permission from OMH and the State Department of Health (DOH) to use Medicaid data to identify the people in the community who had used the most resources with the least benefit. Using existing case management items, the County identified two positions it would define as Care Coordinators who would be responsible for doing “whatever it takes” to achieve better outcomes for individuals who appear to be “falling between the cracks.” Shortly after the project began, the results were so dramatic, the County Legislature funded two additional positions, bringing the total number of positions to four and the total number of people served by the program to 48.

Results of the project are significant. In just the first two years of operation, County inpatient mental health care and jail costs were reduced by half. A key ingredient for success is the flexible use of the \$1500 per-person self-determination funds. These are funded by the County and as such, have more flexible capacity for use. Unlike intensive case management service dollars, these funds are not meant to buy coats, shoes and daily living essentials. Instead, these funds are for gym memberships, music lessons, tuition payments or anything it takes to support an individual’s journey to recovery. A second important element of the program is the peer mentor program. This partnership with the Empowerment Center offers program participants the opportunity to work with a peer who provides additional support and mentoring.

The project has received national attention. Recently selected as one of sites to be studied by the Bazelon Center, Westchester will be on the front lines communicating with the Center for Medicare and Medicaid Services (CMS) regarding more flexible use of Medicaid funding to assist people to stay out of the hospital and remain in their homes in the community.

An important distinguishing factor for this project is the orientation to person-centered planning. Each person is in the driver seat and designs his or her own plan for treatment and recovery.

Person-centered planning was a new concept in the treatment community in Westchester County. As the County prepared to embark on this new initiative, it was evident that staff and recipients both needed to learn about putting the people receiving services at the center of the planning process. Experts in the field were consulted and a countywide training initiative was launched. Over the three years that this project has been operational, staff in every agency has had the opportunity to participate in the training and to learn how to promote recovery among members.

The MHA is one agency that took this opportunity very seriously. As the agency providing the Care Coordinators for the Westchester Care Coordination Project, the MHA heard first hand from its own Care Coordinators what an important difference the recovery orientation and person-centered planning had been making for the

participants. The MHA realized that the benefits achieved by participating in the Care Coordination project could be enhanced by extending the person-centered principles throughout the entire organization. The agency took advantage of all the training offered by the County and even benefited from some extra time devoted to having one of the experts provide advice on how to implement transformation throughout the organization.

As a provider with multiple programs and 160 employees, the philosophy and approach of transformation to a recovery-focused organization “jumped off the page” as an important element in changing the underpinning of what “we do on the ground.” Leadership and perseverance have been critical elements. “She just won’t back down . . .” Doris Schwartz, Chief Operating Officer, says of her boss, Dr. Amy Kohn of the MHA.

And so, it began. Doris, who had been trained in the Boston University Psychiatric Rehabilitation principles a few years back, had left the field for a short time, but missed it. When offered the opportunity to join the MHA, even without a job description, she enthusiastically accepted when told, “I don’t know what this job will be; you will have to create it.” Two years later, she describes the MHA journey to a recovery-oriented system as an interesting and energizing study in organizational and systems change. For the MHA, transformation implies sweeping change rather than simple reengineering, redesign or restructuring. The MHA has launched a transformation initiative that embraces a recovery-based model of practice, utilizing a person-centered approach to service delivery that goes from the very top of the organization starting with the Board of Directors to the very core—to the people participating in services and to the staff working with them.

To guide the journey, the MHA is following the five key elements of Mental Health System Transformation as outlined by the Substance Abuse and Mental Health Administration (SAMSHA). The five elements include:

Vision: The MHA will be the go-to agency in Westchester County for people managing a psychiatric disability. The MHA promotes recovery through a partnership between individuals and their service providers that embraces a person-centered planning approach based on many principles, including the fact that individuals identify their own hopes, dreams and goals.

Strong Leadership: MHA leaders at all levels participate in the change process. Senior leaders must buy into a unified vision to effectively communicate, organize and manage the change in all corners of the agency. A map—with clear goals, an action plan, and performance measures—has been created.

Organizational Alignment: The MHA’s structure, policies, procedures, practices and physical environment must be fully aligned with the transformation vision to ensure success. This includes an assessment of all systems that will be affected by

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the change: Reception, Information and Referral, Supervision, Human Resources (job descriptions, etc.), Board, Forms, Billing, Environment and Intake.

Culture: With the right structure, training, systems and supervisors to build on a well-communicated vision, the MHA is finding it has the capability to tap an enormous source of power to improve organizational performance.

Continual Process: Transformation will be a long-term, multi-year endeavor requiring continual evaluation. Multiple opportunities for learning must be available, for instance, ongoing training, supportive supervision and learning collaboratives. The MHA continuously asks itself how it is doing. Since the initiative began, the training schedule has included 37 sessions, with two major conferences devoted to transformation to person-centered planning. In addition, the MHA has received advice from experts who have traveled the transformation road: Adele Gorges, Diane Grieder and Janis Tondora. Finally, the agency has used the Adams and Greider Person-Centered Treatment Plan to develop a roadmap for the organization to become a recovery-oriented system. The goal remains firm: The MHA will be the provider of choice in Westchester County for adults with psychiatric diagnoses as evidenced by utilizing person-centered practices throughout the agency within two years.

To assist with implementation of the five elements and the goal, the MHA formed a Steering Committee and multiple workgroups. The Steering Committee consists of a Board member, a Development Committee member, six members of executive management,

six program managers, four staff members, three recipients of service, and two family members. The work groups, all with specific activities and tasks, include: the Service and Supervision Committee, the Performance Measure Committee, the First Contact Committee, the Human Resources Committee, and the Forms Committee. Interestingly, the Human Resources Committee turned out to be an extremely important component in the transformation process. Changing employee perspectives, as reflected in new job descriptions and performance evaluations, is a critical element in assuring that the staff involved in the process is making a commitment to the change. About seven out of 160 employees felt very respectful of the MHA's intent, but decided to either retire or leave the organization.

To say that the journey so far has been smooth sailing would probably be an exaggeration. Some of the committees haven't produced the expected products and other challenges have occurred. However, one thing is clear. The MHA is fully committed to its goal to transform to a recovery-oriented organization. Step 1 on its work plan reads:

The MHA will be recognized as expert in person-centered planning and recovery-oriented services throughout Westchester County and the State within two years (2/2011).

Looks like the MHA is way ahead of schedule.

As illustrated by the case study, Westchester County and agency leaders seized upon natural opportunities and created the conditions for change. They continue nurturing change and striving for more effective services and supports to help residents cope with mental health issues, recover and be more resilient.

Strong, competent leadership is especially important today in stressed economic times. Consumers are better informed than ever and looking for the services and supports that match their needs. Many are making judgments daily about the effectiveness of mental health services. They know effectiveness when they see it, and more often, when they don't.³

Just as with Westchester County and with other NYS organizations actively engaged in transformation, opportunities continually present for taking stock of processes, procedures and actions that lead to a high level of organizational effectiveness and sustainability. A number of variables believed to be integral to organizational effectiveness⁴ are brought out in the case study. And, as you read it, you may be able to pick out some of the variables that could be linked to the successes experienced in Westchester County:

- ◆ Passionate employees who have high levels of job satisfaction
- ◆ Choice of the “right partners” and building trusting, resilient relationships
- ◆ Strong communication among partners, up and down the levels and between parts of individual agencies, as well as excellent external communications
- ◆ A focus on consumer needs and desires
- ◆ Regard for culture, change and innovation
- ◆ Strong organizational mission and strategy
- ◆ Understandable policies, practices and decisions
- ◆ Emphasis on planning, training, and support
- ◆ Consistency and congruency between words and actions
- ◆ Decision-making authority for staff working closest to consumers
- ◆ Supportive and effective boards of directors
- ◆ Emphasis on efficient and effective processes in harmony with mission, vision and values

As the list indicates, organizational effectiveness “is about doing everything you know to do and doing it well.”⁵ For the

MHA, the five principles articulated by SAMSHA served as its guidepost in doing everything it could do and doing it well. For others, however, the path toward transformation may differ.

In a presentation offered during the Annual Executive Seminar on Systems Transformation sponsored by the New York Association of Psychiatric Rehabilitation in Albany in April 2010, Dr. Ragins spelled out another possible “formula” for success. Doing something different should be an informed process, he noted, that builds on exposure and enthusiasm for recovery, believability and motivation for change, action, technical expertise, and sustainability. The following are the 10 principles he outlined to guide recovery transformation.

1. The purpose of the mental health system is to help people with mental illness have better lives.
2. The mental health system must be centered on people, not illness.
3. Medical treatment should be integrated into the recovery-based system of care, with the goal of helping people rebuild their lives.
4. The outcome of services and supports is not to be symptom free. It is to have a good life.
5. Treatment plans should focus on where people are at in their recovery process, not the state of illness.
6. Sustained, coordinated leadership is essential to transformation. Leadership must keep an eye on change at every step along the way.
7. “Learning cultures” are crucial to helping staff reflect on the work they do and changes they would like to see, and for ongoing discussion and assessment of progress.
8. A culture in which leadership and line staff respect each other fosters collaboration.
9. Employing people engaged in care as well as family members is essential to bring authentic recovery experience to the daily work.
10. Staff needs are important needs. Leadership must attend to the emotional health of employees, showing empathy and nurturing, particularly during challenging times.

Recovery to Practice Resource Center

Headed by Dr. Larry Davidson, the Center is designed to help mental health providers adopt and use recovery-oriented practices. It involves (1) creating a Recovery Resource Center, complete with web-based and print materials, training, and technical assistance for mental health profession-



als, and (2) developing and disseminating curricula and training materials on recovery-oriented practice for each of the major mental health professions. Read the Center's first quarterly newsletter at http://dsgonline.com/rtp/rtp_ene newsletter/Final_4_30_10.html.

Fortunately, there is a growing body of research that demonstrates that people recover and resource materials are available to guide practitioners toward transformation of their practices and their systems of care. One very current example is the “Recovery to Practice Resource Center,” which was set up by SAMSHA in June of 2010 to promote recovery-oriented practices among mental health providers.

So, if you have been considering strengthening effectiveness and seeking change, there is no time like the present to tap into the resources around you and get started.

What are we waiting for?

Chapter 7 Endnotes

- 1 Ragins M. A guide to mental health transformation on a personal level. Available at <http://www.village-isa.org/Village%20Writings/A%20Guide%20to%20Mental%20Health%20Transformation%20526%20final.pdf>.
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